

MEDICAID OPPORTUNITIES & CHALLENGES TASK FORCE

FINAL REPORT



September 16, 2013

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Report Overview

The Patient Protection and Affordable Care Act (ACA) was passed in 2010 and originally required states, beginning in 2014, to expand their Medicaid programs to most adults under age 65 with incomes at or below 138% of the federal poverty level (FPL). For most states, including South Dakota, the ACA requirements would have required an expansion of their Medicaid program to low-income childless adults. The ACA also provided that if a state failed to expand Medicaid, it risked the loss of all current federal Medicaid matching funds.

States, including South Dakota, challenged the ACA on a number of issues before the U.S. Supreme Court. While the Court upheld, in June 2012, the constitutionality of the ACA, the Court's ruling allowed states to "opt-out" of the law's Medicaid expansion without jeopardizing federal funding for their existing Medicaid Program. As a result, South Dakota and other states were presented with the decision to expand Medicaid eligibility to most adults under 65 with incomes at or below 138% of poverty and accept enhanced federal dollars to fund the expansion, or to decline to expand the program.

In accordance with the Governor's recommendation, the South Dakota Legislature chose not to expand Medicaid during the 2013 legislative session. Instead, Governor Dugaard chose to form a Task Force to evaluate the advantages and disadvantages of expanding health insurance coverage through Medicaid to low-income adults outlined by the ACA, as well as to make recommendations on how best to go about expanding Medicaid should the Governor and Legislature decide to do so. The Task Force was not asked to provide recommendations on whether South Dakota should expand Medicaid.

The 29-member Task Force was comprised of a diverse group of stakeholders, including legislators, physicians, behavioral health providers, dentists, community health providers, hospital officials, and state agency personnel. Deb Bowman from the Governor's Office chaired the Task Force. The Task Force held four meetings (in Pierre, Rapid City and Sioux Falls) over the period May – August, 2013, evaluating data that estimated the savings, costs, benefits, advantages, and disadvantages to the State, counties, businesses, and South Dakota citizens. The Task Force also prepared this report for presentation to the Governor and Legislature.

As part of its proceedings, the Task Force heard background presentations and reviewed information relating to South Dakota's Medicaid program, the Supreme Court decision that made the Medicaid expansion optional, the basic components of Medicaid expansion relevant to the State's decision, and the status of state efforts to implement Medicaid expansion nationally. In addition, the Task Force reviewed and discussed decisions relating to the possible expansion of the Medicaid Program that are within the purview of South Dakota. These decisions include the timing of a possible Medicaid expansion, the ability of South Dakota retract a decision to expand the program, possible program changes that could be made to Medicaid coverage, and other decision points. The Task Force also discussed analyzed proposed approaches advanced by other states (such as Arkansas and Iowa) to expand Medicaid by using private coverage that will be available through Health Insurance Exchanges established under the ACA in each state beginning in January, 2014.

In addition to reviewing relevant background information, the Task Force evaluated information and data relating to the possible impact of a decision to expand Medicaid on South Dakota's citizens, general fund budget, healthcare providers, businesses, counties, and other stakeholders. For example, the Task Force reviewed estimates of the number of individuals who would be covered if South Dakota moves forward, the characteristics of the expansion population, Medicaid expansion costs and savings, covered services, Medicaid provider capacity, and other important issues. The results of this evaluation process are set forth in the section of the Report titled "Medicaid Expansion Findings."

The Task Force also reviewed and analyzed the various "pros" and "cons" of Medicaid expansion, and has attempted to faithfully and fairly outline "both sides" of the debate within this Report. The Task Force grouped the "pros" and "cons" into the following categories:

- **Impact on Health and Service Utilization.** One of the topics discussed by the Task Force and identified during public testimony was the possible effect of Medicaid expansion on the individual health and well-being of individuals who would receive coverage, as well as the overall effect of the possible expansion on service utilization.
- **Role of Government.** Many citizens provided testimony relating to the wide-ranging impact of the ACA generally and the Medicaid expansion in particular. These arguments reflected disagreement relating to the appropriate role of government to provide health care for citizens, as well as the effect of Medicaid expansion on the current market for private insurance.
- **Economic Impact.** The Task Force spent a significant amount of time evaluating and discussing the economic impact of the possible expansion on the South Dakota economy, taxpayers, health care providers, businesses and counties.
- **"Moral" Issues.** The Task Force also evaluated arguments related to the issues of equity and fairness, resulting primarily from the unintended consequences of the Supreme Court's decision making Medicaid expansion optional for states.

Finally, the Task Force discussed and identified recommendations relating to the implementation of Medicaid expansion, in the event that the Governor and Legislature decide to move forward. Specifically, the Task Force developed recommendations relating to the timing of a possible expansion, recipient cost-sharing, payment reforms, health workforce capacity, and other important topics. The Task Force also developed recommendations on how best to structure legislation that would implement the expansion.

I. Introduction

Governor Dennis Daugaard appointed the Medicaid Opportunities and Challenges Task Force to evaluate the advantages and disadvantages of expanding health insurance coverage through Medicaid to low-income adults outlined by the ACA, as well as to make recommendations on how best to go about expanding Medicaid should the Governor and Legislature decide to do so. The Task Force was not asked to provide recommendations on whether South Dakota should expand the Medicaid program.

In accordance with the Governor’s recommendation, the South Dakota Legislature chose not to expand Medicaid during the 2013 legislative session. In making this decision, the Governor noted that “due to all the uncertainty surrounding the federal budget and federal health reforms taking effect in 2014, it would have been hasty to proceed with expansion this year.” Instead, Governor Daugaard chose to form a Task Force because it was important “to gather all the information in order to ensure that South Dakota makes the best decision possible based on data and facts.” Many other states have established similar work groups to perform an analysis of this issue, and to provide factual findings to aid the decision-making process. A deadline of September 15, 2013 was identified for the Task Force to issue its Final Report.

Purpose of the Task Force

To evaluate the “pros” and “cons” of Medicaid expansion, as well as to identify recommendations on how best to implement the program in the event that South Dakota decides to expand Medicaid.

The 29-member Task Force was comprised of a diverse group of stakeholders, including legislators, physicians, behavioral health providers, dentists, community health providers, hospital officials, and state agency personnel. Deb Bowman from the Governor’s Office chaired the Task Force. A full list of the Task Force members is included below.

Task Force Member	Organization/ Position
Dr. Rob Allision	Primary Care Physician – Immediate Past President of the SD State Medical Association
Representative Julie Bartling	Democrat (District 21 - Bon Homme, Charles Mix, Gregory, Tripp)
Deb Bowman, Chair	Senior Advisor to the Governor - Governor’s Office
Representative Justin Cronin	Assistant Majority Leader – Republican (District 23 - Campbell, Edmunds, Faulk, Hand, McPherson, Potter, Spink, Walworth)
Terry Dosch	Executive Director - SD Council of Mental Health Centers
Representative Dan Dryden	Republican (District 34 – Pennington)
Dan Ellis	Independent Hospital Administrator - Coteau Des Prairies Hospital
Dixie Gaikowski	Director, Office of Resource Management - Indian Health Services
David Hewett	President - SD Association of Health Care Organizations
Paul Knecht	Executive Director - SD Dental Association
Kim Malsam-Rysdon	Secretary - Department of Social Services
Eric Matt	Policy Analyst - Governor’s Office

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Representative Mark Mickelson	Republican (District 13 - Lincoln, Minnehaha)
Senator Deb Peters	Republican (District 9 - Minnehaha)
Dr. Leah Prestbo	Primary Care Physician
Senator Tim Rave	Assistant Majority Leader – Republican (District 25 - Minnehaha)
Joe Sluka	Executive Vice President & Chief Administrative Officer at Regional Health, Inc.
Fred Slunecka	Chief Operating Officer - Avera Health
Barb Smith	Chief Executive Officer - SD State Medical Association
Kirby Stone	Division Director, Medical Services - Department of Social Services
Senator Billie Sutton	Assistant Minority Leader – Democrat (District 26 - Gregory, Mellette, Todd, Tripp)
Brenda Tidball-Zeltinger	Chief Financial Officer - Department of Social Services
Tony Tiefenthaler	Health Strategy Officer - Sanford Health
Senator Craig Tieszen	Republican (District 34 - Pennington)
Dr. Grant Titze	Dentist – Vice-President, SD Dental Association
Tim Trithart	Chief Executive Officer - Community Health Center of the Black Hills
Gary Tuschen	Executive Director - Carroll Institute
Lynne Valenti	Deputy Secretary - Department of Social Services
Bob Wilcox	Executive Director - SD County Commissioner Association

The Task Force held four meetings (two in Pierre, and one meeting in both Rapid City and Sioux Falls) over the period May – August, 2013, evaluating data that estimated the savings, costs, benefits, and liabilities to the State, counties, businesses, and South Dakota citizens. Numerous background presentations were provided, and several Task Force members shared information on the effect of a possible decision to expand Medicaid on their organizations. The Task Force also solicited public testimony during the meetings. In addition, the Task Force reviewed and evaluated national research findings and studies relating to the possible impact of expanding Medicaid, and tracked the decisions of other states relating to this topic. All of the Task Force meeting agendas, presentations, and recordings of the public testimony can be accessed through South Dakota's website.⁴

The report is divided into the following sections:

- Section I, **General Background**, provides a basic overview of South Dakota's Medicaid Program and relevant provisions of the ACA.
- Section II, **State Decision Points**, provides a summary of decisions relating to Medicaid expansion that are within the purview of states.

⁴ See the following link to access the meeting agendas, presentations, and recordings of public testimony:
<http://sd.gov/governor/medicaidtaskforce.aspx>

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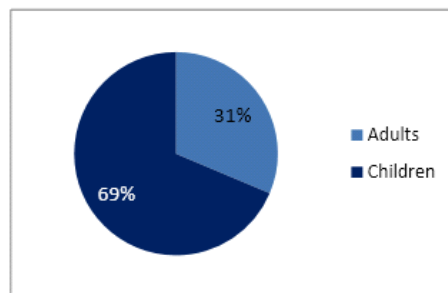
- Section III, **Medicaid Expansion Findings**, outlines the factual findings of the Task Force relevant to South Dakota's decision.
- Section IV, **Medicaid Expansion Considerations**, reviews the "pros" and "cons" of Medicaid expansion identified and discussed by the Task Force.
- Section V, **Implementation Recommendations if South Dakota Decides to Expand**, provides the recommendations of the Task Force relating to Medicaid expansion in the event that the Governor and Legislature decide to expand Medicaid.

II. General Background

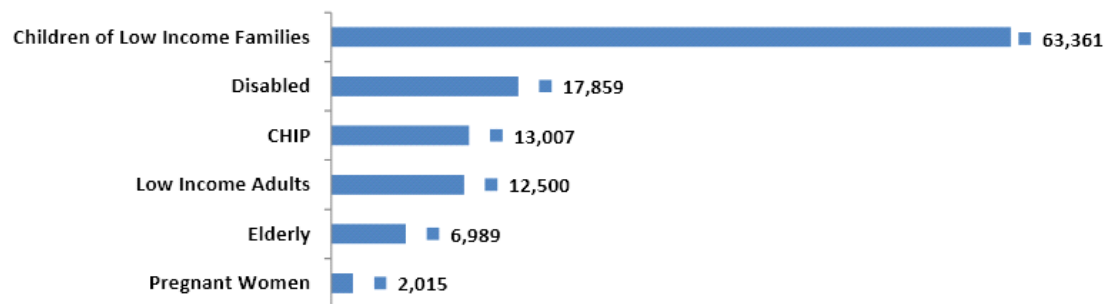
This section of the report “sets the stage” for the rest of the document. Specifically, this section provides background on South Dakota’s Medicaid program to provide context to the discussion, describes the Supreme Court decision relating to the ACA and its effect on Medicaid expansion, discusses the status of states’ implementation of Medicaid expansion nationally, and provides an overview of the basic components of Medicaid expansion.

A. South Dakota’s Medicaid Program

Medicaid is a federal-state partnership that offers medical insurance coverage to certain low-income populations. In South Dakota, approximately 144,373 people were enrolled in Medicaid or CHIP (Children’s Health Insurance Program) at some point during State Fiscal Year (SFY) 2012. On average, approximately 116,000 are enrolled in Medicaid or CHIP each month. Approximately 69% of all enrollees are children from low-income families. South Dakota Medicaid also covers people with disabilities, low-income women who are pregnant, and low-income elderly.



Source: S.D. Department of Social Services (FY 2012)

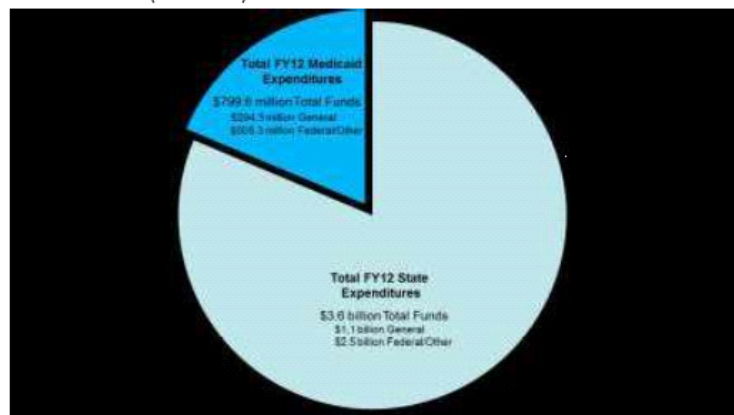


Source: S.D. Department of Social Services (FY 2012)

South Dakota has fairly restrictive eligibility criteria compared to most states. Children are eligible for South Dakota Medicaid or CHIP if they are disabled or their families have income below 140% of poverty (Medicaid) or 200% of poverty (CHIP).² For a family of four, children would qualify for coverage with an income of up to \$47,100/year; however, their parents would not be eligible. For their parents to qualify, their annual family income would have to be less than 52% of FPL, or less than \$12,246/year for a family of four. Low-income childless adults who are not elderly or do not have a disability are not eligible.

Based on comparative cost information and other performance measures, South Dakota's Department of Social Services (DSS) is an effective steward of the State's Medicaid program. The South Dakota claims processing and management information system is highly effective in making accurate and timely payments. In 2011, South Dakota had the lowest claims payment, data processing, and medical records review error rate (1.2%) and the lowest eligibility determination error rate (0.0%) of the 17 states reviewed by CMS during a recent review period. From a cost perspective, South Dakota has a very conservative Medicaid reimbursement policy and focuses on managing program costs. Because of the administrative efficiency of the program, utilization review activities (e.g. prior authorization and post-payment review), and lower reimbursement rates, the State spends less annually for each Medicaid enrollee per capita than surrounding states, including Wyoming (14% less), Nebraska (9% less), Montana (25% less), North Dakota (27% less), and Minnesota (33% less).³

In FY 2012, the federal government contributed \$505.3 million of South Dakota Medicaid's \$799.6 million appropriation, which is about 63% of the program's budget. State general funds account for approximately 37% of Medicaid's budget. In SFY 2012 in South Dakota, Medicaid expenditures constituted approximately 22.2% of the State's total expenditures, and 26.8% of state general fund expenditures.



Source: S.D. Department of Social Services (FY 2012)

Although children make up the majority of Medicaid enrollees, most Medicaid spending is attributable to the elderly and people with disabilities. In South Dakota, similar to the rest of the United States, the

² The Children's Health Insurance Program, more commonly referred to as CHIP, covers health care costs for children and youth. To be eligible for CHIP, children must be under the age of 19 and reside in South Dakota. Generally speaking, CHIP covers children whose family income is too high to qualify for Medicaid.

³ Kaiser Family Foundation, www.statehealthfacts.org

elderly and disabled represent 22% of the Medicaid population but account for roughly 61% of spending.

South Dakota continues to improve its Medicaid program. The Medicaid Solutions Work Group, established by Governor Dugaard during the 2011 Legislative Session, solicited key stakeholder input to develop strategies to contain and control Medicaid costs while maintaining quality services for recipients. As a result of the review of South Dakota-specific data, national trends, an analysis of best practices, the Work Group identified several recommendations for controlling short and long-term costs. The recommendations included strategies to:

- Re-design the primary care delivery system to change the way care is delivered and financed;
- Improve care management for high-cost individuals (including individuals with chronic conditions and pregnant women);
- Address the inappropriate utilization of Emergency Department (ED) services and foster consumer accountability;
- Encourage the appropriate utilization of less costly home and community-based services;
- Reduce pharmacy costs through increased co-pays, while maintaining access and quality; and
- Implement adult dental benefit reductions.

The State has made progress towards completing the recommendations. Among other things, the State is working with South Dakota's health systems and other providers to implement what are known as "Health Homes" to provide enhanced health care services to individuals with high cost chronic conditions or serious mental illnesses, with the goal of keeping people well instead of just treating them when they are sick. A recent Progress Report on the status of the implementation of the Medicaid Solution Work Group's recommendations is available on South Dakota's website.⁴

Medicaid and the Indian Health Service (IHS)

The Federal Government is obligated to provide health care to the American Indian people by authority of treaties signed with sovereign tribal nations, and IHS is the federal agency tasked with fulfilling this obligation. Native Americans in South Dakota are served by the IHS Aberdeen Area Office, which provides health care to members of federally recognized Tribes located in North Dakota, South Dakota, Nebraska, and Iowa. The Aberdeen Area Service Units include four Hospitals, seven Health Centers and one Tribally-Operated Health Service Site in South Dakota.

Native Americans who are an enrolled member of a tribe (and who are eligible to receive health services through IHS) may also be Medicaid-eligible if they meet South Dakota Medicaid eligibility criteria. Medicaid-eligible American Indians can choose to receive services through IHS facilities or through Medicaid-enrolled providers (hospitals, physicians, specialists) not affiliated with the IHS.

⁴ A copy of the report can be accessed at the following link: http://dss.sd.gov/1.03.13_MEDSOLWORKGROUP.pdf

If a Medicaid-eligible American Indian receives services through IHS, IHS bills the Medicaid Program for the services, and the State Medicaid Program is eligible to receive 100% federal funding for services provided by IHS (or contracted IHS providers) to Medicaid-eligible American Indians. Medicaid expenditures relating to services provided by non-IHS facilities are only eligible for federal funding at the regular, and lower, matching rate. During SFY 2011, total expenditures for services provided to Medicaid-eligible American Indians, including services at the IHS, totaled \$238.4 million. Only \$62.8 million of this total amount was 100% federally funded for services provided by IHS.

As noted by this Medicaid expenditure information, while the IHS is responsible for providing health care to American Indians who are enrolled members of a tribe, most Medicaid expenditures relating to Medicaid-eligible American Indians are incurred by non-IHS health care providers or facilities. This is due to IHS capacity issues relating to appropriation shortfalls and difficulties recruiting physicians and other health care providers to serve within the IHS system.

In the event that South Dakota decides to expand its Medicaid Program, a significant number of “new” Medicaid eligibles will be American Indians. While the expansion may help financially support IHS facilities (because Medicaid reimbursement represents a significant portion of their operating revenues), non-IHS providers will likely continue to be a major provider of services for Medicaid eligible American Indians.

B. The ACA Medicaid Expansion

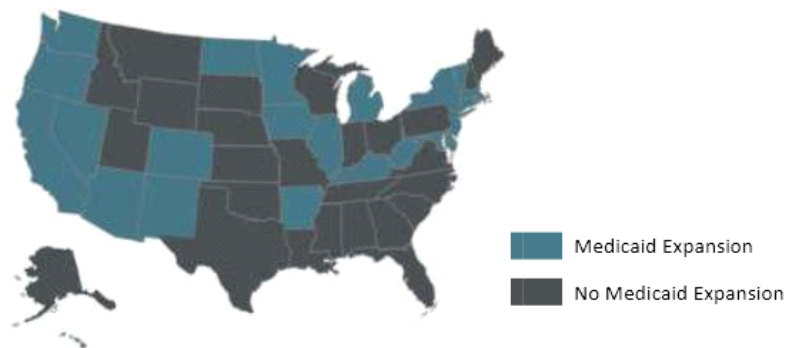
The ACA was passed in 2010 and originally required states, beginning in 2014, to expand their Medicaid programs to most adults under age 65 with incomes at or below 138% of FPL. For most states, including South Dakota, the ACA requirements would have required an expansion of their Medicaid program to low-income childless adults. The ACA also provided that if a state failed to expand Medicaid, it risked the loss of all current federal Medicaid matching funds.

States, including South Dakota, challenged the ACA on a number of issues before the U.S. Supreme Court. While the Supreme Court upheld, in June 2012, the constitutionality of the ACA, the Supreme Court's ruling allowed states to “opt-out” of the law's Medicaid expansion. In other words, the Court ruled that the federal government could not penalize states that decided to not expand Medicaid coverage to low-income adults by withdrawing federal funding to their existing Medicaid programs. As a result, South Dakota and other states were presented with the decision to expand Medicaid eligibility to most adults under 65 with incomes at or below 138% of poverty and accept enhanced federal dollars to fund the expansion, or to decline to expand the program.

The Supreme Court decision was a surprise for state governments, the federal government, and health care providers. Following the decision, some states announced their plans to expand Medicaid consistent with the original intent of the ACA, while other States denounced the expansion. A rigorous public debate began in many states, as advocates both for and against expansion provided reasons for their position based on calculated savings or additional expenses. Other arguments raised included political ideology, the role of government and concerns regarding the national debt.

As of September 1, 2013, 25 states plan to expand their Medicaid programs.⁵ It is worth noting that numerous governors have announced their support to expand Medicaid, but many have to date failed to win legislative support. Other governors are delaying a decision as they gather more feedback. As state legislatures wound up their 2013 sessions, some Governors are contemplating special sessions and others plan to take a new look next year. It is anticipated that this decision will be an ongoing discussion in legislatures over the next several months or, in some cases, years.

The below map identifies the states that are, as of the date of this report, expanding Medicaid (blue), and those that are not (grey). Activities in other states are somewhat fluid, and ongoing monitoring is necessary to stay abreast of recent developments.



C. Medicaid Expansion Requirements

For those states that expand Medicaid, the ACA and its implementing regulations include detailed requirements relating to the group that must be covered, federal funding, the required benefit package, and other program design elements. All of these program components are outlined below.

1. Coverage Eligibility

If a state decides to proceed with the optional expansion of its Medicaid program and accept enhanced federal funds, it would be required to provide coverage to most adults, ages 18 to 64,

Persons in family/household	Poverty guideline (100% FPL)	138% FPL
1	\$11,170	\$15,451
2	\$15,130	\$20,879
3	\$19,090	\$26,344
4	\$23,050	\$31,809

⁵ This assessment is based on an analysis of recent news reports as well as executive and legislative activity in states performed by the Kaiser Commission on Medicaid and the Uninsured. See: <http://kff.org/medicaid/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/#map>

who have a yearly income below 138% of the FPL, or approximately \$15,415 per year in 2012 for a single adult or \$31,809 for a family of four.

The Medicaid expansion population would consist primarily of parents and adults without dependent children. Medicaid currently covers millions of poor and near-poor Americans, but income and categorical restrictions currently exclude millions of low-income people from the program. While all poor children are eligible for Medicaid, many of their parents are not because most states (including South Dakota) have much stricter income eligibility for parents than for children. In addition, federal law categorically excludes most adults without dependent children from Medicaid. In simple terms, the Medicaid expansion would change Medicaid from a program that provides health coverage to a subset of the poor (e.g. children, pregnant women, disabled adults, and the elderly), to a program that covers all low-income individuals below 138% of the FPL.

Federal Subsidies to Purchase Health Insurance in the Exchange

Beginning in 2014, insurance premium subsidies and payment supports will be available under the ACA to millions of lower-income individuals and families. The law's consumer subsidies—premium tax credits and help with out-of-pocket health expenses — will be available to income eligible people who are unable to find affordable coverage from employers or other private insurance plans.

Eligibility for supports are available for individuals between 100% - 400% FPL, provided these individuals purchase coverage through the Exchange.

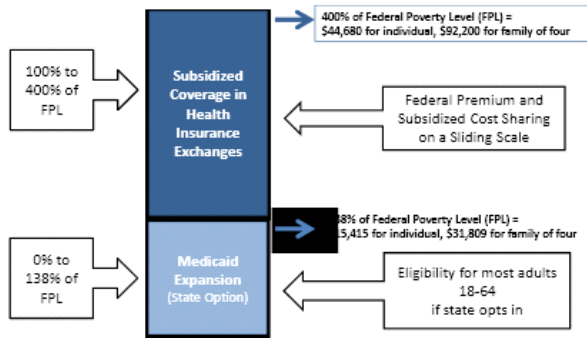
The ACA originally provided for an income-based continuum for health care coverage, where Medicaid would provide coverage to individuals up to 138% of the FPL, and individuals from 138% - 400% FPL would be eligible to receive federally-subsidized premiums and cost sharing, on a sliding scale based on income, through Health Insurance Exchanges (“Exchanges”) established under the law. While the language of the ACA provided for subsidies for individuals above 100% FPL, this subsidy eligibility threshold was not relevant because individuals up to 138% of FPL would be eligible for Medicaid.

Following the Supreme Court decision that made Medicaid expansion optional, many states, including South Dakota, inquired about the possibility of a “partial expansion.” In other words, they were interested in using enhanced federal funding to expand Medicaid to individuals up to 100% FPL, while allowing those individuals over 100% to seek subsidies to purchase insurance through the Exchange. Secretary of the Department of Health and Human Services (DHHS) Kathleen Sebelius clarified during a January 17, 2013 meeting

with Governor Daugaard and key staff, however, that states face a “take it or leave it” decision. That is, to receive the enhanced federal match, states must expand Medicaid to the entire population outlined in ACA up to 138% of FPL. They may not cover only adults up to 100% of FPL and still receive the enhanced federal match.⁶ Through pre-ACA State Plan options or federal waivers, States could expand

⁶ The following Question and Answer Document issued by CMS on December 10, 2012 also clarifies that a “partial expansion” is not permitted: <http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf> (See Question 26, page 12).

Medicaid eligibility differently than specified in ACA. However, the regular federal Medicaid match for the State would apply. This anticipated “continuum” of coverage is reflected in the below visual:



2. Coverage Options for Individuals Below 100%

The fact that the Medicaid expansion is now optional has created unanticipated consequences if states do not expand. Specifically, citizens below 100% of FPL (who would otherwise have been covered by the required Medicaid expansion) will be without coverage and likely remain uninsured because their income level will make it nearly impossible to purchase insurance, but higher-income citizens above 100% FPL will still be eligible for subsidized coverage through the Exchanges. This is the case because the text of the ACA provides that subsidies are available to citizens with incomes between 100% (not 138%) and 400% of FPL. In other words, those below 100% FPL will be without coverage, while those relatively better off (above 100% FPL) will be eligible for subsidized coverage. It is estimated that approximately 26,000 South Dakotans fall into this group.

3. Exchange Coverage Options for Individuals Between 100% and 138% FPL

As noted above, in the event that South Dakota does not proceed with Medicaid expansion, individuals with incomes between 100% and 138% of FPL will still be eligible for subsidized health care coverage through the exchange. Specifically, individuals with incomes above 100% of FPL who purchase health insurance through an Exchange will be eligible for an array of premium and cost sharing subsidies. The premium credits will vary from person to person, and will depend primarily on household income and the premium for the plan in which the person is enrolled. The amount of premium is also capped as a percentage of income. For individuals between 100-138% FPL, the premium is capped at 2% of income.

Exchange Cost-Sharing Example

A family of 3 with income below 138% FPL (\$26,344) will likely incur the following out of pocket costs for a Silver Plan (assuming premium costs of \$9,000 per year):

- Family Pays \$526 Premium (2% of Income)
- Government Pays \$8,474
- Maximum Out-of-Pocket Cap - \$4,500
- Premium Plus Out-of-Pocket Cap - \$5,026
- Required Actuarial Value: 94%

Under this example, a low-income family with significant Medical expenses during a particular year could potentially face significant out-of-pocket costs, although the maximum out-of-pocket costs will not exceed \$5,026.

People who qualify for premium assistance tax credits will also be eligible for cost sharing assistance. This assistance will further reduce the limit on the out of pocket maximum that can apply to their coverage. The out of pockets caps for 2014 are set at \$2,250 for self-only coverage, or \$4,500 for family coverage for individuals or families between 100%-138% of FPL.

In summary, premium tax credits and cost sharing subsidies are intended to make health insurance coverage more affordable for low-income people through the Exchanges. As noted in the above example, however, premiums and out-of-pocket costs may be significant for lower-income individuals. Individuals with incomes from 100 – 138% FPL in States that choose to Expand Medicaid will be subject to lower out-of-pocket costs (due to restrictive Medicaid cost-sharing requirements) and will not be subject to premiums. Approximately 22,500 South Dakotans potentially fall into this group.

4. Federal Funding

The federal government will reimburse states 100% of the service cost of expanding Medicaid eligibility to 138% of FPL for three years beginning in 2014. The reimbursement decreases to 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and thereafter. Recent rulemaking issued by CMS provides that the 90% federal match is permanent (42 C.F.R.

FMAP for Services by Calendar Year	
2014-16	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

433.10), although some have expressed concerns regarding the ability of the federal government to maintain this enhanced match indefinitely.

For example, assume that a state pays \$2,000 for a covered service for an adult eligible under the expansion. During the first three years, there is no state contribution for the cost of the service. In 2017, when the federal match phases down to 95%, the state contribution to pay for a \$2,000 service would be \$100 and the state share would increase to \$200 in 2020 and beyond. The \$200 state share in 2020 leverages \$1,800 in federal funds. It is important to note, however, that the increased administrative costs that will be incurred by states to administer an expanded Medicaid program are not eligible for the enhanced matching fund formula outlined above. These costs will continue be matched at the “traditional” federal matching rate (generally 50%). As will be noted later in the report, administrative costs are estimated to be only a small portion of the total cost of the Medicaid expansion (approximately 0.92% of total Medicaid expansion costs through SFY 2020).

5. Benefit Package

Newly eligible adults under the optional Medicaid expansion will receive what is known as a “benchmark benefit package” that covers the minimum “essential health benefits” (EHB) available to consumers in the state’s Exchange, which will be operated by either the state or federal government beginning in 2014. EHBs are defined in Section 1302(b)(1) of the ACA, and include the following ten benefit categories:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

In many cases, states will simply extend their existing Medicaid benefit package (assuming the package includes all EHBs) to the Medicaid expansion population for reasons of administrative convenience and cost.

6. Implementation Considerations

a. Time Frame

Through the State Plan, Medicaid is a contractual arrangement between the State and CMS. Medicaid expansion will be an “opt-in” through a State Plan Amendment. However, states can opt to expand

their program at some later time. It is not “now or never.” That said, the timing of the enhanced federal match is fixed. Delaying implementation will reduce the time a State receives an enhanced federal match. For example, a state that delays expansion until 2015 will be able to take advantage of the 100% matching rate for two years.

It is important to note that Medicaid expansion requires significant changes to State systems and procedures, and will require the hiring of additional staff to administer Medicaid benefits for the Medicaid expansion population. Thus, state Medicaid agencies will typically need at least several months after a decision is made to expand Medicaid to implement the expansion.

b. Consumer Outcomes

The Task Force reviewed several national studies related to the effects of healthcare coverage including financial considerations. One study observed a sample of adults between the ages of 20 and 64 years for 5 years before and after the expansions (from 1997 through 2007) and found that Medicaid expansions were associated with a statistically significant, 6.1%, reduction in adjusted all-cause mortality, or 19.6 deaths per year per 100,000 adults covered by Medicaid.⁷

Another study done in Oregon delved into greater details on how Medicaid patients used the health-care system and whether their health improved as a result.⁸ This study demonstrated that Medicaid increased the likelihood of using outpatient care, inpatient services and prescription drugs, and recommended preventive care. Observed rates of depression also fell by 30%. However, people with selected chronic conditions did not have significant improvements in their conditions. The study also showed that Medicaid increases the probability of individuals having a usual source of care. Finally, this study found that new Medicaid enrollees tended to self-report better health after gaining coverage, and that catastrophic out-of-pocket spending was virtually eliminated.

The Task Force also reviewed a growing body of research which shows that Medicaid expansion will lead to reductions in bankruptcies, as medical debt factors into 62% of all bankruptcies.

c. Cost Sharing

During the Task Force discussions and proceedings, it was observed by some members and public commenters that the State has limited discretion – under existing federal rules – to impose cost-sharing, premiums, or other personal responsibility criteria (e.g. work requirements) on Medicaid consumers. While new regulations relating to cost sharing have recently been issued, barriers and limitations remain. For example, the rules do not permit premiums or the imposition of work requirements as a

⁷ Benjamin D. Sommers, M.D., Ph.D. et al., *Mortality and Access to Care Among Adults After Medicaid Expansions*, N.Eng.J.Med. (July 25, 2012).

⁸ Katherine Baicker, Ph.D. et al., *The Oregon Experiment - Effects of Medicaid on Clinical Outcomes*, 368:18 N.Eng.J.Med. (May 2, 2013).

prerequisite for Medicaid eligibility. In addition, the rules maintain a 5% aggregate limit to all cost sharing incurred by all individuals in a household.

d. Existing Access to Health Care

Task Force members and individuals who submitted or gave testimony during the task force proceedings also provided information regarding how uninsured individuals who could potentially become eligible for Medicaid currently access the health care system. For example, uninsured individuals can obtain services from Community Health Centers operating in the state, although individuals are charged based on a sliding fee scale with discounts corresponding to family size and income level based on federal poverty guidelines. Individuals can also access care through County Poor Relief programs, which provide modest reimbursements to providers for services provided to individuals who are medically indigent and who have no ability or only limited ability to pay the costs of hospitalization. Hospitals also have a responsibility (pursuant to the Emergency Medical Treatment and Active Labor Act, or “EMTALA”) to provide services to anyone needing emergency healthcare treatment regardless of ability to pay, and provide a significant amount of uncompensated or charity care to individuals who do not have the ability to pay for their own care. Finally, as noted previously in the report, American Indians who would potentially be eligible for Medicaid may have access to services through the IHS.

It was noted, however, that the existing forms of access do not always provide care “at the right time, at the right place, or at the right cost.” Health insurance coverage is associated with having a regular source of care and with greater and more appropriate use of preventative health services. These factors, in turn, improve the likelihood of disease screening and early detection, the management of chronic illness, the effective treatment of acute conditions, and improved health outcomes. The appropriate use of preventative services also serves to reduce costs, because individuals are able to seek care for conditions before the need for costly hospital admissions.

III. State Decision Points

In evaluating the option to expand their Medicaid program, states have some discretion to craft their program for this new population below 138% FPL. This section of the report outlines the primary discretionary elements of a possible Medicaid expansion to provide context for the discussion later in the report relating to recommendations if South Dakota decides to proceed. This section also discusses “alternative models” for Medicaid expansion that are being pursued by some states through the waiver process with CMS, and reviews the ongoing ability of states to reform their care delivery and payment systems.

A. Implementation Timing

As noted above, states have the ability to implement an expansion of their Medicaid program at any time, but the timing of the enhanced federal match is fixed. In addition, the timing of the expansion will be affected by the time frame of each state’s legislative sessions and state fiscal year. Other factors are also likely to be relevant to each individual state’s decision.

B. Recipient Cost-Sharing

States have flexibility to implement cost-sharing for the Medicaid expansion population, consistent with existing regulations relating to this topic. States can implement modest co-payments for the 100% - 138% population that exceed, in many cases, co-payments for individuals with incomes below this amount. In addition, such co-payments are “enforceable,” i.e. providers can require payment before providing services. Under federal rules, however, premiums are not permitted for this population.

Within federal parameters, South Dakota imposes significant cost sharing requirements on its consumers to promote the efficient use of services. However, as a result of South Dakota’s limited eligibility policy, and the broad exemptions included in federal law (including the inability to impose co-payments on American Indians and children), the State has a very low number of Medicaid enrollees to whom copayments are applicable. Examples of South Dakota Medicaid copayment amounts include the following:

- Brand-name prescription drugs: \$3.30
- Generic prescription drugs: \$1.00
- Durable Medical Equipment: 5%
- Non-emergency dental services: \$3 co-pay, \$1,000 annual limit for adults
- Inpatient Hospital: \$50 per admission
- Non-emergency outpatient hospital services, which includes emergency room use for non-emergent care: 5% of billed charges, maximum of \$50

Most recently, as a result of recommendations made by the Medicaid Solutions Work Group established by Governor Dugaard during the 2011 Legislative Session, DSS implemented new copayments on July 1, 2012 for prescription drugs. Copays for brand name prescription drugs increased from \$3.00 to \$3.30.

As the State evaluates this issue, it is important to note that a body of research shows that premiums and cost sharing can act as barriers for low-income population in obtaining, maintaining and accessing health coverage and health care services. These barriers can result in increases in uninsured, unmet health care needs and adverse health outcomes. State savings from cost-sharing and premiums may accrue due to declines in coverage and utilization more so than from increases in revenues. These changes can strain the health care safety-net and effectively reduce reimbursement for providers serving the Medicaid Program, because co-payments reduce the rates paid to providers, and providers are frequently unable to collect payments from consumers.⁹

C. Alternative Service Delivery and Payment Approaches

As States have debated and evaluated the expansion, several Governors have sought to change the nature of the expansion and the operation of Medicaid in their states. The Federal Department of Health and Human Services (HHS) has indicated that it is open to some flexibility, within the confines of federal law and with consideration to the precedent-setting nature of each individual approach.

Generally speaking, in order for a state to obtain flexibility to depart from Medicaid program requirements, it must seek what is known as a “waiver” to test new or existing approaches to financing and delivering Medicaid services. While seeking a waiver is an option for states, obtaining a federal waiver is a complicated and time-consuming process, with no guarantees that the request will be granted. In addition, there are restrictions on the federal requirements that states can seek to waive.

Medicaid Waivers 101

Waivers are vehicles states can use to test new or existing approaches to financing and delivering Medicaid and CHIP health care services. States can use a waiver to change some basic rules of Medicaid related to things like access to services, level of care requirements, services provided, or populations served.

There are numerous types of Medicaid waivers. Of these, Section 1115 Research and Demonstration Project waivers provide the greatest flexibility for states to test and evaluate “experimental” policies that differ from federal Medicaid program rules, but promote federal program objectives. Section 1115 waivers give states flexibility to design and improve their programs by implementing policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible

⁹ Issue Paper, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings*, Kaiser Commission on Medicaid and the Uninsured (February 2013); <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf>

- Providing services not typically covered by Medicaid
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs

Although the HHS Secretary's waiver authority is broad, it is not unlimited. There are some program elements the Secretary does not have authority to waive under any circumstance, such as the federal matching payment formula.

Waivers must be "budget neutral" (i.e. not projected to cost more than the "status quo"). Waivers provide federal matching funds for costs that would not otherwise be included as Medicaid expenditures. Federal spending under a state's waiver must not be more than projected federal spending would have been for the state without the waiver. Budget neutrality is enforced through a cap on federal matching funds over the life of the waiver.

Waivers are also discretionary. Obtaining a waiver is a complex, time-consuming process. Waivers are approved through a series of steps and negotiations between a state and HHS. The State submits a waiver application to CMS, which is subject to state and federal public notice and comment requirements. CMS staff reviews the waiver application (usually with involvement from other federal HHS agencies and the Office of Management and Budget). Usually CMS and state staff negotiate over the terms and conditions of the waiver. If a waiver is approved, CMS issues an award letter to the state along with attachments listing the specific sections of the Social Security Act and applicable regulations that are being waived or modified and the types of expenditures allowed as well as the "terms and conditions" of approval.

One of the primary alternative strategies to the ACA Medicaid expansion is what is known as the "premium subsidy" approach.¹⁰ Under this approach – which would require a federal "waiver" from CMS – a state would accept the Medicaid expansion and the federal government would fund coverage at the same matching rates as it would have funded the traditional Medicaid expansion.¹¹ However, all new-eligibles would enroll in private insurance plans available through the state's Exchange, rather than receiving coverage through traditional Medicaid. Arkansas has received conditional approval for this approach, and is currently pursuing a federal waiver to permit implementation. Iowa is also pursuing a variant of this approach.

¹⁰ Other alternative approaches exist, but they are not, generally speaking, relevant to South Dakota's situation. For example, some states already provide Medicaid benefits to individuals up to 138% FPL, and some of these states are "retracting" Medicaid coverage for this population and shifting these individuals to the Exchange to permit these individuals to obtain federal premium subsidies and cost sharing (and to permit the state to "shift" costs to the federal government). Because of South Dakota's more limited eligibility rules, this approach is not relevant to South Dakota's situation.

¹¹ A premium subsidy approach may be implemented by states without a waiver, but the requirements are too restrictive and would not permit the implementation of a successful program. For example, absent a waiver, the premium subsidy program would have to be "cost effective" under a strict standard and the choice of an Exchange plan would be voluntary, among other requirements.

The following general parameters of the “premium subsidy” approach have been outlined in guidance issued by CMS:¹²

- **The state must continue to provide Medicaid beneficiaries all of the Medicaid benefits to which they are entitled, even if they are not offered by a private plan.** Any state seeking to employ premium assistance must provide all required Medicaid benefits to Medicaid beneficiaries even if they are unavailable through the private health plan available through the Exchange. For example, newly-eligible Medicaid beneficiaries are entitled to non-emergency transportation, a benefit which may not be provided by private plans. States must have mechanisms to provide “wrap-around” coverage to the extent that benefits in private market plans are less than those in Medicaid.
- **Medicaid beneficiaries cannot be forced to bear additional costs.** Any state seeking to employ premium assistance cannot require individual Medicaid beneficiaries to pay cost-sharing in excess of Medicaid cost-sharing limitations established in federal law, unless a waiver is obtained. For instance, under current law, cost-sharing for a beneficiary with income between 100% and 150% of the FPL may not exceed 5% of family income. States will need to have mechanisms in place to wrap around the private Marketplace cost-sharing to the extent that cost-sharing requirements in private coverage are greater than those in Medicaid.
- **Premium assistance must be cost effective.** The cost of premium assistance coverage, including administrative expenditures and any wrap-around benefits, must be comparable to what the state’s Medicaid program would otherwise pay for the same services. CMS has stated that it may take a relatively broad view as it evaluates “cost-effectiveness.” For instance, recent guidance contemplates using the projected savings associated with reducing administrative “churn” (as consumers move between the Exchange and Medicaid as their income fluctuates) as well as efficiencies that may result from having additional enrollees in the Exchanges as factors in determining comparability of cost in the context of obtaining a premium assistance waiver.
- **Medicaid beneficiaries must be provided with plan choice.** CMS has indicated that the state must provide participating beneficiaries with the choice of at least two insurance products available on the Exchange.
- **Only a limited number of states will receive approval and the length of the program will be limited.** CMS made clear that it will grant only a limited number of waivers relating to premium

¹² CMS-issued “Questions and Answers” relating to the premium assistance approach can be found at the following link: <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf>. This guidance was well-summarized in a policy brief prepared by the New Hampshire Fiscal Policy Institute. See Issue Brief, *Arkansas’ Approach to the Medicaid Expansion: Premium Assistance*, New Hampshire Fiscal Policy Institute (May 21, 2013).

assistance; in other words, not every state that applies for such a waiver will necessarily be granted one. In addition, approval will only be granted through calendar year 2016.

All of these complex issues warrant careful exploration before a state seeks a waiver to implement a mandatory premium assistance approach.

In addition to seeking to change the nature of the expansion and the operation of Medicaid in their states by seeking to adopt the “premium subsidy” approach described above, states also continue to have some flexibility to administer their Medicaid program, including the ability to reform payment structures to better incentivize higher quality and lower-cost care. As states evaluate expanding their Medicaid programs, they may seek to concurrently implement program reforms that will serve to contain program costs. Waivers cannot be requested, however, to seek to impose penalties/ denials of coverage on Medicaid consumers based on personal responsibility criteria (e.g. work requirements).

For example, in addition to many of the initiatives implemented as part of the Medicaid Solutions Work Group process, South Dakota plans to implement a prospective payment system for outpatient services. Other reimbursement reform opportunities may also exist.

In summary, while the ACA provides a structured framework for the implementation of Medicaid expansion, some discretion exists relating to the design of the program. In addition, there are also limited opportunities to adopt alternative delivery models through the federal waiver process, and opportunities to implement other program reforms.

IV. Medicaid Expansion Findings

This section of the report outlines factual findings of the Task Force relevant to South Dakota's decision. These findings include the number of individuals who would be covered if South Dakota expands Medicaid, the characteristics of the expansion population, Medicaid expansion costs, Medicaid expansion savings, covered services, Medicaid provider capacity, and other critical issues.

A. Number of Individuals Who Would be Covered if SD Expands

South Dakota Medicaid or CHIP covered 144,373 unduplicated individuals at some point during SFY 2012, or an average of 116,000 individuals per month. This means that nearly 1 of every 7 persons in South Dakota in any given month will have health coverage through Medicaid or CHIP. Even more strikingly, one of every 3 persons under the age of 19 in South Dakota has health coverage through Medicaid or CHIP, and 50% of the children born in South Dakota will be on Medicaid or CHIP during the first year of their life. These numbers are consistent with Medicaid coverage nationally.

Recently, DSS performed an analysis to identify the estimated number of new eligibles – over and above the 144,373 individuals covered during SFY 2012 – that would be covered should the State decide to expand Medicaid. These numbers were validated by a consultant – Market Decisions – as part of its

analysis of the size and extent of the uninsured in South Dakota.¹³ This analysis concluded that South Dakota Medicaid would expand by 54,000. Of this amount, approximately 48,500 individuals would be newly eligible, and 5,500 would be already eligible, but not enrolled (i.e. the “woodwork” effect). These estimates are consistent with the results of national studies relating to the size of the Medicaid expansion population. The Market Decisions analysis also estimated that, of the total potential new Medicaid expansion population, about 14,000 individuals are estimated to have some form of insurance, and that 16,000 individuals are American Indians who may be eligible for IHS services.

Even if South Dakota does not expand Medicaid, 5,500 individuals will potentially be added to the Medicaid rolls due to the “woodwork” effect. This is true for a number of reasons, including the issuance of new federal rules streamlining Medicaid eligibility and enrollment for most current eligibility groups, the requirement that the new Exchanges pre-screen all applicants for existing Medicaid/CHIP eligibility, the requirement that children be covered for any parent to receive federally subsidized

Enrollment Summary

- Existing Medicaid Population: **144,373** (SFY 2012)
- Medicaid Eligibles if SD Expands: **54,000**
- “New” Eligibles: **48,500** (of 54,000)
- Already Eligible, But Not Enrolled: **5,500** (of 54,000)

¹³ The full report can be found at the following link:

http://healthreform.sd.gov/documents/MarketDecisionsHealthInsuranceSurveySummaryReport_000.pdf

premiums in Health Insurance Exchange plans, and the massive federal public and private outreach campaigns expected in 2013-2014 to promote the Exchanges.

It is important to note that while South Dakota will be eligible to receive an enhanced federal match for the estimated 48,500 individuals who would be newly eligible if the State decides to expand the program, it would only receive the regular federal matching percentage (45.80% in SFY 2014) for the 5,500 individuals who are currently eligible for Medicaid but not enrolled. But again, these individuals are anticipated to enroll in the State's Medicaid program regardless of whether South Dakota expands Medicaid eligibility.

B. Characteristics of Expansion Population

As noted above, Market Decisions conducted a survey, as part of the State's ACA planning process, to provide additional information relating to the characteristics of the uninsured in South Dakota.¹⁴ The survey results provide additional insight into the population that would be provided insurance coverage through Medicaid, should South Dakota decide to expand Medicaid.

Of the 48,500 people under 138% FPL who would be eligible for Medicaid expansion, approximately 26,000 have incomes less than 100% FPL, and 22,500 have incomes between 100% and 138% FPL. This breakdown is relevant, as individuals with incomes between 100% and 138% FPL would be eligible for subsidies in the Exchange, while those individuals below the 100% FPL threshold would not be eligible for subsidies. In addition, approximately 14,000 individuals under 138% FPL have insurance.

The Market Decisions survey also revealed the following information regarding the Medicaid expansion population:

- **This group is young.** 61% of the uninsured population up to 138% FPL is between the ages of 18 and 34.
- **There are geographic differences in the location of this group.** The uninsured up to 138% FPL are concentrated in the West Region (28%), Southeast Region (25%) and American Indian counties (18%). See Attachment A for a cross-walk identifying the counties in each region.
- **Most of the uninsured up to 138% of FPL are employed.** 54% of people up to 138% FPL are working, and 57% of working individuals are employed full time.

¹⁴ The survey may be found at the following link:

http://healthreform.sd.gov/documents/MarketDecisionsHealthInsuranceSurveySummaryReport_000.pdf

C. Costs & Potential State Savings

As noted previously, the federal government will pay an enhanced share for services to the expansion group. Administrative costs will continue to be reimbursed at the current matching rate, however, which is 50%. Based on the federal matching percentage, DSS has calculated: 1) the total benefits costs; 2) the total administrative costs; and 3) the total cost of expansion. These costs are reflected in the below chart:

	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020	Total thru SFY 2020
Eligible Benefit Costs (in millions)								
Federal and State	\$57.4	\$272.7	\$321.2	\$340.9	\$361.5	\$383.3	\$406.5	\$2,143.4
Federal	\$57.1	\$272.1	\$320.5	\$331.7	\$340.9	\$357.7	\$371.3	\$2,051.2
State	\$.3	\$.6	\$.7	\$ 9.2	\$ 20.6	\$ 25.6	\$ 35.2	\$ 92.2
(50/50) Admin Costs (in millions)								
Federal and State	\$2.4	\$2.6	\$2.70	\$2.8	\$3.0	\$3.10	\$3.30	\$19.90
Federal	\$1.2	\$1.3	\$1.35	\$1.4	\$1.5	\$1.55	\$1.65	\$9.95
State	\$1.2	\$1.3	\$1.35	\$1.4	\$1.5	\$1.55	\$1.65	\$9.95
Total Benefits and Administration (in millions)								
Federal and State	\$59.8	\$275.3	\$323.90	\$343.7	\$364.5	\$386.40	\$409.80	\$2,163.2
Federal	\$58.3	\$273.4	\$321.85	\$333.1	\$342.4	\$359.25	\$372.95	\$2,061.1
State	\$1.5	\$1.9	\$2.05	\$10.6	\$22.1	\$27.15	\$36.85	\$102.1
Federal %	97.5%	99.3%	99.4%	96.9%	94.0%	93.0%	91.0%	95.3%
State %	2.5%	0.7%	0.6%	3.1%	6.0%	7.0%	9.0%	4.7%

Highlights - Medicaid Expansion Cost Analysis

- Total estimated annual cost: \$59.8 million in SFY 2014, rising to \$409.8 million in SFY 2020
- Total estimated federal expenditures through SFY 2020: \$2.1 **billion**
- Total estimated additional state expenditures through SFY 2020: \$102.1 **million**

To calculate the estimated costs described above, several assumptions were made. In the event that the assumptions deviate from what is anticipated, the actual cost of expanding Medicaid may vary significantly. The assumptions include the following:

- The cost estimates assume, based on DSS’s internal analysis, that Medicaid expansion will require 39 full-time equivalent (FTE) state positions to administer the program (e.g. additional staff to enroll the new eligibles, administer the health benefit, etc.)
- The cost estimates for the expansion population are based on the costs experienced by South Dakota Medicaid’s only current coverage group for non-disabled or non-pregnant adults (Low Income Families with Children). It is estimated that the costs of this group will be most analogous to the Medicaid expansion population.
- The cost estimates assume growth rates of 5% per year for benefit and administrative costs. This assumption is in line with national Medicaid growth rate averages.
- The estimates assume “take-up” rates of 40% of estimated eligibles in SFY 2014, 90% in SFY 2015, and 100% SFY 2016. The estimates also assume a modest enrollment growth of 1% per year in SFY 2017-SFY 2020.
- The estimates assume that the same services provided to the existing population will be provided to the expansion population.

The cost estimate evaluation process also reviewed State general fund savings that could potentially occur because existing programs currently funded with general funds would be funded by Medicaid for the expansion population. As part of the Task Force proceedings, DSS staff performed a comprehensive analysis of the possible savings opportunities. The DSS analysis revealed that, unlike other states, South Dakota does not have a large number of generally funded programs that could be covered by Medicaid for the expansion population. That said, some specific savings opportunities exist. The below table summarizes the DSS findings relating to estimated annual State general fund savings, based on 2012 data.

Program	Description	Potential Annual Savings
Public Health Programs (Breast and Cervical Cancer, Family Planning, HIV/AIDS)	No general funds used to support these programs provided through the Department of Health. Medicaid currently provides full coverage for women screened by DOH and found to have Breast and Cervical Cancer.	None
State subsidized high risk pools	Currently no state funds are used to support risk pool.	None
Behavioral Health Services	Unlike many other states, South Dakota does not currently expend 100% general funds for behavioral health services except those	None

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Program	Description	Potential Annual Savings
	required for Maintenance of Effort for Mental Health and Substance Abuse Block Grants. Criminal Justice Initiative is a potential opportunity.	
Emergency inpatient Medical Care for Indigent Inmates	Inmates who meet all other Medicaid requirements are eligible for Medicaid while incarcerated. However, there is a prohibition on using federal funds for otherwise eligible inmates unless in a medical institution for 24 hours (hospitalized). Currently pregnant women who are inmates and otherwise eligible are the most commonly covered.	\$859,000 general funds

The Task Force and DSS also evaluated potential annual savings at both the county and provider level. The below table outlines savings at the county and provider levels.

Program	Description	Potential Annual Savings
County-Uncompensated Care Costs	Savings potential at the county level. No direct savings to the Medicaid program unless there is agreement to shift savings to the state. County Poor Relief savings opportunities estimated at \$3.3 million. County Relief Medical Indigent expenses could decrease by \$2,632,028.88. County Mandated Jail Medical expenses are reported at 90% outpatient and 10% inpatient for a total of \$2,809,422.23. Therefore, the county jail medical expenses could decrease by 10% for the inpatient expense of \$280,942.22. County Catastrophic Medical Pool could decrease by \$395,459.	\$3.3 million at the county or provider level
Provider-Uncompensated Care Costs	Savings potential at the provider level related to uncompensated charity care. Providers track and report uncompensated care including charity care, bad debt, and other uncompensated care costs.	\$30 million (per estimates submitted by South Dakota Association of Health Care Organizations)

D. “Woodwork” Effect

As noted above, even if the State does not expand Medicaid, there will be some “woodwork effect” that will increase the number of individuals who will be covered by the Medicaid program in South Dakota. The “woodwork effect” is a phenomenon that occurs when an expansion of public program eligibility takes place (whether through federal action or a state-level initiative), and individuals who were already eligible for coverage but who had previously not enrolled choose to sign up—thereby “coming out of the woodwork.” Specifically, it has been estimated that there will be 5,500 “woodwork” eligibles (primarily children).

Internal analysis has concluded that the cost of coverage for this group will be as much as \$16.8 million by SFY 2020. South Dakota (like other states) would only receive the “regular” federal match for this population, not the enhanced match available for the expansion population.

E. Covered Services/ Medical Benefits

Under the ACA, states are required to provide a Medicaid “benchmark” benefit package that includes all ten statutory categories of Essential Health Benefits (EHBs) identified in the ACA.

As part of the cost analysis, DSS engaged an actuary to perform an analysis of the cost of providing EHBs for the Medicaid expansion group under the ACA as compared to providing them with Medicaid benefits enhanced to cover all EHBs. In summary, the comparison of the benefits between the identified EHBs and Medicaid showed that the EHB that are not provided by Medicaid are additional transplant benefits and adult chemical dependency treatment. As a result, these additional benefits must be provided to the expansion population, in the event that South Dakota decides to expand Medicaid, to meet the requirements of federal law. The cost of these benefits is included in the cost estimates outlined in section C. above.

F. Medicaid Provider Capacity

During the Task Force meetings, a significant amount of time was spent discussing the capacity of South Dakota providers to serve the anticipated number of individuals who would be eligible for Medicaid in the event that South Dakota decided to expand the program. The group agreed that Medicaid coverage does not necessarily equate to access to health care. As noted previously in this report, if South Dakota moves forward with Medicaid expansion, approximately 48,500 new Medicaid eligibles would be covered by Medicaid. In addition, approximately 22,000 individuals will be eligible for subsidies through the Exchange beginning in January, 2014, and 5,500 “woodwork eligibles” will enter the Medicaid program, regardless of South Dakota’s Medicaid expansion decision. It was agreed that these coverage expansions would stress South Dakota’s delivery system, despite the fact that many of these individuals may currently be receiving “uncompensated” care from South Dakota providers.

The issue of provider capacity is a difficult issue to analyze, as there are gaps in the available information. That said, this report will attempt to provide some insight into this topic by: 1) outlining information provided by the Department of Health relating to provider supply generally; 2) reviewing, at a high level, a Medicaid access study performed by DSS; 3) summarizing the work and recommendations of South Dakota’s Primary Care Task Force to address provider access issues; and 4) reviewing information from provider organizations describing their ability (or inability) to meet the needs of the Medicaid expansion population.

1. Department of Health Provider Supply Information

During the Task Force proceedings, the Department of Health provided a general overview of “provider supply” in South Dakota, as well as other relevant information relating to the access to care. Among other things, DOH provided demographic data showing an anticipated decrease in the working age population (20-59) of 3,060 by 2030, which should relieve some pressure on provider demand. That said, however, most counties in South Dakota are considered Primary Medical Care “Health Professional Shortage Areas” (HPSAs). A HPSA is a geographic area, population group, or health care facility that has been designated by the Federal government as having a shortage of health professionals. HPSAs are designated using several criteria, including population-to-clinician ratios.

Not surprisingly, DOH’s data showed a lower density of primary care physicians (and other provider types) in more highly rural areas of state. The data also showed that, consistent with national trends, the average age of primary care physicians is increasing.

2. Medicaid Capacity Analysis

In addition to the information provided by the DOH, the Task Force evaluated a report provided by DSS to support the State’s understanding of the potential impact of new Medicaid members on primary care and in-patient health care resources. The study examined the capacity of Medicaid providers to deliver care to individuals who could become eligible for Medicaid under the optional ACA expansion—individuals who have income up to 138% of the Federal Poverty Level.

As part of this analysis, the DSS analysis first divided the state into five geographic regions and identified the number of providers (by category) in each region, as well as the number of current Medicaid Low Income Family (LIF) consumers receiving services, to calculate “provider ratios” (i.e. the ratio of members to providers).¹⁵ Second, the analysis identified the number of additional Medicaid consumers expected to be served by county and region if South Dakota chooses to expand Medicaid, to calculate future “provider ratios.” Finally, the analysis calculated the percentage change in provider ratios by county, region, and provider category if South Dakota moves forward with expansion.¹⁶

The detailed findings of the report are outlined in a detailed presentation provided to the Task Force. At a high level, the report found that:

¹⁵ The eligibility and claims data from State fiscal year (SFY 2012) – the most recent available – was used for the analysis. In addition, the population of beneficiaries who are eligible for South Dakota Medicaid under the LIF category was used as the baseline population due to its similarity in demographic and income characteristics to that of the potential “Medicaid expansion” population. Finally, the analysis excluded long-term care and home health providers who typically provide services for aged or disabled Medicaid beneficiaries.

¹⁶ It is important to note that while the Provider Capacity analysis provides important insight into Medicaid capacity, the study has some internal limitations. For example, there is a lack of “comparison” data from other state Medicaid FFS programs to evaluate the adequacy of South Dakota’s provider capacity nationally. In addition, South Dakota Medicaid does not have private insurance, Medicare or other non-Medicaid claims data. As a result, the analysis does not provide a “full picture” of provider ratios throughout the state.

- For every one provider (primary care, Hospital-based services, dentist, pharmacist or vision provider), there are currently 2.9 income-eligible South Dakota Medicaid LIF adult members served.
- The greatest capacity for providers to serve members within the comparison population is in the Southeast region, where there is one provider for every 1.7 LIF members. Conversely, the American Indian region has the fewest providers serving its LIF Medicaid members (46.4 adult members served by one provider).
- When considering the impact of additional individuals who would become eligible for Medicaid if the State were to expand income eligibility requirements to 138% of FPL, there would be a greater need in capacity overall.
- The greatest change in capacity would be in the Northeast region—likely a factor of 10,439 additional individuals that will become eligible for Medicaid within that region that will require services.
- This region is followed by West, Central, Southeast, and American Indian.

3. South Dakota's Primary Care Task Force

In addition to the DOH and DSS analysis, the Task Force was briefed on the activities of South Dakota's Primary Care Task Force, which was appointed by the Governor in 2012 to consider and make recommendations to ensure accessibility to primary care for all South Dakotans – particularly in rural areas of the state. Members included primary care physicians, nurse practitioners, physician assistants, health systems, hospital administrators, Schools of Medicine, the Board of Regents, IHS, medical students, legislators, consumers, and state agencies. The Primary Care Task Force developed recommendations around five specific areas:

- Capacity of healthcare educational programs
- Quality rural health experiences
- Recruitment and retention
- Innovative primary care models
- Accountability and oversight¹⁷

The Task Force also developed metrics within each area to measure progress and success in maintaining and strengthening the state's primary care system. An Oversight Committee has been established to monitor implementation of the recommendations of the Task Force, and to review metrics established by the Task Force to measure progress. The Oversight committee will meet 3 times a year and provide an annual report to the Governor, Board of Regents, and Legislature by November 1st of each year.

¹⁷ A copy of the Task Force's final report can be found at the following link: <http://doh.sd.gov/documents/PrimaryCareReport.pdf>

4. Ability of South Dakota Providers to Serve the Medicaid Expansion Population

Finally, the ability of providers to absorb the anticipated increase in demand for health care services was addressed during the Task Force discussions, as well as during the public testimony. It was recognized by the Task Force that this is an enormously difficult issue, without an easy answer, and various opinions were offered regarding the capacity of providers to meet anticipated demand.

a. Hospitals

The South Dakota Association of Healthcare Organizations (SDAHO) provided some basic information on the number of hospitals and other medical providers within each geographic area to support their claim that there is adequate existing capacity to support the influx of new Medicaid consumers that would result from Medicaid expansion. Detailed information on provider/consumer ratios, average waiting times or other metrics was not provided. SDAHO also pointed out that Medicaid expansion would, in one sense, represent a “change in the way care is delivered”. In the event that South Dakota chooses to expand Medicaid, individuals who access services on an emergency basis now will become insured and will be able to utilize primary care to seek treatment for emerging conditions.

SDAHO also provided assurances that, to the extent Medicaid access issues exist or develop as a result of Medicaid expansion, they will take steps to ensure that they can meet the increased demand for services, but did not provide any specific information on how they would meet this need.

b. Dentists

In contrast to information provided by SDAHO, the South Dakota Dental Association (SDDA) expressed its opinion that it is unrealistic to expect that dentists will see an increased number of Medicaid patients absent an increase in Medicaid reimbursement rates to providers. Without an expansion of the Medicaid program, SDDA stated that access to dental care for adults is already at its maximum. Simply put, adding more people to the Medicaid program would provide a benefit through which the new beneficiaries would be unlikely to access dental care and could make accessing dental care more difficult for those that already qualify for Medicaid.

c. Physicians

The South Dakota State Medical Association (SDSMA) also provided their thoughts regarding the ability of South Dakota physicians to meet the anticipated increase in demand in the event that South Dakota expands Medicaid. SDSMA pointed out that the South Dakota is currently experiencing geographic physician access problems – especially in rural and frontier areas – and that these issues will only be made worse if the State expands Medicaid. Access to specialists is a particular concern. SDSMA also noted concerns related to Medicaid payment rates, and explained that an increasing number of physicians are less willing to take on new Medicaid patients and that some physicians are limiting the number of Medicaid patients they see. While it is difficult to predict the precise effect of Medicaid

expansion on physician access, it is anticipated that access will be a significant issue if the State expands Medicaid.

d. Community Mental Health Centers

Community Mental Health Centers, which are non-profit agencies that provide comprehensive outpatient behavioral health care to people with serious mental illness, will also be significantly affected by Medicaid expansion. Specifically, according to information provided by the South Dakota Council of Mental Health Centers and Council of Substance Abuse Directors, in the event that South Dakota expands Medicaid, it is anticipated that there will be a modest increase in the number of adults requiring Serious Mental Illness-related services. It is also anticipated that the centers will see a significant increase in the number of eligible outpatient mental health adult clients (4,400 – 6,100), and a modest increase in the number of eligible adults seeking substance abuse services. To address this increase, it will be necessary to increase capacity of mental health/substance abuse outpatient programs and commensurately enhance staffing levels to meet increased demand for services.

e. Federally-Qualified Health Centers

Federally-Qualified Health Centers (FQHCs) are non-profit community-driven clinics providing primary and preventive care to all individuals, with or without insurance and regardless of their ability to pay. Every FQHC provides medical and behavioral/mental health services and some sites also have dental and substance abuse services. Transportation, translation, case management, and health education are also offered. FQHCs accept Medicaid, Medicare, private insurance, and uninsured patients.

FQHCs are also required to use a sliding fee scale with discounts based on patient family size and income in accordance with federal poverty guidelines. In many instances, patients who present for care are unable to pay for their services even at their discounted rates. Importantly, FQHCs qualify for enhanced reimbursement from Medicare and Medicaid. Because of the enhanced Medicaid reimbursement, which essentially reimburses FQHCs for their costs of providing care to Medicaid consumers, additional individuals will be able to access care as a result of Medicaid expansion. Access issues will have to be carefully monitored if the State decides to expand Medicaid.

G. Economic Impact of Expansion on South Dakota Providers

During the Task Force proceedings, much discussion was also held relating to the possible positive economic impact of Medicaid expansion on hospitals and other providers in South Dakota. These discussions centered primarily on the current “uncompensated” care costs incurred by hospitals to treat uninsured South Dakotans, the anticipated negative impact of planned reductions to Medicare payment rates, and how the Medicaid expansion would serve to mitigate these issues. The impact of Medicaid expansion on other provider groups was also evaluated.

Medicaid expansion would have a positive impact on South Dakota hospitals, although it is difficult to quantify the actual financial impact. Hospitals currently provide “uncompensated care” to uninsured

individuals in the state. If South Dakota expands Medicaid, many but not all of these individuals would become insured. Payments from the Medicaid program would serve to “offset” some of the financial burden on hospitals relating to uncompensated care. SDAHO estimated that expanding Medicaid would “offset” uncompensated care to hospitals in the amount of \$30 million, but acknowledged that this estimate would need to be refined to reflect individual patient Medicaid eligibility if the State expands the program. Expansion would also offset reduced growth in federal Medicare payments that were part of the ACA. During a Task Force meeting and in public testimony, representatives of South Dakota’s hospitals provided information to quantify the size and extent of the reductions in future Medicare rate increases. According to presentations from the South Dakota Association of Healthcare Organizations, these reductions to future payment increases are estimated to exceed over \$400 million (in all provider settings) over a ten-year period.¹⁸

Other providers will also be affected financially by Medicaid expansion. For FQHCs, an expansion in the Medicaid population will serve to decrease uncompensated care costs. Community Mental Health Centers will also see an increase in the number of insured patients seeking substance abuse and outpatient mental health services, and a commensurate increase in revenues. Payment rates, however, remain a concern.

¹⁸ A copy of a document that provides detailed information relating to the uncompensated care “offset,” as well as a spreadsheet that outlines SDAHO’s estimates in reimbursement reductions as a result of the ACA, can be found at the following link: <http://sd.gov/governor/medicaidtaskforce.aspx> (See presentation from 3rd Meeting, titled “Impact of Medicaid Expansion on Hospitals”).

V. Medicaid Expansion Considerations (i.e. “Pros and Cons”)

This section of the report will review the “pros” and “cons” of the Medicaid expansion identified and discussed by the Task Force. For example, this section will review costs and savings associated with expansion, discuss the effects of insurance coverage on individuals and public health, review access to care issues, and evaluate the possible effect of the expansion on South Dakota’s budget, insurance market, and taxpayers. This section of the report will also summarize the pros and cons solicited during the public testimony sessions held throughout the State.

In developing this section of the report, the Task Force reviewed all of the public testimony, the Task Force presentations, and the notes from the Task Force meetings to ensure that this section included a comprehensive list of the “pros” and “cons” identified and discussed during this process. The Task Force recognizes that a “pro” to one reader may be a “con” to another. Also, the inclusion of a specific “pro” and “con” in this report does not indicate that each Task Force member necessarily agrees with each item; rather, the intent was to faithfully represent the various points of view outlined during the public testimony and Task Force proceedings. In addition, in outlining the various “pros” and “cons,” the Task Force attempted to group each argument into a number of general categories.

A. Impact on Health and Service Utilization

During the Task Force sessions, one of the topics discussed by the group and identified during public testimony was the possible effect of Medicaid expansion on the individual health and well-being of individuals who would receive coverage, as well as the overall effect of the expansion on service utilization.

Pro: Improved Access to Preventative Care and More Appropriate Use of Medical Services

During the Task Force proceedings, there was much discussion regarding how the expansion of the Medicaid program would provide greater access to medical and preventive care and steer consumers away from more expensive emergency room care.

Pro: Improvements in Mortality Rates

Proponents of Medicaid expansion also cited research findings that demonstrate that expanding Medicaid will lead to a reduction in mortality. A frequently cited study published in the *New England Journal of Medicine* compared three states that substantially expanded adult Medicaid eligibility (New York, Maine, and Arizona) with neighboring states without expansions. The study found that Medicaid expansions were associated with significant reduction in mortality and improvement in self-reported health status.¹⁹

¹⁹ Benjamin D. Sommers, M.D., Ph.D. et al., *Mortality and Access to Care Among Adults After Medicaid Expansions*, *N.Eng.J.Med.* (July 25, 2012).

Con: Strain on the Current Provider Capacity in South Dakota

Task Force members and individuals who testified during the public hearings argued that the State's current provider capacity – especially the capacity of primary care physicians - will be stretched in 2014 when uninsured individuals and families get health insurance through the Health Insurance Exchange as well as if the state expands Medicaid. Opponents argue that the State lacks the primary, specialty, inpatient, and outpatient capacity to take on a large increase in the Medicaid population. Further, new Medicaid enrollees are likely to have a pent-up demand for medical services, placing even more pressure on an already strained health care system. Findings from the Task Force relating to this topic are outlined in section IV. F. above.

Con: Lack of Flexibility in Medicaid Program Design and Administration

Commenters also argued that states have little flexibility to expand health insurance coverage to the uninsured in a state-specific manner under the federal proposal. They pointed out that specific needs vary by state, and the federal "one-size-fits all" approach is unproductive and wasteful. By contrast, the State's County Poor Relief program includes criteria such as employment status, personal assets, and recipient's conduct detrimental to their personal well-being. In addition, the Task Force discussed the inability, under existing federal rules, to ensure that new Medicaid consumers have adequate "skin in the game." Finally, the Task Force expressed frustration that the State could not implement a partial expansion – i.e. expand Medicaid to individuals below 100% FPL and receive enhanced federal funds, and permit individuals above 100% FPL to obtain subsidies through the Exchange.

The Task Force spent some time discussing this topic. While alternatives were discussed, and state-specific coverage options are available, it was stressed that the enhanced federal funding available through the ACA cannot be obtained through alternative approaches that are not otherwise approved by CMS. It was also determined that seeking a federal waiver for a "premium" subsidy approach may not be feasible. It was also pointed out that the State can opt-out of the expansion at any time. It was recognized, however, that once a state expands a program benefit, it may be difficult to withdraw the benefit at a later date.

B. Role of Government

Many citizens expressed concerns relating to the wide-ranging impact of the ACA generally, and the Medicaid expansion in particular. These arguments reflected disagreement relating to the appropriate role of government to provide health care for citizens, as well as the effect of the Medicaid expansion on the current market for private insurance.

Pro: Expansion of Health Insurance to Low-Income South Dakotans

Individuals who testified during the public hearings described the situation of many of their patients, friends, families and neighbors who are ineligible for Medicaid coverage, but nonetheless have such low-incomes that they are unable to afford preventive care. Some of these individuals noted that while Medicaid covers children and disabled individuals, parents are only eligible if they have extremely low incomes, and that other individuals are categorically ineligible. Many testifiers described, in sometimes emotional terms, instances of personal hardship where individuals could not afford necessary preventive care. It was pointed out that expanding Medicaid would provide relief for thousands of individuals who are not currently eligible for Medicaid under existing eligibility rules.

Con: Expansion of Government and Implementation of Obamacare

The implementation of the ACA remains highly controversial and unpopular nationally and in South Dakota. Many citizens view the ACA as an unwarranted expansion of Government authority over the healthcare section in the United States. Many citizens believe that the ACA is too costly and intrusive, and will eventually lead to the reduction or elimination of private coverage. Opinions relating to the wisdom of expanding Medicaid – which is an integral part of the coverage expansions contained in the ACA – are inevitably colored or affected by the unpopularity of the ACA or Obamacare more generally.

Con: Concern that Nationally Medicaid is an Ineffective Program and Should be Reformed, Not Expanded

Some commentators argue that nationally, the Medicaid program is “broken.” They argue that Medicaid spending is swamping state budgets and crowding-out spending on other priorities such as education and highway spending. It is also argued that Medicaid waste, fraud and abuse drain tens of billions of dollars from federal expenditures every year. Finally, it is argued that the program provides poor outcomes for families and low reimbursement rates to providers.

Con: Replacement of Private Insurance Coverage

Another potential “con” of Medicaid expansion is that a portion of individuals newly covered – whether by Medicaid or Exchange subsidized plans – are already privately insured. It is argued that this “crowd-out” effect – where public spending crowds out private spending on the same service – will serve to expand government involvement in the health care sector. Opponents of Medicaid expansion believe that this will serve to inappropriately increase individuals’ reliance on government spending.

In addition, as noted in previous sections of this report, in the event that South Dakota does not expand Medicaid, individuals with incomes between 100-138% FPL who would otherwise be eligible for Medicaid will receive federal premium subsidies and payment supports to purchase private coverage through the Exchange beginning in January 1, 2014. While the cost of coverage for these individuals will be higher in the Exchange, these individuals will have the ability to choose from a number of commercial

health plans that will participate as Qualified Health Plans in the Exchange. This choice will not be available for these individuals if South Dakota expands Medicaid.

C. Economic Impact

The Task Force also spent a significant amount of time evaluating and discussing the economic impact of the possible expansion and numerous perceived “pros” and “cons” related to this aspect of the decision.

Pro: Economic Impact of Expansion on the State’s Economy and Business Environment

Proponents of expansion argued that states that expand Medicaid will likely see revenue from the broader economic effects of the Medicaid expansion such as increased jobs, income and state tax revenues at the state level within the health care sector and beyond due to the “multiplier effect” of spending. Research has shown that federal Medicaid dollars spur economic activity beyond the initial investment.²⁰

A number of individuals who provided public testimony also argued that the State’s failure to expand Medicaid would have an adverse effect on the business community in South Dakota. Specifically, they argued that if lawmakers turn away federal money to pay for expanding Medicaid coverage, companies will restrict growth, businesses will move to states with more competitive health insurance markets, and that companies that pay for health insurance for their employees will see their premiums rise as hospitals and doctors shift their losses from the uninsured to them. Others argued that the availability of Medicaid in neighboring states will attract low-income workers to these states, placing South Dakota businesses that do not offer health insurance at a competitive disadvantage.

Pro: Economic Impact of Expansion on South Dakota Counties

South Dakota counties operate what is known as the Catastrophic County Poor Relief Program (CCPR). CCPR assists counties with the payment of catastrophic medical expenses incurred on behalf of individuals who are medically indigent and who have no ability or only limited ability to pay the costs of hospitalization. Eligibility criteria and funding sources are determined at the county level. Counties also incur costs for county jail medical expenses and a Catastrophic Medical Pool. If the State decides to expand the Medicaid program, much of the cost for these programs – \$3.3 million annually – will be shifted to Medicaid, thus saving costs at the county level. There will be no direct savings to the Medicaid program, however, unless there is agreement to shift savings to the state.

²⁰ The Kaiser Family Foundation issued a report that reviewed 29 state-level studies of Medicaid’s stimulative impact. Kaiser Family Foundation, *The Role of Medicaid in State Economies: A Look at the Research* (Jan. 2009); http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7075_02_es.pdf

Pro: Economic Impact of Expansion on South Dakota Providers

In the event that South Dakota expands Medicaid, South Dakota hospitals will experience financial relief, because anticipated revenues from new Medicaid consumers will significantly offset current “uncompensated costs,” as well as anticipated reductions in future increases to Medicare rates. This financial relief will have a positive impact on hospital employees, contractors, and the larger business community that rely on the financial health of local hospitals. Other providers will also financially benefit from an increase in the number of insured citizens, although the actual impact will vary by provider.

Pro: Leveraging of Federal Funds to Benefit the State

Proponents argue that Medicaid expansion is a “good deal” for South Dakota, because the federal matching formula will serve to leverage federal dollars that could benefit the State. Specifically, while total state expenditures would be \$102 million through SFY 2020, this amount would draw down over \$2 billion in federal funds during this time period. Stated differently, through SFY 2020, the State would pay 4.7% of the total cost of the expansion, while the Federal Government would assume 95.3% of the cost.

Another argument for Medicaid expansion is that there would be state general fund savings should states expand because existing programs currently funded with general funds would be funded with Medicaid for the expansion population. As noted above, DSS staff performed a comprehensive analysis of the possible savings opportunities. While the DSS analysis revealed that, unlike other states, South Dakota does not have a large number of generally funded programs that could be covered by Medicaid for the expansion population, there will be general fund savings of \$859,000 annually if Medicaid is expanded because the program will cover inpatient medical care for indigent inmates.

Finally, it was noted by Task Force members and some individuals who provided public testimony that the federal portion of expansion will be funded through federal taxes and fees paid by South Dakota citizens and businesses (as well as increased federal borrowing), and that these taxes and fees would continue to be paid regardless of whether South Dakota chooses to expand the Medicaid Program. Choosing to expand Medicaid would serve to ensure that a portion of these ongoing and new expenditures would be directed to South Dakota’s citizens and economy.

Con: Cost to South Dakota Taxpayers

As noted previously, the cost of expanding Medicaid will be considerable. The total annual general fund cost would be \$1.5 million in SFY 2014, rising to \$36.8 million in SFY 2020. These costs would include the “state share” of the benefit cost (0% for 2014-6, 5% in 2017, 6% in 2018, 7% in 2019, and 10% in 2020 and thereafter), as well as administrative costs associated with providing coverage to this population (which are primarily reimbursed at a 50% state matching rate).

Con: Effect of Expansion on the National Debt

Many opponents of Medicaid expansion point out that federal health care spending is a substantial driver of the federal government's national debt, and that state Medicaid spending now absorbs nearly a quarter of state government budgets and often forces cuts to local priorities. A recent CBO report (May 2013) estimates that the ACA will cost about \$1.3 trillion over the next 10 years.

Con: Risk of a "Bait and Switch" by the Federal Government

Many opponents of Medicaid expansion argue that the federal government will not be in a financial position to continue the promised enhanced federal match. They argue that federal government spending – and Medicaid and Medicare spending in particular – are fiscally unsustainable, and that the federal government simply does not have the money to pay for the enhanced matching funds offered in ACA. In light of this upcoming fiscal crisis, critics of expansion argue that the risks to states of a federal "bait and switch" are too high.

D. "Moral" Issue

The Task Force also evaluated arguments related to the issues of equity and fairness, resulting primarily from the unintended consequences of the Supreme Court's decision making Medicaid expansion optional for states.

Pro: Provides Coverage for Individuals Below 100% of FPL

The structure of the ACA provides tax subsidies for uninsured individuals with incomes between 100% and 400% FPL to purchase health insurance. These tax subsidies are not available to individuals below 100% FPL. Expanding Medicaid is the only way to ensure that individuals below 100% of FPL will receive subsidized health insurance. This argument in favor of expansion – which is based on principles of fairness and equity – was raised by a significant number of individuals who provided public testimony throughout the State.

Pro: Reduced Financial Burden and Risk of Catastrophic Financial Consequences Related to an Unanticipated Illness

Proponents of Medicaid expansion also argued that expanding the program will lower the financial burden faced by the uninsured. A portion of the Task Force's discussion centered on this financial burden on low-income citizens without insurance, and much of the public testimony focused on costs related to an unanticipated illness.

VI. Implementation Recommendations If South Dakota Decides to Expand Medicaid

One of the charges of the Task Force was to identify recommendations on how to best go about expanding the Medicaid Program, should the State decide to proceed. The Task Force's specific recommendations on this topic are outlined below.

A. Legislative "Circuit Breaker"

One of the objections to Medicaid expansion is the risk of a federal "bait and switch," where the federal government will renege on its promise of an ongoing federal match of 90% beyond 2020. The Task Force recognizes that, with any federally funded program, there is a risk of decreased revenue from the federal government in the future. Consistent with the approach adopted by other states, the Task Force recommends that South Dakota implement Medicaid expansion legislation with a built-in sunset clause based on federal funding levels. If the federal government is committing to a minimum of 90% funding in the year 2020 and going forward, the legislation should state that if the federal match falls below this level, South Dakota will immediately terminate the program. Task Force members noted that this strategy and approach – which has been adopted by a number of states – will serve to put pressure on federal lawmakers to maintain the 90% federal match in future years.

B. Payment Reform

The Task Force also spent a considerable amount of time discussing the need for payment reforms to improve consumer outcomes and contain costs for both the existing and possible new Medicaid expansion population. During this discussion, DSS's novel efforts to obtain federal funding to implement "Health Homes" were discussed, and many Task Force members expressed their support for this effort. That said, the Task Force expressed their belief that South Dakota's service delivery system must continue to be redesigned to shift provider incentives from volume of visits to value of care by creating provider payment incentives to keep people healthy. DSS is in agreement that delivery system reforms must continually be evaluated in the future.

Specifically, it was noted by Task Force members from DSS that many Medicaid programs, including South Dakota, utilize cost reimbursement methodologies for outpatient services where they make an interim payment for each claim based on a percentage of billed charges. Final payment is calculated after a cost settlement process that typically occurs one to three years after the service is performed. This method of payment for outpatient services is generally seen as antiquated and inefficient.²¹

²¹ As Medicare and other payers have moved away from charge-based payment, Medicaid programs have become increasingly vulnerable to "charge inflation." Nationwide, hospital charges are now three times higher than hospital cost, and the gap is larger for outpatient care than inpatient. Medicaid agencies that use cost-based reimbursement are at the mercy of provider decisions about utilization and unit costs.

Alternatives, such as Ambulatory Payment Classification (APC) Groups and Enhanced Ambulatory Patient Groups (EAPGs), have been adopted by a number of state Medicaid Programs. Under both methods, payment rates are set by Medicaid – not determined by costs or charges – giving Medicaid more control over spending. South Dakota will address this issue moving forward.

C. Timing of Expansion

The Task Force discussed the timing of a possible expansion of the Medicaid Program. At such time that the Governor and Legislature decide to expand Medicaid, DSS would require approximately six months to prepare. Necessary steps include amending the Medicaid State Plan, making necessary system changes, and taking other steps to effectuate the expansion.

D. Consumer Cost-Sharing Changes

The Task Force spent a significant amount of time discussing the topic of personal accountability, and a number of citizens raised this issue during their public testimony. In general, the Task Force believes that personal responsibility by the participant would need to be a part of benefit design for the Medicaid expansion population. The Task Force also believes that the co-payments that are applied to the existing Medicaid population should also be applied to the new Medicaid expansion population, for purposes of consistency and ease of administration for providers. Also, in the event that CMS grants federal waivers to other states to implement novel cost-sharing approaches that encourage prevention and behavioral strategies to improve health outcomes and decrease overall system costs, the Task Force recommends that DSS evaluate and consider similar approaches.

That said, the group reviewed research that found that premiums and cost sharing can act as barriers for the low-income population in obtaining, maintaining and accessing health coverage. Task Force members representing provider groups also noted that cost-sharing often constitutes a “hidden tax” where providers are required to provide care when Medicaid recipients cannot make the required co-payments.

E. Access to Care/ Provider Capacity Development Initiatives

The Task Force is acutely aware that expansion may affect the healthcare provider workforce shortage that is already being felt in many areas of the State. Access to primary care (primarily in rural areas), behavioral health care, and to dental services will be a particular problem in South Dakota, as it is in other states. Because access will remain a challenge if South Dakota expands Medicaid, the Task Force recommends that the efforts of South Dakota’s Primary Care Task Force be fully supported in addition to other initiatives to eliminate care provided in inappropriate or unnecessary settings.

F. Ongoing Access and Quality Monitoring

The Task Force also discussed and recommends that South Dakota establish mechanisms to carefully monitor access to care and quality of care to the existing and new Medicaid expansion population. These monitoring efforts – which could include the evaluation of provider/member ratios, wait times, and other metrics – will serve to identify emerging issues and permit the State to pro-actively address possible supply and quality of care issues if the State expands Medicaid.

G. Reinvestment to Provide Access, Enhanced Preventative Care

As noted throughout this report, in the event that South Dakota expands Medicaid, a number of provider groups and counties will be “winners” because the expansion will increase the number of insured individuals receiving care, thus reducing the amount of uncompensated care. Because FQHCs receive favorable reimbursement from Medicaid, they will also be in a stronger financial position in the event that Medicaid is expanded. The Task Force discussed the opportunity for providers and counties to reinvest at least some of the additional revenues that would result if the State expands Medicaid to meet the needs of low-income South Dakotans. Counties committed to at least discussing this concept further.

H. South Dakota “Asks” During Discussions with CMS

State governments that are considering expanding their Medicaid Program typically meet with CMS to discuss their plans, and to obtain clarification regarding the parameters of the expansion. Because CMS is strongly committed to the expansion of the Medicaid Program, these discussions often present an opportunity for the State to seek commitments from CMS relating to outstanding issues of interest to the state.

Prior to making the final decision to expand Medicaid, the Task Force recommends that DSS utilize the opportunity to address outstanding issues with CMS. As noted previously, it may be worth discussing possible flexibilities relating to consumer cost-sharing, program design, and other issues of importance – including the need to improve access to American Indians to services provided by IHS. During the Task Force proceedings, frustration relating to access to care for IHS services was a frequent topic of discussion.

I. Delivery System: Medicaid vs. Exchange (through “Premium Subsidy” Waiver)

The Task Force also evaluated and discussed the option of potentially seeking a federal waiver to implement the optional Medicaid expansion by utilizing the federal Health Insurance Exchange that will begin providing coverage to South Dakota residents effective January 1, 2014 (i.e. the “Arkansas” model).

In order to comply with federal regulations, states employing premium assistance must ensure that Medicaid beneficiaries receive essential health benefits and Medicaid cost-sharing protections, even if

they are enrolled in a private health plan in the Exchange Marketplace. Premium assistance waivers must demonstrate cost effectiveness and cost neutrality. In addition, CMS has explicitly stated that it only plans to approve a “limited number” of waiver requests. At the time of the Task Force discussions, CMS had not approved any state request for premium assistance waivers.

The Task Force believes that the state should continue to track the development of the premium subsidy approach nationally to determine if it would be a feasible option for South Dakota.

Attachment A: Crosswalk of South Dakota Counties Assigned to Five Regions

West Region
Butte County
Custer County
Fall River County
Harding County
Lawrence
Meade County
Pennington County
Perkins County

American Indian Counties
Bennett County
Buffalo County
Corson County
Dewey County
Jackson County
Mellette County
Shannon County
Todd County
Ziebach County

Southeast Region
Bonn Homme County
Clay County
Davison County
Hanson County
Hutchinson County
Lake County
Lincoln County
McCook County
Miner County
Minnehaha County
Moody County
Sanborn County
Turner County
Union County
Yankton County

Central Region
Aurora County
Brule County
Campbell County
Charles Mix County
Douglas County
Gregory County
Haakon County
Hand County
Hughes County
Hyde County
Jerauld County
Jones County
Lyman County
Potter County
Stanley County
Sully County
Tripp County
Walworth County

Northeast Region
Beadle County
Brookings County
Brown County
Clark County
Codington County
Day County
Deuel County
Edmunds County
Faulk County
Grant County
Hamlin County
Kingsbury County
McPherson County
Marshall County
Roberts County
Spink County

Source: Market Decisions Report