DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
Singleton	9-21-12

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 120083	[X] Prepare reply for the Director's signature DATE DUE 9/28/12
2. DATE SIGNED BY DIRECTOR C: Director, Kost, Cuprer (collins) Cleared 11/27/12, letter attached.	[ ] Prepare reply for appropriate signature DATE DUE [ ] FOIA DATE DUE [ ] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			* Deirdra - Tony wants to discuss ASAP.
2.			
3.			
4.			

JOHN W. MATTHEWS, JR.
SENATOR, ORANGEBURG
BAMBERG, BERKELEY, CALHOUN,
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SENATORIAL DISTRICT NO. 39

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September 18, 2012

Mr. Anthony Keck, Director
S.C. Department of Health and Human Services
P.O. Box 8206
Columbia, S.C. 29202

Dear Mr. Keck:

In June, the U.S. Supreme Court decided the constitutionality of the Affordable Care Act (ACA). As a result of the ruling, in the coming months, states, including South Carolina, will decide whether to expand Medicaid eligibility as originally envisioned under ACA.

With Medicaid expansion now being an option for states, it is imperative that I and other members of the General Assembly have accurate information on the advantages and disadvantages, residents impacted and legislative process by which the state must formalize its decision. To assist me in my decision-making process, I am requesting:

- **Information on those potentially affected.** Your agency has identified three categories of individuals potentially affected by expansion. They were identified as: childless adults, low income families and the aged, blind and disabled. Please provide numbers and demographic information – by category – on those currently being served as well as for those who may be served – by category – if eligibility were expanded to 138 percent of federal poverty level.
- **An overview of the legislative steps needed should the state opt to expand.** Please detail the roles you, the governor and the General Assembly would play in formalizing a decision. Discuss whether the option for Medicaid expansion would require stand-alone legislation or could be accomplished via budget proviso. If the state declined Medicaid expansion, would the federal government have to be notified of that decision?
- **Information on the impact the state's decision will have on disproportionate share payments.** I am aware disproportionate share payments are set to decline under ACA. Please provide information on how those payments will be or may be impacted by the decision to expand Medicaid eligibility. Will it help or hurt the state in the long run?
- **A summary as what you see as the advantages and disadvantages of South Carolina expanding Medicaid eligibility at this time.**

I thank you in advance for your prompt attention to this matter. If you have any questions, please contact my office at (803) 212-6056. You also may contact DeAnne Gray, Director of Senate Minority Research, at (803) 212-6632 or by e-mail at deannegray@scsenate.gov.

Thank you for all you do for the people of South Carolina.

Sincerely,

John W. Matthews, Jr.

JWMjr/vrt

South Carolina Department of
Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

To Close
Log 83

November 27, 2012

The Honorable John W. Matthews, Jr.
South Carolina Senate
Post Office Box 142
Columbia, South Carolina 29202

Dear Senator Matthews:

I apologize for the delay in response to your letter. A number of the items you requested have been in the process of analysis and revision in preparation for Senator Peeler's Medical Affairs committee meeting tomorrow.

We will have the response to your request completed by Friday of this week. I look forward to seeing you and other members of the Black Caucus on December 13, 2012.

With best regards,

Anthony E. Keck
Director

Office of the Director
P. O. Box 8206 Columbia South Carolina 29202-8206
803) 898-2504 Fax (803) 255-8235

South Carolina Department of Health & Human Services

Anthony E. Keck, Director
Nikki R. Haley, Governor

To Close
Log 83

November 30, 2012

The Honorable John W. Matthews, Jr.
South Carolina Senate
Post Office Box 142
Columbia, South Carolina 29202

Dear Senator Matthews:

Thank you for your interest in the issue of the optional Medicaid expansion included in the Affordable Care Act (ACA). As part of our goal to purchase the most health for the least amount of money for South Carolina, we have been working diligently to understand the implications and impact of this decision – a decision all states are now facing.

For our state, we want to ensure an inclusive, transparent process, so the public can stay updated and state leaders can make informed decisions. The Department of Health and Human Services (SCDHHS) has been in discussion with state stakeholders, and has shared data as it becomes available. Much of the information and data related to the Affordable Care Act is still incomplete, pending new policy and regulations yet to be formulated. This past July, the Department hosted a public forum to examine the data surrounding this issue – so everyone can understand the assumptions, calculations, and findings currently guiding the Department. This week, Director Keck appeared before the Senate Medical Affairs Committee to further discuss issues related to ACA. And this Monday, December 3rd, the Department has scheduled another public forum to discuss the impacts of ACA, which we invite you to attend. SCDHHS' presentations before legislative bodies and other materials are being posted on the SCDHHS' website.

You asked about the legislative steps required related to South Carolina's Medicaid expansion decision. We suspect much discussion will be devoted to this issue during the upcoming Legislative Session – thus the Department's role as a source of reliable information will be vital to support the process.

Regarding hospital Disproportionate Share (DSH) payments, the ACA directs the Secretary of the US Department of Health and Human Services (USDHHS) to reduce DSH allotments to the states. However, no rules or guidance have been published on how the reductions will be applied. Should the amount allocated to SCDHHS for DSH be reduced and free up state funds, that state funding will not leave the system. These state funds may be used to draw down federal Medicaid funding for rate increases, incentives and/or other allowable Medicaid expenditures.

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You also asked about the populations potentially affected by a Medicaid expansion. We have provided the attached three slides: The Uninsured in South Carolina; ACA's Medicaid Expansion: A New Eligibility Floor; and Medicaid Expansion in SC: 1.7 Million Enrollees by 2020 which address the populations affected. However, we are still gathering demographic data on these populations.

The potential impact on people in these current categories, with a Medicaid expansion, is as follows:

Potential impact of the optional Medicaid Expansion – 351,000

- 252,000 (newly eligible parents/childless adults)
- 92,000 (newly eligible parents/childless adults who drop insurance to go on Medicaid – "crowd out")
- 7,000 (SSI)

In addition to the potential expansion of 351,000 people listed above, there are mandated changes that will affect the state's Medicaid rolls, even without a Medicaid expansion. These changes are as follows:

Impact of *currently* eligible individuals but unenrolled in Medicaid—162,000

- 101,000 (crowd-out children/parents currently eligible)
- 13,000 (eligible but unenrolled children)
- 48,000 (eligible but unenrolled parents)

As we receive further guidance from the federal government and additional analysis, these assumptions and forecasts will continue to be refined and updated.

The cost of our current Medicaid program is already diverting vital state funds from other needs. The preliminary Medicaid budget needs for FY 2014 would require all of the new available state funds. Our strained health delivery system has to address capacity and access issues to prepare for even more patients with insurance cards (Medicaid or private insurance). These are the specific conversations we are having now and plan to continue having during Session.

You requested a summary of the advantages and disadvantages we see in regard to expanding Medicaid. We are enclosing copies of recent articles Director Keck wrote for the *Health Affairs* blog and the *Washington Post*, further exploring these issues in light of South Carolina's circumstances. Additionally, Director Keck will be meeting with the Legislative Black Caucus on December 13th and looks forward to further discussing these very important issues at that time.

Thank you for your letter, and your support of the Medicaid program.

Sincerely,

Deirdra T. Singleton
Chief of Staff

Attachments

The Uninsured in SC

South Carolina Health & Human Services

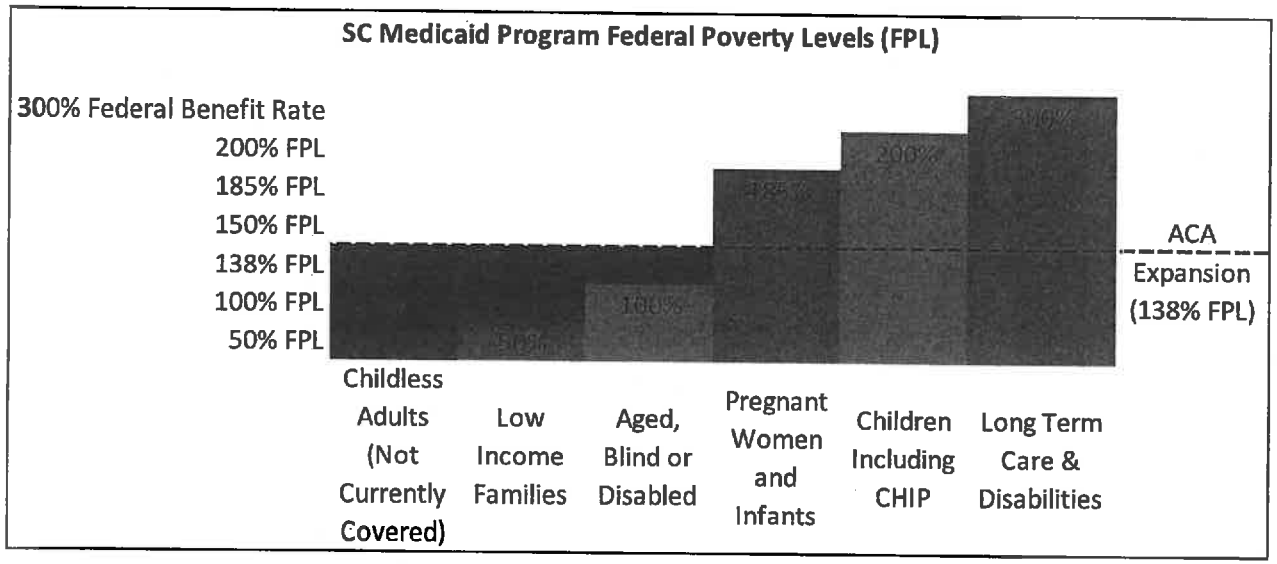
ACA's optional Medicaid expansion would cover up to 138% FPL

FPL	<100% FPL	100% FPL to 138% FPL	139% FPL to 200% FPL	201% FPL to 399% FPL	>400% FPL
2012 Annual Income - Family of 4	<$23,050	$23,051 to $31,809	$31,810 to $46,100	$46,101 to $69,150	>$69,150
Uninsured	284,000	106,000	131,000	127,000	83,000
% of Uninsured	39%	15%	18%	17%	11%

* Source: 2011 American Communities Survey, projected to 2014

ACA's Medicaid Expansion: A New Eligibility Floor

South Carolina Health & Human Services



The red areas represent the population that would be covered by ACA's optional Medicaid expansion

Medicaid Expansion in SC: 1.7 Million Enrollees by 2020

South Carolina Health & Human Services

Projected Enrollment Growth			
Population	**FY 2013**	**SFY 2014**	**FY 2020**
Current Programs			
Medicaid	938,000	985,000	1,077,000
CHIP	70,000	74,000	80,000
Total Current Programs	**1,008,000**	**1,059,000**	**1,157,000**
After ACA - 67% Average Participation			
Expansion Population (Newly Eligible)			
Uninsured Parents/Childless Adults		252,000	267,000
Currently Insured Parents/Childless Adults		92,000	98,000
SSI		7,000	8,000
Eligible but Unenrolled in Medicaid*			
Currently Insured Children/Parents		101,000	107,000
Uninsured Children		13,000	14,000
Uninsured Parents		48,000	51,000
Total Expansion from ACA Participants		**513,000**	**545,000**
Total Medicaid Population After ACA	**1,008,000**	**1,572,000**	**1,702,000**

* Estimates indicate that 162,000 people currently eligible but unenrolled will enroll in Medicaid even without the Medicaid expansion

Source: Milliman ACA Impact Analysis

If SC Chooses to Expand Medicaid:

193,000 could drop private insurance to go on Medicaid

Over 50% increase in SC Medicaid program if the state expands Medicaid

One-third of the state could be on Medicaid in the coming years

- Health Affairs Blog - http://healthaffairs.org/blog -

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 | 4 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.

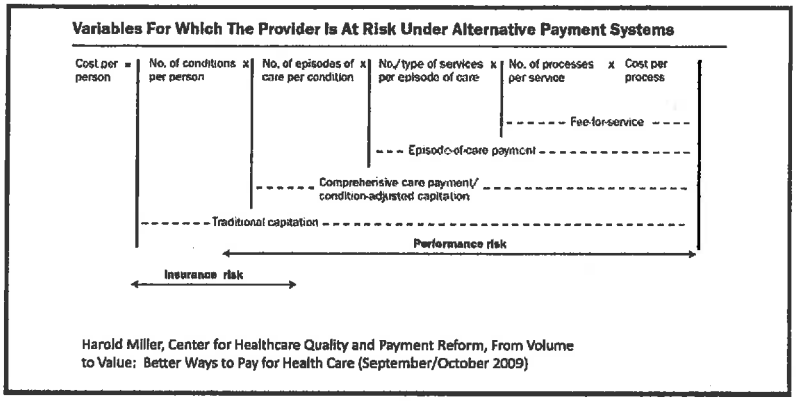
Second, we recognize the United States spends more money per person on health care services than any country in the world. If this spending resulted in better health than the rest of the world, we might tolerate this cost. But we know we are often less healthy than our counterparts in other developed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



[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

SCDHHS Strategies to Improve Value

Payment Reform
- MCO Incentives & Withholds
  - Birth Outcomes
  - HEDIS quality measures
  - Patient Centered Medical Homes
- Payor-Provider Partnerships
- Catalyst for Payment Reform
  - Bundled/Global payments
  - Transparency tools
- Value Based Insurance Design

Clinical Integration
- Dual Eligible Care Coordination
- Patient Centered Medical Homes
- Telemedicine/Monitoring
- GME Accountability

Hotspots & Disparities
- Birth Outcomes Initiative
- Foster Care Coordination
- Health Access/Right Time (HeART)
  - Convenient Care Clinics
  - Community Health Workers

[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

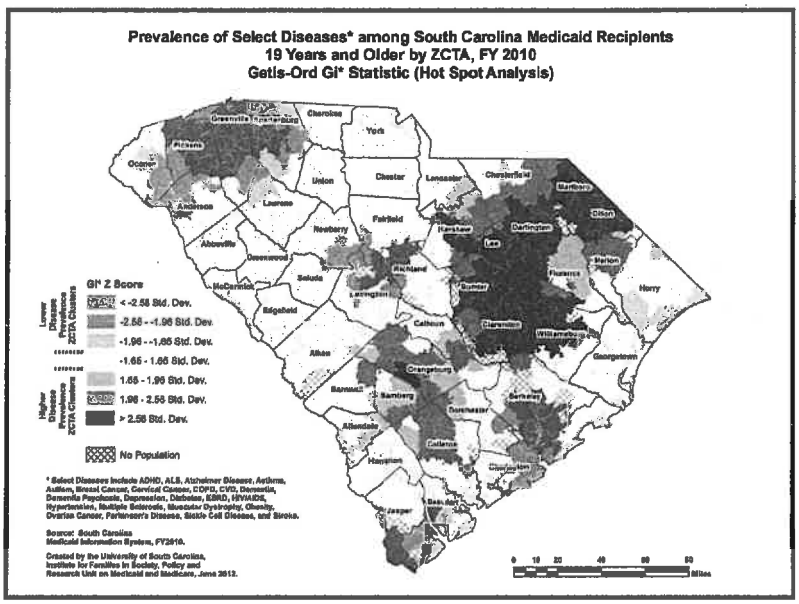
South Carolina is one of 15 states working with the Medicare-Medicaid Coordination Office on a demonstration to better manage our large number of dual eligible individuals. Developed with stakeholders, our proposal emphasizes multidisciplinary care teams that integrate physical and behavioral health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

URLs in this post:

[1] Charles Milligan's earlier : **http://healthaffairs.org/blog/2012/08/29/expanding-medicaid-the-smart-decision-for-maryland/**
[2] a recent study: **http://content.healthaffairs.org/content/31/8/1673.abstract**
[3] *The Healthcare Imperative: Lowering Costs and Improving Outcomes*: **http://iom.edu/Reports/2011/The-Healthcare-Imperative-Lowering-Costs-and-Improving-Outcomes.aspx**
[4] Image: **http://healthaffairs.org/blog/wp-content/uploads/South-Carolina-Figure-1.jpg**
[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**

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print

South Carolina's Health and Human Services Director on why his state might sit out the Medicaid expansion

By Ezra Klein , Updated: July 13, 2012

We've written a lot here at Wonkblog about whether the states will end up participating in the Affordable Care Act's Medicaid expansion (see this article from Sarah Kliff, or this column that I wrote). One of the states that everyone agrees is most likely to sit the program out, at least in the near term, is South Carolina. Tony Keck, director of Health and Human Services for South Carolina Gov. Nikki R. Haley, sent along these thoughts, which he's given us permission to print in full.

Since the Supreme Court's ruling on the Affordable Care Act, there has been considerable commentary that states contemplating rejecting the ACA expansion would be foolish for doing so because the 90% federal match is simply too good to pass up. This argument, however, falls into a classic trap in cost-benefit analysis by comparing a program's attractiveness against an arbitrary benchmark instead of comparing it against its other alternatives. And when governing a state, there are many alternatives.

In South Carolina, for example, the simple inflationary/natural enrollment growth in Medicaid for this coming fiscal year is $66 million state dollars – about the same amount of money the legislature struggled over when considering a small-business tax cut, close to double state-only spending on pre-K education (S.C. is ranked 11th on access and 39th on per pupil spending), and close to double the new state general funds required to keep the state pension fund solvent after other reforms.

I'm afraid that many of those concerned with social justice have been bamboozled by the idea that health = health services = health insurance promoted by those who politically or financially benefit from continual increases in health care spending. It is not such a straightforward equation. The social determinants of health model suggests that somewhere between 80-90% of health and well-being of individuals and their communities are driven by factors such as income, education, race, social support systems, genetics, personal choices and environmental conditions. Health services make up the remaining balance.

Yet in last year's Institute of Medicine roundtable summary, "The Healthcare Imperative: Lowering Costs and Improving Outcomes," participants lamented that out-of-control health care sp ending is destabilizing the health care system, depressing growth in national wages and employment, and forcing states to divert money from other important programs such as education. Thus we have a vicious cycle where out-of-control spending on the 10-20% displaces potentially more effective spending on the 80-90%.

So there are valid arguments for why this expansion decision should ultimately rest with the states. For one, the Court determined it was unconstitutional otherwise. But just as importantly, because states are different. South Carolina is not Massachusetts or Vermont no matter how desperately the think tank crowd would want it to be. We have wildly different rates of poverty, educational attainment, racial mix and economic bases which are the primary drivers of health. Massachusetts was 93% insured prior to their reforms because of their wealth; they weren't wealthy because they were 93% insured.

I think it's fair for South Carolina and other states to want to debate catching-up on much needed investments and policy to increase per capita income and education levels before setting in concrete that health care services are the number one spending priority. And in South Carolina we are doing a pretty good job when you look at our recent economic wins – Boeing, GE, BMW, Bridgestone, and Google to name a few. This certainly isn't to say that South Carolina isn't investing in and improving Medicaid and our health system in general. While many states, (including ACA supporters) have implemented drastic cuts in Medicaid this coming fiscal year, South Carolina allocated an additional $345 million state funds to the program, including $29 million to identify and enroll an additional 70,000 eligible children under 133% poverty, $12 million to reward physicians practicing in patient centered medical homes and $4 million to incentivize leading edge approaches to better birth outcomes. With these new investments, and almost one in four South Carolinians receiving Medicaid last year, it's simply a false generalization to accuse the state of lack of concern.

So 90% federal match requiring an additional $1.1 billion to $2.3 billion state dollars between 2014 and 2020 is not a slam-dunk for South Carolina. If match rate were the most important measure of good policy, then every state should build a massive Medicaid program with the richest benefits, fewest cost controls and most generous eligibility limits possible. But not even President Obama envisioned that. He drew the line of government's generosity somewhere – some would draw it higher and others would draw it lower. Those who attach their measure of morality and compassion to that line should be cautious – there is always someone willing to claim higher ground.

Anthony (Tony) Keck is Director of Health and Human Services for South Carolina Governor Nikki R. Haley. He has over 24 years of experience in health care management, consulting, and policy in the United States and Latin America. Prior to his appointment in South Carolina, Keck served three years in the administration of Louisiana Gov. Bobby Jindal as health and social services policy advisor to the governor, and chief of staff and deputy secretary of the Louisiana Department of Health & Hospitals. He holds both a Bachelor of Industrial & Operations Engineering and Master of Public Health from the University of Michigan and is completing his doctoral thesis in health systems management at the Tulane University School of Public Health focusing on physician workforce issues.

- Health Affairs Blog - http://healthaffairs.org/blog -

The ACA Threatens Access To Care For Medicaid Patients

Posted By Anthony Keck On November 14, 2011 @ 2:45 pm In Access,All Categories,Health Reform,Medicaid,Physicians | 1 Comment

It was recently reported [1] that a study in the Annals of Internal Medicine [2] found, contrary to expectations, that demands on safety-net providers in Massachusetts have actually increased as a result of moving to a full coverage model. While the study concludes that patients choose to use safety-net providers because of affordability and convenience, the underlying story could be more about the choices of the providers, not the patients.

A large number of non safety-net hospitals and physicians now see Medicaid patients because they frankly have no other choice. Nationally about one in three persons is on Medicaid or uninsured, and Medicaid and Disproportionate Share Hospital payments for the uninsured generally cover more than marginal costs. It currently makes financial sense for hospitals and physicians to fill excess capacity with these patients.

With expansion of coverage in the private sector – under an individual mandate or otherwise – these providers *will* have a choice. A large number of the previously uninsured will become covered under commercial plans that will almost surely pay higher rates than Medicaid. The economically rational decision for providers, especially those without a specific safety-net mission, will be to shift their attention from Medicaid patients to more generously reimbursed commercially insured patients. These providers will no longer have the financial imperative to be as affordable or convenient to patients with a Medicaid card.

When this happens, traditional safety nets can expect to see a greater share of the total Medicaid population and the remaining uninsured. This is happening in Massachusetts as emergency room visits have increased and safety-net providers such as community health centers report large increases in Medicaid patients in general.

Federal health reform extends the Massachusetts dynamic nationally. Not only will providers shift away from the current Medicaid population; the new Medicaid expansion population will arrive with many fewer providers to serve them. If Massachusetts is feeling these effects with a high number of primary care doctors per capita and a small uninsured gap to fill, imagine the problem facing South Carolina and others states which have the opposite problem – too few primary care doctors and too many uninsured.

As demand outstrips supply we can expect large increases in waiting time for services and a price war for providers between Medicaid and commercial insurers. Regardless of the administration's arguments, little in the Affordable Care Act (ACA) addresses this dynamic. Increases in primary care physician fees, funding for Federally Qualified Health Centers, and national health services corps slots don't build any new physician capacity; they only drive more competition for limited physicians and fuel a price war. It is likely the administration is relying on the Independent Payment Advisory Board and their new premium rate review power over private insurance to try to control prices, but waiting lines and an increased reliance on the emergency room will be a new fact of life.

Government price controls are tough medicine to administer and swallow – ask any Medicaid director who fights the battles. The Supreme Court case on California's rate reductions should serve as a warning shot over Medicaid's bow. The Centers for Medicare and Medicaid Services, even in the absence of final "access" rules, is already clamping down on proposed rate changes necessary to balance many state budgets. This is at the same time that both the President and Congress are contemplating shifting more costs to the states through changes to the "FMAP" (Federal Medical Assistance Percentages) formula, as well as limits on provider taxes and the Disproportionate Share Program.

Having talked with hundreds of physicians in South Carolina since last January and thousands of physicians over my career, I think we are dangerously underestimating their frustration with the system and overestimating their willingness to "get with the program." Government can't force physicians to work more hours, choose a career in primary care more often, stay in rural areas, or see more Medicaid patients, and we can't easily augment physician capacity through telemedicine, practice changes, and other means in the short timeframe mandated by ACA.

The President should recognize in ACA what he already has in No Child Left Behind: Good intentions at the federal level are nothing without the ability to execute at the local level. He should grant states ACA waivers based on progress toward mutually negotiated health improvement goals before the inevitable occurs – not after. Otherwise I'm afraid the unintended consequences of the President's plan will be to widen health disparities, not narrow them. Poor folks do not traditionally win battles for limited resources, but that battle it is exactly what this plan is bringing.

URLs in this post:

[1] reported: **http://www.medscape.com/viewarticle/750853**
[2] a study in the Annals of Internal Medicine: **http://archinte.ama-assn.org/cgi/content/abstract/171/15/1379**