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South Carolina's View: The Affordable Care Act's Medicaid Expansion Is The Wrong Approach

Posted By Anthony Keck On September 6, 2012 @ 1:56 pm In All Categories,Disparities,Health Care Costs,Health Reform,Medicaid,Payment,Policy,Public Health,Spending,States | 2 Comments

Editor's note: *See Maryland Medicaid director Charles Milligan's earlier* [1] Health Affairs [1] *Blog post* [1] *for a different view of the ACA's Medicaid expansion.*

This year more than 1.1 million people will enroll in South Carolina Medicaid — almost one-quarter of our population — at a total cost of $5.95 billion. According to a recent study [2] published in *Health Affairs*, the state has one of the highest rates of Medicaid physician participation, largely tied to its high Medicaid reimbursement rates. Last year, while many states were cutting services, Gov. Nikki Haley and the Legislature invested $176 million of new recurring state funds in Medicaid to enroll about 65,000 low-income children through Express Lane Eligibility, replace one-time revenue with recurring sources, and expand the number of home and community-based placements available to our beneficiaries.

Any honest assessment of South Carolina's program would conclude that South Carolina considers Medicaid and our citizens' health an important priority. So when Gov. Haley says South Carolina won't accept the expansion of Medicaid under the Patient Protection and Affordable Care Act, she does so because she believes that its version of expansion will ultimately hurt the poor, hurt South Carolina, and hurt the country by doubling down on a system that already delivers some of the lowest value in the world.

There is sufficient money currently in the health care system — we need to do the hard work to shift it from non-productive to productive uses. We rely on a three-pronged strategy of payment reform, clinical integration, and targeting hotspots and disparities to allow for investment in other health-producing activities while lowering the cost of care per person to increase affordability of coverage.

Our Assessment

Peter Drucker once said, "The most serious mistakes are not being made as a result of wrong answers. The truly dangerous thing is asking the wrong questions." President Obama and Congressional Democrats committed the more grievous of the two errors by framing their approach to reform as, "How do we *insure* as many people as possible?" This mistake perpetuates the over-medicalization of health and well-being in this country, and resulted in the individual mandate to buy health insurance, premium subsidies, and a large expansion of Medicaid.

In South Carolina we are instead asking, "How do we most *improve the health* of our citizens?" and it leads us down a different path. First, when we focus on health and well-being, rather than health services and health insurance, we look to the social determinants of health. This well-documented model suggests that health services contribute 10-20 percent to overall health and well-being of an individual and community, while health behaviors and personal choices, income and employment, education, genetics, social supports, race, and place are much larger contributors.

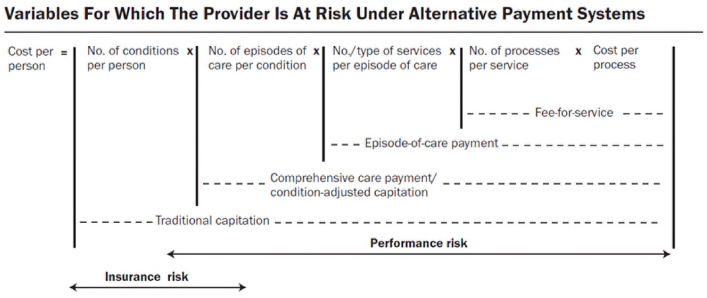
Second, we recognize the United States spends more money per person on health care services than any country in the world. If this spending resulted in better health than the rest of the world, we might tolerate this cost. But we know we are often less healthy than our counterparts in other developed countries.

Out-of-control health care spending gnaws away at investment and spending on critical social determinants of health. Estimating that 30 percent of all health services spending is excess cost, participants in an Institute of Medicine roundtable lamented in the series summary *The Healthcare Imperative: Lowering Costs and Improving Outcomes* [3] that excess health care inflation is destabilizing the health care system, depressing growth in national

wages and employment, and forcing states to divert money from other important investments such as education.

Lowering the cost of health care per person in South Carolina and nationally is therefore imperative to improving health. The IOM roundtable report provides a useful roadmap for cost reduction by prioritizing six domains of excess cost where we should focus: unnecessary services, excess administrative costs, inefficiently delivered services, high prices, fraud, and missed prevention opportunities. Harold Miller at the Center for Healthcare Quality and Payment Reform provides a useful conceptual model shown in Figure 1 (click to enlarge) that emphasizes how costs per person can be broken into manageable components that providers and health plans can address.

Figure 1



Harold Miller, Center for Healthcare Quality and Payment Reform, From Volume to Value: Better Ways to Pay for Health Care (September/October 2009)

[4]

Reducing unnecessary services and the unit cost of these services frees up public and private spending for education, infrastructure, employment and wage growth. This strategy also lowers the cost of health insurance premiums and out-of-pocket spending when the use of health services is needed. Improving affordability means more individuals will become insured individually or through employers. Likewise, state Medicaid programs can afford more coverage for their dollar.

PPACA Medicaid Expansion In South Carolina

South Carolina Medicaid has worked since last year to understand the new spending required under a PPACA Medicaid expansion scenario. What was once a budget exercise is now a policy debate and the department recently began a series of public meetings to vet the analysis in preparation for the 2013 legislative session. Figure 2 (click to enlarge) displays the projected growth in South Carolina Medicaid under PPACA expansion.

Figure 2

Projected Enrollment Growth			
Population	FY 2013	FY 2014	FY 2020
Current Programs			
Medicaid	867,000	880,000	962,000
CHIP	70,000	71,000	78,000
Total Current Programs	**937,000**	**951,000**	**1,040,000**
After Expansion- 71% Average Participation			
Expansion Population			
Parents/Childless Adults		236,000	251,000
Currently Insured Population (Crowd-out)			
Children and Currently Eligible Parents		79,000	84,000
Newly Eligible Parents/Childless Adults		97,000	103,000
Currently Uninsured (Eligible but Unenrolled)			
Children		51,000	55,000
Parents		40,000	43,000
SSI Disable Eligible		7,000	8,000
Total Expansion from ACA Participants		**510,000**	**544,000**
Total Medicaid Population After Affordable Care Act Expansion	**937,000**	**1,461,000**	**1,584,000**

Source: Milliman letter to Anthony Keck, Medicaid Director, South Carolina, Department of Health and Human Services, "Affordable Care – Financial Impact SFY 2014 through SFY 2020", Robert M. Damler, FSA, MAAA, April 6, 2012

[5]

The best estimate is that 510,000 additional South Carolinians would enroll in Medicaid in 2014. 340,000 of these new enrollees would be eligible for the first time as a result of PPACA. 170,000 of them are currently eligible but not enrolled, but because of the dynamics

of PPACA they are expected to enroll and are only eligible for our current match.

Figure 3 (click to enlarge) displays the current estimated range for new state spending over the seven-year period of 2014-2020. The baseline projections prepared to date suggest that Medicaid would spend an additional $1.085 billion in state tax money under expansion. An initial "what-if" analysis was performed resulting in an upper spending limit of more than $2.4 billion in state funds over the same period.

Figure 3

Fiscal Impact - SFY 2014 through SFY 2020 State Budget Dollars (values shown in millions)	Baseline Participation	Full Participation
Medicaid Assistance Expansion to 138%		
Uninsured Expansion Population	$303.8	$376.4
Crowd-out Population - Expansion	125.4	221.7
Crowd-out Population - Eligible	433.5	622.6
Eligible but Unenrolled Population	598.4	854.8
SSI Eligible Population	13.2	13.2
MCO Pharmacy Rebate - current enrollee	(335.5)	(335.5)
Health Insurer Assessment Fee	101.7	109.8
DSH Payment Reduction	(217.5)	(217.5)
CHIP Program - Enhanced FMAP	(130.2)	(130.2)
Physician Fee Schedule Change	0.0	0.0
Administrative Expenses	192.6	192.6
Total	**$1,085.4**	**$1,786.5**
Additional "what-if"		
Increase Fee Schedule to 100% Medicare (all physicians/all services)	$589.5	$624.2
Total with Physician Increases	**$1,674.9**	**$2,410.7**

Source: Milliman letter to Anthony Keck, Medicaid Director, South Carolina, Department of Health and Human Services, "Affordable Care – Financial Impact SFY 2014 through SFY 2020", Robert M. Damler, FSA, MAAA, April 6, 2012 [6]

The what-if scenarios include an unlikely 100 percent participation rate (versus the baseline average of 71 percent) and a more likely need to increase physician reimbursement. Recently published results *in Health Affairs* [7] indicate, not surprisingly, that acceptance of new patients by physicians is tied to reimbursement rates by payers and that nationally one-third of physicians are not currently accepting new Medicaid patients.

While not shown, the second seven-year period is more expensive that the first seven years because the "teaser" federal matching (FMAP) rate of 100 percent eventually decreases to 90 percent. Other one-time enhancements also expire, including 100 percent FMAP to raise certain primary care rates to Medicare levels for two years and an FMAP enhancement of 23 percent for CHIP for four years.

During public meetings sponsored by Medicaid, participation rate estimates were challenged as too high. While this argues against the pressing need to insure these populations, we are performing additional analysis. We are also assessing how much state spending in mental health might shift under expansion, if any.

Stan Dorn's August 2012 policy brief *Considerations in Assessing State-Specific Fiscal Effects of the ACA's Medicaid Expansion* [8] provides state policy makers with useful advice for their analysis. While several of his arguments are still too generous toward expansion, most appreciated is his observation that the time has passed for using national-level survey data and analyses to estimate state fiscal effects of PPACA to justify a position on expansion — states *are* different. "Put simply," he notes, "developing a definitive fiscal analysis for a particular state requires analyzing unique, state-specific information sources."

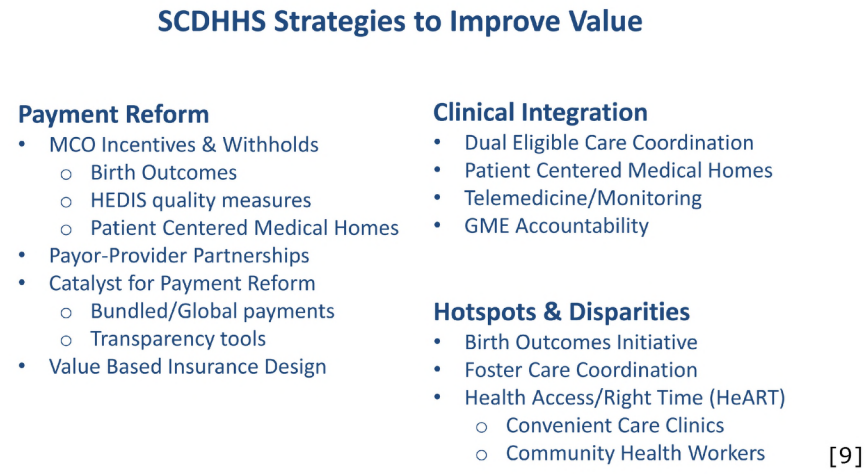
Strategies

Debating the incremental effects of PPACA nationwide is distracting legislatures and other policy makers from the fact that most *current* Medicaid programs are growing at an unsustainable rate. Last year alone the inflation and natural enrollment growth in South Carolina's Medicaid program was $66 million in state funds. Initial budget planning for state fiscal year 2013-14 suggests the Medicaid program may require almost nine of every 10 newly-available state general fund dollars – even without accepting the PPACA expansion.

Therefore, we are working to increase value by increasing efficacy and reducing cost per person through three major strategies: payment reform, clinical integration, and targeting

hotspots and disparities. Our major initiatives within each of these strategies are shown in Figure 4 (click to enlarge). Several are discussed below.

Figure 4



[9]

Payment Reform

Providers and beneficiaries can best manage health care value, yet we now place much of this expectation on health plans. South Carolina is working to place more responsibility and more reward for performance in the hands of individuals and their providers through several initiatives.

Following the lead of Ohio Medicaid, we have joined Catalyst for Payment Reform (CPR). CPR is a purchaser-led group — members include organizations like GE, Boeing, Wal-Mart, and CalPERS — committed to incorporating model language into health plan contracts. The group's goal is 20 percent value-based provider payments by 2020, more health plan and provider transparency, and more provider competition.

Greenville Hospital System and our Blue Cross-Blue Shield (BCBS) Medicaid managed care plan have recently formed a care management partnership in Greenville county. *Healthy Opportunities Greenville* has a shared and flexible governance structure, shared savings performance goals, a narrower network, and a focus on provider-based care management for Medicaid beneficiaries.

Clinical Integration

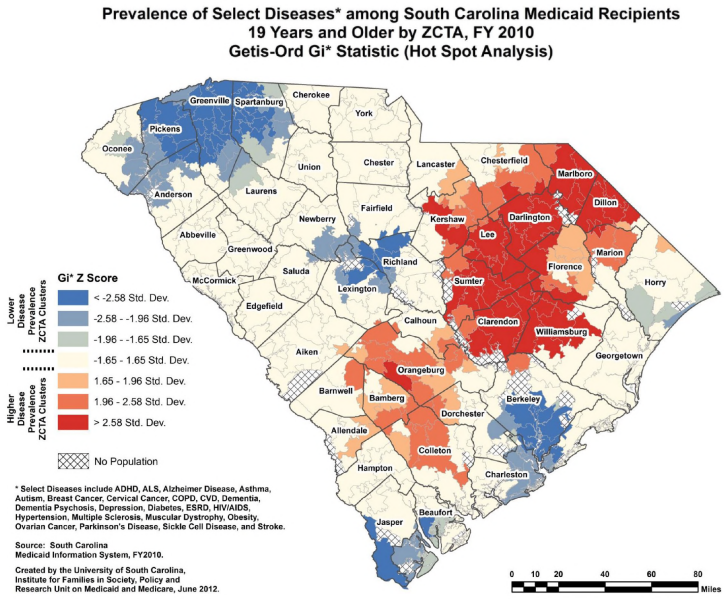
South Carolina is one of 15 states working with the Medicare-Medicaid Coordination Office on a demonstration to better manage our large number of dual eligible individuals. Developed with stakeholders, our proposal emphasizes multidisciplinary care teams that integrate physical and behavioral health with long-term care services for 65,000 beneficiaries.

Effective July 1, 2012, South Carolina is reimbursing primary care practices certified as patient centered medical homes 50 cents to $2 per member per month depending on certification status. In the next round of contracts a more robust care management fee will be available to certified practices that agree to specific performance goals.

Hotspots and Disparities

Figure 5 (click to enlarge) shows geo-coding analysis of hotspots in South Carolina Medicaid for a collection of diseases. Rather than indiscriminately expanding coverage based on income, it is our intent to layer Medicaid on top of other state and local government agency and private resources to address geographic, population and disease hotspots to improve health where it is needed most.

Figure 5



[10]

In partnership with the South Carolina Hospital Association, the March of Dimes, SC ACOG, BCBS and others, we have implemented a statewide Birth Outcomes Initiative to reduce prematurity. This effort has cost-savings targets for which hospitals are at risk. The initial focus is elimination of early elective deliveries; 100 percent Screening, Brief Intervention, Referral, and Treatment of pregnant women for substance abuse, depression and domestic violence; and increased use of 17P, an inexpensive locally compounded hormone injection proven to reduce pre-term births in certain pregnancies.

In a recent survey on over 3,000 Medicaid beneficiaries, 32 percent reported multiple ER use in the past twelve months and 48 percent cited lack of convenient physician office hours as the reason for these visits. As part of our HeART initiative we have recently opened provider enrollment for convenient care clinics such as CVS Minute Clinics to provide more access points for our beneficiaries.

Response To Arguments For Expanding Medicaid

A 90/10 match is too good a deal to pass up

Many advocates for expansion want this to be a conversation about how much money states stand to gain by expanding Medicaid. We are not debating the fact that if the federal government pays for 90 percent of a Medicaid expansion in South Carolina, and provides premium subsidies to hundreds of thousands more, that more money will flow into South Carolina health care providers — it will. We are also not debating that coverage contributes to health — it does.

We *are* arguing that because states are very different in their economic and social development, credible arguments exist for alternatives strategies and investments to improve health. The authors of *Getting Health Reform Right* [11] observe that cost-benefit analysis is actually benefit-benefit analysis. Every dollar spent to produce a health benefit is a dollar taken from somewhere else that produces another benefit – maybe health or maybe education or public safety.

In his recent *Health Affairs* Blog post [12], David Kindig worries that uncritical calls for increasing health expenditures will "subtly lead many to infer that health care and public health are the only or the main expenditures necessary to improve health." He notes that the IOM's latest report *For the Public's Health: Investing in a Healthier Future* [13] states, "Excessive allocation of national spending on medical care services poses major societal opportunity costs and restricts funding opportunities for other essential sectors such as education, energy, water, transportation, agriculture, and employment."

It will grow jobs

Growth in health care sector employment should not be a goal of health reform. The same argument was made during the prison-building boom, and look where that got us. Much of

health care spending is simple transfer payments within the US economy (although there are net positive and negative states). Spending unnecessarily in the health care sector diverts money that would otherwise be spent creating other jobs that make us more competitive, or producing goods or services to sell overseas that grow income, employment and wealth in the United States.

What if we could produce a magic pill that kept us free of disease as we age until the day we die naturally and peacefully in our sleep? And what if that pill only cost a penny a day to produce and only required 5,000 jobs to supply the world? Would we argue against it because of the millions of lost health care jobs in hospitals, dialysis clinics and nursing homes? I hope not, but that is implication of this jobs argument. We shouldn't be trapped by it.

Expanding now will save money and make it easier to control costs later

Little evidence exists to support this argument. Massachusetts has not experienced the hoped for control in health care costs and the legislature had to again intervene with a public and private price control law. Researchers on the Oregon Health Study [14] found that self-reported health of beneficiaries improved and total costs increased significantly (at least in the short term analysis).

Because the health services sector contains so much excess cost, it is unwise to inject several hundreds of billions of new dollars into the system without first requiring significant delivery system improvements. While some argue this new revenue is needed to help the health system make the transition to higher value, it would just as likely allow it to continue complacently accumulating earnings off of increases in volume rather than digging in on the hard work of lowering cost and improving outcomes. Leverage states now have is lost if they uncritically follow the federal lead in expanding Medicaid without expectations of better performance.

Conclusion

We currently estimate that over the next two and a half years, without accepting the Medicaid expansion, the rate of uninsured in South Carolina will decline from 19 percent to less than 10 percent. This decline is the result of the enrollment of eligible but not previously enrolled children and adults in Medicaid and new private enrollment resulting from the PPACA mandate and federal premium subsidies. This will be a significant but costly reduction in the uninsured that our financing and delivery systems will struggle to absorb.

Further gains in coverage should be funded using excess dollars now in the system. In the intervening time, uninsured individuals who need care should be able to receive it. Billions of dollars currently spent on services for the uninsured can be better organized, including Disproportionate Share Hospital (DSH) and Graduate Medical Education funds, Federally Qualified Health Center funding, public health clinic and other public health funds, and the community benefit not-for-profit health care organizations are required to deliver in return for avoiding income and other taxes.

Reining in out-of-control health care spending to produce health care value for our citizens will be hard work. We believe that South Carolina is up to the task.

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[5] Image: **http://healthaffairs.org/blog/wp-content/uploads/South-Carolina-Figure-21.jpg**
[6] Image: **http://healthaffairs.org/blog/wp-content/uploads/South-Carolina-Figure-3.jpg**
[7] Recently published results *in Health Affairs*:
http://content.healthaffairs.org/content/31/8/1673
[8] *Considerations in Assessing State-Specific Fiscal Effects of the ACA's Medicaid Expansion*:
http://www.urban.org/publications/412628.html
[9] Image: **http://healthaffairs.org/blog/wp-content/uploads/South-Carolina-Figure-4.jpg**
[10] Image: **http://healthaffairs.org/blog/wp-content/uploads/South-Carolina-Figure-5.jpg**
[11] *Getting Health Reform Right* :
http://www.oup.com/us/catalog/general/subject/Medicine/PublicHealth/?view=usa&ci=9780195371505
[12] *Health Affairs* Blog post: **http://healthaffairs.org/blog/2012/08/07/do-you-really-mean-health-expenditures/**
[13] *For the Public's Health: Investing in a Healthier Future* :
http://www.iom.edu/Reports/2012/For-the-Publics-Health-Investing-in-a-Healthier-Future.aspx
[14] Oregon Health Study: **http://www.oregonhealthstudy.org/en/home.php**