NCIOM
Understanding North Carolina's Medicaid Agencies
Primer

About the Divisions of Medical Assistance and Health Benefits

The North Carolina Department of Health and Human Services' (DHHS) delegates the responsibility for Medicaid administration and reform to two divisions, the Division of Medical Assistance and the Division of Health Benefits. The Division of Medical Assistance manages the North Carolina Medicaid and Health Choice for Children programs. Medicaid provides health insurance for low-income children, families of dependent children, pregnant women, seniors, and individuals with disabilities.[1] NC Heath Choice, North Carolina's version of the Children's Health Insurance Program (CHIP) benefits children whose family income is too high to qualify for Medicaid but is at or below 211% of the federal poverty level. DMA is divided into the Director's Office and eight specialized sections to oversee the various administrative functions of the Division.[2]

Sections of DMA:

Administration	Coordinates the State Medicaid Plan and waivers, communicates with the Center for Medicaid Services, directs the Division's legislative process, and oversees implementation of policy changes and other projects[3]
Budget Management	Manages DMA's budget and financing, oversees contracting and purchasing, and establishes financial policy[4]
Clinical Policies and Programs	Oversees the administration of clinical services and other programs covered by Medicaid, including setting coverage policies and providing program information to providers, recipients, and the public[5]
Finance Management	Establishes reimbursement methodologies and rates for covered services, conducts audits of healthcare facilities, and assesses and reports program costs[6]
Human Resources	Provides services to recruit, retain, and develop an effective workforce for DMA[7]
Information Technology and HIPAA	Oversees the Medicaid Management Information System, the overall information and claims processing system for the Medicaid program, and HIPAA protections for the electronic exchange of information[8]
Compliance and Program Integrity	Monitors the use of Medicaid dollars and program quality to ensure accountability and prevent fraud and program abuse[9]
Recipient and Provider Services	Establishes eligibility policy, manages the Eligibility Information System, analyzes claims, enrolls providers, and oversees managed care within the Medicaid Program[10]

The Division of Health Benefits (DHB) was created pursuant to legislation signed in 2015 to oversee Medicaid reform as the system shifts from a fee-for-service model to a capitated rate, managed care model.[a] The state Medicaid agencies are advised by the Medical Care Advisory Committee, which provides recommendations on service coverage, care quality, and budgetary goals.[11]

The Role of the Division of Medical Assistance in Influencing Health

DMA's administrative responsibilities for the Medicaid and Health Choice programs include tasks such as outreach and enrollment of beneficiaries, defining the scope of coverage, establishing plan and provider payment rates, enrollment and payment of providers and plans, monitoring the quality of services, processing appeals, and reporting.[12] Under North Carolina's current system, DMA reimburses the enrolled NC Medicaid providers for services provided to Medicaid beneficiaries on a fee-for-service basis.

[a]2015 N.C. Session Law 245

Mental health and substance use services, as well as intellectual and developmental disabilities (I/DD) services covered by Medicaid are administered using a managed care model. Currently, DMA contracts with the seven regional local management entities/managed-care organizations (LME/MCOs) to direct the use of state and federal Medicaid dollars to provide these services to Medicaid beneficiaries.[13] In accordance with North Carolina's 1915(b)/(c) waiver, DMA provides a per member, or capitated, monthly payment to each of the organizations to manage the services of the Medicaid beneficiaries within their catchment areas.[b] Direct community-based services are then provided through contracts between the LME/MCOs and local private providers, or in one of the fourteen state-operated healthcare facilities.

The Division of Health Benefits and Medicaid Reform

In 2015, North Carolina passed Medicaid reform legislation requiring a shift to a capitated, managed care system for many Medicaid recipients, with the goal of controlling the cost of the state's Medicaid program. The legislation proposed six Medicaid regions across North Carolina, in which up to 12 provider-led entities and up to 3 managed care organizations (MCOs) will manage and provide care. Eligible beneficiaries will be able to choose among four health plans in their region.[14] DHB created a plan outlining this transition and strategies to improve health care quality, access, and cost efficiency, initially submitted in June of 2016 to the Centers for Medicare and Medicaid Services (CMS). An amended version that expands on key elements of the managed care transition has since been submitted as of November of 2017.[15] The application is under review and, if approved, North Carolina will have 18 months to implement the proposed changes to the Medicaid program.[14]

Funding and Spending

DMA manages a budget of over $14 billion, with a net appropriation of over $3 billion from the General Assembly in State Fiscal Year (SFY) 2017.[16] Medicaid and Health Choice are jointly funded by the federal and state governments. In both cases, the federal government provides most of the funds, as determined by the federal medical assistance percentage (FMAP)[c]. As of FY 2018, the federal government provides 67.61% of the funds for Medicaid in North Carolina, and 100% of the funds for Health Choice.[17,18, d]

TABLE 1: DMA Expenditures by Program

$ millions	Summary by DMA Program		
	SFY14	SFY15	SFY16
Medicaid:			
Expenditure	$ 13,303.1	$ 13,744.4	$ 13,771.1
Federal Revenue	8,432.7	8,751.7	8,771.3
Other Revenue	1,466.6	1,434.9	1,507.0
Appropriations	**$ 3,403.8**	**$ 3,557.7**	**$ 3,492.8**
Health Choice:			
Expenditure	$ 246.4	$ 175.2	$ 172.8
Federal Revenue	187.3	132.6	160.8
Other Revenue	0.5	0.9	0.8
Appropriations	**$ 58.7**	**$ 41.7**	**$ 11.1**
Special Fund:			
Expenditure	$ 123.6	$ 211.8	$ 205.3
Federal Revenue	-	-	-
Other Revenue	106.1	250.6	206.4
Appropriations	**$ 17.5**	**$ (38.8)**	**$ (1.0)**
Total DMA:			
Expenditure	$ 13,673.1	$ 14,131.3	$ 14,149.2
Federal Revenue	8,620.0	8,884.3	8,932.1
Other Revenue	1,573.1	1,686.4	1,714.2
Appropriations	**$ 3,480.0**	**$ 3,560.6**	**$ 3,502.9**

Blended FMAP: SFY14 = .6571, SFY15 = .6586, SFY16 = .6615

Source: NC Department of Health and Human Services. Medicaid and NCHC Financial Update. Presented to: Joint Legislative Oversight Committee on Medicaid and NC Health Choice; November 29, 2016; Raleigh, NC. https://www.ncleg.net/documentsites/committees/BCCI-6660/Meetings%20by%20Interim/2016-2017%20Interim/November%2029,%202016/Item%20VI%20Medicaid-NCHC_Financial-Update_11.29.16.pdf. Accessed July 1, 2017.

DMA's administrative costs account for a nominal portion of the budget, approximately 0.33% in SFY 2017.[16] Claims, premiums, and additional hospital payments reflect the majority of the costs for the Medicaid and Health Choice programs, accounting for 94% of expenditures in SFY 2017.[19] Spending

[b] 2011 N.C. Session Law 264

[c] FMAPs are calculated annually based on a state's per capita income relative to the U.S. average per capita income. FMAPs have a statutory minimum of 50% and maximum of 83%.

[d] Section 2101(a) of the Affordable Care Act amended Section 2105(c) of the Social Security Act to enhance the FMAP for CHIP (NC Health Choice) by 23% from October 1, 2015 until September 1, 2019.

on claims varies depending on eligibility group. For instance, children make up 54% of Medicaid beneficiaries, yet account for only 25% of claims expenditures. Most claims expenditures (60%) are for the aged, blind, disabled, who comprise 21% of Medicaid beneficiaries.[20]

While Medicaid enrollment in North Carolina has grown rapidly over the past decade, DMA's total costs have increased gradually. The Division has made changes to control the cost of the Medicaid program, including designing programs to reduce hospital utilization and institutionalization, transitioning to a managed care model for mental health and substance use services, and obtaining larger rebates for prescription drugs.[20]

TABLE 2: Medicaid Enrollment and Spending, SFY 2007-2016

SFY	Enrollment[a]	Total Expenditures[b]
2007	1,213,121	$11,252,170760
2008	1,243,989	$11,596,523,640
2009	1,321,820	$12,623,281,487
2010	1,417,358	$12,838,121,598
2011	1,464,009	$13,270,350,502
2012	1,530,920,	$14,241,450,471
2013	1,582,537	$12,643,008,323
2014	1,655,477	$13,303,105,674
2015	1,807,996	$13,744,373,932
2016	1,855,834	$13,771,114,174

Note:
[a]Average monthly enrollment by year
[b]Total expenditures from NC BD-701

Adapted from: Sutten T, Borchik R. Running the Numbers: An Overview of North Carolina Medicaid and Health Choice. *NCMJ.* 2017;78(1):58-62.

Impacts, Challenges, and the Future of DMA and DHB

DMA plays a crucial role in access to health care services for more than two million North Carolinians who are beneficiaries of Medicaid or Health Choice.[21] Low personal income is associated with an increased burden of illness and higher health care costs: Medicaid and Health Choice mitigate financial barriers to accessing health care, increase the likelihood of receiving preventive care, and deliver services of comparable quality to those provided through private insurance.[22] Additionally, in North Carolina, 90% of primary care providers serve Medicaid patients, which is a higher percentage than in most states.[23] DMA's and, more broadly, DHHS' efforts to continually improve quality and cost-effectiveness of Medicaid and Health Choice have created programs that provide essential services for populations that may not otherwise have access to them.

However, North Carolina Medicaid faces challenges that have, in part, led to Medicaid Transformation and the creation of DHB. Many beneficiaries face barriers accessing behavioral health services, primary care, and specialty care, particularly in rural areas that have fewer practicing providers. Additionally, despite relatively high provider participation rates, many beneficiaries may have difficulty finding providers accepting new Medicaid patients, as administrative processes and high costs of caring for patients who tend to be sicker than those who are privately insured can be burdensome for some providers.[24] Finally, a limited ability to address social determinants of health under current program design has made it challenging for Medicaid to improve population health.[25]

The transition to Medicaid Managed Care will change the administrative structure for the Medicaid program. DHHS will maintain oversight of Medicaid, although it will delegate the "direct management of certain health services and financial risks to Prepaid Health Plans (PHPs)."[26] According to the Medicaid reform legislation, DMA will be eliminated and replaced with DHB as the administrative division twelve months after capitated PHP contracts begin.[e] However, as these changes are incumbent upon the approval of the state's waiver application and the full implementation of the program design, DMA will continue to operate the current Medicaid and Health Choice programs. As North Carolina looks to the future of Medicaid, DMA and DHB will continue to play an important role in the health of North Carolina's people.

For more information about North Carolina's Medicaid Program, see the NCIOM Medicaid Primer.

[e] 2015 N.C. Session Law 245

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