

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Singleton</i>	DATE <i>6-8-15</i>
------------------------	-----------------------

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000264</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Kost</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> 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.			



State of South Carolina
Office of the Inspector General

RECEIVED

JUN 08 2015

Department of Health & Human Services
OFFICE OF THE DIRECTOR

June 4, 2015

OIG File #2015-1013-I

Director Christian Soura
South Carolina Department of Health and Human Services
1801 Main Street
Columbia, SC 29201

Re: Review of South Carolina's Medicaid Managed Care Contract Monitoring Process

Dear Director Soura:

The purpose of this letter is to provide the South Carolina Department of Health and Human Services (SCDHHS) the results of the State Inspector General's (SIG) review of the contract monitoring process for its Medicaid Managed Care (MMC) contract. Reporting the results in letter form is designed to avoid the intimidation of a formal report. Hopefully, this will facilitate the review's data to be broadly disseminated to internal and external stakeholders, who have differing levels of technical expertise, in order to establish a common frame of reference upon which to stimulate positive change.

Purpose of Review

The purpose of this review was to assess SCDHHS's effectiveness in monitoring the state's MMC contract with six managed care organizations (MCOs), which provide the administration and delivery of Medicaid services to more than 850,000 beneficiaries at an estimated annual cost of \$2.6 billion. This review was self-initiated by the State Inspector General (SIG) based on other federal and state audits of MMCs across the country, which identified a pattern of contract monitoring weaknesses posing a high risk of government waste on contracts measured in the billions of dollars.

Executive Summary

In 2010, SCDHHS logically committed to the MMC model to deliver Medicaid health services to improve healthcare and contain costs of the multi-billion dollar Medicaid program. It has successfully built a provider network through six MCOs, established and improved its contract in each two-year cycle, and developed informational reporting requirements to permit oversight and contract management. However, SCDHHS has not built a contract monitoring infrastructure needed to optimally operate its MMC contract to fully realize the health outcomes and cost containment potential of the MMC model.

Background of Medicaid Managed Care

The MMC is designed to use non-governmental entities to leverage market forces and managed care techniques to contain costs and improve healthcare for a state's Medicaid program. The MMC model contracts with private and non-profit MCOs to administer and deliver Medicaid health care benefits. The MCOs deliver services through their respective medical provider networks to Medicaid beneficiaries. In South Carolina, MCOs are paid a monthly fixed rate, known as a capitated rate, for each plan enrollee (beneficiary), which is an actuarial estimate of the cost of delivering health care to each enrollee, along with a 9.5% administrative fee.

The State of South Carolina has historically, like other states, delivered Medicaid services through a Fee-For-Service (FFS) model whereby medical providers were directly reimbursed for delivery of Medicaid services based upon a standard FFS payment schedule. South Carolina, like most other states, sought ways to contain the rising costs of Medicaid while achieving higher quality health outcomes. As a result, in 2006, South Carolina gradually moved into the managed care model through voluntary participation in the Medical Home Network (MHN) model which utilized a Primary Care Physician to coordinate services. In 2010, the MHN model eventually gave way to the MMC when South Carolina required all Medicaid beneficiaries to enroll into an MCO, except for long term care, behavioral health, and dual eligible (Medicare-Medicaid) beneficiaries. Since making MCO enrollment mandatory, participation has increased to more than 850,000 Medicaid beneficiaries and accounts for approximately two-thirds of the total Medicaid recipients in South Carolina.

Based on decades of private and public sector experience, managed care offers state Medicaid programs the best chance of improving health and containing costs. Goals addressing access, quality, and cost can be built into a contract, along with contract controls, incentives, and penalties to ensure contract goals are achieved. The MMC model provides these contract "levers" to create the potential to drive improvement which are largely unavailable in a FFS.

MMC Contract Monitoring Program

Migrating to the MMC model has allowed SCDHHS to move from the role of being primarily a payer of claims to a role of orchestrating and coordinating an entire system of care. Success starts with a quality contract which has thoughtfully set the expectations, as well as engineered out problems in advance, in terms of beneficiaries' access to care; quality of care; satisfaction with health care; improved health care, primarily emphasizing outcomes and wellness programs; and contain costs through market forces and coordinated care for better care with less inappropriate or overuse of services. Even with the best contract, success is not guaranteed; it is a function of SCDHHS's execution capability to proactively monitor the contract to ensure its requirements are met, primarily in terms of health care quality and cost containment. This is particularly important for a MMC given the billions of dollars involved; the complexity of successfully operating a dynamic health care delivery system; and the vulnerable population served having greater health care needs and facing higher barriers to access than the general population.

Standard to Assess SCDHHS's Contract Monitoring

The SCDHHS's contract monitoring program was assessed along two dimensions: fundamental contract monitoring principles and federal regulations specific to MCOs. Generally accepted contract management principles establish a written contract monitoring plan itemizing contract deliverables, sets risk based monitoring procedures, and fixes monitoring responsibility with a specific person/position. Monitoring procedures include:

- data collection requirements, primarily standardized reporting;
- verify the accuracy and reliability of data;

- conduct data analysis;
- establish decision thresholds to identify deficiencies;
- feedback mechanism to contractor (MCO) to resolve disputes or deficiencies, to include correction action plans; and
- follow-up to verify successful corrective action.

Federal Medicaid regulations [§42 C.F.R. 438.202(a)] require state Medicaid agencies to have processes for monitoring the MCO's compliance with contract provisions, which is commonly referred to as a "Quality Strategy." States have some latitude in developing their own contract monitoring processes. To facilitate each state's development of these processes, the Centers for Medicare and Medicaid Services (CMS) developed guidance known as the "Quality Strategy Toolkit for States," which sets forth both regulatory required components and best practices.¹

Assessment of SCDHHS's Contract Monitoring

The SCDHHS facilitated complete access to records, staff, and its external contracted entities. The SIG interviewed ten SCDHHS employees, to include senior and mid-level management responsible for the execution of the MMC program. Additionally, the SIG interviewed officials at all six MCOs; MMC's actuary, Milliman; the Carolinas Center for Medical Excellence which conducts the MMC's external quality review; and the University of South Carolina's Institute for Families in Societies (USC-IFS), which provides analysis and trends of Medicaid participation to SCDHHS for use in developing policy, program goals, and initiatives.

This review determined SCDHHS's MMC had no formal written contract monitoring process, nor informal systematic practices, to determine if each MCO met their contractual requirements/deliverables, nor a process to provide improvement feedback and follow-up to a satisfactory resolution. Further, SCDHHS has not met its federal Medicaid requirement to establish a "Quality Strategy."

By admission and without exception, the SCDHHS interviewees stated formal contract monitoring was not occurring. The SCDHHS leadership had delegated responsibility to develop a contract monitoring process to one manager, who has developed ideas on staffing requirements and identified barriers impeding development. SCDHHS staff serving as front-line "MCO account managers" confirmed they did not monitor the contract requirements except to see if MCO contract required reports were uploaded to a Share Point database. These staff were principally occupied with reviewing marketing materials and troubleshooting beneficiary and provider complaints. The general response for not having a defined contract monitoring process was the lack of proper staffing, ongoing modifications to the recent MMC contract inhibiting developing monitoring procedures, and information technology issues of receiving MCO data necessitating the immediate need for a defined structure.

SCDHHS officials reported that during the period from 2010 through most recent contract, effective 7/1/2014, SCDHHS was consumed with standing up and developing this large initiative, with management's efforts focused on basic organizational functions, such as just enrolling Medicaid beneficiaries. Agency officials reported the initial MMC contract's sophistication was low and similar to the FFS model. However, the current contract has matured by adding enhanced measurable requirements to proactively drive improved health care and cost containment, which has now created the need to build a formal contract monitoring program. Further, despite not having a formal contracting monitoring capability, SCDHHS asserted it monitored the contract in a variety of ways in the normal course of business. For example, SCDHHS examines each MCO's self-reported geographical maps identifying its provider networks, reviews beneficiary access to healthcare complaints, and

¹ CMS's "Quality Strategy Toolkit For States" Link: http://oig.sc.gov/Documents/SCDHHS_Toolkit.pdf

even made cold calls to providers to determine if Medicaid patients were still accepted and the availability of appointments. Similar anecdotal monitoring procedures can be proffered for the major aspects of the contract.

The capabilities of a contract monitoring function is directly related to the quality of the underlying contract in its ability to specify contract requirement/deliverables in a measurable manner to facilitate monitoring the contract requirements being accomplished. The SCDHHS MMC's biennial contract with MCOs has incrementally improved in each two year life cycle, which is then further supported by SCDHHS providing a "Policy and Procedure Guide" to elaborate on contract requirements in terms of procedures or expected results.

This review did not evaluate the MMC contract, but an overview noted the contract had established the generally accepted requirements for MCOs, although it has opportunities to improve in the future with enhanced clarity of measurable standards in both the contract and corresponding guidelines. The contract is replete with informational reporting requirements from MCOs to facilitate SCDHHS's contract oversight. This MCO data is further supplemented with data generated from third party contractors of broad performance metrics universally required in all state MMC contracts. These are Healthcare Effectiveness Data and Information Set (HEDIS) performance measures on important dimensions of care and service and an External Quality Review Organization (EQRO) evaluating the quality, timeliness, and access to care and services.

The SCDHHS should take pride in successfully building a provider network through six MCOs, a comprehensive contract, and informational reporting to permit oversight and contract management. However, without an adequate contract monitoring function, SCDHHS does not have the tools needed to optimally operate its MMC contract "levers" to fully realize the health and cost reduction potential of the MMC model. This review acknowledges SCDHHS has a variety of informal, ad hoc, and even maybe some formal recurring contract monitoring meetings, such as reviewing annual HEDIS or Consumer Assessment of Healthcare Providers and Systems (CAHPS) measurements. However, the contract monitoring capability is in its infancy and best described as ad hoc and undocumented, which is inadequate to support spending \$2.6 billion in a highly complex environment. Further, contract monitoring is more critical in a MMC environment to provide reliable assurance its vulnerable population has access and quality healthcare. It creates essential tools and capabilities to make progressively better evidenced based decisions identifying MCO improvement opportunities and support increasingly more sophisticated future MMC contracts to further target and improve more complex health problems.

The good news is the MMC contract has established an information flow through standardized reporting. The challenge now is to develop a risk based monitoring strategy to filter and analyze this information to deliver the right data, the right analysis, in the right format to adequately monitor the contract, and then provide data to SCDHHS managers and policy makers to drive evidence based decisions to optimize the current and future MMC contracts. A national MCO consultant pointed out, "the key is not to just have reports with numbers on them, but rather to build comprehensive plans for gathering, analyzing, disseminating, and using information to drive performance improvement." Contract monitoring in an MMC environment is so much more than ensuring each MCO is meeting basic contract requirements; it is the vehicle to stimulate a continuous improvement environment.

During the review, SCDHHS self-reported an internal memo, dated 8/8/2014, which concluded, "the Agency does not yet have strategic planning, staffing, or processes in place to monitor the performance of the MCOs in a comprehensive and effective manner." Further, the memo identified only eight SCDHHS personnel conducting both day-to-day MCO management and contract oversight, while still having other duties. The SIG's review supports the data, analysis, and conclusions contained in this memo, in its entirety.²

² SCDHHS Bureau of Compliance and Performance Review Memo. Link: http://oig.sc.gov/Documents/SCDHHS_Letter.pdf

Interviews of MCO officials noted providing SCDHHS recurring contract reporting and special requests, yet very little contract performance feedback. The three external components supporting the MMC program (actuary, EQRO, and USC-IFS) also consistently provide SCDHHS with trends and analysis of the MMC program; yet, little feedback from SCDHHS on the value of the information or any policy or program changes. Anecdotal information was consistent among the interviews, both internal and external to SCDHHS, about the data and information which resides with SCDHHS, but seemingly goes unanalyzed.

SCDHHS is operating in a dynamic change environment from FFS to the MMC model, which certainly contributes to its current ad hoc and undocumented contract monitoring approach. By comparison to other states' MMC maturity levels, South Carolina is relatively new, starting in 2010, to the MMC environment. Literature review portrays states having difficulty and challenges instituting an adequate contract monitoring program. A relevant study published in the Health Care Financing Review (winter 2000) uniquely examined four states from their MCO infancy, which concluded, "these (new) implementation issues took the time and attention that might have been devoted to monitoring in a more mature Medicaid managed care world. Thus, monitoring in these demonstrations was slow to start and all these demonstrations were operating for months or years before thorough monitoring of managed care plans became routine. Over time, States were able to develop, implement, and strengthen monitoring structures...After 4 years of operations, we concluded that monitoring was not adequate."

Any new initiative has the tendency to let operations get ahead of its administrative capacity to support. Regardless of SCDHHS's current issues, priorities, and constraints in managing the MMC, it is time to elevate the priority of developing a contract monitoring capability to drive MMC improved performance. Despite the demonstrable change fatigue at the agency, not addressing the contract monitoring issue now inherently creates a high risk of government waste. Further, and perhaps more important, the opportunity for Medicaid cost savings arguably is more substantial if the aged, disabled, and chronically ill populations currently still in a FFS model could be successfully transitioned to the MMC model at a future date. However, SCDHHS must first develop its contract management capabilities in this new MMC environment with a less complex, healthier population. Further delays only cause downstream unrealized cost savings and improved healthcare.

Fortunately, SCDHHS can tap into several decades of lessons learned from other states operating MMCs which use a variety of strategies. There is no "cookie cutter" model. The model is a function of first establishing a risk based quality strategy to account for the current MMC's unique risk factors, as well as the extent SCDHHS executive management may broaden its role into enhanced data analytics, such as comparing performance across all managed care plans and other trends to support enterprise-wide policies and decisions. Regardless of initial strategy and model selection, other states' experience shows the contract monitoring function taking many years to incrementally evolve and mature.

Other Observations

The SCDHHS's MMC contract operates in a repetitive two-year cycle beginning with the formulation phase of selecting requirements for a proposed contract; bid/negotiations; contract award; contract monitoring; and contract close-out leading to lessons learned for the next cycle's formulation phase. As a result, the MMC ecosystem components are closely linked, so this review will set forth relevant observations gleaned outside of the contract monitoring scope to be considered by SCDHHS in managing its entire MMC operation. These observations were:

- The MMC contracts had a pattern of being managed through retroactive contract amendments and policies. One MCO official noted a contributing factor to this retroactive approach was that no contract or rate schedule had been published on time during his extensive tenure working with SCDHHS. Further, these changes often are applied retroactively thereby creating unnecessary administrative costs

of reprocessing previously paid claims. Program initiatives and policy implementation are sometimes rolled out by SCDHHS without forward thought as to the wide-ranging effects. There was a sense of too many health program initiatives without sufficient strategy framework or prioritization. Essentially, the MCOs seemed to be looking for more predictable business processes with sufficient lead times to implement, which would engineer out unnecessary costs and excess time required to address preventable contract changes in a reactive manner.

- The most recent comparison of the MCO model to the state's traditional FFS model yielded an estimated 9.3% savings in calendar year 2013 based on an actuarial analysis. Even with these savings, the actuary noted the state's Medicaid provider rates are "fairly rich" compared to other states. As a barometer, states compare their FFS rates, which varies by state, to the constant Federal Medicare national rate. The average state's rate was 60% of the Medicare rate, while SCDHHS's rate was 78%. There are many factors driving each state's individual rates. However, this does represent an analytical variance to be understood given the magnitude of dollars involved.
- There seemed to be a pattern of SCDHHS front line MCO account managers, up through supervisors and executives, to be overly involved in reactive disturbance handling of issues with some appearing to be the responsibility of the MCO to address. A number of interviews provided examples of MCOs circumventing SCDHHS's chain of command through uncoordinated appeals of lower level SCDHHS employee decisions to higher level SCDHHS managers. One specific example pertained to SCDHHS, based on providers complaints, intervening with MCO to relax its contractual Program Integrity standards with it providers. In the SCDHHS aforementioned 8/8/2014 memo, it reported SCDHHS staff viewed its roles as, "operating primarily as an *intermediary* (emphasis added) between the MCOs and the providers by providing insight on MCO policies and procedures, and claims processing and adjudication. Staff reported that the MCOs govern themselves with little feedback from the Agency." These symptoms, identified by both MCO and SCDHHS interviewees, seem to be consistent with an overall need for the MMC model to mature to allow SCHDDS to move to an oversight role with defined business process routines which will clarify roles and responsibilities between providers, MCOs, and SCDHHS.
- Data integrity issues have created additional obstacles, such as:
 - three MCOs are on a functional legacy system while three MCOs are experiencing data capture issues based on a newer format;
 - one MCO advised its audit found a 30% provider input error rate;
 - no known audit capacity by SCDHHS to validate MCOs self-reported data; and
 - the impact of incomplete encounter data on evaluating MCOs.
- An emerging issue in the managed care arena is the strength of hospital systems and the negotiating power of these entities. Ninety-four percent (94%) of specialty care centers and 72% of primary care physicians are contracted with the major hospital systems in the state (Greenville, MUSC, Spartanburg, McLeod, and Palmetto-Richland).
- The Birth Outcomes Initiative (BOI) was noted as an example of an improvement project that had both positive cost savings of \$11.5 million over a two year period and improved quality health outcomes. A review of its success demonstrates the benefits of a business like focus on planning, a defined strategy, and a structured roll-out by SCDHHS in coordination with the provider networks and the MCOs, and measuring outcomes.

Recommendations

1. SCDHHS should formulate a written “Quality Strategy” for the MMC program as required by §42 C.F.R. 438.202(a), which should serve as the foundation of its contracting monitoring function.
2. SCDHHS should expand its MCO executive management capacity to allow it to fix responsibility, authority, and accountability with one manager for establishing an initial contract monitoring strategy with milestones, as well as the day-to-day development of a systematic contract management function with mechanisms and the authority to ensure inter-departmental cooperation and coordination of data streams from MCOs or internal SCDHHS components. Development should include staffing; roles & responsibilities; risk based monitoring procedures; ensure reliability of data analyzed; a feedback process with controls to ensure MCO deficiencies or improvements are satisfactorily implemented; and a formal mechanism to contribute input to improve formulating future MMC contracts.
3. SCDHHS should consider the use of a subject matter expert consultant in planning its contract monitoring function to leverage lessons learned and best practices from other states’ experiences, in particular establishing the appropriate mix of relying on external consultants versus in-house expertise.
4. SCDHHS should reengineer its MMC contract cycle to establish implementation timeframes (90-day minimum) along with all accompanying materials (payment schedules, policies, procedures, report guides, etc.) prior to contract start date to reduce the number of post-contract amendments and corresponding retroactive re-submission of provider payments by MCOs.
5. SCDHHS should consider reviewing its FFS and MMC personnel resources allocations to ensure properly aligned with its organizational shift to the MMC model.
6. SCDHHS should consider developing medium/long-term strategies or directional guidance on the expected extent of future FFS migration to MMC, which would be a relevant factor in all aspects of planning, to include the MMC contract monitoring function, in its high change environment.
7. SCDHHS should seek opportunities to reinforce the culture change in the MCO model to proactively orchestrate and coordinate an entire system of care and extricate SCDHHS personnel from reactive customer service or provider issues which are more appropriately addressed by MCOs.
8. SCDHHS should formalize communication channels with MCOs based on the type of issue, and then rigorously enforce the chain of command to empower MCO related decisions being made by SCDHHS personnel at the lowest possible level along with clear escalation paths for unresolved issues.

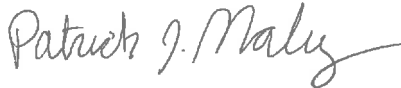
Closing

The SIG appreciates the challenging situation presented to SCDHHS when instituting this new MMC model which affects so many people throughout the state. It was apparent during this review of the dedication of SCDHHS personnel to implement such a huge, complex MMC program encompassing billions of dollars. There is much to be proud of through successfully building a provider network through six MCOs, an improving comprehensive contract, informational reporting to permit oversight and contract management, and demonstrated actuarial savings as high as 9.3% in 2013. Still, the time has come in the evolution of the MMC model to bring contract monitoring capabilities to bear to spur even higher levels of increased health care and cost containment.

SCDHHS's current ad hoc approach to contract monitoring may only be a symptom of the broader challenge to mature SCDHHS's entire MMC model to iron out reactive tendencies from its start-up posture to one of sustained business processes. This shift would solidify operations to set the cornerstone for a continuous improvement environment critical for the long-term success of the MMC model.

The SIG extends its gratitude to all of the SCDHHS staff who participated in this review and assisted in the gathering of documents and the coordination of interviews. The SIG is available to answer any questions you may have or consider additional work to address this important area of contract oversight.

Sincerely,

A handwritten signature in black ink, reading "Patrick J. Maley". The signature is fluid and cursive, with a long horizontal stroke extending from the end of the name.

Patrick J. Maley
Inspector General

Office of the Inspector General
111 Executive Center Drive
Enoree Building, Suite 204
Columbia, SC 29210

RECEIVED

JUN 08 2015

Department of Health & Human Services
OFFICE OF THE DIRECTOR

Christian Soura
SC Department of Health & Environmental Control
1801 Main Street
Columbia, SC 29201

Human Services

1174

1175