South Carolina Legislative Audit Council

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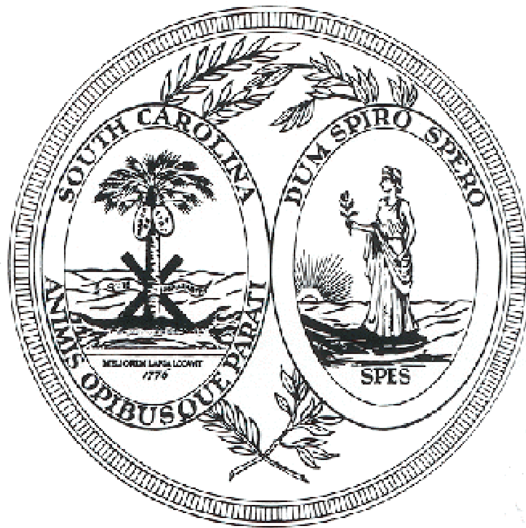
Report to the General Assembly

October 2001

Cost Savings Strategies for the South Carolina Medicaid Program



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Cost Savings Strategies for the South Carolina Medicaid Program
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Cost Savings Strategies for the South Carolina Medicaid Program

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Synopsis

This is our second report on the Department of Health and Human Services' (DHHS) management of the state Medicaid program. Medicaid provides health care for eligible recipients, and is jointly funded by federal and state dollars. Eligible recipients are those who receive cash assistance, as well as children, pregnant women, the disabled, and the elderly who meet income and resource requirements.

Our first report focused on issues involving Medicaid fraud and abuse, prescription drugs costs, and state funding. Based on additional concerns of the audit requesters, we reviewed three other areas, with the goal of identifying cost savings without cutting back on services to Medicaid recipients.

The following questions were examined in this report.

- ❑ Would greater use of managed care improve the cost-effectiveness of the Medicaid program?
- ❑ How could the current Health Insurance Premium Payment (HIPP) program result in cost avoidance for DHHS?
- ❑ Is the contract with the Department of Social Services the most efficient and cost-effective way to perform the Medicaid eligibility function?

Our findings include the following.

- Compared to other states, a very low percentage of Medicaid recipients in South Carolina were enrolled in managed care programs such as HMOs (health maintenance organizations). South Carolina, with only 5% of Medicaid recipients enrolled in managed care, ranked the lowest among ten southeastern states, which averaged 50% of Medicaid recipients in some form of managed care.
- While many states have encountered problems in expanding managed care to greater numbers of recipients, officials in the states we surveyed believed that managed care has reduced costs and expanded access to medical services. Research has shown that states typically discount managed care rates at 5% – 15% of regular Medicaid costs. Based on a 10% savings estimate, an expansion of the managed care program to include all Medicaid-eligible children and families in 19 counties could save an estimated $21 million in federal and state funds.

- DHHS's own policies may have limited the expansion of Medicaid managed care in South Carolina. For example, DHHS has no "lock-in" policy. Medicaid recipients are allowed to terminate their enrollment in a managed care plan at any time and to change their enrollment status on a monthly basis. This can destabilize plan membership.

- DHHS has contracted for an independent, third-party review to study the cost-effectiveness of its managed care program. However, this study may not be completed for several months.

- The Health Insurance Premium Payment (HIPP) program allows DHHS to pay for employer-based group health insurance for Medicaid-eligible individuals when it is cost-effective. By paying the premiums and deductibles for private health insurance, DHHS can shift some healthcare costs from Medicaid. Using the experience of successful HIPP programs in other states, we estimated that South Carolina could save $1,314 per recipient. DHHS staff believe that this program can be expanded to cover up to 5,000 recipients, but the current structure of the program limits its expansion. If the HIPP program were expanded to 5,000 participants, an estimated $6.57 million in federal and state funds could be saved.

- One of the largest administrative expenses incurred by DHHS is the cost of determining eligibility for Medicaid. The bulk of this cost is a $33.8 million contract between DHHS and the Department of Social Services (DSS). DHHS pays Medicaid funds to DSS to provide staff in county DSS offices to take applications and determine eligibility for Medicaid.

- More than 50% of the expenditures charged to Medicaid under the eligibility contract are for DSS's allocated and indirect costs. DHHS does not know how many DSS workers it is paying for, and how many workers are actually needed to perform the job efficiently. Workloads by county are not standardized, ranging from an average of 9.5 applications per worker to an average of 57 applications per worker per month.

- DSS eligibility staff located at the county social services offices cost on average $60,151 per person in FY 99-00, while out-stationed DSS staff located at hospitals and healthcare facilities cost on average $39,513.

- If the contract with DSS was revised and some of the staff costs were eliminated, we estimated that $4.8 million in federal and state funds could be saved.

Introduction

Audit Objectives

After the Department of Health and Human Services (DHHS) incurred a deficit in state general fund appropriations for FY 99-00, members of the General Assembly requested an audit of DHHS's management of the state Medicaid program. Because of the size of the Medicaid program in South Carolina (almost $3 billion) and the number of concerns of audit requesters, we conducted two reviews. The first report was published in February 2001 and concerned DHHS's efforts to detect and control fraud and abuse, the increase in pharmaceutical expenditures, and DHHS's budget deficit. Based on additional concerns of the audit requesters, we examined the following questions in this report.

❑ Would greater use of managed care improve the cost-effectiveness of the Medicaid program?

❑ How could the current Health Insurance Premium Payment (HIPP) program result in cost avoidance for DHHS?

❑ Is the contract with the Department of Social Services the most efficient and cost-effective way to determine Medicaid eligibility?

Scope and Methodology

The period covered by this audit is generally from FY 96-97 through FY 99-00. Our sources of evidence included:

- South Carolina appropriations acts and other relevant statutes as well as federal law, primarily Title XIX of the Social Security Act.
- Financial information from DHHS's accounting system, the Office of the State Treasurer, and the Department of Social Services.
- Agency policies and procedures and the State Medicaid Plan.
- Interviews with officials at DHHS as well as with other state agencies, healthcare groups, and Medicaid officials in other states.
- Materials from the U.S. Health Care Financing Administration, the U.S. General Accounting Office, the Urban Institute, and the Southern Legislative Conference.
- Interviews with and materials provided by healthcare providers.

The focus of our review was to identify improved efficiencies in areas that would not adversely impact health care for Medicaid recipients. In general we did not review DHHS's management controls except for those involved with its contract with the Department of Social Services. We reviewed federal and state requirements only where they specifically pertained to our objectives.

We used some information from reports generated by the Medicaid Management Information System (MMIS) and the Client Information System. Appendix B contains more detail on the data and methodology used to estimate potential cost savings.

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. The South Carolina Department of Health and Human Services is the state agency responsible for administering Medicaid, which comprises about 96% of DHHS's total program costs. Medicaid is the second largest program in South Carolina's state budget, behind education. For FY 00-01, total funds appropriated for Medicaid were $2.9 billion, with approximately 70% of this funding provided by the federal government.

Eligible Medicaid recipients include those who receive cash assistance, as well as children, pregnant women, the disabled and elderly who meet other income and resource requirements. During FY 99-00, 693,778 South Carolinians received medical services paid for by Medicaid. The number of recipients is projected to increase by approximately 117,400 individuals (17%) by FY 01-02.

- The elderly and disabled were 26% of the Medicaid population but accounted for 69% of costs, for an average of $7,190 per person.

- Children and low-income families were 74% of the Medicaid population but accounted for 31% of the costs, for an average of $1,124 per person.

Medicaid pays for:
- Inpatient and outpatient hospital visits;
- Care given by physicians, dentists, therapists, and nurses, and other healthcare professionals;
- Pharmacy services;
- Related services such as lab tests and X-ray;
- Long-term care such as nursing homes and community-based care; and
- Transportation to and from medical appointments.

Medicaid Growth and Cost Containment

In the past two decades, new federal and state legislation has steadily increased the original scope of the Medicaid program, offering new services and including additional groups of people. The goal of Medicaid is to provide low-income families and children, as well as needy aged and disabled individuals, access to quality health care. Federal and state policy has focused on outreach to eligible individuals and groups to ensure that all who are entitled to receive Medicaid are enrolled in the program.

Welfare reform in 1996 further re-defined Medicaid as "health insurance for the poor." Prior to welfare reform, most individuals automatically qualified for Medicaid if they were receiving Aid to Families with Dependent Children (AFDC) or federal Supplemental Security Income, which is primarily for individuals who are aged, blind, or disabled. While Medicaid remains a federal entitlement, eligibility is no longer tied to receipt of cash assistance. States have been allowed to modify Medicaid eligibility criteria which has expanded the eligible population. For example, two-parent, working families can qualify for Medicaid if income is below specified limits.

The federal Balanced Budget Act of 1997 also made significant changes to federal Medicaid laws in the area of eligibility, benefits, managed care, and healthcare provider reimbursement and participation. The effect of these changes was to allow states more flexibility; to provide for program expansions in some areas; and, at the same time, to reduce federal spending over the subsequent five years.

In view of Medicaid's expanding role in ensuring access to health care and potential funding restrictions, cost containment measures have become critical. In this report we review three areas where timely implementation by DHHS might help save funds while not impeding the goals of the program. These areas are: (1) greater use of managed care; (2) expanding the health insurance premium payment program; and (3) revising the eligibility determination contract with the Department of Social Services.

Table 1.1 illustrates potential savings and cost avoidance if these three strategies were adopted or more fully used by DHHS. It would take a minimum of two to three years before savings could be realized because all of these strategies would require changes in information systems, the State Medicaid Plan, DHHS policies, staff assignments, and client education.

Table 1.1: Estimated Annual Savings

COST SAVINGS STRATEGIES	STATE SHARE	TOTAL SAVINGS
Target managed care enrollment to more eligible children and low-income families in 19 counties (see p. 5) *	$6,477,660	$21,592,200
Expand health insurance premium payment program to 5,000 participants (see p. 17)*	1,975,985	6,569,100
Revise DSS eligibility contract to use more out-stationed workers and to eliminate other workers (see p. 21)	2,216,405	4,820,200
TOTAL	$10,670,050	$32,981,500

* Estimated savings using the higher number of recipients and higher dollar amounts.

South Carolina's extremely low participation in managed care for its Medicaid recipients was of special concern to the audit requesters. Managed care is one of the strategies most frequently used by states to control Medicaid costs while ensuring access to health care. The other two areas complement the goal of expanding the use of Medicaid managed care. For example, the premium payment program allows Medicaid-eligible individuals to retain access to private health insurance while avoiding the risk to the Medicaid program. This program can be targeted toward individuals with chronic illnesses and disabilities, who are the most expensive types of Medicaid recipients. Most Medicaid managed care programs are primarily aimed at children and low-income families; these groups are less costly for the Medicaid program.

A revised contract with DSS would bring eligibility determination out of county social services offices and into community facilities, which in turn would reduce administrative costs while streamlining the application process. A streamlined application process at hospitals and community facilities allows better access to both Medicaid managed care and the premium payment program.

Other alternatives for controlling Medicaid costs include reducing benefits, reducing payments to providers, or reducing Medicaid eligibility. All these methods could impede access to health care and diminish the health status of thousands of South Carolinians. At the same time, the measures reviewed in this report, if successfully implemented, could improve access to Medicaid, resulting in more recipients, a greater use of services, and a greater total cost. Given the alternatives, we recommend exploring options to make the current Medicaid program as efficient, streamlined, and accessible as possible, even if that results in increasing the number of people served.

Cost Savings Strategies

Expanding Medicaid Managed Care

In this section, we discuss DHHS's management of Medicaid managed care. Enrollment problems and low rates have impeded the use of managed care, and make it difficult to evaluate its potential to save money. However, we concluded that expanding Medicaid managed care could help improve cost-efficiency and access to health care.

Features of Managed Care

"Managed care" is used to describe a system in which medical services are coordinated by an organization or person with a contract to be responsible for the health care provided to an individual. The goal of a managed care system is to provide high-quality care when it is needed and to reduce unnecessary services. To do this, managed care plans use various strategies designed to encourage cost containment while promoting quality of care. For example, the plan may: (1) pay the doctor or other healthcare provider a set monthly fee for each patient regardless of the amount of services actually used; or (2) base the provider's compensation on meeting some performance threshold, such as limiting the number of referrals to specialists.

Managed care plans take different forms but they share common characteristics — they encourage the use of a network of healthcare providers, they use various techniques to manage utilization of services, and most assume some risk by accepting a negotiated payment per patient rather than payment per service provided. Two of the most common managed care models are defined below.

- ❑ Health Maintenance Organization (HMO) — This type of plan offers its members comprehensive coverage for hospital and physician services for a fixed, prepaid fee (capitation rate). HMOs either contract with or directly employ participating healthcare providers, and patients (members) must choose among these providers for all healthcare services. The HMO shares the financial risk with its medical providers and coordinates service delivery.

- ❑ Primary Care Case Management (PCCM) — In this program, the state contracts with primary care doctors who manage patients' care for a small fee and act as "gatekeepers" in monitoring all health services that are paid on a fee-for-service basis. The state still bears the financial risk for the beneficiary's medical care in this arrangement.

Managed care plans began in the 1970s as a result of the rising costs of traditional fee-for-service health insurance. Many consumers, however, avoided these plans, fearing that efforts to control costs might influence a

doctor's decisions concerning treatment and negatively affect the quality of services provided. Policymakers have responded by enacting regulations to protect patients and providers.

According to government sources, over 81 million Americans (30% of the population) were enrolled in HMOs in 1999; in South Carolina, 10% of the population participated in managed care. Figures from the state Department of Insurance show there were 18 HMOs operating in South Carolina in December 1998, and a total number of 444,428 South Carolina members. By December 2000, the number of HMOs had dropped to 12 and the state membership to 410,128 — a net decrease of 8%. According to Department of Insurance officials, the market is competitive for HMOs in the state, and they are operating in every county.

Expanding Managed Care to Medicaid Recipients

When the federal government expanded the Medicaid program to cover other needy groups, further pressure to contain costs was put on state budgets. Initially, many states placed a limit on the fees a physician could charge for treating Medicaid patients. Many physicians responded by withdrawing their services, forcing Medicaid recipients to rely on hospital emergency rooms for their primary care, which contributed to further increases in healthcare expenditures. Beginning in 1981, states could, with federal government approval, waive certain Medicaid regulations and require Medicaid recipients to enroll in managed care programs. States have generally initiated coverage for the less costly Medicaid groups, i.e., women and children, planning to gradually enroll the higher-cost elderly and disabled beneficiaries.

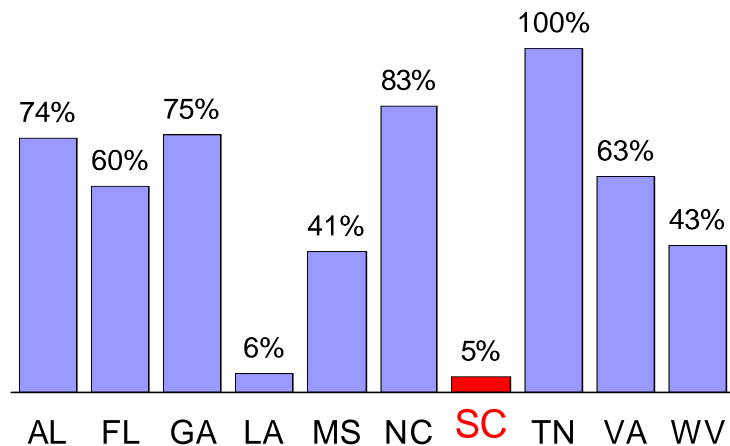
According to enrollment figures from the U.S. Health Care Financing Administration for June 1999, South Carolina had less than 5% of its Medicaid population in some form of managed care — the lowest percentage among ten southeastern states (see Figure 2.1). Average enrollment in 1999 was 56% nationwide and 50% for the southeastern states, excluding Tennessee, which enrolls 100% of its Medicaid population in managed care.

Experience in Other States

We interviewed officials in eight of the ten southeastern states about their experiences with implementing Medicaid managed care (see Appendix A). Because of its long history with Medicaid managed care, we added Washington to our state survey. Despite differences in populations enrolled, these states encountered common problems in attempting to expand managed care programs to Medicaid beneficiaries. Programs were originally implemented in selected counties or urban areas, then later expanded; of the

various types of Medicaid managed care, HMOs were least likely to survive financially, mostly because of poor provider participation. Either doctors have withdrawn from the program because of low fees or there has not been a sufficient number of doctors located in rural areas of the state to support a managed care organization. Two states mentioned problems with educating Medicaid beneficiaries about how managed care programs operate; for example, the need for each individual to choose a primary care physician and to get a referral before going to a specialist. Despite these problems, only Alabama and Mississippi reported they did not have plans to further expand their programs.

Figure 2.1: Percent of Medicaid Recipients Enrolled in Managed Care



Source: U.S. Health Care Financing Administration, June 1999.

Tennessee initially encountered difficulties with its innovative approach to managed care. The state conducted several pilot projects before deciding to implement its statewide HMO program, TennCare, in 1994. All Medicaid recipients are required to enroll in an HMO. The lack of infrastructure to support managed care, combined with the program's short developmental period, about six months, were cited by a state official as the source of its initial problems. Once the program was launched, frequent changes in leadership stalled progress in overcoming these problems. Although TennCare still faces challenges, its operation has been stabilized through the cooperation of physicians agreeing to stay in the program.

The state of Washington has made managed care available for certain groups of Medicaid clients since the early 1970s, but it did not establish Medicaid HMOs until 1986. A program official stated there were no difficulties in the early stages of operation, but mergers of healthcare organizations in recent years have led to fewer plans participating in the managed care provider network. Like others in the survey, Washington has seen a decrease in services in rural areas because payments have not kept up with costs.

Medicaid Managed Care in South Carolina

The Palmetto Health Initiative

In 1994, DHHS received approval from the Health Care Financing Administration to implement the Palmetto Health Care Initiative, a statewide demonstration project comprising a managed care delivery system and expanded eligibility under the state Medicaid program. South Carolina's Medicaid budget was $500 million at the time. The initiative offered a choice between different managed care plans to all South Carolina Medicaid-eligible groups except those residing in long-term care facilities. Enrollment was to be mandatory for all Medicaid beneficiaries; enrollees were free to change plans during the 30-day sign-up period, after which changes could only be made on an annual basis.

According to one state official, the Palmetto Health Initiative generated significant interest; however, the program was never implemented. Various sources gave us several reasons for this:

- South Carolina government officials were wary because of the problems experienced by Tennessee in implementing its program.
- Doctors, hospitals, and state-based HMOs all lobbied against the initiative.
- State HMOs feared the competition with large companies coming in from out of state, attracted by a mandatory program's expanded client base.

Voluntary Managed Care Models

Soon after rejecting mandatory managed care, South Carolina initiated several types of voluntary programs for Medicaid beneficiaries under the administration of DHHS.

An HMO program operated by a private, non-profit company — implemented in 1996. The HMO provides a wide array of core benefits. All services must be provided or arranged for by the member's primary care physician on a 24-hour per day, seven day per week basis. DHHS reimburses the HMO a set per person fee, or capitated rate, to cover all services provided to an individual member. The HMO operates in 19 counties, and its member enrollment as of February 2001 was over 24,000, 86% of which are children age 18 or younger. In 1997, there were three HMOs participating in the program; however, one withdrew in 1999 and another one in 2000. The remaining HMO was nearly forced to leave because of financial losses but was bought out in 1999 by a larger company, giving it the support it needed to continue.

A primary care case management program, the Physician Enhanced Program (PEP) — also implemented in 1996. PEP operates on a partially capitated basis. Participating physicians provide Medicaid patients a basic package of primary care services. DHHS reimburses physicians a set rate per Medicaid client for the basic services; additional services are reimbursed at the doctor's regular fee-for-service rate. Like an HMO, all services must be provided or arranged for by the member's primary care physician on a 24-hour per day, seven day per week basis. The program has expanded into 27 counties, and had an enrollment of over 16,500 as of April 2001.

A fee-for-service managed care program, the Healthy Options Program (HOP) — implemented in 1997. According to DHHS, the HOP program is designed to promote access to health care for all Medicaid eligible children age 18 and under by giving incentives to providers who traditionally avoid HMO plans. DHHS pays physicians an enhanced fee to treat sick children and act as their primary care physician. Over 49,000 children were receiving services through the HOP program as of April 2001.

Medicaid beneficiaries have the option of choosing one of the above managed care programs if it is available in their county, or they may decide to stay with regular Medicaid fee-for-service coverage. DHHS staff report that they are also implementing "disease management" programs for Medicaid recipients with chronic diseases such as diabetes. This is another form of "managed care," in that it focuses on preventive care and helps patients to monitor their own health, thus avoiding more expensive treatment.

Cost-Effectiveness of Managed Care for Medicaid

A key question concerning the use of managed care for Medicaid is whether it will be more cost-effective than regular fee-for-service Medicaid. Managed care plans can potentially save money by (1) ensuring that beneficiaries receive routine medical care from their primary physician rather than in a hospital, (2) emphasizing preventative care, (3) monitoring the use of specialists, and (4) negotiating lower rates with doctors in return for a guaranteed volume of patients.

In South Carolina, DHHS has not yet completed an evaluation of the cost-effectiveness of the state's managed care models. Carolina Medical Review, a private, non-profit corporation which serves as the Health Care Financing Administration's peer review organization for Medicare services in South Carolina, also contracts with the state to provide medical review services for Medicaid. Carolina Medical Review studied the Physician Enhanced Program in 1999 and found savings in some areas which were offset by increased usage of primary care services. They are currently doing a study of the HMO program that will be based on detailed data concerning service use, cost, and recipients' ages and sex. However, the study may not be completed for several more months.

All the states in our survey reported that their managed care programs had both improved access to health care for Medicaid beneficiaries and lowered costs . . .

All the states in our survey reported that their managed care programs had both improved access to health care for Medicaid beneficiaries and lowered costs, although few would put a dollar estimate on the savings. Only two states, Alabama and Mississippi, did not have plans to expand managed care; officials said there was not enough support from doctors and other providers. Most states with established programs were attempting to build a provider network for expanding their HMOs.

South Carolina's Medicaid HMO did its own estimate of savings that have resulted from its program for October 1, 1999, through September 30, 2000. According to the HMO's calculations, the difference between managed care payments and traditional Medicaid costs amounted to $1.5 million or 11% of costs for selected eligible groups. [An explanation of the methodology used by the HMO is in Appendix B.]

Fee-for-Service Costs vs. Managed Care Premiums

Cost data from DHHS shows that in FY 99-00, fee-for-service Medicaid expenditures per recipient under age 19, on average, were more than twice as much as those for the HMO program — $1,090 versus $472, respectively. However, these figures represent gross costs which do not take into account other adjustments and factors. We also reviewed other data which shows the actual premiums paid to the Medicaid HMO. The HMO premiums are paid on a per-member, per-month basis, and vary according to the recipient's age and sex. On average, the HMO received $77.76 per member per month (based on data for FFY 99-00). Over a 12-month period, this would amount to $933; compared to FY 99-00 fee-for-service expenditures, the HMO premium is about 14% less.

Table 2.2: Fee-for-Service Expenditures vs. 12-Month HMO Premium

Average Annual Fee-for-Service Cost Per Person Age 0 – 19*	$1,090
Average HMO Premium Projected for 12 months**	$933
Percent Difference	14%

* Includes all basic services and excludes dental, family planning, residential and long-term care.
** 86% of HMO enrollment are children age 19 and under.
Source: DHHS MARS-Recipient Reports for FY 99-00 and Managed Care Provider Payment Summary

Research has shown that states typically discount managed care rates at 5% to 15% of regular Medicaid costs.

Research has shown that states typically discount managed care rates at 5% to 15% of regular Medicaid costs. Using the 10% estimate and S.C.'s FY 99-00 costs, we estimated that if DHHS implemented a pilot program to include all the Medicaid-eligible children and low-income families in three urban counties where there are currently both HMO and Physician Enhanced Program (PEP) providers, the annual savings could be nearly $7 million; over $2 million of this amount would be state funds. If DHHS subsequently expanded the managed care program to include recipients in all 19 counties where the managed care programs are currently available, annual savings could be $21,592,200 or more, with about $6,477,660 in state funds. [See Appendix B for the methodology used to arrive at this amount.]

Among the 16 states in the Southern Legislative Conference, South Carolina ranked 6th highest in average Medicaid payments per recipient in FFY 97-98 and had the lowest percent managed care enrollment. Compared to two states with a high percentage of Medicaid managed care enrollment, Tennessee and Washington, South Carolina spent on average between $1,600 and $2,000 more per recipient, according to 1998 data from the Health Care Financing Administration.

Barriers to Expanding Medicaid Managed Care in S.C.

In 1998, DHHS requested a consultant to assess the feasibility of implementing a statewide managed care program for Medicaid recipients. The consultant stated that, in order to be cost-effective, a Medicaid managed care program must have (1) reasonable reimbursement levels, (2) opportunity to affect utilization of services, and (3) a sufficient volume of enrollees. Of the three, membership volume is the most critical, and it is even more so in states with lower payment rates. At the time, the consultant stated that South Carolina's cost levels, based on FY 95-96 rates, were among the "lowest" he had seen, and concluded that statewide Medicaid managed care had limited savings potential in South Carolina. Instead, the state should consider implementing mandatory managed care as a pilot program in a major urban center and monitoring its utilization and cost. Another possibility would be expanding the Physician Enhanced Program as a mandatory program in several urban and rural areas.

Several factors have influenced the under-use of managed care in South Carolina's Medicaid program. Low reimbursement rates make it difficult for HMOs to attract physicians and other healthcare providers willing to serve Medicaid recipients. We also found that the policies of DHHS may have limited the expansion of managed care in the Medicaid program. These are described in the following pages.

An Urban Institute study of 41 states . . . published in May 1999, showed that 36 of the states required certain groups of Medicaid recipients to enroll in managed care.

Mandatory vs. Voluntary Programs

The Balanced Budget Amendment of 1997 removed the requirement for a federal waiver before states can implement mandatory Medicaid managed care programs. An Urban Institute study of 41 states' Medicaid managed care programs, published in May 1999, showed that 36 of the states required certain groups of Medicaid recipients to enroll in managed care. Groups most likely to be included are women and children since these recipients are less costly to treat than the elderly and disabled. South Carolina was one of five states in the Urban Institute study that had not initiated some form of mandatory managed care for Medicaid recipients.

All the states in our survey have made enrollment mandatory in one or both of their primary care case management and HMO programs. For example, in North Carolina, there were 35,000 Medicaid recipients in the HMO with mandatory enrollment; an additional HMO with voluntary enrollment never exceeded 500 recipients, and that HMO ended June 30, 2001. Mandatory enrollment guarantees a certain volume of Medicaid recipients, which is critical to the success of a managed care plan. However, South Carolina abandoned the idea of mandatory managed care for Medicaid recipients after the Palmetto Health Initiative was rejected.

Federal regulations still require that recipients have a choice of alternative managed care programs when enrollment is mandatory. It should also be noted that any substantive changes to the Medicaid program may require amendments to the State Medicaid Plan. In addition, South Carolina could be required to obtain a federal waiver for any changes that are not "statewide" in nature.

No Lock-in Policy

The Balanced Budget Amendment of 1997 includes two provisions designed to simplify compliance with enrollment requirements for the Medicaid managed care population. First, states are now free to establish, without federal approval, a maximum enrollment period (lock-in) of up to 12 months. The law requires that beneficiaries be able to terminate their enrollment for cause at any time (e.g., a grievance related to a provider) and without cause within the first 90 days of an enrollment period, but only annually thereafter. Second, states may now guarantee up to six months of Medicaid eligibility to enrollees in all managed care organizations. South Carolina already guarantees 12 months eligibility to children in Medicaid in order to prevent interruptions in medical care.

With monthly enrollment, clients may be in and out of a program before they have learned what to do and to what doctor they have been assigned.

According to a study published in 2000 by the Kaiser Commission, other states are taking advantage of their ability to lock in plan membership. Both the lock-in and guaranteed eligibility provisions were included in the Palmetto Health Initiative.

The lack of a lock-in policy presents a barrier to expansion of managed care. DHHS policy allows Medicaid beneficiaries in managed care plans to terminate their enrollment without cause at any time; furthermore, they may change their enrollment status on a month-to-month basis. A high rate of mobility in the Medicaid managed care population can destabilize plan membership and make it difficult for providers to get timely and accurate enrollment data. Doctors also linked the absence of a lock-in policy to problems with verifying a patient's plan membership and with getting claims paid.

For example, one provider complained that the HMO had left them with a backlog of unpaid claims. HMO officials responded that the continuing need to verify enrollment with DHHS forces them to delay payments, which in turn, can cause doctors and other providers to leave the program.

DHHS's enrollment policies also have an impact on educating Medicaid clients as to how the managed care system works. As various providers pointed out, most recipients are used to going to hospital emergency rooms for all their health care; it is sometimes difficult for them to understand the need to have one primary care physician manage their treatment and authorize visits to specialists. With monthly enrollment, clients may be in and out of a program before they have learned what to do and to what doctor they have been assigned. Implementing an enrollment lock-in would help stabilize plan membership by allowing more time for educating clients and establishing relationships between clients and their primary care physician.

Verification Problems

DHHS contracts with the S.C. Department of Social Services (DSS) to monitor special telephone lines set up for verifying Medicaid eligibility and managed care enrollment. Because patients often either forget to or do not bring their Medicaid card to an appointment, doctors must spend time calling DSS to verify a patient's enrollment before submitting a claim for payment. During our review, doctors complained that DSS staff made the situation inconvenient by closing down the telephone lines early — at 3:30 in the afternoon instead of 5:00. When asked about this, DSS staff responded it was necessary that they close the phone lines early so they could also handle faxed requests for information. Furthermore, they denied being responsible for verifying managed care enrollment, saying they redirect all such calls to DHHS. This was refuted by a DHHS official in a letter directing DSS to verify managed care enrollment and keep the telephone lines open until 5:00 p.m.

Application Process

Medicaid HMO officials blamed the state's application process for its difficulties enrolling members, which contributed to financial problems that nearly put it out of business in 1998. The two-step process required Medicaid recipients to first request a managed care application form from DHHS; once the form was submitted, recipients received a confirmation card that had to be returned before they were actually enrolled in the HMO. Many recipients did not return the confirmation card. DHHS finally changed the process in 1999 — recipients now must return the confirmation card only if they decide *not* to enroll. Following this change, along with its acquisition by a larger healthcare company, the HMO's membership tripled between 1999 and 2000.

Managed Care Capitation Rates

One concern voiced by the consultant in 1998 was that South Carolina Medicaid already paid such low fees to doctors and other healthcare providers, there was no room for DHHS to find additional savings by paying an HMO a fixed rate. For managed care to be cost-effective, the per capita rates must be less than fees paid directly to physicians for comparable services. At the same time, the HMO rates must be high enough that the company can attract healthcare providers to its network. As stated on page 11, recipients in the Medicaid HMO cost less on a per person basis than recipients in regular Medicaid. We could not conclude as to whether these rates are too low to cover service costs.

- For example, as stated earlier, two of three Medicaid HMOs left the managed care market in South Carolina because they could not cover their costs. The remaining HMO showed a net loss in 2000 of over $1 million, according to Department of Insurance data, and only managed to survive with outside support. As of August 2001, DHHS was waiting for the Health Care Financing Administration to approve an increased HMO payment rate for all age categories.

From 1998 to 2001, all three programs have enlarged their networks of medical professionals, individual doctors, and physician groups in urban areas.

- It was difficult to compare South Carolina's Medicaid managed care rates with those paid in other states because states vary in how they set rate categories and whether they establish rates through administrative pricing, negotiation, or competitive bidding. The Urban Institute study examined how states' Medicaid managed care rates compared to their fee-for-service expenditures. [A weighted average per capita cost for Medicare was used because data on Medicaid fee-for-service expenditures were not available.] South Carolina's rate ranked just below the 50th percentile on this comparison.

- Also, the ultimate test of the rate is its capacity to attract enough doctors and other healthcare providers to participate in managed care programs. Low rates make it more difficult for an HMO to maintain an adequate provider network. We compared the number of primary care physicians providing medical services for regular fee-for-service Medicaid, the PEP program and the HMO program. From 1998 to 2001, all three programs have enlarged their networks of medical professionals, individual doctors, and physician groups in urban areas.

Conclusion

In its management of Medicaid managed care programs, DHHS has created barriers to HMO enrollment and established a capitation rate that may be too low for the HMO to successfully negotiate competitive provider fees. DHHS has not yet completed a cost/utilization study to evaluate if managed care has saved money and increased access to health care for Medicaid recipients. All of the nine states surveyed in our review use some form of mandatory managed care, and all reported it has been cost-effective and improved access. The disparity between DHHS's Medicaid fee-for-service and managed care per person costs suggests the potential for major savings, but only if the payment rate is set high enough to attract additional doctors and other healthcare providers.

One state official interviewed in our survey stressed the importance of a supportive attitude towards managed care programs, from providers and regulatory agencies alike. South Carolina rejected a statewide Medicaid mandatory managed care initiative in 1994 for lack of support. But the growth in Medicaid costs should cause DHHS to reconsider its position on managed care. As proposed by its consultant, DHHS should initiate a controlled pilot project in mandatory managed care for a selected area of the state, with an assessment of the impact and cost. Also, if DHHS established a lock-in period for Medicaid recipients enrolled in managed care, more managed care providers may become interested in serving the Medicaid population.

Recommendations

1. The Department of Health and Human Services should expedite the independent, third-party study assessing the cost-effectiveness of its current managed care programs and their impact on access to health care. DHHS should report the results of this study to the appropriate committees of the General Assembly.

2. The Department of Health and Human Services should proceed with a controlled pilot project for a mandatory managed care delivery system for specified Medicaid groups (such as children and low-income families) in one or more urban areas of the state. Based on the results of the study and the pilot project, the department should then determine the feasibility of expanding managed care to include all the clients in specified eligibility groups in the counties where a choice of managed care plans is available.

3. The Department of Health and Human Services should obtain any necessary federal approval prior to implementing the pilot project for mandatory managed care and amend the State Medicaid Plan when necessary.

4. The Department of Health and Human Services should implement an enrollment period of one year for Medicaid beneficiaries currently in managed care programs. Medicaid beneficiaries must still be allowed to disenroll within the first 90 days and/or for justifiable causes.

5. The Department of Health and Human Services should ensure that the capitation rate for the HMO program is competitive with the fee-for-service Medicaid rates.

Expanding the Health Insurance Premium Payment Program

One of our audit objectives was to determine how the Health Insurance Premium Payment (HIPP) program could result in cost savings for the Department of Health and Human Services. By paying the premiums for employer-based health insurance for certain recipients, DHHS could avoid Medicaid costs and realize significant savings. We reviewed the current HIPP program and options for expanding the program. DHHS should consider expanding the program to include more eligible Medicaid recipients.

How the HIPP Program Works

More members of low-income families now qualify for Medicaid as a result of welfare reform and the State Children's Health Insurance Program. Some Medicaid beneficiaries also have access to employer-based group health insurance as an employee or through a working parent. According to national data from the Institute for Health Policy Solutions, 43% of workers making $7 or less per hour in 1996 were offered health insurance by their employers, but only 63% of those workers took this health insurance. Even when the workers did take the insurance, they did not always cover their dependents. In 1996, about 22% of uninsured children had a parent covered by an employer's plan, and an additional 15% had at least one parent offered coverage who did not take it.

According to DHHS, the HIPP program saved $2,196,284 from FY 96-97 through FY 99-00, based on a review of 160 closed cases.

The HIPP program was authorized by the Social Security Act in 1990. This provision allows DHHS to pay all premiums, deductibles, and coinsurance for Medicaid beneficiaries eligible for enrollment in employer-based group health plans when it is cost-effective. The primary objective of South Carolina's program is to continue a Medicaid recipient's private health insurance coverage by paying medical coverage premiums when the recipient cannot afford to pay, and to prevent premature cancellation of existing employer-based group medical insurance by a recipient.

In order to enroll a participant in the program, DHHS determines whether each case is cost-effective. Cost-effectiveness is established if the premiums, deductibles, coinsurance, and administrative costs are less than the expected Medicaid expenditures. Actual cost-savings are not established until after the HIPP case is closed. At this point DHHS staff can review the medical costs incurred. HIPP cases are "closed" when either the recipient dies, loses private insurance coverage, or becomes ineligible for Medicaid in general.

According to DHHS, the HIPP program saved $2,196,284 from FY 96-97 through FY 99-00, based on a review of 160 closed cases. During this time, DHHS also stopped paying the health insurance premiums for 19% of these closed cases because they failed to be cost-effective. [Even though disallowed for the HIPP program, these cases may have been eligible for regular Medicaid.]

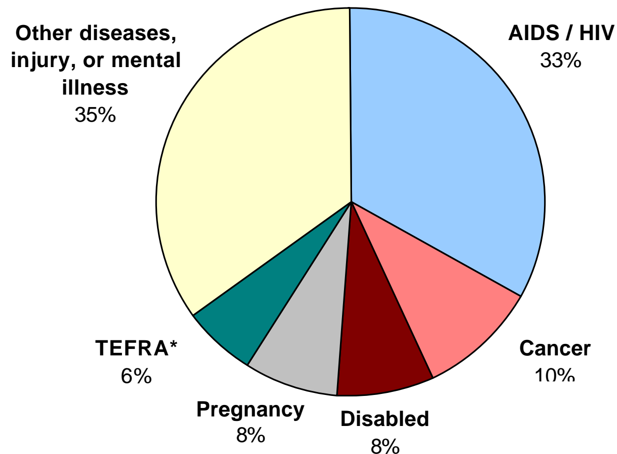
According to data from DHHS, the HIPP program has grown since its inception:

- The program began with 13 participants in 1993 and increased to 193 participants as of May 1, 2001.

- The average monthly premium payment per recipient has increased from $158.30 in 1996 to $243.55 in 2000.

According to DHHS staff, the potential for cost savings is greatest if the program can be targeted to individuals with specific high-cost diagnoses. For example, using the HIPP program for cases involving HIV/AIDS or premature infants can save more than $100,000 per case. The diagnoses for the 160 cases studied include the following.

Figure 2.3: Diagnosis for 160 Closed HIPP Cases



*Permanently and totally disabled children cared for at home instead of in an institution.

Source: DHHS Premium Payment Cost Effectiveness Analysis

Despite the potential for cost savings, DHHS has been limited in the number of participants it can enroll in the HIPP program. The program is very labor- and paper-intensive. The HIPP program staff must prepare purchasing requisitions for each premium. Individual checks are generated by the Comptroller General's office and sent to DHHS for forwarding. Checks are mailed each month to participants or insurance companies to reimburse them for the premium payments. Only 15% of the checks are mailed directly to the insurance company or the recipient's employer. The rest are mailed to individuals as reimbursement for premium payments, most (65%) to the parents of children who are covered by the policy.

Options for Expanding the HIPP Program

DHHS officials believe that the program can possibly serve 5,000 recipients, based on the current Medicaid population. The present structure of the program, however, limits its expansion and can only accommodate very few recipients. In order to expand the program, information technology system and organizational changes would be necessary.

To expand the program, DHHS would first have to improve the method used to identify more potential recipients. Historically, 29% of cases were referred from the Community Long-Term Care Division of DHHS while 33% came from DSS. When DSS determines eligibility for Medicaid, it is supposed to determine if the applicant has private health insurance. Other sources of referrals include providers or outreach groups.

Changes would also be needed to the Medicaid Management Information System (MMIS) to allow analysis to be done to identify potential participants in the HIPP program. For example, recipients who may be cost-effective for the program could be identified by diagnosis or demographic data. This data cannot be obtained in the format needed with the current MMIS system.

The biggest obstacle to expanding the program is processing the payments. Having the Comptroller General's office print the checks and forward them to DHHS for mailing is too time-consuming and labor-intensive for a large number of recipients. DHHS has conducted a feasibility study to determine the software needs and solutions. This study concluded that a database needs to be developed with the appropriate hardware and software. Updates also need to be made to the MMIS system. The payment process could also be automated with the CG's office. This solution is limited, however, in that it could only serve about 1,000 recipients. DHHS officials estimate that this solution would cost approximately $350,000 annually plus a one-time charge for computer system changes of $250,000, not including the cost of the insurance premiums and co-payments.

Another option would be to contract the operations of the HIPP program to a private vendor.

Another option would be to contract the operations of the HIPP program to a private vendor. DHHS staff would monitor the contract and be responsible for identifying Medicaid recipients eligible for the program. Other states contract the management of their HIPP program. DHHS would pay a transaction fee per participant. Using this method, the number of participants in the program could be much higher. DHHS officials estimate that this option would cost approximately $1.5 million annually (again, excluding the cost of premium payments.)

In a 1997 report, the U.S. General Accounting Office (GAO) reviewed three states — Texas, Pennsylvania, and Iowa — considered successful in pursuing a premium payment program. Using the estimated cost savings of successful HIPP programs in these states, the potential cost savings of expanding the S.C. HIPP program can be estimated. The following table illustrates the potential savings for possible options in expanding the program. Amounts shown are net of anticipated administrative and premium costs. Savings in state funds would be based on the current funding ratios for direct healthcare costs — about 30% state, 70% federal.

Table 2.4: HIPP Expansion Potential Savings

	NUMBER OF RECIPIENTS	COST SAVINGS PER RECIPIENT	POTENTIAL ANNUAL COST SAVINGS
In-house	1,000	$1,313.82	$1,313,820
Contract	5,000	$1,313.82	$6,569,100

Source: LAC analysis based on report titled *Medicaid: Three States' Experience in Buying Employer-Based Health Insurance*; U.S. General Accounting Office, July 1997. See Appendix B for more information.

The HIPP program could be expanded in-house first to include 1,000 recipients. The program could then be contracted to an outside vendor.

Recommendation

6. The Department of Health and Human Services should take steps necessary to expand the Health Insurance Premium Payment program. The department should expand in-house capacity first and then analyze savings. If an in-house expansion proves successful, the department should then assess the feasibility of using an outside contractor to further expand the program.

Controlling Cost to Determine Medicaid Eligibility

One of the largest administrative expenses incurred by DHHS is the cost of determining eligibility for Medicaid. The bulk of this cost is for a contract between DHHS and the Department of Social Services (DSS). DSS, through its network of county offices, determines eligibility for most applicants for Medicaid, as well as eligibility for other social programs such as welfare and food stamps.

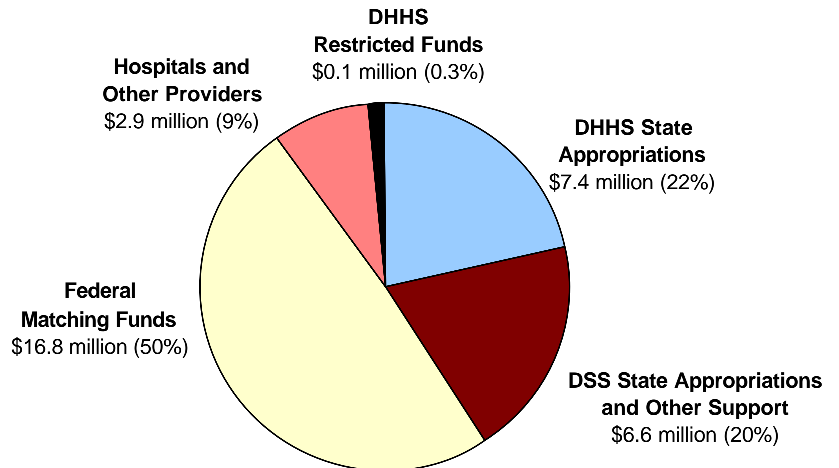
With the advent of welfare reform, Medicaid has become "delinked" from welfare, and Medicaid recipients are not necessarily welfare recipients. Medicaid eligibility is now determined based on categories such as an individual's age, sex, income, and disability or health status. With the separation of Medicaid from welfare, a new way for individuals to gain access to Medicaid may be needed. In view of this, and with the cost and other problems inherent in the contract with DSS, we recommend that the

two agencies work together to overhaul the contract and streamline the system for eligibility determination. During this audit, we found that DHHS staff were studying ways to improve the contract with DSS.

Contract With DSS

For FY 99-00, total cost for the Medicaid eligibility services contract with DSS was $33.8 million. Both DHHS and DSS provide funds from their general state appropriations. Healthcare providers such as hospitals and health clinics also "sponsor" Medicaid eligibility workers and fund half of their salaries and associated costs. About one-half of eligibility determination costs are covered by federal matching funds.

Figure 2.5: Source of Funds for DSS Contract – FY 99-00



Source: DHHS GAFR reports and Analysis of DSS Contract Expenditures. Total cost includes reconciliations processed at close-out of fiscal year.

The Medicaid eligibility workers are DSS employees. DSS sends monthly invoices to DHHS, and DHHS then transfers the federal, state, and other funds to DSS so it can pay salaries, benefits, and operating costs for these employees.

In addition to the DSS contract, DHHS's internal costs involved with eligibility determination were about $1.2 million in FY 99-00. DHHS staff develop and administer Medicaid eligibility policies and also handle eligibility determination for children applying for Medicaid under the

Children's Health Insurance Program. In FY 99-00, DHHS processed about 23,500 applications in-house for the children's insurance program.

DHHS has responsibility for administering Medicaid and paying for eligibility determination, but it has little control over the way these costs are billed under the DSS contract. While DSS has documentation for the expenses charged, the cost allocation system is complicated. For example, it is difficult to determine exactly how many DSS staff are supported by this contract. Moreover, the cost allocation system used by DSS provides no incentive for it to determine Medicaid eligibility in the most efficient and cost-effective manner possible. At the same time, DHHS staff have not actively monitored DSS's performance or results under the contract. We review these problems in the following pages.

Eligibility Workers and Costs

The Medicaid eligibility contract with DSS is expensive, largely because of the allocated workers and operational support that DHHS is paying for. More than 50% of the costs charged to Medicaid under the eligibility contract are for DSS's allocated and "indirect" or operational support costs. In FY 99-00, the direct costs (salaries, benefits and operating expenses) of the Medicaid eligibility workers accounted for only 48% of the contract. DSS has allocated other costs to Medicaid based on a federally-approved cost allocation plan. The cost allocation plan takes all the different funding streams that flow into DSS and allocates the money to different staff and programs. According to DSS budget staff, Medicaid-related duties are handled both by specialized workers (direct costs) and "joint" workers (allocated costs) who also perform duties related to other programs. For example, one DSS worker might be funded by money from the Medicaid, food stamps and TANF (Temporary Aid to Needy Families) programs if that worker performs activities related to all three. The cost allocation plan also pro-rates DSS indirect costs (such as payroll, information management, and state and county administration) to the various programs that fund the agency. A portion of these indirect costs are charged to Medicaid.

Although supported by DSS "time studies" approved by the federal government, the percentage of some of the indirect costs charged to Medicaid appears high. For example, about 16% of county clerical staff time was charged to the Medicaid contract, plus 14% of other county administrative staff (which includes the county director) and 13% of DSS's state office administration.

Cost Per DSS Worker

The costs of the contract with DSS are based on the number of employees directly or indirectly involved with Medicaid eligibility. However, the complexity of the DSS cost allocation system makes it difficult to determine exactly how many staff are involved and what percentage of their time is spent on Medicaid eligibility and related duties. In effect, DHHS does not know how many DSS workers it is paying for, and how many workers are truly needed to perform the job efficiently.

We reviewed contract costs and asked DSS to provide information on the number of eligibility staff for FY 99-00. The contract provides for three different types of DSS employees:

In effect, DHHS does not know how many DSS workers it is paying for . . .

- Medicaid eligibility workers who are mostly located in county offices, as well as supervisory staff for these employees.
- Non-emergency transportation workers who help coordinate transportation to doctors' appointments for Medicaid recipients.
- Sponsored or out-stationed Medicaid eligibility workers who work on-site at hospitals and health clinics.

The average cost per type of DSS eligibility worker varies because of the amount of indirect and allocated costs associated with each type of worker. Table 2.6 below shows the average cost per DSS worker covered by the Medicaid eligibility contract, and includes all operational support/indirect costs allocated to the contract. We based our analysis on documentation provided by DSS to show how DSS staff are counted and what costs are allocated to the various programs managed by the agency.

Table 2.6: Average Cost Per DSS Medicaid Eligibility Worker

Type of DSS Worker	Average	
	Number of Filled Positions	FY 99-00 Cost (50% Federal; 50% State or Other Funds)
Medicaid Eligibility[1]	314	$60,151
QMB-ABD Eligibility[2]	13	$44,323
Transportation Coordinator	63	$43,954
Out-Stationed Eligibility	199	$39,513

1 This number includes Medicaid eligibility staff based in DSS county offices as well as in the state office, plus the full-time equivalent for allocated workers who spend part of their time determining Medicaid eligibility.
2 Specialty workers who handle Medicaid eligibility for applicants who are qualified Medicare beneficiaries (QMB) or aged, blind and/or disabled (ABD).

Source: DHHS and DSS.

The county DSS office-based eligibility workers cost more than the out-stationed workers, even though these employees are performing basically the same duties. This is due to the following reasons:

- Medicaid eligibility staff who are located at county DSS offices account for indirect costs at both the county and state levels.
- This group also includes “allocated” workers. When the costs for allocated staff are calculated on a full-time equivalent basis, they are higher than those for “direct” workers.
- Out-stationed workers do not incur the same level of indirect costs, since support is provided by the healthcare facilities where these workers are stationed.

In fact, state-appropriated general funds are not used to support the salaries of out-stationed workers, since half of their funding comes from the healthcare providers, and half comes from the federal government. Even if state funds were used to pay for these workers, the cost to the state would still be less due to the amount of indirect costs these workers incur.

Inconsistent Workloads Between Counties

Wide ranges in workload and staff productivity in county DSS offices may be contributing to the cost of the contract. DSS may need to shift positions in order to ensure a more efficient use of staff. We reviewed computer-generated reports and DSS payrolls for March 2001 in order to get an idea of the number of Medicaid applications handled by Medicaid eligibility workers in the counties. One report showed the number of applications processed by each worker and the number of days before a determination of eligibility was made. We compared this report to the payrolls which showed the actual number of direct workers for March 2001.

This comparison showed that:

- There were a total of 469 county Medicaid eligibility staff on the DSS payroll for March 30, 2001. [This number includes out-stationed workers and excludes state office staff and “allocated” staff.]
- During this month, approximately 937 county staff processed Medicaid eligibility determinations. The difference between this number and the “payroll” staff are those allocated workers who spend only part of their time on Medicaid activities.
- 57% of the 937 county staff handled only 5 or fewer Medicaid applications that month.

[It should be noted that the DSS Medicaid eligibility workers have other duties in addition to processing applications. However, this is one of their most important functions.]

By having general county staff perform a minimum level of Medicaid activities, DSS can allocate some of the costs for these staff to the Medicaid program. This may not be an efficient use of staff time, however. The fact that many workers handle only a couple of Medicaid applications a month indicates that there may not be a pressing need for these allocated workers.

This is underscored by the great variation in workloads by county. Based on the number of direct Medicaid workers (those on the March 2001 payroll), the average number of applications per worker ranged from a low of 9.5 in Allendale County to a high of 57 in Greenwood County. Within the individual counties, some staff handled as many as 100 applications in the month. Re-arranging workloads, both between and within counties, could eliminate the need to use any allocated workers in the Medicaid program. In turn this could eliminate some of the allocated costs attached to the contract.

. . . there were funded contracts for a total of 199 eligibility workers to be stationed at healthcare facilities. We reviewed the DSS payroll for March 2001 and found only 186 sponsored workers.

Sponsored Workers Not On-Site

As previously noted, out-stationed Medicaid eligibility workers are DSS employees who are required to be on-site at hospitals, health clinics, and physicians' offices to take Medicaid applications from patients where they receive health care. Health Care Financing Administration regulations (CFR 435.904) require that all disproportionate share hospitals and federally-qualified health clinics have a Medicaid eligibility worker on-site. Based on contractual arrangements, these providers furnish half of the cost of the sponsored workers, and DSS receives federal matching funds for the other half. For FY 00-01, there were funded contracts for a total of 199 eligibility workers to be stationed at healthcare facilities. We reviewed the DSS payroll for March 2001 and found only 186 sponsored workers.

According to DHHS staff, the providers are supposed to furnish their half of the salaries up front in the beginning of the year. Therefore, some of the healthcare providers may not be receiving the benefit of the DSS staff that they were helping to fund. In addition, an audit of the sponsored workers program was performed by DHHS's internal audit division in 2001. They found that DSS either was not providing the necessary on-site workers or was using some of the workers to support operations at the county DSS offices.

The contracts for the sponsored workers are between DHHS and the healthcare providers. Yet, the workers themselves are DSS employees, and DHHS seems to have little control over how these workers are stationed and supervised. There is no stipulation in the contract with DSS that gives DHHS control over the utilization of the out-stationed eligibility staff.

Transportation Workers

The Medicaid eligibility contract also contains provisions for non-emergency transportation workers. These are DSS staff who arrange and coordinate transportation for doctors' appointments for Medicaid recipients and verify eligibility. [Medicaid transportation is not actually provided under this contract, just staff to arrange transportation for recipients.] There were approximately 63 staff, with a direct FY 99-00 cost of about $1.36 million.

If DHHS required that this coordination be handled by the transportation providers, there would be no need for the 63 DSS employees.

Each of the 46 county DSS offices has at least one transportation worker. However, in the smaller counties, where the number of Medicaid recipients is low, there may be no need to have an employee dedicate 100% of his or her time just arranging transportation for Medicaid clients. What percent of these workers' time is actually spent arranging transportation, and whether these workers are fulfilling other Medicaid or non-Medicaid duties, is unknown. However, the contract requires DSS to use these employees to deliver transportation coordination services to Medicaid clients, and there is no stipulation that would allow them to perform non-related duties.

In addition, combining the transportation coordination services with the eligibility contract makes an already complicated contract more difficult to administer. DHHS could contract for transportation coordination either through a separate arrangement with DSS or through existing contracts with transportation providers. If DHHS required that this coordination be handled by the transportation providers, there would be no need for the 63 DSS employees.

Contract Oversight Issues

Under federal law, DSS must provide certain kinds of Medicaid "quality control" functions. Quality control in this regard means testing eligibility records to determine whether the determination is made correctly, and then developing an "error rate" to assess the agency's compliance with rules and regulations. For the periods of October 1999 through June 2000, DSS has an error rate of 0%, which is within the federally-mandated error rate of 3%. DSS billings under the contract include about three DSS staff who perform quality control activities.

However, while there are no problems concerning the error rate, we found that general contract monitoring could be better defined. For example, there is a charge for “state office monitoring” in the contract. The current contract does not specify what state office monitoring should consist of, only that DHHS will forward to DSS an “administrative fee” for state office monitoring. The expenditures attributable to this function were about $470,120 for FY 99-00. However, we could find no concrete results of monitoring. Currently, performance measures for the individual counties, such as application processing times, are not officially compiled or published. State office staff do not go on-site to the counties to review eligibility staff performance and workloads. On average, DSS had 10 staff designated for “state office monitoring” in FY 99-00.

Monitoring Responsibilities Not Clear

It would not be appropriate for DSS to monitor its own performance under the contract. However, DHHS’s role in monitoring the results of this contract is not clear, and DHHS staff stated that currently they do not monitor contract results. Even if this were done, the contract has no penalty or fee for poor performance.

The contract requires DSS to furnish DHHS with certain reports generated by the client information system. We found that DHHS does not save all of the reports or use data for monitoring contract performance. Some of the reports are thrown out due to lack of space, according to DHHS staff. DSS does not have the capability to send this kind of information electronically to DHHS.

Also, both agencies have state office staff who handle eligibility-related duties, such as administration of policies and procedures, reporting, technical assistance to counties, and client services. There may be some duplication of functions between these staff.

Re-determinations Past Due

One report generated from the client information system shows the number of “re-determinations” due each month, as well as the number due but not completed in previous months. “Re-determinations” are annual reviews to renew a person’s eligibility for Medicaid. They should occur once every 12 months or when an individual’s financial circumstances change. This function is primarily handled by DSS county staff. Based on a DHHS report for April 2001, a total of 21,149 re-determinations were due. Of these, 64% were re-determinations past due from previous months. This may indicate that: (1) the clients were not responding to notices for eligibility renewal information; or (2) DSS has not been timely in performing this function.

Other Contract Outcomes

In the course of our review we identified two other areas where DSS may need to improve service delivery under the Medicaid eligibility contract.

- When an individual applies for Medicaid, DSS eligibility staff are supposed to determine if the applicant already has access to private health insurance. If the person qualifies, Medicaid may be able to pay for the premiums and allow the person to retain private health insurance. Historically, however, only one-third of participants in the arrangement were referred by DSS (see p. 20).

- The contract also requires DSS staff to provide eligibility and managed care verification to medical providers. During this review we found that DSS was not fully providing this service (see p. 14).

Monthly Medicaid Cards

DHHS issues paper Medicaid cards to recipients on a monthly basis, and as part of its eligibility contract DSS is required to print and issue the cards. While the cost for the monthly cards is not itemized in the billings from DSS, DHHS staff estimated that the annual cost is approximately $1.7 million.

DHHS is prepared to discontinue the monthly card and implement a plastic card system. The card will be permanent and allow for electronic eligibility verification. The cards will have a magnetic stripe so they can be “swiped” and automatically provide eligibility information. Issuing the Medicaid card will no longer be a part of the DSS contract. DHHS staff estimated that, once the plastic card system is implemented, annual savings could be $969,000.

Conclusion

More eligibility staff should be located where recipients go to get health care. DHHS should shift resources away from county DSS offices to provide more eligibility workers at hospitals, health clinics and other community locations. Some staff need to be maintained in county offices to handle those applicants who are also applying for food stamps and welfare. Now that Medicaid is delinked from welfare, an individual should not have to go to the county DSS office to become enrolled. Not only would this provide greater access to Medicaid and better service for recipients, but the cost in state dollars could be greatly reduced if healthcare providers supported eligibility staff.

The Health Care Financing Administration has cited several states as innovative in their use of out-stationed workers. Indiana, for example, has 517 Medicaid enrollment centers throughout the state which take applications mostly for pregnant women, infants, and children. In addition to hospitals and clinics, the enrollment centers are located at schools, child care facilities, community action agencies, and other community facilities. More than 15,000 individuals over a six-month period applied for Medicaid at the enrollment centers. Indiana also makes extensive use of mail-in applications.

The state of Indiana does not pay anything for this service. Staff at the enrollment centers were trained to handle intake for Medicaid applications. They can accept applications and income documentation. The information is then forwarded to a central state office which makes the actual decision on eligibility. [Under federal law, only state employees are authorized to make eligibility decisions.]

Using facilities in the community as Medicaid enrollment centers, and then forwarding the applications to a central state office for processing, could result in significant savings. DHHS could then also move toward reimbursing DSS with a per case rate as opposed to basing the contract on staff costs.

Based on FY 99-00 costs and workers, potential savings that could be achieved by revising the DSS contract include the following.

Table 2.7: Savings from DSS Contract Revision

Out-station 2/3 of the eligibility workers at community locations	$2,986,610
Eliminate transportation coordination workers	1,363,470
Eliminate administrative fee for state office monitoring	470,120
TOTAL	**$4,820,200***

* Approximately $2.2 million or 46% of the total would be state funds. This total also does not include an annual savings of $969,000 that DHHS estimates will come from using the plastic Medicaid cards.

Recommendations

7. The Department of Health and Human Services, with input from the Department of Social Services, should review the Medicaid-eligible population in each county and determine the appropriate number of eligibility staff needed in each county, and whether these staff should be located in the county DSS office or out-stationed at medical providers.

8. The Department of Health and Human Services should not allow the Department of Social Services to bill for "allocated" eligibility staff until it determines the extent to which these staff are needed.

9. The Department of Health and Human Services should initiate more contracts with healthcare providers to locate eligibility workers on-site. DHHS should also begin the process of coordinating with and training other community facilities to take Medicaid applications.

10. The Department of Health and Human Services should not transfer funds to the Department of Social Services for State Office Monitoring until DHHS determines what kinds of monitoring is needed and who should perform it. DHHS should ensure that DSS adequately performs all services required of it under the contract.

11. Both agencies together should review state office-level staff to ensure that no duplication of functions exist.

12. The Department of Health and Human Services should not include funding for the transportation coordination workers in the eligibility contract. Where possible, DHHS should seek to have these transportation coordination services provided by the transportation providers. Otherwise, DHHS in consultation with DSS should determine the number of transportation coordinators needed in DSS county offices.

Appendices

Survey Results From Other States

Medicaid Managed Care Programs

PCCM — Primary Care Case Management
HMO — Health Maintenance Organization
PMPM — Per Member Per Month

State	What Types of Programs are Provided? (Year Implemented)	What Percent of Recipients are Enrolled?	Is Enrollment Mandatory or Voluntary?	Have These Programs Lowered Costs?	Has Access to Health Care Improved?	Are Managed Care Programs Being Expanded?
Alabama	PCCM (1997)	60%	mandatory	$5 PMPM	yes	no
	HMO (1997, ended 1999)		(no data)	4% overall		
Georgia	PCCM (late 1990s)	63%	mandatory	yes	yes	yes, also increase financial incentives for providers
	HMO (1996, ended 1999)		voluntary			
Louisiana	PCCM (1992)	8.6%	mandatory	yes but not sure of dollar amount	yes	yes, PCCM statewide; also HMO again
Mississippi	PCCM (1993)	85%	mandatory	yes but may not continue	yes	no
	HMO (1996, ended 1999)		voluntary			
North Carolina	PCCM (1991)	70%	mandatory for some	$8 PMPM	yes	hoping to if budget cuts allow
	HMO (1996 and 1998) [2 programs]	1%–4%	both; voluntary HMO ended 2001	$2.5 million overall		
Tennessee	HMO (1994)	100%	mandatory	yes	yes	not applicable; already at the limit
Virginia	PCCM (1992)	46%	mandatory (with lock-in)	yes	yes	PCCM has reached limit; hope to expand HMO
	HMO (1996)	53%				
Washington	PCCM (1970s)	52%	mandatory for some	yes	yes	yes, especially into rural areas
	HMO (1986 and 1992)		voluntary			
West Virginia	PCCM (1992)	31%	mandatory	$6 million	yes	would like to expand HMO
	HMO (1996)	16%		$3 million		

Detailed Methodology

Medicaid HMO's Estimate of Savings

The HMO used medical claims information for FY 97-98 taken from the State Data Book, which shows fee-for-service per-member per-month rate history for three years, broken out by age groups and categories of care. The HMO then calculated a trend factor for FY 95-96 – FY 97-98 (6% for medical services and 14% for pharmacy) and projected them forward 2.25 years. A factor was also included for Medicaid program changes (hospital inpatient, outpatient and emergency room fee increases) that took place during the period 10/01/99 – 9/30/00 as referenced in the State Data Book. To estimate the cost of providing services under traditional Medicaid, the HMO then multiplied the cost from the State Data Book for FY 97-98 times the factors for trends and Medicaid program changes described above. A 2% administrative expense was added before comparing the total to the amounts paid to the HMO during the period beginning 10/01/99. The estimated savings to the state during the period 10/01/99 through 9/30/00, as a result of Medicaid recipients enrolling in the HMO, was $1.5 million — nearly 11% of comparable fee-for-service Medicaid expenditures by DHHS during this time.

LAC Methodologies for Estimated Cost Savings

We used several sources of information in trying to estimate the Medicaid savings potential of the three issues we reviewed.

Managed Care

At least two noted sources, which conducted research into Medicaid managed care in other states, found that states used a 5% to 15% reduction in cost when setting managed care rates. We determined the number of Medicaid-eligible low-income families and children for three urban counties — Richland, Greenville, and Charleston — which currently are being served by the Medicaid HMO as well as Physician Enhanced Program (PEP) providers. The number of Medicaid-eligible individuals meeting these criteria in those counties as of January 2001 were 85,949; the number meeting these criteria in 19 counties where the HMO and PEP are available was 221,525. Currently 86% of the HMO's members are children age 18 or under. FY 99-00 cost data from DHHS shows that the average fee-for-service cost per recipient under age 19 was $1,090. This includes hospital, physician services, pharmacy, and other health care. We excluded those costs that normally would not be provided through the Medicaid HMO, such as long-term care, dental, and family planning. We also did not include any of the costs associated with the special populations served by other state agencies. The estimation of the state funds that would be saved was based on the

current federal-state ratio for direct Medicaid healthcare expenditures. For FFY 99-00 this ratio was 30.1% state and 69.9% federal. It should be noted that, if managed care became mandatory, the mix of recipients would be different from those currently served by the HMO. This could affect any potential cost savings if, for example, the HMO began serving clients with greater health problems.

The Health Insurance Premium Payment Program

In its review of 160 cases, DHHS estimated that savings achieved through this program from FY 96-97 through FY 99-00 were $2,196,284, or on average $13,727 per case. This amount, however, is influenced by some extreme cases where more than $100,000 in Medicaid costs were avoided. We opted to use a cost savings estimate provided by a 1997 GAO report: Medicaid: Three States' Experience in Buying Employer-Based Health Insurance. The GAO collected the following information from three states.

State	Number of Participants	Estimated Budgetary Savings
Iowa	2,504	$2.4 million
Pennsylvania	4,700	$9.7 million
Texas	5,507	$4.6 million

We calculated an average savings based on the total number of participants and budgetary savings for the three states. DHHS staff believe the premium payment program could be expanded to include 5,000 Medicaid recipients. As of January 2001, there were about 80,000 Medicaid recipients in the eligibility categories targeted by the premium payment program. These categories primarily include aged, blind, and disabled individuals, as well as severely disabled children and pregnant women. We did not determine what percent of these recipients would have access to employer-based health insurance.

Eligibility Contract With DSS

We calculated the total cost that could be attributed to each type of DSS employee provided under the Medicaid eligibility contract. The source of this information was DSS's quarterly cost reports for FY 99-00, which are submitted to DHHS to document the billings. The total cost was based on the direct cost (salaries, benefits, and operating costs) as well as the indirect costs (DSS's operational support) that could be attributed to each employee. DSS uses payroll data to document the direct costs, and uses a federally-approved cost allocation plan to allocate agency-wide support and administrative costs to the Medicaid program. We estimated the average direct and indirect cost for each type of DSS employee who is being provided under the eligibility contract. Currently, the majority of the eligibility employees are based in county DSS offices. These staff also are the most expensive ($60,151 per person), when compared to the other staff provided under the contract.

HCFA regulations require the use of out-stationed eligibility workers at certain hospitals and health clinics. HCFA policy encourages expanding the use of eligibility staff to other community facilities. These "out-stationed" staff, as billed for under the contract, are the least expensive to the Medicaid program. Not only are direct salary costs less, but the indirect costs associated with these staff are less.

Currently, the state share of the cost for these out-stationed workers is being funded by the healthcare providers, not state general funds. We recommended that DHHS require that at least two-thirds of the current eligibility staff be out-stationed in the community, and only one-third be located in the county DSS offices, for an estimated savings of about $3 million. However, this savings estimate assumes that state funds would pay the match share for the workers who are shifted to the off-site locations. The reduction in cost comes from an average lower cost per worker, not by having healthcare providers pay for more workers. The savings could be even greater if the healthcare providers agreed to pay the state's share of the match for more eligibility staff.

Both DSS and DHHS fund this contract from their state general fund appropriations. These funds are matched by federal funds on a 1-to-1 basis. Any savings in state dollars could be used by either agency to generate federal matching funds at a higher rate if used for direct healthcare services.

Agency Comments

State of South Carolina

Department of Health and Human Services

Jim Hodges
Governor

William A. Prince
Director

October 16, 2001

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

Dear Mr. Schroeder:

Thank you for the opportunity to review and respond to your recent report, *Cost Savings Strategies for the South Carolina Medicaid Program.* We have found it helpful in evaluating our operations in the areas reviewed. However, we are very concerned with the cost savings conclusions between Medicaid fee-for-service and managed care. Our cursory analysis of the comparison figures indicates that the analysis, which was based on a comparison of the gross costs of the two programs, is significantly flawed due to oversimplification. Our comments are included in a separate enclosure 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

William A. Prince
Director

WAP/msb

Enclosure

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

Response to Legislative Audit Council Report
Cost Saving Strategies for the South Carolina Medicaid Program

General Comments:

The Department of Health and Human Services appreciates the opportunity to comment on the Legislative Audit Council's report, Cost Savings Strategies for the South Carolina Medicaid Program. We concur with most of the recommendations in the report and have already begun to implement changes in response. However, we are very concerned with the cost savings conclusions between Medicaid fee-for-service and managed care. Our cursory analysis of the comparison figures indicates that the analysis, which was based on a comparison of the gross costs of the two programs, is significantly flawed due to oversimplification. The comparison did not control for the wide discrepancy in the average number of member months of enrollment for the fee-for-service program (FY 98 -10 months) and HMO program (FY 98 - 6 months) or for the disproportionate representation of lower cost rate groupings in the HMO program than in the fee-for-service program. Additionally, adjustments made throughout the year in both programs were not captured in the comparison figures used. All of these factors resulted in a gross overstatement of the cost of fee-for-service program compared to the HMO program.

Because of the negative experiences of many other states which rushed into Medicaid managed care, South Carolina proceeded with caution. We implemented both the HMO program and the Physicians Enhanced Program (PEP) in 1996 and have carefully monitored the progress of both programs since that time. It took almost four years of operation to grow these programs to adequate membership size to make adequate comparisons between managed care and fee-for-service. We contracted with Carolina Medical Review last year to conduct an independent comparative analysis of costs and utilization between fee-for-service and the HMO and PEP programs. This study, which will control for variations in age, sex, disability, and member months of enrollment, is very near completion. Until the analysis is complete, we urge caution in rushing to conclusions about the cost savings potential of managed care and mandating managed care enrollment. A July 31, 2001 report funded by the Centers for Medicaid and Medicare and recently released by Mathematica, involved a six-year evaluation of five long-term state HMO managed care programs. The report found that the rates of cost increase for the State Medicaid programs reviewed was within 0.5 percentage points of the national average. The report concluded, "States should not expect managed care to generate sizeable reductions in real Medicaid costs, especially during the first few years of operation."

Response to Recommendations

Recommendation # 1: The Department of Health and Human Services should expedite the independent, third-party study assessing the cost effectiveness of its current managed care programs and their impact on access to healthcare. DHHS should report the results of this study to the appropriate committees of the General Assembly.

- *DHHS Response: The independent, third-party study was initially delayed due to problems encountered by the state's single Medicaid HMO in providing timely and accurate encounter data which meets appropriate confidence levels for sound analysis. Calendar year 1999 data was recently made available and the study is proceeding with an analysis based on that year. The results of the study are anticipated within the next few weeks. We will continue to work with the HMO to obtain accurate encounter data for subsequent years for further analysis.*

Recommendation # 2: The Department of Health and Human Services should proceed with a controlled pilot project for a mandatory managed care delivery system for specified Medicaid groups (such as children and low-income families) in one or more urban areas of the state. Based on the results of the study and the pilot project, the department should then determine the feasibility of expanding managed care to include all the clients in specified eligibility groups in the counties where a choice of managed care plans is available.

- *DHHS Response: DHHS is fully committed to appropriately managing care for the citizens of our state served by Medicaid so that their quality of life is improved and costs are reduced. However, this recommendation appears premised on the cost savings comparisons and projections on page 11 of the report which are seriously flawed:*

  - *The analysis is based on a comparison of gross costs which does not take into account adjustments made throughout the year. Consequently, the fee-for-service costs are overstated while the HMO costs are understated. For example, the fee-for-service costs do not reflect negative adjustments for graduate medical education, drug rebates, and retroactive recoveries for third party liability which are not incorporated into HMO rates. The HMO costs do not reflect positive retroactive HMO rate adjustments. Additionally, the fee-for-service figure includes expenditures for the Physician Enhance Program which is also a managed care program. Finally, the fee-for-service costs are based on enrollees who actually receive a service while the HMO costs are based on all enrollees, regardless of service utilization. A comparison of cost per member month would be a more equitable way to compare cost. Without comparing utilization as well as costs, it is not possible to assess whether access to service was at an acceptable level at the same time that costs were being contained. A May, 1997 report by the General Accounting Office found*
    that managed care can "create an incentive to under serve or even deny beneficiaries access to needed care since plans and, in some cases, providers can profit from not delivering services.

- *The fee-for-service vs. HMO cost comparison in Table 2.2 does not control for variations in costs associated with age, sex, disability or member months of enrollment between the HMO program and the Medicaid fee-for-service program. Lower average cost per person in the HMO group are likely in large part due to the result of fewer average member months of enrollment than in the fee-for-service group and/or by a higher disproportionate representation of lower cost age, sex, or disability groupings. For example, the SSI rate group is one of the highest cost rate groupings with a rate in excess of 10 times that of the lowest rate group. In FY 98, SSI enrollees accounted for only 11% of HMO member months while over 18% of fee-for-service member months were for this rate grouping. During the same fiscal year, the average months of enrollment for HMO recipients were six, while the average months of enrollment under fee-for-service were ten. These two factors alone would greatly skew the cost comparisons. As noted in the report, DHHS has a comparison study underway which will control for these factors. After this analysis is complete, if cost savings without a negative impact on access are apparent in one or more of the managed care models used in the SC Medicaid program, DHHS will design appropriate measures to expand the availability of these models. DHHS does not believe that the savings are guaranteed and that careful analysis must be made before any mandatory expansion is determined.*

- *LAC staff indicated that the calculation of the projected cost savings of $7,000,000 was based on an assumed savings of 10% for enrollees from the fee-for-service cost. The estimated 10% cost savings projected by the LAC appears to be based on discounting the HMO rate by a flat percentage as was the practice of many states in the early days of Medicaid managed care. While it is true that early Medicaid HMO programs in some states determined the HMO rate by discounting the fee-for-service cost by a flat percent (for example Florida developed their rates by using a 5% discount), that method was not accepted by the Health Care Financing Administration (HCFA) for South Carolina. The federal requirement at the time SC implemented its managed care program was that the rates be determined to be actuarially sound. The finding of the actuaries was that the SC fee-for-service rates were so low that no discount could be used.*

- *We believe that the current HMO program serves as a pilot of the cost savings potential for managed care which will be assessed in the forthcoming report. We do not believe that the state should proceed with another pilot demonstration, in light of the current budget situation, until the current analysis is complete and cost savings are determined.*

Recommendation #3: The Department of Health and Human Services should obtain any necessary federal approval prior to implementing the pilot project for mandatory managed care and amend the State Medicaid Plan when necessary.

DHHS Response: DHHS concurs and will obtain federal approval as required before proceeding with any major changes which require federal approval.

Recommendation #4: The Department of Health and Human Services should implement an enrollment period of one year for Medicaid beneficiaries currently in managed care programs. Medicaid beneficiaries must still be allowed to disenroll within the first 90 days and/or for justifiable causes.

- DHHS Response: The DHHS experience without lock-in for the participating Health Maintenance Organization indicates that only 38% of disenrollments are voluntary. Because the current program permits voluntary disenrollments, many of those now classified as voluntary would probably be reclassified as "for cause" if voluntary disenrollment after the first ninety days were not allowed. The largest two categories called voluntary disenrollment are "doctor of choice not in network" and "dissatisfaction with the plan." These appear to be "for cause." These reasons raise concern that the HMO may not have fully explained to the potential enrollee the physicians available through the HMO and the rules of participation before enrollment. It is possible that many of the voluntary disenrollees would disenroll "for cause" if voluntary disenrollment were not an option. DHHS will discuss disenrollments with the HMO to determine how many would have been "for cause" and to determine whether there is a problem in the manner in which the HMO enrolls Medicaid eligibles. Disenrollment has not been identified as a problem by other managed care providers in the SC Medicaid program such as PEPs, Medically Fragile program and others.

Recommendation # 5: The Department of Health and Human Services should ensure that the capitation rate for the HMO program is competitive with the fee-for-service Medicaid rates.

- DHHS Response: The methodology used to develop the HMO rates used **all** comparable fee-for-service costs without discounting the fee-for-service rates by any percent. Because the HMO rates are developed in this way, HMOs have every opportunity to compete with fee-for-service providers. Further, because enrollment is voluntary, HMO's can benefit from adverse selection. For example, parents with children who have complex health needs and require expensive care are usually reluctant to enroll in HMO's because they do not want to lose access to the many specialists involved in their child's care.

Recommendation # 6: The Department of Health and Human Services should take steps necessary to expand the Health Insurance Premium Payment program. The department should expand in-house capacity first and then analyze savings. If an in-house expansion proves successful, the department should then assess the feasibility of using an outside contractor to further expand the program.

- DHHS Response: The Department is in the process of developing a five year business plan to significantly expand the Health Insurance Premium Payment program. The goal of this plan will be to maximize the Premium Payment program to its fullest cost savings potential. We anticipate completion and initial implementation of the plan within ninety days.

Recommendation # 7: The Department of Health and Human Services, with input from the Department of Social Services, should review the Medicaid-eligible population in each county and determine the appropriate number of eligibility staff needed in each county, and whether these staff should be located in the county DSS office or out-stationed at medical providers.

- DHHS Response: DHHS is initiating a study to determine appropriate distribution of eligibility workers based on numbers and types of cases by counties. DHHS will assign the maximum number of workers possible to locations where potentially eligible citizens can conveniently apply for Medicaid including medical providers. DHHS will also make applications available at other convenient sites such as senior citizens' centers and schools.

Recommendation # 8: The Department of Health and Human Services should not allow the Depart of Social Services to bill for "allocated" eligibility staff until it determines the extent to which these staff are needed.

- DHHS Response: Allocated staff effort currently billed by DSS needs to be incorporated into the overall plan for distribution of staff by county based on case loads and the distribution of county staff by appropriate local sites for application. DHHS is initiating work on the distribution of cases and caseworkers. Once this plan is developed and implemented, only designated slots, whether full or part time, will be authorized for Medicaid billing.

Recommendation # 9: The Department of Health and Human Services should initiate more contracts with health care providers to locate eligibility workers on-site. DHHS should also begin the process of coordinating with and training other community facilities to take Medicaid applications.

- During the contract period October 2001-June 2002, DHHS will develop a plan for distribution of applications and necessary training for placement of applications with as many providers and advocacy groups as feasible, to include Councils on Aging, DDSN Boards, Health Departments, Mental Health Agencies and Schools. DHHS also will design as many applications as possible for mail-in processing. DHHS will develop a plan for out stationing as many eligibility workers as possible where potential clients are located. DHHS will also actively pursue new contracts with providers for support of outstationed workers.

Recommendation # 10: The Department of Health and Human Services should not transfer funds to the Department of Social Services for State Office Monitoring until DHHS determines what kinds of monitoring is needed and who should perform it. DHHS should ensure that DSS adequately performs all services required of it under the contract.

- DHHS Response: DHHS is currently conducting a review to revise the relationship between DSS and DHHS regarding Medicaid eligibility. This review includes monitoring activities. We are developing a plan for appropriate monitoring activities by each agency. We are requesting documentation from DSS regarding their monitoring activities and will suspend any funding identified as related to monitoring if appropriate documentation is not received.

Recommendation # 11: Both agencies together should review state office-level staff to ensure that no duplication of functions exists.

- DHHS Response: DHHS is initiating a thorough reassessment of both agencies and will take appropriate action in this fiscal year. This should both eliminate duplication and also ensure that appropriate management functions will be carried out.

Recommendation # 12: The Department of Health and Human Services should not include funding for the transportation coordination workers in the eligibility contract. Where possible, DHHS should seek to have these transportation coordination services provided by the transportation providers. Otherwise, DHHS in consultation with DSS should determine the number of transportation coordinators needed in DSS offices.

- DHHS Response: DHHS agrees with the recommendation to remove the transportation workers from the eligibility contract. These workers, historically, were responsible for EPSDT services as well as transportation. When DHHS no longer needed the EPSDT subsystem these workers were left with transportation duties only. DHHS is currently exploring options within the transportation program. One option will include arrangement of transportation as a responsibility of the transportation provider. The Kershaw county transportation provider is currently arranging all transportation in their area and has had much success doing so.

SOUTH CAROLINA DEPARTMENT OF SOCIAL SERVICES

Elizabeth G. Patterson, J.D., State Director, P.O. Box 1520, Columbia, S.C. 29202-1520

October 17, 2001

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

Dear Mr. Schroeder:

Enclosed is the Agency's final comments to the report prepared by your staff, "Cost Savings Strategies for the South Carolina Medicaid Program."

If you have any questions, please contact Michael B. Givens at 898-7325.

Sincerely,

Elizabeth G. Patterson
State Director

EGP:pws

Enclosure

DSS Response to the Legislative Audit Council's Draft Report on Cost Savings Strategies for the South Carolina Medicaid Program

Controlling Cost to Determine Medicaid Eligibility (pages 21-22)

The two agencies are currently working together to overhaul the Medicaid contract and streamline the eligibility determination system. A joint agency Eligibility Workgroup was reactivated several months ago to address streamlining the eligibility determination process. Additionally, DSS received a grant from the Robert Wood Johnson Foundation in December 2000 to examine access, enrollment and retention barriers to Medicaid, the State's Children's Health Insurance program and the Food Stamp program. DSS is collaborating with the Budget and Control Board's Office of Research and Statistics, SC Covering Kids, DHHS and the National Supporting Families After Welfare Reform Office to identify eligibility problem areas and streamline the determination process. DSS will apply for a follow-up Implementation grant from the Robert Wood Johnson Foundation for up to $250,000 to put in place and/or evaluate eligibility intervention strategies to overcome access, enrollment and retention barriers applicants and clients encounter during the eligibility process for Medicaid, the State's Children's Health Insurance program and the Food Stamp program.

The delinking of Medicaid from cash assistance has received a great deal of attention during the past five plus years or so. Delinking is a requirement necessitated by the passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. The act replaced the old AFDC program with the Temporary Assistance for Needy Families (TANF) and required states to establish a separate coverage category (the §1931 group) that would provide Medicaid for Low Income Families (LIF), the old AFDC populace. While eligibility for AFDC under the old rules automatically conferred Medicaid eligibility, TANF does not. The new mandatory category requires states to, at minimum, provide Medicaid to anyone who would have qualified under the state's AFDC state plan as of the creation of TANF. The legislation separated the eligibility determination for the Medicaid and the TANF money payment. In fact, eligibility (or ineligibility) for TANF should have no effect on eligibility for Medicaid with one exception. The exception provides that a state may elect, as a part of its Medicaid state plan, to "sanction" adult Medicaid recipients who do not meet the work requirements imposed by the TANF state plan. South Carolina chose this option. South Carolina also chose to maintain similar categorical and income criteria for the TANF cash assistance grant and for the LIF Medicaid benefit.

The new AFDC/TANF-Medicaid population, the Low Income Families population, represents a very small part of the total Medicaid client population. This population, affected by delinking in April 2001, was only 17% (13.7% if we exclude the Family Planning population) of the total Medicaid population. The fact is that the majority of the recipients eligible for Medicaid have not been "AFDC/TANF" recipients since the mid 80's. Historically, the entire Medicaid population has always been subject to some level of income test.

The categorical requirements relative to age, sex, income, and disability have always been part of Medicaid eligibility requirements. Medicaid has since its inception imposed "categorical and income " requirements on its participants. The program is an income based program providing coverage to a categorically eligible population.

Also, there appears to be a great deal of concern about differences in the processes used within a county office and that of an outstationed worker. There is no difference in the processes used by the in-house staff and the outstationed staff in situations where they perform the same tasks. The fact is that they seldom have the same function. Outstationed staff generally serve simply an intake function - taking applications. County staff

serve both an intake and case maintenance function - redeterminations, reviews, updating changes in income, household, addresses, etc. Outstationed staff generally service a restricted population and/or restricted categories - generally the less complex categories. That seems to have missed the attention of the audit staff.

Contract With DSS (pages 22 - 23)

The Department submits the clarification that DSS expenditures billed for SFY 1999-2000 totaled $32.1 million with DSS state and other support at $5.6 million.

Under provisions of the contract, DHHS is to pay for Medicaid eligibility determination and transportation services expenditures. Billings are made to DHHS based on actual expenditures chargeable to these Medicaid administration activities. Actual expenditures are determined quarterly for federal reporting purposes and submitted to DHHS for that purpose so that the quarterly state claim to the federal Health Care Financing Administration relating to the DHHS/DSS contract would have full documentation. The format used to report costs is based on federal requirements and is similar to the format the Department uses in billing federal grantors. The format has been revised to include costs breakdowns that can be used to analyze costs. The reports are prepared in accordance with the language of Appendix A, Section C.3. of the contract. Billing/reporting is not a question of control - it is a question of understanding the documentation of the billings.

The incentive to determine Medicaid eligibility in the most efficient and cost effective manner possible is not a cost allocation system issue. This matter is a program design issue complicated by Medicaid rules and regulations and increasing categories of eligibility added to the caseload. The Public Assistance Cost Allocation Plan (CAP) that provides the framework for the Department's cost allocation system is a federal requirement for agencies such as the Department of Social Services and the Department of Health and Human Services. The primary purpose of the CAP is to document the process by which the Department determines costs for federal/interagency reports for the purpose of qualifying for and receiving federal funds. The intent of the cost accounting system is to document costs that are chargeable to the various federal programs administered by this agency or under contract from other state agencies. It is inaccurate to portray the CAP as having an effect on decisions that relate to efficient, cost effective eligibility determinations. Use of the CAP is cost effective for the state and federal governments because it allows for flexibility in the assignment of workers to staff programs/activities and reduces the time accounting for staff performing multi-program activities. The Department's CAP is complex because of the seven major programs and twenty-nine additional grants that the Department administers directly. Added to this are eight major contracts with DHHS. In accordance with OMB Circular A-87, the Cost Allocation Plan is required to allocate costs consistently to all benefiting programs. This plan is reviewed and approved by the federal Division of Cost Allocation, Health Care Financing Administration, Administration for Children and Families, and the Food and Nutrition Service, U.S. Department of Agriculture. The Department has strived to streamline the plan in recent years and will keep up that initiative even though certain of the federal agencies would like more cost allocation bases.

Eligibility Workers and Costs (page 23)

As explained to LAC audit staff, there are direct costs and allocated costs charged to Medicaid administration for Medicaid eligibility determination. The real question is not what percentage are direct costs but what are the direct and allocated costs of the eligibility workers and the operational support costs needed for them to do their job and maintain an eligibility error rate under the federal tolerance level.

The allocated costs contain costs that are directly allocable to this activity and those costs that are general administration. There are substantial costs related to "directly allocated" workers who are time studied and

whose Medicaid eligibility "time" is charged to this Medicaid contract. Additionally, there are operational support costs directly associated with the direct and "time studied" workers which should be counted as directly related to Medicaid eligibility. Without these support costs, the county workers would have no facilities and clerical support staff to support their direct activities. All the costs on the quarterly report schedules sent to DHHS can be broken down into direct eligibility related or administrative support. Administrative support can be further broken down into direct and general administration. Without direct administration, the Medicaid eligibility determination would not be fully supported. However, general administration functions such as personnel, finance, General Counsel, play a lesser but still important role in support staff in the state and county offices and health care facilities. During SFY 1999-2000 general administration comprised $4.4 million of $32.1 million in contract costs. The remainder of the costs ($27.7 million) were direct administration or eligibility worker costs.

Finally, the percentages in the second paragraph are supported by the Department's cost accounting system and federally approved Public Assistance Cost Allocation Plan. The cost allocation bases of the county clerical staff time is a time study of these workers. The cost allocation bases for state office and county office administration are based on a prorata share of direct workers by program. This process is based on actual payroll documentation. Under provisions of OMB Circular A-87, the Medicaid program gets its fair share of allocated costs attributable to Medicaid eligibility. The same bases are used to allocate costs to the other federal programs that the Department has financial responsibility for. These allocation percentages are reviewed annually by the State Auditor during the single audit engagement in addition to ongoing review by federal offices. The allocation percentages are neither high nor low; they are representative of the overall Medicaid effort sustained by the Department.

Cost Per DSS Worker (page 24 - 25)

Payroll information regarding direct workers and allocated workers in the Medicaid Joint cost centers are furnished to DHHS for each payroll in accordance with their instructions. DHHS should know by number and name who are the Medicaid eligibility determination workers in each county and facility. The only information regarding the workers assigned as Medicaid eligibility workers that is not sent is a payroll listing of the Family Independence Joint cost centers whose time study shows 5% - 7% of Medicaid time. It would be confusing to send payroll information on these time-studied workers.

The analysis of the average cost per DSS Medicaid eligibility worker does not take into account the varying functions and responsibilities of county office staff. Costs for county office Medicaid eligibility workers should not include costs of county clerical workers. The intake, assessment, and clerical support functions provided by these staff are integral to the eligibility determination process and are not an add-on cost. In the county offices, county clerical support serve in the intake function at a salary rate of approximately $20,000, well below the mean salary for regular Medicaid eligibility workers. This is by design. The screening and clerical function provided by these staff enable county office Medicaid workers to concentrate on the more difficult aspects of initial and ongoing eligibility activities especially nursing home cases.

Additionally factored into the analysis should be recognition of the different job classifications supported by the various categories of eligibility workers. Based upon payroll reports, it is clear that the apparent disparity in per workers cost is due not to allocated costs entirely but to the fact that supervisory responsibility for the Medicaid eligibility program resides at the county offices. Additional added on responsibilities are those for the PHC program referenced on the bottom of page 22. DHHS determines eligibility for approximately 36% of PHC applications. Once eligibility is determined by DHHS, the cases are transferred to the county DSS offices for maintenance and redeterminations. Moreover, county offices also furnish space for workers and storage of all the Medicaid files. In FY 1999-2000, over $900,000 was charged for space related costs in the counties.

Taking these three items into consideration, the average cost per county office Medicaid eligibility worker should be decreased to approximately $47,000 in order to compare to costs of the sponsored workers. A general comment about this cost comparison is that the audit does not look into the relative cost effectiveness of the different class workers. Taking into account relative cost effectiveness, the cost disparity might be even less.

Additionally, even though the operational support costs are currently provided by the health care facilities, such costs are chargeable to the Medicaid program. They are currently not being charged by the health care facilities. It is not known at the time whether a change in funding for these workers would mean a change in the amount of operational support costs that health care facilities would charge if the matching funds were state funds. There is no reason to assume that if state funds were used to support outstationed workers, the provider would not charge operational support to the Medicaid program. If the health care providers decide to charge for operational support costs and other indirect costs, the apparent cost disparity between county office and sponsored Medicaid workers might disappear entirely.

Inconsistent Workloads Between Counties (pages 25 - 26)

Workloads may well appear to be inconsistent if you look only at a staff to applications ratio. Other factors affecting workloads include staffing levels and patterns; the effect of case mix (nursing home and institutional cases, aged, blind and disabled cases take longer to process because of assets tests/verifications where as pregnant women or child related cases are determined quicker because they lack an assets/verification requirement); county economic conditions; and customer churning - the same person periodically applying over and over because of fluctuations in their economic condition. Initial eligibility determinations do not make up the bulk of the average caseworker's workload. Staffing studies over the years have determined that continued maintenance of the ongoing population consumes more effort than the initial eligibility determination.

Sponsored Workers Not On-site (pages 26 – 27)

The Sponsored Medicaid Worker Program Handbook is given to all Sponsored Medicaid Worker program sponsors during contract negotiations and at the sponsors' annual provider meeting (the annual meetings were suspended in 2000 and 2001 due to the uncertainty of contract negotiations and changes being discussed by DHHS). DHHS participates in these meetings. Sponsors are made aware of the benefits and the county DSS office support they receive by having workers outstationed and at the county DSS. However, all sponsor funded staff are not in outstationed locations for good reasons. Some are stationed in county offices to complete the eligibility determination process, maintain case records, perform case reviews and to do annual redeterminations of eligibility. Once a case is initiated, it must be maintained, normally at the county office site. The majority of outstationed workers generate cases but have no on-site area for long term storage of case records. Most outstationed staff perform only the intake function. It should be noted that once intake occurs, ongoing maintenance of the case must occur. The sponsored staff setup simply allows for the division of tasks. Outstationed locations were established to give greater access to clients and to determine eligibility

for clients receiving services in a hospital/health clinic/or other Medicaid provider setting who traditionally left the facilities without paying or applying for Medicaid after services were rendered. Outstationed workers generate increases in the number of people accessing the program so more staff is generally needed to address the increase in caseloads in applications and case maintenance. The DSS contract with DHHS specifies that DSS maintain a minimum number of staff to perform the eligibility determinations according to their policies and procedures. Because the DHHS allocation of new staff has not been commensurate with increasing caseloads, county directors are given flexibility in staffing and organizing the process used in implementing Medicaid policies and procedures established by DHHS based on available resources and caseload demands. Allowing DHHS to mandate specific worker placement, organizational and supervisory processes to be used would be micro managing the county offices. The majority of Medicaid applications and redeterminations are processed at DSS county locations and so are the staff and supportive resources.

DHHS and DSS have known additional staff is needed for outstationed locations but DHHS is limited in funding additional staff so Medicaid providers have been encouraged by DSS since 1985 to provide matching funds for staff to be outstationed at their sites. Consequently, the location of these workers is determined by the sponsoring Medicaid provider. The initial outstationed program and contract was developed by DSS who contracted directly with the providers. DSS maintained overall supervision of these workers, however, the provider in some cases provided on-site supervision. The provider and DSS county director usually agreed on the site location, supervision and number of employees to be hired. Workers remain under DSS supervision so they can access confidential client information in case records and enter the data into the Medicaid eligibility automated system.

As of March 2001, there were contracts for only 182 sponsored workers. Sponsored workers positions are established for one year and turnover will cause a worker's name to remain on the payroll until they receive their last paycheck for the closing pay period.

DSS is very supportive of more outstationed sponsored workers on-site but additional staff must be placed at the county location to accommodate the increases in applications taken, processed and maintained. The allocation of workers has not kept up with program growth. The Medicaid population has grown from 371,000 clients in the early 90s to currently approximately 600,000.

Transportation Workers (page 27)

Some large urban counties require more than one transportation worker due to the volume of clients and providers. DSS's last staffing study indicates the actual need for more than one worker per county. In smaller counties where a full time transportation worker is not spending 100% of the time in arranging Medicaid transportation, they are allowed to assist in other Medicaid supportive duties. The percentage of time spent doing non-transportation Medicaid duties is captured during our Medicaid staffing surveys. Transportation workers are allowed to perform other Medicaid related duties with transportation being their primary responsibilities as noted in their EPMS under other related duties. Our FY 2000-2001 transportation contract funds less than 46 workers with DSS putting up additional match to fund the difference between that number and the 63 workers funded in FY 1999-2000. These workers do primarily Medicaid transportation and other Medicaid related duties are secondary. DSS actually supplements Medicaid transportation beyond the 46 funded workers. Smaller counties may have smaller Medicaid populations but will spend more time than larger counties arranging transportation and recruiting volunteer drivers due to the lack of transportation and Medicaid providers in their county.

DHHS has had separate and joint transportation and Medicaid Eligibility contracts over the years. There appears to be no real distinction or advantage between a separate or joint transportation contract. DHHS and

DSS have always separated EPSDT/Transportation funds from Medicaid Eligibility Determination funds for reporting and tracking purposes.

DSS has long advocated to DHHS that major Medicaid transportation providers like DMH, DDSN, and Regional Transportation Authorities should coordinate and arrange their own client transportation. DHHS and DSS have had several meetings in the late 90s on this issue.

Contract Oversight Issues – State Office Monitoring Costs (pages 27-28)

If this is reference to the Sponsored Workers contract, each sponsored worker contract contains an explanation of the purpose of the State Office Monitoring and Support functions. They include: 1. Monitoring the safeguard of confidential information for outstationed workers as required by federal regulations 42 CFR 431.302; 2. Training the sponsored workers on policy and procedure; 3. Providing technical support to the workers and providers; 4. Production of specific reports regarding worker performance and earned revenue; and 5. Supplying Medicaid manuals and forms.

Monitoring Responsibilities Not Clear (page 28)

The monitoring responsibilities for DHHS are clearly specified in the administrative section of the Medicaid Policy manual (chapter 1- Administrative Requirements, page 49) and the Medicaid eligibility determination contract. DSS does monitor its own compliance with the standards set forth in the Medicaid manual and contract. There is some functional overlap between DSS staff and DHHS staff, but little actual duplication exists. The two monitoring entities have over time developed an understanding of functional differences. Previous contracts contained penalties for DSS' non-compliance with DHHS performance standards such as withholding reimbursements for counties not meeting performance standards.

Both DSS state office and DHHS have eligibility related responsibilities. DHHS is responsible for developing Medicaid eligibility policies and procedures and DSS state office is responsible for their implementation and oversight. DSS provides technical assistance to county eligibility workers and feedback on the eligibility process to DHHS.

DSS transferred its county monitoring unit of four and its primary policy unit supervisor to DHHS as a result of the agencies' joint effort to define roles and responsibilities. Roles and responsibilities were agreed upon and noted in writing. DHHS is responsible for monitoring the counties compliance with the Medicaid Standards as stated in the Medicaid manual and contract.

The initial enabling legislation for DHHS clearly indicated DHHS would administer the Medicaid program setting policy and procedure and would subcontract with DSS to perform eligibility determinations. In recent years, DHHS has started to perform eligibility determinations on its own (Partners for Healthy Children). This is where the primary duplication of functions occurs.

Re-determinations Past Due (page 28)

The number and percentage of cases cited in the report as due or overdue appear to differ from numbers we reviewed. Per one of our ongoing reports, it appears that the total number of cases either due or overdue for review in April was 45,500 or approximately 8.18% of the active caseload. In May, a total of 44,597 cases (8.16% of the total caseload) were either due or overdue for review.

It should be noted that the re-determination process has a built in mechanism which will cause a case to show up overdue if a client does not respond to contact notices. Case termination cannot occur until two attempts at

contact have been documented. Once the two attempts have been documented, a termination notice allowing the client an additional 10 days prior to action must be sent. In many instances, the case will show as overdue in the month that the closure action took place.

Every effort is made to see that clients remain eligible for Medicaid and sometimes this means allowing additional time for clients to respond beyond the two notices. We have implemented a passive review process (effective September 1, 2001) for PHC clients that will not require a client to respond if they have no changes to their household or income status or childcare payments.

Other Contract Outcomes (page 29)

DSS does on every single application determine the applicant's access to health insurance. If health insurance is disclosed or exists, DSS completes a form (DSS 3230) or copies the page of the application requesting the insurance information and forwards this with a copy of any health insurance identification cards or policies to DHHS. This collection activity ensures that DHHS has the information for its main cost avoidance processes. This activity has been consistently supported in practice and policy. DSS is currently awaiting further instructions from DHHS on the full implementation of the Health Insurance Premium Program Act (HIPPA).

As for eligibility and managed care verification, DSS does routinely provide eligibility and managed care verification to providers contacting it. The service is provided by each of the 46 county DSS offices as well as a unit within the state office. The state office verification staff report an average of 6,000 plus calls a month. In addition, this unit and the county offices provide thousands of replacement Medicaid cards monthly, so that providers are in a position to review the client's eligibility when the client presents. Replacement cards are provided within five days of the request.

Monthly Medicaid Cards (page 29)

DSS presented the idea of a permanent plastic card in place of the present paper card to DHHS in the late 90s. The idea surfaced immediately after the implementation of the Food Stamp EBT card. DSS initiated a meeting with staff from DHHS and a private contractor who showed interest in selling the state the technology to upgrade the state's Medicaid program's identification card to a plastic card with a magnetic strip. The vendor was referred to DSS through the Office of the Governor. DHHS showed no interest at that time. The Department concurs with this renewed initiative. The Department will assist DHHS by identifying FY 2000-2001 postage costs and analyzing the FY 2001-2002 postage budget.

Conclusion (pages 29-30)

The conclusion appears to ignore the maintenance requirements of the half million plus ongoing recipients that require ongoing effort. Additionally, the conclusion attributes a lesser cost to outstationed staff without acknowledging the difference in the breadth of their responsibility. Part of the cost-savings for outstationed staff that the auditor appears to count is the allocation towards space for staff. Another reason for the lower cost is the fact that the cost of supervision and the cost of support items have all been rolled into the cost for the DSS in-house staff. Again the auditors ignore the huge dollar cost of maintaining the records system that provides the case record documentation. They cite as a savings a cost shift for the maintenance of the physical structures that county DSS offices are housed in. If we remove one-third of the staff from those offices, certain fixed costs for the maintenance of those offices do not go away. They simply are allocated to the remaining non-Medicaid programs. That does not constitute a savings to the state. The auditor also assumes, without any investigation, that space for the increase in outstationed staff will not be billed to the state by the providers. There is a big difference between the provision of space for minimal intake staff

versus the space required for full service staff. Additionally, the administrative fee for state office monitoring is not a cost savings since it is contributed by outstationed facilities.

The outstationed workers currently process 25% of all Medicaid applications, primarily pregnant women and infant cases. These cases are the easiest of the 28 different categories of Medicaid to process. The DSS county offices remain the central access points for the great majority of Medicaid applicants and recipients' eligibility determinations and redeterminations and support the workers that are outstationed. The majority of the outstationed facilities do not have the capacity to house and administratively support additional workers. Making these facilities the primary access point for Medicaid eligibility would increase client traffic in their facilities and waiting rooms. The initial concept behind the sponsored outstationing of workers was for low-income pregnant women and infants, and children could complete a Medicaid application immediately before or following service delivery so the bills could be paid by Medicaid rather than written off as an uncollectible debt by the facility.

All in all except for savings for the plastic Medicaid cards and the transportation workers, the Department is not sure that this proposed redesign of the eligibility determination process would achieve savings of $2.2 million in state funds. This proposal may be a quick fix but does not address the need for a redesign of the eligibility determination process that would make a difference in efficiently accessing individuals into the Medicaid program. This comprehensive redesign is what is currently being undertaken by both agencies.

RECOMMENDATIONS (page 31)

7. Recommendation: The Department of Health and Human Services, with input from the Department of Social Services, should review the Medicaid-eligible population in each county and determine the appropriate number of eligibility staff needed in each county, and whether these staff should be located in the county DSS office or out-stationed at medical providers.

   Agency Response: Both DHHS and DSS have shared information on such reviews. Both agencies are interested in maximizing available resources to keep up with increases in the Medicaid population and resultant caseload increases. Workload studies have been undertaken to determine the optimal number of staff per county but no new moneys were available. DSS will work with DHHS further on determining where Medicaid eligibility staff should be located. Any redesign in the eligibility determination function will consider how a person can best and timely qualify for Medicaid program benefits. Importantly, any redesign will have to insure that case maintenance is properly provided for and that the Medicaid Quality Control Error Rate remains below the penalty threshold.

8. Recommendation: The Department of Health and Human Services should not allow the Department of Social Services to bill for "allocated" eligibility staff until it determines the extent to which these staff are needed.

   Agency Response: Allocated staff include Family Independence staff who perform Medicaid tasks. Although South Carolina has delinked the welfare cash assistance and Medicaid eligibility determinations as required by law, the program went to great pains to align the eligibility requirements for the Medicaid and Low Income Families programs. Doing this allowed FI staff the ability to service both the self sufficiency and the Medicaid needs of the customers. The FI staff do job seeking and training activities requiring the collection of far more information than a simple eligibility worker collects. As such, they see fewer individual customers per month and do fewer Medicaid determinations than would a dedicated Medicaid staffer. Without this kind of approach, the delinking (splitting of the eligibility determinations) would have doubled the number of worker contacts necessary to provide this population with Family Independence and Medicaid services; this would represent another cost shift,

this time to the customers we are charged with servicing. Disallowance of the allocation of cost to this staff simply means that the work presently handled by one staff member will be shifted to two staff members and require the collection of the same or similar information twice. Cost allocation of eligibility staff being time studied has been approved by the Health Care Financing Administration.

9. Recommendation: The Department of Health and Human Services should initiate more contracts with health care providers to locate eligibility workers on-site. DHHS should also begin the process of coordinating with and training other community facilities to take Medicaid applications.

Agency Response: The Department will work with DHHS to initiate more contracts with health care providers to locate eligibility workers on-site. DSS will also assist DHHS in the identification of community facilities to take Medicaid applications.

10. Recommendation: The Department of Health and Human Services should not transfer funds to the Department of Social Services for State Office Monitoring until DHHS determines what kinds of monitoring is needed and who should perform it. DHHS should ensure that DSS adequately performs all services required of it under the contract.

Agency Response: The Department does supervise, direct and monitor the direct services staff. These costs of staff involved in this function are documented and billable as Medicaid administration. See earlier response to "Monitoring Responsibilities Not Clear."

11. Recommendation: Both agencies together should review state office-level staff to ensure that no duplication of functions exist.

Agency Response: The Department will work with DHHS to prevent duplication of functions.

12. Recommendation: The Department of Health and Human Services should not include funding for the transportation coordination workers in the eligibility contract. Where possible, DHHS should seek to have these transportation coordination services provided by the transportation providers. Otherwise, DHHS in consultation with DSS should determine the number of transportation coordinators needed in DSS county offices.

Agency Response: The Department sees no problem with this function either under a separate contract or under the current Medicaid Eligibility Determination and Transportation Services contract. Currently, these expenditures are accounted for and billed separately from the eligibility determination administrative function. The Department concurs that DHHS should seek to have transportation services provided by the transportation providers.

Additional Recommendation: No matter what changes are done to the Medicaid eligibility determination for South Carolinians, it needs to be done on behalf of the persons needing Medicaid assistance and on behalf of the health care community. Additionally, the process must ensure that the Medicaid Quality Control Error Rate remains under the Medicaid program's tolerance to avoid sanctions that would be applied to the entire Medicaid program (42 CFR 431.865).