Joint Legislative Oversight Committee on Health and Human Services

Medicaid Budget Model

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Presentation Objective

*Why prepare a Medicaid budget model? 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.*

Medicaid Data and Trend Challenges

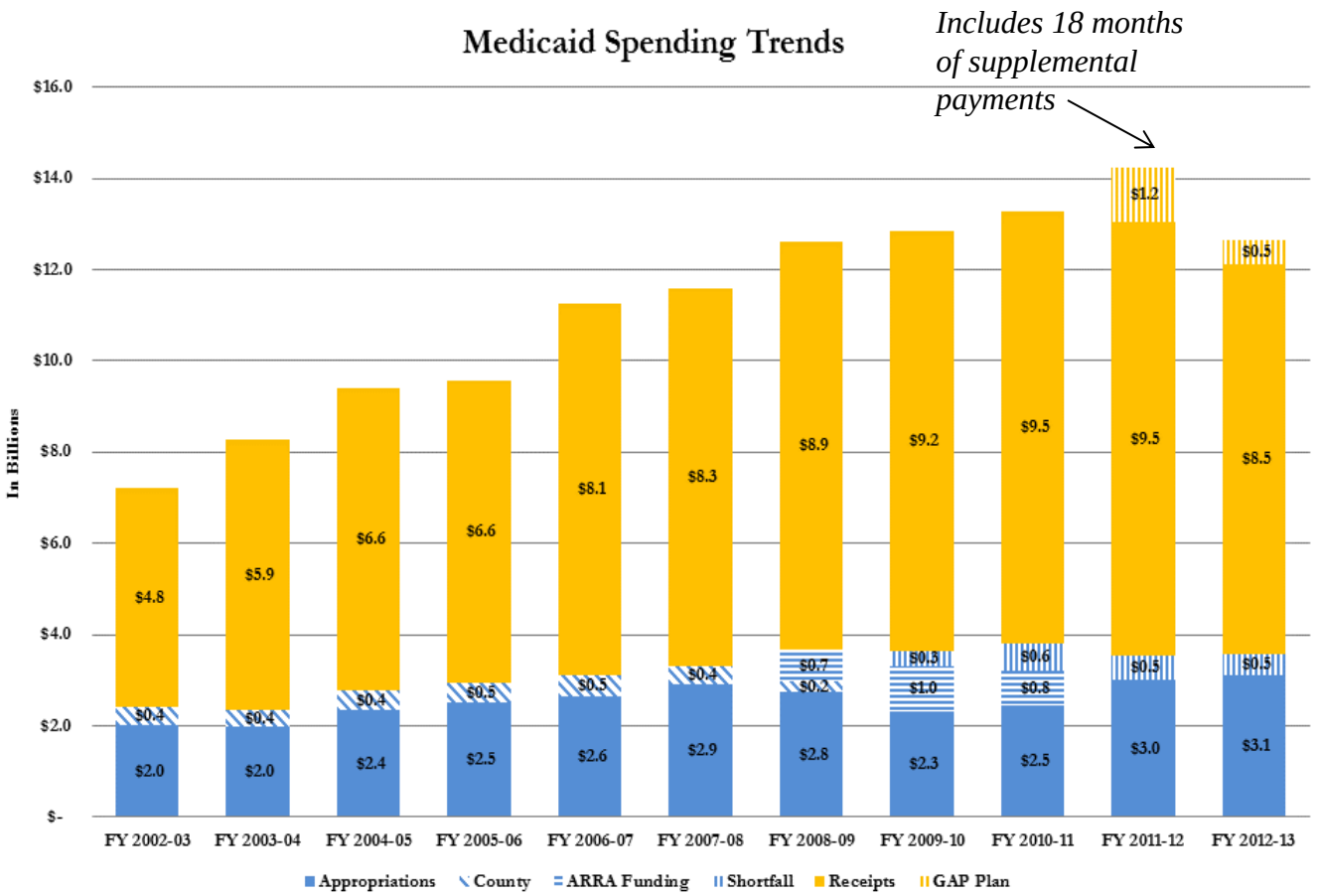
The General Assembly has been confronted with a variety of data sources and ways to interpret and present information about trends in Medicaid spending……..

- 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*

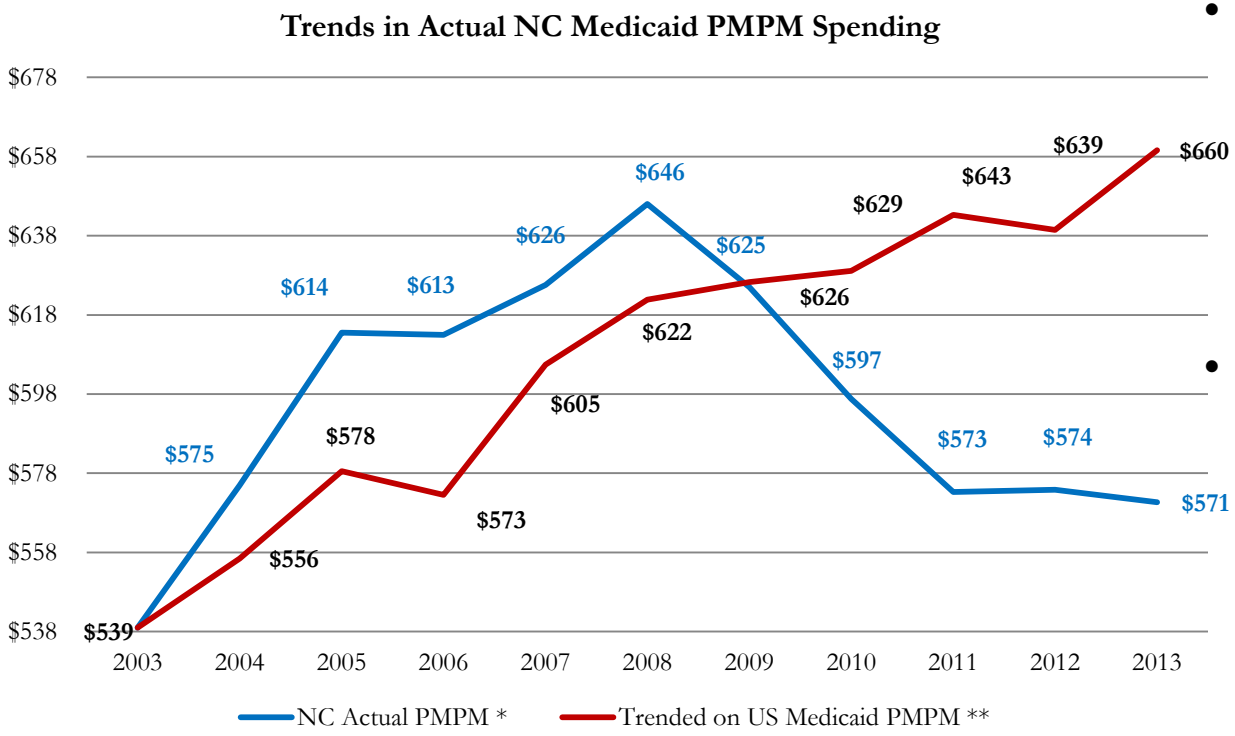
Trends in Overall Medicaid Spending



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

Comparison of Actual Claims Trends



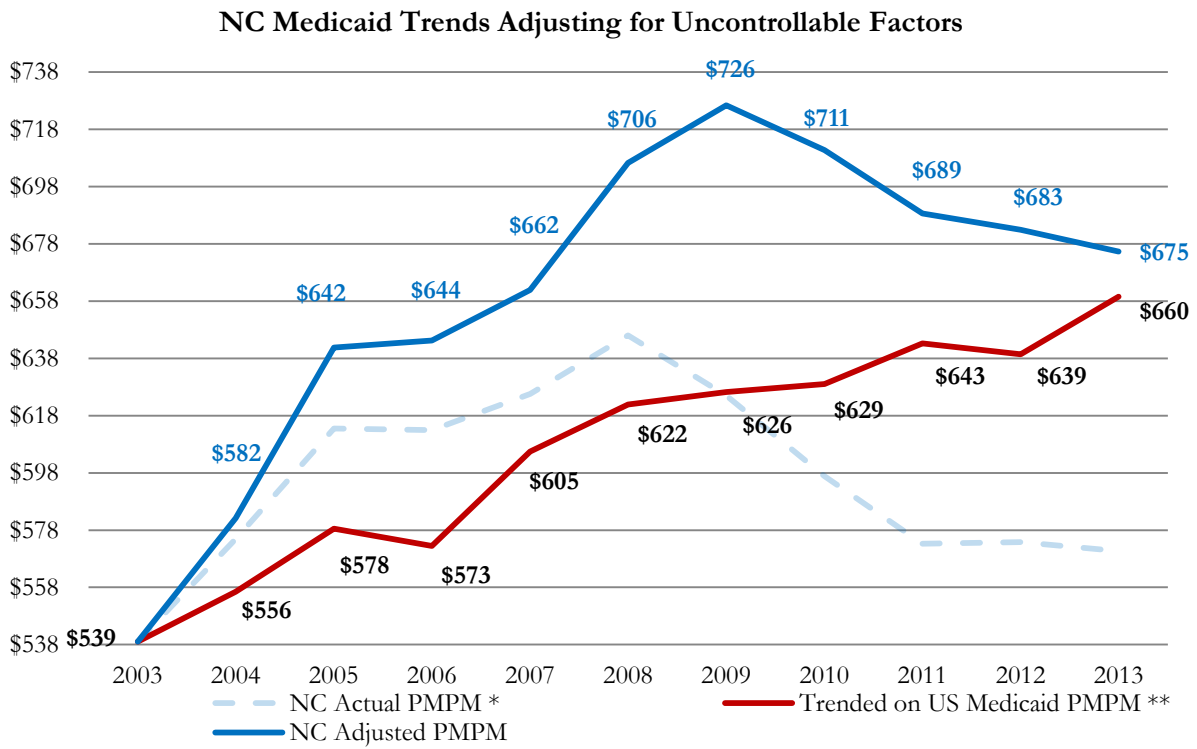
- ***NC Actual Claims PMPM's adjusted to remove the impact of changes in DSH accounting and Hospital GAP and UNC/ECU UPL plans***

** ***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

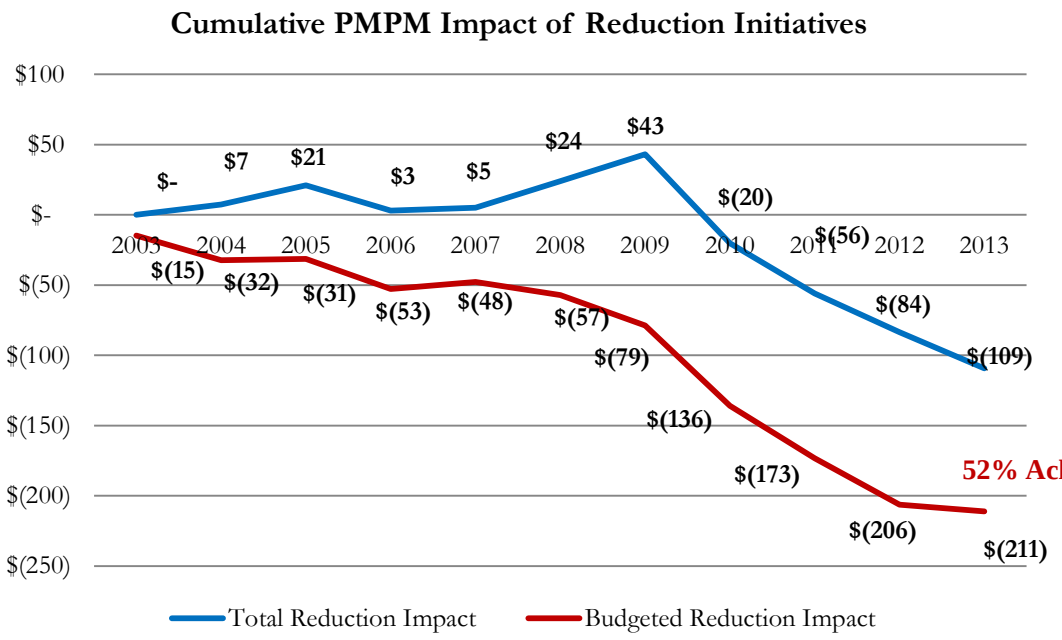
LEGISLATIVE ACTIONS IMPACTING NC MEDICAID SPENDING

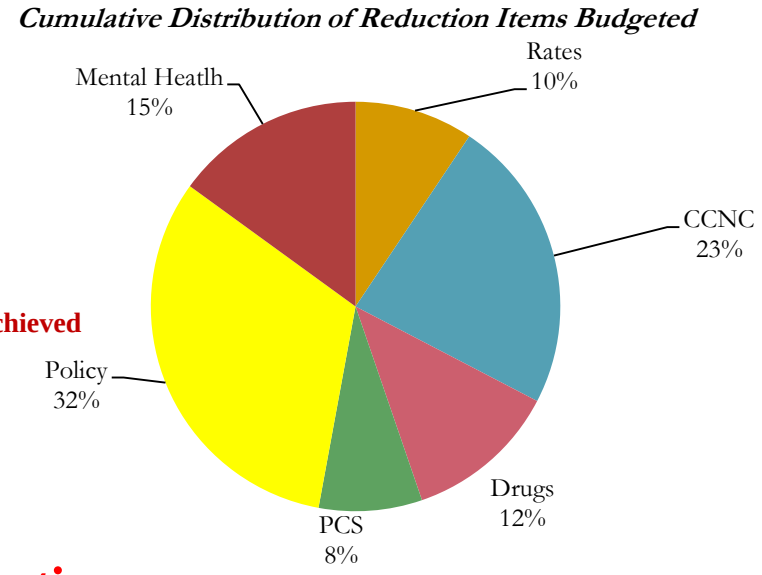
	2013	2012	2011	2010	2009	2008	2007	2006	2005	2004	2003
Provider Inflation	-	62,853,775	-	-	35,324,306	35,441,213	-	62,491,547	-	50,219,296	-
Provider Rates	1,976,636	54,346,840	5,000,000	78,739,674	(5,000,000)	(1,875,000)	(13,500,000)	(2,000,000)	-	-	13,905,346
Pharmacy	6,671,507	25,845,441	16,946,234	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	279,821,850	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

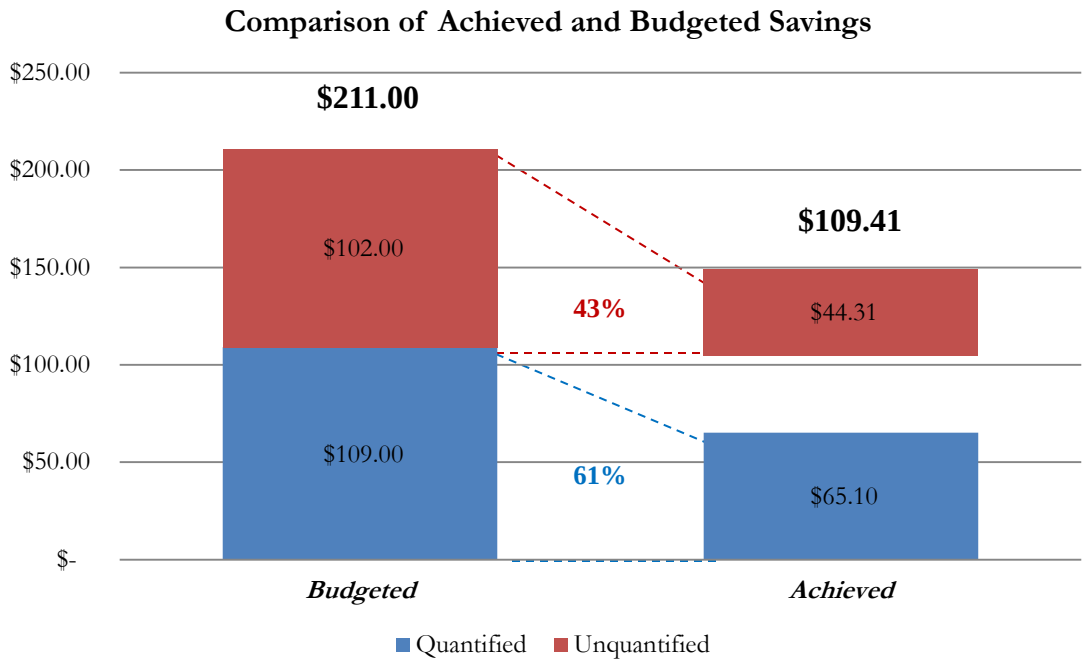
Adjusting Trends to Improve Comparability – Budgeted Savings





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

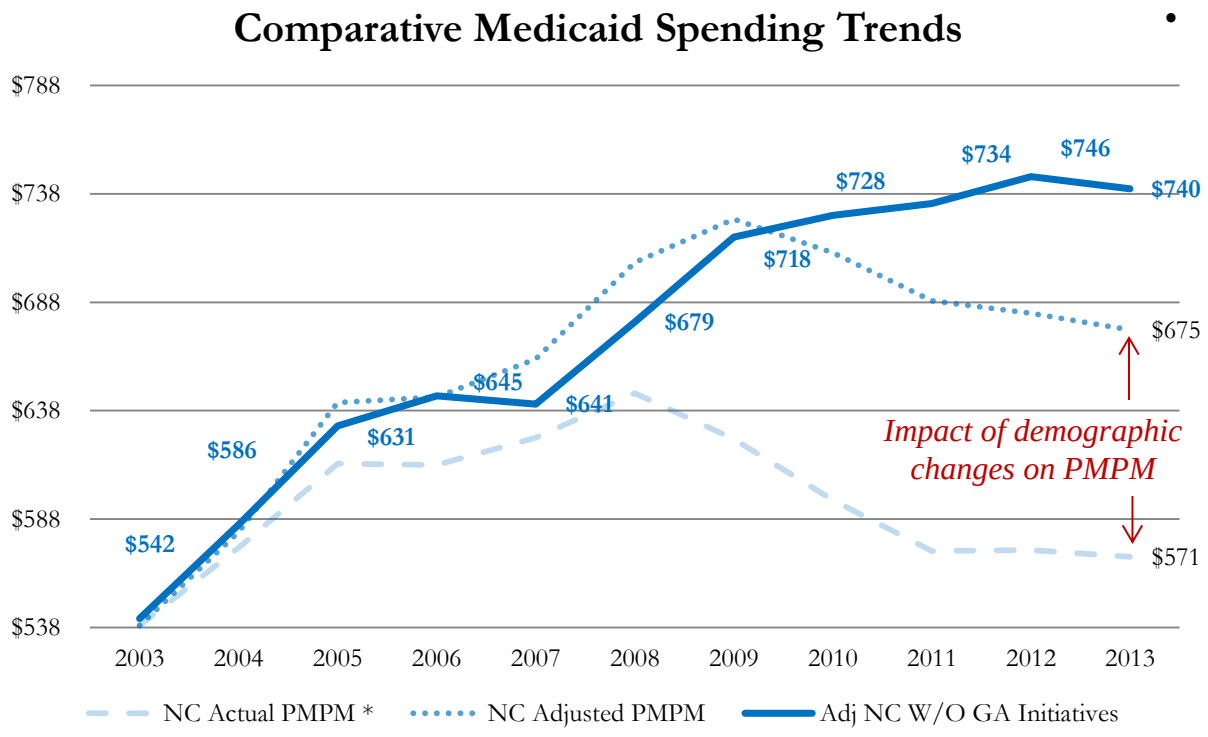


Savings initiatives have been aggressively budgeted.

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

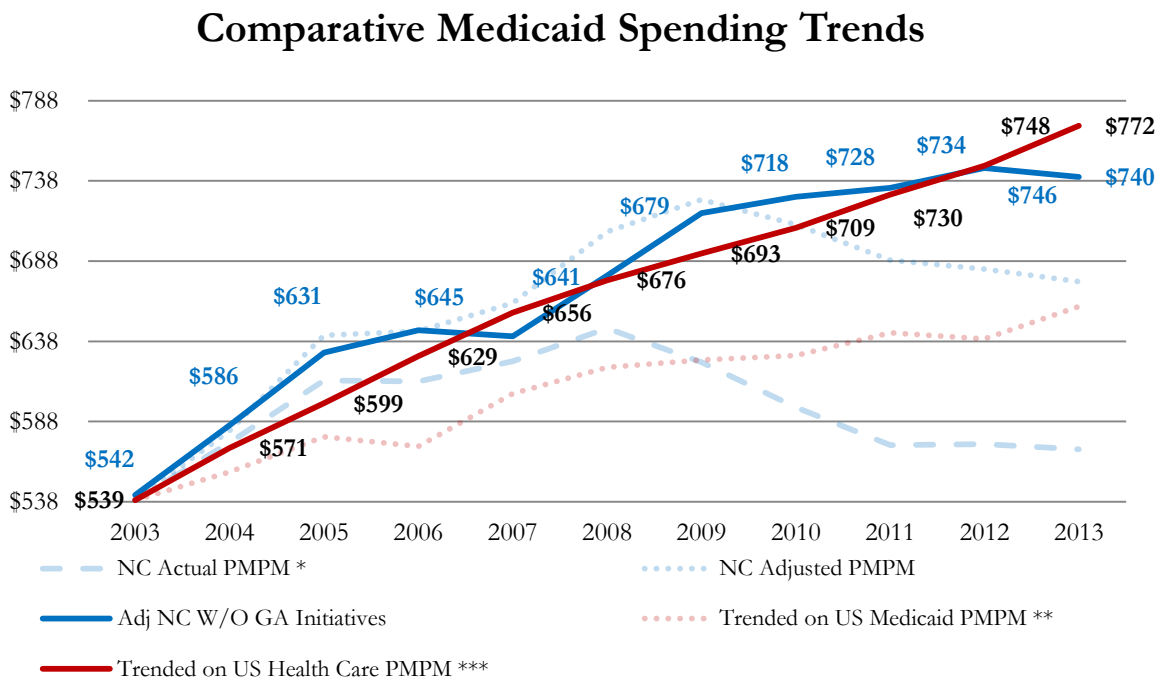


Source: NC Office of State Controller and FRD Calculations

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

Medicaid Budget Model

- **Since complete claims data or enrollment data is not available, aggregate information contained in the North Carolina Accounting System was used to prepare an estimate of Medicaid and Health Choice spending for SFY 2013-14 and 2104-15.**
- **The estimate is not a forecast, but provides a range of potential outcomes from best to worst case for both years.**
- **These estimates serve as the foundation for the Medicaid budget model, based on the assumptions to be discussed. The Medicaid budget model presents a range of funding requirements based on the assumptions.**

Medicaid Budget Model Assumptions

- **NC Medicaid enrollment and utilization will grow similar to national trends*.**

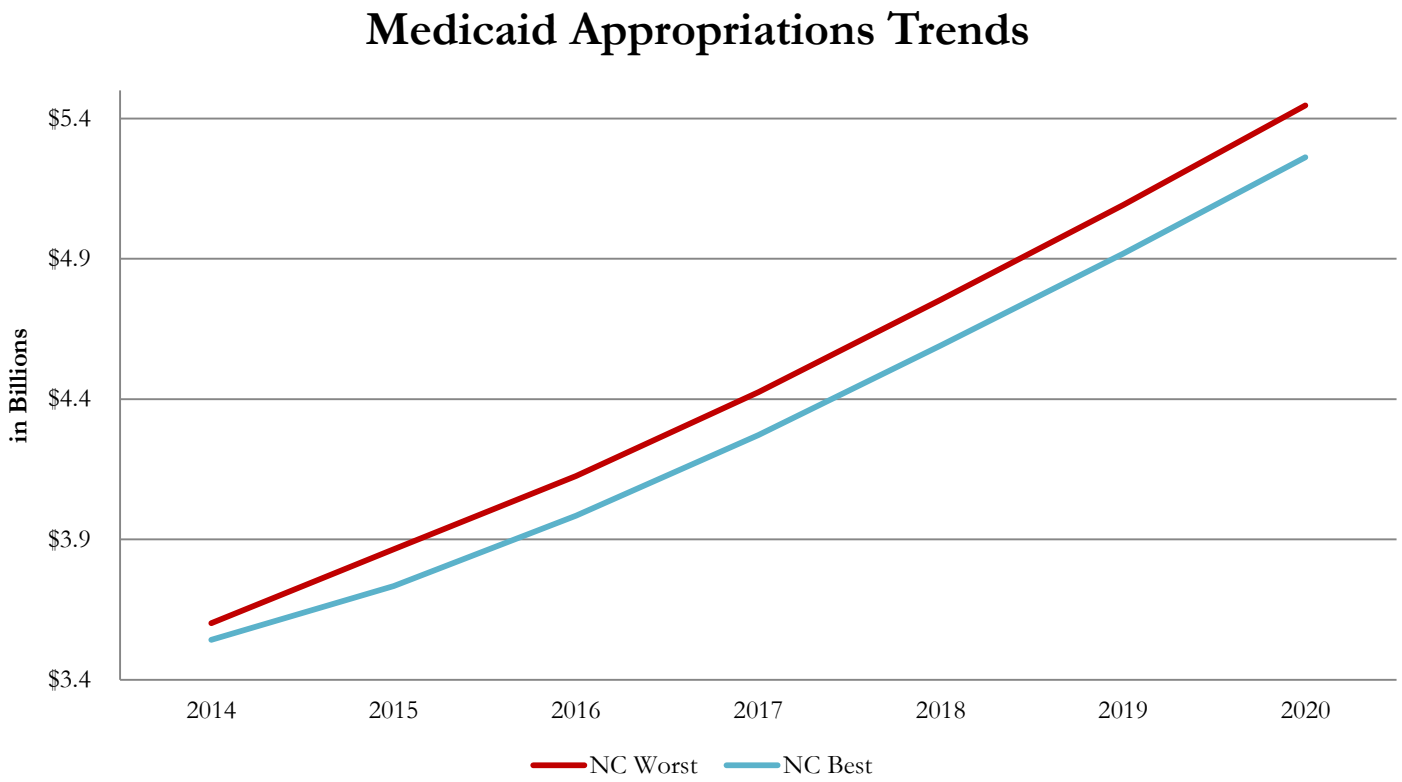
	FY 2015-16	FY 2016-17	FY 2017-18	FY 2018-19	FY 2019-20
Enrollment	1.1%	1.1%	1.1%	1.1%	1.1%
Utilization	5.1%	5.5%	5.7%	5.7%	5.5%
FMAP	66.09%	66.09%	66.09%	66.09%	66.09%

- **The General Assembly does not make any additional changes or reductions to Medicaid policies or payments.**

- **North Carolina does not implement a reform plan that changes who is enrolled, what services are covered, who is paid for services provided or the basis for payment of the services.**

**** Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Care Expenditure Projections 2012-2022***

Medicaid Budget Model



Medicaid budget model assumes that there is no reform initiative to modify expected trends in spending or reductions after SFY 2014-15 approved by the General Assembly.

Medicaid Budget Model

	Worst Case	*Best Case*	*Difference*
2014	$ 3,602,073,988	$ 3,542,368,753	$ 59,705,234
2015	$ 3,864,939,016	$ 3,733,790,623	$ 131,148,393
2016	$ 4,126,507,631	$ 3,984,930,183	$ 141,577,449
2017	$ 4,424,670,418	$ 4,272,150,519	$ 152,519,899
2018	$ 4,754,582,009	$ 4,591,452,431	$ 163,129,578
2019	$ 5,092,474,297	$ 4,918,630,349	$ 173,843,948
2020	$ 5,446,783,028	$ 5,261,681,362	$ 185,101,666

Source of growth in enrollment and utilization projection factors from the National Health Care Expenditure report from CMS and Office of the Actuary.

Questions?

Fiscal Research Division

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www.ncleg.net/fiscalresearch/