

**Date:** August 8, 2014

**To:** Anthony Keck, Director  
Deirdra Singleton, Deputy Director, Office of Health Services

**From:** Kathleen Snider, Bureau Chief, Bureau of Compliance and Performance Review

**Subject:** Recommendations for Strategic Approach to SCDHHS Monitoring Activities over MCOs

With the transition of Medical Home Networks (MHNs) to full risk, capitated managed care plans in January 2014, more than 60% of South Carolina’s Medicaid population and 80% of managed care-eligible members are now covered under one of the six Managed Care Organizations (MCOs)<sup>1</sup> currently contracted with the South Carolina Department of Health and Human Services (SCDHHS). Since managed care is now the predominant model for Medicaid service delivery, the Agency has been in the process of developing a new managed care contract that was finalized July 1, 2014.

Several strategic goals of SCDHHS are tied to the Agency’s restructuring of Medicaid services to a managed care delivery model. The SFY 2013 “Balanced Scorecard” (the Agency’s mechanism for developing strategic goals and objectives) has listed as major goals to:

- Sustain the growth rate of Per Member Per Month (PMPM) costs to 1% less than the Medical Care Component of the Consumer Price Index (CPI).
- Increase to three-stars HEDIS<sup>2</sup> on state reported measures for all coordinated care plans by end of FY2013 with achievement of NCQA<sup>3</sup> rating of excellence for MCO plans by FY2014.
- Serve at least 15% of the dually eligible beneficiaries in a fully integrated continuum of Medicare and Medicaid benefits by end of FY2014.

The Division of Audits has completed a focused assessment of the Agency’s capacity to conduct the required oversight and monitoring of the Medicaid program in a managed care environment. The purpose of our review was to determine whether the SCDHHS has sufficient resources, staffing, and procedures in place to provide a robust system of monitoring over the MCOs that will:

- Facilitate achievement of Balanced Scorecard goals;
- Facilitate performance improvement and quality services on the part of the MCOs;

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<sup>1</sup> Absolute Total Care, Advicare of South Carolina, BlueChoice Health Plan, First Choice by Select Health, Molina Healthcare of South Carolina, and Wellcare of South Carolina

<sup>2</sup> Health Effectiveness Data and Information Set

<sup>3</sup> National Committee for Quality Assurance

- Provide reasonable assurance that the MCOs are compliant with the terms and provisions of the contract; and
- Ensure the SCDHHS carries out its responsibilities and can provide the required federal assurances for Medicaid services delivered through a managed care payment model.

Our consideration of SCDHHS monitoring activities was for the limited purposes described above and was not designed to give an opinion on organizational structure, contractual requirements, or information technology (IT) system activities.

In planning and performing our assessment, we interviewed senior managers from the SCDHHS Deputy Director Office of Health Services to get their overall strategy and perspectives on the managed care program, and to gain an understanding of the processes and procedures they utilize to monitor MCO compliance with regulatory and contractual requirements. We also reviewed the new contract that will be used for the managed care program starting July 2014.

In addition to our discussions with SCDHHS senior managers, we reviewed the following sources of information to form the basis for our conclusions:

- Federal regulations relevant to managed care as well as quality assessment and performance improvement;
- Current SCDHHS MCO contractual documents and Policy and Procedure Guide;
- Most recent Comprehensive Technical Report (CTR) prepared by the Carolinas Center for Medical Excellence (CCME);
- Guidelines from the Centers for Medicare and Medicaid Services (CMS); and
- Best practices from two state Medicaid agencies, Arizona and Tennessee, with long-time experience in managed care.

### **Overall Conclusion**

In general, we found that the Agency does not yet have strategic planning, staffing or processes in place to monitor the performance of the MCOs in a comprehensive and effective manner. To some extent, this could not be implemented until the new contract was at least drafted. The new contract sets much higher levels for performance standards and requirements for the managed care plans than the former contract, and therefore successful management of MCO performance under the new contract will call for a greatly expanded SCDHHS monitoring capacity. The Agency should use the new contractual requirements as a guide for how it will develop this capacity. While the Agency started the contract design and development process in 2012 [and continued throughout 2013 and 2014], a complete draft was not finalized and submitted for comments until May 8, 2014. However, the Agency should have been using the past 12 months to develop a written strategic plan for how it would ramp up monitoring capacity to provide an effective level of oversight in a managed care environment.

There has been some progress:

- The Agency has reorganized and merged the former bureaus of Health Services (which involved only fee-for-service) and Care Management (which was managed care) to one integrated department for all medical services regardless of service delivery system.
- There are major projects underway involving the replacement MMIS and use of encounter data, such as the development of a national standardized encounter reporting format.
- The Division of Program Integrity has developed new policies and procedures and hired/re-trained staff to coordinate with the managed care plans on provider fraud and abuse referrals and cases.

However, we could not identify any strategic plan or project specifically directed at developing an integrated, cohesive system for MCO oversight and that would show the levels of staffing and other resources needed and how the different divisions of the Agency would work together.

Our assessment also noted other significant deficiencies in SCDHHS' current oversight of the MCOs that put the Agency at risk for non-compliance with federal requirements. These should be addressed as soon as possible and also be part of a comprehensive strategy:

- No comprehensive written quality strategy exists that meets the requirements in 42 CFR 438.202;
- No ongoing process to monitor claims to immediately identify fee-for-service payments made in error for services provided to MCO members; and
- Deficiencies reported in the Comprehensive Technical Review are not routinely monitored for remediation and corrective action plans are rarely requested.

We wish to express our appreciation to the Office of Health Services staff for their assistance in completing this review. If you have any questions concerning the information contained in this management letter, please contact me at (803) 898-1050.

cc: Byron Roberts, General Counsel  
Nathaniel Patterson, Director, Health Services  
Bryan Amick, Program Director, Clinical Quality & Population Health  
Stephen Boucher, Program Manager, Health Services

# Index of Attachments

*Comments related to significant deficiencies in SCDHHS oversight of the MCOs and other areas of concern are included in the following attachments and are labelled Attachment A.*

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**OBSERVATIONS****Developing a Strategic Plan for MCO Monitoring**

Federal regulations<sup>4</sup> require state Medicaid agencies to have in effect processes for monitoring the MCOs' compliance with contract provisions. Although monitoring the MCOs is a requirement of the federal regulations, CMS allows state Medicaid agencies to develop their own contract monitoring processes.

We found that SCDHHS has no formal process in place to monitor the South Carolina MCOs for compliance with contract deliverables. There also is no indication that formal, written contract monitoring procedures for the managed care program have ever been developed.

Moreover, we could not identify any strategic plan or project specifically directed at developing an integrated, cohesive system for MCO oversight. While a formal, strategic planning process may not be feasible at this point, in our opinion the Agency will not be able to make the changes needed without a written plan of some sort. A strategic plan for MCO monitoring and oversight could ensure that SCDHHS addresses and develops the following components:

- Provisions for dedicated MCO monitors and/or a monitoring unit separate and independent from day-to-day operations staff;
- Clear designation of job responsibilities and lines of authority for this unit;
- The number and types of new staff needed and the development of job descriptions;
- Timelines for hiring and training the new staff needed;
- Policies and procedures for applying corrective action plans and liquidated damages when MCO non-compliance is identified;
- Processes for tracking and validating the accuracy and completeness of the management reports the MCOs are required to submit;
- Provisions for cross-agency monitoring teams to oversee certain aspects of the MCO contract, such as TPL and Program Integrity;
- Coordination between MCO program monitors and MCO operations, management information systems, the quality contractor, and financial administration;
- Determining external resources needed as part of a robust system of monitoring and oversight.

One approach to providing oversight of the MCOs in a comprehensive manner would be to implement management teams aligned with the critical functional areas of the contract, with program monitors embedded in each team. This would allow monitors to gain the understanding and subject matter expertise needed to be able to oversee such a complex program. For example, five teams could form the core of the Agency's management efforts:

1. Quality Assurance and Encounter Data Validation & Analytics
2. Financial Management and Ratemaking
3. Clinical Policy and Plan Coverage
4. Member Outreach, Marketing and Network Sufficiency

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<sup>4</sup> 42 CFR § 438.66(e)

## 5. Grievances, Fraud and Abuse

While the MCO program monitors would work alongside Health Services operations and policy staff in the programmatic areas listed above, they would report to the program manager who directly reports to the deputy director. A strategic monitoring plan would need to provide for both clear reporting lines and intensive training for monitors. While SCDHHS has a diverse and knowledgeable workforce, few employees have direct experience or training in monitoring managed care. Research shows, however, that a well-trained staff is necessary to support a comprehensive monitoring and oversight program. In fact, many states that have adopted a managed care health delivery system have reported that they had to work with and re-train staff from their traditional Medicaid programs, who usually lacked monitoring experience.<sup>5</sup>

According to Tennessee's Medicaid agency, TennCare, new skillsets are required of staff as state Medicaid agencies shift from fee-for-service (FFS) to managed care – staff are required to function more as regulators in addition to policy and program managers. Automated systems for tracking deliverables are also recommended.<sup>6</sup>

Additionally, according to Arizona's Medicaid agency, Arizona Health Care Cost Containment System (AHCCCS), the most critical component of successful managed care oversight is teamwork. For example, AHCCCS asserts that quality must be integrated and should not just be a quality management team function. AHCCCS recommends multi-division internal meetings to keep lines of communication open, and stresses the importance of information sharing between divisions.<sup>7</sup>

In one sense, MCO monitors would bridge the gap between the day-to-day operations of the account reps and the management staff in the Office of Health Services. Therefore, the role and function of MCO monitoring would:

- Be ongoing, real-time;
- Include daily/weekly/monthly monitoring of the performance measures called for in the contract;
- Include a process for regular communication with SCDHHS staff to ensure receipt of deliverables;
- Include a review of deliverable quality when needed;
- Help ensure the MCOs are following their own quality assurance plans;
- Provide continuous financial monitoring to ensure payment accuracy and that program owners are appropriately monitoring budget lines;
- Conduct problem solving with MCOs and SCDHHS program and operations staff to prevent bigger issues with compliance and deliverables;
- Ensure and/or conduct ongoing tests to evaluate the completeness, accuracy and reliability of data produced through the contract and/or reported by the MCO.

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<sup>5</sup> Wooldridge, M.A. and Hoag, S. Perils of Pioneering: Monitoring Medicaid Managed Care. Health Care Financing Review. Volume 22, Number 2, Winter 2000

<sup>6</sup> TennCare PowerPoint presentation to SCDHHS. January 2014.

<sup>7</sup> Arizona Presentation at the PI Partnership in Managed Care Symposium, Columbia, SC. March 2014

Another key aspect of managed care oversight and monitoring is more direct access to payment and claims data from the MCOs' claims processing systems. We found that Medicaid managed care data cannot be directly or easily accessed by SCDHHS staff. Although much of the information needed can be obtained through system-generated reports by the MCOs, SCDHHS does not have the ability to review claims data or independently validate report contents. A MCO monitoring plan should anticipate and develop a process for obtaining the information needed for real-time monitoring of the Plans' activities and performance.

Further, in line with best practices, SCDHHS will also need to better coordinate the monitoring efforts of the program with other functional areas of the Agency, such as Fiscal, Budgets, Program Integrity, Audits, TPL, etc., and with external parties, such as the Agency's contracted actuarial service provider. Individuals in other parts of the Agency could be assigned to each team to meet regularly and share information on issues, concerns, and policy.

At this point the first priority will be getting enough staff on board to conduct the oversight needed. Currently, the managed care program is under the SCDHHS Deputy Director Office of Health Services which is responsible for setting clinical policy; developing State Plan Amendments (SPAs); oversight of contracts (including managed care contracts) related to the provision of healthcare services; quality and utilization management; health innovations; the dual-eligible demonstration project; and health programs, which includes the day-to-day operations for the managed care program.

However, we could identify only 8 staff directly responsible for both the day-to-day management and monitoring/oversight of the delivery of health benefits by the MCOs and for monitoring MCO contract compliance;<sup>8</sup> these staff have other job duties as well. This number of staff has not been enough to adequately monitor the MCOs' compliance with the provisions in the former contract, and clearly will be inadequate to manage the program going forward under the new contract. For example, the new contract includes requirements for enhanced management reporting, new pay-for-performance and performance improvement standards, and weekly encounter data submissions. With the current levels of staffing in the department, it is doubtful that even half of the reports required to be submitted could be assimilated, read, and used to identify problems and take action.

Furthermore, in order to implement the new contract, these same staff are tasked with writing the corresponding Managed Care Policy & Procedures Guidelines, as well as the reports companion guide and technical requirements for the submission of encounters and other data.

Arizona Medicaid has one of the largest staff to Medicaid member ratios<sup>9</sup> of any state Medicaid agency, with 80 FTEs in the Division of Health Care Management—the division responsible for monitoring Arizona's managed care program.<sup>10</sup>

Employees in Arizona's Division of Health Care Management lead MCO contract procurement activities, provide plan oversight, review encounter data, conduct financial reporting activities, and perform quality and utilization management reviews.<sup>11</sup> While many states often use outside contractors to monitor their

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<sup>8</sup> This is based on an unofficial organization chart provided to the auditors.

<sup>9</sup> Johnson, Jocelyn. "Managing" Medicaid Managed-Care: A Ten-State Comparison. The Nelson A. Rockefeller Institute of Government, 2002.

<sup>10</sup> Arizona Presentation at the PI Partnership in Managed Care Symposium, Columbia, SC. March 2014

<sup>11</sup> Ibid.

MCOs, Arizona does not – the majority of the monitoring and oversight functions are performed by AHCCCS staff.<sup>12</sup>

In order to ensure that Medicaid members receive quality services, it is vital that SCDHHS establish a well-thought out and adequately staffed process to continuously monitor the MCOs' contract compliance and service quality, and report outcomes to Agency management in a timely manner.

To accomplish this, the Agency will need to hire new staff or retrain a considerable amount of its program staff currently allotted for FFS operations into new roles dedicated to managed care. The monitoring staff should be separate from front-line staff who serve as “account managers” for the individual plans and who are responsible for daily operational activities, responding to questions from the plans, providers, and members, running and/or obtaining reports on the MCO's activities, etc. Lastly, to ensure integrity in data reported by the MCOs, SCDHHS staff should have the ability to independently access the MCOs' claims data and reports. We suggest SCDHHS explore designing and implementing an integrated IT system between the Agency and the MCOs.

## **Addressing Immediate Issues to Improve MCO Oversight**

As noted, our assessment also identified other significant deficiencies in SCDHHS' current oversight of the MCOs; these should be addressed as soon as possible and also be a part of a comprehensive management strategy. Failure to address these issues puts the Agency at risk of non-compliance with some of the federal requirements established in 42 CFR 438. Our findings and recommendations are detailed on the following pages.

## **No State Quality Strategy Exists**

A State Quality Strategy is a detailed framework that serves as a critical tool in guiding state quality improvement programs. States that utilize MCOs for providing Medicaid services must specify how the state will measure and improve the quality of care provided in its State Quality Strategy. Per federal rules, states must have an up-to-date Quality Strategy on file with CMS to be compliant:<sup>13</sup>

*In accordance with federal regulations,<sup>14</sup> all states contracting with an MCO must have a written quality strategy that, at a minimum, includes:*

- 1. Procedures that assess the quality and appropriateness of care and services;*
- 2. Procedures that identify race, ethnicity, and primary language spoken;*
- 3. Procedures that regularly monitor and evaluate MCO compliance with the standards;*

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<sup>12</sup> Johnson, Jocelyn. “Managing” Medicaid Managed-Care: A Ten-State Comparison. The Nelson A. Rockefeller Institute of Government, 2002.

<sup>13</sup> NCQA. Medicaid Managed Care Quality Benchmarking Project: Final Report. August 2010.

<sup>14</sup> 42 CFR § 438.202(a) and § 438.204

4. *Arrangements for annual, external independent reviews of quality, timeliness, and access;*
5. *For MCOs, appropriate use of intermediate sanctions;*
6. *An information system that supports operation and review of the state's quality strategy; and*
7. *Standards for access to care, structure and operations, and quality measurement and improvement.*

We found that SCDHHS does not have a State Quality Strategy that meets all of the conditions listed above, however, through its contract with the University of South Carolina's Institute for Families in Societies (IFS) and its external quality review organization, CCME, the Agency has some elements of the Quality Strategy already in place.

IFS, on behalf of SCDHHS, conducts data analysis, and program and outcome evaluations to address access to care, quality, and reporting related to geographical "hot spots" to identify health disparities. The work conducted by IFS addresses some components of the federal regulations but not all. For example, IFS issues quarterly and annual reports to SCDHHS that link all HEDIS, CMS Adult, and Child quality measures for all Medicaid members which may satisfy the requirements of item number 2 and item number 7 in the above listing.

Further, the work performed by CCME may satisfy the requirements of item number 3 and item number 4 in the above listing; the terms and provisions in the new MCO contract may satisfy item number 5.

While SCDHHS does rely on IFS and CCME to measure quality of care and access to services, the work performed by these entities does not satisfy the requirement for the state to specify how it will measure and improve quality of care in one comprehensive written [quality] strategy.

Although a "Managed Care Quality Program Plan" was developed by the SCDHHS Division of Managed Care in 2010, this document neither complies with the CMS requirements of the State Quality Strategy nor has it been approved or implemented.

To ensure the successful achievement of the Agency's goal to obtain the NCQA rating of excellence for MCO plans, it is imperative that SCDHHS begin work immediately in the development of its State Quality Strategy and forward an initial strategy to CMS by the end of FY 2015.

The process can be quite lengthy and tedious; some states (e.g. Florida<sup>15</sup>) took more than a year to develop its strategy, from inception to the final version. To facilitate the successful development of the Agency's Quality Strategy, the SCDHHS Project Management Office should have an involved role, as well as Medicaid members, other stakeholders, and Agency staff familiar with managed care contractual and programmatic activities. Further, per federal rules, the SCDHHS should ensure that the initial strategy is available for public comments before it is adopted as final.

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<sup>15</sup> Florida Medicaid. Quality Assessment and Improvement Strategies: Initial Strategy. [http://www.fdhc.state.fl.us/medicaid/quality\\_mc/pdfs/fl\\_medicaid\\_quality\\_assess\\_improve\\_strategies.pdf](http://www.fdhc.state.fl.us/medicaid/quality_mc/pdfs/fl_medicaid_quality_assess_improve_strategies.pdf).

This plan would also incorporate the new contractual requirements for value-based purchasing and performance improvement, as well as the measures for MCO withholds and incentives for quality improvement.

As a guide, CMS has created a worksheet for states to use in the development and assessment of their Quality Strategy. The “Quality Strategy Toolkit for States” is a recommended flow of key elements that must be incorporated in the Quality Strategy. We believe SCDHHS may find it helpful to use the Quality Strategy Toolkit in developing the South Carolina State Quality Strategy. A copy of the toolkit is included as Attachment B of this management letter.

### **Insufficient Monitoring to Prevent Duplicate FFS Payments**

Federal rules found at 42 CFR 438.60 require that the “State agency must ensure that no payment is made to a provider other than the MCO, PIHP, or PAHP for services available under the contract between the State and the MCO, PIHP, or PAHP, except when these payments are provided for in Title XIX of the Act, in 42 CFR, or when the State agency has adjusted the capitation rates paid under the contract...to make payments for graduate medical education.”

However, we have identified numerous instances when SCDHHS made FFS payments to providers on behalf of members enrolled in and for medical care covered by a managed care plan. The circumstances for these errors vary; however, a common theme is that often such duplicate payments cannot be automatically blocked or prevented, as the current legacy MMIS does not always incorporate sufficient management controls, such as claims edits, to identify and deny payment for duplicate FFS claims. Further, the Agency does not have sufficient staff in place to monitor claims and managed care enrollment reports or intervene when a duplicate payment occurs.

For example, audits and reviews have found the following:

- **Duplicate fee-for-service claims paid for newborns who were retroactively covered under the mother’s managed care plan.** While this situation has largely been corrected through Agency efforts to make sure the newborn is “deemed” within a very short period of time, it still occurs occasionally. Because the baby is eligible for Medicaid from the day of birth, there will always be a potential for duplicate payments since some services will be provided before the baby’s MCO membership shows up in the eligibility system. So for some providers, such as a pharmacy which bills at the point of sale, the Agency will pay the fee-for-service claim before the eligibility system can recognize the newborn as covered under an MCO and therefore block the claim.
- **Managed care per-member, per-month (PMPM) claims paid for individuals ineligible for membership in a managed care plan, such as children admitted to a psychiatric residential treatment facility (PRTF).** Once a member is admitted to a PRTF, which is carved out of managed care services, the member should be suspended from managed care enrollment and all services paid as fee-for-service, and no further PMPM payments should be made.
- **The full PMPM paid for individuals who become eligible for Medicare while receiving services through a Medicaid MCO.** For dully eligible beneficiaries, SCDHHS is supposed to pay

a reduced PMPM rate to the managed care plans, which are then supposed to ensure appropriate coordination of benefits with Medicare. However, even more so than the newborns, Medicare eligibility occurs retroactively, sometimes years after a service has been provided and paid. These kinds of overpayments cannot be prevented but should be corrected on a post-payment basis.

- **Failure of the 989 edit in certain circumstances.** The 989 edit works to block / deny fee-for-service payment to a provider for a member enrolled in a managed care plan and for services available under the contract with the MCO. Normally this edit functions well; however, managed care program staff in the Office of Health Services recently identified fee-for-service payments to Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) for clinic services provided to managed care members. (It should be noted that this issue is currently under review, and the extent and cause of the errors has not been verified yet.)

These duplicate payments are estimated to amount to several million dollars in waste annually. While this is a small percentage of the Agency's managed care expenditures, it is waste that could be avoided if the Agency had sufficient staff for continuous payment monitoring. As noted, in situations involving retroactive eligibility, duplicate FFS payments for managed care members cannot be completely avoided through claims edits. However, the Agency should assign staff to review and analyze reports already generated to identify these instances and recover funds appropriately.

### **Deficiencies Reported in the Comprehensive Technical Report are Not Routinely Monitored**

Federal regulations require states with Medicaid managed care plans to regularly monitor and evaluate MCO compliance with the standards of Part 438.<sup>16</sup> Regulations also require an annual external quality review (EQR) of each contracted MCO, usually performed by an External Quality Review Organization (EQRO).<sup>17</sup> Research shows that many state Medicaid agencies play a key role in monitoring and often have overlapping responsibilities with the EQRO in monitoring the MCOs' activities and performance.<sup>18</sup>

In South Carolina, SCDHHS utilizes the EQRO for identifying deficiencies found during the EQR process and for reporting on the status of corrective actions during the next review period. SCDHHS is responsible for obtaining a quality improvement plan for identified deficiencies.<sup>19</sup>

Our interviews with SCDHHS Office of Health Services staff indicated that SCDHHS does not routinely monitor the EQRs for deficiencies, nor are the findings and deficiencies identified in the Comprehensive Technical Report (CTR) independently validated by SCDHHS to ensure that reported information is correct. Health Services staff stated that a lack of sufficient staff limits the Agency's ability to adequately track and monitor deficiencies for remediation. According to Health Services staff, SCDHHS operates primarily as an "intermediary" between the MCOs and the providers by providing insight on MCO policies

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<sup>16</sup> 42 CFR § 438, Subpart E and 42 CFR § 438.354

<sup>17</sup> 42 CFR § 438.310(b)

<sup>18</sup> Wooldridge, M.A. and Hoag, S. Perils of Pioneering: Monitoring Medicaid Managed Care. Health Care Financing Review. Volume 22, Number 2, Winter 2000

<sup>19</sup> NOTE: SCDHHS may request a quality improvement plan for standards scored as less than 'Met' during the EQR process.

and procedures, and claims processing and adjudication. Health Services staff reported that the MCOs govern themselves with little feedback from the Agency.

The results of the 2014 CTR completed by CCME validate that assertion. Our review of the CTR found that three of South Carolina's MCO health plans failed to implement corrective actions or correct deficiencies identified during the review. According to the findings in the CTR, Absolute Total Care and Select Health failed to correct deficiencies related to Utilization Management and Quality Improvement; BlueChoice failed to correct deficiencies involving credentialing or recredentialing nurse practitioners. Interviews with Health Services staff indicated that SCDHHS did not follow up on these deficiencies, require a corrective action plan (CAP) or assess liquidated damages even though CCME reported the findings.

Although South Carolina's MCO contracts include language for imposing CAPs and assessing liquidated damages, our review found that SCDHHS does not have a process to follow in the event the Agency finds the MCO plans to be non-compliant with program or performance standards, or the terms and conditions of their contract. For example, SCDHHS does not have written procedures on how to monitor CAPs for remediation, how to determine when liquidated damages should be assessed, or even how to make sure the damages are collected and reported.

Some states provide for a more involved role in monitoring the plans for deficiencies. For example, Arizona performs quality review functions internally and requires plans to submit a corrective action plan for all standards that were not in "Full Compliance". Arizona also provides extensive technical assistance to guide the development of the corrective action plans. Further, Arizona conducts bi-annual site visits to the plans and facilitates peer groups to discuss quality outcomes and areas of concern.<sup>20</sup>

Similarly, Tennessee requires all of its MCOs to submit a variety of reports to various divisions in the agency both quarterly and annually. Each report is reviewed by staff and a CAP is required for any report deemed deficient. Tennessee may assess a liquidated damage for deficient reports. Also, Tennessee's Division of Quality Oversight and Behavioral Health Unit conduct periodic site visits to learn about and monitor various aspects of the MCOs' activities. Lastly, Tennessee has developed a variety of surveys to identify issues of interest and/or areas of improvement.<sup>21</sup>

We believe that SCDHHS can improve its monitoring processes to include a more active role in monitoring the MCOs' corrective actions included in the CTR. Specifically, SCDHHS should develop procedures for routine review of deficiencies reported in the CTR. A corrective action plan should be required for all deficiencies identified, and follow up activities performed to ensure that action has been taken. Liquidated damages should be assessed if appropriate action has not been taken. Additionally, SCDHHS should ensure that deficiencies identified in the CTR are accurate by comparing the results of the specific HEDIS measure against the standards.

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<sup>20</sup> Arizona Presentation at the PI Partnership in Managed Care Symposium, Columbia, SC. March 2014

<sup>21</sup> Bureau of TennCare 2013 Quality Strategy.

<http://www.tn.gov/tenncare/forms/QualityStrategy2013FinalDraft.pdf>. Accessed April 17, 2014

## **ATTACHMENT A**

We believe that improving this process will enforce the Agency's performance expectations, provide valuable feedback to Agency management, and clearly delineate year-to-year improvement or deficiencies in plan performance.

Quality Strategy Toolkit for States

QUALITY STRATEGY TOOLKIT FOR STATES

Per 42 C.F.R. § 438.202(a), each state contracting with a Managed Care Organization (MCO) or Prepaid Inpatient Health Plan (PIHP) must have a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The following provides a worksheet for states to use in the development and assessment of their quality strategy.

Instructions: Below is a recommended flow of key elements to incorporate in your state's quality strategy. Any time there is a citation under the "regulatory reference" column, this indicates that the item is a regulatory requirement and states must include information associated with that item in the quality strategy. If there is no citation under the "regulatory reference" column, this indicates that the item is not a regulatory requirement, but instead, is a component that CMS strongly recommends states address in the quality strategy. The inclusion of these optional components will maximize your state's ability to properly frame and then subsequently measure the effectiveness of your state's quality strategy.

SECTION I: INTRODUCTION

Managed Care Goals, Objectives and Overview

This section should provide a brief description of managed care in the state, as well as the goals, guiding principles, and objectives of the managed care program.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	Include a brief history of the state's Medicaid (and CHIP, if applicable) managed care programs.	
	Include an overview of the quality management structure that is in place at the state level.  For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, etc.?	
	Include general information about the state's decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	

Quality Strategy Toolkit for States

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	<p>Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts.</p> <p>For example, "the state will demonstrate a 10 percent improvement in childhood immunization rates over the next three years" or "through expansion of the primary care network, as evidenced by geographical reporting, the state will demonstrate a 5 percent improvement in enrollee access to primary care".</p>	

Development & Review of Quality Strategy

This section should describe how the state initially developed the quality strategy, subsequently reviews the quality strategy for effectiveness, and the timeline/process for revision of the quality strategy.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.202(b)	<p>Include a description of the formal process used to develop the quality strategy. This must include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.</p>	
§438.202(b)	<p>Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.</p>	
§438.202(d)	<p>Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).</p>	
§438.202(d)	<p>Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant changes", include the state's definition of "significant changes".</p>	

Quality Strategy Toolkit for States

SECTION II: ASSESSMENT

Quality and Appropriateness of Care

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(b)(1)	Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO and PHP contracts, and to individuals with special health care needs. This must include the state's definition of special health care needs.	
§438.204(b)(2)	Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid enrollee.  States must provide this information to the MCO and PHP for each Medicaid enrollee at the time of enrollment  Document any efforts or initiatives that the state or MCO/PHP has engaged in to reduce disparities in health care.	

National Performance Measures

At this time, CMS has not identified any required national performance measures. However, CMS has developed a voluntary set of core performance measures for children and adults in Medicaid and CHIP. Many of these measures have already been in widespread use as part of the HEDIS® data set and have readily available national and regional benchmarks. For a list of these measures, refer to <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care---Performance-Measurement.html>.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(c)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.  Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP.	
	If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.	

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Monitoring and Compliance

This section must include methods and procedures the state will use to monitor MCO/PIHP compliance with Federal regulations.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(b)(3)	<p>Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards).</p> <p>Some examples of mechanisms that may be used for monitoring include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Member or provider surveys;</li> <li>• HEDIS® results;</li> <li>• Report Cards or profiles;</li> <li>• Required MCO/PIHP reporting of performance measures;</li> <li>• Required MCO/PIHP reporting on performance improvement projects;</li> <li>• Grievance/Appeal logs, etc.</li> </ul>	

External Quality Review (EQR)

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(d)	<p>Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract.</p> <p>Identify what entity will perform the EQR and for what period of time.</p> <p>Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform.</p> <p>The five optional activities include:</p> <ol style="list-style-type: none"> <li>1. Validation of encounter data reported by an MCO or PIHP;</li> <li>2. Administration or validation of consumer or provider surveys of quality of care;</li> <li>3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO;</li> </ol>	

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	<ol style="list-style-type: none"> <li>4. Conduct of performance improvement projects (PIPs) in addition to those conducted by an MCO or PHP and validated by an EQRO; and</li> <li>5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.</li> </ol>	
§438.360(b)(4)	If applicable, identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 C.F.R. §438.204(g).	
§438.360(c)(4)	If applicable, for MCOs or PHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication option under §438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §§ 438.358(b)(1) and (b)(2).	

SECTION III: STATE STANDARDS

Access Standards

This section should include a discussion of the standards that the state has established in the MCO/PHP contracts for access to care, as required by 42 C.F.R. Part 438, subpart D. These standards should relate to the overall goals and objectives listed in the quality strategy's introduction. States may either reference the access to care provisions from the state's managed care contracts or provide a summary description of the contract provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.206		
§438.206(b)(1)	Availability of Services	
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	
§438.206(b)(2)	Female enrollees have direct access to a women's health specialist	
§438.206(b)(3)	Provides for a second opinion from a qualified health care professional	
§438.206(b)(4)	Adequately and timely coverage of services not available in network	
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PPHP with respect to payment	
§438.206(b)(6)	Credential all providers as required by §438.214	
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service	
§438.206(c)(1)(iii)	Services included in the contract are available 24 hours a day, 7 days a week	

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Regulatory Reference	DESCRIPTION	Page Reference or Comment
\$438.206(c)(1)	Mechanisms/monitoring to ensure compliance by providers	
\$438.206(c)(2)	Culturally competent services to all enrollees	
\$ 438.207	Assurances of Adequate Capacity and Services	
\$438.207(a)	Assurances and documentation of capacity to serve expected enrollment	
\$438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	
\$438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	
\$ 438.208	Coordination and Continuity of Care	
\$438.208(b)(1)	Each enrollee has an ongoing source of primary care appropriate to his or her needs	
\$438.208(b)(2)	All services that the enrollee receives are coordinated with the services the enrollee receives from any other MCO/PIHP	
\$438.208(b)(3)	Share with other MCOs, PIHPs, and PAHPs serving the enrollee with special health care needs the results of its identification and assessment to prevent duplication of services	
\$438.208(b)(4)	Protect enrollee privacy when coordinating care	
\$438.208(c)(1)	State mechanisms to identify persons with special health care needs	
\$438.208(c)(2)	Mechanisms to assess enrollees with special health care needs by appropriate health care professionals	
\$438.208(c)(3)	If applicable, treatment plans developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee; approved in a timely manner; and in accord with applicable state standards	
\$438.208(c)(4)	Direct access to specialists for enrollees with special health care needs	
\$ 438.210	Coverage and Authorization of Services	
\$438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	
\$438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	
\$438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	
\$438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	
\$438.210(a)(3)(iii)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	
\$438.210(a)(4)	Specify what constitutes "medically necessary services"	
\$438.210(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	
\$438.210(b)(2)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	
\$438.210(b)(3)	Any decision to deny or reduce services is made by an appropriate health care professional	

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Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.210(c)	Each MCO/PIHP must notify the requesting provider, and give the enrollee written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	
§438.210(e)	Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	

Structure and Operations Standards

This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for structure and operations, as required by 42 C.F.R. Part 438, subpart D. These standards should relate to the overall objectives listed in the quality strategy's introduction. States may either reference the structure and operations provisions from the state's managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.214	Provider Selection	
§438.214(a)	Written policies and procedures for selection and retention of providers	
§438.214(b)(1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	
§438.214(b)(2)	Documented process for credentialing and recredentialing that each MCO/PIHP must follow	
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	
§438.218	Enrollee Information	
§438.218	Incorporate the requirements of §438.10	
§438.224	Confidentiality	
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	
§438.226	Enrollment and Disenrollment	
§438.226	Each MCO/PIHP complies with the enrollment and disenrollment requirements and limitations in §438.56	

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\$438.228	Grievance Systems	
\$438.228(a)	Grievance system meets the requirements of Part 438, subpart F	
\$438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of enrollees in a timely manner	
\$438.230	Subcontractual Relationships and Delegation	
\$438.230(a)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	
\$438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	
\$438.230(b)(2)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate	
\$438.230(b)(3)	Monitoring of subcontractor performance on an ongoing basis	
\$438.230(b)(4)	Corrective action for identified deficiencies or areas for improvement	

Measurement and Improvement Standards

This section should include a discussion of the standards that the state has established in the MCO/PIHP contracts for measurement and improvement, as required by 42 C.F.R. Part 438, subpart D. These standards should relate to the overall objectives listed in the quality strategy's introduction. States may either reference the measurement and improvement provisions from the state's managed care contracts, or provide a summary description of such provisions. CMS recommends states minimize reference to contract language in the quality strategy. However, if the state chooses the latter option, the summary description must be sufficiently detailed to offer a clear picture of the specific contract provisions and be written in language that may be understood by stakeholders who are interested in providing input as part of the public comment process.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
\$ 438.236	Practice Guidelines	
\$438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of enrollees; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	
\$438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to enrollees	
\$ 438.240	Quality Assessment and Performance Improvement Program	
\$438.240(a)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	
\$438.240(b)(1) &	Each MCO and PIHP must conduct PIPs and measure and report to the state its performance	
\$438.240(d)	List out PIPs in the quality strategy	

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§438.240(b)(2) &	Each MCO and PIHP must measure and report performance measurement data as specified by the state	
§438.240(c)	List out performance measures in the quality strategy	
§438.240(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	
§438.240(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs	
§438.240(e)	Annual review by the state of each quality assessment and performance improvement program	
	If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.	
§ 438.242	Health Information Systems	
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and provide information on areas including, but not limited to, utilization, grievances and appeals, and disenrollments for other than loss of Medicaid eligibility	
§438.242(b)(1)	Each MCO and PIHP must collect data on enrollee and provider characteristics and on services furnished to enrollees	
§438.242(b)(2)	Each MCO and PIHP must ensure data received is accurate and complete	

SECTION IV: IMPROVEMENT and INTERVENTIONS

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	<p>Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to:</p> <ul style="list-style-type: none"> <li>• Cross-state agency collaborative;</li> <li>• Pay-for-performance or value-based purchasing initiatives;</li> <li>• Accreditation requirements;</li> <li>• Grants;</li> <li>• Disease management programs;</li> <li>• Changes in benefits for enrollees;</li> <li>• Provider network expansion, etc.</li> </ul>	

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Regulatory Reference	DESCRIPTION	Page Reference or Comment
	Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	

Intermediate Sanctions

Regulatory Reference	DESCRIPTION	Page Reference or Comment
§438.204(e)	For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I.	
	Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	

Health Information Technology

Regulatory Reference	DESCRIPTION	Page Reference or Comment
438.204(f)	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.	
	Describe any innovative health information technology (HIT) initiatives that will support the objectives of the state's quality strategy and ensure the state is progressing toward its stated goals.	

SECTION V: DELIVERY SYSTEM REFORMS

This section should be completed by states that have recently implemented or are planning to implement delivery system reforms. Examples of such delivery system reforms include, but are not limited to, the incorporation of the following services and/or populations into a managed care delivery

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system; aged, blind, and disabled population; long-term services and supports; dental services; behavioral health; substance abuse services; children with special health care needs; foster care children; or dual eligibles.

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying enrollees in this population.	
	List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.	
	List any performance improvement projects that are tailored to this population/service. This should include a description of the interventions associated with the performance improvement projects.	
	Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.	

SECTION VI: CONCLUSIONS and OPPORTUNITIES

Regulatory Reference	DESCRIPTION	Page Reference or Comment
	Identify any successes that the state considers to be best or promising practices.	
	Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	
	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.	
	Include recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care enrollees, if applicable.	

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State Quality Strategy Reference Library

The following provides examples of potential sources of information that states may find helpful in developing the state quality strategy.

State Sources of Information	CMS/Federal Sources of Information
<ul style="list-style-type: none"> <li>• State-specific Medicaid statutes and regulations, if applicable</li> <li>• Medicaid Management Information Systems (MMIS) data</li> <li>• External Quality Review Technical Reports</li> <li>• State MCO Report Cards</li> <li>• Pay-for-Performance Program Results</li> <li>• Results from Performance Measurement or other Quality Reporting Efforts</li> <li>• Encounter Data</li> <li>• Results of NCOA accreditation reviews</li> <li>• Enrollee and Provider Survey results</li> <li>• Grievance and Appeals reporting</li> <li>• Focused Studies</li> <li>• Contract Compliance reviews</li> <li>• Regional or multi-state Health Information Technology Collaborative</li> <li>• Readiness Reviews</li> <li>• Telemedicine Initiatives</li> <li>• Cross-state Agency Collaborative</li> </ul>	<ul style="list-style-type: none"> <li>• Balanced Budget Act of 1997 and implementing regulations</li> <li>• External Quality Review Protocols, available at: <a href="http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html">http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html</a></li> <li>• CMS Core Set of Child and Adult Performance Measures, available at: <a href="http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care—Performance-Measurement.html">http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care—Performance-Measurement.html</a></li> <li>• Annual Report on the Quality of Care for Children in Medicaid and CHIP, available at: <a href="http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html">http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care.html</a></li> <li>• National Strategy for Quality Improvement in Health Care, available at: <a href="http://www.healthcare.gov/law/resources/reports/quality03212011a.html">http://www.healthcare.gov/law/resources/reports/quality03212011a.html</a></li> <li>• HHS Action Plan to Reduce Racial and Ethnic Disparities, available at: <a href="http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf">http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf</a></li> </ul>

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