LEGISLATIVE AUDIT COUNCIL

FOLLOW-UP

Cost Savings Strategies for the South Carolina Medicaid Program (October 2001)

AUDIT BACKGROUND

This report was the second in a series of three reports which reviewed the South Carolina Medicaid Program. Managed by the SC Department of Health and Human Services (DHHS), the state Medicaid program provides health care for eligible recipients and is jointly funded by federal and state dollars. Eligible recipients are those who receive cash assistance, such as welfare or Supplemental Security Income, as well as low-income children, pregnant women, disabled individuals, and the elderly.

Audit requesters were concerned about Medicaid budget deficits and were interested in identifying costs savings in the Medicaid program without cutting services. We reviewed three areas where implementation by DHHS might help save funds while not impeding the goals of the program. This report focused on:

- Greater use of managed care instead of paying Medicaid claims on a fee-for-service basis;
- Expanding the health insurance premium payment program; and
- Revising the eligibility determination contract with the Department of Social Services.

June 2003

MOST RECOMMENDATIONS NOT IMPLEMENTED

The October 2001 audit estimated a total savings of almost $33 million, including $10.7 million in state funds, if DHHS implemented our recommendations in three areas — greater use of managed care, paying health insurance premiums, and revising the eligibility determination contract. For the most part, our recommendations have not been implemented; however, DHHS has reduced the cost of the Medicaid eligibility system and is actively pursuing an alternative Medicaid management model.

MANAGED CARE

DHHS offers two types of managed care programs. Both are "voluntary," which means a Medicaid recipient cannot be required to join:

- An HMO program, operated by a private nonprofit agency, which covers a wide array of health care services. Services are provided by participating physicians, hospitals, pharmacies and other medical professionals, and Medicaid clients must go to these providers for services. DHHS pays the HMO a per-person fee to cover all services provided.
- The "Physician's Enhanced Program" (PEP), an alternative reimbursement methodology program managed by DHHS. Participating physicians provide Medicaid recipients a basic package of primary care services for an established fee per person, and act as gatekeepers for additional services.

During our review, South Carolina had fewer than 5% of Medicaid recipients enrolled in managed care programs, the lowest rate for the southeastern states. We recommended that DHHS take several steps to increase the use of managed care:

- Contract for an independent, third-party study to assess the cost effectiveness of DHHS' current managed care programs;
- Develop a controlled pilot project for a mandatory managed care delivery system for specified Medicaid groups in one or more urban areas of the state; and
- Implement an enrollment period or "lock-in" of one year for Medicaid clients currently in managed care programs.

While DHHS did proceed with a study of its managed care systems, it has not yet implemented a pilot project for a mandatory managed care program, and neither has it instituted a lock-in period. However, DHHS has begun a managed care initiative that it is calling a "medical management model," and is planning to move away from the traditional fee-for-service reimbursement to an alternative way of paying Medicaid providers. The department has formed a task force which includes physicians and has incorporated this initiative in its strategic plan.

The managed care study, by Carolina Medical Review, reported that the Physician's Enhanced Program saved about $10 per member per month, or approximately 7% over traditional fee-for-service. The study's results for the HMO model were less conclusive, and some of its methodology was questionable. According to DHHS staff, the study needs further review and validation.

Methodology

We received information from the Department of Health and Human Services regarding the implementation of the audit's recommendations. We reviewed this and other information, interviewed officials, and verified evidence supporting DHHS's information as appropriate.

For More Information

Our full report, its summary, and this document are published on the Internet at

www.state.sc.us/sclac

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Health Insurance Premium Payment Program

DHHS has a Health Insurance Premium Payment (HIPP) program to help Medicaid-eligible individuals with access to private health insurance. When it is cost-effective, DHHS can pay all the premiums, deductibles, and coinsurance for Medicaid beneficiaries with employer-based group health insurance plans. The cost savings potential is the greatest for those recipients with high-cost diagnoses like HIV/AIDS. In the October 2001 audit, we recommended two options for expanding the HIPP program:

- In-house expansion, with changes to the information technology system and the organizational structure. This option could serve about 1,000 recipients. It would cost an estimated $350,000 annually with potential annual cost savings of $1.3 million.
- Contract with a private vendor to administer the program. This option could serve 5,000 recipients. It would cost an estimated $1.5 million annually with potential annual cost savings of $6.5 million.

DHHS officials stated that the department has been examining the program and has expanded it. However, as of January 2003, DHHS had 193 participants in the program, the same number who were enrolled on May 1, 2001. Due to the administrative effort involved in the program, DHHS is considering using outside contractors.

Cost of Determining Eligibility

The Department of Health and Human Services formerly contracted with the Department of Social Services (DSS) to conduct eligibility determinations, which in FY 99-00 cost DHHS approximately $34 million. We found that DHHS could cut costs by revising the payment system for the contract, making sure it was only paying for necessary staff, and not duplicating functions with the DSS state office. However, beginning July 1, 2002, the system for determining Medicaid eligibility was more drastically changed. The General Assembly, in the appropriations act, authorized DHHS to perform this function and transferred the eligibility workers from DSS to DHHS.

We compared the FY 99-00 cost of the DSS contract with the estimated FY 02-03 cost of DHHS performing eligibility determinations. Overall, savings are at least $2.6 million; if the cost of implementing a new Medicaid eligibility management information system is excluded, the savings would be more than $5 million.

We also recommended that DHHS initiate more contracts with healthcare providers to provide funding for eligibility workers located on-site. However, as of April 2003, DHHS had contracts for only 182 sponsored eligibility workers compared to 199 in FY 99-00.

We also recommended that DHHS remove funding for transportation coordination workers from the eligibility contract, and seek to have these services provided by Medicaid transportation contractors. The transfer of eligibility also moved these staff to DHHS. However, the department has not sought to shift this cost to the transportation providers since these providers indicated that they would require a significant increase in passenger rates.

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