Many estimates are preliminary projections as of December 2012 and not considered final. These estimates may change as more state and federal data and guidance becomes available.
What is the problem?
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
Total health care spending in the United States has nearly doubled more every decade since 1960.
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.


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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.

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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

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

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.
In 1950 US life expectancy ranked 12th at 68.9 years

In 2009 the US ranked 28th at 79.2 years

In 2007 South Carolina ranked 42nd in the US at 76.6 years

Disturbing disparities exist and for certain groups life expectancy has actually fallen in the past 2 decades.
Disparities in Life Expectancy Persist

![Graph showing life expectancy at birth by years of education and gender for different ethnic groups.](image-url)
Health care spending on Medicaid and Medicare now consumes 23% of the federal budget.
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.

[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
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 30th projected enrollment of 1,034,304

- **FY 2014:** 5.1% growth in member months without ACA’s Medicaid expansion

Source: Projected Enrollment from Milliman Spring 2012 Forecast
The largest number of Medicaid enrollees is in the major metropolitan counties:

- Greenville
- Spartanburg
- Lexington
- Richland
- Charleston
- Horry
The largest percent of total population covered is in the more rural counties:

- Dillon
- Marlboro
- Marion
- Allendale
- Colleton
- Bamberg
Budget Driver History

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.

12/3/2012
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**

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

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

- Obama administration approves massive Medicaid cuts requested by California
- Expanded Medical Coverage Large Part of State Shortfall
- Maine Seeks to Cut Medicaid Eligibility
- Massachusetts Sets Global Cap on Health Care Costs
- Christie Targets Medicaid to Close $10.5 Billion New Jersey Budget Deficit
- Washington state budget outlook predicts shortfall
- Minnesota cuts Medicaid pay...

Kaiser Health News (10/3/2012)
Heartlander (10/9/2012)
Bloomberg (1/3/2011)
State Budget Solutions (11/18/2012)
American Medical News (8/5/2011)
PPACA Overview and Impact
Supreme Court Summary

• 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
• 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**

<table>
<thead>
<tr>
<th>FPL</th>
<th>&lt;100% FPL</th>
<th>100% FPL to 138% FPL</th>
<th>139% FPL to 200% FPL</th>
<th>201% FPL to 399% FPL</th>
<th>&gt;400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012 Annual Income - Family of 4</td>
<td>&lt;$23,050</td>
<td>$23,051 to $31,809</td>
<td>$31,810 to $46,100</td>
<td>$46,101 to $69,150</td>
<td>&gt;$69,150</td>
</tr>
<tr>
<td>Uninsured</td>
<td>284,000</td>
<td>106,000</td>
<td>131,000</td>
<td>127,000</td>
<td>83,000</td>
</tr>
<tr>
<td>% of Uninsured</td>
<td>39%</td>
<td>15%</td>
<td>18%</td>
<td>17%</td>
<td>11%</td>
</tr>
</tbody>
</table>

* Source: 2011 American Communities Survey, projected to 2014
ACA’s Medicaid Expansion: A New Eligibility Floor

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

SC Medicaid Program Federal Poverty Levels (FPL)

- 300% Federal Benefit Rate
- 200% FPL
- 185% FPL
- 150% FPL
- 138% FPL (ACA Expansion)
- 100% FPL (138% FPL)
- 50% FPL

Categories:
- Childless Adults (Not Currently Covered)
- Low Income Families
- Aged, Blind or Disabled
- Pregnant Women and Infants
- Children Including CHIP
- Long Term Care & Disabilities
## Medicaid Expansion in SC: 1.7 Million Enrollees by 2020

### Projected Enrollment Growth

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

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

Source: Milliman ACA Impact Analysis

12/3/2012
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.
ACA’s Optional Medicaid Expansion Penetration Growth

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

- Dillon
- Marlboro
- Allendale
- Bamberg
- Marion
- Darlington
ACA expansion sends much more money into counties that are relatively healthy than it does to counties that are relatively unhealthy.
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Federal Medicaid Match for “Newly Eligible”</th>
<th>State Share for “Newly Eligible”</th>
<th>Administrative Match</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-2016</td>
<td>100%</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>2017</td>
<td>95%</td>
<td>5%</td>
<td>50%</td>
</tr>
<tr>
<td>2018</td>
<td>94%</td>
<td>6%</td>
<td>50%</td>
</tr>
<tr>
<td>2019</td>
<td>93%</td>
<td>7%</td>
<td>50%</td>
</tr>
<tr>
<td>2020 on</td>
<td>90%</td>
<td>10%</td>
<td>50%</td>
</tr>
</tbody>
</table>
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

### ACA in SC: Yearly Impact - State Expenditures (In Millions)

<table>
<thead>
<tr>
<th>Year</th>
<th>No Expansion (Best Estimate Participation)</th>
<th>Partial Expansion &lt;100% FPL (Best Estimate Participation)</th>
<th>Full Expansion &lt;138% FPL (Best Estimate Participation)</th>
<th>Full Expansion &lt;138% FPL (100% Participation)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>$19.5</td>
<td>$31.3</td>
<td>$38.4</td>
<td>$84.0</td>
</tr>
<tr>
<td>2015</td>
<td>$105.4</td>
<td>$117.4</td>
<td>$124.8</td>
<td>$216.3</td>
</tr>
<tr>
<td>2016</td>
<td>$75.8</td>
<td>$93.3</td>
<td>$121.6</td>
<td>$213.6</td>
</tr>
<tr>
<td>2017</td>
<td>$55.5</td>
<td>$104.6</td>
<td>$153.3</td>
<td>$271.5</td>
</tr>
<tr>
<td>2018</td>
<td>$24.1</td>
<td>$108.3</td>
<td>$167.1</td>
<td>$298.2</td>
</tr>
<tr>
<td>2019</td>
<td>$11.4</td>
<td>$197.6</td>
<td>$275.4</td>
<td>$448.0</td>
</tr>
<tr>
<td>2020</td>
<td>$69.1</td>
<td>$360.7</td>
<td>$742.3</td>
<td>$1,701.4</td>
</tr>
<tr>
<td>Total</td>
<td>$360.7</td>
<td>$742.3</td>
<td>$973.9</td>
<td>$1,701.4</td>
</tr>
</tbody>
</table>

Source: Milliman ACA Impact Analysis
Federal dollars will flow into the system under all scenarios.

### ACA in SC: Yearly Impact - Federal Expenditures (In Millions)

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

Source: Milliman ACA Impact Analysis
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

Source: Milliman ACA Impact Analysis
**November 2012 Medicaid Expansion Projections SFY 2014 to 2020 (in $ millions) - State Expenditures**

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

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

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

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
South Carolina Strategy
• 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.
DHHS Fundamental Strategy

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

12/3/2012
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

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

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
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
ACA Issues
Strained Provider Capacity in SC Without Medicaid Expansion

Active Primary Care Physicians per 10,000 Medicaid Enrollees
Based on Current Program Participation by County, FY2014

Primary Care Physicians Per 10,000 Enrollees
- 3.2 - 12.0
- 12.1 - 18.0
- 18.1 - 28.0
- 28.1 - 92.7
- No Population

Blue Highlight Indicates Generalist Physician-to-Population Ratio < 8 per 10,000
As Recommended by the Council on Graduate Medical Education

Note: Total number of active primary care physicians = 3,559; projected FY2014 Medicaid enrollment based on current program participation = 1,059,000.

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

Primary Care Physicians Per 10,000 Enrollees

- 2.4 - 12.0
- 12.1 - 18.0
- 18.1 - 28.0
- 28.1 - 54.5
- No Population

Blue Highlight Indicates Generalist Physician-to-Population Ratio < 8 per 10,000
As Recommended by the Council on Graduate Medical Education

Note: Total number of active primary care physicians = 3,559; projected FY2014 Medicaid enrollment based on current program participation and total ACA expansion = 1,572,000.

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

12/3/2012
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.

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.

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

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<tr>
<th>SFY</th>
<th>Baseline DSH Budget</th>
<th>Estimated ACA DSH Allotment</th>
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**Projected DSH Expenditures (In Millions) - State Only**

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<th>Baseline DSH Budget</th>
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Source: Milliman ACA Impact Analysis

12/3/2012
End