

# Cost Savings Strategies for the South Carolina Medicaid Program

After the Department of Health and Human Services (DHHS) incurred a deficit in state 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 reviewed the issues of Medicaid fraud and abuse and pharmaceutical expenditures.

Based on additional concerns of the audit requesters, we reviewed three other areas, with the goal of identifying cost savings. These areas include an expanded use of managed care, the health insurance premium payment program, and the eligibility determination contract with the DSS.

If these cost savings strategies were adopted or more fully used by DHHS, we estimate a potential savings of about \$33 million annually — \$10.6 million in state funds. It would take a minimum of two to three years before the following cost savings strategies could be realized; all of these strategies would require DHHS to make significant changes.

IN VIEW OF MEDICAID'S EXPANDING ROLE IN ENSURING ACCESS TO HEALTH CARE AND POTENTIAL FUNDING RESTRICTIONS, COST CONTAINMENT MEASURES HAVE BECOME CRITICAL.

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

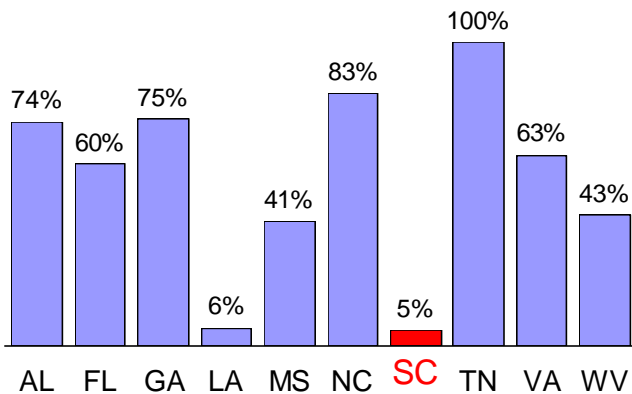
## USE OF MEDICAID MANAGED CARE

The goal of managed care is to provide high-quality health care when it is needed and to reduce unnecessary services. One of the most common types of managed care is a Health Maintenance Organization (HMO). An HMO offers its members comprehensive coverage for hospital and physician services for a fixed, prepaid fee. HMOs either contract with or

directly employ participating doctors, whom patients (members) must use for all health care services.

Federal regulations allow states to require Medicaid recipients to enroll in managed care programs when there is a choice of plans. States have generally mandated enrollment for the less costly Medicaid groups, i.e., women and children. According to federal data, nationally 56% of Medicaid recipients were enrolled in some form of managed care. South Carolina had less than 5% of its Medicaid population in managed care.

MEDICAID RECIPIENTS IN MANAGED CARE



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

In 1994, DHHS had planned to establish a statewide managed care system for Medicaid, but the program was never implemented, largely due to lack of support from the medical community, local HMOs, and state government officials. DHHS currently allows Medicaid recipients to choose, on a voluntary basis, between regular fee-for-service Medicaid, an HMO, and two primary care management programs. Enrollment in the Medicaid HMO was about 24,000 as of February 2001; 86% were children age 18 or younger.

## COST-EFFECTIVENESS OF MANAGED CARE

A key question is whether managed care will be more cost effective than regular fee-for-service Medicaid. Managed care plans can save money by promoting the use of primary care physicians for routine medical care rather than in a hospital and by monitoring the use of specialists. DHHS staff report that an independent study comparing costs and utilization of managed care currently is underway. We concluded that expanding the use of managed care could help improve cost-efficiency in the Medicaid program.

- # We surveyed nine states, and all 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.
- # South Carolina's Medicaid HMO did its own analysis and estimated a savings of \$1.5 million, or 11% of costs for selected eligible groups, that have resulted from its program for FFY 99-00.

- # Data from DHHS show that, in FY 99-00, South Carolina's average fee-for-service Medicaid expenditures per recipient under age 19 were about 14% higher than the average HMO premium projected on a 12-month basis.

FEE-FOR-SERVICE EXPENDITURES VS. HMO 12-MONTH PREMIUM	
Average Annual FFS Cost Per Person Age 0 – 19	\$1,090
Average HMO Premium Projected for 12 months	\$933
Percent Difference	14%

See full report for table notes.

- # Other research has shown that states typically discount managed care rates at 5%–15% of regular Medicaid costs. Using the 10% estimate and S.C.'s FY 99-00 costs, we estimated that if DHHS expanded the managed care program to include the children and low-income families in the 19 counties where both the Medicaid HMO and primary care management programs operate, the annual savings could be \$21 million or more.

## BARRIERS TO EXPANDING MANAGED CARE

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 Medicaid managed care in South Carolina.

### Mandatory Enrollment

South Carolina is one of only a few states which has not initiated some form of mandatory managed care for Medicaid recipients. Mandatory enrollment guarantees a certain volume of Medicaid recipients, which is critical to the success of a managed care plan.

### No Lock-In Policy

DHHS policy allows Medicaid beneficiaries in managed care plans to terminate their enrollment at any time and change their enrollment status on a month-to-month basis. This can destabilize plan membership and make it difficult for providers to get accurate enrollment data.

### Verification

Medical providers have experienced difficulties in verifying a patient's enrollment in Medicaid managed care, which in turn can lead to delayed or denied payments to doctors. Verification is handled by the Department of Social Services, which was shutting down the telephone lines at 3:30 p.m.

THE DISPARITY BETWEEN DHHS'S MEDICAID FEE-FOR-SERVICE AND MANAGED CARE  
PER PERSON COSTS SUGGESTS THE POTENTIAL FOR MAJOR SAVINGS . . . .

ONE STATE OFFICIAL INTERVIEWED IN OUR SURVEY STRESSED THE IMPORTANCE OF A  
SUPPORTIVE ATTITUDE TOWARDS MANAGED CARE PROGRAMS FROM PROVIDERS AND  
REGULATORY AGENCIES ALIKE. DHHS SHOULD INITIATE A PROPERLY CONTROLLED  
PILOT PROJECT IN MANDATORY MANAGED CARE, IN A SELECTED AREA OF THE STATE,  
WITH AN ASSESSMENT OF THE IMPACT AND COST.

## HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

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.

The Health Insurance Premium Payment (HIPP) program was authorized by the Social Security Act in 1990. It 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. By paying the premiums for employer-based health insurance for certain recipients, DHHS could avoid higher

Medicaid costs and realize significant savings. Currently 193 Medicaid recipients are participating in the HIPP program.

DHHS staff believe that this program can be expanded, but the current structure of the program limits its expansion. The process is very time-consuming and paperwork-intensive. DHHS staff believe they could expand the HIPP program to 1,000 participants if changes are made to computer systems and the method of processing payments. The program could be extended to 5,000 recipients if the operations were contracted to a private vendor.

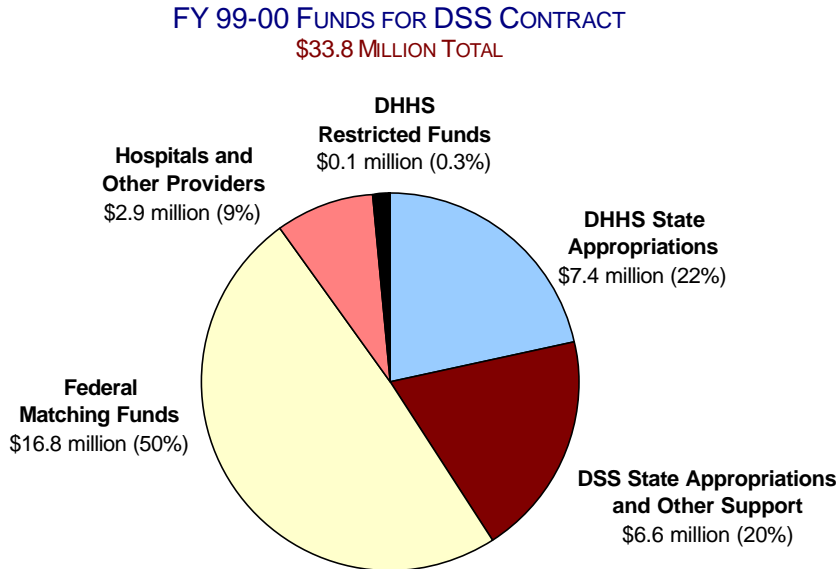
USING THE EXPERIENCE OF SUCCESSFUL HIPP PROGRAMS IN OTHER STATES, WE ESTIMATE THAT SOUTH CAROLINA COULD SAVE \$1,314 PER RECIPIENT .

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

See full report for table notes.

## COSTS 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 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. 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.



## COST OF USING DSS ELIGIBILITY STAFF

The Medicaid eligibility contract with DSS is expensive, largely because of the allocated workers and operational support DHHS is paying for. More than 50% of the costs charged to Medicaid under the eligibility contract are for DSS's allocated and indirect costs. These costs are based on a federally-approved cost allocation plan, but as a result, DHHS is paying up to \$60,151 for each DSS eligibility worker.

More than half of the eligibility staff are based in DSS county offices. Other eligibility staff are "out-stationed" at hospitals, health clinics, and other community facilities. These out-stationed workers cost, on average, \$39,513 each. The difference in the two groups of staff is due largely to the way DSS determines the allocated and indirect costs. In addition, the healthcare providers pay half the costs for the out-stationed workers, while federal funds are received for the other half.

Federal policy encourages the increased use of out-stationed eligibility staff to streamline access to Medicaid. We estimated that, if two-thirds of the current DSS Medicaid eligibility staff were out-stationed and only one-third worked in the county DSS offices, almost \$3 million could be saved.

### Other Issues Involving the Contract

- # Wide ranges in workload and staff productivity in county DSS offices may be contributing to the cost of the contract. In some counties staff process, on average, only 9.5 applications a month each while in other counties the average number of applications per staff is 57.
- # The contract also provides for DSS staff in each county to coordinate transportation to doctors' appointments for Medicaid recipients. However, the smaller counties may not need a full-time employee just to arrange transportation for Medicaid clients. In addition, if the transportation providers themselves furnished this coordination, there would be no need for these DSS employees.
- # DHHS forwards to DSS an "administrative fee" for the state office to monitor the contract. This fee amounted to \$470,120 for FY 99-00. However, we could find no concrete results of monitoring and concluded that DHHS should not forward these funds to DSS.

RECOMMENDED REVISION TO DSS CONTRACT	
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
<b>TOTAL</b>	<b>\$4,820,200</b>

APPROXIMATELY \$2.2 MILLION OR 46% OF THE TOTAL SAVINGS WOULD BE STATE FUNDS. THIS TOTAL ALSO DOES NOT INCLUDE AN ANNUAL SAVINGS OF \$969,000 THAT DHHS ESTIMATES WILL COME FROM REPLACING MONTHLY PAPER MEDICAID CARDS WITH PERMANENT PLASTIC



This document summarizes our full report, *Cost Savings Strategies for the South Carolina Medicaid Program*. Responses from state agencies are included in the full report. Our first report, *A Review of Selected Medicaid Issues — Fraud and Abuse, Prescription Drug Costs, Funding* is also available. All LAC audits are free of charge. Audit reports and information about the LAC are also published on the Internet at [www.state.sc.us/sclac](http://www.state.sc.us/sclac). If you have questions, contact George L. Schroeder, Director.