SC AAP Conference
SCDHHS View on Medicaid

Anthony Keck
July 29, 2012
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• SFY12 and SFY13 Update
• Affordable Care Act Summary
• What Medicaid is looking for from providers
• Efforts underway
SFY 2012 and 2013 Update
Recent Medicaid Growth

Unique members grew 8% from FY 2007 to FY 2011.

PMPM costs grew 12% from FY 2007 to FY 2011.

PMPM costs are projected to grow 2.38% from FY 2012 to FY 2013.

Sources: RSS3870 & Thomson Reuters Advantage Suite and Milliman Winter 2012 Update Preliminary FY10 data in SAP as of 9/13/11 and estimated for FY 2012 and FY 2013
DHHS Medicaid Total Budget

**FY 2010 to FY 2013**

**Member Month Enrollment Growth:** 15.2%

**FY 2010 to FY 2013 Appropriation Growth:** 1.8%

**FY 2010 to FY 2013 Expenditure Growth:** 12.5%

<table>
<thead>
<tr>
<th></th>
<th>FY 2010</th>
<th>FY 2011</th>
<th>FY 2012 Budgeted</th>
<th>FY 2013 Proposed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>9,731,923</td>
<td>10,255,356</td>
<td>10,783,980</td>
<td>11,213,472</td>
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<tr>
<td><strong>Adjusted (Normalized) Expenditures equalizes the managed care premium payment shifts.</strong></td>
<td></td>
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</table>
**FY 2013 Budget All Funds**

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**Summary of FY 2013 Original DHHS Budget Request**

<table>
<thead>
<tr>
<th>Appropriation Purpose:</th>
<th>General Fund &amp; Capital Reserve Fund</th>
<th>Federal Funds</th>
<th>Total Other Funds</th>
<th>TOTAL FUNDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Appropriation for Maintenance of Effort:</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Continuation of Base Budget</td>
<td>$ 917,495,132</td>
<td>$ 3,221,907,596</td>
<td>$ 615,129,975</td>
<td>$ 4,754,532,703</td>
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<tr>
<td>Annualization Non-recurring Funding</td>
<td>$ 242,729,457</td>
<td>$ 576,748,788</td>
<td>$</td>
<td>$ 819,478,245</td>
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<tr>
<td>Subtotal - Base Appropriation Request for Maintenance of Effort</td>
<td>$ 1,160,224,589</td>
<td>$ 3,798,656,384</td>
<td>$ 615,129,975</td>
<td>$ 5,574,010,948</td>
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<tr>
<td>New Spending Requests</td>
<td>$ 103,799,862</td>
<td>$ 245,840,718</td>
<td>$</td>
<td>$ 349,640,580</td>
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<tr>
<td>Non-recurring Capital Request</td>
<td>$ 7,157,264</td>
<td>$ 30,353,993</td>
<td>$</td>
<td>$ 37,511,257</td>
</tr>
<tr>
<td>Total FY 2013 Original DHHS Budget Request</td>
<td>$ 1,271,181,715</td>
<td>$ 4,074,851,095</td>
<td>$ 615,129,975</td>
<td>$ 5,961,162,785</td>
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</tbody>
</table>

**FY 2012 Approved Appropriation - All Funds**

| Fund | $ 5,796,543,317 |

**% Change**

- 2.8%

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**Original SCDHHS Budget Request was $5.96 billion which is a 2.8% increase over the FY 2012 appropriation.**

More than $340 million of new recurring funds were allocated to the budget.

98% of the request is required simply to keep the program operating at the current level.

FY 2013 Revised Forecast projects 32,438 additional members.
Affordable Care Act Summary
Supreme Court Summary

• Individual mandate remains standing under Congress’ taxing authority
• Exchanges, insurance rules, CMMI, Co-ops, and other programs still stand
• Medicaid expansion is now optional for each state
• Subsidies are now technically available to individuals from 100% FPL and above
# Affordable Care Act (ACA)

## Baseline Medicaid Expansion Impact

<table>
<thead>
<tr>
<th>Population</th>
<th>FY 2013</th>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2020</th>
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<tbody>
<tr>
<td><strong>Current Programs</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Medicaid</td>
<td>867,000</td>
<td>880,000</td>
<td>893,000</td>
<td>962,000</td>
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<tr>
<td>CHIP</td>
<td>70,000</td>
<td>71,000</td>
<td>73,000</td>
<td>78,000</td>
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<tr>
<td><strong>Total Current Programs</strong></td>
<td>937,000</td>
<td>951,000</td>
<td>966,000</td>
<td>1,040,000</td>
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<tr>
<td><strong>After Expansion- 71% Average Participation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Expansion Population</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents/Childless Adults</td>
<td>236,000</td>
<td>236,000</td>
<td>251,000</td>
<td></td>
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<tr>
<td>Currently Insured Population (Crowd-out)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children and Currently Eligible Parents</td>
<td>79,000</td>
<td>79,000</td>
<td>84,000</td>
<td></td>
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<tr>
<td>Newly Eligible Parents/Childless Adults</td>
<td>97,000</td>
<td>97,000</td>
<td>103,000</td>
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<tr>
<td>Currently Uninsured (Eligible but Unenrolled)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children</td>
<td>51,000</td>
<td>51,000</td>
<td>55,000</td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td>40,000</td>
<td>40,000</td>
<td>43,000</td>
<td></td>
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<tr>
<td>SSI Disable Eligible</td>
<td>7,000</td>
<td>7,000</td>
<td>8,000</td>
<td></td>
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<tr>
<td><strong>Total Expansion from ACA Participants</strong></td>
<td>510,000</td>
<td>510,000</td>
<td>544,000</td>
<td></td>
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<tr>
<td><strong>Total Medicaid Population</strong></td>
<td>937,000</td>
<td>1,461,000</td>
<td>1,476,000</td>
<td>1,584,000</td>
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<tr>
<td><strong>After Affordable Care Act Expansion</strong></td>
<td></td>
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</table>

## Estimated Fiscal Impact of Population Expansion

<table>
<thead>
<tr>
<th></th>
<th>State Funds</th>
<th>Federal Funds</th>
<th>Total Fiscal Impact - All Funds</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Funds</td>
<td>$ 55,400,000</td>
<td>$ 133,600,000</td>
<td>$ 278,400,000</td>
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<tr>
<td>Federal Funds</td>
<td>932,700,000</td>
<td>1,974,500,000</td>
<td>2,148,800,000</td>
</tr>
<tr>
<td><strong>Total Fiscal Impact - All Funds</strong></td>
<td>$ 988,100,000</td>
<td>$ 2,108,100,000</td>
<td>$ 2,427,200,000</td>
</tr>
</tbody>
</table>

Source: Milliman (April 6, 2012 Projections)
South Carolina can expect to spend $1.1 billion to $2.4 billion more in state funds through FY 2020 as a result of the Affordable Care Act.

Full participation scenario would cover 764,000 individuals under Medicaid.

Affordable Care Act Impact: FY 2014 to FY 2020

<table>
<thead>
<tr>
<th></th>
<th>Baseline Participation</th>
<th>Full Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid Assistance Expansion to 138%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expansion Population</td>
<td>$ 303.8</td>
<td>$ 376.4</td>
</tr>
<tr>
<td>Crowd-out Population</td>
<td>558.9</td>
<td>844.5</td>
</tr>
<tr>
<td>Eligible but Unenrolled Population</td>
<td>598.4</td>
<td>854.8</td>
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<tr>
<td>SSI Eligible</td>
<td>13.2</td>
<td>13.2</td>
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<tr>
<td>Pharmacy Rebate Savings - MCO</td>
<td>(335.5)</td>
<td>(335.5)</td>
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<tr>
<td>Health Insurer Assessment Fee</td>
<td>101.7</td>
<td>109.8</td>
</tr>
<tr>
<td>DSH Payment Reductions</td>
<td>(217.5)</td>
<td>(217.5)</td>
</tr>
<tr>
<td>CHIP Program - Enhanced FMAP</td>
<td>(130.2)</td>
<td>(130.2)</td>
</tr>
<tr>
<td>Physician Fee Schedule Change</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>192.6</td>
<td>271.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$ 1,085.4</strong></td>
<td><strong>$ 1,786.7</strong></td>
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</table>

**Additional Sensitivity**

<table>
<thead>
<tr>
<th></th>
<th>Baseline Participation</th>
<th>Full Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase Fee Schedule to 100% Medicare All Physicians and All Services</td>
<td>$ 589.5</td>
<td>$ 624.2</td>
</tr>
<tr>
<td><strong>Total with Sensitivity</strong></td>
<td><strong>$ 1,674.9</strong></td>
<td><strong>$ 2,410.9</strong></td>
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</tbody>
</table>

Source: Milliman April 6, 2012 Financial Impact Projections
What is Medicaid looking for?
Purchase the most health for our vulnerable citizens at the least cost to the taxpayer.
DHHS Fundamental Analysis

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

1/3 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
DHHS Fundamental Strategy

• Control health care spending to allow for:
  – 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

Major objectives include:

• Payment reform
• Clinical integration
• Focus on hot spots and disparities
Shift of Responsibilities
Division of responsibilities today

Physician w/ time for diagnosis, treatment planning, and followup

Data and analytics to measure and monitor utilization and quality

Coordinated relationships with other specialists and hospitals

Method for targeting high-risk patients (e.g., predictive modeling)

Capability for tracking patient care and ensuring followup (e.g., registry)

Resources for patient educ. & self-mgt support (e.g., RN care mgr)

Health Plan or Disease Mgt Vendor

Patient

Unneeded Testing

Inpatient Episodes
Medical Home Initiatives Expand MD Capacity, But Not Enough

- MD w/ time for diagnosis, treatment planning, and followup
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- Coordinated relationships with other specialists and hospitals
- Method for targeting high-risk patients (e.g., predictive modeling)
- Capability for tracking patient care and ensuring followup (e.g., registry)
- Data and analytics to measure and monitor utilization and quality

Patient
- Unneeded Testing
- Inpatient Episodes
Goal: Give MDs the Capacity to Deliver “Accountable Care”

- MD w/ time for diagnosis, treatment planning, and followup
- Resources for patient educ. & self-mgt support (e.g., RN care mgr)
- Capability for tracking patient care and ensuring followup (e.g., registry)
- Method for targeting high-risk patients (e.g., predictive modeling)
- Coordinated relationships with other specialists and hospitals
- Data and analytics to measure and monitor utilization and quality

\[\text{Physician Practice} + \text{Partners} = \text{ACO}\]
Medical Home Evolution

MEDICAL HOME

First Generation
Second Generation
Third Generation

Outcome-Driven Accountable Care
True Clinical Integration

Prevention + Proactive Intervention

ER Treat & Release

Treat + Address Root Causes

Transition Support

Improve Post-Acute Care

Improve Long-Term Care Mgt

© 2011 Center for Healthcare Quality and Payment Reform, Network for Regional Healthcare Improvement
Reference Price & Cost Sharing
Efforts underway
Catalyst for Payment Reform

• 20/20 Value Oriented Payment
  – P4P: HAC, Readmits
  – Reduced variation: COE, reference price
  – Benefit design

• 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
  FexEx and others
Clinical Integration and Payment Reform

• CCIG
  – Incentives and withholds
  – Move to hybrid model of capitation and MHN
  – Reduce hassle factors

• Dual Eligible Project
  – Targeted toward 68,000 full duals over 65 not already in institutions
  – Strong multi-disciplinary care coordination teams required

Goal is to create a system of care management that provides optimal incentives for patient-centered care, and disincentives for activities that do not contribute to improved health.
Clinical Hot spots and Disparities

• Birth outcomes
  – Early elective deliveries
  – SBIRT
  – P17

• HeART
  – Minute clinics and after-hours
  – Community health workers
  – Public health clinic leveraging

• Foster children in coordinated care

By enhancing prenatal care and reducing pre-term deliveries, overall health outcomes can be improved.

Making care available at off hours will reduce treatment for minor ailments in emergency rooms.
Withholds & Incentives

Withholds
- Prevention and Screening (0.25% withhold)
- Chronic Disease and Behavioral Health (0.25% withhold)
- Access and Availability (0.25% withhold)
- Consumer Experience (0.25% withhold)

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 equal $16 million in capitation
- 8 HEDIS in CY2012
- 12 HEDIS in CY2013
- Floors must be met
- Bonus pool

Incentives $16 million in both CY2012 and CY2013
- PMPM $.50 to $2.00 for NCQA certification
- Centering and NFP
- Baby friendly race to the top
- LBW reductions
Plan Choice CY2011

- Plan 1: 60
- Plan 2: 63
- Plan 3: 8
- Plan 4: 8
- Plan 5: 32
- Plan 6: 29
- Plan 7: 8
- Plan 8: 16
Investing In South Carolina’s Health

Social Determinants

- 90% of health is jobs, education, personal choices, environment, race and genetics
- 10% of health is access to affordable health services

Frees up dollars to grow jobs & invest in education

Average Health Care Cost Per Person

- IOM
- 30% excess cost is:
  - Unnecessary services
  - Admin waste
  - Inefficient services
  - High prices
  - Fraud
  - Missed prevention

Increases affordability which leads to more access / coverage

Strategies

Payment Reform
- Incentive & Withholding
  - PCCM
  - HEDIS
  - Birth Outcomes
- Payor / Provider Partnerships
- CPR
- Cost Sharing

Clinical Integration
- Dual Eligible Project
- PCCM
- Bundled / Global Payments
- Telemedicine / Monitoring

Hotspots of Disparities
- BOI
- Foster Care
- HeART

Other Strategies
- GME Accountability
- Transparency Tool
## Distribution of HEDIS RATES by PERCENTILES

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<tr>
<td>Percentiles</td>
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<td>10th - &lt;24th</td>
<td>21</td>
<td>20</td>
<td>12</td>
<td>7</td>
<td>5</td>
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<tr>
<td>25th – &lt;50th</td>
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<td>11</td>
<td>6</td>
<td>4</td>
<td>7</td>
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<td>50th - &lt;75th</td>
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<td>75th - &lt;90th</td>
<td>7</td>
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<td>&gt; 90th</td>
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<td>2</td>
<td>2</td>
<td>6</td>
<td>7</td>
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<tr>
<td>Total # of Measures</td>
<td>43</td>
<td>43</td>
<td>43</td>
<td>43</td>
<td>43</td>
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</table>

Note: The data indicates approximately 50 percent of the measures fall below the 24th percentile. Implications - Preliminary evidence supports emphasis on quality improvement “can and does make a difference” and supports incentives associated with “PCMH” emphasis.
Percent of Children with Well Child Visits (First 15 Months- 6 Visits)

- CY2009: Non-QTIP 32.3, QTIP 38.7, Medicaid Benchmark 51.6
- CY2010: Non-QTIP 50.2, QTIP 53.8, Medicaid Benchmark 60.1
- FY2011: Non-QTIP 53.1, QTIP 56.2, Medicaid Benchmark 60.1
Percent with Well Child Visits
(Ages 3, 4, 5, and 6 Years)
Percent with Adolescent Well Care Visits (Ages 12 – 21 Years)
Questions?