

North Carolina Department of Health and Human Services

Pat McCrory
Governor

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September 15, 2014

The Honorable Fletcher L. Hartsell, Jr., Co-Chair
Joint Legislative Program Evaluation
Oversight Committee
Room 300-C, Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27603-5925

The Honorable Julia C. Howard, Co-Chair
Joint Legislative Program Evaluation
Oversight Committee
Room 302, Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27603-5925

Dear Senator Hartsell and Representative Howard:

As you know, I inherited a department with a well-documented history of serious and chronic problems. We have been on a path toward a sustainable department over the last 20 months and we have built the foundation for a stronger Medicaid program. I appreciate this opportunity to briefly summarize the steps that we have taken to improve the management, budget forecasting, reporting, and staffing.

Department and Division of Medical Assistance (DMA) Management

Improving our Medicaid program is our top priority. North Carolina's Medicaid program is intertwined with other divisions in the Department of Health and Human Services (Department) — Medicaid eligibility determinations are made by the county departments of social services, which are supervised by the Department's Division of Social Services; Medicaid's behavioral health benefits are administered by regional LME/MCOs, which are overseen by the Department's divisions of Mental Health and Medical Assistance; its financial functions are directed by the Department's Chief Financial Officer; its information technology needs are provided by the Department's Chief Information Officer; its population health initiatives rely heavily on the Department's Division of Public Health and its Office of Rural Health and Community Care; and in many, many other countless ways. Thus, enhancing its management and administration extends beyond the Division of Medical Assistance (DMA). It required a department-wide effort; and, my initial focus was on restructuring and recruiting a strong, focused leadership team to direct the operations of over 17,000 employees with a budget of more than \$18 billion.

Creating a Department-wide Leadership Team

I initially assessed the long-standing organizational structure of the Department and determined that it must be restructured and expanded in order to address its chronic problems and make it sustainable. My restructured leadership team, modeled after private sector companies, is designed to drive accountability, collaboration, and coordination across the Department. I appointed deputy secretaries for Human Services and Health Services reporting directly to me. I also appointed a Deputy Secretary for Behavioral Health and Developmental Disability Services to focus on our many mental health challenges. In addition, I appointed executive level individuals reporting to me with cross-functional responsibilities for Finance, Information Systems, Human Resources, and Compliance. The result has been a leadership team that is focused on effectively and efficiently providing services to the citizens of our State.

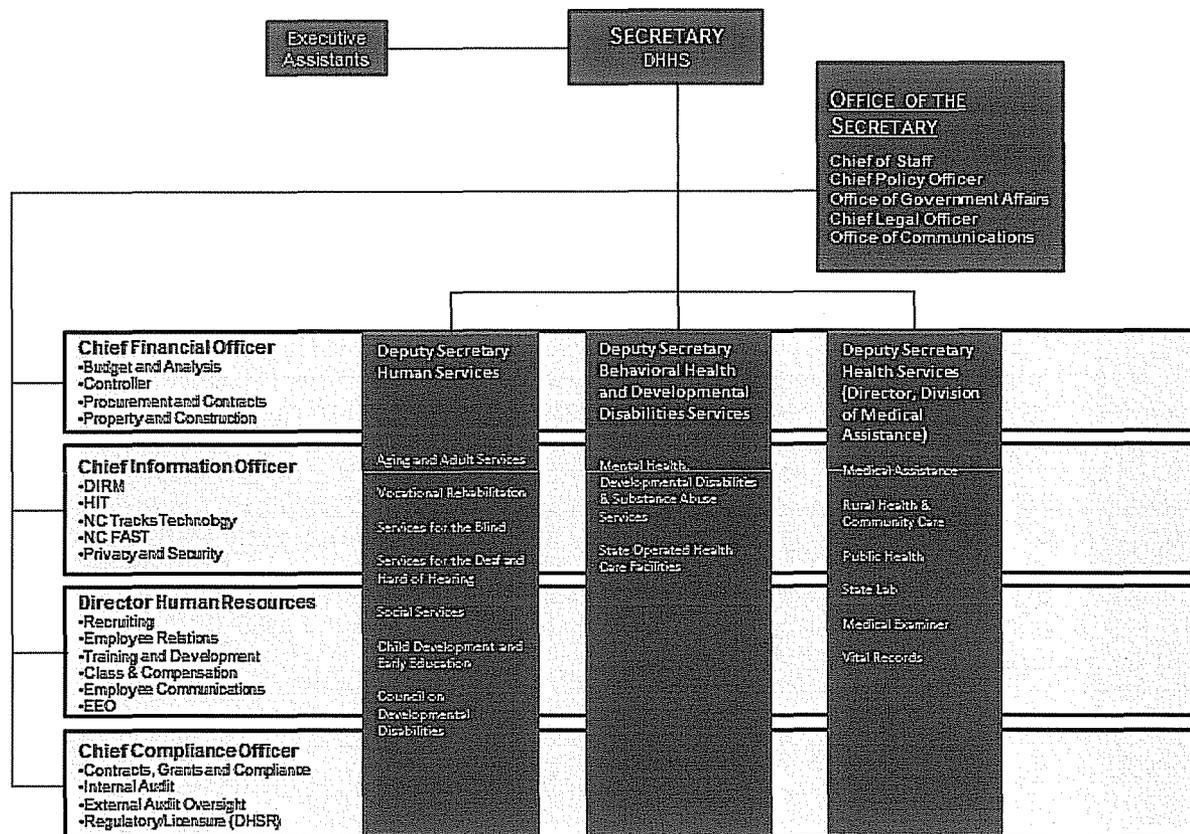
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For the past decade, the Department and DMA have faced significant information technology, budget, and staffing challenges; and yet, I found that the Department did not have a Chief Information Officer (CIO), Chief Financial Officer (CFO), or Compliance Officer, and the Director of Human Resources did not report to the Secretary. I recruited talented individuals to assume these cross-functional responsibilities.

I was fortunate to recruit Joe Cooper to serve as the Department's first ever Chief Information Officer (CIO). Joe has 35 years of experience as an information technology executive. Prior to joining the Department, he served as senior vice president for technology and operations with RBC in Raleigh, executive vice president and chief information officer at First Citizens Bank in Raleigh for 15 years, and in various technology management positions at Bank of America in Charlotte for 17 years.

I also recruited Rod Davis to be the Department's first Chief Financial Officer (CFO). Rod previously served as the CFO and Controller for the N.C. Department of Environment and Natural Resources (DENR). Prior to assuming these responsibilities at DENR in 1996, he served as chief of budget operations and information systems for DHHS after a progression of other financial oversight roles within the Department.

In recognition of the fact that the key to a sustainable organization is a strong workforce and that the Department had limited "bench strength" and focus on cultivating future leaders, I made the Director of Human Resources a direct report to me. I recruited Mark Gogal, an experienced human resources leader with 20 years of diverse HR management background. Previously, Mark was the vice president of human resources for Sigma Electric Manufacturing Corporation, an international precision metals and plastics

manufacturing company. Under Mark's leadership, human resources have been more centralized to create a more effective, strategic, and cohesive HR function across the Department.

I also recruited Mark Payne, who also serves as acting Chief Compliance Officer and my Chief of Staff. Mark is an accomplished corporate attorney and compliance officer with over 25 years of health insurance experience. Prior to joining the Department, he was the vice president and chief compliance and ethics officer for Blue Cross Blue Shield of North Carolina and worked as a senior counsel for Blue Cross, CIGNA Corporation, and Kaiser Foundation Health Plan of North Carolina. Mark also previously served the State as the Deputy Commissioner of the Managed Care and Health Benefits Division of the North Carolina Department of Insurance. Mark's health insurance background has been invaluable to strengthening our Medicaid program.

The Department's Office of Internal Audit also reports to Mark. When I arrived at the Department, its Office of Internal Audit was ineffective, unable to proactively root out waste and abuse, and over a year behind in responding to annual audits. I recruited a strong leader for our Office of Internal Audit and we are in the process of expanding the office, which was staffed by fewer than 10 employees when I arrived, by as many as 30 people to drive resolution, accountability, and efficiency.

DMA Leadership

In March, I appointed Dr. Robin Cummings to serve as our Medicaid Director. Unlike in previous years, the Medicaid Director is a direct report to me. Dr. Cummings has the right combination of strong leadership and extensive involvement in our State's health care system to significantly enhance our Medicaid program. As a native North Carolinian and a member of the Lumbee tribe, Dr. Cummings is personally vested in making the state one of the best places to live and work. A graduate of UNC Chapel Hill and the Duke University School of Medicine, he is a board-certified general and cardiothoracic surgeon. Dr. Cummings' prior Medicaid experience includes the perspectives of a health care provider and serving for 5 years as medical director and executive director for Community Care of the Sandhills, a Community Care of North Carolina (CCNC) network.

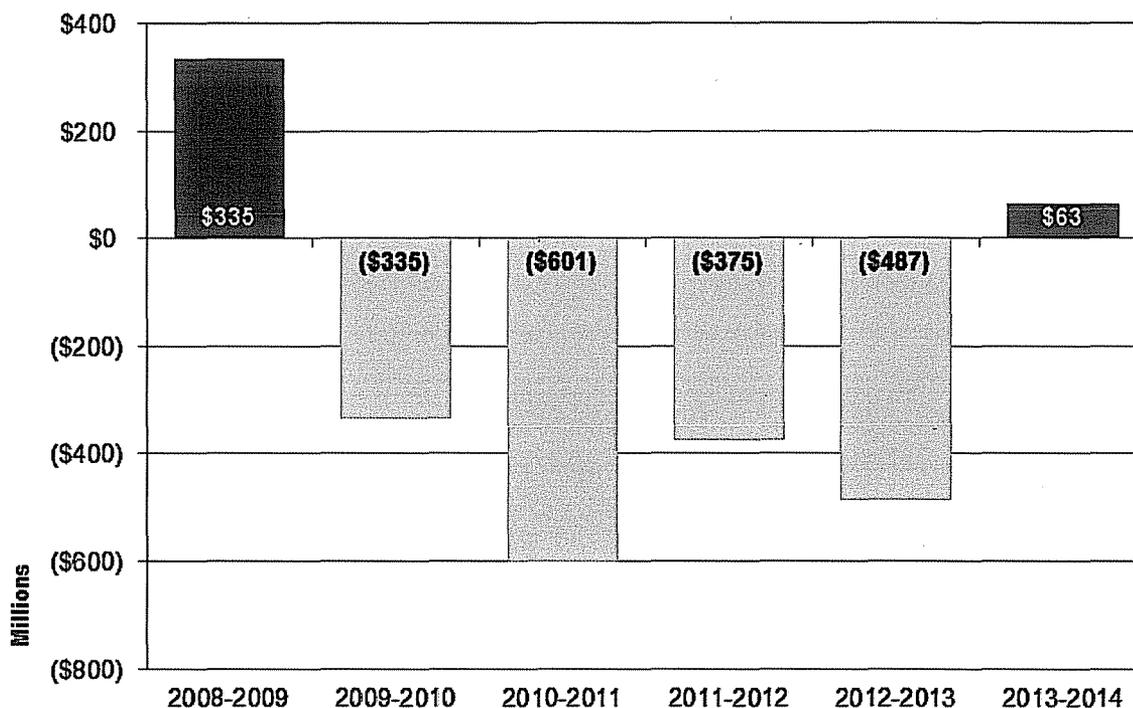
Dr. Cummings initially joined the Department in March of 2013 to lead the Office of Rural Health and Community Care. In August of 2013, he was appointed to serve as the Deputy Secretary of Health Services and assumed responsibility for the Division of Public Health. He is a proven leader with a track record of enhancing the effectiveness of Rural Health and Public Health organizations. Under his leadership, the foundation is being laid for DMA to enhance its effectiveness.

DMA Budget and Forecast

Medicaid budget finished the year in the best shape in 5 years

Thanks to the efforts of the Department, the Governor, the Office of State Budget and Management (OSBM), and the General Assembly, the Medicaid budget finished State Fiscal Year 2014 in the best shape in 5 years. This success was due in large part to better budgeting, collaboration, and, most important, paying attention. It is another clear sign that the path that we are on is the right one.

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



Improvements made to Medicaid budgeting

My first introduction to the challenges the Department faced in budgeting and forecasting was during the transition of administrations (December 2012). It was not long before we experienced flaws in DMA's budgeting and forecasting process first hand. An error in the previous administration's forecasting model resulted in an overestimate of federal receipts, an \$85 million "surprise" in May 2013. It was one of many surprises as the final shortfall for that fiscal year ended up being nearly \$500 million.

We made the following immediate improvements in Medicaid budgeting in collaboration with State Budget Director, Art Pope:

Corrected Medicaid revenue forecasting error to more precise federal receipt calculation. DMA implemented a new cash model to verify and track federal receipts throughout the fiscal year. Receipts now are forecasted and budgeted at the actual FMAP for category of service rather than using a blended historical estimate.

Instituted timely settlement to improve budget and cash flow predictability. Multi-year provider payments affect Medicaid cash flow and disrupt the DHHS/DMA/OSBM payment plan. Settlement timing was improved by completing a multi-year reconciliation of the Federally Qualified Health Centers and expedited distribution.

Separated grouped funds to improve Medicaid budget transparency and monitoring. Separate funds under the Medicaid budget were established July 2013 for Community Care of North Carolina, consolidated hospital payments, rebates and health information technology. This increased the visibility of individual expenditures, enhancing earlier identification of variances.

Implemented new reports to enhance expenditure tracking and earlier identification of potential issues. Reports were introduced to track expenditures in more detail, and compare them to monthly estimates and certified budget. This new analysis, updated weekly, allows for early identification of potential spending issues and adds time to take corrective action.

Accounting procedures were changed to eliminate liability carryover. DMA ended the practice of estimating drug rebates owed to CMS each month, then settling the following month. The new weekly reconciliation process eliminated carrying the federal share of drug rebates into the next state fiscal year.

Improvements made to Medicaid forecasting

I have taken aggressive action to understand and address the past faulty forecasting practices and estimated shortfalls in the State's Medicaid program. In addition to the realigning of the leadership team to better support the Medicaid program, the Department engaged a team of financial and industry experts from Ernst & Young to conduct an in-depth evaluation of the Medicaid forecasting process. Ernst and Young's Medicaid Forecasting – Observations and Findings Report (October 2013) had the following findings:

- *Separate the forecasting and budget processes.* This will ensure that forecasts are a technical process based on strong analytics, which will provide the best information to prioritize and balance funding for the budget.
- *Stronger governance and structure.* This will increase forecast integrity through rigorous testing and scrutiny of inputs and processes.
- *Standardized workflow.* This will improve control throughout the process, producing more stable forecasting.
- *Regimented version management control.* As different forecast scenarios are tested and analyzed, this will keep track of the changes being made and the reasons behind those changes.

In order to execute the necessary transformation in operations, budgeting and forecasting, I engaged Alvarez & Marsal, Public Sector Services (A&M) to facilitate the development of a forecasting model based on their experience working with Medicaid programs in South Carolina, Maryland, and Pennsylvania. The forecasting model is being completely overhauled based on a bottom up analysis of all programs. The new model will be much more robust and will support scenario testing at a micro level. Scenario analysis will allow us to conduct predicative analysis to build a more complete understanding of the Medicaid program. The new forecasting model that will be utilized by DMA for the upcoming fiscal year is currently being tested in preparation for submission at the end of October to OSBM. The following is an update on progress to date:

Process:

- Modular model set-up is underway and sensitivity analyses are being performed
- The processes and methodologies used in model are being documented
- 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 and drivers will be validated and compared with external parties. Findings will then be incorporated into the model.
- Recipients and 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 following chart details how the new model addresses the deficiencies identified in Ernst & Young report:

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

DMA Reporting

Information Technology: the groundwork for better management is better data

There was no greater challenge waiting for us when we arrived than information technology change management. In our first year, we executed rollouts of three major IT systems: our claim processing system (NCTracks), a new data warehouse (Truven/NCAnalytics), and the continued Statewide roll-out of a new eligibility system (NC FAST). It required a tremendous amount of work and I am proud of how our team rose to the challenge.

NCTracks and NCAnalytics

After a decade in development, hundreds of millions of dollars invested by taxpayers, numerous overruns and delays, we made the decision for NCTracks to go-live on July 1, 2013 as scheduled. NCTracks replaced a 35-year-old claims system. The decision to go-live was made after the Department completed testing of the system and based on favorable opinions about the July 1st implementation date provided by two outside experts and the approval of the Centers for Medicare and Medicaid Services (CMS).

CMS further advised that it would only provide funding for the operation of one system. Therefore, the operation of parallel systems was not feasible.

In addition, delaying the go-live date beyond July 1st would have resulted in either converting to a new system during a fiscal year or implementing it effective July 1st of 2014. Implementing during a fiscal year would have complicated the State's closing its books at year end due to the need to consolidate reporting from two very different claims systems. Implementing July 1, 2014 was not a feasible option because providers would have only 3 months to adapt to the new system prior to the mandatory adoption of ICD-10, which at the time was mandated for use by all payers and providers in the United States effective October 1, 2014. In addition, further delaying implementation would have resulted in additional significant costs for the State, i.e., approximately \$3 million per month.

As with any IT launch of its size (i.e., more than 10,000 function points), it was difficult. We have made tremendous progress and, while we will not regard it as a success until every provider is properly paid for the services they have rendered, we continue to see great improvement.

In its first year, NCTracks processed 200 million claims and paid \$10.3 billion to healthcare providers. The benefits of NCTracks include faster claim processing and 50 paydays for healthcare providers per year, compared with 42 under the former system. More than 98 percent of electronically filed, approved claims are paid within a week. NCTracks also automates many processes that were previously manual.



The First Year: July 1, 2013 - June 30, 2014

Claims Processing

**Claims Status Comparisons:
HIP Legacy vs. NCTracks
(Medicaid & Health Choice)**



HIP Legacy data from Jul13-Mar'13 | CSC NCTracks data from Jul13-Mar'14

**200 Million
claims processed.**

\$10.3 Billion paid.



Efficiency

Processing claims by consolidating several computer systems into 1 payment system.

Saves **\$3 Million** a month.

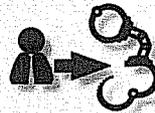


12%
(or almost 2.4 million) fewer claims required human intervention to process and pay.



Fraud & Abuse

All providers must enroll in NCTracks, including those that work in an attending capacity. This requirement helps prevent fraud.



Providers continue to enroll in NCTracks to meet this mandatory enrollment criteria. We currently have **97,377 active providers** in NCTracks.

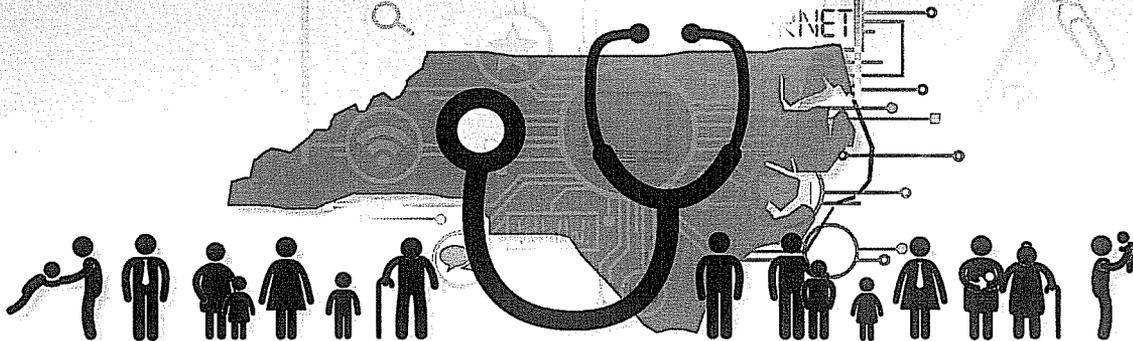
Since NCTracks went live **11,920 additional providers** have enrolled in Medicaid.

Customer Service

NCTracks pays providers more often and providers know the status of their claims almost immediately after submitting them.



Today, **85%** of callers helped on first conversation.



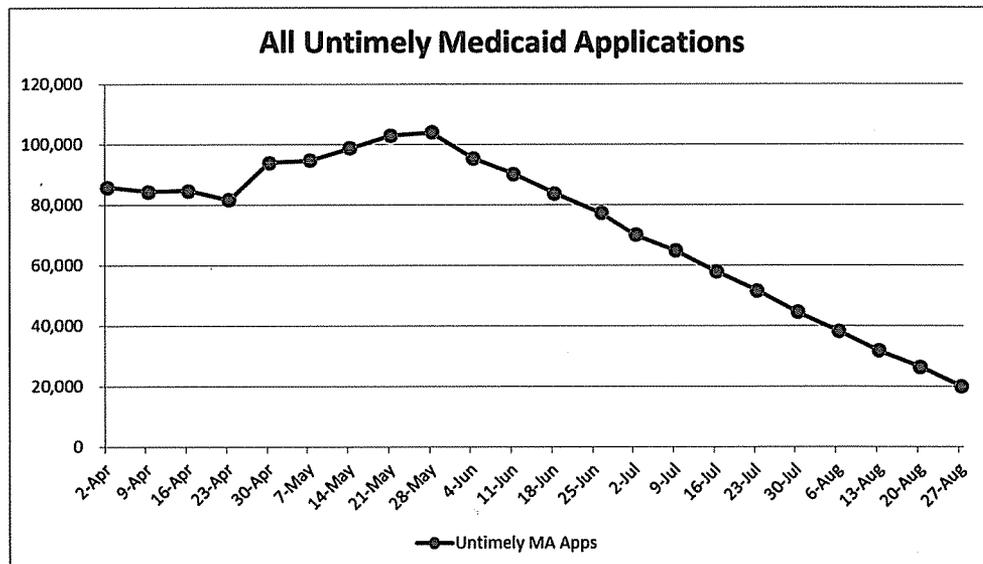
In addition to NCTracks, the Department had engaged Truven Health Analytics to develop a new data warehouse, NCAalytics, prior to my arrival. NCAalytics is the repository for Medicaid claims data. While there are some synergies between NCTracks and NCAalytics, implementing both in the same year was challenging.

We have significantly improved oversight and accountability of the Department's IT solutions under the direction of our CIO, Joe Cooper. Mr. Cooper established and implemented a governance model based on the industry standard System Design Life Cycle (SDLC) with the formation of the Executive Change Control Committee (ECC) in November of 2013. Its governance charter was approved by all of the business units, i.e. staff with subject matter expertise delegated by affected divisions. Under this model, DMA and representatives of other divisions for whom payments are made by NCTracks are responsible for driving and prioritizing the enhancements and future functionality of the system and justifying the funding of such work. DMA and the other divisions are also responsible for accepting the changes and enhancements to the system before it is placed into production. The CIO is not a voting member of the ECC but is responsible for executing on the business directives and must assure that the technology and contract management meets the needs of the business as well as the other stakeholders such as providers who render the services. This model is more efficient because it does not require full-integration of the claims processing system in to DMA which would require it to recruit and retain an internal IT organization capable of managing NCTracks and NCAalytics as such capabilities do not exist in DMA. To replicate the Department's CIO organization's management skills and expertise in DMA would result in significant inefficiencies and likely incur unnecessary costs to the State. NCTracks also serves not only the needs of DMA, but also Division of Mental Health, Division of Public Health, Division of Rural Health, and others. In addition, the federal Centers for Medicare and Medicaid Services (CMS), which paid approximately over 80% of the costs to implement NCTracks, has clearly indicated that the Department's CIO organization should manage the outsourcing contract. In fact, CMS has expressed concerns how the previous MMIS contract was managed by DMA based on their belief that DMA lacked the technology management skills and expertise to manage it.

NC FAST

The North Carolina Families Accessing Services through Technology (NC FAST) system is the culmination of a 40-year attempt by counties and the State to streamline the case management process. The NC FAST system supports case workers in all 100 counties in determining eligibility for a myriad of social services such as food nutritional services, child welfare, and Medicaid. Oversight of change management at the Department level requires coordinated collaboration between the Department's CIO office, Division of Social Services, and DMA.

Implementation of the NC FAST system was substantially impacted by the Affordable Care Act. The Act upended the scheduled roll-out of NC FAST. It necessitated the simultaneous implementation of Projects 2, 6, and 7. These projects were originally planned to be implemented in sequential order. Project 7 was created in order to be ready to process Medicaid applications using the criteria mandated in the Act and receive applications from the federal healthcare.gov website. Over 90,000 applications have been received from healthcare.gov in random groupings, many with missing information. As of the end of August, only 9% of these applications have been approved. This enormous additional workload for county case workers in addition to the change management associated with a new system, led to a peak of approximately 104,000 delayed applications, over half of which were due to Affordable Care Act changes. As a result of the significant collaboration between the Department's Division of Medical Assistance, Division of Social Services, and NC FAST technology team and the hard work of the county case workers, the backlog was reduced by 81% and is on target to be cleared by the end of October.



DMA Business Information Reporting

Reliable data is required for business decisions to be made by DMA and other branches and agencies of State government. Historically, DMA lacked the ability to timely provide the data required. Thus, one area of initial focus was on enhancing DMA's Business Information function.

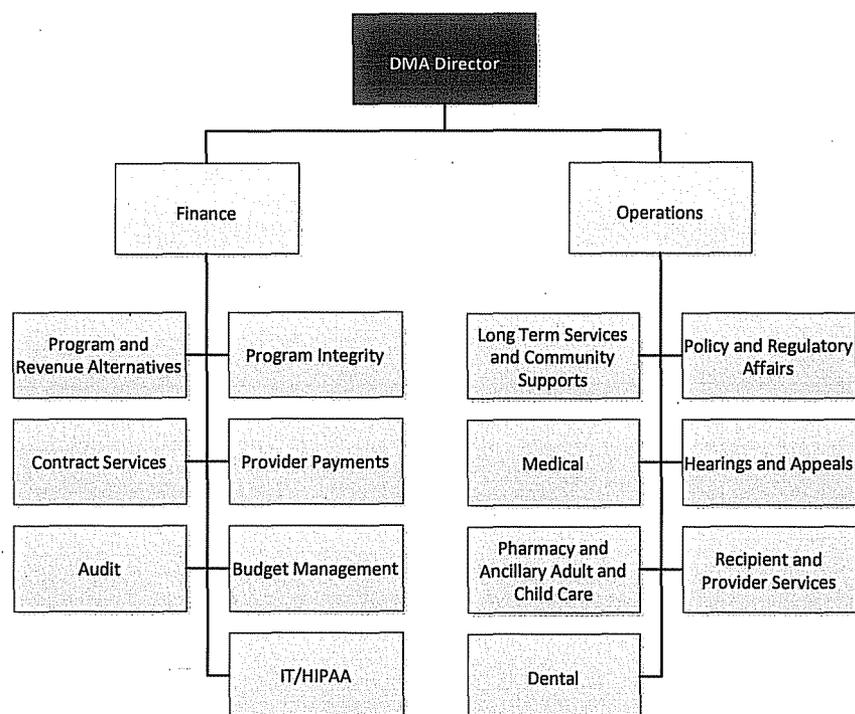
Previously, the Business Information function was buried in DMA's finance section. Based on an assessment of the business requirements and roles and responsibilities of the individuals responsible for the function, we realigned the organizational structure in order to promote timely access to necessary information. These changes included:

- Business Information function reports directly to the DMA Director
- Recruited a senior executive with a demonstrated track record of technology innovation and Medicaid data management
- Restructured the function to include three sub units to advance decision making and interactions with technology investments
- Hiring several additional data analysts

The impact of these changes has been immediate and substantial. We have more than doubled the output within the data analytics group. The data analytics team completed 179 data requests during June-August - more than the total for 7 previous months (175 for November-May).

DMA Organization and Staffing

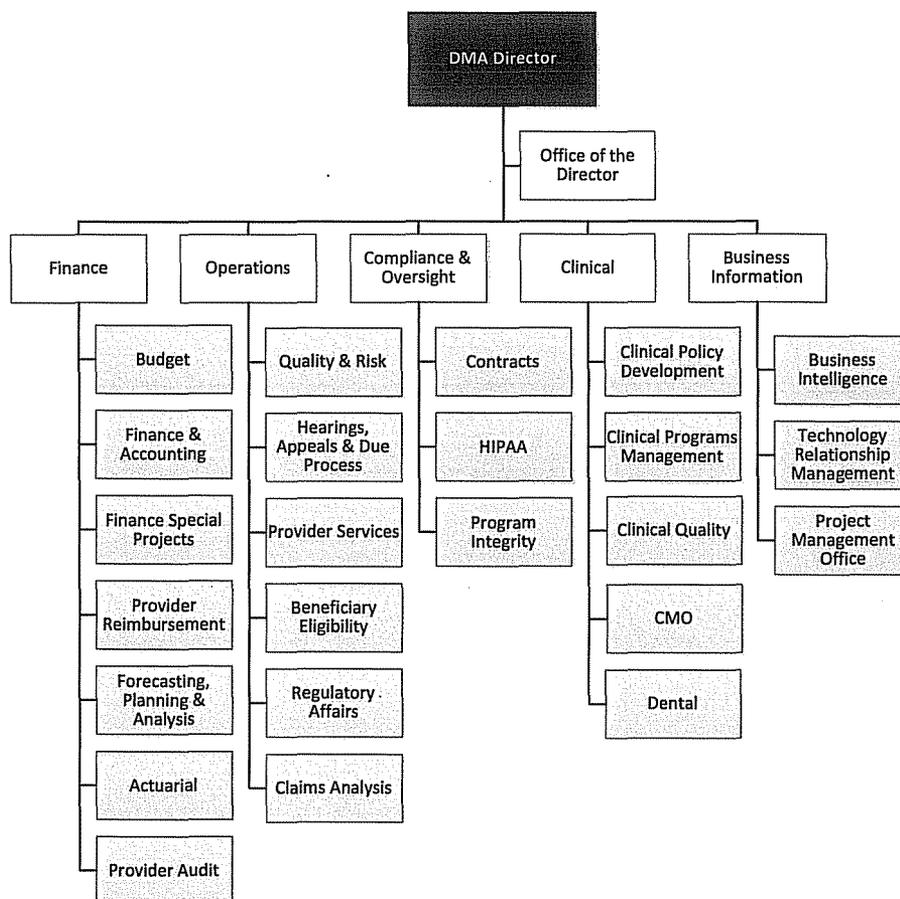
DMA has long had "siloed" organizational structure with two sections, Finance and Operations. That structure substantially contributed to functional misalignment and a lack of coordination and collaboration within the Division.



In addition to engaging A&M to facilitate the development of a forecasting model, we engaged them to assist with the organizational re-alignment of DMA. The following weaknesses were identified by A&M in consultation with Department staff:

- Finance: DMA has weak financial management capabilities as a result of inadequate staffing, an absence of critical skill sets and processes, lack of governance, and inadequate coordination with programmatic functions
- Technology, Data and Business Processes: DMA has experienced significant technology changes over the past 24 months with additional transformation to occur over the next 2-3 years
- Human Resource Management: DMA's ability to operate successfully and efficiently is currently hampered by various prevalent resource-based issues; spanning from long-standing vacancies and personnel turnover to ineffective talent development and a lack of integrated performance management
- Compliance and Oversight: DMA lacks a centralized compliance function. In addition, federal and State requirements have witnessed considerable growth in terms of scale and complexity
- Strategy: DMA lacks the capacity to look forward and engage in strategic planning which keeps the division constantly in a reactive mode versus being proactive thus creating operational issues

We are in the process of implementing a "flattened" organizational structure with five sections with clearly defined and integrated functional responsibilities, i.e., Finance, Business Information, Operations, Clinical, and Compliance. Additionally, we are establishing a strategy function in the Office of the Director to break the ongoing cycle of reactionary "fire drills" that have historically plagued DMA.



This organizational design and implementation strategy will enable DMA to address current challenges across each of the five areas of focus:

- **Finance:** Build capacity to support the new ‘bottom-up’ forecasting and budgeting processes; create programmatic areas of focus across the Budget, Finance and Accounting, and Forecasting, Planning, and Analysis units, and elevate actuarial and special projects units to serve as enterprise functions that will support the entire agency
- **Technology, Data and Business Processes:** Elevate the Business Information Office to a direct report to the DMA Director; and create dedicated units to support each programmatic area with data and analytics
- **Human Resource Management:** Increase accountability through the grouping of logical functions, implementing performance management, and clarifying and documenting roles and responsibilities
- **Compliance and Oversight:** Elevate and consolidate Compliance and Oversight functions into a single section which will be led by a dedicated leader responsible for ensuring enterprise application and adherence to a robust compliance program, including written policies consistent with the requirements of law and CMS directives, training, and monitoring and remediation of compliance issues
- **Strategy:** Grow this capability to proactively identify risks and impacts, planning responses and programmatic changes, and future requirements in the Office of the Director

The new structure has been created to enhance financial control and increase the efficiency and effectiveness of DMA’s financial and data management processes. Critical to improving DMA’s fiscal

capabilities is building a stronger financial management organization. A new horizontal organizational structure with six core disciplines will clearly define individual responsibility and foster greater communication and coordination across the organization. Financial management resources will be allocated to program divisions in order to integrate programmatic planning into the budget and forecasting processes. These processes will also be more structured and standardized in support of the new forecasting model.

DMA is also improving financial and operational controls by reviewing and revising policies and procedures. Implementation of clear policies and procedures will ensure that all staff are working from the same “playbook” and eliminate dependencies. In addition to rewriting these governance documents, they will be implemented and individuals trained and held accountable for following them. A sound management structure will improve compliance and ensure that roles are appropriately supported by resources with the necessary competencies and skills sets. Current job descriptions, roles and responsibilities are being reviewed and rewritten as necessary. The human capital infrastructure has not kept pace and DMA’s plan will enable it to retrain, retool and recruit talent to meet the demands of Medicaid.

Building capacity to support DMA’s new “bottom-up” forecasting and budgeting processes, enhanced data analytics and information technology interface, development and implementation of policies consistent with the requirements of law and CMS directives and monitoring and remediating compliance issues, strategic planning, and recruiting and retaining employees with the required skills are critical both now and in the future -- irrespective of which Medicaid reform plan is ultimately enacted.

Reforming the Medicaid Delivery Model

We worked for over a year on the Medicaid reform plan that was submitted to the General Assembly on March 17, 2014. My team and I traveled across the State and listened to stakeholders in order to develop a plan that leverages North Carolina’s health care delivery system to improve health outcomes for Medicaid recipients.

Today, we have a Medicaid system that pays only for services, not for quality of care. There is little incentive to keep patients healthier – and sometimes the financial incentives encourage unnecessary use of services.

Our reform plan relies on physicians, hospitals, and other providers to coordinate care through Accountable Care Organizations, or ACOs. A number of ACOs already exist in North Carolina and we anticipate that others will be formed as this health care delivery model is being utilized for Medicare and other insured populations. These groups of providers coordinate care services across multiple health care settings in a geographic area. Whole person care will be achieved for Medicaid recipients by their working with our regional behavioral health entities (LME/MCOs) to improve quality of mental health, substance abuse, and developmental disabilities services in addition to physical health. They will be held accountable for achieving benchmarks in quality improvements and reductions in the rate of spending growth. ACOs will share gains and losses with the State. Providers will earn the greatest rewards when quality and costs improve. Losses will be shared when costs exceed target budgets. Quality care and better health outcomes will produce cost savings for our State.

This plan puts patients first, improves whole person care, ensures a more predictable Medicaid budget, and builds on what already works for North Carolina. It reduces waste in the health care system with the goal of making patients healthier and saving money. It is realistic, achievable, and responsible and we believe this is the best plan for North Carolina.

Our Medicaid reform plan has been widely embraced by the public and medical community. A Medicaid reform bill very closely aligned with our plan, the primary policy addition being the implementation of capitation payments (i.e., a per member per month payment in lieu of fee-for-service) for provider-led organizations by 2020, passed the North Carolina House of Representatives with overwhelmingly bipartisan support (113-0). I commend the House for taking an important step toward historic Medicaid reform. I am also encouraged that the Senate continues to make Medicaid reform a priority. I hope progress will be made towards a true reform plan for North Carolina in the interim.

Conclusion

In March of 2013, I stated that “the way to improve Medicaid is not to remove it from the Department but by implementing better management, budget forecasting, reporting, staffing, and communication.” That remains true today.

Our aggressive actions have resulted in measurable progress. We have strengthened the Department and the organizational realignment of DMA and improvements in Medicaid forecasting and budgeting provide the foundation for much needed reforms of our Medicaid program. I am convinced that our current course is the right one.

Sincerely,



Aldona Z. Wos, M.D.
Secretary