

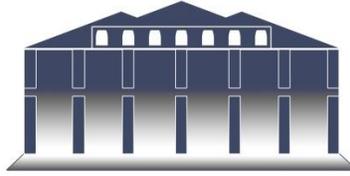
Options for Creating a Separate Department of Medicaid Require Transition Planning



**Final Report to the Joint Legislative
Program Evaluation Oversight Committee**

Report Number 2013-03

March 25, 2013



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John W. Turcotte
Director

March 25, 2013

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Representative Julia Howard, Co-Chair, Joint Legislative Program Evaluation Oversight Committee

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Honorable Co-Chairs:

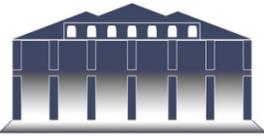
Section 10.9B of N. C. Session Law 2012-142 directed the Program Evaluation Division and the Fiscal Research Division to jointly study the feasibility of creating a separate Department of Medicaid.

I am pleased to report that the Department Health and Human Services and the Division of Medical Assistance cooperated with us fully and were at all times courteous to our evaluators during the evaluation.

Sincerely,

A handwritten signature in black ink, appearing to read "John W. Turcotte".

John W. Turcotte
Director



PROGRAM EVALUATION DIVISION

NORTH CAROLINA GENERAL ASSEMBLY

March 2013

Report No. 2013-03

Options for Creating a Separate Department of Medicaid Require Transition Planning

Summary

The General Assembly directed the Program Evaluation Division and the Fiscal Research Division to jointly study the feasibility of creating a separate Department of Medicaid. Reviewing the current organizational structure for North Carolina's Medicaid Program provides an opportunity to consider whether a different structure can improve the management and operation of the program.

The Department of Health and Human Services (DHHS) expended \$14.8 billion for the Medicaid Program including \$730.9 million to support Medicaid administration. DHHS is the single state agency responsible for administering the Medicaid Program. The North Carolina Medicaid Program must operate within federal guidelines, but it has broad flexibility in how it manages the program. DHHS has delegated Medicaid administrative functions to the Division of Medical Assistance, other DHHS divisions and offices, other state agencies, local government agencies, and private contractors.

The Program Evaluation Division identified options for changing the organizational structure of the North Carolina Medicaid Program based on the experience of other states. Options include creating a

- Department of Medicaid,
- Medicaid Program Authority, or
- Department of Health Services that includes the Medicaid Program.

Other states suggested creating a stand-alone Medicaid agency can provide stronger leadership and increased accountability for costs and policy-making. Creating a separate Medicaid or Health Services department has financial and organizational implications for the North Carolina Medicaid Program, DHHS, and statewide business functions. Implications affect the performance of Medicaid administrative functions, cost allocation of federal Medicaid reimbursement, development and implementation of Medicaid information technology systems, general administrative support for the Medicaid Program, and modifications to statewide business functions.

Creating a new Medicaid agency would require a reasonable transition period before the organization changes are finalized. Other states emphasized the importance of transition planning when making organizational changes. A transition period of 12 to 18 months would allow DHHS and leadership for the new Medicaid agency to plan and implement the necessary changes.

Purpose and Scope

The General Assembly directed the Program Evaluation Division and the Fiscal Research Division to jointly study the feasibility of creating a separate Department of Medicaid.¹ The legislation directed the evaluation to

- review how other states administer their Medicaid Programs;
- analyze the benefits and disadvantages of the North Carolina Medicaid Program becoming a stand-alone department;
- consider how creating a stand-alone Department of Medicaid could affect the Department of Health and Human Services; and
- identify other Medicaid Program organizational structures.

Four research questions guided this inquiry, and this report responds to these questions.

1. How does North Carolina administer the Medicaid Program?
2. How does North Carolina pay for the Medicaid Program?
3. How do other states administer their Medicaid Programs?
4. What options exist for creating a separate Department of Medicaid?

The following data were collected to address these questions:

- interviews with Department of Health and Human Services and Division of Medical Assistance staff;
- administrative query of Department of Health and Human Services's divisions that interact with the Division of Medical Assistance;
- analysis of organizational and financial information from the Division of Medical Assistance and the Department of Health and Human Services;
- review of memorandums of understanding between the Division of Medical Assistance and other state entities;
- survey of Medicaid Program stakeholders including major mandatory service providers and county departments of social services;
- review of North Carolina General Statutes and Session Laws related to the Medicaid Program;
- Medicaid Program survey data from other states collected by the National Association of Medicaid Directors;
- Medicaid Program data from other states compiled by the Kaiser Family Foundation and the Centers for Medicare/Medicaid Services; and
- interviews with and documents from Medicaid Programs in selected states.

¹ N.C. Sess. Law, 2012-142, Section 10.9B.

Background

The General Assembly authorized the creation of a medical assistance program in 1965 in anticipation of federal law that was passed the same year.² Title XIX of the Social Security Act, known as the Medicaid Program, established a federal and state entitlement program that purchases health and long-term care services for eligible low-income individuals. This program operates as a cooperative venture jointly funded by the federal and state governments. States participate in the program voluntarily, and all states have chosen to participate. States administer the program on a day-to-day basis within broad federal guidelines and receive federal matching funds for the costs of providing covered services and administering the program. The North Carolina Medicaid Program began in 1970 after the Medicaid State Plan was approved by the federal government in 1969.

The North Carolina Medicaid Program has always been organized under a human services agency. Under broad federal guidelines, states have the flexibility to determine methods of administration for the Medicaid Program including designating a single state agency to administer or supervise the Medicaid Program. Initially, the Medicaid Program was administered by the Department of Social Services through a contract with Blue Cross/Blue Shield of North Carolina. In 1973, the Executive Organization Act created the Department of Human Resources as an umbrella agency over all human services programs, and the Medicaid Program was administered by the Medical Services Section of the Division of Social Services.³ Based on a consultant's recommendation, a directive from the Secretary of the Department of Human Resources in 1978 created the Division of Medical Assistance (DMA) and gave DMA authority for the Medicaid Program in North Carolina. DMA also operates the North Carolina Health Choice for Children Program (NCHC), which was authorized by the General Assembly in 1998 to provide health care coverage for children under federal Title XXI of the Social Security Act. Although DMA is responsible for operating the Medicaid Program, the North Carolina Medicaid State Plan designates the Department of Health and Human Services (DHHS) as the agency responsible for program administration.

The North Carolina Medicaid Program uses the Primary Care Case Management (PCCM) model to manage care for Medicaid beneficiaries. Community Care of North Carolina and Carolina Access are the PCCMs for North Carolina, and 77% of Medicaid beneficiaries were enrolled in managed care in 2011.

The Medicaid Program's budget has become one of the largest in North Carolina state government—second only to the overall budget for primary and secondary education (See Exhibit 1). In Fiscal Year 2011–12, expenditures for the Medicaid Program were \$14.8 billion.⁴ With this

² N.C. Sess. Law, 1965-1173.

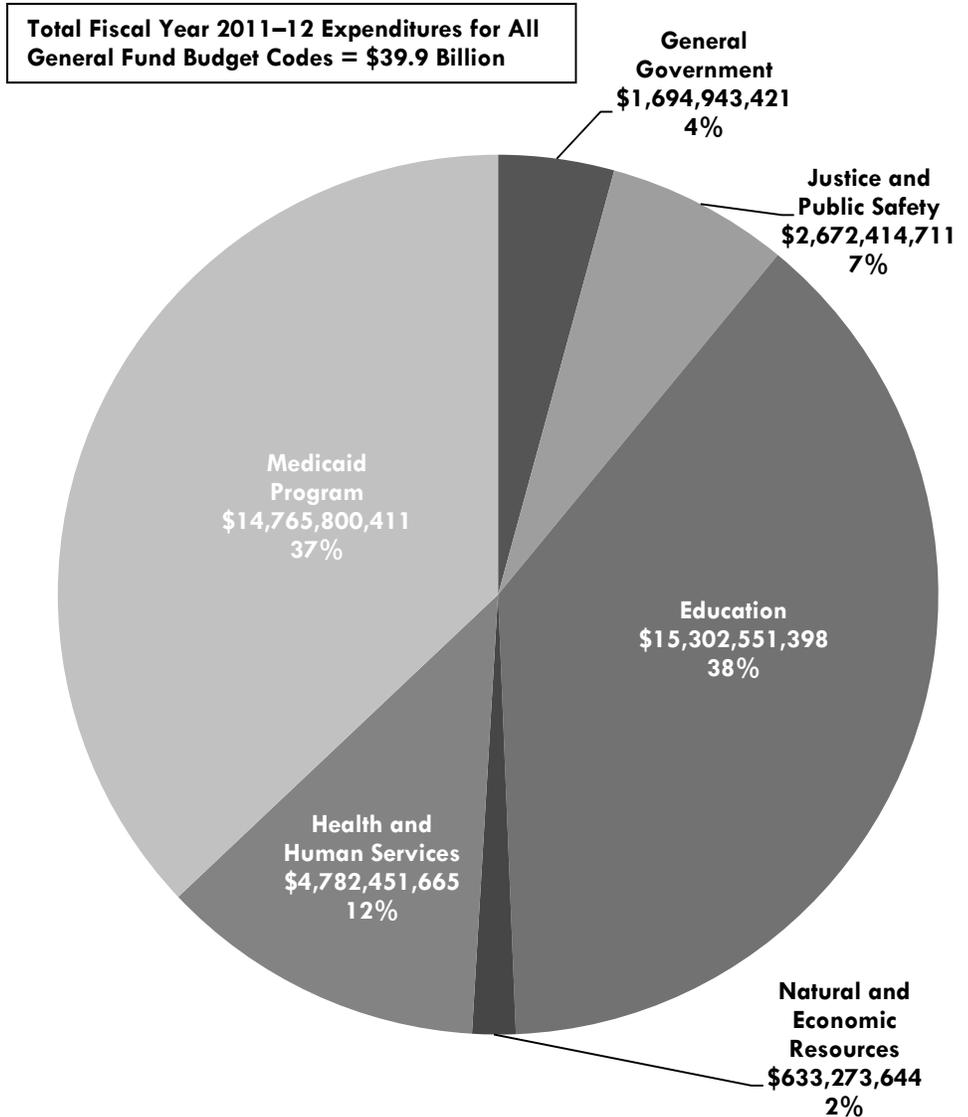
³ The Department of Human Resources was renamed the Department of Health and Human Services in 1997 when most of the Division of Public Health was moved back to the department.

⁴ Fiscal Year 2011–12 expenditures for the Medicaid Program include Medicaid expenditures for the Division of Medical Assistance and other DHHS divisions and offices.

funding, the Medicaid program paid 83,000 providers to serve 1.9 million children, aged, blind, and disabled individuals.⁵ As a federal entitlement program, eligible persons cannot legally be denied service from the Medicaid Program. North Carolina must pay for Medicaid services regardless of revenue availability.

Exhibit 1

Medicaid Program Budget Is the Second Largest in North Carolina State Government



Note: The Health and Human Services category includes all programs except for the Medicaid Program.

Source: Program Evaluation Division based on expenditure data from the Office of the State Controller.

Medicaid Program expenditures represent the majority of DHHS’s total expenditures. During Fiscal Year 2011–12, DHHS spent \$14.8 billion on the Medicaid Program or 76% of total expenditures (see Exhibit 2).

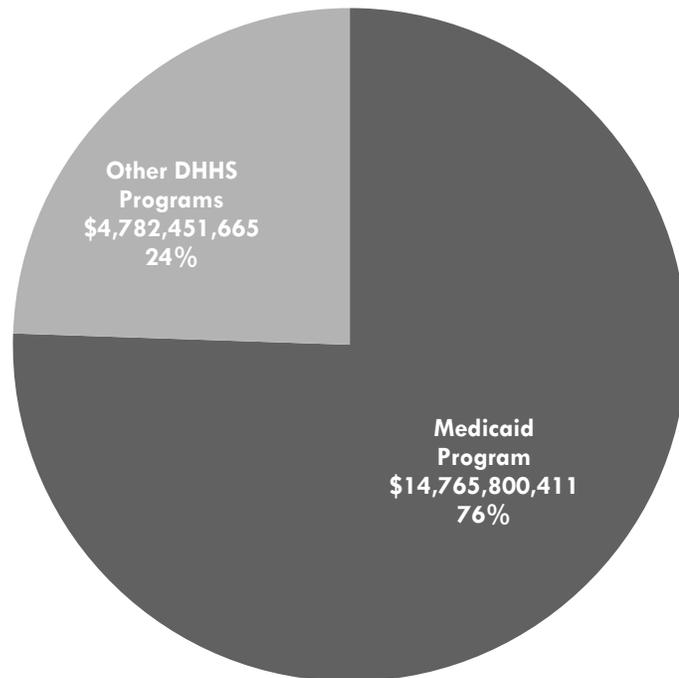
⁵ The number of Medicaid beneficiaries served is an unduplicated count for Fiscal Year 2011–12. The average number of monthly Medicaid beneficiaries is 1.5 million.

Because Medicaid Program services are an entitlement and because Medicaid expenditures play such a significant role in the DHHS budget, discussion of the Medicaid budget overshadows the other health and human services programs managed by DHHS. When the Medicaid Program faces budget shortfalls, the Governor and the Legislature must focus on solving problems, which limits funding for and attention to other DHHS programs. Conversely, DHHS uses the Medicaid Program to maximize federal revenue to benefit departmental programs or to cover administrative overhead throughout the department through its federally approved public assistance cost allocation plans.

Exhibit 2

Three-Fourths of Total Expenditures for the Department of Health and Human Services Go to the Medicaid Program

Total Fiscal Year 2011–12 DHHS Expenditures = \$19.5 Billion



Notes: The expenditures for the Medicaid Program combine expenditures for the Division of Medical Assistance and the costs related to Medicaid administration incurred by other DHHS divisions and offices. The expenditures for Other DHHS Programs do not include expenditures for Medicaid program administration.

Source: Program Evaluation Division based on information from the Office of the State Controller and the Department of Health and Human Services.

During the past three legislative sessions, growth in the Medicaid Program budget has caused funding shortfalls that required the General Assembly to take action. In 2010, the legislature authorized extraordinary measures to address a potential federal funding reduction of \$518.9 million. During the 2012 Session, the General Assembly passed two bills to address the Fiscal Year 2011–12 Medicaid funding shortfall resulting from inaccurate budget forecasting, repayments to the federal government, and unachievable budget reductions. Reviewing the current organizational structure of North Carolina’s Medicaid Program provides an opportunity to consider whether a different structure can improve the management and operation of the program.

Questions and Answers

1. How does North Carolina administer the Medicaid Program?

The North Carolina Medicaid Program is required to operate within federal guidelines and perform nine administrative functions.

- **Beneficiary outreach and enrollment.** Informing individuals who are potentially eligible for Medicaid and enrolling those who are eligible.
- **Defining the scope of covered benefits.** Determining the amount, duration, and scope of mandatory and optional services covered by Medicaid and in what settings services can be provided.
- **Setting provider and plan rates.** Determining how much the Medicaid Program pays for covered benefits.
- **Enrolling providers and plans.** Setting standards for qualifying and enrolling providers that meet the standards.
- **Payment of providers and plans.** Processing claims from fee-for-service providers and making capitation payments to managed care plans.⁶
- **Monitoring service quality.** Monitoring quality of purchased services.
- **Ensuring program integrity.** Ensuring state and federal Medicaid funds are not spent improperly or fraudulently.
- **Processing appeals.** Resolving grievances or disputes by applicants, enrollees, providers, and managed care plans.
- **Collecting and reporting information.** Collecting and reporting information to the federal government necessary for effective program administration and accountability.

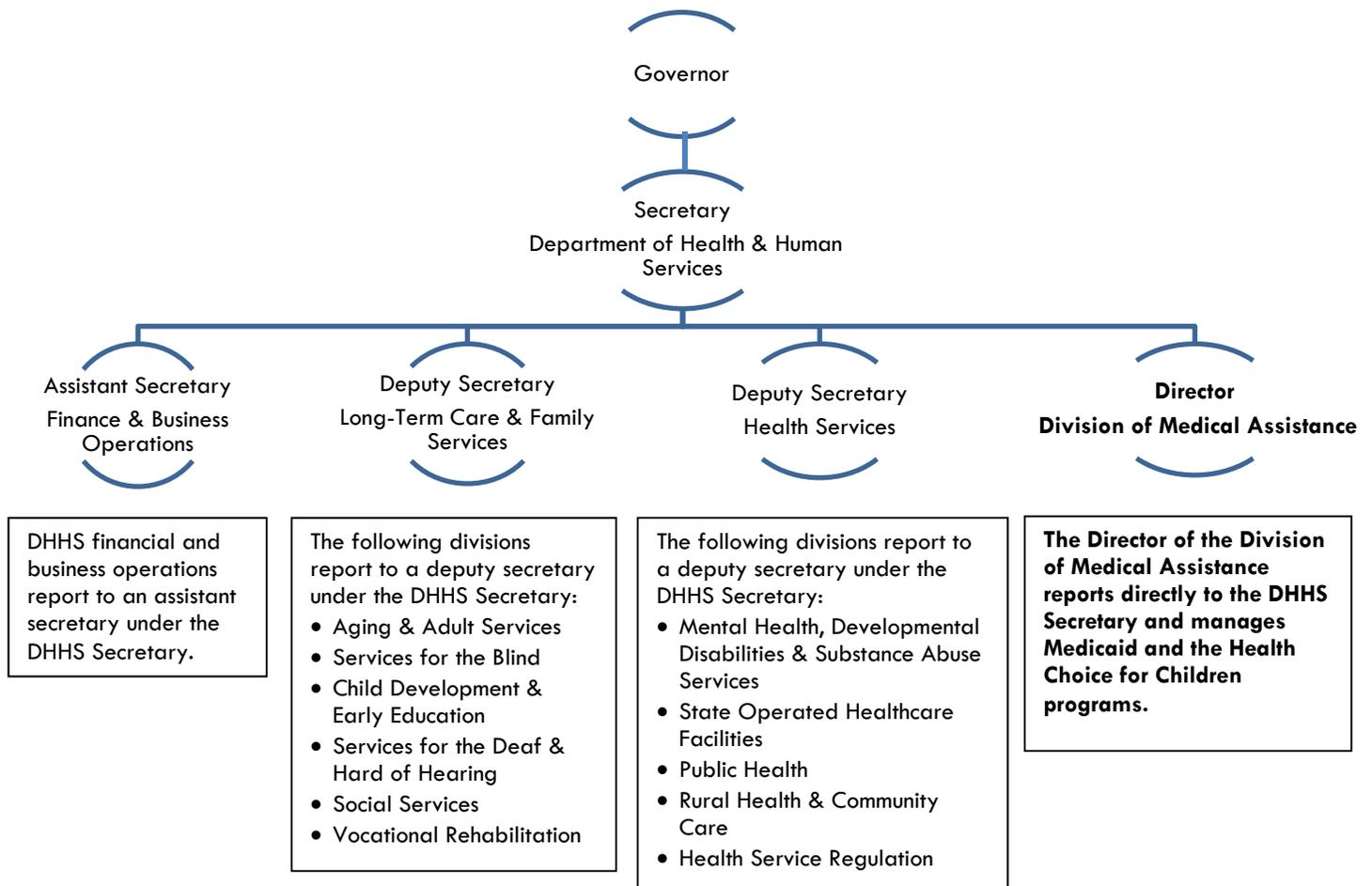
The federal government supports state administration by providing matching funds and establishing general programmatic guidelines. State Medicaid Programs must operate within federal guidelines, but states retain broad flexibility in operating their programs.

North Carolina's Medicaid State Plan designates the Department of Health and Human Services (DHHS) as the single state agency responsible for administering the Medicaid Program. The Division of Medical Assistance (DMA) is responsible for day-to-day management of the Medicaid Program and functions as a division within DHHS. As shown in Exhibit 3, DMA's director reports directly to the DHHS Secretary. All other divisions, offices, and programs within DHHS report to a deputy or assistant secretary. In addition to reporting to the DHHS Secretary, DMA's director serves as a member of DHHS's executive management team. The DHHS Secretary also oversees other health and human services programs that interact with and receive funding from the Medicaid Program.⁷

⁶ Capitation payments are annual fees paid to a health maintenance organization for each participant in a health plan.

⁷ This description reflects the DHHS organizational structure as of December 31, 2012, and before the administration changed in 2013.

Exhibit 3: The Division of Medical Assistance Reports Directly to the DHHS Secretary



Source: Program Evaluation Division based on the organizational chart of the Department of Health and Human Services.

As the single state agency authorized to administer the Medicaid Program, DHHS can delegate administrative functions to other state agencies, local government agencies, or private entities. Exhibit 4 shows how these administrative functions are performed for the North Carolina Medicaid Program.

- **DMA.** As the DHHS division responsible for managing the day-to-day operation of the Medicaid Program, DMA performs some aspects of all federally required Medicaid administrative functions, but contractors and other state and local entities also assist with each function. DMA has 419.5 full-time equivalent positions to operate the Medicaid Program.
- **Other DHHS divisions.** DHHS divisions other than DMA assist with four Medicaid administrative functions including beneficiary outreach and enrollment, setting provider and plan rates, monitoring service quality, and processing appeals. See Exhibit 5 for more information on activities performed by other DHHS divisions.

- **Other state and local government entities.** State and local entities handle some aspects of four Medicaid administrative functions. The Medicaid Investigations Division in the Department of Justice ensures program integrity by investigating and prosecuting health care fraud committed by Medicaid providers. The Office of Administrative Hearings handles contested appeals for Medicaid applicants, beneficiaries, and providers. County departments of social services receive Medicaid funding to enroll eligible individuals into the Medicaid Program and handle eligibility appeals.
- **Contractors.** DMA utilizes private contractors for every administrative function except for beneficiary outreach and enrollment.⁸

Exhibit 4: Other Government Entities and Contractors Perform Medicaid Administrative Functions

Administrative Functions	Division of Medical Assistance	Other State or Local Government Entity	Contractor
Beneficiary outreach and enrollment	✓	County Departments of Social Services Disability Determination Services	
Defining the scope of covered benefits	✓		✓
Setting provider and plan payment rates	✓	DHHS Central Administration	✓
Enrolling providers and plans	✓		✓
Payment of providers and plans	✓		✓
Monitoring service quality	✓	Division of Mental Health, Developmental Disabilities & Substance Abuse Services Division of Health Service Regulation	✓
Ensuring program integrity	✓	Department of Justice	✓
Processing appeals	✓	Office of Administrative Hearings DHHS Central Administration County Departments of Social Services	✓
Collecting and reporting information	✓		✓

Notes: Disability Determination Services is a part of the Division of Vocational Rehabilitation Services. Staff processing Medicaid appeals are funded through the Division of Medical Assistance but report to DHHS’s Assistant Secretary of Finance and Business Operations.

Source: Program Evaluation Division based on document review and interviews with the Division of Medical Assistance.

⁸ Federal law prohibits a state Medicaid agency from delegating responsibility for final eligibility determinations to private contractors (Section 1902(a)(5) of the Social Security Act, 42 U.S.C. 1396a(a)(5)).

In addition to assisting with Medicaid administrative functions, other DHHS divisions provide general administrative support to the North Carolina Medicaid Program. Because DHHS is a large umbrella agency, many general administrative functions are consolidated and provided at the department level for all DHHS divisions, offices, and programs. Most general administrative functions in DHHS are provided by divisions and offices under the Assistant Secretary for Finance and Business Operations and include the

- Office of the Controller;
- Division of Budget and Analysis;
- Office of Internal Audit;
- Office of Procurement and Contracted Services;
- Division of Human Resources;
- Division of Property and Construction;
- Office of Public Affairs;
- Office of Legal Affairs;
- Central Regional Maintenance; and
- Office of Governmental Relations.⁹

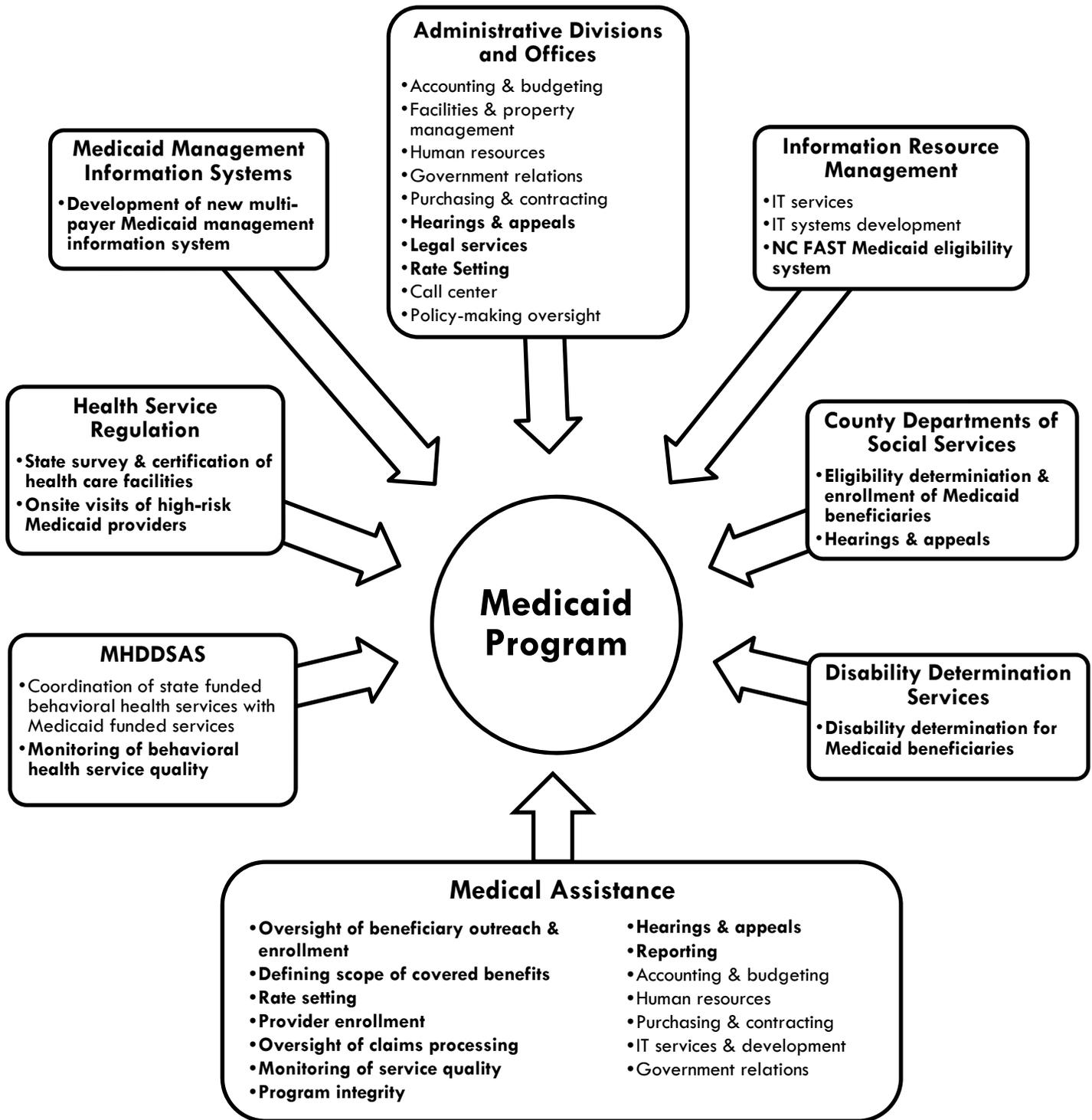
Information technology development and services are provided by the Division of Information Resource Management (DIRM). DIRM is charged with developing the new eligibility determination and case management system for Medicaid and other public assistance programs which is called North Carolina Families Accessing Services through Technology (NC FAST). The Office of Medicaid Management Information Systems (OMMIS) is charged with overseeing the development of the new Medicaid information management system that will serve as the multi-payer claims processing system for the Medicaid program and other health care benefits provided through DHHS. DIRM and OMMIS also report to the Assistant Secretary for Finance and Business Operations.¹⁰ Exhibit 5 summarizes how DHHS supports general administrative functions for the Medicaid Program and assists the Division of Medical Assistance with Medicaid administrative functions.

In sum, the Medicaid State Plan designates DHHS as the single state agency responsible for administering the Medicaid Program in North Carolina. The Medicaid Program must operate within federal guidelines and perform federally required administrative functions, but it has broad flexibility in how it manages the program. DHHS has delegated Medicaid administrative functions to the Division of Medical Assistance, other DHHS divisions and offices, other state agencies, local government agencies, and private contractors.

⁹ This description reflects the DHHS organizational structure as of December 31, 2012, and before the administration changed in 2013.

¹⁰ This description reflects the DHHS organizational structure as of December 31, 2012, and before the administration changed in 2013.

Exhibit 5: Department of Health and Human Services Provides General Administrative Services to the Medicaid Program and Assists with Medicaid Program Functions



Bolded Activities = Medicaid administrative function **Unbolded Activities** = General DHHS administrative function

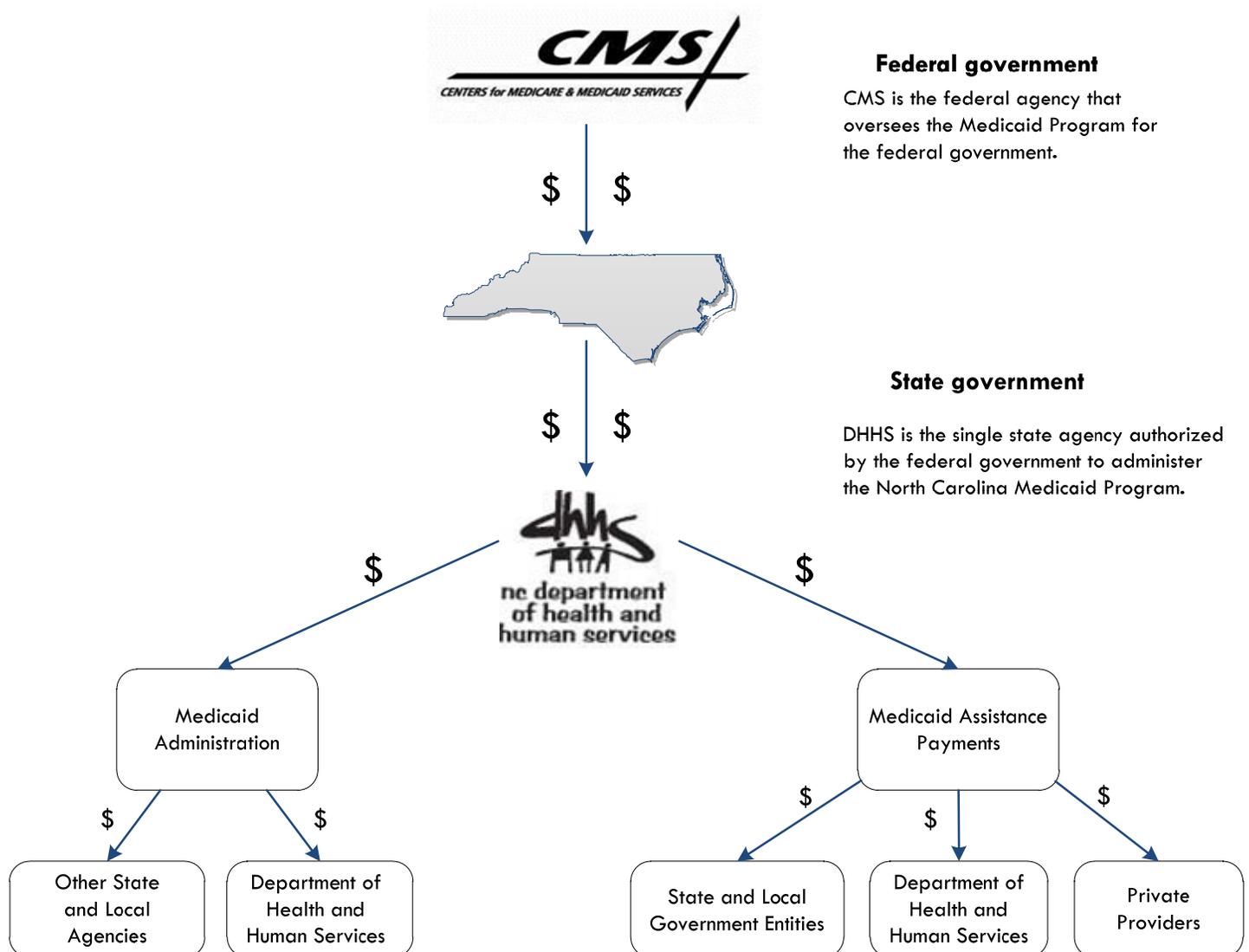
Notes: Disability Determination Services is a part of the Division of Vocational Rehabilitation Services. MHDDSAS is the acronym for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. This exhibit excludes divisions and offices that administer programs that serve Medicaid beneficiaries.

Source: Program Evaluation Division based on document review and interviews with the Division of Medical Assistance.

2. How does North Carolina pay for the Medicaid Program?

North Carolina receives federal matching funds for the Medicaid Program for providing medical services to eligible beneficiaries and administering the program. Federal funds flow to the State from the Centers for Medicare and Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The North Carolina Department of Health and Human Services (DHHS) receives federal funds because North Carolina’s Medicaid State Plan designates it as the single state agency responsible for administering the Medicaid Program. North Carolina must operate a Medicaid program and provide state matching funds to receive federal funds. Exhibit 6 describes how federal funding for the Medicaid Program flows into North Carolina.

Exhibit 6: Federal Government Provides Federal Matching Funds for the Medicaid Program



Federal government

CMS is the federal agency that oversees the Medicaid Program for the federal government.

State government

DHHS is the single state agency authorized by the federal government to administer the North Carolina Medicaid Program.

Source: Program Evaluation Division based on information from the Department of Health and Human Services

The amount of federal funding North Carolina receives is based on matching rates established by CMS. The Federal Medical Assistance Percentage determines the federal share of medical assistance payments to Medicaid providers. A federal Medicaid statutory formula determines the Federal Medical Assistance Percentage using state per capita income. The lower the state’s per capita income, the higher the state’s matching rate. North Carolina’s Federal Medical Assistance Percentage for federal Fiscal Year 2012 was 65.28%, which means the state match was 34.72% for medical assistance payments. The federal financial participation for Medicaid administrative functions is 50%, although some functions receive a higher match rate. The design, development, and installation of a Medicaid management information system receives the highest matching rate. Exhibit 7 describes selected matching rates for the administrative activities that draw down the most federal funds in North Carolina.

Exhibit 7

Selected Matching Rates for Medicaid Administration

Administrative Activity or Function	Matching Rate
Design, development, and installation of MMIS	90%
Management and operation of MMIS	75%
Skilled professional medical personnel	75%
State fraud and abuse control unit activities	75%
State survey and certification	75%
Other program administrative activities	50%

Notes: MMIS is the acronym for the Medicaid Management Information System. By regulation, the matching rate for the cost of upgrading eligibility and enrollment systems incurred before December 31, 2015, is 90%. Other matching rates include electronic health technology, citizenship and immigration verification, reviews of managed care plans, medical and utilization reviews, and preadmission screening.

Source: Medicaid Financing: An Overview of the Federal Matching Rate (FMAP), Kaiser Commission on Medicaid and the Uninsured, September 2012.

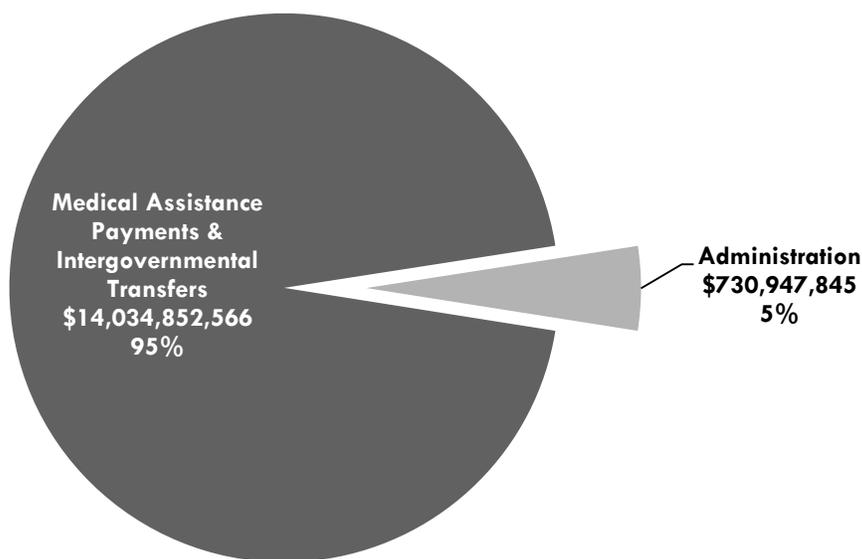
During Fiscal Year 2011–12, DHHS expended \$14.8 billion for medical assistance payments, intergovernmental transfers, and program administration for the Medicaid Program.¹¹ These expenditures represent the total cost for the Medicaid Program because they include spending by DMA and other DHHS divisions and offices. Exhibit 8 shows that 95% of Fiscal Year 2011–12 Medicaid Program expenditures paid for medical assistance payments and intergovernmental transfers. The remaining 5% paid for Medicaid administrative costs incurred throughout DHHS.

¹¹ Intergovernmental transfers are transfers of public funds between governmental entities. The transfer may take place from one level of government to another (i.e., counties to states) or within the same level of government (i.e., from a state university hospital to the state Medicaid agency).

Exhibit 8

Total Fiscal Year 2011–12 Medicaid Program Expenditures = \$14.8 Billion

DHHS Spent 5% of Medicaid Program Expenditures on Administration during Fiscal Year 2011–12



Source: Program Evaluation Division based on information from the Department of Health and Human Services.

The Medicaid Program spent \$730.9 million during Fiscal Year 2011–12 to support Medicaid administrative activities.¹² These expenditures can be grouped into three broad categories.

- Medicaid administration performed by other state and local entities (50%).** County departments of social services, the Department of Justice, and the Office of Administrative Hearings received funding because they performed several Medicaid administrative functions. Local management entities and local education agencies received funding to cover their overhead costs associated with serving Medicaid beneficiaries; they do not perform Medicaid administrative functions.¹³
- Development and implementation of new information technology systems (21%).** The Office of Medicaid Management Information Systems received funding for development of a new multi-payer Medicaid management information system to process and pay claims for Medicaid and other DHHS health care programs. The Division of Information Resource Management received funding for development and implementation of the North Carolina Families Accessing Services through Technology (NC FAST)

¹² The Program Evaluation Division’s calculation of expenditures for Medicaid administration excludes \$50.1 million for Health Information Technology incentive payments paid to Medicaid providers for implementing electronic health record technology.

¹³ Local management entities manage services for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services and receive Medicaid administrative funding to cover administrative costs associated with serving Medicaid beneficiaries. CMS allows local education agencies to receive federal reimbursement for the costs of Medicaid administrative activities performed in the school setting.

system,¹⁴ which will replace the existing eligibility determination and case management system for Medicaid and other public assistance programs.¹⁵

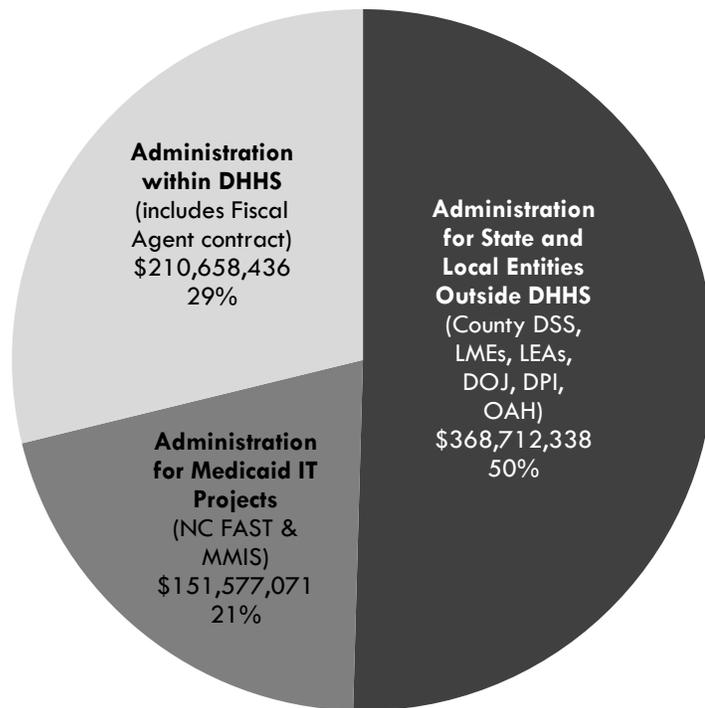
- **Medicaid administration solely performed by DHHS divisions (29%).** Most of DHHS’s expenditures for Medicaid administration were incurred by DMA, but other DHHS divisions and offices also received funding. DMA’s largest expenditure was the payment of \$53.5 million to its fiscal agent to process and pay provider claims for the Medicaid Program.

Exhibit 9 displays how Fiscal Year 2011–12 expenditures for Medicaid administration were spent in these broad categories.

Exhibit 9

DHHS Spent \$730.9 Million for Medicaid Administration

Total Fiscal Year 2011–12 Expenditures for Medicaid Administration = \$730.9 Million



Notes: MMIS is the acronym for the Office of Medicaid Management Information System. NC FAST is the acronym for the North Carolina Families Accessing Services through Technology system. County departments of social services (DSS) received \$231.1 million. Local management entities (LMEs) received \$87.7 million. Local education agencies (LEAs) received \$47 million. The Office of Administrative Hearings (OAH) received \$2.5 million. The Department of Justice (DOJ) received \$346,383. The Department of Public Instruction (DPI) received \$63,156 for the deaf and blind schools.

Source: Program Evaluation Division based on information from the Department of Health and Human Services.

¹⁴ The North Carolina Families Accessing Services through Technology system introduces new technological tools and business processes that enable county departments of social services to spend less time on administrative tasks and more time assisting families.

¹⁵ The Affordable Care Act allowed states to use Medicaid administrative funding to cover the cost of developing and implementing eligibility and enrollment systems for health care programs including Medicaid and Health Choice.

Federal regulations allow DHHS to receive federal reimbursement for costs incurred in support of Medicaid and other public assistance programs.¹⁶ DHHS has federally approved public assistance cost allocation plans identifying how each division or office within the department measures and allocates costs associated with administering the Medicaid Program and other public assistance programs.¹⁷ These plans allow DHHS divisions and offices other than DMA to receive federal Medicaid reimbursement for Medicaid administration because they

- performed Medicaid administrative functions;
- provided general administrative support for the Medicaid Program;
- developed new information technology systems for the Medicaid Program; or
- administered a program serving Medicaid beneficiaries.

Through these cost allocation plans, DHHS maximizes federal reimbursement for Medicaid administration for the department and other state and local entities. Exhibit 10 identifies how 13 DHHS divisions and offices qualify to receive federal reimbursement for Medicaid reimbursement and also provides the same information for six state and local entities. The majority of these entities—seven DHHS divisions and offices and four state and local entities—received reimbursement because some or all of their programs serve Medicaid beneficiaries. County departments of social services and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services also received reimbursement for assisting with Medicaid administration. General administrative support and information technology development for the Medicaid Program were provided by DHHS Central Administration and the Division of Information Resource Management.

¹⁶ See the Office of Management and Budget's Circular No. A-87 for a detailed description of the federal cost allocation process.

¹⁷ The Office of the State Auditor found DHHS lacked a comprehensive cost allocation plan for the department and a separate cost allocation plan for DMA as reported in its 2013 performance audit of the Medicaid Program.

Exhibit 10: Department of Health and Human Services Maximizes Federal Reimbursement for Medicaid Administration

DHHS Division/Office	Provides Medicaid Administration	Provides Administrative Support	Provides Medicaid IT Development	Administers Programs Serving Medicaid Beneficiaries
Medical Assistance	✓			
Medicaid Management Information System			✓	
Public Health				✓
Mental Health, Developmental Disabilities and Substance Abuse Services	✓			✓
Health Service Regulation	✓			
Central Administration	✓	✓		
Social Services				✓
Disability Determination Services	✓			
Information Resource Management (includes NC FAST)		✓	✓	
Rural Health				✓
Aging and Adult Services				✓
Vocational Rehabilitation				✓
Child Development				✓
State and Local Entities				
County Departments of Social Services	✓	✓		✓
Local Management Entities				✓
Local Education Agencies				✓
Office of Administrative Hearings	✓			
Department of Justice	✓			
Department of Public Instruction				✓

Notes: Disability Determination Services is a part of the Division of Vocational Rehabilitation Services. NC FAST is the acronym for the North Carolina Families Accessing Services through Technology system, and the Division of Information Resource Management is responsible for developing this system.

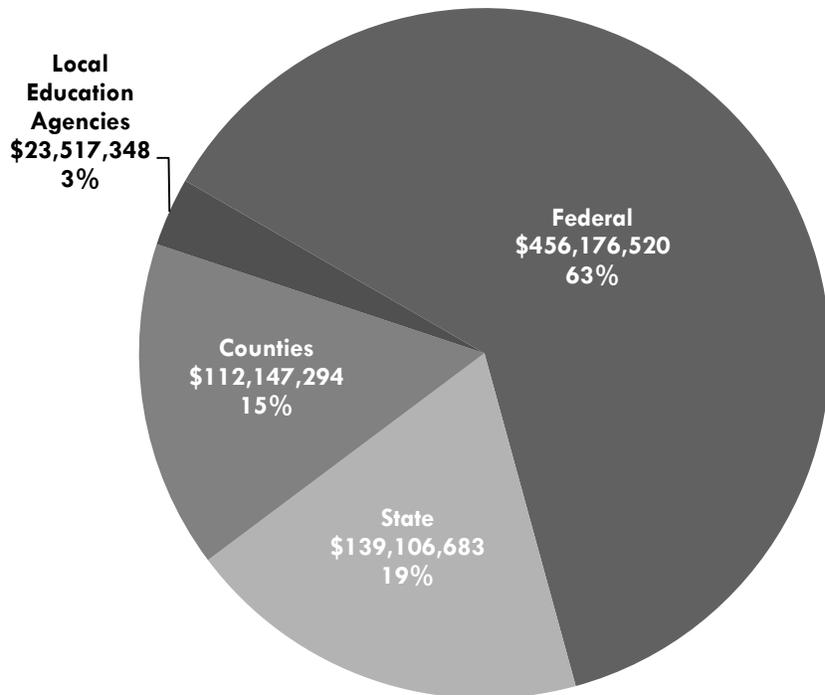
Source: Program Evaluation Division based on information from the Department of Health and Human Services.

Federal reimbursement paid \$456.2 million or 63% of expenditures for Medicaid administration during Fiscal Year 2011–12. The non-federal share of expenditures for Medicaid administration was \$274.8 million. Exhibit 11 shows that state appropriations paid 19% for expenditures for Medicaid administration. Counties paid 15% of expenditures for Medicaid administration for those functions performed by county departments of social services. Through the school-based Medicaid administrative claims process, the Division of Medical Assistance drew down federal reimbursement for local education agencies based on documentation of Medicaid outreach activities and eligible services provided in the school setting. Local education agency expenditures for these activities covered 3% of the expenditures for Medicaid administration for Fiscal Year 2011–12.

Exhibit 11

Federal Funds Paid for 63% of Expenditures for Medicaid Administration for Fiscal Year 2011–12

Fiscal Year 2011–12 Expenditures for Medicaid Administration = \$730.9 Million



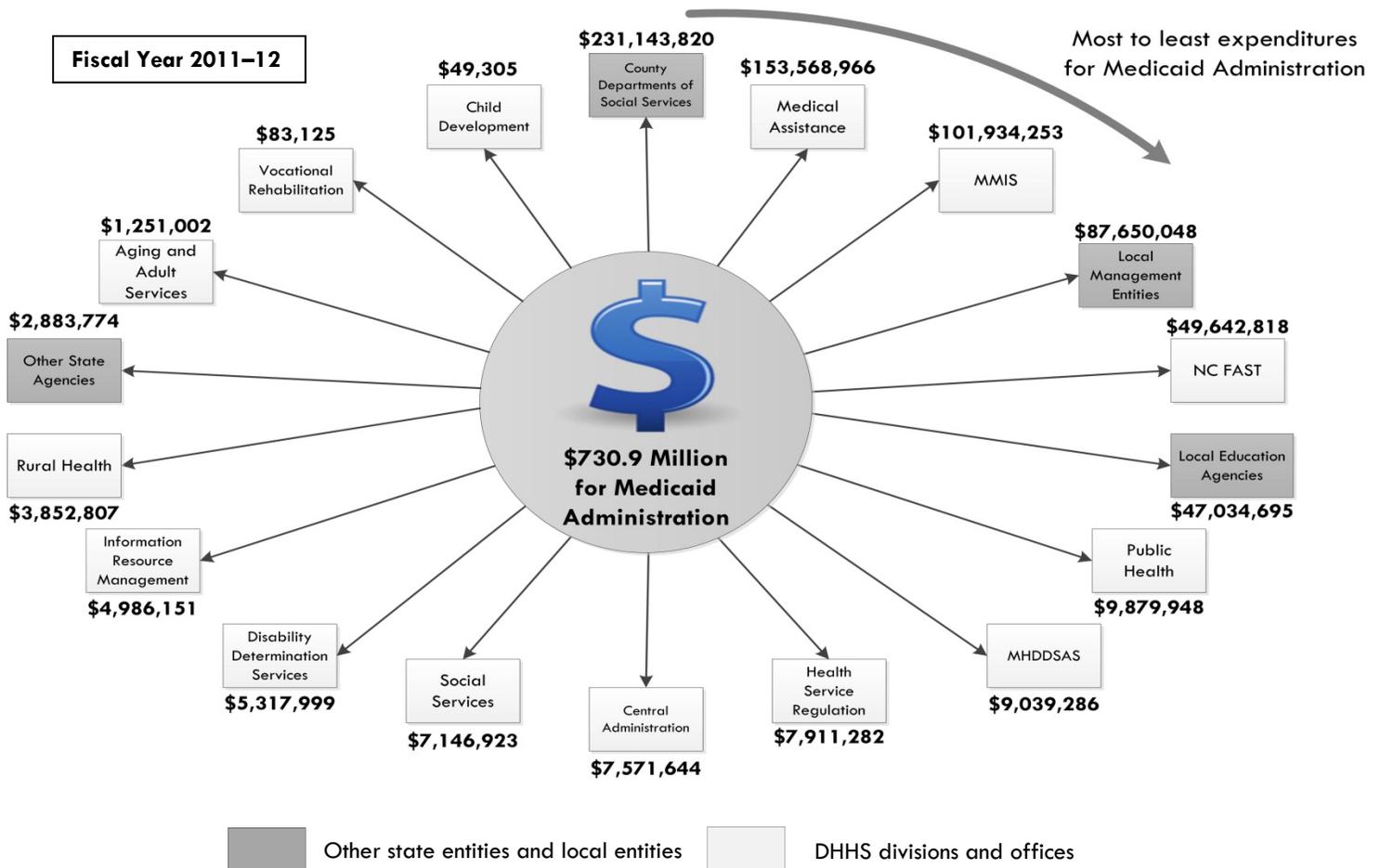
Note: State funding includes \$2,916,820 of county expenditures for American Indian counties that the State is required to cover, \$656,038 transferred from the Office of Administrative Hearings, and \$60,864 from the Health and Wellness Trust Fund.

Source: Program Evaluation Division based on information from the Department of Health and Human Services.

Expenditures for Medicaid administration are spread throughout DHHS and paid to other state and local government entities. Exhibit 12 enumerates the expenditures on Medicaid administration of DHHS and other state and local government entities during Fiscal Year 2011–12. The information is arranged to display expenditures for Medicaid administration in order from the highest to the lowest amount. Expenditures range from \$231.1 million for county departments of social services to \$49,305 for the Division of Child Development in DHHS. County departments of social services spent the most for Medicaid administration

because they perform the enrollment function for the Medicaid Program, provide general administrative support, and administer other programs serving Medicaid beneficiaries. DMA, the DHHS division responsible for the Medicaid Program, spent the second highest amount for Medicaid administration, followed by Medicaid information technology projects, and payments to local management entities and local education agencies for administering programs serving Medicaid beneficiaries. The first six entities shown in Exhibit 12 spent \$671 million or 92% of expenditures for Medicaid administration. DHHS Central Administration and the Division of Information Resource Management spent \$12.6 million to provide administrative support to the Medicaid Program. The DHHS Divisions of Disability Determination Services and Health Service Regulation and other state agencies were paid \$16.1 million to perform Medicaid administrative functions. The remaining DHHS divisions and offices received \$31.3 million for administering programs serving Medicaid recipients.

Exhibit 12: Expenditures for Medicaid Administration Is Spread throughout the Department of Health and Human Services and Includes Other State and Local Government Entities



Notes: Disability Determination Services is a part of the Division of Vocational Rehabilitation Services. MHDDSAS is the acronym for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. MMIS is the acronym for the Office of Medicaid Management Information Systems. NC FAST is the acronym for the North Carolina Families Accessing Services through Technology system. Other state agencies include the Department of Justice (\$346,383), Office of Administrative Hearings (\$2.5 million), and Department of Public Instruction (\$63,156).

Source: Program Evaluation Division based on financial information from the Department of Health and Human Services.

Federal reimbursement for Medicaid administration supports positions throughout DHHS. Exhibit 13 summarizes how funding for Medicaid administration supports DHHS personnel expenditures.

- **Authorized positions.** This column shows the number of authorized positions in each DHHS division or office. These DHHS divisions and offices had 6,787.5 authorized positions in Fiscal Year 2011–12.
- **Affected positions.** Positions included in this column have a portion of their cost supported by Medicaid reimbursement. Over 2,000 positions in DHHS received some support from the Medicaid Program in Fiscal Year 2011–12.
- **Percent affected.** This column calculates the percentage of authorized positions in each DHHS division and office supported by the Medicaid Program. The percentage of affected positions ranged from 1% to 100%. Across these DHHS divisions and offices, 30% of authorized positions received Medicaid reimbursement.
- **Number of FTEs.** This column displays the number of full-time equivalent (FTE) positions supported by Medicaid reimbursement. The number of FTEs is lower than affected positions because most affected positions, other than DMA positions, were supported from multiple funding sources including state appropriations and other federal funds. Medicaid reimbursement supported 973.34 FTE during Fiscal Year 2011–12.
- **Personnel expenditures.** This column enumerates the amount of expenditures for Medicaid administration supporting DHHS personnel. DHHS spent \$94.2 million on DHHS personnel, which amounts to 13% of the \$730.9 million expended for Medicaid administration during Fiscal Year 2011–12.

Exhibit 13: Federal Reimbursement for Medicaid Administration Supports Positions Throughout the Department of Health and Human Services

DHHS Divisions and Offices	Fiscal Year 2011–12				
	Authorized Positions	Affected Positions	Percent Affected	Number of FTEs	Personnel Expenditures
Division of Medical Assistance	419.50	419.50	100%	419.50	\$ 36,306,588
NC FAST	124.00	124.00	100%	92.69	10,878,387
Division of Information Resource Management	200.00	139.00	70%	62.15	7,926,554
Division of Health Service Regulation	558.50	201.00	36%	62.06	7,515,291
Division of Mental Health, Developmental Disabilities and Substance Abuse Services	180.00	162.00	90%	99.18	7,490,667
Office of Medicaid Management Information Management Systems	67.00	67.00	100%	67.00	6,458,794
Division of Disability Determination	762.00	162.00	21%	37.35	5,311,595
Central Administration	490.75	353.75	72%	49.25	3,996,051
Division of Public Health	2,116.00	168.00	8%	44.44	3,416,503
Division of Social Services	416.00	185.00	44%	16.67	2,398,531
Office of Rural Health	45.00	33.00	73%	18.71	1,162,643
Division of Aging and Adult Services	73.50	16.00	22%	3.88	1,233,243
Division of Vocational Rehabilitation	1,030.50	14.75	1%	0.16	31,970
Division of Child Development	304.75	4.00	1%	0.29	49,305
Fiscal Year 2011–12 Totals	6,787.50	2,049.00	30%	973.34	\$ 94,176,122

Notes: FTE is the acronym for full-time equivalent position. FTEs represent current budgeted positions and are calculated based on Fiscal Year 2011–12 statistical cost data. NC FAST is the acronym for the North Carolina Families Accessing Services through Technology system. Central Administration includes the Office of the Controller, Central Regional Maintenance, Division of Human Resources, Division of Budget and Analysis, Office of Procurement and Contracted Services, Executive Office of the Secretary, Office of Internal Audit, Office of Legal Affairs, Office of Property and Construction, and Office of Public Affairs.

Source: Program Evaluation Division based on information from the Department of Health and Human Services.

Several DHHS divisions receive medical assistance payments for services provided to Medicaid beneficiaries or supervise local entities receiving medical assistance payments. As an umbrella agency for health and human service programs, DHHS manages programs and state operated facilities providing direct services to Medicaid beneficiaries. The following DHHS divisions are enrolled as Medicaid providers:

- Division of Public Health;
- Division of Services for the Blind;

- Division of Mental Health, Developmental Disabilities and Substance Abuse Services; and
- Division of Vocational Rehabilitation.

DHHS also supervises and sets policy for local entities enrolled as Medicaid providers including local management entities, local health departments, and county departments of social services. State institutions operated by DHHS's Division of State Operated Healthcare Facilities also receive medical assistance payments for services provided to Medicaid beneficiaries.¹⁸ Having programs receiving medical assistance payments co-located in the same department overseeing the Medicaid Program means that DHHS leadership must balance the competing priorities of cost containment for the Medicaid Program and federal revenue maximization for other DHHS programs.

In sum, DHHS expended \$14.8 billion for the Medicaid Program including \$730.9 million to support Medicaid administrative activities. Expenditures for Medicaid administration are spread throughout DHHS and include other state and local government entities because they performed Medicaid administrative functions, provided general administrative support, developed new information technology systems for the Medicaid Program, or administered a program serving Medicaid beneficiaries.

3. How do other states administer their Medicaid Programs?

The legislation mandating this evaluation specifically directed the Program Evaluation Division to review how other states administer their Medicaid Programs. To accomplish this task, the Program Evaluation Division examined trends for Medicaid administration within the United States, reviewed internal studies examining different structures for the North Carolina Medicaid Program, and conducted a targeted review of six state Medicaid programs administered as stand-alone departments or as divisions of a health care agency.

In the United States, all 50 states, five territories, and the District of Columbia administer Medicaid programs to provide health care services to low-income individuals. Under the broad federal guidelines for administering the Medicaid Program, these 56 programs exist amid a diverse range of administrative structures that make each Medicaid program unique. The National Association of Medicaid Directors surveyed Medicaid directors in 2012 and received responses from 45 of the 56 programs.¹⁹ Survey information revealed that the agency in state government administering the Medicaid program may be organized quite differently across states. Two-thirds of states reported their Medicaid programs are part of a larger umbrella agency, which often houses other health and human services programs. In a quarter of states, the Medicaid

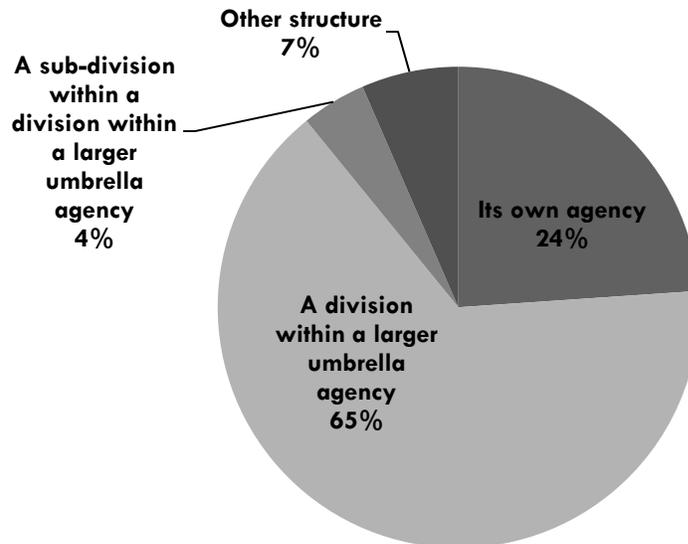
¹⁸ State institutions include Alcohol and Drug Abuse Treatment Centers, Developmental Centers, Neuro-Medical Treatment Centers, Psychiatric Hospitals, and Residential Programs for Children.

¹⁹ The National Association of Medicaid Directors is a 501(c)(3) entity created in large part to help Medicaid directors develop consensus on critical issues and leverage their influence with respect to national policy debates. The Association also exists to facilitate dialogue amongst its members in the 50 states, five territories, and the District of Columbia and to help provide best practices and technical assistance.

program is a stand-alone department, and the remaining 11% of states have some alternative organizational structure (see Exhibit 14). In the vast majority of states, including North Carolina, the Medicaid director reports to an agency head or other executive office, whereas 15% of the directors report directly to their governors.

Exhibit 14

The Medicaid Program Is a Stand-Alone Department in a Quarter of the States Reporting



Source: National Association of Medicaid Directors, 1st Annual Medicaid Operations Survey: Chart Book, 2012.

Two internal studies have examined different structures for administering the North Carolina Medicaid Program. Both studies examined Medicaid programs in other states and offered options for changing the Medicaid Program's organizational structure. These studies were not reported to the General Assembly.

- **Analysis of Medicaid Staffing and Organization (2010).** The Office of State Budget and Management (OSBM) was directed to conduct an analysis of the staffing, organization, and business process for the Medicaid Program operated by the Department of Health and Human Services (DHHS). OSBM analysts conducting this study visited the Alabama and Oklahoma Medicaid Programs to examine Medicaid management in these states. The report found the following issues related to the management of the Medicaid Program:
 - the organizational culture within the Division of Medical Assistance focuses on providing the maximum medical benefit to eligible citizens with less emphasis placed on cost containment;
 - organizational design of the Medicaid Program was fragmented within DHHS;
 - many administrative and information technology functions provided by other divisions within DHHS were not under the control of the Division of Medical Assistance;
 - more staff was needed to meet needs resulting from program growth;

- limitations on salary scales made retaining knowledgeable staff difficult; and
- communication was inhibited by staff located in multiple locations.

The report offered several recommendations for removing the Medicaid Program from DHHS and creating a health care authority using the Oklahoma Medicaid Program as a model or a separate Department of Medicaid. One option suggested merging administration of the State Health Plan into a new Medicaid Agency to create a state health insurance agency. No executive action was taken to implement any of the recommendations.

- **North Carolina Health Benefits Management Plan (2011).** DHHS contracted with consultants to identify options for improving the management of the Medicaid Program and the State Employees' Health Plan. The goal was to improve service delivery, meet participants' needs, and reduce administrative costs. The consultants conducting this study examined how seven states manage their health benefits including Medicaid and state employee health care programs.²⁰ The study considered three options:
 - maintaining the status quo and separation of the programs;
 - common governance structure for the programs; and
 - integrated governance structure with a health care authority managing the programs.

The report recommended full integration of the Medicaid Program and the State Health Plan as the best option to achieve cost savings and improvements in purchasing, oversight, and health care delivery. No executive action was taken to implement any of the recommendations. However, the General Assembly moved management of the State Employees' Health Plan to the Department of State Treasurer in 2011.²¹

The Program Evaluation Division interviewed and reviewed documents for six states with stand-alone Medicaid agencies or Medicaid programs within a health care agency. The more detailed review of how some states structure the administration of their Medicaid programs focused on stand-alone Medicaid agencies. The Program Evaluation Division also reviewed two states with Medicaid programs within a health care agency as another alternative. The states selected for the in-depth review—Alabama, Mississippi, Ohio, Oklahoma, Oregon, and Washington—met two or more of the following criteria:

- located in a stand-alone Medicaid department (Alabama, Mississippi, Ohio, and Oklahoma);
- located in a health care agency (Oregon and Washington);
- located in a southeastern state (Alabama and Mississippi);
- changed its Medicaid administrative structure during the past five years (Ohio, Oregon, and Washington); and

²⁰ The seven states included Florida, Kansas, Maryland, Oklahoma, Oregon, Vermont, and Washington.

²¹ N. C. Sess. Law, 2011-85.

- reviewed by other studies of Medicaid program administration (Alabama, Oklahoma, Oregon, and Washington).

Exhibit 15 provides information about the six states with stand-alone Medicaid agencies or Medicaid programs within a health care agency.

- **Program structure.** Four states have stand-alone Medicaid agencies and two states operate their Medicaid Programs within health care agencies. Among the four stand-alone agencies, only Mississippi's Medicaid Program started as a stand-alone agency and has not changed. The Medicaid Programs in Alabama, Oklahoma, and Ohio started in a human services agency and were moved to a stand-alone Medicaid department. In Oregon and Washington, the Medicaid Programs were moved from human services agencies into health care agencies that include other health care programs. The Oregon and Washington health care agencies also manage the health care benefits programs for state employees.
- **Reporting.** The Medicaid Programs in Alabama, Mississippi, Ohio, and Washington report directly to their Governor. In Oklahoma, the Medicaid Program reports to the Oklahoma Healthcare Authority Board appointed by the Governor and the Legislature. In Oregon, the director of the Division of Medical Assistance reports to the Director of the Oregon Health Authority.

Exhibit 15: Stand-Alone and Health Care Medicaid Agencies in Selected States

State	Medicaid Program Name (Year Structure Established)	Program Structure	Program Reports to	Monthly Medicaid Enrollment	Total Medicaid Expenditures
Alabama	Alabama Medicaid Agency (1977)	Stand-alone agency	Governor	783,083	\$ 4,748,845,604
Mississippi	Mississippi Division of Medicaid (1969)	Stand-alone agency	Governor	600,533	\$ 4,145,597,358
Ohio	Ohio Department of Medicaid (2013)	Stand-alone agency	Governor	1,937,176	\$15,261,773,582
Oklahoma	Oklahoma Health Care Authority (1993)	Stand-alone agency	Oklahoma Health Care Authority Board	601,315	\$ 4,119,103,272
Oregon	Division of Medical Assistance, Oregon Health Authority (2009)	Health care agency	Director, Oregon Health Authority	455,486	\$ 4,007,017,494
Washington	Washington Health Care Authority (2011)	Health care agency	Governor	1,036,615	\$ 7,062,773,112

Notes: The Oklahoma Healthcare Authority Board is the decision-making authority appointed by the Governor and Legislature. The Oregon Health Authority includes the Division of Medical Assistance, Addictions and Mental Health Division, Public Health Authority, Oregon Medical Insurance Pool, Office of Private Health Partnerships, Public Employees Benefit Board, and Oregon Educators Benefit Board. The Washington Health Care Authority includes Medicaid, Public Employees Benefits Board, Basic Health and other health activities. The Monthly Medicaid Enrollment and Total Expenditures are as of June 2010. Monthly Medicaid enrollment presents a "point-in-time" monthly Medicaid enrollment count for June 2010 and differs from the total unduplicated annual enrollment which includes every person enrolled in Medicaid one month or more during the time period.

Source: Program Evaluation Division based on interviews with Medicaid directors in other states, review of documents from other states, and Kaiser Family Foundation.

- **Medicaid program size.** Among the six states reviewed, Ohio and Washington have the largest Medicaid Programs based on monthly enrollment and total expenditures. The Medicaid Programs in Alabama, Mississippi, Oklahoma, and Oregon have monthly enrollments and total expenditures that are considerably smaller.

These states perform the nine administrative functions required by federal guidelines through in-house staff, private contractors, and other state and local entities. Exhibit 16 summarizes how these states administer their Medicaid Programs.

- **Number of positions.** Among the six states reviewed, Oregon has the smallest Medicaid Program. States performing beneficiary outreach and enrollment with in-house staff have more positions than states relying on other state and local entities to perform that administrative function. Mississippi, Washington, and Alabama have the largest number of positions, and these states have in-house staffs performing the enrollment function.
- **Managed Care.** The Medicaid Programs in Alabama and Oklahoma use Primary Care Case Management (PCCM) providers to manage care services. The Mississippi, Ohio, Oregon, and Washington Medicaid Programs contract with and pay capitation fees to Commercial and Medicaid-Only Managed Care Organizations (CMOs and MCOs) that provide services to Medicaid beneficiaries. Five of six states have over half of their Medicaid beneficiaries enrolled in managed care; Mississippi has the lowest percentage of Medicaid beneficiaries enrolled in managed care (8%).
- **In-house staff.** The Medicaid Programs in Mississippi, Oklahoma, Oregon, and Washington perform most administrative functions with in-house staff. The Alabama and Ohio Medicaid Programs utilize contractors and other state and local entities to perform most administrative functions.
- **Contractors.** Under federal law, states may contract with private entities for eight of the nine administrative functions; the beneficiary outreach and enrollment function is the exception. The Alabama Medicaid Program uses contractors for five administrative functions. The other five states contract for only one or two administrative functions. Payment of providers and plans is the one function performed by contractors in all six states.
- **Other state and local entities.** Medicaid programs in these states utilize other state and local entities to perform beneficiary outreach and enrollment, ensure program integrity, and process appeals. In Alabama, Oklahoma, Oregon, and Washington, the human services agencies perform some or all of the enrollment function. The Ohio Medicaid Program uses other state and local entities to perform five of the nine administrative functions, including having county departments of social services performing the enrollment and appeals functions.

Exhibit 16: Medicaid Administration in States with Stand-Alone or Health Care Agencies

Administrative Function	Alabama	Mississippi	Ohio	Oklahoma	Oregon	Washington
Number of Positions	611	1,012	430	502	379	983
Managed Care	Primary Care Case Management	Medicaid Managed Care Organization	Medicaid Managed Care Organization	Primary Care Case Management	Commercial and Medicaid Managed Care Organization	Commercial Managed Care Organization
Percentage Enrolled in Managed Care	59%	8%	75%	64%	77%	62%
Beneficiary outreach and enrollment	In-house and Social Security Administration	In-house	Counties	Online enrollment and Department of Human Services	In-house and Department of Human Services	Shared with Department of Social and Human Services
Defining the scope of covered benefits	In-house	In-house	In-house	In-house	In-house	Managed care health plans
Setting provider and plan rates	In-house	In-house and Contractor	In-house, except nursing home and intermediate care	In-house	In-house	In-house
Enrolling providers and plans	Standards: In-house Enrollment: Contractor	In-house	In-house in conjunction with licensing boards	In-house	In-house	In-house
Payment of providers and plans	Contractor	Contractor	Contractor with in-house call center	Contractor	In-house and Contractor	In-house and Contractor
Monitoring service quality	In-house and Contractor	In-house	Contractor	In-house	In-house	In-house and Contractor
Ensuring program integrity	In-house and Contractor	In-house	In-house in coordination with Attorney General and with State Auditor	In-house	In-house and Department of Human Services	In-house
Processing appeals	In-house	In-house	Shared with counties	In-house	In-house	In-house
Collecting and reporting information	In-house and Contractor	In-house	In-house	In-house	In-house	In-house

Note: .05% of Oregon's Medicaid beneficiaries are enrolled in primary care case management.

Source: Program Evaluation Division based on interviews with Medicaid directors in other states and U.S. Department of Health and Human Services, Centers for Medicare/Medicaid Services, Medicaid Managed Care Enrollment Report: Summary Statistics as of July 1, 2011.

Ohio, Oklahoma, Oregon, and Washington decided to change the administrative structure of their Medicaid Programs because of concerns about health care costs and program performance.

Oklahoma and Ohio created a stand-alone Medicaid agency to

- elevate the Medicaid Program's status within state government;
- provide stronger leadership and focus;
- increase accountability for program costs; and
- improve program performance and efficiency.

Oregon and Washington moved their Medicaid Programs into a health care agency to

- establish a single point of accountability for health and health care costs;
- leverage the purchasing power of multiple health care programs;
- focus state health reform efforts; and
- improve program performance and efficiency.

Oklahoma, Ohio, Oregon, and Washington emphasized the importance of transition planning before changing the administrative structure of their Medicaid Programs.

These states waited six months to two years to complete the transition to a separate Department of Medicaid or a health care agency. The transition period allowed time to determine the staff, contracts, equipment, and physical space that would be moved or affected by changes in the administrative structure of their Medicaid Programs. Steering committees and work groups mapped out processes and procedures and brought staff together to discuss why making changes were important. Two examples of a transition to a stand-alone Medicaid department are described below.

- **Oklahoma.** The Oklahoma Health Care Authority was established through legislation in 1993 to convert the Medicaid program to a managed care system. A board of directors, appointed by the Governor and the Legislature, hired the Chief Executive Officer. During 1994, approximately 20 new staff were hired to create the new agency, write and submit Medicaid managed care waivers to the federal government, and plan for the transfer and integration of the Medicaid program from Department of Human Services. In 1995, the Medicaid program was transferred to the Oklahoma Health Care Authority. Other positions were transferred from the Department of Human Services to support the ongoing information technology, finance, and personnel functions of the Authority. The original legislation establishing the Oklahoma Health Care Authority anticipated that the Oklahoma State Employees' health plan might also be transferred to the Authority for oversight, but it was never moved. Today the Oklahoma Health Care Authority directly manages most of Oklahoma's Medicaid program.
- **Ohio.** In 2011, the Governor of Ohio created the Office of Health Transformation to modernize Ohio's Medicaid Program

that was managed by a division in the Ohio Department of Job and Family Services. Based on recommendations from prior studies and the Office of Health Transformation, legislation was enacted in 2012 to create the Office of Medical Assistance as a work unit within the Ohio Department of Job and Family Services and to transfer legal authority for the Medicaid Program from the director of the Ohio Department of Job and Family Services to the Office of Medical Assistance Director. The Office of Medical Assistance Director has been appointed by the Governor and is leading the effort to transform the Ohio Medicaid Program into a stand-alone department by 2013.

In sum, most state Medicaid Programs are located in a larger umbrella department that includes other health and human services programs, but some states have established stand-alone departments to operate their Medicaid Programs. States reported that the benefits of establishing a stand-alone Medicaid department or a healthcare agency were a higher level of visibility in state government for the Medicaid Program and a clearer focus by the health care agency to work toward more efficient health care purchasing. The states also emphasized the importance of transition planning before changing how the Medicaid program is administered.

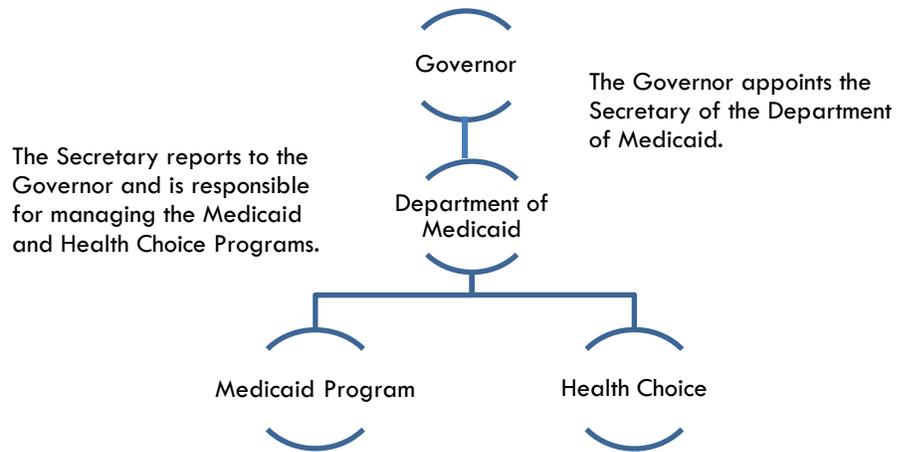
4. What Options Exist for Creating a Separate Department of Medicaid in North Carolina?

The legislation requiring this evaluation directed the Program Evaluation Division and Fiscal Research Division to study the feasibility of creating a separate department of Medicaid and to identify other Medicaid organizational structures. Based on examples in other states and two internal studies within North Carolina, the Program Evaluation Division identified three possible organizational structures for the North Carolina Medicaid Program. These options assume county departments of social services will continue to perform the beneficiary and enrollment function for the Medicaid Program because it would be inefficient to create a separate Medicaid eligibility function.

- **Department of Medicaid.** This option uses the organizational structure of the Alabama and Ohio Medicaid Programs as a model. The Department of Medicaid would become the single state agency designated in the North Carolina Medicaid State Plan to administer the Medicaid Program and receive federal funds from the U.S. Centers for Medicare/Medicaid Services (CMS). Responsibility and funding for the Medicaid and Health Choice Programs would be transferred to the new Department of Medicaid. The Department of Health and Human Services (DHHS) would continue to operate all other health and human services programs. The Department of Medicaid would establish rules and policies for the Medicaid and Health Choice Programs. The Governor would appoint the Secretary for the Department of Medicaid who would report to the Governor (see Exhibit 17 for the organizational structure).

Exhibit 17

Organizational Structure for the Department of Medicaid

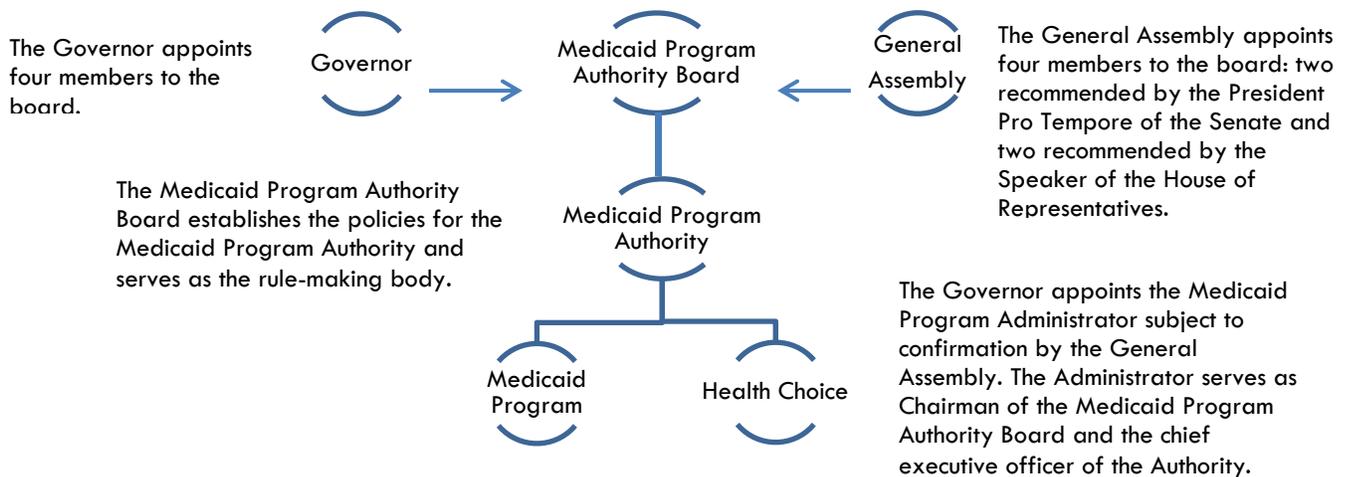


Note: Health Choice is North Carolina’s State Children’s Health Insurance Program.

Source: Program Evaluation Division based on the organization structure of the Alabama and Ohio Medicaid Programs.

- Medicaid Program Authority.** This option uses the organizational structure of the Oklahoma Medicaid Program as a model. The Medicaid Program Authority would become the single state agency designated in the North Carolina Medicaid State Plan to administer the Medicaid Program and receive federal funds from CMS. Responsibility and funding for the Medicaid and Health Choice Programs would be transferred to the new Medicaid Program. DHHS would continue to operate all other health and human services programs. The Medicaid Program Authority Board would be appointed by the Governor and the General Assembly, and the board would establish policies for the Medicaid and Health Choice Programs and serve as the rule-making body (see Exhibit 18 for the organizational structure). The Medicaid Program Administrator would be appointed by the Governor subject to confirmation by the General Assembly.

Exhibit 18: Organizational Structure for the Medicaid Program Authority

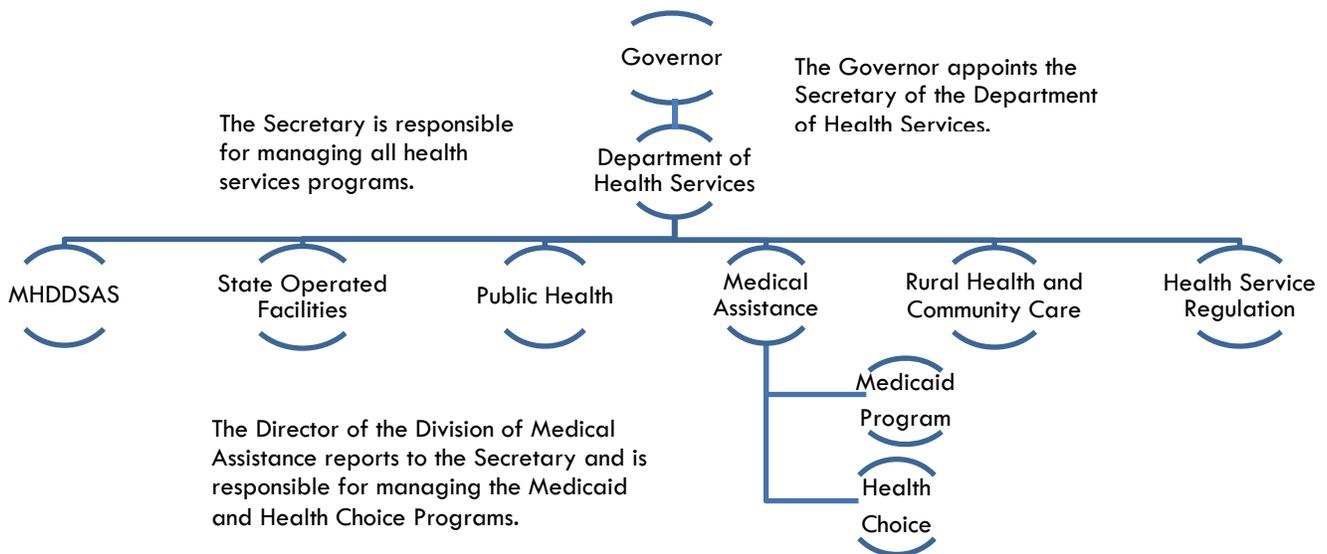


Note: Health Choice is North Carolina’s State Children’s Health Insurance Program.

Source: Program Evaluation Division based on the organization structure of the Oklahoma Medicaid Program.

- Department of Health Services.** This option uses the organizational structure of the Oregon and Washington Medicaid Programs as a model, but it does not include the State Employees' Health Plan.²² Under this option, the responsibility and funding for the Medicaid and Health Choice Programs and all other health care related divisions and offices would be transferred from DHHS to the new Department of Health Services. DHHS would become the Department of Human Services and continue to operate human services programs. The Department of Health Services would become the single state agency designated in the North Carolina Medicaid State Plan to administer the Medicaid Program and receive federal funds from CMS. The Department of Health Services would establish rules and policies for health services programs including the Medicaid and Health Choice Programs. The Governor would appoint the Secretary for the Department of Health Services who would report to the Governor (see Exhibit 19 for the organizational structure).

Exhibit 19: Organizational Structure for the Department of Health Services



Notes: MHDDSAS is the acronym for the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Health Choice is North Carolina's State Children's Health Insurance Program.

Source: Program Evaluation Division based on the organization structure for the Oregon and Washington Medicaid Programs.

Exhibit 20 provides a comparison of the attributes for the three options for changing the organizational structure of the North Carolina Medicaid Program.

²² The Program Evaluation Division did not include the State Employees' Health Plan because the General Assembly moved it to the Department of the State Treasurer in 2011.

Exhibit 20

Comparison of the Options for Changing the Organizational Structure of the North Carolina Medicaid Program

Option Attributes	Department of Medicaid	Medicaid Program Authority	Department of Health Services
Operates as separate department	✓	✓	
Operates within a health services department			✓
Reports to the Governor	✓		✓
Reports to Medicaid Program Authority		✓	
Rule-making performed by department	✓		✓
Rule-making performed by Medicaid Authority Board		✓	

Source: Program Evaluation Division based on interviews with Medicaid directors in other states and review of documents from other states.

Changing the organizational structure for the North Carolina Medicaid Program has several implications that would affect how the program operates within state government. These implications do not affect the feasibility of changing the administration of the Medicaid Program, but the General Assembly should consider these issues if it decides to change the organizational structure of the Medicaid Program. Exhibit 21 summarizes the effects of changing the organizational structure of the North Carolina Medicaid Program.

Exhibit 21

Implications of Changing the Organizational Structure of the North Carolina Medicaid Program

Implications for the North Carolina Medicaid Program	Department of Medicaid	Medicaid Program Authority	Department of Health Services
Focus on the Medicaid Program	✓	✓	
Focus on health services programs			✓
Increased accountability for the Medicaid Program	✓	✓	
Increased independence for the Medicaid Program	✓	✓	
Increased policy-making transparency for the Medicaid Program	✓	✓	
Achieves economies of scale for general administration			✓
Co-located with health care programs receiving medical assistance payments			✓
Leverages health care program purchasing power			✓

Source: Program Evaluation Division based on interviews with Medicaid directors in other states and review of documents from other states.

Creating a separate Medicaid Department or a Department of Health Services has implications for DHHS. As shown throughout this report, the Medicaid Program plays a significant role in departmental operations and removing the Medicaid Program from DHHS has several financial and organizational implications.

- **Medicaid single-state agency designation.** CMS would have to approve amending the North Carolina Medicaid State Plan to change the single-state designation from DHHS to the new Medicaid agency. The new Medicaid agency would then be responsible for administering the Medicaid Program according to federal guidelines and receiving federal reimbursement to operate the program.
- **Policy-making.** DHHS controls Medicaid policy-making at the department level to ensure Medicaid policies are consistent with policies for other DHHS programs. With a new Medicaid agency controlling Medicaid policies, DHHS would need to coordinate with the new agency on Medicaid-related policies affecting DHHS programs.
- **Medicaid administrative functions.** Several DHHS divisions and county departments of social services assist with federally required Medicaid administrative functions. All options for a separate Department of Medicaid assume county departments of social services would continue performing beneficiary outreach and enrollment. The new Medicaid agency would need to decide whether DHHS would continue assisting with Medicaid administrative functions including beneficiary outreach and enrollment, monitoring service quality, and processing appeals. If DHHS continues to perform some Medicaid administrative functions, memorandums of understanding would be required to outline responsibilities, and the new Medicaid agency would pay DHHS and county departments of social services through interagency transfers.
- **Cost allocation.** DHHS has maximized federal Medicaid reimbursement for departmental overhead and administrative costs associated with operating programs serving Medicaid beneficiaries through its cost allocation plans. The new Medicaid agency would be responsible for calculating and receiving federal reimbursement for Medicaid administration. Existing DHHS cost allocation plans would need to be revised and coordinated through the new Medicaid agency. DHHS could continue to receive federal reimbursement to perform some Medicaid administrative functions and to manage programs serving Medicaid beneficiaries. The amount and scope of DHHS reimbursement may decrease which could affect DHHS programs receiving federal Medicaid reimbursement.
- **General administrative support.** DHHS provides general administrative support to the Medicaid Program and receives federal reimbursement for providing these services. With a new Medicaid agency, the General Assembly would need to

transfer a portion of DHHS's general administrative staff to the new agency or authorize the new Medicaid agency to create positions. Exhibit 22 shows how funding for Medicaid administration supports at least some portion of over 350 Central Administration positions within DHHS.

Exhibit 22: Funding for Medicaid Administration Funds Central Administration Positions in the Department of Health and Human Services

DHHS Central Administration	Total Positions	Affected Positions	Percent Affected	Number of FTEs	Personnel Expenditures
Office of the Controller	259.00	161.00	62%	31.80	\$ 1,865,753
Central Regional Maintenance	108.00	108.00	100%	7.90	1,210,798
Division of Human Resources	34.00	34.00	100%	2.49	186,615
Division of Budget & Analysis	14.00	13.00	93%	2.50	312,724
Office of Procurement & Contracted Services	13.00	13.00	100%	0.64	44,541
Executive Office of the Secretary	16.00	8.00	50%	1.47	129,488
Office of Internal Audit	10.00	7.00	70%	1.30	159,131
Office of Legal Affairs	5.75	5.75	100%	0.33	20,995
Office of Property & Construction	13.00	3.00	23%	0.06	4,896
Office of Public Affairs	18.00	1.00	6%	0.76	61,110
Total	490.75	353.75	72%	49.25	\$ 3,996,051

Notes: The FTE column displays the number of full-time equivalent (FTE) positions supported by Medicaid reimbursement. The number of FTEs is lower than affected positions because most affected positions were supported from multiple funding sources including state appropriations and other federal funds. FTEs represent current budgeted positions and were calculated based on Fiscal Year 2011–12 statistical cost data.

Source: Program Evaluation Division based on information from the Department of Health and Human Services.

- Information technology.** Federal reimbursement for Medicaid administration supports information technology services and applications throughout DHHS. The Division of Information Resource Management identified 38 applications supporting Medicaid administrative functions or receiving federal reimbursement for Medicaid administration. Two major systems—the Medicaid Management Information System and the North Carolina Families Accessing Services through Technology system—are controlled at the department level and supported by federal reimbursement. Both systems have been designed to serve health care and public assistance programs throughout DHHS. The new Medicaid agency and DHHS would need to determine which systems should be transferred to the new Medicaid agency or retained by DHHS. To meet the information technology requirements for the Medicaid Program,

the General Assembly would also need to transfer positions from the Division of Information Resource Management to the new Medicaid agency or authorize the creation of new positions.

- **Facilities.** Most Division of Medical Assistance (DMA) employees are located on the Dorothea Dix Campus. DHHS has included them in its plans for a consolidated property lease for all Raleigh-based DHHS employees and assumed federal reimbursement for Medicaid administration would assist with paying for the lease. The new Medicaid agency would need to decide whether its employees would continue to be co-located with DHHS or located in a separate facility.

Establishing a different organizational structure for the North Carolina Medicaid Program would affect state government business functions. Restructuring state government organization affects how the State supports statewide business functions including budgeting and financial management, e-procurement, and mail services. If a new Medicaid agency is created, the following state agencies would need to be involved to make the necessary system changes to support the reorganization:

- Office of the State Controller;
- Office of State Budget and Management;
- Department of the State Treasurer; and
- Department of Administration.

The constitutional limit on the number of principal administrative departments in state government is not an impediment.²³ The North Carolina Constitution allows no more than 25 principal administrative departments, but the creation of the Department of Public Safety in 2012 reduced the number of principal administrative departments from 22 to 20 through consolidation.²⁴

Creating a new Medicaid agency would require a reasonable transition period before the organizational changes are finalized. As shown earlier in this report, other states that changed the administrative structure of their Medicaid Programs emphasized the importance of transition planning. If a stand-alone Department of Medicaid or a Department of Health Services was created in North Carolina, a transition period of 12 to 18 months would be needed. During this transition period, DHHS and leadership for the new Medicaid agency would work together to

- develop a mission and goals for the Medicaid Program;
- determine whether DHHS would continue to perform Medicaid administrative functions and develop memorandums of understanding specifying responsibilities and funding;

²³ North Carolina Constitution, Article III, Section 11.

²⁴ The Department of Public Safety was created by consolidating the Departments of Correction, Crime Control and Public Safety, and Juvenile Justice and Delinquency Prevention.

- develop a plan for coordinating Medicaid policies affecting DHHS programs;
- prepare a public assistance cost allocation plan for the new Medicaid agency;
- revise the DHHS public assistance cost allocation plan;
- determine the administrative overhead positions that would be transferred from DHHS to the new Medicaid agency;
- identify which information technology applications and systems supporting the Medicaid Program would be transferred to the new Medicaid agency;
- decide whether the new Medicaid agency would be co-located with DHHS or in a separate facility;
- identify cost savings or increases resulting from the reorganization; and
- work with other state entities to make the necessary changes to statewide business functions.

To decide whether to create a stand-alone Department of Medicaid, the General Assembly may want to consider whether creating a separate Department of Medicaid is the only way to improve the management of the North Carolina Medicaid Program. Major structural change in Medicaid Program administration could be disruptive and would be a time consuming endeavor. When the Program Evaluation Division asked stakeholders about benefits and challenges of creating a separate Department of Medicaid, several supported strengthening the efficiency and effectiveness of the current North Carolina Medicaid Program over changing the organizational structure. Suggested improvements included better policy management, more accurate budget forecasting, and more efficient management of claims processing and appeals. The January 2013 Performance Audit of the Division of Medical Assistance and the Medicaid Program offered recommendations that could address some of these concerns.²⁵

Agency Response

A draft of this report was submitted to the Department of Health and Human Services to review. Its response is provided following the report.

Program Evaluation Division Contact and Acknowledgments

For more information on this report, please contact the lead evaluator, Carol Shaw, at carol.shaw@ncleg.net.

Staff members who made key contributions to this report include Michelle Beck, Catherine Moga Bryant, and Pamela L. Taylor. Fiscal Research Division staff member Richard Bostic also contributed to this report. John W. Turcotte is the director of the Program Evaluation Division.

²⁵ Office of the State Auditor. (2013, January). Performance Audit: Department of Health and Human Services – Division of Medical Services and Medicaid. Raleigh, NC.



North Carolina Department of Health and Human Services

Pat McCrory
Governor

March 8, 2013

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS

John W. Turcotte, Director
Program Evaluation Division
300 North Salisbury Street, Suite 100
Raleigh, NC 27603-5925

Dear Mr. Turcotte:

Thank you for sharing your report, *Options for Creating a Separate Department of Medicaid Require Transition Planning*, with the North Carolina Department of Health and Human Services (Department).

The Department is in the process of reorganizing to promote efficiencies and to increase accountability. The survey of North Carolina's Medicaid division and the comparison with Medicaid organizational options used by other states was informative. We currently believe the way to improve Medicaid is not to remove it from the Department but by implementing better management, budget forecasting, reporting, staffing, and communication. Especially in light of the findings of the State Auditor in the January 2013 Performance Audit highlighting areas for improvement, we are taking aggressive reform actions within the Division of Medical Assistance and throughout the Department.

We believe the work we are doing now will result in an efficient, transparent, and responsive Division of Medical Assistance, within the Department, dedicated to providing excellent customer service to the 1.5 million North Carolinians and 83,000 providers who interact with the NC Medicaid program statewide and to protecting the interests of our taxpayers.

Sincerely,

A handwritten signature in black ink, appearing to read "Wos", written over a light blue horizontal line.

Aldona Wos, M.D.
Secretary

cc: Carol Steckel
Sherry Bradsher
Sandra Trivett
Adam Sholar
Jim Slate

Susan Jacobs
Pam Kilpatrick
Kristi Huff
Sarah Riser
Patricia Porter