Joint Legislative Commission on Governmental Operations

Trends in North Carolina Medicaid Spending and Data

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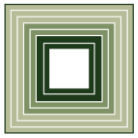


FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Presentation Objective

- ***Part 1 of a 2-Part Presentation.***
- ***Part 1 – Today "Work In Progress"***
  - *Understanding Historical Claim Data.*
  - *Using Historical Data Appropriately and Cautiously.*
  - *Emphasizing the importance of budgeting reduction items that are associated with required, specific policy changes and allowing sufficient time for implementation.*
- ***Part 2 – February?***
  - *Moving from Historical Data Review to Future Projections in order to "set the stage for decision makers".*
  - *Planning beyond 2 years.*

Presentation Objective

*Why? It's an **entitlement** program……if you have a Medicaid Program you have to pay for it.....*

Getting it Right.

- *If the decision is to leave the current program intact…you need to apply methodology that uses the appropriate growth rate in order to have a structurally sound budget and FUND it.*
- *If the decision is to contain or reform the program…you need to apply methodology that uses the appropriate growth rate in order to have a structurally sound budget.*
- *From SFY 2003-2013, 52% of budgeted savings by the General Assembly has been achieved.*

Then the conversation can move forward to HOW to address paying for the programmatic growth (Additional Funds, Cost Containment or a Combination).

Presentation Objective

OBJECTIVE IS NOT:

- *This is not a forecast of expected expenditures.*
- *This is not an assessment of what has or has not or to what degree initiatives have worked in the past.*

OBJECTIVE IS:

- *To facilitate a conversation on Medicaid trends based on a consistent interpretation of data.*
- *To provide a spending comparison that can support planning NC Medicaid funding needs and program direction.*

Medicaid Data and Trend Challenges

The General Assembly is being confronted with a variety of data sources and ways to interpret and present information about trends in Medicaid spending……..

- Uncontrollable factors
  - Changes in federal policy and initiatives, growth in enrollment, mix of enrollment, provider practice patterns, economic trends, NC prices based on external indexes
- Controllable factors/factors that can be influenced
  - Reductions and expansions approved by the General Assembly in rates, policies, programs, benefits and eligibility, use of multi-fund accounting structure, changes in accounting practices and reporting

Current Medicaid Spending Realities

- **NC Medicaid demographics have shifted to a higher percentage of lower cost enrollees than the rest of the country.**
- **Based on PMPM trends, NC appears to have initiated more aggressive/effective measures to control increases in spending than other states since 2008.**
- **North Carolina spending on Medicaid claims has *declined overall* by 11.6% on a per member per month (PMPM) basis since 2008 -** *59% of the decline is attributable to a change in enrollment mix and 41% of the decline was attributable to reduction initiatives included in the budget.*
- **US PMPM Spending on Medicaid has *increased overall* by 6% over the same period –** *US did not experience the degree of demographic change as NC*

Current Medicaid Spending Realities

- **Historically, Medicaid budget issues are not just about expenditures on claims, but include non claims spending, federal funding and state initiatives.**
- **Important Considerations -** ***Financial sustainability and the ability to identify new savings initiatives.***

Establishing a Method for Planning

- **Planning for the future cost of the Medicaid program is dependent on knowing an underlying medical cost index.**
- **A medical cost index provides a basis for forecasting future demand for funding, not a basis for rate setting**
- **Creating a medical cost index would be similar to the process used for planning overall North Carolina revenues, where, for example all tax law changes are stripped away to expose the underlying trends in the tax base.**

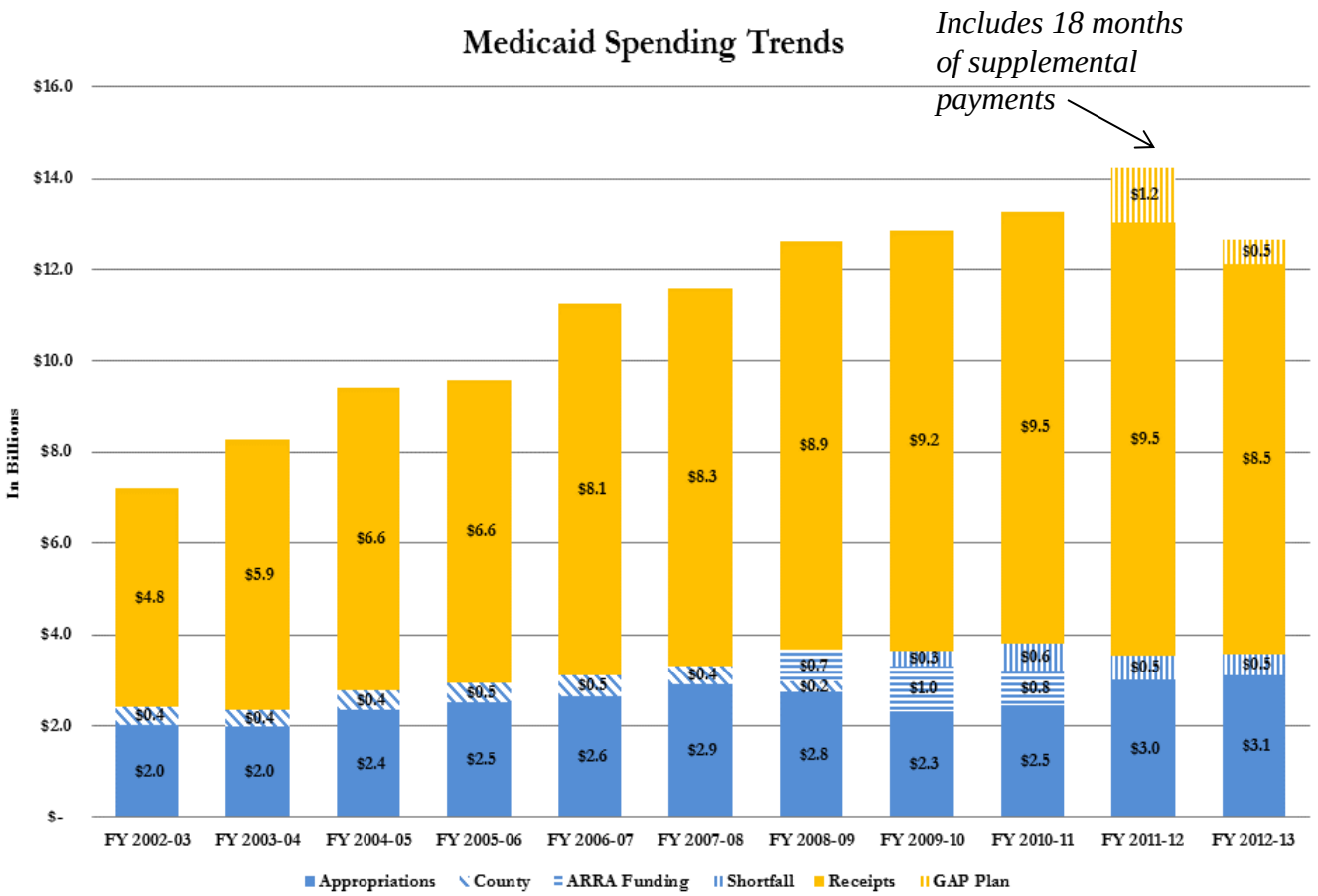
Establishing a Method for Planning

- **To build a medical cost index for NC Medicaid the data needs to be adjusted to remove the impact of changes in enrollment mix and state/federal initiatives that have changed spending growth.**
- **After these adjustments, the NC Medicaid medical cost index reflects a growth rate similar to the PMPM growth rate in total US health care spending.**

Discussion Summary

- Consistent presentation of total spending, appropriations and funding in dollars.
- Actual PMPM claims spending compared to NC trended on National Medicaid spending trends.
- Adjustments to develop a medical cost index to support decision making for future needs and direction.

Trends in Overall Medicaid Spending



Source: NC Office of State Controller

- State and federal changes complicate year to year comparison
- Objective is to present appropriations and non-State shares on a consistent basis across time
- Changes in county share, ARRA and shortfall funding are restated to put appropriations on a consistent basis
- FY 2011-12 and 2012-13 reflect the impact of the GAP and UNC/ECU UPL

Restating Data to Improve Comparability

- **Medicaid spending equation:**

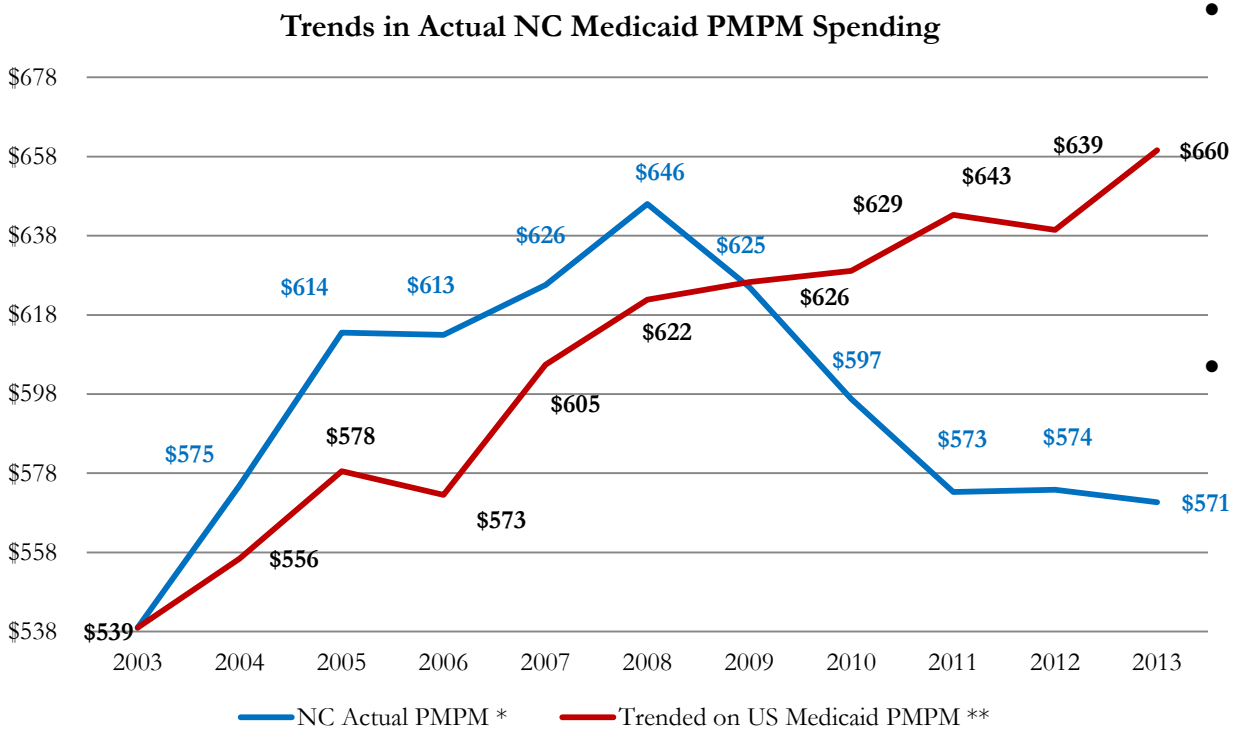
  (Enrollment * utilization * mix * consumption * price * benefits = spending)

- **Claims have represented from 85% to 90% of total spending in NC Medicaid from 2003 – 2013**

- **Converting dollars to a per member per month (PMPM) controls for changes in enrollment**

PMPM calculation = (Claims Expenditures/Average Monthly Enrollment)/12

Comparison of Actual Claims Trends



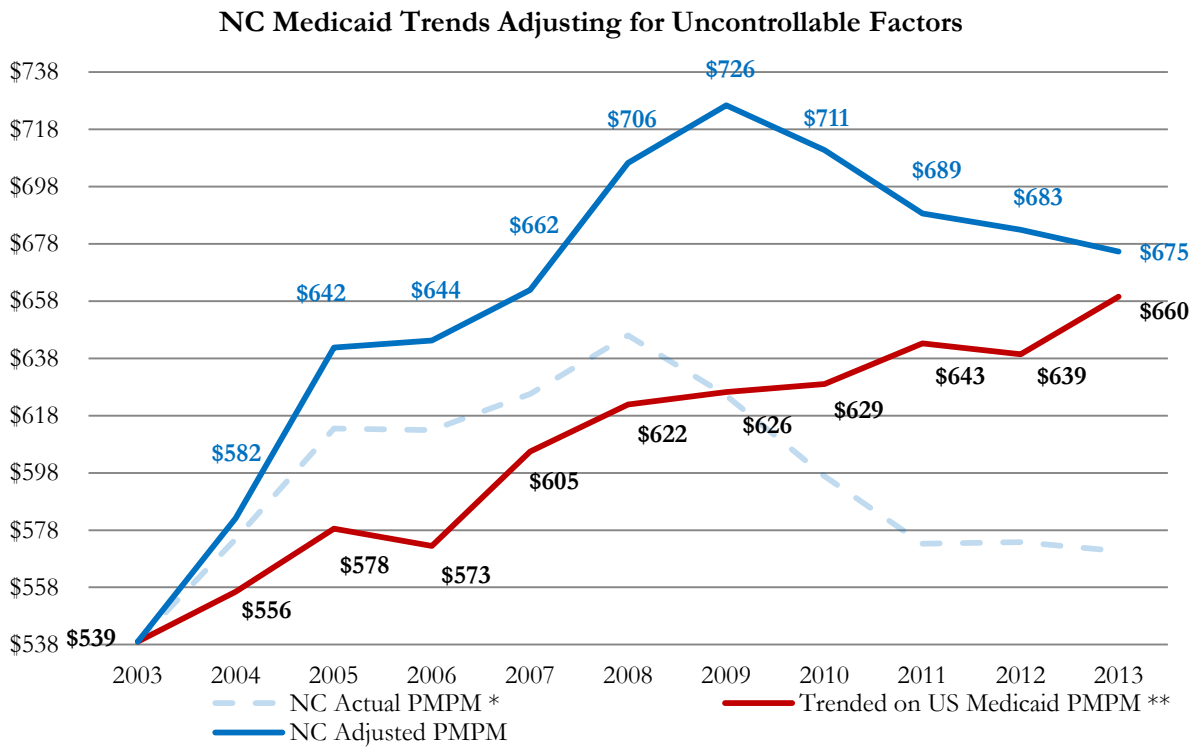
- ***NC Actual Claims PMPM's adjusted to remove the impact of changes in DSH accounting and Hospital GAP and UNC/ECU UPL plans***

** ***Trended on US Medicaid PMPM trends applied to NC 2003 Base PMPM***

- NC Medicaid enrollment transitioning to higher proportion of **non**-Aged, Blind, Disabled populations than US trends
- North Carolina appears to have been more aggressive/effective than other States implementing initiatives to control spending beginning in FY 2008-09
- Variations in enrollment mix make a sole national comparison misleading

Source: CMS Office of the Actuary and NC Office of State Controller

Adjusting Trends to Improve Comparability



Children least costly population covered by Medicaid at $208 PMPM in 2013 compared to $1,377 PMPM for ABD

Source: CMS Office of the Actuary, NC Office of State Controller and FRD Calculations

- **<u>MEDICAL COST INDEX ADJUSTMENT #1</u>: NC PMPM trended for a constant enrollment mix**
- NC children increased from 33% of total enrollment in 2003 to 48% in 2013
- % of US Medicaid enrollment for Non-ABD more consistent than NC from 2004-2013
- Underlying NC cost trended higher than US Medicaid until FY 2008-09 when NC appears of have become more aggressive/effective than other states with initiatives to control spending

Adjusting Trends to Improve Comparability – Budgeted Savings

Every State initiated actions to control spending, NC has utilized numerous methods to reduce Medicaid expenditures

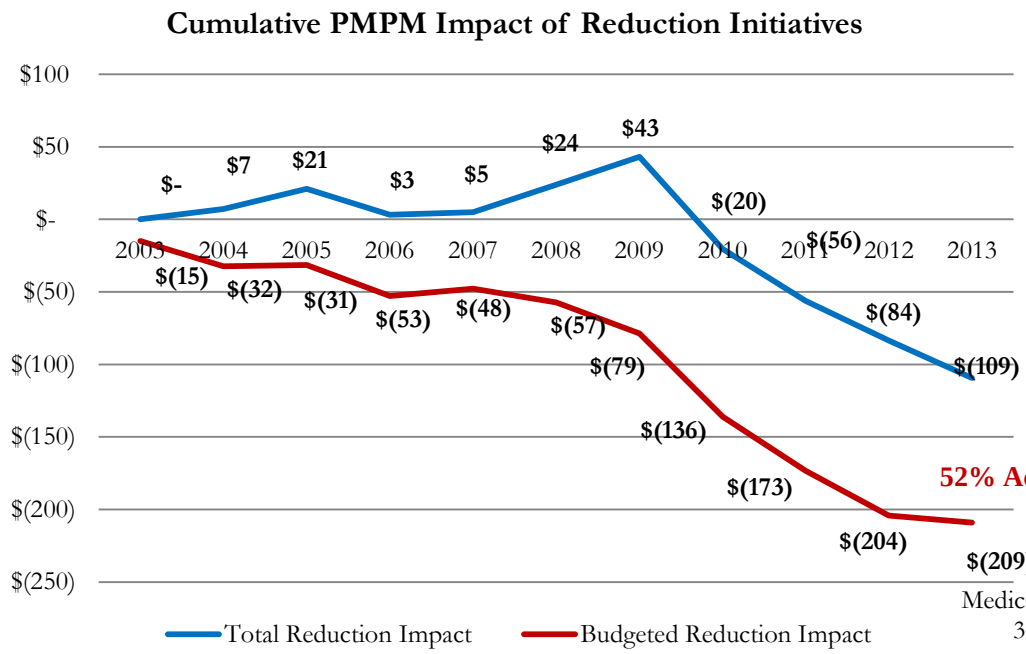
LEGISLATIVE ACTIONS IMPACTING NC MEDICAID SPENDING

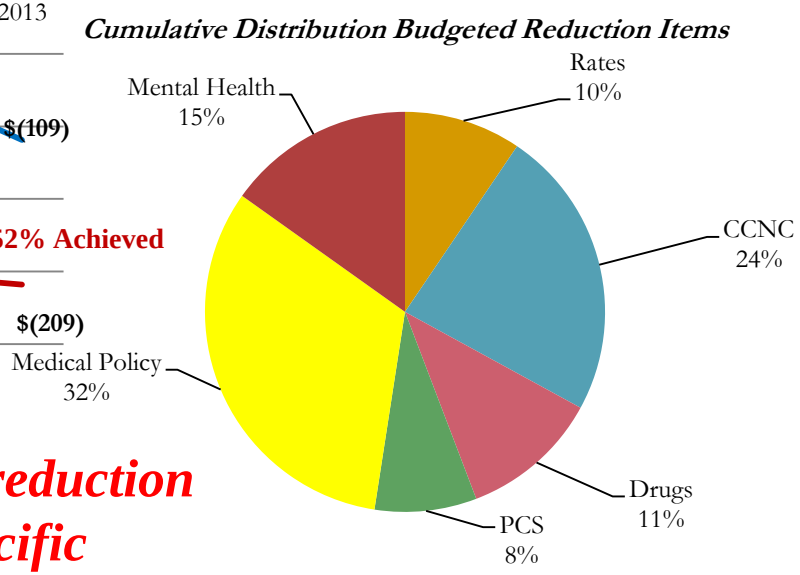
	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003
Provider Inflation	-	62,853,775	-	-	35,324,306	35,441,213	-	62,491,547	-	50,219,296	-
Provider Rates	1,976,636	54,346,840	5,000,000	78,739,674	(5,000,000)	(1,875,000)	(13,500,000)	(2,000,000)	-	-	13,905,346
Pharmacy	6,671,507	12,345,441	16,946,234	35,457,042	5,025,115	7,000,000	-	2,749,963	939,576	31,832,179	37,374,352
PCS	6,000,000	-	50,714,943	40,000,000	-	2,907,387	(1,500,000)	13,711,542	-	-	2,655,057
CCNC	63,455,457	90,528,960	45,000,000	69,894,403	28,945,618	-	-	19,225,000	-	-	9,425,000
Eligibility	-	-	-	-	-	(216,466)	-	(7,098,392)	-	-	668,752
Benefits and Services	-	16,508,903	3,299,618	66,080,464	-	-	-	-	-	-	250,000
Program Integrity	3,807,519	19,200,000	44,000,000	20,000,000	347,560	-	-	-	-	-	-
Administration	(5,000,000)	-	473,224	5,576,280	(3,500,000)	-	-	-	-	-	-
Settlements	(15,000,000)	-	-	-	-	-	-	-	-	-	-
Copays	-	-	2,630,404	3,098,256	-	-	-	5,400,000	-	-	-
Cap Slots	-	-	-	6,646,956	(6,666,667)	(4,500,000)	(3,000,000)	-	-	-	-
Part D	-	-	79,419,834	-	-	-	-	11,000,000	-	-	-
Prior Authorization and UM	-	-	2,999,194	350,000	(2,104,494)	15,345,711	-	-	-	-	-
Appeals	-	-	-	-	(702,634)	-	-	-	-	-	-
Imaging	-	-	-	8,111,250	-	-	-	-	-	-	-
Mental Health	(1,700,000)	10,537,931	50,290,807	65,000,000	86,424,974	-	-	-	-	-	-
TOTAL LEGISLATIVE SPENDING ACTIONS	60,211,119	266,321,850	300,774,258	398,954,325	138,093,778	54,102,845	(18,000,000)	105,479,660	939,576	82,051,475	64,278,507

The impact of NC items that could reasonably be quantified were:

Part D Implementation, Rate reductions, Pharmacy pricing and policy changes, PCS pricing and policy changes, Nursing home bed tax changes, High Risk Intervention policy changes, DME policy changes, Community Support and mental health services policy changes and high tech imaging

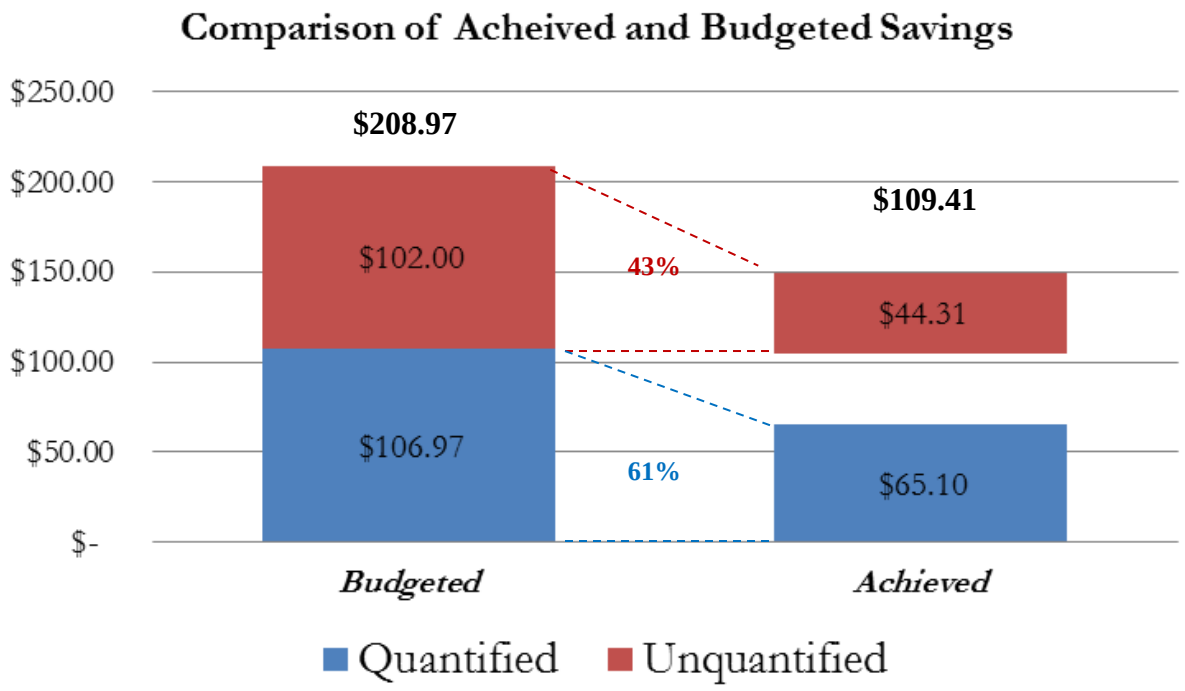
Adjusting Trends to Improve Comparability – Budgeted Savings





Emphasizing the importance of budgeting reduction items that are associated with required, specific policy changes and allowing sufficient time for implementation

Adjusting Trends to Improve Comparability – Budgeted versus Achieved SFY 2003-2013

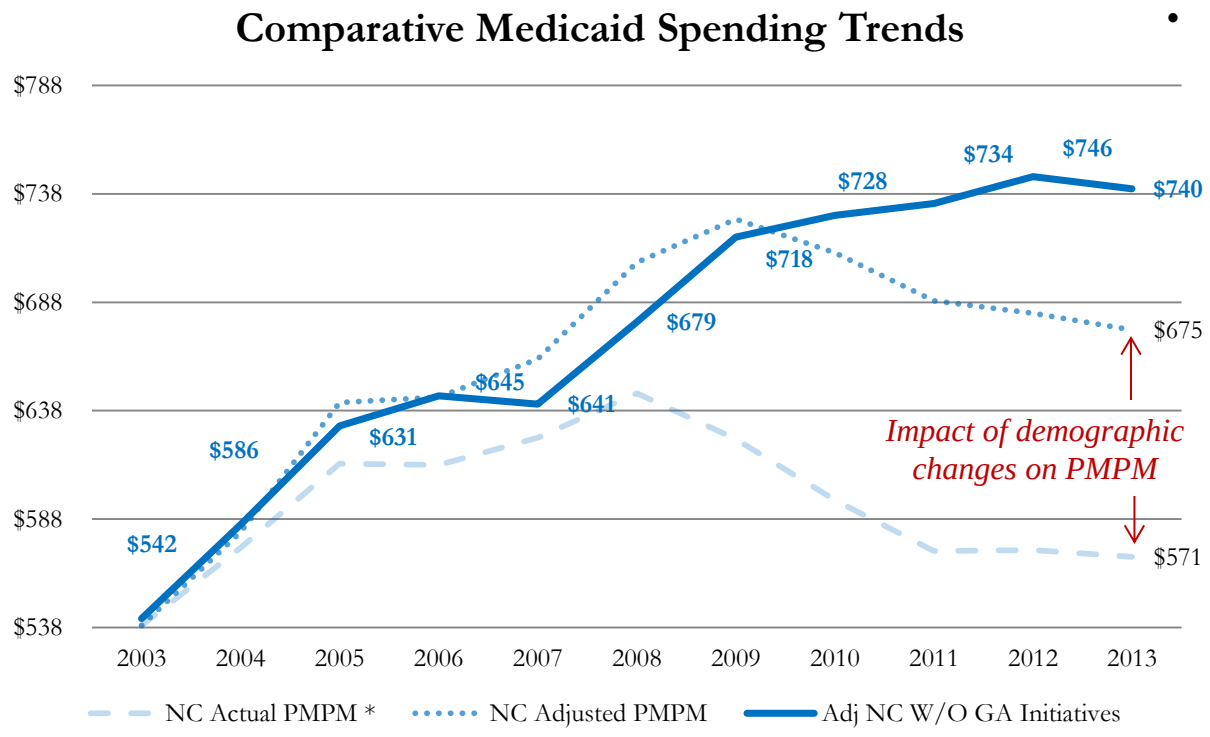


Savings initiatives have been aggressively budgeted.

The Department has been limited by Federal government, Division operations, provider appeals/lawsuits and other pressures from achieving all the savings budgeted.

Key Takeaway – achieving savings is dependent on allowing sufficient time and identifying specific policy changes that will lead to/can be implemented to achieve budgeted savings.

Adjusting Trends to Improve Comparability

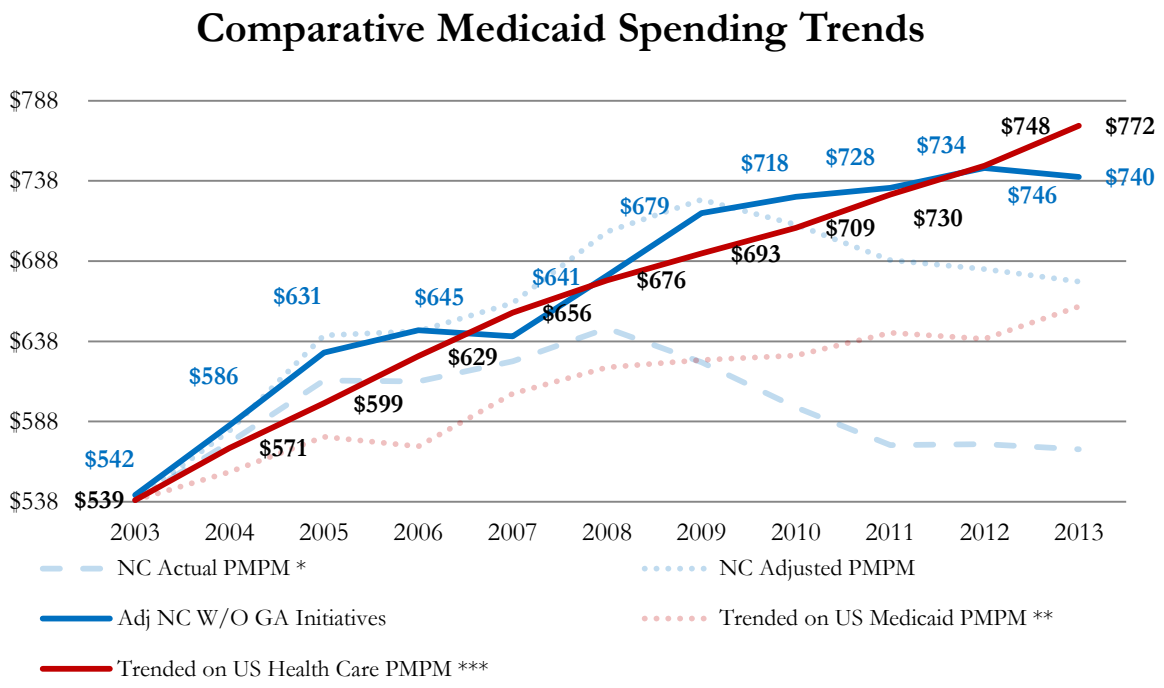


Source: NC Office of State Controller and FRD Calculations

MEDICAL COST INDEX ADJUSTMENT #2: Impact of initiatives approved by the General Assembly that were adjusted to create the medical cost index:

- *Rate reductions*
- *PCS policy changes*
- *High Risk Intervention policy*
- *DME policy changes*
- *Pricing and process changes to increase generic drug prescribing*
- *Nursing home bed tax changes*
- *Capitation of high tech imaging services*
- *Introduction of Part D*
- *Mental health policy and contract changes, including Community Support*

Adjusting Trends to Improve Comparability

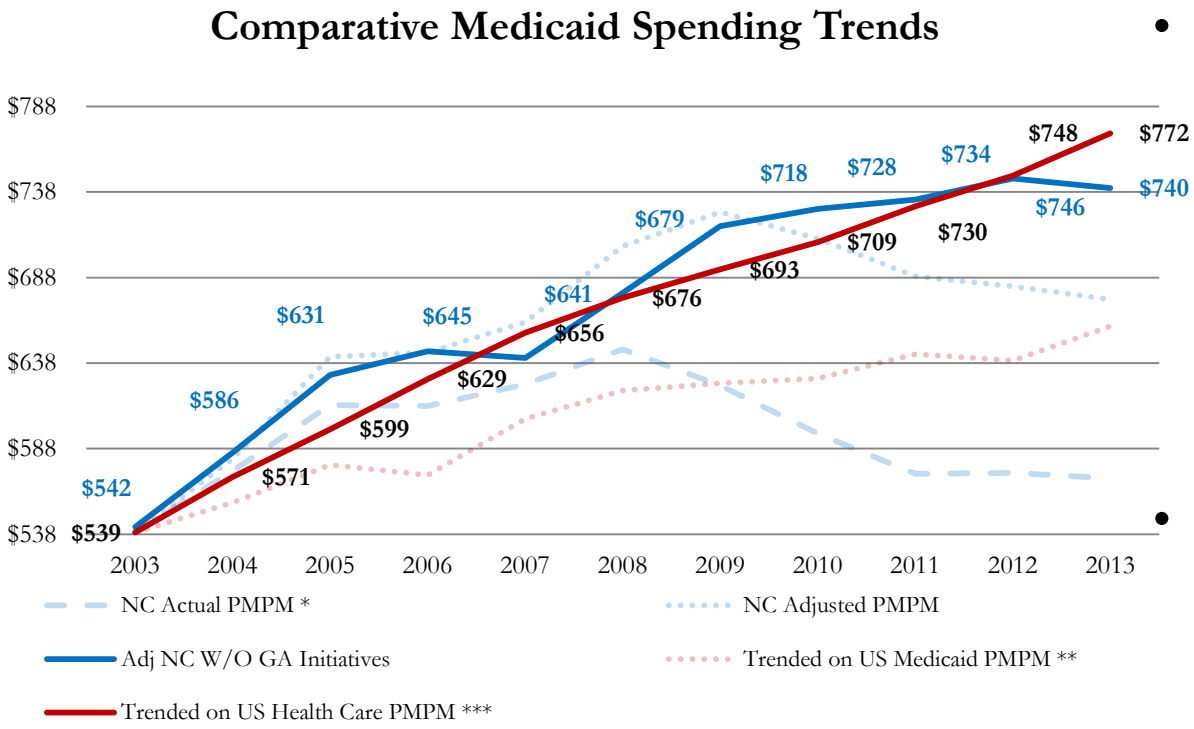


- When the impact of initiatives approved by the General Assembly are removed, NC medical index is more consistent with general US health care spending
- **Implication is that without continued cost containment initiatives; NC spending will grow at a rate similar to the US per capita spending**

****** Trended on US Health Care PMPM reflects Medicaid, Medicare and Commercial spending, trend line developed by applying US percentage change in PMPM to NC 2003 Base PM PM***

Source: CMS Office of the Actuary, NC Office of State Controller, FRD Calculations

Trending Summary



- NC Factors not quantified: CCNC care management, provider inflation freezes, CAP slots changes, prior authorization policies, provider response to changes
- US Factors not adjusted for: Pricing changes and aging of population relative to general population, relative growth of managed care compared to NC

It is safe to assume that if not for these unquantified factors, NC medical cost index would have trended higher than the national health care PMPM spending trends.

Source: CMS Office of the Actuary, North Carolina Office of the State Controller and FRD Calculations

Next Steps for Planning for Medicaid Spending

- Assuming data is available, a forecast should:
  - *Determine expected long term growth and mix of Medicaid enrollment.*
  - *Determine long term utilization and consumption trends.*
  - *Identify all assumptions of other policy changes or factors outside NC's control*
  - *Factor in forecasts for all expenditures and receipts impacting the State appropriation for Medicaid*

Impediments and Concerns

- Enrollment Data – *we do not have accurate data on enrollment by program aid category or a reconciliation of the aggregation methodology for current data with methods used for prior periods enrollment counts.*
- Spending Data – *FY 2013-14 claims data only available at a summary level that has been manually corrected for known issues and there is no system that captures the actual claims backlog.*
- Utilization Analysis – *lack of data prohibits or limits the ability to prepare any analysis of changes in utilization that have been achieved or are emerging.*
- Reduction Initiatives – *ability to accurately assess the short and long term impact on spending based on whether reduction initiatives can and will be achieved.*

Takeaways

- When General Assembly initiative are controlled for, North Carolina has grown like the US health care spending trends.

…it is a reasonable assumption that NC Medicaid to continue to grow similar to US health care spending without implementation of additional policy/rate changes

- Overall, only 52% of the dollars included in budgets for savings has been achieved.
- To avoid future structural budget "holes", savings need to be tied to specific policy changes that can be implemented, allowing sufficient time for implementation.

Questions?

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