DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

EA

TO	DATE
Singleton/Day	7-14-14

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000021	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ CC: Mr. Tuck Cleared 8/12/14, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 7-23-14
	[ ] 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.			
2.			
3.			
4.			

SCAHP
SOUTH CAROLINA ALLIANCE OF HEALTH PLANS

James H. Ritchie, Jr.
Executive Director

(803) 256-9003
www.scalliance.org

July 11, 2014

Pls-log;
Singleton / Day
thx -

Via Email Only
Anthony E. Keck
Director, South Carolina Department of Health & Human Services
P.O. Box 8206
Columbia, SC 29202

Re: Department Policy and July, 2014 Actuarial Rate Inaccuracies

Dear Tony,

The Department has always assured the plans actuarial inaccuracies will be corrected. Given the pendency of the July 1st MCO Contract, to which the rates are integral, the plans request urgent Departmental attention to the following issue set forth in the attached Wakely letter: Milliman has continued its assumption that base period plans paid 113% of the outpatient FFS fee schedule and increased the outpatient savings assumption from 3% to 9.4%. Given the inpatient pricing correction downward from 113% to 103.6% and concomitant removal of the entire expected inpatient savings assumption, complete removal of the expected outpatient savings assumption is warranted and requested.

Milliman's inpatient repricing correction voided the rationale for taking expected inpatient savings. Rather than removing the expected outpatient savings assumption as well, Milliman more than tripled it, meaning Milliman assumes the base period plans paid outpatient claims at a rate nearly 10% higher than inpatient claims, as compared to the FFS fee schedule. However, individual base plan calculations evidence outpatient and inpatient MCO payments are the same or possibly a point lower for outpatient, not 10% higher than the 103.6% currently utilized for inpatient. We have asked for and been refused the calculations justifying the outpatient changes and assumptions.

Further, the Department has not acknowledged the increased outpatient savings assumption or provided rationale for it, leaving no choice but to assume Milliman unilaterally instituted the increase to smooth the impact of its APR-DRG repricing changes down to a

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claimed $8 Million, which amount Milliman asserted to be too small to adjust the capitation rates.

Departmental expectations respecting MCO contracting rates are a matter of policy, and this increase, unsupported by calculation or Departmental recognition, impugns the integrity and credibility of the rate setting process and product.

We request the Department's urgent attention to analyze the efficacy of Milliman's work and to correct this issue, along with the other issues referenced in the attached Wakely letter, so that the Department and the plans may move forward in partnership under the July 1st MCO Contract.

Sincerely,

Lea B. Kerrison

Enclosure

cc: Deirdra Singleton (via Email only)
Nate Patterson (via Email only)

LBK

July 11, 2014

Lea B. Kerrison, Esq.
Kerrison Law, LLC
Director, Medicaid Services, South Carolina Alliance of Health Plans
845 Lowcountry Boulevard, Suite J
Mount Pleasant, South Carolina 29464

RE: July 2014 South Carolina Medicaid Rate Setting Methodology

Dear Lea:

Wakely Consulting Group, Inc. has been retained by the six managed care organizations participating in the South Carolina Medicaid program to assist in an evaluation of the South Carolina Medicaid rate setting process for rates effective July 2014. This letter is in response to the June 26th letter from Milliman. It summarizes areas where we believe the methodologies and/or assumptions used in development of the rates are adversely impacting the draft capitation rates proposed for participating MCOs.

Summary of Outstanding Rate Setting Issues

We thank Milliman for their June 26th responses to the issues outlined in Wakely's May 27th letter. There are a several items that we believe remain unresolved subsequent to those responses. The following highlights our primary outstanding concerns related to rating assumptions or methods.

Repricing of Inpatient Hospital Claims

Background

As part of the original July 2014 rate setting process, Milliman repriced facility claims at 108% of Medicaid fee-for-service (FFS) payment levels. This repricing methodology resulted in unexpectedly large reductions to the facility claim costs projected by Milliman. At our request, Milliman supplied detailed repricing data to the MCOs to validate the repricing methodology and results. The review of the Inpatient repricing data identified significant discrepancies between the DRGs assigned to the original claim and those assigned by Milliman as a part of the repricing process.

Wakely – May 27th Letter

Wakely's May 27th letter outlined several specific reasons why Milliman's DRG assignments were not matching the original claim. The DRG discrepancies reported to Wakely by the MCOs were very consistent across all plans, and were not specific to Select Health. Milliman's revised methodology did not address concerns related to the base period DRG assignments of the other participating MCOs. The following section is repeated from our May 27th letter, and outlines specific issues that are impacting the DRG assignments of all MCOs:

- A significant portion of claims originally coded as low birth weight neonates are being grouped by Milliman under normal birth weight categories. It is our understanding that "occurrence codes" indicate newborn birth weight. There is no field in the encounter data submitted to DHHS indicating occurrence codes. This likely explains why Milliman is grouping low birth weight neonates into normal birth weight categories. The normal birth weight categories carry much lower relative weights and materially understate the reimbursement for these cases.
- Milliman's inpatient repricing methodology does not appear to account for "discharge status". Our understanding is that, for cases where the patient status indicates that the patient has expired (died in the hospital), the hospital is entitled to the full DRG payment even if it is a same day or one day discharge. If discharge status is not incorporated into the payment logic, the same day discharge is priced at a per diem rate which results in a significantly lower payment than the full DRG amount.
- Milliman has grouped a large percentage of claims originally coded as C-Sections into DRGs associated with vaginal deliveries. It is unclear why this is happening.
- Milliman has also reclassified a large number of claims that are ventilation related. This discrepancy may be due to the unavailability of the "Days on Ventilator" field in the data supplied to Milliman.
- It appears Milliman has applied the South Carolina inpatient payment logic and rates for services rendered outside the state. Given that South Carolina FFS reimbursement rates are not available at out-of-state facilities we believe that Milliman should reflect the original paid amounts in their repricing of these facilities.

Milliman – June 26th Response

Milliman's response indicated that specific issues with Select Health's data were identified, and they revised their methodology to use the DRGs assigned to the original Select Health claims.

Wakely Comment – July 11th

We do not believe Milliman has adequately addressed this issue given that issues were identified in the base period data for Absolute Total Care (ATC), Blue Choice, and WellCare. We also have concerns related to the recent "APR-DRG Weight Assignment Comparison" analysis performed by Milliman (Table 1 in the June 26th letter). In that table, Milliman indicates that their DRG assignments for (ATC) result in an increase of 3.2% in composite DRG weights relative to the DRGs assigned to the original claims. An analysis supplied by ATC indicates that Milliman's DRG assignments result in a significant *decrease* in composite weights relative to the DRGs assigned to the original claims. ATC has offered to share their analysis with Milliman in an effort to identify issues which may be impacting the DRG assignments of all MCOs.

Deliveries, neonates, and ventilation claims represent a large portion of the DRG-reassignment cases, but a wide variety of DRGs are impacted by this issue. We believe that Milliman should use the DRGs indicated on the original claim for all MCOs given that they do not have all of the information to properly assign DRGs to every case. The original DRGs are associated with actual reimbursement dollars and therefore have been confirmed by both the MCO and provider.

Repricing of Outpatient Hospital Claims

Background

Unlike the inpatient repricing data supplied by Milliman, the outpatient data is grouped at a high level and does not include individual claim detail.

Wakely – May 27th Letter

In our May 27th letter, Wakely requested that claim level detail be provided for review and validation of the outpatient methodology and results. Additionally, Milliman indicated in their May 21st letter that the November 2012 increase in outpatient reimbursement (13.9%) *"has allowed Medicaid reimbursement to catch up with MCO reimbursement levels."* It is our understanding that a significant portion of MCO outpatient contracts are based on percentages of FFS reimbursement levels. Such contracts will be adversely affected by the 13.9% increase, and the increase in FFS payments may not result in a narrowing of the differences between FFS and MCO reimbursement levels.

Wakely Comment – July 11th

This above issue was raised in our May 27th letter, but was not addressed by Milliman in their June 26th response.

Given the issues identified with the inpatient grouping and repricing, we feel that significant questions exist regarding the outpatient grouping (which is considerably more complicated than inpatient).

Outpatient Contracting Assumptions

Background

As part of the original July 2014 rate setting process, Milliman repriced facility claims at 108% of Medicaid fee-for-service (FFS) payment levels. In the June 26th document, Milliman revised the outpatient contracting target from 108% to 103.6% of FFS.

Wakely Comment – July 11th

Milliman does not explicitly state the historical outpatient percentage of FFS in their rate setting documents, but we believe it is approximately 113% based on our interpretation of their documentation (this is generally consistent with the contracting relativities they have communicated previously for outpatient). The MCOs have indicated that the 113% figure is higher than actual payment levels. They have further indicated that the nearly 10% differential between inpatient (103.6%) and outpatient (113%) payment levels is not reasonable and not reflective of contracting realities.

In the June 26th document, Milliman revised the outpatient savings target from 108% to 103.6%. This change appears to be arbitrary and the reason for making it is undocumented. The corrections made on the inpatient side (described above) increased payments to MCOs, and this change appears

to be an effort to offset those increases. Wakely estimates that the reduced outpatient target results in a $16M reduction in annual capitation revenue.

In their July 2nd letter, DHHS noted that five facilities received updates to the facility-specific outpatient multipliers effective July 1st. These outpatient multiplier changes are not referenced in Milliman's rate setting documentation. We suggest that Milliman evaluate the impact of the changes and revise the calculated rates accordingly given that the revised multipliers will result in payment levels that deviate from those reflected in the base data.

Given the significant issues identified with the repricing methodology Milliman used for the July 2014 rating period we request that Milliman revert to the facility pricing methodology that was used for prior rating periods. This methodology assumed that historical relativities to FFS were retained in future rating periods.

Application of Risk Scoring Results to MHN Prescription Drug Costs

Background

The rate setting documentation indicates that base period MHN pharmacy data was also adjusted for *"risk adjusted utilization"* differences between the MCO and MHN populations.

Wakely – May 27th Letter

This letter noted that we do not believe that CDPS+Rx scores are appropriate for the purpose of adjusting pharmacy utilization. In their May 21st letter Milliman indicated that they will consider revising the MHN SSI utilization adjustment reduction from 85% to 90%. In this letter we suggested that an adjustment factor of 92.3% be applied in this case. This factor is consistent with Milliman's own estimate.

Milliman – June 26th Response

Milliman's June 26th letter indicates they are continuing to review their analysis to determine an appropriate prescription drug utilization adjustment for SSI.

Wakely Comment – July 11th

Given Milliman's calculated factor is 92.3%, we believe that the current 85% factor is not reasonable. We suggest that an adjustment factor of 92.3% be applied in this case. The impact of the chosen factor is significant given that SSI prescription drugs represent a large portion of total drug spend.

Sovaldi

The response to our inquiries regarding Sovaldi was included with the DHHS memorandum dated June 12th. We agree with DHHS that an accurate estimate of annual Sovaldi costs is difficult at this time. We further agree that a retrospective adjustment is appropriate given that emerging costs have materially exceeded the amounts included in the capitation rates for Sovaldi-related costs. We request that DHHS provide detailed documentation of the study that will be performed to determine the appropriate retrospective adjustment to the July 2014 rates. The study parameters will help the

MCOs understand the data that will need to be supplied, and give them comfort that this issue will be appropriately addressed once sufficient data is available.

Conclusion

Wakely relied on data and information provided by DHHS and Milliman in reviewing the capitation rates and in identifying issues and requests for additional information. This feedback is for the evaluation of the methods and assumptions used in development of the July 2014 South Carolina Medicaid rates. Other uses may be inappropriate.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. We are members of the American Academy of Actuaries, and we meet the qualification standards for performing this work. Please do not hesitate to call us if you have any questions or if we may be of additional assistance.

Sincerely,

Taylor Pruisner, FSA, MAAA
Wakely Consulting
9777 Pyramid Court
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Ross Winkelman, FSA, MAAA
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Jan Polatty

From: Lea Kerrison <lea@kerrisonlaw.com>
Sent: Friday, July 11, 2014 3:54 PM
To: Anthony Keck
Cc: Jan Polatty; Deirdra Singleton; Nathaniel Patterson; Cindy Helling; Sean Popson; Andi Rawl; Betsy Hall; Beverly Hamilton; Bill Prince; Cesar Martinez; Chris Horan; Clark Phillip; Dan Gallagher; Dave Shafer; David Smith; Frances Zacher; Gary Ries; Jim Ritchie; Joe Lowry; Kathryn Gailey; Kathy Warner; Nichole Melton Mitchell; Paul Accardi; Robert London; Scott Graves; Stephen Moore; Talvin Herbert; Tom Lindquist
Subject: Department Policy and July, 2014 Actuarial Rate Inaccuracies
Attachments: LBK Cover Letter to Wakely Letter of 7-11-14.pdf; Wakely Letter - July 2014 Rates (2014.07.11).pdf

Tony, attached please find a letter from me respecting the July, 2014 rates, along with a response letter from Wakely to the Milliman letter of June 26th, which we received July 3rd. Due to the policy implications set forth, I deemed it appropriate to address my letter to you. I trust you will give these letters judicious consideration and look forward to the Department's response. Thank you, Lea

Lea B. Kerrison, Esq.
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Log #21

SOUTH CAROLINA
Healthy Connections
MEDICAID

Nikki Haley GOVERNOR
Anthony Keck DIRECTOR
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August 12, 2014

VIA EMAIL ONLY:

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531 South Main Street, Suite 307
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David Shafer, President
WellCare of South Carolina
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Dear Sirs/Madam:

Please find attached Milliman's response to the questions from the Managed Care Organizations (MCOs) and Wakely Consultants regarding the SFY 2015 MCO capitation rates presented in the April 25, 2014 report and other related follow-up correspondence.

I have copied Wakely Consultants, Ross Winkelman and Taylor Pruisner, so that they may communicate their review to you all, as a result of their conference call with Milliman. Wakely's commentary should help to further explain the changes.

If you have any questions or concerns, please contact me at (803)898-2647 or Nathaniel Patterson at (803)898-2018.

Sincerely,

Deirdra T. Singleton
Deputy Director

Attachment

cc: Nathaniel Patterson, SCDHHS, Program Director of Health Services
Adriana Day, SCDHHS, Chief Financial Officer
Donna Parker, SCDHHS, Accountant/Fiscal Manager
Ross Winkelman, Wakely Consultant
Taylor Pruisner, Wakely Consultant

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John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

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August 4, 2014

Ms. Deirdra Singleton
Deputy Director of Health Programs
State of South Carolina
Department of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

Re: Response to July 11 MCO Questions on SFY 2015 Capitation Rates

Dear Deirdra:

At your request, we prepared this letter to address several comments from the MCOs and Wakely regarding the SFY 2015 MCO capitation rates presented in our April 25, 2014 report and other related follow up correspondence. The comments were collected in two separate letters from the Alliance and Wakely dated July 11, 2014. This letter documents the answers to those comments and is appropriate to share with Wakely and the contracted MCOs.

SUMMARY OF RATE CHANGES SINCE APRIL 25 DRAFT REPORT

Table 1 provides a summary of the changes we have made to the draft rates since the April 25, 2014 draft report (with and without supplemental teaching payments (STP)):

Table 1
South Carolina Department of Health and Human Services
Summary of SFY 2015 MCO Capitation Rate Changes Compared to April 25, 2014 Draft Report

Change	Average Rate (with STP)	Rate Change	Average Rate (without STP)	Rate Change
Average MCO capitation rate from Table 1 of April 25, 2014 report	$287.22		$276.86	
Updated the count of maternity kicker payments in composite calculation (rate cell capitation rates did not change, so no rate impact)	278.07	0.00%	267.71	0.00%
Removed TPL adjustment from FFS data, corrected maternity kicker payment formula	278.23	0.06%	267.87	0.06%
Increased MHN SSI prescription drug utilization reduction adjustment from 85% to 90%	278.70	0.17%	268.33	0.17%
Increased hospital outpatient reimbursement adjustment to maintain the historical relationship between MCO outpatient reimbursement and FFS outpatient reimbursement	279.74	0.38%	269.38	0.39%
Increased hospital inpatient reimbursement adjustment to maintain the historical relationship between MCO inpatient reimbursement and FFS inpatient reimbursement	282.93	1.14%	272.56	1.18%
Total Impact of Changes		**1.75%**		**1.81%**

RESPONSE TO QUESTIONS FROM WAKELY

The letter summarizes each issue that was raised by Wakely in bold format, followed by our response.

1. **Repricing of Inpatient Hospital Claims**

   Wakely and the MCOs remain concerned that the SFY 2015 capitation rate methodology, as amended in our June 26, 2014 letter, relies on Milliman's DRG assignment based on submitted encounter data for all MCOs except Select Health.

   After reviewing our June 26, 2014 analysis, we discovered that our calculation relied on the MCO-submitted APR-DRG assignment for all MCOs, rather than for only Select Health as communicated in the June 26, 2014 letter. We included a detailed file as an attachment to this letter that shows our repricing calculation using the MCO-submitted APR-DRGs for all admissions. Note that the FFS repricing included in this file reflects 100% of current (July 2014) FFS payment levels.

   Our analysis shows that during the SFY 2013 base period the MCOs paid, on average, 103.7% of the average FFS reimbursement rates effective during SFY 2013. Table 2 shows how we calculated the 103.7% relationship using the results from the attached file and inpatient FFS reimbursement changes.

Table 2
South Carolina Department of Health and Human Services
Calculation of SFY 2013 MCO Paid Claims Compared to Average SFY 2013 FFS Rates

MCO reimbursement as a percentage of July 2014 FFS rates (calculated as MCO paid / July 2014 FFS from the attached Excel file for admissions with an MCO-supplied APR-DRG, representing 94% of all inpatient paid claims)	**100.86%**
FFS HIP reimbursement trend from SFY 2013 base period to July 2014 FFS:	
July - Oct 2012 claims	
Number of months in period	4
November 1, 2012 FFS change	1.0351
October 1, 2013 FFS change	1.0275
July 1, 2014 FFS change (base rate normalization impact)	0.9894
Total FFS reimbursement trend	1.0523
Nov 2012 - June 2013 claims	
Number of months in period	8
October 1, 2013 FFS change	1.0275
July 1, 2014 FFS change (base rate normalization impact)	0.9894
Total FFS reimbursement trend	1.0166
Average for SFY 2013 base period (weighted by months)	**1.0285**
Estimated SFY 2013 MCO reimbursement as a % of average SFY 2013 FFS reimbursement (100.86% * 1.0285)	**103.7%**

In order to maintain the historical relationship between MCO inpatient reimbursement and FFS inpatient reimbursement of approximately 103.7% of the Medicaid fee schedule, we applied an average inpatient reimbursement adjustment of 1.0285 to the SFY 2013 MCO encounter data, which is consistent with the average inpatient FFS reimbursement change indicated in Table 2.

The 6.7% average inpatient reimbursement adjustment applied to the MHN FFS data is equal to the inpatient FFS reimbursement trend from the SFY 2013 base period to the July 2014 FFS rates multiplied by the historical relationship between MCO paid and FFS reimbursement (1.0285 * 103.7% = 1.067).

With the clarification that all MCO-submitted APR-DRGs were used in our repricing calculation and the additional information provided in this response, we believe the MCOs' inpatient pricing concerns have been addressed.

The total SFY 2015 MCO capitation rate change related to the inpatient reimbursement change discussed in this letter is an increase of 1.14% over the draft SFY 2015 MCO capitation rates documented in the April 25, 2014 report.

2. Repricing of Outpatient Hospital Claims and Outpatient Contracting Assumptions

Wakely and the MCOs expressed concern that the revised hospital outpatient repricing adjustment presented in our June 26, 2014 letter understates the hospital outpatient component of the SFY 2015 capitation rates.

The intent of the hospital outpatient repricing adjustment in the June 26, 2014 letter was to reimburse MCOs using current FFS outpatient fees adjusted by the historical relationship between MCO outpatient reimbursement and FFS outpatient reimbursement. However, after a more detailed review of the repricing methodology, it appears that the hospital outpatient portion of the capitation rates may be somewhat understated in the April 25, 2014 draft report and the revision documented in the June 26, 2014 letter.

We modified our hospital outpatient pricing methodology for the SFY 2015 MCO capitation rates to use a high level trend approach using the FFS rate changes that impact the SFY 2013 base year data (the November 2012 multiplier change, the October 2013 multiplier change, and the July multiplier renormalization). This high level methodology is consistent with paying the MCOs based on their historical contracted rates compared to the FFS rates in place during SFY 2013. MCO paid amounts in SFY 2013 reflect actual MCO contracts in SFY 2013. Trending the MCO paid claims at FFS reimbursement changes preserves the historical relationship between MCO payments and FFS payments.

Table 3 summarizes the FFS reimbursement trend rate that will be applied to SFY 2013 hospital outpatient paid claims.

Table 3
South Carolina Department of Health and Human Services
Summary of Fee-for-Service Hospital Outpatient Reimbursement Change
SFY 2013 Base Period FFS Rates to July 2014 FFS Rates

July - Oct 2012 claims	
Number of months in period	4
November 1, 2012 FFS change[1]	1.1879
October 1, 2013 FFS change[1]	1.0234
July 1, 2014 FFS change (multiplier normalization impact)	0.9685
Total FFS reimbursement trend	1.1774
Nov 2012 - June 2013 claims	
Number of months in period	8
October 1, 2013 FFS change[1]	1.0234
July 1, 2014 FFS change (multiplier normalization impact)	0.9685
Total FFS reimbursement trend	0.9912
Average for SFY 2013 base period (weighted by months)	**1.0532**

[1] *Note: FFS rate changes reflect changes to the outpatient multipliers for applicable services. Approximately 15% of hospital outpatient paid claims are related to services that do not receive a multiplier. For example, the 2.75% rate increase effective October 2013 under Proviso 33.34 only applies to services subject to the multiplier for outpatient services, so the effective increase for October 2013 is approximately 85% of the 2.75% multiplier increase.*

The average reimbursement adjustment for the MCO population in our June 26, 2014 letter was 0.997, therefore we are increasing the MCO hospital outpatient rate component by 5.6% (= 1.0532 / 0.997) compared to the June 26, 2014 letter.

Due to variability observed in our current hospital outpatient repricing algorithm, we do not have a firm estimate of the MCOs' historical contracted outpatient rates compared to the FFS outpatient rates in place during SFY 2013. We will use the hospital inpatient relationship of 103.7% in our pricing adjustment for the MHN population's FFS claims.

The total SFY 2015 MCO capitation rate change related to the outpatient reimbursement change discussed in this letter is an increase of 0.38% over the draft SFY 2015 MCO capitation rates documented in the April 25, 2014 report.

3. **Application of Risk Scoring Results to MHN Prescription Drug Costs**

After further review of our analysis, we determined that a 90.0% adjustment factor for the MHN prescription drug utilization levels compared to MCOs is reasonable for the SSI population. Our risk-adjusted comparison of drug utilization showed a 92.3% relationship between MCO and MHN utilization levels based on risk scores for the April 2012 – March 2013 enrolled population (risk scores for the SFY 2013 enrolled population were not available).

We rounded the result of our analysis to the nearest 5% to reflect uncertainty related to using a risk adjuster calibrated to all covered services (a risk adjuster calibrated to pharmacy services only is not available). The utilization reduction adjustment factors for TANF Children and TANF Adults were also rounded in the same way.

The final SFY 2015 MCO capitation rates will include the following adjustment factors for managed care savings related to prescription drugs for the MHN population shown in Table 4 below.

Table 4
South Carolina Department of Health and Human Services
Prescription Drug Managed Care Savings Assumptions
MHN Population

Eligibility Category	Utilization Reduction Adjustment	GDR Improvement Adjustment	Additional Pharmacy Rebates	Managed Care Adjustment
TANF Children	95.0%	85.0%	99.0%	79.9%
TANF Adults	90.0%	87.4%	99.0%	77.9%
SSI	90.0%	92.5%	99.0%	82.4%
OCWI	100.0%	87.4%	99.0%	86.5%
Family Planning	100.0%	100.0%	99.0%	99.0%
Foster Care	95.0%	85.0%	99.0%	79.9%
Duals	90.0%	92.5%	99.0%	82.4%

The total SFY 2015 MCO capitation rate change related to the prescription drug utilization change discussed in this letter is an increase of 0.17% over the draft SFY 2015 MCO capitation rates documented in the April 25, 2014 report.

4. Sovaldi

We understand the MCOs' need for further information on the analysis of actual annual Sovaldi expenses and determination of retroactive adjustments, if they are deemed required. SCDHHS and Milliman are committed to developing a sound methodology for this analysis. DHHS will provide the MCOs with detailed information once SCDHHS and Milliman have determined a base structure and parameters for this process. However, we envision the proposed methodology to include steps such as those highlighted below:

- Review hepatitis C drug costs (for all drugs used to treat hepatitis C) in the SFY 2013 encounter data (prior to the release of Sovaldi)
  - Trend to SFY 2015 using actual unit cost increases for each specific hepatitis C drug
  - Add the impact of the increased drug trends that were part of the SFY 2015 capitation rate methodology to provide increased funding for Sovaldi and other high-cost hepatitis C drug treatments
  - The sum of these two items equals the funding for hepatitis C drugs included in the SFY 2015 MCO capitation rates
- Review hepatitis C drug costs (all hepatitis C drugs) in the SFY 2015 encounter data
- Determine a retrospective rate change if the difference is outside of predetermined bounds from the amount included in the SFY 2015 MCO capitation rates
  - Preliminary calculations could be performed using data through December 2014

- This methodology would serve as a risk sharing mechanism between SCDHHS and the MCOs

CAVEATS AND LIMITATIONS ON USE

This letter is designed to assist the SCDHHS with responding to questions regarding the SFY 2015 MCO capitation rates. This information may not be appropriate, and should not be used for other purposes.

The information contained in this letter has been prepared for the SCDHHS. It is our understanding that a copy of this letter will be distributed to Wakely and participating MCOs. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of this information must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for SCDHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report

The terms of Milliman's contract with SCDHHS effective July 1, 2013 apply to this report and its use.

Please call me at (262) 796-3434 if you have any questions.

Sincerely,

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

JDM/vrr