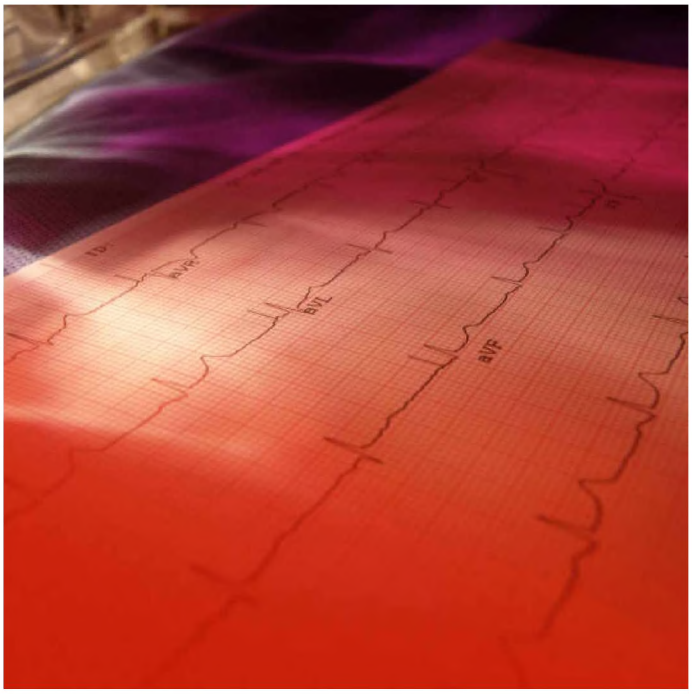
A Brief Guide to Medicaid And Its Status In South Carolina



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A Brief Guide to
Medicaid and Its Status in South Carolina

By

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July 2004

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Introduction

In the literature, Medicaid is frequently labeled as "massive," "complex," and even "enigmatic."[1] Many observers and experts alike believe that the federal Medicaid program is indeed confusing and misunderstood by the vast majority of Americans, despite its prevalence and magnitude, and its importance in the provision of health care to millions.

Since its beginnings some 40 years ago, Medicaid has evolved into an extensive and significant part of the nation's health care system. Figures indicate that in the year 2000, for example, Medicaid represented 17% of the total $1.1 trillion personal health industry in the U.S.[2]

In this monograph, a brief guide to the Medicaid program is presented. It seeks to answer plainly, for instance, what is Medicaid? Who is eligible? What services are provided? What costs are involved? How has Medicaid grown and what methods of cost-containment have been used? And so on.

Additionally, this monograph will examine briefly South Carolina's Medicaid program with the goal of providing an overview of its structures, processes, and costs.

Finally, it should be noted that this monograph is a summary of the Medicaid program. It is brief and outlines, for the reader, the fundamentals of the Medicaid system. In this sense, avoiding oversimplification to the extent possible, it attempts only to touch upon the essentials of what is a highly detailed and intricate public service program.

What is Medicaid?

Medicaid is a federal-state entitlement[3] program which provides funding to pay for medical and health care related services for eligible low-income persons, including qualified elderly and disabled persons. In a way, for all intents and purposes, it is a publicly financed health care "insurance" program for certain individuals who are poor and needy as defined by federal and state criteria. The National Conference of State Legislatures defines Medicaid as "three programs in one."[4]

1) A health insurance program for low-income parents (mostly mothers) and children—more than one-third of all births are covered by Medicaid.
2) A long-term care program for the elderly—nearly 70% of all nursing home residents are Medicaid beneficiaries.
3) A funding source for services to people with disabilities—Medicaid [pays] one-third of the nation's bill for this population.[5]

Medicaid was created in 1965 by amending the Social Security Act to add Title XIX[6] (Grants to States for Medical Assistance Programs). It came into being as result of the recognition that many Americans could not afford to pay for health care services in the late 1950s and early 1960s. President Johnson was instrumental in Medicaid's enactment as part of his "war on poverty" initiative.

Medicaid is a means-tested program, that is, a program that is available for individuals meeting certain qualifications (e.g., regarding status of income (poverty), type and degree of disability, etc.). It is a program that is funded and administered jointly by the federal and state governments. In essence, the federal government establishes the principles or basic requirements for the funding, eligibility, and scope of Medicaid services. States then are permitted a degree of flexibility—within federal parameters—to create and administer their own individual Medicaid programs. Thus, in this way, there are 50 differing state programs.

How do the federal and state governments divide up costs for Medicaid? Administrative costs are split evenly 50-50. For health care services, the federal contribution or federal medical assistance percentage (FMAP) varies from state to state and is driven by a formula based primarily on per capita income. The range of the federal contribution to states, or match, varies from 50% to 80%.[7] In South Carolina, for example, federal contributions in FY 2002 and 2003 were roughly 70%.

In FY 2002, total federal and state spending on Medicaid equaled $258.2 billion. This covered about 47 million Americans.[8] Still, there are estimated to be some 43 million people nationwide who have no medical insurance.[9]

Federally, Medicaid is overseen and administered by the Centers for Medicare and Medicaid Services, which is a division of the U.S. Department of Health and Human Services. In South Carolina, the Medicaid program is run by the S.C. Department of Health and Human Services, a cabinet agency responsible directly to the governor.

Eligibility for Medicaid

Low income is only one test for Medicaid eligibility. As stated earlier, *certain* disabled and elderly persons qualify for Medicaid benefits as well.

To understand Medicaid eligibility clearly, it is best to divide eligibility into to two basic categories: mandatory groups and optional groups. As the term implies, "mandatory" groups include persons specifically required by federal law to be Medicaid eligible, without exception. "Optional" groups are persons who are allowed by federal law to be eligible, but are not compulsory. States have the option, within broad federal guidelines, to elect to cover such optional groups should they desire.

Mandatory Eligibility

According to federal law, generally speaking, Medicaid must cover low-income mothers and children, and pregnant women. "Low income" is defined as those Americans with incomes below the federal poverty guidelines (FPG).[10] For example, in 2001, with the exception of the states of Hawaii and Alaska, the FPG for a family of three was $14,630.[11]

Further, Medicaid must cover people who are eligible for certain federal programs, i.e., have "categorical needy" status. This would include those individuals who receive Supplemental Security Income (SSI) or those who were formerly eligible for Aid to Families with Dependent Children (AFDC). More specifically, this includes:

- Families who meet states' AFDC eligibility requirements in effect on July 16, 1996.
- SSI recipients (i.e., the aged, blind and disabled who meet certain restrictions).
- Individuals and couples who are living in medical institutions and who have monthly income up to 300% of the SSI income standard.
- Children ages 6 to 19 with family income up to 100% of the federal poverty level.[12]
- Pregnant women and children under 6 whose family income is at or below 133% of the federal poverty level.
- Caretakers who are relatives or legal guardians who take care of children under 18.
- Certain Medicare beneficiaries.[13]

Optional Eligibility

Again, states may extend Medicaid eligibility, if they choose, though it is not required, to a number of other groups. Still these groups are ones which must fall within a set of wide-ranging definitions, as expressed in federal law or regulations. Principally, the following groups are optional.

- Infants up to age 1 and pregnant women not covered under mandatory rules whose family income is no more than 185% of the federal poverty level.
- Institutionalized individuals under a 'special income level' (the amount set by each state, up to 300% of the SSI federal benefit rate).
- Individuals who are eligible if institutionalized, but who are receiving care under home and community-based waivers.
- Certain aged, blind, or disabled adults who have incomes above those requiring mandatory coverage, but below the federal poverty level.
- Recipients of state supplementary income payments.

- Certain working and disabled persons with family income less than 250% of the federal poverty level who would qualify for SSI if they did not work.
- TB-infected persons who would be financially eligible for Medicaid at the SSI level if they were within a Medicaid-covered category.
- Certain uninsured or low-income women who have been screened for breast or cervical cancer through a program administered by the Centers for Disease Control.
- Optional targeted low-income children included within the State Children's Health Insurance Program (SCHIP).[14]

Finally, one other important optional group is available for states to include in their state Medicaid plans. This is labeled generically as the "medically needy." A medically needy (group) program permits states to allow individuals "with significant health care expenses" to become eligible for Medicaid despite the fact that such individuals have income above required levels. To qualify as medically needy, individuals must "spend down" to Medicaid eligibility levels that fall within either mandatory or optional income requirements. Thirty-six states have medical needy programs. The South Carolina Medicaid plan does not currently include a medically needy program.

Medicaid Enrollment and Coverage

Medicaid served some 50 million people in FY 2003.[15] Seventy-three percent of Medicaid beneficiaries were parents (primarily mothers) and children. The remaining 27% of Medicaid recipients were certain low-income elderly (10%), and the blind or disabled (17%).[16]

Enrollees receiving Medicaid, according to a Kaiser Commission study made in early 2004, are anticipated to grow by 5.5% on average in FY 2004. This is down from the previous fiscal years of FY 2003 and FY 2002 when the growth rates were 8.8% and 8.5%, respectively.[17]

Interestingly, *who* receives Medicaid is more determinate of costs than the number of enrollees covered. For instance, Medicaid expenditures—on average—for an elderly person are nine times more than those for a child. In fact spending on the elderly, blind and disabled accounts for 70% of all Medicaid expenditures.[18]

Children and Mothers

Nationwide, Medicaid covers over 21 million children and approximately 9 million adults (again mostly mothers). Most of the coverage of children and mothers consist of those individuals who meet the former AFDC eligibility requirements that were intact July 16, 1996.[19] (It should be noted that AFDC was, of course, replaced by the welfare reform program known as Temporary Assistance to Needy Families or TANF, which maintained

the 1996 AFDC eligibility criteria. TANF is a cash assistance program available to qualified low-income persons.)

Though AFDC or now TANF eligibility is tied to the majority of Medicaid recipients, i.e., children and mothers, since mid-1996, other federal or state coverage has added millions of additional persons under varying eligibility criteria. This would include, for example, low-income children under the State Children's Health Insurance Program.[20] It could also include *certain* infants and/or pregnant women whose family income is up to 185% of federal poverty guidelines, older children (under age 21), and institutionalized children, particularly those with mental disabilities.

The majority of service needs for children and mothers receiving Medicaid are preventive and primary care, and various acute care services.[21] These services would include mostly pediatrics, pre-natal care, family planning, physician care, and inpatient or outpatient hospital services. Other services might include differing "clinical" services, intermediate care facilities, and prescribed drugs.

Finally, what are the costs for these children and women under Medicaid? For example, the average cost per annum per child was $1,255 (FY 1998). In contrast, the cost per the aged for the same period was $11,235.[22] As stated earlier, the Medicaid costs for children and adults, while more numerous, are considerably less than for the elderly and disabled.

Elderly Persons

Though Medicare is the primary public health insurance program for persons over the age of 64 in the U.S., Medicaid also covers many older Americans as well. Approximately 5 million or 14% of all elderly persons receive Medicaid benefits.[23] Most are eligible because of low-income status and many meet disability requirements. The vast majority of the Medicaid services received by the elderly are those associated with nursing home care or health-home care.[24] These are followed by prescription drugs and physicians' care services.

Specifically, elderly persons receiving Supplemental Security Income are eligible for Medicaid. SSI is a means-tested cash assistance program authorized under federal law and is equivalent to 74% of the federal poverty level (FPL) for an individual, or $6,645 for FY 2003.[25] States may also provide a SSI benefit separate and distinct from the federal one.

Additionally, federal law permits states the option of providing Medicaid benefits to the elderly whose income exceeds SSI levels. This permits elderly persons with incomes up to 100% of the FPL to receive Medicaid. Twenty-one states currently allow for this option.[26]

Additionally, states may allow Medicaid services to the elderly with incomes in excess of the standard SSI amount. In certain cases, the elderly may receive Medicaid benefits for

care in nursing facilities or other institutions if their income does not exceed 300% of the maximum SSI monthly payment which, for example, was $552 in FY 2003.[27]

Individuals with Disabilities

According to the National Conference of State Legislatures, those that are disabled make up approximately 17.3% of all Medicaid beneficiaries.[28] Like the elderly, those that receive SSI payments qualify for Medicaid. Other disabled individuals qualify for Medicaid assistance, under certain conditions, if they exceed mandated income requirements. These conditions are varied but are in line, on the whole, with those associated with the elderly.

Generally, it can be said that disabled persons receive acute care on a regular basis. This includes frequent use of outpatient services, often those related to psychiatric or neurological problems. Many disabled also use some form of "intensive health services or residential care."[29] Disabilities run the gamut and include, for instance, blindness, physical immobility, mental retardation, mental illness, and acquired immune deficiency syndrome (AIDS).

While those disabled receiving Medicaid are modest in terms of the number of beneficiaries (17.3%), the costs associated with services are substantial, or 43.2% of all Medicaid expenditures. For example, the average yearly cost of a Medicaid recipient receiving intermediate care for problems associated with mental retardation is well over $100,000.[30]

Medically Needy and Other Specified Individuals

Finally, Medicaid coverage may extend to the medically needy, who comprise 8% of all Medicaid recipients or more than 3.5 million people. Again, the *medically needy* are individuals with substantial health care expenses, but exceed normal Medicaid income eligibility guidelines. States have the option to include medically needy persons for Medicaid coverage. In such cases, states can allow persons whose income levels are up to 133.3% of the FPL to receive Medicaid benefits. Other optional groups, which may be covered by states, include:

- Individuals qualifying under demonstration waivers.
- Certain women with breast or cervical cancer.
- Certain individuals with tuberculosis.
- Certain legal immigrants.

Medicaid Services

In terms of services offered, Medicaid allows for a comprehensive package of benefits. Comparatively speaking, Medicaid exceeds—in most cases—the benefits offered by private health plans. Additionally, of significance, Medicaid cannot reject those individuals with pre-existing physical/mental problems.

Medicaid provides mostly preventive, primary, and acute services for children and mothers. The elderly and disabled normally receive services that treat chronic and long-term needs, including, for example, services associated with nursing home care or specialized rehabilitative care.

Statistically, "prescription drugs" are the most utilized of the Medicaid services. In FY 2000, 20.5 million Medicaid recipients were prescribed drugs. This service was followed by physician services (19.1 million recipients), outpatient hospital services (13.2 million), lab and X-ray services (11.4 million), and clinical services (9 million).[31]

Aside from the acute services above, long-term care services, while not as prolific, constitute an important and numerous Medicaid services' area. Essentially, they consist of four types. "Personal support" services are most utilized by Medicaid recipients (in FY 2000, 4.5 million people). The remaining three long-term services include: nursing facility services (1.7 million recipients), home–health services (995,000), and ICF/MR services (118,000).[32]

Required Services

Federal law (i.e., Title XIX of the Social Security Act) requires the provision of certain Medicaid services. Generally, these mandatory services include:

- Inpatient and outpatient hospital services.
- Physician services.
- Nursing facility services (age 21 and older) and home health care.
- Laboratory and X-ray services.
- Pediatric and family nurse services.
- Preventive child-care services (screening, immunizations, physical exams, etc. for persons under age 21).
- Pregnancy services.
- Dental surgery and certain dental care.

Optional Services

Again, states have the flexibility, within certain restraints, to develop various Medicaid options. In this respect, states may choose to provide Medicaid recipients with a wide range of discretionary services. Those optional services most frequently offered are clinical services, emergency hospital services, and care facilities placement for the aged and/or disabled. Other common services that may be allowed by states include:

- Prescription drugs.
- Optometrist services and eyeglasses.
- Rehabilitation and physical rehabilitation.
- Transportation services related to health care.
- Prosthetic devices.

Medical Providers

At this juncture, a few words on Medicaid and its providers and payment system will be useful. Though somewhat complex, which is largely attributable to the flexibility among states, there are a few "basics" regarding Medicaid providers and payment procedures that are straightforward. These are discussed briefly below.

Both private and public sector individuals and facilities qualify as Medicaid providers. Obviously, these providers include doctors, hospitals, clinics, nursing homes, rehabilitative centers, and so on. Principally, states enter into contractual arrangements with providers, paying them for services at a predetermined amount (rate). This amount is normally below market rates, yet is "sufficient" to meet provider costs and allow for a "reasonable" profit.

Actual payment to providers is made in one of two ways. States may pay directly providers on a "fee-for-service" basis, that is, when a Medicaid eligible person receives a health care service, the provider bills Medicaid and then receives payment. Alternately, states may pay Medicaid through various "prepaid" methods (e.g., via a health maintenance organization or HMO). Further, it should be acknowledged that providers must accept Medicaid payment rates as payment in full.[33]

States may also charge, in many cases, Medicaid recipients deductibles, coinsurance, or co-payments. These cost containment methods are now widespread among the states, but there are certain exclusions from these cost-sharing measures. These exclusions include, for example, Medicaid recipients who are pregnant, children under age 18, and hospital and other institutionalized patients who meet qualified income levels.[34]

In certain cases, states are required to make additional or supplementary payments to hospitals that provide services to a high volume or "disproportionate share" of Medicaid beneficiaries. These so-called DSH payments are to offset the costs to hospitals that may derive from heavy use by Medicaid patients (who again pay nominal or below market rates). States classify hospitals as DSH facilities but within the framework of federal legislative requirements. Two such requirements include 1) hospitals that statistically (i.e., one standard deviation above the average) have higher Medicaid utilization rates than others, and 2) hospitals with a 25% or higher use by those eligible for Medicaid.[35]

Medicaid Expenditures

Currently, detailed Medicaid national expenditure data are published and verified for FY1998 through FY 2001.[36] Though technically dated, these are the most comprehensive data sources, and they give—for all intents and purposes—a recent and reasonably accurate picture of Medicaid expenditures today.

In terms of category of service, spending for *acute care* comprised 52.8% of all 1998 Medicaid expenditures. Of the remaining expenditures, *long-term care* was 38.3% and *DSH* was 8.8%.

Specific types of service expenditure vary. For instance, in 1998, services related to skilled nursing facilities and intermediate care services were percentage-wise the highest, or nearly 20% of all Medicaid expenditures. Conversely, at the lowest percentile were physicians' care and laboratory services at 3.8%. This is of particular interest considering that while physicians' care and lab services represented approximately 4% of expenditures, in terms of utilization, 46% of Medicaid recipients received them.[37]

Further, home and health care services (mainly wide-ranging personal care services delivered at home or in a community-based setting) made up 11% of Medicaid expenditures in 1998. This service type was followed by inpatient services (13.3%), payment to managed care organizations (12%), prescription drugs (8.4%), outpatient and clinical services (6%), intermediate care facility/mental retardation services (5.9%), and mental health services (1.7%).[38]

FY 2001 data are similar. The data indicate that total Medicaid assistance payments were $214.9 billion. Of this amount, nursing facility payments totaled $42.8 billion (19.9%), inpatient services were $29.9 billion (13.9%), and prescription drugs were $19.8 billion (9.2%).[39]

Expenditure data by eligibility status are also informative. For FY 2001, using the total expenditure figures from the Centers for Medicare and Medicaid Services' Office of the Actuary, the following breakdown for Medicaid assistance payments by eligibility status were: $57.2 billion (26.5% of total distribution) for Medicaid recipients age 65 years and over; $83.8 billion (38.8%) for blind and disabled; $34.4 billion (15.9%) for dependent children under 21 years of age; $24 billion (11.1%) for adults in families with children; and $16.7 billion (7.7%) for DSH and "other unallocated."[40]

Medicaid Growth

Medicaid expenditures grew by 9.3% in FY 2003. This annual growth rate was down from FY 2002 when Medicaid spending increased by 12.2%.[41] For FY 2004, Medicaid expenditures are projected to increase by 8.2%.[42] According to estimates by the Centers for Medicare and Medicaid Services (CMS), Medicaid spending will continue to increase through 2011.[43] The Congressional Budget Office projects that, on average, Medicaid annual cost growth will be around 9% for this period.[44]

Medicaid enrollment growth is expected to continue as well, fueling expenditures,[45] but less intensely for the immediate future. In FY 2004, annual enrollment is expected to increase 5.5% over the previous year. This growth rate is down from the three previous years when in FY 2003 it was 8.8%, in FY 2002, 8.5%, and FY 2001, 8.3%.[46]

What are the main causes for this growth in Medicaid? One major cause is designated in the literature as "medical price inflation."[47] In general, costs for medical products and services have been on the increase since the mid-1980s. For example, from 1988 to 1991 medical costs increased annually 8.4%. Specifically, hospital costs have increased

substantially as have other acute care costs. Prescription drugs are, however, the chief drivers of costs for the entire health care industry, and particularly for Medicaid. Again, in FY 2001, prescription drugs accounted for 9.2% ($19.8 billion) of total Medicaid expenditures. According to some estimates, prescription drugs are expected to grow annually at 12.7% through 2011.[48] Other medical inflationary cost areas include:

- *New technology*. New or advanced technologies for diagnostic testing and evaluation, treatment, and consultation will be costly. Examples might include costs associated with advanced genetic/diagnostic screening, endoscopic surgery, and computerized prosthetic devices.
- *Labor costs*. The shortage of nurses is clearly a problem and drives labor costs. Other specialist health caregivers, in some areas, are expected to be in demand in the future, further increasing costs.
- *Managed care savings peaked*. The transition to managed care is nearly complete. Savings from HMO's have been largely maximized according to most health finance experts.

Increased use of health care services is also a significant cause for the growth of Medicaid. "Utilization growth" is and will be particularly prominent with regard to those who are disabled. Projected Medicaid growth of the disabled is expected to be 51% for the period FY 2001 through FY 2006. For the same period, elderly beneficiaries are expected to grow 22%, children at 11%, and adults 10%.[49]

"Expansion of services" is another contributory factor to the growth of Medicaid. In recent years, especially during the period from FY 1995 through FY 2000, states have expanded their Medicaid services. One example of this is health-related special education programs for children, a preventive care initiative.[50] Additionally most states have optioned to provide for expanded clinical services and emergency hospital services. The expanded use of many prescription drugs, coupled with their ever-increasing use, is obviously another reason for recent Medicaid expenditure growth.

In sum, Medicaid growth has been striking in the past few years. According to CMS, causes for this exceptional growth have been:

- The increase in Medicaid eligible persons because of federal mandates, population growth, and economic recessions.
- Extended coverage and use of services.
- The DSH program, especially its use to increase federal payments to states.
- The sharp increase in aged and disabled persons.
- Technological advances (and their high costs) for the care of low-weight babies and severely injured or disabled persons.
- The increase in drugs costs, their use, and the expansion of new drug treatments.[51]

Medicaid Cost Containment

Because of the significant growth of Medicaid enrollees and expenditures, states have—out of necessity—undertaken aggressive cost containment efforts, especially over the past few years. All 50 states have pursued cost containment measures, some more than others. State governments, like the private sector as well, have faced and continue to confront skyrocketing health care costs. Cost containment has been a priority of governors, state legislators, and public health administrators and practitioners not only to hold down costs, but also, to maintain—to the extent possible—service levels and their quality.

The cost containment efforts related to Medicaid vary. Managed care is widely used among state Medicaid programs to bring about cost-savings. Other cost containment measures generally include 1) provider rate reductions or freezes, 2) prescription drug actions, 3) benefit limits or reductions, 4) eligibility cuts and restrictions, 5) beneficiary co-payments, and 6) long-term care reduction strategies. According to a December 2003 co-report of the National Governors Association and the National Association of State Budget Officers, states have recently sought to handle the rising costs of Medicaid along these lines:

- 50 states reduced or froze provider payments;
- 50 states implemented policies to control prescription drug costs, such as prior authorization and preferred drug lists;
- 34 states have reduced or restricted eligibility;
- 35 states have reduced benefits; and,
- 32 states have increased co-payments.[52]

In the following narrative, a brief look will be given to three of these cost containment measures or strategies.

Managed Care

Managed care, generally speaking, may be defined as a system or organization that coordinates the health care services of a person(s) in order to provide quality care, and concurrently, reduce unnecessary services and associated costs. In the case of Medicaid, this "managed care" may be accomplished by the state contracting with a third party (e.g., an insurance company like Blue Cross/Blue Shield) which in turn contracts with service providers (i.e., specific doctors, hospitals, etc.) on a fixed monthly payment per enrollee basis. In other instances, Medicaid managed care may also be where a state contracts directly with specified primary caregivers or other health service providers.

About a third of all Medicaid beneficiaries are covered by some form of managed care, sometimes called a health maintenance organization (HMO), a prepaid health program (PHP), or some other appropriate designation. Most states have some type of Medicaid managed care program, to a lesser or greater degree.[53] Many states have found managed care to result in substantial savings.

In the main, research indicates that the cost-savings for managed care groups (versus fee-for-services groups) ranges from 5% to 10% for Medicaid TANF eligible recipients (women and children [acute care]).[54] More specifically, some states have recently reported significant savings to their Medicaid programs due to managed care. These include, for example, Texas, which saved $100 million over four years and diminished overall emergency room use; Maryland, which saved $80 million over four years and improved early periodic diagnostic testing; and, Wisconsin, which saved $36 million over two years and increased access to physicians and other health professionals.[55]

Provider Rate Reductions or Freezes

A common method to reduce or contain Medicaid costs is to cut payment rates made to providers. In some cases, states freeze Medicaid payment rates for providers, making no annual or other periodic adjustments to rates for extended periods, or until Medicaid monies are sufficiently available to cover costs.

For example, for the brief period from July to December 2003, 39 states alone had taken actions to reduce or freeze Medicaid payment rates to help address Medicaid deficits for FY 2004. The rate reductions or freezes impacted various kinds of providers such as personal care services, mental or behavioral health, and transportation. HMO providers were also affected.[56]

It should be noted as well that six states did provide for rate increases to providers in their Medicaid budgets for FY 2004. Additionally, it is important to note that because of the nation's economic slowdown over the past three years, and the many resulting state general fund revenue shortfalls, rate reductions to Medicaid providers have been more pronounced than usual.

Prescription Drug Containment of Costs

The usage and costs of prescription drugs have increased phenomenally over the past few years. In fact, in 2002, prescription drugs were the leading reason for Medicaid expenditure growth.[57] Nationwide, Medicaid spent $23.4 billion for prescription drugs in 2002.[58]

All states have recently initiated drug cost containment measures. These included using prior authorization, using or expanding preferred drug lists, using supplemental rebates on drugs, setting limits on the number of prescriptions, and increasing cost sharing requirements. In mid-fiscal year FY 2004 alone, for example, 12 states took additional prescription drug cost containment measures to offset projected Medicaid shortfalls. Some of these measures included "implementing or expanding a preferred drug list (7 states), requiring prior authorization for more drugs (6 states), implementing a long-term pharmacy initiative (3 states), imposing new limits on prescriptions per month (2 states), and contracting with a pharmacy benefit management vendor (2 states).[59]

South Carolina's Medicaid Program

South Carolina's Medicaid program provides health insurance benefits for roughly 900,000+ state residents who meet federal and state eligibility requirements relating to income, disability, and age. This represents some 20% of the state's total population.

Further, there are over 30,000 Medicaid providers in the state ranging from hospitals to physicians to nursing homes. The total South Carolina budget for Medicaid in FY 2003 was $3.7 billion. The federal government's financial contribution equaled approximately 71% and the state funded the remaining portion, or 29%.[60]

According to the S.C. Legislative Audit Council, total Medicaid expenditures increased from FY 2000 to FY 2002 by roughly 25%. Average growth for this period was about 12%, increasing $360 million per year.[61]

Overall, the scope of South Carolina's Medicaid program can be summarized as follows:

- Consists of a total budget in excess of $3.7 billion.
- Comprises 10% of the state General Fund.
- Provides benefits for 20% of state's population.
- Pays medical costs for 50% of all births.
- Covers health insurance needs for 40% of all children.
- Pays for 75% of all nursing home care.
- Covers health care insurance for 33% of all seniors.
- Processes over 30 million claims annually.[62]

S.C. Department of Health and Human Services

The S.C. Department of Health and Human Services (DHHS) administers the state's Medicaid program. Created by *Act # 181 of 1993*, DHHS also administers three other programs that are federally funded and regulated. These include the *Older Americans Act*, the Child Care Development Fund, and the Social Services Block Grant. However, Medicaid comprises 96% of the agency's budget and functions.[63]

DHHS is a cabinet agency responsible directly to the governor. It is headed by a director who is chosen by the governor with approval by the state's Senate. It is organizationally structured in five main divisions including the Office of General Counsel, Medicaid Eligibility and Beneficiary Services, Finance and Administration, Information Technology, and Medicaid Assistance Programs.

DHHS employs approximately 1,450 full- and part-time workers. Its main office is located in Columbia. It also has offices which handle eligibility and long-term care throughout the state and, additionally, it maintains a child-care monitoring program in Greenville.[64]

DHHS's legal charge is "to establish a unified system for the orderly development of a state policy to ensure that essential services of planning, financing, and administration of interagency health and human service programs are carried out in the most efficient manner."[65] The agency's mission is "to provide access… to effective and comprehensive health care benefits, quality child-care services, and coordinated aging services."[66]

South Carolina Beneficiaries and Services

For South Carolina, DHHS reports that a total 937,762 eligibles received Medicaid benefits in FY 2003. This is an increase from FY 2002 of an additional 9,624 beneficiaries, or a modest 1% annual increase. Low-income families with children comprised the most numerous category of Medicaid recipients equaling 358,758 individuals, or 38% of all eligibles. Children alone consisted of 309,469, or 33% of total Medicaid beneficiaries in the state. The remaining categories of Medicaid eligibles for FY 2003 were: the disabled, 127,729 (13%); the elderly, 79,517 (9%); and pregnant women and infants, 62,289 (7%).[67]

In retrospect, Medicaid recipients in South Carolina have nearly doubled over the past decade. From fiscal years 1994 through 1997, recipients grew marginally from some 550,000 to 570,000. In FY 1998 Medicaid recipients increased substantially compared to prior years or by roughly 70,000 eligibles. Through FY 2001, Medicaid recipients grew exponentially. Reasons for growth are several, including expansion of eligibility and service requirements, demographic changes, and federal programmatic conversions.[68]

Finally, the type of services received on the basis of Medicaid eligibility is of note. Based on the most recent data available, FFY 2002, there were a total (unduplicated) 809,122 Medicaid recipients. Most recipients received physician services, numbering 561,541 beneficiaries. This was followed by dental services (231,454 beneficiaries), and inpatient services (126,734). At the bottom tiers of services received by Medicaid recipients were nursing care (18,246) and ICF/MR services (2,317).[69]

South Carolina Expenditures and Finance

In comparison, Medicaid expenditures stand in stark contrast to the figures related to eligibles. For example, Medicaid expenditure growth in South Carolina has been consistent the last few years, ranging from 10 to 12%.[70] In FY 2003, expenditure growth was approximately 10%. (Compare to 1% growth of eligibles for same year.) Major contributors to this growth in expenditures have been the rising costs associated with prescription drugs, hospitals, and nursing homes.[71]

Additionally, distribution of Medicaid expenditures by recipient group shows that while the blind and disabled only represented 15% of all beneficiaries in South Carolina, in terms of spending, their costs consumed 42% of the state's Medicaid budget for FFY 2000. Further, for the same year, elderly Medicaid expenditures were 25% of the total budget (while 10% of all state beneficiaries), children were 21% (51% of beneficiaries), and adult expenditures were 9% (23% of beneficiaries).[72]

Spending per enrollee per enrollment group (SPEPEG) is also noteworthy. Again for FFY 2000, the SPEPEG for the blind and disabled was $8,692. This was followed by the elderly at $7,745. Significantly lower were SPEPEG children at $1,256, followed by adults at $1,256.[73]

Furthermore, Medicaid expenditures percentage-wise on *acute* care show that for South Carolina, in FFY 2000, inpatient hospital services comprised 28% of total spending. This was followed by outpatient services (23%), prescription drugs (18%), and physician and laboratory x-ray (13%). The remaining percentage spent on acute care (18%) was for "other services," including managed care.[74]

For the same period, Medicaid expenditures on *long-term* care were as follows: nursing facilities contributed to 40% of all expenditures; home health and personal care were 39%; ICF-MR were 18%; and, mental health facilities' costs were 3%.[75]

Finally, again, the state Medicaid program totaled $3.7 billion in FY 2003. Twenty-nine percent or roughly $1.1 billion were state matching monies. The largest portion of these state funds came from the General Fund, 14% or little over $518 million. State agency match was near 8% or $296 million. Rebates and recoveries (1%), non-state-match (4%), and hospital and county taxes (2%) made up the remaining state contribution ($259 million) to Medicaid finances for FY 2003.[76]

South Carolina's Efforts at Cost Containment

In January 2004, the Kaiser Commission on Medicaid and the Uninsured published a 50-state survey on cost containment measures taken by the states. According to this survey report, South Carolina has taken, or plans to take cost containment measures in the areas of provider payments, pharmacy controls, eligibility cuts, and co-payments.[77]

A review of publications prepared by the S.C. Health and Human Services Department, including their FY 2003 Accountability Report, does not speak specifically to the cost containment measures mentioned in the Kaiser report. However, a Legislative Audit Council Report (January 2003) does examine options that DHHS could pursue to effect cost savings or containment.

For example, the Audit Council found that DHHS has implemented prior approval requirements for certain prescription drugs and, additionally, has reduced a 100-day supply of prescription drugs to a maximum 34-day supply per prescription. The Council recommended that DHHS further implement a state preferred drug list, estimating that based on FY 2002 data, DHHS could save $12.8 million in state share funds.[78]

The Legislative Audit Council also recommended the following cost containment measures:

- Reduce adult recipients in low-income eligibility groups (estimated savings $4.7 million).
- Charge a Medicaid enrollment fee (estimated savings $1.4 million).
- Charge a co-payment for optional services (estimated savings ($3.2 million).
- Charge a co-payment for hospital admissions (estimated savings $500,000).
- Improve debt collection (estimated savings $204,000).[79]

Conclusion

Medicaid is a complex federal-state program that provides health coverage for the poor, the elderly, and the disabled. Created in 1965, it has expanded in scope to meet the current health needs of nearly 50 million Americans.

The growth of the Medicaid program has been phenomenal, expanding both in expenditures and enrollment. With a FY 2003 growth rate in expenditures of over 12%, the annual growth rate is expected to continue to increase, averaging about 9% through FY 2011. Additionally, enrollment for FY 2004 is estimated to increase 5.5% over the previous year. It is important also to note that cost containment efforts have been implemented by all 50 states and have met, by most accounts, with reasonable overall success.

In South Carolina, over 900,000 residents received Medicaid benefits in FY 2003. Total Medicaid monies spent for this period were approximately $3.7 billion. Medicaid is an important public service health program for South Carolinians, one which provides critical services to those who are, for various reasons, unable to afford them.

Clearly, knowledge of Medicaid and its impact on millions of people is of benefit to everyone. In this regard, this monograph has provided an overview of Medicaid, a summary narrative intended to be both succinct and informative about a program and subject matter that is complicated and, according to many experts and observers, poorly understood by the majority of Americans.

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Endnotes

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[2] Thompson, P. (February 2004). *Medicaid's federal-state partnership: Alternatives for improving financial integrity*. Washington, DC: The Kaiser Commission on Medicaid and the Uninsured, p. 2.
[3] "Entitlement" means that if one meets a specified eligibility requirement(s), they are *entitled* to receive services or benefits.
[4] King, P. and Christian, S. (2001). *Medicaid survival kit*. Denver, CO: National Conference of State Legislatures, p. 1-1.
[5] Ibid.
[6] See http://www4.law.cornell.edu/uscode/42/ch7schXIX.html for Title XIX legislation.
[7] Op. cit., King and Christian, pp. 1-1 & 1-2.
[8] Retrieved April 20, 2004 from http://waysandmeans.house.gov/media/pdf/greenbook2003/MEDICAID.pdf and http://www.ncsl.org/programs/health/vsmith/sld029.htm.
[9] Op. cit., King and Christian, p. 1-2.
[10] Federal poverty guidelines (FPG) are prospective 'poverty' estimates for a given year to determine eligibility for Medicaid and other means-tested federal/state programs. Federal poverty level (FPL) is also used for determination of eligibility and is alternately used in this monograph to define poverty for purposes of defining or determining eligibility.
[11] Ibid., p. 1-3.
[12] The 2003 annual federal poverty level at 100% for a family of three is, for example, $15,260. See federal poverty levels charts published by Centers for Medicare and Medicaid Services. (2003). *Medicaid at-a-glance*. Washington, DC: U.S. Department of Health and Human Services, p. 6.
[13] Centers for Medicare and Medicaid Services. (2003). *Medicaid at-a-glance*. Washington, DC: U.S. Department of Health and Human Services, p. 1.
[14] Retrieved April 22, 2004 from http://www.cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp.
[15] The FY 2003 total federal/state cost of Medicaid was roughly $275 billion.
[16] Op. cit., King and Christian, pp. 1-11 and 1-14.
[17] Smith, V., et al. (January 2004). *States respond to fiscal pressure: A 50-state update of state spending growth and cost containment actions.* The Kaiser Commission on Medicaid and the Uninsured. Washington, DC: The Kaiser Family Foundation, p. ii.
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[19] Op. cit., King and Christian, p. 1-11.
[20] Section 4911 of the Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33).
[21] Op. cit., King and Christian, p. 1-11.
[22] Ibid.
[23] Ibid., p. 1-17.
[24] Of interest is the fact that Medicaid pays for 70% of all nursing home care in the U.S.
[25] Op. cit., Centers for Medicare and Medicaid Services (2003), p. 6.
[26] Retrieved April 30, 2004 from http://waysandmeans.house.gov/media/pdf/greenbook2003/MEDICAID.pdf.
[27] Ibid.
[28] Op. cit., King and Christian, p. 1-17.
[29] Ibid.
[30] Ibid.
[31] Table 15. Medicaid recipients by service category, FY 2000. Retrieved May 3, 2004 from http://waysandmeans.house.gov/media/pdf/greenbook2003/MEDICAID.pdf.
[32] Ibid.
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[34] Ibid.
[35] Op. cit., King and Christian, p. 1-23.
[36] See http://www.cms.hhs.gov/medicaid/msis/mpub.asp and Op. Cit., King and Christian, pp. 1-25 through 1-30. Varying expenditure data, including that for FY 2001, are available at http://www.cms.hhs.gov/researchers/pubs/03cmsstats.pdf.
[37] Op. cit., King and Christian, p. 1-25.
[38] Ibid.
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[47] Op. cit., King and Christian, p. 1-36.
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[50] Op. cit., King and Christian, p. 1-37.
[51] Op. cit., Centers for Medicare and Medicaid Services (2003, November), p. 8.
[52] Op. Cit., National Governors Association and the National Association of State Budget Officers.
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[66] Op. cit., S.C. Department of Health and Human Services, p. 2.
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