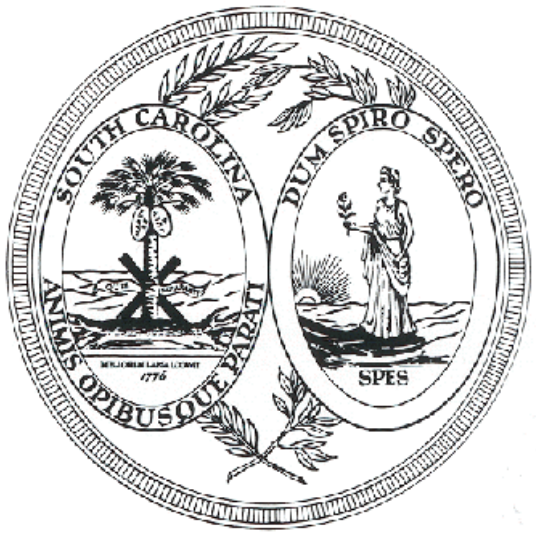
LAC

Report to the General Assembly

February 2001

A Review of Selected Medicaid Issues

- Fraud and Abuse
- Prescription Drug Costs
- Funding



LEGISLATIVE AUDIT COUNCIL

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Authorized by §2-15-10 *et seq.* of the South Carolina Code of Laws, the Legislative Audit Council, created in 1975, reviews the operations of state agencies, investigates fiscal matters as required, and provides information to assist the General Assembly. Some audits are conducted at the request of groups of legislators who have questions about potential problems in state agencies or programs; other audits are performed as a result of statutory mandate.

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A Review of Selected Medicaid Issues was conducted by the following audit team.

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Synopsis

As requested by members of the General Assembly, we conducted a review of the Department of Health and Human Services' (DHHS) management of the state Medicaid program. Medicaid is a federal program that provides financial assistance to states for health care for eligible recipients. Eligible recipients are those who receive cash assistance and those children, pregnant women, the disabled and the elderly who meet income and resource requirements.

The audit requesters were primarily concerned about:

- ❑ DHHS's efforts to detect and control fraud and abuse.
- ❑ The increase in pharmaceutical expenditures.
- ❑ The agency's budget deficit.

They also had additional concerns about DHHS's use of managed care. We will discuss managed care and other issues in a subsequent report.

DHHS has a Division of Program Integrity which investigates potential cases of fraud and abuse. For FFY 98-99, DHHS reported $2,064,460 in collections, including overpayments, identified through fraud and abuse detection efforts.

In South Carolina, Medicaid costs for prescription drugs have increased from $123 million to $260 million in the last five years. In FY 99-00, pharmaceutical services accounted for 11% of total Medicaid expenditures and was the fourth highest expenditure. Between FFY 94-95 and FFY 97-98, the average annual increase in prescription drug expenditures for the southeastern region was 14%, while South Carolina's was 22%.

Our findings include the following.

- While DHHS requires verification of health care providers' licenses and certificates, more stringent requirements could be implemented to ensure that only eligible providers are enrolled in the Medicaid program.

- DHHS does not always verify income for applicants to the Partners for Healthy Children program to ensure that only eligible recipients receive Medicaid services. Specifically, DHHS does not verify information for those applicants who report no income or other sources of income such as child support.

- DHHS has not been providing adequate training to health care providers to ensure that providers understand and are following Medicaid policies and procedures.

- There is little evidence that internal reviews result in questionable cases being referred to DHHS fraud investigators, as policy directs. From FY 95-96 through FY 99-00, only 5 cases were referred for further investigation as a result of reviewing medical services claims.

- DHHS Program Integrity Division has not developed performance measures or an adequate case tracking system that would enable it to assess the effectiveness of its fraud and abuse investigations.

- For FFY 98-99, collections resulting from fraud and abuse detection amounted to only 0.08% of payments to Medicaid providers. DHHS should set a goal to increase collections due to fraud and abuse.

- Since 1995, the Medicaid Fraud Control Unit (MFCU), which is part of the Attorney General's office, has received only 44 cases from DHHS. The Program Integrity Division should increase the rate of, and shorten the time frame for, referral of suspicious cases to MFCU.

- DHHS Program Integrity Division does not have a written fraud and abuse plan. Division officials stated that a plan is being developed.

- DHHS has not developed drug use policies that could help limit increases in prescription drug costs. Such policies should require increased use of generic drugs, prior authorization, and therapeutic protocols for targeted drugs, and could save up to $15.6 million in Medicaid funds.

- While DHHS will pay for only 4 prescriptions per month for adult Medicaid recipients, they are allowed to obtain a 100-day supply for each prescription. This in effect could allow recipients up to 12 prescriptions per month, which impacts DHHS's cash flow and could result in wasted medication.

- DHHS did not amend the State Medicaid Plan, as required by law, when increasing the number of Medicaid prescriptions. As a result, the state could be penalized up to $3.5 million by the federal government. DHHS now has a formal process for all changes that require an amendment to the State Plan.

- Three factors creating pressure on DHHS's state budget for Medicaid include the increase in the number of recipients, the change in the funding mix toward increased use of state funds, and the use of non-recurring funds to make up the state's share of Medicaid funding. DHHS had a $25.8 million deficit in state appropriations in FY 99-00.

Glossary

Disproportionate Share Payments

Federal law requires states to ensure that their Medicaid payment rates include payment adjustments for Medicaid-participating hospitals that serve a large number of Medicaid recipients and other low-income individuals with special needs (referred to as disproportionate share hospitals). South Carolina Medicaid disproportionate share hospital payment adjustments are based on each disproportionate share hospital's unreimbursed Medicaid cost and their unreimbursed cost associated with uninsured patients.

Drug Utilization Review (DUR)

The Medicaid Drug Utilization Review (DUR) Program was created by the Omnibus Budget Reconciliation Act of 1990. The main emphasis of the program is to promote patient safety by an increased review and awareness of outpatient prescribed drugs. Information is collected and used to measure the effect DUR has had on patient safety, provider prescribing habits and dollars saved by avoidance of problems such as drug-drug interactions, drug-disease interactions, therapeutic duplication and over-prescribing by providers.

Federal Medical Assistance Percentage (FMAP)

Represents the federal share of a state's Medicaid spending for medical services. See also "matching funds."

Health Care Financing Administration (HCFA)

The government agency within the Department of Health and Human Services which directs the Medicare and Medicaid programs (Titles XVIII and XIX of the Social Security Act) and conducts research to support those programs.

Matching Funds

For each Medicaid dollar spent in South Carolina — on average 30¢ is from the state, 70¢ is from the federal government.

Medicaid Fraud Control Unit (MFCU)

Federal and state law both require a Medicaid fraud control unit, which must be separate from the single state agency for Medicaid. In South Carolina, the MFCU is located within the Attorney General's office. They investigate and prosecute Medicaid fraud.

Medicaid Management Information System (MMIS)

MMIS processes Medicaid eligibility and pays claims. It processes 15 – 16 million claims a year, and its chief function is to receive, edit, and adjudicate claims from providers of health services. The mainframe is physically located at Clemson. They provide the hardware, software, support and personnel.

Partners for Healthy Children

On August 1, 1997, South Carolina expanded its Medicaid program to include all children ages 1–18 up to 150% of the federal poverty level. This expansion is part of the federal Child Health Insurance Program (CHIP).

Surveillance Utilization and Review System (SURS)

SURS monitors Medicaid usage on a post-payment basis. It monitors, controls, educates, and assists in ensuring the quality of medical services and the development of new cost containment alternatives.

Medicaid Groups

The federal government requires states to cover certain groups and gives states the option of covering other groups. Currently South Carolina provides coverage to the following groups:

- Family Independence recipients — Those who receive a welfare cash benefit.
- Aged, blind and disabled — Those individuals who are over age 65, blind or disabled and who also meet income requirements; receive Supplemental Security Income; and/or are in a nursing home, are institutionalized, or are receiving home and community-based care.
- Medicare Beneficiaries — For qualified Medicare recipients at 100% of poverty, Medicaid will pay all of the Medicare premium; for individuals at 120% of poverty, Medicaid will pay for Medicare Part B; partial payment is available for individuals with income between 135% and 175%.
- Pregnant women and infants with income under 185% of poverty.
- Children age 1–19 if family income is at or below 150% of poverty.
- Children in foster care and children under a state adoption assistance agreement.
- Severely disabled children cared for at home instead of in an institution.
- Individuals considered “working disabled.”

Introduction

Audit Objectives

Members of the General Assembly requested an audit of the Department of Health and Human Services' (DHHS) management of the state Medicaid program, after DHHS incurred a deficit in state general fund appropriations for FY 99-00. Audit requesters were primarily concerned about whether DHHS could manage the Medicaid program in a more efficient and cost-effective manner. Based on some of the specific concerns of audit requesters, we have established the following objectives for this report:

- ❑ Evaluate the effectiveness of the agency's efforts to control and detect fraud and abuse by Medicaid health care providers and recipients.
- ❑ Determine if DHHS can improve the cost-efficiency of its management of the prescription drug program.
- ❑ Track agency appropriations and expenditures over a 10-year period in conjunction with funding changes for the Medicaid program, and determine the impact of this on DHHS's deficit.

Because of the size of the Medicaid program in South Carolina (almost $3 billion) and the number of concerns of audit requesters, we are conducting a second review on the use of managed care in the Medicaid program as well as other cost issues. We plan to release this report in summer 2001.

Scope and Methodology

The time frame covered by this report is generally from FY 95-96 through FY 99-00. We also have reviewed cost data from FY 90-91 through FY 00-01. Our sources of evidence include:

- South Carolina appropriations acts and other relevant statutes as well as federal law, primarily Title XIX of the Social Security Act.
- Information on recipients and claims generated by the Medicaid Management Information System.
- Financial information from DHHS's accounting system.
- Agency policies and procedures, Medicaid bulletins, and the State Medicaid Plan.

- Interviews with officials at DHHS as well as with other state agencies and health care groups.
- Telephone interviews with Medicaid officials in other states.
- DHHS medical services review files and fraud investigation files.
- Material from the U.S. Health Care Financing Administration, the U.S. General Accounting Office, the Southern Legislative Conference, and the National Conference of State Legislatures.

Computer-generated data used in the report was supplied by DHHS and HCFA and was not verified by us. While we did not directly test the data, we attempted to review relevant system controls in order to ensure the data is reliable and valid. This is explained further in the methodology note in Appendix A. This audit was conducted in accordance with generally accepted government auditing standards.

Background

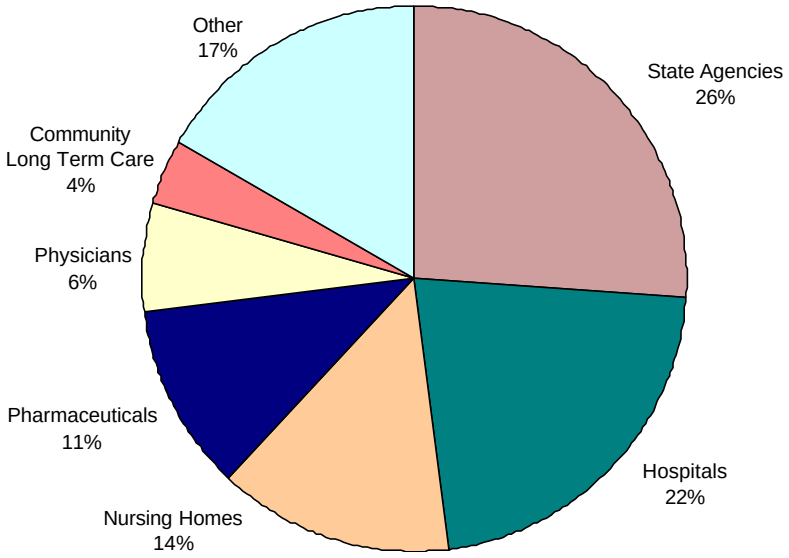
Medicaid is a federal program created under Title XIX of the Social Security Act that provides financial assistance to states for health care for eligible recipients. Medicaid was set up by the federal government in 1965, and South Carolina began participating in 1968. Medicaid began as a small program within the Department of Social Services. In 1983, the Health and Human Services Finance Commission (HHSFC) was established to administer the Medicaid program. On July 1, 1995, HHSFC became a Cabinet agency and was renamed the Department of Health and Human Services.

Eligible Medicaid recipients are those who receive cash assistance and those children, pregnant women, the disabled, and the elderly who meet income and resource requirements. During FY 99-00, 693,778 South Carolinians received health services paid for by Medicaid.

- The elderly and disabled made up 26% of these clients and utilized Medicaid health services valued at $1,605,530,795, or 69% of Medicaid expenditures, for an average per person cost of $7,190.
- Seventy-four percent were children, or recipients who qualified due to eligible children in the family, who received health care valued at $711,708,552. This accounted for 31% of Medicaid expenditures at an average per person cost of $1,124.

During FY 99-00, direct payments to health care providers for services totaled over $2.3 billion in federal and state funds and were paid to the following groups.

Figure 1.1: Medicaid Payments to Providers FY 99-00*



*Total payments amounted to $2,339,099,527, which excludes payments for disproportionate share paid to hospitals.

Source: Department of Health and Human Services FY 99-00 Accountability Report.

Through the new Partners for Healthy Children program, South Carolina began covering children living in families earning 150% of the federal poverty level in 1997. South Carolina also pays for nursing home care for aged and disabled individuals. Through payments to other state agencies such as the Department of Mental Health and the Department of Disabilities and Special Needs, Medicaid is also spent to cover medical services to the disabled.

Health care is provided to Medicaid recipients by providers enrolled in the Medicaid program. Any provider who meets the qualifications must be allowed to enroll and provide services. Payments are made directly to the provider, who bills the Medicaid program for a specific service provided to an eligible recipient. Payments cannot be made to a recipient. The provider must accept the Medicaid payment as the full payment.

Control and Detection of Fraud and Abuse

Introduction

Members of the General Assembly were concerned about DHHS's efforts to control and identify Medicaid fraud and abuse by providers and recipients. We reviewed the various processes used by DHHS to help the agency both detect and prevent fraud and abuse, including:

- Enrollment of Medicaid recipients and health care providers.
- Provider training.
- Medical services reviews.
- Auditing provider contracts.
- Fraud investigations.
- Relationship with the Medicaid Fraud Control Unit.

DHHS monitors health care payments and investigates irregular or suspicious claims through its Program Integrity Division within the Office of Audits and Compliance. Total program integrity staff number 21 employees, including the director.

One of the most important decisions that the Program Integrity Division must make is whether fraud, abuse, or only an overpayment has occurred. The Code of Federal Regulations defines fraud and abuse in the Medicaid program:

❑ Fraud is an intentional deception or misrepresentation knowing that the deception will result in an unauthorized benefit.

❑ Abuse means practices that are inconsistent with sound fiscal, business, or medical practices and result in unnecessary cost to the Medicaid program.

The Program Integrity Division does not consider overpayments less than $500 as fraud or abuse. Instead this is treated as an educational matter, and the overpayment is recouped. All other overpayments are considered within the context of the federal definitions to determine how they will be handled.

In general, we found that DHHS has not aggressively pursued fraud and abuse and has given only minimal recognition to fraud as a major problem. However, during the course of our review, the Program Integrity Division was reorganized under new administrative leadership, and a new automated surveillance system was in the process of being installed. While our review focuses on the division's performance over the past five fiscal years, we found that the division is already taking steps to improve its record in combating Medicaid fraud and abuse.

Control of Fraud and Abuse

By detecting ineligible providers and recipients before they enter the Medicaid program, DHHS can control fraud and abuse by preventing it before the claim is filed. We reviewed DHHS's methods of enrolling recipients and health care providers as well as the training offered to providers on Medicaid billing. DHHS should adopt a more stringent screening process for health care providers; more verification is needed for recipient enrollment; and provider training could be improved.

Provider Enrollment

While we found no major problems with provider enrollment, DHHS could have more comprehensive policies to keep ineligible providers out of the Medicaid program. DHHS contracts with Blue Cross Blue Shield (BCBS) to provide manpower services for its Medicaid Management Information System. As part of this contract, BCBS is responsible for enrolling any health care providers in the Medicaid program and updating information on providers. In the last two calendar years, BCBS enrolled or updated the following number of providers:

	1998	1999
New Enrollments	4,094	5,952
Updates	14,093	24,495

Blue Cross Blue Shield is required to have a 100% accuracy rate for provider enrollment and to verify licenses or certification information. Providers are also checked against a national list of suspended providers to ensure that they have not been suspended from the Medicaid program. As part of the contract monitoring process, DHHS verifies a certain number of provider enrollments. According to a BCBS official, information is not maintained on the number of providers denied enrollment. As a result, no one can determine how successful Blue Cross Blue Shield is in weeding out questionable providers.

For example, BCBS is not required to check business licenses. Program integrity fraud investigators found that a durable medical equipment provider operating in South Carolina was connected with someone convicted of health care fraud in another state. The company never obtained a business license and closed before DHHS could recover any funds for improper billing.

In testimony before Congress in July 2000, the U.S. General Accounting Office (GAO) noted that ". . . it is critical to protect program funds by making efforts to ensure that only legitimate providers bill these programs." The GAO did a survey of Medicaid state agencies and found that only nine states reported performing comprehensive provider enrollment activities. The GAO cited several activities which could be used to make it more difficult for questionable health care providers to enter and remain in the Medicaid program:

". . . it is critical to protect program funds by making efforts to ensure that only legitimate providers bill these programs." (GAO)

- More stringent review of information on the provider enrollment application.
- Developing provider agreements that give the state more flexibility to terminate without cause.
- Re-enrolling existing providers under new, stricter standards.
- Increasing scrutiny of applications from certain provider types, such as independent laboratories and durable medical equipment providers, and continued scrutiny after enrollment.
- Conducting pre-enrollment visits.
- Establishing better control over provider billing numbers.

For example, as a result of problems with provider fraud, in December 1995 Florida began requiring noninstitutional providers to undergo fingerprinting and criminal background checks. For group providers, all officers, directors, managers, and owners of 5% or more of the business must also be similarly screened. Fingerprints are checked with both state law enforcement authorities and the Federal Bureau of Investigation. In 1999, Georgia's provider enrollment unit began conducting site audits on all new noninstitutional provider applicants. When they began the site audits, they detected numerous applicants with nonexistent addresses or mailbox-only operations; now such a finding is rare in Georgia.

While DHHS does require documentation from certain types of health care providers, it does not conduct any of these other activities or require them of BCBS. Some additional provider screening could be conducted with little increase in costs. DHHS should consider strengthening its provider enrollment activities to help ensure that questionable providers are not enrolled.

Recipient Enrollment

DHHS does not verify all income information for applicants to the Partners for Healthy Children program to ensure that only eligible recipients receive Medicaid services. DHHS contracts with the Department of Social Services (DSS) to determine initial eligibility for Medicaid and all eligibility redeterminations. In order to determine eligibility, the Department of Social Services has verified income and resources for 62% of the families applying for the Partners program. DHHS determined the eligibility for the remaining 38% of the applicants for Partners for Healthy Children. During FY 99-00, 55,637 children were served by this program, and 4,360 applications were denied.

Applicants are supposed to provide proof of income which includes pay stubs or tax returns. For the applicants it enrolls, the Department of Social Services requires proof of earned income as well as documentation of income from other sources such as child support or Social Security. Both DHHS and DSS can also verify income by using the State Income and Eligibility Verification System, which is an automated system operated by the Employment Security Commission designed to be used to verify applicants' eligibility for certain programs based on income.

However, for those applicants enrolled by DHHS, no verification is conducted if the applicant states he or she has no income. The Income and Verification System used by DHHS can also be used to determine if a person actually had no earned income. The agency also does not attempt to verify income from other sources. The most common finding in our review of fraud investigations of Medicaid recipients was that the recipients were ineligible for Medicaid due to failure to report other income or valid economic circumstances (see p. 13).

DHHS estimates that there are currently 21,000 children who are eligible for the Partners program who have not been enrolled. If the program is expanded from 150% to 165% of poverty, an additional 12,000 children would be eligible. If DHHS takes steps to ensure that only eligible applicants are accepted for Medicaid, the number of recipients may not be as large as anticipated.

Provider Training

In South Carolina, there are 29,480 health care providers enrolled in the Medicaid program. DHHS has not been able to conduct training for providers on a consistent basis. When a health care provider is enrolled in the Medicaid program, he receives a Medicaid manual which is specific for his provider type. Each provider is also assigned a DHHS representative to contact with questions or problems. When a policy is changed, notices are sent to providers through Medicaid Bulletins. From July 1999 through November 2000, for example, 24 bulletins were sent to physicians. Policy changes can also be communicated through training. With the budget cuts that DHHS took to reduce the deficit, however, funding for travel was drastically reduced. Because staff could not travel to conduct training through the state, training has not been held.

The need for training can be evidenced by the Medicaid bulletins. One bulletin sent to hospitals clarified billing for specific services. The policies for these services were already in place, but DHHS had received a number of questions from the hospitals. Without the ability to provide adequate training, DHHS cannot ensure that providers understand or are following the policies. This can lead to inaccurate billings, overpayments, and possible review by the Program Integrity Division. Given the number of Medicaid providers, DHHS could greatly supplement the training currently offered by contracting with an outside provider. The training cost would be fixed, budget reductions would not affect the ability to provide training, and training could be provided more efficiently.

Computer Edits and Manually Processed Claims

DHHS uses edits in its computer system to help prevent fraud, abuse and billing errors. These edits suspend or reject claims that violate certain criteria. For example, edits have rejected claims for two hysterectomies for the same patient or an OB/GYN service for a male. We found no material problems with this process.

Prepayment reviews may also identify potential fraud and abuse cases. However, over 1½ years, three cases were referred to the Program Integrity Division by the hospital services utilization review team at DHHS. The utilization review team manually processes and reviews claims before they are paid. This area is staffed by Registered Nurses as the claims require a medical decision. The nurses use a variety of sources to make a decision on the claim. These sources include the use of physician consultants; however, the use of these consultants has decreased due to budget constraints. The nurses are relying on the expertise of staff physicians. When a claim is accepted by the reviewer, it is entered into the Medicaid Management Information System and processed like any other claim, and is therefore subject to the system fraud sampling.

Recommendations

1. The Department of Health and Human Services should strengthen its provider enrollment policies to ensure that only eligible providers are enrolled, and ensure that these policies are carried out by the contractor. These policies could include:

    - More stringent review of information on the provider enrollment application.
    - Developing provider agreements that give the state more flexibility to terminate without cause.
    - Re-enrolling existing providers under new, stricter standards.
    - Increasing scrutiny of applications from certain provider types, such as independent laboratories and durable medical equipment providers, and continued scrutiny after enrollment.
    - Conducting pre-enrollment visits.
    - Establishing better control over provider billing numbers.

2. The Department of Health and Human Services should establish procedures to verify eligibility for the Partners for Healthy Children program, when applicants report no income or income from other sources.

3. The Department of Health and Human Services should contract for provider training to ensure that training will be provided efficiently and consistently.

Detection of Fraud and Abuse

DHHS's Program Integrity Division has no method for measuring its performance in detecting fraudulent and abusive practices by Medicaid providers and recipients. While DHHS monitors Medicaid claim payments in various ways, there are few internal referrals of suspicious cases for further investigation. The division does not track investigative outcomes or whether Medicaid funds are repaid when a questionable or fraudulent claim is identified.

The department does not yet have a written fraud and abuse plan or comprehensive policies and procedures for fraud investigations. These problems are discussed below.

Referral of Cases

The Program Integrity Division regularly employs various post-payment monitoring techniques to detect questionable practices that result in overpayment of Medicaid funds, including reviewing medical services claims, auditing provider contracts, and surveying Medicaid recipients. If there is a suspicion that the overpayment is the result of intentional fraud and abuse, the claim is then referred to DHHS investigators for further action. However, we found little evidence that questionable cases are referred to the division's investigative unit, as policy directs. From FY 95-96 through FY 99-00, only 5 cases were referred to the investigative unit as a result of reviewing medical services claims.

Medical Services Review

Medical services review of Medicaid provider and recipient claims is one step in detecting fraudulent or abusive behavior. The agency's major assessment tool, the surveillance utilization and review system (SURS), analyzes health care claims data and identifies patterns of care or utilization that deviate from the norm. The system prepares a profile of the overall treatment pattern for each provider; these indicators are then used to select providers whose treatment patterns are different from their peers. Reviewers follow up by obtaining detailed documentation of claims pertaining to the identified provider. The same process can be used to analyze recipient claims data. From FY 95-96 through FY 99-00, the average number of medical services reviews initiated per year was 203 for providers and 220 for recipients.

. . . only 4.5% of the total cases referred to fraud investigators were initiated from a medical services review.

We found that medical services review was not the main source of cases investigated for fraud and abuse; only 4.5% of the total cases referred to fraud investigators were initiated from a medical services review. Most of Program Integrity's fraud investigations resulted from complaints received from other DHHS program areas, other state agencies, the DHHS website and telephone hotline, or other Medicaid providers and recipients.

Recipient Explanation of Medical Benefits (REOMB)

Each month the Program Integrity Division mails a randomly generated REOMB notice to approximately 400 Medicaid recipients requesting verification of medical services billed to DHHS by providers. According to staff, the response rate is usually just over 50%. Staff follow up on responses in which recipients claim not to have received the Medicaid services as billed to DHHS or that the services were deficient in some way. Responses indicating potential fraud are supposed to be referred for further investigation. For FY 98-99 to FY 99-00, only 32 recipients stated they had not received the Medicaid services as billed. No fraud cases have been generated from the REOMB over the past 10 years, so the usefulness of this process is questionable.

Contract Compliance

Program Integrity staff audit Medicaid contracts for compliance with federal guidelines concerning Medicaid eligibility. Contracts are selected for audit using three criteria: (1) those with prior audit findings, (2) those never reviewed before, and (3) those involving over $50,000. From FY 95-96 through FY 99-00, the amount of recoupment from contract audits totaled $518,668. Staff reported that contractors who have been billing Medicaid improperly eventually change their practices after being audited a few times; therefore, the agency does not consider this fraudulent or abusive behavior.

Performance Measures for Fraud Investigations

The Program Integrity Division at DHHS has not developed performance measures or an adequate case tracking system that would enable it to assess the effectiveness of its fraud and abuse investigations. The division, with two fraud investigators, pursued a total of 273 cases of potential fraud from FY 95-96 through FY 99-00.

The division could not provide complete summary statistics for fraud investigations initiated during this period. Also, some cases may not have been reported by the investigators to the appropriate staff and consequently were not included in the case tracking database. The case tracking database did not record the outcome for each case, such as how many investigations resulted in criminal or civil charges; in recoupment of payments; suspension of the provider; or referral to other law enforcement. The division only kept track of whether a case was closed, and not the actual outcome of the investigation.

Investigative Outcomes

We reviewed a sample of 50 fraud case files — 26 provider and 24 recipient — initiated from FY 98-99 to FY 99-00. For both providers and recipients, approximately half of the sample cases reviewed were resolved within one year's time, and over 75% were resolved within two years. Investigative outcomes were sometimes inconclusive, with no clear determination as to whether incorrect billings leading to an overpayment to a Medicaid provider involved fraudulent intent or were simply a misunderstanding of billing procedures. Work on eight cases was sporadic, and these cases were eventually closed because the evidence was too old. Recoupment of overpayments was not consistently pursued, and it was not always clear from the files why recoupment had not been successful. Roughly one-third of the sample provider files involving potential fraud were eventually referred to the Medicaid fraud unit at the S.C. Attorney General's office or other agency (see p. 16), and usually only after some delay.

Table 2.1: Results of Fraud Investigations for Sample of 50 Cases

Recipients (24 Cases)	Providers (26 Cases)	Outcome of Investigation
14	10	Fraud and/or Abuse Substantiated
3	8	Case Referred to MFCU or Other Agency
9	2	Arrest and/or Prosecution
8	6	Repayment of Funds Requested
3	3	Full Repayment Documented
4	4	Case Closed — Evidence Too Old
6	9	No Action — No Medicaid Fraud Verified
N/A	1	Outcome Not Clear from Files

In the sample of investigations, the 2 most common allegations against providers were false billings, 8 cases (31%), and billing for services or products not rendered, 7 cases (27%); the most common allegation against recipients was not reporting other income or valid economic circumstances that may have made them ineligible for Medicaid, 14 cases (58%).

The majority of fraud case files in our sample included the necessary documentation. However, the opening date of the case often could not be found on the case tracking form, and supervisory review was not always apparent from the documentation.

Recoupment of Overpayments

Recouping Medicaid funds paid as a result of fraudulent or questionable claims is a major goal of the agency's medical services review and fraud investigation process. However, the Program Integrity Division does not have a system to determine whether DHHS has fully recouped the amounts due, making it impossible to determine the success of its program.

Once an overpayment is documented, DHHS staff request recoupment of the specified amount; both providers and recipients can appeal the recoupment. In 1987, the Program Integrity Division installed a case tracking system to help monitor activities involving specific providers and recipients. However, the case tracking database does not record:

- Whether the provider or recipient was ordered to repay Medicaid funds.
- The amount of the funds to be repaid.
- The actual amount collected.

For example, program integrity staff could not provide summary statistics on what percent of medical services reviews result in recoupment of funds. We also examined the case files for a random sample of 39 medical services reviews — 20 provider and 19 recipient — conducted during FY 98-99 and FY 99-00. Files showed evidence of an overpayment of Medicaid funds to nine providers, totaling $50,508, and indicated that all of the overpayments were recouped; but this could not be confirmed from the case tracking system.

Because the system does not record recoupment information, the division does not track whether Medicaid funds are paid back when fraud or abuse is alleged. While some of this information is contained within individual case investigation records, without an adequate case tracking database the Program Integrity Division has no way to monitor or enforce repayment of Medicaid funds.

DHHS can recoup overpayment of Medicaid funds in primarily two ways. A net adjustment can be made against the next check sent to the provider in question, debiting the individual provider the amount he owes to Medicaid. Or, the provider (or recipient) can repay DHHS the funds owed, in which case an accounts receivable would be established. The Program Integrity Division has no formal procedures linking recoupment activity with specific fraud and abuse investigations, making it difficult to follow up on cases in which recoupment of Medicaid funds has been requested.

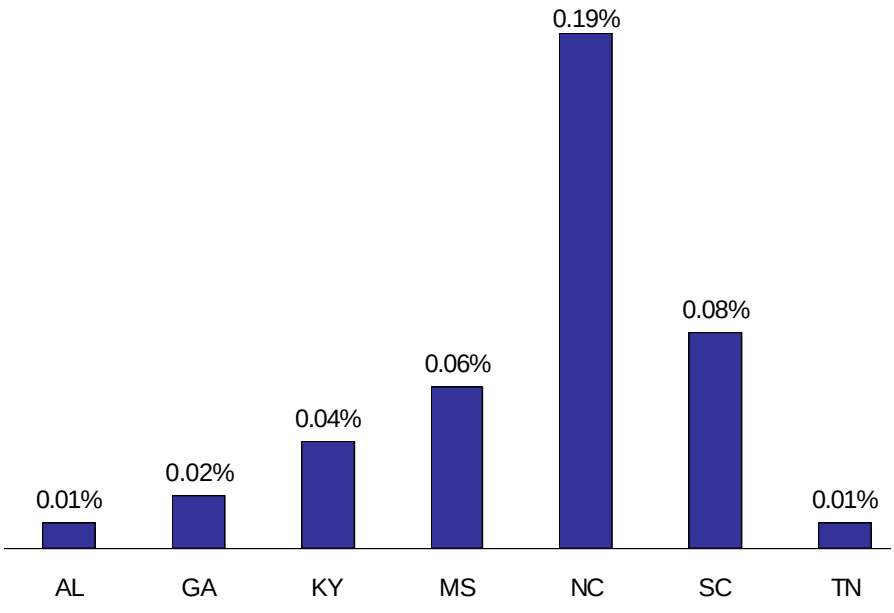
Fraud and Abuse Collections

DHHS should have a goal to increase its collections of funds recouped from health care providers who file incorrect or fraudulent claims. The GAO stated in a 1992 report that the most common estimate of losses resulting from fraud and abuse is 10% of health care spending. Collections for fraud and abuse are reported by states to the federal Health Care Financing Administration. For FFY 98-99, DHHS reported $2,064,460 for South Carolina in collections, including overpayments, identified through fraud and abuse detection efforts. This is more than the other southeastern states with the exception of North Carolina. However, it represents only 0.08% of direct payments to providers.

North Carolina collects more than other states in the southeastern region — $9.3 million in fraud and abuse collections for FFY 98-99 based on total Medicaid expenditures of almost $5 billion. Compared to South Carolina, therefore, North Carolina has twice the Medicaid budget but collects almost five times the amount for fraud and abuse.

However, according to information published by the North Carolina Medicaid agency, they have approximately 60 staff in their program integrity unit, and they recently expanded their existing automated utilization review system to specifically target fraud and abuse. Also, according to an N.C. Medicaid official, their reporting process better accounts for fraud and abuse collections.

Figure 2.2: Southeastern Collections for Fraud and Abuse as a Percent of Total Medicaid Expenditures, FFY 98-99



Florida did not report fraud and abuse collections.

Source: HCFA 64 Reports.

Relationship With the Medicaid Fraud Control Unit (MFCU)

Low referral rates of potential fraud cases to the S.C. Attorney General's office may handicap investigative outcomes for the agency. Federal law requires DHHS to refer all cases of suspected provider fraud to the Medicaid Fraud Control Unit, housed in the AG's office. DHHS must give MFCU records, computerized data or other information needed for a particular fraud investigation, and also initiate action to recover improper payments to a provider. The two agencies are to enter into a "memorandum of understanding" that governs their relationship and sets forth principles designed to minimize duplication of effort in the detection and pursuit of Medicaid fraud. The role of DHHS is prevention and detection, that of the Medicaid Fraud Control Unit is investigation and prosecution.

Staff at the Medicaid Fraud Control Unit cite as a problem the reluctance of DHHS to refer potential fraud cases to the AG's office. Since FY 95-96, the fraud unit has received only 44 cases from DHHS. Compared with other southeastern states, South Carolina has one of the lowest case referral rates to its Medicaid Fraud Control Unit.

Compared with other southeastern states, South Carolina has one of the lowest case referral rates to its Medicaid Fraud Control Unit.

Furthermore, MFCU staff claim that the delays in referrals they do receive sometimes hinder their investigation because the evidence is too old. The length of time specified in the memorandum is "the earliest practical moment." Six of the 26 fraud case files we reviewed were eventually referred to the Medicaid Fraud Control Unit; 2 of them were referred within 14 days, 2 more within 5 months, and the final 2 were referred within 8–10 months. Correspondence from MFCU staff in one of the files confirms that the delay was a handicap in their efforts to prove fraudulent intent.

The two cases described on page 17 were several months old before DHHS referred them to the Medicaid Fraud Control Unit. They also illustrate the difficulty involved in proving fraud and recouping the funds.

We reviewed DHHS compliance with the memorandum of understanding, which was signed on September 22, 1994. The memorandum directs representatives of DHHS and MFCU to meet "at least monthly" to coordinate activities, discuss specific cases, and consult on the design and use of fraud detection technology. DHHS could only provide monthly meeting minutes dating from August 2000; however, staff indicated that the agency is establishing more systematic procedures for meetings with the Medicaid Fraud Control Unit.

FRAUD CASE HISTORIES

In January 1996, DHHS received a complaint from the Department of Defense Investigation Service concerning an excessive number of ultrasound treatments being performed on Medicaid recipients by an OB/GYN doctor. A medical services review of the provider in 1992 had found valid documentation for the number of ultrasound treatments. A later review again showed an unusual billing pattern. In September 1996, DHHS referred the case to MFCU, which returned it after four months, claiming that the evidence was "too remote" to proceed with a prosecution against the provider. Further prodding from the federal investigative service led DHHS to reopen the case in February 1997; the billing pattern had not changed. Documentation reviewed onsite at the provider's office supported each claim. Many doctors working at the same hospital agreed that the provider was not following normal standards of care, yet none of them were willing to make a statement or report him to the South Carolina Medical Association. Unable to prove intentional fraud, DHHS closed the case again; the exact date of closure was unclear from file records.

A tip from the Georgia Medicaid program in January 1998 prompted DHHS to investigate a fraudulent counseling group operating out of a church. A claims review showed a total of $54,477 billed to Medicaid for psychotherapy over a four-month period. Investigators found insufficient claims documentation during an onsite visit and referred the case to MFCU in August 1998. After identifying the overpayment and discovering that one of the "counselors" had lost his license, MFCU returned the case to DHHS in February 1999. According to DHHS investigations staff, the group closed its office and left the state. None of the Medicaid money was recovered.

Comparison With Other States

We found the relationship between DHHS and MFCU to be much the same as their counterparts in the other southeastern states, except that, as noted earlier, South Carolina has one of the lowest case referral rates. Likewise, at a series of regional seminars in 1998-99 sponsored by HCFA, 21 states reported that their Medicaid agency directors gave only minimal recognition to fraud and abuse as a serious problem, and were generally reluctant to refer cases for further investigation. The lack of aggressiveness in the pursuit of potential fraud that characterizes DHHS is mirrored in other state Medicaid agencies and stems from the same basic issue — the idea of program integrity is at odds with the social welfare tradition.

From the HCFA seminars came several suggestions for increasing awareness of Medicaid fraud among agency heads and elected officials; for example, conducting formal studies to provide statistically valid estimates of overpayment rates, and using fraud detection technology vendors to establish pilot or demonstration projects.

Improved Information Technology

The department does not yet have a written fraud and abuse plan, and policies and procedures for payment reviews and fraud investigations currently exist in piecemeal fashion, applicable only to separate functions, such as medical services review and fraud investigation. Division officials stated that both the plan and policies are being developed in conjunction with the new surveillance utilization and review system (SURS) being implemented and would not be completed until the system is fully operative.

With the advanced surveillance utilization and review system, the Program Integrity Division now has the opportunity to increase its effectiveness in detecting overpayment and potential abuse of Medicaid funds. The original surveillance system was criticized in a 1998 performance audit for its limitations in making queries and developing reports to help in pursuing cases of potential fraud. In June 2000, DHHS began the process of installing a PC-based SURS with more comprehensive review capabilities; staff training was being completed as of December 2000. The new system allows users to analyze a more refined selection of claims, such as “all physicians performing coronary bypass surgery.” Instead of having to sift through a lot of irrelevant data, users may single out one specific episode of care and analyze all medical services related to that episode.

Several states participating in the HCFA seminar identified inadequate technology as an obstacle to detection of fraudulent billing practices. Ten states in addition to South Carolina were in the process of acquiring or updating utilization review systems while another five, including Louisiana and North Carolina, were expanding existing systems to specifically target fraud. Some states had also developed new techniques aimed at detecting suspicious billing practices, such as computerized billing schemes (Hawaii), third-party billers (Nevada), and kickback schemes (New York).

While DHHS's new surveillance system highlights suspicious utilization patterns more efficiently, its potential for innovative analysis may be more important for fraud detection purposes. A noted authority in the field of health care fraud stresses that access to the latest technology does not, by itself, guarantee effective detection of abusive practices. Organizations tend to apply their sophisticated detection tools only to lower levels of health care fraud, such as recipient fraud, as opposed to more complex types of fraud such as multi-party billing conspiracies. Now that it has a system that supports this type of analysis, the Program Integrity Division should develop appropriate policies and analytic strategies targeted at higher levels of health care fraud. Division staff have already visited other states, especially North Carolina, to review their fraud detection systems and policies.

Recommendations

4. The Department of Health and Human Services should ensure that questionable claims identified through its medical services reviews and other internal reviews are referred for further investigative action.

5. The Department of Health and Human Services should develop performance measures and a case tracking system that would enable it to assess the effectiveness of its fraud and abuse investigations. The case tracking system should include all reviews and investigations and record the outcomes. Investigations should be completed as quickly as possible, and either resolved or referred to other law enforcement agencies.

6. The Department of Health and Human Services should ensure that a case tracking database records all instances where a provider or recipient is supposed to reimburse Medicaid funds, the amount of the reimbursement, and the actual monies collected.

7. The Department of Health and Human Services should set a goal to increase collections due to fraud and abuse.

8. The Department of Health and Human Services should increase the rate of, and shorten the time frame for, referral of suspicious cases to the Medicaid Fraud Control Unit in the Attorney General's office.

9. Program Integrity staff should meet more often with Medicaid Fraud Control Unit staff and coordinate with them on proactive fraud investigation projects, and keep a written record of these meetings.

10. The Department of Health and Human Services should develop a written fraud and abuse plan and comprehensive policies and procedures for the Program Integrity Division.

11. The Department of Health and Human Services should develop new strategies for applying its updated surveillance and utilization review system to more complex networks of health care fraud and abuse.

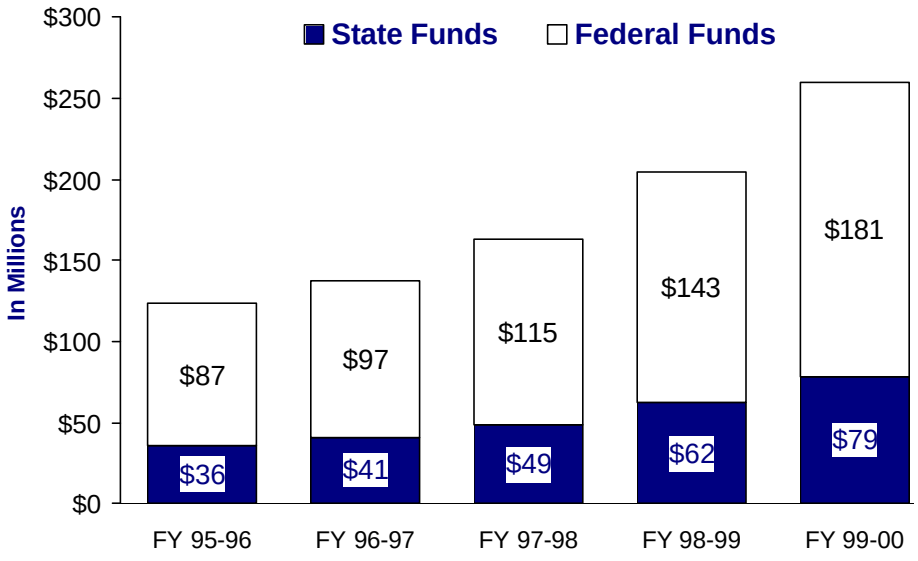
Prescription Drug Expenditures

Introduction

One area of Medicaid expenditures that concerned audit requesters was the prescription drug benefit. The South Carolina Medicaid program covers outpatient prescription drugs for recipients, allowing four prescriptions per month for adults and unlimited prescriptions for children under age 21.

In South Carolina, net Medicaid expenditures for prescription drugs have more than doubled in the last five years, from $123 million to $260 million. In FY 99-00, pharmaceutical services accounted for 11% of Medicaid payments to providers and ranked as the fourth highest expenditure. The following figure illustrates the increase in S.C. Medicaid prescription drug costs.

Figure 3.1: South Carolina Prescription Drug Expenditures



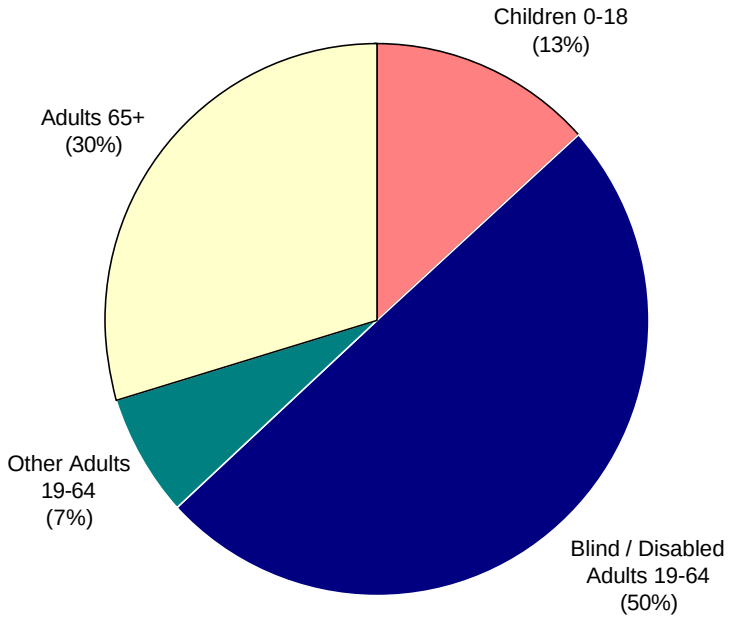
Expenditures after rebates from drug manufacturers and other gross adjustments have been taken into account.

Source: DHHS Program Structure Appropriation Summary Reports.

Demographic Distribution of Drug Payments

Two Medicaid recipient categories dominate spending for prescription drugs — the blind/disabled and the aged adults 65 and older. Combined they account for 80% of the payments, but only 33% of the total recipients. Blind/disabled adults comprise 20% of those receiving drugs and account for half of the payments. The aged population represents 14% of drug recipients and 30% of the payments. Additionally, the aged population also has the highest average number of claims per recipient (25) and the highest average number of days' supply per claim (42.5). Although children under the age of 18 account for half of the recipients and are allowed an unlimited number of prescriptions, their drug payments account for 13% of the expenditures, and they have the lowest average days' supply per claim.

Figure 3.2: Percentage of Payments by Recipient Category

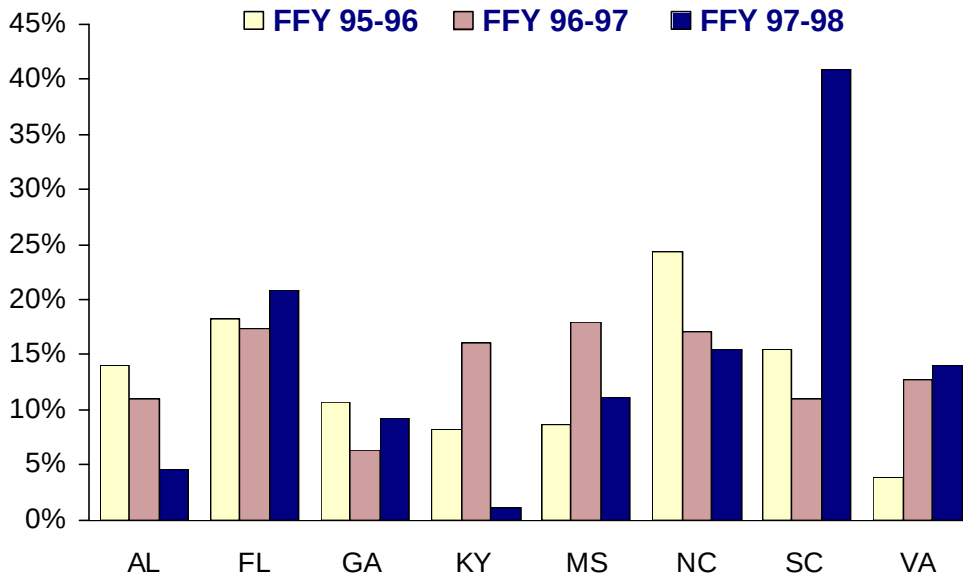


Source: DHHS Bureau of Information Systems.

South Carolina Compared to Other Southeastern States

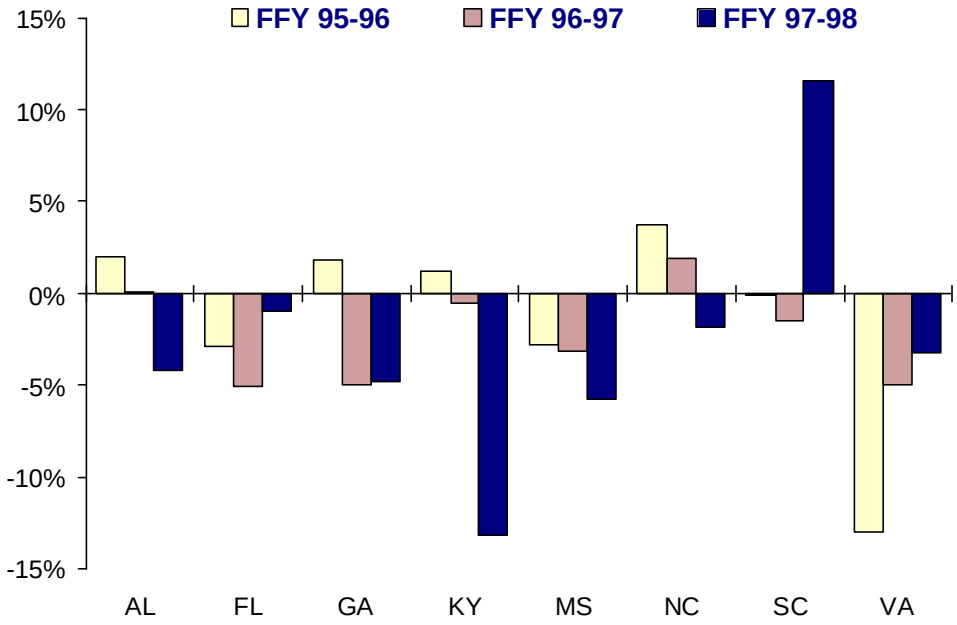
According to the federal Health Care Financing Administration (HCFA), the general trend in the southeastern states has been an increase in expenditures and a decline in the number of recipients receiving pharmaceutical services through Medicaid. However, in FFY 97-98, the number of recipients in South Carolina increased 12% from the previous year with the addition of over 40,000 more recipients and a cost increase of 41%, accounting for an additional $65 million. Overall, between FFY 94-95 and FFY 97-98, the average annual increase in prescription drug expenditures for the southeastern region was 14%, while South Carolina's was 22%. Despite the increase in expenditures, South Carolina spent $100 less per recipient than the average cost both regionally and nationally, according to FFY 97-98 data.

Figure 3.3: Drug Payment Percent Change



Source: HCFA 2082 Reports.

Figure 3.4: Percentage Change of Drug Recipients



Source: HCFA 2082 Reports.

Prescription Drug Benefit Plans

Compared to the other southeastern states, South Carolina has one of the most conservative Medicaid prescription drug programs. The dispensing fee paid to pharmacists and the limit placed on the number of prescriptions are the lowest of the eight states, and the recipients' co-payment is one of the highest.

Table 3.5: Southeastern States Medicaid Drug Plans

State	Dispensing Fee	Reimbursement Rate[A]	Co-Payment[B]	Number of Prescriptions Per Month		Dispensing Limitations Days Supply
				Adults	Children	
Alabama	$5.40	WAC[C] + 9.2%	$.50 – $3.00	Unlimited	Unlimited	30
Florida	$4.23	AWP[D] – 13.25%	None	4 brand name; Generics & Long Term Care Unlimited	Unlimited	34
Georgia	$4.63	AWP – 10%	$.50	5	6[E]	30 days, $3,000 Limit
Kentucky	$4.75	AWP – 10%	None	Unlimited	Unlimited	30
Mississippi	$4.91	AWP – 10%	$1.00	5	10[E]	Greater of 34 days or 100 units
North Carolina	$5.60	AWP – 10%	$1.00	6	6	100
South Carolina	$4.05	AWP – 10%	$2.00	4	Unlimited	100
Virginia	$4.25	AWP – 9%	$1.00	Unlimited	Unlimited	Lesser of 30 days or 100 doses

A Medicaid reimbursement to pharmacies for the cost of the drug.
B Recipients' out-of-pocket expense per prescription.
C WAC = Wholesale Acquisition Cost.
D AWP = Average Wholesale Price.
E Limits can be increased with prior authorization

Source: LAC Telephone Survey.

Reasons for the Increase in Cost

The cost and utilization of prescription drugs has increased dramatically, not only in the Medicaid program, but also universally. According to the National Conference of State Legislatures, U.S. per capita health expenditures increased 4.5% in 1998; however, the increase in drug expenditures was 14.3% and is expected to rise to 18% in 2000.

HCFA projects Medicaid spending on drugs will increase by 182% through 2008 and comprise 13.6% of total program costs. Additionally, managers of the South Carolina State Health Plan estimate an increase of 20% a year, for the next 3 – 5 years, for prescription drug costs. The rising costs are attributed to many factors, including the following:

- Higher utilization.
- Adoption of new drugs that dominate their therapeutic classes and command a higher price when they enter the market.
- Physicians prescribing more new drugs that have a higher price.
- Advertising by the pharmaceutical companies directly to the consumer.
- The shift toward an older population.

Between 1990 and 1999, Medicaid spending on drugs nationwide showed an annual growth of 14.7%. During this time, South Carolina's Medicaid program was influenced not only by the general factors that increased the costs, but also by extending the three prescription limit to four and offering unlimited prescriptions for children. These policy changes were implemented, without an additional increase in funding, on July 1, 1998, for the unlimited prescriptions for children, and January 1, 1999, for the fourth prescription.

Top Drugs Paid by Medicaid

A small number of drugs dominate Medicaid drug expenditures in South Carolina. The top 50 drugs prescribed for Medicaid patients in FY 99-00 accounted for 32% of the total payments for prescription drugs. Most of these drugs are new to the market, and dominate their therapeutic class. Of the top 50 drugs in FY 99-00, 15 were not in the top 50 in FY 96-97, and for those that were in existence, total expenditures increased by almost $70 million. One example of increasing cost and utilization is in the anti-ulcer drug, Prilosec. In FY 96-97, $5 million was spent on two types of Prilosec capsules, and in FY 99-00, that cost skyrocketed to $12 million. The following table illustrates the top four categories of drugs, the specific brand name of the drugs prescribed, and the amount spent on the category.

Table 3.6: Top Categories of Medicaid Prescription Drugs in FY 99-00

CATEGORY	DRUG NAME	COST
Anti-Ulcer	Prilosec Pepcid Axid Prevacid	$26,548,198
Anti-Psychotic	Risperdal Clozaril Zyprexa	$23,112,384
Anti-Depressant	Paxil Prozac Wellbutrin Zoloft	$13,891,384
Anti-Arthritic	Celebrex Vioxx	$10,143,300

Costs are not reflective of the drug manufacturers rebate.

Source: DHHS Report, "Drug Usage Frequency Analysis — Drugs Listed by Amount of Payment."

Prescription Drug Cost Containment

There are several measures that state Medicaid agencies can use to contain prescription drug costs. Generally, these measures include:

- Drug utilization review systems.
- Prior authorization and generic substitution for certain drugs.
- Limits on the number of prescriptions.
- Drug rebate program.

South Carolina uses all these measures to some extent. In addition, DHHS is implementing a new automated system that is expected to have a major impact on cost savings for the prescription drug program. To date, however, the department has been largely ineffective in slowing the growth of prescription drug costs, especially those for the newer, brand name expensive medicines. Until the agency can control costs for prescription drugs, spending in this area will continue to create financial problems for the Medicaid program. We have identified some cost savings measures that could help control expenditures.

Drug Utilization Review Systems

Federal legislation in 1990 required that all state Medicaid agencies implement "drug utilization review" (DUR) systems. These are programs designed to measure prescription drug use against predetermined standards and to analyze drug use and physician prescribing habits. For example, drug utilization review monitors for adverse drug interactions, therapeutic appropriateness, over-utilization, or incorrect dosage. The federal government also requires that states conduct drug utilization reviews both prospectively – when prescriptions are filled, typically at the point of sale – and retrospectively – after the prescription drug claims have been processed through the Medicaid payment system. DHHS has had a retrospective drug utilization review program but not a prospective program.

Prospective Drug Utilization Review

Until November 2000, DHHS had never implemented its own prospective drug utilization review (proDUR) system but rather required individual pharmacies to conduct proDUR on-site. DHHS does not monitor pharmacists to determine if they are conducting drug utilization review at the point of sale. DHHS does, however, conduct monthly surveys of Medicaid recipients, and one of the questions on the survey asks if the individual received counseling when his or her prescription was filled. Approximately 73% of those recipients surveyed in FFY 98-99 who received the prescription drug benefit stated that some form of medication counseling was performed. But,

because there has been no automated, centralized proDUR system, DHHS has missed opportunities to monitor drug usage and generate cost savings for the Medicaid program.

The seven other southeastern states we contacted have all had a point-of-sale system for at least three years. DHHS implemented a point-of-sale, electronic claims management system for prescription drugs on November 1, 2000, through a contract with a private health services corporation called First Health. The five-year costs for all the services provided through this contract are expected to be about $8.7 million.

Aspects of the New Point-of-Sale System

With the new point-of-sale system, Medicaid claims can be processed at the pharmacy counter. When a Medicaid client brings in a prescription to be filled, the pharmacist will enter the individual's Medicaid number and prescription information into the computer, and be able to file the claim to DHHS for Medicaid payment, at the time the medicine is dispensed. The point-of-sale system facilitates the payment of pharmacy claims. The system will also be a prospective drug utilization program. It will alert the pharmacist when the prescription is in some way inappropriate or fails to meet certain criteria, and will not process the claim until the pharmacist does certain things. Many of these criteria will be based on standard clinical practice and will be used to determine whether a particular drug will have an adverse reaction with another drug, or is inappropriate for the patient's condition. According to research on prescription drugs, major cost savings will result through avoided hospitalization due to inappropriate drug therapy. But other alerts or "edits" in the system can directly affect cost savings in the prescription drug program. These edits would screen for the following conditions:

- ❏ Early Refills — The system would alert the pharmacist that the patient already had a prescription and that it was too soon for him or her to need a refill. Early refills can be an indication that the recipient is misusing the drug.

- ❏ Therapeutic Duplications — A therapeutic duplication occurs when the patient has been prescribed two medicines for the same problem, with no additional medical benefit; in effect, one of the two prescriptions is not needed and therefore wastes money.

- ❏ Excessive Dosage —Too high a dose or overuse of a drug can not only be harmful to the patient but also results in wasted resources.

- ❑ Client Eligibility — With an automated point-of-sale system, the pharmacist can immediately tell if the client is eligible for Medicaid or has exceeded the limit on the number of prescriptions. The system can also screen for duplicate prescriptions. This could help reduce recipient fraud and abuse.

The edit messages triggered by proDUR criteria will require pharmacists to take action before the claim can be processed. For example, the pharmacist may need to counsel the patient, or may need to obtain authorization from the system contractor (First Health) before the drug can be dispensed. In some cases, the system will reject the claim and the pharmacist will not be able to fill the prescription. In addition, the proDUR system can identify patterns of prescribing and dispensing drugs that are harmful and/or wasteful, and identify providers who deviate from predetermined norms. At this point DHHS can intervene, usually by sending the doctor a letter.

(DHHS) needs to design drug use criteria and have policies in place that would place some limitations on prescription drug use.

DHHS Needs Policies to Support ProDUR

According to the contract, the new point-of-sale system is capable of all aspects of drug use review. Therefore, this is a tool that DHHS can use to manage the Medicaid prescription drug program more effectively and efficiently. However, the agency needs to design drug use criteria and have policies in place that would place some limitations on prescription drug use. For example, currently DHHS:

- Does not include high-price, brand name drugs on the list of those requiring prior authorization.
- Has no policy to use the point-of-sale system to reduce the use of brand name drugs.
- Has no policy to require step therapy protocols for certain medications.

According to DHHS staff, they plan to analyze data from the new point-of-sale system and to eventually phase in more requirements. However, as of November 2000, there was no timetable or internal plan for changing any prescription drug policies. Material changes to drug policy would also require federal approval from the federal Health Care Financing Administration (HCFA) and amendments to the State Medicaid Plan.

Prior Authorization, Generic Substitution, and Therapeutic Protocols

Most state Medicaid programs, including S.C., do not pay for drug treatments for baldness, weight loss, smoking cessation, cosmetic purposes, and other non-medical conditions. However, if the state wishes to participate in the drug rebate system (see p. 34), it must have an "open formulary" —that is, it cannot exclude specific prescription drugs from Medicaid coverage. But many states do require physicians and pharmacists to request and receive permission before a specific medicine can be dispensed. This procedure is called prior authorization. Some of the reasons for requiring prior authorization are to limit the use of drugs that are easily abused, extremely expensive, or already paid for by Medicare.

South Carolina has established a limited number of drugs needing prior authorization, primarily certain vitamins, immunosuppressants, and drugs to treat sexual dysfunction (i.e., Viagra).

None of the categories of drugs shown on the table on page 26 (the top 4 types of drugs by dollar amount) require prior approval from the department. Other state Medicaid programs, however, do require prior authorization for products that treat ulcers or arthritis. The following table shows the states which require prior authorization for certain drugs and/or classes of drugs, and the amount the S.C. Medicaid program spent for these types of drugs in FY 99-00. Before it implemented the automated point-of-sale system, DHHS had to manually process all prior authorizations, and therefore put only a limited number of drugs in this status.

Table 3.7: Drugs Needing Prior Authorization in Other States

Type of Drug (Clinical Use)	Common Brands	States With Prior Authorization	Amount[1] Spent in SC
NSAIDs (Osteo-Arthritis)	Vioxx Celebrex	AL, GA, HI, IA MS, MT, WV	$10,143,300
Anti-Psychotics (Schizophrenia)	Clozaril Zyprexa Risperdal	AL, AK, HI, MS	$23,112,384
Proton Pump Inhibitors (Anti-Ulcer)	Prevacid Prilosec	GA, HI, IA, MA, MN, MT, OK OR, PA, UT, WV	$22,941,118
H2 Antagonists (Anti-Ulcer)	Axid Pepcid	GA, HI, MA, MT, OK, OR, PA, UT, WV	$3,607,080

1 Dollar amount includes both federal and state funds for FY 99-00 not offset by rebates.

Source: DHHS Drug Usage Frequency Analysis; and *Pharmaceutical Benefits,* National Pharmaceutical Council.

Three southeastern states we contacted (Alabama, Georgia and Mississippi) are restricting the use of some brand name drugs through prior authorization. Prior authorization works as a cost savings mechanism because it helps ensure that there is a medical need for the drug, and it also serves as a mechanism for the Medicaid program to deny coverage of certain drugs.

Generic Substitution

Generic substitution can save money because generic drugs usually are cheaper than brand name drugs. Information from the pharmaceutical industry estimates that generic drugs cost at least 30% – 50% less than their brand name equivalents. In the South Carolina Medicaid program, individual patient consent is not needed for the pharmacist to substitute an *equivalent* generic drug, as long as the doctor has not specified "brand name medically necessary" on the prescription.

However, of the top 50 drugs (by cost) prescribed for Medicaid patients in FY 99-00, only 3 had an equivalent, generic substitute available.

Currently DHHS has no data to determine how often generics are substituted for brand name drugs. However, of the top 50 drugs (by cost) prescribed for Medicaid patients in FY 99-00, only 3 had an equivalent, generic substitute available. This supports the contention that the most expensive drugs are also the newest. Generally, new drugs are patent-protected for 20 years from the time of filing.

Through its contract with First Health, DHHS has the ability to promote increased use of generic substitution. For example, there is a category of drugs called NSAID (non-steroidal, anti-inflammatory drug) that are commonly used to treat arthritis. In FY 99-00, DHHS spent more than $10 million on two brand name drugs in this category. However, other drugs in the NSAID category have generic substitutes. According to First Health, through the use of automated proDUR systems in other states, it has been able to reduce the use of brand name NSAIDs by as much as 50%.

Therapeutic Protocols

Therapeutic guidelines can be incorporated in an automated proDUR system to promote the use of the most cost-effective drugs. This could include limiting dosages and duration of treatment for certain drugs, and also requiring that certain types of drugs be tried first before a new, brand name drug is prescribed.

For example, H2 receptor antagonists and proton pump inhibitors (PPI) are two types of drugs used to treat ulcers and other gastrointestinal diseases. According to the experience of pharmacy benefit managers, H2 antagonists and PPIs tend to be over-prescribed because they are considered to be safe

and effective medicines. Prilosec, a proton pump inhibitor, is a brand name drug, and was the number one prescribed drug in the S.C. Medicaid program in FY 99-00, for a total cost of more than $14.6 million.

However, some H2 antagonists are cheaper than PPIs and also come in generic and over-the-counter versions. Common H2 antagonists are medicines such as Zantac, Axid, and Pepcid AC. In the S.C. Medicaid program for FY 99-00, the average cost per claim (per prescription) for an H2 antagonist was $109, while the average cost for a proton pump inhibitor was $198.

Also, for H2 antagonists, treatment is divided into active and maintenance treatment periods. Full dosages are required during the active treatment period to promote healing, while reduced dosages are required during the maintenance period to prevent recurrence. Keeping the patient on an acute dosage beyond the recommended time limit could have no discernable medical benefits but would increase costs since acute dosages are more expensive.

Through a prospective drug utilization review system, S.C. could set guidelines to encourage more cost-effective use of medicines. According to one pharmacy benefit manager, only a few specific drugs and prescribing patterns have to be flagged to yield savings of 2% to 6% of total drug spending. Six percent of Medicaid net drug costs in FY 99-00 is $15.6 million, of which $4.7 million would be savings in state funds. The anti-ulcer drugs are one example of this; others include:

- ❑ Limiting the use of brand name, non-steroidal anti-inflammatory drugs as mentioned on page 31.
- ❑ Reducing the use of "second-line antibiotics," which are broad spectrum, usually brand name drugs that should be reserved for special situations or when first-line antibiotics have failed.
- ❑ Limiting the use of expensive allergy medications such as Claritin (for which S.C. Medicaid spent $3.9 million in FY 99-00).
- ❑ Limiting the use of anti-depressants to 7 – 12 months where appropriate.

DHHS through the new point-of-sale system will have alerts for early refills, therapeutic duplication, and drug-drug interactions. However, the department has yet to institute any new guidelines that promote the use of the most cost-effective medicines. As previously stated, DHHS staff told us they were planning to implement such policies but wanted to phase them in after the new point-of-sale system was functioning smoothly.

Number of Prescriptions

South Carolina allows unlimited prescriptions for children in the Medicaid program. Prescriptions for adults were limited to three per month until January 1999 when this was increased to four per month. In this regard the S.C. Medicaid program has one of the most restrictive prescription drug allowances, compared to other southeastern states (see p. 25). However, S.C. allows each prescription to be for a 100-day supply. Therefore, an adult could be taking up to12 prescriptions per month funded by Medicaid.

According to DHHS, 29% of the prescription drug claims for adults in 1999 were for a supply of more than 31 days. We found that the average days supply for the top-prescribed drug, Prilosec, was 50 days, according to FY 99-00 data from the Medicaid information system. In correspondence to DHHS in 1999, the S.C. Pharmacy Association Board stated that any action which hinders patients' access to prescribed medications will harm their health, but that using a one-month supply as a standard dispensing quantity would address budget problems while not reducing patient access to needed medicines.

Allowing a 100-day supply can be wasteful, especially if the prescription is for a brand name, expensive drug that the patient has not used before. If the drug does not work or if the patient has an adverse reaction to the drug, most of the supply may go unused. The overall effect of this policy is to encourage doctors and patients to obtain 100 days supply of medicines even when that much may not be needed.

This also has an immediate effect on DHHS's cash flow. To use the example of Prilosec again, a patient who receives a 90-day supply costs the Medicaid program $339.34 as opposed to the patient who receives a 30-day supply of Prilosec at $115.81. (This is the price of the drug plus the dispensing fee that Medicaid would pay a pharmacist.)

A 100-day supply can be more efficient for patients with chronic conditions who must remain on a drug for a long period of time, since this would save the monthly dispensing fee. However, a 100-day supply should only be allowed when it has been established that a particular drug and dosage is appropriate for the patient, and the medicine is for a chronic condition.

Other Issues

The automated point-of-sale, prospective drug utilization review system will help DHHS promote more long-term changes in the Medicaid prescription drug program. For example, the key to greater use of more cost-effective drugs is changing the prescribing habits of physicians and other health care providers. DHHS already plans to use the automated proDUR system to develop profiles of physicians' prescribing habits that can be compared with those of their peers. In addition, DHHS should take the following steps:

- ❑ Create an ad hoc committee, composed of physicians, pharmacists, and members of the academic community, to help develop policies for the prescription drug program for the increased use of therapeutic protocols, prior approval, and generic drugs. This committee could also make recommendations for other ways to contain prescription drug costs, and should focus immediately on areas such as ulcer medications which have a high cost.

- ❑ Develop a continuing education program for doctors and other health care providers that uses data from the Medicaid prescription drug program as well as current clinical guidelines and best practices for appropriate prescribing and patient care.

- ❑ Develop health management programs to encourage appropriate prescribing and use of drugs, especially for patients with chronic conditions where drug therapy and careful self-management can result in improved outcomes. Conditions such as diabetes, depression, hypertension and gastrointestinal problems can be targeted for pharmacy-based health management programs.

Drug Rebates

The Medicaid drug rebate program was established by Congress in 1990. Any drug manufacturer that wishes to have its drugs reimbursed through Medicaid must agree to participate in the rebate. The purpose of the rebate is to allow states and the federal government to receive the same price reductions received by other large volume purchasers, such as chain drugstores and hospitals. DHHS has implemented a drug rebate program that has offset the costs of Medicaid prescriptions by $312 million as of August 2000.

The amount of the rebate for each drug is established by the federal Health Care Financing Administration. Based on pricing information received from the manufacturers, HCFA sets a "unit rebate amount" for each drug as identified by its national drug code. Therefore, neither the states nor the individual pharmacists are involved in negotiating rebate amounts. Rebate funds are used to offset both federal and state costs — 70% federal and 30% state for FY 99-00.

After DHHS staff get information from HCFA showing the unit rebate amount, they use data from the Medicaid information system to compute the rebate. This amount is the number of units of paid pharmacy claims times the unit rebate amount. For rebates invoiced from FY 92-93 (first full year for rebate collections) through FY 99-00, current receipts amount to $312,544,210 in South Carolina, approximately 19% of the total amount spent for prescription drugs. Through the end of 1999, DHHS achieved a 97% collection rate. The remaining funds are disputed by manufacturers; however, DHHS is still trying to resolve these disputes.

For rebates invoiced from FY 92-93 . . . through FY 99-00, current receipts amount to $312,544,210 in South Carolina . . . .

According to DHHS staff, disputes with drug manufacturers over the amount of the rebate owed primarily arise from differences in drug utilization data. Disputes with manufacturers can tie up millions in dollars in rebates owed to the state. In June 1998, DHHS contracted with a medical data researcher to help resolve a backlog of old drug rebate disputes dating from 1992 – 1996, which had amounted to $4.1 million. As of August 2000, the backlog of old disputes was down to $1.2 million.

Current disputes have been handled in-house by DHHS staff. Starting in the second quarter of 2001, however, rebate billing and current dispute resolution will be handled by First Health, the contractor for the new prescription drug point-of-sale system. DHHS officials cite staffing and expertise as the reason to turn this function over to First Health. Because the point-of-sale system will generate more detailed drug use data, DHHS staff believe that fewer manufacturers' disputes and better cash flow will result.

Recommendations

12. The Department of Health and Human Services should develop new policies, appropriate for the automated point-of-sale prospective drug utilization review system, that promote a more cost-effective use of prescription drugs. Such policies should require:

    - Increased use of generic drugs.
    - Prior authorization for more prescription drugs, especially those which are very expensive or tend to be over-prescribed.
    - Therapeutic guidelines and protocols for targeted drugs.

13. The Department of Health and Human Services should allow a 100-day supply only after it has been determined that the prescription is appropriate and a chronic condition exists.

14. The Department of Health and Human Services should establish an ad hoc committee, composed of physicians, pharmacists, and members of the academic community, to help develop policies for the prescription drug program to promote a more cost-effective use of medications.

15. The Department of Health and Human Services should develop a continuing education program for doctors and other health care providers that uses current clinical guidelines and best practices for appropriate prescribing and patient care within the S.C. Medicaid program.

16. The Department of Health and Human Services should develop health management programs for providers and recipients to encourage appropriate prescribing and use of drugs, especially for patients with chronic conditions where drug therapy and careful self-management can result in improved outcomes.

17. The Department of Health and Human Services should annually report cost savings that result from the automated point-of-sale, prospective drug utilization review system. The Department of Health and Human Services should track total pharmacy costs to ensure these costs are decreasing.

Failure to Amend the State Medicaid Plan

In January 1999, DHHS increased the number of Medicaid prescriptions allowed for adults from three to four per month. DHHS, however, neglected to amend the State Plan. The State Medicaid Plan is a comprehensive written statement submitted by the state to the federal government that describes the state's Medicaid program and provides assurance of compliance with federal requirements. As a result of DHHS's oversight, the state may have to pay back federal funds up to $3,528,390 that were used to pay for the fourth prescription from January 1, 1999, to September 30, 1999.

According to 42 Code of Federal Regulations §430.12(c), a State plan must:

> . . . be amended whenever necessary to reflect changes in Federal law, regulations, policy interpretations, or court decisions; or ***material changes in State law***, organization, or policy, or in the State's operation of the Medicaid program . . . . [Emphasis added.]

An amendment must be submitted no later than 60 days from the effective date of the new policy in order for HCFA to determine whether the policy meets the requirements for approval and to ensure the availability of federal match money.

According to DHHS officials, agency staff initially discovered the oversight in November 1999 and reported it to HCFA. Also during this time, an analyst from the HCFA Regional Office in Atlanta was conducting a routine, onsite review of expenditure reports. The analyst questioned the increase in pharmaceutical expenditures, whereupon DHHS staff explained that these were the result of increasing the monthly prescription limit from three to four. The HCFA analyst requested a copy of the State Plan amendment that authorized the change, but it could not be produced. The amendment was subsequently submitted to HCFA, and DHHS's director contacted federal officials and congressmen from South Carolina to begin remedying the situation and avoid financial penalties.

DHHS claims that HCFA was aware of the change well before the formal amendment was filed. Medicaid Bulletins had been sent to the HCFA regional office alerting them of changes to the program, and discussions had been held with their staff. DHHS also has sent a series of letters to HCFA, attempting to explain and resolve the situation. As of January 2001, the issue has not been resolved.

Prior to this incident, DHHS had no formal procedures in place for amending the State Plan. Responsibility for amending the plan was delegated to the program area that originated the proposed changes. However, following this problem, DHHS's director outlined a formal process for all changes that require an amendment to the State Plan, and made DHHS's General Counsel responsible for overall coordination of the State Plan amendment process.

10–Year Funding Review

Medicaid Expenditures and Appropriations

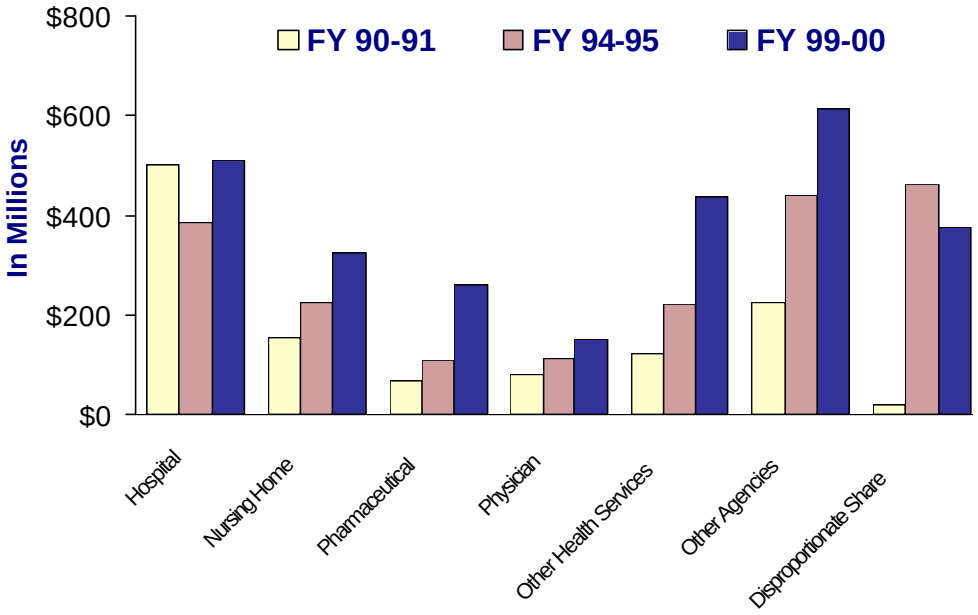
Medicaid is the largest single program in South Carolina's state budget outside of education. For FY 00-01, total monies appropriated to DHHS were more than $3 billion; $2.9 billion were appropriated for health services, with approximately 70% of this funding provided by the federal government. Over the past ten years, Medicaid has amounted to approximately 96% of DHHS total program costs. The non-Medicaid programs administered by the agency provide child care, services to the elderly, and other social services, and have different federal sources of funding than Title XIX.

At least three factors are creating pressures on DHHS's state budget for Medicaid:

- The increase in the number of individuals receiving Medicaid.
- The change in the funding mix toward increased use of state general funds.
- The reliance on non-recurring funds to make up the state's share of Medicaid funding.

Medicaid payments to health care providers, including disproportionate share payments to hospitals, have increased 37% over the past 5 years and 128% over the past 10 years. Figure 4.1 shows the increases in specific health care services funded by Medicaid. Pharmaceutical services show one of the largest increases in Medicaid spending (see Chapter 3).

Figure 4.1: Medicaid Payments for Health Services



Source: DHHS Program Structure Appropriation Summary Status Reports.

Impact of Increased Number of Recipients

According to data published by the Southern Legislative Conference (SLC), the average annual growth in Medicaid payments for the 16 southern states from 1992 to 1998 (the latest year comparative data are available) was 7.55% a year, for a total growth of 54.76%. South Carolina's average annual Medicaid growth was higher than the southern average, at almost 10% per year and a total growth of 75%. According to the SLC, South Carolina's Medicaid growth is almost entirely due to the increased number of recipients who entered Medicaid coverage.

Data provided by DHHS show that the number of Medicaid recipients increased 38% from FY 94-95 through FY 99-00. DHHS also projects that the Medicaid population will grow another 17.4% by FY 01-02. The largest factor in this growth is the increase in the number of children and low-income families eligible for Medicaid.

South Carolina's average annual Medicaid growth was higher than the southern average, at almost 10% per year and a total growth of 75%.

The increase in recipients is not entirely due to changes in eligibility standards. According to DHHS, census data underestimated the number of children age 1 – 19 in families earning less than 150% of poverty; 75,000 children were projected, but between October 1997 and October 1999, more than 99,000 children became eligible for the program. In addition, there was a 62% increase in the number of low-income families entering Medicaid coverage. DHHS was surprised by this increase because it thought most individuals had already been identified through the Temporary Aid to Needy Families (TANF) program at DSS.

These increases in the Medicaid-eligible population, plus the high cost of prescription drugs, were cited by DHHS as two chief causes for its FY 99-00 deficit.

Sources of Funding

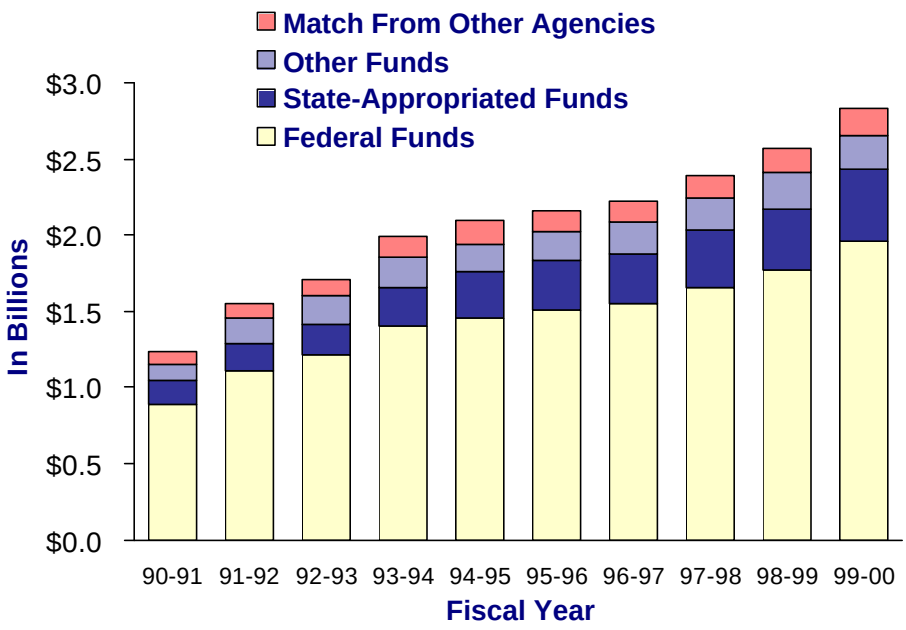
Federal funding provided through Title XIX of the Social Security Act paid for slightly less than 70% of South Carolina's Medicaid program in FY 99-00. Medicaid is not a fixed grant or a "capped" program — federal funds are provided to meet actual expenditures as long as the state provides its share of matching funds. The sources of matching state funds include:

- State general fund appropriations as well as non-recurring funds such as the tobacco settlement money.
- County funds, including $13 million assessed annually on county governments. (This amount has not changed over the past 11 years.)
- Funds spent by other state agencies which receive federal Medicaid funds or provide health services to Medicaid recipients. (The agencies certify they have spent these funds; these funds are reported in DHHS's budget).
- Nursing home fines, hospital taxes, and other collections that DHHS is allowed to retain in earmarked and restricted accounts.

State funds appropriated directly to DHHS funded 13% of Medicaid spending in FY 90-91 but funded 17% of Medicaid spending in FY 99-00, while other sources of funds decreased slightly or stayed about the same. While this change in the funding mix seems relatively small, it actually amounts to $113 million more in expenditures from state funds in FY 99-00 than if the share from general appropriations had remained at 13%. The federal share of Medicaid expenditures, which is based on a formula that takes into account the relative wealth of the state, has been slowly decreasing over the past ten years, from 72% to slightly less than 70%.

Figure 4.2 shows total expenditures for the S.C. Medicaid program for the past ten years. The amounts shown include federal Medicaid funds that DHHS reimburses to other state agencies for the Medicaid services they provide. The state share put up by these agencies is shown as a separate item. DHHS administrative costs for the Medicaid program during this time are approximately 1% – 2% of program costs.

Figure 4.2: Funding Sources for Medicaid Expenditures



Source: DHHS Program Structure Appropriation Summary Status Reports.

State Appropriations

Based on appropriation acts from FY 90-91 through FY 99-00, DHHS's "base" allocation of state general funds has increased 154%. (This base allocation is for all of DHHS's programs — not just Medicaid.) The agency has received additional state funds every year. Despite this increase, DHHS has continued to need additional funding. Over time, the need for additional state funds for Medicaid has been filled with non-recurring funds (one-time or surplus funds that the General Assembly divides among state agencies). However, these funds are not added to agencies' "base" budgets and there is no guarantee that they will receive them the following year.

For 7 of the 10 previous budget cycles, state funds appropriated to DHHS have come from non-recurring sources as well as from recurring. This trend is particularly apparent in the current fiscal year. For FY 00-01, DHHS received $190 million, including $140 million in tobacco settlement monies, from non-recurring, one-time sources. About $178 million of these funds are for recurring expenditures.

Therefore, ongoing, core Medicaid expenditures are being funded with one-time money. This is contributing to a statewide problem know as "annualization." The State Budget Office has indicated that the state currently needs to annualize $587 million for state programs. This means that DHHS's non-recurring funds for this fiscal year account for approximately one-third of the state's annualization need.

Table 4.3: State Fund Appropriations to DHHS

Fiscal Year	Base From Prior FY	Legislative Increase After Adjustments	Appropriations Per Act	Non-Recurring	Total Budget
91-92	$161,090,408	$31,149,527	$192,239,935	$0	$192,239,935
92-93	$192,239,935	$23,239,335	$215,479,270	$0	$215,479,270
93-94	$215,479,270	$44,090,595	$259,569,865	$0	$259,569,865
94-95	$259,569,865	$13,291,847	$272,861,712	$25,191,509	$298,053,221
95-96	$272,861,712	$27,426,395	$300,288,107	$24,985,469	$325,273,576
96-97	$300,288,107	$24,986,480	$325,274,587	$4,910,978	$330,185,565
97-98	$325,274,587	$36,243,515	$361,518,102	$15,387,281	$376,905,383
98-99	$361,518,102	$29,134,289	$390,652,391	$13,008,051	$403,660,442
99-00	$390,652,391	$18,342,099	$408,994,490	$56,521,616	$465,516,106
00-01	$408,994,490	$21,801,518[a]	$430,796,008	$190,532,622[b]	$621,328,630

a This amount includes disproportionate share funding formerly allocated to MUSC.
b This amount includes $140,732,185 in one-time money from the state's tobacco settlement.

Source: State Budget Office

DHHS Deficit

DHHS ran into serious budget problems in FY 99-00, although, according to staff, this was not the first time DHHS's state appropriations were inadequate to cover costs. In October 1999, DHHS's director notified the State Budget and Control Board of a potential $63.7 million deficit in state appropriations. DHHS was able to reduce this deficit to $25.8 million by delaying certain program expansions and rate increases, reducing reimbursement rates to pharmacists, and using agency cash reserves. The Budget and Control Board provided supplemental funds to DHHS, of which DHHS spent $13 million in FY 99-00 and carried forward the remaining $12 million for FY 00-01.

One earmarked account in particular has been used by DHHS in the past to make up state fund shortfalls. A proviso in the appropriations act since FY 91-92 states that:

> To the extent that the Department can increase Medicaid federal matching funds through changes in reimbursement formulas for other state providers, the Department, with the permission of the state providers, is authorized to retain these funds in an earmarked account . . . and use these funds to cover unanticipated health and human services expenditures.

Most of these funds came from state hospitals contributing a portion of their disproportionate share revenues to DHHS. According to information furnished by DHHS staff, since FY 91-92 DHHS has used funds from this account to:

- Cover general funds deficits amounting to $48.1 million.
- Help other state agencies provide matching funds in the amount of $10 million.

However, changes in federal procedures no longer allow DHHS to use this method to generate funds. The agency will no longer be able to use this account to cover unanticipated expenditures. In addition, the cuts DHHS took to decrease the size of its deficit were largely one-time cuts. The agency could not continue these actions without either decreasing the payments that health care providers receive or decreasing the level of health care services the Medicaid clients receive.

Conclusion

DHHS for the past several years has requested more state funds to annualize the previous year's non-recurring funds, to provide for increasing numbers of individuals eligible for Medicaid, and to pay for the increased costs of prescription drugs. Given the size and scope of the Medicaid program, it has a major impact on other state agencies as well as the whole state budget. Since it seems that Medicaid expenditures will only keep increasing, the impact on state funds will continue to be severe.

In this report we reviewed two areas — fraud and prescription drugs — where proactive policies on the part of DHHS could help slow Medicaid cost increases. In addition, we plan to conduct a second review which will examine the role of managed care in Medicaid expenditures. However, a larger scale review involving all the agencies which use Medicaid funds is also needed. DHHS should be a lead agency in a statewide study that looks at the ramifications of continuing to fund Medicaid at its present rate of growth versus the impact of cutbacks in medical care for needy individuals and/or reimbursements to health care providers. The results of this study should be reported within one year (at the beginning of the legislative session for 2002) to the S.C. House Ways and Means Committee, the Senate Finance Committee, and the chairmen of appropriate subcommittees.

Recommendation

18. The Department of Health and Human Services should initiate a study that involves other state agencies which use Medicaid funds and that examines ways to slow down the growth in Medicaid expenditures without negatively affecting the access of needy individuals to health care. The results of this study should be reported within one year (at the beginning of the legislative session for 2002) to the S.C. House Ways and Means Committee, the Senate Finance Committee, and the chairmen of appropriate subcommittees.

Methodology Note

DHHS's primary source of information about Medicaid claims and payments is the Medicaid Management Information System (MMIS). This system processes approximately 16 million individual Medicaid claims per year. DHHS uses several contractors for this system.

- Clemson University — which houses the mainframe computer and provides all the technical support.
- Blue Cross Blue Shield — which provides the manpower for claims processing including data entry, provider enrollment, and other services.
- S.C. Department of Social Services — which enrolls recipients and verifies income and eligibility. DSS enrolls recipients using its own computer system which interfaces automatically with the MMIS.

In addition, DHHS recently signed a contract for a point-of-sale, prospective drug utilization review system that will process prescription drug claims. DHHS also runs several sub-systems from the MMIS.

DHHS's contract with BCBS calls for error rates of not more than 2% for data entry. DHHS also keeps onsite staff at BCBS to monitor the contract. The federal government had conducted systems performance reviews of the MMIS until about three years ago. The MMIS was originally certified in 1981 but has been updated since then.

Other statistical information is provided by the U.S. Health Care Financing Administration (HCFA). South Carolina, as well as other states, sends disaggregate data to HCFA which compiles the "2082" Report, which provides information on the number of recipients, eligibility categories, expenditures, and number and types of claims. As of December 2000, HCFA had not published the 2082 Report for FFY 98-99.

DHHS performs the accounting functions for Medicaid and uses the GAFR (governmental accounting and financial reporting) system. Claims processed by the MMIS are reconciled to the GAFR system, which in turn is reconciled to the S.C. Comptroller General's accounts. DHHS also keeps accounts receivable for drug manufacturers' rebates and other collections such as fraud and abuse. Drug rebates are computed based on detailed claims and cost data that are also scrutinized by the drug manufacturers. DHHS's accounts receivable are audited by the S.C. State Auditor. DHHS also reports Medicaid expenditures to HCFA on a quarterly basis (the "HCFA 64" Report).

In compiling this report, we used reports generated by DHHS from the MMIS for information on the number of recipients per year, prescription drug claims, drug costs and rebates, and for overall expenditures by health services category and recipient category. We used annual GAFR reports for financial information on DHHS's sub-funds and expenditures. Information on DHHS's budget requests and appropriations was provided by the S.C. State Budget Office. We used the HCFA 2082 Reports for comparisons between the states, and HCFA 64 Reports for information on fraud and abuse collections.

Therefore, while we could not directly test DHHS's information systems, we identified the sources of the information and any internal or external controls over the reliability and accuracy of the data. We also reviewed all reports obtained from DHHS to ensure the information was reasonable in light of other sources of data.

Agency Comments

Appendix B
Agency Comments

State of South Carolina
Department of Health and Human Services

Jim Hodges
Governor

William A. Prince
Director

February 21, 2001

George L. Schroeder
Director
Legislative Audit Council
1331 Elmwood Ave., Suite 315
Columbia, SC 29201

Dear Mr. Schroeder:

Thank you for the opportunity to review and respond to your recent report, A Review of Selected Medicaid Issues. We have found it helpful in evaluating our operations in these areas. Our comments are included in a separate attachment and are organized according to your specific recommendations. I would like to thank you for the professional manner in which your staff performed this review. If you need additional information, please let me know.

Sincerely,

William A. Prince
Director

WAP/bkp

Office of the Director
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South Carolina Department of Health & Human Services

Response to Legislative Audit Council Report
A Review of Selected Medicaid Issues

Chapter 2, Control of Fraud and Abuse, Page 10

Response to Recommendation # 1

The agency has procedures in place to ensure that providers are enrolled in accordance with the standards defined by the Code of Federal Regulations and applicable state law. These include, but are not limited to:

- Verifying licensure and certifications
- Checking against the HCFA list of excluded providers
- Requiring submission of social security or tax identification number along with street addresses
- Periodically purging inactive provider numbers

In addition, we are exploring the potential of accessing other available national databanks to check provider backgrounds. We believe the suggestions made to strengthen provider enrollment are good and we will examine our current procedures as well as perform additional audits to determine if further controls are warranted and cost justifiable.

Response to Recommendation # 2

The agency has established income verification standards that it believes strikes the appropriate balance between accuracy of eligibility and the efficiency of the enrollment process. It is our intent to simplify the eligibility process as much as possible while maintaining a strong program integrity environment. We measure our performance by the standards defined in HCFA'S Medicaid Eligibility Quality Control process. Currently, we are operating at an error rate of approximately one-half of one percent, which is well below the three percent maximum limit.

Response to Recommendation # 3

We strongly disagree with the recommendation to contract for provider training. As you stated, previous budget cuts were the cause behind our reduction in training. In the past, statewide training was held by county or region, depending on the provider type and number of providers in the area. Local training was, and still is, held at DHHS. One on one provider education and training held in the provider's office is most effective for Medicaid.

Due to program expansions and growth in the number of providers, the volume of claims submitted for payment grew by 43% from SFY 1995 to SFY 2000. The number of claims that had to be recycled due to provider errors grew by 51% during the same period, with over 1.2 million claims being recycled during SFY 1995 to SFY 2000. During the same period, the number of providers grew 28% from 23,041to 29,480. The number of staff assigned to assist providers in resolving billing and payment errors as well as to provide technical assistance and training on billing and payment processing remained static during the same period.

Rather than contract, we believe it is more efficient and cost effective to provide adequate resources to staff to provide technical assistance and training to providers. Program staff are organized by specific program areas and are given the responsibility to develop and interpret policy, provide billing updates and procedures, and establish training for respective provider groups. These policies and procedures change frequently in response to changes in state and federal law and resources. If DHHS were to contract for provider training, the entity providing training would have to become as well versed in the unique policies of each one of the multitude of diverse programs provided under Medicaid as the staff who currently work in the program areas. This would be an unnecessary duplication of functions.

The recommendation to contract for training suggests that training cost "would be fixed" and not subject to budget reductions. In actuality, training provided under an administrative contract would be much more vulnerable to cuts than training provided by staff.

Chapter 2, Detection of Fraud and Abuse, Page 19

Response to Recommendation # 4

The Department is concerned about improving the referral rate of questionable claims. We are currently implementing the necessary steps to ensure that all claims suspected of intentional misrepresentation are referred for further investigative action. The new administration in the Program Integrity Division has identified the following factors that it believes contributed to prior low referral rates.

- The division was previously divided into three separate units among which communication was severely restricted. The area has been reorganized to remove inter-departmental barriers that impeded staff cooperation.
- The aged mainframe Surveillance and Utilization Review System (SURS) had limited capabilities and was somewhat unreliable. Its relative inflexibility coupled with the fact that access was closely held to only a few staff members constrained productivity. The old system was replaced in December with a new client server based SURS that provides more flexibility at a variety of levels of specificity. Most importantly, we have chosen to distribute system access to all review staff. This is the largest network installation for the vendor, UPI of California, which has described the aggressive implementation as "the smoothest and fastest to date."

- Previous case selection and management practices were not always effective in identifying significant fraud and abuse. To provide a better focus on material fraud and abuse we are implementing cost-benefit criteria, improved employee performance feedback, and improved management and data reporting.
- Training opportunities for staff have been lacking. We are currently implementing training plans that emphasize cross-training, statistical analysis, and fraud detection and prevention.

The previously mentioned factors involved referrals internal to the agency. We are also very interested in maximizing external referrals. In November, we established an internal task force to examine the Recipient Explanation of Medical Benefits process and suggest methods to improve its effectiveness. Additionally, we have developed a complaint tracking mechanism, placed fraud and abuse information on our website, and opened a fraud and abuse hotline.

Response to Recommendations # 5, # 6

The agency concurs with these findings. One of the major problems initially identified by the new administration was the inadequacy of the existing case tracking system to account for all cases reviewed by the division. We believe this to be a vital area because we rely on this system to provide feedback as to our overall performance and efficiency. To resolve this problem we have taken the following steps:

- manually accounted for all open cases prior to, and activity during, the current state fiscal year;
- acquired a new automated, comprehensive case management system that provides for greater reporting flexibility;
- implemented procedures that improve accountability and consolidate case tracking responsibilities under one administrative area; and,
- implemented procedures to ensure the effective set up and tracking of accounts receivable as well as the quarterly reconciliation of collections with the agency's accounting system.

Response to Recommendations # 8, # 9

As suggested, the agency will continue to take steps to improve its coordination with the Attorney General's Medicaid Fraud Control unit. In August, we initiated the process of holding monthly meetings to discuss such items as the status of critical cases, coordinate case reviews, review outstanding complaints, identify effective SURS selection criteria, and develop training programs. We have completed the updated Memorandum of Agreement with the Attorney General that ensures cases are appropriately referred on a timely basis.

Response to Recommendations # 7, # 10, # 11

We agree with these recommendations and are currently in the process of developing a written business plan that includes both short and long range strategies. In the past, there was no clear mission for the agency's fraud and abuse effort. Review plans were generally based on outdated HCFA performance requirements that required utilization review across a broad body of active providers. This approach tended to dilute our ability to detect significant fraud and abuse. We are in the process of re-focusing the unit's mission from a general review process to one that emphasizes the objectives of identifying, stopping, and preventing Medicaid fraud and abuse. With the implementation of the new SUR system, we are developing new strategies that generate significant returns thereby maximizing our resources. To identify these strategies we have improved communications with the Medicaid Fraud Control Unit and other law enforcement entities. In the last few months, we have visited several other states in the region as well as sought out professional associations to determine best practices. In addition to detection, we are stressing the importance of prevention to staff. We believe that the most effective role we can play is to identify improvements to our own agency's system and processes that, as much as possible, avoids the initial payment of fraudulent claims. To this end, we are requiring that staff evaluate internal processes associated with each case and provide feedback as to what changes may be appropriate.

Chapter 3, Prescription Drug Expenditures, Page 36

Response to Recommendation # 12

With the implementation of the POS System, DHHS has begun to develop and implement policies that increase the use of generic drugs, greater use of prior authorization and therapeutic guidelines.

Response to Recommendation # 13

The 100-day supply issue/four prescription limit is being reviewed.

Response to Recommendation # 14

DHHS currently utilizes the Medical Care Advisory Committee (all provider types and Medicaid recipients), the Retrospective DUR Panel (2 physicians and 2 pharmacists) and the Indigent Care Committee of the South Carolina Medical Association to assist DHHS in policy development.

Response to Recommendation # 15
DHHS will be able to advise physicians as to their prescribing habits as compared with their peers with the full implementation of the Point of Sale System.

Recommendation # 16
DHHS utilizes Disease State Management programs to advise physicians. Currently, an Asthma Case Management program for physicians is underway in the Pee Dee Area.

Recommendation # 17
DHHS will be able to determine cost savings through Point of Sale.

Chapter 4, 10-Year Funding Review, Page 45

Recommendation # 18
DHHS, in coordination with other state agencies, will continue to look for ways to manage growth in the program without negatively affecting access and delivery of services. We will fully cooperate with any initiatives or studies that are directed by the Governor's Office or Legislature.