HEALTHCARE AND REGULATORY SUBCOMMITTEE
MONDAY, APRIL 26, 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, April 26, 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

Chair Wm. Weston J. Newton

First Vice-Chair:
Joseph H. Jefferson, Jr.

Kambrell H. Garvin
Rosalyn D. Henderson-Myers
Jeffrey E. "Jeff" Johnson
John R. McCravy, III
Adam M. Morgan
Melissa Lackey Oremus
Marvin R. Pendarvis
Tommy M. Stringer
Chris Wooten

Jennifer L. Dobson
Research Director

Cathy A. Greer
Administration Coordinator

Legislative Oversight Committee

South Carolina House of Representatives

Post Office Box 11867
Columbia, South Carolina 29211
Telephone: (803) 212-6810 • Fax: (803) 212-6811

Room 228 Blatt Building

Gil Gatch
William M. "Bill" Hixon
Kimberly O. Johnson
Josiah Magnuson
Timothy A. "Tim" McGinnis
Travis A. Moore
Russell L. Ott
Michael F. Rivers, Sr.
John Taliaferro (Jay) West, IV

Charles L. Appleby, IV
Legal Counsel

Lewis Carter
Research Analyst/Auditor

Riley E. McCullough
Research Analyst

Legislative Oversight Committee
Monday, April 19, 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 19, 2021, in Room 110 of the Blatt Building. All members were present for all or a portion of the meeting. Representatives Gil Gatch; Rosalyn D. Henderson-Myers; 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 Gatch makes a motion to approve the meeting minutes from the March 8, 2021, meeting. A roll call vote was held, and the motion passed.

Rep. Gatch motion to approve the March 8, 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. Quincy Swygert, Director of Planning and Budget; Mr. Jeff Leiritz, Director of External Affairs; and Ms. Jenny Stirling, Deputy Chief of Staff for Legislative Affairs.

Chair West reminds Mr. T. Clark Phillip, Interim Director and Chief Financial Officer, that he remains under oath.

II. Interim Director Phillip provides a finance overview of the agency related to Medicaid financing. Topics discussed in the overview include:

a. outline of future presentations;

b. agency purpose: review of agency mission, principles, and goals:

c. agency strategic plan;

d. agency deliverable #7 to exercise fiscal responsibility in the use of taxpayer resources;

e. related agency performance measures for fiscal year 2019-20;

f. turnover data for finance department;

g. related state and federal agency statutes;

h. department employee equivalents and costs;

i. employee satisfaction;

j. finance organizational chart;

k. agency and program framework;

l. what the agency is not;

m. Medicaid obligations beyond coverage;

n. level-setting;

o. who is responsible for what;

p. value proposition for healthcare coverage;

q. major finance concepts;

r. major finance concepts – federal portion;

s. major finance concepts – state portion; and

t. major finance concepts – ways DHHS pays

III. Subcommittee members ask questions relating to the following:

a. public cross-subsidy;
b. performance measures;
c. employee engagement;
d. turnover of finance department;
e. employee satisfaction;
f. matching funds;
g. impact of an aging population on Medicaid;
h. supplemental teaching payments to hospitals;
i. graduate medical education payments to hospitals;
j. Medicaid expansion;
k. Block grant funding model – potential changes if implemented;
l. Coverage of Sickle cell services;
m. Prescription coverage;
n. Medicaid in-patient reimbursement rate the same for private providers and mental health;
o. Federal poverty level eligibility level for CHIP funding;
p. Review of funding acronyms;
q. CHIP funding levels by the federal governments; and
r. How do you determine a fair rate for in-patient hospital services.

Agency staff respond to the members' questions.

Adjournment

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

STUDY TIMELINE

Timeline of Agency Study

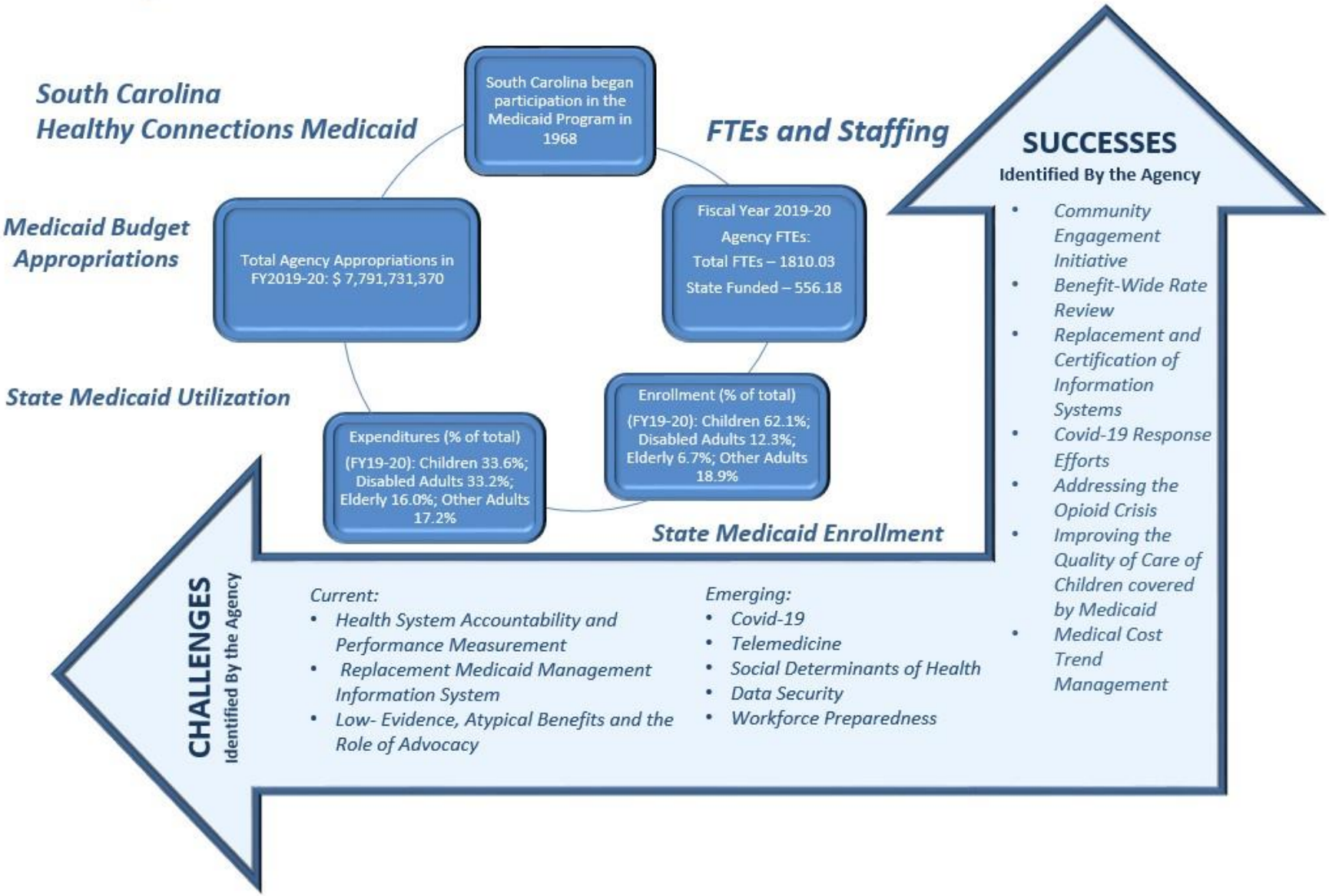
The House Legislative Oversight Committee's (Committee) process for studying the Department of Health and Human Services (agency, Department, or DHHS) includes actions by the full Committee; Healthcare and Subcommittee (Subcommittee); the agency; and the public. Key dates and actions are listed below.

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.

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 Program Integrity Overview

Deirdra T. Singleton

Deputy Director for Administration and Chief Compliance 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 Services Waiver Programs
- Health Improvement Programs
- Replacement Medicaid Management Information System
- Emerging and Priority Issues

Today's Agenda

- Purpose
- Program Evaluation Report Information
- Program Integrity Structure and Scope
- Types of Fraud
- Identifying Fraud, Waste, and Abuse
- Sanctions
- Provider Fraud, Waste, and Abuse Data
- Recipient Fraud, Waste, and Abuse Data
- Cost Avoidance
- COVID-19 Impact
- Outlook

Purpose

SCDHHS Mission, Principles, and Goals

Mission

The mission of the 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

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

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

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

Program Evaluation Report (PER) Information

FY 2019-2020 Performance Measures

- Maintain an opioid prescribing rate for Medicaid beneficiaries of no more than the statewide average
  - Target: 709 opioid prescriptions (per 1,000 residents)
  - Actual: 194.56 opioid prescriptions (per 1,000 full benefit Medicaid beneficiaries)

Turnover Data

- Program Integrity
  - FY 2019-2020: 12.77%
  - FY 2018-2019: 4%
  - FY 2017-2018: 23.53%
  - FY 2016-2017: 0%

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 § 44-6-40(3)
  - Continuously review and evaluate programs to determine the extent to which they: (a) meet fiscal, administrative, and program objectives; and (b) are being operated cost effectively
- S.C. Code Ann. Reg. Article 4 Program Evaluation, Subarticle 1 Administrative Sanctions Against Medicaid Providers, Subarticle 2 Program Integrity

Statutes Included in PER *(cont.)*

- 42 U.S. Code § 1396a. State plans for medical assistance:
  - (a)(35) & (38) – Ownership and disclosure requirements
  - (a)(39) – Provider exclusion and termination
  - (a)(41) – Notification requirements regarding certain provider sanctions
  - (a)(42) – Recovery audit contractors
  - (a)(49) – Information concerning sanctions taken by state licensing authorities against health care practitioners and providers
  - (a)(61) – Medicaid Fraud Control Unit (MFCU)
  - (a)(64) – Fraud hotline
  - (a)(69) – Centers for Medicare and Medicaid Services (CMS) Medicaid Integrity Program
  - (a)(77) – Provider screening and enrollment
  - (p) – Provider exclusion
  - (kk) – Provider and supplier screening, oversight, and reporting requirements
  - (ll) – Termination notification database

Statutes Included in PER *(cont.)*

- 42 U.S. Code § 1396u-6
  - CMS Medicaid Integrity Program
- 42 U.S. Code 1320a–3
  - Disclosure of ownership and related Information
- 42 U.S. Code 1320a–5
  - Disclosure of individuals who have been convicted of certain offenses
- 42 U.S. Code 1320a–7
  - Exclusion from participation in Medicare and state health care programs
- 42 C.F.R. Part 1001
  - Program Integrity: Medicare and state health care programs
- 42 C.F.R. Part 1002
  - Program Integrity: State-initiated exclusions from Medicaid
- 42 C.F.R. Part 455
  - Program Integrity: Medicaid

Department Cost

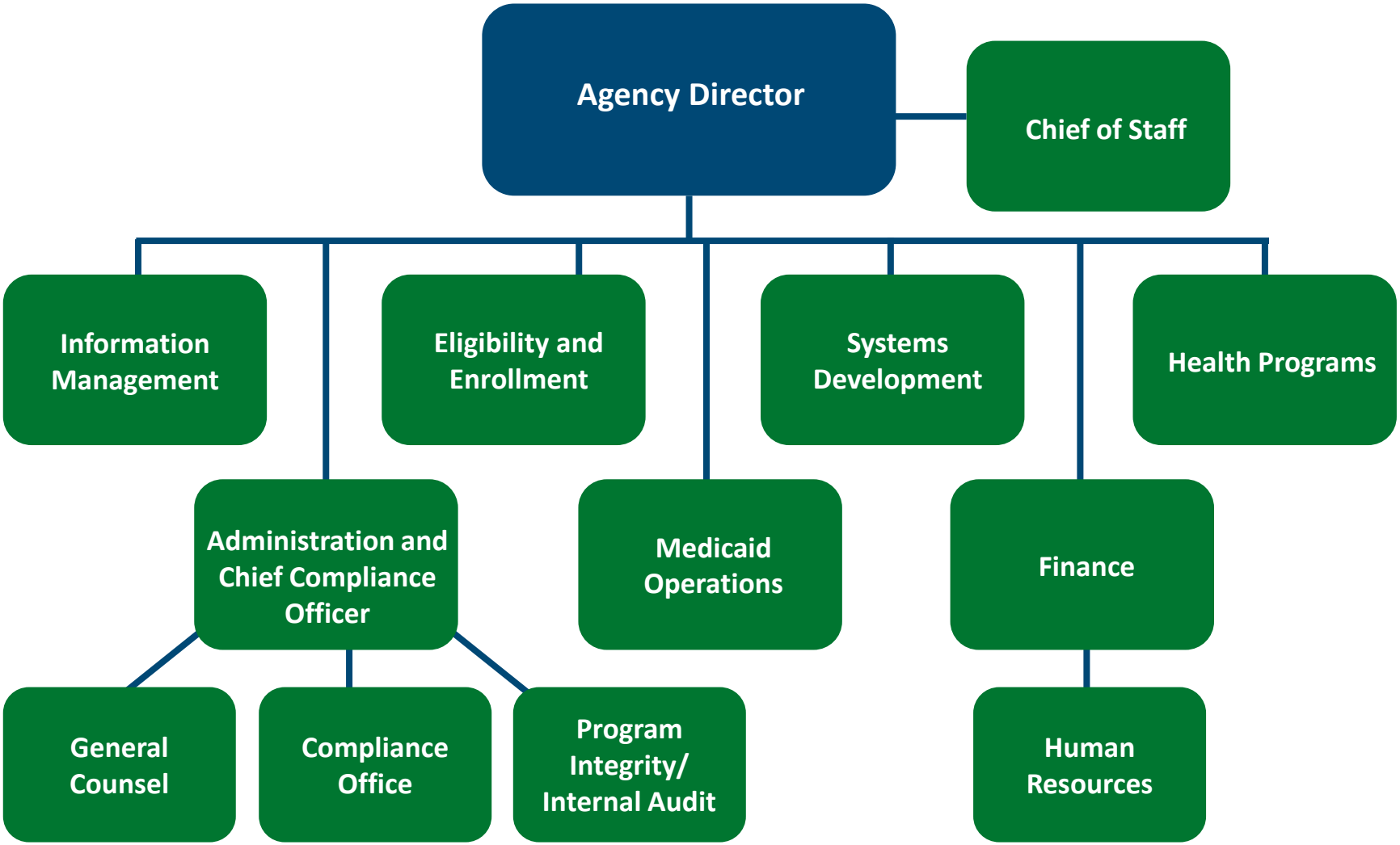
- Employee Equivalents:
  - FY 2019-2020: 29
  - FY 2018-2019: 28
  - FY 2017-2018: 32
  - FY 2016-2017: 35
- Costs:
  - FY 2019-2020: $3,055,609
  - FY 2018-2019: $2,750,901
  - FY 2017-2018: $2,991,521
  - FY 2016-2017: $3,302,187
- Percent of Total Spend:
  - FY 2019-2020: 0.04%
  - FY 2018-2019: 0.04%
  - FY 2017-2018: 0.04%
  - FY 2016-2017: 0.05%
- Cost per Deliverable:
  - FY 2019-2020: $4,952.36
  - FY 2018-2019: $4,554.47
  - FY 2017-2018: $5,061.80
  - FY 2016-2017: $4,322.23

Employee Satisfaction

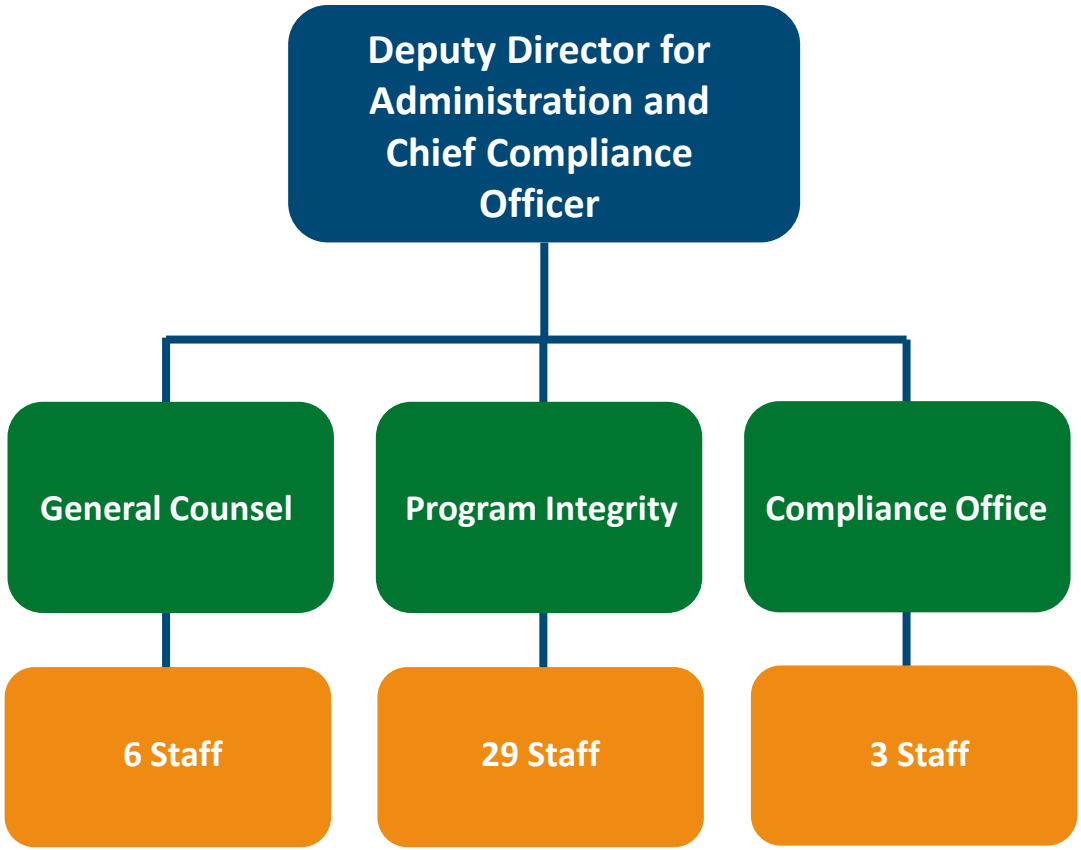
- Employee satisfaction tracked?
  - FY 2019-2020: No (new vendor awarded Sept. 2020)
  - FY 2018-2019: Yes
  - FY 2017-2018: Yes
  - FY 2016-2017: Yes

Program Integrity Structure and Scope

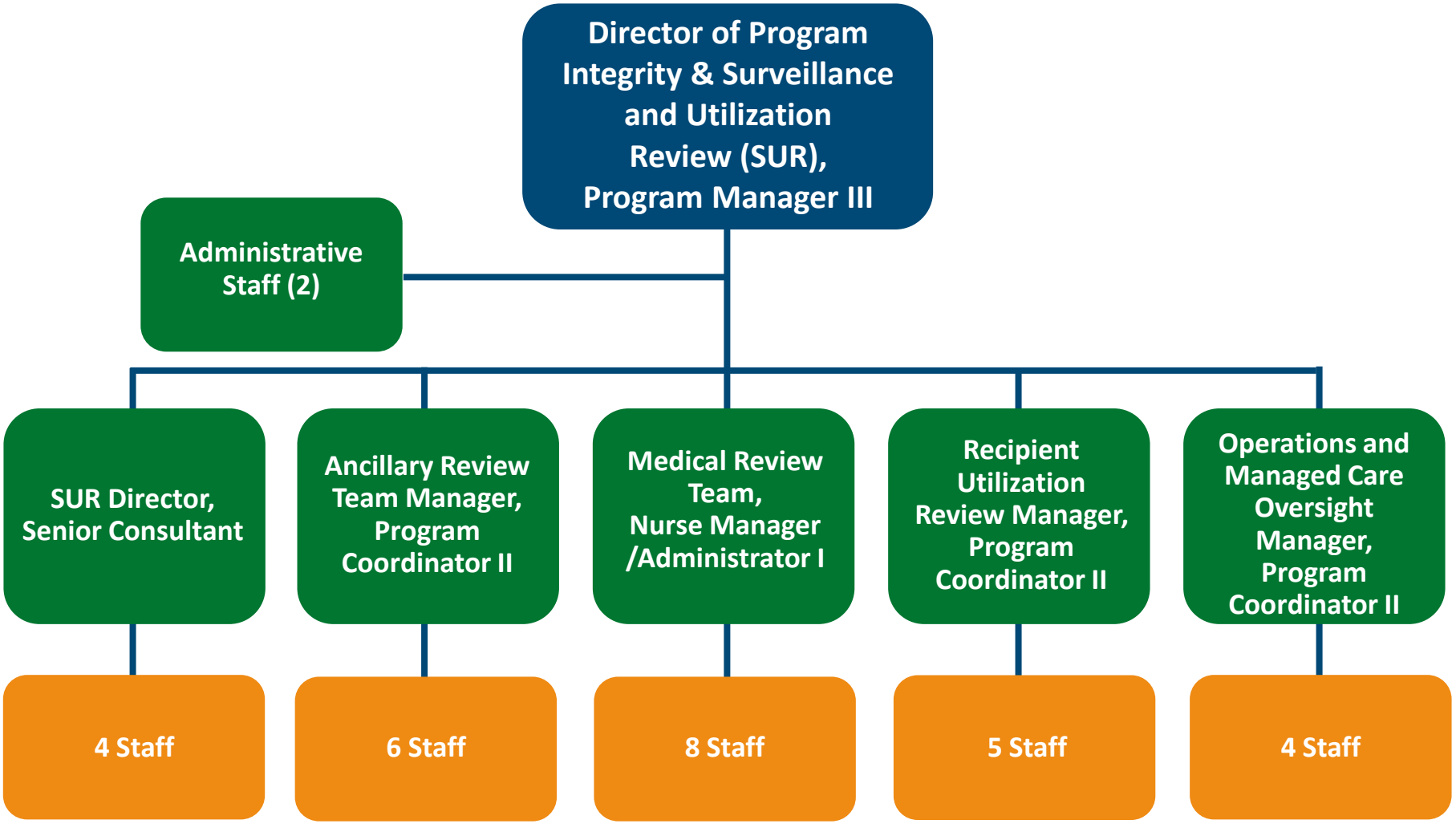
Agency Composition - Organizational Chart



Administration and Chief Compliance Officer - Organizational Chart



Program Integrity (PI) - Organizational Chart



PI Overview

- As the single state agency responsible for administering the state's Medicaid program, SCDHHS is required to have methods and criteria in place to detect fraud and conduct preliminary investigations.
- SCDHHS' PI is the office within the agency tasked with the identification, investigation, and referral of suspected fraud and abuse cases.
- PI identifies and recovers state and federal funds from both providers and recipients lost through fraud, waste, and abuse.

Stewardship & Return on Investment

- Stewardship: Every dollar that is lost to fraud, waste, or abuse is one that otherwise could have been used to provide access to quality care for Medicaid beneficiaries.
- State Fiscal Year (SFY) 2020 year-to-date return on investment (ROI): For every state dollar spent on PI, the agency received $1.91 in return.
- SFY 2019 ROI: For every state dollar spent on PI, the agency received $2.10 in return.

PI Scope – What PI Does

- Monitor the integrity of the Healthy Connections Medicaid program by holding providers and recipients accountable to established policies and regulations.

- Recoup funds from providers that have committed waste and abuse or otherwise been paid funds for which they are not entitled.
- Preliminary investigations of provider and recipient fraud.
- Refer suspected provider and recipient fraud to the South Carolina Attorney General's Office (SCAG) for full investigation and potential prosecution/recovery.
- Enforce provider sanctions and/or administrative actions.
- Receive and process recipient overpayment notices from eligibility staff.

PI Scope – What PI Does NOT Do

- License individual providers
  - PI does verify licensure requirements through the licensure agency.
- Oversee Medicaid provider enrollment or recipient eligibility
- Complete eligibility investigations or prosecute provider or recipient fraud
- Investigate recipient/patient abuse
  - PI does refer complaints for recipient/patient abuse in long-term care facilities to the Medicaid Fraud Control Unit (MFCU).
- Investigate recipient drug abuse

Partnerships

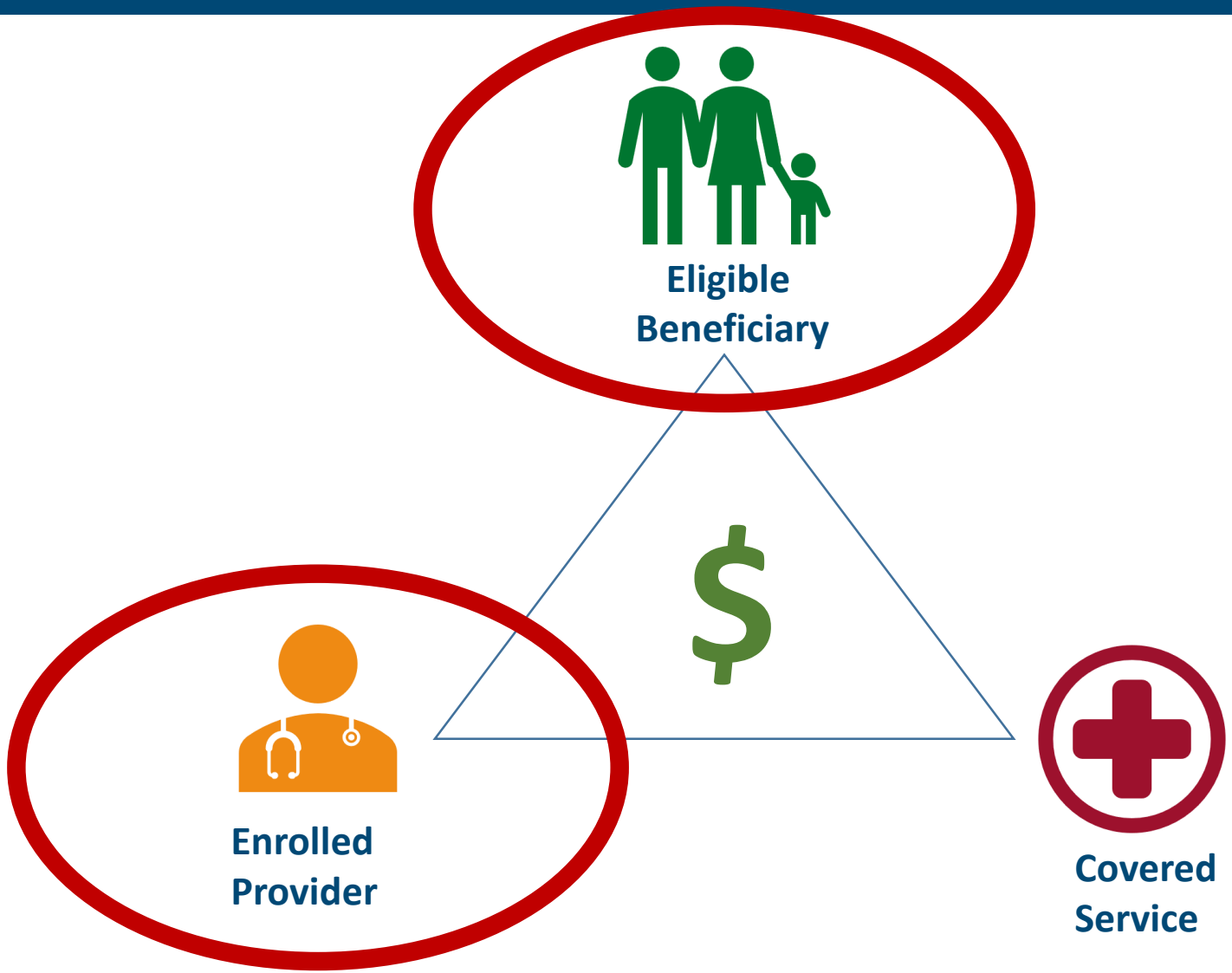
- PI coordinates fraud, waste, and abuse efforts to include identification, review, collection, fraud referral, and sanctions with the:
  - South Carolina Attorney General (SCAG)
    - Medicaid Fraud Control Unit (MFCU)
    - Medicaid Recipient Fraud Unit (MRFU)
  - Managed care organizations (MCOs)
  - Unified program integrity contractors (UPICs)
  - Recovery audit contractor (RAC)
  - Administrative service organizations (medical, pharmacy and dental)

Fraud

Fraud vs. Waste or Abuse

- **Fraud** – An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.
- **Waste** – The unintentional misuse of Medicaid funds through inadvertent error that most frequently occurs as incorrect coding and billing.
- **Abuse** – Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Types of Fraud



Provider Fraud

- Provider fraud occurs when a Medicaid provider knowingly makes, or causes to be made, a false or misleading statement or representation for use in obtaining reimbursement from the Medicaid program.
- PI refers all suspicions of fraud to MFCU for investigation.
- Several schemes are often used by individuals and corporations to defraud the Medicaid program.

Common Provider Schemes

- Billing for services not rendered
- Billing for medically unnecessary services
- Double-billing
- Kickbacks

Examples of Provider Waste and Abuse

- Common examples of waste and abuse include:
  - Waste:
    - Billing claims under the incorrect provider legacy/National Provider Identifier (NPI) number
    - Duplicate billing
    - Billing unnecessary tests for every patient
  - Abuse:
    - Billing services without prior authorization
    - Upcoding - performing one service and billing for a higher code
    - Unbundling of codes to obtain higher reimbursement
    - Billing for services after the discharge date

Recipient Fraud

- Recipient actions to defraud the Medicaid program include:
  - Submission of a false application for Medicaid benefits
  - Providing false or misleading information about income, assets, family members, or resources
  - Sharing a Medicaid card with another individual
  - Selling or buying a Medicaid card
  - Diverting for resale prescription drugs, medical supplies, or other benefits
  - Participating in doctor or pharmacy shopping
  - Obtaining Medicaid benefits that they were not entitled to through other fraudulent means
- PI refers recipients to MRFU to investigate allegations of illegal recipient activity.

Identifying Fraud, Waste, and Abuse

Document and Record Collection

- Records are collected and reviews are performed through on-site visits to providers (both announced and unannounced), desk reviews, or provider self-audits.
- Documentation must be present and clearly indicate the need for the service.
- At any point in the review process, if there is reason to believe that an incident of fraud or abuse has occurred, PI is required to refer the case to MFCU.
- PI documents all case activity in its case management system which tracks cases and enables faster turnaround and recovery of funds.

MCOs' Role

- PI works jointly with the MCOs who serve the South Carolina Healthy Connections Medicaid population in order to ensure that all complaints for fraud and abuse are reviewed and investigated in a timely manner and fraud referrals are made when appropriate.
- Bi-monthly meetings are held with PI, the MCOs, and MFCU to discuss active provider cases, schemes, and patterns, and to receive joint training.
- MCOs have flexibility to maintain their own provider networks as long as they meet time and distance requirements.

Credible Allegation of Fraud

- SCDHHS will suspend payments in cases of a "credible allegation of fraud" unless the agency has good cause not to suspend payments.
- Once a credible allegation of fraud is determined, the case is referred to MFCU.
- As mandated by the MCO contract, MCOs must suspend payments to a provider for which SCDHHS determines there is a credible allegation of fraud.

Surveillance Utilization and Review (SUR)

- PI's SUR program conducts data mining and develops algorithms, profiles, and peer comparisons for all types of providers enrolled in the South Carolina Healthy Connections Medicaid program.
- If MCO encounters are identified during the data analysis, the MCO is notified and asked to review the providers and the claims identified.

Prepayment Review

- To ensure provider claims for payment meet the requirements of federal and state laws and regulations and claims payment criteria as defined by program-specific policies and procedures, a provider may be required to undergo prepayment review with oversight by PI/SUR.
- Any provider that SCDHHS places on prepayment review must also be placed on prepayment review by the MCOs.

Pharmacy Lock-In Program

- SCDHHS identifies recipients who are using Medicaid pharmacy services at a frequency or amount that is not medically necessary.
- Identified recipients are restricted to one single pharmacy to fill their Medicaid paid prescriptions for a two-year period.
- On July 1, 2014, significant enhancements were made to the Pharmacy Lock-In Program.
  - MCOs required to participate in the statewide program monitored and maintained by PI.
  - Enrollment increased from 400 to 2,500 beneficiaries, due in part to identifying program-eligible beneficiaries against a 21 criteria set versus the previous three.
  - The lock-in period was increased from one year to two continuous years.

Sanctions

Sanctions Criteria

- PI may impose administrative sanctions against Medicaid providers determined to have filed false, excessive, and/or inappropriate claims; to be non-compliant with Medicaid policies, procedures, and regulations; and/or have otherwise abused the Medicaid program.
- MCOs must:
  - Enforce the same administrative sanctions taken by PI including, terminating their agreement with the provider for cause

Types of Sanctions—Abuse

- Below are some of the administrative sanctions that may be invoked against a Medicaid provider who has been determined to have abused the Medicaid program:
  - Educational intervention
  - Post-payment review of claims
  - Prepayment review of claims
  - Referral to licensing/certifying board or agencies
  - Suspension
  - Termination

Types of Sanctions—Crime

- One or more of the following administrative sanctions may be invoked against a Medicaid provider who has been found guilty of fraud or convicted of a crime related to his or her participation in Medicare or Medicaid:
  - Suspension
  - Termination
  - Exclusion

Provider FWA Data

Top 5 Specialties Based on Overpayments Identified

Top 5 Provider Specialties Based on Overpayments Identified:
SFYs 2019 and 2020

Provider Specialty or Type	Provider Count	Total Overpayment Identified
Home Health/Hospice	1	$2,071,133.15
Therapist/Multiple Specialty Group	12	$1,318,274.74
Private Mental Health	12	$1,026,633.35
Dentistry	47	$808,618.06
Community Long Term Care (CLTC)	55	$480,169.85

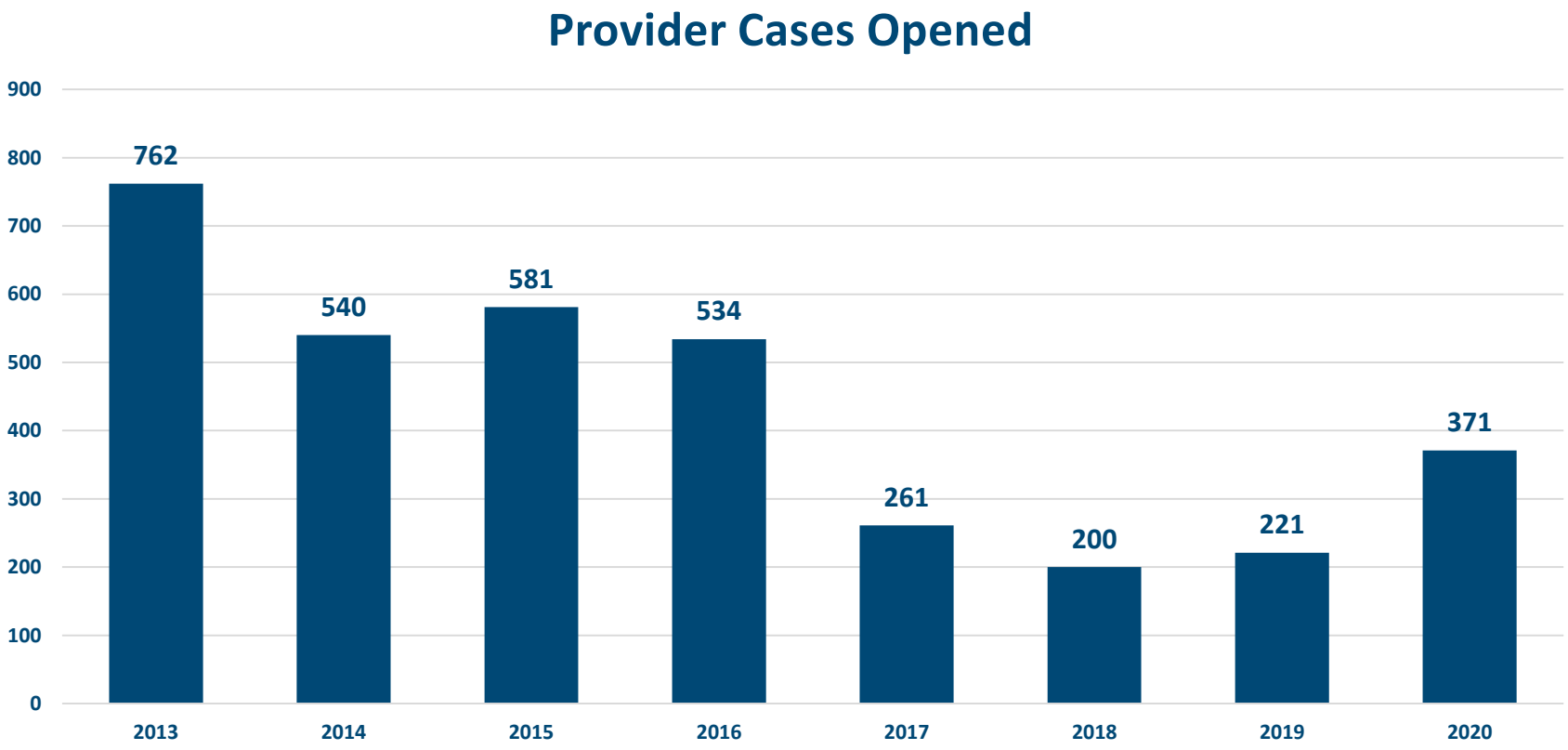
SFY 2020 – Top 10 Individual Provider Cases of Identified Overpayments

Specialty/Type	Overpayment Identified
Dentistry	$658,394.12
Therapist/Multiple Specialty Group	$364,718.61
Private Mental Health	$189,647.04
Therapist/Multiple Specialty Group	$186,141.12
Therapist/Multiple Specialty Group	$155,858.91
Therapist/Multiple Specialty Group	$139,787.18
Private Mental Health	$125,724.00
CLTC	$123,580.31
Private Mental Health	$122,866.34
Private Mental Health	$122,305.00
Total	**$2,189,022.63**

SFY 2019 – Top 10 Individual Provider Cases of Identified Overpayments

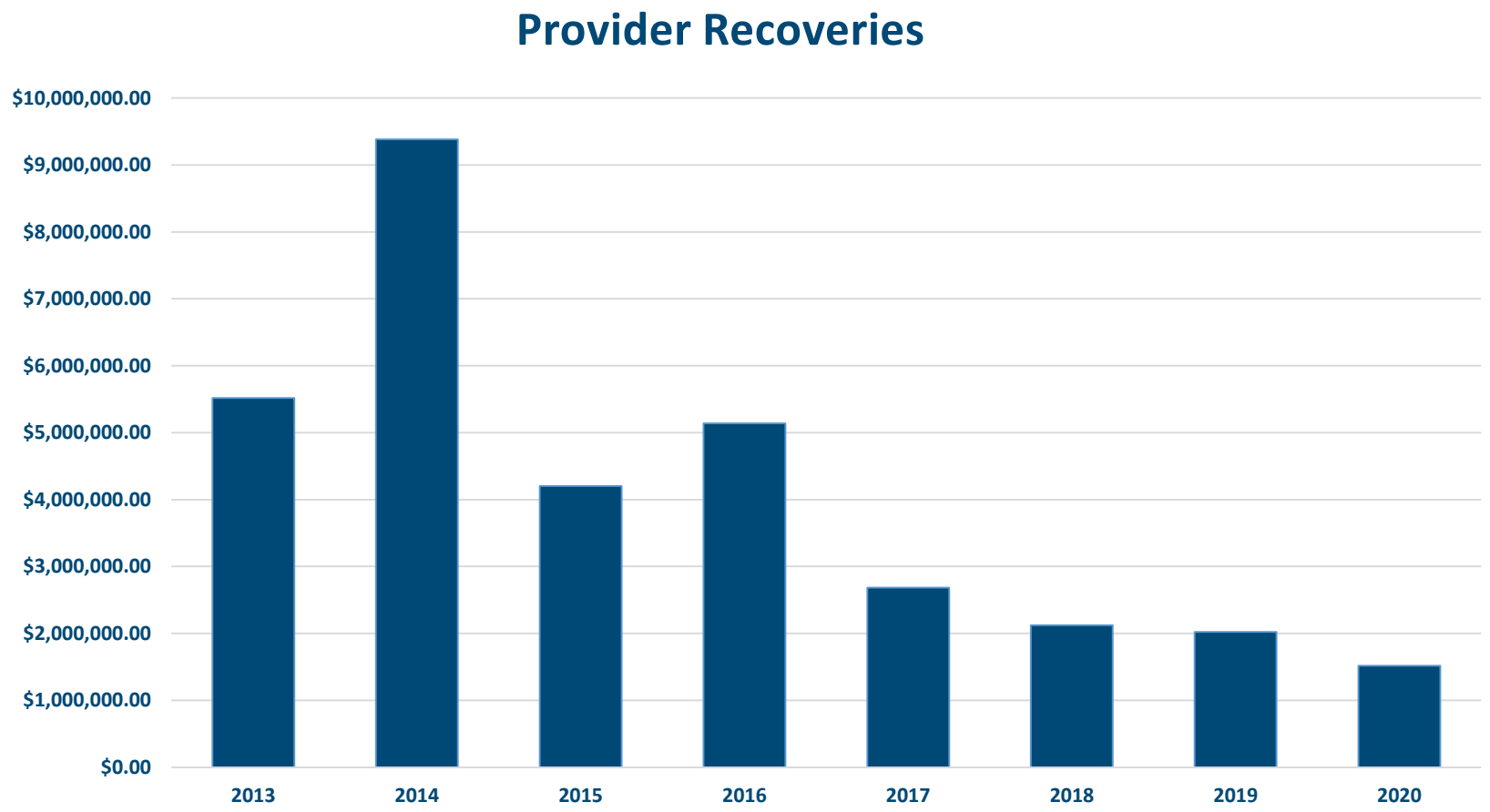
Specialty/Type	Overpayment Identified
Home Health/Hospice	$2,071,133.15
Private Mental Health	$260,085.31
Family Practice	$109,692.72
Therapist/Multiple Specialty Group	$53,218.08
Therapist/Multiple Specialty Group	$43,121.33
Private Mental Health	$42,099.00
CLTC	$38,219.22
Private Mental Health	$35,836.93
Nephrology/ESRD	$22,116.99
Durable Medical Equipment (DME)	$20,592.96
Total	**$2,696,115.69**

Provider Fraud, Waste, and Abuse Cases Opened: Eight-year Trend



Based on state fiscal year

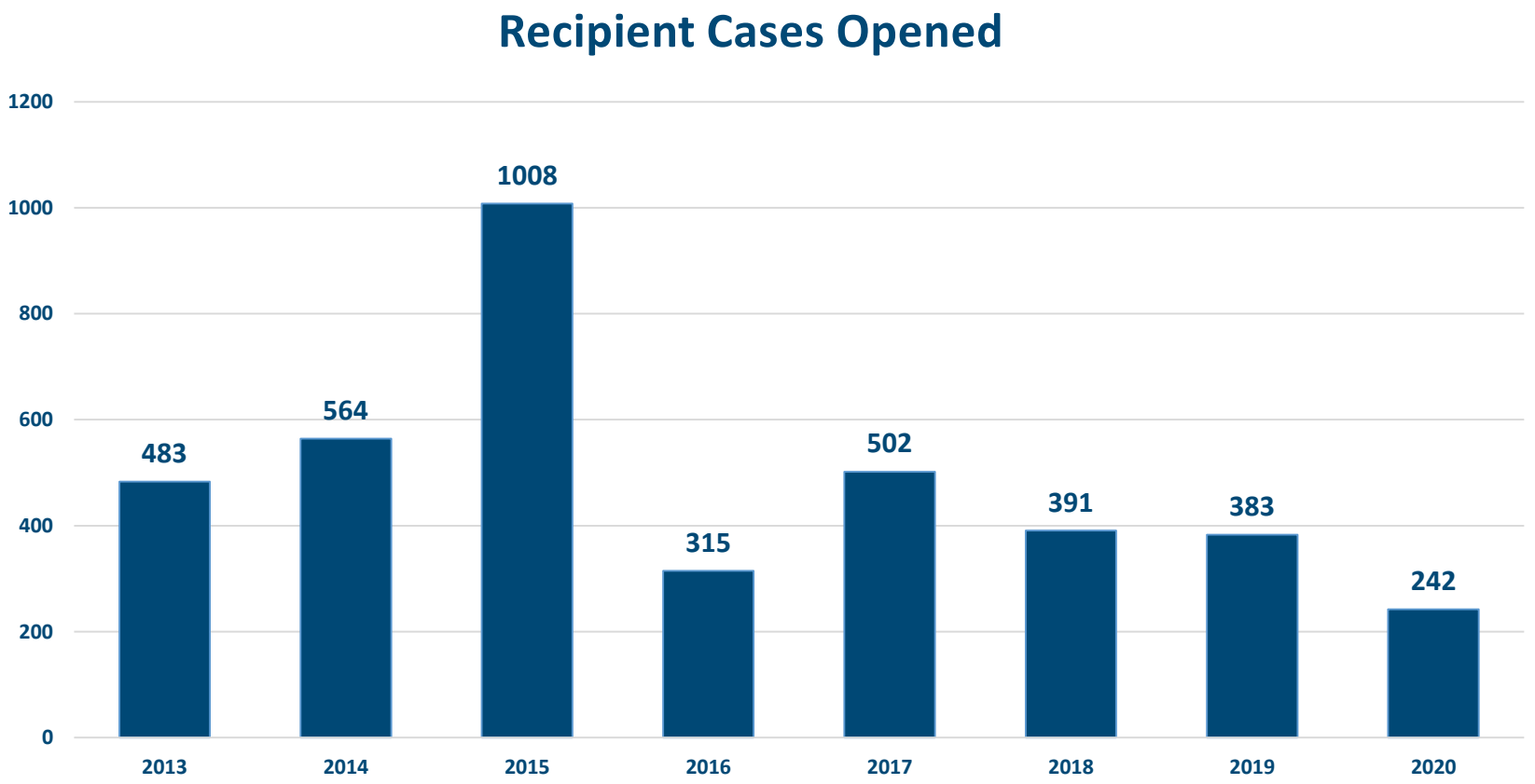
Provider Fraud, Waste, and Abuse Recovered Funds: Eight-year Trend



Based on SFY, recoveries generally lag behind case closings.

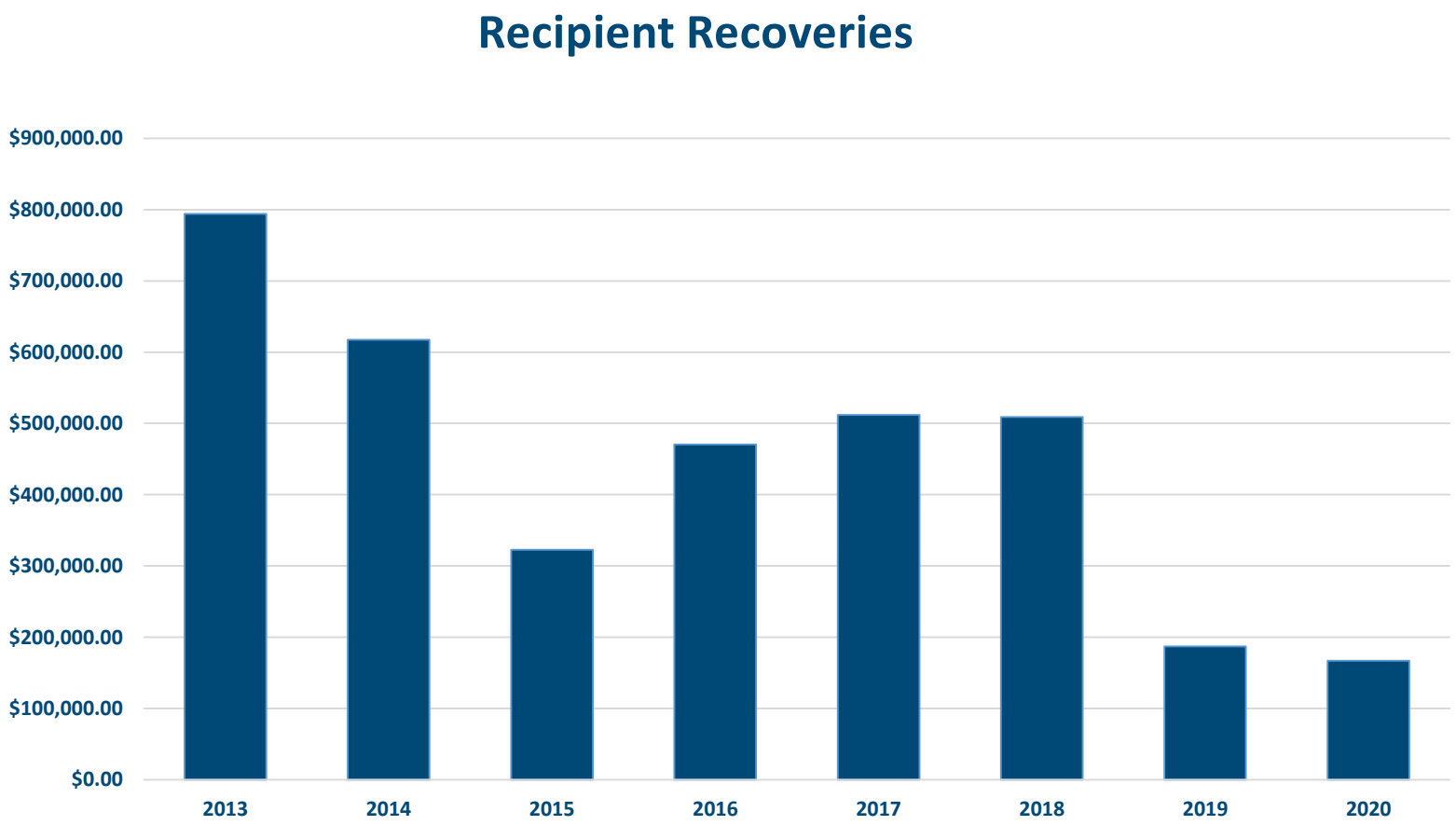
Recipient Fraud, Waste, and Abuse Data

Recipient Fraud, Waste, and Abuse Cases Opened: Eight-year Trend



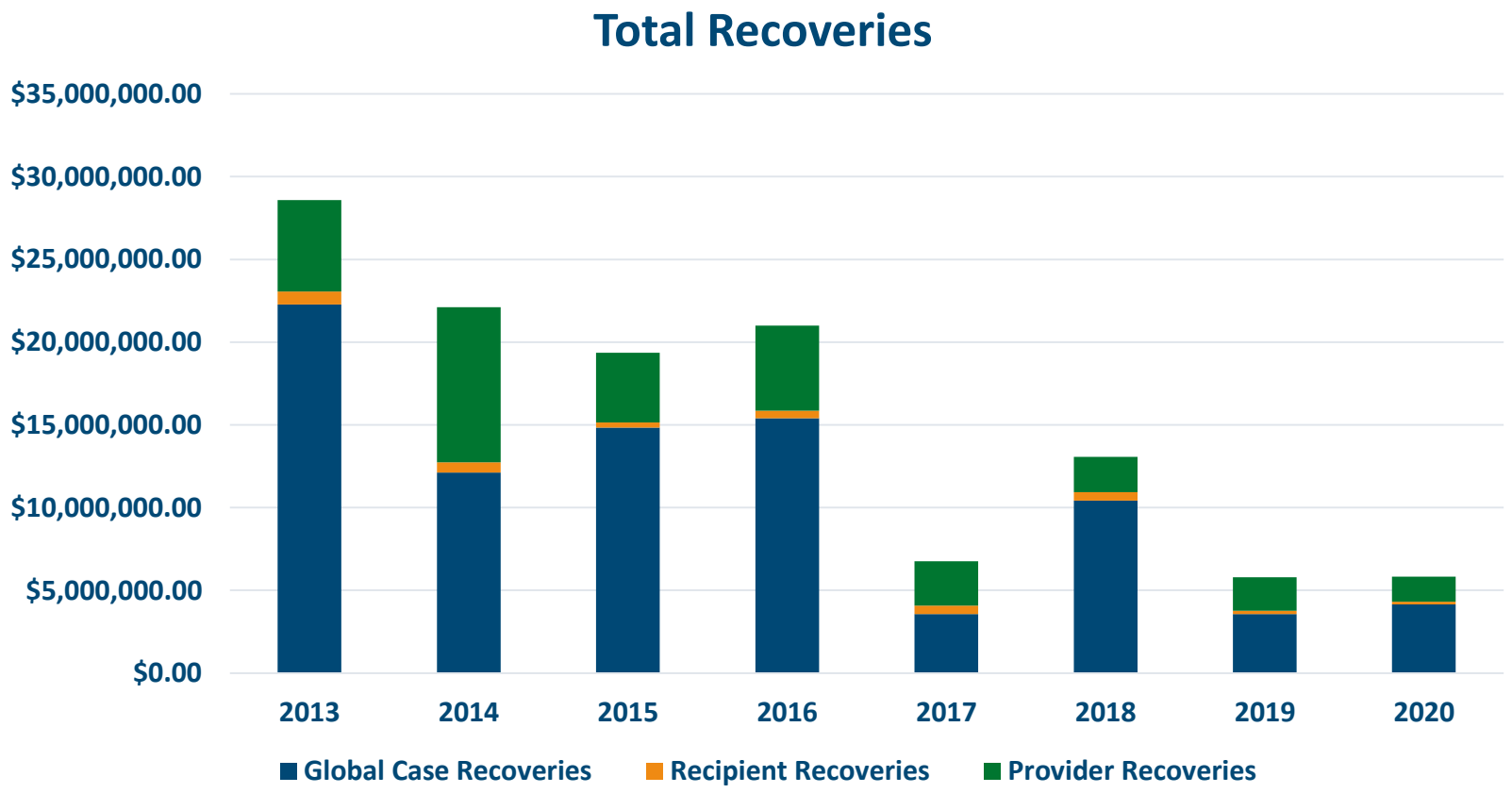
Based on state fiscal year

Recipient FWA Recovered Eight-year Trend



Based on state fiscal year, recoveries generally lag behind case closings.

South Carolina Total Recovered Funds



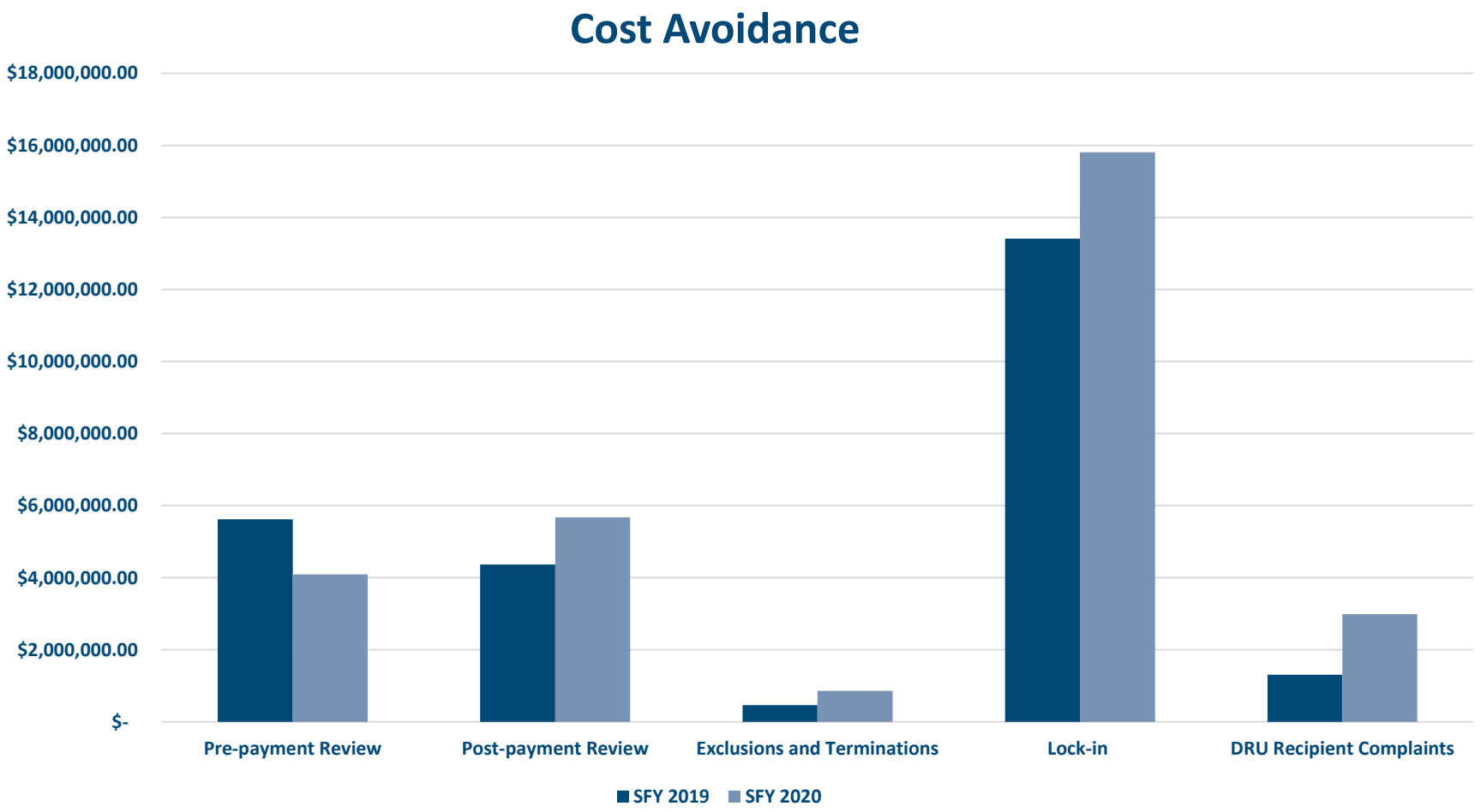
Based on state fiscal year
Global recoveries represent South Carolina's portion of national cases

Cost Avoidance

Focus on Cost Avoidance

- In the past, PI's success was measured by overpayments recovered.
- Approximately 10 years ago, PI units nationally noted trends of increased behavioral health cases and decreased overpayments recovered.
- However, it was also noted that providers' behaviors were being altered by reviews, sanctions, and prepayment reviews.
- Today, PI units nationally include a measure in their success rate to identify dollars saved and or cost avoided due to actions taken by the PI unit.

Provider and Recipient Fraud Cost Avoidance



Based on state fiscal year,
Amounts include both MCO and fee for service

COVID-19 Impact

COVID-19 Actions

- Temporarily altered procedure to interact with providers and witnesses through desk reviews and telephone interviews.
- Both PI and the MCOs developed early fraud detection algorithms based on known schemes related to the pandemic.
- PI altered two procedures:
  - Staff were instructed not to conduct on-site visits or face-to-face interviews with providers or beneficiaries.
  - The Pharmacy Lock-In restriction was lifted for beneficiaries for April and May 2020.
- PI/SUR continued to monitor active provider prepayment review cases.

Outlook

PI Strategic Plan

The current PI strategic plan is focused on five goals:

- Optimizing unit structure and recruiting and retaining qualified staff
- Expanding managed care oversight
- Increasing efficiency in detecting and investigating fraud, waste, and abuse through leveraging available tools
- Increasing efforts to prevent fraud, waste, and abuse
- Increasing recovery of overpayments

Reporting Fraud

Anyone may report an allegation of fraud, waste or abuse using the below methods:

- Fraud hotline: (888) 364-3224
- Email: fraudres@scdhhs.gov
- Fax: (803) 255-8224
- Direct intake: (803) 898-2614
- Mailing address: SCDHHS-Program Integrity
  P.O. Box 100210
  1801 Main Street
  Columbia, SC 29202

Oversight Presentation Series Topics

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