Medicaid

in North Carolina

Annual Report

State Fiscal Year 2007

Division of Medical Assistance







Michael F. Easley, Governor
Dempsey Benton, Secretary
Tara R. Larson, Acting Director

north carolina medicaid

This annual report was produced by the

North Carolina Department of Health and Human Services

Division of Medical Assistance

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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

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December 2008

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 2007. The report is a testament to the fine work of the staff of the Division of Medical Assistance and our many partners. I trust that you will find this report helpful in gaining additional insight into this complex and vital program. It represents the combined efforts of a diverse and committed team of state employees and fellow citizens.

Sincerely,

Tara R. Larson

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Table of Contents

Exhibits, Tables and Maps

Exhibits

Tables

Maps

Mission Statement & 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 state fiscal years (SFYs) 2005–2007 were:

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 healthcare 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 and 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), N.C. Medicaid's home in the Department of Health and Human Services (DHHS), had another productive year providing health care services to the citizens of North Carolina. Our accomplishments included:

- Served more individuals in State Fiscal Year (SFY) 2007 (1,684,411) than last year (1,673,510).
- Saved, recovered or cost-avoided over $1 billion.
- Extended Community Care of North Carolina (CCNC) case management services to all 100 N.C. counties.
- Linked a total of 27,012 children enrolled in the N.C. Health Choice program (23 percent of all NCHC children) with a CCNC medical home.
- Awarded a five-year Money Follows the Person (MFP) federal demonstration grant to increase access to community-based services.
- Implemented citizenship verifcation policies mandated by the Deficit Reduction Act of 2005.
- Awarded a federal Medicaid Transformation grant to support a Perinatal Quality Collaborative of North Carolina (PQCNC), which was formed to improve the health of infants and mothers in North Carolina.
- Honored our second graduate of the LeadershipDHHS program.

For the fiscal year ending June 30, 2007, N.C. Medicaid served one out of every five citizens, or approximately 19 percent of the total population. The number of Medicaid enrollees grew by 2.3 percent over the previous year, as compared to a 2.1 percent increase in the overall state population. Statistical highlights of our expenditure and recipient data include:

- 1,684,411 individuals received at least one service during the year.
- $9 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).
- The skilled nursing facility expenditure category was the highest at roughly $1.1 billion.
- The prescription drug expenditure category, which had the most expenditures during the previous year, dropped to $934 million (before drug rebates) largely due to the second year of the Medicare Part D program and cost containment initiatives targeting prescription drugs.
- Total service and Medicare premium expenditures for Medicare-Medicaid dual eligible individuals increased by 5 percent.
- Elderly and disabled recipients comprised 9.9 percent and 16.2 percent of total recipients, respectively; however, service expenditures for these two groups combined totaled approximately $5.6 billion, or 65 percent of total Medicaid expenditures.
- Recipients from the families and children group represented approximately 72 percent of all recipients but accounted for approximately $3 billion, or 35 percent of total service expenditures.

Program Accomplishments

A number of operational improvements and special initiatives were accomplished or initiated during the past fiscal year.

Community Care of North Carolina (CCNC)

CCNC made significant progress during State Fiscal Year (SFY) 2007, including the following highlights:

- CCNC now covers all 100 counties.
- N.C. Health Choice (NCHC) children ages birth through 5 were more fully incorporated into CCNC after being transitioned to Medicaid.
- Congestive heart failure was added as a priority chronic care initiative in all networks. Baseline performance data were collected, and all networks began to implement evidence-based best practices for treatment of heart failure.
- To advance the mental health integration, CCNC primary care practices began co-locating a behavioral health specialist at primary care sites to help address the behavioral health care needs of their patient populations. Additionally, several behavioral health care facilities co-located a primary care provider to address the physical health care needs of their patient populations.
- CCNC received a six-month planning grant from the Kate B. Reynolds Foundation to develop a prevention model for childhood obesity and stroke prevention. A two-year grant was submitted to implement these two initiatives in nine CCNC networks (five for childhood obesity and four for stroke prevention).
- Nine CCNC networks began piloting a chronic care initiative designed to reduce inefficiencies and contain the cost of providing care to Medicaid recipients who are aged, blind or disabled. The networks have been reorganizing the delivery of care to those with chronic needs in ways that enhance appropriate access; increase service delivery options; improve efficiencies in the identification, assessment and care planning processes; and reduce the rate of institutionalization. The networks also partnered with long-term care providers to improve the organization and delivery of services and to create local accountability for managing the care delivered to these Medicaid recipients. Independent analyses have demonstrated significant cost savings as a result of this initiative.
- The most recent asthma audit results, completed in the spring of 2007, revealed that the program has been consistent in maintaining the number of patients with with proper documentation of their care. Results have repeatedly demonstrated that more than 90 percent of Medicaid patients with persistent asthma are prescribed appropriate medications.
- Over-the-counter (OTC) non-sedating antihistamine prescription use has increased by 72 percent over the last year; overall, OTC prescribing is increasing as availability issues are being resolved. Use of these lower-cost options with no loss in efficacy provides more efficient use of program expenditures.

- An actuarial study from Mercer Human Resource Consulting Group found that the CCNC program avoided approximately $154 million in expenses during the fiscal year through concerted efforts to control costs.

Linking North Carolina Health Choice to Community Care of North Carolina

In 2006, the General Assembly passed legislation requiring NCHC children between the ages of 6 and 18 to be linked to a CCNC provider. An eligible child is linked with a CCNC provider during the child's application and review process at the county department of social services. This linkage improves access to care by enrolling children into medical homes, led by a primary care provider who manages and coordinates patient care. Having a stable doctor–patient relationship reduces inappropriate utilization of services. NCHC children are eligible to receive case management services if medically necessary and if they are enrolled with a provider who participates in the enhanced CCNC plan. As of the end of SFY 2007, a total of 27,012 NCHC children (23 percent of all NCHC children) were linked with a CCNC provider.

Money Follows the Person Grant

On May 3, 2007, CMS approved DMA for a five-year Money Follows the Person (MFP) demonstration. MFP is a rebalancing initiative to help state Medicaid agencies enhance their efforts to restructure long-term support systems so that individuals have a choice of where they live and receive services. These demonstration projects also allow Medicaid agencies to adopt strategic approaches for improving quality in both home and community-based services and reducing reliance on institutional settings. Over the course of the five-year project, DMA is projected to rebalance $2.2 million dollars so that individuals may receive services in their choice of settings.

Quality, Evaluation and Health Outcomes (QEHO)

The QEHO Unit published county-specific reporting on the DMA Web site to assist county governments, as well as local and state agencies and legislators, in planning and decision-making. This information may be found online at **www.ncdhhs.gov/dma/countyreports/countyreports.html**. The unit also obtained the renewal of the 1915(b) waiver for the Piedmont Behavioral Health Program effective April 1, 2007, through March 31, 2009. Under the renewal, CMS approved the provision of additional services to affected Medicaid recipients due to savings realized from the waiver.

Program Integrity Section

The various units within the Program Integrity Section succeeded another year in saving, recovering and cost avoiding a significant amount of money for N.C. Medicaid and N.C. Health Choice as well as assuring the accuracy of payments to providers and claim data coordination with Medicare. The section's main activities include the following (for more details, please see Appendix II):

- The Third Party Recovery Unit saved, recovered or avoided costs in excess of $1 billion for N.C. Medicaid during SFY 2007.
- The four Provider Investigative Units recovered $13,070,968, a 27 percent increase in recovery from SFY 2006, and cost avoided $8,161,125.
- The Quality Assurance Unit developed a sampling plan that outlines the steps necessary to meet the Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) requirement for conducting eligibility reviews.
- North Carolina was one of the initial six pilot states to participate in a national project called the Medicare–Medicaid Data Match Project, or Medi–Medi Project, which is now being expanded to all 50 states.

- The Program Integrity Section and Advance Med, a CMS Program Safeguard Contractor for Medicare, initiated federal and state joint on-site reviews which together identified over $2 million dollars at risk.

Citizenship and Identity Requirements

DMA implemented requirements, mandated by the Deficit Reduction Act of 2005, that require Medicaid applicants and recipients who declare United States citizenship to provide, or cooperate in obtaining, documentation of U.S. citizenship and identity. Exceptions to this requirement include Title IV-E and Title IV-B children receiving Medicaid; individuals who have received or are currently receiving Medicare, SSI or Social Security Disability Insurance; and people who have verified status as a current or former lawful permanent resident (LPR). The law specifies certain forms of acceptable evidence of U.S. citizenship. Once citizenship has been proven through acceptable documentation, it does not need to be documented again unless later evidence raises a question. Aliens with documentation, such as LPR, must continue to provide their alien status information. Frontline staff at the county level diligently obtained the necessary documents for this requirement; therefore, our state did not experience a significant number of people losing Medicaid due to this new provision.

DMA Provider Services Unit

During SFY 2007, the total number of providers under N.C. Medicaid enrollment, and available to provide care to our recipients, was 72,259, an increase of 27 percent over the previous year's enrollment. Much of this growth can be attributed to a sharp increase in enrollment of mental health providers. The Provider Services Unit collected 36,800 National Provider Identifiers (NPIs) for Medicaid providers in North Carolina.

Perinatal Quality Collaborative of North Carolina

During SFY 2007, the Perinatal Quality Collaborative of North Carolina (PQCNC) was formed in order to improve the health of infants and mothers in North Carolina. PQCNC is a statewide network of perinatal care providers, hospital administrators, government officials, health care payers and families. DMA's participation in the network, as a government agency as well as a health care payer, is vital since more than half of the state's premature deliveries involve women who are covered by Medicaid. PQCNC will identify opportunities to improve perinatal healthcare at both the state and local levels. The goals of this collaboration are a reduction in the number of premature births; improvement in the care of premature infants; reduction of the mortality rate among premature babies; and better parental education on the care of premature children both at the hospital and in the home.

LeadershipDHHS Program Graduate

Angie Yow, Nurse Supervisor in the QEHO Unit, became DMA's second 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. Ms. Yow and her team successfully completed a project titled "Technology Training of the DHHS Workforce."

Overview of N.C. Medicaid

Brief History

The state of North Carolina submitted its original Medicaid State Plan to the Health Care Financing Administration (now known as the Centers for Medicare and Medicaid Services or CMS) in 1969 and, following federal approval and legislative action, the state's Title XIX program was implemented on Jan. 1, 1970. (See **Exhibit 1** for a description of the national Medicaid Program created under Title XIX.)

Initially, the N.C. 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 program has always existed within the 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 the North Carolina Administrative Code (NCAC), Title 10A, Chapters 21 and 22. Clinical coverage policies are located 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 may 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 over the years, please refer to DMA's Web site at **www.ncdhhs.gov/dma/publications.htm** to read "History of the North Carolina Medicaid Program."

Exhibit 1

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 covered 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 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**

Eligibility Criteria and Trends

N. C. Medicaid provides funding for health care to individuals who are eligible for one of the mandatory or optional Medicaid coverage groups (see **Exhibit 2**) and who have low income and resources. This includes a Medicare-Aid program that provides assistance to eligible individuals by sharing the cost of Medicare expenses, such as deductibles, premiums and coinsurance charges. 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 the N.C Medicaid Program are issued a Medicaid identification card each month. These individuals may receive medical care from providers enrolled in the program. Providers submit claims to DMA's fiscal agent, EDS, for reimbursement of services they provide to Medicaid enrollees.

Medicaid enrollees, applicants and others who have questions regarding the N.C. Medicaid program may call or visit the department of social services for the county in which they reside or telephone the Office of Citizen Services' toll free CARE-LINE, Information and Referral Service. The CARE-LINE forwards calls to the appropriate DMA section.

Exhibit 2

N.C. Medicaid Eligibility by Mandatory and Optional Groupings

MANDATORY

- Aged, blind and disabled persons receiving Supplemental Security Income (SSI)
- Certain SSI recipients who upon receipt of Social Security benefits became ineligible for SSI
- Medicare beneficiaries up to 100 percent 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
- 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

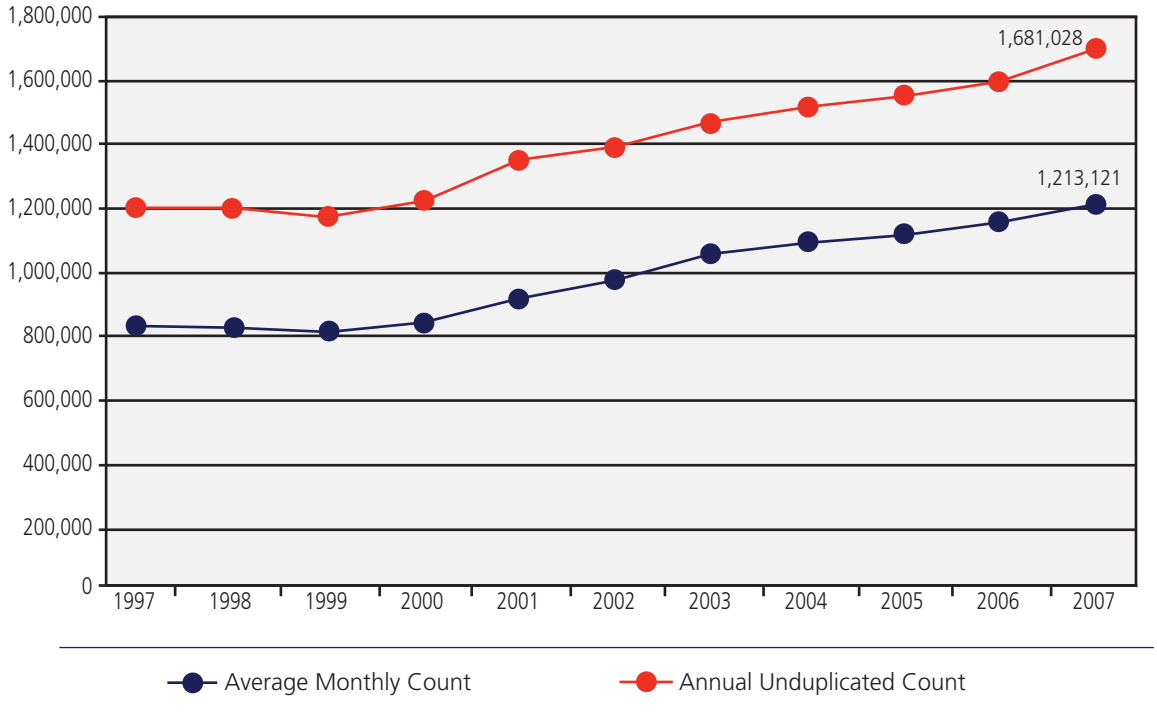
- Aged, blind and disabled persons not receiving SSI, including adult care home residents, recipients at 100 percent of poverty and medically needy recipients
- Pregnant women and infants up to 185 percent FPL
- Pregnant women determined by a qualified provider based on preliminary information to be presumptive eligible
- Children ages 0 to 1 year whose families are between 150 percent and 200 percent FPL
- Children ages 1 through 5 years whose families are between 133 percent and 200 percent FPL
- Children ages 19 and 20 years
- Non-IV-E foster children and/or adoptive children with special needs and caretaker relatives in families not eligible under AFDC rules in July 1996
- Women screened by and enrolled in the N.C. Breast & Cervical Cancer Control Program
- Medically needy persons
- Family planning services for women aged 19 through 55 and men aged 19 through 60 with incomes at or below 185 percent FPL

A more detailed list of N.C. Medicaid's eligibility groups can be found in Table 2a, "N.C. Medicaid Eligibility during State Fiscal Year (SFY) 2007." 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.

When the N.C. Medicaid program was established, roughly 456,000 individuals were determined to be eligible. That number has at times fallen, but has mostly risen through the years. For SFY 2007, a total of 1,682,028 individuals were determined to be eligible for Medicaid. A more detailed snapshot of the growth in eligibility from 1997 to the present can be found in **Exhibit 3**. That exhibit depicts two numbers: the average monthly and the annual numbers of eligible people. The difference in the two numbers reflects newly eligible recipients entering the program and existing eligible people exiting the program.

Exhibit 3

Eligibility of N.C. Medicaid Residents
SFYs 1997 - 2007



Populations and Eligibility Groups

North Carolina's population during SFY 2006 (the most recent year for which census information is available) was 8,860,341. A total of 1,682,028 people (or 19 percent of the population) were eligible for Medicaid. Compared with the previous year, the state population rose by 2.1 percent; however, the number of people eligible for Medicaid increased by 2.3 percent.

As indicated in **Exhibit 4**, the largest category of eligible people during SFY 2007 was pregnant women and children, with an annual total of 687,907 individuals, or about 41 percent of total eligibility. The Aid to Families with Dependent Children (AFDC) category was second-largest, with 451,053 individuals, or about 27 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 4

N.C. Medicaid Eligibility by Category – SFY 2007

Eligibility Group	Number of Eligibles	% of Total Eligibles
Pregnant Women & Children	687,907	40.9%
AFDC-related	451,053	26.8%
Disabled	261,594	15.6%
Aged	147,813	8.8%
Qualified Medicare Beneficiaries	56,612	3.4%
M-SCHIP*	54,009	3.2%
Refugees & Aliens	20,731	1.2%
Blind	1,988	0.1%
Breast & Cervical Cancer	321	0.0%
Total	**1,682,028**	**100.0%**

*M-SCHIP are the formerly N.C. Health Choice eligible children age 0 through 5 who were transitioned to N.C. Medicaid.

Source: Medicaid Eligibility Report, EJA752 - SFY 2007

As **Exhibit 5** shows, the Pregnant Women and Children population experienced the largest numerical increase of enrollees—35,461, or 5.4 percent. Each of the AFDC-Related, Aged and Blind categories experienced decreases.

Exhibit 5

Change in N.C. Medicaid Eligibility by Category SFY 2006 vs. 2007

Eligibility Group	SFY 2006 Eligibles	SFY 2007 Eligibles	Amount of Change	% Change
Pregnant Women & Children	652,446	687,907	35,461	5.4%
AFDC-related	468,662	451,053	-17,609	-3.8%
Disabled	257,344	261,594	4,250	1.7%
Aged	149,961	147,813	-2,148	-1.4%
Qualified Medicare Beneficiaries	52,895	56,612	3,717	7.0%
M-SCHIP*	41,812	54,009	12,197	29.2%
Refugees & Aliens	18,980	20,731	1,751	9.2%
Blind	2,084	1,988	-96	-4.6%
Breast & Cervical Cancer	273	321	48	17.6%
Total	**1,644,457**	**1,682,028**	**37,571**	**2.3%**

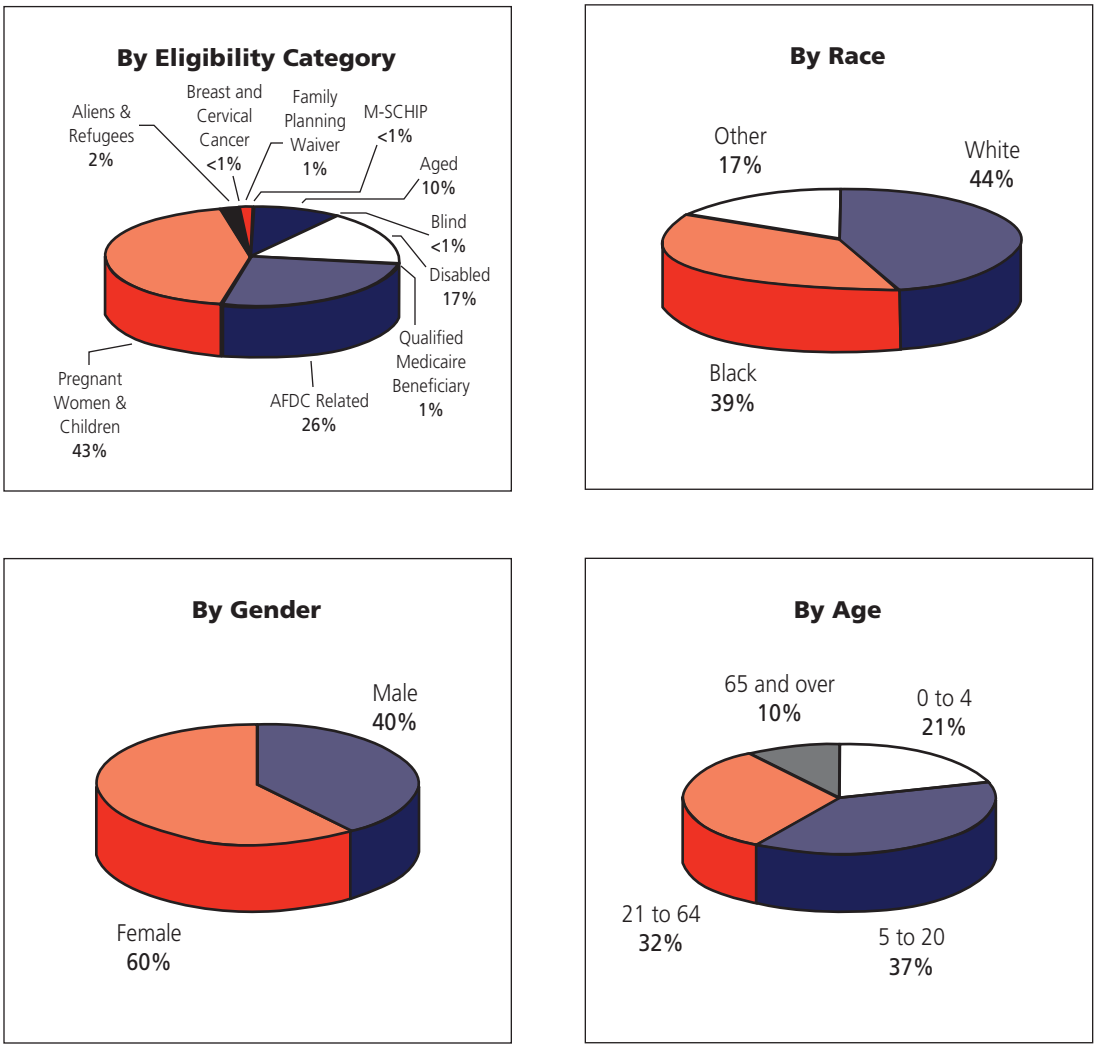
*M-SCHIP are the formerly N.C. Health Choice eligible children age 0 through 5 who were transitioned to N.C. Medicaid.

Source: Medicaid Eligibility Report, EJA752 - SFY 2007

Exhibit 6 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 4**, 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 2007, even though the services might have been ***provided*** the previous year.

Exhibit 6

Recipients of N.C. Medicaid Services



Forty-four percent of recipients were white, 39 percent were black, and the remaining 17 percent were of other races. A total of 60 percent of recipients were female and 40 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 (32 percent), followed by young children from birth to age 4 (21 percent) and the elderly ages 65 and older (10 percent).

Covered Services

N.C. Medicaid covers a comprehensive array of mandatory and optional services for eligible enrollees (see Exhibit 7). 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 Health Check. Covered benefits include services and supplies to address virtually all acute and chronic illnesses.

Medicaid has certain standard limitations on services. These include annual limits on ambulatory visits 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. Other 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
- with life-threatening conditions.

Medicaid recipients are limited to eight prescriptions per month. A pharmacist may override the monthly prescription limit with three additional prescriptions per recipient per month for recipients aged 21 and older. Overrides are available at the discretion of the pharmacist and prescribing providers based on the assessment of the recipient's need for additional medications during the month of service.

Recipients under 21 years of age are exempt from the prescription limitation under guidelines established through Medicaid for Children (Health Check/EPSDT). Recipients who reside in nursing facilities, intermediate care facilities for individuals with mental retardation (ICF/MRs), assisted living facilities and group homes are also exempt from the prescription limitation. Exemption from the monthly limitation for these recipients is incorporated in the recipient eligibility file.

Some recipients have clinical indications that warrant more than the allowed 11 prescriptions per month. When this occurs, DMA requires the recipient to be evaluated under the protocols of the Focused Risk Management (FORM) program. The recipient's pharmacist, as the facilitator, coordinates, integrates and communicates medication regimen discussions with the patient's primary care provider. Upon provider consensus, the pharmacist may translate this information to the recipient.

Utilization of Covered Services

As **Exhibit 8** shows, 90 percent of North Carolina's Medicaid recipients received services at least once during SFY 2007 from a physician; 61 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 7

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

MANDATORY

- Ambulance and Other Medical Transportation
- Durable Medical Equipment
- Family Planning
- Federally Qualified Health Centers & Rural Health Centers
- Health Check (EPSDT)
- Hearing Aids (children)
- Home Health
- Hospital Inpatient
- Hospital Outpatient
- Nurse Midwife
- Nurse Practitioner
- Nursing Facility
- Other Laboratory and X-ray
- Physician
- Psychiatric Residential Treatment Facility Services and Residential Services (treatment component only) for under age 21
- Routine Eye Exams & Visual Aids (children)

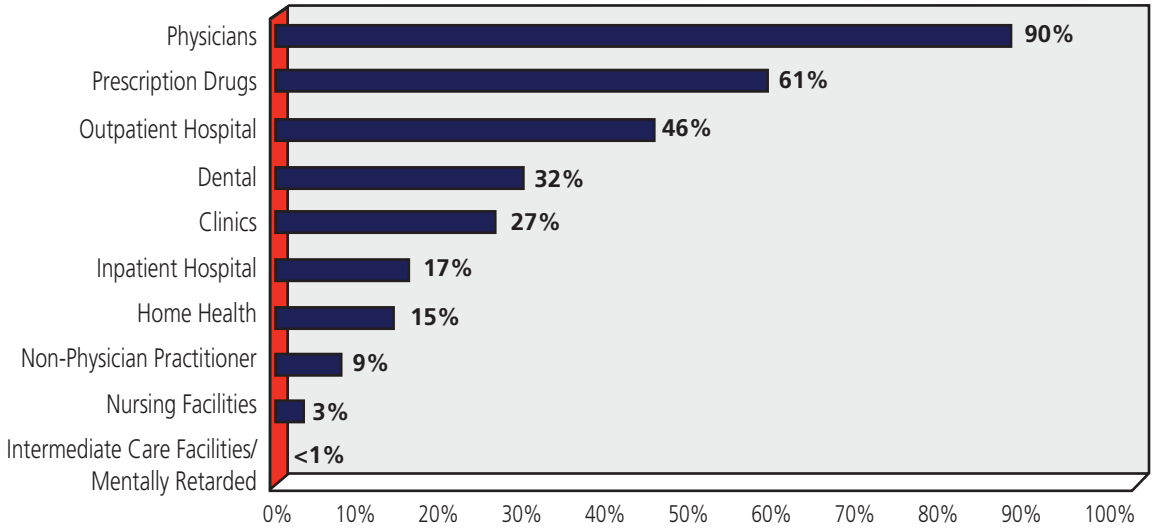
OPTIONAL

- Case Management
- Chiropractor
- Clinical
- Community Alternatives Programs (CAP)
- Dental and Dentures
- Diagnostic
- Eye Care
- Health Maintenance Organization (HMO) Membership
- Home Infusion Therapy
- Hospice
- Intermediate Care Facilities for the Mentally Retarded
- Mental Health
- Nurse Anesthetist
- Orthotic and Prosthetic Devices (children and adults)
- Personal Care
- Physical and Occupational Therapy and Speech/Language Pathology
- Podiatrist
- Prescription Drugs
- Preventive
- Private Duty Nursing
- Rehabilitative
- Respiratory Therapy (children)
- Routine Eye Exams & Visual Aids (adults)
- Screening
- Transportation

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

Exhibit 8

Selected Medicaid Service Usage by Recipient
Percent of Total Users
SFY 2007



Service Delivery Programs

The N.C. Medicaid program has developed service delivery programs 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 programs are not necessarily mutually exclusive; a recipient may be eligible to receive services from a number of programs.

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 2007, there were 863,332 recipients enrolled in managed care plans, or 77 percent of the 1,123,069 people eligible for Medicaid managed care. An additional 4 counties were added through various networks (96 counties are currently part of Community Care of North Carolina, or CCNC), and recipient enrollment increased 5 percent during the year. These figures do not include the approximately 90,000 Medicaid recipients enrolled in the Piedmont Cardinal Health Plan, a managed behavioral health care pilot program which has been operating in 4 counties since April 1, 2005 (details may be found in the Behavioral Health section of this report on page 26).

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 the following:

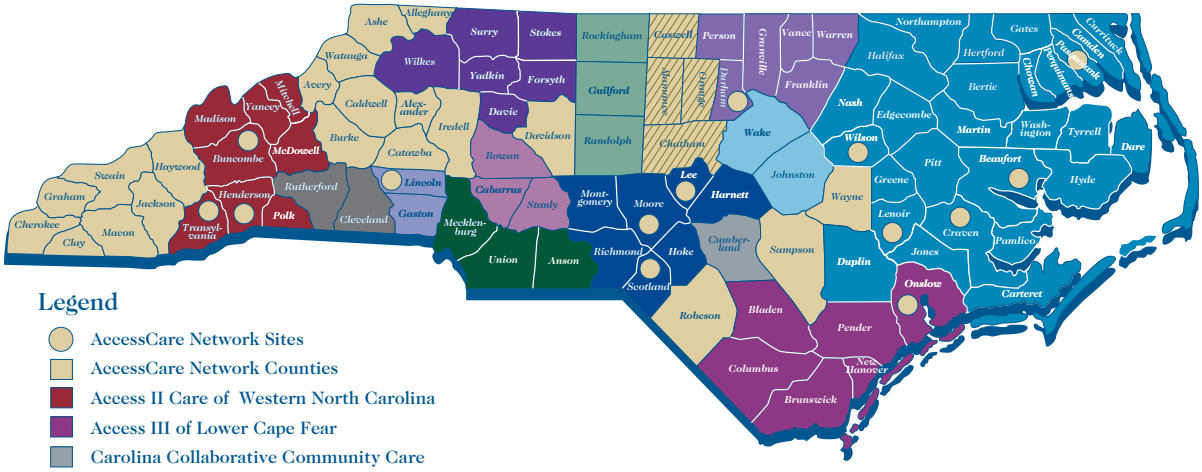
- Carolina ACCESS — A primary care case management model (PCCM), characterized by a primary care provider (PCP) medical home.
- CCNC — This program, formerly known as ACCESS II and ACCESS III, is a demonstration program that began in July 1998 and aims to build upon Carolina ACCESS by working with community 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 health care 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:

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
- Central Carolina Health Network
- 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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- **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.

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 74,024 of the 124,567 live births in North Carolina, or 59 percent, during SFY 2006 (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 the Division of Public Health (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 8.1 infant deaths per 1,000 live births in 2006, the lowest infant mortality rate recorded in North Carolina.

Health Check

In 1993, North Carolina expanded the federally mandated Early Periodic Screening, Diagnosis and Treatment (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, 94 Health Check coordinators serve 97 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 (medical home) 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 other setttings identified in the Individualized Education Plan (IEP).

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 the state and to 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 the following:

- 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 (32 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, CAP, private duty nursing, home infusion therapy, hospice, adult care home and personal care services). As indicated in **Exhibit 10** on page 33, total expenditures for long-term care during SFY 2007 were approximately $2.9 billion, an increase of 2.5 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, a 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 Pre-Admission Screening and Annual Resident Review (PASARR), which also must be met, screens and evaluates applicants and residents of Medicaid-certified nursing facilities for mental illness, mental retardation, developmental disabilities and related conditions.

FACT:

In SFY 2007, a total of 44,843 Medicaid recipients in North Carolina received care in nursing facilities at a cost of approximately $1.06 billion.

Intermediate Care Facilities for Individuals with Mental Retardation

Intermediate care facilities for individuals with mental retardation (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.

FACT:

During SFY 2007, a total of 4,315 recipients in North Carolina were treated in ICF-MRs at a cost of $449 million.

Home and Community-Based Services

Home and community-based long-term care is a cost-effective and preferable alternative to institutionalization. A variety of services are available including:

Adult Care Home Personal Care Services

Since 1995, N.C. Medicaid has covered basic personal care services for residents in adult care homes who are eligible for State and County Special Assistance for Adults or the Disabled (SA). The SA program is administered by the Division of Aging and Adult Services (DAAS). 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 October 2006, N.C. Medicaid began covering services for the care of residents residing in Special Care Units for Persons with Alzheimer's and Related Disorders (SCU-As) located in adult care homes.

FACT 1:

In SFY 2007, a monthly average of 19,971 N.C. Medicaid recipients received basic PCS at an annual cost of $139 million.

FACT 2:

Of these, an average of 3,203 North Carolinians each month received enhanced PCS in adult care home settings (including SCU-As) at an annual cost to N.C. Medicaid of $13 million.

FACT 3:

A monthly average of 19,680 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.

FACT:

In SFY 2007, a monthly average of 16,228 N.C. Medicaid recipients received home health services at an annual cost of $68 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.

FACT:

In SFY 2007, a monthly average of 1,514 N.C. Medicaid recipients received hospice care at an annual cost of $56 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.

FACT:

In SFY 2007, a monthly average of 390 N.C. Medicaid recipients received HIT at an annual cost of $7 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.

FACT:

In SFY 2007, a total of 434 N.C. Medicaid recipients received PDN services at an annual cost of $50 million.

Personal Care Services

In-home Personal Care Services (PCS) covers in-home 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.

FACT:

In SFY 2007, a monthly average of 33,484 N.C. Medicaid recipients received PCS or PCS-Plus at an annual cost of $300 million.

HIV Case Management

HIV case management is a targeted case management program funded by N.C. Medicaid and operated jointly by DMA and the Division of Public Health (DPH). Whereas DMA has administrative oversight of the program, the day-to-day operations are managed by the AIDS Care Unit within DPH. For further information on HIV case management, please access the DPH Aids Care Unit Web site: **www.epi.state.nc.us/epi/hiv/aidscare2.html**

FACT:

In SFY 2007, a monthly average of 1,432 N.C. Medicaid recipients received HIV Case Management services at an annual expense of $6.5 million.

Community Alternatives Program (CAP)

- **Community Alternatives Program for the Mentally Retarded and Developmentally Disabled (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 community care is cost-effective in comparison to ICF-MR care. The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) manages the daily operation of the program under an agreement with DMA.

The program is available statewide through local area mental health, developmental disabilities and substance abuse programs.

FACT 1:

The N.C. General Assembly provided an additional $3 million in funding during SFY 2007, allowing an increase of approximately 230 CAP/MR-DD slots.

FACT 2:

CAP/MR-DD served a monthly average of 8,178 N.C. Medicaid recipients in SFY 2007 at an annual cost of $376 million.

FACT 3:

The average monthly cost per recipient of CAP/MR-DD services was $4,591 or 37 percent of the average monthly cost of care per recipient at a state-owned ICF/MR facility ($12,540) and 63 percent of the average monthly expense per recipient at a non-state-owned facility ($7,338).

Note: This comparison assumes that patients are covered by Medicaid in all cases.

- **Community Alternatives Program for Children (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.

FACT:

In SFY 2007, CAP/C served an average 627 children each month at an annual cost of $31 million.

- **Community Alternatives Program for Disabled Adults (CAP/DA)** provides a package of services to allow adults (ages 18 and older) who qualify for nursing facility care to remain in their private residences. CAP/DA 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.

FACT:

CAP/DA served a monthly average of 10,937 citizens in SFY 2007 at a yearly cost of $256 million.

- **Community Alternatives Program for AIDS (CAP/AIDS)** provided home-based care for persons with AIDS as an alternative to nursing home placement. The program ended on Dec. 31, 2006, at which time CAP/AIDS waiver participants transitioned to either the CAP/DA or the CAP/C program. This waiver program had been a cooperative effort between DMA and DPH. The AIDS Care Unit, part of DPH, handled the program's operation, including approving plans of care, with DMA providing oversight. Local CAP/AIDS case management agencies were the entry point. Recipients that were approved for the program were potentially eligible for special waiver services in addition to regular Medicaid services.

FACT:

For the six months of SFY 2007 in which CAP/AIDS was operational, the program served a total of 73 recipients (monthly average 34) at an annual expense of $728,000.

Transplants and Transplant-Related Services

Blood (stem cell) and bone marrow transplants are used along with high-dose chemotherapy to treat several types of leukemia, genetic disorders, lymphomas and many other blood disorders.

Stem cells are taken from the patient's own body or from a matched donor, and can also be found in placentas and umbilical cords after birth and stored for later use. Solid organ transplants covered by Medicaid include heart, lung, heart/lung, liver, kidney, kidney/pancreas, small bowel, multi-visceral and thymus.

In calendar year 2006, the most recent year for which data are available, there were a total of 439 solid organ and stem cell transplant requests, with 314 additional procedures approved prior to the end of the year.

Ancillary Services

Durable Medical Equipment

Medicaid covers 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 treating physician, physician's assistant or nurse practitioner 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 devices and related supplies have established lifetime expectancies and quantity limitations.

FACT:

During SFY 2007, a monthly average of 54,885 N.C. Medicaid recipients received DME services at annual expense of $97 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.

FACT:

During SFY 2007, a total of 25,582 N.C. Medicaid recipients received independent practitioner services at annual expense of $56.1 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 co-payment is applicable to ophthalmological visits, and a $2 co-payment applies to visual aids. Although a $2 co-payment 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.

FACT:

During SFY 2007, a monthly average of 17,186 N.C. Medicaid recipients received optical services at annual expense of $21 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 (ear, nose and throat, or 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 frequency modulation (FM) systems for preschool-age children. Through FM systems, the teacher transmits and the child receives clear and direct voice communications. The federal Individuals with Disabilities Education Act (IDEA) requires public schools to provide FM systems for educational purposes for students. There are no co-payments for hearing aids, hearing aid accessories or hearing aid services.

FACT:

During SFY 2007, a monthly average of 189 N.C. Medicaid recipients received hearing aid services at an annual expense of approximately $895,000.

Behavioral Health

N.C. Medicaid covers a variety of services for behavioral health, some under the rehabilitation option and others under the clinic option. In the rehabilitation option, local management entities (LMEs) must endorse providers for a particular service or package of services before those providers may enroll 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 and assessments for individual, family or group outpatient psychotherapy
- residential services for recipients under the age of 21 years

Clinic services include outpatient therapy and psychological testing provided by enrolled independent providers, hospitals, health departments, physicians and local education agencies (LEAs). Medicaid also covers inpatient psychiatric care in community hospitals for recipients of all ages and in free-standing psychiatric hospitals and psychiatric residential treatment facilities for recipients under the age of 21.

Inpatient services, residential services and outpatient therapy must be approved through a prior approval process. For additional information, refer to the Behavioral Health Prior Approval subsection of this annual report on page 40.

DMA also provides services in intermediate care facilities for individuals with mental retardation (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 ICF/MR subsection of this report on page 21 for additional information.

FACT 1:

During SFY 2007, a total of 196,883 N.C. Medicaid recipients received behavioral health services at an annual expense of approximately $2.2 billion.

FACT 2:

Of the above, 73,423 children received behavioral health services at an annual expense of $738 million, and 123,460 adults received behavioral health services at an annual expense of $1.5 billion.

Piedmont Waiver Program

The Piedmont Cardinal Health Plan (PCHP) is a managed behavioral health care pilot which has been operating in Cabarrus, Davidson, Rowan, Stanly and Union counties since April 1, 2005. The program operates under 1915(b) and 1915(c) Medicaid waivers, which enable the state to mandate that Medicaid recipients enroll in and receive any needed mental health, developmental disabilities and substance abuse (MH/DD/SA) services through a single managed care entity; offer home and community based services as an alternative to care in an intermediate care facility for persons with mental retardation (ICF-MR); and restrict the program to a specific geographic area of the state. PCHP is administered by Piedmont Behavioral Healthcare, a local management entity (LME) for publicly funded MH/DD/SA services. DMA pays PCHP a flat, per-member-per-month payment and PCHP in turn arranges and pays for MH/DD/SA services for recipients in the five-county catchment area.

The PCHP achieved a savings in excess of $6 million during its first year of operation. In December 2006, DMA requested and received approval from CMS to reinvest the savings in additional behavioral health services that are designed to prevent the need for more expensive care in residential or institutional settings. In March 2007, CMS approved DMA's request to renew the 1915(b) waiver and continue providing additional alternative services funded by savings through March 2009.

FACT:

DMA made capitated payments to PCHP of approximately $103 million during SFY 2007 to cover all MH/DD/SA services for 90,000 Medicaid recipients in the Piedmont catchment area. Approximately thirty percent of the $103 million was expended for individuals participating in Innovations, the home- and community-based services waiver program.

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 aged 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 cavities.

FACT:

During SFY 2007, a total of 535,545 N.C. Medicaid recipients received dental services, an increase of 10.1 percent over those served during SFY 2006, at an annual expense of $240 million, an increase of 8.7 percent over SFY 2006 expenditures.

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**—The 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 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, selected over-the-counter (OTC) products and other pharmaceuticals 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 the drug is on the Federal Upper Limit (FUL) or State Maximum Allowable Cost (SMAC) list and if they had a previous 30-day fill for the same medication. Only one co-payment is collected and only one dispensing fee is paid for the 90-day supply. A recipient co-payment of $3 applies to each prescription, including refills, unless the recipient falls into the co-payment exemption categories. Exemptions include the following: 1) the recipient is under 21 years of age; 2) the

recipient resides in a nursing home facility, ICF/MR or mental health hospital (however, adult care homes and hospice patients are responsible for co-payments); 3) the recipient is pregnant; 4) the drug is classified as family planning; or 5) the recipient is enrolled in CAP as indicated on the recipient's Medicaid card.

On June 1, 2006, DMA implemented a new prescription limit policy allowing eight prescriptions per recipient per month for recipients aged 21 and older. This limitation does not apply to recipients under 21 years of age under guidelines established through Medicaid for Children (Health Check/EPSDT) or to recipients who reside in nursing facilities, ICF/MRs, assisted living facilities and group homes. 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 receiving more than 11 prescriptions per month will be evaluated as part of a Focused Risk Management (FORM) 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 primary care physician (PCP) and, upon consensus between both providers, the pharmacist may translate the information to the recipient. The pharmacist will perform the FORM review at least every three months to ensure the clinically appropriate, efficacious, and cost-effective use of drug therapy. Pharmacies participating in this program are eligible for a quarterly FORM fee upon the completion of the comprehensive review plan required for each Medicaid recipient being managed.

DMA has identified all recipients receiving greater than 11 prescriptions who qualify for the FORM 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. Once identified as qualifying for the FORM program, the recipient will have the opportunity to select a pharmacy provider of choice. 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 in two out of the last three months, or if fewer than 12 prescriptions were dispensed in the sixth month.

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 N.C. Physician Advisory Group (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 imposes quantity limitations for episodic drugs based on advice from the NCPAG. The NCPAG and DMA 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 are 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.

Administration of N.C. Medicaid

Funding Sources of the N.C. Medicaid

The N.C. Medicaid program has historically been jointly funded by federal, state and county governments, with the federal government paying the largest share of the costs. The federal share is established annually by the Centers for Medicare and Medicaid Services (CMS) and is based upon the most recent three-year average per capita income for the state compared with the national average per capita income. As a state's per capita income rises, the federal share declines, requiring states to increase their share of the Medicaid payments. Nationwide the share of federal reimbursement ranges from a low of 50 percent to a high of 80 percent with the exception of family planning services at 90 percent.

The federal share for services, reflected in Medicaid payments to providers, is applicable to the federal fiscal year (FFY), which is October 1 through September 30—not the state fiscal year (SFY) which is July 1 through June 30. Because the federal and state fiscal years are not the same, different federal shares may apply for each part of the state fiscal year. The federal share for administrative costs does not change from year to year. Table 1 provides the federal, state and county shares for SFY 2007.

During the 2007 North Carolina legislative session, the General Assembly passed legislation to incrementally phase out the county portion of the non-federal share of Medicaid costs. Traditionally, North Carolina's 100 counties have paid 15 percent of the non-federal share. Beginning October 1, 2007, the counties will pay 11.25 percent of the non-federal share. Beginning July 1, 2008, the counties will pay 7.5 percent of the non-federal share and beginning July 1, 2009, the State will pay 100 percent of the non-federal share.

Some N.C. Medicaid recipients are required to pay a modest co-payment. These co-payments do not apply to certain services. Current co-payment requirements can be found in Table 15 of this report.

A Look at Expenditures

During SFY 2007, the Medicaid budget categories with the highest levels of expenditures were nursing facilities, inpatient hospital services, non-physician provider services and prescription drugs (see **Table 9** and **Exhibit 9**). Provider reimbursements for prescription drugs were $934 million, or approximately 10.4 percent of total expenditures. However, when manufacturers' rebates of $282 million are applied, the net amount spent on prescription drugs was $652 million, or 7.2 percent of total expenditures. The decrease in prescription drug expenditures is attributable to DMA's continuing prescription drug cost containment efforts as well as to the previous year's transition of dually eligible recipients to Medicare Part D prescription drug coverage.

Exhibit 9

Medicaid Services Expenditures for SFY 2007

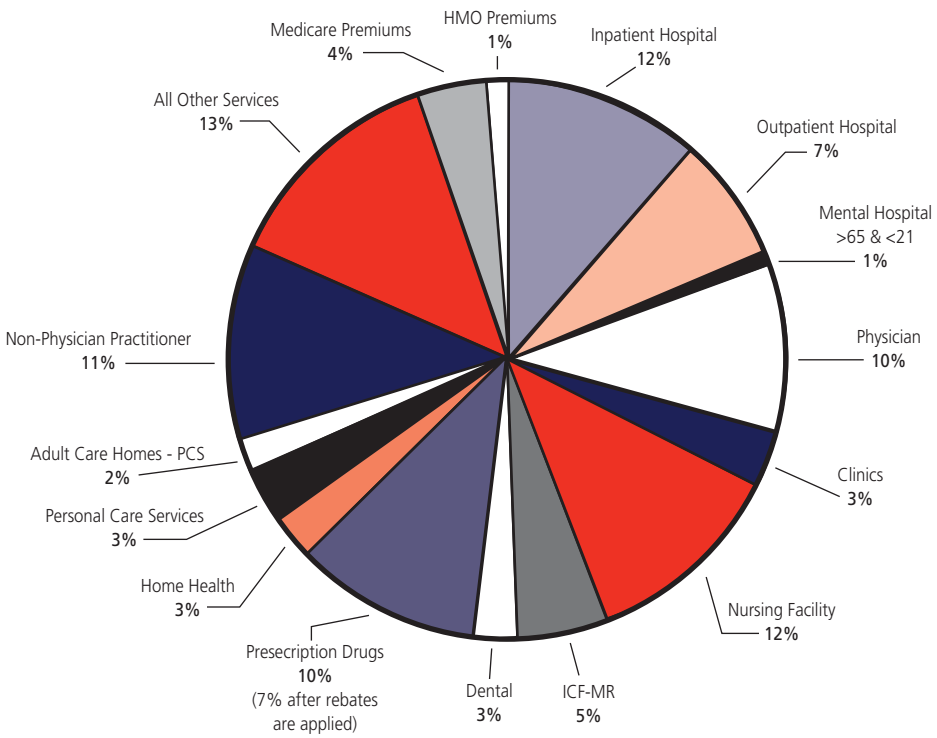


Exhibit 10 compares long-term and non–long-term care expenditures. There are a few points of special interest. First, long-term care expenditures grew by only 2.5 percent, whereas non–long-term care expenditures grew by 6.2 percent. Expenditures for non-physician practitioner increased by approximately 547 percent due to the rapid expansion of community support services as part of the restructuring of mental health service delivery. However, there was a 71 percent drop in mental health clinic expenditures due to mental health reform and the resulting service realignment which began during SFY 2006 and continued through SFY 2007. Medicare Part D expenses rose by 143 percent, but Medicare Part D coverage was in effect for only six months during SFY 2006.

As indicated in **Table 9**, a total of $9 billion was spent on health services and premiums for 1,684,411 Medicaid recipients, or $5,351 per recipient, during the year. While total service and premium expenditures increased by 5 percent over SFY 2006, there was a 4 percent increase per recipient over the same period.

Exhibits 11 and 12 show that elderly and disabled recipients comprised 9.9 percent and 16.2 percent of total recipients, respectively, or 26 percent combined. Service expenditures for these two groups amounted to approximately $5.6 billion, or 65 percent of total expenditures. Recipients from the Families and Children group represented 72 percent of all recipients; however, they accounted for approximately $3 billion, or 35 percent, of total service expenditures.

Exhibit 10

Growth in N.C. Medicaid Service Expenditures By Long Term Care and Non-Long Term Care Groupings SFY 2006 vs. 2007

Category of Service	SFY 2007 Expenditures	SFY 2006 Expenditures	% Change
Inpatient Hospital	$1,025,325,554	$1,024,293,989	0.1%
Non-Physician Practitioner	$ 999,990,509	$ 154,686,715	546.5%
Prescription Drugs	$ 934,276,607	$1,385,039,301	-32.5%
Physician	$ 853,358,974	$ 817,055,723	4.4%
Outpatient Hospital	$ 624,047,899	$ 599,306,708	4.1%
Medicare Part B Premiums	$ 251,247,518	$ 228,234,475	10.1%
Dental	$ 239,997,938	$ 217,965,881	10.1%
Medicare Part D	$ 223,684,818	$ 91,999,451	143.1%
Mental Health Clinics	$ 138,851,990	$ 472,785,462	-70.6%
Other Non-Long-Term	$ 955,917,112	$1,231,018,534	-22.3%
Total Non-Long Term	**$6,107,846,929**	**$5,749,600,779**	**6.2%**
Total Long Term	**$2,904,766,751**	**$2,833,862,694**	**2.5%**
Grand Total	**$9,012,613,680**	**$8,583,463,472**	**5.0%**

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

Source: BD-701, June 2006 and 2007

Exhibit 11

N.C. Medicaid Recipients & Service Expenditures by Percentages SFY 2007

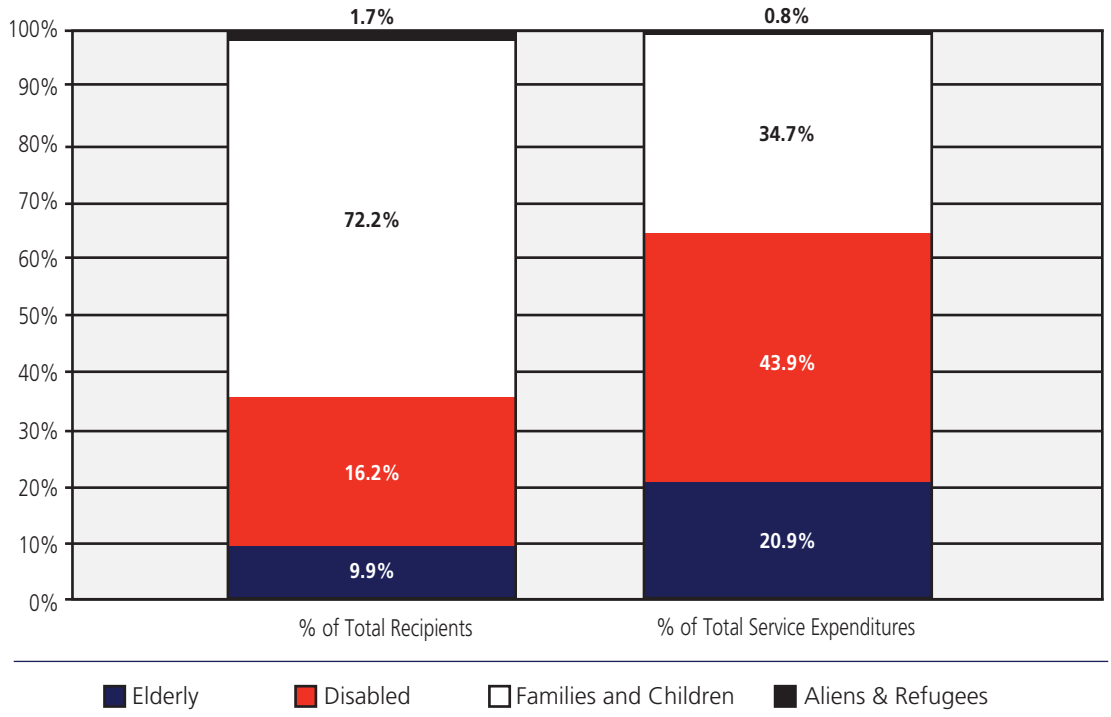


Exhibit 12

N.C. Medicaid Expenditures by Recipient Groups SFY 2007 (in $ Billions)

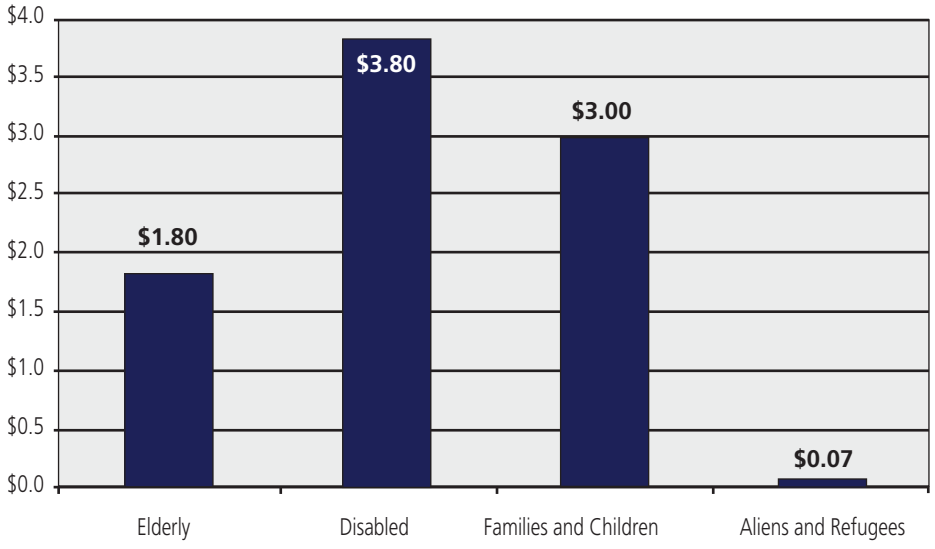
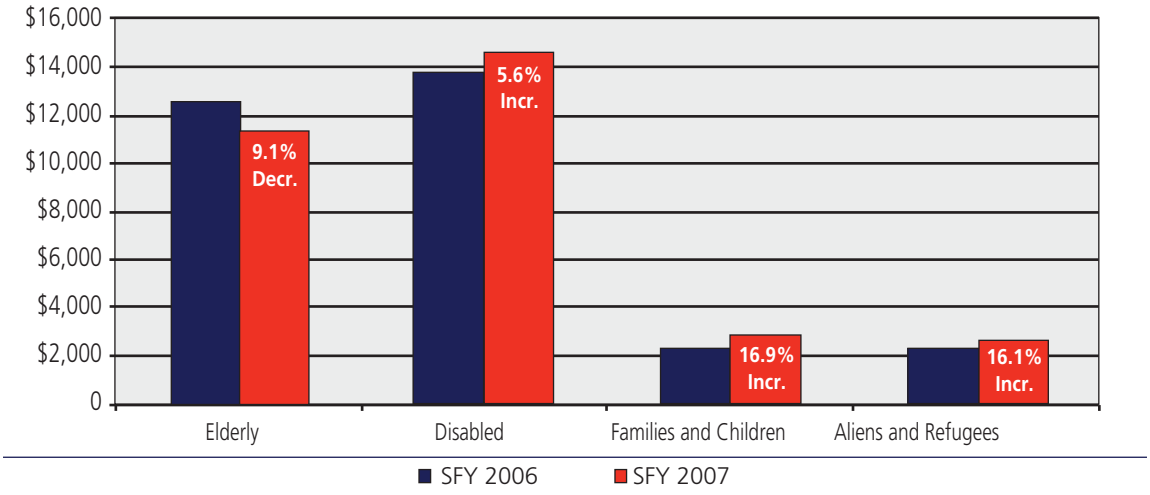


Exhibit 13 shows that expenditures per recipient decreased for the elderly and increased for all other eligibility groups during SFY 2007.

Exhibit 13

Expenditures per N.C.Medicaid Recipient
SFY 2006 vs. 2007



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 clinical coverage policies 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 developed 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 2007, a total of 30 new or significantly revised policies were introduced to the NCPAG by DMA and DHHS. The NCPAG completed reviews and provided clinical recommendations for 28 Medicaid policies. Of those, over 86 percent were reviewed and approved by the NCPAG within three months of initial presentation by DMA to the NCPAG. The percentage approved within three months increases to 92 percent if one excludes two very complex and lengthy policies that had not been updated for many years. The majority of these policies were then posted to DMA's Web site for public comment within three months of receiving the NCPAG's recommendations.

DMA's clinical coverage policies are located online at the following DMA Web page: **www.ncdhhs.gov/dma/mp/mpindex.htm**.

Providers

During SFY 2007, the total number of providers under N.C. Medicaid enrollment, and actively providing care to our recipients, was 72,259. That number represented an increase of 27 percent over the previous year's enrollment of approximately 57,000 providers. 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 for the provider type and services that are to be provided. Enrollment guidelines and applications are posted at **www.ncdhhs.gov/dma/provenroll.htm**. The enrollment process normally takes six to eight weeks. DMA Provider Enrollment staff review applications and perform background checks to ensure that providers are in good standing before enrolling in the Medicaid program. If information is discovered that conflicts with statements on the application, enrollment is delayed so that appropriate followup can occur.

Upon enrollment, providers receive written notification of their Medicaid provider number(s) along with 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 the accuracy of information on file with the Medicaid program for their practices or facilities.

National Provider Identifier Implementation

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 for health care providers. Mandatory use of the NPI was initially required by CMS by May 2007; however, there was concern that the nation would not be ready by that date. Therefore, CMS made compliance by May 2007 voluntary. Even though DMA made a great deal of progress in preparation for the transition, it was decided to continue with the use of the Medicaid Provider Number. In the meantime, DMA continued to work with its fiscal intermediary, EDS, to make changes within the Medicaid Management Information System (MMIS) and collected the NPIs for thousands of Medicaid providers in North Carolina.

Direct Enrollment of Mental Health Providers

During SFY 2007, the DMA Provider Services Unit continued the direct enrollment of providers of enhanced mental health and substance abuse services. The expansion of private providers is a part of the 2001 legislative mandate for mental health reform and replaces the old system of primarily public providers for mental health services. These providers utilize qualified professionals, associate professionals and paraprofessionals to deliver medically necessary services to eligible recipients. Providers must be endorsed by the local management entity (LME) for each service before enrolling with the N.C. Medicaid program.

Program Integrity

DMA's Program Integrity Section is responsible for seeking payment from available third-party health care resources on recipients' behalf, 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 2007 include

- Program Integrity's Third Party Recovery (TPR) Unit increased its recoveries from Medicare by 22 percent and Estate Recovery by 7 percent over the previous year. These and other recoveries saved the Medicaid program $56,575,910. TPR also implemented cost avoidance procedures that are projected at over $1 billion.
- Efforts by Program Integrity's four provider billing investigative units resulted in the recovery of $13,070,968 and cost avoidance of $ 8,161,125.
- Program Integrity ensures that Medicaid payments are prohibited, withheld or recovered in accordance with disciplinary actions and sanctions imposed against providers by licensing boards, law enforcement or other state and federal regulatory agencies. Additionally, Program Integrity takes action when appropriate to terminate sanctioned providers from the Medicaid program. Examples include
  - The Home Care Review Unit implemented a payment-withholding action against a provider with multiple sites in North Carolina for violating the terms of its provider participation agreement, which resulted in cost avoidance in excess of $3 million.
  - A dental provider was terminated from the Medicaid program as the result of an investigation by the Provider Administrative Review Unit. Based on the provider's average payments to three separate billing numbers, a cost savings of $1.2 million is projected.
  - DMA's continuing partnership with law enforcement was evident in the successful prosecution of a N.C. Medicaid transportation provider. Exclusion of this provider from participation in Medicare and Medicaid is saving potential Medicaid payments of more than $700,000 annually.
- The Quality Assurance Unit developed a sampling plan that outlines the steps necessary to meet the Centers for Medicare and Medicaid Services (CMS) payment error rate measurement (PERM) requirement for conducting eligibility reviews. North Carolina's sampling plans were approved and applauded as models for use by other states.

Medicaid Eligibility Error Rate Reduction and Quality Assurance

Program Integrity's Quality Assurance (QA) Unit 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 DMA eligibility staff. DMA then works with the county departments of social services to promote and develop corrective actions whenever appropriate. County eligibility supervisors 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 and training and on the recovery of overpayments.

Investigation of Provider Fraud and Abuse

Program Integrity staff use computer software in a unique fraud and abuse detection system. The software identifies unusual patterns of utilization of services by recipients and providers. Program Integrity medical and administrative staff perform desk reviews or site visits 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. DMA Program Integrity efforts include:

- protecting recipients' rights
- 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

When provider fraud or abuse is suspected, referrals are made to the Attorney General's Medicaid Investigations Unit (MIU) to determine if civil or criminal prosecution is warranted. 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.

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 200 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, N.C. Medicaid continued to operate under a rate freeze for SFY 2007. Effective with date of service Jan. 1, 2007, the division was allocated $12 million for rate increases by the legislature. All providers' rates were reviewed for an allocation by a third party, and rate increases were allotted accordingly.

Audit

The Medicaid Audit Unit is responsible for reviewing Medicaid cost reports and financial records of Medicaid providers rendering services to N.C. Medicaid recipients. These audits and reviews ensure that Medicaid reimbursements to providers are based upon reasonable and allowable costs as defined by federal and state regulations.

FACT:

During this fiscal year, the internal and contracted audit staff completed more than 770 audits and settlements.

Utilization Management and Prior Approval

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 appropriate and effective continuing care. For example, all admissions to psychiatric hospitals are reviewed by ValueOptions.

Prior approval may be required in order to verify the medical necessity of some services before they are 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, the following:

- 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
- Community Alternatives Program (CAP) participation
- 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 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.

Prescription Drug Prior Approval

DMA contracts 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 as follows:

- Procrit, Epogen and Aranesp
- OxyContin

- growth hormones
- Provigil
- Celebrex (for persons 59 years of age or younger)
- Botox and Myobloc
- sedative hypnotics
- proton pump inhibitors

Behavioral Health Prior Approval

ValueOptions conducts utilization reviews for mental health services, certain developmental disabilities services and substance abuse services for N.C. They may authorize mental health and substance abuse services to recipients throughout the state. The exception is recipients who live in the Piedmont catchment area, who are covered by 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 aged 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

Therapy services requiring prior approval include all outpatient treatment for occupational, physical, speech/language, respiratory and audiological therapy, regardless of where the services are provided. Psychological services in schools are prior approved through use of the Individualized Education Plan (IEP) process. All other prior approval functions are carried out through a contract with the Carolinas Center for Medical Excellence (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.

Community Alternatives Program for Disabled Adults (CAP/DA) Utilization Review

CCME quality assurance reviews determine whether CAP/DA clients are assigned the correct 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 whether clients have been given the option to choose home care versus nursing home placement; if the plan of care is relevant to the assessed needs of the clients; and if 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 lead agencies to strengthen local programs, thus enabling individuals who would otherwise be admitted to a nursing facility to be served in their homes.

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 to achieve the dual goals of improving access to care and reducing unnecessary costs. The PCP is expected to provide 24-hour-a-day, seven-day-a-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.

The Managed Care Section's utilization management processes ensures that appropriate services are delivered to Medicaid enrollees through the identification of aberrant utilization patterns and potential quality-of-care issues. The process helps 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.

During SFY 2007, DMA provided care through two managed care organizations (MCOs). One was Piedmont Behavioral Healthcare, a multi-county mental health MCO, and the other a traditional MCO located in Mecklenburg County (this contract was terminated on July 31, 2006). Each MCO is required 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 program must describe the procedures to evaluate medical necessity, including the evaluation 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. DMA and EDS continue to work with Piedmont Behavioral Healthcare to develop an encounter reporting process that provides data accurately reflecting the delivery of services to enrollees.

Information Technology and HIPAA

The Information Technology and HIPAA (an acronym for the Health Insurance Portability and Accountability Act) section is responsible for overseeing the Medicaid Management Information System (MMIS), the Decision Support Team and the HIPAA Team. The section works closely with the fiscal intermediary EDS to maintain and improve the MMIS. The Decision Support Team utilizes DRIVE, a data warehouse system and SAS querying capabilities, to generate a variety of operational data and management reports. The HIPAA Team ensures system security and privacy. The section provides key support to literally every aspect of the work of DMA through these major areas as well as numerous special projects.

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 Medicaid and SCHIP populations, but also on the state's underinsured

and uninsured residents. The group is responsible for guiding health care policy formulation in support of the division's goals and objectives.

Quality, Evaluation and Health Outcomes

The focus of the Quality, Evaluation and Health Outcomes (QEHO) unit is identifying opportunities for the improvement of efficiency and effectiveness of the services supported by DMA. 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. Monitoring and improving services is accomplished in a variety of ways such as annual focus care studies, data analysis, waiver coordination, and initiation and participation of various projects within the agency as well as with external organizations and associations. Please refer to the Web site **www.ncdhhs.gov/dma/quality/qehodisclaimers.html** for more information.

Policy Changes and Reports

New Federal Regulations and Guidance Affecting Medicaid

Medicaid Program and State Children's Health Insurance Program (SCHIP) Payment Error Rate Measurement – Effective Oct. 1, 2006, the Centers for Medicare and Medicaid Services (CMS) implemented requirements for states to provide information to them for purposes of estimating improper payments in Medicaid and SCHIP. The Improper Payments Information Act of 2002 (IPIA) requires heads of federal agencies to estimate and report to the Congress annually these estimates of improper payments for the programs they oversee and submit a report on actions the agency is taking to reduce erroneous payments.

Citizenship Identification Requirements – CMS Letter SMDL 06-012 to State Medicaid Directors dated June 9, 2006, provided guidance to states on the implementation of the section of the Deficit Reduction Act of 2005 (DRA) that requires individuals claiming U.S. citizenship to provide satisfactory documentary evidence of citizenship or nationality when initially applying for Medicaid or upon a recipient's first Medicaid re-determination on or after July 1, 2006.

Collection of Rebates on Physician-Administered Drugs – CMS Letter SMDL 06-016 to State Medicaid Directors dated July 11, 2006, provided a brief summary of the new provisions under the DRA regarding state collection and submission of utilization data for certain physician administered drugs as well as specifics on how to qualify for federal financial participation (FFP) for these drugs.

Qualified State Long Term Care (LTC) Insurance Partnership Programs – CMS Letter SMDL 06-019 to State Medicaid Directors dated July 27, 2006, provided guidance to states on the implementation of the section of the DRA that provides for Qualified State Long Term Care (LTC) Insurance Partnership programs and permits an exception to estate recovery provisions for individuals who receive benefits under LTC insurance policies sold in states that implement a Partnership program.

National Provider Identifiers (NPIs) – CMS Letter SMDL 06-020 to State Medicaid Directors dated Sept. 19, 2006, contained an urgent reminder to all state Medicaid programs that, as covered entities under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), states must accept and use, by May 23, 2007 (deadline was later extended until May 23, 2008), NPIs in electronic transactions for which the Secretary of Health and Human Services (federal) has adopted a standard.

State False Claims Act – CMS Letter SMDL 06-024 to State Medicaid Directors dated Sept. 19, 2006, encouraged states to implement a State False Claims Act. Section 6031 of the DRA and provides incentives for adoption of State False Claims Acts by decreasing the federal medical assistance percentage by 10 percentage points for recoveries from legal actions brought pursuant to such laws. Section 6031, which became effective Jan. 1, 2007, also equally rewarded those already in place that meet the specified requirements.

Employee Education About False Claims Recovery – CMS Letter SMDL 06-025 to State Medicaid Directors dated Dec. 13, 2006,

provided guidance to State Medicaid agencies on the implementation of the section DRA that relates to "Employee Education About False Claims Recovery" and provided clarifying definitions to that section.

Policy Changes Mandated by the N.C. General Assembly

Programmatic Issues:

Pilot Projects to Control Cost and Improve Quality of Care for Aged, Blind & Disabled Medicaid Recipients (S.L. 2006-66, Section 10.7A.(a)&(b)) – DMA was allocated the amount of $3 million to pilot communitywide initiatives and expand statewide successful models to control costs and improve quality of care for the aged, blind, and disabled recipients of Medicaid. DMA was given the authority to contract for services, hire additional staff or provide grants through the Office of Rural Health and Community Care

Medicaid Reimbursement for Ocular Prosthetists (S.L. 2006-198) – In order to be eligible for reimbursement of ocular prosthetics, providers must now be licensed or certified by the occupational licensing board or the certification authority having jurisdiction over the provider's license. This is in response to legislation in the 2005/2006 session of the General Assembly to expand the types of accreditation that were acceptable for the enrollment of ocularists. In December 2005, the enrollment of orthotic and prosthetic providers was expanded to include ocularists certified by the Board of Certification in Clinical Anaplastology–Certified Ocularists. Medically necessary prosthetics and orthotics are now subject to prior approval and utilization review.

Mental Health Reform Changes (S.L. 2006-142) – This mandate ensured that the State Plan for Mental Health, Developmental Disabilities and Substance Abuse Services would be coordinated with the Medicaid State Plan and N.C. Health Choice. The purpose of the State Plan was to provide a strategic template regarding how State and local resources would be organized and used to provide services. The plan would identify specific goals to be achieved by the Department, area authorities and county programs over a three year period and benchmarks for determining whether progress was being made towards those goals.

Eligibility and Benefit Coverage Issues:

Transfer of Assets Rewrite (S.L. 2006-66, Section 10.5(a)&(b)) – This section of the law mandates ineligibility for medical assistance when an individual or their spouse transfers assets for less than fair market value and specifies the period of ineligibility. The rewrite also redefines the terms medical services, assets, fair market value and uncompensated value, etc. and addresses exceptions to the law, life estates and income producing property and hardship waivers.

Increase Health Care Access for Uninsured Persons (S.L. 2006-66, Section 10.12(a)) – The NCGA mandated DMA to develop a plan to expand health care access for the approximately 1.3 million uninsured North Carolinians through the use of public/private partnerships, federal flexibility and resources and promotion of charity care by health care providers. The resulting "N.C. Plan" outlined the use of the significant savings realized through a previous expansion of CCNC to cover the Medicare-Medicaid "dual eligible" population. The plan describes using the savings to support N.C. Health Net, a care management program for the uninsured. Savings would also be used to create a stand alone premium assistance plan to assist low to moderate income individuals and families in purchasing private health insurance and employer sponsored health insurance, the creation of a high risk pool to make health insurance more affordable to individuals with pre-existing health conditions and a reinsurance program to spread risk more broadly among

insurers. The plan also emphasizes prevention and the development of health information technologies.

Medicaid Dually Eligible to Enroll in Medicare Parts B and D (S.L. 2006-66, Section 10.6) – N.C. Medicaid recipients who qualify for Medicare are now required to enroll in Medicare in order to have Medicaid pay medical expenditures that qualify for payment under Medicare Part B and D, except that enrollment in Part D is not required if the recipient has creditable prescription drug coverage as defined by federal law.

Required Data Sharing by Private Health Insurers (S.L. 2006-66, Section 10.8) – Health insurers and pharmacy benefit managers regulated as third-party administrators are required to provide DMA with third-party coverage information on its eligible population. This information includes the period that the individual or the individual's spouse or dependents were covered and the nature of the coverage. Sharing of information is to be done not more often than twelve times per year at the request of DMA and at no cost to DMA. In its request for this information, DMA will provide an automated list of its eligibles for the purpose of matching with the covered population of the third-party insurer or pharmacy benefit manager.

Extend Effective Date on Changes to Liens on Real Property for Purposes of Estate Recovery Under Medicaid (S.L. 2006-66, Section 10.9B) – This section amends S.L. 2005-276, Section 10.21C mandating the inclusion of liens on real property in Medicaid estate recoveries to extend the effective date from July 1, 2006, to July 1, 2007.

Budget and Other Financial Issues:

Inflationary Increases for Medicaid Providers (S.L. 2006-66, Sections 10.3A and 10.11) – The NCGA required DMA to study and develop an equitable standard for providing inflationary and other cost-related increases to service providers in the Medicaid program. An additional $12 million in State funding was appropriated for inflationary increases beginning Jan. 1, 2007, to a broad range of provider groups including physicians, dentists, nursing facilities, home health agencies, personal care services, adult care homes, intermediate care facilities for the mentally retarded, CAP, CCNC, ancillary services, etc. The report was presented by DMA management at the January 2007 Government Operations meeting.

Reports and Studies Mandated by the N.C. General Assembly

Medical Policy Changes (S.L. 2006-66, Section 10.3.(c)(4)) – DMA provides the Office of State Budget and Management and the Fiscal Research Division with a quarterly report itemizing all medical policy changes with total requirements of less than three million dollars.

Ticket to Work/Medicaid Eligibility (S.L. 2006-66, Section 10.9(b)) – On April 15, 2007, DMA submitted to the N.C. General Assembly a required report titled "Ticket to Work Program Study: Health Coverage for Workers with Disabilities." The report included an analysis of system changes needed in order to implement the Ticket to Work Program, how soon the changes could be made and an analysis of the five-year fiscal impact of the program. During the previous session of the N.C. General Assembly, S.L. 2005-276, Section 10.18(a) enacted G.S. 108-54.1 titled the "Health Coverage for Workers with Disabilities Act," which authorized North Carolina to provide optional Medicaid coverage to working individuals with disabilities who, except for their earnings, would be eligible for Medicaid.

Medicaid/Health Choice Dental Administrative Services Study (S.L. 2006-66, Section 10.9A) – On July 31, 2007, DMA reported to the N.C. General Assembly on its study of the costs and benefits of implementing a carve

out of dental administrative services provided by third party administrators for Medicaid and N.C. Health Choice recipients. In the study, DMA reviewed the experiences of other states using a carve out for administrative services and the likelihood that a carve out would increase the number of dentists willing to serve Medicaid and N.C. Health Choice recipients and enhance access to care for these recipients. Findings of the study indicate that the N.C. programs are as successful as the TennCare dental services carve-out, which was the most impressive of the four existing state dental carve-outs. Allocating funds for dental reimbursement rate increases would be more cost-effective in increasing both the number of participating dentists in the programs, as well as recipient access to care, than would be adoption of a dental carve-out.

Pilot Program to Evaluate Use of Telemonitoring Equipment in Home Care Services (S.L. 2006-66, Section 10.9C) – The N.C General Assembly mandated DMA to implement a pilot program to evaluate the use of telemonitoring equipment in home care services and community based long term care services no later than October 1, 2007. The purpose of the pilot is to evaluate the use of telemonitoring equipment as a tool to improve the health of home care clients and community based long term care clients through increased monitoring and responsiveness, resulting in increased stabilization rates. As of the end of SFY 2007, DMA has designed a pilot program consisting of nine participating home health agencies that will carry out the study with a sample of 200 Medicaid patients with congestive obstructive pulmonary disease, congestive heart failure and diabetes. Half of the patient population will receive home telemonitoring services and conventional visits and the other half will receive only conventional home health care. The sample population will include individuals who are elderly and/or disabled and live in rural, urban and suburban areas of the state.

Strategies to Offset the Cost of Pharmacists of Providing Services to Medicaid Recipients Enrolled in Medicare Part D (S.L. 2006-66, Section 10.9D) – DMA was mandated to study strategies for assisting pharmacists in providing pharmacy services to Medicaid recipients enrolled in Medicare Part D and, specifically, to address the special circumstances of pharmacists who provide pharmacy services to long term care facilities. The study included strategies that may potentially resolve related problems in both the Medicare and Medicaid programs such as prior authorization and formulary issues, coordination of benefits, delayed provider reimbursements, etc. DMA was also required to assess the impact of the Deficit Reduction Act of 2005 on the payment for generic drugs under the Medicaid Program. The Division submitted its report to the N.C. General Assembly in October 2007.

One-Time Cap on Medicaid County Share (S.L. 2006-66, Section 10.9E) – The N.C. General Assembly provided funds for one-time assistance to counties to reduce the 15 percent share of the nonfederal share of Medical Assistance payments during SFY 2007. DMA was required to provide a monthly report to the N.C. General Assembly on each county's portion of the nonfederal share of Medical Assistance payments, excluding administrative costs, during the fiscal year 2006 2007, as if the counties were still paying the regular county share of all applicable nonfederal costs.

Study Medicaid Provider Rate Increases for Nursing Homes (S.L. 2006-66, Section 10.11(c)) – DMA was also required to study the reimbursement system for skilled nursing facilities and develop recommendations regarding rebasing the payment rates for the 2006 2007 fiscal year. This report was also presented by DMA management at the January 2007 Government Operations meeting.

CAP/DA Review and Report (S.L. 2006-109) – Legislation mandated that DMA examine the Community Alternatives Program for Disabled Adults (CAP/DA) in response to issues identified in the Medicaid Institutional Bias Study and submit an interim and final report of its findings to the North Carolina Study Commission on Aging. The Division submitted the interim report on Nov. 1, 2006, and a progress report in lieu of a final report in September 2007.

Survey of Pharmacy Providers Participating in the Medicaid Program (S.L. 2006-248 Section 44) – DMA was required to either conduct a survey of pharmacy providers participating in the Medicaid program to determine the cost of dispensing a Medicaid prescription in North Carolina or to use a recently conducted national survey of a statistically relevant sample of pharmacies. DMA opted for the latter and submitted its findings to the N.C. General Assembly in a report on Feb. 13, 2007.

Clinical Policy Changes

The following clinical coverage policies were considered by the North Carolina Physician Advisory Group (NCPAG) and promulgated with effective dates during SFY 2007. They are grouped according to the type of action taken.

Initial promulgation of existing coverage:

- Endovascular Repair of Aortic Aneurysm
- Botulinum Toxin Treatment: Type A (Botox) and Type B (Myobloc)
- Hysterectomy
- Therapeutic and Non-therapeutic Abortions
- Fetal Surveillance
- Burn Treatment
- Bioengineered Skin
- Telemedicine and Telepsychiatry
- Breast Imaging
- Home Infusion Therapy

Promulgation of a new policy:

- Services for Individuals with Mental Retardation/Developmental Disabilities and Mental Health/Substance Abuse Co-Occurring Disorders
- Home Tocolytic Infusion Therapy

Documentation of requirements for and limitations on therapeutic leave:

- Psychiatric Residential Treatment Facilities for Children under the Age of 21
- Residential Treatment Services

Other actions:

- All current clinical coverage policies — All existing policies were updated twice, in both cases to improve the explanation of Early Periodic Screening, Diagnosis and Treatment (EPSDT) coverage.
- Over-the-Counter Medications — Removed a packaging requirement; added coverage of 22 types or packages of drugs.
- Prior Authorization for Outpatient Pharmacy Point-of-Sale Medications — Made multiple changes relating to evaluating and recommending drugs to be covered and utilization review.
- Ocular Photodynamic Therapy — Updated Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) code information.
- Hospice Service — Clarified coverage for co-insurance on drugs and respite days.
- Dental Services — Code changes, forms and formatting updates.
- Orthodontics — Added 2006 American Dental Association claim form.
- Durable Medical Equipment — Added respiratory assist devices, continuous positive airway pressure (CPAP) devices, high-frequency chest wall oscillation devices,

cough-stimulating devices, Farrell valves; code updates.

- Orthotics and Prosthetics — Revised prior approval requirements and quantity limitations; added some types of providers; code updates; added coverage for helmets for plagiocephaly and for cast boots; hourly labor rate no longer required on repair estimates.
- Hearing Aid Services — All replacement parts require prior approval.
- Enhanced Mental Health and Substance Abuse Services — Significant changes to providers, service orders, case management; updated job titles and some service definitions.
- Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers — Code and job title updates.
- Psychological Services in Health Departments and School Based Health Centers Sponsored by Health Departments to the Under 21 Population — Added information on referral requirements.
- Children's Development Service Agencies (CDSAs) — Deleted references to services provided to 3- and 4-year-old recipients. Amended the requirements for an occupation therapist to indicate that, where applicable, the therapist must be licensed by the State.
- Outpatient Pharmacy Program — Allows pharmacists to override eight-prescription limit by up to three prescriptions per month; clarified Opt-In program and storage of pharmacy records; billing and prior approval updates.
- Outpatient Specialized Therapies — Provided clarifications to the definitions of medical necessity and prior approval requirements, added reference to American Speech-Language-Hearing Association (ASHA) guidelines on bilingual service.
- Independent Practitioners (IP) — Provided clarifications to definition of medical necessity and prior approval requirements, added reference to ASHA guidelines on bilingual service; code updates.
- Local Education Agencies — Provided clarifications to the definitions of medical necessity and prior approval requirements, added reference to ASHA guidelines on bilingual service; updated Certification of Non-Federal Match form; online verification of staff credentials is acceptable.

Medicaid Tables

Table 1

Federal Matching Rates for N.C. Medicaid SFY 2007

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
(7/1/06 - 9/30/06)

	Services Except B&CC and Family Planning	Breast and Cervical Cancer	Family Planning
Federal	63.49%	74.44%	90.00%
State	31.03%	21.73%	8.50%
County	5.48%	3.83%	1.50%

Benefit Costs
(10/1/06 - 6/30/07)

	Services Except B&CC and Family Planning	Breast and Cervical Cancer	Family Planning
Federal	64.52%	75.16%	90.00%
State	30.16%	21.11%	8.50%
County	5.32%	3.73%	1.50%

Administrative Costs
(7/1/06 - 6/30/07)

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

*MMIS-Medicaid Management Information System

Source: DMA Budget Management Section

Table 2a N.C. Medicaid Eligibility Requirements – SFY 2007

GROUP	BENEFITS	BASIC REQUIREMENTS[1]						SPECIAL PROVISIONS (updated 4/07)
		Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit (updated 4/07)	Resource Limit	Deductible/Spenddown		
Recipients of Cash Assistance Programs	Full Medicaid Coverage	Recipients of the following cash assistance programs are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination are required. The cash assistance programs are: • Work First Family Assistance – NC program under the federal Temporary Assistance to Needy Families law that provides cash assistance to families with children. • Supplemental Security Income (SSI) – Federal cash assistance program for the aged, blind, and disabled. • State/County Special Assistance – State cash assistance program for aged and disabled individuals, primarily who are in adult care homes. • Special Assistance to the Blind – State cash assistance program for blind individuals.						
Aged	Full Medicaid coverage	Age 65 or older	Spouse's income and resources if live together	100% of Poverty 1 – $ 851/mo 2 – $1,141/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 they 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/mo and can be as much as $2,541 depending upon at-home spouse's cost for housing. The amount protected for the at-home spouse is not counted in determining the eligibility of the spouse in the nursing facility. **Protection of resources for spouse at home:** Additionally, the countable resources of the couple are combined and a portion is protected for the spouse at home. That portion is ½ the total value of the countable resources, but currently not less than $20,328 or more than $101,640. The amount protected for the at-home spouse is not countable in determining the eligibility of the spouse in the facility. **Transfer of resources:** When a person gives away resources and does not receive compensation with a value at least equal to that of the resources given away, he may be penalized. Medicaid will not pay for care in a nursing facility or care provided under the Community Alternative Placement program or other in-home health services & supplies for a period of time that depends on the value of the transferred resource.
Blind	Full Medicaid coverage	Blind by Social Security standards	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 851/mo 2 – $1,141/mo	SSI Limits 1 – $2,000 2 – $3,000	Yes		
Disabled	Full Medicaid coverage	Disabled by Social Security standards	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 851/mo 2 – $1,141/mo	SSI Limits 1 – $2,000 2 – $3,000	Yes		
Qualified Medicare Beneficiaries	Payment of Medicare premiums and deductibles and co-insurance charges for Medicare covered services	Entitled to Medicare Parts A & B	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 851/mo 2 – $1,141/mo	2 x SSI Limits 1 – $4,000 2 – $6,000	No		
Specified Low-Income Medicare Beneficiaries	Payment of Medicare Part B premium	Entitled to free Medicare Part A	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	120% of Poverty 1 - $1,021/mo 2 - $1,369/mo	2 x SSI Limits 1 – $4,000 2 – $6,000	No		
Qualifying Individuals	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.	135% of Poverty 1 - $1,149/mo 2 - $1,541/mo	2 x SSI Limits 1 – $4,000 2 – $6,000	No		
	Note: Total number of eligible individuals is limited to available funds.							
Working Disabled	Payment of Medicare Part A premiums	Lost entitlement to free Medicare A due to earnings but still has disabling impairment.	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	200% of Poverty 1 - $1,702/mo 2 - $2,282/mo	2 x SSI Limits 1 – $4,000 2 – $6,000	No		

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

Table 2a (cont.) N.C. Medicaid Eligibility Requirements – SFY 2007

GROUP	BENEFITS	BASIC REQUIREMENTS						SPECIAL PROVISIONS (updated 4/07)
		Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit (updated 4/07)	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.	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 - $1,575/mo 2 - $2,111/mo 3 - $2,648/mo 4 - $3,184/mo 5 - $3,721/mo	No resource limit if eligible with income no more than 185% of poverty	Yes		When determining the family size for the pregnant woman the unborn child is included. For example the family size for a single pregnant woman would be 2.
Children under age 6	Full Medicaid coverage	Be under age 6	Parents' income if living in the home.	200% of Poverty 1 - $1,702/mo 2 - $2,282/mo 3 - $2,862/mo 4 - $3,442/mo 5 - $4,022/mo	No resource limit if eligible with income no more than 200% of poverty	Yes		
Children age 6 thru 18	Full Medicaid coverage	Be age 6 thru age 18	Parents' income if living in the home.	100% of Poverty 1 - $ 851/mo 2 - $1,141/mo 3 - $1,431/mo 4 - $1,721/mo 5 - $2,011/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	**MNIL:** 1 - $242/mo 2 - $317/mo 3 - $367/mo 4 - $400/mo 5 - $433/mo **Resource limit:** All deductible cases have a resource limit: $3000 for families and children and $2,000 (1) and $3,000 (2) for aged, blind and disabled.	
Breast & Cervical Cancer Medicaid	Full Medicaid coverage	A woman who has been screened and enrolled in the NC Breast & Cervical Cancer Control Program and is otherwise ineligible for Medicaid	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 Medicare.
Family Planning Waiver	Family Planning exams & services. Screening & treatment for STI. Screenings for HIV. Sterilizations.	Women age 19 thru 55 Men age 19 thru 60 Not otherwise eligible for Medicaid	Count spouse's income. Do not count parent's income for children.	185% of Poverty 1 - $1,575/mo 2 - $2,111/mo 3 - $2,648/mo 4 - $3,184/mo 5 - $3,721/mo	No resource limit	No	There is no deductible or spenddown provision for Family Planning coverage. If a recipient's income increases to more than 185%, he will be ineligible for family planning coverage	
NC Health Choice (NCHC)	Coverage of the NC State Employees Health Plan, plus vision, hearing, & dental	Be an uninsured child over age 5 & under age 19.	Parents' income if living in the home.	200% of Poverty 1 - $1,702/mo 2 - $2,282/mo 3 - $2,862/mo 4 - $3,442/mo 5 - $4,022/mo	No resource limit	No	There is no deductible or spenddown provision for NCHC. If a child is ineligible due to too much income, they will be evaluated for Medicaid with a deductible.	Income over 150% of poverty, must pay enrollment fee. 1 - $1,277 2.-$1,712 3 - $2,147 4 - $2,582 5 - $3,017

Table 2b

Financial Eligibility for Medicaid Based on Percentage of Federal Poverty Level SFY 2007

Family Size	100%	120%	133%	135%	185%	200%	SSI	MNIL	SA/ACH	SA/SCU	SA/In-Home
1	$ 10,210	$ 12,252	$13,580	$ 13,784	$ 18,889	$ 20,420	$ 7,476	$ 2,904	$14,634	$18,726	$10,212
2	$ 13,690	$ 16,428	$ 18,208	$ 18,482	$ 25,327	$ 27,380	$ 11,208	$ 3,804			
3	$ 17,170		$ 22,837		$ 31,765	$ 34,340					
4	$ 20,650		$ 27,465		$ 38,203	$ 41,300					
5	$ 24,130		$ 32,093		$ 44,641	$48,260					

Note 1: The Federal Poverty Level amounts change each year effective April. The above figures were effective April 1, 2007, and remained in effect through the end of SFY 2007

Note 2: SSI recipients are automatically eligible. Income limits are $7,476 for a family of one and $11,208 for a family of two. Adult care home (ACH) residents who receive state-county special assistance (SA) are also automatically eligible. Income limit for SA/ACH is $14,634 for a family of one; for SA/SCU (Special Care Unit) the income limit is $18,726 for a family of one. Income limit for SA/In-Home is $10,212 for a family of one.

Note 3: Those with incomes 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 2007 MNIL is $2,904 for a family of one and $3,804 for a family of two. Eligibility is determined in six-month increments.

Source: DMA Recipient and Provider Services Section

Table 3

Providers Enrolled in N.C Medicaid SFY 2007

Providers	Number
Adult Care Home Providers	2,372
Ambulance Service Providers	303
Carolina ACCESS II Entities	16
Children Development Services Agency (CDSAs)	20
Chiropractors	1,055
Community Alternatives Program Providers: CAP/C, CAP/AIDS, CAP/MR-DD, CAP/DA	1,604
Community Based Providers	6,412
Dental Service Providers: Dentists, Oral Surgeons, Pediadontists, Orthodontists	4,605
Durable Medical Equipment Suppliers	2,772
Hearing Aid Suppliers	92
Home Health Agency Providers: Home Infusion Therapy, Private Duty Nursing	421
Hospice Agency Providers	80
Hospital Providers	1,073
Independent Laboratory Providers	183
Independent Practitioners: Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, Audiologists	2,949
Managed Care Programs (HMOs)	1
Mental Health HMO	1
Mental Health Program Providers	94
Mental Health Providers	8,148
Nursing Facility Providers	1,223
Optical Service Providers and Suppliers: Opticians, Optometrists	1,201
Other Types of Clinics: Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers	246
Personal Care Service Providers	1,186
Pharmacists	2,184
Physician Extenders: Nurse Midwives, Nurse Practitioners, Nurse Anesthetists	3,134
Physicians (individuals and groups)	28,692
Podiatrists	360
Portable X-ray Service Providers	28
Psychiatric Facility Providers	862
Public Health Program Providers	530
Rural Health Clinic/Federally Qualified Health Center Providers	412
Total	**72,259**

Note: This is an unduplicated count of all providers active at any time during SFY 2007 with the exception that physicians may be counted individually and/or as a group.

Source: DMA Recipient and Provider Services Section

Table 4

Services Covered by N.C. Medicaid SFY 2007

Adult Care Home Personal Care Services
Ambulance & Other Medical Transportation
Targeted Case Management for:
- Pregnant women
- Developmentally disabled children (ages 0 – 5)
- Chronically mentally ill adults
- Emotionally disturbed children
- Chronic substance abusers
- Adults & children at risk of abuse, neglect or exploitation
- Persons with HIV disease

Chiropractors
Clinic Services (Federally Qualified, Rural Health, Health Dept & Mental Health)
Community Alternatives Programs
Dental Care Services
Domicile Care
Durable Medical Equipment
Health Check Services (EPSDT)
Family Planning Services and Prescription Drugs
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 adult)
Rehabilitative Services (under Behavioral Health Services)
Screening
Specialized Therapies
- (Occupational, Physical and Respiratory Therapy, Speech/Language Pathology and Audiology)

Source: DMA Clinical Policy & Programs Section

Table 5

Sources of N.C. Medicaid Funds SFY 2007 vs. SFY 2006 (Services Expenditures Only)

	2007	Percent	2006	Percent
Federal	$ 5,286,618,011	58.66%	$ 5,209,510,606	60.69%
State*	$ 2,437,990,063	27.05%	$ 2,348,873,427	27.37%
Other State**	$ 823,318,439	9.14%	$ 567,149,647	6.61%
County	$ 464,687,167	5.16%	$ 457,929,792	5.34%
Total	**$ 9,012,613,680**	**100.00%**	**$ 8,538,463,472**	**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, 2007 and June 29, 2006, respectively. NCAS

Table 6

A History of N.C. Medicaid Expenditures (Program Services Expenditures Only) SFYs 1995 - 2007

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%
SYY 2007	9,012,613,680	5.0%	5,286,618,011	1.5%	464,687,167	1.5%	3,261,308,502	11.8%

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

A History of N.C. Medicaid Eligibility
SFYs 1979 - 2007

Fiscal Years	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Medicaid Pregnant Women Coverage	Medicaid Indigent Children Coverage	Other Children	M-SCHIP	Aliens and Refugees	Breast Cervical Cancer (BCC)	Total	Percent Change
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	N/A	N/A	N/A	455,702	
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	N/A	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	N/A	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	N/A	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	N/A	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	N/A	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	N/A	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	N/A	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	N/A	N/A	481,326	6.48%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	N/A	561	N/A	561,614	16.68%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	N/A	1,011	N/A	639,351	13.84%
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	N/A	1,675	N/A	753,292	17.82%
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	N/A	1,955	N/A	877,923	16.54%
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	N/A	2,437	N/A	992,697	13.07%
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	N/A	2,330	N/A	1,058,603	6.64%
1994-95	127,514	48,373	2,716	155,215	533,300	48,115	216,888	3,808	N/A	2,857	N/A	1,138,786	7.57%
1995-96	131,496	53,072	2,710	171,204	496,501	52,466	261,525	3,696	N/A	3,919	N/A	1,176,589	3.32%
1996-97	132,173	58,036	2,593	176,160	462,881	55,838	295,882	3,747	N/A	4,823	N/A	1,192,133	1.32%
1997-98	131,332	61,032	2,531	180,461	414,853	58,899	337,849	3,905	N/A	6,311	N/A	1,197,173	0.42%
1998-99	152,582	32,737	2,497	199,523	344,621	60,896	371,986	3,941	N/A	8,036	N/A	1,176,819	-1.70%
1999-00	154,222	33,302	2,428	205,205	330,113	60,918	421,158	4,063	N/A	9,857	N/A	1,221,266	3.78%
2000-01	154,284	36,053	2,357	212,798	450,472	57,318	424,436	4,195	N/A	12,680	N/A	1,354,593	10.92%
2001-02	153,282	39,799	2,334	221,813	456,232	53,009	444,299	4,737	N/A	14,523	N/A	1,390,028	2.62%
2002-03	151,672	41,030	2,226	228,159	478,842	51,111	474,557	4,881	N/A	14,805	N/A	1,447,283	4.12%
2003-04	151,478	42,413	2,177	238,810	485,856	53,768	517,251	4882	N/A	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	N/A	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	41,812	18,980	273	1,644,457	5.16%
2006-07	147,813	56,612	1,988	261,594	451,053	60,016	622,292	5,599	54,009	20,731	321	1,682,028	2.28%
SFY 2006 Percent Total Eligibles:	**9.1%**	**3.2%**	**0.1%**	**15.6%**	**28.5%**	**3.6%**	**35.8%**	**0.3%**	**2.5%**	**1.2%**	**0.0%**	**100.0%**	
SFY 2007 Percent Total Eligibles:	**8.8%**	**3.4%**	**0.1%**	**15.6%**	**26.8%**	**3.6%**	**37.0%**	**0.3%**	**3.2%**	**1.2%**	**0.0%**	**100.0%**	

Source: Medicaid Eligibility Report, EJA752 - SFY 2007

Table 8

N.C. Medicaid Eligibility and Program Payments for Which the County is Responsible for Its Computable Share*
SFY 2007

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 2006 POPULATION
ALAMANCE	139,786	26,018	$127,499,692	$4,900	$912	74	186	18.61%
ALEXANDER	36,296	6,599	29,879,975	4,528	823	82	182	18.18%
ALLEGHANY	11,012	2,358	14,309,766	6,069	1,299	30	214	21.41%
ANSON	25,371	7,073	57,310,895	8,103	2,259	2	279	27.88%
ASHE	25,774	5,497	31,078,714	5,654	1,206	42	213	21.33%
AVERY	18,174	3,261	17,979,700	5,514	989	57	179	17.94%
BEAUFORT	46,346	11,398	80,906,357	7,098	1,746	11	246	24.59%
BERTIE	19,355	6,378	46,815,137	7,340	2,419	1	330	32.95%
BLADEN	32,870	10,192	56,744,360	5,568	1,726	12	310	31.01%
BRUNSWICK	94,964	17,899	83,793,921	4,681	882	78	188	18.85%
BUNCOMBE	221,320	41,922	236,987,761	5,653	1,071	51	189	18.94%
BURKE	88,663	18,100	93,860,977	5,186	1,059	52	204	20.41%
CABARRUS	157,179	25,851	107,685,198	4,166	685	91	164	16.45%
CALDWELL	79,298	16,866	83,167,940	4,931	1,049	53	213	21.27%
CAMDEN	9,284	1,237	5,998,955	4,850	646	93	133	13.32%
CARTERET	63,558	9,723	52,160,222	5,365	821	83	153	15.30%
CASWELL	23,523	5,448	29,634,148	5,439	1,260	36	232	23.16%
CATAWBA	151,128	27,690	123,973,266	4,477	820	84	183	18.32%
CHATHAM	57,707	8,026	40,908,108	5,097	709	90	139	13.91%
CHEROKEE	26,816	5,761	34,561,659	5,999	1,289	31	215	21.48%
CHOWAN	14,664	3,752	24,153,057	6,437	1,647	16	256	25.59%
CLAY	10,144	1,975	10,353,248	5,242	1,021	55	195	19.47%
CLEVELAND	96,714	24,779	132,067,476	5,330	1,366	23	256	25.62%
COLUMBUS	54,656	18,069	104,453,812	5,781	1,911	9	331	33.06%
CRAVEN	95,558	16,774	92,823,675	5,534	971	60	176	17.55%
CUMBERLAND	306,545	62,955	283,705,336	4,506	925	70	205	20.54%
CURRITUCK	23,518	2,885	13,307,817	4,613	566	96	123	12.27%
DARE	34,674	3,865	18,722,017	4,844	540	98	111	11.15%
DAVIDSON	155,348	29,591	138,435,127	4,678	891	76	190	19.05%
DAVIE	39,836	5,437	26,866,985	4,942	674	92	136	13.65%
DUPLIN	52,710	13,279	65,774,958	4,953	1,248	37	252	25.19%
DURHAM	246,824	42,872	240,054,818	5,599	973	59	174	17.37%
EDGECOMBE	52,644	18,905	93,950,329	4,970	1,785	10	359	35.91%
FORSYTH	331,859	59,237	309,406,330	5,223	932	67	179	17.85%
FRANKLIN	55,315	11,531	54,281,733	4,707	981	58	208	20.85%
GASTON	197,232	43,548	242,761,925	5,575	1,231	39	221	22.08%
GATES	11,602	2,134	12,124,285	5,681	1,045	54	184	18.39%
GRAHAM	8,109	2,261	13,643,333	6,034	1,682	14	279	27.88%
GRANVILLE	53,840	9,737	50,109,519	5,146	931	68	181	18.09%
GREENE	20,833	4,783	27,558,016	5,762	1,323	26	230	22.96%
GUILFORD	449,078	81,150	351,804,744	4,335	783	87	181	18.07%
HALIFAX	55,606	18,702	108,418,476	5,797	1,950	7	336	33.63%
HARNETT	103,714	20,941	97,001,438	4,632	935	66	202	20.19%
HAYWOOD	56,662	11,580	62,178,786	5,369	1,097	48	204	20.44%
HENDERSON	100,107	15,812	81,722,300	5,168	816	85	158	15.80%
HERTFORD	23,878	7,298	48,040,815	6,583	2,012	6	306	30.56%
HOKE	42,202	9,684	47,291,506	4,883	1,121	45	229	22.95%
HYDE	5,511	1,392	8,675,762	6,233	1,574	20	253	25.26%
IREDELL	145,234	23,371	106,409,644	4,553	733	88	161	16.09%
JACKSON	36,312	6,149	32,071,226	5,216	883	77	169	16.93%
JOHNSTON	151,589	30,454	138,348,438	4,543	913	73	201	20.09%
JONES	10,318	2,247	13,412,528	5,969	1,300	29	218	21.78%
LEE	55,282	11,632	51,318,710	4,412	928	69	210	21.04%
LENOIR	58,172	16,252	89,686,894	5,519	1,542	21	279	27.94%

Table 8 (cont.)

N.C. Medicaid Eligibility and Program Payments for Which the County is Responsible for Its Computable Share* SFY 2007

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 2006 POPULATION
LINCOLN	71,302	12,118	60,721,481	5,011	852	81	170	17.00%
MACON	33,076	6,285	31,819,831	5,063	962	63	190	19.00%
MADISON	20,454	4,600	26,062,452	5,666	1,274	33	225	22.49%
MARTIN	24,396	6,992	52,054,178	7,445	2,134	3	287	28.66%
MCDOWELL	43,632	9,293	47,610,822	5,123	1,091	49	213	21.30%
MECKLENBURG	826,893	133,561	593,294,204	4,442	717	89	162	16.15%
MITCHELL	15,906	3,335	21,074,530	6,319	1,325	25	210	20.97%
MONTGOMERY	27,506	7,164	35,917,217	5,014	1,306	28	260	26.05%
MOORE	82,292	13,024	65,819,273	5,054	800	86	158	15.83%
NASH	92,220	20,079	93,567,494	4,660	1,015	56	218	21.77%
NEW HANOVER	184,120	28,891	165,766,567	5,738	900	75	157	15.69%
NORTHAMPTON	21,524	6,864	41,443,778	6,038	1,925	8	319	31.89%
ONSLOW	161,212	21,865	103,517,154	4,734	642	94	136	13.56%
ORANGE	123,766	12,350	78,928,532	6,391	638	95	100	9.98%
PAMLICO	13,097	2,509	16,639,191	6,632	1,270	34	192	19.16%
PASQUOTANK	39,956	8,782	48,275,330	5,497	1,208	41	220	21.98%
PENDER	48,724	9,245	46,478,217	5,027	954	64	190	18.97%
PERQUIMANS	12,442	2,763	13,533,089	4,898	1,088	50	222	22.21%
PERSON	37,448	7,968	43,981,287	5,520	1,174	43	213	21.28%
PITT	146,403	29,568	201,056,044	6,800	1,373	22	202	20.20%
POLK	19,080	2,802	16,559,463	5,910	868	80	147	14.69%
RANDOLPH	138,586	27,796	121,372,294	4,367	876	79	201	20.06%
RICHMOND	46,700	13,855	77,272,897	5,577	1,655	15	297	29.67%
ROBESON	129,048	45,547	263,852,827	5,793	2,045	5	353	35.29%
ROCKINGHAM	91,830	20,726	101,144,478	4,880	1,101	47	226	22.57%
ROWAN	134,540	26,212	123,484,099	4,711	918	72	195	19.48%
RUTHERFORD	63,178	15,219	81,089,930	5,328	1,284	32	241	24.09%
SAMPSON	64,057	17,506	87,020,401	4,971	1,358	24	273	27.33%
SCOTLAND	36,994	12,665	63,537,047	5,017	1,717	13	342	34.24%
STANLY	59,128	11,200	55,430,511	4,949	937	65	189	18.94%
STOKES	46,335	8,054	42,791,262	5,313	924	71	174	17.38%
SURRY	72,990	16,269	81,047,340	4,982	1,110	46	223	22.29%
SWAIN	13,938	3,574	17,386,019	4,865	1,247	38	256	25.64%
TRANSYLVANIA	30,360	5,357	29,267,987	5,464	964	62	176	17.64%
TYRRELL	4,240	1,017	6,829,109	6,715	1,611	18	240	23.99%
UNION	172,087	22,714	88,674,597	3,904	515	100	132	13.20%
VANCE	43,920	15,610	71,712,412	4,594	1,633	17	355	35.54%
WAKE	790,007	90,331	424,065,888	4,695	537	99	114	11.43%
WARREN	19,969	5,870	31,451,438	5,358	1,575	19	294	29.40%
WASHINGTON	13,360	4,366	28,409,487	6,507	2,126	4	327	32.68%
WATAUGA	43,410	4,320	24,059,794	5,569	554	97	100	9.95%
WAYNE	114,930	26,897	134,087,543	4,985	1,167	44	234	23.40%
WILKES	66,925	14,544	80,936,138	5,565	1,209	40	217	21.73%
WILSON	77,468	19,546	101,215,927	5,178	1,307	27	252	25.23%
YADKIN	37,810	6,479	36,560,486	5,643	967	61	171	17.14%
YANCEY	18,368	3,966	23,228,057	5,857	1,265	35	216	21.59%
STATE TOTAL	**8,860,341**	**1,682,028**	**$8,546,239,914**	**$5,081**	**$965**		**190**	**18.98%**

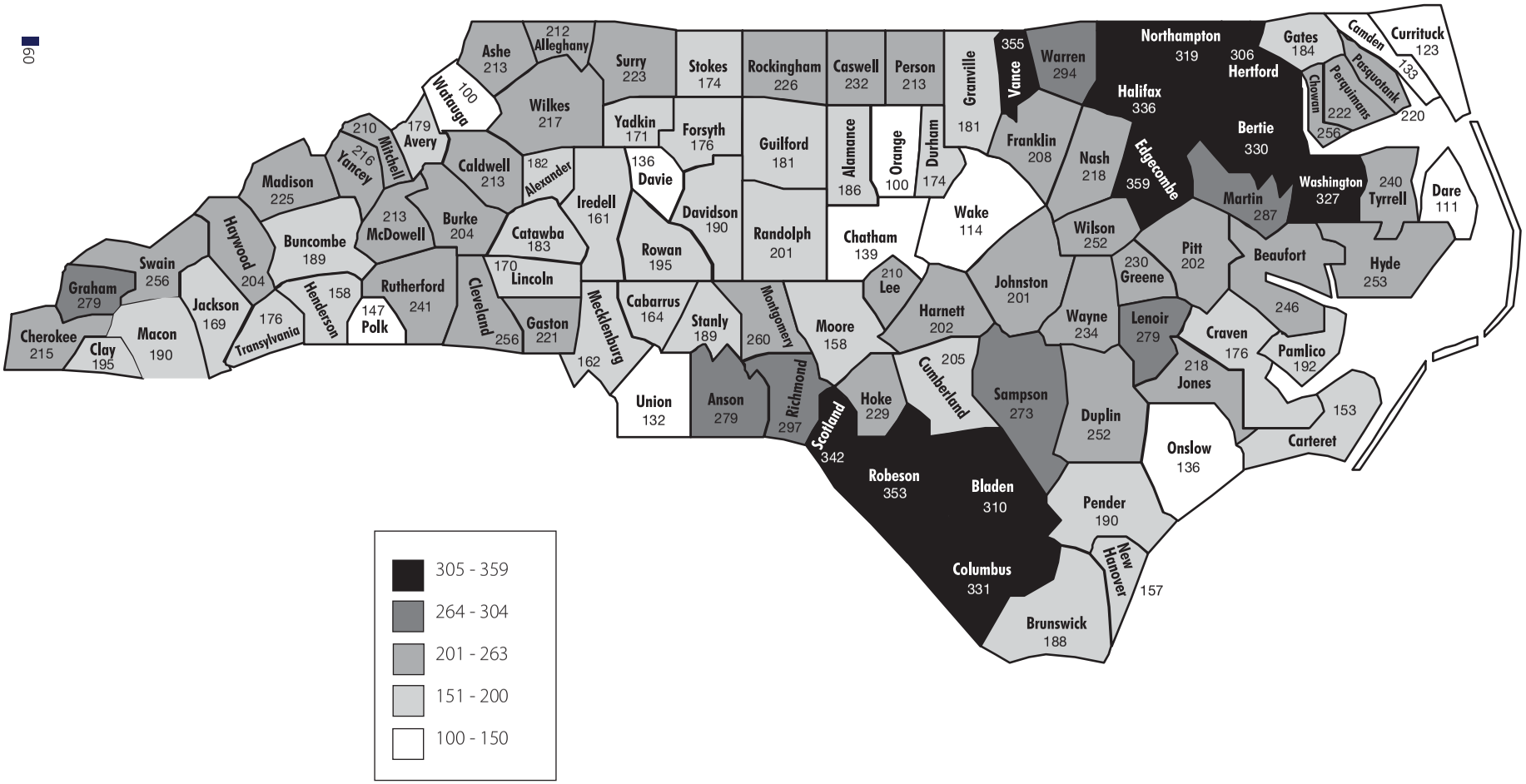
Notes:

* 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 $9.01 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 2007.

Medicaid Eligibles per 1,000 Population by County, SFY 2007



Medicaid Expenditures per Eligible by County, SFY 2007

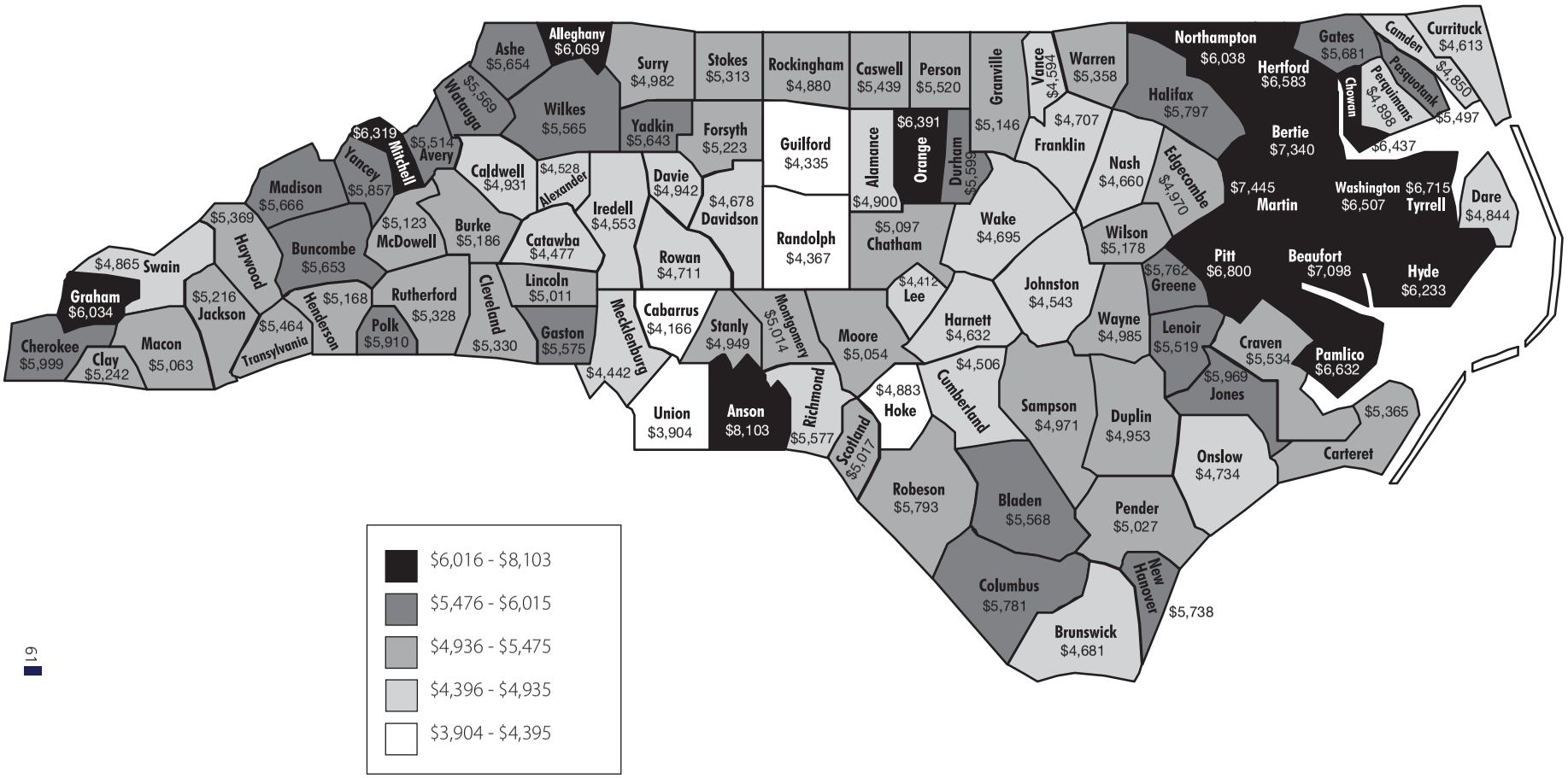


Table 9

N.C. Medicaid Program Services Expenditures SFY 2007

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	$1,025,325,554	11.4%	12.3%	292,365	$ 3,507
Outpatient Hospital	$ 624,047,899	6.9%	7.5%	770,748	$ 810
Mental Hospital <21 & >65	$ 58,823,076	0.7%	0.7%	3,036	$ 19,375
Physician	$ 853,358,974	9.5%	10.3%	1,516,925	$ 563
Clinics	$ 271,783,880	3.0%	3.3%	461,213	$ 589
Nursing Facilities	$1,055,070,554	11.7%	12.7%	42,721	$ 24,697
ICF-MR	$ 442,336,468	4.9%	5.3%	4,157	$106,408
Dental	$ 239,997,938	2.7%	2.9%	535,545	$ 448
Prescription Drugs	$ 934,276,607	10.4%	11.2%	1,023,202	$ 913
Home Health	$ 221,844,636	2.5%	2.7%	258,262	$ 859
Personal Care Services	$ 299,741,177	3.3%	3.6%	51,564	$ 5,813
Adult Care Homes - Personal Care Services	$ 156,399,361	1.7%	1.9%	28,679	$ 5,453
Non-Physician Practitioner	$ 999,990,509	11.1%	12.0%	158,235	$ 6,320
All Other Services	$1,141,150,760	12.7%	13.7%	1,236,984	$ 923
Subtotal, Services	$8,324,147,392	92.4%	100.0%		
Medicare Premiums: (Part A, Part B)	$ 352,713,724	3.9%	4.2%		
Part D Clawback	$ 223,684,818	2.5%	2.7%		
HMO Premiums	$ 104,567,747	1.2%	1.3%		
Transfers	$ 7,500,000	0.1%	0.1%		
Subtotal, Other	$ 688,466,288	100%			
Fund 1310 Total Title XIX Services	$9,012,613,680				
Total Recipients (unduplicated)**				1,684,411	
Total Expenditures Per Recipient (unduplicated)					$ 5,351

* "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 2007

Table 10

N.C Medicaid Service Expenditures by Recipient Group SFY 2007

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 2007 Expenditures Per Recipient	SFY 2006 Expenditures Per Recipient	06/07 Percent Change
Total Elderly	**$1,828,017,369**	**20.9%**	**161,722**	**9.9%**	**$11,303**	**$12,441**	**-9.1%**
Aged	1,771,870,667	20.3%	151,763	9.3%	$11,675	13,101	-10.9%
Medicare-Aid (MQBQ & MQBB & MQBE)*	56,146,702	0.6%	9,959	0.6%	$5,638	3,754	50.2%
Total Disabled	**$3,828,821,490**	**43.9%**	**263,514**	**16.2%**	**$14,530**	**$13,761**	**5.6%**
Disabled	3,798,835,296	43.5%	261,554	16.0%	$14,524	13,752	5.6%
Blind	29,986,195	0.3%	1,960	0.1%	$15,299	14,928	2.5%
Total Families &Children	**$3,026,110,988**	**34.7%**	**1,177,952**	**72.2%**	**$2,569**	**$2,198**	**16.9%**
AFDC Adults (> 21)**	728,739,469	8.3%	230,524	14.1%	$3,161	3,033	4.2%
Medicaid Pregnant Women (MPW)	255,509,057	2.9%	62,552	3.8%	$4,085	3,447	18.5%
AFDC Children & Other Children	727,361,253	8.3%	215,170	13.2%	$3,380	2,513	34.5%
Medicaid Infants&Children (MIC)	1,243,207,933	14.2%	615,639	37.8%	$2,019	1,702	18.7%
Breast and Cervical	6,554,355	0.1%	350	0.0%	$18,727	17,573	6.6%
M-SCHIP***	64,738,922	0.7%	53,717	3.3%	$1,205	569	111.8%
Aliens and Refugees	**$67,788,794**	**0.8%**	**27,432**	**1.7%**	**$2,471**	**$2,128**	**16.1%**

* "MQB" designates Medicare Qualified Beneficiaries; the recipient count does not include all eligible individuals whose Medicare premiums were paid by NC Medicaid, rather only those individuals whose Medicare premiums were paid and who received direct services.

** Includes individuals age 21 & over under TANF or AFDC-related coverage or family planning waiver.

*** M-SCHIP are the NC Health Choice children age 0 through 5 who were transitioned to NC Medicaid.

Source: SFY 2007 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

N.C. Medicaid Service Expenditures for Selected Major Medical Services by Program Category SFY 2007

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ* Medicare Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Blind	Disabled	Other Adult**	Children***	M-SCHIP****	Breast & Cervical Cancer	Alien & Refugees	Adjustments Unattributable to a Specific Category
Inpatient Hospital	$1,018,765,315.41	11.67%	$ 12,040,135	$ 23,232	$ 9,936	$ 1,313,336	$ 454,111,022	$ 235,128,265	$ 275,739,857	$ 4,386,084	$ 571,534	$ 45,823,783	$ (10,381,868)
Outpatient Hospital	624,208,200	7.15%	19,909,504	85,896	-	957,631	242,372,037	175,196,509	171,745,966	10,136,746	2,786,426	2,888,836	(1,871,351)
Mental Hospital (> 65)	7,749,981	0.09%	7,742,200	-	-	23,889	-	-	-	-	-	-	(16,108)
Psychiatric Hospital (< 21)	51,088,915	0.59%	-	-	-	3,385	15,154,725	11,122	35,958,567	31,114	-	16,476	(86,473)
Physician	853,548,695	9.78%	44,833,658	149,844	16	1,164,624	262,955,257	217,432,676	298,554,391	15,934,313	2,389,984	13,344,943	(3,211,011)
Clinics	275,375,863	3.15%	10,719,732	15,408	-	835,800	115,249,925	37,528,191	107,667,719	2,693,271	21,040	2,331,524	(1,686,746)
Nursing Facility	1,055,070,554	12.08%	894,726,867	517	-	2,369,877	157,858,002	218,846	26,412	-	-	543,866	(673,833)
Intermediate Care Facility for Mental Retardation	442,336,468	5.07%	30,693,265	-	-	7,756,608	401,580,657	-	2,282,951	-	-	46,886	(23,899)
Dental	240,226,701	2.75%	12,396,877	-	-	242,596	46,704,695	42,661,078	131,639,172	6,339,827	50,231	362,284	(170,059)
Prescribed Drugs	922,328,332	10.56%	8,495,283	-	-	2,621,837	495,340,177	156,820,475	246,245,127	12,031,956	547,850	413,414	(187,786)
Home Health	221,858,606	2.54%	39,365,704	25,092	-	1,517,042	146,621,376	14,765,878	19,085,380	888,303	88,223	381,903	(880,294)
CAP/Disabled Adult	256,895,512	2.94%	177,152,766	-	-	1,554,812	78,149,043	-	27,580	-	-	29,794	(18,481)
CAP/Mentally Retarded	376,113,959	4.31%	8,138,739	-	-	2,993,101	361,438,752	-	3,675,916	-	-	-	(132,549)
CAP/Children	30,794,410	0.35%	-	-	-	319,874	29,935,315	-	588,948	-	-	-	(49,726)
Personal Care	299,740,961	3.43%	150,152,139	-	-	2,418,323	138,408,691	6,258,620	2,746,280	21,254	16,770	21,210	(302,325)
Hospice	56,065,908	0.64%	37,647,128	-	-	166,132	17,610,968	410,020	170,486	49,278	23,044	16,287	(27,436)
EPSDT (Health Check)	58,918,901	0.67%	64	-	-	5,726	1,600,955	64,458	54,112,146	3,163,658	5	7,829	(35,941)
Laboratory & Imaging Services	45,994,904	0.53%	565,394	1,457	-	51,064	9,113,230	21,015,780	14,813,468	347,194	30,268	105,208	(48,157)
Adult Home Care	156,399,361	1.79%	88,640,409	-	-	254,555	67,434,952	89,050	48,846	-	-	1,050	(69,501)
High Risk Intervention Residential	143,758,387	1.65%	-	-	-	-	37,911,002	-	105,832,318	6,169	-	62,842	(53,944)
Other Services	1,136,140,080	13.01%	37,279,889	23,803	1,370	1,253,784	538,052,011	71,948,593	478,879,311	8,039,372	26,240	1,313,460	(677,753)
Total Services	**$ 8,273,380,014**	**94.76%**	**$1,580,499,751**	**$ 325,249**	**$ 11,322**	**$27,823,996**	**$3,617,602,791**	**$979,549,560**	**$1,949,840,838**	**$64,068,539**	**$6,551,615**	**$67,711,594**	**$(20,605,240)**
Premiums:													
Medicare, Part A Premiums	51,607,233	0.59%	50,973,045	16,179	(410)	470,977	1,999	-	-	-	-	-	145,443
Medicare, Part B Premiums	301,106,491	3.45%	137,554,989	842,483	54,951,878	1,158,629	105,203,055	923,779	12,078	-	-	76,963	382,637
HMO Premiums	104,567,744	1.20%	2,842,883	-	-	532,593	76,027,451	3,775,186	20,716,271	670,383	2,740	238	-
Total Premiums	**$ 457,281,468**	**5.24%**	**$ 191,370,917**	**$ 858,662**	**$54,951,468**	**$ 2,162,199**	**$ 181,232,505**	**$ 4,698,965**	**$ 20,728,349**	**$ 670,383**	**$ 2,740**	**$ 77,201**	**$ 528,080**
Program Category Totals			**$1,771,870,667**	**$1,183,911**	**$54,962,790**	**$29,986,195**	**$3,798,835,296**	**$984,248,525**	**$1,970,569,187**	**$64,738,922**	**$6,554,355**	**$67,788,794**	**$(20,077,160)**
Medicare Part D Payments***	**$ 223,619,806**		**$ 129,916,055**	**$ 151,647**	**$ 2,013,959**	**$ 942,696**	**$ 90,226,515**	**$ 329,325**	**$ 6,482**			**$ 33,128**	

* 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 or family planning waiver.

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

**** Medicaid for children transferred from the State Children's Health Insurance Program

***** Source for Medicare Part D Payments: SFY 2007 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 2007 Program Expenditure Report

Table 12

N.C. Medicaid Expenditures for the Elderly SFY 2007

Type of Service	Aged	Percent of Service Dollars	MQBQ Medicare Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Total Qualified Beneficiaries	Percent of Service Dollars	Total Elderly Dollars	SFY 2007 % of Total Dollars	SFY 2006 % of Total Dollars	SFY 2005 % of Total Dollars
Inpatient Hospital	$ 12,040,135	0.7%	$ 23,232	$ 9,936	$ 33,168	0.1%	$ 12,073,303	0.7%	0.6%	0.5%
Outpatient Hospital	19,909,504	1.1%	85,896	-	85,896	0.2%	19,995,400	1.1%	1.0%	1.0%
Mental Hospital (> 65)	7,742,200	0.4%	-	-	-	0.0%	7,742,200	0.4%	0.3%	0.3%
Physician	44,833,658	2.5%	149,844	16	149,860	0.3%	44,983,518	2.5%	2.3%	2.1%
Clinics	10,719,732	0.6%	15,408	-	15,408	0.0%	10,735,139	0.6%	0.7%	0.6%
Nursing Facility	894,726,867	50.5%	517	-	517	0.0%	894,727,384	48.9%	43.9%	41.7%
Intermediate Care Facility for Mental Retardation	30,693,265	1.7%	-	-	-	0.0%	30,693,265	1.7%	1.3%	1.1%
Dental	12,396,877	0.7%	-	-	-	0.0%	12,396,877	0.7%	0.5%	0.4%
Prescribed Drugs	8,495,283	0.5%	-	-	-	0.0%	8,495,283	0.5%	13.6%	21.7%
Home Health	39,365,704	2.2%	25,092	-	25,092	0.0%	39,390,795	2.2%	1.9%	1.6%
CAP/Disabled Adult	177,152,766	10.0%	-	-	-	0.0%	177,152,766	9.7%	8.8%	7.3%
CAP/Mentally Retarded	8,138,739	0.5%	-	-	-	0.0%	8,138,739	0.4%	0.3%	0.2%
CAP/Children	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Personal Care	150,152,139	8.5%	-	-	-	0.0%	150,152,139	8.2%	7.5%	6.7%
Hospice	37,647,128	2.1%	-	-	-	0.0%	37,647,128	2.1%	1.7%	1.3%
EPSDT (Health Check)	64	0.0%	-	-	-	0.0%	64	0.0%	0.0%	0.0%
Laboratory & Imaging Services	565,394	0.0%	1,457	-	1,457	0.0%	566,851	0.0%	0.0%	0.0%
Adult Home Care	88,640,409	5.0%	-	-	-	0.0%	88,640,409	4.8%	4.0%	3.9%
High Risk Intervention Residential	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Other Services	37,279,889	2.1%	23,803	1,370	25,173	0.0%	37,305,062	2.0%	0.9%	0.7%
Total Services	**$ 1,580,499,751**	**89.2%**	**$ 325,249**	**$ 11,322**	**$ 336,571**	**0.6%**	**$1,580,836,322**	**86.5%**	**89.3%**	**91.2%**
Premiums:										
Medicare, Part A Premiums	50,973,045	2.9%	16,179	(410)	15,769	0.0%	50,988,814	2.8%	2.3%	2.0%
Medicare, Part B Premiums	137,554,989	7.8%	842,483	54,951,878	55,794,361	99.4%	193,349,350	10.6%	8.2%	6.7%
HMO Premiums	2,842,883	0.2%	-	-	-	0.0%	2,842,883	0.2%	0.1%	0.0%
Total Premiums	**$ 191,370,917**		**$ 858,662**	**$54,951,468**	**$55,810,130**	**99.4%**	**$ 247,181,047**	**13.5%**	**10.7%**	**8.7%**
Grand Total Services and Premiums	**$1,771,870,667**	**100.0%**	**$1,183,911**	**$54,962,790**	**$56,146,702**	**100.0%**	**$1,828,017,369**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 105,711,591**		**$ 325,229**	**$ 5,091**	**$ 330,320**		**$ 106,041,911**			
Total Elderly Recipients	**151,763**		**634**	**9,325**	**9,959**		**161,722**			
Expenditures Per Recipient**	**$ 11,675**		**$ 1,867**	**$ 5,894**	**$ 5,638**		**$ 11,303**			
Medicare Part D Payments***	**$ 129,916,055**		**$ 151,647**	**$ 2,013,959**	**$ 2,165,605**		**$ 132,081,660**			

* 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 2007 BD701 Report

Source: SFY 2007 Program Expenditure Report

Table 13

North Carolina Medicaid
State Fiscal Year 2007
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	SFY 2007 % of Total Dollars	SFY 2006 % of Total Dollars	SFY 2005 % of Total Dollars
Inpatient Hospital	$ 454,111,022	12.0%	$ 1,313,336	4.4%	$ 455,424,357	11.9%	12.6%	12.8%
Outpatient Hospital	242,372,037	6.4%	957,631	3.2%	243,329,669	6.4%	6.4%	6.2%
Mental Hospital (> 65)	-	0.0%	23,889	0.1%	23,889	0.0%	0.0%	0.0%
Psychiatric Hospital (< 21)	15,154,725	0.4%	3,385	0.0%	15,158,109	0.4%	0.3%	0.3%
Physician	262,955,257	6.9%	1,164,624	3.9%	264,119,881	6.9%	7.0%	6.8%
Clinics	115,249,925	3.0%	835,800	2.8%	116,085,725	3.0%	8.7%	9.1%
Nursing Facility	157,858,002	4.2%	2,369,877	7.9%	160,227,879	4.2%	4.4%	4.5%
Intermediate Care Facility for Mental Retardation	401,580,657	10.6%	7,756,608	25.9%	409,337,265	10.7%	10.5%	11.0%
Dental	46,704,695	1.2%	242,596	0.8%	46,947,291	1.2%	1.1%	1.1%
Prescribed Drugs	495,340,177	13.0%	2,621,837	8.7%	497,962,013	13.0%	19.2%	23.3%
Home Health	146,621,376	3.9%	1,517,042	5.1%	148,138,418	3.9%	4.0%	3.7%
CAP/Disabled Adult	78,149,043	2.1%	1,554,812	5.2%	79,703,854	2.1%	2.2%	1.9%
CAP/Mentally Retarded	361,438,752	9.5%	2,993,101	10.0%	364,431,852	9.5%	7.6%	7.5%
CAP/Children	29,935,315	0.8%	319,874	1.1%	30,255,189	0.8%	0.8%	0.7%
Personal Care	138,408,691	3.6%	2,418,323	8.1%	140,827,014	3.7%	4.0%	3.5%
Hospice	17,610,968	0.5%	166,132	0.6%	17,777,101	0.5%	0.5%	0.4%
EPSDT (Health Check)	1,600,955	0.0%	5,726	0.0%	1,606,681	0.0%	0.0%	0.0%
Laboratory & Imaging Services	9,113,230	0.2%	51,064	0.2%	9,164,293	0.2%	0.2%	0.2%
Adult Home Care	67,434,952	1.8%	254,555	0.8%	67,689,507	1.8%	1.8%	1.9%
High Risk Intervention Residential	37,911,002	1.0%	-	0.0%	37,911,002	1.0%	0.8%	0.8%
Other Services	538,052,011	14.2%	1,253,784	4.2%	539,305,795	14.1%	3.0%	1.7%
Total Services	**$3,617,602,791**	**95.2%**	**$27,823,996**	**92.8%**	**$3,645,426,786**	**95.2%**	**95.2%**	**97.2%**
Premiums:								
Medicare, Part A Premiums	1,999	0.0%	470,977	1.6%	472,976	0.0%	0.0%	0.0%
Medicare, Part B Premiums	105,203,055	2.8%	1,158,629	3.9%	106,361,684	2.8%	2.6%	2.3%
HMO Premiums	76,027,451	2.0%	532,593	1.8%	76,560,044	2.0%	2.1%	0.4%
Total Premiums	**$ 181,232,505**	**4.8%**	**$ 2,162,199**	**7.2%**	**$ 183,394,704**	**4.8%**	**4.8%**	**2.8%**
Grand Total Services and Premiums	**$3,798,835,296**	**100.0%**	**$29,986,195**	**100.0%**	**$3,828,821,490**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 84,258,815**		**$ 808,018**		**$ 85,066,833**			
Total Disabled/Blind Recipients	**261,554**		**1,960**		**263,514**			
Service Expenditures Per Recipient**	**$ 14,524**		**$ 15,299**		**$ 14,530**			
Medicare Part D Payments***	**$ 90,226,515**		**$ 942,696**		**$ 91,169,211**			

* 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 2007 BD701 Report

Source: SFY 2007 Program Expenditure Report

Table 14

N.C. Medicaid Expenditures for Families and Children
SFY 2007

Type of Service	AFDC Adults***	% of Service Dollars	Special Pregnant Women	% of Service Dollars	AFDC Children & Other Children	% of Service Dollars	Infants & Children	% of Service Dollars	MSCHIP	% of Service Dollars	Breast Cervical	% of Service Dollars	Total Families & Children Dollars	SFY 2007 % of Total Dollars	SFY 2006 % of Total Dollars
Inpatient Hospital	$ 142,511,022	19.7%	$ 92,617,242	36.2%	$ 56,609,443	7.8%	$ 219,130,413	17.6%	$ 4,386,084	6.8%	$ 571,534	8.7%	$ 515,835,050	17.1%	19.7%
Outpatient Hospital	144,410,113	19.9%	30,786,396	12.0%	56,573,708	7.8%	115,172,258	9.3%	10,136,746	15.7%	2,786,426	42.5%	359,597,977	11.9%	13.1%
Psychiatric Hospital (< 21)	-	0.0%	11,122	0.0%	22,037,945	3.0%	13,920,621	1.1%	31,114	0.0%	-	0.0%	36,000,803	1.2%	0.9%
Physician	145,870,671	20.1%	71,562,005	28.0%	79,459,328	10.9%	219,095,063	17.6%	15,934,313	24.6%	2,389,984	36.5%	534,309,618	17.7%	19.0%
Clinics	16,388,249	2.3%	21,139,942	8.3%	58,058,225	8.0%	49,609,493	4.0%	2,693,271	4.2%	21,040	0.3%	147,910,001	4.9%	10.4%
Nursing Facility	218,846	0.0%	-	0	13,499	0.0%	12,913	0.0%	-	0	-	0	245,257	0.0%	0.0%
Intermediate Care Facility for Mental Retardation	-	0.0%	-	0.0%	1,767,233	0.2%	515,718	0.0%	-	0.0%	-	0.0%	2,282,951	0.1%	0.1%
Dental	40,265,443	5.6%	2,395,635	0.9%	40,564,451	5.6%	91,074,721	7.3%	6,339,827	9.8%	50,231	0.8%	180,690,308	6.0%	6.3%
Prescribed Drugs	144,228,696	19.9%	12,591,779	4.9%	85,438,594	11.7%	160,806,533	12.9%	12,031,956	18.6%	547,850	8.4%	415,674,149	13.8%	14.5%
Home Health	12,285,453	1.7%	2,480,425	1.0%	5,613,250	0.8%	13,472,130	1.1%	888,303	1.4%	88,223	1.3%	34,827,586	1.2%	1.3%
CAP/Disabled Adult	-	0.0%	-	0.0%	23,421	0.0%	4,159	0.0%	-	0.0%	-	0.0%	27,580	0.0%	0.0%
CAP/Mentally Retarded	-	0.0%	-	0.0%	3,675,916	0.5%	-	0.0%	-	0.0%	-	0.0%	3,675,916	0.1%	0.1%
CAP/Children	-	0.0%	-	0.0%	588,948	0.1%	-	0.0%	-	0.0%	-	0.0%	588,948	0.0%	0.0%
Personal Care	6,224,936	0.9%	33,683	0.0%	1,322,338	0.2%	1,423,941	0.1%	21,254	0.0%	16,770	0.3%	9,042,923	0.3%	0.4%
Hospice	396,839	0.1%	13,181	0.0%	17,960	0.0%	152,525	0.0%	49,278	0.1%	23,044	0.4%	652,828	0.0%	0.0%
EPSDT (Health Check)	31,174	0.0%	33,284	0.0%	10,740,931	1.5%	43,371,215	3.5%	3,163,658	4.9%	5	0.0%	57,338,333	1.9%	2.0%
Laboratory & Imaging Services	12,504,103	1.7%	8,511,677	3.3%	4,173,874	0.6%	10,639,594	0.9%	347,194	0.5%	30,268	0.5%	36,206,709	1.2%	1.2%
High Risk Intervention Residential	-	0.0%	-	0.0%	58,639,298	8.1%	47,193,020	3.8%	6,169	0.0%	-	0.0%	105,838,488	3.5%	3.7%
Adult Home Care	81,429	0.0%	7,620	0.0%	31,198	0.0%	17,647	0.0%	-	0.0%	-	0.0%	137,895	0.0%	0.0%
Other Services	59,543,977	7.7%	12,404,616	4.9%	230,356,849	31.7%	248,522,462	20.0%	8,039,372	12.4%	26,240	0.4%	555,158,133	18.4%	5.9%
Total Services	**$724,960,953**	**99.5%**	**$254,588,607**	**99.6%**	**$715,706,410**	**98.4%**	**$1,234,134,428**	**99.3%**	**$64,068,539**	**99.0%**	**$6,551,615**	**100.0%**	**$2,996,041,451**	**99.1%**	**98.5%**
Premiums:															
Medicare, Part A Premiums	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Medicare, Part B Premiums	818,914	0.1%	104,865	0.0%	8,625	0.0%	3,453	0.0%	-	0.0%	-	0.0%	935,857	0.0%	0.0%
HMO Premiums	2,959,601	0.4%	815,585	0.3%	11,646,219	1.6%	9,070,053	0.7%	670,383	1.0%	2,740	0.0%	25,164,380	0.8%	1.4%
Total Premiums	**3,778,515**	**0.5%**	**920,450**	**0.4%**	**11,654,844**	**1.6%**	**9,073,505**	**0.7%**	**670,383**	**1.0%**	**2,740**	**0.0%**	**26,100,237**	**0.9%**	**1.5%**
Grand Total Services and Premiums	**$728,739,469**	**100.0%**	**$255,509,057**	**100.0%**	**$727,361,253**	**100.0%**	**$1,243,207,933**	**100.0%**	**$64,738,922**	**100.0%**	**$6,554,355**	**100.0%**	**$3,026,110,988**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 692,057**		**$ 85,577**		**$ 20,858**		**$ (5,599)**								
Total Family & Child Recipients	**230,524**		**62,552**		**215,170**		**615,639**		**53,717**		**350**		**1,177,952**		
Service Expenditures Per Recipient**	**$ 3,161**		**$ 4,085**		**$ 3,380**		**$ 2,019**		**$ 1,205**		**$ 18,727**		**$ 2,566**		
Medicare Part D Payments***	**$ 329,325**		**$ 65,012**		**$ 4,143**		**$ 2,339**						**$ 400,818**		

* 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 2007 BD701 Report

Source: SFY 2007 Program Expenditure Report

Table 15

N.C. Medicaid Copayment Amounts SFY 2007

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

Appendix I

Glossary

ABD	Aged, Blind and Disabled categories of Medicaid eligibility
Aid category	One of the sets of criteria used to qualify an individual for Medicaid eligibility
Beneficiary	A person enrolled in the N.C. Medicaid program
CAP	Community Alternatives Program; offered for children (CAP/C), disabled adults (CAP/DA), persons with mental retardation and/or developmental disabilities (CAP-MR/DD) and persons with AIDS (CAP/AIDS)
Categorically needy	Obtaining eligibility for Medicaid by meeting the income and resource criteria for a particular eligibility category
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
DPH	Division of Public Health
EDS	Electronic Data Systems; DMA's fiscal intermediary, which processes claims and makes payments for the N.C. Medicaid program
Eligible person	An individual who qualifies for Medicaid coverage under one of the categories of eligibility
Enrollee	An eligible individual who has received a Medicaid identification card and may begin receiving covered services
EPSDT	Early Periodic Screening, Diagnosis and Treatment; Medicaid's comprehensive and preventive child health program for individuals under the age of 21
FFS	Fee-for-service; reimbursement to a provider, based upon a fee schedule, for each submitted claim
FFY	Federal fiscal year; October 1 through September 30
FMAP	Federal medical assistance percentage; the federal dollar match percentage
FPL	Federal poverty level; poverty guidelines that are issued by the U.S. Department of Health and Human Services to determine eligibility for some federal programs including Medicaid
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
Medically needy	Medicaid eligibility through a combination of low income and resources as well as significant medical expenses
MMIS	Medicaid Management Information System; the software operated by EDS to process claims and make payments
NCHC	North Carolina Health Choice; the state's Children's Health Insurance Program
NCPAG	N.C. Physician Advisory Group
NPI	National Provider Identifier
OTC	Over-the-counter; non-prescription drugs
PASARR	Preadmission Screening and Annual Resident Review
PCP	Primary care provider
PCS	Personal Care Services
QMB	Qualified Medicare Beneficiary; a Medicare beneficiary who is eligible for Medicaid because the person's income is under 100 percent of the poverty level and their resources are less than a certain amount. Medicaid covers Medicare Part A and B premiums as well as deductibles and co-payments within Medicaid allowable limits
Recipient	A Medicaid enrollee who receives at least one service during the fiscal year
SCHIP	State Children's Health Insurance Program; in North Carolina, the program is titled N.C. Health Choice
SFY	State fiscal year; July 1 through June 30
SSI	Supplemental Security Income; an insurance program for those who have worked a specified amount of time and have lost their source of income due to a disability
TANF/AFDC	Temporary Assistance for Needy Families; formerly known as Aid to Families with Dependent Children
Title XIX	The federal statute, enacted in 1965 under the Social Security Act, which created the Medicaid program
Unduplicated count	Counting an individual only once per fiscal year even if they leave and re-enter the Medicaid program or are enrolled under more than one eligibility category during the year

Appendix II

Program Integrity Key Initiatives

Third Party Collections and Cost Avoidance

Efforts of the staff in Program Integrity's Third Party Recovery Section saved, recovered or avoided N.C. Medicaid costs in excess of $1 billion during SFY 2007. 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 state and local law enforcement.

Recoveries	**SFY 2007**	**SFY 2006**	**% Change**
Medicare	$ 8,847,961	$ 7,261,493	22
Health Insurance	18,852,170	21,039,509	(10)
Casualty Insurance	17,989,923	19,241,466	(7)
Estate Recovery	10,885,856	10,210,409	7
Totals	**$ 56,575,910**	**$57,752,877**	**(2)**

Cost Avoidance	**SFY 2007**	**SFY 2006**	**% Change**
Medical Insurance Avoided	$ 162,649,307	$ 192,113,800	(15)
Medicare Avoided	675,660,051	642,852,073	5
Insurance Payments Reported on Claims	250,920,629	273,172,044	(8)
Totals	**$1,089,229,987**	**$1,108,137,917**	**2**

Program Integrity Investigative Sections Collections and Cost Avoidance

Efforts by Program Integrity's four provider investigative units resulted in the recovery of $13,070,968, a 27% increase in recovery from SFY 2006, and cost avoidance of $ 8,161,125.

Program Integrity ensures that Medicaid payments are prohibited, withheld, or recovered in accordance with disciplinary actions and sanctions imposed against providers by licensing boards, law enforcement, or other state and federal regulatory agencies. Additionally, Program Integrity takes action when appropriate to terminate sanctioned providers from the Medicaid program.

The following examples illustrate collections and cost avoidance resulting from Program Integrity's increased emphasis on administrative actions and other initiatives in SFY 2007:

- The Provider Medical Review Section monitors the actions of the North Carolina Medical Board to avoid inappropriate payments to providers whose medical licenses have been suspended or terminated. Program Integrity's followup of Board actions against 34 physicians resulted in cost savings of $137,744. In addition, following withdrawal of a provider's endorsement by DMH, the PI Provider Medical Review Section took action to terminate the provider's Medicaid enrollment, for cost savings of $225,758 in SFY 2007.

- The Pharmacy Review Section found providers were incorrectly billing expensive injectables by unit rather than by volume. Working closely with Clinical Policy and EDS, these drugs were forced to hit the unbreakable package system edit, resulting in $131,623 in savings based on denials of incorrectly billed claims.
- The Pharmacy Review Section estimates cost savings of $2.5 million in SFY 2007 as a result of a Hospice edit implemented last year.
- Program Integrity's continuing partnership with law enforcement was evident in the successful prosecution of a N.C. Medicaid transportation provider. PI's case became a collaborative investigation with the AGO Medicaid Investigations Unit and the U.S. Attorney's Office. The provider was convicted on multiple counts of health care fraud, sentenced to prison and ordered to pay a large restitution and penalties. Exclusion of this provider from participation in Medicare and Medicaid is saving Medicaid payments of more than $700,000 annually.
- The Home Care Review Section initiated claims suspension for a provider for not upholding the terms of its provider participation agreement. The suspension requires submission of paper claims with supporting documentation to be reviewed prior to allowing the claim to be paid. Additionally, the provider was suspended from Medicaid participation for 12 months, offsetting approximately $266,000 in annual payments.
- The Home Care Review Section implemented a payment withholding action against a provider with multiple sites in North Carolina for violating the terms of its provider participation agreement which resulted in cost avoidance in excess of $3 million.
- A dental provider was terminated from the Medicaid program as the result of an investigation by the PI Provider Administrative Review Section. Based on the provider's average payments to three separate billing numbers, a cost savings of $1.2 million is projected.
- Recipient fraud investigators in the local departments of social services recovered $1,271,721 in overpayments in N.C. Medicaid. The state assisted county investigators in collecting an additional $209,632 by intercepting North Carolina income tax refund checks from delinquent debtors. In addition, the state assisted county investigators in collecting $383 by intercepting N.C. Education Lottery winnings from delinquent debtors.
- Program Integrity's Provider Self Auditing procedure allows some providers to conduct their own investigation and by self disclosure voluntarily refund Medicaid when overpayments are identified. This method is offered only to providers whose billing errors are not considered fraudulent and is performed under the direction of Program Integrity reviewers. For fiscal year 2007, a total of 53 self audit cases were completed by the four investigative sections which initiated a recoupment of $963,736.

  The PI Pharmacy Review Section had two notable examples of provider self audits. One provider had misbilled an injectable for an extended period of time resulting in a recoupment of $262,490. Another provider employed a pharmacist that was excluded by the Office of Inspector General (OIG). That pharmacist should not have participated in any activity that was billed to any federally funded programs, which resulted in recoupment of $81,822.33.

Other Program Integrity Initiatives

- Program Integrity's Quality Assurance Section developed a sampling plan that outlines the steps necessary to meet the Centers for Medicare and Medicaid Services (CMS) PERM requirement for conducting eligibility reviews. North Carolina's sampling plans were approved and applauded as models for other states to follow.
- North Carolina was one of the initial six pilot states to participate in a national project called the Medicare-Medicaid Data Match Project or Medi-Medi project, which is now being expanded to all 50 states. North Carolina's DMA Program Integrity Section and Advance Med, a CMS Program Safeguard Contractor for Medicare, initiated Federal and State joint on-site reviews which together has identified over $2 million at risk.
- The Program Integrity Special Projects Section was established in June 2007, with primary responsibility to coordinate PI's efforts on several federally mandated and state required projects, including PERM (Payment Error Rate Measurement), Medi-Medi (Medicare/Medicaid Data Match), OSA (Office of State Auditor) claims samples, and FADS (Fraud and Abuse Detection System).
- Federal Medicaid Payment Error Rate Measurement (PERM) Project — Effective Nov. 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 review contractor to perform data processing and medical record reviews and to provide results to the statistical contractor. The state is required to provide the contractor with quarterly universe of claims information, provider contact information, medical and other related policies, current managed care contracts, rate setting and pricing information, data processing systems manuals, 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. A review of Medicaid and SCHIP fee-for-service claims, managed care payments and eligibility reviews will be performed every three years. DMA is participating in the FFY 2007 sampling, and the NC PERM project team will address any identified claim errors, complete the difference resolution process on disputed claims, reprice claims as indicated, recover claim overpayments, review eligibility determinations and develop corrective action plans to address causes of improper payments.

Appendix III

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 — DMA had two contracts with EDS as follows:

- **Fiscal Agent** — Processed claims, provided billing guidance, provided helpdesk services to enrolled Medicaid providers, conducted provider education seminars, operated the prior approval system for most Medicaid services and operated the N.C. Medicaid Management Information System (MMIS+).
- **Uniform Screening** — Developing and implementing a uniform screening program for eight Medicaid programs and services that target recipients with chronic conditions or illnesses and for the federally mandated Preadmission Screening and Annual Resident Review (PASARR) for certain institutionalized individuals. The eight programs and services are the Personal Care Services (PCS), PCS Plus, 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) — DMA had five contracts with CCME as follows:

- **Personal Care Services (PCS) Compliance Review Services** — Provided PCS compliance reviews to ensure that PCS providers were in compliance with applicable statutes, rules, regulations, administrative policies and procedures; performed targeted case reviews of PCS recipients to ensure that the type, scope, amount and duration of PCS were medically necessary and consistent with the recipient's current plan of care; developed and conducted regional training programs for PCS providers aimed at improving PCS compliance, utilization, quality and cost-effectiveness.
- **Alien Emergency Medicaid Services Review Service** — Provided 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 met the federal definition of "medical emergency."
- **Prior Approval of Outpatient Therapies** — Processed requests for prior approval of outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompassed all outpatient treatment for occupational, physical, speech/language, respiratory and audiological therapy regardless of where the services were provided.
- **Post Payment Diagnosis Related Group (DRG) Reviews of Inpatient Medicaid Services** — Evaluated provider DRG coding to identify improper reimbursement maximization and other potential incorrect billings and assisted in a federal Payment Accuracy Measurement (PAM) grant to determine the accuracy rate of Medicaid claim payments. DMA's participation as one of nine grant states helped develop a process to determine a national model for all states. Payment accuracy measurement has been subsequently mandated in federal law known as the "Improper Payments Reduction Act of 2002" (Ref. HR 4878).

- **Quality Assurance and Quality Improvement for Community Based Services Program** — Designed a web-based database and automated quality assurance quality improvement assessment tool to: 1) conduct annual reviews of each participant in CAP/DA and CAP/DA-Choice; 2) monitor and evaluate provided services to ensure they are within cost limits for individual recipients as well as provide aggregate program expenditure data; and 3) monitor and evaluate the services provided and operation of the programs in order to identify quality concerns and improve overall program operation.

Navigant Consulting — Evaluated 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 provided 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 was 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 provided assistance with cost settlement and activities associated with the Disproportionate Share and Supplemental Payment Programs. The DMA Audit Unit contracted with Myers & Stauffer to conduct onsite compliance audits of Medicaid-enrolled nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR).

ValueOptions — Performed 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 encompassed all elective and emergency admission reviews, concurrent continued-stay reviews and post-discharge reviews.

ACS State Healthcare — Oversaw the prior authorization process for certain prescription drugs that were selected 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 Fraud and Abuse Detection Systems (FADS) and Decision Support System (DRIVE) software packages (see below).

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

Clifton Gunderson and Myers & Stauffer — Certified public accounting firms, under contract with the DMA Audit Unit, conducted onsite compliance audits of Medicaid-enrolled nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR). They also conducted 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 provided assistance with audits for teaching hospitals, nursing facilities, teaching physicians and inpatient hospitals.

Mercer Government Human Services Consulting — Provided capitated rates for the HMO programs, as well as support for the pilot PACE program in the Home and Community Based Care Unit of DMA. Mercer also provided actuarial services for the Rate Setting Unit of DMA and assisted 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 assisted 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 for 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 ensured that providers who were seeking enrollment with N.C. Medicaid were eligible to participate.

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

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

Center for Evidence-Based Policy, Oregon Health and Science University —Coordinated 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.

Appendix IV

Partnerships

Although DMA administers Medicaid, partnering with other state and local agencies is necessary 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 of determining Medicaid eligibility for that county's residents. In addition, counties contributed approximately five percent of the cost of services for Medicaid recipients during SFY 2007 (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, Develop¬mental 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 Annual 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. Effective Jan. 1, 2007, DMA eliminated its CAP/AIDS program and serves recipients through either the CAP/C or CAP/DA program depending upon the individual's age.

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 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 partnering with DMA to manage the CCNC program.

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

N.C. Division of Health Services Regulation (DHSR) (formerly the Division of Facility Services) — DHSR has the responsibility for licensing, certifying and monitoring nursing homes, hospitals and adult care homes in North Carolina. DHSR 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 Individualized Education Program (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.

N.C. Department of Insurance (DOI) — DMA and DOI work together on many issues that are important to the Medicaid population, including Medicare Part D coverage.

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 carried out and reported on a primary care provider availability survey for Carolina ACCESS.

Acknowledgments

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

Darlene Creech
Financial Analyst
Budget Management

Brad Deen
Public Information Officer
DHHS Public Affairs Office

Sharon Doorley
Nurse Analyst, Special Projects Section
Program Integrity

Julia McCollum
Human Services Planner/Evaluator
Managed Care

Lue Anne McSwain
Chief, Special Projects Section
Program Integrity

Susan Ryan
Policy Project Manager, Medicaid Eligibility Unit
Recipient & Provider Services

Contributing Writers

Darlene Baker

Loretta Bohn

Marie Britt

M. Kimberly Carter

Mark Casey

Richard Cobb

Tracy Colvard

Darlene Creech

Tom D'Andrea

Vanessa Davison

Sharon Doorley

Jim Flowers

Aydlett Hunike

Gary Kugler

Julia McCollum

Lue Anne McSwain

Mona Moon

Ronda Owen

Terri Paynter

Debbie Pittard

Nora Poisella

Linda Pruitt

Susan Ryan

Lynne Testa

Lorie Williams

Melody Yeargan

Angie Yow

Data, Tables and Graphics

Emad Attiah

Richard Cobb

Charles Dewar

Patricia Slaughter

Production

Christie Adams

north carolina medicaid

nc department of health and human services

DMA/Director's Office - 17

2501 Mail Service Center
Raleigh, NC 27699-2501

(919) 855-4102

www.ncdhhs.gov/dma

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