Joint Legislative Oversight Committee on Health and Human Services

Medicaid Budget Status Update

Susan Jacobs and Steve Owen
Fiscal Research Division

Jennifer Hillman
Research Division

November 19, 2013

Medicaid Budget Status Update

Susan Jacobs,
Fiscal Research Division

FY 12/13 Medicaid Budget Comparison
General Fund Appropriation and Expenditures

	2012-13 (Actual)	2012-13 (Certified)	Difference
Certified Appropriation	$3,517,694,237	$3,101,448,568	(416,245,669)
Non-Recurring Expenditures	*($209,522,354)*		*$209,522,354*
Non-Recurring Receipts	*74,000,000*		*($74,000,000)*
Adjusted Totals	$3,382,171,883	$3,101,448,568	**($280,723,315)**

Non-Recurring expenditures include the repayment to CMS for the overdraw of federal funds that occurred in 2009. The repayment was completed in FY 2012-13. Additionally, the cost incurred during the transition from fee for service behavioral health to managed care for overlapping payment of claims run out after capitation payment began is included in non-recurring expenditures.

FY 13/14 Medicaid Budget Comparison
General Fund Appropriation and Expenditures

	2012-13 (Actual)	2013-14 (Certified)	Difference
Certified Appropriation	$3,517,694,237	$3,461,950,119	(55,744,118)
FY 12/13 Non-Recurring Expenditures	*($209,522,354)*		*$209,522,354*
FY 12/13 Non-Recurring Receipts	*$74,000,000*		*($74,000,000)*
FY 13/14 Budget Reductions		$147,320,146	$147,320,146
Adjusted Totals	$3,382,171,883	$3,609,270,265	**$227,098,382**

Non-Recurring Expenditures detail included on previous slide, Non-Recurring Receipts include rebates recovered in FY 2012-13 that had been over returned to CMS.

Medicaid Budget Status Update

Steve Owen,
Fiscal Research Division

Budget Status – October 2013

- Caveats
  - **Assuming no unreported or unrecognized liabilities**
  - **Assuming reasonableness of estimates:**
    - Unprocessed claims as a result of NCTracks implementation,
    - Unrecorded NCTracks costs.

- Budget Status
  - **Overall Medicaid budget within approved budget and rebase for the first 4 months of FY 2013-14** *(see attached summary)*.

The Budget status is not a forecast of where the year is expected to end, only an update of where spending is through October 31, 2013 compared to expected spending

Budget Drivers

- Enrollment
- Enrollment Mix
- Utilization
- Policy Decisions

Budget Risks/Areas for Focused Tracking

- Actual impact of the delay in processing claims as a result of the implementation of the MMIS.
- Recovery of hardship payments.
- ACA woodwork and consumption.
- Timing of CMS approval of state plan amendments (SPA's).
- Provider appeals and lawsuits to prevent or delay implementation of budget changes.
- Ability of the new NCTracks system to accommodate changes in programming to achieve savings items.

No Risk	$	(3,757,682)
Timing Risk	$	(52,000,000)
Low SPA Risk	$	(23,122,268)
High SPA Risk	$	(68,440,196)

- Many issues in addition to normal operations that are competing for scarce DMA human resources puts the achievement or quality of results at risk.
- Competency and capacity of behavioral health MCO to achieve savings impact on rate renewals.
- Enrollment and utilization risk.
- PCS appeals, rulings, enrollment, hours and rate.
- Timing variations in provider settlement payments.
- Lack of data to plan and monitor Medicaid performance.
- Presumptive eligibility impact.

Medicaid Presumptive Eligibility under the Affordable Care Act (ACA)

Jennifer Hillman
Staff Attorney
Research Division
(919) 733-2578

November 19, 2013

What is presumptive eligibility?

- "Presumptive eligibility" means that an individual is **temporarily eligible for Medicaid while their eligibility status is being determined**. It is allowed only when preliminary information suggests that the individual meets the criteria for Medicaid eligibility.
- A person who is presumptively eligible may submit a Medicaid application by the last day of the month following the month in which the presumptive eligibility determination is made. If the person submits a timely application, presumptive eligibility will continue until an eligibility decision is made. If the person does not submit an application by the deadline, presumptive eligibility ends when the deadline expires.
- Regardless of whether a person is presumptively eligible, any Medicaid beneficiary may receive retroactive coverage up to three months prior to the date of their application.

NC's Pre-ACA Presumptive Eligibility Coverage

- Under current federal law, states may offer presumptive eligibility only for:
  - Pregnant women
  - Children
  - Breast and Cervical Cancer
  - Family Planning
- North Carolina currently allows presumptive eligibility **only for pregnant women**.
- The Department of Health and Human Services determines which providers are qualified to make presumptive eligibility determinations.

ACA Additional Presumptive Eligibility

- In addition to the State's current presumptive eligibility practices, beginning January 1, 2014, **hospitals may elect to make presumptive eligibility determinations** for the following Medicaid eligibility categories:
  - Pregnant women
  - **Children**
  - **Parents and Caretaker Relatives**
  - **Former Foster Children**
  - Individuals with incomes up to 133% (for expansion states)
  - Individuals with incomes above 133% of the federal poverty level (for states that cover such individuals)
  - **Individuals with breast or cervical cancer, or who are eligible for family planning services**
- Presumptive eligibility does **not** apply to the following Medicaid eligibility categories:
  - Individuals aged 65 and above
  - Individuals who are blind or disabled

Qualified Hospitals

- A hospital must meet the definition of a "qualified hospital" in order to make presumptive eligibility determinations.
  - Must be an enrolled Medicaid provider
  - Must give notice to the State of their election to make presumptive eligibility determinations
  - Must agree to make presumptive eligibility determinations consistent with State policies and procedures
  - Must not be disqualified
  - The State may also require hospitals to assist individuals with the application process.

Disqualification of Hospitals

- The State may establish standards for disqualifying a hospital based on the proportion of presumptively eligible individuals who ultimately submit an application or who ultimately are determined to be eligible for Medicaid.
- If a hospital is not making presumptive eligibility determinations in accordance with State Medicaid policies and procedures, the hospital must be disqualified.
- Before a hospital can be disqualified, the State must provide additional training or take other reasonable corrective action.
- The State may not recoup funds paid to hospitals on the basis that a presumptively eligible individual is later determined to be ineligible. (Likewise, the State will not be required to return the federal share of these funds.)

Joint Legislative Oversight Committee on Health and Human Services

Medicaid Administrative Costs

Steve Owen,
Fiscal Research Division

November 19, 2013

Administrative Cost Review

- Follow up from 10/8/13 Legislative Oversight Committee
- How does North Carolina Medicaid's administrative cost compare to other states Medicaid programs?
- Information Reviewed
  - NC Office of State Auditor January 2013 Report
  - Center for Medicare and Medicaid Services (CMS) data files for states
  - Milliman Annual Reports
  - State websites and other public information
  - Interviews with State Medicaid program staff

Review Summary

- NC Office of the State Auditor report
  - There were 4 findings pertaining to lack of DMA oversight and management of administrative cost and the lack of a cost allocation plan, but no finding regarding the comparison of administrative costs to other states.
  - The Auditor's report accurately reported and calculated administrative cost based on reporting guidelines for the CMS-64 that each state is required to submit.
- CMS-64 Report
  - The report is structured to ensure standardized reporting of information to CMS, not to provide a basis for an "apples to apples" comparison for each category.
  - As managed care has grown the report has not changed to require states to separately report service and administration embedded in capitation rates paid to MCO's ***making it even less useful for comparative purposes at a detail level***.

Extract from the CMS-64

	CMS-64 Report Arizona	% of Total	CMS-64 Report North Carolina	% of Total	% of NC
TOTAL SERVICE PAYMENTS	$ 8,988,386,558		$ 10,297,057,563		**87%**
Inpatient Hospital - Reg. Payments	$ 133,319,021	1.5%	$ 1,295,465,607	12.6%	**10%**
Managed Care Organization	$ 6,400,740,633	71.2%	$ 128,705,175	1.2%	**4973%**
Information Processing	$ 19,342,938	12.4%	$ 92,002,653	14.2%	**21%**
TOTAL ADMINISTRATIVE PAYMENTS	$ 155,835,205		$ 648,762,805		**24%**

Comparing two of the states at either end of the spectrum in the auditor's report for the percentage of MCO service expenditures, it is evident that the impact of increasing MCO payments complicate the comparison of state's Medicaid expenditures using the CMS-64 as the only basis.

Review Summary

- Milliman report
  - Documents the medical loss ratios for each state with a Medicaid Managed Care Organization (MCO), with the exception of Arizona and California.
- Fiscal Research Division interviews with State Medicaid program staff
  - Arizona, Georgia, Michigan, Massachusetts and Tennessee programs were interviewed to identify administrative functions delegated to the MCO and the percentage embedded in the capitation rate for those functions.

Summary Comparison of Administrative Costs

"Apples to Apples" Total Administrative Cost Comparison

State	Adj Service Costs	Adjusted Admin	Admin to Total
Tennessee	7,529,397,927	854,222,601	11.35%
Georgia	7,613,227,008	851,799,879	11.19%
Arizona	8,220,297,682	923,924,081	11.24%
New Jersey	10,169,858,739	902,651,784	8.88%
Michigan	11,613,198,848	965,079,026	8.31%
Massachusetts	12,726,998,133	836,207,207	6.57%
North Carolina	**10,287,726,438**	**658,093,930**	**6.40%**
Illinois	12,741,109,145	773,407,781	6.07%
Missouri	7,875,478,247	421,962,854	5.36%

- MCO administrative cost includes the traditional costs for provider enrollment, contracting, claims adjudication and appeals. Unlike a state's Medicaid program, the MCO must also provide for a profit in the administrative percentage.

Additional Considerations

- All else being equal, it is reasonable to expect Medicaid MCO administrative cost to be higher than fee for service programs because of profit and the requirement for the MCO to actively manage utilization.
- The "apples to apples" comparison makes the same adjustment to each state's costs to identify comparable administrative costs, including NC.
- These costs are estimates, since the actual administrative costs of the MCO is not known, only the percentage that the state has factored into the rate.

Questions?

Fiscal Research Division

Room 619, LOB

919-733-4910

www.ncleg.net/fiscalresearch/