DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese	6-15-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10-481	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Deps Use same response as Log # 480. Cleared 7/2/12 letter attached.	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

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

United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 14, 2012

Via Electronic Transmission

Anthony E. Keck
Director
South Carolina, Department of Health and Human Services
P. O. Box 8206 Columbia, SC 29202-8206

Dear Director Keck:

This letter is to follow up with the request in my February 23, 2012 letter regarding South Carolina's use of Medicaid funds to contract with managed care entities. To date, my office has not received a response from South Carolina.

The federal and state governments spend roughly $300 billion every year on the Medicaid program. Unfortunately, Medicaid suffers from systemic weaknesses that lead to fraud, waste, and abuse across the program. Fraud results in higher costs and less health care to those who are in need. As a U.S. Senator, I take seriously my responsibility to ensure that taxpayer dollars are appropriately spent on federal health care programs.

The Medicaid statute 1903(m)(2)(iii) requires that state payments to managed care entities be made on an actuarially sound basis. In 2009, the Government Accountability Office (GAO) was asked to investigate CMS's oversight of the states' compliance with the statutory requirement. The GAO found that "CMS has been inconsistent in reviewing states' rate setting for compliance with the Medicaid managed care actuarial soundness requirements, which specify that rates must be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.[1]"

The recent investigation into the State of Minnesota Medicaid managed care highlights the importance of providing oversight into how states appropriately and adequately manage federal dollars. Every state utilizing managed care has to account for the way Medicaid dollars are being spent in their state.

The following questions from my February 23 letter are necessary to better understand what your state is doing to ensure that resources are being properly spent through managed care entities.

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[1] GAO Report: "CMS's Oversight of States' Rate Setting Needs Improvement;" http://www.gao.gov/new.items/d10810.pdf

1. Does your state have an independent audit requirement for managed care entities? If so, under what professional auditing standards must these audits be conducted?

   a) Does the auditor perform a financial audit to validate reported information on medical-loss ratio, administrative costs, profit, and reserves?

   b) Does the auditor perform a performance/compliance audit to validate performance measures and adherence to contractual requirements?

   c) Please provide a copy of the rules and/or regulations that establish this requirement in your state.

   d) Please provide a list of all managed care entities operating in your state, number of times each has been audited, the date of the most recent audit, and a summary of the results.

2. Your state's definition(s), per managed care entity contract language, of allowable medical costs (all items allowable in calculating the medical loss ratio);

3. Your state's definition(s), per managed care entity contract language, of what allowable administrative costs are;

4. An example copy of the reporting document(s) that plans are required to provide your state for reporting on medical costs, administrative costs, and profit;

5. A certification stating whether the actuary performing work for your state is, or is not, also providing services to one or more of your plans;

6. Any guidance document, white-papers, or presentation from CMS with respect to defining medical-loss ratio, administrative costs, profit, and reserves; and

7. Has your state contacted CMS to gain clarification and guidance on these issues in the past three years? If so, has CMS adequately aided your state?

Thank you for your prompt attention and response to the questions raised in this inquiry. In responding to the aforementioned questions, please repeat each enumerated request followed by your response. Please provide responses to the questions no later than June 29, 2012. Should you have any questions regarding this request, please contact Erika Smith on my staff at 202-224-5225.

Sincerely,

Charles E. Grassley
Ranking Member

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

→ Copy → Jennifer 6-18-2012

ACTION REFERRAL

TO	DATE
Giese / Campbell	6-15-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10481	[X] Prepare reply for the Director's signature DATE DUE 6-25-12
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Deps	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.	GOB 6/21/12 JE 6/21/12 KeH 6-25-12		From what I can tell we did not receive his letter from Fdo. I checked with Bren - we found a letter from 1/23/12 regarding prescriptions / mental health drugs. Ignore the cover Blue Sheet - Bren did not realize it was a copy of the Fdo letter. Thanks! 6/18
2. BB Shaw	6/25/12		
3.			
4.			

RECEIVED
JUN 18 2012

United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

June 14, 2012

Via Electronic Transmission

Anthony E. Keck
Director
South Carolina, Department of Health and Human Services
P. O. Box 8206 Columbia, SC 29202-8206

Dear Director Keck:

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The Medicaid statute 1903(m)(2)(iii) requires that state payments to managed care entities be made on an actuarially sound basis. In 2009, the Government Accountability Office (GAO) was asked to investigate CMS's oversight of the states' compliance with the statutory requirement. The GAO found that "CMS has been inconsistent in reviewing states' rate setting for compliance with the Medicaid managed care actuarial soundness requirements, which specify that rates must be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.[1]"

The recent investigation into the State of Minnesota Medicaid managed care highlights the importance of providing oversight into how states appropriately and adequately manage federal dollars. Every state utilizing managed care has to account for the way Medicaid dollars are being spent in their state.

The following questions from my February 23 letter are necessary to better understand what your state is doing to ensure that resources are being properly spent through managed care entities.

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[1] GAO Report: "CMS's Oversight of States' Rate Setting Needs Improvement;" http://www.gao.gov/new.items/d10810.pdf

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   a) Does the auditor perform a financial audit to validate reported information on medical-loss ratio, administrative costs, profit, and reserves?

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7. Has your state contacted CMS to gain clarification and guidance on these issues in the past three years? If so, has CMS adequately aided your state?

Thank you for your prompt attention and response to the questions raised in this inquiry. In responding to the aforementioned questions, please repeat each enumerated request followed by your response. Please provide responses to the questions no later than June 29, 2012. Should you have any questions regarding this request, please contact Erika Smith on my staff at 202-224-5225.

Erika_Smith@judiciary.rep.senate.gov

Sincerely,

Chuck Grassley

Charles E. Grassley
Ranking Member

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Giese	6-15-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 10480	[X] Prepare reply for the Director's signature DATE DUE 6-25-12
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Singleton, Deps	[ ] Prepare reply for appropriate signature DATE DUE_____ [ ] FOIA DATE DUE_____ [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
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United States Senate
COMMITTEE ON THE JUDICIARY
WASHINGTON, DC 20510-6275

February 23, 2012

Anthony E. Keck
Director
South Carolina Department of Health and Human Services
P. O. Box 8206
Columbia, SC 29202-8206

Dear Director Keck:

In the United States, the federal and state governments spend roughly $300 billion every year on the Medicaid program. Like the Medicare program, Medicaid suffers from systemic weaknesses that lead to fraud, waste, and abuse across the program, resulting in higher costs and less health care to those who are in need. I take seriously my responsibility to ensure that taxpayer dollars are appropriately spent on federal health care programs.

Medicaid is a vital program administered by the states and funded jointly by the federal and state governments. Through this partnership, Medicaid serves the most fragile of populations who depend upon the critical services provided. For many years, states have been allowed to provide services to Medicaid recipients through managed care entities to help control the increasing costs for services. Historically, managed care entities have proven to better coordinate the often complex health care needs of Medicaid beneficiaries.

In order for recipients to receive adequate services from these managed care entities, states must appropriately and correctly reimburse for services provided. Recently, questions have arisen regarding the process states have utilized in determining the appropriate payment to managed care entities by the Medicaid program.

The Medicaid statute 1903(m)(2)(iii) requires that state payments to managed care entities be made on an actuarially sound basis. In 2009, the Government Accountability Office (GAO) was asked to investigate CMS's oversight of the states compliance in meeting the statutory requirement. The GAO found that "CMS has been inconsistent in reviewing states' rate setting for compliance with the Medicaid managed care actuarial soundness requirements, which

specify that rates must be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.[1]"

In the 18 months since that report was issued, I have seen nothing to convince me CMS or the states have improved in their ability to confirm that managed care entities are appropriately and correctly reimbursing for the services provided. If an entity is paid too little, the access to and quality of care provided to beneficiaries is jeopardized. If an entity is paid too much, scarce Medicaid resources are diverted away from providing services to beneficiaries.

In order to better understand what your state is doing to ensure that resources are being properly spent through managed care entities, please provide the following information:

1. Does your state have an independent audit requirement for managed care entities? If so, under what professional auditing standards must these audits be conducted?

    a) Does the auditor perform a financial audit to validate reported information on medical-loss ratio, administrative costs, profit, and reserves?

    b) Does the auditor perform a performance/compliance audit to validate performance measures and adherence to contractual requirements?

    c) Please provide a copy of the rules and/or regulations that establish this requirement in your state.

    d) Please provide a list of all managed care entities operating in your state, number of times each has been audited, the date of the most recent audit, and a summary of the results.

2. Your state's definition(s), per managed care entity contract language, of allowable medical costs (all items allowable in calculating the medical loss ratio);

3. Your state's definition(s), per managed care entity contract language, of what allowable administrative costs are;

4. An example copy of the reporting document(s) that plans are required to provide your state for reporting on medical costs, administrative costs, and profit;

5. A certification stating whether the actuary performing work for your state is, or is not, also providing services to one or more of your plans;

6. Any guidance document, white-papers, or presentation from CMS with respect to defining medical-loss ratio, administrative costs, profit, and reserves; and

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[1] GAO Report: "CMS's Oversight of States' Rate Setting Needs Improvement;" http://www.gao.gov/new.items/d10810.pdf

7. Has your state contacted CMS to gain clarification and guidance on these issues in the past three years? If so, has CMS adequately aided your state?

Thank you for your prompt attention and response to the questions raised in this inquiry. In responding to the aforementioned questions, please repeat each enumerated request followed by your response. Please provide responses to the questions no later than March 16, 2012. Should you have any questions regarding this request, please contact Erika Smith on my staff at 202-224-5225.

Sincerely,

Charles E. Grassley
Ranking Member
Committee on the Judiciary

South Carolina Department of Health & Human Services

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

July 2, 2012

The Honorable Charles E. Grassley
United States Senate
Committee on the Judiciary
Washington, DC 20510-6275

Dear Senator Grassley:

This letter is in response to your June 14, 2012 request regarding South Carolina's use of Medicaid funds to contract with managed care entities. Our responses should assist you in better understanding how South Carolina Medicaid is focused on being a good steward of taxpayer's dollars and improving quality outcomes. I appreciate the opportunity to respond to your questions.

Question 1 – Does South Carolina have an independent audit requirement for managed care entities? **No, however, since January 1, 2012 South Carolina has contracted with Clifton Gunderson to perform a financial/administrative audit of MCOs currently operating in the state. We will be happy to provide you a copy of the results when completed.**

Question 2 – Your state's definition(s), per managed care entity contract language, of allowable medical costs (all items allowable in calculating the medical-loss ratio); **Not applicable, as we do not address this in our current contracts but will consider addressing this matter in our 2014 contracting period. Clifton Gunderson's financial/administrative audit of MCOs will be conducted following federal accounting requirements.**

Question 3 – Your state's definition(s), per managed care entity contract language, of allowable administrative costs are; **Not applicable**

Question 4 – An example of the reporting document(s) that plans are required to provide your state for reporting on medical costs, administrative costs and profit; **This is not a contract requirement, but is a South Carolina Department of Insurance requirement. I have included, as an example, a report from one of our largest health plans. This report includes their annual business statement from the previous calendar year (2010).**

Question 5 – A certification stating whether the actuary performing work in your state is, or is not also providing services to one or more of your plans; **Our actuarial contract is with Milliman, Inc. and in Section BB of the contract, under the conflict of interest clause it states that they will not work for a South Carolina health plan on any South Carolina Medicaid issue for as long as Milliman works for SCDHHS. (I have attached this conflict of interest documentation for your review).**

Question 6 – Any guidance document, white-papers, or presentations from CMS with respect to defining medical-loss ratio, administrative costs, profit, and reserves; and **Not applicable.**

Question 7 – Has your state contacted CMS to gain clarification and guidance on these issues in the past three years? **No, we are not aware of any contact.**

Office of the Director
P. O. Box 8206 Columbia South Carolina 29202-8206
(803) 898-2504 Fax (803) 255-8235

In conclusion, it is important to note that earlier this year I convened a Coordinated Care Improvement Group consisting of representatives of the Managed Care Organizations, Medical Home Networks, provider groups and consumers to recommend performance objectives and specific performance improvements to our coordinated care model. The outcome of this effort can be expected to result in changes to our current coordinated care contracts to include incentives and withholds, all with an emphasis on better health, satisfaction and cost management. We are on track to complete this initiative before the end of this calendar year 2012.

I trust you find this information is helpful in your efforts to ensure that taxpayer dollars are being appropriately spent on all federal health care programs.

Sincerely,

Anthony E. Keck
Director

AEK/gc

Enclosures