Joint Legislative Oversight Committee on Health and Human Services

Medicaid Reform/Reorganization Subcommittee

NC MEDICAID SPENDING
Trends and Comparisons

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Discussion Guide

- Drivers of Health Care Spending
- Medicaid Spending Trends
- The Impact of Volume/Enrollment
- The Impact of Enrollment Mix
- The Impact of State Actions
- Comparisons
- Conclusions

Health Care Spending Drivers

Health Care spending is a function of volume – price – mix - use

- Volume/Enrollment
  - Controllable by DHHS
    - Informed population (relative and controllable from one side)
    - State eligibility policies (must be approved by CMS)
  - Uncontrollable by DHHS
    - Federal policy
    - Birth and death rates
    - Population age and rate of aging
    - Individual decision not to or to enroll
    - Employment and economy
- Price

Must be approved by CMS

  - Controllable by DHHS
    - Fee for service and negotiated rates
    - Rate definitions, policies and methodologies
  - Uncontrollable by DHHS w/o Policy Change
    - Cost based provider's cost *(change the definition of cost)*
    - Trends in external benchmarks *(change the benchmark or multiplier)*
    - Invoice based or rates set externally *(change the multiplier, program or entity)*

Pricing Structure in NC

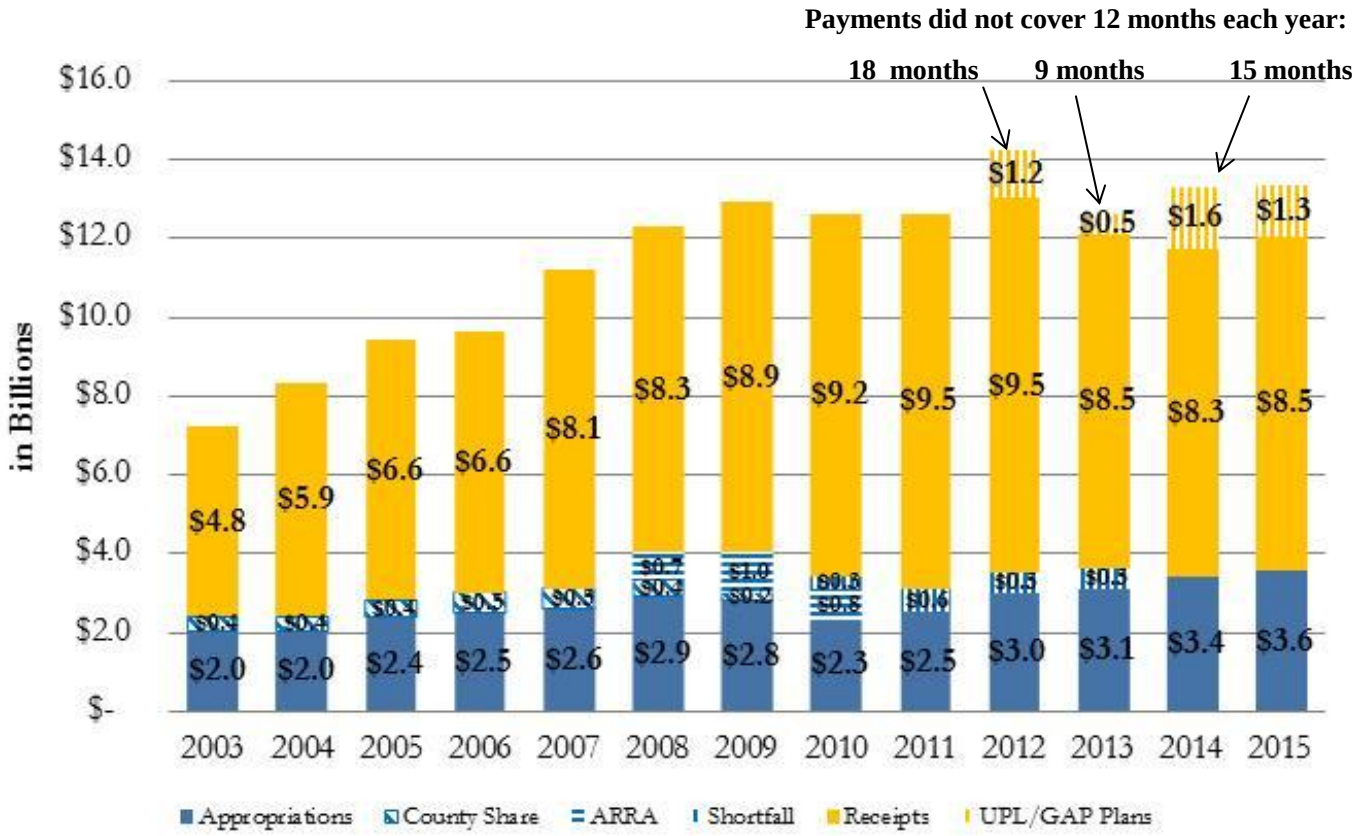
• Fee for service	• Hospital inpatient (DRG), dental, physician services, other professional, nursing homes, home care/PCS, lab, optical (professional), DME, hearing aids, ICF&PRTF for non-LME/MCO covered recipients
• Negotiated rates	• LME/MCO behavioral health capitation rates, High tech imaging capitation rates, PACE premiums, optical supplies
• Cost based rates	• UNC/ECU inpatient, Hospital emergency and outpatient (70%), critical access hospitals (100%), State facilities, health departments/LEA/Public Ambulance (federal share only)
• Rates tied to external benchmark	• Retail Drugs, case mix and facility components of nursing home rate system (frozen 1/1/15)
• Invoiced based rates	• Dentures and selected DME (when Medicare rates not available), EPDST, Non-emergency transport
• Rates or methodologies set by external entity	• Part A, B and D premiums, third party insurance where Medicaid secondary, hospice, FQHC/RHC, clinical reference lab

Health Care Spending Drivers

- Mix
  - Controllable by DHHS
    - Health conditions and health status (able to influence)
  - Uncontrollable by DHHS
    - Enrollment program aid category
    - Severity of illness, chronic illnesses and type of service
    - Health conditions and health status
- Use/Utilization
  - Controllable by DHHS
    - Clinical policy, caps & prior authorization (CMS approved)
    - Lack of coordination or the fragmentation of care
    - Payment policy that incentivizes more or higher cost settings
  - Uncontrollable by DHHS
    - Frequency and level of service (potential provider control)
    - New technology
    - Standards of care and practice
    - Malpractice driven services and practices
    - Environmental conditions and factors
    - Recipient lifestyles and decisions
    - Knowledge and demands of recipient for treatment

Medicaid Spending Trends

Chart reflects total net Medicaid spending including claims, administration, contracts, settlements, program integrity, transfers and other spending



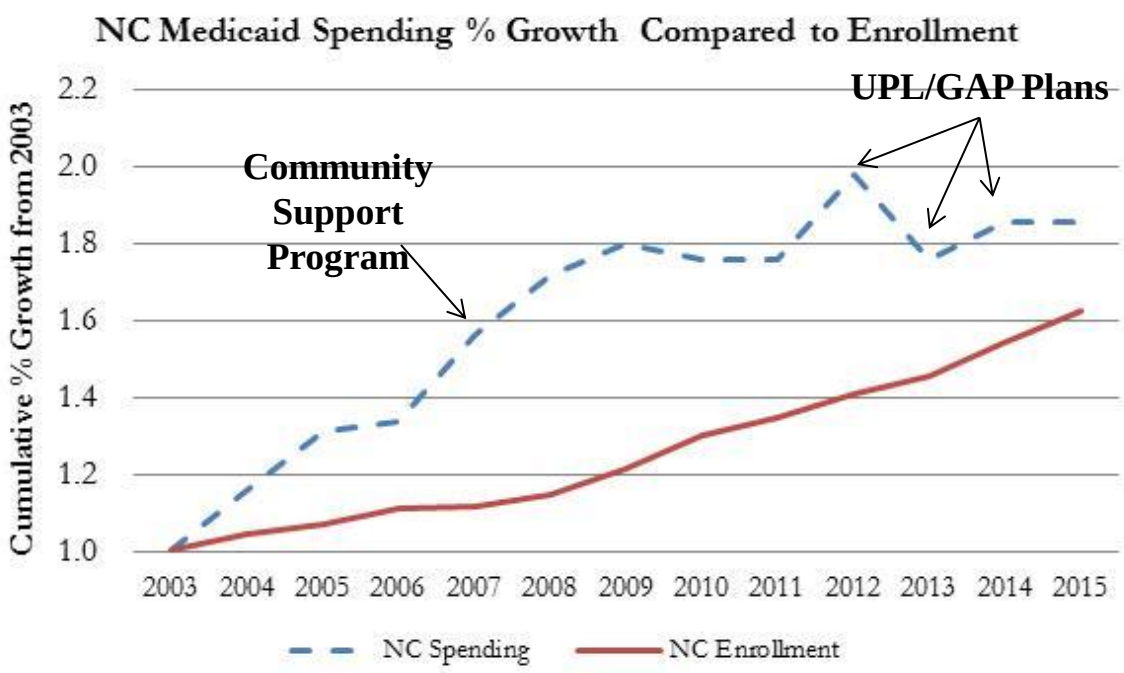
SFY 2014-15 FRD estimate does not include the $186 M contingency reserve

Source: NC Office of the State Controller and NCAS BD701 and FRD estimate for SFY 2014-15

Medicaid Spending Trends

VOLUME FACTORS

Medicaid – The Impact of Volume/Enrollment



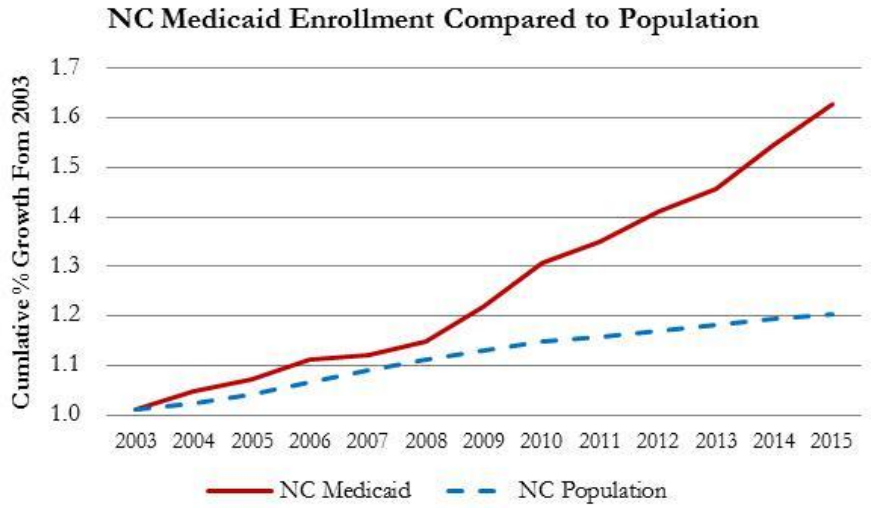
1) Total enrollment is one element driving the change in Medicaid spending

2) UPL/GAP plans began in 2012 and created spending anomalies through 2014

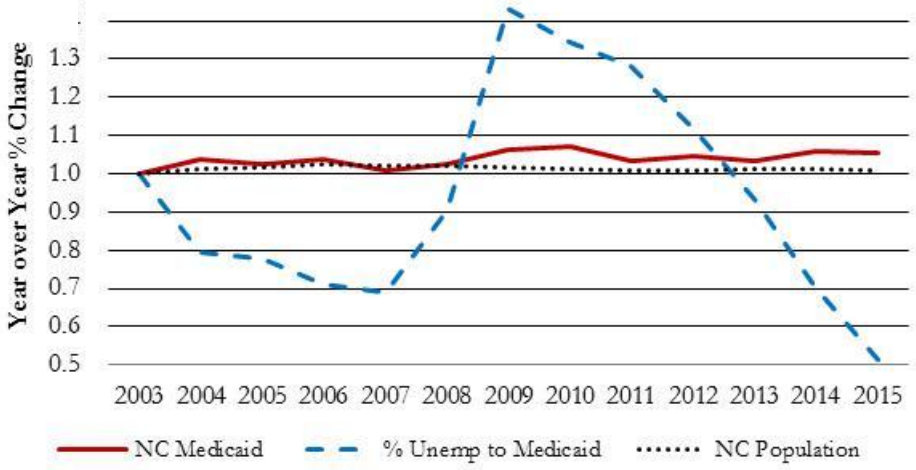
3) General Assembly approved reductions and expansions impacted the spend throughout 2003 - 2015

Source: NC Office of the State Controller, NCAS BD701, DMA Data, FRD Calculation

Medicaid – What Drives Volume/Enrollment



NC population and unemployment are key drivers in Medicaid enrollment, though not the sole drivers and may be leading indicators

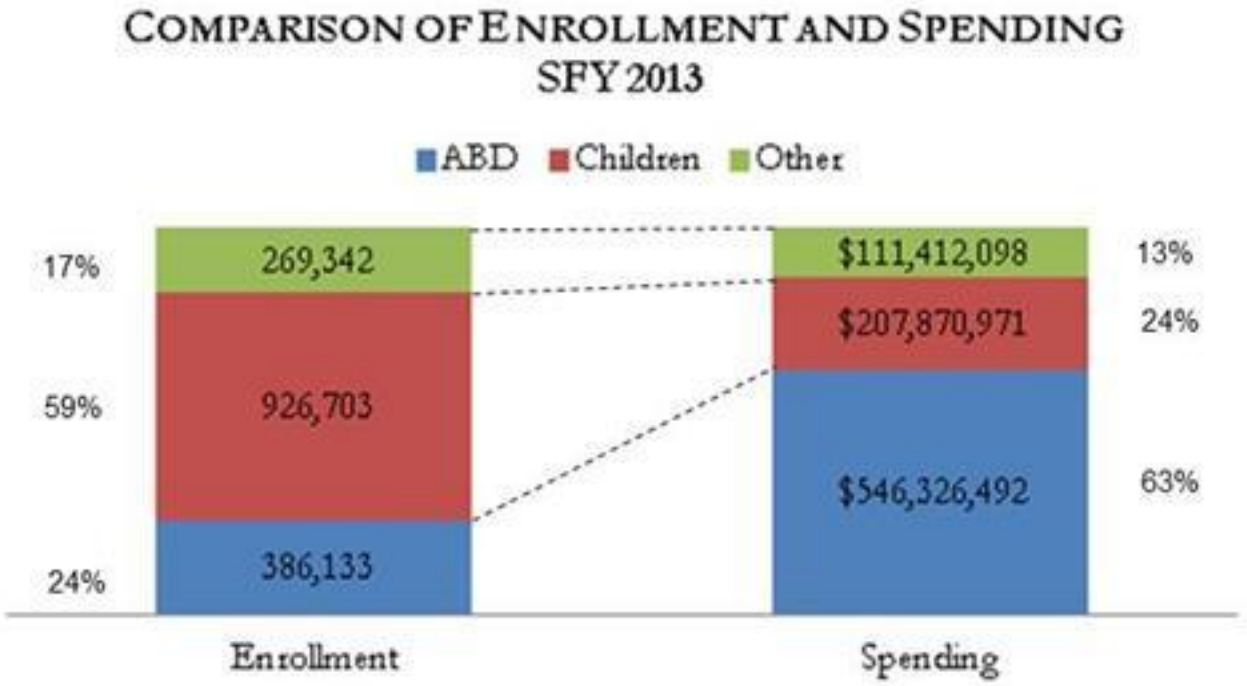


Other factors impacting 2014 and 2015 include the shift of 72,000 children from Health Choice and increases related to the "woodwork" effect of the Affordable Care Act January 1, 2014

Source: OSBM, DMA Data and FRD Calculations

Medicaid – What Drives Volume/Enrollment and Spending

NOT ALL ENROLLMENT IS EQUAL



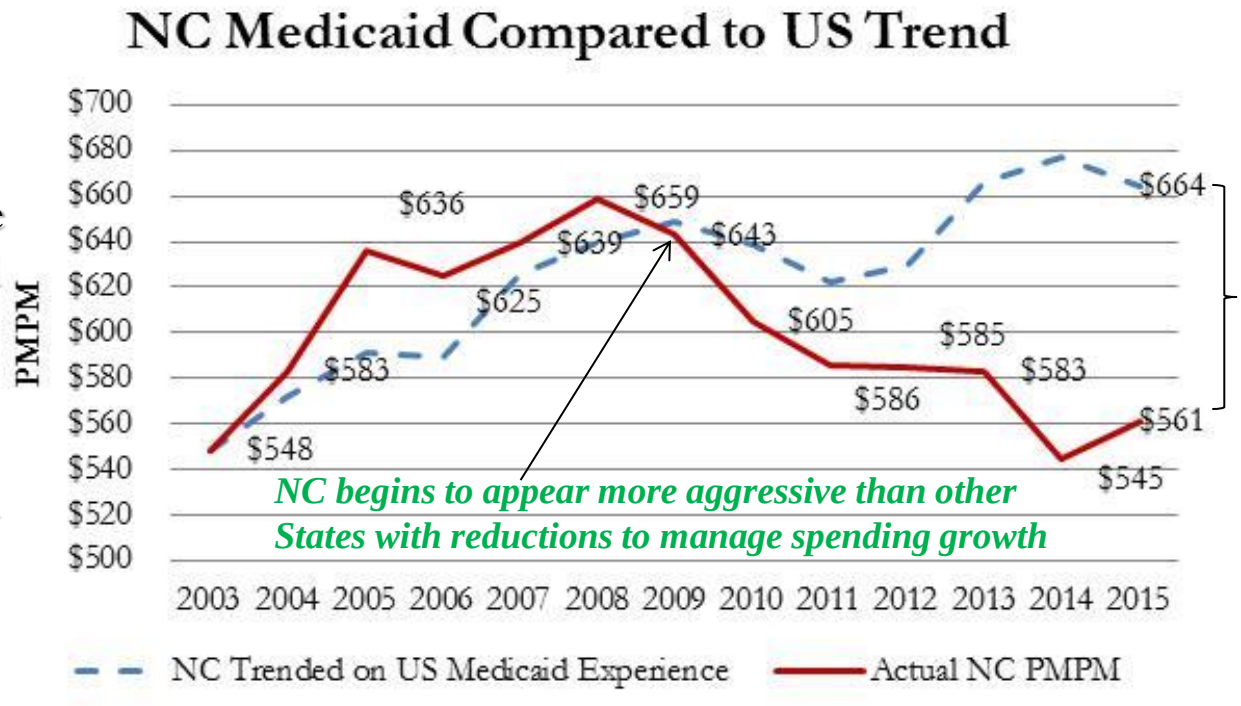
Source: DMA Data and FRD Calculations

Medicaid Spending Trends

MIX – PRICE – USE FACTORS

Medicaid Base Line Spending Trends

In order to enhance comparability of NC to the US dollars have been converted to a per member per month (PMPM) which removes the impact of enrollment on trends

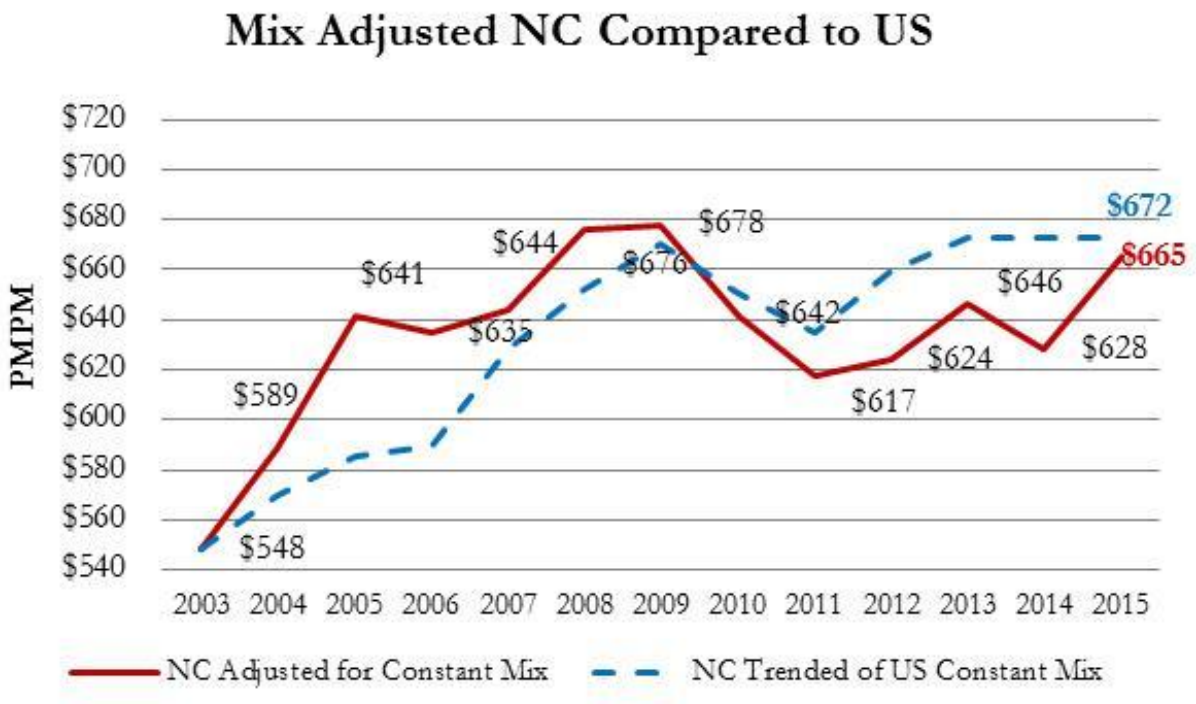


A primary component of the gap between US and NC's PMPM after2007 is the increasing proportion of NC enrollment attributable to children and families compared to the US

PMPM's include claims and settlement cost only

Source: North Carolina Accounting System BD 701, FRD Calculations

Medicaid – The Impact of Mix

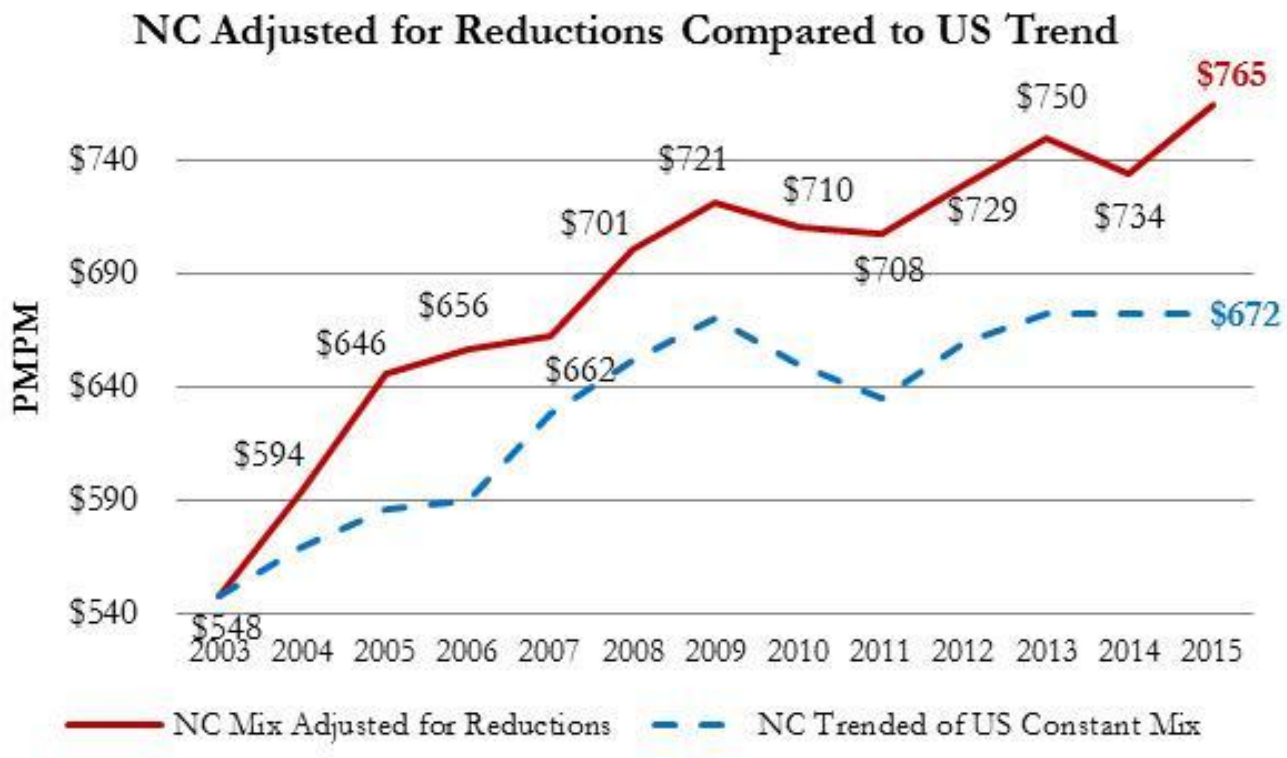


PMPM's adjusted to hold enrollment mix constant throughout the forecast period

Source: North Carolina Accounting System BD 701, FRD Calculations and Estimates

The gap between NC PMPM's adjusted for constant enrollment mix compared to NC trended on US mix trends reduced by 93% or $96 PMPM as a result of a larger shift to lower cost recipients in NC beginning in 2008 (children and families)

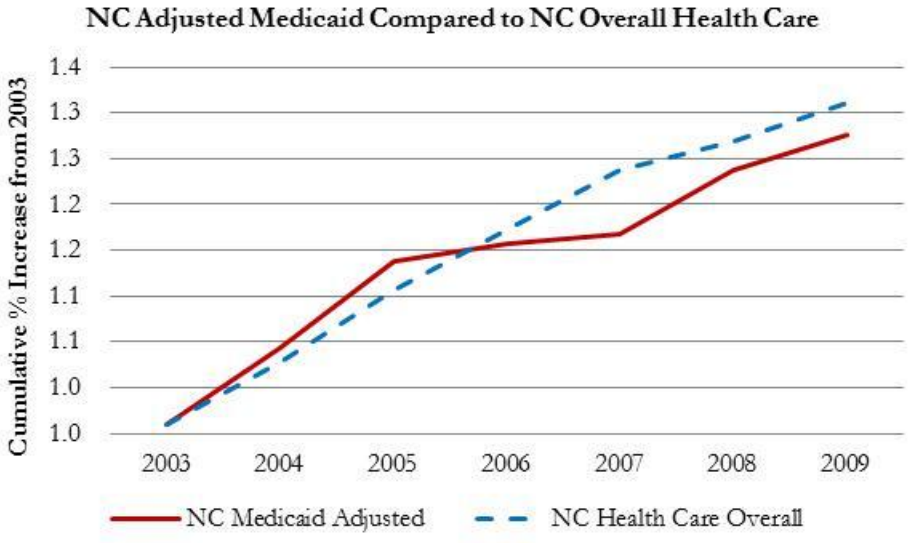
Medicaid – The Impact of Legislative Actions



This chart adjusts the constant mix PMPM's to remove the estimated impact on spending of changes and reductions approved by the General Assembly in each year presented

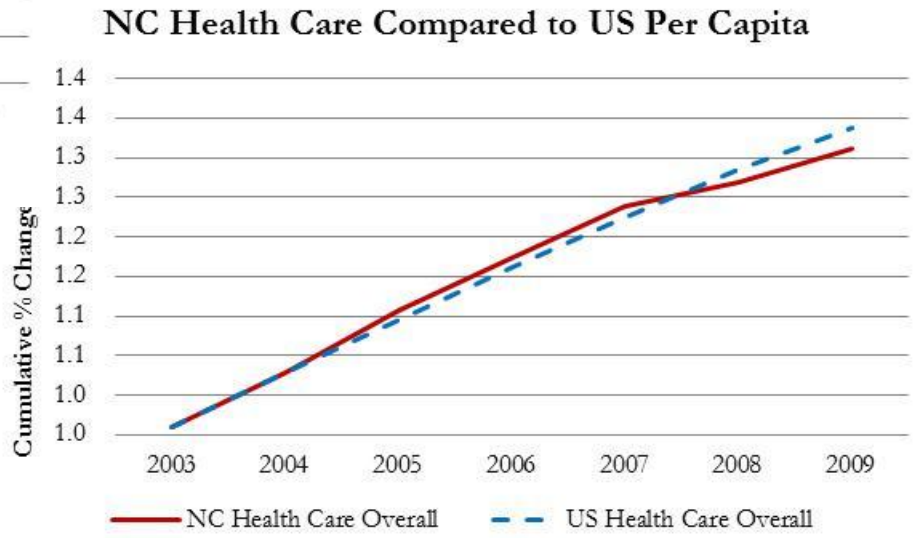
Source: North Carolina Accounting System BD 701, DMA Data, FRD Calculations and Estimates

Spending Comparisons



With the exception of 2006 – 2007, NC Medicaid trended similar to total health care consumption in the State

NC health care spending trends almost identical to US spending on health care between 2003 and 2009



Source: NC Accounting System BD 701, http://esesc23.esc.state.nc.us/d4/LausSelection.aspx, FRD calculations

Basic Medicaid Spending Conclusions

- Medicaid enrollment is driven by NC population growth, changes in the State's economy and an inherent growth in enrollment; ***which in turn drives spending***,

- If not for the variations in enrollment mix the impact of General Assembly approved reductions; NC Medicaid base spending would have grown consistent with national trends – ***therefore using national projections for growth of NC spending is reasonable as one component of setting a range for future expectations***,

- Utilizing the national projections for health care spending growth; by maintaining status quo in terms of eligibility, benefits, rates and programs, Medicaid appropriations will likely grow at a faster rate than overall revenue - ***Medicaid will consume a larger proportion of available funding***.

Some Considerations

*Medicaid is an **entitlement** program……if you have a Medicaid Program you have to pay for it..... **Getting it Right.***

- *Whether the decision is to leave the current program intact, to contain or to reform the program…you still need to apply a methodology that uses the appropriate growth rate in order to have a structurally sound budget.*

- *From SFY 2003-2013, 52% of budgeted savings are estimated to have been achieved.*

- *KEY CONSIDERATION : What kind of program does NC want - what outcomes need to be achieved/? **Should answer before moving forward to address HOW to pay for the program and growth (Additional Funds, Cost Containment, Policy Changes, Rate or Payment Changes, Reform or a Combination).***

QUESTIONS

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