DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Myers	1-28-10

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 001319	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR _____ CC: Wells Cleared 2/3/10, letter attached.	[X] Prepare reply for appropriate signature DATE DUE 2-8-10 [ ] 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.			

From: Jan Polatty
To: Brenda James
Date: 1/28/2010 1:21 PM
Subject: TO LOG : Fwd: Senator Rose - Constituent Inquiry Dr. Thomas Duncan
Attachments: Healthy%20Connections%20Fact%20Sheet.pdf; SC%20Healthy%20Connections%20Release.pdf; Healthy Connections Provider Letter October 2007.pdf; SouthCarolinaHealthyConnectionsSeptember6_2006.pdf; Rep. James Smith- Letter of 11-19-09 - Managed Care - Response 12-09.docx

Jan Polatty
Director's Office
SCDHHS
1801 Main Street
Columbia, SC 29201
803-898-2504
>>> Emma Forkner 1/28/2010 1:14 PM >>>
Can you all work together to draft an appropriate response? This is Dr. Thomas Duncan from the Summerville area. He is an internist and according to our 09 transparency website, he saw 77 Medicaid pts.

1 & 2: William is going to get the data for questions 1 & 2. He will show for 2006,07,08 & 09 in a format similar to how its been shown in the annual report.
3: This could be a discussion about the Medicaid Transformation Plan. Primarily an agency decision that included support from the health care community, legislators and governor. Letters were sent to Medicaid enrolled providers, bulletins on the agency website, information about the program on the agency website. Since the roll out started, 68% of the Medicaid eligible population enrolled in a MCO/MHN. Don't know if he is signed up to be part of the list serve or not. I would assume he received the bulletins that announced the program. However, he may not have had a chance to read our information.
4. I would recommend a "bait and switch" technique on question 4 and speak directly about the quality improvement in the HEDIS measure over the entire population. Might pull some words out of the Rep Smith letter on long term cost-containment that resulted in more quality. And, I'd list the names/numbers of the plans so that he can contact them and sign up. He missed everything and is just now aware of what we've been doing for nearly 2 1/2 yrs. We'd like to help him catch up with his peers who are participating.

Attached are a number of documents that may be useful in copying and pasting good words into the answers.

Jan, we ought to log this.

Thanks,
emma

Emma Forkner
Director
Department of Health and Human Services
1801 Main Street
Columbia, South Carolina 29201
(803) 898-2504
(803) 255-8338 fax

>>> Angie Stoner <AngieStoner@scsenate.gov> 1/28/2010 10:59 AM >>>

Emma,

Senator Rose received the following inquiry regarding the Medicaid program's expenditures for administration and the transition of the program to managed care. Please provide a response to Dr. Duncan's questions enumerated 1-4 in the letter below.

Thank you for your assistance and if you have any questions, please let me know.

Angie
212-6656

From: Michael Rose [mailto:mrose5@sc.rr.com]
Sent: Tuesday, January 26, 2010 8:10 AM
To: Mike Hitchcock
Cc: mrose5@sc.rr.com; 'Carroll Duncan'
Subject: FW: Letter Medicaid Dr. Tommy Duncan

Mike,

In the file attachment above and reprinted below is a letter dated Jan. 17, 2010, from Dr. J. Thomas Duncan to me asking
Certain questions about Medicaid.

Please either answer the questions or tell me where to go to get the answers.

Thank you.

Mike Rose

January 17, 2010
Senator Michael Rose
409 Central Ave.
Summerville, SC 29483

Dear Senator Rose,
As a practicing physician in SC, it has come to my attention that many of my patients on Medicaid have been advised to (and some have said they were required to) join Medicaid HMO's.
This would appear to me to add an additional (and perhaps unnecessary) administrative cost to an already strapped and underfunded program designed to help the less fortunate of our society at the expense of those of us paying both state and federal taxes.
Obviously, there was previously in place an administrative level for Medicaid disbursements before the "hiring" of these HMO's. I would ask you to look into several questions I have as follows:
1. How much of the total funds allocated for Medicaid, both state and federal, are actually

spent directly and only for goods and services, and how much for administration at any and all levels;
2. How the above mentioned allocation compares to "administrative costs" prior to initiation of these HMO's, both in toto and as a percentage;
3. At what level, legislative or bureaucratic, the decision to establish this system was made, when and why;
4. And finally, if this HMO level of administration is truly more financially efficient, could not even greater savings be obtained by reducing or eliminating most or all other administrative levels.
Thanking you in advance for your reply.

Yours truly,

J. Thomas Duncan, MD

South Carolina Healthy Connections Choices

Fact Sheet

What is South Carolina Healthy Connections Choices?

Healthy Connections Choices is a new program that helps Medicaid members enroll in health plans. Beginning in late August 2007, members may start enrolling in Healthy Connections Choices and receive health services from a health plan.

When members enroll, they choose a health plan and a doctor (or clinic). Healthy Connections Choices will help members choose a health plan that is best for them.

When can members enroll in Healthy Connections Choices?

Each region throughout the state will have a start date after which members may enroll. On the start date for each region, we will send enrollment packets to those who are newly eligible for Medicaid and members who are up for renewal that month.

Region		Start Date
Midlands	Aiken, Allendale, Bamberg, Barnwell, Calhoun, Clarendon, Fairfield, Kershaw, Lancaster, Lee, Lexington, Marion, Newberry, Orangeburg, Richland, Sumter and York	***August 27, 2007***
Low Country	Beaufort, Berkeley, Charleston, Colleton, Dorchester, Georgetown, Hampton and Jasper	***January 1, 2008***

Can members enroll before they get their Healthy Connections Choices enrollment packets?

Yes. Enrollment is voluntary and current members (with regular, fee-for-service Medicaid) can enroll anytime after the start date in their region.

Important deadlines for choosing

- *Initial Enrollment Period: The first 30 days*

  All members have at least 30 days (from the day we mail the enrollment packet) to choose a health plan or choose to stay in regular (fee for service) Medicaid. If they don't choose a plan or tell us that they want to stay in regular Medicaid, we will assign them to a plan.

continued

- *Choice Period: The first 90 days*

  Members have 90 days after enrolling in a health plan to transfer to another plan or return to regular Medicaid.

- *Continuous Enrollment Period: One year*

  After the 90 day Choice Period has expired, members stay in their health plan until their one year anniversary date unless they have a special reason to make a change.

How will members enroll?

There will be four easy ways for members to enroll:

1 Enroll by mail or fax, by completing the form in the enrollment packet and sending it to us.
2 Enroll over the phone, by calling the South Carolina Healthy Connections Choices toll-free number.
3 Enroll online at the South Carolina Healthy Connections Choices website.
4 Enroll in person, by meeting with a community enrollment counselor.

Will members have a choice of health plans?

Yes. Members will have a choice between at least two different health plans. Healthy Connections Choices can help members choose the health plan that is best for them.

Do members have to choose the same health plan for all members of the family?

No. Each member of the family can choose the plan that is best for them.

Does every member have to enroll in a plan?

No. Enrolling in a health plan is not mandatory. A member can indicate that they want to stay in regular Medicaid during the Initial Enrollment Period or during the 90 day Choice Period. After the Choice Period, members must get approval from the South Carolina Department of Health and Human Services to go back to regular Medicaid.

Will Medicaid benefits change?

No. Members enrolled in the Healthy Connections Choices program will receive all of their current Medicaid benefits plus the enhanced benefits provided by their health plans.

South Carolina Department of
Health & Human Services

Managing the Medicaid program to provide the best healthcare value for South Carolinians.

August 16, 2007
FOR IMMEDIATE RELEASE

Contact: Jeff Stensland
(803) 898-2584

SCDHHS Launches Medicaid Choice Campaign

The South Carolina Department of Health and Human Services (SCDHHS) is launching a campaign to inform Medicaid beneficiaries that they will soon have the option to choose their own health plans. About 560,000 Medicaid beneficiaries statewide will be eligible to participate in the agency's *Healthy Connections Choices* program, which will rollout over the next 18 months.

A kick-off luncheon detailing the program is scheduled for Tuesday, August 21 from 10 a.m.--1 p.m. at the SC Hospital Association, located at 1000 Center Point Road in Columbia.

Healthy Connections Choices is part of the state's overall Medicaid reform plan and is designed to get a better return on South Carolina's heath care investment. Through partnerships with managed care organizations, Medical Home Networks and special enrollment counselors, SCDHHS seeks to increase care coordination and disease prevention methods not found in traditional Medicaid. Those who choose to enroll in a health plan also will establish crucial relationships with a primary care doctor. Currently, many Medicaid beneficiaries are left to navigate the health care system on their own, leading many to seek only sporadic care or emergency services.

"By encouraging increased education and valuable one-on-one time with primary care physicians, we assist Medicaid patients to actively participate in their health management," said SC Department of Health and Human Services Director Emma Forkner. "Choosing the health plan that offers the right combination of delivery services for the individual or family is a significant step for the Medicaid population. We anticipate many of our beneficiaries will learn to manage chronic diseases and adopt healthy behaviors and lifestyles. Our goal is a healthier Medicaid population for South Carolina."

Under *Healthy Connections Choices*, participants will receive the same benefits as those in traditional Medicaid, and also extra services offered through the individual plans. These may include benefits such as unlimited doctor visits, eyeglasses and dental care for adults, smoking cessation classes and programs tailored for those with specific diseases.

Medicaid beneficiaries will receive enrollment information detailing various plan options beginning August 27 in the Midlands. Enrollment in a plan is voluntary, but those who do not make an active choice—either by choosing a plan or opting to stay in traditional Medicaid—will have one chosen for them. Those dissatisfied with their plan will have 90 days to select a new one.

Aside from direct mailings to beneficiaries, the *Healthy Connections Choices* awareness campaign will include outreach through community groups and radio, television and print media outlets. Through a partnership with Maximus, Inc., special enrollment counselors will be available to help Medicaid beneficiaries select a plan that's best for them. Please visit www.scdhhs.gov for more information and a list of plans currently available.

About 60 percent of Medicaid beneficiaries nationwide are now enrolled in some form of managed care. South Carolina's initiative is unique because it uses market-based principles—choice and competition—to encourage a high level of accountability and value from the plans. Medicaid managed care plans have been available in South Carolina since 1996, and currently enroll about 150,000 beneficiaries.

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State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

October 17, 2007

Dear participating Medicaid provider,

Thank you for your commitment to caring for our Medicaid beneficiaries. This letter is to provide you with additional information regarding a new initiative at the SC Department of Health and Human Services called *South Carolina Healthy Connections Choices (SCHCC).* This program's goal is to encourage Medicaid beneficiaries to establish and maintain a relationship with a network of physicians they know and trust.

Over the next 18 months DHHS will be sending *Healthy Connections Choices* enrollment packets to all new Medicaid members and current beneficiaries (during the annual re-certification process) who are eligible to sign up for either a Managed Care Organization (MCO) or Medical Homes Network (MHN). DHHS is committed to assisting in your efforts to provide care coordination, disease management and promote healthy behaviors. Medicaid agencies nationally have increasingly moved in this direction and now more than half of all Medicaid enrollees in the nation are part of some form of managed care.

The new *Healthy Connections Choices* program may present some challenges. I want to personally assure you that the agency will make every effort to maintain existing relationships between doctors and their Medicaid patients. When beneficiaries call our enrollment counselors to discuss their health plan options, one of the first questions the counselors ask is whether or not they have a doctor they wish to continue to see. Additionally, if a beneficiary enrolls in a plan and is unhappy with their choice, they have the option to change plans within 90 days of the original selection.

For more information about the *Healthy Connections Choices* program, please visit www.SCchoices.com. Feel free to share the information with your Medicaid patients. They can speak to an enrollment counselor by calling 1-877-552-4642. If you would like to discuss this further, please do not hesitate to call Physician Services at 803-898-2660 or our Managed Care Services at 803-898-4614. We at DHHS share your commitment to the patients you serve. I look forward to developing a strong partnership with our state's medical community as we work together to create a healthier South Carolina.

Emma Forkner

Emma Forkner

Director

EF:jp

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

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert M. Kerr
Director

September 6, 2006

Mr. Dennis Smith
Director, Center of Medicaid and State Operations
National Institutional Reimbursement Team
7500 Security Boulevard, M/S S2-01-16
Baltimore, MD 21244-1850

Dear Dennis:

I want to thank you for your help during our ongoing efforts to evaluate the impact of the Deficit Reduction Act on our original 1115 waiver request. As you know, passage of the Act significantly changed the landscape of Medicaid and opened new avenues for states to modernize their programs. We believe the DRA allows us to implement much of what we originally proposed and eliminates the need for a global waiver. However, we will pursue individual waivers if you deem them necessary for specific components of our reform plan.

We have compiled many of our initiatives into one document that describes our overall approach to effective Medicaid transformation. This planning document incorporates many of our original waiver concepts such as consumer choice and benefit flexibility while integrating new innovations that focus on quality and value. The plan presents several innovative steps toward transformation that South Carolina is uniquely positioned to offer. We believe some of these innovations, particularly in the area of personal health records, can help set the stage to move health care forward across the nation.

We are continuing to make progress in implementing various components of our plan. We look forward to receiving your guidance. Working together, we are confidant that CMS and South Carolina can offer a transformation plan that will benefit Medicaid across the nation.

Sincerely,

/s/

Robert M. Kerr
Director

RMK:lm
Enclosure

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

Medicaid Transformation Plan

Presented by

The
South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Robert Kerr
Director

Index

I. The Need for Change

Medicaid is a necessary investment for South Carolina. We spend one-fifth of our state budget on health care for almost twenty-five percent of our population. Despite this significant investment, our general health outcomes remain remarkably poor. The truth is our real problem is less about cost than it is about value. We have narrowly measured success by how well we control costs without considering outcomes. Such a narrow focus can actually result in a lower return on investment. By focusing on quality, we can improve outcomes and achieve a higher, more effective return on our investment.

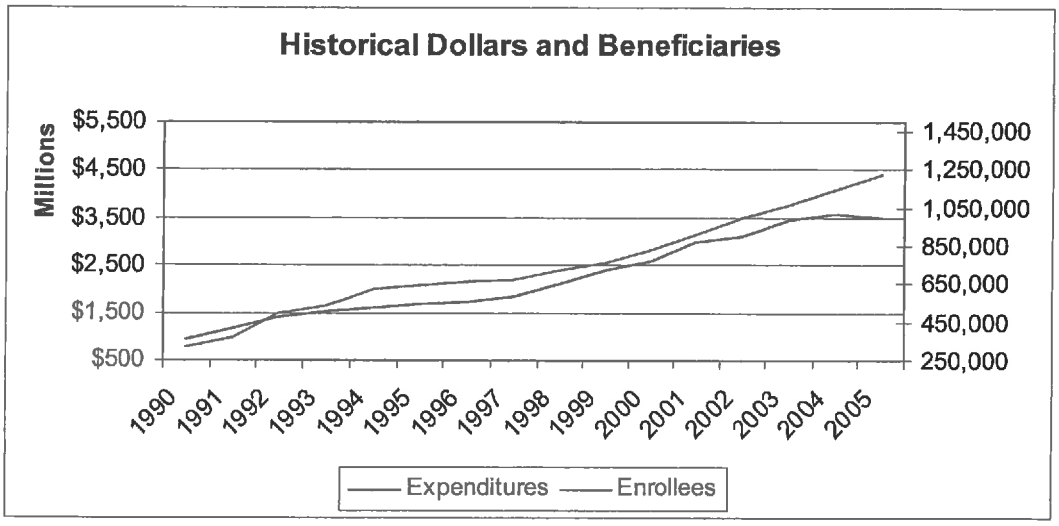
To have any hope of achieving lasting and successful reform we must accept certain realities. One is that we have a massive and diverse health care system; yet, its many parts are inter-dependent. If you change one component you will affect the others. This principle begs for widespread, synchronized change but such global transformation is unlikely. The reality is that change will come incrementally. The key is to identify powerful changes that confront the fundamental inefficiencies driving up cost. We have identified several such underlying issues that, if addressed, can have a dramatic impact on the Medicaid program and the system as a whole.

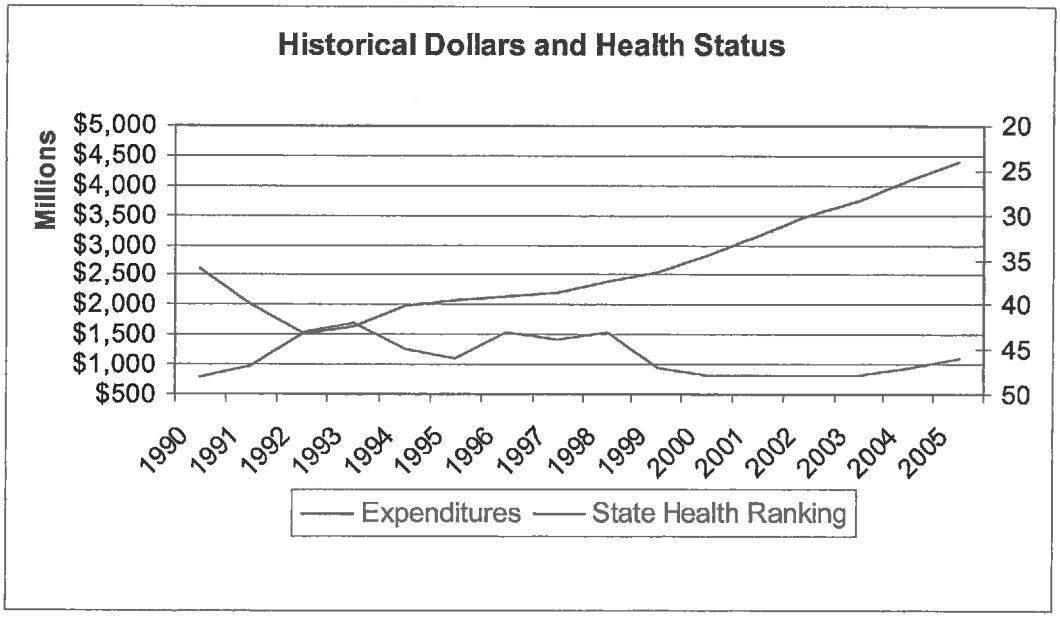
First is the fact that many South Carolinians are generally of poor health. We currently rank forty-sixth in overall health among the fifty states. Our citizens are some of the more obese in the nation and the state generally falls in the top ten for occurrences of most major diseases. It has been estimated that over half of one's individual health is controlled by personal behavior. If this is the case, then we have an opportunity to significantly improve our present situation. To adequately sustain a health care system over the long term, it is clear that South Carolina must address its attitudes toward healthy behavior.

The second cost driver is best characterized by the so-called eighty/twenty principle. It seems that health care is also subject to this phenomenon of unequal distribution in cause and effect. Roughly twenty percent of Medicaid recipients account for approximately eighty percent of all cost. Acute and sometimes unavoidable conditions contribute to this disparity. However, these costs also include chronic conditions that are treatable and often preventable. To expect critical short-term success in controlling costs and improving health outcomes, Medicaid must identify those manageable conditions within the twenty percent population. More importantly, we must refine our ability to predict who will likely become a high utilizer and encourage timely interventions.

The third issue relates to the lack of an overall coordinating force that demands and rewards continuous value from the system. Historically, the Medicaid agency has functioned primarily as a process or claims payment entity. It has been less effective at controlling costs outside of the traditional options of reducing rates, services, or eligibles. Even if techniques to improve value were identified, the agency lacked an effective delivery system by which such measures could be put into action on the local level. What prevails is a somewhat fragmented system of independent service providers with independent objectives. The result for both patient and provider is often a lack of coordinated care and essential information. To realize lower costs, the agency must realign its focus to become a coordinating influence that promotes innovation, responsibility, quality and efficiency. We must become the binding link to coordinate a fragmented delivery system around the patient and to move the system towards providing quality.

While Medicaid is a necessary investment for South Carolina, it can become a better investment. This plan provides the blueprint for actualizing a better investment by moving the system to focus on quality.





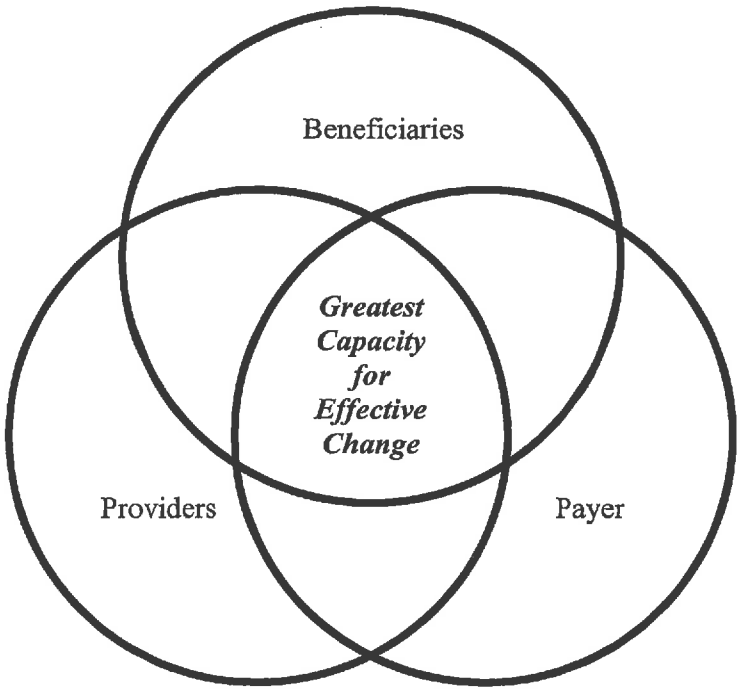
Health Index Rating Source: United Health Foundation

The above charts dramatically show increased coverage, increased expenditures and decreased ranking in health status. South Carolina's Medicaid enrollment and expenditures have more than doubled in the last decade. At the same time, the state's health status has declined.

II. Healthy Connectors

Overview

Health care reform is ultimately about changing behavior and relationships. It involves embracing a cultural change concerning individual health as well as how health care is delivered. Successful reform must bring solutions to bear at the point where the relationships of payer, provider, and beneficiary intersect. It is at this convergence that the capacity for effective change is greatest.



Healthy Connections is designed to create an effective framework that addresses our fundamental cost drivers at this critical point of intersection. The plan's foundation is a delivery system that incorporates competition based on quality, enhances primary care and care coordination, and provides beneficiaries the opportunity to become vested and informed consumers. Beneficiaries should be able to choose from a variety of health plan options that compete on results and quality.

This foundation is then reinforced with unique initiatives or "connectors" that we believe will help drive Medicaid to a value-based health system. These connectors work as catalysts in the form of information and incentives that drive efficiency and innovation. The remainder of this section is devoted to describing these connectors.

Personal Health Account

The Personal Health Account (PHA) will be the primary means to empower the beneficiary to become a well-informed consumer of health care. The PHA is a tool to connect the beneficiary to the status of their own health, health service options, and the cost of health care. Each Medicaid enrollee will be provided a PHA. It will keep the beneficiary informed regarding their use and cost of services. The PHA will reflect the cost of the plan option chosen by the beneficiary against Medicaid's historical actuarial experience for each risk group. The actuarial experience amount does not function as a cap or limitation on services but only as a cost reference point. For example, if a beneficiary chooses a pre-paid health plan, the PHA will show premium payments made on their behalf. Subsequently, we will incorporate periodic encounter data. If the beneficiary requests a primary care case management plan or fee for service product, then the PHA will indicate all claims activity and related costs. Traditional Medicaid explanation of benefits (EOBs) have been difficult for the beneficiary to understand and have provided no information on cost of services. The PHA will improve this process so that it will provide information to the beneficiary, not only about specific services provided, but also alternative scenarios so that a beneficiary can better understand the choices and benefits of different plan selection. As the PHA is refined, cost savings and health alerts will be phased in. Such alerts might include brand name pharmaceuticals with generic alternatives, the use of the emergency room for non-emergency care, or the cost of alternative treatments that could have been chosen. The PHA may advise beneficiaries of the need for health care interventions such as immunizations, health screenings, and check ups. The PHA becomes the portal to a personal health record.

Electronic Personal Health Records

Data is critical to an efficiently operating system. A provider needs as complete information as possible on a beneficiary to provide the best care. This is true of every level of care from the primary care physician to critical emergency care provided in a trauma center. The PHA not only functions to help the beneficiary become aware of health delivery and costs, it also provides the foundation for the development of an Electronic Personal Health Record (EPHR) which will be an essential tool for providers in enhancing the quality of care provided to a beneficiary.

Physicians can provide better care and more effective preventive and ameliorative care if they have readily accessible information about the medical condition and history of a

patient. Electronic medical records systems are typically expensive, vendor based and not compatible with each other. In order to provide assistance to physicians who treat Medicaid beneficiaries, South Carolina is developing access to a HIPAA compliant Electronic Personal Health Record system based on its data maintained by the State Office of Research and Statistics (ORS). The EPHR will provide information on all services and drugs provided including diagnosis. It will also have the capacity for the physician to add information about health status and laboratory results. We are working on the next generation of the EPHR database to include environmental data such as air quality conditions for a geographic area. The database is dynamic so that an individual EPHR can be matched to environmental data. For example, a physician with a patient who has asthma could determine if the patient lives in an area with air pollution problems. This unique innovation has tremendous potential in aiding practitioners in making accurate diagnosis. Information will be accessible when beneficiaries present to providers including hospital emergency rooms to support comprehensive informed care. Because the state will provide the format and access, the EPHR system will be compatible across all providers, free to providers and generated through a system that will be continuously enhanced. Therefore, it will avoid the pitfalls of independent systems that quickly become obsolete.

Quality Rating System

The most significant change South Carolina Healthy Connections brings to the South Carolina Medicaid program is a shift in focus from simply claims processing to improving the health of our beneficiaries. Developing an environment that encourages effective use of data, measuring outcomes, and making evidence-based decisions will drive this change in focus and provide a constant cycle of health care improvement.

Currently, the majority of staff time and resources are expended on establishing measurement of individual service provision and rates, processing claims, and detecting fraud and/or abuse. Limited resources contribute to a reactive program and inhibit attention to defining and measuring quality of care and related health outcomes. As claims processing responsibilities decrease, State administrative resources will be redirected to measuring quality of care and health outcomes

Measurement and reporting of plan performance to the beneficiaries is vital to encouraging health care quality. By providing consumers information that objectively compares plan performance, Healthy Connections will hold health plans accountable for delivery of quality health care. The purpose of rating participating plans is twofold: to educate the beneficiary and to reward plans that work to enhance quality.

One of the objectives of Healthy Connections is to engage the beneficiary in making health care decisions. To actively engage beneficiaries into the process, they need information about health care plans. A report card will be developed to provide the beneficiaries with pertinent information about participating plans that will allow them to

choose plans that best meet their needs. The report card will rate plans on quality of care and other indicators important to beneficiaries. Examples of report card indicators may include the following:

- Customer Satisfaction
  - 24/7 user friendly access
  - Availability of appointments
  - Distance to provider
  - Referrals to specialists
  - Co-payments

- Services to Beneficiaries
  - Disease management programs
  - Pregnancy and newborn special programs
  - Lifestyle programs such as smoking cessation, weight loss, nutrition classes

- Incentives for Healthy Lifestyles of Beneficiaries
  - Rewards for healthy lifestyles (not smoking, maintaining ideal body weight, exercise, compliance with plan of care for certain conditions) can be in the form of financial rewards, gift certificates, reduction of co-payments, et cetera.

It is anticipated that beneficiaries will make better informed decisions about health plan options when provided with report card results. Public reporting of plan performance should also lead plans to focus on quality improvement and better services to attract the purchasing power represented by the beneficiaries.

The second purpose of the report card is to hold participating plans accountable, measure plan performance and to establish incentives for demonstrated excellence in quality of care. Health plans participating in Healthy Connections will be required to measure and report their performance in a number of nationally recognized quality of care categories. Incentives and pay-for-performance strategies will be implemented to reward plans for improving quality of care for beneficiaries. In addition to monetary incentives and public recognition, plans that receive the highest quality scores will receive a higher number of assignments from the pool of beneficiaries that do not choose a plan.

Examples of report card indicators to evaluate quality of care may include:

- Plan Accreditation

- Provider Qualifications and Performance
  - Percentage of board certified physicians within network

- Percentage of primary care physicians who comply with national best practice guidelines for certain conditions
- Rates of inpatient infections for network hospitals
- Readmissions due to infections

- Utilization and Health Status Indicators
  - Inpatient hospitalizations per 1000 beneficiaries
  - Emergency room use per 1000 beneficiaries
  - Percentage of members receiving at least one service during plan year
  - Percentage of members with chronic conditions whose treatment programs conform to national protocols
  - Percentage of diabetics whose hemoglobin AIC levels reflect glycemic control
  - Percentage of asthmatics who do not require an emergency room/hospital visit because of appropriate treatment program based on the severity of their disease
  - Selected Health Plan Employer Data and Information Set (HEDIS) measures

- Incentives to Network Providers
  - Differential rates for board certified physicians
  - Pay-for-performance strategies to reward network providers for improving quality
  - Bonus payments to physicians who provide outstanding primary care including such measures as immunizations, diabetes and asthma care consistent with national guidelines
  - Recognize and reward providers that adopt information technology, such as electronic medical records, to improve care

To ensure that the best information is available to plans regarding quality of care and outcomes, the State will establish a Quality Improvement Advisory Council. The purpose of this council will be to assist in the development of medical standards to promote prevention and improve health for beneficiaries. The Council will include representatives from the provider community, and will receive technical support from the State's medical schools, public health agencies and research and statistics office.

The Council will support the development of standards that shift the focus from improved treatment to improved prevention and on the delivery of appropriate, evidence-based care through:

- Identifying best practices
- Developing health assessments that identify the need for health care interventions for beneficiaries

- Developing provider profiles and peer review processes
- Setting spending benefit plan priorities and limitations
- Providing training for providers to promote evidence-based care and technologies that yield positive health outcomes
- Promoting incentives and rewards for plan providers

The proposed direction in the South Carolina Healthy Connections program is a fundamental shift from reacting to bills from providers to proactively promoting data-influenced policies and procedures to enhance patient care and outcomes while reducing long-term costs. In short, the State will be paying for performance. These changes will be implemented through a system of appropriate reporting and use of data to influence purchasing decisions, measure outcomes of care to provide objective results based data, and adherence to evidence based treatment options. The new system will be based on incentives to improve quality care.

Decision Support System

Every state needs to understand and predict its health care trends. This is necessary to implement policies and procedures to maximize beneficiary outcomes. To successfully do this, the State must understand its data and develop predictive rather than reactive models.

The Department has implemented a decision support system that enables the agency to efficiently use its data to identify problems and opportunities to improve health care and status. With this system, the agency can "drill down" to identify gaps in care, duplicative care and best practices. For example, in the treatment of diabetics, the system could identify all diabetics that used the emergency room for care related to diabetes; identify which of these individuals did not get related prescriptions filled routinely before using emergency room care, and whether routine visits to their primary care physicians were made. Based on the analysis, individuals who would benefit from enrollment in disease management programs and medical homes could be identified and appropriate action taken. Additionally, plans can be provided data on its member providers that are not managing their patients in accordance with recognized standards of health care.

The system is the fundamental backbone for plan performance in our quality rating system. The enrollment counselors receive comparative analysis summarizing individual plan quality performance on selected disease states that have been determined to be priorities based on frequencies or severity. As candidates for plan selection are counseled, known beneficiary disease states are reviewed. A recommendation can then be made that is meaningful to the health status of the beneficiary and presents an opportunity for significant beneficiary health status improvement.

This system also provides the basis for constructive intervention for beneficiaries with advanced chronic diseases - that twenty percent of the beneficiaries who use eighty

percent of the resources. This also provides the basis for a predictive modeling system that allows us to intervene with beneficiaries who are likely to become part of the twenty percent. We provide longitudinal health history to the beneficiary, physicians, and health plans that can be used to improve health care value and decrease costs even during periods of transition.

While addressing beneficiaries who have current chronic conditions, the application also provides data that makes it possible to employ predictive modeling to determine conditions that lead to a beneficiary's eventual treatment of chronic conditions. This one system, on an individual beneficiary basis, provides the framework to move away from the "one size fits all" approach to health care, to individualized care that can make the greatest progress to improving health status and return on investment.

Academic Detailing Program

Prescription drug costs continue to escalate in most sectors of society including state Medicaid programs. Unfortunately, this increased expenditure often does not come with improved patient outcomes. In some cases, the consequence of increased drug use is unwanted side effects, drug interactions, and poly-pharmacy leading to secondary costs for the health care system.

Physicians face many challenges when prescribing medicines for patients. Important factors in prescribing are the quality and quantity of information available to prescribers as decisions are being made. Some readily available sources of drug information are the representatives and marketing literature of pharmaceutical companies. Unfortunately these sources of information can be biased and incomplete. It is well known that drug companies are very effective at marketing their products even though these medicines may not be the best medicine for many patients. South Carolina is addressing this problem by implementing an academic detailing program through the South Carolina College of Pharmacy, which is under the auspices of the Medical University of South Carolina and the University of South Carolina. The purpose of the program is to provide prescribers with the information and motivation for optimizing the use of prescription drugs for the patients they serve by providing timely unbiased information about prescription drugs to clinicians.

The program will have the following four major arms to support the effort:

> The academic detailing program will use the College of Pharmacy's center of excellence program to provide unbiased information on the efficacy and optimal use of prescription pharmaceuticals. The College conducts independent analyses of drug use, effectiveness and outcomes through both literature reviews and research. Objective information about pharmaceutical products is the cornerstone of the program. Much objective research is conducted and published that does not reach the attention of most prescribers. The program will focus on identifying

specific drugs that may be over prescribed, inappropriately prescribed, or better therapeutic alternatives.

Identifying both the prescription drugs and prescribers that will be targeted is key to ensuring the effectiveness and cost benefit of the program. By using a current database of Medicaid payments for prescriptions and physician services, both the drugs to be targeted and the prescribers will be identified. It is essential that the database be current because prescribing patterns quickly change in response to the drug detailing efforts of the manufactures. The program will begin by targeting high volume drugs that have been identified as having a high potential for inappropriate or unnecessary use. The prescribers to be targeted will be those who serve the highest number of enrollees who fall into the demographic for receiving the targeted drug.

Once the problems and potential for improvement have been identified though the activities of the College's program to identify best use of drugs and the drugs and prescribers to be targeted have been identified, the program will prepare information for prescribers in a user friendly format and deliver it to the prescribers. Concise information about the targeted drugs will be prepared including clear information sheets on patient conditions, step therapy, and the efficacy of the possible drugs that can be used. Clear and simple data analysis and such tools as "prescription pads" that contain life style directions will be provided to prescribers. In addition, "academic detailers" will visit prescribers, just as manufacturer detailers do now. The academic detailers will have training in presentation methods and tools available to them so that they can compete with the detailers that represent manufacturers. Rather than focusing on selling a specific drug, the academic detailers will focus on the best treatment for a patient with a specific condition.

The final arm of this program will be e-prescribing. The easier it is to access the preferred therapeutic intervention, the more likely the prescriber is to utilize the information provided through the academic detailing program. Additionally, e-prescribing reduces errors in both the writing and filling of prescriptions. The program will identify the best way to provide the high volume Medicaid prescribers with the support of e-prescribing technology. This phase of the program will include identification of barriers to physicians using e-prescribing technology, development of a strategy to overcome these barriers including training in the use of e-prescribing technology and provision of the technology to high prescribers and tailoring the e-prescribing technology to be used to incorporate information developed through the other arms of the academic detailing program.

Enrollment Counseling Services

Prior to Healthy Connections, the Medicaid administration interfaced with the beneficiary only at the point of eligibility determination. Once determined eligible, the beneficiaries was on their own to find providers and manage their health care and life style. Healthy Connections changes this lack of interaction by providing ongoing interaction through enrollment and utilization feedback. The goal of Healthy Connections is to support the beneficiary so that they can make informed consumer choices.

Toward this end, Healthy Connections provides the services of an enrollment counselor and ongoing communication services creating an interface between the beneficiary and the plans available to the beneficiary. As a first step, the enrollment counselor conducts a health assessment to help match the best health plan for the individual beneficiary's health needs. It is this step that brings the benefits of the quality and rating system to the beneficiary.

To ensure that beneficiaries are connected to the best delivery option based on their needs and circumstances, an enrollment counselor will assist the beneficiary in selecting the system of care. The counselor will combine information about the beneficiary's current physician, health status and care needs with the rating information on provider plans and services offered by the plans. The health plans are precluded from both targeted individual marketing activities and directly enrolling members. They present proposed coverage and rate packages to the State for approval. The State evaluates the plan and prepares a plan report card.

The information is presented to the beneficiary in easily understood format, by specially trained enrollment counselors. Services include the use of written and audio/visual materials to explain the Healthy Connections program, benefit plan options, and features of each plan at an appropriate educational level.

The enrollment counselor utilizes health appraisal tools to consider the known needs and prior/projected expense of the beneficiaries' given budget group factors such as:

- Age and sex of member(s)
- Frequency of medical visits during last 12 months
- Access to medical home (regular physician)
- Occurrence of emergency room visits in the last 12 months
- Maintenance drugs
- Known chronic conditions
- Ongoing trauma related conditions
- Other insurance available
- Expected due date, if pregnant

The enrollment counselor uses this information with predictive modeling applications and explains how the different benefit plan options could enhance or limit the beneficiary's ability to meet their specific health care needs. The counselors utilize the State approved marketing and the state developed rating/report card to illustrate how different beneficiaries could benefit from the various plans. Equipped with this information, the beneficiaries will have a determined number of days to select a benefit coverage plan. If a beneficiary chooses not to select a plan, one will be assigned to them.

Finally, the enrollment counselor provides ongoing counseling to the beneficiary upon beneficiary request and processes complaints about the plans from their enrolled members. Beneficiaries can contact a counselor at any time during the enrollment year to discuss any problems or issues or to obtain answers to questions through typical toll-free access call center functions. Written information is mailed to beneficiaries prior to the annual enrollment process to remind them of the enrollment period, provide updates to plan information and to encourage contact with their counselor for assistance and updated plan options.

A toll-free enrollment counseling number allows beneficiaries to speak with enrollment counselors to answer questions and provide assistance regarding the various options available. The call center is staffed with professionals qualified to address the needs of the beneficiaries and applicants including the appeal or grievance process related to plan enrollment. The Department maintains its toll-free beneficiary call center to provide assistance beyond that which is offered by the enrollment counselors.

Prevention and Healthy Living

The Medicaid program continues its efforts to promote prevention and healthy lifestyles. For example, we have recently expanded coverage for smoking cessation products and routine colonoscopy screenings. As described in the Quality Rating System section, emphasis will be placed on robust plan coverage for prevention and healthy lifestyle programs. While coverage issues are a keystone to the promotion of health for our beneficiaries, the Healthy Connections program extends beyond program coverage options. We address this broader responsibility through two major initiatives.

First, the Department is the State's clearinghouse for prevention and healthy lifestyle activities. As a part of this responsibility, the Department reviews all State funded efforts to identify and report gaps and duplication. To address the potential for improvements and new initiatives, the Department is developing a program of community health grants targeted to those communities that are high drivers of Medicaid cost. These grants will be awarded to communities on a competitive basis. Factors determining successful proposals include impact on community health status, reduction of health disparities, innovation and potential for replication. We believe that it is critical that communities play a key role in enhancing the healthy lifestyles of their citizens. It is at the community level that the message of consumer empowerment and responsibility can be reinforced.

Community support and reinforcement is essential to change community culture and move a large number of residents from unhealthy lifestyles toward healthy lifestyles.

Next, one of the most exciting opportunities that Healthy Connections provides to address improved prevention and healthy lifestyles is through the state's geo-coding capacity. Through the Office of Research and Statistics (ORS) data warehouse, health status problems can be identified geographically down to levels as specific as a city block. Using this technology, interventions will be targeted for high risk/high incidence areas. Programs tailored to specific small communities can efficiently address issues that span the spectrum of the environmental problems, cultural issues, and healthcare access. This approach offers the opportunity to engage local community leaders and resources to maximize the awareness and acceptability of new programs and interventions while having the greatest impact on the community residents.

Transportation

Getting the beneficiary to the right place to receive the right health care service at the right time is critical to having an efficient health care system. Beneficiaries who cannot get to physician and therapy appointments end up in emergency rooms with more critical health care needs. The current transportation system has received little attention and priority. Scheduling non-emergency transportation has been difficult and unreliable. No one entity has had this responsibility and it has been an add-on job for staff that is fully employed with other primary responsibilities.

To correct this problem, Healthy Connections is implementing a regional broker model for non-emergency transportation services to control inflationary growth and ensure beneficiary access to covered medical services. The State will pay a broker(s) a per member per month rate based on historical data per region of the state and includes both contractual and individual transportation provider services. The broker(s) will provide a single point of contact for recipients, eligibility verification, determination of least expensive appropriate mode of travel, trip scheduling and dispatching, and cost and trip reporting. Broker(s) will enroll and reimburse non-emergency transportation providers and oversee beneficiary services. This system was initially authorized through a waiver and is now being transitioned under authority of the Deficit Reduction Act.

By providing reliable and routinely available transportation services, patients gain access to primary and preventive care services. It is an integral and essential component of the Medicaid reform offered through Healthy Connections.

Community Choices for Long Term Care

As the State's 1915(c) Independence Plus waiver, *SC Choice,* was set to expire on June 30, 2006, a decision was made to use the renewal of this waiver as an opportunity to combine it with the state's existing 1915(c) elderly/disabled waiver. The purpose of this action was twofold: 1) to simplify administrative functions for waiver administration and

operations and 2) to promote participant direction opportunities through the creation of a continuum of options.

Effective July 1, the more than 11,000 participants in this new waiver, *Community Choices,* have four options to choose from in determining how their long term care services will be delivered. These are:

> Option 1 – This option is all agency-based services with no participant direction. Participants may choose to have the traditional home and community-based services provided by agencies.
>
> Option 2 – This option allows for some degree of participant direction in two services: attendant care and companion services. Participants may choose an individual who meets specified qualifications to provide these services and have supervisory authority over the attendant in hiring/firing, scheduling, and determining daily activities. In addition, agency-based services are also available.
>
> Option 3 – In this option, participants receive attendant care services provided by an individual who meets specified qualifications, and they have limited budget authority. In addition to supervisory authority, participants have a budget based upon their personal assistance needs. This option allows them to negotiate salary levels with the attendant and potentially increase the hours of service they receive.
>
> Option 4 – In this option, participants have supervisory authority as well as substantial budget authority. A six-month budget is developed based upon services that would have been received if the participant had chosen agency-directed services. (Adult day health care, in-home personal care services and home-delivered meals are included.) This budget can then be used by the participant for these or similar service as well as for appliances and chores services, which are not available in Option 1, 2 or 3.

Participants may move back and forth among these options so as to determine which option will best meet their particular needs. Case managers are charged with working with participants in explaining and exploring all available options and setting up services within the option chosen. Fiscal intermediary services are utilized in options 2, 3 and 4.

Partnerships for Long Term Care

South Carolina, like most other states, is experiencing a tremendous growth in the aging population. Additionally, the escalating costs of long term care places a significant burden on the Medicaid system. To qualify for assistance through the Medicaid program, individuals must meet financial eligibility guidelines. Those with excess assets must spend down their assets to show financial need. Healthy Connections will utilize Section 6021 of the Deficit Reduction Act to provide for a Qualified State Long-Term Care Insurance Partnership program in South Carolina. The agency will pursue a state plan

amendment that will provide an exemption from state recovery in an amount equal to the benefits paid by qualified long tern care insurance policies, where those benefits were disregarded in determining an individual's eligibility for Medicaid. Healthy Connections will promote individual responsibility and planning for long term care services by allowing consumers to purchase a long-term care policy whose benefits must be exhausted before qualifying for Medicaid. Once the insurance coverage is exhausted, individuals may apply for Medicaid while protecting the level of assets as defined in their policy. The partnership program provides an incentive for individuals to purchase long-term care insurance and offset program expenses through private sector insurance products. Through this initiative, fewer citizens should require public assistance to meet their long term care expenses.

Adults with Persistent Mental Illness

Although a significant portion of Medicaid funding is expended on beneficiaries with a mental illness diagnosis, little attention is usually given to this population in Medicaid reform proposals. Any proposal that does not address the needs of this population cannot meet the goals of improving the health of the beneficiary population and achieving efficiency in the program. As individuals with persistent mental illness have become deinstitutionalized, it has become imperative that any effective Medicaid reform address this population.

Generally, beneficiaries with persistent mental illness live in the community. Long-term institutionalization has become the exception and most who had been long-term residents of institutions have been discharged into the community. This change has resulted from developments in pharmaceutical treatments and the resulting availability of atypical drugs that enable the recipient to function in the community most of the time. These recipients' primary use of services is through the community mental health delivery system. There is little, if any, coordinated physical health care. Many do not get identification of or care for physical problems until they are in crisis. Even then, their physical problems may go undiagnosed and their symptoms attributed to their mental illness. Frequently, the site of their crisis care for their mental illness as well as their physical problems is the local acute care hospital emergency room.

Case managers in the community mental health system are limited in their effectiveness because they currently only have the information the patient reports to them as the basis for their understanding of many health care components that affect the patient. While they have access to information prescribed for the patient through the community mental health system, they do not know how the patient complies with the prescriptions for care. For example they may know that a community mental health physician has prescribed an atypical drug: however, they have only the report of the patient regarding whether they are taking the medication routinely. Further, they do not know whether the patient is getting other prescriptions for the same condition from physicians outside the community mental health system. There also is no information available to the case manager about

physical health problems. Patient reporting is often an unreliable source of information, and this is especially so for individuals with persistent mental illness.

The EPHR will provide the case manager a dynamic tool. From the EPHR, the case manager will be able to see whether the patient is routinely getting prescriptions filled and whether, for example, he is getting multiple atypical prescriptions. The case manager can see which patients are frequenting the emergency room and for what diagnoses. By patterns of use, the patients in most critical need of a medical home for primary care can be identified. Information about co-occuring physical health problems can greatly impact the overall care the patient receives. Armed with the information from the EPHR, the case manager will be able to make major improvements in the quality of life for many of the individuals with persistent mental illness and for the first time, become an effective case manager.

As an additional effort to address the needs of this population, the Department is proposing a pilot project. Individuals with persistent mental illness need to have comprehensive care and a medical home that provides care for all of their needs. To provide integrated comprehensive care, the Department will use one all inclusive rate to pay one provider. This provider will be responsible for managing the total care of the individual and meeting or otherwise arrange for all of their health care needs. If it is necessary to arrange services outside of the managing provider's service capacity, the provider is responsible for the financial payment of the services.

This program will begin with a pilot of high utilizers of Medicaid services, who are over the age of 18, and have a diagnosis of persistent mental illness. The initial pilot will provided a capitated rate and will establish risk corridors within which the managed care provider and the Medicaid agency will share risk and/or savings.

Once implemented with success, the program will be expanded to provide the Medicaid service system for adults with persistent mental illness.

Emotionally Disturbed Children

The current system of care for emotionally disturbed children is heavily biased toward institutional services. If placed in a Psychiatric Residential Treatment Facility (PRTF), all of the child's care is covered by Medicaid, providing an incentive for continued institutionalization. However, for this same child, there are no community based alternative services. Services provided in the community setting are not only more cost effective, but also often more effective in strengthening the family. Community services have better outcomes for preparing the child to successfully live with his family and in the community, and to be successful in school. These factors are key to treatment approaches that enable a child to become healthy and have success as an adult.

While RTF care will remain a critical component for some children for a period of time, it should not be the only alternative. The DRA has recognized this inappropriate

institutional bias and has provided for the alternative path of a home and community based waiver for children with serious emotional disturbance. The Department is applying for a waiver and is working on the development of community based services for these children.

Traumatic Head and Spinal Cord Injury

Many people who experience a traumatic head and/or spinal cord injury become disabled for life. At the point of confirmed long term disability, South Carolina offers services through a home and community based waiver. However, South Carolina Medicaid does not offer early rehabilitation services. Lack of access to specialized intensive rehabilitative services as soon as the patient is medically stabilized, not only results in permanent loss of functioning, it also results in extended stays in expensive inpatient hospital care.

In some cases, early intervention with intense rehabilitation could avoid long term disability. In almost all cases the level of disability could be reduced. Many victims could avoid lifelong dependence on Medicaid with early intensive intervention.

The opportunity for maximum rehabilitative impact is immediately after the trauma. The Department will provide a time limited intense rehabilitative program for individuals who experience traumatic head and spinal cord injury. The rehabilitative programs will require national certification for head and spinal cord injury and also must meet detailed state specified qualifications.

Many individuals are not Medicaid eligible before trauma who ultimately receive Medicaid eligibility back to the time of trauma. South Carolina will pilot a presumptive disability determination process. This will expedite entry of patients into rehabilitative care.

The result of this early intervention program should be reduced cost to Medicaid, improved care and outcomes for patients, and an overall decrease in long term disability.

Cost Sharing

Co-payments are an integral part of any health care plan. For Medicaid, its purpose goes beyond just the financial considerations of cost sharing. Co-payments offer an opportunity for consumers to become price sensitive and encourage the use of the most cost efficient health care settings. The obvious challenge within a Medicaid program is to establish meaningful and affordable cost sharing levels, yet not create obstacles to obtaining services. The new co-payment schedule becomes a dynamic force in the Medicaid program. We encourage preventive and primary care by eliminating all co-payments for these services. We encourage prudent use of health care services by imposing higher co-payments for inappropriate use of emergency rooms and use of name brand drugs where equivalent generic drugs are available.

All beneficiaries will be subject to co-payments with the exception of children, pregnant women, institutionalized individuals, and those in home and community based waiver programs. Family planning services will also be exempt from co-payments. Each provider will be responsible for the collection of co-payments when it is a required part of a benefit plan. As provided in Section 6041 of the DRA, it is important to allow providers to withhold non-emergency services until a plan for payment of co-payments is established with the beneficiary. Providers and beneficiaries should establish a plan for payment of co-payments, acceptable to both, before services are rendered. If the beneficiary fails to follow through with the payment plan, the provider may terminate services to the beneficiary. A beneficiary's inability to pay does not eliminate his or her liability for the co-payment.

Proposed Cost Sharing Schedule

	Current	Proposed	Plan Range
Hospital Inpatient	$25	$40	$0 - $40
Hospital Outpatient	$3	$10	$0 - $10
Emergency Room	$0	$0	$0
Emergency Room (non-emergency)	$0	$25	$0 - $25
DME – Supplies	$3	$1	$0 - $1
DME – Equipment	$3	$10	$0 - $10
Dentist (Adult emergency services)	$3	$6	$0 - $6
Pharmacy – Generic	$3	$1	
Pharmacy – Brand with no generic	$3	$4	$0 - $4
Pharmacy – Brand with generic	$3	$6	$0 - $6
Primary Care Physician	$2	$0	$0
Other Physician with referral	$2	$2	$0 - $2
Other Physician without referral	$2	$4	$0 - $4
Nurse Practitioner/Midwife	$2	$0	$0
Ambulatory Surgery Center	$2	$10	$0 - $10
Home Health	$2	$4	$0 - $4
Optometrist	$2	$4	$0 - $4
Chiropractor	$1	$2	$0 - $2
Podiatrist	$1	$2	

III. The Delivery System

Overview

To create a value based delivery system, the role of the state must move from the myopic function of processing individual claims to a management approach that moves the whole system toward quality.

While Healthy Connections will include current market choices such as Prepaid Health Plans and Medical Homes Networks, it will also serve as an incubator for the innovative forces in the marketplace to develop new approaches to the delivery of health care. Healthy Connections intends to harness the competitive and innovative edge of private industry forces to deliver the best possible products and choices to the consumer. The DRA opens opportunities for providers to offer beneficiaries plans that better meet their needs. Through such a competitive, open environment, the market should respond with efficient and more relevant delivery systems. The real winner in this scenario is the health care end user, the beneficiary. Value based choices enable the beneficiary to become a proactive consumer rather than a passive utilizer.

In the following sections, we describe the operational specifics around plan options. The options described run the spectrum from prepaid plans to primary care case management models; however, we believe one of the greatest values from this demonstration will be attained though the new creative models yet to come.

Pre-Paid Plans

Early experiences with Medicaid managed care often resulted in artificial controls on supply and demand. A value-based health system should instead have plans compete on results and quality. Health plans have the means to contribute to overall value. They have the opportunity to form an infrastructure the Medicaid agency lacks to help beneficiaries navigate the health care system, obtain first-rate care, and manage their own health. Plans can be instrumental in improving the health outcomes delivered by the entire health care system, coaching the beneficiary in methods to improve their overall health and reducing their health care expenses and risk. Most importantly, they can support providers as a critical link in care coordination and case management. By collaborating with providers and measuring performance, plans can open up beneficiary choice rather than constraining it.

Under this option, beneficiaries have the ability to use the PHA to choose managed care organization (MCO). The beneficiary is free to shop for benefits that best meet their coverage needs from the approved plans and becomes not only a consumer of medical services but also a consumer of insurance products.

The beneficiary directs the Medicaid program to pay the insurance company the premium on their behalf. Again, better service and better coverage offer the basis for competition.

The Department provides the MCOs the premium structure for coverage to use as a benchmark to develop their pricing. The plans compete for the beneficiary's premium dollars through their service package and pricing. To the extent that the final MCO pricing is less than the target rates published by the Department, the MCO is then required to provide to the beneficiary a stored value card for the value of the difference, rounded down to the nearest $10. The beneficiary is free to use this residual of their PHA to directly purchase products and services that support health as limited by the MCO. The intent is that plans compete for the beneficiary's business by creating an array of attractive coverage packages or pricing while bringing their expertise in disease management to the market to influence quality, health status and cost.

Medicaid recipients are responsible for any required co-payments that the insurance plan may require. Plans are not required to charge co-payments; however, if charged, co-payments cannot exceed the established cost sharing schedule discussed earlier.

Plan benefit design must comply with Deficit Reduction Act benchmark coverage requirements. Plans may design a package of services that is more limited in scope for one or more individual services. They may also offer optional services that are not covered by the current Medicaid program. This might include vision or dental services for adults. They may also choose not to cover some optional services that SC Medicaid covers. Plans may limit the amount of any service they cover as long as they meet the amount, duration and scope test for that service and requirements for EPSDT coverage for children under age nineteen.

Plans will be required to contract with the State and will be expected to meet certain standards, which are detailed in the South Carolina Medicaid Managed Care Organization Model contract and the Managed Care Organization Policy and Procedure Handbook. These include, but are not limited to, the following:

- SC Department of Insurance regulations
- Administration and Financial Management requirements
- Benefits requirements
- Reporting requirements
- Quality Assessment and Improvement requirements
- Marketing requirements
- Member Services requirements
- Grievance and Appeal requirements
- Provision of encounter data

Compliance with these requirements will be strictly monitored. Failure to meet established benchmarks could result in monetary sanctions, a freeze on enrollment, the withholding of payment, or other administrative remedies. The existing contract and policy manual will be revised to reflect the standards outlined in the proposal.

Primary Care Case Management (PCCM) Plans

The Medical Homes Network Program is a physician-driven service delivery system designed for Medicaid beneficiaries. Beneficiaries who choose to enroll in this program agree to utilize the primary care physician for their medical needs. This "partnership for care" provides the beneficiaries the assurance that they will receive coordinated medical services. It is anticipated that beneficiaries enrolled in a Medical Homes Network will utilize the emergency rooms less and have fewer inpatient hospitalizations as a result of enhanced primary care.

The goals of the Medical Homes Network are to:

- Establish medical homes for Medicaid beneficiaries to promote continuity of care and improve care coordination
- Emphasize wellness and prevention to improve quality of life
- Better utilize resources through increased patient monitoring, evidenced-based practices, and physician accountability
- Enhance the beneficiaries' ability to participate more fully in health care decisions

The agency will enter into a risk-based contract with a Care Coordination Service Organization (CSO) for the purpose of the development and maintenance of a Medical Homes Network. The network is comprised of participating physician practices, any advisory boards, and the CSO. The CSO shall be the designated agent for the Network. The agency will contract with any qualified network that meets the standards developed for Medical Homes Networks.

The premium for this plan is actuarially equivalent to the current fee-for-services experience and effectively requires the full amount of the PHA. Additionally, the network will receive a prospective per member per month care coordination/ management fee. The agency will share documented cost savings with the CSO. If the CSO fails to achieve cost savings, the network could forfeit up to the total amount of the prospective payments.

The CSO may disburse a per member per month care coordination fee to participating providers and is responsible for developing an incentive or risk based formula to distribute shared savings.

While providers claim reimbursement on a fee-for-service basis, the agency would encourage the development of Medical Homes Network arrangements where the CSO and the network assume more risk and perform more administrative functions to include claims processing. It is anticipated that the Medical Homes Network program can migrate from a fee-for-service system into a Prepaid Ambulatory Health Care Program where the CSO is paid a capitated rate for primary care services.

Option-Out Program

A funding source as large as Medicaid has a tremendous impact on the health care system. That impact sometimes occurs in the form of unintended consequences that often include limiting competition and system-wide cost shifting. Under ideal conditions, Medicaid should simply finance a beneficiary's entry into a mainstream health plan. Unfortunately, Medicaid's lower than market pricing and lack of access to mainstream products are often obstacles to this effort. However, families in the workplace who have access to group coverage do offer us an opportunity to move in this direction. The option-out program facilitates this opportunity.

The option-out program allows qualified beneficiaries to choose to receive medical care outside the Medicaid program with Medicaid providing only a defined amount of financial support. Under this program, the potential Medicaid eligible will not be considered a Medicaid beneficiary in the traditional sense. Instead, they will receive a PHA that can be used to purchase group health insurance through their employer. Using the PHA amounts, low-income working families can pay the employee contribution necessary to enroll (or remain enrolled) in Employer-Sponsored Insurance (ESI) coverage that is available to them. South Carolina believes many low income beneficiaries would prefer to be a part of the mainstream system which insures most working people in this country. Therefore, the State wishes to maximize the number of persons covered through private employment-based coverage, using PHAs to fund premiums. Workplace coverage will provide benefit equity for the poor and for those for whom adequate private coverage is not affordable or accessible. Because it builds on enrollment in mainstream, employment-based health coverage, this initiative may be able to reach uninsured children whose parents are otherwise unable to afford the premium and may expand the available coverage to all family members. Worker premiums for employment-based family coverage generally do not vary with family size (and may or may not vary based on whether the worker's spouse is or is not included), while public program costs do vary with family size.

In some instances, using the Personal Health Accounts (PHA) to fund ESI premiums will allow families to enroll together in a single health plan. Because employer-based insurance is family based, payment of premiums will provide health insurance for some family members who would not be eligible for the regular Medicaid program. These family members are an expansion population under the reform proposal and receive benefits in accordance with the employer group benefit plan. This model forges a partnership between Medicaid, private business, and working citizens.

Health Opportunity Plan Pilot

It is essential to both enable and require the Medicaid beneficiary to participate as a prudent buyer of health care services. The Medicaid beneficiary, just like other consumers, needs to be financially vested as a purchaser of health care and needs to be armed with information that enables him to make informed decisions.

The Healthy Connections program is focused on:

Creating patient awareness of the high cost of medical care – The PHA reporting tool provides the HOA participant with routine reporting of the services received and fees paid through the patient's account. Additionally, prevention and healthy lifestyles information is provided through the PHA account reporting.

Providing incentives to patients to seek preventive care and reduce inappropriate use of health care services – through access to enrollment counselor services, the beneficiary is educated regarding the economy of preventive services. Since the beneficiary is able to carry the balance of the account with them, there is an incentive to make routine use of low cost, highly effective services.

Enabling patients to take responsibility for health outcomes – through activities such as smoking cessation, balanced nutrition, exercise and maintenance medication compliance, the beneficiary experiences fewer expenses against the HOA, keeping a larger balance in their account.

Providing enrollment counselors and ongoing educational activities – as described above, the Healthy Connections program provides extensive counseling and educational services to all beneficiaries.

Providing transactions electronically and without cash – the PHA establishes a beneficiary account from which "charges" similar to a credit transaction is processed. Once the account is exhausted, the beneficiary is moved over to the regular Medicaid program.

Providing access to negotiated provider rates - enrolled Medicaid providers will be required to accept the normal fee schedule from HOA participants.

Within Healthy Connections, there will be a self-directed care demonstration utilizing the Health Opportunity Accounts of the DRA. The purpose is to determine:

- The extent beneficiaries consider price when they are in control of their own spending
- Whether a self-directed plan is viable for a Medicaid population
- If successful for some beneficiaries, but not others, for which population this program is beneficial
- Refine criteria for participation

- What education supports and resources are essential for the covered population
- Impact on health status
- Impact on expenditures

The self-directed program will be implemented by geographic area and expanded incrementally based on the success of each area. Initial criteria to identify beneficiaries who may be successful candidates for participation in this option include the following:

- Should not have a history of unstable expensive acute care crises
- Must have a medical home (Primary Care Physician)
- Should demonstrate a reasonable understanding of their health care needs

Beneficiaries in the self-directed plan will receive an age-appropriate deposit to their Personal Health Account (PHA) as set forth under DRA.

Beneficiaries will use their PHA to obtain covered services directly from health care providers. Enrolled Medicaid providers will be required to accept the normal fee schedule from HOA participants. The providers would also be required to accept HOA participants on the same basis as other Medicaid clients. The recipients will not be subject to the current service limits and can use their funds to purchase what is most important to them in relation to their health care. The PHA balance will be accessed using a stored value card and will function under the same premises as existing flexible spending accounts. The flexibility of this account allows a beneficiary to choose to customize their care to meet their needs. For example, one beneficiary may not use other optional services, but choose to cover additional prescriptions per month.

The demonstration will provide protection for the beneficiary by moving the beneficiary to a full service MCO or MHN when the beneficiary exhausts their PHA. This coverage will be limited to mandatory services and prescription drug coverage. The beneficiary will be responsible for cost sharing obligations under the MCO or MHN once the coverage begins. Beneficiary health status and health care utilization will be assessed at their point of entry into the program and annually thereafter. Additionally, beneficiary satisfaction will be assessed annually.

The State will contract with a vendor to develop and provide the administrative frameworks for this project that will include:

- A system for provider participation
- Consumer education on the use of the Health Opportunity Account
- Pricing information

The vendor's design may create opportunities for reduced administration such as capitated payments for primary care and pharmacy discount cards.

Fee-for-Service

The current fee-for-service will be maintained for eligibility categories excluded from participation in Healthy Connections. Fee-for-service will also be maintained as an option as the state transitions to Healthy Connections; however, it will not be considered the primary default option during enrollment.

Fee-for-service is the mechanism used to pay for retro-active services; however, this coverage is limited. Retroactive coverage extends only to the date of receipt of a complete application or up to thirty days prior for an emergency service or pregnancy related service. Dual eligibles are limited to participation under the Fee-for- service option. The Department is open to negotiations with Medicare in the event that a joint program allowing participation with a MHN or MCO would be beneficial.

Other Considerations:

Risk Adjustment and risk sharing - A risk adjustment methodology will be used which will consider health status in addition to age, gender and eligibility group. Risk adjustment reduces the affects of adverse selection and provides a better match of payment level and risk. The Adjusted Clinical Group (ACG) method developed by Johns Hopkins University is the risk adjustment method that will be used for Healthy Connections.

The State has an interest in encouraging plans to participate in Healthy Connections to promote maximum competition and beneficiary choice. The State also recognizes that the risk of covering the relatively small number of beneficiaries with extremely high cost cases may present a barrier to participation for some plans. In such cases, the state excludes these costs from the managed care rate. For example, transplants will continue to be covered separately by the State under contract with the Medical University of South Carolina.

Drug Rebates - It is necessary for the State to continue to realize the savings under the national Medicaid drug rebate agreements with drug manufacturers. MCO's participating in Healthy Connections will be assigned through their contracts with the State the authority and responsibility to report the required drug claim information to the manufacturers and to collect the drug rebates on behalf of the State. In setting the rates for the MCO's an adjustment will be made by the actuaries based on the assumption that the MCO's will realize the full Medicaid rebate on drug claims paid by the MCO. This approach is cost neutral to the federal government because the rate paid to the MCO is net of the drug rebate amount, thus no federal expenditure has been incurred for the federal share of the drug rebate.

Hospital Payments - The State is proposing three alternatives for the treatment of hospital payments in relation to the Healthy Connections proposal. First, the State intends to exclude the Medicaid Disproportionate Share Hospital (DSH) Payment Program and

the Hospital Upper Payment Limit (UPL) Program from the Healthy Connections proposal. An alternative proposal is to treat the inpatient and outpatient hospital services provided to South Carolina Medicaid recipients enrolled in a managed care setting or any other health insurance plan (that provides coverage for inpatient and outpatient hospital services) in a similar manner as those federal regulations (Section 1902 (bb) (5)) that pertain to Medicaid FQHC and RHC services provided to Medicaid recipients enrolled in a managed care plan. The third alternative that the State proposes is to create a Safety Net Pool for qualifying hospitals using the funds currently designated for hospital UPL payments. The qualifying hospitals will be those identified in accordance with Attachment 4.19-A of the South Carolina State Plan.

Third Party Liability - Under Healthy Connections the same assumptions that are currently used to adjust the capitated rates for MCO's to allow for third party collections by the MCO's will be used in the rate-setting for all types of plans and providers. In other words, the rates will be adjusted based on our current experience in third party collections and the providers will be allowed to collect and retain all third party revenues. This will be cost neutral to the federal government because the rates will be net of third party recoveries, thus no federal expenditure has been incurred for the federal share of the costs that were covered by third party insurance. To facilitate this process and to maintain the current level of third party recoveries during the demonstration period, the State will continue to capture third party coverage information on Healthy Connections beneficiaries and will make this data available to plans and providers. The state is pursuing additional legislation to ensure that all reasonable measures are taken to ascertain the legal liability for a health care claim.

South Carolina Healthy Connections

Improving Medicaid for South Carolinians in Need

Healthy Connections will bring the benefits of consumer choice to South Carolina's Medicaid system to improve the long-term fiscal health of Medicaid and the physical health of its recipients.

Current 20th Century Model	Healthy Connections 21st Century Model
- A "one-size-fits-all" plan for 850,000 recipients	+ Patients have a choice of several plans tailored to individual needs
- Medicaid program is the only choice for Medicaid-eligible workers	+ Medicaid-eligible workers can choose to join Medicaid or opt to receive help with paying their employer insurance premium
- Most recipients lack an appropriate medical home	+ Most recipients have a medical home with a primary care physician who knows them and understands their needs
- Reactive, uncoordinated care results in Medicaid recipients using emergency room 66% more than other patients	+ Proactive, coordinated care keeps more recipients healthy and out of the emergency room
- DHHS is an input focused, volume driven state health provider	+ DHHS is a results-focused, patient-centered manager of health plans
- Outcomes are under-measured	+ Outcomes are more closely measured and used to increase quality
- Providers are rewarded for filing more claims and providing increased, more expensive services.	+ Providers are rewarded for quality care and share in program savings
- Patient is too often seen as part of the problem as utilization and health care costs escalate	+ Patient becomes a part of the solution as their consumer choices improve quality and stabilize the growth in cost
- Medicaid program is financially unsustainable, raising the possibility of future cuts in services or beneficiaries	+ Medicaid program placed on more sustainable financial footing, making future benefits more secure

December 21, 2009

The Honorable James E. Smith, Jr.
The House of Representatives
State of South Carolina
P.O. Box 11867
Columbia, South Carolina 29211

Dear Representative Smith:

Thank you for your letter on November 19, 2009. We appreciate your interest in learning more about the Medicaid program and gaining a better understanding of the status of our transition from the traditional fee for service model of the past to our Healthy Connections model. Healthy Connections Choices, the name of the program that offers enrollment counseling services, seeks to link beneficiaries to a medical home by providing a choice of several Managed Care Organization (MCO) plans and a Medical Home Network (MHN).

We believe that Healthy Connections provides an opportunity for Medicaid beneficiaries to stay healthier and have more control over their own health care by allowing them to choose among several health plans. Although we have just recently ended the first complete cycle of the roll-out process, we are already beginning to see some positive results in our quality of care measures. We also see evidence that the Healthy Connections model will provide an opportunity to reduce the future rate of expenditure growth in the Medicaid program as our program reaches maturity.

You have asked a number of detailed and thought-provoking questions in your letter, and we have drawn our responses from a number of sources, including our actuaries, Milliman, Inc. Where necessary, we have provided a summary response to your question, and have provided supporting materials in electronic and hard copy form. We hope that our response meets your needs, and we would be happy to meet with you to review the material and answer any additional questions. Our responses are as follows:

Smith Question #1: Based on historical spending over the past four years, please provide the breakdown of spending in coordinated care and fee-for-service. For fiscal years 2007-2008 and 2008-2009 respectively, please provide the actual savings the Department has realized from utilizing capitated payments to managed care organizations over fee-for-service payments. Additionally, please provide a description of the methodology utilized to determine any savings, including how you accounted for the health status of the populations enrolled.

DHHS Response: The table below answers the first part of your question and shows the breakdown of expenditures between coordinated care and fee for service for the past four fiscal years.

Department of Health and Human Services Comparison of Fee for Service versus Coordinated Care for SFY2006 through SFY2009				
	SFY2006	SFY2007	SFY2008	SFY2009
Fee For Service Expenditures	$2,633,120,440	$2,489,724,999	$2,909,660,498	$2,827,549,769
Coordinated Care Expenditures	$117,641,644	$169,306,341	$276,071,412	$779,081,697
Total Medicaid Services Expenditures	$2,750,762,084	$2,659,031,340	$3,185,731,910	$3,606,631,466

The second part of your question regarding savings from capitated payments is more complex. While claims are often made that managed care can produce savings in the form of actual reductions in health care spending in a relatively short period of time, in our experience, that is not a realistic expectation. It is more appropriate to view savings in terms of reducing the rate of growth when assessing a managed care model because health care costs in general continue to steeply rise.

It is also important to note that making a major change in the delivery model of a health care system as large as Medicaid takes time and may actually increase some expenditures in the short term. In our case the main objective is not to reduce short term expenditures, but rather to control long-term expenditure growth by producing better health outcomes through care coordination and reducing unnecessary utilization of health care services. In order to provide a more thorough response to your question, we have enclosed a letter prepared by Milliman which discusses in more detail the various issues associated with the concept of managed care savings. The letter is located in Appendix A.

Smith Question #2: A detailed description of the rate development process used to contract with the state's managed care organizations. Please include any actuarial analysis that shows how the capitation rates compare to fee-for-service. Provide the actuarial based rates paid and the documentation provided to CMS justifying the rate. Additionally, what is the administrative fee that is paid to the managed care organizations and how it is applied to the rate?

DHHS Response: DHHS contracts with Milliman to develop capitation rates and to provide a capitation rate certification of the actuarial soundness of the rates as required by the Centers for Medicare and Medicaid Services (CMS). A summary discussion of the rate development process is provided in the Milliman letter found in Appendix A. A copy of the most recent actuarial report (Appendix B) is provided electronically on the enclosed CD. The actuarial report for Healthy Connections Kids, the state's stand alone CHIP program, is also provided (Appendix C). Since both reports are voluminous, we have provided only the electronic copy.

In response to the second part of your question, it should be clarified that there is not a separate "administrative fee" paid to MCOs. In developing the capitated rate, the costs of the medical care incurred by the members and the administrative costs incurred by the MCO are included. The administrative cost includes care management, disease management, claims administration and other administrative functions. The current administrative load included in the capitated rates is 12 %. This is discussed in more detail in the Milliman letter and in the capitated rate report.

Smith Question #3: The Department reported a total expenditure growth of 13% at the end of the fiscal year 2008-2009. Please provide detailed information about how much of that expenditure growth is attributable to the total growth in the number of eligible Medicaid beneficiaries. Recognizing that the legislature appropriated in the amount of $20 million for the stand along State Children's Health Insurance Program (SCHIP), please note what percentage of the growth due to the increase in the number of beneficiaries on the program can be attributed to the growth in beneficiaries of the remaining programs.

Smith Question #4: Please provide the overall percentage and dollar amount of the expenditure increase in the last fiscal year that can be attributed to:

a) Any increase in utilization of services by existing beneficiaries broken down by the category and amount of growth for that category;
b) The net change in total enrollment;
c) Enrollment in capitated Managed Care Organizations;
d) Enrollment in Medical Home Network programs.

DHHS Response to Question #3 and #4: Since Questions 3 and 4 are closely related, we have combined the responses. It is very difficult to break out the percentage and dollar amounts of the expenditure increase between FY 2008 and FY 2009 into separate components because many of the components are interdependent. For example, an increase in expenditures due to utilization of a particular service could be influenced in part by an increase in enrollment, in part by a change in medical practice guidelines, or in part by a change in reimbursement. This makes a precise breakout virtually impossible. Therefore, we asked for Milliman's assistance in developing estimates based on the major contributing factors to the expenditure growth. The estimates in response to Questions 3 and 4a are provided in the Milliman letter found in Appendix A. The responses to the remainder of Question 4 are:

4b. The change in enrollment from the end of FY 2008 to the end of FY 2009 was an increase of 30,693 unduplicated members (from 909,397 to 934,090). This represents an increase of 3.4%. An unduplicated count is a reflection of each individual we serve throughout the reporting period. The monthly enrollment count for July 08 – August 09 shows the total change in enrollment is an increase of about 52,000. These enrollment reports are located in Appendix D.

4c. The enrollment in MCOs was 91,157 prior to the beginning of the roll-out of Healthy Connections Choices enrollment in August 2007. As of July 1, 2009, MCO enrollment had grown to 314,926, which is an increase of 245%. As of December 1, 2009, MCO enrollment has grown to 350,694.

4d. The enrollment in MHNs was 66,221 prior to the beginning of the roll-out of Healthy Connections Choices in August 2007. By July 1, 2009, MHN enrollment had grown to 87,432, which is an increase of 32%. As of December 1, 2009, MHN enrollment has grown to 95,006.

Smith Question #5: Please provide the requirements for all Managed Care Organizations and Medical Home Network programs to report encounter data to the Department. Additionally, please provide the following information:

a) A detailed account, by plan, as to compliance with submission requirements as well as the process the department uses to validate the data.
b) Any actions the Department has taken to ensure compliance with submission requirements.

c) Information as to how the Department utilizes encounter data and copies of any comparative analyses completed.

DHHS Response: MCOs are required by contract to submit encounter data; these requirements are detailed in the Policy and Procedure (P&P) Guide that accompanies each new contract cycle. The P&P Guide contains the detailed file layout specifications, description of fields and submission timelines; all of these items are essential components for reporting and enable the state to gather consistent, verifiable data. The South Carolina Alliance for Health Plans in addition to program and technology staff from each MCO plan previews the drafts of the P&P Guide. The agency considers their feedback prior to making the P&P Guide specifications into a final document. Copies of the contracts and P&P Guides for 2008 and 2009 can be found in Appendices E and F which are provided electronically on the enclosed CD.

When the state had a relatively low enrollment rate in MCOs in 2005/2006, there was less dependency or emphasis on the reporting of encounter data. This is in large part because the capitated rates were established using the SC Medicaid fee for service experience. At the start of the increased MCO participation and member enrollment and with the ultimate goal of actuaries setting rates based upon actual MCO experience, a heightened urgency was placed on improving the reporting and use of encounter data. As a result, a task force comprised of DHHS program and information technology (IT) staff, IT staff from Clemson University who design the DHHS's Medicaid Management Information System, program and IT staff from the MCOs, program and IT staff from Thomas Reuters, researchers/evaluators from the Institute for Families in Society (IFS) at the University of South Carolina and consultants from Milliman was formed. This task force assessed the detailed components and evaluated the upgrades that were indicated to establish the encounter lay-out that you will find referenced in the current P&P Guide.

DHHS also utilizes an encounter edit resolution process that rectifies any erroneous data. DHHS staff works with the individual MCO plan to address specific concerns that arise during the verification process. MCOs then submit adjusted/corrected encounter data when necessary. Through this process, DHHS and the MCOs have greatly improved the encounter data submissions.

Importantly, terms of the current MCO contracts outline actions that will be taken with plans found to be non-compliant with encounter reporting requirements. Specifically, MCOs are subject to financial penalties and a percentage of their capitated, premium payments can be recouped by the agency. A copy of a current encounter record analysis is shown in Appendix G. This analysis provides encounter record history from July 07 through September 09. Appendix H shows an earlier analysis prepared by Thomson Reuters in 2008. This analysis will be rerun in the spring of 2010 with the objective to assess the completeness, accuracy and quality of encounter data submitted by the MCOs thus far.

The MHN program is not required to submit encounter information because the claims associated with those managed care members adjudicate through the fee for service claims processing system.

Smith Question #6: Please provide a detailed account about the process the Department uses to evaluate the performance of all MCO's, how the evaluation process was developed, and the criteria used for determining what data was utilized for the evaluation.

a) Copies of all report cards that have been published for both internal and public use and how this information is provided to current and potential beneficiaries of the Medicaid program.
b) Copies of any comparative analyses conducted over the past four years for internal or external use regarding the cost effectiveness of the various forms of managed care.

DHHS Response: Prior to the full implementation of Healthy Connections Choices in August 2007, and back when DHHS was initiating Health Reform activities in 2006 as a result of the Deficit Reduction Act of 2005, DHHS recognized the need to establish performance measurement strategies for the South Carolina Medicaid Managed Care program. As a result, the external program evaluation contract between DHHS and IFS was amended to include this work so that benchmark quality measures could be established. In addition and in order to meet the requirements of the original cost and quality effectiveness proviso, DHHS engaged Michael A. Madalena, M.S., Healthcare Econometric and Actuarial Consultant, and Zi Hu, FSA, MAAA, CEBS, to conduct a baseline cost effective study of the managed care programs – including MCOs and MHNs. This can be found in Appendix I.

In order to monitor and effectively oversee the South Carolina Medicaid Managed Care program, the following strategies were initiated:

- DHHS reorganized its management structure to include a bureau/department that includes health care management professionals who focus solely on the managed care delivery system. These staff members are responsible for ensuring compliance with state and federal regulations related to Medicaid managed care programming and developing contracts and accompanying policies and procedures to ensure the programs are designed to meet the needs of Medicaid beneficiaries. Some of the state and federal regulations include, but are not limited to: State Budget Provisos; Code of Federal Regulations Part 438; State Medicaid Manual; State Medicaid Director letters; and the Social Security Act, which contains provisions enacted by the Balanced Budget Act of 1997. These DHHS team members interact daily with representatives from each plan as well as with staff from other internal Divisions within the agency (i.e. Contracts, Legal, Finance, Reporting, Systems/IT). In addition, these DHHS team members assist beneficiaries who may encounter health care system issues and perform MCO site visits – both announced and unannounced – to ensure standards are being met.

- In accordance with 42 CFR Ch. IV, § 438.350 regarding external quality review, DHHS contracts with an External Quality Review Organization to perform both "readiness reviews" and annual quality reviews. The contractor who is currently responsible for performing these tasks is the Carolinas Center for Medical Excellence (CCME). This organization is a physician-sponsored, independent non-profit corporation that assesses quality, cost effectiveness and accessibility of healthcare. It is staffed with licensed medical professions. While CCME offers an array of services, DHHS contracts with this group to perform independent, external quality reviews for any and all managed care entities with whom the state is engaged. A copy of the state and federally approved review procedures tool can be found on the attached CD labeled Appendix J. A copy of the external review report and applicable corrective action plans for each managed care entity currently on contract with South Carolina is considered proprietary information and will be released if deemed necessary.

- As mentioned above, DHHS contracts with the USC's IFS on an ongoing basis to evaluate Healthcare Effectiveness Data and Information Set (HEDIS) results and to survey consumers utilizing the Consumer Assessment of Healthcare Providers and Systems (CAPHS). The monitoring of HEDIS measures is a laborious task and requires 11 months of continuous enrollment by a beneficiary to be valid, but does enable the state to compare the managed care experience with the traditional fee for service delivery system as well as enabling the state to compare our managed care experience with other states and national benchmarks. CAPHS is the national standard for measuring and reporting the experiences of consumers with their health plans. This is the fourth full year that the IFS has collected and examined the HEDIS and

CAPHS results. The most current report entitled "Measuring the Quality Year 2009" is attached in hard copy only for your review as well as copies of the reports from the previous two years (Appendix I). As noted before, a full 11 months of data must be collected before any reporting can be done.

- The MHN contract also includes a unique evaluation that is performed on a quarterly basis by an outside actuary. The contract was written so that the state could reward Administrative Services Organizations who operate a MHN if there are recognized health care cost savings for enrolled members. The state splits the recognized savings 50/50 with the MHN, which in turn distributes financial rewards to primary care physicians for their care to the Medicaid beneficiary. Savings generally occur because beneficiaries are part of a in a stable primary care medical home benefit from targeted disease management. The MHN now operating in the state is South Carolina Solutions and they have received $ 3,776,331 in payments during this past fiscal year.

The state is requiring all contracting MCOs and the MHN to achieve full accreditation by the National Committee for Quality Assurance by the end of 2011, and has developed a "Report Card" format to be published that will be enable beneficiaries to compare available Medicaid health plans. Certain aspects of the report card data are not yet ready, but the format is included for your review (Appendix K).

Smith Question #7: What is the Agency doing to implement the new choices on CHIP to help get more kids enrolled? Specifically, is the Agency going to allow people on before they get their citizen documentation to the agency as is now permitted? Is the Agency prepared to do this through Social Security Administration match starting in December as I understand SSA will be able to do? When is the Agency going to use other agency information to help document someone is eligible for benefits or to continue their eligibility like in Virginia or Louisiana?

DHHS Response: DHHS has engaged numerous strategies to raise awareness of the CHIP program and encourage those who are potentially eligible to apply. Outreach efforts, which began prior to the implementation of Healthy Connections Kids in 2008, have focused on reaching insured children through direct advertisements placed in physicians' offices, Medicaid eligibility offices and schools. The program is also featured at community events throughout the state. A summary of outreach efforts has been provided in Appendix L.

The recently enacted Children's Health Insurance Program Reauthorization Act (CHIPRA) provides bonus payments for FY 2009 through FY 2013 for purposes of providing additional funds to offset the costs of increased Medicaid enrollment. States are eligible for bonus payments only if certain enrollment and retention conditions are met. A state must implement at least five of the following, several of which South Carolina has already implemented:

- ☑ Continuous Eligibility
- ☑ Liberalization of Asset (or Resource) Requirements
- ☑ Elimination of In-Person Interview
- ☑ Use of Same Application and Renewal Form and Procedures for Medicaid and CHIP
- ☐ Automatic/Administrative Renewal
- ☐ Presumptive Eligibility for Children

☐ Express Lane

☐ Premium Assistance Subsidies

(Note: DHHS is currently researching the option of Administrative Renewal and will soon begin piloting it in several counties.)

In addition to CHIPRA specific policies, the agency has also implemented the rule allowing individuals declaring citizenship a 90-day period of coverage while they obtain their proof of citizenship. Rules state that there is no limit to how many 90-day periods an individual can receive while obtaining proof of citizenship. The agency is working with the Social Security Administration to develop the alternative option to verify names, Social Security numbers and the declaration of citizenship provided by Medicaid and CHIP applicants. Individuals are given an opportunity to resolve any inconsistencies or provide documentation prior to disenrollment.

Regarding outreach, DHHS sent mailings to 30,000 families in May who participate in the Food Stamp program but according to our records do not receive Medicaid benefits. In conjunction with Appleseed Legal Justice, we have twice provided information for each child in school or daycare with information regarding our programs and have provided information to county offices of the Employment Commission. Focus groups have been conducted with FQHC's to identify barriers in the eligibility process.

Palmetto Project, based in Mount Pleasant, was recently awarded a CHIPRA Outreach and Enrollment Grant totaling over $900,000. DHHS has established a partnership with Palmetto Project and will assist in coordinating their efforts to enroll and retain eligible children in both Medicaid and CHIP programs.

We hope that this information will be helpful to you in better understanding the current status of the Medicaid program and Healthy Connections Choices. If I can be offer further assistance please let me know.

Sincerely,

Emma Forkner
Director

EF:jp

Enclosure

314
to close

State of South Carolina
Department of Health and Human Services

Mark Sanford
Governor

Emma Forkner
Director

February 3, 2010

J. Thomas Duncan, M.D.
1000 Lipton Street
Summerville, SC 29483

Dear Dr. Duncan:

Thank you for your participation in the state's Medicaid program, and your recent interest in the transition from the traditional fee for service model to our Healthy Connections Choices model. We believe that that Healthy Connections Choices provides an opportunity for Medicaid beneficiaries to stay healthier through enhanced care coordination and have more control over their own health care by allowing them to choose among several health plans. In addition, other states' experiences have shown that coordinating care through managed care models that include stable medical homes has helped contain the ever-increasing health care costs. The program began in 2007 and now nearly 460,000 Medicaid beneficiaries have joined a managed care plan.

In your letter to Senator Rose, you asked several questions related to the administrative costs of the Medicaid program, the effect of Healthy Connections on the administrative costs, and how the state made the decision to pursue the medical home model for Medicaid.

Your first question asked for a breakdown of Medicaid expenditures between administration and services. The first attachment to this letter is a spreadsheet which provides the breakdown of expenditures between administrative costs, medical contracts and Medicaid assistance payments, which is how we report these costs in our annual reports. The data is provided for the last four state fiscal years. As you can see in the spreadsheet, administrative costs make up less than three percent of Medicaid expenditures.

Your second question asked for a comparison of administrative costs prior to and after the transition to our Healthy Connections Choices model. As the spreadsheet shows, there has been growth in both administrative costs and service costs over the past four years, but both have grow at about the same rate, so that the administrative percentage has remained constant. Therefore there is no difference in administrative costs as a percentage of total expenditures between State Fiscal Year 2006 prior to the transition to managed care and State Fiscal Year 2009 after the majority of eligible Medicaid beneficiaries had transitioned to managed care.

The capitated payments to the Managed Care Organizations (MCO's) are included within the Medicaid assistance payments. These full risk rates must meet standards of actuarial soundness required by the Centers for Medicare and Medicaid Services (CMS). The rates include the costs of the medical care incurred by the members and the administrative costs incurred by the MCO's. The MCO administrative costs are not comparable to the overall administrative cost of Medicaid because they include functions such as care management and disease management in addition to claims administration and other administrative functions. Within these rates is an administrative load assumption of 12% which is offset by anticipated reductions to due to managed care efficiencies. As the managed care transition is completed and the system matures, overall reductions in the growth of Medicaid costs of five percent or more can be expected as compared to what growth would have been under the traditional fee for service program.

South Carolina came to the decision to offer managed care options to those in the Medicaid program with two goals in mind – delivering higher quality care, and stabilizing the growing costs of Medicaid. The decision was primarily that of the South Carolina Department of Health and Human Services (SCDHHS), with extensive guidance from the health care community, legislators, and the governor. I am attaching a press release, fact sheet, and provider letter – all from 2007 – that the agency issued as the transition to Healthy Connections Choices began. Since the state has offered managed care plans to those on Medicaid, 68% of the eligible population has enrolled in one of the health plans. These include a traditional health maintenance organization/managed care organization or a primary care case management program.

We are proud of our efforts to ensure beneficiaries make an informed choice prior to selecting a health plan. Special enrollment counselors help navigate beneficiaries through the selection process, sharing information on enhanced benefits the health plans offer. Importantly, counselors also inform beneficiaries of the plans with which their physicians work.

But beyond the administrative and enrollment numbers, we are seeing real results in improved quality of services and early measurements related to outcomes for people who rely on Medicaid. By utilizing the coordinated care models of the health plans, patient encounter data we collect provides useful care quality measurements to the state. By evaluating Healthcare Effectiveness Data and Information Set (HEDIS) results, we know that Medicaid patients who enroll in a health plan are enjoying higher quality and better coordination of care on average than those beneficiaries being served in a fee for service environment. In addition, by requiring all health plans to achieve accreditation by the National Committee for Quality Assurance, a "Report Card" will be published that will give Medicaid beneficiaries another tool to compare available health plans– so they can choose the plan that best serves them or their family.

These are brief answers to large questions, and I hope I have given you a snapshot of the benefits the state is beginning to realize from utilizing managed care programming in the Medicaid program. I am including a list of the plans and their contact information so that you can evaluate their offerings. I would invite you to visit the SCDHHS website, which has includes extensive information about the Healthy Connections Choices program, including plan choices, enrollment data and frequently asked questions (www.scdhhs.gov). Also, I would be glad to talk with you further. Again, thank you for your work.

Sincerely,

Emma Forkner
Director

EF/mwh

Attachments

cc: The Honorable Michael T. Rose