



## State of South Carolina Office of the Inspector General

August 25, 2016

Director Christian Soura  
South Carolina Department of Health and Human Services  
1801 Main Street  
Columbia, SC 29201

Re: Rehabilitative Behavioral Health Services

Dear Director Soura:

As you were aware, the State Inspector General (SIG) conducted a review of the Rehabilitative Behavioral Health Services (RBHS). The SIG initiated its review in October 2015 after observing the South Carolina Department of Health and Human Resources (DHHS) was still experiencing disproportionately high RBHS Medicaid expenditures and corresponding fraud cases despite attempts to increase its management controls for nearly a year. As the SIG was nearing the end of its field work in February 2016, the DHHS made the decision to move RBHS to managed care, effective 7/1/2016. Given DHHS took this bold and appropriate step to address the inadequate RBHS management control environment, a final SIG report was not considered necessary to tediously set forth a factual foundation to support findings & recommendations to drive needed change in the RBHS. However, it is incumbent upon the SIG to summarize issues identified and lessons learned, which are transferable to other aspects of DHHS operations, particularly the planned changes in the next several years in how Medicaid reimburses providers serving disabled and special needs patients.

### Background

In July 2014, the DHHS assumed operational management of Behavioral Health Services (BHS) from its sister State agencies, primarily the Department of Mental Health. Previously, the sister State agencies authorized BHS services; provided services; supervised clinicians; and provided case management for referrals to private providers. BHS was moved from a “high” management control environment in its sister State agencies to a “low” management control environment at DHHS. The DHHS did not adequately plan or initially implement adequate management controls, which led to dramatic increases in Medicaid expenditures, to include fraud, waste, and abuse.

The overall BHS Medicaid expenditures increased from a July 2014 baseline of \$4.3 million/month to a peak of \$16.3 million/month (279% increase) in 10 months. However, a subcomponent of BHS, RBHS, increased at a higher rate from a \$2 million/month baseline to a peak of \$9.95 million/month (391% increase) in these same 10 months. Without the sister State agencies’ management controls, often referred to as a gatekeeper function, new RBHS facilities and clinicians, many from out of state, enrolled and billed Medicaid for RBHS. Unique to RBHS facilities, a single licensed clinical director can authorize Medicaid billing for non-licensed individuals

providing the actual RBHS therapies. This leveraging capability multiplied the fraud, waste, and abuse from a single wrongdoing provider.

From October 2014 through February 2016, SC DHHS implemented new RBHS management controls about every other month to gain control of the escalating expenditures and mitigate the risks of fraud, waste, and abuse. The cumulative impact of these new controls had some effect, but the expenditure level at the decision point in February 2016 to move to managed care was still nearly a 252% and 188% baseline increase for RBHS and BHS, respectively. Since July 2014, the DHHS opened 64 RBHS provider fraud and abuse investigations with 30 cases currently pending; 20 fraud case referrals to the South Carolina Attorney General; terminated two providers for failure to provide records; and suspended six providers based on a determination of a credible allegation of fraud.

In February 2016, the DHHS essentially outsourced the management of these RBHS services from DHHS to managed care organizations (MCO). The MCO option does represent an administrative vehicle to potentially better manage costs and outcomes, to include leveraging MCO's superior technology and having more latitude in managing the quality of providers. However, the MCO's success is still a function of policy requirements supplied by DHHS, which was a root cause of the RBHS fraud, waste, and abuse.

### Analysis

The DHHS's initial approach of operating in a low control environment had the noteworthy goal of maximizing beneficiary access to private providers. To DHHS's credit, it recognized the significant risk of fraud, waste, and abuse using low management controls within several months. This resulted in hiring consultants to develop management control options to address the problem, which included immediately terminating 50 providers for failing to maintain proper accreditation. Even with adding management controls over the course of 20 months through February 2016, the DHHS RBHS management controls were still not considered high, as well as substantially short of other RBHS management control models examined by this review operating in South Carolina. The critical difference was the DHHS lacked establishing clear standards for acceptable treatment and outcomes.

Provider flexibility literally created provider unaccountability. Without clarity for treatment standards and outcomes, some RBHS services resembled after school daycare. From a taxpayer perspective, this failed the common sense test, but these services were not prohibited under DHHS provider professional discretion in designing treatment plans. Additionally, the DHHS management had an unrealistic over-reliance on its Program Integrity Unit to address fraud, waste, and abuse, and an under-appreciation of management's duty to build adequate management controls as preventative tools to cost/effectively mitigate the risk of fraud, waste, and abuse.

This review focused on the RBHS, which composed 60% of the BHS services. The review did not examine the impact of DHHS's new policies on the residual services composing 40% of the BHS. This 40% had \$100 million in expenditures during the 20 month period under review (July 2014 – February 2016). All program services increased from their respective July 2014 baseline as follows: LIPS (79%); TCM (188%); and Other Programs (130%). These programs did not have the out of state providers leveraged by unlicensed treatment providers as indicators of fraud, waste, and abuse risk, but other data suggests these programs' risk of fraud, waste, and abuse has also increased.

In the medical field, as well as in virtually all businesses, variations exist in providers' professional skills and integrity, which left unmanaged, has the risk of lowering health outcomes and increasing costs. The only question is how to deploy management controls to get the best outcomes (health & cost) while balancing the administrative burden which can also impact access and outcomes through delayed care. In the case of RBHS,

a major lesson learned was an emphasis on provider preferences and beneficiary access came at the expense of taxpayers and beneficiaries being subjected to lower quality of care. The initial treatment/outcome policies, as well as the modifications to address fraud, waste, and abuse (i.e., prior notice for an audit; rate fee adjustments; and elimination of independent diagnostic assessment) seemingly accommodated providers at the expense of taxpayers. The more subtle lesson learned from these lesser standards was it also risked lower quality of care for a fragile beneficiary population. Both intentional wrongdoing and unintentional ineffective providers continued to operate within DHHS's system because high usage providers without positive outcomes were not, based on policy and procedures, effectively addressed by DHHS short of a fraud referral.

### Recommendations

1. The DHHS should consider requiring prior to significant policy changes, a formal risk assessment and corresponding management control fraud, waste, and abuse risk mitigation strategies, which could be enhanced by examining other states' best practices and DHHS using its internal audit function to consult with management, particularly managers with technical healthcare expertise without a corresponding depth of organizational management skills.
2. The DHHS should consider reviewing management controls on the residual BHS programs after transferring RBHS to the MCOs, which are LIPS, TCM, and Other Programs, inasmuch as these three programs have increased 79%, 188%, and 130%, respectively, from its July 2014 baseline with the most recent 12 month's expenditures totaling \$67.8 million.
3. The DHHS should consider consolidating policy manuals to provide consistency to all providers and add efficiency to DHHS operations.

The SIG had a number of recommendations pertaining to management controls in the areas of diagnostics, treatment policies, and outcome frameworks. However, these recommendations were not consider necessary inasmuch as manage care organizations (MCO) are well versed in management control options, and it appears the MCOs are already planning to institute an initial high control environment.

This is the third review the SIG has conducted at DHHS in the past 18 months. I do get a sense the complexity, operational tempo, and change environment may have outpaced your resources to literally keep up. The personal commitment and personal stress on your employees who are "building the plane while flying it" has not gone unnoticed, and the public should be proud of their dedication and service under challenging conditions.

If you have any questions or concerns, don't hesitate to call 24/7 on my cell (803/429-4946).

Sincerely,



Patrick J. Maley  
State Inspector General