

BRIEFING PAPER ON MEDICAID

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ISSUE/CONCERN: RISING COST OF MEDICAID

Objective of Inquiry: To examine Medicaid situation and identify alternatives for providing services to beneficiaries at the least cost possible.

A. Factors Which May be Responsible for or Lead to High Medicaid Costs

1. High level of Medicaid utilization by enrollees

Medicaid expenditures during fiscal years 1977 and 1976 have reached or exceeded the maximum federal and local support available for Medicaid spending. The expenditure level for these two years have exceeded \$1.8 million.

During 1975 and 1974, the total expenditures made for Medicaid were _____ and _____ respectively. The number of enrollees throughout the years were as follows: in FY77, 7,000; in FY76 _____; in FY75 _____; and, in FY74 _____.

Medicaid enrollees are supposedly over utilizing their Medicare cards, thus, resulting in high program usage and costs. Since there is no real education program conducted by Medicaid, it is possible that an education program directed at Medicaid users could reduce Medicaid utilization. Additionally, there seemingly is still a lot of improvements needed in the program with respect to utilization. Monitoring activities of Medicaid expenditures seems to be needed. It is felt that the utilization of Medicaid benefits could be

controlled through some degree by:

- a) a strong utilization review (control) mechanism to periodically monitor the cost of Medicaid and issue warnings to planners and management when cost data reveals problems in the "utilization";
- b) education program for Medicaid beneficiaries to teach them when to utilize services and how to maximize their use of medical services. The program should instill in users, the concept of "preventive care"; and indicate to them that overuse of their Medicaid cards might lead to higher medical costs which is detrimental to their best interests and which may "exhaust" the funds appropriated for Medicaid use.

Medicaid funds can also be used by (States) the Guam Medicaid Program to pay the deductibles and co-insurance under Medicare Part A Hospital Insurance and the premiums for the Supplementary Medical Insurance under Medicare Part B for the medically indigent. It is possible that this may be a factor in the increase of Medicaid costs.

According to an evaluation made by PH&SS on Medicaid, the Medicaid Program is responsible for part or almost all of the medical care for approximately 50% of the individuals over age 65. If this data is correct, this means Medicaid is providing health care to somewhere between ^{1,000 -} 1,600 ^{of some} ~~to slightly over~~ 3,200 elderly citizens.

If this is the case, then it becomes more critical to determine fully, of our population age 65 and over,

(i) how many are covered by Medicare?

a) Part A (insurance for hospital care and related services)?

b) Part B (insurance for doctor's bill and outpatient care)?

(ii) how much (dollars) is the Medicaid Program currently subsidizing for those currently eligible under Medicare?

(iii) how much is Medicaid subsidizing of those age 65 and over for--

a) Part A care?

b) Part B care?

This information is needed in order for us to fully understand the dollar impact of the care provided to those age 65 and over.

2. Some Costs which may not be currently absorbed by the program but absorbed by GovGuam:

The total costs of Medicaid is not clearly portrayed, since some of the costs are being absorbed by GovGuam and not reflected as Medicaid expenditures.

A review of the nature of Medicaid expenditures is needed to ascertain which Medicaid expenses the Federal government is paying for and at what price; and services and procedures Medicaid patients are using which are not being charged to Medicaid simply because the local government does not have an "eligibility criterion" and such health services are as a normal course provided "free" by the Government of Guam and consequently, cannot be charged to the Medicaid Program.

Medicaid expenditures also need to be assessed to find out who we are paying out these Medicaid costs to, and what they are going out for. In other words, how much is going for physician fees, for limited dental care, etc. Who are the health providers with a high or inappropriate level of utilization?

3. Legislative Amendatory Actions

Legislative actions may inadvertently cause increases in Medicaid expenditure.

The Legislature, under P.L. 14-91, directed that the Department of Public Health and Social Services pay costs incurred by patients who are unable to pay their medical bills.

If the current Medicaid enrollees is comprised mainly of public assistance clients and a limited number of the medically indigent, and the above law results in an increase of potential and qualified beneficiaries to the Medicaid Program, Medicaid expenditures can be expected to increase beyond the \$1.8 million level; and how much beyond this will depend on how PH&SS develops their Medicaid eligibility criteria; and whether the abatement (hospital) program will cease. If the mandate given under P.L. 14-91 is to be resolved in another manner and not to be regarded as a Medicaid burden, then, P.L. 14-91 will not be expected to have an impact on Medicaid costs, but will be subsidized by local funds much like the abatement program found at GMH.

There are some thoughts pending recently to create an Enterprise Fund, where all charges incurred by patients unable to pay for medical bills may be paid from. This fund is to be used for the use of the "medically indigent" not covered by or eligible for Medicaid.

4. Future Possibility of Increase Hospital Costs and other Medical Costs:

If GMH increases its rates or if physicians increase their fees, you can expect Medicaid costs to rise correspondingly. If medical supplies and related costs increases, it will affect Medicaid expenditures.

5. Increase Costs for Administration, Federal Compliance and Monitoring and Research and Analysis:

As the Medicaid enrollment increases, administrative costs for monitoring utilization and assuring federal compliance will also cause Medicaid expenditures to rise. Currently, there is a staff of five people under this program. The administrative program cost is approximately \$72,000 per annum which is included in the projected \$1.8 million total Medicaid budget at a 50/50 match basis.

6. Increase of Medicaid Clientele:

PH&SS has been encountering a marked level of increase of Medicaid clientele. Prior to FY74, its total program expenditure never exceeded the \$1.8 million level. In the last 2 years, we have been maximizing the \$1.8million level which included a substantial amount

of unpaid prior year's billings.

In addition, the number of patients on renal dialysis have significantly increased to a new high of 12 patients from the previous level of 6. There are supposedly 26 individuals on renal dialysis presently of which are 12 covered by Medicaid.

According to PH&SS, the increase in Medicaid clientele is about 12% over last year; and covers some 7,000 individuals. This compares to a Medicaid clientele of some 4,000 a year or so ago.

B. Other Factors Which Affect the Medicaid Problem/Situation:

There are other factors and/or elements which need to be reviewed in looking at the Medicaid situation. These briefly are as follows:

1. A review needs to be made on the payments provided providers.

The Medicaid program uses the Hawaii Relative Value Scale as their guide in determining physician compensation. It is not clear whether the Hawaii Relative Value Scale is payment based on "reasonable cost" or on "customary charge". If one is interested in keeping Medicaid cost down, our interest would focus on trying to obtain wherever possible for costs to be maintained on a "reasonable cost" basis, not what is customary and usual or the so called prevailing rate found in the community.

Generally also, an agreement is usually negotiated between providers and the Medicaid program for "costs" so that "limitations" may be

set; and to arrive at a reasonable cost reimbursement formula. According to Mr. Mackie, August 28, 1978, PH&SS does not have any such formal agreement with GMH. Since GMH is now a separate authority with desire to maintain its full independent authority, it behooves the government to formalize an agreement to ensure that the reimbursement to GMH for services provided Medicaid is based on reasonable costs. Such agreements should also be made with other providers. It was also indicated by Mr. Mackie that, it is not known if the services secured off-island with certain health providers is charging us for costs based on "reasonable costs" or the "customary rate".

It should also be noted here that those services which are provided "free" as a ^{normal} ~~normal~~ course of action by PH&SS are not being charged to the Medicaid program. It was indicated that PH&SS is however keeping track of certain such costs. It appears to us again that the costs incurred by Medicaid beneficiaries in the public health facilities should be fully determined so that we can know the dollar impact of the services rendered.

2. Under the Federal Law, Professional Standards Review Organizations (PSROs) are authorized to assume certain responsibility for reviewing the quality and appropriateness of care provided under Medicare, Medicaid, and Maternal Child Health (MCH) programs. Guam, prior to U.S. P. L. 93-641, was covered under the Hawaii PSRO.

According to Mr. Mackie, the first visit ever made by the Hawaii PSRO group to Guam was in May, 1977. It appears that there were some reluctance by physicians, possibly the Guam Medical Society, to undertake this review function. The organization designed to handle this type of review functions should be made. If the Guam Medical Society is unwilling to perform this function, a non-physician group could perhaps be organized and directed to perform this function.

3. The Medicaid Program on Guam offers more than the basic five services required by Federal Law.

In addition to the basic services of inpatient and outpatient hospital care, certain laboratory and x-ray services, physician services and skilled nursing home services, the local program provides -

a) Limited Dental Care:

Emergency dental care and extractions are provided to all beneficiaries. In addition, WIN mothers may receive certain cosmetic dental services, if they are planning to work.

b) Optometry Services:

Clients are provided eye examinations and eye glasses.

c) Drugs:

All drug costs are absorbed by Medicaid when prescribed by the physician.

d) Prosthetic Devices

- e) Home Care Services
- f) Renal Dialysis Treatment

It is not known how much is spent providing the above supplementary services and what the exact dollar impact would be were the Medicaid Program to be amended to delete these services. The effect this would have on Medicaid clients would also have to be determined. The current PH&SS estimate is that the dollar value of these services is somewhere between \$100-\$200,000.

4. Utilization Review Plan.

The hospital participation under Medicare/Medicaid is required to have a Utilization Review Plan which applies to services furnished by GMH to inpatients who are beneficiaries under Title XVIII (Medicaid). This Plan would review utilization admissions, duration of stay, and professional services furnished. According to Mr. Mackie, August 26, 1978, this is currently being performed by PH&SS by Dr. Lorie, the new head for the Medicaid program.

In addition, there are other requirements that GMH is required to meet under the Federal Law. It is not known how we are assuring compliance of these requirements.

C. Summary of Salient Facts About Medicaid:

These basic facts are indicated below to give the reader a basic synopsis of basic information about the Medicaid Program. These are as follows:

1. Medicaid is intended to provide medical assistance to the medically indigent under a program in which the States and the Federal government shares expenses. The Federal Government's share ranges from 50 to 83% of the total cost depending on the per capita income of the State and the States' ability to share costs. By 1970, States had to participate in Medicaid or lose aid for medical programs for the blind, crippled and aged. These programs and the welfare program have been absorbed into Medicaid.
2. Guam's Medicaid program provides more than the five health services which are considered basic. These additional services include drugs, home care services, renal dialysis treatment, etc. among others.
3. The bulk of the Medicaid funds goes to GMH.
4. However, we do not know about other Medicaid costs which are important for our analysis such as:
 - a) How much of the Medicare Part A deductibles and co-insurance and Part B are we paying.
 - b) How much of the costs going to providers are based on "reasonable costs".
 - c) How much of the Medicaid costs goes for drugs, physician fees, limited dental care, off-island providers, etc.

5. Guam is maximizing its Federal allotment. Although, the House of Representatives has recently approved amending Guam's Federal ceiling for Medicaid, we are uncertain how the Senate will act on the measure in view of the many national concerns about limiting government spending and reports which have reached Congress which are not favorable about Guam's management of Federal funds.
6. The Medicaid clientele is comprised of Guam's public assistance roll, supposedly a significant segment of the elderly and the "medically indigent". Hence, these groups will be those most likely to utilize medical services and require a higher level of hospitalization costs. Also PH&SS indicated that many of the children and youth covered under the Early and Periodic, Screening, Diagnosis and Treatment Program (EPSDT) have seldom receive preventive health care. If this is so, it is all the more urgent and important that the children of the families covered by Medicaid would benefit by an early screening program; and a greater level of outreach should be made to reach a higher level of these groups.
7. Local Law prohibits the Government of Guam from over expending its appropriation. Yet the Federal Law requires that people eligible for Medicaid services do in fact receive services. This raises a very fundamental issue. Can the Government of Guam cease to provide services simply because it has no funds to continue to do so? This raises legal questions which has to be explored.

D. Possible Alternatives Towards Resolving the Medicaid Situation:

The Medicaid issue is more complex than what appears on the surface. Adequate data are needed to fully clarify the parameters of the issue before meaningful alternatives at resolving the problem can be generated.

It was suggested that the option of an HMO be raised as a possible solution. In our viewpoint, other things have to be carefully studied before this option is accepted as a way of resolving our Medicaid dilemma.

Some of the questions which would have to be resolved with respect to this are:

1. If the HMO alternative was chosen,
 - a) Would any of the current HMOs accept the role desired of it and under what terms or conditions?
 - b) If none would accept Medicaid, is the Government planning to propose the formation of another HMO option?
2. If PH&SS opted to be a GovGuam subsidized HMO, how would this government entity resolve the conflict of role it may face in light of this?
 - a) If PH&SS were to operate a portion of its operation in an HMO fashion, wouldn't this conflict with its traditional public health role, that of providing preventive care instead of moving into providing direct patient care?

- b) If PH&SS were able to provide all of the Medicaid cost at a lower rate, what assurance would be made that it would continue to do so?
- c) Who will handle the preventive public health role?
- d) What will be the public reaction to this change in public policy?
- e) Is this shift-in policy worth the benefit at the margin?

We see the desirability of enrolling Medicaid beneficiaries under an HMO type of organization if it will result in the provision of health services to those eligible; and if it will contain costs.

If, however, the option selected is to have PH&SS operate as an HMO, A number of factors should be assessed to determine whether this alternative is the best way of providing services to Medicaid clients at the lowest possible cost or within the program's budget limitations.

The other alternatives which should realistically be explored include the following:

1. Develop a strong utilization review and education program. By improving the utilization review functions, Medicaid usage could be reduced to some degree. A strong education program directed at Medicaid cardholders could also help people to maximize the use of Medicaid services; and avoid unnecessary utilization. Additionally, Medicaid beneficiaries could be encouraged to choose their principal their principal physician and try to as much as possible to seek health services from him mainly.

2. Certain services now offered by Medicaid which are optional could perhaps be modified or reduced thereby reducing costs. Before this is attempted, however, we should examine Medicaid expenditures in more detail; and closely, since some of this type of data is not presently known by PH&SS. Some of the cost data provided by PH&SS are estimates.
3. A certain known level of Medicaid costs could conceivably be reduced if efforts could be successfully made to limit physician and hospital fees to "reasonable fees". This option, however, carries with it the possibility of discouraging physicians from treating Medicaid patients. The largest benefit would come from assuring that GMH charges Medicaid patients on a "reasonable cost basis" since some of the outpatient services currently provided are rather high.
4. The termination of the Medicaid program will not resolve the basic problem of providing care to the "medically indigent". Since health is regarded as a right nationwide, the Local government will have to provide services somehow to those in society who need medical services irrespective of their ability to pay.
5. The limitation of Medicaid to people who meet only certain eligibility requirements may reduce Medicaid costs to some degree. Currently, PH&SS also includes in the Medicaid coverage:
 - a) some 600 individuals on a cost share basis. This group is supposedly costing Medicaid an estimated \$100,000. This group could be considered for exclusion. If they are excluded from coverage under Medicaid, however, the Government should still seek somehow to assure this group receives medical services when it needs to on a cost-share type of proposition.