

North Carolina

Medicaid and NC Health Choice

Annual Report for State Fiscal Year 2015
July 1, 2014 - June 30, 2015



*Using the resources and partnerships of Medicaid
to improve health care for all
North Carolinians.*





Medical Assistance
HEALTH AND HUMAN SERVICES

Division of Medical Assistance

OUR MISSION

Using the resources and partnerships of Medicaid to improve health care for all North Carolinians.

OUR VISION

Leading the transformation to a healthier North Carolina.

OUR VALUES

ACCOUNTABILITY. Own Your Work.

INTEGRITY. Own Your Actions.

COLLABORATION. Value Partnerships.

INNOVATION. Identify Solutions.

COMMUNICATION. Connect with Others.

State of North Carolina • Pat McCrory, Governor
Department of Health and Human Services • Richard O. Brajer, Secretary
Division of Medical Assistance • www.ncdhhs.gov

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6/2016

Message from Dave Richard

Deputy Secretary for the Division of Medical Assistance

Our North Carolina Medicaid and NC Health Choice programs had a successful fiscal year. We continued to improve our service delivery system, managed cost within our budget and addressed many challenges related to the Medicaid program. These successes are the result of strong leadership from Governor Pat McCrory, who established the expectation of excellent customer service and collaboration.

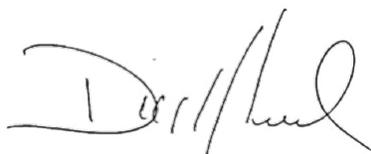
The increased collaboration among the dedicated staff at the Division of Medical Assistance, our Department of Health and Human Services and other state agency partners, the General Assembly and, most importantly, the community stakeholders – including providers, advocates and beneficiaries – has created an environment that fosters success.

Under the leadership of my predecessor, Dr. Robin Cummings, the Medicaid agency established a set of core values: accountability, integrity, collaboration, innovation and communication. Using these as our guide, we believe that Medicaid can improve health care for all North Carolina citizens. Our staff is committed to these values!

In SFY 2015, we made very specific program and finance improvements, and addressed significant challenges. Included in these are adding more children to the Community Alternatives Program for Children (CAP/C) and additional organizations to the Program of All-Inclusive Care for the Elderly (PACE), and developing a more person-centered model for the Innovations Waiver that supports people with intellectual and developmental disabilities. We continued to work with all providers to improve our primary care case management program and support our patient-centered medical homes.

Although faced with challenges, including the increase of specialty drug costs of over \$100 million and implementation of the ICD-10 medical classification changes, we were able to finish the fiscal year with \$131 million of cash on hand. This is primarily due to a more transparent budgeting process, a better forecasting model and the oversight of the DMA team.

We are excited about the future as we manage our current Medicaid program, and work with our DHHS and Division of Health Benefits partners to implement the Medicaid reform plan developed by Governor McCrory and legislative leaders. We will uphold our commitment to partner with stakeholders to ensure that the Medicaid and NC Health Choice programs improve, and are the best value for citizens who rely upon the programs for their health care and for all North Carolina taxpayers.



Message from Trey Suttan

Chief Financial Officer for the Division of Medical Assistance

On behalf of the Division of Medical Assistance, I am pleased to share the North Carolina Medicaid and NC Health Choice Annual Report for State Fiscal Year 2015. The DMA team did an admirable job of compiling the data and information, and I thank them for their dedication to the preparation of an excellent overview of the year's results.

The Annual Report outlines the financial results and key activities of DMA programs and policies for state fiscal year 2015. In short, DMA continued to build on the positive momentum of the prior year: The Medicaid and NC Health Choice programs ended SFY 2015 with \$131 million cash on hand, doubling the \$64 million cash on hand results at the end of SFY 2014. After four years of shortfalls totaling nearly \$2 billion, I am confident that two consecutive successful years are evidence that strategic improvements are moving DMA financial processes in the right direction, including:

- Bolstering the finance team with additional skills and talents sourced internally and externally
- Strengthening financial controls and oversight capabilities
- Investing strategically in budget development and financial analysis tools

The implementation of a new forecast and budgeting model, one that was developed specifically to address North Carolina needs, is one example of an improvement that significantly contributed to the outstanding SFY 2015 results. In addition to more detailed calculations and reporting, this model created the opportunity for DMA to evaluate real-time financial results with our partners, including the General Assembly and its Fiscal Research Division. This collaboration enabled DMA to deliver more predictable financial estimates to the General Assembly as it prepared the Medicaid and NC Health Choice part of the state budget.

As chief financial officer and a fellow North Carolinian, it is my professional and personal obligation to ensure our \$14 billion Medicaid and NC Health Choice budget is effectively and efficiently managed to improve the health and quality of life for as many people as possible. My team and I take this responsibility seriously as we strive to improve current processes and explore new methods of maximizing our available financial resources.

As we move forward, I am certain that all our stakeholders will benefit as we continue to deliver on our mission while adhering to our values: accountability, integrity, collaboration, innovation and communication.

If you have questions about the Annual Report, please contact me at **(919) 855-4100** or **trey.suttan@dhhs.nc.gov**.





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About the Annual Report

The North Carolina Medicaid and NC Health Choice Annual Report for State Fiscal Year 2015 is an overview of the financial results, and related programs and services, administered by the Division of Medical Assistance.

The annual report focuses on the primary fund, which covers claims and premiums. Unless otherwise specified, comparisons to prior years refer to SFY 2014. Significant changes to the accounting and payment systems occurred during SFY 2013 that render meaningful comparisons to years SFY 2013 and earlier as impractical without substantial normalization. This normalization process would result in individual expenses being mapped to funds or accounts that were not used originally. Therefore, service-level comparisons focus on SFY 2015 and SFY 2014.

Please contact Trey Suttan at trey.suttan@dhhs.nc.gov or **(919) 855-4100** with questions or requests for additional information.

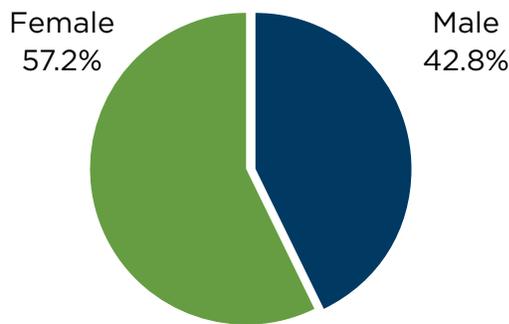


North Carolina Medicaid and NC Health Choice State Fiscal Year 2015 Snapshot

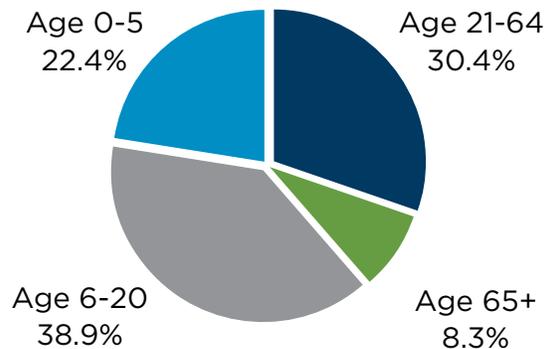
EXHIBIT 1

Financials	\$B	Statistics	#
Expenditures	13.9	Medicaid Beneficiaries ¹	1.8M
Revenue: Federal	8.9	Health Choice Beneficiaries ¹	0.08M
Revenue: Other	1.4	Providers ²	64K
State Appropriations	3.6	NCTracks Claims Processed	174.8M

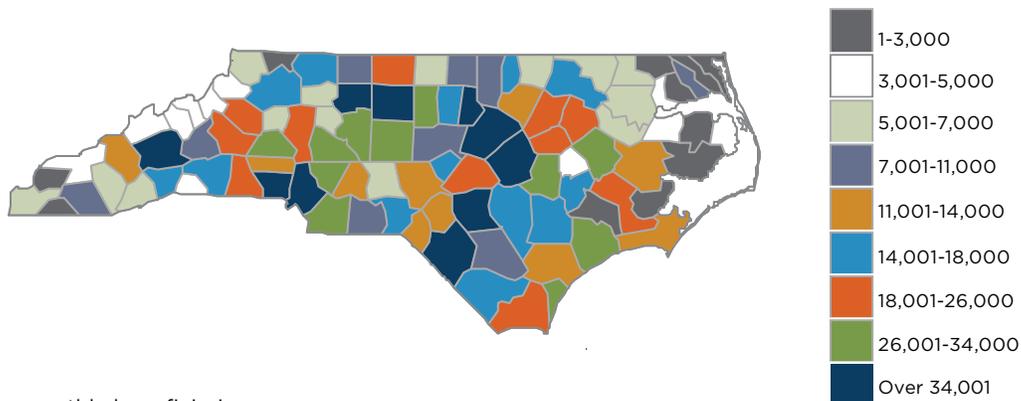
Beneficiary Gender



Beneficiary Age



Total Beneficiaries by County



¹ Average monthly beneficiaries

² Provider count represents the number of unique National Provider Identifiers registered in the DMA system

Sources: Financials from NCAS BD-701; beneficiary count and geographic distribution from Monthly Enrollment Report, DMA Business Information Office; provider count and beneficiary age and gender from customer data retrievals, DMA Business Information Office; claims processed from DHHS Information Technology Division



Executive Summary

In state fiscal year 2015 (July 1, 2014-June 30, 2015), the North Carolina Medicaid and NC Health Choice programs continued to successfully provide our most vulnerable citizens with access to needed and valuable health services. With the support of Governor Pat McCrory and the General Assembly, the Division of Medical Assistance (DMA) worked closely with providers and other stakeholders to develop and implement policy, operational and financial improvements to increase budget predictability and control costs.

Those efforts ensured a productive and eventful year for the Medicaid and NC Health Choice programs, resulting in strong financial results, and better health and quality of life for North Carolinians.

DMA administers the Medicaid and NC Health Choice programs as part of the North Carolina Department of Health and Human Services (DHHS) cabinet agency. More information is available at dma.ncdhhs.gov.

Financial Results

\$131 million under budget

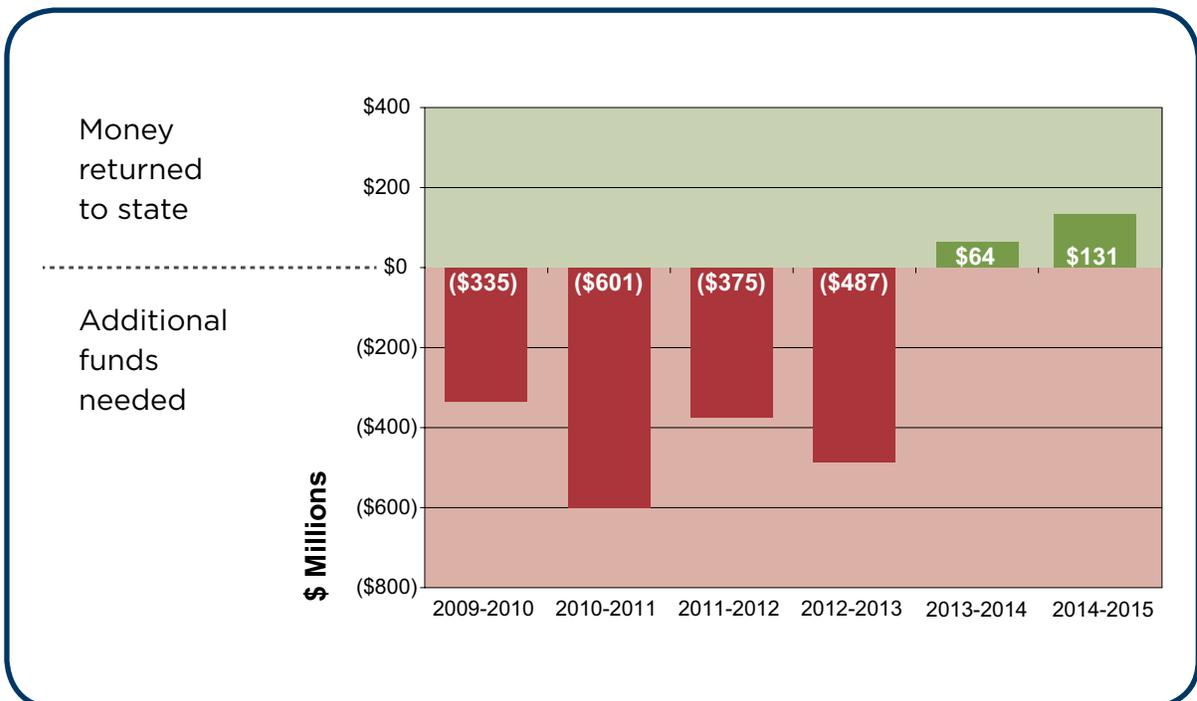
North Carolina’s Medicaid budget finished with cash on hand for the second consecutive state fiscal year. Prior to these two fiscal years, the Medicaid program experienced shortfalls of nearly \$2 billion over a four-year period.

Actual state appropriations for the Medicaid and NC Health Choice programs totaled nearly \$3.7 billion in SFY 2015, bringing the programs in \$131 million under budget. These programs provided health care coverage to nearly 2.3 million individuals in North Carolina.

What is Medicaid?

Medicaid provides health coverage to eligible low-income adults, children, pregnant women, elderly adults and people with disabilities. The program is jointly funded by North Carolina and the federal government.

EXHIBIT 2



Several factors affected SFY 2015 financial results:

- 1. Proactive strategies.** The existing management team was bolstered with additional leaders from other areas of DHHS and private industry. The impact was a division-wide focus on proactive management practices to improve DMA's ability to identify and address potential issues at the earliest stage possible.
- 2. Financial management.** DMA implemented a number of changes to how the Division manages its finances. These changes included strengthening the team, improving the budgeting and forecasting processes, and proactively managing cash. The changes resulted in stronger oversight and improved financial management contributing to SFY 2015 results.
- 3. Utilization.** The amount of services and the number of people using services as a percentage of the total enrollees are critical factors in the cost of Medicaid and NC Health Choice. In SFY 2015, there were fewer Medicaid beneficiaries who required or sought medical services compared to budget. The lower utilization was a significant factor in DMA's year-end results.

What is NC Health Choice?

NC Health Choice is our state's name for the Children's Health Insurance Program (CHIP). It provides health coverage to eligible children in addition to Medicaid. NC Health Choice is jointly funded by North Carolina and the federal government.

*The Centers for Medicare & Medicaid Services certified NCTracks, saving the state about **\$19 million** each year.*

- 4. Rate changes.** State legislation required rates be held constant or reduced in SFY 2015 for several service categories. The limits placed on rate increases contributed to DMA finishing the year with cash on hand.

Accomplishments

Innovation and collaboration led to significant advances

DMA saw significant successes in many areas in SFY 2015, including:

- **Budget process.** DMA revitalized its budget process with a foundational commitment to transparency. By engaging the General Assembly and the Executive Branch closely during the process, a more predictable and understandable budget was developed.
- **Organizational structure.** DMA began a full reorganization process, starting with the Finance and Business Information sections, to align its structure according to the needs of North Carolina today and into the future.
- **Pharmaceutical spending.** DMA implemented strategies resulting in lower overall drug and health care spending, including the aggressive pursuit of higher drug rebates, which led to a \$160 million increase in rebates. Drug rebates as a percentage of expenditures rose from 45% to 48%. DMA also added a preauthorization requirement for certain specialty drug prescriptions to ensure proper utilization of more costly prescriptions.
- **Fraud and abuse.** More than 8,000 individual complaints were received and reviewed, of which 597 cases were referred to the North Carolina Attorney General's Office for investigation.
- **NCTracks.** The largest IT project in North Carolina history, NCTracks was certified by the Centers for Medicare & Medicaid Services in April 2015. This resulted in approximately \$19 million in additional federal funding to the state.
- **Health Check preventive services.** North Carolina children received early preventive screenings at well-above the national averages in the crucial developmental window of birth through the fifth year of life. Preventive dental services for children increased nearly 20% over the past three years.

Expenditures by Funding Level

State share was \$3.9B out of \$13.9B

Medicaid and NC Health Choice programs combined are roughly \$14 billion. Of this amount, approximately 80% are service expenditures, such as claims, premiums and capitation payments. Service expenditures are divided into different categories of service, and

are discussed in detail throughout the annual report. Pharmacy rebates flow into a different fund, but are combined and netted with claims expenditures for annual report purposes. The net cost for drugs is more relevant to operations.

Other significant funds include:

- **Supplemental hospital payments** reimburse hospitals for the treatment of uninsured patients or other significant costs to hospitals.
- **Cost settlements** are payments or recoveries to reconcile whether a participating hospital was paid a predetermined reimbursement rate for inpatient and outpatient costs.

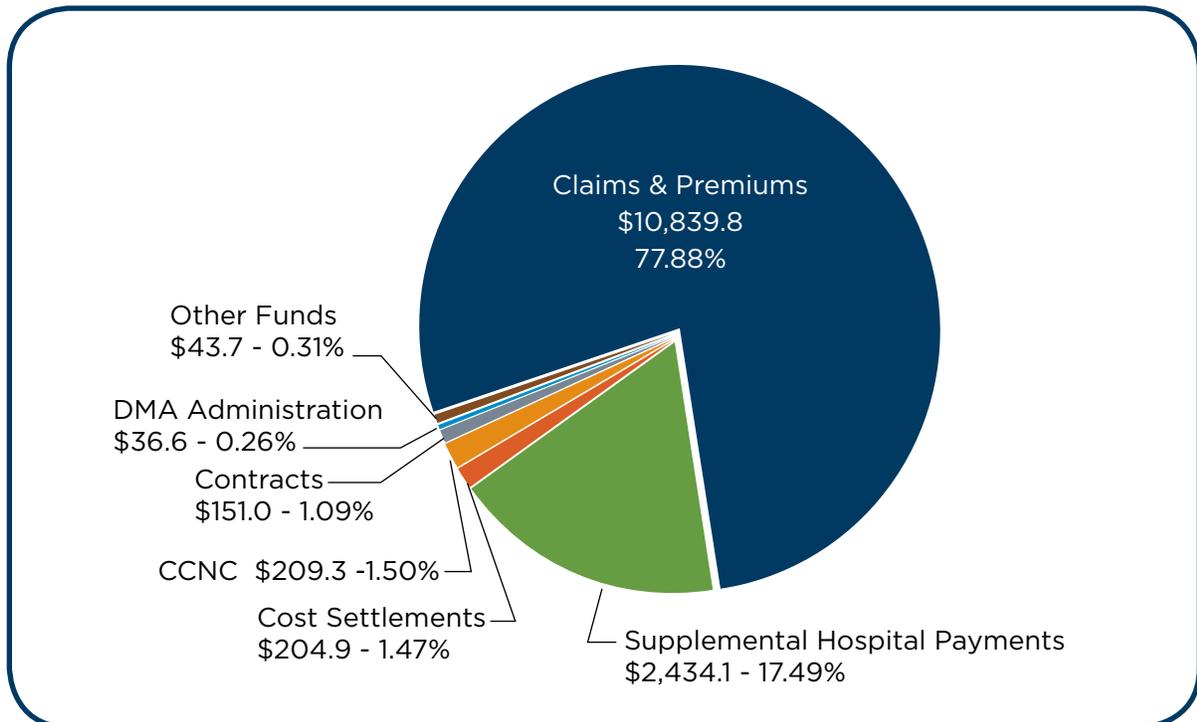
- **Community Care Network of North Carolina** is a primary care case management health care plan for the majority of North Carolina Medicaid beneficiaries.

Other costs include contract payments, DMA administrative costs, health information technology payments, and accounting adjustments due to audits or financial activities affecting a prior year.

Some operations bring revenue into DMA. For example, program integrity ensures claims are appropriately and accurately paid, and third-party liability recovers funds paid by DMA for incidents that should have been covered by other insurers.

\$13.9 Billion of Expenditures in SFY 2015 (\$ millions)

EXHIBIT 3



Source: NCAS BD-701

Exhibit 4 on page 7 breaks down the \$10.8 billion in claims and premiums into the programs and services that will be discussed in greater detail later in this report.

A Look at SFY 2016

In SFY 2016, DMA will continue to experience significant changes that will require additional focus and energy from DMA staff:

- **Medicaid reform.** DMA will continue to manage and improve the Medicaid and NC Health Choice programs while assisting the new Division of Health Benefits as it builds the infrastructure for health care reform. This will include a Section 1115 demonstration waiver application and design for the North Carolina Health Transformation Center.
- **Continue reorganization.** The DMA restructuring effort will expand to cover other sections of the division and improve the overall service delivery process of DMA.
- **Financial management.** DMA will remain committed to providing better financial reporting, with the goal of

more frequent, transparent and accurate communication with stakeholders. In addition, the team will continue to make improvements to the budgeting, forecasting and financial management processes.

- **ICD-10.**¹ The clinical policy team will complete extensive preparations for the national launch of ICD-10, scheduled for October 2015.

Above all, DMA will remain committed to transparency and collaboration in its ongoing efforts to lead the transformation to a healthier North Carolina.

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More information on program services, practices and results for SFY 2015 are outlined in the following section. These programs represent \$10.8B or 77% of DMA's total expenditures.

¹ Tenth revision to the International Classification of Diseases coding system, the standard diagnostic tool in the health care industry.

Medical Assistance Payments

By Category of Service

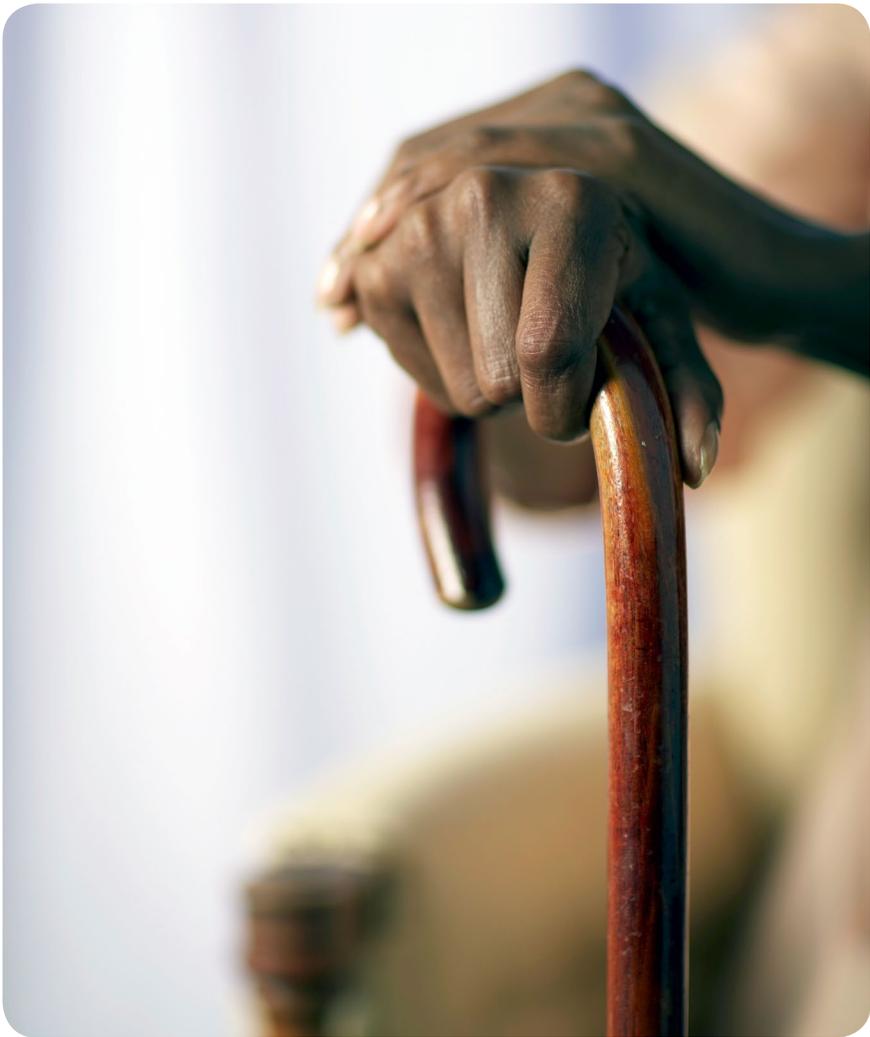
EXHIBIT 4

SFY2015 Claims & Premiums Medicaid & Health Choice (Ranked by Claims Expenditure)			
Service Category	Claims & Premiums (\$ millions)	Unduplicated Recipients ¹	Cost Per Recipient
Local Management Entity-Managed Care Organization	\$2,578.3	1,799,669	\$1,433
Hospital	1,581.8	785,819	2,013
Skilled Nursing Facilities	1,153.6	43,144	26,738
Physician Services	1,131.4	1,738,674	651
Pharmacy Services ²	739.2	1,275,326	580
Medicare Aid Program	700.4	1,048,510	668
Personal Care Services	461.0	50,982	9,043
Hospital Emergency Department Services	405.8	613,230	662
Dental Services	378.3	896,765	422
Community Alternatives Program for Disabled Adults	238.6	11,731	20,341
Durable Medical Equipment Services	192.7	236,602	814
Outpatient Specialized Therapies	146.5	78,137	1,875
Clinic Services	132.9	375,754	354
Home Health Services	125.6	28,669	4,383
Lab & X-ray Services	122.4	547,286	224
Health Check Services	110.7	720,577	154
Community Alternatives Program for Children	95.0	2,181	43,562
Hospice Services	65.6	6,381	10,283
Non-Emergency Transportation Services ³	53.9	N/A	N/A
Ambulance Services	45.0	159,811	282
Program of All-Inclusive Care for the Elderly	44.4	1,496	29,703
Optical Services	25.9	269,439	96
Ambulatory Surgery Center Services	15.3	33,148	462
Other Services	142.7	1,872,368	76
Total	\$10,839.8	2,274,068	\$4,767

¹ Some individuals may enter and exit one or more service categories on multiple occasions throughout the fiscal year depending on eligibility status. "Unduplicated" means those individuals are counted only one time to avoid multiple counts of a single person. The column total represents the number of unique individuals served across the various service categories and not just the sum total of individuals served within each category, as individuals could be counted more than once.

² Claims expenditures are net of drug rebates

³ Unduplicated recipient data are not available for Non-Emergency Transportation Services as these data are only produced at the county level



NC Medicaid & NC Health Choice *Programs and Services*

Local Management Entities- Managed Care Organizations (LME-MCOs)

Local Management Entities-Managed Care Organizations (LME-MCOs) manage, coordinate, facilitate and monitor the provision of mental health, developmental disabilities and substance use services in the geographic area that they serve.

LME-MCOs strive to meet the needs of people who prefer to receive long-term behavioral health care services and supports in their home or community, rather than in an institutional setting. The program was initiated as a way to control and more accurately budget for the rising costs of Medicaid-funded mental health, and intellectual and developmental disability services.

LME-MCOs provide system improvements, and better management of funds and behavioral health services. They also are authorized to adjust rates to meet local needs and to pay claims to ensure fiscal responsibility.

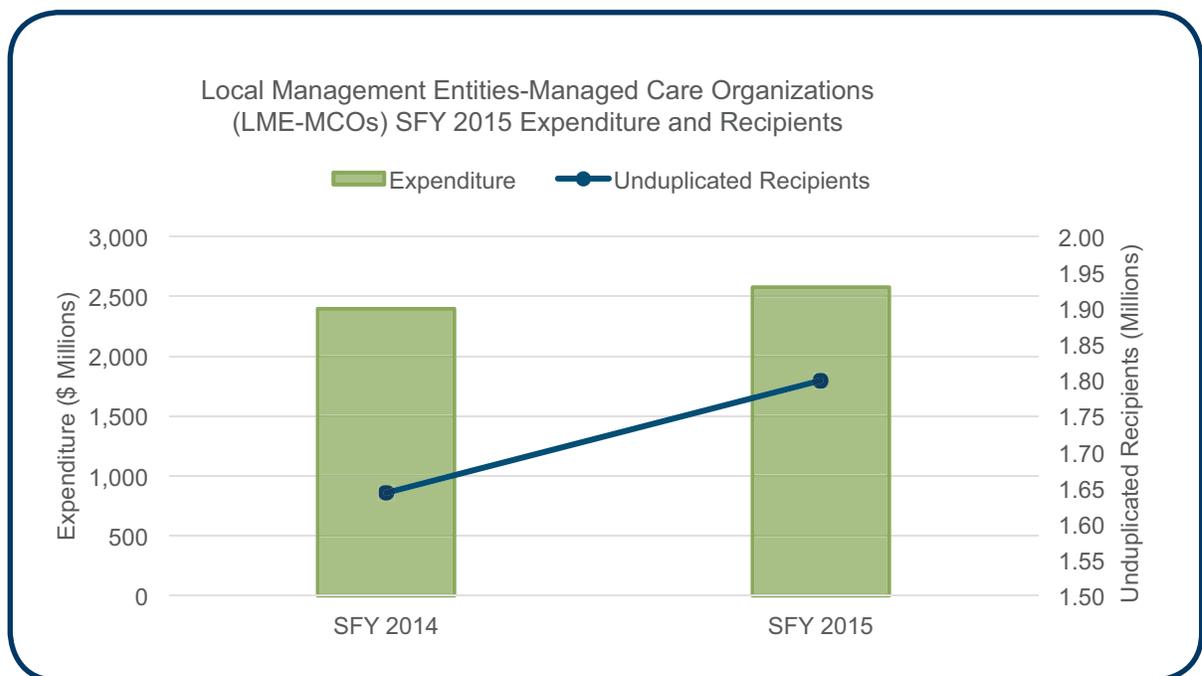
LME-MCOs have:

- Achieved cost savings (which have been reinvested in the system) through a simplified, capitated (per member per month) payment model, which bases prices on historic costs
- Managed utilization, providing the right amount of service while keeping costs down
- Managed care or care coordination to provide direct support to the individuals who need it most

A beneficiary is eligible for LME-MCO services if they are at least 3 years of age and eligible as determined by the applicable county Department of Social Services.

SFY 2015 Highlights

EXHIBIT 5



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

DMA continued to make improvements in SFY 2015 to increase flexibility of choice and stakeholder input.

- Worked on building a resource allocation model for the NC Innovations Waiver, which will provide options to enable individuals with intellectual or developmental disabilities to live a more independent lifestyle
- Formed a state-level stakeholder group to solicit input from MCOs, providers, beneficiaries and families, and gathered input through a statewide listening tour
- Increased the flexibility of service choice while controlling cost by amending the NC Innovations Waiver
- Began the process of the state transition plan to comply with the Home and Community Based Services (HCBS) final rule, which includes requirements for the qualities of HCBS providers

Looking Forward

The successful implementation of LME-MCOs has set the stage for additional growth in the managed care model across North Carolina. Lessons from this implementation will be a valuable part of the next stages of any form of managed care.

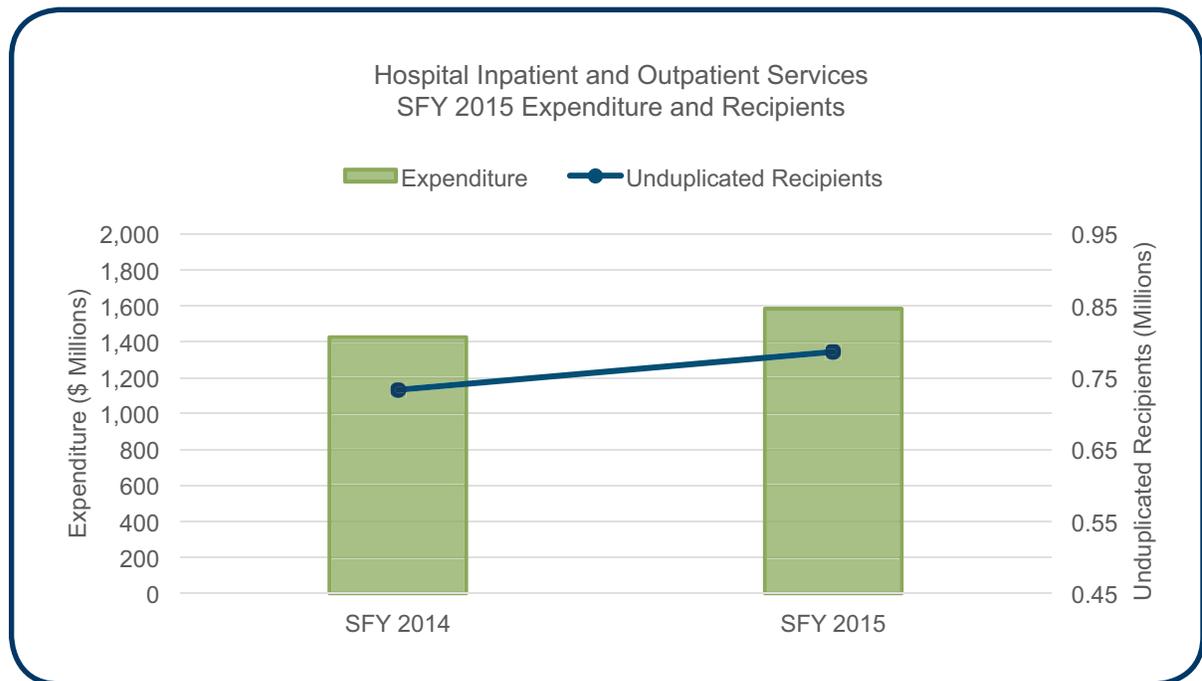
Hospital Inpatient Services

Hospital inpatient services are primarily treatments that are not practical or advisable to be delivered on an outpatient basis, provided under the direction of a physician or a dentist, and received by a Medicaid patient in a facility qualified to participate in Medicare as a hospital.

Hospital inpatient services hold a significant role in diagnosing and treating illness while also providing opportunities for Medicaid beneficiaries to become a healthier population with enhanced quality of life based on improved quality of care.

Hospital inpatient services are an important aspect of any health care system. Without this Medicaid coverage, beneficiaries suffering from significant illnesses or physical trauma would not have access to necessary procedures or intensive care.

EXHIBIT 6



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

Effective Jan. 1, 2015, legislation to reduce inpatient costs established a single base rate for inpatient hospital services using the statewide median base rate at June 30, 2014.

Looking Forward

Hospital inpatient service expenditures are expected to increase due to Medicaid enrollment growth and an aging population. However, nationwide efforts to reduce inappropriate use of all hospital services also are anticipated to continue. These efforts include plan design changes, such as primary care physicians and medical homes, case management and enhanced public education.

Hospital Outpatient Services

Hospital outpatient services cover a wide variety of treatments including preventive, diagnostic, therapeutic, rehabilitative and palliative. These services ordinarily do not require admission to a facility, are provided by or under the direction of a physician or dentist, and are received by a Medicaid patient in a hospital setting.

Hospital outpatient services provide access to critical medical care for beneficiaries, while enabling hospitals to provide that care in a quality-oriented and efficient manner. Services that do not require patients to be admitted allow hospitals to dedicate necessary resources to their inpatient services.

The hospital outpatient benefit also provides cost-effective laboratory and radiology services, which can be costly in other settings. This ensures Medicaid beneficiaries have access to a wider variety of these services.

SFY 2015 Highlights

Despite legislated rate reductions for both inpatient and outpatient services, expenditures on all hospital services increased by 10.9% in SFY 2015 compared to SFY 2014 due to an increase in utilization and program enrollment. See Exhibit 6, “Hospital Inpatient and Outpatient Services.”

Looking Forward

DMA projects outpatient expenditures to continue to grow in SFY 2016 and SFY 2017. This assumption is based on the expanding list of inpatient procedures that can be performed on an outpatient basis, which will result in a more costly outpatient recipient mix.

Skilled Nursing Facilities

A skilled nursing facility provides beneficiaries with daily nursing care that does not require the more complex acute care medical consultations and support services available in a traditional hospital setting.

Skilled nursing facilities (SNFs) provide short-term and long-term care to beneficiaries, placing patients under the close supervision of doctors and nurses specially trained to treat a variety of conditions. Additionally, skilled nursing facilities offer rehabilitative care to patients recovering from stroke, surgery or other events, offering patients an alternative to hospitalization that still offers continued full-time care.

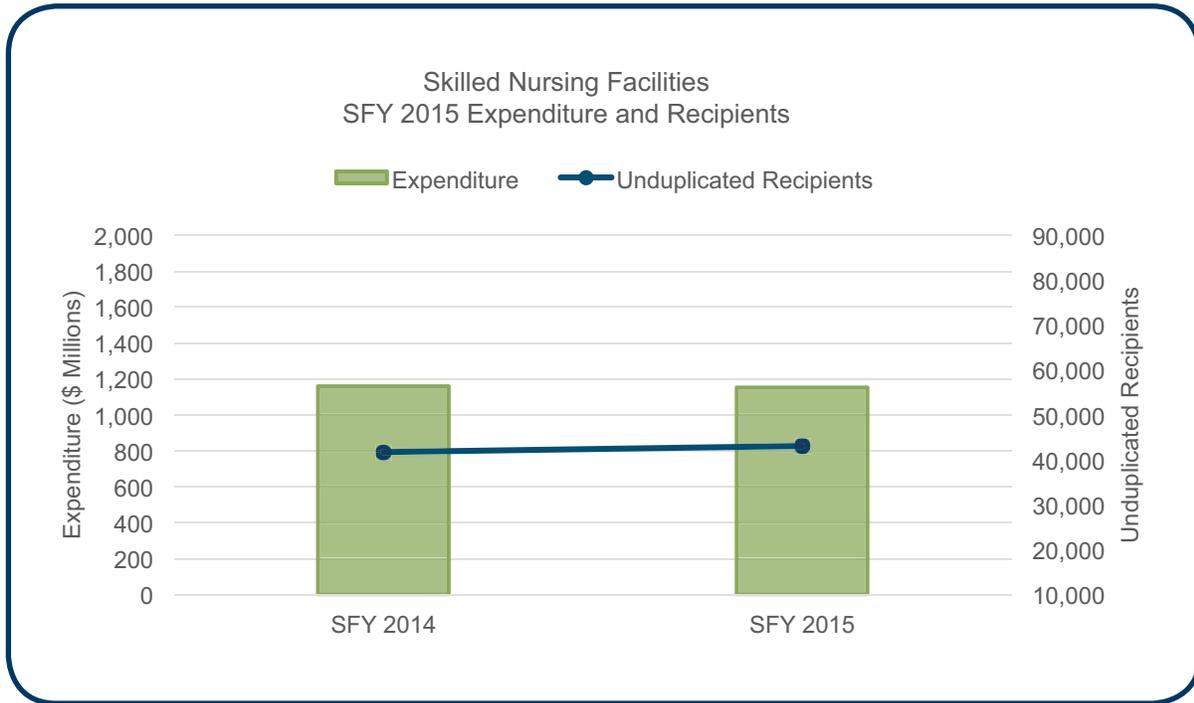
Medicare covers 100% of SNF costs for the first 20 days, but only 80% afterward, up to 100 days. Some beneficiaries are unable to cover the cost of treatment when Medicare runs out. Medicaid coverage for skilled nursing care helps ensure continued access to care for beneficiaries.

SFY 2015 Highlights

- The case mix for nursing home direct care services was frozen effective Jan. 1, 2015
- The 3% rate reduction to nursing home rates was repealed effective June 1, 2015²

² Sections 12H.7 and 12H.18.(b) of Session Law 14-100

EXHIBIT 7



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

Looking Forward

DMA will continue to work with stakeholders to ensure the program maintains the highest level of quality for North Carolina citizens who need this level of care, and to support efforts to allow individuals to live at home as long as possible.

Physician Services

North Carolina Medicaid physician services are provided by all physician specialties. Also included are the non-physician practitioners, such as nurse practitioners, physician assistants, certified nurse midwives and certified nurse anesthetists. Services are provided to Medicaid-eligible beneficiaries, with certain restrictions depending on the eligibility category. Prenatal care physician services are provided to pregnant beneficiaries.

North Carolina is dedicated to providing access to health care for low-income children, families and seniors. Without this care, health issues can develop into long-term, chronic illnesses that prevent people from experiencing a full life, providing for their families and contributing to their communities.

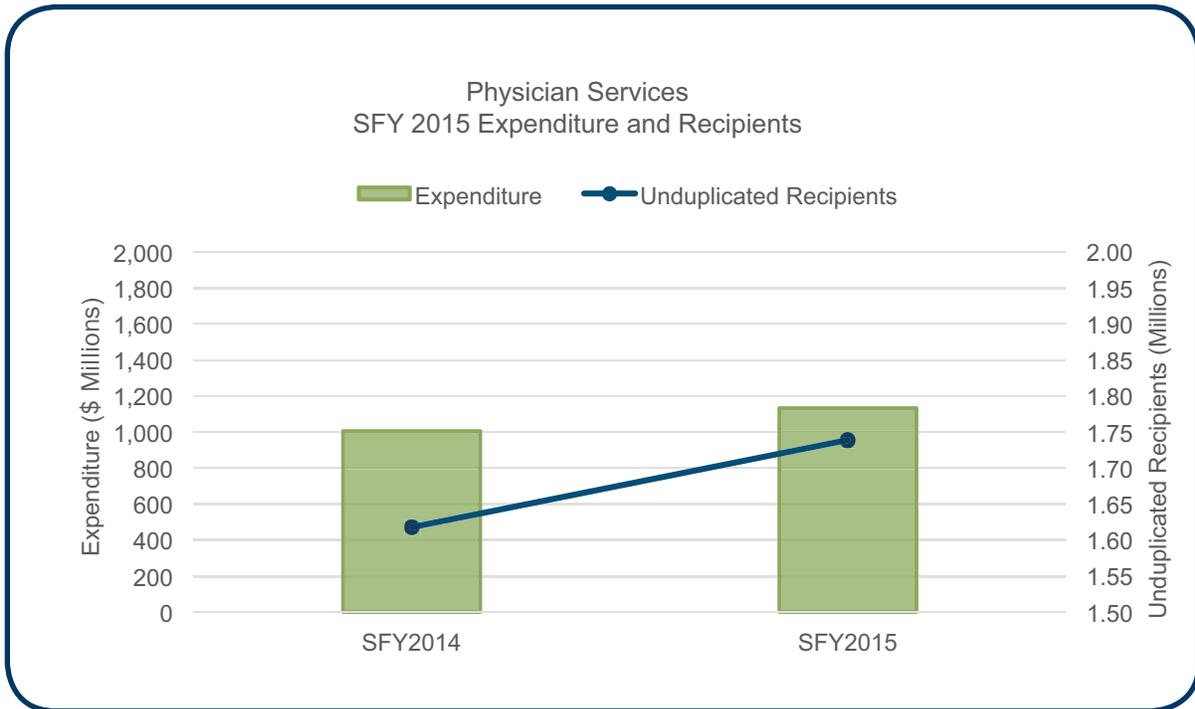
Physician services provide continuing and comprehensive medical care, health maintenance and preventive services to Medicaid beneficiaries, including the appropriate use of consultants, health services and community resources.

Physician services also include case management to ensure Medicaid beneficiaries receive a coordinated approach to their overall health care needs.

SFY 2015 Highlights

A legislated 3% rate reduction in 10 Medicaid and Health Choice services took effect for some physician services providers in SFY 2014 and all providers in SFY 2015.

EXHIBIT 8



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

Looking Forward

Overall, physician services will experience a moderate increase in expenditures in SFY 2016, in line with forecasted enrollment trends.³ The rate reduction enacted in SFY 2015 will offset some of the increased expenditures.

An indirect increase in physician services may occur as more beneficiaries select a medical home and primary care physician through Community Care of North Carolina.

³ The Centers for Medicare & Medicaid Services, National Health Expenditure Projections, 2014-2015, Table 7

Pharmacy

The North Carolina Medicaid Pharmacy Program provides prescription drug coverage (an optional benefit under federal Medicaid laws) to enrolled Medicaid and Health Choice beneficiaries, and to individuals enrolled in both Medicare and Medicaid.

Prescription drugs hold a significant and growing role in maintaining health and treating illnesses, giving beneficiaries the opportunity to become healthier and improve their quality of life. While groundbreaking research continues to lead to new and more effective medications to address a wider range of diagnoses, some new specialty drugs have a significant cost. DMA works proactively to balance health of beneficiaries and the cost of care.

Program management through effective use of drug rebates and careful selection of drugs on a Preferred Drug List (PDL) are among the ways DMA provides access to the right drugs at the most advantageous cost. The result is a pharmacy program that provides the best overall value to beneficiaries, providers and the state.

SFY 2015 Highlights

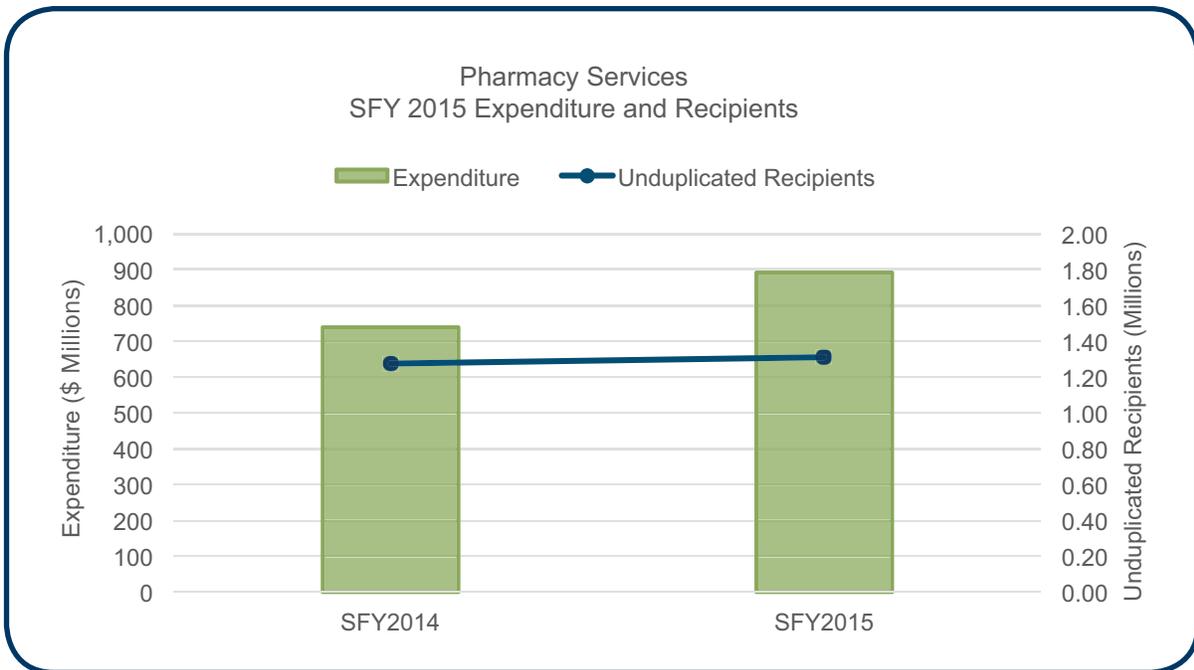
In SFY 2015, pharmacy expenditure growth outpaced total Medicaid expenditures, with pharmacy expenditures increasing by 21% with a corresponding 3% increase in beneficiaries. Increased expenditures were driven primarily by growth in enrollment, and secondarily by increased prescription volume and greater use of certain specialty drugs.

- Utilization rate remained steady at approximately 23%
- Prescriptions per enrollee were up nearly 6%
- Specialty drug expenditures rose over \$100 million, which included a \$34 million increase for hepatitis C drugs

DHHS implemented a number of strategies aimed at lowering overall drug and health care spending, including:

- **Drug rebates.** In SFY 2015, DHHS aggressively pursued higher drug rebate rates. This led to a \$160 million increase in rebates. Drug rebates as a percentage of expenditures rose from 45% to 48%.
- **Prior authorization for specialty drugs.** In SFY 2015, DHHS added the requirement that hepatitis C specialty drug prescriptions be authorized by Medicaid prior to being filled.
- **Appropriate use of prescription drugs.** Specialty drugs, such as hepatitis C medication, may result in higher upfront costs, but will ultimately result in lower medical costs as diseases are cured and future medical needs are abated.

EXHIBIT 9



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

Looking Forward

The pharmacy program will continue to offset expenditures that are a result of a growing number of enrollees, increased annual prescription volume and expensive specialty drugs, through the following three successful cost savings strategies:

1. Generate savings through the aggressive pursuit of higher rebates on drugs
2. Cover expensive breakthrough drugs, such as hepatitis C drugs that will generate long-term savings by avoiding the cost of hospitalizations and liver transplants
3. Manage drug utilization through prior approval on select, expensive drugs and encourage the use of generic drugs by paying pharmacists higher dispensing fees



Medicare Aid Program

The Medicare Aid Program helps Medicare beneficiaries pay for Medicare premiums, copayments and deductibles.

There are four different types of Medicare Aid, each with eligibility and coverage levels that depend on the beneficiary's income and resource limits.

- **Comprehensive Medicare Aid (MQB-Q).** The Medicaid program helps pay for Medicare Part A and B premiums, deductibles, coinsurance and copayments.
- **Limited Medicare Aid (MQB-B).** The Medicaid program pays for Medicare Part B premiums.
- **Limited Medicare Aid Capped Enrollment (MQB-E).** The Medicaid program pays Medicare Part B premiums for those with income too high to qualify for MQB-B.
- **Qualified Disabled and Working Individuals (QDWI).** The Medicaid plan pays Medicare Part A premiums for individuals with a disability who have lost Medicare eligibility because their earnings are greater than the amount allowed by the Social Security Administration.

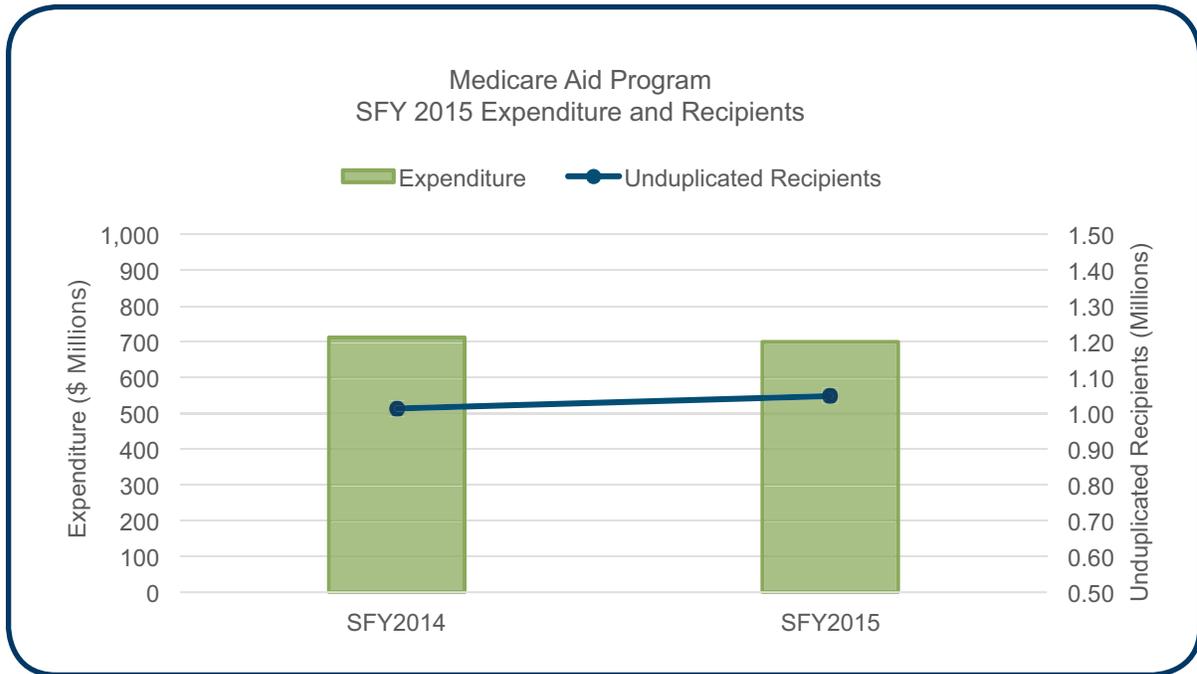
By offering Medicare Aid as part of the North Carolina Medicaid program, the state collaborates with the Centers for Medicare & Medicaid Services and the Social Security Administration to ensure eligible individuals have access to health care services.

Further, Medicare Aid for Working Individuals with a Disability enables individuals with disabilities to pursue employment without jeopardizing continued Medicare coverage.

SFY 2015 Highlights

The Limited Medicare Aid Capped Enrollment program uses federal funding to provide Medicare Part B premium coverage to eligible Medicare beneficiaries. Traditionally, federal funding has been allocated on an annual basis. In SFY 2015, federal legislation was enacted that extended this federal contribution through 2017.

EXHIBIT 10



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

Looking Forward

With the aging of North Carolina's population and the Affordable Care Act requirement that individuals secure health care coverage, Medicare Aid programs are expected to be an increasingly important resource for Medicare beneficiaries on fixed incomes.

Although not effective for several years, planning will be required for dual-eligible beneficiaries carved out of the Medicaid reform capitated plan. DHHS and DMA will begin partnering with providers and beneficiaries in SFY 2016 to develop a plan for dually eligible individuals not covered by reform.

Personal Care Services

Personal care services include a range of human assistance to help with common activities of daily living for Medicaid beneficiaries of all ages with disabilities and chronic conditions. Services are provided to over 59,000 Medicaid beneficiaries in various settings.

The personal care services (PCS) program allows beneficiaries who need assistance with common activities of daily living (ADLs) with the opportunity to avoid placement in a nursing home by offering long-term service in a home environment. ADLs for this program are eating, dressing, bathing, toileting and mobility.

PCS provides person-to-person, hands-on assistance with ADLs by a direct care worker in the beneficiary's home or other setting. PCS also includes assistance with instrumental activities of daily living (IADLs), such as light housekeeping tasks, when directly related to the approved ADLs and the assistance is specified in the beneficiary's PCS service plan.

North Carolina Medicaid beneficiaries receiving PCS must have a medical condition, disability or cognitive impairment, and demonstrate unmet needs for a certain number of qualifying ADLs at varying levels of required assistance.

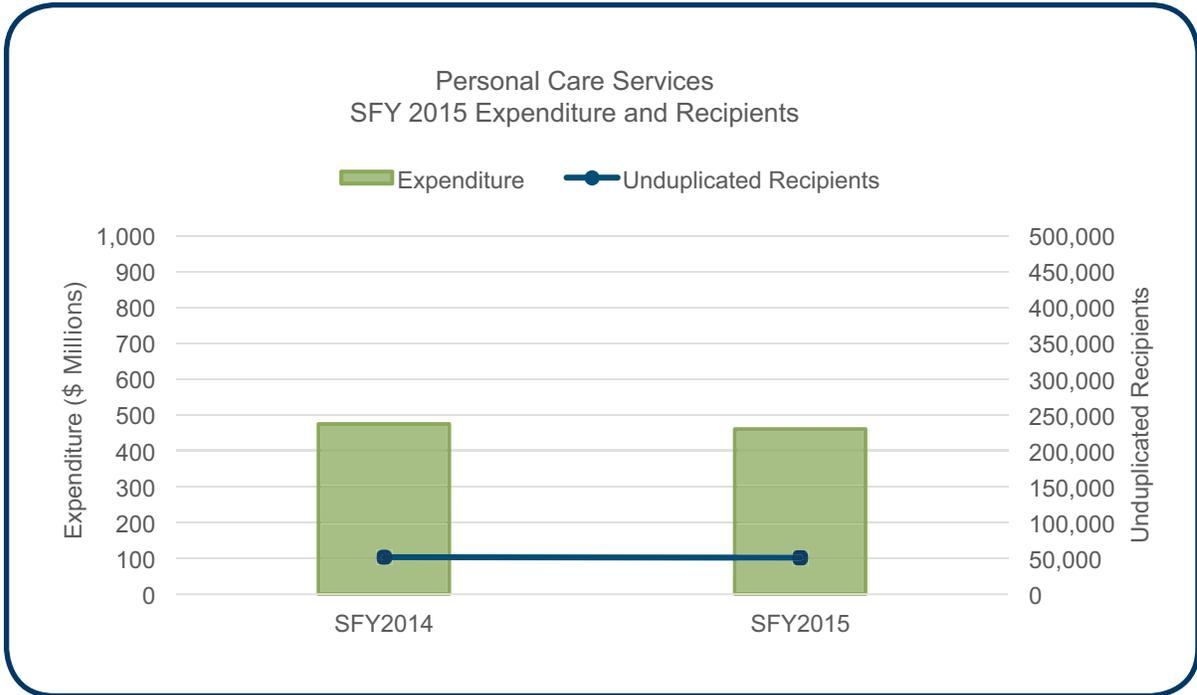
SFY 2015 Highlights

In SFY 2015, legislative changes to the PCS program were implemented that:

- Increased additional hours that PCS beneficiaries age 21 and over could receive if certain criteria were met
- Balanced the increased cost of those additional hours by reducing the PCS hourly rate by 3%

In addition, oversight and monitoring procedures were modified. Physicians became required to note the time period of the ADL limitations and whether they were 1) expected to resolve or improve, 2) chronic or stable, or 3) age appropriate. Limitations are required to be reassessed at certain intervals.

EXHIBIT 11



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

Looking Forward

DMA projects that the combined effects of policy changes and budget reductions will result in a sustainable budget for the PCS program in the future.

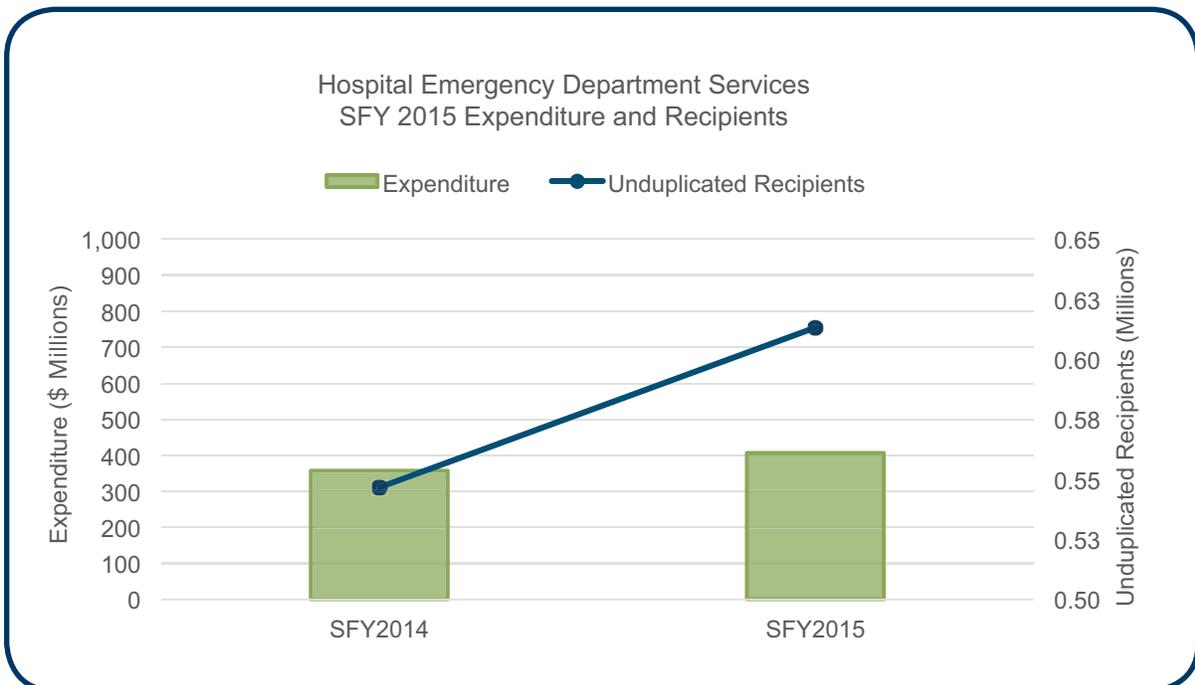


Hospital Emergency Department Services

Hospital emergency department services provide acute care ordered by a physician or dentist for short-term diagnosis and treatment of surgical and medical conditions that may or may not require hospital inpatient admission. Emergency department services received within 24 hours of admission are included as part of the inpatient hospital stay.

Without hospital emergency department benefits, emergency services would shift to physicians and clinics. A hospital emergency department benefit provides for stronger hospital systems that provide emergency health care needs by uniquely qualified staff in an appropriate setting, while allowing physicians and clinics to practice primary and integrated care.

EXHIBIT 12



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

Hospital emergency department expenditures increased in SFY 2015 due to growth in enrollment and utilization.

Looking Forward

DMA projects utilization of emergency hospital services to start to decrease in SFY 2016 and SFY 2017 based on improved clinical policy and better care management practices aimed at reducing readmission rates and emergency department visits.

DMA projects emergency department spending will decrease over five to 10 years based on the implementation of improved care models.

Dental Services

Dental services are provided to Medicaid beneficiaries of all ages and NC Health Choice beneficiaries 6-18 years of age. Dental services include the following types of services: check-ups, X-rays and cleanings; fillings and extractions; complete and partial dentures; and certain surgery procedures.

Orthodontic services, with prior authorization, are provided to beneficiaries under age 21 with functionally impairing malocclusions (impaired or painful ability to speak, eat, swallow or chew due to crooked teeth or jaw alignment). Orthodontic services are provided to NC Health Choice beneficiaries 6-18 years of age with severe malocclusions caused by deformities in head or facial bone growth, like cleft palate.

Uncontrolled oral disease may lead to a higher risk of developing or exacerbating systemic problems like diabetes, heart disease and bacterial pneumonia. Oral health care is even more important for beneficiaries who are chronically ill or have special needs (aged, blind, disabled, intellectual or developmental disabilities, and other diagnoses).⁴

Over half of the births in North Carolina are to Medicaid-eligible women.⁵ Pregnant women with poor oral health are at higher risk for adverse birth outcomes like pre-term and low birth-weight babies,⁶ and may more readily transmit bacteria that cause oral disease to their young children.⁷

Medicaid and NC Health Choice dental services provide the opportunity for North Carolinians to improve oral health and lower the risk of compounding future health issues.

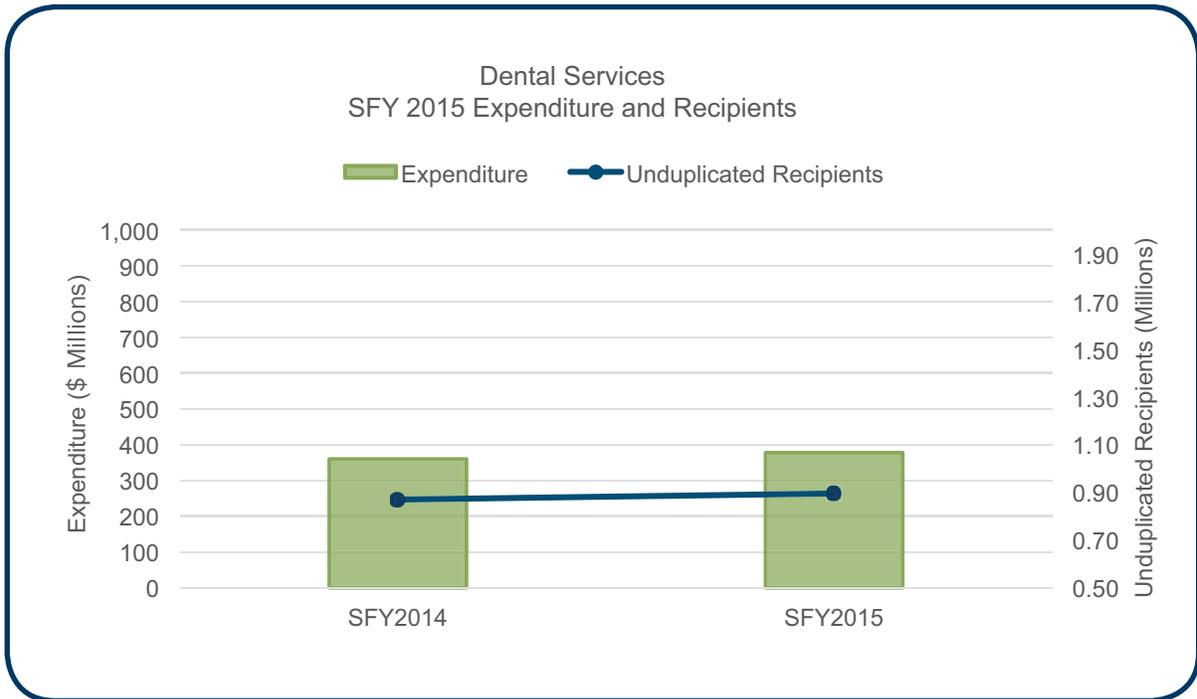
⁴ Williams RC, Barnett AH, Claffey N, et al. The potential impact of periodontal disease on general health: a consensus view. *Curr Med Res Opin.* 2008;24(6):1635-43.

⁵ <http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/>

⁶ Dasanayake AP, Gennaro S, Hendricks-Muñoz KD, Chhun N. Maternal periodontal disease, pregnancy, and neonatal outcomes. *MCN Am J Matern Child Nurs* 2008;33(1):45-9.

⁷ www.aapd.org/media/policies_guidelines/g_perinataloralhealthcare.pdf

EXHIBIT 13



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

In SFY 2015, dental services were provided to 897,000 adults and children in North Carolina, representing a 3.1% increase from the prior year. Expenditures increased by 5.3% from SFY 2014.

Looking Forward

The East Carolina School of Dental Medicine will expand access to oral health services for underserved North Carolinians and Medicaid beneficiaries in rural areas of the state through the opening of new Community Service Learning Centers.

Community Alternatives Program for Disabled Adults

The Community Alternatives Program for Disabled Adults is a Medicaid home- and community-based care program that makes care at home a real possibility for many people who face nursing home placement.

The Community Alternatives Program for Disabled Adults (CAP/DA) waives certain North Carolina Medicaid requirements allowing an array of home- and community-based services to be furnished to adults with disabilities age 18 and older who are at risk of institutionalization. The services provide an alternative to institutionalization for beneficiaries who prefer to remain at home.

CAP/DA supplements the formal and informal services and supports already available to a beneficiary. The program is intended for situations where no household member, relative, caregiver, landlord, community, agency, volunteer agency or third-party payer is able or willing to meet all medical, psychosocial and functional needs of the beneficiary.

SFY 2015 Highlights

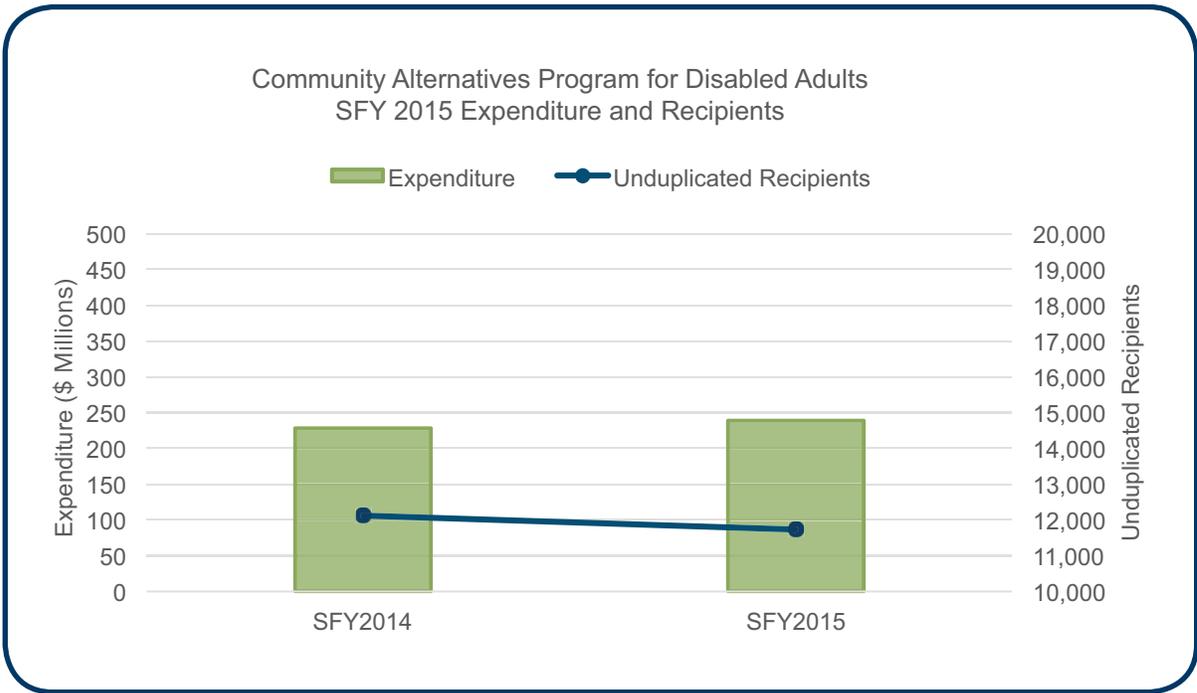
The implementation of e-CAP, a new case management and business system, increased the efficiency of CAP/DA administration for case managers. The e-CAP tool provides:

- Assistance with management of daily administrative functions
- A quality assurance system
- Service request forms that are used to determine eligibility for CAP/DA participation

NCTracks and NC FAST improved program efficiency, resulting in:

- Better management of enrolled waiver providers
- Improved process to establish prior approval for level of care
- Reduced erroneous claims that did not meet waiver criteria

EXHIBIT 14



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

Looking Forward

DMA, in partnership with stakeholders, will continue to review and adjust the waiver to create a stronger person-centered approach that allows individuals and families more choice by:

- Providing support for more inclusive and integrative settings
- Supporting the use of more assistive technology

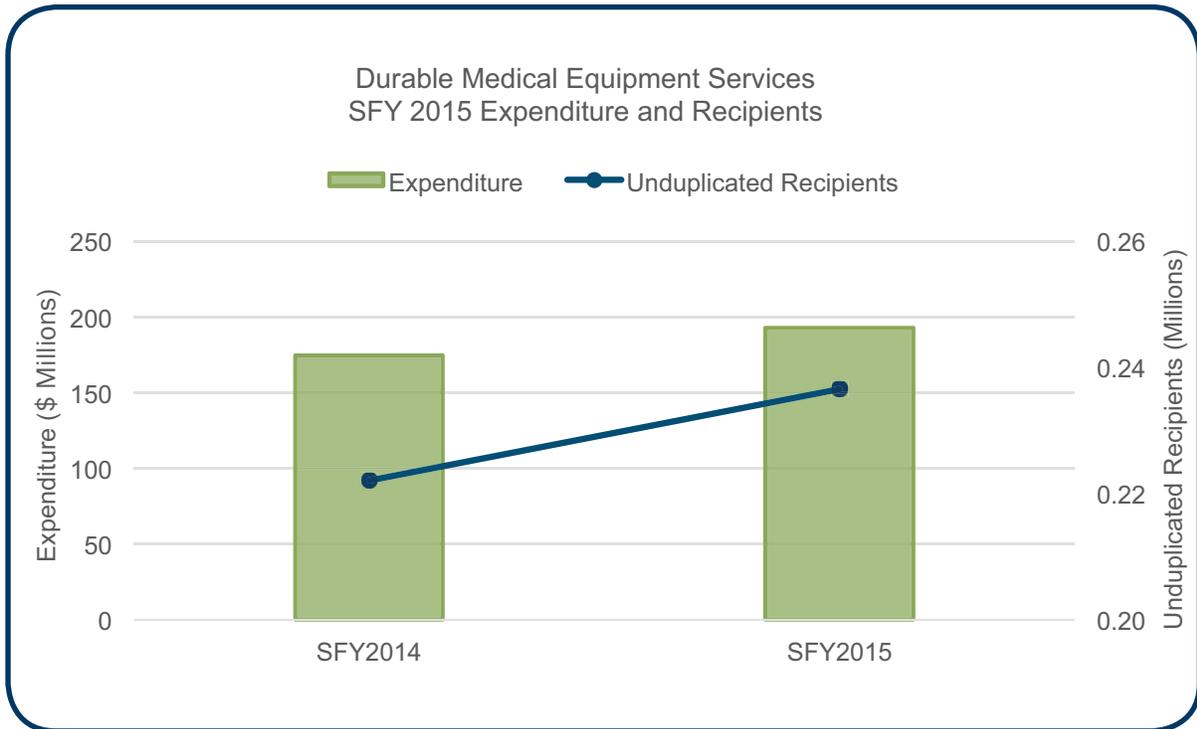
Durable Medical Equipment

The North Carolina Medicaid Durable Medical Equipment Program covers durable medical equipment and supplies, orthotics and prosthetics to enrolled Medicaid and NC Health Choice beneficiaries, and to individuals enrolled in both Medicare and Medicaid.

Medicaid and NC Health Choice programs cover durable medical equipment (DME) when it is medically necessary for beneficiaries to function in their home or an adult care home, and are ordered by a physician, physician assistant or nurse practitioner.

Covered items include wheelchairs, hospital beds, ambulation devices, enteral formulas, bedside commodes, oxygen, respiratory equipment and miscellaneous supplies. Orthotic and prosthetic devices, including braces and artificial limbs, also are covered. Some DME items require prior approval, and all DME, orthotic and prosthetic devices have established lifetime expectancies and quantity limitations.

EXHIBIT 15



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

In SFY 2015, DME expenditures increased by 10.4% as beneficiaries grew by 6.6%.

Looking Forward

Rates for DME services have been frozen since January 2013. The average cost per beneficiary is expected to remain constant in SFY 2016 and SFY 2017.

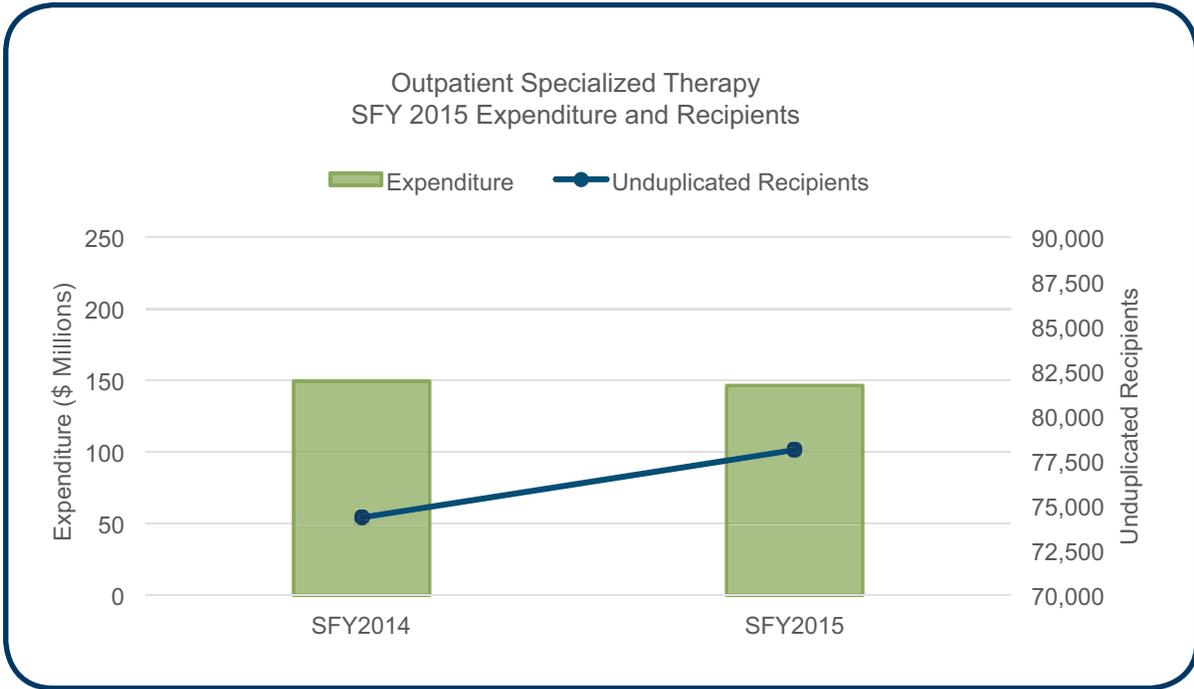
Outpatient Specialized Therapy

Outpatient specialized therapy services are assessments and treatments performed by independent practitioners licensed to provide occupational, physical, respiratory and speech therapy, and audiology services. A physician's order and a preauthorization is required for these services.

Child development service agencies (CDSAs), home health agencies, hospitals and local education agencies (LEAs) provide Medicaid therapy services for specific age groups. This leaves gaps where therapy for certain age groups and care settings, such as home or school, are not covered.

To ensure all children receive therapy to improve developmental skills delayed by impairments or during recovery from an injury or illness, independent practitioners provide Medicaid outpatient specialized therapy services to eligible Medicaid beneficiaries under age 21 and NC Health Choice beneficiaries under age 19. The therapies are provided in the beneficiary's home, day care, preschool, school or clinical office.

EXHIBIT 16



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

Legislation enacted in SFY 2014 limited outpatient specialized therapy services available to adult Medicaid beneficiaries. As a result, outpatient specialized therapies demonstrated a slight expenditure decrease in SFY 2015 compared to the prior year.

Looking Forward

Expenditures for services are expected to increase in SFY 2016 and SFY 2017 in line with the annual enrollment of Medicaid beneficiaries under age 21 and NC Health Choice beneficiaries under age 19.

Clinic Services

With the collaboration of the federal government and other state and local partners, the Medicaid program offers an array of clinic services, including those providers licensed to practice within a clinic service setting. These include federally qualified health centers, rural health clinics, local health departments, and end stage renal disease dialysis facilities.

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) provide a core set of health care services mandated by federal Medicaid laws. FQHCs are Medicaid-certified health centers for underserved populations. RHCs are Medicaid-certified health clinics with services provided by a physician, physician assistant, nurse practitioner or certified nurse midwife. The Office of Rural Health and DMA work together to oversee RHCs.

A local health department is a district health department, a public health authority or a county health department that meets the North Carolina General Assembly mandate to ensure all citizens in the state have access to essential health services fundamental to promoting the highest level of health possible to citizens.

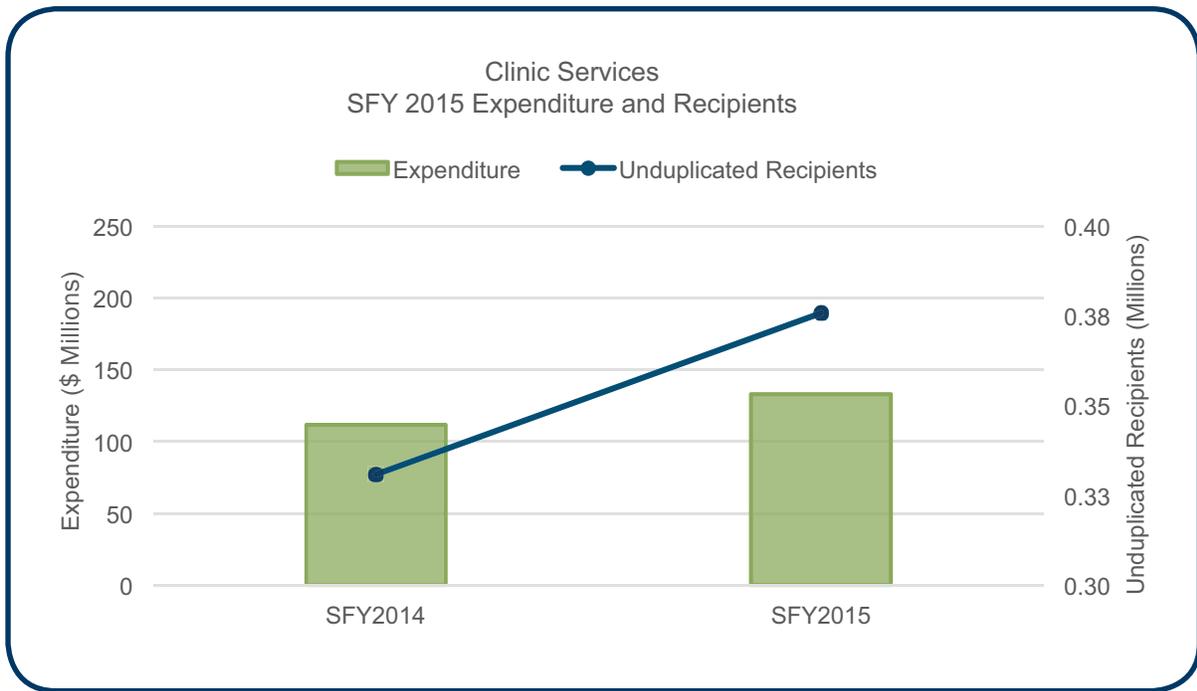
End stage renal disease (ESRD) facilities provide dialysis treatments to enrolled Medicaid beneficiaries. North Carolina Health Services Regulation and DMA oversee more than 180 ESRD facilities across the state.

Clinic services provide continued comprehensive medical care for Medicaid beneficiaries unable to find a Medicaid provider due to access or transient care. Moreover, clinics in North Carolina also serve as safety net providers for all citizens who have difficulty obtaining medical care because they are either underinsured or uninsured.

SFY 2015 Highlights

Compared to SFY 2014, clinic services in SFY 2015 saw a 13.6% increase in beneficiaries and a 19% increase in expenditures.

EXHIBIT 17



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

Looking Forward

Clinics, in their various forms, will continue to serve an integral role as safety net providers in the North Carolina health care system. DMA expects a slight to moderate increase in SFY 2016 expenditures, driven by the forecasted increase in Medicaid enrollment.

From 2015 to 2018, the average national growth in physician and clinical services is expected to be 5.5% per year due to increased demand for services associated with continuing coverage expansion. From 2019 and beyond, the state and the nation will continue to see an aging population with an expected average spending growth of 6.6%⁸ per year.

⁸ The Centers for Medicare & Medicaid Services, National Health Expenditure Projections, 2014-2015, Table 7

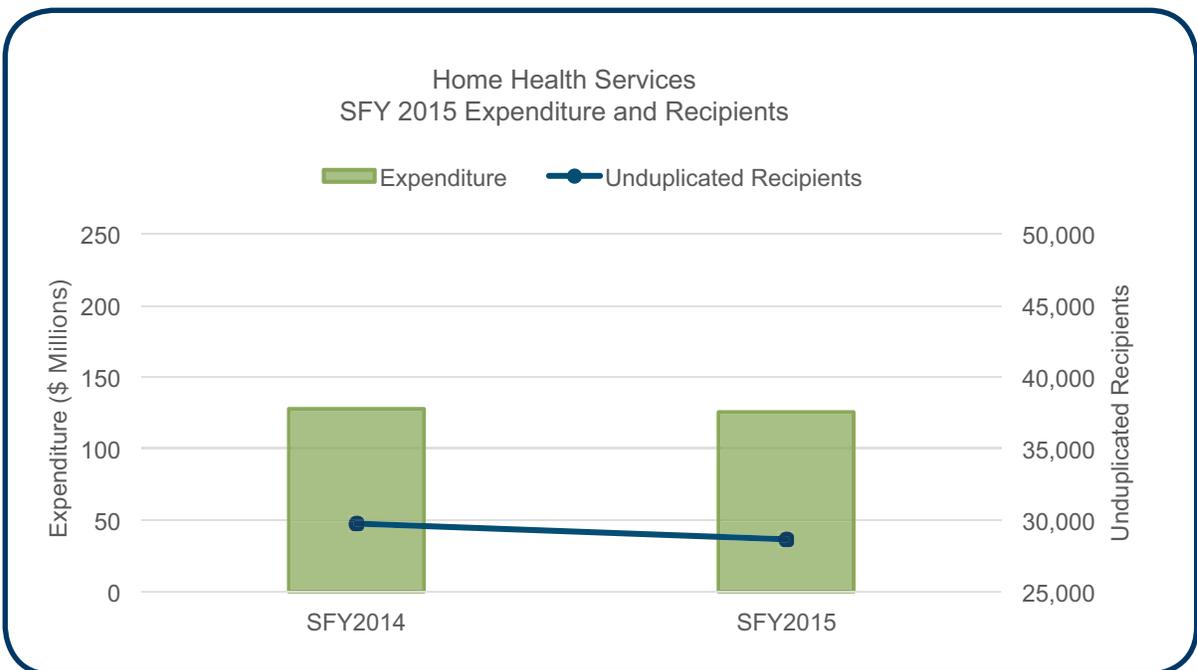
Home Health Services

Home health services are medically necessary skilled nursing services, specialized therapies (physical therapy, speech-language pathology and occupational therapy), home health aide services and medical supplies provided to beneficiaries at home or in adult care homes. Services are available to all Medicaid and NC Health Choice beneficiaries at any age.

Home health services reduce the length and cost of hospital stays for beneficiaries while promoting independence and self-sufficiency. These services are designed to be offered on a short-term or intermittent basis.

Home health services are less expensive than hospital or skilled nursing facility care. They reduce admission into skilled nursing facilities and allow beneficiaries to receive required treatment in the comfort of their homes.

EXHIBIT 18



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

- Nearly 30,000 individuals were served by home health services through Medicaid in SFY 2015
- Home health services beneficiaries declined by 3.8% and expenditures declined by 1.5% from SFY 2014 to SFY 2015

Looking Forward

Home health services costs are expected to decrease due to policy implementation and system changes effective Nov. 1, 2015. These system changes occur primarily on the billing side and will ensure that providers are billing accurately by reducing the use of miscellaneous billing codes, leading to reduced costs for home health services.

Lab and X-ray Services

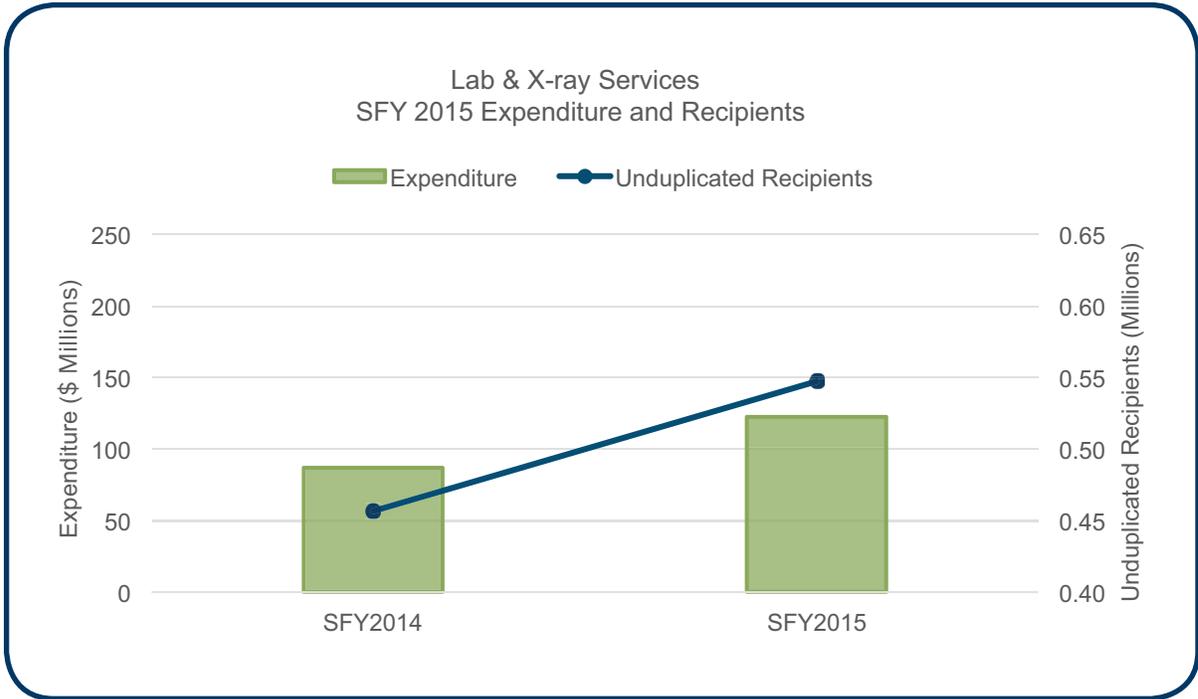
Lab and X-ray services include diagnostic lab tests performed in independent laboratories, and lab tests, portable X-rays and ultrasounds that take place in independent diagnostic testing facilities.

North Carolina provides laboratory services to enrolled Medicaid and NC Health Choice beneficiaries, and to individuals enrolled in both Medicare and Medicaid. X-ray services are included in this category and typically account for a small percentage of total expenditures.

SFY 2015 Highlights

A 19.8% increase in recipients compared to SFY 2014, combined with the introduction of new lab procedures, led to a 40.9% expenditures increase for the program.

EXHIBIT 19



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office



Looking Forward

Lab and X-ray services expenditures for SFY 2016 are expected to hold steady compared to SFY 2015. DMA will continue to monitor per-recipient expenditures for lab and X-ray services to ensure an appropriate level of service is offered to beneficiaries.

Changes in SFY 2016 to the genetic testing policy could result in more or different coverage for certain tests and other lab series. These changes could affect the average cost per recipient for lab services in future periods and will be closely monitored by DMA in SFY 2016 and SFY 2017.

Health Check Preventive Services

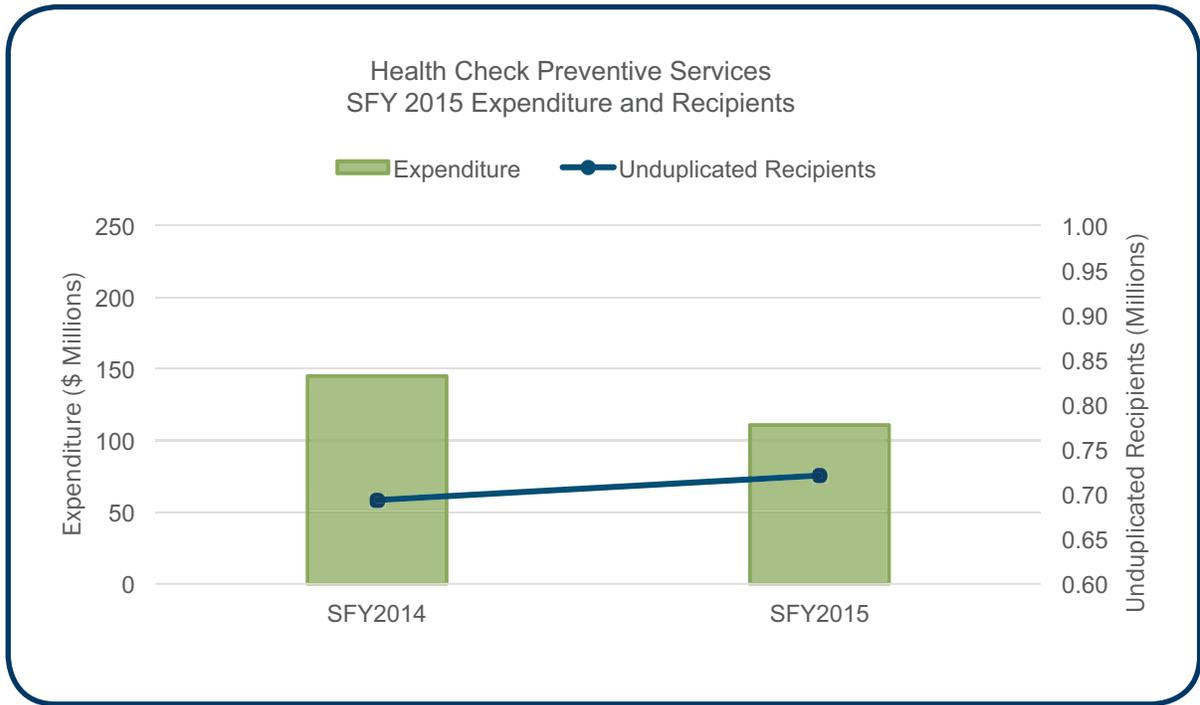
Health Check is North Carolina's preventive health and periodic screening services program for Medicaid beneficiaries under age 21. These services are part of the federal Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefit required by the Centers for Medicare & Medicaid Services.

Health Check ensures eligible children have access to early and regular medical surveillance and preventive services, including screenings,⁹ physical assessments, referrals and follow-up care to promote good health, and to ensure earliest possible diagnosis and treatment of health problems.

Under EPSDT, diagnostic and treatment services must be provided when Health Check wellness screens indicate a need for further evaluation of a child's medical condition. Wellness visits are offered and encouraged at intervals recommended by the American Academy of Pediatrics.

⁹ Includes dental, vision, hearing, mental health and developmental screenings

EXHIBIT 20



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

Health Check statewide participation in wellness visits is reported to the Centers for Medicare & Medicaid Services each federal fiscal year. The CMS-416 FFY 2015 report shows:

- North Carolina children receive wellness screens on par (57%) with the national average (59%)
- North Carolina participates in early preventive screening visits at well-above the national average in the critical developmental window of birth through the fifth year of life
- Preventive dental services for children have increased nearly 20% over the past 3 years

EXHIBIT 21

North Carolina and National Participation Rates, Early Periodic Screening			
Geography	Under 1 year old	1 to 2 years old	3 to 5 years old
North Carolina	96%	89%	73%
All States Combined	92%	80%	69%

Source: CMS-416 FFY 2015

Looking Forward

North Carolina will continue to provide preventive screens and comprehensive health counseling to its pre-adolescent and adolescent population through Health Check. Establishing and maintaining relationships with health care providers during these years of rapid social and emotional growth, and increasing personal independence can provide the foundation for a lifetime of good health habits. Participation has increased by 12% over the past 3 years, and local Health Check coordinators will continue efforts to strengthen outreach and health education.

Community Alternatives Program for Children

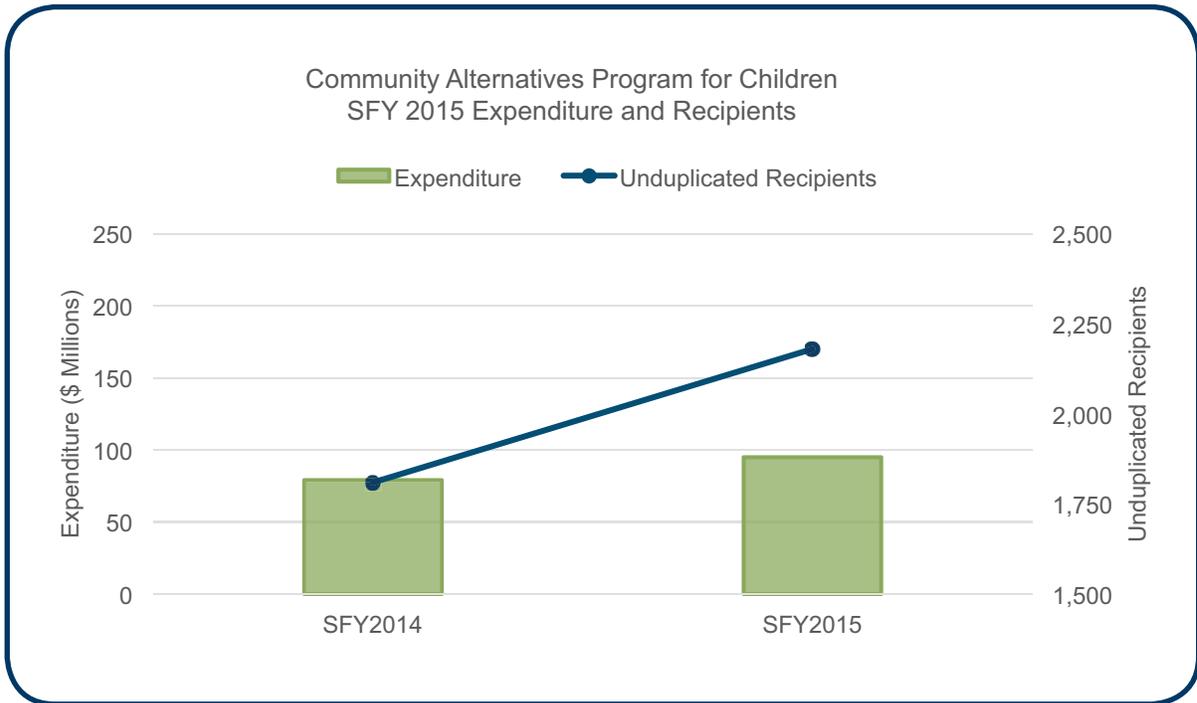
The Community Alternatives Program for Children is a home- and community-based care program, making care at home a real possibility for many children who face nursing home placement.

The Community Alternatives Program for Children (CAP/C) offers an array of home- and community-based services to children, including foster children, from birth to age 18 who have a disability and are at risk of institutionalization. This program provides an alternative to institutionalization for beneficiaries to remain at home.

CAP/C supplements the formal and informal services and supports already available to a child. The program is intended for situations where no household member, relative, caregiver, landlord, community, agency, volunteer agency or third-party payer is able or willing to meet all medical, psychosocial and functional needs of the child.

CAP/C ended SFY 2015 with 1,896 beneficiaries, a 27% increase from SFY 2014, continuing a growth trend from SFY 2014. The increase was likely driven by an increased awareness of the program among providers, which led to more referrals from hospitals, county Department of Social Services offices and pediatricians.

EXHIBIT 22



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

The implementation of e-CAP, a new case management and business system, increased the efficiency of CAP/C administration for case managers. The e-CAP tool provides:

- Assistance with management of daily administrative functions
- A quality assurance system
- Service request forms that are used to determine eligibility for CAP/C participation

NCTracks and NC FAST improved program efficiency, resulting in:

- Better management of enrolled waiver providers
- Improved process for establishing level of care prior approval
- Reduced erroneous claims that did not meet waiver criteria

Looking Forward

DMA, in partnership with stakeholders, will continue to review and adjust the waiver to create a stronger person-centered approach that allows individuals and families more choice by:

- Providing support for more inclusive and integrative settings
- Supporting the use of more assistive technology

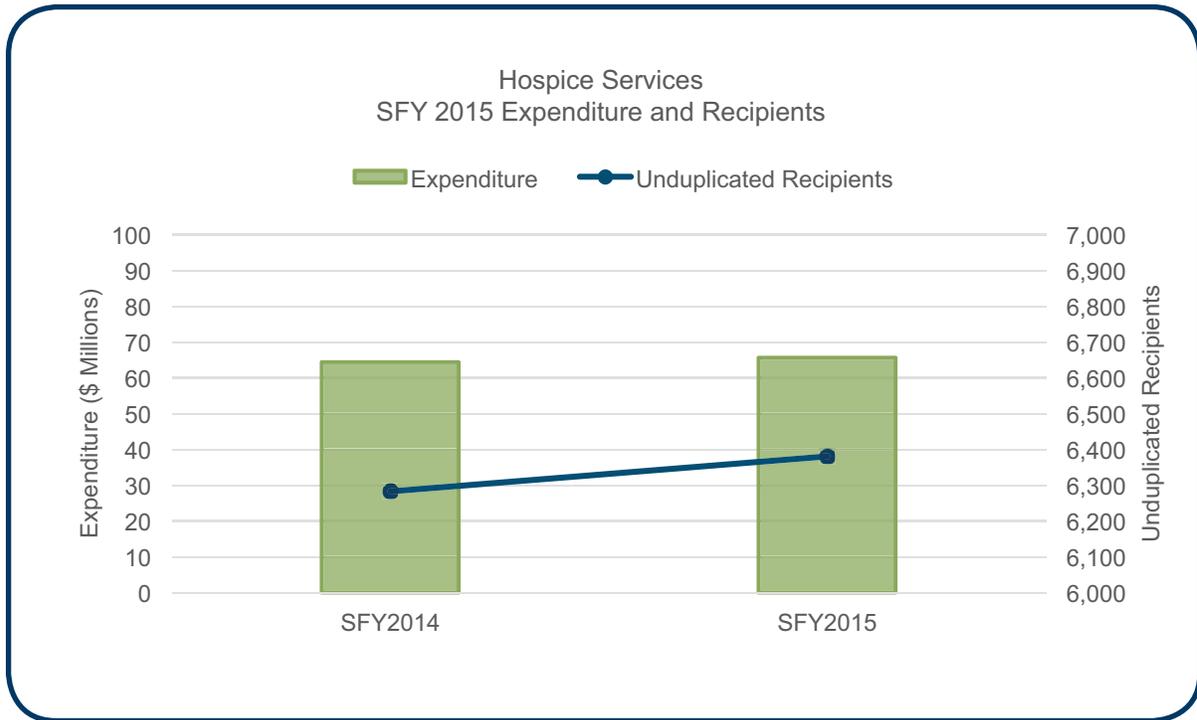
Hospice Services

The Medicaid and NC Health Choice hospice benefit provides coordinated and comprehensive services for the physical, psychosocial, spiritual and emotional needs of terminally ill beneficiaries, their families and caregivers. Services are provided in private homes, hospice residential care facilities and a variety of other settings.

Individuals in their last phase of life may prefer to manage pain and other symptoms in the comfort of their own home rather than continue treatment in a hospital setting. Providers with specialized skills and training to care for those in their final days are necessary to ensure the most appropriate physical and emotional care.

With Medicaid hospice services, beneficiaries with a life expectancy of six months or less may choose to forgo curative measures and, instead, use palliative medicine to manage symptoms. Hospice provides a compassionate approach to end-of-life care, improving the quality of life for beneficiaries and their families.

EXHIBIT 23



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

The North Carolina Medicaid hospice services policy changed to allow hospice services to be provided at the same time as in-home personal care services (PCS), allowing recipients of hospice care to continue receiving assistance with activities of daily living from PCS aids. This improvement allowed beneficiaries to receive both service types with coordinated efforts and increased quality of life.

Looking Forward

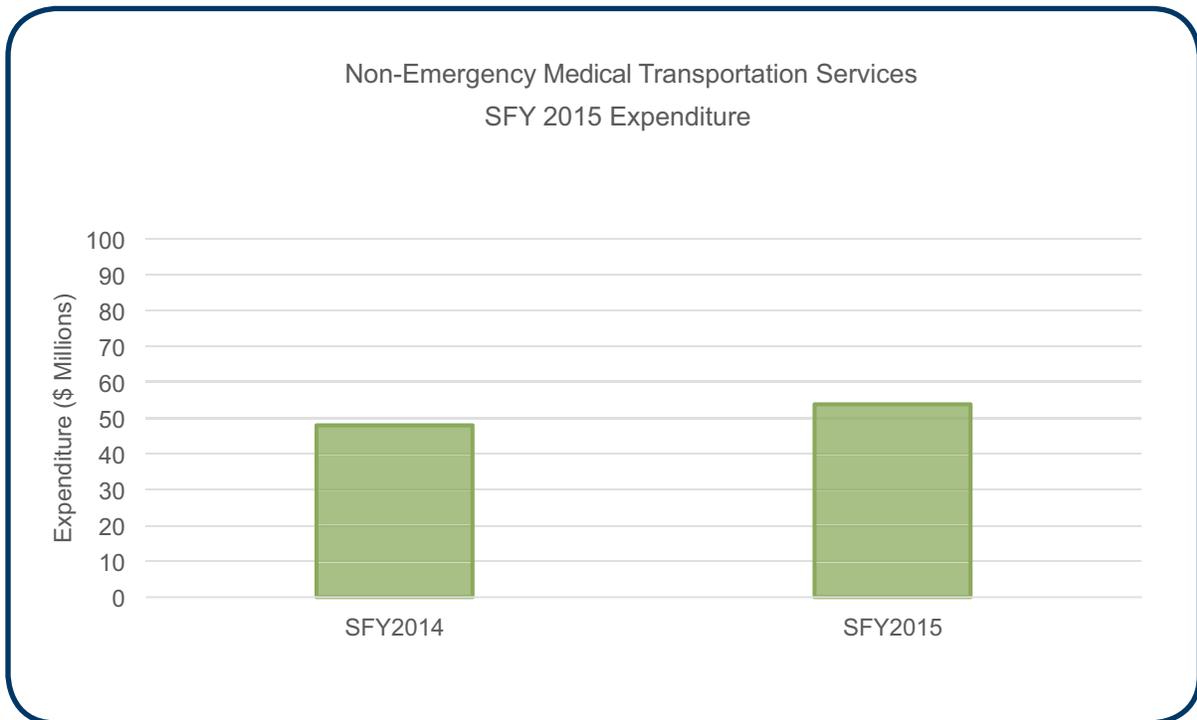
The policy change to provide concurrent hospice and PCS will be fully implemented Jan. 1, 2016. The integration of these services could result in an increase in utilization going forward.

Non-Emergency Medical Transportation

Medicaid beneficiaries are provided transportation services to and from medical appointments through county Department of Social Services (DSS) offices. DSS contracts with vendors, including public transportation, taxi cabs, private transportation companies, volunteers and DSS staff, using private and agency vehicles.¹⁰

Medicaid beneficiaries often do not have the resources to travel to their medical appointments. Non-emergency medical transportation (NEMT) ensures that all eligible Medicaid beneficiaries have access to vital health care.

EXHIBIT 24



Note: Unduplicated recipient data for NEMT was not available when this report was published.
 Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

¹⁰ In addition, NEMT addresses special needs such as an attendant, wheelchair or a specific mode of transportation.

Transportation providers are reimbursed for mileage and provided gas vouchers when they drive their own vehicles, and travel-related expenses, such as meals and overnight stays.

SFY 2015 Highlights

NEMT expenditures increased by 12.5% in SFY 2015. Changes in eligibility requirements and income thresholds under the Affordable Care Act increased eligible Medicaid beneficiary access to transportation services.

Looking Forward

Direct enrollment for NEMT providers will move forward in SFY 2016 and SFY 2017, enabling a more streamlined and uniformed reimbursement system across all 100 counties. Additionally, rates for services will be the same in each county. These improvements will decrease payment errors and increase quality assurance.

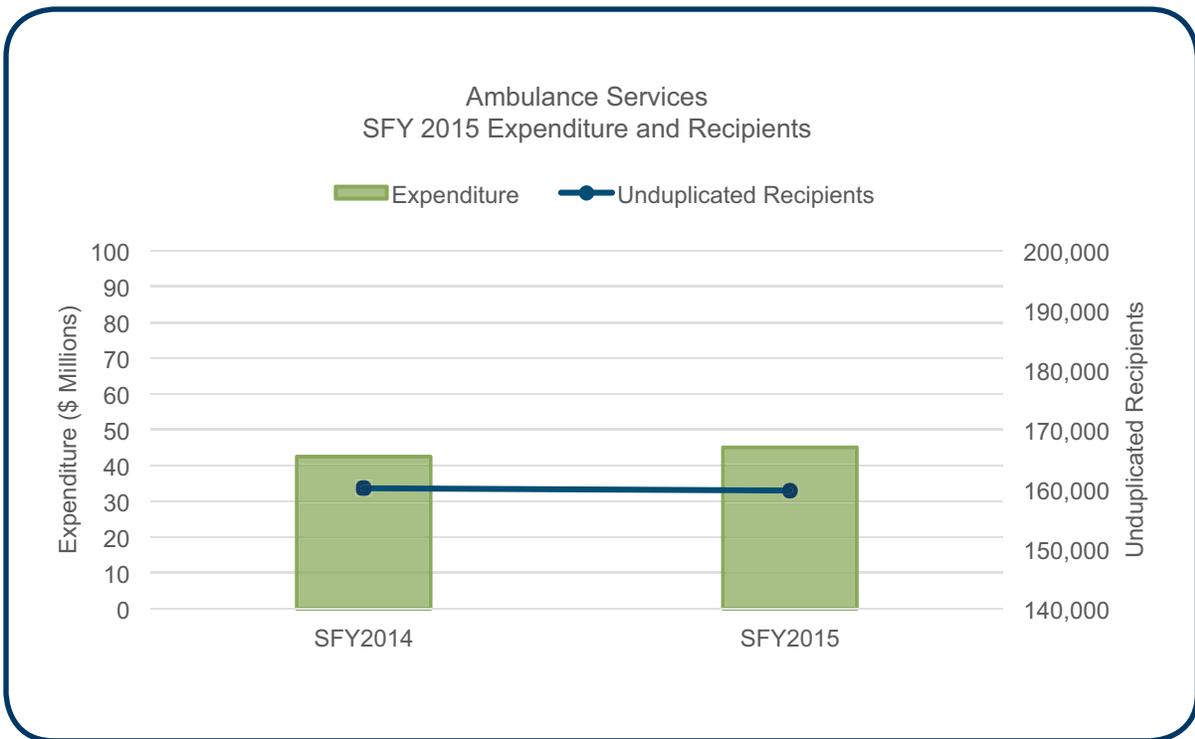


Ambulance Services

Ambulance services provide ground and air transportation for Medicaid beneficiaries who experience a sudden medical emergency and cannot be safely transported by other means, like a car or taxi, to receive medically necessary treatment.

Medicaid provides ambulance services to ensure beneficiaries receive appropriate care as soon as possible in a medical emergency. The beneficiary’s condition must meet medical necessity and require medical services that cannot be provided in the beneficiary’s home. There are currently 396 ambulance providers enrolled in North Carolina Medicaid.

EXHIBIT 25



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

An ambulance policy was developed to replace the ambulance manual. The policy is currently in the review and approval process for Medicaid clinical policies as determined by the General Assembly. The final policy will outline requirements to provide ambulance services to Medicaid beneficiaries. Unlike Medicaid manuals, the policy will serve as a legally binding document.

Looking Forward

Average ambulance service expenditures and utilization rates are expected to remain constant in SFY 2016 and SFY 2017.

Program of All-Inclusive Care for the Elderly

Program of All-Inclusive Care for the Elderly (PACE) is a national model of a capitated managed care program for adults ages 55 and older who require nursing facility level of care. The overall goal is to provide higher quality care by managing all health and medical needs to delay or avoid hospitalization and long-term care placement.

PACE is a community-based alternative to nursing facility placement for beneficiaries who qualify. As the North Carolina population ages, the need for long-term, community-based support options like PACE becomes increasingly important. PACE offers a comprehensive array of services including primary health clinics, adult day care health programs, areas for therapeutic recreation, personal care, and other acute, emergency care and long-term care services for those enrolled in the program.

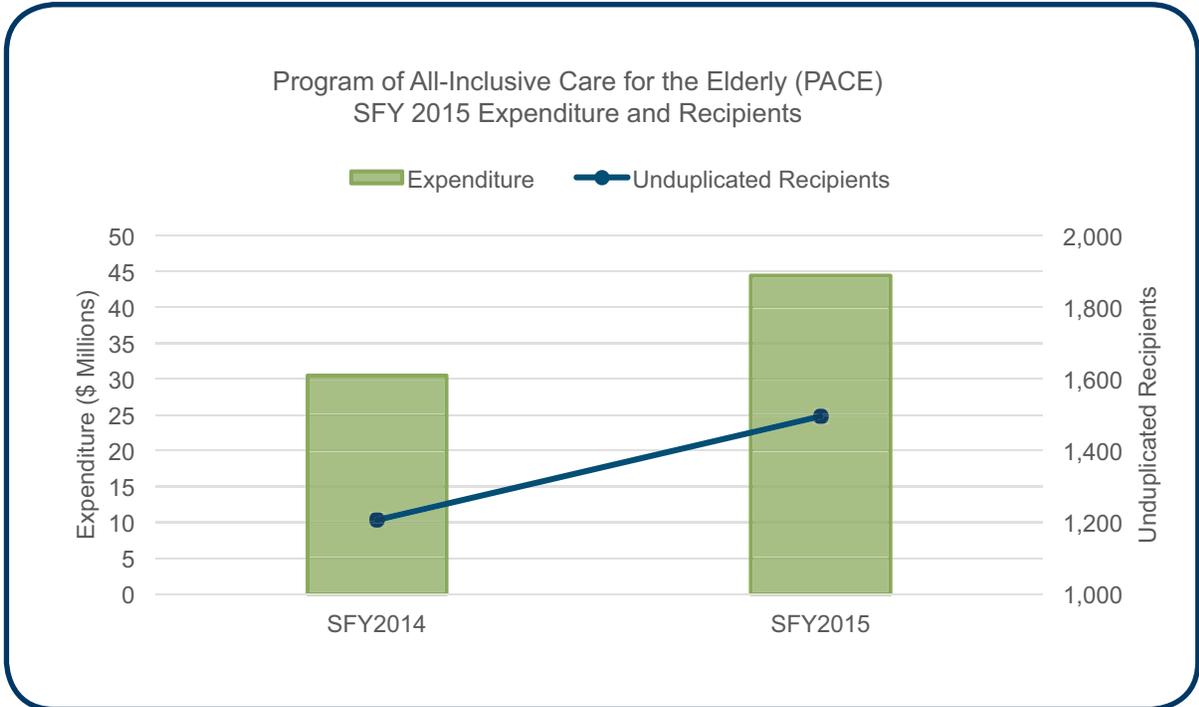
With its comprehensive service package, PACE provides integrated, holistic support that addresses both the clinical and social determinants of health. PACE strives to provide this integrated care in a manner that:

- Enhances the quality of life and autonomy for older adults
- Maximizes dignity and respect for older adults
- Enables older adults to live in their homes as long as medically and socially feasible
- Preserves and supports the older adult’s family unit

SFY 2015 Highlights

In SFY 2015, DMA facilitated the launch of two additional PACE organizations in North Carolina, for a total of 11 PACE operations in 12 locations. With this expansion, only one state in the country exceeds North Carolina in its number of PACE organizations.¹¹

EXHIBIT 26



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

¹¹ NC PACE Association, State Program Data.

DMA implemented an enrollment allocation methodology that facilitated controlled growth and development of the PACE network. This enrollment allocation methodology resulted in increased predictability for Medicaid budget forecasting while also enabling more beneficiaries to be served. At the close of SFY 2015, PACE served 1,324 individuals, representing nearly a 30% growth in one year.¹²

Looking Forward

In collaboration with stakeholders, DMA will continue to improve and streamline its oversight of PACE in ways that promote the model as a viable, cost-effective, community-based option for eligible beneficiaries. Areas of focus for PACE in SFY 2016 and beyond include:

- Revision of guidelines and policy to ensure quality and continuity of care for beneficiaries transitioning into PACE from long-term care settings
- Streamlining and automating reporting requirements to minimize duplication for PACE agencies
- Development of agreements within PACE organizations to clarify DHHS expectations for financial reporting, rate setting development and program integrity practices

¹² DMA PACE Enrollment Data; July 2014 enrollment was 1,023.

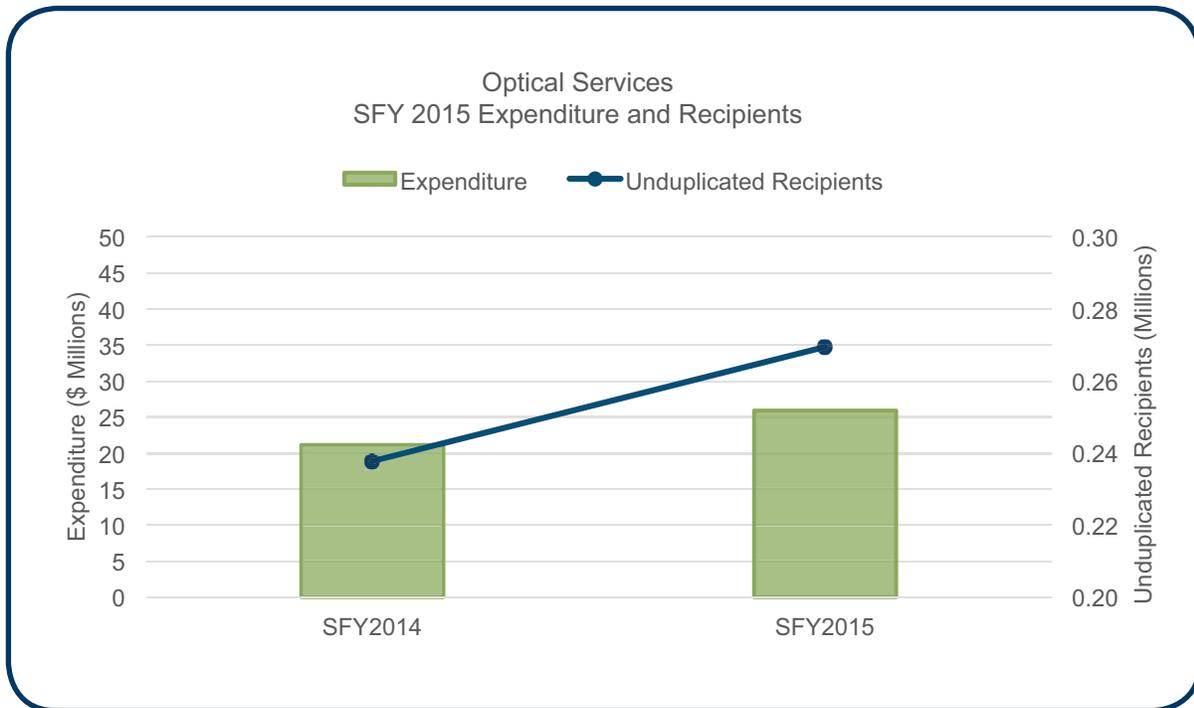
Optical Services

Medicaid and NC Health Choice programs cover optical services, which include routine eye examinations, eyeglasses and medically necessary contact lenses for Medicaid beneficiaries under age 21 and NC Health Choice beneficiaries under age 19.

Through a partnership between DHHS and the Department of Public Safety (DPS), eyeglasses are fabricated by Nash Correctional Institution inmates at Nash Optical Plant, a state-owned and state-operated full-service optical laboratory.

There have been no cost increases since 1998 for lenses or add-ons fabricated by Nash Optical Plant. Frame costs have increased minimally with frame updates.

EXHIBIT 27



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

Nearly 270,000 individuals received optical benefits through Medicaid in SFY 2015; an increase of 13.3%. This corresponds with a 22.6% increase in expenditures for the optical program.

The Nash Optical Plant inmate program resulted in continued savings to Vocational Rehabilitation and Services for the Blind. Additionally, the General Assembly requested a study of the impact to the state should adult optical services be reinstated, and results were presented to the General Assembly March 1, 2016.

Looking Forward

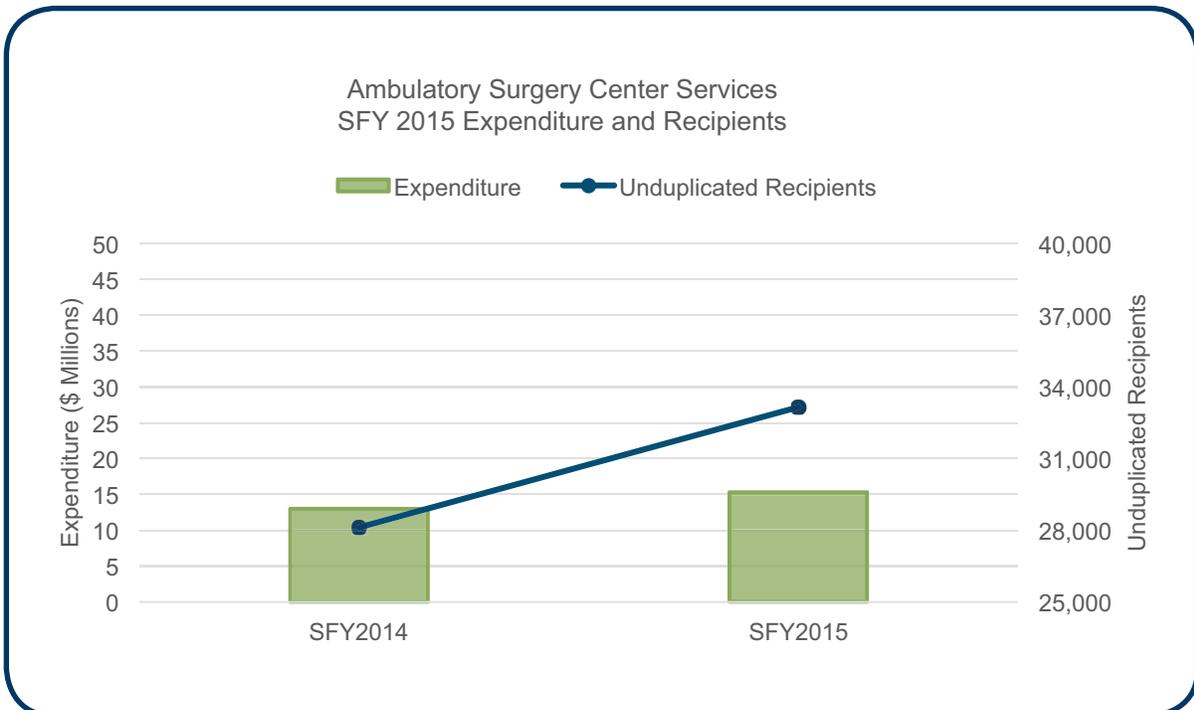
DMA looks forward to partnering with the General Assembly and Executive Branch on the best path forward.

Ambulatory Surgery Center Services

An ambulatory surgery center provides surgical procedures in an outpatient setting. A beneficiary receives scheduled procedures, including diagnostic and preventive services, and is discharged on the same day. Most Medicaid beneficiaries are eligible to receive ambulatory surgery center services.

Ambulatory surgery centers (ASCs) relieve the workload of hospitals by offering an alternative outpatient setting for a growing number of critical procedures. Without ASCs, Medicaid beneficiaries would be required to visit the hospital for surgical procedures. As of December 2014, there were 118 ASC providers enrolled in North Carolina Medicaid.

EXHIBIT 28



Source: Expenditures from NCAS BD-701; Recipients from DMA Business Information Office

SFY 2015 Highlights

In SFY 2015, ASC expenditures and beneficiaries each grew by 17.9%, largely driven by the addition of 52 procedure codes covered under the Medicaid program.

Looking Forward

DMA anticipates ASC expenditures will grow in line with Medicaid enrollment growth in SFY 2016 and SFY 2017, assuming no major future policy changes, rates remain the same and Medicaid enrollment increases as expected. In addition, new technology could lead to more procedures approved for coverage as providers have more capability to serve beneficiaries in an outpatient setting. For example, improvements in anesthetics and less invasive technologies have been documented as driving patients to ASCs.¹³



¹³ www.ascaconnect.org/CONNECT/Communities/Resources/ViewDocument/?DocumentKey=7d8441a1-82dd-47b9-b626-8563dc31930c

Other Division of Medical Assistance Highlights

Clinical Policy

The DMA Clinical Policy section is responsible for the overall administration of programs and clinical services covered in the North Carolina Medicaid and NC Health Choice programs, ensuring the delivery of high-quality, cost-effective health care services and products to eligible beneficiaries.

Clinical Policy develops clinical coverage policies and procedures, administers those policies and procedures, manages associated programs and contracts, and provides related educational activities. Clinical Policy coordinates with other DMA sections that are responsible for determining eligibility, reimbursement and monitoring the program integrity of covered services. Clinical Policy also provides program information to Medicaid recipients, service providers and the general public.

Preparing for SFY 2016 and Beyond

Clinical Policy must be prepared to address the challenges of a rapidly changing health care industry. Efforts to improve care while containing costs can come from different local and national sources, such as state and federal legislation, advancements in medical technology and services, and innovative health system models. Recent Clinical Policy activities to address anticipated health policy changes include:

- ICD-10¹⁴ will be an extremely substantial update to the current ICD-9 coding system that will affect health care providers and payers nationwide. Although the implementation will take effect in October 2016, Clinical Policy started the extensive transition work in early 2015.
- The evolving field of genetic testing has led to Clinical Policy development of a policy draft that addresses benefit coverage criteria for cytogenetic studies, DNA self-read and genetic disorder symptoms.

Additionally, as North Carolina continues its work to reform the Medicaid delivery system, Clinical Policy will be a close partner as it prepares to modify policies and programs accordingly. Through sound policymaking, Clinical Policy will hold a vital position to balance access to care, quality of care and cost effectiveness.

¹⁴ Tenth revision to the International Classification of Diseases coding system, the standard diagnostic tool in the health care industry.

Program Integrity

The Office of Compliance and Program Integrity ensures compliance, efficiency and accountability within the North Carolina Medicaid program by detecting and preventing fraud, waste and abuse. Program Integrity works to ensure dollars are paid appropriately for Medicaid services using claims reviews and investigations, implementing recoveries, pursuing recoupments, and aggressively identifying other opportunities for cost avoidance.

The Office of Compliance and Program Integrity also protects Medicaid and NC Health Choice beneficiary rights with respect to the privacy of health records as required under the Health Insurance Portability and Accountability Act (HIPAA).

Primary efforts of Compliance and Program Integrity:

- Respond to consumer complaints related to fraud, waste and abuse by providers and beneficiaries participating in the Medicaid and NC Health Choice programs
- Complete investigations and recoveries related to instances of fraud and pursuing recoveries of inappropriately expended funds
- Use predictive analytics to identify unusual billing practices to predict and identify fraudulent activities within the Medicaid and NC Health Choice programs
- Apply prepayment reviews for providers suspected of fraud, waste or abuse to ensure funds are not misused
- Oversee LME-MCOs to ensure provider networks deliver stated services and comply with federal and state regulations
- Work directly with the North Carolina Attorney General's Office and its Medicaid Investigations Division to prosecute providers and beneficiaries indicted for Medicaid fraud

- Enforce HIPAA privacy rules that have been established to ensure accountability and responsibility for the use or disclosure of protected health information for the purposes of treatment, payment or health care operations. This includes all medical records and health information used or disclosed in any form, whether electronic, written or oral.

Responding to Consumer Complaints

Compliance and Program Integrity receives complaints from patients, their families, other providers, former employees of providers, and through federal and state referrals. Referrals include complaints made through calls or submitted online:

- DMA Medicaid fraud, waste and abuse tip line
1-877-DMA-TIP1 (1-877-362-8471)
- DMA Medicaid Fraud and Abuse Confidential Complaint form at www2.ncdhhs.gov/dma/fraud/reportfraudform.htm

DMA also responds to Medicaid fraud calls referred from the State Auditor's Waste Line, **1-800-730-TIPS**.

During SFY 2015, Compliance and Program Integrity received and reviewed more than 8,000 individual complaints through these sources, of which 597 cases were referred to the North Carolina Attorney General's Office for investigation.

Predictive Analytics

To predict and identify fraudulent Medicaid program activities, DMA also invested resources to examine and review Medicaid claims data for unusual billing practices. DHHS owns two data analytics tools:

- **Fraud and Abuse Management System (FAMS)**, which performs peer group behavioral predictive modeling to identify providers with suspicious activities
- **Identity Insight System**, which performs network analysis to determine connections among provider identifications and relationships within the Medicaid system

These two tools are used to review paid claims, refer providers for reviews and screen incoming provider applications.

As a result of predictive analytics, in SFY 2015:

- 66 Medicaid providers were referred for suspension of payments and for placement on prepayment billing review (see Prepayment Reviews for additional information on this process)
- 46 providers were referred for investigation of improper Medicaid claim payments
- 25 Medicaid provider applications were referred for additional review or denial of application based on suspicious activity
- 87 Medicaid providers were placed on an internal watchlist to monitor their billing practices based on suspected fraudulent activity
- 3 providers were referred for investigation to the Medicaid Investigations Division for possible legal action

DMA also encourages LME-MCOs to use the DHHS FAMS to perform their own analytics. This provides DHHS and LME-MCOs with a comparison of behavioral health providers' billing patterns.

Prepayment Reviews

The Compliance and Program Integrity prepayment review process has significantly reduced incorrect or potentially fraudulent Medicaid claims and inappropriate use of services. This preventive model identifies non-physician, outpatient providers who are at a high risk of inappropriate billing or fraud. Prepayment review uses objective criteria, such as:

- Credible allegation of fraud received by DHHS
- Identification of unusual billing practices through predictive analytics
- Potential for fraud waste and abuse identified through related investigations

For identified providers, DMA reviews billed services prior to payment to ensure that services are accurate and clinically appropriate. Prepayment review creates several cost efficiencies:

- Prepayment reviews and associated costs are limited to less than 2% of the provider population
- Fraudulent claims are more efficiently mitigated by eliminating many of the costs associated with post-payment recoveries
- For SFY 2015, prepayment reviews resulted in denied claims representing \$11,362,833 in savings to the state

NCTracks

NCTracks, the first multi-payer system in the country and the largest IT project in North Carolina history, was certified April 2015 by the Centers for Medicare & Medicaid Services. This resulted in approximately \$19 million in additional federal funding to the state.

While other states have a system that pays Medicaid providers only, NCTracks pays for the services of providers for the Division of Medical Assistance; and also the Division of Mental Health, Developmental Disabilities and Substance Abuse Services; Division of Public Health; and Office of Rural Health. By combining these systems into one, NCTracks provides efficiencies saving North Carolina \$3 million each month.

NCTracks replaced a paper-based, 35-year-old system with a practically paperless, virtual system. It runs on taxonomy codes, which coordinate detailed information on a claim. This taxonomy-based system reduces the likelihood of fraud and abuse.

Statistics and Facts

Since NCTracks launched July 2013 through the end of SFY 2015, a total of 421,901,355 claims have been processed and \$21.6 billion paid to DHHS providers in 100 checkwrites. Other facts:

- 12% (almost 2.4 million) fewer claims required human intervention to process and pay each month
- An average 90% of calls were answered in less than 60 seconds in the NCTracks Contact Center with more than 85% of callers helped on the first conversation
- NCTracks enables faster processing and responses with:
 - Online provider enrollment and record updates, and prior approval requests and status
 - Online submission for claim and prior authorization attachments, and real-time claim processing
 - Recipient access to eligibility Information
- Authentication is integrated with North Carolina's statewide identity management system (NCID), enabling virtually seamless access to an integrated set of tools, including the Learning Management System (SkillPort)

NC FAST

NC FAST (North Carolina Families Accessing Services through Technology) improves the way DHHS and all 100 county Departments of Social Services (DSS) conduct business. NC FAST uses technological tools and business processes that enable staff to spend less time performing administrative tasks and more time assisting families.

County DSS uses the NC FAST system to determine Medicaid and NC Health Choice eligibility for individuals applying for benefits. NC FAST also is used to re-determine eligibility for all

Medicaid and NC Health Choice programs. The tool provides case management, tracking tools and data sharing eligibility factors. This allows for efficient and effective assessments, provides greater program accountability across Medicaid, and ensures accurate beneficiary placement within programs.

Finance

Over the last year, DMA made a number of changes to improve the overall financial management of Medicaid and NC Health Choice programs. The changes include strengthening the organization and its talent pool, improving the processes and investing in tools. The following sections highlight some of the changes made to improve the management and stewardship of taxpayers' investment in the crucial services funded by DMA.

Organizational Changes

DMA completed a full assessment and redesign of the finance function, the first organization-wide restructuring since North Carolina Medicaid was established 45 years ago. Highlights include:

- Defined and implemented roles and responsibilities across the workforce providing essential tools for a more robust performance management program
- Developed a functionally aligned, right-sized resource base to address the complex operations of the division
- Enhanced organizational design to support and improve financial controls and transparency
- Improved reporting capabilities and communication channels across the clinical and finance units, and external stakeholders

- Redesigned the management and governance structure, allowing for more specialized and focused oversight to fewer direct reports; and, as a more horizontal organization, DMA became better suited to capitalize on various areas of expertise and specific scopes of service

The realignment created two new finance functions, Financial Planning & Analysis and Finance & Accounting, to better support DMA.

Process

These organizational changes supported a number of process improvements. Examples of these improved processes are:

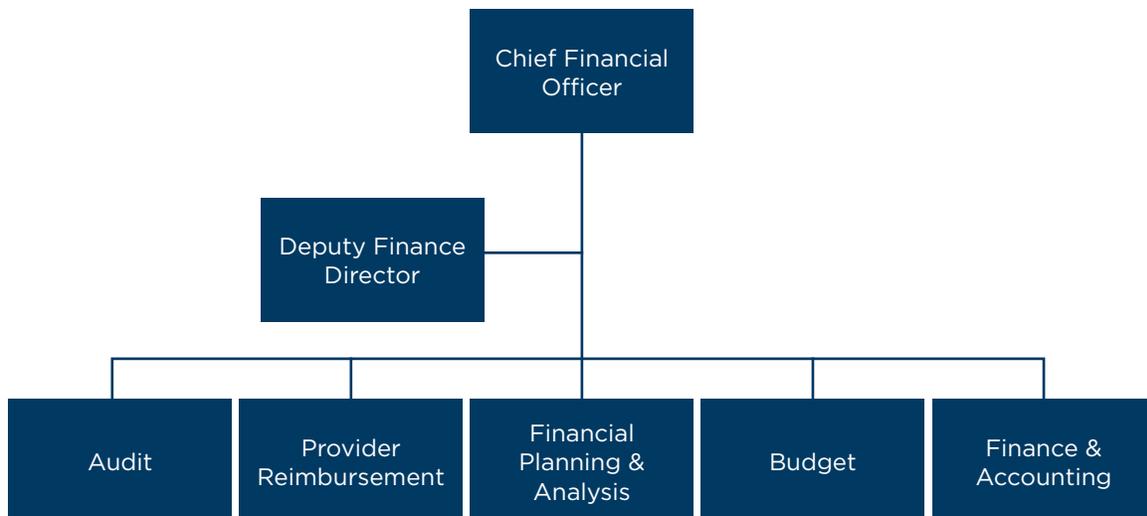
- **Drug Rebates.** Implemented a tracking and recovery mechanism of DMA's \$800 million drug rebate program. The new procedure provided for a proactive approach for recovering rebates from manufacturers while improving DMA's cash flow and forecasting accuracy. The new procedure resulted in the accelerated recovery of \$27 million from drug labelers in SFY 2014.
- **Cash Management.** Established a process to improve internal communications by bringing together representatives across DMA to better communicate regarding cash management, including monthly cash planning meetings and weekly checkwrite reporting.
- **Contract Management and Procurement.** Developed a detailed forecast for contract spending for SFY 2015 and SFY 2016; documented a detailed process flow depicting current processes for vendor sourcing, contract administration and vendor management; and developed recommendations for future state processes of vendor sourcing, contract administration and vendor management.

Tools

- Developed a robust, bottom-up financial model that was used to forecast and budget Medicaid's expenditures, revenue and net appropriations. The new forecasting and budgeting tool was used to develop DMA's next biennium budget.
- Developed a detailed three-year financial trend analysis of DMA's claim expenditures covering 44 programs and over \$10 billion in total costs. The budgeting process included regular meetings with clinical policy and program teams to identify key drivers affecting DMA's overall spend. The financial review provided the crucial baseline for the development of DMA's biennial budget.

Organizational Structure

Core finance functions, while not fundamentally changed, were strengthened with new personnel, leadership and other process improvements. The following provides an overview of each of these areas and their primary responsibilities.



Audit is responsible for audits and reviews of annual Medicaid cost reports submitted by various provider types, including hospitals, long-term care facilities, federally qualified health centers, rural health clinics, local health departments, local education agencies, public ambulance, and state-owned and operated institutions. These reviews are required to comply with state and federal regulations, certify public expenditures, furnish audited data to establish rates, and to effect cost settlements with certain provider types allowed by the state plan. In addition, analyses of other Medicaid programs are conducted to determine the extent to which various types of program risk exist, and to develop appropriate measures and responses to risk.

Provider Reimbursement, previously called “Rate Setting,” is focused primarily on establishing reimbursement methodologies that comply with federal regulations and legislative authority. Provider Reimbursement develops and establishes reasonable reimbursement rates for North Carolina Medicaid covered health care services. This unit also administers the financial implementation of the 1915 (b)/(c) waiver, including financial monitoring and oversight of the eight LME-MCOs.

Financial Planning & Analysis is responsible for internal and external management reporting, quantifies the impact of program and policy changes, responds to ad hoc requests from various stakeholders (legislative members, legislative constituents, department managers, citizens and companies), analyzes financial trends and variances, partners with program managers to offer financial insight, provides executive management with financial observations that inform, and assists with the development of the biennial budget.

Budget develops the biennial and continuation budgets. The group also proactively monitors spending versus the budget, revises budget amounts based on latest forecasts, and engages with program and service representatives to understand changes that may impact the overall budget results.

Finance & Accounting is one of the larger units within the Finance section and is broadly responsible for maintaining accurate financial records, tracking payments and receipts, and managing the federal reporting requirements to the Centers for Medicare & Medicaid Services. The following table lists the Finance & Accounting units and several key responsibilities.

Finance & Accounting Unit	Key Responsibilities
Cash Management	<ul style="list-style-type: none">• Federal and State Funding Requests• Cash Reporting / Cash Projections• Drug Rebates• Hardship Advances
Accounting	<ul style="list-style-type: none">• Accounts Payable / Account Receivable• Employee Travel and eProcurement• Federal Reporting• Month, Quarter and Year-End Closeout• Claims Payment System Changes
Third-Party Liabilities	<ul style="list-style-type: none">• Ensures Medicaid is “payer of last resort”• Health Insurance Identification• Overpayment Recovery• Casualty and Estate Recovery Services



Additional Exhibits

Funding Sources, SFY 2014-2015

EXHIBIT 29

Medicaid						
(\$ millions)	2014 Budget	2014 Actuals	2014 Variance	2015 Budget	2015 Actuals	2015 Variance
	Expenditures	\$13,645.9	\$13,303.1	\$342.8	\$14,042.5	\$13,744.4
Revenues-Federal	\$8,688.0	\$8,432.7	\$255.3	\$8,865.6	\$8,751.7	\$113.8
Revenues-Other	\$1,490.4	\$1,466.6	\$23.8	\$1,488.5	\$1,434.9	\$53.6
Appropriations-State	\$3,467.4	\$3,403.8	\$63.6	\$3,688.4	\$3,557.7	\$130.7

Health Choice						
(\$ millions)	2014 Budget	2014 Actuals	2014 Variance	2015 Budget	2015 Actuals	2015 Variance
	Expenditures	\$283.7	\$246.4	\$37.3	\$175.5	\$175.2
Revenues-Federal	\$215.5	\$187.3	\$28.2	\$132.5	\$132.6	\$(0.0)
Revenues-Other	\$0.3	\$0.5	\$(0.2)	\$1.1	\$0.9	\$0.1
Appropriations-State	\$68.0	\$58.7	\$9.3	\$41.9	\$41.7	\$0.3

Medicaid & Health Choice						
(\$ millions)	2014 Budget	2014 Actuals	2014 Variance	2015 Budget	2015 Actuals	2015 Variance
	Expenditures	\$13,929.6	\$13,549.5	\$380.1	\$14,218.0	\$13,919.5
Revenues-Federal	\$8,903.5	\$8,620.0	\$283.5	\$8,998.1	\$8,884.3	\$113.8
Revenues-Other	\$1,490.7	\$1,467.1	\$23.6	\$1,489.6	\$1,435.9	\$53.7
Appropriations-State	\$3,535.4	\$3,462.4	\$72.9	\$3,730.3	\$3,599.4	\$131.0

Note: Due to rounding, budget minus actuals may not equal variance shown.

Source: NCAS BD-701

Medicaid Providers by Type, SFY 2015

EXHIBIT 30

North Carolina Medicaid State Fiscal Year 2015 Active Medicaid Providers ¹		
Provider Type	Number By Type ²	Number with Multiple Taxonomy Codes ³
Agencies	2,232	2,509
Allopathic & Osteopathic Physicians	25,876	37,688
Ambulatory Health Care Facilities	740	890
Behavioral Health & Social Service Providers	2,586	2,998
Chiropractic Providers	382	382
Dental Providers	2,395	2,833
Eye and Vision Services Providers	895	899
Group (Physicians)	7,494	8,293
Hospital Units	12	12
Hospitals	772	781
Laboratories	198	198
Managed Care Organizations	35	36
Nursing & Custodial Care Facilities	1,874	2,177
Other Service Providers	2	2
Pharmacy Service Providers	2,444	2,444
Physician Assistants & Advanced Practice Nursing Providers	10,778	12,955
Podiatric Medicine & Surgery Service Providers	255	666
Residential Treatment Facilities	69	71
Respiratory, Developmental, Rehabilitative and Restorative	1,530	1,602
Respite Care Facility	55	55
Speech, Language and Hearing Service Providers	1,517	1,624
Suppliers	1,691	2,611
Transportation Services	288	351
Total	64,120	82,077

Source: NCTracks, Custom Data Retrieval, DMA Business Information Office

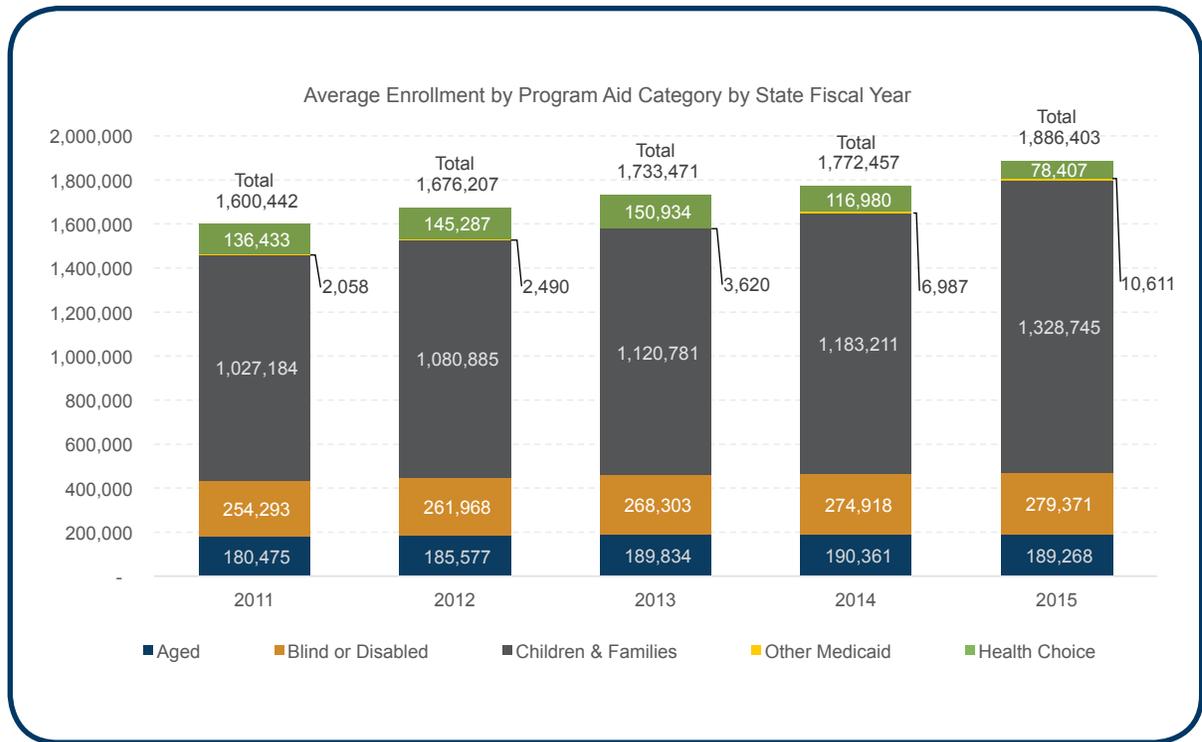
¹ Billing or rendering providers that have filed one or more claims during the fiscal year

² Number of distinct providers (NPI) by level one taxonomy or service

³ Number of providers (NPI) by service type or taxonomy code; providers could be in multiple provider types or service

Average Enrollment by Program Aid Category, SFY 2011-SFY 2015

EXHIBIT 31



Source: 2016 Average Monthly Enrollment; Monthly Enrollment Report; DMA Business Information Office

Total Expenditure by Category of Service, SFY 2014-SFY 2015

EXHIBIT 32

Service Category	Medicaid & Health Choice (Ranked by SFY 2015 claims expenditures)						
	SFY 2014			SFY 2015			Cost Per Recipient Variance (vs. SFY 2014)
	Claims Expenditure (\$ millions)	Unduplicated Recipients	Cost Per Recipient	Claims Expenditure (\$ millions)	Unduplicated Recipients	Cost Per Recipient	
LME-MCO ¹	\$2,394.3	1,643,048	\$1,457	\$2,578.3	1,799,669	\$1,433	-1.7%
Hospital (Inpatient & Outpatient) ²	1,425.5	733,069	1,945	1,581.8	785,819	2,013	3.5%
Skilled Nursing Facilities	1,158.8	41,738	27,765	1,153.6	43,144	26,738	-3.7%
Physician Services	1,004.7	1,617,725	621	1,131.4	1,738,674	651	4.8%
Pharmacy Services ³	739.2	1,275,326	580	891.9	1,312,835	679	17.2%
Medicare Aid Program	711.7	1,013,582	702	700.4	1,048,510	668	-4.9%
Personal Care Services	474.8	51,327	9,250	461.0	50,982	9,043	-2.2%
Hospital Emergency Department Services	357.0	546,612	653	405.8	613,230	662	1.3%
Dental Services	359.4	870,053	413	378.3	896,765	422	2.1%
CAP ⁴ for Disabled Adults	227.5	12,128	18,757	238.6	11,731	20,341	8.4%
Durable Medical Equipment Services	174.5	222,044	786	192.7	236,602	814	3.6%
Outpatient Specialized Therapies	149.6	74,331	2,012	146.5	78,137	1,875	-6.8%
Clinic Services	111.7	330,859	337	132.9	375,754	354	4.8%
Home Health Services	127.6	29,786	4,283	125.6	28,669	4,383	2.3%
Lab & X-ray Services	86.9	456,593	190	122.4	547,286	224	17.6%
Health Check Services	144.7	693,517	209	110.7	720,577	154	-26.4%
CAP ⁴ for Children	79.0	1,810	43,627	95.0	2,181	43,562	-0.2%
Hospice Services	64.4	6,283	10,244	65.6	6,381	10,283	0.4%
NEM Transportation Services ⁵	47.9	-	N/A	53.9	-	N/A	N/A
Ambulance Services	42.5	160,214	265	45.0	159,811	282	6.3%
PACE ⁶	30.5	1,206	25,267	44.4	1,496	29,703	17.6%
Optical Services	21.1	237,741	89	25.9	269,439	96	8.2%
Ambulatory Surgery Center Services	13.0	28,116	462	15.3	33,148	462	0.0%
Other Services	148.4	1,944,162	76	142.7	1,872,368	76	-0.2%
Total	\$10,094.4	2,184,795	\$4,620	\$10,839.8	2,274,068	\$4,767	3.2%

Source: Financials from NCAS BD-701, Recipient data from DMA Business Information Office with DMA Finance mapping to service category.

¹ Local Management Entities-Managed Care Organizations provide behavioral health care management

² Excludes supplemental hospital payment programs like the Medicaid Reimbursement Initiative

³ Claims expenditure data is net of drug rebates

⁴ Community Alternatives Program provides home and community based care as an alternative to institutionalization

⁵ Unduplicated recipient data for Non-Emergency Medical Transportation Services was not available at the time of publishing

⁶ Program of All-Inclusive Care for the Elderly provides services as an alternative to nursing home placement

Medicaid Expenditure by Category of Service, SFY 2014-SFY 2015

EXHIBIT 33

Service Category	Medicaid (Ranked in order by SFY 2015 claims expenditures)						
	SFY 2014			SFY 2015			Cost Per Recipient Variance (vs. SFY 2014)
	Claims Expenditure (\$ millions)	Unduplicated Recipients	Cost Per Recipient	Claims Expenditure (\$ millions)	Unduplicated Recipients	Cost Per Recipient	
LME-MCO ¹	\$2,394.3	1,643,048	\$1,457	\$2,578.3	1,799,669	\$1,433	-1.7%
Hospital (Inpatient & Outpatient) ²	1,389.9	702,671	1,978	1,554.6	764,516	2,033	2.8%
Skilled Nursing Facilities	1,158.8	41,738	27,765	1,153.6	43,144	26,738	-3.7%
Physician Services	957.2	1,484,586	645	1,101.3	1,650,512	667	3.5%
Pharmacy Services ³	671.7	1,170,240	574	839.6	1,243,542	675	17.6%
Medicare Aid Program	711.7	1,013,582	702	700.4	1,048,510	668	-4.9%
Personal Care Services	474.8	51,327	9,250	461.0	50,982	9,043	-2.2%
Hospital Emergency Department Services	345.1	518,326	666	397.6	594,079	669	0.5%
Dental Services	333.0	772,119	431	361.0	834,326	433	0.3%
CAP ⁴ for Disabled Adults	227.5	12,128	18,757	238.6	11,731	20,341	8.4%
Durable Medical Equipment Services	171.3	213,903	801	189.7	231,081	821	2.5%
Clinic Services	108.0	311,107	347	130.7	363,630	359	3.5%
Outpatient Specialized Therapies	119.9	64,009	1,873	126.1	68,973	1,828	-2.4%
Home Health Services	127.5	29,698	4,292	125.6	28,608	4,389	2.3%
Lab & X-ray Services	85.3	436,972	195	121.3	533,957	227	16.3%
Health Check Services	144.7	693,025	209	109.0	700,309	156	-25.4%
CAP ⁴ for Children	79.0	1,810	43,627	95.0	2,181	43,562	-0.2%
Hospice Services	64.4	6,283	10,244	65.6	6,379	10,285	0.4%
NEM Transportation ⁵	47.9	-	N/A	53.9	-	N/A	N/A
Ambulance Services	42.1	157,928	267	44.8	158,499	283	6.1%
PACE ⁶	30.5	1,206	25,267	44.4	1,496	29,703	17.6%
Optical Services	18.3	207,057	88	23.7	246,692	96	8.6%
Ambulatory Surgery Center Services	12.4	27,227	457	15.0	32,556	459	0.5%
Other Services	145.2	1,757,900	83	142.6	1,770,184	81	-2.5%
Total Medicaid	\$9,860.5	1,987,676	\$4,961	\$10,673.2	2,146,675	\$4,972	0.2%

Source: Financials from NCAS BD-701; Recipient data from DMA Business Information Office with DMA Finance mapping to service category

¹ Local Management Entities-Managed Care Organizations provide behavioral health care management

² Excludes supplemental hospital payment programs like the Medicaid Reimbursement Initiative

³ Claims expenditure data is net of drug rebates

⁴ Community Alternatives Program provides home and community based care as an alternative to institutionalization

⁵ Unduplicated recipient data for Non-Emergency Medical Transportation Services was not available at the time of publishing

⁶ Program of All-Inclusive Care for the Elderly provides services as an alternative to nursing home placement

NC Health Choice Expenditure by Category of Service, SFY 2014-SFY 2015

EXHIBIT 34

Service Category	NC Health Choice (Ranked in order by SFY 2015 claims expenditures)						
	SFY 2014			SFY 2015			Cost Per Recipient Variance (vs. SFY 2014)
	Claims Expenditure (\$ millions)	Unduplicated Recipients	Cost Per Recipient	Claims Expenditure (\$ millions)	Unduplicated Recipients	Cost Per Recipient	
Pharmacy Services ¹	\$67.5	105,086	\$642	\$52.3	69,293	\$755	17.7%
Physician Services	47.5	133,139	357	30.1	88,162	341	-4.3%
Hospital (Inpatient & Outpatient)	35.6	30,398	1,170	27.1	21,303	1,274	9.0%
Outpatient Specialized Therapies	29.7	10,322	2,877	20.5	9,164	2,232	-22.4%
Dental Services	26.4	97,934	269	17.3	62,439	277	2.7%
Hospital Emergency Department Services	11.9	28,286	420	8.3	19,151	432	2.6%
Durable Medical Equipment Services	3.2	8,141	394	3.0	5,521	543	37.7%
Optical Services	2.8	30,684	93	2.3	22,747	99	6.9%
Clinic Services	3.7	19,752	185	2.2	12,124	185	-0.2%
Health Check Services	0.0	492	65	1.7	20,268	83	26.1%
Lab & X-ray Services	1.5	19,621	77	1.2	13,329	88	13.5%
Ambulatory Surgery Center Services	0.6	889	624	0.4	592	633	1.5%
Ambulance Services	0.4	2,286	161	0.2	1,312	156	-3.3%
Home Health Services	0.1	88	1,227	0.1	61	1,195	-2.6%
Hospice Services	-	-	N/A	0.0	2	3,484	N/A
Other Services	3.2	186,262	17	0.1	102,184	1	-97.0%
Total Health Choice	\$233.9	197,119	\$1,187	\$166.6	127,393	\$1,308	10.2%

Source: Financials from NCAS BD-701; Recipient data from DMA Business Information Office with DMA Finance mapping to service category

¹ Claims expenditure data is net of drug rebates

Acknowledgements

Thank you to the many North Carolina Department of Health and Human Services team members who contributed to the development and production of the North Carolina Medicaid and NC Health Choice Annual Report for State Fiscal Year 2015, including:

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Dora Boissy	Regina Harrell	Janice Norris
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Andrew Bryk	Tracey Jarrett	Dave Richard
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