Medicaid in North Carolina

Annual Report

State Fiscal Year 2003

Division of Medical Assistance

nc department of health and human services

Michael F. Easely
Governor

Carmen Hooker Odom
Secretary

Gary H. Fuquay
Director

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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Gary H. Fuquay, Director

Dear Fellow North Carolinians:

I am pleased to present the North Carolina Medicaid Annual Report for State Fiscal Year 2003.

With the economy still in deep recession, it was an extremely challenging year for all of the state governments throughout the nation to sustain their Medicaid programs at existing levels. As the North Carolina SFY 2003 budget was being formulated, our legislature was faced with an estimated shortfall of $1.6 billion. Since state appropriations for the North Carolina Medicaid Program during the previous year were approximately $2 billion out of a total state budget of $14 billion, the Medicaid program was under tremendous scrutiny. Fortunately, when the last vote was cast, an appropriation of $2.2 billion was authorized, meaning that over a million North Carolinians would continue to receive the same level of health care insurance coverage they had in the previous year.

In order to continue to offer our citizens accessible, quality health care it was vital to sustain our on-going cost containment efforts and to expand them under new initiatives. The legislature mandated a variety of cost-saving measures, particularly through the elimination of provider reimbursement rate increases, prescription drug utilization management and the expansion of the Community Care managed care program. Additionally, the dedicated staff of the N.C. Medicaid program took a variety of steps to improve the administration and management of the program.

I invite you to read this report in its entirety in order to gain better insight into the N.C. Medicaid program and its many challenges and accomplishments during the year.

Sincerely,

Gary H. Fuquay, Director

Mission Statement

The mission of the Division of Medical Assistance is to manage the Medicaid program efficiently so that cost effective health care services are available through enrolled providers to all eligible persons across the state.

Table of Contents

List of Exhibits and Tables

Exhibits

Addenda Exhibits

Tables

Policy and Program Changes

State fiscal year 2003 brought a number of policy and program changes that were implemented either as a result of legislative or federal mandates or at the discretion of the Division of Medical Assistance (DMA).

Policy Changes Enacted by Mandates

Asset Policy Change

DMA adopted the Supplemental Security Income (SSI) method for considering equity value in incomeproducing property for aged, blind, and disabled persons. Accordingly, Medicaid no longer excludes the entire equity value of income-producing property for eligibles in the Medically Needy category. Any equity over $6,000 is a countable resource. This change does not affect business property such as an active farm. This policy change applies only to recipients enrolled in Medicaid as of December 1, 2002. Additionally, the General Assembly authorized sanctioning transfers of tenancy-in-common interest in real property. The uncompensated transfer of tenancy-in-common interest in real property results in a sanction unless it is transferred to an
allowable person.

Transfer of Assets Policy for Specified Home Care Services

Effective with dates of service of February 1, 2003 and after, DMA began to apply the federal transfer of asset policies to Medicaid recipients in the aged, blind, disabled and qualified Medicare beneficiaries (MQBQ) eligibility categories receiving the following services: personal care in private residences, home health services (including the supplies provided by home health agencies), durable medical equipment (including the supplies provided by durable medical equipment providers), home infusion therapy, supplies on the home health fee schedule provided by private duty nursing providers to their patients (not including nursing care). This policy change was similar to the transfer of asset requirements currently in place for Medicaid eligibles receiving care at nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR), as well as for those recipients participating in the Community Alternatives Programs. The policy change did not apply to adult care residents receiving State/County Special Assistance, but it does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories.

Drug Utilization Management

Various drug utilization measures were implemented to expand prescription drug cost containment, including expanding the use of generic drugs and a preferred drug list. One such initiative was the pilot ACCESS II and III Prescription Advantage List (PAL). The ACCESS Program's clinical directors developed a voluntary PAL as an educational resource for physicians in the ACCESS II and III programs and, beginning November 1, 2002, a list

of FDA approved drugs was piloted in ACCESS sites. The list placed drugs in the 10 highest cost classes into tiers based solely on their Average Wholesale Price (AWP). This pilot effort was intended to assess physician acceptance of a voluntary list. There was no prior approval process associated with the choice of drugs on the list. Medicaid continued to pay for any medication a physician considered medically necessary for the patient regardless of cost.

Another ACCESS II and III drug utilization initiative, the Nursing Home Polypharmacy Project, was piloted in November 2002. Benefits of the initiative include the potential for use of more appropriate drugs for the elderly and an increase in coordination between pharmacists and physicians. The initiative will be evaluated based on the following aims: decreased prescription drug costs; the preservation or the enhanced quality of prescription-drug related care; and a decrease in other health care service costs.

The Nursing Home Polypharmacy Project represents an effort by the ACCESS Medical Directors team to better manage prescribing practices for a patient population that averages nine prescriptions per month each. The program depends on the interaction and collaboration between the consultant pharmacist and the prescribing physician. Only the physician can authorize the recommended change to a recipient's drug regimen.

The medications in this initiative will be flagged if: 1) they appear on the PAL; 2) they represent a therapeutic duplication; 3) they appear on the Beers list; 4) the length of therapy appears excessive; or 5) the drugs appear on a list developed by a committee of long-term care pharmacists that feature drugs associated with potential significant savings.

Personal Care Services Limitations

The monthly limit for Personal Care Services was reduced from 80 hours per month to 60 hours per month effective with date of service December 1, 2002.

Pregnant Women Coverage for Minors

The N.C. Legislature mandated a policy change, to be effective October 1, 2002, that would have modified the determination of eligibility for pregnant women coverage for minors by the counting of parental income if the minor is residing in the parents' home as long as the minor has not been married, has not served in the military or has not been legally emancipated. The Centers for Medicare and Medicaid Services denied the State Plan amendment submitted by DMA that would have authorized this change, thus the policy was not changed.

Hospital Payments

NC Medicaid payments to hospitals were reduced by 0.5 percent. This was implemented through system and process changes.

Prospective Rates for Home Health Services

A prospective rate payment system was established for home health services. The new system pays for services based on an assessment of the specific needs of the Medicaid recipient. Payment for services is no longer tied to the number of provider visits.

Optional Services

Coverage of routine circumcision procedures were eliminated effective with date of service December 1, 2002.

ACCESS II and III Expansion and Cost Savings

The Medicaid budget was reduced to reflect anticipated savings from the expansion of ACCESS II and III care management activities including reducing hospital admissions, reducing emergency department visits, using best prescribing practices, increasing generic prescribing, implementing polypharmacy review, reducing therapy visits and better management of high risk/high cost patients. The entire NC Medicaid Managed Care Program, consisting of Carolina ACCESS, ACCESS II and III, and HMO's has been renamed "Community Care of North Carolina". Enrollment in ACCESS II and III is anticipated to increase gradually from the current level of 250,000 to 650,000. To encourage the expansion of ACCESS II and III networks, effective April 1, 2003, the monthly case management fee for Carolina ACCESS providers not linked with an ACCESS II and III administrative entity was reduced to $1.00 per member per month, while those linked with ACCESS II and III, and working on care management activities, continued to receive $2.50 per member per month.

Medicare Issues

Effective with dates of service October 1, 2002, Medicaid medical coverage policy was applied to Medicare crossover claims. Crossover claims are those claims that Medicare submits to DMA for health-care services provided to Medicare-Medicaid dual eligible recipients where Medicare is considered to be the primary payer. By March 1, 2005, Medicaid payment of a dual-eligible's Medicare Part B deductible and co-payments will be limited to the amount that would be paid for the rendered Medicaid service using Medicaid rates.

Case Management Services

Case management services for adults and children were reduced by lowering reimbursement rates, streamlining services and eliminating duplicative services.

Reimbursement Rate Reductions

Reimbursement rates for high-risk intervention, optical services and services provided by ambulatory surgical centers were reduced by 5 percent. Reimbursement rates for durable medical equipment and supplies, home health supplies and home infusion therapy were also reduced.

Medicare Coverage in Nursing Facilities

Effective with dates of service December 1, 2002, DMA began requiring nursing facilities to bill NC Medicaid for services only after the appropriate services had been billed to Medicare.

HIPAA Compliance

NC Medicaid implemented Health Insurance Portability and Accountability Act (HIPAA) standard transactions on May 1, 2003. Providers were required to submit electronic claims in the pre-HIPAA format until May 1, 2003. After May 1, 2003, Medicaid began accepting electronic claims in the new HIPAA format and will require the new format after October 16, 2003.

Policy Changes Not Mandated

Change in Carolina ACCESS Override Policy

Effective September 1, 2002, Carolina ACCESS overrides were no longer approved when an enrollee has failed to establish a medical record with the primary care provider designated on the enrollee's Medicaid identification card.

Outpatient Specialized Therapy Services

Beginning October 1, 2002, Medical Review of North Carolina began processing the requests for prior approval of outpatient specialized therapy services provided to all Medicaid recipients. Therapy services encompass all outpatient treatment for physical, occupational, speech, respiratory and audiological therapy regardless of where the services are provided. Additionally, specific medical necessity criteria were incorporated into the Outpatient Specialized Therapies medical coverage policy.

"Medically Necessary" Replaces "Dispense as Written"

Effective January 1, 2003, the words "medically necessary" written on a prescription were required to dispense a trade or brand name drug, except for antipsychotic drugs and drugs listed in the narrow therapeutic index.

Mental Health Services for HMO Enrollees Provided by Direct-Enrolled Mental Health Providers

Beginning with dates of service on or after February 1, 2003, direct-enrolled mental health providers were allowed to bill Medicaid for services rendered to HMO-enrolled recipients without a referral from the Area Mental Health Authority.

Note: For a brief history of the NC Medicaid Program and a year-by-year record of program and policy changes over the years, please go to the following website:
http://www.dhhs.state.nc.us/dma/publications.htm

Populations, Services and Expenditures

Populations and Eligibility Groups

The estimated population in North Carolina during SFY 2003 was 8,323,375. A total of 1,447,283 North Carolinians, or 17 percent of the total population, were eligible for Medicaid coverage at some time during the year. The monthly average number of eligibles was 1,047,444 or roughly one out of eight people. The number of recipients (i.e., those eligibles who actually received Medicaid services of any kind at some point in the fiscal year) was 1,454,661. This figure is slightly larger than the total number of eligibles because it counts some recipients who were eligible in SFY 2002 for whom claims were paid during SFY 2003. Compared with SFY 2002, the state population rose by 1.7 percent, the number of

Exhibit 1

NC Medicaid Average Monthly Eligibles by Eligibility Group - SFY 2003

Eligibility Group	Number of Eligibles	% of Total Eligibles
Pregnant Women & Children	352,101	33.6%
AFDC-related	339,210	32.4%
Disabled	192,306	18.4%
Aged	127,260	12.1%
Qualified Medicare Beneficiaries	34,040	3.2%
Blind	2,054	0.2%
Aliens & Refugees	473	0.0%
Total	**1,047,444**	**100.0%**

As indicated in **Exhibit 1** above, the largest category of eligibles during SFY 2003 was Pregnant Women and Children with a monthly average of 352,101 individuals, or about 34 percent of total eligibles. The Aid to Families with Dependent Children (AFDC) category was next in size with 339,210 individuals, or about 32 percent of the total eligibles. The AFDC category includes families with children who would have met eligibility criteria for the former AFDC program as of July 1996. As **Exhibit 2** on the next page shows, the AFDC-related population experienced the largest increase of enrollees of 26,691, or 8.5 percent. As was the case during SFY 2002, this relatively large increase was due primarily to the worsening of the economy and an unemployment rate in excess of 6 percent, resulting in a larger number of families qualifying for Medicaid. The Disabled category increased only modestly during SFY 2003 at 6,565, or 3.5 percent, while both the Aged and Blind categories experienced slight decreases.

Exhibit 2

Change in NC Medicaid Average Monthly Eligibles by Eligibility Group

SFY 2002 vs. 2003

Eligibility Group	SFY 2003 Eligibles	Amount of Change	% Change
AFDC-related	339,210	26,691	8.5%
Pregnant Women & Children	352,101	22,467	6.8%
Disabled	192,306	6,565	3.5%
Qualified Medicare Beneficiaries	34,040	2,639	8.4%
Aliens & Refugees	473	193	68.9%
Blind	2,054	(70)	-3.3%
Aged	127,260	(904)	-0.7%
Total	**1,047,444**	**57,581**	**5.8%**

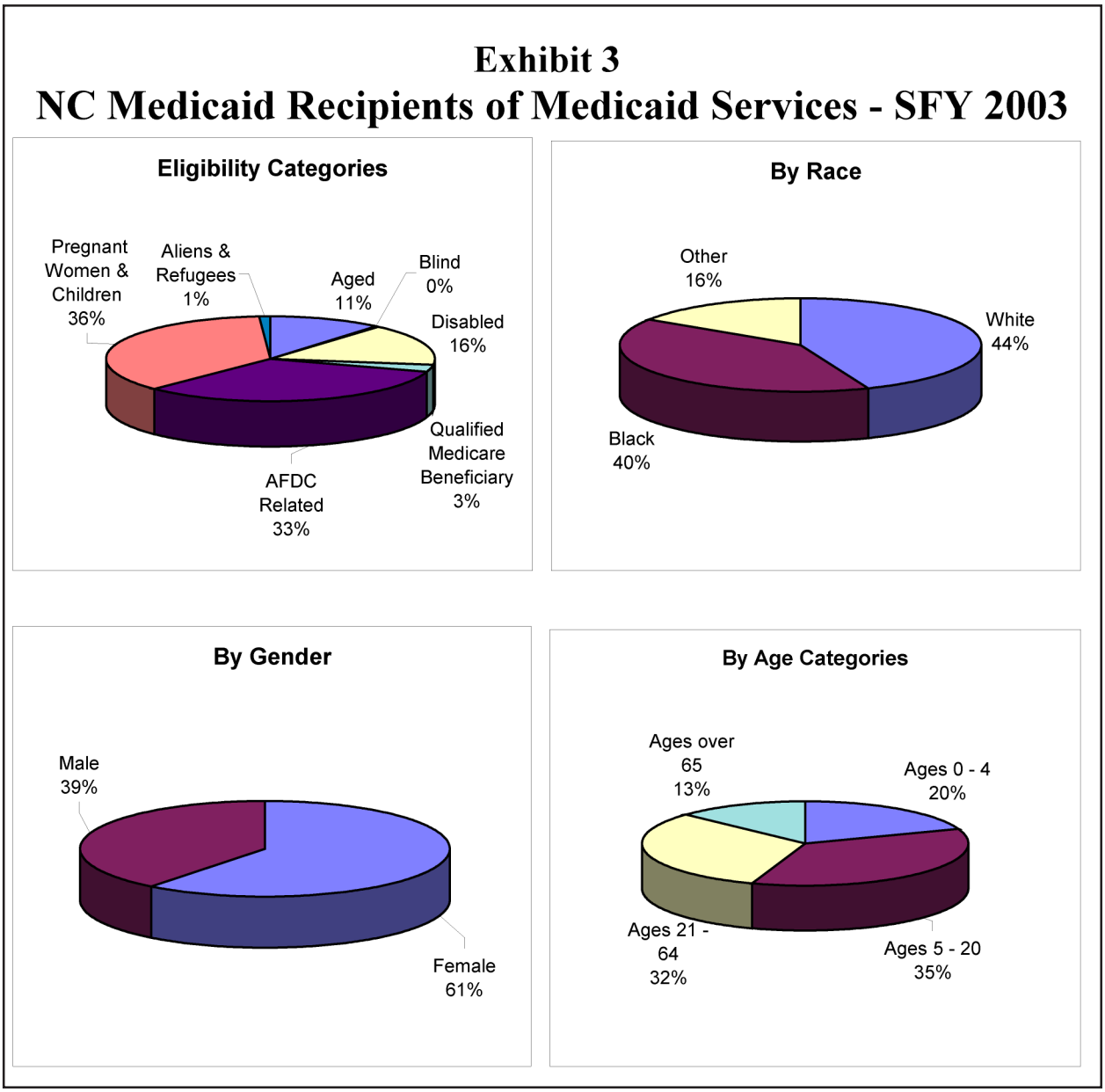
Exhibit 3 on the next page shows the distribution and some of the characteristics of recipients of Medicaid services. The percentage of recipients in each program category approximates the distribution of eligibles shown in **Exhibit 1,** but it varies somewhat because not all eligibles actually become recipients of one or more services in a given year. For instance, Pregnant Women and Children were the largest recipient group and represented almost 36 percent of Medicaid recipients, while they constituted 34 percent of Medicaid eligibles. Forty-four percent of recipients were white, 40 percent were black, and the remaining 16 percent were of other races. A total of 61 percent of recipients were female and 39 percent male. When Medicaid recipients are grouped by age, children ages 5 to 20 constitute the largest group at 35 percent, while adults aged 21 to 64 are the second largest group, followed by young children from birth to 4 (20 percent) and the elderly, ages 65 and older, at 13 percent.

Services and Expenditures

With the continuing stagnation in the national and North Carolina economies, SFY 2003 was an extremely challenging budget year for State government. On the heels of a 2001-02 revenue shortfall exceeding $1.5 billion, which Governor Easley addressed through end-of-year emergency spending cuts, the N.C. Legislature faced an estimated 2002-03 revenue shortfall of $1.6 billion as it passed the final SFY 2003 budget. The final outcome was the passage of a budget that included State appropriations for the NC Medicaid Program in the amount of approximately $2.2 billion. This was a reduction of approximately $35.5 million in the amount that was initially set aside for SFY 2003 in the 2001-03 biennium budget.

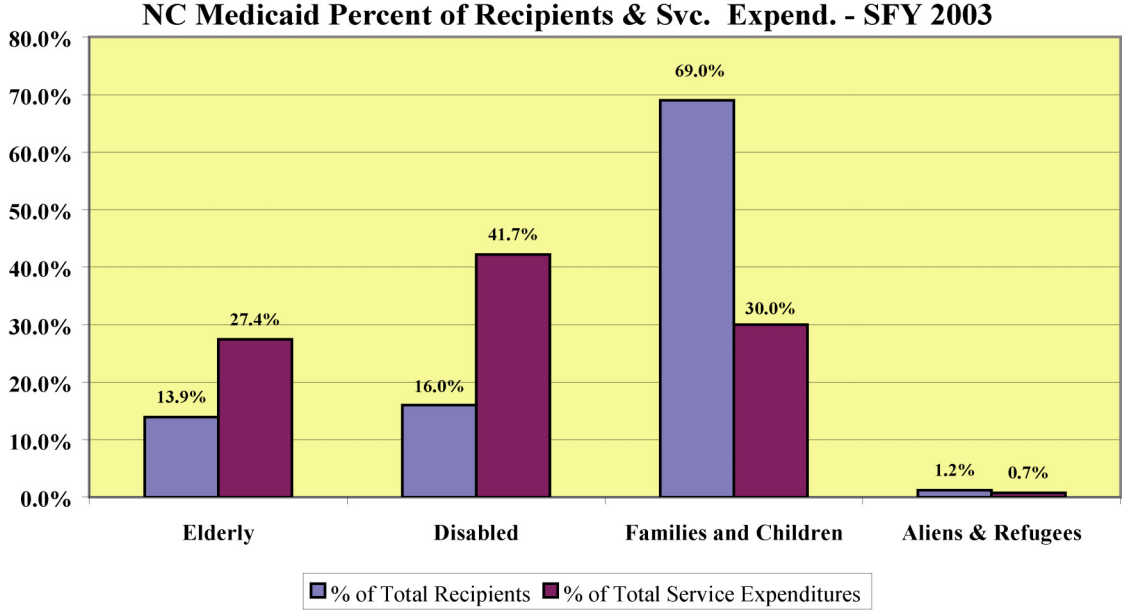
The SFY 2003 Medicaid budget included various funding increases and reductions as mentioned above in the "Policy and Program Changes" section. It is noteworthy that in spite of the adverse financial climate, the NC Medicaid program was able to avoid massive reductions in its medical benefit package and, therefore, in related service expenditures; nor were cost savings achieved through restrictions in program eligibility except for the relatively small changes related to assets mentioned in the "Policy and Program Changes" section above. During SFY 2003, many states resorted to applying drastic restrictions in the "optional" eligible population in order to balance their budgets. Such was not the case in North Carolina.

Exhibit 3
NC Medicaid Recipients of Medicaid Services - SFY 2003



As indicated in **Tables 6 and 10** (see the "Medicaid Tables" section at the back of this report), a total of approximately $6.6 billion was spent on health services and premiums for 1,454,661 Medicaid recipients, or $4,530 per recipient during the year. While total service and premium expenditures increased by 6.7 percent, the per recipient increase was a very modest 2.8 percent over SFY 2002. **Exhibits 4** below and **Exhibit 5** on the next page show that Elderly and Disabled recipients numbered 13.9 percent and 16 percent of total recipients respectively. Yet, service expenditures for these two groups amounted to approximately $4.6 billion, or 69.6 percent. These two groups received more services and services that were more expensive per unit than any other group. Recipients from the Families and Children group, on the other hand, represented 69 percent of all recipients, however they accounted for approximately $2 billion, only 30 percent, of total service expenditures. **Exhibit 6** on the next page shows that per recipient expenditures for each of the recipient groups increased between SFY 2002 and SFY 2003 with the exception of Aliens & Refugees, which realized a 2.7 percent decrease.

Exhibit 4
NC Medicaid Percent of Recipients & Svc. Expend. - SFY 2003



As **Table 6 and 7** indicate (again, see "Medicaid Tables"), the grand total of Medicaid and Medicaid-related expenditures in SFY 2003 was $7,439,757,929, an increase of only 1% over SFY 2002. Of this amount, $6,589,067,833 was spent on direct health care services to Medicaid recipients as mentioned above. The balance of approximately $850 million in expenditures was allocated to a variety of categories including adjustments, cost settlements, disproportionate share hospital payments, transfers and State and county administration. Lower expenditures for these items in SFY 2003 offset the 6.7% increase in service and premium expenditures, thus, resulting in the 1 percent increase in the grand total of

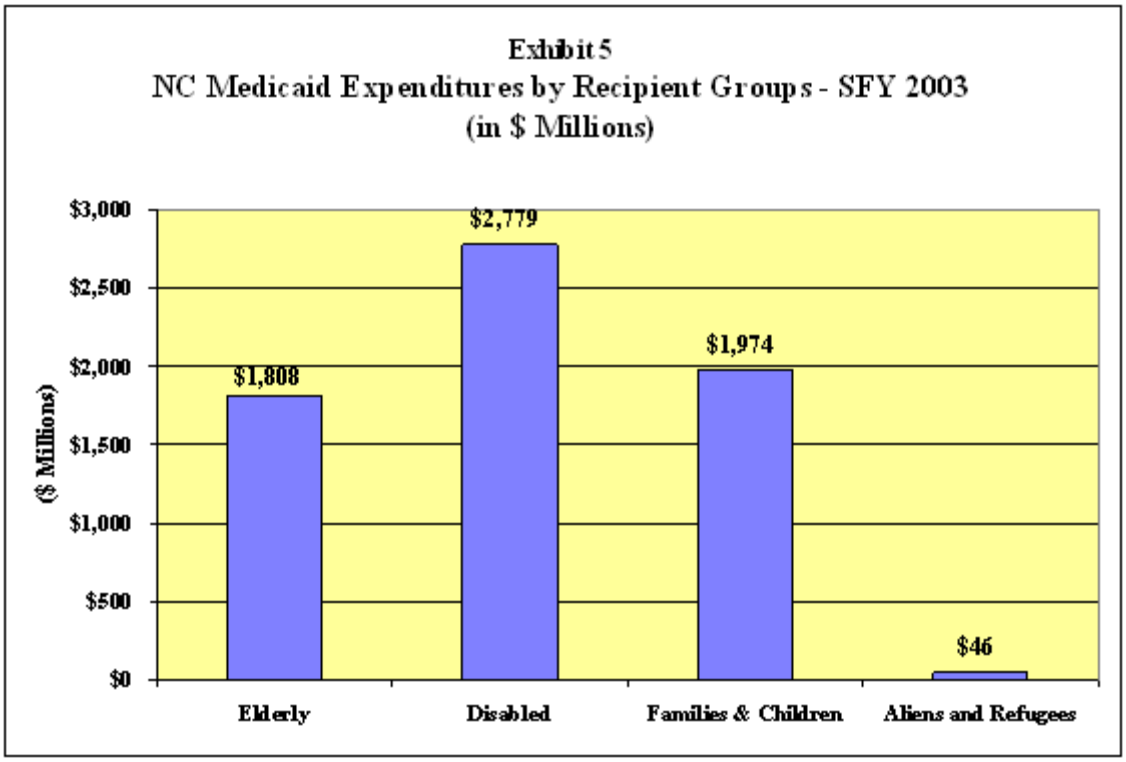


Exhibit 5
NC Medicaid Expenditures by Recipient Groups - SFY 2003
(in $ Millions)
($ Millions)
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
$1,808
$2,779
$1,974
$46
Elderly
Disabled
Families & Children
Aliens and Refugees

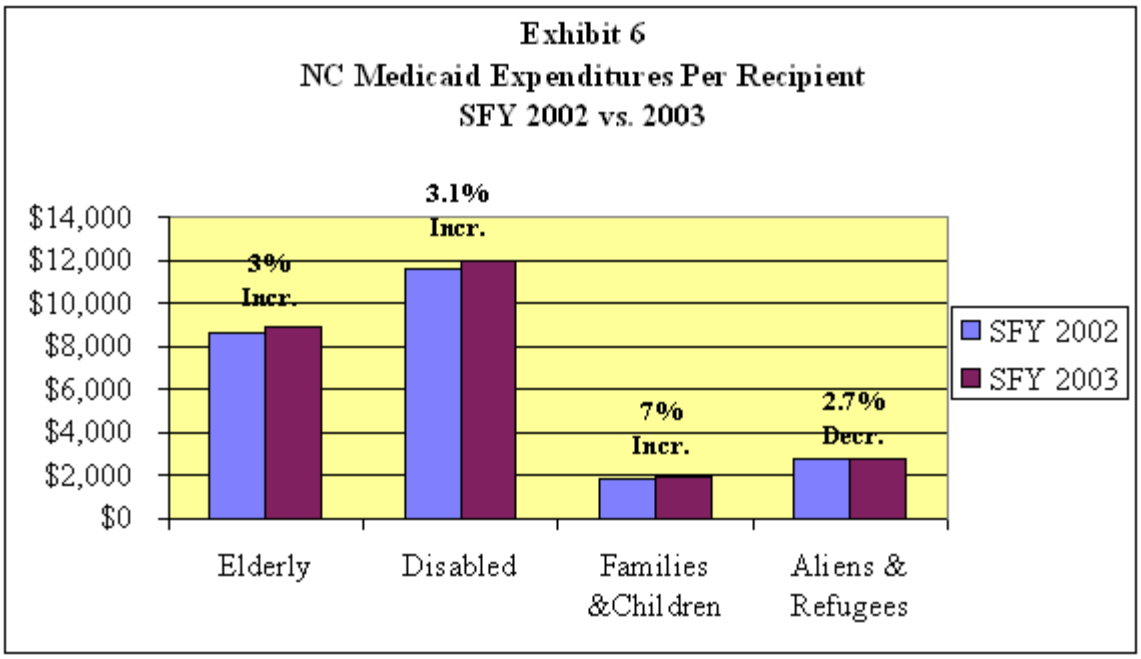


Exhibit 6
NC Medicaid Expenditures Per Recipient
SFY 2002 vs. 2003
$14,000
$12,000
$10,000
$8,000
$6,000
$4,000
$2,000
$0
3% Incr.
3.1% Incr.
7% Incr.
2.7% Decr.
Elderly
Disabled
Families &Children
Aliens & Refugees
SFY 2002
SFY 2003

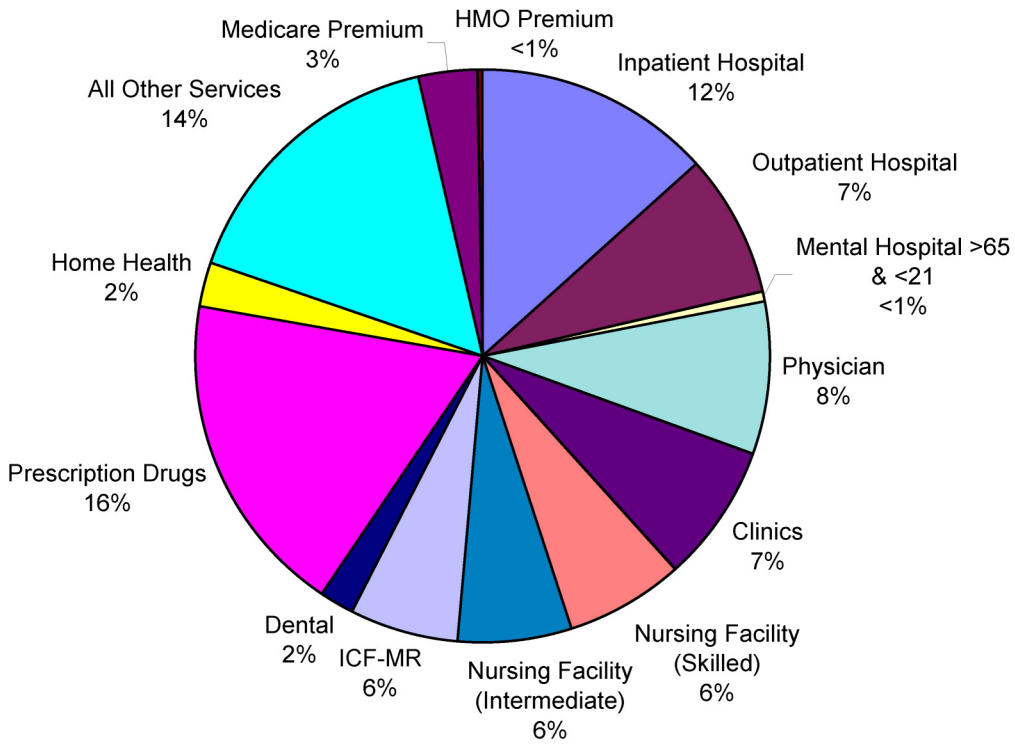
expenditures. DMA spent approximately $310 million or 4.2 percent of total SFY 2003 expenditures on administration. This is a relatively modest amount when compared with Medicaid programs in the other 49 states (source: Federal Fiscal Year 2001 CMS 64 Report; the most recent comparative data). Of all Medicaid services provided, the Prescription Drug service category was the most expensive, at roughly $1.2 billion, or 16.2 percent of all service expenditures as shown in **Table 6** and **Exhibits 7 below and 8** on the next page. This was an increase of roughly $147 million, or 14 percent, over the previous fiscal year. Approximately 51 percent of the increased expenditure was due to the change in the average monthly number of recipients. A total of 35 percent of the Prescription Drug expenditure increase was due to a change in the average amount paid per prescription, due in part to price increases and the type of drugs prescribed. The remaining 14 percent was due to an increase in the average number of prescriptions per recipient. Increased annual expenditures at 14 percent are compelling DMA to continue its intensive prescription drug cost containment efforts during SFY 2004 and beyond. Inpatient hospital services, the second highest category of service expenditures, accounted for approximately $843 million, or 11.8 percent, of total service expenditures. This was an increase of approximately $10 million, or 1.2 percent, mostly attributable to an increase in the number of individuals receiving this service. **Exhibit 7** gives a picture of the growth of DMA's service expenditures from SFY 2002 to SFY 2003, showing the highest categories of non-long term care expenditures, while grouping the long term care expenditures. It is worthwhile noting that while Total Services and Premiums expenditures grew by $411 million, or 6.7 percent, the non-long term care expenditures grew by 9.7 percent while long term care grew by only 1.2 percent.

Exhibit 7
NC Medicaid Highest Categories of Non-Long Term Care Expenditures
SFY 2002 vs. 2003
Sorted on Amount of Change

Category of Service	SFY 2003 Expenditures	Amount of Change	% Change
Prescription Drugs	$1,203,630,913	$147,472,163	14.0%
Outpatient Hospital - General	$339,777,292	$86,972,807	34.4%
Mental Health Clinics	$394,342,036	$79,164,556	25.1%
Outpatient Hospital - ER	$166,031,246	$44,341,161	36.4%
Dental	$129,089,384	$24,701,381	23.7%
Inpatient Hospital	$843,137,417	$9,848,155	1.2%
Physician	$571,538,736	($12,256,273)	-2.1%
Other Non-Long Care Term	$691,978,615	$4,034,051	0.6%
Total Non-Long Care Term	**$4,339,525,639**	**$384,278,001**	**9.7%**
Total Long-Term Care	$2,247,261,944	$26,599,360	1.2%
Total Services & Premiums	**$6,586,787,583**	**$410,877,362**	**6.7%**

Note: Long-term care includes skilled and intermediate care nursing facilities, hospital long term care, home health, durable medical equipment, Community Alternative Programs, home infusion therapy, hospice, personal care services and adult care home services.

Exhibit 8
NC MEDICAID SERVICE EXPENDITURES - SFY 2003



As indicated in **Table 10** and in **Exhibit 9**, overall health services costs per recipient rose slightly. The SFY 2003 total annual service expenditures for each recipient were $4,407, a modest 2.8 percent increase over the previous year. Among the service provider groups shown here, per recipient expenditures were the highest for Hospital services ($966 per recipient) and lowest for Medicare Part A and Part B premiums ($145 per recipient). Between SFY 2002 and 2003, the highest per recipient expenditure increase was 9.9 percent for Pharmacy and the largest decrease was 4.8 percent for Institutional services (i.e., non-behavioral health skilled nursing and intermediate care facilities).

As **Exhibit 10** on the next page indicates, approximately 88 percent of North Carolina's Medicaid recipients received services from a physician at least once during SFY 2003

Exhibit 9
NC Medicaid Expenditures Per Recipient - SFY 2003
All Eligibles by Service Provider Group

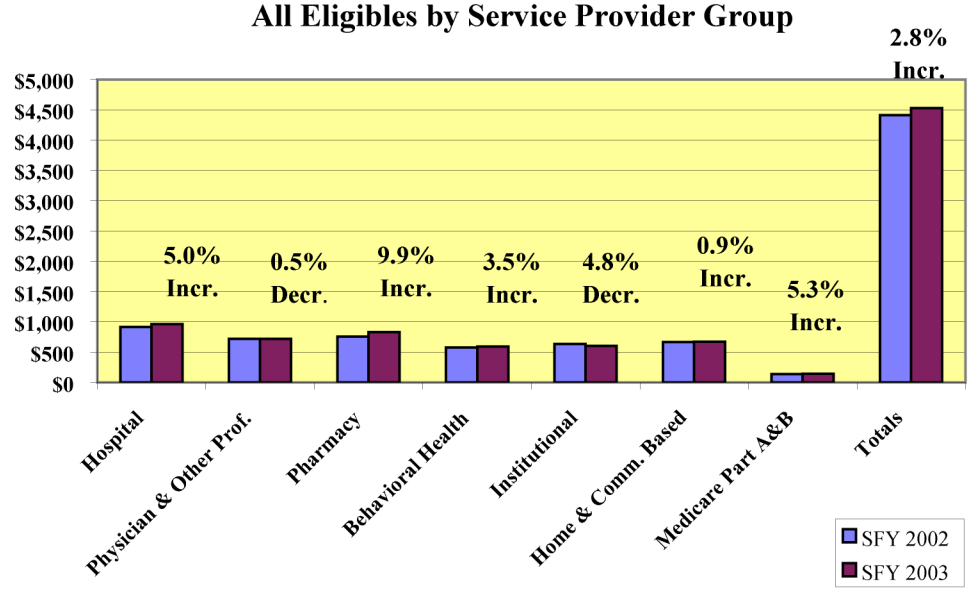
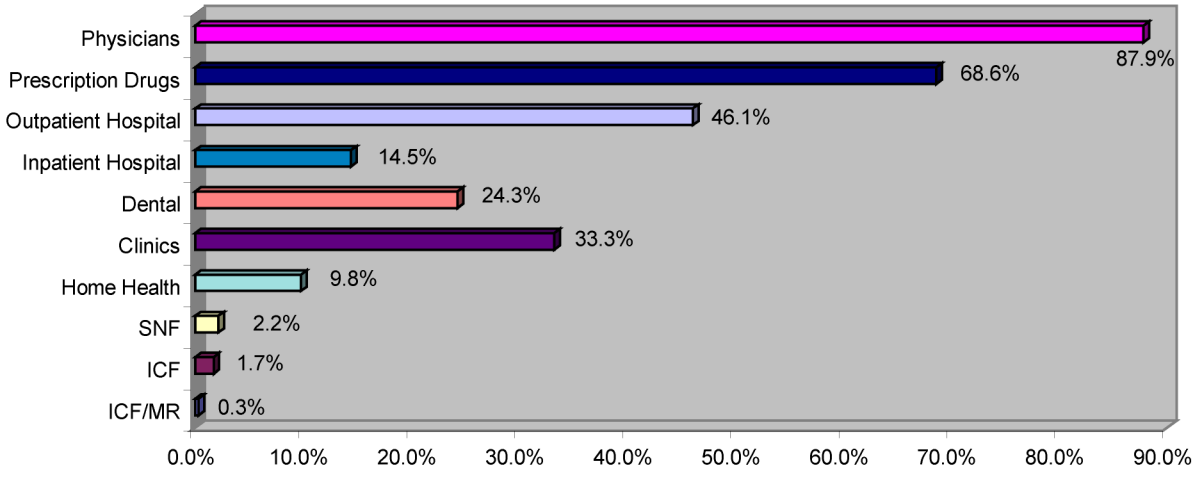


Exhibit 10
State Fiscal Year 2003
Selected Medicaid Services
Percent of Total Users



and 69 percent received at least one prescribed drug. The utilization rate falls off dramatically for other service providers.

Medicaid eligibility and expenditures vary widely among the 100 North Carolina counties, as **Table 9** in the "Medicaid Table" section indicates. The percentage of Medicaid eligibles in the general population is as high as 34 percent in Robeson County and as low as 8.4 percent in Orange County. Expenditures per eligible ranged from a high of $5,889 in Avery County to a low of $3,529 in Cumberland County. Lastly, expenditures per capita were the highest in Bertie County at $1,659 and the lowest in Wake County at $424.

Note: Detailed information regarding expenditures and services is available in the "Medicaid Tables" section of this report.

Major Accomplishments

Settlement of the Medicaid Dental Lawsuit

In November 2000, a class action lawsuit entitled *McCree et al v. Odom et al* was filed against DMA. The lawsuit focused on improving access to dental care for children (under age 21) enrolled in the NC Medicaid program. In January 2003, the plaintiffs and defendants agreed to a settlement of the lawsuit and on March 6, 2003, Federal District Court Judge Malcolm Howard approved a contingent settlement. The main element of the settlement was an increase in reimbursement rates for 36 dental procedures selected to benefit children. The agreed-upon rates were set at 73 percent of the corresponding UNC-CH Dental Faculty Practice fees current at that time. The original rate increases went into effect on April 1, 2003. Subsequently, the plaintiffs and defendants agreed to several minor modifications of these rates. It is important to note that these increased rates apply to Medicaid recipients of any age for whom the listed procedures are applicable. So it is hoped that this settlement will improve access for adults as well as children.

Even at current levels of access, these new rates have been projected to increase Medicaid dental expenditures by $18.5 million on an annualized basis. This represents an approximately 14 percent increase in Medicaid dental expenditures based on actual spending of $129 million for the 2002-03 state fiscal year.

A second important element of the lawsuit settlement is the establishment of a Medicaid Dental Advisory Committee under the auspices of the NC Physicians Advisory Group (NC PAG). The NC PAG is a non-profit organization of health care providers that the NC General Assembly has charged to provide policy guidance to DMA. Dr. Jasper L. Lewis, Jr. of Greenville has been appointed to serve as the first dentist on the NC PAG Board of Directors. Dr. Cindy Bolton of Reidsville, a member of the North Carolina Dental Society Board of Trustees, has been nominated to chair the Dental Advisory Committee.

Program Integrity Collections and Cost Avoidance

A total of $1,329,538,709 was saved in the NC Medicaid Program through collections and cost avoidance in SFY 2003. The DMA Program Integrity Section worked cooperatively with the Attorney General's Medicaid Investigation Unit, and the 100 county departments of social services to achieve these savings. Recoveries and cost avoidance savings were accomplished through reviews of provider billings and medical records, coordination with other insurers and payers where Medicaid was not the primary payer, through estate recovery, and through legal and civil actions cooperatively with State and local law enforcement. DMA Financial Operations, Audit Section staff also audited provider's financial records.

- Program Integrity's Third Party Recovery Section cost avoided Medicaid payments of $1,026,280,066 for Medicare claims and $214,975,840 for private health insurance.

- Direct recoveries, resulting from casualty, medical insurance and estates, increased to $47 million.
- Program Integrity's four investigative units resulted in the recovery of $11,268,920 in overpayments billed by providers.
- The Attorney General's Medicaid Investigations Unit (MIU) collected $14,000,000 in restitution, fines, penalties, and interest when they concluded criminal and civil cases. Money from the fines went to the State's School Fund as required by the NC Constitution. The MIU also had 31 convictions. PI nursing staff act as consultants to the AGO in many of these cases.
- Recipient fraud investigators in the local departments of social services recovered $1,683,700.98 in overpayments. The State helped the county investigators collect $106,801.45 by intercepting North Carolina income tax refund checks from delinquent debtors.
- Financial Operations auditors recovered $14,330,182 through audits of nursing home and ICF/MR facilities.
- The state continues to have a 99.3 percent accuracy rate in Medicaid eligibility determinations. Program Integrity's Medicaid Eligibility Quality Assurance Unit reviews a sample of all Medicaid cases statewide and provides helpful feedback for corrective action to the county agencies.

The Program Integrity Section operates one of the more unique fraud and abuse detection software systems in the country. Only a handful of states utilize the technology similar to that used by DMA. The accomplishments listed above were made possible through the use of increased automation and effort on the part of staff. The average return per employee is over $1 million.

Program Integrity also assists the Office of State Auditor in determining the Medicaid program accuracy rates for claims billed by providers to Medicaid (see **Exhibit 11**).

Exhibit 11
NC Medicaid - SFY 2003
Annual Error Rates for Claims Billed to Medicaid

	# Of Claims in Sample	Error Rate per OSA	Confidence Level	Sampling Precision
1995-96	283	0.50%	95%	-0.04
1996-97	282	2.20%	95%	-0.04
1997-98	279	1.10%	95%	-0.04
1998-99	274	2.20%	95%	-0.04
1999-00	300	1.50%	95%	-0.04
2000-01	300	0.80%	95%	-0.04
2001-02	270	2.80%	95%	-0.04
2002-03	272	1.80%	95%	-0.04

Medicaid Payment Accuracy Measurement Demonstration Project

DMA Program Integrity received a grant from the Centers for Medicare and Medicaid Services (CMS) to participate in a Medicaid Payment Accuracy Measurement (PAM) demonstration project. The goal of the project is to help CMS determine the feasibility of estimating Medicaid claim payment accuracy for the Medicaid program at the state and national level. This is an effort supported by the U.S. House of Representatives (HR 4878) and the Office of Inspector General (OIG). This was Program Integrity's second PAM grant year. Year three has already been approved for this coming federal fiscal year.

An essential part of this project consists of a review of a stratified sample of Medicaid claims and a review of the corresponding medical records. Program Integrity staff and Medical Review of North Carolina will contact providers whose claims fall in the sample to obtain medical records for the services billed to Medicaid. Samples will be taken from inpatient hospital services, long-term care services, independent practitioners and clinics, prescription drugs, home- and community-based services, and other supplies and services.

Pharmacy

The NC Physician Advisory Group (PAG) and the leadership of the Community Care Program (ACCESS II/III) have partnered with NC Medicaid to further evaluate the pharmacy program and recommend strategies to control costs while maintaining our focus on quality of care for our recipients. When reviewing pharmacy expenditures, we found: (1) the top 15-16 therapeutic drug classes of medications by cost account for almost 60 percent of the total pharmacy cost expenditures, (2) there are opportunities for educating prescribers on the actual drug costs to NC Medicaid program and (3) it would be timely to request "voluntary" help from all of our prescriber community to prescribe less expensive medications whenever appropriate. From the above philosophy, the Prescription Advantage List (PAL) was developed first as a pilot and then for statewide implementation. The PAL list can be found at www.dhhs.state.nc.us/dma/prov.htm under the "Pharmacy" heading. Another initiative that arose from the PAL was the PAG Pharmacy Committee recommendation to DMA to allow coverage for selected OTC medications under a well written policy, which can be located at www.dhhs.state.nc.us/dma/mp/mpindex.htm under A2 OTC. The criteria for coverage are:

- A legend drug is approved by FDA as an OTC drug and, if covered by Medicaid, the cost of the OTC version would result in significant cost savings to Medicaid.
- An efficacious drug is available only as OTC and not legend, and all other legend treatments are significantly (>20 percent) more expensive without a significant increase in effectiveness.
- Coverage for an OTC or a group of OTCs expands treatment options because they have been shown to decrease the total cost of care for certain conditions.

In addition to costs, providers have stated they would like an up-to-date evidenced-based review of literature regarding drug therapy and difference among medications within each class of medication (clinical pearls). North Carolina has partnered with Oregon and currently nine other states to contract with Evidenced-Based Practice Centers (EPCs) to perform comprehensive reviews of selected classes of medications. The full reviews will be made available to NC providers on the Internet. The PAG Pharmacy Committee will be asked to develop key clinical pearls for inclusion in future PAL updates. By providing our NC providers with relative cost and current evidence-based information regarding medications, they will have available the necessary tools to make the best clinically sound, cost-effective choice for their patients.

HIPAA Project

The primary accomplishments of the Health Information Portability and Accountability Act (HIPAA) project during SFY 2003 were in the areas of the business review of transaction and code sets and the subsequent technical development and testing of these requirements. There was an on-going analysis and research effort for HIPAA code conversions culminating in the processing of 23 code conversion requests to EDS, our claims processing contractor. DMA staff training sessions relating to the HIPAA privacy requirements were conducted such that we met the April 16, 2003 deadline. Both code conversion and training have now become an on-going effort.

In addition to the work on HIPAA transactions, other accomplishments were made in several related areas. The cross-walk of Explanation of Benefits (EOB) codes to the HIPAA national codes was completed and loaded to the MMIS + Browser to support the use of the new "835" electronic remittance advice. DMA uses the 835 to respond to a provider's submission of an "837" electronic claim (the 837 replaces the old HCFA 1500 claim form). A draft of the Trading Partner Agreement was submitted for review. The Recipient and Provider Services section continued to receive and process HIPAA questionnaires. Frequently asked questions (FAQ) were published on the DMA HIPAA web site. Education sessions for the provider community were also conducted during the year.

Highlights of Carolina ACCESS Provider Satisfaction Survey

In March through May of 2002, the Division of Medical Assistance (DMA) Managed Care Section conducted a Provider Satisfaction Survey using a random sample of participating Carolina ACCESS primary care providers. The purpose of this survey was twofold: To measure provider satisfaction for submission with the 1915(b) Managed Care waiver renewal and to strengthen the program by identifying potential educational opportunities.

The state is divided into six geographical regions, each region is assigned a Managed Care consultant. The six regional Managed Care Consultants administered the survey by telephone or by office visit. The survey was designed to measure five areas of satisfaction: overall satisfaction with Carolina ACCESS, satisfaction with the referral process, satisfaction with billing/claims, satisfaction with administrative support and education and satisfaction with recipient education.

The results of the survey indicate that overall, the Carolina ACCESS program is meeting its goal of ensuring provider satisfaction. Provider comments and suggestions for improvement have been reviewed to identify strengths and possible areas for improvement within the Carolina ACCESS program. The Managed Care Section will develop policies and strategies to address the provider issues identified in the survey.

Highlights of Carolina ACCESS Contractual Compliance Survey

In the spring of 2002, the Managed Care Section conducted a Contractual Compliance Survey using a random sample of participating Carolina ACCESS primary care providers. The survey results indicate that the majority of providers are meeting their contractual requirements. The programmatic areas surveyed included coordination of care, appointment availability, access to medical advice, office hours, hospital admitting privileges, patient disenrollment and the Women, Infant, and Children Special Supplemental Nutrition Program (WIC). The survey supported DMA's efforts to provide quality care to Medicaid recipients.

Quality and Healthcare Outcome Improvements

The Quality Management (QM) Unit within DMA's Managed Care section continued efforts in quality improvement through initiatives regarding prenatal care, pediatric asthma, Health Check and immunization compliance, HEDIS and other utilization data reporting and follow up, children with ADHD, adults with congestive heart failure and the evaluation of the prescribing of unnecessary antibiotics. Results of completed studies and initiatives may be found under "Publications – Quality Management Initiatives" on the DMA web page at www.dhhs.state.nc.us/dma/ca/qm.htm.

HEDIS

The QM Unit, in conjunction with DMA Information Systems staff, utilized the Health Plan Employer Data and Information Set (HEDIS) to measure and evaluate the quality of care and delivery of services to Medicaid beneficiaries in all systems of care within the Community Care Program (Carolina ACCESS, ACCESS II/III and HMOs) and provide a basis for setting quality standards for ongoing performance.

The analysis for HEDIS CY 2002 data (reporting year 2003) was completed and showed similar results to the HEDIS CY 2001 (reporting year 2002) in the areas of children's

access to primary care practitioners and breast and cervical cancer screenings. There were noted increases in the areas of childhood immunizations (61.16 percent during SFY 2002, up from 58.27 percent in SFY 2001) and diabetic HbA1c testing (31.34 percent during SFY 2002 vs. 27.09 percent in SFY 2001). These increases could be attributed to interventions undertaken by the DMA Managed Care QM Section in these two areas. Re-measures in the future will further confirm the impact of these strategies to improve diabetic care and improve the immunization rate for children. Areas noted for improvement are adolescent immunization rates, which fell below the NCQA Medicaid Mean in all systems of care and prenatal care in the first trimester. The QM Section continues to work collaboratively with the Health Check Program and the Division of Maternal and Child Health to improve the care for these populations. Additionally, the rates for appropriate medications for persons with asthma fell slightly from SFY 2001 data in the three age groups (age 5-9, age 10-17 and age 18-56) by 2.87 percent to 7.92 percent. The QM Section anticipates that these numbers will be improved across all systems of care as strategies are implemented across the state to educate physicians, patients and families with standardized asthma action plans (see "Pediatric Asthma" below). The SFY 2002 HEDIS data indicates a rise in Emergency Department visits (60 visits per 1000 member months as compared to 42.3 visits per 1000 member months during SFY 2001). This increase can be attributed, in part, to the Balanced Budget Act requirement for emergency services. The QM Unit will develop strategies to address this issue through the development of a medical home collaborative in conjunction with the NC Children's Health Initiative Group through UNC-CH. The collaborative will involve educating physicians in the medical home model who in turn will educate patients enrolled in their practice. Physicians are also being encouraged to expand offices hours and provide flexible scheduling to increase access to primary care after normal office hours.

Pediatric Asthma

In an effort to spread asthma quality improvement initiatives across the state, Managed Care staff are working with the North Carolina Center for Children's Healthcare Improvement (formerly known as the Children's Primary Care Research Group or CPCRG) and the National Initiative for Children's Healthcare Quality (NICHQ) to develop and implement site visit tools and protocols to support practice level quality improvement activities for Carolina ACCESS primary care providers. Currently, this project is in test phase for implementation during SFY 2004.

ADHD Collaborative

A learning collaborative focusing on children with Attention Deficit Hyperactivity Disorder was completed during SFY 2003 in cooperation with NCCHI and NICHQ. This collaborative involved approximately 20 North Carolina ACCESS and ACCESS II/III practices with the specific objectives of early identification, diagnosis, appropriate medication and psychotherapeutic intervention, patient and family education and support, and community collaboration particularly with the school systems. Collaborative data indicated improvement in the following process and outcomes measures:

- Percent of patients with the benefits and risks of treatment options explained increased from 45 percent at baseline to 84 percent.

- Percent of patients with a structured diagnostic assessment in the chart from 41 percent at baseline to 75 percent.
- Percent of patients with a written care plan in the chart from 53% at baseline to 91 percent.
- Percent of patients with identified goals documented on their care plan from 38 percent at baseline to 60 percent.
- Percent of patients who maintain an acceptable level or improve functioning by 25 percent or more from 15 percent at baseline to 51 percent.
- Percent of patients who maintain an acceptable symptoms score or improve symptoms score by 25 percent or more from 25 percent at baseline to 56 percent.

Collaborative follow up activities with the NC Department of Public Instruction are scheduled for implementation during SFY 2004.

Congestive Heart Failure

A baseline study on congestive heart failure was completed in early 2001 in conjunction with a national project undertaken by Medical Review of North Carolina, Inc. (MRNC). Quality interventions that were implemented include a medical record flow sheet which was mailed to all physicians for use in care management and a brochure providing disease specific information which was mailed to CHF patients. MRNC completed the second phase of data abstraction to evaluate effectiveness of these interventions. The May 2003 report indicated sustained improvement in assessment of heart function and the use of appropriate medications for the treatment of CHF. The use of patient education materials and practice support were noted to be effective tools for quality improvement.

Utilization Reporting

The Quarterly Utilization Review Report is distributed to Community Care Program (except HMOs) providers to allow a comparison of an individual provider's utilization of services to recipients to the provider's peer group. QM staff, in conjunction with Managed Care Program Operations staff, has implemented a process to identify providers that may benefit from a site visit and medical record review to assess access to care and other quality indicators for improvement opportunities.

Antimicrobial Resistance

North Carolina and the Southeastern United States have among the highest antimicrobial resistance rates for common respiratory tract pathogens in the nation. The excessive use of antibiotics for common outpatient infections is a major contributing factor in the emergence of antibiotic resistant bacteria. QM is participating in a study with Medical Review of North

Carolina (MRNC) to estimate the prevalence of oral antibiotic treatment for acutenonbacterial respiratory tract infections among the adult Medicaid recipients in North Carolina and to promote a pilot project aimed at reducing the prevalence of oral antibiotic treatment among this population. In SFY 2002, an initial measure using paid claims data revealed that, overall, 63 percent of Medicaid recipients filled a prescription for a diagnosis for a nonbacterial respiratory tract infection. A total of 43,709 oral antibiotic prescriptions were filled. More than $1.5 million dollars was paid for these prescriptions. Several interventions have taken place including the administration of "cold kits" of symptom relief measures as a substitute for antibiotic prescriptions. Re-measurement of antibiotic use was completed in SFY 2003 and the report indicated that three of the four practices distributing cold and flu kits demonstrated substantial reduction in oral antibiotic use (-14 percent, -24 percent, -11 percent and +8 percent). The fourth practice indicated that the kits were lost during a move. The study concluded that while many organizations have introduced cold care kits, to our knowledge this is the first reported study of its kind and is highly suggestive that cold care kits may be of use in reducing antibiotic prescriptions. Larger studies are warranted to further assess the efficacy of this intervention and the effects on healthcare costs and on antibiotic resistance.

Prenatal Care

In an effort to improve the identification of cases of low birth weight and infant mortality and to reduce their rates, QM conducted a prenatal study of Medicaid Managed Care enrolled mothers who delivered in 1999. The report of this study was completed during SFY 2003 and included data on demographics, prenatal visits, documentation of prenatal care components, documentation of required tests, low birth weight and premature deliveries and the incidence of sexually transmitted diseases. The results of this study will serve as baseline information for the evaluation of future quality improvement strategies.

Health Check and Immunizations

During SFY 2003, a Health Check/Immunization/Medical Record study was completed in conjunction with Medical Review of North Carolina, Inc. and the North Carolina State Center for Health Statistics. The purpose of the study was to evaluate and compare compliance with the required components and schedules of preventive health visits (Health Check screenings) and immunizations throughout the Community Care Program. This data will be used in future quality initiatives to address identified areas for improvement.

The QM Unit completed the third and final year of participation in the Government Performance and Results Act (GPRA) national initiative to improve the rate of immunizations administered to 2-year-olds in the Medicaid program. The results of the calendar year 2002 HEDIS data showed an overall rate of 61.8 percent indicating improvement exceeding the targeted goal of 10 percent for the project.

Table 1
North Carolina Medicaid
State Fiscal Year 2003
Federal Matching Rates

Benefit Costs
(7/1/02 - 9/30/02)

	Family Planning		All Other
Federal	90.00%	Federal	61.46%
State	8.50%	State	32.76%
County	1.50%	County	5.78%
			100.00%

Benefit Costs
(10/1/02 - 3/31/03)

	Family Planning		All Other
Federal	90.00%	Federal	62.56%
State	8.50%	State	31.82%
County	1.50%	County	5.62%

Benefit Costs
(04/1/03 - 6/30/03)

	Family Planning		All Other
Federal	90.00%	Federal	65.51%
State	8.50%	State	29.32%
County	1.50%	County	5.17%

Administrative Costs
(7/1/02 - 6/30/03)

	Skilled Medical Personnel & MMIS*	All Other
Federal	75.00%	50.00%
Non-Federal	25.00%	50.00%

***MMIS-Medicaid Management Information System**

Table 2a
North Carolina Medicaid
State Fiscal Year 2003
Medicaid Financial Eligibility Standards

GROUP	FAMILY SIZE:	1	2	3	4	5
Pregnant Women and Children under age 1		$1,385/mo	$1,869/mo.	$2,353/mo.	$2,837/mo.	$3,321/mo.
	Resource Limit:	None				
Children age 1 through 5	Income Limit:	$996/mo.	$1,344/mo.	$1,692/mo.	$2,040/mo	$2,388/mo.
	Resource Limit:	None				
Children age 6 through 18	Income Limit:	$749/mo.	$1,010/mo.	$1,272/mo.	$1,534/mo.	$1,795/mo.
	Resource Limit:	None				
Children age 19 and 20	Income Limit:	$362/mo.	$472/mo.	$544/mo.	$594/mo.	$648/mo.
	Resource Limit:	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Caretaker Relatives - Individuals (usually parents) who live with children under age 19 to whom they are related when one or both of the child's parents are out of the home, dead, incapacitated or working less than 100 hours a month.	Income Limit:	$362/mo.	$472/mo.	$544/mo.	$594/mo.	$648/mo.
	Resource Limit:	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Aged (over age 65), **Blind** or **Disabled** by Social Security standards.	Income Limit:	$749/mo.	$1,010/mo.			
	Resource Limit:	$ 2,000	$ 3,000			
Medicare Beneficiaries - Persons who have Medicare Part A -						
* Medicaid pays for Medicare premiums, deductibles, and co-payments.	Income Limit:	$749/mo.	$1,010/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
* Medicaid pays Medicare Part B premiums only.	Income Limit:	$898/mo.	$1,212/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
* Medicaid pays Medicare Part B premiums only (Federal share of payment is 100%).	Income Limit:	$1,011/mo.	$1,364/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
Deductible/Spendown - Individuals who do not meet the income limits specified above and who have high medical bills may be eligible for Medicaid after meeting a deductible.	The deductible is based on how much the monthly income exceeds this	$242/mo.	$317/mo.	$367/mo.	$400/mo.	$433/mo.
	Resource Limit:					
	Families & Children	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
	Aged,Blind,Disabled	$ 2,000	$ 3,000			

Note: The Federal Poverty Level amounts change each year effective April. The above figures were in effect at the end of SFY 2003

Table2b
Financial Eligibility for Medicaid
based on
Percentage of Poverty (Annual)
SFY 2003

Family Size	100%	120%	133%	135%	185%	200%	SSI	MNIL	SA
1	$ 8,988	$10,776	$11,952	$12,012	$16,620	$17,964	$6,624	$2,904	$13,524
2	$12,120	$14,544	$16,128	$16,368	$22,428	$24,240	$9,948	$3,804	
3	$15,264		$20,304		$28,326	$30,528			
4	$18,408		$24,480		$34,044	$36,804			
5	$21,540		$28,656		$39,852	$43,080			

Note: The Federal Poverty Level amounts change each year effective April. The above figures were in effect at the end of SFY 2003

Table 3
North Carolina Medicaid
State Fiscal Year 2003
Enrolled Medicaid Providers

Providers	Number
Adult Care Home Providers	2,634
Ambulance Service Providers	407
Chiropractors	1,712
Community Alternatives Program Providers (CAP/C, CAP/AIDS, CAP/DD-MR, CAP/DA)	1,230
Dental Service Providers (Dentists, Oral Surgeons, Pedodontists, Orthodontists)	4,075
Durable Medical Equipment Suppliers	3,266
Health Maintenance Organizations (HMOs)	1
Hearing Aid Suppliers	196
Home Health Agency Providers (Home Infusion Therapy, Private Duty Nursing)	966
Hospice Agency Providers	79
Hospital Providers	888
Independent Laboratory Providers	201
Independent Practitioners (Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, Audiologists)	3,818
Local Education Agencies (LEAs)	105
Mental Health Program Providers	168
Mental Health Providers	3,026
Nursing Facility Providers	1,352
Optical Service Providers and Suppliers (Opticians, Optometrists)	1,880
Other Types of Clinics (Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers)	237
Personal Care Service Providers	793
Pharmacists	2,393
Physician Extenders (Nurse Midwives, Nurse Practitioners, Certified Registered Nurse Anesthetists)	2,326
Physicians	36,869
Podiatrists	513
Portable X-ray Service Providers	27
Psychiatric Facility Providers	551
Public Health Program Providers	616
Rural Health Clinic/Federally Qualified Health Center Providers	353
Total	**70,682**

Note: This is an unduplicated count of any provider enrolled during the year. Physicians may be counted individually and/or as a group. Includes 22,446 providers terminated by 6/30/2003

Table 4
North Carolina Medicaid
State Fiscal Year 2003
Medicaid Covered Services

1. Ambulance Transportation
2. Case Management for:
    - Pregnant women
    - High risk children (0-5)
    - Chronically mentally ill adults
    - Emotionally disturbed children
    - Chronic substance abusers
    - Adults & children at risk of abuse, neglect or exploitation
    - Persons with HIV disease
3. Chiropractors
4. Clinic Services
5. Community Alternatives Programs (CAP)
6. Dental Care Services
7. Domicile Care
8. Durable Medical Equipment
9. Health Check Services (EPSDT)
10. Family Planning Services
11. Hearing Aids (for children)
12. HMO Membership
13. Home Health Services
14. Home Infusion Therapy Services
15. Hospice
16. Inpatient & Outpatient Hospital Services
17. Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
18. Laboratory & X-ray Services
19. Mental Hospitals (age 65 & over)
20. Migrant Health Clinics
21. Nurse Midwives
22. Nurse Practitioners
23. Nursing Facilities (NF)
24. Optical Supplies
25. Optometrists
26. Personal Care Services
27. Physical, Occupational and Speech Therapy
28. Physicians
29. Podiatrists
30. Prepaid Health Plan Services
31. Prescription Drugs
32. Private Duty Nursing Services
33. Prosthetics and Orthotics (children)
34. Rehabilitative Services: (under the auspices of area mental health programs)
35. Respiratory Therapy for Children
36. Rural Health Clinics
37. Specialty Hospitals
38. Transportation

Table 5
North Carolina Medicaid
State Fiscal Year 2002 & 2003
Sources of Medicaid Funds

		2002	Percent		2003	Percent
Federal	$	4,262,533,647	57.87%	$	4,477,523,570	60.18%
State*	$	1,967,890,766	26.72%	$	2,039,415,957	27.41%
Other State	$	684,135,803	9.29%	$	458,210,905	6.16%
County	$	338,293,885	4.59%	$	350,301,574	4.71%
Admin - Other DHHS Divisions	$	96,678,025	1.31%	$	95,494,421	1.28%
Admin - Non-DHHS State Agencies	$	16,597,304	0.23%	$	18,811,502	0.25%
Total	**$**	**7,366,129,430**	**100.00%**	**$**	**7,439,757,929**	**100.00%**

* State Appropriation of funds

Source: BD701, the Authorized Monthly Budget Report for the period ending June 29, 2003
Medicaid Cost Calculation Report, June 2003
NCAS

Table 6
North Carolina Medicaid
State Fiscal Year 2003
Uses of Medicaid Funds

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	$ 874,533,504	11.75%	13.27%	210,463	$ 4,155
Outpatient Hospital	538,024,825	7.23%	8.17%	670,519	802
Mental Hospital >65 & <21	32,761,633	0.44%	0.50%	2,561	12,793
Physician	572,206,549	7.69%	8.68%	1,278,204	448
Clinics	499,919,525	6.72%	7.59%	484,052	1,033
Nursing Facility (Skilled)	448,975,984	6.03%	6.81%	31,666	14,178
Nursing Facility (Intermediate)	419,208,704	5.63%	6.36%	25,027	16,750
ICF-MR	410,557,951	5.52%	6.23%	4,601	89,232
Dental	129,107,695	1.74%	1.96%	353,626	365
Prescription Drugs	1,203,809,178	16.18%	18.27%	998,701	1,205
Home Health	157,985,231	2.12%	2.40%	143,066	1,104
All Other Services	1,067,105,690	14.34%	16.20%	974,975	1,094
Subtotal, Services	**$ 6,354,196,467**	**85.41%**	**96.44%**		
Medicare Premiums:					
(Part A, Part B, QMB, Dually Eligible)	210,394,375	2.83%	3.19%	274,640	
HMO Premium	24,476,991	0.33%	0.37%	34,816	
Subtotal Services	**$ 6,589,067,833**	**88.57%**	**100.00%**	**1,454,661**	**$ 4,530**
Adjustments, Cost Settlements & Transfers	86,455,622	1.16%			
Disproportionate Share Payments**	340,835,304	4.58%			
Transfer to State Treasurer	108,510,735	1.46%			
Transportation-Program County Share	1,199,942	0.02%			
VR DSH Non-federal Share	3,420,366	0.05%			
Title XIX Program - All Dollars	**$ 7,129,489,802**	**95.83%**			
Title XIX Adminstration - All Dollars	310,268,127	4.17%			
Grand Total Medicaid Related Expenditures	**$ 7,439,757,929**	**100.00%**			
Total Recipients (unduplicated)* **				**1,454,661**	
Total Expenditures Per Recipient (unduplicated)					**$ 5,114**

* "Users of Services" is a duplicated count. Recipients using one or more services are counted in each service category.
** Additional payments for hospitals providing services to a higher than average number of Medicaid patients.
*** "Total Recipients" is unduplicated, counting recipients only once during the year regardless of the number or type of services they use. There were 230 unrecognized Medicaid recipients excluded from the total recipients for which the eligibility status could not be established when the claim was paid.

Note: Numbers may not add to the dollar due to rounding.
SOURCE: State 2082 Report -SFY 2003, PER Report YTD June 2003, BD701 Report June 2003, HCFA-64 quarterly reports covering SFY 2003, MCC Report June 2003 and NCSA.

Table 7
North Carolina Medicaid
A History of Medicaid Expenditures
SFYs 1979-2003

Fiscal Year		Expenditures	Percentage Change
1979	$	379,769,848	N/A
1980	$	410,053,625	8%
1981	$	507,602,694	24%
1982	$	521,462,961	3%
1983	$	570,309,294	9%
1984	$	657,763,927	15%
1985	$	665,526,678	1%
1986	$	758,115,890	14%
1987	$	861,175,819	14%
1988	$	983,464,113	14%
1989	$	1,196,905,351	22%
1990	$	1,427,672,567	19%
1991	$	1,942,016,092	36%
1992	$	2,478,709,587	28%
1993	$	2,836,335,468	14%
1994	$	3,550,099,377	25%
1995	$	3,550,468,230	0%
1996	$	4,113,344,777	16%
1997	$	4,640,421,917	13%
1998	$	4,715,733,033	2%
1999	$	4,934,136,597	5%
2000	$	5,789,133,085	17%
2001	$	7,065,354,618	22%
2002	$	7,366,129,429	4%
2003	$	7,439,757,929	1%

Table 8
North Carolina Medicaid
State Fiscal Years 1979-2003
A History of Total Unduplicated Medicaid Eligibles

Fiscal Years	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Medicaid Pregnant Women Coverage	Medicaid Indigent Children Coverage	Other Children	Aliens and Refugees	Total	Percent Change
1978-79	82,930	N/A	3,219	59,187	301,218	N/A	N/A	6,620	N/A	453,174	-
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	N/A	455,702	0.56%
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	459,364	0.80%
1981-82	70,010	N/A	2,349	48,266	298,483	N/A	N/A	6,125	N/A	425,233	-7.43%
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	N/A	415,552	-2.28%
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	N/A	407,806	-1.86%
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	N/A	414,353	1.61%
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	N/A	441,930	6.66%
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	N/A	452,025	2.28%
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	N/A	481,326	6.48%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561	561,614	16.68%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	1,011	639,351	13.84%
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	1,675	753,292	17.82%
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	1,955	877,923	16.54%
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	2,437	992,697	13.07%
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	2,330	1,058,603	6.64%
1994-95	127,514	48,373	2,716	155,215	533,300	48,115	216,888	3,808	2,857	1,138,786	7.57%
1995-96	131,496	53,072	2,710	171,204	496,501	52,466	261,525	3,696	3,919	1,176,589	3.32%
1996-97	132,173	58,036	2,593	176,160	462,881	55,838	295,882	3,747	4,823	1,192,133	1.32%
1997-98	131,332	61,032	2,531	180,461	414,853	58,899	337,849	3,905	6,311	1,197,173	0.42%
1998-99	152,582	32,737	2,497	199,523	344,621	60,896	371,986	3,941	8,036	1,176,819	-1.70%
1999-00	154,222	33,302	2,428	205,205	330,113	60,918	421,158	4,063	9,857	1,221,266	3.78%
2000-01	154,284	36,053	2,357	212,798	450,472	57,318	424,436	4,195	12,680	1,354,593	10.92%
2001-02	153,282	39,799	2,334	221,813	456,232	53,009	444,299	4,737	14,523	1,390,028	2.62%
2002-03	151,672	41,030	2,226	228,159	478,842	51,111	474,557	4,881	14,805	1,447,283	4.12%
SFY 2002 Percent Total Eligibles:	11.0%	2.9%	0.2%	16.0%	32.8%	3.8%	32.0%	0.3%	1.0%	100.0%	
SFY 2003 Percent Total Eligibles:	10.5%	2.8%	0.2%	15.8%	33.1%	3.5%	32.8%	0.3%	1.0%	100.0%	

Source: Medicaid Eligibility Report, EJA752-SFY 2003

Table 9
North Carolina Medicaid
State Fiscal Year 2003
Eligibles and Program Payments for Which the County is Responsible for Its Computable Share*

COUNTY NAME	2002 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES**	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% OF MEDICAID ELIGIBLES BY COUNTY, BASED ON 2002 POPULATION
ALAMANCE	136,144	20,426	$ 93,701,732	$ 4,587	$ 688	79	150	15.00%
ALEXANDER	34,224	5,542	23,923,049	4,317	699	75	162	16.19%
ALLEGHANY	10,860	2,030	11,539,974	5,685	1,063	26	187	18.69%
ANSON	25,358	6,778	35,094,593	5,178	1,384	9	267	26.73%
ASHE	24,734	4,850	28,008,196	5,775	1,132	21	196	19.61%
AVERY	17,946	3,120	18,373,807	5,889	1,024	30	174	17.39%
BEAUFORT	45,672	10,781	56,691,681	5,258	1,241	16	236	23.61%
BERTIE	19,807	6,541	32,864,910	5,024	1,659	1	330	33.02%
BLADEN	32,656	10,005	48,890,356	4,887	1,497	5	306	30.64%
BRUNSWICK	79,054	15,533	65,762,821	4,234	832	59	196	19.65%
BUNCOMBE	210,550	34,942	172,167,405	4,927	818	61	166	16.60%
BURKE	89,354	16,095	79,556,589	4,943	890	48	180	18.01%
CABARRUS	140,176	19,996	86,000,764	4,301	614	91	143	14.26%
CALDWELL	78,234	14,079	66,285,844	4,708	847	52	180	18.00%
CAMDEN	7,328	999	5,098,429	5,104	696	77	136	13.63%
CARTERET	60,064	9,091	45,207,717	4,973	753	70	151	15.14%
CASWELL	23,718	4,640	21,948,254	4,730	925	44	196	19.56%
CATAWBA	146,548	23,178	92,498,626	3,991	631	87	158	15.82%
CHATHAM	52,582	6,774	32,659,157	4,821	621	90	129	12.88%
CHEROKEE	25,080	5,630	30,617,295	5,438	1,221	17	224	22.45%
CHOWAN	14,304	3,614	17,142,809	4,743	1,198	18	253	25.27%
CLAY	9,216	1,763	8,873,565	5,033	963	40	191	19.13%
CLEVELAND	97,271	21,106	98,088,834	4,647	1,008	33	217	21.70%
COLUMBUS	54,890	17,388	85,703,863	4,929	1,561	2	317	31.68%
CRAVEN	91,902	16,197	71,620,697	4,422	779	66	176	17.62%
CUMBERLAND	305,851	54,397	191,962,272	3,529	628	88	178	17.79%
CURRITUCK	19,632	2,615	10,032,625	3,837	511	94	133	13.32%
DARE	32,177	3,245	16,384,302	5,049	509	95	101	10.08%
DAVIDSON	150,799	23,878	98,191,706	4,112	651	82	158	15.83%
DAVIE	36,770	4,679	20,788,072	4,443	565	92	127	12.73%
DUPLIN	50,612	12,233	51,422,467	4,204	1,016	32	242	24.17%
DURHAM	233,548	35,153	173,049,084	4,923	741	72	151	15.05%
EDGECOMBE	54,945	17,484	68,753,627	3,932	1,251	15	318	31.82%
FORSYTH	314,853	47,194	202,125,578	4,283	642	84	150	14.99%
FRANKLIN	50,326	9,821	42,007,939	4,277	835	57	195	19.51%
GASTON	191,874	36,661	184,729,733	5,039	963	41	191	19.11%
GATES	10,708	1,947	8,734,574	4,486	816	62	182	18.18%
GRAHAM	8,030	2,247	12,484,152	5,556	1,555	3	280	27.98%
GRANVILLE	51,540	8,289	35,100,324	4,235	681	81	161	16.08%
GREENE	19,471	4,598	19,404,516	4,220	997	35	236	23.61%
GUILFORD	428,794	66,352	267,884,116	4,037	625	89	155	15.47%
HALIFAX	57,105	18,892	77,464,157	4,100	1,357	10	331	33.08%
HARNETT	96,152	19,400	76,077,815	3,922	791	65	202	20.18%
HAYWOOD	55,114	10,373	48,720,488	4,697	884	49	188	18.82%
HENDERSON	92,988	14,119	69,693,888	4,936	749	71	152	15.18%
HERTFORD	23,863	7,384	33,837,194	4,583	1,418	7	309	30.94%
HOKE	36,000	8,394	30,389,413	3,620	844	53	233	23.32%
HYDE	5,846	1,419	7,567,353	5,333	1,294	12	243	24.27%
IREDELL	130,362	19,025	82,634,016	4,343	634	86	146	14.59%
JACKSON	34,132	5,752	25,796,088	4,485	756	69	169	16.85%
JOHNSTON	132,660	23,796	97,306,659	4,089	734	73	179	17.94%
JONES	10,243	2,268	10,858,494	4,788	1,060	27	221	22.14%
LEE	49,810	10,068	39,910,944	3,964	801	64	202	20.21%
LENOIR	59,294	15,484	66,982,445	4,326	1,130	22	261	26.11%

Table 9 (Cont.)
North Carolina Medicaid
State Fiscal Year 2003
Eligibles and Program Payments for Which the County is Responsible for Its Computable Share*

COUNTY NAME	2003 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES**	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% OF MEDICAID ELIGIBLES BY COUNTY, BASED ON 2002 POPULATION
LINCOLN	66,598	10,028	46,393,121	4,626	697	76	151	15.06%
MACON	30,936	5,813	25,881,784	4,452	837	55	188	18.79%
MADISON	19,856	4,206	20,920,288	4,974	1,054	28	212	21.18%
MARTIN	25,082	6,823	34,823,824	5,104	1,388	8	272	27.20%
MCDOWELL	42,960	7,865	36,455,119	4,635	849	51	183	18.31%
MECKLENBURG	734,365	106,699	402,444,677	3,772	548	93	145	14.53%
MITCHELL	15,934	3,119	16,576,326	5,315	1,040	29	196	19.57%
MONTGOMERY	27,282	6,390	25,269,172	3,954	926	43	234	23.42%
MOORE	77,424	11,917	49,824,439	4,181	644	83	154	15.39%
NASH	89,185	18,227	78,067,679	4,283	875	50	204	20.44%
NEW HANOVER	166,072	25,520	128,263,277	5,026	772	68	154	15.37%
NORTHAMPTON	21,773	7,045	33,392,663	4,740	1,534	4	324	32.36%
ONSLOW	152,424	19,879	71,117,478	3,578	467	98	130	13.04%
ORANGE	119,746	10,098	57,054,740	5,650	476	97	84	8.43%
PAMLICO	13,024	2,642	13,281,721	5,027	1,020	31	203	20.29%
PASQUOTANK	35,816	8,440	35,700,807	4,230	997	34	236	23.56%
PENDER	43,135	8,345	36,346,309	4,355	843	54	193	19.35%
PERQUIMANS	11,607	2,633	10,540,651	4,003	908	46	227	22.68%
PERSON	36,764	6,944	35,875,128	5,166	976	38	189	18.89%
PITT	137,901	26,338	114,729,404	4,356	832	58	191	19.10%
POLK	18,866	2,439	13,115,225	5,377	695	78	129	12.93%
RANDOLPH	133,836	22,643	85,633,422	3,782	640	85	169	16.92%
RICHMOND	46,721	13,209	58,481,715	4,427	1,252	14	283	28.27%
ROBESON	125,206	42,622	180,558,193	4,236	1,442	6	340	34.04%
ROCKINGHAM	92,589	18,040	86,963,901	4,821	939	42	195	19.48%
ROWAN	132,921	22,798	94,210,540	4,132	709	74	172	17.15%
RUTHERFORD	63,345	13,679	58,162,831	4,252	918	45	216	21.59%
SAMPSON	61,768	15,983	69,215,419	4,331	1,121	23	259	25.88%
SCOTLAND	35,766	11,476	47,290,154	4,121	1,322	11	321	32.09%
STANLY	58,974	10,142	49,259,734	4,857	835	56	172	17.20%
STOKES	45,355	6,562	30,992,014	4,723	683	80	145	14.47%
SURRY	72,028	13,657	65,115,023	4,768	904	47	190	18.96%
SWAIN	13,287	3,395	14,567,400	4,291	1,096	25	256	25.55%
TRANSYLVANIA	29,400	4,870	22,889,308	4,700	779	67	166	16.56%
TYRRELL	4,170	956	4,655,963	4,870	1,117	24	229	22.93%
UNION	138,928	17,050	69,084,906	4,052	497	96	123	12.27%
VANCE	44,378	14,346	51,172,741	3,567	1,153	19	323	32.33%
WAKE	679,510	68,469	288,150,653	4,208	424	100	101	10.08%
WARREN	20,000	5,584	22,680,808	4,062	1,134	20	279	27.92%
WASHINGTON	13,600	4,133	17,458,676	4,224	1,284	13	304	30.39%
WATAUGA	42,892	3,745	20,009,369	5,343	467	99	87	8.73%
WAYNE	113,844	24,544	94,369,663	3,845	829	60	216	21.56%
WILKES	66,660	13,052	65,118,252	4,989	977	37	196	19.58%
WILSON	75,374	17,548	73,796,901	4,205	979	36	233	23.28%
YADKIN	36,958	5,567	29,634,023	5,323	802	63	151	15.06%
YANCEY	17,944	3,538	17,466,114	4,937	973	39	197	19.72%
STATE TOTAL	**8,323,375**	**1,447,283**	**$ 6,301,626,561**	**$ 4,354**	**$ 757**	**N/A**	**174**	**17.39%**

Source: Medicaid Cost Calculation Fiscal YTD June 2003.

Notes:

* Program payments do not include a total of approximately $502 million in Disproportionate Share Hospital for which there is no county share and all administration expenditures.

** Eligibles is a statewide unduplicated count indicating only eligibility in the last county of residence during the fiscal year

Table 10
North Carolina Medicaid
State Fiscal Year 2003
Medicaid Service Expenditures by Recipient Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 2003 Expenditures Per Recipient	SFY 2002 Expenditures Per Recipient	02/03 Percent Change
Total Elderly	**$ 1,807,717,487**	**27.4%**	**202,377**	**13.9%**	**$ 8,932**	**$ 8,671**	**3.0%**
Aged	1,780,878,696	27.0%	162,015	11.1%	10,992	11,086	-0.8%
Medicare-Aid (MQBQ & MQBB & MQBE)	26,838,791	0.4%	40,362	2.8%	665	454	46.4%
Total Disabled	**$ 2,779,255,514**	**42.2%**	**232,166**	**16.0%**	**$ 11,971**	**$ 11,606**	**3.1%**
Disabled	2,750,631,537	41.7%	229,900	15.8%	11,964	11,599	3.2%
Blind	28,623,976	0.4%	2,266	0.2%	12,632	12,294	2.7%
Total Families &Children	**$ 1,973,688,839**	**30.0%**	**1,003,271**	**69.0%**	**$ 1,967**	**$ 1,838**	**7.0%**
AFDC Adults (> 21)	559,308,156	8.5%	204,789	14.1%	2,731	2,491	9.7%
Medicaid Pregnant Women Coverage (MPW)	199,448,052	3.0%	51,889	3.6%	3,844	3,549	8.3%
AFDC Children & Other Children	511,206,017	7.8%	273,233	18.8%	1,871	1,699	10.1%
Medicaid Indigent Children (MIC)	701,446,363	10.6%	473,178	32.5%	1,482	1,417	4.6%
Breast and Cervical	2,280,250	0.0%	182	0.0%	12,529		
Aliens and Refugees	**$ 46,080,274**	**0.7%**	**16,847**	**1.2%**	**$ 2,735**	**$ 2,812**	**-2.7%**
Adjustments Not Attributable to a Specific Category	**$ (17,674,281)**	**-0.3%**					
Total Service Expenditures All Groups	**$ 6,589,067,833**	**100.0%**	**1,454,661**	**100.0%**	**$ 4,530**	**$ 4,407**	**2.8%**

Source: SFY 2003 Program Expenditure Report

Table 11
North Carolina Medicaid
State Fiscal Year 2003
Service Expenditures for Selected Major Medical Services by Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ* Medicaire Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Blind	Disabled	Other Adult**	Breast Cervical	Children***	Alien & Refugees	Adjustments Unattributable to a Specific Category
Inpatient Hospital	$ 874,533,504	13.3%	$ 19,159,016	$ 38,199	$ -	$ 1,831,369	$ 385,724,943	$ 203,821,966	$ 225,326	$ 237,269,155	$ 31,243,980	$ (4,780,450)
Outpatient Hospital	538,024,825	8.2%	34,939,624	114,406	519,939	1,276,835	200,167,849	153,130,520	1,109,155	147,227,607	2,006,212	(2,467,323)
Mental Hospital (> 65)	7,274,997	0.1%	7,262,458	840	-	-	16,740	-		-	-	(5,042)
Psychiatric Hospital (< 21)	25,486,637	0.4%	-	-	-	-	7,080,671	18,945	-	18,405,165	4,318	(22,462)
Physician	572,206,549	8.7%	29,457,183	80,439	232,100	1,156,850	169,798,726	159,205,471	667,813	204,833,285	10,156,101	(3,381,418)
Clinics	499,919,525	7.6%	10,008,226	24,518	41,055	1,038,268	234,799,554	45,860,419	12,751	211,010,466	1,389,770	(4,265,503)
Nursing Facility:												
Skilled Level	448,975,984	6.8%	377,718,999	-	-	1,401,695	69,866,151	239,616	-	58,586	66	(309,129)
Intermediate Level	419,208,704	6.4%	374,603,967	-	-	1,150,280	43,484,669	4,482	-	81,725	2,329	(118,747)
Intermediate Care Facility (Mentally Retarded)	410,557,951	6.2%	22,967,285	-	-	7,092,169	377,809,607	-	-	2,699,346	-	(10,457)
Dental	129,107,695	2.0%	7,479,483	13	-	185,378	23,627,717	25,465,417	18,311	72,272,466	376,565	(317,654)
Prescription Drugs	1,203,809,178	18.3%	380,507,356	-	-	4,135,509	569,595,501	107,395,229	178,264	142,073,303	196,580	(272,565)
Home Health	157,985,231	2.4%	32,474,363	8,978	75,616	953,386	105,013,270	7,965,231	35,297	11,945,040	36,217	(522,168)
CAP/Disabled Adult	184,618,681	2.8%	134,827,369	-	-	1,593,539	48,305,629	-	-	-	-	(107,856)
CAP/Mentally Retarded	259,746,740	3.9%	5,070,250	-	-	2,796,935	249,844,956	-	-	2,498,645	-	(464,046)
CAP/Children	24,027,668	0.4%	-	-	-	277,001	23,071,606	-	-	687,502	-	(8,440)
Personal Care	189,319,390	2.9%	120,690,426	-	-	1,710,230	64,713,508	1,769,829	8,460	538,410	2,043	(113,517)
Hospice	23,799,114	0.4%	13,437,202	-	-	170,949	9,925,921	222,985	4,753	58,114	-	(20,811)
EPSDT (Health Check)	44,488,613	0.7%	444	-	-	5,573	1,201,005	39,116	16	43,309,713	4,271	(71,524)
Lab & X-ray	25,730,285	0.4%	128,568	222	312	47,247	4,902,943	10,978,752	11,866	9,645,234	62,022	(46,880)
Adult Home Care	121,226,198	1.8%	71,922,335	-	-	344,676	48,972,888	13,642	-	15,457	-	(42,800)
High Risk Intervention Residential	78,164,707	1.2%	-	-	-	-	18,397,068	-	-	59,865,503	-	(97,864)
Other Services	115,984,294	1.8%	9,634,373	4,661	1,938	213,624	36,250,283	31,652,382	8,236	37,985,432	592,492	(359,128)
Total Services	**$ 6,354,196,467**	**96.4%**	**$ 1,652,288,930**	**$ 272,275**	**$ 870,961**	**$ 27,381,513**	**$ 2,692,571,206**	**$ 747,784,001**	**$ 2,280,250**	**$ 1,202,480,153**	**$ 46,072,965**	**$ (17,805,786)**
Medicare:												
Part A Premiums	41,487,836	0.6%	40,986,004	12,065	(319)	533,061	6,034	-	-	-	-	(49,009)
Part B Premiums	168,906,539	2.6%	87,603,562	449,560	25,234,249	677,494	54,464,353	287,775	-	6,671	2,198	180,677
HMO Premiums	24,476,991	0.4%	201	-	-	31,908	3,589,944	10,684,433	-	10,165,557	5,112	(164)
Total Premiums	**$ 234,871,366**	3.6%	**$ 128,589,767**	**$ 461,625**	**$ 25,233,930**	**$ 1,242,464**	**$ 58,060,331**	**$ 10,972,207**	**-**	**$ 10,172,227**	**$ 7,310**	**$ 131,505**
Grand Total Services and Premiums	**$ 6,589,067,833**		**$ 1,780,878,696**	**$ 733,900**	**$ 26,104,891**	**$ 28,623,976**	**$ 2,750,631,537**	**$ 758,756,209**		**$ 1,212,652,380**	**$ 46,080,274**	**$ (17,674,281)**

* Reflects expenditures for those who were eligible as QMBs (Medicare-covered services only) at the end of the year. As a result, expenditures include more services than are available through QMB coverage.

** Includes individuals covered under SOBRA Pregnant Women policies or individuals age 21 & over under TANF or AFDC-related coverage.

*** Includes SOBRA Children, individuals under age 21 in TANF or AFDC-related coverages or other children in foster care.

Note: Grand total expenditures do not include adjustments processed by DMA, settlements, disproportionate share costs and State and county administration costs and certified public funds in other agencies.

Table 12
North Carolina Medicaid
State Fiscal Year 2003
Expenditures for the Elderly

Type of Service	Aged	Percent of Service Dollars	MQBQ Medicare Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Total Qualified Beneficieries	Percent of Service Dollars	Total Elderly Dollars	SFY 2003 % of Total Dollars	SFY 2002 % of Total Dollars	SFY 2001 % of Total Dollars
Inpatient Hospital	$ 19,159,016	1.1%	$ 38,199	$ -	$ 38,199	0.1%	$ 19,197,215	1.1%	1.1%	1.3%
Outpatient Hospital	34,939,624	2.0%	114,406	519,939	634,345	2.4%	35,573,969	2.0%	2.0%	1.8%
Mental Hospital (> 65)	7,262,458	0.4%	840	-	840	0.0%	7,263,298	0.4%	0.4%	0.7%
Physician	29,457,183	1.6%	80,439	232,100	312,539	1.2%	29,769,722	1.6%	1.6%	3.5%
Clinics	10,008,226	0.6%	24,518	41,055	65,573	0.2%	10,073,799	0.6%	0.6%	0.7%
Nursing Facility:										
Skilled Level	377,718,999	20.9%	-	-	-	0.0%	377,718,999	20.9%	20.9%	20.3%
Intermediate Level	374,603,967	20.7%	-	-	-	0.0%	374,603,967	20.7%	20.7%	23.4%
Intermediate Care Facility (Mentally Retarded)	22,967,285	1.3%	-	-	-	0.0%	22,967,285	1.3%	1.3%	1.2%
Dental	7,479,483	0.4%	13	-	13	0.0%	7,479,496	0.4%	0.4%	0.4%
Prescription Drugs	380,507,356	21.0%	-	-	-	0.0%	380,507,356	21.0%	21.0%	18.7%
Home Health	32,474,363	1.8%	8,978	75,616	84,594	0.3%	32,558,958	1.8%	1.8%	1.5%
CAP/Disabled Adult	134,827,369	7.5%	-	-	-	0.0%	134,827,369	7.5%	7.5%	8.7%
CAP/Mentally Retarded	5,070,250	0.3%	-	-	-	0.0%	5,070,250	0.3%	0.3%	0.3%
Personal Care	120,690,426	6.7%	-	-	-	0.0%	120,690,426	6.7%	6.7%	4.8%
Hospice	13,437,202	0.7%	-	-	-	0.0%	13,437,202	0.7%	0.7%	0.4%
EPSDT (Health Check)	444	0.0%	-	-	-	0.0%	444	0.0%	0.0%	0.0%
Lab & X-ray	128,568	0.0%	222	312	534	0.0%	129,101	0.0%	0.0%	0.0%
Adult Home Care	71,922,335	4.0%	-	-	-	0.0%	71,922,335	4.0%	4.0%	3.9%
High Risk Intervention Residential	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Other Services	9,634,373	0.5%	4,661	1,938	6,600	0.0%	9,640,972	0.5%	0.5%	0.7%
Total Services	**$ 1,652,288,930**	**91.5%**	**$ 272,275**	**$ 870,961**	**$ 1,143,236**	**4.3%**	**$ 1,653,432,166**	**91.5%**	**91.5%**	**92.2%**
Medicare:										
Part A Premiums	40,986,004	2.3%	12,065	(319)	11,746	0.0%	40,997,750	2.3%	2.3%	2.3%
Part B Premiums	87,603,562	6.3%	449,560	25,234,249	25,683,809	95.7%	113,287,371	6.3%	6.3%	5.5%
HMO Premiums	201	0.0%	-	-	-	0.0%	201	0.0%	0.0%	0.0%
Total Premiums	**$ 128,589,767**	**8.5%**	**$ 461,625**	**$ 25,233,930**	**$ 25,695,555**	**95.7%**	**$ 154,285,322**	**8.5%**	**8.5%**	**7.8%**
Grand Total Services and premiums	**$ 1,780,878,696**	**100.0%**	**$ 733,900**	**$ 26,104,891**	**$ 26,838,791**	**100.0%**	**$ 1,807,717,487**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers**	**$ 94,684,977**									
Total Elderly Recipients	**162,015**		**713**	**39,649**	**40,362**		**202,377**			
Expenditures Per Recipient*	**$ 10,992**		**$ 1,029**	**$ 658**	**$ 665**		**$ 8,932**			

* Service Expenditure/Recipient amounts do not contain adjustments, settlements or administrative costs.

** Medicare Crossovers are amounts that Medicaid bills Medicare for those Medicaid-eligible people who are also eligible for Medicare.

Source: SFY 2003 Program Expenditure Report

Table 13
North Carolina Medicaid
State Fiscal Year 2003
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	2003 % of Total Dollars	2002 % of Total Dollars
Inpatient Hospital	$ 385,724,943	14.0%	$ 1,831,369	6.4%	$ 387,556,312	13.9%	14.7%
Outpatient Hospital	200,167,849	7.3%	1,276,835	4.5%	201,444,684	7.2%	6.4%
Mental Hospital (> 65)	16,740	0.0%	-	0.0%	16,740	0.0%	0.0%
Psychiatric Hospital (< 21)	7,080,671	0.3%	-	0.0%	7,080,671	0.3%	0.2%
Physician	169,798,726	6.2%	1,156,850	4.0%	170,955,576	6.2%	7.0%
Clinics	234,799,554	8.5%	1,038,268	3.6%	235,837,823	8.5%	7.6%
Nursing Facility:							
Skilled Level	69,866,151	2.5%	1,401,695	4.9%	71,267,846	2.6%	2.6%
Intermediate Level	43,484,669	1.6%	1,150,280	4.0%	44,634,949	1.6%	1.7%
Intermediate Care Facility (Mentally Retarded)	377,809,607	13.7%	7,092,169	24.8%	384,901,776	13.8%	15.0%
Dental	23,627,717	0.9%	185,378	0.6%	23,813,095	0.9%	0.8%
Prescription Drugs	569,595,501	20.7%	4,135,509	14.4%	573,731,010	20.6%	19.3%
Home Health	105,013,270	3.8%	953,386	3.3%	105,966,656	3.8%	3.9%
CAP/Disabled Adult	48,305,629	1.8%	1,593,539	5.6%	49,899,168	1.8%	2.1%
CAP/Mentally Retarded	249,844,956	9.1%	2,796,935	9.8%	252,641,891	9.1%	9.5%
CAP/Children	23,071,606	0.8%	277,001	1.0%	23,348,607	0.8%	0.8%
Personal Care	64,713,508	2.4%	1,710,230	6.0%	66,423,739	2.4%	1.9%
Hospice	9,925,921	0.4%	170,949	0.6%	10,096,871	0.4%	0.3%
EPSDT (Health Check)	1,201,005	0.0%	5,573	0.0%	1,206,577	0.0%	0.1%
Lab & X-ray	4,902,943	0.2%	47,247	0.2%	4,950,190	0.2%	0.2%
Adult Home Care	48,972,888	1.8%	344,676	1.2%	49,317,563	1.8%	1.8%
High Risk Intervention Residential	18,397,068	0.7%	-	0.0%	18,397,068	0.7%	0.4%
Other Services	36,250,283	1.3%	213,624	0.7%	36,463,907	1.3%	1.4%
Total Services	**$ 2,692,571,206**	**97.9%**	**$ 27,381,513**	**95.7%**	**$ 2,719,952,719**	**97.9%**	**97.7%**
Medicare, Part A Premiums	6,034	0.0%	533,061	1.9%	539,095	0.0%	0.0%
Medicare, Part B Premiums	54,464,353	2.0%	677,494	2.4%	55,141,847	2.0%	1.9%
HMO Premiums	3,589,944	0.1%	31,908	0.1%	3,621,853	0.1%	0.4%
Total Premiums	**$ 58,060,331**	**2.1%**	**$ 1,242,464**	**4.3%**	**$ 59,302,795**	**2.1%**	**2.3%**
Grand Total Services & Premiums	**$ 2,750,631,537**	**100.0%**	**$ 28,623,976**	**100.0%**	**$ 2,779,255,514**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 70,107,822**		**$ 774,747**		**$ 70,882,569**		
Number of Disabled/Blind Recipients	**229,900**		**2,266**		**232,166**		
Service Expenditures Per Recipient**	**$ 11,964**		**$ 12,632**		**$ 11,971**		

* Medicare Crossovers are amounts that are billed to Medicare for those Medicaid clients who are also eligible for Medicare.
** Service Expenditures Per Recipient does not include adjustments, settlements or administrative costs.
Source: SFY 2003 Program Expenditure Report

Table 14
North Carolina Medicaid
State Fiscal Year 2003
Expenditures for Families and Children

Type of Service	AFDC Adults	% of Service Dollars	Special Pregnant Women	% of Service Dollars	AFDC Children & Other Children	% of Service Dollars	Indigent Children	% of Service Dollars	Breast Cervical	% of Service Dollars	Total Families & Children Dollars	SFY 2003 % of Total Dollars	SFY 2002 % of Total Dollars
Inpatient Hospital	$ 129,013,007	23.1%	$ 74,808,958	37.5%	$ 63,595,699	12.4%	$ 173,673,456	24.8%	$ 225,326	9.9%	$ 441,316,447	22.4%	24.9%
Outpatient Hospital	127,684,081	22.8%	25,446,439	12.8%	61,874,202	12.1%	85,353,406	12.2%	1,109,155	48.6%	$ 301,467,283	15.3%	13.4%
Psychiatric Hospital (< 21)	-	0.0%	18,945	0.0%	11,299,580	2.2%	7,105,585	1.0%	-	0.0%	$ 18,424,110	0.9%	0.9%
Physician	106,492,959	19.0%	52,712,512	26.4%	72,190,839	14.1%	132,642,446	18.9%	667,813	29.3%	$ 364,706,569	18.5%	19.4%
Clinics	26,373,714	4.7%	19,486,705	9.8%	125,375,586	24.5%	85,634,880	12.2%	12,751	0.6%	$ 256,883,636	13.0%	12.7%
Nursing Facility:													
Skilled Level	239,616	0.0%	-	0.0%	58,586	0.0%	-	0.0%	-	0.0%	298,202	0.0%	0.0%
Intermediate Level	4,482	0.0%	-	0.0%	80,462	0.0%	1,263	0.0%	-	0.0%	86,207	0.0%	0.0%
Intermediate Care Facility													
(Mentally Retarded)	-	0.0%	-	0.0%	1,957,357	0.4%	741,988	0.1%	-	0.0%	2,699,346	0.1%	0.2%
Dental	24,393,081	4.4%	1,072,336	0.5%	30,113,092	5.9%	42,159,374	6.0%	18,311	0.8%	97,756,193	5.0%	4.3%
Prescription Drugs	99,922,282	17.9%	7,472,947	3.7%	59,452,114	11.6%	82,621,189	11.8%	178,264	7.8%	249,646,796	12.6%	11.7%
Home Health	6,951,321	1.2%	1,013,910	0.5%	4,520,834	0.9%	7,424,206	1.1%	35,297	1.5%	19,945,569	1.0%	1.0%
CAP/Disabled Adult	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
CAP/Mentally Retarded	-	0.0%	-	0.0%	2,498,638	0.5%	7	0.0%	-	0.0%	2,498,645	0.1%	0.2%
CAP/Children	-	0.0%	-	0.0%	687,502	0.1%	-	0.0%	-	0.0%	687,502	0.0%	0.0%
Personal Care	1,743,778	0.3%	26,051	0.0%	287,211	0.1%	251,200	0.0%	8,460	0.4%	2,316,699	0.1%	0.1%
Hospice	222,985	0.0%	-	0.0%	23,859	0.0%	34,255	0.0%	4,753	0.2%	285,853	0.0%	0.0%
EPSDT (Health Check)	4,971	0.0%	34,146	0.0%	12,071,880	2.4%	31,237,832	4.5%	16	0.0%	43,348,845	2.2%	2.4%
Lab & X-ray	7,106,352	1.3%	3,872,401	1.9%	3,058,393	0.6%	6,586,841	0.9%	11,866	0.5%	20,635,852	1.0%	0.9%
Adult Home Care	13,642	0.0%	-	0.0%	11,225	0.0%	4,231	0.0%	-	0.0%	29,099	0.0%	0.0%
High Risk Intervention Residential	-	0.0%	-	0.0%	36,990,599	7.2%	22,874,905	3.3%	-	0.0%	59,865,503	3.0%	2.1%
Other Services	21,087,417	3.8%	10,564,965	5.3%	19,933,121	3.9%	18,052,311	2.6%	8,236	0.4%	69,646,050	3.5%	3.7%
Total Services	**$ 551,253,686**	**98.6%**	**$ 196,530,316**	**98.5%**	**$ 506,080,780**	**99.0%**	**$ 696,399,373**	**99.3%**	**$ 2,280,250**	**100.0%**	**$ 1,952,544,405**	**98.9%**	**98.1%**
Medicare, Part A Premiums	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Medicare, Part B Premiums	278,534	0.0%	9,241	0.0%	2,395	0.0%	4,276	0.0%	-	0.0%	294,446	0.0%	0.0%
HMO Premiums	7,775,936	1.4%	2,908,496	1.5%	5,122,843	1.0%	5,042,714	0.7%	-	0.0%	20,849,989	1.1%	1.9%
Total Premiums	**$ 8,054,471**		**$ 2,917,737**		**$ 5,125,238**		**$ 5,046,990**		-		**$ 21,144,435**	**0.5%**	**1.9%**
Total Services & Premiums	**$ 559,308,157**		**$ 199,448,052**		**$ 511,206,017**		**$ 701,446,363**		**$ 2,280,250**		**$ 1,973,688,840**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 814,437**		**$ 60,937**		**$ (18,237)**		**$ (13,946)**				**$ 843,191**		
Number of Family & Child Recipients	**204,789**		**51,889**		**273,233**		**473,178**		**182**		**1,003,271**		
Service Expenditures Per Recipient**	**$ 2,731**		**$ 3,844**		**$ 1,871**		**$ 1,482**		**$ 12,529**		**$ 1,967**		

* Medicare Crossovers are Medicare charges that are billed to Medicaid.

** Service Expenditures per Recipient does not include adjustments, settlements, or administrative costs.

Source: SFY 2003 Program Expenditure Report

Table 15
North Carolina Medicaid
State Fiscal Year 2003
Medicaid Copayment Amounts

Service	Copayment Amount
Chiropractor visit	$1.00
Dental visit	$3.00
Optical service	$2.00
Optometrist visit	$2.00
Outpatient visit	$3.00
Physician visit	$3.00
Podiatrist visit	$1.00
Prescription drugs (including refills):	
Generic & Insulin	$1.00
Brand Name	$3.00

How the NC Medicaid Program Works

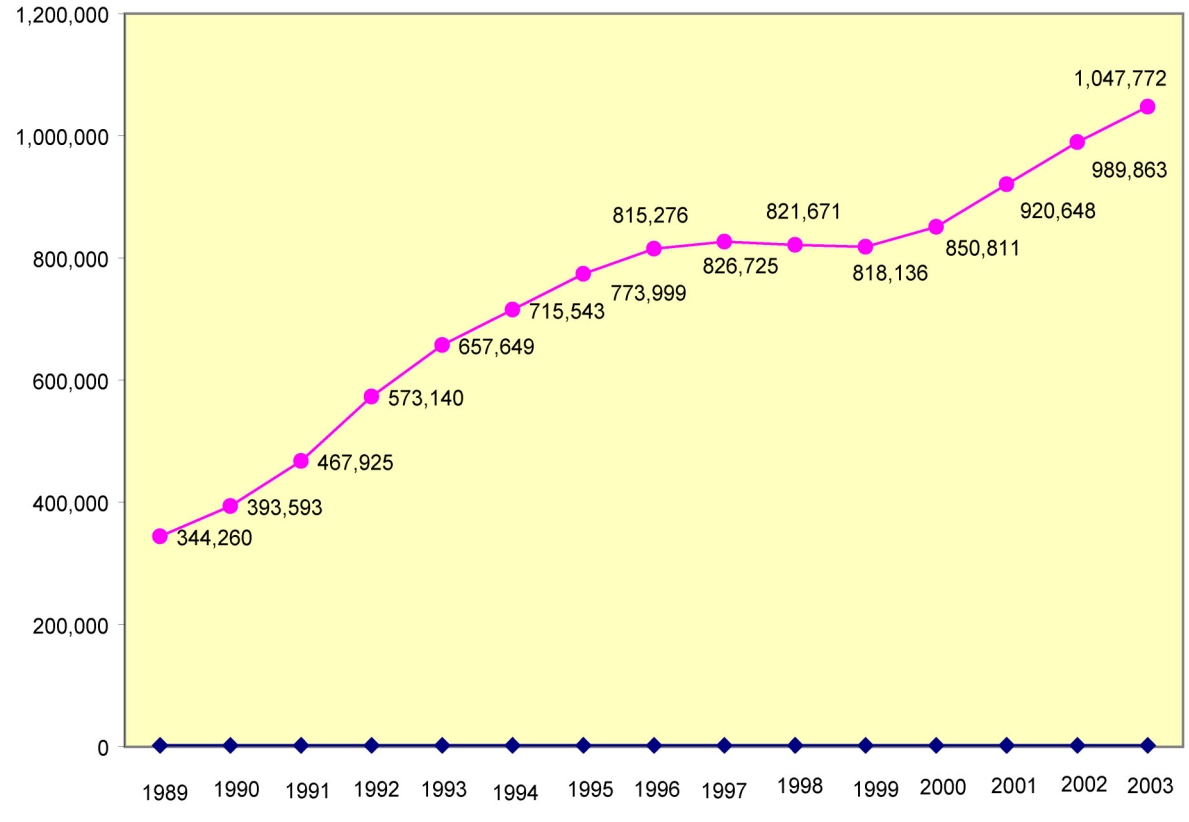
Major Sections: **Page**

Brief History

The State of North Carolina submitted its Medicaid State Plan to the Health Care Financing Administration in 1969 and received approval that year. North Carolina General Statutes, Chapter 108A is the law that implemented Title XIX in North Carolina, thus beginning the NC Medicaid Program, on January 1, 1970 under the direction of the North Carolina Division of Social Services. G.S. 108A defined certain technical aspects of the North Carolina Medicaid Program not spelled out in federal law. North Carolina Administrative Code, Title 10, Chapter 50 and Chapter 26, provided further definition of North Carolina Medicaid policy not addressed in federal law and regulation nor state law. Each year new legislation that is passed by the North Carolina General Assembly establishes changes to the program and its policies such as eligibility and benefit coverage expansions and contractions, management and administrative mandates, special funding, etc.

Exhibit A-1

The History of Average Monthly Medicaid Eligibles



In 1978, the administration of the NC Medicaid Program was assigned to the newly-created Division of Medical Assistance (DMA), a separate division within the Department of Human Resources, which has since been renamed the Department of Health and Human Services. From 1978 to 2003, the annual number of people eligible for Medicaid has increased from 456,000 to 1,447,283 and Medicaid expendi-tures have grown from approximately $307 million to $7.4 billion. As shown above, the number of average monthly eligibles has increased from 344,260 during SFY 1989 to 1,047,772 during SFY 2003.

In 35 years of operation, the programmatic complexity of Medicaid has paralleled the growth in both program expenditures and number of reci-pients. However, DMA has historically spent a modest percent-age of its budget on administration, which during SFY 2003 was approximately $310 million or 4.2 percent of total expenditures.

Exhibit A-2

"What is Medicaid?"

Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and services within a state can change during the year.

Source: Centers for Medicare and Medicaid Services

For further general information about the Medicaid Program, eligibility and services, please refer to CMS's article "Medicaid: A Brief Summary" online at:
http://cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp

For specific information about the NC Medicaid Program's State Plan and amendments, please refer to CMS's article "Table of Contents for the State of NC" at:
http://cms.hhs.gov/medicaid/stateplans/toc.asp?state=NC

Medicaid Eligibility

Medicaid provides funding for health care primarily to individuals who receive some form of financial assistance from the state. In North Carolina, caseworkers at each of the 100 county departments of social services determine an individual's eligibility

Exhibit A-3
Basic Overview of Medicaid Eligibility

Who (coverage group)	Upper Income Limit	Assets *(see explanation below)*
Elderly Aged 65+	$749/month single person ($8,980 annually) $1,010/month couple ($12,120 annually)	$2,000 single person $3,000 couple
Disabled/Blind	Same as elderly	Same as elderly
Medicare Beneficiaries	$1,011 monthly for single person ($12,123 annually) $1,364 monthly for couple ($16,362 annually)	$4,000 $6,000
Pregnant Women and Infants	$2,837 monthly for family of 4 ($34,040 annually)	N/A
Children ages 1 through 5	$2,040 monthly for family of 4 ($24,472 annually)	N/A
Children ages 6 through 18	$1,534 monthly for family of 4 ($18,400 annually)	N/A
Persons aged 19 and 20	$362 per month for single person ($4,344 annually)	$3,000
Parents/Caretakers	$594 monthly for family of 4 ($7,128 annually)	$3,000
Medically Needy (must meet spenddown*)	$242 monthly for single person $317 monthly for couple	$2000 elderly and disabled person $3000 for couple or family

The following items are not counted as assets:
- Burial money
- Home
- Vehicle
  - 1 vehicle for elderly, disabled/blind, and Medicare beneficiaries
  - 1 vehicle per adult for 19 and 20 year olds and parents/caretakers
- clothing, appliances, furniture

In addition to financial requirements, recipients must meet the following general requirements:
- NC resident
- Citizen or "qualified alien"
- Not incarcerated
- Provide information on other health insurance
- Provide Social Security Number

* **Spenddown** is an amount of medical bills equal to the difference between income and the income limit; eligibility begins on day the "incurred" medical bills equal the spenddown amount. Many spenddown recipients are patients in nursing homes

for Medicaid benefits based on policies established by the federal government as implemented by the State. Eligible families and individuals enrolled in the NC Medicaid Program are issued a Medicaid identification card each month. These individuals may receive medical care from providers who enroll in the Medicaid Program. Providers submit claims to DMA for reimbursement of services they render to the Medicaid population.

Medicaid enrollees, applicants, and caretakers who have questions regarding any aspect of the NC Medicaid program may telephone North Carolina's toll free CARE-LINE Information and Referral Service. The CARE-LINE forwards calls regarding covered benefits to the DMA Recipient Ombudsman in DMA's Recipient and Provider Services Section. The Ombudsman ensures that the question is answered in a timely manner. During SFY 2003, the Ombudsman answered questions for approximately 5,000 callers.

Exhibit A-4

Medicaid Eligibility by Mandatory and Optional Groupings

MANDATORY	OPTIONAL
• Aged, Blind and Disabled receiving SSI • Children ages 1 through 5 up to 133% Federal Poverty Level (FPL) • Foster children and adoptive children under Title IVE • Families with children under the age of 19 who would have been eligible for AFDC on July 1996 • Children ages 6 through 18 up to 100% FPL (mandatory as of October 1, 2001) • Pregnant women and infants (under the age of 1) up to 150% FPL • Medicare beneficiaries up to 100% FPL qualify for Medicare cost-sharing • Medicare beneficiaries between 101% and 135% FPL qualify for payment of Part B premium; however, total enrollment is capped by appropriated federal funds for beneficiaries with income between 121% and 135% FPL	• Aged, Blind and Disabled not receiving SSI, including adult care home residents, 100% of poverty eligibles and medically needy • Non-IVE foster children and/or adoptive children with parents in families not eligible under AFDC rules in July 1996 (medically needy) • Children ages 19 and 20 • Pregnant women and infants up to 185% FPL • Medically needy

Funding the NC Medicaid Program

Federal, state, and local county governments jointly finance Medicaid, with the federal government paying the largest share of Medicaid costs. In North Carolina, the 100 county governments con-tribute 15 percent of the non-federal share of costs. The fed-er-al share of costs for services is established by the Centers for Medicare and Medicaid Services (CMS). CMS calculates the rate based on the most re-cent three-year average per capita income for each state and the national per

capita income. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the State and the counties to increase their share of Medicaid payments.

The established federal matching rates for services are applicable to the federal fiscal year (FFY), which extends from October 1 to September 30. The State's fiscal year (SFY) runs from July 1 through June 30. Because the federal and state fiscal years do not coincide, different federal ser-vice matching rates may apply for each part of the overlapped state fiscal year. The federal match rate for administrative costs does not change from year to year.

Administrative Contracts

Certain functions of the Medicaid program are performed for DMA under contract. Some of these include the following:

EDS Corporation

DMA contracts with EDS to perform many of Medicaid's administrative functions. Currently, EDS processes claims, provides billing guidance and help desk services to enrolled Medicaid providers, , conducts provider education seminars, operates the prior approval system for most Medicaid services, and operates the NC Medicaid Management Information System (MMIS+).

Medical Review of North Carolina (MRNC)

MRNC conducts quality assurance re-views of the services provided to recipients through the Community Alternatives Program for Disabled Adults (CAP/DA), Level of Care reviews for residents in Medicaid-certified nursing facilities, and the Health Maintenance Organization (HMO) contracts. MRNC also works with the DMA Program Integrity Section to 1) evaluate provider DRG coding to identify improper reimbursement maximization and other potentially incorrect billings and 2) assist in a federal Payment Accuracy Grant to determine the accuracy rate of Medicaid claim payments. DMA's participation as one of nine grant states will help develop a process to determine a national model for all states. Payment accuracy measurement has been subsequently mandated in federal law known as the "Improper Payments Reduction Act of 2002" (Ref. HR 4878). Beginning October 1, 2002, MRNC began processing the requests for prior approval of outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech, respiratory and audiological therapy regardless of where the services are provided.

ValueOptions (VO)

DMA contracts with ValueOptions for utilization review of acute inpatient/substance abuse hospital care for recipients through age 64; Psychiatric Residential Treatment Facilities (PRTF); Levels II through IV Residential Treatment Facilities (four beds or more); and outpatient psychiatric services. The contract encompasses all elective and emergency admission reviews, concurrent continued stay reviews and post discharge reviews when applicable.

First Health Services Corporation (FHSC)

DMA contracts with FHSC to perform certain components of the retrospective Drug Use Review (DUR) Program. FHSC generates quarterly recipient and provider profiles from the paid claims computer tapes in accordance with the DUR Board's criteria.

Pharmacy Prior Approval Contract

Beginning March 4, 2002, DMA implemented a prior authorization (PA) process for certain prescription drugs through a contract with ACS State HealtCare in Atlanta, Georgia. These prescription drugs were chosen by a panel of clinical and academic physicians and pharmacists based on cost and the high potential for overuse. Prior authorization allows NC Medicaid to ensure that these prescription drugs are used responsibly and as they are intended.

Optical Contract

Medicaid contracts with the NC Department of Correction's Correctional Enterprises to provide eyeglasses at predetermined rates. In most cases, providers of Medicaid eye care services must obtain eyeglasses through this organization.

Audit Contracts

The DMA Audit Section has contracts with two certified public accountants to conduct onsite compliance audits of nurs-ing facilities and intermediate care facilities for the mentally retarded (ICF-MR) who are enrolled in the Medicaid Pro-gram. These audits supplement DMA's in-house audit activities and verify the accuracy of the providers' cost reports.

In addition, DMA contracts with Blue Cross Blue Shield of Tennessee to perform Medicaid settlement activities for Rural Health Clinics and with Blue Cross Blue Shield of North Carolina to perform Medicaid settlement activities for hospitals and State-operated nursing facilities and ICF-MRs.

Partnerships

Although DMA administers Medicaid, other State and local agencies work closely in partnership with the program and perform important functions:

County Departments of Social Services

The departments of social services in each of North Carolina's 100 counties have the central role in determining Medicaid eligibility for their residents. In ad-dition, counties contribute approximate-ly 5 percent of the cost of ser-vices for Medicaid patients (see Table 5 in the main body of the SFY 2003 Medicaid Annual Report).

NC Division of Social Services (DSS)

The DSS conducts Medicaid recipient appeals when the person making the application contests eligibility denials.

Division of Vocational Rehabilitation Services (DVR)

DVR's Disability Determination Unit determines whether an individual is eligible for Medicaid based on disability. This unit also makes disability deter-minations for two federal programs under a contract with the Social Secur-ity Administration including Title II - Social Security benefits and Title XVI - Supple-mental Security Income.

Division of Mental Health, Develop-mental Disabilities, and Substance Abuse Services (DMH/DD/SAS)

DMA works closely with the DMH/DD/SAS to plan for and monitor community mental health services. These agencies also work cooperatively to operate the Community Alternatives Program for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD), a valuable resource for providing community-based services as a cost-effective alternative to institutional care in an ICF-MR. Under the federal mandate for PASARR, DMH/DD/SAS staff are authorized to make the final determination for service and placement needs for all those individuals identified with MI, MR or RC diagnoses (see the "Nursing Facility Prior Approval and Retrospective Review" section of Addendum A).

Division of Public Health (DPH)

DMA and DPH cooperate in a number of efforts to improve care for people with HIV and AIDS. The AIDS Care Unit in DPH operates HIV Case Management Services (HIV/CMS) and the Community Alternatives Programs for Persons with AIDS (CAP/AIDS). DMA and DPH also cooperate in the provision of pediatric equipment for Medicaid-eligible recipients ages birth through 20 years old.

The Women and Children's Health Section (WCH) within DPH operates a variety of health care programs that are Medicaid-funded. WCH and local health departments also play a central role in the operation of the Baby Love Program, a care coordination pro-gram designed to assure appropriate medical care for pregnant women. It also plays a key role in the Health Check Program, which provides preventive and other health care services for children. Both programs are discussed in more detail in the "Programs" section of this report.

State Center for Health Statistics (SCHS)

The SCHS within DPH supports a variety of NC Medicaid's data needs for program planning and evaluation.

NC Office of Research, Demonstrations, and Rural Health Development

The NC Office of Research, Demonstrations, and Rural Health Development, an agency within DHHS, provides technical assistance to small hospitals and community health centers in rural and medically under-served communities. This agency also recruits health care providers to work in rural and medically under-served communities and provides grants for community health centers and is the lead agency for demonstrations in the delivery and financing of health care for DHHS. Presently, they are working with DMA on the Community Care managed care program.

Division of Aging (DOA)

DMA and DOA staff work together on many issues that are important to the aged population. Jointly, DMA and DOA design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development pro-jects on housing and in-home aide services.

Division of Facility Services (DFS)

DFS has the responsibility for licensing, certifying, and monitoring facil-ities in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a facility.

Department of Public Instruction (DPI)

The Individuals with Disabilities Education Act (IDEA) is the federal law requiring education-related services to be provided to pre-school and school aged children with special needs who are receiving special education services as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, such as speech, physical, audiological and occupational therapies as well as psychological services.

University of North Carolina at Chapel Hill (UNC-CH)

The UNC-CH School of Public Health and the Cecil G. Sheps Center for Health Services Research have collaborated with NC Medicaid on a number of research projects and efforts to support program planning and evaluation.

University of North Carolina at Charlotte (UNC-C)

Faculty within UNC-C have conducted evaluations of patient satisfaction with the Health Care Connection, NC Medicaid's mandatory HMO program in Mecklenburg County. They have also carried out and reported on a primary care provider availability survey for Carolina ACCESS.

Covered Services

NC Medicaid covers a com-pr-ehensive array of preventive and treatment services for eligible enrollees (see Exhibit A-5). Preventive services include one annual physical for adults and child health screenings provided under the Health Check (EPSDT) Program. Treatment services address virtually all acute and chronic illnesses.

Medicaid has certain standard lim-itations on services. These include a limit of 24 ambulatory visits per SFY to prac-titioners, clinics, and outpatient departments and a limit of six pre-scr-iptions per month. There are ex-cep-tions to these limits for preven-tive care to pregnant women, children eligible for Health Check, people with life threatening conditions, participants in the Community Alternatives Programs (CAP), and other selected groups. Some services require nominal co-payments and others require prior approval. Both requirements en-sure that the care received is medically necessary

Providers of Care

During SFY 2003, over 70,000 enrolled Medicaid providers offered a wide variety of services to North Carolina's Medicaid population (see Exhibit A-6). Many providers are enrolled in more than one type of service and participate with a group as well as individually. DMA's Provider Services Unit oversees the enrollment of new providers in the NC Medicaid Program and maintains licensing and credentialing information for providers enrolled with Medicaid.

During 2003, Medicaid began a policy to terminate the enrollment of providers who have not billed the Medicaid Program within the previous 12 months. Providers are notified by mail of DMA's intent to terminate their inactive number and have two weeks to respond if they wish to request that their number not be terminated. These notices are sent to the current mailing address listed in the provider's file. Once terminated, providers are subject to the full re-enrollment process and can experience a period of ineligibility as a Medicaid provider.

This policy also addresses the problem of having an incorrect billing address in the provider's file. If remittance advices and checks cannot be delivered due to an incorrect address, all claims for the provider are suspended and the subsequent remittance advice and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider, the provider has 90 days to submit an address change. If after 90 days the address has not been corrected, claims in suspension deny and the provider's enrollment is terminated.

Exhibit A-5

COVERED SERVICES

MANDATORY	OPTIONAL
• Hospital Inpatient • Hospital Outpatient • Psychiatric Residential Treatment Facility Services and Residential Services (treatment component only) for under age 21 • Other Laboratory and X-ray • Nursing Facility • Physician • Home Health • Health Check (EPSDT) • Family Planning • Durable Medical Equipment • Nurse Midwife and Nurse Practitioner • Hearing Aid • Medical Transportation • Federally Qualified Health Centers & Rural Health Centers	• Clinical • Diagnostic • Intermediate Care Facilities for the Mentally Retarded • Personal Care • Prescription Drugs • Dental and Dentures • Eye Care • Mental Health • Chiropractor • Podiatrist • Physical, Occupational and Speech Therapy • Respiratory Therapy for Children • Hospice • Private Duty Nursing • Home Infusion Therapy • Case Management • Nurse Anesthetist • Preventive • Rehabilitative • Orthotic and Prosthetic Devices • Screening • Transportation

Note: All optional services are mandatory for children under age 21

Providers are notified in writing and have 21 days from the date of the letter to respond to DMA Provider Services. If the letter is returned to DMA as undeliverable, the provider's enrollment is terminated.

Exhibit A-6

Enrolled Medicaid Services Providers

State Fiscal Year 2003

Provider Type:	Number
Adult Care Home Providers	2,634
Ambulance Service Providers	407
Chiropractors	1,712
Community Alternatives Program Providers (CAP/C, CAP/AIDS, CAP/DD-MR, CAP/DA)	1,230
Dental Service Providers (Dentists, Oral Surgeons, Pedodontists, Orthodontists)	4,075
Durable Medical Equipment Suppliers	3,266
Health Maintenance Organizations (HMOs)	1
Hearing Aid Suppliers	196
Home Health Agency Providers (Home Infusion Therapy, Private Duty Nursing)	966
Hospice Agency Providers	79
Hospital Providers	888
Independent Laboratory Providers	201
Independent Practitioners (Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, Audiologists)	3,818
Local Education Agencies	105
Mental Health Program Providers	168
Mental Health Providers	3,026
Nursing Facility Providers	1,352
Optical Service Providers and Suppliers (Opticians, Optometrists)	1,880
Other Types of Clinics (Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers)	237
Personal Care Service Providers	793
Pharmacists	2,393
Physician Extenders (Nurse Midwives, Nurse Practitioners, Certified Registered Nurse Anesthetists)	2,326
Physicians	36,869
Podiatrists	513
Portable X-ray Service Providers	27
Psychiatric Facility Providers	551
Public Health Program Providers	511
Rural Health Clinic/Federally Qualified Health Center Providers	353
Total	**70,682**

Note: This is an unduplicated count of any provider enrolled during the year. Physicians may be counted individually and/or as a group. Includes 22,446 providers terminated by 6/30/2003.

Rate Setting

Prospective payment rates and fee schedules are very important in controlling Medicaid program costs. Taking into account the leve-l of funding provided by the N.C. General Assembly, payment rates are established accord-ing to federal and state laws and reg-ulations. In-depth analysis of providers' cost of service is required to ensure fair and reasonable reimbursement. DMA reviews, monitors, and adjusts all reimbursement rates.

Program Integrity

DMA's Program Integrity Section is tasked with multiple responsibilities. These include:

Identifying fraud, abuse, waste, and administrative overpayments in Medicaid billings by health care providers

- Coordinating recipient fraud and abuse identification with the county departments of social services
- Determining the accuracy of Medicaid eligibility determinations by the county departments of social services and claim payment accuracy for claims paid by the Medicaid program.
- Collecting money and cost avoiding Medicaid payments when a third party is responsible for paying for the Medicaid service.
- Ensuring, through prospective and retrospective drug use reviews, that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and not likely to result in adverse medical effects.

The efforts of Program Integrity Section promote program fiscal efficiency of Medicaid money spent and the services rendered.

Medicaid Eligibility Error Rate Reduction

Program Integrity's Quality Assurance (QA) Section is responsible for monitoring the accuracy rate of eligibility determinations made by the county departments of social services in each of North Carolina's 100 counties. The QA staff conducts both federally mandated quality control reviews and State-designed targeted reviews. This review process looks at both active and denied cases. Error trends, error-prone cases, and other important error reduction information are communicated quickly to eligibility staff. DMA then works with the counties to promote corrective actions whenever appropriate. County eligibility supervisors then conduct evaluations and training and make the necessary adjustments to eliminate errors and to prevent future mistakes.

North Carolina has never been penalized for exceeding the three percent federal tolerance level for payment error rates. North Carolina's low payment error rate is the result of a successful partnership between DMA and North Carolina's counties.

QA also coordinates with the counties on recipient fraud and abuse identification, prevention, detection, training, and recovery.

Third Party Recovery (TPR)

Medicaid is, by law, the payer of last resort. As a condition of receiving Medicaid benefits, recipients agree to allow Medicaid to seek payment from avail-able third party health care resources on their behalf. All other third party resources must be used before Medicaid dollars are spent. These resources, such as health and casualty insur-ance and Medicare, are important means of keeping Medicaid costs as low as possible.

Utilization Management

Utilization Management functions ensure optimal health care delivery in a cost effective manner, to Medicaid-eligible individuals who either reside in a nursing facility or live at home. It is a joint effort by DMA and the fiscal agent to reimburse providers for services provided based on needs identified by completion of an FL2 or MR2 and authorized by a physician. The methods of these services are as follows:

Prior Approval

The prior approval function, carried out under a contract with EDS, encompasses medical services, long-term care, specific out-of-state hospital services, and other Medicaid services specified by DMA. Health care providers identify the need for services that require prior approval then complete and submit the state-specified prior approval request form and any applicable supporting documentation. Based on DMA's medical policy, approved medical criteria, and medical judgment, the EDS Prior Approval Unit is authorized to approve, pend or deny the request. Subsequently, the MMIS prior approval files are updated with the information from the request, indicating that the request has been approved, pended for additional information or denied. The claims processing system accesses the prior approval file to validate that the provider's services are consistent with the authorization prior to adjudicating the claim for payment. EDS uses policies developed by DMA to maintain a current medical coverage policy library. In all matters of policy, regulations, and compliance, the EDS Medical Director collaborates closely with DMA.

Prescription Drug Prior Approval

Beginning March 4, 2002, DMA implemented a prior authorization (PA) process for certain prescription drugs through a contract with ACS State Healthcare in Atlanta, Georgia. These prescription drugs were chosen based on cost and the high potential for overuse by a panel of clinical and academic physicians and pharmacists. Prior authorization allows NC Medicaid to ensure that these prescription drugs are used responsibly and as they are intended. They are:

- Drugs used to treat ADHD (for persons 19 and older)
- Procrit, Epogen
- Neupogen
- OxyContin
- Growth hormones
- Provigil

- Rebetron
- Vioxx, Celebrex, Bextra (for persons 59 years of age or younger)
- Enbrel
- Botox, Myobloc, Zyban, Nicotrol, Habitrol
- Synagis, RespiGam (these required prior authorization beginning April 1, 2002)

CAP Utilization Review

CAP/DA cases, randomly selected on a monthly basis from among all lead agencies for CAP, are monitored by MRNC. Quality assurance (QA) reviews determine that clients are classified correctly at either intermediate care or skilled nursing level of nursing facility care. The review also determines that clients have been given the option to choose home care versus nursing home placement, that the plan of care is relevant to the assessed needs of the clients, and that the health, safety, and well-being of clients is reasonably assured by the services provided. Results of the monthly monitorings are reviewed by DMA CAP consultants and shared with the agencies that have been reviewed. The findings enable the agencies to improve the manner in which CAP/DA is operated. The QA review process is not a negative process, but one that leads to the strengthening of programs, enabling agencies to better serve individuals who have nursing facility needs but opt for the range of home care services available through CAP/DA.

Behavioral Health Prior Approval

Prior approval is required for all psychiatric/substance abuse inpatient hospital care, all psychiatric residential treatment facility (PRTF) care for recipients under the age of 21, all residential treatment levels of care II through –IV, after 8 outpatient therapy visits for adults and after 26 outpatient visits for recipients under the age of 21. Medicaid has a contract with ValueOptions to perform utilization review.

Medicaid recipients age 21 and over receiving outpatient mental health services require prior approval after the 8th visit. This includes area mental health programs and private providers. This process replaces the policy of requesting prior approval after the 2nd visit for non-area mental health programs.

The 24-office visit limitation per year was removed and replaced by the requirement for prior approval after the 8th visit for mental health services subject to independent utilization review. Approval is based on medical necessity.

Outpatient Specialized Therapies Prior Approval

Beginning October 1, 2002, prior approval became a requirement for outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech, respiratory and audiological therapy regardless of where the services are provided as well as psychological services in the schools. The prior approval process for services provided in the schools is met by the IEP process. All other prior approval functions are carried out through a contract with MRNC. Based on

DMA's medical policy, approved medical criteria, and medical judgment, the MRNC Prior Approval Unit is authorized to approve or deny the request. Validation reviews are performed by MRNC with review findings sent to DMA on a quarterly basis.

Managed Care Referral Authorization and Utilization Management

Each recipient who is enrolled in either Carolina ACCESS, ACCESS II or ACCESS III (now collectively known as "Community Care of North Carolina) chooses or is assigned to a primary care provider (PCP). The PCP serves as "gatekeeper" for the recipient in achieving the dual goals of improving access to care while reducing unnecessary costs. The PCP is expected to provide 24 hour, 7 day per week access to medical care for enrolled members and to arrange for after hours coverage and authorization for appropriate referrals for specialty care as needed. The PCP provides the referral physician with an authorization number that must appear on the medical claim to ensure Medicaid reimbursement.

From the perspective of the Managed Care Section, utilization management is a process that is used to ensure that appropriate services are delivered to Medicaid enrollees through the identification of aberrant utilization patterns and potential quality of care issues. The process provides the opportunity to identify areas to target for the development of quality improvement activities. Utilization Management also serves to provide the Managed Care Section with cost data based on service utilization, which affords cross-analysis of the efficiency and effectiveness of managed care program types.

Each Carolina ACCESS, ACCESS II, and ACCESS III provider receives quarterly utilization reports and monthly emergency department and referral reports. Data contained in these reports is extracted by EDS from paid claims data. These utilization reports include both inpatient and outpatient utilization statistics and are useful for peer performance comparisons. The Managed Care Quality Management Unit produces internal reports that stratify the data according to provider specialty and the number of enrollees per provider.

Participating managed care organizations (MCOs), of which there is currently only one and it is located in Mecklenburg County, are required by contract to have a written utilization management program that is consistent with federal regulations and includes mechanisms to detect under/over-utilization of services. The written description must address procedures to evaluate medical necessity, the criteria used, information sources, and the process used to review and approve the provision of medical services. MCOs are also required to submit encounter data to EDS within 90 days from the end of the month in which the service was rendered. Additionally, MCOs are required to submit HEDIS data, emergency department visits, inpatient utilization, ambulatory surgical procedures, OB discharges, and newborn data derived from their internal data collection systems to DMA on an annual basis. DMA and EDS continue to work with the sole MCO to develop an encounter reporting process that provides data that accurately reflects the delivery of services to enrollees.

Nursing Facility Prior Approval and Retrospective Review

In order for Medicaid to pay for placement in a nursing facility, an individual must meet both financial and medical eligibility requirements. The county departments of social services have the responsibility of determining financial eligibility. DMA contracts with their fiscal agent, EDS, to determine medical eligibility by utilizing a prior approval process. Prior approval does not guarantee financial eligibility or Medicaid payment.

In addition to the prior approval process for level of care, North Carolina is mandated to perform pre-admission screening – part of the Preadmission Screening and Annual Resident Review (PASARR) process – for all residents applying for, or residing in, a Medicaid-certified nursing facility. This statutory requirement became effective January 1989 as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203). This section of OBRA was enacted to assure that recipients with serious mental illness, mental retardation or related conditions entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services. The pre-admission screen (Level I and, if appropriate, Level II) must be completed and the special identification number, known as the **PASARR** number, must be documented on the state-approved FL2 prior approval form before nursing facility level of care will be considered.

North Carolina has two distinct levels of care for nursing facility placement (skilled and intermediate) that are governed by the level of care criteria. The **FL2** form is used to document information specific to the individual including diagnoses, special care needs, requested level of care, and the PASARR number. This information is used to determine the appropriate level of care. The **FL2** must be completed with current information and must be signed and dated by the physician. Prior approval requests are generally initiated via telephone and must be submitted to EDS within ten working days of the telephone review. Requests can also be initiated by written review. Records may be attached to justify the requested level of care.

On January 1, 2001, DMA initiated a change in procedure for consideration of retroactive prior approval requests. If the retroactive request is within 30 days from the telephone prior approval or FL2 criteria review, medical records may not be needed by EDS to make a level of care decision. If the retroactive request is for a time period exceeding 30 days, medical record documentation will be required by EDS to support the retroactive request and level of care decision. Retroactive prior approval will not be granted for time periods exceeding 90 days from the date Medicaid eligibility was determined. In addition, requests exceeding 90 days when unusual circumstances occur must be submitted to DMA for consideration of approval. Certain requests where it can be proven that the provider failed to determine eligibility or follow the prior approval level of care process will be denied. Under these circumstances the resident or family cannot be billed for services provided.

Major Initiatives and Subprograms

Major Sections: **Page**

The NC Medicaid program has developed a number of initiatives and subprograms to meet federal or state government mandates, to respond to recipient lawsuits, to meet specific medical needs identified among Medicaid recipients or to give recipients better access to care or more care options. Some of these programs are only available to specific groups of recipients, such as pregnant women, and some are available to all. Services under the various subprograms are not necessarily mutually exclusive; a recipient may be eligible to receive services from a number of subprograms.

Managed Care

Managed care options for Medicaid recipients are available in all 100 North Carolina counties. As of June 2003, there were 751,789 Medicaid eligibles enrolled in a managed care plan out of a total of 991,827 average monthly Medicaid managed care eligibles (most, but not all, Medicaid eligibles are eligible for managed care), or approximately 76 percent. Options include Carolina ACCESS, ACCESS II, ACCESS III, and Risk Contracting with state-licensed health maintenance organizations (HMOs). Each of the NC Medicaid managed care program options are now referenced collectively using the umbrella name of "Community Care of North Carolina."

All managed care options operate under the authority of Section 1915(b) of the Social Security Act. Eligibility to participate in a managed care plan is mandatory for a majority of Medicaid recipients in North Carolina. Although recipients of Medicaid who are dually eligible for Medicaid and Medicare are optionally enrolled in Carolina ACCESS, they are not enrolled in HMOs. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan. Managed care options are as follows:

- **Carolina ACCESS -** A primary care case management model (PCCM), characterized by a primary care provider gatekeeper.
- **ACCESS II and ACCESS III -** These programs build on the Carolina ACCESS program by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of health care. ACCESS II and ACCESS III, originally created as a healthcare demonstration project by the NC Office of Research, Demonstrations, and Rural Health Development, are currently a joint collaborative effort between DMA and this office.
- **Healthcare Connection/Risk Contracting -** A program operating in Mecklenburg County requiring the mandatory enrollment in either the HMO, Carolina ACCESS or ACCESS II for a majority of Medicaid recipients in the county. DMA contracts with an HMO in Mecklenburg County to provide and coordinate medical services for certain Medicaid eligibles on a full risk-capitated basis. Recipients may choose between the participating HMO, Carolina ACCESS or ACCESS II. The State must license all HMOs that contract with DMA.

For all of these healthcare models the objectives are:

- cost-effectiveness
- appropriate use of healthcare services
- improved access to primary preventive care

Maternity and Child Health Subprograms

Providing preventive medical services and basic medical care for mothers and children is a continuing priority for the Medicaid program and for the State of North Carolina. Medicaid covered 52,209 of the 117,833, or 44 percent, of all live births in North Carolina during SFY 2002 (the most recent fiscal year for which population data were available). Medicaid coverage is federally mandated for children with family incomes below 100 or 133 percent of the federal poverty level, depending on the age of the child. Over the years, North Carolina has taken advantage of federal options to expand Medicaid coverage to pregnant women and children with incomes ranging up to 185 percent of the poverty level. Since implementing the initiatives and programs described below, North Carolina has experienced many positive outcomes, including reductions in the infant mortality rate and better access to preventive health care for Medicaid recipients and low-income children.

Baby Love

Baby Love was implemented in 1987 and is administered jointly by DMA and the Division of Public Health. The program provides pregnant women with comprehensive care through an expanded Medicaid benefit package which includes childbirth and parenting classes, in-home nursing care for high-risk pregnancies, nutrition counseling, psychosocial counseling, and postpartum/newborn home visits. Specially trained nurses and social workers called Maternity Care Coordinators assist the women in accessing medical care and support services. In addition, Maternal Outreach Workers, who are specially trained to assist at-risk families, are available in 58 counties.

Evaluations of the Baby Love Program have shown that women who receive Maternity Care Coordinator services average more prenatal visits per pregnancy, have a higher participation rate in the WIC program, experience better birth outcomes, and are more likely to receive postpartum family planning services. Likewise, their children are more likely to receive well-child care and WIC services.

Health Check

In 1993, North Carolina expanded the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program to form Health Check. Health Check encourages regular preventive health care and the diagnosis and treatment of any health problem detected during a screening**.** Medicaid recipients under the age of 21 are automatically eligible for Health Check services.

An integral part of the Health Check program is a special initiative called the Health Check Outreach Project. Specially trained Health Check Coordinators work through this program to reduce barriers and educate families on the importance of preventive health services. Recently, a plan was endorsed by the NC Health Directors' Association to expand Health Check Coordinators statewide. This plan will eventually place Health Check Coordinators in all counties by reallocating existing positions. Health Check Coordinators are located in 76 counties as well as the Qualla Boundary (the reservation of the Eastern Band of

Cherokee). DMA's Managed Care Section is the administrative entity for the Health Check Program and coordinators. The Managed Care Section works closely with the Division of Women and Children's Health to provide guidance to the counties.

The Health Check Automated Information and Notification System (AINS) is a computerized system for identifying and following the health care activities of Medicaid-eligible children

It enables Health Check Coordinators to determine which Medicaid-eligible children in their respective counties are receiving regular and periodic Health Check screenings, immunizations, and referrals for special health care problems. AINS generates notices to the parents of Medicaid-eligible children, notifying them of the Health Check Program, scheduled screening appointments, missed appointments, immunizations, and available programs and services. For children enrolled in a Medicaid managed care program, the name of the Carolina ACCESS primary care provider or the HMO appears on letters sent to providers to whom referrals are being made. Access to and utilization of health care services for Medicaid-eligible children and youth have improved since the program was initiated.

Health-Related Services for Children

In order to assure that a comprehensive array of services is accessible to children, Medicaid pays for physical therapy, occupational therapy, audiological services, speech/language services, and psychological services for children in public schools and Head Start programs. These services are provided to eligible children through Local Education Agencies (LEAs) and local Head Start programs. In addition, North Carolina has an Independent Practitioner Program, which enrolls and reimburses individual independent practitioners to provide physical therapy, occupational therapy, respiratory therapy, speech and language therapy, and audiological services to children from birth through 20 years of age.

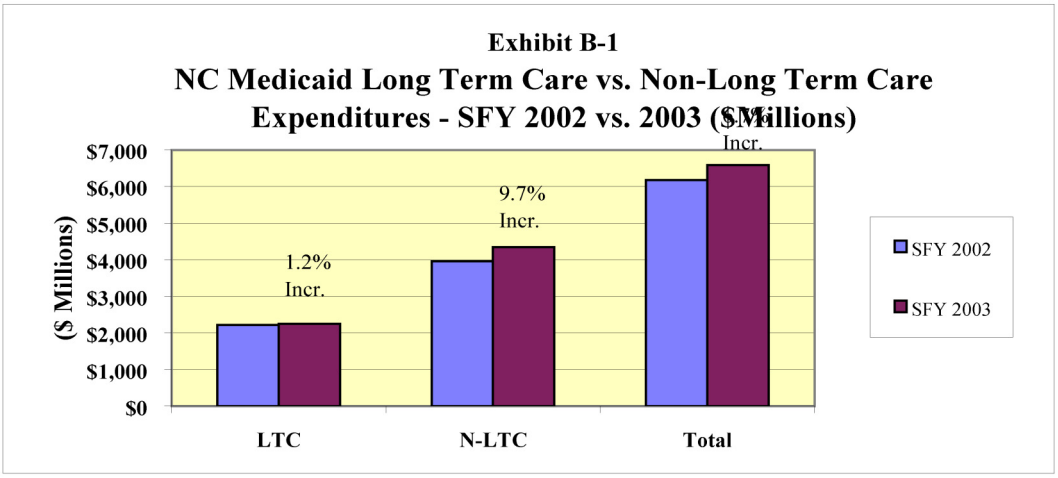
Practitioner and Clinical Services

Practitioner and Clinical Services comprises services provided by physicians including injectible drugs given in the physicians office, ambulance services, ambulatory surgery centers, dialysis services, anesthesiology, labs, clinics, birthing centers, radiology services, nurse practitioners, podiatrists and chiropractors. The annual updates of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes occur in this program area. During this fiscal year staff began the intense process of converting local and state created codes to national codes to comply with HIPAA mandates.

Long-Term Care

NC Medicaid spends a large portion of its service dollars (approximately 36 percent) on long-term care. Long-term care includes nursing facility care (both skilled and intermediate levels of care), intermediate care facilities for the mentally retarded (ICF-MR), adult care home personal care services and a variety of home and community-based services. As shown below, total expenditures for long-term care during SFY 2003 were approximately $2.2 billion, a modest increase of 1.2 percent over the previous year.

Exhibit B-1



Facility Care Services

Nursing Facility Care

There are times when nursing facility care is the best option for Medicaid recipients. All Medicaid-certified nursing facilities are required to provide skilled nursing (SN) and intermediate care (IC). Nursing facility reimbursement rates differ based on whether a resident requires skilled or intermediate level of care. In SFY 2003, a total of 31,666 Medicaid recipients received skilled care in nursing facilities costing $449 million. A total of 25,027 recipients received intermediate care costing $419 million.

All Medicaid recipients must receive prior approval before admission to a nursing facility. Prior approval is given only if recipients meet the State's stringent medical criteria for admission. There is also a federal requirement for preadmission screening and annual resident review (PASARR) to screen and evaluate applicants and residents of Medicaid certified nursing facilities for mental illness, mental retardation, developmental disabilities, and related conditions.

Medicaid allows an individual with a spouse living in a nursing facility to keep a larger portion of the couple's income than normally allowed under Medicaid eligibility rules. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The income of the spouse living at home is considered in determining whether an allowance is budgeted. The total income and resources amount that may be protected for the at-home spouse increases each year.

Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

ICF-MR facilities are long-term care facilities for the mentally retarded/developmentally disabled that meet certain federal criteria. The criteria include the need for active treatment for individuals that have mental retardation or a related condition and who have a severe, chronic disability. ICF-MR facilities must meet certification requirements relating to the provision of habitable services as well as basic intermediate care services. ICF-MRs are paid prospective per diem rates. During SFY 2003, a total of 4,601 recipients were treated in ICF-MRs at a total cost of $411 million.

Adult Care Home Personal Care Services

In 1995, NC Medicaid began covering personal care services for residents in adult care homes who are eligible for Special Assistance for Adults (SA) and Medicaid (see the "Personal Care Services" subsection below for a description of personal care services in the home). In 1996, Medicaid expanded this coverage by creating "enhanced" adult care home personal care and adult care home case management services for residents of adult care homes who met Medicaid criteria for being a "heavy care" resident. A monthly average of 20,515 North Carolinians received personal care services in Adult Care Home settings in SFY 2003 at a total cost of $107 million. Another 3,796 per month on average received enhanced personal care services at a total of $9.7 million. Additionally, a monthly average of 20,140 received transportation services related to the Adult Care Home program at a total expense of $4.5 million.

Home and Community-Based Services

Home and community-based long-term care is a cost-effective and preferable alternative to institutionalization. Medicaid recipients can receive several home-based services such as home health, personal care services, home infusion therapy and hospice.

Home Health Services

Medicaid covers visits provided by certified home health agencies for skilled nursing, physical therapy, speech-language pathology services, occupational therapy and home health aide services when the home is the most appropriate setting for the care. Medical supplies such as adult diapers, disposable bed pads, catheter and ostomy supplies are also covered under home health. Agencies are paid the lower of their customary charge to the general public or a maximum per visit rate established by DMA for each service.

Community Alternatives Program (CAP)

North Carolina operates four Community Alternatives Programs as another option for home and community care as a cost-effective alternative to insti-tutionalization. These are known as "waiver" programs because standard federal program requirements are waived to allow the program to operate. The waiver programs provide some services that otherwise are not covered under Medicaid.

- **Community Alternatives Program for Disabled Adults** (CAP/DA) - CAP/DA provides a package of services to allow adults, age 18 and older, who qualify for nursing facility care, to remain in their private residences. CAP/DA experienced significant growth for many years as DMA pushed its expansion into all counties and fostered the growth of existing county programs. CAP/DA has been the state's primary answer to controlling the growth of nursing facility expenditures while addressing quality of life issues for the expanding frail elderly and disabled adult population. It offers North Carolina the only significant avenue for addressing Olmstead issues for the frail elderly and physically disabled adults. Due to the state budget crisis, participation in the program was frozen in October 2001 through July 2002. Additional support from the legislature enabled the freeze to be lifted. The program served a total of 10,714 citizens in SFY 2003 at a total cost of $185 million.
- **Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP-MR/DD)** - CAP-MR/DD is a special Medicaid home and community-based "waiver" program. It was implemented in 1983 to serve individuals who would otherwise qualify for care in an ICF-MR. It allows these individuals the opportunity to be served in the community instead of residing in an institutional setting. The Medicaid cost for community care must be cost effective in comparison to the cost of ICF/MR care. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services manages the daily operation of the program under an agreement with DMA. The program is available statewide through local area mental health, developmental disabilities and substance abuse programs. CAP-MR/DD served a total of 5,742 people in SFY 2003 at a total cost of $260 million. The average monthly cost per recipient of CAP-MR/DD services was approximately 41 percent of the average cost of care at a state-owned ICF/MR facility and 61 percent of that at a non-state-owned facility.
- **Community Alternatives Program for Children (CAP/C) -** CAP/C provides home-based care for medically fragile children through age 18 who would otherwise require long-term hospital care or nursing facility care. A total of 734 children participated in CAP/C in SFY 2003 at a cost of $24 million. The program contributed to the quality of life for the children and their families/caregivers, while providing care that was cost effective in comparison to a mix of institutional care at either hospital intensive care units (approximately 40 percent of the institutional care, at an average cost of roughly $15,000 and $20,000 per month) or nursing facilities.

- **Community Alternatives Program for Persons with AIDS (CAP/AIDS)** - CAP/AIDS offers a home care alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive with other qualifying conditions. CAP/AIDS is a cooperative effort with the Division of Public Health's AIDS Care Unit. The AIDS Care Unit administers the program with DMA providing oversight. This program began in late 1995 and is still developing statewide. A total of 96 people were served in SFY 2003 at a cost of $947,034 or $9,865 per person, which is a significantly lower cost than the alternative mix of institutional care at hospitals and nursing facilities, thus saving NC Medicaid roughly $30,000 per recipient per year.

Overall, CAP has been very successful in giving individuals an alternative to living in an institution, while containing costs to the Medicaid program. The programs have allowed those who otherwise would be institu-tionalized to remain with their family in familiar surroundings. All of these benefits cost Medicaid less than institutional care.

Personal Care Services (PCS)

PCS covers personal aide services in private residences to perform personal care tasks for recipients who, due to a debilitating medical condition, need help with such basic personal activities as bathing, toileting, and moving about. Aides also monitor the patient's vital signs. Services may also include housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining the patient's basic personal health. PCS is provided for the patient according to a physician's authorized plan of care. Recipients could receive up to 80 hours of PCS in a calendar month for dates of service between July 1 and November 30, 2002 and up to 60 hours per month for dates of service on and after December 1, 2002. During SFY 2003, a total of $189 million was spent on a monthly average of 20,902 PCS recipients.

Home Infusion Therapy (HIT)

HIT is for recipients who live in a private residence or adult care home. Coverage is for self-administration of a drug or nutrition therapy. The recipient or an unpaid caregiver may administer the therapy after appropriate training.

Private Duty Nursing (PDN)

PDN coverage is for recipients who live in a private residence and require substantial and complex continuous nursing care as ordered by the attending physician. PDN must have prior approval, which may include a visit to the recipient's home to verify the medical necessity for the service.

Hospice

Hospice is a package of medical and support services for terminally ill patients with a medical prognosis of a six month or less life expectancy. Services are provided in a private residence, adult care home, hospice residential care facility or a hospice inpatient unit. They may also be provided in a hospital or nursing facility under arrangement with the hospice agency.

Durable Medical Equipment (DME)

Medicaid pays for DME when it is medically necessary for a recipient to function in his home or an adult care home. The list of covered items includes wheelchairs, hospital beds, blood glucose monitors, ambulation devices, enteral formulas, bedside commodes, oxygen

and respiratory equipment and supplies used with DME. Orthotic and prosthetic devices, including braces and artificial limbs, are covered for recipients from birth through age 20. The patient's physician must order DME and document medical necessity on the Medicaid Certificate of Medical Necessity and Prior Approval form. Some items require prior approval. All DME and related supplies have established lifetime expectancies and quantity limitations.

Behavioral Health

NC Medicaid covers a variety of services for behavioral health, some under the rehabilitation option and others under the clinic option. Services provided under the rehabilitation option are provided by Area Mental Health Centers and include Outpatient Therapy, Psychological Testing, Day Treatment, Partial Hospitalization, Psychosocial Rehabilitation, Facility-Based Crisis, and Community-Based services for recipients of all ages and Residential services for recipients under the age of 21. Clinic services include Outpatient Therapy and Psychological Testing provided by directly enrolled providers and LEAs. Medicaid also covers inpatient psychiatric care in psychiatric units for recipients of all ages and in free-standing psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTFs) for recipients under the age of 21. Inpatient services, residential services, and outpatient therapy must go through a prior approval process (see "Behavioral Health Prior Approval" under the Utilization Management section of "How the NC Medicaid Program Works", Addendum A to the NC Medicaid SFY 2003 Annual Report).

DMA also provides services in ICF-MRs, which are long-term care facilities for individuals with mental retardation or a related condition that occurred before the age of 22. Please see the "Intermediate Care Facilities for the Mentally Retarded (ICF-MR)" subsection of the "Long-Term Care" section of this addendum.

Dental Health

NC Medicaid covers most general dental services such as diagnostic exams and radiographs, and preventive services such as dental cleanings, fluoride treatments, and sealants. Restorations, surgeries, and partial and full dentures are covered as well as orthodontic services for children under age 21. Most dental services do not require prior approval. Except where a coverage category is exempted from copays by law, recipients are charged a $3 copayment per visit. A special children's initiative effective February 1, 2001, allowed children from birth to age three to receive special preventive dental services provided by physicians in an attempt to decrease the incidence of early childhood caries and improve access to dental care

Pharmacy

Prescription drugs and insulin (where the manufacturers have signed a rebate agreement with CMS) are covered under the pharmacy program. Recipients may have up to six prescriptions per month and are locked into one pharmacy provider during the month of service. A recipient copayment of $1 applies for generic medications and $3 for brand medications. NC Medicaid does not pay for a drug to be refilled during the same month that the prescription is originally filled. Recipients may have a 34-day supply of their prescription medication and a 3-month supply of birth control pills (BCP) and hormonal replacement

therapy (HRT) dialpaks. The pharmacy reimbursement fee structure is as follows: AWP (average wholesale price) – 10 percent, State MAC, Federal Upper Limit or Usual and Customary, whichever is lower, plus a dispensing fee of $5.60 per generic prescription or $4.00 per brand name prescription.

Drug Use Review Program

NC Medicaid established a Drug Use Review (DUR) Program as required by OBRA of 1990 to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and are not likely to result in adverse medical effects. The DUR program is characterized by the following four major components:

- **DUR Board** - A DUR Board is composed of five licensed and actively practicing physicians, five licensed and actively practicing pharmacists, two other individuals with expertise in drug therapy problems, and the DMA DUR Coordinator. The DUR Board makes recommendations to DMA on DUR policies and procedures.
- **Prospective DUR** - Prospective DUR requires that, prior to dispensing, the pharmacist must screen for potential drug therapy problems and counsel patients about the medications they are taking in order to enhance patient compliance.
- **Retrospective DUR -** Retrospective DUR is an ongoing periodic examination of Medicaid claims data and other records to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients associated with specific drugs or groups of drugs and the appropriate treatment of disease states. These analyses are based on predetermined standards established by the DUR Board. North Carolina contracted with FHSC to provide the computer support for the retrospective DUR.
- **Education** - Education is the key to an effective DUR Program. The DUR Program must provide ongoing outreach programs to educate physicians and pharmacists about common drug therapy problems with the goal of improved prescribing and dispensing practices.

The DUR Program uses a Provider Profiling System to complement the retrospective patient-based drug utilization reviews. This system is designed to be a retrospective characterization of drug use patterns. The Provider Profiling System identifies any prescribing and dispensing practices that deviate from accepted norms. These norms may be defined by the Board, taken from published literature or modified as needed. The Provider Profiling System is criteria driven and accommodates client-specific criteria within any of 12 broad problem types. Since the primary focus of the DUR Program is educating providers about common drug therapy problems to improve prescribing and dispensing practices, the providers who are profiled receive educational letters with profiles of each recipient who receives the medication and prescribing information related to the patient's drug therapy.

Optical Services

The Optical Services Program within the Medical Policy Section of DMA is responsible for the overall administration of visual services covered in the NC Medicaid Program. Medicaid covers routine and medical eye examinations, corrective eyeglasses, medically necessary

contact lenses and some other visual aids. Prior approval is required for all visual aids and is recommended for routine eye examinations. There are limitations regarding the frequency of eye examinations and the number of dispensed visual aids during specific eligibility periods. A $3 copayment is applicable to ophthalmologist visits, while a $2 copayment applies to optical services and supplies. Although a $2 copayment is generally required for new eyeglasses, eyeglass repairs and contact lenses, there are some exemptions.

Medicaid eyeglasses are supplied through a contractual agreement with the North Carolina Department of Correction Enterprise, Nash Optical. Providers must obtain Medicaid eyeglasses through this laboratory. Prior approval for exceptions may be granted under extenuating circumstances.

Hearing Aid Services

Single and binaural hearing aids are covered for recipients under 21 years of age that have received medical clearance from a physician. An ENT specialist, otologist, otolaryngologist, audiologist or hearing aid dealer must submit a prior approval request for the hearing device, audiogram, evaluation report and manufacturer's warranty information. Each prior approval request for replacement hearing aids due to hearing changes, damaged hearing aids or lost hearing aids is reviewed individually for medical necessity. Providers may seek prior approval for FM systems for recipients from birth up to the time of school enrollment. There are no co-payments for hearing aids, hearing aid accessories, or hearing aid services.

Medicare-Aid

In February 1989, North Carolina began a new limited Medicaid program for Qualified Medicare Beneficiaries. The program, known as Medicare-Aid, provides assistance to eligible individuals with Medicare cost-sharing expenses, such as deductibles, premiums, and coinsurance charges. The eligibility income limit for Medicare-Aid is 100 percent of the federal poverty level. This level is adjusted in April of each year.

Effective January 1, 1993, the Medicare-Aid program was expanded to include qualified individuals with income greater than 100 percent of the federal poverty level but not greater than 120 percent. These individuals are referred to as Specified Low-Income Medicare Beneficiaries. Eligible individuals in this group receive assistance with the payment of their Medicare Part B premium only.

In January 1998, the Medicare-Aid program was further expanded to include two new groups of Medicare beneficiaries. Eligible individuals with incomes between 121 percent and 135 percent of the federal poverty level receive assistance with the payment of their Medicare Part B premiums. Funding for these groups is capped and approval of assistance is based on a first-come first-serve basis.

During SFY 2003, a total of 40,362 recipients benefited from Medicare-Aid. Total cost for this coverage was $27 million.

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