From: Chad Walldorf <chad@eightysixllc.com>
To: Soura, ChristianChristianSoura@gov.sc.gov
Date: 7/24/2013 3:33:49 AM
Subject: Fwd: Medicaid
Attachments: DOI - HMO Results - Q113.xlsx
ATT00001.htm

As mentioned during our recent meeting, thanks for giving this the appropriate level of consideration.

Chad

Begin forwarded message:

> From: Lea Kerrison <lea@kerrisonlaw.com>
> Date: July 19, 2013, 1:09:27 PM MDT
> To: Chad Walldorf <chad@eightysixllc.com>
> Subject: Medicaid
> Reply-To: "lea@kerrisonlaw.com" <lea@kerrisonlaw.com>
>
> Chad, thank you again for your time last week. As promised, I have attached a spreadsheet comparing 2013 Q1 operating results of the four SC Medicaid MCO plans (WellCare of SC, Absolute Total Care, BlueChoice Health Plan and Select Health of SC), as reported by each plan to the SC Department of Insurance for solvency oversight. Given the caveats below, I understand the losses of Absolute and Select to be consistent, evidencing Milliman's actuarial calculations and assumptions as overaggressive, despite any and all assertions to the contrary. I further understand plan losses are expected to be continuing and consistent for Q2. If continued indefinitely, the underpayments would ultimately jeopardize sustainability and continuity of the Medicaid program and the health focused mission. The only question is how long it will take. The caveats are:
>
> 1. WellCare recently purchased United HealthCare's Medicaid business in SC and is in process to be fully recognized by SCDHHS. The purchase transaction would need analysis of information to which I am not privy before any reasonable results comparison with the other plans.
> 2. Absolute's Q1 MLR and operating results for rate analysis purposes are proportionally aligned by enrollment with Select. However, two first quarter issues unique to Absolute hid such alignment. Both issues, set forth below, are now resolved.
>   a. Absolute had to retool a number of its processes to reduce claims denial issues. These issues have been resolved to SCDHHS satisfaction, as I understand from various Department staffers, but corrections inflated costs to make up for previous underpayment and also resulted in higher administrative expense. Absolute's CEO, Paul Accardi, quickly learned these issues when he joined Absolute last year and, by all accounts, has done an excellent job resolving them.
>   b. Absolute's parent, Centene, is a publicly traded corporation subject to auditing standards prohibiting booking of announced payments unsupported by signed agreements. At reporting time, the plans had not signed a November, 2012 contract amendment which included a payment increase materially affecting the first quarter due to disagreement over actuarial calculation of the payment, among other things. Since Q1, stern Departmental

demand prompted the plans to sign the agreement and receive payment, while continuing to dispute the actuarial calculation. Absolute has booked the payment since report of Q1 numbers. Select's audit requirements authorize booking of announced payments, and the increased payment is reflected in Select's Q1 reported numbers.

3. As the reports are submitted to DOI for solvency evaluation, Blue Choice mixes commercial insurance business in the reporting. BlueChoice's reported numbers do not provide an accurate picture of the current Medicaid capitation payments' fiscal sustainability.
4. Select Health's Q1 enrolled population includes 58 D-SNP enrollees, whose care is funded directly by Medicare, not Medicaid. These enrollees present minimal impact, positive or negative, when mixed with Select's then 225,000+ SC Medicaid enrollees. Select has the longest running Medicaid MCO program in South Carolina (1995), and its executive director, Cindy Helling, has been in senior management with Select since day 1.

There are a few causes the plans would attribute to underfunding, including actuarial underestimation of November 2012 hospital rate increases, erroneous selection factor assumptions, the Department's systematic reduction of administrative expense allocations for the plans and Milliman's assumption of immediate, substantial fiscal impact from the Birth Outcomes Initiative's 39 week hospital pledge, when Oklahoma, one of the first states to implement a similar policy took 18 months to begin to see results. The MCOs have not yet seen the savings assumed. I suspect these issues and the issue below all contribute and relish debating anyone who might claim underpayment the result of the plans not doing "good enough" at selling health. When you drill down any such assertion, you will find it conclusory and little more than misdirection from the real issues.

Ultimately, the main, real issue is the average premium of 10+% paid by MCOS to hospitals and specialists critical to satisfying the Department's county-by-county provider network requirements for MCOs. The Department and Milliman have asserted this a black eye on all of the plans and their individual ability to negotiate reasonable contracts, a spurious assertion. The reason MCOs pay premiums to many hospitals is that the Department's county-by-county provider network adequacy requirements place many hospitals in negotiation control. Plans often are and have been left with an ultimatum: agree to pay 110% or 120% or more of the hospital's FFS rate or try to get county network approval without the only hospital in the county. This has been the standard, Department understood, accepted and promoted way of business in South Carolina Medicaid since managed care's inception. This historical and continuing Department policy has bolstered a powerful course of action for providers who vocally prefer the unchecked FFS model or the enhanced FFS model SC created in 2005, the MHN.

I do not suggest hospitals are overpaid, rather they receive unreasonably imbalanced funding due to SC Medicaid's evolutionary flaw. I believe Tony and the Department are working through the flaw to realign the contracting playing field by discontinuing the MHN program, reducing reliance on FFS and redefining network adequacy requirements. However, we do not have significant detail on network adequacy changes, except the Department intends to move from 46 county networks to 6 regions. Assuming the changes are well-thought, they still are not planned to take effect until July, 2014.

Tony has also considered and rejected other options, one of which is making SC an RFP state for Medicaid. However, instability of care management and bidding tactics inherent to RFP reduce Departmental ability to create and drive sustainable change.

SCDHHS currently projects a $200 Million budget surplus for the year, from which SCDHHS will pay the $65-77 Million earmarked in Proviso 33.34. As an aside, due to CMS approval timing issues, most of the money earmarked for hospitals in the Proviso to assist reduced ER utilization in the uninsured population will be reimbursed via a 3% hospital rate increase for Medicaid population services. That I understand the predicament does not make the last sentence any less absurd.

Insufficient capitation rates have been implemented on occasion in SC Medicaid managed care history and

have been dealt with in more than one way, which I am happy to discuss.

Thank you,
Lea

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