

# UPDATE ON MEDICAID

*March 2, 2011*

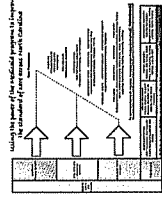
## *Joint Appropriations Subcommittee Health and Human Services*

*Craigian Gray, MD, MBA, JD*

*Director*

*Steve Owen*

*Chief Business Operating Officer*

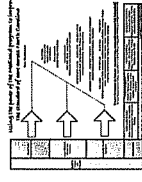


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*Using the power of the Medicaid program to improve the standard of health care across North Carolina*

# ***DISCUSSION GUIDE***

- Medicaid – Fact and Fiction
- Medicaid - Opportunities
- Medicaid – What Drives the Budget
- Medicaid – Controlling the Budget



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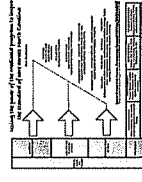
# Medicaid Fact and Fiction

- What is Medicaid?

- Health insurance for low income families, elderly and people with disabilities

*Differs over time, the issue and who is involved*

- Jobs creation for North Carolina
- Economic protectionism for North Carolina providers
- An entitlement

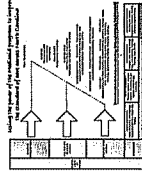


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# Fact and Fiction

- Who's eligible
- Who's covered
  - Low income families, elderly and people with disabilities
  - 1,450,000 enrollees at 1/31/11 in 15 program aid categories – increases by at least 525,000 in 2014
- What's covered
  - Mandatory and optional services
- What does it cost
  - \$10 billion in total requirements for claims in SFY 2011
- Who pays for Medicaid
  - Beginning in July 2011, 2/3 paid by federal dollars 1/3 paid by NC



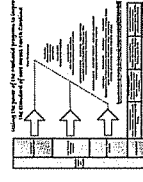
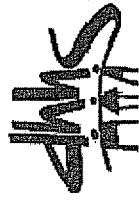
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# Who is eligible for Medicaid?

- Aged, Blind & Disabled
- Pregnant Women
- Infants and Children

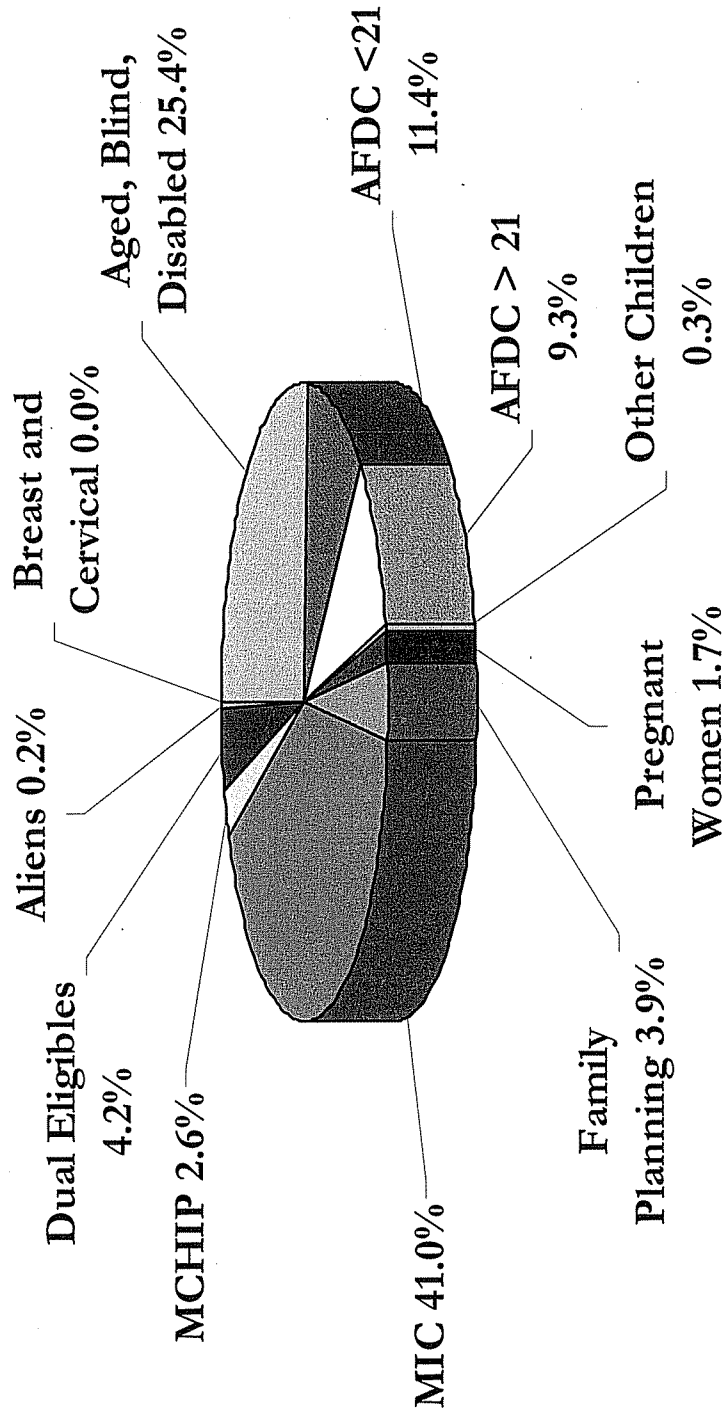
*Low income families, elderly and people with disabilities fall into 15 different program aid categories based on income and assets*

- 100% of FPL, automatically eligible if receive SSI
- 185% of FPL for services related to the pregnancy
- Age 0 to 5: 200% of FPL
- Ages 6 to 18: 100% of FPL
- Age 19 to 21: 45% of FPL

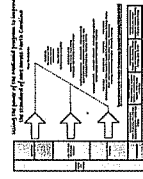


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# Who is enrolled in Medicaid?



1.5M by the end of SFY 2011



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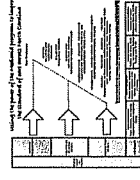
# What is Covered?

## Mandatory Services

- Ambulance
- Children's Dental
- Durable Medical Equipment
- Family Planning
- Early Periodic Diagnosis Screening and Treatment (EPDST)
- Children's Hearing Aids
- Clinics
- Home Health
- Hospital Services
- Midwife and Nurse Practitioner
- Nursing Facility
- Other Lab and Xray
- Physician
- Psychiatric Residential Treatment Facilities (PRTFS)
- Routine Eye Examinations and Visual Aids for Children

## Optional Services

- Case Management
- Chiropractor
- Podiatry
- CAP Programs
- Adult Dental and Dentures
- HMO Membership
- Home Infusion Therapy
- Hospice
- ICF-MR
- Mental Health
- Personal Care
- Orthotics and Prosthetics
- Prescription Drugs
- PT, OT and Speech Therapy
- Private Duty Nursing
- Respiratory Therapy
- Transportation

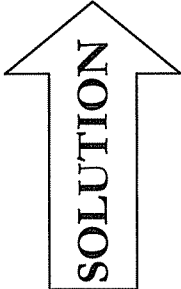


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# Opportunity to Focus

## Clinical outcomes driving Financial expenditures

*Understand the issue, define the outcome and THEN set the economics*

- North Carolina is 44<sup>th</sup> in the US in infant mortality  Pregnancy home

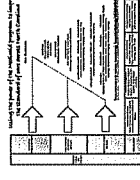
**Outcome** – a) reduce c-section rate      b) raise infant birth weight      c) engage providers  
d) reduce NICU utilization      e) reduce infant mortality      f) outcomes driven

**Economics** – a) equalize the normal delivery and c-section rates for physicians,

b) implement payment for assessment of mothers and bonus payment for delivery and 2 months post natal services

c) integrate Local Health Department care/case management paid for based on population

**Expenditure Results** – lower hospital delivery and nursery costs, lower specialty physician costs and lower costs in the first year of life for the infant – **healthier babies**

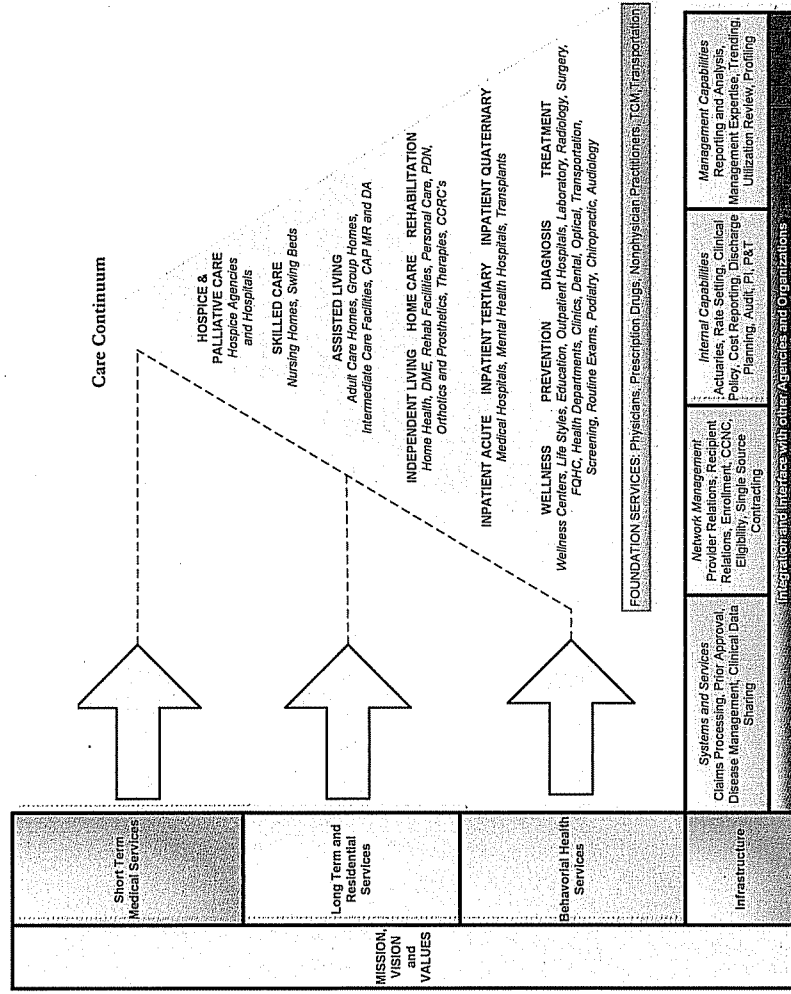


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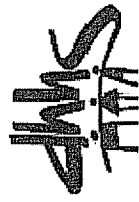
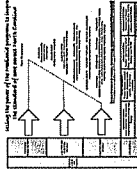
# Opportunity Leads to Vision

*Using the power of the Medicaid program to improve the standard of health care across North Carolina*



# What Drives Medicaid's Budget?

- Environmental Factors
  - Changes in number of enrollees in response to economy/other factors
  - Changes mix of enrollees
  - Consumption
  - Rates and payment policies
- DMA Controllable Factors
  - Clinical Policy
  - Services and ~~Eligibility~~
  - CMS approval required for changes
- Federal Involvement
  - Prior authorization
  - Independent assessment
- Mitigation Strategies
  - Prepayment review
  - High cost/expensive case review



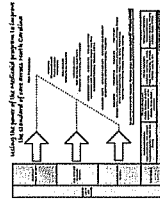
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# Environmental Factors



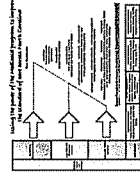
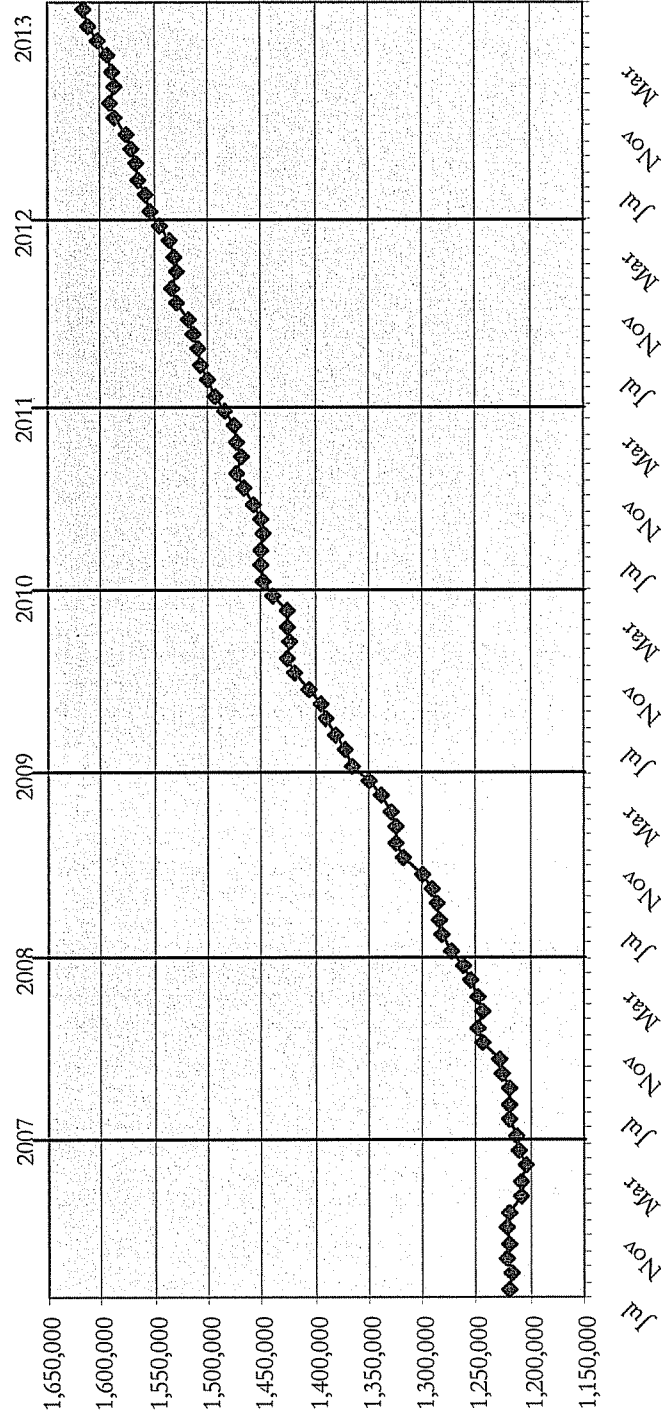
- Enrollment
  - Recipients enrolled in 15 program aid categories - influenced by such factors as unemployment, income, birth rates
- Mix of enrollees
  - The significance of this factor is that the average expenditures per month ranges from MIC at \$206 per month to Breast and Cervical at \$4,046 per month
- Consumption
  - This measures changes in how enrollees utilize each category of service (COS). The proportion of people enrolled that access a COS, the number of different COS's enrollees access and the expenditures per recipient all contribute to changes in costs attributable to consumption

*All factors must be understood because they are tied together and don't stand*

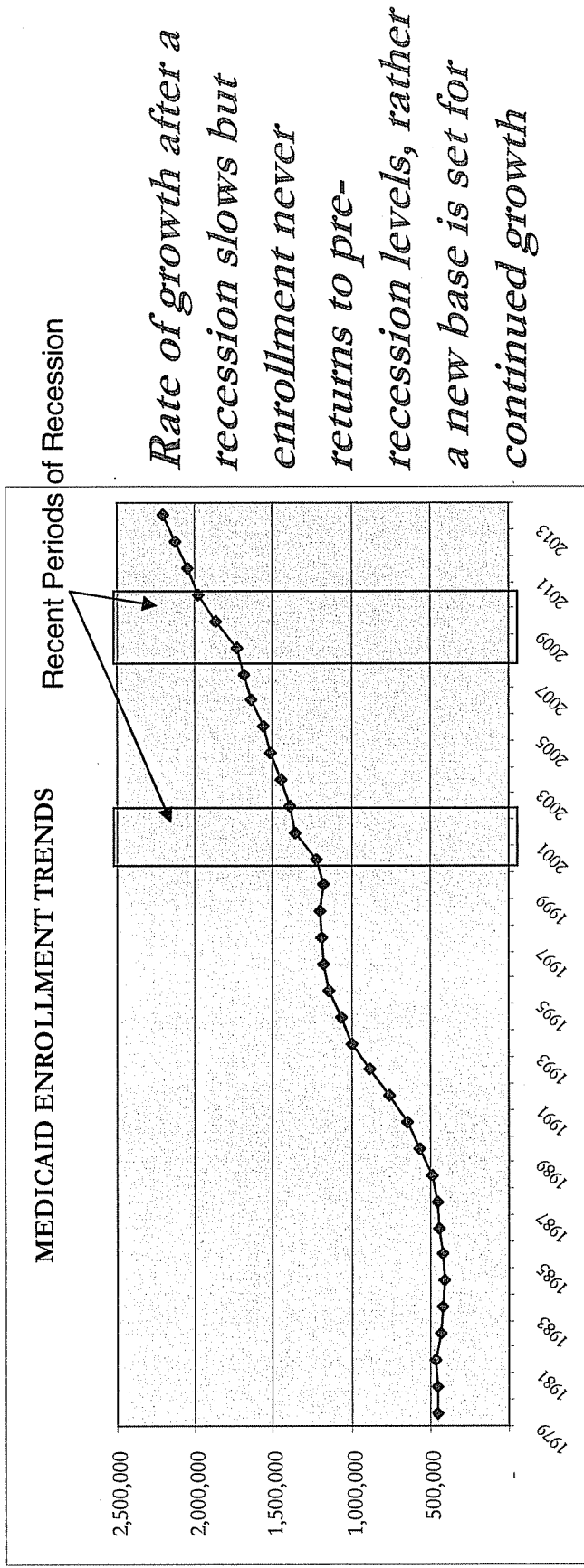


# **Medicaid Enrollment**

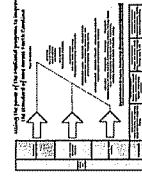
Trends in the number of people enrolled in Medicaid at a point in time



# Medicaid Enrollment



Trends in the number of different people enrolled in Medicaid each year



# Enrollment Mix

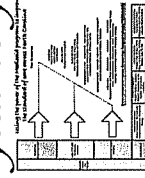
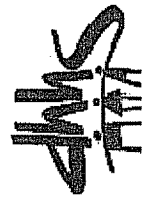
## SFY 2011 Trends

AGED  
 BLIND  
 DISABLED  
 AFDC <21  
 AFDC >21  
 OTHER CHILDREN  
 MPW  
 FAMILY PLANNING  
 MIC  
 MCHIP  
 MQBQ  
 MQBB  
 ILLEGAL ALIENS  
 LEGAL ALIENS  
 BREAST AND CERVICAL CANCER

PMPM	Percentage Enrollment
\$ 1,339.02	8.2%
\$ 1,396.98	0.1%
\$ 1,370.33	17.4%
\$ 295.08	11.5%
\$ 554.82	9.5%
\$ 1,542.51	0.3%
\$ 847.15	1.7%
\$ 14.94	4.0%
\$ 206.29	41.6%
\$ 139.29	2.6%
\$ 173.42	0.2%
\$ 123.19	2.7%
\$ 2,706.24	0.1%
\$ 740.93	0.1%
\$ 4,045.77	0.0%

*PMPM is the amount per month that Medicaid spends on the average recipient enrolled in each program aid category*

*Depending on which enrollment category the growth or decline is occurring will have a disproportionate impact on changes in expenditures from year to year*



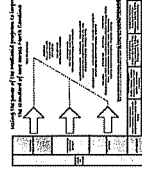
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# Consumption

- Consumption measures the impact of changes in the rate of usage of Medicaid services by recipients. Consumption is measured in 3 ways:

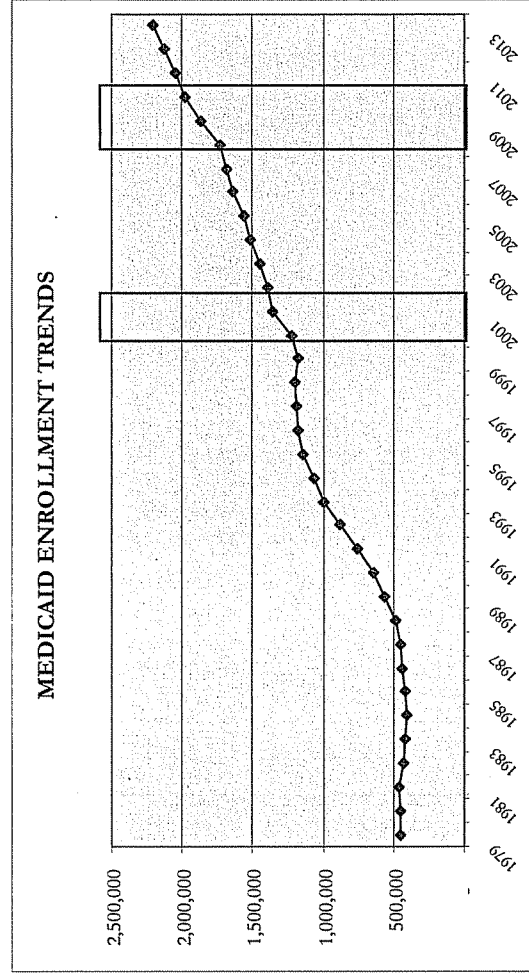
- Recipients/1,000 enrollees – reflects changes in the percentage of enrollees accessing each covered service*
- Service/Recipient – reflects changes in the number different types of services a recipient accesses on average*
- Cost/Recipient/Category of Service – reflects changes in the average cost of the services accessed*



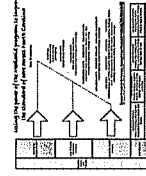
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# Consumption

- Typically when there are periods with high growth of new enrollees, most will consume more services on average in the first 6 to 12 months of eligibility than longer term enrollees.



*Recent year  
trends escalated  
consumption  
costs in 2010  
and 1011*





# Consumption

	SFY 2010	SFY 2011 **	Change
Dental Expenditures	\$ 355,610,931	\$ 366,314,481	\$ 10,703,550
Enrollment	1,400,231	1,449,355	49,124
Recipients/1,000 Enrollees	83.2	83.8	0.6
Cost per Recipient per Year	\$ 3,053.53	\$ 3,015.42	\$ (38.11)

## Dental Analysis

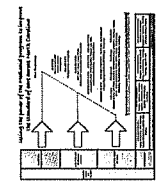
Expected Recipients	120,545	Recipients represent the number of enrollees that access a particular service
Actual Recipients	121,480	
Increase in Enrollment from change in consumption	936	

Cost per recipient in SFY 2010	\$ 3,053.53
Impact of Rate Reduction October 2009	(3.94)
Impact of Program Changes	(1.98)
Expected Cost per recipient in SFY 2011	<u>\$ 3,047.61</u>

Expenditures in 2010	\$ 355,610,931
Increase in enrollment	12,475,821
Impact of Reduction Initiatives	(713,441)
Consumption	
Increase in recipients/1,000 enrollees	2,851,694
Decrease in Cost per recipient	<u>(3,910,524)</u>

Expenditures in 2011	<u>\$ 366,314,481</u>
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\*\* SFY 2011 reflects forecasted expenditures



# Consumption

	SFY 2010	SFY 2011 **	Change
Physician Expenditures	\$ 1,084,710,316	\$ 1,054,066,763	\$ (30,643,554)
Enrollment	1,400,231	1,449,355	49,124
Recipients/1,000 Enrollees	873.4	885.0	11.6
Cost per Recipient	\$ 886.91	\$ 821.74	\$ (65.18)

## Physician Analysis

Expected Recipients	1,265,925
Actual Recipients	1,282,733

Increase in Enrollment from change in consumption

16,808

Cost per recipient in SFY 2010  
 Impact of Rate Reduction October 2009  
 Impact of Program Changes  
 Expected Cost per recipient in SFY 2011

\$ 886.91
(66.70)
(16.67)
<u>\$ 803.54</u>

Expenditures in 2010  
 Increase in enrollment  
 Impact of Reduction Initiatives  
 Consumption  
 Increase in recipients/1,000 enrollees  
 Increase in Cost per recipient

\$ 1,084,710,316
12,475,821
(79,965,517)

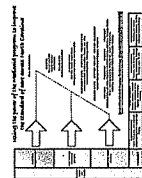
\*\* SFY 2011 reflects  
 forecasted expenditures

Expenditures in 2011

<u>\$ 1,054,066,763</u>
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Increase in recipients/1,000 enrollees  
 Increase in Cost per recipient

13,505,899
23,340,244

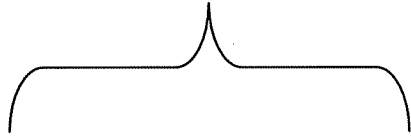


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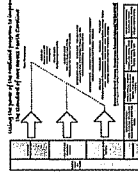
# *Environmental Factors*

- Enrollment
- Mix
- Consumption
- Cost Based Payments



Directly effect  
Medicaid  
Expenditures

DMA HAS NO DIRECT CONTROLS FOR  
MEDICAID ON TRENDS IN THESE FACTORS



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# *DMA Controllable Factors*

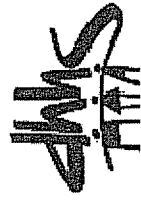
- Rates
- DMA sets nearly all rates independent of external requirements based on costs, per diems, fee schedules, case rates, etc – exceptions include services such as Hospice which must be at or above Medicare rates

## *IMPACT ACCESS*

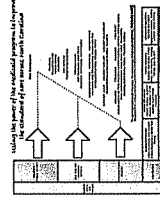
- Clinical Policy
- DMA establishes policies that define what is covered, level of coverage, limits on coverage, review requirements – with input from Physician Advisory Group and communication with provider groups – often controlled by EPDST
- Payment Policies
- Basis for how providers are paid for services – such as cost based versus prospective

## *IMPACT QUALITY*

## *IMPACT EQUITY*



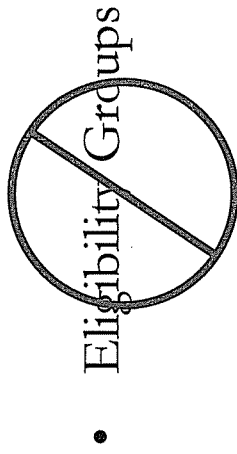
**All will influence healthcare practice**



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# DMA Controllable Factors



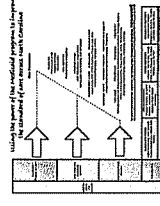
- Eligibility Groups

- ARRA and Health Care Reform established that a state can not adopt eligibility standards any more or less restrictive than those in existence in

June 2008

- Services

- Mandatory services can not be eliminated and the elimination of an optional service can only truly be done for adults because of EPSDT. Even then eliminating the service doesn't always eliminate the cost



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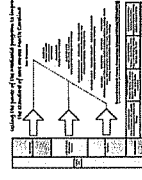
# Federal Involvement

- Timing of changes to the State Plan – CMS approval
- Maintenance of Effort requirements for enrollment standards
- Federal changes such as FDA adoption of new
- Changes must be submitted by the end of the quarter change is effective, CMS\*\* has 90 days to approve, deny or request addition information – the clock starts over – *typical approval 6 to 9 months*
- ARRA and health care reform require that standards for enrollment be no more restrictive than on June 1, 2008
- If a drug is approved by Food and Drug Administration, Medicaid is required to cover it

drugs



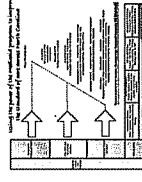
**\*\*CMS – Centers for Medicare and Medicaid Services.**



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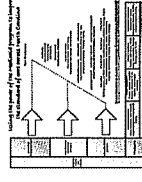
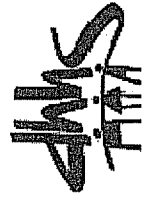
# Mitigation Strategies

DMA has utilized a series of processes to ensure that claims from providers are for appropriate services prior to adjudication or processing for payment



# Mitigation Strategies

- Prior Authorization
  - DMA has processed that require providers to obtain authorization before providing certain services. This service is outsourced to Value Options and ACS, Inc.
- Independent Assessments
  - DMA has a process that requires Medicaid recipients be assessed prior to receiving PCS, Inc services. This service has been outsourced to CCME, Inc
- Prepayment Review
  - DMA has implemented a process for providers where compliance issues are identified that requires all claims to be reviewed prior to adjudication.
- High Cost Review
  - DMA has a dollar threshold for automatic review by prior to adjudication. This service is performed by DMA staff.



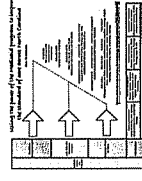
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# ***Levers Used to Control Medicaid Expenditures in SFY 2010 and 2011***

- Rate reductions
- Capitating management of services
- Payment incentives to alter patterns
- Reducing access to services
- Managing patient care
- Restriction on services
- Consolidation of services



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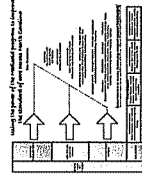
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# Impact of Control Levers on Medicaid Costs

	2009	2010	2011
Beginning Overall Average PMPM	\$ 626.25	\$ 619.25	\$ 594.64
Enrollee Mix Changes	(18.91)	(8.98)	(6.49)
Consumption	4.09	5.54	5.81
Inflation	5.90	9.70	6.63
New Service and Policy	1.91	1.83	1.78
Rate Reductions	-	(15.60)	(5.20)
Service and Program Changes	-	(17.11)	(43.25)

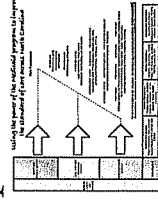
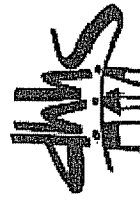
Ending Overall Average PMPM \$ 626.25 \$ 619.25 \$ 594.64 \$ 553.92

*PMPM is the amount per month that Medicaid spends on the average recipient enrolled in each program aid category*



# Trends in Utilization and Cost

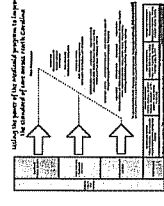
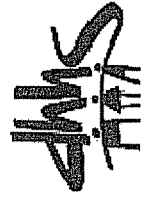
- Inpatient Services
  - Per Member Per Month's (PMPM) decreasing due to rate reductions
  - Days/1,000 enrollee's increasing
  - Decreasing non-maternity admissions in 2010 lowering overall PMPM
- Outpatient Services
  - PMPM's increased due to cost based payments in 2009, decreased by 8.9% in 2011
  - Number of surgical recipients increasing but cost per recipient declining at a faster rate – overall PMPM down 4.2% in 2011
  - Emergency visit rate declining per recipient but cost per visit increasing



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# Trends in Utilization and Cost

- Mental Health Services
  - Increased inpatient cost with higher proportion of non-state owned days – consistent with funding development of community hospital beds
  - I/P days per recipient stable
  - Outpatient expenditures decreasing because of cost and utilization
  - 5.3% increase in 2009 from utilization - 9% decrease in 2010 due to rate reduction
  - Decreases in cost/visit – rate reductions and capitated services
- Laboratory
- Radiology

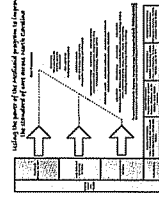


# Trends in Utilization and Cost

- Prescription Drugs
- Increased use rates offset by decreasing cost with generic prescribing increasing from 66% to 74%

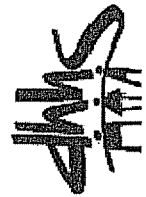
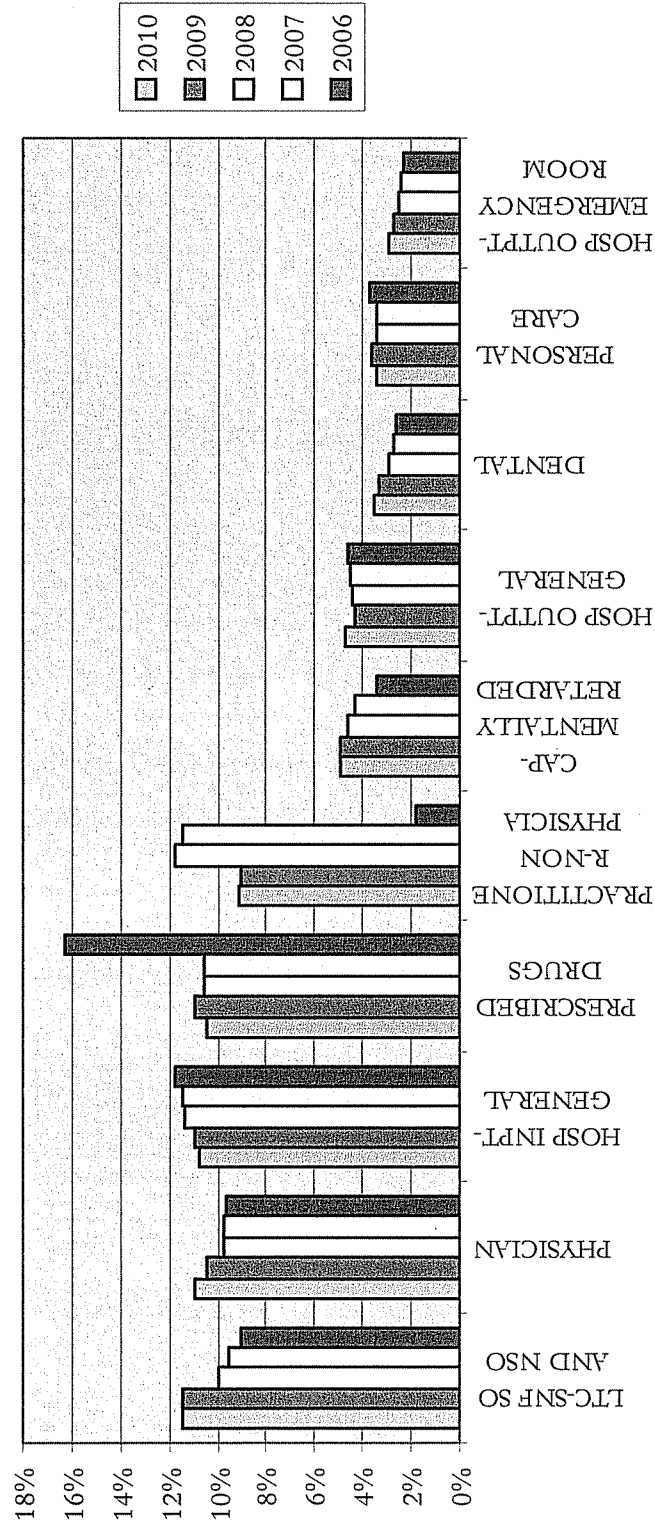
## Trends in Cost per Visit/Admission

	2009	2010	2011
Non-Maternity Inpatient	\$ 7,520	\$ 7,235	\$ 6,750
Maternity Inpatient	\$ 2,328	\$ 2,414	\$ 2,341
Emergency Services	\$ 177	\$ 189	\$ 202
Outpatient Surgery	\$ 288	\$ 282	\$ 204
Outpatient Diagnostic	\$ 64	\$ 66	\$ 60
I/P Mental Health	\$ 6,268	\$ 6,644	\$ 6,853
O/P Mental Health	\$ 1,106	\$ 1,073	\$ 922
Laboratory	\$ 67	\$ 68	\$ 66
Radiology	\$ 225	\$ 227	\$ 209



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# Trends in Top 10 Expenditures

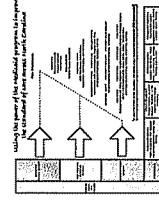


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# Trends in Top 10 Expenditures

	Total Expenditures				
	2010	2009	2008	2007	2006
LTC-SNF SO AND NSO	\$ 1,146,354,124	\$ 1,105,802,820	\$ 921,777,335	\$ 830,894,702	\$ 760,251,107
PHYSICIAN	\$ 1,084,710,316	\$ 1,008,973,800	\$ 900,285,567	\$ 851,156,965	\$ 815,020,088
HOSP INPT-GENERAL	\$ 1,072,494,510	\$ 1,051,569,076	\$ 1,049,063,081	\$ 995,995,649	\$ 995,163,797
PRESCRIBED DRUGS	\$ 1,045,385,821	\$ 1,049,983,658	\$ 973,100,802	\$ 921,809,223	\$ 1,373,014,510
PRACTITIONER-NON PHYSICIAN	\$ 915,421,592	\$ 872,228,571	\$ 1,083,054,818	\$ 999,990,264	\$ 154,662,289
CAP-MENTALLY RETARDED	\$ 488,520,746	\$ 470,544,418	\$ 427,977,911	\$ 376,113,959	\$ 288,169,935
HOSP OUTPT-GENERAL	\$ 468,405,405	\$ 417,982,192	\$ 405,879,823	\$ 393,127,921	\$ 387,743,789
DENTAL	\$ 355,610,931	\$ 320,971,201	\$ 269,608,979	\$ 240,176,470	\$ 217,935,223
PERSONAL CARE	\$ 342,538,687	\$ 345,006,361	\$ 318,712,072	\$ 299,724,191	\$ 313,181,303
HOSP OUTPT-EMERGENCY ROOM	\$ 293,066,310	\$ 257,126,586	\$ 231,890,190	\$ 214,469,395	\$ 198,358,544

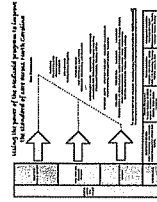


DIVISION OF MEDICAL ASSISTANCE



# Utilization of Top 10 Services

	<i>Recipients per 1,000 Enrolled</i>			
	2010	2009	2008	2007
LTC-SNF SO AND NSO	18.2	19.1	19.0	18.3
PHYSICIAN	873.4	845.3	848.9	822.1
HOSP INPT-GENERAL	20.1	19.1	17.3	23.1
PRESCRIBED DRUGS	306.3	310.3	312.2	311.1
PRACTITIONER-NON PHYSICIAN	63.1	63.2	65.2	54.1
CAP-MENTALLY RETARDED	6.8	7.3	7.2	6.7
HOSP OUTPT-GENERAL	70.3	70.6	72.9	75.8
DENTAL	83.2	78.2	79.3	74.6
PERSONAL CARE	25.9	29.2	27.4	27.6
HOSP OUTPT-EMERGENCY ROOM	55.6	54.3	52.0	51.0
				50.7

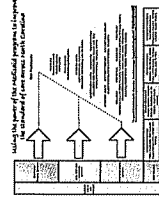


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# Trends in Recipient Costs

	Cost per Recipient				
	2010	2009	2008	2007	2006
LTC-SNF SO AND NSO	\$ 44,503	\$ 43,754	\$ 39,017	\$ 37,350	\$ 37,872
PHYSICIAN	\$ 887	\$ 903	\$ 853	\$ 854	\$ 836
HOSP INPT-GENERAL	\$ 37,664	\$ 41,731	\$ 48,620	\$ 35,560	\$ 29,921
PRESCRIBED DRUGS	\$ 2,408	\$ 2,560	\$ 2,505	\$ 2,442	\$ 3,132
PRACTITIONER-NON PHYSICIAN	\$ 10,233	\$ 10,437	\$ 13,362	\$ 15,244	\$ 4,631
CAP-MENTALLY RETARDED	\$ 50,373	\$ 49,030	\$ 47,500	\$ 45,991	\$ 46,092
HOSP OUTPT-GENERAL	\$ 4,700	\$ 4,478	\$ 4,475	\$ 4,278	\$ 4,037
DENTAL	\$ 3,054	\$ 3,105	\$ 2,732	\$ 2,656	\$ 2,711
PERSONAL CARE	\$ 9,318	\$ 8,945	\$ 9,338	\$ 8,951	\$ 9,033
HOSP OUTPT-EMERGENCY ROOM	\$ 3,716	\$ 3,580	\$ 3,588	\$ 3,466	\$ 3,346

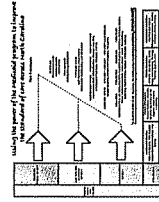
Medicare Part D  
Implemented



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# Inpatient Hospitalization

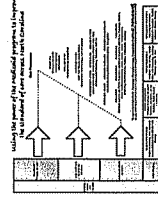
	2010	2008	2010 Cost Per	2008 Cost Per
	Recipients	Recipients	Recipient	Recipient
Delivery	41%	41%	\$ 5,219	\$ 5,791
Orthopedic	2%	2%	\$ 7,711	\$ 8,094
Cardiac	4%	4%	\$ 11,031	\$ 11,792
Respiratory	6%	5%	\$ 4,676	\$ 5,627
Substance Abuse	2%	2%	\$ 2,803	\$ 2,996
Mental Health	5%	6%	\$ 6,644	\$ 6,253
Cancer	2%	2%	\$ 8,682	\$ 8,945
Neurology	4%	4%	\$ 6,318	\$ 7,023
Diabetes	1%	1%	\$ 3,147	\$ 3,335
Renal	2%	2%	\$ 4,292	\$ 4,656
Urology	1%	1%	\$ 3,280	\$ 3,467
Other Surgery	7%	8%	\$ 9,774	\$ 10,796
Other Medical	23%	21%	\$ 5,401	\$ 5,686



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# Hospital Outpatient Costs

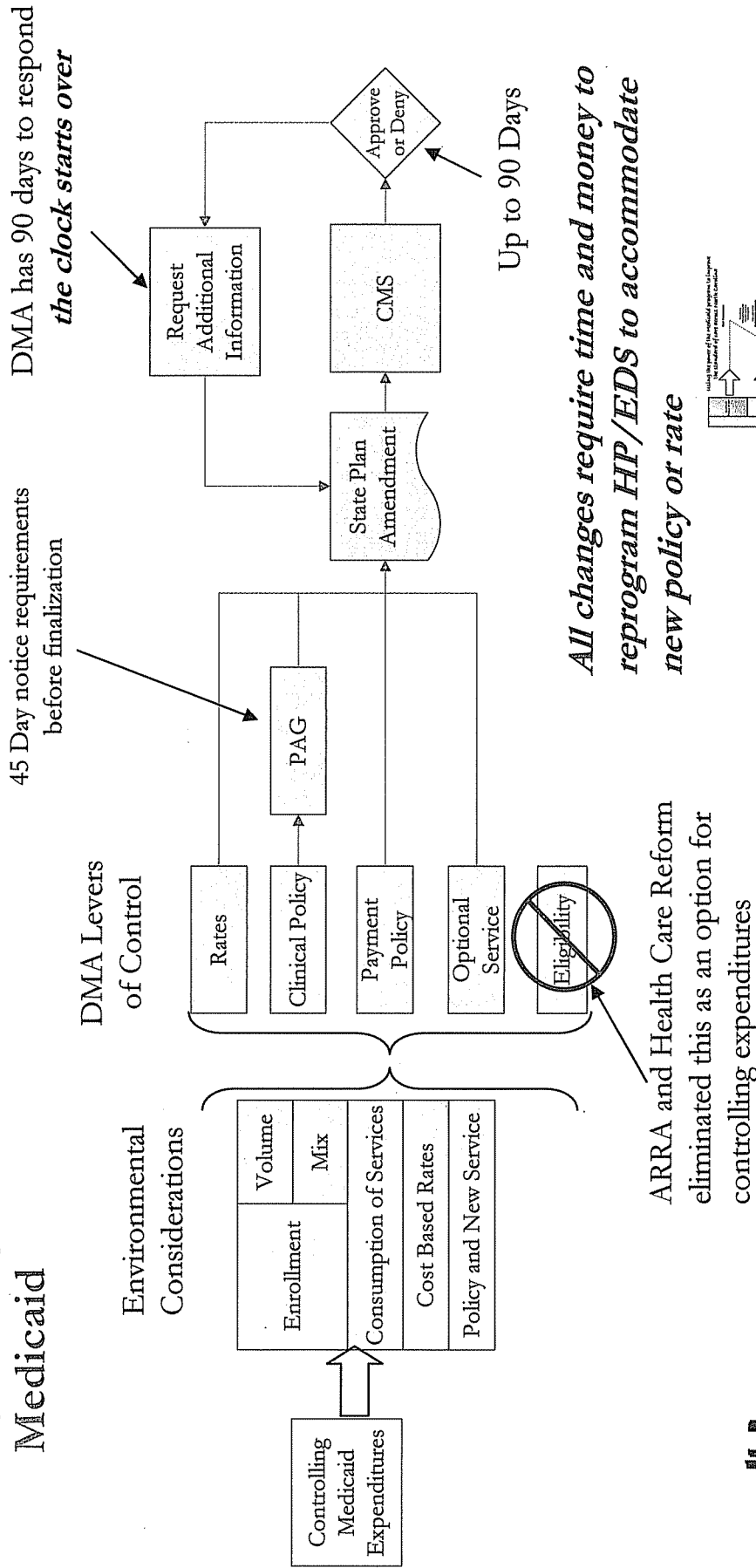
	2010	2008	2010 Cost Per	2008 Cost Per
	Recipients	Recipients	Recipient	Recipient
Surgery	3%	3%	\$ 589	\$ 640
Imaging	11%	11%	\$ 292	\$ 290
Cardiology	2%	2%	\$ 289	\$ 304
OT/ST and PT	2%	2%	\$ 168	\$ 180
Respiratory	1%	1%	\$ 65	\$ 54
Observation	1%	1%	\$ 159	\$ 157
Emergency	3%	4%	\$ 189	\$ 172
Other Surgery	6%	7%	\$ 218	\$ 227
Gastro	0%	1%	\$ 362	\$ 369
Clinic and Treatment Room	5%	5%	\$ 85	\$ 87
Drugs	3%	1%	\$ 202	\$ 147
Lab	61%	62%	\$ 45	\$ 58



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# Medicaid Summary

Making a change in  
Medicaid



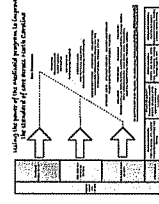
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Using the power of the Medicaid program to improve the standard of health care across North Carolina

# Medicaid Summary

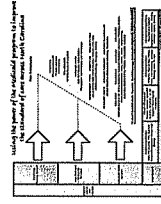
	Total Requirements			State Only	
	SFY 2009	SFY 2010	SFY 2011	SFY 2012	SFY 2012
Base Medicaid Claims	\$ 9,935,866,409	\$ 9,935,866,409	\$ 10,178,993,262	\$ 9,751,885,283	
Enrollment	683,676,469	348,840,374		377,735,492	132,207,422
Enrollment Mix	(177,788,867)	(89,853,742)		(1,372,990)	(480,547)
Consumption	93,087,580	101,048,077		63,042,980	22,065,043
Cost Based Payments	163,009,350	158,870,473		204,246,921	71,486,422
New Service/Policy	30,755,454	30,941,056		79,756,937	27,914,928
Rate Reductions	(262,162,839)	(90,453,414)			-
Reduction Initiatives	(287,450,294)	(886,500,803)		390,838,776	(117,631,935)
Part D Changes				78,037,210	78,037,210
Other Factors				17,412,939	6,094,529
Leap Year		-		56,852,530	19,898,386
Claims Costs - Total Requirements	\$ 9,935,866,409	\$ 10,178,993,262	\$ 9,751,885,283	\$ 11,018,436,078	\$ 239,591,458
Decrease in FMAP from ARRA, Assessments and other Receipt changes				\$	\$ 818,173,497
State Appropriations - Claims Cost	\$ 2,963,075,185	\$ 2,167,362,647	\$ 2,047,969,261	\$ 3,105,734,216	\$ 1,057,764,955



DIVISION OF MEDICAL ASSISTANCE

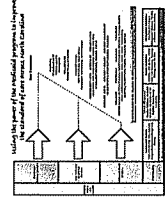
# Medicaid SFY 2012 and Beyond

- The Governor's budget proposes to implement assessments to *leverage federal dollars*, target rate reductions to *avoid access issues*, modify services to *ensure appropriateness* of services paid to *avoid eliminating services*, implement care management to *produce better health outcomes at lower costs*, *focus on recovering monies* that Medicaid should not pay, *maximize federal opportunities* for incentives to create health homes.
- The "Question Is" ..... *do we reshuffle, reshape, redistribute or restructure the state and federal dollars devoted to health care for nearly 20% of North Carolina's population, growing to nearly 30% in 2014 based on dollars or outcomes/providers or recipients and how those decisions get made..... What is Medicaid?*



DIVISION OF MEDICAL ASSISTANCE

# QUESTIONS



DIVISION OF MEDICAL ASSISTANCE

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*Using the power of the Medicaid program to improve the standard of health care across North Carolina*