SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections
MEDICAID

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May 28, 2021

The Honorable John Taliaferro "Jay" West, IV
South Carolina House of Representatives
Post Office Box 11867
Columbia, South Carolina 29211

RE: DHHS Response to May 17, 2021 Subcommittee Letter

Dear Representative West:

Please see below in response to your May 17, 2021 follow-up letter.

Agency Director

1. [Director Kerr] Now that you have worked in both the public and private sector, what tools do you believe are available to motivate private sector employees that are not as readily available to motivate public employees (e.g., merit raises, bonuses, schedule flexibility, etc.)?
   Several recruitment and retention tools stand out that offer a contrast to those available in the private sector. Merit pay increases that are available on an individual basis and other targeted fringe benefits including subsidized childcare that is available to employees and student loan forgiveness that would encourage retention and a well-educated resource would help the agency recruit and retain talent. Additionally, while the state has the ability to offer bonuses, they are capped at a significantly lower level than the private sector typically offers. The state is also limited in its ability to recognize individual achievement and performance through non-monetary awards.

   The state does have tools that compare favorably to the private sector including its health care insurance package. The health care insurance offered by the state includes reasonable coverage with a low monthly premium, protecting the coverage offered at the competitive premium will help the state recruit and retain a talented workforce.

2. Are there any changes to state government human resources you believe may provide agency director's more flexibility in retaining the best and brightest?

In addition to the tools described in the response to the first question, the agency believes competitive incentives such as tuition reimbursement might be a helpful tool to retrain agency staff.

Agency Metrics

3. The agency uses the statewide average opioid prescribing rate as a baseline metric. Do other state Medicaid programs' use a similar benchmark to compare their opioid prescribing rate?

In 2015, the Centers for Medicare and Medicaid Services (CMS) provided a Medicaid Opioid Prescribing Mapping Tool. This tool was updated in 2019. The Medicaid State Opioid Prescribing Mapping Tool is an online interactive mapping tool that presents geographic comparisons of the opioid prescribing rate at the state level. This mapping tool allows the user to see both the number and percentage of de-identified Medicaid opioid claims to better understand how this critical issue impacts states nationwide. More information can be found at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Provider-Charge-Data/Downloads/Medicaid_Opioid_Methodology.pdf

4. Is the agency going to amend its target opioid prescribing rate metric so that it more appropriately fits agency performance?

The agency will amend the population to which the target opioid prescribing rate metric is applied. Currently this metric is applied using the entire Medicaid population, which includes children, but for state fiscal year 2022 (July 2021 – June 2022) SCDHHS will apply this metric using data for only the adults in the Medicaid fee-for-service (FFS) and managed care populations.

Fraud, Waste, and Abuse

5. Does the agency, or its federal partners, have state level forecasts or estimates regarding the total amount of Medicaid funding lost annually due to fraud, waste, or abuse?

National reports indicate Medicaid health care fraud ranges from 3 – 10% of total expenditures. The uniqueness of each state's Medicaid program makes it difficult to establish meaningful comparisons. SCDHHS does however track internal metrics to compare the agency against its previous years' performance. Annually, SCDHHS publishes the Medicaid Provider Fraud Report at Medicaid Provider Fraud: Report for Proviso 33.17 | SC DHHS.

6. When is the next Payment Error Rate Measurement (PERM) review?

The next PERM cycle will review Medicaid and Children's Health Insurance Program (CHIP) payments made from July 1, 2021, through June 30, 2022. A kick-off webinar was held on April 29, 2021.

7. The Centers for Medicare and Medicaid Services (CMS) recommends that state Medicaid agencies document key staff, data sources, programs, and technical issues at the end of a completed PERM cycle.

   - Does the agency have a written pre and post PERM process? If yes, please briefly describe the process.

     While we do not have a formal written PERM process, below are pre and post PERM processes that the state performs based on CMS recommendations:

     Pre-PERM Process
     - *Identify and support a state representative who serves as the central point of contact, coordinates state PERM activities, and provides additional state resources to support cycle operations*
     - *Participate in PERM cycle and state-specific calls*
     - *Coordinate access to state systems*
     - *Develop provider bulletin information to announce the beginning of the PERM cycle, CMS partners, and the importance of responding timely to record requests*

     Post PERM Process
     - *Communicate final errors to appropriate staff for evaluation*
     - *Coordinate Corrective Action Plan (CAP) responses and submission to CMS*
     - *Request disabling system access given to PERM reviewers when the cycle ends.*
       - *Follow up on CAP actions and implementations*
       - *Coordinate the return of federal share recoveries*

8. Agency staff testified that providers do not incur financial penalties for administrative sanctions imposed by the agency.

   - Is the agency permitted to seek financial restitution for the administrative cost associated with these sanctions (e.g., educational intervention, prepayment review of claims, etc.)?

     The state regulations do not authorize Program Integrity (PI) to seek financial restitution for the administrative cost associated with the imposition of administrative sanctions listed in the SC Code of Annotated Regulations 126-401.

9. Agency staff testified that the agency has the resources to detect double-billing and upcoding, but opportunities for improvement do exist.

   - Will the agency require additional resources to improve detection of double-billing and upcoding? If so, please identify the type of resources needed (e.g., software, personnel, etc.).

PI expects pre-payment detection of double-billing and upcoding to improve with the implementation of the Administrative Services Organization (ASO) module of the Replacement Medicaid Management Information System (RMMIS) project. This new module will include enhanced system controls and additional fraud, waste and abuse detection methods that include automated algorithms, data analysis, and predictive modeling.

No additional tools are required for post-payment detection of double-billing and upcoding. The agency has an advanced Business Intelligence System (BIS) fully capable of detecting these types of billing issues. However, as these advanced tools identify additional patterns, additional staff will be helpful in conducting reviews of the anomalies identified and other common fraud scenarios.

10. How many Explanation of Benefit (EOB) forms are issued by the agency each month for the purpose of verifying provider services?

    - *PI mails approximately 350 EOB letters each month to randomly selected beneficiaries. In addition, our managed care organization partners are required by contract to generate EOB letters to a statistically valid sample each month.*

    - What percentage of EOB forms are returned by beneficiaries?
        - *PI's percent of EOB forms returned by beneficiaries is 28%.*
    - Does the agency text beneficiaries to inform and remind them to respond to the EBO letter?
        - *No, the agency does not currently text beneficiaries to remind them to respond to EOB letters. The agency is not allowed to require beneficiaries to provide a mobile phone number and therefore is limited in its ability to communicate with beneficiaries via text messages.*
    - Can beneficiaries complete EOB forms online or is the process completely paper based?
        - *The process in completely paper based.*

11. Who is involved in determining a credible allegation of fraud?

    The final determination of whether a creditable allegation of fraud (CAF) exists lies with the Director of Program Integrity. These final determinations are made after reviewing all allegations, facts, and evidence on a case-by-case basis and determining if allegations are credible. Allegations are considered credible in accordance with CFR § 405.370. Many individuals may be involved in assembling the supporting information and providing clarification of the related policies used to prepare the CAF referral form. This could include but is not limited to the reviewer, the review supervisor, a Surveillance Utilization Review (SUR) analyst, SCDHHS' Office of the General Counsel, and the related health program area(s).

12. Who decides if the case is sent to the Medicaid Provider Fraud Unit?

    Once the Director of Program Integrity determines a CAF exists, a referral with all related case information is sent to the Medicaid Fraud Control Unit (MFCU).

    - Provide a step-by-step process flowchart from receipt of the allegation to final determination of credibility.

      Complaint/Allegation Process Flowchart is attached.

13. How does the agency verify that the managed care organizations (MCOs) are conducting appropriate investigations of fraud, waste, and abuse cases after being notified by the agency?

    The MCOs submit quarterly reports detailing case activity and overpayment collections. These reports are reviewed by PI staff and any follow-up questions are addressed with the MCO. The MCOs, PI and MFCU staff meet quarterly to discuss cases, investigations, arrests, and collections. PI is increasing MCO oversight by incorporating MCO encounter claims in its reviews and conducting semi-annual audits of the MCOs.

14. Please identify the 21-criteria used to determine beneficiary placement into the pharmacy lock-in program?

    Please note that the PI presentation to the House Oversight Committee by Deirdra Singleton on April 26, 2021, inadvertently referenced 21 Pharmacy Lock-In criteria. There are 20 criteria used in determining beneficiary placement in the Pharmacy Lock-In program. Please see attached document.

    - Does the agency have a policy in place to review these criteria on a regularly scheduled basis?

      PI continually monitors the criteria to determine if changes need to be made but does not have a written policy with a regular schedule. PI also receives regular feedback on these criteria from our MCO partners.

15. Please identify all administrative sanctions currently at the agency's disposal.

    - Identify the type of provider behavior associated with each sanction.
    - For each identified sanction, provide the total number of instances it was levied by provider type (FY15-FY20).

Administrative sanctions available to the agency include the below. In addition to the administration sanctions listed here, the agency is able to recoup funds from providers when it has identified overpayments.

- *Educational Intervention:*
  - *Non-compliance of policy and procedure*
  - *Total number of instances it was levied by provider type (FY15-FY20): 1,036*

- *Post Payment Review of Claims:*
  - *Provider billing as an outlier compared to peers*
  - *Complaints of providers billing for services not rendered*
  - *Referral from another agency*
  - *Total number of instances it was levied by provider type (FY15-FY20): 2,024*

- *Prepayment Review of Claims:*
  - *Provider billing as an outlier compared to peers*
  - *Provider billing for services without accreditation*
  - *Total number of instances it was levied by provider type (FY15-FY20): 5*
    - *All 5 providers were provider type - Mental/Rehabilitation*

- *Referral to Licensing/Certifying Board or Agencies:*
  - *Provider is practicing outside of their scope of practice*
  - *Staff not licensed and/or credentialed*
  - *Total number of instances it was levied by provider type (FY15-FY20): 5*

- *Peer Review:*
  - *A review of the provider by their peers is a sanction that has not been used by PI*
  - *Total number of instances it was levied by provider type (FY15-FY20): 0*

- *Suspension:*
  - *Items or services furnished by a provider who has been convicted of a program-related offense in a Federal, State, or local court*
  - *Total number of instances it was levied by provider type (FY15-FY20): 0*

- *Termination:*
  - *Provider presents fraudulent claims for payment for services not rendered*
  - *Upcoding*
  - *Provider fails to make available to SCDHHS records of services*
  - *Submitting false information for the purpose of meeting prior authorization requirements*
  - *Conviction for a criminal offense related to their involvement in Medicaid or Medicare*

- *Failure to meet required State or Federal laws for Medicaid participation.*
- *Failure to repay identified overpayments*
- *Termination for cause under Medicare or under the Medicaid or CHIP program of another State*
- *Total number of instances it was levied by provider type (FY15-FY20): 152*

- *Exclusion:*
  - *Conviction of a criminal offense related to the delivery of an item or services, the neglect or abuse of a patient or a felony related to fraud.*
  - *Conviction relating to program or health care fraud or obstruction of an investigation or audit*
  - *Licensure revocation or suspension*
  - *Exclusion or suspension under a Federal or State health care program*
  - *Exclusions of entities owned or controlled by a sanctioned person*
  - *Exclusion of individuals with ownership or control interest in sanctioned entities*
  - *Total number of instances it was levied by provider type (FY15-FY20): 203*

16. How does South Carolina's Medicaid fraud conviction rate compare regionally and nationally?

- *Statistical data is collected annually from all MFCUs and is available at the link below. https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/expenditures_statistics/fy2020-statistical-chart.pdf*

17. When a provider is suspended, terminated, or excluded from the Medicaid program, is the provider required to inform its Medicaid patients?

- *For most provider types, the provider is not required to inform their Medicaid patients of a suspension, termination, or exclusion from the Medicaid program. In instances, i.e., termination or exclusion of a nursing home provider from the Medicaid program, SCDHHS requires the nursing home provider to notify the beneficiary/responsible party that the facility is no longer participating in Medicaid. When provider types such as home and community-based services (HCBS) providers, are being terminated, the contracted case manager will contact the member to offer a new choice of provider.*

18. How many FTEs are dedicated to conducting on-site visits to providers?

- *PI has 14 FTEs dedicated to conducting provider reviews, including on-site visits. Two of these positions are currently vacant. During the period of FY15-FY21, PI faced a significant turnover in staff, which resulted in vacant positions. PI has been diligently attempting to fill all allocated positions.*

- Please provide the total number of on-site reviews (FY15-FY21).

There were a total of 1,835 cases opened by PI for the period FY15-FY21, of which 186 were conducted as on-site reviews. Due to the COVID-19 pandemic, no on-site visits have been conducted since March 23, 2020. PI is in the process of reintegrating staff to on-site reviews.

Our MCO partners also conducted on-site reviews.

- *In accordance with the 2018 contract, the MCOs are required to maintain at least 2 FTE Investigators per 100,000 members.*
- *With the July 1, 2021 contract, each MCO partner will be required to conduct a minimum of 12 provider on-site reviews per year.*

19. What percentage of on-site visits result in some form of corrective action for the provider?

99% of on-site visits resulted in some form of corrective action as outlined in the Findings Letter after the completion of the review.

20. How many providers were suspended, terminated, or excluded in FY15-20?

- *Suspended = 0*
- *Terminated for Cause (TFC) = 152*
- *Excluded = 203*

- If a Medicaid beneficiary has to find a new provider due to a suspension, termination, or exclusion of their provider, can that provider charge them for a copy of their individual medical records upon their exit from that practice?

Since the provider is no longer enrolled in the Medicaid program, the Medicaid rules and regulations no longer apply to them. Pursuant to SC Code Section 44-115-80, a physician in SC can charge fees for medical records subject to various rules and requirements, and there does not appear to be an exception carved out for Medicaid beneficiaries.

21. Has the agency considered developing an online fraud reporting form to receive allegations of fraud?

Yes. PI is considering a streamlined form available on-line to receive allegations of fraud.

22. What percentage of reported fraud is found to be legitimate following an investigation by the agency?

17% (This percentage was calculated by dividing the number of cases opened due to a complaint by the total number of complaints received.)

- How much does it cost the agency to investigate alleged cased of fraud?

  All allegations come to PI as complaints. After an initial review, if not substantiated, the complaint is closed. If substantiated, the complaint will become a case and reviewed for fraud, waste, or abuse. The determination of fraud or waste/abuse is not made until after a full review. The entire PI unit plays a role, from complaint intake to fraud referral. For SCDHHS PI, the cost per case is tracked annually and is as referenced in the PER:
  - *SFY2020: $4,952.36*
  - *SFY2019: $4,554.47*
  - *SFY2018: $5,061.80*
  - *SFY2017: $4,332.23*

- What percentage of reported fraud resulted in sanctions or convictions (FY16-20)?

  The below information was provided by the Attorney General's Office (MFCU):

  - *5.44% (28/515) resulted in sanctions or convictions over this period*
  - *140 referrals were not opened as formal cases*
  - *139 cases are still open*

- If an allegation of fraud is found to be illegitimate, does the agency have any recourse against the person who levied the allegation?

  No. Sources are encouraged to report any appearance of fraud, waste, or abuse. Only MFCU can determine if the allegation rises to the level of fraud. PI is heavily reliant on referrals from the public and penalizing the referral source could have a negative impact or put a chilling effect on reporting.

- Please provide the total number of allegations received via email, fax, direct intake, mail, or fraud hotline (FY16-20).

  Total number of complaints received (FY16 – 20) = 7,561.

23. If a provider requires pre and post-payment review, how much longer does it typically take for the provider to be reimbursed for services?

    With a pre-payment review, although the provider has submitted a bill for service, they will not be reimbursed until a manual review of the submitted documentation is completed.
    - *If the submitted documentation does not demonstrate the correct procedure code for the indicated service was billed, payment will not be authorized.*
    - *While this is a manual process, the agency's goal is to process prepayment review claims within 30 days of receipt.*

Post-payment reviews are performed on claims that have already been paid to the provider so there is no delay in the issue of reimbursement for services.

24. How often does the agency update its excluded provider spreadsheet?

PI submits monthly updates to be published on the SCDHHS Website.

- Please provide a chart illustrating excluded providers by provider type.

  See attached Excluded Provider List. Not all individuals or entities listed on the SCDHHS Excluded Provider List are or were enrolled as providers of services in the South Carolina Medicaid program. Individuals listed on the excluded provider list may include provider principals, officers, agents, managing employees or affiliated persons.

Recruitment and Retention

25. Provide the following turnover data:

SCDHHS included three years of this data in the Program Evaluation Report (PER) document submitted in June 2020 and will include updated agency wide and department-specific information in the final PER document. Beginning in State Fiscal Year 2021-2022, the agency director will require each program area to report its turnover data internally each month.

26. Has the agency conducted a compensation study?

No, the agency hasn't conducted a compensation study.

- Please provide the total amount of funding, by fiscal year, spent on employee compensation (FY15-20).

  The totals below include total salaries and fringe benefits. Much of the year-over-year increase reflected below is attributable to development of information technology and information management systems.

  - *2020: $81,416,222*
  - *2019: $76,057,379*
  - *2018: $72,902,687*
  - *2017: $67,581,130*
  - *2016: $65,919,033*
  - *2015: $65,095,018*

27. Agency staff testified that a consultant assisted the agency with its evaluation of position titles and descriptions.

The agency hired a consultant to evaluate position titles and descriptions within its program integrity unit.

- Has the agency implemented the recommendations given by the consultant?
    - *The consultant's recommendations included title changes and additional compensation for employees. The agency has implemented the title changes and has also increased compensation. The consultant also recommended other policy and procedure changes. The agency has implemented some of the recommendations, some are currently in the process of being implemented and others are being evaluated for future implementation.*

- How much has the agency spent on the consultant?
    - *$135,000*

28. Has the agency engaged the Division of State Human Resources to evaluate pay bands and other related issues specific to employee compensation?

    The agency has not found a need to evaluate pay bands. The agency has hired a staff member in human resources to evaluate classification and compensation among its staff.

29. Identify the positions that, on average, are being under-compensated or over-compensated based on market specific metrics.

    In evaluating position descriptions, classes and pay bands, the agency found some inconsistency in compensation for those working in its eligibility program area. To address this, the agency has offered performance-based bonuses in this program area and is continuing to evaluate compensation levels as a part of its broader evaluation of worker class and compensation.

    The agency has also identified that when it hires contractors for hard-to-fill or highly specialized positions, particularly in IT, that it pays a premium in compensation and has worked to reduce the number of contracted employees in this program area over the past year.

30. Does the agency track comparative ratio to determine the competitiveness of employee compensation?

    No, this is not currently tracked.

31. Please identify positions that are the most difficult to recruit.

    The agency has experienced the most difficulty in recruiting candidates to fill nursing and social work.

- What is the average length of service for each position?
    - *Nursing – 7 years*
    - *Social work – 8 years*
- What is the average length of time each position type remains vacant after being posted?
    - *Nursing – 6 months*
    - *Social work – 1.5 years*
- How long does it take to effectively train each position type?
    - *Nursing – 1 year*
    - *Social work – 1 year*
- How much does it cost the agency to train a person for each of these positions?
    - *Nursing – $55,000**
    - *Social Work – $45,000**

**As it takes one year to effectively train each position type, the agency has included the average first year's salary for each position in the training cost provided.*

32. Provide the percentage of agency staff who worked remotely during COVID-19 office closures.

47% of SCDHHS staff worked remotely during the COVID-19-related office closures.

- Which agency operations were found to be efficient and manageable in a remote environment?

    - *The agency found nursing, human resources, contracts, eligibility, and most office-based areas where direct customer contact is not required were able to work most efficiently in a remote environment.*

- Did the agency survey staff to gauge their interest or support for a continuation of remote work options?

    - *No, the agency has not surveyed staff on this topic to date.*

- Did the agency make any considerable investments in IT infrastructure to support the remote work environment?

    The agency invested in IT equipment and IT infrastructure upgrades to support the remote work environment. IT equipment included 600 Chromebooks, 150 laptops and docking stations, 600 new mobile phone lines 600 additional mobile phones and 93 computer monitors. The total investment in IT equipment was $809,365 ($688,282 in federal funds and $121,083 in state funds).

IT infrastructure included investments in the agency's virtual private network, virtual desktop infrastructure, cloud services and bandwidth. The total investment in IT infrastructure was $405,625 ($314,906 in federal funds and $90,719 in state funds).

33. Has the agency investigated the efficacy of remote work options as a means to reduce the cost of leased office space?

    The agency has not evaluated remote work as a means to reduce the cost of leased office space.

    - How much does the agency spend on leased office space?

      The agency spends approximately $5.8 million annually on leased space.

34. Has the agency considered permanently implementing remote work options as a way recruit and retain staff?

    The agency will initiate a study to determine which areas can effectively incorporate remote work while also maintaining staff performance.

Leadership Development and Accountability

35. Are division directors, managers, and supervisors accountable for turnover and employee satisfaction?

    SCDHHS constantly reviews turnover rates to identify staffing needs and work alignment. Staff leadership, including program area directors, managers and supervisors, review annual employee satisfaction data with their leadership team to identify opportunities for improvement, areas of strength that can be expanded or replicated and outstanding staffing or training needs.

36. Do agency deputy directors, managers, and supervisors receive regularly scheduled leadership training? If so, how many hours are spent annually on training?

    Yes, training opportunities for deputy directors, managers, and supervisors are coordinated by the SCDHHS Office of Training and Development. Our clinical managers and supervisors are also given opportunities to earn continuing education unit (CEU) credits through various course offerings in their discipline. The agency also holds bi-annual leadership development reviews where all senior leaders go offsite for a full day to receive leadership training, review the agency's strategic plan, analyze and discuss metrics' performance, review the budget, and network with other agency leaders. The amount of annual training varies by job classification and function. For example, new supervisors and managers receive between 105.5-120.5 hours of training in their first year at the agency.

37. How many agency staff have completed the Certified Public Manager program?

Since 2001, 75 agency staff have completed the Certified Public Manager program.

38. Do agency senior executives have metric-driven performance goals?

All agency senior executives have metric-driven performance goals which tie directly back to the strategic plan. The development of our agency's strategic plan was designed around our five key principles: Access, Engagement, Integration, Quality and Stewardship. Our senior executives' goals and strategies, which include metrics that are used to measure progress over the course of the year, are aligned with these key principles. The metrics always tie directly back to our goals, strategies and key principles. Tracking these metrics helps foster learning, supports the strategic plan, integrates its many components, and encourages good decision-making. The agency also encourages mid-level managers and staff to integrate these metrics into their daily work and assess how they can help the agency meet its goals over the course of the next year.

39. How does the agency hold senior leaders, managers, and supervisors accountable for agency performance?

Agency leaders' metrics are tied to the agency's goals, performance goals, strategies and key principles as described in the response to question 38. Many of these metrics and performance goals are reported every year in the agency's accountability report.

40. Is the agency director required to participate in executive leadership development programs?

The agency director is required to complete mandatory annual training as described in the response to question 36. In addition, the director participates in the biannual leadership development review and other training and leadership exercises throughout the year.

Agency Partnerships

41. Please list all state agencies that receive Medicaid reimbursement.

- *SC Department of Mental Health*
- *SC Department of Disabilities and Special Needs*
- *SC Department of Education*
- *SC Department of Health and Environmental Control*
- *Medical University of South Carolina*
- *University of South Carolina*

- Do these state agencies accept all Medicaid MCO plans?
    - *Yes.*

42. Does DHHS collaborate with the Public Employee Benefit Authority (PEBA) to share best practices regarding MCO performance and healthcare quality improvement? If so, please explain how the agencies work together.

Historically, SCDHHS has worked with PEBA to access service reimbursement information. Medicaid generally indexes itself to a percentage of Medicare reimbursement but on occasion Medicare may not have coverage and benefit information, particularly on specific children's services. In these instances, SCDHHS works to identify the PEBA coverage rules and reimbursement to use it as a source of information in service reimbursement.

Graduate Medical Education

43. In FY2013-14, per Proviso 33.34, DHHS collaborated with the South Carolina GME Advisory Group, to produce a report, "Leveraging Graduate Medical Education to Increase Primary Care and Rural Physician Capacity in South Carolina".

- Have there been any GME policy changes at the agency since the release of this report?

  No GME policy changes have been made to date since the release of this report.

  - If so, please identify and explain the policy change and the issue(s) it seeks to resolve.
- Have there been any GME legislative changes at the state level since the release of this report?

  There have not been any GME legislative changes at the state level to date since the release of this report. Proviso funding has supported development of new and expanded medical residency programs, clinical rotations and fellowships (all in underserved geographical areas and/or underserved medical specialties

  - If so, please identify and explain the legislative change and the issue(s) it seeks to resolve.
- Identify GME issues or challenges specific to the agency.
  - *SCDHHS has not identified any issues specific to the agency. However, recruitment and retention of providers remains a challenge in rural areas and underserved medical specialties for the state as a whole.*

Staff Productivity

44. What percentage of agency positions complete tasks that can be counted (e.g., processing applications, sorting mail, call center, etc.)?

Approximately 70% of agency positions complete tasks that can be counted.

- What percentage of the identified staff are tracked using a define productivity metric?
  - Approximately 60%

45. Does the agency utilize performance based productivity data to assign bonuses or targeted raises?

Yes, the agency uses performance data to assign bonuses and targeted raises for its eligibility staff.

46. Does the agency utilize a productivity dashboard to track productivity metrics on a weekly or monthly basis?

Yes, the agency uses a productivity dashboard to track productively metrics with its eligibility staff.

47. Does the agency require additional resources to improve employee performance, efficiency, and productivity? If so, please identify these resources.

Not that it has identified at this time.

48. Provide the total number of provider applications processed by the agency (FY16-20).

The agency processed the following number of provider enrollment applications:

- *2020: 14,159*
- *2019:15,850*
- *2018: 12, 269*
- *2017: 13,990*
- *2016: 9,513*

The agency processed the following number of BabyNet provider applications:

- *2020: 443*
- *2019: 502*
- *2018: 366*
- *2017: 352*
- *2016: 271*

Most BabyNet providers are enrolled in both the BabyNet and Medicaid programs and are therefore counted in both figures.

- How many FTEs were needed to process these applications?

SCDHHS has contracted the provider enrollment functions to a third party through a sole source procurement. SCDHHS has one designated staff member and the Claims and Provider Services manager who oversees provider enrollment activities. There is a

separate SCDHHS staff member dedicated to BabyNet enrollment, which is processed in house.

MCO Performance Measures

49. Please identify all of the current MCO based performance incentives.

- *Withhold and Bonus Program*
- *Alternative Payment Methodologies*
- *Quality Auto-assignment Algorithm*

50. Does the agency mandate minimum provider reimbursement rates in its MCO contracts for inpatient hospital, outpatient hospital, or primary care physicians?

The agency does not mandate minimum provider reimbursement rates in its MCO contracts. The federal rules to implement these arrangements have changed and separate application and assurances must be made to the federal government in order to mandate minimum provider reimbursement rates. The state must have prior written approval from CMS prior to instituting minimum reimbursement rates and this must be renewed annually by the state. The specific federal rule may be found in 42 CFR 438.6c of the federal code.

51. Does the agency utilize kick payments, one-time fixed, supplemental payments made to plans, allowing them to cover certain services (e.g., maternity care) without assuming financial risk for their use?

Yes, currently the agency utilizes this non-risk methodology for the following services:

- *Maternity* care
- *New pharmaceuticals that are expected to cost in excess of $500,000 annually per member*
- *COVID vaccine administrations to foster and encourage vaccine administration for Medicaid members*

52. Is the agency requiring MCOs to adopt minimum or maximum provider payment fee schedules or provide uniform dollar or percentage increases for network providers that provide a particular service under the contract?

The agency does not mandate minimum or maximum provider reimbursement rates in its MCO contracts. The federal rules to implement these arrangements have changed and separate application and assurances must be made to the federal government in order to mandate minimum provider reimbursement rates. The state must have prior written approval from CMS prior to instituting minimum reimbursement rates and this must be renewed annually by the state. The specific federal rule may be found in 42 CFR 438.6c of the federal code.

53. Does the agency have a strategy to ensure beneficiaries across the state have access to primary care and specialty providers? **Michael/Janelle**

The agency is mandated by federal rule to assess network adequacy of its Medicaid program. Assessing network adequacy is a portion of the external quality review that is completed annually by our vendor, the Carolina Center for Medical Excellence. The assessment that is done for these providers is drive time/distance from a member's home with parameters set to ensure at least 90% of Healthy Connections Medicaid members within a managed care plan have access within acceptable drive time/distance limits.

SCDHHS performs the network adequacy assessment for the managed care program on a bi-annual basis in January and July of each year. SCDHHS continues to invest in and research additional ways to encourage provider participation in the South Carolina Medicaid program. These strategies have included the use of an enhanced fee schedule for primary care physicians and a pediatric subspecialty fee schedule to encourage providers to accept Medicaid members for care.

Additionally, SCDHHS has created an incentive program in its managed care program for providers that become NCQA certified as a Patient Centered Medical Home (PCMH) that provides for an additional per member, per month (PMPM) payment of up to $1.75 PMPM payment for each member the provider adds to their medical home.

54. Does the agency track metrics specific to beneficiary access to care?

Yes, SCDHHS conducts a network adequacy assessment that is performed biannually which includes the following components:

- *Availability*
- *Accessibility*
- *Accommodation*
- *Acceptability*
- *Affordability*
- *Realized Access*

The Realized Access tracks MCO's HEDIS scores around beneficiary access to care. SCDHHS also included several metrics related to access to care which will be updated and included in the final PER document.

55. Did the agency require MCOs to make retainer payments to allow certain Home and Community Based Services (HCBS) providers to continue to bill for individuals enrolled in Medicaid even if HCBS services cannot be provided during a public health emergency?

Yes, SCDHHS applied for and received approval from CMS to add retainer payments for certain individual services when individual members may not have received services during the public health emergency, or when providers were unable to render services because of the COVID-19 emergency response. All MCOs currently operating through the PRIME program are required to make the same payments that are made on behalf of the waiver participants that reside in the Medicaid fee-for-service program.

56. Has the agency found that its beneficiaries have improved health and lower utilization as a result of MCO contractually required quality benchmarks? **Michael/Janelle**

SCDHHS has found improvement around the specific metrics that it includes in its withhold program on an annual basis. The agency continues to evaluate options that provide more holistic ways to improve member health care. This supports the agencies decision to include both an initiation and sunsetting phase in order for the agency to create a continuous improvement life cycle.

57. Does the agency require MCOs to provide care coordination for beneficiaries with sickle cell anemia?

Coverage and care coordination for members with sickle cell anemia is included; however, the agency does not specify disease states within the MCO contract. This is to ensure it does not exclude certain disease states from care coordination. Instead, SCDHHS contractually requires the MCOs to provide care coordination and to categorize their membership for care coordination by risk level and to provide members at high-risk with intensive case management.

58. Does the agency survey beneficiaries with chronic diseases (e.g., sickle cell anemia, rheumatoid arthritis, etc.) regarding their health status, disease management, access to care, and patient satisfaction?

The agency is not currently surveying beneficiaries but all MCOs must be NCQA accredited, and all accredited health plans are evaluated by NCQA on consumer satisfaction. NCQA publishes Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses as part of the MCO health plan rating. The consumer satisfaction survey includes questions in areas around health status, patient satisfaction, disease management and access to care.

59. Has the agency implemented alternative payment methods (APMs) to incentivize high-quality and cost-efficient care? **Michael/Janelle**

Yes, since 2015, MCOs must make a percentage of provider payments pursuant to APM.

- If so, do these APMs apply to specific clinical conditions or patient populations?

Yes, although SCDHHS has taken a broader approach to the implementation of alternative payment methodologies, it has adopted a payment method specific to subspecialists in some cases. For example, in 2019 SCDHHS adopted a payment method which allowed neonatologists and pediatric subspecialists to be reimbursed 140% above the SCDHHS base rate for any given procedure code, and allowed obstetricians, as well as primary care physicians to be paid 129% above the SCDHHS base rate.

60. Has the agency leveraged MCO contracts to promote strategies to address social determinants of health?

SCDHHS will require all MCOs to earn NCQA's Multicultural Health Care distinction by Jan. 1, 2023. This particular NCQA distinction is focused on social determinants of health and is currently the agency's primary method to drive more innovation and discussion around the subject area with the MCOs.

- If so, please identify the contractual requirements specific to social determinants of health.

Please see response above.

61. Does the agency require MCOs to employ community health workers or other non-traditional health workers?

The agency does not currently contractually require MCOs to employ community health workers. MCOs contract with network providers including FQHCs and RHCs that utilize community health workers on a routine basis.

62. Is the agency incentivizing MCOs to help beneficiaries connect with social services related to housing, nutrition, education, or employment?

Under the current MCO contract, MCOs have the ability to offer additional benefits and rewards that address many social determinants of health issues, including the ability to incentivize members to complete specific actions. Additionally, SCDHHS will require all MCOs to earn NCQA's Multicultural Health Care distinction by January 1, 2023. This particular NCQA distinction is focused on social determinants of health and is currently the agency's primary method to drive more innovation and assistance towards these types of issues.

63. How does the agency evaluate the effectiveness and parity of the algorithm used to auto-assign members into a MCO plan?

The assignment methodology has been evaluated several times over the past five years. The most recent evaluation that SCDHHS undertook altered the component of the methodology that assigns members based on their past enrollment history with a particular managed care plan. All plans continue to have the opportunity to improve their auto-assignment levels by

improving their overall NCQA rating. As each plan gains a higher quality ranking from NCQA they will gain a greater share of auto-assigned members.

64. How many beneficiaries were enrolled in FY15-20 and what percentage of them were auto-assigned?

See chart below.

Managed Care Total Enrollment and Auto Enrollment %		
Fiscal Year	Enrolled Managed Care Members in June Each Year	Average Percent Auto Enrolled
2020	839,621	54%
2019	797,584	55%
2018	732,533	53%
2017	767,627	52%
2016	712,645	52%
2015	765,063	46%

65. Please provide the auto-assignment percentage each MCO received (FY2015-20).

SCDHHS tracks this information on a calendar year basis. See chart below.

Percentage of Total Auto-Assigned Members Received by Each MCO Per Calendar Year						
MCO Name	% Auto Assignment CY 2020	% Auto Assignment CY 2019	% Auto Assignment CY 2018	% Auto Assignment CY 2017	% Auto Assignment CY 2016	% Auto Assignment CY 2015
Absolute Total Care	18%	27%	18%	17%	19%	17%
Advicare	Left Market	Left Market	Left Market	Left Market	4%	14%
BlueChoice Healthplan	18%	25%	17%	16%	14%	12%
Select Health	23%	5%	34%	33%	32%	29%
Molina	23%	22%	18%	17%	16%	17%
WellCare	18%	22%	14%	17%	14%	11%

66. Does the agency give beneficiaries the option to receive enrollment packets electronically?

The enrollment broker currently allows people to enroll in their managed care plan via the web, email, or fax. The actual enrollment packet at this point in time is mailed to the member.

67. Has the agency considered sending enrollment notification reminders to beneficiaries via text message?

The agency is in the process of entering into an agreement with a vendor to implement a texting platform that can text members whose eligibility is due for redetermination. The text message will encourage beneficiaries to contact SCDHHS to update their contact information.

68. What percentage of beneficiaries select a different MCO during the annual right to change period?

SCDHHS currently analyzes this by the total number of transfers processed by the enrollment broker from one MCO to another. The average monthly total number of transfers was 1,165 members per month in calendar year 2020.

69. If a beneficiary decides to switch plans, does the agency inquire as to why the change was made? If so, how does the agency use this information?

The enrollment broker provides enrollment and disenrollment choice information to the agency on a monthly basis. Currently SCDHHS reviews this information for plan comparison and looks for significant changes month-to-month on the reasons that a member may choose one over another MCO.

70. Large MCOs have cost advantages due to economies of scale. Does the agency consider the size of a MCOs operation when determining medical loss ratio?

The agency sets its medical loss ratio (MLR) for the entire managed care program. SCDHHS-contracted actuaries review statutory financial statements from contracted MCOs and assess the MLRs soundness in setting capitated rates annually for all MCOs participating in the program.

71. Please provide the metrics used by the agency to determine bonuses associated with the withhold program.

The bonus metrics may change over time but the current bonus HEDIS metrics for Measurement Year 2021 (MY21) are:

- *Postpartum care (women's health)*
- *Antidepressant medication management, continuation phase (behavioral health)*
- *Follow-up care for children prescribed attention deficit hyperactivity disorder medication, Continuation (behavioral health)*

- *Metabolic monitoring for children and adolescents on antipsychotics, total (behavioral health)*
- *Initiation and engagement of alcohol and other drug dependence*
- *Treatment, engagement (behavioral health)*

The plans are also able to gain bonuses within each withhold index of Diabetes, women's health, and pediatric preventative care if other MCOs have forfeited funds within the index and the MCO is at the 90% or better within the withhold index.

72. Provide the withhold percentage received by each MCO (FY2015-20).

SCDHHS withholds 1.5% of capitation payments from each MCO. MCOs that do not meet the assigned quality metrics lose the withhold and that money is added to the bonus pool. The chart below reflects the percentage of the MCOs withhold amount that the plan earned back in total including any bonus dollars that were earned by the MCO.

Total Withhold Amount Returned to MCO as a percentage of Total Contributed to Pool						
Fiscal Year	**Advicare**	**Absolute Total Care**	**BlueChoice**	**First Choice**	**Molina**	**WellCare**
2015	0%*	84%	45%	134%	89%	60%
2016	Left Market	94%	92%	110%	94%	83%
2017	Left Market	103%	92%	108%	85%	92%
2018	Left Market	117%	67%	111%	99%	67%
2019	Left Market	97%	75%	113%	100%	92%
2020	WITHHOLD SUSPENDED FOR YEAR DUE TO COVID					

**Left market mid-year contract terms indicate full return of withhold dollars*

73. Please identify the external quality review organization responsible for performing annual quality reviews for each MCO?

Carolina Center for Medical Excellence (CCME)

74. How often does the contractor conduct on-site and in-person interactions with MCO staff and personnel?

The contractor conducts in-person interactions annually.

- What is the contractor looking for during the audit?
  - *The contractor conducts audits annually of each MCO operating in South Carolina. During the audit, the following areas are reviewed and assessed by the quality contractor:*
    - *Administration*
    - *Provider services*

- *Member services*
- *Quality improvement*
- *Utilization management*
- *Delegation*
- *State mandated services*

- What information is made available in the final report?
  - *The final report provides findings related to the categories above.*

- Is the final report posted on the agency's website?
  - *Yes. The results are posted on the SCDHHS website at: EQR Reports | Managed Care (scdhhs.gov)*

Carve-in Services Michael/Janelle

75. How have the carve-in of BabyNet, opioid treatment programs, freestanding inpatient psychiatric care, and Hepatitis C medications benefited the agency, members, and providers?

The carve-in of these services have helped to integrate and coordinate care for members. The more integrated and coordinated the care, the less potential for duplication of services. Providers are less likely to need to bill for services through multiple payors and the agency is more able to focus its attention on benefit management and member outcomes.

The carve-in of BabyNet has provided families with more options of providers to serve their children and created consistency across the program as each MCO is required to cover the same services. The carve-in has also created more defined reimbursement process for services and a more clear escalation processes for denials of services.

The carve-in of freestanding inpatient psychiatric care resulted in the entire behavioral health benefit being added to managed care. This means that there is no perverse incentive on behalf of the plans to allow members to "fail up" to a more intensive level of care.

The carve-in of opioid treatment programs (OTPs) to the managed care benefit has allowed for MCO members to receive additional as-needed care coordination in conjunction with their utilization of OTPs.

The carve-in of hepatitis C medications has reduced call center activity in the Medicaid pharmacy call center, as well as provided more consistency in the management of hepatitis C by providing drug coverage and care management in one place.

- Are there other services being considered for carve-in? If so, please identify these services.

- *The agency's current primary focus is on developing its strategy and approach to take for Managed Long Term Supports and Services (MLTSS). In the coming months, SCDHHS will engage with stakeholders to gather input.*

COVID-19 Response

76. Will the agency seek feedback from members and providers prior to determining whether to discontinue certain COVID-19 related service changes (e.g., telehealth, office visit limitations, etc.)?

The public health emergency has provided valuable data, feedback and insight that should be used to make informed decisions about post-pandemic telehealth flexibility and other policies. The agency has already received input and suggestions from providers, members and managed care organizations regarding the temporary policy changes it has implemented during the current public health emergency. SCDHHS will use available data, clinical guidelines and best practices from other health payors and the feedback it has received from stakeholders to make decisions on future policy changes.

- If the agency does seek feedback from members and providers, how will the agency capture this information (e.g., survey, etc.)?

  SCDHHS may utilize surveys but routinely holds meetings with providers through program areas across the agency. The agency established a shared inbox to receive input related to the pandemic from providers, members and other stakeholders and regularly analyzes and discusses the feedback it receives. Additionally, the agency holds its Medical Care Advisory Committee meeting quarterly where stakeholders may provide input on agency policy and future agency direction.

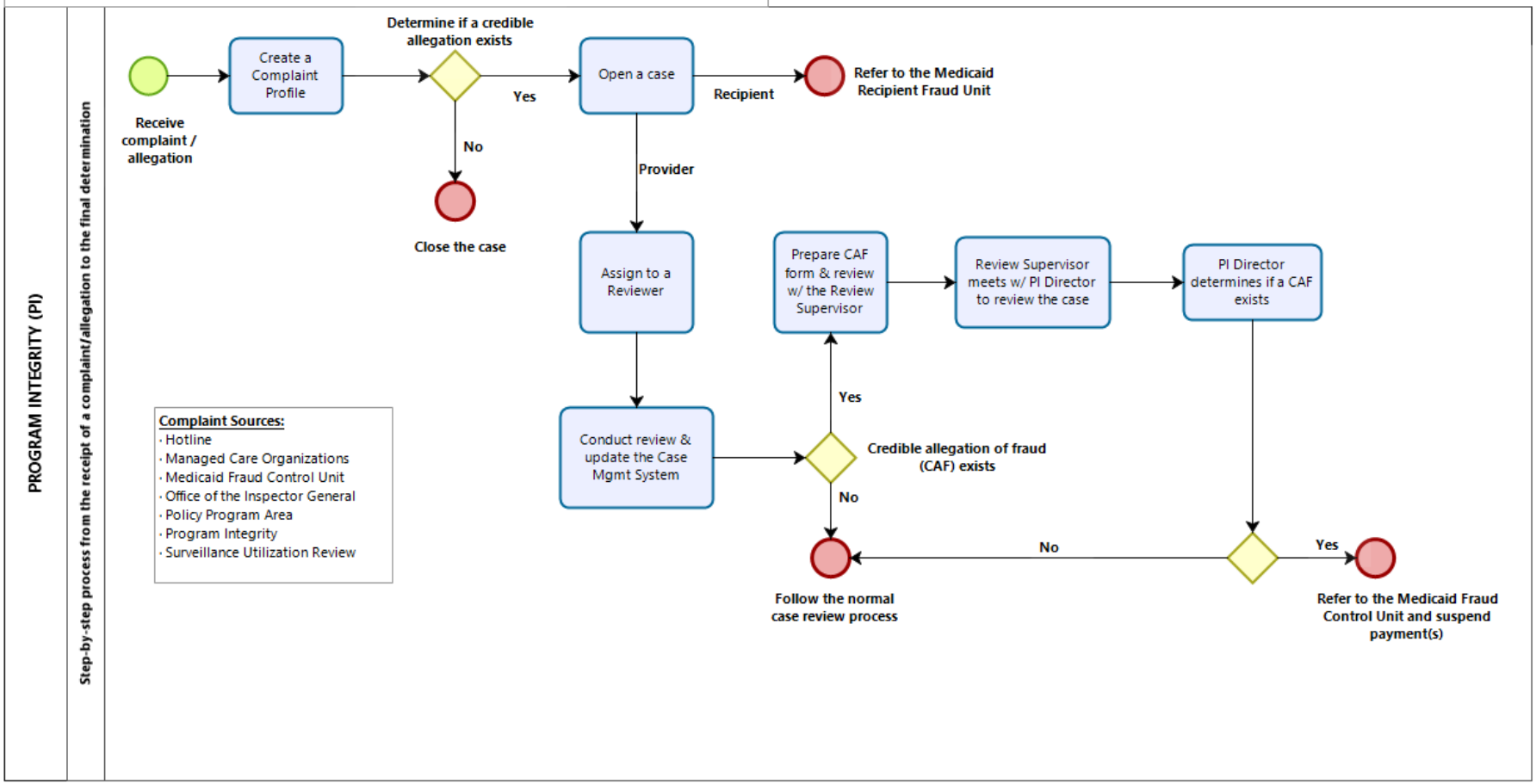
Sincerely,

Robert M. Kerr

cc: The Honorable Gil Gatch
The Honorable Rosalyn Henderson-Myers
The Honorable Timothy "Tim" McGinnis

Response to Question #12 - Who decides if the case is sent to the Medicaid Provider Fraud Unit?

- Provide a step-by-step process flowchart from receipt of the allegation to final determination of credibility.



SCDHHS Pharmacy Lock-in Criteria

1. CII Without Prof Claim in Previous 6 Mo: Identifies any member with a DEA Schedule II prescription without a professional claim in the previous six months. The professional claims look back was not limited to the time period of this report.
2. Fifteen or More RX in 30 Days: Identifies members with 15 or more prescriptions (any schedule) within a thirty day period. This measure is based on a rolling 30 days within the 6 month time period of this report.
3. Five of More Controls in Thirty Days: Identifies members with 5 or more DEA Schedule II-V prescriptions within a thirty day period. This measure is based on a rolling 30 days within the 6 month time period of this report.
4. Two or More ER Visits In 30 Days and Controlled RX: Identifies members with 2 or more non-emergent ER visits within a thirty day period and a DEA Schedule II-V prescription within the same 30 days. Uses a facility revenue code of '0450' or '0451' and a outpatient service level of '1'. Note that outpatient service level was tagged to encounter claims using a lookup based on their primary diagnosis code.

5. Greater Than 3600mg Oxycodone HCL in 30 Days: Identifies members with more than 3600 mg of Oxycodone HCL (generic name for Oxycontin) in a thirty day period. This measure is based on a rolling 30 days within the 6 month time period of this report. The total mg per prescription was calculated as strength * quantity dispensed. Note that this measure includes only drugs with a generic drug name like '%OXYCODONE HCL%' and does not include hydrocodone.
6. Two or More Out of State Pharmacies for Controls: Identifies members with DEA Schedule II-V prescriptions from two or more out of state pharmacies.
7. Two Controls From 2 Pharmacies within 2 Days: Identifies members with 2 or more DEA Schedule II-V prescriptions dispensed by 2 different pharmacies on 2 consecutive days.
8. Suboxone or Methadone within 6 Months: Identifies members with Suboxone or Methadone prescriptions during the time period of this report. Includes generic drug names like '%BUPRENORPHINE%NALOXONE%' and '%METHADONE%' and CPT codes H0016 and H0020.

9. Opioid Within 30 Days After Suboxone or Methadone: Identifies members with an opioid prescription within 30 days after a Suboxone or Methadone prescription. Suboxone and Methadone are identified as in rule 8 and opioids were identified as drugs with a therapuetic class (tc) of 40 and a DEA class of 2 or 3.
10. Ten or More Pills Per Day For Controlled RX: Identifies members with DEA Schedule II-V prescriptions allowing for 10 or more pills per day. Drugs for this measure were limited to those in either tablet or capsule form. Pills per day was calculated as quantity dispensed / days supply.
11. Pill Count for Controls Greater Than 600: Identifies members with a pill count exceeding 600 for all DEA Schedule II-V prescriptions dispensed during the six month time period of this report. Drugs for this measure were limited to those in either tablet or capsule form.

12. History of Drug Dependence with Benzo or Opiate RX: Identifies members with a drug dependence diagnosis code and a Benzodiazapine or Opiate prescription during the six month time period of this report.
    - Opioids were identified as drugs with a therapuetic class (tc) of 40 and a DEA class of 2 or 3.

- Benzodiazepines were identified as drugs with a generic name like '%BENZODIAZEPIN%' and a DEA class of 4.
- Diagnosis codes indicating drug dependence were F11.XXX-F16.999 to F18.XXX to F19.999. This excludes F10.XXX (alcohol dependence) and F17.999 (nicotine dependence). All diagnosis codes are considered.

13. History of Poison Overdose with Benzo or Opiate RX: Identifies members with a poisoning/overdose diagnosis code and a Benzodiazapine or Opiate prescription during the six month time period of this report.
- Opioids were identified as drugs with a therapuetic class (tc) of 40 and a DEA class of 2 or 3.
- Benzodiazepines were identified as drugs with a generic name like '%BENZODIAZEPIN%' and a DEA class of 4.
- Diagnosis codes indicating drug dependence were T36.XXX-T50.XXX where the last two characters are not 5 or 6. All diagnosis codes are considered.

14. Five or More Prescribers: Identifies member with five or more prescribers during the six month time period of this report. All prescriptions are included.
15. Two or More Opioid Prescribers: Identifies members with two or more prescribers issuing an opioid prescription during the six month time period of this report.
- Opioids were identified as drugs with a therapuetic class (tc) of 40 and a DEA class of 2 or 3.

16. Three or More Prescribers for Controlled Substance: Identifies members with three or more prescribers issuing a controlled substance (DEA Schedule II-V) during the six month time period of this report.
17. Four or More Pharmacies: Identifies members with drugs dispensed by four or more pharmacies during the six month time period of this report. All prescriptions included.
18. Two or More Pharmacies for Controlled Substances: Identifies members with controlled substances (DEA Schedule II-V) dispensed by two or more pharmacies during the six month time period of this report.
19. Three or More Controlled Substances and Drugs of Concern: Identifies member with three or more drugs between controlled substances (DEA Schedule II-V) and other drugs of concern. Other drugs of concern include tramadol, cyclobenzaprine, methocarbamol, tizanidine and metaxalone.
20. On Cocktail Reports: Identifies members also found on the "Holy Trinity" or "The Cocktail" reports for the same six month time period. These reports identify members who were dispensed all components of a known drug cocktail during a thirty day period.
- Holy Trinity: Muscle relaxant, benzo and (narcotic or tramadol)
  - Muscle relaxant: Drugs with a therapuetic class of 8.
  - Benzo: Drugs with a therapuetic class of 7, 47 or 48 and a DEA of 4.
  - Narcotic: Drugs with a therapuetic class of 40 or 46 and a DEA class of 2 or 3.
  - Cocktail: Carisoprodol, alprazolam, and (oxycodone or hydrocodone)

The following members were excluded from the Pharmacy Lock-in Program:
- Members in hospice
- Members with a date of death
- Members that are no longer eligible for Medicaid

Program Integrity responses for the House Oversight Committee
#14 - Pharmacy Lock-in Criteria

- Members currently in the lock-in program
- Members aged 16 or younger with an aid category of 57 (TEFRA) or an RSP in the following list:
  - AUTW (Autism Waiver)
  - CHPC (CLTC Childrens PCA)
  - DMRE (DMR Waiver/Established)
  - DMRN (DMR Waiver/New)
  - MCFC (Medically Fragile Children Pgm)
  - MCNF (Med Fragile Non-Foster Care)
  - WMCC (Medically Complex Children)
- Members with certain diagnosis codes related to Sickle Cell Anemia occuring sometime in the last seven years.