Medicaid
in North Carolina

Annual Report
State Fiscal Year 2006

Division of Medical Assistance

Michael F. Easley
Governor

Carmen Hooker Odom
Secretary

L. Allen Dobson, Jr., M.D.
Assistant Secretary for Health Policy and Medical Assistance

Mark T. Benton
Chief Operating Officer

William W. Lawrence, Jr., M.D.
Deputy Director for Clinical Affairs

north carolina medicaid

North Carolina Department of Health and Human Services
Division of Medical Assistance
2501 Mail Service Center • Raleigh, N. C. 27699-2501
Tel 919-855-4100 • Fax 919-733-6608

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary
for Health Policy and Medical Assistance

April 2007

Dear Fellow North Carolinians:

It is my honor to present you with the enclosed copy of the North Carolina Medicaid Annual Report for State Fiscal Year 2006. The report is a testament to the fine work of the staff of the Division of Medical Assistance. I hope you enjoy reading this report, as I have, and gain additional insight into this complex and vital program.

Sincerely,

L. Allen Dobson, Jr., M.D.

Location: 1985 Umstead Drive • Dorothea Dix Hospital Campus • Raleigh, N.C. 27603
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Essential Acronyms

This is a list of the most commonly used and important acronyms in this report. Other acronyms that appear in the report are defined as they were used and were omitted from this list in order to save space.

CAP	Community Alternatives Program; offered for children (CAP/C), disabled adults (CAP/DA and CAP/Choice), persons with mental retardation and/or developmental disabilities (CAP-MR/DD), and persons with AIDS (CAP/AIDS)
CCME	Carolinas Center for Medical Excellence
CCNC	Community Care of North Carolina
CMS	Centers for Medicare and Medicaid Services
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance
DMH	Division of Mental Health, Developmental Disabilities and Substance Abuse Services
DPH	Division of Public Health
EPSDT	Early and Periodic Screening, Diagnosis and Treatment
FFP	Federal Financial Participation
FMAP	Federal Medical Assistance Percentages
FPL	federal poverty level
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
ICF-MR	intermediate care facility for the mentally retarded
IEP	Individualized Education Plan
IFSP	Individualized Family Service Plan
LME	local management entity
NCHC	North Carolina Health Choice
NCPAG	N.C. Physicians Advisory Group
NPI	National Provider Identifier
OTC	over-the-counter (related to drugs)
PASARR	Pre-Admission Screening and Resident Review
PCP	primary care provider
PCS	Personal Care Services

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's goals for SFYs 2005 – 2007 are:

***Budgetary Control** – we will successfully reduce costs and exceed our budgetary targets each year.*

***Management rather than Regulation** – we will establish a culture of proactive health care management rather than a pure regulatory function for the division.*

***Quality Improvement** – we will improve the care provided to Medicaid patients by reducing variability and promoting best practice standards by utilizing & expanding Community Care of North Carolina (CCNC).*

***Accountability** – we will establish a culture of accountability within the agency and with provider groups by benchmarking and measuring all key services. We will aggressively eliminate unnecessary utilization of services and fraud.*

***Customer Service** – we will identify the populations and groups that we serve and strive to meet or exceed agreed-upon expectations.*

***Public Image** – we will improve the public image of the Division and the Medicaid program.*

***Job Satisfaction** – we will make the Division a great place to work, and will find ways to reward our colleagues.*

Executive Summary



The Division of Medical Assistance (DMA), Medicaid's home in the North Carolina Department of Health and Human Services (DHHS), exceeded its budgetary targets, improved its organizational structure and operation and added several new services and programs during SFY 2006. Our major accomplishments included:

- *Finished the year 4 percent or $350 million under budget.*
- *Served more individuals in SFY 2006 (1,673,510) than last year (1,585,238) AND at a lower cost per recipient ($5,129 vs. $5,154 respectively).*
- *Saved, recovered or cost-avoided over $1.1 billion.*
- *Brought an additional 10 counties into Community Care of North Carolina (CCNC) through various networks. Recipient enrollment in CCNC increased 11 percent during the year. A recent actuarial study from Mercer Human Resource Consulting Group found that the CCNC program avoided approximately $124 million during the fiscal year through concerted efforts to control costs.*
- *Responded to the needs of Hurricane Katrina victims by providing essential services to 1,680 evacuees from Louisiana, Mississippi and Alabama.*
- *Received CMS approval on our Disproportionate Share Hospital (DSH) State Plan Amendment (retroactively to October 1, 2005) and reached agreement with several federal agencies regarding DSH payments made during October 1997 through September 2002.*
- *Created two new administrative units, focused on quality management and strategic planning, within the Director's Office.*
- *Implemented a Medicaid Family Planning Waiver for women between the ages of 19 and 55 and men between the ages of 19 and 60 whose incomes are at or below 185 percent of the federal poverty level.*
- *Successfully transitioned approximately 30,000 children, ages 0 – 5, to Medicaid from the N.C. Health Choice program.*
- *Established several new enhanced mental health services and received CMS approval to renew our Community Alternatives Program for the Mentally Retarded and Developmentally Disabled.*
- *Recognized a DMA employee as the first graduate of LeadershipDHHS, a six-month program designed to identify and introduce tomorrow's leaders to the issues and challenges facing the Department.*

For the year ending June 30, 2006, the N.C. Medicaid program served one out every eight citizens – or approximately 18.5 percent of the total population. The number of Medicaid recipients grew by 2.5 percent over the previous year, as compared to a 1.6 percent increase in the overall state population. Statistical highlights of our expenditure and recipient data include:

- *1,673,510 individuals received at least one service during the year (an unduplicated count)*
- *$8.6 billion was expended on health services and premiums.*
- *The two largest eligibility categories were "Pregnant Women and Children" and "Aid to Families with Dependent Children" (AFDC).*
- *Prescription drugs were the most expensive category at roughly $1.4 billion (before drug rebates) – which accounted for 16 percent of total expenditures. This was a decrease*

of almost 17 percent from the previous fiscal year which was largely due to the implementation of the Medicare Part D program.

- *While total service and premium expenditures increased by 5.1 percent, per-recipient service and premium expenditures actually decreased by 0.5 percent below the SFY 2005 level.*
- *Elderly and disabled recipients comprised 12.5 percent and 15.9 percent of total recipients, respectively; however, service expenditures for these two groups amounted to approximately $5.8 billion, or 69 percent of total Medicaid expenditures.*
- *Recipients from the families and children group represented approximately 69 percent of all recipients but accounted for approximately $2.6 billion, only 31 percent, of total service expenditures.*

Major Accomplishments

Numerous operational improvements and special initiatives were either implemented during the past fiscal year or are still in progress.

DMA Budget

During SFY 2006, N.C. Medicaid spent $350 million, or about 4 percent, less in provider payments than budget writers had anticipated. The reduced spending was largely the result of increased enrollment in managed care networks, prescription drug savings, monitoring of in-home PCS and other cost-cutting initiatives. Annual Medicaid expenditures were only 3.89 percent higher than those of the previous year.

Hurricane Relief

In response to the destruction resulting from Hurricane Katrina in September 2005, N.C. Medicaid helped to coordinate efforts to provide essential services for Medicaid recipients who evacuated to North Carolina from Louisiana, Mississippi and Alabama. A special Katrina Medicaid waiver program was established by the U.S. Congress under the authority of the Deficit Reduction Act of 2006 in order to provide guidance and financial assistance to the 32 states that hosted Katrina evacuees. Applicants who met North Carolina eligibility requirements became eligible for five months of Medicaid or NCHC coverage for the period of September 1, 2005, through January 31, 2006. The waiver covered low-income children, parents, pregnant women, the elderly, individuals with disabilities and those in need of long-term care. The waiver allowed for coverage to evacuees who already had Medicaid in their home state as well as those who may not have qualified before the storm, but who lost everything to it. N.C. Medicaid provided benefits that were equivalent to or better than the benefit package of a recipient's home state Medicaid program. DMA enrolled a total of 1,680 recipients and was reimbursed by the federal government for approximately $1.5 million in related Medicaid service expenditures.

Collections and Cost Avoidance

Efforts of the staff in the Program Integrity Section saved, recovered or avoided N.C. Medicaid costs of more than $1.1 billion during SFY 2006. Recoveries and cost avoidance savings were accomplished through reviews of provider billings and medical records, coordination with other insurers and payors where Medicaid was not the primary payor, estate recovery and legal and civil actions carried out cooperatively by federal, state and local law enforcement.

Recoveries	**SFY 2006**	**SFY 2005**	**% Change**
Medicare	$ 7,261,493	$ 4,864,745	49
Health Insurance	21,039,509	24,242,991	(13)
Casualty Insurance	19,241,466	16,917,611	14
Estate Recovery	10,210,409	8,430,611	21
Totals	**$57,752,877**	**$54,455,958**	**6**

Cost Avoidance	**SFY 2006**	**SFY 2005**	**% Change**
Medical Insurance Avoided	$ 192,113,800	$ 207,900,683	(8)
Medicare Avoided	642,852,073	578,496,817	11
Insurance Payments Reported on Claims	273,172,044	266,516,819	2
Totals	**$1,108,137,917**	**$1,052,914,319**	**5.2**

Additionally:

- *Efforts by Program Integrity's four provider investigative units resulted in the recovery of $10,278,091 and costs avoided of $29,470,239. Costs avoided include the following:*
  - hospice edit savings
  - drug limits that were implemented in conjunction with Pharmacy Clinical Policy to avoid rebate disputes and incorrect pharmacy billings as identified by Program Integrity's Pharmacy Review Section
  - removal of sanctioned providers by Provider Enrollment and recovery of any Medicaid payments that were made to sanctioned providers
  - warning letters sent to providers ordering them to stop specific abusive practices
- *N.C. Medicaid was recently hailed as a model for effective use of edits and audits that prevent abuses of the Medicaid pharmacy benefit.*
- *Program Integrity referred 46 cases to the Attorney General's Medicaid Investigations Unit.*
- *Recipient fraud investigators in the local departments of social services recovered $1,577,152 in overpayments in N.C. Medicaid. The state assisted county investigators in collecting an additional $183,665 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 DMA's Recipient Services staff and the county departments of social services.*

During the year, Health Management Systems (HMS) became the Program Integrity Section's new contractor, providing primary contributions with additions of new insurance

policies and assisting our Casualty Unit with increased recoveries. HMS also provided credit balance reviews, which led to increased credit balance reporting by providers.

With the implementation of a fraud and abuse detection software system, and the continuing commitment and competence of its staff, the Program Integrity Section has significantly improved its efficiency in detection, investigation and recovery.

Medicaid Payment Error Rate

Federal Medicaid Payment Error Rate Measurement (PERM) Project

Effective November 4, 2005, CMS required states to conduct error rate measurements for both Medicaid and the State Children's Insurance Program (SCHIP) in accordance with the Improper Payments Information Act of 2002. CMS has engaged three national contractors to conduct the claims review process: a statistical contractor for sampling and error rate calculation; a documentation/database contractor to gather medical policy, medical records and other information from states; and a medical records review contractor to use the information collected by the documentation/database contractor to perform the reviews and provide findings to the statistical contractor. The state will be required to provide the contractor with quarterly claims information, provider contact information, medical and other related policies, current managed care contracts and rate information, data processing systems manuals, repricing information for claims, information on claims that substantively changed after selection, adjusted claims and any other information determined necessary by the contractor in estimating improper payments and determining the error rate. Results of the reviews will provide the basis for state-specific error rates, upon which the national improper payment error rates for both Medicaid and SCHIP will be determined. States will be selected once every three years for review of Medicaid and SCHIP fee-for-service claims, managed care payments and eligibility reviews. DMA will participate in the federal fiscal year 2007 sampling and will address any identified claim errors, reprice claims, recover claim overpayments, review eligibility determinations and develop corrective action plans to address causes of improper payments.

State Auditor's Annual Measurement of Medicaid Payment Errors

Program Integrity assists the Office of the State Auditor in determining the Medicaid program accuracy rates for claims billed by providers to Medicaid. In partnership since 1996-97, Program Integrity has annually reviewed a stratified sample of paid claims to determine the accuracy of system payments. In addition to processing claim reviews, nurse reviewers request provider medical records to substantiate the medical necessity of recipient services. Below is a partial chart of the error rate findings for this year and previous years.

Exhibit 1

Annual Error Rates for Claims Billed to Medicaid SFYs 2001 – 2006

State Fiscal Year	# Claims in Sample	Error Rate per OSA	Confidence Level	Sampling Precision
2000-01	300	0.80%	95%	+/-0.04
2001-02	270	2.80%	95%	+/-0.04
2002-03	272	1.78%	95%	+/-0.04
2003-04	273	3.33%	95%	+/-0.04
2004-05	270	4.21%	95%	+/-0.04
2005-06	In Progress			

Disproportionate Share Hospital Issues

On December 15, 2005, CMS approved DMA's Disproportionate Share Hospital (DSH) State Plan Amendment retroactively to October 1, 2005. This plan incorporated the certification of public hospital annual expenditures (CPEs) on behalf of Medicaid recipients and the uninsured as the basis for earning federal matching funds for public hospitals in N.C. Medicaid's DSH Program. North Carolina was the first state to successfully implement this approach, which has become the model that CMS offers to other states seeking to use a similar method.

On August 18, 2006, DMA reached a settlement agreement with CMS, the U.S. Department of Justice and the U.S. Office of Inspector General covering all DSH payments made during the period October 1, 1996, through September 30, 2002. The investigation found that, except for the delay of annual settlements and data errors resulting in the agreed payback, the issues raised in the State Auditor's report for SFY 2003 were unfounded.

National Provider Identifier Project

The National Provider Identifier (NPI) is a unique 10-digit number that will replace the various existing national, state and proprietary provider identifiers, including the Medicaid provider number. NPI is the result of the mandate in the 1996 Health Insurance Portability and Accountability Act (HIPAA) that the NPI be used as the sole provider identifier on all HIPAA electronic transactions. Though mandatory use of the NPI is not required until May 2008, DMA staff made a great deal of progress in preparation for the transition. This has included making changes within the Medicaid Management Information System (MMIS) and collecting the NPIs of the thousands of Medicaid providers in North Carolina.

Family Planning Waiver

During SFY 2006, DMA implemented a Medicaid Family Planning Waiver for women between the ages of 19 and 55 and men between the ages of 19 and 60 with incomes at or below 185 percent of the federal

poverty level. Under the waiver, recipients are eligible to receive the following services:

- *annual family planning exams*
- *most types of birth control*
- *testing for pregnancy*
- *testing for sexually transmitted infections*
- *assistance in planning when to have a baby*
- *voluntary sterilization.*

The goal of the waiver is to reduce unintended pregnancies and improve the well-being of children and families in North Carolina.

CAP-MR/DD Waiver

CAP-MR/DD served approximately 10,000 people during SFY 2006 through local area mental health, developmental disabilities and substance abuse programs. The waiver is administered on a daily basis by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) under the authority of a memorandum of agreement with DMA to provide oversight and monitoring functions. DMH/DD/SAS and DMA are committed to making services and supports for adults and children with developmental disabilities available in the communities of their choice. This commitment is consistent with North Carolina's continuing efforts to reform the public mental health, developmental disabilities and substance abuse services system. The goals of the CAP-MR/DD program are to:

- *address the needs of individuals in their community*
- *ensure person-centered planning for each individual*
- *provide for simplicity and ease of service delivery*
- *lift the individual fiscal limit on available services and supports*
- *promote movement of individuals to the community from ICF-MRs, group homes and state developmental centers.*



Direct Enrollment of Mental Health Providers

The Recipient and Provider Services Section continued its efforts to improve the process for enrolling mental health care providers in N.C. Medicaid. DMA began enrolling the following as Medicaid providers: licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, certified clinical addiction specialists and certified clinical supervisors. Independent providers were enrolled beginning in January 2005; those employed by mental health centers, health departments and hospitals began to enroll in SFY 2006.

Quality and Health Care Outcome Improvements

In SFY 2006, the Quality Management (QM) Unit within DMA's Managed Care section continued efforts in quality improvement through studies and initiatives, including the evaluation of the Open Access collaborative, the use of preventive services by Children with Special Health Care Needs (CSHCNs) and the Healthy Development Collaborative. The QM Unit worked with the DMA Information Systems staff to report a subset of Medicaid health outcome data using the nationally accepted standards of the Health Plan Employer Data and Information Set (HEDIS). In October 2005, the QM staff submitted a Quality Strategy update to CMS for the Mecklenburg County HMO and Piedmont Behavioral Healthcare. Results of completed studies, initiatives and updates may be found under Publications – Quality, Evaluation and Health Outcomes (QEHO) Unit on the DMA Web page at www.ncdhhs.gov/dma/ca/qm.htm.

Community Care of North Carolina (CCNC)

CCNC made significant progress during SFY 2006, including the following highlights.

Cost Avoidance
A recent actuarial study from Mercer Human Resource Consulting Group found that the CCNC program avoided approximately $124 million during the fiscal year through concerted efforts to control costs.

Network and Enrollment Issues
An additional 10 counties were added through various networks (96 counties are currently part of CCNC), and recipient enrollment increased 11 percent during the year. NCHC children ages birth through 5 years were transitioned to Medicaid beginning in January 2006. By June, 71 percent of the eligible children had enrolled in CCNC practices.

Program Activities
CCNC implemented its program priority activities in all expansion counties. These activities included asthma and diabetes disease management, case management for high-risk populations and management of emergency room visits and pharmacy utilization.

The Diabetes Disparities pilot is entering its third year with positive results. This initiative focuses on community outreach and self-management education, targeted towards minority populations in several networks.

Six networks are now providing case management to the CAP/Children (CAP/C) recipients in their counties at the request of DMA. The CAP/C program targets the frailest children: those who are eligible for hospital or nursing facility levels of care.

PrimeCare, a pilot in ACCESS II Care of Western N.C., demonstrated that a non-specialist case manager within the primary care provider (PCP) practice could be effective in helping to care for recipients with depression. Expansion of this model is under way.

A provider satisfaction survey was conducted in the summer of 2005 to allow physicians to express their views on the strengths and weaknesses of the CCNC program. A sample of physicians was chosen from each network. The survey response rate was 24 percent. The results demonstrated a positive perception of CCNC and the disease management initiatives.

Several networks continued in the Sickle Cell Disease Management Pilot, which was created to address related primary care best practices, emergency department utilization, case management and care coordination.

Four CCNC networks launched Mental Health Integration pilot initiatives in conjunction with local management entities (LMEs). These initiatives provide integrated health care to clients with dual medical and mental health needs and are focusing on the integration of depression care with primary care. The networks created protocols for screening, referral and services to serve this population. Depending upon an evaluation of the initiative, this model could be expanded to the entire CCNC system of care in the future.

Promoting Healthy Weight in Kids through Primary Care, another pilot project, was completed this past year. Practical tools and interventions for the prevention and management of childhood obesity in children ages 0 through 12 years were tested in the Pediatrics Continuity Clinic at UNC-Chapel Hill and in

four AccessCare community practices. Development of the tools was a collaborative effort among AccessCare, the UNC-Chapel Hill Center for Health Promotion and Disease Prevention (HPDP) and the Division of General Pediatrics and Adolescent Medicine in the Department of Pediatrics at UNC-Chapel Hill. Preliminary results have led to refinement of tools and interventions. A National Institutes of Health grant to HPDP will allow expansion and further testing of tools and strategies in about two dozen practices in the CCNC networks.

Five networks piloted a chronic obstructive pulmonary disease (COPD) program based upon the CCNC Asthma Disease Management Program. They developed guidelines, performance measures, an assessment and a quality of life tool to assist in the care and management of their patients with COPD.

The Healthy Communities Access Program (HCAP), providing health care to uninsured people, is under way in five networks. Through the use of the Case Management Information System (CMIS), the networks enroll, assess, case manage and gather encounter data for the care of the uninsured in their counties.

Two networks are piloting group medical visits for their diabetic population. These extended office visits meet the physical, medical, educational, social and psychological concerns of 10 to 20 patients in a two-hour period.

In the fall of 2005, CCNC launched its Web site, www.nccommunitycare.com.

Performance Indicators

All audited program-wide initiatives are conducted at the practice level. Results of the diabetes audit from the fall of 2005 showed an increase in foot and monofilament exams and consistently reported blood pressure readings at every continued care visit. The Diabetes Disparities pilots have demonstrated a steady decrease in HbA1C values, indicating that patients are managing their blood sugar levels and maintaining better glycemic control.

The latest asthma audit results showed increases in both the number of patients with action plans and the number of patients who received a flu vaccine. Results have consistently demonstrated that more than 90 percent of patients with persistent disease are prescribed appropriate medications.

Over-the-counter (OTC) non-sedating antihistamine prescription use has increased by 83 percent, and overall OTC prescribing is increasing as availability issues are being resolved.

Of the high-risk patients identified by the Case ID Database, 49 percent (14,196 patients) were evaluated for case management status.

Division of Medical Assistance Customer Service

In keeping with the department's goal of quickly identifying customers and providing excellent customer service, DMA has created a Customer Service Center within the Managed Care Section. Medicaid recipients are the center's primary customers. The center receives and responds to inquiries about Medicaid-covered services and administrative procedures. The center coordinates resources and information with the Office of Citizen Services to address the needs of the callers. Lastly, the center provides outreach to enrollees and potential enrollees of CCNC and Carolina ACCESS for the purpose of providing education, maximizing enrollment and maximizing cost savings through a knowledgeable client population.

LeadershipDHHS Program Graduate

Tracy Colvard became DMA's first graduate of the department's LeadershipDHHS program, a six-month program designed to identify and introduce tomorrow's leaders to the issues and challenges facing the department. Some of the key program areas and challenges reviewed by this class included:

- *the budget process*
- *how DHHS influences legislation*
- *current DHHS initiatives*
- *setting performance expectations*
- *state events and trends that affect the department.*

How the N.C. Medicaid Program Works

Brief History

The state of North Carolina submitted its original Medicaid State Plan to the Health Care Financing Administration (now known as CMS or the Centers for Medicare and Medicaid Services) in 1969 and, following federal approval and legislative action, our Title XIX program was implemented on January 1, 1970.

Initially, North Carolina's Medicaid program was administratively housed under the Division of Social Services (DSS), but was transferred in 1978 to the newly established Division of Medical Assistance (DMA), where it has remained. The Medicaid program has always been a component of the North Carolina Department of Health and Human Services (DHHS).

The enabling state legislation for the N.C. Medicaid program can be found in Chapter 108A of the General Statutes. Administrative rules are located in North Carolina Administrative Code (NCAC), Title 10A, Chapters 21 and 22. And clinical coverage policies may be found at DMA's Web site (www.ncdhhs.gov/dma/mp/mpindex.htm). Each year, new legislation is passed by the N.C. General Assembly related to eligibility thresholds, covered services and reimbursement standards. Legislation could also address expansion of eligibility or benefits, special studies and management and administrative mandates.

Note: For additional information about the history of N.C. Medicaid and a year-by-year record of program and policy changes, please refer to DMA's Web site at www.ncdhhs.gov/dma/publications.htm to read "History of the North Carolina Medicaid Program."

Exhibit 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: www.cms.hhs.gov/MedicaidGenInfo/01_Overview.asp#TopOfPage

For state-specific information, please refer to CMS's publication "Medicaid At-a-Glance 2005" at: www.cms.hhs.gov/MedicaidGenInfo/Downloads/MedicaidAtAGlance2005.pdf

Medicaid Eligibility

N.C. Medicaid provides funding for health care coverage to individuals who are eligible for one of the "mandatory" or "optional" Medicaid coverage groups (see Exhibit 3) and who also have low income and resources. Medicaid caseworkers in each of the 100 county departments of social services are responsible for determining an individual's eligibility for Medicaid benefits based on policies established by the federal and state governments.

Eligible families and individuals enrolled in N.C. Medicaid are issued a Medicaid identification card each month. These individuals can receive medical care from approximately 57,000 providers enrolled in the Medicaid program. Providers submit claims to the DMA fiscal contractor for reimbursement of services they provide to the Medicaid population.

Exhibit 3

N.C. Medicaid Eligibility by Mandatory and Optional Groupings

MANDATORY

- Aged, blind and disabled persons receiving Supplemental Security Income (SSI)
- Medicare beneficiaries up to 100 percent of the federal poverty level (FPL) qualify for Medicare cost-sharing
- Medicare beneficiaries between 101 percent and 135 percent FPL qualify for payment of Part B premium; however, total enrollment is capped by the amount of appropriated federal funds for beneficiaries with incomes between 121 percent and 135 percent FPL
- Pregnant women and infants (under the age of 1 year) up to 150 percent FPL
- Children ages 1 through 5 years whose families are at or below 133 percent FPL
- Children ages 6 through 18 years up to 100 percent FPL (mandatory as of October 1, 2001)
- Families with children under the age of 19 years who would have been eligible for Aid to Families with Dependent Children (AFDC) in July 1996
- Foster children and adoptive children under Title IV-E

OPTIONAL

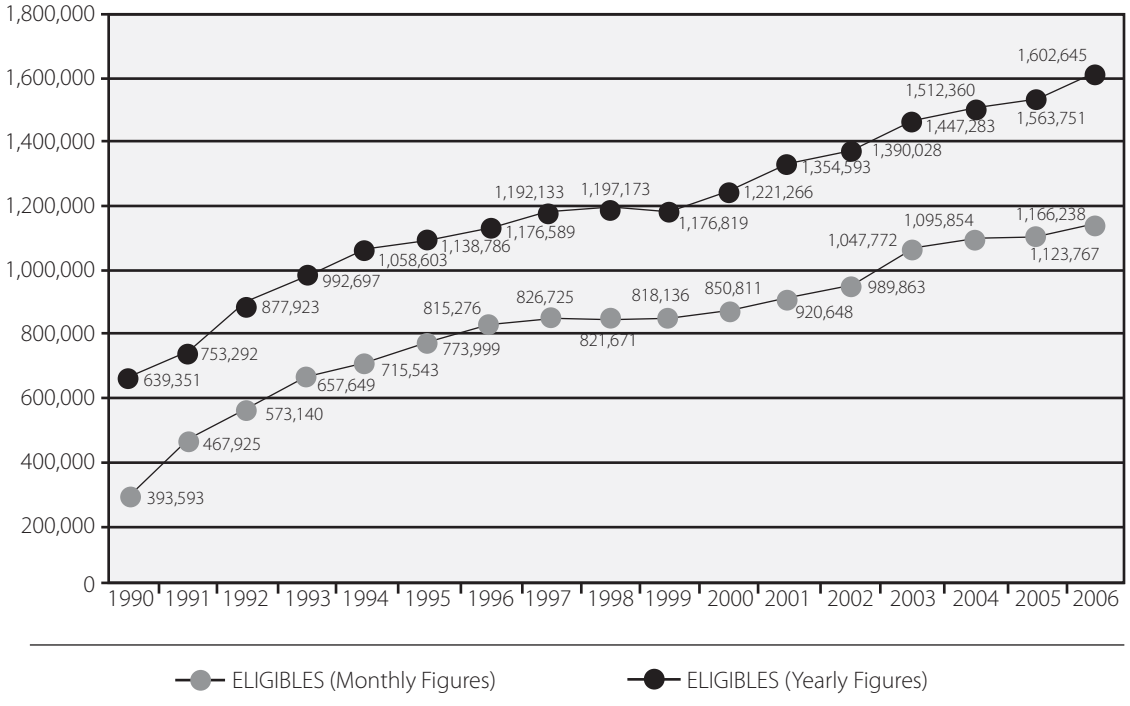
- Aged, Blind and Disabled not receiving SSI, including adult care home residents, 100 percent FPL poverty eligibles and medically needy
- Pregnant women and infants up to 185 percent FPL
- Children ages 19 and 20
- Non-IVE foster children and/or adoptive children with parents in families not eligible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

A more detailed list of N.C. Medicaid's eligibility groups can be found in Table 2a, "NC Medicaid Eligibility during SFY 2006." This chart provides a high-level overview of our basic eligibility requirements, income and resource limits, deductible or spend-down requirements and any applicable special provisions.

In 1978, at the time the N.C. Medicaid program was transferred to the newly created Division of Medical Assistance, an annual total of roughly 456,000 individuals were determined eligible. That number has at times fallen, but has mostly risen through the years. For SFY 2006, a total of 1,602,645 individuals were determined eligible for Medicaid. A more detailed snapshot of the growth in eligibility from 1990 to the present can be found in Exhibit 4 (on the following page). That table depicts two numbers: the average monthly number of eligibles and the unduplicated annual number of eligibles. The annual number of eligibles is higher than the monthly average due to new eligibles entering the program and existing eligibles exiting the program.

Exhibit 4

History of Average Monthly Medicaid Eligibles and Yearly Medicaid Eligibles



Funding the N.C. Medicaid Program

Federal, state and county governments jointly finance the N.C. Medicaid program, with the federal government paying the largest share of the costs. The federal share is established annually by CMS and is based upon the most recent three-year average per capita income for the state and the national per capita income. As a state's per capita income rises, the federal match for Medicaid will decline – requiring the state (and in North Carolina, the counties) to increase their share of Medicaid payments. The rate of federal reimbursement ranges from a low of 50 percent to a high of 75 percent.

The established federal matching rates for services (Medicaid payments to providers) are applicable to the federal fiscal year (FFY), which is October 1 to September 30 – not the state fiscal year (SFY), which runs July 1 to 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. Table 1 details the federal, state and county reimbursement rates for SFY 2006.

In North Carolina, the legislature requires our 100 county governments to contribute to the non-federal share of Medicaid costs. Those county costs are generally limited to 15 percent of the non-federal share, with the state picking up the remaining 85 percent.

During the 2006 Session of the General Assembly, legislation was passed that provided for one-time, non-recurring assistance to the counties by capping the share of each county at the amount it paid in SFY 2006.

Some of N.C. Medicaid's recipients are subject to a modest "copayment." These copayments do not apply to recipients who are under the age of 21, those who are enrolled in the Community Alternatives Program (CAP), those receiving services related to pregnancy or those receiving family planning services. Our copayment requirements can be found in Table 15 of this report.

Medicaid Covered Services

N.C. Medicaid covers a comprehensive array of "mandatory" and "optional" services for eligible enrollees (see Exhibit 5). Preventive services include one annual physical for adults as well as child health screenings provided under the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program, known in our state as the "Health Check" program. Treatment services address virtually all acute and chronic illnesses.

Medicaid has certain standard limitations on services. These include limits on ambulatory visits per year to practitioners, clinics and outpatient departments. Prenatal services, dental services and mental health services that are subject to independent utilization review are not subject to this limit. Exemptions from this limit include services provided to recipients:

- *with end-stage renal disease*
- *undergoing chemotherapy and/or radiation therapy for malignancies*
- *with sickle cell disease*
- *with hemophilia or other blood clotting disorders*
- *under the age of 21*
- *enrolled in a CAP.*

Medicaid recipients are limited to eight prescriptions per month. However, recipients under the age of 21 and recipients enrolled in CAP are not subject to this limitation. And recipients being treated for one of the following conditions may also be exempted from the dispensing limitation if it is deemed medically necessary by the recipient's primary prescribing physician:

- *end-stage renal disease*
- *malignancies requiring chemotherapy and/or radiation therapy*
- *sickle cell disease*
- *hemophilia or other blood clotting disorders*
- *unstable diabetes*
- *end-stage lung disease*
- *terminal stage of any illness or any life-threatening illness.*

Exhibit 5

Services Covered by N.C. Medicaid, by Mandatory and Optional Categories

MANDATORY	OPTIONAL SERVICES
• Hospital Inpatient	• Clinical Services
• Hospital Outpatient	• Community Alternatives
• Psychiatric Residential Treatment Facility Services and Residential Services (treatment component only) for under age 21	• Diagnostic Testing
• 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 and Occupational Therapy and Speech/Language Pathology
• Medical Transportation	• Respiratory Therapy for Children
• Federally Qualified Health Centers & Rural Health Centers	• Hospice
	• Private Duty Nursing
	• Home Infusion Therapy
	• Case Management
	• Nurse Anesthetist
	• Preventive Services
	• Rehabilitative Services
	• Orthotic and Prosthetic Devices
	• Screening
	• Transportation
	• HMO Membership

Note: All optional services are available to children under age 21 if they are medically necessary.

Medicaid Expansion in SFY 2006

DMA is also responsible for administering Title XXI of the Social Security Act, known in this state as "N.C. Health Choice" (NCHC). This program was implemented in 1998 and, unlike Medicaid, is not an entitlement program. NCHC has experienced great success in providing health coverage for children of families unable to afford private coverage but who are not eligible for Medicaid.

Due to impending shortfalls in federal funding, the N.C. Legislature made changes to the program to ensure that the most vulnerable children continue to have health insurance coverage while maximizing limited funds. Session Law 2005-276 mandated that NCHC participation be limited to eligible children age 6 through 18 years, and that children age 0 to 5 (once served by NCHC) be transferred to the Medicaid program. That transition occurred on January 1, 2006.

To further ensure the long-term viability of the NCHC program, enrollment growth was capped at 3 percent every six months (or 0.5 percent each month) and the reimbursement rates paid to NCHC providers would be stepped down to the rates paid by Medicaid. As of July 1, 2006, NCHC providers were paid at 100 percent of the Medicaid reimbursement rate.

Medicaid Clinical Policies and the NCPAG

The North Carolina Physician Advisory Group (NCPAG) is a not-for-profit association that plays an important role in Medicaid medical coverage policy and system reform. Chapter 108A-54.2 of the N.C. General Statutes requires DMA to consult with and seek the advice of the NCPAG during the development of medical coverage policy or amendment to existing medical coverage policy.

The NCPAG membership includes more than 170 professionals from a wide array of disciplines comprising voting and non-voting members, consultants and staff. Medical coverage policies are reviewed in either standing committees or ad hoc committees, often assisted by a consulting council, and must be board-approved in order to be recommended to DMA.

During SFY 2006, the NCPAG reviewed and recommended a total of 22 Medicaid policies covering a wide range of clinical services at the request of DMA and DHHS. More than 85 percent of the policies were reviewed and approved by the NCPAG

within three months of initial presentation from DMA to the NCPAG. The majority of these policies were then posted to DMA's Web site for public comment within two months of receiving the NCPAG's recommendations.

DMA's clinical coverage policies are located at our Web site (www.ncdhhs.gov/dma/mp/mpindex.htm).

Medicaid Providers

Approximately 57,000 providers were enrolled in the N.C. Medicaid program during SFY 2006. That number represented an increase of 4.6 percent over the previous year's enrollment of 54,206. A detailed listing by provider type can be found in Table 3.

To enroll in the N.C. Medicaid program, providers must submit specific applications by the particular provider type and specific services that are to be provided. Enrollment guidelines and applications are posted on the DMA Web site at www.ncdhhs.gov/dma/provenroll.htm. The enrollment process takes four to six weeks.

Upon enrollment, providers receive written notification confirming their enrollment, indicating their new Medicaid number(s) and sharing initial instructions on claim submission and other administrative matters. Enrollment periods vary by provider type and, once enrolled, providers are responsible for maintaining the required licensure and accreditation specific to their provider type to remain qualified as N.C. Medicaid providers. Enrolled providers are also responsible for ensuring that information on file with the Medicaid program for their practices or facilities remains up-to-date.

Medicaid Program Integrity

DMA's Program Integrity Section is tasked with the responsibility for: identifying provider fraud and abuse; assisting county departments of social services (DSS) with identifying recipient fraud and abuse; and determining the accuracy of Medicaid eligibility determinations and Medicaid provider payments.

Chief accomplishments of the Program Integrity Section during SFY 2006 include:

- *Efforts by Program Integrity's four provider billing investigative units resulted in the recovery of $10,278,091 and costs avoided of $29,470,239.*

- *Program Integrity referred 46 cases to the MIU during SFY 2006. By federal statute, any cases where the provider is suspected of fraud must be referred to the Medicaid Investigations Unit (MIU) within the Attorney General's Office.*

- *Recipient fraud investigators in the local DSS offices recovered $1,577,152 in overpayments. The state assisted county investigators to collect an additional $183,665 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 as reported by the North Carolina Office of State Auditor. Program Integrity's Medicaid Eligibility Quality Assurance Unit reviews a sample of all Medicaid cases statewide and provides helpful feedback for corrective action to DMA's Recipient Services staff and the county DSS.*

- *DMA's Third Party Recovery (TPR) Unit increased its recoveries from Medicare by 49 percent and Estate Recovery by 21 percent over the previous year. These and other recoveries saved the Medicaid program $57,752,877. TPR also implemented cost avoidance procedures that totaled $1,108,137,917, a 5.2 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.*

- *N.C. Medicaid was recently hailed as a model for effective use of system edits and audits that prevent potential abuses of the Medicaid pharmacy benefit.*

Medicaid Eligibility Error Rate Reduction and Quality Assurance

Program Integrity's Quality Assurance (QA) Section is responsible for monitoring the accuracy rate of eligibility determinations made by North Carolina's 100 county departments of social services. The QA staff conducts both federally mandated quality control reviews and state-designed targeted reviews. This review process looks at active, terminated and denied cases. Error trends, error-prone cases and other important error reduction information are communicated quickly to eligibility staff within DMA. DMA then works with the county departments of social services to promote and develop 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 3 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 county departments of social services.

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

Investigation of Provider Fraud, Abuse and Administrative Errors

Program Integrity staff use sophisticated computer software in a unique fraud and abuse detection system. The software identifies unusual patterns of utilization of services by recipients and providers. Medical desk reviews or site visits are conducted for those providers or recipients whose medical practice or utilization of services appears to be outside of 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 suspected 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 provider fraud or abuse is suspected, the Attorney General's Medicaid Investigations Unit reviews it for criminal or civil prosecution. Cases of suspected recipient fraud are investigated by the local county DSS.

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 The Carolinas Center for Medical Excellence (CCME) to evaluate diagnosis-related group (DRG) coding to identify improper reimbursement maximization and other potentially fraudulent billing practices. In addition, paid claims are reviewed periodically. Those claims 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 federal 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.

Medicaid Rate Setting

Each year, the N.C. Medicaid program reviews, monitors and/or adjusts approximately 500,000 rates. These rates apply to almost 200 different billing specialties with more than 100 different provider types. Understandably, rate-setting plays an important role in determining how much the Medicaid program will cost each year. Taking into account the level of funding provided by the N.C. General Assembly, reimbursement rates are established according to federal and state laws and regulations.

At the direction of the N.C. General Assembly, Medicaid operated under a rate freeze for SFY 2006. Exceptions to the rate freeze were considered and approved by the DHHS Rate Review Board.

Medicaid Audit

The Medicaid Audit Section is responsible for audits and reviews of annual Medicaid cost reports submitted by various provider types including hospitals, nursing facilities, intermediate care facilities for mental retardation, federally qualified health centers, rural health clinics, public health departments, local management entities and state-owned and operated institutions. These audits and reviews are conducted to effect cost settlements with certain provider types allowed by the State Plan and to ensure that Medicaid reimbursements to providers are based on reasonable and allowable costs as defined by state and federal regulations.

☑ During this fiscal year, internal and contracted audit staff completed more than 800 audits and settlements.

Medicaid Utilization Management (UM) and Prior Approval (PA)

Utilization management (UM) activities ensure optimal health care delivery in a cost-effective manner to Medicaid-eligible individuals. These activities are conducted jointly by DMA and the fiscal agent or other DMA contractors. Utilization management is used in order to verify medical necessity and to authorize services, including ensuring that continuing care is provided appropriately and effectively. For example, all admissions to psychiatric hospitals are reviewed by ValueOptions. A Special Bulletin on this topic was published in July 2006 and is available at www.ncdhhs.gov/dma/bulletin/UR.pdf.

Prior approval may be required in order to verify the medical necessity of some services prior to being rendered. 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:

- *certain prescription drugs*
- *behavioral health*
- *outpatient specialized therapies*
- *managed care referral authorization and utilization management*
- *certain surgeries, including transplants*
- *visual aids*
- *hearing aids*
- *certain durable medical equipment items*
- *dental services*
- *out-of-state services*
- *nursing facilities*
- *CAP*
- *adult care home enhanced personal care services*
- *private-duty nursing*.

Nursing Facility Prior Approval

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 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, N.C. Medicaid is federally 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 in 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 who enter or reside 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.

N.C. 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, signed and dated by the physician and then sent to EDS, DMA's fiscal intermediary, 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.

Prescription Drug Prior Approval

Since SFY 2002, DMA has contracted with ACS State Healthcare in Atlanta, Ga., to manage a prior approval process for certain prescription drugs. These prescription drugs were chosen based on clinical criteria established by a panel of clinical and academic physicians and pharmacists. Prior authorization allows N.C. Medicaid to ensure that these prescription drugs are used responsibly and as intended. The prescription drugs that currently require prior authorization are:

- *Procrit, Epogen and Aranesp*
- *Neupogen*
- *OxyContin*
- *growth hormones*



- *Provigil*
- *Celebrex*
  (for persons 59 years of age or younger)
- *Botox and Myobloc*
- *sedative hypnotics.*

Behavioral Health Prior Approval

ValueOptions (VO) provides utilization review activities for mental health services, certain developmental disabilities services and substance abuse services for several agencies (N.C. State Employees' Health Plan and N.C. Health Choice), including Medicaid. VO may authorize mental health and substance abuse services to recipients throughout the state except for those who reside in the Piedmont catchment area due to their coverage under the Piedmont Mental Health Managed Care Waiver.

Outpatient services for recipients under the age of 21 years include 26 unmanaged outpatient visits per calendar year. Prior authorization must be obtained prior to the 27th visit. For recipients age 21 and over, outpatient services include eight unmanaged visits per calendar year. Prior authorization must be obtained after the eighth visit.

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/language, respiratory and audiological therapy, regardless of where the services are provided. Prior approval is also applied to psychological services in schools through use of the Individualized Education

Plan (IEP) process. All other prior approval functions are carried out through a contract with CCME. The CCME Prior Approval Unit is authorized to approve, modify or deny the request based on DMA's clinical policy, approved medical necessity criteria and medical judgment. Validation reviews are performed by CCME and review findings are sent to DMA on a quarterly basis.

CAP/DA Utilization Review

CCME quality assurance reviews determine whether CAP/DA clients are classified correctly at either intermediate care or skilled nursing levels of nursing facility care. These reviews collect and track key indicators of recipient outcomes and documentation of services in the Automated Quality and Utilization Improvement Program (AQUIP). 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 are reasonably assured by the services provided. Results of the monthly monitoring of each agency are reviewed by DMA CAP consultants and then shared with the agency under review. 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.

Managed Care Referral Authorization and Utilization Management

Each recipient who is enrolled in Community Care of North Carolina (CCNC), N.C. Medicaid's managed care program, either 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, seven-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 ensures 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 CCNC provider receives quarterly utilization reports and monthly emergency department and referral reports. Data contained in these reports, which are extracted by EDS from paid claims data, 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 2006, 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- or 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. Annually, MCOs are required to submit to DMA statistics derived from their internal data collection systems including: Health Plan Employer Data and Information Set (HEDIS) data, emergency department visits, inpatient utilization, ambulatory surgical procedures, obstetrical discharges and newborn data.

Note: The Mecklenburg County MCO contract was terminated on August 1, 2006.

Strategic Planning and Quality Initiatives

During SFY 2006, DMA created two new administrative units within the Director's Office that address the need for enhanced strategic planning and quality assurance. They are:

Strategic Planning, Assessment and Research Team

The Strategic Planning, Assessment and Research Team (SPART) was created to provide research and planning support to the division. The team is responsible for researching and analyzing health care practices, policies, innovations and trends at the local, regional, state and federal levels, focusing not only on the current Medicaid population, but also on the state's underinsured and uninsured residents.

This internal think tank will help guide health care policy formulation in support of the division's goals and objectives and assist in transforming it from a financing



and regulatory agency to one that is focused on overall health care management and that emphasizes access, quality and efficiency.

Quality, Evaluation and Health Outcomes Unit

The Quality, Evaluation and Health Outcomes (QEHO) Unit was created in June 2006, and combined existing Managed Care Quality Management staff with other experienced program, analytical and clinical personnel from within the agency. While continuing to provide ongoing managed care quality activities and initiatives, the QEHO Unit focuses on studying and identifying opportunities for improvement of efficiency and effectiveness of the services supported by DMA. A key role for QEHO is management of DMA projects that involve staff from many units and sometimes from other divisions. Unit staff will play crucial roles for organization-wide activities such as waivers and coordination with Medicare programs. In addition, the section supports compliance with federal requirements concerning the quality, accessibility, continuity and efficiency of care provided within all systems of care in the Medicaid program through the development and implementation of a coordinated, multifaceted plan for monitoring and improving services.

Medicaid Administrative Contracts

DMA contracts with a number of vendors to perform various administrative and clinical functions of the Medicaid program. Those vendors and their responsibilities include:

EDS — Developed and implemented a uniform screening program for eight Medicaid programs and services that target recipients with chronic conditions or illnesses and for the federally mandated PASARR program. The eight programs and services are the Personal Care Services (PCS) group, including PCS, PCS Plus and Adult Care Homes PCS; Nursing Facility Care; CAP for Disabled Adults (CAP/DA and CAP/DA-Choice); CAP for Children; and Private Duty Nursing.

The Carolinas Center for Medical Excellence (CCME) — Provides PCS compliance reviews to ensure that PCS providers are in compliance with applicable statutes, rules, regulations, administrative policies and procedures; performs targeted case reviews of PCS recipients to ensure that the type, scope, amount and duration of PCS is medically necessary and consistent with the recipient's current plan of care; develops and conducts regional training programs for PCS providers aimed at improving PCS compliance, utilization, quality and cost-effectiveness. CCME also provides day-by-day, retrospective medical reviews of cases in order to determine whether the medical condition of undocumented aliens and legal aliens not qualifying for full Medicaid benefits meets the federal definition of "medical emergency."

Navigant Consulting — Assesses access to care, quality of services and the cost effectiveness of Piedmont Cardinal Health Plan, the state's Medicaid managed behavioral health care delivery system. Navigant Consulting and Myers & Stauffer provide assistance with cost settlement and activities associated with the Disproportionate Share and Supplemental Payment Programs.

Myers & Stauffer — Designed and is implementing a program to determine the validity of the Minimum Data Set information collected and recorded by the nursing facilities that participate in the Medicaid case-mix reimbursement system. Myers & Stauffer is responsible for selecting the sample for review, conducting the reviews and making judgments on the supporting documentation for the submitted minimum data sets. Myers & Stauffer and Navigant Consulting provide assistance with cost settlement and activities associated with the Disproportionate Share and Supplemental Payment Programs. The DMA Audit Unit contracts with Myers & Stauffer to conduct onsite compliance audits of Medicaid-enrolled nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR).

ValueOptions — Performs utilization review of acute inpatient substance abuse hospital care, psychiatric residential treatment facilities that offer services at the three highest levels of care and have at least four beds and outpatient psychiatric services. The contract encompasses all elective and emergency admission reviews, concurrent continued-stay reviews and post-discharge reviews when applicable.

ACS State Healthcare — Oversees the prior authorization process for certain prescription drugs that are chosen and periodically updated on the basis of clinical criteria established by a panel of clinical and academic physicians and pharmacists. Prior authorization allows N.C. Medicaid to ensure that these prescription drugs are used responsibly. DMA also has contracts with ACS for FADS and DRIVE software packages (see next page).

N.C. Department of Correction, Nash Optical Plant — Provides eyeglasses at predetermined rates. In most cases, providers of Medicaid eye care services must obtain eyeglasses through this organization.

Clifton Gunderson and Myers & Stauffer — The DMA Audit Unit contracts with several certified public accounting firms, such as Clifton Gunderson and Myers & Stauffer, to conduct onsite compliance audits of Medicaid-enrolled nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR). They also conduct 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. Clifton Gunderson provides assistance with audits for teaching hospitals, nursing facilities, teaching physicians and inpatient hospitals.

Blue Cross Blue Shield of Tennessee – Performs Medicaid settlement activities for Rural Health Clinics.

Mercer Government Human Services Consulting – Provides capitated rates for the HMO programs, as well as support for the pilot PACE program in the Home-Based and Community Care Unit of DMA. Mercer also provides actuarial services for the Rate Setting Unit of DMA and assists the Pharmacy Unit of DMA with the State Maximum Allowable Cost (SMAC) list of drugs, analysis of the Prior Authorization program, utilization reviews and clinical evaluations of drugs and future pharmacy initiatives.

Fraud and Abuse Detection Systems (FADS) Contract with ACS — FADS software assists the Program Integrity Section in fraud and abuse activities by detecting outliers in provider practices and recipient usage of Medicaid services and pharmaceuticals.

Decision Support System (DRIVE) Contract with ACS — DRIVE is a data warehouse that mirrors the claims data in Medicaid's management information system. This database can be queried to pull reports on specific information regarding usage, payments, classes of services, drugs and providers. DRIVE also supports FADS in seeking audit anomalies.

Professional Credential Verification Service — Health care provider credentialing services under



this contract ensure that providers who are seeking enrollment with N.C. Medicaid are eligible to participate.

Health Management Systems (HMS) — Identifies entities with third-party liability (TPL) for health care charges and aids in the recovery of all overpayments, mispayments and erroneous payments to providers; casualty recovery; and claims reviews. Responsible for placing TPL identifiers on recipient data for the fiscal agent so that Medicaid is the payor of last resort.

Michigan Peer Review Organization (MPRO) and Advanced Medical Reviews (AMR) — A pool of physicians with specialty expertise who provide external independent reviews for clinical topics and cases as needed.

AdvanceMed — North Carolina is one of six pilot states to participate in a national project called the Medicare–Medicaid Data Match Project, or Medi-Medi. The purpose of the project is to combine three years of each state's Medicare and Medicaid claim data into a single database for data mining. AdvanceMed, a CMS Program Safeguard Contractor for Medicare, analyzes claims and refers suspect claims (those that might represent fraud, waste or abuse) to law enforcement (such as the Federal Bureau of Investigation or the Office of the Attorney General), DMA and Medicare. The current fiscal agent, EDS, provides Medicaid claims to AdvanceMed and the DMA Program Integrity Section, which is responsible for follow-up of any suspect providers.

Center for Evidence-Based Policy, Oregon Health and Science University — Coordinates a collaboration among states, other governments and private organizations for the purpose of obtaining

and keeping current an evidence-based, drug-to-drug comparison of effectiveness within each of the top 25 pharmaceutical classes, as determined by expenditures. The research, obtained through a self-governed process, will not only provide these organizations and their constituents the information they need to more wisely and cost-effectively purchase pharmaceuticals, but will also help establish the international standards for effectiveness comparisons between drugs in the same class. The project also shows promise for use by commercial purchasers of pharmaceuticals, such as insurance companies, health plans and self-insuring employers, by providing them with better research syntheses than they can routinely create on their own.

Medicaid Partnerships

Although DMA administers Medicaid, we partner with other state and local agencies to perform several important functions. Those partner agencies and their Medicaid responsibilities include:

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 that county's residents. In addition, counties contribute approximately 5 to 6 percent of the cost of services for Medicaid recipients (see Table 5 in the Tables Section of this report).

N.C. Division of Social Services (DSS) — DSS conducts Medicaid recipient appeals when the person making the application contests eligibility denials.

N.C. Division of Vocational Rehabilitation Services (DVR) — DVR's Disability Determination Unit determines whether an individual is eligible for Medicaid based on disability. Under a contract with the Social Security Administration, this unit also makes disability determinations for two federal programs: Title II Social Security Benefits and Title XVI Supplemental Security Income.

N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) — DMA works closely with DMH/DD/SAS to plan for and monitor community mental health services. These agencies also work cooperatively to operate the CAP 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 Preadmission Screening and Resident Review (PASARR), DMH/DD/SAS staff are authorized to make the final determination for service and placement needs for all those individuals identified with diagnoses for mental illness, retardation or related conditions (see the "Nursing Facility Prior Approval and Retrospective Review" section of this portion of the annual report).

N.C. 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 CAP 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. Note: DMA has recently eliminated its CAP/AIDS program and shifted these recipients to either our CAP/C or CAP/DA program depending upon the individual's health status.

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 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. Lastly, DMA and WCH collaborate in the Family Planning Waiver and the Breast and Cervical Cancer Program.

N.C. Office of Rural Health and Community Care — This agency within DHHS provides technical assistance to small hospitals and community health centers in rural and medically underserved communities. It recruits health care providers to work in these communities and provides grants for community health centers. It is also the lead agency for demonstrations in the delivery and financing of health care for DHHS. Presently, the agency is working with DMA on the CCNC managed care program.

N.C. Division of Aging and Adult Services (DAAS) — DMA and DAAS staff work together on many issues that are important to the aged and adult population. Jointly, DMA and DAAS 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.

N.C. Division of Facility Services (DFS) — DFS has the responsibility for licensing, certifying and monitoring nursing homes, hospitals and adult care homes in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a facility.

N.C. 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 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 collaborate 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, N.C. 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.

N.C. Association of Pharmacists, N.C. Association of Community Pharmacists, Chain Pharmacy Committee of the N.C. 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.

Major Initiatives and Subprograms

The N.C. Medicaid program has developed a number of initiatives and subprograms to meet federal or state government mandates, 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 available only to specific groups of recipients (such as pregnant women) and some are available to everyone. Note: 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-eligible people qualify for managed care. As of the end of SFY 2006, there were 818,799 recipients enrolled in managed care plans, or 73 percent of the 1,121,578 people eligible for Medicaid managed care. An additional 10 counties were added through various networks (as of the publication of this report, 100 counties are currently part of Community Care of North Carolina, or CCNC), and recipient enrollment increased 11 percent during the year. N.C. Health Choice children ages birth through 5 years were transitioned to Medicaid beginning in January 2006. By June, 71 percent of the eligible children had enrolled in CCNC practices.

Participation in a managed care plan is mandatory for the majority of Medicaid recipients in North Carolina. Recipients of Medicaid who are dually eligible for Medicare and Medicaid are optionally enrolled in Carolina ACCESS and CCNC. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan.

Statewide managed care program options include:

- ***Carolina ACCESS*** *— A primary care case management model (PCCM), characterized by a primary care provider (PCP) gatekeeper.*
- ***CCNC*** *— This program, formerly known as ACCESS II and ACCESS III, is a demonstration program that began in July 1998 and aims to build upon Carolina ACCESS by working with community providers to better manage the enrolled Medicaid population. The program is sponsored by the Office of the Secretary of DHHS, DMA and the N.C. Foundation for Advanced Health Programs Inc. Program direction, administration and technical assistance are provided by the Office of Rural Health and Community Care.*

For all of these health care models, the objectives are cost-effectiveness, appropriate use of healthcare services and improved access to primary preventive care.

CCNC is designed to bring together providers to plan cooperatively for meeting patient needs and to strengthen the community health care delivery infrastructure. Providers are expected to take responsibility for managing the care of an enrolled population, to provide preventive services and to develop processes by which at-risk patients can be identified and their care managed before high-cost interventions are necessary. The CCNC program is distinguished by the following features:

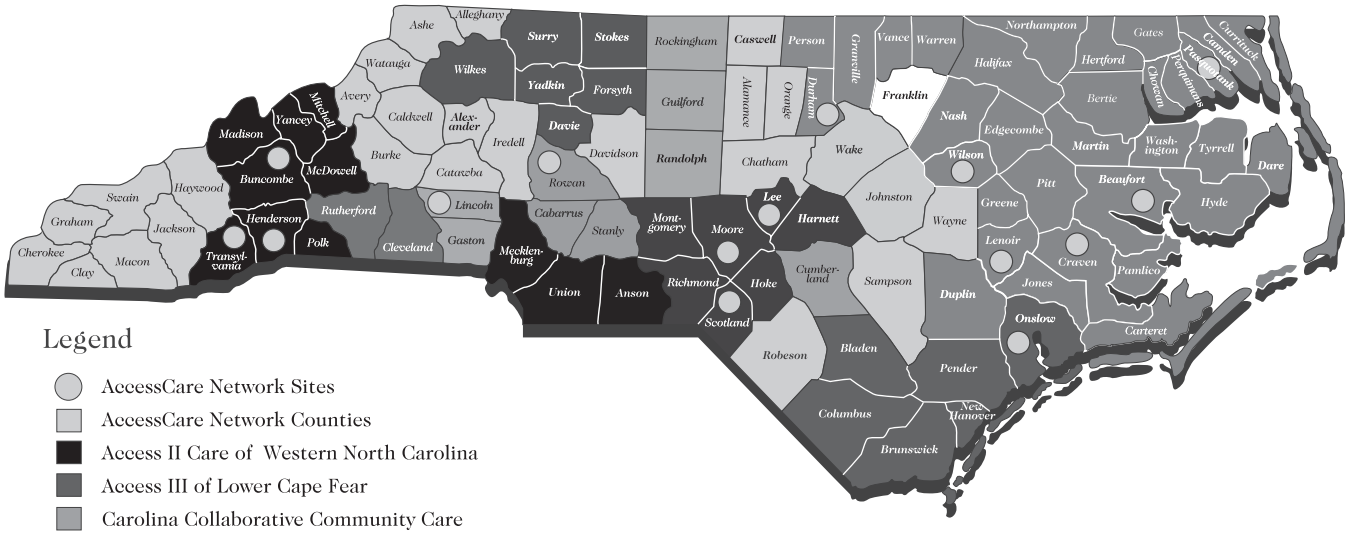
- *Partnership — The program is a partnership of essential local providers including community physicians, hospitals, health departments and*

departments of social services working cooperatively to plan and develop programs for meeting the health needs of local Medicaid enrollees. The program is also a state/local partnership in which the state provides resources, information and technical support to help the CCNC networks effectively deliver and manage enrollee care.

- *Population Health Management Approach — Under a population health management approach, participating networks address the overall health status of enrollees by proactively managing their care. By employing such tools as risk stratification, disease management, case management and access management, the networks are establishing the care management processes and support mechanisms needed to improve enrollee care and achieve program objectives.*
- *Accountability — All CCNC networks are working with each other and with the state in defining, tracking and reporting performance measures that will gauge the effectiveness of participating networks in achieving quality, utilization and cost objectives.*

Community Care of North Carolina

Access II and III Networks



Legend

- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western North Carolina
- Access III of Lower Cape Fear
- Carolina Collaborative Community Care
- Carolina Community Health Partnership
- Community Care of Wake / Johnston Counties
- Community Care Partners of Greater Mecklenburg
- Community Care Plan of Eastern Carolina
- Community Health Partners
- Northern Piedmont Community Care
- Northwest Community Care Network
- Partnership for Health Management
- Sandhills Community Care Network
- Southern Piedmont Community Care Plan

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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 70,877 of the 123,040 live births in North Carolina, or 57.6 percent, during SFY 2005 (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 FPL, 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

Implemented in October 1987, the "Baby Love" program was designed to reduce North Carolina's high infant mortality rate by improving access to health care and the service delivery system for low-income pregnant women and children. Jointly administered by DMA and DPH, the program enables pregnant women whose incomes are up to 185 percent of the FPL to receive comprehensive care through a Medicaid benefit package. This package includes targeted case management services, childbirth education classes, in-home nursing care for high-risk pregnancies, medical nutrition therapy, health and behavior intervention and postpartum and newborn home visits. Maternity Care Coordination Program (MCCP) staff — including nurses, social workers and paraprofessionals — assist women in accessing medical care and support services. MCCP services are available in every county in North Carolina. Since the inception of the program, the infant mortality rate in North Carolina has decreased from 14.9 infant deaths per 1,000 live births in 1987 to 8.8 infant deaths per 1,000 live births in 2005. The lowest infant mortality rate recorded in North Carolina was 8.2 infant deaths per 1,000 live births in 2002 and 2003.

Health Check

In 1993, North Carolina expanded the federally mandated EPSDT program to form "Health Check," which 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. The N.C. Health Directors Association recently endorsed a plan to expand Health Check coordinators statewide. This plan will eventually place Health Check coordinators in all 100 counties by reallocating existing positions. Currently, Health Check coordinators are located in 91 counties as well as the Qualla Boundary (the reservation of the Eastern Band of Cherokee).

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 PCP 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.

DMA's Managed Care Section is the administrative entity for the Health Check program and coordinators. The Managed Care Section works closely with DPH's Women and Children's Health Section to provide guidance to the counties.

Local Education Agencies

Medicaid is a critical source of health care coverage for children. To ensure that a comprehensive array of services is accessible to the children, Medicaid pays for certain health-related services provided by local education agencies (LEAs) 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 to assist children who are already enrolled in Medicaid to access benefits that may be available to them. Special-needs children whose IEPs require certain health-related services are able to gain access to those services through Medicaid, which pays for services that otherwise would incur considerable costs to state and local school districts. Direct medical services that are currently available within the LEA setting are audiology, speech/language therapy, occupational therapy, physical therapy and psychological and counseling services. DMA anticipates adding nursing services in the near future. In addition to



providing funding for the direct medical services, Medicaid provides reimbursement for administrative activities in support of delivering the direct medical service. Eligible children who otherwise might not be able to obtain these medically necessary services have access to them because of Medicaid funding in the school setting.

Practitioner and Clinical Services

Practitioner and Clinical Services comprise services provided by:

- *ambulance services*
- *ambulatory surgery centers*
- *anesthesiology services*
- *birthing centers*
- *child services coordination*
- *chiropractors*
- *clinic services*
- *dialysis services*
- *laboratories*
- *maternity care coordination services*
- *nurse midwives*
- *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.

Long-term Care

The N.C. Medicaid program spends a large portion of its service dollars (33 percent) on long-term care. Long-term care includes institutional care (all nursing facility and hospital long-term care) and home and community-based care (home health, durable medical equipment, CAP, home infusion therapy, hospice, adult care home and PCS). As indicated in Exhibit 12 on page 56, total expenditures for long-term care during SFY 2006 were approximately $2.8 billion, an increase of 5.2 percent over the previous year.

Facility Care Services

Nursing Facility Care

There are times when nursing facility care is the best option for Medicaid recipients. Nursing facility reimbursement 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 medical criteria for admission. The federal PASARR requirement, which must also be met, screens and evaluates applicants and residents of Medicaid-certified nursing facilities for mental illness, mental retardation, developmental disabilities and related conditions.

☑ In SFY 2006, a total of 43,117 Medicaid recipients in North Carolina received care in nursing facilities at a cost of approximately $1.09 billion.

Intermediate Care Facilities for the Mentally Retarded

ICF-MRs are long-term care facilities for persons who are mentally retarded and/or developmentally disabled and who meet certain federal criteria — including the need for active treatment for individuals who have mental retardation or a related condition and 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 2006, a total of 4,143 recipients in North Carolina were treated in ICF-MRs at a cost of $415 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, PCS, home infusion therapy and hospice.

Adult Care Home PCS

Since 1995, N.C. Medicaid covers basic PCS for residents in adult care homes who are eligible for

Special Assistance for Adults and Medicaid. With prior approval, Medicaid has covered enhanced PCS since 1996 for residents of adult care homes who meet criteria for significant or total assistance with toileting, eating or ambulation/locomotion.



☑ In SFY 2006, a monthly average of 20,442 N.C. Medicaid recipients received basic PCS at an annual cost of $140 million.

☑ Of these, an average of 3,289 North Carolinians each month received enhanced PCS in adult care home settings at an annual cost to N.C. Medicaid of $9 million; and a monthly average of 20,042 persons received non-medical transportation services related to the adult care home program at an annual expense of $4.5 million.

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 recipient's illness in the home setting when provided by a Medicare-certified home health agency. The services may be provided in the recipient's private residence or in an adult care home (with the exception of home health aide services in the adult care home). The services are considered part-time and intermittent and must be provided under a plan of care authorized by the patient's physician.

☑ In SFY 2006, a monthly average of 16,885 N.C. Medicaid recipients received home health services at an annual cost of $120 million.

Hospice

Hospice, which is 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 six months or less life expectancy as certified by a physician. The services include nursing care, medical social services, counseling, the professional care of a physician, in-home aide services, home management 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 2006, a monthly average 1,425 N.C. Medicaid recipients received hospice care at an annual cost of $54 million.

Home Infusion Therapy

Home infusion therapy (HIT) provides for infusion nursing services, 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 or epidural. HIT services are available for recipients who live in a private residence or an adult care home.

☑ In SFY 2006, a monthly average of 441 N.C. Medicaid recipients received HIT at an annual cost of $6 million.

Private Duty Nursing

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

☑ In SFY 2006, a total of 409 (monthly average of 285) N.C. Medicaid recipients received PDN services at an annual cost of $48 million.

Personal Care Services

In-home 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.

☑ In SFY 2006, a monthly average of 34,670 N.C. Medicaid recipients received PCS or PCS-Plus at an annual cost of $313 million.

HIV Case Management

HIV case management is a targeted case management program funded by N.C. Medicaid and operated jointly by DMA and DPH. Whereas DMA has administrative oversight of the program, the day-to-day operations are managed by the AIDS Care Unit within DPH.

☑ In SFY 2006, a monthly average of 1,453 N.C. Medicaid recipients received HIV Case Management services at an annual expense of $8.6 million.

Community Alternatives Program

CAP-MR/DD is a special Medicaid home and community-based waiver program. Implemented in 1983 to serve individuals who would otherwise qualify for care in an ICF-MR, it allows these individuals to remain in their communities instead of residing in an institution. Medicaid is required to ensure that the cost of community care is cost-effective in comparison to the cost of ICF-MR care. DMH/DD/SAS manages the daily operation of the program under an agreement with DMA.

The program is available statewide through local management entities (LMEs).

☑ CAP-MR/DD served a monthly average of 6,252 N.C. Medicaid recipients in SFY 2006 at an annual cost of $288 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 the average expense at a non–state-owned facility.

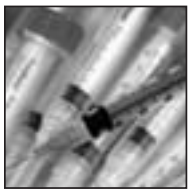
CAP/C is a Medicaid waiver program that provides home-based care for medically fragile children through age 18. Participants must meet criteria for medical necessity and must be at risk for institutionalization. CAP/C provides skilled nursing or in-home aides, case management and other waiver services. 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 2006, CAP/C served an average 585 children each month at an annual cost of $29 million.

CAP/AIDS provides home-based care for persons with AIDS as an alternative to nursing home placement. This waiver program is a cooperative effort between DMA and DPH. The AIDS Care Unit, part of 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. Recipients approved for the program are potentially eligible for special waiver services in addition to regular Medicaid services.

☑ In SFY 2006, CAP/AIDS served a monthly average of 73 recipients at an annual expense of $1.7 million.

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 has been the state's primary answer to controlling the growth of nursing facility expenditures while addressing quality-of-life issues for the expanding population of frail elderly and disabled adults and complying with the requirements of the Olmstead Act. In January 2005, DMA launched a pilot waiver program entitled CAP/Choice as an alternative to the CAP/DA approach. CAP/Choice is a program of consumer-designated care for elderly and disabled adults who wish to remain at home and have increased control over their services and supports. CAP Choice allows recipients



(consumers) who prefer to select their individual workers to more fully direct their care and have more flexibility in tailoring plans of care to their home care requirements.

☑ CAP/DA served a monthly average of 11,205 citizens in SFY 2006 at a yearly cost of $266 million.

Ancillary Services

Durable Medical Equipment

Medicaid pays for durable medical equipment (DME) when it is medically necessary for a recipient to function in his or her 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 also covered. The patient's physician must order the items and document medical necessity on the Medicaid Certificate of Medical Necessity and Prior Approval form. Some items require prior approval. All DME, orthotic and prosthetic and related supplies have established lifetime expectancies and quantity limitations.

☑ During SFY 2006, a monthly average of 56,871 N.C. Medicaid recipients received DME services at annual expense of $92 million.

Independent Practitioner Program

The Independent Practitioner Program enrolls and reimburses individual independent practitioners to provide physical, occupational and respiratory therapy,

speech/language pathology and audiological services to children from birth through 20 years of age.

☑ During SFY 2006, a total of 22,863 N.C. Medicaid recipients received independent practitioner services at annual expense of $4.8 million.

Optical Services

The Optical Services Program, which is responsible for the overall administration of vision care services covered by N.C. Medicaid, covers eye exams and materials and services related to the provision of visual aids (corrective eyeglasses, medically necessary contact lenses and other visual aids). Prior approval is required for all visual aids. There are limitations regarding the frequency of eye examinations and the number of dispensed visual aids during specific eligibility periods. Eye examinations in excess of these limitations require prior approval. A $3 copayment is applicable to ophthalmological visits, and a $2 copayment applies to visual aids. Although a $2 copayment is generally required for new eyeglasses, eyeglass repairs and contact lenses, there are some exemptions.

Medicaid eyeglasses are supplied by the Nash Correctional Institution's Optical Plant through a contractual agreement with Correction Enterprises, a division of the N.C. Department of Correction. Providers must obtain Medicaid eyeglasses through this laboratory. Prior approval for exceptions may be granted under extenuating circumstances.

☑ During SFY 2006, a monthly average of 22,821 N.C. Medicaid recipients received optical services at annual expense of $22 million.

Hearing Aid Services

Monaural and binaural hearing aids are covered for recipients under 21 years of age who have received medical clearance from a physician, preferably an otologist, otolaryngologist or otorhinolaryngologist. Along with the prior approval request for the hearing aid, Medicaid-enrolled hearing aid providers (ENT doctors, audiologists or hearing aid dealers) must submit an audiogram, evaluation report and manufacturer's warranty information. Each prior approval request for replacement hearing aids due to hearing changes or damaged or lost hearing aids is reviewed individually for medical necessity. Providers may seek prior approval for FM systems for pre-school-age children. The federal Individuals with Disabilities Education Act requires public schools to provide FM systems for educational purposes for students. There are no copayments for hearing aids, hearing aid accessories or hearing aid services.

☑ During SFY 2006, a monthly average of 194 N.C. Medicaid recipients received hearing aid services at annual expense of approximately $714,000.

Behavioral Health

N.C. Medicaid covers a variety of services for behavioral health, some under the rehabilitation option and others under the clinic option. Services available under the rehabilitation option are provided by providers who are endorsed by the local management entity (LME) to provide a particular service or package of services before they are enrolled as Medicaid providers. Rehabilitation services include:

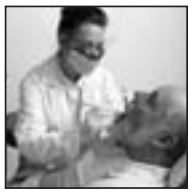
- *community support —adult (individual and group)*
- *community support — child (individual and group)*
- *community support teams (adult)*

- *assertive community treatment team*
- *child and adolescent day treatment*
- *diagnostic assessment*
- *intensive in-home*
- *mobile crisis management*
- *multisystemic therapy*
- *partial hospital*
- *professional treatment services in facility-based crisis programs*
- *psychosocial rehabilitation*
- *substance abuse comprehensive outpatient treatment*
- *substance abuse intensive outpatient program*
- *substance abuse medically monitored residential treatment*
- *substance abuse non-medical community residential treatment*
- *ambulatory detoxification*
- *medically supervised detoxification/crisis stabilization*
- *non-hospital medical detoxification*
- *outpatient opioid treatment*
- *evaluation/assessments/individual outpatient psychotherapy/outpatient family therapy/group therapy*
- *residential services for recipients under the age of 21 years.*

Clinic services include outpatient therapy and psychological testing provided by directly enrolled providers, hospitals, health departments, physicians and 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 for recipients under the age of 28.

Inpatient services, residential services and outpatient therapy must go through a prior approval process. For additional information, refer to the Behavioral Health Prior Approval subsection of this annual report on page 20.





DMA also provides services in ICF-MRs, which are long-term-care facilities for individuals with mental retardation or a related condition that occurred before the age of 22. Please refer to the Intermediate Care Facilities for the Mentally Retarded (ICF-MR) subsection of this report on page 39 for additional information.

☑ During SFY 2006, a total of 184,720 N.C. Medicaid recipients received behavioral health services at annual expense of approximately $1.6 billion.

☑ Of the above, 88,447 children received behavioral health services at annual expense of $748 million.

☑ The remainder, 96,273 adults, received behavioral health services at annual expense of $837 million.

Dental Health

N.C. 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 also covered. Orthodontic services are covered for children under age 21 with functionally handicapping malocclusions. Most dental services do not require prior approval. Recipients age 21 years and older are charged a $3 co-payment unless their coverage category is exempted from co-payment. “Into the Mouths of Babes,” an

initiative for recipients age birth through 3 years, aims to decrease the incidence of early childhood caries.

☑ During SFY 2006, a monthly average of 80,387 N.C. Medicaid recipients received dental services at annual expense of $218 million.

Pharmacy Services

Drug Use Review Program

As required by federal law, N.C. Medicaid has established a Drug Use Review (DUR) Program to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary and not likely to result in adverse medical effects. The DUR program is characterized by the following four major components:

- *DUR Board – A DUR Board consists 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 screens for potential drug therapy problems and counsels 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.*
- *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.*

Outpatient Pharmacy Program

Prescription drugs, insulin and selected over-the-counter (OTC) products for which manufacturers have signed rebate agreements with CMS are covered under the pharmacy program. Recipients may have a 34-day supply of their prescription medication and a three-month supply of birth control pills and hormone replacement therapies. Since October 2003, Medicaid recipients have been able to obtain 90-day supplies of generic, non-controlled maintenance medications at the discretion of their health care providers if they had a previous 30-day fill for the same medication. A recipient copayment of $3 applies for brand-name medications and a $1 copayment for insulin and selected OTC products. On November 1, 2005, the copayment for Medicaid prescriptions increased to $3 for generic drugs. The copayment for brand name drugs remained at $3.

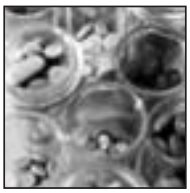
On June 1, 2006, DMA implemented a new prescription limit policy allowing eight prescriptions per recipient per month for recipients age 21 and older. This limitation does not apply to EPSDT-eligible children. A pharmacist may override the monthly limitation with up to three additional prescriptions per recipient per month based on assessment of the recipient's need for additional medications during the month of service. Recipients who reside in nursing facilities and ICF-MRs are exempt from the prescription limitation and OPT-IN program (see next paragraph).

Recipients receiving more than 11 prescriptions per month will be evaluated as part of a new Medication Therapy Management (MTM) Program. Under this program, the recipient's pharmacist will perform a comprehensive drug regimen review to identify, resolve and recommend cost-effective and efficacious therapies. The pharmacy provider coordinates, integrates and communicates medication regimen discussions with the recipient's personal care physician and, upon consensus agreement between both providers, the pharmacist may convey the information to the recipient. The pharmacist will review the recipient's medication profile at least every three months to ensure the clinically appropriate and cost-effective use of drug therapy. Pharmacies participating in this program are eligible for a monthly MTM fee for each managed Medicaid recipient.

DMA has identified all recipients receiving greater than 11 prescriptions who qualify for the MTM program. Since this is a higher level of professional service, it is extremely important that the recipient receive medications from one pharmacy location for continuity of care. The recipient will have the opportunity to select a pharmacy provider of choice, once identified as qualifying for the MTM program. Since the recipient elects a pharmacy provider, this is an "OPT-IN" program. Every six months recipients will be systematically removed from the OPT-IN program when fewer than 12 prescriptions were dispensed.

Since November 2003, the state has utilized a statewide Prescription Advantage List (PAL), which ranks drugs in the 16 most costly therapeutic drug classes according to their net cost to N.C. Medicaid. The PAL was developed by the NCPAG and CCNC in cooperation with DMA as a voluntary effort to help control rising pharmacy costs in N.C. Medicaid. The goal of the PAL is to share with N.C. providers a guide for prescribing clinically appropriate, less expensive medications whenever possible.

On May 1, 2006, the episodic drug policy became effective. Some drugs are meant to be used episodically and are dispensed in quantities that support less-than-


daily use. DMA will impose quantity limitations for episodic drugs based on advice from the NCPAG. The NCPAG and DMA will consider Federal Drug Administration (FDA) labeling, evidence-based guidelines and systematic reviews and consultation with the CCNC clinical directors as to North Carolina community and best practice standards. Sedative hypnotics, therapeutic drug classes H2E and H8B, were the first group of drugs on which quantity limits were imposed. Recipients will be able to obtain 15 units each month without prior authorization.

Prescribed drugs are reimbursed at the lowest of the following:

- *average wholesale price (AWP) less 10 percent plus a dispensing fee*
- *state maximum allowable cost (SMAC) plus a dispensing fee*
- *federal upper limit (FUL) plus a dispensing fee*
- *usual and customary charge.*

Dispensing fees are $5.60 for generic and OTC drugs and $4 for brand name drugs. The dispensing fee is not paid for repeats or refills of the same drug twice within the same calendar month. Two prescriptions for the same drug may not be billed on the same day.

Medicare-Aid

The Medicare-Aid program began in 1989 as a limited Medicaid program for Qualified Medicare Beneficiaries (MQB-Q). This program provides assistance to eligible individuals with Medicare cost-sharing expenses, such as deductibles, premiums and coinsurance charges. The eligibility resource limit is $4,000. The eligibility income limit is 100 percent of the FPL, which is adjusted in April of each year.

In 1993 the Medicare-Aid program expanded to include qualified individuals with incomes between 100 percent and 120 percent of the FPL. The eligibility resource limit for this group is also $4,000. These individuals are referred to as Specified Low-Income Medicare Beneficiaries (MQB-B). Eligible individuals in this group receive assistance with the payment of their Medicare Part B premiums only.

In 1998 Medicare-Aid further expanded to include a new group of Medicare beneficiaries, Qualifying Individuals (QI-1). The eligibility resource limit for this group is also $4,000. The eligibility income limit is between 121 percent and 135 percent of the FPL. Eligible individuals in this group also receive assistance with the payment of their Medicare Part B premiums only. Funding for this group is capped, and approval of assistance is on a first-come, first-served basis.

Medicare Prescription Drug Benefit (Part D)

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) established the Medicare Prescription Drug Program, also known as Medicare Part D. This program went into effect on January 1, 2006. There are two parts to the prescription drug benefit: (1) the Low Income Subsidy (LIS), also referred to as "extra help," and (2) prescription drug coverage through a Medicare Prescription Drug Plan (PDP) or Medicare Advantage Prescription Drug Plan (MA-PD).

The MMA created the prescription drug plan to assist Medicare beneficiaries with prescription drug costs. The basic coverage includes an annual deductible, cost-sharing or copayments of 25 percent up to the initial coverage limit in total drug costs and a monthly premium. The beneficiary is then responsible for 100 percent of prescription drug costs until the total cost reaches the catastrophic limit. The gap in coverage where the beneficiary is responsible for the 100 percent of drug costs is referred to as the "doughnut hole." Medicaid recipients do not have annual deductibles, cost-sharing or coverage gaps. In addition, the cost of a basic Part D premium for Medicaid recipients is paid by Medicare.

Individuals can apply for the LIS for assistance with the premium, deductible and copayments of a PDP. LIS assistance is available for Medicare beneficiaries who have income less than 150 percent of the FPL and who meet an asset test. Medicare beneficiaries may apply for the LIS through the Social Security Administration, the local county department of social services or online at www.medicare.gov.

Medicaid recipients who are enrolled in or entitled to Medicare Part A or B no longer receive prescription drug coverage through Medicaid. These individuals continue to be eligible for Medicaid to pay for other covered services. Medicaid recipients with Medicare are automatically eligible for the LIS and do not need to apply.

To ensure that prescription coverage continues for full Medicaid recipients with Medicare, Medicare automatically enrolls these recipients in a prescription drug plan. Medicare began the enrollment process of all full Medicaid recipients with Medicare in October 2005 for coverage beginning on January 1, 2006. Medicare will continue to enroll these individuals on an ongoing basis as they become Medicaid- and Medicare-eligible. Medicaid recipients with Medicare can choose to change plans at any time.

Policy and Service Highlights



Policy Changes and Reports

Policy Changes Mandated by the N.C. General Assembly

PROGRAMMATIC ISSUES:

Limitations on Quantity of Prescription Drugs
DMA received guidance that it may establish authorizations, limitations and reviews for specific drugs, drug classes, brands or quantities in order to effectively manage the Medicaid pharmacy program. The only exception to this is that DMA is not to impose limitations on brand-name medications for which there is a generic equivalent in cases in which the prescriber has determined, at the time the drug is prescribed, that the brand-name drug is medically necessary and has written on the prescription order the phrase "medically necessary."

Expansion of CCNC
DMA is mandated to expand the scope of the CCNC care management model to recipients of Medicaid and Medicare-Medicaid dually eligible individuals with chronic conditions and long-term care needs. The implementation of this mandate has been carried forward into SFY 2007.

Medicaid PCS Limitations
N.C. Medicaid was required to reduce the cost of providing personal care services by approximately $13.7 million during SFY 2006 and by $16.1 million during SFY 2007. This is to be accomplished by implementing a utilization management system for PCS and PCS-Plus. DMA was also mandated to work with CCNC to determine how that program can help with the review of the need for and utilization of personal care services.

CAP Reimbursement System
DMA was instructed to develop a new system for reimbursing CAP services. DMA was required to report to the N.C. General Assembly on the development of the new system, including the provision of an implementation schedule.

Adult Care Home PCS for Residents of Special Care Units
The amount of PCS allowed to residents of special care units in adult care homes was increased from 1.1 hours per day to 4.07 hours per day.

Mental Health Reform
Legislation defined new coverage, provider types and payments for mental health services. Coverage was expanded to include services provided by licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, licensed clinical addictions specialists and licensed clinical supervisors, when Medicaid-eligible children are referred by the CCNC PCP, a Medicaid-enrolled psychiatrist or the area mental health program or LME. Coverage also applies to Medicaid-eligible adults, except that they may be self-referred. This issue was carried over from the 2004 Session of the N.C. General Assembly. Implementation of the new enhanced benefit services began in March 2006.

ELIGIBILITY AND BENEFIT COVERAGE ISSUES:

Ticket to Work/Medicaid Eligibility
DMA received a mandate from the N.C. General Assembly to implement a Medicaid buy-in eligibility category as permitted under the Ticket to Work and Work Incentives Improvement Act of 1999 (federal law).

Verification of State Residency for Medical Assistance

This provision requires that at the time of application for medical assistance benefits, an applicant shall provide satisfactory proof that he or she is a resident of North Carolina and not maintaining a temporary residence for the purpose of receiving medical assistance. The effective date was January 1, 2006.

Medicaid Estate Recovery to Include Liens on Real Property

DMA was allowed to impose liens against real property, including the home, of a recipient of medical assistance. DMA was also given the authority to postpone or waive placing a lien on the real property of a Medicaid recipient, in whole or in part, when it determines that the enforcement of its claim would result in an undue hardship to an heir or a beneficiary of the Medicaid recipient. The SFY 2007 budget bill passed in July 2006 has since delayed the effective date for this legislation.

BUDGET AND OTHER FINANCIAL ISSUES:

Freeze Medicaid Rates

Reimbursement rates for most Medicaid providers were frozen during SFY 2006 at the level authorized in SFY 2005.

Copayments

Copayments were increased for chiropractic, optometry, podiatry and emergency room visits that are not true emergencies as well as for inpatient hospital stays and generic prescription drugs.

Dental Services

Effective with date of service October 1, 2005, reimbursement rates were increased for a number of dental procedures. The new rates were entered into the Medicaid automated claims payment system on May 5, 2006. Claims that processed before that date were subjected to automatic system adjustments to pay the additional reimbursement.

Policy Changes Not Mandated by the N.C. General Assembly

PROGRAMMATIC ISSUES:

CAP-MR/DD Waiver

The current CAP-MR/DD program, a Medicaid community care funding source for persons with mental retardation and developmental disabilities, became effective September 1, 2005, and will continue for a period of three years. The program operates and is funded under a Medicaid Home and Community Based 1915(c) waiver granted by CMS. The program provides a cost-effective alternative to care in an ICF-MR by offering specific services in the community to individuals of all ages who require ICF-MR level of care. For more details on this waiver, see the related paragraphs under the "Major Accomplishments" section of this report.

Family Planning Waiver

On October 1, 2005, DMA implemented Be Smart, a five-year demonstration waiver project for family planning services for the citizens of North Carolina. Designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina, the program extends eligibility for family planning services to North Carolinians who:

- *are women ages 19 through 55 or men ages 19 through 60*
- *are U.S citizens or qualified aliens*
- *have income at or below 185 percent FPL.*

More details of this waiver may be found in the related section of "Major Accomplishments."



CLINICAL POLICY CHANGES :

The following clinical coverage and general coverage policies that were promulgated through the NCPAG became effective during SFY 2006:

- *Stem Cell and Solid Organ Transplants — Describes coverage criteria in detail. Effective July 1, 2005.*
- *Orthotics and Prosthetics — Expands coverage to recipients 21 years of age and older. Effective August 1, 2005.*
- *Pharmacy/Outpatient — This policy applies to Medicaid-covered legend drugs and covered OTC drugs dispensed by outpatient pharmacy providers. Effective September 1, 2005.*
- *Home Health Services — Includes home health services for medically necessary skilled nursing services, specialized therapies (physical, speech/language and occupational), home health aide services and medical supplies provided to recipients who reside in private residences. Nursing, specialized therapies and medical supplies can also be provided if the recipient resides in an adult care home (such as a rest home or family care home). Effective September 1, 2005.*
- *Inpatient Behavioral Health Services — This policy describes inpatient behavioral health services provided in a hospital setting 24 hours a day. Supportive nursing and medical care are provided under the supervision of a psychiatrist or a physician. This service is designed to provide continuous treatment for recipients with acute psychiatric or substance abuse problems. Effective November 1, 2005.*
- *PCS — This policy provides for the services of an aide in a Medicaid recipient's private residence to assist with the recipient's personal care needs that are directly linked to a medical condition. The services must be authorized by the recipient's primary care physician or by a physician assistant or nurse practitioner working under the supervision of a physician. Effective November 1, 2005.*
- *Case Management for Adults and Children at Risk for Abuse/Neglect/Exploitation —Assists this population in gaining access to needed medical, social, educational and other services. Encourages the use of cost-effective medical care by referrals to appropriate providers and discourages over-utilization of costly services. Effective November 1, 2005.*
- *Medically Necessary Routine Foot Care — This policy outlines the medical necessity criteria for the coverage of routine foot care. Effective March 1, 2006.*
- *Podiatry — This policy addresses the surgical, medical or mechanical treatment of ailments of the human foot and ankle and their related soft tissue structure to the level of the myotendinous junction. Effective March 1, 2006.*
- *Transcranial Doppler Studies — This policy describes the transcranial Doppler study procedure as used for the noninvasive assessment of blood flow to the brain. Effective March 1, 2006.*
- *Hospice — This policy describes the Medicaid hospice benefit in detail. Effective April 1, 2006.*
- *ICF/MR — This policy has been amended to specify in greater detail the required services and treatments at an ICF/MR. Effective April 1, 2006.*
- *Pharmacy/Quantity and Episodic Drug Coverage — New service requirements allow DMA to impose quantity limitations for drugs used episodically and in quantities that support less than daily use. Quantity limitations are based on Food and Drug Administration (FDA) labeling and evidence-based guidelines that are in line with best practice standards. DMA will monitor utilization of designated episodic drugs on an annual basis, or more frequently, if*

necessary, to assess the need for changes in the limits. Effective May 1, 2006.

- *Hearing Aid Services — This policy describes the hearing aid services available to children under 21 years of age. Effective June 1, 2006.*
- *Pharmacy/Global Limits — The Outpatient Pharmacy Program was updated to reflect the mandated change to the prescription limitation (an increase to eight prescriptions per recipient per month for recipients age 21 and older). Only recipients obtaining more than 11 prescriptions per month are now restricted to obtaining their medications from a single pharmacy. Effective June 1, 2006.*

Special Studies, Reports and Projects Mandated by the N.C. General Assembly

Limitations on Quantity of Prescription Drugs
On August 1, 2006, DMA submitted to the N.C. General Assembly a required report titled "DHHS Policies and Procedures Establishing Authorizations, Limitations and Reviews for Specific Drugs, Drug Classes, Brands or Quantities to Effectively Manage the Medicaid Outpatient Pharmacy Program."

Expansion of Community Care of North Carolina
DMA is required to report on the implementation of this section, including resulting savings and quality improvement benchmarks, on March 1, 2007; therefore, this requirement was carried into SFY 2007.

Medicaid PCS Limitations
On June 1, 2006, DMA submitted its report titled "Utilization Management for Medicaid's Personal Care Services and Other Home and Community Based Services" to the N.C. General Assembly.

CAP Reimbursement System
On June 1, 2006, DMA submitted a report titled "Community Alternatives Reimbursement System" to the N.C. General Assembly. The study outlined the complex and highly technical aspects of developing a case-mix system for reimbursing CAP services and included a timetable for its implementation by January 1, 2007.

Medicaid Study of Dually Eligible Recipients
The N.C. General Assembly mandated that DMA study the provision of Medicaid services for individuals who are dually eligible for Medicaid and Medicare. The focus of this report will be the Medicare Part D impact on these services, the financial impact of Medicare clawback provisions to the state and efficiencies that can be realized in services for this dually eligible population. The study must also assess the impact on the Medicaid program as a whole.

Medicaid Institutional Bias Study
The appropriations bill from the 2004 Session of the N.C. General Assembly required DMA to contract with an independent entity to study whether the state's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home. If a bias is found, DMA must determine and recommend ways to alleviate it. On January 1, 2005, DMA submitted a progress report to the N.C. Legislative Study Commission on Aging. DMA awarded a contract to carry out the study to the Lewin Group, which reported its findings to the Commission on Aging in January 2006. DMA staff met with the commission in March 2006 to answer members' questions and provided a final written report to the commission on July 31, 2006.

Populations, Services and Expenditures

Populations and Eligibility Groups

North Carolina's population during SFY 2005 (the most recent year for which census information is available) was 8,682,066. Approximately 1,602,645 people (or 18.5 percent of the population) were eligible for Medicaid. Compared with the previous year, the state population rose by 1.6 percent; however, the number of people eligible for Medicaid increased by 2.5 percent.

As indicated in **Exhibit 6**, the largest category of eligible people during SFY 2006 was pregnant women and children, with an annual total of 652,446 individuals, or about 41 percent of total eligibility. The Aid to Families with Dependent Children (AFDC) category was second-largest with 468,662 individuals, or about 29 percent of the total. This category includes families with children who would have met eligibility criteria for the former AFDC program, now known as Temporary Assistance to Needy Families, or TANF, as of July 1996.

Exhibit 6

N.C. Medicaid Yearly Unduplicated Eligibles by Eligibility Group - SFY 2006

Eligibility Group	Number of Eligibles	% of Total Eligibles
Pregnant Women & Children	652,446	40.7
AFDC-related	468,662	29.2
Disabled	257,344	16.1
Aged	149,961	9.4
Qualified Medicare Beneficiaries	52,895	3.3
Blind	2,084	0.1
Refugees & Aliens	18,980	1.2
Breast & Cervical Cancer	273	0.0
Total	**1,602,645**	**100.0**

As **Exhibit 7** shows, the Pregnant Women and Children population experienced the largest numerical increase of enrollees — 22,830, or 3.6 percent. The AFDC-related, Aged and Blind categories experienced decreases.

Exhibit 7

Change in N.C. Medicaid Yearly Unduplicated Eligibles by Eligibility Group SFY 2005 vs. 2006

Eligibility Group	SFY 2005 Eligibles	SFY 2006 Eligibles	Amount of Change	% Change
Pregnant Women & Children	629,616	652,446	22,830	3.6
AFDC-related	468,711	468,662	-49	0.0
Disabled	249,921	257,344	7,423	3.0
Aged	151,512	149,961	-1,551	-1.0
Qualified Medicare Beneficiaries	44,130	52,895	8,765	19.9
Blind	2,130	2,084	-46	-2.2
Refugees & Aliens	17,496	18,980	1,484	8.5
Breast & Cervical Cancer	235	273	38	16.2
Total	**1,563,751**	**1,602,645**	**38,894**	**2.5**

Exhibit 8 shows the distribution and some of the characteristics of recipients of Medicaid services. The percentage of recipients in each program category approximates the eligibility distribution of eligible individuals shown in **Exhibit 6**, with some variation because not all those who are eligible 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 on claims ***paid*** during SFY 2006, even though the services might have been ***provided*** the previous year.

Forty-five percent of recipients were white, 39 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 (37 percent), while adults aged 21 to 64 are the second-largest group (33 percent), followed by young children from birth to age 4 (20 percent) and the elderly ages 65 and older (10 percent).

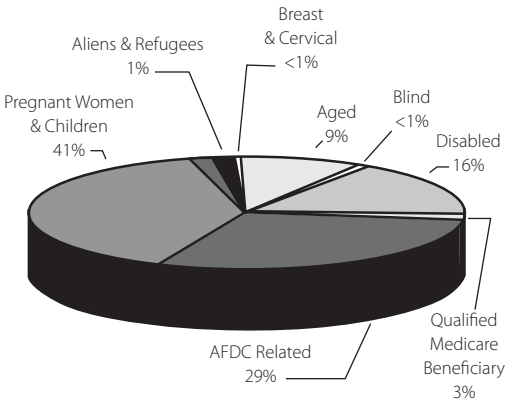
Services and Expenditures

As indicated in **Table 9** (see the "Medicaid Tables" section of this report), $8.6 billion was spent on health services and premiums for 1,673,510 Medicaid recipients, or $5,129 per recipient during the year. While total service and premium expenditures increased by 5.1 percent from SFY 2005, there was a decrease of 0.5 percent per recipient over the same period.

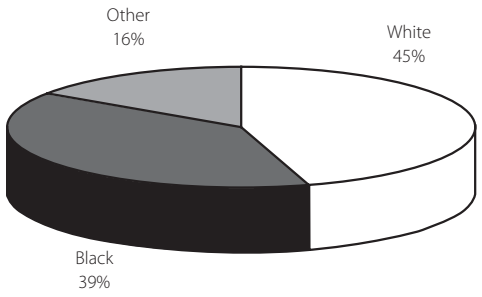
Exhibit 8

N.C. Medicaid Recipients of Medicaid Services - SFY 2006

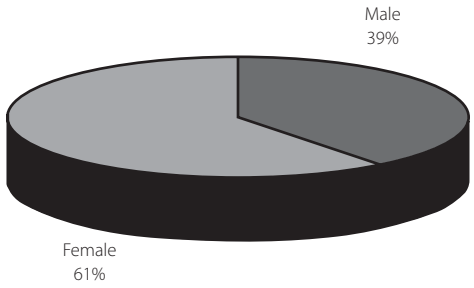
By Eligibility Category



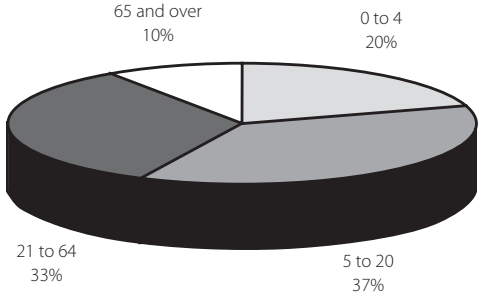
By Race



By Gender



By Age



Exhibits 9 and **10** show that elderly and disabled recipients comprised 12.5 percent and 15.9 percent of total recipients, respectively. Service expenditures for these two groups amounted to approximately $5.8 billion, or 69 percent. These two groups received a greater number of services and services that were more expensive per unit. Recipients from the Families and Children group represented 69 percent of all recipients; however, they accounted for approximately $2.6 billion, or 31 percent, of total service expenditures. **Exhibit 11** shows that expenditures per recipient increased during SFY 2006 for two groups (Disabled and Families & Children) and decreased for two groups (Elderly and Aliens & Refugees groups).

Exhibit 9

N.C. Medicaid Percentage of Recipients & Service Expenditures SFY 2006

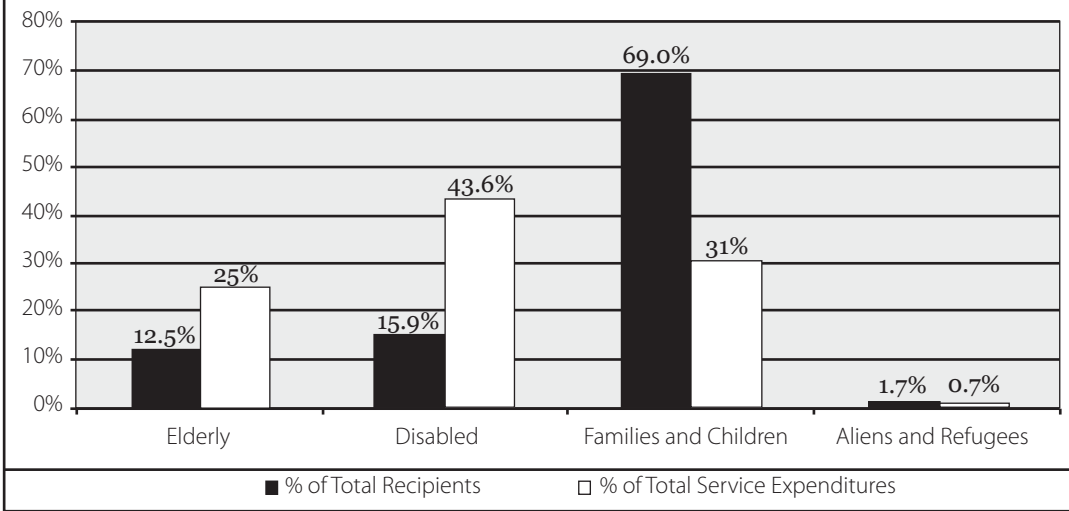


Exhibit 10

N.C. Medicaid Expenditures by Recipient Groups SFY 2006 (in $ Billions)

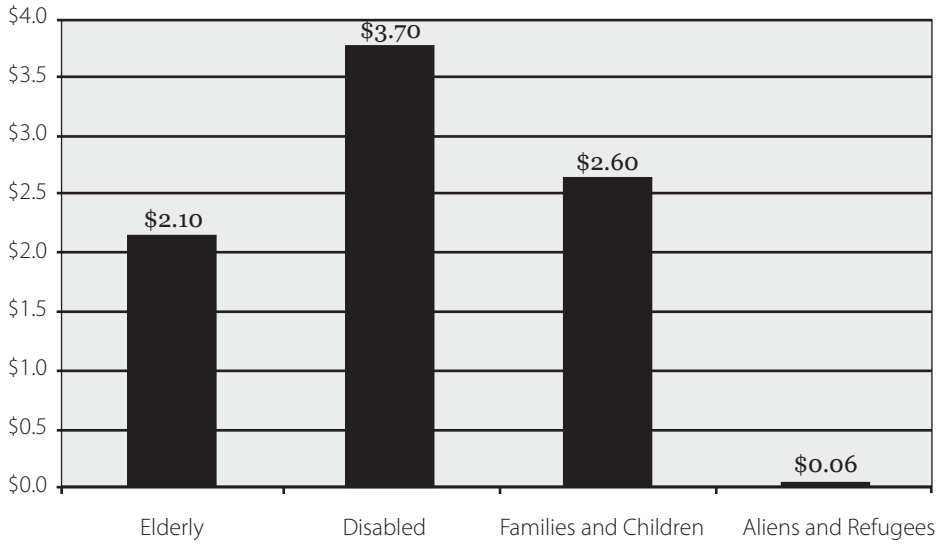


Exhibit 11

N.C. Medicaid Expenditures per Recipient SFY 2005 vs. 2006

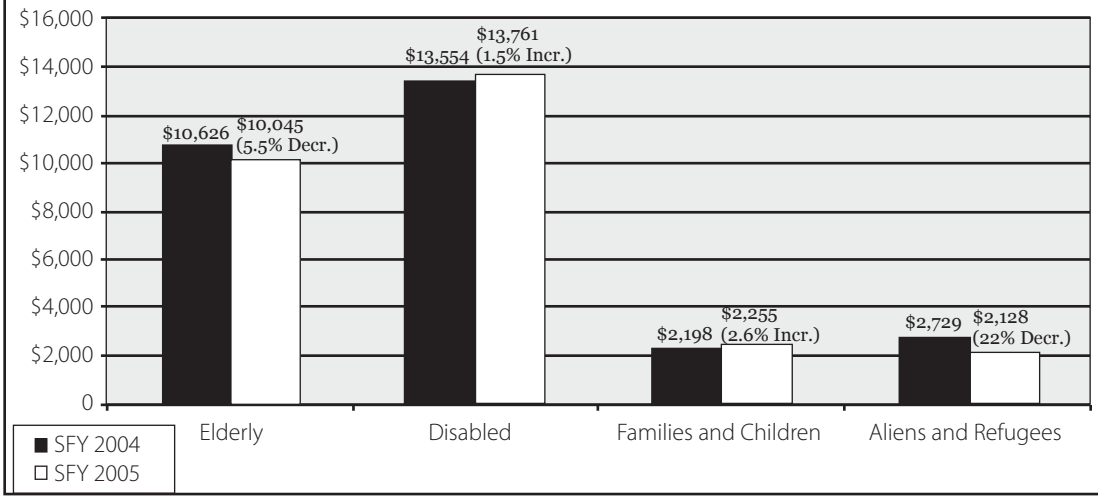


Exhibit 12

N.C. Medicaid Growth in Expenditures SFY 2005 vs. SFY 2006

Category of Service	SFY 2006 Expenditures	SFY 2005 Expenditures	% Change
Prescription Drugs	$1,385,039,301	$1,648,039,897	-16.0
Inpatient Hospital	$1,024,293,989	$961,904,185	6.5
Physician	$817,055,723	$751,474,742	8.7
Outpatient Hospital	$599,306,708	$533,837,438	12.3
Mental Health Clinics	$472,785,462	$502,084,896	-5.8
Medicare Part B Premiums	$228,234,475	$219,553,075	4.0
Dental	$217,965,881	$194,367,043	12.1
Other Non-Long-Term	$1,004,919,238	$666,127,163	50.9
Total Non-Long-Term	**$5,749,600,779**	**$5,477,388,439**	**5.0**
Total Long-Term	**$2,833,862,694**	**$2,692,640,458**	**5.2**
Grand Total LTC & N-LTC	**$8,538,463,472**	**$8,170,028,897**	**4.5**

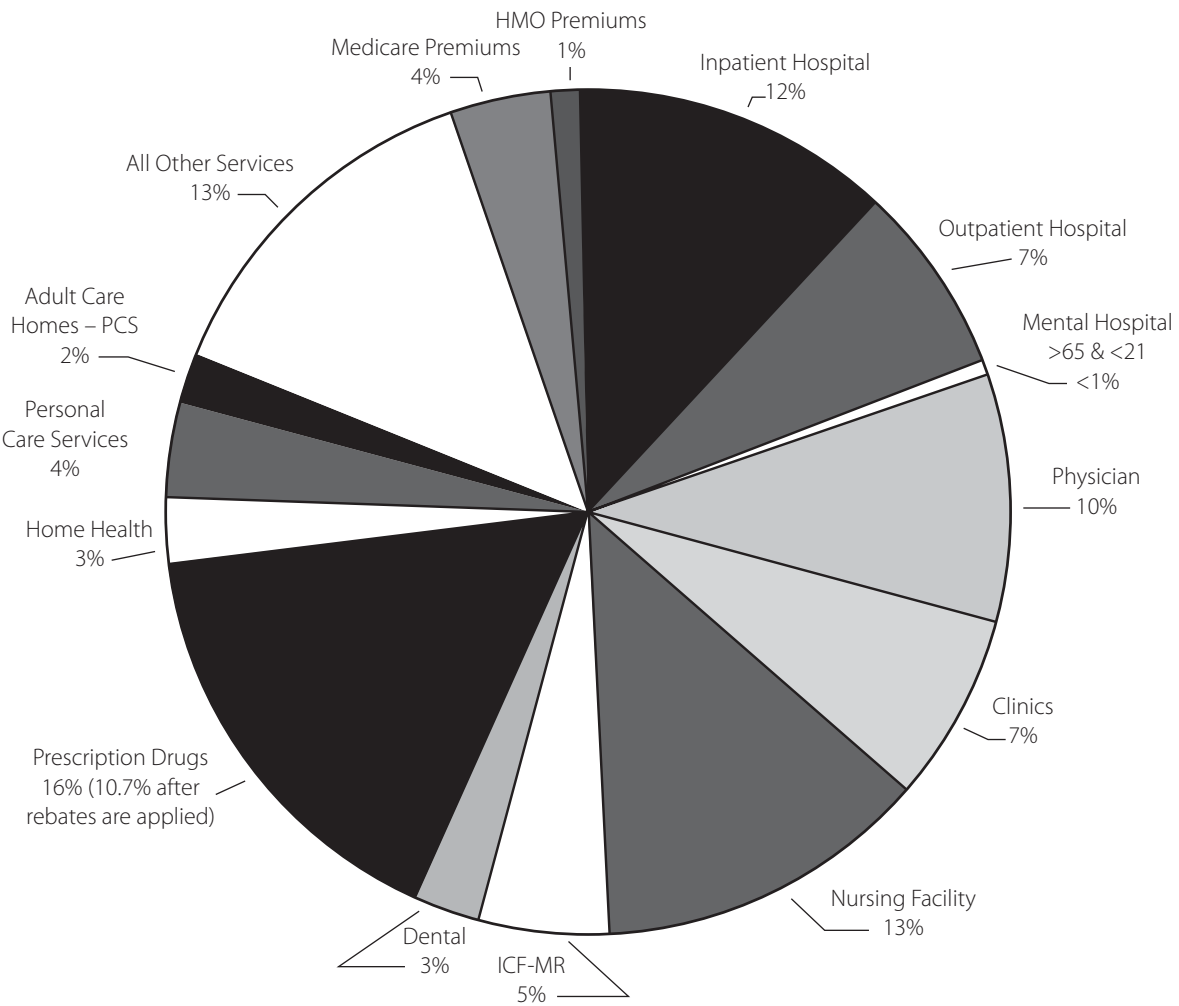
Notes: "Long term care" includes nursing facilities, hospital long-term care, home health, durable medical equipment, CAP, home infusion therapy, hospice, PCS and adult care home services. Amounts are service expenditures (Fund 1310) only and are sorted by amount of non–long-term-care expense.

Source: BD-701, June 2005 and 2006

The two most expensive Medicaid service categories in SFY 2006 were prescription drugs and inpatient hospital services. Prescription drugs cost $1.4 billion, or approximately 16 percent of total expenditures, as shown in **Table 9** (see the "Medicaid Tables" section of this report) and **Exhibit 13**. This was a decrease of 16 percent over the previous fiscal year, as shown in **Exhibit 12**. When manufacturers' rebates of $468 million are applied, the net amount spent on prescription drugs was $917 million, or 10.7 percent of total expenditures. The decrease in prescription drug expenditures was due to DMA's continuing prescription drug cost containment efforts as well as to the mid-year transition of dually eligible recipients to Medicare Part D prescription drug coverage. Inpatient hospital services, the second-highest category of service expenditures, accounted for approximately $1 billion, or 11.9 percent of total service expenditures. This was an increase of 6.5 percent.

Exhibit 13

Medicaid Services Expenditures for SFY 2006

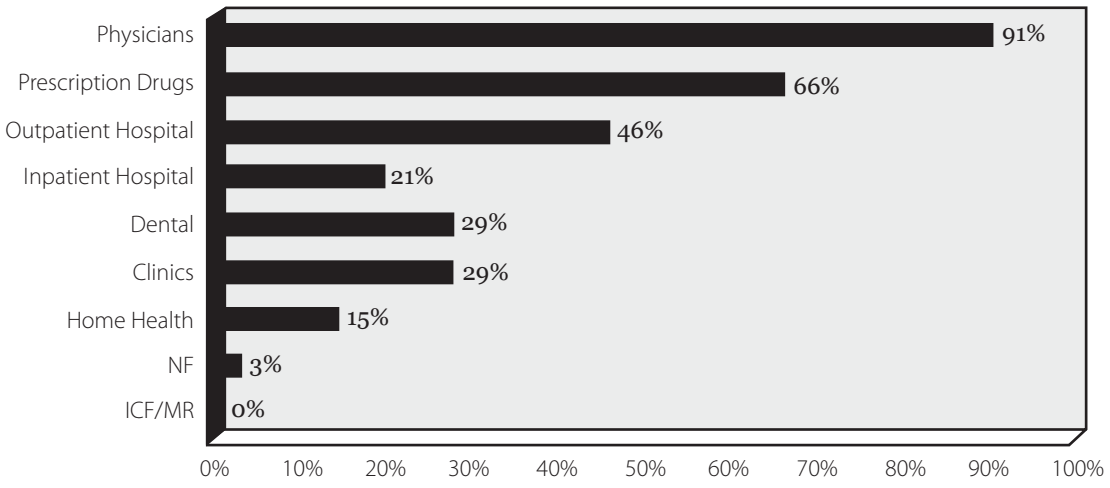


Two other items of special interest appear in **Exhibit 12**. One is the growth of DMA's long-term and non–long-term service expenditures from SFY 2005 to SFY 2006. Non–long-term care expenditures grew by only 2.8 percent, whereas long-term care expenditures grew by 5.2 percent. The other is the 5.8 percent drop in mental health clinic expenditures, due to mental health reform and the resulting service realignment during SFY 2006.

As **Exhibit 14** shows, 91 percent of North Carolina's Medicaid recipients received services at least once during SFY 2006 from a physician; 66 percent received at least one prescribed drug; and 46 percent received services in a hospital outpatient setting. The utilization rate falls off dramatically for other service providers and locations.

Exhibit 14

Selected Medicaid Service Usage by Recipient
Percent of Total Users
State Fiscal Year 2006



Medicaid eligibility and expenditures vary widely among the 100 North Carolina counties, as **Table 8** in the "Medicaid Tables" section demonstrates. The percentage of Medicaid-eligible residents in the general population was as high as 35.57 percent in Vance County and as low as 9.77 percent in Orange County. Average expenditures per eligible person ranged from a high of $6,557 in Bertie County to a low of $3,857 in Cumberland County. Expenditures per capita were the highest in Bertie County, $2,157, and the lowest in Wake County, $508.

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

Medicaid Tables

Table 1

North Carolina Medicaid State Fiscal Year 2006 Federal Matching Rates

The N.C. Medicaid Program is funded by federal, state and county sources which operate on different fiscal years (July 1 through June 30 for state and county and October 1 through September 30 for federal). Therefore, two separate financial participation rates are shown below as they are phased in during the year.

Note: Administrative reimbursement does not change during the year as it is not affected by the difference in our fiscal years.

Benefit Costs (7/1/05 - 9/30/06)

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

Benefit Costs (10/1/05 - 6/30/06)

	Services except Family Planning	Family Planning
Federal	63.63%	90.00%
State	30.91%	8.50%
County	5.46%	1.50%

Benefit Costs (10/1/05 - 6/30/06)

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

**MMIS - Medicaid Management Information System*

Table 2a N.C. Medicaid Eligibility during SFY 2006

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 is required. The cash assistance programs are: • Work First Family Assistance – N.C. 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 aged, blind and disabled persons. • State/County Special Assistance – State cash assistance program for aged and disabled individuals, primarily those 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 they live together	100% of Poverty 1 – $ 817/mo 2 – $1,100/mo	SSI Limits 1 – $2,000 2 – $3,000	Yes	If income exceeds income limit and the indicator is "yes", 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 $1,650 and can be as much as $2,489, depending upon the 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 half the total value of the countable resources, but currently not less than $19,908 or more than $99,540. 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 CAP or other in-home health services and 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 they live together. Parents' income and resources if under age 18 and lives with parents.	100% of Poverty 1 – $ 817/mo 2 – $1,100/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 they live together. Parents' income and resources if under age 18 and lives with parents.	100% of Poverty 1 – $ 817/mo 2 – $1,100/mo	SSI Limits 1 – $2,000 2 – $3,000	Yes		
Qualified Medicare Beneficiaries	Payment of Medicare premiums, deductibles and co-insurance charges for Medicare-covered services	Entitled to Medicare Parts A & B	Spouse's income and resources if they live together. Parents' income and resources if under age 18 and lives with parents.	100% of Poverty 1 – $ 817/mo 2 – $1,100/mo	2 x SSI Limits 1 – $4,000 2 – $6,000	No		
Specified Low-Income Medicare Beneficiaries	Payment of Medicare Part B premiums	Entitled to free Medicare Part A	Spouse's income and resources if they live together. Parents' income and resources if under age 18 and lives with parents.	120% of Poverty 1 – $ 980/mo 2 – $1,320/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 they live together. Parents' income and resources if under age 18 and lives with parents.	135% of Poverty 1 – $1,103/mo 2 – $1,485/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 they live together. Parents' income and resources if under age 18 and lives with parents.	200% of Poverty 1 – $1,634/mo 2 – $2,200/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, and state residence) that can also affect eligibility of the level of benefits are not reflected on this chart.

Table 2a (cont.) N.C. Medicaid Eligibility during SFY 2006

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 or 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 they live together. Parents' income and resources if under age 21 and lives with parents.	45% of Poverty 1 - $362/mo 2 - $472/mo 3 - $544/mo 4 - $594/mo 5 - $648/mo	$3,000	Yes	If income exceeds income limit and the indicator is "yes", the individual or family may be able to be eligible for Medicaid if he can meet a deductible. **Medicaid Deductible:** When an individual or 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-month deductible. Once medical bills are incurred for which they are responsible, they are authorized for the remainder of the 6-month 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: $3,000 for families and children; and for aged, blind and disabled $2,000 (1 person) and $3,000 (2 people)	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 of the pregnant woman and, if in the home, the father of the unborn.	185% of Poverty 1 - $1,511/mo 2 - $2,035/mo 3 - $2,560/mo 4 - $3,084/mo 5 - $3,608/mo	No resource limit if eligible with income no more than 185% of poverty	Yes		When determining the family size for the pregnant woman, include the unborn child. 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. Children covered through 200% FPL.			Yes		
Children aged 1 through 5 years	Full Medicaid coverage	Be over age 1 through age 5	Parents' income if living in the home.	200% of Poverty 1 - $1,634/mo 2 - $2,200/mo 3 - $2,767/mo 4 - $3,334/mo 5 – $3,900/mo	No resource limit if eligible with income no more than 200% of poverty	Yes		
Children aged 6 through 18 years	Full Medicaid coverage	Be age 6 through age 18	Parents' income if living in the home.	100% of Poverty 1 - $ 817/mo 2 - $1,100/mo 3 - $1,384/mo 4 - $1,667/mo 5 - $1,950/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	Be a woman who has been screened and enrolled in the N.C. 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.
Family Planning Waiver	Family Planning exams and services. Screening and treatment for STI. Screenings for HIV. Sterilizations	Women aged 19 through 55. Men aged 19 through 60. Not otherwise eligible for Medicaid.	Count spouse's income. Do not count parents' income for children.	185% of Poverty 1 - $1,511/mo 2 - $2,035/mo 3 - $2,560/mo 4 - $3,084/mo 5 - $3,608/mo	No resource limit.	There is no deductible or spenddown provision for Family Planning coverage. If a recipient's income increases to more than 185% of poverty, s/he will be ineligible for Family Planning coverage.		

Table 2b

Financial Eligibility for Medicaid based on Percentage of Poverty (Annual) SFY 2006

Family Size	100%	120%	133%	135%	185%	200%	SSI	MNIL	SA/ACH	SA/SCU	SA/In-Home
1	$ 9,800	$ 11,760	$ 13,034	$ 13,230	$ 18,130	$ 19,600	$ 7,236	$ 2,904	$13,962	$18,726	$9,800
2	$ 13,200	$ 15,840	$ 17,556	$ 17,820	$ 24,420	$ 26,400	$ 10,848	$ 3,804			
3	$ 16,600		$ 22,078		$ 30,710	$ 33,200					
4	$ 20,000		$ 26,600		$ 37,000	$ 40,000					
5	$ 23,400		$ 31,122		$ 43,290	$ 46,800					

Note 1: The Federal Poverty Level amounts change each year effective April. The above figures were effective April 1, 2006 and remained in effect through the end of SFY 2006

Note 2: SSI recipients are automatically eligible. Income limits are $7,236 for a family of one and $10,848 for a family of two. Adult care home residents who receive state-county special assistance are also automatically eligible. Income limit for SA/ACH is $13,962 for a family of one; for SA/SCU, the income limit is $18,726 for a family of one. Income limit for SA/In-Home is $9,800 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 2006 MNIL is set by the N.C. General Assembly and equals $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 2006 vs. 2005 Enrolled Medicaid Providers

Providers	2006	2005	Percent Change
Adult Care Home Providers	2,083	2,086	-0.1%
Ambulance Service Providers	281	273	2.9%
Chiropractors	951	1,064	-10.6%
Community Alternatives Program Providers: CAP/C, CAP/AIDS, CAP/MR-DD, CAP/DA, CAP/Choice	1,321	1,237	6.8%
Dental Service Providers: Dentists, Oral Surgeons, Pediadontists, Orthodontists	4,381	4,234	3.5%
Durable Medical Equipment Suppliers	2,202	2,200	0.1%
Hearing Aid Suppliers	84	92	-8.7%
Home Health Agency Providers: Home Infusion Therapy, Private Duty Nursing	364	414	-12.1%
Hospice Agency Providers	78	78	0.0%
Hospital Providers	417	556	-25.0%
Independent Laboratory Providers	150	160	-6.3%
Independent Practitioners: Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, Audiologists	2,450	2,258	8.5%
Managed Care Programs (HMOs)	1	1	0.0%
Mental Health Program Providers	95	132	-28.0%
Mental Health Providers	5,819	4,161	39.8%
Nursing Facility Providers	1,207	1,231	-1.9%
Optical Service Providers and Suppliers: Opticians, Optometrists	1,136	1,194	-4.9%
Other Types of Clinics: Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers	219	218	0.5%
Personal Care Service Providers	946	822	15.1%
Pharmacists	2,054	2,012	2.1%
Physician Extenders: Nurse Midwives, Physician Assistants, Nurse Practitioners, CRNAs	2,320	2,141	8.4%
Physicians	24,917	25,547	-2.5%
Podiatrists	337	373	-9.7%
Portable X-ray Service Providers	27	28	-3.6%
Psychiatric Facility Providers	622	683	-8.9%
Public Health Program Providers	489	497	-1.6%
Rural Health Clinic/Federally Qualified Health Center Providers	388	344	12.8%
Community Based Providers	1,348	172	683.7%
Total	**56,687**	**54,208**	**4.6%**

Note: This is an unduplicated count of active providers enrolled during SFYs 2005 and 2006. Physicians may be counted individually and/or as a group.

Table 4

North Carolina Medicaid State Fiscal Year 2006 Medicaid Covered Services

Adult Care Home Personal Care Services
Ambulance & Other Medical Transportation
Targeted Case Management for:
- Pregnant women
- Developmentally disabled children (ages 0 – 5 years)
- 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 for:
- Persons with AIDS
- Children
- Disabled Adults
- Mentally Retarded/Developmentally Disabled Persons

Dental Care Services
Diagnostic Testing
Domicile Care
Durable Medical Equipment
Health Check Services (EPSDT)
Family Planning Services, Supplies and Devices
General and Specialty Inpatient and Outpatient Hospital Services
Hearing Aids (children)
HMO Membership
Home Health Services
Home Infusion Therapy Services
Hospice
Intermediate Care Facilities for the Mentally Retarded
Laboratory and Radiological Services
Mental Health Services
Migrant Health Clinics
Nurse Anesthetists
Nurse Midwives
Nurse Practitioners
Nursing Facilities
Optical Services and Supplies
Personal Care Services
Physicians
Podiatrists
Prescription Drugs
Preventive Services
Private Duty Nursing Services
Prosthetics and Orthotics (children and adults)
Psychiatric Residential Treatment Facilities (children under age 21)
Rehabilitative Services (under Behavioral Health Services)
Screening
Specialized Therapies (Occupational, Physical and Respiratory Therapy, Speech/Language Pathology and Audiology)

Table 5

North Carolina Medicaid Program
State Fiscal Year 2006 vs. 2005
Fund 1310 - Sources of Medicaid Funds - Services Expenditures Only

	2006	Percent	2005	Percent
Federal	$ 5,209,510,606	60.69%	$ 5,168,013,772	63.26%
State*	$ 2,348,873,427	27.37%	$ 2,045,751,219	25.04%
Other State**	$ 567,149,647	6.61%	$ 529,046,035	6.48%
County	$ 457,929,792	5.34%	$ 427,217,872	5.23%
Total	**$ 8,583,463,472**	**100.00%**	**$ 8,170,028,897**	**100.00%**

* "State" refers to state appropriation of funds

** "Other State" funds includes collection of nursing facility assessments, prior year earned revenues, receipts from DSH and certified public expenditures applicable to Local Education Agencies and Qualified Public Hospitals where DMA pays only the federal share.

Source: BD701, the Authorized Monthly Budget Report for the periods ending June 29, 2006 and June 29, 2005, respectively. NCAS

Table 6

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

STATE FISCAL YEAR	TOTAL EXPENDITURES	Increase over Prior Year	FEDERAL EXPENDITURES	Increase over Prior Year	COUNTY EXPENDITURES	Increase over Prior Year	STATE EXPENDITURES	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%
SFY 2005	8,170,028,897	10.3%	5,168,013,772	6.2%	427,217,872	14.8%	2,574,797,253	19.0%
SFY 2006	8,583,463,472	5.1%	5,209,510,606	0.8%	457,929,792	7.2%	2,916,023,074	13.3%

NOTES:

1) 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.

2) "State" expenditures include state appropriations from the NC General Assembly as well as "Other State" funds ("Other State" funds include collection of nursing facility assessments, prior year earned revenues, receipts from DSH and certified public expenditures applicable to Local Education Agencies and Qualified Public Hospitals where DMA pays only the federal share.)

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

Table 7

North Carolina Medicaid
State Fiscal Years 1979 - 2006
A History of Unduplicated Medicaid Eligibles

Fiscal Years	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Medicaid Pregnant Women	Medicaid Indigent Children	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%
2004-05	151,512	44,130	2,130	249,921	468,711	57,190	567,060	5366	17,496	235	1,563,751	3.40%
2005-06	149,961	52,895	2,084	257,344	468,662	58,518	588,417	5,511	18,980	273	1,602,645	2.49%
SFY 2005 Percent Total Eligibles:	**9.7%**	**2.8%**	**0.1%**	**16.0%**	**30.0%**	**3.7%**	**36.3%**	**0.3%**	**1.1%**	**0.0%**	**100.0%**	
SFY 2006 Percent Total Eligibles:	**9.4%**	**3.3%**	**0.1%**	**16.1%**	**29.2%**	**3.7%**	**36.7%**	**0.3%**	**1.2%**	**0.0%**	**100.0%**	

Source: Medicaid Eligibility Report, EJA752 - SFY 2006

Table 8

North Carolina Medicaid
State Fiscal Year 2006
Eligibles and Program Payments for Which the County is Responsible for Its Computable Share*

COUNTY NAME	2005 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES**	TOTAL EXPENDITURES	EXPENDITURES PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% OF MEDICAID ELIGIBLES BY COUNTY, BASED ON 2005 POPULATION
ALAMANCE	138,572	24,606	$ 120,864,084	$ 4,912	$ 872	70	178	17.76%
ALEXANDER	35,898	6,519	28,888,042	4,431	805	82	182	18.16%
ALLEGHANY	10,912	2,314	14,275,612	6,169	1,308	24	212	21.21%
ANSON	25,766	7,130	43,083,786	6,043	1,672	8	277	27.67%
ASHE	25,500	5,349	32,281,759	6,035	1,266	29	210	20.98%
AVERY	18,030	3,324	19,271,547	5,798	1,069	47	184	18.44%
BEAUFORT	46,010	11,300	71,090,554	6,291	1,545	14	246	24.56%
BERTIE	19,640	6,460	42,360,246	6,557	2,157	1	329	32.89%
BLADEN	32,866	10,255	51,963,010	5,067	1,581	12	312	31.20%
BRUNSWICK	89,463	17,380	76,298,783	4,390	853	76	194	19.43%
BUNCOMBE	216,738	40,951	220,677,195	5,389	1,018	54	189	18.89%
BURKE	88,293	17,845	91,428,448	5,123	1,036	51	202	20.21%
CABARRUS	150,434	24,866	108,147,271	4,349	719	89	165	16.53%
CALDWELL	78,492	16,268	80,331,905	4,938	1,023	53	207	20.73%
CAMDEN	9,008	1,177	6,083,252	5,168	675	92	131	13.07%
CARTERET	62,760	9,789	49,686,306	5,076	792	84	156	15.60%
CASWELL	23,759	5,393	29,422,753	5,456	1,238	33	227	22.70%
CATAWBA	149,032	27,128	118,995,662	4,386	798	83	182	18.20%
CHATHAM	56,090	7,847	40,388,331	5,147	720	88	140	13.99%
CHEROKEE	26,180	5,798	33,126,947	5,714	1,265	30	221	22.15%
CHOWAN	14,470	3,630	20,414,696	5,624	1,411	19	251	25.09%
CLAY	9,876	2,069	8,893,056	4,298	900	66	209	20.95%
CLEVELAND	97,056	24,230	130,388,074	5,381	1,343	21	250	24.96%
COLUMBUS	54,524	17,906	95,632,843	5,341	1,754	5	328	32.84%
CRAVEN	92,670	16,679	87,622,945	5,253	946	62	180	18.00%
CUMBERLAND	305,173	60,289	232,561,574	3,857	762	86	198	19.76%
CURRITUCK	22,984	2,763	12,951,880	4,688	564	97	120	12.02%
DARE	34,790	3,778	18,808,674	4,978	541	99	109	10.86%
DAVIDSON	154,294	28,212	140,741,779	4,989	912	65	183	18.28%
DAVIE	38,930	5,370	25,598,248	4,767	658	93	138	13.79%
DUPLIN	51,920	13,081	61,009,491	4,664	1,175	41	252	25.19%
DURHAM	242,210	41,267	201,402,111	4,880	832	79	170	17.04%
EDGECOMBE	53,034	18,861	86,065,102	4,563	1,623	11	356	35.56%
FORSYTH	326,340	57,511	270,958,994	4,711	830	80	176	17.62%
FRANKLIN	54,106	11,122	53,967,100	4,852	997	55	206	20.56%
GASTON	193,886	42,303	229,739,408	5,431	1,185	38	218	21.82%
GATES	11,219	2,140	11,543,658	5,394	1,029	52	191	19.07%
GRAHAM	8,119	2,216	14,504,413	6,545	1,786	3	273	27.29%
GRANVILLE	53,356	9,464	45,859,819	4,846	860	74	177	17.74%
GREENE	20,173	4,696	23,983,076	5,107	1,189	36	233	23.28%
GUILFORD	441,428	78,498	331,256,977	4,220	750	87	178	17.78%
HALIFAX	56,253	18,975	97,615,858	5,144	1,735	6	337	33.73%
HARNETT	101,608	20,774	89,187,652	4,293	878	69	204	20.45%
HAYWOOD	56,595	11,474	59,221,422	5,161	1,046	50	203	20.27%
HENDERSON	97,792	15,909	84,601,057	5,318	865	72	163	16.27%
HERTFORD	23,864	7,345	40,212,504	5,475	1,685	7	308	30.78%
HOKE	40,696	9,522	38,817,360	4,077	954	60	234	23.40%
HYDE	5,587	1,360	8,268,523	6,080	1,480	17	243	24.34%
IREDELL	139,727	22,879	99,690,247	4,357	713	90	164	16.37%
JACKSON	35,752	6,079	30,898,586	5,083	864	73	170	17.00%
JOHNSTON	146,312	28,747	128,642,178	4,475	879	68	196	19.65%
JONES	10,246	2,280	13,289,503	5,829	1,297	25	223	22.25%
LEE	53,789	11,343	46,178,342	4,071	859	75	211	21.09%
LENOIR	58,278	16,174	86,930,231	5,375	1,492	15	278	27.75%

Table 8 (cont.)

North Carolina Medicaid
State Fiscal Year 2006
Eligibles and Program Payments for Which the County is Responsible for Its Computable Share*

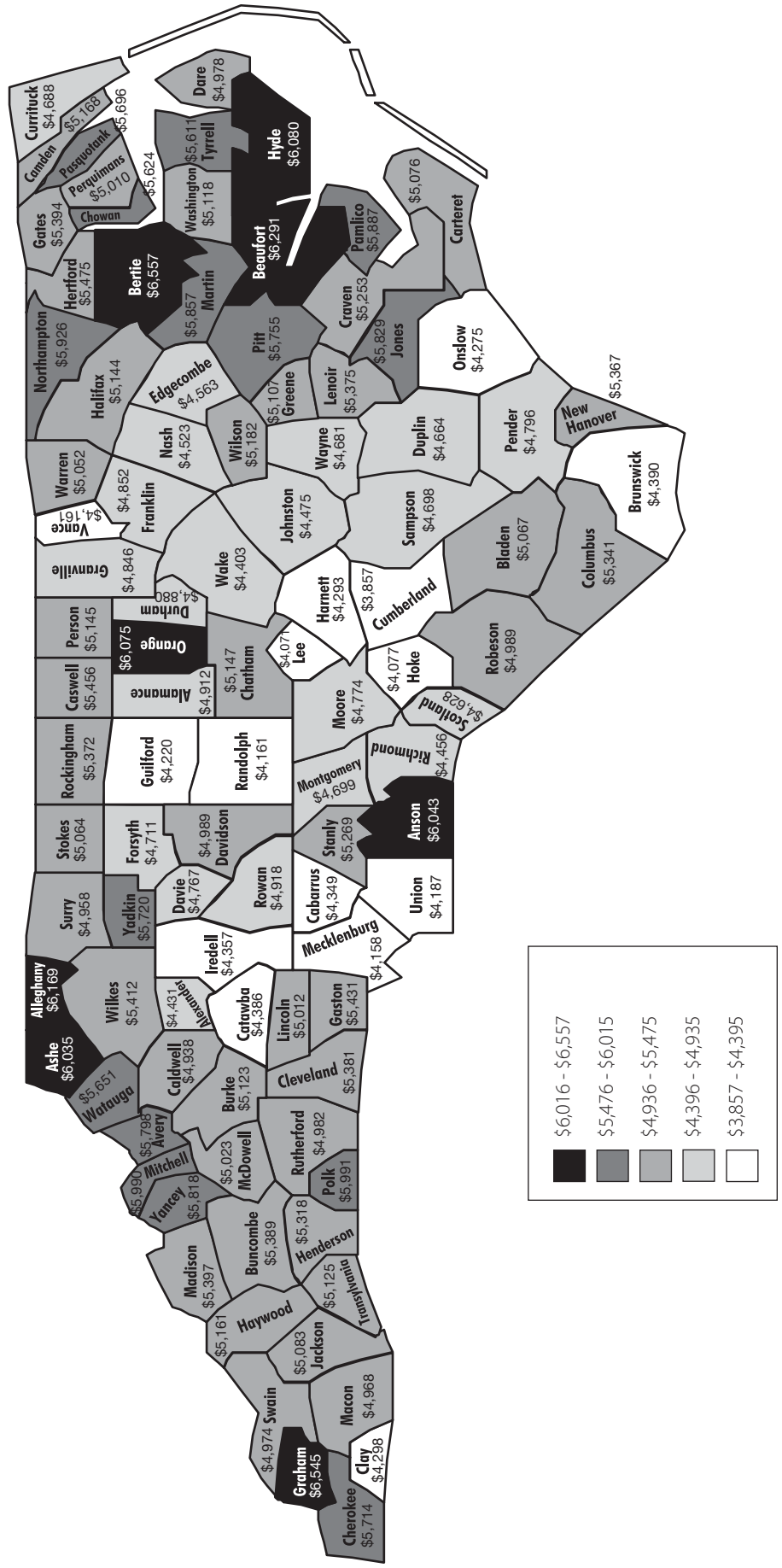
COUNTY NAME	2005 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES**	TOTAL EXPENDITURES	EXPENDITURES PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% OF MEDICAID ELIGIBLES BY COUNTY, BASED ON 2005 POPULATION
LINCOLN	69,529	11,831	59,295,525	5,012	853	77	170	17.02%
MACON	32,550	6,279	31,196,302	4,968	958	59	193	19.29%
MADISON	20,296	4,483	24,194,443	5,397	1,192	35	221	22.09%
MARTIN	24,580	6,989	40,933,425	5,857	1,665	9	284	28.43%
MCDOWELL	43,175	9,097	45,697,257	5,023	1,058	49	211	21.07%
MECKLENBURG	796,232	130,413	542,317,400	4,158	681	91	164	16.38%
MITCHELL	15,880	3,334	19,970,860	5,990	1,258	32	210	20.99%
MONTGOMERY	27,359	7,083	33,281,903	4,699	1,216	34	259	25.89%
MOORE	80,867	12,999	62,057,139	4,774	767	85	161	16.07%
NASH	91,544	19,886	89,939,189	4,523	982	56	217	21.72%
NEW HANOVER	180,358	28,307	151,913,847	5,367	842	78	157	15.69%
NORTHAMPTON	21,568	6,855	40,622,557	5,926	1,883	2	318	31.78%
ONSLOW	157,748	21,386	91,431,719	4,275	580	95	136	13.56%
ORANGE	121,991	11,922	72,426,226	6,075	594	94	98	9.77%
PAMLICO	13,068	2,559	15,064,677	5,887	1,153	43	196	19.58%
PASQUOTANK	38,882	8,715	49,644,694	5,696	1,277	28	224	22.41%
PENDER	46,538	9,150	43,880,250	4,796	943	63	197	19.66%
PERQUIMANS	12,154	2,684	13,447,078	5,010	1,106	45	221	22.08%
PERSON	37,125	8,025	41,286,913	5,145	1,112	44	216	21.62%
PITT	143,207	29,084	167,380,616	5,755	1,169	42	203	20.31%
POLK	19,006	2,854	17,097,442	5,991	900	67	150	15.02%
RANDOLPH	137,283	26,961	112,190,627	4,161	817	81	196	19.64%
RICHMOND	46,676	13,800	61,496,283	4,456	1,318	23	296	29.57%
ROBESON	127,695	45,137	225,187,858	4,989	1,763	4	353	35.35%
ROCKINGHAM	91,817	20,289	108,992,977	5,372	1,187	37	221	22.10%
ROWAN	133,339	25,289	124,379,384	4,918	933	64	190	18.97%
RUTHERFORD	63,303	14,969	74,578,181	4,982	1,178	39	236	23.65%
SAMPSON	63,566	17,390	81,694,432	4,698	1,285	27	274	27.36%
SCOTLAND	36,838	12,449	57,615,692	4,628	1,564	13	338	33.79%
STANLY	58,912	10,760	56,696,890	5,269	962	58	183	18.26%
STOKES	46,234	7,910	40,052,493	5,064	866	71	171	17.11%
SURRY	73,028	15,740	78,035,922	4,958	1,069	48	216	21.55%
SWAIN	13,585	3,647	18,139,872	4,974	1,335	22	268	26.85%
TRANSYLVANIA	29,880	5,526	28,319,810	5,125	948	61	185	18.49%
TYRRELL	4,203	1,015	5,694,664	5,611	1,355	20	241	24.15%
UNION	161,332	21,412	89,655,979	4,187	556	98	133	13.27%
VANCE	43,624	15,519	64,576,714	4,161	1,480	16	356	35.57%
WAKE	755,034	87,105	383,533,889	4,403	508	100	115	11.54%
WARREN	20,215	5,787	29,234,545	5,052	1,446	18	286	28.63%
WASHINGTON	13,418	4,287	21,942,542	5,118	1,635	10	319	31.95%
WATAUGA	42,934	4,302	24,308,786	5,651	566	96	100	10.02%
WAYNE	115,714	26,573	124,387,615	4,681	1,075	46	230	22.96%
WILKES	66,897	14,550	78,747,490	5,412	1,177	40	217	21.75%
WILSON	76,826	19,133	99,153,663	5,182	1,291	26	249	24.90%
YADKIN	37,404	6,396	36,583,543	5,720	978	57	171	17.10%
YANCEY	18,152	3,931	22,869,648	5,818	1,260	31	217	21.66%
STATE TOTAL	**8,682,066**	**1,602,645**	**$ 7,907,271,830**	**$ 4,934**	**$ 911**		**185**	**18.46%**

Notes: * Data reflect only net vendor payments for which the county is responsible for its computable share. That is why Total Expenditures does not equal the $8.58 billion reported in Tables 5, 6 and 9.

** 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 2006.

Medicaid Expenditures per Eligible by County, SFY 2006



Medicaid Eligibles per 1,000 Population by County, SFY 2006

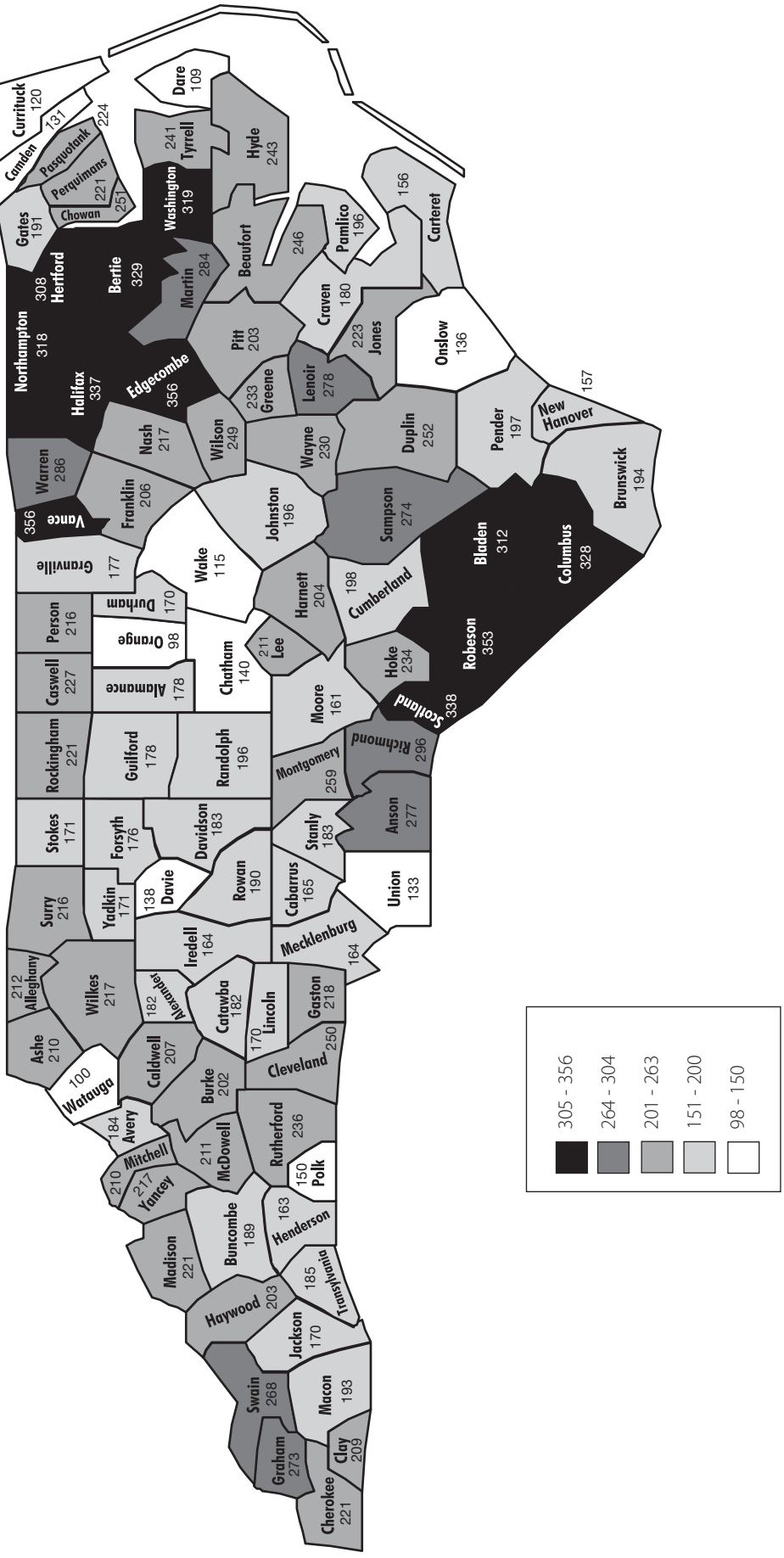


Table 9

North Carolina Medicaid
State Fiscal Year 2006 Program Services Expenditures
Budget Code 14445, Fund 1310
(Division of Medical Assistance Only)

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	$ 1,024,293,989	11.9%	12.7%	357,069	$ 2,869
Outpatient Hospital	$599,306,708	7.0%	7.5%	768,702	$ 780
Mental Hospital <21 & >65	$39,432,017	0.5%	0.5%	2,400	$ 16,430
Physician	$817,055,723	9.5%	10.2%	1,521,914	$ 537
Clinics	$603,205,761	7.0%	7.5%	493,594	$ 1,222
Nursing Facilities	$ 1,086,831,460	12.7%	13.5%	43,117	$ 25,207
ICF-MR	$415,064,521	4.8%	5.2%	4,143	$ 100,185
Dental	$217,965,881	2.5%	2.7%	481,207	$ 453
Prescription Drugs	$ 1,385,039,301	16.1%	17.2%	1,108,467	$ 1,250
Home Health	$218,569,334	2.5%	2.7%	247,574	$ 883
Personal Care Services	$313,198,284	3.6%	3.9%	54,019	$ 5,798
Adult Care Homes - Personal Care Services	$153,094,077	1.8%	1.9%	29,504	$ 5,189
All Other Services	$ 1,166,871,315	13.6%	14.5%	1,193,752	$ 977
Subtotal, Services	**$ 8,039,928,372**	**93.7%**	**100.0%**		
Medicare Premiums: (Part A, Part B)	$321,053,823	3.7%	4.0%		
Part D Clawback	$91,999,451				
HMO Premiums	$ 118,984,041	1.4%	1.5%		
Transfers	$11,497,786	0.1%	0.1%		
Subtotal, Other	**$ 543,535,100**				
Fund 1310 Total Title XIX Services	**$ 8,583,463,472**				
Total Recipients (unduplicated)**				**1,673,510**	
Total Expenditures Per Recipient (unduplicated)					**$ 5,129**

* "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 individual 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.

SOURCE: BD-701 Report June 2006

Table 10

North Carolina Medicaid
State Fiscal Year 2006
Medicaid Service Expenditures by Recipient Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 2006 Expenditures Per Recipient	SFY 2005 Expenditures Per Recipient	SFY 05/06 Percent Change
Total Elderly	**$2,106,663,745**	**25.0%**	**209,719**	**12.5%**	**$ 10,045**	**$ 10,626**	**-5.5%**
Aged	2,061,775,404	24.5%	157,376	9.4%	$ 13,101	$ 13,165	-0.5%
Medicare-Aid (MQBQ & MQBB & MQBE & M-SCHIP)	44,888,341	0.5%	52,343	3.1%	$ 858	$ 810	5.8%
Total Disabled	**$ 3,667,723,028**	**43.6%**	**266,525**	**15.9%**	**$ 13,761**	**$ 13,554**	**1.5%**
Disabled	3,635,941,536	43.2%	264,396	15.8%	$ 13,752	$ 13,553	1.5%
Blind	31,781,492	0.4%	2,129	0.1%	$ 14,928	$ 13,707	8.9%
Total Families & Children	**$ 2,605,257,873**	**31.0%**	**1,155,305**	**69.0%**	**$ 2,255**	**$ 2,198**	**2.6%**
AFDC Adults (> 21)	715,976,135	8.5%	236,057	14.1%	$ 3,033	$ 3,086	-1.7%
Medicaid Pregnant Women (MPW)	243,146,466	2.9%	70,529	4.2%	$ 3,447	$ 3,895	-11.5%
AFDC Children & Other Children	608,235,631	7.2%	242,050	14.5%	$ 2,513	$ 2,322	8.2%
Medicaid Indigent Children (MIC)	1,031,942,251	12.3%	606,330	36.2%	$ 1,702	$ 1,611	5.7%
Breast and Cervical	5,957,389	0.1%	339	0.0%	$ 17,573	$ 18,426	-4.6%
Aliens and Refugees	**$ 61,093,589**	**0.7%**	**28,707**	**1.7%**	**$ 2,128**	**$ 2,729**	**-22.0%**

Source: SFY 2006 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 107 Budget Reports

Table 11

North Carolina Medicaid
State Fiscal Year 2006
Service Expenditures for Selected Major Medical Services by Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ* Medicare Qualified Beneficiary	MQBQ+MQBE Part B Premium Only	Blind	Disabled	Other Adult**	Breast & Cervical Cancer	Children	Aliens & Refugees	Adjustments Unattributable to a Specific Category
Inpatient Hospital	$ 1,016,669,108	12.08%	$ 11,957,721	$ 20,392	$ 10,832	$ 1,823,273	$ 459,344,083	$ 236,233,922	$ 508,810	$ 276,418,562	$ 41,754,107	$ (11,402,594)
Outpatient Hospital	595,192,318	7.07%	21,224,329	65,564	-	1,118,024	231,961,782	172,891,575	2,790,307	164,409,149	2,874,169	(2,142,581)
Mental Hospital (> 65)	6,353,568	0.08%	6,256,306	-	-	91,128	-	-	-	-	19,720	(13,586)
Psychiatric Hospital (< 21)	33,060,206	0.39%	-	-	-	9,666	9,703,927	22,150	-	23,358,732	576	(34,845)
Physician	811,165,650	9.64%	49,176,687	126,718	-	1,437,344	256,135,494	212,756,601	2,004,227	281,192,482	11,937,232	(3,601,135)
Clinics	602,279,496	7.16%	13,949,101	7,662	-	1,535,036	316,995,440	47,731,005	22,100	223,559,823	2,158,846	(3,679,516)
Nursing Facility	1,086,714,475	12.91%	924,152,451	38	1,102	2,610,340	159,720,940	366,782	-	63,900	272,383	(473,461)
Intermediate Care Facility for Mental Retardation	414,984,058	4.93%	26,409,884	-	-	7,279,809	378,919,972	52,765	-	2,354,951	-	(33,322)
Dental	215,658,936	2.56%	10,685,188	127	-	257,749	41,116,521	40,631,573	47,621	122,839,226	282,457	(201,527)
Prescribed Drugs	1,368,892,492	16.26%	286,466,213	-	-	4,265,537	701,428,032	158,270,400	433,671	218,126,383	342,439	(440,183)
Home Health	218,247,272	2.59%	39,183,366	13,269	-	1,333,303	144,459,537	14,126,334	68,101	19,369,784	299,163	(605,585)
CAP/Disabled Adult	265,865,843	3.16%	186,128,068	-	-	1,618,924	78,051,938	-	-	45,355	29,513	(7,955)
CAP/Mentally Retarded	288,169,935	3.42%	5,648,515	-	-	2,601,849	277,863,828	-	-	2,473,230	-	(417,488)
CAP/Children	28,970,196	0.34%	-	-	-	334,518	27,979,640	-	-	675,384	-	(19,345)
Personal Care	313,194,129	3.72%	158,261,595	-	-	2,504,210	142,913,421	7,039,703	20,171	2,542,947	10,246	(98,164)
Hospice	53,655,409	0.64%	35,388,485	-	-	122,877	17,569,683	452,681	576	192,839	3,611	(75,342)
EPSDT (Health Check)	53,517,566	0.64%	-	-	-	4,433	1,505,025	57,111	2	51,985,464	6,403	(40,870)
Laboratory & Imaging Services	40,204,304	0.48%	807,142	921	-	49,416	7,894,028	18,419,654	20,407	12,989,986	76,224	(53,472)
Adult Home Care	153,074,133	1.82%	85,204,754	-	-	302,792	67,460,664	97,105	243	43,566	-	(34,991)
High-Risk Intervention Residential	125,822,759	1.49%	-	-	-	-	30,745,654	-	-	95,125,326	-	(48,220)
Other Services	285,709,748	3.39%	19,819,974	9,651	-	436,661	110,395,301	39,001,756	37,695	115,329,987	995,162	(316,438)
Total Services	**$ 7,977,401,602**	**94.78%**	**$ 1,880,719,777**	**$ 244,341**	**$ 11,933**	**$ 29,736,888**	**$ 3,462,164,910**	**$ 948,151,117**	**$ 5,953,930**	**$ 1,613,097,075**	**$ 61,062,248**	**$ (23,740,617)**
Premiums:												
Medicare, Part A Premiums	49,423,073	**0.59%**	49,154,303	10,770	-	478,600	5,019	-	-	-	-	(225,619)
Medicare, Part B Premiums	271,628,735	**3.23%**	129,097,863	590,388	44,030,909	1,017,402	95,767,875	775,650	-	16,262	19,408	312,979
HMO Premiums	118,631,568	**1.41%**	2,803,461	-	-	548,602	78,003,731	10,195,834	3,459	27,064,547	11,933	-
Total Premiums	**$ 439,683,376**	**5.22%**	**$ 181,055,627**	**$ 601,158**	**$ 44,030,909**	**$ 2,044,604**	**$ 173,776,626**	**$ 10,971,485**	**$ 3,459**	**$ 27,080,808**	**$ 31,341**	**$ 87,360**
Program Category Totals			**$ 2,061,775,404**	**$ 845,499**	**$ 44,042,842**	**$ 31,781,492**	**$ 3,635,941,536**	**$ 959,122,601**	**$ 5,957,389**	**$ 1,640,177,883**	**$ 61,093,589**	**$ (23,653,258)**
Medicare Part D Payments****	**$ 91,999,451**		**$ 53,458,509**	**$ 20,904**	**$ 983,609**	**$ 402,185**	**$ 36,990,421**	**$ 136,135**	**$ -**	**$ 4,233**	**$ 3,455**	

* 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.

**** Source for Medicare Part D Payments: SFY 2006 BD701 Report

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.

Source: SFY 2006 Program Expenditure Report

Table 12

North Carolina Medicaid
State Fiscal Year 2006
Expenditures for the Elderly

Type of Service	Aged	Percent of Service Dollars	MQBQ Medicare Qualified Beneficiary	MQBQ+MQBE Part B Premium Only	Total Qualified Beneficiaries	Percent of Service Dollars	Total Elderly Dollars	SFY 2006 % of Total Dollars	SFY 2005 % of Total Dollars	SFY 2004 % of Total Dollars
Inpatient Hospital	$ 11,957,721	0.6%	$ 20,392	$ 10,832	$ 31,224	0.1%	$ 11,988,945	0.6%	0.5%	0.8%
Outpatient Hospital	21,224,329	1.0%	65,564	-	65,564	0.1%	21,289,893	1.0%	1.0%	1.6%
Mental Hospital (> 65)	6,256,306	0.3%	-	-	-	0.0%	6,256,306	0.3%	0.3%	0.4%
Physician	49,176,687	2.4%	126,718	-	126,718	0.3%	49,303,405	2.3%	2.1%	2.3%
Clinics	13,949,101	0.7%	7,662	-	7,662	0.0%	13,956,763	0.7%	0.6%	0.5%
Nursing Facility	924,152,451	44.8%	38	1,102	1,139	0.0%	924,153,590	43.9%	41.7%	39.8%
Intermediate Care Facility for Mental Retardation	26,409,884	1.3%	-	-	-	0.0%	26,409,884	1.3%	1.1%	1.3%
Dental	10,685,188	0.5%	127	-	127	0.0%	10,685,315	0.5%	0.4%	0.5%
Prescription Drugs	286,466,213	13.9%	-	-	-	0.0%	286,466,213	13.6%	21.7%	22.8%
Home Health	39,183,366	1.9%	13,269	-	13,269	0.0%	39,196,635	1.9%	1.6%	1.7%
CAP/Disabled Adult	186,128,068	9.0%	-	-	-	0.0%	186,128,068	8.8%	7.3%	7.4%
CAP/Mentally Retarded	5,648,515	0.3%	-	-	-	0.0%	5,648,515	0.3%	0.2%	0.3%
Personal Care	158,261,595	7.7%	-	-	-	0.0%	158,261,595	7.5%	6.7%	6.6%
Hospice	35,388,485	1.7%	-	-	-	0.0%	35,388,485	1.7%	1.3%	1.0%
EPSDT (Health Check)	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Laboratory & Imaging Services	807,142	0.0%	921	-	921	0.0%	808,062	0.0%	0.0%	0.0%
Adult Home Care	85,204,754	4.1%	-	-	-	0.0%	85,204,754	4.0%	3.9%	4.0%
High-Risk Intervention Residential	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Other Services	19,819,974	1.0%	9,651	-	9,651	0.0%	19,829,624	0.9%	0.7%	0.5%
Total Services	**$ 1,880,719,777**	**91.2%**	**$ 244,341**	**$ 11,933**	**$ 256,275**	0.6%	**$ 1,880,976,051**	**89.3%**	**91.3%**	**91.4%**
Premiums:										
Medicare Part A Premiums	49,154,303	2.4%	10,770	-	10,770	0.0%	49,165,073	2.3%	2.0%	2.2%
Medicare Part B Premiums	129,097,863	6.3%	590,388	44,030,909	44,621,296	99.4%	173,719,159	8.2%	6.7%	6.5%
HMO Premiums	2,803,461	0.1%	-	-	-	0.0%	2,803,461	0.1%	0.0%	0.0%
Total Premiums	**$ 181,055,627**	**8.8%**	**$ 601,158**	**$ 44,030,909**	**$ 44,632,066**	**99.4%**	**$ 225,687,694**	**10.7%**	**8.7%**	**8.6%**
Grand Total Services and Premiums	**$ 2,061,775,404**		**$ 845,499**	**$ 44,042,842**	**$ 44,888,341**	**100.0%**	**$ 2,106,663,745**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 106,979,260**									
Total Elderly Recipients	**157,376**		**520**	**52,343**	**52,863**		**209,719**			
Expenditures Per Recipient**	**$ 13,101**		**$ 1,626**	**$ 841**	**$ 849**		**$ 10,045**			
Medicare Part D Payments***	**$ 53,458,509**		**$ 20,904**	**$ 983,609**	**$ 1,004,513**		**$ 54,463,022**			

* 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 for Medicare Part D Payments: SFY 2006 BD701 Report

Source: SFY 2006 Program Expenditure Report

Table 13

North Carolina Medicaid
State Fiscal Year 2006
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	SFY 2006 % of Total Dollars	SFY 2005 % of Total Dollars	SFY 2004 % of Total Dollars
Inpatient Hospital	$ 459,344,083	12.6%	$ 1,823,273	5.7%	$ 461,167,356	12.6%	12.8%	13.5%
Outpatient Hospital	231,961,782	6.4%	1,118,024	3.5%	233,079,806	6.4%	6.2%	6.3%
Mental Hospital (> 65)	-	0.0%	91,128	0.3%	91,128	0.0%	0.0%	0.0%
Psychiatric Hospital (< 21)	9,703,927	0.3%	9,666	0.0%	9,713,593	0.3%	0.3%	0.2%
Physician	256,135,494	7.0%	1,437,344	4.5%	257,572,838	7.0%	6.8%	6.8%
Clinics	316,995,440	8.7%	1,535,036	4.8%	318,530,476	8.7%	9.1%	9.1%
Nursing Facility	159,720,940	4.4%	2,610,340	8.2%	162,331,280	4.4%	4.5%	4.0%
Intermediate Care Facility for Mental Retardation	378,919,972	10.4%	7,279,809	22.9%	386,199,781	10.5%	11.0%	12.3%
Dental	41,116,521	1.1%	257,749	0.8%	41,374,271	1.1%	1.1%	1.0%
Prescribed Drugs	701,428,032	19.3%	4,265,537	13.4%	705,693,569	19.2%	23.3%	22.6%
Home Health	144,459,537	4.0%	1,333,303	4.2%	145,792,839	4.0%	3.7%	3.6%
CAP/Disabled Adult	78,051,938	2.1%	1,618,924	5.1%	79,670,863	2.2%	1.9%	1.8%
CAP/Mentally Retarded	277,863,828	7.6%	2,601,849	8.2%	280,465,677	7.6%	7.5%	8.3%
CAP/Children	27,979,640	0.8%	334,518	1.1%	28,314,157	0.8%	0.7%	0.7%
Personal Care	142,913,421	3.9%	2,504,210	7.9%	145,417,631	4.0%	3.5%	2.8%
Hospice	17,569,683	0.5%	122,877	0.4%	17,692,560	0.5%	0.4%	0.4%
EPSDT (Health Check)	1,505,025	0.0%	4,433	0.0%	1,509,458	0.0%	0.0%	0.0%
Lab & X-ray	7,894,028	0.2%	49,416	0.2%	7,943,443	0.2%	0.2%	0.2%
Adult Home Care	67,460,664	1.9%	302,792	1.0%	67,763,456	1.8%	1.9%	1.8%
High Risk Intervention Residential	30,745,654	0.8%	-	0.0%	30,745,654	0.8%	0.8%	0.8%
Other Services	110,395,301	3.0%	436,661	1.4%	110,831,962	3.0%	1.7%	1.5%
Total Services	**$ 3,462,164,910**	**95.2%**	**$ 29,736,888**	**93.6%**	**$ 3,491,901,798**	**95.2%**	**97.2%**	**97.8%**
Premiums:								
Medicare, Part A Premiums	5,019	0.0%	478,600	1.5%	483,619	0.0%	0.0%	0.0%
Medicare, Part B Premiums	95,767,875	2.6%	1,017,402	3.2%	96,785,277	2.6%	2.3%	2.1%
HMO Premiums	78,003,731	2.1%	548,602	1.7%	78,552,333	2.1%	0.4%	0.1%
Total Premiums	**$ 173,776,626**	**4.8%**	**$ 2,044,604**	**6.4%**	**$ 175,821,229**	**4.8%**	**2.8%**	**2.2%**
Grand Total Services and Premiums	**$ 3,635,941,536**	**100.0%**	**$ 31,781,492**	**100.0%**	**$ 3,667,723,028**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 83,743,972**		**$ 856,542**		**$ 84,600,514**			
Total Disabled/Blind Recipients	**264,396**		**2,129**		**266,525**			
Service Expenditures Per Recipient**	**$ 13,752**		**$ 14,928**		**$ 13,761**			
Medicare Part D Payments***	**$ 36,990,421**		**$ 402,185**		**$ 37,392,606**			

* 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 for Medicare Part D Payments: SFY 2006 BD701 Report

Source: SFY 2006 Program Expenditure Report

Table 14

North Carolina Medicaid
State Fiscal Year 2006
Expenditures for Families and Children

Type of Service	AFDC Adults	Percent of Service Dollars	Pregnant Women	Percent of Service Dollars	AFDC Children & Other Children	Percent of Service Dollars	Indigent Children	Percent of Service Dollars	Breast Cervical	Percent of Service Dollars	Total Families & Children Dollars	SFY 2006 % of Total Dollars	SFY 2005 % of Total Dollars
Inpatient Hospital	$ 149,153,494	20.8%	$ 87,080,428	35.8%	$ 61,522,243	10.1%	$ 214,896,319	20.8%	$ 508,810	8.5%	$ 513,161,294	19.7%	20.0%
Outpatient Hospital	143,729,029	20.1%	29,162,546	12.0%	57,983,502	9.5%	106,425,647	10.3%	2,790,307	46.8%	340,091,032	13.1%	13.4%
Psychiatric Hospital (< 21)	-	0.0%	22,150	0.0%	12,941,151	2.1%	10,417,581	1.0%	-	0.0%	23,380,882	0.9%	0.8%
Physician	145,514,852	20.3%	67,241,749	27.7%	80,835,393	13.3%	200,357,088	19.4%	2,004,227	33.6%	495,953,310	19.0%	19.1%
Clinics	25,608,563	3.6%	22,122,442	9.1%	124,475,278	20.5%	99,084,545	9.6%	22,100	0.4%	271,312,928	10.4%	12.3%
Nursing Facility	366,782	0.1%	-	0.0%	23,487	0.0%	40,413	0.0%	-	0.0%	430,682	0.0%	0.0%
Intermediate Care Facility for Mental Retardation	52,765	0.0%	-	0.0%	1,830,481	0.3%	524,470	0.1%	-	0.0%	2,407,716	0.1%	0.1%
Dental	38,350,988	5.4%	2,280,585	0.9%	40,757,481	6.7%	82,081,745	8.0%	47,621	0.8%	163,518,420	6.3%	6.1%
Prescribed Drugs	146,246,766	20.4%	12,023,634	4.9%	80,537,435	13.2%	137,588,948	13.3%	433,671	7.3%	376,830,454	14.5%	14.6%
Home Health	12,050,925	1.7%	2,075,410	0.9%	5,962,162	1.0%	13,407,623	1.3%	68,101	1.1%	33,564,220	1.3%	1.3%
CAP/Disabled Adult	-	0.0%	-	0.0%	5,656	0.0%	39,699	0.0%	-	0.0%	45,355	0.0%	0.0%
CAP/Mentally Retarded	-	0.0%	-	0.0%	2,472,116	0.4%	1,114	0.0%	-	0.0%	2,473,230	0.1%	0.1%
CAP/Children	-	0.0%	-	0.0%	675,384	0.1%	-	0.0%	-	0.0%	675,384	0.0%	0.0%
Personal Care	6,970,016	1.0%	69,687	0.0%	1,262,307	0.2%	1,280,640	0.1%	20,171	0.3%	9,602,821	0.4%	0.3%
Hospice	452,681	0.1%	-	0.0%	19,700	0.0%	173,138	0.0%	576	0.0%	646,095	0.0%	0.0%
EPSDT (Health Check)	24,422	0.0%	32,689	0.0%	11,308,971	1.9%	40,676,493	3.9%	2	0.0%	52,042,576	2.0%	2.0%
Lab & X-ray	11,273,669	1.6%	7,145,985	2.9%	3,773,548	0.6%	9,216,438	0.9%	20,407	0.3%	31,430,047	1.2%	1.2%
High Risk Intervention Residential	-	0.0%	-	0.0%	54,967,803	9.0%	40,157,523	3.9%	-	0.0%	95,125,326	3.7%	3.8%
Adult Home Care	84,231	0.0%	12,874	0.0%	25,481	0.0%	18,085	0.0%	243	0.0%	140,914	0.0%	0.0%
Other Services	27,853,332	3.9%	11,148,424	4.6%	52,267,312	8.6%	63,062,675	6.1%	37,695	0.6%	154,369,437	5.9%	4.1%
Total Services	**$ 707,732,513**	**98.8%**	**$ 240,418,603**	**98.9%**	**$ 593,646,891**	**97.6%**	**$ 1,019,450,183**	**98.8%**	**$ 5,953,930**	**99.9%**	**$ 2,567,202,121**	**98.5%**	**99.2%**
Premiums:													
Medicare, Part A Premiums	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Medicare, Part B Premiums	698,445	0.1%	77,205	0.0%	9,750	0.0%	6,512	0.0%	-	0.0%	791,912	0.0%	0.0%
HMO Premiums	7,545,177	1.1%	2,650,658	1.1%	14,578,991	2.4%	12,485,556	1.2%	3,459	0.1%	37,263,840	1.4%	0.8%
Total Premiums	**$8,243,622**	**1.2%**	**$ 2,727,863**	**1.1%**	**$ 14,588,740**	**2.4%**	**$ 12,492,068**	**1.2%**	**$ 3,459**	**0.1%**	**$38,055,752**	**1.5%**	**0.8%**
Grand Total Services and Premiums	**$ 715,976,135**	**100.0%**	**$ 243,146,466**	**100.0%**	**$ 608,235,631**	**100.0%**	**$ 1,031,942,251**	**100.0%**	**$ 5,957,389**	**100.0%**	**$ 2,605,257,873**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 716,318**		**$ 109,173**		**$ 6,948**		**$ (12,416)**				**$ 820,023**		
Total Family & Child Recipients	**236,057**		**70,529**		**242,050**		**606,330**		**339**		**1,155,305**		
Service Expenditures Per Recipient**	**$ 3,033**		**$ 3,447**		**$ 2,513**		**$ 1,702**		**$ 17,573**		**$ 2,255**		
Medicare Part D Payments***	**$ 116,354**		**$ 18,917**		**$ 2,591**		**$ 1,641**		**-**		**$ 139,504**		

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

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

*** Source for Medicare Part D Payments: SFY 2006 BD701 Report

Source: SFY 2006 Program Expenditure Report

Table 15

North Carolina Medicaid State Fiscal Year 2006 Medicaid Copayment Amounts

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

Acknowledgements

Editorial Panel

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

Loretta Bohn
Information and Communications Specialist
Clinical Policy & Programs

Richard Cobb
Budget Officer
Budget Management

Brad Deen
Public Information Officer
DHHS Public Affairs Office

Julia McCollum
Human Services Planner/Evaluator
Managed Care

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Policy Project Manager, Medicaid Eligibility Unit
Recipient & Provider Services

Ann Slade
Section Chief, Pharmacy Review Unit
Program Integrity

Contributing Writers

Darlene Baker
Loretta Bohn
Deborah Bowen
Marie Britt
Richard Cobb
Tom D'Andrea
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Lorie Williams
Melody Yeargan

Data, Tables and Graphics

Emad Attiah
Richard Cobb
Charles Dewar
Patricia Slaughter

Production

Christie Adams

north carolina medicaid

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State of North Carolina
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DMA/Director's Office - 17
2501 Mail Service Center
Raleigh, NC 27699-2501
(919) 855-4100

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