Medicaid Budget Update

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DMA Finance

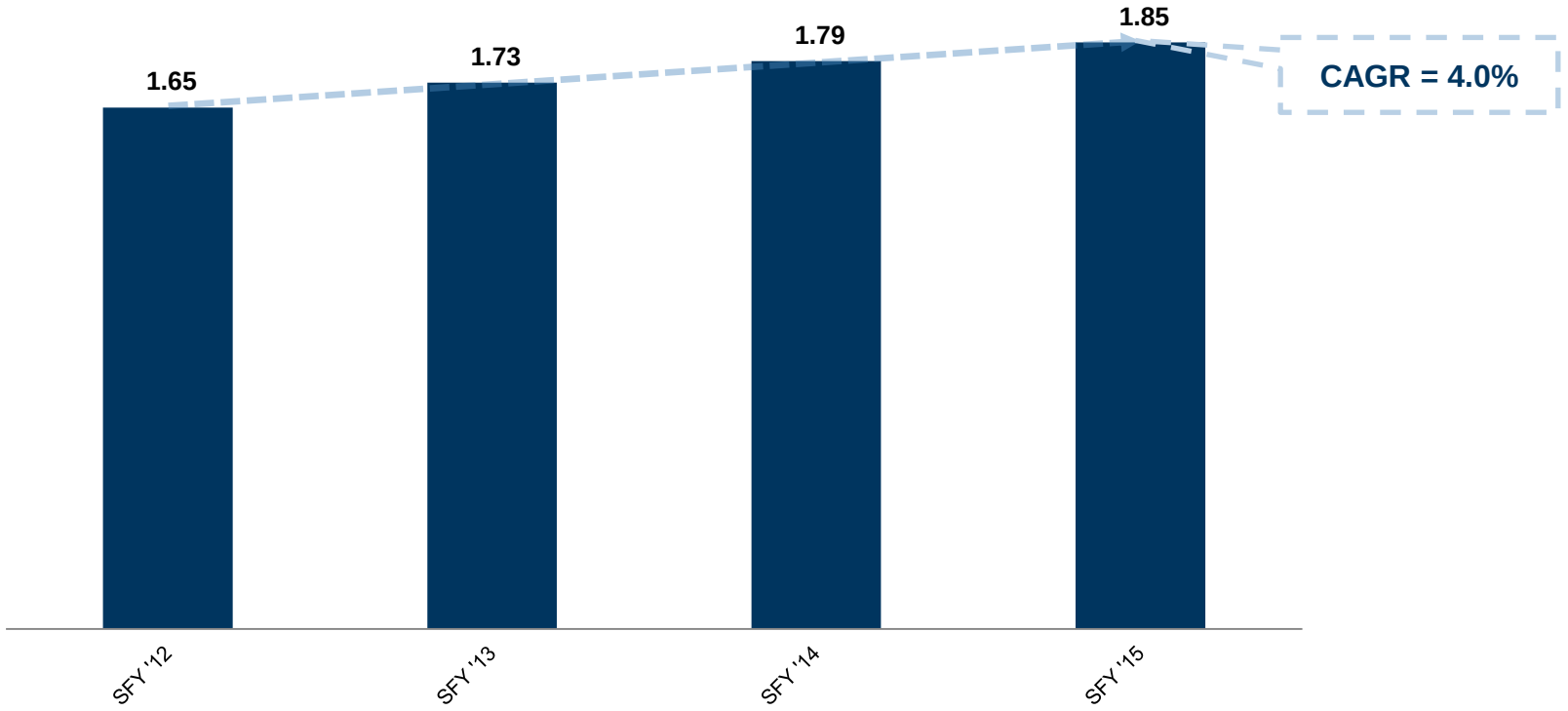
September 9, 2014

Agenda

1. Overview of Historical Enrollment and Expenditures
2. Weekly Spend Analysis
3. Certain Services Overview
   - LME / MCO PMPM
   - Pharmacy Expenditures
   - Skilled Nursing Facilities
   - Dental Services
5. Forecast and Budget Model Overview

N.C. Medicaid enrollment growth has exceeded the national average

DMA Enrollment in Millions



Observations

- Total enrollment has increased 4.8% and 3.9% in SFYs 2012 and 2013 versus the national averages of 3.3% and 2.5% respectively.[1]
- The increase has been steady: there has been a month-over-month decrease in only seven of the last 38 months.

[1] Source: "Medicaid Enrollment: An Overview of the CMS April 2014 Data Update", The Kaiser Commission on Medicaid and the Uninsured, June 2014.
Note: Figure includes Health Choice enrollees and values are reported as of a snapshot at the end of Sept. of each year

CAGR: Compound Annual Growth Rate

While enrollment growth has been consistent, funding levels and sources have been subject to significant changes year over year

Historical State and Federal Funding - SFY 2010-11 thru SFY 2013-14

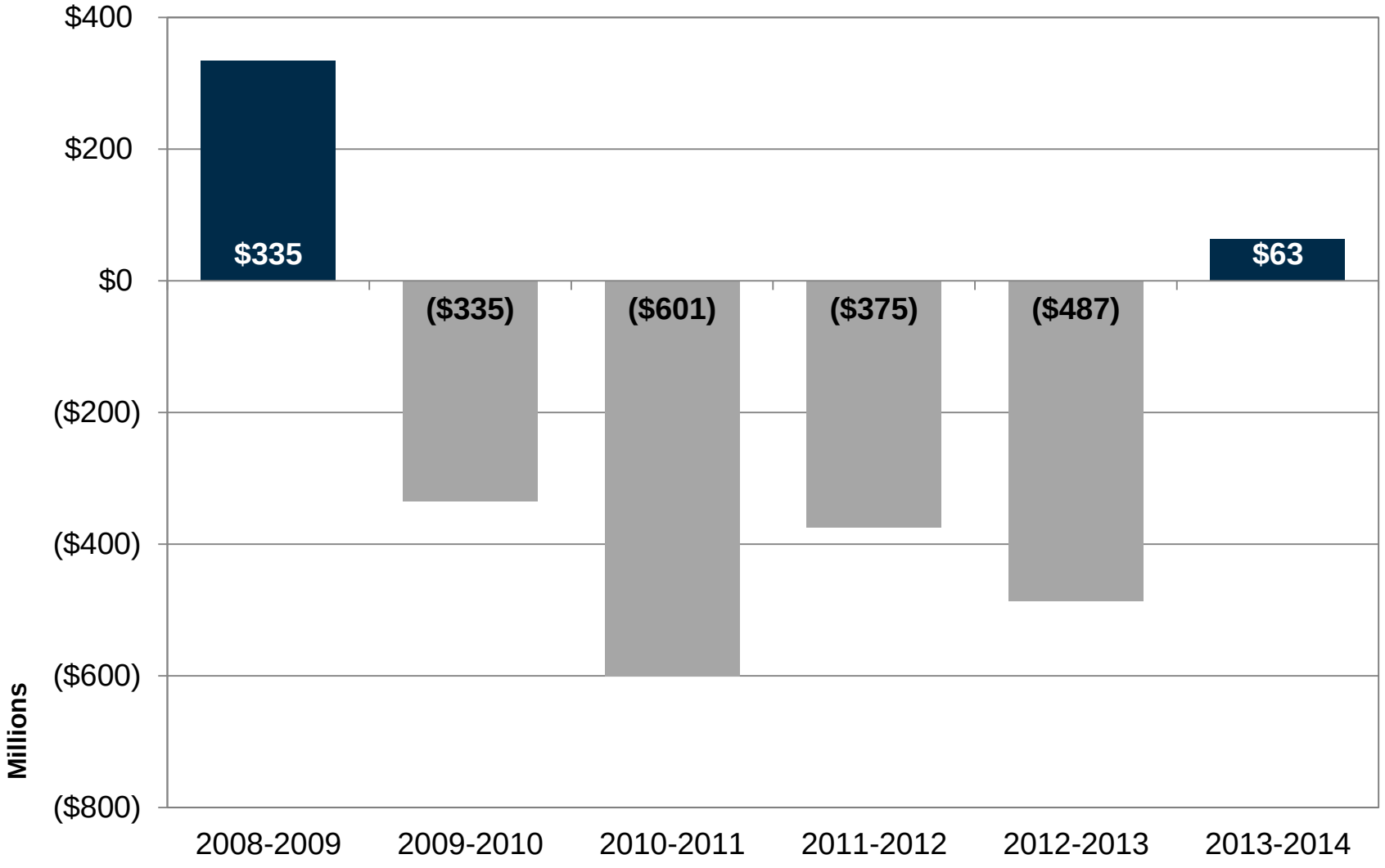
$ in millions	SFY 2010-11	SFY 2011-12	SFY 2012-13	SFY 2013-14
Requirements	$ 13,270	$ 14,241	$ 12,643	$ 13,303
Receipts	10,805	11,214	9,125	9,899
State Share	$ 2,465	$ 3,027	$ 3,518	$ 3,404
Receipts	*81.4%*	*78.7%*	*72.2%*	*74.4%*
State Share	*18.6%*	*21.3%*	*27.8%*	*25.6%*

Last year of ARRA Funding

Increase related to SPAs for hospitals and physicians affecting UPL supplemental payments back to SFY 2010-11

Source: NCAS Report BD701 from June of each state fiscal year

SFY 2014 marked the first time in five years that DMA has ended the year without a deficiency in funding

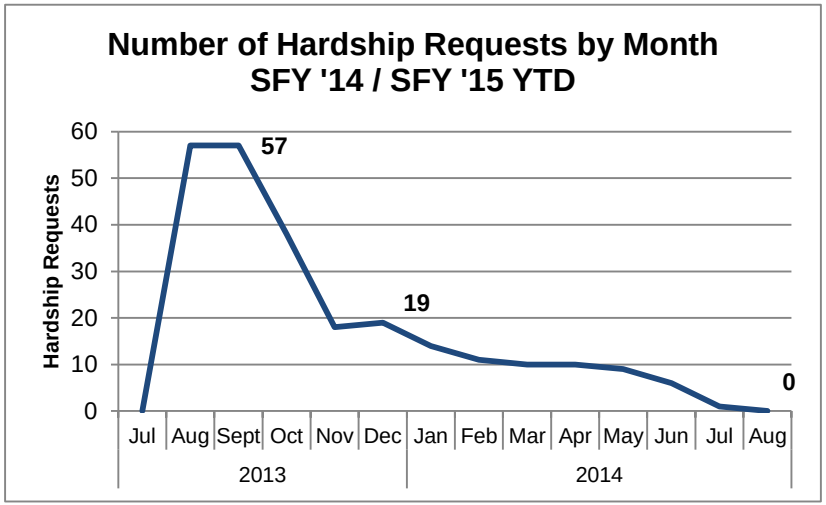


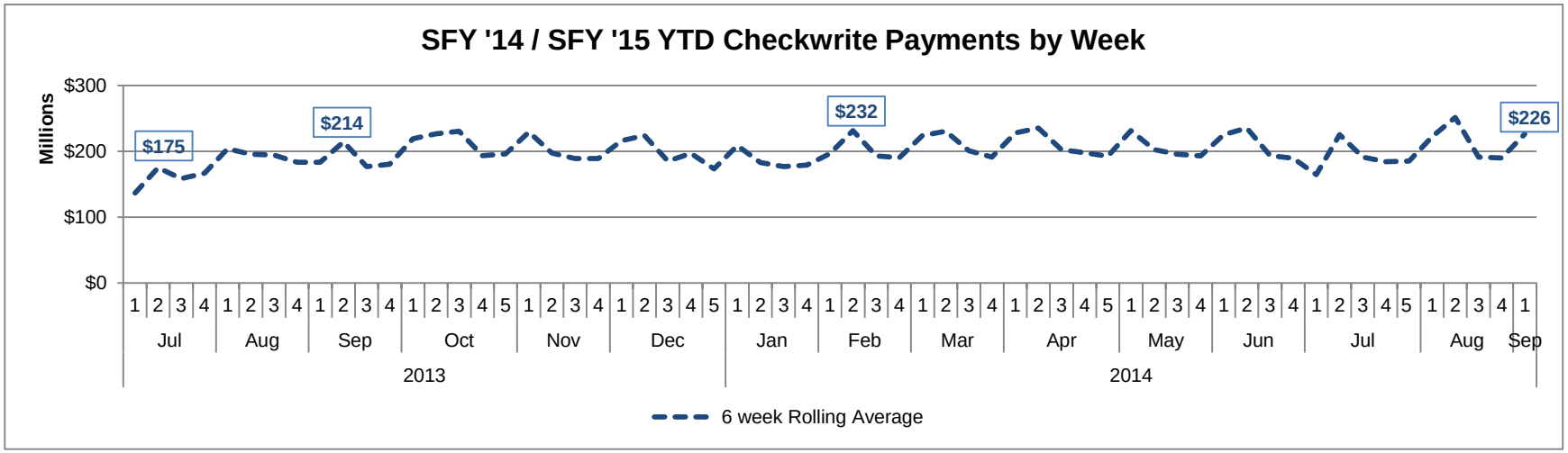
Source: OSBM Memorandum, 6/24/2014

A spike in claim payments resulting from a backlog has not materialized

Observations

- Payment requests as a result of hardships peaked in August and September of 2013 before declining sharply in the subsequent months, indicating DMA has made progress in resolving billing issues.
- DMA's average weekly checkwrite payments have remained relatively steady over the last half of SFY '14 into SFY '15.



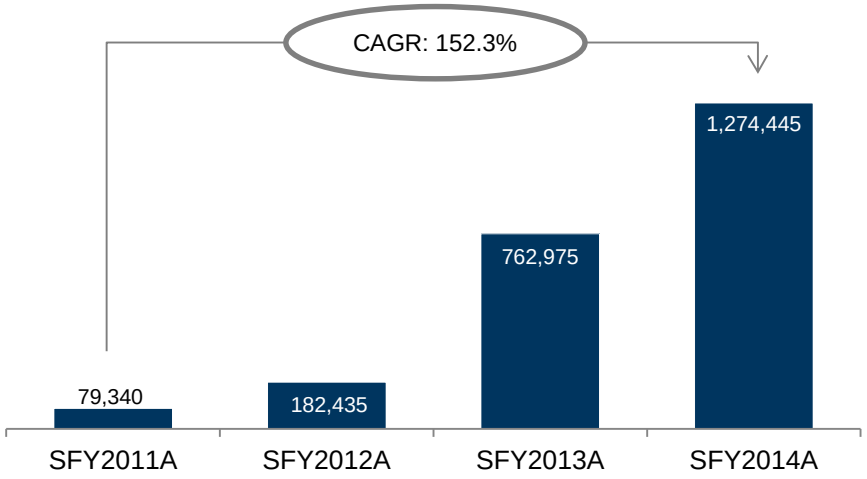


Sources: (Bottom) NCAS Checkwrite Payments, including Health Choice, current as of 9/3/2014
. (Top Right) Hardship Log as maintained by DMA Budget Management, current as of 8/29/2014

LME / MCO PMPM Overview

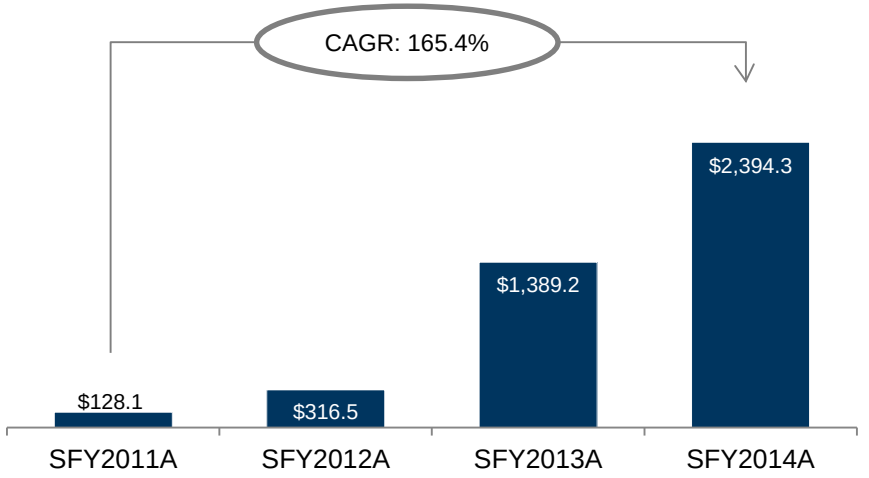
- The main driver of the DMA's LME / MCO Premium services' cost growth was the expansion of the Piedmont Behavioral Health pilot – started in 2005 – that grew rapidly from SFY2011 to full county participation in SFY2013
- Going forward, modest growth in spending is expected due to increased adults with developmental disabilities being served as a result of the 1915(c) waiver amendment

Average Monthly Recipients

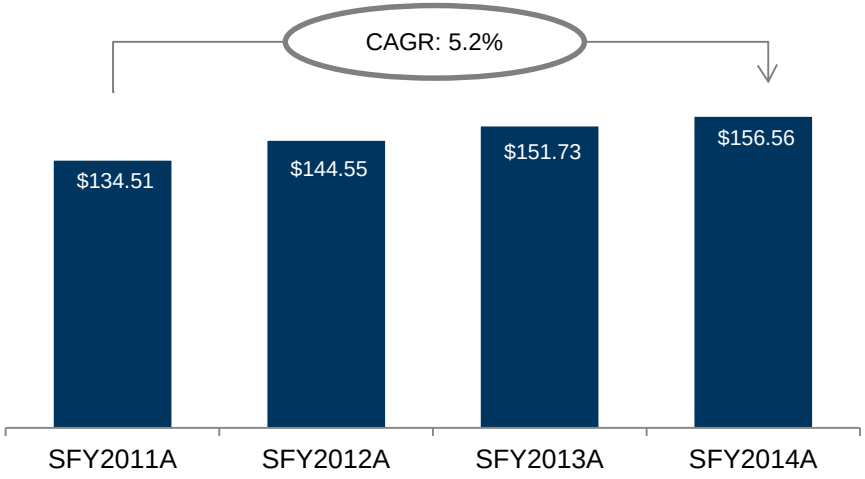


Historical Expenditures

($ millions)



Average PMPM



Source: DMA Expenditure Data SFY2011 - 14 from BD701, DMA Recipient Data SFY2011 - 14 from Truven, Joint Legislative Oversight Committee LME/MCO Consolidation March 12, 2014 Presentation, Senate Bill 745, Section 12H.5 from May 15, 2014, "Section 1915(b) Waiver, State of North Carolina NC MH/IDD/SAS Health Plan", DMA Interviews, "County DSS Office Letter"

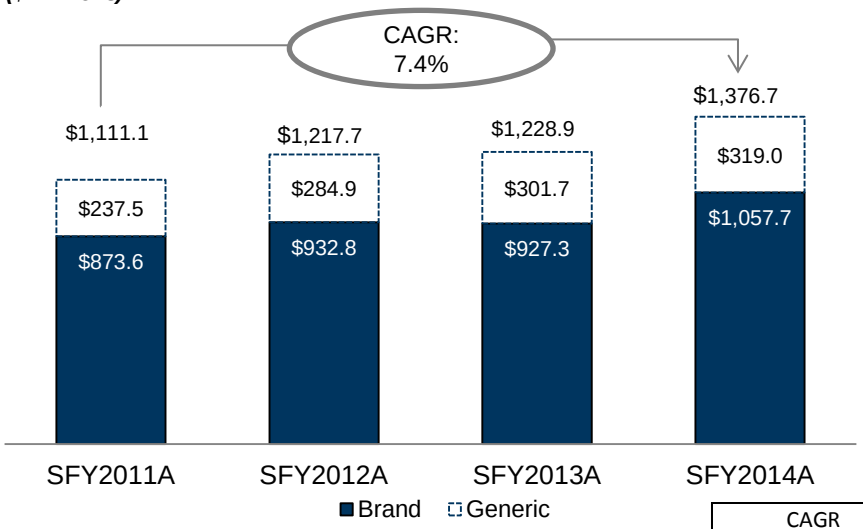
CAGR: Compound Annual Growth Rate

Pharmacy Services Overview

- Pharmacy services spending has increased due to increased utilization of specialty drug therapies as well as overall increased in Medicaid pharmacy pricing for both Brand and Generic drug therapies
- To contain increasing pharmacy costs, DMA promotes the use of generic prescriptions
- Generics are still cheaper relative to Branded drugs, but their comparative pricing benefit is shrinking, as the generic drug makers have consolidated (and prices have risen)

Historical Expenditures (Before Rebates)

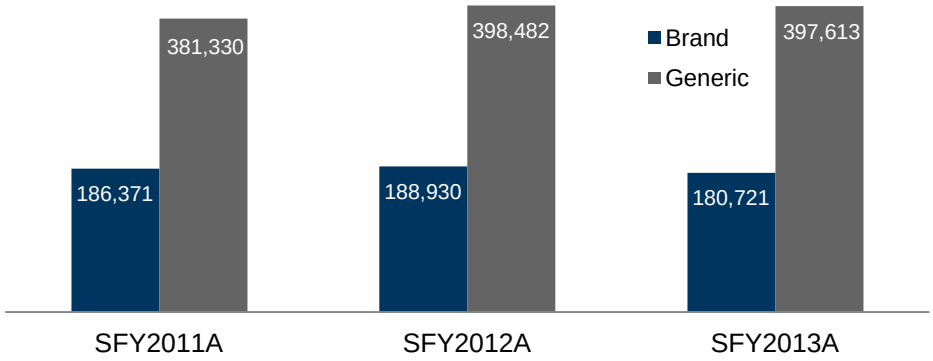
($ millions)



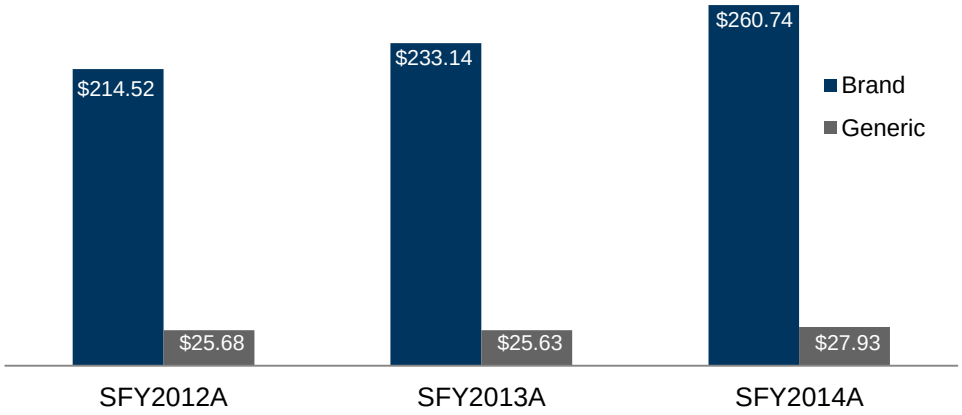
CAGR	
Brand	10.2%
Generic	4.3%

Average Monthly Recipients(1)

CAGR	
Brand	(1.5%)
Generic	2.1%



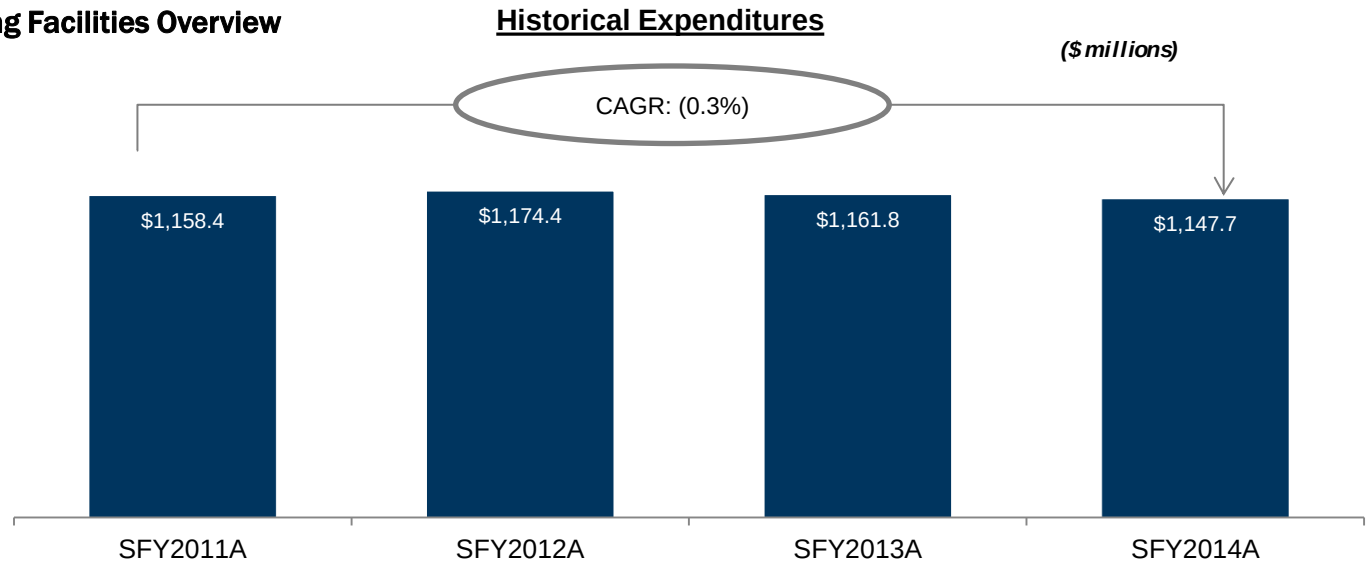
Average Cost / Prescription(2)



Source: DMA Expenditure Data SFY2011-14 from BD701; DMA recipient Data SFY2011-13 from Truven;
(1) Recipient data for SFY2014 is currently not available for these accounts
(2) Prescription information from a truven report provided by the pharmacy program manager

CAGR: Compound Annual Growth Rate

Skilled Nursing Facilities Overview



- **Although total spending has remained relatively flat, the recipient acuity has been on an upward trend. The freezing of the case mix index component of the rate beginning January 1, 2015 will assist in controlling the future expenditures.**

- **DMA continues to explore home and community-based alternative programs to further lower the overall spend**

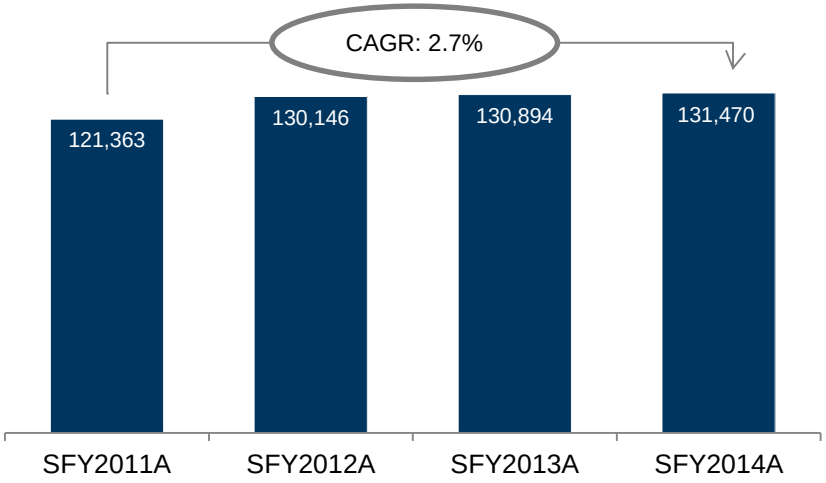
Source: DMA Expenditure Data SFY2011-14 from BD701

CAGR: Compound Annual Growth Rate

Dental Services Overview

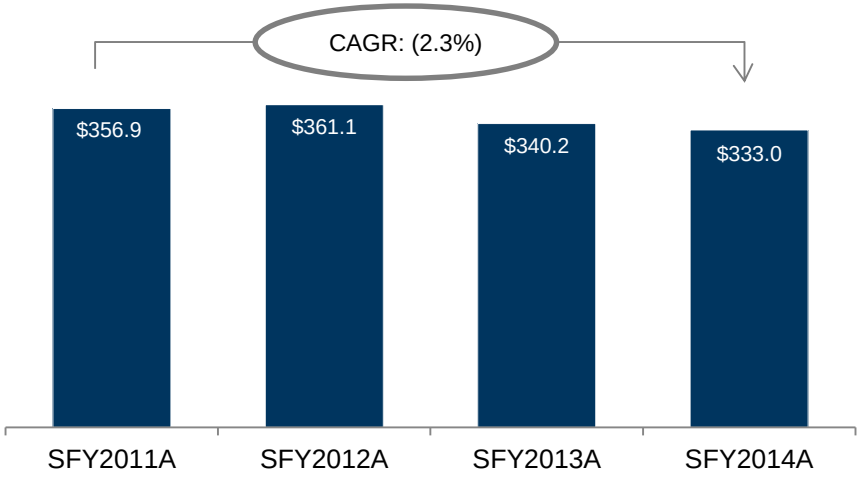
- Reimbursement rate changes implemented in SFY2009 have continued, leading to cost savings
- Recipients increased due to a rise in Medicaid-eligible children ages 0-20
- Increased demand for providers in the northeastern and western counties of the state are expected to lead to increased dental service costs

Average Monthly Recipients

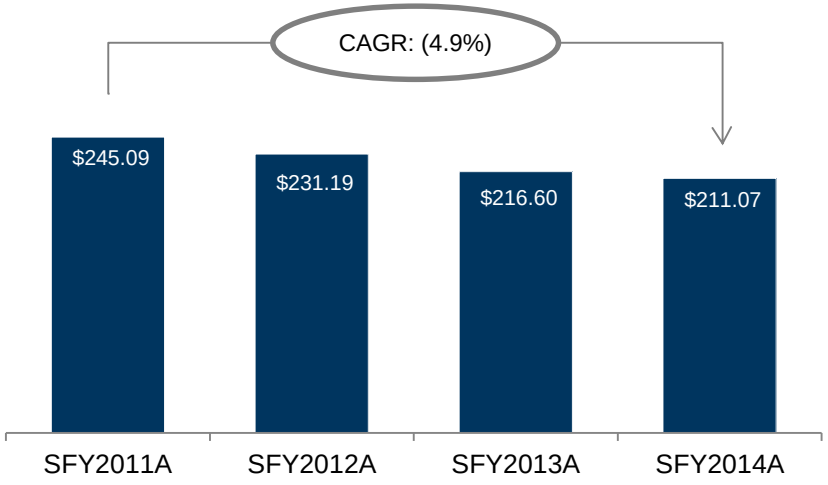


Historical Expenditures

($ millions)



Average Monthly Cost per Recipient



Source: DMA Expenditure Data SFY2011 - 14 from BD701, DMA Recipient Data SFY2011 - 14 from Truven; "NC Medicaid Reform – Status and Recommendations DMA Dental 111713", 2013 CMS National Health Spending Report, DMA Interviews

CAGR: Compound Annual Growth Rate

Forecast and Budget Model: Development Notes To Date

Process

- Processes and methodologies used in model are being documented
- Modular model set-up will facilitate performing sensitivity analyses
- Version management protocols have been established
- Collaborating with outside subject matter experts to provide input into enrollment projections
- Engaging with key parties to normalize data between NCTracks / NC Analytics (claims data source) and NCAS (General Ledger) to build baseline on which to do SFY2015 forecast and the next biennial budget

Methodology

- Key expenditure drivers are being identified through sessions with DMA program managers; Drivers will be validated and compared with external parties. Findings will then be built into the model.
- Recipients and net expenditures monthly data have been loaded at the account/program aid category level

Tool

- Excel model has been developed to accept key inputs to drive forecasts and budget
- Sample dashboard mock-up has been created

The Updated Forecast and Budget Model Addresses E&Y's Recommendations

E&Y Recommendations (October 2013 Report)	E&Y Observations: Former Model	Approach: Current Model
Process		
Documentation on process and methodology is in place	No	Yes
Multi-year forecasts are capable of scenario and sensitivity analyses	No	Yes
Forecasting workflow includes multi-level reviews and approvals	No	Yes
Rigorous version management protocols are in place	No	Yes
Methodology		
SAS, Strata or similar forecasting tools are used to project enrollment, receipts, expenditures	No (1)	No (1)
Key expenditure and receipt drivers are clearly identified	No	Yes
Statistical testing and model testing used as part of forecast exercise	No	Yes
Seasonality is identified in forecast	No	Yes
A data governance plan is in place and incorporated in forecast	No	Yes
Tool		
One single tool is used that supports multiple types of models, including cross-sectional, time-series, and limited dependent variable models (e.g. OLS, ARIMA, ARCh, logit, probit)	No	No
Performance reporting, including variance analysis, is automated	No	Yes
A dashboard platform is in place	No	Yes
An active information governance model is in place	No	Yes

(1) SAS is used to develop enrollment projections only