



July 31, 2013

The Honorable Joseph R. Pitts
Chairman
Subcommittee on Health
U.S. House Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Chairman Pitts:

Thank you for allowing me the opportunity to present to the House Committee on Energy and Commerce's Subcommittee on Health June 12, 2013, regarding the need for Medicaid reform. It was an honor to share my perspective with the members, and gain some perspective on the issues important to them.

Attached are my responses to the additional questions posed by members. If you or any members have questions regarding these, please contact me.

Thank you for your service in the U.S. House, and your commitment to exploring ways to reform our states' Medicaid programs. If I can ever be of assistance, please let me know.

Sincerely,



Anthony E. Keck

AEK/kl

Enclosure

Responses to Follow-up Questions from House Energy and Commerce Hearing

Director Tony Keck, South Carolina Department of Health and Human Services

The Honorable Joseph R. Pitts

- 1) **Most states have implemented Medicaid managed care to some degree, but there remain certain areas of the program that do not have much managed care penetration, such as long-term care and behavioral health. Obviously, there are valid concerns about these especially vulnerable populations, but as Medicaid costs continue to balloon, do you see a need for more managed care in these areas? If so, what kind of rules, if any, should the Congress or the Administration give states with regard to Medicaid managed long-term care and/or behavioral health? Are there particular state programs that serve as an effective model for how to implement managed care in these areas of Medicaid?**

The term “managed care” can be applied to a broad spectrum of delivery and financing mechanisms used in Medicaid. These include Primary Care Case Management (PCCM) programs which overlay patient care management expectations and care management payments on a traditional Fee-For-Service (FFS) primary care system as well as capitation payment to private health plans to accept full financial risk for certain Medicaid populations.

There is clear evidence in South Carolina Medicaid and nationally that these managed care mechanisms generally produce better quality at lower overall cost than unmanaged FFS. Yet FFS continues as the default preference for the Centers for Medicare and Medicaid Services (CMS). In fact, individuals and population groups most in need of comprehensive care management – such as individuals living with disabilities and foster children – are often excluded from mandatory enrollment in managed care without a waiver.

Instead of requiring that states obtain waiver authority Congress should implement legislation that requires all individuals to be enrolled in some form of managed care as the default, and that mutually agreed upon and nationally validated outcome measures for access, quality and cost control are identified, measured and reported on a regular basis.

- 2) **Much news has been made in recent months about using Medicaid dollars to enroll individuals in private coverage through the state exchanges. What federal barriers exist for states to exercise this option, and what unanswered questions do states have with regard to premium assistance?**

There seems to be a fundamental misunderstanding of recent efforts by several states to provide “private coverage” in lieu of Medicaid expansion:

- A. States already use private health plans to manage millions of current Medicaid beneficiaries in FFS and both PCCM and capitated Medicaid managed care. This is not new.
- B. States involved in “private coverage” negotiations are planning to cover the same population and number of covered lives as would otherwise be covered under the Affordable Care Act Medicaid expansion.
- C. Typical Medicaid premium assistance combines contributions from employers, the individual and the state to achieve cost effectiveness. In the states currently negotiating these “private

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coverage” arrangements, employers do not appear to be eligible to contribute and beneficiary cost sharing – especially under 100% FPL – appears to be limited.

- D. States that currently pay private health plan premiums to manage Medicaid lives operate similar to self-insurers where premiums are set to reflect the service utilization of the covered populations – not of the general population. Current models being negotiated with CMS that propose to pay the health insurance exchanges/marketplaces a market-based premium forgoes the advantage of self-insuring and puts Medicaid in the position of being a premium “price-taker” on the open market. In fact, where medically frail populations are being carved out of the exchange/marketplace and placed in traditional Medicaid, states will end up not only managing and paying for the most costly individuals, but will also pay excessive premiums on the exchange/marketplace for the remaining Medicaid expansion beneficiaries that are healthy, low-utilizers of services. This arrangement actually subsidizes exchanges/marketplaces that may struggle with adverse selection and low enrollment by guaranteeing a base of healthy (and profitable) Medicaid beneficiaries. If and how the OMB will certify that these arrangements are cost neutral is unclear.

The Honorable Michael Burgess

- 1) **The Medicaid statute 1903(m)(2)(iii) requires that state payments to managed care entities be made on an actuarially sound basis. In 2009, the Government Accountability Office (GAO) was asked to investigate CMS’s oversight of the state’s compliance in meeting the statutory requirement. The GAO found that CMS has been inconsistent in reviewing states’ rate setting for compliance with the Medicaid managed care actuarial soundness requirements, which specify that rates must be developed in accordance with actuarial principles, appropriate for the population and services, and certified by actuaries.**
- a. **Can you explain how your states analyzes, interprets and calculates payments made to managed care entities on an actuarially sound basis?**
 - b. **What methods are used to determine if rates paid to managed care entities are actuarially sound?**
 - c. **What methods are used to confirm the accuracy of data used in computing actuarial soundness? Are the plans consulted to confirm accuracy of the data?**

The South Carolina Department of Health and Human Services (SCDHHS) contracts with an actuarial consulting firm, Milliman, Inc., to provide the actuarial certification required under 42 CFR 438.6(c) regarding actuarially sound capitation rates. The actuaries involved in the capitation rate development and rate certification are Members of the American Academy of Actuaries and meet the qualification standards established for rendering the certification. The actuaries have extensive experience in Medicaid managed care programs.

CMS regulations govern the development and approval of capitation rates paid by state Medicaid agencies to Medicaid Managed Care Organizations (MCOs) under full-risk contracts, including:

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- Code of Federal Regulations, 42 CFR 438.6(c)
- The CMS rate setting checklist, also known as “Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-Risk Capitated Contracts Rate setting”

These regulations require capitation rates to be actuarially sound and that states obtain an actuarial certification from a qualified actuary. CMS does not have set criteria to determine actuarial soundness of capitation rates and relies on qualified actuaries to certify to the soundness of the rates in an actuarial certification. However, CMS uses a checklist to assist the regional offices in reviewing the materials prepared and submitted by the states and their consulting actuaries in support of their proposed Medicaid managed care capitation rates. The checklist is also used to document the capitation rate methodology and assumptions used in developing the capitation rates. The checklist was issued in draft form in July 2003. CMS has begun a review process of the checklist and is anticipated to issue an updated checklist.

In 2005, the American Academy of Actuaries published a nonbinding Practice Note to be used as guidance to actuaries certifying Medicaid capitation rates. The goals of the Practice Note were to:

- Provide guidance to the actuary when certifying rates or rate ranges as meeting the requirements of 42 CFR 438.6(c) for capitated Medicaid managed care programs, and
- Provide examples of responses to certain situations and issues.

However, practice notes do not have the same standing as an Actuarial Standard of Practice (ASOP) in determining what constitutes generally accepted actuarial principles and practices. ASOPs are considered part of an actuary’s professional code of conduct and have the highest standing. In contrast, practice notes are not a definitive statement as to what constitutes generally accepted practice.

Currently, no ASOP applies specifically to actuarial work performed to comply with CMS requirements for rate certification. However, several ASOPs apply to certain components of a Medicaid managed care capitation rate development methodology. For example, ASOP No.23 on Data Quality addresses the binding guidance to an actuary surrounding the topic of data. The American Academy of Actuaries Actuarial Standards Board has approved the development of an ASOP that specifically addresses the actuarial certifications for Medicaid managed care capitation rate development under 42 CFR 438.6(c). It is anticipated that the ASOP will be final by the end of calendar year 2014.

The Practice Note includes the following definition of actuarial soundness related to Medicaid managed care capitation rates:

“Medicaid benefit plan premium rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected capitation payments, including expected reinsurance and governmental stop loss cash flows, governmental risk adjustment cash flows and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, state-mandated assessments and taxes and the cost of capital.”

In other words, Medicaid managed care capitation rates are actuarially sound if they provide the participating plans an opportunity to cover their projected expenses and generate a modest profit if they are operated in an efficient manner.

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For the Medicaid managed care rate setting and certification process in South Carolina, the contracted actuaries work closely with SCDHHS and the managed care plans to assure complete and accurate information is utilized in the rate setting process. The following provides a general outline of the rate setting process:

- **Collection of historical utilization and cost experience for the managed care population:** The State has developed and maintained an encounter data reporting process for the managed care health plans. The encounter data represents the claim experience incurred by the managed care plans. The encounter data is monitored on a quarterly basis for completeness and accuracy. The state's contracted actuaries use the encounter data in the capitation rate setting process. The managed care plans are given an opportunity to review the encounter data used in the rate calculation.
- **Adjust historical data for trend and policy and program changes:** The historical data is trended forward to reflect medical inflation. The data is further adjusted to reflect policy and program changes that have been implemented in the Medicaid managed care program since the historical data period.
- **Adjust for health plan administration:** The historical data is further adjusted to reflect the cost of health plan administration services.
- **Documentation:** The capitation rate setting process, including assumptions, are outlined in a report along with an actuarial certification.
- **Communication of results to the state and the contracted health plans:** The actuaries present the capitation rate development process to the state Department of Health and Human Services and the contracted health plans. This allows for a review of the development of the capitation rates by interested parties, who typically employ outside actuaries of their own to comment on the Department's calculation.
- **Monitoring of health plan financial results:** The actuaries regularly review the financial results of the contracted health plans.

The state's contracted actuaries provide on-going support to SCDHHS in the rate approval process. The state's contracted actuaries participate in follow-up telephone conversations with CMS to address any questions related to the rate certification.

- 2) In your testimony you highlight the false illusion that health insurance equals access, and therefore leads to health. As the Affordable Care Act further extends health insurance coverage to millions of more Americans, your point becomes even more valuable. However, there are specific issues within Medicaid that create a disincentive for physicians to accept patients with Medicaid coverage.**

The federal government has attempted to manage Medicaid expenditures through maintenance of effort requirements and by focusing on combating fraud and abuse.

- a. How has the federal maintenance of effort requirements affected state Medicaid rates?**

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Most states must maintain balanced budgets. In times of economic downturn or when circumstances may require a state to increase spending or investment in certain programs or sectors, states must either draw on reserves, cut state spending across the board or in select programs, or raise new revenues through taxes, fees or revenue maximization schemes.

State Medicaid programs' major cost drivers are eligibility limits, beneficiary enrollment rates, provider enrollment, benefit design, service utilization and service reimbursements. Total spending may be managed up or down by manipulating each of these drivers.

MOE requirements on states – including those not expanding – generally do not allow states to reduce eligibility limits or implement changes that would restrict or reduce beneficiary enrollment rates for a set period of time. This leaves the other drivers as the only options to manage overall spending, however:

- Many benefits are mandatory, and optional services which may be reduced (such as home and community based services) are in-fact more cost effective than mandatory services;
- CMS is applying increased scrutiny to most benefit or service-level reductions or restrictions and is in fact requiring states to actually expand services without regard to state or federal budget considerations (such as recently requiring South Carolina to make adult incontinence supplies available in the state plan rather than as a waiver-only service);
- Service utilization management programs (such as prior authorization) take significant time to implement and have in many cases already reached their maximum effectiveness where they are implemented;
- Medicaid FFS must generally continue to enroll all willing providers regardless of their quality and cost effectiveness.

Given the MOE and the other constraints listed above, reducing reimbursement rates provides the largest opportunity and quickest means to manage substantial state shortfalls; and both expansion states and non-expansion states have consistently cut Medicaid provider reimbursement rates over the past several years. Recent studies clearly show that relative reimbursement rates are directly tied to the likelihood of accepting Medicaid patients, and these reductions undoubtedly have had an effect on access. Fortunately, because South Carolina has not generally made eligibility or benefit commitments it cannot keep, our reimbursement rates remain competitive and we have among the highest rates of physician Medicaid participation in the country.

- 3) Nearly 10% of Medicaid beneficiaries have third-party coverage, in addition to their Medicaid coverage. In these circumstances, the third party payer is required to pay prior to Medicaid, as Medicaid, by statute, is the “payor of last resort”. The Deficit Reduction Act of 2005 (DRA) requiring states to amend their Medicaid programs with certain provisions to ensure that Medicaid is the payor of last resort.**

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a. Are you aware of what challenges states continue to face in recovering third –party payments?

South Carolina continues to encounter challenges in collecting from third party carriers. The most common reasons that third party carriers will not pay or will fail to properly process claims include: requiring additional information; carriers using numerous locations for claims processing; requiring a National Provider Identifier (NPI) to process claims even though Medicaid is not a provider and therefore does not have an NPI; invalid prescriber last name; basis of cost; claims previously processed; duplicate claims; timely filing not following DRA. Pay and chase requirements make recovery more difficult and are less successful than cost avoidance.

Verifying TPL policies has become challenging for various reasons including customer service representatives who fear that obtaining coverage information violates HIPPA. Verification can also be difficult when Medicaid's information does not must match the private insurers records exactly.

TPL recoveries have also been impacted by Supreme Court rulings (*Ahlborn* and *Wos v. E.M.A.*) and state legislative changes that limit recovery.

b. What impediments prevent third party payers from following through on their payments?

SC Medicaid's paper invoicing is an issue for third party carriers. Electronic billing could expedite claims payment.

In casualty cases, the lack of the prioritization of Medicaid claims or the allocation of settlement proceeds to medical damages negatively impacts recoveries.

4) How does the increased use of managed care influence TPL issues?

The Medicaid agency has included a TPL recovery factor in the capitation rate to account for TPL coordination of benefits.

5) The dramatic expansion of Medicaid under ACA exacerbates the administration complexity of determining eligibility and tracking enrollees. How would this additional complexity influence the ability of states to ensure third-parties pay what they are responsible for?

It is imperative that new enrollee information be shared with TPL once eligibility is determined so that verification can begin in order to start the cost avoidance process. If TPL has to depend on post-payment recoveries, Medicaid will experience increased problems with third party reimbursement as we continue to pay and chase.

The Honorable Cathy McMorris Rodgers

1) For many states, innovation and reforms in their respective Medicaid programs translate into not only improved quality of care but substantial monetary savings. Section 1115 is intended to allow states to test these innovations. Yet, as we know from experience, CMS's implementation of the

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1115 waiver process has been slow. Are there ways that the waiver process can be updated to improve the approval process? For example, if there are demonstration models that CMS has previously approved through the waiver process and another state would like to adopt that model, should the state have to go through the entire application process to obtain approval for a model that already has been approved?

South Carolina does not currently operate Section 1115 waivers. However, based on experience in Louisiana as well as conversations with my colleagues, it is clear that 1115 waivers are granted less on the needs of a particular state and more so on the policy objectives of the federal administration in place at the time.

The limitation of 1115 waivers is that in complex system improvement, the best solution is rarely evident at the outset of the effort. In many cases the root causes of a problem or set of problems cannot even be sufficiently defined, much less best-practice solutions be devised, without significant expenditure of effort and resources.

For this reason, a preferable, albeit more partnership-based approach, would be to view demonstrations not as pilots of fully-formulated and unchanging solutions, but instead as a series of well-formulated and strategic rapid-cycle performance improvement efforts based on mutually negotiated and measurable population health outcomes. While uncertainty regarding the exact solutions that will eventually be implemented increases under this model, certainty regarding the goals and the progress towards those goals would increase.

Short of this transformational shift in approach, the suggestion that waivers (1115 or otherwise) that have been approved should be, for instance, "conditionally approved" for use in other states is a generally a good one. While the nature of 1115 waivers as demonstrations/pilots might suggest that other states could receive conditional approval only once the demonstration has been renewed in the pilot state, other waivers, including common home and community based waivers, etc., which are less experimental in nature, should receive immediate conditional approval in other states. One potential unintended consequence is that CMS would greatly slow down or restrict innovative waivers in one state if it meant that the same waiver would quickly become available for other states.

The Honorable Gus Bilirakis

- 1) Can you talk about your work with states and working with CMS on obtaining an 1115 waiver? Florida took almost two years to get an 1115 Medicaid waiver for a state wide managed care plan. What have other states tried through the waiver process? How was interacting with CMS during this process, and how long did it take for CMS to approve the waiver?**

South Carolina does not currently operate Section 1115 waivers. However, based on experience in Louisiana, one relatively large waiver to improve access to primary care services for a previously uninsured population in the greater New Orleans area took approximately 30 days to grant, while a relatively small waiver related to assisted living dragged on for three years until it was eventually denied. A third effort was in the informal, but often relied upon, pre-application stage for approximately a year until it was eventually determined that approval in a formal application process would not occur. This occurred under both the Bush and Obama administrations.

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- 2) **The recent Oregon Medicaid study published in the New England Journal of Medicine seemed to show that individuals on Medicaid did not have better health outcomes than individuals without health insurance. Have you seen the study and what are your thoughts on it?**

Yes, I have reviewed this study as well as another study published in the New England Journal of Medicine "Mortality and Access to Care among Adults after State Medicaid Expansions" also co-authored by Katherine Baicker, Ph.D. I am also familiar with a third study recently published in Health Affairs by Kindig and Chen titled "Even as Mortality Fell in most US Counties, Female Mortality Nonetheless Rose in 42.8 Percent of Counties from 1992 to 2006". All three of these studies provide insight and support to a body of evidence related to the Social Determinants of Health model.

As both a policy maker as well as an executive responsible for implementing reimbursement and financing strategies that lead to better health, I do believe that insurance is one method of promoting better health, but not the only method nor always the most cost effective or efficient depending on the covered population.

For example, what properly constructed insurance (health, life, home, auto, etc.) does do well is protect individuals from catastrophic financial loss by spreading the very high costs of rare events across a large population. The Oregon study findings indicate that the increased coverage provided to the expansion population did indeed provide protection from catastrophic financial losses. It can even be inferred that the lower levels of depression found in the expansion population could be attributed to the protective effect of coverage on their financial status. The finding that there was no additional increase in the use of medication for depression, despite the observed decrease in depression, may bolster this argument.

Several questions not addressed in this article, although Dr. Baicker has referenced them during interviews on the subject, are what is the value of that economic protective effect to each individual and society, how much should be paid to achieve it, is health insurance the best way to do it, and importantly, are there alternative uses of the money elsewhere which produce more value – such as the protective effect of extending unemployment benefits beyond their current level, or reducing the burden of child care or higher education tuition on low-income families?

As far as improvements on physical health, the data is less clear in the Oregon study. Utilization of services increased but measures of health outcomes generally did not. And while the Mortality and Access study showed significant reductions in mortality in expansion states versus non-expansion states *as a group* there was no significant reduction in mortality in two (Maine and Arizona) of the three individual states studied, and in fact, the authors identified as a limitation that the overall results were driven by the positive results in the largest state (New York).

Further confusing the picture as to the benefits of health insurance are the findings of Kindig and Chen in their study of factors associated with mortality in all 3,140 counties in the United States. They conclude that none of the medical care factors examined in the study, including the county specific rates of primary care providers or preventable hospitalizations, nor the percentage of uninsured, predicted changes in mortality.

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Does this suggest insurance does not promote health? No. But the results are consistent with Social Determinants of Health model accepted broadly within the public health community, which suggests that approximately 20% of overall health is driven by health services and 80% is driven by factors such as income, education, race, personal behavior, social supports, environment and genetics.

In order for insurance to make a difference in health, it first has to ensure good access to health services, and this is increasingly becoming problematic, especially in Medicaid as reimbursement leads physicians to drop out of the program. This is well documented.

Once access is gained, the services must be effective. A recent CDC Morbidity and Mortality Weekly Review examined hypertension in the United States and reported that over half of American adults with hypertension had out-of-control hypertension, and that of these individuals 85 percent had health insurance and 89 percent identified having a regular source of care. Overall, insurance only reduced the probability of being out-of-control from approximately 70 percent (uninsured) to approximately 50 percent (insured).

Why don't insurance and a regular source of care result in better outcomes? There is certainly substantial research that a large amount of ineffectual care is being delivered by a poorly functioning health system. But more importantly, the good care that is being delivered is often short circuited by overwhelming barriers confronting patients related to low education, race, lack of family and community supports, etc.

If a patient leaves a physician's office and doesn't fill a prescription for lack of understanding of its importance or transportation to the pharmacy; or fills the prescription but doesn't take it properly again for lack of understanding or support from family members to remember to take it; or takes the medication but continues to eat poorly and not exercise; then much of the time and money spent on the physician visit as well as the prescription is wasted.

The ability of insurance to improve health – Medicaid or otherwise – is critically dependent on the ability to overcome these social barriers. Yet our excessive spending per capita on health insurance and health services continues to crowd out spending and investment on the very things – job and wage growth, education, community building and smart infrastructure – that drive health the most.

Our current publicly financed health care system has two major flaws. First it fails to find the people most in need of our services. Most health care providers and insurers passively wait for individuals to access care. If an individual presents and needs services, they are delivered and paid for. And in our FFS system, even if an individual presents and *doesn't* need services, they still receive them (though not as many) and they are paid for. But the people that are most in need of services are walking around undiagnosed, shut-in their home, or sleeping under a bridge. These patients are difficult. They drive provider quality and patient satisfaction scores down. They may disturb the other (better paying) patients in waiting rooms. So the system doesn't work very hard to find these individuals. We've lost all sense of the mission of public health in the United States to reach those in most need and even our public health clinics act like physician offices. Flooding the health care system with more money and more patients simply reinforces the tendency for the system to take the path of least resistance and highest profitability.

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Once we do get those hard-to-find, difficult-to-treat patients, our system tends to treat them like everyone else. A physician on the six-minute primary care visit hamster wheel does not have the time, nor the training or system support, to slow down for the one in seven or eight patients with significant social barriers that will diminish or eliminate the effectiveness of the physician visit. *In most cases the clinician doesn't even know that they should slow down.*

South Carolina Medicaid is identifying priority populations most in need – our community hotspots – and investing in the systems and supports that will make their medical treatment as effective and sustainable as possible. This includes our Birth Outcomes Initiative which has already reduced harmful early elective deliveries; our Community Health Worker program to help improve treatment plan adherence by bridging the cultural gaps between individuals and the health system; our aggressive push to open more convenient after hour access points such as CVS Minute Clinics; and our most recent state-wide effort just getting underway to significantly lower the cost and improve the clinical outcomes of 10,000 uninsured, chronically ill, high utilizers of emergency department services through focused case management, social interventions and community partnerships.