Section 3 —
Medicaid Issues —

STATE PURCHASE OF HEALTH CARE

KPMG Peat Marwick
Government Services Management Consultants
for
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Issue Statement

North Carolina purchases or provides health care services through numerous government agencies. These include:

- Department of Human Resources
    - Division of Medical Assistance
    - Division of Services for the Blind
    - Division of Vocational Rehabilitation
    - Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
- Department of Environment, Health, and Natural Resources
- Department of Correction
- Teachers' and State Employees' Comprehensive Major Medical Plan

Additionally, North Carolina State agencies and universities self-fund employee workers' compensation obligations for lost wages, disability payments, and medical services.

This issue paper identifies our recommendations for coordination of the agencies' efforts to purchase and provide health care services. The recommendations position the State of North Carolina to benefit in terms of cost-containment, reduced administrative expense, availability of consolidated data on health care purchases, improved health care purchasing power, and improved access to care for program beneficiaries.

Background

Exhibit 1 summarizes total expenditures on health-related care for the State of North Carolina. The expenditures shown are based on the fiscal year 1993 budget and information provided by the administering agencies.

The exhibit separates expenditures purchased by the agencies from those provided by agency personnel. Costs of services furnished through contracts are considered purchased services.

EXHIBIT 1

SUMMARY OF NORTH CAROLINA EXPENDITURES FOR HEALTH CARE SERVICES, FY93

Program	Expenditures (in Millions)		Source of Funds	
	Purchased	Provided	General	Federal/Other
Department of Human Resources				
Division of Medical Assistance	$2,675.0	--	$675.0	$2,000.0
Division of Services for the Blind	4.3	--	2.5	1.8
Division of Vocational Rehabilitation	17.0	--	6.8	10.2
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	270.0	425.0	387.0	308.0
Department of Environment, Health, and Natural Resources (1)	19.0-20.0	--	16.0	3.0-4.0
Department of Correction	9.3	34.3	43.6	0.0
Workers' Compensation (State Employees)	11.0	--	11.0	--
State Employees' Comprehensive Major Medical Plan	651.8	--	--	651.8 (2)
TOTAL EXPENDITURES	$3,657.40	$459.30	$1,141.90	$2,974.80

(1) Includes only Children's Special Services, Sickle Cell, and Adult Health Care programs. Other DEHNR programs purchase or provide health care. Although data is not generally available, estimates appear to be closer to $50 million, with $30 million in Federal or other funding.

(2) Premium collections, investment income, and reserves

Source: KPMG interviews with State staff and telephone surveys of State agencies

Many of the health care programs administered by the agencies are supported by funds outside of the State general fund. We have attempted to identify the appropriate source of funds in the exhibit. In some cases, only estimated percentages were available from the agencies.

To provide a base for the discussion of our recommendations, we provide a brief description of the programs administered by each agency in the following paragraphs. Each agency is described in terms of the services purchased or provided, the recipients or beneficiaries serviced by the agency's programs, and the methods of reimbursement in the major service areas.

Division of Medical Assistance

The Division of Medical Assistance (DMA) in the Department of Human Resources is responsible for administration of North Carolina's Medicaid program. The Medicaid program provides health care to Title XIX eligibles, which include the indigent elderly, disabled, pregnant women and children, and other poor citizens of the State.

DMA contracts with Electronic Data Systems, Inc. (EDS) to process Medicaid claims and perform other Medicaid-related administrative activities. Payments to EDS will be $9.8 million in FY93. Of the Division's $2.7 billion budget, $675 million is appropriated from State funds, and the remainder is Federal funding.

The Medical Assistance program reimburses most providers on a flat fee per service, which is based on a relative value for each service. Inpatient hospitals and long-term care facilities are reimbursed on a prospective per diem rate. Reimbursement for prescription drugs is 90 percent of the average wholesale price plus a $5.60 dispensing fee. Ambulance rates are based on mileage.

All North Carolina medical programs are required to reimburse providers "at rates no more than those under the North Carolina Medical Assistance program" according to Section 172 of Chapter 689 of State law. A few exceptions for DEHNR reimbursement rates are noted. Exhibit 2 presents a reimbursement comparison across programs for a sample of medical services.

Division of Services for the Blind

The Division of Services for the Blind in the Department of Human Resources provides assistance to individuals who are visually impaired, which will enable them to retain or engage in education, employment, and independent living. The Division operates three programs that furnish medical care to the visually impaired. Approximately 14,000 clients are served by the three programs.

EXHIBIT 2

COMPARISON OF PAYMENT LEVELS FOR NORTH CAROLINA MEDICAL PROGRAMS

Service	Program							
	DMA	DSB	DVR	DMH	DEHNR	DOC	Workers Compensation	State Employees
Pharmaceuticals*								
Prozac (20 mg)	$57.70	$57.70	$57.70	$57.70	$57.70	$49.50	Charges	$51.11
Seldane (30 mg)	$49.79	$49.79	$49.79	$49.79		$40.80	Charges	$44.19
Capotene (25 mg)	$56.66	$56.66	$56.66	$56.66	$56.66	$46.80	Charges	$51.06
Psychology/ Psychiatry Visit	$42.50	$42.50	$42.50	$71.18	N/A	By contract: $70.00 (psychiatrist); $20.00 (psychologist)	$115.00	UCR $56.50-$105.00
Physician Office Visit	$30.00	$30.00	$30.00	$71.18	$30.00	By contract	$45.00	UCR $44.00-$85.00
Inpatient Stay (Pitt Memorial)	$595.07	$595.07	$609.95	N/A; $505 for rehab	$595.07 (CSMS); $609.95 (adult)	Charges	$170.00 (room and board only)	$7,630 per stay (general surgery)
Motorized Wheelchair	$3,587	$3,587	Bid basis; $8,500	$3,587	$3,587 (Adult); $8,000 average (CSMS)	Bid basis; $5,057-$7,692	Charges	Charges
Ambulance (One-Way)	$47.00 (BLS); $83.00 (ALS)	$47.00 (BLS); $83.00 (ALS)	$60.00-$90.00	N/A	N/A	$135 average	Charges	Charges

* Reported payments are for 30-day supplies, and uniform daily dosages

Source: KPMG Peat Marwick telephone survey

The Medical Eye Care program provides services, such as eye examinations, eyeglasses, and surgery, to low-income citizens through State-sponsored clinics and purchased services from private providers. The program also provides vision screenings, glaucoma detection, and vision care education to all citizens of North Carolina, regardless of income. The Medical Eye Care program is funded with 100 percent State funds.

The Personal Care Services program provides personal care services in the homes of visually impaired and blind eligibles who have medical needs. This program provides personal care services to 350 eligibles who would require institutionalization if services were not available. Contracted personal care aides perform medical services for the visually impaired, and their claims are submitted directly to DMA. The Division is enrolled as a personal care provider of Title XIX services, and it receives Medicaid payments for 100 percent of program costs. Personal care services are, therefore, not included in the Division totals shown in Exhibit 1.

The Rehabilitation for the Blind program provides evaluation, vocational training, physical restoration, and job placement to approximately 5,200 blind or visually impaired individuals. The rehabilitation program provides hospital, physician, psychiatric, and dental services and pharmaceutical and durable medical equipment to its program eligibles. Approximately 80 percent of the program is federally funded, with the remaining 20 percent funded by the State.

The Division of Services for the Blind uses the Medicaid reimbursement methodology for all services provided. Most eyeglasses are supplied through a State (DMA) contract with a sheltered workshop.

Division of Vocational Rehabilitation

The Division of Vocational Rehabilitation in the Department of Human Resources provides services to the handicapped citizens of North Carolina. The Division's objective is to enable eligibles with physical or mental disabilities to obtain or maintain employment by providing vocational rehabilitation services. Services include counseling, physical/mental restoration training, guidance, and job placement. Approximately 26,000 clients receive medical services.

Most client referrals come from hospitals. Those persons who may be eligible for Title XIX funds are asked to apply for Medicaid, but Division workers will help develop a plan of care for Title XIX eligibles. Most medical providers are hospital-based, individual practitioners. All claims for Medicaid eligibles are processed through DMA. Division funding is approximately 60 percent Federal and 40 percent State funds.

Reimbursement for vocational rehabilitation services is usually the same as for Medicaid. Because of specialized needs for certain medical equipment, such as wheelchairs, Division

payments exceed Medicaid ranges for customized wheelchairs needed to maintain the employability of its clients. Hospital rates are paid on a prospective per diem basis, like Medicaid; however, usually the rehabilitation unit rates apply.

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services provides services to North Carolina citizens with mental health, mental retardation, developmental disabilities, and substance abuse problems. Their objective is to promote mental health and increase their clients' abilities to function as independently as possible through the provision of treatments and rehabilitative services.

The Division manages 41 local programs and 15 State institutions. The Community-Based Services program, which manages the 41 local programs, promotes mental well-being through prevention, outreach, consultation, and treatment/rehabilitation activities. It also aims to develop the skills of persons with mental health, mental retardation, developmental disabilities, and substance abuse problems so that they can remain in the community. Approximately 193,000 clients are served by the Community-Based Services program, which has an FY93 budget of approximately $270 million.

The Institutional Services program provides services to approximately 18,000 individuals in mental health institutions. Institutional Services has an FY93 budget of approximately $425 million and 5,600 positions to operate 15 State institutions. These include four psychiatric hospitals, two schools for emotionally disturbed adolescents, one long-term care facility for the elderly, five residential facilities for individuals with mental retardation, and three alcohol and drug abuse treatment centers.

Community-Based Services receives approximately $17 million, and Institutional Services receives about $291 million in Federal funds.

The Division follows Medicaid reimbursement for most services. State-operated institutions are reimbursed based on facility-specific Medicaid rates. The Community-Based Services program reimburses outpatient mental health providers at a provider-specific rate (cost-based). Rates range from $48.00 to $95.00 per client hour, with an average of $70.00. Rates are about 5 percent higher than Medicaid rates.

Department of Environment, Health, and Natural Resources

The Department of Environment, Health, and Natural Resources (DEHNR) is responsible for promoting public health through public education, in addition to its objectives of conserving natural resources and protecting the environment. DEHNR administers a number of programs that purchase medical services, including:

- **Maternal and Child Health** - Provides comprehensive prenatal care to low-income pregnant women and promotes the health of low-income children by providing health assessment, diagnostic, and treatment services

- **Children's Special Health Services** - Provides diagnostic and treatment services through a network of specialty clinics (orthopedics, neurology, speech and hearing, cardiology, etc.) and through reimbursement for hospital and physician services, special therapies, drugs, and other services; estimated recipients are 56,000 children with chronic illnesses and disabilities (malignancies, cerebral palsy, sickle cell, seizures) who meet poverty requirements

- **Sickle Cell/Genetic Counseling** - Provides screening, diagnostic, and treatment services to families to identify potential genetic diseases in children

- **Developmental Evaluation Centers** - Maximizes the health status of children with developmental disabilities and reduces future expenditures for medical and rehabilitative care by providing clinical evaluations, treatment, and services coordination

- **Perinatal** - Ensures that medically high-risk pregnant women and newborns receive an appropriate level of care from the twentieth week of pregnancy through the first 27 days of life

- **Adult Health Care and Education** - Promotes good health habits and provides services to medically indigent persons, migrant farmworkers, and refugees; Adult Health Care includes programs for cancer, epilepsy, and in-home health care

- **Local Health Services** - Supports public health activities through grants which constitute the only noncategorical money available from the State to local public health agencies; this program also disburses funds collected on behalf of the local health departments by the Division of Health Services, which acts as a third-party intermediary with Medicaid

- **Women's Preventive Health** - Provides medical, social, and educational contraceptive services through local health departments

- **Public Health Lab Services** - Offers examinations and provides consultation and technical assistance to the public health providers, including physicians, local health departments, other laboratories, agencies, and individuals

- **Dental Health Services** - Provides fluoridation of water supplies, dental health education, fluoride supplements and rinses, and routine professional care

- **Acute Communicable Disease Control** - Provides vaccines and other pharmaceuticals to local health departments; provides technical assistance, training, and health education; and performs surveillance, testing, and control of communicable diseases

- **Tuberculosis Control** - Purchases hospital inpatient and physician services and purchases pharmaceuticals for the prevention and control of tuberculosis

- **Sexually Transmitted Diseases** - Provides assistance to local health departments, private practitioners, hospitals, private laboratories, and community-based organizations in culture screening, counseling, contact referral, and treatment of STDs

Other DEHNR programs purchasing or providing limited medical services include the Medical Examiner Services program, the Office of Chief Nurse, Public Health Education, Information Services, Occupational Health, and Environmental Health Services.

Because there are a number of small programs administered by DEHNR and these programs do not budget medical expenditures separately in every case, it is difficult to estimate the amount of medical services purchased or provided by the Department. The largest programs (concerning medical services) are the Adult Health Care program and the Children's Special Health Services program. These programs total approximately $11 million dollars in fees paid to providers, and another estimated $8 to $9 million are paid through contracts. Because the most information was available on these programs, figures for only the two programs are included in Exhibit 1.

Based on the line items in the DEHNR budget that can be identified as medical, this appears to be an extremely conservative estimate of services purchased or provided. Programs which include medical care are budgeted at over $100 million dollars, and it appears that at least half of that amount could be considered "medical" in nature. Approximately $32 million in receipts appear to be from Federal grants and sources other than the State general fund.

For its fee-for-service payments to providers, DEHNR usually reimburses using Medicaid rates. Exceptions noted are for customized medical equipment (such as wheelchairs) for the Children's Special Health Services program. Adult Health Services most often pays rehabilitation per diem rates for inpatient services. Contracted rates are kept as close to Medicaid rates as possible, although DEHNR is permitted to make exceptions to gain access to providers for certain programs.

Department of Correction

The Department of Correction (DOC) provides health care services to inmates through Prison Health Services, which offers inpatient, physician, registered nurse, mental health, and dental services. As shown in Exhibit 1, Prison Health Services includes purchased services and services provided by employees of the Department of Correction.

Approximately 1,800 inmates receive mental health services. There are approximately 21,000 inmates who receive general health services. The Department of Correction administers four inpatient, residential facilities with 810 inpatient beds.

Currently, there is no medical director. There is a physician (usually contracted) for each of the 91 prison units. Most DOC medical employees are nurses and physician assistants. Dental services are contracted. There are about 26 dental clinics and 20 dentists under contract.

Because access is a problem, the DOC must usually pay higher than Medicaid rates for medical services.

Mental health providers are contracted on an hourly rate. Psychiatrists received from $65 to $75 per hour. DOC currently holds about 200 contracts for medical providers. Contracted payments are based on hourly, per visit, or per patient rates.

Pharmaceuticals are ordered through the State's central pharmacy when possible. If DOC demands cannot be met by the State pharmacy, local pharmacies are used. Durable medical equipment is competitively bid out. Eyeglasses are supplied by the State sheltered workshop that provides eyeglasses for Medicaid and the Division of Services for the Blind.

Inpatient hospital services are available on contracts for men and boys. No contracted hospital services are available for women. Most noncontracted hospital charges are paid at 100 percent of billed charges.

The Department has no automated claims processing. All invoices are paid manually, and utilization control is left to the 91 individual units.

State Employees

The State of North Carolina provides health care benefits to its eligible teachers, employees, retirees, and their dependents. Approximately 300,000 active and retired employees and 163,000 dependents are covered by the plan.

Claims are processed by Blue Cross and Blue Shield of North Carolina (BCBSNC). BCBSNC operates the COSTWISE program to help control health care costs. COSTWISE

providers file claims for beneficiaries and agree to accept Plan reimbursement as payment in full (minus deductibles and copayments).

Physicians and private practitioners are paid based on usual, customary, and reasonable (UCR) allowances. Most payments are subject to the deductibles and copayments paid by beneficiaries. Many services, such as home health services, prosthetics and orthotics, hospice care, private-duty nursing, certain therapies, DME rentals, require prior authorization.

The plan pays for inpatient stays at fixed prices per case based on seven admission categories. Inpatient rates are facility-specific. Preadmission testing and second surgical opinions are required of certain procedures. All inpatient admissions must be certified by the claims processing contractor.

The plan will pay up to a semiprivate room rate in a Medicare-approved skilled nursing facility. Intermediate and custodial care are not covered.

Allowed amounts for prescription drugs are 90 percent of the AWP. Beneficiaries pay a copayment of $5.00 per prescription.

The State Employees' Major Medical Plan paid approximately $505.45 million in benefits in FY 1992. Projected payments for FY 1992 are $637 million in claims benefits and $14.8 million for claims administration by BCBSNC.

The Workers' Compensation program for State employees pays approximately $11.0 million per year in medical benefits. Claims are administered through State personnel offices in the individual agencies.

Findings

The analysis of North Carolina's programs that purchase or provide health care leads to specific findings on automation, utilization controls, and payment levels, as well as general findings across the programs.

Findings on Automation

Exhibit 3 shows the functions that are automated in the various agencies' claims systems. Findings related to automation of claims functions are listed below.

EXHIBIT 3

AUTOMATION OF MEDICAL PAYMENT FUNCTIONS IN NORTH CAROLINA PROGRAMS

Program	Electronic Claims Submission	Data Entry	Claims Processing	Check Production	Utilization Control
DMA	Yes	Yes	Yes	Yes	Yes
DSB	No	No	No	Yes	No
DVR	No	Yes	No	Yes	Yes
DMH	No	No	No	N/A	Yes
DEHNR	No	Yes	Yes	Yes	No
DOC	No	No	No	Yes	No*
WC	No	No	No	Yes	No
SE	Yes	Yes	Yes	Yes	Yes

* With the exception of some automated tracking of mental health services

Finding 1: All programs utilize accounting systems to track expenditures for budgeting purposes.

All programs track expenditures to providers. Because of budgetary constraints, programs such as those within DEHNR track expenditures on a monthly basis, and program payments are ended once the budget is spent. All programs have automated processes for production of checks to providers. DEHNR and DMA have the capability to issue one check per provider for all fee-for-service payments.

Finding 2: Existing information systems are ill-prepared to support cost-containment efforts.

With the exception of DMA's Medicaid Management Information System (MMIS) and the State Employees' Plan, the State's claims processing systems lack sophisticated automated features that will support future cost-containment efforts. Most systems are focused on accounts payable functions. Some systems, such as those at DSB, DVR, DMH, and DEHNR, have the capability to access Medicaid fee schedules to assist in pricing. The DEHNR system has some automated pricing features, but limited editing capabilities.

Cost-containment features, such as procedure code unbundling edits, procedure versus diagnosis comparability, and complex duplicate services editing, are not available in any system outside of the MMIS and the BCBSNC system.

Outside of the contracted systems (the MMIS and the BCBSNC system), claims processing is a mostly manual process. Although some of the programs are small enough to process claims without automation, manual processing is prone to human error and inconsistency across processors. Additionally, data useful for analysis and program administration is not captured.

Finding 3: Postpayment claims databases and consolidated reporting are limited or nonexistent within most agencies; cross-program sharing of postpayment data is nonexistent.

With the exception of DMA's MMIS and the State Employees' Plan, North Carolina's programs have limited or no data on paid claims. While payments to providers are available, the agencies, in general, do not establish databases of paid claims information at the client and procedure level. DEHNR has some data on its fee-for-service payments, but no data on contracted medical payments.

This lack of consolidated information and analysis of the data place the programs in a poor position to contain costs or react to changes in provider billing patterns.

Even within departments, there was no consolidation of paid claims data for the various programs administered under a single department. The only consolidated data is available through the MMIS for those programs that are enrolled as providers under the Medicaid program. Since this is a limited portion of the Department's total health-related expenditures, there is no global picture of services provided to clients.

Going beyond departmental boundaries, there are no successful efforts for shared postpayment databases across the various departments that purchase or provide services. The State should consolidate postpayment data before it undertakes any effort to improve its health care purchasing power through coordination of purchases.

Finding 4: The Medicaid Management Information System, which is contracted by the Division of Medical Assistance, is the most sophisticated of the State's claims systems and it is a candidate for replacement.

DMA's MMIS, like most MMIS' of its generation, is a comprehensive claims processing system that is adequate for basic claims processing activities and highly tailored to meet individual states' Medicaid program requirements.

Because of the age of the base system, however, the North Carolina MMIS cannot be easily or inexpensively modified to incorporate more modern system features. The system is sufficient to continue to perform basic claims processing operations for a few more years.

Because of increasing costs of modification and maintenance, it is becoming more and more a candidate for replacement each year. If North Carolina wishes to consider processing claims for other programs through its MMIS to a large extent, the MMIS will need to be replaced with a more flexible, modern system. Moreover, any replacement effort should be preceded by a requirements analysis to determine the long-term desirability of processing the states' medical claims through a single system.

Finding 5: Development of claims processing systems appears to be more short-term than long-term in its approach.

Various agencies are proceeding with development of new, small systems to handle tracking and processing requirements. The Department of Mental Health, Developmental Disabilities, and Substance Abuse is currently developing two small systems to handle claims for court-ordered programs that cannot be processed by their other system. The Department of Correction is attempting to hire a contractor to process its claims or modify another existing system and bring it in-house.

These developmental efforts are necessary to respond to short-term requirements. Some of the solutions are independently adequate to support the programs. However, continued development or acquisition of systems without a statewide long-term plan will make it more

difficult to consolidate information in the future and does not position the State to be a more prudent purchaser.

Findings on Utilization Control

Exhibit 4 compares utilization controls before, during, and after claims processing for the various programs. Specific findings are discussed in the following sections.

Finding 6: Most programs practice good utilization control through prior authorization.

All programs have some prior authorization requirements. The smaller programs, such as the DSB, DVR, and DEHNR programs, require prior authorization of all services. Prior authorization is an effective control of services, especially in the case of the small programs, which do not have automated claims processing systems with cost-containment features.

Because prior authorization in most programs is a manual process, it is prone to human error and inconsistencies across processors, and it is not a completely adequate substitute for automation.

Finding 7: Utilization control in some programs is limited or nonexistent.

Because of limited staffing and fragmentation of responsibility for claims payments, some programs do not have adequate utilization controls. The Department of Correction has not, in the past, had the staff positions available to hire a medical director and utilization control manager at the nurse level. Utilization control has been a distributed responsibility at the prison unit level. Plans are now in place to fill these positions to improve centralized utilization control and consistency.

Similarly, the State employees' workers' compensation program has a distributed approach to utilization control and, because the program is funded through lapse salaries, there is a potential disincentive to cost containment.

Finding 8: Most programs adhere to the Medicaid fee schedule for most services.

As shown in the exhibit, the DHR programs and DEHNR cap payments at the Medicaid fee schedule amounts. Exceptions are for special services (such as customized wheelchairs), for payments to providers when participation is a problem, and for services not covered by Medicaid (such as over-the-counter drugs).

EXHIBIT 4

COMPARISON OF UTILIZATION CONTROLS FOR NORTH CAROLINA MEDICAL PAYMENTS

Program	Prepayment	During Processing	Postpayment
DMA	Automated/Contracted	Automated	Automated/Contracted
DSB	Manual	Manual	None
DVR	Manual	Manual	None
DMH	None	None	None*
DEHNR	Manual	Manual	None
DOC	None	None	None*
WC	None	None	None
SE	Automated	Automated	Contracted

* The Department of Mental Health and the Department of Correction track units of service rendered, but not at the specific recipient level.

Source: KPMG Peat Marwick interviews with agency staff and telephone survey

Finding 9: Contracted medical services do not always follow Medicaid limitations and are at risk for cost shifts.

Many programs have individual, provider-specific contracts. Some programs, such as DMH and DEHNR, attempt to keep contracts consistent with Medicaid rates to the extent possible. The Department of Correction has over 350 contracts with providers, very few of which are within Medicaid limits because of provider participation problems.

Although contracted medical costs control expenditures, there is no coordination of contract negotiation efforts across programs. Comparability of payments to providers across programs is not available for contracted costs.

With increased focus on cost containment by fee-for-service programs, payments to contracted providers will depend on the individual program's negotiation capabilities. Without coordination of contract negotiations, smaller programs may be more vulnerable to provider demands for higher reimbursement.

Finding 10: Programs not paying Medicaid fee levels have the highest risk for cost shifting.

Programs paying a percentage of billed charges or a percentage of usual and customary rates are most at risk for cost shifting. If DMA and other programs, through their use of the Medicaid fee schedule, reduce or control costs, providers may increase charges to other payors. Programs, such as the State employees' medical and workers' compensation programs, may absorb increased costs in the form of increased billed charges from providers.

Finding 11: Current combined purchasing efforts appear to be effective.

As shown in the exhibit, pharmaceutical costs for the Department of Correction are lower than the Medicaid rate. The Department purchases most drugs through the State's central pharmacy. The public mental health institutions also use the central pharmacy. Many programs also purchase eyeglasses through the sheltered workshops. Consolidated purchasing efforts such as these appear to be cost-effective, and there may be opportunities to expand the efforts to more agencies.

The following summarize our findings on program automation, utilization controls, and payments levels, and assess agency readiness to respond to changes in the provision and payment of health care services.

Finding 12: North Carolina programs are not positioned to avoid a cost shift.

With the exception of the Department of Medical Assistance, North Carolina's programs do not have the tools available to deal with a potential cost shift. If one agency implements cost-containment measures, the other programs will be vulnerable to provider pressure for increased payments.

Programs will need formalized, consistent policies; automated systems to support policy analysis and utilization control; and fortitude and experience in dealing with provider pressure. These tools are not currently in place in most agencies. Programs that do not currently reimburse at Medicaid rates, such as the State employees' workers' compensation and major medical programs, will be particularly vulnerable to cost shifting or provider billing tactics to increase revenue.

Finding 13: Useful data on health care services and expenditures is limited.

Programs carefully track expenditures and payments to providers for budget purposes. Most agencies' systems are primarily accounts payable systems, which record payments at the provider level.

Data needed to detect changes in utilization or billing patterns is not generally available to the agencies. Most systems do not have the ability to consolidate and report on paid claims data at the service and client level. Systems that track authorized services, such as the one used by the Department of Vocational Rehabilitation, do not produce the postpayment information needed to analyze utilization patterns. Some programs, such as the Department of Mental Health, Developmental Disabilities, and Substance Abuse, track costs at the unit of service level by provider for the purpose of cost settlement, but information is not available at the client or specific procedure level.

The Department of Medical Assistance has the most advanced information system with automated capabilities to track data by service, recipient, or provider. DMA's current ad-hoc reporting capabilities include production of reports internally with user-oriented software packages. Because of the cost-containment emphasis on the Medicaid program and because of Federal requirements, DMA does produce utilization reports.

The programs, other than Medicaid, do not have the data available, the automated tools, or the expertise necessary to model service utilization patterns.

Finding 14: Sharing of technical expertise and data across programs is minimal.

North Carolina has employees with technical expertise in claims processing systems and experience in reimbursement policy and provider relations. The State employees' program and the Division of Medical Assistance have expertise in the procurement of claims

processing systems, reimbursement policy, and provider negotiations and relations. These agencies need to become more proactive in assisting small programs without purchasing power or claims expertise in acquiring or developing systems, working with claims contractors, and negotiating provider reimbursement methodologies.

Recommendations

Recommendation 1: Establish an office for health care within the Governor's office and empower the office as the central agent for coordination and design of the North Carolina health care strategy.

Short-term activities will focus on development of the long-range strategic plan and initiation of formal collaboration between programs and agencies that purchase or deliver health care services. Longer-term activities include creation of a central database of purchased health care services for use in policy formulation, reimbursement analysis, and negotiating better arrangements with the provider community. As program policies and reimbursement changes occur, activities should include installation of efficiencies that reduce provider office overhead, such as common claim forms, standard procedure terminology, and increased electronic submission of claims.

Recommendation 2: Consolidate the administration of State employee workers' compensation claims and reform the funding approach.

Accept the recommendations of the Office of State Personnel, Employee Safety and Health Division, regarding administrative consolidation (with some possible exceptions) and establishment of a reserve fund for future liability on current cases. Discontinue funding current liabilities with agency "lapse salary dollars," or remove the agency incentives to expend this budget line item to protect future budget requests.

Recommendation 3: Initiate planning for the replacement of the current Medicaid Management Information System (MMIS).

Emphasis during the feasibility and planning effort should focus on Medicaid future directions, such as expanded managed care, and the design of a system capable of supporting many, if not all, of North Carolina's publicly administered health care programs. Planning should be in concert with, but in advance of, Federal health reform planning, to provide North Carolina with the full opportunity to define and promote a strategy consistent with State political and social objectives. The planning should include representation from each agency involved in health care claims processing.

Recommendation 4: Support Department of Correction efforts to secure automated claims processing support from a contractor.

The Division of Medical Assistance and the Teachers' and State Employees' Comprehensive Major Medical Plan should assist DOC in discussions and possible negotiations with their claims processing contractors. In the near term, this option is preferable to the purchase and installation of a stand-alone system.

Implications

Office for Health Care

Establish three positions in the Governor's Office for FY 93, and increase positions to seven or eight in FY 94. Funding estimates are:

Category	FY 93	FT 94	FY 95
Personnel	$60,000 (1)	$280,000	$320,000
Operations	25,000	100,000	100,000
Outside Services	25,000	400,000	100,000
TOTAL	$110,000	$780,000	$550,000

(1) Partial year funding

Savings accruing from office activities will offset costs within the first full year of operations.

MMIS Replacement Planning

The current base contract with the Medicaid fiscal agent ends on June 30, 1993. Four option years are provided under the terms of the contract. The time required for full planning through installation of a new system is 30 to 36 months. The planning phase should begin in early to mid-calendar year 1993. Existing agency personnel can be redirected for the planning phase. Outside consulting services to augment State resources during the six- to nine-month planning phase are estimated at $300,000 to $500,000, depending on the intensity of consultant involvement. Planning phase costs would be shared equally between the State and the Federal government.

Cost Savings

According to the Office of State Personnel study, administrative consolidation could reduce personnel requirements by ten positions and create savings from uniform application of policy. Personnel savings were estimated at $240,000 per year by OSP. A 10 percent

savings in program expenditures is a realistic target as incentives are realized and policy is administered uniformly. First year's cost savings would total approximately $1.1 million. Cost savings over ten years total $13.9 million. More details are provided in Exhibit 5.

EXHIBIT 5

CONSOLIDATE WORKMAN'S COMPENSATION FOR STATE EMPLOYEES

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Current Program	$11.0	$11.55	$12.12	$12.73	$13.3	$14.0	$14.7	$15.4	$16.2	$17.1
Proposed Program	$0.99	$10.39	$10.91	$11.5	$11.97	$12.6	$13.2	$13.9	$14.58	$15.39
State Savings	$1.1	$1.16	$1.21	$1.27	$1.33	$1.4	$1.5	$1.57	$1.62	$1.71
Cumulative Savings	$13.88	$2.27	$3.48	$4.75	$6.08	$7.48	$8.98	$10.55	$12.17	$13.88

Assumptions

- *Expenditures are projected to increase at a rate of 5.5 percent*