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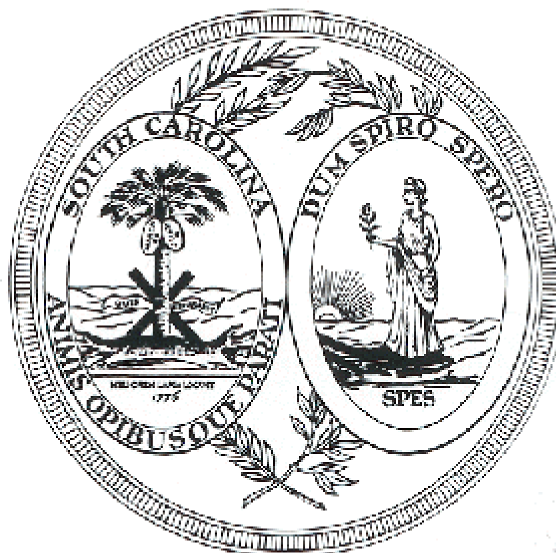
Report to the General Assembly

January 2003

# Options for Medicaid Cost Containment



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South Carolina Legislative Audit Council

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Report to the General Assembly

# Options for Medicaid Cost Containment

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# Synopsis

Due to continuing concerns about the growth in Medicaid expenditures and number of recipients, members of the General Assembly requested that we review the South Carolina Medicaid program. This is our third recent Medicaid report. Two LAC reports published in 2001 focused on fraud and abuse, prescription drug costs, state funding, managed care, premium payments, and the eligibility determination contract with the Department of Social Services.

The audit requesters were primarily concerned with identifying ways to reduce the cost of the Medicaid program without reducing services. We reviewed Medicaid enrollment and how the Department of Health and Human Services (DHHS) ensures that only eligible people receive Medicaid and that the recipients use those benefits appropriately. We also looked at strategies that the department can use to improve the cost-effectiveness of the Medicaid program including a state preferred prescription drug list, a focus on community long term care, recipient cost sharing, estate recovery, and debt collection.

In South Carolina, Medicaid is a $3.6 billion program, with the federal government paying approximately 69%. In FY 01-02, DHHS spent about $480 million in state general funds. From FY 99-00 through FY 01-02, total Medicaid expenditures increased 25% for an average of 12% or $360 million a year. During the same period, general fund revenues in the state *decreased* 1.53%. The growth in Medicaid is also tied to the growth in private health care spending, and states cannot control health care costs on their own. However, strategies that can slow the rate of growth by 2% to 3% can result in millions of dollars of savings.

Our findings include the following:

- DHHS could improve the application process to better verify if a Medicaid applicant has private health insurance. There is only one question about private health insurance included in the Medicaid application. The department also needs to ensure that the Medicaid eligibility quality assurance division and its reviews are used to strengthen the eligibility determination process.

- The Medicaid program has experienced rapid growth in two eligibility categories — low income families and transitional Medicaid for former welfare recipients. In order to restrict enrollment in these groups, DHHS could limit income disregards, conduct more frequent eligibility reviews, and eliminate the second year of transitional Medicaid, which is not required by federal law. DHHS is already taking steps to implement these changes.

- DHHS should improve its process for identifying cases of recipient fraud. While prescription drugs are a common area for recipient fraud, the DHHS pharmacy division does not routinely share information from its point-of-sale system that would help the program integrity unit to identify cases of recipient and provider fraud.

- The S.C. Medicaid program includes several groups that are not required by federal law to be covered. However, eliminating coverage for these individuals would most likely result in severe consequences for them as well as for the state and the health care market in general.

- DHHS has slowed the growth in prescription drug expenditures to an increase of only one-third of one percent in FY 01-02. However, it could further reduce costs by implementing a state preferred drug list similar to that used by the state of Michigan. In November 2002, DHHS began the process to amend the State Medicaid Plan and request federal permission to allow for a state preferred drug list.

- Only six of the top 50 drugs used in the S.C. Medicaid program require prior approval from DHHS. One drug in particular, OxyContin, a narcotic pain reliever, should be placed on the prior approval list.

- In order to control the costs for long term care, DHHS will need to shift its focus from nursing homes to home and community-based care (CLTC). Nursing home care for Medicaid recipients costs more than twice as much as care in a home or community-based setting. However, there is a waiting list of 3,600 for the CLTC program, and current policy and funding trends favor nursing home care.

- DHHS does not take full advantage of federal options for cost-sharing by Medicaid recipients. These could include charging an enrollment fee for some Medicaid recipients and a co-payment on optional services and hospital admissions.

- DHHS does not use all available methods to collect from the estates of persons who have received Medicaid services. State law limits estate recovery only for CLTC and nursing home services. DHHS should also expand its estate recovery efforts to include placing liens on real property and expanding the definition of estate.

- DHHS could improve its success in collecting unpaid debts from Medicaid providers and recipients by using the S.C. Department of Revenue to collect debts. DHHS needs to adjust its information system to allow regular debt payments to be deducted from providers' reimbursement checks.

We estimated $22.9 million savings in state funds that could occur if DHHS implemented the recommendations in this report. Significant Medicaid savings, in addition to those listed below, are possible based on our analyses in this report and previous reports. Implementing some program changes would require federal approval and revision of the State Medicaid plan, and most savings would take a year or more to be realized. Since it is difficult to accurately project potential savings, we tried to ensure our estimations were reasonable and conservative.

| Our Recommendation | Estimated Savings/Revenues (Based on FY 01-02 Data) |
|---|---|
| Reduce Adult Recipients in Low Income Eligibility Groups by 10% | $4.7 million |
| Enact a State Preferred Drug List | $12.8 million |
| Charge a Medicaid Enrollment Fee | $1.4 million |
| Co-Payment for Optional Services | $3.2 million |
| Co-Payment for Hospital Admissions | $500,000 |
| Increase Estate Recovery | $110,000 |
| Improve Debt Collection | $204,000 |

# Introduction

## Audit Objectives

Members of the General Assembly requested that we review the South Carolina Medicaid program because of continuing concern over increases in the number of Medicaid recipients and expenditures. Other Medicaid reports we have recently published include *A Review of Selected Medicaid Issues: Fraud and Abuse, Prescription Drug Costs, Funding* (February 2001), and *Cost Savings Strategies for the South Carolina Medicaid Program* (October 2001).

The S.C. Medicaid program is administered by the Department of Health and Human Services (DHHS). Based on the concerns of audit requesters, legislative committee staff, and DHHS staff, we have established the following objectives for this report:

- Identify state and federal policies that determine Medicaid eligibility and influence cost and utilization of services.
- Determine which services and client groups accounted for cost increases over the past three years.
- Identify options for, and the impacts of, reducing enrollees and/or coverage for medical services.
- Review DHHS's system for verifying Medicaid eligibility.
- Review DHHS management controls used to prevent and identify recipient fraud and abuse of Medicaid.
- Identify cost-savings strategies for the Medicaid prescription drug program, especially strategies adopted by other states.
- Determine the cost-savings potential of third party recoveries, including recipient premiums and co-payments and estate recovery for nursing home clients.

Previous LAC reports focused on fraud and abuse, prescription drug costs, state funding, managed care, premium payments, and the eligibility determination contract with the Department of Social Services.

## Scope and Methodology

The period of our review was generally from FY 99-00 through FY 01-02. Our sources of information included:

- South Carolina appropriations acts and other relevant statutes as well as federal law, primarily Title XIX of the Social Security Act.
- Information on recipients, transactions, and expenditures generated by DHHS's Medicaid management information and accounting systems.

- Agency policies and procedures, Medicaid bulletins, and the State Medicaid plan.
- Interviews with staff at DHHS as well as other state agencies and health care providers.
- Telephone interviews with Medicaid officials in other states and Medicaid reviews performed by other states.
- Material from the federal Centers for Medicare and Medicaid Services (CMS), the Kaiser Family Foundation, the National Conference of State Legislatures, the National Governor's Association, and various health care studies.

Computer generated data used in the report was supplied by DHHS and CMS. While we did not directly test the data, we accepted DHHS data as reliable for our purposes. DHHS uses the Medicaid management information system to generate federally-required reports which must be within federal data standards. Appendix A contains further information about the Medicaid data used in the report. Also, during the time of our review, DHHS was in the process of revamping its system for eligibility determination and quality control. Therefore, we did not review Medicaid recipient files to determine the accuracy of eligibility information but rather reviewed how DHHS plans to revise the eligibility determination process.

This audit was conducted in accordance with generally accepted government auditing standards.

## Background

Medicaid is a joint state-federal program created under Title XIX of the Social Security Act that funds health care for millions of poor, elderly, and disabled individuals nationwide. In South Carolina, Medicaid is a $3.6 billion program and is managed by the Department of Health and Human Services (DHHS). Health care is provided to Medicaid recipients by doctors, dentists, pharmacists, and other health care professionals enrolled in the Medicaid program. Any qualified provider is allowed to enroll and provide services. Payments are made directly to the provider, who bills DHHS for a specific service provided to an eligible recipient. Under federal law, state Medicaid programs must cover the costs of medical care such as inpatient and outpatient hospital services; physician visits; medical and surgical dental services; home health care; family planning services and supplies; and laboratory and x-ray services. In addition, DHHS channels Medicaid funding to other state agencies which provide services to Medicaid-eligible clients, such as the departments of Mental Health and Disabilities and Special Needs.

In South Carolina, Medicaid is the second largest program in the state budget, behind education.

DHHS is appropriated state and other funds to provide the match needed to receive the federal share of Medicaid funding. For FFY 01-02, the federal share of Medicaid medical spending in S.C. was 69.34%. The match rate differs for each state, and is determined by the per capita income in the state. After slowly decreasing for the past several years, the federal match rate for South Carolina will increase in FFY 02-03 to 69.81%.

According to the National Association of State Budget Officers, "Medicaid expenditures account for 20% of all state spending. … Medicaid spending has escalated in recent years, and combined with a dramatic revenue slowdown in states, is the most significant cost issue affecting state budgets." In South Carolina, Medicaid is the second largest program in the state budget, behind education.

Health care costs in general have increased. According to the S.C. Department of Insurance, rates for individual and small group health insurance plans rose 18% – 20% in 2000-2001. Payments per subscriber in the South Carolina state employee health plan increased 11% in 2000-2001.

The growth in Medicaid costs has been of particular concern to state legislatures. Of the 49 states responding to a survey conducted by the National Association of State Budget Officers, 39 states experienced Medicaid shortfalls in FY 2001. On average, Medicaid spending nationally grew 25% during 2001 and 2002. The reasons for the increase in costs in recent years stem from both increased caseloads due to the downturn in the economy as well as price increases in the health care sector. We found that concerns about Medicaid in South Carolina were no different from those in other states.

## Growth in Medicaid Expenditures in South Carolina

From FY 99-00 through FY 01-02, total Medicaid expenditures increased 25%, with an average rate of growth of 12% or about $360 million per year. Each medical services category showed a spending increase, as illustrated in Table 1.1.

## Table 1.1: Medicaid Spending in South Carolina

| | FY 99-00 | FY 00-01 | FY 01-02 | 2-Year Increase |
|---|---|---|---|---|
| Medical Services | | | | |
| Hospital | $522,328,501 | $539,588,905 | $616,263,806 | 18% |
| Nursing Home | 323,998,103 | 341,331,485 | 360,362,235 | 11% |
| Disproportionate Share[1] | 374,783,790 | 371,947,763 | 391,164,960 | 4% |
| Pharmaceutical[2] | 334,121,130 | 416,489,852 | 417,965,171 | 25% |
| Physician Services | 158,848,726 | 184,129,357 | 203,633,032 | 28% |
| Dental Services | 36,766,832 | 70,630,456 | 79,718,384 | 117% |
| CLTC-Based Services [3] | 90,200,681 | 90,030,706 | 92,525,708 | 3% |
| Other Medical Services | 97,163,686 | 112,053,937 | 140,817,021 | 45% |
| Family Planning | 12,672,946 | 13,162,199 | 15,740,278 | 24% |
| Medicare Premiums[4] | 68,468,227 | 74,654,000 | 82,454,600 | 20% |
| Hospice Program | 2,590,427 | 3,026,984 | 3,384,361 | 31% |
| Residential Services | 15,450,655 | 16,143,117 | 16,088,596 | 4% |
| Clinical Services | 51,612,816 | 60,948,026 | 62,713,300 | 22% |
| Durable Medical Equip | 36,688,882 | 41,798,978 | 38,657,053 | 5% |
| Sub-Total Medical Services | $2,125,695,402 | $2,335,935,765 | $2,521,488,505 | 19% |
| Other State Agencies | 655,191,532 | 775,129,438 | 960,116,474 | 47% |
| Health Services Contracts[5] | 81,625,945 | 89,312,712 | 100,705,120 | 23% |
| Administration, Medical Management | 33,248,627 | 33,484,618 | 38,100,248 | 15% |
| GRAND TOTAL | $2,895,761,506 | $3,233,862,533 | $3,620,410,347 | 25% |
| | | | | |
| State General Funds | $490,551,339 | $472,221,603 | $480,643,390 | -2% |
| Other State Matching Funds | $400,851,893 | $512,451,344 | $645,267,718 | 61% |

1 Disproportionate share provides supplemental payments to hospitals that serve a large number of Medicaid and uninsured patients.
2 Expenditures do not include rebates and also reflect accounting adjustments which move some prescription drug expenditures to other service lines.
3 Community long term care; adjusted to include costs for Palmetto Senior Care.
4 Medicare premiums and co-pays for eligible individuals.
5 Contracts are for the management of claims and Medicaid information systems, nursing aides' training, and eligibility determination.

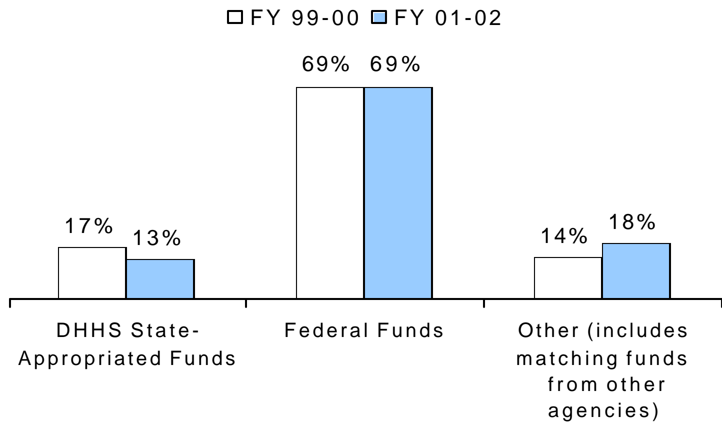
Source: DHHS, Program Structure Appropriation Summary Status Reports (GAFRS)

While Medicaid spending increased 25% . . . the state's general fund revenues . . . *decreased* 1.53%.

Medicaid expenditures by other state agencies increased almost twice as much as Medicaid spending in general. Most of this is due to state efforts to claim federal Medicaid matching funds for services previously provided by other state agencies with state funds. The Department of Disabilities and Special Needs and the Department of Mental Health account for the majority of Medicaid spending by state agencies other than DHHS.

Continued growth in Medicaid spending will have serious implications for the state's budget. While Medicaid spending increased 25% from FY 99-00 to FY 01-02, the state's general fund revenues during this time *decreased* 1.53%. Since South Carolina's match rate for federal Medicaid funding is approximately 69%, the state must provide 31% in matching funds in order to receive the federal funds. The state match can come from general fund appropriations as well as other sources, including hospital taxes, tobacco settlement funds, and funds allocated to other state agencies which provide health services to Medicaid-eligible clients. In FY 99-00, DHHS's state general funds accounted for 17% of total Medicaid appropriations, but by 2002 this had decreased to 13%, reflecting the increasing role played by matching funds from other state agencies.

**Figure 1.2: Source of Medicaid Funds**




Source: DHHS, Program Structure Appropriation Summary Status Reports (GAFRS)

## Increase in Medicaid Recipients

A primary factor fueling the growth in S.C.'s Medicaid program has been the number of individuals receiving Medicaid coverage, which increased 18% from FY 99-00. DHHS paid Medicaid claims for 816,112 recipients in FY 01-02. Eligibility for Medicaid coverage is based primarily on three criteria C income, age, and disability.

INCOME Almost all recipients of Medicaid have to meet strict income limits and asset tests, and many have incomes that are at 100% of federal poverty levels or below. Different client groups are covered at different income levels. For example, recipients eligible under the "low income families" category must be at 50% of poverty or below. Pregnant women and infants are eligible for Medicaid if the family's income is up to 185% of poverty.

AGE Children (up to age 19) are categorically eligible for Medicaid if their families' incomes are less than 150% of poverty. Clients age 65 and older are also eligible if they meet income and asset standards. Most other adults, even if they are below poverty guidelines, are not eligible for Medicaid unless they are also disabled.

DISABILITY Clients of all ages are covered by Medicaid if they are completely and permanently disabled and also meet income guidelines.

Table 1.3 shows the major eligibility categories, recipients, and Medicaid expenditures for FY 01-02, and the increase since FY 99-00. Appendix A shows data from the 2000 census on statewide poverty levels compared with the number of Medicaid eligible individuals in 1999.

Caring for elderly and disabled people is a major area of Medicaid spending. Compared to children and families, these groups are likely to be in poorer health or to need long term care. In FY 01-02, about 64% of S.C.'s Medicaid expenditures were for the elderly and disabled and 36% were for low income families and children.

### Table 1.3: Increases in Recipients and Costs by Major Coverage Groups in South Carolina

| Categories | Requirements | FY 01-02 | | Increase from FY 99-00 | |
|---|---|---|---|---|---|
| Low Income Families and Children | | Recipients[1] | Expenditures[2] | Recipients | Expenditures |
| Low Income Children | Children under 100% of poverty traditionally covered by Medicaid plus children up to 150% poverty added under the Partners for Healthy Children Program | 280,153 | $339,303,892 | 19% | 42% |
| Low Income Families | Must have child under age 18 in the home & receive welfare benefits or have family income below 50% of poverty | 172,456 | $248,277,377 | 71% | 120% |
| Pregnant Women & Infants | Pregnant women and infants under age 1, up to 185% of poverty | 104,004 | $237,722,731 | -5% | 3% |
| Transitional | Families who leave welfare due to earned income have 2 years of Medicaid benefits if under 185% of poverty | 76,227 | $83,622,675 | 38% | 86% |
| Family Planning | Expanded family planning services (no other health care) to post-partum women up to 185% of poverty. | 66,367 | $14,961,741 | -3% | 25% |
| TANF Sanctioned | Welfare recipients who have lost benefits due to sanctions; children in family still Medicaid-eligible | 14,989 | $15,011,760 | -26% | 5% |
| Foster Care & Adopted | Children up to age 21 at least partially supported by the state, living in foster homes or institutions; children with a state adoption assistance agreement | 9,271 | $74,306,220 | 11% | 17% |
| Elderly and Disabled | | | | | |
| Supplemental Security Income (SSI) | Aged (65+), blind or disabled individuals who receive supplemental security benefits; income less than $545 a month | 118,998 | $848,320,382 | -2% | 11% |
| Aged, Blind & Disabled (ABD) | Aged, blind, or disabled individuals with income limit of $716 / month; includes qualified Medicare beneficiaries (QMB) | 61,125 | $294,558,366 | 8% | 14% |
| Medical Assistance Only | Aged, blind or disabled and meets intermediate or skilled care criteria; receives nursing home or home & community based "waivered" service; income limit is $1,365 a month. | 29,398 | $554,432,291 | 4% | 11% |
| Optional State Supplement (OSS) | Must live in a residential care home and meet SSI criteria except income limit is $893 a month. | 6,737 | $73,593,101 | 4% | 24% |
| TEFRA | Severely disabled children living at home. Parent income not counted. | 2,447 | $15,464,832 | 31% | 66% |
| Working Disabled | Under age 65, totally & permanently disabled but working. Family income up to 250% of poverty. | 108 | $873,767 | 74% | 226% |
| TOTALS | | 816,112 | $2,800,449,134 | 18% | 21% |

1 The number of recipients is unduplicated for each category but they cannot be added together since some individuals may "shift" from one category to the other during the course of one year. See Appendix A for further information on recipient data.

2 Expenditures will not total those reported for FY 01-02 in summary status reports Table 1.1 because these costs do not include disproportionate share, Medicaid administration, and Medicaid contracts, and also do not reflect certain accounting adjustments.

Source: DHHS Information on Major Coverage Groups and MARS reports

## What are the Options?

A 2002 report from the National Conference of State Legislatures summarized the issues of controlling health care costs:

> Few challenges legislators face are as difficult and complex as the urgent need to wisely manage health care spending, particularly in the Medicaid program. Curtailing spending in an arbitrary way creates the risk of real harm to needy senior citizens, people with disabilities, and adults and children who have few or no other options to have their medical costs covered. Yet, failure to rein in program costs can wreak havoc on all other legal and programmatic state responsibilities such as education, environment, criminal justice, economic development, and non-health related human services. [*Forum for State Health Policy Leadership, National Conference of State Legislatures]*

In this report we examine some of the specific causes for the increases in South Carolina's Medicaid costs and make some targeted recommendations for cost containment. In general, options for controlling the growth in Medicaid spending include limiting enrollments and ensuring that services are delivered in the most cost-effective manner.

It is important to remember that South Carolina is not the only state facing a budget crisis in its Medicaid program, and that the growth in Medicaid is tied to the growth in private health care spending. As stated by the NCSL, "States cannot on their own reverse the overall growth in health sector spending." However, strategies that can slow the rate of growth by two to three percent can result in millions of dollars of savings. We have made recommendations with this goal in mind; however, due to time and personnel constraints we could not review all areas of the Medicaid program for cost-savings potential. The General Assembly and the Department of Health and Human Services should continue to review the Medicaid program to find the most efficient and effective ways to fund health care for needy individuals.

## Glossary

### Centers for Medicare and Medicaid Services (CMS)

The federal agency that administers Medicare, Medicaid, and the State Child Health insurance programs. Formerly called the Health Care Financing Administration (HCFA).

### Community Long Term Care (CLTC)

The Medicaid waiver program that authorizes home and community-based services for individuals in need of long term care and includes personal care aides, respite care, adult day health care, home management services, homemaker services, nursing services, attendant care services, and home modifications.

### Disregards

Amounts deducted from the incomes of low income families that reduce income to the level necessary to qualify them to receive Medicaid benefits.

### Disproportionate Share

Supplemental payments provided directly to Medicaid-participating hospitals that serve a disproportionate or large number of Medicaid and uninsured patients.

### Eligible Counts

The count of individuals who have applied for and were enrolled in the Medicaid program each month.

### Family Independence Act (FIA)

South Carolina's welfare reform law.

### Management and Accounting Reporting System (MARS) Reports

Medicaid reports that show by month and year-to-date the number of transactions, recipients, expenditures and in-patient days for each type of medical service and for each eligibility group.

### Matching Funds

For each Medicaid dollar spent in South Carolina, about 69% comes from the federal government and South Carolina matches 31% .

### Medicaid Management Information System (MMIS)

The system that processes Medicaid eligibility and pays claims. Its chief function is to receive, edit, and adjudicate claims from providers of health services. The mainframe is physically located at Clemson University where hardware, software, support and personnel are provided.

### Partners for Healthy Children
South Carolina's expanded Medicaid program for children, which receives an enhanced match (79%) and is authorized by the federal State Child Health Insurance Program (S-CHIP). Children ages 1-5 between 133% and 150% of federal poverty are covered as well as children ages 6-19 between 100% and 150% of poverty. (Children ages 1-5 up to 133% of poverty and ages 6-19 up to 100% of poverty were already covered under regular Medicaid.)

### Recipient Counts
A count of individuals for whom Medicaid claims were paid during the year.

### Supplemental Security Income (SSI)
A federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind, and disabled people, who have little or no income; it provides cash to meet basic needs.

### Surveillance Utilization and Review System (SURS)
A system used to monitor Medicaid usage on a post-payment basis. It can be used to monitor trends in billing and utilization of medical services, and is designed to identify patterns that can indicate misuse, fraud or abuse of Medicaid.

### Silver Card Plus
A prescription drug program for low-income South Carolina seniors (65 years or older). They must not have access to insurance coverage or any other assistance for prescription drug purchases.

### TEFRA Children (Tax Equity and Fiscal Responsibility Act)
A provision of the 1982 act, also known as the Katie Beckett option, TEFRA is a category of Medicaid that provides care to disabled children in their homes rather than in institutions.

### Temporary Assistance for Needy Families (TANF)
Federal welfare program which provides welfare funding as a block grant to states.

# Medicaid Enrollment: Controlling Eligibility

In this chapter, we review how the Department of Health and Human Services ensures that only eligible people receive Medicaid and that recipients use those benefits appropriately. We examined:

- The optional and mandatory Medicaid eligibility groups and the eligibility requirements for these groups.
- The process the department follows to determine eligibility and how the agency monitors the determination.
- The department's procedures for handling recipient fraud and abuse.

DHHS could slow Medicaid spending by tightening eligibility criteria for low income families and improving efforts to recoup funds for recipient fraud cases. It is difficult to accurately project savings that could be realized through these actions. However, we estimated that a 10% decrease in the number of adult recipients, eligible through the "low income families" and "transitional" Medicaid categories, would represent a $4.7 million savings in state funds.

## Medicaid Eligibility

We have identified ways that DHHS can improve the process to ensure that only eligible persons receive Medicaid benefits. These include better utilization of eligibility quality assurance information and identification of private health insurance. Furthermore, the eligibility criteria for low income groups can be strengthened to reduce Medicaid enrollments and expenditures.

### Eligibility Determination

Since its creation in 1983, DHHS has been required by state law to contract for Medicaid eligibility determination. DHHS had contracted with the Department of Social Services (DSS) to conduct the determinations at an annual cost of approximately $34 million. Beginning in July 1, 2002, the appropriations act required DHHS to be responsible for determining the eligibility of applicants for Medicaid. As of October 2002, 672 permanent and temporary employees transferred from DSS to DHHS. Because DSS had also used family independence and food stamp workers to determine Medicaid eligibility, DHHS estimates that it will have to perform this function with 20% less personnel. In order to compensate for this shortfall, workers may work in more than one county, and DHHS is using more sponsored workers. "Sponsored" workers are eligibility workers who are partially funded by providers but are still considered state employees.

DHHS has also developed a new information system, Medicaid Eligibility Determination System (MEDS), to assist workers in the eligibility determination process. It contains eligibility information and allows workers to enter data more easily. The system went into statewide use in October 2002. DHHS has taken other steps to streamline some of the eligibility process:

- DHHS contracts with the Vocational Rehabilitation Department (VR) to conduct disability determinations. These records are now being scanned into computer databases, and VR provides a weekly update on the status of these determinations.

- Recipients now receive annual plastic Medicaid cards instead of the monthly paper cards. Providers can verify eligibility over the telephone or electronically.

Because DHHS has just assumed the responsibility for determining eligibility for Medicaid, we did not test the accuracy of their process by sampling client files. We did review DHHS's polices and procedures in the following three areas — income determination, identification of private- or employer-sponsored health insurance, and quality assurance.

## Income Determination

A key part in determining if someone is eligible for Medicaid is verifying the individual's income and assets. Federal and state laws require that Medicaid recipients meet certain income limits, usually the federal poverty limit, which is $8,860 for an individual and $15,020 for a family of three. Most individuals also have to meet a resource test and not possess assets of more than $2,000 for an individual and $3,000 for a couple, with some exceptions.

In order to verify income and assets, DHHS staff are using some of the following methods:

INCOME — Workers review pay stubs, forms filled out by the employer, or federal tax records for those that are self employed. They also perform a search using the Income and Eligibility Verification Systems (IEVS) – an automated wage and income matching system that holds past and present income.

RESOURCES AND ASSETS — Staff obtain information about bank accounts, use standard sources to determine the value of autos and other personal property, or consult property assessments.

We concluded that these procedures were standard and reasonable, and if consistently applied, should adequately verify the income and resources of an individual applying for Medicaid. Income verification will also be monitored by DHHS's quality control process (see p.14). DHHS staff have stated they are planning to use additional sources, such as the Department of Revenue, to verify income of low income families.

## Private Health Insurance

DHHS is refining the application process to better verify if a Medicaid applicant has private or employer-sponsored health insurance. The department currently has a contract for Medicaid insurance verification services and uses other means to identify recipients who have other insurance and don't report it. Federal law requires that Medicaid be the payor of last resort; so private health insurance is supposed to pay first. Additionally, recipients may be eligible for the Health Insurance Premium Payment (HIPP) program that pays the premiums and co-insurance for private health insurance when it is cost-effective.

Medicaid policy requires recipients to report existing private health insurance. However, there is only one question about private health insurance included in the Medicaid application, and according to a DHHS official, eligibility workers do not usually discuss this issue during the application process. According to DHHS officials, Medicaid applicants do not always report private health insurance because of a misconception that persons with private health insurance are not eligible for Medicaid. DHHS has stated that it will improve training for eligibility workers to enhance skills used to interview Medicaid applicants to determine resources.

When Medicaid recipients do not report their coverage by private health insurance, DHHS pays for claims that should be covered by this insurance. Recipients sometimes drop their private insurance when they become eligible for Medicaid. This results in "crowd-out" of the private insurance market. Crowd-out occurs when the eligibility for public programs causes individuals to drop their private coverage and switch to public programs such as Medicaid. Some of these recipients may also be eligible to participate in the HIPP program.

In limited circumstances it may cost less in state funds to cover some children under Medicaid than under the state employees' health plan. According to information from the B&CB division of insurance, the average cost in state dollars to cover the dependent children of state employees was $27.70 per person per month (based on data for October 2002). The average Medicaid monthly expenditures for children under age 19 in FY 01-02 were

$102.83. For those children covered under the Partners for Healthy Children program, which receives an enhanced federal match, the state share would average $21.87 per month. For children covered under regular Medicaid the state share would average $31.25 per month. (The data used in this analysis is discussed further in Appendix A.) According to DHHS, 3,451 dependents of state employees shifted coverage from the state health plan to Medicaid as of October 2001. It should be noted that federal law prohibits states from deliberately shifting employees from state health plans onto Medicaid. However, state employees who are also eligible for Medicaid can make their own decision to drop state health insurance and enroll in Medicaid.

## Medicaid Eligibility Quality Assurance

As part of the transfer of eligibility functions from DSS, DHHS became responsible for monitoring Medicaid eligibility determinations. This monitoring is required by federal law and is conducted by the Medicaid eligibility quality assurance (MEQA) division. When DSS conducted these reviews, they sampled approximately 175 open cases for each six-month period, and reported that the error rate for FY 99-00 through FY 00-01 was 0%.

As an alternative to these standard reviews, federal law allows states to conduct pilot projects which target certain eligibility groups or program administration. The FY 02-03 appropriations act specifically directs DHHS to review outstationed workers. DHHS has received approval from the federal Centers for Medicare and Medicaid Services (CMS) to conduct a review of the eligibility determinations made by sponsored workers in larger hospitals. The act also requires DHHS to “improve the accuracy and integrity of the eligibility determination program.” The MEQA division has plans to conduct targeted reviews of eligibility groups in future years.

DHHS should incorporate the MEQA process and its findings into the eligibility program. The department does not have a written policy to formalize communication between the eligibility division and the MEQA division. The findings from the MEQA review are intended to improve the eligibility process.

## Recommendations

1. The Department of Health and Human Services should strengthen its controls over the identification of private health insurance available to Medicaid applicants.

2. To strengthen eligibility determination controls, the Department of Health and Human Services should institute a formal process for communication between the eligibility division and Medicaid eligibility quality assurance division.

## Growth in Certain Eligibility Categories

DHHS is in the process of strengthening eligibility criteria for certain low income enrollment groups. The Medicaid program has experienced rapid growth in two eligibility categories from FY 99-00 to FY 01-02. Recipients eligible through the low income families and transitional Medicaid categories have increased 71% and 31%, respectively. Medicaid spending on low income families increased 120% and transitional Medicaid increased 86% during this period. Reducing the enrollment of adults in these categories could result in a savings of $4.7 million in state funds.

### Low Income Families

The low income families (LIF) eligibility category includes welfare recipients in the S.C. Family Independence program as well as very low income families who do not receive a welfare check but meet the same income limits. In FY 01-02 there were 172,456 recipients in this category with Medicaid expenses of more than $248 million. Federal law makes Medicaid coverage mandatory for these families. DHHS is aware of the increase in the number of recipients in this category, and has surveyed eligibility workers to identify reasons for this growth and ways to limit the increase in low income families.

One of the reasons for the increase in low income families receiving Medicaid may be the economic downturn in the state. In South Carolina, there was a 24% increase of Family Independence cases from January 2000 to December 2001. Persons receiving welfare are automatically eligible to receive Medicaid. According to a DHHS official, the economy has caused recipients to work fewer hours or lose their jobs due to layoffs.

## Transitional Medicaid

Transitional Medicaid benefits are available to families who leave the low income families category or welfare because of increased income due to finding a job or losing income disregards. In FY 01-02 there were 76,227 recipients in this category with Medicaid expenses of $83.6 million. Federal law requires that former welfare and LIF recipients be eligible for one year of transitional Medicaid. This year is divided into two six-month stages. The first six months are virtually unconditional. The second six months cover recipients whose earnings are less than 185% of poverty after a $200 child care deduction.

In addition, §43-5-1240(A) of the S.C. Family Independence Act entitles recipients in this category to a second year of transitional Medicaid if a client's gross income, after disregards and childcare deductions, is 185% of poverty or less. If the former welfare or LIF recipient is earning too much to meet the 185% of poverty income limit, he or she gets only the one year of transitional Medicaid.

One reason for the increase in recipients under the transitional Medicaid category is that 17,037 welfare recipients in 2000 and 2001 found jobs and left welfare.

## Assumptive Eligibility

The practice of assumptive eligibility is another area that increases Medicaid costs. Assumptive eligibility occurs when an applicant is approved for Medicaid pending verification of information such as income and resources. If a recipient receives services and is then found to be ineligible, the recipient does not have to reimburse Medicaid. For example, for FYs 00-02, the department estimated that 2,488 recipients in the low income families category were approved under assumptive eligibility but were later determined to be ineligible. About 136 of the recipients received Medicaid services costing an estimated $46,456.

## Options for Reducing Enrollments and Costs

While coverage of low income families and transitional Medicaid is required by federal rules, DHHS is currently preparing State Medicaid Plan amendments that could limit enrollment in these categories. These and other changes should include:

- Changing the "disregards" taken. In order to become eligible for Medicaid under the LIF category, families can disregard or exclude 50% of gross monthly earned income for the first four months of

If low income families lost Medicaid eligibility due to changes in criteria, the children in the family would still be eligible . . . .

employment, and then disregard $100 of earned income monthly after that. Fifty dollars of the total amount of child support received by the applicant is also disregarded each month. The disregards allow more families to meet the income limits required for Medicaid eligibility. To change the amounts disregarded, DHHS will need approval from the Centers for Medicare and Medicaid Services.

- Requiring more frequent eligibility reviews. A client's eligibility is typically reviewed once a year to determine if he or she is still eligible. Low income families and transitional Medicaid may be groups at higher risk for abuse. Therefore, the department should consider reviewing the eligibility of LIF and transitional Medicaid recipients every three to six months to ensure they are still eligible.

- Eliminating the second year of transitional Medicaid. The second year of transitional Medicaid is required only under the S.C. Family Independence Act. DHHS offers the second year of transitional Medicaid under waivers which are due to expire June 1, 2003.

- Eliminating assumptive eligibility for the low income groups. DHHS does not need federal approval to discontinue assumptive eligibility. DHHS informed us in December 2002 that it plans to implement this change for all eligibles (except pregnant women) effective January 2003.

It should be noted that the low income families and transitional Medicaid coverage groups include relatively healthy adults who are probably working, since their eligibility is linked to welfare status, not age or disability. These adults are the least medically needy out of all the eligibility groups and could be an area where the department could decrease enrollment. If low income families lost Medicaid eligibility due to changes in criteria, the children in the family would still be eligible under regular Medicaid or the expanded children's health insurance program.

It is difficult to estimate the amount of Medicaid funds that could be saved if enrollment was reduced by taking these steps. For example, DHHS's eligibility data system does not contain statistics on the incomes and poverty levels of recipients. Reducing the number of adult recipients (age 19 and older) in the low income families category by 10% would mean $3.4 million in potential savings in state funds. Reducing the number of adults by 10% in transitional Medicaid would mean $1.3 million in potential savings in state funds.

## Recommendations

3. The Department of Health and Human Services should proceed with amending the state plan to change or eliminate the following income disregards:

   - The low income families Medicaid category's 50% of gross monthly earned income disregard.
   - The disregard of $50 of total child support received by the applicant.

4. The General Assembly may wish to revise S.C. Code §43-5-1240(A) so that it includes only one year of the federally-mandated transitional Medicaid instead of the two years of transitional Medicaid for low income families and welfare recipients.

5. The Department of Health and Human Services should consider reviewing the eligibility of low income families and transitional Medicaid recipients at three- to six-month intervals rather than annually to ensure that only eligible people are receiving Medicaid.

6. The Department of Health and Human Services should proceed with eliminating assumptive eligibility.

7. The Department of Health and Human Services should continue to review the eligibility criteria for Medicaid to identify areas where changes can be made to slow the growth in the number of Medicaid recipients.

## Recipient Fraud

The Department of Health and Human Services' program integrity unit is responsible for safeguarding Medicaid against waste, fraud, and abuse. One of the missions of the program integrity unit is to implement a systematic process for detecting, investigating, and prosecuting recipient fraud cases. The department is in the process of establishing new policies regarding recipient fraud. We also found that these policies should include better access to information created by other Medicaid divisions.

Some examples of fraudulent behavior include:

- Making a false statement or misrepresentation.
- Failing to disclose material facts for eligibility determination.
- Loaning or selling Medicaid cards to other individuals.
- Re-selling items paid for by the Medicaid program.
- Intentionally receiving excessive, duplicative, or contraindicated services, medications, or supplies.

DHHS previously contracted out recipient fraud investigations but is now conducting these investigations in-house with existing staff. Plans for the unit include hiring one investigator per regional office, which would be approximately one investigator per 100,000 clients.

Table 2.1 shows the recipient fraud cases reported by DHHS from FY 00-01 through FY 01-02.

**Table 2.1: Recipient Fraud Cases from FY 00-01 to FY 01-02**

| Fiscal Year | Cases Opened | Cases Closed | Funds Recouped |
|---|---|---|---|
| 00-01 | 64 | 66 | $72,296 |
| 01-02 | 89 | 83 | 56,576 |
| TOTAL | 153 | 149 | $128,872 |

Source: DHHS Program Integrity Unit

The program integrity unit uses a number of sources to identify recipient fraud cases. An official in the program integrity unit said that the biggest identifier of fraud is the Surveillance Utilization Review System (SURS), which allows workers to run reports showing how recipients are using Medicaid. The unit also has a telephone hotline where the general public may call and report fraud anonymously. It also relies on tips from county offices and other state agencies.

The program integrity unit is developing a process to prioritize and resolve cases of recipient fraud. It plans to adopt a three-tier approach towards recipient fraud which includes:

- “Locking in” clients the department suspects are misusing services. A lock in involves restricting a client to one provider and pharmacy.
- Terminating eligibility until penalties have been paid and funds recouped.

- Denying future eligibility to recipients convicted of Medicaid fraud. The FY 02-03 appropriations act allows the department to terminate enrollees who have provided false information. Federal law, however, requires that the period of ineligibility not exceed one year.

An agency official estimated that 80% of recipient fraud cases will be lock-ins and that 20% will be fully investigated for criminal intent.

## Pharmacy and Recipient Fraud

Department of Health and Human Services officials believe that pharmacy fraud is the most common type of recipient fraud. The Surveillance Utilization Review System includes data from the pharmacy division's point-of-sale system. For example, SURS indicates if recipients have been using multiple pharmacies to get extra prescriptions.

However, the program integrity unit does not have access to pharmacy division reports that may benefit them in their investigations of recipient and provider fraud. According to DHHS officials, having access to reports from point-of-sale system would be beneficial to the program integrity unit. In the past, the unit has requested reports from the pharmacy department that were not standard reports, and the requests were not given high priority. Two types of reports that would benefit program integrity are override reports and information about prescribers. Recipients over the age of 21 are limited to four prescriptions per month, but the point-of-sale system permits the pharmacist to override the limit under certain conditions. Reports about overrides would allow the program integrity unit to see how the pharmacists were utilizing this function. The prescriber information would allow the unit to see which provider was prescribing the drug being abused by a recipient. Therefore, the two divisions should share information in an attempt to reduce recipient and provider fraud.

## Fraud Policies in Other Southeastern States

In addition to more cooperation within the agency, the department should develop formal policies involving inter-agency cooperation. Currently, if the division discovers that a Medicaid client who also receives social services, such as food stamps and welfare, is abusing Medicaid, it does not have specific guidelines for how to inform the Department of Social Services. We reviewed other southeastern states' recipient fraud programs and found that these states have formal guidelines for referring and investigating Medicaid fraud and abuse.

Recipient education was another area emphasized by the southeastern states. The North Carolina Department of Health and Human Services indicated that one of the methods used to prevent fraud was education of Medicaid recipients during the initial application, at reviews, and when changes occur. More recipient fraud education should occur when an individual applies for Medicaid, according to an official in the program integrity unit at DHHS. The official noted that recipient fraud reviews reveal that misutilization occurs due to lack of education, and often the client needs some guidance on how to use the system. Oklahoma's Department of Human Services stressed education of Medicaid workers about eligibility fraud and the steps necessary to report it as one way to reduce fraud cases.

DHHS's division of health promotion and analysis is currently working on initiatives to educate Medicaid recipients. The division will utilize the eligibility workers and distribute a newsletter to recipients that will highlight benefit changes, coverage groups, and promote general health and wellness. The recipient fraud division should work with this group to also inform recipients about Medicaid waste, fraud, and abuse.

# Recommendations

8. The Department of Health and Human Services, as it establishes new policies on recipient fraud, should include requirements for coordination and communication between the program integrity unit, other DHHS divisions, and other state agencies.

9. To help reduce recipient and provider fraud cases, the Department of Health and Human Services should require its pharmacy division to share information from the point-of-sale system with the program integrity unit.

10. The Department of Health and Human Services should increase its efforts to educate recipients about Medicaid fraud and how to use Medicaid benefits appropriately.

## Other Optional Coverage Offered by Medicaid

One way of reducing Medicaid costs would be to limit "optional" populations. Federal rules require Medicaid coverage for low income individuals who are elderly, disabled, on welfare, children, and pregnant women. In addition to these "mandatory" groups, the state has considerable flexibility to set the criteria for and serve additional people under the Medicaid program. The South Carolina Medicaid program includes several optional groups. However, denying or eliminating Medicaid coverage to these individuals would most likely result in severe consequences for them as well as for the state and the health care market in general. Providing Medicaid to optional groups may be good health care policy for the state.

- Many of the individuals covered under optional groups are low-income and aged or disabled. Most, if not all, of these individuals have no access to private or employer-based health insurance.
- Without Medicaid many of these individuals would become uninsured. They would lose access to basic and preventive health care, including prescription drugs, which could result in increased hospitalizations, thus shifting the cost to the private market and state and local governments.
- Medicaid pays for many optional recipients in nursing homes or residential care facilities; without it these individuals would be displaced with no other place to go. Large reductions in Medicaid funding would create problems for the nursing home and residential care industries.
- Optional recipients receiving home and community based long term care, and severely disabled children being cared for at home, might have to go into nursing homes or institutional care if Medicaid coverage were withdrawn.
- In some cases eliminating Medicaid coverage would cost the state more. For example, foster care children, while an optional group for Medicaid, are the responsibility of the state. If Medicaid coverage was not provided, the state would have to pay for their medical care with 100% state funds. Working disabled individuals may be able to maintain employment and possibly private health insurance if Medicaid can pay for a personal health aide; without this coverage a disabled individual might not be able to work and thus would be dependent on government support for all health care and living expenses.

Major optional coverage groups in the S.C. Medicaid program are shown in Table 2.3 (see p. 26). About 30% of the FY 01-02 Medicaid expenditures were for these optional groups.

## Cost Savings Limited

The potential harm to individuals and the impact on future health care costs could outweigh any cost savings that limiting optional coverage groups would have. State Medicaid programs are mandated to serve the poorest, sickest populations, who naturally would have the highest medical costs. Supplemental Security Income (SSI) recipients, for example, who are automatically eligible for Medicaid, accounted for more than $800 million in Medicaid expenditures, an average annual cost per person of $7,129 (see Table 1.3 on page 7).

On the other hand, the "optional" children added to Medicaid under the Partners for Healthy Children initiative are relatively inexpensive to serve (on average $951 a year per client, with the federal government paying 79% of the cost versus 69% for regular Medicaid). Also, many optional recipients who are disabled receive medical services from DDSN or DMH. State agencies would have to provide these services with 100% state funding if the recipients were not Medicaid eligible.

States which cover optional groups must provide the mandatory Medicaid benefits and may provide optional benefits. The largest optional benefit provided by S.C. is prescription drugs. With the exception of prescription drugs, the amounts spent for other optional benefits are relatively small. Rather than eliminating optional benefits, which could have unintended consequences, the state could charge a small co-payment for the use of these services. S.C. already charges a $3 co-payment for prescriptions. (This is reviewed further on p. 41.)

## South Carolina Compared to Other States

South Carolina is somewhat conservative with optional Medicaid benefits when compared to other states. Many states serve more kinds of optional populations or have higher income limits so more individuals qualify for coverage. For example, South Carolina is 1 of 16 states that does not have a "medically needy" coverage option. Under this option, states provide Medicaid coverage to individuals who have large medical expenses that consume so much of their resources they "spend down" to the level that would qualify them for Medicaid.

However, South Carolina does cover several optional groups and provides coverage to special groups under waivers. For example, a recent Medicaid expansion, added in 2001, extended coverage to women under 200% of poverty with breast or cervical cancer.

Once a state expands eligibility coverage, it may not be allowed to rescind coverage. For example, the federal government in 1987 allowed states to raise the income limit for pregnant women and infants, from 133% of federal poverty limits up to 185%. South Carolina, like many other states, expanded this coverage to include pregnant women and infants up to 185% of poverty. However, 185% of poverty is now the minimum income limit for states that initially elected to provide that coverage to pregnant women and infants. Generally, according to DHHS, the federal Centers for Medicare and Medicaid Services will not approve eligibility changes that would deny coverage to children.

Many states set income limits higher for both optional and mandatory coverage groups. For example, states may cover pregnant women and children with incomes of 200% of poverty and even higher. Table 2.2 shows eligibility criteria for pregnant women, infants, and children for several southern states. Only Louisiana had limits that were consistently lower than South Carolina's.

**Table 2.2: Income Limits in Other Southeastern States**

| State | % of Poverty | | | |
|---|---|---|---|---|
| | Pregnant Women | Infants | Children Under Age 6 | Children 6-18 |
| Alabama* | 133% | 200% | 200% | 200% |
| Florida | 185% | 200% | 200% | 200% |
| Georgia | 235% | 235% | 235% | 200% |
| Louisiana | 133% | 150% | 150% | 133% |
| Mississippi | 185% | 185% | 133% | 200% |
| North Carolina | 185% | 200% | 200% | 200% |
| **South Carolina** | **185%** | **185%** | **150%** | **150%** |
| Texas | 185% | 200% | 200% | 100% |

The eligibility levels for each state reflect coverage under Medicaid, the State Children's Health Insurance Program (S-CHIP), or both.

*Alabama extends coverage to children through age 19.

Source: October 2000 data, National Conference of State Legislatures

## Conclusion

DHHS is re-structuring its processes for eligibility determination and recipient fraud investigation. The department should continue to strengthen those controls which ensure that only eligible individuals are receiving Medicaid benefits. The number of recipients eligible for Medicaid through the “transitional “ and “low income families” categories has increased rapidly since FY 99-00, faster than all other eligibility categories. DHHS is planning to make some adjustments to the eligibility process for these coverage groups that would slow down the growth. While this could result in some families losing Medicaid coverage, the children would still be eligible for Medicaid under other criteria. Therefore, potential ill effects of eliminating Medicaid for some low income families could be alleviated.

However, we could identify no other groups where eligibility criteria could be tightened without denying children, elderly, or disabled adults Medicaid coverage. DHHS may not be able to restrict enrollment in Medicaid for these groups. DHHS can freeze eligibility to current levels, which at least will not make new groups eligible for Medicaid. Even this may prove difficult in the face of new initiatives, such as the Silver Card, to provide Medicaid coverage to needy individuals. The Silver Card Plus program was created by a proviso in the FY 02-03 appropriations act. DHHS was directed to provide financial assistance for purchasing prescription drugs for senior citizens who otherwise are not eligible for Medicaid or do not have other coverage for prescriptions. While this allows the state to collect federal matching funds for the Silver Card program, it also expands the number of citizens eligible for a Medicaid benefit.

. . . we could identify no other groups where eligibility criteria could be tightened without denying children, elderly, or disabled adults Medicaid coverage.

In 2001, the National Governor’s Association adopted a proposal for Medicaid re-structuring to allow states more flexibility to determine benefits and cost sharing for optional eligibility groups. The NGA proposal also called for changes to allow states the ability to structure eligibility to simplify program administration and cover more uninsured individuals. Approval of these proposals by the Centers for Medicare and Medicaid Services would assist South Carolina in efforts to contain Medicaid costs while continuing to serve needy individuals.

## Table 2.3: Optional Medicaid Eligibility Groups in South Carolina FY 01-02

| Description | Recipients | Expenditures | Cost Per Person | % of Total Medicaid Cost |
|---|---|---|---|---|
| PARTNERS FOR HEALTHY CHILDREN<br>Children ages 1-5 in families with incomes between 133% and 150% of poverty, and children ages 6-18 with family income up between 100% and 150% of poverty. These children were added to Medicaid coverage under a federal expansion which provides a 79% match to the state. | 55,086 | $52,412,608 | $951 | 1.9% |
| AGED, BLIND AND DISABLED<br>People over age 65, blind, and/or disabled with incomes up to 100% of poverty ($8,592 per year). Many of these clients are disabled adults who receive services from DDSN and DMH. | 26,487 | $130,315,519 | $4,920 | 4.7% |
| MEDICAL ASSISTANCE ONLY (MAO)- NURSING HOME<br>Aged, blind and/or disabled individuals who need nursing home care; incomes up to $1,590 per month. Individuals eligible under this coverage group make up the majority of those in Medicaid nursing home beds. | 19,533 | $435,700,469[1] | $22,306 | 15.6% |
| MAO, HOME & COMMUNITY BASED CARE<br>Same as above. Recipients include the elderly/disabled, HIV/AIDS patients, and clients with mental retardation and related disabilities receiving home and community based services. | 9,293 | $113,114,958[1] | $12,172 | 4.0% |
| OPTIONAL STATE SUPPLEMENT<br>Aged, blind or disabled individuals who live in residential care facilities, with insufficient income to pay for room & board and no family support system. | 6,737 | $73,593,101 | $10,924 | 2.6% |
| TEFRA CHILDREN<br>Severely disabled children who need nursing home or institutional care but whose parents want to care for them at home. Parental income is not considered. Medical bills for some of these children are so high that even families with good incomes have spent all their resources or maximized private medical insurance. | 2,447 | $15,464,832 | $6,320 | 0.55% |
| FOSTER CARE CHILDREN<br>Children in foster care or with a subsidized adoption agreement who are not eligible under other Medicaid categories. | 1,974[2] | $12,495,975 | $6,329 | 0.45% |
| WORKING DISABLED<br>Permanently and totally disabled individuals with incomes up to 250% of poverty ($21,480 a year ), who are employed. | 108 | $873,767 | $8,090 | 0.03% |

1 The number of recipients and expenditures include other Medicaid services, such as prescription drugs, received by recipients eligible in this category.
2 The number of recipients adjusted to leave out foster care children who would require Medicaid coverage under another category.

Source: DHHS eligibility criteria and general background material; FY 01-02 MARS Reports

# Making Medicaid Services More Cost-Effective

In this chapter, we review a broad range of strategies that the Department of Health and Human Services can use to improve the cost-effectiveness of the Medicaid program.

We examined:

- Improving the efficiency of the prescription drug program with increased use of prior authorization and a state preferred drug list.
- Increased use of home and community-based care to help contain long term care costs.
- Using co-payments and enrollment fees to improve Medicaid revenues and reduce utilization.
- Maximizing estate recovery from persons receiving Medicaid services.
- Improving DHHS efforts to collect unpaid debts.

We estimated savings in state funds and additional state revenues that could occur based on some of these options:

| Our Recommendation | Estimated Savings/Revenues (Based on FY 01-02 Data) |
|---|---|
| Enact a State Preferred Drug List | $12.8 million |
| Charge a Medicaid Enrollment Fee | $1.4 million |
| Co-Payment for Optional Services | $3.2 million |
| Co-Payment for Hospital Admissions | $500,000 |
| Increase Estate Recovery | $110,000 |
| Improve Debt Collection | $204,000 |

## Prescription Drug Costs

Although costs for prescription drugs, which were about $428 million in gross expenditures for FY 01-02, continue to account for a large portion of Medicaid expenditures, the Department of Health and Human Services has made some changes that have slowed the growth in this area. After average increases of 23% a year since FY 95-96, expenditures for prescription drugs increased only one-third of one percent in FY 01-02. However, DHHS could further reduce those costs through a preferred drug list and prior approval of additional name brand prescriptions. DHHS is already taking steps to initiate these cost control measures.

We had previously recommended a number of measures to reduce Medicaid expenditures for prescription drugs in our February 2001 audit, *A Review of Selected Medicaid Issues.* Effective July 2001, the Department of Health and Human Services implemented three of the changes that we recommended.

- The 100-day supply per prescription was reduced to a 34-day supply per prescription or refill.
- Prior approval was required for certain medications.
- Generic drugs, if available, were required instead of brand name drugs.

Also, in December 2001, the recipient co-payment per prescription was increased from $2 to $3.

**Table 3.1: Annual Percent Changes in Prescription Drug Costs and Utilization**

| | FY 99-00 | FY 00-01 | FY 01-02 |
|---|---|---|---|
| Expenditures | 29.10% | 24.59% | 0.33% |
| Number of Prescriptions | 21.57% | 11.09% | 33.59% |
| Cost per Recipient | 14.53% | 12.83% | -13.50% |
| Cost per Prescription | 6.19% | 12.15% | -24.90% |

Source: DHHS Division of Health Services.

## Types of Drugs

Requiring prior approval has had some effect on the kinds of medications prescribed under the Medicaid prescription drug program. While the top five prescriptions by amount spent in FY 01-02 were the same as the top five in FY 99-00, therapeutic classes of the top drugs changed in the two-year period.

In FY 99-00, expenditures were highest in the anti-ulcer category. In FY 01-02, spending was highest for anti-psychotic drugs. None of the anti-psychotic drugs are on the DHHS prior approval list, while some anti-ulcer drugs require prior authorization. Costs for anti-arthritic drugs have dropped 25.4% in the past two years; DHHS now requires prior authorization for all brand anti-arthritis drugs, with limited exceptions. The top 50 drugs prescribed for Medicaid claims represented 46.4% of the total drug costs in FY 01-02. The following table reflects the four classes of drugs that had the most expenditures in FY 01-02.

**Table 3.2: Top Categories of Medical Prescription Drugs in FY 01-02**

| Therapeutic class | Total Cost | Includes Drugs such as: |
|---|---|---|
| Anti-Psychotics | $34,978,403 | Zyprexa, Risperdal |
| Anti-Depressants | $22,256,178 | Zoloft, Paxil |
| Anti-Ulcer | $18,624,350 | Prilosec, Prevacid |
| Anti-Convulsant | $16,690,968 | Neurontin, Depakote |

Source: DHHS Division of Health Services.

## State Preferred Drug List

In order to contend with a $42 million Medicaid budget cut, the state of Michigan launched the Michigan Best Practices Initiative — a system to more tightly screen the authorization process for drugs prescribed to Medicaid patients. Medicaid will no longer routinely pay for drugs unless they are on the state's "preferred drug list" (PDL). Other drugs will be reimbursed only if the doctor obtains prior authorization before prescribing them. Generic drugs are automatically included in the PDL.

The program excludes many newer brand-name drugs from the preferred list for reimbursement and requires the use of generic drugs or substitutes with supplemental rebates. Among the well-known drugs excluded from the preferred list are Prozac, Ritalin, Celebrex, Cipro, and Zyrtec.

. . . the real benefit of the PDL and clinical drug review (prior authorization) programs is that they promote appropriate utilization of quality pharmaceuticals in cost-effective ways.

The Michigan governor appointed physicians and pharmacists to a Michigan Pharmacy and Therapeutics Committee. This committee, working with the state Medicaid agency, identified 40 classes of drugs that accounted for the majority of increased drug spending in the Medicaid program. They recommended at least two drugs in every therapeutic class as "best in class," based on clinical effectiveness, safety, outcomes, and cost. A drug not selected as best in class can be placed on the preferred drug list if the manufacturers offer supplemental rebates to bring Medicaid's cost in line with the "best in class."

Michigan was one of the first states to initiate a preferred drug list. Since its inception on February 1, 2002, state Medicaid officials estimate an overall savings on pharmaceutical expenditures of 10% – 12%. Michigan contracts with First Health, a private pharmacy benefits manager, to manage its Medicaid prescription drug program. (South Carolina also contracts with First Health for its point-of-sale system.) Ten percent of South Carolina's gross Medicaid prescription drug costs for FY 01-02 would be $42.8 million in total funds and $12.8 million for the state's share.

According to First Health, the real benefit of the PDL and clinical drug review (prior authorization) programs is that they promote appropriate utilization of quality pharmaceuticals in cost-effective ways. First Health indicates that in the 40 therapeutic classes of drugs on the Michigan PDL, the preferred drugs are being prescribed by physicians over 90% of the time, and the program has generated overwhelming physician compliance.

The state of Florida also has a preferred drug list that is set up much like Michigan's. Florida Medicaid officials looked at utilization and clinical effect before placing the drugs on the preferred list so that the recommended drugs would be the most effective. Even though both Michigan and Florida have been sued by drug manufacturers, several other states are planning PDL programs. According to a Florida official, that state thus far has prevailed in its lawsuit. Michigan administrators have readily shared with other states the development process of their best practices initiative, as well as their preferred drug and prior authorization lists.

During the time we were drafting this report, DHHS had already begun the implementation of a state preferred drug list for South Carolina. DHHS has directed First Health to assemble a committee of physicians and pharmacists for a clinical review of appropriate drug classes. Also, in November 2002, DHHS began the process to amend the State Medicaid Plan and request federal permission to allow for a state preferred drug list.

## Recommendation

11. In order to further contain prescription drug costs, the Department of Health and Human Services should proceed with implementing a state preferred drug list by taking the following steps:

    - Negotiate supplemental rebates with drug manufacturers whose products are not on the preferred list and who want to protect or expand their market share.

    - Amend the State Medicaid Plan and obtain all necessary approvals from the federal Centers for Medicare and Medicaid Services.

## Prior Authorization

Prior authorization of drugs requires medical justification before a specific medicine may be dispensed. This procedure can help limit the use of drugs that are easily abused, or encourage doctors to prescribe less expensive drugs that may be just as effective. The Department of Health and Human Services expanded its Medicaid prior authorization list in July 2001 to cover some frequently prescribed brand drugs. Included were anti-ulcer therapies and anti-arthritis products with brand names such as Prilosec and Vioxx.

The prior authorization restriction is effective in reducing the use of many brand name drugs. In FY 01-02, the prescribers changed more than 35% of the original prescriptions to less expensive or generic brands. However, only 6 of the South Carolina top 50 drugs for FY 01-02 are subject to prior approval. In contrast, 24 of the South Carolina top 50 drugs are listed on Michigan's Preferred Drug List and 17 require prior approval in Michigan's program.

According to one pharmacist we contacted, DHHS could expand the prior approval list for other brand drugs, especially for 24-hour non-sedating antihistamines, such as Zyrtec. In his opinion, generic antihistamines could be more effective in many cases than the highly advertised brands that are frequently prescribed.

### OxyContin

The case of OxyContin illustrates how prior approval not only helps reduce drug costs but can also reduce abusive or inappropriate use of a drug.

The U. S. Drug Enforcement Administration (DEA) describes OxyContin as "a central nervous system depressant, a prescription painkiller." The drug contains oxycodone, a very strong narcotic pain reliever similar to morphine. OxyContin contains a much larger amount of oxycodone than similar painkillers, such as Percocet and Percodan. With prolonged use of OxyContin, users become physically dependent. Addicts can crush the time-release tablet and then chew, snort, or inject it to release a large amount all at once. According to a First Health spokesperson, all states are watching OxyContin in order to deter abuse, especially with Medicaid recipients.

On May 18, 2001, DHHS issued a Medicaid Bulletin stating *"Effective immediately, all Medicaid prescriptions for OxyContin® will be subject to prior authorization requirements. This action is being taken due to the potential misuse and abuse of this specific oxycodone product."* However, five months later, DHHS issued another Medicaid Bulletin which decreased the prior approval restrictions, and stated that effective November 1, 2001,

prior authorization of OxyContin would be required for only those prescriptions that exceeded a maximum of six tablets per day or a maximum of 180 tablets per 30-day period (regardless of strength for either).

The prior authorization of OxyContin was protested by its manufacturer during the time that full approval was required. However, according to DHHS officials, they loosened the restrictions on OxyContin because they had successfully reduced its use.

During the three months before the prior approval restriction, OxyContin expenditures accounted for about half of the prescriptions in its narcotic class. During the five months that restricted all OxyContin prescriptions to prior approval, expenditures for OxyContin were on average 10% of the narcotics in its class, and total monthly expenditures decreased by nearly $400,000, a drop of 22%. In the ten months after prior authorization was relaxed, use of and expenditures for OxyContin again increased (see table below). The costs for OxyContin range from $1.29 to $8.25 per tablet, with strengths that vary from 10mg to 80mg, respectively.

**Table 3.3: OxyContin Activity March 2001 – August 2002**

| Period | Status | OxyContin % of Narcotic Class | Narcotic Class Expenditures Monthly Average |
|---|---|---|---|
| March – May, 2001<br>3 months | No prior authorization | 49.6% | $1,767,632 |
| June – October, 2001<br>5 months | Prior authorization required | 10.0% | $1,376,917 |
| Nov. 2001 – Aug. 2002<br>10 months | Reduced prior authorization | 25.3% | $1,643,812 |

Source: DHHS Division of Health Services.

During FY 01-02, OxyContin, inclusive of all strengths, ranked 21 of the top 50 Medicaid drugs in South Carolina. It would have ranked higher had all prescriptions for the drug not been restricted to prior approval during that time.

## Other Southeastern States' Pharmacy Limits

South Carolina ranks among the most conservative states in the southeast in Medicaid prescription cost management. It is the most restrictive with a limit of four monthly prescriptions per adult. Only Florida and Kentucky have lower rates for reimbursement. South Carolina has the lowest dispensing fees per prescription. South Carolina also has the highest co-pay per prescription of $3, while two other states have a co-pay scale that maximizes at $3.

**Table 3.4: Medicaid Prescription Comparison Among Southeastern States**

| State | Number of Prescriptions Allowed | Dispensing Limit | Provider Cost Reimbursement + Dispensing Fee[1] | Patient Co-Pay[4] |
|---|---|---|---|---|
| Alabama | Not specified | 30-day supply; 5 refills | (AWP[2] – 10%) or (WAC[3] + 9.2%) + $5.40 | $.50 to $3.00 |
| Florida | 4 brand; Unlimited generic | Refills up to 1 year | (AWP – 13.25%) or (WAC + 7%) + $4.23 | - $0 - |
| Georgia | Not specified | 31-day supply; Refills – adult = 5 children = 6 | (AWP – 10%) + $4.63 | $.50 to 3.00 |
| Kentucky | Not specified | 32-day supply; 5 refills within 6 months | (AWP – 12%) + $4.51 | - $0 - |
| Mississippi | 10 | Greater of 34-day or 100 doses; 5 refills | (AWP – 10%) + $4.91 | $1.00 |
| North Carolina | 6 | 100-day supply | (AWP – 10%) + $5.60 | $1.00 |
| South Carolina | Over age 21 = 4; Under age 21 = unlimited | 34-day supply | (AWP – 10%) + $4.05 | $3.00 |
| Virginia | Not specified | 30-day supply or 100 units | (AWP – 9%) + $4.25 | $1.00 |

1 Medicaid reimbursement for the cost of the drug. The dispensing fees are paid to the pharmacies.
2 AWP - Average Wholesale Price
3 WAC - Wholesale Acquisition Cost
4 Out-of-pocket expense per prescription

Source: 2001 Pharmaceutical Benefits under State Medical Assistance Programs, National Pharmaceutical Council (NPC).

# Recommendations

12. If the Department of Health and Human Services is unable to implement a state preferred drug list, it should reduce its Medicaid drug expenditures by including more therapeutic classes of drugs as well as frequently prescribed brand name drugs on the prior authorization list.

13. The Department of Health and Human Services should reconsider the October 18, 2001, Medicaid bulletin and once again place all OxyContin prescriptions on prior approval.

# Costs for Long Term Care

In addition to prescription drugs, another high-cost Medicaid service is long term care in nursing homes. In FY 01-02, nursing home care cost $360 million and was the third highest area for Medicaid spending, behind hospitals and prescription drugs. From 1990-1999, Medicaid reimbursements to nursing facilities increased 143%. After a decade of skyrocketing growth, Medicaid expenditures for nursing homes increased 11% since FY 99-00.

In addition, nursing home care will have a large effect on future increases in Medicaid costs. Since a large proportion of nursing home residents are over age 65, the aging of the "baby-boom generation" will create more demand for long term care. One of the fastest growing segments of the population is those past their 85th birthday.

Long term care is not only provided by nursing facilities. The other side of long term care is home and community-based care (CLTC), which allows an elderly or disabled person to remain at home and receive services otherwise provided in an institutional setting. In order to control the cost of long term care, DHHS will need to shift its focus from nursing home to home and community-based care.

## Nursing Home Versus Home and Community-Based Care

Nursing home care for Medicaid recipients costs more than twice as much per person as care in a home or community-based setting. Medicaid recipients of long term care must meet the same criteria whether they receive care in a nursing home or in a home and community-based setting. Eligibility for Medicaid long term care requires:

- Low incomes (under 200% of poverty).
- Limits on resources such as a home, car, financial assets.
- A medical diagnosis.
- Needing either skilled nursing care or intermediate level of care.

For the amount it costs to provide a single recipient with nursing home care, DHHS could provide CLTC to 2.4 Medicaid recipients who need the same level of care. While recipients must meet the same long term care criteria, there are differences between the CLTC and the nursing home populations. Recipients in nursing homes tend to be more frail. CLTC clients must have a place to live, and many have a caregiver in the home since CLTC does not provide round-the-clock care. The main purpose of CLTC is to allow patients to remain at home for as long as possible.

The following table, based on data reported by DHHS to the federal government for FFY 00-01, shows the cost differences between CLTC and nursing home care. These figures include Medicaid acute care and other costs as well as the long term care costs incurred by recipients.

**Table 3.5: Comparison of CLTC and Nursing Home Costs, FFY 00-01**

| Average Total Cost | CLTC* | Nursing Home |
|---|---|---|
| Per Recipient | $10,257 | $21,452 |
| Per Day | $37 | $88 |
| Per Slot/Bed per Year | $13,494 | $32,087 |

* Elderly/disabled waiver program only.

Source: DHHS, Bureau of Long Term Care Services

## Availability of CLTC Limited

For FFY 00-01, DHHS served 14,431 elderly/disabled recipients in home and community-based long term care and 18,727 in nursing home care. Medicaid-funded care in both settings is limited by DHHS and state and federal laws: CLTC by available "slots" and nursing homes by allowable "bed days." The approval process is different for each type of care.

### Community Long Term Care Requirements

CLTC provides services needed to care for the person at home or in a community setting. These include personal care aides, adult day care, home delivered meals, respite care, counseling, and environmental modifications such as wheelchair ramps. Regular Medicaid-funded health services (hospital if needed, physician visits, prescription drugs) are also provided.

DHHS operates the CLTC program under a waiver from the federal government. The purpose of a Medicaid waiver is to allow the state to offer services or to serve groups of people that are not traditionally covered by Medicaid. DHHS actually operates five different CLTC waiver programs, covering the following groups:

- Elderly/disabled (has the most clients);
- Those with mental retardation and related diseases;
- Those with HIV and AIDS;
- Those with head and spinal cord injuries; and
- Those dependent on ventilators.

The number of CLTC recipients is limited to the number of available slots, which is primarily limited by DHHS's budget. The General Assembly authorizes additional CLTC slots through the appropriations bill. If a person qualifies for long term care and wishes to receive this care in a home or community setting, the person has to go on a waiting list if there are no more available slots. As of November 2002, the waiting list for CLTC was about 3,600, with an average waiting time of six to nine months, according to DHHS officials.

### Nursing Home Requirements

Nursing homes are required to provide skilled or intermediate nursing care, as well as needed medical, dietary, and social services. To serve Medicaid patients, nursing homes must be certified and obtain a permit from the Department of Health and Environmental Control that specifies the number of "bed-days" (plus or minus 10%) each home can provide Medicaid recipients during the year. The General Assembly, in the annual appropriations act, establishes the maximum number of Medicaid patient days which DHEC is authorized to issue. DHEC distributes the allowable permit days among the Medicaid-certified nursing homes based on current allocations, available funds, and relative need. Relative need is based on a county's number of clients approved for Medicaid nursing home care and still awaiting placement.

As of October 2002, the nursing home waiting list was 281. However, DHHS staff attribute the nursing home waiting list not to a lack of available Medicaid beds. Rather, some people are waiting for space in a specific facility and some are waiting for their eligibility determination to be finalized. On average, in FFY 00-01 nursing homes in the state had an overall occupancy rate of 94.5% and Medicaid beds accounted for 75.7% of the total occupancy (Medicare and private pay accounted for the rest).

## Funding Issues

Both CLTC and nursing homes are separate items in the Medicaid budget. In this sense funds do not follow the patient. Once funds for CLTC are spent, DHHS cannot use nursing home allocations to increase slots in CLTC, even though the waiting list for CLTC is currently more than 12 times the waiting list for nursing homes.

. . . the demand for long term care will create tremendous pressure on the Medicaid budget.

While patient demand is for more home and community-based care, the institutional bias has been toward nursing home care. For example, DHHS is mandated through the state Medicaid plan to provide nursing home care, while CLTC is considered an "optional" service. Also, nursing homes are the only medical service singled out in the appropriation act to receive rate increases every year; this is in addition to increases in Medicaid beds. However, we found no federal requirements that would actually bar DHHS from using nursing home allocations to expand CLTC slots. There may be several state-level barriers:

- The budget process, as noted above, designates specific funding for nursing home care and CLTC, even though both programs are long term care.

- State law (The Nursing Home Act of 1987) establishes that the number of nursing home beds, and thus the level of funding, will be determined by the permit days allocated by DHEC and approved by the General Assembly.

If DHHS is to slow down growth in Medicaid spending, then it should consider redirecting resources to home and community-based long term care. Otherwise, the demand for long term care will create tremendous pressure on the Medicaid budget. With the CLTC waiting list currently at 3,600, a Medicaid recipient who is no longer able to function independently might be forced into a nursing home even though they would prefer to be cared for at home at less than half the price. Likewise, a hospital patient who needed to be discharged into long term care may have to choose nursing home care and would not have CLTC as an option. (Under limited conditions DHHS can allow a hospital patient to go to the head of the CLTC waiting list in order to avoid a nursing home admission.)

## Other States

Other states have developed programs to serve people in the most appropriate community setting rather than in an institution. According to a letter from the Centers for Medicare and Medicaid Services, these programs and activities, developed under existing authority, include:

- Transition programs to move people from the nursing home back to a home or community-based setting. New Jersey, for example, employs 40 counselors who are dedicated to informing nursing home patients and hospital patients awaiting nursing home admission about CLTC alternatives. In the first three years of this initiative, New Jersey's Medicaid nursing home population decreased by about 5%.

- Programs where the "money follows the person." Texas, for example, implemented a law that provides for the Medicaid funding to follow an individual when transitioning from a nursing facility to the community. Since September 2001 the Texas Department of Human Services has assisted more than 700 individuals to move back to community living.

DHHS received a federal grant in September 2002 for the planning and design of a similar program. The department will look at various ways it can help people move from a nursing home to a community setting.

Nursing homes dependent on Medicaid funding could experience problems if the number of allowable beds days begins to decrease. Nursing homes are reimbursed by Medicaid based on the actual number of patients and number of days of care received. Even if the number of patients declined, nursing homes' fixed costs would remain the same while reimbursements would decrease. DHHS may need to take steps to alleviate the effect on nursing homes if more Medicaid recipients were diverted into CLTC. One way to accomplish this would be to certify nursing homes as CLTC providers themselves. Nursing homes could provide adult day care, personal care aides, and other services that would enable an elderly or disabled person to remain in the home.

# Recommendations

14. The General Assembly should consider authorizing more slots for the CLTC program and freezing the number of nursing home beds.

15. The General Assembly should consider approving a combined appropriation for long term care in DHHS' budget, in order to give DHHS flexibility in funding CLTC and nursing home care based on client demand.

16. The Department of Health and Human Services should implement a system that allows funding to follow patients from nursing homes into a home or community-based setting.

17. The Department of Health and Human Services should work with the nursing home industry to help them diversify into home and community-based care.

## Recipient Cost Sharing

Federal law allows limited cost sharing with Medicaid recipients for services. Cost sharing means requiring out-of-pocket contributions from recipients for health services. Private health insurance plans have increased cost sharing to control rising expenditures. DHHS currently only charges a $3 co-payment for prescription drugs. We found that DHHS has several options available to expand cost sharing with recipients. These include enrollment fees and co-payments for certain services. While cost sharing may create some hardship for Medicaid recipients, the alternative of not providing optional services would be a greater burden.

### Background

Section 1902(a)(14) of the Social Security Act provides that Medicaid may impose “enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges.” The following types of cost sharing may be used:

- Co-payments — a fixed dollar fee per visit or item paid at the point of service.
- Co-insurance — a defined percentage of total charges for a service.
- Premiums — a set amount paid to obtain health insurance coverage.
- Deductibles — flat dollar amounts for medical services that have to be paid by the patient before the insurer picks up all or part of the remainder of the price of services.
- Out-of-Pocket Limit — the total amount (except for the premium contribution) of cost sharing for a period of time, typically for one year.
- Enrollment fee — annual charge based on family size to participate in the Medicaid program.

In July 1993, the U.S. Department of Health and Human Services conducted a national study of Medicaid cost sharing. The study recommended that the federal government promote the use of cost sharing by recommending changes in federal law and providing information to the states. The department found that “implementing or expanding cost sharing programs

would allow States to (1) reduce program expenditures; (2) maintain or increase eligible populations; (3) maintain or increase covered services; and/or (4) maintain or increase reimbursement rates."

Federal law places several restrictions on the costs that can be shared with recipients.

- Children, HMO enrollees, pregnancy services, emergency services, hospice services, and services provided to residents of nursing facilities or medical institutions are exempt from cost sharing.
- Deductibles may not exceed $2 per month per family per period of eligibility.
- Coinsurance rates may not exceed 5% of the service payment.
- Maximum co-payment chargeable to recipients for services is $.50 to $3.00, depending on the cost of the service.

## Enrollment Fees

Enrollment fees would be a viable cost sharing option for DHHS because the fee could be applied consistently and the administrative burden would be minimal. This is an annual fee paid by the recipient to the Medicaid agency and is not dependent on the services used. The enrollment fee could be collected when the initial eligibility determination is made and then at the annual re-determination. For example, Texas is considering implementing an enrollment fee for all non-institutionalized Medicaid populations above 100% of poverty, including waiver programs. The fee would be $5–$10 for an individual and $15–$25 for a family.

Enrollment fees would be a viable cost sharing option for DHHS . . . .

Federal law allows enrollment fees to be charged but exempts categorically needy recipients which include children, aged, blind and disabled, and pregnant women. However, enrollment fees may be collected from certain optional groups such as the Partners for Healthy Children program. In order for South Carolina to charge an enrollment fee to this group, the following changes to the state plan must be made and approved by CMS:

- Change the Partners for Healthy Children program to a separate program instead of a Medicaid expansion program.
- Implement an enrollment fee based on income for enrollees in the program.

All states with a separate Medicaid children's health insurance program have some form of cost-sharing. North Carolina charges an enrollment fee of $50. By charging a $20 annual fee to enrollees in the Partners for Healthy Children program, DHHS could collect about $1.4 million.

## Cost Sharing in South Carolina

The only recipient cost sharing currently imposed by DHHS is a $3 co-payment for prescription drugs for adults. According to a DHHS official, the agency charged a co-payment of $1 for physician visits in the late 1980s and early 1990s but encountered administrative problems. Any cost sharing measures proposed by DHHS would have to be approved by the Centers for Medicare and Medicaid Services.

The FY 02-03 appropriations act requires DHHS to:

> …submit an application for a waiver to increase the agency's discretion in administering the program including the use of premiums, deductibles, and co-pays by persons earning more than $30,000. The purpose of the waiver is to allow the agency to adjust eligibility standards. The waiver should be used to lower the costs of providing service to current higher income recipients.

According to a DHHS official, this waiver would apply to a very small number of recipients, mostly disabled children in the TEFRA program or pregnant women. However, children and pregnant women are excluded from cost sharing by federal law.

## Optional Services

Federal law requires states to cover certain services including hospital and physician services. States may also choose to cover additional services such as prescription drugs and optometrist services. In FY 01-02, South Carolina covered a number of additional services at a cost of $708 million with 58% for prescription drugs.

One option available to the state to contain Medicaid costs is to reduce the optional services covered by the program. Only those services provided to adults can be considered since many of these services can be mandatory for recipients aged 21 or younger. For FY 01-02, the total cost of optional services, excluding pharmacy, to adults over 21 was $178 million with a state share of approximately $55 million. Any change in coverage would have to be approved by the federal government.

The cost of optional services can also be reduced by charging a co-payment for these services. The provider collects the co-payment from the recipient, and the provider's check from DHHS is reduced by the amount of the co-payment. The co-payment can only be a nominal amount but the charge also results in a decreased usage of the services. Cost savings can be achieved through the collection of the co-payment as well as decreased utilization of services. The following table estimates the amount that could

be saved if South Carolina charged a co-payment of $2 per transaction on adults over age 21 and if use of services decreased 10%.

**Table 3.6: Estimated State Share of Cost Savings of $2 Co-payment on Optional Services Based on FY01-02 Transactions**

| | Transactions | Revenue: $2 co-pay* | Savings: Decreased Use of Service | Total Savings |
|---|---|---|---|---|
| Clinic Services | 277,679 | $499,822 | $740,941 | $1,240,763 |
| Durable Medical Equipment | 206,644 | 371,960 | 651,382 | 1,023,342 |
| Dental | 179,134 | 322,442 | 349,888 | 672,330 |
| Optometrist | 52,349 | 94,228 | 38,909 | 133,137 |
| Chiropractic | 20,265 | 36,476 | 14,435 | 50,911 |
| Podiatrist | 17,154 | 30,878 | 17,782 | 48,660 |
| Nurse Anesthetists | 11,171 | 20,108 | 26,752 | 46,860 |
| Optician | 2,198 | 3,956 | 717 | 4,673 |
| Audiologist | 19 | 34 | 14 | 48 |
| TOTAL | 766,613 | $1,379,904 | $1,840,820 | $3,220,724 |

* Federal law allows a $2 co-pay for services for which the state pays between $25 and $50. Most of these optional services have rates of at least $25.

Source: DHHS MARS Reports, June 2002

### Other Services

Transportation is another optional service provided to Medicaid recipients. Many of the transportation services are provided through contracts with transportation providers. Although the Medicaid data system does not report the number of individual trips provided through these contracts, the total paid under these contracts for FY 01-02 was $23 million. A one dollar co-payment could be charged to eligible recipients for many of these trips. Having a co-payment could discourage inappropriate use of this service and offset the increasing costs of transportation.

Federal law allows a co-payment to be charged for a hospital admission if it does not exceed 50% of Medicaid's payment for the first day of service and is not a result of an emergency admission. Other states charge anywhere from $2 up to $200 per hospital admission. Based on FY 01-02 hospital admissions for adult enrollees in certain eligibility groups, DHHS could save almost $500,000 if a $25 co-payment were charged.

## Recommendations

18. The Department of Health and Human Services should amend the state Medicaid plan to make the Partners for Healthy Children program a separate program and to charge an enrollment fee to enrollees in the program.

19. The Department of Health and Human Services should review charging co-payments on optional services and hospital admissions as a cost-saving measure.

## Estate Recovery

DHHS does not use all available methods to collect from the estates of persons who have received Medicaid services. In 1993, federal law required states to implement an estate recovery program to collect for some services paid for by Medicaid. In 1994, South Carolina passed an estate recovery law mirroring the federal law. S.C. amended that law in 1995 to restrict recovery to community long term care (CLTC) and nursing home services. In a preamble to the act, the General Assembly stated that they:

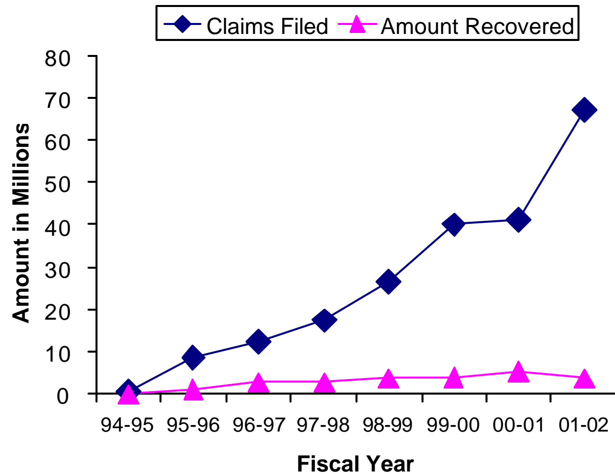
> …reluctantly complied with the federal mandate, with particular concerns about applying the mandated estate recovery provisions to payments for noninstitutional Medicaid services since this might discourage older patients from seeking needed medical care.

### Current Recoveries

Medicaid must have paid at least $500 in claims for a recipient in order for the estate to be subject to recovery, and an estate must have a value of at least $10,000. The value of the estate can be determined through a questionnaire sent to family members or from the probate court. Medicaid claims have priority for payment after funeral expenses, attorney fees, and court costs.

For FY 01-02, DHHS collected approximately $3.7 million from estate recoveries. Approximately $1.1 million of those funds were the state's share. Since the program's inception in 1994 through June 30, 2002, there have been over 40,000 cases opened. Claims were filed in only 14% of the cases, and DHHS has collected 11% of the recovery sought. For FY 00-01 and FY 01-02, 95% of the cases were closed without collecting any funds. The vast majority of those cases were closed due to insufficient assets in the estate to pay for the Medicaid claims. The following chart shows the claims filed versus recoveries.

**Chart 3.7: Claims vs. Recoveries: FY 94-95 – FY 01-02**




Source: DHHS Estate Recovery Department

## Additional Recovery Methods

If South Carolina collected 10% more through its estate recovery efforts, it would net the state an additional $110,000 based on FY 01-02 collections. DHHS only collects for some of the services which are allowed under federal law and does not use all of the available methods to collect from estates.

- Federal law allows collections for all services for persons 55 and older while S.C. collects only for nursing home and CLTC services.
- Federal and state law allow hardship waivers which exempt estates from recovery to be granted in certain circumstances. However, federal law has specific limits on who can claim the waiver while the state has broad hardship criteria which is interpreted very loosely. For FY 01-02, DHHS granted 272 waivers.
- If a waiver is granted, federal law allows liens to be filed on real property to ensure that it is not sold or transferred without the state having the opportunity to seek repayment of Medicaid costs from any equity that has accumulated. DHHS does not file these liens.

By not utilizing all legal means to collect from estates, DHHS may not be maximizing its estate recovery collections.

Other states use more aggressive means to conduct estate recoveries. A 1998 study conducted by the North Carolina Department of Health and Human Services looked at the estate recovery efforts of other states and identified methods used by those states with higher collection rates. The study found that states with higher collection rates:

- Applied estate recovery to services in addition to those mandated by federal law.
- Placed liens on real property.
- Had a broader definition of estate for recovery collection purposes.

South Carolina ranked 21st out of the 34 states reporting collections for the survey. The state does not use the methods outlined in the study for higher collection rates.

## Notification of Death

The estate recovery department in DHHS receives notification of recipients' deaths through a variety of sources. South Carolina Code §44-23-1120 requires the probate court to notify the Department of Mental Health "upon the death of a person who is or has been a patient or trainee of a state mental health facility." A similar DHHS law for persons who received nursing home or CLTC services paid for by Medicaid could improve the identification of cases and ensure that claims are filed in a timely manner. For FY 00-01 and FY 01-02, 256 cases were closed because the time period for filing claims had expired.

# Recommendations

20. The General Assembly should amend S.C. Code §43-7-460 to increase estate recovery collections by:
    - including services in addition to nursing home and community long term care;
    - authorizing liens on real property; and
    - expanding the definition of estate.

21. The General Assembly should amend S.C. Code §43-7-460 to require personal representatives and the probate judge to notify the Department of Health and Human Services upon the death of a person who has received nursing home or community long term care services paid for by Medicaid.

# Collection Efforts

DHHS's division of accountability and collections has the responsibility of collecting unpaid debts. DHHS could improve its collections by participating in programs available to state agencies. In addition, DHHS needs to change its information technology system to automatically collect debts owed by providers.

## Background

DHHS collects payments from numerous sources. The largest collectible is drug rebates. The drug rebate program is required by federal law and rebate amounts are set by the Center for Medicare and Medicaid Services. DHHS has contractors to collect these rebates. We discussed the issue of drug rebates and collections in our February 2001 report titled *A Review of Selected Medicaid Issues*.

Additional debts are owed by providers such as nursing homes or recipients as a settlement of program integrity investigations. DHHS uses several collection methods for provider and recipient debts:

- The debtor is sent three letters attempting to collect the outstanding balance.
- If the debt is between $100 and $1,000, the debt is reported to the Municipal Association of South Carolina for collection through the State Setoff Debt Program.
- If the debt is over $1,000, it is referred to the DHHS General Counsel's office for further action. The legal office makes one attempt to collect the debt and then refers it to a private attorney who is contracted to the department for collections.
- If the debt is owed as a result of a legal action, the debt is referred to program integrity so the appropriate court may be notified.

The following table shows uncollected debts for the past three fiscal years.

**Table 3.8: DHHS Outstanding Accounts Receivable for FY 99-00 Through FY 01-02**

| | FY 99-00 | FY 00-01 | FY 01-02 |
|---|---|---|---|
| Drug Rebate[1] | $51,182,859 | $36,234,206 | $55,540,848 |
| Inter-Governmental Transfers[2] | 9,479,253 | 6,945,614 | 18,144,511 |
| Provider Recoupments | 6,720,679 | 5,215,441 | 4,391,583 |
| Medicaid Recipients | 858,833 | 470,584 | 484,973 |
| Childcare Recoupments | 105,642 | 35,803 | 61,419 |
| Other | 5,228 | 1,344 | 220 |
| TOTAL | $68,352,494 | $48,902,992 | $78,623,554 |

1 Includes amounts in dispute for which final amount due is not yet determined.
2 Represents amounts due from state agency contracts and most were paid in full in July 2002.

Source: DHHS Bureau of Fiscal Affairs.

According to DHHS, only $680,000 of the funds owed by providers and recipients is past due. If DHHS collected 30% of these funds, it could receive an additional $204,000.

## Collections

DHHS could use the Department of Revenue (DOR) to collect debts from Medicaid providers and recipients. For debts between $100 and $1,000 due from individuals, DHHS currently contracts with the Municipal Association to collect from income tax refunds through the Setoff Debt program. DHHS pays 15% of each debt collected to the association and the debtor pays an additional $25 fee to DOR. DHHS contracts with a private attorney to handle collections of debts over $1,000. This attorney retains 33% of all amounts collected with a cap of $8,000. DHHS also pays the expenses such as court costs and transportation associated with these collection efforts. The contract requires quarterly written reports on the status of each pending case. DHHS has not received these reports but, as of October 2002, there are 16 active cases. Four of these cases need additional information from DHHS in order to help locate the debtor.

The Department of Revenue offers the Governmental Enterprise Accounts Receivable Collections (GEAR) service to political entities. Governmental entities can participate in both the Setoff Debt Program and GEAR. The GEAR program costs 28.5% of the funds collected and these funds would be retained within state government. The Department of Revenue has a successful collection rate of 11% to 27% depending on the debt type. Additionally, all debts over $100 could be collected by GEAR as opposed to the two-tiered system DHHS now uses. The GEAR program provides a monthly collections report and a yearly inventory of all outstanding debts.

## Information Technology System Changes

Through program integrity reviews, DHHS can identify providers' claims that are incorrect or inappropriate and which result in overpayments and losses of Medicaid funds. These funds are supposed to be repaid to the department. To ensure payment and efficient collections, the disallowed amount is deducted from the provider's next Medicaid reimbursement check. If the debt is greater than the reimbursement, accounts receivable sets up a payment system with the provider who is to mail a check to DHHS each month. The DHHS Medicaid Management Information System does not have the ability to withhold a set amount from each reimbursement until the debt is paid, and DHHS will not use the entire reimbursement amount to pay off the debt. This results in fewer payments that are actually collected.

# Recommendations

22. The Department of Health and Human Services should consider using the Department of Revenue for debt collection.

23. The Department of Health and Human Services should adjust its Medicaid Management Information System to allow for regular deductions from reimbursements for debt collection.

# Sources of Data

## Difference Between Eligibiles and Recipients

There are different sets of data used to describe the number and type of people on Medicaid. "Eligible" is a count of individuals who have applied for and were enrolled in the Medicaid program each month. According to DHHS, there were 913,788 eligible individuals in the Medicaid program in FY 01-02. "Recipient" is a count of individuals for whom Medicaid claims were paid for during the year. DHHS reports that there were 816,112 recipients in the Medicaid program in FY 01-02. There are several reasons why these two counts vary. For example, more than 100,000 women in FY 01-02 were eligible for Medicaid-funded family planning, but only 66,367 actually used the service. For this reason counts of eligibles will be higher than counts of recipients.

According to DHHS staff, recipient counts include people whose Medicaid dates of service incurred in a prior year, but were paid in the current year. Medical providers have up to 12 months to file a claim with Medicaid. Therefore, annual recipient counts include persons who were eligible in a prior year but might not be included as an eligible during the current year. In addition, recipient data counts clients in whatever eligibility category they qualified under during the year. Recipients can be counted under different eligibility categories if their income or health status changes. Eligible data only counts clients in the eligibility category they *last* qualified in. For these reason counts of recipients in specific eligibility categories can be higher than counts of eligibles. In tables and descriptions throughout this report we have identified whether we used "recipient" counts or "eligible" counts.

### Costs for State Health Insurance Plan versus Medicaid

One question we attempted to review was the issue of state employees dropping state health insurance coverage if their children were eligible for Medicaid. According to DHHS, 3,451 dependents of state employees shifted coverage from the state health plan to Medicaid as of October 2001. Based on a DHHS analysis, however, it was cheaper to cover children under Medicaid than under the state health plan. Information from the B&CB insurance division showed that the average cost in state dollars to cover the dependent children of state employees was $27.70 per person per month. A DHHS analysis found that the Medicaid cost per child per month was $28.40 for regular Medicaid and $10.46 for the Partners for Healthy Children program, which receives a greater federal match. However, this analysis used the number of children *eligible* during FY 01-02 as opposed to children who actually received services. We used the average Medicaid cost per child for all recipients under age 19 in FY 01-02. This resulted in a higher average

cost in state dollars per child per month — $31.25 if the regular Medicaid match was received, and $21.87 if an enhanced match was received.

Most likely, children of state employees would qualify for Medicaid under the Partners for Healthy Children program, which allows families to have a higher income limit. In that case it would be cheaper to cover children under Medicaid than under the state employees health insurance plan. However, this analysis shows the difficulties involved in analyzing Medicaid expenditures, since the outcome is greatly influenced by whether "eligibles" or "recipients" are used.

## Expenditure Information

DHHS's primary source of information about Medicaid payments and recipients is the Medicaid Management Information System (MMIS). The department uses the MMIS to produce a series of reports (Management and Reporting System or MARS) that show, by month and year-to-date, the number of transactions, recipients, expenditures and in-patient days for each type of medical service and for each different eligibility group. We used this data in tables throughout the report.

For the accounting functions in the Medicaid program, DHHS uses the governmental accounting and financial reporting (GAFR) system. Claims processed through the MMIS are reconciled to the GAFR system which in turn is reconciled to the S.C. Comptroller General's accounts. The GAFR and the MMIS systems produce slightly different expenditure information. GAFR includes items that are not directly linked to individual Medicaid claims, such as disproportionate share, certain service contracts, and administrative costs. In tables and descriptions throughout this report we have identified whether data came from GAFR or MARS reports.

## 2000 Census Data

The S.C. State Data Center in the B&CB's Office of Research and Statistics furnished us with poverty statistics from the 2000 Census. We sought to determine what portion of low income people in the state were covered by Medicaid. The data are not very comparable, however, and Medicaid eligibility depends on qualities other than income, such as age and disability status. However, we were able to draw some broad conclusions.

The 2000 Census shows 368,490 children age 0–17 in South Carolina were at or below 175% of federal poverty limits. Medicaid covers children up to their 19th birthday at or below 150% of federal poverty limits. Infants

age 0–1, as well as children in transitional Medicaid families, are also covered up to 185% of poverty. In December 1999, there were a total of 353,015 children eligible in the Medicaid program. Therefore it appears that Medicaid covers the majority of low income children, with "low income" being at about 175% of poverty or below. Medicaid coverage for children quickly falls off as families' incomes approach 200% of poverty.

**Table A.1: Medicaid and Poverty Levels in South Carolina 1999 – 2000**

| December 1999 | S.C. 2000 Census | | |
|---|---|---|---|
| Medicaid Eligible Children | Children Under 150% Poverty | Children Under 175% Poverty | Children Under 200% Poverty |
| 353,015 | 308,538 | 368,490 | 426,484 |

Source: DHHS and S.C. State Data Center

For all ages, DHHS data for 1999 shows that a total of 724,555 individuals in South Carolina were eligible for Medicaid. It should be noted that income alone does not qualify a person for Medicaid. Many poor adults are not eligible for Medicaid, even if their income is well under poverty levels, unless they are also disabled, have children, or are pregnant.

**Table A.2: Federal Poverty Levels for 2002**

| Annual Poverty Level | 100% | 125% | 150% | 175% | 200% |
|---|---|---|---|---|---|
| Individual | $8,860 | $11,075 | $13,290 | $15,505 | $17,720 |
| Family of 3 | $15,020 | $18,775 | $22,530 | $26,285 | $30,040 |
| # Individuals – S.C. 2000 Census | 547,869 | 727,004 | 922,834 | 1,111,962 | 1,301,528 |

Total South Carolina population in 2000 census was 4,012,012.

Source: Federal Register, Vol. 67, No. 31, 2/14/02; Office of Research and Statistics

## Appendix A
## Sources of Data

# Agency Comments

# State of South Carolina

## Department of Health and Human Services

Jim Hodges
Governor

William A. Prince
Director

Mr. George Schroeder
Director
Legislative Audit Council
1331 Elmwood Avenue, Suite 315
Columbia, South Carolina 29201

Dear Mr. Schroeder:

Thank you for the opportunity to comment on the Legislative Audit Council Report: *Options for Medicaid Cost Containment.* Enclosed are our comments. If you have any questions, please feel free to contact our office, at 803-898-2500.

Sincerely,

William A. Prince
Director

WAP/bj

Enclosure

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# South Carolina Department of Health and Human Services
# Response to Legislative Audit Council Report:
# *Options for Medicaid Cost Containment*

1. The Department of Health and Human Services should strengthen its controls over the identification of private health insurance available to Medicaid applicants.

**Response:** The Third Party Liability Division (TPL) has taken steps to put recipient requirements regarding their health insurance into the beneficiary newsletter that is being created by the Division of Health Promotion and Analysis. TPL has made the Health Insurance Referral Form available to all DHHS staff for referral through TPL/Medicaid Insurance Verification Services (MIVS). TPL can make available to eligibility workers the health insurance prototype file and a summary list of the plans included as a reminder to inquire about health insurance if an applicant has worked or is working at one of the major employers represented. TPL will re-establish a training process for eligibility workers who are now DHHS staff. TPL will attempt to locate the training video professionally created for DSS to assist them in interview discovery techniques that enhance applicant compliance to disclosure of primary resources.

DHHS has had in place a number of discovery sources in addition to the recipient declaration at the time of application and approval for Medicaid. The majority have been in place since 1990. In addition to the historic sources of insurance discovery listed below, the Medicaid Insurance Verification Services (MIVS) contract has implemented online query of primary insurance coverage with some major South Carolina plans for all Medicaid recipients that do not already have an insurance record online.

The historic insurance sources and the percent of insurance records online at the end of SFY 02 are listed:

| | |
|---|---|
| Employment Security Match | 10% |
| Champus Match | 4% |
| Partners for Health Children | 7% |
| Medicaid Eligibility Determination | 30% |
| Provider Referrals and Claims | 34% |

The remaining 15% are from accident questionnaires, BEERS and other Matches, Community Long Term Care, Social Security Administration, Child Support, insurance company checks and correspondence, and auto or other casualty insurance.

The Medicaid Eligibility determination process generates somewhat more than the percentage of the insurance referrals listed above. The MIVS contract has been tasked to work all referrals from all sources within twenty-five (25) days of receipt to meet the federal requirements. As a result of aggressive insurance filing from the provider community, referrals received weekly from claims processing may be researched and added online prior to receipt of the eligibility referral.

2. To strengthen the eligibility determination controls, the Department of Health and Human Services should institute a formal process for communication between the eligibility division and Medicaid eligibility quality assurance division.

**Response:** Since taking over the Eligibility Quality Assurance (EQA) process July 1st of this year, the Department has developed the following processes to ensure information is appropriately shared within the agency. We have developed "alert notices" and distributed over twenty notices sent July. Additionally, all Letters of Final Review and final reports are provided to the Eligibility Divisions. Finally, error case conferences have been scheduled and will be held periodically with the Division of Eligibility Policy.

3. The Department of Health and Human Services should proceed with amending the state plan to change or eliminate the following income disregards:
   - The low-income families Medicaid category's 50% of gross monthly earned income disregard.
   - The disregard of $50 of total child support received by the applicant

**Response:** Over the past year, SCDHHS has carefully scrutinized the entire eligibility process and formulated a number of changes among which are changes in disregards. As a result, at the time we received the LAC draft report, we were already in the process of preparing State Plan Amendments which will include both of the above recommendations. Since states are required to provide Medicaid eligibility to low income families who meet the pre-welfare reform AFDC income and resource standards, methodologies and certain other requirements under the State's AFDC plan in effect on July 16, 1996, SCDHHS will amend our State Plan to utilize the income disregard in place on July 16, 1996. That is to disregard $30 plus one third of the remaining gross income for 4 months; then disregard $30 for 8 months; then continue only the Child Care/Incapacitated Adult disregard when applicable. The State Plan is also being amended to remove the $50 child support disregard.

3. The General Assembly may wish to revise SC Code §43-5-1240 so that it includes only one year of the federally mandated transitional Medicaid instead of the two years of transitional Medicaid for low-income families and welfare recipients.

**Response:** DHHS made this recommendation to the General Assembly last year but the proposal was not enacted. Once the State law is changed SCDSS will also need to amend the

TANF plan and SCDHHS will need to change the Medicaid Waivers to effect this change. The Medicaid waivers expire on June 1, 2003. Therefore SCDHHS recommends June 1, 2003 as the target date for this change.

4. The Department of Health and Human Services should consider reviewing the eligibility of LIF and transitional Medicaid recipients at three to six month intervals rather than annually to ensure that only eligible people are receiving Medicaid.

**Response:** Effective July 1, 2002, the Department assumed complete control and responsibility for the management and processing of Medicaid. Since that time we have reduced the operational cost of the eligibility process by approximately $5 million dollars and approximately 100 workers. Given the reduced workforce, SCDHHS proposes that targeted interim reviews be conducted. That is if an income of zero is provided at the time of application, then a review is completed in 3 months. If inconsistent income is identified through a data match with the SC Department of Revenue and the income is such that it would disqualify the family, then a review will be completed.

5. The Department of Health and Human Services should consider eliminating assumptive eligibility.

**Response:** As noted above, SCDHHS has carefully scrutinized the entire eligibility process and formulated a number of changes over the last year. Among changes already in process at the time of receipt of the LAC draft report was the elimination of assumptive eligibility. SCDHHS agrees with this recommendation and has already taken action to implement this change effective January 1, 2003, for all eligibles except for Pregnant Women. It is important to note that changes to the eligibility process cannot and should not be made in a vacuum based solely on cost savings but rather must be made in the context of the overall goals we are trying to achieve in the Medicaid program. Improved birth outcomes is a major health outcome of the program and warrants continuation of assumptive eligibility for pregnant women to assure they receive the early prenatal care and intervention required to prevent infant mortality and morbidity.

6. The Department of Health and Human Services should continue to review the eligibility criteria for Medicaid to identify areas where changes can be made to slow the growth in the number of Medicaid recipients.

**Response:** SCDHHS agrees with this recommendation and will continue to review where changes can be made to slow the growth of Medicaid beneficiaries.

7. The Department of Health and Human Services, as it establishes new policies on recipient fraud, should include requirements for coordination and communication between the program integrity unit, other DHHS divisions, and other state agencies.

**Response:** The responsibility for recipient fraud was transferred to the Department on July 1, 2002. The Department has been developing policies and procedures for recipient fraud that include cooperation with Eligibility Quality Control unit as well as coordination within agency divisions. We have taken additional steps that include developing "lock-in " procedures for recipients abusing services, establishing a fraud hot-line and publishing the number on recipient cards and provider bulletins, and creating a recipient fraud unit that analyzes claims data to identify fraudulent and abusive recipient practices.

8. To help reduce recipient and provider fraud cases, the Department of Health and Human Services should require its pharmacy division to share information from the point-of-sale system with the program integrity unit.

**Response:** This issue has been addressed and appropriate reports will be shared between the point-of-sale system and Program Integrity.

10. The Department of Health and Human Services should increase its efforts to educate recipients about Medicaid fraud and how to use Medicaid benefits appropriately.

**Response**: Information about fraud is already included on the Medicaid card, the card carrier which is utilized to mail the card, the Medicaid handbook, the Medicaid application and the DHHS web site. The content of these messages is outlined below. The Department will continue to identify ways to incorporate fraud education into information distributed to recipients, including placing information in the newly developed beneficiary newsletter. We will also develop training materials for eligibility staff to distribute when they conduct periodic community awareness programs.

The Medicaid card has the following two statements:

1. It is against the laws to let someone else use your card. Violators will be prosecuted.
2. To report possible fraud or abuse call 1-888-364-3224.

The Medicaid card carrier has the following statement:

> Selling, changing or letting someone else use your Medicaid card is against the law. Those who do so will be prosecuted and lose Medicaid. If you think that someone is using another person's Medicaid card, please call the Medicaid Fraud Line at 1-888-364-3224.

The Medicaid Handbook states:

> You could be fined, sent to prison, or both, if you do any of the following things on purpose:
> a. Give false information when you apply or when your case is being reviewed, or
> b. Fail to report anything that would affect your eligibility for benefits or the eligibility of anyone for whom you applied, or
> c. Give your plastic card to another person.

On the Medicaid application, the applicant's signature statement is as follows:

> I certify that the information I have provided is true to the best of my knowledge and I give permission for the State of South Carolina to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities. I know that I could be penalized if I knowingly give false information.

The DHHS Website lists Penalties for recipient Fraud.

The state will also include information about recipient fraud in its beneficiary education plan. The brochure to be used by eligibility workers in educating beneficiaries about the partnership concept and their role and responsibilities in it will include the following:

- Keep your Partners card in a safe place.
- Never let someone else use your card.

These same statements will be included on the refrigerator magnet being designed for beneficiaries as a more permanent reminder.

11. In order to further contain prescriptions drug costs, the Department of Health and Human Services should implement a state preferred drug list by take the following steps:
    - Negotiate supplemental rebates with drug manufacturers whose products are not on the preferred list and who want to protect or expand their market share.

    - Amend the State Medicaid Plan and obtain all necessary approvals from the South Carolina General Assembly and the federal Centers for Medicare and Medicaid Services.

    **Response:** DHHS agrees and has been working with our Pharmacy Services contractor (First Health) since July 2002. At our direction First Health assembled a committee of South Carolina physicians and pharmacists for a clinical review of appropriate drug classes. This clinical review by the committee has been completed and the committee has selected those products they feel should not require prior approval and are therefore "preferred".

DHHS will utilize the services of our pharmacy contractor (First Health) in negotiating supplemental rebates for South Carolina Medicaid once the Center for Medicare and Medicaid approves the South Carolina Medicaid state plan amendment.

At the November 2002 Medical Care Advisory Committee (MCAC), DHHS sought and was granted unanimous approval to request of the Center for Medicare and Medicaid Services (CMS) a South Carolina Medicaid State Plan Amendment that will allow supplemental drug rebate agreements between the South Carolina Department of Health and Human Services and pharmaceutical manufacturers with respect to Medicaid outpatient prescription drugs. No action by the South Carolina General Assembly is necessary to implement Medicaid supplemental rebates.

3. If the Department of Health and Human Services is unable to implement a state preferred drug list, it should reduce its Medicaid drug expenditures by including more therapeutic classes of drugs as well as frequently prescribed brand name drugs on the prior authorization list.

**Response:** DHHS agrees and prior approval will be necessary for non-selected products in those therapeutic classes for which a preferred product(s) has been selected. To avoid prior approval of a non-selected product(s), a pharmaceutical company can provide sufficient supplemental rebates to warrant coverage without prior approval.

4. The Department of Health and Human Services should reconsider the October 18,2001, Medicaid bulletin and once again place all Oxycontin® prescriptions on prior approval.

**Response:** DHHS' monitoring and review of physician prescribing habits regarding Oxycontin® indicate that prescribers have changed their prescribing habits regarding Oxycontin® resulting in a marked reduction in its use. However, given our activities as outlined above in the response 11, we would expect changes in prior approval resulting from clinical review and the resulting enhanced prior approval initiative.

5. The General Assembly should consider authorizing more slots for the CLTC program and freezing the number of nursing home beds.

**Response:** We agree with the recommendation that the General Assembly should consider authorizing more slots for CLTC and over the past two years have included the need for more slots as part of the discussion in our budget presentation. However, we would not recommend that the number of nursing home beds be decreased because there is rapid growth in the number of seniors in our state resulting from in-migration and the aging of "the baby boomers". The two

fastest growing segments of the senior population are those 75 + and 85+. While longevity and quality of life are increasing, these groups are the most likely to suffer from Alzheimer's and related dementias. Unless methods of prevention of Alzheimer's are discovered, the number of South Carolinians with Alzheimer's Disease will increase from 42,020 in 2000 to 125,190 in 2025. People in the latter stages of dementia usually require nursing home care. Additionally, many individuals who enter nursing homes relinquish their place of residence and/or do not have the necessary family support system to successfully remain in the home to receive their long term care services and would therefore require nursing home placement.

6. The General Assembly should consider approving a combined appropriation for long term care in DHHS' budget, in order to give DHHS more flexibility in funding CLTC and nursing home care based on client demand.

**Response:** We believe that there are not currently great numbers of nursing home residents who would or could move back to the community. Further, there will always be a need to fund nursing home beds. However, as the thrust toward home and community based services increases and the cost of nursing home care increases, it would seem that some formula should be developed to fund both CLTC and new nursing home beds. For instance, the Legislature could fund six new CLTC slots for each new nursing home bed.

7. The Department of Health and Human Services should implement a system that allows funding to follow patients from nursing homes into a home or community - based setting.

DHHS has already begun a process of working to transition nursing home patients from nursing homes into home or community based settings. The agency was awarded funding in September, 2002 for *South Carolina Home Again,* a Nursing Home Transition Grant sponsored by the Center for Medicare and Medicaid Services (CMS, formerly HCFA). This project, directed by Community Long Term Care (CLTC), partners with the Department of Mental Health (DMH) and the Department of Disabilities and Special Needs (DDSN). The grant's primary objective is to identify and transition nursing home clients who want to return to the community, and to test and implement, infrastructure system changes needed for this purpose. This project should eventually realize cost-savings to the Medicaid program since community care provided through the CLTC waivers costs only 42% of the cost for Medicaid-sponsored nursing home care.

The issue of having nursing home funds follow the patient is a much more difficult proposition. As noted in the responses to recommendations # 15 and #16 above, there are a only a limited number of nursing home residents who could or would move back into the community and there is an ever growing demand for nursing home beds because of the aging of the population. Having money follow the recipient would require leaving a much needed resource (nursing home beds) standing idle while there is a burgeoning demand for that very resource.

Notwithstanding the above, we believe that there will likely be litigation in federal courts

concerning the money following the client in order to help refine the Olmstead decision in the near future. This has been the case with the interpretation of the initial parts of the Americans with disabilities act.

8. The Department of Health and Human Services should work with the nursing home industry to help them diversify into home and community based care.

**Response:** A number of years ago, the hospitals had to "re-gear" the way they treated patients in response to changes in reimbursement. For example, hospitals moved to more out-patient surgeries, shorter stays, beds for re-habilitation, etc. If Medicaid law is changed so that home and community based services become the "entitlement" as opposed to nursing home care being the "entitlement" then nursing homes will find it necessary to diversify their services and use areas of their facilities for respite care, assisted living, adult day care, etc. As the Medicaid agency, it is our responsibility to pay for the most appropriate care for the people we serve and it is important to the state that this diversification be supported by appropriate training from the Medicaid Agency. We are already seeing nursing facilities in other states make this transition. We believe that
the national nursing homes associations will also begin providing this type of
training for their members.

9. The Department of Health and Human Services should amend the state Medicaid plan to make the Partners for Healthy Children program a separate program and to charge an enrollment fee to enrollees in the program.

**Response:** The Department will continue to evaluate its Partners for Healthy Children Program to ensure the most effective and efficient delivery of health care services.

Even though the Social Security Act addresses enrollment fees in 1902(a)(14), the State is not allowed to assess enrollment fees per 1916 of the Act and 42 CFR 457.51(a). Specifically, enrollment fees are precluded for categorically eligible individuals and all of South Carolina's eligibility groups are categorical, precluding charging of an enrollment fees. An enrollment fee may only be assessed for medically needy as defined in 42 CFR 435.4 and 436.3.) South Carolina's State Plan does not include coverage of the medically needy.

Our regional office for the Centers for Medicare and Medicaid Services stated that no states in our region charge an enrollment fee for their medically needy population.
We also contacted the Texas Medicaid program. While they charge an enrollment fee for their separate SCHIP program, they do not charge an enrollment fee for their medically needy program. Texas was able to charge an enrollment fee for its SCHIP program because it is a "stand alone" program, i.e. it is not a Medicaid program. South Carolina's SCHIP program is a Medicaid expansion and therefore falls under the preclusions of 1916(1)(1) of the Act. After

careful review, South Carolina has determined that it cannot charge an enrollment fee. Given the above information, the cost savings of $2-6 million projected in the report is in error.

10. The Department of Health and Human Services should review charging co-payments on optional services and hospital admissions as a cost-saving measure.

**Response:** DHHS agrees with the concept of expanding the use of co-pays, however, we believe the imposition of co-pays must be made in concert with the overall objectives of the Medicaid program such as accessing medical homes and changing behavior which adversely impacts health, not solely based on cost savings. Each service should be assessed independently and blanket co-pays should not be adopted solely for fiscal considerations. Additionally, there a number of limitations on co-pays relative to amounts, services and coverage groups. As stipulated in 42 CFR 447.53(b), co-pays may not be imposed on children, pregnant women, institutionalized individuals, or HMO enrollees, nor for emergency services, family planning, or hospice services. Co-payment amounts are restricted based on family income and the amount of the payment the State makes for a service (42 CFR 447.52 and 447.54).

Given the above restrictions, we are concerned that the cost savings estimates based on co-payments are overstated. Additionally, we believe that there is no basis for assuming that imposition of a co-payment will cut utilization by 10% which was built into the projection of costs.

11. The General Assembly should amend S.C. Code§ 43-7-460 to increase estate recovery collections by:
    - Including services in addition to nursing home and community long term care;
    - Authorizing liens on real property; and
    - Expanding the definition of estate.

**Response:** The Department executes the State Law as it is currently written. We will certainly implement and comply with any changes made by the General Assembly.

4. The General Assembly should amend S.C. Code§ 43-7-460 to require personal representatives and the probate judge to notify the Department of Health and Human Services upon the death of a person who has received nursing home or community long term care services paid for by Medicaid.

**Response:** The Department executes the State Law as it is currently written. We will certainly implement and comply with any changes made by the General Assembly.

5. The Department of Health and Human Services should consider using the Department of Revenue for debt collection.

**Response:** The overall receivable collection rate for the agency is 99.13% within the year it is set up. However, DHHS has been in contact with the Department of Revenue regarding the GEAR program. We are in the process of evaluating GEAR and will implement the program should it provide significant efficiency and cost effectiveness.

6. The Department of Health and Human Services should adjust its Medicaid Management Information System to allow for regular deductions from reimbursements for debt collections.

**Response:** The Department currently manually submits monthly adjustments to MMIS. We have submitted a request to modify this process to our contractor. This request will be assigned a priority relative to the importance of other pending requests. Though we agree this is an area that can be automated, we have no evidence that the existing manual process has comprised the ultimate collection of debts as indicated in the report.