POLICY PERSPECTIVES

Volume 3, No. 2
September 2003

South Carolina Consumers and Medicaid Reform

The South Carolina General Assembly is currently considering a series of proposals to change our state's Medicaid system. Since 1994, Medicaid spending has grown from under $2 billion to over $3.5 billion per year while total state spending has grown from $7 billion to $13 billion. The growth rate in Medicaid spending in South Carolina dropped from 12 % in FY '01-'02 to FY '02-'03.

In 2003, the House of Representatives passed H. 3768, "South Carolina Health and Human Services Reorganization and Accountability Act of 2003." That legislation attempts to limit growth in Medicaid spending by combining structural reorganization with program changes, commercialization and spending caps.

The focus of some members of the General Assembly has been on limiting Medicaid spending. That is a shortsighted view.

The real question is: "**How do the United States and South Carolina ensure that everyone in our state has affordable access to quality health care.**" The far too limited Medicaid eligibility levels, coupled with problems in the health care delivery and insurance markets, leads us to a situation in which far too many South Carolinians are unable to access affordable, quality health care.

What is Medicaid?

Medicaid is South Carolina's grant-in-aid program by which the federal and state governments share the cost of providing medical care for needy persons who have low income. Unlike Medicare, the federal health program for senior citizens, Medicaid is a needs-tested program.

Medicaid is not a single program, but a collection of medical care programs. Twenty-eight are mandatory programs required by the federal government as a condition of state participation. Twenty-one others are optional. All carry a federal match for state dollars, averaging $2.33 in federal money for every state dollar expended.

Medicaid in South Carolina Covers

- 20 % of population
- 50 % of all births
- 40 % of all children
- 33 % of all seniors
- 75 % of all nursing homes beds

Category	% of Enrollees	% of Spending
Children	31	11
Pregnant Women & Infants	6	9
Low-Income Families	37	16
Disabled	13	41
Elderly	13	23

Source: SCDHHS Director Robert Kerr Presentation to Gov. Mark Sanford, July 24, 2003

South Carolina has not been the only state experiencing growth in Medicaid costs because of a poor economy, which has pushed more children and non-disabled adults onto the rolls and rising health care costs–especially for prescription drugs. Forty-two percent of the increase in FY2003 Medicaid costs came from pharmacy costs. Other contributors to cost increases were hospitals (17 %), physicians (11 %), managed care (10 %), nursing homes (10 %), clinics (6 %) and SMI premiums (4 %).

Medicaid costs of care, however, have grown significantly more slowly than those for private health insurers. (John Holahan and Brien Bruen, "Medicaid Spending: What Factors Contributed to the Growth Between 2000 and 2002?" (Kaiser Commission on Medicaid and the Uninsured, September 2003; http://www.kff.org/content/2003/4139/4139.pdf)

MEDICAID SPENDING CAPS AND ELIGIBILITY LIMITATIONS

The House-passed [H. 3768](), "South Carolina Health and Human Services Reorganization and Accountability Act of 2003," imposes a self-executing cap on Medicaid spending " . . . so as to not exceed an amount equal to the percentage growth of the state's general fund revenue for that fiscal year as estimated by the Board of Economic Advisors." Given recent growth rates in Medicaid costs a cap tied to state General Fund revenues could quickly put the state out of compliance–and out of the Medicaid business–by forcing elimination of required programs.

Medicaid Caps Are Backwards Economics

Medicaid is counter-cyclical–needed more in bad times and less in good times. "During the [current] economic downturn, Medicaid has played an important role as a 'counter-cyclical' program that expands to meet rising needs when the economy is weak." As private health coverage fell for both children and working adults as a result of rising unemployment and increasingly inexpensive private health coverage, Medicaid took up some of the slack. Leighton KU, "*CDC Data Show Medicaid And SCHIP Played A Critical Countercyclical Role In Strengthening Health Insurance Coverage During The Economic Downturn*" (Center on Budget & Policy Priorities, October 2003; http://www.cbpp.org/9-23-03health.htm).

A spending cap tied to revenue growth means that we cut the program when we need it most.

The Department of Health and Human Services has already begun efforts to slow spending by raising eligibility levels for low-income families, putting in place more difficult recertification procedures and, we hear, using bureaucratic slowdowns to keep the rolls lower. In the past year, HHS removed 100,000 South Carolinians from the rolls. Enrollment[1], however, has not declined because of the economy. Many–probably the vast majority–of the clients who have not been recertified are still eligible to reenroll for Medicaid services. When those citizens need services, they will reenroll.

Optional Isn't Optional. Listening to some commentators would lead you to believe that government faced with tight economic times should do as we do in our families–just tighten our belts. There are three problems with this analysis. First, the so-called optional Medicaid services are not optional to anyone receiving them. We can see from the list of "optional" services and groups that these programs are only "optional" in a bureaucratic sense that the federal law won't shut you down if you do not have this program. These programs are not "optional" for the South Carolina citizens receiving the life-saving and life-enhancing services paid for through Medicaid.

"Because few Medicaid beneficiaries have access to alternative sources of insurance, beneficiaries in states that are reducing eligibility are likely to become uninsured. Reducing the benefits Medicaid covers or imposing relatively substantial cost-sharing charges may leave beneficiaries unable to obtain the medical services they need." ("State Budgets Under Stress: How are States Planning to Reduce the Growth in Medicaid Costs? Preliminary Results based on the Kaiser Commission on Medicaid and the Uninsured 50-State Budget Survey" (July 30, 2002), p. 6, http://www.kff.org/content/2002/20020730/statbudupdate73002.pdf)

The State Would Have to Pay for Many Services with Unmatched Dollars. Second, many of the recipients of these Medicaid funded services are in state institutions or wards of the state. The 1,300 foster children, for example. DSS has to provide medical services with or without Medicaid. Without Medicaid, the state has to pick up the whole tab without the federal government's Medicaid contribution. Nearly all of the Department of Disability and Special Needs' budget and more than half of the Department of Mental Health's budget is Medicaid dollars. State agencies represented $848 million of the 2003 Medicaid budget. Without Medicaid, unmatched state dollars would have to cover both the state contribution and the federal match.

[1] SCDHHS calls persons enrolled in Medicaid "eligibles". It helps hide the fact that many thousands of South Carolinians who are legally eligible for Medicaid services are not receiving them. When the SCHIP program was instituted, SCDHHS grossly underestimated potential enrollment because they had failed to appreciate that many thousand children eligible for the regular Medicaid program were not enrolled. Outreach programs for Partners for Healthy Children (SCHIP) signed up more children who had previously been eligible but unenrolled.

Estimated Impact of Optional Services and Groups South Carolina Medicaid Program					
Services			**Groups**		
Service	**People**	**Dollars**	**Groups**	**People**	**Dollars**
Pharmacy	250,000	$70 million	Aged, Blind & Disabled	49,700	$89 million
Silvercard	66,000	$23 million	SSI – Medical Assistance Only	20,000	$10 million
Nursing Home Intermediate Care Facility	6,000	$65 million	State Children's Health Insurance Programs (SCHIP)	43,000	$10 million
Community Long Term Care	12,000	$29 million	Foster Care	1,300	.25 million
Durable Medical Equipment	70,000	$14 million	Katie Beckett (disabled children)	2,300	$2.8 million
Hospice	500	$1 million	Optional State Supplementation (OSS)–community residential care	2,000	$11 million
Licensed Professional	140,000	$5 million	Working disabled	80	.2 million
			Breast & Cervical	90	.2 million

The Hidden Tax–Moving Costs Off the Medicaid Budget Just Moves Them Somewhere Else. The business community in South Carolina has been very supportive of fully funding Medicaid. That support is not the result of humanitarian zeal but clear self-interest.

Moving citizens off the Medicaid rolls reduces preventive care and early-onset care for the uninsured. Sick people eventually get treatment. That treatment in an emergency room setting or the hospital is substantially more costly than in the office of a primary care physician. Private pay insurers and employers end up eating those costs of uncompensated care as providers shift those costs onto paying customers.

> "When Medicaid is not funded adequately, the costs of the uninsured are simply shifted to the insured through a "hidden tax", in the form of higher healthcare payments and health insurance premiums for individuals and businesses (i.e., private payers). Because the federal government funds 67% of Medicaid spending, through a match of $2.25 for each $1 that South Carolina spends, a cut in South Carolina's contribution to Medicaid means that South Carolina loses significant federal funds it would have otherwise received. Since the lack of ability to pay does not diminish the need for health care, the loss of funding for the cost of health care for the uninsured would have to be funded entirely by individuals and businesses in South Carolina rather than funded 67% by the federal government. Unlike those with insurance who can afford preventive care, the uninsured are more likely to be hospitalized for conditions that could have been avoided, such as pneumonia and uncontrolled diabetes. As a result, the cost of treatment and hospital utilization may increase, since the uninsured will be forced to use more expensive alternatives such as hospital emergency rooms for their care.
>
> GrantThornton, *Analysis of How a Decrease in Medicaid Funding would Increase Cost for Individuals and Businesses in South Carolina* (February 2003).

COST-SHARING AND CO-PAYMENTS

The Department in January will institute co-payments ranging from one to three dollars for many services and twenty-five dollars for inpatient hospitalization. These co-pays do not apply to children under 19, pregnant women, institutionalized persons, and hospice care or emergency services. The policy assumption is that co-pays will inhibit unnecessary care and

reduce reimbursements to providers (who get the co-pay) by $3.6 million. There is little available research on cost-sharing effects, especially with respect to children and persons living below poverty.

As a literature review for the U.S.D.H.H.S. suggests: "Cost-sharing may affect the Medicaid population differently from the general population, because it usually represents a higher proportion of income for that population than other higher income populations." (Anne Markus, Sara Rosenbaum, and Dylan Roby, "CHIP, Health Insurance Premiums And Cost-Sharing: Lessons From The Literature (Prepared for the Health Resources and Services Administration Department of Health and Human Services , Contract No. 98-OA-140506, October 1998, p. 18; http://cms.hhs.gov/schip/lesslit.pdf.)

> "What we know about cost-sharing and children's use of services is that drops due to cost-sharing were observed across all types of insurance for all of the outpatient services under study. Although the evidence shows that cost sharing decreases utilization of unnecessary care, but that cost sharing is not the appropriate mechanism to discriminate between necessary and unnecessary care. Hospitalizations were not affected, except for Medicaid patients who appeared to delay care, which resulted in higher hospitalization rates overall."
>
> Anne Markus, Sara Rosenbaum, and Dylan Roby, "CHIP, Health Insurance Premiums And Cost-Sharing: Lessons From The Literature (Prepared for the Health Resources and Services Administration Department of Health and Human Services , Contract No. 98-OA-140506, October 1998, p. 19; http://cms.hhs.gov/schip/lesslit.pdf.

"A substantial and rigorous body of research has demonstrated that low-income individuals are more vulnerable to the adverse effects of cost-sharing than other groups are. Cost-sharing policies that cause only modest reductions in health care use among middle-class individuals can result in more substantial reductions in health care use and lead to significant adverse health consequences among poorer individuals, especially those with chronic health problems." Leighton Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid" (Center on Budget and Policy Priorities, May 7, 2003, p. 1; http://www.cbpp.org/5-7-03health.pdf)

Cost-sharing leads not only to reduced services but also to longer-term costs with delayed hospitalizations and delayed or avoided preventive care–especially for children. It's penny wise and pound foolish.

MANAGED CARE

A center piece of H. 3768 is a mandatory managed care "pilot" which would require the majority of Medicaid recipients (those in Charleston, Florence, Greenville, Horry, and Richland counties, and in one rural county) to enroll in an HMO-type managed care program or the existing Physicians Enhancement Program (PEP). Managed care of the HMO/PPO variety was the pipe dream of health care cost-containment over the past couple decades. There are only four ways to save money in these systems: 1) cut provider rates through market power; 2) reduce benefits or quality of care; 3) improve health care delivery or 4) manage paper work more efficiently.

> "The bottom line is that expectations of between 5 and 10 percent savings on those enrolled in managed care based on early studies (Hurley et al. 1993 and Holahan, et al. 1998) did not materialize and managed care did not translate into dramatically slower growth in program costs per beneficiary."
>
> Robert Hurley and Stephan Zuckerman, "Medicaid Managed Care: State Flexibility in Action," *Assessing the New Federalism: An Urban Institute Program to Assess Changing Social Policies* (March 2002), p. 29; http://www.urban.org/UploadedPDF/310449.pdf

In the private market, managed care has proven less than perfect as consumers have revolted against reduced services or quality and providers have revolted against inadequate reimbursements and control.

"Early evidence on the implantation of Medicaid managed care [nationwide] shows some improvement in access to a regular provider but more difficulty obtaining care and dissatisfaction with care for managed care enrollees compared to those in Medicaid fee for service." "Medicaid and Managed Care," *Key Facts,* Kaiser Commission on Medicaid and the Uninsured, December 2001; http://www.kff.org/content/2001/206803/206803.pdf

Moreover, managed care has not proven as capable of reducing costs as its adherents had hoped. The failure of HMO/PPO systems to save money over fee-for-service Medicaid is hardly surprising. Medicaid reimbursement rates are already so low that we can expect no savings there. Providers are already at the point of walking. Contrary to conventional wisdom on government inefficiency, Medicaid runs on a 3 % overhead. As SCDHHS Director Robert Kerr noted to the Senate subcommittee looking at H. 3768, the real question with traditional managed care is whether you think that they can administer the program more efficiently than SCDHHS. We can't imagine they can–and turn a profit.

The real advantage to recipients of managed care approaches has been in finding medical homes for recipients. That has been the goal of the PEP program. This reduces emergency room access but also establishes more knowledgeable relationships with providers. PEP has been very successful in some areas and less successful in others where physicians have not participated. SCDHHS has managed to do good work on medical homes outside of managed care arrangements.

SCDHHS is exploring other approaches to health care delivery such as that disease management. The goal is to improve long-term health while avoiding emergency room visits and hospitalizations. As Ashley C. Short, Glen P. Mays, Jessica Mittler, "Disease Management: A Leap of Faith to Lower-Cost, Higher-Quality Health Care" (Center for Studying Health System Change, Issue Brief No. 69, October 2003**;** http://www.hschange.com/CONTENT/607/) note:

> Disease management programs typically identify a population of patients with a specific chronic condition, particularly those such as asthma and diabetes, where well-established, evidence-based treatment guidelines exist and patient self-care and compliance are important factors in managing the condition. Disease management interventions include sending patients educational materials about their condition and reminding them to adhere to prescribed medications or seek a preventive screening. Interventions also often include educational efforts, treatment guidelines and reminders aimed at physicians and other providers.

South Carolina Has Found HMOs Just Cost More . . .

"A preliminary report issued in 2001 indicated the Physician Enhanced Program (PEP) provided more service to Medicaid beneficiaries, reduced hospital and emergency room utilization, and saved the State approximately 7 percent per member over the traditional Medicaid fee-for-service program. The same study indicated the HMO Program maintained hospital or emergency room utilization at the same level as under the traditional Medicaid program while saving the State approximately 1.58 percent. An updated study of the HMO Program completed in September 2002 showed a deterioration in the savings of the HMO Program. A latter study based on calendar year 2000 data indicated *the HMO Program cost $22 more per member per month in 2000 than the Medicaid fee-for-service program.* DHHS requested actuarial review of the results of this study in November 2002 to assess why the HMO program is costing more than fee-for-service."

http://www.dhhs.state.sc.us/InsideDHHS/Bureaus/BureauofHealthServicesandDeliverySystems/Link1644152003.htm

Especially for vulnerable populations, a changed health care delivery system can provide both better health care and, in the end, lower costs. In the short run that may require significant investment. HMO/PPO type managed care is at best a poor bet on achieving those outcomes. The Department should be encouraged creatively to address health care deliver, but not mandated to adopt any particular method or system.

Thus, there are no quick and easy fixes to the costs of ensuring our most vulnerable citizens access to affordable, quality health care.

Commercialization of Eligibility

Among the efforts to limit the number of persons on the Medicaid rolls is in H. 3768, is a requirement for ". . . a pilot project to assess the viability of privatizing the determination and redetermination of Medicaid eligibility. HHS must implement this pilot project in at least four major metropolitan areas of the State and may test both partial and total privatization of the eligibility process. The data must be collected and analyzed to evaluate the integrity of a privatized process."

Federal law requires that a government employee determine Medicaid eligibility. That, in itself, limits options for privatization.

Government privatizes services by contracting out to for-profit businesses, nonprofit organizations or community based organizations. The talk around H. 3768 has assumed that the services would be commercialized–taken over by for-profit businesses.

The research literature on privatization of social services is mixed with respect to both savings and quality. Where there are savings, they have been modest.

"The empirical evidence, limited though it is, suggests that the quality of privatized services might generally be the same or somewhat higher than when these services are provided by the public sector. However, experts note that these analyses may be somewhat biased in favor of the commercial sector. Privatization often occurs only when public services are particularly ineffective, providing a point of comparison that might not be typical of public-sector provision (Nightingale and Pindus 1997; GAO 1996." Pamela Winston, Andrew Burwick, Sheena McConnell, and Richard Roper, *Privatization of Welfare Services: A Review of the Literature* (Mathematica Policy Research, Inc., Submitted to Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, May 2002; http://aspe.hhs.gov/hsp/privatization02/).

If eligibility is privatized, protections needs to be in place so that there are no financial incentives for denying eligibility, that due process and appeals rights are protected and that savings come from better processes and not just from creating more low wage/low benefits jobs in place of state employment. Error rate incentives should apply in both directions–denying benefits to eligible persons as well as granting benefits to ineligible persons.

Emergency Room Visits
It's the System That's Broken

The University of Pennsylvania's Krogman Growth Center's The Nemours Longitudinal Study of Child Health Child Quest 2000 study of Delaware children found: "Emergency room services account for a substantial portion of health care costs. The data identified a number of areas of inappropriate utilization. These costs could be decreased for all segments of the population, and could be substantially reduced by the improvements in care delivery . . . . In addition to the cost of care, there was a substantially increased frequency of medication prescription by ER physicians associated with this pattern of excess ER utilization."
http://www.upenn.edu/krogman/ER.html

Policy makers tend to treat overuse or inappropriate use of emergency rooms by Medicaid recipients as akin to a moral failure. Research, however, clearly indicates that, although increased education of Medicaid recipients would yield lowered ER use, delivery system failures are responsible for much inappropriate ER use. Among strategies recommended by the Tufts Managed Care Institute are:

- Access to office appointments when needed and at reasonable hours. If Bi-Lo only sold groceries from 9 am to 5:30 pm, we'd all be buying groceries at the 7-11 at inflated prices. Some private health plans have profited from rewards for physicians to have extended office hours and same-day scheduling.
- Triage (screening with advice and referral) and telephone services available 24 hours daily.
- Patient education especially for those at high risk of ER use.
- Better communications among the ER and the primary care physician.

"Emergency Department Utilization: Trends and Management" (November-December 2001; http://www.thci.org/downloads/topic1112_01.pdf)

As the Penn study notes: "Medically homeless children demonstrated a pattern of inappropriate emergency room utilization. These children had a significantly increased pattern of utilization of emergency room services for colds, and a decreased overall reporting of asthma/bronchitis, possibly indicating under-diagnosis of an important chronic disease." http://www.upenn.edu/krogman/medhomeless.html Establishing medical homes for patients is a critical aspect of reducing ER use.

RESTRUCTURING

H. 3768 includes a number of structural changes. They make the Department of Mental Health a cabinet agency and move numerous functions among state agencies. Those are not Medicaid reform.

They also create super-audit and super-information technology agencies that may or may not deliver on improvements in cost and efficiency. Most significant is creation of a Joint Legislative Oversight Committee on Medicaid that would have substantial authority over a cabinet agency. The mission statement of the joint committee appears only to be cutting spending. That is not Medicaid reform either.

REAL MEDICAID REFORM

Real Medicaid reform is about many things: improved health care delivery through increased use of medical homes and effective disease management, lowered costs from preventive and early-onset care, strategies to provide timely and effective care outside emergency rooms, and effective leveraging of purchasing power for prescription drugs. Those changes also cut costs in the long term.

Clearly, HHS should continue to pay attention to fraud. However, policymakers should recognize that Medicaid fraud is mostly provider fraud. We do not object to going after recipient fraud–there is just no evidence that there is any money there. An excessive focus on recertification misses the reality that most folks removed from the rolls are still legally eligible. They did not complete paper work on a deadline. They will probably return when they need medical services.

Real Medicaid reform also recognizes that costs of health care are a rapidly growing burden for South Carolina businesses–large and small. Costs of uncompensated care get shifted to those businesses making them less competitive. So, one of the goals of Medicaid reform should be to reduce uncompensated care by keeping as many people on the rolls as possible.

Moreover, poor health and delayed care also undermine the ability of our children to learn and our workforce to be productive. The long-term well-being of our state requires a health care system with broad coverage that encourages healthy children and a healthy workforce.

The long-term smart solution is not Medicaid contraction, but Medicaid expansion to ensure that all of our children have access to affordable, quality health care. The literature is clear that children receive medical care in homes where parents get medical care. That calls for a Medicaid expansion to cover uninsured working poor parents. That also goes a long way to reduce pressures on small business, which are especially hard-pressed to provide health coverage to their employees.

Real Medicaid reform means lessening bureaucratic barriers to enrollment and recertification. If one stop shopping is good enough for foreign corporations, it should be good enough for South Carolina citizens.

So the response to: “Yeh, but how are you going to pay for it?” is simple. We–as taxpayers, as employers, as employees as consumers–are going to pay for it either way. If we pay for it “off-budget” it costs a whole lot more. It is the government finance version of borrowing from title lenders.

So real Medicaid reform is not about limiting coverage and cutting costs but about improving health care delivery systems and expanding coverage to ensure that all South Carolinians have access to quality, affordable health care. Real Medicaid reform is not about chasing the airy hope that HMOs or privatization will save dollars without sacrificing quality. Focusing only on reducing state spending is shortsighted and counter-productive policy that drives up long-term costs while shifting costs onto the private sector and other budget lines without benefit of federal match dollars.

Real Medicaid reform entails a focus on building a quality health care system for all South Carolinians. It is not only the right thing to do; it is the smart thing to do–good public policy and good fiscal policy.

South Carolina Fair Share Policy Perspectives

This is the third *South Carolina Fair Share Policy Perspectives* for 2003. The *Policy Perspectives* are an addition to our regular *Legislative Update* and *Margins of Health*, which go to SCFS members.

Our intention is to explore more fully than the *Legislative Update* format allows important issues facing everyday South Carolinians. We hope to provide a better explanation of the roots of problems and creative approaches to solving them.

South Carolina Fair Share's interests and concerns are broad. This month's subject is Medicaid Reform. Future Perspectives will cover the variety of consumer and family issues that occupy our advocacy work.

We look to our community to assist us in preparing *Policy Perspectives*. We invite other organizations and persons working to better South Carolina to join us in producing future *Policy Perspectives*. If you have an issue that you think should be a subject of a *Policy Perspective*, please give us a call or e-mail.

South Carolina Fair Share • 1338 Main St.–Ste. 301 • P.O. Box 8888 • Columbia, SC 29202
803-252-9813 • info@scfairshare.org

P.O. Box 8888
Columbia, South Carolina 29202
Address Service Requested