Medicaid in North Carolina
Annual Report
State Fiscal Year 2004

Division of Medical Assistance

Michael F. Easley
Governor

Carmen Hooker Odom
Secretary

Mark T. Benton
Interim Director

This annual report was produced by the
North Carolina Department of Health and Human Services
Division of Medical Assistance
June 2005

North Carolina
Department of Health and Human Services
Division of Medical Assistance
Director's Office
2501 Mail Service Center - Raleigh, N.C. 27699-2501
Courier Number 56-20-06

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Mark T. Benton, Interim Director

Dear Fellow North Carolinians:

I am pleased to present the North Carolina Medicaid Annual Report for the State Fiscal Year ending June 30, 2004. The N.C. Medicaid Program continues to offer its recipients accessible, quality health care through on-going cost containment efforts and new program initiatives. Our dedicated staff also took further steps to improve the overall administration and management of the program.

I invite you to read this report in order to gain better insight into our state's Medicaid Program and the many challenges and accomplishments we faced during the preceding state fiscal year.

Sincerely,

Mark T. Benton

Executive Summary

State Fiscal Year 2004 was another challenging year as the State began to emerge from a prolonged period of recession and high unemployment. However, the Division was able to avoid cutting program eligibility or benefits. This was due in large measure to the continued financial commitment of the North Carolina General Assembly, a one-time 4 percent increase in the amount of federal support of the program, and the Division's on-going cost containment activities.

Approximately 18 percent of the total population of North Carolina was eligible for Medicaid coverage at some time during the year. The number of recipients was 1,541,450. As the state population rose by 1.1 percent between SFY's 2003 and 2004, the number of Medicaid eligibles increased by 4.5 percent. The two largest categories of eligibles during the year were Pregnant Women and Children and Aid to Families with Dependent Children (AFDC), respectively.

Approximately $7.4 billion was spent during the year on health services and premiums, amounting to $4,804 per recipient. While total service and premium expenditures increased by 12.1 percent, the increase per recipient was only 5.6 percent above SFY 2003 expenditures. Within the total increase, non-long term care expenditures grew by 15.2 percent and long term care expenditures grew by only 5.4 percent. Of all Medicaid services provided, the Prescription Drug service category was the most expensive at roughly $1.18 billion after manufacturer's rebates, or about 14 percent of total expenditures.

Elderly and Disabled recipients comprised approximately 13 percent and 16 percent of total recipients respectively; however, service expenditures for these two groups amounted to approximately $5 billion, or 69 percent of total Medicaid expenditures. Recipients from the Families and Children group, on the other hand, represented approximately 70 percent of all recipients, but accounted for approximately $2.3 billion, only 31 percent, of total service expenditures.

A variety of program and service initiatives were begun to improve accessibility and quality. To mention a few of these:

- The Division accomplished a number of pharmacy utilization and quality improvement initiatives.
- Community Care of North Carolina (CCNC) (which builds on ACCESS, Medicaid's managed care program), grew substantially and currently has 13 networks with more than 3,000 physicians. These networks are responsible for providing a "medical home" and for improving access to and quality of care for over 550,000 Medicaid enrollees while containing health care costs.
- The Quality Management Unit within the Managed Care Section broke new ground through a variety of activities including studies and initiatives related to asthma care, adult preventive services, Health Check and immunizations and improving access to health care.
- The Division collaborated with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to help develop and implement mental health reform. A related activity was a collaboration with Piedmont Behavioral HealthCare to develop a waiver program to pilot mental health managed care in five contiguous counties.
- Over a billion dollars was saved, recovered or cost avoided through the efforts of the Program Integrity Section.
- DMA partnered with representatives of home care provider agencies and the Division of Facility Services to address changes needed in the Personal Care Services Program.
- Access to dental services has increased significantly due to targeted fee increases and a close collaboration with the NC

Dental Society and the Dental Committee of the NC Physicians Advisory Group, resulting in a 23 percent increase in the average number of recipient visits per month.

- The Provider Services Unit enhanced the quality of its service through redesigning the application and agreement forms utilized by physician providers and implementing a new credentialing process.

- DMA participated in the review and selection process of the new Medicaid Management Information System (MMIS).

- As a result of an analysis of the Division's management infrastructure conducted by DHHS and DMA's Management Team, the Division's organizational structure was redefined in order to improve the oversight and coordination of the Clinical Affairs and Budget and Finance subdivisions.

Mission Statement and Goals

The mission of the Division of Medical Assistance is to provide access to high quality, medically necessary health care for eligible North Carolina residents through cost effective purchasing of health care services and products.

In order to carry out this mission, DMA will:

- *Provide excellent customer service for our recipients, providers, other governmental agencies, the public, and our colleagues*
- *Provide clear, evidence-based medical policy which meets regulatory requirements*
- *Establish and maintain accurate and clear enrollment criteria of eligible recipients and providers*
- *Establish and maintain a network of qualified providers capable of providing the goods and/or services necessary to provide medically necessary care and treatment for our beneficiaries*
- *Be a responsible, value-based purchaser of goods and services in the healthcare marketplace*
- *Recruit, hire, train, retain and fairly compensate a qualified staff*
- *Develop and implement process improvements through utilization review, claims payment, customer input, and other feedback mechanisms*
- *Operate in compliance with state and federal requirements in an accurate, confidential, and timely manner*
- *Identify and address opportunities to improve access to and use of health care services*

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Policy Changes and Reports

Policy Changes Mandated by the North Carolina Legislature

Medical Coverage Policy Development

A special provision within the appropriations bill of the 2001 Session mandated the process by which the Division of Medical Assistance (DMA) is to develop, amend and adopt new medical coverage policies. It specified that during the development of new or amended medical policies, DMA must consult with, and seek the advice of, the Physician Advisory Group of the North Carolina Medical Society (NCPAG). A 45-day public comment period is required after NCPAG review and prior to implementation of a new or modified policy. In accordance with a revision of that mandate during the 2003 Session, effective July 1, 2003, DMA must also consult with potentially affected professional societies and associations representing provider groups. The internal DMA policies and procedures for medical coverage policy development were amended to reflect this change.

Cost Avoidance Model for Pharmacy Claims

Since the Fall of 2003, DMA has established a cost avoidance model for pharmacy claims to ensure that claims are billed first to third-party insurers and that NC Medicaid is the payer of last resort.

Drug Utilization Management

Expanded implementation of the various drug utilization management activities to contain the cost of prescription drugs:

- In November 2003, DMA implemented a statewide Prescription Advantage List (PAL) in order to reduce expenditures in the top fifteen most costly therapeutic drug classes.

- Effective October 1, 2003, certain over-the-counter (OTC) medications that provide cost-effective treatment options were added to the NC Medicaid benefit package. The decision for coverage is based on the analysis of the potential cost benefit of using the OTC medication and the recommendations of the NCPAG using an evidence-based approach.

- Effective October 1, 2003, Medicaid-enrolled physicians were given the flexibility to order a 90-day supply of generic, non-controlled, maintenance prescription medications provided there had been a previous 30-day fill of the same medication. The objectives are to simplify prescribing for physicians and patients and to encourage the use of generic drugs.

- 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. DMA has continued these efforts as described in Appendix A of this report.

- During the year, Community Care of North Carolina (CCNC), formerly known as ACCESS II and ACCESS III, implemented a polypharmacy program in nursing facilities to provide case management for patients receiving multiple prescriptions (see details under "Community Care of North Carolina Expansion and Cost Savings" in the Major Accomplishments section of this report).

State Transitional Medicaid Coverage

Effective September 1, 2003, an optional 12 months of State Transitional Medicaid Coverage was eliminated. Families remain eligible for 12 months of Medicaid coverage when they go to work and are no longer receiving welfare payments, however they are no longer able to receive a 12 month extension of Medicaid coverage.

Home Care Personal Care Services

The NC Legislature provided funds to maximize federal Medicaid matching funds for Home Care Personal Care Services. These funds were used to implement the PCS Plus Program (described immediately below).

PCS Plus

In December 2002, the NC General Assembly reduced the monthly limit on personal care service (PCS) hours from 80 to 60. However,

after those reductions were implemented, it became clear that there were many PCS clients that needed more than 60 hours of PCS per month in order to remain at home. The personal care services policy was modified on November 1, 2003 to establish medical necessity criteria for 20 additional hours of PCS monthly for recipients whose condition requires care that is beyond the standard 60 hour limitation. Recipients receiving these additional hours of PCS are enrolled in DMA's "PCS Plus" program. Providers must submit a request for prior approval to DMA to put a recipient into the PCS Plus program.

Community Care

The Community Care of North Carolina Program (which expands on ACCESS, the NC Medicaid managed care program) was expanded by one additional network to a total of 13 networks, representing 24 additional counties. During SFY 2004, a total of 326 providers joined the various networks and enrollment increased by 142,669 recipients (34 percent) to a new total of 539,649 by June 2004.

Medicaid Assessment Program for Skilled Nursing Facilities

Effective October 1, 2003, DMA implemented a Medicaid assessment program, or "provider tax", for skilled nursing facilities. As mandated by the North Carolina General Assembly, funds realized from these assessments are being used to draw down federal Medicaid matching funds to implement and support a new reimbursement plan for nursing homes.

New Reimbursement Methodology for Nursing Facilities

DMA's nursing facility reimbursement was changed from a "cost-based" to a "prospective, patient acuity-based" methodology. The new system uses the standardized Minimum Data Set (MDS) to calculate the average "case mix" of the patient population and then aligns facility payments with average facility acuity. Under the new system, facilities serving the patients requiring the highest level of care command a higher reimbursement rate. The FL2 patient assessment form is still used for admission purposes, but the skilled and intermediate nursing level of care system (that was formally derived from the FL2) has been replaced by 34 levels of care attributable to the MDS. Based on the patient's acuity level, as further defined by their "Activities of Daily Living" score, the patient is assigned to one of 34 Resource Utilization Groups (RUGs). The RUG indicates the amount of resources, in terms of nursing staff and aide staff, a patient needs. A nursing facility is then reimbursed during the following quarter according to its specific case mix index factor that was determined by the overall MDS and RUG profile established in the preceding quarter. The new system does not apply to state-owned or federally-managed nursing facilities.

Medicaid-related Services to Public School Students with Disabilities

The Department of Health and Human Services (DHHS), the Department of Public Instruction (DPI) and local education agencies (LEAs) were directed to collaborate on the provision of Medicaid-related services for public school students with disabilities. Procedures and guidelines are to be streamlined to ensure that local education agencies receive Medicaid reimbursement in a timely manner for Medicaid-related services and administrative outreach to Medicaid-eligible students with disabilities. Several DMA medical policy changes and LEA training sessions have been completed. New services are in the process of being added to the program. Clear lines of communication have been established between DPI, DMA and the LEAs.

Medicare Enrollment Required

Effective July 1, 2004, NC Medicaid began to deny claims for recipients age 65 and over who were entitled to Medicare benefits but failed to enroll. These individuals will need to enroll in Medicare in order to obtain Medicaid payment for medical expenditures that qualify for payment under Medicare Part B. Additionally, a provider may seek payment for services from Medicaid enrollees who are eligible for, but not enrolled in, Medicare Part B. Legal aliens who have not lived in the United States for five consecutive years are exempt from this requirement. It is worth noting that the NC Medicaid Program pays the Medicare Part B premium for Medicare-eligible recipients through the Medicare-Aid Program (see Addendum B, "Medicare-Aid").

Other Policy Changes

Special Services: After-Hours

On November 1, 2003, the "Special Services: After Hours" policy was amended to encourage recipients to go to their primary care providers for medical care that is needed outside of regular office hours (which is defined as between 8:00 a.m. and 5:00 p.m., Monday through Friday) instead of using the more expensive option of emergency rooms.

Ultrasonic Osteogenesis Stimulators

Since 1982, the NC Medicaid Program has reimbursed providers for electrical osteogenic stimulation to aid in the repair of long bone fractures. Beginning on February 1, 2004, coverage was added for ultrasonic osteogenesis stimulators for this same purpose.

Ocular Photodynamic Therapy (OPT) with Verteporfin

Coverage was added on April 1, 2004 for OPT, which treats age-related macular degeneration, the most common cause of blindness in the elderly, when it is used in conjunction with the drug Verteporfin.

Electronic Submission of FL2s

For a number of years, "FL2" forms have been used in documenting patient assessment information for nursing facility level of care authorizations. Effective July 1, 2003, providers were given the option of submitting FL2 forms electronically via the new "FL2e" form developed by ProviderLink, Inc. FL2e's may now be submitted to the NC Medicaid Program's claims processing contractor EDS through a web-based browser interface.

Special Studies, Reports and Projects Mandated by NC Legislature

Vision Screening Task Force

Through the NC Physician Advisory Group, DMA convened a 19-member task force to review the current Medicaid standards for vision screening for Medicaid-eligible children to determine whether the standards were meeting the vision needs of children. The resulting report of the task force was submitted to the North Carolina Legislature on April 28, 2004. The task force reported that "the consensus is that current NC Medicaid policy is adequate to support a comprehensive and effective vision-screening program and does not recommend changes to the current policy at this time." However, the task force made several recommendations toward strengthening vision services for Medicaid-eligible children, especially vision screening among preschoolers. These recommendations are currently under review by DMA staff.

Audit of CAP/DA Programs by State Auditor

The Office of the State Auditor was mandated to examine the Community Alternatives Program for Disabled Adults (CAP/DA) and report its findings to the North Carolina Study Commission on Aging. On March 1, 2004, the State Auditor reported that "just as there is a critical need to capture important information on the utilization of public expenditures for long-term care populations across settings of care, it is equally important to understand the relationship between utilization of services and the medical needs of the recipients. Existing systems of collecting, storing and accessing data are in need of improvement and DHHS is aggressively working towards building the necessary program tools and data systems that will lead to strengthening public policy, developing an improved long-term care service delivery system and evaluating the impact of the improvements over time." The State Auditor's report on the CAP/DA program noted that DMA has made considerable progress in addressing many of the findings and recommendations made in the audit. DMA continues to use the audit recommendations to make improvements to CAP/DA.

Medicaid Hospital Payments

DHHS was mandated to evaluate all medical payment programs and policies administered by the Department that may affect the future viability and sustainability of financially vulnerable hospitals. A study committee was formed consisting of the DHHS Assistant Secretary for Health, two hospital administrators and representatives of the

NC Hospital Association, the Office of Research, Demonstrations and Rural Health Development and DMA. The committee's report, submitted to the North Carolina Legislature on November 12, 2003, found "…among the one hundred and nineteen acute care hospitals in the State there are numerous facilities that are, in fact, financially vulnerable. That is, there are many for which cash flow and reserves mandate that they operate perilously close to the margin. In fact, there are hospitals that appear solvent only by virtue of prior periods of prosperity and for which certain State programs (i.e. Disproportionate Share Hospitals or "DSH") are absolutely critical." It further stated that "….the Department continues to recognize the eleven critical access hospitals (CAH's) in the state as financially vulnerable." It also noted that "…DHHS has recently proposed to take definitive action to uniformly address the vulnerability of the State's CAH's."

Adult Care Home Personal Care Service Funding Study

DHHS was mandated to review activities and costs related to the provision of care in adult care homes and to determine what costs may be considered to properly maximize allowable reimbursement available through Medicaid personal care services for adult care homes under federal law. DMA is participating on the Adult Care Cost Modeling Committee to study this matter. A report was not mandated by the NC General Assembly.

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 (the most recent year for which data were available) was 8,418,090. A total of 1,512,360 North Carolinians, or approximately 18 percent of the total population, were eligible for Medicaid coverage at some time during the year. The monthly average number of eligibles was 1,095,854 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 1,541,450. This figure is slightly larger than the total number of eligibles (1,512,360, see Table 8) because it counts some recipients who were eligible in SFY 2003 for whom claims were paid during SFY 2004. Compared with SFY 2003, the state population rose by 1.1 percent, however the number of Medicaid eligibles increased by 4.5 percent and the number of monthly average eligibles increased by 4.6 percent.

Exhibit 1
NC Medicaid Average Monthly Eligibles by Eligibility Group - SFY 2004

Eligibility Group	Number of Eligibles	% of Total Eligibles
Special Pregnant Women & Children	379,234	34.6%
AFDC-related	351,424	32.1%
Disabled	200,744	18.3%
Aged	126,257	11.5%
Qualified Medicare Beneficiaries	35,847	3.3%
Blind	1,989	0.2%
Aliens & Refugees	274	0.0%
Breast & Cervical Cancer	85	0.0%
Total	**1,095,854**	**100.0%**

As indicated in **Exhibit 1** above, the largest category of eligibles during SFY 2004 was Pregnant Women and Children with a monthly average of 379,234 individuals, or about 35 percent of total eligibles. The Aid to Families with Dependent Children (AFDC) category was second largest with 351,424 individuals, or about 32 percent of the total eligibles. This category includes families with children who would have met eligibility criteria for the former AFDC program as of July 1996. As **Exhibit 2** shows, the Pregnant Women and Children population experienced the largest increase of enrollees of 27,133, or 7.7 percent. The Aged, Blind and Aliens & Refugees categories experienced decreases.

Exhibit 2
Change in NC Medicaid Average Monthly Eligibles by Eligibility Group
SFY 2003 vs. 2004

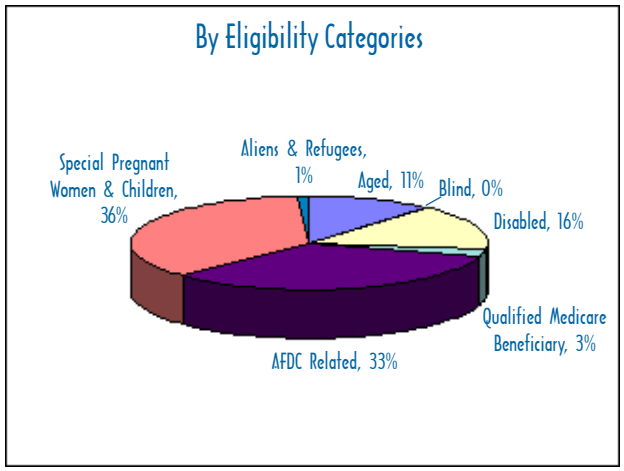
Eligibility Group	SFY 2004 Eligibles	Change	Amount of % Change
Special Pregnant Women & Children	379,234	27,133	7.7%
AFDC-related	351,424	12,214	3.6%
Disabled	200,744	8,438	4.4%
Qualified Medicare Beneficiaries	35,847	1,807	5.3%
Breast & Cervical Cancer	85	85	N/A
Blind	1,989	(65)	-3.2%
Aliens & Refugees	274	(199)	-42.1%
Aged	126,257	(1,003)	-0.8%
Total	**1,095,854**	**48,410**	**4.6%**

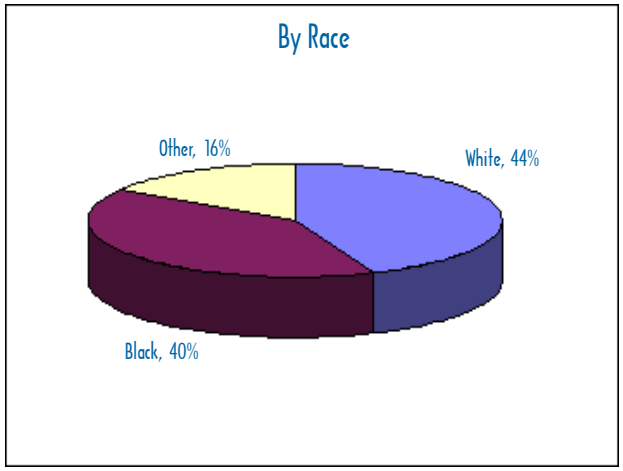
Exhibit 3 shows the distribution and some of the characteristics of recipients of Medicaid services. The percentage of recipients in each program category approximates the distribution of eligibles shown in **Exhibit 1,** but it varies somewhat. This is due to the fact that not all eligibles actually become recipients of one or more services in a given year. The variance is also attributable to the fact that the recipient count is based upon claims paid during SFY 2004. These paid claims may include claims for services provided the previous year that were carried over for payment in SFY 2004. 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 (36 percent), while adults aged 21 to 64 are the second largest group (32 percent), followed by young children from birth to 4 (19 percent) and the elderly, ages 65 and older (12 percent).

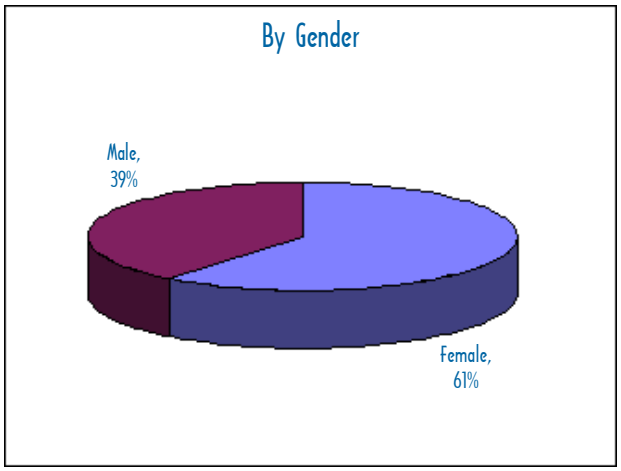
Services and Expenditures

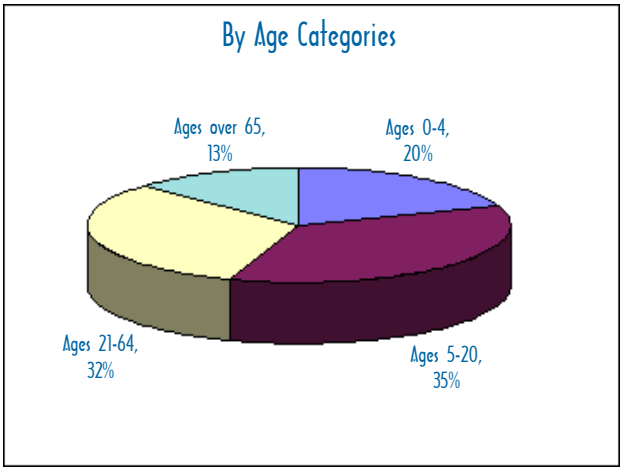
This was yet another challenging budget year for state government. In the early spring of 2003, the NC General Assembly faced a possible budget shortfall of $2 billion, or 14 percent, within a projected total $14 billion SFY 2004 budget. However, there was some positive news for the Medicaid budget. First, the forecast for Medicaid expenditures for both years of the biennium declined by $219 million and $321 million respectively. Secondly, the federal government passed the "State Budget Relief Act" which provided a one-time "enhancement" in the federal financial participation rate to all state Medicaid programs, including North Carolina. This allowed our legislature to reduce the State appropriation within the SFY 2004 budget by $191 million. Additionally, inflationary adjustments (i.e. increases) to most reimbursement rates were eliminated.

Exhibit 3
NC Medicaid Recipients of Medicaid Services – SFY 2004









As indicated in **Table 6** (see the "Medicaid Tables" section further back in this report), a total of approximately $7.4 billion was spent on health services and premiums for 1,541,450 Medicaid recipients (again, those individuals who actually received services), or $4,804 per recipient during the year. While total service and premium expenditures increased by 11.9 percent, the increase per recipient was only 5.6 percent over SFY 2003.

Exhibits 4 and **Exhibit 5** show that Elderly and Disabled recipients comprised 13.2 percent and 15.8 percent of total recipients, respectively. Yet, service expenditures for these two groups amounted to approximately $5 billion, or 68.7 percent. These two groups received a greater number of 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 approximately 70 percent of all recipients, however they accounted for approximately $2.3 billion, only 31 percent, of total service expenditures. **Exhibit 6** shows that per recipient expenditures for each of the recipient groups increased during SFY 2004 with the exception of Aliens & Refugees, which realized a 0.5 percent decrease.

Exhibit 4
NC Medicaid Percentage of Recepients & Service Expenditures – SFY 2004

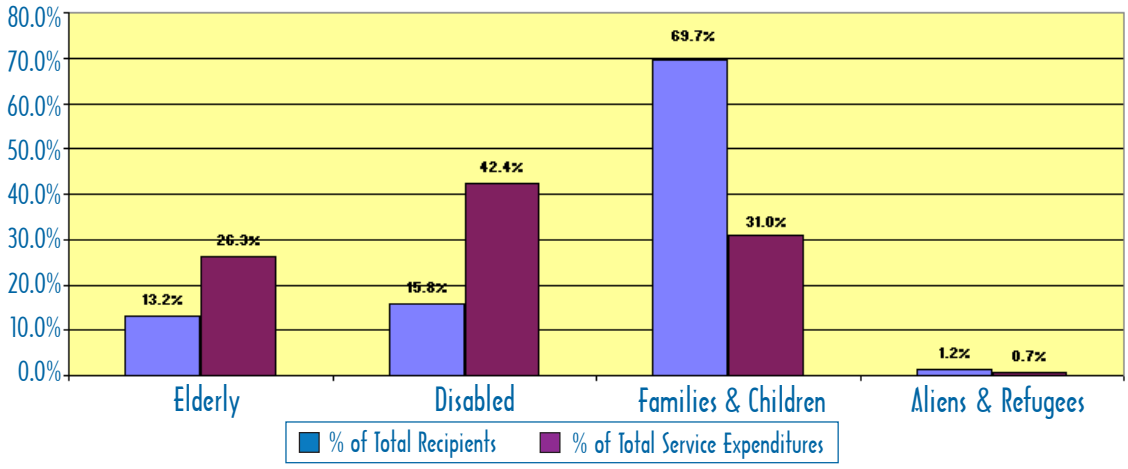
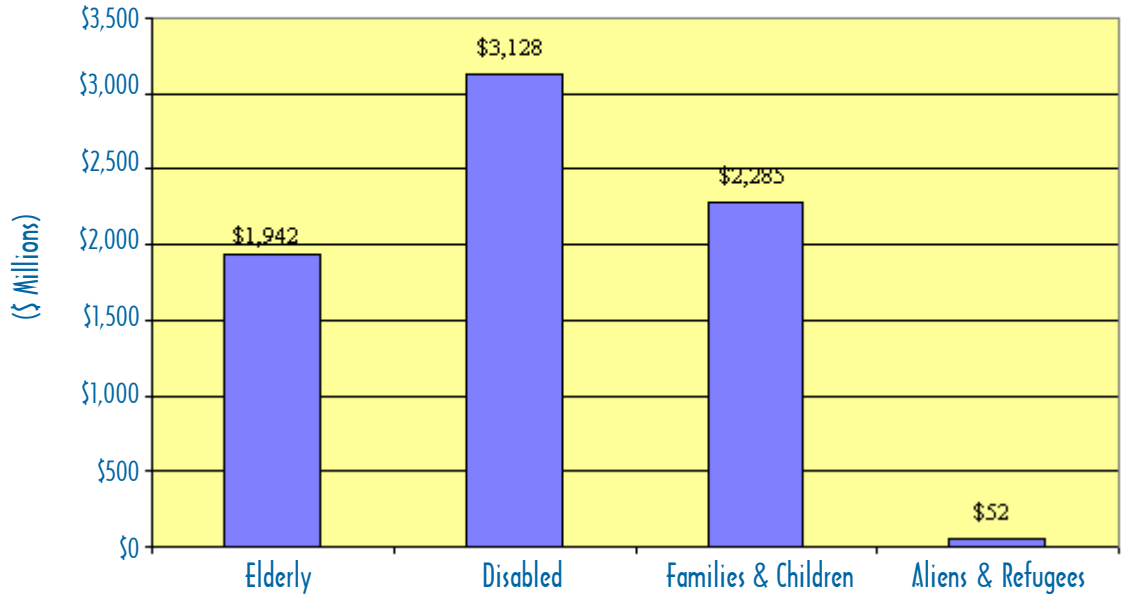


Exhibit 5
NC Medicaid Expenditures by Recipient Groups – SFY 2004
(in $ Millions)



Of all Medicaid services provided, the Prescription Drug service category was the most expensive at roughly $1.47 billion, or 17.35 percent of total expenditures as shown in **Table 6** and **Exhibit 8**. This was an increase of roughly $267 million, or 22 percent, over the previous fiscal year (see **Exhibit 7**). When manufacturer's rebates of approximately $293 are applied, the net amount spent on prescription drugs was approximately $1.18 billion or 14.4 percent of total expenditures. The increase in prescription drug expenditures, as well as a mandate from the NC General Assembly, compelled DMA to continue its intensive prescription drug cost containment efforts during SFY 2004. Inpatient hospital services, the second highest category of service expenditures, accounted for approximately $952 million, or 11 percent of total service expenditures. This was an increase of approximately $84 million, or 10 percent.

Exhibit 6
NC Medicaid Expenditures per Recipient
SFY 2003 vs. 2004

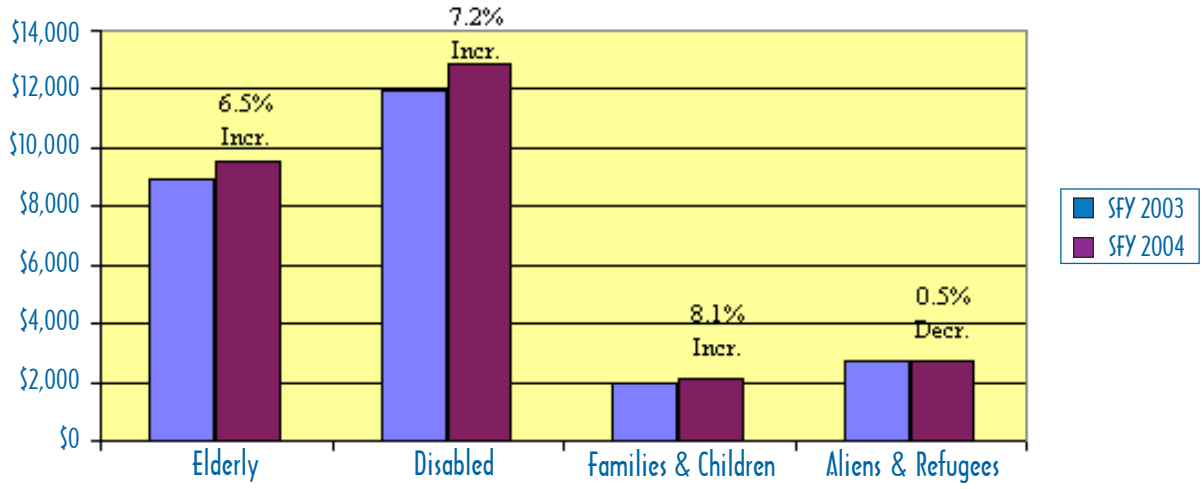


Exhibit 7 depicts the growth of DMA's long-term and non-long term service expenditures from SFY 2003 to SFY 2004, showing the highest categories of non-long term care expenditures, while grouping the long term care expenditures. The non-long term care expenditures grew by 15.2 percent and long term care expenditures grew by only 5.4 percent.

Exhibit 7
NC Medicaid Highest Categories of Non-Long Term Expenditures
SFY 2003 vs. 2004
Sorted by Amont of Expenditures

Category of Service	SFY 2004 Expenditures	Amount of Change	% Change
Prescription Drugs	$1,470,328,522	$266,697,609	22.2%
Inpatient Hospital	$927,059,649	$83,922,231	10.0%
Physician	$696,397,203	$124,858,467	21.8%
Mental Health Clinics	$476,670,180	$82,328,144	20.9%
Outpatient Hospital - General	$335,345,994	($4,431,298)	-1.3%
Medicare Part B Premiums	$190,394,800	$21,488,262	12.7%
Dental	$179,180,156	$50,090,772	38.8%
Other Non-Long Term	$729,060,584	$37,677,011	5.3%
Total Non-Long Term	**$5,004,437,088**	**$662,631,199**	**15.2%**
Total Long Term	**$2,368,274,354**	**$121,012,410**	**5.4%**

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.

As **Exhibit 9** shows, approximately 90 percent of North Carolina's Medicaid recipients received services at least once during SFY 2004 from a physician, 69 percent received at least one prescribed drug and 48 percent received services in a hospital outpatient setting. The utilization rate falls off dramatically for other service providers and locations.

Medicaid eligibility and expenditures vary widely among the 100 North Carolina counties, as **Table 9** in the "Medicaid Table" section demonstrates. The percentage of Medicaid eligibles in the general population was as high as 34.24 percent in Robeson County and as low as 8.91 percent in Orange County. Average expenditures per eligible ranged from a high of $6,267 in Alleghany County to a low of $3,411 in Lee County. Lastly, expenditures per capita were the highest in Bertie County at $1,838 and the lowest in Wake County at $449.

Exhibit 8
Medicaid Services Expenditures for SFY 2004

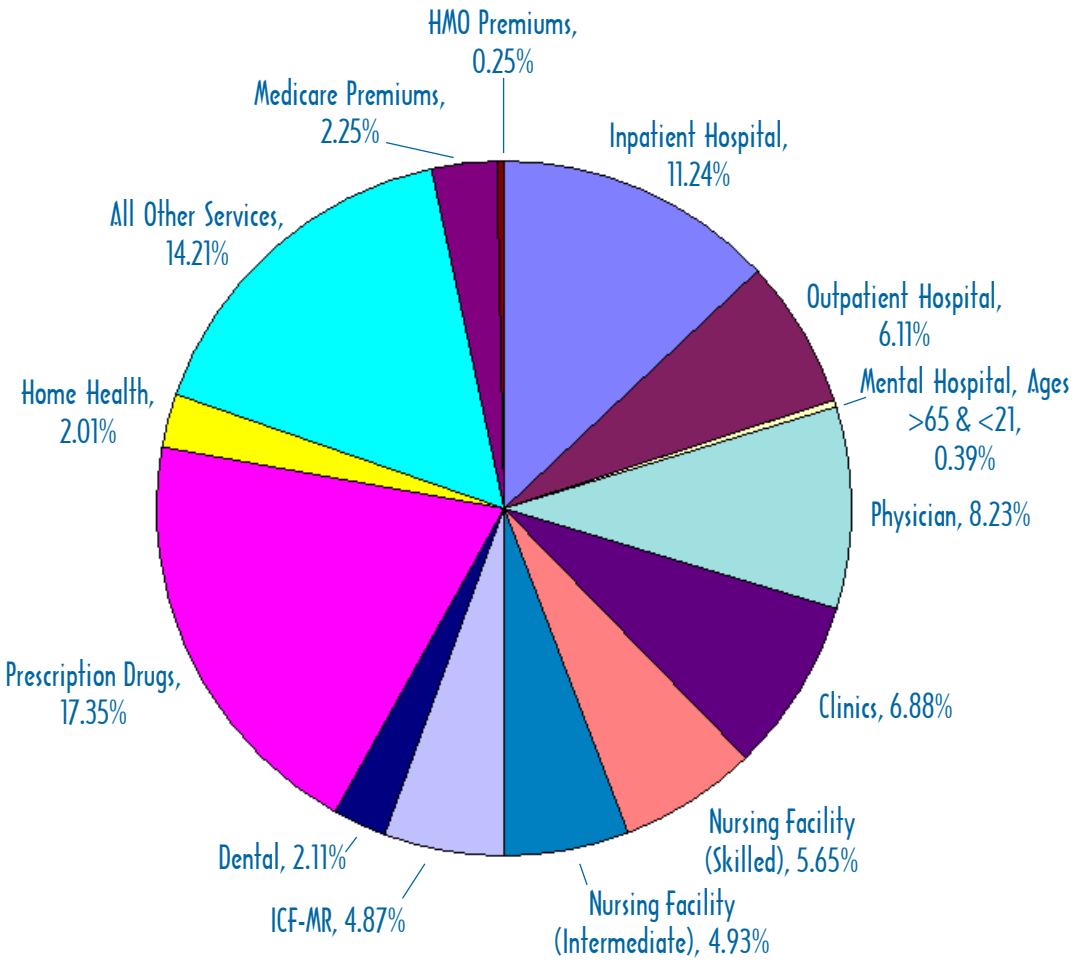
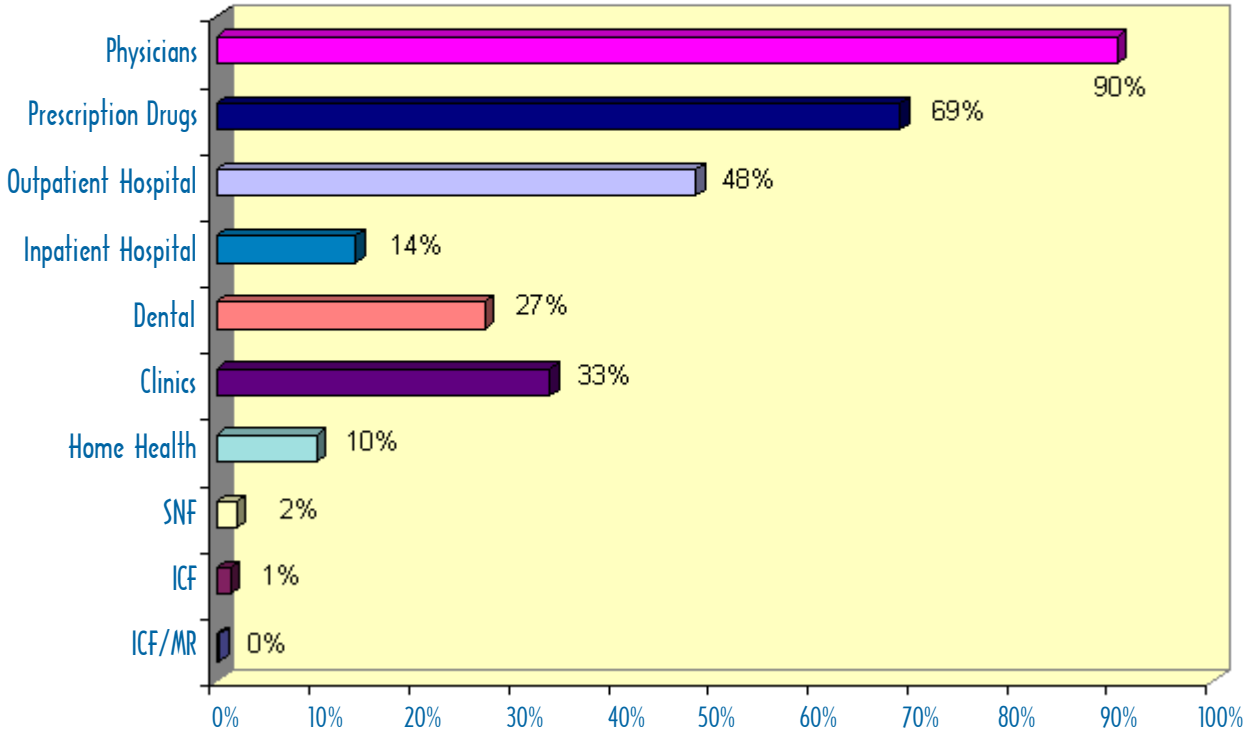


Exhibit 9

State Fiscal Year 2004
Selected Medicaid Service Usage by Recipient
Percent of Total Recipients



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

Major Accomplishments

Numerous operational improvements and special initiatives were either implemented during the past fiscal year or are still in progress. Please also see the initiatives mentioned in the "Policy Changes" section and Addendum B "Major Initiatives and Subprograms" of this report. They will not be repeated in this section.

Program Integrity Collections and Cost Avoidance

Over a billion dollars was saved, recovered or cost avoided in the NC Medicaid Program during SFY 2004. 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 carried out cooperatively by state and local law enforcement. For example:

- Efforts by Program Integrity's four provider billing investigative units resulted in the recovery of $26,154,859 compared to $11,268,920 received in SFY 2003.

- The Medicaid Investigations Unit (MIU) within the Attorney General's Office collected over $19 million in restitution, fines, penalties and interest when they concluded criminal and civil cases. As required by the North Carolina Constitution, proceeds from the fines went to the individual County School Funds. The MIU also had 31 convictions. Program Integrity nursing staff acted as consultants to the Attorney General's Office in many of these cases.

- Recipient fraud investigators in the local departments of social services (DSS) recovered $1,449,544 in overpayments. The State assisted county investigators to collect an additional $120,109 by intercepting North Carolina income tax refund checks from delinquent debtors.

- 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.

With the implementation of a fraud and abuse detection software system, the Program Integrity Section has significantly improved its efficiency in detection, investigation, and recovery. The accomplishments listed above were made possible through the use of increased automation and effort on the part of staff. Program Integrity investigators average $500,000 per year in overpayment dollars found. 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 10**).

Program Integrity's Third Party Recovery Efforts

During SFY 2004, the Program Integrity Section's Third Party Recovery (TPR) Unit increased its recoveries from all sources by 26 percent over the previous year. This saved the Medicaid Program an additional $59,454,429. TPR also implemented cost avoidance procedures that totaled $961,086,008, a 21 percent increase over last year. These increases resulted primarily from staff/contractor productivity and investments in automation and improved utilization of our computer software capabilities. These savings are detailed below:

Recoveries	SFY 2004	SFY 2003	% Increase
Health Insurance	$32,638,423	$23,776,925	37
Medicare	3,852,807	3,710,079	4
Casualty Insurance	16,791,951	14,813,806	13
Absent Parent	224,208	56,967	294
Estate Recovery	5,947,040	4,974,821	20
Totals	$59,454,429	$47,332,058	26

Cost Avoidance	SFY 2004	SFY 2003	% Increase
Medical Insurance Avoided	$132,128,262	$126,607,140	4
Medicare Avoided	558,279,892	452,929,690	23
Payments Reported – Claims	270,677,854	214,975,840	26
Totals	$961,086,008	$794,512,670	21

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 Error Rate Measurement (PERM) 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 and the U.S. Office of Inspector General. SFY 2004 was Program Integrity's third and final year of participation in the Payment Accuracy Measurement grant.

Exhibit 10
NC Medicaid Annual Error Rates for Claims Billed to Medicaid – SFY 2004

	# Claims in Sample	Error Rate per OSA	Sampling Precision
1999-00	300	1.50%	-0.04
2000-01	300	0.80%	-0.04
2001-02	270	2.80%	-0.04
2002-03	272	1.80%	-0.04
2003-04	273	3.33%	-0.04

Medi-Medi Project

NC Medicaid was one of only seven pilot states selected by CMS to participate in a national project called "Medi-Medi". The purpose of the four year project is to build a data warehouse consisting of all Medicare and Medicaid claims which can be data-mined to detect fraud and abuse. The combined database makes it possible for investigators to observe the manner in which providers bill each program and discover instances of overbilling. For example, providers billing for 22 service hours per day (perhaps 11 hours to Medicare and 11 hours to Medicaid) will be identified. Medicare and Medicaid investigators will investigate and refer potential fraud cases to the appropriate law enforcement entities.

PCS Redesign

DMA has partnered with representatives of home care provider agencies and the NC Division of Facility Services to address changes needed in the Personal Care Services Program. The PCS restructuring plans include improved clinical policy criteria, new assessment tools, improved training and qualifications requirements for providers and a new utilization management program for providers and the state.

EPSDT

Health Check is the name of NC Medicaid's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. During the past year, Health Check's client outreach activities were expanded to include enhanced member education. The program is credited with assisting Community Care of North Carolina (CCNC) in saving thousands of dollars through reduced reliance on the emergency room. Parents and guardians of children who frequently use the hospital emergency department for non-emergent sick care are being redirected to their primary care provider. Currently, there are Health Check outreach projects in 87 counties supported by over 100 Health Check Coordinator positions.

Pharmacy Initiatives

DMA accomplished a number of pharmacy utilization and quality improvement initiatives that are mentioned in the "Policy Changes" section above and the "Community Care of North Carolina Expansion and Cost Savings" section below.

AQUIP System for CAP/DA

The Community Alternatives Program for Disabled Adults (CAP/DA) has worked with its contractor, Medical Review of North Carolina, to develop the Automated Quality and Utilization Improvement Plan (AQUIP) for the CAP/DA program. AQUIP is a web-based assessment and plan of care program that has been piloted by sixteen CAP lead agencies. AQUIP is an enhancement to the case management process and yields a wealth of data for monitoring and planning purposes. AQUIP utilizes quality measures that apply to patterns of care and indicate, for example, the percent of patients receiving a specific service within their plan of care. It also sets flags to alert care managers when the services provided are at a variance with the prescribed plan of care. Lastly, the AQUIP System provides automated cost review by capturing and analyzing claims for each recipient and comparing the amount total paid with the cost limit established for the recipient.

Piedmont Behavioral HealthCare Waivers

DMA collaborated with the Division of Mental Health, Developmental Disabilities, Substance Abuse Services (DMH/DD/SAS) and Piedmont Behavioral HealthCare to develop a waiver program to pilot managed care under Mental Health Reform. Two separate waiver authorities were combined to create the new program, Piedmont Cardinal Health Plan (PCHP), which has been approved by CMS. PCHP is a prepaid health plan and will be operated by the authorized "Local Management Entity" for five counties in the Piedmont area of North Carolina. PCHP will be responsible for providing all Medicaid covered mental health, developmental disabilities and substance abuse services, including inpatient, outpatient, institutional (ICF-MR) and Innovations waiver services. Innovations is a new home and community based services waiver program which is an alternative to care in an ICF-MR and allows consumers to direct their own care. Innovations is available only to Medicaid recipients in the Piedmont five-county area.

The Piedmont waiver was implemented on April 1, 2005.

Mental Health Reform

DMA collaborated with DMH/DD/SAS to complete the development and begin the implementation of Mental Health Reform. Work in this area included the establishment of new service definitions and reimbursement rates, the implementation of the contractual relationship for the Local Management Entities (LME) and the establishment of a flexible utilization management approach for all behavioral health services. This includes the direct enrollment of licensed mental health practitioners regardless of the location of their work place. It also includes reimbursing providers at the discipline rate instead of the LME or physician rate. A state-wide utilization review contract will be awarded requiring prior approval of all mental health and substance abuse services. Review decisions will be entered in the fiscal agent automated system to affect payment. This is currently being done on a limited number of services. The state contract will also conduct post payment reviews on all services that are not reviewed by the Program Integrity Section. This will ensure that services were provided as billed and that claims were paid appropriately. Once an LME is approved by DHHS, it may assume a portion of these utilization review functions for certain services in its catchment area.

Mental Health Needs Assessment Project for Adult Care Homes

DMA served as the lead agency for a DHHS-sponsored Mental Health Needs Assessment Project for Adult Care Homes. This comprehensive effort was conducted under a contract with First Health Services Corporation. The project focused on assessments of all Medicaid-eligible recipients who reside in adult care homes to determine: those who need mental health services and the level of services needed; the degree to which these services are not being met; and the impact this has had on the facilities. The project report was completed July 2004 and the findings were presented to the Long Term Care Cabinet.

Children's Developmental Service Agencies

In October 2003, the former Development Education Centers (DECs) were converted into Children's Developmental Service Agencies (CDSAs). CDSAs are the local lead agencies of the North Carolina Infant-Toddler Program, under Part C of the Individuals with Disabilities Education Act (IDEA). The responsibilities of the local lead agency are to provide oversight of all the North Carolina Infant-Toddler Program services for children ages zero through three. This includes receiving all referrals for the North Carolina Infant-Toddler Program, contacting families of young children with special needs who may be eligible for the Program, determining eligibility status of children referred, and providing initial and continuing services through their staff and public and private contract agencies. CDSAs also create and periodically review the Individualized Family Service Plan (IFSP) for each child and family served under the Program. Community based rehabilitative services may be rendered to this population only if the providers are endorsed by the CDSA and enrolled with Medicaid.

Disproportionate Share Hospital Program

During SFY 2004, the Office of the State Auditor conducted an audit of DMA for the year ending on June 30, 2004. In response to the audit, DMA implemented major improvements in the control environment of the Disproportionate Share Hospital (DSH) Program. Policies and procedures were established to ensure staff depth of knowledge, re-establish control of the DSH program within the Division, and ensure that financial and eligibility data utilized for the DSH program were complete, accurate and up to date.

Dental Services

Following targeted fee increases that were implemented near the end of SFY 2003, access to dental services has increased significantly. In SFY 2004, the average monthly number of Medicaid eligibles that received at least one dental service increased to 68,475, which represents a 23 percent increase over the SFY 2003 figure of 55,667. Working with the NC Dental Society and the Dental Committee of the NC Physicians Advisory Group, DMA has reviewed dental coverage policy carefully to assure that it meets appropriate standards of care and is consistent with HIPAA-mandated national coding and claims payment standards. While a number of recommended policy revisions were implemented in the fall of 2004, collaborative work with the NC Dental Society and the NCPAG Dental Committee continues.

Community Care of North Carolina Expansion and Cost Savings

The Community Care of North Carolina (CCNC), which builds on the ACCESS primary care management model, has grown substantially

3,000 physicians. These networks are responsible for improving access to and quality of care for over 550,000 Medicaid enrollees while containing health care costs. The program is targeting an expansion to a total of 610,000 enrollees by the end of June 2005.

A report that was released from Mercer Human Resource Consulting Group during SFY 2004 found that during SFY 2003 the CCNC avoided unnecessary health care expenditures in the amount of approximately $60 million through its case management and patient education and outreach efforts. Other successes include:

- Between SFY 2000 and 2004, the program documented total savings of over $6 million through case management of individuals with asthma and diabetes.
- Since 1998, providers have made a 34 percent improvement in identifying the severity level of disease for patients with asthma.
- An independent evaluation conducted by the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill demonstrated that lower monthly costs and lower hospitalization rates were achieved for patients with asthma, resulting in an estimated cost avoidance of $3.5 million.
- Similar improvements in implementing best practice guidelines occurred in the management of patients with diabetes, resulting in savings of $2.1 million.

The CCNC physician leadership chose the area of pharmacy as one of its major focal points in helping the State to control Medicaid costs. They have implemented a "prescription advantage list" (PAL) which rates drugs based on their costs to the Medicaid program. CCNC also developed a nursing home pharmacy initiative which is being replicated statewide. The initial pilot saved $2.1 million for 36 percent of the nursing home population.

The CCNC continues to partner with other local agencies serving the Medicaid population to develop improved systems of care. Dedicated case managers, targeting high-cost and high-risk enrollees, are key components of the CCNC program. These care systems are intended to increase access to and quality of care, reduce health disparities, control costs and improve patient satisfaction.

For further information on the NC Medicaid Managed Care Program please read the "Managed Care" section of Addendum B.

Redesign of Provider Enrollment

The Provider Services Unit redesigned the application and agreement forms that are utilized by physician providers to assure that they are eligible for participation in the Medicaid Program. Credentialing processes have also been put into place to confirm licensure and other participation requirements. These forms will ultimately be implemented along with the new MMIS system and utilized across all provider types.

Quality and Health Care Outcome Improvements

The Quality Management Unit within the Managed Care Section continued efforts in quality improvement through a variety of activities including studies and initiatives related to asthma care, adult preventive services, Health Check and immunizations and improving access to health care. The results of completed studies and initiatives may be found under the "Publications – Quality Management Initiatives" link on the DMA website at: www.dhhs.state.nc.us/dma.

MMIS Replacement Project

DMA participated in the proposal review and selection process of the new Medicaid Management Information System (MMIS). The Division continues to support the design effort lead by the DHHS Office of MMIS Services (OMMISS).

DMA recognizes the importance of ensuring a smooth transition to the new software and Fiscal Agent. To ensure this transition, 13 permanent staff were re-assigned to OMMIS in order to provide staff who are fully knowledgeable of the NC Medicaid Program during the developmental effort. In addition, another 50 DMA staff have been identified as Subject Matter Experts (SMEs). The SMEs assist the

project staff in the detailed design as needed. DMA has made a commitment to support this effort and will continue to ensure that the needs of Medicaid have been properly documented. We anticipate continuing this effort throughout the implementation phase during calendar year 2006.

Divisional Infrastructure Changes

DHHS and DMA's Management Team conducted an analysis of the Division's management infrastructure. The analysis focused on increased supervision, oversight and internal controls and it included an evaluation of programs and clinical policy. As a result of this study, 40 new positions were added to the areas of Clinical Policy, Program Integrity, Budget Management and Finance Management. The Division's organizational structure was redefined in order to appropriately establish infrastructure for Clinical Affairs and Programs and for Budget and Finance.

Acknowledgments

Editorial Panel

Gary Kugler, *Senior Editor*
Social Services Program Administrator
Director's Office

Richard Cobb
Budget Officer
Budget Management

Gina Rutherford
Information & Communications Specialist
Clinical Policy & Programs

Carleen Massey
Interim Assistant Director
Program Integrity

Julia McCollum
Human Services Planner/Evaluator
Managed Care

Andy Wilson
Social Services Program Coordinator
Recipient and Provider Services

Lois Nilsen
Public Information Officer
DHHS Office of Public Affairs

Contributing Writers

Deborah Bowen
Richard Cobb
Geoff Elting
Pat Jeter
Gary Kugler
Sharman Leinwand
Carleen Massey
Julia McCollum
Bo Nowell
Rhonda Owen
Nora Poisella
Carol Robertson
Gina Rutherford
Ronald Venezie
Andy Wilson
Melody Yeargan

Data, Tables and Graphics

Emad Attiah
Richard Cobb
Patricia Slaughter

Production

Christie Adams

State of North Carolina
Michael F. Easley, Governor
Department of Health and Human Services
Carmen Hooker Odom, Secretary
Division of Medical Assistance
Mark T. Benton, Interim Director

DMA/Director's Office - 17
2501 Mail Service Center
Raleigh, NC 27699-2501
(919) 855-4102

www.dhhs.state.nc.us/dma/

250 copies of this public document were printed at a cost of $905.33 or $3.62 each. June 2005

Medicaid Tables

Table 1
North Carolina Medicaid
State Fiscal Year 2004
Federal Matching Rates

Benefit Costs
(7/1/03 - 9/30/03)

	Services except Family Planning	Family Planning
Federal	65.51%	90.00%
State	29.32%	8.50%
County	5.17%	1.50%

Benefit Costs
(10/1/03 - 6/30/04)

	Services except Family Planning	Family Planning
Federal	65.80%	90.00%
State	29.07%	8.50%
County	5.13%	1.50%

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 Financial Eligibility Standards

GROUP	BENEFITS	BASIC REQUIREMENTS [1]						SPECIAL PROVISIONS
		Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit	Resource Limit	Deductible/ Spenddown		
Recipients of Cash Assistance Programs	Full Medicaid coverage	Recipients of the following cash assistance programs are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination are required. The cash assistance programs are: Work First Family Assistance – NC program under the federal Temporary Assistance to Needy Families law that provides cash assistance to families with children. Supplemental Security Income (SSI) – Federal cash assistance program for the aged, blind, and disabled. State/County Special Assistance – State cash assistance program for aged and disabled individuals, primarily who are in adult care homes. Special Assistance to the Blind – State cash assistance program for blind individuals.						
Aged	Full Medicaid Coverage	Age 65 or older	Spouse's income and resources if live together	100% of Poverty 1 – $ 776/mo 2 – $1,041/mo	SSI Limits 1 - $2,000 2 - $3,000	Yes	If "yes" and income exceeds income limit, the individual or family may be able to be eligible for Medicaid if he can meet a deductible. See discussion of Medical Deductible on page 2 of this same column. **Individuals in nursing facilities** generally do not have to meet a deductible to be eligible for Medicaid. However, they must pay all of their monthly income, less a $30 personal needs allowance and the cost of medical expenses not covered by Medicaid or other insurance to the nursing facility. Medicaid pays the remainder of their cost of care.	**Protection of income for spouse at home:** When an individual is in a nursing facility and has a spouse living at home, a portion of the income of the spouse in the facility may be protected to bring the income of the spouse at home up to a level specified by federal law. Currently, that amount is $1,562/mo and can be as much as $2,319 depending upon at-home spouse's cost for housing. The amount protected for the at-home spouse is not counted in determining the eligibility of the spouse in the nursing facility. **Protection of resources for spouse at home:** Additionally, the countable resources of the couple are combined and a portion is protected for the spouse at home. That portion is ½ the total value of the countable resources, but currently not less than $18,552 or more than $92,760. The amount protected for the at-home spouse is not countable in determining the eligibility of the spouse in the facility. **Transfer of resources:** When a person gives away resources and does not receive compensation with a value at least equal to that of the resources given away, he may be penalized. Medicaid will not pay for care in a nursing facility or care provided under the Community Alternative Placement program or other in-home health services & supplies for a period of time that depends on the value of the transferred resource.
Blind	Full Medicaid Coverage	Blind by Social Security Standards	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 776/mo 2 – $1,041/mo	SSI Limits 1 - $2,000 2 - $3,000	Yes		
Disabled	Full Medicaid Coverage	Disabled by Social Security Standards	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 776/mo 2 – $1,041/mo	SSI Limits 1 - $2,000 2 - $3,000	Yes		
Qualified Medicare Beneficiaries	Payment of Medicare premiums and deductibles and co-insurance charges for Medicare covered services	Entitled to Medicare Parts A & B	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 776/mo 2 – $1,041/mo	2 x SSI Limits 1 - $4,000 2 - $6,000	No		
Specified Low Income Medicare Beneficiaries	Payment of Medicare Part B premium	Entitled to free Medicare Part A	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	120% of Poverty 1 - $ 931/mo 2 - $1,249/mo	2 x SSI Limits 1 - $4,000 2 - $6,000	No		
Qualifying Individuals	Payment of Medicare Part B Premiums **NOTE:** Total number of eligible individuals is limited to available funds.	Entitled to free Medicare Part A	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	135% of Poverty 1 - $1,048/mo 2 - $1,406/mo	2 x SSI Limits 1 - $4,000 2 - $6,000	No		
Working Disabled	Payment of Medicare Part A premiums	Lost entitlement to free Medicare A due to earnings but still has disabling impairment.	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	200% of Poverty 1 - $1,552/mo 2 - $2,082/mo	2 x SSI Limits 1 - $4,000 2 - $6,000	No		

[1] This chart addresses benefits and basic eligibility requirements. Other requirements (such as citizenship/alien status, incarceration, & state residence) which can also affect eligibility or the level of benefits are not reflected on this chart.

Table 2a (cont) North Carolina Medicaid Financial Eligibility Standards

GROUP	BENEFITS	BASIC REQUIREMENTS						SPECIAL PROVISIONS
		Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit	Resource Limit	Deductible/Spenddown		
Families & Children	Full Medicaid coverage	Parents/Caretaker relatives must be living with and caring for a child to whom they are related who is under age 19. Children must be under age 21.	Spouse's income and resources if live together. Parents' income and resources if under age 21 and live with parents.	1 - $362/mo 2 - $472/mo 3 - $544/mo 4 - $594/mo 5 - $648/mo	$3,000	Y es	If "yes" and income exceeds income limit, the individual or family may be able to be eligible for Medicaid if he can meet a deductible **Medicaid Deductible**: When an individual/family is ineligible for Medicaid due to income over the income limit, they may become eligible by meeting a Medicaid deductible. The deductible is determined by subtracting the Medically Needy Income Limit (MNIL) (*see limits below)* from the countable monthly income to determine the monthly excess income. Medicaid deductibles are generally determined for 6 months, so the monthly excess income is multiplied by 6 to determine the 6-mo. deductible. Once medical bills are incurred for which they are responsible, they are authorized for the remainder of the 6-mo. period. Medicaid cannot pay for any of the bills applied to the deductible. MNIL 1 - $242/mo 2 - $317/mo 3 - $367/mo 4 - $400/mo 5 - $433/mo **Resource limit** All deductible cases have a resource limit: $3000 for families and children and $2,000 (1) and $3000 (2) for aged, blind and disabled.	Children with special needs who are adopted under state adoption agreements have their eligibility for Medicaid determined without counting the income of the adoptive parents.
Pregnant Women	Coverage is limited to treatment for conditions that affect the pregnancy.	Medical verification of pregnancy	Count only the income only of the pregnant woman and, if in the home, the father of the unborn.	Preg. Women and children under age 1 185% of Poverty 1 - $1,436/mo 2 - $1,926/mo 3 - $2,416/mo 4 - $2,907/mo 5 - $3,397/mo	No resource limit if eligible with income no more than 185% of poverty	Yes		When determining the family size for the pregnant woman the unborn child is included. For example the family size for a single pregnant woman would be 2.
Children under age 1	Full Medicaid Coverage	Be under age 1	Parents' income if living in the home.			Yes		
Children age 1 thru age 5	Full Medicaid Coverage	Be over age 1 and under age 6.	Parents' income if living in the home.	133% of Poverty 1 - $1,032/mo 2 - $1,385/mo 3 - $1,737/mo 4 - $2,090/mo 5 – $2,442/mo	No resource limit if eligible with income no more than 133% of poverty	Yes		
Children age 6 thru 18	Full Medicaid Coverage	Be age 6 thru age 18	Parents' income if living in the home.	100% of Poverty 1 - $ 776/mo 2 - $1,041/mo 3 - $1,306/mo 4 - $1,571/mo 5 - $1,836/mo	No resource limit if eligible with income no more than 100% of poverty.	Yes		
Title IV-E Children	Full Medicaid Coverage	Be an Title IV-E adoptive or foster child	Medicaid eligibility is automatic. There is no income or resource determination.			No		
Breast & Cervical Cancer Medicaid	Full Medicaid Coverage	A woman who has been screened and enrolled in the NC Breast & Cervical Cancer Control Program	Medicaid eligibility is automatic. There is no income or resource determination.			No		To be eligible under the Breast and Cervical Cancer Medicaid program, the woman can have no medical insurance coverage including Medicaid.
NC Health Choice (NCHC)	Coverage of the NC State Employees Health Plan, plus vision, hearing, & dental	Be an uninsured child under age 19.	Parents' income if living in the home.	200% of Poverty 1 - $1,552/mo 2 - $2,082/mo 3 - $2,612/mo 4 - $3,142/mo 5 - $3,672/mo	No resource limit	There is no deductible or spenddown provision for NCHC. If a child is ineligible due to too much income, they will be evaluated for Medicaid with a deductible.		

Table2b

Financial Eligibility for Medicaid based on Percentage of Poverty (Annual) SFY 2004

Family Size	100%	120%	133%	135%	185%	200%
1	$9,312	$11,172	$12,384	$12,576	$17,232	$18,624
2	$12,492	$14,988	$16,620	$16,872	$23,112	$24,980
3	$15,672		$20,884		$28,992	$31,344
4	$18,852		$25,080		$34,884	$37,704
5	$22,032		$29,304		$40,764	$44,064

Note 1: The Federal Poverty Level amounts change each year effective April. The above figures were effective April 1, 2004 and remained in effect through the end of SFY 2004

Note 2: SSI recipients are automatically eligible. Income limits are $6,772 for a family of one and $10,157 for a family of two. Adult care home residents who receive state-county special assistance are also automatically eligible. Income limits are $13,896 for a family of one.

Note 3: Those with income over the limits are eligible if medical bills are high enough. Medical bills must be equal to or greater than the amount by which their income exceeds the Medically Needy Income Levels (MNIL). The annual 2004 MNIL is $2,904 for a family of one and $3,804 for a family of two (eligibility is determined in six month increments).

Table 3
North Carolina Medicaid
State Fiscal Year 2004
Number of Enrolled Medicaid Providers

Providers	Number
Adult Care Home Providers	2,074
Ambulance Service Providers	283
Chiropractors	1,163
Community Alternatives Program Providers:	
CAP/C, CAP/AIDS, CAP/DD-MR, CAP/DA	1,143
Dental Service Providers:	
Dentists, Oral Surgeons, Pediadontists, Orthodontists	4,166
Durable Medical Equipment Suppliers	2,199
Hearing Aid Suppliers	97
Home Health Agency Providers:	
Home Infusion Therapy, Private Duty Nursing	472
Hospice Agency Providers	77
Hospital Providers	513
Independent Laboratory Providers	163
Independent Practitioners:	
Physical, Occupational, Respiratory & Speech Therapists, Audiologists	2,204
Managed Care Programs (HMOs)	1
Mental Health Program Providers	158
Mental Health Providers	2,291
Nursing Facility Providers	1,229
Optical Service Providers and Suppliers:	
Opticians, Optometrists	1,256
Other Types of Clinics:	
Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers	214
Personal Care Service Providers	707
Pharmacists	1,986
Physician Extenders:	
Nurse Midwives, Physician Assistants, Nurse Practitioners, CRNA's	1,977
Physicians	26,481
Podiatrists	378
Portable X-ray Service Providers	22
Psychiatric Facility Providers	649
Public Health Program Providers	509
Rural Health Clinic/Federally Qualified Health Center Providers	347
Community Base Providers	78
Total	52,837

Note: This is an unduplicated count of active providers enrolled during SFY 2004.
Physicians may be counted individually and/or as a group.

Table 4
North Carolina Medicaid
State Fiscal Year 2004
Medicaid Covered Services

Ambulance & Other Medical Transportation
Targeted 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

Chiropractors
Clinic Services (Federally Qualified, Rural Health, Health Dept & Mental Health)
Community Alternatives Programs
Dental Care Services
Domicile Care
Durable Medical Equipment
Health Check Services (EPSDT)
Family Planning Services
Hearing Aids (for children)
HMO Membership
Home Health Services
Home Infusion Therapy Services
Hospice
Inpatient, Outpatient & Specialty Hospital Services
Intermediate Care Facilities for the Mentally Retarded
Laboratory & X-ray Services
Mental Hospitals (age 65 & over)
Migrant Health Clinics
Nurse Anesthetists
Nurse Midwives
Nurse Practitioners
Nursing Facilities
Optical Supplies
Optometrists
Personal Care Services
Physicians
Podiatrists
Prescription Drugs
Preventive
Private Duty Nursing Services
Prosthetics and Orthotics (children)
Rehabilitative (under Behavioral Health Services)
Screening
Specialized Therapies (Occupational, Physical, Respiratory & Speech)

Table 5
North Carolina Medicaid Program
State Fiscal Year 2003 vs. 2004
Fund 1310 - Sources of Medicaid Funds - Services Expenditures Only

	2004	Percent	2003	Percent
Federal	$ 4,868,510,671	65.75%	$ 4,172,894,036	63.08%
State*	$ 1,869,297,326	25.24%	$ 1,850,750,558	27.98%
Other State**	$ 294,812,636	3.98%	$ 220,469,147	3.33%
County	$ 372,120,792	5.03%	$ 371,267,939	5.61%
Total	**$ 7,404,741,424**	**100.00%**	**$ 6,615,381,680**	**100.00%**

* State appropriation of funds

**Primarily transfers from other agencies and other state funds.

Source: BD701, the Authorized Monthly Budget Report for the periods ending June 29, 2004 and June 29, 2003, respectively
NCAS

Table 6
North Carolina Medicaid
State Fiscal Year 2004
Program Services Expenditures
Fund 1310 Source of Medicaid Funds - DMA Only

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	$ 951,401,113	12.85%	13.32%	214,478	$ 4,436
Outpatient Hospital	511,730,500	6.91%	7.16%	741,934	690
Mental Hospital <21 & >65	23,813,468	0.32%	0.33%	2,379	10,010
Physician	697,369,742	9.42%	9.76%	1,392,685	501
Clinics	562,838,599	7.60%	7.88%	515,808	1,091
Nursing Facilities	896,995,683	12.11%	12.56%	43,421	20,658
ICF-MR	412,470,745	5.57%	5.77%	4,580	90,059
Dental	179,085,614	2.42%	2.51%	415,195	431
Prescription Drugs	1,470,497,694	19.86%	20.59%	1,057,239	1,391
Home Health	99,101,136	1.34%	1.39%	154,828	640
Personal Care Services	220,873,275	2.98%	3.09%	41,268	5,352
Adult Care Homes - Personal Care Services	130,332,985	1.76%	1.82%	28,537	4,567
All Other Services	986,965,177	13.33%	13.82%	1,078,167	915
Subtotal, Services	**$ 7,143,475,732**	**96.47%**	**100.00%**		
Medicare Premiums:					
(Part A, Part B, QMB, Dually Eligible)	239,728,567	3.24%			
HMO Premium	21,537,125	0.29%			
Subtotal, Other	**$ 261,265,692**	**3.53%**			
Fund 1310 Total Title XIX Services	**7,404,741,424**	**100.00%**			
Total Recipients (unduplicated)**				**1,541,450**	
Total Expenditures Per Recipient (unduplicated)					**$ 4,804**

* "Users of Services" is a duplicated count. Recipients using one or more services are counted in each service category.

** The word "recipient" refers to an individuals who is eligible for Medicaid who actually received at least one service during a given fiscal year. "Total Recipients" is unduplicated, counting recipients only once during the year regardless of the number or type of services they use.

Note: Numbers may not add to the dollar due to rounding.
"Users of Services" in "All Other Services" is obtained from the State History Table by taking an unduplicated count of the number of users.

SOURCE: BD-701 Report June 2004

Table 7
North Carolina Medicaid
A History of Medicaid Expenditures - Fund 1310 Program Services Expenditures Only

State Fiscal Year	EXPENDITURES	Increase over Prior Year	FEDERAL	Increase over Prior Year	COUNTY	Increase over Prior Year	STATE	Increase over Prior Year
SFY 1995	3,104,096,450		2,033,890,406		156,970,582		913,235,462	
SFY 1996	3,549,309,272	14.3%	2,319,069,750	14.0%	183,329,798	16.8%	1,046,909,725	14.6%
SFY 1997	3,910,496,650	10.2%	2,558,186,929	10.3%	203,048,680	10.8%	1,149,261,041	9.8%
SFY 1998	4,106,345,835	5.0%	2,694,947,300	5.3%	223,297,504	10.0%	1,188,101,030	3.4%
SFY 1999	4,239,989,114	3.3%	2,726,521,783	1.2%	231,552,651	3.7%	1,281,914,680	7.9%
SFY 2000	4,783,840,430	12.8%	2,998,403,878	10.0%	253,995,385	9.7%	1,531,441,167	19.5%
SFY 2001	5,480,241,286	14.6%	3,430,145,921	14.4%	310,019,848	22.1%	1,740,075,518	13.6%
SFY 2002	6,185,038,224	12.9%	3,827,151,587	11.6%	353,624,465	14.1%	2,004,262,173	15.2%
SFY 2003	6,605,712,421	6.8%	4,172,894,036	9.0%	371,267,939	5.0%	2,061,550,446	2.9%
SFY 2004	7,404,741,424	12.1%	4,868,510,671	16.7%	372,120,792	0.2%	2,164,109,962	5.0%

NOTE: The expenditures in this table are only for Medicaid Program Services paid through the Division of Medical Assistance. Program Services expenditures paid through other DHHS divisions are not included. Adjustments, recoveries and rebates are not included.

Source: BD 701 Budget Reports, Budget Code 14445, Fund 1310.

Table 8
North Carolina Medicaid
State Fiscal Years 1979 - 2004
A History of 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	Breast Cervical Cancer (BCC)	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%
2003-04	151,478	42,413	2,177	238,810	485,856	53,768	517,251	4882	15,528	197	1,512,360	4.50%
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%	
SFY 2004 Percent Total Eligibles:	10.0%	2.8%	0.1%	15.8%	32.1%	3.6%	34.2%	0.3%	1.0%	0.0%	100.0%	

Source: Medicaid Eligibility Report, EJA752 - SFY 2004

Table 9
North Carolina Medicaid
State Fiscal Year 2004
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 2003 POPULATION
ALAMANCE	136,372	21,726	$ 101,375,010	$ 4,666	$ 743	77	159	15.93%
ALEXANDER	34,532	5,935	26,134,383	4,403	757	75	172	17.19%
ALLEGHANY	10,790	2,176	13,637,508	6,267	1,264	17	202	20.17%
ANSON	25,224	6,948	38,559,847	5,550	1,529	8	275	27.55%
ASHE	25,086	5,100	30,977,988	6,074	1,235	23	203	20.33%
AVERY	18,093	3,195	19,558,954	6,122	1,081	35	177	17.66%
BEAUFORT	45,589	10,936	61,340,868	5,609	1,346	15	240	23.99%
BERTIE	19,813	6,567	36,410,284	5,544	1,838	1	331	33.14%
BLADEN	32,784	10,053	49,473,039	4,921	1,509	9	307	30.66%
BRUNSWICK	81,810	16,138	69,802,724	4,325	853	63	197	19.73%
BUNCOMBE	212,246	36,624	188,633,465	5,151	889	59	173	17.26%
BURKE	88,790	16,454	82,743,956	5,029	932	51	185	18.53%
CABARRUS	143,433	21,385	95,034,240	4,444	663	88	149	14.91%
CALDWELL	78,132	14,873	73,390,560	4,934	939	50	190	19.04%
CAMDEN	7,844	1,057	4,819,769	4,560	614	92	135	13.48%
CARTERET	60,574	9,398	47,282,851	5,031	781	72	155	15.51%
CASWELL	23,720	4,902	25,223,324	5,146	1,063	39	207	20.67%
CATAWBA	146,458	24,220	103,137,170	4,258	704	84	165	16.54%
CHATHAM	53,684	7,227	34,488,285	4,772	642	90	135	13.46%
CHEROKEE	25,280	5,722	33,094,194	5,784	1,309	16	226	22.63%
CHOWAN	14,366	3,666	17,716,006	4,833	1,233	24	255	25.52%
CLAY	9,368	1,833	9,574,666	5,223	1,022	43	196	19.57%
CLEVELAND	97,548	22,241	115,396,638	5,188	1,183	25	228	22.80%
COLUMBUS	54,557	17,440	89,961,005	5,158	1,649	3	320	31.97%
CRAVEN	92,692	16,388	81,280,279	4,960	877	62	177	17.68%
CUMBERLAND	307,856	55,731	200,885,010	3,605	653	89	181	18.10%
CURRITUCK	20,598	2,724	12,267,830	4,504	596	93	132	13.22%
DARE	33,328	3,457	19,577,222	5,663	587	95	104	10.37%
DAVIDSON	151,935	25,431	109,254,820	4,296	719	83	167	16.74%
DAVIE	37,222	4,847	23,244,565	4,796	624	91	130	13.02%
DUPLIN	50,775	12,375	53,502,709	4,323	1,054	40	244	24.37%
DURHAM	236,088	36,865	175,494,972	4,760	743	78	156	15.61%
EDGECOMBE	54,077	17,892	73,590,673	4,113	1,361	14	331	33.09%
FORSYTH	317,643	50,383	231,645,310	4,598	729	81	159	15.86%
FRANKLIN	51,652	10,243	43,849,152	4,281	849	64	198	19.83%
GASTON	191,236	38,701	212,825,385	5,499	1,113	32	202	20.24%
GATES	10,834	1,979	9,788,746	4,946	904	55	183	18.27%
GRAHAM	8,044	2,191	13,465,319	6,146	1,674	2	272	27.24%
GRANVILLE	52,442	8,855	39,125,006	4,418	746	76	169	16.89%
GREENE	19,882	4,585	20,207,233	4,407	1,016	45	231	23.06%
GUILFORD	431,199	69,422	303,058,167	4,365	703	85	161	16.10%
HALIFAX	56,874	19,111	85,774,245	4,488	1,508	10	336	33.60%
HARNETT	97,794	19,737	79,047,630	4,005	808	69	202	20.18%
HAYWOOD	55,822	10,874	55,066,420	5,064	986	47	195	19.48%
HENDERSON	94,496	14,906	74,639,740	5,007	790	71	158	15.77%
HERTFORD	23,755	7,303	36,760,578	5,034	1,547	7	307	30.74%
HOKE	36,990	8,698	35,655,034	4,099	964	48	235	23.51%
HYDE	5,720	1,425	8,444,700	5,926	1,476	12	249	24.91%
IREDELL	133,280	20,428	91,495,186	4,479	686	87	153	15.33%
JACKSON	34,990	5,797	27,281,133	4,706	780	73	166	16.57%
JOHNSTON	136,304	25,409	111,218,194	4,377	816	68	186	18.64%
JONES	10,184	2,250	11,817,595	5,252	1,160	29	221	22.09%
LEE	49,792	10,538	35,943,340	3,411	722	82	212	21.16%
LENOIR	58,900	15,551	72,790,131	4,681	1,236	22	264	26.40%

Table 9 (Cont.)
North Carolina Medicaid
State Fiscal Year 2004
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 2003 POPULATION
LINCOLN	67,394	10,753	55,396,965	5,152	822	66	160	15.96%
MACON	31,376	5,896	25,251,873	4,283	805	70	188	18.79%
MADISON	19,976	4,360	23,192,433	5,319	1,161	28	218	21.83%
MARTIN	24,928	6,963	39,610,567	5,689	1,589	5	279	27.93%
MCDOWELL	43,080	8,283	39,753,077	4,799	923	53	192	19.23%
MECKLENBURG	750,221	116,273	446,318,332	3,839	595	94	155	15.50%
MITCHELL	15,925	3,198	17,477,297	5,465	1,097	33	201	20.08%
MONTGOMERY	27,332	6,663	30,572,831	4,588	1,119	31	244	24.38%
MOORE	78,226	12,455	54,609,053	4,385	698	86	159	15.92%
NASH	89,626	18,883	80,461,164	4,261	898	56	211	21.07%
NEW HANOVER	169,050	27,026	139,057,086	5,145	823	65	160	15.99%
NORTHAMPTON	21,798	6,917	35,073,463	5,071	1,609	4	317	31.73%
ONSLOW	156,967	20,312	79,295,415	3,904	505	99	129	12.94%
ORANGE	120,881	10,774	64,666,598	6,002	535	97	89	8.91%
PAMLICO	12,992	2,595	14,223,495	5,481	1,095	34	200	19.97%
PASQUOTANK	36,432	8,602	41,578,602	4,834	1,141	30	236	23.61%
PENDER	43,699	8,552	39,131,175	4,576	895	57	196	19.57%
PERQUIMANS	11,712	2,593	11,271,276	4,347	962	49	221	22.14%
PERSON	36,980	7,314	39,470,017	5,397	1,067	37	198	19.78%
PITT	139,007	27,315	123,645,470	4,527	889	58	197	19.65%
POLK	18,896	2,551	14,372,962	5,634	761	74	135	13.50%
RANDOLPH	134,980	24,118	99,643,616	4,132	738	80	179	17.87%
RICHMOND	46,490	13,589	58,576,375	4,311	1,260	19	292	29.23%
ROBESON	125,554	42,989	195,744,742	4,553	1,559	6	342	34.24%
ROCKINGHAM	92,423	18,989	96,768,594	5,096	1,047	41	205	20.55%
ROWAN	133,134	23,799	109,199,089	4,588	820	67	179	17.88%
RUTHERFORD	63,432	14,095	64,699,016	4,590	1,020	44	222	22.22%
SAMPSON	62,214	16,279	72,785,324	4,471	1,170	27	262	26.17%
SCOTLAND	35,506	11,879	52,937,036	4,456	1,491	11	335	33.46%
STANLY	59,060	10,345	51,983,613	5,025	880	61	175	17.52%
STOKES	45,604	7,038	33,733,973	4,793	740	79	154	15.43%
SURRY	71,980	14,353	72,378,420	5,043	1,006	46	199	19.94%
SWAIN	13,353	3,461	15,736,601	4,547	1,179	26	259	25.92%
TRANSYLVANIA	29,468	5,281	25,978,539	4,919	882	60	179	17.92%
TYRRELL	4,226	975	5,338,687	5,476	1,263	18	231	23.07%
UNION	144,708	18,500	74,323,079	4,017	514	98	128	12.78%
VANCE	43,860	14,741	54,786,158	3,717	1,249	20	336	33.61%
WAKE	699,503	73,831	314,426,086	4,259	449	100	106	10.55%
WARREN	20,054	5,833	25,005,780	4,287	1,247	21	291	29.09%
WASHINGTON	13,468	4,242	19,327,029	4,556	1,435	13	315	31.50%
WATAUGA	42,772	3,881	23,044,621	5,938	539	96	91	9.07%
WAYNE	113,988	24,986	104,202,946	4,170	914	54	219	21.92%
WILKES	66,909	13,572	72,158,368	5,317	1,078	36	203	20.28%
WILSON	75,662	17,882	79,172,504	4,427	1,046	42	236	23.63%
YADKIN	36,821	5,857	34,079,122	5,819	926	52	159	15.91%
YANCEY	17,926	3,655	19,092,030	5,224	1,065	38	204	20.39%
STATE TOTAL	**8,418,090**	**1,512,360**	**$ 6,906,313,559**	**$ 4,567**	**$ 820**		**180**	**17.97%**

Notes: * Data reflect only net vendor payments for which the county is responsible for its computable share.
** Eligibles is a statewide unduplicated count indicating only eligibility in the last county of residence during the fiscal year
Source: Medicaid Cost Calculation Fiscal YTD June 2004.

Table 10
North Carolina Medicaid
State Fiscal Year 2004
Medicaid Service Expenditures by Recipient Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 2004 Expenditures Per Recipient	SFY 2003 Expenditures Per Recipient	03/04 Percent Change
Total Elderly	**$ 1,941,800,149**	**26.3%**	**204,135**	**13.2%**	**$ 9,512**	**$ 8,932**	**6.5%**
Aged	1,912,877,837	25.9%	162,675	10.6%	11,759	10,992	7.0%
Medicare-Aid (MQBQ, MQBB & MQBE)	28,922,311	0.4%	41,460	2.7%	698	665	4.9%
Total Disabled	**$ 3,127,627,817**	**42.4%**	**243,774**	**15.8%**	**$ 12,830**	**$ 11,971**	**7.2%**
Disabled	3,098,896,953	42.0%	241,560	15.7%	12,829	11,964	7.2%
Blind	28,730,864	0.4%	2,214	0.1%	12,977	12,632	2.7%
Total Families &Children	**$ 2,285,088,549**	**31.0%**	**1,074,554**	**69.7%**	**$ 2,127**	**$ 1,967**	**8.1%**
AFDC Adults (> 21)	662,377,368	9.0%	224,740	14.6%	2,947	2,731	7.9%
Medicaid Pregnant Women Coverage (MPW)	211,141,242	2.9%	57,047	3.7%	3,701	3,844	-3.7%
AFDC Children & Other Children	581,291,151	7.9%	270,548	17.6%	2,149	1,871	14.8%
Medicaid Indigent Children (MIC)	826,938,099	11.2%	521,991	33.9%	1,584	1,482	6.9%
Breast and Cervical	3,340,690	0.0%	228	0.0%	14,652	12,529	16.9%
Aliens and Refugees	**$ 51,681,385**	**0.7%**	**18,987**	**1.2%**	**$ 2,722**	**$ 2,735**	**-0.5%**

Source: SFY 2004 Program Expenditure Report (PER) and State 2082 Report. Note: Financial data reported in the PER originates from and relates to "claims paid" within MMIS during the fiscal year and is not identical with financial data reported in the BD 701 Budget Reports.

Table 11
North Carolina Medicaid
State Fiscal Year 2004
Service Expenditures for Selected Major Medical Services by Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ* Medicare 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	$ 952,315,340	12.9%	$ 15,067,951	$ 16,748	-	$ 1,574,381	$ 419,847,747	$ 231,056,692	$ 364,950	$ 254,178,374	$ 36,351,357	$ (6,142,860)
Outpatient Hospital	517,492,495	7.0%	30,885,192	74,945	-	1,195,268	195,812,082	157,121,226	1,509,497	144,127,630	1,978,785	(15,212,129)
Mental Hospital (> 65)	7,177,974	0.1%	7,179,028	-	-	-	(46)	-	-	-	-	(1,007)
Psychiatric Hospital (< 21)	25,969,008	0.4%	-	-	-	-	7,591,541	6,191	-	18,422,543	-	(51,268)
Physician	697,495,106	9.5%	43,908,023	112,354	(32)	1,257,726	210,835,173	188,433,473	1,097,903	246,184,910	10,658,891	(4,993,316)
Clinics	582,769,700	7.9%	10,476,312	11,426	164	1,273,701	283,072,000	48,855,990	17,936	242,526,533	1,302,089	(4,766,449)
Nursing Facility:												
Skilled Level	479,238,470	6.5%	401,591,097	605	-	1,066,855	76,555,501	283,407	-	25,515	1,454	(285,966)
Intermediate Level	418,220,811	5.7%	372,127,634	-	(1,042)	1,037,300	45,093,305	3,502	-	80,462	1,143	(121,493)
Intermediate Care Facility (Mentally Retarded)	412,470,709	5.6%	24,466,196	-	-	7,017,502	378,465,752	32,392	-	2,530,366	-	(41,499)
Dental	179,199,630	2.4%	9,313,687	-	-	199,955	32,472,187	35,517,437	19,474	101,820,018	152,298	(295,427)
Prescription Drugs	1,470,555,037	19.9%	442,920,522	-	-	4,726,513	702,175,531	139,353,861	226,514	181,308,535	138,935	(295,375)
Home Health	170,719,146	2.3%	32,431,571	7,958	-	904,782	112,665,820	10,251,717	50,456	14,840,252	63,422	(496,833)
CAP/Disabled Adult	201,733,127	2.7%	144,185,448	-	-	1,578,707	56,086,167	181	-	1,186	18,807	(137,368)
CAP/Mentally Retarded	265,713,701	3.6%	5,298,714	-	-	2,638,663	255,960,094	-	-	2,148,256	-	(332,026)
CAP/Children	23,775,920	0.3%	-	-	-	319,104	22,872,512	-	-	609,178	-	(24,875)
Personal Care	220,873,275	3.0%	127,838,732	-	125	1,821,868	87,111,926	3,023,208	15,662	1,133,107	2,224	(73,577)
Hospice	31,551,395	0.4%	18,932,203	-	-	122,182	12,027,400	362,322	-	155,884	-	(48,595)
EPSDT (Health Check)	48,877,457	0.7%	8,424	-	-	6,327	1,356,892	60,580	5	47,489,455	2,180	(46,406)
Lab & X-ray	28,724,183	0.4%	187,843	159	-	48,548	5,721,439	13,083,100	17,129	9,658,316	58,681	(51,033)
Adult Home Care	134,809,630	1.8%	77,678,298	-	-	346,260	56,759,995	34,068	6,745	28,532	(15)	(44,251)
High Risk Intervention												
Residential	102,598,399	1.4%	-	-	-	-	24,030,245	4,761	-	78,653,760	-	(90,367)
Other Services	145,862,149	2.0%	9,730,480	3,690	-	231,404	46,251,218	36,465,405	14,418	52,485,884	931,407	(251,757)
Total Services	**$ 7,118,142,661**	**96.5%**	**$ 1,774,227,356**	**$ 227,884**	**$ (784)**	**$ 27,367,045**	**$ 3,032,764,478**	**$ 863,949,515**	**$ 3,340,690**	**$ 1,398,408,697**	**$ 51,661,658**	**$ (33,803,877)**
Medicare:												
Part A Premiums	42,636,856	0.6%	42,058,432	7,249	-	494,900	3,981	-	-	-	-	72,294
Part B Premiums	190,394,800	2.6%	96,592,049	423,103	28,264,860	846,350	63,687,462	317,531	-	11,452	6,868	245,124
HMO Premiums	21,537,125	0.3%	-	-	-	22,569	2,441,032	9,251,564	-	9,809,101	12,860	-
Total Premiums	**$ 254,568,781**	**3.5%**	**$ 138,650,481**	**$ 430,352**	**$ 28,264,860**	**$ 1,363,819**	**$ 66,132,475**	**$ 9,569,095**	-	**$ 9,820,553**	**$ 19,728**	**$ 317,418**
Program Category Totals			**$ 1,912,877,837**	**$ 658,236**	**$ 28,264,076**	**$ 28,730,864**	**$ 3,098,896,953**	**$ 873,518,610**	**$ 3,340,690**	**$ 1,408,229,249**	**$ 51,681,385**	**$ (33,486,459)**

* 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: Program Category Totals do not include adjustments processed by DMA, settlements, disproportionate share costs and State and county administration costs and certified public funds in other agencies. Also, financial data reported in the PER originates from and relates to "claims paid" within MMIS during the fiscal year and is not identical with financial data reported in the BD 701 Budget Reports.
Source: SFY Program Expenditure Report

Table 12
North Carolina Medicaid
State Fiscal Year 2004
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 2004 % of Total Dollars	SFY 2003 % of Total Dollars	SFY 2002 % of Total Dollars
Inpatient Hospital	$ 15,067,951	0.8%	$ 16,748	-	$ 16,748	0.1%	$ 15,084,699	0.8%	1.1%	1.1%
Outpatient Hospital	30,885,192	1.6%	74,945	-	74,945	0.3%	30,960,137	1.6%	2.0%	2.0%
Mental Hospital (> 65)	7,179,028	0.4%	-	-	-	0.0%	7,179,028	0.4%	0.4%	0.4%
Physician	43,908,023	2.3%	112,354	(32)	112,321	0.4%	44,020,345	2.3%	1.6%	1.6%
Clinics	10,476,312	0.5%	11,426	164	11,590	0.0%	10,487,902	0.5%	0.6%	0.6%
Nursing Facility:										
Skilled Level	401,591,097	21.0%	605	-	605	0.0%	401,591,703	20.7%	20.9%	20.9%
Intermediate Level	372,127,634	19.5%	-	(1,042)	(1,042)	0.0%	372,126,592	19.2%	20.7%	20.7%
Intermediate Care Facility (Mentally Retarded)	24,466,196	1.3%	-	-	-	0.0%	24,466,196	1.3%	1.3%	1.3%
Dental	9,313,687	0.5%	-	-	-	0.0%	9,313,687	0.5%	0.4%	0.4%
Prescription Drugs	442,920,522	23.2%	-	-	-	0.0%	442,920,522	22.8%	21.0%	21.0%
Home Health	32,431,571	1.7%	7,958	-	7,958	0.0%	32,439,530	1.7%	1.8%	1.8%
CAP/Disabled Adult	144,185,448	7.5%	-	-	-	0.0%	144,185,448	7.4%	7.5%	7.5%
CAP/Mentally Retarded	5,298,714	0.3%	-	-	-	0.0%	5,298,714	0.3%	0.3%	0.3%
Personal Care	127,838,732	6.7%	-	125	125	0.0%	127,838,857	6.6%	6.7%	6.7%
Hospice	18,932,203	1.0%	-	-	-	0.0%	18,932,203	1.0%	0.7%	0.7%
EPSDT (Health Check)	8,424	0.0%	-	-	-	0.0%	8,424	0.0%	0.0%	0.0%
Lab & X-ray	187,843	0.0%	159	-	159	0.0%	188,002	0.0%	0.0%	0.0%
Adult Home Care	77,678,298	4.1%	-	-	-	0.0%	77,678,298	4.0%	4.0%	4.0%
High Risk Intervention Residential	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Other Services	9,730,480	0.5%	3,690	-	3,690	0.0%	9,734,170	0.5%	0.5%	0.5%
Total Services	**$ 1,774,227,356**	**92.8%**	**$ 227,884**	**$ (784)**	**$ 227,100**	**0.8%**	**$ 1,774,454,456**	**91.4%**	**91.5%**	**91.5%**
Medicare:		0.0%								
Part A Premiums	42,058,432	2.2%	7,249	-	7,249	0.0%	42,065,681	2.2%	2.3%	2.3%
Part B Premiums	96,592,049	5.0%	423,103	28,264,860	28,687,963	99.2%	125,280,012	6.5%	6.3%	6.3%
HMO Premiums	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Total Premiums	**$ 138,650,481**	**7.2%**	**$ 430,352**	**$ 28,264,860**	**$ 28,695,212**	**99.2%**	**$ 167,345,693**	**8.6%**	**8.5%**	**8.5%**
		0.0%								
Grand Total Services and premiums	**$ 1,912,877,837**	**100.0%**	**$ 658,236**	**$ 28,264,076**	**$ 28,922,311**	**100.0%**	**$ 1,941,800,149**	**100.0%**	**100.0%**	**100.0%**
Medicaire Crossovers*	**$ 98,689,090**									
Total Elderly Recipients	**162,675**		**647**	**40,813**	**41,460**		**204,135**			
Expenditures Per Recipient**	**$ 11,759**		**$ 1,017**	**$ 693**	**$ 698**		**$ 9,512**			

* Medicare Crossovers are amounts that Medicaid bills Medicare for those Medicaid-eligible people who are also eligible for Medicare.
** Service Expenditure/Recipient amounts do not contain adjustments, settlements or administrative costs.
Source: SFY 2004 Program Expenditure Report

Table 13
North Carolina Medicaid
State Fiscal Year 2004
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	2004 % of Total Dollars	2003 % of Total Dollars	2002 % of Total Dollars
Inpatient Hospital	$ 419,847,747	13.5%	$ 1,574,381	5.5%	$ 421,422,128	13.5%	13.9%	14.7%
Outpatient Hospital	195,812,082	6.3%	1,195,268	4.2%	197,007,349	6.3%	7.2%	6.4%
Mental Hospital (> 65)	(46)	0.0%	-	0.0%	(46)	0.0%	0.0%	0.0%
Psychiatric Hospital (< 21)	7,591,541	0.2%	-	0.0%	7,591,541	0.2%	0.3%	0.2%
Physician	210,835,173	6.8%	1,257,726	4.4%	212,092,899	6.8%	6.2%	7.0%
Clinics	283,072,000	9.1%	1,273,701	4.4%	284,345,700	9.1%	8.5%	7.6%
Nursing Facility:								
Skilled Level	76,555,501	2.5%	1,066,855	3.7%	77,622,357	2.5%	2.6%	2.6%
Intermediate Level	45,093,305	1.5%	1,037,300	3.6%	46,130,605	1.5%	1.6%	1.7%
Intermediate Care Facility (Mentally Retarded)	378,465,752	12.2%	7,017,502	24.4%	385,483,253	12.3%	13.8%	15.0%
Dental	32,472,187	1.0%	199,955	0.7%	32,672,142	1.0%	0.9%	0.8%
Prescription Drugs	702,175,531	22.7%	4,726,513	16.5%	706,902,044	22.6%	20.6%	19.3%
Home Health	112,665,820	3.6%	904,782	3.1%	113,570,601	3.6%	3.8%	3.9%
CAP/Disabled Adult	56,086,167	1.8%	1,578,707	5.5%	57,664,874	1.8%	1.8%	2.1%
CAP/Mentally Retarded	255,960,094	8.3%	2,638,663	9.2%	258,598,757	8.3%	9.1%	9.5%
CAP/Children	22,872,512	0.7%	319,104	1.1%	23,191,616	0.7%	0.8%	0.8%
Personal Care	87,111,926	2.8%	1,821,868	6.3%	88,933,794	2.8%	2.4%	1.9%
Hospice	12,027,400	0.4%	122,182	0.4%	12,149,582	0.4%	0.4%	0.3%
EPSDT (Health Check)	1,356,892	0.0%	6,327	0.0%	1,363,218	0.0%	0.0%	0.1%
Lab & X-ray	5,721,439	0.2%	48,548	0.2%	5,769,987	0.2%	0.2%	0.2%
Adult Home Care	56,759,995	1.8%	346,260	1.2%	57,106,254	1.8%	1.8%	1.8%
High Risk Intervention Residential	24,030,245	0.8%	-	0.0%	24,030,245	0.8%	0.7%	0.4%
Other Services	46,251,218	1.5%	231,404	0.8%	46,482,622	1.5%	1.3%	1.4%
Total Services	**$ 3,032,764,478**	**97.9%**	**$ 27,367,045**	**95.3%**	**$ 3,060,131,523**	**97.8%**	**97.9%**	**97.7%**
Medicare, Part A Premiums	3,981	0.0%	494,900	1.7%	498,881	0.0%	0.0%	0.0%
Medicare, Part B Premiums	63,687,462	2.1%	846,350	2.9%	64,533,812	2.1%	2.0%	1.9%
HMO Premiums	2,441,032	0.1%	22,569	0.1%	2,463,601	0.1%	0.1%	0.4%
Total Premiums	**$ 66,132,475**	**2.1%**	**$ 1,363,819**	**4.7%**	**$ 67,496,294**	**2.2%**	**2.1%**	**2.3%**
Grand Total Services & Premiums	**$ 3,098,896,953**	**100.0%**	**$ 28,730,864**	**100.0%**	**$ 3,127,627,817**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 71,506,549**		**$ 644,018**		**$ 72,150,567**			
Number of Disabled/Blind Recipients	**241,560**		**2,214**		**243,774**			
Service Expenditures Per Recipient**	**$ 12,829**		**$ 12,977**		**$ 12,830**			

* 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 2004 Program Expenditure Report

Table 14
North Carolina Medicaid
State Fiscal Year 2004
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 2004 % of Total Dollars	SFY 2003 % of Total Dollars
Inpatient Hospital	$ 151,750,520	22.9%	$ 79,306,172	37.6%	$ 64,945,799	11.2%	$ 189,232,575	22.9%	$ 364,950	10.9%	$ 485,600,016	21.3%	11.2%
Outpatient Hospital	131,678,108	19.9%	25,443,118	12.1%	59,269,196	10.2%	84,858,435	10.3%	1,509,497	45.2%	302,758,353	13.2%	7.6%
Psychiatric Hospital (< 21)	-	0.0%	6,191	0.0%	10,206,731	1.8%	8,215,812	1.0%	-	0.0%	18,428,734	0.8%	0.5%
Physician	131,874,926	19.9%	56,558,548	26.8%	82,887,756	14.3%	163,297,154	19.7%	1,097,903	32.9%	435,716,286	19.1%	9.2%
Clinics	28,920,337	4.4%	19,935,653	9.4%	143,628,440	24.7%	98,898,092	12.0%	17,936	0.5%	291,400,459	12.8%	6.5%
Nursing Facility:													
Skilled Level	283,407	0.0%	-	0.0%	25,515	0.0%	-	0.0%	-	0.0%	308,922	0.0%	0.0%
Intermediate Level	3,502	0.0%	-	0.0%	80,462	0.0%	-	0.0%	-	0.0%	83,965	0.0%	0.0%
Intermediate Care Facility (Mentally Retarded)	32,392	0.0%	-	0.0%	1,747,471	0.3%	782,896	0.1%	-	0.0%	2,562,758	0.1%	0.1%
Dental	34,076,003	5.1%	1,441,434	0.7%	40,970,610	7.0%	60,849,409	7.4%	19,474	0.6%	137,356,930	6.0%	2.5%
Prescription Drugs	130,318,458	19.7%	9,035,403	4.3%	75,193,698	12.9%	106,114,837	12.8%	226,514	6.8%	320,888,910	14.0%	6.3%
Home Health	8,871,773	1.3%	1,379,944	0.7%	5,142,401	0.9%	9,697,851	1.2%	50,456	1.5%	25,142,425	1.1%	0.5%
CAP/Disabled Adult	181	0.0%	-	0.0%	223	0.0%	962	0.0%	-	0.0%	1,366	0.0%	0.0%
CAP/Mentally Retarded	-	0.0%	-	0.0%	2,147,448	0.4%	808	0.0%	-	0.0%	2,148,256	0.1%	0.1%
CAP/Children	-	0.0%	-	0.0%	609,178	0.1%	-	0.0%	-	0.0%	609,178	0.0%	0.0%
Personal Care	2,978,710	0.4%	44,498	0.0%	607,008	0.1%	526,098	0.1%	15,662	0.5%	4,171,977	0.2%	0.1%
Hospice	362,322	0.1%	-	0.0%	2,284	0.0%	153,600	0.0%	-	0.0%	518,206	0.0%	0.0%
EPSDT (Health Check)	33,373	0.0%	27,207	0.0%	12,626,235	2.2%	34,863,221	4.2%	5	0.0%	47,550,041	2.1%	1.1%
Lab & X-ray	8,482,911	1.3%	4,600,189	2.2%	3,064,455	0.5%	6,593,862	0.8%	17,129	0.5%	22,758,546	1.0%	0.5%
Adult Home Care	34,068	0.0%	-	0.0%	22,701	0.0%	5,831	0.0%	6,745	0.2%	69,345	0.0%	0.0%
High Risk Intervention Residential	-	0.0%	4,761	0.0%	46,221,321	8.0%	32,432,439	3.9%	-	0.0%	78,658,521	3.4%	1.5%
Other Services	24,850,772	3.8%	11,614,633	5.5%	27,252,693	4.7%	25,233,191	3.1%	14,418	0.4%	88,965,708	3.9%	1.8%
Total Services	**$ 654,551,762**	**98.8%**	**$ 209,397,752**	**99.2%**	**$ 576,651,625**	**99.2%**	**$ 821,757,072**	**99.4%**	**$ 3,340,690**	**100.0%**	**$ 2,265,698,901**	**99.2%**	**99.5%**
Medicare, Part A Premiums	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Medicare, Part B Premiums	310,691	0.0%	6,841	0.0%	7,300	0.0%	4,152	0.0%	-	0.0%	328,983	0.0%	0.0%
HMO Premiums	7,514,915	1.1%	1,736,649	0.8%	4,632,226	0.8%	5,176,875	0.6%	-	0.0%	19,060,665	0.8%	0.5%
Total Premiums	**$ 7,825,606**		**$ 1,743,489**		**$ 4,639,526**		**$ 5,181,027**		-		**$ 19,389,648**	**0.8%**	**0.5%**
Total Services & Premiums	**$ 662,377,368**		**$ 211,141,242**		**$ 581,291,151**		**$ 826,938,099**		**$ 3,340,690**		**$ 2,285,088,549**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 846,632**		**$ 62,070**		**$ 19,203**		**$ 9,634**				**$ 937,539**		
Number of Family & Child Recipients	**224,740**		**57,047**		**270,548**		**521,991**		**228**		**1,074,554**		
Service Expenditures Per Recipient**	**$ 2,947**		**$ 3,701**		**$ 2,149**		**$ 1,584**		**$ 14,652**		**$ 2,127**		

* Medicare Crossovers are Medicare charges that are billed to Medicaid.
** Service Expenditures per Recipient does not include adjustments, settlements, or administrative costs.
Source: SFY 2004 Program Expenditure Report

Table 15
North Carolina Medicaid
State Fiscal Year 2004
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	
Generic & Insulin	$1.00
Brand Name	$3.00

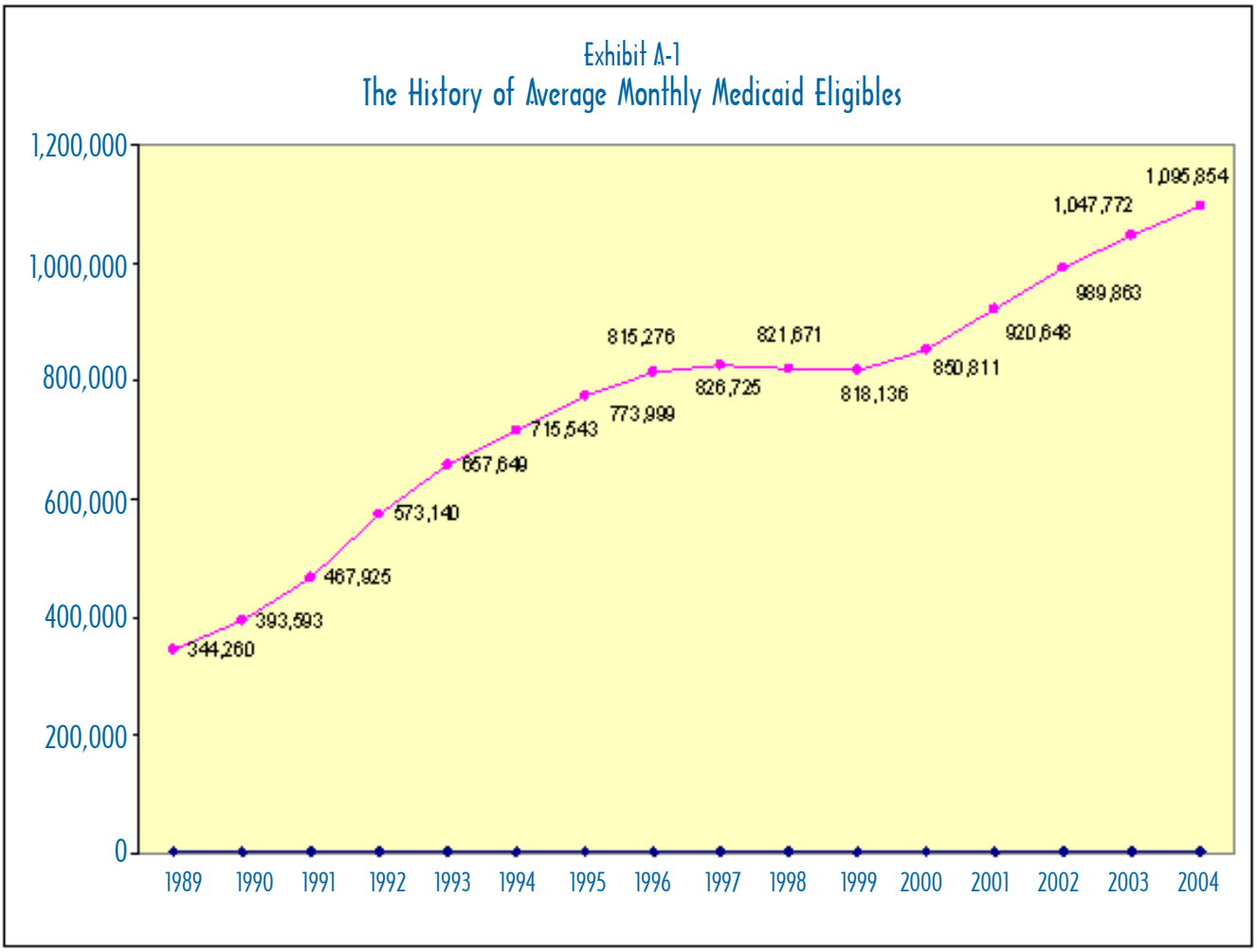
How the NC Medicaid Program Works

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. General Statutes, Chapter 108A is the law that implemented Title XIX in North Carolina 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 10A, Chapters 21 and 22 provide 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 organizational unit within the Department of Human Resources, which has since been renamed as the Department of Health and Human Services. From 1978 to 2004, the annual number of people eligible for Medicaid has increased from 456,000 to 1,512,360 (unduplicated) and Medicaid service expenditures 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 1,095,854 during SFY 2004.

In 36 years of operation, the programmatic complexity of Medicaid has paralleled the growth in both program expenditures and number of recipients. However, DMA has historically spent a modest percentage of its budget on administration, which during SFY 2004 was approximately $172 million or 2 percent of total expenditures.

Exhibit A-2
What is Medicaid?

Title XIX of the Social Security Act is a federal 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 to individuals who fit into one of the Medicaid coverage groups and who have low income and resources. In North Carolina, case-workers in each of the 100 county departments of social services determine an individual's eligibility 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 any provider enrolled in the Medicaid program. Providers submit claims to DMA for reimbursement of services they provide to the Medicaid population.

Medicaid enrollees, applicants, and caretakers who have questions regarding the NC Medicaid program, may telephone North Carolina's toll free CARE-LINE Information and Referral Service (800-662-7030). The CARE-Line forwards calls regarding covered benefits to DMA's Recipient Ombudsman Unit which ensures that questions are answered in a timely manner.

Exhibit A-3
NC Medicaid Eligibility by Mandatory and Optional Groupings

MANDATORY

- Aged, Blind and Disabled persons receiving SSI
- 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
- Pregnant women and infants (under the age of 1) up to 150% FPL
- Children ages 1 through 5 up to 133% Federal Poverty Level (FPL)
- Children ages 6 through 18 up to 100% FPL (mandatory as of October 1, 2001)
- Families with children under the age of 19 who would have been eligible for AFDC in July 1996
- Foster children and adoptive children under Title IV-E

OPTIONAL

- Aged, Blind and Disabled not receiving SSI, including adult care home residents, 100% of poverty eligibles and medically needy
- Pregnant women and infants up to 185% FPL
- Children ages 19 and 20
- Non-IVE foster children and/or adoptive children with parents in families not eligible under AFDC rules in July 1996 (medically needy)
- Women screened by and enrolled in the NC Breast & Cervical Cancer Control Program
- Medically needy

Exhibit A-4
Basic Overview of Medicaid Eligibility

Who (coverage group)	Upper Income Limit	Assets (see explanation below)
Elderly Aged 65+	$776/month single person ($9,312 annually) $1,041/month couple ($12,4920 annually)	$2,000 single person $3,000 couple
Disabled/Blind	Same as elderly	Same as elderly
Medicare Beneficiaries	$1,048 monthly for single person ($12,576 annually) $1,406 monthly for couple ($16,872 annually)	$4,000 $6,000
Pregnant Women and Infants	$2,907 monthly for family of 4 ($34,844 annually)	N/A
Children ages 1 through 5	$2,090 monthly for family of 4 ($25,080 annually)	N/A
Children ages 6 through 18	$1,571 monthly for family of 4 ($18,852 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	Individuals not in the above categories qualify if they are considered to be "medically needy," that is, very low income and/or with high medical bills. The 2004 medically needy income limit (MNIL) is $2,904 for a family of one and $3,804 for a family of two (eligibility is determined in six month increments). Also, those with income above this limit may still qualify if medical bills are high. Medical bills must be equal to or greater than the amount by which their income exceeds the MNIL. Eligibility begins on day the incurred medical bills equal the spend-down amount. Many recipients with a spend-down are patients in nursing homes.	$2,000 elderly and disabled person $3,000 for couple or family
Women who have been screened by and enrolled in the North Carolina Breast & Cervical Cancer Control Program	There is no Medicaid income or resource limit for these women. Their eligibility is solely based on the Breast & Cervical Cancer Control program screening and enrollment.	N/A

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

Funding the NC Medicaid Program

Federal, state, and local county governments jointly finance the NC Medicaid Program, with the federal government paying the largest share of costs. In North Carolina, the 100 county governments contribute 15 percent of the non-federal share of costs. The federal share of costs for services is established annually by the Centers for Medicare and Medicaid Services (CMS). CMS calculates the rate based on the most recent 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 are not the same, different federal service 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.

During SFY 2004, the federal government provided a special, one-time enhancement of approximately 4% in its match rate to all state Medicaid programs in order to partially compensate for the lingering negative financial impact of the recent recession.

Administrative Contracts

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

EDS Corporation – DMA contracts with EDS to processes claims, provide billing guidance and help desk services to enrolled Medicaid providers, conduct provider education seminars, operate the prior approval system for most Medicaid services and operate the NC Medicaid Management Information System (MMIS+).

Medical Review of North Carolina (MRNC) – MRNC conducts quality assurance reviews 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 Measurement (PAM) 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). MRNC also processes 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 – During SFY 2002, DMA implemented a prior authorization process for certain prescription drugs through a contract with ACS State HealthCare in Atlanta, Georgia.

based on clinical criteria. Prior authorization allows NC Medicaid to ensure that these prescription drugs are used responsibly.

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 contracts with the certified public accounting firms of Cliffton Gunderson and Meyers and Stauffer to conduct onsite compliance audits of nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR) who are enrolled in the Medicaid Program as well as settlement activities for hospitals and state-operated nursing facilities and ICF-MRs. 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.

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 department of social services in each of North Carolina's 100 counties has the central role in determining Medicaid eligibility for their residents. In addition, counties contribute approximately 5 percent of the cost of services for Medicaid patients (see Table 5 in the Tables Section of this 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 determinations for two federal programs under a contract with the Social Security Administration including Title II - Social Security benefits and Title XVI - Supplemental Security Income.

Division of Mental Health, Developmental 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 this portion of the annual report).

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 program 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 "Major Initiatives and Subprograms" 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 of North Carolina managed care program.

Division of Aging and Adult Services (DOAAS) – DMA and DOAAS staff work together on many issues that are important to the aged and adult population. Jointly, DMA and DOAAS design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development projects on housing and in-home aide services.

Division of Facility Services (DFS) – DFS has the responsibility for licensing, certifying, and monitoring facilities 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 a 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 DMA 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.

NC Association of Pharmacists, NC Association of Community Pharmacists, Chain Pharmacy Committee of the NC Retail Merchants Association and the Long-Term Care Pharmacy Alliance – These associations have entered into an agreement with DMA to reduce Medicaid drug costs. Under the agreement, pharmacists will help move patients to more cost-effective generic drugs. This will be done by educating prescribing physicians on the cost-savings that are possible through use of generic drugs and working closely with them to attain these savings as appropriate.

Covered Services

NC Medicaid covers a comprehensive 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 limitations on services. These include a limit of 24 ambulatory visits per year to practitioners, clinics, and outpatient departments and a limit of six prescriptions per month. There are exceptions to these limits for preventive 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 ensure that the care received is medically necessary.

Providers of Care

During SFY 2004, over 52,000 enrolled Medicaid providers offered a wide variety of services to North Carolina's Medicaid population (see Table 3). 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

Exhibit A-5
SERVICES COVERED BY NC MEDICAID BY MANDATORY AND OPTIONAL CATEGORIES

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

Note: All optional services are mandatory for children under age 21 when they are medically necessary.

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.

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.

Rate Setting

Payment rates and fee schedules are very important in controlling Medicaid program costs. Taking into account the level of funding provided by the N.C. General Assembly, payment rates are established according to federal and state laws and regulations. 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.

Investigation of provider fraud, abuse or administrative errors

Program Integrity staff use sophisticated computer software in a unique fraud and abuse detection system. The software programs identify unusual patterns of utilization of services by recipients and providers. Medical desk reviews or visits are conducted for those providers or recipients whose medical practice or utilization of services appears outside comparative norms. Additionally, the staff investigates fraud complaints and allegations from many internal and external sources including calls made to the CARE-LINE to report fraud. DMA Program Integrity efforts include:

- Identifying providers and recipients who abuse or defraud the Medicaid program
- Identifying and recovering provider and recipient overpayments
- Educating providers or recipients when errors or abuse are detected
- Protecting recipients' rights
- Evaluating the medical claims processing procedures for accuracy and improvement

When an administrative overpayment is found, staff recovers it from the provider. When possible fraud or abuse is suspected, the Attorney General's Medicaid Investigations Unit reviews it for criminal or civil prosecution.

DMA operates several other programs directly or under contract to ensure that Medicaid funds are spent appropriately. These programs are designed to prevent and recover incorrect payments. DMA contracts with MRNC to evaluate DRG coding to identify improper reimbursement maximization and other potentially fraudulent billing practices. In addition, paid claims are reviewed periodically and those that differ significantly from established norms are analyzed to determine whether the services were medically necessary and appropriate.

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 available 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 insurance and Medicare, are important means of keeping Medicaid costs as low as possible.

Utilization Management and Prior Approval Activities

Utilization Management

Utilization management activities ensure optimal health care delivery in a cost effective manner to Medicaid-eligible individuals. These activities are conducted jointly by the Division of Medical Assistance (DMA) and the fiscal agent or through a contract with DMA. Utilization management is used to verify medical necessity and to authorize services as well as to ensure that continuing care is provided appropriately and effectively.

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.

Prior Approval

Prior approval may be required to verify medical necessity before rendering some services. 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. Services requiring prior approval include, but are not limited to:

- Long term care
- Prescription drugs
- Behavioral health
- Outpatient specialized therapies
- Managed care referral authorization and utilization management
- Certain surgeries, including transplants
- Visual aids
- Hearing aids
- Durable medical equipment
- Out-of-state services
- Nursing facilities

Nursing Facility Prior Approval

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 its 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, NC Medicaid is mandated to perform preadmission screening, as a 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) for 1987 (P.L. 100-203). This section of OBRA was enacted to ensure that recipients with serious mental illness, mental retardation or related conditions entering into 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 prior approval form (the FL2/FL2e). This must be completed prior to admission to a Nursing Facility.

NC Medicaid has one level of care for nursing facilities. The FL2/FL2e form is used to document information specific to the individual including diagnosis, special care needs and the PASARR number. This information is used to determine the appropriate care needs for the individual. The FL2/FL2e must be completed with current information and signed and dated by the physician and then sent to EDS to for evaluation.

Effective July 1, 2003, providers were permitted to submit FL2 information for nursing facility prior approval authorizations electronically to EDS by using a service developed by ProviderLink, Inc. This company provides web-based communications technology to enable health care providers and payors to manage all of their patient-related external communication through a single browser interface.

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 clinical criteria 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)

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. ValueOptions performs these utilization reviews.

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 for services by a private provider 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 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 Community Care of North Carolina 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 was only one during SFY 2004, 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.

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. Most, but not all, Medicaid eligibles qualify for managed care. As of June 2004, there were 776,396 Medicaid eligibles enrolled in a managed care plan out of a total of 1,030,014 Medicaid **managed care eligibles**, or approximately 75%. Managed care program options include Carolina ACCESS and Community Care of North Carolina.

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 Medicaid 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.

- **Community Care of North Carolina** (formerly Carolina ACCESS) – A primary care case management model characterized by a primary care provider gatekeeper. Community Care expands the traditional managed care model 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. This program was originally created as a health care demonstration project by the NC Office of Research, Demonstrations, and Rural Health Development, and is currently a joint collaborative effort between that office and DMA.

- **Healthcare Connection/Risk Contracting** – A program operating in Mecklenburg County requiring a majority of the Medicaid recipients in the county to enroll in the HMO, Carolina ACCESS or Community Care of North Carolina. The recipient is free to choose one of these options. DMA contracts with an HMO in Mecklenburg County to provide and coordinate medical services for certain eligibles on a full risk-capitated basis. 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

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 56,227 of the 117,273, or 47.9 percent, of all live births in North Carolina during SFY 2003 (the most recent fiscal year for which 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 the Division of Medical Assistance (DMA) and the Division of Public Health (DPH). The program provides pregnant women with comprehensive care through an expanded Medicaid benefit package, which includes targeted case management services, childbirth education classes, in-home nursing care for high-risk pregnancies, medical nutritional therapy, health and behavior intervention, 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 Coordination 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. Currently, Health Check Coordinators are located in 89 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 interperiodic 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, immunizations, and available programs and services. For children enrolled in a Medicaid managed care program, the name of the Community Care 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.

Local Education Agencies

Medicaid is a critical source of health care coverage for children. Thus in order to assure that a comprehensive array of services is accessible to the children, Medicaid pays for certain health related services provided within the public schools and Head Start Programs. The school setting provides an opportunity to enroll eligible children in the Medicaid program as well as assist children who are already enrolled in Medicaid to access benefits that may be available to them. Medicaid pays for certain health-related services that are provided to these children at considerable costs to State and Local school districts. Direct Medical

Services that are currently available within the LEA and Head Start Program setting are Audiology, Speech/Language, Occupational Therapy, Physical Therapy and Psychological/Counseling Services. Nursing, an additional service is in the process of being added. In addition to providing funding for the direct medical service, Medicaid also provides reimbursement for Administrative activities in support of delivering the direct medical service. Providing funding for these services within the school environment, improves access of these services to eligible children whom otherwise may not be able to obtain these medically necessary services.

Practitioner and Clinical Services

Practitioner and Clinical Services comprise services provided by:

- ambulance services
- ambulatory surgery centers
- anesthesiology services
- birthing centers
- chiropractors
- clinic services
- dialysis services
- labs
- maternity care coordination services
- nurse practitioners
- outpatient hospital services
- physicians
- podiatrists
- radiology services

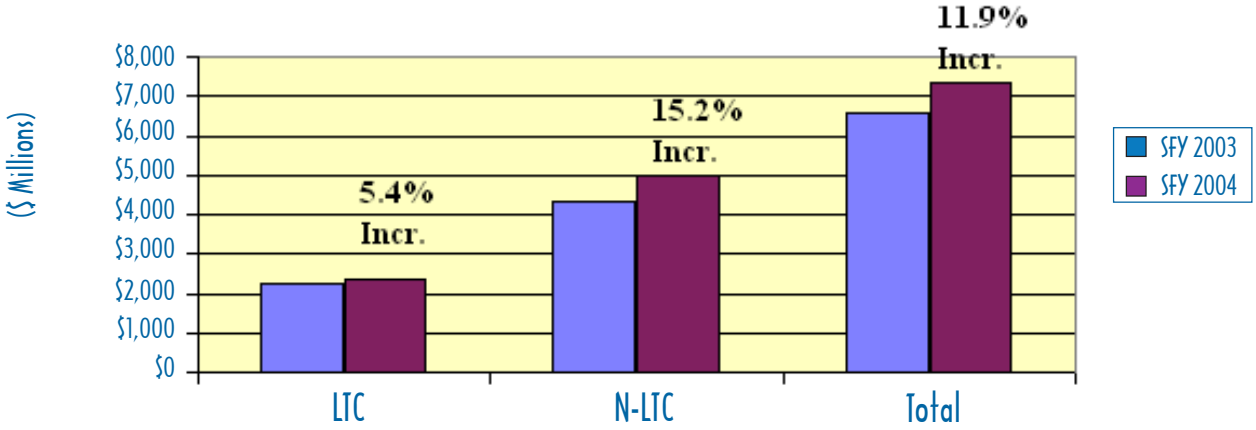
The annual updates of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes occur in this program area. During this fiscal year, staff completed the intense process of documenting all current policies and provided the necessary input for the construction of the new MMIS+ system.

Long Term Care

The N.C. Medicaid program spends a large portion of its service dollars (approximately 32 percent) on long term care. Long term care includes institutional care (all intermediate and skilled nursing facility and hospital long term care) and home and community based care (home health, durable medical equipment, Community Alternatives Programs, home infusion therapy hospice, adult care home and personal care services). As shown in Exhibit B-1, total expenditures for long term care during SFY 2004 were approximately $2.4 billion, an increase of 5.4 percent over the previous year.

Exhibit B-1

NC Medicaid Long Term Care vs. Non-Long Term Care Expenditures – SFY 2003 vs. 2004 ($ Millions)



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) care. Nursing facility reimbursement rates are based on the average state nursing facility per diem rate. The rates are determined by use of the Resource Utilization Groups-III, case mix reimbursement system.

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.

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.

In SFY 2004, a total of 30,602 Medicaid recipients received skilled care in nursing facilities costing $479 million. A total of 21,505 recipients received intermediate care in nursing facilities costing $418 million.

Intermediate Care Facilities for the Mentally Retarded

Intermediate Care Facilities for the Mentally Retarded (ICF-MR) facilities are long term care facilities for the mentally retarded/ developmentally disabled who meet certain federal criteria. The criteria include the need for active treatment for individuals who 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 2004, a total of 4,580 recipients were treated in ICF-MRs at a total cost of $414 million.

Adult Care Home Personal Care Services

Since 1995, NC Medicaid covers Basic Personal Care Services for residents in Adult Care Homes who are eligible for Special Assistance for Adults (SA) and Medicaid. It has covered Enhanced Personal Care Services since 1996 for residents of Adult Care Homes who meet Medicaid criteria for being a "heavy care" resident.

In SFY 2004, a monthly average of 20,060 persons received Basic Personal Care Services at an annual cost of $121 million. Another monthly average of 3,598 North Carolinians received Enhanced Personal Care Services in Adult Care Home settings at an annual cost of $9 million. Additionally, a monthly average of 19,738 persons received non-medical transportation services related to the Adult Care Home program at an annual 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

Home health services include medically necessary skilled nursing care, specialized therapies (physical therapy, occupational therapy, and speech therapy), home health aide services, and medical supplies needed for diagnosis, treatment or rehabilitation of a patient's illness in the home setting when provided by a Medicare Certified Home Health Agency. The services may be provided in the patient's private residence or in an adult care home (exception: home health aide services in the adult care home). The services are considered part time and intermittent and must be under a plan of care authorized by the patient's physician. In SFY 2004, a total of 13,975 recipients were served at a cost of $99 million.

Hospice

Hospice services, which are elected by the recipient, is a benefit package of medical and support services for terminally ill individuals. An individual is considered terminally ill if he or she has a medical prognosis of a six month or less life expectancy as certified by a physician. The services include nursing care, medical social services, counseling, the professional care of a physician, home health aide and homemaker services, physical and occupational therapy, speech-language pathology, medical appliances and supplies, drugs and biologicals, and short-term inpatient care (general and respite) when related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility or a hospice inpatient unit. The services also may be provided in a hospital or nursing facility under arrangement with the hospice agency. In SFY 2004, an average monthly total of 890 recipients were served at an annual cost of $31.6 million.

Home Infusion Therapy

Home Infusion Therapy (HIT) coverage provides for infusion nursing service, pharmacy services, medical equipment, supplies and training. HIT is for self-administration (by the recipient or unpaid caregiver) of a drug or nutrition therapy such as total parenteral nutrition, pain management or antibiotics. The route of administration may be intravenous, enteral, parenteral, intrathecal or epidural. HIT coverage is for recipients who live in a private residence or an adult care home. In SFY 2004, a monthly average of 354 recipients were served at an annual cost of $6.8 million.

Private Duty Nursing

Private Duty Nursing (PDN) coverage is for recipients who live in a private residence and require substantial and complex continuous skilled nursing care as ordered by the attending physician. PDN must be prior approved and be supported by a physician's letter of medical necessity.

Personal Care Services

Personal Care Services (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 are eligible to receive up to 60 hours of PCS per month depending on their needs. Recipients who receive prior approval from DMA may be eligible for an additional 20 hours of PCS if they meet more stringent eligibility criteria. These additional hours are available through the PCS-Plus program.

HIV Case Management

HIV Case Management (HIV CM) is a targeted case management program funded by NC Medicaid. The program is owned jointly by DMA and DPH. While DMA has administrative oversight of the program, the day-to-day operations are managed by the AIDS Care Unit within DPH. In SFY 2004, a monthly average of 1,175 recipients were served at an annual expense of $6.8 million.

Community Alternatives Program

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (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 monthly average of 5,518 people in SFY 2004 at an annual cost of $266 million. The average monthly cost per recipient of CAP-MR/DD services was approximately 40 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

Community Alternatives Program for Children (CAP/C) is a Medicaid waiver program which provides home-based care for medically fragile children through age 18. Participants must meet criteria for medical necessity and must be at risk for institutionalization. CAP/C provides skilled nursing or "in-home" aides, case management and waiver services. The case manager is responsible for developing a plan of care and a budget that is based on the level of care determination. In SFY 2004, a monthly average of 551 recipients were served at an annual cost of $24 million.

New level of care budget limits were established for SFY 2005 at $2,630 for intermediate care, $3,437 for skilled care, and $28,679 for hospital level of care for SFY 2005.

Community Alternatives Program for Persons with AIDS

Community Alternatives Program for Persons with AIDS (CAP/AIDS) provides home based care for persons with AIDS. This waiver program is a cooperative effort between DMA and DPH. The AIDS Care Unit, within DPH, handles the program's operation, including approving plans of care, with DMA providing oversight. Local CAP/AIDS case management agencies are the entry point. There is a federal limit on the total unduplicated number of participants

each year. The program provides an alternative to nursing home placement. To be eligible for participation, the following must meet certain medical criteria. If approved for the program, recipients are potentially eligible for special waiver services in addition to regular Medicaid services. In SFY 2004, a monthly average of 66 recipients served at an annual expense of $1.4 million.

Community Alternatives Program for Disabled Adults

Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults, ages 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. CAP/DA offers North Carolina the only significant avenue for addressing Olmstead issues for the frail elderly and physically disabled adults. The program served a monthly average of 8,799 citizens in SFY 2004 at a yearly cost of $202 million. The legislature continues to support the program and has authorized additional program funding for SFY 2005 which will enable the CAP/DA to serve an additional 2,500 individuals during the year.

Ancillary Services

Durable Medical Equipment

Medicaid pays for Durable Medical Equipment (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 miscellaneous 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.

Independent Practitioner Program

The Independent Practitioner Program 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.

Optical Services

The Optical Services Program 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 NC 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.

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
community-based services for recipients of all ages
residential services for recipients under the age of 21

Clinic services include outpatient therapy and psychological testing provided by directly enrolled providers, hospitals, health departments, physicians, and local education agencies (LEAs). Medicaid also covers inpatient psychiatric care in community hospitals 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. (Refer to the Behavioral Health Prior Approval subsection under the Utilization Management section of Addendum A: How the NC Medicaid Program Works for additional information.)

DMA also provides services in intermediate care facilities for the mentally retarded (ICF-MRs), which are long term care facilities for individuals with mental retardation or a related condition that occurred before the age of 22. (Refer to the Intermediate Care Facilities for the Mentally Retarded (ICF-MR) subsection of the Long term Care section of Addendum B: Initiatives and Subprograms for additional information.)

Dental Health

NC Medicaid covers most diagnostic and preventive dental services such as exams, radiographs, dental cleanings, fluoride treatments, and sealants. Dental restorations, root canals, periodontal services, oral surgeries, and partial and full dentures are covered in addition to orthodontic services for children under age 21 with functionally handicapping malocclusions. Most dental services do not require prior approval. Except where a coverage category is exempted from copayments by law, recipients are charged a $3 copayment per visit. A special children's initiative to decrease the incidence of early childhood caries was implemented statewide effective February 1, 2001. This program, allows children from birth to age three to receive a limited set of preventive dental services provided by specially trained physicians and local health departments.

Pharmacy Services

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 therapyproblems 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. Our DUR vendor contract is with the University of North Carolina School of Pharmacy
- **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 and ad hoc reporting to complement the retrospective patient-based drug utilization reviews. The Provider Profiling System, criteria driven, identifies prescribing and dispensing practices that deviate from accepted norms. These norms may be defined by the Board, taken from published literature or pre-determined standards. The primary focus of the DUR Program is educating providers about common drug therapy problems to improve prescribing and dispensing practices

Outpatient Pharmacy Program

Prescription drugs, insulin, and selected over the counter (OTC) products (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 co-payment of $1 applies for generic and selected OTC 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 except for cases in which medication has been lost. 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. Effective October 2003, Medicaid recipients were able to obtain a 90 day supply of a medication at the discretion of the prescriber if the claim is for a generic, non-controlled maintenance medication (listed on the FUL or SMAC) if the recipient had a previous 30 days fill for the same medication.

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

In November 2003, the State implemented a statewide Prescription Advantage List (PAL). The PAL's methodology is to take the top 15 most costly therapeutic drug classes and place them in 3 tiers according to their net cost to NC Medicaid. This is a voluntary collaborative initiative between all provider groups

Medicare-Aid

In February 1989, the N.C. Medicaid program 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 a new group of Medicare beneficiaries. Referred to as "Qualifying Individuals," they have incomes between 121 percent and 135 percent of the federal poverty level and receive assistance with 135 percent of the federal poverty level and 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-served basis.