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A REVIEW OF CHILDREN'S BEHAVIORAL HEALTH SERVICES

S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES

LEGISLATIVE AUDIT COUNCIL

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S.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Introduction and Background

Audit Objectives

Members of the S.C. General Assembly requested that we conduct an audit of the S.C. Department of Health and Human Services (DHHS) and determine how the agency's reimbursement policy and other policy changes since 2007 have impacted children's behavioral health services in South Carolina.

We conducted survey work at the agency, reviewed relevant documentation, and consulted with the primary audit requestor to clarify and define issues for review. Our audit objectives are as follows:

- Discuss how the primary changes made in S.C. Department of Health and Human Services' (DHHS) policies and practices and other state agencies in recent years affected the delivery of children's behavioral health services.
- Determine how DHHS is monitoring the managed care organizations (MCOs), including what performance measures are used, how DHHS is ensuring that children are receiving the proper treatment and length of stay to complete the plan of care, appropriate discharge planning, and tracking outcomes of the children discharged from Psychiatric Residential Treatment Facilities (PRTFs).
- Evaluate the effects of introducing MCOs on July 1, 2017, including the different protocols of each MCO.
- Determine what steps DHHS has taken to ensure the current method of payment and rates for children's behavioral health services are sufficient to ensure access to quality care.
- Determine if state laws regarding placement and education of children in PRTFs are being followed and if these children are receiving the required educational services and proper oversight.
- Review DHHS' decision to place a moratorium on new providers in the state and, if lifted, how the agency will vet, enroll, and monitor new providers.
- Evaluate DHHS' transparency and communication with other state agencies and providers, including notification of policy changes, provider manual changes, and responsiveness to questions.

Scope and Methodology

The period of our review was generally years 2007 through 2018, with consideration of earlier and more recent periods when relevant. To conduct this audit, we used a variety of sources of evidence, including the following:

- Interviews with DHHS employees, employees of other state agencies, officials from other states, and interested parties.
- Medicaid Management Information System (MMIS) data.
- Surveys of states in the Centers for Medicare & Medicaid Services (CMS) Region 4.
- Practitioners in the field of psychiatry.
- Survey of South Carolina psychiatric residential treatment facilities (PRTF).
- Federal and state laws and regulations.
- Medicaid state plans from South Carolina and neighboring states.
- Rehabilitative behavioral health services (RBHS) provider maps produced by University of South Carolina Institute for Families in Society.
- DHHS' policies, procedures, and internal reports.
- Inter-agency agreements.
- Medicaid bulletins and memoranda.
- Contracts for children in out-of-state placements.
- Records of Medicaid claims.
- MCO contracts and reports.
- External quality review reports for managed care organizations.

We notified other state agencies that we may develop recommendations applicable to any of these agencies because of their involvement with children's behavioral health services. These agencies included:

DEPARTMENT OF SOCIAL SERVICES (DSS)
DEPARTMENT OF JUVENILE JUSTICE (DJJ)
DEPARTMENT OF MENTAL HEALTH (DMH)
DEPARTMENT OF EDUCATION (SDE)
DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS (DDSN)
CONTINUUM OF CARE (COC)

Criteria used to measure performance included, primarily, state and federal laws, agency regulations and policies, the practices of other state agencies handling Medicaid, and principles of good business practices and financial management. We reviewed some data in its entirety and used several samples, both statistically valid and judgmental, of children with MCO claims, children placed in PRTFs, behavioral health providers, and behavioral health fraudulent providers. Sampling methodologies are described in the audit report. Our findings are detailed in the report.

We also interviewed staff regarding various information systems used by the agency. We determined how the data was maintained and what the various levels of control were. We reviewed internal controls of the systems in several areas and noted any identified weaknesses in the report.

We conducted this performance audit in accordance with generally accepted government auditing standards, with one exception (see *Scope Impairment*). Those generally accepted government auditing standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We did not conclude from this review that the S.C. Department of Health and Human Services should be eliminated; however, our audit includes recommendations for improvement in several areas.

Scope Impairment

Generally accepted auditing standards require us to report significant constraints imposed upon the audit approach that limit our ability to address audit objectives. One of our primary audit objectives was to determine how DHHS is monitoring the managed care organizations (MCOs), including what performance measures are used, how DHHS is ensuring that children are receiving the proper treatment and length of stay to complete the plan of care, appropriate discharge planning, and tracking outcomes of the children discharged from psychiatric residential treatment facilities.

To make these determinations, we requested:

RAW DATA

We provided parameters to identify a population from which to select a sample in April 2018; however, we did not receive this data until late September 2018 (after legislative involvement). We could not identify the population without this data. Once we reviewed the data, we found that it was missing the MCOs with which the children were affiliated and provider data. DHHS resubmitted the data with this information. Later, while researching our inquiry concerning missing data on providers, DHHS realized that the data originally failed to include children whose Medicaid ID began with the digit "0". DHHS then submitted another 65,000 lines of data. This delayed our analysis by six months.

DOCUMENTATION

Auditors asked questions and requested information or documentation repeatedly but were met with incomplete or erroneous information and constant delays. For example, we identified over a dozen requests made with reasonable turnaround times (usually developed by the staff involved) with few answered by those times. In fact, at least five requests took over one month to be answered, either partially or in its entirety. One of those requests took DHHS over three months to answer and one took over five months to respond. Some of the requested information was documentation that should be readily available. We noted some of these instances throughout the report.

MANAGEMENT MONITORED DOCUMENTATION REQUESTED BY AUDITORS

All answers, documentation, and evidence forwarded to us by DHHS staff was channeled through the agency's liaison. Management commented that this was to ensure that we received the correct information. In most cases, however, we had requested this information from senior-level staff in the appropriate divisions who would have the most knowledge about the requests. We found no need for this much control by the agency. At one point, we were told that all responses to auditors were forwarded to the agency director before being sent to the auditors. This was, in our opinion, a deliberate delay which hindered our ability to complete the audit in a timely manner.

This behavior by DHHS significantly delayed the audit.

LAC Surveys

In June 2018, we surveyed Southeastern states including North Carolina, Georgia, Florida, Mississippi, Kentucky, Alabama, and Tennessee. We requested each state's Medicaid state plan. We also requested information on best practices for children's behavioral health services (now referred to as RBHS), including how they monitor the managed care organizations (MCOs) and availability and access to care, appeals, and if the agency tracks children when discharged from PRTFs or other care. Managed care is defined as a health care delivery system that attempts to manage the quality and cost of medical services through contracted arrangements between state Medicaid agencies and managed care organizations.

We also surveyed all South Carolina PRTFs in June 2018. We had an 83% response rate. Questions were designed to obtain anonymous feedback on how changes implemented by DHHS, rate changes, and the change in funding for group homes have affected the PRTFs. We asked about the benefits and concerns of working with the MCOs and the PRTFs' overall impressions about children's behavioral health in South Carolina.

Survey of Southeastern States' Results

We found that DHHS has not implemented some of the successful program practices used by neighboring states. To determine the effectiveness of South Carolina's Children's Behavioral Health Services (CBHS) Medicaid program and how rates are calculated, we surveyed Medicaid state agencies within CMS Region 4, including Georgia, Mississippi, Alabama, Tennessee, Florida, Kentucky, and North Carolina. North Carolina only responded to the rate calculation portion of the survey. The survey reveals several examples of ways neighboring states have successfully implemented CBHS.

Identifying Best Practices

One of the questions on the survey asked respondents what they considered best practices for implementing CBHS. The general consensus among the surveyed states was to integrate other stakeholders involved in CBHS in the decision-making processes.

GEORGIA
An interagency directors' team was created in which all child-serving agencies, child/family advocates, and provider organizations collaborate to develop a strategic roadmap for improving children's behavioral health across the state.

TENNESSEE
In order to improve CBHS, Tennessee partnered with various stakeholders such as the Tennessee Department of Children's Services, the Tennessee Council on Children and Youth, and the Tennessee Department of Health and Substance Abuse Services.

KENTUCKY, MISSISSIPPI, AND ALABAMA
Wraparound services were implemented where providers and parents were included to provide better behavioral care for children.

In South Carolina, different types of wraparound services, or community support services, are offered. One of the community support services offered by DHHS is Family Support Services. The purpose of Family Support Services is to assist and encourage families of children with behavioral healthcare needs to use resources and supports available to strengthen and empower the families and improve their quality of life.

While DHHS has made efforts to integrate family members/caregivers into the care of beneficiaries, these groups have not been central in the policy development process for CBHS. DHHS did not include families/caregivers in leadership meetings regarding the RBHS and PRTF inclusion into the managed care benefit (also referred to as the carve-in.) Additionally, no public forums were held for the RBHS and PRTF carve-ins.

Determining Adequate Provider Networks

When asked how a state ensured that the provider networks were adequate, the surveyed states responded as follows:

- All the surveyed states have methods to determine the sufficiency of their provider networks. These included practices such as utilization reports and specific provider network requirements (e.g. number of providers relative to the number of beneficiaries).
- Most of the surveyed states explained that there is a shortage in behavioral health providers. This is true in South Carolina, as well as nationally.

South Carolina requires MCOs to submit a monthly claims accuracy report.

Monitoring Access to Care

In monitoring access to care, most of the surveyed states mentioned that their MCOs are contractually obligated to abide by particular criteria for access to care.

MISSISSIPPI
Provider network requirements are used, such as geographic access standards and appointment scheduling timeframes, to measure access to care. Mississippi's provider network requirements are found in its coordinated care organization (CCO) contracts.

GEORGIA
Access to care is monitored through a contracted external quality review organization (EQRO) and stays in regular contact with the provider community.

ALABAMA
Has its own Quality Monitoring Unit and Data Analytics Unit.
South Carolina follows similar practices by requiring its providers to meet the department's standards for timely access to care and services in MCO contracts. Ensuring that providers are open at hours that are accessible to beneficiaries, providers are located in areas accessible to beneficiaries, and that a sufficient number of providers speak a language other than English to communicate with beneficiaries can improve care for beneficiaries.

Measuring Effectiveness of CBHS

Another question we asked the surveyed states was how they measure the effectiveness of CBHS. The surveyed states responded that they use a variety of tactics to measure the effectiveness of RBHS including:

- External quality reviews.
- Evaluations through state agency partnerships.
- Requiring submissions of quality measures by CCOs.
- Access monitoring plans.

DHHS requires annual external quality review reports of MCOs. DHHS also requires MCOs to have ongoing Quality Assessment and Performance Improvement projects to improve the quality of care provided to enrolled members through performance improvement processes. DHHS only requires submission of these projects as necessary.

Analyzing Cost Benefit of MCOs

Georgia, Tennessee, and Mississippi have stated that they conducted cost-benefit analyses before implementing a managed care benefit. We asked DHHS for documentation of cost-benefit analyses for major policy changes such as the RBHS and PRTF carve-ins. DHHS was unable to provide us with this information.

Recommendations

1. The S.C. Department of Health and Human Services should widen the scope of access to care described in MCO contract provider network requirements to include a provider hours of operation requirement and a requirement on the number of providers available to speak a language other than English.

2. The S.C. Department of Health and Human Services should implement cost-benefit analyses for future, major children's behavioral health policy changes.

Background

According to the S.C. Department of Health and Human Services' website, its mission is to purchase the most health for our citizens in need at the least possible cost to the taxpayer. Its vision is to be a responsive and innovative organization that continuously improves the health of South Carolina. The agency administers Title XIX of the Social Security Act (Medicaid). As of February 2019, the agency employed 1,261 staff.

FY 17-18	
TOTAL BUDGET	$7,623,134,767
GENERAL FUNDS (included)	$1,317,414,661

Impacts of Policy Changes in Children's Behavioral Health Services (CBHS)

One of our audit objectives was to evaluate how the changes made to policies and practices by DHHS and other state agencies in recent years affected the delivery of children's behavioral health services.

We found areas in need of improvement:

- There is a lack of planning by child-placing state agencies to continue funding for children needing placement in an appropriate group home facility.
- Private providers may or may not accept children needing behavioral health services, based on various criteria, and the closure of DMH's "no-eject, no-reject" PRTF has decreased the options that are available for placement, especially for DJJ youth.
- South Carolina does not currently have a coordinated system to track children who are placed in out-of-state care.
- DHHS does not track or monitor managed care enrollees who are placed in out-of-state facilities to ensure they are receiving the appropriate level of care.
- DHHS lacks policies and procedures for tracking out-of-state placements for children needing behavioral health services and waiver participant placements.
- The RBHS moratorium on the enrollment of providers is preventing school districts, that opted not to enroll at the time of the carve-in to managed care, from re-enrolling to offer RBHS services.
- State agencies that place children in out-of-state facilities do not always notify school districts, in a timely manner, that one of their students has been placed in an out-of-state treatment facility.

Policy Changes Impacting South Carolina Children

The transition of children's behavioral health, psychiatric residential treatment, and autism services involves multiple state and non-state agencies including, but not limited to:

DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)
DEPARTMENT OF JUVENILE JUSTICE (DJJ)
DEPARTMENT OF MENTAL HEALTH (DMH)
DEPARTMENT OF SOCIAL SERVICES (DSS)
DEPARTMENT OF ALCOHOL AND OTHER DRUG ABUSE SERVICES (DAODAS)

A timeline is provided for this multi-faceted system of care.

CMS' Guidance to DHHS

In 2004, the Centers for Medicaid & Medicare Services (CMS) requested that South Carolina Medicaid rework its state plan related to children's services to move all children's services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) section of the state plan. In June 2004, CMS notified DHHS that certain services may be at risk for disallowance of federal funds.

Further adding to the requirement that DHHS update the state plan, a financial management review of South Carolina mental health rehabilitative services, covering FY 06-07, was completed in 2010. CMS found certain rehabilitative services to be ineligible for federal funds participation (FFP), approximately $33 million.

In addition, CMS found that two facilities with more than 16 beds were engaged in providing diagnosis, treatment, or care for persons with mental diseases. CMS declared those two facilities to be institutions for mental disease (IMD), which are not eligible for FFP. CMS completed an additional review and found 26 facilities that it considered to be IMDs, of which only one was authorized as a PRTF. CMS held that DHHS improperly claimed FFP for services provided by 25 facilities that it considered to be IMDs, which included group homes.

CMS also found that DHHS used bundled payments to reimburse at the same payment level regardless of the types of services provided, the types of practitioners who provided the service, or the number of services received by a beneficiary. CMS policy prohibits the use of bundled payment rates for non-institutional services because such rates violate the requirements of Section 1902(a)(30)(A) and 1902(a)(32) of the Social Security Act.

The services in question included therapeutic foster care, therapeutic behavioral services, psychosocial rehabilitation services, and others.

In response, DHHS agreed to update the state plan to ensure that the service descriptions, provider qualifications, and reimbursement methodology were in compliance with federal guidelines. DHHS agreed to no longer submit claims for FFP for any non-institutional residential facilities that could be considered an IMD. Therapeutic behavioral health services (group homes) were transitioned to 100% state funding over an 18-month period. DHHS agreed to update the state plan to implement a system that makes payments to individual providers based on the discrete service being provided and on the qualifications of the practitioner providing the service.

Children's Behavioral Health Services—Bundled to Discrete

The updates that DHHS made to the state plan included separating bundled children's behavioral health services into discrete services. The discrete services were renamed "rehabilitative behavioral health services" (RBHS) and were approved by CMS effective July 1, 2010.

In February 2013, DHHS returned to using bundled rates for some services, which included substance abuse care for outpatient and residential treatment services for adults and children. The bundled services are restricted for services rendered by the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS). Even though bundled rates were developed for substance abuse services, DAODAS is still required to track and report the discrete service components of each bundled service according to the state plan.

In July 2014, DHHS removed the referral form that other state agencies were required to complete in order for children to receive services. DHHS' goal at the time was to open access to care. DHHS' concern was that access was being limited by the agencies and that individuals would not be referred to care if the respective agency did not have sufficient matching funds. As part of this process, DHHS officials worked to get the required matching funds, previously given to each state agency, transferred to DHHS.

During this period of transition, with the removal of state agencies as the "gatekeepers" to refer individuals for care, RBHS provider enrollment and the use of behavioral health services dramatically increased.

In February 2015, DHHS implemented a moratorium on the enrollment of RBHS providers, which was still in place as of April 2019. Over time, DHHS implemented multiple policy changes regarding the use of prior authorization, staff credentials, staff-to-client ratios, frequency limits of services, and other restrictions. An agency official noted that DHHS utilizes policies to limit and control provider behavior.

In July 2016, DHHS transitioned RBHS into managed care. According to an agency official, MCOs have more flexibility in the providers with whom they choose to contract; therefore, MCOs have more flexibility in controlling the provider network for their enrollees.

Psychiatric Residential Treatment Facility Services

Psychiatric Residential Treatment Facilities (PRTFs) originally received payment as an all-inclusive, per diem rate for Medicaid-eligible individuals residing in a residential treatment facility. Length of stay for an individual ranged from 1 month to more than 12 months, depending on the individual's psychiatric condition, which requires a physician's review every 30 days.

In 2009, CMS notified DHHS that certain facilities, including group homes, did not qualify for federal funds. South Carolina subsequently enabled those facilities to become PRTFs in order to continue to receive federal funding for Medicaid beneficiaries placed in the PRTF. According to a DHHS official, these changes led to a decrease in placement options for individuals.

By 2012, the DMH Mental Health Commission had decided to close both the female PRTF and the male PRTF that it operated. These facilities primarily housed DJJ juveniles and were considered to be the only "no eject, no reject" facilities available.

In July 2017, the PRTF services were carved into managed care services. The rate was adjusted to remove ancillary services and allow those to be billed separately by the appropriate provider. DHHS' intent was that PRTFs could enroll the ancillary services and bill for those outside of the per diem rate. As of February 2019, no providers had elected to enroll ancillary providers.

Autism Spectrum Disorder Services

In July 2014, CMS issued an informational bulletin guiding state Medicaid programs toward offering medically necessary diagnostic and treatment services to children under the age of 21 with Autism Spectrum Disorders (ASD). In July 2017, DHHS added ASD treatment services to the Medicaid state plan, which made services available via fee-for-service or managed care. South Carolina currently has some of the lowest rates of reimbursement for autism services.

Timeline

Table 2.1 reflects the numerous changes that DHHS and other entities have made regarding Medicaid services and other significant events that impact how South Carolina cares for children in its custody and children who receive Medicaid.

Table 2.1: S.C. Timeline of Medicaid Policy and Other Changes in Children's Behavioral Health Services

Effective Date		Subject of Impact	Description
State Plan Language Prior to Changes Below		PRTF	PRTFs shall be paid an all-inclusive per diem rate, calculated using the base year cost report data trended forward for each facility. The all-inclusive rate provides reimbursement for all treatment related to the psychiatric stay, psychiatric professional fees, and all drugs prescribed and dispensed to a client while residing in the residential treatment facility.
		PRTF	Residential treatment facilities are neither acute care nor long-term care facilities. Length of stay may range from 1 month to more than 12 months depending on the individual's psychiatric condition, as reviewed every 30 days by a physician.
		PRTF	PRTFs required to file Medicaid HCFA-2552 cost reports based on each facility's fiscal year end, to be submitted within 150 days of the last day of the cost reporting period.
		PRTF	State-owned and -operated PRTFs will receive retrospective cost settlements at 100% of allowable costs.
1994	Apr-01	PRTF	In-state psychiatric residential treatment facilities are required to be licensed by DHEC in order to receive Medicaid reimbursement.
1995	Feb-17	DJJ	*Alexander S. v. Boyd* lawsuit regarding juveniles in the care of S.C. Department of Juvenile Justice settlement.
2001	Oct-01	PRTF	PRTF rate methodology changed to be an "all-inclusive" rate.
2004		RBHS	CMS requested that South Carolina re-work its State Plan related to children's services to include all children's services under the EPSDT section.
	Jun-24	DHHS	DHHS was notified by CMS that services may be at risk for disallowance for certain services provided through its EPSDT Children's Rehabilitation Services Program.

Table 2.1: (Continued)

Effective Date		Subject of Impact	Description
2005		PRTF	PRTF services require prior authorization and referral by child-placing state agencies and Greenville Hospital System MIP using Form 254. Agencies include Continuum of Care, DMH, DSS, DDSN, DJJ and, on a limited basis, DAODAS and MUSC.
2007	Jul-25	PRTF & Group Homes	Proviso 8.35 allowed entities enrolled as High Management Group Homes to become PRTFs with Medicaid-provided licensing obtained from DHEC. High Management Group Homes allowed to request and be granted a Certificate of Need exemption from DHEC for up to the number of beds existing as of 1/1/07 to establish PRTFs.
	Aug-01	Group Homes	Notification issued to state agencies regarding the initial rate reduction for Therapeutic Behavioral Services (formerly high and moderate management group homes) and supervised independent living skills. Each agency was also notified of its respective allocation of the $13 million appropriated by the General Assembly to offset the anticipated loss of federal funds for group homes services.
2008	Sep-01	PRTF	State-owned and -operated PRTFs and non-state government-owned and -operated PRTFs will be settled at 100% of allowable costs. No cost settlement for PRTFs paid the statewide average rate.
2009	Jan-01	CBHS	Notification issued that federal reimbursement for therapeutic behavioral services (formerly high and moderate management rehabilitative services and supervised independent living) will no longer be available.
	Jul-01	PRTF	The Child and Adolescent Level of Care Utilization System (CALOCUS) will be required as pre-admission criteria for placement in a PRTF. Only clinical professionals certified by DHHS shall administer the CALOCUS.
	Aug-01	CBHS	Notification that Therapeutic Foster Care (TFC) will be reduced on or after 8/1/09. In addition, $13 million was appropriated by the General Assembly to DHHS to be transferred to child-placing state agencies within the first quarter of FY 09-10 to offset the loss of federal funds for TFC services. No additional state funds will be forthcoming from DHHS for this purpose.
	Oct-14	DHHS	CMS notified DHHS of issues identified in a review of FY 06-07 activity. The issues included the lack of discrete services identified in the state plan, bundled rate payment issues, and IMD-related payment issues that required corrective action.
2010	Jul-01	RBHS	Medicaid bulletin issued to announce the new RBHS manual. Discrete RBHS services and rates approved for implementation. State owned and non-state owned governmental providers will be reimbursed at 100% of their allowable Medicaid costs based on the review and reconciliation of annual cost reports.
		PRTF	DHHS Form 257 for Inpatient Psychiatric Residential Treatment Services Authorization required.
		RBHS	DHHS announces the new Licensed Independent Practitioner (LIP) Rehabilitative Services Provider Manual and the transition from the DHHS referral/authorization form 252 to 254.
		PRTF	The DMH Mental Health Commission decided to close the female PRTF, Directions.
2011	Apr-08	PRTF	Revision of rate methodology with 3% reduction to 97% of the rates in effect as of 10/1/2010 except for the largest teaching hospital in the state.
2012	Oct-01	PRTF	Eliminates retrospective cost settlement and establishes prospective per-diem rates based on the providers' most recent cost report trended to the rate year ending September 2013 for PRTFs.
		PRTF	DMH will no longer receive retrospective cost settlements for its PRTF. Cost reports will be reviewed. If overpaid, federal portion of payment will be recouped.
		PRTF	DMH Mental Health decided to close the male PRTF, Options, upon relocation of the Hall Institute from the Bull Street property to Northeast Columbia (which occurred in 2015).

Table 2.1: (Continued)

Effective Date		Subject of Impact	Description
2013	Jan-01	PRTF	DHHS will require prior authorization (PA) for Inpatient Psychiatric Services for Children under 21 from the Quality Improvement Organization (QIO), KEPRO.
	Feb-01	RBHS	Adds substance abuse to outpatient and residential treatment services for adults and children as part of RBHS and provides for bundled rates for these services. Provider reporting for bundled services requires the tracking and reporting of individual-covered services included in the bundle.
2014	Jul-01	PRTF & RBHS	Elimination of the referral forms 254 and 257 requiring state agency approval. Trainings offered several dates in May 2014.
		PRTF	5% rate increase for PRTFs.
	Jul-07	ASD	CMS issued an informational bulletin guiding state Medicaid programs toward offering medically necessary diagnostic and treatment services to children under the age of 21 with Autism Spectrum Disorders (ASD).
2015	Jan-12	DSS	*Michelle H. v. Haley/DSS* lawsuit filed regarding shortages of foster homes, excessive caseloads, and failure to provide basic and necessary health care to kids.
	Feb-6	RBHS	Moratorium on enrollment of RBHS providers implemented.
	Mar-01	RBHS	RBHS policy changes involving medical necessity and prior authorizations, staff credentials, staff-to-client ratio, frequency limits and reimbursement rates and modifier changes apply to fee for service RBHS only. KEPRO provided web-based training three dates in February 2017.
	May-01	RBHS	RBHS policy changes involving prior authorization, staff credentials, staff-to-client ratio, frequency limits, and reimbursement rates and modifier changes for Psychosocial Rehabilitative Services. These changes apply to fee for service RBHS only.
	Sep	PRTF	DMH PRTF, Options, officially closed.
	Nov-01	RBHS	Implementation of changes to the RBHS policy manual to strengthen fee-for-service Medicaid requirements related to several areas of the provider manual including: provider accreditation, provider and staff credentials, and business requirements. Clinical directors required to be SC Licensed Practitioners of the Healing Arts.
2016	Jan-01	RBHS	Notification of RBHS policy manual general revisions that will be effective on or after 1/1/16. Changes will apply to fee for service RBHS only. Policy changes include clarifications regarding medical necessity, parent/caregiver/guardian agreement required by KEPRO, same day service exclusions, frequency and reimbursement change in the CALOCUS assessments, modification of the minimum CALOCUS score for prior authorization, training changes, list of non-billable activities, and changes to identify billable places of service.
	Mar-22	RBHS	Outpatient and RBHS managed care training offered. Providers wishing to continue to provide services are required to attend a training on 3/22/16, 3/25/16, 4/6/16, or 4/7/16.
	Apr-01	RBHS	Announcement of revisions to the RBHS policy manual to clarify what practitioners may provide core treatment services. This revision will be applicable on or after 4/1/16.
	Jun-03	DSS	*Michelle H. v. Haley/DSS* lawsuit settled with agreement to increase caseworker staffing, reduce caseloads, redesign the foster care licensing system, and conduct a campaign to recruit foster care parents.
	Jul-01	RBHS	RBHS added to managed care.
		RBHS	Adds community integration service and therapeutic foster care services to the RBHS service array.
		RBHS	Changes to the RBHS policy manual will impact medical necessity, prior authorization documentation, clinical service note deadlines, service changes, discharge plan of action required, medical necessity for community support services, addition of a behavior modification plan, clarification regarding the diagnostic assessment, and the inclusion of new services including Community Integration Services and Therapeutic Childcare Center services. The bulletin notes that it is not intended to reflect all of the revisions in the manual.

Table 2.1: (Continued)

Effective Date		Subject of Impact	Description
2017	Early	PCSC Waiver	DHHS issues notice that the agency intends to apply to CMS for a 1915(c) waiver for children and youth up to age 21 with significant behavioral health challenges who would otherwise be treated for psychiatric conditions in inpatient settings - Palmetto Coordinated System of Care waiver.*
	Jul-01	ASD	Effective 7/1/17, Autism Spectrum Disorder (ASD) treatment services will be added to the SC Medicaid State Plan. Services will be available via FFS and managed care organizations. Providers could enroll 4/21/17.
		PRTF	DHHS will include PRTF services and providers in the coordinated care benefit provided by SCDHHS-contracted managed care organizations (MCOs). Individuals not choosing or not mandatorily assigned to an MCO will continue to access PRTF services through the DHHS Medicaid fee-for-service benefit. Additional changes in policy were also noted including: emphasis on family-driven, youth-guided care; seclusion and restraint requirements; serious occurrence reporting; changes to training requirements including mental health first aid training; documentation changes for admission and continued stay; continuity of care; notification to DHHS regarding monthly treatment team meeting, and addition of therapeutic home time service
		PRTF	Elimination of all-inclusive rate for PRTFs. Established pay rate for core facility services, room and board, psychological training, testing, and assessment services on a per diem basis. All ancillary services will be billed separately and paid based on a fee schedule.
2018	Apr-01	ASD	The policy manual for autism spectrum disorder (ASD) services will be implemented including quality improvement organization prior authorization, age guidelines for definitive diagnosis, behavior technician provider qualifications, guidelines for linking Applied Behavior Analysis (ABA) providers to their group, and guidelines regarding transition and discharge planning.
	Jul-01	ASD	ABA provided by a registered behavior technician increased to $15.50 per 30 minutes for procedure codes 0364T and 0365T. Providers will no longer utilize procedure codes 0360T, 0361T, 0362T, and 0363T for ABA services.
		PRTF	Public notice issued regarding a 3% rate increase for PRTFs for the additional cost increases incurred as a result of program requirements mandated by the agency during the previous year.

* As of September 2019, this waiver had not been implemented.

A few of the significant changes by DHHS are shaded in blue.

Source: LAC

Group Home Funding

There is a lack of planning by state agencies to continue funding for children needing placement in an appropriate group home facility. DHHS officials have acknowledged that there is a gap in placement options between the PRTF level and therapeutic foster care. DHHS discontinued payment for high and moderate management group home placements following an FY 06-07 financial review by the Centers for Medicare & Medicaid Services (CMS). CMS found that 25 of 52 facilities were considered institutions for mental disease (IMD), for which DHHS should not have requested federal funds. South Carolina transitioned these services to 100% state funds.

History

Prior to 2009, DHHS funded an array of children's behavioral health services, including high and moderate management residential group care, known as therapeutic behavioral services. The homes were licensed by DSS, and facilities varied in bed size from a 5-bed group home to a facility with up to 150 beds. For Medicaid beneficiaries, the services were paid for as a per diem rate that required authorization by a referring state agency in order to be reimbursed by Medicaid. State referring agencies included:

CONTINUUM OF CARE
DEPARTMENT OF MENTAL HEALTH
DEPARTMENT OF SOCIAL SERVICES
DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
DEPARTMENT OF JUVENILE JUSTICE
DEPARTMENT OF EDUCATION

CMS conducted a final financial management review of South Carolina mental health rehabilitative services for FY 06-07. During this review, CMS identified facilities that were engaged in providing diagnosis, treatment, or care of persons with mental diseases. CMS indicated that DHHS should not have billed the federal Medicaid program for these services. Of the 52 facilities reviewed, 26 had more than 16 beds and only 1 of those was licensed as a PRTF. CMS deemed 25 facilities to be IMDs.

DHHS resolved this by discontinuing to claim federal Medicaid funds for any non-institutional residential facilities that could be considered IMDs. These services were transitioned to 100% state funding over an 18-month period, beginning August 1, 2007 and ending December 31, 2008.

DHHS notified applicable child-placing agencies that the General Assembly provided $13 million in FY 07-08 as the first year of multi-year transitional funding to these agencies to offset the anticipated loss of federal funds for group home services. A separate allocation of $900,000 for group home reimbursement of non-treatment services, only for high management levels of care, was also distributed to the impacted state agencies. Additional funds were provided in the following two fiscal years as well. DHHS notified the child-placing state agencies in July 2009 that no additional funding would be forthcoming from DHHS for group home placements.

Impact

We requested information from each of the six child-placing state agencies regarding use of the transitional funds for group home placements.

Most agencies were not able to provide the requested information due to the transition to the South Carolina Enterprise Information System (SCEIS) and the lack of available records. Two agencies, DSS and DMH, indicated that funds may have been used for purposes other than group home placements, and one agency noted that mid-year budget cuts reduced the amount of funds available for group home placements.

Only one agency, DSS, indicated that it requested funds from the General Assembly beyond the three-year transition to state funding for group home placements; however, the funds were not appropriated.

According to a DHHS official, the typical path of care for a child with behavioral health needs would start with an in-patient facility, transition to a PRTF, next would be group home placement, and then therapeutic foster care; however, there is currently a gap between PRTFs and therapeutic foster care. Several state agencies noted that youth are awaiting placement in group home facilities due to a lack of available beds.

Chart 2.2: Children's Step-Down Medical Placements

Source: DHHS

Recommendation

3. The S.C. General Assembly should direct the Child Advocacy Office to create a task force to study and recommend ways to incentivize the development of additional levels of placement for youth and prioritize funding, and the tracking thereof, for children's residential placement.

S.C. Department of Mental Health Psychiatric Residential Treatment Facility (PRTF)

Alternative placements for DMH and DJJ children are limited. Private providers may or may not accept the youth, based on various criteria, and the closure of DMH's "no-eject, no-reject" PRTFs has decreased the options that are available for placement.

DMH PRTFs

In 2003, DMH separated its PRTF facility into two programs, by gender. Females were served by the Directions program and males were served by the Options program. Both PRTFs primarily served the DJJ population with few referrals from the community. In 2010, the referrals to the DMH PRTFs started declining. In December 2010, the Mental Health Commission decided to close the Directions facility due to the decreased need for female PRTF beds. With additional declines in referrals, the Mental Health Commission decided, in 2012, to discontinue PRTF services upon relocation of the Hall Institute from the Bull Street property to Northeast Columbia. The result was the closure of the Options PRTF in September 2015. This closure created a placement gap in the system of care for these individuals.

DMH officials noted that it is difficult to take DJJ children into one PRTF. They typically do not get the necessary therapy due to the disruptive nature of the juveniles when kept together and "…It basically created another juvenile justice system outside of DJJ." Officials also noted that law enforcement had to be kept onsite when the PRTF was in operation.

When asked whether DMH would reconsider opening a new PRTF, agency officials indicated that DMH does not have the space for a PRTF or a facility to renovate to use as a PRTF. The agency also noted that hiring the appropriate staff is a huge issue. The agency received funding in FY 17-18 to open 30 forensic unit beds; however, hiring staff to care for individuals in those beds has been difficult. As of February 2019, the agency only had sufficient staffing to provide care for 21 of the 30 beds.

DMH officials mentioned that the nature of PRTF services has changed. Juveniles were typically in the DMH PRTF for one or two years based on the DJJ guidelines; however, Medicaid services are authorized for shorter periods of time and are based on medical necessity rather than sentencing guidelines. Stays beyond the prior authorization of Medicaid, if eligible, would require state funding to cover the cost.

DJJ Group Home

DJJ officials have noted increased difficulties in accessing appropriate placements. The closure of the DMH PRTFs left DJJ officials seeking alternative placements for the juveniles in its care. DJJ officials indicated that private providers do not want to provide PRTF services to DJJ juveniles. The only "no-eject, no-reject" placement facility available was DMH's PRTFs. DJJ officials acknowledged that extended stays in secure facilities have occurred due to the unavailability or inability to access and place children at the appropriate level of care in the community.

DJJ officials have experienced increased challenges in working with other state agencies that question 'subclass' inclusion. 'Subclass' juveniles are those who would be deemed seriously mentally ill, whose custody would be ordered from DJJ to DMH. DJJ officials feel that this may be due to the potential need for state funds to be used to pay for residential care when Medicaid funds are not available. Officials noted that staffing for juveniles has become more about who is responsible for the placement and, thus, who is responsible for full payment for that individual's care from state funds.

In an effort to provide alternative placement for DJJ juveniles, DJJ is in the process of issuing a request for proposal (RFP) to open an intensive service group home for DMH and DJJ children that will provide step-down placement with PRTF-type services and staffing. The intent is to have a facility available in order to remove the children with mental illness from "behind the fence."

In May 2018, DJJ officials stated that the intended date for requesting bids was at the end of the month with a projected "go-live" date of September 2018 to open the group home for seriously mentally ill juveniles. However, as of April 2019, the RFP had not been issued.

Recommendation

4. The S.C. Department of Juvenile Justice should continue to assess the need for alternative placements for the youth it serves and pursue appropriate levels of care, including the establishment of an intensive group home.

Out-of-State Placements

South Carolina does not currently have a coordinated system to track children who are placed in out-of-state care. A state law requiring that no child be placed in an out-of-state alternative setting beyond 50 miles without exhausting all in-state options and justifying the necessity of placement was repealed by Act 160 of 2018.

DHHS lacks policies and procedures for tracking out-of-state placements for children with behavioral health, medical and health placements, and waiver participant placements. DHHS does not track or monitor managed care enrollees who are placed in out-of-state facilities to ensure they are receiving the appropriate level of care.

No State Entity Tracking Out-of-State Placements

A DHHS official stated that, as of January 2018, 11 South Carolina Medicaid children were in out-of-state placements. We requested documentation from DHHS, beginning in August 2018, regarding the children placed in out-of-state care and the fees paid for that care. We did not receive all of the information until the end of January 2019. We confirmed the 11 placements based on a review of contracts between DHHS and the respective out-of-state facilities. Children were placed in out-of-state facilities for specialty care, such as pediatric specialty nursing care, care for eating disorders, and other mental health and medically-needed care. However, we found that the data did not include all Medicaid-enrolled individuals who were placed in out-of-state facilities for treatment.

In an effort to ensure that we received a complete list of individuals in out-of-state placement, we reviewed placement data from DSS and identified several individuals who were Medicaid managed-care enrollees who were placed in out-of-state care. These children were not included in the data that we received from DHHS. We asked DHHS whether there would be a placement agreement directly with DHHS when individuals are sent out-of-state by an MCO. The agency responded that the contract would be between the MCO and the provider. When asked if DHHS tracked the individuals placed out-of-state by managed care, DHHS indicated that "…it is the MCO's primary responsibility to monitor and track these individuals."

We also found that DHHS does not have agency policies or procedures for tracking out-of-state placements. One employee was responsible for tracking all out-of-state placements; however, when that individual left the department, the work was transferred with only verbal instruction. Tracking is now separated into three groups—behavioral health placements, medical and health program placements, and waiver participant placements. However, it does not include out-of-state placements by managed care entities.

Repeal of the Children's Case Resolution System

Act 160 of 2018 repealed the Children's Case Resolution System (CCRS) and statutory language formerly in Article 11, Chapter 11 of the S.C. Code of Laws governing placement of emotionally-disturbed children in out-of-state treatment facilities. State law required that no child could be placed in an alternative setting out-of-state, beyond 50 miles of the state line, without first exhausting placement options in state and unless the affected state agencies, working with a child, explained the necessity of that placement.

Since CCRS was repealed, we tried to determine what entity would be responsible for tracking children placed out-of-state. We found that no agency would assume responsibility. If children placed by a state agency in treatment facilities out-of-state, notwithstanding their Medicaid status, are not properly tracked and monitored, some children may possibly be placed in facilities longer than necessary or become unaccounted for altogether.

Medicaid Payments for Out-of-State Care

A DHHS official acknowledged that certain specialty providers do not exist in South Carolina. Examples would include PRTF facilities that treat individuals who are deaf, in need of pediatric nursing care, or facilities that treat eating disorders. When individuals need this specialized care, DHHS utilizes facilities in other states to provide the necessary services.

An agency official indicated that when South Carolina sends a child out-of-state, DHHS' position to negotiate is weak and the agency may pay the market based rate. Another agency official stated that he attempts to ensure that the rate paid by DHHS is the state-approved Medicaid rate for the provider in its respective state.

We reviewed the contracts received from DHHS for services provided by out-of-state medical and PRTF providers. The rates paid by Medicaid for PRTF services ranged from approximately $306 to $550 per day. Medical specialty services ranged from $463 to $1,220 per day.

We focused on PRTF services and compared the respective state-allowed, Medicaid rate for each of the PRTF providers with the rate paid by South Carolina Medicaid. For services rendered by one out-of-state provider, DHHS paid approximately 13% less than that provider's state Medicaid-allowed daily rate for 2018; however, DHHS paid 30% more than the state, Medicaid-allowed rate for another out-of-state provider.

DHHS paid the state Medicaid-allowed rate for a PRTF facility in another state; however, according to an official at the facility, the daily rate includes educational costs as part of the all-inclusive rate. DHHS may be using federal Medicaid funds to pay for the educational component of the rate, an expense which is not an allowable cost.

Other Agencies' State Funds Utilized for Out-of-State Care

State agencies are covering the remaining daily amount charged by out-of-state providers to ensure the children receive placement. A review of DSS' out-of-state placement contracts revealed that one out-of-state provider's daily rate is $531.53 per day, not the $305.55 paid by Medicaid. For several individuals, Medicaid paid $305.55 while DSS paid the remaining balance. In some instances, DSS paid for full care of individuals being placed out-of-state.

Other state agencies also provide additional funding in order to pay for placements. For example, South Carolina does not have an in-patient facility that offers treatment for eating disorders, so individuals requiring that level of care must be sent out of state. The daily rate for treatment at one provider is $1,350 per day. South Carolina currently has individuals receiving this treatment. Medicaid is paying $305.55 per day, the daily PRTF rate. The remaining balance is paid by one or more state agencies with state funds, over $1,000 per day, per person.

Recommendations

5. The S.C. Department of Health and Human Services should develop policies and procedures for tracking and monitoring all Medicaid out-of-state placements for children.

6. The General Assembly should amend state law to direct the S.C. Department of Administration, Office of the Governor, (or new Office of Child Advocacy) to monitor the placement of all children in out-of-state treatment facilities when those children are placed by a state agency, regardless of their Medicaid status, and the funding sources for payments for all such treatment.

7. The S.C. Department of Health and Human Services should ensure that unallowable Medicaid costs are not included in the per-diem rate, and, if so, are paid with allowable, non-Medicaid, funds.

8. The S.C. Department of Health and Human Services should evaluate ways to incentivize specialty care providers, such as those that treat eating disorders or provide pediatric nursing care, to operate within South Carolina.

Oversight of MCOs Needs Improvement

Our audit objectives were to evaluate how DHHS is monitoring the managed care organizations (MCOs) and the effects of transitioning children's behavioral health services to managed care.

We found that DHHS:

- Did not undertake a cost-benefit analysis before transitioning rehabilitative behavioral health services (RBHS) and psychiatric residential treatment facility (PRTF) services into managed care.
- Had not, prior to our review, measured the MCOs' performance using measures related to children's behavioral health.
- Is unable to effectively monitor the incidence of events that occur to children when they are discharged from a behavioral health facility, including a PRTF.
- Relies on an external quality review (EQR) process that does not provide information specific to children's behavioral health services and does not disaggregate data by significant characteristics that would allow the agency to determine whether certain issues are disproportionately affecting enrollees.
- Fails to systematically review the MCOs' documentation of the use of the "medical necessity" standards and relies on the relatively few appeals that members file as a way to monitor whether MCOs are correctly applying it.
- Does not sufficiently analyze grievances and appeals handled by the MCOs.
- Fails to document and conduct meetings and site visits conducted in connection with its monitoring of MCOs.

Review of Medicaid Claims for Children Denied Initial or Reauthorized PRTF Placement

From our review of prior authorization data and Medicaid claims data, we found:

- Approximately one in four children who were denied placement in a PRTF sought inpatient or outpatient treatment within 30 days after submitting a prior authorization request that was denied.
- Almost one in five of these children sought treatment on an inpatient or outpatient basis within 31–60 days.
- Families are not taking advantage of the internal appeal process when MCOs deny a prior authorization.
- A determination that the placement is not medically necessary is the primary reason MCOs deny placement.

Overall Population

We requested data on children who received behavioral health services from any provider, including doctors, therapists, hospitals, and pharmacies. We requested data on children who were no older than 18 on the date of service, had a primary or secondary behavioral health diagnosis, were continuously enrolled in Medicaid from October 1, 2015 to March 31, 2018, and with two professional outpatient placements or one in-patient placement during the period. DHHS responded with 4,947,330 Medicaid claims covering the period October 1, 2015–May 30, 2018. We reviewed these 4.9 million claims and found that 2.6 million of them were claims for children enrolled in managed care. The remainder were claims for children enrolled as Medicaid fee-for-service beneficiaries. We counted 20,290 children with behavioral health diagnoses, of whom 18,173 were enrolled in an MCO.

Prior Authorization Requests for Placement in a PRTF

We requested data on prior authorization requests for PRTF placements. DHHS submitted data on 3,210 prior authorization requests for PRTF placements. The data show that that MCOs approved 92.8% of the requests and denied 6.9%. The remainder were either partially approved or pending. The children ranged in age from 8–18. The average age of the child at the time of the request was 14.

Children Denied Prior Authorization for PRTF

We reviewed the cases of those children who had prior authorization requests to determine whether any of these denials were followed by inpatient or outpatient treatment within one to two months of their making a request that would be denied. We identified 170 children and 200 prior authorization denials.

We compared the Medicaid claims data of each child to determine if the children represented by those 200 denials received medical treatment within 30 days of their initial prior authorization request or within 31–60 days. In slightly fewer than one of four cases where the MCO denied a prior authorization, the child would receive inpatient or outpatient services within 30 days; in one in five cases where the MCO denied a prior authorization, the child would receive inpatient or outpatient services within 31–60 days.

Table 3.1: Number of Cases Where the MCO Denied a Prior Authorization and the Child's Family Requested a Review of that Decision and the Denial Was Followed by Other Inpatient or Outpatient Treatment within 30 Days

Internal Review	Number of Cases Where Denial was Followed by Other Treatment within 30 days			Total
	No	Yes	Cannot Determine	
No	96	35	16	147
Yes	34	13	6	53
TOTAL	130 (65%)	48 (24%)	22 (11%)	200 (100%)

Sources: DHHS and LAC

Our claims data only covered medical claims filed through May 30, 2018. In some cases, we were unable to determine whether a child sought treatment within 31–60 days because the claims data was unavailable. We report these cases as "cannot determine." Therefore, the number of cases in which children were denied placement, but subsequently sought treatment, could be higher.

Table 3.2: Number of Cases Where the MCO Denied a Prior Authorization and the Child's Family Requested a Review of that Decision and the Denial Was Followed by Other Inpatient or Outpatient Treatment within 31–60 Days

Internal Review	Number of Cases Where Denial was Followed by Other Treatment within 31–60 days			Total
	No	Yes	Cannot Determine	
No	91	28	28	147
Yes	32	11	10	53
TOTAL	123 (61.5%)	39 (19.5%)	38 (19%)	200 (100%)

Sources: DHHS and LAC

Diagnosis of Children Who Sought Treatment

We found cases where children who were denied placement sought treatment within 60 days for a variety of conditions. In one case, a child with a primary diagnosis of conduct disorder sought treatment for a black eye. Although we were unable to determine whether this condition resulted from behavior that was connected to his behavioral health diagnosis, we thought we should include this case among those who sought treatment subsequent to his denial. Similarly, we included the case of the child who sought treatment for lacerations and who suffers from mood disorders. We also found children who sought treatment and whose primary diagnosis was homicidal ideations. The number of such cases may be small relative to the total number of children with Medicaid claims; however, it remains unclear that DHHS or anyone else is reviewing such data. Such analysis will allow the agency to have more confidence that MCOs are appropriately applying the medical necessity standard and that children who should be approved are not being denied services because of errors in the application of this standard.

Reason for Denying Requests

Of the 200 cases we reviewed, we found MCOs denied two-thirds of them on grounds of failure to meet the medical necessity standard. MCOs also reported denying requests because the child was not enrolled in the MCO at the time, the provider failed to provide sufficient clinical documentation, or the provider was out of network.

Type of Request and Requests for Appeal

When an MCO denies a request to cover a service, the children and families have a right to request an internal review. As shown in Table 3.3, nearly two-thirds of those cases were not subject to internal review, suggesting that families did not request one.

Table 3.3: Number of Appeals by Type of Request

Request Type	No	Yes	Total
Initial	48	11	59
Reauthorization	99	42	141
TOTAL	147 (73.5%)	53 (26.5%)	200 (100%)

Sources: DHHS and LAC

Of the 200 requests, 141 (71%) were requests for reauthorization. Only 59 (29%) were requests for initial placement. Requests for reauthorization were more likely to undergo internal review than were initial requests, possibly because the child is already in a PRTF and could be better positioned to request an appeal.

Relying on the MCOs' own data, they are approving most prior authorization requests. MCOs are denying requests for any of several reasons, including insufficient information or the fact that a child was not enrolled in the MCO at the time of the request; but the overwhelming reason is a lack of medical necessity. Most of the prior authorization requests that were denied were requests to reauthorize PRTF services. In most cases, the families of these children are not appealing for a review of their children's denials; but when they do, it generally occurs when the child has a placement and is requesting an extension.

Recommendations

9. The S.C. Department of Health and Human Services should follow-up with children who are denied approval for initial or extended placement in psychiatric residential treatment facilities to determine if they are requiring medical treatment within 60 days of their request and if the conditions for which they are seeking treatment are connected in any way to the diagnosis for which they originally sought placement in a psychiatric residential treatment facility.

10. The S.C. Department of Health and Human Services should use the results of this systematic follow-up, along with other information it collects, to determine if managed care organizations are applying the medical necessity standard correctly.

Evaluating Effects of Managed Care Carve-In

Before integrating RBHS and PRTF services into managed care, DHHS:

- Did not undertake a cost-benefit analysis.
- Overlooked the possibility that children, faced with fewer approval decisions on extended PRTF placement, would be forced to find alternative placements and the means to pay for them.
- Failed to consider whether alternative, step-down placement options for children, upon discharge, were even available.
- Made decisions intended to result in cost savings to Medicaid, over the long-term, without regard to the costs that would be shifted to children and families and other stakeholders in the mental health system.
- Relied exclusively on MCOs to attest that they had provider networks sufficient to meet the needs of mentally ill children enrolled in managed care.

We attempted to trace the agency's decision process which led to the managed care carve-ins. DHHS was only able to produce two memoranda—a Medicaid bulletin and the minutes of one Medical Care Advisory Committee (MCAC) meeting. We had requested all documentation, including any cost-benefit analysis that led to the decision to integrate behavioral health services into managed care. DHHS was unable to provide any analysis to support its argument that integration with managed care would benefit children needing behavioral health services. The one set of minutes of the MCAC stated only that DHHS presented on the PRTF carve-in and that no one asked a question. There was nothing to suggest that DHHS had considered its approach to monitoring the MCOs or patient access to, or quality of, care.

No Cost-Benefit Analysis

DHHS did not perform a cost-benefit analysis. We made two requests for documentation of a cost-benefit analysis. In response, DHHS claimed that the plan to include behavioral health within managed care was something that had been under consideration for an unspecified length of time. According to DHHS, managed care was necessary to gain control of RBHS expenditures and ensure that PRTF placements were medically necessary; if they were not, then the state risked losing federal match dollars. DHHS believes that managed care has advantages over traditional fee-for-service when it comes to care coordination, care quality, and access to a better network of qualified providers.

Managed care was expected to be budget neutral in the short term, resulting in savings over time. Managed care was to provide better care coordination and, in the case of PRTF services, shorter stays in PRTF facilities. DHHS also relied on a report of an independent organization, on which a DHHS management official served, to support its decision to integrate behavioral health into managed care. This report emphasized the need to integrate physical and mental health care. Improved coordination of health services and cost containment, especially cost containment resulting from shorter stays in PRTFs, were among the goals of the managed care carve-in.

Lack of Viable Aftercare Placements for Children Discharged from PRTFs

We were contacted by families, PRTF operators, and other stakeholders about children who were in need of treatment in secured facilities, but who had been denied initial and extended placement because the MCO concluded that PRTF placement was not “medically necessary.” We spoke with PRTF operators and parents struggling to find medical care for mentally ill children who have been denied PRTF placement, and for whom no viable placement alternative exists. Children are caught in the crossfire between MCOs that refuse to pay for placement; PRTFs unable to provide treatment for free, yet, unwilling, in some cases, to release a child they know to be too ill to be discharged; and state agencies incapable or unwilling to pay for care from their own funds.

In our review of the documentation of DHHS’ decision to implement the carve-in, we found nothing to indicate that the agency considered whether appropriate aftercare existed. DHHS is not solely responsible for the mental health system in South Carolina, but is a key payer of mental health treatment. DHHS should have recognized that its actions would have consequences for that system; and it had a responsibility to, at least, not worsen the problems in the mental health system.

We asked DHHS if the agency monitored post-discharge experiences such as emergency department visits or contacts with law enforcement. According to DHHS, the agency tracks post-discharge clinical treatment for fee-for-service and managed care, but did not document that with any examples or explain what is done with that analysis. DHHS provided us with a chart to document its claim that MCOs are approving PRTF placements, but for shorter lengths of stay. Since placement in PRTFs was integrated into managed care effective July 1, 2017, DHHS can only show results for one year, from FY 16-17 to FY 17-18. DHHS should expand this analysis to determine if shorter lengths of stay continue and are followed by more frequent visits to emergency departments and more prior authorization requests for PRTF services for these same children.

Provider Network

DHHS did not take any steps to ensure that the MCOs had sufficient networks to handle the caseload and verify that the providers possessed the proper credentials, at the time of the RBHS carve-in. MCOs were only required to attest that services would continue as they had been. DHHS did not independently confirm that the MCOs' provider networks were sufficient to address the needs of the Medicaid enrollees.

The decision to integrate behavioral health services into managed care has been made. If MCOs continue to approve shorter lengths of stay, then there will continue to be a need for alternative placements for some children.

Recommendation

11. The S.C. Department of Health and Human Services should track post-discharge clinical treatment for children discharged from psychiatric residential treatment facilities.

Quality Strategy

We reviewed DHHS' quality strategy, which is its plan for improving the quality of managed care services required by federal regulation. We found that DHHS did not respond to our request for the following:

- An explanation on what triggers a review of the quality strategy.
- Information on whether the quality strategy is reviewed periodically, the frequency, and documentation of any changes made to the strategy in the wake of the RBHS and PRTF carve-ins.
- Anything to indicate what triggers adjustment to the quality strategy or what defines a significant change.
- Any indication that the agency solicited or received input from other stakeholders, including those from the behavioral health community, unless stakeholders and beneficiaries communicated their concerns directly to members of the Medical Care Advisory Committee (MCAC).

States are required to develop a written strategy with input from recipients and other stakeholders and make the strategy available for public comment. The agency's strategy for monitoring the quality of services provided by the MCOs includes:

- History of South Carolina Medicaid managed care.
- Agency goals for better health, fiscal responsibility, member services, and agency management of the Medicaid program.
- Brief description of the process for developing the plan and goals.
- Monitoring strategies, including the external quality review and a list of reports that MCOs must submit.
- Standards for access to care, member enrollment in a MCO, and provider selection.
- Detailed description of the grievance and appeal procedures.
- Explanations of quality improvement initiatives, such as the agency's quality index withhold program, in which a portion of the MCO's claim payment is withheld and earned back if the MCO meets certain performance thresholds.

In January 2019, we requested the latest version of the quality strategy, list of recipients and stakeholders who provided input, and agency policy, if available, detailing what triggers a review of the quality strategy. We also requested information on whether the strategy is reviewed periodically, and the frequency and documentation of any changes made to the strategy in the wake of transitioning RBHS and PRTF services into managed care.

In response, DHHS submitted a document for 2018 marked "DRAFT." We confirmed that this was the agency's response to our request.

DHHS did not provide a list of stakeholders who provided input, nor did the agency respond to the other requests. However, we found language in the document which states that:

> …The process for assessing and updating the Quality Strategy document is to examine MCOs' quality performance through the year, make adjustments whenever significant changes are needed to the Quality Strategy document and publish the Quality Strategy document for solicitation of public comment for 30 days.

There is nothing to indicate what triggers adjustment to the quality strategy or what defines a significant change. According to the document, "key partners and stakeholders will be solicited for feedback" through the MCAC. We found nothing to indicate that the agency solicited or received input from other stakeholders, including those from the behavioral health community, unless the range of interests and concerns among stakeholders and beneficiaries are effectively channeled through the MCAC. The MCAC includes representatives from various sectors of the healthcare community, including the National Alliance for Mental Illness and the Protection and Advocacy for People with Disabilities.

Providers and interested parties told us they had concerns that their voices have not been heard. This could be another example of the agency's failure to communicate effectively with stakeholders outside the agency. In the absence of any documentation to the contrary, we have no reason to believe this failure does not extend to DHHS' process for producing this quality strategy.

We recognize that the quality strategy is required by federal regulation to be submitted to the Centers for Medicare & Medicaid Services. However, the quality strategy is a description of the state's plan for monitoring quality in managed care; and, as such, the state has a significant interest in seeing that DHHS has a quality strategy that is aggressive and robust.

Recommendation

12. The S.C. Department of Health and Human Services should actively expand its solicitation for input, including those serving children with a behavioral health diagnosis, parents, and caregivers, and document the approaches it takes, the type of input received, and how that input is incorporated into the agency's quality strategy.

Assessing Quality of Care

When measuring the quality of care provided by each MCO, prior to October 2018, DHHS had not fully:

- Applied any standards for behavioral health to evaluate the MCOs or determine if they are eligible for any financial rewards.
- Evaluated the MCOs' performance using measures related to children's behavioral health.
- Implemented performance measures that capture the incidence of events that occur to children when they are discharged from a mental health facility, including a PRTF.

In October 2018, DHHS informed the MCOs that it had decided to create a behavioral health index comprised of four behavioral health measures from a national dataset and information system. The agency will decide at a later date whether any or all of those measures will be used in making decisions about each MCO's eligibility to receive financial incentive rewards. DHHS currently relies on measures from the Healthcare Effectiveness and Data Information Set (HEDIS) to measure the quality of the five managed care plans with which it has contracts.

Healthcare Effectiveness and Data Information Set (HEDIS)

HEDIS is a set of healthcare performance measures developed by the National Committee for Quality Assurance (NCQA), a nonprofit national organization that develops and maintains measures used by health plans and states to monitor healthcare program quality and effectiveness. These measures allow consumers and policy-makers to compare how well a health plan performs in terms of quality of care, access to care, and health plan member satisfaction. The 2019 list of HEDIS measures includes 78 measures applicable to Medicaid. Of those 78, we identified 5 pertaining to children's behavioral health and effectiveness of care and 2 more measures addressing access to and availability of care for CBHS.

DHHS requires all MCOs to be accredited by NCQA. NCQA evaluates each MCO using HEDIS measures, including those dealing with behavioral health, as part of its accreditation program. Therefore, performance on behavioral health measures has been a factor in determining whether an MCO is eligible to enter into a contract with DHHS to become a health plan provider; but those measures have not been used to reward performance.

Quality Withhold Bonus Program

The quality withhold bonus program is an incentive program to reward MCOs when they meet performance standards selected by DHHS as measured using HEDIS metrics. Under this program, DHHS withholds 1.5% of the quarterly premium payments, approximately $42 million per year. If the MCOs perform well on the HEDIS measures, they can earn back the money that was withheld. The funds that are not earned back are left for a bonus pool. Exceptional performance can result in their receiving additional payouts from the bonus pool. None of the states responding to our survey of other states reported that they provide bonuses/incentives to MCOs. However, we found that pay-for-performance programs are becoming popular among states as they try to incentivize behavior aimed at improving health outcomes.

Until 2017, behavioral health was not a factor in determining whether an MCO was awarded a bonus under this program. At that time, DHHS limited the data to measures dealing with diabetes, women's health, and pediatric preventive care. In 2017, DHHS required the MCOs to collect data on six behavioral health HEDIS measures for the purpose of deciding which among them would continue to be used to evaluate MCO performance. As shown in Table 3.4, most—five of the six—HEDIS measures relate to children.

Table 3.4: HEDIS Behavioral Health Measures on Which MCOs Collected Data, 2017

HEDIS Measure	Target Population
Antidepressant medication management	Assesses adults 18 years and older with a diagnosis of major depression who were newly treated with antidepressant medication and remained on their antidepressant medication.
Follow-up care for children prescribed ADHD medication Initiation Phase	Children 6-12 years diagnosed with ADHD and who had one follow-up visit with a practitioner with prescribing authority within 30-days of their first ADHD prescription.
Follow-up after hospitalization for mental illness	Adults and children 6 years of age and older hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 7 days of discharge and within 30 days of discharge.
Use of first-line psychosocial care for children and adolescents on antipsychotics	Children/adolescents, without an indication for antipsychotic medication use, had documentation of psychosocial care as first-line treatment before being prescribed an antipsychotic medication.
Metabolic monitoring for children and adolescents on antipsychotics	Children and adolescents with ongoing antipsychotic medication use who had metabolic testing during the year.
Initiation and engagement of alcohol and other drug dependence treatment Initiation Phase	Adults and adolescents 13 years and older with a new episode of alcohol or other drug dependence who initiated treatment within 14 days of diagnosis.

Source: DHHS and the National Committee for Quality Assurance

In October 2018, DHHS notified the MCOs that they should continue to collect data on all the measures but the data they collect on four of the six could be used to determine their eligibility for monetary incentives in 2019. The four are:

- Antidepressant medication management.
- Follow-up care for children prescribed ADHD medication—initiation phase.
- Metabolic monitoring for children and adolescents on antipsychotics.
- Initiation and engagement of alcohol and other drug dependence treatment.

Three of the four measures involved assessments on children. DHHS explained that methodological considerations and alignment with other priorities, including the agency's commitment to addressing the opioid epidemic, led to its decision.

Member Enrollment

DHHS uses the MCO performance on HEDIS measures to enroll a Medicaid beneficiary to a managed care organization when the beneficiary fails to make that selection. DHHS assigns those individuals to an MCO using a weighted formula that considers each MCO's ranking according to the NCQA standards as measured using HEDIS metrics. Therefore, according to DHHS, MCOs have an incentive to perform better and "earn" or attract more Medicaid enrollees.

We asked DHHS if the agency used, or was aware of, any HEDIS measures that focused on mental health-related emergency room visits. DHHS confirmed that there are two such HEDIS measures, both of which MCOs must also report annually, but which are not included in the determination of any financial reward. One is emergency department visits for adults and children with a mental health diagnosis who received a follow-up visit for mental illness; the other is emergency department visits for patients 13-years and older with a principal diagnosis of alcohol and other drug abuse dependence who had a follow-up visit for this.

We recognize the value of HEDIS, especially as HEDIS data is used to accredit MCOs with which DHHS contracts. The problem with relying exclusively on HEDIS, or any other system of its type, is that the agency risks defining quality in terms of the measures that are already available. The quality performance measures that DHHS collects should follow the agency's operational definition of quality and could include measures that are not on the HEDIS menu. That would require DHHS to include measures from other sources or develop its own.

For example, DHHS does not capture events that occur post-discharge from a behavioral health facility, including PRTFs. Expanding efforts to measure an event such as this will help ensure that children with behavioral health problems are receiving the quality of care they need as well as identify obstacles to care that the agency needs to overcome in order to provide quality care to this population. If such measures become available through HEDIS, then DHHS should consider implementing those; if not, then the agency should look elsewhere or develop its own.

Recommendations

13. The S.C. Department of Health and Human Services should include managed care organization performance on behavioral health measures when making awards through its quality withhold bonus program and the beneficiary assignment process.

14. The S.C. Department of Health and Human Services should implement performance measures that capture the incidence of events that occur when children are discharged from a mental health facility, including a psychiatric residential treatment facility.

15. The S.C. Department of Health and Human Services should analyze the behavior of each managed care organization to ensure none of the performance measures it uses has consequences that undermine access to care and the quality of care for children with behavioral health issues.

16. The S.C. Department of Health and Human Services should develop its own performance measures for children's behavioral health if none are already available from the National Committee for Quality Assurance or any other authoritative source.

External Quality Reviews

DHHS relies singularly on an external quality review (EQR) process, to the exclusion of any other independent review, despite the fact that the process falls woefully short of its potential to drill down and extract additional, substantive information that can be used to improve the quality of care for Medicaid children with a behavioral health diagnosis. We reviewed the external quality review reports for the five MCOs and found:

- The reports include nothing specific to children's behavioral health services.
- Data is not disaggregated by any significant characteristics that would allow the agency to know if the costs and benefits of managed care are disproportionately affecting one group of enrollees or another.
- No information about the sampling sizes or method of selecting samples of grievances and utilization management, including the prior authorization process.
- The provider network analysis does not include specialists in children's behavioral health.

- The reports include HEDIS measures, which are outcome measures of behavioral health services, but nothing in the reports allows DHHS to know how the MCO performs on those measures with respect to children's behavioral health services. Data is not disaggregated by age, gender, or another potentially significant characteristic.
- Nothing in the review of the grievance or appeal process explains how the cases were selected or how the number of records was determined.
- Sample sizes are only identified in the discussion of the provider access analysis.
- Nothing in the reports indicates that data has been disaggregated and analyzed in a way that allows DHHS to determine whether problems with the grievances and appeals or access to care are being overlooked.

Federal regulation requires that these reviews include:

- Validation of performance measurements reported by the MCO.
- Validation of performance improvement projects.

We asked DHHS for a list of all audits performed on each of five managed care organizations—Select Health, Molina, WellCare, Blue Choice, and Absolute Total Care. DHHS responded only with the external quality reviews. Therefore, we reviewed the most recently-available, external quality review reports for these MCOs. The external quality review is a review of managed care services, by an independent third party, known as external quality review organizations (EQRO). The EQRO evaluates and analyzes information made available by the MCO, on the quality, timeliness, and access to healthcare services. Federal regulations require that it occur annually.

We were told that the external quality review process takes approximately three months and involves a review of:

- MCO staffing and organizational charts.
- Provider list, member handbooks with information on the grievance procedure and call center operation, and documentation that the MCO is delivering all services required by the contract.
- Quality improvement plans.
- Policies and procedures for prior authorization, medical necessity determination, and appeals, and case management activities.
- Grievance, appeal, and complaint logs.
- Information on contracts between the MCO and third parties.

The EQRO submits a report to DHHS for its input. According to one EQRO official, DHHS has never provided input. DHHS sends the report to the MCO which develops a corrective action plan for any problem identified in the report. The corrective action is included in the next year's review. EQRO reviewers request files from the MCO, and each MCO has a particular time of year it is under review. This predictability could be problematic as MCOs know when they are likely to be reviewed. However, given the fact that reviews must be conducted annually, the opportunity to stagger them so as to minimize their predictability is limited.

We inquired about the sampling strategy used by the EQRO. An EQRO official told us that sometimes it allows the MCO to select the sample of records that its staff will review. This should never occur. In other instances, we were told that the EQRO staff will also select records. For example, they will request the MCO to provide a certain number of records, such as 20–25 records of appeals or grievances, within a certain date range.

DHHS does not ask that samples be stratified to account for different types of behavioral health. Instead, the reviewers ask the MCOs for "some acute care" and "some behavioral health." Reviewers look for "medical necessity' determination and randomly select files so they include behavioral health. They also include the pre-authorization, grievance, and appeals process within their audit scope.

States have flexibility to ask for other measures to be included in the external quality review in addition to the HEDIS quality measures. According to the EQRO official, Mississippi and North Carolina develop some of their measures; but we could not find documentation to substantiate that. There is nothing to prevent DHHS from developing metrics unique to children's behavioral health services, independent of the collection of data on HEDIS measures.

The external quality review process includes a provider access study that involves calling a sample of providers from a list of primary care physicians supplied by the MCO. The provider access study, however, does not include specialists in children's behavioral health services.

The independence of the external quality review process must be assured. When sampling methodologies are unclear or when it appears that some records might have been selected by the organization under review, the findings can be suspect. The number of records selected for review should be sufficient in size and scope to allow DHHS to monitor the effectiveness of the MCOs to which it has delegated so much authority.

Recommendations

17. The S.C. Department of Health and Human Services should require the external quality review organization to select the files according to a sampling strategy that allows the agency to be informed about the quality, timeliness, and access to behavioral health services that the managed care organization provides to children enrolled in its managed care plan.

18. The S.C. Department of Health and Human Services should require the external quality review organization to be specific in its reports about the sampling process, including sample sizes and the sample selection process.

19. The S.C. Department of Health and Human Services should stipulate in its contract with the external quality review organization that the managed care organization under review should not be allowed to select the records that will be audited.

20. The S.C. Department of Health and Human Services should require the external quality review organization to disaggregate data by any significant characteristics that will inform the agency as to how the managed care organization is performing so as to improve the quality, timeliness, and access to children's behavioral services.

21. The S.C. Department of Health and Human Services should require that the external quality review include a provider network access and telephone access study of behavioral health providers to determine if the managed care organizations have provider networks sufficient to meet the needs of children in need of behavioral health services.

Prior Authorization Reports

DHHS fails to provide MCOs with sufficient guidance on a definition of "medical necessity" and relies on the relatively few appeals that members file as a way to monitor whether MCOs are correctly applying the "medical necessity" standard. DHHS needs some other way to strengthen monitoring of the MCOs' application of this standard. We reviewed utilization management practices and prior authorizations and found that DHHS fails to require MCOs to:

- Submit prior authorization reports with data specific to children with behavioral health diagnoses.
- Use shared protocols for "medical necessity."
- Provide the names and qualifications of MCO staff, other than the name of the chief medical officer, involved in screening prior authorization requests.

Legal Framework

Federal Regulation

We found no definition of "medical necessity" in federal law, although MCOs must ensure that medical services are sufficient, in amount, for there to be a reasonable expectation to succeed. While MCOs cannot arbitrarily deny or reduce the amount of a service, Federal regulation 42 CFR 438.210 allows MCOs to place appropriate limits on services using criterion such as medical necessity. MCOs must specify what constitutes medical necessity in a way that is no more restrictive than state law, the state plan, and other state policies and procedures.

State Regulation

South Carolina Regulation 126-425 defines "medically reasonable and necessary" as being in keeping with:

> …procedures, treatments, medications or supplies ordered by a physician, dentist, chiropractor, mental health care provider, or other approved, licensed health care practitioner to identify or treat an illness or injury. Procedures, treatments, medications or supplies must be administered in accordance with recognized and acceptable medical and/or surgical discipline at the time the patient receives the service and in the least costly setting required by the patient's condition. All services administered must be in compliance with the patient's diagnosis, standards of care, and not for the patient's convenience. The fact that physician prescribed a service or supply does not deem it medically necessary.

Therefore, according to South Carolina law, treatment must be consistent with what the medical community recognizes and is acceptable at the time the treatment is received. It must be provided in the least costly setting, but the setting in which the treatment is administered must be consistent with what the patient needs. This suggests the opportunity for some discretion and the use of one's best clinical judgment when making a prior authorization decision. State regulation concludes by stating that what constitutes medical necessity should be consistent with the patient's medical needs, and not the patient's convenience. Meeting the "medically reasonable and necessary" standard demands more than simply referring to the fact that a particular service has been ordered.

State Contracts

We reviewed the contracts that DHHS has with each of the five MCOs. We found that, among the provisions governing utilization management, these contracts:

- Require MCOs to have policies and procedures and protocols for determining medical necessity and ensure that only licensed clinical professionals with appropriate clinical expertise review and approve prior authorization requests. There is nothing that requires the person to be licensed and in good standing in South Carolina.
- Establish timeframes for service authorization and have a process for expedited authorizations.

Monthly Prior Authorization Reports

We found that the utility of the monthly prior authorization reports in monitoring services for children with behavioral health diagnoses is not as compelling as it could be. DHHS informed us that it uses prior authorization reports, in addition to other reports, to monitor the MCOs.

We asked DHHS to tell us the specific questions the prior authorization reports were intended to answer. DHHS told us the reports, themselves, reflect the questions. Therefore, we requested monthly prior authorization reports from July 1, 2016–September 30, 2018. DHHS responded with documents labeled "PRTF Prior Authorization Report" from each MCO from October 2017–October 2018.

The format allows the MCO to report the number of:

- MCO enrollees.
- Prior authorization requests held over from the previous month.
- Prior authorization requests received in the current month.
- Approved new and continuing service requests.
- Denied requests for new or continuing services.

We found that the reports are inconsistent.

- Four MCOs reported the number of enrollees; one did not.
- Three MCOs were not consistent in the information provided on "average processing time," the average amount of time to respond to a prior authorization request.
- One consistently reported "24" with no further explanation. Two others had a similar response in several of their reports.

Incomplete and inaccurate reports diminish their usefulness. The prior authorization process is critical to access to care. Therefore, information in these reports should be timely, accurate, and complete.

LAC Review of Prior Authorization Information

DHHS is unable to conduct more thorough analyses of the prior authorization process and its impact on the access to and quality of care for Medicaid children with behavioral health diagnoses enrolled in managed care because it lacks the information necessary from the prior authorization reports. We requested reports summarizing prior authorization requests for each child requesting placement in a PRTF.

DHHS was unable to provide this information to us directly. The information came from the MCOs. Each MCO provided a report on the medical condition to be treated, the dates the authorizations were received by the MCO and when they were resolved, the number of days approved, and whether denials were subsequently reviewed by the MCOs.

We did not have access to the original prior authorization requests so we could not substantiate the accuracy of the information we received. We reviewed information on 3,210 prior authorization requests for initial and continued treatment from all five MCOs.

DHHS does not do any systematic review of the notes of MCO medical officers or other documentation to determine whether MCOs are correctly applying the medical necessity standard. According to DHHS, as reflected in Table 3.5, MCOs approved the overwhelming majority of authorization requests. While we found the frequency of denials reported by the MCOs to be low, we found, from the MCOs' own data, how few of them result in a request for an internal review on behalf of the child at the MCO level. For example, 124 denials by one MCO resulted in requests for only 20 internal reviews. Similar patterns were reflected in the summary reports of other MCOs.

Table 3.5: Frequency of Prior Authorization Decisions and Internal Reviews

Prior Authorizations	MCOs			
	Molina	Absolute Total Care*	Select Health	WellCare **
Approved	246	617	1,810	159
Denied	56	16	124	15
TOTAL	302	641	1,934	175
Internal Reviews	23	1	20	4

Note: Blue Choice submitted a report showing 45 authorizations. However, the report was organized to show the number of days, not individual authorizations, that were approved and disapproved. Therefore, the data, as presented, could not be compared in this table.

* 8 approvals were pending at the time of the report.
** 1 was partially denied.

Sources: DHHS and LAC

Children and their families must avail themselves of the MCOs' internal review processes, which may be intimidating to some, before appealing an adverse decision by a MCO to the state. Since there are so few children and families seeking those internal reviews, it follows that the number of appeals to the state will also be relatively few in number.

According to DHHS, it uses the appeal process as an opportunity to determine whether MCOs are correctly applying the medical necessity standard. We asked if DHHS reviews the notes of medical officers or other documentation to determine whether MCOs are correctly applying the medical necessity standard. According to DHHS, the agency does not do any systematic review, but, if someone appeals an adverse decision, the MCO must justify its decision. Since our review of prior authorization data found such appeals to be rare, there appears to be a need for some other vehicle by which to strengthen monitoring of the MCOs application of the medical necessity standard.

No Shared Protocols Across MCOs

We found that MCOs using InterQual, a protocol (a procedure or system of rules) used by three of the MCOs, were at least twice as likely to deny a prior authorization request as a MCO using an alternative protocol. We reviewed the protocols for the MCOs provided by DHHS. As stated previously, authorization hinges on whether a service is considered to be medically necessary. Three of the MCOs use InterQual, a health screening tool criticized by some interested parties as being invalid when assessing the needs of children with behavioral health diagnoses. The other two MCOs have different protocols. MCOs submit their protocols to DHHS for approval. As part of the external quality review process, each MCO's prior authorization decision process is evaluated for internal consistency. What is lacking is any focus on consistency in decision-making across MCOs, a condition made more challenging when managed care organizations use different protocols.

While our review of prior authorizations found that the MCOs reported that they overwhelmingly approved authorization requests, we did see evidence that a majority of denials were issued by MCOs using InterQual. Making a determination of medical necessity involves the application of valid criteria coupled with clinical judgment within the context of the child's overall medical condition and standards of practice. We understand that the same protocols, even if they were practiced by each of the five MCOs, in deciding the request for the same child, would not always result in exactly the same decision. However, DHHS does not have an adequate process to maximize consistency.

Inadequate Reporting on Qualifications of MCO Staff Conducting the Screening

DHHS' failure to have MCOs report so it can verify the qualifications of every person in the approval process is a serious abrogation of its oversight responsibilities given the pivotal role that this process plays in access to care. Despite delegating responsibility for the care of children with behavioral health diagnoses to private, for-profit managed care companies, DHHS does not know the names and qualifications of every person who participates in the screening and authorization approval process. DHHS only requires MCOs to provide the names of the chief medical officers. Other staff participate in the initial screening process.

We have heard numerous accounts of children denied authorization for initial or continued treatment in PRTFs. We found that the number of approvals is higher than incidence of denial, but DHHS confirms that while MCOs are approving prior authorizations for PRTF placement, lengths of stay since the PRTF carve-in have been declining. DHHS has a responsibility to ensure that those involved in the screening process are qualified and licensed in South Carolina.

The Inspector General (IG) of the U.S. Department of Health and Human Services is launching an investigation into whether MCOs are denying Medicaid beneficiaries access to covered services. This was in response to news reports of alleged abuses in the Medicaid managed care industry. The federal IG has agreed to add an audit to its schedule to determine if MCOs have a financial incentive to deny access to care.

Recommendations

22. The S.C. Department of Health and Human Services should ensure that the managed care organizations provide accurate and complete information as requested on the monthly prior authorization reports.

23. The S.C. Department of Health and Human Services should expand its data collection effort and analyze the prior authorization process and its impact on the access to and quality of care for Medicaid children with behavioral health diagnoses enrolled in managed care.

24. The S.C. Department of Health and Human Services should provide sufficient guidance to managed care organizations to enhance consistency in the application of the medical necessity criterion across managed care organizations.

25. The S.C. Department of Health and Human Services should know the names and qualifications of all persons in each managed care organization who are involved in the screening and approvals of prior authorization decisions and ensure that they are licensed in South Carolina.

Discharge Planning

We found evidence of MCOs denying continued authorization for PRTF treatment and children, subsequently being discharged from PRTFs, with no viable placement alternative. We also found that DHHS does not track children, after discharge, in order to monitor contact with emergency departments or the juvenile justice system. For example, we received information about children who have been:

- Discharged from a PRTF to a terminally-ill parent.
- Discharged with a four-day notice to a parent who had relocated to another state.
- Discharged to be returned to the grandparents he threatened to kill and who were already caring for another child.
- Denied continued treatment services despite having Autism and seizures and a parent who was institutionalized at the time.

The absence of viable placement alternatives once a child is discharged is aggravated when parents are not notified until the last minute. For example, we heard from two parents, each of whom was notified just days before their children were to be discharged. MCO contracts require that for termination, suspension, or reduction of a previously-authorized service, the MCO must give at least ten calendar days' notice before the date of action. In one case, a parent received notice that the MCO denied coverage and the child would be discharged within one day of the notification. That meant the PRTF would either discharge his child, continue to treat his child and absorb the cost, or continue to treat his child while forcing him to pay the cost.

Discharge planning is the responsibility of the PRTF. If a child is enrolled in managed care, the PRTF is supposed to include the MCO in discharge planning, along with the beneficiary's parents or guardians. If the child is enrolled in Medicaid as fee-for-service, the PRTF has the option of making a referral for targeted case management services.

The decision by a MCO to discontinue payment for treatment is not the same as a decision to deny care, although the ultimate effect is the same. Only the PRTF can discontinue treatment because the PRTF is the service provider. However, when a parent is confronted with having to care for a mentally ill child who is being discharged from treatment for which the insurer is no longer covering the cost, the need for viable placement alternatives becomes acute. We received information from interested parties about group homes with waiting lists and facilities that refuse to accept children with certain medical conditions or children who had been referred by DJJ.

We asked DHHS if the agency tracked children for whom behavioral health treatment services had been discontinued, to determine if, for example, they had subsequent contact with law enforcement or emergency departments. DHHS responded that it started tracking post-PRTF discharge behavioral health treatment and hospitalization in July 2017. However, DHHS also reported that for children receiving behavioral healthcare in managed care, the agency can only track emergency department visits if they are reported in the encounter records. Otherwise, there is no way to track those visits.

Tracking the effects on children denied coverage for PRTF treatment, including the extent to which costs are shifted to other players in the healthcare system, education, or the criminal justice system, would provide a more accurate picture of the gaps in our mental health system for children.

No Systematic Review of Medical Necessity

DHHS does not systematically review MCO documentation of its application of the "medical necessity" criterion for prior authorization decisions for behavioral health treatment, including placement of children in a PRTF. Federal regulation authorizes states and MCOs to place appropriate limits on medical services using criterion such as medical necessity. There is no federal definition of medical necessity, but MCOs are required to adopt protocols consistent with the definition as found in the state Medicaid plan, statute, and regulation.

DHHS reported that it does not review the notes of the MCO medical officers, or any other documentation from the MCOs, to determine whether the MCO medical officers or other MCO staff correctly applied the medical necessity standard in responding to a prior authorization request. According to DHHS, such reviews would only occur in the event of an appeal regarding medical necessity. In such instances, the MCO would have to defend its medical necessity decision.

As discussed in this audit, we found shortcomings in the external quality review (EQR) process as reflected in published reports. We found that those reports fail to document the number of records selected for review when auditors review the MCOs' utilization management program. DHHS can require that outside reviewers select and review children's records in sufficient numbers so as to be better assured that children in need of treatment and who meet the medical necessity standard are not inadvertently denied appropriate care. DHHS is responsible for ensuring that MCOs, to whom it has delegated responsibility for coordinating care, provide care to children who meet the medical necessity criterion. DHHS should not rely on the appeals process as a surrogate vehicle by which to police the appropriate use of the medical necessity standard.

Recommendation

26. The S.C. Department of Health and Human Services should conduct systematic reviews of prior authorization decisions for children requesting behavioral health services.

Grievances and Appeals

DHHS does not sufficiently analyze grievances and appeals handled by the MCOs. We reviewed the process for grievances and appeals and found:

- DHHS does not maintain documentation of its review of grievance and appeal logs.
- DHHS denied us access to some grievance data because it contained personally identifiable information.
- Families reported to us receiving correspondence from MCOs denying reauthorization for children in PRTFs with insufficient advance warning to find alternative placement or to file an appeal.
- Decisions by MCOs to deny authorization for services often do not result in requests for appeal.

Federal regulation, 42 CFR 438.400, requires MCOs to establish internal procedures under which Medicaid enrollees or providers acting on their behalf may challenge denial of coverage or payment for medical assistance. Federal regulation defines grievances and appeals and requires MCOs to establish procedures for processing grievances and appeals from members and providers.

Grievances

A grievance is an expression of dissatisfaction about any matter affecting the member's relationship with the MCO and provider, except actions. An "action" is defined as a decision to deny or limit services, deny payments, or failure to respond to grievances and appeals in a timely manner as required by federal law. As part of their monitoring responsibilities, states must have procedures for monitoring how MCOs process grievances. States must require MCOs to maintain records of grievances and must review their quality strategy documents.

In its contracts with the MCOs, DHHS requires each MCO to establish and maintain grievance procedures. MCOs must provide DHHS with monthly logs summarizing each grievance and appeal, with the member's name, Medicaid ID, filing date, resolution, and corrective action.

We asked DHHS how it monitors the MCOs' grievance processes. DHHS relies on the external quality review process (EQR) and its MCO liaisons to review monthly logs of grievances. We requested documentation of any problems or concerns that the EQR process or DHHS' liaisons have found. DHHS responded that the EQR process has not found any "systemic" problems.

We specifically asked DHHS about the types of reviews undertaken regarding the grievance data. We asked if the data was analyzed, how it was analyzed, and by whom. We also asked if DHHS looked for trends, if analysts compare MCOs to one another or against an independent standard for handling grievances. DHHS responded that its staff review grievance logs for appropriateness of entries, timeliness of resolution, and grievance patterns; but there are no standards for comparing MCO performance.

According to DHHS, its managed care staff discuss the results of these reviews during internal staff meetings. We requested documentation of meetings between MCOs and DHHS staff. DHHS responded that it had no minutes or other forms of documentation. Therefore, we were unable to verify, independently, what topics DHHS staff discussed and how they resolved any problems. We specifically asked for documentation of the reviews of grievance logs. DHHS informed us that it does not maintain documentation, but would implement a procedure for doing so.

Analysis of Grievance Logs

We requested the grievance logs for each MCO from July 1, 2015 through March 31, 2018. DHHS provided grievance reports containing aggregated data for each of the five managed care organizations. The months for which grievance data were available were inconsistent because some MCOs began reporting member-specific information that DHHS refused to release to us. For example, DHHS refused to provide reports for one MCO covering the period from July 2017–March 2018. Two others were missing for the period from April 2017–March 2018. Since October 2017, all MCOs must submit grievance logs that contain member-specific information. The reports that DHHS did provide showed the number of grievances related to billing, difficulty accessing care, member eligibility, MCO administration, medical treatment quality, dissatisfaction with a provider unrelated to medical care, and other issues that fail to fall within any of those categories.

PRTFs and Grievances

We surveyed PRTFs on the impact of managed care. Six PRTFs had not filed grievances against any MCO, while one filed two formal grievances and two others responded that they had filed “several.” PRTFs reported that they filed grievances because of authorization denials and premature discharges.

Appeals

Federal regulations also require states to establish an additional appeal process for members who are not satisfied with the results of the MCO's internal review process. As part of their monitoring responsibilities, states must also have procedures for monitoring how MCOs handle appeals. Just as they do with grievances, states must require MCOs to maintain records of appeals and must review their quality strategy documents.

MCOs must mail notices to members at least ten calendar days before ending or reducing a previously-authorized service. We received information describing communications received on a weekend, with only one day to spare, or with no sufficient alternative placement other than home before children faced discharge from a PRTF. We heard from a parent who received notification over a Thanksgiving holiday that the MCO coordinating care for the child would no longer pay for PRTF services. This same parent also told us that the MCO did not respond to a request for an internal review of its decision. While not required to do so, the MCO did not send any correspondence by certified mail, so there was no record to substantiate the date on which these families received their notifications.

In its contracts with MCOs, DHHS requires each MCO to establish and maintain an appeals' process. MCOs must authorize certain behavioral health services, including placement in a PRTF; and if the MCO denies services, the member can appeal that decision and request that the MCO review its decision. If the MCO does not reverse its initial decision, members can appeal to DHHS' Division of Appeals and Hearings. The contract that DHHS has with each of the MCOs provides timeframes within which MCOs must notify members of decisions to deny or modify services and for members to appeal. Members must use the MCO's internal review process before appealing to DHHS. Each month, MCOs must provide DHHS with logs summarizing each appeal, with the member's name, Medicaid ID, filing date, resolution, and corrective action.

We also asked DHHS about its approach to monitoring the appeals processes. As with grievance data, DHHS relies on the external quality review process and its MCO liaisons to review monthly logs of appeals. DHHS could not provide any documentation of DHHS' reviews.

MCO Appeal Process

In order to determine whether MCO enrollees were taking advantage of their right to request an internal review of a MCO's decision to deny services, we requested, from each of the five managed care organizations, reports showing each request for initial authorization and reauthorization for services in a PRTF for children over a 23-month period, from July 1, 2016–May 30, 2018. According to reports provided by each MCO and summarized in Table 3.6, MCOs approved a majority of the authorization requests for PRTF services.

Table 3.6: Determination of Prior Authorization Requests for PRTF Placements

	Absolute Total Care	Healthy Blue	Molina	Select Health	WellCare	Total
Approval	617	148	246	1810	159	2,988
Denial	16	10	56	124	16	222
TOTAL	641*	158	302	1934	175	3,210

* Eight requests were pending at the time the MCO reported data.

Source: DHHS and LAC

However, in those instances where MCOs denied authorization, families did not pursue a review through the MCO's internal appeal process. Across all MCOs, families confronting a denial of an authorization for PRTF services failed to appeal nearly 75% of the time.

Table 3.7: Request for Internal Review of Prior Authorization Denial

Type Of Prior Authorization	Internal Review		
	No	Yes	Total
Initial	48	11	59
Reauthorization	99	42	141
TOTAL	147 (73.5%)	53 (26.5%)	200 (100%)

Source: DHHS and LAC

State Fair Hearing

All Medicaid enrollees can appeal decisions to deny services to DHHS' Division of Appeals and Hearings in what is called the state "fair hearing" process. The division purports to operate at arms-length from the rest of the agency and is staffed with six hearing officers housed separately from the rest of the agency staff. According to a DHHS official, the appeals process can be confusing and people sometimes want to appeal directly to the division before exhausting their appeals with the MCO or KEPRO. KEPRO provides prior authorization for services for Medicaid children enrolled in fee-for-service (FFS).

We requested a report of all appeals filed since July 1, 2015 with the division by, or on behalf of children, who were currently receiving, or who had sought, behavioral health services. DHHS submitted a report showing 24 appeals covering the period from July 2015 through November 2018. Only nine of the appeals resulted from decisions by MCOs. The rest involved appeals of decisions affecting fee-for-service cases. Only 2 of the 24 went to an actual hearing, while the rest were dismissed or the issues were resolved before a hearing. Beyond this, we found the number of cases is too small to conclude whether beneficiaries are more, or less, likely to succeed in having an adverse decision governing their treatment reversed on appeal. However, it is clear that few instances of authorization denials result in the state fair hearing process.

Recommendations

27. The S.C. Department of Health and Human Services should maintain documentation of its review of grievance and appeals logs that deal with children's behavioral health services.

28. The S.C. Department of Health and Human Services should develop and implement a methodology for analyzing grievances and appeals involving children's behavioral health services so that the agency can retain the data and its analysis over time, so that it can detect trends and diagnose problems.

29. The S.C. Department of Health and Human Services should require managed care organizations to send correspondence denying reauthorization of psychiatric residential treatment facilities' services via certified mail so that there is a record substantiating when the child's family receives it.

30. The S.C. Department of Health and Human Services should develop standards against which to compare managed care organization grievance data to determine whether the number of and types of grievances indicate problems in particular areas of care coordination that the agency needs to address with the managed care organization.

Lack of Documentation and Inconsistencies in Conducting Site Visits and Meetings

DHHS has conducted site visits and held quarterly meetings with MCOs, but had no documentation of what occurs during these meetings including any issues, problems, or concerns that were identified; who was in attendance; what steps were to be taken, by whom, and according to what timeline. Also, according to information that DHHS could provide, the agency conducted these site visits and quarterly meetings on an inconsistent basis.

Quarterly Site Visits

According to DHHS, its staff make quarterly site visits to the offices of the MCOs for the purpose of meeting staff and understanding their operations. DHHS staff discusses those concerns with DHHS senior managed care staff. We requested documentation of these site visits. DHHS reported dates for site visits by DHHS staff, but could not provide any documentation to substantiate that the visits occurred and what was found.

We reviewed the dates of these visits and found that agency staff have not been consistent in conducting site visits. Agency staff missed conducting site visits to four MCOs at least 80% of the time.

Quarterly Meetings

We also found that DHHS relies on quarterly meetings with the MCOs as part of the contract monitoring process. We found that meetings with all MCOs were not always held on a quarterly basis. We reviewed whether DHHS met with MCOs at any point during 7 quarters from July 1, 2016 to May 15, 2018—the period for which DHHS submitted data. Over a period covering seven quarters, DHHS did not meet with one MCO in four of them; it did not meet with three others in three of seven quarters; and it did not meet with a fifth MCO in two of seven quarters.

Meetings might not always be necessary. According to DHHS, there are no formal notes or minutes from these meetings, although individual staff maintain their own notes on items that might require their further review. Previously, we asked for minutes, correspondence, emails and notes associated with these meetings. DHHS provided nothing. In the absence of any evidence to the contrary, we can only conclude no documentation of what occurs during these meetings exists, at least in a form that would allow anyone to track what problems or issues were discussed, actions to be taken, and points of accountability for remedial action.

Therefore, there is no way to document any outcomes; whether additional actions were necessary; and, if so, what follow-up actions, if any, were to be taken, by whom, and during what timeframe.

Conclusion

DHHS includes site visits and meetings as part of its contract monitoring approach. MCOs coordinate care for thousands of children with behavioral health problems. The absence of documentation undermines transparency without which effective oversight cannot exist.

Recommendation

31. The S.C. Department of Health and Human Services should conduct site visits and hold its quarterly meetings consistently and should document these visits and meetings to include, at a minimum, the date of the event, the names and affiliations of attendees, topics discussed, actions to be taken, by whom, and according to what timeline.

Education Services for PRTF Children

The S.C. Department of Education (SDE) brought several issues involving the education of children in PRTFs to our attention. We found that:

- No written guidelines exist that describe what steps are to be taken, and by whom, in order to implement the requirements of state law governing the education of children placed in residential treatment facilities in South Carolina or in out-of-state treatment facilities.
- Since the RBHS carve-in, 20 school districts stopped providing behavioral health services during the managed care carve-in; and the moratorium on new providers is preventing those districts from re-enrolling as behavioral health providers.
- State agencies that place children in out-of-state facilities are not always notifying school districts, in a timely manner, that their students have been placed in an out-of-state treatment facility.

Notifying the Home District

Proviso 1.40 of the FY18-19 Appropriations Act affirms the right of each South Carolina resident of school age to receive educational services from the school district in which a PRTF is located. The proviso details the responsibility for providing educational services, billing for those services, and reimbursing the provider of those educational services for children placed in all types of residential treatment facilities, including PRTFs. We received information that school districts are, sometimes, unaware that one of their students is now residing in a residential treatment facility and receiving instruction from another school district, or, in some cases, from the treatment facility itself.

In developing Proviso 1.40, SDE met with representatives of agencies that place children and with residential treatment facilities in order to discuss the roles and responsibilities of each party when a child is placed. However, SDE never reduced that discussion to written guidelines for all parties to follow.

Proviso 1.40 states that SDE, in collaboration with state agencies that place children, school districts, and residential treatment facilities, should implement a system to follow the release of children from a residential treatment facility and re-enrollment in public, private, or special schools, in order to ensure that these children are not recorded as dropouts. We asked SDE if there is such a system. According to SDE, this should not be a problem as long as the child's resident school district is aware of his placement and the child's status is properly coded in the statewide student information system. We did not test this system, but SDE has described examples where local districts were surprised to learn that students from their districts were in residential treatment facilities. Therefore, there is a need to ensure that all parties involved in the placement of a child, treatment, education, and discharge are aware of their roles and responsibilities as they relate to the education of the child.

School Districts and Behavioral Health Services

Prior to the RBHS carve-in, 31 districts provided RBHS services; after the carve-in, that number fell to 11. Once a district has opted out of offering rehabilitative behavioral health services, the moratorium on provider enrollment precludes it from re-enrolling as a behavioral health provider.

Education Services for Children in PRTFs

We reviewed educational services provided to children in PRTFs. PRTFs may hire their own teachers who must hold South Carolina certification or the children may receive services through the school district in which the PRTF is located. Greenville County School District has a department whose mission is to serve children in group homes and residential treatment facilities. Facilities that provide instruction can bill the local school district for the cost of the educational services they provide, not to exceed $45 per day.

According to SDE, school districts have expressed the following concerns about children placed in residential treatment facilities:

- State agencies sometimes fail to notify a child's home school district when they place a child, of school age, in an out-of-state treatment facility, and the district only becomes aware of the placement when it receives a bill from an out-of-state school district for educational services provided to that child.
- Reduction in the length of time a child is placed in a residential treatment facility can disrupt the education plan and, therefore, the progress of a child.
- Differences between the work schedules of treatment facility staff who accompany children from a facility to a nearby school and the time of the normal school day can be inconsistent. We received information about one district where instructors reduced the amount of class time so that the PRTF staff members who accompanied the children could return to the PRTF and end their shifts. According to SDE, this potentially puts the students in violation of compulsory attendance laws.

Recommendations

32. The S.C. Department of Education should develop written guidelines that specify the roles and responsibilities of all parties involved in the placement of children in residential treatment facilities, including who is responsible for informing local school districts of the initial placement and what steps to follow upon discharge.

33. The S.C. Department of Education should coordinate with local school districts, residential treatment facilities, state agencies that place children, and the Children's Advocate to determine if children placed in psychiatric residential treatment facilities are at risk of violating compulsory attendance laws and, if so, develop corrective strategies.

Rates

Another audit objective was to review the steps that DHHS has taken to ensure the current method of payment and rates for children's behavioral health services (CBHS) are sufficient to ensure access to quality care. This review covers:

REHABILITATIVE BEHAVIORAL HEALTH SERVICES (RBHS)
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES (PRTFS)
AUTISM SERVICES

We found areas in need of improvement:

- South Carolina's statewide average PRTF rate is less than that paid by North Carolina and Georgia.
- PRTF rates were rebased July 1, 2017, without taking into consideration additional administrative requirements that would increase costs to the providers, causing PRTFs to potentially incur additional costs without being reimbursed for those additional requirements.
- DHHS does not track or monitor the service rates paid by the MCOs to the Medicaid providers to determine whether the rates are reasonable and appropriate.
- South Carolina Medicaid rates for Applied Behavioral Analysis (ABA) Autism services are among the lowest in comparison with 19 other states reviewed. Low rates result in a lack of service providers and potential denial of access to services for those in need.
- Separate contractual relationships between MCOs and Medicaid providers result in a lack of transparency regarding the rates paid by managed care for Medicaid services.
- There is a lack of transparency regarding the rates paid to PRTF providers, which makes it difficult for patients and taxpayers to know the price of treatment in order to make informed choices regarding health care.

Payment Rate Methodology Background

South Carolina Medicaid primarily uses three types of rates to pay for children's behavioral health, autism, and psychiatric residential treatment facility services—fee-for-service (FFS) rates, bundled payments, and managed care capitation per-member, per-month rates. Medicaid payment rates are typically lower, impacting beneficiaries' access to medical care.

Impact of Payment Rates

Research by the Kaiser Family Foundation has shown, on average, that Medicaid pays providers 72% of what Medicare, the federal health plan for the elderly, pays for the same services. The lower rates have a substantial impact on access to medical services. A 2013 analysis of federal data found that physician acceptance rates of new patients in Medicaid was significantly lower than in Medicare or private insurance, particularly in states with lower Medicaid payment rates. This results in longer wait times to see providers and having to travel farther from home to get health care.

Rate Types

Over the years, health care providers have experimented with various payment models in an attempt to discover a methodology that aligns payment incentives with improvements in the value of health care. The intent being to keep people healthy at the lowest possible cost.

Fee-For-Service Rate

The traditional method of payment has been FFS. Under this model, health care providers are paid for each service delivered to patients. FFS is considered to emphasize productivity, i.e. the more services a provider performs results in increases in billings and payments. It is a flexible payment mechanism that may be used in any type of organization regardless of the size or type of medical practice. On the other hand, this payment model does not provide for accountability since providers are paid based on the volume of care, rather than the quality of the care provided.

Bundled Payment

Another payment method is episode or bundled payments. A single payment is made for a group of services related to the treatment or condition that may involve multiple providers in multiple settings. This model is known to support flexibility in how and where care is delivered and creates incentives to effectively manage an episode.

Difficulties associated with this model include determining what services fall within and outside of the episode, the lack of incentive to reduce unnecessary episodes, and the possibility that providers will avoid patients considered "high-risk" or cases that may exceed the average payment per episode.

Capitation Rate

Managed care models provide a single payment to providers for the full range of health care services needed by a specified group of people for a fixed period of time. This model provides opportunity for innovation in the delivery of services, incentives to deliver care efficiently, improved incentives for providers to coordinate with each other, and an emphasis on maximizing health. Limitations include the potential to overemphasize population health at the expense of an individual patient's health, incentives to avoid high-risk or noncompliant patients, limitation of patient choice of provider and location of services, and the potential that care will be withheld.

While other payment models exist, South Carolina Medicaid primarily utilizes these three methods for children's behavioral health services, psychiatric residential treatment facility services, and autism services.

Allowable Cost Guidance

The following documents provide guidance for state Medicaid agencies regarding the development of payment methodologies:.

STATE MEDICAID MANUAL

Resource of information that states need in order to administer the state Medicaid program and develop the state plan. The state plan must be comprehensive enough to allow interested parties an understanding of the rate setting process and the items and services that are paid through these rates.

PROVIDER REIMBURSEMENT MANUAL

Provides guidelines and policies to implement Medicare regulations to establish the principles for determining the reasonable cost of provider services. This manual also provides information on cost reports that must be filed by facilities such as PRTFs; therefore, Medicaid uses this manual as well.

OMB CIRCULAR A-87
Establishes principles and standards for determining allowable and unallowable costs for federal awards. Cost must meet certain criteria to be allowable, such as being necessary and reasonable for the federal award, being allocable to the federal award, not being prohibited under state or local laws or regulations, and being adequately documented, along with other requirements.

Federal Oversight

The state plan sets out groups of individuals to be covered, services to be provided, methodologies for providers to be reimbursed and the administrative activities performed by the state. When a state decides to make a change, it submits a state plan amendment to the Centers for Medicare & Medicaid Services (CMS). CMS then reviews the state plan amendment and determines whether it will be approved. Once approved, CMS issues a letter acknowledging the approval of the state plan amendment and designates the effective date of the amendment. Minor rate changes, such as converting an approved individual rate to a group rate, do not require submission of a formal state plan amendment.

In 2004, CMS requested that the state revise its state plan related to children's services to include all children's services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) section. In 2009, CMS conducted a financial management review of South Carolina's mental health rehabilitative services.

CMS found reimbursement for mental health services in facilities with more than 16 beds to be out of compliance and identified issues with the state plan regarding the lack of service definitions and descriptions of the related reimbursement methodology. CMS extended its review and found 26 facilities that were considered to be institutions for mental diseases (IMDs) with more than 16 beds. CMS noted that DHHS used bundled payments to reimburse for services and indicated that CMS policy prohibits the use of bundled payment rates for non-institutional services because such rates violate the requirements of §1902(a)(30)(A) and 1902(a)(32) of the Social Security Act. CMS stated that the bundled rates are not viewed by CMS as economic and efficient.

PRTF Reimbursement Rates

DHHS did not increase PRTF rates for the additional programmatic requirements that were placed on providers due to a lack of communication between two of the agency's departments during the transition to managed care, effective July 1, 2017. This may have resulted in the PRTFs to incur additional costs to provide the same services at a rate that did not compensate the PRTFs for those additional requirements. While the PRTF rates were increased by 3% as of July 1, 2018, there is uncertainty as to whether the rate increase is sufficient to cover the additional costs.

Rates Rebased Without Consideration of Additional Administrative Requirements for PRTFs

According to an agency official, the PRTFs have not been treated fairly, and the agency has not been proactive regarding PRTF services. In July 2017, the PRTF rates were rebased and were carved into managed care. During this transition, an increase in programmatic responsibilities was not communicated by the program area to the reimbursements area in order to ensure that the revised PRTF rates would be adjusted accordingly.

Rather than paying an all-inclusive, per diem rate for each child receiving care in a PRTF setting, the rates were modified to provide for core facility services, including room and board, as well as psychological training, testing, and assessment services. All medical-related ancillary services, as well as psychiatric pharmaceutical costs, may be billed separately by the ancillary service provider to the state Medicaid program.

With the transition of PRTF services to managed care, each of the five MCOs has its own policies and protocols that must be followed. Each has its own approach to approving admissions, reauthorizations, and prescription drugs. Several PRTF providers indicated that they have had to hire at least one or more staff to handle the additional administrative work involved with the implementation of managed care.

According to PRTF providers, the transition time and cost involved in modifying computer systems to capture billing details at a patient level and identify every service provided was not sufficiently considered by DHHS. PRTFs that had existing in-house ancillary service provider(s), such as a pharmacy, for example, had to enroll the ancillary service provider as a separate Medicaid provider. This change also increased provider system and billing requirements.

Some providers decided to shut down in-house ancillary services and contract with other enrolled Medicaid providers rather than enrolling their own ancillary service providers and incurring the additional administrative responsibilities. The rates that were calculated for implementation as of July 2017 were based upon each PRTF's fiscal year end 2015 base year cost report and statistical information.

The lack of communication regarding the additional requirements meant that the additional responsibilities were not considered as part of the calculation of the PRTF rates as of July 2017. This omission potentially resulted in rates being lower than they should have been.

As of July 1, 2018, DHHS raised the PRTF rates by 3% in order to compensate for the additional administrative requirements. DHHS indicated that FY 18-19 cost reports will reflect the first full year of activity under the new service and rate methodology. The cost reports are due to DHHS in 2020. An analysis of this information, once available, should indicate whether the rates are sufficient or require additional adjustments.

Recommendations

34. The S.C. Department of Health and Human Services should review psychiatric residential treatment facility rates to determine whether the rates are reasonable and adjust the rates based on the applicable Medicaid rate-setting guidance, as appropriate.

35. The S.C. Department of Health and Human Services should establish procedures to ensure that data is shared between departments regarding updates to the state plan that impact provider rate setting.

36. The S.C. Department of Health and Human Services should review allowable cost guidance to determine whether there are any allowable costs that South Carolina is not including in psychiatric residential treatment facility rates and include them.

South Carolina PRTF Rate Less Than North Carolina and Georgia

DHHS' statewide average PRTF Medicaid rate (fee-for-service) is lower than Georgia's PRTF rate cap and North Carolina's statewide average rate.

South Carolina and North Carolina do not make their fee-for-service rates available to the general public; however, Georgia posts its rates publicly. The lack of transparency makes it difficult for patients and taxpayers to clearly see the price of treatment and does not enable patients to make more informed decisions about their healthcare.

Comparison with Other States

We obtained individual provider PRTF rates from South Carolina, North Carolina, and Georgia for this analysis.

In comparing the rates, we focused on the rate prior to July 1, 2017, when all of the rates were considered to be "all-inclusive" in each state. Table 4.1 shows that South Carolina rates are lower than those paid in Georgia and North Carolina by approximately $79 to $132 per day.

Table 4.1: PRTF Rate Comparison Prior to July 1, 2017

STATE	# PROVIDERS	FFS DAILY RATE
South Carolina	19	$291.00
Georgia	6	$370.00
North Carolina	43	$423.26

Note: Statewide weighted average for South Carolina and North Carolina compared to Georgia's rate cap.

Source: DHHS, N.C. Department of Health and Human Services, and Georgia Department of Community Health

In Table 4.2, we compare the rates as of January 1, 2019. South Carolina rates are lower by approximately $102 to $118 per day. However, this comparison does not take into account the changes in South Carolina's PRTF service definition that took effect July 1, 2017. As a part of this change, South Carolina Medicaid providers are no longer required to cover medications and other ancillary services under the per diem rate. These services are billed separately by the ancillary service provider.

Table 4.2: PRTF Rate Comparison as of January 1, 2019

STATE	# PROVIDERS	FFS DAILY RATE
South Carolina	13	$305.01
Georgia	6	$407.00*
North Carolina	43	$423.26

Notes: Statewide weighted average for South Carolina and North Carolina compared to Georgia's rate cap.

* Pending CMS approval of rates.

Source: DHHS, N.C. Department of Health and Human Services, and Georgia Department of Community Health

South Carolina

Historically PRTF per-diem rates have been based on each individual PRTF's cost report. The rates are calculated based on allowable costs as defined by the federal allowable cost guidelines. The rates covered all costs including room and board, mental health services, and other medical services. State plans typically allow rates to be adjusted for add-ons, such as new program requirements, using data from future cost reports and/or budgeted cost and statistical data, and occupancy adjustments.

As of July 1, 2017, DHHS changed the definition of the per-diem rate for PRTF services. Rather than being "all-inclusive," the rate changed to cover core facility services, including room and board, as well as psychological training, testing, and assessment services. All other medically-related ancillary services and psychiatric pharmaceutical costs incurred by Medicaid recipients residing in PRTFs must be billed by the ancillary service provider.

DHHS revised the per diem rate which was calculated based on each PRTF's fiscal year end 2015 cost report. The rates were then compared to each facility's pre-July 1, 2017 rate. If the pre-July 1, 2017 rate was higher, DHHS allowed the facility to keep its higher rate and subtracted the per diem ancillary costs incurred by the facility to determine the new per diem. For facilities whose pre-July 1, 2017 rates were lower than the newly-calculated rate, the new rate was awarded and trended forward for inflation.

South Carolina's statewide average rate is reflected in Table 4.3. The pre-July 1, 2017 rate is based on 13 Medicaid PRTF providers and reflects the revised rate methodology. The July 1, 2018 rate reflects an increase to account for additional program requirements that were mandated in 2017, but were not factored into the PRTF rate until 2018.

Table 4.3: South Carolina PRTF Statewide Average Rates

Prior to July 1, 2017	July 1, 2017	July 1, 2018
$291.00	$295.41	$305.01

Source: DHHS

South Carolina defines PRTF services as inpatient psychiatric services for children under 21 who do not need acute inpatient psychiatric care, but need a structured environment with intensive treatment services.

Georgia

The Georgia Medicaid state plan caps the payment to PRTF providers at $370 per day, per Medicaid beneficiary. While two of Georgia's six PRTF Medicaid providers are at the rate cap, the remaining PRTFs are below the cap. Georgia utilizes the annual reporting of audited allowable costs and facility utilization data to determine the program specific per diem cost for each provider.

Georgia defines PRTF services as follows:

> 1) Short-term, intense, focused treatment programs that will address medical necessity related to the primary behavioral health diagnoses and promote a successful return by the child or adolescent to the community.
>
> 2) Discharge planning, including the family, significant other/s, community resources the youth will need once returned to their community and the referring organization.
>
> 3) Outcomes of the resident returning to the family or to another less restrictive community living situation.

Georgia posted a public notice regarding its plans to increase rates, pending CMS approval, to $407 per day beginning January 1, 2019. In addition, for children with a co-occurring diagnosis of autism, the rate will increase to $440 per day. This would increase three of the six providers to the rate cap of $407 per day, with the remaining providers ranging from approximately $318 to $352 per day for individuals without a co-occurring diagnosis of autism.

North Carolina

The weighted statewide average PRTF rate in North Carolina is $423.26, which is based on 43 private PRTFs, as determined by the N.C. Division of Medical Assistance. In comparison with Georgia, the majority of North Carolina PRTF facilities exceed the Georgia daily cap of $370 and the South Carolina statewide average of approximately $305 per day.

According to the North Carolina State Medicaid plan, as of January 1, 2015, the North Carolina PRTF rates were frozen at the rates that were in effect as of July 1, 2012. The rates were determined based on reasonable costs from the providers' cost reports. Reasonable costs were determined based upon the federal provider reimbursement manual.

North Carolina defines PRTF services as follows:

> Inpatient psychiatric services for recipients under age 21 must be provided by a psychiatric facility or an inpatient program in a psychiatric facility that meets specific accreditation standards.

During our review, several individuals, including DHHS officials, mentioned that North Carolina PRTF rates might be higher due to the inclusion of educational costs as a component. We verified with North Carolina officials that educational cost is not a component of the Medicaid PRTF rates.

Lack of Rate Transparency

Individual PRTF Medicaid fee-for-service rates are not posted publicly by North Carolina or South Carolina. States calculate individual PRTF fee-for-service rates based on each provider's cost report. Each state has its own definition for its PRTF service and rate methodologies used in calculating the rate. Due to the facility-specific rate calculations, South Carolina and North Carolina do not publish the rates. Georgia, on the other hand, does not consider the individual PRTF fee-for-service rates to be confidential, making them available to the general public.

PRTF rate information for services rendered through MCOs is not publicly available since MCOs are allowed to negotiate rates with the providers and maintain confidentiality through contractual relationships.

According to the Robert Wood Johnson Foundation, a large philanthropy dedicated solely to health, "Health economists and other experts are convinced that significant cost containment cannot occur without widespread and sustained transparency in provider prices." More comparative information fuels competition, improves the overall level of services, and provides a relative yardstick that providers can use to gauge how they are doing in comparison with other providers.

Recommendations

37. The S.C. Department of Health and Human Services should re-base the psychiatric residential treatment facility rates based on the most recent, complete set of provider cost reports.

38. The S.C. Department of Health and Human Services should publish individual psychiatric residential treatment facility rates.

Managed Care Rates

DHHS stated that it does not monitor the rates paid by the MCOs to their networks of providers. DHHS contracts with MCOs to administer an array of Medicaid services, and each MCO, in turn, establishes its own network of medical providers to offer services to enrolled Medicaid beneficiaries.

The separate contractual relationship between the MCOs and individual Medicaid providers results in a lack of transparency regarding the rates paid by MCOs and an inability to independently verify whether the rates paid by the MCOs are reasonable and appropriate.

DHHS Payments to MCOs

Milliman, Inc., an actuarial firm hired by DHHS, provides rate setting and budget forecasting guidance to DHHS. Based on the rates developed by the actuaries, DHHS pays a per-member, per-month (PMPM) rate for each MCO-enrolled beneficiary. As of July 1, 2018, the benefits covered under the managed care rate included physician services, maternity services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT), autism spectrum disorder services (ASD), and more.

MCO Payments to Medicaid Providers

MCOs make money by saving money. MCOs achieve their goals by:

- Controlling patient access to care and eliminating unnecessary services.
- Integrating health care delivery and payment systems.
- Limiting provider fees by establishing fixed rates for physicians and hospital services.
- Controlling drug costs by implementing pharmacy benefits management plans.

Each MCO is required to establish its own network of providers to meet the needs of enrolled beneficiaries. The MCOs have the authority to establish payment rates with providers, above or below the fee-for-service rates, to ensure that there is a sufficient network of providers. MCOs must pay the applicable Medicaid fee-for-service rate to the provider if there is not a negotiated rate. The use of managed care makes state costs more predictable; however, managed care is often still driven by fee-for-service systems. The main difference is that it shifts the bills from the state to the managed care health plan(s).

We requested information from DHHS on the rates paid by each MCO for children's behavioral health and PRTF services. DHHS indicated that it does not maintain a standard database or rate sheet of MCO provider contracts and rates that can readily be provided to us. Without access to this information, we were unable to determine whether the Medicaid providers are actually receiving a rate that is considered reasonable and appropriate.

We also requested documentation on how DHHS monitors the rates paid by MCOs to the providers in order to ensure that rates are reasonable and appropriate. DHHS' response is that it "… does not monitor the rates paid by the MCOs to their networks of providers. The payment rates for MCO providers [are] established through the contract between the MCO and the provider." The agency indicated that the premiums it pays are predicated on the rate setting process, and that this process ensures that network providers are paid reasonably for the services provided. In essence, the agency is relying on the rate setting process that would reflect a decrease in the future per-member, per-month payment to the MCOs, if the MCOs reduce the payments to the MCO providers. The agency stated that many of the services that are covered by the MCOs are paid at a rate reflective of 100% of the Medicaid allowable fee schedule; however, we could not verify this.

How Do MCOs Make Money?

MCOs have substantial administrative overhead, so they must achieve savings in physician, pharmacy, and hospital charges. There are a few ways that savings may be achieved:

- Reduce the rate the MCO pays to providers.
- Limit access to care, or shift to cheaper care than would have been provided outside the MCO.
- Provide more services that are profitable and fewer services that are not.

States utilize managed care with the goal of improving access to care, improving the quality of care, increasing Medicaid budget predictability, and reducing Medicaid spending. According to the Louisiana State University Medical and Public Health Law Site, managed care is intended to counter traditional fee-for-service reimbursement incentives that encouraged physicians to provide more care for each patient.

Instead, physicians are encouraged to see patients more quickly, use fewer tests and specialty referrals, use less expensive drugs, and keep patients out of the hospital. Physicians who do not deliver cost-effective care are typically not allowed to continue to treat MCO patients. The hidden incentives to deny care pose a conflict between the interests of the physician and the patient. These can breach the physician's fiduciary duty to the patient, which is actionable on its own, as well as support criminal actions for fraud.

Do MCOs Save Money?

According to a Harvard School of Public Health professor of political economy, the best plans reduce the cost of care by organizing the care process cost effectively. The worst plans "bully" doctors and hospitals into offering them price discounts and/or limited cost by making it more difficult for patients to receive care.

Studies completed by groups such as The Lewin Group, a healthcare consultant, and the Georgetown University Health Policy Institute have reported conflicting results. The Lewin Group shows that states that have tried some form of managed care have saved between 0.5% and 20% from their anticipated costs. The Georgetown University Health Policy Institute concluded that Florida's five-county pilot program yielded little in the way of evidence of either efficiencies or cost reductions.

The Menges Group, a strategic health policy and care coordination consultant, issued a report in 2015 which estimated that South Carolina would save $108 million in 2016 from existing MCO-covered services, and $187 million from 2016 through 2025 if all impactable fee-for-service costs were transitioned in the managed care model.

In October 2018, we requested information from DHHS on whether the use of managed care has, or has not, saved money for children's behavioral health-related services since its implementation. As of February 2019, the agency does not have this analysis available. This lack of assessment and oversight makes it impossible for the agency to determine whether the state plan changes are achieving the desired result from a financial perspective.

Recommendations

39. The S.C. Department of Health and Human Services should maintain a database of rates paid by managed care organizations that is available for audits by entities, such as the S.C. Legislative Audit Council, with legislative authority and confidentiality requirements.

40. The S.C. Department of Health and Human Services should annually select at least two different medical services each year and audit the rates paid by managed care organizations to Medicaid providers for those services to ensure the rates are reasonable and appropriate.

41. The S.C. Department of Health and Human Services should implement policies and procedures to monitor whether the use of managed care plans save the state money as compared to other alternatives.

Autism Payment Rates

South Carolina Medicaid rates for Applied Behavioral Analysis (ABA) services are among the lowest in comparison with other states that were reviewed. Low rates may result in a lack of service providers and potential denial of access to services for those in need.

Federal Law

Federal law requires that states assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to attract enough providers so that Medicaid beneficiaries have the same access to treatment that members of the general public have.

Payment Rates

Autism spectrum disorder services are included in the South Carolina Medicaid state plan in the EPSDT section, along with children's RBHS. Since these services impact children, we compared autism rates in 19 states. We found that South Carolina's ABA Medicaid rates are among the lowest rates paid for ABA services.

In order to complete this analysis, we searched for information from every state using the Internet and/or direct request. We received information from 23 of 50 states. Of the 23 responses, 4 were not comparable due to differing autism services and non-disclosure of payment rates (see *Appendix B*).

South Carolina offers the following limited array of autism services.

Table 4.4: South Carolina Autism Service Rates

Service	July 2018			January 2019			July 2019
	Procedure Code	Unit	Rate	Procedure Code *	Unit	Rate	Rate
Behavior Identification Assessment	0359T	30 min	$47.02	97151	15 min	$23.51	**
Adaptive Behavior Treatment	0364T/ 0365T	30 min	$15.50	97153	15 min	$7.75	$8.64
Adaptive Behavior Treatment with Protocol Modification	0368T/ 0369T	30 min	$29.10	97155	15 min	$14.55	$15.74
Family Adaptive Behavior	0370T	30 min	$29.10	97156	15 min	$14.55	$15.74

* DHHS did not transition to the January 2019 category 1/CPT codes until May 2019.

** We attempted to confirm this July 2019 rate; however, the Autism fee schedule on the DHHS website had not been updated as of September 6, 2019.

Source: DHHS

Autism services and rates have been in transition since July 2016 in South Carolina. Our review focused on the services and rates offered prior to the change in procedure codes, effective January 2019.

Table 4.5 reflects the comparative rates for two of the services offered by South Carolina Medicaid. Rates highlighted in gray reflect the lowest three rates paid by states for the respective Medicaid service. South Carolina Medicaid is one of the lowest three payers for adaptive behavior treatment.

While additional study could be done to compare rates in each state, by the type of professional providing the service, location of services, frequency of services, etc., this overall assessment compares favorably with work completed by other nonprofit entities that have pointed out South Carolina's low Medicaid reimbursement rates for autism services. Low reimbursement rates may cause children to go without services or to have services delayed.

See *Appendix B* for additional rate comparison information for all ABA autism services offered by the 19 states reviewed. Service descriptions are available in *Appendix A*.

Table 4.5: State-by-State Autism Rates Comparison, as of December 2018

ADAPTIVE BEHAVIOR TREATMENT				
STATE	PROTOCOL		MODIFICATION, DESIGNATED PROFESSIONAL, AND 1 PATIENT	
	0364T (FIRST 30 MIN RATE)	0365T (EACH ADD'L 30 MIN RATE)	0368T (FIRST 30 MIN RATE)	0369T (EACH ADD'L 30 MIN RATE)
AL	$20	$20	$30	$30
AK	$38.04	$38.04	$50.06	$50.06
FL	—	—	$30.48	$30.48
GA	$148.18 - $30.26	$148.18 - $30.26	$116.42 - $60.02	$148.18 - $60.02
LA	$23 - $19	$23 - $19	$45 - $35	$45 - $35
MD	$35 - $20	$35 - $20	$55 - $30	$55 - $30
MI	$30 - $27.5	$30 - $27.5	$60 - $42.5	$60 - $42.5
MS	$31.68	$31.68	$77.52	—
MT	$19.42	$19.42	$35.02 - $25.92	$35.02 - $25.92
NV	$60.20 - $15.65	$60.20 - $15.65	$60.20 - $36.12	$60.20 - $36.12
NM	$30 - $25	$30 - $25	$70 - $50	$70 - $50
ND	$18.36	$18.36	$53.84	$53.84
OH	$25.38	$25.38 (Reduced 20% after 1 unit)	$33.20	$33.20 (Reduced 20% after 1 unit)
SC	$15.50	$15.50	$29.10	$29.10
UT	$15	—	$40	—
VT	$30	$30	$50.00 - $43.42	$50.00 - $43.42
WI	$66.30 - $19.05	$66.30 - $19.05	$36.67	$36.67
WY	$42.06 - $14.5	$42.06 - $14.5	$42.06	$42.06

Notes: Dashed fields indicate that the Medicaid service is not available.

North Carolina's rate information for autism services was not available for inclusion.

Rates highlighted in gray reflect the lowest three rates paid by states for the respective Medicaid service.

Source: LAC analysis of state websites

Fraud Allegations

State and federal investigators have been looking into allegations of fraud involving South Carolina's autism children's services' program based on a whistleblower lawsuit. DHHS officials have indicated that the fraud may have resulted in a mistaken impression for years that the program's provider rates and service availability were in better shape than they actually were.

The U.S. Attorney's Office for the District of South Carolina found that the Early Autism Project, Inc., (EAP) submitted false claims to TRICARE (federal insurance program for active and retired military members and their families) and the South Carolina Medicaid programs for therapy services for children with autism. EAP is South Carolina's largest provider of intensive behavioral treatment to children with autism. In mid-2018, EAP paid in excess of $8 million to resolve the False Claims Act investigation. The accusations included billing for therapy services by individuals who were not actively working with the child for whom the therapy was billed and/or were "padding" the hours billed for therapy services.

Access to Care

DHHS' director stated that the agency is committed to providing Medicaid benefits at the lowest cost to taxpayers. However, while the agency's focus is on the lowest cost, there is another requirement, which is to ensure that the rates are high enough to have an adequate network with access to care.

A membership survey conducted by the South Carolina Association for Behavior Analysis in July 2017 found that 80 out of 95 respondents indicated that they were not accepting new Medicaid patients. The primary reason given for not accepting new Medicaid clients was that reimbursement rates are too low to cover employee costs and sufficiently pay staff.

At the time of this report, follow-up information regarding the impact of changes to the autism service rates, effective January 2019, is not available. The impact of these changes should be tracked and monitored by DHHS in order to ensure that beneficiaries receive the autism services for which they qualify.

Recommendations

42. The S.C. Department of Health and Human Services should reevaluate autism rates and establish service rates that will improve the availability of services and service providers in South Carolina.

43. The S.C. Department of Health and Human Services should review the overall array of applied behavioral analysis services to determine whether and/or which additional services should be offered.

44. The S.C. Department of Health and Human Services should implement policies and procedures to track, monitor, and reduce the wait times for beneficiaries seeking autism services.

Rehabilitative Behavioral Health Services' (RBHS) Rates

South Carolina's rates for RBHS are difficult to compare with those of other states due to the variation allowed within Medicaid. Each state defines its services, determines the authorized practitioners, and develops the rate methodology, all of which may differ and impact the rates. For the three most utilized services, based on the total paid in South Carolina, South Carolina Medicaid payment rates, last adjusted in 2010, were around the mid-point or higher, in comparison to North Carolina and Georgia rates.

Fee-For-Service Reimbursement Methodology

As of July 1, 2010, formerly bundled services and rates for children's behavioral health services were unbundled into what is now known as RBHS. This was done in response to the Centers for Medicare & Medicaid Services (CMS) request in 2004 that the state include all children's services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) section of the state plan. Payment rates for the RBHS discrete services were developed as follows:

- An overall average annual compensation amount was determined for each provider type and staff educational level by utilizing data from state agencies, the S.C. Office of Human Resources, and the U.S. Department of Labor.
- The maximum number of billing hours, for each provider type, for each billable service was calculated.

  (37.5 hours per week x 52 weeks x 50% productivity factor = 975 hours)
- The overall annual average compensation amounts were then divided by the maximum number of billable hours to determine an hourly billing compensation rate for each provider type.

- The rate, determined above, was increased by 30% for fringe benefits. The rate was based on the representative state government fringe benefit rate.
- An additional 10% was added for indirect costs (overhead).
- Another 10% was added to provider types which require supervision.
- A work adjustment factor was subsequently applied to adjust the rate based upon the level of effort deemed to be required to provide specific rehabilitative services by provider type.
- The Medicaid rate was then determined by dividing the rate by each service's measurement unit (15 minutes, etc.), for each provider type, for each service that the provider is authorized to render.

If a service was already listed on the South Carolina physician fee schedule with an established rate, that rate was used for the service.

According to a DHHS official, the inclusion of materials and supplies, travel, and training costs were considered to be components of the indirect cost adjustment and productivity factor. These rates have not been adjusted since inception, in 2010.

Bundled Rates

While the initial transition from children's behavioral health services to rehabilitative behavioral health services resulted in the elimination of bundled rates, in February 2013, DHHS re-established bundled rates for certain services that include substance abuse and addictive disorder treatment, specifically, for the S.C. Department of Alcohol and Other Drug Abuse Services (DAODAS). Allowable costs include DAODAS personnel costs (including tax and fringe), materials and supplies, training and travel expenses (with limitations), supervisory costs, and administrative overhead. While the services are bundled, the state plan requires DAODAS to report the discrete services annually, including utilization of the individual covered services in the bundled payment and the cost, by practitioner, and type of service delivered under the bundled rate.

South Carolina RBHS Rate Comparison with North Carolina and Georgia

We obtained RBHS rate information from North Carolina and Georgia. Based on the South Carolina fee-for-service claims payments for FY 15-16, the most complete fiscal year for claims submissions at the time of this review, the three most utilized services were psychotherapy (90837), behavior modification or skills training and development (H2014), and psychosocial rehabilitation service (H2017). The S.C. Medicaid service definitions are provided in *Appendix A*.

Table 4.6 shows an analysis of the three services that South Carolina pays a rate that is either comparable or higher than that paid by North Carolina and Georgia. Rates vary by service, allowed practitioner, and allowed service location, depending on the approved state plan for each state, so it is difficult to compare the rates and services. A full listing of rehabilitative behavioral health services offered in South Carolina, North Carolina, and Georgia is available in *Appendix C*.

Table 4.6: Rehabilitative Behavioral Health Service Rate Comparison, July 2018

Service Proc Code	South Carolina		North Carolina		Georgia	
	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates
H2017	Psychosocial Rehabilitation 15 min.	$7.81* or $3.00 - $13.02	Psychosocial Rehabilitation 15 min.	$2.69	Psychosocial Rehabilitation 15 min. or Psychosocial Rehabilitation (Group) 1 hour	$15.13-$24.36 or $13.20-$21.64
H2014	Skills Training and Development* or Behavior Modification 15 min.	$7.81* or $7.11 - $25.82	—	—	Group Outpatient 15 min. or Family Outpatient 15 min.	$3.30-$5.41 or $15.13-$24.36
90837	Psychotherapy 60 minutes	$111.90 - $314.82* or $99.32- $382.00	—	—	Individual Outpatient approx. 60 min.	$60.51-$187.04

Note: Dashed fields indicate that the Medicaid service is not available.

* DAODAS only rates

Source: LAC analysis of state websites

Recommendation

45. The S.C. Department of Health and Human Services should review the rehabilitative behavioral health service rates to evaluate and update the rates, as appropriate.

Internal Audit Interference

DHHS has an ineffective internal audit function that is not independent and objective, as required by professional auditing standards. During our audit, we found:

- The internal audit department is impaired due to management interference, including its organizational reporting structure.
- Of 24 audits conducted from FY 14-15 through FY 17-18, only 10 audits were completed with reports or management letters issued.
- Risk-based audit plans have not been completed since January 2017.

Independence

We reviewed the independence of the internal audit function at DHHS and found that there are conditions that threaten the ability of the department to carry out internal audit responsibilities in an unbiased manner. In January 2017, internal audit started reporting to the Chief Finance Officer (CFO), an area that the internal audit function may be tasked to audit. This creates a risk that the internal auditor may not be allowed to audit the finance area, which is responsible for approximately $7 billion, without interference. According to the Institute of Internal Auditors, the audit executive must report to a level within the organization that allows the department to fulfill its responsibilities. In this case, the proper reporting level within the agency would be the agency director or an audit committee.

DHHS recently hired a consultant to evaluate organizational alternatives for DHHS' internal audit function. Each recommendation also included the restructuring of the internal audit department so that it reports to an audit committee composed of individuals who represent the leadership throughout the agency. The report proposed three recommendations:

1. Keep the existing internal audit team, hire a director, and hire additional staff to fulfill the needs of the internal audit department.
2. Keep the existing internal audit team, hire a director, and outsource additional internal audit functions.
3. Outsource all internal audit functions; however, DHHS should hire a director in-house.

It is critical to ensure that internal audits are free from interference in determining the scope, performing the work, and communicating results. A review of internal audits conducted from FY 14-15 through FY17-18 revealed 24 audits. Only ten were actually completed with reports or management letters issued.

According to agency officials, DHHS management would opt not to recoup funds identified by internal audit because "it would get political once the department asked the auditee to return funds." It was also noted that management would suppress audits, potentially so that the auditee would not "look bad." This interference is a violation of internal auditing standards.

Lack of Risk-Based Audit Plans

The Internal Audit Standards, developed by the Institute of Internal Auditors, require that the audit executive establish a risk-based plan to determine the priorities of the internal audit activity consistent with the organization's goals. The plan should be developed at least annually.

Our review found that DHHS has not completed a risk-based audit plan since 2017. Furthermore, the internal audit department lacks leadership. Since the audit director's departure in April 2018, the agency has not hired or appointed an interim audit director. In December 2018, DHHS posted a temporary-grant, full-time program manager position for a director of the division of audits. Audit engagements must be properly supervised to ensure objectives are achieved, quality is assured, and staff is developed.

DHHS could utilize its internal audit department to review the agency's oversight of MCOs, especially regarding children's behavioral health.

Recommendations

46. The S.C. Department of Health and Human Services should structure the internal audit department to report directly to an audit committee or the agency director to maintain independence.

47. The S.C. Department of Health and Human Services should ensure that internal audits are free from interference in determining the scope, performing the work, and communicating results.

48. The S.C. Department of Health and Human Services should ensure that a risk-based audit plan is completed and followed annually.

Lack of Transparency and Communication

Our audit objectives included evaluating how DHHS is communicating with other state agencies and providers, and reviewing the agency's decision to implement a moratorium on RBHS providers.

We found that:

- DHHS' methods of communication are not sufficient to inform stakeholders of policy changes.
- DHHS has not been responsive to the input of stakeholders on major policy changes.
- DHHS' website is difficult to navigate and contains contradictory and confusing information and missing links, which does not allow it to effectively communicate information to stakeholders.
- DHHS does not have a reliable process for ensuring that the RBHS providers terminated from the Medicaid program do not re-enroll.
- RBHS provider moratorium has been in place for four years with no plans for it to end.

Transparency and Communication

DHHS' methods of communication are not sufficient to inform stakeholders of policy changes. We found that DHHS has not been responsive to the input of stakeholders on major policy changes. DHHS has made substantial policy changes in the past years, including the RBHS moratorium, and the carve-in of RBHS and PRTF services into the managed care benefit. DHHS communicates policy changes to stakeholders through its website, Medicaid bulletins, and public notices sent through email, public forums, and stakeholder meetings.

Navigation Through DHHS' Website

The DHHS website is difficult to navigate and contains contradictory and confusing information and missing links. Outdated information and missing links may create confusion for stakeholders when trying to obtain information from the DHHS website.

DHHS cannot effectively communicate information to stakeholders through its website. One section on the website displays all provider manuals; however, some of the titles are misleading. For example, the title of the Rehabilitative Behavioral Health Services (RBHS) provider manual says the March 1, 2008 edition is posted. The link to the RBHS provider manual shows the most updated edition—July 1, 2018.

Navigation is also difficult throughout the DHHS website. We found:

- A user must click through several screens to get to the full Adobe® PDF version of a provider manual. The link to a provider manual requires scrolling through different sections to find the full Adobe® PDF provider manual at the bottom of the page.
- The link to the full provider manual is in a small font. This does not allow stakeholders to easily and quickly find information.

As of August 2018, there were also inactive links and outdated information throughout the DHHS website. For example:

- The link for the Palmetto Coordinated System of Care (PCSC), a potential waiver program in DHHS, projected to launch in August 2018, led to a 'page not found' notification. As of September 2019, the waiver had not been implemented.
- When searching for an MCO committee on the DHHS website, the Medicaid Coordinated Care Improvement Group (CCIG) was one of the first items shown. When clicking the 'CCIG Website' link for more information on this group, a 'page not found' notification was shown. We asked DHHS for further clarification about this group and were told that MCO liaisons in DHHS regularly hold meetings with the MCOs. The website does not indicate that the CCIG group is no longer active.

New Email System

During this audit, DHHS converted to a new email system and the DHHS website was updated to reflect these changes. Updates included a pop-up notification throughout the website that requested website users to subscribe to the new DHHS email system. DHHS notified us that all previous subscribers of the old email system would be grandfathered into the new system. To verify this, we used two email accounts. One account has received DHHS emails since February 2015 and the other email account was a new subscriber. The new subscriber received DHHS emails while the account that should have been grandfathered in did not receive the emails. If this has occurred with other email accounts, some providers, thought to be grandfathered in, may not be receiving emails regarding important policy changes.

Updates to Provider Manuals

DHHS' method of updating its provider manuals is also confusing. Each provider manual has a change control record. We reviewed the change control record as of August 2018. The change control record tracks all changes that have been made to a provider manual. However, it often does not explain the specific change that was made. Therefore, it can be difficult to determine what was changed.

For example, on July 1, 2018, DHHS updated the Retro-Health Insurance and Retro-Medicare sections of the RBHS manual. However, the change control record did not specify what was changed in those sections. When reviewing the sections in the RBHS manual, it is difficult to determine the changes made without comparison of a previous version of the manual, which is not available on the website. A DHHS official explained that the agency has received complaints that the change control record is brief and unclear.

Stakeholder Input

Policy Development Process

DHHS has not adequately responded to provider input on a variety of policy changes. This may be due to several problems such as the lack of public forums for major policy changes, the infrequency of stakeholder meetings for major policy changes, and insufficient communication from DHHS.

As part of the process for policy development, DHHS has both a policy determination checklist and a final review checklist. The policy determination checklist is completed at the beginning of the policy development process and the final review checklist is created at the end. Each checklist has a list of yes or no questions that must be answered to ensure all parts of a policy are addressed. One of the questions in the policy determination checklist asks, "Will the initiative require external stakeholder input?" This can include methods such as a telephone client satisfaction survey or a public forum.

Although meetings were conducted with various state agencies, such as the South Carolina Department of Education (SDE), the S.C. Department of Juvenile Justice (DJJ), and the S.C. Department of Social Services (DSS), for the PRTF carve-in and RBHS carve-in, no public forums were held. Public forums are useful for getting the opinions of all interested parties, including parents/caretakers of children needing these services. The leadership meetings were very limited in the scope of stakeholders that were included in discussions.

Timeline for Implementation of Policy Changes

DHHS did not provide a sufficient amount of time to prepare stakeholders for major policy changes.

Table 5.1: Timeline of Public Notices for Policy Changes

RBHS Carve-In		
2016	Feb-16	First public notice about the policy change was posted on the DHHS website
	Mar-31	Final public notice was posted on the DHHS website
	Jul-01	Implementation of the carve-in
PRTF Carve-In		
2016	Sep-07	First public notice about the policy change was posted on the DHHS website
2017	Feb-16	DHHS posted two additional public notices
	Mar-27	
	Jul-01	Implementation of the PRTF carve-in

Source: DHHS

DHHS' written policy development process includes several steps in which stakeholders are supposed to be informed about the changes.

For both the RBHS and PRTF carve-ins, the first public notice date to the implementation date was less than one year apart. In order to fully communicate with potential stakeholders and carefully go through the DHHS policy development process, public notices of policy changes should be sent at least one year prior to the intended policy change effective date.

We also documented times when stakeholders requested deadline extensions or expressed concerns about the timeline of major policy changes. For example, DHHS posts public notices on its website for major policy changes and accepts written comments from the public on public notices. However, several people who wrote comments about the RBHS carve-in expressed concerns about the July 1, 2016 implementation date. During the stakeholder meetings that took place regarding the RBHS carve-in, SDE requested an extension of the RBHS carve-in implementation in at least two meetings. Letters from non-profit organizations and PRTFs were also sent to DHHS prior to the PRTF carve-in expressing concerns about the expedited timeline for implementation.

Recommendations

49. The S.C. Department of Health and Human Services should improve its website by:

    - Prominently displaying the link to the entire provider manual at the top of the provider manual page.
    - Updating the change control record to show more detailed descriptions of changes made to the provider manual.
    - Correcting all missing links throughout the agency website.

50. The S.C. Department of Health and Human Services should inform stakeholders at least one year prior to the effective dates of major policy changes involving children's behavioral health services.

51. The S.C. Department of Health and Human Services should hold public forums to discuss upcoming, major policy changes regarding children's behavioral health services.

Stakeholder Meetings

As shown in Table 5.2 and Table 5.3, the frequency of meetings held for the PRTF and RBHS carve-ins varied.

During a five-week hiatus, the PRTF carve-in was implemented, which may have been problematic. DHHS also did not include other key stakeholders (e.g. DJJ, DSS, and SDE, parents/caretakers of children in PRTFs, etc.) in meetings regarding the PRTF carve-in. Unlike meetings for the RBHS carve-in where training was included, the agendas for the PRTF carve-in meetings and the DHHS website did not show that training was provided to PRTFs before the carve-in implementation date.

Table 5.2: PRTF Stakeholder Meeting Dates

2016	Sep-19 Sep-22	
2017	Mar-02 Apr-27 May-04 May-11 May-18 Jun-01 Jun-08	Regular stakeholder meetings • PRTF providers • MCO representatives • DHHS representatives
5-WEEK HIATUS		
2017	Jul-01	PRTF Carve-In
	Jul-13	More stakeholder meetings • PRTF providers • MCO representatives • DHHS representatives
	Aug-10	

Source: DHHS

Table 5.3 shows meetings that were held with certain stakeholders regarding the RBHS carve-in. Representatives of these meetings included, DHHS, DMH, DJJ, SDE, DSS, MCOs, and COC. After the July 1, 2016 RBHS carve-in implementation date, DHHS held meetings with DMH, SDE, and the MCOs through October 24, 2016. DHHS conducted meetings with various stakeholders prior to the carve-in; however, additional and more frequent meetings with all stakeholders after the RBHS carve-in would have been useful to better communicate stakeholder concerns. Frequent stakeholder meetings before and after managed care carve-ins is a best practice that has been implemented by other state health and human services agencies throughout the country.

Table 5.3: RBHS Stakeholder 2016 Meeting Dates

		DMH and MCOs	Prior Authorization	SDE and MCOs	Contracting and Credentialing	DMH IT/Claims	COC	DSS and MCO	DJJ and MCOs
Mar	25	✓	✓						
Apr	01	✓	✓		✓				
	04			✓					
	08	✓	✓						
	11			✓					
	15	✓	✓		✓		✓		✓
	18			✓					
	22	✓	✓						
	25			✓					
	29		✓						
May	02			✓					
	03					✓			
	06	✓	✓						
	09			✓					
	13		✓						
	16			✓					
	20	✓	✓						
	23			✓					
	31			✓					
Jun	03	✓						✓	
	06			✓					
	09						✓		
	10	✓							
	13			✓					
	17	✓							
	20			✓					
	27			✓					
Jul	01	RBHS Carve-in							
	21	✓							
	25			✓					
Aug	22			✓					
	25	✓							
Sep	19	✓							
Oct	17			✓					
	24	✓							

✓ = In attendance at meeting.

Source: DHHS

Our review of the meeting agendas show that SDE requested training for the RBHS carve-in on as early as April 4, 2016; however, it was not until July 25, 2016, after the carve-in implementation date, that the agenda documented that training was provided to SDE by the MCOs. During the months leading up to the RBHS carve-in, DHHS should have more quickly responded to concerns from stakeholders.

Recommendation

52. The S.C. Department of Health and Human Services should, for major policy changes regarding children's behavioral health services:

    - Hold leadership meetings on a consistent basis before and after the implementation date.
    - Hold meetings on a weekly basis after the implementation date for at least two months or until the majority of stakeholders' issues are resolved.
    - Hold public forums.
    - Include stakeholders in meetings, including families of beneficiaries.
    - Provide training to stakeholders prior to policy implementation.

DHHS Has Not Addressed Concerns from Stakeholders

DHHS has not been responsive to requests and concerns from stakeholders regarding major policy changes during the past two-years.

Many communication issues can be found through the discussions that took place prior to the implementation of the PRTF carve-in of managed care in July 2017. Prior to the PRTF carve-in, letters were sent to DHHS with concerns about the carve-in by providers and advocates. The concerns included low reimbursement rates, intensified scrutiny and restriction of care by MCOs, and a "stagnant" Medicaid schedule. The letters also mentioned DHHS' lack of response to previous inquiries. Several letters indicated that the July 1, 2017 implementation date should be delayed to allow stakeholders to prepare for the change. One letter noted that credentialing requirements could take up to 60 days, which would not be completed until after the July 1, 2017 implementation date. This could mean that the providers would not be able to provide services until the credentialing was completed. Despite these requests, DHHS implemented the carve-in, as scheduled, on July 1, 2017.

We also received input from some MCOs regarding the PRTF carve-in. Representatives from the MCOs explained that there were communication issues with DHHS and state agencies. This resulted in a lack of buy-in from state partners. Additionally, the MCOs explained to us that there was a need for additional training and continued communication between PRTF providers and MCOs.

Statewide Comparison to Other States on MCO Implementation

To further highlight the importance of proper planning and communication for major policy changes, we reviewed the methods that other state Medicaid programs have used to successfully integrate managed care into behavioral health services. According to a 2016 article from the Center for Health Care Strategies, officials from five state health and human services agencies—Arizona, Florida, Kansas, New York, and Texas—were interviewed to determine what practices they used to successfully implement managed care into their behavioral health services. Some of the best practices that these states implemented prior to integration of managed care included:

- Rolling out the managed care benefit in small regions of a state before statewide expansion and selecting MCOs through a competitive bidding process.
- Requiring explicit continuity of care requirements.
- Engaging stakeholders to facilitate implementation.
- Balancing oversight and collaboration with MCOs.

South Carolina launched the RBHS carve-in statewide. Other states, such as Arizona and New York, implemented managed care in small regions before expanding into the entire state. In contrast, Texas implemented the carve-in statewide, but implemented the program in two stages. Implementing the carve-in on a smaller level allows state agencies time to test and refine any possible issues that may arise with implementation. For an easier transition, DHHS should have started the MCO carve-in with partial implementation.

Many of the surveyed states started by carefully selecting MCOs through a competitive bidding process. DHHS did not issue requests for proposals or qualifications prior to the RBHS carve-in, but its policy does requires that MCOs undergo a readiness review with the DHHS external quality review organization.

Another best practice that the surveyed states implemented was the balance of oversight and collaboration with the MCOs. These states accomplished this by regularly holding meetings before and after MCO carve-ins, requiring monthly reports of MCO providers, and creating an oversight methodology. As shown on Table 5.3, meetings were held regularly prior to the RBHS carve-in but were limited in quantity and stakeholder participants following the implementation. Regular meetings after the carve-in would have helped facilitate better communication between DHHS and stakeholders to resolve possible issues.

Recommendation

53. For future policy changes regarding children's behavioral health services, the S.C. Department of Health and Human Services should:

    - Implement policy changes in stages or start implementation of policy changes in smaller regions.
    - Develop a detailed oversight methodology for all managed care organizations.
    - Conduct pre- and post-implementation meetings with managed care organizations and applicable stakeholders regularly.
    - Address concerns from managed care organizations and applicable stakeholders during pre- and post-implementation in a transparent, public manner.

Vetting, Enrolling, and Monitoring New Providers

DHHS does not have a reliable process to prevent providers that have been terminated from the Medicaid program from re-enrolling as Medicaid providers. DHHS and the Medicaid Fraud Control Unit (MFCU) officials explained that some excluded providers enter the system again by enrolling under a new name. DHHS keeps a list on its website of all excluded providers, including individuals and businesses.

To target provider fraud, many of DHHS' processes are reactive. DHHS' Division of Program Integrity focuses on detecting fraud, waste, and abuse. Apart from this division, the MFCU in the Office of the Attorney General also works to investigate provider fraud. MFCU is responsible for investigating and criminally convicting Medicaid provider fraud cases.

Provider Enrollment

DHHS officials have explained that the primary way of excluding providers from the Medicaid program is through provider enrollment. In order for a provider to enroll, it must meet the following requirements:

- Complete a provider enrollment application with supporting documentation.
- Accept the terms and conditions of the online enrollment application.
- Continuously meet South Carolina licensure and certification requirements.
- Comply with all federal regulations and state laws.
- Comply with all policies, procedures, and standards required by the Medicaid program.
- Be located within the United States.

Additionally, all providers must pass a screening by DHHS to be enrolled as Medicaid providers. The extent of providers' screening is determined by whether DHHS categorizes providers as a "low", "moderate", or "high" risk. Due to the moratorium, all RBHS providers are categorized as high risk. High-risk providers are screened for:

- Meeting federal and state policy requirements.
- Compliance with licensing and certification requirements.
- Federal and state database checks.
- Pre-and-post enrollment background checks.
- Completion of criminal background checks.
- Submission of fingerprints.

While DHHS' requirements and screening for enrollment meet the federal regulations on provider enrollment, DHHS has not implemented stricter enrollment policies to address the increase in fraudulent provider cases that occurred prior to the moratorium. For example, 42 CFR §455.414 requires that all providers are revalidated at least every five years. DHHS requires that all providers, except for durable medical equipment providers, are revalidated for enrollment every five years. DHHS is operating by the minimum standards, despite the drastic increase in provider fraud it encountered.

Overpayments in Provider Fraud Cases

We reviewed whether providers charged with overpayments were still in the Medicaid program. DHHS provided us with a list of all RBHS cases that the Division of Program Integrity reviewed and found that there were overpayments since July 1, 2014. Overpayments can occur when a provider overbills DHHS for services. Since the moratorium was put in place in February 2015, providers on this list are included in the influx of provider fraud that resulted in the moratorium.

We called ten randomly-chosen providers that DHHS determined had an overpayment to see if they were still accepting Medicaid beneficiaries. Nine of the providers either no longer had working telephones or were no longer accepting Medicaid patients. One provider from the list was still accepting Medicaid beneficiaries. Officials from DHHS explained that this provider is still enrolled in the Medicaid program. Although the provider was found to have established overpayments, the provider reached a settlement agreement with MFCU. Settlement agreements can be used as a way to avoid termination from the Medicaid program if the provider makes no admission of guilt. We found that three other RBHS providers, since July 1, 2014, have also had settlement agreements in order to avoid termination from the Medicaid program.

DHHS is not federally mandated to terminate a provider due to overpayments. According to the provider enrollment manual, when DHHS finds an overpayment, the provider has the opportunity to appeal the overpayment. If the provider does not repay the overpayment, then the provider may be excluded from the program. While this is in line with federal regulations for provider termination, this exposes DHHS to additional possible threats of provider fraud.

Program integrity policy allows providers to stay enrolled in the Medicaid program with a settlement agreement with no admission of guilt. In order to deter provider fraud, especially in the area of overpayments, stricter policies should be enforced for providers who are found to overbill DHHS for services.

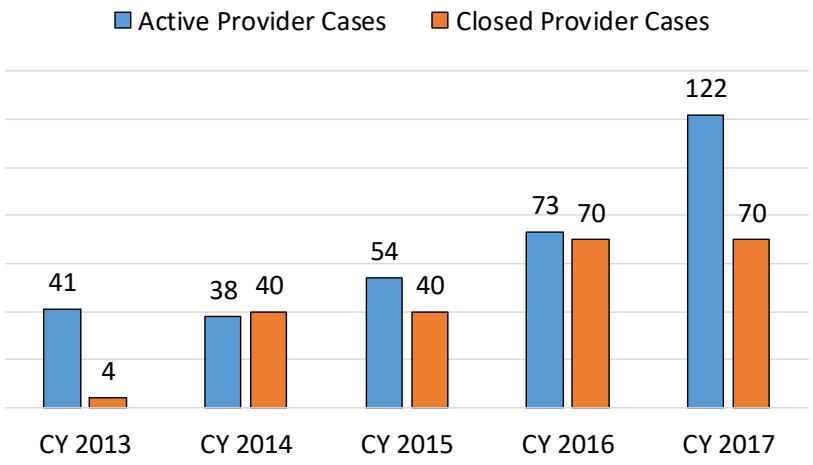
DHHS reserves the right to suspend payments to providers when a "credible allegation of fraud" is determined. A credible allegation of fraud is up to the discretion of DHHS. Stricter policies for suspending providers that are found to have overpayments may be a possible solution to deterring Medicaid provider fraud in South Carolina.

Medicaid Fraud Control Unit (MFCU)

The Medicaid Fraud Control Unit in the Office of the Attorney General is responsible for investigating and prosecuting fraudulent Medicaid providers. Officials from MFCU explained to us that they noticed an increase in fraudulent providers after the implementation of the 2014 RBHS treatment referral policy. Prior to this change, RBHS providers had to receive treatment referrals from child-placing agencies. The referral policy amended this so that RBHS providers no longer had to receive referrals.

Since then MFCU has steadily taken on many more provider fraud cases as shown in Chart 5.4. MFCU has explained that it is often difficult to prove Medicaid provider fraud cases. The standard timeline for MFCU to close a provider fraud case is two years.

Chart 5.4: Medicaid Provider Fraud Cases CY13–CY17



Source: DHHS

Recommendation

54. The S.C. Department of Health and Human Services should implement stricter sanctions for provider fraud, especially regarding overpayments.

Moratorium on RBHS Providers

DHHS has had a moratorium on the enrollment of RBHS providers for four years and does not have any definitive plans to end this moratorium. We reviewed the effects of the moratorium on RBHS providers and found that it has had an adverse impact on access.

On February 5, 2015, DHHS placed a moratorium on RBHS providers due to an exponential increase in the number of RBHS providers enrolling in the Medicaid program. DHHS indicated that through November 2014, there had been a 337% increase in the number of providers paid per month. This significant increase may suggest that overpayments were made during this time. Since July 2014, DHHS' program integrity division conducted 109 provider fraud cases, 84 of which identified overpayments.

The Centers for Medicare & Medicaid Services (CMS) required DHHS to submit written justification for the moratorium on the enrollment of RBHS providers. This justification included an analysis of an increased number of paid providers per month, increased number of paid expenditures, and increased number of beneficiaries per month. DHHS' documentation also includes steps to revise the RBHS policies.

In order to extend the moratorium, DHHS is required to submit an extension request every six months. CMS allows this extension under the condition that the moratorium does not adversely impact beneficiaries' access to medical assistance and DHHS provides written documentation of the necessity for the extension. DHHS' documentation includes steps to revise RBHS policies, including:

- Clarification of the DHHS medical necessity policy.
- Revision of the DHHS service manual to reflect clinically-appropriate daily service limits after researching the point at which services cease to have a therapeutic effect.
- Establishment of a DHHS behavioral health quality assurance team that will make site visits to educate newly-enrolled providers on DHHS policy and intervene and correct any identified inappropriate billing practices and errors.

As of December 2018, DHHS has continued to file extension requests for the RBHS moratorium; however, DHHS was unable to provide us with the latest concurrence letter from CMS.

Moratorium's Adverse Impact on Access to RBHS Providers

The RBHS moratorium has contributed to adverse impacts in access to behavioral health providers in South Carolina. Access to behavioral health providers can be defined in several ways, including the number of RBHS providers throughout the state and travel time for a beneficiary to reach a behavioral health provider.

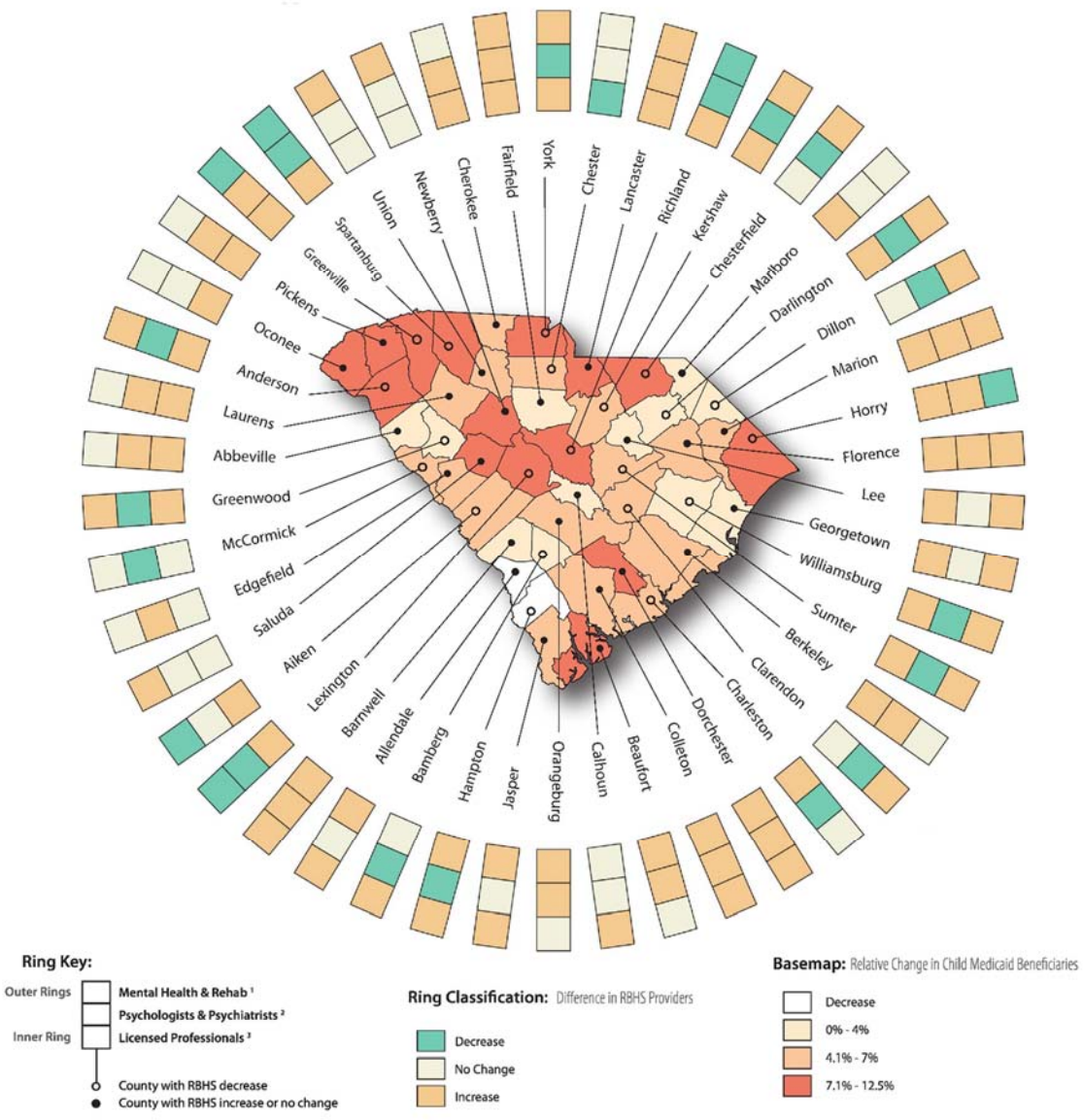
In order to review the moratorium's effects on access to care, we consulted with the University of South Carolina Institute for Families in Society to develop maps that show the average travel time for Medicaid beneficiaries to RBHS providers in 2014 (before the RBHS moratorium) and 2017 (after the RBHS moratorium was implemented). Maps 5.5 and 5.6 show the change in the total number of RBHS providers between 2014 and 2017.

Multiple counties in South Carolina have experienced a decrease in the number of RBHS providers between 2014 and 2017. During that time period, there were fewer psychologists, psychiatrists, private mental health providers, DMH professionals, alcohol and substance abuse counselors, and development rehabilitation providers throughout South Carolina. A decrease in RBHS providers throughout almost half of the state can cause issues of access to care for beneficiaries.

While almost half of South Carolina counties experienced a decrease in the number of RBHS providers, the travel time for beneficiaries to reach providers stayed generally stable. Map 5.6 shows that the average travel time to access three types of behavioral health providers increased in 15 counties between 2014 and 2017:

- Licensed professionals.
- Psychologists/Psychiatrists.
- Mental health/rehabilitation professionals.

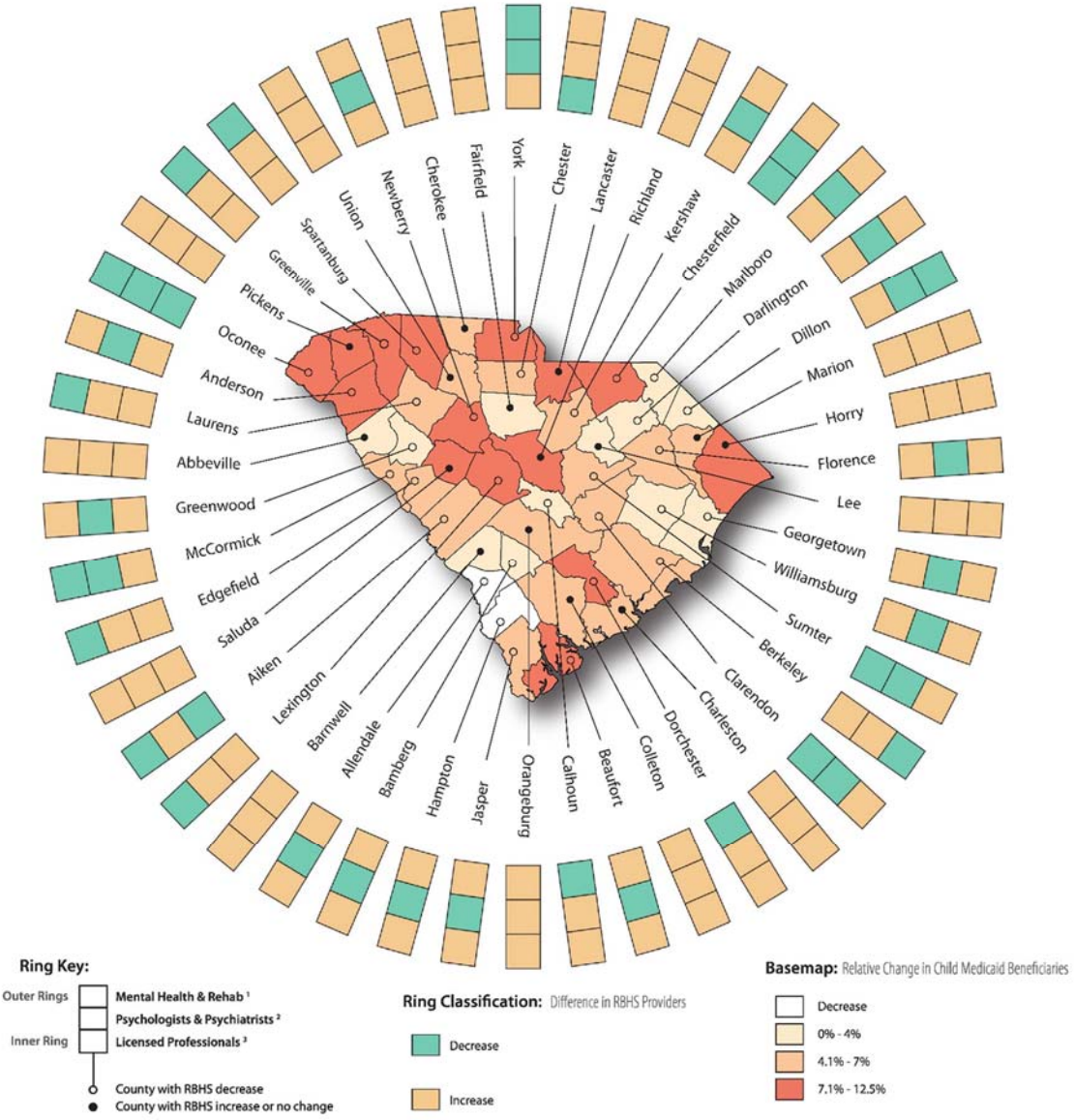
Map 5.5: Change in South Carolina's Child Medicaid Beneficiaries, 2014–2017 and Change in RBHS Providers, by County



1 **Mental Health & Rehab**: RBHS Providers with a code of 20 (Private Mental Health), 28 (SC Department of Mental Health), 90 (Alcohol & Substance Abuse), or 95 (Development Rehabilitation).
2 **Psychologists & Psychiatrists**: RBHS Providers with a code of 82 (Psychologist) or 48 (Psychiatrist).
3 **Licensed Professionals**: RBHS Providers with a code of LT (Licensed Marriage and Family Therapist), LW (Licensed Master Social Worker), PC (Licensed Professional Counselor), PS (Licensed Psycho-Education Spec.), or SW (Licensed Independent Social Worker),

RBHS Provider Data Sources: SC MMIS, CY2014 (Y14M12), CY2017 (Y17M12)
Child Medicaid Beneficiary Date Sources: SC MMIS, CY2014, FY2017
LAC Source: University of South Carolina Institute for Families in Society

Map 5.6: Change in South Carolina's Child Medicaid Beneficiaries, 2014–2017 and Change in Average Travel Time to RBHS Providers, by County



1 **Mental Health & Rehab**: RBHS Providers with a code of 20 (Private Mental Health), 28 (SC Department of Mental Health), 90 (Alcohol & Substance Abuse), or 95 (Development Rehabilitation).
2 **Psychologists & Psychiatrists**: RBHS Providers with a code of 82 (Psychologist) or 48 (Psychiatrist).
3 **Licensed Professionals**: RBHS Providers with a code of LT (Licensed Marriage and Family Therapist), LW (Licensed Master Social Worker), PC (Licensed Professional Counselor), PS (Licensed Psycho-Education Spec.), or SW (Licensed Independent Social Worker),

RBHS Provider Data Sources: SC MMIS, CY2014 (Y14M12), CY2017 (Y17M12)
Child Medicaid Beneficiary Date Sources: SC MMIS, CY2014, FY2017
LAC Source: University of South Carolina Institute for Families in Society

Patient Access to Care Study

We also conducted a provider access study to determine whether providers identified as participants in the managed care program accept Medicaid patients. We found that there is a shortage of RBHS providers in counties with rural populations. Table 5.7 highlights the main findings we discovered from this study.

To conduct this study, DHHS provided us with a list of all active behavioral health providers that are in the Medicaid program. We called a random, judgmental sample of 50 behavioral health providers throughout South Carolina. At least one provider from each county in South Carolina was included. Each provider was asked a series of questions, including whether it currently accepted Medicaid patients, the earliest appointment available, and whether it requires a pre-screen process before seeing a patient.

We found that 13 counties in South Carolina currently have only 1 behavioral health provider. U.S. census data revealed that a majority of these counties are mostly rural.

There is a significant portion of rural counties currently facing a major shortage of behavioral health providers throughout South Carolina. The moratorium exacerbates this by preventing the enrollment of new behavioral health providers.

Table 5.7: Patient Access Study Quick Facts and Implications

QUICK FACTS	IMPLICATIONS
For providers that answered our calls during the study, approximately 87% accepted Medicaid patients.	DHHS' network of RBHS providers is mostly comprised of providers that are active and accept Medicaid patients.
One-third of the providers that were able to provide an "earliest appointment time" were able to schedule a patient within one month or less of the phone call.	Long wait times for an appointment with an RBHS provider were generally not an issue.
A majority of providers we questioned confirmed that a pre-screen process is required before an appointment. The pre-screen process for these providers included an assessment or patient documentation.	Before accepting a patient for official appointments, many RBHS providers require an assessment of the patient.
7 providers in the sample did not have working phone numbers.	Some providers on DHHS' list of active RBHS providers may no longer be providing services.
10 providers in the sample had working phone numbers, but did not answer their phones after two separate calls.	These providers may either no longer be in operation or are difficult to reach by telephone.
34% percent of providers in the sample were not reachable by telephone.	Inability to contact providers by telephone presents barriers in access to care for behavioral health beneficiaries.

Source: LAC

Other States' Programs to Address Provider Shortages

While the moratorium has impacted access to behavioral health care in parts of South Carolina, the issue of access to behavioral health care is a nationwide issue. According to a 2016 article from the health policy journal, *Health Affairs*, over half of U.S. counties do not have psychiatrists. Mental health professionals tend to be concentrated in urban areas. Our study revealed several rural counties in South Carolina have only one mental health provider.

Some states have implemented ways to address the national shortage of RBHS providers. For example, Vermont has the Vermont Educational Loan Repayment Program for Health Care Professionals. This program offers loan repayments between $10,000 to $20,000 per year to health care professionals who commit to work in Vermont for 1–2 years. Some health centers in Vermont provide local incentives like bonuses.

As of May 2018, Los Angeles County in California was offering financial incentives to doctors who agree to work within the county jails. The county has also funded a fast track training program with California State University to assist registered nurses in becoming nurse practitioners. Other states such as Oklahoma, Kentucky, and Georgia have developed loan forgiveness plans for medical students who commit to work in rural areas within the state for a certain period of time.

A study conducted by the N.C. Rural Health Research and Policy Analysis Center reveals that loan reimbursement programs for healthcare practitioners are commonly funded in states throughout the U.S. The study explained that, as of 2010, there have been 63 state-funded loan reimbursement programs for healthcare practitioners. Many of these programs have proven to be successful. For example, from 2000–2017 Vermont has been able to retain 100% of psychiatrists placed through the 1–2 year duration of the loan reimbursement program. Vermont has also retained 67% of psychiatrists in this program for long-term positions. Oklahoma conducted a 25-year study and found that 82% of physicians that participated in its loan reimbursement program continued to practice in Oklahoma; 67% of physicians placed in rural areas continued to practice.

South Carolina also has a loan forgiveness program that recruits medical students to practice in rural areas. The program funds five students in three state-affiliated medical schools. The program funds up to $25,000 per year for each student. The program is open to primary care physicians and some critical need specialties such as psychiatry.

Oversight of Travel Time Requirement

DHHS does not provide much oversight over travel time for Medicaid patients to RBHS providers. An external quality review organization conducts evaluations of provider distance. During the audit process, we asked DHHS to provide a map indicating where RBHS providers are in relation to the Medicaid population. DHHS explained that such a map does not exist. We consulted with the University of South Carolina Institute for Families in Society to develop these maps. Not having a map of providers in relation to beneficiaries restricts the ability of DHHS to ensure that RBHS providers are located within an acceptable distance to Medicaid beneficiaries.

Efforts to Review and Revise RBHS Services

Since implementation of the moratorium, DHHS has undergone various efforts to review and revise RBHS policy. Due to the moratorium, all RBHS providers are considered high-risk providers and, as required by 42 CFR §455.432, undergo mandatory site visits conducted by DHHS contractors. These site visits require completion of a core screening checklist and RBHS checklist in which providers are vetted for potential notices of fraud, waste, and abuse. The core screening checklist and RBHS checklist also require accreditation and licensing documentation from providers. DHHS carved in RBHS into the managed care benefit in 2016. The purpose of this policy change was to integrate physical and behavioral health services. Site visits and the RBHS carve-in are just two examples of ways DHHS has made revisions to RBHS.

There are also several policies and procedures that have been revised during the moratorium. These include changes to maintenance of staff credentials, staff qualifications, core treatment (psychotherapy and counseling services), and documentation of medical necessity. A more specific example of change is accreditation. As of November 1, 2015, all private RBHS providers are required to ensure:

- That each service rendered is accredited.
- All locations owned and/or operated by private RBHS providers in South Carolina and/or in the Medicaid service area are accredited.
- Claims submitted for any service that is not accredited are not to be paid.

Ending the RBHS Moratorium

Placing a moratorium to prevent possible behavioral health providers from entering to serve Medicaid beneficiaries impacts rural areas in disproportionate ways. While lifting the moratorium may not fix all issues of access to behavioral healthcare due to the national shortage in behavioral health providers, lifting the moratorium on RBHS providers possibly presents an opportunity for more behavioral health providers to enter the Medicaid system and provide behavioral health care to Medicaid beneficiaries.

Despite the changes, DHHS has yet to develop an exit plan to end the RBHS moratorium. DHHS officials have explained that they do not have "immediate plans" to end the moratorium, but they said they discussed this topic internally. In order to ensure a smooth transition to enrolling new RBHS providers into the Medicaid program, it would be useful for DHHS to develop and implement a moratorium exit plan that ensures:

- All fraudulent RBHS provider cases since the moratorium have been resolved.
- All fraudulent RBHS providers convicted of provider fraud have effectively been terminated from the Medicaid program.
- Preventative measures to avert provider fraud have been implemented by DHHS.
- Implementation of better vetting procedures for new RBHS providers enrolled in the Medicaid program.
- All policy changes to RBHS since the moratorium have been addressed and are successfully being implemented.

Recommendations

55. The S.C. Department of Health Human Services should develop a preventative plan to ensure fraudulent providers are terminated from the Medicaid program. After implementation of a preventative plan, the S.C. Department of Health and Human Services should end the moratorium as soon as possible.

56. The S.C. Department of Health and Human Services should monitor the distance of all rehabilitative behavioral health services' providers in relation to beneficiaries by creating a master map for all South Carolina Medicaid coverage areas.

57. The S.C. Department of Health and Human Services should ensure it conducts a yearly analysis of each managed care organization provider network, in addition to the external quality reviews.

Medicaid Service Definitions

This appendix is for information only.

The definitions in this appendix were taken directly from the South Carolina Medicaid State Plan, as of January 2019. Any questions about these definitions should be directed to the S.C. Department of Health and Human Services. The definitions are presented in three categories.

REHABILITATIVE BEHAVIORAL HEALTH
AUTISM SPECTRUM DISORDER
PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY

REHABILITATIVE BEHAVIORAL HEALTH

Behavioral Health Screening

The purpose of this brief screening is to provide early identification of mental health and/or substance use disorders to facilitate appropriate referral for assessment and/or treatment services.

Diagnostic Assessment

I. *Diagnostic Assessment without Medical* — The purpose of this face-to-face assessment is to determine the need for rehabilitative behavioral health services, to establish or confirm a diagnosis (diagnoses), to assist in the development of an individualized plan of care based upon the beneficiary's strengths and deficits, or to assess progress in and need for continued treatment. This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and educational records.

II. *Diagnostic Assessment with Medical* — When a determination of the appropriateness of initiating or continuing the use of psychotropic medication is required, the diagnostic assessment must be carried out by a physician/psychiatrist or advanced practice registered nurse with prescriptive authority.

Psychological Testing and Evaluation (PTE)

Psychological Testing and Evaluation services includes psychodiagnostic assessment of emotionality, intellectual abilities, personality and psycho-pathology. Testing and evaluation must involve face-to-face interaction between a licensed psychologist and the beneficiary. When necessary or appropriate, consultation shall only include telephone or face-to-face contact by a psychologist.

Service Plan Development (SPD)	The purpose of this service is the development of an individual plan of care (IPOC) for the beneficiary. The IPOC, which may be developed by an interdisciplinary team, establishes the beneficiary's needs, goals, and objectives and identifies appropriate treatment/services needed by the beneficiary to meet those goals. An interdisciplinary team is typically composed of the beneficiary, his/her family and/or other individuals significant to the beneficiary, treatment providers, and care coordinators. The IPOC will incorporate information gathered during screening and assessment. The IPOC will be person/family centered and the beneficiaries must be given the opportunity to determine the direction of his/her IPOC. An interdisciplinary team may be responsible for periodically reviewing progress made toward goals and modifying the IPOC as needed.
Individual Psychotherapy (IP)	The purpose of this face-to-face intervention is to assist the beneficiary in improving his/her emotional and behavioral functioning. The therapist assists the individual in identifying maladaptive behaviors and cognitions, identifying more adaptive alternatives, and learning to utilize those more adaptive behaviors and cognitions.
Group Psychotherapy (GP)	The purpose of this face-to-face intervention is to assist several beneficiaries, who are addressing similar issues, in improving their functioning. The group process allows members to offer each other support, share common experiences, identify strategies that have been successful for them, and to challenge each other’s behaviors and cognitions. The therapist guides the group to ensure that the process is productive for all members and focuses on identified issues.
Multiple Family Group Psychotherapy (MFGP)	Multiple Family Group Psychotherapy treatment will allow beneficiaries and families with similar issues to meet face-to-face in a group with a clinician. The group’s focus is to assist the beneficiary and family members in resolving emotional difficulties, encourage personal development and ways to improve and manage their functioning skills.

Family Psychotherapy (FP)	The purpose of this face-to-face intervention is to address the beneficiary's relationship with his/her family unit. The therapist assists the family members in developing a greater understanding of the beneficiary's mental health and/or substance use disorders and appropriate treatment, identifying maladaptive interaction patterns between family members and how they contribute to the beneficiary's impaired functioning, and identifying and developing competence in utilizing more adaptive patterns of interaction. Treatment is focused on changing the family dynamics, reducing and managing conflict, improving interaction and communication, and promoting the family's support to facilitate the beneficiary's progress. Services can be rendered with or without the beneficiary present, but the beneficiary's issues must be the main focus of the discussion. This service provides guidance to the family or caregiver on navigating systems that support individuals with mental health and/or substance use disorders.
Crisis Management(CM)	The purpose of this face-to-face, or telephonic, short-term service is to assist a beneficiary, who is experiencing a marked deterioration of functioning related to a specific precipitant, in restoring his/her level of functioning. The goal of this service is to maintain the beneficiary in the least restrictive, clinically-appropriate level of care. The clinician must assist the beneficiary in identifying the precipitating event, in identifying personal and/or community resources that he/she can rely on to cope with this crisis, and in developing specific strategies to be used to mitigate this crisis and prevent similar incidents.
Medication Management (MM)	The purpose of this face-to-face service is to determine any physiological and/or psychological effects of medication(s) on the beneficiary and to monitor the beneficiary's compliance with his/her medication regime. Intervention is focused on topics such as possible side effects of medications, possible drug interactions, and the importance of compliance with medication.

Community Integration Service (CIS)

The purpose of this face-to-face service is to treat serious and persistent mental health disorder(s) and/or co-occurring substance use disorders. This service assists beneficiaries to achieve identified psychosocial rehabilitative goals in a supportive and structured environment. CIS is a program designed to help beneficiaries regain their best personal functional level using interventions that are strength-based and focus on promoting recovery.

CIS assists in:
- The restoration of social skills (e.g., expressive skills, receptive behaviors, interactive behaviors, social intelligence).
- The restoration of adaptive skills (e.g., accessing and managing resources related to self-care and community tenure).
- The enhancement of communication and problem solving skills (e.g., conflict resolution, sound decision-making, critical thinking).
- Monitoring of changes in psychiatric symptoms/or functioning (e.g., identifying changes in mood, behavior, cognition, and urges).

CIS is designed to prevent inpatient hospitalizations, emergency department visits, and social isolation, increasing the beneficiary's stability in home and community environments. Providers are encouraged to utilize evidence-based best practice models.

Therapeutic Child Care (TCC) Service

The purpose of this face-to-face service is to treat mental health disorders related to trauma, neglect, and/or abuse. TCC promotes or enhances appropriate developmental functioning which fosters social and emotional self-regulatory competence. The service is intended to restore functioning that the beneficiary either had or would have achieved if normal development had not been impaired by risk factors of trauma exposure and/or mental health disorders. TCC is a child-focused, family-centered intervention which targets the relationship between the child and the primary caregiver. Grounded in attachment theory, components of the service include Evidence Based Practices (EBPs) that are relationship-based, developmentally appropriate, and trauma informed. TCC is provided for the direct benefit of the Medicaid eligible individual.

TCC assists in restoring:

- Age-appropriate social and emotional skills (e.g., emotion regulation and appropriate social interaction).
- Secure attachments to caregivers (e.g., engage in verbal and nonverbal emotional exchange with their primary caregiver; learn to communicate their needs in a way which fosters security and balance; comfort with seeking support and nurturing from caregiver).
- Appropriate boundaries (e.g., observing limits, gaining self-control to regulate behavior, increasing safety and sense of control).
- Parallel work with the primary caregiver is an essential component of this service. A minimum of one hour per week must be spent with the primary caregiver that includes parent-child interaction to encourage language and play, interpretation of child's behavior, and reinforcement of a primary caregiver's appropriate actions and interactions.

Psychosocial Rehabilitation Services (PRS)

The purpose of this face-to-face service is to assist beneficiaries in the restoration of skills needed to promote and sustain independence and stability in their living, learning, social, and working environments. PRS is designed to assist individuals with compensating for or eliminating functional deficits and interpersonal and/or environmental barriers associated with their challenges. This service includes activities that are necessary to achieve goals in the plan of care in the areas of 1) skills enhancement related to life in the community and to increasing the beneficiary's ability to manage the illness, to improve quality of life and to live as actively and independently in the community as possible; 2) understanding the practice of healthy living habits and self-care skills; 3) enhancing the beneficiary's self-management and communication skills, cognitive functioning and ability to develop and maintain environmental supports; and 4) consumer empowerment that improves the beneficiary's basic decision-making and problem-solving capabilities. Services are rendered individually and in a group setting. The group sessions support the beneficiary in the sharing of life experiences, and practicing these behaviors while in a supportive treatment relationship/environment.

Behavior Modification (B-Mod)	The purpose of this face-to-face service is to provide the beneficiary with in vivo redirection and modeling of appropriate behaviors in order to enhance his/her functioning within his/her home or community. The individual's plan of care should determine the focus of this service.
Family Support (FS)	The purpose of this face-to-face or telephonic service is to enable the family/caregiver (parent, guardian, custodian or persons serving in a caregiver role) to serve as a knowledgeable member of the beneficiary's treatment team and to develop and/or improve the ability of families/caregivers to appropriately care for the beneficiary. FS does not treat the family or family members other than the identified beneficiary. FS is not for the purpose of history taking or coordination of care. This service includes the following discrete services when they are relevant to the goal in the individualized plan of care: providing guidance to the family/caregiver on navigating systems that support individuals with mental health and/or substance use disorder needs, such as mental health and/or substance use disorder advocacy groups and support networks; fostering empowerment of family/caregiver by offering supportive guidance for families with mental health and/or substance use disorder needs and encouraging participation in peer/parent support and self-help groups; and modeling these skills for parent/guardian/caregivers. The Family Support service does not include respite care or child care services.
Peer Support Service (PSS)	The purpose of this service is to allow people with similar life experiences to share their understanding to assist beneficiaries in their recovery from mental health and/or substance use disorders. This service is person centered with a recovery focus and allows beneficiaries the opportunity to direct their own recovery and advocacy process. The Peer Support Specialist will utilize her/his own experience and training to assist beneficiaries in understanding how to manage her/his illness in their daily lives by helping them to identify key resources, listening and encouraging beneficiaries to cope with barriers, working towards their goals, providing insight, and sharing information on services and empowering the beneficiary to make healthy decisions. The unique relationship between the Peer Support Specialist and the beneficiary fosters understanding and trust in beneficiaries who otherwise would be alienated from treatment. The beneficiary's plan of care determines the focus of this service.

Substance Use Disorder Treatment Services

DHHS and the South Carolina Department of Alcohol and Other Drug Abuse Services (DAODAS) have implemented a statewide system to coordinate substance abuse treatment services that are critical to serving eligible Medicaid beneficiaries. The purpose of these services is to provide interventions for the treatment and management of substance abuse and addictive disorders in an outpatient or residential treatment setting. Services must have a rehabilitative and recovery focus aimed at managing acute intoxication and withdrawal. Services are designed to promote skills for beneficiaries identified as having a substance abuse disorder. Services can also address, if present, a co-occurring mental health disorder.

DHHS has adopted the American Society of Addiction Medicine's (ASAM-PPC-2R) Patient Placement Criteria for the Treatment of Substance-Related Disorders as the basis for a beneficiary's placement in the appropriate levels of care with documentation reflecting applicable medical necessity on each of the ASAM dimensions. Treatment is based on the severity of the beneficiary's illness and his/her response to treatment.

Substance Use Disorder Discrete Services

A. Alcohol and Drug Screening (ADS) and Brief Intervention Services
Alcohol and Drug Screening are designed to identify beneficiaries who are at risk of development of a substance use problem. The assessment will allow early identification of a substance use disorder and facilitate appropriate referral for a focused assessment and/or treatment. Services can also address, if present, a co-occurring mental health disorder.

B. Alcohol and Drug Assessment (ADA)
The purpose of this face-to-face assessment is to determine the need for alcohol and drug and/or rehabilitative services, to establish or confirm a diagnosis, to provide the basis for development of an effective, comprehensive individual plan of care based upon the beneficiary's strengths and deficits, or to assess progress in and the need for continued treatment. This assessment includes a comprehensive bio-psychosocial interview and review of relevant psychological, medical, and education records. A follow-up assessment occurs after an initial assessment to reevaluate the status of the beneficiary, identify any changes in behavior and/or condition, and to monitor and ensure appropriateness of the treatment.

C. Alcohol and Drug/Substance Abuse Counseling (SAC)
The purpose of this face-to-face intervention is to assist beneficiaries in their recovery process. The counseling is focused on acknowledging the consequences of continued maladaptive behaviors, identifying triggers for those behaviors, and developing alternative coping strategies and skill sets. This service provides reinforcement of the beneficiary's ability to function without the use of substances. This service addresses goals identified in the plan of care that involve the beneficiary relearning basic coping mechanisms, understanding related psychological problems that trigger addictive behavior, and encouraging the beneficiary to develop healthy boundaries. Services can be rendered individually or in a group setting. The intended outcome of the group is to share similar experiences, learn coping skills, manage maladaptive behaviors, understand and reduce substance use triggers, and assist in resolving identified problems.

D. Skills Training (ST) and Development Services for Children
The purpose of this service is to provide activities that will restore or enhance targeted behaviors and improve the child's ability to function in his or her living, learning, and social environments. The service is intended to restore functioning that the beneficiary either had or would have achieved if normal development had not been impaired by risk-factors of substance use disorder, or co-occurring substance use and mental health disorders. Skills Training and Development focuses on enhancing healthy behaviors to reduce disability. Interventions are planned in such a way that they are constantly supporting, guiding, and reinforcing the beneficiary's ability to learn and utilize life skills.

E. Psychological Testing and Reporting (PTR)
The purpose of the service is to evaluate the beneficiary's intellectual, emotional, and behavioral status. Testing may include measures of intellectual and cognitive abilities, neuropsychological status, attitudes, emotions, motivations, and personality characteristics, as well as the use of other non-experimental methods of evaluation. The professional provides the administering of the test and technical aspects of the test. This service is rendered face-to-face with the Medicaid-eligible beneficiary.

F. Alcohol and Drug Assessment Nursing Services (ADN)
Delivery of this service involves a face-to-face interaction between a qualified health care professional and the beneficiary to assess the beneficiary's status, and to provide a diagnostic evaluation and screening as a mechanism to provide referral for substance abuse treatment services. This service may also include monitoring medical treatment, medication and provide a physical assessment of the beneficiary to determine the level of substance use dependency and/or the readiness for treatment. This assessment may also be used as a component of the process to establish medical necessity for the provision of substance abuse treatment services.

G. Evaluation and Management of Medical Services (E&M)
The purpose of the service is to allow a health care professional to provide a medical assessment of the beneficiary and make decisions for treatment and/or referral for services. The service is delivered face-to-face, which includes time spent performing an examination to obtain the beneficiary's medical history.

H. Medication Administration (MA)
The purpose of this service is to allow a health care professional to administer an injection to the beneficiary. The medical record must substantiate the medical necessity for this treatment.

I. Vivitrol Injection (VI)
This code is the specific injectable medication, provided by a qualified health care professional with a medical prescription. The purpose of this monthly treatment is to restore, or improve a beneficiary's behavior or substance use disorder and to decrease the craving for alcohol use.

Substance Abuse Outpatient Treatment Program

General Criteria
Treatment includes an array of services delivered in a community-based setting consistent with the beneficiary's treatment needs. The treatment must be rehabilitative and recovery focused and designed to promote coping skills to manage substance abuse symptoms and behaviors. The duration of treatment varies with the severity of the beneficiary's illness and response to treatment. The frequency and intensity of the services must reflect the needs of the beneficiary and must address the objectives of the beneficiary's plan of care.

A. Alcohol and/or Drug Services — Intensive Outpatient Treatment Program (IOP) *Level II.1*
IOP services are provided in the community to beneficiaries who are in need of more than discrete outpatient treatment services or as an alternative to residential treatment. The appropriate level of care takes into consideration the beneficiary's cognitive and emotional experiences that have contributed to substance abuse or dependency. IOP allows the beneficiary opportunities to practice new coping skills and strategies learned in treatment, while still within a supportive treatment relationship and environment. The treatment program is comprised of the following services: Individual, Family, Group, Multiple-Family Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support and Medication Management are included within the program.

B. Alcohol and/or Drug Treatment — Day Treatment/Partial Hospitalization *Level II.5*
The treatment program is a structured and supervised intense treatment program that provides frequent monitoring/management of the beneficiary's medical and emotional concerns in order to avoid hospitalization. The program has access to psychiatric, medical, and laboratory services. Intensive services at this level of care provide additional clinical support in a community setting. The treatment program is comprised of the following services: Individual, Family, Group, Multiple-Family Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management are included within the program.

Residential Substance Abuse Treatment

General Criteria
Residential Substance Abuse Treatment Services include an array of services consistent with the beneficiary's assessed treatment needs, with a rehabilitative and recovery focus designed to promote coping skills and manage substance abuse symptoms and behaviors in a residential setting. Services include physician monitoring, nursing care, and observation as needed, based on clinical judgment. Services are delivered in a residential setting with 16 beds or less.

A. Alcohol and/or Drug Sub-Acute Detox — Clinically Managed Residential Detoxification *Level III.2-D*
The treatment program relies on established clinical protocols and 24-hour medical supervision for beneficiaries who are intoxicated or experiencing withdrawal. The Registered Nurse or Licensed Practical Nurse staff will administer the Clinical Institute Withdrawal Assessment of Alcohol Assessment (CIWA-Ar) for intoxicated beneficiaries and medical supervision for the management of substance use or alcohol withdrawal. The program also provides emergency medical services, laboratory work as needed and medication ordered by a Physician or an Advanced Practice Licensed Nurse. A physical examination is completed within 24 to 48 hours after admission. The treatment program is comprised of the following services: Individual, Family, Group, Multiple-Family Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management are included within the program.

B. Alcohol and/or Drug Acute Detox — Medically Monitored Residential Detoxification Services *Level III.7-D*
The treatment program consists of 24-hours of medical supervision and treatment, observation, laboratory screening, and medication orders as needed for beneficiaries who are intoxicated or experiencing withdrawal in a residential setting. The Registered Nurse or Licensed Practical Nurse will administer an initial alcohol and drug assessment. At this level of care, a physician is available 24 hours per day and is available to assess the beneficiary within 24 hours of admission (or sooner, if medically necessary).

The physician must be available to provide onsite monitoring of care and further evaluation on a daily basis. Primary emphasis is placed on ensuring that the beneficiary is medically stable (including the initiation and tapering of medications used for the treatment of substance use withdrawal); assessing for adequate bio-psychosocial stability; intervening immediately to establish bio-psychosocial stability; and facilitating effective linkage to other appropriate residential and outpatient services. The treatment program is comprised of the following services: AOD Assessment Nursing Services, Individual, Family, Group, Multiple-Family Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management are included within the program.

C. Behavioral Health Long Term Residential Treatment Program — Clinically Managed High-Intensity Residential Treatment
Level III.5-R
The treatment program is designed to promote abstinence from substances and antisocial behavior and to effect an overall change in the lifestyle, attitude and values of persons who have significant social and psychological problems. This service provides comprehensive, multi-faceted treatment to beneficiaries who have multiple deficits and psychological problems (including serious and persistent mental disorders) in a residential setting. The Registered Nurse and Licensed Practical Nurse provides 24-hour observation, monitoring and treatment. The program provides laboratory work as needed, physical examination within 24 hours after admission or sooner, and medication orders by a Physician or an Advanced Practice Registered Nurse. Priority admission is provided to pregnant women, whose stay may be longer due to complications of substance use disorder or co-occurring mental health disorder. The treatment program provides the following services: AOD Assessment Nursing Services, Individual, Family, Group, Multiple-Family Group Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management are included in the program.

D. Behavioral Health Short Term Residential Treatment Program — Medically Monitored Intensive Residential Treatment *Level III.7-R*
The treatment program provides a planned regimen of professionally directed services that are appropriate for beneficiaries whose sub-acute, biomedical and emotional, behavioral or cognitive problems are so severe that residential care is required. The beneficiaries of this service have functional deficits affecting the ability to manage intoxication/withdrawal, bio-medical symptoms and/or emotional instability, medical, behavioral or cognitive conditions that interfere with or distract from recovery efforts. The program also provides 24-hour medical observation, monitoring, and treatment, emergency medical services, laboratory work, medication order by a Physician or an Advanced Practice Registered Nurse, physical examination within 24 hours after admission, and provides face-to-face evaluations at least once a week. A Registered Nurse or Licensed Practical Nurse will be responsible for overseeing the monitoring of the beneficiary's progress and medication administration. The treatment program comprises the following services: Individual, Family, Group, Multiple-Family Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management are included within the program.

E. Behavioral Health Short Term Residential Treatment Program — Medically Monitored High-Intensity Residential Treatment Services *Level III.7-RA*
The treatment program is designed to provide a regimen of 24-hour medical monitoring, addiction treatment, and evaluations in a residential setting. The program functions under a defined set of policies, procedures and clinical protocols and are appropriate for children and adolescent beneficiaries up to age 21, whose sub-acute biomedical and emotional, behavioral or cognitive problems are so severe that they require residential treatment. The program also provides 24-hour medical observation, monitoring, and treatment, laboratory screening, medication order by a qualified health care professional, physical examination within 24 hours after admission, and provides face-to-face evaluations at least once a week.
A registered nurse is responsible for monitoring of the beneficiary's progress and medication administration. The treatment program comprises the following services: AOD Assessment Nursing Services, Individual, Family, Group, Multiple-Family Psychotherapy, AOD/Substance Abuse Counseling, Peer Support Services, PRS, Family Support, and Medication Management are included in the program.

AUTISM SPECTRUM DISORDER (ASD)

Behavior Identification Assessment	Direct beneficiary contact (and collaterals as clinically indicated) in order to identify maladaptive behaviors, completing a mental health evaluation to establish treatment needs and a treatment plan. This service may include psychological testing, as clinically indicated.
Observational Behavioral Follow-Up Assessment	Direct beneficiary contact (and collaterals as clinically indicated) to identify and evaluate factors that may impede adaptive behavior. This assessment includes structured observation and/or standardized tests to determine adaptive behavior. This service may include psychological testing, as clinically indicated.
Exposure Behavior Follow-Up Assessment	Direct beneficiary contact to examine triggers, events, cues, responses, and consequences associated with maladaptive behavior.
Adaptive Behavior Treatment	Direct beneficiary contact (and collaterals as clinically indicated) to address the beneficiary's treatment goals as defined by the assessments and Individualized Plan of Care. Adaptive behavior treatment includes analysis and alteration of motivating factors and contextual events, stimulus-consequence strategies and replacement behavior, as well as the monitoring of outcome variables.
Family Adaptive Behavior Treatment Guidance	Direct contact with the family/caregiver for specialized training and education to assist with the beneficiary's treatment goals and development. The provider observes and trains the family/caregivers on the beneficiary's status, as well as instructs family/caregivers on techniques to promote the child's development.

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF)

An accredited institution primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons (21 years and under) who require less than hospital services. Psychiatric Residential Treatment Facilities are neither acute care nor long-term care facilities. A Psychiatric Residential Treatment Facility is a facility that is accredited by the Joint Commission of Accreditation of Health Care Organizations, The Council on Accreditation of Services to Families and Children, or The Commission on Accreditation of Rehabilitation Facilities operated for the primary purpose of providing active treatment services for mental illness in a non-hospital based residential setting to persons under 21 years of age. Length of stay in a Psychiatric Residential Treatment Facility may range from one (1) month to more than twelve (12) months depending upon the individual's psychiatric condition as reviewed every 30 days by a physician.

State-by-State Autism Rate Comparison, as of December 2018

State	Behavior Identification Assessment		Observational Behavioral Follow–Up Assessment			
	0359T		0360T		0361T	
	Rate Range	Frequency	Rate Range	Frequency	Rate Range	Frequency
Alabama	--	--	--	--	$ 25.00	30 min
Alaska	$480.76 – $259.61	Encounter	--	--	--	--
Florida	$385.19 – $192.59	Encounter per year/ reassess 3 per year	--	--	--	--
Georgia	$444.54 – $180.06	90 min	$148.18 – $30.26	30 min	$148.18 – $30.26	30 min
Louisiana	$400 – $320	Encounter	$50 – $22	30 min	$50 – $22	30 min
Maryland	$220.00	Encounter per year	$ 55.00	30 min	$ 55.00	30 min
Michigan	$480 – $340	Encounter	--	--	--	--
Mississippi	$200.14	1 per 6 months	$ 81.20	2 per 6 months	$ 81.20	2 per 6 months
Montana	$276.72 – $204.76	Encounter per 6 months	--	--	--	--
Nevada	$280.75	Encounter per 180 days	$70.19 – $15.65	30 min	$70.19 – $15.65	30 min
New Mexico	$330 – $283	Encounter	$82.50 – $73.50	30 min	$82.50 – $73.50	30 min
North Dakota	$500.00	Encounter	$ 39.84	30 min	$ 39.84	30 min
Ohio	$27.68	30 min; reduced 50% after 3 units	--	--	--	--
South Carolina	$ 47.02	30 min	--	--	--	--
Utah	$480.00	Encounter	$240	Encounter	--	--
Vermont	$550.00	Encounter	$100.00 – $86.84	30 min	$100.00 – $86.84	30 min
Virginia	$ 60.00	Hourly to 5 units	--	--	--	--
Wisconsin	$331.50	Encounter per 6 months	$ 36.67	30 min	$ 36.67	30 min
Wyoming	$314.28	Encounter 2x year	$ 42.06	30 min	$ 42.06	30 min

Appendix B
State-by-State Autism Rate Comparison, as of December 2018

State	Exposure Behavioral Follow–Up Assessment		Adaptive Behavior Treatment by Protocol		Group Adaptive Behavior Treatment by Protocol	
	0362T	0363T	0364T	0365T	0366T	0367T
	Rate Range		Rate Range		Rate Range	
	(first 30 min)	(each add'l 30 min)	(first 30 min)	(each add'l 30 min)	(first 30 min)	(each add'l 30 min)
Alabama	$ 60.00	$ 60.00	$20.00	$20.00	$8	$8
Alaska	--	--	$38.04	$38.04	$15.21	$15.21
Florida	$ 38.10	$ 38.10	--	--	$24.38 – $15.16	$24.38 – $15.16
Georgia	$148.18 – $30.26	$148.18 – $30.26	$148.18 – $30.26	$148.18 – $30.26	$148.18 – $30.26	$148.18 – $30.26
Louisiana	--	--	$23 – $19	$23 – $19	$9	$9
Maryland	$ 75.00	$ 75.00	$35 – $20	$35 – $20	$15 – $10	$15 – $10
Michigan	$60 – $42.5	$60 – $42.5	$30 – $27.5	$30 – $27.5	$8.57 – $7.86	$8.57 – $7.86
Mississippi	$162.40	--	$31.68	$31.68	$15.84	$15.84
Montana	--	--	$19.42	$19.42	--	--
Nevada	$70.19 – $42.11	$70.19 – $15.65	$60.20 – $15.65	$60.20 – $15.65	$14.28 – $5.22	$14.28 – $5.22
New Mexico	$100.00	$100.00	$30 – $25	$30 – $25	$17 – $7.25	$17 – $7.25
North Dakota	--	--	$18.36	$18.36	--	--
Ohio	--	--	$25.38	$25.38 Reduced by 20% after 1 unit	--	--
South Carolina	--	--	$15.50	$15.50	--	--
Utah	--	--	$15.00	--	$11.25 – $5.18	--
Vermont	$100.00 – $86.84	$100.00 – $86.84	$30.00	$30.00	$30	$26
Virginia	--	--	--	--	--	--
Wisconsin	--	--	$66.30 – $19.05	$66.30 – $19.05	--	--
Wyoming	--	--	$42.06 – $14.5	$42.06 – $14.5	$7.25	$7.25

Appendix B
State-by-State Autism Rate Comparison, as of December 2018

State	Adaptive Behavior Treatment with Protocol Modification, Designated Professional, One Patient		Family Adaptive Behavior Treatment Guidance		Multiple–Family Group Adaptive Behavior Treatment Guidance	
	0368T	0369T	0370T		0371T	
	Rate Range (first 30 min)	Rate Range (each add'l 30 min)	Rate Range	Frequency	Rate Range	Frequency
Alabama	$30.00	$30.00	$60.00	1 hour	$10.00	1 hour
Alaska	$50.06	$50.06	$62.83	Encounter per day	--	--
Florida	$30.48	$30.48	--	--	--	--
Georgia	$116.42 – $60.02	$148.18 – $60.02	$106.86 – $52.82	1 hour	$185.79 – $79.23	90 min
Louisiana	$45 – $35	$45 – $35	$90 – $70	Encounter	$36 – $28	Encounter
Maryland	$55 – $30	$55 – $30	$60 – $35	Encounter	$37.00	Encounter
Michigan	$60 – $42.5	$60 – $42.5	$120 – $85	Encounter	$72 – $51	Encounter
Mississippi	$77.52	--	$55.00	Encounter per week	$39.72	Encounter per week
Montana	$35.02 – $25.92	$35.02 – $25.92	--	--	--	--
Nevada	$60.20 – $36.12	$60.20 – $36.12	$84.68	Per session	--	--
New Mexico	$70 – $50	$70 – $50	$90 – $65	Per session	$45 – $32.50	Per session
North Dakota	$53.84	$53.84	--	--	--	--
Ohio	$33.20	$33.20 Reduced by 20% after 1 unit	--	--	--	--
South Carolina	$29.10	$29.10	$29.10	30 min	--	--
Utah	$40.00	--	$80.00	Encounter	$60 – $27.64	Encounter
Vermont	$50.00 – $43.42	$50.00 – $43.42	$65.00 – $56.45	Encounter	--	--
Virginia	--	--	--	--	--	--
Wisconsin	$36.67	$36.67	$89.67	Encounter per week	--	--
Wyoming	$42.06	$42.06	$84.12	60–75 min	$29.01	60–75 min

State	Adaptive Behavior Treatment Social Skills Group		Exposure Adaptive Behavior Treatment with protocol modification requiring >1 technicians for severe maladaptive behavior(s)		
	0372T		0373T		0374T
	Rate Range	Frequency	Rate Range	Frequency	Rate Range (each add'l 30 min)
Alabama	$20.00	1 hour	$80.00	1 hour	$40.00
Alaska	--	--	--	--	--
Florida	--	--	--	--	--
Georgia	$185.79 – $79.23	90 min	$296.36 – $60.52	1 hour	$148.18 – $30.26
Louisiana	$40 – $30	Encounter	--	--	--
Maryland	$30.00	Encounter	$150.00	1 hour per day	$75.00
Michigan	$51.43 – $36.43	Encounter	$120 – $110	1 hour	$60 – $55
Mississippi	$39.72	3 per week	$77.51	Encounter per month	--
Montana	--	--	--	--	--
Nevada	$14.28	Per session	$76.28 – $31.31	1 hour	$38.14 – $15.65
New Mexico	$40 – $16	Per session	$300.00	1 hour	$150.00
North Dakota	--	--	$44.06	1 hour	$22.03
Ohio	--	--	--	--	--
South Carolina	--	--	--	--	--
Utah	$60 – $27.64	Encounter	--	--	--
Vermont	--	--	$104.00	1 hour	$52.00
Virginia	--	--	--	--	--
Wisconsin	--	--	--	--	--
Wyoming	--	--	--	--	--

Appendix B
State-by-State Autism Rate Comparison, as of December 2018

Notes: North Carolina's rate information for autism services was not available for inclusion.

"Encounter" is defined as a health care contact between the patient and the provider who is responsible for diagnosing and treating the patient.

Dashed fields indicate that the Medicaid service is not available.

Source: LAC analysis of state websites

Appendix B
State-by-State Autism Rate Comparison, as of December 2018

Rehabilitative Behavioral Health Service Rate Comparison, as of July 2018

	South Carolina		North Carolina		Georgia	
Proc Code	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates
90791	Psychiatric Diagnostic Evaluation without Medical (Comprehensive Diagnostic Assessment – Initial) Encounter = 1 unit	$224.63-$153.94	--	--	Diagnostic Assessment Per Encounter	$140.28-$90.03
90792	Psychiatric Diagnostic Evaluation with Medical Services Encounter = 1 unit	$145.83-$48.12* or $445.60-$201.74	--	--	Diagnostic Assessment Per Encounter	$222.26-$116.90
90832	Psychotherapy, 30 min Encounter = 1 unit Unit = 1 session	$191.00-$49.66* or $104.94-$37.30	--	--	Individual Outpatient Services (approx. 30 min), includes telehealth Per Encounter	$77.93-$25.21
90833	Psychotherapy, 30 min Encounter = 1 unit Unit = 1 session	$56.03-$17.50*	--	--	Psychiatric Treatment (Ind Psychotherapy w E7M + 30 min add-on) Per Encounter	$123.48-$64.95
90834	Psychotherapy, 45 min Encounter = 1 unit Unit = 1 session	$286.50-$74.49* or $209.88-$74.60	--	--	Individual Outpatient Services (approx. 45 min), includes telehealth Per Encounter	$140.28-$45.38
90836	Psychotherapy, 45 min Encounter = 1 unit	$73.57-$24.28*	--	--	Psychiatric Treatment (Ind Psychotherapy w E7M + 45 min add-on) Per Encounter	$222.26-$116.90
90837	Psychotherapy, 60 min Encounter = 1 unit Unit = 1 session	$382.00-$99.32* or $314.82-$111.90	--	--	Individual Outpatient Services (approx. 60 min), includes telehealth Per Encounter	$187.04-$60.51
90839	Crisis Intervention	--	--	--	Crisis Intervention, includes telehealth option, Per Encounter	$296.36-$120.04
90840	Crisis Intervention	--	--	--	Crisis Intervention, includes telehealth option, Per Encounter	$148.18-$60.02
90846	Family Psychotherapy, 50 min Encounter = 1 unit Unit = 1 session	$382.00-$99.32* or $301.17-$107.04	--	--	Family Outpatient Services, includes telehealth 15 min	$46.76-$15.13

	South Carolina		North Carolina		Georgia	
Proc Code	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates
90847	Family Psychotherapy, including patient 50 min Encounter = 1 unit Unit =1 session	$382.00- $99.32* or $301.17- $107.04	--	--	Family Outpatient Services, includes telehealth 15 min	$46.76- $15.13
90849	Multiple Family Group Psychotherapy Encounter = 1 unit Unit =1 session	$186.46- $48.48* or $24.30- $16.65	--	--	--	--
90853	Group Psychotherapy Encounter = 1 unit Unit =1 session	$186.46- $48.48* or $24.30- $16.65	--	--	Group Outpatient Services 15 min	$10.39- $3.30
96101	Psychological Testing and Evaluation 1 unit = 60 min	$90.43	--	--	Psychological Testing, includes telehealth 1 hour	$187.04- $155.87
96101	Psychological Testing and Reporting Encounter = 1 unit Unit = 1 session	$60.90*	--	--	Psychological Testing, includes telehealth 1 hour	$187.04- $155.87
96102	Psychological Testing and Reporting Encounter = 1 unit Unit = 1 session	$52.82*	--	--	Psychological Testing, includes telehealth 1 hour	$146.71- $81.18
96150	Nursing Services 15 min	--	--	--	Nursing Services, includes telehealth option, Per 15 min	$46.76- $20.30
96151	Nursing Services 15 min	--	--	--	Nursing Services, includes telehealth option, Per 15 min	$46.76- $20.30
96372	Medication Administration 1 unit	$3.88*	--	--	Medication Administration Per contact	$42.51- $17.40
99201	Psychiatric Treatment (E&M-Newpt-10 min) Encounter	--	--	--	Psychiatric Treatment (E&M-Newpt-10 min), Per Encounter	$49.39- $25.98
99202	Psychiatric Treatment (E&M-Newpt-20 min) Encounter	--	--	--	Psychiatric Treatment (E&M-Newpt-20 min)	$98.79- $51.96
99203	Medical evaluation and Management (New Patient: 30 min) Encounter = 1 unit	$67.37- $55.97*	--	--	Psychiatric Treatment (E&M - NewPt-30 min) Per Encounter	$148.18- $77.94
99204	Psychiatric Treatment (E&M-Newpt-45 min) Encounter	--	--	--	Psychiatric Treatment (E&M-Newpt-45 min) Per Encounter	$222.26- $116.90
99205	Psychiatric Treatment (E&M-Newpt-60 min) Encounter	--	--	--	Psychiatric Treatment (E&M-Newpt-60 min) Per Encounter	$296.36- $155.88
99211	Psychiatric Treatment (E&M-EstabPt-5min) Encounter	--	--	--	Psychiatric Treatment (E&M-EstabPt-5min) Per Encounter	$24.70- $12.99

	South Carolina		North Carolina		Georgia	
Proc Code	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates
99212	Psychiatric Treatment (E&M-NewPt-10min) Encounter	--	--	--	Psychiatric Treatment (E&M-NewPt-10min) Per Encounter	$49.39-$25.98
99213	Medical Evaluation and Management (Established Patient: 15 min) Encounter = 1 unit	$45.37-$37.69*	--	--	Psychiatric Treatment (E&M - EstabPt-15 min) Per Encounter	$74.09-$38.97
99214	Psychiatric Treatment (E&M-NewPt-25min) Encounter	--	--	--	Psychiatric Treatment (E&M-NewPt-25min) Per Encounter	$123.48-$64.95
99215	Psychiatric Treatment (E&M-NewPt-40min) Encounter	--	--	--	Psychiatric Treatment (E&M-NewPt-40min) Per Encounter	$197.57-$103.92
99366	Service Plan Development – Team Conference w/Client/Family Encounter = 1 unit	$39.54	--	--	--	--
99366	Service Plan Development Interdisciplinary Team w/Client Encounter = 1 unit Unit = 1 session	$45.71*	--	--	--	--
99367	Service Plan Development – Team Conference w/o Client/Family Encounter = 1 unit	$26.10* or $39.54	--	--	--	--
99408	Alcohol and Drug Screening (ADS) and Brief Intervention Service Encounter = 1 unit Unit = 1 session	$56.98-$12.54*	--	--	--	--
99446	Psychiatric Consultation Encounter	--	--	--	Psychiatric Consultation Per Encounter	$38.81-$25.98
H0001	Alcohol and Drug Assessment – Initial w/o Physical Encounter = 1 unit (1.5 hour session)	$153.94-$134.79*	--	--	--	--
H0001	Alcohol and Drug Assessment – Follow-up w/o Physical Encounter =1 unit (1 hour session)	$79.34*	--	--	--	--
H0001	Alcohol and Drug Assessment Nursing Services 15 min = 1 unit	$33.87*	--	--	--	--
H0002	Behavioral Health Screening 15 min = 1 unit	$37.13-$11.23	--	--	--	--
H0004	Alcohol and Drug Counseling - Individual 15 min = 1 unit	$19.40*	--	--	Group Outpatient Services 15 min or Family Outpatient Services, includes telehealth 15 min	$10.39-$3.30 Group or $46.76-$15.13 Family

	South Carolina		North Carolina		Georgia	
Proc Code	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates
H0005	Alcohol and Drug Counseling - Group Encounter = 1 unit	$48.48*	--	--	--	--
H0010	Alcohol and/or Drug Sub-Acute Detox - Clinically Managed Residential Detoxification Encounter	$96.92*	Non-Hospital Medical Detoxification Per Diem	$325.58	--	--
H0011	Alcohol and/or Drug Acute Detox – Medically Monitored Residential Detoxification Services Encounter	$288.82*	--	--	--	--
H0013	SA Medically Monitored Community Residential Treatment Per-diem	--	SA Medically Monitored Community Residential Treatment, Per-diem	$241.81	--	--
H0014	Ambulatory Detoxification 15 min	--	Ambulatory Detoxification, 15 min	$21.25	Ambulatory Detox	$38.97- $20.30
H0015	Alcohol and/or Drug Services – Intensive Outpatient Treatment Encounter	$32.53*	Substance Abuse Intensive Outpatient Program, Per-diem	$131.56	SAIOP-C&A (Bundled rate for combo of discrete Services) 1 hour	$33 - $13.20
H0018	Behavioral Health Short Term Residential Treatment Program – Medically Monitored Intensive Residential Treatment Encounter	$266.23*	--	--	Crisis Stabilization (Bundled rate for combo of discrete Services) 1 day	$209.22
H0018	Behavioral Health Short Term Residential Treatment Program – Medically Monitored High-Intensity Residential Treatment Services Encounter	$321.52*	--	--	Crisis Stabilization (Bundled rate for combo of discrete Services) 1 day	$209.22
H0019	Behavioral Health Long Term Residential Treatment Program - Clinically Managed High-Intensity Residential Treatment Encounter	$193.82*	High Risk Intervention Level III HQ <= 4 beds, TJ >= 5 beds; Level IV HK <= 4 beds, UR >= 5 beds Per Diem	HQ $232.88 TJ $189.75 HK $315.71 UR $315.71	TG Community Living Supports I; TF Community Residential Rehabilitation II; 00 Community Living Supports III 1 day	TG $99.23 TF $64.13 00 $46.43
H0020	Opioid Treatment Per event	--	Opioid Treatment, Per event	$16.60	Opioid Maintenance	$33.40- $17.40
H0025	Peer Support Whole Health & Wellness, 15 min	--	--	--	Peer Support Whole Health & Wellness, Per 15 min	$36.68- $13.20
H0031	Mental Health Comprehensive Diagnostic Assessment – Follow–up Encounter = 1 unit	$112.32- $76.97	--	--	Behavioral Health Assmt & Service Plan Development, includes telehealth option 15 min	$46.76- $15.13
H0032	Mental Health Service Plan Development – Non–Physician 15 min = 1 unit	$11.73- $7.04	Targeted Case Management - Mental Health/ Substance Abuse, Per week	$81.25	Behavioral Health Assmt & Service Plan Development, includes telehealth option 15 min	$46.76- $15.13

	South Carolina		North Carolina		Georgia	
Proc Code	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates
H0032	Mental Health Service Plan Development – Non-Physician w/client Encounter = 1 unit Unit = 1 session	$45.71*	Targeted Case Management - Mental Health/Substance Abuse, Per week	$81.25	--	--
H0032	Mental Health Service Plan Development – Non-Physician w/out client Encounter = 1 unit Unit = 1 session	$26.10*	Targeted Case Management - Mental Health/Substance Abuse, Per week	$81.25	--	--
H0034	Medication Management 15 min = 1 unit	$15.82-$5.19* or $24.29-$6.68	--	--	--	--
H0035	Partial Hospital Per-diem	--	Partial Hospital, Per-diem	$132.32	--	--
H0036	Intensive Family Intervention 15 min	--	--	--	Intensive Family Intervention, Per 15 min	$30.01-$16.50
H0038	Peer Support 15 min = 1 unit	$6.56-$2.62*	--	--	Peer Supports; group, AD group, individual, youth, parent, AD individual, includes telehealth options 15 min	$24.36-$13.20
H0038	Peer Support Service – **Provided by DMH and DAODAS only** 15 min = 1 unit	$5.98	--	--	Peer Supports; group, AD group, individual, youth, parent, AD individual, includes telehealth options 15 min	$24.36-$13.20
H0039	Assertive Community Treatment – Group 15 min	--	--	--	Assertive Community Treatment - Group, Per 15 min	$6.60-$3.30
H0039	Assertive Community Treatment - Bundled rate for combo of discrete services 15 min	--	--	--	Assertive Community Treatment - Bundled rate for combo of discrete services Per 15 min	$32.46
H0039	Community Support Team	--	--	--	Community Support Team	$36.68-$15.13
H0040	Assertive Community Treatment Team (ACTT) Per-diem	--	Assertive Community Treatment Team (ACTT), Per-diem	$295.32	--	--
H0046	High Risk Intervention - Level 1 Per-diem	--	High Risk Intervention – Level 1, Per-diem	$49.75	--	--
H2000	Child Adolescent Level of Care Utilization System (CALOCUS) Encounter = 1 unit	$224.63-$153.94	--	--	--	--
H2010	Medication Administration Per contact	--	--	--	Medication Administration Per contact	$42.51-$12.97
H2011	Crisis Management 15 min = 1 unit	$19.31* or $56.12-$16.97	Mobile Crisis Management 15 min	$33.68	Crisis Intervention, includes telehealth 15 min	$74.09-$15.13

	South Carolina		North Carolina		Georgia	
Proc Code	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates
H2012	Child and Adolescent Day Treatment Per hour	--	Child and Adolescent Day Treatment Per hour	$31.41	--	--
H2014	Skills Training and Development* or Behavior Modification 15 min = 1 unit	$7.81* or $25.82-$7.11	--	--	Group Outpatient Services 15 min or Family Outpatient Services, includes telehealth 15 min	$5.41-$3.30 Group or $24.36-$15.13 Family
H2015	Community Support Individual 15 min	--	--	--	Community Support Individual, includes telehealth option, Per 15 min	$24.36-$15.13
H2017	Psychosocial Rehabilitation Service 15 min = 1 unit	$7.81* or $13.02-$3.00	Psychosocial Rehabilitation 15 min	$2.69	Psychosocial Rehabilitation - Individual (PSR-I), includes telehealth 15 min or Psychosocial Rehabilitation – Group 1 hour	$24.36-$15.13 (15 min) or $21.64-$13.20 (hour)
H2020	High Risk Intervention - Level II Group Homes Per-diem	--	High Risk Intervention - Level II Group Homes, Per-diem	$126.31	--	--
H2021	Community Living Supports IV (in individual's home) 15 min	--	--	--	Community Living Supports IV (in individual's home), Per 15 min	$13.96
H2022	Intensive In-Home Services Per-diem	--	Intensive In-Home Services, Per-diem	$239.66	Intensive Customized Care Coordination, Per month	$915.96
H2025	Task Oriented Rehabilitation Services 15 min	--	--	--	Task Oriented Rehabilitation Services, Per 15 min	$24.36-$15.13
H2030	Community Integration Services 15 min = 1 unit	$6.52-$5.42	--	--	--	--
H2033	Multi-Systemic Therapy (MST) 15 min	--	Multi-Systemic Therapy (MST), 15 min	$36.57	--	--
H2035	Alcohol and/or Drug Treatment – Day Treatment/Partial Hospitalization Encounter	$27.84*	SA Comprehensive Outpatient Treatment Program Per hour	$45.35	--	--
H2037	Therapeutic Child Care 15 min = 1 unit	$13.02-$4.50	--	--	--	--
J2315	Vivitrol Injection 380 units	$3.39*	--	--	--	--
S5145	High Risk Intervention - Level II Family Setting Per-diem	--	High Risk Intervention - Level II Family Setting, Per-diem	$88.58	--	--
S5145	Intensive Alternate Family Treatment Per-diem	--	Intensive Alternate Family Treatment, Per-diem	$214	--	--

Appendix C
Rehabilitative Behavioral Health Service Rate Comparison, as of July 2018

	South Carolina		North Carolina		Georgia	
Proc Code	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates	Service Name/ Frequency	FFS Rates
S9482	Family Support 15 min = 1 unit	$6.16* or $25.82 - $7.11	--	--	--	--
S9484	Facility-Based Crisis Program - Children and Adolescents Per hour	--	Facility-Based Crisis Program - Children and Adolescents up to age 21, Per hour	$15.93	--	--
T1001	Nursing Services 15 min	--	--	--	Nursing Services, includes telehealth option, Per 15 min	$46.76- $20.30
T1002	Nursing Services 15 min	--	--	--	Nursing Services, includes telehealth option, Per 15 min	$46.76- $30.01
T1003	Nursing Services 15 min	--	--	--	Nursing Services, includes telehealth option, Per 15 min	$24.36- $20.30
T1017	Targeted Case Management - Developmental Disability Per week	--	Targeted Case Management - Developmental Disability, Per week	$61.01	--	--
T1023	Diagnostic Assessment Per event	--	Diagnostic Assessment, Per event	$231.30	--	--

Notes: Dashed fields indicate that the Medicaid service is not available.

* Bundled rates which include alcohol and other drug abuse Services, DAODAS only.

Source: LAC analysis of state websites

Appendix C
Rehabilitative Behavioral Health Service Rate Comparison, as of July 2018

Agency Comments

Appendix D
Agency Comments

Healthy Connections MEDICAID

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September 19, 2019

K. Earle Powell, Director
Legislative Audit Council
1331 Elmwood Ave., Suite 315
Columbia, SC 29201

Dear Director Powell,

The management of the South Carolina Department of Health and Human Services (SCDHHS) thanks you for the opportunity to comment on the final draft report from the Legislative Audit Council (LAC) regarding elements of publicly funded children's behavioral health services (CBHS) in South Carolina. At 136 pages, 57 recommendations, and with a scope that touches topics spanning the breadth of Medicaid fee-for-service (FFS), managed care, and program oversight, this is a subject that will not be fully covered in SCDHHS management's brief comments.

In this final and public opportunity to comment on the report, SCDHHS has elected to focus largely on points of thematic agreement, disagreement, and outstanding points of process and professionalism as opposed to providing lengthy, detailed commentary on individual items or issues. As the LAC has requested that SCDHHS' comments be limited to 10 pages or less, not all detailed comments from prior submissions will be reproduced in this letter. This includes items for which SCDHHS has previously submitted correcting information and regulatory guidance that remains uncorrected in the final report.

Recommendations for Other Agencies and Entities

Several conclusions and recommendations in the report largely involve issues of policy or operations for agencies other than SCDHHS. Accordingly, the agency is not providing direct comments on recommendations 3, 4, 6, 32, and 33. SCDHHS notes that the single recommendation focused on the mental health provider workforce in the draft report, recommendation 62, was not included in the final report.

Recommendations Not Included in the Final Report

SCDHHS acknowledges that two recommendations related to the performance of SCDHHS's program integrity division were removed pursuant to guidance provided in the draft report and thanks the LAC for those deletions. Further, recommendations worded similarly to others regarding documenting managed care organization (MCO) site visits and time and distance requirements for providers were removed. SCDHHS did not find either to be objectionable but agrees with their deletion.

Points of Agreement

SCDHHS appreciates the LAC's acknowledgement of efforts already underway at the agency or areas where the agency has self-identified the need for improvement. In all, there are 57 recommendations; SCDHHS agrees it should address or has has already taken action to address 60% of the LAC's recommendations. In addition, 9% of the recommendations do not apply to SCDHHS directly. Draft comments by the agency went into greater detail on each, and the agency has summarized these points in Table 1 for brevity.

Table 1: SCDHHS efforts supported by LAC recommendations

Chapter of Report	Agency Comments
Impacts of Policy Changes in Children's Behavioral Health Services (CBHS)- Recommendation 5	SCDHHS has centralized out-of-state placement requests into the Microsoft Service Manager platform for fee-for-service. The agency will extend this effort to analyze MCO encounters for out-of-state requests and placements.
Oversight of MCOs Needs Improvements – Recommendation 9 Recommendation 11 Recommendation 12 Recommendation 13 Recommendation 14 Recommendation 15 Recommendation 16 Recommendation 17 Recommendation 18 Recommendation 19 Recommendation 20 Recommendation 21 Recommendation 27 Recommendation 28 Recommendation 29 Recommendation 30 Recommendation 31	1. The agency has incorporated several new evaluations into the quarterly program performance review process including post-discharge metrics and MCO-specific utilization. 2. Behavioral health measures are currently a component of MCO performance contracting, which is reviewed annually. These measures influence a broad array of financial and operational outcomes for MCOs, which incentivizes them to act in a manner that would improve these measures. 3. The agency agrees that the External Quality Review Organization (EQRO) contract used to evaluate certain aspects of MCOs can be expanded in scope and is currently drafting an EQRO request for proposals in, following results of a request for information received in December 2018. Some recommendations, such as access to care evaluations, may be better suited for other vendors, but SCDHHS agrees thematically with the EQRO recommendations and all have been fully implemented or are in progress. 4. The agency intends to incorporate the LAC's feedback into existing processes related to review of MCO service authorizations, denials, and grievances. 5. The agency agrees that a more formal documentation of MCO interactions to include site visits and periodic leadership meetings is warranted. The agency has incorporated the LAC recommendations for a more formal process that includes quarterly meetings and site reviews and their documentation into existing processes as of 2Q CY2019.
Rates – Recommendation 34 Recommendation 35 Recommendation 36 Recommendation 37 Recommendation 38 Recommendation 42 Recommendation 43 Recommendation 44 Recommendation 45 Recommendation 46 Recommendation 47 Recommendation 48	1.The agency has rebased Psychiatric Residential Treatment Facility (PRTF) rates and has incorporated a periodic review of all institutional provider rates in SFY2019-20. The agency disagrees with some of the conclusions reached regarding PRTF rates, which SCDHHS discusses later in the response. 2. Although the agency does not currently post non-fee schedule rates, SCDHHS is comfortable with that level of transparency in institutional pricing. 3. As part of the Rehabilitative Behavioral Health Services (RBHS) and Applied Behavior Analysis (ABA) carve-ins and review of governmental provider rates, the agency routinely reviews rates for the mentioned services and is engaged in a cycle of comprehensive rate reviews of all fee schedules and reimbursement methodologies from SFY2018-20. Further, as part of the foster care health plan resulting from the *Michelle H.* settlement, the agency is conducting a comprehensive review of children's therapies, care management of children in out-of-home placements, and RBHS services for effectiveness, access, and quality. 4. In SFY2018-19, the agency ordered a review of its internal audit function from an external firm and selected a hybrid state-contract model. SCDHHS has hired an internal auditor, procured a firm who completed an agency-wide risk assessment, and formed an audit committee to oversee the internal audit function.
Lack of Transparency and Communication – Recommendation 50 Recommendation 51 Recommendation 52 Recommendation 53	The agency currently engages in broad stakeholder input but agrees there are always opportunities to better engage beneficiaries, providers, and other stakeholders in the process. Some recommendations are untenable given the lifecycle and expectation of some policy implementations, but the recommendations will be incorporated into the agency outreach process.

Clarifying Points for Constructive Feedback

In addition to the points of agreement above, SCDHHS accepts the LAC's feedback on several points, although it believes some additional points of clarification are needed to provide the public with a more complete understanding of some issues raised in the review.

Issues that Transcend Any One Payor

The LAC makes several reasonable points about access to behavioral health services in South Carolina, including several conclusions and recommendations related to access to providers that participate in multiple health plans. These comments address operations during non-traditional hours and non-English proficiency (recommendation 1), access to in-state specialized providers (recommendation 8), reasonable rates paid by MCOs (pages 72-75), and monitoring wait times (page 79, recommendation 44). While the agency thematically agrees with these issues, SCDHHS believes the LAC's approach has several fundamental shortcomings:

- First, the review lacks a benchmark of provider participation against networks generally available to the public. The LAC makes value judgements about the program's performance without appropriate context about performance that may be reasonably attained in South Carolina's broader healthcare market.

- Second, rates may correlate with provider participation, but are not necessarily a direct indicator of it. Recommendations, such as 39 and 40, assert the agency should monitor networks indirectly through MCO-provider contract rates, while SCDHHS prefers the more direct and relevant measure of actual provider participation in MCO networks.

- Third, the review approaches utilization of out-of-state therapies as a failure of the market. In some cases, regional or national centers of excellence provide care in settings that are not financially sustainable in small states and markets such as South Carolina. SCDHHS accounts for availability and appropriateness of service type and specialty when placing children out-of-state on a case-by-case basis.

- Fourth, the review makes assertions about the need for SCDHHS to maintain universal waiting lists for services but again does not benchmark this to industry standard healthcare payor practices, nor does it acknowledge the natural limitations of SCDHHS' data. In short, the agency's most complete set of information about a child is claims payment data – an after-the-fact record of services and not an indicator of an individual's current need. Further, the General Assembly contemplated limiting SCDHHS' role in the health care delivery system by prohibiting it from providing services directly. This review almost entirely attributes shortfalls in the state's behavioral health delivery system to Medicaid funding. There is little mention of the role that the state agencies statutorily responsible for the provision of care and other payors play in building provider capacity and access to services.

- Fifth, the agency notes that the review makes little mention of the need to build a pipeline of mental health professionals through recruitment, training, and professional placement, nor does the review make any mention of SCDHHS' efforts in this area. These efforts include direct educational subsidies for behavioral health providers educated at state universities. The shortage of mental health professionals is a national problem best addressed through education, training, and career incentives – an issue with which reimbursement may play a role but is not the primary driver. Instead, the review portrays provider network building as a predictable, but short-sighted, zero-sum recruiting contest between South Carolina, Georgia, and North Carolina.

- Finally, the review incorrectly generalizes the RBHS moratorium as impacting all behavioral health access and provider enrollment. In fact, Licensed Independent Practitioners (LIPs), who are subject to nearly identical education, training, and credentialing requirements as RBHS providers are not subject to a moratorium. All major behavioral health benefits, with the exception of community support services, have been open to new credentialed providers throughout the lifecycle of the RBHS moratorium. Further, modifications to the moratorium in December 2018 allowed child-placing agencies licensed by the South Carolina Department of Social Services (SCDSS) to re-enroll as RBHS providers for the purpose of providing therapeutic foster homes. Taken as a whole, access to behavioral health providers has improved since 2014.

While the individual recommendations listed in this section seem reasonable, the review does not offer the evidence basis of the recommendations, a detailed account of the desired outcome, or a quantification of the value of the anticipated impact.

In short, no cost-benefit analysis is offered to support these recommendations. In total, these recommendations, ranging from offering alternative business hours to employing multilingual staff, represent a significant change from current business models. These model changes may introduce a disincentive for providers to participate in Medicaid, not all of which can be overcome by increased rates or incentive contracting.

Fee Schedules

On page 71 and in recommendation 37, the LAC notes a lack of updated fee schedules for certain benefits. During the implementation of phase I of SCDHHS' comprehensive rate review project detailed earlier, SCDHHS discovered that some automated processes for periodically updating and posting fee schedules were producing errors in the schedules. The agency is actively remediating this and, in the interim, manually posting updated fee schedules to the SCDHHS website.

Cost-Benefit Analyses

On page 31, the LAC notes a lack of cost benefit analyses performed prior to program implementation. While the agency does not support the conclusion, the agency does agree that such efforts can always be improved. Accordingly, there are several agency-led initiatives underway that are relevant to this recommendation:

- SCDHHS is a national leader in implementation of programmatic evaluation of services for certain high-risk children using academically rigorous randomized control trials (RCT) and pay-for-performance contracting with providers under a public-private partnership evaluated by Harvard University.

- SCDHHS has an agreement with Northwestern University to perform comparative analyses of Medicaid MCO(s), particularly with respect to utilization, access, and the relative experience of randomly assigned beneficiaries.

- SCDHHS has a revised internal governance process to implement an Investment Review Board (IRB) as part of its regular programmatic review and to initiate new coverage or benefits. The selection process contemplates improvement to access, care integration, quality, and beneficiary engagement against market alignment, risk, cost, and the agency's maturity regarding such an implementation.

- SCDHHS has instituted a schedule of quarterly policy, coding, and initiative releases to align with the agency's quarterly Medical Care Advisory Committee (MCAC) public forums and to provide regular expected release schedules for the provider community.

- SCDHHS has engaged in an aggressive effort to integrate systems that focus on early identification of individuals with developmental, physical, or mental health delays and impairments through engagements with SCDSS to resolve the *Michelle H.* settlement and integration of the Individuals with Disabilities Education Act (IDEA) Part C services in a manner consistent with prior executive, legislative, and LAC findings.[1]

Points of Policy

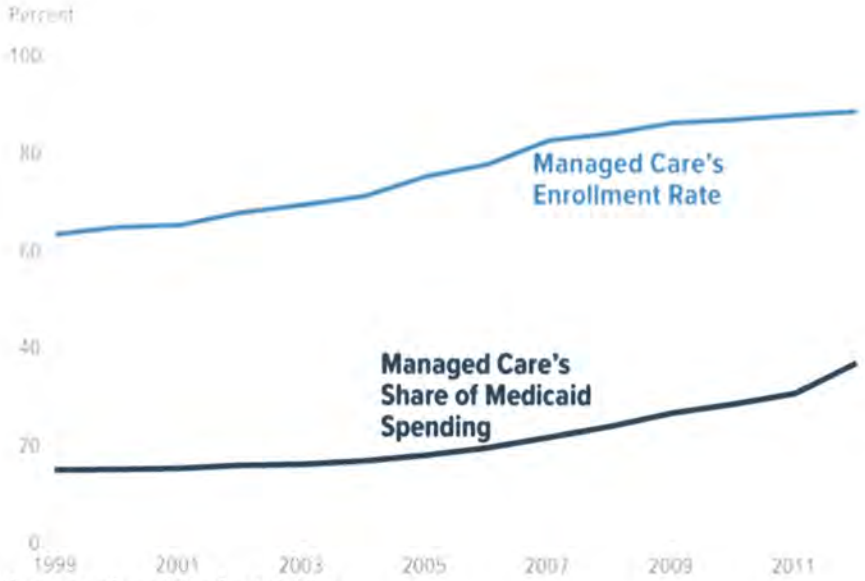
Managed Care Oversight

Many passages and sections of the review appear to reflect fundamental policy disagreements with the use of Medicaid MCOs in the health financing and delivery system. Therefore, recommendations to revert to a single-payer, state-administered FFS system do not appear to represent proposals to strengthen the state's managed care program. While SCDHHS does not intend to defend all practices of MCOs generally, or even individual plans within the market, the need for care management of high-needs and medically complex individuals is apparent, regardless of the delivery system used.

This apparent policy disagreement may bias the review conclusions against the effectiveness of MCOs in delivery quality and cost-effective services. Further, such a position runs counter to prevailing national norms regarding the use of MCOs and alignment of physical and behavioral health under a common care management platform. It also runs counter to guidance from the Centers for Medicare and Medicaid Services (CMS) that promotes the use of managed care in high-needs and medically complex individuals. Although SCDHHS does not expect the LAC to modify its view of managed care, it should be noted that recommendations to move the state away from a managed care model may not be viable, given the posture of state and federal policymakers.

[1] BabyNet Program: A Review of Early Intervention Services for Infants and Toddlers with Developmental Delays (Legislative Audit Council, 2011)

Although the state has partnered with Medicaid MCOs since 1996, the movement to significantly increase the use of MCOs in the Medicaid program is only about a decade old. At the early stage of the series of "carve-ins" that created the state's current managed care program, a series of comparisons of FFS and managed care were published. Based on these reports and analyses of governmental and non-governmental organizations, some of which were ordered by and delivered to the General Assembly, a cooperative decision was made to engage in incremental migration of populations and services to managed care, rather than a one-off migration.



Source: Congressional Budget Office

The agency accepts recommendations 13-16 related to MCO performance measures, as noted earlier. Nonetheless, the LAC should note that the primary use of Healthcare Effectiveness Data and Information Set (HEDIS) in evaluating MCO program performance traces back to policy decisions made in concert with the General Assembly prior to the most recent series of carve-ins. HEDIS is regarded as the industry standard for evaluating health system performance for consistency, relevance, and comparability to other health systems. Further, Congressional Budget Office (CBO) recommendations regarding state-to-state plan comparisons for federal policymakers emphasize standard data sets, which would include HEDIS; and, agency claims and enrollment data submitted to CMS through the Transformed Medicaid Statistical Information System (T-MSIS). Although the use of state-specific goals and metrics is advisable, HEDIS will remain an integral component of the agency's health plan performance strategy.

Medical Necessity: Recommendations 10, 22-26

On page 43, the report draws a conclusion that SCDHHS fails to provide MCOs with "sufficient guidance" with respect to the definition of medical necessity. Despite this, the report notes that the definition used in regulation and policy generally defers to reasonable decisions made by professionals in a manner consistent with generally accepted current clinical practice. In this manner, SCDHHS allows medical professionals with analogous credentials or licensure to review the requests of similarly situated medical professionals. SCDHHS further requires in-state licensure for key clinical personnel and requires that core responsibility for the clinical review process be placed on a physician licensed in South Carolina. Finally, the external quality review (EQR) process includes a review of clinical licensure for appropriateness, as does National Committee for Quality Assurance (NCQA) accreditation.

As detailed in Table 1, above, SCDHHS is in procurement with an expanded EQRO solicitation. That said, if management were to implement all the LACs recommendations related to definition of medical necessity, the agency would effectively duplicate the efforts of each current EQRO vendor. Management does not believe this level of redundancy in oversight for the EQR process is time or cost effective, nor will it lead to better care management outcomes.

Clinical Utilization of Children Discharged from PRTF

While SCDHHS recognizes the LAC's role in working with the legislature to develop and further policy objectives, it has some concerns about the rationales and assumptions employed to justify these policy objectives. As an example, SCDHHS

notes the statements and conclusions drawn on pages 26-30 indicating that individuals who receive treatment within 60 days of discharge from a PRTF or PRTF authorization denial is a negative outcome of the health delivery system. The actual expectation is the opposite – children discharged from a PRTF should seek community supports, primary care intervention, immunizations, sick and urgent care for illness, and all of the other services that are encompassed in the broad spectrum of "inpatient or outpatient treatment (page 27)."

Further, both SCDHHS and CMS operate under state and federal standards[2] and state and federal court rulings that incentivize community reintegration as a primary tenet of the care delivery system. Reviews of clinical literature indicate that the outcome of intermediate and long-term inpatient psychiatric stays is often not better than outpatient treatment, and individual progress often degrades following discharge from an inpatient stay.[3] In addition to being counter to prevailing clinical evidence and guidelines, long-term institutionalization is met with resistance, and occasionally outright prohibition, by federal funders. This shifts the financial responsibility of such decisions to the state, and more specifically the state-administered child-serving agencies that direct such placements.

Inaccurate or Misdrawn Conclusions

While SCDHHS has cited many points of concurrence on the themes and recommendations noted in the report, there are several places where the LAC presents inaccurate or incomplete facts, draws erroneous conclusions, produces recommendations that are inconsistent with relevant regulatory structures, or simply overstates the veracity of the presented conclusion. SCDHHS notes that in the draft comments presented in July, SCDHHS presented 21 points of clear error or misdrawn conclusion. While it appears that the LAC addressed five of these instances through revision of its final report, most of the original issues remain and are therefore restated.

SCDHHS also notes the concerning practice of using terms such as "potentially" to cite unsubstantiated concerns, errors, or patterns; four instances where the LAC uses an otherwise unquantified "sometimes" to address anecdotally identified practices without respect to the materiality of the occurrence (in contradiction to generally accepted auditing standards); and more than 10 instances where a single "official" is cited as the justification for including an issue or conclusion. In sum, SCDHHS continues to have significant concerns about the lack of substantiation, corroboration, and core data analysis used prior to the publication of nearly 20 individual assertions in the report, in addition to those stated below. Such unsubstantiated assertions presented in a public report by an institution of public may have the unintended consequence of leading policymakers and citizens to believe such assertions were verified prior to publication; and, ultimately lead to policies being developed based on inaccurate information.

On page 6, the report references Georgia's "interagency directors' team" as a best practice for CBHS. It should be noted that South Carolina has three such groups to address children's issues specific to behavioral health and health and development generally:

- The Joint Council on Children & Adolescents (JCCA), currently chaired by the SCDHHS director, is a formal group with bylaws that seats all child-serving agencies and their directors along with community advocacy groups, community funders, parents, and other relevant child-focused groups. The JCCA has an executive steering committee that meets more frequently and is staffed by deputy director-level leaders to work on issues under the direction of the JCCA. The executive steering committee has several subcommittees, which focus on specific topics including cultural and linguistic competence, continuing education, and system of care issues.

- The Joint Citizens and Legislative Committee on Children (Committee on Children) was created by statute to research issues regarding the children of South Carolina and to offer policy and legislative recommendations to the governor and legislature. Membership of the Committee on Children is comprised of legislators, child-serving agency heads, and appointees by the governor. The Committee on Children conducts public hearings to receive information on a variety of topics specific to children including behavioral health.

- In 2013, SCDHHS began convening a weekly meeting of child-serving state agency heads to discuss the formation of a system of care which eventually became known as the "Palmetto Coordinated System of Care."

[2] SMD Letter 18-011, Issued November 13, 2018

[3] Perspectives on Residential and Community-Based Youth and Families (Magellan, 2008)

On page 7, the report refers to the EQR reports of MCOs in the section of the document titled "Measuring Effectiveness of CBHS" but fails to acknowledge the self-directed SCDHHS initiatives detailed on page 2. This team was created in 2014 and periodically conducts site visits of providers, participates in treatment team meetings for high-needs children, and performs prepayment review of providers subject to additional scrutiny as part of proactive fraud detection.

Recommendation 2 and assertions on page 12 make clear that the LAC does not fully understand many of the motivations behind a carve-in of PRTF services into managed care or the restructuring of the PRTF rate on July 1, 2017. First, the prior bundled rate for PRTF services placed responsibility, and therefore financial risk of funding both psychiatric treatment and physical health, on the PRTF. Such a capitated or sub-capitated payment system for a small population has the potential to create perverse incentives to ration care or expedite the discharge of medically complex children. Providing for separate ancillary billing reduces such incentives and more easily allows PRTFs to allow children to receive care from third-party medical professionals for physical health care. Also, the nature of bundling pharmacy with inpatient psychiatric care reimbursement made monitoring the use of psychotropic medications on children difficult to perform; an issue improved with a discrete rate and billing for ancillary services. Second, recent CMS guidance on controlling average length of stay, improved discharge planning, and integration of physical and behavioral health all provide regulatory expectations of a carve-in. Finally, separation of ancillary services improves the agency's ability to participate in the Medicaid Drug Rebate Program – the source of approximately $100 million in state funds recovery from pharmaceutical manufacturers annually.

On page 13, the report incorrectly states that Autism Spectrum Disorder (ASD) treatment services were made available via FFS in July 2017. In fact, the agency began authorizing ASD services through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) authority in February 2015 and continued through the sunset of the Pervasive Developmental Disorder waiver in December 2017 at which point the agency transitioned to offering ABA as a state plan service.

On page 23 and in recommendation 7, the report implies that the agency paid for unallowable Medicaid costs in the per diem rate related to ensuring PRTF rates include only allowable costs. This recommendation is apparently based on a single anecdote from a staff member of an out-of-state child-serving institution. As the LAC acknowledges on page 75, cost is not the only basis of negotiating rates for single case agreements, and market rates and "efficiency, economy, and quality of care" (42 CFR 447.200) are also reasonable bases. Ultimately, the rate paid to out-of-state providers is based upon single-case negotiation and the result of what the agency and market will bear in accordance with 42 CFR 447.200.

On page 24, the report addresses other state agencies providing funding for out-of-state care with the example of facilities specializing in eating disorders. It should be noted that all children currently subject to such an agreement are not subject to this cost sharing. SCDHHS does acknowledge, however, that this analysis would not extend to children for whom the agency has no financial responsibility and were placed out-of-state by another state agency.

On page 57, the report incorrectly concludes the agency had not conducted meetings with MCOs over an 18-month span simply because formal minutes were not taken at those meetings. Generally, SCDHHS has hosted a quarterly meeting with each plan (on a one-on-one basis), as well as quarterly operations meetings. Additional focus groups, such as the MCO medical directors, have also held meetings on a quarterly basis.

On page 65, the report addresses PRTF provider concerns regarding their rates effective July 2017 with the implied conclusion that the rates were insufficient to cover the administrative burden of engaging with MCOs. It should be noted when analyzing the PRTF fee schedule net of ancillary services that all providers received a rate increase in concert with the carve-in of at least 3%, with the maximum increase being 25%, along with being relieved of the burden of covering the costs of ancillary services and pharmacy.

On page 87, the report states "DHHS has not adequately responded to provider input on a variety of policy changes." SCDHHS notes that the LAC has equated responsiveness to stakeholder concerns with accommodating all stakeholder requests. Put simply, the agency is often responsive to stakeholder requests in a prompt and professional manner but may opt not to accommodate the request. Although this may leave the stakeholder dissatisfied with the outcome, the agency was nonetheless responsive and transparent.

On page 92, the report incorrectly implies that the agency did not meet with the South Carolina Department of Education (SDE) until July 25, 2016, after the RBHS carve-in implementation date. In addition to bimonthly meetings for several years prior to the carve-in between the agency and SDE, the agency also held an all-day training with SDE and the MCOs on May 23, 2016.

On page 94, the report states that "DHHS does not have a reliable process to prevent providers that have been terminated from the Medicaid program from re-enrolling as Medicaid providers" and that "DHHS and the Medicaid Fraud Control Unit (MFCU) officials explained that some excluded providers enter the system again by enrolling under a new name." Providers convicted of Medicaid fraud are excluded from participation in Medicaid and, therefore, cannot re-enroll, regardless of the name of the enrolling entity. The SCDHHS provider enrollment department checks the exclusion list for all individuals listed on the entity's ownership and control disclosure (OCD). The OCD includes any person (individual or corporation) who has a 5% or more interest in the provider, or who is related to another person with ownership or control interest in the entity as a spouse, parent, child, or sibling. It also includes any managing employees and anyone with an ownership or control interest in a subcontractor.

On page 96, the report states that "settlement agreements can be used in a way to avoid termination from the Medicaid program if the provider makes no admission of guilt." A settlement agreement is not executed for the purpose of avoiding termination for the provider but rather is used when MFCU does not have sufficient evidence to bring criminal indictment and enters into a civil settlement agreement with the provider in order to recover overpayments that have been documented through their investigation. SCDHHS does not determine whether MFCU enters into a settlement agreement with a provider that is under investigation.

On page 96, the report states "DHHS reserves the right to suspend payments to providers when a 'credible allegation of fraud' is determined." To be factually accurate, the statement should reflect that the agency is required by federal regulations (42 CFR 455) to suspend payments to providers when a "credible allegation of fraud" is determined by the agency, unless the suspension of a provider is subject to a "good-cause" exemption granted pursuant to 42 CFR 455.23. The agency has exercised these exemptions in the case of RBHS providers, as nearly 17,000 children (59% of those served by a provider from 2015-2017) were served by an RBHS or LIP provider under investigation for fraud. Roughly one-quarter of children receiving RBHS or LIP services saw a provider ultimately terminated over the same period. The agency considered similar exemptions for the South Carolina Early Autism Project, the state's largest Applied Behavior Analysis (ABA) provider, ultimately deferring to the U.S. Attorney's negotiated settlement and corporate integrity agreement.

On page 96, the report incorrectly states "A credible allegation of fraud is up to the discretion of DHHS." To be factually accurate, the statement should reflect that a credible allegation of fraud is up to the discretion of SCDHHS, following the definition provided in 42 CFR 455.2.

On page 97, recommendation 54 states the agency "should implement stricter sanctions for provider fraud, especially regarding overpayments." The agency disagrees with this recommendation as we already utilize the strongest sanction, termination for cause, when a provider is convicted of Medicaid fraud. The result of a sanction of termination for cause means that the provider is no longer enrolled with the South Carolina Medicaid program, and under federal requirements, will subsequently be terminated from any other state's Medicaid program and from federal healthcare programs such as Medicare and TRICARE. The provider is also restricted from enrolling or re-enrolling with any other state's Medicaid program and from federal healthcare programs. Additionally, the sanction may prevent the provider from credentialing with any private insurance plan. This recommendation again confuses fraudulent behavior with overpayments due to issues that are not fraudulent in nature.

LAC's Assertion of Scope Impairment

The LAC opens this report with statements of scope impairment, focused on three major issues: SCDHHS management's requests for a disciplined process for information sharing, the adequacy and completeness of documentation, and the quality and timeliness of data received from SCDHHS. The agency's response to the LAC's commentary on the impaired scope of the report is below.

Agency Activity

At an entry conference in 2017, SCDHHS recommended that the LAC engage in a disciplined exchange of information using a single point of contact, who was identified as the agency's legislative liaison. This is the practice of the agency with every review, including engagements with:

- Annual external financial auditors
- Disproportionate Share Hospital cost report auditors
- U.S. Department of Health Human Services Office of the Inspector General

- Government Accountability Office
- Payment Error Rate Measurement (PERM) auditors
- South Carolina Inspector General
- South Carolina Attorney General's Office
- United States Attorney for the District of South Carolina

Given the broad and varied oversight SCDHHS is subject to, the agency takes seriously the need to comply with requests from oversight and auditing authorities in a complete and timely manner. The purpose of a disciplined and coordinated process is three-fold: first, to ensure appropriate follow-up from staff in the organization, second, to ensure that individuals with information about all or part of a request participate in the response, and third, to ensure organization awareness of questions and responses when clarification is necessary. Although the agency disagrees wholesale with the characterization of the events and conclusions about scope impairment, The agency is enclosing the two previous letters to detail SCDHHS' concerns about data security throughout this process and the LAC's material departure from Generally Accepted Government Auditing Standards (GAGAS) with respect to auditor independence. In addition, SCDHHS will note:

- LAC staff were not denied access to individuals for interview or information sharing and agency management did not instruct staff to delay release of information, except those relevant to the attached letter on data security.

- Although the agency's legislative liaison was identified as a central point of contact for information sharing, the LAC often chose not to utilize her for that purpose.

- SCDHHS requested answers for awareness only and, based on assertions made in the report and several corrections noted on pages 4-8 of this letter, allowed potentially incomplete answers to be released in order to preserve their authenticity. Further, some of the corrections noted by SCDHHS are supported by information in the public domain, which the LAC could have availed itself of with proper guidance from agency staff.

- SCDHHS awareness of activities cannot impair the scope of a review, and interference by management did not occur. The agency did delay the release of millions of individual data elements containing identified personal information of South Carolinians due to security concerns, as noted in the attached letter.

Ultimately, SCDHHS' preservation of the LAC's preferences to resist a coordinated information gathering effort resulted in the needed corrections about routine attributes of the Medicaid program late in the review process.

Documentation

Throughout the review, LAC staff made assumptions about the agency's organizational and decision-making structure that were often incorrect. As the agency did not control access to staff, LAC staff were allowed to ask questions of any member of the agency they chose. As a result, the report may be informed by perspectives of many employees, but the LAC chose not to interview many of the actual decision-makers to establish the rationale or process of decision-making. In fact, the LAC did not interview two former agency directors responsible for many of the policy decisions noted in the review, the sitting agency director (except for a 2017 entrance conference), or two relevant deputy directors with the exception of a brief interaction with one about the agency's MCO quality strategy.

The report asserts on page 4 that documents received were incomplete, erroneous, and delayed. SCDHHS found no erroneous information provided by the agency and believes that any delays or incompleteness are attributable to the LAC's preference for decentralized information collection. While individual staff members may be incorrect about individual issues – several are noted and clarified in this letter – no official response of the agency contained erroneous information. Further, the report does not note any actual erroneous documentation or conclusions provided by SCDHHS.

Data Exchange

While SCDHHS acknowledges its responsibility to provide data to external review organizations charged with appropriate state or federal authority, it is also bound by state and federal standards to limit the release of information and document its purpose in accordance with 42 CFR 431.306 and other applicable laws. As noted in the enclosed letter, SCDHHS made great efforts to balance the provision of broad data sets to the LAC for analysis, preservation of individual beneficiary identities, prevention of external breaches through procedural controls, and provision of technical assistance to reviewers. Ultimately, the LAC refused to enter into any standard agreement with SCDHHS, attest to their information

technology security posture, or agree to work with de-identified data sets for statistical sampling to reduce the release of personally identifiable information. While these negotiations did take some time, the agency notes the following:

- SCDHHS stands firmly behind the decision to follow industry-standard practices with respect to the release of millions of individual data elements and believes that reviewers grossly overstated the impact a standard data-sharing agreement and security controls would have had on their analysis.

- Ultimately, data requested was provided. On page 53, the report asserts SCDHHS refused to release grievance logs from several MCOs. Upon review, the grievance logs were withheld initially due to the existence of personally identifying information on the logs. Had reviewers accepted a system of disciplined information sharing, SCDHHS would have a log of released and withheld information and would have been able to release these logs along with all other requested data. Because of the decentralized approach to information gathering, these logs were withheld as an oversight, not refusal by SCDHHS staff or management.

- SCDHHS ultimately agreed to a higher threshold of confidentiality practices and procedural controls to protect drafts of this review than the reviewers agreed to for millions of clinical records transferred from SCDHHS to the LAC.

- The agency does accept that initial exclusion criteria used to eliminate test or erroneous Medicaid identifiers led to the omission of individuals with Medicaid identifiers beginning with a '0' digit, an error that was corrected within three business days.

In summary, SCDHHS has been transparent about several straightforward concerns about data security, process integrity, and the LAC's deviation from GAGAS standards with respect to auditor independence throughout the engagement. Not only did the LAC ignore material steps to address these concerns, it went further by refusing even to acknowledge them in the form of a response or audit conference.

SCDHHS appreciates the opportunity to provide comment on this report. The agency offers the comments and corrections listed above and remains committed to implementing such recommendations listed that are accurate, relevant, and allowable.

Joshua D. Baker

Encl (2)
September 6, 2018 Letter to Senator Shealy Re: Data Security
February 26, 2019 Letter to K.E. Powell Re: GAGAS Standards

STATE OF SOUTH CAROLINA
DEPARTMENT OF EDUCATION

MOLLY M. SPEARMAN
STATE SUPERINTENDENT OF EDUCATION

September 19, 2019

Thank you for providing the South Carolina Department of Education (SCDE) with an additional opportunity to submit written comments regarding the Legislative Audit Council's final draft report, *A Review of Children's Behavioral Health Services – S.C. Department of Health and Human Services*. After reviewing the excerpt from the report relative to the education of children in psychiatric residential treatment facilities (PRTF) and the recommendations that relate to the SCDE, we are is providing the following comment, which was also included in our June 19, 2019 comments.

Recommendation 32:

The S.C. Department of Education should develop written guidelines that specify the roles and responsibilities of all parties involved in the placement of children in residential treatment facilities, including who is responsible for informing local school districts of the initial placement and what steps to follow upon discharge.

Comment:

In accordance with state law at S.C. Code Ann. § 44-7-260 and the implementing state regulation at S.C. Code Ann. Reg. 61-103, the South Carolina Department of Health and Environmental Control (SCDHEC) is the licensing agency for PRTFs for children of school age. Additionally, the South Carolina Department of Health and Human Services (SCDHHS) is the primary funding source for children placed or referred to PRTFs by state agencies. Therefore, with regard to the implementation of this specific recommendation, based upon statutory and regulatory authority, the SCDE believes the SCDHEC is the appropriate lead agency to initiate this recommendation. The SCDE would welcome the opportunity to participate in drafting guidelines that specify the roles and responsibilities of the parties involved with placing and serving children in PRTFs, but these guidelines will not improve services to children without the statutory or regulatory support and enforcement necessary for a more effective and efficient system of providing education to these children.

In a previous attempt to facilitate a continuation of appropriate educational programs, specifically for children with disabilities placed by state agencies in residential and other

out-of-home placements, the legislature enacted S.C. Code Ann. § 59-33-90(2). Despite the enactment of this provision of law, and subsequent provisos in the General Appropriations Act that address the education of children placed in or referred to facilities and other out-of-home placements by state agencies, the placing agencies have not complied with the notification and collaborative mandates that already exist. Both the SCDHEC and the SCDHHS have to agree to corrective actions or sanctions, such as not funding placements with Medicaid funds or consequences to the facility's licensure if the PRTF does not follow the required steps.

Thank you for the opportunity to participate in and provide written comments as a part of this process. Please do not hesitate to contact us if we may provide additional clarification, information, or assistance in this task.

SOUTH CAROLINA
DEPARTMENT OF
JUVENILE JUSTICE

Freddie B. Pough
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Henry McMaster
Governor

September 18, 2019

Mr. K. Earle Powell, Director
SC General Assembly Legislative Audit Council
1331 Elmwood Ave., Suite 315
Columbia, SC 29201

Dear Director Powell,

Please accept this letter in answer to your request for final comments related to the final draft report entitled *A Review of Children's Behavioral Health Services – SC Department of Health and Human Services,* wherein an excerpt contained a recommendation for the South Carolina Department of Juvenile Justice (SCDJJ).

While we agree with the overall recommendation made in the report (which states SCDJJ *"should continue to assess the need for alternative placements for the youth it serves and pursue appropriate levels of care, including establishment of an intensive group home"*), we would like to provide an update to this recommendation. We would also like to provide contextual information which may be relevant to the statements made by Department of Mental Health officials in their comments regarding provision of PRTF services for DJJ-involved youth.

While we do not disagree with DMH's comments that managing youth with serious mental illness as well as severe behavioral problems is difficult, statutorily, DMH is the state agency tasked with doing so. In December of 1996, a request for reconsideration and modification of terms set forth in the October 15th, 1996 court order pursuant to Alexander S., et al. v. Flora Brooks Boyd, et al., was presented in Family Court for the purpose of *"certifying the authority of SCDJJ to transfer physical custody of certain mentally ill 'subclass' juveniles to the physical custody of the SC Department of Mental Health."* DMH was *"charged in the consent order with developing levels of restrictiveness and concomitant security requirements for such juveniles, and required to place all such juveniles in the least restrictive environment appropriate under the circumstance, consistent with the treatment of all other mentally ill juveniles."* DMH was directed to treat these youth *"in accordance with the consent order in Robert K., et al v. Robert Bell, et al* (a class action lawsuit against the psychiatrists at William S. Hall Psychiatric Institute, under the auspices of DMH, for failure to provide minimally appropriate care to committed DJJ youth).

Based on the legal precedents set in our state for custody and care of DJJ youth with serious mental illness, it is concerning that DMH officials indicated that they *"do not have the space for a PRTF"* and that *"hiring appropriate staff is a huge issue"* when we continue to struggle with managing such complex youth in the less therapeutic environment of an agency tasked primarily with rehabilitating delinquent youth. Given the limited options available in SC, it would appear that for these youth, the Juvenile Justice system has become the (often) first and last stop, despite their significant needs.

Additionally, based on this history, our Division of Legal Services has struggled with the notion that SCDJJ should be responsible for providing intensive group home services to serious mentally ill youth who should otherwise be alternately placed and treated by DMH; as a result, oversight and review of the Request for Proposals (RFP; as mentioned in the report excerpt) for such a group home has garnered scrutiny by our agency counsel, who have expressed concern about this responsibility being in the wheelhouse of SCDJJ. Therefore, while the RFP has not yet been submitted for final review by state procurement officials, we have had internal discussions about finalizing this process in order to move forward and better serve these youth. As part of our plan, we have begun to make renovations and modifications to the property we plan to use for this facility, which are well-underway. We also are in discussion regarding procurement of an additional three intensive-level group home beds in already-established SC group home facilities (for a total of 15 beds) upon completion of the final procurement and bid acceptance process. Our efforts continue to be focused on ensuring these youth receive the treatment they need in the most appropriate setting that we, as SCDJJ, can provide for them.

Finally, It is important to note that, ***while establishing these additional and more therapeutic beds will be of benefit to our youth with serious mental illness, they will not eliminate nor replace the overarching need such youth have for psychiatric residential treatment facilities. While intensive group homes can provide excellent care for those with mild to moderate levels of functional impairment as a result of their mental illness, they cannot replace the level of care provided by PRTFs.*** This means that ultimately, DJJ will continue to seek accountability from DMH for the seriously mentally ill youth committed to our juvenile justice facilities.

We appreciate the opportunity to provide a response to the excerpt from the final report draft. Should you require further information or clarification, please do not hesitate to ask.

Sincerely,

Freddie B. Pough
Executive Director
SC Department of Juvenile Justice

This report was published for a total cost of $89; 25 bound copies were printed at a cost of $3.56 per unit.