SUMMARY

A Review of Children's Behavioral Health Services
S.C. Department of Health and Human Services

SEPTEMBER 2019

Objectives

Members of the General Assembly requested an audit of the S.C. Department of Health and Human Services (DHHS) to determine how the agency's reimbursement policy and other policy changes since 2007 have impacted children's behavioral health services in our state.
Our objectives included:

- Determine how changes made in DHHS policies affected the delivery of children's behavioral health services.
- Determine how DHHS is monitoring the managed care organizations (MCOs) to ensure that children are receiving the proper treatment and evaluate the effects of introducing MCOs on July 1, 2017.
- Determine steps DHHS has taken to ensure the current method of payment and rates are sufficient to ensure access to quality care.
- Determine if state laws regarding the education of children in Psychiatric Residential Treatment Facilities (PRTFs) ensure proper oversight.
- Review DHHS' decision to place a moratorium on new providers and its effects.
- Evaluate DHHS' transparency and communication.

Impacts of Policy Changes

DHHS' Policy Changes

Since 2004, DHHS made a significant number of policy changes regarding children's behavioral health services, now referred to as rehabilitative behavioral health services (RBHS). The Centers for Medicaid & Medicare Services (CMS) requested that South Carolina Medicaid rework its state plan to move all children's services under one section of the state plan. Subsequently, CMS notified DHHS that 25 of 52 facilities were considered institutions for mental disease (IMDs), and were, therefore, ineligible for reimbursement with federal funds.

DHHS agreed to update the state plan to ensure that the service descriptions, provider qualifications, and reimbursement methodology were in compliance with federal guidelines. The agency agreed to no longer submit claims for any non-institutional residential facilities that could be considered an IMD. According to a DHHS official, there is now a gap in placement options between the psychiatric residential treatment facility (PRTF) level and therapeutic foster care.

Group Home Funding

Funding for therapeutic behavioral health services (group homes) transitioned to 100% state dollars over an 18-month period. 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. We reviewed how these agencies used these funds for group home placements. The agencies include:

Continuum of Care	Department of Disabilities and Special Needs
Department of Mental Health	Department of Juvenile Justice
Department of Social Services	Department of Education

Only DSS and DMH indicated that funds may have been used for purposes other than group home placements. DSS indicated that it requested funds from the General Assembly beyond the three-year transition; however, the funds were not appropriated. Most agencies were unable to provide information on how the transitional funds were used.

DMH PRTF Programs Closed

DMH closed the state's only "no eject, no reject" PRTF programs by 2015. This created a placement gap in the system for children, especially affecting DJJ youth, who other facilities may not accept for placement.

Scope Impairment

- DHHS did not respond to our requests for data or other documentation in a timely manner.
- Numerous issues were found with some of the data.
- Management monitored all requests.
- Management channeled answers through the agency's liaison.

These actions hindered our ability to complete the audit in a timely manner. See the full scope impairment statement in our report.

Oversight of MCOs Needs Improvement

Review of Medicaid Claims

We reviewed Medicaid claims for children who were initially denied or not reauthorized for PRTF placements. Almost 5 million Medicaid claims and more than 3,000 prior authorization requests were analyzed to determine whether children enrolled in managed care and denied a prior authorization for PRTF placement would subsequently seek medical treatment. We found:

- One in four children sought inpatient or outpatient treatment within 30 days after discharge from a PRTF and one in five sought treatment within 31–60 days.
- MCOs are more likely to approve an initial request for placement than a reauthorization.
- Families are not taking advantage of the internal appeals process when MCOs deny a prior authorization.
- "Lack of medical necessity" is the most prevalent reason for denying a prior authorization.

While many of these children are seriously ill, we cannot confirm that a child's behavioral health diagnosis contributed to the need for medical treatment after discharge from a PRTF; however, we found nothing to indicate that anyone is doing any analysis allowing DHHS and families to have greater confidence that MCOs are appropriately applying the "medical necessity" standard or that the children needing PRTF services are receiving the care needed.

Evaluating Effects of Managed Care

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 placements, would have 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 available.
- Relied exclusively on MCOs to attest that they had a sufficient number of network providers.

Lack of Documentation of MCO Oversight

DHHS reports it conducts site visits and holds quarterly meetings with MCOs, but had no documentation of what was discussed, issues, problems, or concerns identified, who was in attendance, what steps were to be taken and by whom, and according to what timeline.

Assessing Quality of Care

DHHS has not evaluated the MCOs' performance using measures related to children's behavioral health. The agency also has not implemented performance measures that capture what happens to children when they are discharged from a mental health facility, including a PRTF.

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 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. Also, the sampling strategy for these reviews needs improvement.

Medical Necessity

DHHS has failed to provide MCOs with sufficient guidance on a definition of "medical necessity" and relies on the relatively few appeals as a way to monitor whether MCOs are correctly applying the medical necessity standard. DHHS does not systematically review MCO documentation of its application of the medical necessity criterion for prior authorization decisions, including placement of children in a PRTF. DHHS has failed to have MCOs report the qualifications of every person involved in the approval process.

Discharge Planning

We heard numerous accounts of children denied authorization for initial or continued treatment in PRTFs. There were various accounts of MCOs denying continued authorization for PRTF treatment and children, subsequently discharged from PRTFs, with no viable placement alternative. DHHS does not track children, after discharge, in order to monitor contact with emergency departments or the juvenile justice system to determine if children may have been discharged too soon.

Grievances and Appeals

DHHS does not sufficiently analyze grievances and appeals handled by MCOs. Only 25% of families who were denied authorization for PRTF services appealed those decisions. DHHS relies on the external quality review process and its MCO liaisons to review monthly logs of appeals; however, DHHS could not provide any documentation of these reviews.

Education Services for PRTF Children

The S.C. Department of Education brought several issues involving the education of children in PRTFs to our attention, including that a child's home district is not always notified that the child has been placed in a facility. Before the RBHS carve-in, 31 districts provided RBHS services; after the carve-in, that number fell to 11. Since the moratorium is in place, the districts are not able to re-enroll as providers. There are no written guidelines describing what steps are to be taken, and by whom, in order to implement the requirements of state law governing children placed in residential treatment facilities within the state or in out-of-state treatment facilities.

Out-of-State Placements

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.

In January 2018, DHHS indicated that 11 children were placed in out-of-state care. In August 2018, we requested documentation, including the out-of-state placement contracts, from DHHS regarding these children. We received the last part of this documentation in June 2019. We obtained another list from DSS and identified children, enrolled in Medicaid managed-care, placed in out-of-state care, but who did not appear on DHHS' list. DHHS defers to the MCOs to track these children.

Rates

Payment Rates

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 rates, bundled payments, and managed care capitation per-member, per-month rates. We found that DHHS:

- Did not increase PRTF rates for the additional programmatic requirements that were placed on providers effective July 1, 2017. While PRTF rates were increased by 3% as of July 1, 2018, there is uncertainty whether the rate increase is sufficient to cover additional costs.
- Has a statewide average PRTF Medicaid rate (fee-for-service) which is lower than Georgia's PRTF rate cap and North Carolina's statewide average rate.
- Does not monitor the rates paid by the MCOs to their network of providers.

Autism Rates

South Carolina's Medicaid rates for applied behavioral analysis (ABA) autism services are among the lowest in comparison with other states that we reviewed. Low rates may result in a lack of service providers and potential denial of access to services for those in need.

RBHS Rates

South Carolina's rates for rehabilitative behavioral health services 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 (psychosocial rehabilitation, behavior modification or skills training and development services, and psychotherapy), South Carolina Medicaid payment rates, last adjusted in 2010, were around the mid-point or higher, compared to North Carolina and Georgia rates.

Internal Audit Interference

DHHS has an ineffective internal audit function that is not independent and objective. The internal audit department does not report to the proper level of management, risk-based audit plans have not been completed since January 2017, and only 10 of 24 audits conducted from FY 14-15 through FY 17-18 were completed.

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

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.
- 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 over four years with no plans for it to end.

In reviewing DHHS' processes for notifying stakeholders of major policy changes such as the RBHS carve-in, we found that the agency did not provide a sufficient amount of time to prepare stakeholders for these changes and did not adequately respond to stakeholder input.

FOR MORE INFORMATION

Our full report, including comments from relevant agencies, is published on our website. Copies can also be obtained by contacting our office.

LAC.SC.GOV

SOUTH CAROLINA GENERAL ASSEMBLY
Legislative Audit Council
Independence, Reliability, Integrity

K. Earle Powell
Director

1331 Elmwood Avenue
Suite 315
Columbia, SC 29201
803.253.7612

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. When DHHS changed its referral policy in 2014 to no longer require RBHS providers to receive treatment referrals from child-placing agencies, instances of provider fraud increased dramatically. To help eliminate this issue, the agency implemented the moratorium on providers. DHHS' requirements and screening for enrollment meet the federal regulations, but may be inadequate to address the increase in fraudulent providers.

Moratorium on RBHS Providers

The agency has had a moratorium on the enrollment of RBHS providers for four years and has no definitive plans to end it. We found that the moratorium has had an adverse impact on access to providers. Fifteen counties in South Carolina have experienced a decrease in the number of RBHS providers (psychologists, psychiatrists, private mental health professionals, DMH professionals, alcohol and substance abuse counselors, and development rehabilitation providers) between 2014 and 2017 (before and after the implementation of the moratorium). While this decline affects access to care, we found the travel time for beneficiaries to reach providers remained relatively stable.

Patient Access to Care Study

We conducted a provider access study to determine whether providers identified as participants in the managed care program accept Medicaid patients. Consistent with national trends, we found that there is a shortage of providers in counties which are mostly rural.

DHHS provided us with a list of all active behavioral health providers currently in the Medicaid program. We called a sample of 50 behavioral health providers throughout the state, including at least one provider from each county. Thirteen counties in South Carolina have only one behavioral health provider and the majority of these counties were in rural areas. The moratorium exacerbates this issue by preventing the enrollment of new behavioral health providers.

Quick Facts	
7	providers in the sample did not have working phone numbers.
10	providers in the sample had working phone numbers, but did not answer their phones after two separate calls.
34%	percent of providers in the sample were not reachable by telephone.