

Division of Medical Assistance

Mission: The Division of Medical Assistance manages Medicaid and NC Health Choice for Children for the state of North Carolina. Medicaid is a health insurance program for certain low-income and needy people paid with federal, state, and county dollars. It covers more than 1 million people in our state, including children, the aged, blind, and/or disabled, and people who are eligible to receive federally assisted income maintenance payments. <http://www.dhhs.state.nc.us/dma/>

Sections/Programs: Five programs/sections in the Division of Medical Assistance (DMA) responded to the disparity assessment survey. These programs/sections include: North Carolina Health Choice for Children; Medical Policy; Managed Care; Medicaid Eligibility; and Medicaid.

Priority Conditions/Issues: The top priority conditions for the Division of Medical Assistance included developmental disabilities, newborns or neonatal conditions (poor birth outcomes, pregnancy, and childbirth) and chronic conditions (i.e. asthma, heart diseases, diabetes, mental health, and disabilities).

Service Delivery Challenges: The three most cited service delivery challenges for the programs in the Division of Medical Assistance (DMA) were access and coordination of health services, cost containment, and reimbursement for services, and health education and training needs for educating consumers on appropriate use of services. For example, one section mentioned the need to develop after business hour alternatives to reduce emergency department use as service delivery challenge, while another cited the need to improve the appropriate use of Medicaid covered services by African Americans and other minority Medicaid recipients. Curtailing health care costs was a common theme emerging from almost all the Medical Assistance sections. In terms of health education and training,

programs such as the NC Health Choice for Children cited “convincing families to feel empowered to use the system at the first sign of illness rather than as a last resort for wellness” as a primary challenge.

Socio-Cultural Challenges: The main socio-cultural challenges faced by the division are summarized in the figure below. The most frequently cited socio-cultural challenge was language, communication and attitudes and conflicting, values systems of clients and providers. Examples of language related challenges include “lack of Spanish speakers and those sensitive to Hispanic/Latino culture among professional community”. Other socio-cultural challenges mentioned include “need for after hours clinics staffed with Spanish speakers”, “educating cross-cultural families about how to use and trust the health system here”, “elimination of beliefs that keep people from seeking medical care” and elimination of provider and provider/staff attitudes that discourage Medicaid recipients, particularly minority Medicaid recipients from seeking or obtaining medical care. Some of the sections also indicated that beliefs or myths related to the health care system were also important socio-cultural challenges.

Disparity Focus Areas: The main disparity focus areas for DMA include income, disability, age, and race/ethnicity. According to the division, these focus areas are largely determined by state and federal mandates, which determine income eligibility to programs such as Medicaid or State Children Health Insurance Programs (SCHIP). Eligibility is usually based on income, age, and disability status.

DIVISION OF MEDICAL ASSISTANCE – HEALTH DISPARITIES IMPLEMENTATION PLAN

KEY RECOMMENDATIONS		ACTION STEPS		TIME LINE		EVALUATION		DATA NEEDS		AVAILABLE RESOURCES	
1. Increase awareness of health and service disparities, especially disparities related to race/ethnicity, disability and socioeconomic status.		Examine Medicaid paid claims data and Medicaid eligibility data for patterns of disparity among race/ethnic groups.	November 1, 2002	Report of data analysis Report to DMA Health Disparities Committee	Medicaid eligibility information by race/ethnicity Medicaid recipient information by race/ethnicity Medicaid expenditures and utilization by race/ethnicity Primary Care and ER visits by race/ethnicity Eligibility Categories by race/ethnicity	Medicaid paid claims data DMA Decision Support Staff DRIVE reports DMA Medical Policy Staff DMA Health Disparities Committee					
		Examine Medicaid paid claims data and statewide data for similarities in health disparities.	April 1, 2003	Report of data analysis Report to DMA Health Disparities Committee	Leading causes of death and morbidity in NC Various statewide studies and reports	DMA Health Disparities Committee Reports/Studies from State Center for Health Statistics Data from N.C. Primary Health Care Association Information from Office of Minority Health Data from HBCU Health Promotion Alliance Information from National Healthy People 2010 Office of Rural Health Information from members of DHHS Health Disparities Steering Committee See immediately above.					
		Measure, analyze and document health status inequities to identify priority areas for health interventions.	April 1, 2003	Report of data analysis Report to DMA Health Disparities Committee	Medicaid paid claims data analysis of diagnoses billed Correlation of diagnoses billed and leading causes of death						

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KEY RECOMMENDATIONS	ACTION STEPS	TIME LINE	EVALUATION	DATA NEEDS	AVAILABLE RESOURCES
2. Explore the possibility of working with identified groups of providers and other resource groups to communicate, document, and champion best practices in eliminating health disparities	Approach organized groups of providers to assist in promoting evidence based programs and interventions to address health disparities.	May 1, 2003	Evidence of partnerships with identified providers	Results of data analysis in 1 above Identification of target provider Groups	Medicaid Carolina Access ACCESS II & III Office of Rural Health HBCU N.C. Primary Health Care Association NC PAG DSS Directors Association NC Council (MH/DD/SAS) Assoc. of Public Health Directors Faith Community Old North State Medical Society
3. Promote, develop, and enhance community's capacity to engage in healthy living and elimination of disparities in health status.	Increase the appropriate use of medically necessary services by Medicaid eligible recipients in racial/ethnic groups at greatest risk of targeted health status inequities	June 30, 2003 – have plan established for this objective	Evidence of plan to increase appropriate use	Data similar to that analyzed in 1 above and additional data identified during process Identification of targeted health status inequities	See immediately above DMA health Disparities Committee
4. Monitor progress towards the elimination of health disparities	Collect and analyze data from Medicaid paid claims and other available statewide data on a regular basis.	June 30, 2003 – have regular monitoring schedule established	Evidence of regular monitoring schedule	Data similar to that analyzed in 1 above and additional data identified during process	DMA Health Disparities Committee
5. Promote customer friendly services that meet the needs of under served populations	Promote the hiring of bilingual Medicaid staff.	December 1, 2002 – have recruitment plan established	DMA employment statistics	Employment statistics relative to numbers/types of bilingual Medicaid staff hired	DMA Personnel Office DMA Supervisors and Managers
6. Demonstrate accountability and ownership for health outcomes	Identify an area of focus for improving health outcomes for a health indicator that indicates disparity	June 30, 2003 – have focus identified	Evidence of identified focus area	Analysis of data in 1 above	DMA Health Disparities Committee Other pertinent stake holders from 1 above