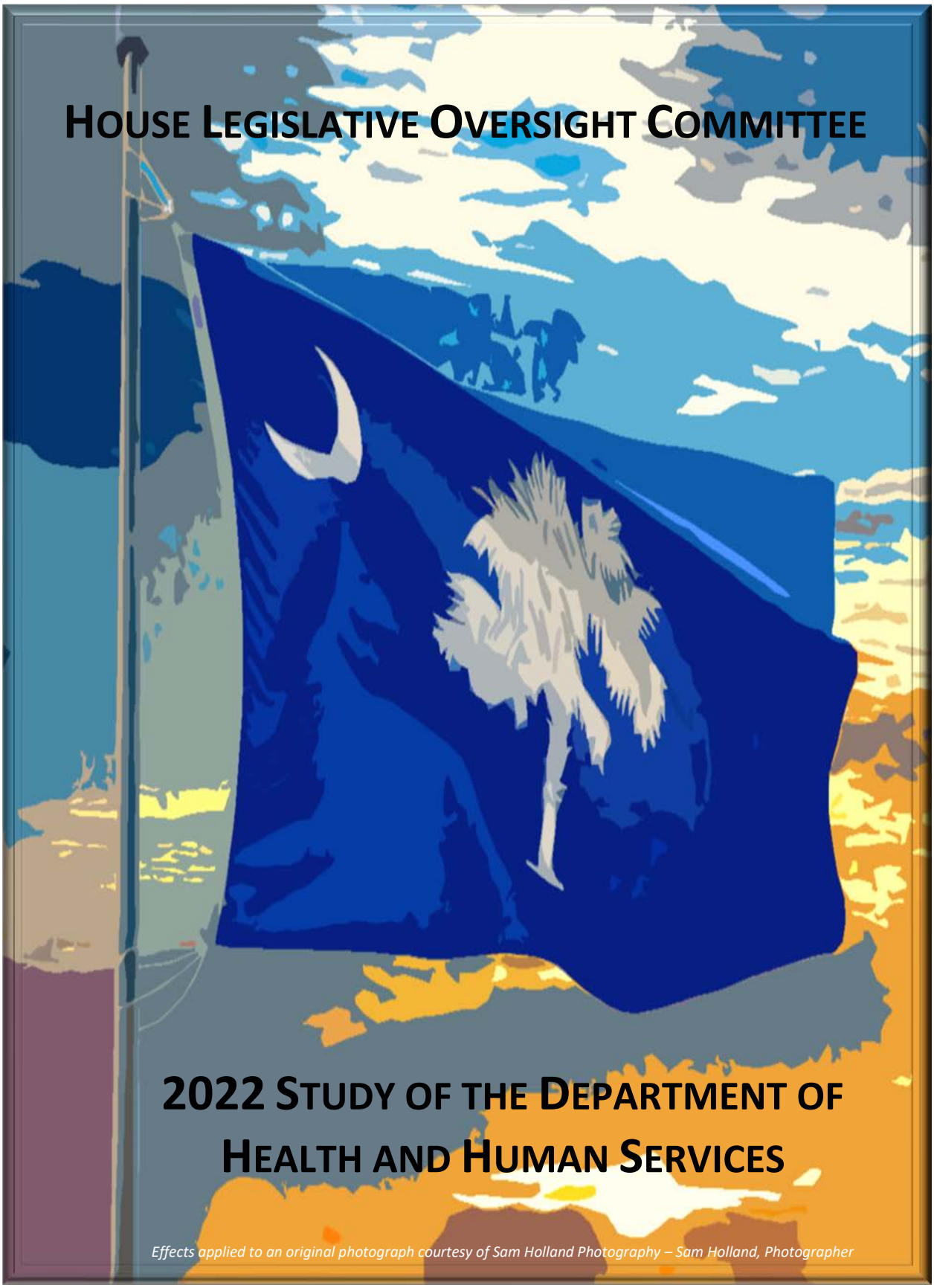

HOUSE LEGISLATIVE OVERSIGHT COMMITTEE

2022 STUDY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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S.C. House Legislative Oversight Committee

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The purpose of the S.C. House Legislative Oversight Committee's (Committee) work is to determine if agency laws and programs are implemented and carried out in accordance with the intent of the General Assembly and whether they should be continued, curtailed, or eliminated. The Committee's member-driven process enhances the ability of Representatives to make informed decisions about state government and agency responsiveness to the needs of South Carolinians. The process is also a resource for public access to information about the performance of state agencies and their programs.

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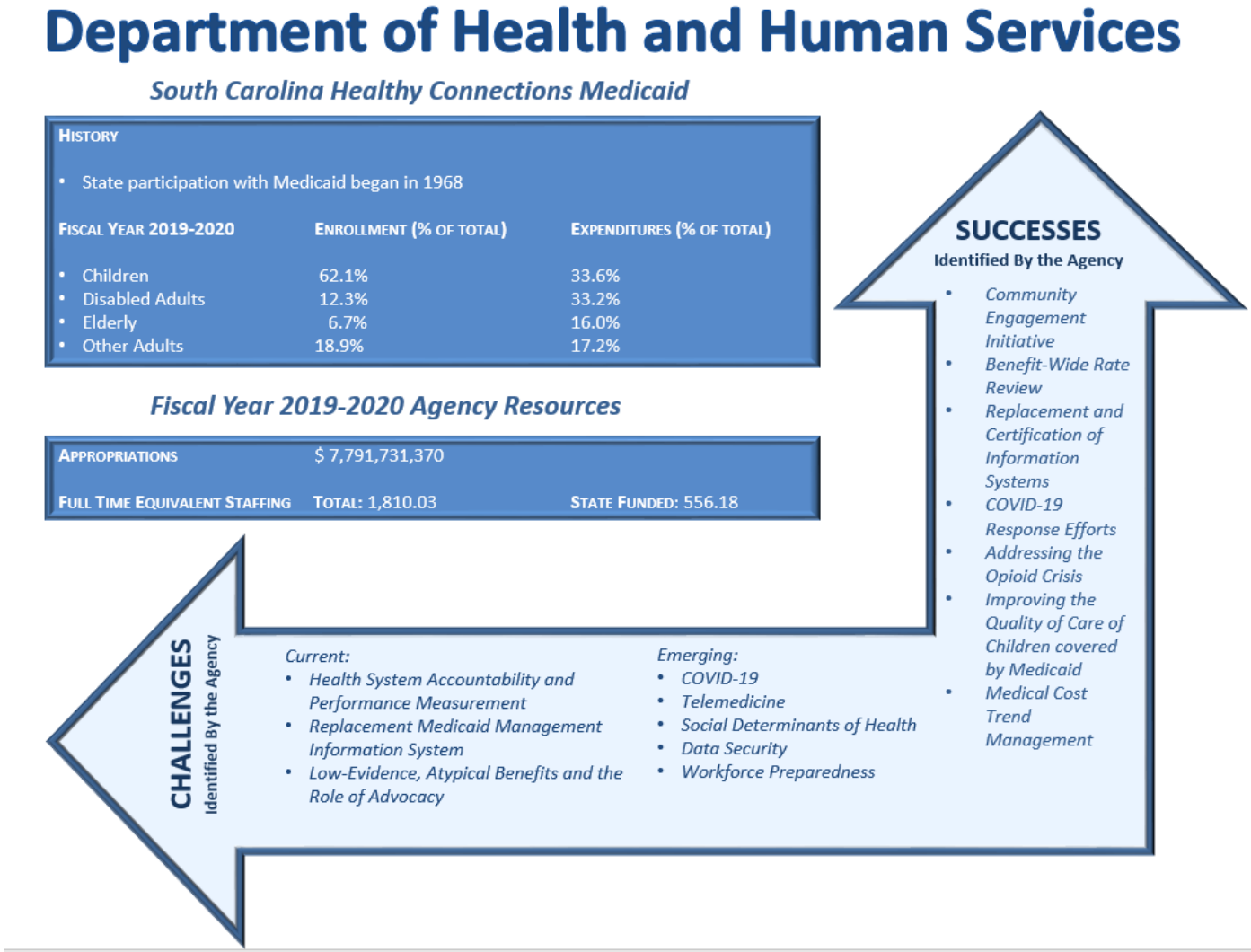


Figure 1. Overview of the agency' history, fiscal year 2019-20 Medicaid enrollment and expenditures; agency resources (employees and funding), successes, and challenges[1]

COMMITTEE OVERVIEW

Oversight Purpose and Methods

PURPOSE

To determine if agency laws and programs:

- are being implemented and carried out in accordance with the intent of the General Assembly; and
- should be continued, curtailed, or eliminated.

METHODS

The Committee and Subcommittee evaluate:

- the application, administration, execution, and effectiveness of the agency's laws and programs;
- the organization and operation of the agency; and
- any conditions or circumstances that may indicate the necessity or desirability of enacting new or additional legislation pertaining to the agency.

S.C. Code Ann. § 2-2-20(B) and (C)

Study Process

Figure 2: House Legislative Oversight Committee's study process

Public Input

115 Responses to an online public survey

9 Online comments received

Subcommittee Membership

HEALTHCARE AND REGULATORY SUBCOMMITTEE

The Honorable John Taliaferro "Jay" West, IV (chair)
The Honorable Gil Gatch
The Honorable Timothy A. "Tim" McGinnis
The Honorable Rosalyn D. Henderson-Myers

Study Milestones

MEETINGS

Full Committee	12.09.2019 4.08.2021
Subcommittee	7.08.2020 3.08.2021 4.26.2021 5.03.2021 5.24.2021 8.30.2021

AGENCY REPORTS

March 2015	Seven-Year Plan Report
June 2020	Program Evaluation Report
September 2020	FY 2018-19 Accountability Report
September 2021	FY 2019-20 Accountability Report

FINDINGS

During the study of the Department of Health and Human Services (agency or DHHS), the Healthcare and Regulatory Subcommittee (Subcommittee) of the House Legislative Oversight Committee (Committee) adopts **10 findings pertaining to Medicaid beneficiaries, Medicaid providers, and agency resources**.

Findings note information a member of the public, or General Assembly, may seek to know or on which they may desire to act. The Subcommittee addresses some of these findings through various recommendations.

Medicaid Beneficiaries

The three findings relating to Medicaid beneficiaries are summarized in Table 1.

Table 1. Summary of findings relating to Medicaid beneficiaries

Utilization Disparities	1. South Carolina has nine counties with a Medicaid population of 40% or more of the total county population (i.e., Dillon [47.07%], Marion [46.69%], Barnwell 42.90%], Marlboro [42.84%], Allendale [42.54%], Williamsburg [41.97%], Lee [41.63%], Colleton [41.04%], and Orangeburg [40.53%]).
Enrollment in Managed Care Organizations	2. Over 50% of Medicaid beneficiaries enrolled in a managed care organization (MCO) plan are auto-assigned. Beneficiaries can select their own MCO plan within 60 days from the time they become Medicaid eligible. If a MCO is not selected, agency personnel will auto-assign the beneficiary. Once a beneficiary has been auto-assigned, the beneficiary has another 90 days to opt out of that plan if desired. *See recommendations 4, 13, and 22.*
Waiver Sustainability	3. There are multiple challenges (e.g., wait lists and access to service providers) specific to Medicaid beneficiaries receiving services through waiver programs (i.e., requirements differ from the standard federal program). South Carolina offers multiple waiver programs, and many of these allow Medicaid beneficiaries to remain in home rather than receive institutional care. While DHHS processes Medicaid payments for services provided through waiver programs, some of the waiver programs are operated by other state agencies.

FINDING #1. South Carolina has nine counties with a Medicaid population of 40% or more of the total county population (i.e., Dillon [47.07%], Marion [46.69%], Barnwell 42.90%], Marlboro [42.84%], Allendale [42.54%], Williamsburg [41.97%], Lee [41.63%], Colleton [41.04%], and Orangeburg [40.53%]).[2]

Medicaid enrollment, at the population level, correlates to other issues within a community (e.g., socioeconomic, public health, education, etc.).[3] Total Medicaid enrollment for each of the nine identified counties is illustrated Figure 3.[4] A comparison of Medicaid enrollment statewide is shown in Figure 4.

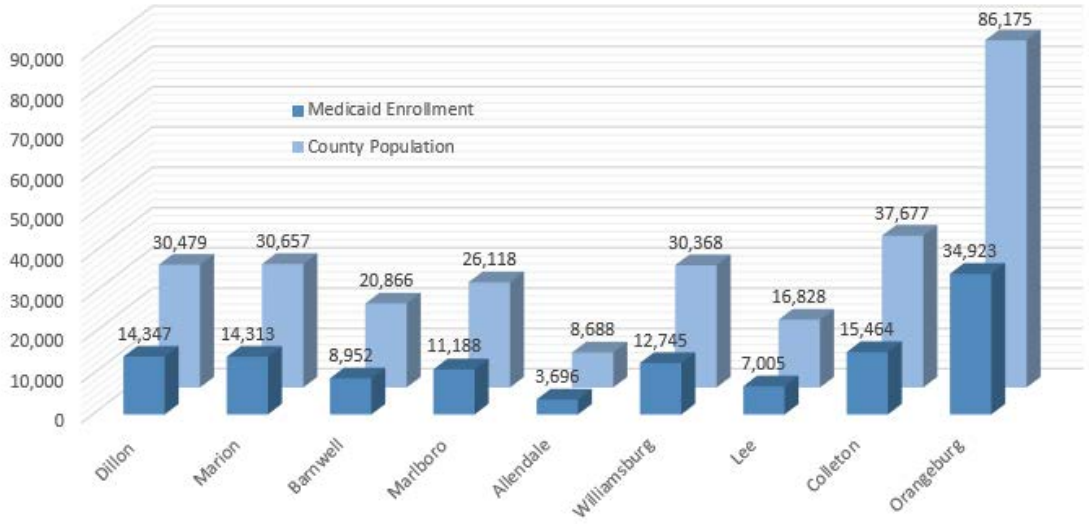


Figure 3. Total enrollment for each of the nine counties with a Medicaid population of 40% or more of the total county population[5]

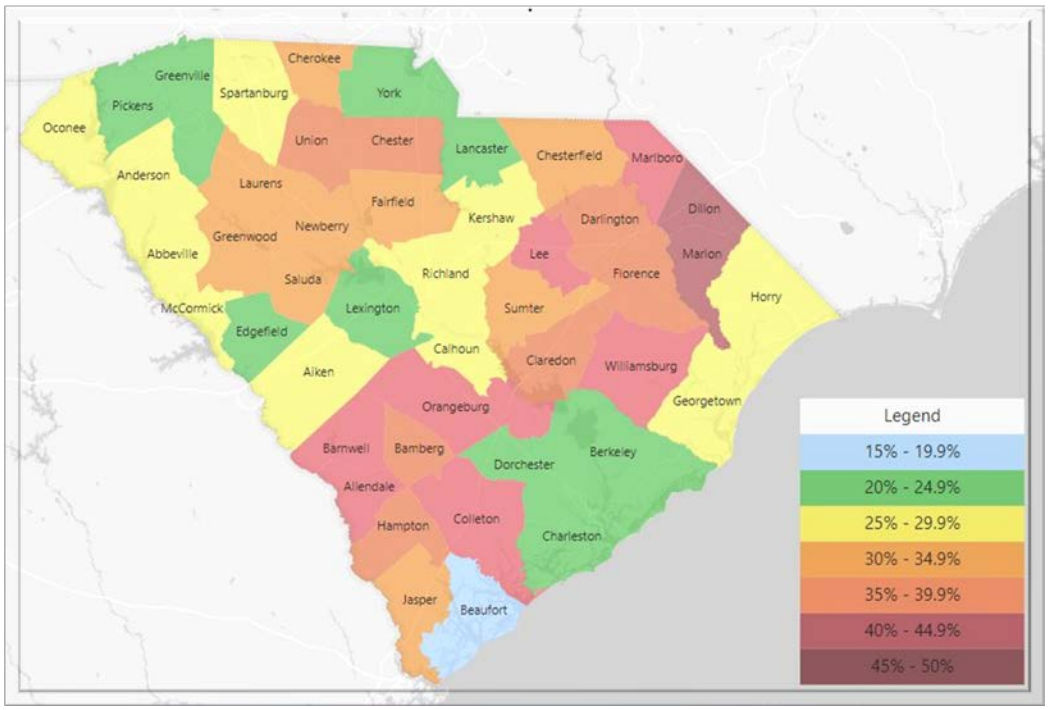


Figure 4. Comparison of statewide Medicaid enrollment

FINDING # 2. Over 50% of Medicaid beneficiaries enrolled in a managed care organization (MCO) plan are auto-assigned.[6] Beneficiaries can select their own MCO plan within 60 days from the time they become Medicaid eligible.[7] If a MCO is not selected, agency personnel will auto-assign the beneficiary.[8] Once a beneficiary has been auto-assigned, the beneficiary has another 90 days to opt out of that plan if desired.[9]

Since 2016, over 50% of Medicaid beneficiaries have been auto-assigned into a MCO plan.[10] Auto enrollment data is in Figure 5. According to agency staff, an algorithm determines which plan beneficiaries are placed.[11] The algorithm considers factors such as prior plan participation and MCO quality metrics.[12] Agency leadership testified that "choice" is promoted.[13] However, the majority of beneficiaries are not choosing their own plan but, instead, are relying on agency personnel to make the decision.

Recommendations 4, 13, and 22 address this finding.

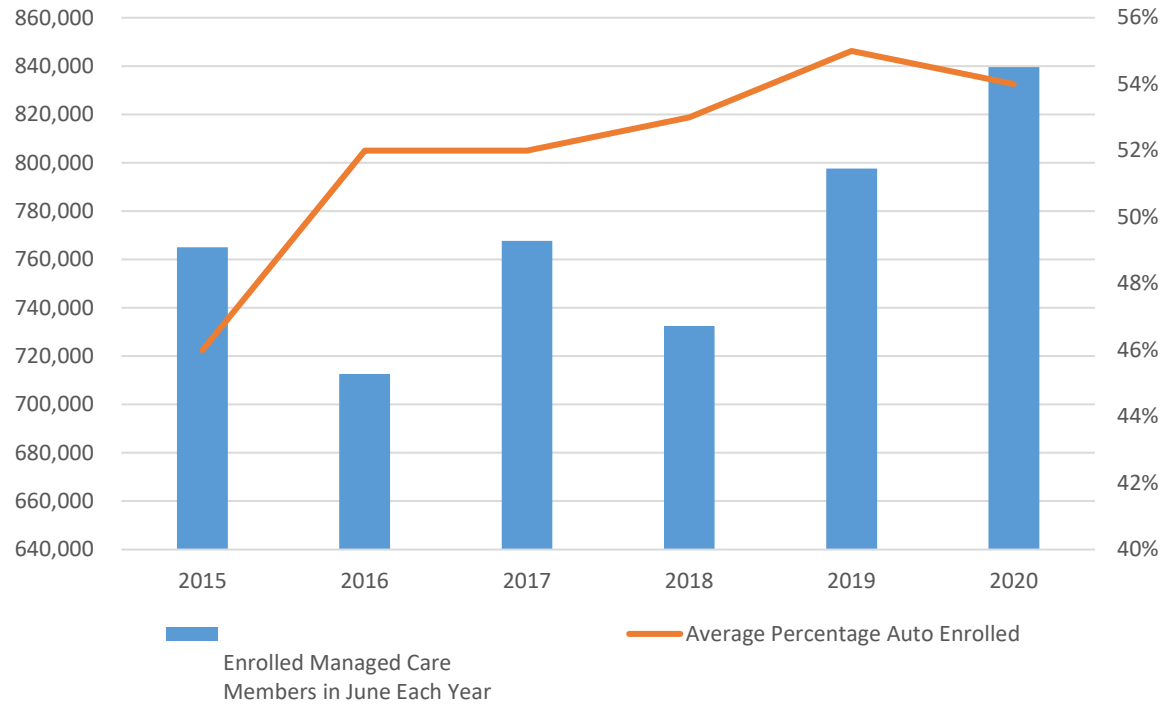


Figure 5. Auto enrollment of Medicaid beneficiaries into managed care organizations from 2015 - 2020

FINDING # 3. There are multiple challenges (e.g., wait lists and access to service providers) specific to Medicaid beneficiaries receiving services through waiver programs (i.e., requirements differ from the standard federal program). South Carolina offers multiple waiver programs, and many of these allow Medicaid beneficiaries to remain in home rather than receive institutional care. While DHHS processes Medicaid payments for services provided through waiver programs, some of the waiver programs are operated by other state agencies.

A summary of these waiver programs is provided in Table 2.

One challenge is there are waiting lists to receive services through some waiver programs. The following waivers have waiting lists: Intellectual Disability and Related Disabilities (5.4 years); Community Supports (3.6 years); and Head and Spinal Cord Injury (0.4 years).[14] According to agency staff, as of August 2021, approximately $214 million in recurring state funds is required to accommodate every person currently on a waiting list.[15] The methodology used to calculate this figure required the application of the historical average cost per member per month, which was annualized to provide total annual expenditures.[16] Total annual expenditures were used to estimate the state share of the cost using 30% of the total, which represents the approximate historic state share for Medicaid services.[17] Agency personnel produced this figure to provide additional perspective and scope on waiver services and expenses.[18]

Accordingly, a second challenge is obtaining funding to enhance and strengthen home and community-based waiver services. Agency personnel recognize the General Assembly is not likely to be able to increase recurring funding to the level necessary to accommodate every person currently on a waiting list; however, incremental increases in state funds allocated to these waiver programs may help increase access to these services.[19]

Another challenge is a limited provider network.[20] Agency leadership communicates with service providers regarding resources and service infrastructure across the state.[21] Provider rates for direct services (e.g., private nursing, home care services, respite providers, etc.) require ongoing evaluation as agency personnel implements strategies specific to recruitment and retention.[22]

Table 2. Summary of South Carolina waiver programs[23]

Waiver Name	Individuals Served	Services Summary
Community Choices	Individuals ages 65 – no max age and Individuals with physical disabilities ages 18 – 64	Provides adult day health care, case management, personal care/ personal care I + II, respite, adult day health care transportation, adult day health care-nursing, attendant care, companion care, home accessibility adaptations, home delivered meals, personal emergency response system, residential personal care II, specialized medical equipment and supplies, and telemonitoring
HIV/AIDS	Individuals with HIV/AIDS ages 0 - no max age	Provides case management, personal care/personal care I and II, prescription drugs, except drugs furnished to participants who are eligible for Medicare Part D benefits, attendant care services, companion care, home accessibility adaptations, home delivered meals, private duty nursing, and specialized medical equipment and supplies
Mechanical Ventilator Dependent	Technology dependent individuals ages 21 - no max age	Provides case management, personal care I and personal care II, respite, attendant care, home accessibility adaptations, home delivered meals, personal emergency response system, pest control, private duty nursing, specialized medical equipment and supplies
Medically Complex Children	Individuals who are medically fragile ages 0-18	Provides care coordination, respite, and pediatric medical day care
Psychiatric Residential Treatment Facilities Alternative CHANCE	Individuals with serious emotional disturbance ages 4 - 18	Provides case management, prevocational services, respite, customized goods and services, intensive family services, medication monitoring and wellness education, peer support, and wraparound para-professional

Community Supports **(Wait List – 3.6 years)**	Individuals with intellectual disability ages 0 – no max age	Provides adult day health care services, personal care services, respite care services, waiver case management, incontinence supplies, adult day health care nursing, adult day health care transportation, assistive technology and appliances assessment/consultation, assistive technology and appliances, behavior support services, career preparation services, community services, day activity, employment services, environmental modifications, in-home support services, personal emergency response systems, private vehicle assessment/consultation, private vehicle modifications, and support center services
Head and Spinal Cord Injury **(Wait List – 0.4 years)**	Individuals with physical and other disabilities ages 0-64	Provides attendant care/personal assistance services, career preparation services, day activity, residential habilitation, respite care services, waiver case management, incontinence supplies, occupational therapy, physical therapy, speech and hearing services, behavioral support services, employment services, environmental modifications, health education for participant-directed care, Medicaid waiver nursing, peer guidance for participant-directed care, personal emergency response systems, pest control bed bugs, pest control treatment, private vehicle assessment/consultation, private vehicle modifications, psychological services, supplies, equipment and assistive technology assessment/consultation, supplies, and equipment and assistive technology
Intellectually Disabled and Related Disabilities **(Wait List – 5.4 Years)**	Individuals with intellectual disability ages 0 – no max age	Provides adult day health care, adult day health care services, personal care 2, personal care 1, residential habilitation, respite care, waiver case management, adult dental services, adult vision, audiology services, incontinence supplies, prescribed drugs, adult attendant care services, adult companion services, adult day health care nursing, adult day health care transportation, behavior support services, career preparation services, community services, day activity, employment services, environmental modifications, nursing services, personal emergency response system, pest control bed bugs, pest control treatment, private vehicle assessment/consultation, private vehicle modifications, psychological services, specialized medical equipment and assistive technology assessment/consultation, specialized medical equipment, supplies and assistive technology, and support center services
Pervasive Developmental Disorder	Individuals w/autism ages 3 – 10	Provides case management, Early and Intensive Behavioral Intervention (EIBI) assessment, EIBI plan implementation, EIBI program development and training, lead therapy, line therapy I, line therapy II, self-directed line therapy I, and self-directed line therapy II
Palmetto Coordinated System of Care for Children Home and Community Based	Individuals with serious emotional disturbance ages 0-21 years	Provides high fidelity wraparound, respite, and individual directed goods and services

Table Note: Shading indicates there is a wait list for the waiver. Wait list information is accurate as of July 2021.

Medicaid Providers

There are six findings relating to Medicaid providers. A summary is included in Table 3.

Table 3. Summary of findings relating to Medicaid providers

Recruitment and Retention	4. There is only one pediatric medical day care serving Medically Complex Children waiver participants in the state, and it is located in Greenville, South Carolina.[See recommendation 10] 5. Managed care organizations contracted with the state Medicaid program have reported difficulties placing their pediatric beneficiaries, particularly children who have been diagnosed with autism spectrum disorder or who struggle with controlling behavioral issues (e.g., sexually aggressive behavioral health, eating disorders, history of violence, general aggressiveness, etc.), in psychiatric residential treatment facilities in the state. 6. The South Carolina Graduate Medical Education Advisory Group, of which agency personnel was a participant, provided recommendations to the General Assembly, Governor's Office, and the Department of Health and Human Services regarding how to improve graduate medical education in South Carolina.
Reimbursement	7. After agency personnel increased rates for autism disorder providers, individual provider enrollment increased. Prior to the provider rate increase in 2018, the agency had 151 individual providers. Provider enrollment increased to 213 individual providers (a 41% increase) by June 30, 2019. Another rate increase occurred on July 1, 2019, and 347 individual providers enrolled (a 63% increase) by May 15, 2021.[See recommendation 16.] 8. From fiscal year 2015-21 the agency's Program Integrity Unit opened 1,835 cases, of which 186 were on-site provider reviews. According to agency staff, 99% of those reviews resulted in some form of corrective action for providers. [See recommendations 22, 23, 24, 25, and 26.] 9. Several state agencies receive reimbursement from the state Medicaid program. These agencies include the following: Department of Disabilities and Special Needs; Department of Education; Department of Health and Environmental Control; Department of Mental Health; Medical University of South Carolina; and University of South Carolina.

FINDING #4. There is only one pediatric medical day care serving Medically Complex Children (MCC) waiver participants in the state, and it is located in Greenville, South Carolina.[24]

See Table 2 for a summary of MCC wavier. According to agency personnel, "[t]here is also some risk to the MCC program in having only one service provider for care coordination and pre-admission screening functions."[25] Prisma Health Upstate DBA [Prisma Health Wonder Center], which is located in Greenville, SC, is geographically challenging for many MCC waiver

participants to reach as illustrated in Figure 6. For many low country residents (e.g., Charleston, Hilton Head, and Myrtle Beach), the one-way travel time to the facility exceeds four hours.

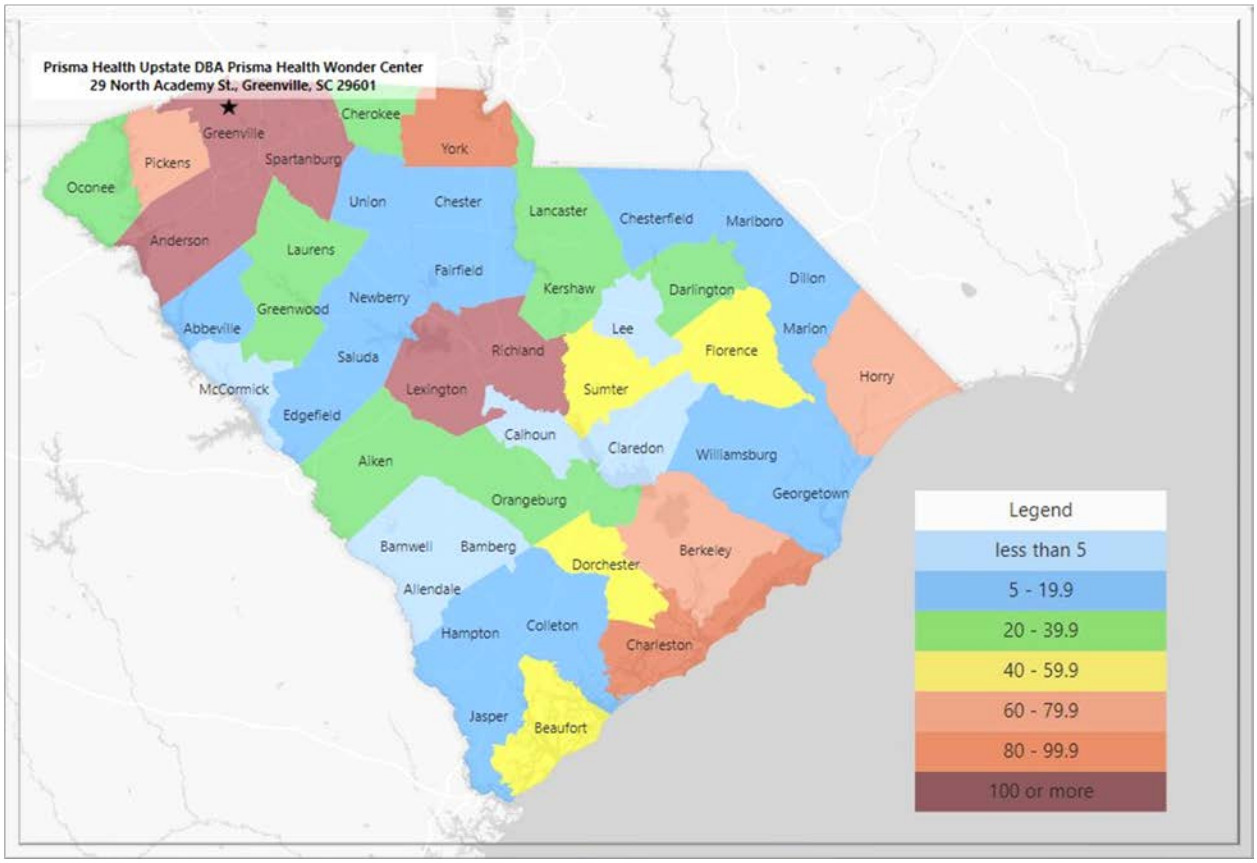


Figure 6. Medically complex children population across South Carolina

The limited provider network creates challenges for some families as it impacts their ability to work. According to agency personnel, "[f]amilies rely on state government programs as 54% of families that have a medically complex child have a family member who had to stop working to care for their child."[26] Generally, children with complex medical needs cannot attend regular daycare, which limits employment options for their parents or guardians. The one pediatric medical day care provider accessible via the MCC waiver employs a child development specialist and pediatric nurses.[27] Traditional daycare providers do not provide, nor are they required or equipped to offer, this level of care.

DHHS updated the MCC waiver reimbursement rates in 2014.[28] According to agency leadership, these rates require reevaluation as it is essential that reimbursement covers the cost of services.[29]

Recommendation 10 addresses this finding.

FINDING #5. Managed care organizations contracted with the state Medicaid program have reported difficulties placing their pediatric beneficiaries, particularly children who have been diagnosed with autism spectrum disorder or who struggle with controlling behavioral issues (e.g., sexually aggressive behavioral health, eating disorders, history of violence, general aggressiveness, etc.), in psychiatric residential treatment facilities in the state.[30]

The Department of Juvenile Justice (DJJ) closed its psychiatric residential treatment facilities (PRFT), which created fewer options for services.[31] According to agency staff, DJJ PRFT beds were essential for managing adolescents with aggressive behavioral health or other behavior requiring specialized intervention.[32]

The agency's website reports 513 in-state PRTF beds and 54 out-of-state.[33] Per agency personnel, MCOs indicate the need for additional PRTF beds to meet the need of beneficiaries.[34] The PRTFs listed on the agency's website are found in Figure 7.

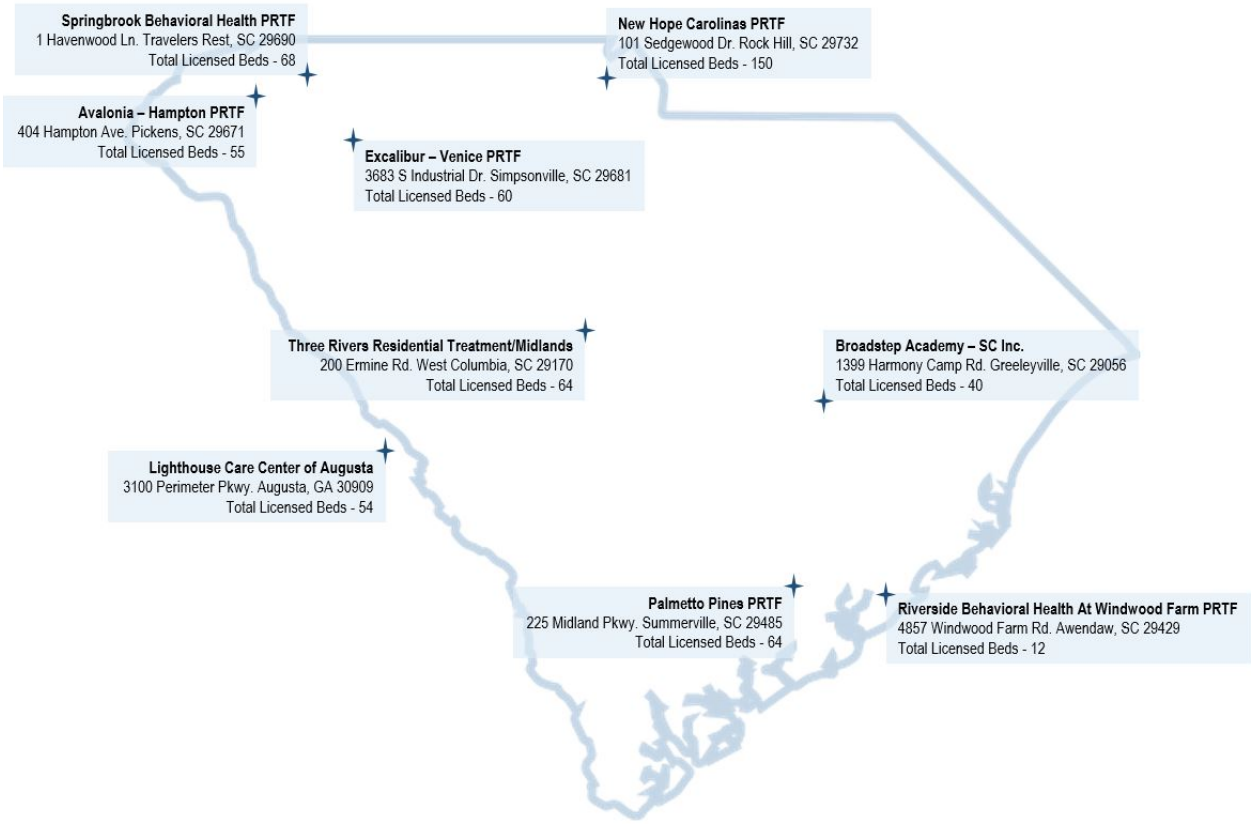


Figure 7. Medicaid psychiatric residential treatment facilities (PRTF) locations and licensed bed totals

FINDING #6. The South Carolina Graduate Medical Education (GME) Advisory Group, of which agency personnel was a participant, provided recommendations to the General Assembly, Governor's Office, and the Department of Health and Human Services regarding how to improve graduate medical education in South Carolina.

A proviso in the fiscal year 2013-14 state budget directed DHHS to leverage the GME program and develop a methodology to improve accountability and increased outcomes for the State's GME and Supplemental Teaching Payments investment by January 1, 2014.[35] The advisory group recommendations are listed in Table 4.

According to DHHS staff, there have been no graduate medical education (i.e., formal medical education after receipt of a medical degree) policy changes at the agency or legislative changes since the release of the report in January 2014.[36] Also, according to agency staff, DHHS has not encountered any issues or challenges specific to GME .[37] However, agency staff noted recruitment and retention of providers remains a challenge in rural areas and underserved medical specialties across the state, which adversely affects Medicaid beneficiaries.[38]

Table 4. South Carolina GME Medical Advisory Group recommendations[39]

Leveraging Graduate Medical Education to Increase Primary Care and Rural Physician Capacity in South Carolina			
Conclusions and Recommendations:			
1	Expand effective existing programs and develop initiatives shown to be successful for recruiting more students from rural and underserved areas into college pre-med and advanced practice professional programs.	7	Support the creation a permanent GME advisory council, which will include rural providers and representatives of medically-underserved areas, through executive order or other available means.
2	Collaborate with the deans of the state medical and osteopathic colleges in facilitating the admission and medical school support of students likely to practice primary care and serve in rural and underserved areas.	8	In coordination with existing programs, develop a data collection and assessment system to evaluate the effectiveness of GME and STP payments and other "physician pipeline" support programs in meeting statewide health care workforce needs.
3	Create new graduate medical education residencies in family medicine and other primary care specialties that are critically needed in the rural and underserved areas of South Carolina.	9	Target up to 15% of GME and STP payment funding toward meeting physician workforce goals as outlined in the recommendations presented above. Phase in this implementation based on a multi-year schedule, with budgets reviewed in advance and existing GME and STP funding reallocated as new programs are developed and implemented.
4	Collaborate with state teaching hospitals to expand GME residencies to include more extensive practice opportunities in community based health organizations.	10	Develop a state Medicaid plan amendment to change the methodology for obtaining federal matching funds for the supplemental teaching physicians' payment program, using the average commercial payment methodology proposed as Method II in this report. The average commercial rate is based on what commercial payers reimburse for services as a percentage of charges for those services. As part of the state plan amendment process, SCDHHS should determine whether CMS would allow a common commercial payer rate that is equal in rate and applied across all STP participants.
5	Broaden the scope of existing GME funding to promote and expand the use of telemedicine, support education of advanced practice professionals such as physician assistants and nurse practitioners and enhance programs to recruit and retain physicians, Pas and NPs in medically underserved areas.	11	Explore the development of a Delivery Health System Reform Incentive Pool (DSRIP), and/or other payment reform methodologies made possible under waivers granted by CMS, which provide more flexibility in leveraging the GME and STP payment programs to meet the workforce needs of South Carolina. SCDHHS should remain open to other new federal sources of funding that can be used to expand GME programs and provide seed money for pilot programs and new GME initiatives.
6	*Support the efforts of SCDHHS to implement Medicaid payment rates that value family medicine and other general primary care providers.*		

FINDING # 7. After agency personnel increased rates for autism disorder providers, individual provider enrollment increased. Prior to the provider rate increase in 2018, the agency had 151 individual providers. Provider enrollment increased to 213 individual providers (a 41% increase) by June 30, 2019. Another rate increase occurred on July 1, 2019, and 347 individual providers enrolled (a 63% increase) by May 15, 2021.[40]

As background, the agency has faced scrutiny over its low rates, which many therapists refuse to accept.[41] This created a scarcity of therapists and long waiting lists for families of autistic children. According to agency staff, DHHS included autism spectrum disorder (ASD) treatment services to the state plan in 2017, which allowed for coverage of Medicaid beneficiaries with an ASD diagnosis between the ages of 0 and 21.[42] Provider capacity has increased through grants, rate increases, and outreach efforts.[43] Since April 2018, 1,454 Medicaid beneficiaries have received these services.[44]

Recommendation 16 addresses this finding.

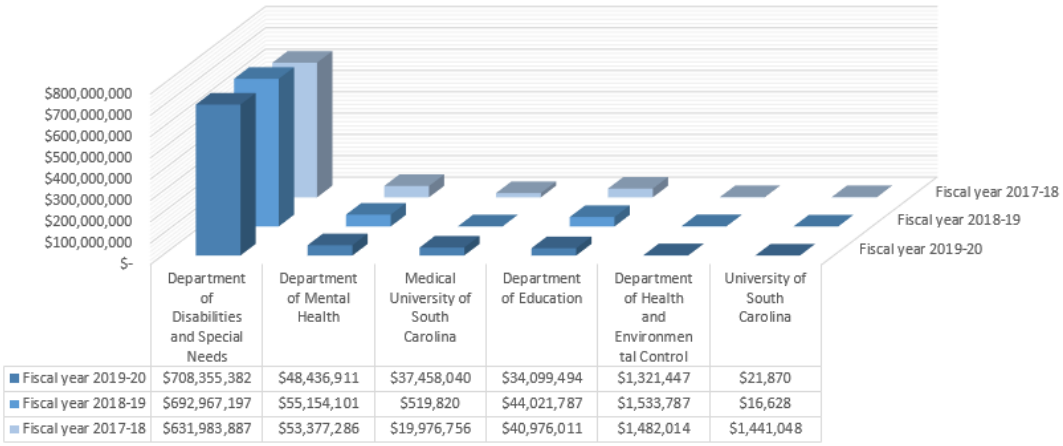
FINDING # 8. From fiscal year 2015-21, the agency's Program Integrity Unit opened 1,835 cases, of which 186 were on-site provider reviews.[45] According to agency staff, 99% of those reviews resulted in some form of corrective action for providers.[46]

These reviews involve the collection and review of medical records and related information. The agency conducts these reviews to ensure that payment for services meet all Medicaid requirements. Agency staff noted the Program Integrity Unit has 14 FTEs dedicate to conducting provider reviews, but the unit has faced issues with turnover.[47]

Recommendations 22, 23, 24, 25, and 26 address this finding.

FINDING #9. Several state agencies receive reimbursement from the state Medicaid program. These agencies include the following: Department of Disabilities and Special Needs; Department of Education; Department of Health and Environmental Control; Department of Mental Health; Medical University of South Carolina; and University of South Carolina.

Medicaid rates and reimbursement affect the operations of multiple state agencies and the constituencies they serve.[48] If Medicaid reimbursement does not cover the administrative cost and overhead of associated programs and services, there could be requests for state appropriations to subsidize rates. In fiscal year 2019-20, the agency reimbursed $829,693,144 for programs and services provided by other state agencies.[49] Agencies receiving this reimbursement, and the associated amounts, are shown in Figure 8.



	Department of Disabilities and Special Needs	Department of Mental Health	Medical University of South Carolina	Department of Education	Department of Health and Environmental Control	University of South Carolina
Fiscal year 2019-20	$708,355,382	$48,436,911	$37,458,040	$34,099,494	$1,321,447	$21,870
Fiscal year 2018-19	$692,967,197	$55,154,101	$519,820	$44,021,787	$1,533,787	$16,628
Fiscal year 2017-18	$631,983,887	$53,377,286	$19,976,756	$40,976,011	$1,482,014	$1,441,048

Figure 8. DHHS Medicaid reimbursement to other state agencies[50]

Agency Resources

Table 5. Summary of finding relating to legislatively directed contracts

LEGISLATIVELY DIRECTED CONTRACTS	10. In fiscal year 2019-20, the Department of Health and Human Services received $13,875,104 in state funds for projects and services not specifically requested by agency personnel.

FINDING #10. In fiscal year 2019-20, the Department of Health and Human Services received $13,875,104 in state funds for projects and services not specifically requested by agency personnel.[51]

"Through the appropriations process, the General Assembly directs the agency to contract with organizations to perform various functions."[52] "During [fiscal year] 2019-20, DHHS was directed to enter into medical contracts with 49 organizations through the appropriations process."[53]

RECOMMENDATIONS

The **Subcommittee has 26 recommendations.** These are directed to the General Assembly, Department of Health and Human Services, and Department of Administration's Division of State Human Resources.

With any study, the Committee recognizes **these recommendations (e.g., continue, curtail, and/or eliminate agency programs, areas for potential improvement, etc.) will not satisfy everyone nor address every issue or potential area of improvement at the agency**. These recommendations are based on the agency's self-analysis requested by the Committee, discussions with agency personnel during multiple meetings, and analysis of the information obtained by the Committee. This information, including, but not limited to, the Program Evaluation Report, Accountability Report, Restructuring Report, and videos of meetings with agency personnel, is available on the Committee's website.

Recommendations to General Assembly

Accountability

The Subcommittee makes one recommendation to the General Assembly related to accountability, and a summary is in Table 6.

Table 6. Summary of accountability recommendation to the General Assembly

ACCOUNTABILITY	1. Consider updating S.C. Code Section 44-115-80 to require suspended, terminated, or excluded Medicaid providers to give patients a complete copy of their medical record at no cost. Patients should not incur a financial penalty due to the fraud, waste, or abuse of the offending provider.

RECOMMENDATION #1. Recommend the General Assembly consider updating S.C. Code Section 44-115-80 to require suspended, terminated, or excluded Medicaid providers to give patients a complete copy of their medical record at no cost. Patients should not incur a financial penalty due to the fraud, waste, or abuse of the offending provider.

Suspended, terminated, or excluded providers are not eligible to participate in the Medicaid program, and affected Medicaid beneficiaries must obtain new healthcare providers.[54] Under current law, suspended, terminated, or excluded Medicaid providers can charge up to $150 for electronic medical records and $200 for copies of printed records.[55] Finding a new provider requires time and resources, and the additional expense for the medical record is a further burden to Medicaid beneficiaries impacted by provider malfeasance. The associated cost of the medical record may be cost prohibitive for some Medicaid patients, as many qualify for the program due to lack of financial resources. As providers are directly responsible for punitive actions imposed by agency personnel, Medicaid beneficiaries should receive a copy of their

medical record at no charge from a suspended, terminated, or excluded provider to share with a new provider for continuity of care.

Modernization of Laws

The Subcommittee makes one recommendation to the General Assembly regarding modernization of laws, and a summary is in Table 7.

Table 7. Summary of modernization of laws recommendations to the General Assembly

MODERNIZATION OF LAWS	2. Consider eliminating an outdated requirement for the establishment of child development services by repealing S.C. Code Sections 44-6-300 through 320 (Child Development Services).[Agency Request] This program is no longer operated by DHHS.

RECOMMENDATION # 2. Recommend the General Assembly consider eliminating an outdated requirement for the establishment of child development services by repealing S.C. Code Sections 44-6-300 through 320 (Child Development Services). This program is no longer operated by DHHS.

The agency requested this law change.[56]

Recommendations to the Department of Health and Human Services

Accountability

The Subcommittee makes four recommendations to the Department of Health and Human Services related to accountability, and a summary is in Table 8.

Table 8. Summary of accountability recommendations to DHHS

ACCOUNTABILITY	3. Amend S.C. Code Reg. Section 126-401 to include financial penalties associated with administrative sanctions imposed on service providers. Imposition of these penalties may offset the administrative cost incurred b the agency. 4. Develop a strategy to reduce the percentage of Medicaid beneficiaries auto-assigned to a managed care organization.[See finding 2.] 5. Regularly perform (i.e., every 3 - 5 years) a comprehensive compa-ratio study as a means to address employee recruitment and retention. Compa-ratio is a formula used by human resources professionals to assess the competitiveness of an employee's pay level. The DHHS evaluation should include a written report regarding pay equity within the agency (e.g., gender, ethnicity, average salary by ethnicity and gender, etc.).

6. The Department of Health and Human Services should consult with the Department of Administration (e.g., Division of State Human Resources and Division of Program Management) on trainings and resources to improve employee morale, inclusivity, productivity, and respect among all employees.

RECOMMENDATION # 3. The Department of Health and Human should amend S.C. Code Reg. 126-401 to include financial penalties associated with administrative sanctions imposed on service providers. Imposition of these penalties may offset the administrative cost incurred by the agency. Sanctions resulting from provider error, malfeasance, or indolence are not a fault of the agency.

During the study, agency personnel noted there are administrative sanctions available to address violations of Medicaid rules by providers.[57] These sanctions include: educational intervention; post payment review of claims; prepayment review of claims; prepayment of review claims; referral to licensing/certifying board or agencies; peer review; suspension; termination; and exclusion.[58] As noted in Figure 9, from fiscal years 2015-20, DHHS imposed 3,425 administrative sanctions on service providers.

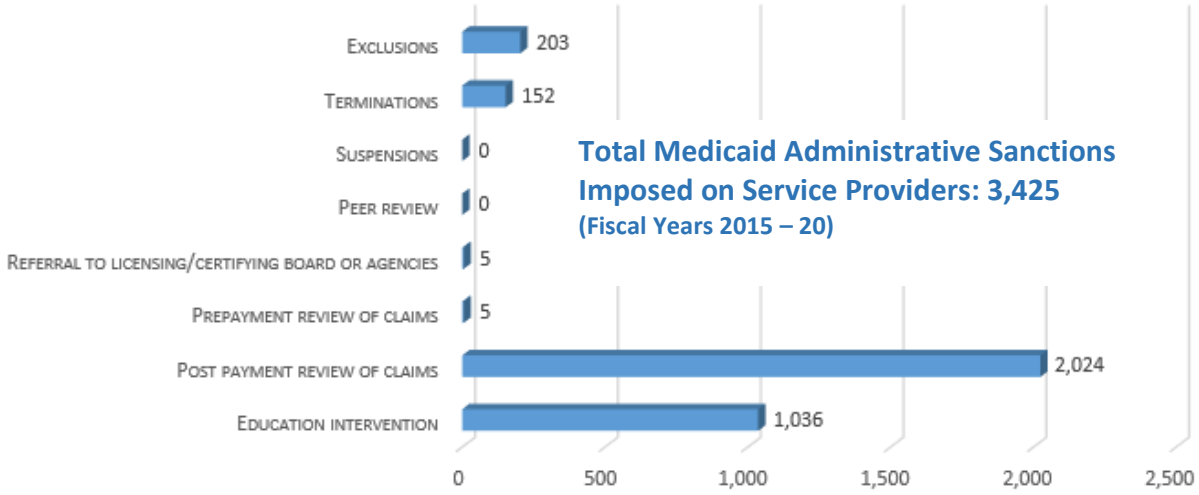


Figure 9. Medicaid administrative sanctions activity in fiscal years 2015-20

The costs associated with the administration, management, and oversight of sanctions are borne completely by the agency.[59] Agency personnel reported $2.7 million in cost associated with Program Integrity and Internal Audit Investigations deliverables in fiscal year 2018-19.[60] Agency personnel could set a fee structure to offset cost associated with administrative sanctions in a regulation subject to legislative approval.[61] These fees could save the agency funding, which may be redirected to services and programming for Medicaid beneficiaries. Imposition of these fees may act as an additional deterrent and promote aggressive administrative management at the provider level.

RECOMMENDATION #4. The Department of Health and Human Services should develop a strategy to reduce the percentage of Medicaid beneficiaries auto-assigned into a managed care organization.

According to agency staff, Medicaid beneficiaries have 60-days, from the time they become Medicaid eligible, to choose a managed care plan.[62] If a beneficiary does not select a plan, an algorithm selects a plan using data and qualifiers provided by agency personnel.[63] In fiscal year 2020, 54% of eligible Medicaid beneficiaries were auto-enrolled. Agency personnel testified that they promote choice, but the percentage of beneficiaries not selecting a MCO has increased 8 percentage points between 2015 and 2020).[64] See Figure 5 to view auto enrollment data.

Agency personnel should seek to understand why beneficiaries are not selecting a plan within the 60-day time period. Accordingly, it is recommended that agency personnel develop a metric to track auto-assignments and include a requisite agency goal in the agency's strategic plan. From this data, agency personnel may be able to make informed decisions to help increase beneficiary selection of managed care plans.

This recommendation addresses Finding 2.

RECOMMENDATION # 5. The Department of Health and Human Services should regularly perform (i.e., every 3 – 5 years) a comprehensive compa-ratio study as a means to address employee recruitment and retention. Compa-ratio is a formula used by human resources professionals to assess the competitiveness of an employee's pay level. The DHHS evaluation should include a written report regarding pay equity within the agency (e.g., gender, ethnicity, average salary by ethnicity and gender, etc.).

The report should include, but is not limited to, salary by ethnicity and gender; notably, women account for approximately 88% of the agency's workforce.[65] Also, the report should provide a comprehensive market competitiveness analysis. Wage competition, from the private sector healthcare market and other state agencies, was specifically noted by agency leadership as an obstacle to employee recruitment and retention.[66] Competitive wages are essential to building and maintaining a tenured staff.

During the study, agency leadership, across organizational units, identified employee recruitment and retention as an issue of considerable impact on agency readiness and effectiveness.[67] On July 1, 2020, DHHS experienced an FTE vacancy rate of 33.25% (i.e., 602 vacant positions out of 1,810 authorized).[68] This is not a challenge unique to DHHS as the Committee has observed employee recruitment and retention as an issue affecting multiple state agencies.[69]

DHHS employee institutional knowledge is of intangible and tangible value to the agency. Agency staff testified that it takes approximately six months to fill vacant nursing positions and 1.5 years to fill vacant social worker positions.[70] These jobs are the most difficult for the agency

fill. It takes a year to train both nurses and social workers at a cost of $55,000 and $45,000 respectively.[71]

Agency leadership should use the levers within their control to address and reduce turnover. Conducting a compa-ratio study, to analyze pay equity within the agency, may illuminate pay disparities that might not have risen to the surface due to lack of available data. Pay equity by gender, ethnicity, average salary by ethnicity and gender, should be evaluated. This data may provide insight for agency leadership and employees. Transparency, with the results of the analysis and subsequent policy decisions to rectify any identified disparities in pay, may improve employee morale and commitment to the agency.

RECOMMENDATION # 6. The Department of Health and Human Services should consult with the Department of Administration (e.g., Division of State Human Resources and Division of Program Management) on trainings and resources to improve employee morale, inclusivity, productivity, and respect among all employees.

During the study, agency personnel testified to the challenge of recruiting and retaining staff throughout the organization.[72] Issues of compensation, and competition from private sector healthcare organizations, were identified as factors specific to this issue.[73] While it is important to have competitive wages, it is also necessary for leadership to evaluate the agency culture to ensure all employees feel valued, appreciated, and included.

Training specific to agency culture, employee morale and inclusivity, is common across varied organizations and industry sectors. Implementation of these training programs, in combination with strategies to address compensation, should be considered.

Effectiveness

The Subcommittee makes nine recommendations to the Department of Health and Human Services related to effectiveness, and a summary is in Table 9.

Table 9. Summary of effectiveness recommendations to DHHS

EFFECTIVENESS	7. Conduct an annual Medicaid provider network survey to evaluate provider satisfaction with the agency and managed care organizations. 8. Develop a strategy for the evaluation and assessment of COVID-19 related service changes. 9. Incorporate an explanation of benefits (EOB) submission metric (e.g., average % of EOBs returned) to encourage agency personnel to implement strategies to improve Medicaid beneficiary EOB return rate. These strategies may include but are not limited to, offering electronic

ways (e.g., email, text messaging, online via agency website, etc.) for Medicaid beneficiaries to complete EOBs.

10. Create an interactive map to identify Medicaid providers and their locations across the state. The map should have the capability to illustrate concentrations of providers (i.e., heat map), to inform policymakers of provider need across the state. The interactive map should be assessable via the agency's website.[See finding 4.]

11. Participate in executive training specific to senior executives, including the agency director, who have overall responsibility for an organization (e.g., leadership, strategic direction, profit & loss, agency culture, etc.)

12. Develop and implement an annual formal process to evaluate the 20 criteria used in determining Medicaid beneficiary placement in the Pharmacy Lock-in program, which "locks" a Medicaid beneficiary to a specific pharmacy due to an identified pattern of excessive and uncoordinated use of prescription drugs and other Medicaid benefits (e.g., pharmacy shopping for controlled substances). The agency should solicit input from participating Medicaid MCOs, the Department of Alcohol and Other Drug Abuse Services, and the Department of Health and Environmental Control.

13. Conduct a complete user experience audit of the agency's website and develop a strategic plan to address the following: usefulness of information; accessibility of information; ease of finding information; credibility of information; location of social media links; and attractiveness of website.[See finding 2.]

14. Conduct an annual survey of Medicaid beneficiaries with chronic diseases (e.g., sickle cell anemia, rheumatoid arthritis, etc.), regarding their health status (e.g., disease management, access to care, pain management, patient satisfaction with providers, etc.).

15. Report to appropriate entities (e.g., Department of Administration's Division of State Human Resources, Ways and Means' Healthcare Subcommittee, etc.) specific rules prohibiting the expenditure of agency funds for internal employee engagement (e.g., meals, etc.).

RECOMMENDATION # 7. The Department of Health and Human Services should conduct an annual Medicaid provider network survey to evaluate provider satisfaction with the agency and managed care organizations.

The purpose of the survey is to assess service provider perceptions of the four participating managed care organizations (MCO) (i.e., Select Health, Absolute Total Care, Healthy Blue, and Molina). Service providers should be asked to rate their satisfaction with the MCO they participate with or otherwise interact. The survey questionnaire should include questions on finance issues, utilization management, customer service, and service provider relations.

Agency personnel testified MCO performance is measured based on specific clinical indicators and metrics.[74] High performing MCOs receive performance incentives to encourage desired results. Similarly, service provider satisfaction contributes to patient outcomes. A comprehensive survey of service provider satisfaction with MCOs may provide an additional vantage point for agency personnel to evaluate MCO contracts and performance incentives.

RECOMMENDATION # 8. The Department of Health and Human Services should develop a strategy for the evaluation and assessment of COVID-19 related service changes.

The agency director testified that DHHS produced 32 pieces of guidance and responded to more than 600 stakeholder inquiries in the first six weeks of the federally implemented public health emergency declaration.[75] Agency personnel testified several changes were made to provide additional flexibility to providers and beneficiaries.[76] In March 2020, DHHS submitted a waiver under Section 1135 of the Social Security Act requesting a variety of administrative and regulatory flexibilities to aid in the state's preparation and response to COVID-19. The initial approval granted by the federal Centers for Medicare and Medicaid Services extended flexibilities to DHHS in matters related to pre-approval for health services, nursing facility admissions, appeals and fair hearings, provider enrollment, and alternative care settings.[77]

According to agency staff, DHHS has received input and suggestions from service providers, Medicaid beneficiaries, and managed care organizations regarding the temporary policy changes implemented during the current public health emergency.[78] The agency plans to use this information to inform future policy changes.[79]

RECOMMENDATION # 9. The Department of Health and Human Services should incorporate an explanation of benefits (EOB) submission metric (e.g., average % of EOBs returned) to encourage agency personnel to implement strategies to improve Medicaid beneficiary EOB return rate. These strategies may include but are not limited to, offering electronic ways (e.g., email, text messaging, online via agency website, etc.) for Medicaid beneficiaries to complete EOBs.

The EOB is a statement sent by agency personnel to covered individuals explaining what medical treatments and/or services a provider submitted for reimbursement. According to agency staff, EOBs verify the Medicaid beneficiary actually received services submitted for reimbursement.[80] The agency's Program Integrity division mails approximately 350 EOB letters each month to randomly selected beneficiaries.[81] Contracted MCOs are required to generate EOB letters to a statistically valid sample each month.

Agency personnel testified that the EOB process is completely paper based, and there is no other mechanism for beneficiaries to receive this information (e.g., email, text messaging, online via agency website, etc).[82] Additional convenient options for EOB review and submission may yield higher return rates. Of the EOB letters mailed by agency personnel, approximately 28% come back completed.[83] Additionally, electronic EOB review and submission would save

the agency the cost of printing, postage, and staff productivity dedicated to receiving and documenting physical mail.

RECOMMENDATION # 10. The Department of Health and Human Services should create an interactive map to identify Medicaid providers and their locations across the state. The map should have the capability to illustrate concentration of providers (i.e., heat map) to inform policymakers of provider need across the state. The interactive map should be accessible via the agency's website.

According to agency staff, the state has a shortage of medical professionals, particularly in rural areas.[84] The interactive heat map may illustrate whether current and past policy efforts have improved access to providers across the state. Agency personnel testified that proviso funding has supported the development of new and expanded medical residency programs, clinical rotations and fellowships (all in underserved geographical areas and underserved medical specialties).[85] These investments have sought to improve the state of the provider shortage, but additional innovative measures are necessary.

This recommendation addresses Finding 4.

RECOMMENDATION # 11. The Department of Health and Human Services senior executives, including the agency director, should participate in executive training specific to senior executives who have overall responsibility for an organization (e.g., leadership, strategic direction, profit & loss, agency culture, etc.).

The agency director should satisfactorily complete an executive leadership course within two years of being confirmed by the South Carolina State Senate.

Agency directors, whether nominated by the Governor or selected by a commission or board, must have the ability to lead people under the banner of a shared vision, and create a work environment promoting and inspiring innovation. Leaders benefit from continual training and exposure to the latest in leadership theory and business practices to innovate their organizations.

The Department of Health and Human Services has a multi-billion-dollar budget, complex information technology systems, staff with wide ranging skillsets and responsibilities and approximately 1.1 million full benefit beneficiaries across the state.[86] Proficient leadership is critical to agency success, innovation, and quality customer service.

RECOMMENDATION # 12. The Department of Health and Human Services should develop and implement an annual formal process to evaluate the 20 criteria used in determining Medicaid beneficiary placement in the Pharmacy Lock-in program, which "locks" a Medicaid beneficiary to a specific pharmacy due to an identified pattern of excessive and uncoordinated use of prescription drugs and other Medicaid benefits (e.g., pharmacy shopping for controlled substances). The agency should solicit input from participating Medicaid MCOs, the Department of Alcohol and Other Drug Abuse Services, and the Department of Health and Environmental Control.

According to agency staff, the purpose of this program is to address issues including: coordination of care, patient safety, improper or excessive utilization of benefits, and potential fraud and abuse associated with the use of multiple pharmacies and/or physicians.

Beneficiaries placed into this program used Medicaid pharmacy services at a frequency or amount that is not medically necessary. Identified beneficiaries are restricted to one single pharmacy to eliminate potential abuse from "pharmacy shopping." Beneficiaries placed on this list remain there for a two-year period. Opioid prescribing limits, pursuant to Title XIX of the Social Security Medical Assistance Program (Medicaid), prohibit providers from exceeding a five-day supply or 90 morphine milligram equivalents (MMEs) daily, except in the cases of chronic pain, cancer pain, pain related to sickle cell disease, hospice care, palliative care, or medication-assisted treatment for substance use disorder.[87] To prevent the potential for gaps in service or interruptions in patient care, an initial supply of more than five days or 90 MMEs, if determined medically necessary by the prescriber, must be documented in the patient's medical record.[88]

In 2014, DHHS made several changes to the program in an effort to more accurately identify abuse of pharmacy services. After implementation of these changes, enrollment in the program increased 525% (i.e., increased from 400 to 2,500 Medicaid beneficiaries). Agency personnel attributes the increase in criteria, from three to 20, as the primary factor associated with this increase.[89]

The implementation of an annual review of pharmacy lock-in criteria may promote continuous improvement and keep agency policy and procedures in line with social and behavioral changes within its membership. Agency leadership should solicit input from participating Medicaid MCOs, Department of Alcohol and Other Drug Abuse Services, and Department of Health and Environmental Control during this annual review.

RECOMMENDATION #13. The Department of Health and Human Services should conduct a complete user experience audit of the agency's website and develop a strategic plan to address the following: usefulness of information; accessibility of information; ease of finding information; credibility of information; location of social media links; and attractiveness of website.

A user experience audit is the process of evaluating a website or mobile applications interface. This type of audit is useful to detect problematic areas prompting users to abandon the website

due to poor usability and difficulty in finding information pertinent to their visit. According to agency staff, a complete user experience audit, of the agency's website, has never been performed.[90]

The agency's communications strategy falls under the purview of its external affairs division. According to agency staff testimony, the communications strategy focuses on beneficiaries, providers, and internal agency stakeholders.[91] An effective user experience audit requires agency personnel to identify who their website it designed for, as its features and information must support its defined stakeholders. User demographics, behavior, and where those users are coming from must be identified by agency personnel to determine if staff are reaching the intended audience.

This recommendation addresses Finding 2.

RECOMMENDATION # 14. The Department of Health and Human Services should conduct a survey of beneficiaries with chronic diseases (e.g., sickle cell anemia, rheumatoid arthritis, etc.), regarding their health status (e.g., disease management, access to care, pain management, patient satisfaction with providers, etc.).

Figure 10 lists chronic conditions. Medicaid beneficiaries with these conditions should be included in the disease management survey. The agency should evaluate the results of the survey, determine the efficacy of existing programming and services, and incorporate interventions to improve unsatisfactory findings.

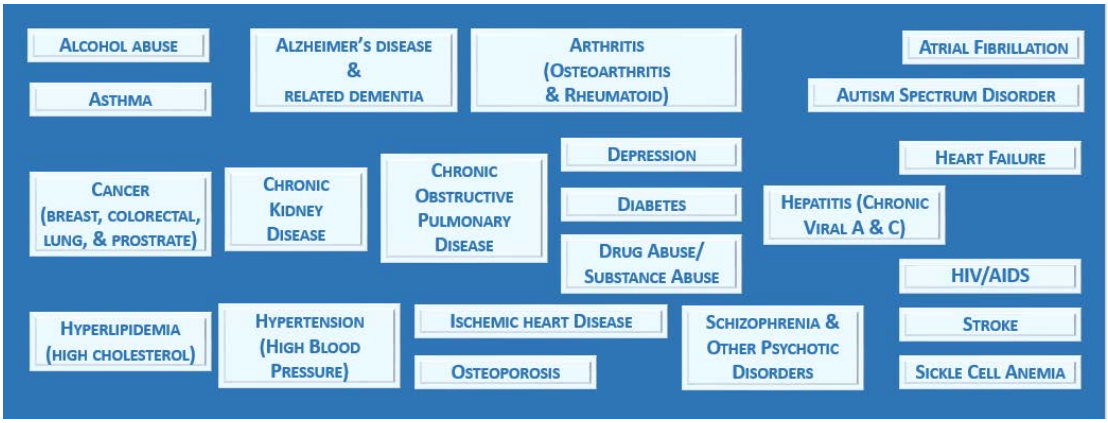


Figure 10. Chronic diseases[92]

Chronic disease, if not managed effectively through partnerships between the agency, beneficiaries, providers, and MCOs, may lead to increases in cost and beneficiary morbidity.[93] As beneficiaries are customers of the agency, providers, and MCOs, it is the agency's responsibility to effectively manage these relationships; Figure 11 provides information about Medicaid beneficiaries with a diagnosed chronic condition. Proper evaluation of disease

management, from the vantage point of the Medicaid beneficiary, is central to cost reduction, improved quality of care, and reductions in beneficiary morbidity.

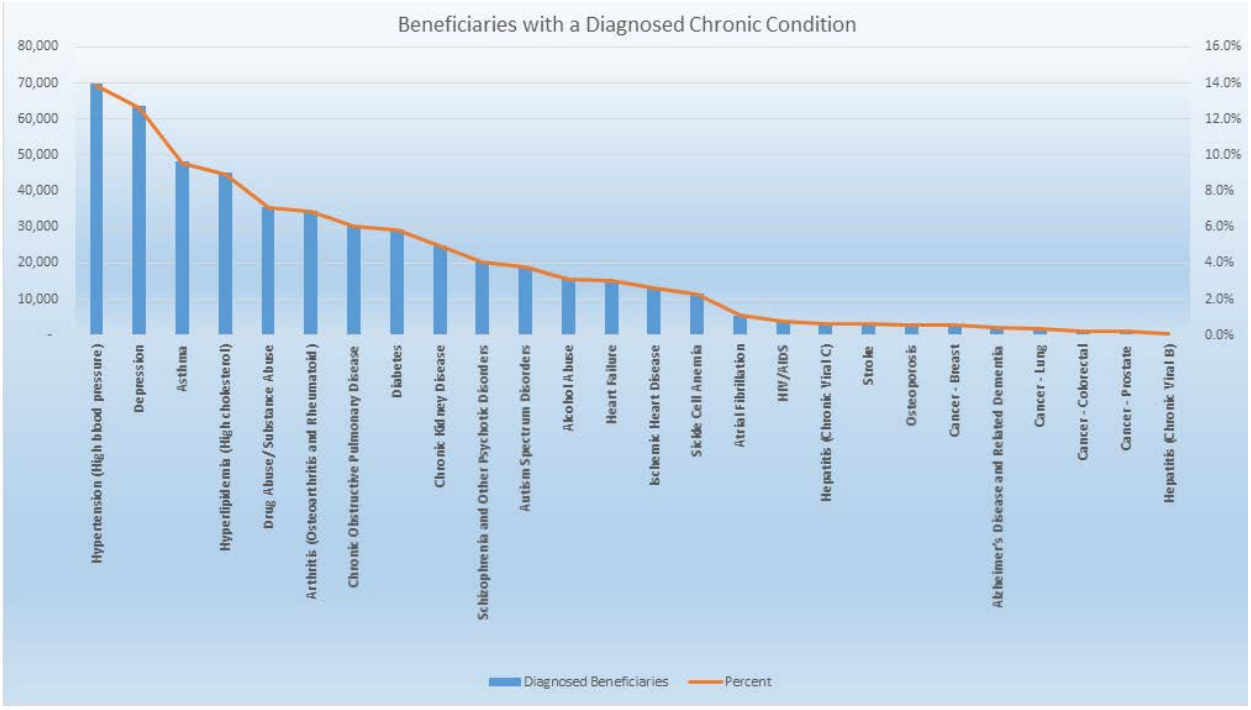


Figure 11. Beneficiaries with a diagnosed chronic condition
Figure Note: The identified chronic conditions, with the exception of sickle cell anemia, are defined as such by the Centers for Medicare and Medicaid Services. Information is accurate as of July 2021.[94]

RECOMMENDATION # 15. The Department of Health and Human Services should report to appropriate entities (e.g., Department of Administration's Division of State Human Resources, Ways and Means' Healthcare Subcommittee, etc.) specific rules prohibiting the expenditure of agency funds for internal employee engagement (e.g., meals, etc.).

Agency leadership's ability to effectively engage with staff, both formally and informally, is important to the overall morale of an organization. Recruitment and retention of staff, due to competition from well-resourced private sector organizations, is an ongoing challenge for the agency.[95] According to agency personnel, the agency is prohibited from providing lunch to agency leadership during strategic planning retreats.[96] These, and other limitations, should be shared with the appropriate authoritative bodies on a recurring basis.

Efficiency

The Subcommittee makes seven recommendations to the Department of Health and Human Services related to efficiency, and a summary is in Table 10.

Table 10. Summary of efficiency recommendations to DHHS

EFFICIENCY	16. Identify, define, develop, and post on the agency website a strategic plan (including metrics) to improve the social determinants of health that most greatly affect the South Carolina Medicaid population.[See finding 7] 17. Conduct an internal study to evaluate remote work options. The study should include the identification of data needed by agency personnel, on an ongoing basis, to verify and substantiate the efficacy of a remote workforce. 18. Incorporate a productivity standard for the 70% of agency positions completing tasks that can be counted. Evaluate the merits of hiring an industrial engineer (i.e., agency FTE) to create and monitor agency productivity standards and train staff regarding how to use and evaluate productivity standards and metrics. 19. Evaluate the efficacy of implementing an online enrollment packet as an option for Medicaid beneficiaries. Currently, Medicaid beneficiary packets are mailed at a cost of over two hundred thousand for each of the past three fiscal years. 20. Develop and implement an online fraud reporting form as an additional means for receipt of allegations of Medicaid fraud.

RECOMMENDATION # 16. The Department of Health and Human Services should identify, define, develop, and post on the agency's website a strategic plan (including metrics) to improve the social determinants of health that most greatly affect the South Carolina Medicaid population.

The U.S. Department of Health and Human Services groups the social determinants of health into five domains: (1) economic stability; (2) education access and quality; (3) health care access and quality; (4) neighborhood and built environment; and (5) social and community context.[97] Examples of social determinants of health include the following: transportation, job opportunities, income, polluted air and water, safe housing, violence, and discrimination.

According to agency staff, they prioritized the inclusion of social determinants of health in their Quality Strategy 2022.[98] Also, agency personnel mentioned they are identifying which determinants to consider as the highest priority for the agency, which requires the stratification of data so specific determinants can be identified and investigated.[99]

Agency personnel intend to evaluate beneficiary data and make determinations regarding which, if any, of the identified determinants are affecting beneficiaries. Since most Medicaid beneficiaries qualify based on economic factors, agency personnel, upon review of its data, is likely to find a considerable number of their beneficiaries fall into the domains identified by the U.S. Department of Health and Human Services.

This recommendation addresses Finding 7.

RECOMMENDATION # 17. The Department of Health and Human Services should conduct an internal study to evaluate remote work options. The study should include the identification of data needed by agency personnel, on an ongoing basis, to verify and substantiate the efficacy of a remote workforce.

At the height of pandemic office closures, according to agency staff, approximately 47% of agency staff worked remotely.[100] To ensure continuity of workflow and program management, agency personnel purchased 600 Chromebooks, 150 laptops and docking stations, 600 new mobile phone lines, 600 additional mobile phones, and 93 computer monitors.[101] The total investment was $809,365 ($688,282 in federal funds/$121,083 in state funds).[102] Information technology infrastructure investments were needed to upgrade the agency's virtual private network, virtual desktop infrastructure, cloud services, and bandwidth.[103] The total investment in infrastructure was $405,625 ($314,906 in federal funds/$90,719 in state funds).[104] In aggregate, agency personnel made a total investment of $1,214,990 to ensure continuity of services.[105]

Agency leadership further testified that nursing, human resources, contracts, eligibility, and most office-based areas where direct customer contact is not required were able to most efficiently work remotely. Agency leadership also stated they have not surveyed employees to gauge their interest or support for a continuation of remote work options.[106] Implementation of remote work options may allow DHHS to reduce their office space footprint, of which approximately $5.8 million is spent annually on leased space.[107] There has not been an evaluation of potential savings, through the reduction of leased office space, with the implementation of remote work options.

The move to remote work across state government and the private sector has led to a paradigm shift regarding where staff do their work. As private sector industries embrace remote work, state government must also adapt as recruitment and retention, which is currently a challenge for DHHS, is likely to become more challenging as employees seek opportunities for increased flexibility.

Remote work (i.e., telecommuting) that results in greater efficiency and cost savings is authorized by state statute.[108] Additionally, the Department of Administration's Division of State Human Resources has made available a Telecommuting Toolkit to assist state agencies with the development of a remote work implementation strategy.[109] The following items are included in the Toolkit: Agency Telecommuting Checklist; Model Telecommuting Policy; Sample Telecommuting Application; Sample Telecommuting Agreement; Sample Telecommuting Workplace Checklist; Sample Telecommuting Activities Form; Suggested Space Guidelines for Telecommuting Employees; Sample Business Case for Telecommuting; Telecommuting Pilot Tracking Spreadsheet; Spreadsheet to Record Telecommuting in SCEIS; and Required Telecommuting Reporting for Non-SCEIS organizations.

RECOMMENDATION # 18. The Department of Health and Human Services should incorporate a productivity standard for the 70% of agency positions completing tasks that can be counted. The agency should evaluate the merits of hiring an industrial engineer (i.e., agency FTE) to create and monitor agency production standards and train staff how to use and evaluate productivity standards.

According to agency personnel testimony, while approximately 70% of agency positions complete countable tasks (e.g., processing applications, sorting mail, answering calls, ect.), only 60% of the identified positions are tracked using a defined productivity metric.[110] Measuring productivity allows agency leadership to: determine if employees are working efficiently; provides objective data to support hiring additional staff; encourages innovation and technological investment; and informs resource allocation decisions.

Agency leadership should evaluate whether investments in staff with "systems engineering" expertise should be added as a resource for agency personnel. DHHS is an agency with complex systems, which require expertise to effectively manage stakeholder relationships across multiple platforms.[111] A review of processes, across all agency organizational units, may yield valuable objective data for agency leadership. For example, the agency has offices across the state and effective productivity data may support the realignment of offices to create efficiencies and improvements to services for customers.[112]

RECOMMENDATION # 19. The Department of Health and Human Services should evaluate the efficacy of implementing an online enrollment packet as an option for beneficiaries. Currently, Medicaid beneficiary packets are mailed at a cost of over two hundred thousand for each of the past three fiscal years.[113]

An electronic platform will save the agency costs associated with mailing enrollment packets and the requisite time spent by staff to review paper documents as illustrated in Figure 12.[114] Hard-copy packets, not completed accurately, require productive staff time to reengage beneficiaries at additional expense to the agency. The productivity saved with electronic packets may be reassigned to other agency priorities.

Enrollment Packet Annual Expense			
	FY18-19	FY19-20	FY20-21
Medicaid ID Card/Slim Card	$ 160,833.13	$ 143,793.06	$ 131,603.39
Medicaid Handbook	$ 32,367.89	$ 28,992.02	$ 27,990.62
Notice of Privacy Policy	$ 12,904.14	$ 11,558.28	$ 1,147.75
ID Card Postage	$ 81,776.39	$ 73,634.22	$ 71,593.62
Total	$ 287,881.55	$ 257,977.58	$ 232,335.38

Figure 12. Enrollment packet annual expense for fiscal years 2018 - 2021

RECOMMENDATION # 20. The Department of Health and Human Services should develop and implement an online fraud reporting form as an additional means for receipt of allegations of Medicaid fraud.

Agency personnel reported a total of 7,561 allegations of fraud from fiscal years 2015-20.[115] Allegations of fraud are reported by the following methods: email; fax; direct intake; mail; or fraud hotline; Figure 13 shows the utilization of these methods for reporting.

	Email	Fax	Direct Intake	Mail	Fraud Hotline	Total
FY15-16	62	-	117	172	560	911
FY16-17	80	-	216	374	891	1,561
FY17-18	133	-	253	81	905	1,372
FY18-19	129	-	348	92	709	1,278
FY19-20	127	-	1,751	70	491	2,439
Total	531	-	2,685	789	3,556	7,561

Figure 13. Methods used to report fraud for fiscal years 2015 - 2020[116]

Agency personnel testified that Medicaid healthcare fraud, waste, and abuse ranges from 3 - 10% of total expenditures based on national reports. Total DHHS expenditures, for fiscal year 2020, were $7,813,366,726. When utilizing the 3 -10% fraud estimate, approximately $234,400,000 to $781,300,000, would be the cost impact of fraud, waste, and abuse. According to agency personnel, the agency does not utilize national percentages to determine baseline targets for potential fraud, waste, and abuse recoveries.[117]

Figure 14 lists common forms of provider and recipient fraud.

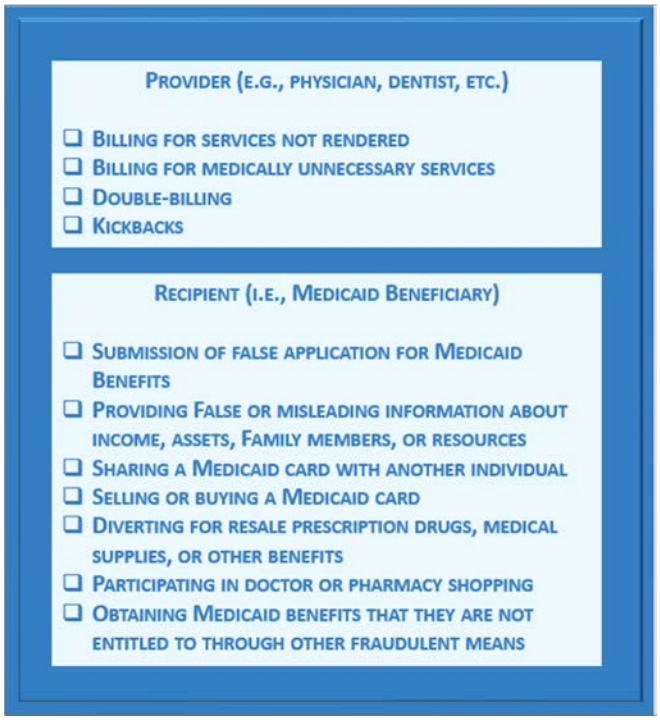


Figure 14. Common forms of provider and recipient fraud

Interagency Collaboration

The Subcommittee makes one recommendation to the Department of Health and Human Services related to interagency collaboration, and a summary is in Table 11.

Table 11. Summary of interagency collaboration recommendations to DHHS

INTERAGENCY COLLABORATION	21. Collaborate with the Public Employee Benefit Authority to share and identify best practices regarding health care quality, provider and member satisfaction, social determinants of health, wellness programs, MCO contracting, and other related insurance provider services.

RECOMMENDATION # 21. The Department of Health and Human Services should collaborate with the Public Employee Benefit Authority to share and identify best practices regarding health care quality, provider and member satisfaction, social determinants of health, wellness programs, MCO contracting, and other related insurance provider services.

As of January 2021, the State Health Plan has approximately 517,000 beneficiaries. The Public Employee Benefit Authority (PEBA), the plan sponsor, is responsible for providing a comprehensive plan of benefits at a cost that is affordable to both beneficiaries (i.e., state employees and their families) and their employers.[118] PEBA works with third-party administrators to provide benefits, process claim, and customize a comprehensive benefits package. The State Health Plan's medical claims are processed by BlueCross BlueShield of South Carolina processes and Express Scripts is the pharmacy benefits manager.

The Department of Health and Human Services and PEBA both provide healthcare services via third-party administrators. DHHS utilizes MCOs (i.e., Molina Healthcare; Select Health of South Carolina; Healthy Blue; and Absolute Total Care). Managed care plans utilize network contracting, information technology, and utilization management systems to reduce cost and improve the health of beneficiaries. Similarly, PEBA uses its relationship with Blue Cross BlueShield of South Carolina to increase the value of each dollar spent on health care for its beneficiaries.

Both agencies, through years of evaluation and data analysis, have refined agreements and contractual terms with third-party administrators. Collaboration and shared best practices may benefit the respective agencies, the state, and tax payers.

Transparency

The Subcommittee makes four recommendations to DHHS related to transparency, and a summary is in Table 12.

Table 12. Summary of transparency recommendations to DHHS

TRANSPARENCY	22. Provide to the Subcommittee a written summary of the findings and recommendations identified by the consultant hired to evaluate Program Integrity Unit position titles and descriptions. Include whether the agency has or intends to incorporate the recommendations identified by the paid consultant.[See findings 2 and 8.] 23. Require suspended, terminated, or excluded Medicaid providers to inform their Medicaid patients that such action is pending or has been levied against them by DHHS.[See finding 8] 24. Create and post on the agency website an interactive dashboard, which provides information illustrating metrics tracked by the agency and other notable statistics of interest to the public and policymakers (e.g., percent of providers National Committee for Quality Assurance certified; suspended, terminated, or excluded providers; withhold percentage received by MCOs; explanation of benefit return rate; administrative sanctions by type; allocations of fraud; percent of fraud cases found to be legitimate; fraud conviction rate; etc.).[See finding 8] 25. Estimate the South Carolina Medicaid programs annual fraud, waste, and abuse, as a percentage of total Medicaid expenditures and use it as an internal baseline for the agency's annual recovery goal.[See finding 8.]

RECOMMENDATION # 22. The Department of Health and Human Services should provide to the Subcommittee a written summary of the findings and recommendations identified by the consultant hired to evaluate Program Integrity Unit position titles and descriptions.[119] The summary should include whether the agency has or intends to incorporate the recommendations identified by the paid consultant.

The consultant's recommendations include title changes and additional compensation for employees. Agency personnel noted that changes specific to title changes and compensation have been made.[120]

However, the consultant recommended other policy and procedure changes that are either being implemented or are under consideration for implementation. Accordingly, the summary provided by the agency should discuss why the agency did or did not implement recommendations for policy and procedure changes (e.g., funding, organizational structure, existing law/statute, etc.). For recommendations currently under consideration, note when a decision is likely to be made and whether initial findings are likely to support implementation of the consultant's recommendations.

This recommendation addresses Findings 2 and 8.

RECOMMENDATION #23. The Department of Health and Human Services should require suspended, terminated, or excluded Medicaid providers to inform their Medicaid patents that such action is pending or has been levied against them by DHHS.[121]

Also, this notification should include information regarding steps in the investigatory process and how a beneficiary can obtain additional information or answers to questions. Transparency, regarding such pending or levied sanctions against healthcare providers, will allow impacted Medicaid beneficiaries time to make informed healthcare decisions. Medicaid beneficiaries experience barriers to access that may make it more challenging for them to find a healthcare provider (e.g., transportation, scheduling, location, etc.). If a provider, has a pending action or a final determination, which leads to suspension, termination, or exclusion, the agency should notify affected beneficiaries.

This recommendation addresses Finding 8.

RECOMMENDATION # 24. The Department of Health and Human Services should create and post on the agency website an interactive dashboard, which provides information illustrating metrics tracked by the agency and other notable statistics of interest to the public and policymakers (e.g., percent of providers National Committee for Quality Assurance certified; withhold percentage received by MCOs, explanation of benefit return rate; administrative sanctions by type; allocations of fraud; percent of fraud cases found to be legitimate; fraud conviction rate; etc.)

This recommendation addresses Finding 8.

RECOMMENDATION # 25. The Department of Health and Human Services Program Integrity Unit should estimate the South Carolina Medicaid program's annual fraud, waste, abuse, as a percentage of total Medicaid expenditures and use it as an internal baseline for the agency's annual recovery goal.

According to agency personnel, 3-10% of total Medicaid expenditures, at the national level, are fraudulent based on national reporting data. DHHS's total expenditures for state fiscal year 2020 were $7,813,366,726.[122] When utilizing the national fraud percentages for comparative purposed, 3-10% of total agency expenditures are approximately $234,400,000 to $781,300,000, per agency personnel. According to agency personnel, it is believed that South Carolina's Medicaid fraud, waste, and abuse is lower than the range calculated. Given the anecdotal nature of this response, the agency should perform a more comprehensive examination of fraud, waste, and abuse within its system.

Total recoveries, per agency personnel, totaled $4,152,348 in fiscal year 2019-20. There has been a steep decrease in recoveries from 2013 as illustrated in Figure 15. Agency personnel intimated, during testimony, the lack of recovery audits, contributed to the decline in total recoveries. The agency submitted a Request for Proposal on June 9, 2020, requesting proposals to operate its Medicaid Recovery Audit Contractor (RAC) program in compliance with the federal Patient Protection and Affordable Care Act .[123] According to agency personnel, a RAC auditor has been selected and is providing services.[124]

This recommendation addresses Finding 8.

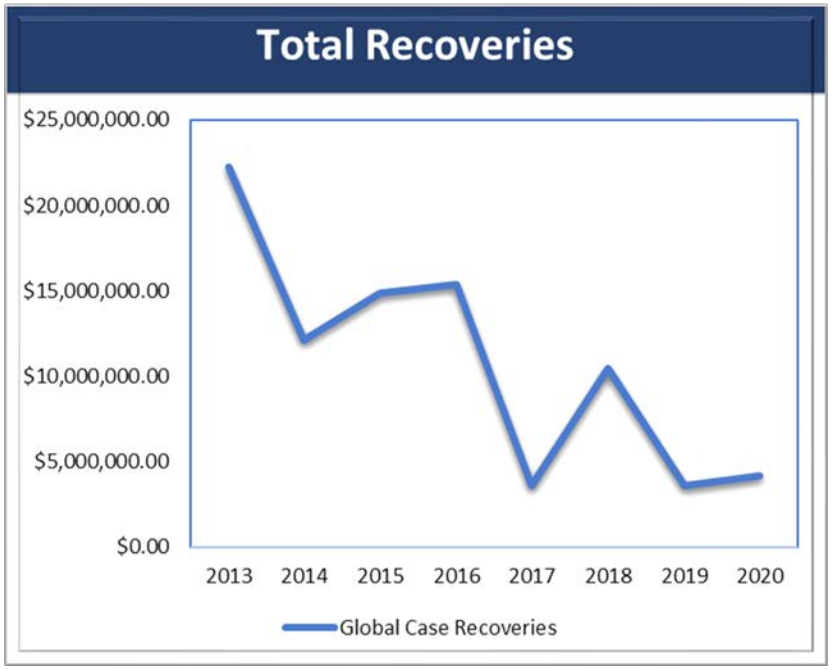


Figure 15. Total recoveries by DHHS' Program Integrity Unit

Recommendation to the Department of Administration's Division of State Human Resources

Transparency

The Subcommittee makes one recommendation to the Department of Administration's Division of State Human Resources related to transparency, and a summary is in Table 15.

Table 15. Summary of transparency recommendation to Department of Administration's Division of State Human Resources

TRANSPARENCY	26. Coordinate employee morale surveys across state government on a regular basis and within three years after administering employee morale surveys, investigate the feasibility of coordinating exit and entrance interviews across state government.[See finding 8.]

RECOMMENDATION # 26. The Department of Administration's Division of State Human Resources (State HR) should coordinate employee morale surveys across state government on a regular basis and within three years after administering employee morale surveys, investigate the feasibility of coordinating exit and entrance interviews across state government.

Analysis of employee morale among the state government workforce and motivations for seeking and leaving state employment may advance efforts to retain and recruit talent.

The number of willing, and forthcoming, participants in morale surveys may increase if it administered by a neutral third party, like State HR, as opposed to an agency's human resources division. Additionally, State HR collecting information statewide may facilitate analysis and insight into trends across state government that lead to recommendations for all agencies. Further, it may lead to recommendations for the General Assembly and Governor on what aspects of state government (e.g., pay, benefits, grievance procedure, etc.) are influencing individual's decisions about working for state government.

The Department of Administration states its ability to implement this recommendation depends on resources available.[125]

This recommendation addresses Finding 2.

SELECTED AGENCY INFORMATION

Department of Health and Human Services. "Program Evaluation Report, 2020."
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/Dept%20Health%20and%20Human%20Services%20(PER).pdf

Department of Health and Human Services. "Restructuring and Seven-Year Plan Report, 2016."
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/HHS%20-%202016%20Annual%20Restructuring%20Report.PDF

Department of Health and Human Services. "Agency Accountability Report, 2019-2020."
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/aar2020/J020.pdf

S.C. House of Representatives, Legislative Oversight Committee. "July 17 - August 20, 2018 Survey Results."
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpag es/Corrections/Public_Survey_JulAug2018.PDF (accessed November 21, 2019)

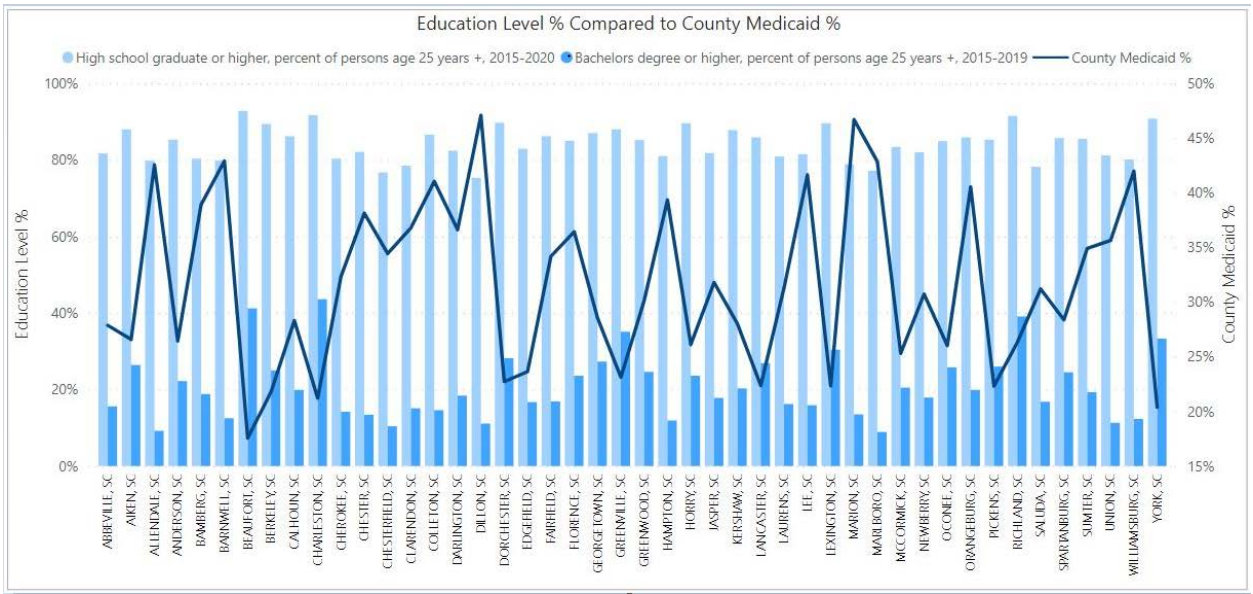
REPORT ACTIONS

FULL COMMITTEE OPTIONS STANDARD PRACTICE 12.4	FULL COMMITTEE ACTION(S)	DATE(S) OF FULL COMMITTEE ACTION(S)
(1) Refer the study and investigation back to the Subcommittee or an ad hoc committee for further evaluation; (2) Approve the Subcommittee's study; or (3) Further evaluate the agency as a full Committee, utilizing any of the available tools of legislative oversight.	Subcommittee study report available for consideration Subcommittee study presentation and discussion Approval of the Subcommittee's study	10.15.2021 3.2.2022 & 4.6.2022 4.6.2022

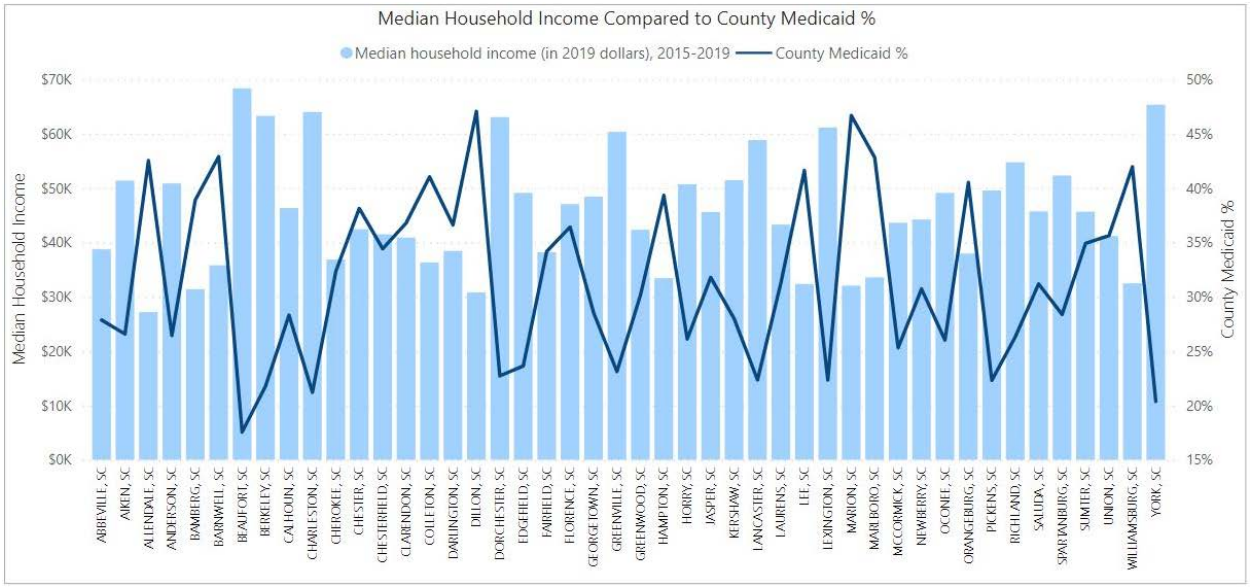
[1] Figure 1 is compiled from information in the Department of Health and Human Services study materials available online under "Citizens' Interest," under "House Legislative Oversight Committee Postings and Reports," and then under "Health and Human Services, Department of (DHHS)" https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyPHPFiles/DHHS.php (accessed September 2, 2021).

[2]S.C. House of Representatives, House Legislative Oversight Committee, "Agency Response to Committee Letter (4.16.21)," under "Committee Postings and Reports," under "House Legislative Oversight Committee," under "Health and Human Services, Department of (DHHS)," and under "Correspondence," https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/4.16.21%20response%20to%20subcommittee%20questions%20from%203.8.21%20meeting%20-%20signed%20copy.pdf (accessed September 1, 2021). See response to question four provided in attachment on pages 16-17 listing South Carolina Medicaid Members in January 2021. Hereinafter "Agency Response to Committee Letter (4.16.21)."

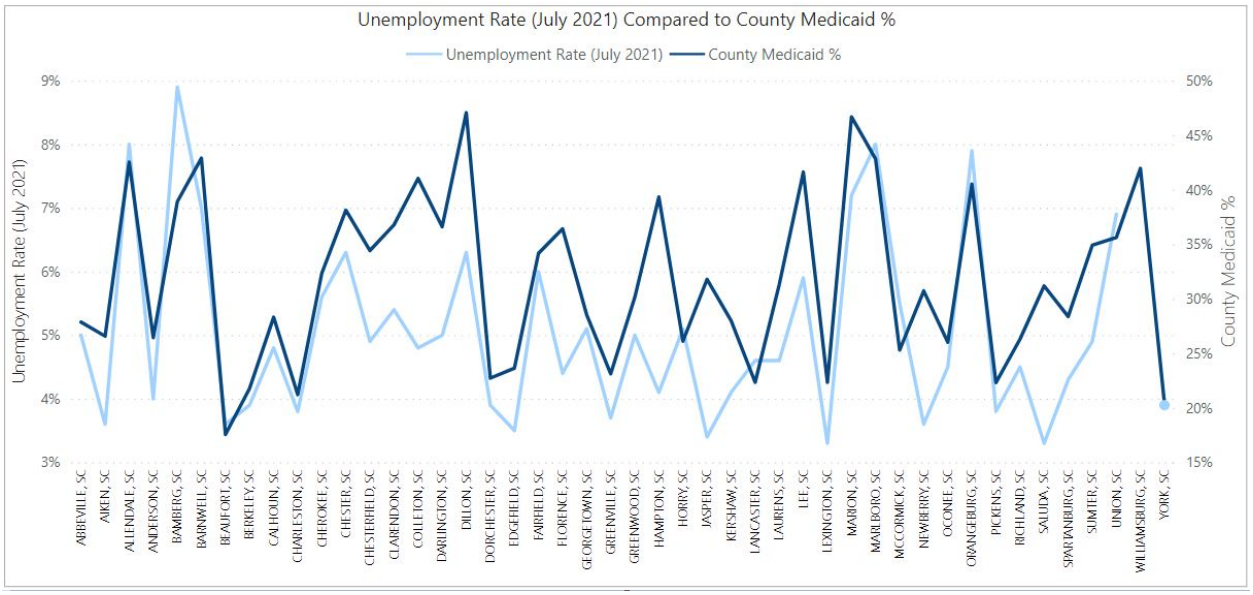
[3] Information presented in the following series of charts comes from data provided by DHHS, U.S. Bureau of Labor Statistics https://data.bls.gov/lausmap/showMap.jsp;jsessionid=5A98F6B03395AE8139772EEC1C81D1C5._t3_07v, and U.S. Census Bureau https://www.census.gov/quickfacts/fact/table/US/PST045219.



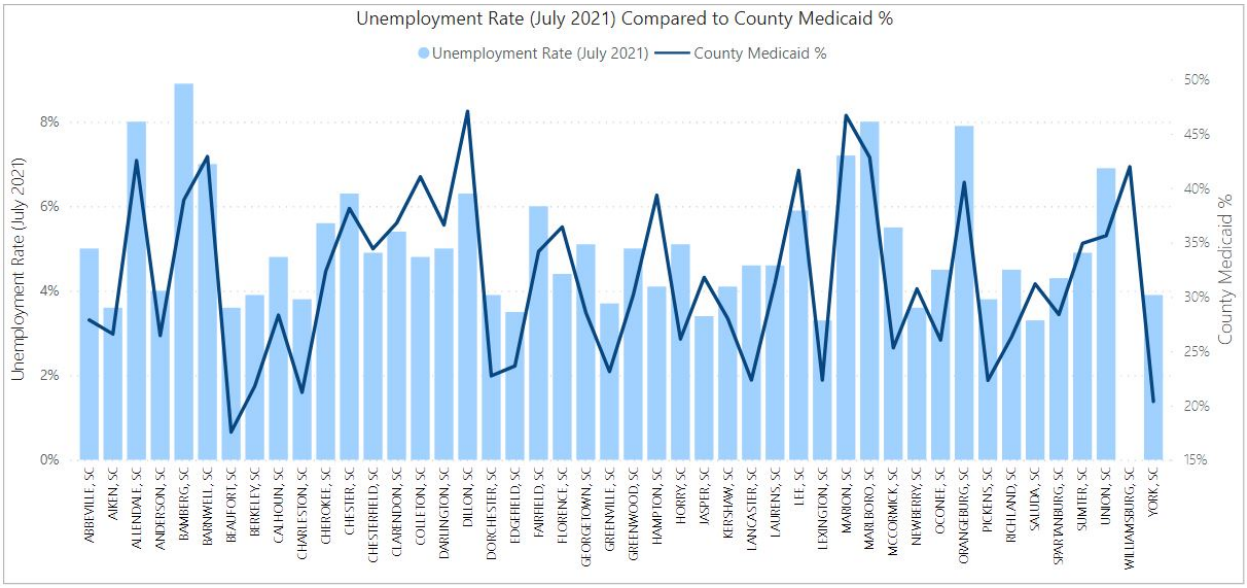
Endnote Figure #1. Education level percentage compared to county Medicaid percentage



Endnote Figure #2. Median household income compared to county Medicaid percentage



Endnote Figure #3. Unemployment rate (July 2021) compared to county Medicaid percentage



Endnote Figure #4. Unemployment rate (July 2021) compared to county Medicaid percentage

[4] Agency Response to Committee Letter (4.16.21). See response to question four provided in attachment on pages 16-17 listing South Carolina Medicaid Members in January 2021.
[5] Population estimates are as of July 1, 2019.

Endnote Table #1. Comparison of full and limited benefit membership enrollment

County Name	Total Estimated July 1, 2019 Population	Full Benefit Medicaid Membership	Limited Benefit Medicaid Membership	Total Medicaid Membership	County Medicaid %
Dillon	30,479	11,961	2,386	14,347	47.07%
Marion	30,657	11,887	2,426	14,313	46.69%
Barnwell	20,866	7,650	1,302	8,952	42.90%
Marlboro	26,118	9,216	1,972	11,188	42.84%
Allendale	8,688	3,123	573	3,696	42.54%
Williamsburg	30,368	10,544	2,201	12,745	41.97%
Lee	16,828	5,789	1,216	7,005	41.63%
Colleton	37,677	12,887	2,577	15,464	41.04%
Orangeburg	86,175	28,996	5,927	34,923	40.53%

[6] S.C. House of Representatives, House Legislative Oversight Committee, "Agency Response to Committee Letter (5.28.21)," under "Committee Postings and Reports," under "House Legislative Oversight Committee," under "Health and Human Services, Department of (DHHS)," and under "Correspondence,"https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/(2021-05-28)%20House%20Legislative%20Oversight%20Response%20Letter.pdf. See response to question 64. Hereinafter "Agency Response to Committee Letter (5.28.21)."
[7] S.C. House of Representatives, House Legislative Oversight Committee, "Meeting Minutes" (May 3, 2021), under "Committee Postings and Reports," under "House Legislative Oversight Committee," under Health and Human Services, Department of (DHHS)," and under "Meetings and Agency Presentations,"
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/May%203,%202021%20-%20Meeting%20Minutes%20-%20DHHS%20(Managed%20Care%20Plans).pdf (September 2, 2021). A video of the meeting is available at

https://www.scstatehouse.gov/video/archives.php?key=11335&part=1. See video at 00:44:43 - 00:45:14. Hereinafter, "May 3, 2021 meeting minutes and video."
[8] May 3, 2021 meeting minutes and video.
[9] May 3, 2021 meeting minutes and video.
[10] Agency Response to Committee Letter (5.28.21). See question 64.
[11] May 3, 2021 meeting minutes and video.
[12] May 3, 2021 meeting minutes and video.
[13] May 3, 2021 meeting minutes and video.
[14] S.C. House of Representatives, House Legislative Oversight Committee, "Agency Response to Committee Letter (6.24.21)," under "Committee Postings and Reports," under "House Legislative Oversight Committee," under "Health and Human Services, Department of (DHHS)," and under "Correspondence," https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/2021-06-24%20SCDHHS%20response%20to%206.3.21%20subcommittee%20follow-up%20letter.pdf (accessed September 8, 2021). See response to question 52. Hereinafter "Agency Response to Committee Letter (6.24.21)."
[15] Agency Response to Committee Letter (6.24.21). See response to question 52.
[16] S.C. House of Representatives, House Legislative Oversight Committee, "Agency Response to Committee Letter (9.24.21)," under "Committee Postings and Reports," under "House Legislative Oversight Committee," under "Health and Human Services, Department of (DHHS)," and under "Correspondence,"https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/9.24.21%20DHHS%20response%20letter%20to%20LOC.pdf. See response to question 1. Hereinafter "Agency Response to Committee Letter (9.24.21)."
[17] Agency Response to Committee Letter (9.24.21).
[18] Agency Response to Committee Letter (6.24.21). See response to question 52.
[19] Agency Response to Committee Letter (6.24.21). See response to question 52.
[20] Agency Response to Committee Letter (6.24.21). See response to question 52.
[21] Agency Response to Committee Letter (6.24.21). See response to question 52
[22] Agency Response to Committee Letter (6.24.21). See response to question 52
[23] Information included in the "Individuals Served" and "services summary" columns was obtained from Medicaid.gov Factsheet https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/Waiver-Descript-Factsheet/SC#02 (accessed August 13, 2021).
[24] The Wonder Center a medical day treatment program of the Children' Hospital of Prisma Health in Greenville, South Carolina. For more information about this program visit https://www.ghschildrens.org/programs/the-wonder-center/ (accessed September 20, 2021). Hereinafter, "Wonder Center Website."
[25] Agency Response to Committee Letter (6.24.21). See response to question 63.
[26] Agency Response to Committee Letter (6.24.21). See response to question 63.
[27] Wonder Center Website.
[28] Agency Response to Committee Letter (6.24.21). See response to question 63.
[29] Agency Response to Committee Letter (6.24.21). See response to question 63.
[30] A PRTF is a provider of inpatient psychiatric services who has a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21. Agency Response to Committee Letter (6.24.21). See response to question 32.
[31] Agency Response to Committee Letter (6.24.21). See response to question 32.
[32] Agency Response to Committee Letter (6.24.21). See response to question 32.
[33] Department of Health and Human Services, "Medicaid Psychiatric Residential Treatment Facility (PRTF) Directory," https://www.scdhhs.gov/site-page/medicaid-psychiatric-residential-treatment-facility-prtf-directory (accessed October 1, 2021).
[34] Agency Response to Committee Letter (6.24.21). See response to question 32.
[35] 2013 Act No. 101. This is the 2013-2014 appropriations bill (H. 3710). See Part 1B Proviso, 33.34 (DHHS: Medicaid Accountability and Quality Improvement Initiative).
[36] Agency Response to Committee Letter (5.28.21). See response to question 43.
[37] Agency Response to Committee Letter (5.28.21). See response to question 43.
[38] Agency Response to Committee Letter (5.28.21). See response to question 43.
[39] Department of Health and Human Services, "Leveraging Graduate Medical Education to Increase Primary Care and Rural Physician Capacity in South Carolina," https://msp.scdhhs.gov/proviso/sites/default/files/GME%20Advisory%20Group%20Report%20%20January%202014%20final.pdf (accessed October 1, 2021). See pages 51-53.
[40] Agency Response to Committee Letter (6.24.21). See response to question 41.
[41] Department of Health and Human Services, "State Plan list of Attachments," https://www.scdhhs.gov/site-page/state-plan-list-attachments (accessed October 1, 2021). See Attachment 4.19-B of the Medicaid State Plan, which details how agency personnel determines rates. The section applicable to Board Certified Behavioral Analyst states, "To determine an hourly rate for the services provided by a Board Certified Behavior Analyst (BCBA) and a Board Certified Assistant Behavior Analyst (BCaBA), the Medicaid Agency uses the midpoint of the comparable South Carolina state government positions and determines the average hourly rate for BCBA/BCaBA staff. After applying the applicable fringe rate and adding estimated operational expenses, the sum is divided by a productivity factor representative of an estimated number of billable

hours to determine an hourly billing rate. Hourly rates are then converted to the time units corresponding to approved billing (HCPCS/CPT) codes to determine the reimbursement rate by billing codes." The section applicable to Registered Behavior Technician (RBT) states, "To determine an hourly rate for the services provided by a Registered Behavior Technician (RBT), the Medicaid Agency uses the midpoint of the comparable South Carolina state government position and other data sources such as RBT wage surveys and interviews of ABA provider practices to determine the average hourly rate for an RBT. After applying the applicable fringe rate and adding estimated operational expenses for an RBT, the sum of each position is divided by a productivity factor representative of an estimated number of billable hours to determine an hourly billing rate. Hourly rates are then converted to the time units corresponding to approved billing (HCPCS/CPT) codes to determine the reimbursement rate by billing codes.

[42] S.C. House of Representatives, House Legislative Oversight Committee, "Meeting Minutes" (May 24, 2021), under "Committee Postings and Reports," under "House Legislative Oversight Committee," under Health and Human Services, Department of (DHHS)," and under "Meetings and Agency Presentations,"
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/DHHS%20-%20Meeting%20Minutes%205.24.21.pdf (September 20, 2021). A video of the meeting is available at https://www.scstatehouse.gov/video/archives.php?key=11337&part=1. See video at 00:50:32. Hereinafter, "May 24, 2021 meeting minutes and video."

[43] May 24, 2021 meeting minutes and video. See video at 00:50:32.

[44] May 24, 2021 meeting minutes and video. See video at 00:50:32.

[45] Agency Response to Committee Letter (5.28.21). See response to question 18.

[46] Agency Response to Committee Letter (5.28.21). See response to question 19.

[47] Agency Response to Committee Letter (5.28.21). See response to question 18.

[48] Agency Response to Committee Letter (5.28.21). See response to question 41. See also, Jenny L. Stirling, Department of Health and Human Services Deputy Chief of Staff for Legislative Affairs, email message to House Legislative Oversight Committee Auditor/Research Analyst Lewis M. Carter, July 28, 2021. Hereinafter, "Email Correspondence (July 28, 2021)."

[49] Email Correspondence (July 28, 2021).

[50] Email Correspondence (July 28, 2021). **Note**: The variances are due to the timing of Supplemental Teaching Payments (STP) payments. For fiscal year 2020, MUSC had two years of STP payments as we paid fiscal year 2019's as well. The USC variances are related to STP as well. Once Prisma bought healthcare facilities in the Midlands previously owned by USC, the STP moved to the "other entities" line, as the facilities were no longer connected to a state agency.

[51] S.C. House of Representatives, House Legislative Oversight Committee, "DHHS-Legislatively Directed Contracts," under "Committee Postings and Reports," under "House Legislative Oversight Committee," under "Health and Human Services, Department of (DHHS)," and under "Correspondence,"
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/DHHS%20-%20Legislatively%20Directed%20Contracts.pdf (accessed September 30, 2021). Hereinafter, DHHS-Legislatively Directed Contracts."

[52] S.C. House of Representatives, House Legislative Oversight Committee, "Meeting Minutes" (April 19, 2021), under "Committee Postings and Reports," under "House Legislative Oversight Committee," under Health and Human Services, Department of (DHHS)," and under "Meetings and Agency Presentations,"
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/4.19.21%20Minutes%20Final.pdf (September 20, 2021). A video of the meeting is available at https://www.scstatehouse.gov/video/archives.php?key=11132&part=1. See video at 2:32:08. Hereinafter, "April 19, 2021 meeting minutes and video."

[53] April 19, 2021 meeting minutes and video. See video at 2:32:08.

[54] Agency Response to Committee Letter (5.28.21). See response to question 20. See also, S.C. Code Reg. Section 126-401.

[55] S.C. Code Section 44-115-80.

[56] Department of Health and Human Services, "Dept of Health and Human Services (PER) (June 2, 2020)," under "Committee Postings and Reports," under "House Legislative Oversight Committee," and under "Health and Human Services, Department of (DHHS)"
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/Dept%20Health%20and%20Human%20Services%20(PER).pdf (accessed September 22, 2021). See pages 44-45. Hereinafter, "Agency PER."

[57] Agency Response to Committee Letter (5.28.21). See response to question 15.

[58] Agency Response to Committee Letter (5.28.21). See response to question 15.

[59] Agency Response to Committee Letter (5.28.21). See response to question 8.

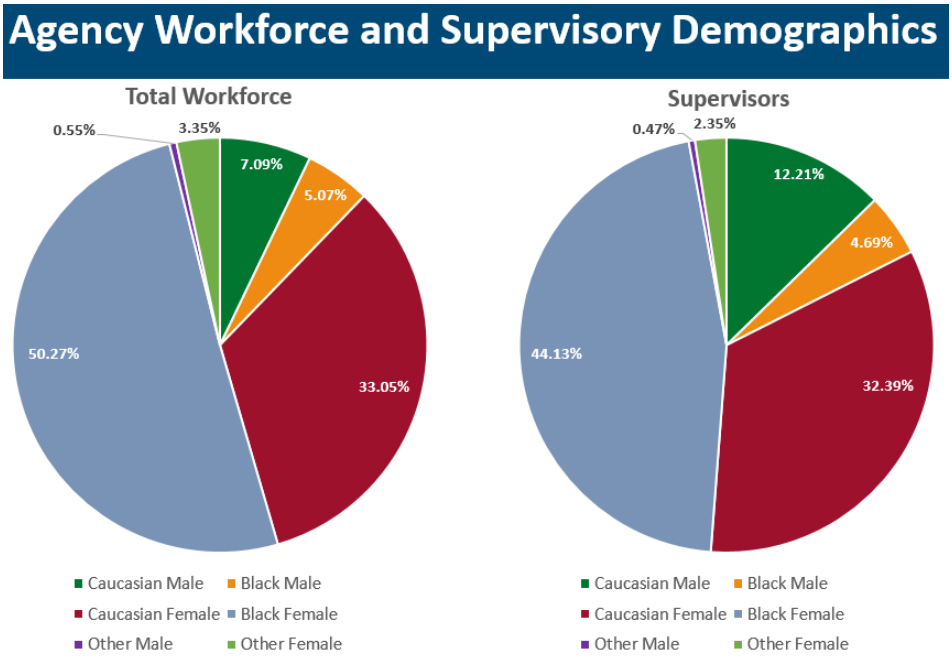
[60] Agency PER.

[61] Agency PER.

[62] May 3, 2021 meeting minutes and video. See video at 00:44:43 - 00:45:14.

[63] May 3, 2021 meeting minutes and video. See also, Agency Response to Committee Letter (5.28.21). See question 64.

[64] May 3, 2021 meeting minutes and video. Ideally, promoting choice means beneficiaries know and understand the difference between managed care organization plans and if those plans are best suited for their needs.



[65]

Endnote Figure # 5. Screenshot of agency's presentation slide 23 made to the Healthcare and Regulatory Subcommittee on July 28, 2020

S.C. House of Representatives, House Legislative Oversight Committee, "Meeting Packet" (June 28, 2020), under "Committee Postings and Reports," under "House Legislative Oversight Committee," under ""Health and Human Services, Department of (DHHS)," and under "Meetings and Agency Presentations," and under "Meetings,"
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/7.28.20%20-%20DHHS%20Meeting%20Packet.pdf (accessed September 20, 2021). Hereinafter, "Meeting Packet (June 28, 2020)."

[66] S.C. House of Representatives, House Legislative Oversight Committee, "Meeting Minutes" (April 26, 2021), under "Committee Postings and Reports," under "House Legislative Oversight Committee," under "Health and Human Services, Department of (DHHS)," and under "Meetings and Agency Presentations,"
https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/4.26.21%20Minutes.pdf (September 20, 2021). A video of the meeting is available at https://www.scstatehouse.gov/video/archives.php?key=11291&part=1. See video at 00:05:42-00:05:58. See also, video at 00:24:28-00:24:39. Hereinafter, "April 26, 2021 meeting minutes and video."

[67] April 26, 2021 meeting minutes and video. See video at 5:46. See also, May 3, 2021 meeting minutes and video. See video at 45:43. See also, May 24, 2021 meeting minutes and video. See video at 11:05.

[68] Meeting Packet (June 28, 2020).

	Authorized	Filled	Vacant	Vacancy %	Vacant in Use
FTEs	1,810.00	1,100.00	710.00	39.23	408.00
TGEs	407.00	190.00	217.00	53.32	101.00

(Updated September 24, 2021)

FTEs - Full Time Employees

TGEs - Temporary Grant Employees

Endnote Figure #6. Screenshot of agency's presentation slide 22 made to the Healthcare and Regulatory Subcommittee on June 28, 2021.

[69] Examples include: Department of Corrections; Department of Juvenile Justice; Department of Mental Health; Department of Public Safety; and Human Affairs Commission.
[70] Agency Response to Committee Letter (5.28.21). See response to question 31.
[71] Agency Response to Committee Letter (5.28.21). See response to question 31. See also, S.C. House of Representatives, House Legislative Oversight Committee, "Meeting Minutes" (July 28, 2020), under "Committee Postings and Reports," under "House Legislative Oversight Committee," under Health and Human Services, Department of (DHHS)," and under "Meetings and Agency Presentations," https://www.scstatehouse.gov/CommitteeInfo/HouseLegislativeOversightCommittee/AgencyWebpages/DHHS/7.28.20%20DHHS%20Minutes%20Final.pdf (September 20, 2021). A video of the meeting is available at https://www.scstatehouse.gov/video/archives.php?key=10492&part=2. See video (Part 2) at 00:44:06. Hereinafter, "July 28, 2020 meeting minutes and video."
[72] April 26, 2021 meeting minutes and video. See video at 00:24:19 – 00-24:32.
[73] April 26, 2021 meeting minutes and video. See video at 00:24:19 – 00-24:32.
[74] May 24, 2021 meeting minutes and video. See video at 00:25:33-00:25:59.
[75] Meeting Packet (June 28, 2020). See agency presentation slide 90.
[76] May 24, 2021 meeting minutes and video. See video at 01:01:26 - 01:02:10. Increased flexibility and access to telehealth services have been critical pieces to the agency's efforts to ensure Medicaid beneficiaries receive quality care. According to agency staff, they experienced a significant increase in claims billed for services delivered via telehealth during the pandemic. With this increase in billing, agency personnel have data to evaluate the efficacy of utilizing telehealth for an expanded number of services. Access to care, which can be challenging for Medicaid beneficiaries, particularly in rural areas or for persons lacking adequate transportation, is an issue, which telehealth flexibility may address.

DHHS, through bulletins posted on its website, identified additional flexibilities designed to ensure access to providers and reimbursement to providers. Agency personnel submitted a request to CMS to amend the Palmetto Coordinated System of Care waiver; published an updated fee schedule for COVID-19 testing; issued a Medicaid Alert announcing it was granting certain temporary regulatory flexibilities related to admissions to skilled nursing facilities and participation in the Medicaid nursing home program; published a fee schedule for telehealth codes that have been created during the public health emergency; and authorized reimbursement for early intervention providers to develop relevant portions of a beneficiary's Individualized Family Service Plans using curriculum-based assessments via telemedicine.

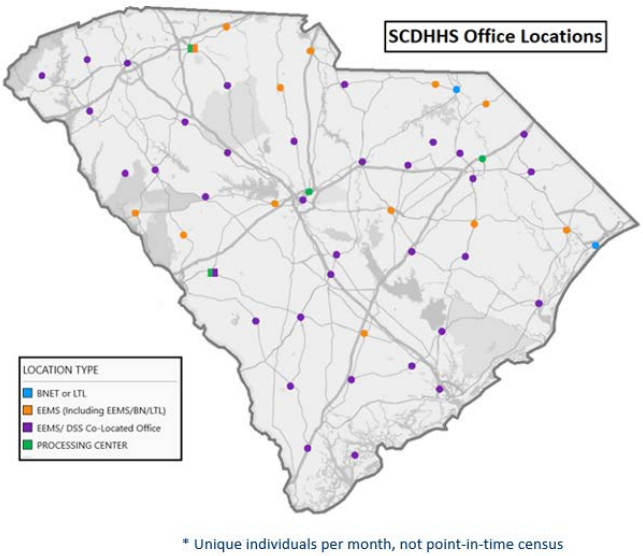
[77] March 31, 2020, Correspondence from U.S. Department of Health and Human Services to South Carolina Department of Health and Human Services https://msp.scdhhs.gov/covid19/sites/default/files/SC%201135%20Flexibilities%20Approval%20Letter%20-%20Signed.pdf (accessed September 20, 2021). The letter is in reference to Section 1135 flexibilities requested in March 27, 2020, communication.
[78] May 24, 2021 meeting minutes and video. See video at 01:01:11.
[79] May 24, 2021 meeting minutes and video. See video at 01:01:11.
[80] Agency Response to Committee Letter (5.28.21). See question 10. See also, April 26, 2021 meeting minutes and video. See video at 00:38:38-00:39:12.
[81] Agency Response to Committee Letter (5.28.21). See question 10.
[82] Agency Response to Committee Letter (5.28.21). See question 10.
[83] Agency Response to Committee Letter (5.28.21). See question 10.
[84] April 19, 2021 meeting minutes and video. See video at 00:50:00. Also, data from the federal Health Resources & Services Administration supports the agency's assessment regarding the shortage of medical practitioner resources.
[85] Agency Response to Committee Letter (5.28.21). See question 43.
[86] Agency PER.
[87] Department of Health and Human Services, "Public Notice: Opioid Prescribing Limits (Submitted March 1, 2018 – 6:00 pm)," https://www.scdhhs.gov/public-notice/public-notice-opioid-prescribing-limits (accessed September 28, 2021). Hereinafter, "Public Notice: Opioid Prescribing Limits (Submitted March 1, 2018 – 6:00 pm)."
[88] Public Notice: Opioid Prescribing Limits (Submitted March 1, 2018 – 6:00 pm).
[89] Endnote Table # 2. DHHS pharmacy lock-in criteria definitions

DHHS Pharmacy Lock-in Criteria		
	Criteria	Definition
1	Schedule II Without Professional Claim in Previous 6 Months	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 Day	Identifies beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries with DEA Schedule II-V prescriptions from two or more out of state pharmacies.
7	Two Controls From 2 Pharmacies within 2 Days	Identifies beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries 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; and 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 beneficiaries 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; and 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 beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries 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 beneficiaries also found on the "Holy Trinity" or "The Cocktail" reports for the same six-month time period. These reports identify beneficiaries 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))

[90] Agency Response to Committee Letter (6.24.21). See response to question 81.
[91] May 24, 2021 meeting minutes and video. See video at 02:33:06-02:33:21. See also, video at 02:33:42-02:33:50.
[92] The identified chronic conditions, with the exception of sickle cell anemia, are defined as such by the Centers for Medicare & Medicaid Services
[93] May 24, 2021 meeting minutes and video. See video at 00:35:10-00:35:23.
[94] Agency Response to Committee Letter (9.24.21). See response to question 6.
[95] April 26, 2021 meeting minutes and video. See video at 00:24:19 – 00-24:32. See also, video at 00:05:42 – 00:05:51.
[96] S.C. House of Representatives, House Legislative Oversight Committee, "Video" (August 30, 2021), under "Committee Postings and Reports," under "House Legislative Oversight Committee," under Health and Human Services, Department of (DHHS)," and under "Meetings and Agency Presentations," https://www.scstatehouse.gov/video/archives.php?key=11492&part=1 (October 1, 2021). See video at 00:26:54-00:27:19. See also, video at 00:27:20-00:27:46. The minutes for this meeting have not been published as of the date of publication of the report.
[97] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, "Social Determinants of Health," https://health.gov/healthypeople/objectives-and-data/social-determinants-health (accessed September 23, 2021).
[98] May 24, 2021 meeting minutes and video. See video at 39:51.
[99] Stratification is the process of sorting data, people, and objects into distinct groups. This is generally done in concert with other data analysis tools.
[100] Agency Response to Committee Letter (5.28.21). See question 32.
[101] Agency Response to Committee Letter (5.28.21). See question 32.
[102] Agency Response to Committee Letter (5.28.21). See question 32.
[103] Agency Response to Committee Letter (5.28.21). See question 32.
[104] Agency Response to Committee Letter (5.28.21). See question 32.
[105] Agency Response to Committee Letter (5.28.21). See question 32.
[106] Agency Response to Committee Letter (5.28.21). See question 33.
[107] Agency Response to Committee Letter (5.28.21). See question 33.
[108] S.C. Code Section 8-11-15(B) authorizes state agencies to "use alternate work locations, including telecommuting, that result in greater efficiency and cost savings."
[109] Department of Administration Telecommuting Toolkit (Updated June 2021) https://admin.sc.gov/dshr/model_policies#telecommuting (accessed September 20, 2021).
[110] Agency Response to Committee Letter (5.28.21). See question 44.
[111] April 26, 2021 meeting minutes and video. See video at 22:22 – 22:31.
[112] Meeting Packet (June 28, 2020).



Endnote Figure #7. Screenshot of agency's presentation slide 19 made to the Healthcare and Regulatory Subcommittee on June 28, 2021.

[113] Agency Response to Committee Letter (5.28.21). See response to question 66. See also, Agency Response to Committee Letter (9.24.21). See response to question 8.
[114] Agency Response to Committee Letter (9.24.21). See response to question 8.
[116] Agency Response to Committee Letter (9.24.21). See response to question 9.
[117] Agency Response to Committee Letter (5.28.21). See response to question 5.
[118] South Carolina Public Benefit Authority, https://www.peba.sc.gov/health (accessed September 22, 2021).
[119] Agency Response to Committee Letter (5.28.21). See response to question 27. According to agency personnel, the consultant was paid $135,000.
[120] Agency Response to Committee Letter (5.28.21). See response to 27.
[121] S.C. Code Reg. Section 126-400.

Endnote Table #3. Administrative sanctions against Medicaid providers defined

ARTICLE 4 **PROGRAM EVALUATION** **SUBARTICLE 1** **ADMINISTRATIVE SANCTIONS AGAINST MEDICAID PROVIDERS** **126–400. Definitions.**
Suspension of Payment - means that upon determination by the Department that there is a credible allegation of fraud against a specified provider for which an investigation is pending under the Medicaid program, all payments pending at the time of determination and all payments for items or services furnished by the specified provider will be retained by the Department until resolution of the investigation, unless the Department determines that good cause to not suspend or to only suspend in part exists, as set forth in 42 CFR § 455.23(e) and § 455.23(f) respectively. [§ 455.23].
Termination - occurs when the Medicare program, a State Medicaid program, or Children's Health Insurance Program (CHIP) has taken an action to revoke a provider's billing privileges, a provider has exhausted all applicable appeal rights or the timeline for appeal has expired, and there is no expectation on the part of a provider or supplier or the Medicare program, State Medicaid program, or CHIP that the revocation is temporary. The requirement for termination based upon a termination in another program applies in cases where providers, suppliers, or eligible professionals were terminated or had their billing privileges revoked for cause which may include reasons based on fraud, integrity, or quality. [Section 6501 of the Affordable Care Act amended section 1902(a)(39) of the Social Security Act (the Act) and requires State Medicaid agencies to terminate the participation of any individual or entity if such individual or entity is terminated under Medicare or under the Medicaid program or CHIP of any other state].
Suspension - means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.[42 CFR § 455.2].

[122] Agency Response to Committee Letter (6.24.21). See response to question 90.
[123] State Fiscal Accountability Authority, Division of Procurement Services, "Medicaid Recovery Audit Contractor (RAC) (June 9, 2020)" https://scbo.sc.gov/online-edition?c=13-2020-06-09 (accessed September 28, 2021)
[124] April 26, 2021 meeting minutes and video. See video at 00:56:55-00:57:18.
[125] Karen Wingo, Department of Administration's Director of Division of State Human Resources, email message to House Legislative Oversight Committee Legal Counsel, Charles Appleby, August 3, 2020. ("Our budget request [State HR's fiscal year 2020-21 budget request seeks six additional full time equivalent (FTE) positions, including an individual responsible for data and reporting, and asserted with the additional FTEs, it could administer annual employee morale surveys for non-higher education agencies.] has not been granted at this time and, as a result, we have not received any additional FTEs. Additionally, the pandemic has significantly impacted human resources operations across the state and we are not in position without the additional FTEs to conduct surveys for all non-higher education state agencies this year. However, we have experience working with agencies and independently to administer employee surveys and would be available to develop and implement one for Department of Corrections, if desired.")

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House of Representatives

State of South Carolina

Member Statement

For the House Legislative Oversight Committee

Study of the South Carolina Department of Health and Human Services

A common refrain, voiced by agency leaders across our state, is the challenge of hiring and retaining talented employees. Our state's dedicated employees provide a range of services, which allow South Carolinians to run their businesses, drink clean water, and educate their children. Many of these vital state positions remain vacant and unfilled due to a shrinking labor force, competition from the private sector, widening wage disparities, and a recent shift in where and how employees work. State agency leaders, in many respects, are at a significant disadvantage due to these factors. As state agency leaders grapple with a changing workforce paradigm, it will be increasingly important to maximize the levers available to senior level agency executives.

The Department of Health and Human Services (DHHS) is a multibillion-dollar agency which provides services to 1.1 million full benefit Medicaid beneficiaries. Medicaid, through contracts with managed care organizations and healthcare providers, ensures healthcare services are provided to eligible South Carolinians. According to agency staff, approximately 60% of South Carolina children under the age of 18 receive Medicaid services. The elderly, disabled, and other qualifying adults also depend on these vital services. In the absence of these services, eligible populations would lack adequate access to healthcare, which would lead to increased morbidity and increased healthcare costs. Our local hospitals, which already contend with the challenges of keeping their doors open, would face irreparable harm in the absence of Medicaid.

It is abundantly clear our state Medicaid program is critical to the physical and fiscal health of South Carolina. Ensuring each Health and Human Services team member is valued, appreciated, and respected is important, not only to the rank-in-file staff, but to every resident of our state. Dollars for raises and bonuses are finite and not easily leveraged, but interagency morale, and the development of a culture defined by respect, do not require significant financial investment. It requires intentionality, training, and a solid commitment from agency leadership.

According to information provided by agency personnel, 1,138 employees, which represents 87% of agency staff, participated in the 2021 employee satisfaction survey. Several survey questions point to issues of culture within the agency. For example:

- Only 63% of employees believe they work in an environment that embraces change, new ideas, respect for the individual and equal opportunity to succeed.
- Only 52% of employees feel like SCDHHS values them as an employee.

- Only 33% of employees believe SCDHHS is concerned with the long-term welfare of all its employees.
- Only 33% of employees believe they are paid fairly to other employees at SCDHHS
- Only 66% of staff feel their performance evaluations are administered fairly and appropriately.

The culture at DHHS, as illustrated by these survey results, needs significant rehabilitation. Changing negative perspectives starts with creating a set of values, expectations, and practices to guide and inform the actions of every team member. People are the fabric of an organization. When employees know their culture, history, and lived experiences are valued, the fabric of an organization is strong. They come to work confident their organization puts people first. This is the type of organization where people want to build long-term careers and invest their time and talent.

I would like to conclude by saying I believe DHHS, under Director Robert M. Kerr's leadership, is headed in the right direction. Director Kerr has committed himself to identifying the critical issues impacting his staff. Leaders who value cultural awareness create a better workplace, a more empowered staff, and a better product for the residents of South Carolina. From his testimony, I know Director Kerr is steadfast in his commitment to the agency and the 1.1 million full benefit Medicaid beneficiaries. It is imperative we help maintain the positive momentum built under the director's leadership, as he addresses deficiencies in the cultural philosophy at DHHS. Moving forward, I expect future employee surveys will provide the empirical evidence to validate the importance of investing in cultural awareness and respect for all employees.

Rosalyn Henderson-Myers
House District 31 (Spartanburg County)