Medicaid

Principles:

- Government should be willing to spend what it is already spending, but in a more rational manner. Hundreds of millions of dollars are spent annually in Georgia on uncompensated care for the uninsured. The uninsured may not have coverage but they do get sick; one way or another, we all pay for their care in a way that is terribly inefficient.
- Money should follow people. It is important to support the institutions and providers that make up Georgia's safety net, but solutions should be people-centered, not institution-centered.
- Innovation requires flexibility and choices. Micromanaging every last detail is a recipe for the status quo.

Facts:

The accompanying table shows the most recent data on the average enrollment and cost per Georgia enrollee for the overall Medicaid program and each major enrollee group. (Spending includes state and federal dollars.)

FY 2015 Medicaid Statistics (State and Federal Dollars)

	Total	Aged/Blind/Disabled	Low Income (Adults)	PeachCare (Children)
Cost	$8,961,150,309	$4,976,383,474	$3,984,766,835	$310,723,284
Average Enrollment	1,807,977	488,999	1,318,587	158,537
Annual Cost per Enrollee	$4,956	$10,177	$3,022	$1,960

Between 2000 and 2015, total Medicaid enrollment nearly doubled, going from 947,000 recipients to 1.8 million recipients. That represents an increase from 12 percent of the state population to 19 percent. Total spending has grown from $3.5 billion to nearly $9 billion.

Recommendations:

- Create a Patient-Centered Approach to the Uninsured
- Expand Access to Primary Care
- Expand Scope of Practice
- Encourage Innovation
- Focus on Wellness

Overview

Medicaid Expansion: Why Georgia Should Pursue an Alternative

The federal Patient Protection and Affordable Care Act (ACA) expanded Medicaid to all individuals under age 65 with incomes up to 138 percent of the federal poverty level (FPL). The U.S. Supreme Court later ruled that states are not mandated to expand Medicaid coverage. As of April 2016, Georgia and 18 other states had chosen not to expand Medicaid.

The citizens affected by this decision in the so-called "coverage gap" are low-income, able-bodied adults who are not eligible for Medicaid and whose income is below 100 percent of the federal poverty level and therefore ineligible for subsidies in the federal exchange. It is estimated by the

White House that approximately 389,000[1] Georgians fall into this category. The Urban Institute estimates that 53 percent are male, 87 percent do not have children, 53 percent are under age 35, 34 percent are between ages 35 and 54, and 13 percent are over age 55.[2]

The discussion revolves around how best to ensure access to health care for these individuals. Expanding the Medicaid program to provide access to care presents several concerns, including uncertainty of funding and costs, the effectiveness of the Medicaid program and the impact on existing Medicaid recipients.[3]

Uncertainty of federal funding

The federal government has promised to pick up 100 percent of the cost of these newly eligible Medicaid recipients for the first three years, dropping to 90 percent by 2020. This compares to a 65 percent match for Georgia's existing Medicaid population. The total cost of expansion is more than $3 billion a year, which is not a trivial amount.

As entitlement spending and interest on the national debt continue to grow in the near future, the federal government will come under increased pressure to reduce funding. Medicaid spending will be a very large target.

Perverse incentives

Even if the federal government keeps its promise to cover 90 percent of the cost, the difference in matching rates creates perverse incentives for policy-makers. Reducing spending on able-bodied adults creates $1 of state savings for every $10 of spending cuts, while reducing spending for low-income mothers creates $1 of savings for every $3 of spending cuts. This puts budget writers in a difficult position during the inevitable next recession. Conversely, new spending on the expansion population would bring nine dollars for every state dollar as opposed to spending targeted at the more vulnerable populations in the current Medicaid population.

Medicaid is already crowding out other state priorities

Georgia is struggling to fund current Medicaid recipients. The state was forced to implement a provider fee increase in 2013 to raise $689 million to fill a Medicaid funding shortfall.[4] As in other states, the growing cost of the existing Medicaid program is already diverting money from other important state priorities such as public safety, education, and infrastructure maintenance and improvements.

Negative impact on access for existing vulnerable populations

A third of Georgia doctors already refuse new Medicaid patients.[5] Adding several hundred thousand more recipients to the program will further strain the system and could negatively impact existing Medicaid recipients: the elderly, the disabled, pregnant women and children.[6]

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[1] White House document published June 2015, http://1.usa.gov/1FwekCI
[2] "Opting in to the Medicaid Expansion under the ACA: Who are the Uninsured Adults Who Could Gain Health Insurance Coverage," Urban Institute, August 2012, http://urbn.is/1pePjdj
[3] "Expanding Medicaid: The Conflicting Incentives Facing States," Mercatus Institute at George Mason University, http://mercatus.org/expert_commentary/expanding-medicaid-conflicting-incentives-facing-states
[4] http://1.usa.gov/1VhmriN
[5] "Study: Nearly A Third Of Doctors Won't See New Medicaid Patients," Kaiser Health News, http://bit.ly/1aqKTGm
[6] The PPACA requirement that primary care physician rates match Medicare rates will expire after 2014.

Increased emergency room use

Excessive use of expensive emergency room care is one reason often cited for the need for Medicaid expansion. But an extensive study in Oregon showed Medicaid recipients utilized the emergency room 40 percent more than the uninsured.[7] A majority of the visits were for non-emergency care. This aligns with other studies showing an increase in emergency room use[8] and charity care costs increasing in states like Maine, Arizona and Massachusetts after Medicaid expansion.[9]

Very little, if any, improvement in health status

The Oregon study showed no statistically significant improvement in physical health outcomes for Medicaid recipients versus the uninsured. The study showed better diagnosis and treatment for depression, but Forbes' Avik Roy notes that this could be accomplished at a fraction of the cost of Medicaid coverage.[10] A separate survey focused on Medicaid expansion in Arkansas and Kentucky also found no statistically significant change in mental or physical health.[11]

Medicaid expansion would triple government spending, produce scant improvement in health outcomes and increase emergency room usage.

Crowd out

As much as a third of the newly insured could be individuals who already have private insurance. According to the Census Bureau,[12] 222,000 Georgia adults under age 65 with income below 100 percent of the FPL are currently covered by private insurance. These individuals (or their employers) would be tempted to drop their private insurance in favor of "free" Medicaid coverage.[13] That is one reason the uninsured rate declined less than expected in many Medicaid expansion states.[14]

Lack of cost-effectiveness

By one estimate, the average uninsured individual consumes approximately $2,000 of health care over the course of a year that he or she does not pay for, much of which is covered by taxpayers.[15] The Georgia Department of Community Health estimated in April 2012 that new Medicaid enrollees would cost almost $6,000 per person in 2016. The White House on June 2015 estimated 389,000 new individuals would be covered by insurance if the state expands Medicaid at a cost of $2.85 billion, or more than $7,300 per newly insured individual. If the findings of the

[7] "Least Surprising Health Research Result Ever: Medicaid Increases ER Use," NCPA, http://bit.ly/1rgfHp4
[8] "Better Health Care Access in Kentucky and Arkansas, Study Says," New York Times, January 5, 2016 http://www.nytimes.com/2016/01/06/us/in-kentucky-and-arkansas-access-to-health-care-improves-study-says.html
[9] "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability, http://bit.ly/1MNQoUJ; "Analysis of hospital cost shift in Arizona," Arizona Chamber Foundation / Lewin Group; "Massachusetts health care cost trends: Efficiency of emergency department utilization in Massachusetts," Massachusetts Health and Human Services
[10] "Oregon Study: Medicaid 'Had No Significant Effect' On Health Outcomes vs. Being Uninsured," Forbes magazine, http://onforb.es/1iZF9I6
[11] "Both The 'Private Option And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults," Journal Health Affairs, https://dash.harvard.edu/handle/1/25156227
[12] U.S. Census Bureau, http://www.census.gov/cps/data/cpstablecreator.html
[13] "Medicaid and Displacement of Private Insurance," Mackinac Center for Public Policy, http://bit.ly/1QkTbzs
[14] "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability, http://bit.ly/1MNQoUJ
[15] "Uncompensated Care for the Uninsured in 2013: A Detailed Examination," The Kaiser Foundation, May 30, 2014, http://kff.org/uninsured/report/uncompensated-care-for-the-uninsured-in-2013-a-detailed-examination/

aforementioned studies are accurate, Medicaid expansion would triple government spending, produce scant improvement in health outcomes and increase emergency room usage.

Access to primary care

One of the central problems with Medicaid is the low reimbursement rates that limit the number of doctors willing to see new patients, causing Medicaid recipients to use hospital emergency rooms, the most expensive place possible, for non-emergency health care needs. Giving individuals Medicaid eligibility without access to primary care is like giving them an ATM card with no money in the account.

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Finding a Way Forward for the Uninsured and Georgia's Safety Net

Georgia, like many states, faces a host of health care challenges: access to care, too many people without health insurance, failing rural hospitals and unsustainable health care spending that is crowding out other priorities – for governments and for families.

The debate over how best to address these challenges has Georgia seemingly stuck between two options: Expand a government program (Medicaid) with its own long list of challenges or do nothing. It is a false choice to believe those are the only options. Georgia has an opportunity to put forth a better solution.

What if Georgia were to become a leader in creating innovative ways to provide better health for more people at lower cost?

What if Georgia could convert the funds spent subsidizing the care for the uninsured after-the-fact into vouchers or refundable tax credits? Low-income individuals could use the funds to buy in to an employer's plan or purchase private insurance. The value of the funds could be adjusted by age and health status, providing purchasing power for older and sicker individuals and creating an opportunity for cost savings by keeping them healthy.

What if these low-income individuals can't find insurance at a price they can afford or if they choose not to sign up? These unused funds should follow the people to where they get their care: the safety net providers in each community. Under such a system, instead of seeing low-income, uninsured patients or patients with Medicaid's low reimbursement rates, rural hospitals and clinics would be seeing patients with private insurance coverage or receiving funds to cover the cost of the care. Even if no one signed up for insurance in the first year, needed funding would immediately flow to safety net providers. Eventually, these newly empowered low-income individuals would create the customer demand for new ways to provide access to affordable health care.

Georgia is an ideal state to allow the powers of disruptive innovation to attack our health care challenges. Georgia is a leader in telehealth and health information technology. At almost any technology incubator in Georgia, one is likely to find a startup company focused on using technology to improve care to people with chronic diseases. Combining these assets in unique ways could make Georgia a leader in solving the nation's health care problems.

Finally, the cost of the this alternative would be less than what the federal government was willing to spend on Medicaid expansion, so Georgia would be in good position to limit the cost to state taxpayers.

Recommendations:

Create a patient-centered approach to the uninsured

- Uninsured, low-income adults would be offered premium assistance (individual amounts risk-adjusted based on age and health status) to enroll in a health care plan that meets minimum standards for primary care and catastrophic coverage.
- Individuals with special needs would have access to additional benefits such as substance abuse treatment, mental health treatment and medication, and case management. Examples include recently released inmates with a high-risk of recidivism without treatment or individuals with a chronic disease.
- If no plans are available at this price or the individual chooses not to sign up, the funds will be distributed to safety-net providers.
- The plan could be funded through a federal block grant and/or Medicaid waiver, but recipients would not be Medicaid recipients subject to Medicaid rules, regulations or maintenance-of-effort requirements. The state would take responsibility for health care outcomes, such as the number of individuals covered and basic quality metrics.

Critical components:

- Access to primary care (the biggest challenge with Medicaid) through a Direct Primary Care[16] arrangement, where possible.[17]
- Catastrophic insurance coverage to protect individuals and taxpayers.
- Personal responsibility: Individuals would contribute to the premium, up to a maximum percentage of their income.
- Engagement: Rewards and incentives focused on those with chronic disease. Compliant individuals may have their deductibles lowered or eliminated.
- Safety net provision: If an individual doesn't "sign up" the funding will be available to safety net providers.
- Commercial availability: Poor have access to the same private plans as everyone else.
- "Braided" payments: In addition to the government subsidy and the required individual contribution, funds can be supplemented by employers, charitable or religious organizations and/or friends and family.

Benefits:

- Improved access to physicians means better, timely care, reducing ER use
- Uses existing funds more effectively
- Access to care and treatment for unexpected, expensive conditions such as cancer
- Stabilizes rural hospitals financially
- Eliminates regulations and price controls
- Requires personal responsibility and involvement
- Showcases market solutions and encourages innovation; if this works for Georgia's poor it could revolutionize health care for the nation
- Does not expand an inadequate entitlement program

[16] American Academy of Family Physicians, http://bit.ly/1nQel17
[17] Direct Primary Care: An Innovative Alternative to Conventional Health Insurance, Heritage Foundation, August 2014, http://thf_media.s3.amazonaws.com/2014/pdf/BG2939.pdf

Comparison of Options:

	Uninsured	Medicaid	Patient-Centered
Access to Doctors	ER	Difficult	Same as Private Pay
Avg. Cost Per Person	$2,000	$6,000	$2,000-$3,000
Quality	Poor	Questionable	Same as Private Pay
Avg. Reimbursement	5% of cost	80% of cost	100%+

Expand access to primary care

Charity Care: Regardless of Georgia's decision on Medicaid expansion, hundreds of thousands of Georgians will remain uninsured. One immediate way to help the uninsured (and save money) is to provide access to primary care clinics instead of expensive and unnecessary trips to emergency rooms. Thanks to leadership and private support, Georgia is a national leader in charity care.[18] Leveraging this great asset should be the first step to helping the indigent and uninsured.[19]

Direct Primary Care (DPC) is, "an emerging model that has gained some attention in California and nationally in recent years.[20] Sometimes referred to as 'retainer practices,' DPC practices generally do not accept health insurance, instead serving patients in exchange for a recurring monthly fee – usually $50 to $80 – for a defined set of clinical services," according to the California Healthcare Foundation.[21]

Writing in Forbes magazine, David Chase[22] explains how DPC could be used for low-income individuals:

> The issue of using DPC for the poor is from my point of view a no brainer. Why use the most expensive inflationary system available (by which I mean the insurance system, whether public or private) to take care of those with the least money and most in need of basic services? The structure that makes sense to me is to create a thriving marketplace in direct primary care, competing on price, access and quality – and working exclusively for our patients. Then add a fixed monthly stipend for primary care for every Medicaid patient in the United States – a stipend that covers the lowest priced/highest functioning primary care available. This could be a voucher or credit card account for each Medicaid patient. The allowance could only be spent on primary care and the patients could buy up to higher priced practices if they saw value worth purchasing. That would convert the Medicaid patient from being a low paying, high utilizing patient to a valued customer who can pay cash for care at a reasonable price. This makes all kinds of sense economically:
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> - No government management system to control or manage care – it manages itself with the patient at the helm
> - Converting dependent impoverished citizens into patients with economic clout and respectful treatment
> - Eliminating the cost overhead of insurance billing on both the physician and the

[18] "Georgia Should Maintain its Leadership in Charity Care," Georgia Public Policy Foundation, February 2014, http://www.georgiapolicy.org/georgia-should-maintain-its-leadership-in-charitable-primary-care-clinics/
[19] "Creating a 'Good Samaritan' Network of Charity Clinics," Galen Institute, October 2013, http://www.galen.org/topics/creating-a-good-samaritan-network-of-charity-clinics/
[20] "More Care Up Front for $54 a Month, New York Times, May 2012, http://nyti.ms/1SiZRjT
[21] "On Retainer: Direct Primary Care Practices Bypass Insurance," California Healthcare Foundation, April 203, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/O/PDF%20OnRetainerDirectPrimaryCare.pdf
[22] "The Marcus Welby/Steve Jobs Solution to the Medicaid-driven State & County Budget Crisis," Forbes, March 11, 2012, http://onforb.es/1IcMQ9o

government side
- No more barriers to basic care for Medicaid patients – they can use all they need
- Eliminating the fee-for-service incentive disaster that produces massive overutilization and huge downstream expenses
- Financially stabilizing the primary care world with consistent monthly fee payments to cover our fixed costs while allowing those docs with better ideas or higher prices to go for the upscale patients or those wanting better art work and longer visits
- Free up primary care docs to further improve their quality, access and patient-centered services – not their billing savvy.

One of the drawbacks of participation in DPC is that physicians are not allowed to treat Medicare patients: Federal laws prohibit charging rates lower than Medicare rates. Unless this federal mandate is waived, it would preclude many rural doctors from participation.

Retail Clinics: Many health care institutions have established after-hours clinics. In addition, the private sector has responded with retail clinics that are often found in grocery stores or other retail settings. These clinics are staffed by nurse practitioners and offer convenient, low-cost primary care services.

Expand scope of practice

Allowing for a reasonable expansion of the scope of practice of advanced practice nurses, dental hygienists and other medical personnel could help enhance critical access to care and address shortages of physicians and dentists in many areas of Georgia.

The Georgia Center for Opportunity made this argument in a recent report.[23]

> Georgia ranked 41st in the country in active physicians and 44th in primary care physicians per capita in 2010. … In 2010, 31 of Georgia's 159 counties did not have an internal medicine physician; 63 did not have a pediatrician; 79 did not have an OB/GYN; and 66 did not have a general surgeon.
>
> Nurse practitioners (NPs) are an important provider of primary care across the country. In many states, NPs evaluate and diagnose patients, order and interpret diagnostic tests, and initiate and manage treatments. A literature review by the National Governors Association found that most studies show that NPs provide comparable care to physicians and achieve equal or higher satisfaction rates among their patients. The review did not find any studies that raised concerns about the quality of care offered by NPs.
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> Georgia's laws and regulations for NPs are more restrictive than almost any other state. A 2007 study ranked Georgia's NP regulations 48th in the country because the state's NP limitations affect patients' freedom to choose providers and NPs' ability to provide primary care. Georgia's restrictions include requiring NPs to be supervised by a physician and to have a collaborative agreement with a physician or a physician's supervisor/delegation in order to prescribe drugs. These limitations do not exist in over one-third of states.

The Pew Charitable Trusts and others have made a similar case to expand access to dental care. Georgia ranks 49th in the nation in the number of dentists per person.

[23] "Increasing Access to Quality Healthcare for Low-Income Uninsured Georgians," Georgia Center for Opportunity, June 2014, http://georgiaopportunity.org/assets/2014/06/Charity-Care-Report.pdf

One proposal would have Georgia join the 45 other states that allow dentists to authorize hygienists to perform preventive care services without the dentist present in a variety of safety-net settings. Legislation to that effect failed in 2016 after dentists campaigned against it.[24]

A recent report published by the Pew Charitable Trusts[25] makes the case for increasing access to quality, affordable dental care by increasing the number of providers who can provide routine care. Currently in Georgia, only dentists are allowed to fill cavities, but several U.S. states and about 50 other countries have authorized a mid-level dental provider (usually called a dental therapist) to fill cavities and deliver other preventive and basic restorative care. These providers play a similar role to that filled by nurse practitioners and physician assistants in medicine.

Encourage innovation

Create an opportunity for the working poor to benefit from innovative options for convenient care such as telehealth, mobile health, direct pay options and concierge services. A recent article in The New York Times[26] echoes other studies showing that for the working poor, a lack of time may be even more important than lack of money.

Focus on wellness

Focus on wellness that includes prevention, early intervention and health management programs that reward and incentivize healthy lifestyles and choices. Plan designs and services should emphasize and assist those who are healthy and want to stay healthy; those who are currently unhealthy and will adhere to provider treatments to stabilize their chronic condition; participants who will engage in medical and lifestyle changes to improve their health status; and patients who want to succeed in full recovery.

[For recommendations on addressing the elderly Medicaid population, see the chapter on Long-Term Care.]

[24] "A dirty deal on dental hygienist legislation," Georgia Health News, http://bit.ly/1peQsS5
[25] "Expanding the Dental Team," Pew Charitable Trusts, June 2014, http://bit.ly/1qX7JRl
[26] "No Money, No Time, New York Times, June 2014, http://nyti.ms/1Wd4Jfg