Report Summary

LAC

February 2001

A Review of Selected Medicaid Issues

- Fraud and Abuse
- Prescription Drug Costs
- Funding

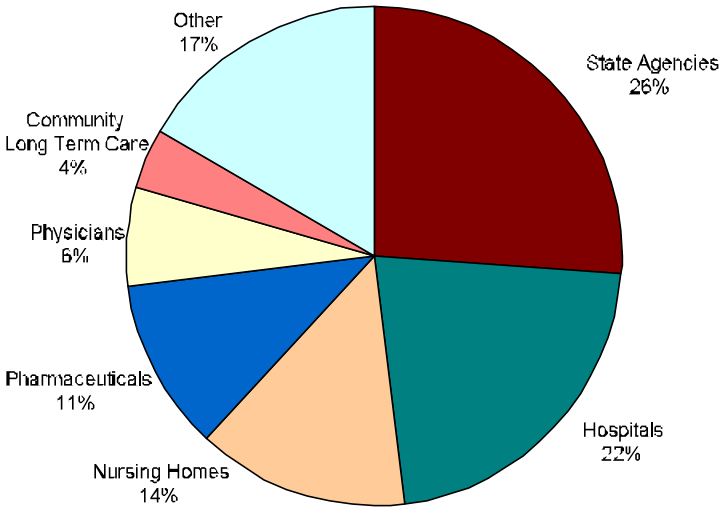
As requested by members of the General Assembly, we conducted a review of the Department of Health and Human Services' (DHHS) management of the state Medicaid program. The audit requesters were primarily concerned about DHHS's efforts to detect and control fraud and abuse, the increase in pharmaceutical expenditures, and DHHS'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.

Eligible Recipients

Medicaid is a federal- and state-funded program that pays for health care for eligible recipients. Eligible recipients include children in low-income families, as well as pregnant women, the disabled, and the elderly who also must meet income and resource requirements.

DURING FY 99-00, HEALTH CARE FOR 690,000 SOUTH CAROLINIANS WAS PROVIDED BY MEDICAID, WITH MORE THAN $2.3 BILLION PAID DIRECTLY TO HEALTH CARE PROVIDERS.

Medicaid Payments to Health Care Providers



Source: DHHS FY 99-00 Accountability Report.

FINDING AND PREVENTING MEDICAID FRAUD AND ABUSE

DHHS monitors health care payments and investigates irregular or suspicious claims through its Program Integrity Division. 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. We found that the division is already taking steps to improve its record in combating Medicaid fraud and abuse.

FRAUD AND ABUSE PREVENTION

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 found several ways in which DHHS could improve its procedures in this area.

- More stringent requirements could be implemented to ensure that only eligible providers are enrolled in the Medicaid program. This could include site visits or increased scrutiny of certain types of health care providers.
- DHHS does not always verify income for applicants seeking Medicaid for their children through the Partners for Healthy Children program. DHHS handled this function in-house for 38% of the applicants, and did not verify income for those families who reported 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.

DETECTION OF FRAUD AND ABUSE

Program Integrity

The Program Integrity Division conducts several different kinds of reviews as well as fraud investigations in order to detect overpayments, fraud, and/or abuse of Medicaid funds. We reviewed Program Integrity's operations from FY 95-96 through FY 99-00, and noted several areas where the division could improve its efforts to detect and follow up on fraud and abuse.

- Internal reviews do not generate many fraud investigations. During the five-year period, only five cases were referred to DHHS fraud investigators as a result of reviewing medical service claims.

- DHHS lacks performance measures and a case tracking system that would enable it to assess the effectiveness of its fraud and abuse investigations. The division pursued a total of 273 cases of potential fraud but did not have summary statistics on the outcome for each case, such as how many investigations resulted in:
  - Criminal or civil charges;
  - Recoupment of payments;
  - Suspension of the provider; or
  - Referral to other law enforcement agencies.

- DHHS is supposed to refer suspicious cases to the Medicaid Fraud Control Unit (MFCU), which is part of the Attorney General's office. However, since 1995, MFCU has received only 44 cases from DHHS. MFCU is charged by law to investigate and prosecute cases of Medicaid fraud.

NORTH CAROLINA HAD $9.3 MILLION IN FRAUD AND ABUSE COLLECTIONS FOR FFY 98-99 — MORE THAN THE OTHER SOUTHEASTERN STATES. HOWEVER, N.C. HAD TOTAL MEDICAID EXPENDITURES OF $5 BILLION AND 60 STAFF IN ITS PROGRAM INTEGRITY DIVISION.

Timely Completion and Documentation of Fraud Investigations

In a sample of 50 fraud case files, we found that half were resolved within one year's time, and over 75% were resolved within two years. Eight cases were eventually closed because the evidence was too old. Investigative outcomes were often inconclusive, with no clear determination as to whether overbillings by providers involved fraudulent intent or were simply a misunderstanding of Medicaid procedures.

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

Collections Due to Fraud and Abuse

For FFY 98-99, DHHS reported $2,064,460 in collections, including overpayments, identified through fraud and abuse detection efforts. However, this amounted to only 0.08% of payments to Medicaid providers in South Carolina. Recoupment of overpayments was not consistently pursued, and it was not always clear from the division files why recoupment had not been successful.

PRESCRIPTION DRUG PROGRAM

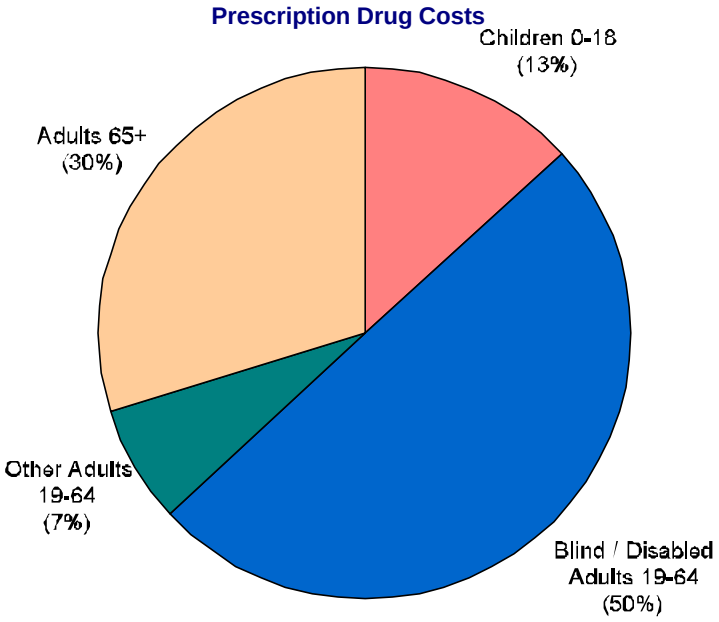
INCREASED EXPENDITURES

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.

- Net Medicaid expenditures for prescription drugs in South Carolina have more than doubled in the last five years — from $123 million to $260 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%.

- 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 eight southeastern states.



Source: DHHS Bureau of Information Systems.

PRESCRIPTION DRUG COST CONTAINMENT

DHHS has not developed drug use criteria and policies that could help limit increases in prescription drug costs. Such policies should require increased use of generic drugs, prior authorization for more brand name drugs, and therapeutic protocols for targeted drugs. DHHS could use the new automated point-of-sale, prospective drug utilization review (proDUR) system to implement more cost saving measures. DHHS should also create an ad hoc committee of physicians, pharmacists, and members of the academic community to help develop such policies and make recommendations for other ways to contain prescription drug costs.

- A small number of drugs dominate Medicaid drug expenditures in South Carolina. The top 50 drugs prescribed in FY 99-00 accounted for 32% of the total drug payments. One example is 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.

- We found that DHHS has successfully implemented a prescription drug rebate program, and has collected $312 million since the program began in FY 92-93.

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

- When DHHS increased the number of Medicaid prescriptions for adults from three to four per month, it neglected to amend the State Medicaid Plan. The state could have to pay back federal funds up to $3,528,390. As of January 2001, this issue was undecided by the federal government.

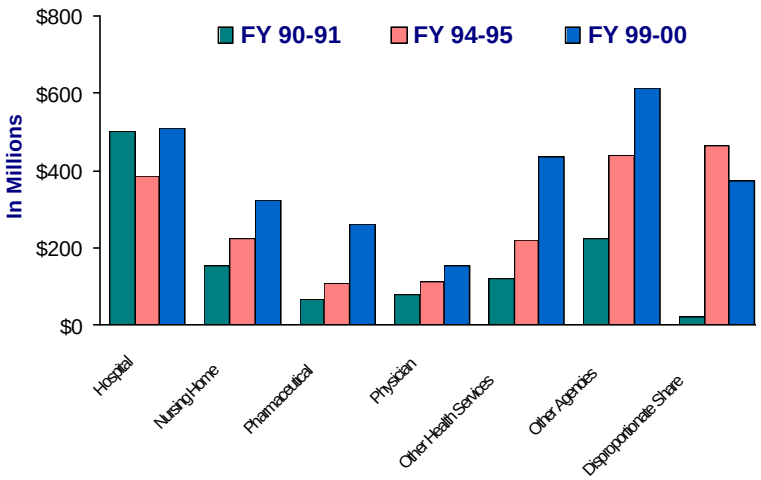
ONLY A FEW SPECIFIC DRUGS AND PRESCRIBING PATTERNS HAVE TO BE FLAGGED TO YIELD SAVINGS OF 2% TO 6% OF TOTAL DRUG SPENDING. SIX PERCENT OF $260 MILLION IS $15.6 MILLION IN FEDERAL AND STATE MONEY SAVED.

MEDICAID FUNDING

Medicaid is the largest single program in South Carolina's state budget outside of education. For FY 00-01, total monies appropriated to DHHS for Medicaid were $2.9 billion. Federal funds comprise slightly less than 70% of Medicaid spending — the rest is from state-appropriated funds and other sources. Medicaid payments to health care providers have increased 37% over the past 5 years and 128% over the past 10 years.

DHHS had a $25.8 million deficit in state appropriations in FY 99-00. At least three factors are creating pressures on DHHS's state budget for Medicaid.

10-Year Increase in Medicaid Payments for Health Services



Source: DHHS Program Structure Appropriation Summary Status Reports.

THE INCREASE IN THE NUMBER OF INDIVIDUALS RECEIVING MEDICAID

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 CHANGE TOWARD INCREASED USE OF STATE GENERAL FUNDS

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 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 RELIANCE ON NON-RECURRING FUNDS

Even though DHHS's base allocation of state general funds increased 154% over the 10-year period, the agency continued to need additional state funds for Medicaid. This has been filled with non-recurring funds (one-time or surplus funds). For FY 00-01, DHHS received $190 million from one-time sources, including $140 million in tobacco settlement monies.

This document summarizes our full report, ***A Review of Selected Medicaid Issues***. Responses from state agencies are included in the full report. All LAC audits are available free of charge. Audit reports and information about the LAC are also published on the Internet at www.state.sc.us/sclac. If you have questions, contact George L. Schroeder, Director.