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**Medical Care Advisory Committee (MCAC)**  
**February 11, 2020**  
**SCDHHS, 1801 Main Street, Columbia, South Carolina 29202**  
**10:00AM-12:00PM**

- I. Welcome by Director
- II. SCDHHS Deputy Updates  
  
Elizabeth Ryan, Deputy Director, Eligibility, Enrollment, and Member Services
  - Eligibility, Enrollment, and Member Services (EEMS)  
Quincy Swygert, Administrative Budget Manager, Planning and Budget
  - Quarter 2 FY 2020 Year to Date Budget Update  
Bryan Amick/Pete Liggett, Program Managers, Center for Health Policy Innovation
  - Center for Health Policy Innovation
- III. Public Comment
- IV. Closing Comments
- V. Adjournment



**Medical Care Advisory Committee  
December 3, 2019 Meeting Minutes**

Present

\*Graham Adams  
Sue Berkowitz  
William Bilton  
Maggie Cash  
Amy Holbert  
Bill Lindsey  
J.T. McLawhorn  
Michael Leach  
Mary Poole  
Loren Rials  
Tricia Richardson  
Dr. Jennifer Root  
Amanda Whittle  
Lathran Woodard

Not Present

John Barber  
Dr. Amy Crockett  
Dr. Tom Gailey  
Chief Bill Harris  
Tysha Holmes  
Melanie Matney  
Dr. Kashyap Patel  
Dr. Keith Shealy

*\*Shannon Chambers attended MCAC on behalf of Graham Adams*

**Agenda**

A few amendments were made to the agenda. They include:

- A draft advisement was provided regarding early intervention and case management rates;
- A change in the order in which topics were presented, which is reflected in the minutes below; and,
- The minutes from the previous meeting were omitted from the MCAC packet but will be provided to the committee along with the minutes from the Dec. 3, 2019, meeting and the early intervention and case management rates advisement.

Advisements

**Advisement: South Carolina Medicaid Disproportionate Share (DSH) Payment Programs**

An overview of the advisement was provided by Jeff Saxon, Program Manager, Finance and Administration.

Director Joshua Baker briefly summarized the uncertainty caused by Congress with potential cuts to DSH and the agency's goal to make the impact roughly cost neutral in the aggregate.



**The following questions were asked:**

1. How does the state track billing for individuals who are considered uncompensated care compared to DSH payments toward their bill?
  - a. SCDHHS responded that if the individual is eligible for Medicaid, SCDHHS makes a payment, that patient revenue can be considered revenue that offsets that cost and that in the aggregate the hospital must consider that cost. SCDHHS also clarified that hospitals are required to report revenue in the aggregate and that the agency is not in a position to compel hospitals to reconcile accounts at the individual level.
2. Is DSH paid annually and are payments from previous periods considered double dipping by hospitals? Is there a system in place to take care of patients?
  - a. SCDHHS responded that payments are paid annually and in the aggregate. The agency accounts for any money that comes into a hospital as revenue and does not see a systemic issue with the offset program. SCDHHS also affirmed that payments made on the individual level for non-Medicaid beneficiaries are outside of its scope.
3. Is there a responsibility on the hospitals' side?
  - a. SCDHHS responded that protections are in place that require hospitals to account for revenue.
4. Bottomline, is there any way to track payments to hospitals?
  - a. SCDHHS responded that it does not have a method to track on an individual account level but that other entities have data that could track payment.

**Advisement: Essential Public Safety Net (EPSN) Nursing Facility Supplemental Payment Program**

An overview of the advisement was provided by Jeff Saxon, Program Manager, Finance and Administration.

**The following question was asked:**

1. Will there be any change to the nursing home staff?
  - a. SCDHHS responded that nothing will change for nursing home staff.

**Advisement: 1915 (c) HCBS Waiver Amendment—Community Choices**

An overview of the advisement was provided by Dr. Peter Liggett, Deputy Director, Long-Term Living.

**The following questions were asked:**

1. Does this impact those covered in the future?
  - a. SCDHHS clarified that this does not reflect a policy change by the agency and stated that the amendment and some staffing changes made by the agency have helped the agency clear backlogs and make more data-driven decisions about the operation of the waiver.
  - b. SCDHHS also stated that it would operate the waiver in essentially the same manner in which it operates DDSN waivers and that it has submitted a funding request to cover all who have applied for the waiver. If the request is granted, the agency will set a cap as it always has with the waiver. If the request isn't granted, it will effectively cap the waiver slots just above the current population number, which may necessitate a waiting list, although the agency doesn't anticipate the list being long.
2. This isn't just for the elderly, we have folks who are on this waiver that aren't elderly, right?
  - a. SCDHHS affirmed and stated that some of the normal churn in this waiver population is due to people transitioning from community choices to community supports.

**Advisement: Private Duty Nursing Rates**

An overview of the advisement was provided by Dr. Peter Liggett, Deputy Director, Long-Term Living.

**No questions were asked**

**Advisement- Drug Utilization Review (DUR) SUPPORT Act**

An overview of the advisement was provided by Dr. Bryan Amick, Deputy Director, Health Programs.

**No questions were asked**

**Advisement- Podiatry Services for Adults**

An overview of the advisement was provided by Dr. Bryan Amick, Deputy Director, Health Programs.

**No questions were asked, but several members expressed their appreciation.**

**Advisement- Early Intervention and Case Management Rates**

A brief overview of the advisement was provided by Director Joshua Baker. A copy of the advisement will be provided to the committee.

**No questions were asked**

**Deputy Updates****Eligibility, Enrollment and Member Services**

The enrollment update was provided by Elizabeth Ryan, Deputy Director, Eligibility, Enrollment and Member Services.

**The following questions were asked:**

1. Are you able to share changes in the data between who is newly enrolled and who has been dropped?
  - a. SCDHHS responded that it could and explained trend lines visible in the slide being presented. In addition, the agency outlined how reviewing its old mainframe system has allowed it to verify eligibility without needing to send anything to beneficiaries, which has reduced the burden on beneficiaries and churn. The review has also allowed the state to find instances where beneficiaries are legitimately no longer eligible for coverage, examples included beneficiaries who are 21 years-old and listed as a child or women who have been listed as pregnant for 23 consecutive months.
  - b. SCDHHS further elaborated that it expects the review of the system to continue for two years, expects a natural churn of 17-22,000 per month as it examines its systems and is working with its MCOs every month to verify their rolls.
2. A follow-up question was asked about proprietary data coming from MCOs.
  - a. SCDHHS responded that the information is not proprietary but may be protected.
3. When looking at full-benefit enrollment, can family planning figures be reviewed as well?
  - a. SCDHHS agreed to provide family planning figures as well.
4. Can we add a churn slide so we can see the churn and how many are approved through ex parte?
  - a. SCDHHS agreed and clarified that it can provide information about automated verifications, but the figures may not include ex parte determinations that were performed manually.

5. If members are dropped, do they reenroll and get a new plan?
  - a. SCDHHS responded that if a beneficiary is dropped and re-enrolled, their coverage becomes fee-for-service. The agency tends to then auto-assign beneficiaries to the same plan to maintain continuity, but the beneficiary may choose to join a new plan.

### **Community Engagement Waiver**

The waiver update was provided by Director Joshua Baker. Director Baker stated that the state was continuing to negotiate its community engagement initiative with CMS and was inclined to believe that CMS would approve pieces of the waiver soon.

### **Quality Metrics**

The quality update was provided by Sharon Mancuso, Director, Division of Clinical Quality and Health Outcomes, Office of Health Programs, and included the results of the MCO Quality Withhold program for reporting year (RY) 2019. A brief background of the program was provided, as well as a description of the individual clinical measures, which are known in the industry as HEDIS. For RY2019, HEDIS measures were grouped into four indices of clinical quality: diabetes, women's preventive, children's preventive, and behavioral health. The behavioral health index is not yet a withhold; rather, it is available only as a bonus if MCOs perform well on measures in that index.

MCAC members were briefed on the performance of each individual measure. Overall, nine out of 12 individual withhold rates exceeded the 50<sup>th</sup> percentile goal for the HHS Atlanta region, which includes South Carolina. Of the 12, two rates also exceeded the 75<sup>th</sup> percentile goal.

MCAC members were then briefed on planned updates to the withhold program for RY2020. The behavioral health index will remain a bonus index. Postpartum care, continuation of follow-up care for children's ADHD medications, and engagement of alcohol and other drug dependence treatment will be reported as information only, meaning that they will not be subject to penalties or eligible for bonuses in RY2020. In addition, a new member quality index will be introduced as information only for RY2020. The new member quality index will be based on questions selected from the Consumer Assessment of Health Plans Survey (CAHPS), which is used across the health plan industry.

Throughout the presentation, MCAC members asked process-related questions about how individual measures were calculated and what the rates were. **Other questions included:**

1. Regarding the diabetes A1c poor control measure, does the measure punish providers for individuals with diabetes not taking their medicines?
  - a. SCDHHS responded that it is expecting MCOs to use their knowledge as the health plan to work with members and/or providers on achieving better A1c results for patients.
2. Regarding the measure of follow-up for children prescribed ADHD medication, since many children have special plans in schools, is there any follow-up with their behavior relative to those plans and whether they've met certain benchmarks?
  - a. SCDHHS responded that the types of interventions it knows have been used to improve performance on this measure are those that work with pediatricians about how to schedule kids so they do come in for follow-up. The biggest opportunity a plan has to impact this is to work with pediatricians on tips for scheduling the appointments. The impact of school settings, as well as social determinants of health, adds a layer of complexity to addressing the issue. SCDHHS' first step is to try to first get children at least to see their pediatrician for follow-up care. As a health system, the agency has a long way

to go even to get that part of addressing their care. On a positive note, SCDHHS has seen some pediatricians have success on this measure, and has found from our QTIP program that pediatricians are very good at teaching each other and being receptive to learn from each other the ways in which they can improve their outcomes.

3. Are there any other practices other than medicine that could be included, for example biofeedback? Is there an opportunity for other things that may work?
  - a. SCDHHS responded that the follow-up care for children prescribed ADHD medications measure is triggered by the prescription of ADHD medications, and the measure itself indicates the rate at which children had claims for follow-up visit coded according to HEDIS specifications. Care provided during the visit for which the claim is coded appropriately would be up to the individual practitioner.
4. How can patients distinguish questions on the CAHPS surveys being about their doctor versus being about their health plan? Can we see the questions on the CAHPS survey?
  - a. SCDHHS responded that there are separate questions on the CAHPS survey about how members would rate their personal physician and the specialist they've seen most often, as well as how they would rate their health plan. SCDHHS compares these rates with the rates reported by all other health plans in the HHS Atlanta Region. Because CAHPS measures are based on patient impression and open to their interpretation, it is reasonable to assume that patients are generally subject to the same kinds of interpretations across health plans. Comparing the differences provides perspective on the performance of the managed care organizations. The agency also responded that it should be able to share a list of the CAHPS survey questions.
5. How does the HHS Atlanta region's HEDIS performance compare to national rates?
  - a. SCDHHS responded that overall, the HHS Atlanta region benchmarks are generally lower than national rates.
6. What percentage of the \$40 million that was withheld from MCOs was earned back (before bonuses)?
  - a. SCDHHS responded that the percentage paid out in earned-back withhold dollars was almost 87%.

### **Health Programs**

The update was provided by Dr. Bryan Amick, Deputy Director, Health Programs. Dr. Amick introduced Dr. Michael Psikogios as SCDHHS' new chief medical officer; noted that the Nurse Family Partnership was listed on the agenda because there will be an advisement presented in the next MCAC meeting and that slides will be distributed so the advisement can be discussed at the next meeting; and, noted that there is a need for the state to be aware of troubling trends in the costs of durable medical equipment. He also stated that SCDHHS is partnering with KEPRO to monitor the clinical decision-making process and the state will flag potential inappropriate expenditures while maintaining access to those who need it.

### **Public Comment Period**

#### **The following questions were asked:**

1. I know most Medicaid recipients are in MCOs, but SCDHHS is still responsible for evaluating if we're making an impact on health outcomes. What's the return on investment the state is receiving on MCO enrollment for its members? How is it evaluating in layman's terms? Is there a way it can see all of it together?

- a. SCDHHS responded that HEDIS metrics are the best metrics it has, which have improved over the last three years.
- 2. Do you have a member advisory group?
  - a. SCDHHS responded that it does not currently.
- 3. Has the agency done focus groups across the state? What is the state doing to understand what is going on across the state beyond using surveys, which are biased?
  - a. SCDHHS responded that, in part, it is more focused on patient-centered clinical experience and stressed the importance of focusing on how patients perceive their experience.
- 4. What is the agency doing to help those who live in a food desert?
  - a. SCDHHS responded it will have to evaluate and respond to the question later.

# Eligibility, Enrollment, & Member Services

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Elizabeth Ryan

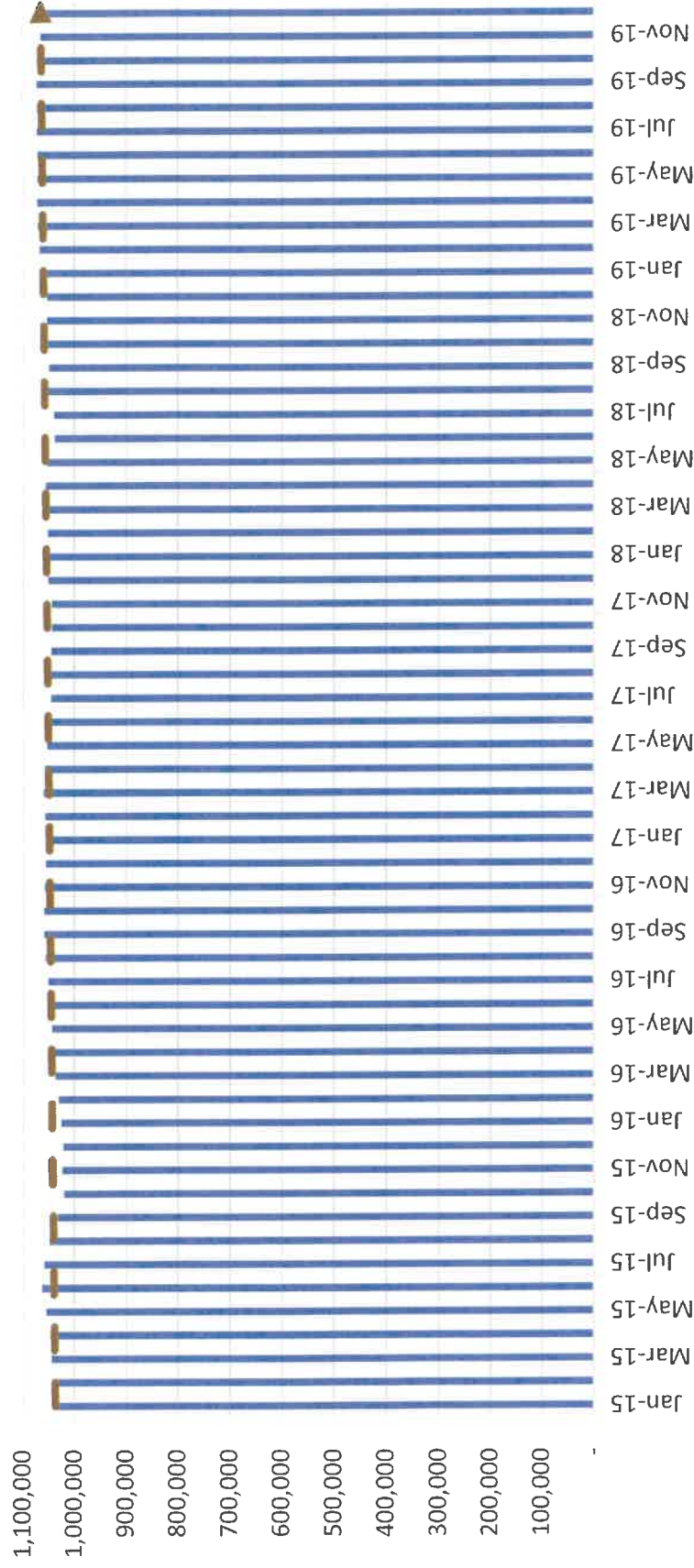
Deputy Director of Eligibility, Enrollment & Member Services

February 11, 2020



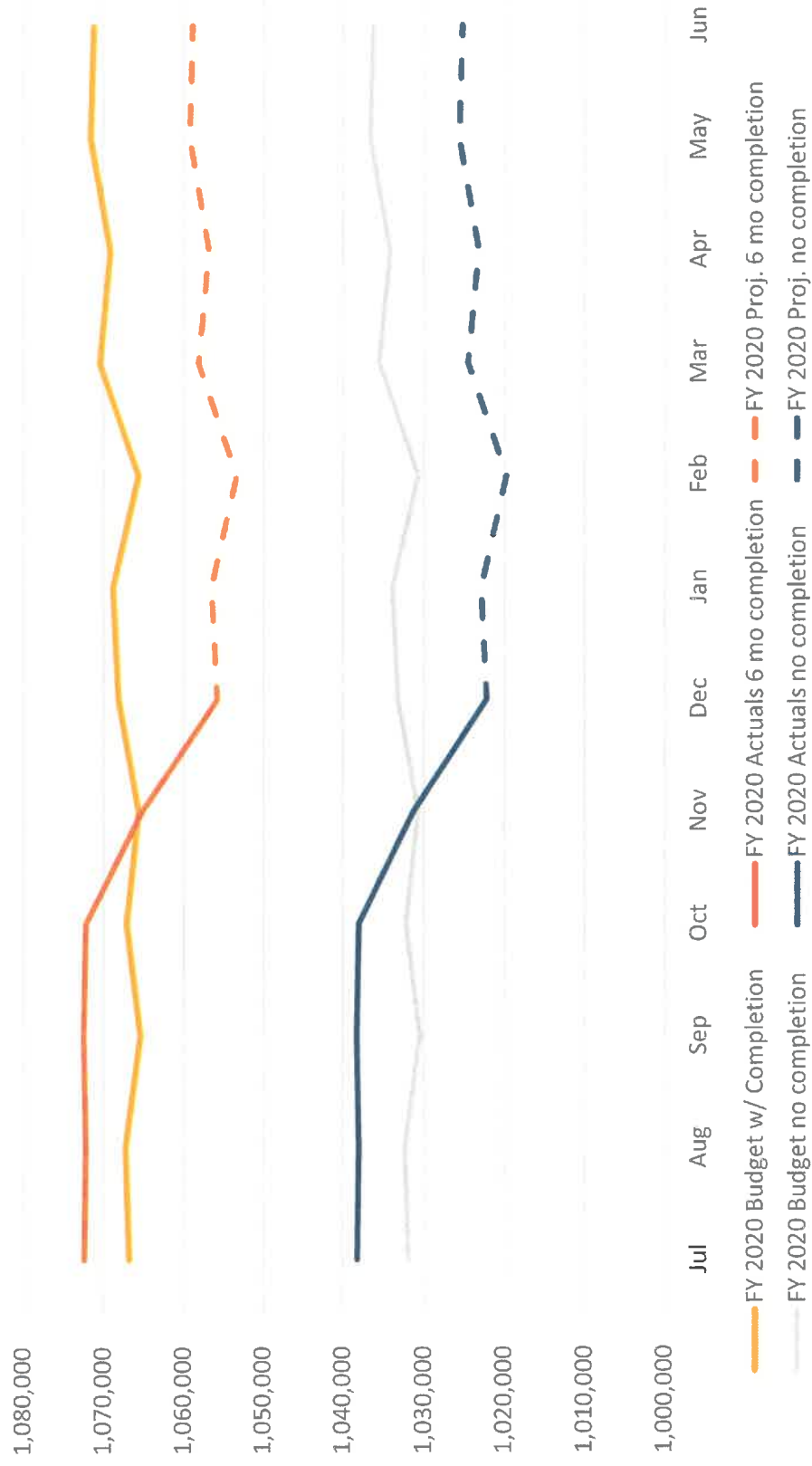


# Full-Benefit Membership

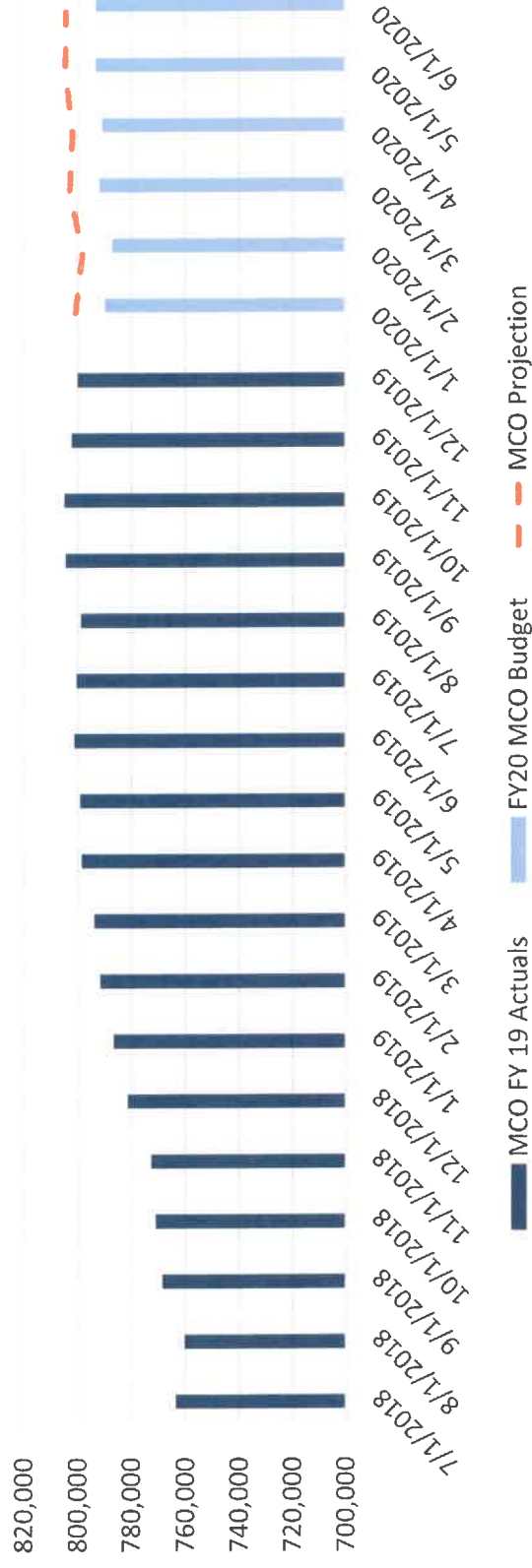
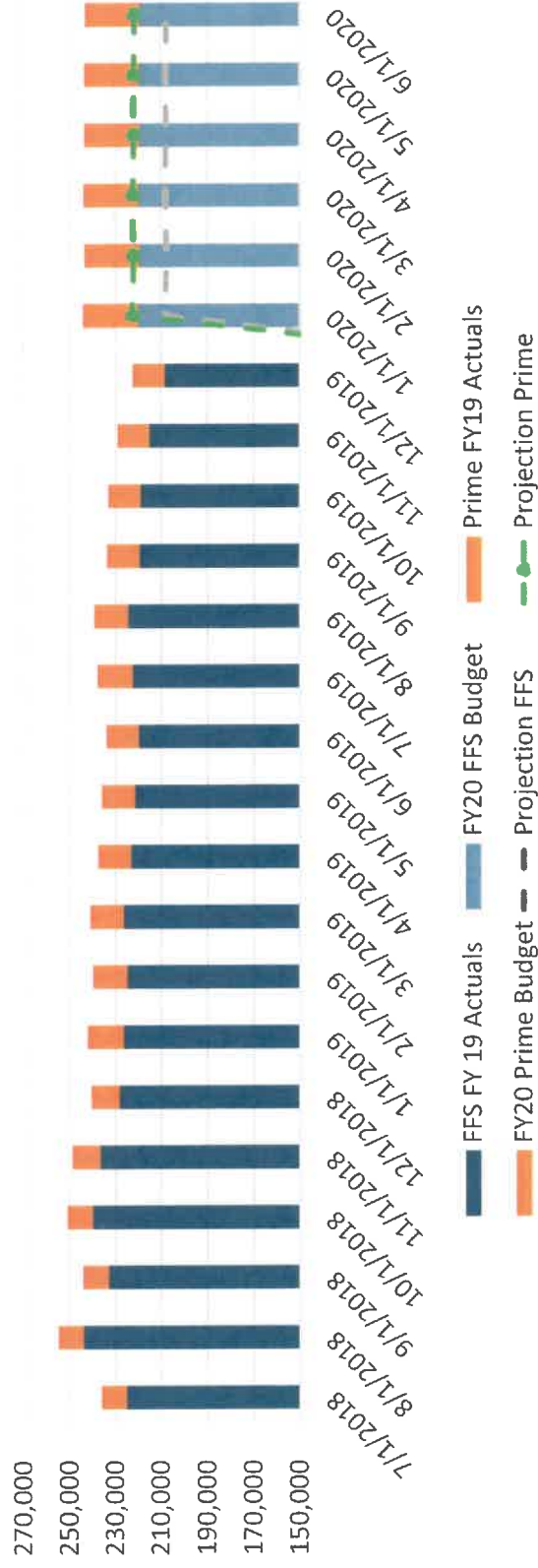


- Full-benefit membership continues to hold around 1 million.

# FY 2020 Full-Benefit Enrollment



# FY 2020 Full-Benefit Enrollment



# Quarter 2 FY 2020 Year to Date Budget

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Quincy Swygert  
Administrative Budget Manager  
February 11, 2020



**Appropriation/Authorization to Year to Date Actual Spending  
FY 2020 YTD (Through December-QTR 2)**

Budget by Major Program and Spending Purpose	FY 2020 Realligned Appropriation	FY 2020 Expenditures	Remaining from Approp./Auth.	% Expended	Variance Notes
<b>SCDHHS Medicaid Assistance</b>					
Coordinated Care	3,211,533,433	1,584,434,931	1,627,098,502	49%	
Hospital Services	570,679,187	311,535,610	259,143,577	55%	
Disproportionate Share	551,388,621	274,444,566	276,944,065	50%	
Nursing Facilities	652,042,013	328,267,520	323,774,493	50%	
Pharmaceutical Services	161,827,370	68,258,397	93,568,973	42%	
Physician Services	101,830,682	52,126,955	49,703,727	51%	
Community Long-term Care (CLTC)	194,404,049	139,511,981	54,892,068	72%	CC and PCA seeing significant growth beyond budgeted, CC FY20 variance average at 50% over
Dental Services	154,521,932	74,287,149	80,234,783	48%	
Clinical Services	45,774,768	27,068,871	18,705,897	59%	
Transportation Services	93,817,099	43,820,169	49,996,930	47%	
Medical Professional Services	27,515,628	16,158,289	11,357,339	59%	
Durable Medical Equipment	33,611,651	19,834,684	13,776,967	59%	
Lab & X-Ray Services	12,415,512	9,921,367	2,494,145	80%	Expenses increased due to utilization of STI codes and new genetic testing codes
Hospice	15,813,290	8,391,062	7,422,228	53%	
Program of All-Inclusive Care (PACE)	16,211,851	5,772,301	10,439,550	36%	PACE under due to utilization lower than projected
EPSDT	3,976,527	2,239,104	1,737,423	56%	
Home Health Services	13,042,685	7,076,552	5,966,133	54%	
OSCAP	8,300,611	3,289,273	5,011,338	40%	
Optional State Supplement (OSS)	20,633,161	9,597,891	11,035,270	47%	
Premiums Matched	257,979,091	122,821,438	135,157,653	48%	
MMA Phased Down Contributions	114,156,884	55,445,264	58,711,620	49%	
Premiums 100% State	22,605,412	11,699,081	10,906,331	52%	
Children's Community Care	20,510,164	9,786,522	10,723,642	48%	
Behavioral Health	75,212,140	25,615,143	49,596,997	34%	Budget alignment between Coordinated Care and FFS
<b>Total SCDHHS Medicaid Assistance</b>	<b>\$ 6,379,803,761</b>	<b>\$ 3,211,404,110</b>	<b>\$ 3,168,399,651</b>	<b>50%</b>	
Disabilities & Special Needs (DDSN)	702,448,900	340,216,714	362,232,186	48%	
Education (DOE)	46,091,978	16,402,525	29,689,453	36%	Spend weighted towards end of year
Health & Environmental Control (DHEC)	1,739,760	597,180	1,142,580	34%	Hemophilia/FP shifted to agency match
Medical University of SC (MUSC)	17,935,870	37,258,810	(19,322,940)	208%	Timing of Supplemental Teaching Payments (FY2019 & FY2020 pd)
Mental Health (DMH)	54,937,749	24,282,450	30,675,299	44%	
University of South Carolina (USC)	510,321	16,363	493,958	3%	Timing of Supplemental Teaching Payments
Other Entities Funding	12,249,758	5,292,710	6,957,048	43%	
<b>State Agencies &amp; Other Entities</b>	<b>\$ 835,914,336</b>	<b>\$ 424,046,752</b>	<b>\$ 411,867,584</b>	<b>51%</b>	
<b>SCDHHS Operating Expenditures</b>					
Personnel & Benefits	86,409,229	41,477,399	44,931,830	48%	
Medical Contracts	416,806,993	106,553,521	310,253,472	26%	Contracts issued annually; spend weighted towards end of fiscal year
Other Operating Costs	72,797,051	26,813,500	45,983,551	37%	Spend weighted towards end of year
<b>Total SCDHHS Operating Expenditures</b>	<b>\$ 576,013,273</b>	<b>\$ 174,844,420</b>	<b>\$ 401,168,853</b>	<b>30%</b>	
<b>Total Budget - Annual Budget Appropriation</b>	<b>\$ 7,791,731,370</b>	<b>\$ 3,810,295,282</b>	<b>\$ 3,981,436,088</b>	<b>48.9%</b>	

# SC Center for Health Policy Innovation

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Bryan Amick/Peter Liggett

South Carolina Center for Health Policy Innovation

February 11, 2020

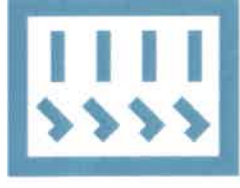




# South Carolina Center for Health Policy Innovation



Policy



Evaluation



Experience

## Focusing on on...

- Improving the care of the highest need and highest cost individuals
- Incorporating new technologies into the Medicaid benefit
- Integrating the delivery of care across payers
- Developing and incorporating data-driven decision-making principles
- Evolving reimbursement structures to incentivize value over volume