SOUTH CAROLINA GENERAL ASSEMBLY

Legislative Audit Council

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July 2012

A LIMITED REVIEW OF MEDICAID MANAGED CARE RATES AND EXPENDITURES AND OTHER ADMINISTRATIVE ISSUES AT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

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A Limited Review of Medicaid Managed Care Rates and Expenditures and Other Administrative Issues at the Department of Health and Human Services
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Introduction and Background

Audit Objectives

After the South Carolina Department of Health and Human Services (DHHS) incurred a deficit in state general fund appropriations for FY 10-11, members of the General Assembly requested an audit of DHHS's management of the state Medicaid program in South Carolina. Due to the number of concerns of the audit requesters, we conducted two reviews. The first report titled *A Review of Budgeting Practices and Recent Deficits at the Department of Health and Human Services* was published in June 2012 and focused on DHHS's budgeting process and issues contributing to the deficit. We examined the following issues in this review:

- The number of clients enrolled in Medicaid from 2006 through 2011.
- How DHHS enrolls clients in Medicaid health plans and identify potential cost savings.
- How DHHS manages the administrative costs for managed care organizations and identify potential cost savings.
- If DHHS could achieve additional cost savings in other Medicaid programs.

Scope and Methodology

We reviewed how DHHS administers its managed care plans, determined how many clients are enrolled in and receive Medicaid services, and reviewed other Medicaid programs to identify potential cost savings. The period of review included FY 06-07 through FY 10-11, with consideration of earlier and more recent periods when relevant.

To conduct the audit, we used evidence which included the following:

- Data from DHHS's Medicaid Management Information System (MMIS).
- Federal and state law and regulations and South Carolina appropriations acts.
- Interviews with officials at DHHS, other state agencies, and healthcare groups.
- Information from the Centers for Medicare and Medicaid Services and the Kaiser Family Foundation.
- Contracts with managed care organizations and reports from actuarial firms.

Criteria used to measure performance included federal law and regulations, agency contracts, and agency policies. We reviewed internal controls in the monitoring of managed care contracts. We used computerized data from the Medicaid Management Information Services (MMIS) to report information on Medicaid enrollment. Where possible, we compared this data with other reports to verify the totals. When viewed in relation to other evidence, we believe the data used in this report is reliable.

We conducted this performance audit in accordance with generally accepted government auditing standards with the exception of the general standard concerning quality control. Due to LAC's budget reductions, funding was not available for a timely quality control review. In our opinion, this omission had no effect on the results of the audit.

Those generally accepted government auditing standards required that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

The Department of Health and Human Services (DHHS) administers the state Medicaid program, Title XIX of the federal Social Security Act. Medicaid is a health insurance program that pays for medical services needed by poor, elderly, and disabled people. In South Carolina, about 70% of the program is funded by the federal government, and about 30% is paid for with state funds. For federal FY 08-09 and FY 09-10, S.C. received additional federal funding from the American Recovery and Reinvestment Act which increased the federal share to about 79%. In the FY 11-12 appropriations act, DHHS was appropriated almost $5.8 billion in total funds, including $917 million in state funds.

Medicaid pays for services that are medically necessary. These services can include physician visits, prescription medicines, hospital services, and transportation to medical appointments. Some adults may have to pay a co-payment for some services. The state Medicaid program offers three types of coverage to enrollees:

Fee-for-Service (FFS) — The enrollees can go to any doctor they choose who accepts Medicaid. Services are paid to the provider on a per-visit basis.

Managed Care Organization (MCO) — An MCO is a company that contracts with doctors, hospitals, and other providers. Enrollees choose a primary care doctor who is a member of the MCO. This doctor arranges all needed care. DHHS pays a per patient per month fee for each person enrolled in an MCO.

Medical Home Network (MHN) — MHNs are operated by local physicians who coordinate health care. DHHS pays for services on a per-visit basis and pays a monthly administrative fee per patient to the MHN.

The type of coverage an enrollee may choose depends on how the person is eligible for Medicaid. For example, low-income families are required to choose an MCO or an MHN.

In November 2011, there were 896,132 individuals enrolled in Medicaid — 57% of these were children, 34% were adults, and 9% were elderly.

Audit Results

Medicaid Enrollment

We reviewed the number of people enrolled in Medicaid from FY 04-05 through FY 10-11 to determine whether the Medicaid population is increasing. We also reviewed the number of Medicaid enrollees who actually received services to determine if more people are accessing services. We found that DHHS reports on Medicaid enrollment in different ways and, as a result, the change in the Medicaid population differs depending on the data used. The number of people enrolled in Medicaid has increased from FY 04-05 through FY 10-11 and a greater percentage of those enrolled are receiving services.

There are different ways to measure enrollment in the Medicaid program. Point-in-time enrollment measures the number of individuals enrolled in Medicaid as of a certain date such as three months after the end of a fiscal year. Cumulative enrollment measures the cumulative count of unduplicated individuals enrolled in Medicaid over a certain period of time such as a fiscal or calendar year as measured at some point in the future such as the present day.

Cumulative Enrollment

The unduplicated cumulative enrollment in Medicaid in South Carolina has fluctuated over the past several years. While the overall number of people enrolled in Medicaid has increased about 11% from FY 04-05 through FY 10-11, there have been increases and decreases between fiscal years during that time. The number of people enrolled in Medicaid who received services has increased 37% during that time period. Table 2.1 shows the changes in the Medicaid growth rate as of April 9, 2012.

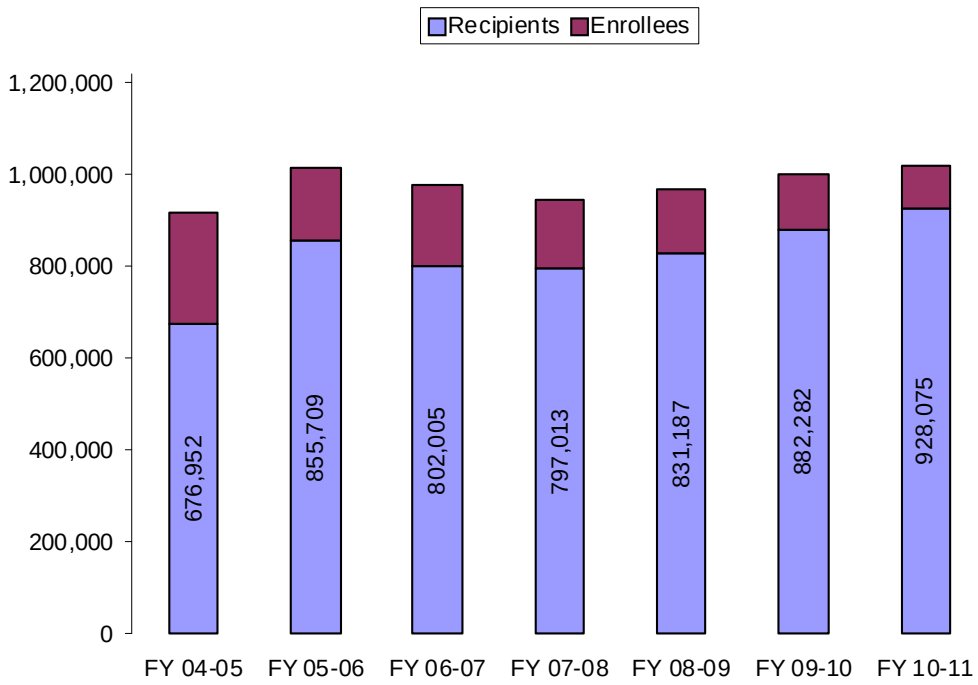
Table 2.1: Changes in Medicaid Enrollment and Usage FY 04-05 through FY 10-11

FY	Number Enrolled	% Change	Number Receiving Services	% Change
04-05	917,360	--	676,952	--
05-06	1,014,692	10.61%	855,709	26.41%
06-07	978,471	-3.57%	802,005	-6.28%
07-08	944,835	-3.44%	797,013	-0.62%
08-09	971,331	2.80%	831,187	4.29%
09-10	1,000,430	3.00%	882,282	6.15%
10-11	1,021,664	2.12%	928,075	5.19%
TOTAL		**11.37%**		**37.10%**

Source: DHHS

In addition to the increase in enrollment, more people are receiving the services. In FY 04-05, about 74% of those enrolled in Medicaid received a service. In FY 10-11, about 91% of those enrolled in Medicaid received a service. According to DHHS officials, the increase in Medicaid enrollees receiving a service is due in part to DHHS paying a per month fee for each managed care enrollee. Chart 2.2 illustrates the increase.

Chart 2.2: Medicaid Enrollees and Recipients



Source: DHHS

Point-in-Time Enrollment

The number of people enrolled during a fiscal year at a point in time three months after the end of the fiscal year has also increased from FY 07-08 to FY 10-11. The elderly have seen the smallest increase of 1% while children have increased the most at 15%. Table 2.3 shows the change in enrollment by major coverage groups.

Table 2.3: Change in Medicaid Enrollment by Major Coverage Groups FY 07-08 through FY 10-11

	FY 07-08	FY 08-09	% CHANGE	FY 09-10	% CHANGE	FY 10-11	% CHANGE
Children	495,414	519,072	4.78%	548,196	5.61%	568,146	3.64%
Elderly	85,399	84,698	-0.82%	84,904	0.24%	86,631	2.03%
Disabled Adults	120,221	125,198	4.14%	130,480	4.22%	137,131	5.10%
Other Adults	202,363	205,122	1.36%	211,694	3.20%	227,600	7.51%
TOTAL	**903,397**	**934,090**	**3.40%**	**975,274**	**4.41%**	**1,019,508**	**4.54%**

Source: DHHS

Medicaid Managed Care

We reviewed South Carolina Medicaid managed care options, enrollment, rates, and expenditures. We found that total enrollment in and expenditures on Medicaid managed care in South Carolina have increased since 2007 and fee-for-service (FFS) total enrollment and expenditures have decreased. However, average expenditure per enrollee has increased in both fee-for-service and managed care, but to different degrees. We also found that the agency lacks a sufficient review process for some managed care rates.

South Carolina's Medicaid beneficiaries receive services which are paid either fee-for-service or by a combination of managed care and fee-for-service. Fee-for-service is a delivery system where the Department of Health and Human Services (DHHS) pays the provider for each service performed. Managed care is a health care delivery model implemented by DHHS to establish a medical home for all managed care eligible beneficiaries. The goals of a medical home are to provide accessible, comprehensive, family-centered coordinated care and manage the beneficiary's health care. Beneficiaries enrolled in managed care have access to all services available through fee-for-service and any additional benefits offered by the managed care plan.

Managed care has been available since 1996, but became widely available for voluntary enrollment in 2007. DHHS excluded some groups from participating in managed care because the managed care model would not be appropriate for the type of care needed. For instance, beneficiaries receiving only family planning services are not eligible for the entire package of benefits provided by managed care, so their care is paid for completely through fee-for-service. DHHS mandated that the following groups participate in managed care in 2010:

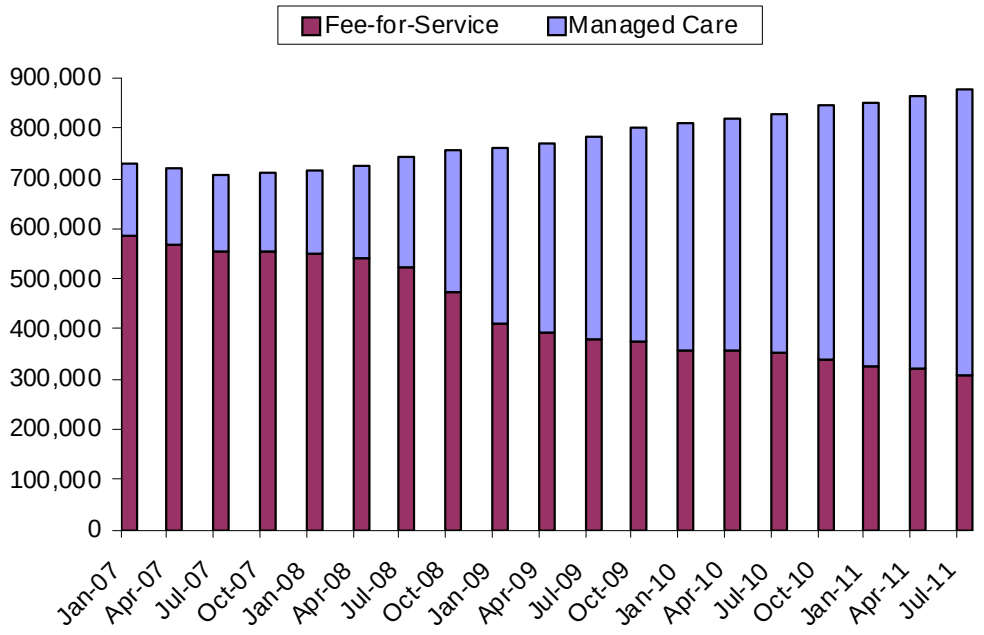
- Children up to age 19, disregarding foster care and children whose eligibility is based on disability.
- Low-Income Families.
- Optional Coverage for Pregnant Women.
- Beneficiaries over age 18 eligible for federal Social Security Insurance.

See Appendix A for detail on mandatory or voluntary enrollment of specific categories of beneficiaries. Federal law prohibits states from mandating that some categories of beneficiaries enroll in managed care. Mandating enrollment in managed care meant that approximately 80,000 beneficiaries using fee-for-service were required to enroll in managed care.

Enrollment

On July 1, 2011, there were 878,491 people enrolled in Medicaid in South Carolina; 571,139 (65%) were enrolled in one of the two managed care models. Chart 2.4 shows the progression of enrollment in managed care since it became available statewide in 2007.

Chart 2.4: Monthly Total Medicaid Enrollment



Source: DHHS

Enrollment Process

Managed care enrollment is facilitated by a contract enrollment broker. When a person is determined eligible to participate in Medicaid, the broker sends either an enrollment packet to those required to enroll in managed care or an outreach packet to those who can voluntarily enroll in managed care. Beneficiaries required to enroll have at least 30 days to select a health plan. If a beneficiary does not make a selection, the broker makes at least five attempts to contact him. If the beneficiary still does not respond, he is assigned to a health plan based on his previous enrollment, his family's enrollment, or a random assignment process. As of April 2012, the percentage of beneficiaries randomly assigned to a plan is around 30%. A newborn baby is assigned to his mother's plan.

South Carolina Medicaid Managed Care Models

In 1981, the federal government began to allow states to implement managed care in their Medicaid programs. In 1996 and 1997, DHHS implemented three types of managed care plans in a limited number of counties. Two of those models are used today. MHNs provide care coordination. MCOs provide both medical/pharmacy services and care coordination.

Medical Home Network (MHN)

Medical Home Networks link a beneficiary with a primary care provider. DHHS facilitates this by contracting with a Care Coordination Services Organization (CSO). The CSO supports member primary care providers and beneficiaries by providing care coordination, disease management, and data management. DHHS pays a per member per month fee to the CSO to provide these services. The CSO subcontracts with primary care providers to serve as beneficiary medical homes. The primary care provider arranges and provides most of the beneficiary's health care. DHHS pays for medical/pharmacy services on a fee-for-service basis.

South Carolina's Medicaid beneficiaries currently have three options for MHNs. These include Community Health Solutions, Carolina Medical Homes, and Palmetto Physician Connections. The latter two were added in the spring of 2011, increasing MHN capacity. As of November 2011, there were 160,283 beneficiaries enrolled in MHNs. This was approximately 18% of total enrollment.

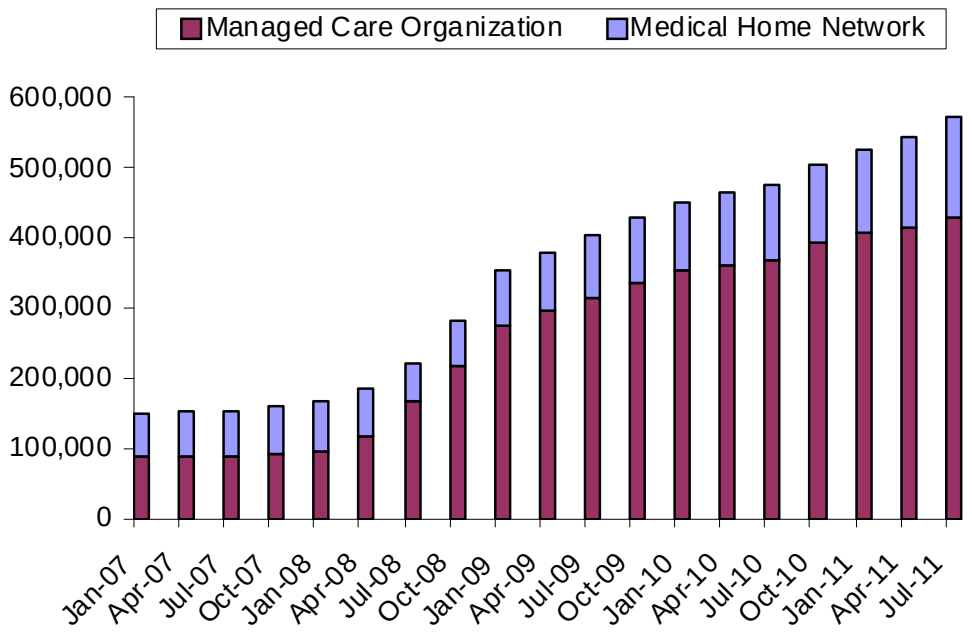
Managed Care Organization (MCO)

Managed Care Organizations (MCOs) provide healthcare services to beneficiaries through a network of healthcare professionals, pharmacies, and hospitals. DHHS pays a per member per month fee to the MCO that covers most of the care for the beneficiary. There are some services that DHHS does not include in managed care and pays for on a FFS basis. Each MCO is required to provide a core benefits package that, at the very least, includes all services available to a beneficiary enrolled in DHHS's fee-for-service plan. MCOs are free to provide benefits additional to the core plan.

South Carolina's Medicaid beneficiaries currently have four options for MCOs. These include UnitedHealthCare Community Plan, Absolute Total Care, First Choice by Select Health, and BlueChoice. As of November 2011, there were 439,612 beneficiaries enrolled in MCOs. This was approximately 49% of total enrollment.

Chart 2.5 shows the progression of enrollment in the two types of managed care options available in South Carolina.

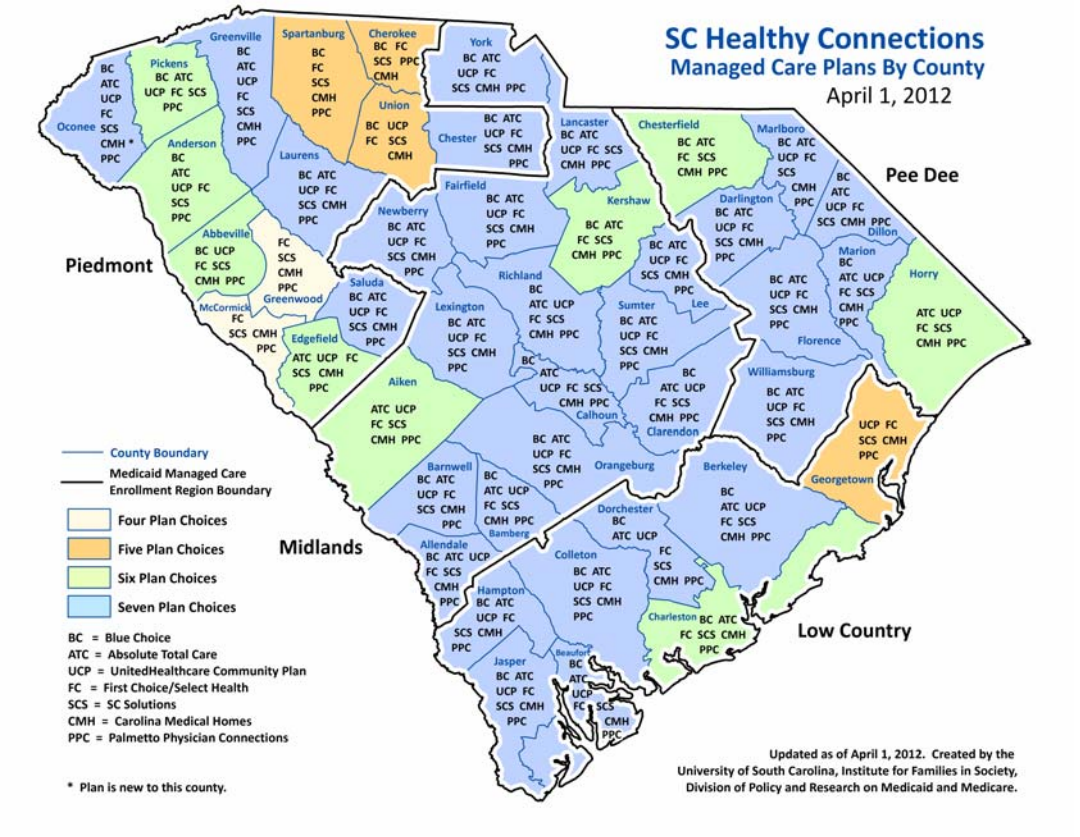
Chart 2.5: Managed Care Enrollment



Source: DHHS

Figure 2.6 shows the availability of plans for residents in South Carolina's counties. In two counties, the choices are limited to one MCO and three MHNs. In each of the rest of the counties, there is at least two of each type of plan from which beneficiaries choose.

Figure: 2.6: Managed Care Plans by County



Source: University of South Carolina, Institute for Families in Society, Division of Policy and Research on Medicaid and Medicare.

Medicaid Rates

We reviewed Medicaid reimbursement rates from FY 06-07 to the present. DHHS develops fee-for-service rates using one of the following methods:

- A percentage of the Medicare rate — applies to all services priced by Medicare.
- A percentage of the Resource Based Relative Value Scale (RBRVS) — based on the resource cost needed to provide the service and applies to procedures not priced by Medicare but covered under the scale.
- DHHS manual pricing — based on comparisons to State Health Plan and other insurers and applies to procedures not priced by Medicare or the RBRVS.

Detailed Medicaid fee schedules for fee-for-service can be found on the DHHS website.

MHN (CSO) Rates

Until April 1, 2007, DHHS paid three separate fees per member per month (PMPM). The MHN received an administrative rate and a care coordination rate. Also each primary care provider received $2.50 for case management. Table 2.7 shows the total PMPM rate for each medical home network.

Table 2.7: Medical Home Network Fees Through April 1, 2007

Medical Home Network	Administrative Rate	Care Coordination	Primary Care Provider
Upstate Carolina Best Care	N/A*	$2.50	$2.50
PhyTrust of SC Through 05/31/06	$12.00 for Marion, Dillon, Marlboro, Horry, Georgetown, and Williamsburg $7.00 for all others		
PhyTrust of SC 06/01/06 Through 03/31/07	$7.00		
SC Solutions	$6.67 - $7.14 for Aiken, Barnwell, Bamberg, Allendale, and Hampton $7.00 for all others		
Palmetto MHN	N/A*		

*The data provided by DHHS did not include administrative rates for all of the organizations.

Source: DHHS

From April 1, 2007, to present, all networks have received a $10.00 PMPM rate. The CSO pays the primary care provider a fee agreed upon between the two out of that $10.00. Current DHHS staff do not know how the $10 PMPM rate was initially established. The rate developed in 2007 remains the same in 2012. Table 2.8 shows the approximate total amount paid to CSOs for the PMPM rate during the time that DHHS did not have an internal review process for the PMPM rate.

Table 2.8: Total Payments to CSOs for the PMPM Rate

FY	Total Paid to CSOs for the PMPM Rate
07-08	$7,803,210
08-09	$8,745,090
09-10	$11,617,860
10-11	$14,392,090

Source: DHHS

DHHS's process for determining that the rate is currently adequate and appropriate is based on CMS's continued approval. In 2010, the United States Government Accountability Office found that CMS's oversight of states' Medicaid managed care rate setting was inadequate. This finding was based on failure to actually review or document the review of the rates submitted by the states. CMS also failed to use a consistent method to review rates. Despite CMS's reported attempts to improve upon this process, South Carolina's method of determining whether our rates are appropriate should not solely rely on CMS's approval.

In addition, despite the contract between each CSO and DHHS requiring that the CSO submit to DHHS the care coordination fee paid to the primary care provider, DHHS officials are not sure what the range of fees is. DHHS's failure to either collect or review the care coordination fees leaves agency officials without a method for determining whether primary care providers are paid a fee appropriate to the care coordination services DHHS expects them to provide. Other states in CMS Region 4 pay care coordination fees that range between $1.00 and $5.00 (see Table 2.9).

Table 2.9: CMS Region 4 Case Management Fees

STATE	CARE COORDINATION FEE
Alabama	$2.60
Florida	$2.00
Georgia	$1.75
Kentucky	$4.00
Mississippi	N/A*
North Carolina	$1.00 - $5.00
Tennessee	N/A*

*These states do not use the MHN model in their Medicaid programs.

Source: Kaiser Family Foundation

Recommendations

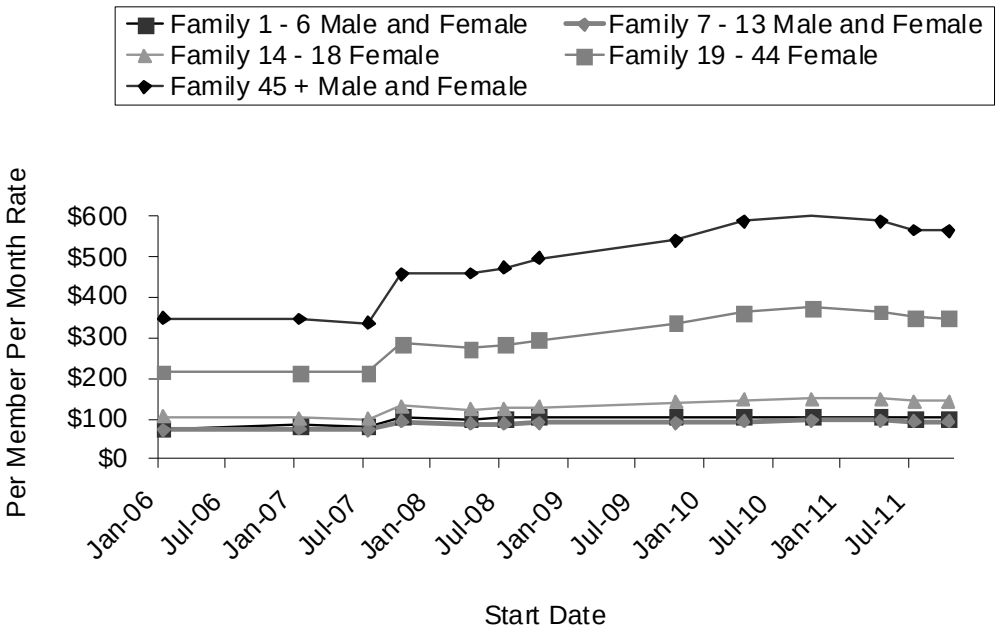
1. The Department of Health and Human Services should develop a formal process for regularly reviewing Medical Home Network rates for adequacy and appropriateness.

2. The Department of Health and Human Services should review the care coordination fees paid to primary care providers to ensure that they are adequate and appropriate.

MCO Rates

From October 1996 through September 2009, DHHS established two sets of MCO rates — one for the standard contract and another for the ethical contract. The ethical contract rates applied to an MCO that did not provide family planning services, making rates in certain categories slightly different. The remaining MCOs received the rates on the standard contract. On October 1, 2009, DHHS began using risk scores for each MCO. The risk scores consider the projected risk assumed by each MCO based on patient demographics and pharmacy usage. Chart 2.10 depicts rates for selected categories that existed throughout the complete time frame of this review. The rates shown from January 2006 – September 2009 are from the standard contract. The rates from October 1, 2009, to present are averages of rates from all plans but the one that would have been previously subject to the ethical contract.

Chart 2.10: Select Medicaid Managed Care Premiums by Rate Code



Source: DHHS

The rates generally rose or fell without significant decreases or increases, with the exception of October 2007 where rates significantly increased. DHHS staff attribute this increase to the following:

- Suspension of adverse selection adjustment (periodic adjustment paid to an MCO when a sicker than expected population selects that MCO).
- Provider reimbursement updates building certain payments into the MCO rates that had been paid separately.
- Additional trend built in to account for an extended contract period.

Rate Setting

We reviewed DHHS's method for setting MCO rates. DHHS does not negotiate rates with the MCOs. DHHS officials administratively set rates. DHHS contracts with an actuarial firm to perform most of the calculations used to determine the final capitation rate paid to each MCO. According to a 50-state survey by the Kaiser Family Foundation, approximately 75% of the states with MCOs also use actuaries to assist them in administratively setting the rates. The calculation method for rates paid through March 31, 2012, is detailed below.

- Extract fee-for-service hospital inpatient, hospital outpatient, professional, and other services experience data. When examining this data, the actuarial firm excludes certain services not included in managed care per the MCO Policies and Procedures Guide (e.g., mental health and substance abuse, dental, BabyNet).

- Apply adjustments that reflect differences between the base period and current managed care programs; the April 2011-April 2012 rates were based on experience data from FY07-FY09. These adjustments include reimbursement, benefit limitations, and managed care impact.

- Calculate estimated managed care costs using trended and adjusted base FFS data.

- Adjust for third-party liability recoveries, administrative days, administrative expenses (see p. 19), and supplemental teaching payments.

- Perform a similar set of calculations for pharmacy services and add to the rate calculated for medical services to determine a base capitation rate in each category.

- Adjust for MCO specific risk scores. This risk score accounts for the differences in morbidity (incidence of disease) among the populations enrolled in each MCO.

The final MCO capitation rate is calculated by a DHHS staff person by multiplying the base capitation rate for a particular age category by the MCO adjusted risk score. For instance, in 2011 the base rate for a specific rate category was $113.55 and the risk score for one of the MCOs providing services within that category was .973. The final risk adjusted rate for that category paid to the MCO was $110.48. We reviewed the calculations for the April 1, 2011, MCO contracts and all of the capitation rates were consistent with the process described above.

Beginning in the spring of 2012, the above process will be enhanced by encounter data collected by the MCOs. As stated above, MCO rates were previously based on FFS experience data. Encounter data are records of the health care services for which MCOs pay. It is a more accurate picture of the needs/usage of the MCO population than FFS experience data. DHHS's use of this data in setting MCO rates should result in improved rate setting. DHHS requested that MCOs collect and report certain data for a period of time and tested the data to determine the reliability of MCO data collecting before beginning to rely on MCO encounter data for rate setting purposes.

More than 80% of states responding to the Kaiser survey use encounter data to set rates. Table 2.11 describes the changes to the rate calculation method detailed above.

Table 2.11: MCO Rate Setting Changes from April 1, 2011 - March 31, 2013

APRIL 1, 2011 – MARCH 31, 2012	APRIL 1, 2012 – MARCH 31, 2013
Extract **fee-for-service experience** data. Exclude certain services not included in managed care per the MCO Policies and Procedures Guide (e.g. mental health and substance abuse, dental, BabyNet).	Extract **MCO** hospital inpatient, hospital outpatient, professional, and other services **encounter** experience data. In addition, extract FFS experience data for services not covered by managed care during the base period contract period but now covered by managed care.
Adjust for third-party liability (TPL) recoveries. The capitation rates include an adjustment to reflect TPL recoveries by MCOs which would not be reflected in FFS experience data.	**No TPL adjustment** is needed because MCOs report encounter experience data net of TPL recoveries.

Source: DHHS

Department of Insurance Involvement in Rate Setting

In South Carolina, the Department of Insurance (DOI) regulates the health insurance industry, which includes reviewing and analyzing managed care premiums. When DHHS first implemented managed care, DOI was formally involved in developing the premiums. DOI does not currently advise the rate setting process. However, DOI reviews the MCOs for financial solvency. A portion of that review is based on adequate and appropriate rates. DHHS could invite DOI to share findings from its financial solvency reviews of Medicaid MCOs during the regular rate review process. This could assist DHHS in ensuring that the MCOs are in a sound business position and can continue to provide the level of service that DHHS desires for Medicaid beneficiaries.

Recommendation

3. The Department of Health and Human Services should communicate with the Department of Insurance about DOI's financial solvency reviews of Medicaid MCOs.

Managed Care Expenditures

We reviewed managed care expenditures from FY 08-09 through FY 10-11. A DHHS official reported that data from previous years in our scope of review may not be reliable. Table 2.12 shows expenditures of total funds for enrollees in MCO and MHN plans. The amounts for MCOs and MHNs include the capitation/care coordination fee and any fee-for-service expenditures on behalf of beneficiaries enrolled in MCOs and MHNs.

Total expenditures on fee-for-service enrollees have decreased, though not to the same degree as the decrease in enrollment. This could be attributed to increases in expenditures in areas like Community Long Term Care (Elderly and Disabled Waiver, HIV/AIDS Waiver, and the Children's PCA) and Nursing Home Services. Total expenditures for MCOs and MHNs increased at a rate consistent with enrollment.

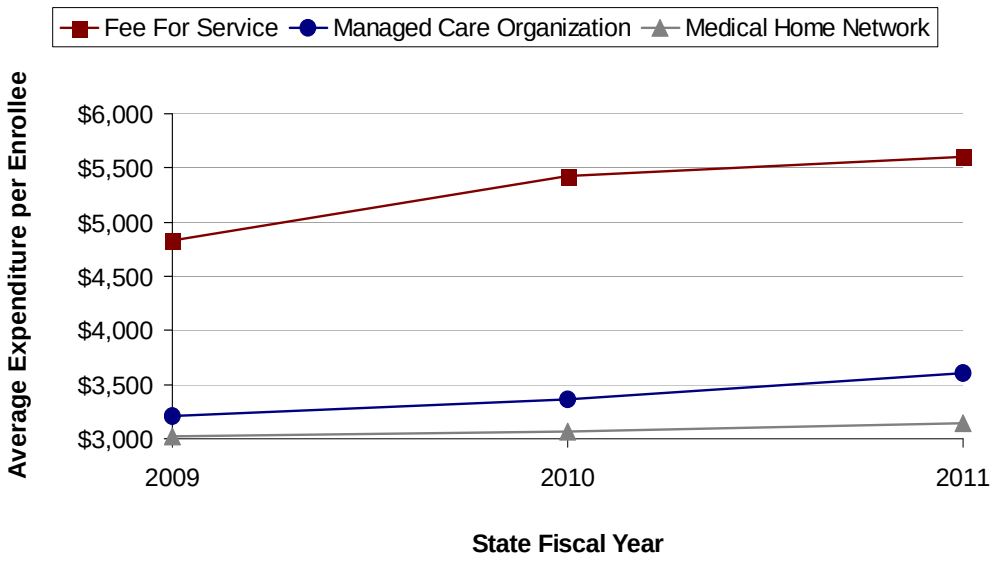
We also calculated average expenditure per enrollee and in addition to Table 2.12 those figures are reported in Chart 2.13.

Table 2.12: Expenditures for FFS, MCOs, and MHNs: FY 08-09 through FY 10-11

		FY 08-09	FY 09-10	% Change	FY 10-11	% Change
Fee-for-Service	Expenditures (Millions)	$2,112.4	$1,953	-7.5%	$1,861.7	-4.7%
	Average Monthly Enrollment	437,152	359,680	-17.7%	332,377	-7.6%
	Average Annual Expenditure per Enrollee	$4,832.19	$5,429.83	12.4%	$5,601.17	3.2%
Managed Care Organization	Expenditures (Millions)	$806.5	$1,169.97	45.1%	$1,436.33	22.8%
	Average Monthly Enrollment	251,004	347,445	38.4%	398,279	14.6%
	Average Annual Expenditure per Enrollee	$3,213.10	$3,367.36	4.8%	$3,606.34	7.1%
Medical Home Network	Expenditures (Millions)	$220.1	$297.29	35.1%	$377.21	26.9%
	Average Monthly Enrollment	72,876	96,816	32.9%	119,934	23.9%
	Average Annual Expenditure per Enrollee	$3,020.20	$3,070.69	1.7%	$3,145.13	2.4%

Source: DHHS

Chart 2.13: Average Expenditure per Enrollee



Source: DHHS

Fee-for-service average expenditure/enrollee increased. This can be attributed to the departure to managed care of lower cost enrollees which would hold the average down. MHN and MCO average expenditure per enrollee slightly increased.

MCO Administrative Expense

We reviewed Medicaid MCO administrative expenses and costs for FY 06-07 through FY 10-11 to determine if those costs included adjustments, how such costs are set, if they are counted in the actuarial soundness of the MCO capitation rate plan, and what type of costs can be included. We found DHHS has not reviewed MCO administrative costs leading to the possibility that the capitation rates may include payment of unallowable administrative costs. See page 22 for a discussion of unallowable administrative costs. We also found DHHS has no method in place to review how MCO administrative costs are trending on a per-enrollee basis. Total administrative costs outpaced average MCO enrollment by over 30% over the last five years.

MCO capitation rates, paid to each MCO in our state for medical services provided to Medicaid MCO enrollees, include an administrative cost component, which is referred to as an administrative loss ratio (ALR) by actuaries. The ALR is also referred to as an administrative allowance in connection with capitation rates and is stated as a percentage of the capitation rate. See page 10 for an explanation of the capitation rates and the MCO reimbursement process. Capitation rates are a projection of future costs based on a set of assumptions. The capitation rate is a per member per month charge paid by the state Medicaid program for services for MCO enrollees and revenue to the MCO, who use the revenue to provide services or pay the providers of medical and pharmacy services.

The administrative allowance is a component of the capitation rate and is designed to provide for the MCO being able to cover its administrative overhead costs. Those include items such as the cost of marketing, buildings and rent, interest, depreciation, and non-medical costs associated with the expense of personnel not directly involved in MCO patient care activities. The administrative rate also includes a 1.0% profit factor and contribution to margin, which is determined and recommended by the actuary setting the rates for the department. Table 2.14 shows the administrative rates for South Carolina MCOs for FY 06-07 through FY 12-13.

Table 2.14: South Carolina Historical Administrative Expense Rates

FY	RATE
06-07	13.75%
07-08	13.00%
08-09	12.25%
09-10	12.00%
10-11	11.63%
11-12	10.5%
12-13	9.5%

Source: DHHS

MCO Costs FY 06-07 through FY 10-11

We obtained the amount of MCO total expenditures, in the form of capitation rate payments that were made to South Carolina MCOs during FY 06-07 through FY 10-11. Administrative costs as a part of total MCO payments ranged from an average of 13.0% in the earlier years to 11.63% in FY 10-11. These percentages are contractually set and are the same for each MCO in the state.

We found total administrative costs increased from $31 million in FY 06-07 to $172.7 million for FY 10-11. However, enrollment also increased during this period. Therefore, we have calculated MCO administrative costs on a per-enrollee basis, in order to account for the change in enrollment as shown in Table 2.15 below.

MCO administrative costs increased each year at varying rates, depending on the cost increase between years with respect to enrollment increases each year. From FY 06-07 through FY 10-11, we found that:

- Average annual administrative expenses per enrollee increased 24.3%.
- Average monthly enrollment increased 347.5%.
- Total administrative expenses increased 456.4%.

When comparing the rate of growth of MCO administrative expenses to the rate of growth of MCO enrollment from FY 06-07 to FY 10-11, the rate of growth of administrative expense exceeded that of enrollment by 109 percentage points, over 30%.

Table 2.15: Percentage Change in the Average Annual Administrative Expense from FY 06-07 through FY 10-11

FY	Total Expenditures	Administrative Expenditures	Average Monthly MCO Enrollment	Average Annual Administrative Expense Per Enrollee	% Change
06-07	$225,741,788	$31,039,496	89,007	$348.73	NA
07-08	$276,071,412	$35,889,284	106,042	$338.44	-2.9%
08-09	$779,081,696	$95,437,508	251,004	$380.22	12.3%
09-10	$1,201,388,981	$144,166,678	347,445	$414.93	9.1%
10-11	$1,485,633,206	$172,704,860	398,279	$433.63	4.5%

Source: DHHS

The actuary cited several factors affecting administrative costs that could partially account for the substantial percentage increase over the five-year period including payments not subject to the administrative allowance, changes in benefits, and changes in eligibility.

DHHS has no formal method for determining the rate of change in administrative costs. Also, DHHS did not review MCO administrative expenses to identify and remove unallowable administrative costs, for future rate setting purposes. Unallowable costs are costs that the Center for Medicare and Medicaid Services (CMS) has determined are not related to patient care and are therefore, not subject to reimbursement by the Medicare program. Those same expenses are currently allowable for S.C. Medicaid MCOs; however, some other states remove these costs from the MCO cost data for future rate setting purposes. See page 26 for examples of unallowable expenses. A clause in its MCO contracts allows the department access to MCO financial data including cost data. There is currently no restriction on the type of costs the MCOs may include in administrative costs. However, in December 2011, the department contracted with an audit firm using Medicare unallowable expense guidelines to review South Carolina Medicaid MCO administrative costs to identify unallowable administrative expenses. The results of the audit are not yet available.

DHHS, in order to set the administrative rate component of the capitation rates in its contracts with South Carolina MCOs, relies on its contracted actuary to; (1) review and use South Carolina MCO data, and (2) use its experience with rate setting activities with other states' Medicaid plans. The problem with this methodology of rate setting is that it doesn't account for the fact that other plans, whose cost data was used by the actuary to set their rates, may include unallowable costs, as defined by CMS in the Medicare program. The actuary has indicated that some states do restrict administrative costs in their contracts with MCOs; however, it is likely that many of the states include unallowable costs in their administrative costs because there are few states that have laws or contractual restrictions providing for the exclusion of such costs. The setting of rates using the data of other states that have not been audited for unallowable expenses is a process that may result in rates with cost data inflated by unallowable expenses, leading to inflated rates.

Administrative Allowance

The administrative component of the capitation rate is set by a contracted actuary and is a part of the determination of actuarial soundness of the plan rates. The administrative loss ratio (ALR) is a common financial metric used in the industry to report and benchmark the financial performance of an MCO. It is partially the basis for setting future administrative cost allowances (along with other factors including changes to the factors that comprise the MCOs' administrative expenses).

The ALR formula is claims adjustment expenses plus general administrative expenses divided by total revenue:

$$\frac{\text{Claims adjustment expenses + Administrative expenses}}{\text{Total Revenue}}$$

Claims adjustment expense refers to claims department expenses and to the administrative effort, required by a claims processor at the MCO, to fix a claim processed in error (denied, wrong amount paid, etc.) and to reprocess the amount paid, resulting in a refund or additional payment. General administrative expenses include all the MCO administrative expenses required to administer the Medicaid MCO plan.

Benchmarks

The actuary for DHHS used administrative cost benchmarks, its experience with other state Medicaid agencies and MCO clients, and other data particular to South Carolina MCOs in setting the percentage of the rate attributable to cover MCO administrative expense and profit.

Some elements of administrative cost benchmarks are:

The geographical region of the country in which the MCO operates.
Health care spending varies widely across the United States with the price of services one of the factors contributing to the variance. A substantial portion of the variation remains unexplained.

MCO size determined by the amount of annual revenue it receives.
As revenue increases, and due to the fixed nature of a portion of MCO administrative costs, the percentage of administrative expenses decreases.

MCO type.
MCOs that participate in Medicaid only have higher ALRs than those which also administer other programs such as Medicare and private insurance.

MCO affiliation type

When an MCO is affiliated with a larger organization, it often experiences economies of scale not available to independent organizations.

Financial structure

The actuarial data shows that for-profit companies exhibit a higher ALR when compared with nonprofits. Nonprofits may be generally focused on "break-even" results as long as they experience sufficient contribution to surplus to fund research and development or capital initiatives.

South Carolina has 4 MCOs operating in the state who administer Medicaid managed care programs, all of which are "for-profit" organizations.

Provide pharmacy services

Actuaries indicate the pharmacy component of MCO services has a lower administrative cost structure than other services.

Type of enrollee

Disabled enrollees account for higher administrative costs than do enrollees from low-income families.

Enrollment requirement

Required mandatory enrollment generally results in increased covered MCO population leading to reduced administrative costs on a per member basis. States with voluntary enrollment may allow more marketing by the MCOs. Both of these conditions of enrollment have an effect on administrative cost rates.

The actual administrative rate is determined by more than just the items listed above. Requirements established by the contract with the state Medicaid agency will also influence the administrative costs. Items such as what level of reporting is required and what type of MCO staffing ratios may be required, etc., are examples of a number of factors within the contract that may impact the administrative costs of the health plan. These data and all factors influencing administrative rates eventually become a part of the benchmarks as national data is collected by actuaries.

Administrative Cost Benchmark Comparison 2011

The actuary provided the administrative expense rates of two states in CMS Region 4 for comparison with South Carolina rates. For 2011-2012 data, South Carolina had an administrative expense of 10.5% of the capitation rate while Florida's was 12% and Mississippi's was 10%.

We have compared several states' administrative rates; however, it is difficult to compare individual states' MCO administrative cost percentages in a fair and meaningful way due to the potential differences of factors affecting the administrative rates of plans from different states. For example, states covering only low income populations, which require lower administrative effort and costs, than those covering a disabled population, which require much more administrative effort and higher costs, will have a much different cost structure.

In a study of national data from calendar year 2010, the results of which were published in a July 2011 report from Milliman, the actuary, entitled "Milliman Research Report," along with the agency's contractual rates, we note the following results of administrative costs. The South Carolina administrative cost rate for FY 09-10 was 12% and FY 10-11 was 11.625% while the national average in the survey data for calendar year 2010 ranged from 11.3% to 12.6% considering MCO groupings with some characteristics similar to South Carolina MCOs.

The South Carolina rate is about the same as the national rate. However, as discussed previously, South Carolina MCO administrative costs have steadily increased for the last five years and have outpaced enrollment increases by over 30%.

Allowable MCO Administrative Costs

Currently there are no federal or South Carolina laws specifically excluding certain types of administrative costs for MCOs contracted to administer Medicaid managed care plans. This can lead to inflated administrative costs paid for by the state Medicaid plan as a part of the capitation rate. DHHS and actuary officials have indicated just a few states have laws or rules substantially limiting the type of expenses that can be included in MCO administrative costs.

An audit firm will review Medicaid MCO administrative costs when contracted to do so by state Medicaid agencies. Their purpose is to identify unallowable administrative costs for the purpose of setting future rates that exclude unallowable costs for inclusion in the rate setting process.

The unallowable costs are determined by applying reimbursement principles from the Medicare Provider Reimbursement Manual (PRM) and the Federal Acquisitions Regulations (FAR) manual. Using the principles of these federal restrictions on administrative costs in those programs, auditors have excluded such items as the following listed costs for future Medicaid MCO rate setting:

- Lobbying.
- Income taxes.
- Overstated administrative expenses.
- Expenses related to Securities and Exchange Commission (SEC) filings.
- Broker commissions.
- Marketing department expenses not related to Medicaid.
- Related party expenses (which are costs that are inflated by transactions between parties related by company ownership or control that increase MCO cost).

In the review of MCO Medicaid administrative costs of several states, the auditors found the following amounts of unallowable expense in the MCO data they reviewed and planned to use the results for future rate setting purposes:

- Maryland — reduced administrative expenses by 13% ($18 million) in FY 2004, 20% ($29.4 million) in FY 2003, 20% ($25.9 million) in FY 2002 and 15% ($18.5 million) in FY 2001.

- Nevada — reduced administrative expenses by 32% ($18 million) in FY 2010.

- Virginia — reduced administrative expenses by over $14 million.

The expense reductions noted above do not necessarily translate into the exact same amount of dollar savings to the state Medicaid agency. The removal of the unallowable expenses provide the agency, and its actuary, a better sense of what the administrative cost rate should be for the purpose of setting future rates.

Three of the four MCOs operating in South Carolina have multiple lobbyists registered with the State Ethics Commission, reporting a total of $214,035 paid to lobbyists for calendar year 2011. One MCO has no lobbyist registered with the commission. Lobbying expense is currently not excluded when setting MCO rates in South Carolina.

DHHS Action

The department has contracted with this audit firm to review all four Medicaid MCO annual cost reports to identify unallowable administrative expense for rate setting purposes. The Office of the State Auditor approved the contract on November 14, 2011.

The audit was to be completed "ASAP," as indicated in the audit firm's letter of submittal, in order to determine "appropriate administrative costs for the pending rate-setting process." However, the most recent rates do not include the results of the audit effort because the administrative cost portion of the audit has not been completed. This could cause the department to set the rates without the benefit of knowing how much unallowable administrative costs had been included in the prior capitation rates. This may lead to continued inflated administrative costs.

The department did reduce the MCO administrative allowance for contract period, April 2012 to March 2014, to 9.5% from 10.5% in the previous contract period, April 2011 to March 2012. The reasons for the determination reducing the administrative rate by one percentage point are varied. According to an agency official, it is a result of MCO best practices and continued increased enrollment in managed care for Medicaid in South Carolina. The actuary has indicated DHHS wanted to move to a percentage of ALR consistent with the lower values observed in the national data — 9.8% at the 25th percentile in CMS region 4, where our MCOs operate.

National survey data regarding administrative rates can be useful in considering a state's administrative cost level. However, the agency should use its own analysis and develop its own standard for evaluating the level of administrative cost that is acceptable by taking into account the state's MCO contractual conditions, administrative expense audit results, benefit levels, and the risk and relative morbidity of the covered populations. By using a data driven approach the agency may be able to reduce administrative expenses but avoid potential unintended consequences, such as reducing the number of MCO administrative firms from participating in South Carolina. This could happen if administrative rates are set too low.

The agency has little direct authority to remove unallowable administrative costs for future rate setting of the MCO administrative component of the capitation rate. This can lead to higher administrative costs than necessary and could result in payments being made for MCO lobbying activities, expenses not related to patient care, and other unallowable expenses being included in the rates. Legislation, adopting some of the key principles of the Provider Reimbursement Manual and the Federal Acquisitions Regulations manual, would provide the authority needed to reset rates based on removal

of unallowable expenses. This could lead to a reduction of administrative expenses from 13%, up to as much as 32%, as has been experienced in other states. For South Carolina, with a last year's administrative expense of over $172 million, this allows for a range of potential savings from approximately $22 million to approximately $55 million. However, the actual savings of administrative costs for South Carolina may vary significantly from these results depending on how much unallowable expense is being included in MCO annual expense statements. Some states accomplish restricting administrative costs by contractually defining what expenses are unallowable.

Recommendations

4. The Department of Health and Human Services should track managed care organization (MCO) administrative costs annually on a per enrollee basis in order to determine the rate at which administrative costs are rising.

5. The Department of Health and Human Services should review, or have reviewed, Medicaid MCO administrative costs, when its analysis of the administrative cost trend reveals MCO administrative costs are not in an acceptable range as determined by its analysis and standards.

6. The Department of Health and Human Services should include in its contracts with the MCOs the authority to make mid-contract period adjustments to the administrative allowance of the capitation rate to prevent administrative costs from increasing faster than the rate of enrollment without valid reasons such as changes in morbidity and other risk factors.

7. The Department of Health and Human Services should identify which MCO administrative costs are considered unallowable. These costs should be included in state law or DHHS rules and contracts with managed care organizations.

8. The Department of Health and Human Services should include in its contracts with the MCOs the authority to make mid-contract or mid-year adjustments to the capitation rate administrative component based upon the most recent audit results of the review of the MCOs' administrative expense, adjusting for unallowable costs.

Pharmacy

We reviewed DHHS's pharmacy division to determine the cost of pharmacy services and if that cost was appropriate. We found that DHHS's payments for pharmacy services have decreased 27% from FY 06-07 through FY 10-11. We also found that DHHS has not established a regular schedule to review what the agency pays pharmacists and how much beneficiaries are charged in co-payments.

Background

DHHS's Medicaid program has a pharmacy division that handles pharmacy and prescription drug issues for the department, including how much pharmacies are paid by the Medicaid program.

Medicaid beneficiaries can have coverage through fee-for-service or managed care. The coverage a Medicaid beneficiary has is determined by how the beneficiary is eligible for Medicaid. Beneficiaries in the traditional fee-for-service Medicaid plan have all of their pharmacy payments billed directly to DHHS for payment.

Beneficiaries participating in a managed care organization (MCO) have their pharmacy services handled through their managed care provider. DHHS pays the managed care providers a set amount per member per month. The managed care providers are also responsible for setting up their own networks of pharmacies. Beneficiaries in the medical home plans have their prescriptions handled the same as beneficiaries in the fee-for-service model.

DHHS currently allows four prescription drugs a month for adults and unlimited prescriptions for children. Beneficiaries can receive up to 31 days of medicine per prescription. S.C. Code §40-43-86(H)(6) was amended in 2008 to allow the use of generic drugs whenever possible.

DHHS contracts with a private vendor that operates a point-of-sale computer system that checks eligibility, captures claim data, adjudicates claims, and assists pharmacists in getting paid. DHHS uses a preferred drug list, requires prior authorization for some drugs, and operates a drug utilization review system.

Drugs on DHHS's preferred drug list are clinically proven, but usually cost less than other drugs that perform the same functions. Pharmaceutical manufacturers give supplemental rebates to DHHS for putting their drugs on the list. DHHS's Pharmacy and Therapeutic Committee, which consists of 4 pharmacists and 11 doctors, decides which drugs to add to the preferred drug list. An agency official described preferred list drugs as both clinically

appropriate and cost beneficial. Prior authorization may be required for some drugs, such as those that are easily abused.

DHHS also operates a Drug Utilization Review (DUR) program which assures that prescriptions for outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results. The DUR board membership includes pharmacists, physicians, and other health professionals. The DUR program includes prospective review of drug therapy at the point of sale or point of distribution before each prescription is filled or delivered to the Medicaid beneficiary. The DUR program also includes retrospective DUR through its mechanized drug claims processing and information retrieval system.

According to an agency official, South Carolina and its MCOs also participate in receiving drug rebates from pharmaceutical companies. MCOs send DHHS data on the number of each drug filled for beneficiaries participating in their MCO. DHHS then adds those numbers to the fee-for-service prescriptions filled for that particular drug. The agency sends that information to the drug manufacturer to get the agency's rebate.

Pharmacy Rate Methodology

DHHS currently uses three different formulas to determine what a pharmacist is paid for filling a prescription. The agency always pays the lowest amount of the three formulas. The formulas consist of different methods to determine the cost of a drug (ingredient fee), along with a dispensing fee that always remains the same amount.

A dispensing fee is the amount that DHHS pays a pharmacy to fill a prescription. An ingredient fee is what DHHS pays the pharmacy for the actual cost of the drug.

Table 2.16 shows how South Carolina compares to the other states in the state's CMS region (Region 4) regarding dispensing fees and co-pays for beneficiaries (not all Medicaid categories allow co-pays).

Table 2.16: CMS Region 4 Dispensing and Co-Pay Amount

STATE	DISPENSING FEE	BENEFICIARY CO-PAY AMOUNT
Alabama	$10.00 – $10.64	$0.50 – $3.00*
Florida	$3.73 – $7.50	2.5% of payment up to $300, capped at 5% of total family income
Georgia	$4.33 – $4.63	$0.50 – $3.00
Kentucky	$4.50 – $5.00	$1.00 – $3.00 ($225.00 cap per beneficiary, per year)
Mississippi	$3.91 – $5.50	$3.00
North Carolina	$4.00 – $5.60	$1.00 – $3.00
South Carolina	$3.00	$3.40
Tennessee	$2.50 – $25.00	$0 – $3.00

*Co-pay varies by cost of prescription.

Source: Center for Medicare & Medicaid Services

DHHS lowered its dispensing fee from $4.05 to $3.00 on July 8, 2011. In the six months prior to the lowering of the dispensing fee, DHHS spent $7,524,418 on dispensing fees. In the six months after the lowering of the dispensing fee, DHHS spent $4,916,616 on dispensing fees. However, DHHS also had a lower number of claims over the six-month period following the lowering of the dispensing fee. Also, DHHS increased its co-payment to $3.40 on April 1, 2011.

South Carolina has one of the lowest dispensing fees paid to pharmacists in CMS Region 4. The state also has one of the highest co-payments charged to beneficiaries. Any changes to the state's dispensing fees and co-payments must be approved by CMS.

DHHS Drug Dispensing Costs FY 06-07 to FY 10-11

Table 2.17 shows what DHHS has paid for dispensing and ingredient fees for the last five fiscal years. The table also shows how much Medicaid beneficiaries, who are required to pay a co-pay, have paid over the same period. Over the last five fiscal years, DHHS's drug dispensing costs have decreased by approximately $100 million (27%).

Table 2.17: DHHS Drug Dispensing Costs FY 06-07 to FY 10-11

FY	Number of Paid Claims	Total Amount Paid* by DHHS Minus Other Insurance and Co-Pays	Ingredient Fees	Dispensing Fees	Incentives to Compounding Pharmacies	Amount Paid by Other Insurance on Behalf of Beneficiaries	Co-pays
06-07	5,716,629	**$366,387,527	$367,873,095	$22,629,218	$3,108	$16,511,239	$7,606,224
07-08	5,611,471	$374,992,693	$378,604,187	$22,035,491	$100	$18,235,905	$7,411,180
08-09	4,447,198	$305,028,195	$310,154,888	$17,361,248	$0	$17,492,393	$4,995,548
09-10	3,982,861	$268,268,640	$272,269,474	$15,469,386	$0	$15,562,327	$3,907,893
10-11	3,805,980	$266,883,508	$264,112,104	$14,747,679	$0	$8,474,975	$3,501,300

*Amount does not include money that DHHS receives in rebates from pharmaceutical companies.
**Amount does not calculate correctly. An agency official stated this was due to rounding.

Source: DHHS

In 2011, DHHS performed a drug dispensing cost review because the agency wanted to lower the rates the agency pays to pharmacists, and because CMS required a review in order to allow the state to lower the rates. The review found that DHHS could lower its rates and still ensure that pharmacies would participate in the Medicaid program. However, DHHS does not have a schedule to review its pharmacy rates on a regular basis. If DHHS were to review pharmacy rates regularly, then the agency may discover additional savings.

Administrative Costs for the Pharmacy Program

DHHS pays MCOs a capitation rate, which is a per member per month charge paid by the Medicaid program for MCO beneficiary services and revenue to the MCO. The MCOs then pay providers of medical and pharmacy services with which it subcontracts. Within the capitation rate is an administrative component, which is expressed as a percentage of the capitation rate. Currently, DHHS pays MCOs 8% of the capitation rate for pharmacy administrative services.

The administrative component of the capitation rate is set by a contracted actuary for DHHS. DHHS's actuary used administrative cost benchmarks in setting the 8% pharmacy administrative rate. Factors that are considered in determining benchmarks are MCO revenue size, for-profit vs. non-profit, etc. (see p. 23).

In addition to what DHHS pays to MCOs, the agency also has agency personnel costs related to the pharmacy program. Finally, DHHS also

contracts with a private vendor that operates a point-of-sale computer system that checks eligibility, captures claim data, adjudicates claims, and assists pharmacists in getting paid.

Table 2.18 shows what DHHS has paid out in DHHS personnel costs, as well as the point-of-sale pharmacy vendor costs for the last five fiscal years. According to an agency official, these two expenses are how DHHS defines administrative costs in the pharmacy program.

Table 2.18: Administrative Costs for the Pharmacy Program FY 06-07 to FY 10-11

	FY 06-07	FY 07-08	FY 08-09	FY 09-10	FY 10-11
DHHS Personnel	$458,019	$447,825	$363,829	$228,182	$240,797
Pharmacy Point-of-Sale Vendor	$5,803,320	$6,515,186	$6,845,666	$5,776,639	$7,025,849
TOTAL	**$6,261,339**	**$6,963,011**	**$7,209,495**	**$6,004,821**	**$7,266,646**

Source: DHHS

From FY 06-07 through FY 10-11, DHHS's pharmacy personnel costs have decreased while the costs for the pharmacy point-of-sale vendor have increased. The pharmacy point-of-sale vendor is paid an escalating contracted rate for administering the contract. Also, policy changes have affected the cost of the point-of-sale contract.

Future Changes

According to CMS, proposed regulations under the Affordable Care Act would save states nearly $18 billion on Medicaid prescription drugs in five years. The savings would come from changing reimbursement rates for pharmacies to better reflect what they pay for prescription drugs, increasing rebate amounts paid by drug manufacturers, and allowing rebates for drugs prescribed to recipients in managed care plans. Although DHHS already receives drug rebates for recipients in managed care plans, any other savings the agency receives would allow further savings for South Carolina's Medicaid program.

Recommendation

9. The Department of Health and Human Services should establish a regular schedule to perform reviews of the agency's pharmacy rates.

Provider Enrollment and Procurement

We reviewed how DHHS obtains providers to participate in the agency's Medicaid program. We reviewed DHHS's methods for enrolling doctors, pharmacists, and other medical service providers. We also reviewed DHHS's sole source and emergency procurement of other providers. We found that DHHS is not correctly procuring providers under the emergency procurement regulation in state law.

Enrollment of Medical Services Providers

Managed care organizations (MCO) are required to be licensed by the S.C. Department of Insurance as a health maintenance organization, whereas medical home networks, doctors, dentists, and pharmacists can enroll in Medicaid, as long as they meet all requirements. The requirements for doctors, pharmacists, etc., are:

- Be licensed by the appropriate licensing body.
- Enroll in Medicaid.
- Obtain a National Provider Identifier (NPI) if required.
- Continuously meet S.C. licensure requirements.

Based on the type of provider, they are required to either complete a provider enrollment agreement or sign a contract with DHHS. Providers can limit the number of Medicaid patients they see, but cannot discriminate on the type of patients they see. Also, Medicaid beneficiaries can choose any doctor that is willing to accept them as a patient.

All doctors, dentists, pharmacists, etc., are paid the same Medicaid rates based on the type of provider they are and the medical services being performed. MCO network doctors and medical service providers do not have to be Medicaid-enrolled providers; instead they enroll with the MCO.

Sole Source and Emergency Procurements

We reviewed DHHS's quarterly sole source and emergency procurement reports from the time period of October 1, 2010, through December 31, 2011. During this time DHHS had nine sole source procurements. These sole source procurements totaled $585,109 and were for computer software and other services. In addition, over this same time period, DHHS had seven emergency procurements totaling $135.4 million.

State law exempts agencies from using competitive procurement methods when goods or services need to be obtained quickly because of an emergency. S.C. Regulation 19-445.2110 states that an emergency procurement may be used in a "situation which creates a threat to public health, welfare, or safety such as may arise by reason of floods, epidemics, riots, equipment failures, fire loss, or such other reason . . . ."

In our March 2009 audit of DHHS's Non-Emergency Medical Transportation (NEMT) program, we recommended that the agency comply with state law regarding the use of emergency procurements. However, from January 1, 2011, through December 31, 2011, DHHS had emergency procurements totaling $132.3 million for NEMT services.

We also reviewed three other emergency contracts that DHHS had during the time period of October 1, 2010, through December 31, 2011. The first emergency contract we examined concerned services for the restructuring of DHHS and financial advisory services on behalf of the agency. This contract was originally for $770,000, but through amendments has increased to an amount not to exceed $2,384,232, as of March 2012. The second emergency contract we reviewed dealt with the processing of other health insurance claims for beneficiaries. This contract was originally for $1,890,731, but instead cost DHHS $919,998. The final emergency contract we reviewed dealt with providing medical utilization reviews on beneficiaries' use of medical services. This contract was originally for $23,923 per month, but through amendments increased to $40,826 per month by the end of the contract. After review of these three contracts, we concluded that DHHS procured processing of other health insurance claims for beneficiaries and medical utilization reviews of beneficiaries' use of medical services in accordance with state law.

However, DHHS did not procure restructuring and financial advisory services in accordance with state law. DHHS had an ample amount of time to secure this contract under normal procurement methods, and emergency procurement was not necessary for this contract. By engaging in emergency procurement, DHHS may be limiting other providers who may wish to bid on providing these services to the agency, as well as possibly increasing the amount that the agency pays for these services. Also, South Carolina may not be getting the best service for the best price.

Recommendation

10. The Department of Health and Human Services should comply with state law regarding the use of emergency procurements.

Managed Care Eligibility Payment Categories and Recipient Special Programs

REQUIRES PARTICIPATION (MCO AND MHN)	
PCAT	**PAYMENT CATEGORY**
11	MAO (Extended/Transitional)
16	Pass Along Eligibles
17	Early Widows/Widowers
18	Disabled Widows/Widowers
19	Disabled Adult Children
20	Pass Along Children
32	Aged, Blind, Disabled (ABD) (Age 19 and Above)
40	Working Disabled
59	Low Income Families
71	Breast and Cervical Cancer
80	SSI (Age 19 and Above)
81	SSI With Essential Spouse (Age 19 and Above)
87	OCWI Pregnant Women /Infants
88	OCWI Partners For Healthy Children
91	Ribicoff Children

NOT ELIGIBLE TO PARTICIPATE IN MANAGED CARE	
PCAT	**PAYMENT CATEGORY**
10	MAO (Nursing Home)
14	MAO (General Hospital)
33	ABD Nursing Home
48	Qualifying Individuals (QI)
50	Qualified Disabled Working Individual
52	SLMB
54	SSI Nursing Home
55	Family Planning
70	Refuge Entrant
90	Qualified Medicare Beneficiary
92	GAPS (Medicare Part D Plan)
Limited Benefit Indicators: E, I, C, D, J, P, A	
RSP	**DESCRIPTION**
NHTR	Nursing Home Transition
MCSC	Palmetto Senior Care (PACE)
HOAD	Healthy Opportunity Account
HOAP	Healthy Opportunity Account
MFPG	Money Follows the Person Grant
MCFC	Med Fragile Children's Waiver
MCNF	Med Fragile Children's Waiver – Non Foster Care
–	Beneficiaries who have private managed care insurance (HMO)

CHOICE ONLY (MCO/MHN/FFS)	
PCAT	**PAYMENT CATEGORY**
12	OCWI (Infants)
13	MAO (Foster care/Adoption)
31	Title IV-E Foster Care
32	Aged, Blind, Disabled (ABD) (Under Age 19)
51	Title IV-E Adoption Assistance
57	Katie Beckett/TEFRA
60	Regular Foster Care
80	SSI (Under Age 19)
81	SSI w/ Essential Spouse (Under Age 19)
85	Optional Supplement
86	Optional Supplement & SSI
RSP	**DESCRIPTION**
ISED	Interagency Sys. Of Care for Emotion. Disturbed Children
CHPC	CLTC Children's Personal Care Aide
MCPC	Integrated Personal Care Services
COSY	Cosy Project Beaufort Co.
WAHS	Waiver Healthy Start
–	Members who are Indians and part of a Federally recognized tribe

CHOICE ONLY (MHN/FFS)	
PCAT	**PAYMENT CATEGORY**
15	MAO (Waivers - Home & Community)
RSP	**DESCRIPTION**
AUTW	Autism Waiver
CLTC	Elderly Disabled Waiver
CSWE	Community Supports Waiver – Est.
CSWN	Community Supports Waiver – New
DMRE	DMR Waiver/Established
DMRN	DMR Waiver/New
HIVA	CLTC HIV AIDS
HSCE	Head & Spinal Cord Waiver Est.
HSCN	Head & Spinal Cord Waiver New
MCHS	Hospice
VENT	CLTC Ventilator Dependent Waiver
PRTF	Psychiatric Residential Treatment Facility
WMCC	Medically Complex Children's Waiver
–	Dual Eligibles (Medicare/Medicaid)
–	Age 65 and Over

Source: DHHS

Appendix A

Agency Comments

Appendix B

South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

July 27, 2012

Mr. Perry K. Simpson, Director
Legislative Audit Council
331 Elmwood Avenue, Suite 315
Columbia, South Carolina 29201

Dear Mr. Simpson:

Thank you for the opportunity to review and comment on the Legislative Audit Council's report *A Limited Review of Managed Care Rates and Expenditures and Other Administrative Issues at DHHS*.

The Department is in general agreement with the LAC's recommendations on managed care, although several aspects of the LAC's analysis require important clarification, which is provided as an attachment to this letter. This portion of the audit reviews SFY 04-05 through SFY 10-11. Several recommendations deal with the growth in managed care administrative expenses. I am pleased that the auditors recognized that since Governor Haley took office, SCDHHS has reduced MCO administrative expenses from 12.0% to 9.5% - a decrease that will save taxpayers more than $40 million in administrative costs in the coming fiscal year. SCDHHS also initiated its own draft audit of unallowable MCO administrative expenses. We will forward a final version of this audit to the LAC once it is complete.

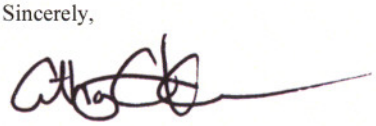
LAC did not detail in this audit that SCDHHS began restructuring its MCO/MHN contracts to provide better value. SCDHHS has convened a Coordinated Care Improvement Group composed of health plan, hospital, physician and patient advocate stakeholders who are advising this process. An important immediate result of these meetings is that a substantial portion of MCO payments are now contingent on achieving quality performance standards. In CY2012 the amount at risk will amount to approximately $8 million. In CY2013 this will increase to more than $24 million.

Please see the one page attachment regarding the LAC pharmacy findings. The audit finds that payments for pharmacy services decreased SFY06-07 through SFY10-11 by 27%. Please note, however, the net cost to the state actually decreased 59% when including rebates. We agree with the LAC's single recommendation that SCDHHS should regularly review pharmacy reimbursement, and note that prior to 2011, South Carolina Medicaid pharmacy reimbursement was legislatively mandated at AWP – 10% plus a dispensing fee of $4.05.

We are also in agreement that SCDHHS should comply with state procurement law regarding emergency procurements. We disagree with the LAC finding that the department did not comply with the law for transportation and financial advisory service contracts. The law is clear that when "there exists an immediate threat to public health, welfare, critical economy and efficiency, or safety" that the agency Director may make the determination to proceed with emergency procurement. All contracts received the required approvals at the Department and state procurement office. In the case of the transportation contracts, protests of awards made for a new contract cycle requiring emergency extension of the existing contracts. Failing to extend these contracts would have put a halt to transportation services critical to life-saving medical treatment for thousands of Medicaid beneficiaries. Regarding the financial advisory services contract, we point to your recently released audit of the Department's SFY10-11 deficit as evidence of the serious threat to "critical economy and efficiency" of the Department's operations which justified immediate action to overhaul our budgeting process, expenditure monitoring and cash management functions. We believe the resulting financial performance of SCDHHS in SFY11-12 has validated this emergency action.

It has been our pleasure to work with you and your staff, and as always, the work of your organization will help SCDHHS pursue its mission to "*purchase the most health for our vulnerable citizens at the least cost to the taxpayer*". If I may be of any further assistance, please contact me.

Sincerely,



Anthony E. Keck, Director

Attachments

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July 27, 2012

Mr. Anthony Keck
Medicaid Director
State of South Carolina
Department of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

RE: RESPONSE TO LEGISLATIVE AUDIT COUNCIL JUNE 29, 2012 REPORT

Dear Director Keck:

Milliman, Inc. (Milliman) has been retained the State of South Carolina, Department of Health and Human Services (DHHS) to provide actuarial and consulting services related to the Medicaid program. We have been requested to provide comments related to the South Carolina General Assembly, Legislative Audit Council report entitled, *A Limited Review of Medicaid Managed Care Rates and Expenditures and Other Administrative Issues at the Department of Health and Human Services* (LAC Report). The version of the LAC Report shared with Milliman was still in draft form. Further, the LAC Report has been shared with Milliman under strict confidentiality rules. Due to the confidentiality requirements of the LAC Report, this letter should be held confidential to only those with access to the LAC Report. This letter is an update to our letters dated June 14, 2012 and July 5, 2012. We have updated our letter to reflect revisions to the LAC Report as indicated in the version dated July 19, 2012.

LIMITATIONS

The information contained in this letter has been prepared for DHHS. The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the letter must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented. The terms of Milliman's contract with DHHS effective July 1, 2011 apply to this letter and its use.

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To the extent that Milliman consents to the distribution of this letter, we make no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for DHHS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties.

In the development of the data and information presented in this letter, Milliman has relied upon certain data from the State of South Carolina and their vendors. To the extent that the data was not complete or accurate, the values presented in the letter will need to be reviewed for consistency and revised to meet any revised data.

SUMMARY COMMENTS

The LAC Report focused on the following items:

- "The number of clients enrolled in Medicaid from 2006 through 2011.
- How DHHS enrolls clients in Medicaid health plans and identify potential cost savings.
- How DHHS manages the administrative costs for managed care organizations and identify potential cost savings.
- If DHHS could achieve additional cost savings in other Medicaid programs."

Based on their review, the LAC Report outlines ten different recommendations. I have been requested to provide comment on several of these issues. The following provides the individual recommendations and my comments.

> **LAC Report Comment**: (Medicaid Enrollment – page 3) "The number of people enrolled in Medicaid has increased from FY 04-05 through FY 10-11 and a greater percentage of those enrolled are receiving services."
>
> **Comment**: During this time period, the Medicaid program has modified different eligibility programs. These modifications resulted in a decrease in enrollment between SFY 05-06 and SFY 07-08 time periods. There were observable decreases in the Elderly and Disabled categories during the SFY 05-06 and SFY 06-07 fiscal periods due to changes and elimination of certain eligibility categories. Specifically, the Silver Card program was eliminated on January 1, 2006 with the implementation of Medicare Part D. Further, the analysis associated with the number of recipients receiving services needs to be analyzed with caution. The number of recipients receiving services increases with managed care enrollment. This is a result of the fact that beneficiaries enrolling in a managed care program will generate a monthly claim for either the capitation payment to the managed care plan or the administration fee paid to the medical home network. These payments are made based on eligibility and enrollment in a managed care plan and do not directly coincide with receipt of an encounter with a health care professional or provider.

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LAC Report Recommendation #1. "The South Carolina Department of Health and Human Services should develop a formal process for regularly reviewing Medical Home Network rates for adequacy and appropriateness."

Comment: The Medical Home Network rates are currently comprised of two different components: (1) the monthly administration fee of $10 per member and (2) the shared savings component of the contract. The monthly administration fee is used by the Medical Home Network provider to contract with physicians to serve as the primary care providers for the enrolled members. The Medical Home Network pays a monthly management fee to the primary care provider.

The residual amount of the monthly administration fee is used to perform the administrative functions of the Medical Home Network, including care management and care coordination functions. Many of these functions are consistent with the risk-based managed care organizations; however, the Medical Home Network is not responsible for certain functions including claims processing. The DHHS processes the claims for Medical Home Network enrollees on a fee-for-service basis. Given the limited scope of administration functions, it would be expected that the Medical Home Network administration fee would be less than the administration component of the risk-based managed care capitation rate. The administration component of the capitation rate is projected to be $26 per member per month for the current contract period beginning April 2012. A more refined comparison of the Medical Home Network administration fee and the capitation rate administration fee could be performed as part of the contract renewal process for the Medical Home Networks.

The Medical Home Networks also receive shared savings through the current contract with DHHS. The shared savings are required to be shared with the primary care providers with the primary care provider receiving 60% of the shared savings and the MHN receiving 40% of the shared savings amounts. It is anticipated that the shared savings methodology will be reviewed during the next contract renewal with the MHNs.

LAC Report Recommendation #3. "The Department of Health and Human Services should communicate with the South Carolina Department of Insurance about DOI's financial solvency review of Medicaid MCOs.

Comment: As specified in federal regulation 42 CFR 432.6(c), the capitation rates must meet the following requirements.

- have been developed in accordance with generally accepted actuarial principles and practices;
- are appropriate for the populations to be covered and the services to be furnished under the contract; and

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- have been certified as meeting the requirements of the regulation by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

The Department currently contracts with an independent actuarial consulting firm, Milliman, Inc., to perform the actuarial certification of the capitation rates. The capitation rates have been developed from either fee-for-service experience or managed care encounter data. The historical data is adjusted for many factors including, but not limited to: contracted service differences, provider reimbursement, population variances and expected health care management. The rates are then certified as actuarially sound by a qualified actuary. The actuaries that provide these services for the Department have an extensive amount of experience in multiple states in setting capitation rates.

In addition to meeting the federal regulation, the capitation rate setting process in the Medicaid managed care environment is different than the commercial health insurance market. The Medicaid managed care contracted rates are established as actuarially sound for the populations to be covered and the benefits to be furnished. The Medicaid capitation rates are certified as meeting this requirement. However, the certification does not guarantee adequacy for all contracted health plans. The following provides the definition of actuarially sound rates as specified in the American Academy of Actuaries Health Practice Council Practice Note, "Actuarial Certification of Rates for Medicaid Managed Care Programs", August 2005.

> Actuarial Soundness—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 premiums, including expected reinsurance and governmental stoploss 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, any state-mandated assessments and taxes, and the cost of capital.

The Practice Note further clarifies that: "the words "reasonable, appropriate, and attainable" clarify that the costs of the Medicaid benefit plan do not normally encompass the level of all possible costs that any MCO might incur, but only such costs as are reasonable, appropriate, and attainable for the Medicaid program."
This methodology of establishing capitation rates varies from the methods of the development of premium rates in the commercial health insurance market. The actuaries for a commercial health insurance carrier are specifying that the premium rates are appropriate for the specific health insurance carrier or managed care plan. Due to the different certification methodologies of the two programs, the role of the Department of Insurance would also be different.

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LAC Report Recommendation #4. The South Carolina Department of Health and Human Services should track MCO administrative costs annually on a per enrollee basis in order to determine the rate at which administrative costs are rising.

Comment: The LAC Report on page 21 indicated the following:

"MCO administrative costs increased each year at varying rates, depending on the cost increase between years with respect to enrollment increases each year. From FY 06-07 through FY 20-11, we found that:

- Average annual administrative expenses per enrollee increased 24.3%.
- Average monthly enrollment increased 347.5%.
- Total administrative expenses increased 456.4%.

When comparing the rate of growth of MCO administrative expenses to the rate of growth of MCO enrollment from FY 06-07 to FY 10-11, the rate of growth of administrative expense exceeded that of enrollment by 109 percentage points, over 30%." (Table 2.15)

There are several issues that account for the growth in the average annual administrative expense per enrollee. The following also outlines a few comments regarding the values illustrated in Table 2.15 and rate of growth as indicated by the LAC Report.

- Development of Administrative Expenditures: The application of the administrative percentages in Table 2.14 to the Total Expenditures in Table 2.15 is not appropriate. The administrative percentages shown in Table 2.14 are not applied to the total expenditure. The total expenditure value includes supplemental teaching payments. Starting in 2009, the administration percentage does not apply to supplemental teaching payments. Supplemental teaching payments will account for approximately $50 million in FY 2012.

- Higher Morbidity of Population Enrolled in MCOs: During the analysis period illustrated in Table 2.14, the relative morbidity of the population enrolled in the health plans has increased. In FY 2006 – 2007, managed care enrollment was voluntary. Therefore, the healthier lives were enrolled in the managed care plans, which result in a lower medical expenditure and a lower administration expenditure. As mandatory enrollment has been implemented, the relative morbidity of the population enrolled in managed care plans has increased dramatically with the enrollment of more SSI/Disabled beneficiaries, as well as the decrease in selection of the higher morbidity population being enrolled in the health plans rather than choosing fee-for-service. We have introduced a selection factor adjustment to reflect the change in the morbidity of the population enrolled in the MCOs. With the increase in relative morbidity, the administration costs have increased, as well. This issue is addressed further in response to LAC Recommendation #6.

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- Change in Covered Benefits and Populations: During the analysis period, there have been several modifications to the populations and benefits covered. For example, DHHS previously provided stop-loss insurance benefit for high cost newborn population. This would have lowered the relative morbidity within the population. The health plans are now fully at risk for all newborn expenditures.

Finally, to compare with the FY 06-07 administrative value, I have reviewed the most recent actuarial certification of capitation rates for the contract year beginning April 1, 2012. Table 2.15 indicates that the average administrative expense per enrollee was estimated at $348.73 per year or $29.06 per month. The actuarial certification for the current contract year capitation rates indicates an average administrative expense load of $24.04 per month. This equates to a decrease of 17% without regard to enrollment changes, as compared to a 30% increase as developed by LAC.

LAC Report Recommendation #5: The South Carolina Department of Health and Human Services should review, or have reviewed, Medicaid MCO administrative costs, when its analysis of the administrative cost trend reveals MCO administrative costs are not in an acceptable range as determined by its analysis and standards.

Comment: As indicated in the prior comments to LAC Report Recommendation #4, it is our belief that the administrative load has not fallen outside of an acceptable range. The administrative expense load for the current contract years is $24.04 per eligible enrollee per month. The Milliman Research Report, "Medicaid risk-based managed care: Analysis of financial results for 2010" by Jeremy D. Palmer, FSA, MAAA analyzed the statutory annual statements of more than 140 Medicaid managed care plans. Based on results in that report, the national average administration rate is approximately $29.55 per eligible member per month, although the value varies from a 9.1% administrative expense ratio at the 25th percentile to a 14.2% administrative expense ratio at the 75% percentile. The 50th percentile administrative expense ratio was 12.1%. Note, these values do not include any margin for profit or contingency, where the administrative load in the capitation rates does include the profit and contingency margin.

LAC Report Recommendation #6: The South Carolina Department of Health and Human Services should include in its contracts with the MCOs the authority to make mid-contract period adjustments to the administrative allowance of the capitation rate to prevent administrative costs from increasing faster than the rate of enrollment without valid reasons such as changes in morbidity and other risk factors.

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Comment: The administrative portion of the capitation rates paid to the MCOs only increases in relation to the population enrolled and the relative morbidity of the population enrolled. For example, if the population grows by 10%, then the administrative expenditures paid to the health plans will grow by 10%. However, if a higher morbidity population enrolls in the health plan (e.g., more SSI Disabled lives as compared to the Low Income Family lives), then the administrative expenditures paid to the health plans will also grow in relation to the relative morbidity.

In several places throughout the report, it is stated that "Total administrative costs outpaced average MCO enrollment by over 30% over the last five years." (page 21 and others) However, this calculation does not adjust for the morbidity change as observed by the capitation rates. While LAC indicated that the administrative costs outpaced average MCO enrollment by over 30%, the average morbidity of the population exceeded the rate of growth of administrative costs.

The other recommendations outlined in the LAC report will be addressed by DHHS or other contracted vendors. These comments have been provided to DHHS to support discussions with the Legislative Audit Council.

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

If you have any questions regarding the enclosed information, please contact me at (317) 524-3512.

Sincerely,

Robert M. Damler

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/lrb

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ADMINISTRATION

Legislative Audit Council Report

A Limited Review of Medicaid Managed Care Rates and Expenditures and Other Administrative Issues at DHHS

Pharmacy Section

Introduction:

While reimbursement to providers for pharmacy services has decreased by 27%, NET cost for pharmacy products has decreased by 59% over this period. This is a result of the focused approach to evaluating the actual net cost of products as opposed to maximizing rebate dollars without regard to final cost. In addition the implementation of utilization management techniques and the enhancement of the Maximum Allowable Cost (MAC) program contribute to a reduction in net cost of pharmacy dispensed products for SCDHHS.

SFY	Payment	FFS rebate	Net Payment
07	$366,387,527	$119,836,708.08	$246,550,818.83
08	$374,992,693	$151,772,519.81	$223,220,172.86
09	$305,028,195	$153,987,752.16	$151,040,442.42
10	$268,268,640	$125,967,857.59	$142,300,782.66
11	$266,883,508	$166,825,061.44	$100,058,446.56

Pharmacy Rate Methodology:

The report comments on variation of dispensing fee and copay among sister states. In order to accurately compare reimbursement across states, the determination of ingredient cost should be factored into the equation. The table in the report has been revised to include ingredient cost determination and more definition around dispensing fees. All of the states included in the report, including South Carolina, utilize logic which incorporates Maximum Allowable Cost (MAC) and Federal Upper Limit (FUL) pricing. It is important to note that there is wide variability in the states' approach to determining ingredient cost which makes direct comparison difficult.

State	Ingredient Cost	Dispensing Fee
Alabama	AAC ; WAC + 9.2% Clotting Factors – ASP + 6%	$10.64 $10.00 (tab split/maint)
Florida	AWP – 16.4% WAC + 1.5%	$3.73 $7.50 (340B only)
Georgia	AWP - 11% ** other rates for specialty and injectables*	$4.63 (for profit) $4.33 (not-for profit)
Kentucky	AWP – 14% (generic) AWP – 15% (brand)	$4.50 (brand) $5.00 (generic)
Mississippi	AWP – 12% (brand) WAC + 9% (brand); AWP – 25%	$3.91 (brand) $5.50 (generic)
North Carolina	WAC + 7% AWP – 14.5%	$4.00 (brand) $5.60 (generic)
South Carolina	WAC + .8%	$3.00 *Variable fee for cmpds*
Tennessee	AWP – 13%	$2.50 (brand) $3.00 (generic) $5.00 (brand NH) $6.00 (generic NH) $25 (compound)

The report notes that reimbursement to pharmacy providers had not been evaluated or revised until 2011. Prior to 2011, South Carolina Medicaid pharmacy reimbursement was legislatively mandated to be: AWP – 10% plus a dispensing fee of $4.05.

This report was published for a
total cost of $49;
65 bound copies were printed
at a cost of 76¢ per unit.