JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEATH AND HUMAN SERVICES
MEDICAID BUDGET STATUS UPDATE – NOVEMBER 19, 2013

Based on information recorded in the state's accounting system, adjusting for a variety of factors, Medicaid spending through the first four months of FY 2013-14 is within the Certified Budget and rebase. Factors that must be considered to appropriately determine Medicaid's position against the state's appropriations budget in the first three months that include:

- Claims not processed as a result of the implementation of NCTracks on July 1, 1013 $132,100,000
- Unrecorded administrative cost for CSC claims processing $ 6,400,000

Fiscal staff reviewed all available expenditure data and identifiable adjustments for all budget codes, discussed results with DMA staff and; assuming there are no outstanding unrecognized financial liabilities remaining in the program, it appears that Medicaid is within its certified budget in the first four months of FY 2013-14 by as much as $56M. While this is ***not an annual forecast*** it does provide a status of where Medicaid is at this point.

The following is a summary of key Medicaid performance indicators:

	Actual Oct 2013	*Actual Oct 2012*	*Variance*	*Budget Oct 2013*	*Variance*	*Actual YTD 2014*	*Actual YTD 2013*	*Variance*	*Budget YTD 2014*	*Variance*
Total Member Months	1,595,217	1,584,586	10,631	1,626,843	(31,626)	6,371,642	6,303,462	68,180	6,480,357	(108,715)
ABD	466,813	458,402	8,411	468,953	(2,140)	1,861,398	1,824,115	37,283	1,869,479	(8,081)
Families	282,904	289,333	(6,429)	286,198	(3,294)	1,125,822	1,152,299	(26,477)	1,142,151	(16,329)
Women	81,185	83,083	(1,898)	81,015	170	328,320	334,322	(6,002)	324,651	3,669
Children	764,315	753,764	10,551	790,677	(26,362)	3,056,102	2,992,722	63,380	3,144,076	(87,974)
% ABD in CCNC		70%		75%			70%		75%	
**Total Provider PMPM	$ 923.00	$ 550.00	$ 373.00	$ 691.00	$ 232.00	$ 832.00	$ 775.00	$ 57.00	$ 793.00	$ 39.00
** Admin to Provider Pmt	2.0%	7.6%	-5.7%	3.6%	-1.6%	3.6%	3.8%	3.6%	3.1%	0.5%
Rebates	$ 30,394,098	$ 42,721,634	$ (12,327,536)	$ 4,978,606	$ 25,415,492	$ 177,732,303	$ 199,828,713	$ (22,096,410)	$ 162,085,685	$ 15,646,618
**Appropriations	$ 323,166,565	$ 345,546,296	$ (22,379,731)	$ 330,983,877	$ (7,817,312)	$ 1,302,408,277	$ 1,372,597,336	$ (70,189,059)	$ 1,358,034,917	$ (55,626,640)

***** NOTES:***

1) Provider Payments have been adjusted to recognize the estimated impact of the lag claims processing as a result of the new MMIS implemented in July 2013

2) Administrative costs have been adjusted to recognize the estimated impact CSC costs for claims processing that have not been recording in DMA expenditures

Risk Factors/Areas for Focused Tracking:

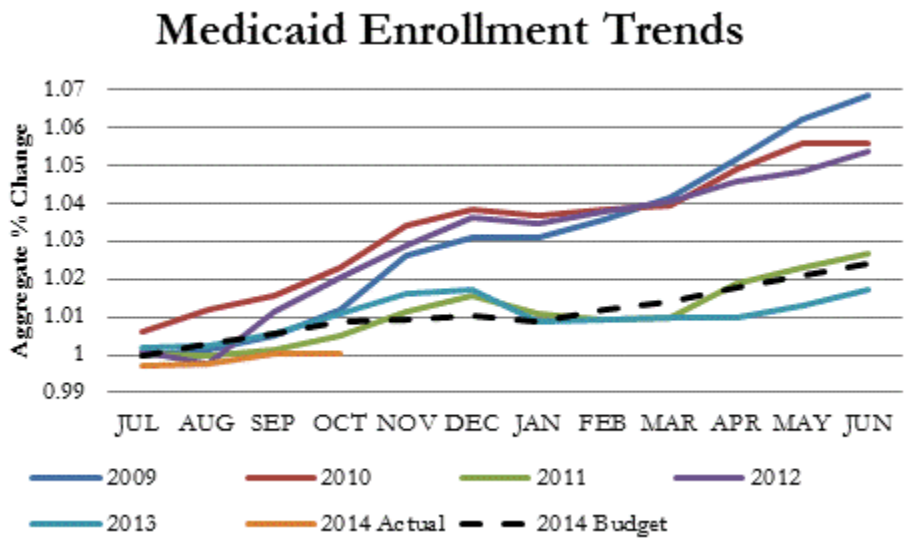
1) The estimated impact of the delay in processing claims as a result of the implementation of the MMIS is based on historical PMPM's and enrollment; there is not a source of information to validate the reasonableness of this calculation.
2) DMA has provided $20M in hardship payments funded be a blend on State and Federal Funds through the end of October. At October 31, 2013, there was $10.9M of the hardship payments made still outstanding, of which $6.8M was funded with State dollars. The risk is the recovery of all state and federal funds and correction of system issues to allow normal processing of claims.
3) Enrollment – the impact of ACA woodwork is a prediction and does not appear to have begun to effect overall enrollment. The consumption of resources of this population is assumed to mirror existing populations, this is still an assumption.
4) Source of enrollment variance – economy versus system implementation.
5) Timing of CMS approval of state plan amendments (SPA's) for changes included in the FY 2013-15 biennium budget.
6) Provider appeals and lawsuits to prevent or delay implementation of budget changes.
7) Ability of the new NCTracks system to accommodate changes in programming to achieve savings items.
8) Many issues in addition to normal operations that are competing for scarce human resources puts the achievement or quality of results at risk – such as planning and implementation of the "Partnership for a Healthy North Carolina" (Medicaid reform), budget saving's SPA's, NCTracks system resolution, shared savings plan development and recruitment of a new Director.
9) Competency and capacity of behavioral health MCO's to achieve savings impact on future contracts and rate renewals.
10) Normal enrollment and utilization risk.
11) PCS appeals, rulings, enrollment, hours and rate.
12) Timing variations in provider settlement payments
13) Lack of data to plan and monitor Medicaid performance.
14) Presumptive eligibility may accelerate woodwork enrollment and the volume of individuals that are deemed presumptively eligible that are ultimately determined as not eligible not known. Additionally, how rapidly this population will begin to consume non-hospital services covered by Medicaid is not known. Overall impact on spending not known.

MEDICAID MONTHLY FINANCIAL REVIEW – OCTOBER 2013

Medicaid spending is "driven" by numerous factors that can be analyzed to provide a more precise understanding of the status of expenditures during the fiscal year. The factors include volume, price, policy, mix and use.

ENROLLMENT

One measure of enrollment is the member month; a member month is recognized for each month a person is enrolled in Medicaid. In other words, if there was an average of 1.5M people enrolled in Medicaid in the each of the first 3 months of FY 2013-14, that would equate to 4.5M member months in the first three months of FY 2013-14. For the period ending October 31, 2013 there were 108,715 less member months than budgeted or a variance of 1.7%. This variance assumes that the "woodwork" impact included in the budget to begin January has not contributed to the variance through October 31, 2013.



The absolute variance in member months is one aspect of understanding the impact of enrollment on spending. The second aspect is the mix of enrollment. Thus far in FY 2013-14 the proportion of aged, blind and disabled (ABD-25,133 more member months) and legal aliens (13,535 more member months) are higher than budgeted and children had 41,332 less member months. The significance of these variances is that the ABD and legal aliens are more expensive (average $1,394 PMPM) than children ($216 PMPM).

PRICING AND POLICY

The only change approved in the budget for pricing or policy that should have impacted the first quarter of FY 2013-14 is the change in the hospital assessment plan to convert to percentage retention.

UTILIZATION

Without the reporting and analytics system operational, there is limited data to evaluate trends in utilization, other than a macro per member per month (PMPM) comparison. For the first four months of FY 2013-14 Medicaid was budgeted to spend $598 PMPM in claims. The actual expenditures are $599, however when the enrollment mix is factored in, spending that reflects overall utilization is actually $6 PMPM less than budget.

One specific area that is being tracked is the expenditures for personal care services (PCS). The FY 2013-14 budget contained provisions to increase maximum hours allowed to 130 hours per month and to lower the per unit rate to remain within budgeted funds. The increase in hours and change in rate was to be effective 10/1/13, pending CMS approval. Since the time of the budget two court rulings have resulting in expanding the individuals covered under the PCS program. In FY 2012-13 a limit of 80 hours per month was implemented. Since June 30, 2013 the average hours per recipient has steadily risen.

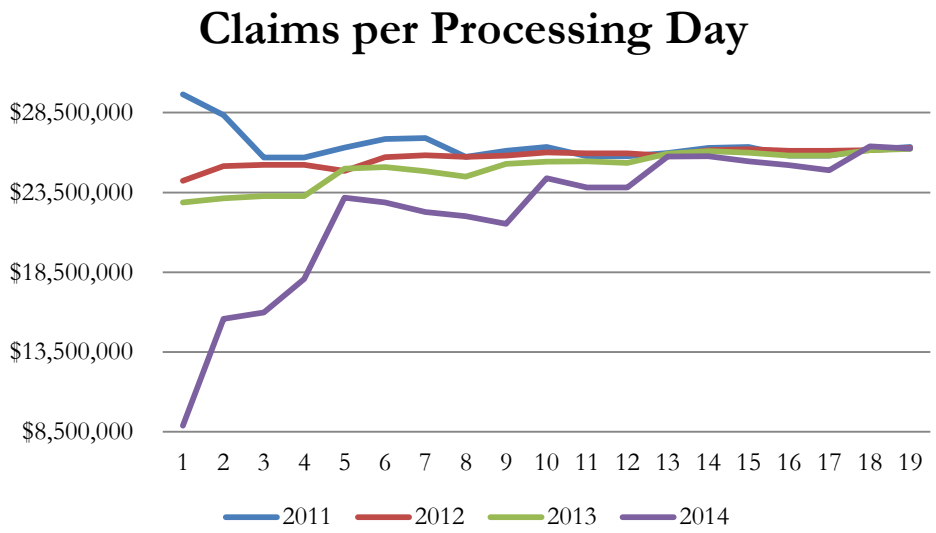
Neither of these factors was considered in the preparation of the FY 2013-14 budget. The increased recipients and hours have resulted in total expenditures for Medicaid being $3.56 PMPM over budget.

Spending for all Medicaid provider payments is $39 PMPM more than budget through October 2013, primarily because supplemental payments and transfers are higher than budgeted.

Factors unique to FY 2013-14 thus far include

a) Timing of claims adjudication following the implementation of NCTracks.
b) Delay in quarterly invoicing drug manufacturers for rebates following the implementation of NCTracks.

Claims processed in September and October 2013 were near levels consistent with enrollment, processing days and expected PMPM's for the first time in FY 2013-14. Year to date claims per processing day were at levels comparable to 2011, 2012 and 2013:



It is important to keep in mind that the claims processed for FY 2013-14 were budgeted at a level higher than 2013 or 2012, as reflected in the claims PMPM for budget at $598 compared to FY 2012-13 of $580 PMPM. Normal financial forecasting for the Medicaid program will continue to be difficult until the processing of claims is current and complete and reliable payment data from NCTracks can be used to forecast with reasonable confidence.

North Carolina Medicaid Program
Summary of Operations (Cash Basis)
Consolidated Report, Actual vs. Certified Budget
For the Month Ended October 2013
Fiscal Year 2013 - 2014

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q
	Adjusted Actual October 2013	Actual October 2012	Percentage	Certified Budget August 2013	Monthly Variance Over/(Under) Certified Budget	Percent Variance	Adjusted Actual Year to Date FY 2013-14	Actual Year to Date FY 2012-13	Percentage	Certified Budget Year to Date FY 2013-14	Year to Date Variance Over/(Under) Certified Budget	Percent Variance	Certified Annual Budget FY 2013-14	Authorized Changes to the Certified Budget FY 2013-14	Authorized Annual Budget FY 2013-14	Year to Date Authorized Budget Remaining	Percentage
1 **MEDICAID ENROLLMENT:**	1,595,217	1,584,586	1%	1,626,843	(31,626)	-2%	6,371,642	6,303,462	1%	6,480,357	(108,715)	-2%	19,292,369		19,292,369	12,920,727	##
2 **MEDICAID FUNDING:**																	
3 Federal Match	1,133,881,027	$ 438,398,726	159%	$ 699,672,856	$ 434,208,171	62%	$ 3,457,597,365	$ 2,921,031,127	18%	3,182,305,257	$ 275,292,108	9%	$ 8,190,542,242	$ (78,961)	$ 8,190,463,281	$ 4,732,865,916	##
4 Provider Assessments and IGT's	104,265,293	14,303,691	629%	33,203,027	71,062,266	214%	418,943,568	379,195,314	10%	398,094,650	20,848,918	5%	696,285,871		696,285,871	277,342,303	##
5 Rebates	30,394,098	42,721,634	-29%	4,978,606	25,415,492	510%	177,732,303	199,828,713	-11%	162,085,685	15,646,618	10%	633,721,525		633,721,525	455,989,222	##
6 Transfers from Other Divisions or Departments	(152,520,089)	96,049,599	-259%	13,886,996	(166,407,085)	###	42,730,907	137,710,587	-69%	55,547,984	(12,817,077)	-23%	166,643,957		166,643,957	123,913,050	##
7 Other	58,588,829	(9,727,838)	-702%	70,950,542	(12,361,713)	-17%	77,871,943	16,220,950	380%	96,899,330	(19,027,387)	-20%	352,998,932		352,998,932	275,126,989	##
8 **Net Funding**	**1,174,609,158**	**581,745,812**	**102%**	**822,692,027**	**351,917,131**	**-**	**4,174,876,086**	**3,653,986,691**	**14%**	**3,894,932,906**	**279,943,180**	**-**	**10,040,192,527**	**(78,961)**	10,040,113,566	**5,865,237,480**	**##**
9 **MEDICAID RECOVERIES:**																	
10 Net Program Integrity Recoveries	3,407,915	10,893,241	-69%	10,453,491	(7,045,576)	-67%	22,990,211	42,253,714	-46%	$ 41,813,964	(18,823,753)	-45%	125,441,886	(507,058)	124,934,828	101,944,617	##
12 **Other Funding**	**3,407,915**	**10,893,241**	**-69%**	**10,453,491**	**(7,045,576)**	**-67%**	**22,990,211**	**42,253,714**	**-46%**	**41,813,964**	**(18,823,753)**	**-45%**	**125,441,886**	**(507,058)**	**124,934,828**	**101,944,617**	**##**
13 **Total Sources of Funding**	**1,178,017,073**	**592,639,053**	**99%**	**833,145,518**	**344,871,555**	**41%**	**4,197,866,297**	**3,696,240,405**	**14%**	**3,936,746,870**	**261,119,427**	**7%**	**10,165,634,413**	**(586,019)**	**10,165,048,394**	**5,967,182,097**	**##**
14 **MEDICAID EXPENDITURES**																	
15 Hospital Claims Payments	179,600,584	140,979,529	27%	187,886,676	(8,286,092)	-4%	608,409,482	632,949,837	-4%	679,856,984	(71,447,502)	-11%	1,927,984,243		1,927,984,243	1,319,574,761	##
16 Physician Claims Payments	134,811,044	106,319,745	27%	116,858,651	17,952,393	15%	421,935,030	413,900,941	2%	424,439,847	(2,504,817)	-1%	1,212,888,749		1,212,888,749	790,953,719	##
17 Nursing Home Claims Payments	117,796,612	95,576,339	23%	107,684,304	10,112,308	9%	423,037,001	378,873,240	12%	390,981,205	32,055,796	8%	1,106,325,782		1,106,325,782	683,288,781	##
18 Drug Claims Payments	132,339,230	92,184,712	44%	118,901,419	13,437,811	11%	491,916,233	403,984,387	22%	430,701,094	61,215,139	14%	1,220,560,731		1,220,560,731	728,644,498	##
19 Other Claim Payments	499,613,762	393,811,941	27%	517,396,263	(17,782,501)	-3%	1,871,123,471	1,824,901,240	3%	1,948,485,562	(77,362,091)	-4%	5,672,750,923		5,672,750,923	3,801,627,452	##
20 Settlements	42,180,055	26,439,473	60%	24,203,322	17,976,733	74%	135,946,985	151,145,205	-10%	148,909,054	(12,962,069)	-9%	384,086,541		384,086,541	248,139,556	##
21 Supplemental Payments	365,434,384	16,312,657	2140%	51,275,509	314,158,875	613%	1,348,522,953	1,078,461,877	25%	1,113,424,729	235,098,224	21%	1,631,616,997		1,631,616,997	283,094,044	##
22 **Net Provider Payments**	**1,471,775,671**	**871,624,396**	**69%**	**1,124,206,144**	**347,569,527**	**31%**	**5,300,891,155**	**4,884,216,727**	**9%**	**5,136,798,475**	**164,092,680**	**3%**	**13,156,213,966**	**-**	13,156,213,966	**7,855,322,811**	**##**
23 Adjustments	4,405,157	89,230	4837%	-	4,405,157	###	417,709	89,230	368%	-	417,709	###	-		-	(417,709)	##
24 Transfers to Other Divisions or Departments	3,886,403	49,751,187	-92%	15,404,475	(11,518,072)	-75%	122,277,675	95,964,617	27%	61,617,905	60,659,770	98%	184,853,698	(732,016)	184,121,682	61,844,007	##
25 Personnel	2,198,037	2,239,577	-2%	2,676,929	(478,892)	-18%	8,951,430	10,270,360	-13%	10,707,712	(1,756,282)	-16%	32,123,144	(10,033)	32,113,111	23,161,681	##
26 IT Contracts	10,482,616	3,677,156	185%	4,435,480	6,047,136	136%	24,578,653	15,273,910	61%	16,032,234	8,546,419	53%	45,517,327		45,517,327	20,938,674	##
27 PA and Assessment Contracts	3,097,546	1,337,892	132%	7,590,018	(4,492,472)	-59%	23,431,710	24,107,941	-3%	30,360,067	(6,928,357)	-23%	91,080,211		91,080,211	67,648,501	##
28 Other Administrative and Contract Expenses	5,338,208	9,465,911	-44%	9,816,349	(4,478,141)	-46%	19,726,242	38,914,956	-49%	39,265,394	(19,539,152)	-50%	117,796,186	660,580	118,456,766	98,730,524	##
29 **Total Plan Expenses**	**1,501,183,638**	**938,185,349**	**60%**	**1,164,129,395**	**337,054,243**	**29%**	**5,500,274,574**	**5,068,837,741**	**9%**	**5,294,781,787**	**205,492,787**	**4%**	**13,627,584,532**	**(81,469)**	**13,627,503,063**	**8,127,228,489**	**##**
30 State Appropriation	**323,166,565**	**345,546,296**	**-6%**	**330,983,877**	**(7,817,312)**	**-2%**	**1,302,408,277**	**1,372,597,336**	**-5%**	**1,358,034,917**	**(55,626,640)**	**-4%**	**3,461,950,119**	**504,550**	**3,462,454,669**	**2,160,046,392**	**##**
31																	
32 **KEY RATIOS:**																	
33 Percent Administration to Total	0.4%	1.0%		0.8%	-0.4%		0.4%	0.8%		0.7%	-0.3%		0.9%		0.9%		
34 Assessments to Provider Payments	7.1%	1.6%		3.0%	4.1%		7.9%	7.8%		7.7%	0.2%		5.3%		5.3%		
35 Rebates to Pharmacy and DME Claims	16.9%	30.3%		2.6%	14.3%		29.2%	31.6%		23.8%	5.4%		32.9%		32.9%		
36 PI Recoveries to Claims	1.9%	7.7%		5.6%	-3.7%		3.8%	6.7%		6.2%	-2.4%		6.5%		6.5%		
37 PMPM - Claims	$ 667	$ 523	28%	$ 645	22	3%	$ 599	$ 580	3%	$ 598	1	0%	$ 577		$ 577	22	
38 PMPM - Total Provider Payments	$ 923	$ 550	68%	$ 691	232	34%	$ 832	$ 775	7%	$ 793	39	5%	$ 682		$ 682	150	
39																	