LEGISLATIVE AUDIT COUNCIL

SUMMARY

Options for Medicaid Cost Containment

INTRODUCTION

Due to continuing concerns about the growth in Medicaid expenditures and number of recipients, members of the General Assembly requested that we review the South Carolina Medicaid program. The audit requesters were primarily concerned with identifying ways to reduce the cost of the Medicaid program without reducing services. Two previous LAC reports, published in 2001, also focused on strategies for reducing Medicaid costs.

We reviewed Medicaid enrollment and how the Department of Health and Human Services ensures that only eligible people receive Medicaid. We looked at strategies to improve the cost-effectiveness of the Medicaid program including a state preferred prescription drug list, a focus on community long term care, recipient cost sharing, estate recovery, and debt collection.

January 2003

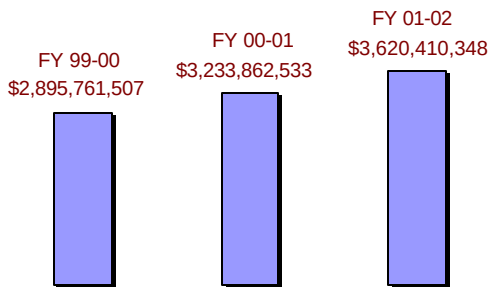
GROWTH IN MEDICAL EXPENDITURES

Medicaid is a joint state-federal program created under Title XIX of the Social Security Act that funds health care for millions of poor, elderly, and disabled individuals nationwide. In South Carolina, the Department of Health and Human Services (DHHS) is the state Medicaid agency. Health care is provided to Medicaid recipients by health care providers enrolled in the Medicaid program.

> "MEDICAID . . . IS THE MOST SIGNIFICANT COST ISSUE AFFECTING STATE BUDGETS."
>
> National Association of State Budget Officers

In South Carolina, Medicaid is a $3.6 billion program, with the federal government providing 69%. In FY 01-02, DHHS spent about $480 million in state general funds on Medicaid. From FY 99-00 to FY 01-02, Medicaid expenditures in S.C. increased 25%, for an average of 12% or $360 million a year. During this same period, general fund revenues in the state *decreased* 1.53%.

Health care costs in general have increased. For example, payments per subscriber in the S.C. state employee health plan increased 11% in one year (2000 to 2001). The growth in Medicaid is also tied to the growth in private health care spending, and states cannot control health care costs on their own. However, strategies that can slow the rate of growth by 2% to 3% can result in millions of dollars of savings.



We estimated $22.9 million savings in state funds that could occur if DHHS implemented our recommendations. Significant savings, in addition to those listed below, are possible based on our analyses in this report and previous reports. Any estimated savings would take a year or more to be realized. Since it is difficult to accurately project potential savings, we tried to ensure that our estimations were reasonable and conservative.

OUR RECOMMENDATION	ESTIMATED SAVINGS / REVENUES (BASED ON FY 01-02 DATA)
Reduce Adult Recipients in Low Income Eligibility Groups by 10%	$4.7 million
Enact a State Preferred Drug List	$12.8 million
Charge a Medicaid Enrollment Fee	$1.4 million
Co-Payment for Optional Services	$3.2 million
Co-Payment Hospital Admissions	$500,000
Increase Estate Recovery	$110,000
Improve Debt Collection	$204,000

Determining Medicaid Eligibility

A primary factor fueling the growth in S.C.'s Medicaid program has been the number of individuals receiving Medicaid coverage, which increased 18% from FY 99-00 to FY 01-02, to a total of 816,112 recipients. Eligibility for Medicaid coverage is based primarily on three criteria — income, age, and disability. Since 1983, DHHS has been required by state law to contract for Medicaid eligibility determination, and had previously contracted with the Department of Social Services (DSS). On July 1, 2002, DHHS became responsible for determining the initial eligibility of applicants. DHHS is revising policies and practices in the following areas and needs to ensure that only eligible people are receiving Medicaid benefits.

Income Verification

DHHS workers use several means to verify income, including an automated wage and income matching system that holds past and present income. DHHS is also planning to use additional sources, such as the Department of Revenue, to verify income of low income families. We concluded that these procedures were standard and reasonable.

Private Health Insurance

DHHS is refining the application process to better verify if a Medicaid applicant has private or employer-sponsored health insurance. Federal law requires that Medicaid be the payer of last resort; so private health insurance is supposed to pay first. However, there is only one question about private health insurance included in the Medicaid application.

Quality Assurance

Monitoring Medicaid eligibility determinations is required by federal law. When DSS conducted these reviews, they sampled approximately 175 cases for each six-month period and found a 0% error rate. As an alternative to standard reviews, DHHS received federal permission to focus eligibility monitoring on specific types of recipients. DHHS will also conduct a review of the eligibility determinations made by sponsored workers in larger hospitals.

Recipient Fraud

The program integrity unit in DHHS is responsible for safeguarding Medicaid against fraud and abuse by recipients. New policies regarding recipient fraud should include better access to information created by other Medicaid divisions, such as reports on pharmacy use.

Growth in Low Income Enrollment Groups

The Medicaid program has experienced rapid growth in two eligibility categories:

- Low income families , which includes welfare recipients and other low income families.
- Transitional Medicaid, which is available to families who leave welfare because of increased income.

The number of recipients eligible in these categories increased 71% and 31%, respectively, in the past two years. DHHS could strengthen eligibility criteria to limit enrollment of these groups. If low income families lost Medicaid due to changes in criteria, the children in the family would still be eligible under other Medicaid programs. Limiting enrollment of adults in these categories could save $4.7 million in state funds and would include:

- Making it more difficult to meet income limits by changing the amounts "disregarded."
- Limiting transitional Medicaid to one year instead of two years.
- Reviewing these recipients every three to six

Limiting Optional Coverage

One way of reducing Medicaid costs would be to limit "optional" populations. While federal rules require Medicaid coverage for some groups, such as Supplemental Security Income or welfare recipients, the state has considerable flexibility to include additional people under the Medicaid program. About 30% of expenditures in the S.C. Medicaid program were for services to optional groups in FY 01-02.

However, denying or eliminating Medicaid coverage to these individuals would most likely result in severe consequences for them. Many of the individuals covered under optional groups are aged or disabled, in nursing homes or community long term care.

Cost of Prescription Drugs

Although gross expenditures for prescription drugs, which were about$428 million in FY 01-02, continue to account for a large portion of S.C.'s Medicaid expenditures, the Department of Health and Human Services has made some changes that have slowed the growth in this area. After average increases of 23% a year since FY 95-96, expenditures for prescription drugs increased only **a** of 1% in FY 01-02. Some of the changes made by DHHS that were recommended in our 2001 audit include:

- Reducing the 100-day supply per prescription to a 34-day supply per prescription or refill.
- Requiring prior approval for certain medications.

However, DHHS could further reduce those costs through a preferred drug list and prior approval of additional name brand prescriptions.

Changes in S.C. Prescription Drug Costs			
	Fiscal Year		
	99-00	00-01	01-02
Expenditures	29.10%	24.59%	0.33%
Cost Per Recipient	14.53%	12.83%	-13.50%
Cost Per Prescription	6.19%	12.15%	-24.90%

The case of OxyContin also illustrates how prior approval not only helps reduce drug costs but can also reduce inappropriate use of a drug. OxyContin is a very strong narcotic pain reliever similar to morphine. When DHHS required prior approval of OxyContin, prescriptions were reduced and total expenditures for all narcotics decreased by nearly $400,000 a month. After prior authorization was relaxed, use of and expenditures for OxyContin again increased.

Implementing a State-Preferred Drug List

DHHS has begun the implementation of a state preferred drug list for the Medicaid prescription drug program. A "state preferred drug list" (PDL), as developed by the states of Michigan and Florida, is a system to more tightly screen the authorization process for drugs prescribed to Medicaid patients. In these states, Medicaid will no longer routinely pay for drugs unless they are on the state's preferred drug list. Drugs not on the list will be reimbursed only if the doctor obtains prior authorization before prescribing them. In Michigan, for example, the PDL was developed by a committee of physicians and pharmacists who identified 40 classes of drugs that accounted for the majority of increased drug spending in the Medicaid program. They recommended at least two drugs in every therapeutic class as "best in class," based on clinical effectiveness, safety, outcomes, and cost. A drug not selected as best in class can be placed on the preferred drug list if the manufacturers offer supplemental rebates. Michigan officials estimated that the PDL will save 10%-12% of Medicaid drug costs. Ten percent of South Carolina's gross Medicaid prescription drug costs for FY 01-02 would be $42.8 million in total funds and $12.8 million for the state's share.

Increased Use of Home and Community-Based Care

Long term care is provided by nursing homes and also by home and community-based care programs (CLTC), which allow an elderly or disabled person to remain at home and receive services otherwise provided in an institutional setting. Nursing home care for Medicaid recipients costs more than twice as much per person as care in a home or community-based setting. However, the waiting list for CLTC was 3,600 (as of November 2002), while the waiting list for a Medicaid nursing home bed was 281. Nursing home care cost the Medicaid program $360 million in FY 01-02.

Both CLTC and nursing homes are separate items in the Medicaid budget. In this sense funds do not follow the patient. If DHHS is to slow growth in Medicaid spending, then it should consider redirecting resources to home and community-based long term care. Otherwise, Medicaid patients who could be cared for at home may have no options other than nursing home care.

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

ENROLLMENT FEES AND COLLECTIONS

Federal law allows limited cost-sharing with Medicaid recipients which DHHS currently does not utilize. DHHS could realize additional cost savings through charging nominal fees to recipients and also by improving collections from third parties.

G$1.4 Million

Enrollment fees would be the most viable cost-sharing option for DHHS because the fee could be applied consistently and the administrative burden would be minimal. This is an annual fee paid by the recipient to the Medicaid agency and is not dependent on the services used. Federal law allows enrollment fees to be required from Medicaid recipients but only for certain optional groups such as the Partners for Healthy Children. In order for South Carolina to charge an enrollment fee to this group, DHHS must amend the State Medicaid Plan to change the Partners for Healthy Children to a separate program. Then it can charge an enrollment fee based on income. By charging a $20 annual fee to enrollees in this group, DHHS could collect about $1.4 million.

G$500,000

Federal law allows limited co-payments for hospital services, and other states charge anywhere from $2 up to $200 per hospital admission. Based on FY 01-02 hospital admissions for adult enrollees in certain eligibility groups, DHHS could save almost $500,000 if a $25 co-payment were charged.

G$110,000

DHHS does not use all available methods for recovering from estates of persons who have received Medicaid services. DHHS could place liens on real property, collect for more services, and expand the types of assets from which it can collect. A 10% increase in estate recoveries could yield $110,000 in additional state revenues.

G$3.2 Million

Federal law requires states to cover certain services including hospital and physician services. States may also choose to cover additional services such as prescription drugs and optometrist services. In FY 01-02, South Carolina covered a number of additional services at a cost of $708 million, 58% of which was for prescription drugs. The cost of optional services can be reduced by charging a co-payment for these services. The co-payment can only be a nominal amount but the charge also results in a decreased usage of the services. S.C. already charges a co-payment of $3 for prescription drugs but not for other optional services. If DHHS charged a co-payment for the other optional services of $2 per transaction for adults over age 21, and with an estimated decrease in use of 10%, it could save approximately $3.2 million annually in state funds.

G$204,000

DHHS could improve its collection of unpaid Medicaid debts by using the S. C. Department of Revenue's debt collection program. DHHS should also adjust its information technology system to allow for regular debt withholding from providers' checks. A 30% improvement in recovering overdue debts owed by Medicaid providers and recipients could result in $204,000 in additional collections for DHHS.

AUDITS BY THE LEGISLATIVE AUDIT COUNCIL CONFORM TO GENERALLY ACCEPTED GOVERNMENT AUDITING STANDARDS AS SET FORTH BY THE COMPTROLLER GENERAL OF THE UNITED STATES.

FOR MORE INFORMATION

Our full report, including comments from relevant agencies, and this document are published on the Internet at

www.state.sc.us/sclac

Copies can also be obtained by calling

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