An Overview of Medicaid in North Carolina*

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Abstract:

In North Carolina, as in other states, Medicaid cost containment is an increasingly pressing concern. This brief offers details on North Carolina's Medicaid program in order to provide recent state level information, and to help set the stage for the consideration of specific cost containment strategies discussed in the subsequent briefs. This brief illustrates who is eligible for coverage and the expenditures for the different population groups of recipients. A description of benefits available under North Carolina Medicaid and the costs of each type of benefit is also described. This brief describes changes to North Carolina's Medicaid program in the past 15 years, including expansions in eligibility criteria, and program changes in managed care, prescription drugs, provider rates, recipients, and recipient services. Finally, next steps in Medicaid cost containment in North Carolina are considered from a family impact perspective.

* This brief is based on information presented in *Medicaid Program Overview* by Carol Shaw, Fiscal Research Division, North Carolina General Assembly, March 2005, and supplemented with additional, forthcoming information provided by the North Carolina Department of Health and Human Services, Division of Medical Assistance, and, for national data, by information from the Michigan Family Impact Seminar. Portions of this brief are derived from the work of Vernon K. Smith, Jr. (See "A National Challenge: How States Try to Control Medicaid Costs and Why It Is So Hard.")

Medicaid: A Snapshot

In 1965, as part of the "War on Poverty," President Johnson created the Medicaid program to extend health insurance coverage to low income Americans. Medicaid is an entitlement program, which means that the government must pay for the covered health services of eligible Medicaid beneficiaries. Medicaid provides health insurance to pregnant women, low income children, parents of dependent children, seniors (age 65 or older), people with disabilities, and certain other specified groups (such as women diagnosed with breast or cervical cancer). In addition to belonging to one of these target groups, Medicaid recipients must satisfy certain financial requirements in order to qualify. Medicaid also supplements Medicare coverage for many low income seniors or people with disabilities.[1] Medicaid is the largest publicly funded insurance program, serving over 52 million low income children and adults. Medicaid plays a major role in the U.S. health care system. In the area of maternal and child health, Medicaid pays for prenatal care and delivery of more than a third of all U.S. births and comprehensive health care for about one quarter of all children. In relation to care for seniors and people with disabilities, Medicaid covers about half of the care for all nursing home patients and pays for both home- and community-based long-term care services.

In FY 2004, 1.5 million North Carolina residents, about 18%, received Medicaid. Over 870,000 children participated, and Medicaid covered approximately 45% of all births. Two thirds of the state's 41,000 nursing home beds were also financed by Medicaid.

Medicaid Cost Containment in North Carolina: A Growing Concern

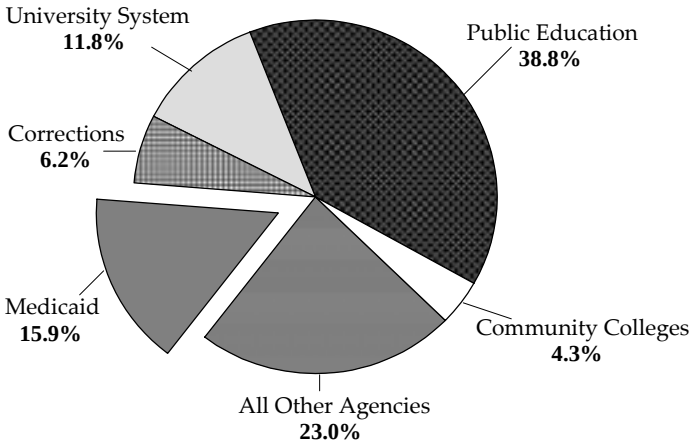
Medicaid is administered by states and counties. Costs are shared between federal and state governments, depending on need, with a formula based on state per capita income (the Federal Medical Assistance Percentage or FMAP). States may finance the nonfederal share completely or may require local governments to share up to 60% of the program costs. In North Carolina, the state pays for 85% of the nonfederal share of Medicaid services and requires counties to pay 15% of the nonfederal share.

In North Carolina, as is typical in other states, Medicaid is the second largest program in the state budget after education. In FY 2004, Medicaid expenditures were $8.5 billion, 16.1% of all North Carolina (governmental and nongovernmental) health care expenditures. Medicaid accounts for 15.9% of the 2005 General Fund operating budget (see Figure 1) and 63.5% ($2.45 billion) of the state's Health and Human Services General Fund (see Figure 2).

Figure 1: The NC Medicaid Program

General Fund Appropriations by Major Program Area

FY 2005

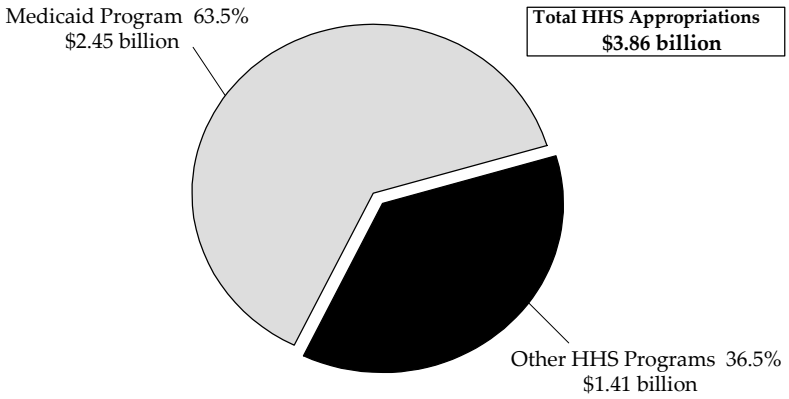


Source: NC General Fund Operating Appropriations SFY 2005 Fiscal Research Division 2/05

Figure 2: The NC Medicaid Program

Medicaid's Share of HHS General Fund

Appropriations for FY 2005



Source: NC General Fund Operating Appropriations SFY 2005 Fiscal Research Division 2/05

Figure 3: The NC Medicaid Program

History of Medicaid Expenditures

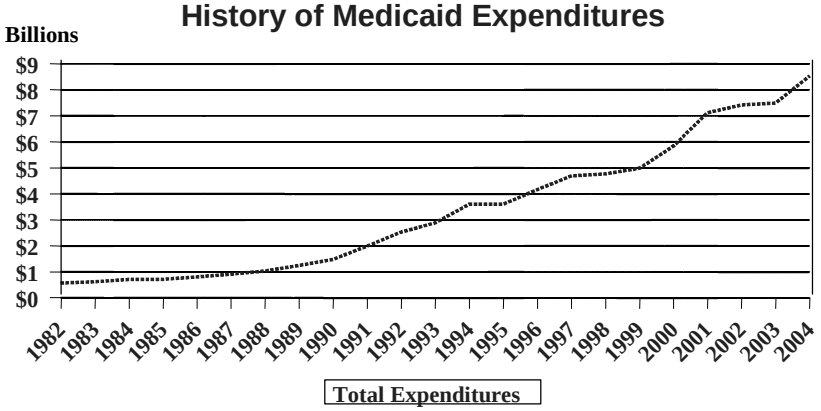


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Figure 3 depicts the history of North Carolina Medicaid expenditures between 1982 and 2004. In FY 2004, U.S. Medicaid spending grew at an annual rate of 9.5%, while in North Carolina it grew 11.9%. Medicaid cost containment is an increasingly pressing concern in North Carolina and other states.

North Carolina Medicaid in Detail

The remainder of this brief offers details on North Carolina's Medicaid program in order to provide recent state level data and to help set the stage for consideration of specific cost containment strategies discussed in the subsequent briefs. Three subsections follow: North Carolina Medicaid beneficiaries, North Carolina Medicaid benefits, and changes to North Carolina's Medicaid program in the past 15 years (since 1990). Expenditures and cost containment issues are highlighted throughout.

North Carolina Medicaid Beneficiaries

Under federal law, all states operating a Medicaid program must serve specific groups of people called mandatory population groups. Current federal law also provides federal reimbursements for coverage to certain optional population groups that are selected at states' discretion but allowed under federal law. Each state is allowed to choose which optional population groups it serves.

The mandatory population groups are as follows:

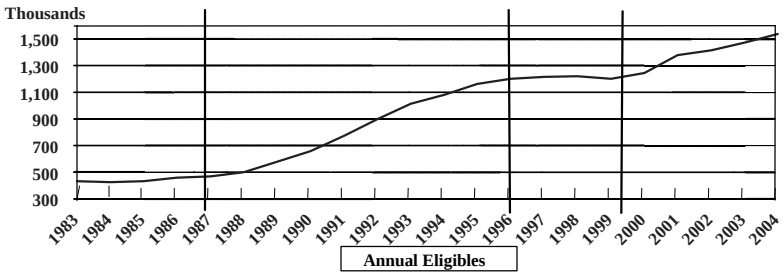
- Adults in Families with Children (based on the AFDC State Plan as of July 16, 1996)
- Persons Eligible for Transitional Benefits (individuals transitioning off of welfare)
- Aged, Blind, and Disabled Supplemental Security Income (SSI) Recipients
- Infants born to Medicaid eligible women with family incomes equal to or less than 133% of Federal Poverty Guidelines (FPG)
- Children ages one through five with family incomes equal to or less than 133% of FPG
- Pregnant Women with family incomes equal to or less than 133% of FPG
- Children 100% of FPG ages six through age 18 with family incomes equal to or less than 100% of FPG
- Recipients of Adoption Assistance and Foster Care
- Refugees/Aliens
- Certain Medicare Recipients (Dual Eligibles, Qualified Medicare Beneficiaries, Specified Low income Medicare Beneficiaries, Qualified Disabled and Working Individuals)

The optional population groups served in North Carolina are as follows:

- Children ages 19 and 20 meeting AFDC income standards
- Special Needs Adoptive children
- Recipients of State/County Special Assistance
- Recipients of State Assistance to the Blind
- Persons receiving care under home- and community-based waivers
- Aged, Blind, and Disabled persons presumed eligible for but not receiving SSI
- Aged, Blind, and Disabled persons with incomes equal to or less than 100% FPG (these are individuals with incomes that are too high to qualify for SSI)
- Medically Needy Persons (must meet the spend down requirement)
- Women with Breast and Cervical Cancer (income must be 185% of FPG or less)

Figure 4: The NC Medicaid Program

History of Annual Eligibles



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A series of expansions in 1987, along with the economic downturns of the early 1990s and early 2000s led to significant increases in both Medicaid participation and Medicaid expenditures.

Figures 4 and 5 illustrate the history of North Carolina Medicaid participation since 1987. During the early 1980s, the number of eligible people did not grow significantly (see Figure 4). Beginning in 1987, a series of mandated and optional eligibility expansions took place. These expansions, along with the economic downturns of the early 1990s and early 2000s led to significant increases in both Medicaid participation and Medicaid expenditures. Between FYs 2003 and 2004, the state population grew by 1.1% and the number of people eligible for Medicaid increased by 4.5%.

When Medicaid began, the program focused on providing medical care for the disabled, aged, and families – generally those receiving cash assistance. Since 1987, Medicaid has been expanded to cover many individuals, including children and pregnant women who are not receiving welfare or SSI (see Figure 5).

Figure 6 illustrates the proportions of participants served by North Carolina's Medicaid program in FY 2004. The two largest categories of Medicaid participants are children (34.5%) and low income adults in families with children (32.1%). Thus, almost 70% of all Medicaid recipients in 2004 were low income children and their families.

Figures 7 and 8 illustrate North Carolina's Medicaid costs in FY 2004 per population group. Although children and families make up the largest of the three principal groups of Medicaid recipients, they account for only about $2.3 billion or 31% of Medicaid costs. Elderly recipients and those with disabilities comprise approximately 13% and 16% of total recipients respectively. However, these two groups account for approximately $5 billion or 60% of total expenditures.

Figure 5: The NC Medicaid Program
New Groups since 1987

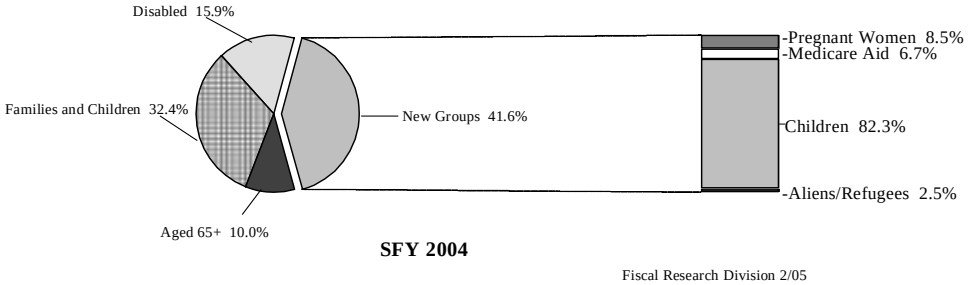
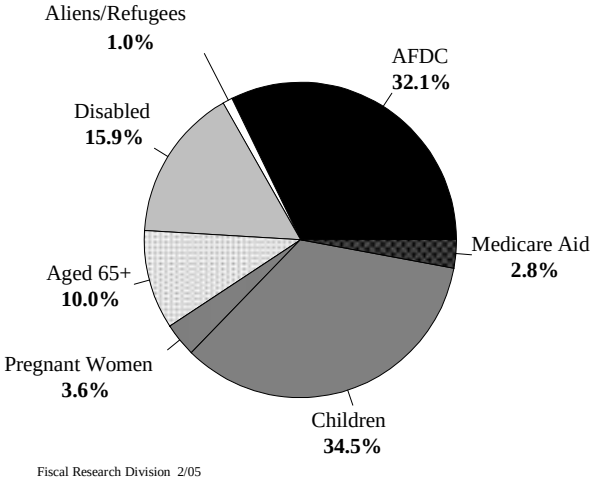


Figure 6: The NC Medicaid Program
Medicaid Eligibles- FY 2004



North Carolina's Medicaid Benefits
Under federal law all state Medicaid programs must cover specific mandatory benefits. State programs may also elect to provide certain optional benefits.

The mandatory benefits are as follows:

- Health Check (Early Periodic Screening, Diagnosis, and Treatment, EPSDT) Services for children under 21
- Family Planning Services
- Federally Qualified Health Center Services (Community, migrant health centers)
- Home Health Services (includes supplies and durable medical equipment used in the home)

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Figure 7: The NC Medicaid Program
Expenditures and Recipients- FY 2004

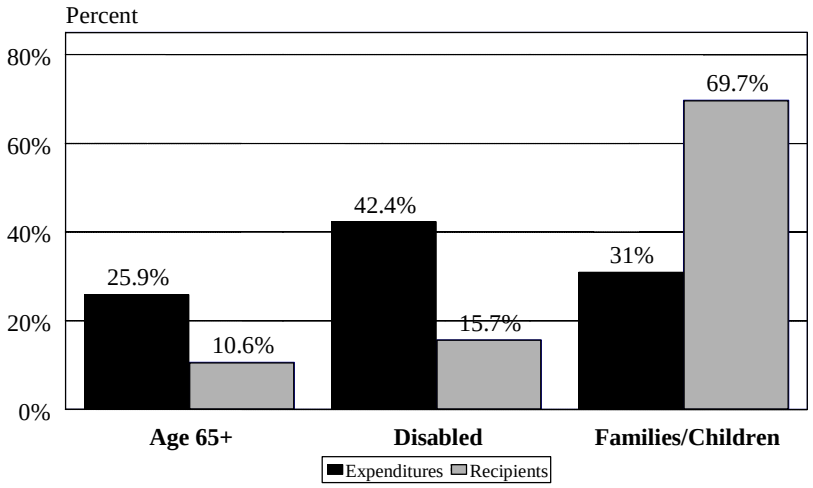

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Figure 8: The NC Medicaid Program
Expenditures and Recipients- FY 2004

Eligibility Category	Number of Recipients	Expenditures	Annual Cost Per Recipient
Elderly	204,135	$1,941,800,149	$8,932
•Aged	162,675	$1,912,877,837	$10,992
•Medicare-Aid	41,460	$28,922,311	$665
Disabled	243,774	$3,127,627,817	$11,971
Families & Children	1,074,554	$2,285,088,549	$1,967
Aliens & Refugees	18,987	$51,681,385	$2,735

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- Rural Health Clinic Services
- Inpatient Hospital Services
- Outpatient Hospital Services
- Physician Services
- Laboratory and X-Ray Services
- Nurse Midwife Services
- Nurse Practitioner Services
- Nursing Facility Services for individuals ages 21 or older
- Specialty Hospital Services
- Transportation
- Vaccines for Children

With respect to optional benefits, North Carolina's Medicaid program covers all of the allowable optional benefits except for nonmedical services offered in a religious hospital or setting:

- Ambulance Transportation
- Targeted Case Management Services
- Chiropractic Services
- Community Alternatives Program (CAP) Services (Home- and Community-based Care)
- Dental Care Services (including dentures)
- Diagnostic, Screening, Preventive Services
- Eyeglasses
- Hospice
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Inpatient Hospital for Individuals 65 or older in Institutions for the Mental Diseases
- Nurse Anesthetist Services
- Medical Social Work Services
- Inpatient Psychiatric Care for individuals under 21
- Occupational, Physical, and Speech Therapies
- Optometry Service
- Personal Care Services

- Podiatry Services
- Prescription Drugs
- Prosthetics and Orthotics
- Private Duty Nursing Services
- Psychology (Mental Health) Services
- Rehabilitation Services (Mental Health)
- Respiratory Care Services for ventilator-dependent individuals
- Speech, Hearing, and Language Services

Individuals eligible for Medicaid can receive these services from a variety of different sources, including public agencies (e.g., local health departments, county owned home health agencies), state hospitals, and other public and private health care providers.

Figure 9 illustrates the proportions of services covered by North Carolina's Medicaid program in FY 2003. The two largest service categories are inpatient and outpatient hospital services (20% of all expenditures) and long-term care (31% of all expenditures).

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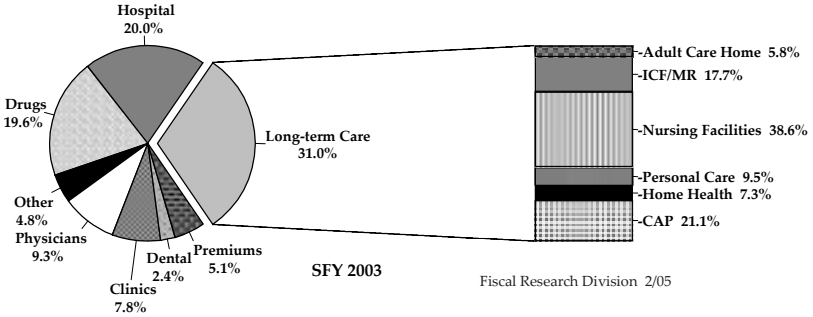
Figure 9: Medicaid Program

Expenditures for Services



Changes to North Carolina's Medicaid Program Since 1990: Expansion of Eligibility Criteria and Initiation of Managed Care and Other Cost Containment Strategies

Since 1990, the North Carolina Medicaid program has expanded eligibility criteria for both mandatory and optional eligibility groups.

In addition, managed care initiatives have been introduced, beginning in 1991 with Carolina ACCESS, Carolina Alternatives, and ACCESS II. These initiatives aim to increase access to care, promote community-based systems of care, enhance care management, and improve the quality of care and cost effectiveness of the Medicaid program. The Medicaid managed care program in North Carolina is now known as Community Care of North Carolina (CCNC).

CCNC is a collaborative effort among the state, counties, community institutions, and physicians. CCNC is composed of 13 local networks consisting of more than 3,000 physicians. The networks include more than 900 physician practices and serve 555,000 Medicaid recipients across 82 counties. The program is expected to operate statewide by December 2005.

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For FY 2003-04 the cost of CCNC was $28.5 million. Medicaid pays $5 per member per month (split evenly between the network as an enhanced care management fee and the primary care provider for case management). In return, the networks are responsible for identifying high cost patients and developing plans to manage service use and costs, providing evidence-based disease management services, controlling prescription drug use, and controlling unnecessary emergency room use.

Other cost containment strategies that have been implemented fall under four major domains and are listed below. Where possible, relevant legislative sessions are also noted:

Prescription Drugs[2]:

- Established Prior Authorization Program for certain high cost drugs
- Created Maximum Allowable Cost (MAC) drug list
- Limited most drugs to a 34-day supply
- Increased use of generic drugs
- Established a voluntary preferred drug list, known as the Prescription Advantage List (PAL)

- Increased copayments for brand name drugs
- Created new requirements for coordination of pharmacy benefits
- Eliminated coverage for weight loss and weight gain drugs
- Reduced dispensing fees

Provider Rates:

- Reduced physician rates from 100% of Medicare rates to 95% (2002 Regular Session)
- Eliminated inflationary increases for FY 2003 and 2004 (2003 Regular Session)
- Reduced reimbursement rates by 5% for the following providers or services: Private duty nursing, home infusion therapy, home health supplies, durable medical equipment, optical services, ambulatory surgery centers, and high risk procedures (2002 Regular Session)
- Reduced hospital payments by .5% (2002 Regular Session)
- Limited reimbursement of Medicare crossover claims to Medicaid rates (2002 Regular Session)
- Applied Medicaid medical policy to Medicare crossover claims (2002 Regular Session)

Recipients:

- Applied federal transfer of asset policies to real property excluded as tenancy-in-common, or as nonhome site property made income producing under Title XIX of the Social Security Act (2002 Regular Session)
- Applied estate recovery policies to Medicaid costs for in-home personal care services (2002 Regular Session)
- Adopted the SSI method for considering equity value in income-producing property for seniors, blind, and otherwise disabled persons[3] (2002 Regular Session)
- Required parental income to be counted when determining eligibility for pregnant minors[4] (2002 Regular Session)
- Eliminated 12-month State Transitional Medicaid coverage for families and children who are working and are no longer receiving welfare payments (2003 Regular Session)

Services:

- Reduced the monthly and daily limits for personal care services (2001 General Session)
- Eliminated coverage of optional circumcision
- Reduced case management services for adults and children (2001 General Session)

In addition to these measures, North Carolina received a one-time, temporary fiscal relief package from the federal government with enhanced reimbursements that have allowed North Carolina to reduce state appropriations to the Medicaid program. This measure expired June 30, 2004. To maximize federal revenues, North Carolina has used state expenditures in the five state hospitals as match to draw federal funds for Medicaid recipients served in those facilities.

Medicaid Cost Containment in North Carolina: Next Steps According to a Family Impact Perspective

An understanding of North Carolina's Medicaid program and its recent cost containment efforts can help policymakers consider specific next steps. In doing so, a family impact perspective may be valuable for considering particular cost containment strategies. Undoubtedly, different strategies will have various effects on different types of families: rural families compared with urban families; large, multigenerational families compared with single parent families, etc. Cost containment strategies that limit recipients to particular providers may force families in some rural areas already experiencing provider shortages to travel farther for care. Strategies that focus on long-term care will likely have the greatest impact on multigenerational families including elder members. Cost containment strategies that focus on prescription drugs will likely have the greatest impact on families who make heavy use of prescription drugs, such as families with a special needs child. As such differential impacts are documented, more nuanced information and more informed strategies will evolve.

Endnotes

[1] Medicaid pays the Medicare premiums and deductibles for certain low income Medicare recipients who cannot qualify for comprehensive Medicaid benefits.

[2] Legislative dates are not noted for this section because these measures were enacted by a combination of legislative mandate and discretion of the Division of Medical Assistance.

[3] Under the SSI rules, individuals can only exclude property as income producing if the equity value of the property is no greater than $6,000 and the person makes at least 6% of the value in income each year. In the past, individuals were allowed to exclude real or personal property of any amount regardless of the value if it produced any net income.

[4] This provision was subsequently repealed because it was found to conflict with federal law.