DEPARTMENT OF HEALTH AND HUMAN SERVICES
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Giese | 7-25-11 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
|---|---|
| 1. LOG NUMBER 10:648 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR<br>Cleared 8/10/11, letter attached. | [X] Prepare reply for appropriate signature<br>DATE DUE 8-1-11<br>[ ] FOIA<br>DATE DUE _____<br>[ ] Necessary Action |

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

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July 19, 2011



Melanie "Bz" Giese
Deputy Director, Medical and Managed Care Services
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, SC 29201

VIA Email and Regular Mail

Dear Bz,

Thank you for your time over the past few days to discuss Absolute Total Care's ("ATC") network adequacy submissions for the following counties: Cherokee, Greenville, Laurens, Pickens, Spartanburg and Union. Network adequacy submissions ("Submissions") were provided in connection with ATC's impending termination with Regional Health Plus. ATC provided both hard-copy and electronic Submissions for each county's provider network (with RHP providers removed) to SCDHHS on July 7, 2011. These Submissions are provided in accordance with the Network Termination/Transition Process project plan as outlined in Section 13 of the current MCO P&P guide.

I understand you will be receiving staff recommendations on the 20th related to the approval of ATC's Submissions. In addition, a meeting is scheduled between ATC and SCDHHS on the 21st to review the decisions around network adequacy for the six counties. In anticipation of these meetings, I wanted to highlight the network adequacy requirements under our contract with DHHS and current MCO P&P Guide that ATC relied upon in developing the Submissions. In addition, there are a few contract/P&P provisions related to the process that I believe are worth noting.

In preparing the Submissions, ATC followed the specific requirements outlined in Sections 2.10 (Provider County Network Approval Process) and 2.11 (Network Provider and Subcontractor Listing Spreadsheet) of the current MCO P&P Guide, attached for your convenience. We also reviewed requirements under Sections 4.12 and 4.13 of our contract with DHHS as adequacy of providers, access, and service standards are considered in these sections of the contract as well. Section 2.10 is applicable to the RHP termination as the first paragraph states:

> *"The following guidelines are used in the review and approval of an MCO's Provider networks. Any changes (terminations/additions) to an MCO's network in any county are evaluated by the Department of Managed Care using the same criteria."*

As we discussed today, the network adequacy criteria outlined in Sections 2.10 and 2.11 are very objective, and include a) specific provider types required (designated as a "1" status) at b) defined proximity guidelines (PCP within 30 miles, Specialist within 50 miles, and Hospital within 50 miles of members' residence). To provide further flexibility, SCDHHS has discretion to make exceptions beyond these criteria under the second to last line in Section 2.11:

> *"SCDHHS considers all the facts and circumstances in reviewing Subcontracts and networks. SCDHHS may grant exceptions to its' stated criteria on a case-by-case basis."*

Paragraph 4 of Section 2.3 of the current MCO P&P Guide also discusses proximity guidelines and SCDHHS discretion to make exceptions:

> *"Services must be accessible as described in the Proximity Guidelines. Generally this is within a thirty (30) mile radius from a Medicaid MCO members' residence for PCPs. Specialty care arrangements must meet normal service patterns as determined by SCDHHS. Exceptions may be made if the travel distance for medical care exceeds the mileage guidelines."*

Due to the close proximity between Greenville and Spartanburg (30 miles or less), normal service patterns for specialty care will include referrals between the two cities in our assessment. Even though ATC satisfies all proximity requirements based on our internal review, it is important to note that this section also provides discretion to SCDHHS to make exceptions beyond the specific mileage criteria.

The Submissions provided by ATC on July 7th satisfy all relevant network adequacy requirements under ATC's contract with SCDHHS and the current MCO P&P guide, as discussed above. We are able to have confidence in this determination as the criteria under the contract and P&P Guide is very objective and the requirements include appropriate discretion for SCDHHS to make exceptions, when necessary. SCDHHS should also find additional comfort in the fact that all current members in these six counties in question will be provided with a 90 day choice period to change plans in the event their network preferences are different than those included in our network after the RHP termination takes effect.

In the event SCDHHS does not approve the Submissions for network adequacy in one or more of the counties in question, we anticipate receiving the response and an opportunity to resubmit for reconsideration under sub-section 5 of Section 2.10 of the P&P guide:

> *"5. If SCDHHS determines that a network is not adequate, the MCO will be notified, in writing (either electronic or paper format), the network is not approved and the specific reasons for that decision. The MCO may resubmit this network for consideration once the reasons for disapproval have been corrected".*

In fairness, ATC should have a reasonable period of time to respond to SCDHHS with revised Submissions in the event there are issues or discrepancies.

I appreciate your support and consideration in this process. If I can provide assistance or further clarification, please do not hesitate to contact me.

Thank you,

Aaron

Aaron W. Brace
President and CEO
Absolute Total Care, Inc.

## 2.10 Provider County Network Approval Process

The following guidelines are used in the review and approval of an MCO's Provider networks. Any changes (terminations/additions) to an MCO's network in any county are evaluated by the Department of Managed Care using the same criteria.

The MCO submits its network listing for a specific county to the Department of Managed Care, requesting approval to commence Medicaid MCO Member Enrollment in that county. The MCO is to follow the Network Provider and Subcontractor Listing Spreadsheet requirements found in the MCO Reports Guide located on the agency Web site – www.scdhhs.gov, along with the Model Attestation Form found at the end of this section. The model attestation must be executed and provided with all new and/ or resubmitted Network Provider and Subcontractor Listing Spreadsheets.

The MCO is responsible for ensuring that all enrolled Providers are eligible to participate in the Medicaid Program. If a Subcontractor is **not** accepting new Medicaid MCO Members, the Subcontractor cannot be listed on the Spreadsheet. Additionally if a PCP or specialist does not have admitting privileges to at least one of the contracted Hospital (s) listed on the Spreadsheet, the MCO must provide a detailed description of the mechanisms that will be used to provide services to Medicaid MCO Members. SCDHHS reserves the right to disapprove any Provider Network submission based on the information provided. The MCO shall check the LEIE and other applicable federal reporting sources to ensure compliance with the MCO contract. (See Contract Section 5)

The MCO shall only submit enrolled Providers who have completed the MCO's contract and have been credentialed by the MCO:

1. Using the Network Provider and Subcontractor Listing Spreadsheet and other appropriate Provider listings, the Department of Managed Care examines the listing for the inclusion & availability of Provider types for the following categories of service: Ancillary, Hospital, Primary Care and Specialists.
2. Network adequacy is determined by SCDHHS and based on the MCO's projected maximum Medicaid MCO Member Enrollment for a specific county, member proximity guidelines to Providers, and historical service patterns.

   There are four (4) different Provider statuses listed on the County Network spreadsheet:

   - Status "1" = Required Provider; Requires an executed contract for a period of no less than one (1) year
   - Status "2" = MCOs are not required to contract with this Provider type (RHC/FQHC) unless this Provider type is in support of network approval.
   - Status "3" = Attestation; MCOs will provide services through any means necessary. While MCOs may attest to status "3" services, a contract is not required when MCO reimbursement is at or above the established

Medicaid fee schedule for the date of service. A contract is required should an MCO choose to compensate at a rate less than the Medicaid fee schedule for the date of service.

- Status "4" = Additional services provided for and reimbursed by the MCO that are not available under Medicaid. Such services must comply with the terms of the Policies and procedures, and contract between SCDHHS and the MCOs. MCOs must have contracts to support all Additional Services. Before an MCO may offer these services, prior approval is required from the SCDHHS.

3. The goal is to ensure the approval of a network that will guarantee appropriate level of access to care for Medicaid MCO Members.
4. If the submitted Provider network is determined not to be adequate by the Department of Managed Care, the submitted Provider network, documentation and reasons for denial of the county by the Department of Managed Care is shared with management at the division, bureau and executive levels.
5. If SCDHHS determines that a network is not adequate, the MCO will be notified, in writing (either electronic or paper format), the network is not approved and the specific reasons for that decision. The MCO may resubmit this network for consideration once the reasons for disapproval have been corrected.
6. If SCDHHS determines the MCO has submitted an adequate network for a county, the Department of Managed Care will approve the network, set the effective date for enrollment and notify the MCO in writing. SCDHHS will also notify the MMIS system to modify the "counties served" indicator in the Provider file to allow Medicaid MCO Member enrollments to be processed. Also, both the enrollment and transportation brokers are informed of the addition of approved counties.

   Upon SCDHHS approval of a network, the MCO must maintain its adequacy and cannot **refuse** to accept new members; change their Medicaid MCO Member assignment formula; or limit member choice of Providers without prior approval by SCDHHS, under penalty of sanctions and/or damages.

   SCDHHS may modify the auto assignment, or Medicaid MCO Member choice processes, at its discretion. If an MCO requests to limit auto-assignment and/or Medicaid MCO Member choice, SCDHHS will re-evaluate the adequacy of the county network. As a result of this review, SCDHHS reserves the right to rescind its approval of the affected county(ies) and institute a transition plan to move the MCO's Medicaid Members to other managed care options. The affected MCO will pay all cost associated with the transition plan.

7. SCDHHS reserves the right to perform a review (on-site or off-site), announced or unannounced. Upon request MCOs are required to provide access to electronic copies of the Provider Subcontracts, including any applicable approved amendments, credentialing, Hold Harmless Agreements and any other documentation SCDHHS deems as necessary for review. Access to requested documentation must be provided to the SCDHHS within one (1) hour following the request.

   At its discretion, SCDHHS may request the MCO to provide copies (electronic or paper) of all original contracts, credentialing materials, and rate information at no cost to SCDHHS. MCOs must deliver the requested documentation to SCDHHS no later than noon (12 PM ET) the next business day. SCDHHS may, at its discretion, contact Subcontractors to verify the accuracy of the information submitted by the MCO. Renewals of existing contracts cannot be for a time period of less than twelve (12) months.

## 2.11 Network Provider and Subcontractor Listing Spreadsheet

| NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET | | |
|---|---|---|
| SERVICE | STATUS | SCDHHS COMMENTS |
| ***ANCILLARY SERVICES:*** | | |
| **Ambulance Services** | 3 | |
| **Durable Medical Equipment** | 1 | |
| **Orthotics/Prosthetics** | 1 | |
| **Home Health** | 1 | |
| **Infusion Therapy**** | 1 | Follow proximity guidelines for specialists |
| **Laboratory/X-Ray** | 1 | |
| **Pharmacies*** | 1 | Follow proximity guidelines for Primary Care Providers |
| **Hospitals** | 1 | Follow proximity guidelines for specialists |
| ***PRIMARY CARE PROVIDERS:*** | | |
| **Family/General Practice** | 1 | |
| **Internal Medicine** | 1 | |
| **RHC's/FQHC's** | 2 | Not required but may be utilized as a PCP provider |
| **Pediatrics** | 1 | |
| **OB/GYN** | 1 | |
| ***SPECIALISTS*** | | |
| **Allergy/Immunology** | 1 | |
| **Anesthesiology** | 3 | |
| **Audiology** | 3 | |
| **Cardiology** | 1 | |
| **Chiropractic** | 3 | |
| **Dental** | 4 | |
| **Dermatology** | 1 | |
| **Emergency Medical** | 3 | |
| **Endocrinology and Metab** | 1 | |
| **Gastroenterology** | 1 | |
| **Hematology/Oncology** | 1 | |

| NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET | | |
|---|---|---|
| SERVICE | STATUS | SCDHHS COMMENTS |
| **Infectious Diseases** | 1 | |
| **Neonatology** | 3 | |
| **Nephrology** | 1 | |
| **Neurology** | 1 | |
| **Nuclear Medicine** | 3 | |
| **OB/GYN** | 1 | Serving as PCP for pregnant women, follow Proximity Guidelines for Primary Care Providers |
| **Ophthalmology** | 1 | |
| **Optician** | 4 | |
| **Optometry** | 1 | |
| **Orthopedics** | 1 | |
| **Otorhinolaryngology** | 1 | |
| **Pathology** | 3 | |
| **Pediatrics, Allergy** | 3 | |
| **Pediatrics, Cardiology** | 3 | |
| **Podiatry** | 3 | |
| **Psychiatry (private)** | 3 | |
| **Pulmonary Medicine** | 1 | |
| **Radiology, Diagnostic** | 3 | |
| **Radiology, Therapeutic** | 3 | |
| **Rheumatology** | 1 | |
| **Surgery - General** | 1 | |
| **Surgery - Thoracic** | 3 | |
| **Surgery - Cardiovascular** | 3 | |
| **Surgery - Colon and Rectal** | 3 | |
| **Surgery - Neurological** | 3 | |
| **Surgery - Pediatric** | 3 | |
| **Surgery - Plastic** | 3 | |
| **Urology** | 1 | |
| **Private Physical Therapy** | 1 | |
| **Private Speech Therapy** | 1 | |

| NETWORK PROVIDER AND SUBCONTRACTOR LISTING SPREADSHEET | | |
|---|---|---|
| SERVICE | STATUS | SCDHHS COMMENTS |
| **Private Occupational Therapy** | 1 | |
| **Hospital Based Physical Therapy*** ** | 1 | |
| **Hospital Based Speech Therapy*** ** | 1 | |
| **Hospital Based Occupational Therapy*** ** | 1 | |
| **Long-Term Care** | 3 | MCO responsibility begins once the Medicaid MCO Member has been approved for, and admitted to the LTC facility. If the Medicaid MCO Member stays in the facility for 30 consecutive days, the Medicaid MCO Member will be disenrolled from the MCO at the earliest opportunity by SCDHHS. The MCO financial responsibility will not exceed 60 days total. |
| Status | **1 = Required**<br>**2 = Not required unless serving as PCP for the county**<br>**3 = Attestation**<br>**4 = Attest, if offered** | |
| **Proximity Guidelines** | | |
| *Primary Care Providers should be within a maximum of 30 miles of the Medicaid MCO Member's place of residence | | |
| **Specialty Care Providers should be within a maximum of 50 miles of the Medicaid MCO Member's place of residence | | |
| SCDHHS considers all the facts and circumstances in reviewing Subcontracts and networks. SCDHHS may grant exceptions to its' stated criteria on case-by-case basis. | | |
| ***Therapies are in-patient or out-patient based | | |

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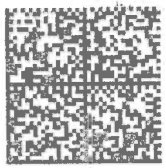

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OFFICE OF THE DIRECTOR

Melanie "Bz" Giese
Deputy Director, Medical and Managed Care Services
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**DEPARTMENT OF HEALTH AND HUMAN SERVICES**
*OFFICE OF DIRECTOR*

# ACTION REFERRAL

| TO | DATE |
|---|---|
| Giese / Campbell | 7-25-11 |

| DIRECTOR'S USE ONLY | ACTION REQUESTED |
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| 1. LOG NUMBER 11G:648 | [ ] Prepare reply for the Director's signature<br>DATE DUE _____ |
| 2. DATE SIGNED BY DIRECTOR _____ | [X] Prepare reply for appropriate signature<br>DATE DUE 8-1-11 |
| | [ ] FOIA<br>DATE DUE _____ |
| | [ ] Necessary Action |

| APPROVALS (Only when prepared for director's signature) | APPROVE | * DISAPPROVE (Note reason for disapproval and return to preparer.) | COMMENT |
|---|---|---|---|
| 1. James Bradford | 6/27/11 | | |
| 2. Jenni for Campbell | 6-27-11 | | |
| 3. BS Giese | 8/4/11 | 7/31 | |
| 4. | | | |

Rec'd mcave 7/26/2011

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

August 10, 2011

Mr. Aaron W. Brace
President and CEO
Absolute Total Care, Incorporated
1441 Main Street
Columbia, South Carolina 29201

Dear Mr. Brace: Aaron

Thank you for your letter of July 19, 2011, regarding Absolute Total Care's network adequacy submissions for Cherokee, Greenville, Laurens, Pickens, Spartanburg and Union Counties. As you are aware, we met with your team on July 22, 2011, and addressed each of your concerns, and provided you with both written and electronic details of the networks submission by ATC's team. You indicated that you would be sending additional information and new county submissions (with supporting documentation) by noon, August 5, 2011, which was delivered. Once we have reviewed your re-submission we will notify you immediately.

If you have any other questions or concerns, please do not hesitate to contact me directly.

Sincerely,

Melanie "Bz" Giese, RN
Deputy Director

MG/bcc

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