DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers / Hamilton	5/13/09

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER J0u538	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Ms. Forkner Wells Cleared 4/16/09, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 5/22/09
	[ ] FOIA DATE DUE _____
	[ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

PALMETTO HEALTH

May 7, 2009

Ms. Emma Forkner, Director
DHHS – Medicaid
1801 Main Street, 11th Floor
Columbia, SC 29201

Dear Emma:

I am writing to address my continued concerns with the SC Department of Health and Human Services' approval of certain MCOs that have seriously inadequate networks to provide services in various portions of the state. In central South Carolina, Palmetto Health operates the only Children's Hospital and its related pediatric specialists and sub specialists, level one trauma center, regional perinatal level III nursery and high risk OB program. As a result, MCO's that do not contract with Palmetto Health can not provide all necessary services within their network and have patients in reasonable proximity to care.

Palmetto Health successfully contracted with five of the seven approved HMOs in our service area with all five agreeing to the same basic terms. Knowing the program was transitioning, we have served patients of non-contracted and contracted plans for the past 18 months, while pursuing contracts with the two uncontracted HMOs. We offer nothing more or less than the same terms agreed to by the other plans.

Under the current system, non-contracted plans are at an advantage over the contracted plans because they are allowed to pay rates that are below the other HMOs. In addition, all services provided to patients in non-contracted plans must be authorized before services are provided, placing a further administrative burden on hospitals and the physicians who are expecting treatment for their patients. These medical and administrative issues are not easily resolved without the formal relationship a contract provides. This situation is unreasonable and can no longer be tolerated.

Our concerns have been elevated by the recent transfer of Amerigroup members, a contracted HMO, to Absolute Total Care (ATC), a non-contracted HMO. We had hoped that the Amerigroup agreement would be assigned to ATC. Since this did not happen, we are "out of network" for an even larger population of patients.

Fundamentally, HMOs should provide the vast majority of care to their members with contracted providers. In the Midlands, that is simply not possible without contracting with Palmetto Health. During the month of March alone, we had 34 inpatient admissions and 358 outpatient services provided to members of Absolute Total Care. Additionally, we had 26 inpatient admissions and 162 outpatient services provided to members of Blue

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Choice Medicaid. It is not reasonable to expect patients in any of these plans to travel a significant distance to receive medically necessary services when the closest appropriate level of care may be across the state where none of their physicians practice.

Medicaid managed care has been in place for almost two years and the issue of state approved HMOs having inadequate networks has not been addressed. Therefore, Palmetto Health is in the extremely unfortunate position to begin refusing access to Medicaid beneficiaries having coverage with non-contracting HMOs effective June 1, 2009. Emma, this is causing stress on our management and physicians as it represents an extreme departure from our mission and culture.

It is our understanding the SCDHHS was to be monitoring its' approved HMOs and producing report cards. I expect these report cards would include the out of network utilization for each plan, whether the plans are meeting the prompt pay guidelines, and the denial rates for in and out of network hospitals. I am requesting a copy of these report cards for all state approved HMOs.

In conclusion, for all the reasons I have outlined, I would ask that plans that do not contract with safety net hospitals like Palmetto Health no longer be approved, or minimally not be included in the auto assignment or reassignment process in the safety net hospital's geographic survey area. I would be happy to discuss my concerns with you in more detail in person or by phone at (803) 296-2106. Thank you for your attention to this important issue.

Sincerely,

Paul K. Duane
Executive Vice President
And Chief Financial Officer

PKD/psf

Log #638

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

June 16, 2009

Mr. Paul K. Duane
Executive Vice President and Chief Financial Officer
Palmetto Health
Post Office Box 2266
Columbia, South Carolina 29202-2266

Dear Mr. Duane:

Thank you for articulating your concerns regarding the state of Medicaid managed care and its effects on Palmetto Health and the other health service centers associated with the hospital. We are researching the issues you described and determining the necessary steps that may be needed to ensure that services are available and provided to beneficiaries who are enrolled in each plan.

We appreciate that you have contracted with many of the Medicaid managed care plans. We understand also that you have reached a temporary agreement with Absolute Total Care so that their members can be served at your facility. We thank you for this. We will continue to monitor the completeness of networks.

Also, we are developing the Report Card that will be used by the state to rate each plan. We are close to having it completed and would welcome your input on the format once we are a little further along. I will ask Roy Hess, Division Director of Care Management, to share this document with you in the near future.

We are focusing a great deal of attention on quality of service delivery of the plans and will be monitoring very closely the referral patterns, use of out of network providers, and payment patterns for each plan. In addition, we are requiring each plan to be accredited by the National Centers for Quality Assurance by 2011, but this does take two-three years as the accreditation process is lengthy.

Again, I appreciate your taking the time to write. If we need to discuss further, I will be pleased to meet with you at your convenience. Thank you for your ongoing support of the South Carolina Medicaid program.

Sincerely,

Felicity Myers, Ph.D.
Deputy Director

FM/hm

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