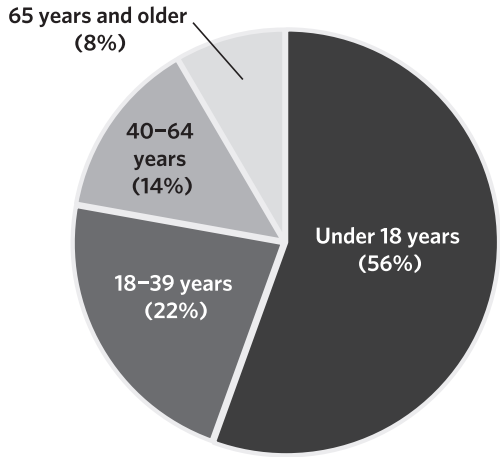
Running the Numbers

A Periodic Feature to Inform North Carolina Health Care Professionals About Current Topics in Health Statistics

An Overview of North Carolina Medicaid and Health Choice

North Carolina Medicaid primarily serves the state's most vulnerable populations: children from low-income households, older adults, people with disabilities, pregnant women, and refugees. North Carolina's Medicaid program, the 12th largest by expenditure in the United States, served an average of more than 1.8 million beneficiaries each month during state fiscal year (SFY) 2016. Children under the age of 18 years make up over half of the beneficiary population for these programs (see Figure 1).

FIGURE 1.
Ages of Medicaid Beneficiaries as of July 1, 2016



North Carolina Health Choice, the state's version of the Children's Health Insurance Program, provides health care to a monthly average of more than 80,000 children whose household incomes are too high for them to qualify for Medicaid but who still cannot afford private health insurance. Given that significant changes in the state's Medicaid system are anticipated in the near future, it is important that readers understand the current system, who it benefits, and how current funds are spent. This article provides an overview of the scope of North Carolina's medical assistance programs and outlines the ways that tax dollars provide critical health care to North Carolina families.

Medicaid and Health Choice Enrollment

Over the past 10 fiscal years, enrollment in the North Carolina Medicaid program increased by 53% (see Figure 2) [1]. During this period, the biggest increase in monthly average enrollment occurred in SFY 2015 [2], largely as a result of the Patient Protection and Affordable Care Act's open enrollment period, during which potential Medicaid-eligible beneficiaries were directed to available resources. Additionally, changes in the processing and recertification of Medicaid cases led to an increase in retention as the information gathering process became more automated, removing the need for beneficiaries to repeatedly provide eligibility information. From an eligibility grouping perspective, growth in Medicaid over the past 5 years has been driven by an increase in the number of children covered under Medicaid and Health Choice, along with an increase in the number of beneficiaries who qualify for limited family planning services.

North Carolina Health Choice enrollment as a share of total enrollment in medical assistance programs declined sharply over the past 5 years. In January 2014, more than 60,000 children in the Health Choice program became eligible for full Medicaid coverage as a result of eligibility determination methodology changes brought about by the Affordable Care Act.

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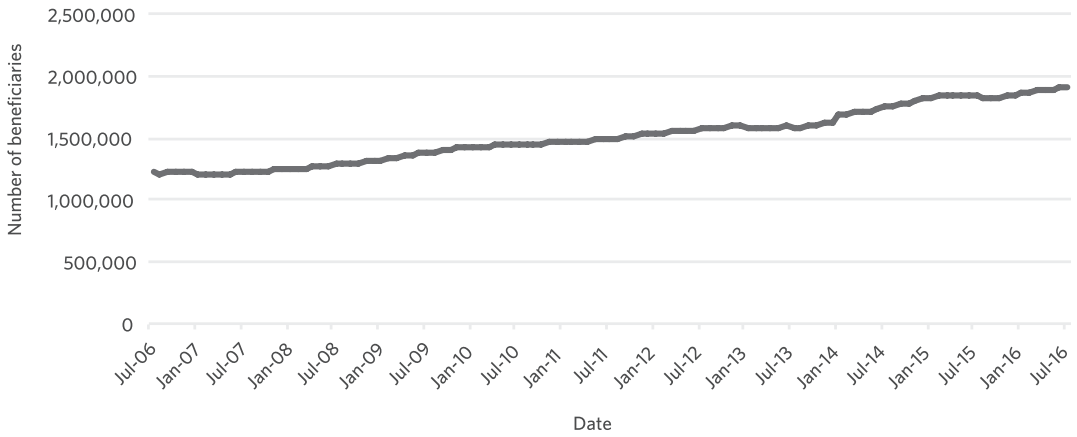
FIGURE 2.
Medicaid Enrollment by Month, SFY 2007–2016



Note. SFY, state fiscal year.

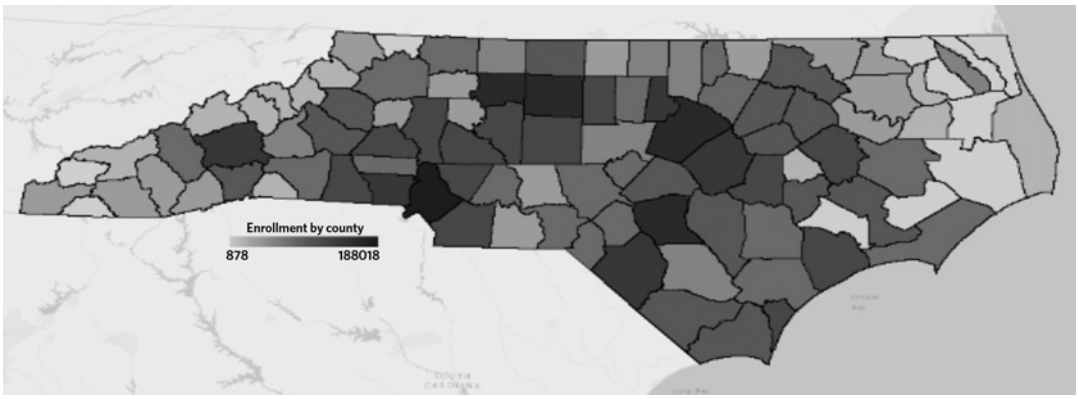
From a geographic perspective, Medicaid and Health Choice enrollment as a raw count is concentrated in North Carolina's major metropolitan areas: Charlotte, Raleigh-Durham, Greensboro–Winston-Salem, Fayetteville, and Asheville (see Figure 3). However, enrollment as a proportion of the population is greater in parts of the eastern half of the state, specifically along the I-95 corridor between Raleigh and the coast. The counties near the northern and southern ends of this path—around the Rocky Mount and Fayetteville metropolitan areas—have many of the highest proportions of residents enrolled in Medicaid. Based on population estimates, approximately 36% of Robeson County residents are enrolled in Medicaid or Health Choice, the highest percentage in the state. The statewide average is slightly more than 20%.

Eligibility Groups

Eligibility criteria such as age, disability, and income level help to place beneficiaries within program aid categories (PACs). These categories determine what benefits are available, and they prove useful in the budgeting and financial planning process for these programs (see Table 1).

Children make up more than half of the North Carolina Medicaid program, but they only account for roughly a quarter of claims expenditures. The leading drivers of Medicaid and Health Choice

FIGURE 3.
North Carolina Medicaid and North Carolina Health Choice Enrollment by County, SFY 2016



Note. SFY, state fiscal year.

TABLE 1.
Enrollment and Spending by Eligibility Groups, SFY 2016

Eligibility groups	Enrollment[a]	Claims dollars[b] (in millions)	Percent of Medicaid beneficiaries	Percent of claims expenditures
Children	1,038,113	$2,765	54%	25%
Aged, blind, and disabled	414,251	$6,721	21%	60%
Other adult[c]	297,271	$1,217	15%	11%
Health Choice	81,897	$171	4%	2%
Medicare qualified beneficiaries[d]	75,889	$9	4%	0.1%
Pregnant women	17,437	$155	1%	1%
Foreign nationals	12,873	$83	1%	1%
Other claims dollars[e]	—	$60		1%
Totals	**1,937,731**	**$11,182**	**100%**	**100%**

Note. SFY, state fiscal year.
[a]SFY 2016 monthly average enrollment.
[b]Claims dollars include all claims and premiums paid through NC Tracks; it excludes Medicare premiums and nonemergency medical transportation expenses, as well non-claims expenditures, which amount to a substantial budgetary impact but do not tie to individual beneficiaries.
[c]The other adult group includes parents, family planning beneficiaries, and breast and cervical cancer patients.
[d]Medicare premiums are not paid through the NC Tracks claims system and as such are not included in Table 1. The claims expenditures that appear in the chart are in reference to the Medicare copayments and deductibles available to certain individuals in this eligibility group, which are paid through NC Tracks.
[e]Other claims dollars are those not tied to individual eligibility groups.

costs for children are pharmacy expenses, physician services, and monthly capitation payments for behavioral health services. Behavioral health services are provided through local management entities (LMEs), managed care organizations (MCOs), and prepaid inpatient health plans. Since SFY 2011, enrollment in children's eligibility groups has grown by 28%. Certain services are available only to children or are limited in their availability when provided to adults.

Health Choice beneficiaries consume services in much the same way as those in the children's Medicaid PACs, but the former group do not have access to certain Medicaid services, including behavioral health services through LME/MCOs, which is the highest expenditure in the Medicaid program and the leading cost driver for children enrolled in Medicaid PACs.

Individuals in the Medicaid PACs for the aged, blind, and disabled eligibility category make up 21% of total Medicaid beneficiaries, but they account for more than 60% of total claims expenditures. These beneficiaries are more likely to use more expensive services such as skilled nursing facilities, personal care services, and home health services.

North Carolina Medicaid also covers prenatal care, delivery, and some postpartum services for pregnant women whose incomes fall outside of the threshold for full Medicaid coverage. This coverage extends up to 196% of the federal poverty limit. As a result, more than half of all births in North Carolina are financed by Medicaid, ranking North Carolina 6th highest in terms of the percentage of births paid for by Medicaid [3].

Another group eligible for Medicaid coverage includes refugees and immigrants who fall within income and resource limits. These beneficiaries typically access emergency services more than other services, with hospital (inpatient and outpatient) and emergency room services accounting for roughly half of the cost of care for these populations. Medicaid also reimburses providers for certain emergency services provided to undocumented immigrants.

Other adults who qualify for Medicaid include parents and caretakers living with children who meet the state's income and resource requirements for Medicaid coverage, beneficiaries who qualify due to a diagnosis of breast or cervical cancer, and those who qualify for limited family planning services. Service utilization patterns among these beneficiaries vary widely. While the PAC that includes individuals eligible for family planning services is one of the fastest-growing groups in the Medicaid program, these beneficiaries only qualify for limited services related to reproductive health. Conversely, the PAC that includes beneficiaries with breast and cervical cancer makes up a small portion of Medicaid enrollment, but members of this group tend to access relatively high-cost medical services such as outpatient hospitals, physicians, and high-cost prescription drugs.

North Carolina pays Medicare premiums for all full Medicaid beneficiaries eligible for Medicare coverage. Seniors and individuals with disabilities whose incomes and/or resources fall just above the threshold for Medicaid eligibility can still receive assistance with their Medicare premiums through the Medicare Qualified Beneficiary PACs, but these beneficiaries are typically eligible only for Medicare Part B premium payments. For a small number of beneficiaries within these PACs, Medicaid will also pay Medicare Part A premiums and certain Medicare copayments and deductibles.

Overall Spending

Over the past 10 years, enrollment in North Carolina's medical assistance programs has grown sharply while total costs for the Division of Medical Assistance have increased only modestly (see Table 2). Strategic changes within the Division of Medical Assistance have helped manage costs despite the rapid growth of services. The growth of programs designed to avoid costly institutionalization of patients who can receive care in home- and community-based settings has improved health outcomes and helped to reduce costs. Aggressive pursuit of larger rebates for prescription drugs has helped reduce the cost of pharmacy services, one of the largest services by expenditure. Expansion of the capitation model to cover services such as behavioral health care and coordinated care for seniors has reduced financial risk and improved budget management for the state.

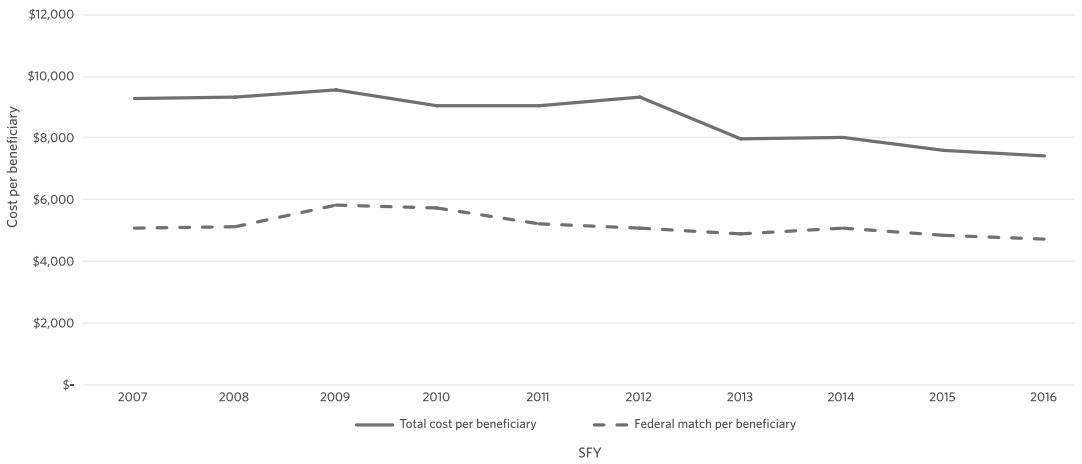
TABLE 2.
Medicaid Enrollment and Spending, SFY 2007–2016

SFY	Enrollment[a]	Total expenditures[b]
2007	1,213,121	$11,252,170,760
2008	1,243,989	$11,596,523,640
2009	1,321,820	$12,623,281,487
2010	1,417,358	$12,838,121,598
2011	1,464,009	$13,270,350,502
2012	1,530,920	$14,241,450,471
2013	1,582,537	$12,643,008,323
2014	1,655,477	$13,303,105,674
2015	1,807,996	$13,744,373,932
2016	1,855,834	$13,771,114,174

Note. SFY, state fiscal year.
[a]Average monthly enrollment by year.
[b]Total expenditures from NC BD-701.

The proportion of North Carolina's Medicaid and Health Choice programs funded by the federal government has increased over the past 10 years, lessening the budgetary burden on the state for the management of these programs (see Figure 4 and Table 3). Over the past 3 years, total expenditures for claims and premiums through the Medicaid and Health Choice programs have increased by approximately 6%, although total expenditures in SFY 2016 declined slightly compared to SFY 2015. Pharmacy services, hospital services, and physician services were major contributors to the

FIGURE 4.
Cost Per Medicaid Beneficiary, SFY 2007–2016



Note. SFY, state fiscal year.
Total cost per beneficiary is the total expenditure by the Division of Medical Assistance divided by monthly average enrollment. Federal match per beneficiary is federal revenue divided by monthly average enrollment.

TABLE 3.
Expenditures by Category of Service, by 2016 Expenditures

Category of service	Fiscal year 2014	2015	2016
LME/MCO	$2,394M	$2,578M	$2,612M
Skilled nursing facilities	$1,159M	$1,154M	$1,211M
Physician services	$1,005M	$1,131M	$1,035M
Hospital inpatient	$938M	$1,018M	$947M
Pharmacy services	$739M	$892M	$779M
Buy-in/dual eligible services	$712M	$700M	$754M
Hospital outpatient	$488M	$563M	$527M
Personal care services	$475M	$461M	$453M
Dental services	$359M	$378M	$380M
Hospital emergency room services	$357M	$406M	$377M
Other services	$1,469M	$1,557M	$1,617M
Total	$10,094M	$10,840M	$10,692M

Note. LME/MCO, local management entity/managed care organization.

spending drop in SFY 2016, in part due to increased pharmaceutical rebates, hospital claims reprocessing, and the end of enhanced physician payments through the Affordable Care Act.

The costs of many programs, for instance LME/MCOs, have increased in line with total enrollment and recipients. Some program services—including ambulatory surgical centers, laboratory, and radiology services—have seen significant cost increases in recent years as a result of new technologies and new procedures.

Conclusion

North Carolina residents can be proud of the way their tax dollars offer vital services to populations that may not otherwise have access to the services they need. Future changes to Medicaid will enable the state to continue providing these services effectively and efficiently while the Division of Medical Assistance remains attentive to effective use of taxpayer dollars. NCMJ

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