HEALTHCARE AND REGULATORY SUBCOMMITTEE
MONDAY, MAY 3, 2021

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AGENDA

South Carolina
House of Representatives

Legislative Oversight Committee

HEALTHCARE AND REGULATORY SUBCOMMITTEE
The Honorable John Taliaferro "Jay" West, IV, Chair
The Honorable Gil Gatch
The Honorable Rosalyn D. Henderson-Myers
The Honorable Timothy A. "Tim" McGinnis

Monday, May 3, 2021
2PM
321 - Blatt Building

Pursuant to Committee Rule 6.8, S.C. ETV shall be allowed access for internet streaming whenever technologically feasible.

AGENDA

I. Approval of minutes

II. Discussion of the study of the Department of Health and Human Services

III. Adjournment

MINUTES

Legislative Oversight Committee
Monday, April 26, 2021
2:00 pm Blatt Room 110

Archived Video Available

I. Pursuant to House Legislative Oversight Committee Rule 6.7, South Carolina ETV was allowed access for streaming the meeting. You may access an archived video of this meeting by visiting the South Carolina General Assembly's website (http://www.scstatehouse.gov) and clicking on *Committee Postings and Reports*, then under *House Standing Committees* click on *Legislative Oversight*. Then, click on *Video Archives* for a listing of archived videos for the Committee.

Attendance

I. The Healthcare and Regulatory Subcommittee meeting was called to order by Chair John Taliaferro (Jay) West on Monday, April 26, 2021, in Room 110 of the Blatt Building. All members were present for all or a portion of the meeting. Representatives Gil Gatch and Timothy A. (Tim) McGinnis participated virtually in the meeting.

Minutes

I. House Rule 4.5 requires standing committees to prepare and make available to the public the minutes of committee meetings, but the minutes do not have to be verbatim accounts of meetings.

Approval of Minutes

I. Representative Henderson-Myers makes a motion to approve the meeting minutes from the April 19, 2021, meeting. A roll call vote was held, and the motion passed.

Rep. Henderson-Myers motion to approve the April 19, 2021, meeting minutes.	Yea	Nay	Not Voting
Rep. Gatch	✓		
Rep. Henderson-Meyers	✓		
Rep. McGinnis	✓		
Rep. West	✓		

Discussion of Department of Health and Human Services

I. Chair West places the following under oath: Mr. Robert M. Kerr, Director, Ms. Deirdra Singleton, Deputy Director for Administration and Chief Compliance Officer; Mr. Mike Targia, Director of Audits; Mr. Larry Overbaugh, Surveillance and Utilization Review Manager.

Chair West reminds Mr. T. Phillip Clark, Chief Financial Officer; Ms. Jenny Stirling, Deputy Chief of Staff for Legislative Affairs, that she remains under oath.

II. Director Kerr provides brief comments to the subcommittee about his initial objectives as a newly appointed agency head. These include addressing staffing needs and assessing agency performance measures.

III. Deputy Director Singleton provides an overview of the agency's program integrity unit. Topics discussed include:

a. reminder of agency's purpose;
b. reminder of agency's strategic plan;
c. related agency deliverables that align with program integrity;
d. related performance measures from fiscal year 2019-2020;
e. department turnover data;
f. related state and federal laws;
g. department cost;
h. department employee satisfaction;
i. program integrity structure and scope: organizational chart
j. stewardship and return on investment;
k. scope: what program integrity does and does not do:
l. partnerships;
m. fraud v. waste or abuse;
n. types of fraud;
o. provider fraud;
p. common provider schemes;

q. examples of provider waste and abuse;
r. recipient fraud;
s. identifying fraud, waste and abuse;
t. document and record collection;
u. managed care organization's role;
v. credible allegation of fraud;
w. surveillance utilization and review;
x. prepayment review;
y. pharmacy lock-in program;
z. sanctions;
aa. sanctions criteria;
bb. types of sanctions – abuse;
cc. types of sanctions – crime;
dd. provider fraud, waste, and abuse data;
ee. top five specialties based on overpayments identified;
ff. top ten individual provider cases identified overpayments;
gg. provider fraud, waste, and abuse cases opened – eight-year trend;
hh. provider fraud, waste, and abuse recovered funds – eight-year trend;
ii. recipient fraud, waste, and abuse data;
jj. recipient fraud, waste, and abuse cases opened – eight-year trend;
kk. recipient fraud, waste and abuse fraud, waste, and abuse recovered eight-year trend;
ll. South Carolina total recovered funds;
mm. cost avoidance;
nn. focus on cost avoidance;
oo. provider and recipient fraud cost avoidance;
pp. COVID-19 impact;
qq. Outlook;
rr. Reporting fraud.

IV. Subcommittee members ask questions relating to the following:

a. agency performance measures and benchmarking with other states;
b. staff turnover; filling vacancies; data from recent employee survey;
c. mechanisms to detect recipient fraud;
d. provider coding practices and training;
e. agency practices for detecting services billed for but not provided to recipients;
f. employee training;
g. sanctions;
h. agency strategic plan;
i. pharmacy lock-in program.

Agency staff respond to the members' questions.

Adjournment

I. There being no further business, the meeting is adjourned.

STUDY TIMELINE

Timeline of Agency Study

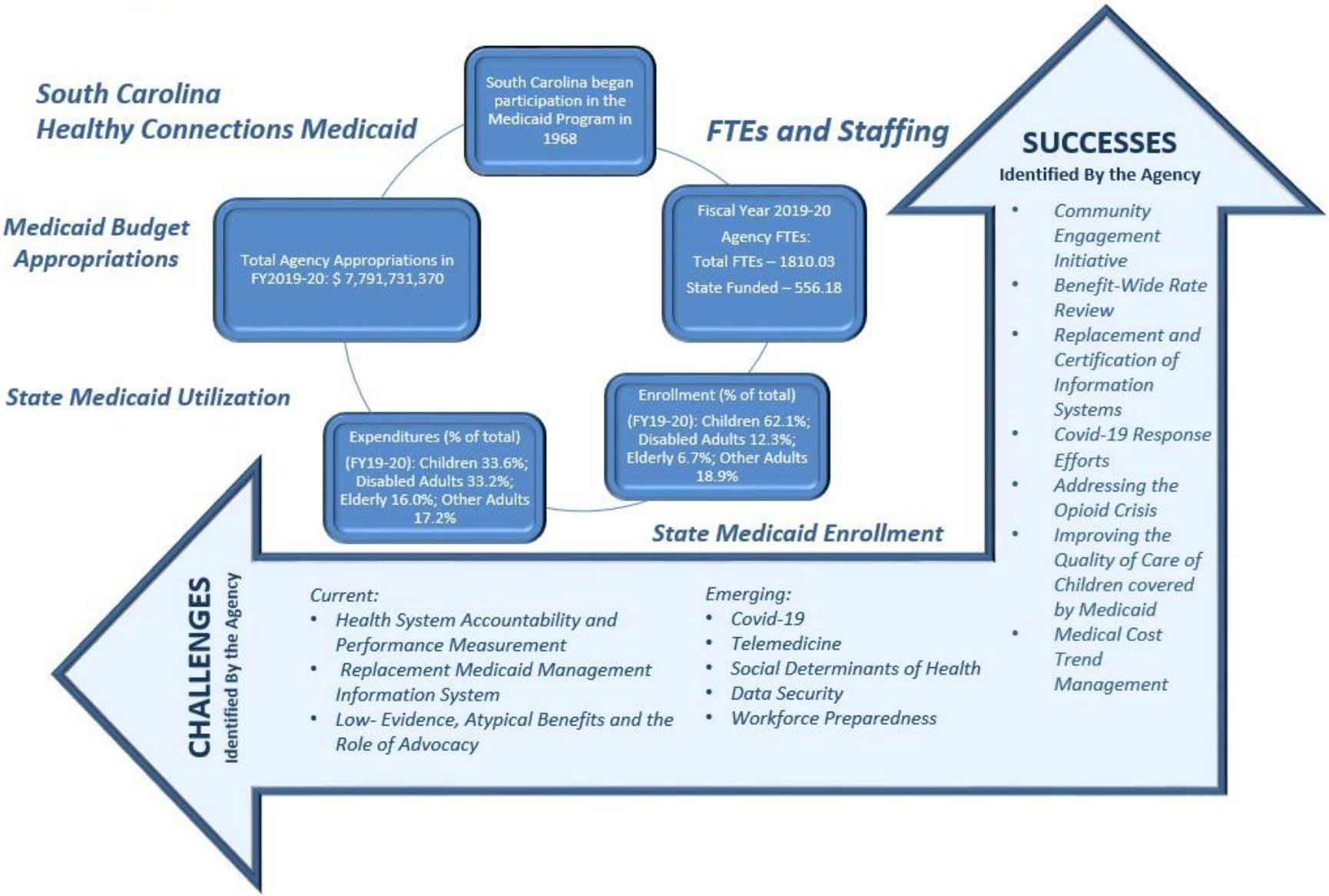
The House Legislative Oversight Committee's (Committee) process for studying the Department of Health and Human Services (agency, Department, or DHHS) includes actions by the full Committee; Healthcare and Subcommittee (Subcommittee); the agency; and the public. Key dates and actions are listed below.

December 9, 2019	At Meeting 1, the Committee selects the Department of Health and Human Services as the next agency for the Healthcare and Regulatory Subcommittee to study.
January 15, 2020	The Committee provides the agency with notice about the oversight process.
February 28 – April 1, 2020	The Committee solicits input from the public about the agency in the form of an online public survey.
June 2, 2020	The Department of Health and Human Services submits its Program Evaluation Report.
July 28, 2020	The Subcommittee holds Meeting 2 with the agency to discuss an overview of its mission, history, resources, major programs, successes, challenges, and emerging issues.
March 8, 2021	The Subcommittee holds Meeting 3 with the agency to discuss South Carolina Healthy Connections Medicaid eligibility.
April 8, 2021	At Meeting 4 the Committee receives public input about the agency.
April 19, 2021	The Subcommittee holds Meeting 5 with the agency to discuss Medicaid financing.
April 26, 2021	The Subcommittee holds Meeting 6 with the agency to discuss the Program Integrity division.
May 3, 2021	The Subcommittee holds Meeting 7 with the agency to discuss the Basics of Medicaid Managed Care.

Figure 3. Summary of key dates and actions in the study process

AGENCY SNAPSHOT

Department of Health and Human Services



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AGENCY PRESENTATION

SOUTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
Healthy Connections MEDICAID

South Carolina Healthy Connections Medicaid
The Basics of Medicaid Managed Care

Michael Jones

Deputy Director for Medicaid Operations and

Chief Operating Officer

South Carolina Department of Health and Human Services

Oversight Presentation Series Topics

- Agency Overview
- Medicaid Eligibility
- Medicaid Financing
- Program Integrity
- **Medicaid Managed Care**
- Home and Community Based Waiver Programs
- Health Improvement Programs
- Replacement Medicaid Management Information System
- Emerging and Priority Issues

Today's Agenda

- Purpose
- Program Evaluation Report Information
- South Carolina Medicaid Health Payment Models
- South Carolina Medicaid Population
- Matching South Carolina Populations to Models
- South Carolina Medicaid by the Numbers
- Managed Care Incentives and Quality
- COVID-19 Impact
- Evolution of South Carolina Managed Care

Purpose

SCDHHS Mission, Principles and Goals

Mission

The mission of the South Carolina Department of Health and Human Services (SCDHHS) is to purchase the most health for our citizens in need at the least possible cost to the taxpayer.

Principles

Engagement, Stewardship, Quality, Access, and Integration

Goals

- Purchase and evaluate care through evidence-based systems and models
- Strengthen the health and well-being of South Carolinians across their lifespan
- Limit the burden to provide and receive care
- Utilize public resources efficiently and effectively
- Maintain or improve healthcare marketplace stability

SCDHHS Strategic Plan

Agency Deliverables

2) Design and provide reimbursement for evidence-based, high-value health benefits to Medicaid beneficiaries, based on medical necessity.

Strategic Plan Alignment				
Stewardship	**Access**	**Quality**	**Integration**	**Engagement**
				

Agency Deliverables

5) Safeguard taxpayer resources against fraud, waste and abuse.

Strategic Plan Alignment				
Stewardship	**Access**	**Quality**	**Integration**	**Engagement**
				

Agency Deliverables

6) Administer the Medicaid program in a manner that is consistent with state and federal law.

Strategic Plan Alignment				
Stewardship	Access	Quality	Integration	Engagement
				

Agency Deliverables

7) Exercise fiscal responsibility in the use of taxpayer resources.

Strategic Plan Alignment				
Stewardship	**Access**	**Quality**	**Integration**	**Engagement**
				

Program Evaluation Report (PER) Information

FY19-20 Performance Measures

- Process 99% of provider applications within 30 days
  - Target: 99+%
  - Actual: 96%
- Process 99% of all electronic claim submissions within 30 days
  - Target: 99+%
  - Actual: 99+%
- Achieve 97% of claims adjudicated on the provider's first submission
  - Target: 97%
  - Actual: 96%
- Ensure MCO performance, based on National Committee for Quality Assurance (NCQA) health plan rankings, is at or above the southeastern average (child measure)
  - Target: At or above southeastern average
  - Actual: NCQA temporarily stopped providing rankings due to COVID-19

FY19-20 Performance Measures *(cont.)*

- Ensure MCO performance, based on NCQA health plan rankings, is at or above the southeastern average (adult measure)
  - Target: At or above southeastern average
  - Actual: NCQA temporarily stopped providing rankings due to COVID-19
- Increase the percentage of Healthcare Effectiveness Data and Information Set (HEDIS) withhold metrics at or above the 50th percentile by 2% annually
  - Target: 2%
  - Actual: 3.3%
- Provide at least 20% of managed care payments using a value-based approach
  - Target: 20%
  - Actual: 35%
- Maintain medical loss ratio (MLR) at or above 86%
  - Target: 86%
  - Actual: 87.5%-95.4%

Turnover Data

- Managed Care
  - FY19-20: 0%
  - FY18-19: 0%
  - FY17-18: 22.2%
  - FY16-17: 11.8%
- Agency Operations (claims processing, project management office, provider enrollment, etc.)
  - FY19-20: 34.7%
  - FY18-19: 10.3%
  - FY17-18: 29.3%
  - FY16-17: 9.8%

Statutes Included in PER

- S.C. Code § 44-6-30(1) - Administer Title XIX of the Social Security Act (Medicaid), including the Early and Periodic Screening, Diagnostic and Treatment program, and the Community Long Term Care System
- S.C. Code § 44-6-40(1) - Prepare and approve state and federal plans prior to submission to the appropriate authority as required by law for final approval or for state or federal funding, or both. Such plans shall be guided by the goal of delivering services to citizens and administering plans in the most effective and efficient ways possible.
- S.C. Code § 44-6-70 - Preparation of state plan and resource allocation recommendations
- S.C. Code of Reg. Article 3 Medicaid, Subarticle 1 Scope of the Program (for all covered services)
  - Medical necessity
  - Prior authorization
  - Copayment
  - Service limits
- 42 U.S. Code § 1396d. Definitions
  - Mandatory and optional service definitions
- 42 U.S. Code 1396u–2 – Provisions related to managed care
- 42 C.F.R. Part 438 – Managed care

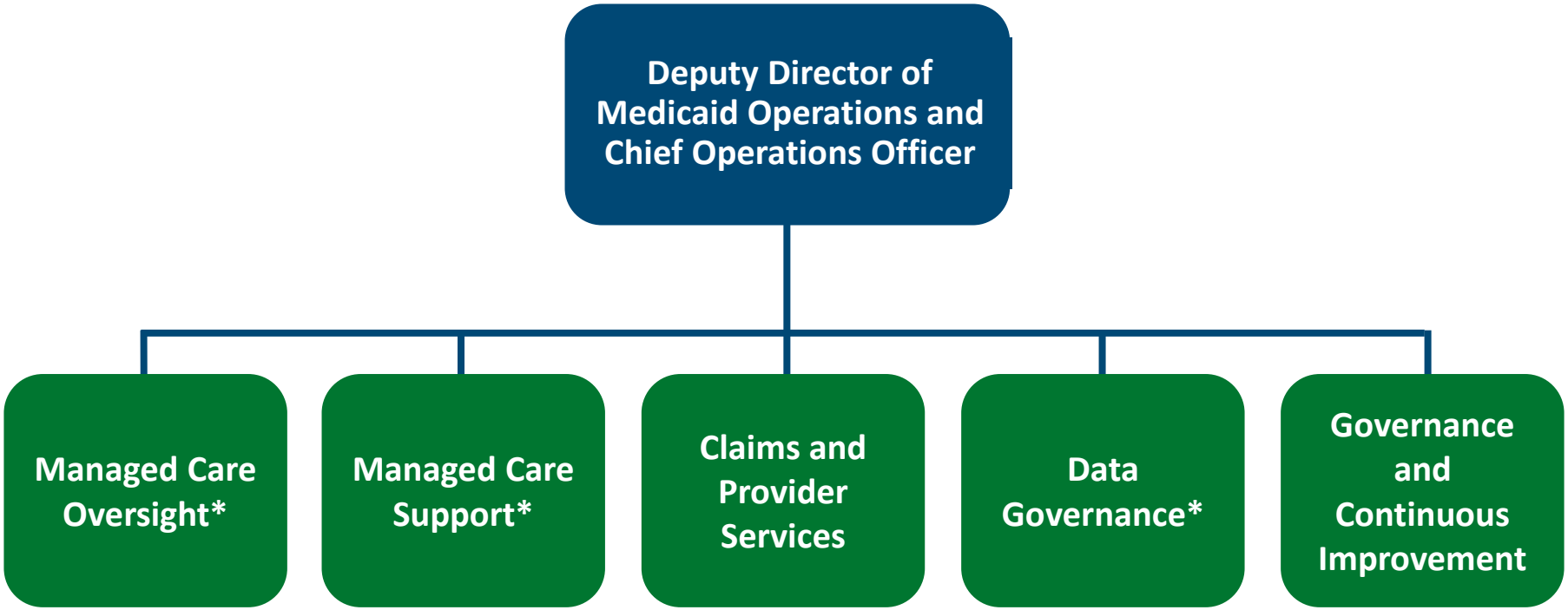
Department Cost – Claims and Capitation Payments

- Employee Equivalents:
  - FY19-20: 111
  - FY18-19: 136
  - FY17-18: 157
  - FY16-17: 160
- Costs:
  - FY19-20: $7,490,258,271
  - FY18-19: $7,146,405,058
  - FY17-18: $6,933,547,007
  - FY16-17: $6,874,889,743
- Percent of Total Spend:
  - FY19-20: 95.86%
  - FY18-19: 95.83%
  - FY17-18: 96.48%
  - FY16-17: 96.78%
- Cost per Deliverable:
  - FY19-20: $260.33
  - FY18-19: $241.93
  - FY17-18: $237.70
  - FY16-17: $240.74

Employee Satisfaction

- Employee satisfaction tracked?
  - FY19-20: No (new vendor awarded September 2020)
  - FY18-19: Yes
  - FY17-18: Yes
  - FY16-17: Yes

Managed Care and Operations Organizational Chart



**Indicates an area that is being restructured; chart reflects the planned structure.*

South Carolina Medicaid Health Payment Models

Fee-for-Service and Managed Care Definitions

- Fee-for-service (FFS)
  - The state pays providers directly for each covered service received by a Medicaid beneficiary.
- Care coordination
  - Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care.
- Managed care organization (MCO)
  - The state pays a fee to a managed care plan for each person enrolled in the plan.
- Capitation payment
  - A fixed dollar amount per member per month, to cover medical services and health plan administrative costs.

Managed Care Authorities

- States can implement a managed care delivery system using one of three federal authorities:
  - State plan authority - Section 1932(a)
  - Section 1915(a) and (b) waiver authority
  - Section 1115 waiver authority
- SCDHHS uses the state plan authority approach
  - Permanent authority vehicle for states
  - Application state: Allows any willing and qualified MCO to enter market
  - Does not allow some populations to be required to enroll in an MCO:
    - Dual eligibles (members enrolled in Medicare and Medicaid)
    - Members of federally recognized tribal organizations
    - Children with special healthcare needs

South Carolina Medicaid Health Payment Models

Outlook

Managed Care for Additional Populations, or New Models?

2013-Present

MCOs

- Added HEDIS quality metrics and NCQA accreditation
- Medical loss ratio added
- Medicare/Medicaid dual demonstration started (Prime)
- Moved MHN members to MCOs

2006-2013

Additional Managed Care Options

- State Plan approved in 2010 for mandatory managed care for certain federally-approved populations.
- In 2007, added enrollment broker to assist in plan selection.
- Started primary care case management (PCCM) via medical home network (MHN) where services were paid FFS with enhanced rate for MHN to assist with coordinating care

1994-2006

First Waiver for Managed Care

- The Palmetto Health Initiative pilot to research feasibility of a managed care delivery system
- In 1996, began to offer managed care for certain populations

1968-1994

FFS Only

- All Medicaid members

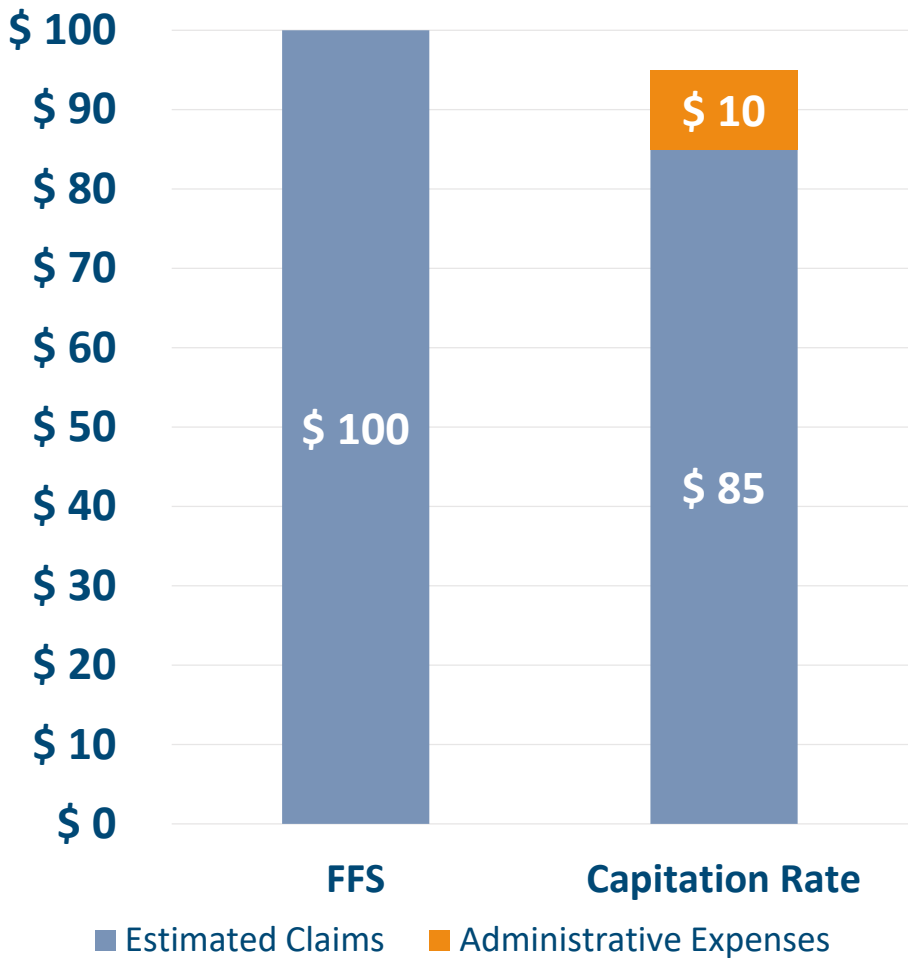
FFS Overview

- Most traditional healthcare payment model
- Providers are reimbursed directly by the agency for covered services delivered
- Patients and providers determine services to be delivered and billed
- All risks are assumed by payor
- Prior authorizations are used to help monitor medical necessity of services

Managed Care Overview

- In the 1990s, managed care came into the healthcare delivery system to help manage cost, analyze utilization and improve quality.
- MCOs accept a set per member per month (capitation) payment for these services (e.g. MCOs assume risk).
  - Capitation payments
    - Fixed, pre-defined monthly payments received by an MCO per patient enrolled in the MCO's plan
      - Per member per month (PMPM)
  - How are capitation payments calculated?
    - Actuarially sound rates are developed by using local costs and average utilization of services

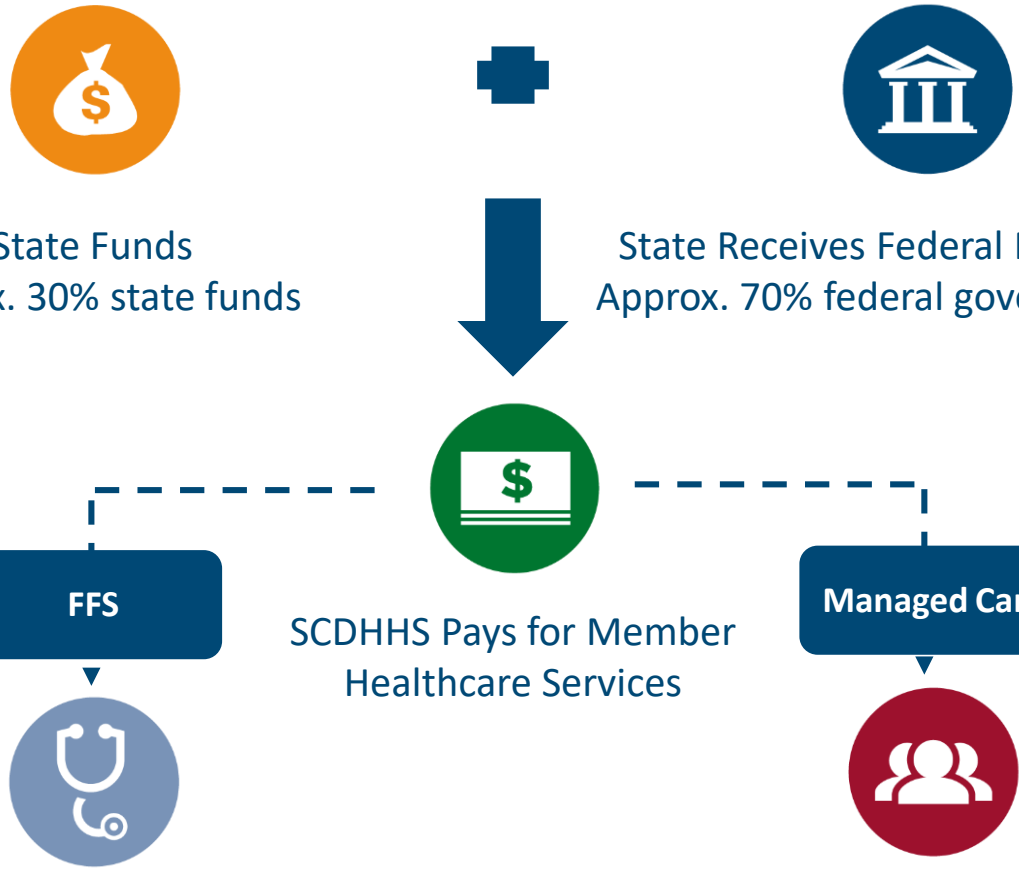
Capitation



Illustrative example:

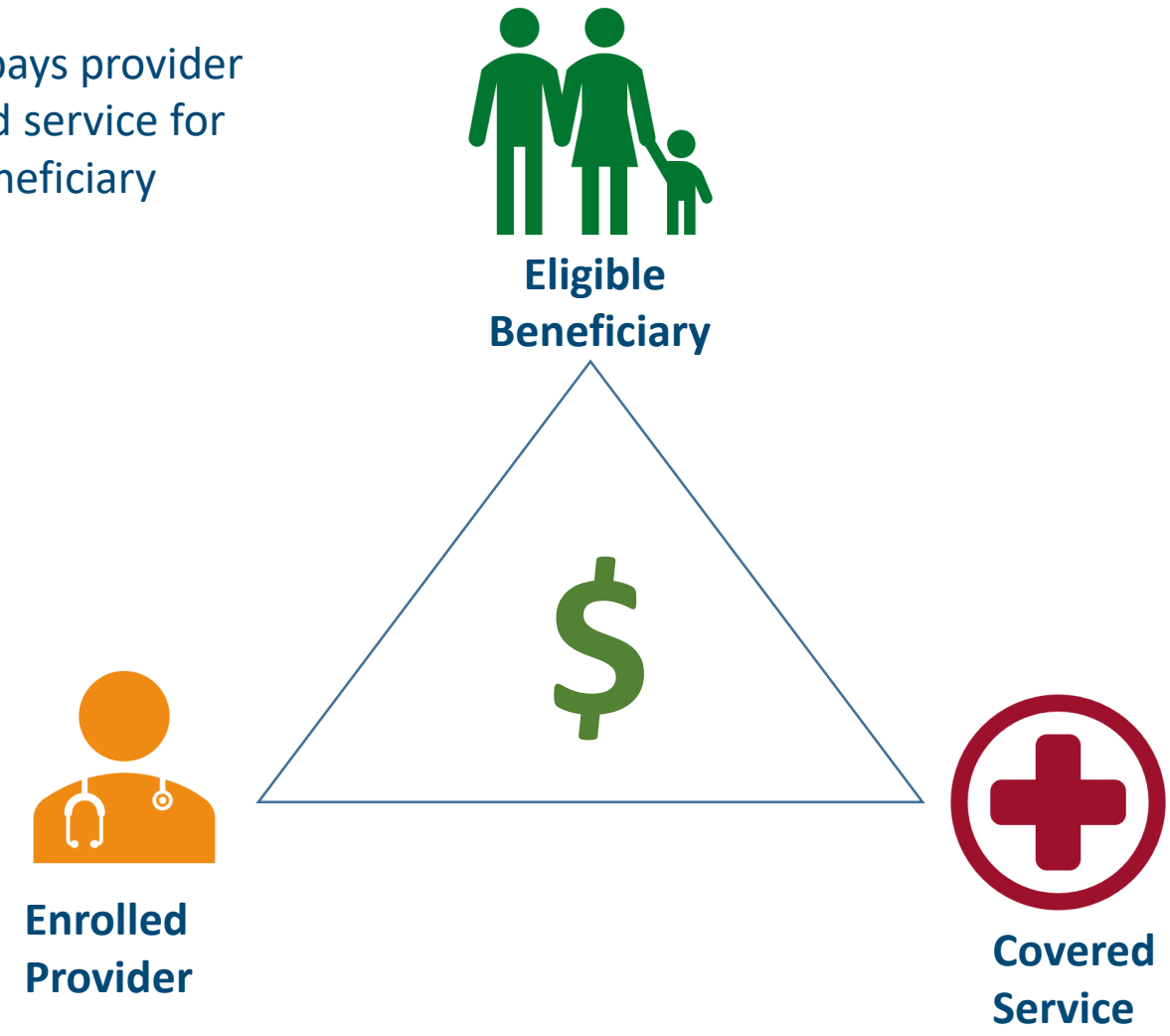
- If paid FFS, services cost $100.
- When delivered through managed care and effectively managed, direct service costs are expected to cost $85 (reduction of $15).
- Estimated MCO administrative expenses are $10.
- Capitation rate is $95.
- Managed care creates a savings of $5 for the Healthy Connections Medicaid program.

Funding Medicaid Coverage



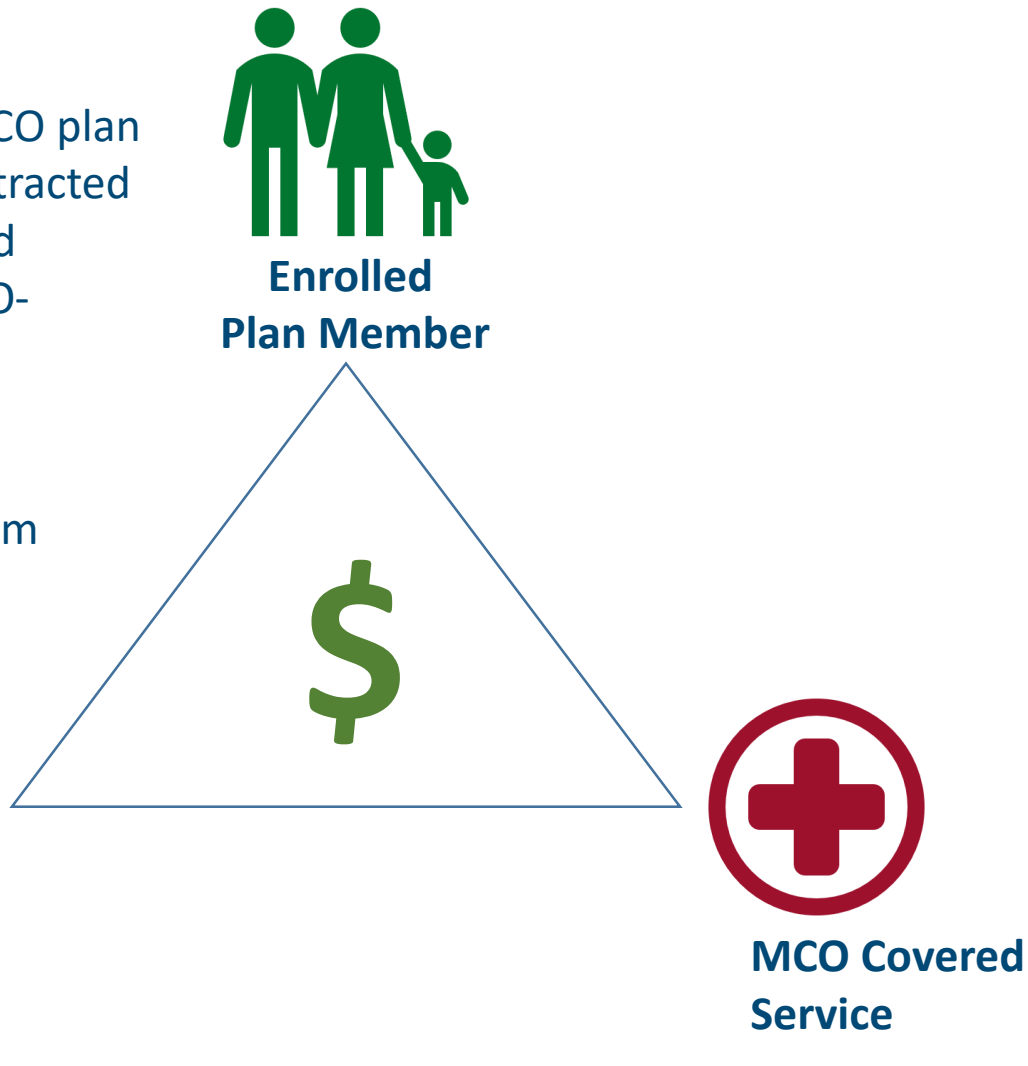
Medicaid FFS Transactions

- Medicaid pays provider for covered service for eligible beneficiary



Medicaid Managed Care Transactions

- Medicaid pays monthly capitation payment to MCO plan
- MCO plan pays MCO-contracted provider for MCO-covered services delivered to MCO-enrolled members
  - MCOs must cover all contracted covered services at a minimum



South Carolina Medicaid – Coverage Structure

Managed Care

- Tasked with coordinating care and providers contract individually with MCOs.
- MCOs provide a service array defined in the managed care contract.
- Track various nationally recognized quality measures and quality indices.

FFS

- FFS benefits are State Plan services reimbursed directly by SCDHHS.
- Providers adhere to policies outlined in provider manuals and contracts with SCDHHS.
- Prior authorizations are used to help manage quality and appropriate utilization.

Managed Care Flexibilities and Efficiencies

Managed Care

- **Flexibility to cover** services, benefits and incentives **that FFS does not provide.**
- **Ability to maintain their own provider networks as long as they maintain network adequacy.**
- **Capitation rates are set by actuaries and are tied to rate cells based on age, gender and eligibility categories.**

FFS

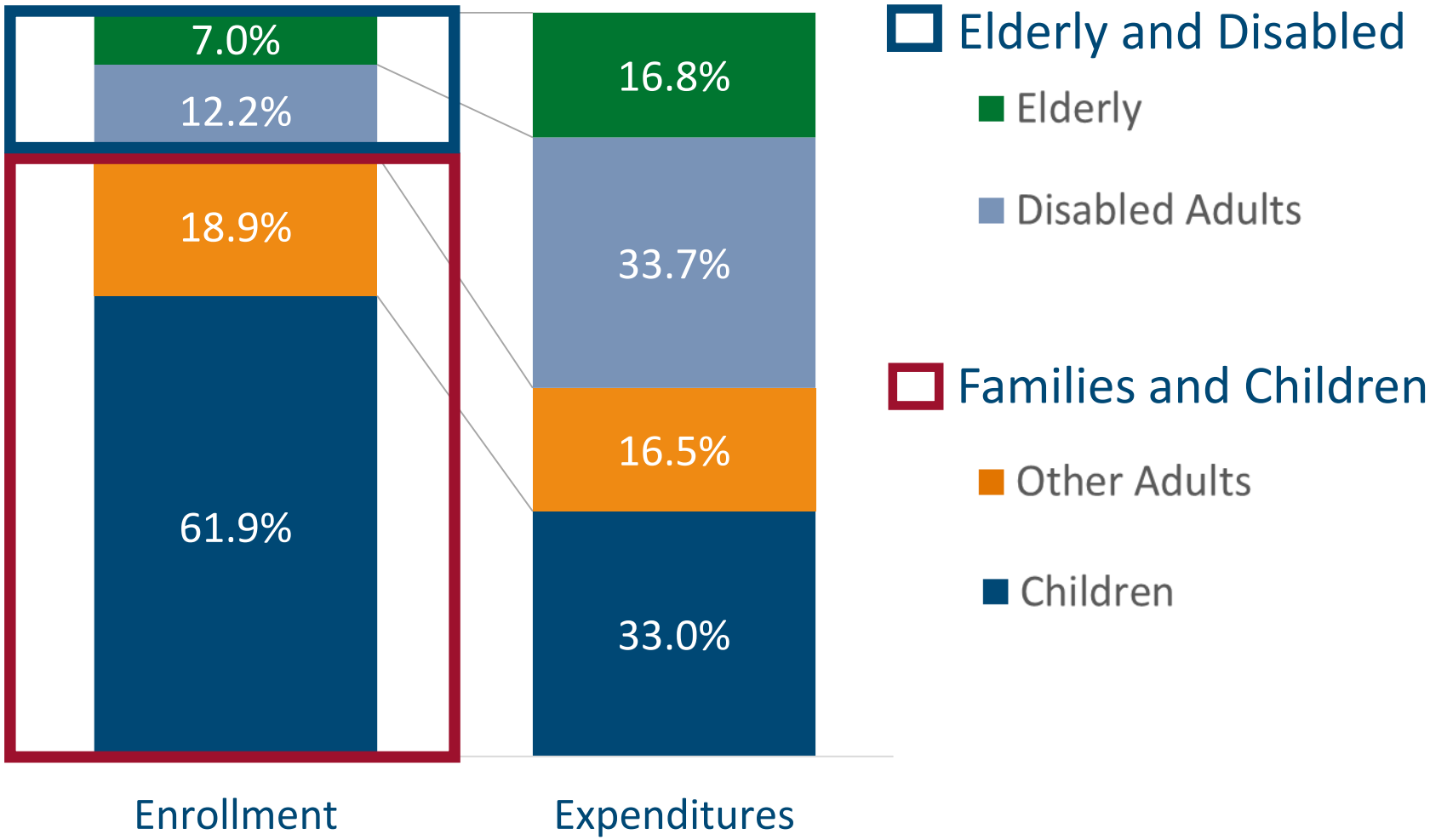
- **Covers services as defined by State Plan or waiver authority only.**
- **Any "willing and qualified" provider may enroll.**
- **Rates are primarily set as a percentage to Medicare reimbursement.**

South Carolina Medicaid Population

South Carolina Full Benefit Medicaid Population Groupings

- Families and children
  - Categories of eligibility:
    - Parent caretaker relatives (formerly low-income families), children, infants, pregnant women, etc.
  - Approximately 80% of South Carolina's Medicaid population
- Elderly and disabled adults
  - Categories of eligibility:
    - Aged, blind and disabled, nursing home, community long term care, etc.
  - Approximately 20% of South Carolina's Medicaid population

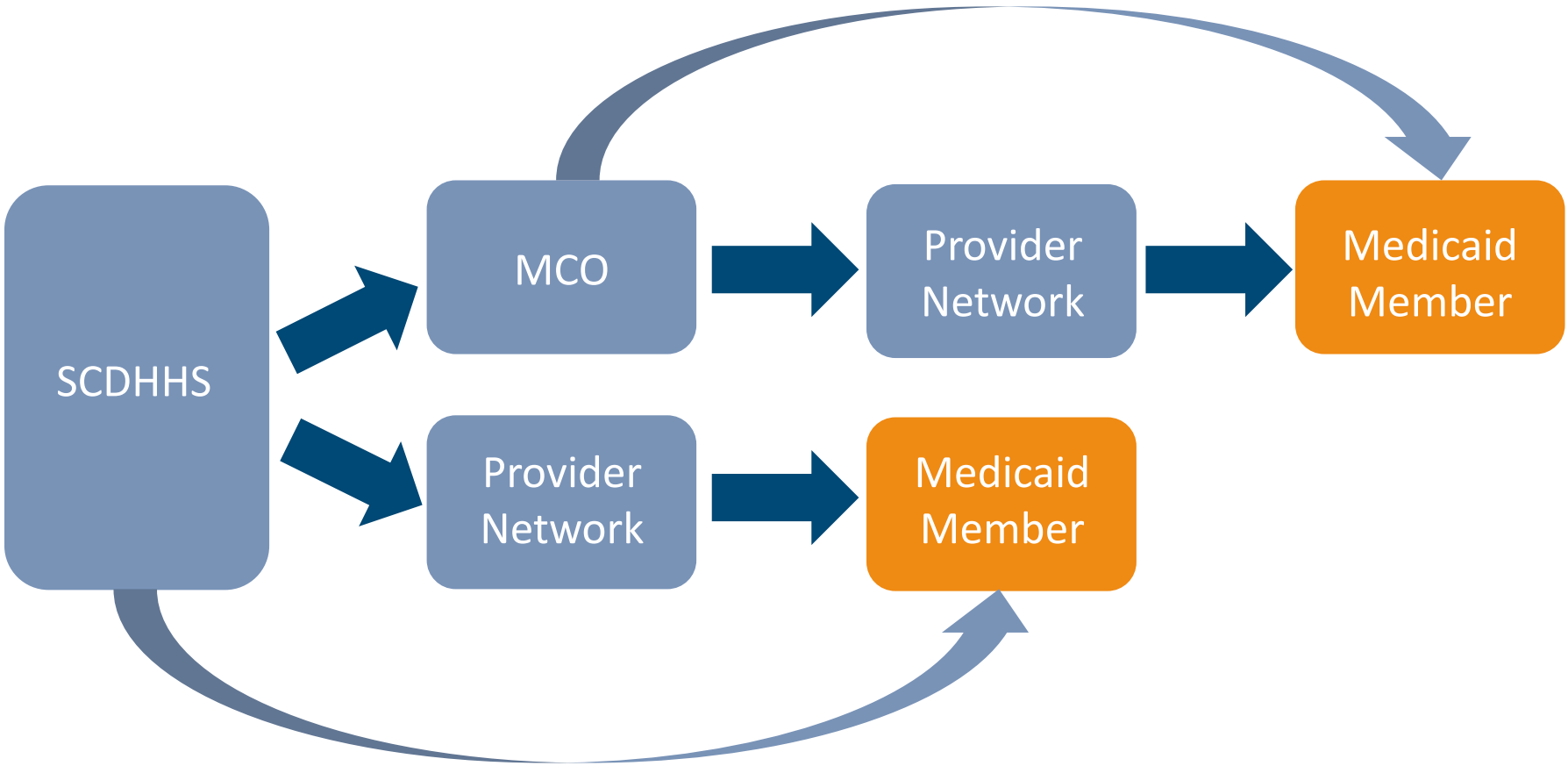
South Carolina Full Benefit Medicaid Population Groupings *(cont.)*



Matching South Carolina Populations to Models

Alignment With the Health Financing Market

Care Delivery in Medicaid



Creating Models That Meet Population Need

Families and Children*

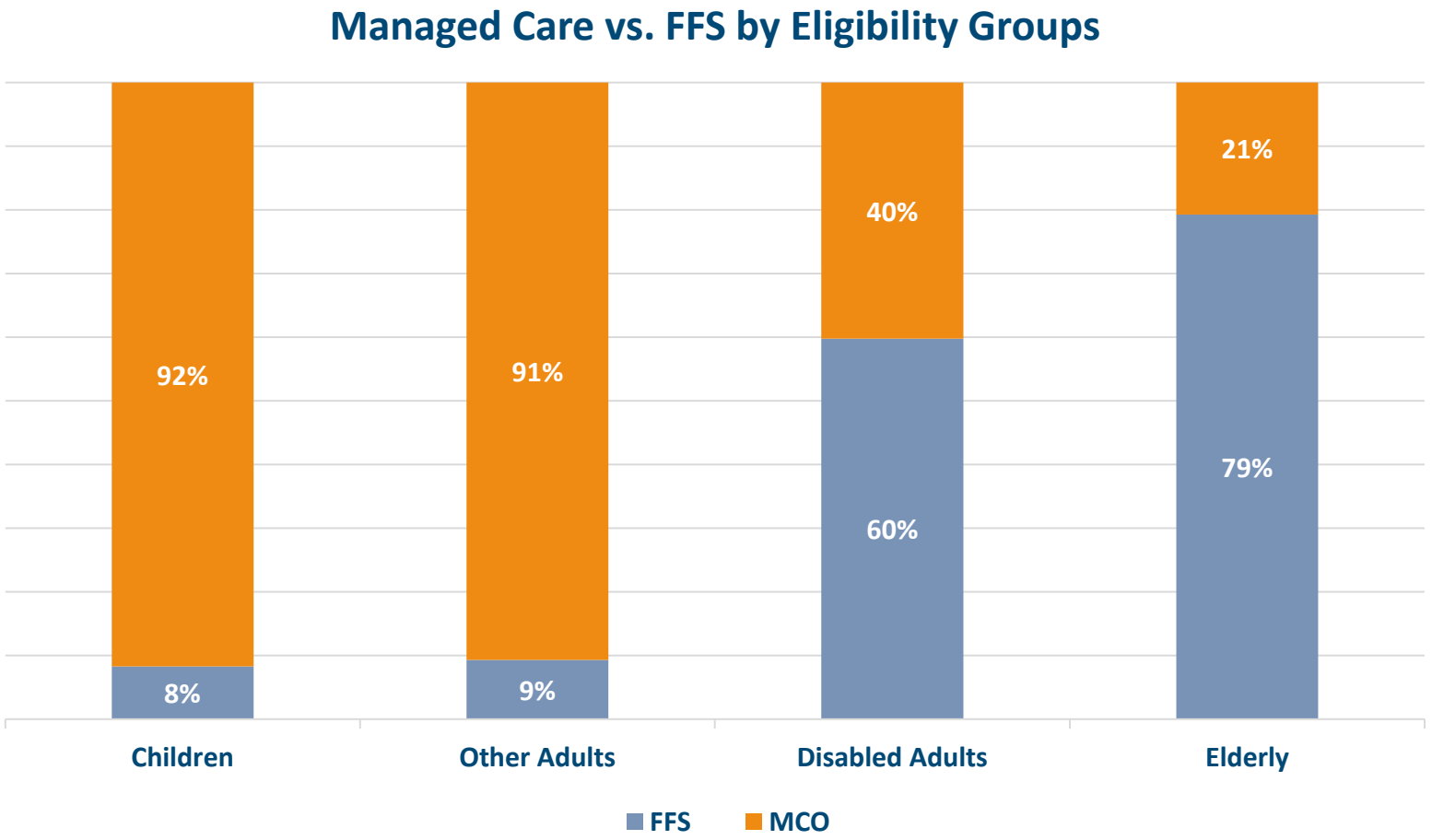
- Professional (MD)
- Inpatient Care
- Prescription Drugs
- Outpatient Hospital Services

Elderly and Disabled Adults*

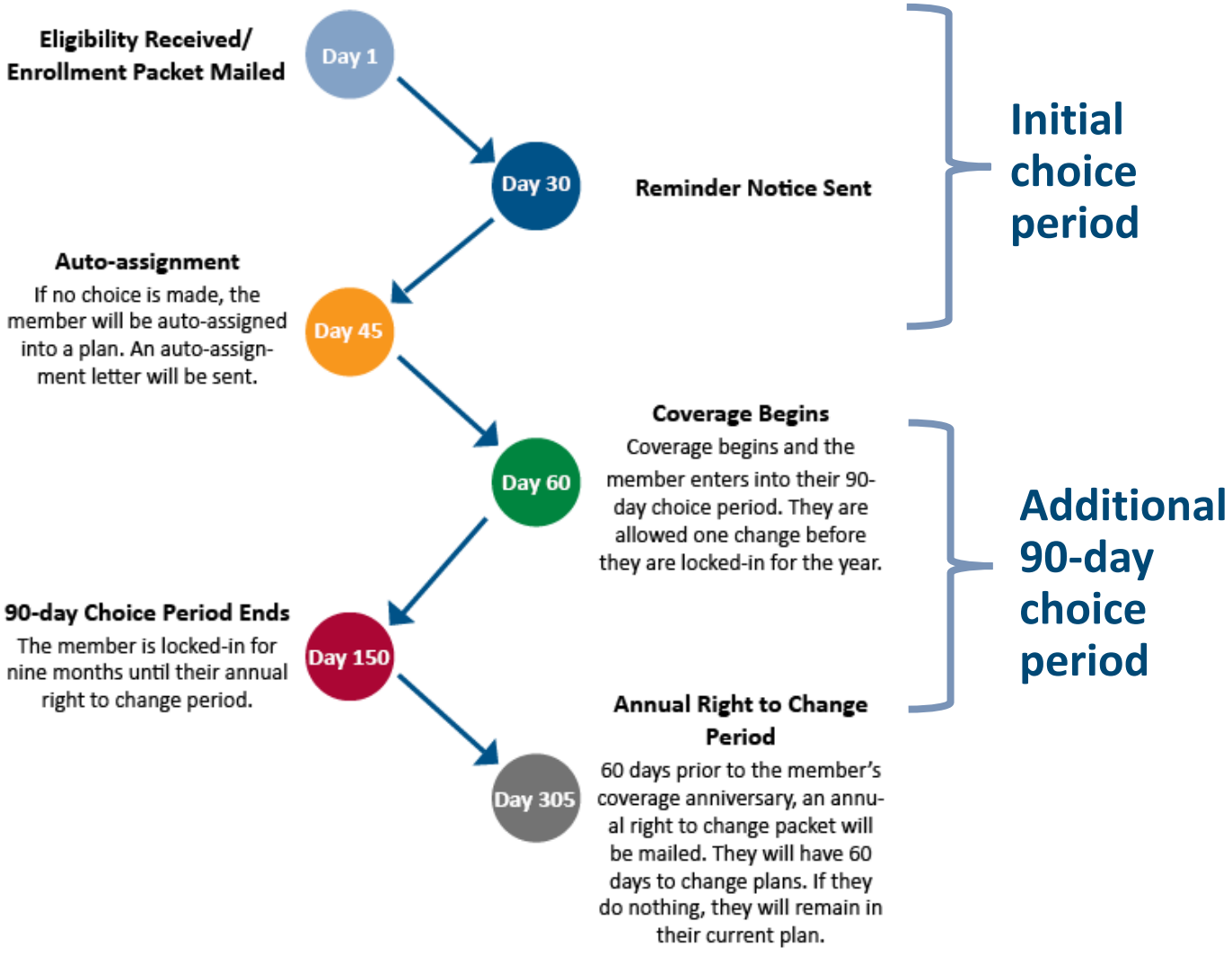
- Institutional
- Waiver Services
- Inpatient Care
- Medicare Premium, Optional State Supplementation (OSS), Optional Supplemental Care for Assisted Living Program (OSCAP)

**All medically necessary Medicaid services are available to all full benefit members.*

South Carolina Full Benefit Medicaid Managed Care Population



Managed Care Plan Selection and Enrollment Process



Healthy Connections Choices vs. Prime

Healthy Connections *Choices*:

Approx. 900,000 members

- Lower income families
- Aged, blind, and disabled
- Pregnant women

Basic acute healthcare
Maternity
Prescription drugs

Healthy Connections *Prime*:

Approx. 16,000 members

Age 65 years or older
Not in an institution (at enrollment)
Eligible for Medicare

Traditional Medicaid services
Traditional Medicare services
Home and community-based services

South Carolina Medicaid
By the Numbers

South Carolina Medicaid – Coverage Structure

Managed Care

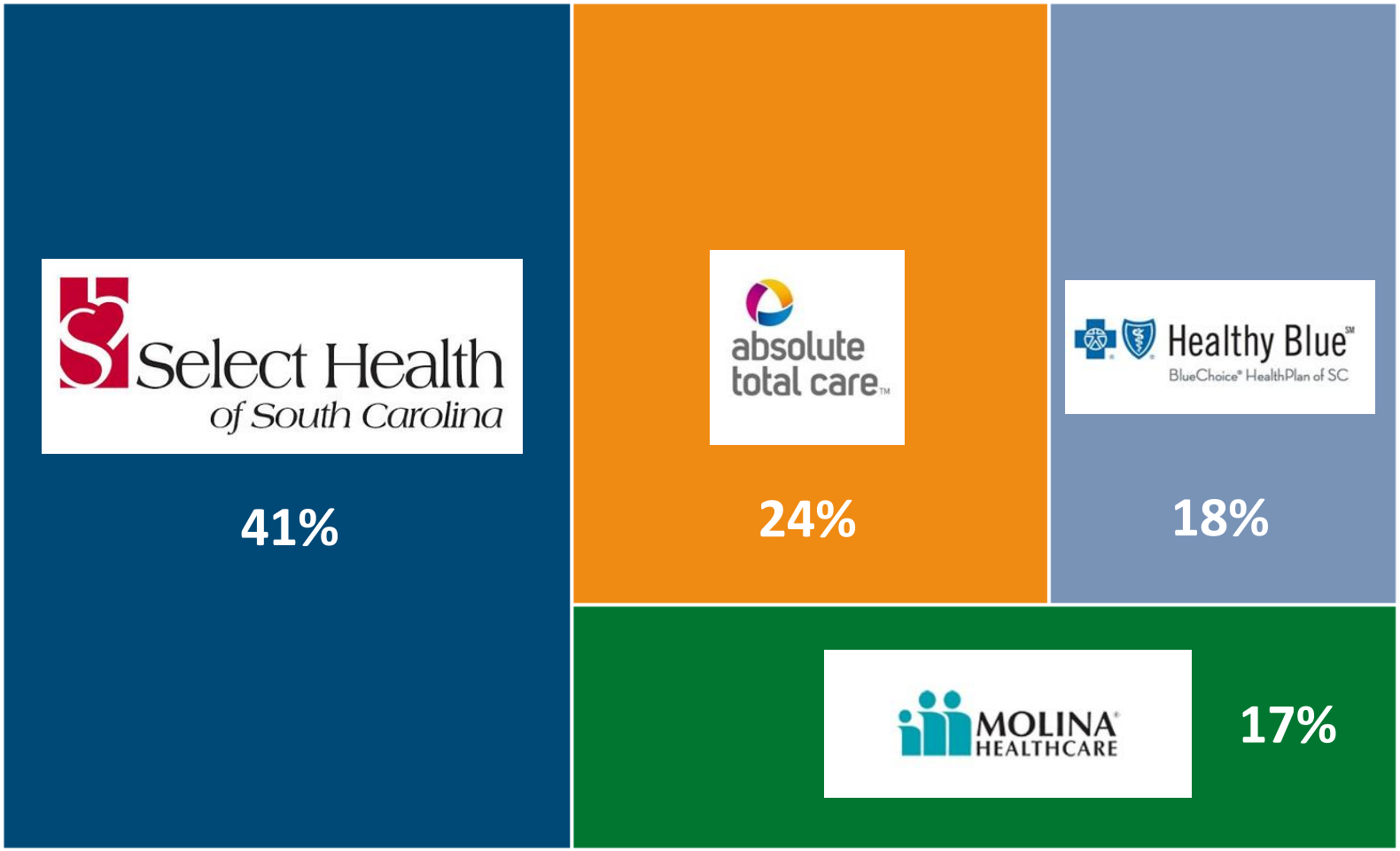
- **Approx. 900,000 members**
- **Approx. $3 billion**
- Low-income families
  Disabled children and adults
  Pregnant women

FFS

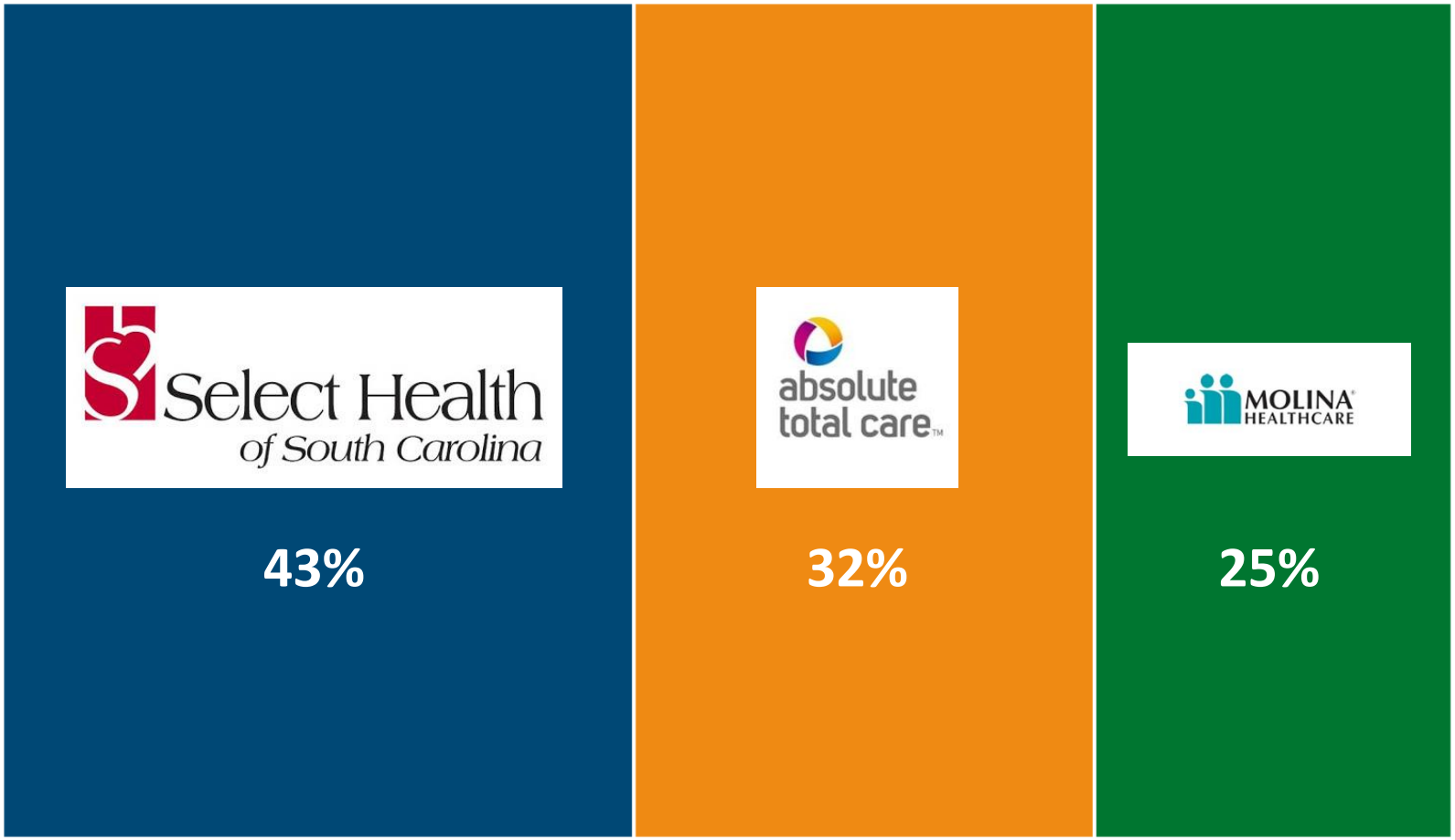
- **Approx. 215,000 full benefit members**
- **Approx. $3 billion**
- •Long-term care
  •Recipients of home and community-based services
  Recipients of other waiver services
  •MCO carved-out services

South Carolina Managed Medicaid Market

Current Managed Care Enrollment by Plan



Healthy Connections Prime Enrollment by Plan



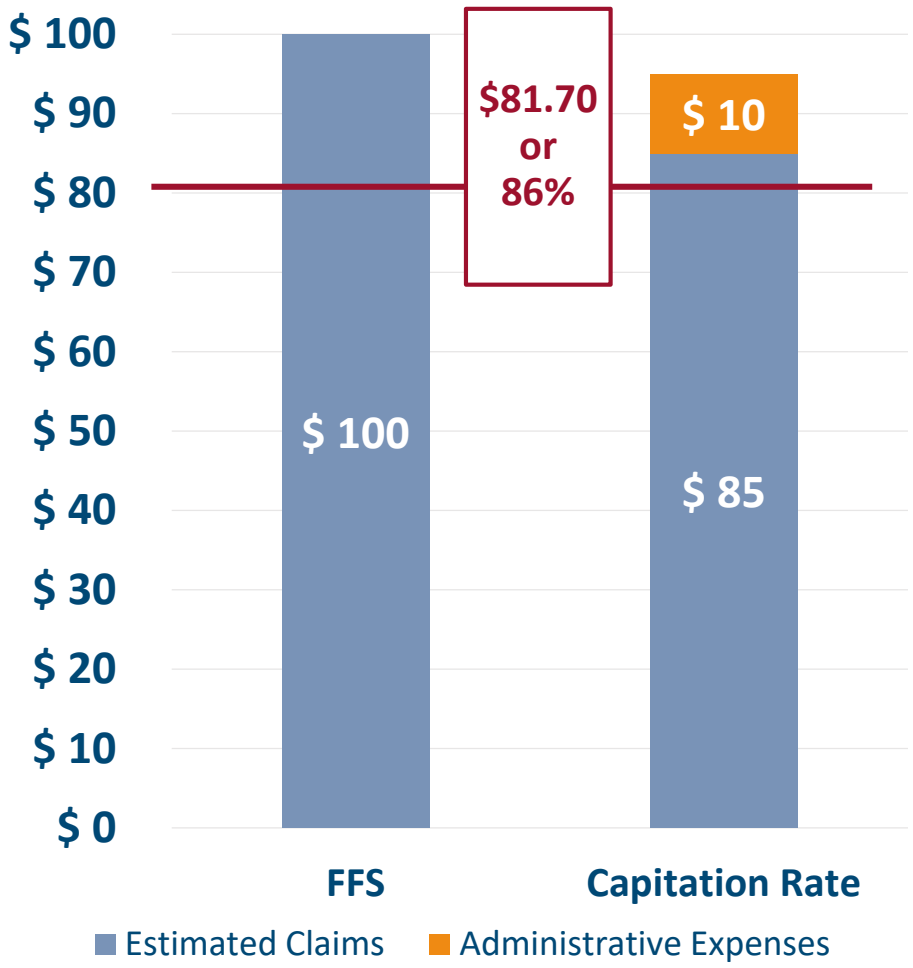
Managed Care Incentives and Quality

Medical Loss Ratio

SCDHHS requires that MCOs spend ***$0.86 out of every $1*** of capitation to pay for medical claims and activities that improve the quality of care.

Absolute Total Care	
First Choice by Select Health of South Carolina	
Healthy Blue by BlueChoice of SC	
Molina Healthcare of SC	
WellCare	

Medical Loss Ratio Example

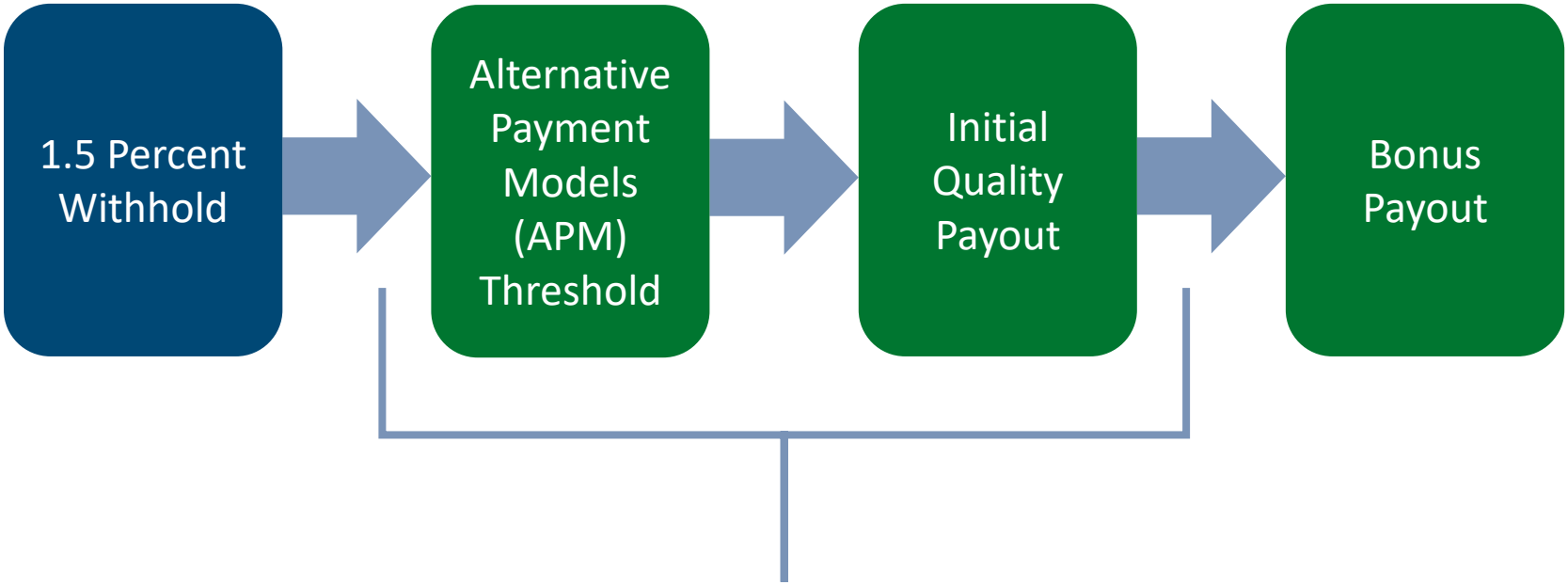


Illustrative example:

- If paid FFS, services cost $100.
- Capitation rate is $95.
- MCOs are required to spend at least 86% of capitation rate on medical services per SCDHHS minimum medical loss ratio requirements ($81.70 = 86% of $95).

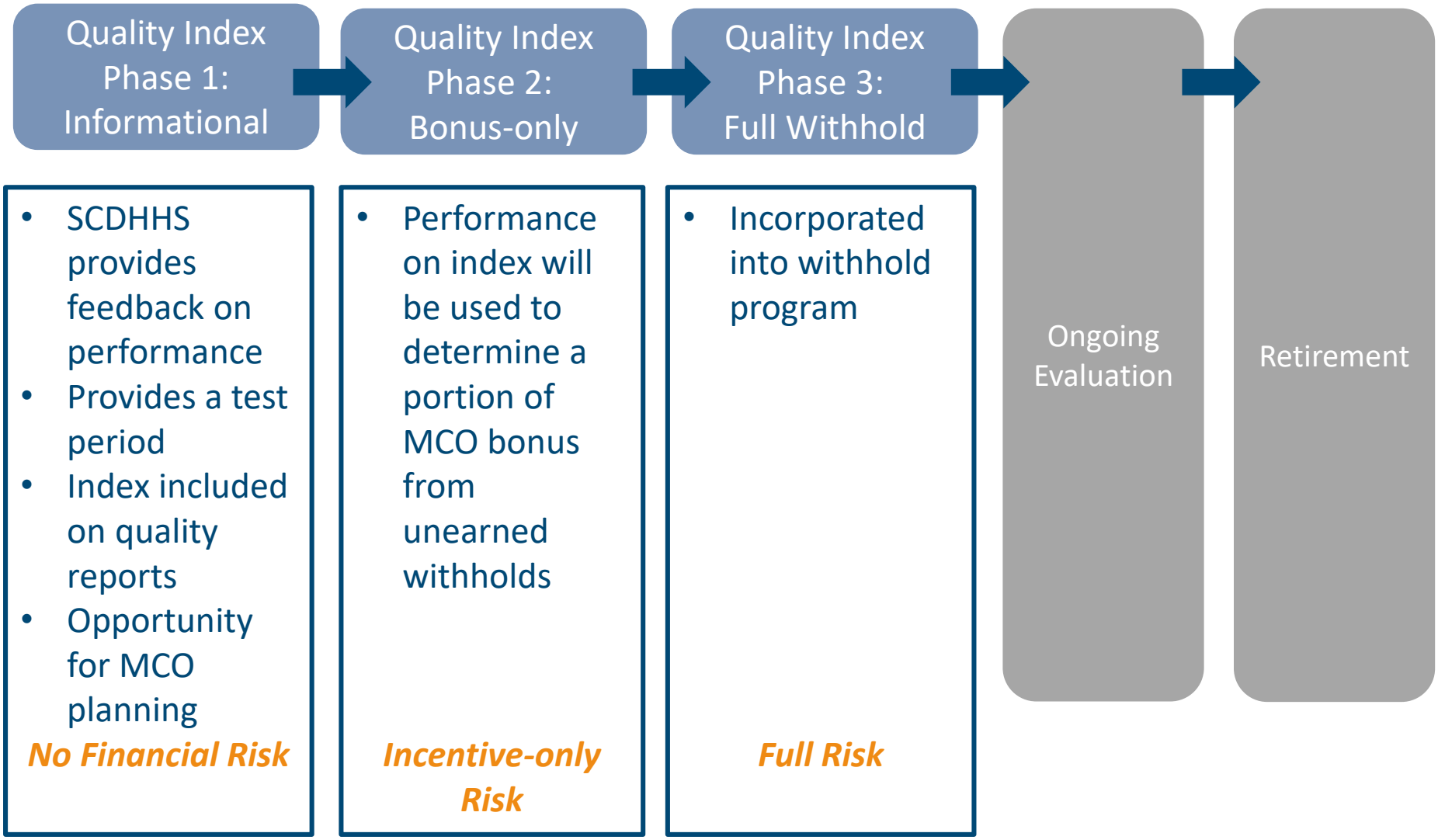
Withhold Program

Holds approximately $40 million in total MCO capitation payments that must be *earned back* by the MCOs based on quality of care.



Blending Quality and Payment Reform

Quality Index Life Cycle



Selection Criteria for Index Measures

- Current performance
  - National performance: Is current plan performance below national and regional benchmarks?
  - Local performance: Does variability suggest potential for improvement?
- Alignment
  - NCQA accreditation measures
  - CMS core measures
  - National Quality Forum (NQF) endorsement
  - SCDHHS
- Relevance
  - Population: Do measures affect a significant number of Medicaid members?
  - Financial: Do measures influence a significant level of Medicaid spend?

Current Indices of Quality

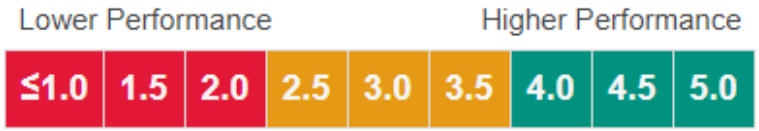
- Diabetes care
  - A1c testing, A1c poor control, testing for nephropathy, eye exam
- Women's preventive health
  - Timeliness of prenatal care, breast cancer and cervical cancer screenings, chlamydia testing
- Children's preventive health
  - Well-child visits (15 months, 3-6 years, adolescent) and body mass index
- Incentive-only quality metrics
  - Heavily weighted towards behavioral health
  - Includes integration of several metrics

Health Plan Quality Metrics

- Plans must meet accreditation standards.
- All South Carolina managed care plans are accredited by NCQA.
- All plans are graded on aggregate and by subcategories (composites), including consumer satisfaction, prevention and treatment.

Health Plan Quality Metrics – 2019 NCQA Ratings

- Rating is a weighted average based on all measures, not just the average of the three composites.



3.5	Molina Healthcare of South Carolina, LLC
3.5	Select Health of South Carolina, Inc.
3.0	Absolute Total Care, Inc.
3.0	BlueChoice HealthPlan of South Carolina
3.0	WellCare of South Carolina, Inc.

**Absolute Total Care and WellCare merged after the 2019 ratings were issued.*

Multicultural Health Care Quality Standards

- MCOs must achieve the NCQA distinction in Multicultural Health Care by the end of 2022
  - Developed to address disparities in health status and outcomes
  - The U.S. Department of Health and Human Services notes that "by tailoring services to an individual's culture and language preferences, health professionals can help bring about positive health outcomes for diverse populations."
- Benefits
  - Identify gaps in care
  - Establish standardization
  - Stand out as a market leader
  - Lower costs

External Quality Review (EQR)

- EQR is the analysis and evaluation of aggregated information on quality, timeliness and access to the health services that an MCO provides to Medicaid beneficiaries.
- SCDHHS is required by federal regulation (42 CFR §438 Subpart E) to ensure that a qualified external quality review organization (EQRO) performs an annual EQR for each MCO.
- EQR evaluations involve on-site and in-person interactions between the EQRO contractor and each MCO.
- At the conclusion of each MCO's audit, the EQRO vendor develops a public facing technical report that is posted on the state's website.

Managed Care Financial Oversight

- Risk corridor
- Medical loss ratio
- Three main strategies are used to reduce fraud, waste and abuse:
  - Provider screening and validation before enrolling into a plan
  - Prepayment review of claims before paying
  - Post payment review of claims

COVID-19 Impact

COVID-19 MCO Coordination

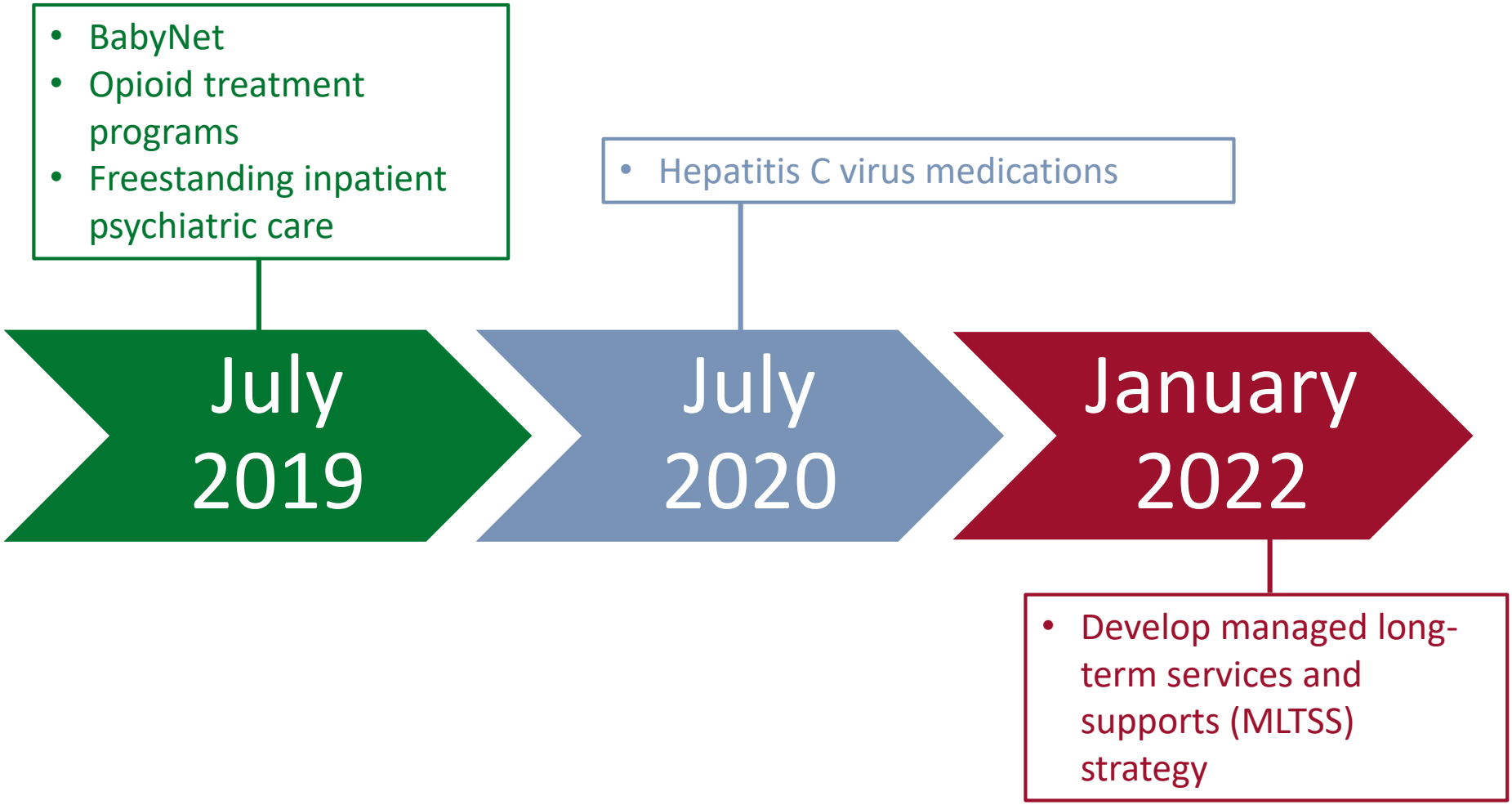
- SCDHHS worked alongside the MCOs and swiftly implemented certain measures designed to lessen the impact of COVID-19. These actions included:
  - A March 28, 2020, memo to MCO executives directing MCOs to waive or modify prior authorization requirements
  - Twice a week calls with MCOs to promote consistency in billing changes
  - Requesting MCOs broadly implement telehealth coverage flexibilities in a manner consistent with SCDHHS' actions

COVID-19 Impact on Delivery Methods and Utilization

- Most routine clinical visits shifted to telehealth as providers ceased face-to-face visits.
- Elective surgeries (non-life-threatening) were postponed.
- SCDHHS modified reimbursement policies to increase telehealth visits.
- Removed copayment requirements for professional evaluation and management services.
- Suspended annual office visit limitations for Medicaid members.
- Implemented COVID-19-related risk corridor

Evolution of South Carolina Managed Care

Carve-In History and Projected Timeline



Changing Managed Care Landscape in South Carolina

- Most managed care plans are now owned by national parent corporations.
- Parent corporations can purchase corporations or plans.
- New plans can apply to enter the market at any time.
- Working collaboratively with MCOs to develop MLTSS strategy.

Oversight Presentation Series Topics

- Agency Overview
- Medicaid Financing
- Medicaid Eligibility
- Program Integrity
- **Medicaid Managed Care**
- Home and Community Based Waiver Programs
- Health Improvement Programs
- Replacement Medicaid Management Information System
- Emerging and Priority Issues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