

PROVIDER REVIEW

2022

**South Carolina Department of
Mental Health
School-Based Services**



SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

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**Bureau of Program
Integrity and
Internal Audit**

May 3, 2022

Executive Summary

OBJECTIVE:

To assist the executive leadership of the South Carolina Department of Health and Human Services (SCDHHS) in evaluating the school-based services provided by the South Carolina Department of Mental Health (DMH), determine if services are provided and billed to Medicaid in accordance with applicable policies, and make recommendations regarding enhancements that could be made to the program to increase access and address mental health needs of South Carolina students across the state.

BACKGROUND:

The 2019 novel coronavirus (COVID-19) pandemic has negatively impacted the mental health and social and emotional wellbeing of many students and children in South Carolina. Mental health issues continue to rise among the state's youth.

DMH provides mental health clinicians who render mental health assessment, intervention and treatment services on site in South Carolina's public schools (School Mental Health Services Program or SMHSP). SMHSP is currently available in fewer than 50% of the state's public schools and DMH is struggling to employ enough credentialed clinicians to staff the program. Eighty percent (80%) of children receiving services under the SMHSP are funded through the Medicaid program.

Governor Henry McMaster issued Executive Order No. 2022-02 directing SCDHHS to perform a review and analysis of DMH's SMHSP and make recommendations for improving the program.

Executive Summary

(cont.)

OBSERVATIONS AND FINDINGS:

Behavioral health issues are on the rise among school-age children. Behavioral health issues generally begin showing signs during school years and are often witnessed by teachers and counselors. There is a growing need to ensure behavioral health services are available to students to address their needs. In addition, crisis intervention and counseling are not readily available to students in crisis. Crisis counseling is critically needed in schools. Students referred for behavioral health services often do not receive these services if they are not available at the schools.

DMH is the primary provider of school-based behavioral health services in South Carolina. Services delivered through DMH are currently available in less than 50% of the state's public schools. DMH struggles to hire and retain counselors, presumably due to compensation not keeping up with market rates. DMH counselors commonly do not provide crisis counseling services. Many school administrators expressed preference for school-based behavioral health services to be provided by school district employees.

Private insurance generally does not pay for school-based services provided by DMH. Approximately 80% of DMH school-based services are paid for by Medicaid, despite the fact that students enrolled in Medicaid only make up about 65% of the student population. Children covered by private insurance might not receive services due to their guardian's inability to pay for co-pays and deductibles. In most circumstances, DMH will not deny services based on inability to pay.

SCDHHS' Bureau of Program Integrity and Internal Audits (PI) randomly selected 1,000 recipients to contact by mail showing the dates of services provided by DMH. Recipients were asked to confirm whether services were received and if they were satisfied with the services. PI received 350 responses from recipients for a response rate of 35.0%. Of the 350 responses received, 96.0% (336) confirmed receipt of services. Of the 336 responses confirming that services were received, 83.6% (281) respondents were satisfied and 2.0% (seven) were not satisfied with the services received (see section 4.1 for additional details).

SCDHHS PI was assigned Lee County to review. PI requested 127 recipient medical records from DMH. This amounted to a total of \$158,514 claims paid for the review period of Jan. 1, 2019, through Dec. 31, 2021. The review consisted of reviewing each claim line and noting all associated errors. Records were reviewed in accordance with existing Rehabilitative Behavioral Health Services and Community Health Program policies. Overpayment identified to date is \$73,962, although this may decrease if DMH provides additional supporting documentation. The review did not show a widespread issue with

DMH billing for services that were not provided. Frequently, medical records reviewed had documentation errors, which lacked elements to meet established policies.

Timeliness of service oversight was also a common issue (see section 4.2 for additional details).

SCDHHS' managed care organization (MCO) partners were assigned Charleston, Darlington, Dorchester, Florence, Greenville, Horry, Marion, and Orangeburg counties schools to review. The MCOs requested a total of 368 medical records from DMH: 65 records in Charleston and Dorchester counties, 100 records in Greenville County, 100 records in Darlington, Florence, and Marion counties, 68 records in Horry County, and 35 records in Orangeburg County. This amounted to 2,037 claim lines totaling \$390,620 claims paid for the review period Jan. 1, 2019, through Dec. 31, 2021. Records were reviewed in accordance with applicable provider contracts, as well as existing Rehabilitative Behavioral Health Services and Community Health Program policies. Overpayment identified to date is \$306,026, although this may decrease if DMH provides additional supporting documentation (see section 4.3 for additional details).

SCDHHS PI interviewed four administrators, five guidance counselors and seven DMH staff from Lee and Richland counties. Questions addressed the services provided, referral process, school and service satisfaction and challenges to the school-based services program (see section 4.4 for additional details).

Common findings from SCDHHS PI interviews conducted include:

- The school-based program is essential and very beneficial.
- There are not enough hours dedicated to providing services at the school by the DMH clinician.
- The caseloads are too high to be managed effectively.
- There are more children that need counseling than are being seen due to not having a counselor available.
- Utilizing a school employee for counseling would better serve the program because they would be available every day during school hours.
- Lack of parent participation is an issue.
- The salary is not enough for the required work.
- The physicians do not have adequate office hours.
- The evaluations are taking the full 90 days or longer to complete.

MCO partners selected 90 stakeholders from Charleston, Darlington, Dorchester, Florence, Greenville, Horry, Marion, and Orangeburg counties' schools to interview. Questions were similar to those used by SCDHHS PI. Common findings were similar to those documented by PI (see section 4.5 for additional details).

Common findings from MCO interviews conducted include:

- The school-based program is essential and very beneficial.
- There is an increased need for these services since the beginning of COVID-19.
- Many DMH clinicians cover multiple schools and caseloads are too high to be managed effectively.
- There are more children needing counseling than are being seen.

SCDHHS PI interviewed DMH staff responsible for billing at the main office and the satellite offices, reviewed documentation related to the billing process, including examples of explanation of benefits for private insurance denials, and documented the school-based services billing process.

Billing is a multipart process with tasks performed by both DMH county and main offices. There is a lack of consistent processes among county offices. The Medicaid billing process is well-established. DMH is moving to an electronic process for billing private insurance. Private insurance generally does not pay for school-based services provided by DMH, due to provider not being “in-network”, not meeting “credentialing criteria”, and/or “not authorized” based on contractual stipulation. DMH lacks sufficient resources to address denied claims.

PI compared Medicaid reimbursement rates paid to DMH with those paid to the school districts. For the majority of school-based behavioral services provided, the school districts are paid 53% less than DMH. PI estimated an annual salary based upon DMH reimbursement rates and a conservative estimate of counseling time. Based on SCDHHS PI’s calculations, the rate paid to DMH could easily support a fully loaded annual salary of at least twice what DMH is currently paying its counselors.

PI obtained the schedule of school district contributions per contract with DMH and compared it to the number of schools served by DMH in the district to determine if school district contributions were equitable statewide. Currently, there is not an equitable method or standardized rate charged to a school district by DMH.

Executive Summary

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RECOMMENDATIONS:

PI makes the following recommendations to aid in addressing the growing need for behavioral health services in South Carolina's schools. For more details on recommendations, see the Conclusions and Recommendations section of this report beginning on page 30.

PI recommends that SCDHHS and DMH work cooperatively with the South Carolina Department of Education (DOE) to provide a structure and assist schools with hiring counselors to provide school-based mental health and crisis counseling services. PI also recommends that the DOE considers requiring counselors to be licensed to help ensure the quality of services provided.

Alternatively, to meet current needs, DOE may want to consider allowing counselors to be credentialed, with a goal of moving to licensure within a specific timeframe. PI recommends that SCDHHS and DMH assist DOE with developing an expedited credentialing process for DOE hired counselors.

To aid in recruitment, PI recommends that counselor salaries be analyzed to ensure they are competitive in the current marketplace. DOE may also want to consider providing financial support or incentives for counselors who become licensed.

PI also recommends, where appropriate, that DOE consider providing an option for a 10-month school year contract to enhance recruitment. The applicant pool could be increased by offering some form of incentive for South Carolina graduates to take a position with the DOE, such as a sign-on bonus or reduction to student loan debt.

PI recommends that all counselors be trained in providing crisis services.

PI recommends that SCDHHS reimburse claims filed by DOE at a rate consistent with that of DMH to ensure feasibility, and that policy is properly modified to allow for this.

As billing was cited as a barrier for the school districts to provide behavioral health services, PI recommends that SCDHHS provide a list of qualified medical billing companies that school districts could opt to contract with to assist with billing, or for DOE to develop a centralized billing department properly trained to bill Medicaid and other insurers.

For school districts that will process their own billing, PI recommends that DOE develop consistent well-documented procedures to be followed by all districts. PI also recommends that the school districts have adequate and trained staff to monitor claims, including denied claims, to ensure maximum generation of revenues to offset the cost of the programs.

As recipients, guardians, and school staff are generally satisfied with the services provided by DMH, DMH should continue to be an option for school-based services. We recommend

DMH remain a provider option with whom school districts could opt to contract to provide school-based services.

There are some fundamental issues DMH would need to address in order for them to remain competitive with other providers.

DMH has seen a continued loss of counselors over the past three years. Recruitment and hiring cannot keep up with the rate of loss. PI recommends that DMH increase the starting pay for a master's-level counselor to be more competitive with the market. PI also recommends that DMH have adequate administrative support to reduce counselors' time spent on administrative tasks.

There is an increased need for crisis counseling in the schools. PI recommends that DMH provide further training to its counselors to ensure they are adequately trained and encouraged to provide these services.

DMH's current process for billing payers requires processing at both the local DMH county office and their main office in Columbia. This two-part process allows for inconsistencies between centers. If DMH is to continue to provide school-based services, PI recommends that DMH develop consistent procedures to be followed by all centers. PI also recommends DMH ensures that they have adequate and trained staff to monitor denied claims to prevent lost revenues.

In order to ensure adequate counselors are available to provide school-based behavioral health services, PI recommends private providers also be used for school-based behavioral health services.

Due to a history of fraud and abuse of the Medicaid program by behavioral health service providers, PI recommends SCDHHS review and tighten policies around behavioral health provider enrollment, and behavioral health services provided in schools, to prevent fraud, waste and abuse.

Once policies are revised to prevent possible abuse of the Medicaid program, PI recommends reimbursement rates for school-based service be analyzed and adjusted to encourage more participation by private providers.

As there is a high need for crisis counseling services, PI recommends SCDHHS adjust policies to allow providers to be reimbursed for these services prior to conducting an assessment, which may not be feasible. To prevent abuse of the crisis counseling services codes, PI recommends limits be placed on the number of services that could be billed prior to an assessment as well as a directed course of continued care.

SCDHHS may also want to consider requiring counselors employed by the state to be licensed in order to receive Medicaid reimbursement for services provided. This would encourage both DOE and DMH to move towards employing only licensed counselors.

To ensure the children of South Carolina have access to the needed behavioral health services in the schools, PI recommends SCDHHS enforces policies that prevent balance billing by providers, both state and private, for any services paid for by Medicaid.

The above recommendations, if properly implemented, should aid the state in meeting the growing need for behavioral health services in South Carolina's schools.

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2 - Foreword

AUTHORIZATION

The Agency was created in 1984 pursuant to § 1-30-10 et. seq. of the SC Code of Laws. The SC Code of Laws, § 44-6-30, mandates that SCDHHS administer the Medicaid program (Title XIX of the Social Security Act). Federal Regulation 42.CFR 455.12-13 requires the state Medicaid agency to have methods and criteria in place for identifying suspected fraud and investigating these cases. If the agency receives a complaint of Medicaid fraud or abuse from any source, or identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full investigation. If the findings of a preliminary investigation give the agency reason to believe that an incident of fraud or abuse has occurred in the Medicaid program, the agency must investigate the matter until it is resolved between the agency and the provider, and appropriate actions are taken.

SCDHHS' PI unit is part of the system in place for safeguarding the state's Medicaid program against fraudulent, abusive, inappropriate, and excessive use of Medicaid. PI's authority is provided through Federal and State regulations and is outlined in Chapter 1 of the SCDHHS' Provider Administrative and Billing Manual.

REPORT DISTRIBUTION

This report is intended for the information and use of the Director and Executive Management of the SCDHHS. However, this report is a matter of public record, and its distribution is not limited.

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ACKNOWLEDGEMENT

PI would like to thank the management and staff of DMH for their assistance and cooperation during the performance of this review.

3 - Engagement Overview

3.1 BACKGROUND

The COVID-19 pandemic has negatively impacted the mental health and social and emotional wellbeing of many students and children in South Carolina. According to recent studies, mental health-related emergency department visits among adolescents increased by 31% in 2020, compared to 2019. Also, in February and March of 2021, emergency department visits for suspected suicide attempts were 51% higher among girls between the ages of 12 and 17 than during the same period in 2019.

DMH provides mental health assessment, intervention, and treatment services on site in SMHSP and provides mental health clinicians to the program to provide services. SMHSP is currently available in fewer than 50% of the state's public schools and DMH is struggling to employ enough credentialed clinicians to meet the program's needs. Eighty percent (80%) of children receiving services under the SMHSP are funded through the Medicaid program.

Governor McMaster issued Executive Order No. 2022-02 directing SCDHHS to perform a review and analysis of DMH's SMHSP and make recommendations for improvement.

To perform the review and analysis, PI, in conjunction with its MCO partners, reviewed medical records, interviewed various stakeholders and recipients, gained an understanding of the current billing practices and conducted a comprehensive Beneficiary Explanation of Medicaid Benefits (BEOMB) letter campaign. The review covered the period from Jan. 1, 2019, through Dec. 31, 2021.

3.2 OBJECTIVES

The objectives of the review:

- Assist the Executive Leadership of SCDHHS in evaluating the school-based services provided by DMH.
- Determine if services are provided and billed to Medicaid in accordance with applicable policies.
- Make recommendations regarding enhancements that could be made to the program to increase access and address mental health needs of South Carolina students across the state.

3.3 SCOPE

As part of the engagement, six counties were selected for review of the school-based mental health services provided by DMH. These included Greenville, Lee, Orangeburg, Horry, Florence, and Charleston counties. SCDHHS' PI unit reviewed Lee County. The remainder of the selected counties were reviewed by PI's MCO partners under the direction of SCDHHS' PI. Records were selected from a listing of all DMH recipients of school-based mental health services paid by Medicaid for the selected counties for Jan. 1, 2019, through Dec. 31, 2021. A total of 127 recipients' medical records were selected for review of Lee County school-based services recipients. A total of 368 recipients' medical records of school-based recipients were selected for review by SCDHHS' MCO partners. This included 65 records in Charleston and Dorchester counties, 100 records in Greenville County, 100 records in Darlington, Florence, and Marion counties, 68 records in Horry County, and 35 records in Orangeburg County.

Additionally, 1,000 BEOMB letters were mailed to recipients across all South Carolina counties who received school-based services provided by DMH and paid for by Medicaid from July 1, 2021, through Dec. 31, 2021.

In addition to the above detailed records review, PI interviewed various stakeholders at DMH offices and schools in the selected counties, reviewed testimony made before the Joint Citizens and Legislative Committee on Children, analyzed data from a survey conducted by the South Carolina DOE, and examined policy documentation.

3.4 METHODOLOGY

To aid in meeting the objectives of the review, PI performed the following procedures with assistance from their MCO partners:

- Mailed BEOMB letters to 1,000 recipients receiving school-based services throughout the state of South Carolina.
- Reviewed 495 medical records for beneficiaries receiving school-based services from DMH in six key areas it served.
- Conducted interviews with recipients, counselors and school administrators.
- Analyzed responses to a survey of school superintendents regarding school-based services conducted by DOE.

4 - Procedures and Findings

4.1 Beneficiary Explanation of Medicaid Benefits Letter Campaign

Procedure: From a list of all recipients who received school-based services provided by DMH during the period July 1, 2021, through Dec. 31, 2021, PI randomly selected 1,000 recipients. Recipients were mailed a letter showing the dates of services provided by DMH and were asked to confirm whether services were received and if they were satisfied with the services. Letters were mailed the week ending Feb. 11, 2022. A second request was mailed the week ending March 11, 2022, to encourage additional responses.

Results: PI received 350 responses from recipients for a response rate of 35.0%. Of the 350 responses received, 336 (96.0%) confirmed receipt of services. Six (1.7%) of the responses noted that they were unsure if services were received as listed. Three (0.8%) response stated that, to their knowledge, services had not been received on the dates listed. These are being investigated. Five (1.4%) noted that services were provided via telehealth from the DMH area office.

Of the 336 responses confirming that services were received, 281 (83.6%) respondents were satisfied and seven (2.0%) were not satisfied with the services received. Of the 337 responses, 48 (14.3%) did not indicate whether they were satisfied with the services received.

Comments made on the survey mostly relate to the type of services being provided. There were also generally positive comments related to the services provided.

4.2 Fee-for-service Medical Records Review

Procedure: SCDHHS PI was assigned Lee County to review. PI requested 127 recipient medical records from DMH. Claims associated with the selected medical records totaled \$158,514 for the review period of Jan. 1, 2019, through Dec. 31, 2021. PI received and reviewed 127 recipients' records. The review consisted of analyzing each claim line and noting all associated errors. In instances of multiple errors per claim line, the identified overpayment was only counted once. Overpayment identified to date is \$73,962. Any additional support provided by the DMH may change the amount of the overpayment identified. Records were reviewed in accordance with existing Rehabilitative Behavioral Health Services and Community Health Program policies.

Results:

The identified errors are as follows:

- Physician/psychiatrist did not see the client within the first 90 days from the date of admission to a Community Mental Health Center (CMHC).
 - Instances - 179
- The physician/psychiatrist signature date on the plan of care (POC) was not completed within 90 calendar days of admission.
 - Instances noted - 62
- The medical record was missing documentation for a specific date of service.
 - Instances noted - 211
- The medical record did not contain a signed and/or dated consent for examination and treatment by the recipient or legal guardian.
 - Instances noted - 31
- The record did not contain a signed and signature dated statement regarding Notice of Privacy Practices or authorization to release medically necessary information for claims processing.
 - Instances noted - 50
- The documentation did not contain required clinician signature and/or title (consents, assessment, POC, and CSN).
 - Instances noted - 47
- The documentation did not contain the required signature date (consents, assessment, POC, and CSN).
 - Instances noted - 43
- The POC was not signed by the recipient or legal guardian.
 - Instances noted - 143
- CSNs were not signed in a timely manner (10 working days).
 - Instances noted - 9
- The documentation did not contain an Initial Physician Medical Order (PMA Physician Medical Assessment with Physician Medical Order).
 - Instances noted - 88

- The documentation did not contain summaries every 90 days.
 - Instances noted - 2

4.3 MCO Medical Record Review

Procedure: SCDHHS' MCO partners were assigned Charleston, Darlington, Dorchester, Florence, Greenville, Horry, Marion, and Orangeburg counties' schools to review. The MCOs requested a total of 368 medical records from DMH: 65 records in Charleston and Dorchester counties, 100 records in Greenville County, 100 records in Darlington, Florence, and Marion counties, 68 records in Horry County, and 35 records in Orangeburg County. This amounted to 2,037 claim lines totaling \$390,620 claims paid for the review period Jan. 1, 2019, through Dec. 31, 2021. Records were reviewed in accordance with applicable provider contracts, as well as existing Rehabilitative Behavioral Health Services and Community Health Program policies. Overpayment identified to date is \$306,026, although this may decrease if DMH provides additional supporting documentation.

Results: From the 368 medical records reviewed, we noted the following findings:

Summary of MCO Findings:

MCO	County(ies)	# Of Medical Records Reviewed	Claim Lines	Total of Claims Reviewed	Identified Overpayment
ATC	Charleston, Dorchester	65	70	\$10,744.10	\$3,577.09
Healthy Blue	Greenville	100	105	\$15,900.93	\$5,699.75
Molina	Horry	68	1,117	\$194,097.79	\$128,304.64
Select	Darlington, Florence, Marion	100	689	\$160,199.13	\$159,955.57
Wellcare	Orangeburg	35	56	\$9,678.26	\$8,489.13
Totals:		368	2,037	\$390,620.21	\$306,026.18

1. ATC - The identified errors that resulted in an overpayment are as follows:

- Physician/psychiatrist signature was missing on the POC to confirm diagnosis, medical necessity of treatment and appropriateness of care and authorization of all services.
 - Instance noted - 1
- The medical record was missing documentation for a specific date of service.
 - Instances noted - 6
- The type of service and or start time/bill time was not specifically identified on the CSN in the beneficiary's medical record.
 - Instances noted - 3
- The documentation did not contain the required signature date on consents, assessments, POCs, and/or CSNs.
 - Instances noted - 5

- The POC did not adequately address goals and objectives of treatment, types of interventions, planned frequency, criteria for achievement, estimated duration of treatment and long-term or discharge goals.
 - Instances noted - 6
- Clinical service notes lacking components (focus, interventions, progress, plan).
 - Instances noted - 13
- Limited or lack of progress noted.
 - Instance noted - 1

2. Healthy Blue - The identified errors that resulted in an overpayment are as follows:

- Medical records missing documentation for a specific date of service.
 - Instances noted - 5
 - No CSN provided for date of service billed - 1
 - No POC provided for service period - 2
 - POC (hard copy) containing member/guardian signature was not provided - 2
- Documentation did not contain a signed and dated consent for examination/treatment.
 - Instances noted - 11
- Documentation did not contain the required signature(s) and/or titles(s) on consents, assessments, treatment plans and/or CSNs.
 - Instances noted - 21
- Documentation did not contain required signature date(s) on consents, assessments, treatment plan and/or CSNs.
 - Instances noted - 21
- The physician/psychiatrist signature date on the POC was not completed within 90 calendar days of admission.
 - Instances noted - 6
- The CSN did not contain required components as required by policy (start time or service type)
 - Instances noted - 13

The identified errors that resulted in an education are as follows:

- Billing an incorrect procedure code.
 - Instances noted - 7

3. Molina - The identified errors that resulted in an overpayment are as follows:

- Physician/psychiatrist did not see the client within the first 90 days from the date of admission to a CMHC.
 - Instances noted - 11

- Physician/psychiatrist signature is missing on the POC to confirm diagnosis, medical necessity of treatment and appropriateness of care and authorization of all services.
 - Instances noted - 4
- The physician/ psychiatrist signature date on the POC was not completed within 90 calendar days of admission.
 - Instances noted - 11
- The medical record was missing documentation for a specific date of service.
 - Instances noted - 114
- The type of service and or start time/bill time was not specifically identified on the CSN in the beneficiary's medical record.
 - Instances noted (missing start time/bill time) - 13
 - Instances noted (wrong type of service) - 2
- The documentation did not contain required clinician signature(s) and/or title(s) on consents, assessments, POCs and/or CSNs.
 - Instances noted - 6
- The documentation did not contain the required signature date on consents, assessments, POCs and/or CSNs.
 - Instances noted - 6
- The POC was not signed by the beneficiary or legal guardian.
 - Instances noted - 68
- Inappropriate modifier or lack of modifier.
 - Instances noted - 52
- Clinical service notes lacking components (focus, interventions, progress, plan).
 - Instances noted - 239
- Limited or lack of progress noted.
 - Instances noted - 98

4. Select - The identified errors that resulted in an overpayment are as follows:

- Missing entire medical record:
 - Instances noted - 12
- Missing consent form:
 - Instances noted - 250
- Missing assessment:
 - Instances noted - 199
- Missing physician medical order:
 - Instances noted - 33

- Missing POC
 - Instances noted - 201
- Missing 90-day progress summary:
 - Instances noted - 7
- Missing CSN:
 - Instances noted - 33
- POC missing client signature:
 - Instances noted - 449
- POC missing physician signature:
 - Instances noted - 37
- CSN not signed within the required timeframe:
 - Instance noted - 1
- Duplicate billing:
 - Instances noted - 15
- Upcoding - billed more units than documented:
 - Instances noted - 129
- Place of service documented does not match place of service billed:
 - Instances noted - 49

5. Wellcare - The identified errors that resulted in an overpayment are as follows:

- The medical record was missing documentation for a specific date of service.
 - Instances noted - 8
- The type of service and or start time/bill time was not specifically identified on the CSN in the beneficiary's medical record.
 - Instances noted - 48

4.4 PI Interview Process

Procedure: SCDHHS PI interviewed stakeholders from Lee and Richland County schools. These included school administration, school guidance counselors, DMH counselors and staff at the DMH county offices. The following schools were visited: Manning Elementary, Manning Junior High, Manning High, Ebenezer Middle, Crosswell Elementary, Sumter High, Chestnut Oaks Middle, LeMira Elementary, St. Andrews Middle and Sandel Elementary. PI interviewed four administrators, five guidance counselors and seven DMH staff. Questions centered on the services provided, referral process, school and service satisfaction and challenges of the school-based services program.

SCDHHS PI also interviewed billing staff at the DMH main office.

Results:

Common findings from interviews conducted with school administrators include:

- There are not enough hours dedicated to providing services at the school by the DMH counselor. There are more children that need counseling than are being seen due to not having a counselor available.
- The school-based program is essential and very beneficial.
- It would be better for the program to utilize a school employee for the counseling because they would be available every day during school hours.

Common findings from interviews conducted with school guidance counselors include:

- There are not enough hours dedicated to providing services at the school by the DMH clinician. There are more children that need counseling than are being seen due to not having a counselor available.
- The school-based program is essential and very beneficial.
- It would be better for the program to utilize a school employee for the counseling because they would be available every day during school hours.

Common findings from interviews conducted with school DMH counselors include:

- The caseloads are too high to be managed effectively. When asked how they handle the high numbers, they stated, "I manage." Scheduling is an issue. Clinicians try to make sure the high-risk clients are scheduled then fill in the others as they can.
- Counseling sessions are typically only 30 minutes due to the number of students that need to be seen, although some clinicians manage to do 45-minute sessions.
- Some clinicians do not have a designated place of their own to conduct their sessions and get interrupted during the sessions by school staff.
- Medical evaluations take up to the full 90 days frequently due to not having more time available by the physicians who are usually only available a few days a week and for a limited number of hours.
- Parent participation is an issue. Parents do not show up for sessions.
- Interruptions at the DMH office are a distraction. At times, when they are in counseling sessions, they receive phone calls and other interruptions that take away from the time they can spend with the client.
- Burnout is a common concern.
- The salary is not enough for the required work.
- Meeting productivity is a common concern, even though the goal is being met despite the high caseloads.

Common findings from interviews conducted with school DMH area staff:

- Clinicians' paperwork is reviewed before it is sent to the Sumter office for billing.
- Some of the offices, Kershaw for example, currently do not have any clinicians.
- Clinicians must cover multiple schools in addition to the office.
- There is a staffing shortage, while caseloads continue to climb.
- At times there are issues with having someone available to see crisis patients that come in.
- The physicians do not have enough office hours. The evaluations are taking the full 90 days to complete and sometimes it takes more than 90 days.

4.5 MCO Interview Process

Procedure: MCO partners interviewed 90 stakeholders from Charleston, Darlington, Dorchester, Florence, Greenville, Horry, Marion, and Orangeburg counties' schools to interview. These included school administration, school guidance counselors, DMH counselors and staff at the DMH county office. There were 42 schools visited: Woodland High, Harleyville-Ridgeville Middle, Harleyville Elementary, Clay Hill Elementary, Alston Elementary, Sand Hill Elementary, Oakbrook Middle, Ladson Elementary, Windsor Hill Elementary, River Oaks Middle, Fort Dorchester High, Jerry Zucker Middle, AC Corcoran Elementary, Deer Park Middle, Northwoods Middle, Pinehurst Elementary, Liberty Hill Elementary/Middle, Sanders Clyde Elementary, Slater Elementary, Hannah Sterling Elementary, Socastee Elementary, St James High, Myrtle Beach Middle, Myrtle Beach Elementary, South Florence High, Johnakin Middle, Carolina Elementary, Marion High, Southside Middle, North Hartsville Elementary, Edisto High, Rivelon Elementary, Edisto Primary, Dover Elementary, North High, Marshall Elementary, Whitaker Elementary, Holly Hill Elementary, Lake Marion High, Sandy Run K-8, St. Matthews K-8 and William-Clark Middle. Questions were similar to those used by SCDHHS PI.

Results:

1. Common findings from interviews conducted with school administrators:

- Most schools are satisfied with the services from DMH clinicians when those services are actually provided, however, they feel there is not nearly enough coverage within their schools.
 - Many of those interviewed stated they need a clinician in the school full-time or an additional clinician to handle the large caseload at their school. Some DMH clinicians cover multiple schools and are only in a particular school on certain days per week and not readily available when needed, which often leaves only the school administrators to deal with a crisis.
 - Many administrators described scenarios in which a student was in crisis, but the clinician was not available due to being at another school. Some of the crisis situations involve destructive or self-harm behaviors. Some administrators reported that they could reach their school-based clinician via phone to assist in navigating crisis situations.
 - When the assigned DMH clinician is out for the day the school is not always notified and another clinician is not provided. The school administrators would like to be informed if the clinician is going to be out for the day in order to provide additional support the students may need.
 - There are limitations to the services that DMH clinicians can provide. For example, DMH clinicians are allowed to provide individual and family therapy, but not group therapy. At least one administrator mentioned that group therapy is essential for students who have trouble interacting with peers in a school setting.
 - Even at schools that have a DMH clinician, many referrals are being declined because the clinician's caseload is so high.
- One principal was frustrated with the clinician assigned to the school due to the lack of experience and interaction with the children. The principal felt that the clinician is timid and too inexperienced to meet the extensive need for mental health support for the children in her school. Complaints have been sent to DMH in regard to this clinician, but no action has been taken at this time.

- School administrators understand Health Insurance Portability and Accountability Act (HIPAA) privacy requirements, but would appreciate more communication, and a team-based approach to ensure the students' needs are met.
- School administrators would like to see additional outreach or therapy approaches before dropping services due to factors such as parents not responding to letters or the lack of student progress. There are instances when students are unable to receive services due to the lack of effort from the clinician.
- Example: There is concern that at the end of this school year the contract is not being renewed with the Waccamaw DMH and they will be pulling out of Horry County schools. Waccamaw DMH employees are currently at the school from the start to the end of the day, every day. There are rehabilitative behavioral health services counselors onsite.

2. Common findings from interviews conducted with school guidance counselors:

- The guidance counselors were very complimentary of their DMH clinicians and described working together as a team. At most schools, referrals are streamlined through guidance counselors and parents are made aware of the referral prior to it being sent to the DMH clinician. However:
 - All agreed DMH was understaffed and there was a significant amount of turnover among DMH employees due to long hours, travel and poor compensation.
 - Some schools currently did not have a clinician due to vacancies created by a clinician leaving DMH. So far, DMH has not been able to fill those vacancies.
 - DMH clinicians are not in school enough days and hours. In some cases, the clinician is in the school once or twice a week. There are more children that need counseling than are being seen due to not having more counselors available. Each school needs at least one fulltime onsite DMH clinician and additional school counselors.
- The education piece is missing within the school system when it comes to clinicians not communicating to guidance counselors and/or teachers to assist them in dealing with students' behavior outside of treatment.
 - School staff would like to have team meetings with DMH clinicians to discuss cases to better assist students with their needs especially since the clinicians are not onsite every day.
 - Schools would like brochures or pamphlets that would provide knowledge and make students feel comfortable asking for help.

3. Common findings from interviews conducted with school DMH counselors include:

Understaffed:

- Clinicians reported that they have seen an increase in mental health referrals due to COVID-19. The mental health issues being presented currently are different than they were pre-COVID-19. Students at all grade levels are presenting with anxiety, grief, self-harm, lack of coping skills and other mental health issues brought on by COVID-19 and the loss of in-school instruction. Due to the increase in caseloads and shortage of clinicians, this often results in children's sessions not being fulfilled as indicated in the POC.
- Salary is a concern and the cause of much turnover. In a few instances, clinicians left DMH to work with a school district. Many clinicians work at several schools, often up to four different schools at a time due to vacancies and the lack of help. Clinicians are not compensated for mileage.

- Medical evaluations can take up to the full 90 days frequently due to not having enough physicians. During one period of seven to eight months, no physicians had seen children, but they were still seen by a counsellor.
- Concerns of productivity not being met when it comes to meeting a child as determined in POC. This is due to caseload and traveling to various locations.
 - Most clinicians covered multiple schools with high caseloads. On average, the clinicians try to meet with four to six students per day. The duration of the counseling sessions largely depends on the child's age and severity of the mental health issue being addressed. All clinicians reported that each school provides a dedicated office for the clinicians to meet with the students. In addition to the school setting, clinicians meet with students at home, at the clinic and sometimes in the community. School-based mental health services continue during the summer as well. During the quarantine for COVID-19, clinicians met with students via virtual platforms such as Zoom and Doxy.me.
 - The caseloads are high, with some therapists having 60 students on current caseload.
 - It is considered a "good day" if the therapist has seen five students.
 - The clinicians try to make sure that the high-risk clients are scheduled then fill in the others as they can.
 - The caseloads are managed effectively. The ratio of students to clinicians was from 21 to 35 students. One clinician stated she does not turn any student away.
 - One clinician sees students at two schools, one being virtual with sessions one day a week.
 - Clinicians are unaware of a cap on the number of cases allowed per clinician.
 - Supervising therapists are required to carry a caseload, and the expected therapeutic services are reduced by 50%.

Referrals:

- Most referrals are received through the guidance counselors, but can also come from parents, teachers and other state agencies. Referrals can be received in multiple forms: paper, email and telephone. Parents are made aware of the referral for services prior to the clinician beginning the assessment process. No services are rendered without the consent of a parent or guardian. Clinicians require parents to sign documentation in person and participate in person whenever possible. Efforts are made to accommodate parents due to transportation or employment issues. When parents are not able to attend in-person, some clinicians utilize video platforms such as Zoom and Doxy.me.
- Every effort is made to complete intake within seven days of referral. The common delay in processing referrals is due to the parent's availability to come into the office.
- One school has a pilot program for referral intake and processing that uses a scoring system called "On Track" which considers as a part of the metric attendance, grades, and behavioral red flags.

Scheduling:

- Process for getting student to treatment varies:
 - Counseling sessions are typically only 30, 45 or 60 minutes due to the number of students who need to be seen. Some manage to do sessions during the student's elective periods.
 - Some schools prohibit therapy during core classes, but some do not.
 - In some schools, the process to get a student to therapy is an internal phone call from teachers using coded language. Other school administrators do not allow the classroom call-in, and the therapist walks to the classroom to escort the student.

- Parents of referred minors are usually notified first by school staff (admin and/or guidance counselor).

Parent participation is an issue:

- Parents do not show up for sessions or are not available due to their work schedules.
- Several clinicians stated that the student is with them, and they have the parent on the telephone during intake/assessments. Paperwork preparation is done before this happens. The parental consent is verbally agreed upon and documented for each consent. The physician has the consents signed during the visit by the parents.
- If family counseling is deemed necessary, the clinicians encourage the parent to be involved in sessions. There are no consequences if a parent does not participate. The clinicians continue to encourage parental involvement while they continue to provide services to the child.
- Parents must sign the consent form unless the patient is 16 years of age or older. When the clinician is unable to receive the parent's consent for children under 16 years of age, there are no real consequences, other than discharging the child from the program, even if the child may need services. This may also involve contacting a physician to discontinue medication due to no parent participation/approval.

Intake and Assessment:

- The intake and assessment are too lengthy, and the questions are repetitive. Completion often takes up to four hours, which makes it difficult for parent and child to participate. At times, this causes a delay in starting services.
- The assessment and POC can take two to three weeks to complete.
 - Both the assessment and POC are completed with the child and parent present. Assessments can take up to three visits to complete. By the second or third session, after assessment and all screenings are completed, there should be identified goals.
 - Services usually begin immediately following the completion of the POC with the parent's signature. Clinicians will engage in service delivery prior to the POC being returned from parents under the premise that the POC was discussed by telephone and agreed to, but not returned signed. Once the POC is completed, it is sent electronically to a DMH psychiatrist who then evaluates the child in person or virtually. The DMH psychiatrist approves the diagnosis and signs the POC. The main source of verification if the child is being seen as determined in the POC is periodic audits by quality assurance (QA).
 - Clinicians have up to 90 days to complete the POC. The DMH Electronic Health Records (EHR) system prompts the clinician at 30, 60 and 90 days to ensure continuity of service.
 - Clinicians meet with their DMH supervisor monthly for a review of their caseload. Progress summaries are completed every 90 days. The POC is updated as progress is made or if the child regresses, annually at a minimum. Parents are informed of their child's progress through family sessions, email, and phone calls.
- Example: Orangeburg Area Mental Health requires clinicians to conduct the assessment at the clinic located in the city of Orangeburg. According to clinicians, this creates a hardship for families who live in the outlying areas served by the clinic.

Clinical Notes:

- Clinicians indicate they make every effort to complete progress notes the same day or within 24 hours at the latest. They strive to complete the note in real time with the child present, but that is not feasible with the increased caseload. Realistically, in most cases, this task takes up to two to three days for completion.

- All clinicians stated that, to their knowledge, no one can alter their notes once submitted. Clinician notes do not require an additional signature for approval. No one else but the clinician can edit the note.
- Clinical notes are occasionally audited by QA, however, they are not reviewed and/or approved prior to being billed.

Medicaid vs. non-Medicaid eligible:

- A common notion among therapists interviewed was that approximately 80-90% of students receiving services are Medicaid recipients.
- Most students receiving school-based mental health services are Medicaid eligible. When asked what they perceive as barriers to services, the clinicians indicated that DMH only accepts Medicare, Medicaid, and some private insurance. Although DMH offers sliding scales, the fees are too expensive for some families to afford.
- Oftentimes, the parent or guardian cannot afford to travel to the clinic for services, or they lack transportation to get there.
- In few cases, clinicians were unable to provide services when parent/child was not Medicaid eligible, and prices were too expensive with private pay and/or the sliding scale offered by DMH.
- There is no remedy for non-Medicaid recipients when the costs of the DMH service is the barrier for services (i.e. no articulable referral process to introduce the private sector behavioral health options in the local community). Non-Medicaid students usually do not continue therapy. The DMH rate for private pay is \$165 per hour of psychotherapy.

4. Common findings from interviews conducted with school DMH area staff:

Staffing and High Turnover Concerns:

- Turnover is significantly impacted by salary. Several clinicians left DMH to work with school districts, private practices and other facilities in the community due to compensation. COVID-19 funds were given to school districts to hire employees at a higher salary for these types of positions.
- COVID-19 was also a cause of the turnover rate. Many clinicians resigned due to COVID-19 and exposure in high transmission areas and the lack of availability of the utilization of telehealth in some areas. Several clinicians accepted positions from employers that offered a 100% work from home option.
- DMH offers additional opportunities such as hiring unlicensed clinicians and assist them with obtaining their license and hiring bachelor's-level employees in hopes they can retain them for a longer period.
- Many schools have hired clinicians to work in the school fulltime as social workers or in other positions to aid children on a regular basis. Concerns in exit interviews were focused on salaries and bachelor's-level employees in schools making more money.

Examples of Staffing Concerns:

- In Orangeburg County, the current clinician-to-student in need of services ratio is approximately one clinician to 50 or 60 students. The percentage of children receiving school-based mental health services who are eligible for Medicaid is approximately 90%. Fully staffed, there are 12 school-based clinicians. Two new clinicians have recently been hired to fill vacancies. There are approximately 35 schools serviced by the Orangeburg Area Mental Health Center. Caseloads are large and new referrals are coming in daily. The clinicians are having to cover multiple schools, which are spread out across a very large area. There has been a significant amount of turnover among DMH clinicians.

- Currently there are a total of 118 schools within Charleston-Dorchester School District and 29 vacancies. There are currently 53 clinicians employed. The normal staff for clinicians is approximately 82. Charleston-Dorchester is one of the highest areas for cost of living but salaries do not reflect this. The average yearly starting pay for master's degree-level counselor with no experience is \$36,000, one-year of experience is \$39,200, and two-year's experience is \$42,000.
- DMH is contracted with Greenville County School District to place DMH counselors in their schools. DMH is paid based on number of counselors assigned.
- DMH processes DMH employees through human resources (HR), but hiring is on a local level.

Insurance:

- The only network insurances generally accepted are Medicaid, Medicare, and State BCBS. This is a deterrent for some families to receive services due to the affordability. Every effort is made to meet family needs and finding alternative ways to pay, however, most parents opt to see counselors where insurance is in network.

Fee Schedule:

- The fee schedule for DMH is set by the State Mental Health Commission, which is the governing body of DMH.
- The fee schedule is justified by the "medical component" with DMH services. A statement was made that "everyone is charged the same by law."

Training:

- Mandatory training is required for DMH clinicians. They are expected to take an evidence-based practice training monthly. They are evaluated yearly on the number of trainings completed. Training is offered continually throughout the year and was one of the greatest attributes of the agency when asked during exit interviews.
- There is a "corporate compliance" component that ensures annual trainings for both licensed and non-licensed therapists.
- For non-licensed therapists, there is no additional training to match what licensed therapists received to keep licensure with South Carolina Department of Labor, Licensing and Regulation.
- The DMH corporate HR does require a "sign off" on receiving policy and procedures of the agency.

Audits:

- There are quarterly audits of clinical service notes (three at the county level, one at the corporate level).
- Audits identify strengths/weaknesses and any matters of relevance, both good and bad, are passed down to be covered during meetings at the county level.

4.6 Billing Process

Procedure: SCDHHS PI conducted the following procedures regarding amounts billed by DMH for school-based services:

- Obtained and reviewed a draft copy of the December 2021 DMH Revenue Cycle Assessment conducted by SAVISTA.
- Interviewed DMH staff responsible for billing at the main office and the satellite offices.
- Examined examples of explanation of benefits for private-insurance denials.
- Mapped the school-based services billing process.

Results: Billing is a multipart process with tasks performed by both the county DMH offices and the DMH's main office. There is a lack of consistent processes among county offices. Medicaid is billed electronically. The processes have been in place for some time making it "less stressful" on billing staff. Medicaid payments are posted electronically. After payments have posted, billing staff runs a report to ensure accuracy.

Private insurance, until recently, has been billed manually. DMH is now working through moving to an electronic process for billing. Private insurance payments are not electronically posted and must be entered by hand. Secondary payers are addressed manually. Claims are frequently rejected by private insurance for the following reasons: provider not being "in-network," provider not meeting "provider credentialing criteria" and "provider not authorized" based on contractual stipulations. If a private insurance claim is not denied but no payment is rendered due to patient responsibility, such as a deductible or co-pay, DMH is obligated to only collect payment in the amount of the patient's responsibility. DMH writes off the remainder.

Self-pay patients may request a "reduction" which is a process of reducing the owed amount based on household income and family size. If reduction is granted, the patient must re-submit the required information yearly to continue with the reduced payment schedule.

4.7 Provider Rates Analysis

Procedure: PI obtained the schedule of rates paid by SCDHHS to DMH for school-based services and compared the rates to those paid to the school districts that provide their own school-based behavioral health services to determine if rates paid were equitable. In addition, PI projected an annual salary sustainable based upon the DMH rates and an estimated annual number of counseling hours.

Results:

The table below shows the current Medicaid reimbursement rates for the DMH compared to the rate paid to schools that provide their own school-based behavioral health services. Medicaid rates paid to the school districts are currently paid at a rate 53% lower than the rate paid to the DMH for approximately 89% of the services provided.

Rate Table DMH vs. School Districts

		Service Increment (Hours)	Est.% of Time	DMH Reimbursement Rate	School Reimbursement Rate	Difference \$	Difference %
H0031	MENTAL HEALTH ASSESSMENT BY NON-PHYSICIAN	0.50	9%	\$ 80.44	\$ 76.97	\$ (3.47)	-4.31%
90832	PSYCHOTHERAPY W/PATIENT 30 MINUTES	0.50	24%	79.77	37.30	(42.47)	-53.24%
90834	PSYCHOTHERAPY W/PATIENT 45 MINUTES	0.75	29%	159.10	74.60	(84.50)	-53.11%
90837	PSYCHOTHERAPY W/PATIENT 60 MINUTES	1.00	36%	239.67	111.90	(127.77)	-53.31%
90846	FAMILY PSYCHOTHERAPY W/O PATIENT PRESENT 5	0.83	less than 1%	240.03	107.04	(132.99)	-55.41%
90847	FAMILY PSYCHOTHERAPY W/PATIENT PRESENT 50	0.83	less than 1%	243.56	107.04	(136.52)	-56.05%
99366	TEAM CONFERENCE FACE-TO-FACE NONPHYSICIAN	0.50	less than 1%	80.06	37.56	(42.50)	-53.09%
99367	TEAM CONFERENCE NON-FACE-TO-FACE PHYSICIAN	0.50	less than 1%	80.02	79.08	(0.94)	-1.17%

4.8 School Contributions

Procedure: PI obtained the schedule of school district contributions per contract with DMH and compared it to the number of schools served by DMH in the district to determine if school district contributions were equitable statewide.

Results:

Testing shows there is currently not a fixed rate charged to a school district by the number of schools or students in the related district.

5 - Conclusions and Recommendations

Behavioral health issues are on the rise among school-age children. These issues result in societal problems and disruption to education. There has been a noted increase in anxiety and depression in students since the onset of the pandemic. Children with behavioral health issues generally begin showing signs during school years and these signs are often witnessed by teachers and counselors. Behavioral health issues will likely have a long-term effect on the health and wellbeing of the citizens of South Carolina, if not addressed. There is a growing need to ensure behavioral health services are available to students to address their needs. In addition, crisis intervention and counseling are not readily available to students in crisis. Crisis counseling is critically needed in schools.

Students referred for behavioral health services often do not receive these services if they are not available at the schools. DMH is the primary provider of school-based behavioral health services in South Carolina. School districts contribute to the support of the school-based services program operated by DMH via their contracts with DMH. Contract amounts are not based on a specified rate resulting in inconsistent contributions made to the program. Some school districts have opted not to contract with DMH for school-based behavioral health services. These school districts use school district employees, an outside third-party provider, or a combination of both, to meet their students' needs. DMH counselors are currently available in less than 50% of the state's public schools. DMH counselors do not commonly provide crisis counseling services.

School staff and parents are generally satisfied with the school-based services provided by DMH. Many school administrators expressed a preference for school-based behavioral health services to be provided by school district employees. School administrators' largest concerns are the need for more services and the loss of time for the DMH counselors to provide these services due to DMH counselors' duties outside of their school. One of the barriers cited by school administration is the difficulty in billing and being reimbursed for services provided.

DMH counselors, while credentialed, are not required to be licensed. DMH struggles to hire and retain counselors, presumably due to compensation not keeping up with market rates. Due to the lack of counselors, counselors are often stretched between schools. Based on PI's calculations, the rate paid to DMH could easily support a fully loaded annual salary of at least twice what DMH is currently paying its counselors. The starting pay for a master's-level counselor at DMH is approximately \$36,500.

Counselors are sometimes pulled for duties other than providing counseling, such as cafeteria or car line, which takes time away from their schedules. Travel time takes away from the time services could be provided. Counselors traveling between schools might not be reimbursed for travel.

Private insurance generally does not pay for school-based services provided by DMH due to provider not being "in-network," not meeting "credentialing criteria" and/or "not authorized" based on contractual stipulations. Private insurers insist they do not deny claims based on place of service. Some private insurance companies do not cover school-based behavioral health services. Tricare, which insures most of the military families, generally does not reimburse for similar reasons above.

Conclusions and Recommendations (continued)

Approximately 80% of DMH school-based services are paid for by Medicaid, despite the fact that students enrolled in Medicaid only make up about 65% of the student population.

Some parents may see DMH as the provider of last resort or prefer to keep their child's behavioral health services out of the school setting to avoid any impact it may have on the child's record. Children not covered by Medicaid may not receive services due to their guardian's inability to pay for co-pays and deductibles under private insurance. DMH, in most circumstances, will not deny services based on inability to pay.

Medical billing can be a complicated process. DMH's current billing practice lacks consistency across counties. DMH also struggles with being paid for services, particularly by private insurance and lacks the systems and staff to address denied claims.

Our review did not show a widespread issue with DMH billing for services that were not provided. Medical records reviewed frequently had documentation errors where they lack elements to meet established policies. Timeliness of service oversight was also a common issue. Staffing and training may be contributing factors to these issues.

Increasing the state's ability to meet the behavioral health needs of school-age children is not an easy task. It will likely take a multipronged approach to increase behavioral health services available to students and their families. This would include increasing the number of providers, ensuring funding is available, ensuring providers are paid regardless of the type of health care coverage a student is eligible for and increasing the services available to include crisis counseling. PI makes the several recommendations to help address this.

PI recommends that SCDHHS and DMH work cooperatively with DOE to provide a structure and assist schools with hiring counselors to provide school-based mental health and crisis counseling services. Currently, DMH counselors are credentialed but not required to be licensed. PI recommends that the DOE consider licensure as a requirement for these positions. Licensure helps ensure counselors have adequate knowledge and ongoing professional education. To expedite filling of positions, DOE may want to allow for counselors to meet credentialing requirements and work toward licensure within a specified period of time. DOE may want to provide financial assistance or incentives to aid counselors in obtaining licensure. As the current need is great, PI recommends that SCDHHS and DMH assist DOE with developing an expedited credentialing process for DOE-hired counselors.

To aid in recruitment, PI recommends that counselor salaries be analyzed to ensure they are competitive in the current marketplace. Based on our calculation, a \$65,000 fully loaded annual salary for a counselor could easily be supported, if DOE is paid at the same rates as DMH. PI also recommends that where appropriate, DOE consider providing an option for a 10-month school year contract to enhance recruitment.

PI recommends that SCDHHS reimburse claims filed by DOE at a rate consistent with that of DMH to ensure feasibility and that policy is properly modified to allow for this.

One of the key services cited as being of great need in the schools is crisis counseling. PI recommends that the counselors are trained in providing these services. The applicant pool could be increased by offering some form of incentive for South Carolina graduates to take a position with DOE, such as a sign-on bonus or reduction to student loan debt.

Conclusions and Recommendations (continued)

As billing was cited as a barrier for the school districts to provide behavioral health services, PI recommends SCDHHS provide a list of qualified medical billing companies that school districts could opt to contract with to assist with billing. Another option would be for the DOE to develop a centralized billing department properly trained to bill Medicaid and other insurers.

For school districts that will process their own billing, PI recommends DOE develop consistent well-documented procedures to be followed by all districts. PI also recommends school districts have adequate and trained staff to monitor claims, including denied claims, to ensure maximum generation of revenues to offset the cost of the programs.

As recipients, guardians and school staff are generally satisfied with the services provided by DMH, it should continue to be an option for school-based services. There is an ongoing need for increased availability of behavioral services to school-age children. The current labor market would not support an immediate move from DMH as a provider. Nor would an immediate move allow for adequate ramp up of the school and provider community to provide these services.

There are some fundamental issues that DMH would need to address in order for them to remain competitive with other providers.

Foremost is a staffing issue. DMH has seen a continued loss of counselors over the past three years. Recruitment and hiring cannot keep up with the rate of loss. Counselor salaries are not competitive. The starting pay is approximately \$36,500 for a master's-level counselor. The counselors are frequently put into volatile and stressful situations but are not compensated adequately for their efforts. This low salary is further exasperated by a very tight post-COVID job market. Private healthcare entities, telemedicine and school districts are all competing for the same pool of applicants, and generally pay higher salaries.

PI recommends DMH increases the starting pay for a master's-level counselor to be more competitive with the market. PI also recommends that DMH have adequate administrative support to reduce counselor's time spent on administrative tasks. The applicant pool could also be increased by offering an incentive for South Carolina graduates similar to the one mentioned above. PI also recommends that travel between schools be limited, and if necessary, utilize state vehicles or the employee be reimbursed for travel expenses.

There is also an increased need for crisis counseling in the schools. DMH counselors tend to avoid providing these types of services, possibly due to their explosive nature or disruption to an already full schedule. PI recommends DMH provides further training to its counselors to ensure they are adequately trained and encouraged to provide these services. The accountability for providing these services should be monitored.

Medical billing can be a complicated process. DMH's current process requires processing at both the local DMH county office and at their main office in Columbia. This two-part process allows for inconsistencies between centers. If the DMH will continue to bill for school-based services, PI recommends DMH develops consistent procedures to be followed by all centers. PI also recommends DMH ensures it has adequate and trained staff to monitor denied claims to prevent lost revenues.

Conclusions and Recommendations (continued)

In order to ensure adequate counselors are available to provide school-based behavioral health services, PI recommends that private providers also be used for school-based behavioral health services. However, there has been a history of fraud and abuse of the Medicaid program by behavioral health service providers. As such, PI recommends that SCDHHS review and tighten policies around behavioral health provider enrollment and behavioral health services provided in schools to prevent unscrupulous providers from taking advantage of the Medicaid program. Once policies are revised to prevent possible abuse of the Medicaid program, PI recommends reimbursement rates for school-based service be analyzed and adjusted to encourage more participation by private providers.

SCDHHS may also want to consider requiring counselors employed by the state to be licensed in order to receive Medicaid reimbursement for services provided. This would encourage both DOE and DMH to move toward employing only licensed counselors.

As there is a high need for crisis counseling services, PI recommends that SCDHHS adjust policies to allow providers to be more easily reimbursed for these services. Current policy requires an assessment before providing such services which may not be feasible. To prevent abuse of the procedure codes for crisis counseling, PI recommends limits be placed on the number of services that could be billed prior to an assessment and a directed course of continued care.

During the record reviews, there were multiple instances where critical documentation was missing proper signatures. Internal DMH QA documents found during the review process reflected that the verification or check for signatures is not a part of the matrix. PI recommends incorporating signature verifications into the internal QA process.

To ensure the children of South Carolina have access to the behavioral health services in the schools they need, PI recommends SCDHHS policies prevent balance billing by providers, both state and private, for any services covered by Medicaid.