JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

Division of Medical Assistance Budget Update

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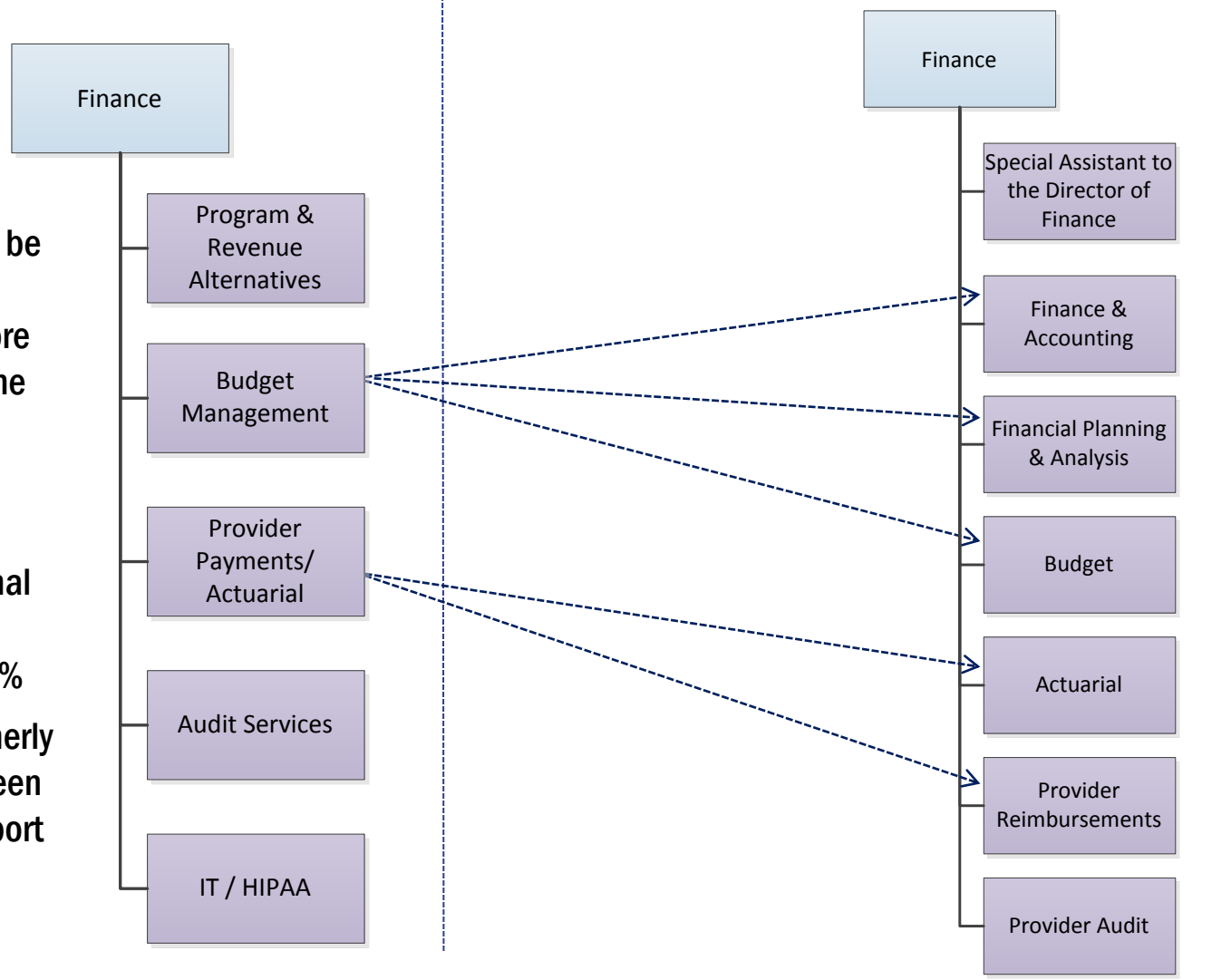
Agenda

I. DMA Finance Section Realignment
II. DMA Budget Management Improvements
III. Update on DMA Forecasting Process
IV. Enrollment Trends
V. Expenditure Analysis
VI. Net Expenditure Analysis: Pharmacy
VII. Backlog Review

DMA Finance Section Realignment

- Director of Finance will be a direct report to DMA Director, focused on core financial functions of the organization
- Budget Management group will be split into three separate functional areas and FTEs will increase by approx. 50%
- Additionally, BIO (formerly IT/HIPAA) group has been elevated as a direct report to DMA Director



DMA Budget Management Improvements

People

Realigned financial management team into 3 discreet but complementary functions:

- Budget: Develop and track biennial budget, and develop forecasts
- Financial Planning & Analysis: Create financial and operational reporting packages to provide analysis of trends in key programmatic cost drivers in each fund/account
- Finance & Accounting: Ensure proper maintenance of general ledger; monitor and report on DMA cash needs; and financial reporting to stakeholders

Process

Over 50 procedures for DMA Budget Management key tasks are being memorialized to:

- Standardize workflows and responsibilities
- Establish repeatable and auditable standard operating procedures
- Aid in knowledge transfer for new hires
- Identify operational improvement opportunities

DMA Forecasting Process Update

Progress

- Built initial assumptions list for each fund and program
- Highly transparent draft model for SF2015F, SFY2016B and SFY2017B expenditures and revenues
- Reviewed preliminary results to understand key forecast/budget variances
- Built scenario manager for real-time review of potential expenditures, revenue and appropriations policy changes
- Developed write-up of model's underlying assumptions and structure
- Confirmed model functionality and methodology of model
- Commenced finance staff integration into forecasting processes

Next Steps

- Refine assumptions with DHHS, OSBM and FRD experts
- Incorporate enrollment projections from external experts
- Perform scenario analyses on enrollment and savings initiatives
- Prepare budget forms/files for submission by 10/31 to OSBM

Enrollment Trends

Medicaid enrollment increased by 272,000 over the 3-year period from SFY12–15, resulting in a compound annual growth rate (CAGR) of 5.7%.

SFY15 Enrollment Characteristics				
Service Category	**#**	**% of Total**	**CAGR**	**CAGR – Adj [1]**
Medicaid for Infants and Children (MIC)	**735,502**	**41.4%**	**5.6%**	**5.6%**
Aged, Blind and Disabled (ABD)	**398,078**	**22.4%**	**1.5%**	**1.5%**
Aid to Families with Dependent Children (AFDC)	**366,202**	**20.6%**	**6.4%**	**6.4%**
All Other	**276,970**	**15.6%**	**12.3%**	**2.7%**
Grand Total	**1,776,752**	**100.0%**	**5.7%**	**4.4%**

[1] "Other" includes impacts of approximately 65,000 enrollees who transferred from Health Choice into Medicaid. Net of this effect, the overall CAGR drops to 4.4% and the CAGR of the "Other" category is 2.7%.

- Excluding the transfer of Health Choice children in 2014, growth rate (4.4%) is in line with prior 3-year period from SFY09–12 (5.2%)
- MIC primarily drove growth: In SFY12, NC stopped requiring MIC enrollees to recertify ex parte, resulting in a 9.4% increase in that year alone
- As of the end of September, there were 12,932 applications beyond standard processing time (from a peak of 95K in June); applying an historical approval rate of 56% would have resulted in a slight increase in the CAGR to 5.8%

Source: Enrollment data is provided via the NC FAST and EIS systems, current as of Sept. 2014

Expenditure Analysis

July & August YTD Medicaid Expenditure Comparison SFY2015 vs. SFY2014

		August YTD Actuals $M				$ Variance
		[A]	[B]	[C] = [A] + [B]	[D]	[E] = [D] - [C]
Fund	Fund Name	SFY2014	Adj [1]	SFY2014 Adj	SFY2015	SFY14Adj to SFY15
1102	Contracts and Agreements	20		20	11	(10)
1310	Medical Assistance Payments	2,158	(588)	1,570	1,863	293
1311	Community Care of North Carolina (CCNC)	-		-	33	33
1320	Medical Assistance Cost Payments	74		74	81	7
1330	Medical Assistance Adj. & Refunds	(53)		(53)	(5)	48
1331	Rebates	-		-	(48)	(48)
1337	Consolidated Supp. Hospital Payments	82	(82)	-	-	-
All	Other Funds	15		15	17	2
Total		**$ 2,297**	**$ (670)**	**$ 1,627**	**$ 1,952**	**$ 325**

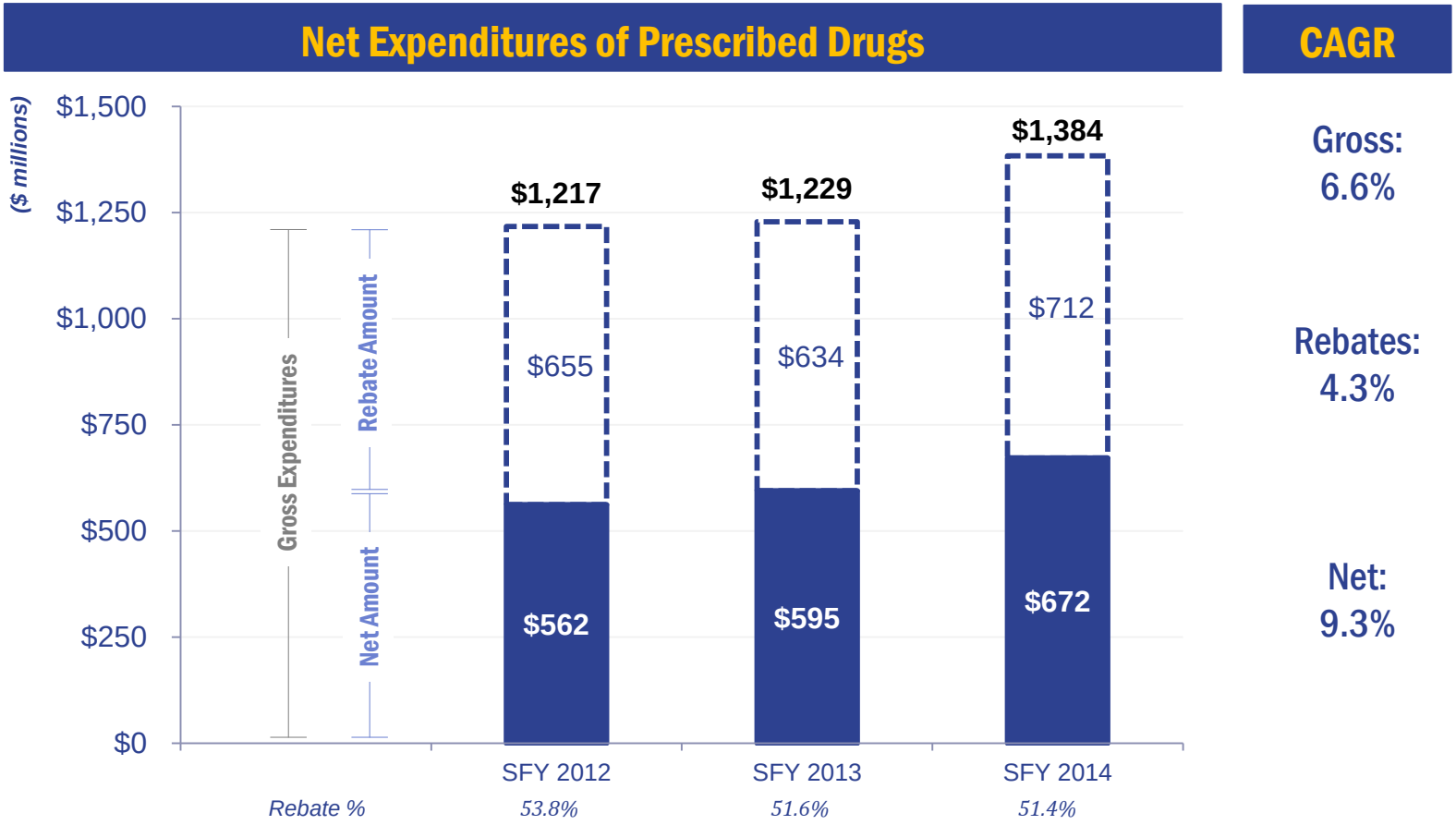
[1] for periodic payments for UPL of $287M, Hospital Equity Payments of $301, and DSH of $82M made in SFY14, and not yet in SFY15

The primary drivers of the $325M increase in expenditures from SFY14Adj to SFY15 YTD August are:

- $101M results from increased payments related to CCNC, MedSolutions and for HMO Premiums based on increased eligibility
- Remaining $224M is from increased claims activity in SFY15 – driven from higher enrollment as well as lower-than-normal payment activity in SFY14Adj due to rollout of NC Tracks

Net Expenditure Analysis: Pharmacy

Net drug expenditure growth is outpacing gross expenditure growth due to increased use of generic drugs which have a lower associated rebate component than brand drugs

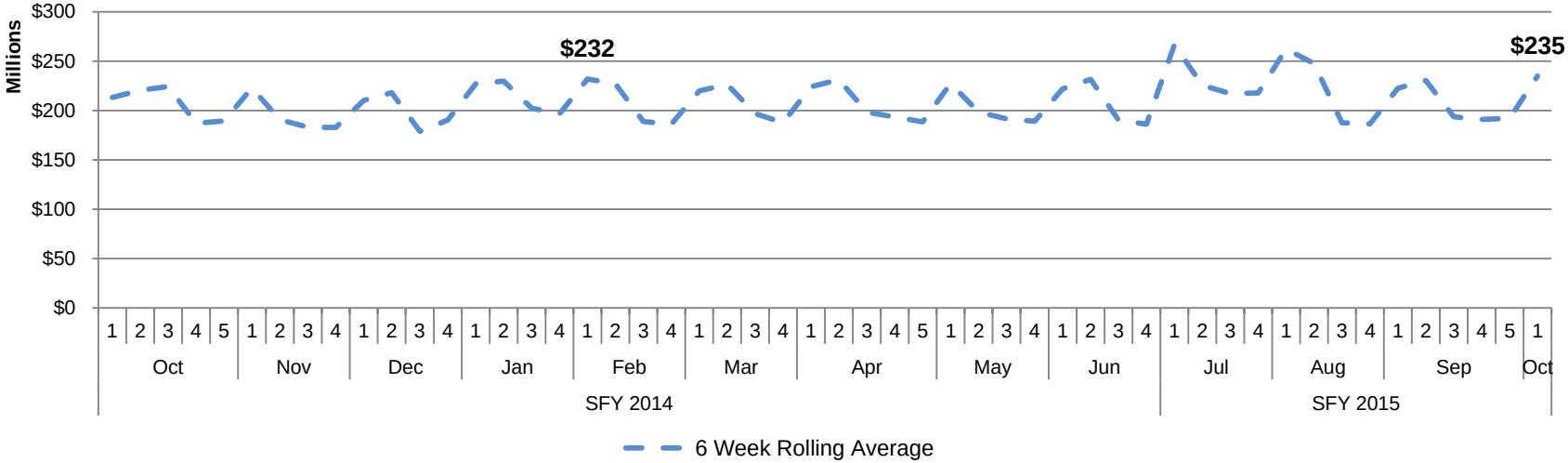


Source: (1) DMA expenditure and Rebate SFY2012-14 data from BD701, Expenditure totals include accounts: 536130, 536130050, 536130051, and 536130052
(2) Rebate totals include the following accounts: 536150010, 536150012, and 536150015 for fund 1310 and 1331
Accurate SFY2011 expenditure data was not available and therefore excluded from this analysis

CAGR: Compound Annual Growth Rate

Backlog Review – Weekly Checkwrite

Checkwrite Analysis through October 7

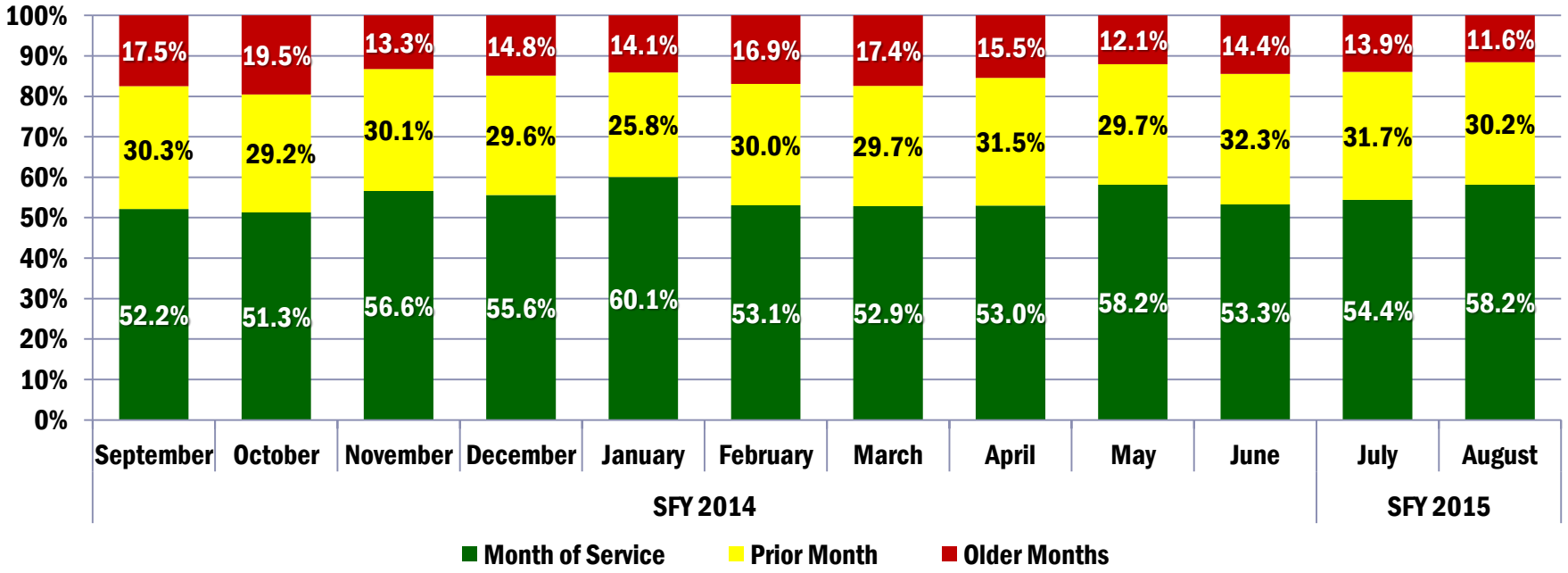


Year over Year Comparison

- Payments are higher Oct YTD compared to last year primarily due to NC Tracks rollout in July 2013 and ACA-driven shift in eligibility from Health Choice to Medicaid in January 2014
- Overall Q1 SFY2015 claim payments continue to remain constant compared to recent prior months

Backlog Review – Claims Aging

- August 2014 came in at 11.6% compared to an average of 15% for the last three months leading up to the NCTracks conversion
- Payment for services rendered two or more months or prior accounted for 17.5% of total payments in September and 19.5% in October versus the overall average of 15.1% for the most recent 12-month period
- Claims payments from older months averaged 14.2% for the last six months (March – August) versus 16.0% in the previous six months (September 2013 – February 2014)



Above chart shows monthly claims payments analyzed by whether services were performed in the same month, immediate previous month, or 60 days and over.

Quantifying and Tracking Claims Backlog

DMA has instituted the following steps to quantify and settle the potential backlog claims:

- Developed a weekly checkwrite dashboard that allows DMA management and stakeholders to more easy identify unexpected changes in expenditures
- Established meetings with LME / MCO representatives to identify eligibility discrepancies and potential impact on PMPM payments
- Engaged NC Hospital Association to provide input in quantifying the potential backlog
- Established regular working sessions with CCNC's financial representative to compare eligibility data used to calculate PMPM payments
- Created a committee that includes DMA Finance, DMA's Fiscal Agent and Office of NCTracks to work with MedSolutions in identifying potential backlog claims
- Engagement across DMA's core operating units to quantify and track potential backlog payments