



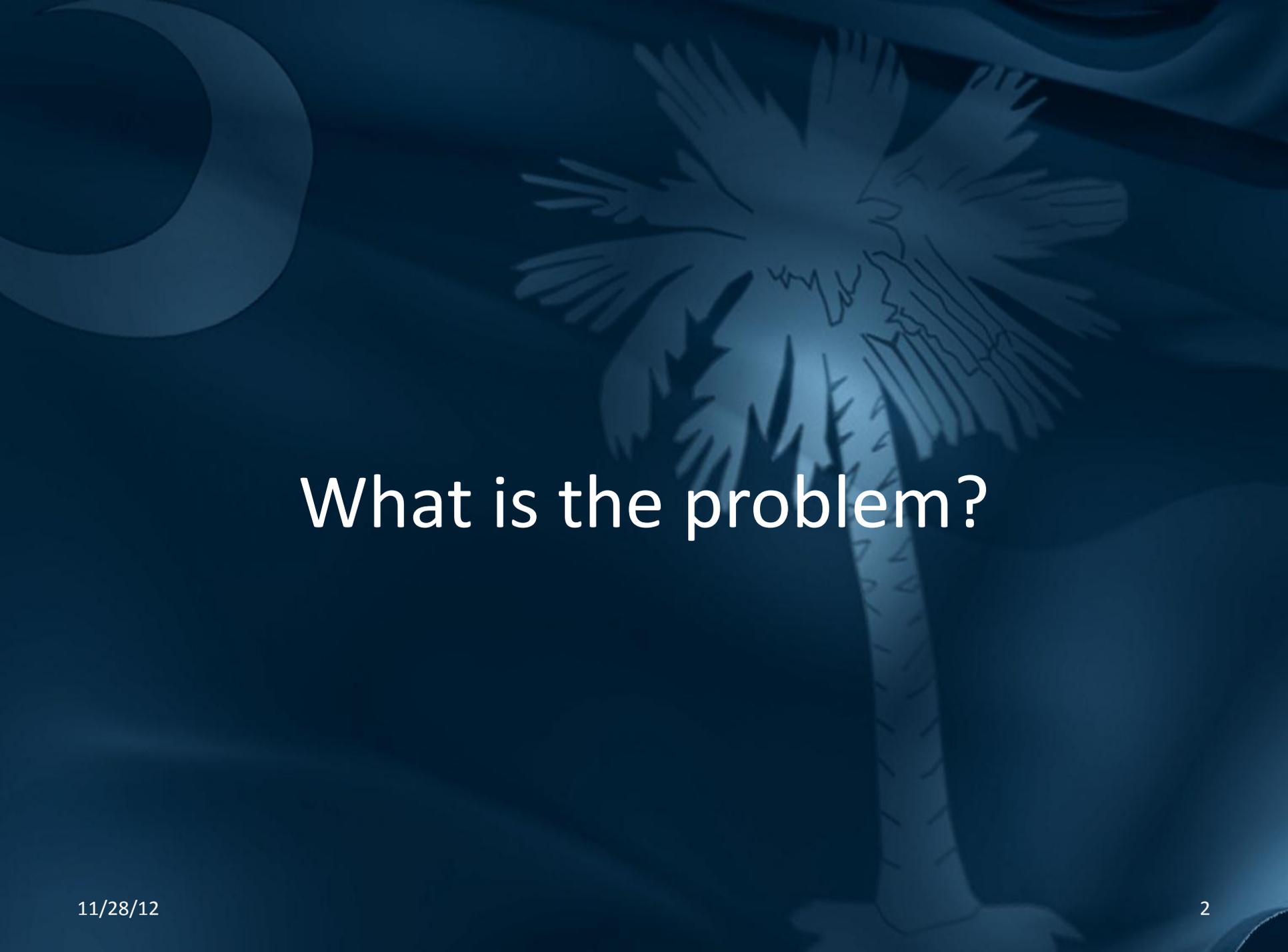
# Medical Affairs Committee

## Affordable Care Act

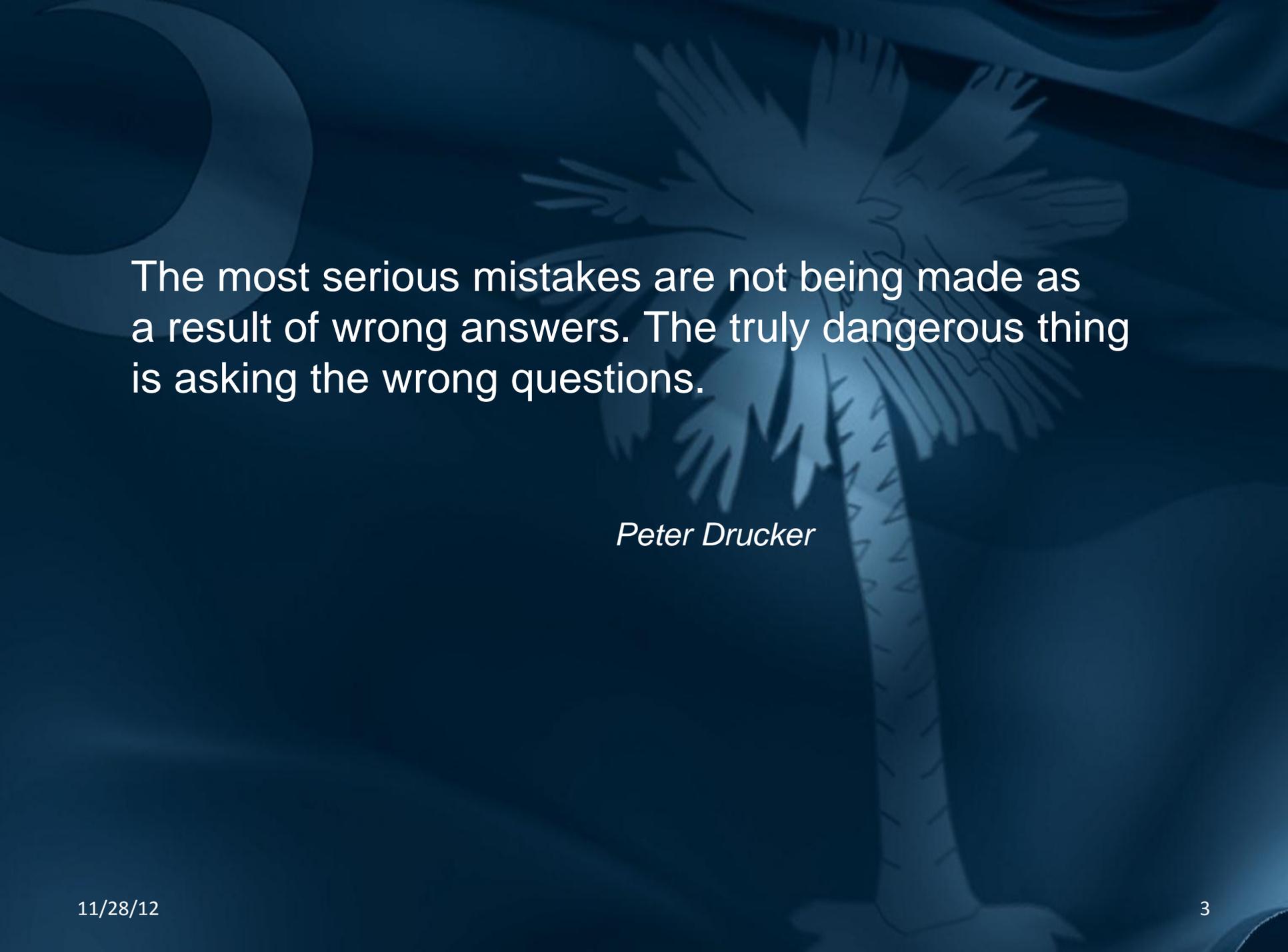
South Carolina  
Department of Health and Human Services

November 28, 2012

Many estimates are preliminary projections as of November 2012 and not considered final. These estimates may change as more state and federal data and guidance becomes available.

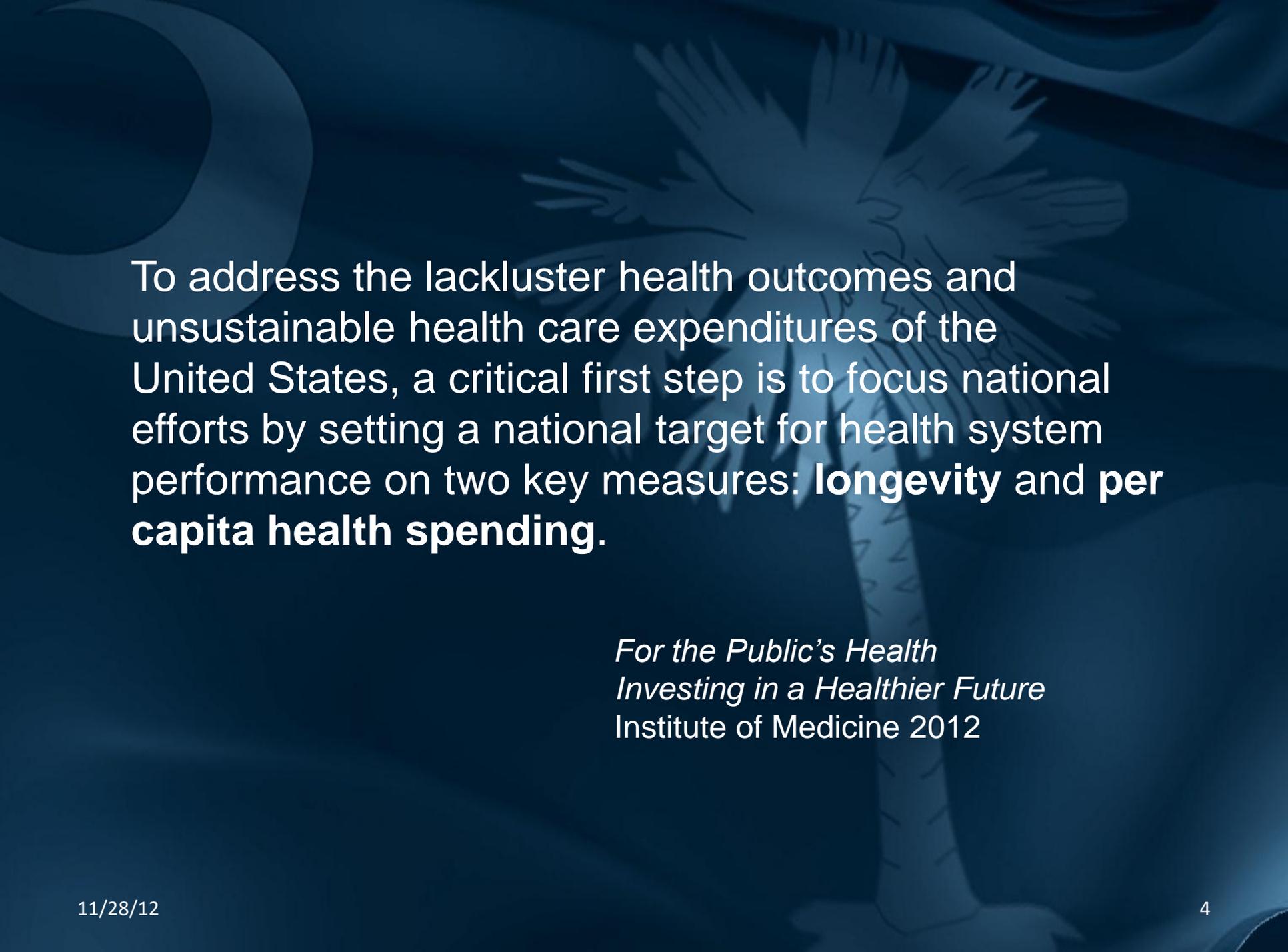


What is the problem?

The background features a dark blue gradient with a stylized palm tree in the center and a crescent moon in the upper left corner. The palm tree has a textured trunk and a starburst-like canopy. The crescent moon is a simple white outline.

The most serious mistakes are not being made as a result of wrong answers. The truly dangerous thing is asking the wrong questions.

*Peter Drucker*



To address the lackluster health outcomes and unsustainable health care expenditures of the United States, a critical first step is to focus national efforts by setting a national target for health system performance on two key measures: **longevity** and **per capita health spending**.

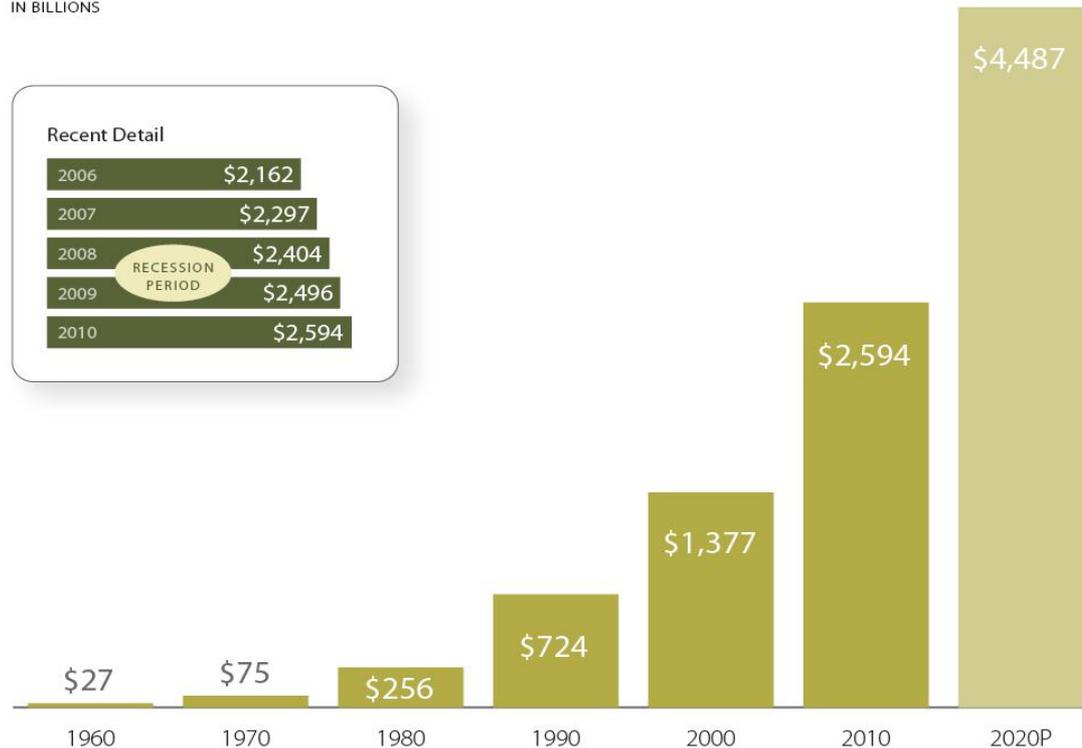
*For the Public's Health  
Investing in a Healthier Future  
Institute of Medicine 2012*

# Growing US Health Spending

## Health Spending

United States, 1960 to 2020, selected years

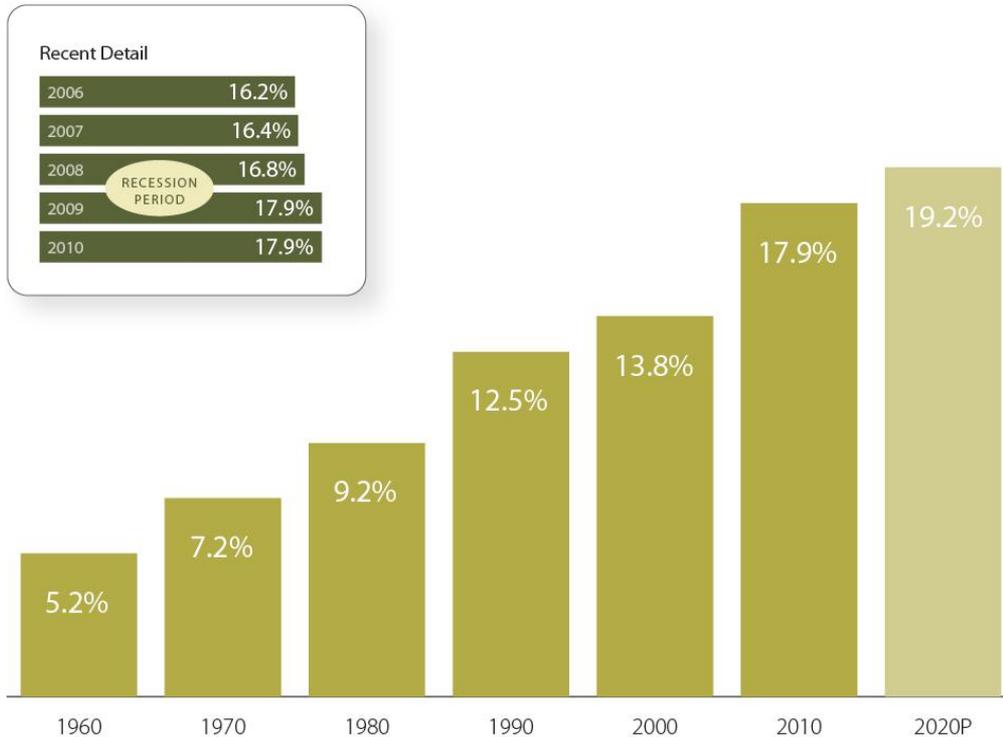
IN BILLIONS



*Total health care spending in the United States has nearly doubled more every decade since 1960*

Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act.  
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

# US Health Spending as a Share of GDP 1960 to 2020, Selected Years

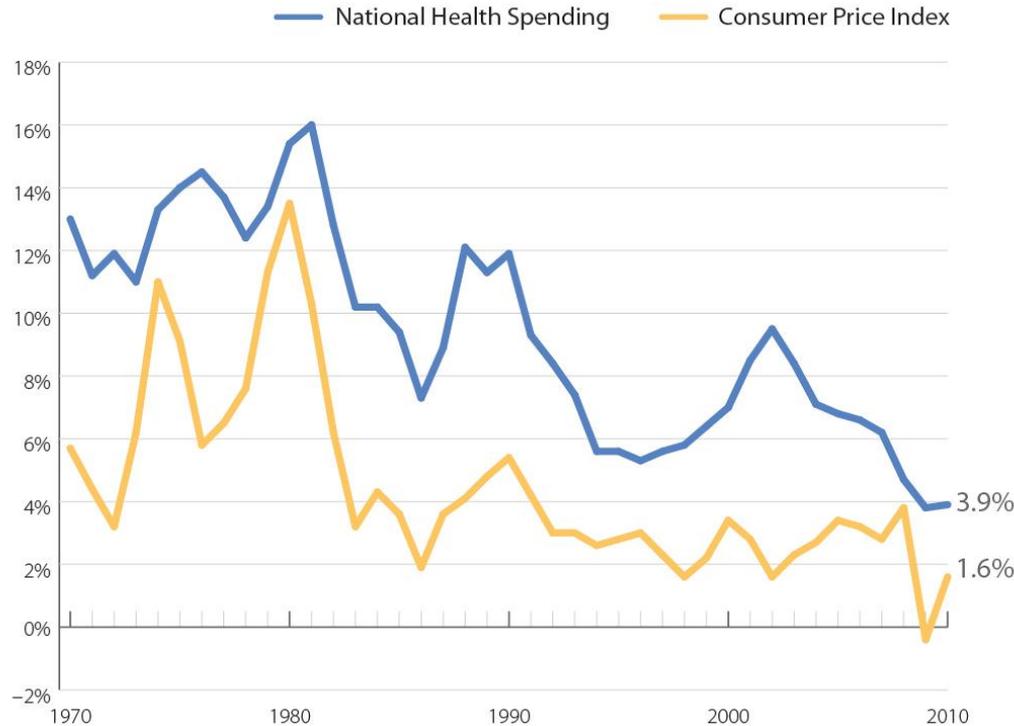


*Increases in overall health care spending are outpacing increases in population and US economic growth*

*A large portion of our economy is devoted to health care spending year after year*

Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act. 2010 figure reflects a 4.2% increase in GDP and a 3.9% increase in national health spending. CMS projects national health spending will also have accounted for 17.9% of GDP in 2011 and 2012.  
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

# Annual Growth Rates, Health Spending Vs. Inflation



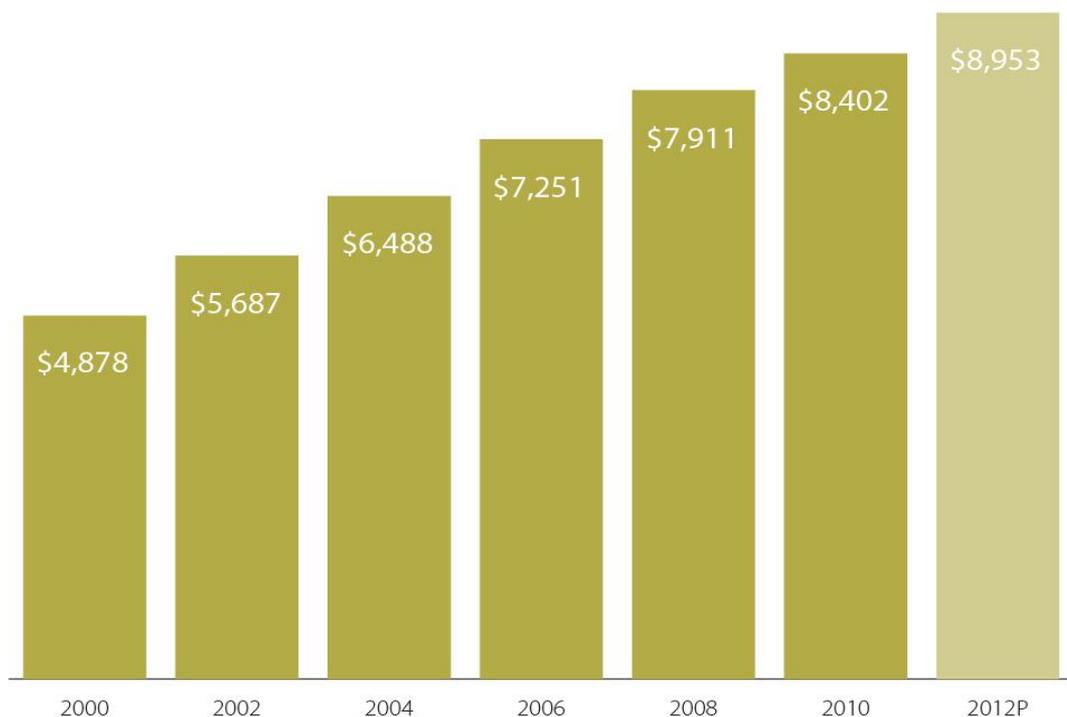
*Health care spending growth has not been less than growth in the Consumer Price Index in 40 years*

Notes: Health spending refers to National Health Expenditures. The recent economic recession spanned the period from December 2007 to June 2009.  
Sources: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release. Bureau of Labor Statistics (CPI-U, US city average, annual figures).

# Health Spending Per Capita

## Health Spending Per Capita

United States, 2000 to 2012, selected years



Notes: Health spending refers to National Health Expenditures. Projections (P) include the impact of the Affordable Care Act.  
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

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*Why does spending per person continue to climb?*

*This is a primary concern of the Institute of Medicine – much of it is not justifiable*

# Health Spending Per Capita and as a Share of GDP



Notes: US spending per capita as reported by OECD differs from CMS figures reported elsewhere in this report. Health spending refers to National Health Expenditures.  
 Source: Organization for Economic Cooperation and Development, *OECD Health Data 2012*, June 2012, [www.oecd.org](http://www.oecd.org).

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*We spend about twice per person than the average country in the Organization for Economic Cooperation and Development*

*Our out-of-pocket spending is in line with many other countries*

*Our public spending is already higher than these other countries with “socialized” medicine*

# US is Falling Behind in Life Expectancy

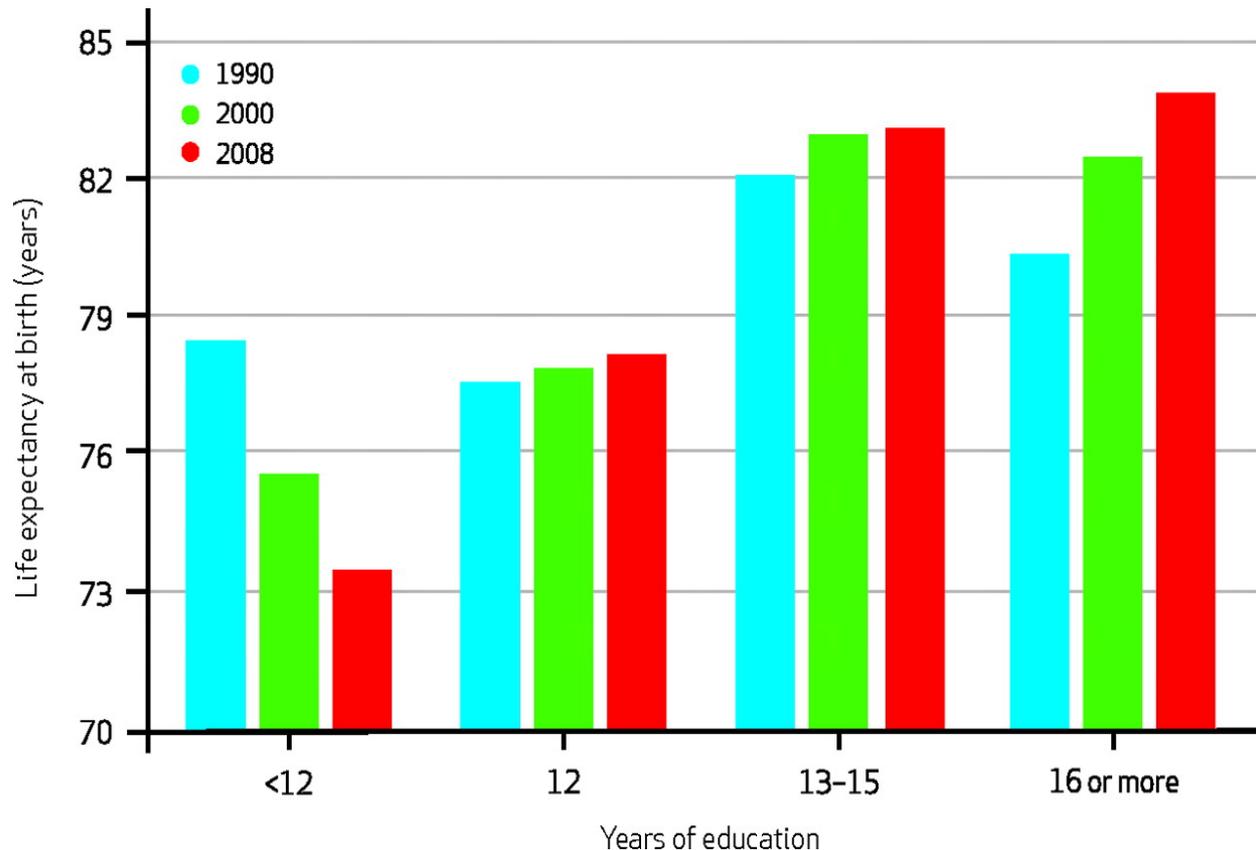
*In 1950 US life expectancy ranked 12<sup>th</sup> at 68.9 years*

*In 2009 the US ranked 28<sup>th</sup> at 79.2 years*

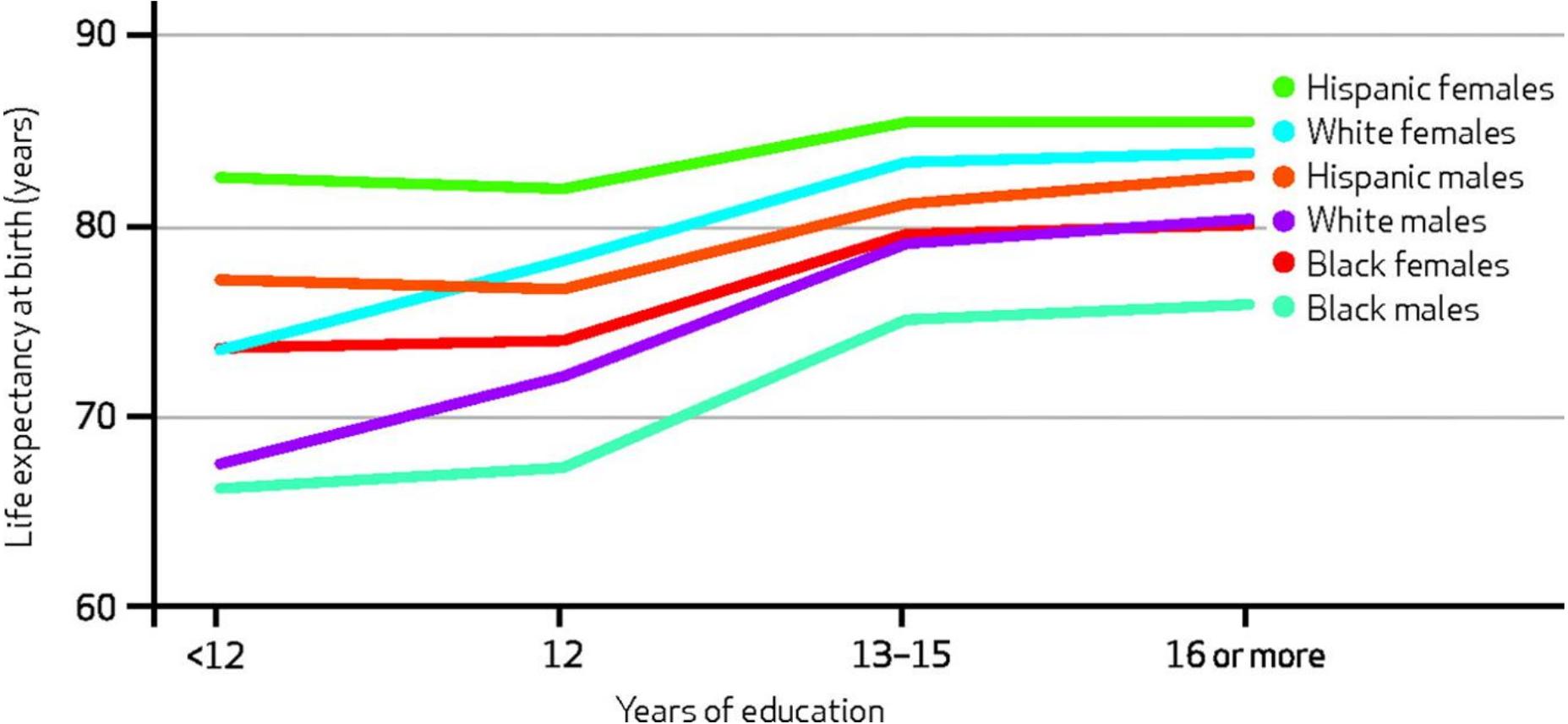
*In 2007 South Carolina ranked 42<sup>nd</sup> in the US at 76.6 years*

*Disturbing disparities exist and for certain groups life expectancy has actually fallen in the past 2 decades*

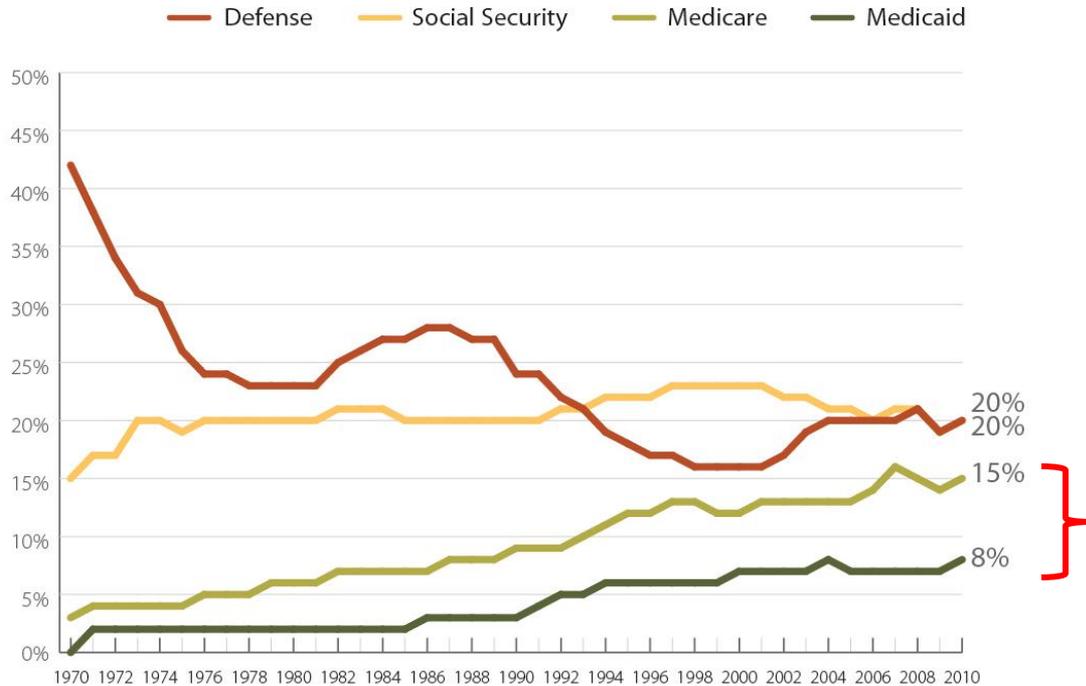
## Life expectancy for white women by years of education



# Disparities in Life Expectancy Persist



# Major Programs as a Share of the Federal Budget

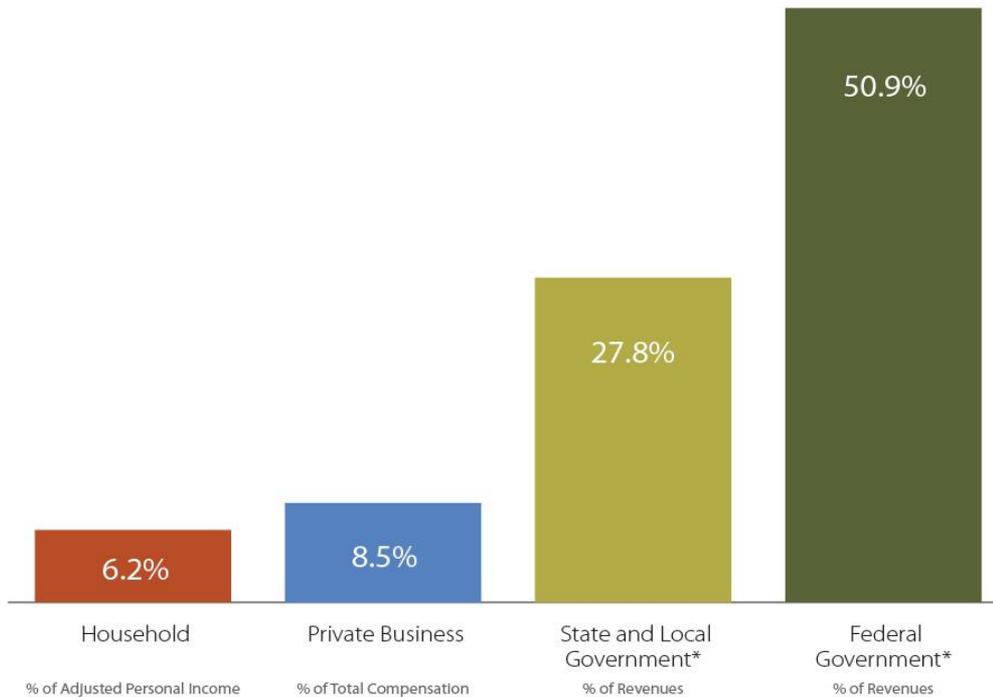


*Health care spending on Medicaid and Medicare now consumes 23% of the federal budget*

Notes: Spending shares computed as percentage of federal outlays. All outlays reflect federal spending only (i.e., Medicaid outlays shown reflect federal portion of Medicaid).  
 Sources: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release. Congressional Budget Office, *The Budget and Economic Outlook: Fiscal Years 2012 to 2020*, January 31, 2012, Appendix F, "Historical Budget Data," www.cbo.gov.

# Major Programs as a Share of the Federal Revenue

## Health Care's Consumption of Contributor Resources United States, 2010



**50.9 percent of federal revenues for Medicaid and Medicare compared to 23% of the federal budget**

**The difference is FEDERAL BORROWING**

\*Government revenues are receipts minus contributions for government social insurance; due to borrowing, federal government revenues are less than outlays.  
Source: Centers for Medicare and Medicaid Services (CMS), Office of the Actuary, National Health Expenditure Data, 2012 release.

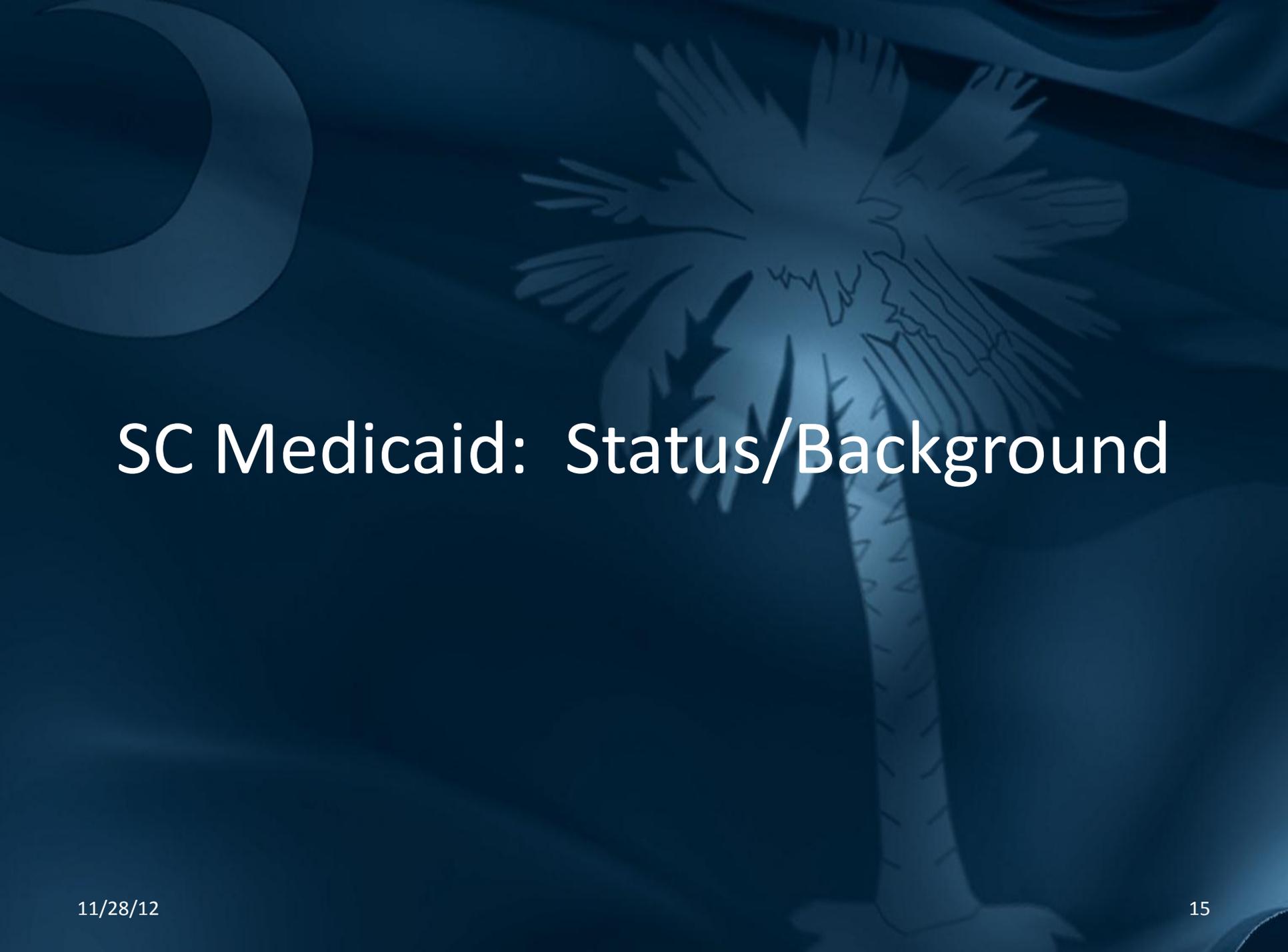
[Medicare] fails the test of short-range financial adequacy, as projected assets are already below one year's projected expenditures and are expected to continue declining...

[We] project that [Medicare] will pay out more in hospital benefits and other expenditures than it receives in income in all future years, as it has since 2008.

Social Security and Medicare Boards of Trustees  
*2012 Trustees Report*

...the financial projections shown in this report...do not represent a reasonable expectation for actual program operations in either the short range (as a result of the unsustainable reductions in physician payment rates) or the long range (because of the strong likelihood that the statutory reductions in price updates for most categories of Medicare provider services will not be viable).

Richard Foster; CMS Actuary  
*2012 Trustees Report; Statement of Actuarial Opinion*

The background features a stylized illustration of a palm tree with a textured trunk and a large, fan-like canopy of fronds. In the upper left corner, there is a large, dark crescent moon. The entire scene is rendered in shades of blue and teal against a dark background.

# SC Medicaid: Status/Background

# SC Medicaid: A Growing Investment



- FY 2013: \$1.882 billion State and Other Funds; \$4.063 billion Federal Funds; \$5.946 Total Funds
- FY 2013: The Medicaid budget represents about 18% of SC's State Funds and 25% of Total Funds
- FY 2013: June 30<sup>th</sup> projected enrollment of 1,034,304
- FY 2014: 5.1% growth in member months without ACA's Medicaid expansion

***22.4% of South Carolinians are currently enrolled in Medicaid***

***Pays for more than half of South Carolina births***

***Covers 40% of the state's children***

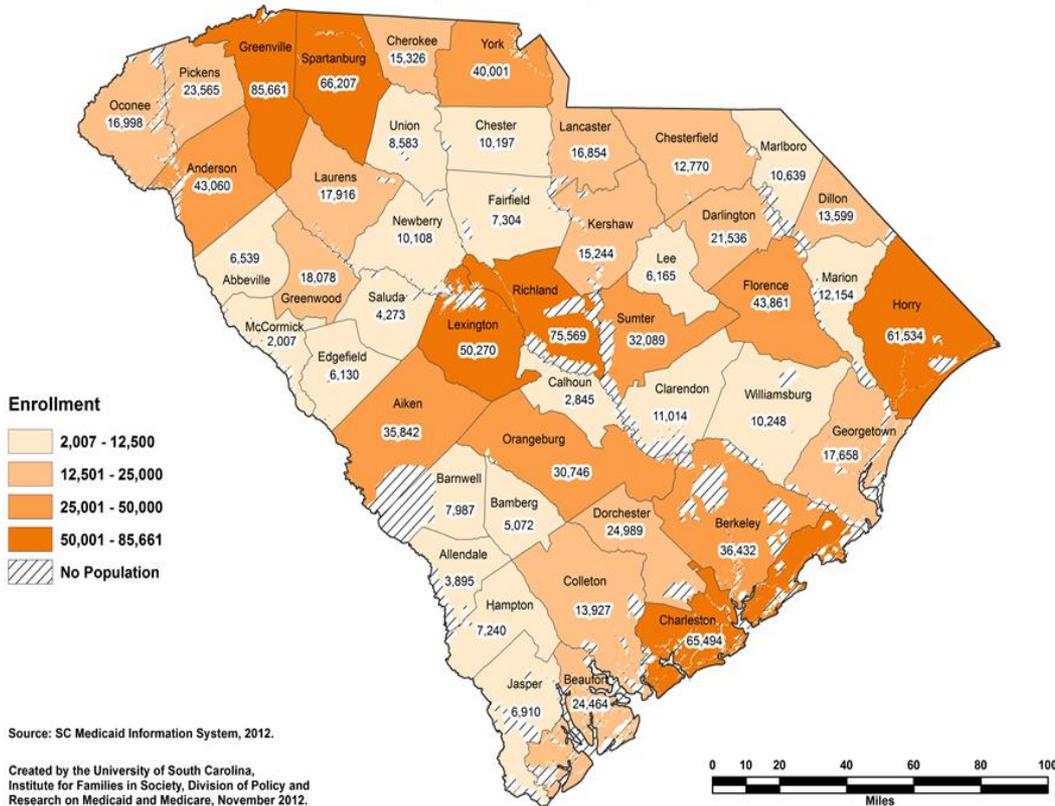
***Contracts with 82% of the state's nursing homes, and pays for 70% of the people in those facilities***

***Supplements Medicare for 130,000+ dual eligibles***

Source: Projected Enrollment from Milliman Spring 2012 Forecast

# SC Medicaid: Enrollees by County

Projected FY2014 Medicaid Enrollment Based on Current Program Participation by County  
(N = 1,059,000)

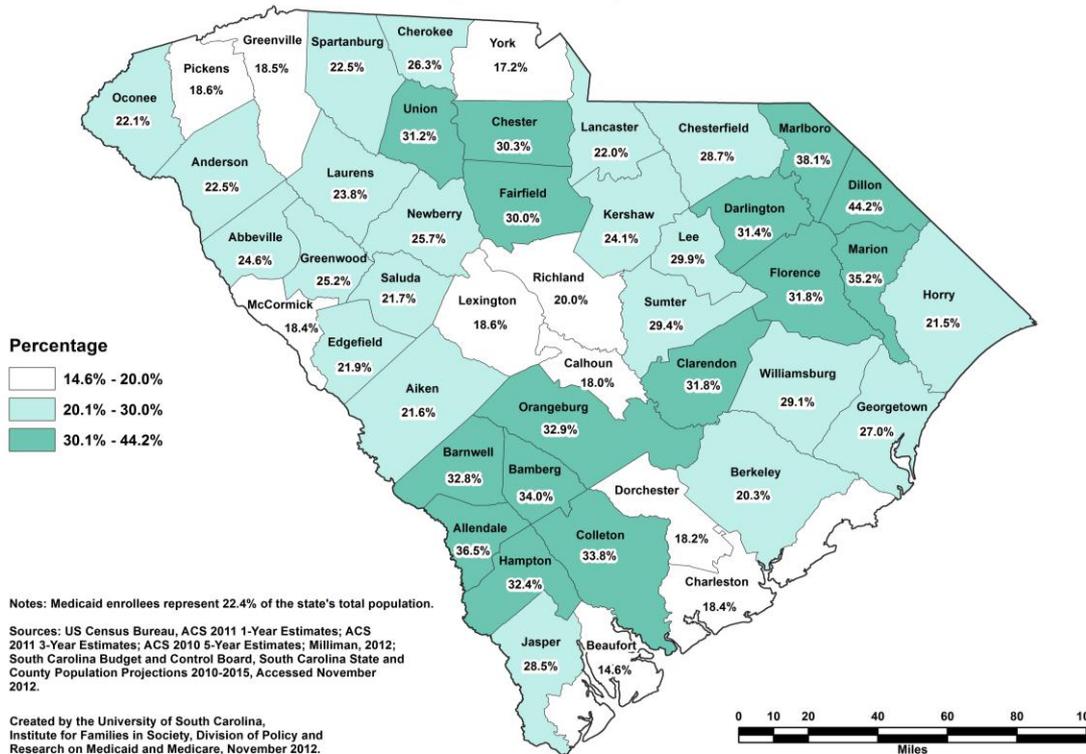


*The largest number of Medicaid enrollees is in the major metropolitan counties:*

- Greenville
- Spartanburg
- Lexington
- Richland
- Charleston
- Horry

# SC Medicaid: Penetration by County

South Carolina Medicaid Enrollees as a Percentage of Total Population by County  
Current Program Participation, FY2014  
(N = 1,059,000)

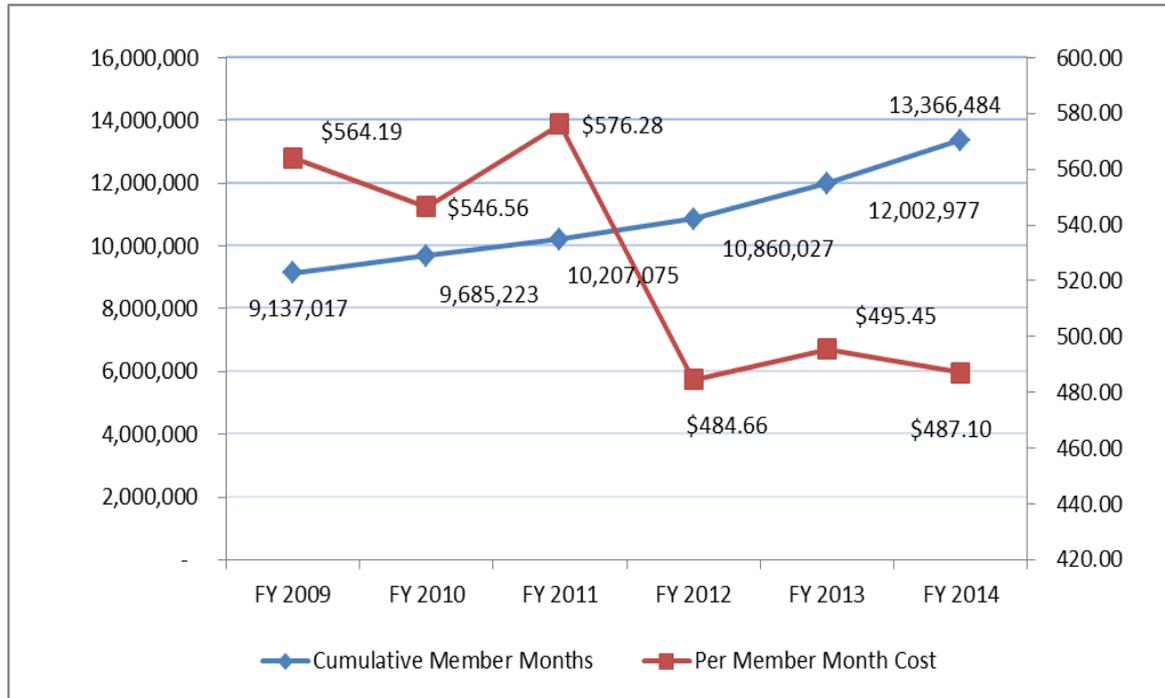


*The largest percent of total population covered is in the more rural counties:*

- **Dillon**
- **Marlboro**
- **Marion**
- **Allendale**
- **Colleton**
- **Bamberg**

# Budget Driver History

## Comparison of Cumulative Member Months to Costs

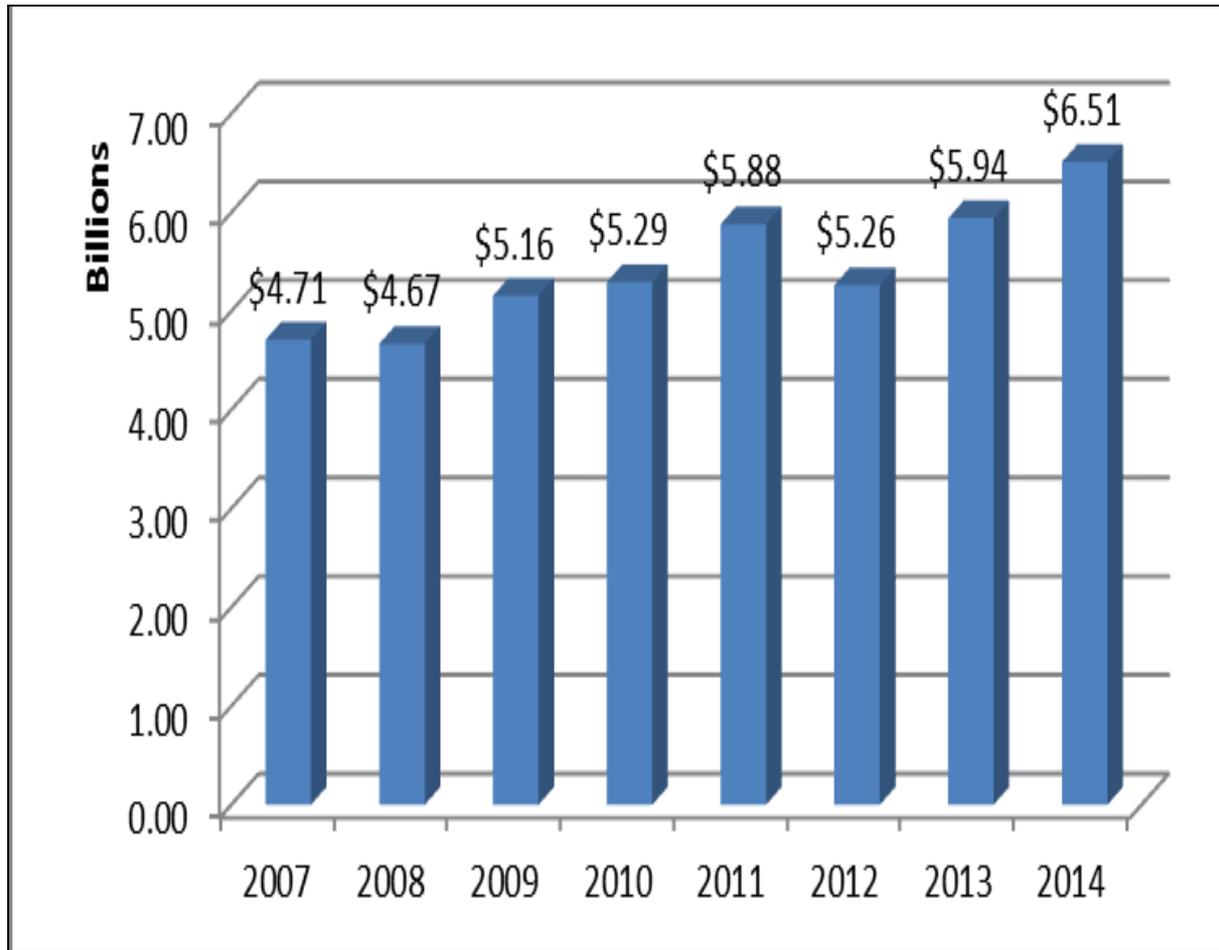


*Cumulative member months are currently projected to grow 46% from FY 2009 to budgeted FY 2014*

*PMPM is currently projected to decline 14% from FY 2009 to budgeted FY 2014*

Source: Milliman Spring 2012 Forecast and Department budget documents

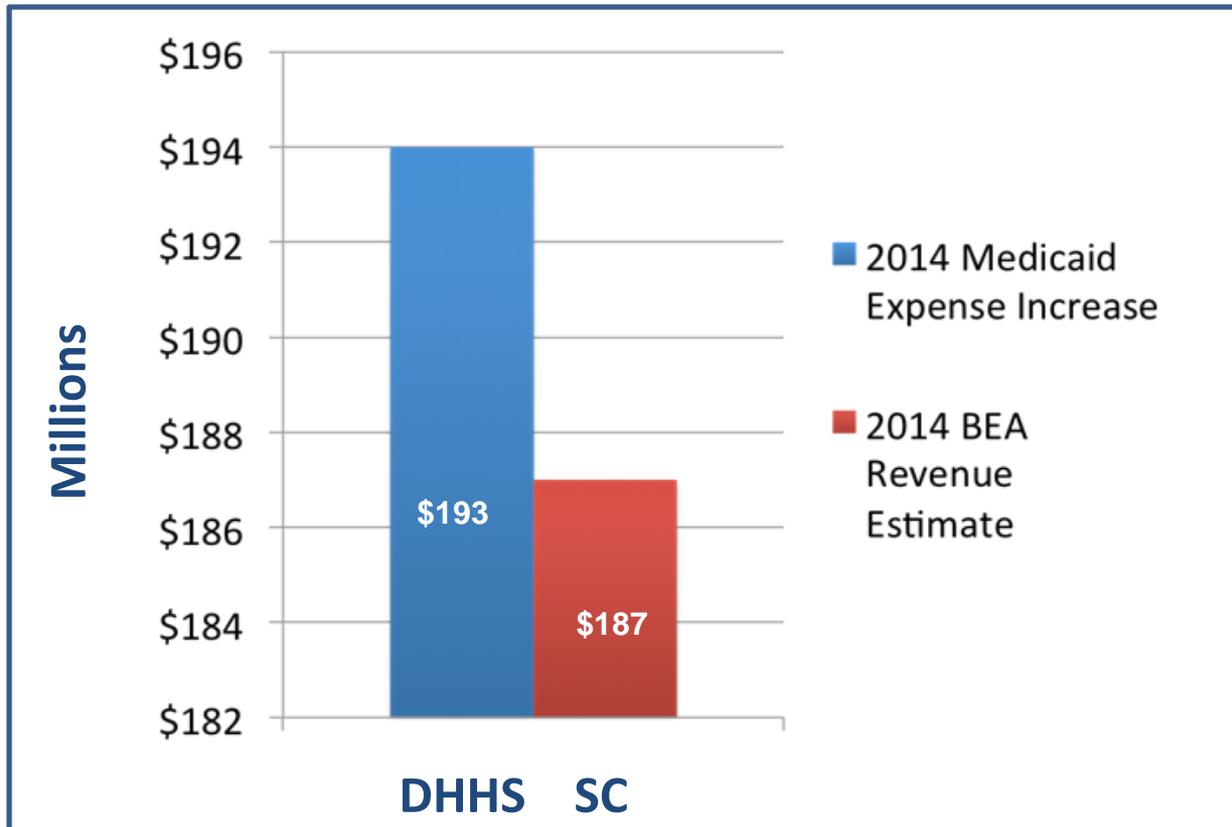
# SC Medicaid Total Expenditures



***Medicaid expenditures will have grown 38.21% from FY 2007 to FY 2014***

2007-2012 are actual expenditures, 2013 and 2014 are projected expenditures.

# SC Medicaid: Crowding Out Other Investments



*September budget submission for FY 2014 is \$6.510 billion in total funds*

*Unchanged, DHHS requires more new state general fund than is available to the state in FY 2014*

*The Governor's budget will reflect a significant decrease in this request*

# FY 2014 Medicaid Budget: Mandatory ACA Costs

Components of FY 2014 Budget Submission (State Funds)	
Enrollment	\$64,010,409
Inflation	\$27,272,707
Non Recurring to Recurring Revenue	\$60,781,757
Mandated Affordable Care Act	\$69,721,579
FMAP Rate Change	(\$25,731,476)
Efficiencies/Savings/Other	(\$2,577,256)
<b>Total</b>	<b>\$193,477,720</b>

*Mandated costs associated with ACA require \$69.7 million state funds in FY 2014*

*These mandated ACA costs do not include the optional Medicaid expansion costs*

# Other States' Experiences

The Hill-Healthwatch (10/27/2011) ✓

Obama administration approves massive Medicaid cuts requested by California

Hartford Courant (11/19/2012) ✓

Expanded Medical Coverage Large Part of State Shortfall

✗ Kaiser Health News (10/3/2012)

Maine Seeks to Cut Medicaid Eligibility

Heartlander (10/9/2012) ✓

Massachusetts Sets Global Cap on Health Care Costs

Bloomberg (1/9/2011) ✗

Christie Targets Medicaid to Close \$10.5 Billion New Jersey Budget Deficit

State Budget Solutions (11/18/2012) ✓

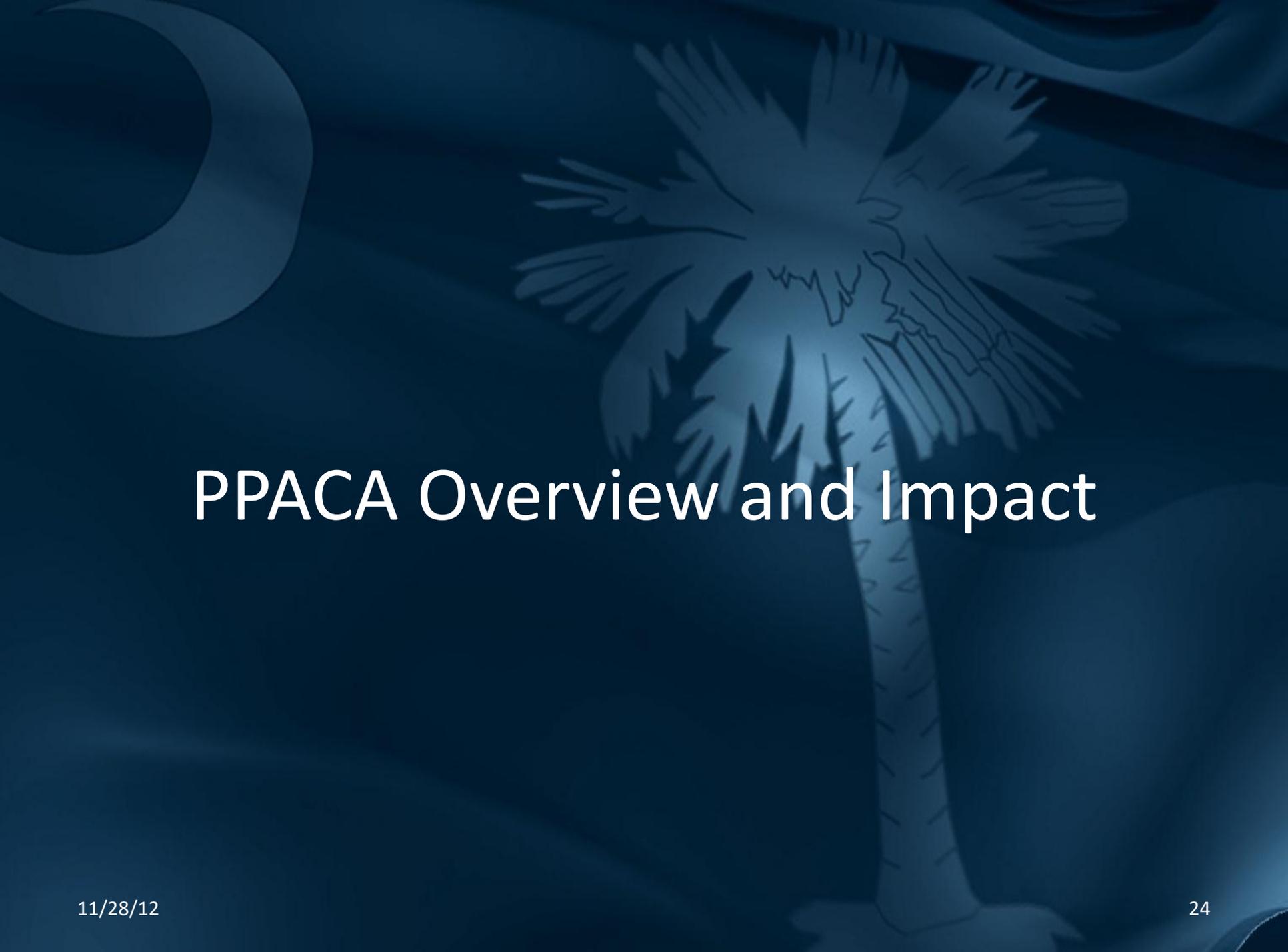
Washington state budget outlook predicts shortfall

Becker's Hospital Review (7/8/2011) ✓

Quinn-Backed Budget Means 5-Month Delay in Illinois Medicaid Payments

American Medical News (8/5/2011) ✓

Minnesota cuts Medicaid pay...

The background of the slide features a dark blue, monochromatic illustration of a tropical scene. On the left, a large, stylized crescent moon is visible. In the center and right, a palm tree with a textured trunk and a full, spiky crown of fronds stands prominently. The overall aesthetic is clean and modern, with a focus on geometric shapes and a limited color palette.

# PPACA Overview and Impact

- Individual mandate remains standing under Congress' taxing authority
- Exchanges, premium tax credits, insurance rules, Co-ops and other programs still stand
- Medicaid expansion is now optional for each state
- Subsidies are available to individuals from 100% FPL and above

# SC ACA Timeline

- 2013
  - Temporary bump in Primary Care Payments
  - January: State exchanges certified
  - Qualified Health Plans certified
  - October: Exchanges begin enrollment for Medicaid and qualified health plans for Jan 14
  - New Medicaid Application in place
- 2014
  - Individual Mandate/Penalty/Tax Begins
  - Advance Premium Tax Credits Begin
  - Optional Medicaid Expansion
  - MAGI for Eligibility Determination, Exchanges, Streamlined Enrollment
  - New rating rules for private insurance

***These are high level program deadlines required by the statute that the public and many stakeholders will generally need to be aware of***

# ACA Project Timeline

## 2013 Mandated Project Examples

- Temporary Primary Care Physician Payment Increase
  - Improves Medicaid beneficiary access to primary care services
- Tobacco Cessation Drug Coverage
  - Requires states cover tobacco cessation products, including barbiturates and benzodiazepines
- Single Streamlined Application
  - Part of a “no wrong door” experience for consumers seeking public or private health insurance
- Modified Adjusted Gross Income
  - Simplifies the eligibility process by consolidating categories
- Interface with the Federally Facilitated Exchange
  - Ensures that eligible South Carolinians have access to federal tax credits

*SCDHHS currently has 41 ACA related projects*

*The number of projects continues to grow as regulations are released*

*The delay of these regulations creates uncertainty*

- *No regs for Presumptive Eligibility in Hospitals*
- *Not enough Single Streamlined App and Interfacing guidance*
- *Not enough time for IT implementations*

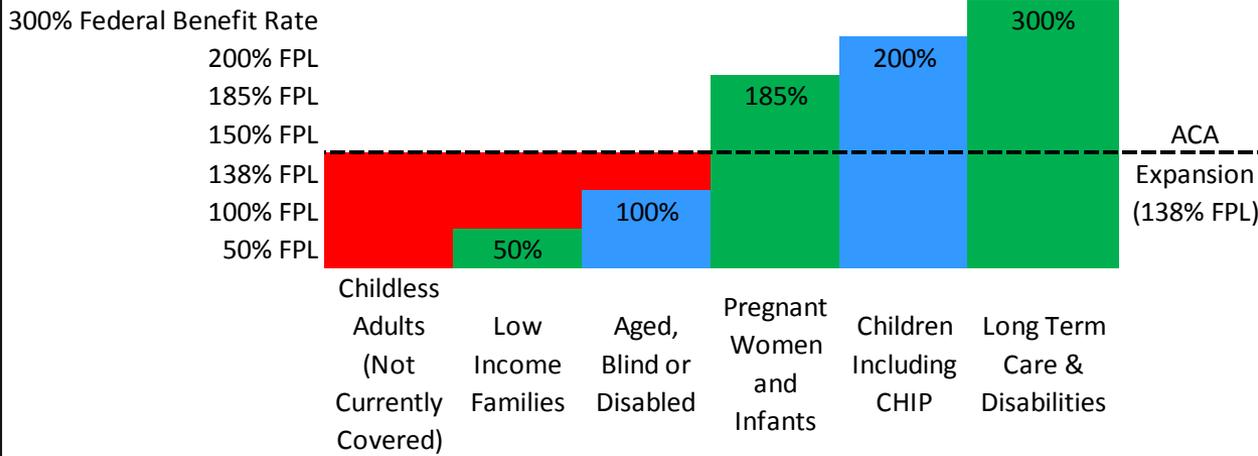
## ACA's optional Medicaid expansion would cover up to 138% FPL

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

\* Source: 2011 American Communities Survey, projected to 2014

# ACA's Medicaid Expansion: A New Eligibility Floor

SC Medicaid Program Federal Poverty Levels (FPL)



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

# Medicaid Expansion in SC: 1.7 Million Enrollees by 2020

## If SC Chooses to Expand Medicaid:

**193,000 could drop private insurance to go on Medicaid**

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

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

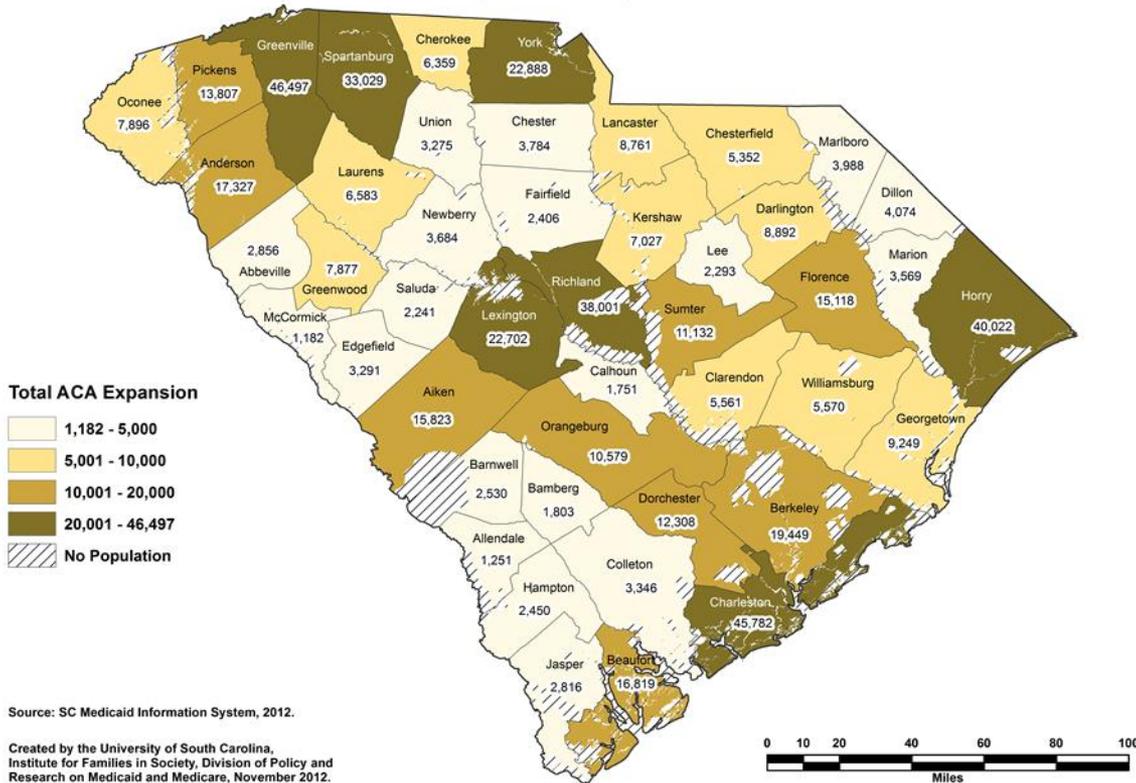
Projected Enrollment Growth			
Population	FY 2013	SFY 2014	FY 2020
<b>Current Programs</b>			
Medicaid	938,000	985,000	1,077,000
CHIP	70,000	74,000	80,000
<b>Total Current Programs</b>	<b>1,008,000</b>	<b>1,059,000</b>	<b>1,157,000</b>
<b>After ACA - 67% Average Participation</b>			
<b>Expansion Population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

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

Source: Milliman ACA Impact Analysis

# ACA's Optional Medicaid Expansion Enrollee Growth

Projected FY2014 Total Expansion from ACA Participation by County  
(N = 513,000)



*FY 2014: 513,000 new enrollees would come onto Medicaid under the best estimate scenario of full expansion*

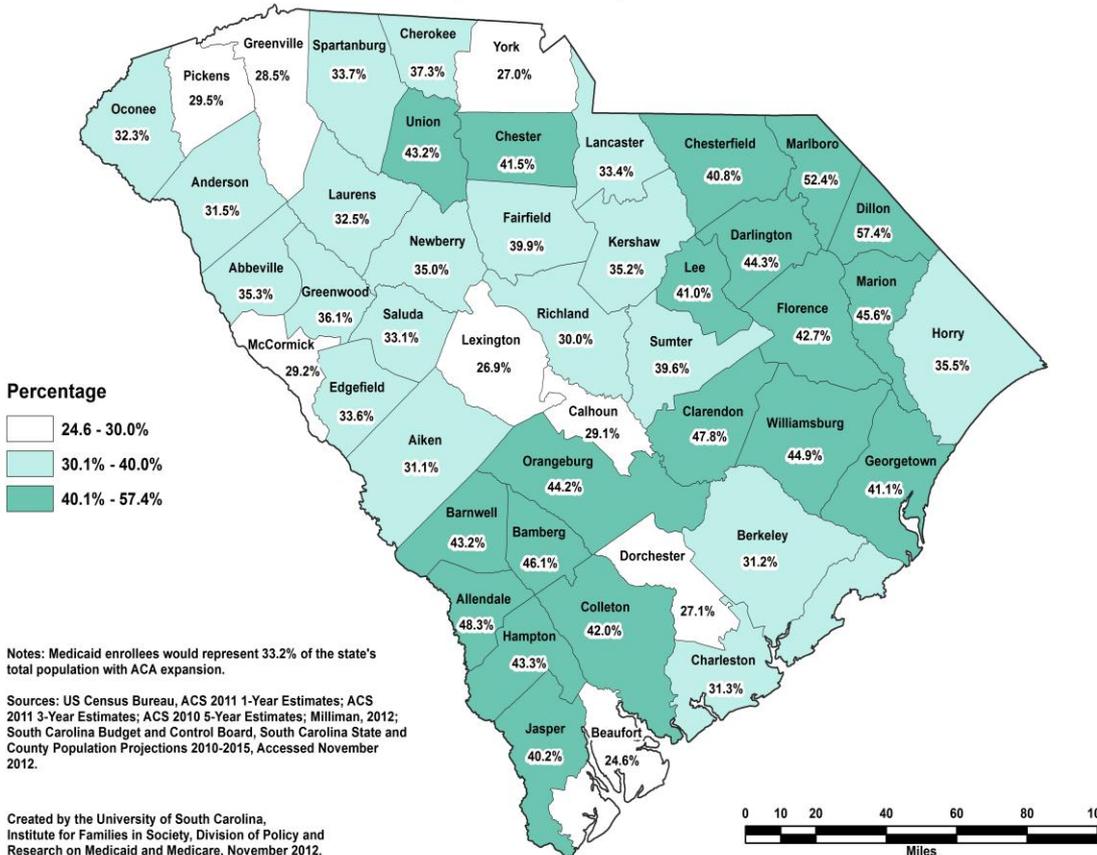
*The largest increase in numbers (and money) flow into the metropolitan counties*

Source: SC Medicaid Information System, 2012.

Created by the University of South Carolina, Institute for Families in Society, Division of Policy and Research on Medicaid and Medicare, November 2012.

# ACA's Optional Medicaid Expansion Penetration Growth

South Carolina Medicaid Enrollees as a Percentage of Total Population by County  
Current Program Participation and ACA Expansion, FY2014  
(N = 1,572,000)



*The largest percent of total population covered remains in the more rural counties:*

- *Dillon*
- *Marlboro*
- *Allendale*
- *Bamberg*
- *Marion*
- *Darlington*



# New FMAP Rates for Optional Expansion

Year	Federal Medicaid Match for “Newly Eligible”	State Share for “Newly Eligible”	Administrative Match
2014-2016	100%	0%	50%
2017	95%	5%	50%
2018	94%	6%	50%
2019	93%	7%	50%
2020 on	90%	10%	50%

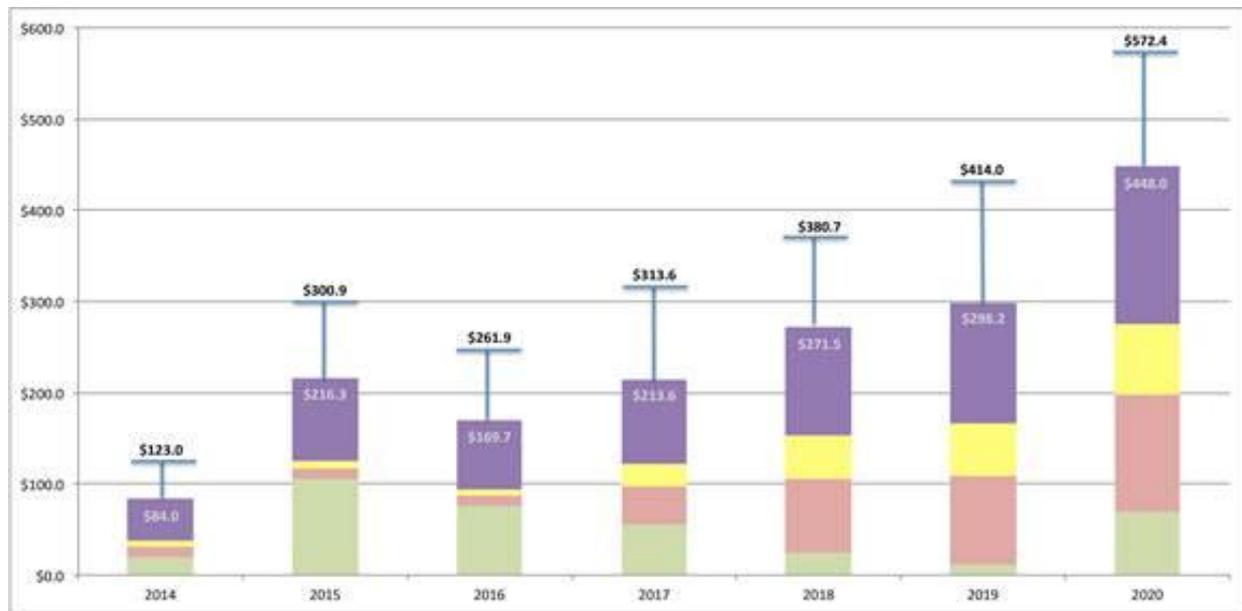
*States pay for half the administrative costs for a Medicaid Expansion*

*States continue with regular match rate for those eligible but not enrolled*

*President’s budget has suggested changes to these matching rates to obtain savings*

# ACA in SC:

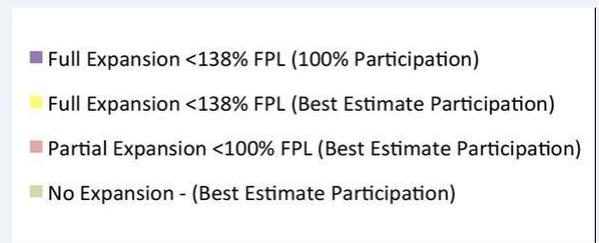
## Yearly Impact - State Expenditures (In Millions)



*These include costs and credits of the ACA*

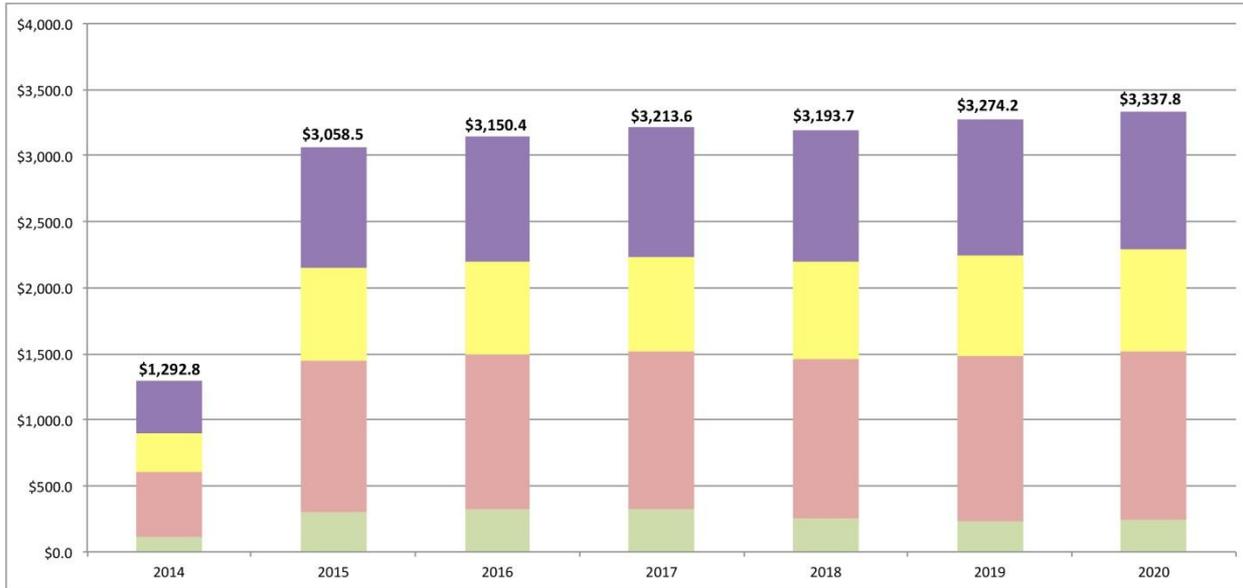
*The higher amount includes increasing the physician fee schedule for all physicians up to 100% of Medicare*

	No Expansion (Best Estimate Participation)	Partial Expansion <100% FPL (Best Estimate Participation)	Full Expansion <138% FPL (Best Estimate Participation)	Full Expansion <138% FPL (100% Participation)
<b>2014</b>	\$19.5	\$31.3	\$38.4	\$84.0
<b>2015</b>	\$105.4	\$117.4	\$124.8	\$216.3
<b>2016</b>	\$75.8	\$86.6	\$93.3	\$169.7
<b>2017</b>	\$55.5	\$96.6	\$121.6	\$213.6
<b>2018</b>	\$24.1	\$104.6	\$153.3	\$271.5
<b>2019</b>	\$11.4	\$108.3	\$167.1	\$298.2
<b>2020</b>	<u>\$69.1</u>	<u>\$197.6</u>	<u>\$275.4</u>	<u>\$448.0</u>
<b>Total</b>	\$360.7	\$742.3	\$973.9	\$1,701.4



# ACA in SC:

## Yearly Impact - Federal Expenditures (In Millions)



*Federal dollars will flow into the system under all scenarios*

- Full Expansion <138% FPL (100% Participation)
- Full Expansion <138% FPL (Best Estimate Participation)
- Partial Expansion <100% FPL (Best Estimate Participation)
- No Expansion - (Best Estimate Participation)

	No Expansion (Best Estimate Participation)	Partial Expansion <100% FPL (Best Estimate Participation)	Full Expansion <138% FPL (Best Estimate Participation)	Full Expansion <138% FPL (100% Participation)
<b>2014</b>	\$114.9	\$601.5	\$897.4	\$1,292.8
<b>2015</b>	\$304.0	\$1,450.0	\$2,145.5	\$3,058.5
<b>2016</b>	\$320.8	\$1,491.8	\$2,201.9	\$3,150.4
<b>2017</b>	\$320.2	\$1,512.8	\$2,235.9	\$3,213.6
<b>2018</b>	\$253.8	\$1,462.0	\$2,194.7	\$3,193.7
<b>2019</b>	\$231.8	\$1,481.0	\$2,238.4	\$3,274.2
<b>2020</b>	\$239.2	\$1,517.1	\$2,291.5	\$3,337.8
<b>Total</b>	\$1,784.8	\$9,516.1	\$14,205.2	\$20,520.9

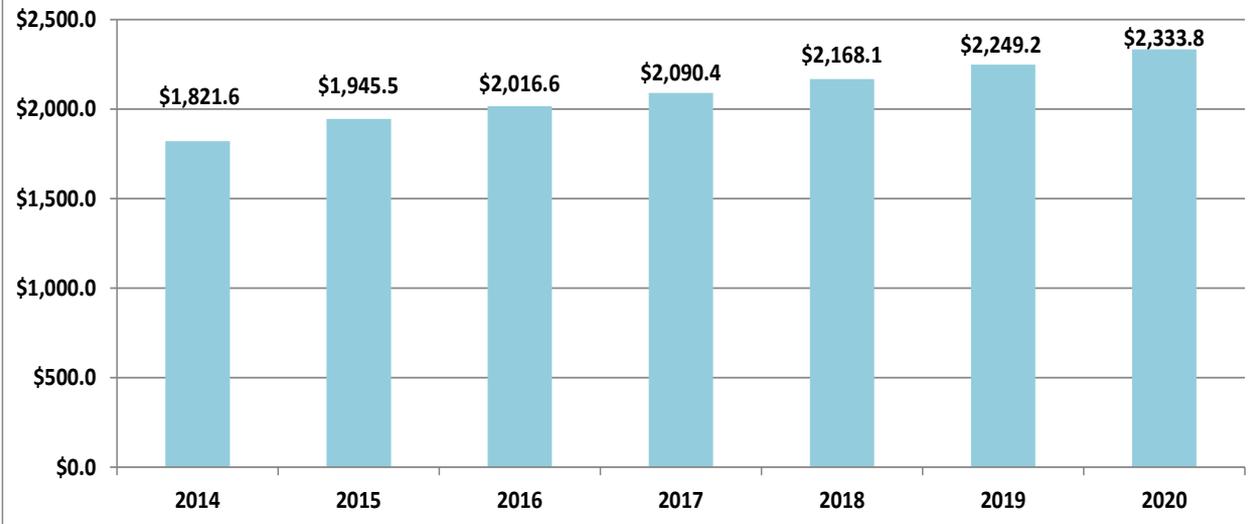
# Current Medicaid Program: Paying for What We Already Have

*Even without the optional Medicaid expansion:*

*Natural Medicaid growth would cost the state \$2.334 million annually by 2020*

***In 2020 Medicaid will require \$512 million more state match per year to support our current program***

Current Program - State Expenditures (In Millions)



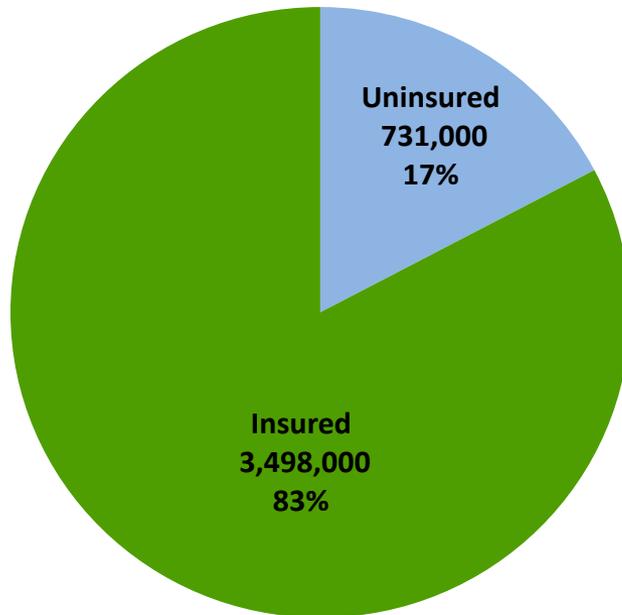
Source: Milliman ACA Impact Analysis

# This is the Cost: \$360 M to \$2.3 B

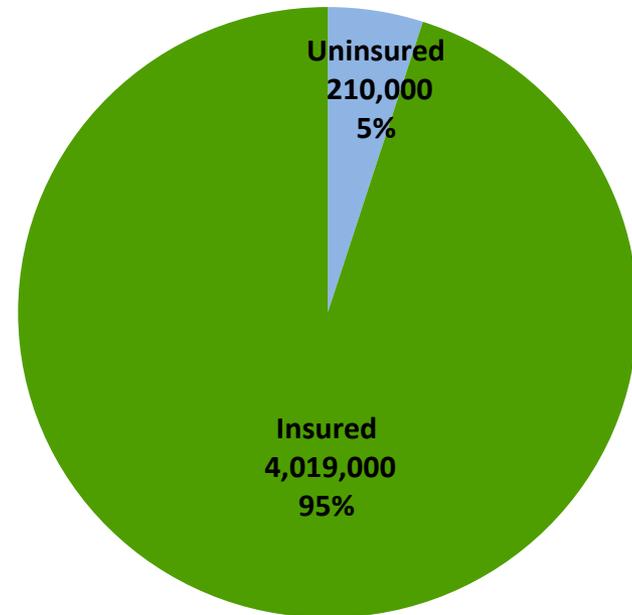
November 2012 Medicaid Expansion Projections SFY 2014 to 2020 (in \$ millions) - State Expenditures				
Category	Without Expansion - Woodwork Effect (Best Estimate Participation)	Partial Expansion to 100% FPL (Best Estimate Participation)	Full Expansion to 138% FPL (Best Estimate Participation)	Full Expansion to 138% FPL (100% Participation)
<b>Pre-ACA : Expected Program Growth</b>	<b>\$2,071.3</b>	<b>\$2,071.3</b>	<b>\$2,071.3</b>	<b>\$2,071.3</b>
ACA Impact to Current Program				
Pharmacy Rebate Savings – MCO	(\$477.3)	(\$477.3)	(\$477.3)	(\$477.3)
DSH Payment Reduction	(\$166.6)	(\$166.6)	(\$166.6)	(\$166.6)
CHIP Program – Enhanced FMAP	(\$128.6)	(\$128.6)	(\$128.6)	(\$189.9)
ACA Impact - Currently Eligible				
Eligible but Not Enrolled - Uninsured	\$520.5	\$520.5	\$520.5	\$746.6
Eligible but Not Enrolled - Currently Insured	\$476.4	\$476.4	\$476.4	\$790.3
CHIP Program – Enhanced FMAP	(\$66.3)	(\$66.3)	(\$66.3)	(\$97.9)
ACA Impact - Expansion Population				
Expansion Population - Uninsured	\$0.0	\$220.4	\$330.3	\$407.9
Expansion Population - Currently Insured	\$0.0	\$55.0	\$120.6	\$215.2
SSI Eligible	\$0.0	\$14.8	\$14.8	\$14.8
Health Insurer Assessment Fee	\$138.0	\$145.5	\$149.7	\$164.4
Physician Fee Schedule Change	\$3.5	\$3.5	\$3.5	\$3.6
Expenditure Shift from Other State Agencies	\$0.0	\$2.1	\$3.5	\$4.8
Administrative Expenses	\$61.1	\$142.9	\$193.4	\$285.5
<b>Sub-total</b>	<b>\$360.7</b>	<b>\$742.3</b>	<b>\$973.9</b>	<b>\$1,701.4</b>
Non-Medicaid Other State Agency Offsets	\$0.0	(\$26.8)	(\$43.7)	(\$61.4)
Sensitivity - Increase Physician Reimbursement to 100% Medicare	\$0.0	\$610.5	\$620.8	\$665.1
<b>Sub-total</b>	<b>\$360.7</b>	<b>\$1,326.0</b>	<b>\$1,551.0</b>	<b>\$2,305.1</b>
<b>Post-ACA : Expected Program Growth</b>	<b>\$2,432.0</b>	<b>\$3,397.3</b>	<b>\$3,622.3</b>	<b>\$4,376.4</b>

# ACA Impact on South Carolina Uninsured without Expansion

Pre-ACA: 2013 Uninsured



Post-ACA: 2014 Projected Uninsured



## By 2015

*Significant growth will occur in the number of insured adults in both the Medicaid and private market*

*The system will have a difficult time absorbing this growth – it may require between 250-300 full-time physician equivalents*

# How Will the Market Change with ACA's Optional Medicaid Expansion

Category	Current Market	2014 No Expansion	2014 100% FPL Expansion	2014 133% FPL Expansion
Uninsured	731,000	210,000	42,000	42,000
Medicaid	1,059,000	1,228,000	1,438,000	1,572,000
Private Market	2,439,000	2,358,000	2,316,000	2,266,000
Exchange	0	433,000	433,000	349,000
<b>Total</b>	<b>4,229,000</b>	<b>4,229,000</b>	<b>4,229,000</b>	<b>4,229,000</b>

*Significant growth will occur in the number of insured adults in both the Medicaid and private market*

*The number of uninsured in South Carolina will decrease by 71 percent (521,000) even without Medicaid expansion*

Source: 2011 American Communities Survey, projected to 2014

The background features a dark blue gradient with a stylized, light blue illustration of a palmetto tree in the center. To the left, there is a large, light blue crescent moon. The overall aesthetic is clean and modern, with a focus on South Carolina's state symbols.

# South Carolina Strategy

# DHHS Fundamental Analysis

- Social determinants are 80-90% of health
- IOM: Health care spending rising faster than GDP is
  - Creating a health care bubble
  - Depressing economic growth
  - Diverting state investment in education and infrastructure

***One-third of all health care spending is wasteful. \$750 billion nationally in 2009 and \$1.8 billion in SC Medicaid next year.***

## ***Excess spending:***

- ***Unnecessary services***
- ***Administrative waste***
- ***Inefficient services***
- ***High prices***
- ***Fraud and abuse***
- ***Missed prevention opportunities***

Improve value by lowering costs and improving outcomes:

- Increased investment in education, infrastructure and economic growth
- Shift of health care spending to more productive health and health care services
- Increased coverage/treatment of vulnerable populations

## *SC Strategic Pillars:*

- *Payment reform*
- *Clinical integration*
- *Focus on hot-spots and disparities*

# South Carolina Strategic Pillars

## Payment Reform

- MCO Incentives & Withholds
- Payor-Provider Partnerships
- Catalyst for Payment Reform
- Value Based Insurance Design

## Clinical Integration

- Dual Eligible Project
- Patient Centered Medical Homes
- Telemedicine/Monitoring

## Hotspots & Disparities

- Birth Outcomes Initiative
- Express Lane Eligibility
- Foster Care Coordination
- Health Access/Right Time (HeART)

## *Purchasing Quality Health Outcomes*

*(Social Determinants of Health)*

## *Pushing Out Excess*

*Costs (IOM: Health Care  
Inefficiencies)*

## *Providing Value to the Taxpayer*

# Payment Reform: MCO Incentives & Withholds

## Withholds based on performance

- HEDIS Scores
  - Prevention and Screening
  - Chronic Disease and Behavioral Health
  - Access and Availability
  - Consumer Experience

## Incentives

- Patient Centered Medical Homes
  - PMPM payment will be made to provider and health plan in four payment levels
  - Payments will be quarterly based on enrollment
- Birth Outcomes Initiative (BOI)
  - Screening, Brief Intervention, Referral and Treatment
  - Centering Program
  - Nurse Family Partnership
  - Reduce prematurity or low birth weight

## *Withholds*

- ***\$8 million CY 2012***
- ***\$24 million+ CY 2013***

## *Incentives*

- ***\$16 million CY 2012***
- ***\$16 million+ CY 2013***

# Payment Reform: Catalyst for Payment Reform

- 20/20 Value Oriented Payment
  - P4P: HAC, Readmits
  - Reduced variation: COE, reference price
  - Benefit design
  - Early elective deliveries
- Transparency
  - Price and quality for providers and plans
- Competition and Consumerism
  - Tiered and narrow networks



**C**ATALYST  
*FOR*  
**P**AYMENT  
**R**EFORM

*8 million covered lives nationally*

*Members include:*

- *3M*
- *Boeing*
- *GE*
- *Delta*
- *Wal-Mart*
- *SC and OH Medicaid*
- *Marriott*
- *Dow*
- *FedEx and others*

# Payment Reform: Value Based Insurance Design (VBID)

- Aligns patients' out-of-pocket costs, such as copays and premiums, with the value of health services
- Recognizes that different health services have different levels of value
- Reduces barriers to high-value treatments (through lower costs to patients) and encourages reconsideration of low-value treatments (through higher costs to patients)

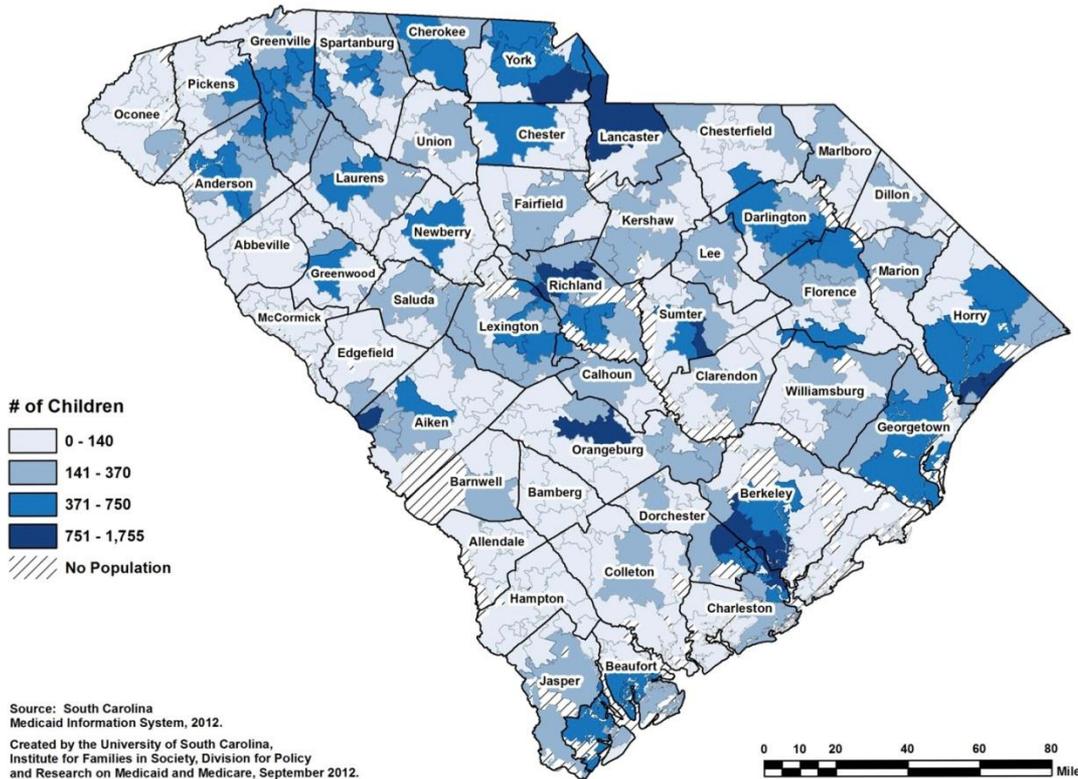
*How do we make Medicaid look more like successful private plans in terms of benefit design?*

*SCDHHS is discussing VBID with other payors in the state and is hosting a workshop in December*

*This is the most effective, evidence based way to get more patient "skin" in the game*

# Express Lane Eligible Children

Children Newly Eligible for Medicaid in South Carolina by ZCTA



*45,000 children have been enrolled in the past 6 weeks through Express Lane Eligibility*

*Last year 140,000 kids became ineligible for at least one day*

*150,000 ELE redeterminations have essentially eliminated this problem*

*Some of the biggest gains are in hot spots of poor health*

# Hotspots & Disparities: Foster Care Coordination

Effective November 1, 2012, in accordance with an evaluation conducted by SCDSS:

- Approximately 2,300 children currently in foster care, and all new children entering foster care, will be enrolled in First Choice by Select Health of South Carolina, an MCO
- Approximately 1,000 children currently in foster care will be enrolled in South Carolina Solutions, an MHN

*SCDSS is working with SCDHHS to provide medical homes for the foster care children*

*Applying the benefits of care coordination to the foster care population will provide better quality outcomes*

# Hotspots & Disparities: Health Access/Right Time (HeART)

- Minute clinics and after-hours
- Community health workers
- Telehealth
- Free Clinics Conversion (integrate as Medicaid Providers)
- Obesity/Hypertension/Diabetes
- Enhance Capacity of Nurse Practitioners/Physician Assistants

*Making care available at off hours and in more convenient places will reduce treatment for minor ailments in emergency rooms*

*It will also increase screening rates*

## A Path Forward

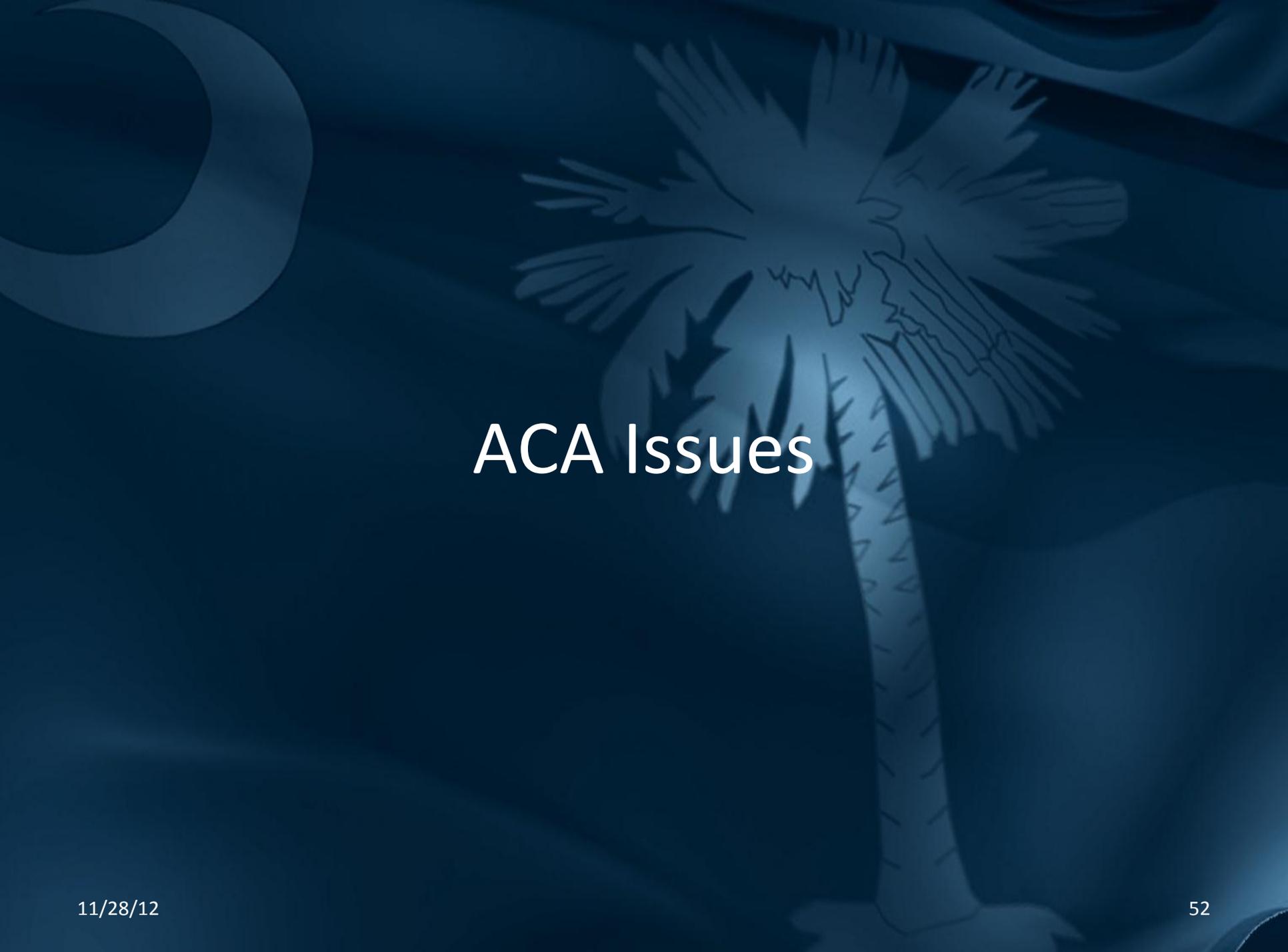
- Continue working on the three strategic pillars
- Manage mandated enrollment growth under ACA
- Set performance expectations for health system to improve value
- Look for flexible means of increasing high need coverage using future savings

***The amount of implementation risk is significant***

***Just expanding coverage does not mean meaningful connection will be made between providers and patients***

***Projection risk is very high***

***A conservative approach is imperative***

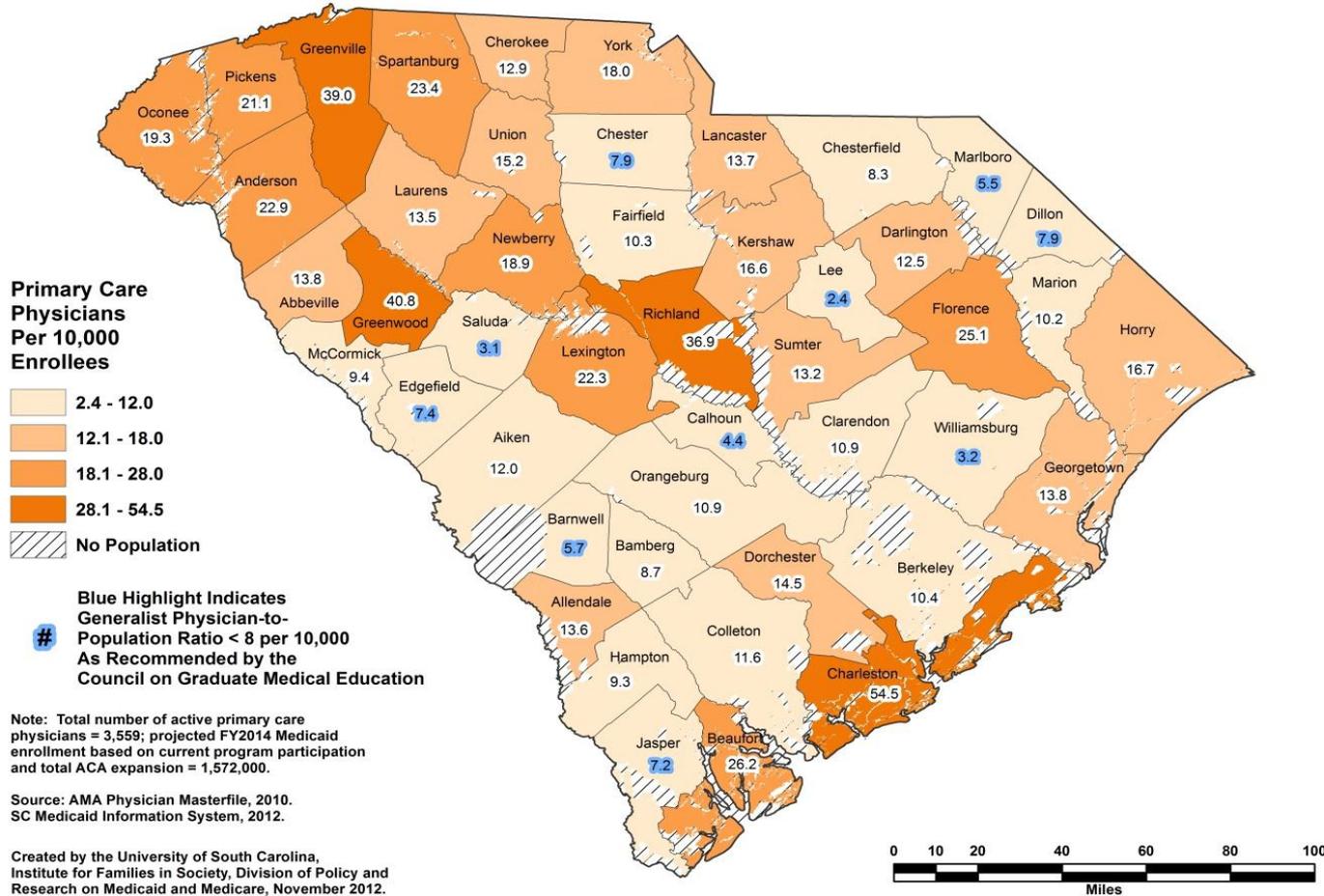
The background of the slide is a dark blue gradient. In the upper left, there is a large, light blue crescent moon. In the center and right, there is a stylized palm tree with a textured trunk and a crown of fronds. The text "ACA Issues" is centered in white.

# ACA Issues



# Strained Provider Capacity in SC with Medicaid Expansion

**Active Primary Care Physicians per 10,000 Medicaid Enrollees  
Based on Current Program Participation  
And Total Expansion from ACA Participation by County, FY2014**



# DSH Shifts But Funds Don't Disappear

## Projected DSH Expenditures (In Millions) - State & Federal

SFY	Baseline DSH Budget	Estimated ACA DSH Allotment	Estimated ACA DSH Reduction	Net DSH
2014	\$461.5	\$472.0	\$0.0	\$461.5
2015	\$461.5	\$463.3	\$0.0	\$461.5
2016	\$461.5	\$462.2	\$0.0	\$461.5
2017	\$461.5	\$423.4	(\$38.1)	\$423.4
2018	\$461.5	\$307.3	(\$154.2)	\$307.3
2019	\$461.5	\$253.4	(\$208.1)	\$253.4
2020	\$461.5	\$298.6	(\$162.9)	\$298.6

*Presumably as the rate of uninsured declines, hospitals need less DSH to pay for the uninsured*

*Estimates are that the number of uninsured will decrease by 521,000*

## Projected DSH Expenditures (In Millions) - State Only

SFY	Baseline DSH Budget	Estimated ACA DSH Allotment	Estimated ACA DSH Reduction	Net DSH
2014	\$136.5	\$139.6	\$0.0	\$136.5
2015	\$136.5	\$137.0	\$0.0	\$136.5
2016	\$136.5	\$136.7	\$0.0	\$136.5
2017	\$136.5	\$125.2	(\$11.3)	\$125.2
2018	\$136.5	\$90.9	(\$45.6)	\$90.9
2019	\$136.5	\$74.9	(\$61.5)	\$74.9
2020	\$136.5	\$88.3	(\$48.2)	\$88.3

*If we don't need to use state match for DSH – we can use it elsewhere in the program*

*The federal government has not released DSH rules*

Source: Milliman ACA Impact Analysis

# Jobs

The background is a dark blue gradient. In the upper left, there is a large, light blue crescent moon. In the center-right, there is a stylized palm tree with a textured trunk and a crown of fronds. The word "End" is written in white, sans-serif font in the center of the image.

End