Medicaid

in North Carolina

Annual Report
State Fiscal Year 2008

Division of Medical Assistance

Beverly Eaves Perdue, Governor
Lanier M. Cansler, Secretary
Craigan L. Gray, MD, MBA, JD, Director

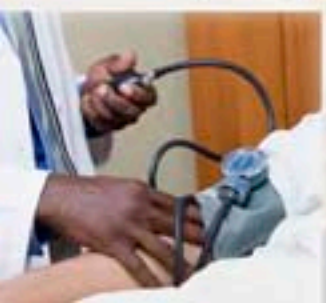
north carolina medicaid











This annual report was produced by the

North Carolina Department of Health and Human Services

Division of Medical Assistance

September 2009

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Division of Medical Assistance
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Beverly Eaves Perdue, Governor
Director
Lanier M. Cansler, Secretary

Craigan L. Gray, MD, MBA, JD,

September 17, 2009

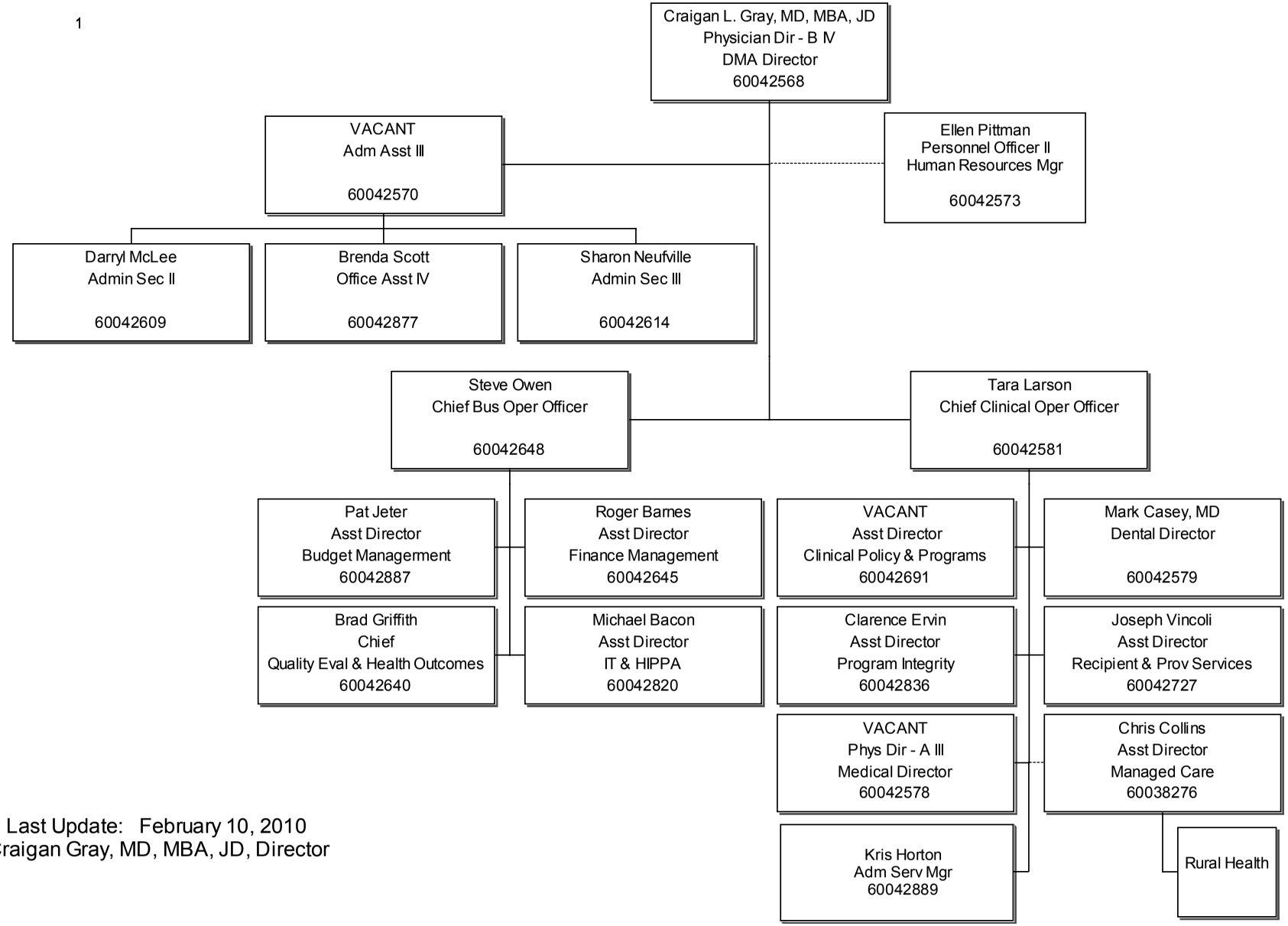
Dear Fellow North Carolinians:

It is my honor to present you with the enclosed copy of the North Carolina Medicaid Annual Report for State Fiscal Year 2008. 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,

Craigan L. Gray, MD, MBA, JD

Department of Health and Human Services
Division of Medical Assistance



Last Update: February 10, 2010
Craigan Gray, MD, MBA, JD, Director

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 resulting in improved quality of life.

In order to carry out this mission, DMA's goals for State Fiscal Years 2008-2009 are:

Quality Assurance—we will reduce variability and promote best practice standards in health care delivery by utilizing Community Care of North Carolina (CCNC) networks, expanding Medicaid and North Carolina Health Choice (NCHC) recipient enrollment in CCNC, and increasing the use of evidence based clinical practices to improve the quality of health care for Medicaid and NCHC recipients.

Accountability—we will eliminate unnecessary utilization of services and fraudulent behavior by evaluating, monitoring, and benchmarking all key health care services in order to eliminate wasteful spending in the Medicaid program.

Coverage—we will reduce the number of uninsured individuals in the state through the NCHC and Medicaid Programs so that the population served will be healthy and ready to learn and work.

Payment—we will provide for the payment of appropriate health care services delivered to disadvantaged North Carolinians to ensure their medical needs are met through system monitoring and testing.

Customer Service—we will provide good customer service to Medicaid providers and recipients through partnerships and collaboration with provider groups to increase access to services and ensure good health care for recipients.

Program Highlights

The Division of Medical Assistance (DMA), N.C. Medicaid's home in the Department of Health and Human Services (DHHS), had another productive year meeting the health care needs of the citizens of North Carolina. For the year ending June 30, 2008, 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 2.6 percent over the previous year, as compared to a 2.3 percent increase in the overall state population– due in part to the early stages of the recent economic downturn.

Statistical highlights of our expenditure and recipient data included the following:

- More individuals were eligible for Medicaid in State Fiscal Year (SFY) 2008 (1,726,412) than last year (1,682,028), a 2.6 percent increase, and this was the highest number of eligible individuals to date.
- We spent a total of $11.6 billion, of which $9.5 billion was spent on health services and premiums, an increase of roughly $500 million in health services and premiums, or 5.5 percent, over SFY 2007 (see Exhibit 9 on page 38 for details).
- Total expenditures per N.C. Medicaid recipient were $6,424, which was 3.8 percent less than the previous year. This was due in large measure to the increasing proportion of recipients in the Medicaid Infants and Children category, which has a much lower average cost per eligible person, and to a lower cost per user for non-physician practitioner services.
- The two largest eligibility categories were "Pregnant Women and Children" and "Aid to Families with Dependent Children" (AFDC) as was the case for the previous year.
- The inpatient hospital and nursing facility expenditure categories were the two highest, at roughly $1.1 billion each, with prescribed drugs being the third highest cost with $974 million. The nursing facility expense category was the highest during SFY 2007.
- Elderly and disabled recipients comprised 29 percent of total recipients; however, service expenditures for these two groups totaled approximately $6.2 billion, or 65 percent of total Medicaid expenditures. On the other hand, recipients from the Families and Children group represented approximately 70 percent of all recipients but accounted for approximately $3.3 billion, or 34 percent, of total service expenditures.

A number of special initiatives were accomplished during the past fiscal year including:

Community Care of North Carolina (CCNC)

CCNC is DMA's managed care program, serving a majority of N.C. Medicaid recipients. Its accomplishments include:

- The Ashe Institute for Democratic Governance and Innovations at Harvard's John F. Kennedy School of Government named Community Care the recipient of the 2007 Annie E. Casey Innovations Award in Children and Family Systems Reform. One of seven given to government agencies nationwide, the award included a $100,000 grant for statewide and national promotion efforts. The award recognized CCNC's success in providing cost-effective health care services to low-income children and families through a network of 3,500 primary care physicians in all 100 N.C. counties as well as pharmacists, local health departments, social services agencies and community support providers. The network provides information and training to doctors so they can prescribe the most effective treatment for chronic diseases. Other states have developed pilot programs based on the CCNC model.
- Medicaid currently has 1,266 Carolina Access (CA) primary care practices linked to a CCNC network, representing a 12 percent increase over the previous year. These networks bring together the key care providers in order to achieve the desired quality, cost, access and utilization goals of the managed care program. CA is a primary care, case management (PCCM) model of managed care
- The number of N.C. Health Choice children linked with a CCNC primary care provider increased from 27,010 in SFY 2007 to 87,292 in SFY 2008, or 223 percent.
- Over 50 primary care practices added behavioral health specialists at primary care sites in order to improve the early diagnosis and treatment of mental health problems. By the same token, behavioral health care facilities addressed the physical health care needs of their patient populations by adding preventive primary care practitioners.
- The Community Care Chronic Care initiative, targeting individuals who are aged, blind or disabled, expanded from nine counties within nine networks in SFY 2007 to 24 counties within 12 networks this year, now providing services to 47,050 individuals. 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
  - reduce the rate of institutionalization
  - reduce the unnecessary inefficiencies and expenses inherent in the current system.
- CCNC, working in partnership with DMA Managed Care consultants and Smart Start, assisted primary care providers in implementing the N.C. Health Check policy that supports early developmental screening, identification and referral to public health early intervention services for young children.

Improved Dental Access

Children's access to dental care was improved through increased dental provider reimbursement and the Physician Fluoride Varnish Program (also known as "Into the Mouth of Babes").

- As a direct result of past legislated dental reimbursement rate increases, the number of dentists participating in the N.C. Medicaid program has increased substantially. During SFY 2008, a total of 2,326 active licensed dentists in North Carolina, well over 50 percent of all dentists in the state, were reimbursed for at least one Medicaid dental claim. This represents an increase of approximately 18 percent over SFY 2001. The number of billing providers with paid claims greater than or equal to $10,000 per year, considered by DMA to be the threshold level for significant activity, has increased from 644 in SFY 2001 to 1,006 in SFY 2008, or 56 percent.
- Gains in dental provider enrollment and activity have continued to translate into increases in oral health access measures for Medicaid recipients. During SFY 2008, a total of 42 percent of all Medicaid-eligible children ages 0 through 20 received at least one dental service, compared to 25 percent during SFY 2001. This percentage gain in access to oral health care was made despite the growth in the number of Medicaid-eligible children from approximately 750,000 in SFY 2001 to well over 1 million in SFY 2008.
- The "Into the Mouth of Babes" program (IMB), is an innovative medical model approach to providing preventive oral health care to preschool Medicaid recipients through fluoride varnish applied by physicians at primary care office visits. A collaborative effort between DMA, the Division of Public Health – Oral Health Section, the UNC Schools of Dentistry and Public Health and other medical and dental provider organizations, the program continues to grow and provide much-needed preventive oral health care services to a population of recipients who have traditionally faced difficulty in accessing dental care. Since the inception of IMB in SFY 2001, the number of Medicaid children receiving oral health care services from primary care medical providers has increased from roughly 8,000 children to approximately 60,000 during SFY 2008. This pioneering initiative is widely admired and has drawn favorable attention from other states' Medicaid agencies (over 20 have adopted a similar program).
- The same collaboration that worked on IMB continues to work on "Carolina Dental Home," a pilot project in a three-county area in eastern North Carolina. Funded by a federal grant to DPH from the Health Resources and Services Administration, the new strategy builds upon the success of IMB by identifying high-risk preschool Medicaid recipients and facilitating their care coordination and referral from participating IMB physicians to general and pediatric dentists termed "dental homes." From April 1, 2008, through June 30, 2008, a total of 33 preschool Medicaid recipients deemed to be at high risk for early childhood caries were referred from participating primary care physicians to participating dentists in the Carolina Dental Home pilot project. Approximately 90 at-risk children have been referred to date.

Outpatient Pharmacy Program

The outpatient pharmacy program implemented several new initiatives during the year:

- tamper-resistant prescription pads as mandated by federal law (September 2007)

- the ACS SmartPA program, which allows point-of-sale clinical editing and prior authorizations on pharmacy claims and helps providers determine the appropriateness of dispensing certain medications, thus streamlining the pharmacy prior authorization process (April 2008)
- prior authorization on certain medications in the second-generation antihistamine drug class in order to encourage the use of cost-effective, over-the-counter alternatives (May 2008)

Be Smart

The January 2008 "Be Smart Family Planning Waiver Year One Interim Annual Report" by Navigant Consulting, Inc. indicated that, during its first year of operation, the Be Smart program drastically reduced Medicaid covered costs associated with unintended pregnancies through improved access to Medicaid family planning services for low-income men and women. A total of 876 births were averted during the year October 1, 2005 – September 30, 2006 through the effective use of contraceptives and maternal and infant health. This resulted in a Medicaid cost savings of $9,505,557.

Quality, Evaluation and Health Outcomes (QEHO)

QEHO researches and publishes a variety of data for the Division's internal use in ensuring the quality and efficiency of services. A county-specific subset of this research and analysis is published on the DMA Web site to assist county governments, local and state agencies and legislators in planning and decision-making. With the assistance of the DMA Decision Support Unit, QEHO created software queries to generate most of this reporting during the year, resulting in a substantial savings in staff hours.

Program Integrity Section

The various units within the Program Integrity Section succeeded in saving, recovering and cost avoiding a significant amount of money for the NC Medicaid and NC Health Choice as well as assuring the quality of payments and data coordination with Medicare. Their main activities include the following:

- The Third Party Recovery Section saved, recovered or avoided costs in excess of $1 billion for N.C. Medicaid during SFY 2008.
- The four provider investigative units recovered $88,862,379 and cost avoided $3,691,957 in SFY 2008.
- The Quality Assurance Section 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.

For further details on all of these activities, please see the Provider Integrity portion of the "Administration of N.C. Medicaid" on page 41 and Appendix II.

Direct Support Professional Work Group

N.C. Medicaid recipients who have both developmental disabilities and mental health and/or substance abuse issues—mostly clients of the Division of Mental Health, Developmental Disabilities and Substance Abuse—benefit from services provided by direct support professionals. DMA, along with other stakeholders, recognized the need to address issues related to the quality of support provided and won a CMS technical assistance grant to create a work group. The N.C. Council on Developmental Disabilities also provided funding and staff. Working together with them, DMH/DD/SAS, the Division of Aging and Adult Services, the Commission for Mental Health, and a broad stakeholder group, DMA held many conversations about successful approaches. Our goal is to develop cohesive statewide policies and practices to recruit, retain and train direct support workers.

The work group produced a unified report that was published under the aegis of the Commission for Mental Health and was presented to the North Carolina Commission on Workforce Development in November 2007. Workforce Development accepted the report with very few changes and presented it to the General Assembly in the 2008 Session, seeking appropriations to carry out the recommendations.

Program for All-inclusive Care for the Elderly (PACE)

PACE is a unique managed care program for the frail elderly. It is a center-based program that provides comprehensive medical and social services to seniors with chronic diseases while maintaining their independence in their homes for as long as possible. DMA was mandated by the 2004 Session of the N.C. General Assembly to establish two PACE pilot sites, one located in the southeastern area of the state and the other in the western area of the state. After several years of planning, North Carolina's first PACE center, Elderhaus PACE, opened in Wilmington in February 2008 and serves New Hanover and northern Brunswick counties. Two other PACE centers are in the planning stages. The NCGA did not allocate funds beyond the pilot stage, therefore growth of PACE depends upon non-profit organizations willing to sponsor PACE facilities and assume the financial risk inherent in a fully capitated payment arrangement.

National Provider Identifier Implementation

The National Provider Identifier (NPI) is a unique 10-digit number that is replacing 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. During SFY 2008, the Provider Services Unit completed the collection of NPIs for Medicaid providers in North Carolina.

False Claims Act Compliance

In September 2007, DMA implemented a plan to comply with the regulations mandated by False Claims Act, Section 6031 of the Deficit Reduction Act (DRA). As part of this plan, the Provider Services Unit notifies providers

in writing when they are identified as having received $5 million or more in Medicaid payments during the previous federal fiscal year. Over 4,500 letters of attestation were returned to DMA by providers acknowledging their compliance with the DRA, which was a compliance rate of 95 percent.

LeadershipDHHS Program Graduate

Kris Horton, special assistant and project manager in the Director's Office, graduated with the third cohort of LeadershipDHHS, a six-month program designed to introduce upcoming leaders to the key issues and challenges that confront the Department. Ms. Horton and her group researched the generational differences in the workplace, developed a tool to assist managers in identifying and communicating with persons of the various generations, and outlined specific strategies for employee retention.

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. 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

Medicaid Eligibility Groups

Medicaid eligibility is based on policies established by the federal and state governments. 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. Mandatory eligibility is spelled out in Title XIX; however, states have some flexibility in adding optional eligibility groups with the approval of CMS. Medicaid caseworkers in each of the 100 county departments of social services are responsible for determining an individual's eligibility for Medicaid benefits at the same time they apply for social services programs.

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 the Medicaid population.

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, for beneficiaries with incomes between 121 percent and 135 percent FPL, total enrollment is capped by the amount of appropriated federal funds
- 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 FPL, 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 presumptively 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 up to 185 percent FPL

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

North Carolina and each of its contiguous states—Virginia, Tennessee, Georgia and South Carolina—have expanded mandatory coverage with optional eligibility groups, but the criteria for coverage is established by each state to meet its individual objectives. The following are several state-to-state comparisons:

- Aged, blind and disabled (ABD) category—N.C. and Ga. cover those not receiving Supplemental Security Income (SSI), recipients with incomes at or below 100 percent of the federal poverty level (FPL) and medically needed recipients. Va. covers the ABD category at 80 percent of FPL or 300 percent of SSI. Tenn., a totally managed care Medicaid program, covers ABD at 300 percent of SSI. S.C. covers ABD at or below 100 percent of FPL and covers working disabled adults below age 65 if income is at or below 250 percent of FPL.
- Pregnant women and infants—N.C., S.C. and Va. cover pregnant women and infants with incomes up to 185 percent of FPL; Ga. covers this group at or below 200 percent; and Tenn. up to 250 percent.
- Children aged 0 through 1 year old—In N.C. and Ga., this group is covered up to 200 percent of FPL; in Tenn. and S.C. it is up to 185 percent; in Va. it is up to 133 percent.
- Children aged 1 through 5 years old—In N.C. they are covered up to 200 percent of FPL; in S.C. it is up to 150 percent; and in Ga., Tenn. and Va. it is up to 133 percent.
- Children aged 6 through 18—In N.C., Ga. and Tenn., this group is covered up to 100 percent of FPL; in Va. it is up to 133 percent; and in S.C. it is up to 150 percent.
- Children aged 19 and 20—Covered in N.C.
- Foster care and adopted children—Covered in N.C., Ga. and S.C.
- Breast and Cervical Cancer—All N.C. and Ga. women screened by and enrolled in a breast and cervical cancer control program are covered. Tenn.. women in this category are covered up to and including 250 percent of FPL, as are S.C. women up to and including 200 percent of FPL with no other insurance.
- Medically needy—N.C., Va., Ga. and Tenn. cover individuals who are medically needy.
- Family planning—Optional family planning coverage is provided in N.C. to women aged 19 through 55 and men aged 19 through 60 up to 185 percent of FPL. Va. covers uninsured women and men up to 133 percent of FPL. S.C. covers women aged 10 through 55 at or below 185 FPL.

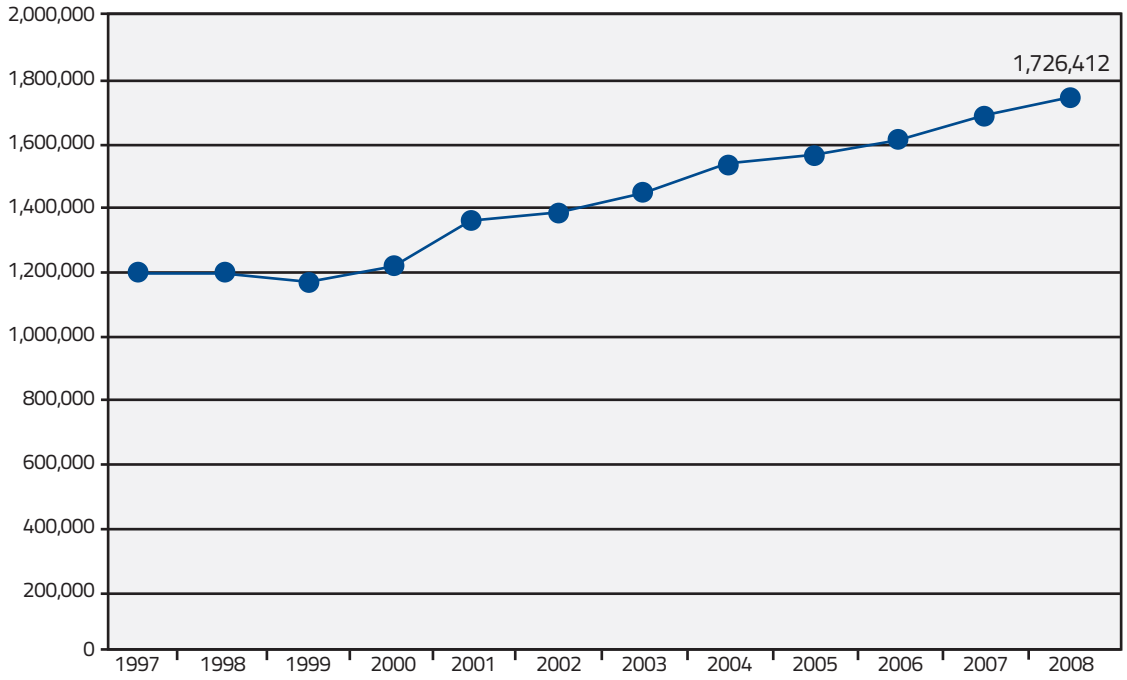
Populations and Eligibility Groups

When the N.C. Medicaid program was established, approximately 456,000 individuals were determined to be eligible. For SFY 2008, a total of 1,726,412 individuals were determined to be eligible for Medicaid (see **Exhibit 3**). North Carolina's population during SFY 2007 (the most recent year for which census information is available) was 9,069,398, thus approximately 19 percent of the population were eligible for Medicaid. Compared to the previous year, the state population rose by 2.3 percent; however, the number of people eligible for Medicaid increased by 2.6 percent. This may

be attributable to the early stages of the economic downturn of 2008. Compared to the nation and our neighboring states, N.C. is in the middle of the range of percentages of Medicaid eligibility (United States at 19 percent, Virginia at 10 percent, Georgia at 17 percent, South Carolina at 25 percent and Tennessee at 29 percent).

Exhibit 3

Medicaid Eligible North Carolina Residents SFYs 1997 - 2008



Source: Annual Unduplicated Count: Unduplicated Medicaid Eligibles Report, EJA752

As indicated in **Exhibit 4**, the largest category of eligible people during SFY 2008 was pregnant women and children, with an annual total of 720,685 individuals, or about 42 percent of total eligibility. The Aid to Families with Dependent Children (AFDC) category was second-largest, with 451,186 individuals, or about 26 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 2008

Eligibility Group	Number of Eligibles	% of Total Eligibles
Pregnant Women & Children	720,685	41.74%
AFDC-related	451,186	26.13%
Disabled	267,843	15.51%
Aged	145,898	8.45%
Qualified Medicare Beneficiaries	59,428	3.44%
M-SCHIP (1)	57,396	3.32%
Refugees & Aliens	21,626	1.25%
Blind	1,923	0.11%
Breast & Cervical Cancer	427	0.02%
Total	**1,726,412**	**100.0%**

(1) M-SCHIP includes the children age 0 through 5, formerly eligible for N.C. Health Choice, who are now served by N.C. Medicaid.

Source: Unduplicated Medicaid Eligibles Report, EJA752, SFY 2008

Comparing the eligibility distribution in the N.C. Medicaid program with our neighboring states yields the following observations:

- N.C. has the highest percentage of families, children and pregnant women at 78 percent, followed by S.C. (72), Ga. (67), Va. (65) and Tenn. (64).
- N.C. is on the low end of the scale for the percentage of disabled enrollees at 16 percent, compared with S.C. (15), Ga. (16), Va. (18) and Tenn. (29).
- N.C. is in the middle of the range for aged and Qualified Medicaid Beneficiaries with 11 percent, compared with Va. (15), Ga. (12), S.C. (8) and Tenn. (5).

As **Exhibit 5** shows, the Pregnant Women and Children population experienced the largest numerical increase of enrollees—32,778, or 4.76 percent. Only the Aged and Blind categories experienced a decrease.

Exhibit 5

Change in N.C. Medicaid Eligibility by Category SFY 2007 vs. 2008

Eligibility Group	SFY 2007 Eligibles	SFY 2008 Eligibles	Amount of Change	% Change
Pregnant Women & Children	687,907	720,685	32,778	4.76%
AFDC-related	451,053	451,186	133	0.03%
Disabled	261,594	267,843	6,249	2.39%
Aged	147,813	145,898	-1,915	-1.30%
Qualified Medicare Beneficiaries	56,612	59,428	2,816	4.97%
M-SCHIP (1)	54,009	57,396	3,387	6.27%
Refugees & Aliens	20,731	21,626	895	4.32%
Blind	1,988	1,923	-65	-3.27%
Breast & Cervical Cancer	321	427	106	33.02%
Total	**1,682,028**	**1,726,412**	**44,384**	**2.64%**

(1) M-SCHIP includes the children age 0 through 5, formerly eligible for N.C. Health Choice, who were transitioned to N.C. Medicaid.

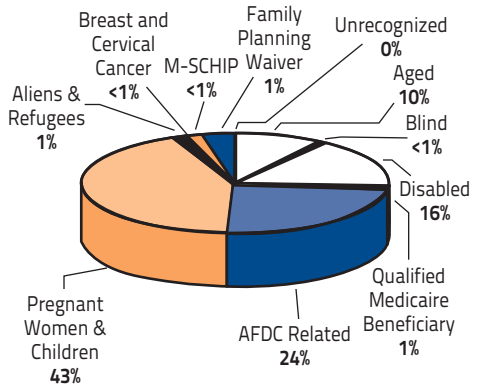
Source: Unduplicated Medicaid Eligibles Report, EJA752, SFY 2008

Exhibit 6, on the next page, shows the distribution and some of the characteristics of recipients of Medicaid services. The percentage of recipients in each eligibility category approximates the distribution of eligible individuals shown in **Exhibit 4**, with some slight variations because not all those who are eligible actually become recipients of, or receive, one or more services in a given year. The percentage of recipients is based on an unduplicated count of recipients, given their eligibility category at the end of the fiscal year. The variance is also attributable to the fact that the recipient count is based on claims ***paid*** during SFY 2008, even though the services might have been ***provided*** the previous year.

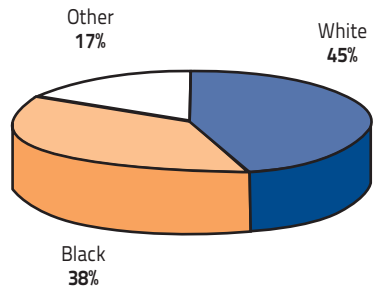
Exhibit 6

Recipients of N.C. Medicaid Services

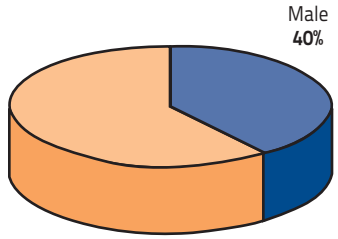
By Eligibility Category



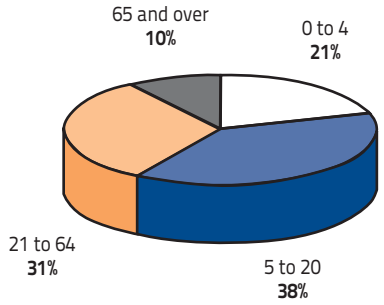
By Race



By Gender



By Age



Forty-five percent of recipients were white, compared to 68 percent in the general N.C. population; 38 percent were black, compared to 22 percent; and the remaining 17 percent were of other races, compared with 10 percent. A total of 60 percent of recipients were female and 40 percent male, compared to 51 and 49 percent respectively in the general N.C. population. When Medicaid recipients are grouped by age, children ages 5 to 20 constitute the largest group (38 percent, versus 24 percent general population), while adults aged 21 to 64 are the second-largest group (31 percent, versus 57 percent), followed by young children from birth to age 4 (21 percent, versus 7 percent) and the elderly ages 65 and older (10 percent, versus 12 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. Treatment services address virtually all acute and chronic illnesses.

Medicaid has certain standard lim¬itations on services. These include annual limits on ambulatory visits to prac¬titioners, 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.

Exhibit 7

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

MANDATORY

- Ambulance and Other Medical Transportation
- Dental Services (children; includes dentures)
- Durable Medical Equipment
- Family Planning
- Clinic Services (Federally Qualified Health Centers and Rural Health Clinics)
- 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

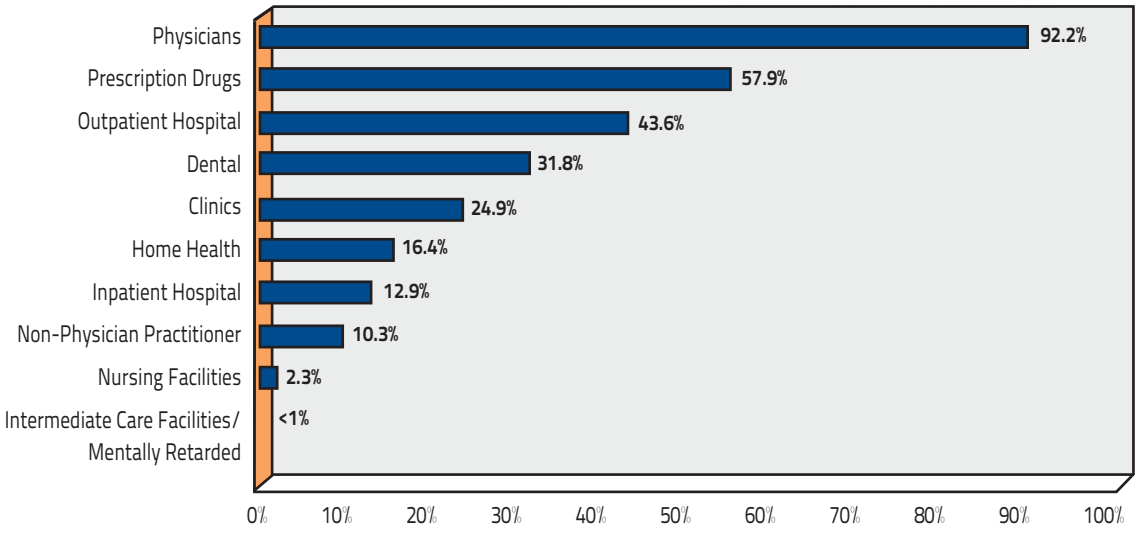
- Case Management
- Chiropractor
- Clinical
- Community Alternatives Programs (CAP)
- Dental and Dentures
- Diagnostic
- Eye Care
- Health Maintenance Organization (HMO) Membership
- Home Infusion Therapy
- Hospice
- Intermediate Care Facilities for the Mentally Retarded
- Mental Health
- Nurse Anesthetist
- 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.

As **Exhibit 8** shows, 92 percent of North Carolina's Medicaid recipients received services at least once during SFY 2008 from a physician; 58 percent received at least one prescribed drug; and 44 percent received services in a hospital outpatient setting. The utilization rate falls off dramatically for other service providers and locations. This list is almost identical to that of SFY 2007 and the percentages are very similar.

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 and 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. A recipient may be eligible to receive services from a number of programs.

Managed Care

Community Care of North Carolina /Carolina ACCESS (CCNC/CA)

In 1991, North Carolina initiated a primary care, case management (PCCM) model of managed care known as Carolina ACCESS (CA) which currently exists in all 100 counties. In 1998, Community Care of North Carolina (CCNC) emerged as a further development upon the primary care foundation established by CA.

CCNC builds regional, community-driven networks that bring together the key care providers needed to achieve the quality, cost, access and utilization objectives that are the cornerstone of managed care for Medicaid recipients in North Carolina. The networks are governed by CA primary care providers (PCPs), hospitals, health departments and county departments of social services (DSS). Network providers collaborate to meet patient needs and strengthen the community health care delivery infrastructure. Providers manage the care of their enrollees, providing preventive services and developing processes by which at-risk patients can be identified and their care managed before high-cost interventions are necessary. For example, a study published in the *Archives of Internal Medicine* found that N.C. Medicaid recipients with five years or more with the same PCP—relationships fostered through CCNC/CA—are more than twice as likely as newer patients to be screened for cervical, breast and colorectal cancers, which are all highly treatable when caught early.[1]

Medicaid recipients enter CA by being enrolled and educated about the program at their county DSS, in partnership with the DMA Managed Care Section. Educational topics include the benefits of a "medical home" and the steps to access care in a managed care plan. In North Carolina, a Medicaid recipient's category of aid determines if he or she is eligible for enrollment in CCNC/CA and, if so, whether enrollment is mandatory or optional. CA is available in all 100 counties; of the state's 1.2 million Medicaid recipients, 82 percent (984,489 during SFY 2008) are enrolled in the Managed Care programs. That is, they obtain their primary care health services from Managed Care–enrolled providers, PCPs whom they have selected to serve as their medical homes.

PCPs contract with DMA to serve as medical homes and gatekeepers for health care. PCPs

[1] DuBard, C. A., Schmid, D., Yow, A., Rogers, A. B., & Lawrence, W. W. (2008). Recommendation for and receipt of cancer screenings among Medicaid recipients 50 years and older. *Archives of Internal Medicine*, 168, 2014-2021.

are responsible for providing primary care services and authorizing referrals for specialized services they deem medically necessary. Over 3,000 PCP medical practices participate in N.C. Medicaid's Managed Care programs, opening access to medical care, and especially preventive primary care, in the private sector.

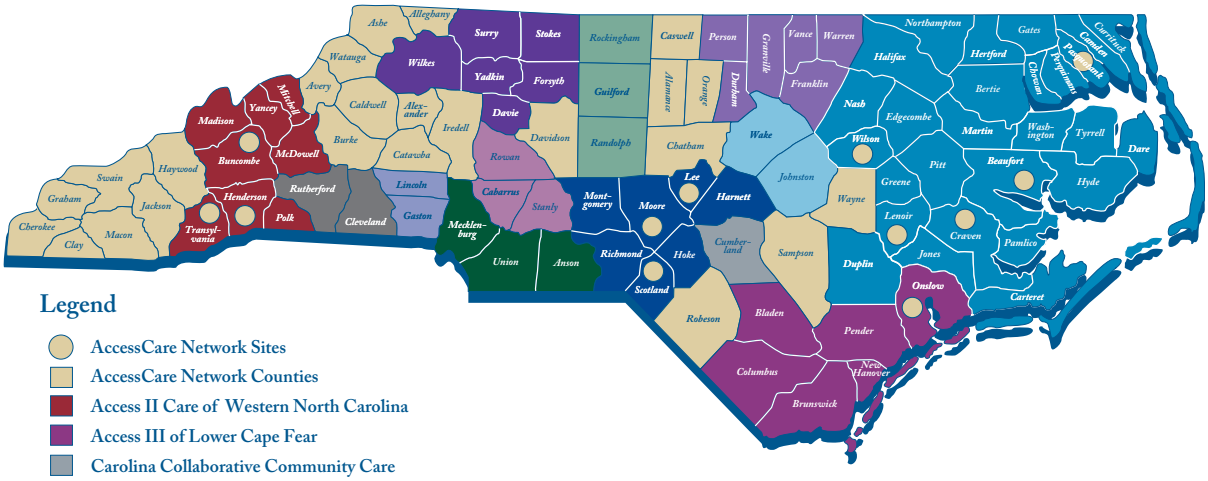
For Medicaid recipients, the Managed Care Section ensures access to high-quality, cost-effective health care. We operate a customer service line that provides support, education and referrals for Medicaid recipients. Together with EDS, the Managed Care Section develops policies and processes to ensure that claims have the proper primary care authorization and that exceptions to the normal reimbursement rules are tightly monitored.

For providers, Managed Care Consultants are available statewide to ensure the correct implementation of all Medicaid and Managed Care policies and procedures. Consultants support practices that serve the Medicaid population by keeping providers informed of policy changes and providing documentation, training and other resources.

Three traits are characteristic of CCNC/CA operations:

- Partnership—The program is a partnership of essential local providers, including community physicians, hospitals, health departments, DSS and other community-based agencies working cooperatively to plan and develop programs for meeting the health care 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/CA networks effectively deliver and manage enrollee care. CCNC receives monetary, technical and clinical support through a variety of public–private partnerships that include DMA, the Office of Rural Health and Community Care, the N.C. Foundation for Advanced Health Programs and other public funding sources.
- Population Health Management Approach—The 3,000 PCPs and 16 participating networks address the overall health status of the 984,489 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/CA networks collaborate with each other and with the state to define, track and report performance measures that gauge the effectiveness of participating networks in achieving quality, utilization and cost objectives.

Community Care of North Carolina Networks



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 79,666 of the 130,886 live births in North Carolina, or 61 percent, during SFY 2007 (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 8.5 infant deaths per 1,000 live births in 2007, one of the lowest in North Carolina state history. This compares with the U.S. infant mortality rate of 6.4 infant deaths per 1,000 live births (2007 data) and the following rates of our neighboring states: Virginia, 7.1 (2006 data); Tennessee, 8.9 (2002 – 06 data); Georgia, 8.3 (2007 data); and South Carolina, 8.4 (2006 data).

Also under the Baby Love umbrella, the Child Service Coordination Program (CSCP) provides targeted case management services to eligible children ages 0–5 years who are at risk for or diagnosed with developmental delay or disability, chronic illness or social/emotional disorder. Through the CSCP, families can identify concerns, improve their access to services, gain and develop self-reliance skills, and strive to reach their maximum potential.

Be Smart

In October 2005 DMA implemented the "Be Smart" Family Planning Waiver, a five-year Medicaid research and demonstration waiver project for family planning services. Be Smart is a Medicaid program that was designed to reduce unintended pregnancies and improve the well-being of children and families in North Carolina by extending eligibility for family planning services to eligible women between the ages 19 through 55 and men ages 19 through 60 whose income is at or below 185 percent of the federal poverty level.

Fact:

A total of 876 births were averted during the year Oct. 1, 2005 Sept. 30, 2006, through the effective use of contraceptives and maternal and infant health, resulting in a Medicaid cost savings of $9,505,557.

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 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.

Fact: During SFY 2008, a total of $63 million was spent on 435,239 Health Check screening examinations, compared to $59 million on 411,085 screening examinations during the previous year.

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, psychological and counseling services, and nursing services. 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.

Fact: During SFY 2008, $16 million was spent on services through LEAs for 18,801 children, compared with $15 million for 17,285 children during the previous year.

Practitioner and Clinical Services

The services of practitioners and clinics covered by the N.C. Medicaid program vary according to the type of provider. The criteria governing the conditions under which covered medical services should be provided are included in clinical policies, MMIS claims payment system audits and edits and medical review criteria. An annual update of *Current Procedural Terminology* (CPT) and

Healthcare Common Procedure Coding System (HCPCS) codes incorporates the Medicaid-approved new and revised codes used by providers to bill services. The staff in the Practitioner and Clinical Services Unit provide guidance in each of the above matters for the following:

- ambulance services
- ambulatory surgery centers
- anesthesia services
- birthing centers
- child services coordination
- chiropractors
- certified registered nurse anesthetists
- dialysis services
- family planning waiver
- federally qualified health centers
- health departments
- laboratory services
- maternity care coordination services
- nurse midwives
- nurse practitioners
- obstetric services
- outpatient hospital services
- physicians
- podiatrists
- radiology services
- rural health centers

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, Community Alternatives Program, or CAP, private duty nursing, home infusion therapy, hospice, adult care home and personal care services). Total expenditures for long-term care during SFY 2008 were approximately $3.1 billion, an increase of 5.8 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 completed, screens and evaluates applicants and residents of Medicaid-certified nursing facilities for mental illness, mental retardation, developmental disabilities and related conditions.

Fact: In SFY 2008, a total of 41,782 Medicaid recipients in North Carolina received care in nursing facilities at a cost of approximately $1.07 billion. During SFY 2007, the total was 42,721 recipients at a cost of $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 habilitative services as well as basic intermediate care services. ICF-MRs are paid prospective per diem rates.

Fact:

During SFY 2008, a total of 4,168 recipients in North Carolina were treated in ICF-MRs at a cost of $471 million. During SFY 2007, the total was 4,157 recipients at a cost of $442 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, described below.

Adult Care Home Personal Care Services

Since 1995, N.C. Medicaid has covered basic personal care services (or PCS) for recipients who are residents in adult care homes and 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 recipients who are residents of adult care homes and 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:

In SFY 2008, a total of 28,877 N.C. Medicaid recipients received basic PCS at an annual cost of $168 million. During SFY 2007, a total of 28,679 recipients received basic PCS at $156 million.

Fact:

Of these recipients, 5,834 received enhanced PCS in adult care home settings (including SCU-As) at a cost to N.C. Medicaid of $22 million. During SFY 2007, the total was 5,374 recipients at $13 million.

Fact:

A total of 28,146 people received non-medical transportation services related to the adult care home program at an annual expense of $4.5 million. During SFY 2007, a total of 28,056 recipients received this service at $4.5 million.

Program for All-inclusive Care for the Elderly (PACE)

People who are 55 or older and qualify for nursing facility level of care can often live safely in their communities despite their medical needs. PACE is a center-based program that provides the entire continuum of care to seniors with chronic care needs while maintaining their independence in their homes for as long as possible. It's a one-stop-shopping model that includes adult day health

care; physical, occupational, speech, social and recreational therapies; nutritional counseling and meals; social work and social services; skilled nursing and personal care provided in the center and at home; medical care provided by a PACE physician; all necessary prescription drugs; medical specialists; respite care; hospitalizations; nursing home care; and hospice. The advantage to providers is a capitated funding arrangement that rewards providers who are flexible and creative in providing the best care possible. PACE gives providers the ability to coordinate care for their patients across settings and medical disciplines, and it allows payors like N.C. Medicaid to meet increasing consumer demands for individualized care and supportive services arrangements.

Fact:

Since Elderhaus Inc. began operations on Feb. 1, 2008, as the sole PACE provider in North Carolina, and since most of their activity for the first few months was marketing, the total enrollment for SFY 2008 was 4 and total expenditures were $38,349.

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 necessary in the treatment of the recipient's illness, injury or medical condition in the home setting. The service is provided by a Medicare-certified home health agency and in accordance with a physician-approved plan of care. The services are 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). Home health services are provided on a part-time, intermittent basis with no provision for continual care.

Fact:

In SFY 2008, a total of 296,490 N.C. Medicaid recipients received home health services at an annual cost of $253 million. During SFY 2007, a total of 258,262 recipients received these services at $222 million.

Hospice

The Medicaid hospice benefit is a coordinated program of services that provides medical, supportive and palliative care to terminally ill recipients and their families/caregivers. The services are provided by a hospice agency established in accordance with federal guidelines outlined in the Code of Federal Regulations (42CFR 418). 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 recipient must elect hospice by signing an election statement that waives eligibility to Medicaid coverage of certain other services. Hospice services include nursing care, medical social services, counseling, physician services, chaplain services, in-home aide and 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 the recipient's private residence, in an adult care home or in a hospital or nursing facility under arrangement with the hospice agency.

Fact:

In SFY 2008, a total of 6,022 N.C. Medicaid recipients received hospice care at an annual cost of $54 million. During SFY 2007, 5,836 recipients received hospice care for a total of $56 million.

Home Infusion Therapy

The Home Infusion Therapy (HIT) program covers self-administered infusion therapy and enteral supplies provided to a Medicaid recipient residing in a private residence or an adult care home. Covered therapies include total parenteral nutrition (TPN), chemotherapy, pain management, antibiotic and tocolytic infusion therapy. The route of administration for parenteral therapies may be intravenous, subcutaneous (for pain management only), epidural or intrathecal. Enteral supplies include nutritional supplements and related supplies.

Fact:

In SFY 2008, a total of 2,159 N.C. Medicaid recipients received HIT at an annual cost of $7.6 million. During SFY 2007, HIT was provided to 21,908 recipients for $6.9 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 2008, a total of 546 N.C. Medicaid recipients received PDN services at an annual cost of $59 million, compared with a total of 481 recipients during SFY 2007 at a cost of $52 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 hands-on assistance with bathing, dressing, mobility, eating, toileting and incontinence care. Aides may also monitor the patient's vital signs and perform housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining the patient's basic personal health. All PCS activities must be ordered by a physician and documented on an authorized plan of care. Recipients are eligible for up to 60 hours of PCS per month depending on their needs. Recipients who obtain 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 2008, a total of 51,018 N.C. Medicaid recipients received PCS or PCS Plus at an annual cost of $319 million. During SFY 2007, the total was 51,564 recipients at $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**. This service is offered under Title II of the Ryan White CARE Act which provides federal funding to states and territories to ensure the provision of necessary HIV care services to low income persons infected with HIV.

Fact:

In SFY 2008, a total of 2,642 N.C. Medicaid recipients received HIV Case Management services at an annual expense of $5.4 million. A total of 2,721 recipients received these services during SFY 2007 at $6.5 million.

Community Alternatives Programs (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:

The N.C. General Assembly provided an additional $4.5 million in funding during SFY 2008, allowing an additional 300 CAP/MR-DD slots to be offered to state residents.

Fact:

CAP/MR-DD served a total of 10,043 N.C. Medicaid recipients in SFY 2008 at an annual cost of $428 million. The figures for SFY 2007, were 9,497 recipients at $376 million.

Fact:

The average monthly cost per recipient of CAP/MR-DD services was $3,958, or 30 percent of the average monthly cost of care per recipient at a state-owned ICF-MR facility ($13,281) and 50 percent of the average monthly expense per recipient at a non state-owned facility ($7,901). 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 2008, CAP/C served a total of 905 children at an annual cost of $36 million. During SFY 2007, a total of 809 children received this service for $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 total of 14,455 citizens in SFY 2008 at a cost of $268 million. During SFY 2007, a total of 14,662 recipients received CAP/DA services for $257 million.

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.

Fact:

In calendar year 2007, the most recent year for which data are available, there were a total of 572 solid organ and stem cell transplant requests compared with 439 transplant requests during SFY 2006.

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 2008, a total of 282,400 N.C. Medicaid recipients received DME services at annual expense of $110 million. A total of 244,783 recipients received DME during SFY 2007 for $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 2008, a total of 28,298 N.C. Medicaid recipients received independent practitioner services at annual expense of $67 million. During SFY 2007, a total of 24,471 recipients received these services at an annual expense of $56 million.

Optical Services

The Optical Services Program, which is responsible for the overall administration of

optical services covered by N.C. Medicaid, covers routine eye exams with refraction and materials and services related to the provision of visual aids (corrective eyeglasses, medically necessary contact lenses, etc.). Prior approval is required for all visual aids. There are limitations regarding the frequency of routine eye examinations, refractions and the number of dispensed visual aids during specific eligibility periods. Routine 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 2008, a total of 252,762 N.C. Medicaid recipients received optical services at annual expense of $22 million. During SFY 2007, a total of 239,199 recipients received optical services for $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 2008, a total of 1,510 N.C. Medicaid recipients received hearing aid services at an annual expense of approximately $814,000. During SFY 2007, a total of 1,369 recipients received hearing aid services at $2.3 million.

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 44.

DMA also provides services in ICF-MRs, which are long-term-care facilities for individuals with mental retardation or a related condition that occurred before the age of 22. Please refer to the ICF-MR subsection of this report on page 25 for additional information.

Fact:

During SFY 2008, a total of 218,158 N.C. Medicaid recipients received behavioral health services at an annual expense of approximately $2.3 billion, compared with 200,610 recipients at $2.4 billion during SFY 2007.

Fact:

Of the above, 113,313 children received behavioral health services at an annual expense of $1.1 billion, compared with 100,487 children at $1.2 billion during SFY 2007.

Fact:

Of the above, 104,845 adults received behavioral health services at an annual expense of $1.2 billion. During 2007, a total of 100,123 adults received these services at a cost of $1.2 billion.

Piedmont Waiver Program

The Piedmont Cardinal Health Plan (PCHP) is a managed behavioral health care pilot that 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 ICF-MR; and restrict the program to a specific geographic area of the state. PCHP is administered by Piedmont Behavioral Healthcare, an LME for publicly funded MH/DD/SA services. DMA pays PCHP a flat, per-member-per-month payment; PCHP, in turn, arranges and pays for MH/DD/SA services for recipients in the five-county catchment area.

The PCHP achieved 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 2008 to cover all MH/DD/SA services for 92,038 Medicaid recipients in the Piedmont catchment area, compared to 88,905 recipients and $103 million in expenditures during SFY 2007.

Fact:

During each of these fiscal years, approximately 30 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 2008, a total of 574,718 N.C. Medicaid recipients received dental services at an annual expense of $270 million, compared to 535,545 recipients during SFY 2007 at $240 million.

Pharmacy Services

Drug Use Review Program

As required by federal law, N.C. Medicaid has established a Drug Use Review (DUR) Program to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary and not likely to result in adverse medical effects. The DUR Board consists of five licensed and actively practicing

physicians; five licensed and actively practicing pharmacists; the DMA DUR coordinator; and two health care professionals with expertise in drug therapy, medical quality assurance or drug utilization review. The Board makes recommendations to DMA regarding DUR policies and procedures.

The DUR Program consists of a prospective and a retrospective component. Prospective DUR requires that, prior to dispensing, the pharmacist screens for, responds to DUR alerts about, and offers to counsel Medicaid patients for potential drug therapy problems such as over- or underutilization, therapeutic duplication, drug–drug interactions, incorrect drug dosage and drug–disease contraindications.

Retrospective DUR is an ongoing review of Medicaid outpatient pharmacy claims for the same potential drug therapy problems mentioned above as well as for identifying inappropriate patterns of behavior involving physicians, pharmacists and individual Medicaid recipients associated with specific drugs, groups of drugs or disease states. Interventions are made when necessary.

Outpatient Pharmacy Program

Prescription drugs, insulin and selected over-the-counter (OTC) products for which manufacturers have signed rebate agreements with CMS are covered under the pharmacy program. Recipients may have a 34-day supply of their prescription medication and a three-month supply of birth control pills and hormone replacement therapies. Since October 2003, Medicaid recipients have been able to obtain 90-day supplies of generic, non-controlled maintenance medications at the discretion of their health care providers if 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 unduplicated 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 unduplicated 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 unduplicated prescriptions were dispensed in two out of the last three months or if fewer than 12 unduplicated prescriptions were dispensed in the sixth month.

The state utilizes a Prescription Advantage List (PAL), which was developed by the North Carolina Physician Advisory Group (NCPAG) and Community Care of North Carolina (CCNC) in cooperation with DMA as a voluntary effort to control pharmacy costs in Medicaid. The PAL includes some of the medications that are most costly to Medicaid. The net cost per unit of the medications, including rebates, is evaluated. The medications are then ranked in order from least to most expensive and placed in a tier. The tiers are calculated on a quartile distribution system. The lowest-cost medications are tier 1 medications and the most expensive are tier 4 medications. No judgment as to efficacy is implied by this list, which is intended as an educational tool based on cost alone. The PAL Pocket Card was also developed to assist physicians in changing prescribing behaviors for selected, commonly prescribed, high-cost, high-utilization medications when good generic alternatives are available. The drugs chosen for the PAL Pocket Card were identified using more stringent criteria than the tier methodology. The following criteria had to be met:

- The drug was identified as a drug commonly prescribed by Medicaid providers.
- The drug was identified as being in a class with a significant price differential between drugs based on cost analysis from the most recent quarter available and a review of 6–9 months of prior data to see trends of cost per drug and drug dose.
- Evidence exists to compare efficacy and safety between the drugs in the class (as well as trials with head-to-head comparisons of drugs within the drug class when available).

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 Food and 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
- the enhanced specialty discount rate plus a dispensing fee (for single-source specialty medications)
- 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 N.C. Medicaid

Since its inception, the N.C. Medicaid program has 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 procedures, products and services is reflected in Medicaid payments to providers. It is applicable to the federal fiscal year (FFY), which is Oct. 1 through Sept. 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, three different federal shares may apply during the same 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 2008.

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 Oct. 1, 2007, the counties paid 11.25 percent of the non-federal share. Beginning July 1, 2008, the counties paid 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 for certain services. Current co-payment requirements can be found in **Table 14** of this report.

A Look at Expenditures

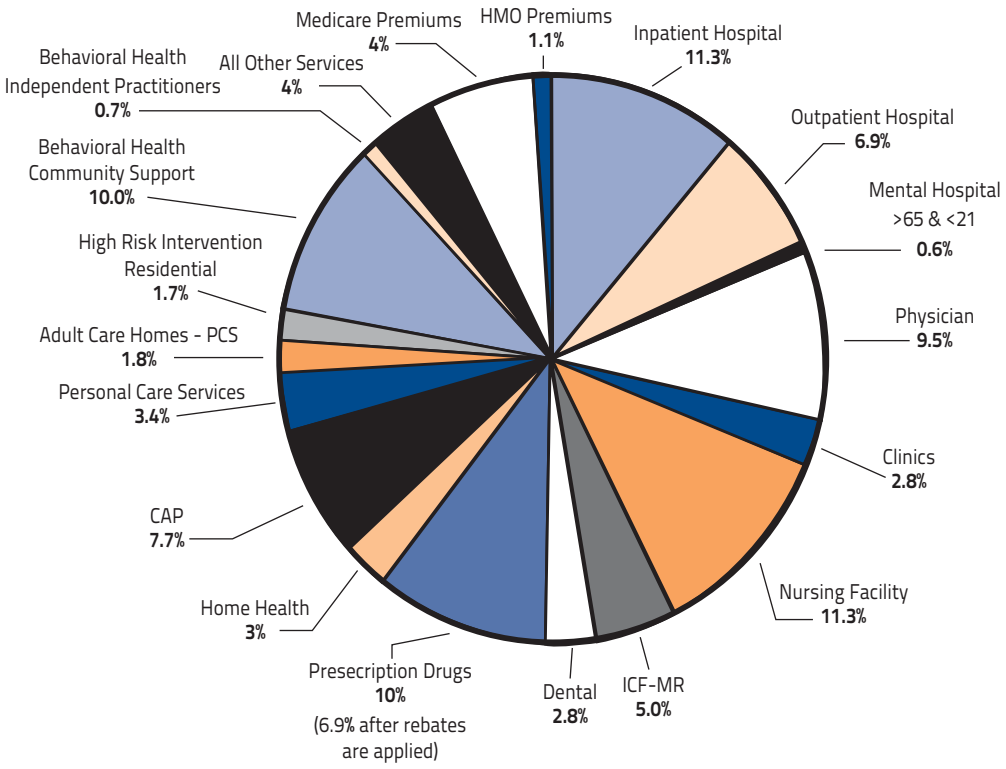
As indicated in **Table 8** (see the **Tables** section of this report), a total of $11.6 billion was spent on 1,805,254 Medicaid recipients during the year—$6,424 per recipient. Of the total expenditures, $9.5 billion was spent on services and premiums. Total expenditures per recipient decreased by $256, or 3.8 percent, during SFY 2008 compared to the previous year. DMA spent $153.2 million on administration of the program representing 1.3 percent of the total budget.

During SFY 2008, the Medicaid service categories with the highest levels of expenditures were inpatient hospital services, nursing facility services, prescription drugs, physician services and behavioral health community support services (see **Table 8** and **Exhibit 9**). Provider reimbursements for prescription drugs were $974 million, or 10.3 percent of total service and premium expenditures. However, federal law mandates

that prescription drug manufacturers provide rebates to state Medicaid programs on the drugs that are reimbursed by Medicaid. When manufacturers' rebates of $312 million are applied, the net amount spent on prescription drugs was $662 million, or 6.9 percent of total service and premium expenditures. The "All Other Services" category in **Exhibit 9** (4 percent of service and premium expenditures) includes such services as ambulance, transportation to medically-necessary appointments, family planning, durable medical equipment, Health Check (EPSDT), hospice, laboratory and x-ray.

Exhibit 9

Medicaid Services & Premium Expenditures for SFY 2008



Exhibits 10 and **11** show that the Elderly and Disabled & Blind categories constituted 13.1 percent and 15.5 percent of total recipients, respectively, or approximately 29 percent combined, while service and premium expenditures for these two groups amounted to approximately $6.2 billion, or 65 percent of total service and premium expenditures. Recipients from the Families & Children group represented approximately 70 percent of all recipients; however, they accounted for approximately $3.3 billion, or 34 percent, of total service and premium expenditures.

Exhibit 10

N.C. Medicaid Recipients & Service and Premium Expenditures by Percentages SFY 2008

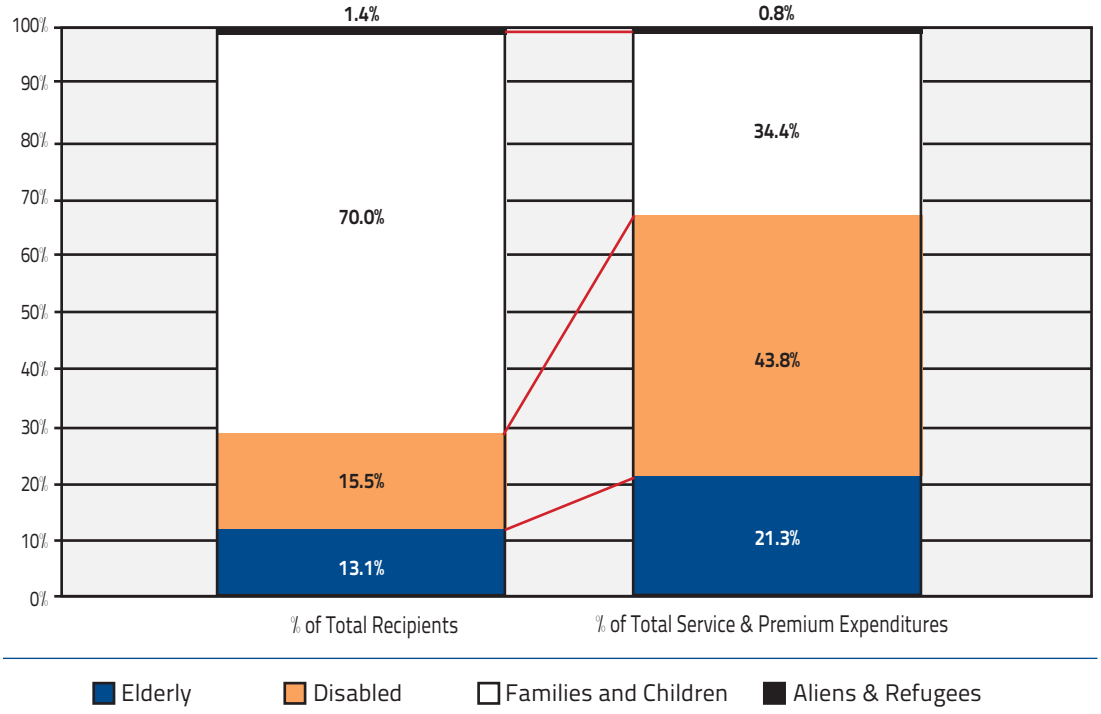


Exhibit 11

Total Service and Premium Expenditures by N.C.Medicaid Recipient Group SFY 2007 vs. 2008 ($ billions)

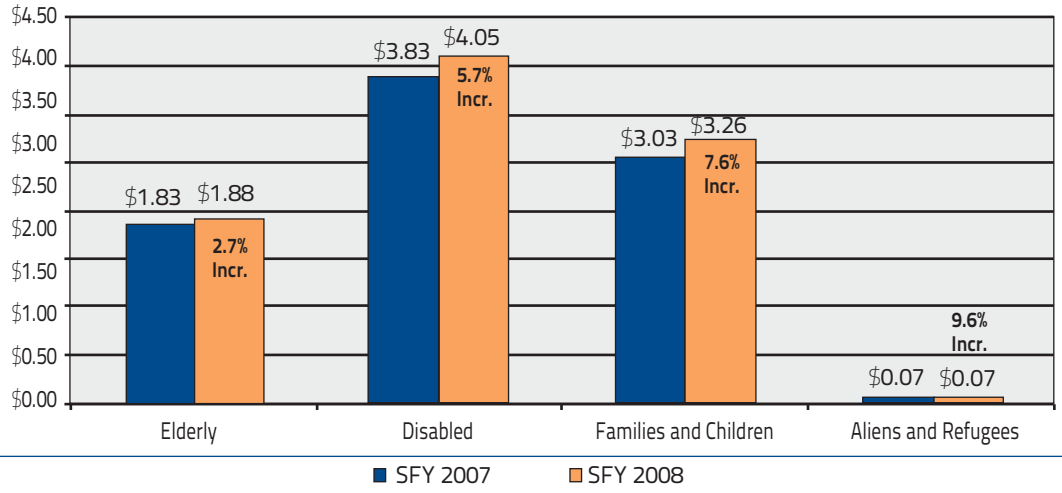
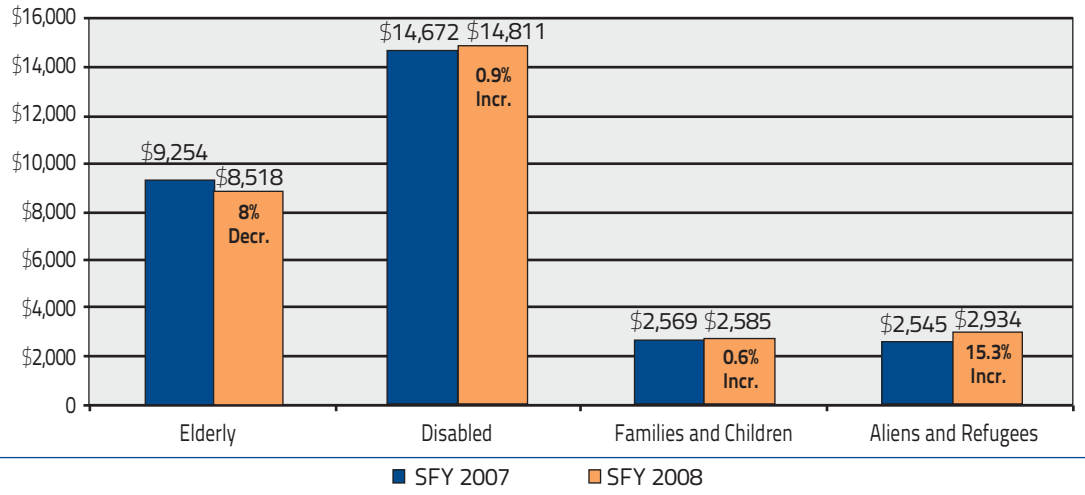


Exhibit 12 shows that expenditures per recipient decreased for the elderly and increased for all other eligibility groups during SFY 2008.

Exhibit 12

Total Service and Premium Expenditures per N.C. Medicaid Recipient SFY 2007 vs. 2008



Clinical Policies and the NCPAG

The North Carolina Physician Advisory Group (NCPAG) is a charitable, nonprofit organization that was created for the purpose of advising DHHS on ways to improve the health of the state's vulnerable populations by expanding access to quality, cost-effective health care services. The N.C. General Statutes require DMA to consult with and seek the advice of the NCPAG during the development of clinical coverage policy or amendment to existing clinical 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. DMA's medical coverage policies are developed by the NCPAG 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 2008, a total of 39 new or significantly revised policies were introduced to the NCPAG by DMA and DHHS. The NCPAG completed reviews and provided clinical recommendations for 38 Medicaid policies. Of those, over 76 percent were reviewed and approved by the NCPAG within three months of initial presentation by DMA to the NCPAG. 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. This relatively quick, but thorough, process enables DMA to keep its clinical coverage policies in alignment with best practices as they emerge from the various health care professions.

Providers

During SFY 2008, the total number of providers enrolled in the NC Medicaid program, and actively providing care to our recipients, was 71,539. That number represented a decrease of one percent compared to the previous year's enrollment of 72,259 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 available 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 them in the Medicaid program. If information is discovered that conflicts with statements on the application, enrollment is delayed so that appropriate follow-up can occur.

Upon enrollment, providers receive written notification of their Medicaid 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.

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.

Medicaid Eligibility Error Rate Reduction and Quality Assurance

Program Integrity's Quality Assurance (QA) Section is responsible for monitoring the accuracy rate of eligibility determinations made by North Carolina's 100 county departments of social services. The QA staff conducts both federally mandated quality control reviews and state-designed targeted reviews. This review process looks at active, terminated and denied cases. Error trends, error-prone cases and other important error reduction information are communicated quickly to 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 appro¬priately. 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 re-views, monitors and/or adjusts approximately 500,000 rates. These rates apply to roughly 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 operated under a reduced budget for SFY 2008. Effective with date of service Jan. 1, 2008, the division budget for rate increases was reduced by $35,441,213. All providers' rates were reviewed according to State Plan requirements and rate changes 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 720 audits and settlements, compared to 770 during SFY 2007. The goal for SFY 2008 was 600 audits.

Utilization Management and Prior Approval

Utilization management (UM) is used to verify the necessity of health care services and to authorize only appropriate and cost-effective services, for both initial and continuing care. UM is a best practice among health insurers. These activities are conducted jointly by DMA and the fiscal agent or other DMA contractors.

Prior approval (PA) 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 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.

Fact:

During SFY 2008, there were a total of 35,080 PA referrals for nursing home with 32,983 approvals and 378 denials, compared with 32,590 referrals during SFY 2007 with 25,250 approvals and 347 denials. There were a large number of unfinished cases requiring further information that carried into, and were completed during, SFY 2008.

Prescription Drug Prior Approval

DMA contracts with ACS State Healthcare 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
- growth hormones
- Provigil
- sedative hypnotics
- proton pump inhibitors
- brand-name schedule II (CII) narcotics
- Qualaquin
- second-generation antihistamines
- Celebrex (for persons 59 years of age or younger)
- Botox and Myobloc

Fact:

During SFY 2008, there were 7,081 outpatient pharmacy prior authorization denials from 49,186 total reviews. During the second half of SFY 2007 (data are only available for the period Jan. 1 June 30, 2007), there were 3,194 PA denials from 14,852 reviews.

Behavioral Health Prior Approval

ValueOptions conducts utilization reviews for outpatient and inpatient mental health services, certain developmental disabilities services, and substance abuse services for North Carolina. They authorize mental health and substance abuse services to recipients throughout the state, with the exception of recipients who live in the Piedmont catchment area, who are covered by the Piedmont Mental Health Managed Care Waiver (see next paragraph). Authorization of services is based on specific medical necessity criteria and service limitations for the service as specified in Medicaid clinical policies.

Fact:

During SFY 2008, there were 36,337 denials from 423,234 utilization management reviews, compared with 3,725 denials from 341,355 reviews during SFY 2007.

The managed care entity (MCE) that implemented the Piedmont Mental Health Managed Care Waiver in SFY 2008 was

Piedmont Behavioral Healthcare, a multi-county prepaid inpatient health plan (PIHP). Like other MCEs, Piedmont is required to have a written utilization management program that is consistent with federal regulations and includes mechanisms to detect under- or overutilization of services. The program must describe the procedures to evaluate medical necessity, including the evaluation criteria used, information sources consulted and the process used to review and approve the provision of medical services. MCEs 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, MCEs 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 and inpatient utilization. The fiscal agent will work with Piedmont Behavioral Healthcare to develop an encounter reporting process that provides data accurately reflecting the delivery of services to enrollees.

Fact:

There were 186 denials from a total of 54,038 utilization management reviews for PIHP during SFY 2008, compared with 147 denials from 52,861 reviews during SFY 2007.

Outpatient Specialized Therapies Prior Approval

Therapy services requiring prior approval include all outpatient visits for occupational, physical, speech/language, respiratory and audiological therapy, regardless of where the services are provided. All 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.

Fact:

During SFY 2008, there were a total of 99,079 outpatient specialized therapy PA referrals with 23 denials, compared with 99,466 referrals and 26 denials during SFY 2007.

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 reviews also determine 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.

Fact:

During SFY 2008, there were 38 utilization management denials from 355 reviews and 173 prior authorization denials from 3,822 reviews. During SFY 2007, there were 50 utilization management denials from 523 reviews and 114 prior authorization denials from 2,090 reviews.

Managed Care Referral Authorization and Utilization Management

Each recipient who is enrolled in CCNC/CA, 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 quality of care and reducing unnecessary costs. In addition to providing regular office hours, the PCP must arrange or provide medical care or advice 24/7. The PCP gives the provider to whom a referral or authorization is being made an authorization number that must appear on the claim to ensure Medicaid reimbursement.

Utilization management ensures that appropriate services are delivered to Medicaid enrollees through the identification of abnormal 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 cost data, which affords cross-analysis of the efficiency and efficacy of managed care initiatives.

Each CCNC/CA provider receives quarterly utilization reports and monthly emergency department, provider enrollment and referral reports. Data contained in these reports are extracted from paid claims data and include both inpatient and outpatient utilization statistics. These data also provide useful peer performance comparisons. Utilization review is done by clinical staff at the Office of Rural Health and Community Care, who develop program initiatives and work with the individual CCNC/CA networks to create strategic plans to improve the health care of Medicaid recipients.

Information Technology and HIPAA

The Information Technology and HIPAA section is responsible for overseeing the Medicaid Management Information System (MMIS), the Decision Support Team and the Health Insurance Portability and Accountability Act (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 Quality, Evaluation and Health Outcomes (QEHO) unit identifies 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 in various projects inside and outside the agency.

In this year's annual focused care study, 4,000 recipient medical charts were reviewed to evaluate the prevalence and treatment of pediatric obesity. This study has now moved into the data analysis phase. All phases for last year's focused care study evaluating the recommendations for and the incidence of cancer screening were completed. The results indicated that, while there was no indication of racial disparities among several of the screening measures, there was still significant room for improvement in overall screening rates. The study results were presented to the Justus-Warren Heart Disease and Stroke Prevention Task Force and accepted for publication in the *Archives of Internal Medicine*.

QEHO's consulting physician published an article in the *North Carolina Medical Journal* stressing the importance of the medical home in prevention and identification of chronic kidney disease. Another article, in the *Journal of the American Medical Association*, highlighted trends in Medicaid expenditures for undocumented immigrants in North Carolina.

QEHO supports the Division as well as other agencies locally and nationally by participating in projects and programs such as these:

- the national project to evaluate atypical antipsychotic medication use in children
- the Perinatal Quality Collaborative of North Carolina
- the Division of Public Health awards for perinatal and neonatal outreach coordinators
- the Agency for Healthcare Research and Quality (AHRQ) conference on quality tools to measure and ensure the quality of care received by Medicaid recipients

Policy Changes and Reports

New Federal Regulations and Guidance that Resulted in Changes of N.C. Medicaid

National Provider Identifier (NPI) Compliance Guidance – CMS provided states with NPI Compliance Guidance to assist in the implementation of the mandatory use by states of NPIs. During SFY 2008, the DMA completed the collection of NPIs for Medicaid providers in North Carolina.

Emergency Room Co-payments for Non-Emergency Care – CMS added a new subsection to the Social Security Act providing a state option to impose higher cost sharing for non-emergency care furnished in a hospital emergency department without a waiver. DMA did not opt to implement this provision during SFY 2008.

Peer Support Services – CMS provided guidance to states interested in providing peer support services under the Medicaid program to assist individuals recovering from a mental illness or substance abuse while still being able to live, work, learn and participate fully in their communities. The two behavioral health services within N.C. Medicaid that contain allowances for peer support services are Community Support Team and Assertive Community Treatment team.

Tamper-Resistant Prescription Pads – CMS provided guidance to State Medicaid agencies on the use of tamper-resistant prescription pads. DMA implemented the use of tamper-resistant prescription pads in September 2007.

Participation in Permanent Error Rate Measurement (PERM) – CMS provided states with preliminary information regarding participation in the PERM measurement. DMA has been participating in PERM for a number of years.

Disputing Errors in Permanent Error Rate Measurement – CMS provided guidance on a CMS policy change that allowed states to dispute medical review errors that were cited for insufficient documentation and explained the process for states to dispute such errors.

Expanded Access to Home- and Community-Based Services (HCBS) for the Elderly and Disabled – CMS provided guidance on the implementation of the section titled "Expanded Access to Home- and Community-Based Services for the Elderly and Disabled" of the Deficit Reduction Act of 2005 (DRA). This section adds a new section to the Social Security Act specifying that states have the option to amend their state plans to provide HCBS without regard to offering all services statewide or meeting certain other Medicaid requirements. This was a one-time opportunity which DMA declined to exercise during SFY 2008.

Medicaid State Plan Amendment (SPA) Preprint – CMS provided a Medicaid SPA preprint that states may use to comply with the requirements of the Social Security Act that established the Medicaid Integrity Program.

Policy Changes Mandated by the N.C. General Assembly

Programmatic Issues:

Collaboration among Departments of Administration, Health and Human Services, Juvenile Justice and Delinquency Prevention, and Public Instruction on School-Based Child and Family Team Initiative (S.L. 2007-323, Section 10.9) – The purpose of the initiative is to identify and coordinate appropriate community services and supports for children at risk of school failure or out of home placement in order to address the physical, social, legal, emotional and developmental factors that affect academic performance.

Medicare Crossover Claims (S.L. 2007-323, Section 10.36(d)(19)) – Allowed DMA to disregard Medicaid medical policy with respect to Medicare claims for dually eligible recipients when the application of the policy would adversely affect patient care.

Adoption of Temporary or Emergency Rules (S.L. 2007-323, Section 10.36(1)) – DHHS must adopt rules requiring providers to attend training as a condition of enrollment.

Pilot Program/Medicaid Dual-Eligible Special Needs Plan (S.L. 2007-323, Section 10.40F) – Directed DMA to evaluate and establish a pilot program to offer dual-eligible Medicaid recipients skilled nursing facility services through a "Special Needs Plan" in at least two, but not more than four, counties. The Special Needs Plans must work directly with CCNC.

Implement Electronic Quality Prescription Management Program (S.L. 2007-323, Section 10.41) – This amendment to Sec. 10.19B of S.L. 2006-66 allowed DMA to designate CCNC as the lead program to implement the Electronic Quality Prescription Management Program. DMA was also allowed to transfer cost-containment funds to the Office of Rural Health to pay for PDAs, connectivity, software and other related costs.

Prescription Orders/Electronic Image (S.L. 2007-248) – Effective July 7, 2007, this law allowed a pharmacist manager of a pharmacy to use electronic imaging and storage of the prescription order to comply with the 3-year storage and retrieval capability of originals of prescription orders and refills as required under G.S. 90-85.26. Pharmacy managers who adopt this method do not need to maintain a hard copy of the original. The pharmacy's computer must be capable of printing and providing, in an electronic or paper format, a copy of the original within 48 hours of the request.

Eligibility and Benefit Coverage Issues:

State–County Special Assistance (S.L. 2007-323, Section 10.13(a)) – The eligibility of Special Assistance recipients residing in adult care homes as of Aug. 1, 1995, will not be affected by an income reduction in the Special Assistance eligibility criteria resulting from adoption of the Rate Setting Methodology Report, providing these recipients are otherwise eligible.

Coverage of "Independent Foster Care Adolescents" (S.L. 2007-323, Section 10.36(c)(4)) – DMA was directed to provide Medicaid coverage to foster children aging out of foster care, ages 18, 19 and 20, without regard to the adolescents' assets, resources or income levels.

Prior Authorization (PA) of Personal Care Services (PCS) (S.L. 2007-323, Section 10.36(d)(21)) – Prior authorization is required for all personal care services effective Oct. 1, 2007. The PA criteria must be developed in consultation with the NCPAG of the N.C. Medical Society. Recipients must be notified of PA approvals or denials within seven working days of the receipt of the PA request.

Utilization Review (UR) of Prescription Drugs for Mental Illness and HIV/AIDS (S.L. 2007-323, Section 10.36(d)(28)) – DMA is required to perform continuous utilization review of medications prescribed for treatment of mental illness, including but not limited to medications for schizophrenia, bipolar disorder or major depressive disorder. For individuals 18 years of age or under, the UR system must incorporate clinical edits to target inefficient or potentially harmful prescribing patterns and peer-to-peer consultation with targeted prescribers.

Provider Visit Limits (S.L. 2007-323, Sections 10.36(e)(2) & 10.36(f)(1)) – DMA was directed to do the following:

- Increase the annual visit limit from 24 visits per recipient to 30
- Add nurse practitioners, nurse midwives and health departments to the list of providers to which the visit limit applies
- Distribute the allowable number of visits for each service or each group of services consistent with federal law
- Establish a threshold for some number of visits for each service or each group of services to notify the appropriate primary care providers or CCNC network when a patient is nearing the established threshold so that care coordination and intervention may be provided as needed
- Authorize exceptions to the 30-visit limit if additional care is medically necessary; except that exceptions to the 30-visit limit for *routine* or *maintenance* visits are allowable only if additional visits are necessary to actively manage a life-threatening disorder or as an alternative to more costly care options

N.C. Kids' Care (S.L. 2007-323, Section 10.48) – DMA was required to evaluate and make recommendations regarding the most cost-efficient and cost-effective method of developing and implementing a program to expand comprehensive health care benefits to children ages 0 to 18 years with family incomes between 200 percent and 300 percent of the federal poverty level (FPL). DHHS was allowed to begin providing health insurance coverage to children in families with incomes between 200 percent and 300 percent of the FPL on July 1, 2008.

Build Community Infrastructure for Mental Health, Developmental Disabilities, and Substance Abuse Services (S.L. 2007-323, Section 10.49) – This law addressed a wide range of mental health, developmental disability and substance abuse services, and funding issues. The **Housing Assistance** subsection required DHHS to complete the development of a Uniform Screening Tool to determine the mental health of an individual admitted to any long-term care facility by Jan. 1, 2008.

The Additional Home- and Community-based Waivers subsection required DHHS to apply for additional home- and community-based waivers for persons with developmental disabilities to fill service gaps through a tiered systems of services in conjunction with the existing CAP/MR-DD waiver.

Delay the Effective Date of the Ticket to Work Program (S.L. 2007-144) – This law amended Sec. 10.18(c) of S.L. 2005-276, as amended by S.L. 2006-66, to delay the effective date of the Ticket to Work Program to July 1, 2008.

Medicaid Transfer of Assets Hardship Waiver; Estate Recovery and Data Share between DMA and Health Insurers (S.L. 2007-442) – Effective Aug. 2, 2007, this law repealed all of the extended effective dates and the underlying changes, thus eliminating the provisions relating to liens, estate recovery hardship waiver and notice. It also made technical changes to G.S. 108A-55.4, which requires health insurers and pharmacy benefit managers regulated as third-party administrators under Article 56 of Chapter 58 to provide certain information to DHHS. Finally, it added a new section, 108A-58.2, to codify 10A-NCAC 21B.0314, the Medicaid "Transfer of Assets Hardship Waiver" rule.

Budget and Other Financial Issues:

Comprehensive Treatment Services Program/Establishment of Task Force on the Coordination of Children's Services (S.L. 2007-323, Section 10.10) – DHHS was directed to continue the Comprehensive Treatment Services Program for children at risk for institutionalization and out-of-home placement. The intent of the program is to provide appropriate and medically necessary nonresidential and residential treatment alternatives for the children served by the program. To accomplish this, the program must maximize the use of local and state funds and expand the use of Medicaid funds.

State–County Special Assistance (S.L. 2007-323, Sections 10.13(a)–(e)) – Sections (a) through (c) established the maximum monthly rate for Special Assistance recipients residing in adult care homes (ACH). Section (d) established the maximum monthly rate for Special Assistance residents in Alzheimer/Dementia special care units. Section (e) required DHHS to review activities and costs related to the provision of care in ACHs and determine what costs may be considered to properly maximize allowable reimbursement available through Medicaid personal care services for adult care homes (ACH PCS) under federal law. Section (e) also allows DHHS, with approval from CMS and OSBM, to transfer necessary funds from the State County Special Assistance program within the Division of Social Services to DMA and to use those funds as state match to draw down federal matching funds to pay for ACH PCS activities and costs under Medicaid's personal care services for adult care homes, thus maximizing available federal funds.

Allocation of Nonfederal Cost of Medicaid (S.L. 2007-323, Section 10.36(a)(2)) – The State began to incrementally take over county funding of Medicaid according to the following schedule:

- Effective Oct. 1, 2007, the state began paying 25 percent of the county share, at a cost of $86,200,000 for SFY 2008;
- Effective July 1, 2008, the state will pay 50 percent of the county share, at a cost of $271,200,000 for SFY 2009;
- Effective July 1, 2009, the state will pay 100 percent of the county share.

Fraud and Abuse Incentives to Counties (S.L. 2007-323, Section 10.36(b)(3)) – DMA is now required, rather than allowed, to provide a share of the state's savings to counties that successfully recover fraudulently spent Medicaid funds.

Medicaid Cost-Containment Activities (S.L. 2007-323, Section 10.37) – This amendment to Sec. 10.14 of S.L. 2005-276, as amended by Sec. 10.7A(b) of S.L. 2006-66, increased the amount of funds available to DHHS for program services to support the cost of administrative activities, when cost-effectiveness and savings are demonstrated, to $5 million for each fiscal year of the 2007–2009 biennium. The Session Law also deleted the requirement that the cost savings must be demonstrated in the same fiscal year that the proposed expenditures for administrative activities occur.

Disposition of Disproportionate Share (DSH) Receipts (S.L. 2007-323, Section 10.39) – DMA was required to transfer up to $100 million of DSH payments to the State Treasurer during each year of the biennium. Transfers were to be made as funds associated with DSH payments were received from the state hospitals.

Skilled Nursing Facility (SNF) Reimbursement Rates (S.L. 2007-323, Section 10.39A) – This law described the schedule and sources for recalculating the basis for (rebasing) case-mix reimbursement rates and increasing the skilled nursing provider assessment as follows:

- **Schedule for rebasing case-mix reimbursement rates:** Effective Jan. 1, 2008, one-half of rate rebasing was implemented using 2005 audited cost data. The remaining half of rate rebasing will be implemented in SFY 2009. Funding for the rebased rates came from for inflationary increases for SNFs for SFYs 2008 and 2009.
- **Increases in provider assessment:** Effective Jan. 1, 2008, the provider assessment was increased by $1.00. Effective Jan. 1, 2009, provider assessment will again increase by $1.00. Increased revenue is used to reduce state appropriations needed to rebase the rates. If additional funds are needed to implement the rebasing, DHHS may use available funds.
- **Schedule for ongoing rebasing of case-mix reimbursement:** DMA must develop a schedule for ongoing rebasing of rates.

Medicaid Special Fund Transfer (S.L. 2007-323, Section 10.40) – This amendment to Sec. 10.15 of S.L. 2005-276, as amended by Sec. 10.7 of S.L. 2006-66, decreased the amount of funds transferred to DHHS from the Medicaid Special Fund from $53 million to $43 million for each of SFYs 2008 and 2009 in order to divert $10 million each fiscal year to the hospital supplemental payment program.

Extend Implementation of the Community Alternatives Programs Reimbursement System (S.L. 2007-323, Section 10.44) – This amendment to Sec. 10.20 of S.L. 2005-276 extended the Jan. 1, 2007, deadline for full implementation of a new system for reimbursing the Community Alternatives Programs to a date not later than 12 months after the date on which the replacement MMIS becomes operational and stabilized.

Families Pay Part of the Cost of Services Under the CAP/MR-DD Program and the CAP/Children's Program Based on Family Income (S.L. 2007-323, Section 10.45) – This law required DMA, after holding at least one public hearing on the matter, to develop a schedule of cost-sharing requirements based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit. The cost sharing requirement may be in the form of monthly deductibles. This section was effective July 1, 2008, for children enrolled in CAP/MR-DD or CAP/C on or after that date. For currently enrolled CAP/MR-DD and CAP/C recipients, this section became effective at the recipient's first certification period following July 1, 2008.

Developmental Center Downsizing (S.L. 2007-323, Section 10.50) – This law continued the downsizing of the state's Developmental Centers at a target rate of 4 percent each year, if individual needs and availability of community services allow. Admissions of the client population to state-operated ICF-MR facilities were permitted only as a last resort and with approval of DHHS. Any savings resulting from downsizing are to be placed in a Trust Fund for MH/DD/SAS and Bridge Funding Needs to facilitate transition of residents into appropriate community services. DMA must transfer any recurring Medicaid savings resulting from downsizing from the ICF-MR line to fund Medicaid services in continued community services placements.

State Assumes Medicaid Responsibilities (S.L. 2007-323, Section 31.16) – This section of the appropriations bill established a schedule for the state to assume the non-federal share of Medicaid services expenditures and claims payment, amended G.S. 108A-54 and established state and county responsibility for taxes (see S.L. 2007-323, Sec. 10.36, above).

Other Initiatives:

MMIS+ Development and Implementation Reporting (S.L. 2007-323, Section 10.40D) – As DHHS develops and implements its new MMIS, this section required that it include plans to ensure the timely and effective implementation of future enhancements to the system. These enhancements include the capacity to receive and track premium or other payments as well as compatibility with N.C. Health Choice, N.C. KIDSCare, the State Employees Health Plan, the Health Information System (of the Division of Public Health), Medicaid waivers and any possible Medicare 646 waiver. DHHS may not delay implementation of the core system in order to include the enhancements and must engage private counsel with information technology and computer law experience to review requests for proposals and to negotiate and review MMIS+ contracts.

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

DMA was mandated to provide the N.C. General Assembly with a number of reports as follows (an online copy of each report is available on the DMA Web site at **www.ncdhhs.gov/dma/legis/legisreports.html**):

Study Respite Care (S.L. 2007-39) – In March 2008, DMA, in conjunction with the Division of Health Service Regulation and the Division of Aging and Adult Services, submitted a report to the Study Commission on Aging on the mandated study of the availability and delivery of respite care services in North Carolina, along with recommendations for improvements to the current respite care delivery system including:

- That the N.C. General Assembly:
  - Secure a recurring state appropriation of $500,000 to sustain Project C.A.R.E: "Caregiver Alternatives to Running on Empty" prior to June 30, 2008.
  - Support an increase in the State Adult Day Care Fund (SADCF).
  - Secure state funding to continue the expansion of Aging and Disability Resource Connections (ADRC) to increase information and access on respite services for caregivers.
- The Division of Aging and Adult Services will further study the place of group respite programs in the long-term care continuum and assess the adequacy of service standards and funding.
- DMA will continue to study the potential of Respite as a State Plan Service

Medical Policy Changes (S.L. 2007-323, Section 10.36(b)(4)) – DMA provided the Office of State Budget and Management and the Fiscal Research Division with quarterly reports itemizing all medical policy changes with total requirements of less than $3 million. There were a total of 10 such policy changes.

Prior Authorization (PA) of Personal Care Services (PCS) (S.L. 2007-323, Section 10.36(d)(21)) – DMA submitted a report documenting that the required components of a preauthorization program for PCS were in place and being utilized for prior authorization of PCS-Plus services. PCS-Plus serves approximately 2,000 of the most costly PCS recipients per year. DMA made the recommendation not to expand PA to all Medicaid in-home personal care services because the savings would not justify the additional related expenses.

Utilization Review of Prescription Drugs for Mental Illness and HIV/AIDS (S.L. 2007-323, Section 10.36(d)(28)) – DMA reported on the implementation of new utilization review requirements related to prescription drugs for mental illness and HIV/AIDS in January 2008 and followed this with its first quarterly report in April 2008. Among other findings, the second report mentioned estimated cost savings of approximately $2 million during February 2006 and March 2007.

Medicaid Cost-Containment Activities (S.L. 2007-323, Section 10.37) – DMA reported that the amounts it paid for cost-containment activities in SFY 2004 through SFY 2007 totaled approximately $1.25 million and the amount of savings realized from cost-containment activities during those fiscal years amounted to approximately $18.7 million. DMA also provided a copy of its cost-containment proposals within this report.

Skilled Nursing Facility Reimbursement Rates (S.L. 2007-323, Section 10.39A) – DMA was required to report on the schedule and sources of rebasing skilled nursing facility case mix reimbursement rates, to increase the skilled nursing provider assessment reimbursement rate and to describe how rebasing would effectively replace the existing system for providing inflationary increases for skilled nursing facilities. The report provided information on various rebasing methodologies from 15 surveyed states. DMA recommended that skilled reimbursement rates be rebased on a schedule of not less than every four years with rate increases subject to budgetary constraints. During those years between rebasing, rates would be subject to inflationary increases as allowed by the

General Assembly. In any year in which a pre-selected national inflationary index for nursing facility cost exceeds a predetermined aggregate increase since the last rebasing, nursing facility reimbursement would be rebased and the four year rebasing cycle would be reset beginning in the year of that rebasing. This would allow for a defined rebasing methodology while adhering to budgetary constraints.

Pilot Program/Medicaid Dual Eligible Special Needs Plan (S.L. 2007-323, Section 10.40F) – DMA was required to evaluate and establish a pilot program to offer dual eligible Medicaid recipients skilled nursing facility services through a "Special Needs Plan" working directly with Community Care of North Carolina in at least two, but not more than four, regions of the state and to report on the evaluation, selection, implementation, associated cost savings and the feasibility of expansion of the pilot programs. The study found that the quality and cost effectiveness of SNPs has not been proven. Given this finding, the report recommended that the pilot be aligned with the efforts of CCNC to manage the aged, blind and disabled populations and to build upon the CCNC management approach.

Families Pay Part of the Cost of Services Under the CAP/MR-DD Program and the CAP/Children's Program Based on Family Income (S.L. 2007-323, Section 10.45) – DMA was required to develop a schedule of cost-sharing requirements for these two CAP programs based on a sliding scale of family income for children with family incomes above the Medicaid allowable limit and to submit a report on the related cost-sharing requirements. In March 2008, DMA reported on the cost-sharing requirements, including a summary of public comments received at the public hearing and indicated possible barriers to implementing the cost-sharing schedule. DMA reported on savings realized due to the cost-sharing on March 1, 2009.

Continue Efforts to Expand Community Care and Improve Quality of Care for Aged, Blind and Disabled Medicaid Recipients (S.L. 2007-323, Section 10.46) – DMA reported on the status of its expansion of the scope of the CCNC care management model to recipients of Medicaid and dually eligible individuals with a chronic condition and long-term care needs, focusing on the aged, blind, disabled and CAP/DA populations. The report described the core disease and care management initiatives being extended to this population, including: asthma, diabetes and congestive heart failure disease management initiatives; pharmacy initiatives addressing cost and utilization; emergency department utilization activities; and management of enrollees at the highest risk and services at the highest cost.

N.C. Kids' Care (S.L. 2007-323, Section 10.48) – DMA was required to study and submit an interim and final report the most cost-efficient and effective method of expanding health care coverage to children age 0 to 18 years in families with incomes between 201 to 300 percent of the federal poverty level (FPL). The Division recommended that N.C. Kid's Care be implemented as an expansion of the N.C. Health Choice program for children in families with incomes of up to 250 percent of the FPL and that the administration of the program be handled under the current contract with the State Health Plan.

Build Community Infrastructure for Mental Health, Developmental Disabilities, and Substance Abuse Services: Housing Assistance (S.L. 2007-323, Section 10.49(k)) – DMA was required

to develop and report on a Medicaid Uniform Screening Tool (MUST) to determine the mental health of individuals admitted to long-term care facilities. MUST is intended to replace several existing screening tools used to evaluate and document an applicant's medical, functional and behavioral health status. The report indicated that the development and testing of MUST, under contract with Electronic Data Systems (EDS), was significantly delayed due to the complexity of the tool and the need for rigorous testing, North Carolina's stiff requirements related to information technology security and architecture and the fact that funding had not been allocated to fully implement the project. Therefore, the project would not meet the Jan. 1, 2008 implementation date.

Build Community Infrastructure for Mental Health, Developmental Disabilities, and Substance Abuse Services: Home- & Community-based Waivers (S.L. 2007-323, Section 10.49(dd)) – DMA reported on the status of its application for additional home- and community-based waivers for persons with developmental disabilities and the related tiered system of services. The Division has been working on the development of three, and possibly four, tiered waivers. Each of the waivers will include self-direction, contain service definitions tailored to the needs of the specific covered population and support individualized services and supports. The use of a Supports Intensity Scale will provide a comprehensive assessment process that will serve to inform the person-centered planning process.

Build Community Infrastructure for Mental Health, Developmental Disabilities, and Substance Abuse Services: Home- & Community-based Waivers: One-time & Monthly Reporting (S.L. 2007-323, Section 10.49(ee)(10)) – In conjunction with DMH/DD/SAS, DMA reported to the NCGA on a number of items related to mental health care reform, including the use and cost of community support services, the modification of the Medicaid claims payment system, contracting with additional Local Management Entities (LMEs) with outside utilization review vendors, etc.

Medicaid Transfer of Assets Hardship Waiver; Estate Recovery and Data Share Between DMA and Health Insurers (S.L. 2007-442) – In May 2008, DMA provided the NCGA with expenditure, recipient and estate recovery information regarding personal care services. The Division recommended that the Estate Recovery program only seek recovery against assets of estates if DMA has paid more than $3,000 for services and the estate assets are greater than $5,000.

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 2008. They are grouped according to the type of action taken.

Initial promulgation of existing coverage:

- medically necessary circumcision
- physician fluoride varnish services
- chiropractic services
- dietary evaluation and counseling
- electrocardiography, echocardiography and intravascular ultrasound

Promulgation of new policies:

- moderate (conscious) sedation

- PACE (Program of All-inclusive Care for the Elderly)

Other actions:

- All applicable clinical coverage policies were updated to change the name of the Division of Facility Services to the Division of Health Service Regulation.
- surgery for the lingual frenulum—added general coverage criteria and dental codes; revised specific coverage criteria and prior approval requirements
- sleep studies and polysomnography services—substituted specific diagnosis codes for a general code
- breast imaging procedures—clarified table headings; corrected procedure codes
- home health services—updated a form number and illustration; updated name and contact information for prior approval contractor; added "medical supplies" to the list of items that may be provided in a private residence; deleted CAP/AIDS and added CAP/Choice; and clarified the requirements for a PRN skilled nursing visit
- hospice services—Medicare-AID recipients are not eligible for Medicaid-covered hospice services; added a revenue code
- home infusion therapy—clarified that nursing services are not covered; clarified billing instructions
- home tocolytic infusion therapy—updated prior approval request form
- dental services—added procedure code D0145; deleted "Medicaid Post-Payment Review" information and replaced it with "Medical Record Documentation"
- durable medical equipment—updated codes and oxygen policy; removed bold and asterisks as indicators of Medicare coverage and prior approval (this information is on the fee schedule, which is Web based and easier to update); reflected change in prior approval responsibility from Children's Special Health Services to EDS
- orthotics and prosthetics—added allowance for medical doctors and doctors of osteopathic medicine to supply some items; added certified fitters of therapeutic shoes; added note about prior approval for recipients 18 or older; deleted references to pediatric mobility systems; updated codes
- outpatient pharmacy program—changed references to Medication Therapy Management Program to Focused Risk Management (FORM) Program; updated requirements; DMA may use a certification form and procedures for medically necessary brand-name drugs; added clarification for claims submitted by 340B providers; added narcotic analgesics and narcotic analgesic combination drugs to the list of those that don't allow a hospice edit override; added the word "unduplicated" to references to 11 or 12 prescriptions
- outpatient specialized therapies—added CPT code to Occupational Therapy Assessment and Speech/

Language Therapy Assessment; removed pre-vocational assessment and training from the services provided; added nursing services and supporting information; removed requirement for audiologists to hold master's or doctoral degrees; added information regarding collaboration with the student's primary physician

- independent practitioners (IP)—added CPT code to Occupational Therapy Assessment and Speech/Language Therapy Assessment
- local education agencies—extended service through the school year 2007–2008
- provider visit limits—effective July 1, 2007, implemented the legislative mandate (S.L. 2007-323, §10.36(e)(2) & 10.36(f)(1)) by allowing up to 22 visits per year for mandatory services and up to eight visits per year for optional services. Certain diagnostic exceptions are permitted.











Medicaid Tables











Table 1

Federal Matching Rates for N.C. Medicaid SFY 2008

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, three separate financial participation rates are shown below as they are phased in during the year. Effective October 1, 2007, the state share of non-federal Medicaid expenditures increased from 85% to 88.75% and the county share correspondingly decreased from 15% to 11.25%. Effective June 1, 2008, the state share of non-federal Medicaid expenditures increased from 88.75% to 92.5% and the county share correspondingly decreased from 11.25% to 7.5%.

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

Benefit Costs
(7/1/07 - 9/30/07)

	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%

Benefit Costs
(10/1/07 - 5/31/08)

	Services Except B&CC and Family Planning	Breast and Cervical Cancer	Family Planning
Federal	64.05%	74.84%	90.00%
State	31.91%	22.33%	8.88%
County	4.04%	2.83%	1.12%

Benefit Costs
(6/1/08 - 6/30/08)

	Services Except B&CC and Family Planning	Breast and Cervical Cancer	Family Planning
Federal	64.05%	74.84%	90.00%
State	33.25%	23.27%	9.25%
County	2.70%	1.89%	0.75%

Administrative Costs
(7/1/07 - 6/30/08)

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

*MMIS-Medicaid Management Information System

Source: *DMA Decision Support*

Table 2a N.C. Medicaid Eligibility Requirements – SFY 2008

GROUP	BENEFITS	BASIC REQUIREMENTS[1]						SPECIAL PROVISIONS
		Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit (updated 4/08)	Resource Limit	Deductible/Spenddown		
Recipients of Cash Assistance Programs	Full Medicaid Coverage	Recipients of the following cash assistance programs are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination is required. • 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 those who are in adult care homes. • Special Assistance to the Blind – State cash assistance program for blind individuals.						
Aged	Full Medicaid coverage	Age 65 or older	Spouse's income and resources if live together	100% of Poverty 1 $ 867/mo 2 $1,167/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 $1,750/mo and can be as much as $2,610, depending upon the at-home spouse's cost for housing. The amount protected for the at-home spouse is not counted in determining the eligibility of the spouse in the nursing facility. **Protection of resources for spouse at home:** Additionally, the countable resources of the couple are combined and a portion is protected for the spouse at home. That portion is 1/2 the total value of the countable resources, but currently not less than $20,880 or more than $104,400. 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 $ 867/mo 2 $1,167/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 $ 867/mo 2 $1,167/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 $ 867/mo 2 $1,167/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 - $1,040/mo 2 - $1,400/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 live together. Parents' income and resources if under age 18 and live with parents.	135% of Poverty 1 - $1,170/mo 2 - $1,575/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 - $1,734/mo 2 - $2,334/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 2008

GROUP	BENEFITS	BASIC REQUIREMENTS						SPECIAL PROVISIONS
		Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit (updated 4/08)	Resource Limit	Deductible/Spenddown		
Families & Children	Full Medicaid coverage	Parents/Caretaker relatives must be living with and caring for a child to whom they are related who is under age 19.	Spouse's income and resources if live together.	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 s/he/they can meet a deductible. **Medicaid Deductible:** When an individual/family is ineligible for Medicaid due to income over the income limit, they may become eligible by meeting a Medicaid deductible. The deductible is determined by subtracting the Medically Needy Income Limit (MNIL) (see limits below) from the countable monthly income to determine the monthly excess income. Medicaid deductibles are generally determined for 6 months, so the monthly excess income is multiplied by 6 to determine the 6-mo. deductible. Once medical bills for which they are responsible totaling the amount of the deductible are incurred, they are authorized for the rest of the 6-mo. period. Medicaid cannot pay for any of the bills applied to the deductible. **MNIL:** / **Resource limit:** 1 - $242/mo — All deductible cases have a resource limit: $3,000 for families and children and $2,000 (1) and $3,000 (2) for aged, blind and disabled. 2 - $317/mo 3 - $367/mo 4 - $400/mo 5 - $433/mo	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	Treatment for conditions that affect the pregnancy	Children must be under age 21.	Parents' income and resources if under age 21 and live with parents.	185% of Poverty 1 - $1,604/mo 2 - $2,159/mo 3 - $2,714/mo 4 - $3,269/mo 5 - $3,824/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	Medical verification of pregnancy	Income of the pregnant woman; income of the father of the unborn if living in the home.	200% of Poverty 1 - $1,734/mo 2 - $2,334/mo 3 - $2,934/mo 4 - $3,534/mo 5 - $4,134/mo	No resource limit if eligible with income no more than 200% of poverty	Yes		
Children Ages 6 Through 18	Full Medicaid Coverage	Children under age 6	Parents' income if living in the home.	100% of Poverty 1 - $867/mo 2 - $1,167/mo 3 - $1,467/mo 4 - $1,767/mo 5 - $2,067/mo	No resource limit if eligible with income no more than 100% of poverty.	Yes		
Title IV-E Children	Full Medicaid Coverage	Children ages 6 through age 18	Medicaid eligibility is automatic. There is no income or resource determination.			No		
Breast & Cervical Cancer Medicaid	Full Medicaid Coverage	Title IV-E adoptive or foster child	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	Family Planning exams & services; screenings & treatment for STIs; screenings for HIV; sterilizations	A woman who has been screened and enrolled in the N.C. Breast &Cervical Cancer Control Program and is otherwise ineligible for Medicaid	Count spouse's income. Do not count parent's income for children.	185% of Poverty 1 - $1,604/mo 2 - $2,159/mo 3 - $2,714/mo 4 - $3,269/mo 5 - $3,824/mo	No resource limit	No	There is no deductible or spenddown provision for Family Planning coverage. A recipient whose income increases to more than 185% of poverty is ineligible for family planning coverage.	
N.C. Health Choice (NCHC)	Coverage of the N.C. State Employees Health Plan, plus vision, hearing, & dental	Uninsured child over age 5 & under age 19	Parents' income if living in the home.	200% of Poverty 1 - $1,734/mo 2 - $2,334/mo 3 - $2,934/mo 4 - $3,534/mo 5 - $4,134/mo	No resource limit	No	There is no deductible or spenddown provision for NCHC. A child who is ineligible due to too much income 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 2008

Family Size	100%	120%	133%	135%	185%	200%	SSI	MNIL	SA/ACH	SA/SCU	SA/In-Home
1	$10,400	$12,480	$13,832	$14,040	$19,240	$20,800	$7,644	$ 2,904	$14,634	$18,726	$10,404
2	$14,000	$16,800	$18,620	$18,900	$25,900	$28,000	$11,472	$ 3,804			
3	$17,600		$23,408		$32,560	$35,200					
4	$21,200		$28,196		$39,220	$42,400					
5	$24,800		$32,984		$45,880	$49,600					

Note 1: The Federal Poverty Level amounts change each year effective April. The above figures were effective April 1, 2008 and remained in effect through the end of SFY 2008

Note 2: SSI recipients are automatically eligible. Income limits are $7,644 for a family of one and $11,472 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 $10,404 for a family of one.

Note 3: Those with incomes over the limits are eligible if their 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 2008 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

North Carolina Medicaid State Fiscal Year 2008 Enrolled Medicaid Providers

Providers	SFY 2008	SFY 2007	% Change
Adult Care Home Providers	2,356	2,372	-0.7%
Ambulance Service Providers	322	303	6.3%
Carolina ACCESS II Entities	15	16	-6.3%
Child Development Services Agency (CDSAs)	19	20	-5.0%
Chiropractors	1,082	1,055	2.6%
Clinics:			
Rural Health Clinic/Federally Qualified Health Center Providers	435	412	5.6%
Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers	270	246	9.8%
Community Alternatives Program Providers:			
CAP/C, CAP/AIDS, CAP/DD-MR, CAP/DA	1,633	1,604	1.8%
Community Based Providers[1]	2,254	6,412	-64.8%
Dental Service Providers:			
Dentists, Oral Surgeons, Pediadontists, Orthodontists	4,779	4,605	3.8%
Durable Medical Equipment Suppliers	2,973	2,772	7.3%
Hearing Aid Suppliers	100	92	8.7%
Home Health Agency Providers:			
Home Infusion Therapy, Private Duty Nursing	402	421	-4.5%
Hospice Agency Providers	82	80	2.5%
Hospital Providers	1,064	1,073	-0.8%
Independent Diagnostic Testing Facilities	20	12	66.7%
Independent Laboratory Providers	201	183	9.8%
Independent Practitioners:			
Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, Audiologists	3,412	2,949	15.7%
Local Management Entities[2] (formerly Area Mental Health Program Providers)	38	94	-59.6%
Managed Care Programs (HMOs)	1	1	0.0%
Mental Health HMO	1	1	0.0%
Mental Health Providers	8,847	8,148	8.6%
Nursing Facility Providers	1,210	1,223	-1.1%
Optical Service Providers and Suppliers:			
Opticians, Optometrists	1,248	1,201	3.9%
Personal Care Service Providers	1,144	1,186	-3.5%
Pharmacists	2,212	2,184	1.3%
Physician Extenders:			
Nurse Midwives, Nurse Practitioners, Nurse Anesthetists	3,571	3,134	13.9%
Physicians	30,075	28,692	4.8%
Podiatrists	372	360	3.3%
Portable X-ray Service Providers	15	16	-6.3%
Psychiatric Facility Providers	826	862	-4.2%
Public Health Program Providers	560	530	5.7%
Total	**71,539**	**72,259**	**-1.0%**

(1) Beginning in SFY 2008, provider organizations with multiple sub-entities are counted here as a single provider.
(2) This decrease is due to the merger of local management entities to provide behavioral health activities.

Note: The counts shown above are unduplicated counts of providers active at any time during the fiscal year. Physicians may be counted individually and/or as a member of a group practice.

Source: DRIVE System Provider Table

Table 4
Sources of N.C. Medicaid Funds SFY 2008 vs. SFY 2007

	2008	Percent[3]	2007	Percent[3]
Federal	$ 6,401,881,878	55.2%	$ 6,152,419,490	54.7%
State[1]	$ 2,915,133,475	25.1%	$ 2,649,478,406	23.5%
Other State[2]	$ 790,570,317	6.8%	$ 450,825,899	4.0%
County	$ 407,599,854	3.5%	$ 841,171,478	7.5%
Certfied Public Expenditures	$ 1,081,338,116	9.3%	$ 1,158,275,487	10.3%
Total	**$ 9,012,613,680**	**100.00%**	**$ 11,252,170,760**	**100.00%**

(1) "State" refers to the state appropriation of funds

(2) 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.

(3) Percentages differ from those in Table 1 because the above figures are an aggregation of the 3 separate match rates applied at different periods during the state fiscal year.

Source: BD701, Authorized Monthly Budget Report, Budget Code 14445, for the periods ending June 29, 2008 and June 29, 2007

Table 5
A History of N.C. Medicaid Program & Administrative Expenditures SFYs 2004 - 2008

STATE FISCAL YEAR	TOTAL EXPENDITURES	Total Expenditure Change from Prior Year	Eligibles Change from Prior Year	Program Expenditures	Change from prior year	Administrative Expenditures	Change from prior year
SFY 2004	8,277,870,990	N/A	4.5%	8,104,408,262	N/A	173,462,729	N/A
SFY 2005	9,407,122,849	13.6%	3.4%	9,285,992,429	14.6%	121,130,420	-30.2%
SFY 2006	9,567,707,678	1.7%	5.2%	9,440,982,997	1.7%	126,724,680	4.6%
SFY 2007	11,252,170,760	17.6%	2.3%	11,108,696,561	17.7%	143,474,200	13.2%
SFY 2008	11,596,523,640	3.1%	2.6%	11,449,927,697	3.1%	153,239,123	6.8%

PROGRAM EXPENDITURES					
STATE FISCAL YEAR	Federal Share	State Share	County Share	Other State	Certfied Public Expend.
SFY 2004	62.6%	24.1%	4.1%	8.2%	1.1%
SFY 2005	59.7%	24.9%	4.4%	9.8%	1.2%
SFY 2006	57.2%	26.2%	4.5%	6.2%	5.9%
SFY 2007	54.7%	23.5%	4.1%	7.4%	10.3%
SFY 2008	55.2%	25.1%	3.6%	6.8%	9.4%

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.

(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 Authorized Budget Report, Budget Code 14445

Table 6

A History of N.C. Medicaid Eligibility SFYs 1979 - 2008

Fiscal Years	Aged	Blind	Disabled	AFDC Adults & Children	Other Children	Pregnant Women	Infants & Children	Qualified Medicare Beneficiaries	Aliens and Refugees	Breast Cervical Cancer	MSCHIP	Total	Percent Change
1978-79	82,930	3,219	59,187	301,218	6,620	N/A	N/A	N/A	N/A	N/A	59,187	453,174	
1979-80	82,859	2,878	56,265	307,059	6,641	N/A	N/A	N/A	N/A	N/A	56,265	455,702	0.56%
1980-81	80,725	2,656	56,773	315,651	6,559	N/A	N/A	N/A	N/A	N/A	56,773	459,364	0.80%
1981-82	70,010	2,349	48,266	298,483	6,125	N/A	N/A	N/A	N/A	N/A	48,266	425,233	-7.43%
1982-83	67,330	2,000	46,537	293,623	6,062	N/A	N/A	N/A	N/A	N/A	46,537	415,552	-2.28%
1983-84	65,203	1,755	46,728	288,619	5,501	N/A	N/A	N/A	N/A	N/A	46,728	407,806	-1.86%
1984-85	65,849	1,634	48,349	293,188	5,333	N/A	N/A	N/A	N/A	N/A	48,349	414,353	1.61%
1985-86	69,193	1,554	51,959	313,909	5,315	N/A	N/A	N/A	N/A	N/A	51,959	441,930	6.66%
1986-87	72,295	1,462	54,924	317,983	5,361	N/A	N/A	N/A	N/A	N/A	54,924	452,025	2.28%
1987-88	76,308	1,394	58,258	323,418	5,563	9,842	6,543	N/A	N/A	N/A	58,258	481,326	6.48%
1988-89	80,044	1,304	62,419	352,321	6,009	20,277	19,615	19,064	561	N/A	62,419	561,614	16.68%
1989-90	80,266	1,220	64,875	387,882	5,176	28,563	36,429	33,929	1,011	N/A	64,875	639,351	13.84%
1990-91	81,466	1,116	70,397	451,983	4,296	37,200	61,210	42,949	1,675	N/A	70,397	753,292	17.82%
1991-92	83,337	1,064	79,282	513,023	4,139	43,330	94,922	56,871	1,955	N/A	79,282	877,923	16.54%
1992-93	85,702	1,003	87,664	562,661	4,133	45,629	132,348	71,120	2,437	N/A	87,664	992,697	13.07%
1993-94	86,111	929	90,889	581,397	4,100	46,970	162,417	83,460	2,330	N/A	90,889	1,058,603	6.64%
1994-95	127,514	2,716	155,215	533,300	3,808	48,115	216,888	48,373	2,857	N/A	155,215	1,138,786	7.57%
1995-96	131,496	2,710	171,204	496,501	3,696	52,466	261,525	53,072	3,919	N/A	171,204	1,176,589	3.32%
1996-97	132,173	2,593	176,160	462,881	3,747	55,838	295,882	58,036	4,823	N/A	176,160	1,192,133	1.32%
1997-98	131,332	2,531	180,461	414,853	3,905	58,899	337,849	61,032	6,311	N/A	180,461	1,197,173	0.42%
1998-99	152,582	2,497	199,523	344,621	3,941	60,896	371,986	32,737	8,036	N/A	199,523	1,176,819	-1.70%
1999-00	154,222	2,428	205,205	330,113	4,063	60,918	421,158	33,302	9,857	N/A	205,205	1,221,266	3.78%
2000-01	154,284	2,357	212,798	450,472	4,195	57,318	424,436	36,053	12,680	N/A	212,798	1,354,593	10.92%
2001-02	153,282	2,334	221,813	456,232	4,737	53,009	444,299	39,799	14,523	N/A	221,813	1,390,028	2.62%
2002-03	151,672	2,226	228,159	478,842	4,881	51,111	474,557	41,030	14,805	N/A	228,159	1,447,283	4.12%
2003-04	151,478	2,177	238,810	485,856	4882	53,768	517,251	42,413	15,528	N/A	238,810	1,512,360	4.50%
2004-05	151,512	2,130	249,921	468,711	5366	57,190	567,060	44,130	17,496	N/A	249,921	1,563,751	3.40%
2005-06	149,961	2,084	257,344	468,662	5,511	58,518	588,417	52,895	18,980	41,812	257,344	1,644,457	5.16%
2006-07	147,813	1,988	261,594	451,053	5,599	60,016	622,292	56,612	20,731	54,009	261,594	1,682,028	2.28%
2007-08	145,898	1,923	267,843	451,186	5,746	59,628	655,311	59,428	21,626	57,396	267,843	1,726,412	2.64%
SFY 2007 Percent Total Eligibles:	8.8%	0.1%	15.6%	26.8%	0.3%	3.6%	37.0%	3.4%	1.2%	3.2%	15.6%	100.0%	
SFY 2008 Percent Total Eligibles:	8.5%	0.1%	15.5%	26.1%	0.3%	3.5%	38.0%	3.4%	1.3%	3.3%	15.5%	100.0%	

Source: EJA752 Report, Unduplicated Medicaid Eligibles

Table 7

N.C. Medicaid Eligibility and Program Expenditures for Which the County is Responsible for Its Computable Share (1) SFY 2008

COUNTY NAME	2007 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES (2)	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 2007 POPULATION
ALAMANCE	143,154	26,858	$ 138,610,831	$ 5,161	$ 968	66	188	18.76%
ALEXANDER	36,656	6,601	31,403,413	4,757	857	85	180	18.01%
ALLEGHANY	11,088	2,391	14,906,538	6,234	1,344	31	216	21.56%
ANSON	25,332	6,930	51,113,465	7,376	2,018	7	274	27.36%
ASHE	26,003	5,480	32,788,383	5,983	1,261	41	211	21.07%
AVERY	18,292	3,256	17,071,345	5,243	933	75	178	17.80%
BEAUFORT	46,070	11,506	76,232,751	6,625	1,655	17	250	24.98%
BERTIE	19,971	6,340	48,112,021	7,589	2,409	1	317	31.75%
BLADEN	32,500	10,249	60,310,384	5,885	1,856	12	315	31.54%
BRUNSWICK	99,440	18,357	88,215,218	4,806	887	80	185	18.46%
BUNCOMBE	225,609	42,601	248,455,220	5,832	1,101	53	189	18.88%
BURKE	88,439	18,288	99,622,875	5,447	1,126	48	207	20.68%
CABARRUS	164,384	26,959	115,537,769	4,286	703	92	164	16.40%
CALDWELL	79,376	17,213	89,025,312	5,172	1,122	49	217	21.69%
CAMDEN	9,519	1,161	5,953,257	5,128	625	95	122	12.20%
CARTERET	63,294	9,919	55,314,677	5,577	874	82	157	15.67%
CASWELL	23,508	5,565	31,243,082	5,614	1,329	32	237	23.67%
CATAWBA	153,404	28,587	131,278,373	4,592	856	86	186	18.64%
CHATHAM	59,168	8,297	44,505,584	5,364	752	88	140	14.02%
CHEROKEE	27,026	5,889	34,581,356	5,872	1,280	38	218	21.79%
CHOWAN	14,660	3,733	25,163,089	6,741	1,716	15	255	25.46%
CLAY	10,326	2,096	10,700,439	5,105	1,036	58	203	20.30%
CLEVELAND	97,144	25,476	145,143,603	5,697	1,494	21	262	26.22%
COLUMBUS	54,460	18,130	113,454,276	6,258	2,083	6	333	33.29%
CRAVEN	96,406	17,331	102,378,339	5,907	1,062	56	180	17.98%
CUMBERLAND	313,616	64,616	302,768,287	4,686	965	68	206	20.60%
CURRITUCK	23,731	2,945	14,837,182	5,038	625	96	124	12.41%
DARE	34,272	3,985	21,208,692	5,322	619	97	116	11.63%
DAVIDSON	156,400	31,118	143,475,348	4,611	917	76	199	19.90%
DAVIE	40,447	5,650	28,491,703	5,043	704	91	140	13.97%
DUPLIN	53,133	13,235	66,341,292	5,013	1,249	42	249	24.91%
DURHAM	254,740	44,081	263,123,527	5,969	1,033	59	173	17.30%
EDGECOMBE	51,813	19,210	104,291,052	5,429	2,013	8	371	37.08%
FORSYTH	338,679	61,261	306,269,211	4,999	904	78	181	18.09%
FRANKLIN	56,456	11,636	61,056,656	5,247	1,081	54	206	20.61%
GASTON	200,972	44,759	255,098,542	5,699	1,269	40	223	22.27%
GATES	11,819	2,173	10,686,368	4,918	904	79	184	18.39%
GRAHAM	8,144	2,281	14,777,309	6,478	1,815	13	280	28.01%
GRANVILLE	55,667	9,968	52,558,103	5,273	944	71	179	17.91%
GREENE	21,110	4,823	27,658,157	5,735	1,310	36	228	22.85%
GUILFORD	460,780	84,621	395,930,803	4,679	859	84	184	18.36%
HALIFAX	55,352	18,406	104,895,358	5,699	1,895	11	333	33.25%
HARNETT	106,506	21,497	103,167,018	4,799	969	65	202	20.18%
HAYWOOD	57,031	11,722	63,428,268	5,411	1,112	52	206	20.55%
HENDERSON	102,142	16,065	90,356,070	5,624	885	81	157	15.73%
HERTFORD	23,730	7,290	46,036,698	6,315	1,940	9	307	30.72%
HOKE	42,932	9,956	49,040,299	4,926	1,142	47	232	23.19%
HYDE	5,447	1,388	8,256,726	5,949	1,516	20	255	25.48%
IREDELL	150,421	24,506	113,052,842	4,613	752	89	163	16.29%
JACKSON	36,815	6,232	31,784,711	5,100	863	83	169	16.93%
JOHNSTON	157,296	31,596	143,440,871	4,540	912	77	201	20.09%
JONES	10,315	2,311	14,734,352	6,376	1,428	23	224	22.40%
LEE	56,376	12,133	54,834,227	4,519	973	64	215	21.52%
LENOIR	57,642	16,208	93,934,138	5,796	1,630	18	281	28.12%

Table 7 (cont.)

N.C. Medicaid Eligibility and Program Expenditures for Which the County is Responsible for Its Computable Share (1) SFY 2008

COUNTY NAME	2007 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES (2)	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 2007 POPULATION
LINCOLN	72,776	12,423	68,185,013	5,489	937	74	171	17.07%
MACON	33,626	6,562	33,628,089	5,125	1,000	61	195	19.51%
MADISON	20,495	4,611	27,180,552	5,895	1,326	33	225	22.50%
MARTIN	23,906	6,991	51,258,447	7,332	2,144	4	292	29.24%
MCDOWELL	44,064	9,699	50,974,935	5,256	1,157	46	220	22.01%
MECKLENBURG	863,147	139,391	644,308,134	4,622	746	90	161	16.15%
MITCHELL	15,950	3,431	21,003,676	6,122	1,317	35	215	21.51%
MONTGOMERY	27,588	7,370	36,032,543	4,889	1,306	37	267	26.71%
MOORE	83,932	13,204	69,119,404	5,235	824	87	157	15.73%
NASH	92,915	20,371	103,829,945	5,097	1,117	50	219	21.92%
NEW HANOVER	189,922	29,133	177,969,309	6,109	937	73	153	15.34%
NORTHAMPTON	21,235	6,874	44,862,348	6,526	2,113	5	324	32.37%
ONSLOW	169,302	22,700	110,521,275	4,869	653	93	134	13.41%
ORANGE	127,344	12,722	82,306,750	6,470	646	94	100	9.99%
PAMLICO	12,947	2,540	17,625,493	6,939	1,361	28	196	19.62%
PASQUOTANCK	40,880	8,808	45,658,108	5,184	1,117	51	215	21.55%
PENDER	50,430	9,439	48,633,811	5,152	964	70	187	18.72%
PERQUIMANS	12,722	2,906	13,654,011	4,699	1,073	55	228	22.84%
PERSON	37,640	8,212	48,040,550	5,850	1,276	39	218	21.82%
PITT	151,970	30,258	216,715,858	7,162	1,426	24	199	19.91%
POLK	19,040	2,918	19,308,393	6,617	1,014	60	153	15.33%
RANDOLPH	139,422	29,060	134,729,386	4,636	966	67	208	20.84%
RICHMOND	46,672	14,326	75,550,772	5,274	1,619	19	307	30.70%
ROBESON	129,425	45,988	301,049,853	6,546	2,326	2	355	35.53%
ROCKINGHAM	91,646	20,820	107,517,331	5,164	1,173	45	227	22.72%
ROWAN	136,486	27,658	128,768,600	4,656	943	72	203	20.26%
RUTHERFORD	62,926	15,425	85,561,487	5,547	1,360	29	245	24.51%
SAMPSON	64,522	17,863	90,953,104	5,092	1,410	25	277	27.69%
SCOTLAND	36,830	12,721	70,595,083	5,549	1,917	10	345	34.54%
STANLY	59,158	11,286	57,584,440	5,102	973	63	191	19.08%
STOKES	46,257	8,042	44,642,052	5,551	965	69	174	17.39%
SURRY	73,150	16,581	89,126,285	5,375	1,218	43	227	22.67%
SWAIN	13,889	3,722	18,856,126	5,066	1,358	30	268	26.80%
TRANSYLVANIA	30,758	5,430	30,609,834	5,637	995	62	177	17.65%
TYRRELL	4,290	1,084	6,280,885	5,794	1,464	22	253	25.27%
UNION	182,344	24,075	98,237,131	4,080	539	100	132	13.20%
VANCE	43,583	15,612	78,620,042	5,036	1,804	14	358	35.82%
WAKE	832,590	93,773	451,802,280	4,818	543	99	113	11.26%
WARREN	19,919	5,778	33,177,416	5,742	1,666	16	290	29.01%
WASHINGTON	13,214	4,371	29,096,427	6,657	2,202	3	331	33.08%
WATAUGA	44,696	4,365	24,309,642	5,569	544	98	98	9.77%
WAYNE	115,225	27,504	137,481,246	4,999	1,193	44	239	23.87%
WILKES	67,182	14,977	88,618,299	5,917	1,319	34	223	22.29%
WILSON	77,970	19,821	109,493,189	5,524	1,404	26	254	25.42%
YADKIN	37,850	6,760	39,486,798	5,841	1,043	57	179	17.86%
YANCEY	18,550	3,922	25,505,357	6,503	1,375	27	211	21.14%
State Total	**9,069,398**	**1,726,412**	**$ 9,085,125,122**	**$ 5,262**	**$ 1,002**		**190**	**19.04%**

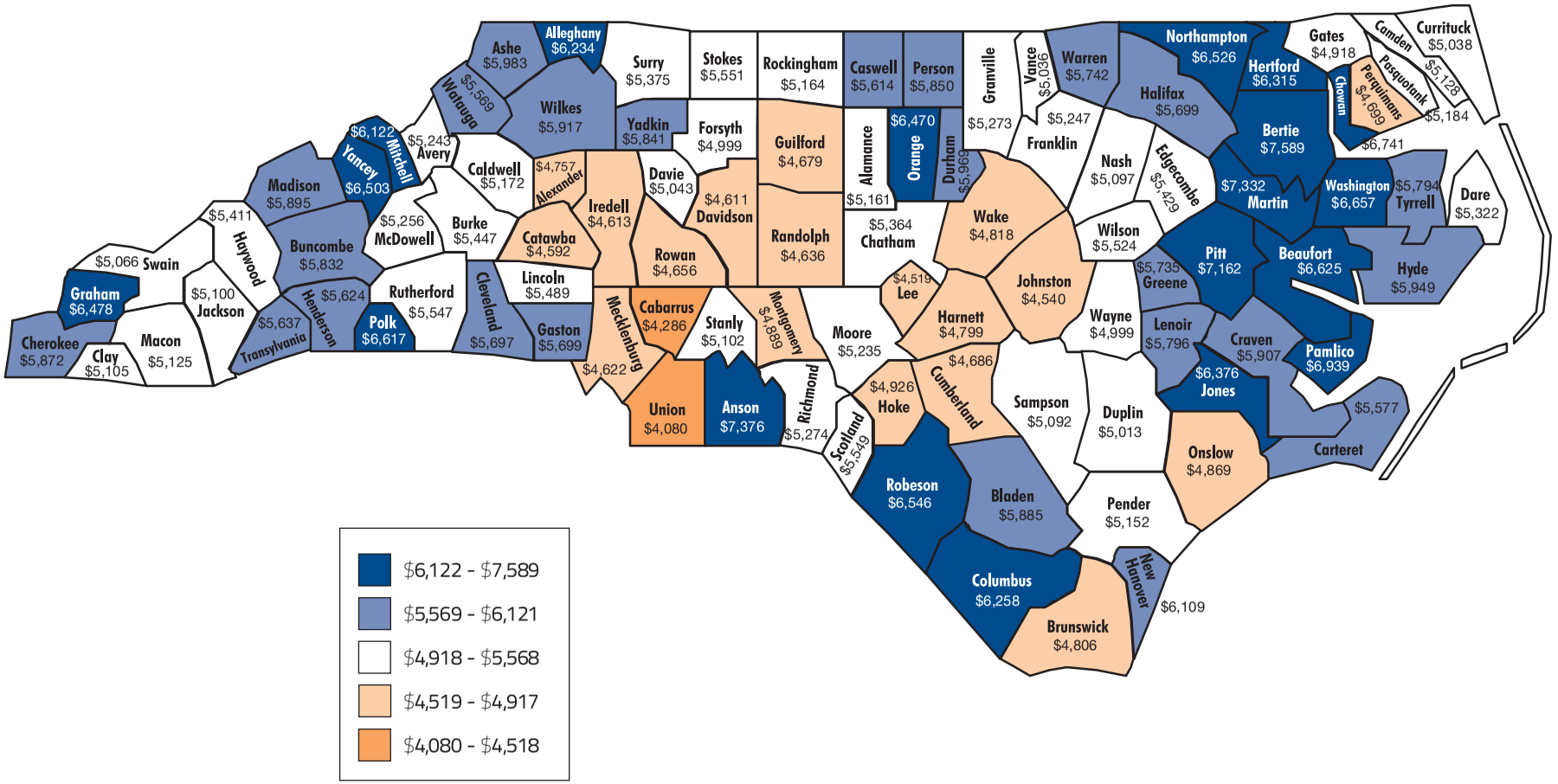
Notes:

(1) Expenditures' reflect net payments for which the county is responsible for its computable share, not Program Expenditures as reported in Tables 5 and 8.

(2) Eligibles' is a statewide unduplicated count indicating eligibility in the last county of residence during the fiscal year.

Source: Medicaid Cost Calculation Fiscal YTD June 2007.

Medicaid Expenditures per Eligible by County, SFY 2008



Medicaid Eligibles per 1,000 Population by County, SFY 2008

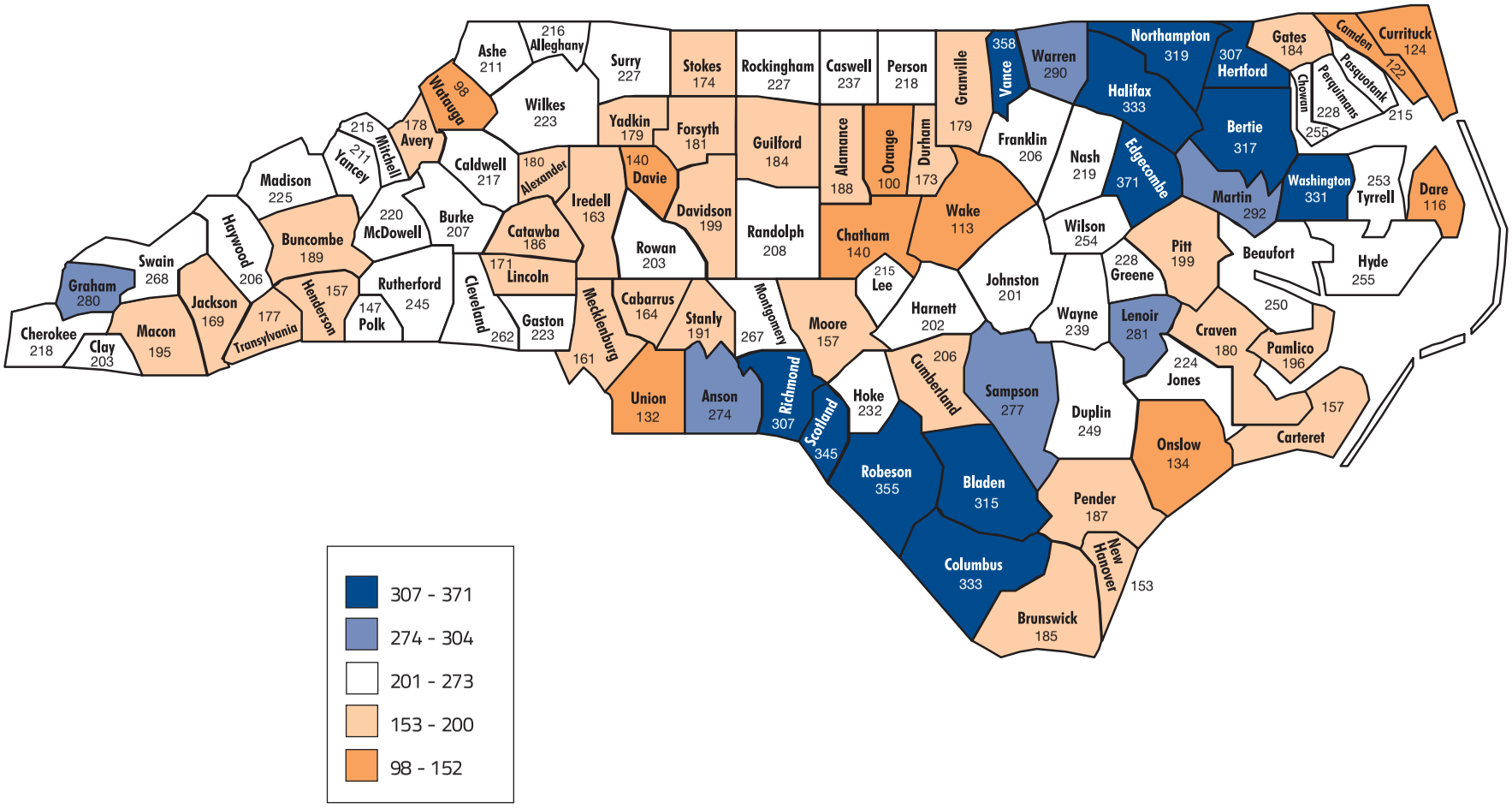


Table 8

North Carolina Medicaid Expenditures SFY 2008

Claims	Expenditures	Percentage of Claims and Premiums Paid	Percentage of Claims Paid	SFY 2008 Number of Recipients (1)	SFY 2008 Expenditures per Recipient	SFY 2007 Number of Recipients (1)	SFY 2007 Expenditures per Recipient
Inpatient Hospital	$ 1,073,691,222	11.3%	12.2%	232,192	$ 4,624	292,366	$ 3,485
Outpatient Hospital	657,311,343	6.9%	7.5%	786,550	836	770,748	810
Mental Hospital (> 65)	3,689,306	0.0%	0.0%	145	25,443	209	37,081
Psychiatric Hospital (<21)	61,375,560	0.6%	0.7%	2,936	20,904	2,827	18,072
Physician	903,005,553	9.5%	10.3%	1,664,915	542	1,516,925	563
Clinics	265,738,515	2.8%	3.0%	448,642	592	461,213	597
Nursing Facility	1,068,012,860	11.3%	12.2%	41,782	25,562	42,721	24,697
Intermediate Care Facility (Mentally Retarded)	471,169,626	5.0%	5.4%	4,168	113,045	4,157	106,408
Dental	269,692,850	2.8%	3.1%	574,718	469	535,545	449
Prescribed Drugs	973,762,882	10.3%	11.1%	1,045,084	932	1,023,202	901
Home Health	252,816,839	2.7%	2.9%	296,490	853	258,262	859
CAP/Disabled Adult	267,959,803	2.8%	3.1%	14,455	18,538	14,662	17,521
CAP/Mentally Retarded	427,977,911	4.5%	4.9%	10,043	42,615	9,497	39,603
CAP/Children	35,573,672	0.4%	0.4%	905	39,308	809	38,065
Personal Care	318,722,026	3.4%	3.6%	51,018	6,247	51,564	5,813
Hospice	54,324,979	0.6%	0.6%	6,022	9,021	5,836	9,607
EPSDT (Health Check)	63,326,326	0.7%	0.7%	888,137	71	810,924	73
Lab & X-ray	54,198,513	0.6%	0.6%	407,401	133	379,901	121
Adult Home Care	168,197,354	1.8%	1.9%	28,877	5,825	28,679	5,453
High Risk Intervention Residential	159,693,090	1.7%	1.8%	4,320	36,966	3,952	36,376
Behavioral Health Community Support (Professional Services)	823,907,297	8.7%	9.4%	81,515	10,107	64,604	12,508
Behavioral Health Community Support (Other Services)	124,440,897	1.3%	1.4%	37,599	3,310	35,774	2,316
Other Behavioral Health Independent Practitioners	68,000,692	0.7%	0.8%	114,811	592	93,796	566
Other Services	201,603,384	2.1%	2.3%	522,952	386	495,054	388
Claims Paid	**$ 8,768,192,497**	**92.5%**	**100.0%**				
Premiums							
Medicare, Part A Premiums	53,411,065	0.6%					
Medicare, Part B Premiums	318,382,153	3.4%					
Medicare, Part D Payments	231,829,138	2.4%					
HMO Premiums	102,624,480	1.1%					
Premiums Paid	**$ 706,246,836**	**7.5%**					
Total Claims and Premiums Paid	**$ 9,474,439,333**	**100.0%**					
Adjustments, Cost Settlements and Transfers	1,480,231,224						
Disproportionate Share Hospital Payments	454,297,796						
County Transportation and Program Costs	34,316,165						
Total Program Expenditures	**$ 11,443,284,517**						
Administrative Expenditures	153,239,123						
Total Expenditures	**$ 11,596,523,640**						
Total Recipients (Unduplicated) (2)				**1,805,254**		**1,684,411**	
Total Expenditures per Recipient (Unduplicated)					**$ 6,424**		**$ 6,680**

(1) The term "recipient" refers to an individual who is eligible for Medicaid and who actually received at least one service during a given fiscal year.

(2) The number of "Total Recipients" is unduplicated for all services, and includes recipients only once regardless of the number or types of services they used during the fiscal year.

Table 9

North Carolina Medicaid Claim and Premium Expenditures by Eligibility Category SFY 2008

Eligibility Group	Expenditures	Percent of Expenditures	Unduplicated Recipients	Percent of Recipients	SFY 2008 Expenditures Per Recipient	SFY 2007 Expenditures Per Recipient	07/08 Percent Change
Total Elderly	$ **2,019,503,089**	**21.3%**	**237,091**	**13.1%**	$**8,518**	$**9,254**	**-8.0%**
Aged	1,956,356,078	20.6%	177,836	9.9%	11,001	12,313	-10.7%
Medicare-Aid (MQBQ & MQBB & MQBE) (1)	63,147,011	0.7%	59,255	3.3%	1,066	1,060	0.5%
Total Disabled	$ **4,150,259,450**	**43.8%**	**280,215**	**15.5%**	$**14,811**	$**14,672**	**0.9%**
Disabled	4,118,710,461	43.5%	278,143	15.4%	14,808	14,667	1.0%
Blind	31,548,989	0.3%	2,072	0.1%	15,226	15,395	-1.1%
Total Families &Children	$ **3,263,131,932**	**34.4%**	**1,262,188**	**69.9%**	$**2,585**	$**2,569**	**0.6%**
AFDC Adults (>21) (2)	771,557,848	8.1%	243,419	13.5%	3,170	3,162	0.2%
Medicaid Pregnant Women (MPW)	265,828,998	2.8%	60,174	3.3%	4,418	4,085	8.1%
AFDC Children & Other Children	754,016,176	8.0%	213,785	11.8%	3,527	3,380	4.3%
Medicaid Infants & Children (MIC)	1,391,113,212	14.7%	682,955	37.8%	2,037	2,019	0.9%
Breast and Cervical	8,339,710	0.1%	441	0.0%	18,911	18,727	1.0%
M-SCHIP (3)	72,275,987	0.8%	61,414	3.4%	1,177	1,205	-2.3%
Aliens and Refugees	$ **74,311,560**	**0.8%**	**25,328**	**1.4%**	$**2,934**	$**2,545**	**15.3%**
Subtotal	9,507,206,031	100.3%	1,804,822	100.0%			
Adjustments Not Attributable to an Eligibility Category	(32,766,698)	-0.3%	432	0.0%			
Total Claim and Premium Expenditures	**9,474,439,333**	**100.0%**	**1,805,254**	**100.0%**			
Other Program and Administrative Expenditures	2,122,084,307						
Total Expenditures	$ **11,596,523,640**						

(1) "MQB" designates Medicare Qualified Beneficiaries; the count includes all eligible individuals whose Medicare premiums were paid by NC Medicaid, as well as those individuals whose Medicare premiums were paid and who also received medical services during the fiscal year.

(2) Includes individuals age 21 & over under TANF or AFDC-related coverage or Family Planning Waiver.

(3) M-SCHIP designates the NC Health Choice children, age 0 through 5, who were transitioned to NC Medicaid.

Source: SFY 2008 Program Expenditure Report (PER), BD701 Budget Report, and State 2082 Report.

Table 10

N.C. Medicaid Claim and Premium Expenditures for Medical Services by Eligibility Category
SFY 2008

Claims	Total (1)	Percent of Claim and Premium Expenditures	Aged	MQBQ (2) Medicare Qualified Beneficiary	MQBB+MQBE Part B Only	Blind	Disabled	Other Adult (3)	Children (4)	M-SCHIP (5)	Breast & Cervical Cancer	Aliens & Refugees	Adjustments Unattributable to an Eligibility Category
Inpatient Hospital	$ 1,073,691,222	11.3%	$ 13,309,778	$ 30,811	$ 7,905	$ 1,363,966	$ 484,148,820	$ 244,944,921	$ 283,339,738	$ 4,082,378	$ 625,716	$ 50,043,055	$ (8,205,865)
Outpatient Hospital	657,311,343	6.9%	19,491,797	83,304	0	1,124,192	253,379,579	185,837,138	180,461,109	10,915,185	3,952,040	3,479,063	(1,412,063)
Mental Hospital (> 65)	3,689,306	0.0%	3,715,128	0	0	0	0	0	0	0	0	0	(25,822)
Psychiatric Hospital (< 21)	61,375,560	0.6%	0	0	0	0	20,953,219	13,022	40,456,306	7,253	0	0	(54,240)
Physician	903,005,553	9.5%	47,629,339	197,604	45	1,260,522	275,426,491	222,687,861	324,647,445	18,411,446	2,717,541	13,801,756	(3,774,498)
Clinics	265,738,515	2.8%	11,414,522	32,828	0	684,356	111,608,718	36,127,281	100,468,220	3,175,117	19,681	3,118,747	(910,954)
Nursing Facility	1,068,012,860	11.3%	898,236,766	217	261	2,335,058	166,824,892	336,304	29,506	0	0	615,446	(365,591)
Intermediate Care Facility (Mentally Retarded)	471,169,626	5.0%	36,343,137	0	0	7,842,431	424,809,447	12,540	2,133,726	0	0	29,088	(743)
Dental	269,692,850	2.8%	13,433,341	0	0	268,180	53,440,528	49,846,541	145,196,614	7,046,822	83,162	636,541	(258,879)
Prescribed Drugs	973,762,882	10.3%	8,938,431	0	0	2,548,856	523,899,546	155,633,622	268,935,869	12,909,972	655,861	466,101	(225,377)
Home Health	252,816,839	2.7%	42,901,525	25,604	0	1,491,754	169,417,657	15,846,177	21,980,562	1,087,838	103,436	436,685	(474,399)
CAP/Disabled Adult	267,959,803	2.8%	183,128,049	0	0	1,861,983	82,930,778	0	3,981	0	0	42,711	(7,700)
CAP/Mentally Retarded	427,977,911	4.5%	9,651,234	0	0	3,339,128	411,152,513	0	3,924,339	0	0	0	(89,303)
CAP/Children	35,573,672	0.4%	0	0	0	369,724	34,238,790	0	981,706	0	0	0	(16,548)
Personal Care	318,722,026	3.4%	154,397,356	0	0	2,442,751	153,607,640	6,663,821	1,623,689	38,548	9,954	22,584	(84,317)
Hospice	54,324,979	0.6%	49,693,551	0	0	92,404	16,760,526	440,656	238,101	8,691	43,565	45,868	(12,998,382)
EPSDT (Health Check)	63,326,326	0.7%	54	0	0	5,198	1,667,084	60,332	58,047,304	3,566,056	9	13,541	(33,253)
Lab & X-ray	54,198,513	0.6%	584,901	825	0	53,024	10,695,426	25,879,152	16,383,266	396,947	54,194	195,254	(44,475)
Adult Home Care	168,197,354	1.8%	98,521,357	0	0	241,867	69,368,241	43,496	50,426	0	0	561	(28,594)
High Risk Intervention Residential	159,693,090	1.7%	0	0	0	0	46,214,907	0	113,510,363	0	0	0	(32,181)
Behavioral Health Community Support (Professional Services)	823,907,297	8.7%	11,667,748	0	0	671,448	355,051,040	32,638,431	421,721,290	2,090,968	23,639	42,732	0
Behavioral Health Community Support (Other Services)	124,440,897	1.3%	2,717,062	0	0	112,657	78,318,976	10,312,742	32,007,899	960,546	9,328	1,688	0
Other Behavioral Health Independent Practitioners	68,000,692	0.7%	849,058	565	0	68,802	19,154,598	7,232,867	40,132,628	544,101	10,393	7,679	0
Other Services	201,603,384	2.1%	20,105,522	27,410	110	371,909	70,710,871	38,297,544	68,850,272	6,326,042	27,709	1,161,024	(4,275,029)
Claims Paid	**$ 8,768,192,497**	**92.55%**	**$ 1,626,729,656**	**$ 399,168**	**$ 8,321**	**$ 28,550,208**	**$ 3,833,780,286**	**$ 1,032,854,445**	**$ 2,125,124,360**	**$ 71,567,911**	**$ 8,336,230**	**$ 74,160,125**	**$ (33,318,212)**
Premiums													
Medicare, Part A Premiums	53,411,065	0.6%	52,738,324	14,597	(423)	460,420	846	0	0	0	0	0	197,301
Medicare, Part B Premiums	318,382,153	3.4%	141,555,150	1,010,630	59,201,709	1,123,860	114,125,043	903,526	15,618	1,142	0	91,262	354,213
Medicare, Part D Payments	231,829,138	2.4%	132,135,031	160,931	2,352,079	972,197	95,747,763	388,012	12,864	88	0	60,173	0
HMO Premiums	102,624,480	1.1%	3,197,917	0	0	442,304	75,056,523	3,240,863	19,976,547	706,846	3,480	0	0
Premiums Paid	**$ 706,246,836**	**7.45%**	**$ 329,626,422**	**$ 1,186,158**	**$ 61,553,365**	**$ 2,998,781**	**$ 284,930,175**	**$ 4,532,400**	**$ 20,005,029**	**$ 708,076**	**$ 3,480**	**$ 151,435**	**$ 551,514**
Total Claims and Premiums Paid	**$ 9,474,439,333**	**100.0%**	**$ 1,956,356,078**	**$ 1,585,325**	**$ 61,561,686**	**$ 31,548,989**	**$ 4,118,710,461**	**$ 1,037,386,846**	**$ 2,145,129,388**	**$ 72,275,987**	**$ 8,339,710**	**$ 74,311,560**	**$ (32,766,698)**
Adjustments, Cost Settlements and Transfers	1,480,231,224												
Disproportionate Share Hospital Payments	454,297,796												
County Transportation and Program Costs	34,316,165												
Total Program Expenditures	**$ 11,443,284,517**												
Administrative Expenditures	153,239,123												
Total Expenditures	**$ 11,596,523,640**												

Source for Claim and Premium Expenditures (Other than Medicare Part D): SFY 2008 Program Expenditure Reports
Source for Medicare Part D Payments: SFY 2008 BD701 Report. Amounts are allocated to program groups based on the recipient's eligibility status at the end of the fiscal year
(1) Expenditures reported in the Program Expenditure Report relate to claims paid by MMIS during the fiscal year and are not identical with the financial data reported from the BD 701 Budget Report on Table 8.
(2) Reflects expenditures for those who were eligible as QMBs (Medicare-covered services only) at the end of the year. As a result, expenditures might include more categories of services than are available through QMB coverage.
(3) Includes individuals covered under SOBRA Pregnant Women policies, or individuals age 21 & over under TANF or AFDC-related coverage, or the Family Planning Waiver.
(4) Includes SOBRA Children, individuals under age 21 in TANF or AFDC-related coverages, or other children in foster care.
(5) Medicaid for children transferred from the State Children's Health Insurance Program
(6) The adjustment related to Hospice expenditures is a recoupment of provider overpayments.

Table 11

N.C. Medicaid Claim and Premium Expenditures for the Elderly SFY 2008

Claims	Aged	Percent of Dollars Used	MQBQ Medicare Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Total Qualified Beneficiaries	Percent of Dollars	Total Elderly Dollars	SFY 2008 % of Total Dollars	SFY 2007 % of Total Dollars	SFY 2006 % of Total Dollars
Inpatient Hospital	$ 13,309,778	0.68%	$ 30,811	$ 7,905	$ 38,716	0.06%	$ 13,348,495	0.66%	0.62%	0.55%
Outpatient Hospital	19,491,797	1.00%	83,304	-	83,304	0.13%	19,575,100	0.97%	1.02%	0.99%
Mental Hospital (> 65)	3,715,128	0.19%	-	-	-	-	3,715,128	0.18%	0.39%	0.29%
Psychiatric Hospital (< 21)	-	-	-	-	-	-	-			
Physician	47,629,339	2.43%	197,604	45	197,649	0.31%	47,826,988	2.37%	2.29%	2.28%
Clinics	11,414,522	0.58%	32,828	-	32,828	0.05%	11,447,350	0.57%	0.55%	0.65%
Nursing Facility	898,236,766	45.91%	217	261	478	0.00%	898,237,245	44.48%	45.65%	42.76%
Intermediate Care Facility for Mental Retardation	36,343,137	1.86%	-	-	-	-	36,343,137	1.80%	1.57%	1.22%
Dental	13,433,341	0.69%	-	-	-	-	13,433,341	0.67%	0.63%	0.49%
Prescribed Drugs	8,938,431	0.46%	-	-	-	-	8,938,431	0.44%	0.43%	13.26%
Home Health	42,901,525	2.19%	25,604	-	25,604	0.04%	42,927,129	2.13%	2.01%	1.81%
CAP/Disabled Adult	183,128,049	9.36%	-	-	-	-	183,128,049	9.07%	9.04%	8.61%
CAP/Mentally Retarded	9,651,234	0.49%	-	-	-	-	9,651,234	0.48%	0.42%	0.26%
CAP/Children	-	-	-	-	-	-	-			
Personal Care	154,397,356	7.89%	-	-	-	-	154,397,356	7.65%	7.66%	7.32%
Hospice	49,693,551	2.54%	-	-	-	-	49,693,551	2.46%	1.92%	1.64%
EPSDT (Health Check)	54	0.00%	-	-	-	-	54	0.00%	0.00%	0.00%
Laboratory & Imaging Services	584,901	0.03%	825	-	825	0.00%	585,726	0.03%	0.03%	0.04%
Adult Home Care	98,521,357	5.04%	-	-	-	-	98,521,357	4.88%	4.52%	3.94%
High Risk Intervention Residential	-	-	-	-	-	-	-			
Behavioral Health Community Support (Professional Services) (3)	11,667,748	0.60%	-	-	-	-	11,667,748	0.58%		
Behavioral Health Community Support (Other Services) (3)	2,717,062	0.14%	-	-	-	-	2,717,062	0.13%		
Other Behavioral Health Independent Practitioners (3)	849,058	0.04%	565	-	565	0.00%	849,623	0.04%		
Other Services	20,105,522	1.03%	27,410	110	27,520	0.04%	20,133,042	1.00%	1.90%	0.92%
Claims Paid	**$ 1,626,729,656**	**83.15%**	**$ 399,168**	**$ 8,321**	**$ 407,488**	**0.65%**	**$ 1,627,137,145**	**80.57%**	**80.65%**	**87.04%**
Premiums										
Medicare, Part A Premiums	52,738,324	2.70%	14,597	(423)	14,174	0.02%	52,752,498	2.61%	2.60%	2.27%
Medicare, Part B Premiums	141,555,150	7.24%	1,010,630	59,201,709	60,212,339	95.35%	201,767,489	9.99%	9.86%	8.04%
Medicare, Part D Premiums (1)	132,135,031	6.75%	160,931	2,352,079	2,513,010	3.98%	134,648,040	6.67%	6.74%	2.52%
HMO Premiums	3,197,917	0.16%	-	-	-	-	3,197,917	0.16%	0.15%	0.13%
Premiums Paid	**$ 329,626,422**	**16.85%**	**$ 1,186,158**	**$ 61,553,365**	**$ 62,739,523**	**99.35%**	**$ 392,365,944**	**19.43%**	**19.35%**	**12.96%**
Total Claims and Premiums Paid	**$ 1,956,356,078**	**100.00%**	**$ 1,585,325**	**$ 61,561,686**	**$ 63,147,011**	**100.00%**	**$ 2,019,503,089**	**100.00%**	**100.00%**	**100.00%**
Medicare Crossovers included above (2)	**$ 108,107,460**		**$ 399,167**	**$ 6,682**	**$ 405,849**		**$ 108,513,309**			
Unduplicated Service Recipients	**173,551**		**830**	**12,907**	**13,737**		**187,288**			
Claim Expenditures Per Service Recipient	**$ 9,373**		**$ 481**	**$ 1**	**$ 30**		**$ 8,688**			
Unduplicated Recipients	**177,836**		**1,130**	**58,125**	**59,255**		**237,091**			
Total Claims and Premiums Paid Per Recipient	**$ 11,001**		**$ 1,403**	**$ 1,059**	**$ 1,066**		**$ 8,518**			

(1) Source for Medicare Part D Payments: SFY 2008 BD701 Report. Amounts are allocated to program groups based on the recipient's eligibility status at the end of the fiscal year.
(2) Medicare Crossovers are amounts that Medicare bills Medicaid for those Medicare recipients who are also eligible for Medicaid.
(3) This item was not recorded separately in previous fiscal years.
Source: SFY 2008 Program Expenditure Report (HMGR0901)

Table 12

N.C. Medicaid Claim and Premium Expenditures for the Blind and Disabled SFY 2008

Claims	Disabled	Percent of Dollars	Blind	Percent of Dollars	Total Blind & Disabled Dollars	SFY 2008 % of Total Dollars	SFY 2007 % of Total Dollars	SFY 2006 % of Total Dollars
Inpatient Hospital	$ 484,148,820	11.8%	$ 1,363,966	4.3%	$ 485,512,785	11.7%	11.6%	12.4%
Outpatient Hospital	253,379,579	6.2%	1,124,192	3.6%	254,503,771	6.1%	6.2%	6.3%
Mental Hospital (> 65)	-	0.0%	-	0.0%	-	0.0%	0.0%	0.0%
Psychiatric Hospital (< 21)	20,953,219	0.5%	-	0.0%	20,953,219	0.5%	0.4%	0.3%
Physician	275,426,491	6.7%	1,260,522	4.0%	276,687,014	6.7%	6.7%	7.0%
Clinics	111,608,718	2.7%	684,356	2.2%	112,293,074	2.7%	3.0%	8.6%
Nursing Facility	166,824,892	4.1%	2,335,058	7.4%	169,159,950	4.1%	4.1%	4.4%
Intermediate Care Facility for Mental Retardation	424,809,447	10.3%	7,842,431	24.9%	432,651,877	10.4%	10.4%	10.4%
Dental	53,440,528	1.3%	268,180	0.9%	53,708,708	1.3%	1.2%	1.1%
Prescribed Drugs	523,899,546	12.7%	2,548,856	8.1%	526,448,402	12.7%	12.7%	19.0%
Home Health	169,417,657	4.1%	1,491,754	4.7%	170,909,411	4.1%	3.8%	3.9%
CAP/Disabled Adult	82,930,778	2.0%	1,861,983	5.9%	84,792,761	2.0%	2.0%	2.2%
CAP/Mentally Retarded	411,152,513	10.0%	3,339,128	10.6%	414,491,641	10.0%	9.3%	7.6%
CAP/Children	34,238,790	0.8%	369,724	1.2%	34,608,513	0.8%	0.8%	0.8%
Personal Care	153,607,640	3.7%	2,442,751	7.7%	156,050,390	3.8%	3.6%	3.9%
Hospice	16,760,526	0.4%	92,404	0.3%	16,852,930	0.4%	0.5%	0.5%
EPSDT (Health Check)	1,667,084	0.0%	5,198	0.0%	1,672,282	0.0%	0.0%	0.0%
Laboratory & Imaging Services	10,695,426	0.3%	53,024	0.2%	10,748,450	0.3%	0.2%	0.2%
Adult Home Care	69,368,241	1.7%	241,867	0.8%	69,610,108	1.7%	1.7%	1.8%
High Risk Intervention Residential	46,214,907	1.1%	-	0.0%	46,214,907	1.1%	1.0%	0.8%
Behavioral Health Community Support (Professional Services) (3)	355,051,040	8.6%	671,448	2.1%	355,722,488	8.6%		
Behavioral Health Community Support (Other Services) (3)	78,318,976	1.9%	112,657	0.4%	78,431,632	1.9%		
Other Behavioral Health Independent Practitioners (3)	19,154,598	0.5%	68,802	0.2%	19,223,400	0.5%		
Other Services	70,710,871	1.7%	371,909	1.2%	71,082,780	1.7%	13.8%	3.0%
Claims Paid	**$ 3,833,780,286**	**93.1%**	**$ 28,550,208**	**90.5%**	**$ 3,862,330,494**	**93.1%**	**93.0%**	**94.2%**
Premiums								
Medicare, Part A Premiums	846	0.0%	460,420	1.5%	461,266	0.0%	0.0%	0.0%
Medicare, Part B Premiums	114,125,043	2.8%	1,123,860	3.6%	115,248,903	2.8%	2.7%	2.6%
Medicare, Part D Premiums (1)	95,747,763	2.3%	972,197	3.1%	96,719,960	2.3%	2.3%	1.0%
HMO Premiums	75,056,523	1.8%	442,304	1.4%	75,498,827	1.8%	2.0%	2.1%
Premiums Paid	**$ 284,930,175**	**6.9%**	**$ 2,998,781**	**9.5%**	**$ 287,928,956**	**6.9%**	**7.0%**	**5.8%**
Total Claims and Premiums Paid	**$ 4,118,710,461**	**100.00%**	**$ 31,548,989**	**100.00%**	**$ 4,150,259,450**	**100.00%**	**100.00%**	**100.00%**
Medicare Crossovers included above (2)	**$ 92,977,706**		**$ 767,658**		**$ 93,745,364**			
Unduplicated Service Recipients	**275,489**		**2,035**		**277,524**			
Claim Expenditures Per Service Recipient	**$ 13,916**		**$14,030**		**$ 13,917**			
Unduplicated Recipients	**278,143**		**2,072**		**280,215**			
Total Claims and Premiums Paid Per Recipient	**$ 14,808**		**$ 15,226**		**$ 14,811**			

(1) Source for Medicare Part D Payments: SFY 2008 BD701 Report. Amounts are allocated to program groups based on the recipient's eligibility status at the end of the fiscal year.

(2) Medicare Crossovers are amounts that Medicare bills Medicaid for those Medicare recipients who are also eligible for Medicaid.

(3) This item was not recorded separately in previous fiscal years.

Source: SFY 2008 Program Expenditure Report (HMGR0901)

Table 13

N.C. Medicaid Claim and Premium Expenditures for Families and Children SFY 2008

Claims	AFDC Adults	Percent of Dollars	Special Pregnant Women	Percent of Dollars	AFDC Children and Other Children	Percent of Dollars	Infants and Children	Percent of Dollars	MSCHIP	Percent of Dollars	Breast and Cervical	Percent of Dollars	Total Families & Children Dollars	SFY 2008 % of Total Dollars	SFY 2007 % of Total Dollars
Inpatient Hospital	$148,455,677	19.2%	$ 96,489,244	36.3%	$ 53,883,662	7.1%	$ 229,456,076	16.5%	$ 4,082,378	5.6%	$ 625,716	7.5%	$ 532,992,752	16.3%	17.1%
Outpatient Hospital	152,402,753	19.8%	33,223,996	12.5%	55,735,921	7.4%	124,725,189	9.0%	10,915,185	15.1%	3,952,040	47.4%	380,955,083	11.7%	11.9%
Mental Hospital (> 65)	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Psychiatric Hospital (< 21)	-	0.0%	13,022	0.0%	25,439,739	3.4%	15,016,567	1.1%	7,253	0.0%	-	0.0%	40,476,581	1.2%	1.2%
Physician	148,753,254	19.3%	73,934,607	27.8%	79,544,828	10.5%	245,102,616	17.6%	18,411,446	25.5%	2,717,541	32.6%	568,464,293	17.4%	17.7%
Clinics	14,782,187	1.9%	21,345,093	8.0%	54,599,285	7.2%	45,868,935	3.3%	3,175,117	4.4%	19,681	0.2%	139,790,298	4.3%	4.9%
Nursing Facility	336,304	0.0%	-	0.0%	6,228	0.0%	23,279	0.0%	-	0.0%	-	0.0%	365,811	0.0%	0.0%
Intermediate Care Facility for Mental Retardation	12,540	0.0%	-	0.0%	1,543,171	0.2%	590,555	0.0%	-	0.0%	-	0.0%	2,146,266	0.1%	0.1%
Dental	47,306,712	6.1%	2,539,829	1.0%	41,388,333	5.5%	103,808,281	7.5%	7,046,822	9.7%	83,162	1.0%	202,173,140	6.2%	6.0%
Prescribed Drugs	144,605,672	18.7%	11,026,839	4.1%	88,222,240	11.7%	180,713,629	13.0%	12,909,972	17.9%	655,861	7.9%	438,134,213	13.4%	13.8%
Home Health	13,215,117	1.7%	2,631,060	1.0%	6,467,368	0.9%	15,513,194	1.1%	1,087,838	1.5%	103,436	1.2%	39,018,013	1.2%	1.2%
CAP/Disabled Adult	-	0.0%	-	0.0%	3,981	0.0%	-	0.0%	-	0.0%	-	0.0%	3,981	0.0%	0.0%
CAP/Mentally Retarded	-	0.0%	-	0.0%	3,924,339	0.5%	-	0.0%	-	0.0%	-	0.0%	3,924,339	0.1%	0.1%
CAP/Children	-	0.0%	-	0.0%	981,706	0.1%	-	0.0%	-	0.0%	-	0.0%	981,706	0.0%	0.0%
Personal Care	6,634,695	0.9%	29,126	0.0%	781,848	0.1%	841,841	0.1%	38,548	0.1%	9,954	0.1%	8,336,012	0.3%	0.3%
Hospice	440,656	0.1%	-	0.0%	23,638	0.0%	214,462	0.0%	8,691	0.0%	43,565	0.5%	731,013	0.0%	0.0%
EPSDT (Health Check)	18,032	0.0%	42,300	0.0%	10,243,522	1.4%	47,803,782	3.4%	3,566,056	4.9%	9	0.0%	61,673,702	1.9%	1.9%
Laboratory & Imaging Services	15,358,131	2.0%	10,521,020	4.0%	4,682,346	0.6%	11,700,921	0.8%	396,947	0.5%	54,194	0.6%	42,713,559	1.3%	1.2%
Adult Home Care	43,496	0.0%	-	0.0%	34,576	0.0%	15,850	0.0%	-	0.0%	-	0.0%	93,922	0.0%	0.0%
High Risk Intervention Residential	-	0.0%	-	0.0%	64,393,957	8.5%	49,116,407	3.5%	-	0.0%	-	0.0%	113,510,363	3.5%	3.5%
Behavioral Health Community Support (Professional Services) (3)	32,040,641	4.2%	597,790	0.2%	194,313,752	25.8%	227,407,538	16.3%	2,090,968	2.9%	23,639	0.3%	456,474,329	14.0%	
Behavioral Health Community Support (Other Services) (3)	9,579,963	1.2%	732,778	0.3%	14,492,708	1.9%	17,515,191	1.3%	960,546	1.3%	9,328	0.1%	43,290,515	1.3%	
Other Behavioral Health Independent Practitioners (3)	6,949,761	0.9%	283,106	0.1%	19,510,913	2.6%	20,621,715	1.5%	544,101	0.8%	10,393	0.1%	47,919,990	1.5%	
Other Services	26,920,066	3.5%	11,588,978	4.4%	22,855,756	3.0%	45,994,516	3.3%	6,326,042	8.8%	27,709	0.3%	113,713,067	3.5%	18.4%
Claims Paid	**$ 767,855,656**	**99.5%**	**$ 264,998,789**	**99.7%**	**$ 743,073,817**	**98.5%**	**$ 1,382,050,543**	**99.3%**	**$ 71,567,911**	**99.0%**	**$ 8,336,230**	**100.0%**	**$ 3,237,882,946**	**99.2%**	**99.1%**
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	807,365	0.1%	96,161	0.0%	7,108	0.0%	8,509	0.0%	1,142	0.0%	-	0.0%	$ 920,286	0.0%	0.0%
Medicare, Part D Premiums (1)	317,456	0.0%	70,557	0.0%	6,385	0.0%	6,479	0.0%	88	0.0%	-	0.0%	$ 400,965	0.0%	0.0%
HMO Premiums	2,577,372	0.3%	663,491	0.2%	10,928,866	1.4%	9,047,681	0.7%	706,846	1.0%	3,480	0.0%	$ 23,927,736	0.7%	0.8%
Premiums Paid	**$ 3,702,192**	**0.5%**	**$ 830,209**	**0.3%**	**$ 10,942,359**	**1.5%**	**$ 9,062,670**	**0.7%**	**$ 708,076**	**1.0%**	**$ 3,480**	**0.0%**	**$ 25,248,986**	**0.8%**	**0.9%**
Total Claims and Premiums Paid	**$ 771,557,848**	**100.00%**	**$ 265,828,998**	**100.0%**	**$ 754,016,176**	**100.0%**	**$ 1,391,113,212**	**100.0%**	**$ 72,275,987**	**100.0%**	**$ 8,339,710**	**100.0%**	**$ 3,263,131,932**	**100.00%**	**100.00%**
Medicare Crossovers included above (2)	**$ 631,210**		**$ 123,449**		**$ 18,525**		**$ 26,031**		**$ -**		**$ -**		**$ 799,215**		
Unduplicated Service Recipients	**243,394**		**60,166**		**213,785**		**682,955**		**61,414**		**441**		**1,262,155**		
Claim Expenditures Per Service Recipient	**$ 3,155**		**$ 4,404**		**$ 3,476**		**$ 2,024**		**$ 1,165**		**$ 18,903**		**$ 2,565**		
Unduplicated Recipients	**243,419**		**60,174**		**213,785**		**682,955**		**61,414**		**441**		**1,262,188**		
Total Claims and Premiums Paid Per Recipient	**$ 3,170**		**$ 4,418**		**$ 3,527**		**$ 2,037**		**$ 1,177**		**$ 18,911**		**$ 2,585**		

(1) Source for Medicare Part D Payments: SFY 2008 BD701 Report. Amounts are allocated to program groups based on the recipient's eligibility status at the end of the fiscal year.

(2) Medicare Crossovers are amounts that Medicare bills Medicaid for those Medicare recipients who are also eligible for Medicaid.

(3) This item was not recorded separately in previous fiscal years.

Source: SFY 2008 Program Expenditure Reports (HMGR0901, HMGR0903, and HMGR0906)

Table 14

N.C. Medicaid Copayment Amounts SFY 2008

Service	Copayment Amount
Chiropractor visit	$2.00
Dental visit	$3.00
Optical supplies and services	$2.00
Ophthalmologist visit	$3.00
Optometrist visit	$3.00
Outpatient visit	$3.00
Physician visit	$3.00
Podiatrist visit	$3.00
Prescription drugs and insulin:	
Generic	$3.00
Brand Name	$3.00

Appendix I

Glossary

ABD Aged, Blind and Disabled categories of Medicaid eligibility

ACS Affiliated Computer Services

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), and persons with mental retardation and/or developmental disabilities (CAP/MR-DD)

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

CNS Comprehensive Neuroscience

DHHS Department of Health and Human Services

DMA Division of Medical Assistance

DPH Division of Public Health

EDS Electronic Data Systems; DMA's fiscal agent, 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 receive 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	Pre-Admission Screening and Annual Resident Review
PCP	Primary care provider
PCS	Personal Care Services
QMB	Qualified Medicare Beneficiary; a Medicare beneficiary who is also eligible for Medicaid because the person's income is under 100 percent of the poverty level and his or her 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, that 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 Unit saved, recovered or avoided N.C. Medicaid costs in excess of $1 billion during SFY 2008. 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 Units Collections and Cost Avoidance

Efforts by Program Integrity's four provider investigative units resulted in the recovery of $88,862,379 and cost avoidance of $3,691,957.

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 2008:

- The Provider Medical Review Unit 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 follow up of Board actions against 50 physicians resulted in cost savings of $859,771.

- The PI Pharmacy Review Unit had a notable example of a provider self-audit. One 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 a modified recoupment of $94, 047.

- The Pharmacy Review Unit also performs investigations based on referrals from EDS. One example involved a provider whose billing practices led to drug rebate disputes. The related audit resulted in a recoupment of $77,760 and resolution of the dispute status placed on three National Drug Codes (NDC's) encompassing six quarters.

- The Pharmacy Review Unit cost-avoided $2,803,306 based on Edit 902 (quantity outside minimum and maximum edit), Edit 910 (unbreakable package edit) and the hospice edit.

- 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. During SFY 2008, a total of 39 self audit cases were completed by the four investigative sections resulting in a recoupment of $515,217.

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 the following.

EDS—DMA had two contracts with EDS:

- **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**—Designing, developing and implementing an Internet-based screening tool that allows administrative agencies and service providers to screen individuals to determine if they qualify for long-term care Medicaid programs and services. The tool also incorporates the Pre-Admission Screening and Annual Resident Review (PASARR) Level I Screen that is required under federal regulations for all individuals applying for admission to, or currently residing in, a nursing home. In addition to PASARR, the tool uses business decision software to determine if an individual qualifies for care in a nursing facility; admission to an adult care home or special care unit; enrollment in the Community Alternatives Program for Disabled Adults (CAP/DA), including the CAP/DA Choice Option or CAP/C; or services under Private Duty Nursing (PDN) or in-home Personal Care Services (PCS) and PCS-Plus.

The Carolinas Center for Medical Excellence (CCME)—DMA had six contracts with CCME:

- **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 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. Additionally, claim and medical record reviews were performed for the Payment Error Rate Measurement (PERM) project, which requires governmental agencies to assess payment accuracy according to the Improper Payments Act of 2002 (HR4878) and for the annual claims review of the N.C. Office of State Auditor (OSA). Post-payment reviews associated with PERM and OSA involve claims for inpatient hospital and nursing home services.

- **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/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.

- **External Quality Review and Focused Care Studies**—Performed focused care studies of DMA's primary care case management (PCCM) program, Community Care of North Carolina (CCNC); performed external quality reviews (EQR) of DMA's behavioral health managed care initiative, the Piedmont Cardinal Health Plan; and assisted DMA in evaluating its quality strategy.

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. Independently evaluated the 115 Family Planning Waiver from the Centers for Medicare and Medicaid Services (CMS) for program effectiveness, costs and cost neutrality.

Myers & Stauffer—A certified public accounting firm that implemented 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 nurs¬ing facilities and intermediate care facilities for the mentally retarded (ICF-MR).

See also the entry under Clifton Gunderson.

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—DMA had several contracts with ACS State Healthcare:

- **Prior Authorization**—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.
- **Fraud and Abuse Detection Systems (FADS) Contract with ACS**—FADS software assisted the Program Integrity Section 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.

As a result of a settlement between the Division and ACS in Spring 2007, ACS performed additional services for the Division under three distinct contracts:

- **Pharmacy Desk Auditing**—Turn-key, program integrity, desk audit services for out-of-state retail pharmacies in Tennessee, South Carolina and Georgia to determine and recoup amounts owed or potentially owed to the Division.
- **Dialysis Auditing**—Turn-key renal dialysis auditing to determine and recoup amounts owed or potentially owed to the Division by analyzing historical paid claims data and contract reimbursement rates to identify viable cases.
- **SmartPA**—Real-time, point-of-sale application to provide prior authorization and drug utilization services. The SmartPA clinical rules system, in conjunction with prescription drug data, assists the Division in evaluating the appropriateness of dispensing certain medications to Medicaid recipients.

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—A certified public accounting firm that, under contract with the DMA Audit Unit and along with Myers & Stauffer, conducted onsite compliance audits of Medicaid-enrolled nurs¬ing 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. Mercer also provided actuarial services for the Rate Setting Unit and assisted the Pharmacy Unit 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.

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.

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:

- **Prescription Drug Effectiveness Review Project (DERP)**—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.
- **Medicaid Evidence-based Decisions Project (MED)**—Provided access to high-quality, highly relevant, non-biased evaluation of evidence and facilitated important peer discussions with other state Medicaid agencies.

Eli Lilly—At no cost to the State, Ely Lilly and Comprehensive Neuroscience collaborated to provide Behavioral Pharmacy Management (BPM) and Medical Risk Management (MRM) to the Pharmacy section. The Division receives data regarding prescribing patterns for mental health drugs using quality indicators to identify questionable practices, which is useful for policy development and the identification of necessary automated system clinical edits. The quality indicators include focus areas that are specific to quality improvement and safety. The Division also receives integrated health information for the medical home and behavioral home provider for a pilot cohort of recipients.

Comprehensive Neuroscience—Provided Behavioral Pharmacy Management (BPM) and Medical Risk Management (MRM) to the Pharmacy section. See Eli Lilly above.

Fluent Language Solutions—Provided on-site and telephonic translation services to Medicaid recipients involved in formal and informal hearings.

PCG—This sole-source contract fulfilled a pressing need of assisting the Division in conducting manual pre-payment reviews of specific claims from selected providers of community support services.

Active Data Services—Monthly pick up and preparation of Medicaid booklets for bulk mailing.

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 the following.

County Departments of Social Services—The department of social services in each of North Carolina's 100 coun¬ties has the central role of determining Medicaid eligibility for that county's residents. In addition, counties contributed approximately 5 percent of the cost of services for Medicaid recipients during SFY 2007 (see Table 5).

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

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 Secur¬ity Administration, this unit also makes disability determinations for two federal programs: Title II Social Security Benefits and Title XVI Supple¬mental Security Income.

N.C. Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS)—DMA works closely with MH/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 Pre-Admission Screening and Annual Resident Review (PASARR), MH/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). Lastly, the two divisions are working in collaboration with Piedmont Cardinal Health Plan (PCHP), a managed behavioral health care pilot that has been operating in five North Carolina counties under 1915(b) and 1915(c) Medicaid waivers since April 2005.

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). Effective January 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. DMA and DPH also cooperate in the provision of pediatric equipment for Medicaid-eligible recipients ages birth through 20 years old.

The Women and Children's Health Section (WCH) within DPH operates a variety of health care programs that are funded by

Medicaid. WCH and local health departments play a central role in the operation of the Baby Love Program, a care coordination program designed to ensure 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 pro¬jects 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. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a facility.

N.C. Department of Public Instruction (DPI)—The Individuals with Disabilities Education Act (IDEA) is a federal law requiring education-related services to be provided to pre-school and school-aged children with special needs who are receiving special education services as part of an 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.

The University of North Carolina at Chapel Hill (UNC–CH)—The 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.

The 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.

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