

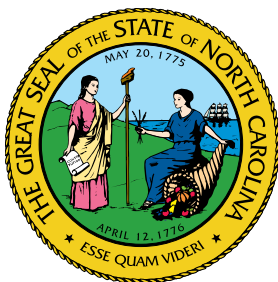
North Carolina

Medicaid and NC Health Choice

Annual Report for State Fiscal Year 2016
July 1, 2015 - June 30, 2016

A large, faded background image of a doctor in a white coat and glasses examining a young child. The doctor is pointing towards the child, who is holding a stethoscope to their chest. The background shows a city skyline.

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



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 • Roy Cooper, Governor
Department of Health and Human Services • Dr. Mandy Cohen, Secretary
www.ncdhhs.gov

Division of Medical Assistance • dma.ncdhhs.gov
Medicaid Reform • ncdhhs.gov/nc-medicaid-reform

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6/2017

Message from Dave Richard

Deputy Secretary for the Division of Medical Assistance

In state fiscal year 2016, our Medicaid and NC Health Choice programs continued to deliver valuable, quality health services to about 20 percent of North Carolinians – that’s nearly two million of our elderly, low-income families and their children, and people with disabilities who may not otherwise have had health care coverage.

Thanks to the ongoing support of our state leaders and the health care community, and the Division of Medical Assistance team’s hard work, we have continued to build on our prior two successful years, ending SFY 2016 \$243 million under budget. This result is directly due to our commitment to:

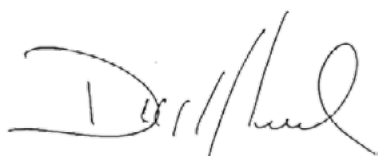
- **Provide the state with a more predictable Medicaid budget and forecast.** Our financial processes and systems are able to identify unanticipated changes and trends early, so our finance experts can make necessary adjustments.
- **Ensure transparency in all areas of Medicaid, especially in financial processes.** Efforts to ensure financial transparency put into place in 2014, and increased collaboration with the Office of State Budget Management and the Fiscal Research Division, contribute to a budget that benefits from a wide variety of viewpoints.
- **Above all, improve the health and health care of all North Carolinians.** As shown throughout this report, Medicaid and NC Health Choice policies and programs are continually being reviewed and evaluated to ensure they offer the right services for the state – beneficiaries, providers, health care systems and businesses – and do so by being good stewards of taxpayer dollars.

Additionally, with the passage of Session Laws 2015-245 and 2016-121, North Carolina has embarked on the path to transform Medicaid to a health care program that puts people first – one where providers are rewarded for helping people live a healthier life outside of the doctor’s office, as well as taking care of patients when they are sick.

In North Carolina, we are preparing for the future of health care: Medicaid will be complemented by services available in our communities; people will receive care that reflects their mental and physical well-being; and a supportive system will be in place to give providers the tools and resources to improve their patients’ overall health.

Such an extensive transformation will take several years to successfully accomplish. In the meantime, the DMA team will continue to improve the Medicaid and NC Health Choice programs so that those two million people have the opportunity to lead healthy and productive lives.

When the dedicated Medicaid team and our community partners work closely together, I am confident we will achieve our common goal of a healthier North Carolina.



Message from Roger Barnes

Interim Chief Financial Officer for the Division of Medical Assistance

On behalf of the Division of Medical Assistance, I am pleased to present the North Carolina Medicaid and NC Health Choice Annual Report for State Fiscal Year 2016. This Annual Report provides North Carolinians with a comprehensive look at financial results and activities from July 1, 2015-June 30, 2016.

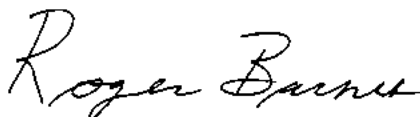
For SFY 2016, we continue to show strong, positive results of our integrated efforts in financial and policy stewardship. For the third consecutive year, the Medicaid and NC Health Choice programs finished strong, with cash on hand of \$243 million, which reverted to the state's General Fund. The continued application of stringent financial controls and oversight capabilities, and improved budget development and financial analysis tools established in SFY 2015 have greatly increased our ability to forecast with an accuracy that provides greater stability in the Medicaid budget—in spite of fluctuations due to common external factors, such as the Affordable Care Act Medicaid enrollment referrals, and state and national economic activity.

Specific accomplishments for the year include:

- For the third consecutive year, the fiscal year ended with cash on hand. The Medicaid and NC Health Choice programs finished the year a combined \$243 million under budget.
- While the number of individuals served by North Carolina's medical assistance programs grew in SFY 2016, the average cost per beneficiary to provide this care declined slightly, a testament to the agency's efforts to manage cost and ensure taxpayer dollars are spent as effectively as possible.
- Relationships continued to strengthen with stakeholder groups, refining periodic reporting and communications with the General Assembly and participating in frequent meetings with provider associations to maintain open feedback.

I want to thank the team of talented professionals who are committed to continually improving Medicaid programs and policies to provide the services for 1.9 million North Carolinians. I especially want to recognize the individuals who worked diligently to provide the data and details needed to prepare this year's Annual Report.

Your comments and questions about the Annual Report are welcome and encouraged. Please let us know what can be improved for the next year's report: (919) 855-4100.





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About the Annual Report

The North Carolina Medicaid and NC Health Choice Annual Report for State Fiscal Year 2016 is an overview of the financial results, and related programs and services, administered by the Department of Health and Human Services' 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 2015 and 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 expense being mapped to funds or accounts that were not originally used. Therefore, service-level comparisons focus on SFY 2016, 2015 and 2014.

Please call the Division of Medical Assistance at (919) 855-4100 with questions or requests for additional information.

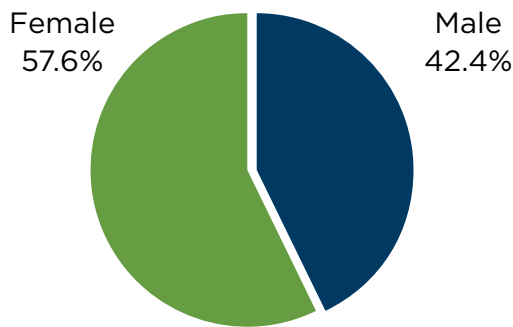


Snapshot: North Carolina Medicaid and NC Health Choice - State Fiscal Year 2016

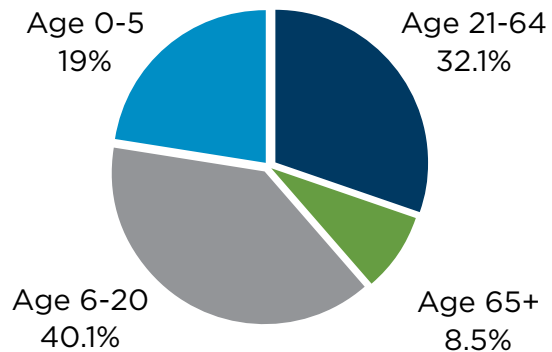
EXHIBIT 1

Financials	\$B	Statistics	#
Expenditures	\$13.9	Medicaid Beneficiaries ¹	1.9M
Federal Revenue	\$8.8	Health Choice Beneficiaries ¹	0.08M
Other Revenue	\$1.5	Providers ²	66K
State Appropriations	\$3.5	NCTracks Claims Processed	178.7M

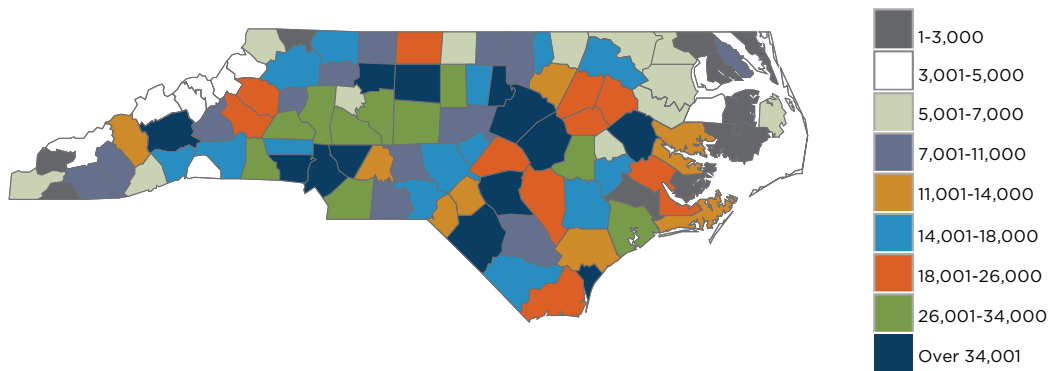
Beneficiary Gender



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 2016 (July 1, 2015 through June 30, 2016), the North Carolina Medicaid and NC Health Choice programs continued to provide our most vulnerable citizens with access to needed and valuable health services. With the support and collaboration of state leaders, providers and citizens passionate about improving the health of all North Carolinians, the Division of Medical Assistance (DMA) successfully developed and implemented policy improvements, while continuing operational and financial controls set in motion over the past two years, to manage costs and improve services.

Of note is the singular focus of the DMA staff to lead the transformation to a healthier North Carolina, a foundational principle followed by each person as they explore and develop policy improvements, incorporate state and federal regulations, and work closely with the people they serve.

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

NC Medicaid Reform Initiative

In September 2015, North Carolina launched its Medicaid reform initiative, the most significant change to the state's Medicaid and NC Health Choice programs since their inception. Legislatively mandated, Medicaid reform directed DHHS to transform most of the current programs from fee-for-service to a managed care service delivery model. Since this legislation was enacted, DHHS, working closely with DMA, met all aggressive deadlines set by the General Assembly. This included establishing a new Division of Health Benefits to oversee the project while working closely with DMA experts and stakeholders, submitting a Section 1115 demonstration waiver proposal to the Centers for Medicare & Medicaid Services, and meeting federal and state requirements necessary to begin the reform process.

Financial Results

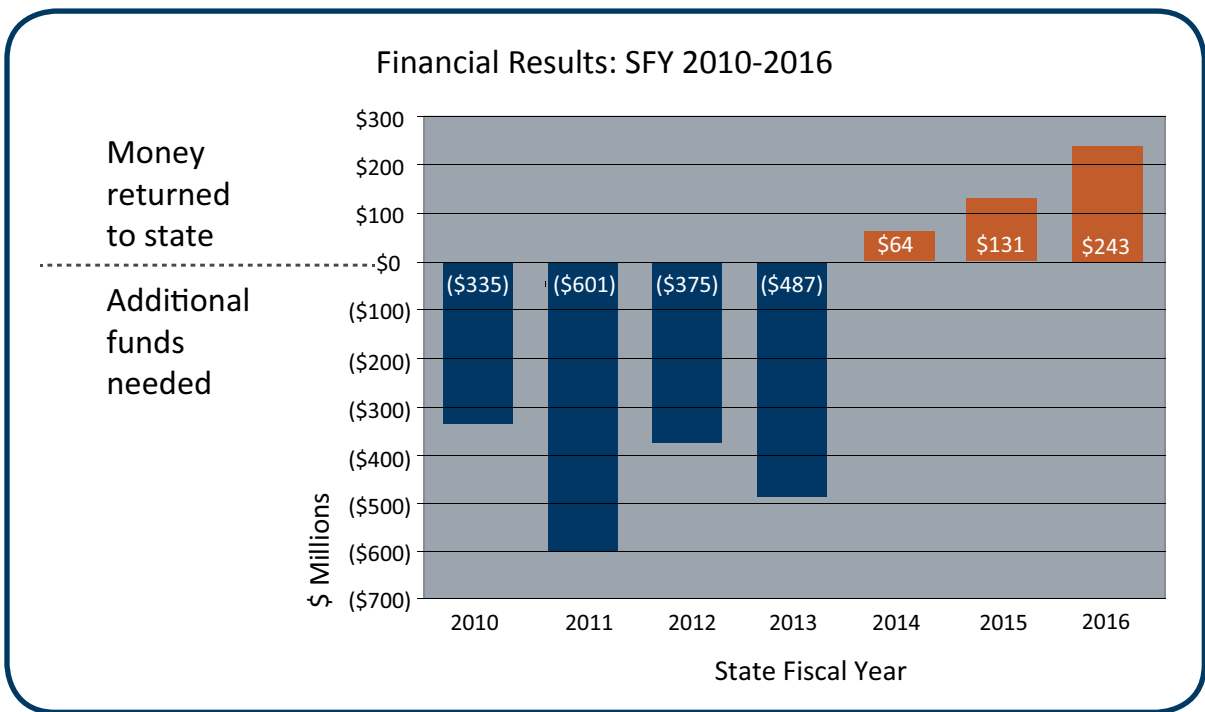
\$243 million under budget

North Carolina’s Medicaid budget finished with cash on hand for the third consecutive state fiscal year. Actual state appropriations for the Medicaid and NC Health Choice programs totaled nearly \$3.5 billion in SFY 2016, bringing the programs in \$243 million under budget. These programs provided health care coverage to more than 1.9 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 2016 financial results:

1. **Financial management.** DMA continued to build on changes made in the prior state fiscal year. These changes included maintaining a strong team, improving budget and forecast processes, and proactively managing cash. For the second year, these changes resulted in stronger oversight and improved financial management, contributing to SFY 2016 results.
2. **Population mix.** The extent to which services are used among total enrollees is a crucial factor in the cost of Medicaid and NC Health Choice programs. For the past three fiscal years, there has been a lower average recipient cost due to growth in enrollment in a younger and healthier Medicaid population.
3. **Rate adjustments.** Rates were modified for several services using fair negotiations with providers while maintaining good stewardship of taxpayer dollars.
4. **Legislative activity.** The discontinuation of the Affordable Care Act enhanced payments for physician services decreased expenditures, negating the cost effect of the growth in recipients. Other legislative activity included revised hospital reimbursement methodology for crossover claims (claims involving Medicare and Medicaid), which

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.

also decreased expenditures. Additionally, the Federal Medical Assistance Percentage increased, providing a slight increase in federal revenue.

The Centers for Medicare & Medicaid Services initiated Hospice Payment Reform effective Jan. 1, 2016, enacting a two-tier payment system where hospice care is reimbursed at a higher rate for the first 60 days and at a lower rate for the remainder of care. Additionally, a Service Intensity Add-on payment is applied for the last seven days of life on top of the routine hospice care rate.

Additionally, a policy change allowing hospice services to be provided at the same time as in-home personal care services was fully implemented Jan. 1, 2016.

Accomplishments

Solutions that fit North Carolina ensured continued good stewardship of tax dollars and created a platform for future innovations

DMA successfully improved delivery of Medicaid services in SFY 2016 to specifically benefit North Carolina and its citizens, including:

- **Drug spending.** DMA strategies implemented last year continue to lower overall drug costs, including focused pursuit of higher drug rebates. Although gross drug spending increased by nearly \$125M (7.1%), these efforts resulted in a decrease of \$59M (6.7%) in net drug expenditure. This result was due primarily to an \$185M increase in drug rebates. Drug rebates as a percentage of expenditures grew from 49.7% to 56.2%.
- **Preferred Drug List utilization.** DMA continued close management and communication of the North Carolina Preferred Drug List, which resulted in provider access to medically appropriate drug therapies that fit the Medicaid population and an increased use of preferred drugs. Additionally, the Preferred Drug List was updated to align with North Carolina initiatives to deter opioid abuse by preferring two abuse-deterrent opioids approved by the federal Food and Drug Administration (FDA), and to support the statewide naloxone standing order by preferring FDA-approved Narcan nasal spray.
- **Ambulance services.** Ambulance expenditures decreased by \$13M (29.2%), although beneficiaries using these services remained steady. This is partly the result of increased program integrity efforts, including a new ambulance policy that outlines provider requirements.
- **Fraud, waste and abuse.** DMA reviewed more than 4,500 complaints in SFY 2016. Of these, prepayment reviewed resulted in over \$20 million in denied or reduced claims. Post-payment review activities collected nearly \$28 million. DMA also made 46 referrals to the North Carolina Attorney General's Office for criminal or civil investigation.
- **Program oversight.** Physician assistants and nurse practitioners were required to enroll in Medicaid to receive reimbursement, providing additional data to oversee policy compliance and to reduce fraud and waste. Additionally, the Personal Care Services program

added several procedures to ensure providers were offering services per the clinical coverage policies, including custom reviews, independent assessor retraining, and internal quality assurance and quality improvement practices.

- **Service access and delivery.** The durable medical equipment program simplified the prior approval and electronic signature process for faster access to needed equipment. Additionally, more than 50 new end-stage renal dialysis facilities were enrolled, increasing access throughout the state.
- **Preventive health care.** Health Check recipients grew by over 30%, providing over 93% of North Carolina's Medicaid enrolled children under age 2 with recommended early preventive check-ups and immunizations. Over 600,000 received preventive dental services, a five-year increase of 40%.
- **ICD-10.** The International Statistical Classification of Diseases (ICD) is a medical classification list used to code health care services throughout the world. DMA and its DHHS partners successfully transitioned roughly 12,000 ICD-9 (ninth edition) codes into the federally required ICD-10 (tenth edition) infrastructure of more than 68,000 codes. This process,

which required several years of preparation, modernized aspects of the medical billing system to be more applicable for today's health care services and environment.

- **Finance organization.** The DMA Finance section continued restructuring efforts that began in SFY 2015. Eight new employees were hired to fill crucial roles on the existing DMA Finance teams, which improved analysis, forecasting and cash management capabilities. Additionally, the DMA Contracts function was moved under the Finance section during the year, improving internal communications and monitoring of contract spending and processes.

Expenditures by Funding Level

State share was \$3.5B out of \$13.9B

Medicaid and NC Health Choice programs are roughly \$14 billion. Of this amount, approximately 75% are service expenditures, such as claims, premiums and capitation payments. Services 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 reporting purposes. The net cost for drugs is more relevant to operations.

Other significant funds:

- **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 of North Carolina** is the primary care case management health care plan for most North Carolina Medicaid beneficiaries.

EXHIBIT 3

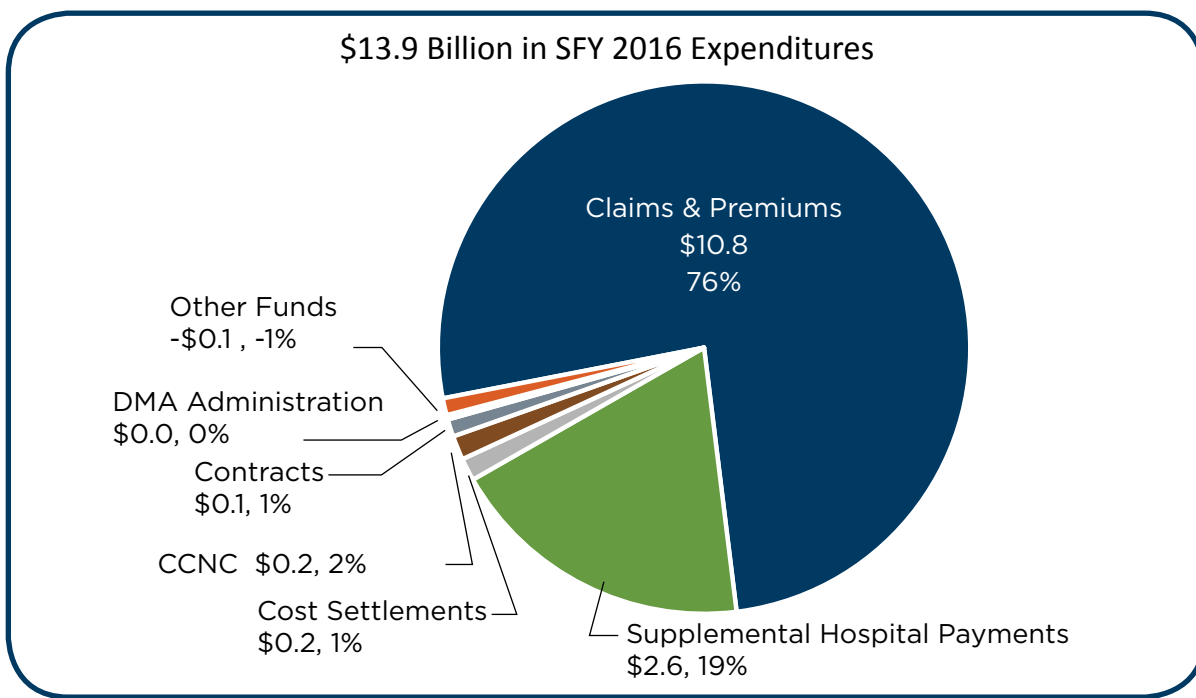


Exhibit 4 on page 8 breaks down the \$10.8 billion in claims and premiums into the programs and services. These are discussed in greater detail later in this report.

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.

A Look at SFY 2017

In SFY 2017, DMA will continue to experience significant events that will require additional focus and energy from DMA staff, including:

- **Medicaid reform.** DMA will continue to manage and improve the Medicaid and NC Health Choice programs while working closely with the Division of Health Benefits as the transformation project continues.
- **CAP/DA access and services.** The NC General Assembly has approved an additional 320 slots for CAP/DA, targeting individuals with Alzheimer's disease or related disorders for this coverage expansion. Changes also are being considered in SFY 2017 that will increase case management hours and add vehicle modification and geriatric nurse aides as waiver services.
- **Medical transportation.** A standard provider enrollment process will be implemented

statewide in SFY 2017. As a result, background checks and federal exclusions will be required for non-emergency medical transportation (NEMT) providers during enrollment, strengthening compliance with federal safety and risk management guidelines. Providers also will begin submitting claims through NCTracks. This shift will allow for greater monitoring and analysis of NEMT spending and utilization

...

More information on program services, practices and results for SFY 2016 are outlined in the following section. These programs represent \$10.8B or 76% of DMA's total expenditures.

Medical Assistance Payments

By Category of Service

EXHIBIT 4

SFY2016 Claims & Premiums Medicaid & NC Health Choice (Ranked by Claims Expenditure)			
Service Category	Claims & Premiums (\$ millions)	Unduplicated Recipients ¹	Cost Per Recipient
Local Management Entity-Managed Care Organizations	\$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





North Carolina Medicaid & NC Health Choice *Programs and Services*

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

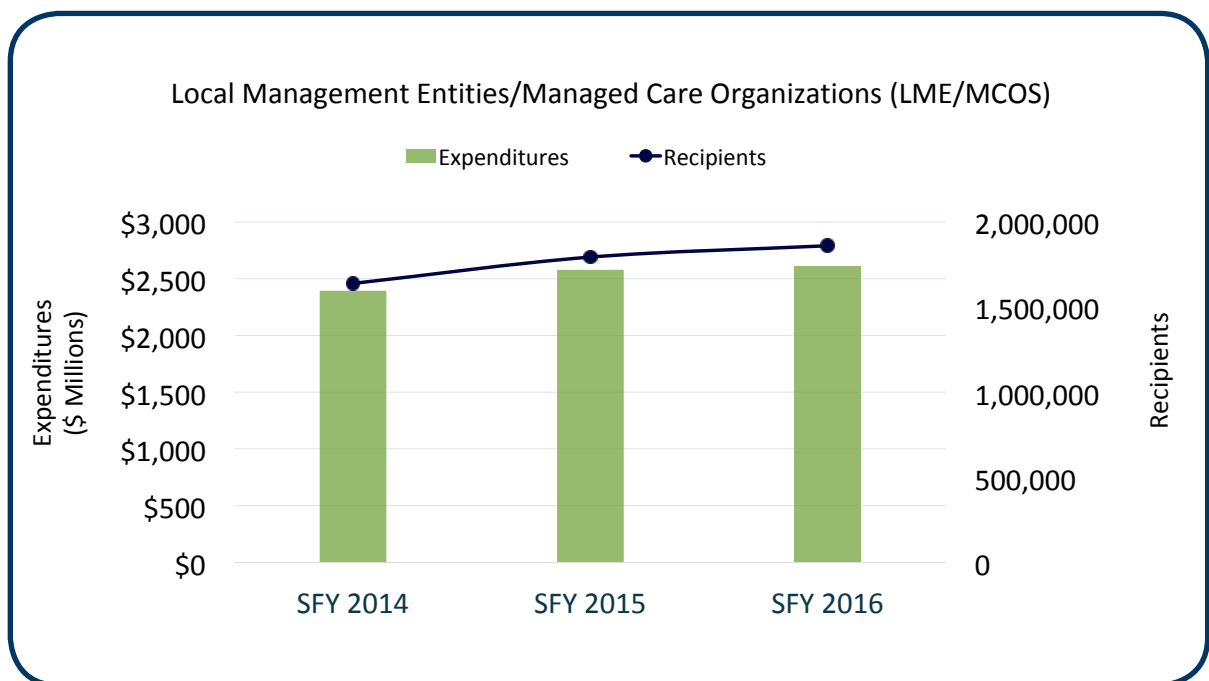
Local Management Entities/Managed Care Organizations (LME/MCOs) are organizations that manage, coordinate, facilitate and monitor the provision of mental health, developmental disabilities and substance abuse services in the geographic area that they serve.

LME/MCO organizations strive to meet the needs of people with short- and long-term behavioral health needs, which could include mental health, substance abuse and developmental disabilities. The service package is comprehensive and covers outpatient and inpatient levels of care, and long-term behavioral health care services and supports in the beneficiary's home or community rather than an institutional setting. The program was initiated as a way to control and more accurately budget the rising costs of Medicaid-funded mental health, intellectual and developmental disability services.

LME/MCOs provide for system improvements, and better management of funds and behavioral health services. The LME/MCOs have:

- Closed provider networks, requiring choices for beneficiaries in their service areas and allowing for competition and choice within a stable network
- Managed utilization, providing the right amount of service to beneficiaries
- Managed care or care coordination to provide direct support to the individuals who need it most
- Achieved cost savings (which have been reinvested in the system) through a simplified, capitated (per member per month) payment model, which bases rates on historical expenditures
- Authority to adjust rates to meet local needs
- Authority of claims payment to ensure fiscal responsibility

EXHIBIT 5



SFY 2016 Highlights

Individuals covered through LME/MCOs and expenditures for these services grew by 3.7% and 1.3% respectively in SFY 2016. This growth in enrollees is roughly in line with overall Medicaid enrollment growth over the course of the year.

For SFY 2016, DMA implemented several updates to the LME/MCO model that involved significant stakeholder engagement, especially in the waiver planning and development of the home- and community-based services (HCBS) waiver update to allow for resource allocation, and an HCBS transition plan that was submitted to the Centers for Medicare & Medicaid Services.

Looking Forward

At the beginning of SFY 2017, the merger of two LME/MCOs in western North Carolina will bring the number of LME/MCO organizations to seven.

DMA will continue collaborating with stakeholders to make improvements to LME/MCO services, including preparing state plan definitions for autism services and for tenancy supports; implementing a pilot program for a waiver serving the Traumatic Brain Injury population; and revising alternative (b)(3) services to more effectively meet the needs of beneficiaries.

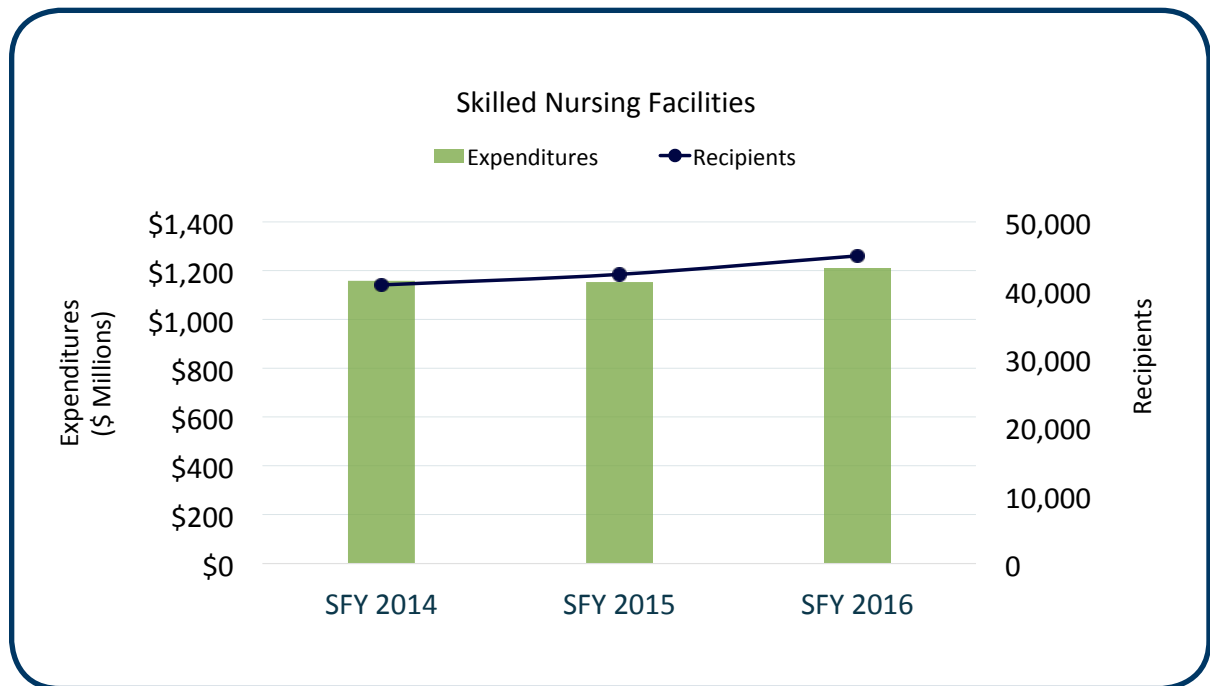
Skilled Nursing Facilities

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 provide short- 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 skilled nursing facility 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.

EXHIBIT 6



SFY 2016 Highlights

Skilled nursing facilities saw a moderate increase in utilization and total expenditure in SFY 2016, resulting a 1.4% drop in the average cost per recipient for skilled nursing services.

In SFY 2016, DMA continued to work with stakeholders to ensure the Skilled Nursing Facility program maintained the highest quality of care for North Carolina beneficiaries, while supporting efforts to allow individuals to live at home as long as possible.

Looking Forward

Reimbursement methodology changes for skilled nursing facilities are estimated have a fiscal impact of approximately \$12 million in additional spending in SFY 2017. Prior rate reductions and the nursing home direct care services case mix will be removed from the reimbursement calculation, restoring the payments that will be made to nursing facility providers.



Physician Services

North Carolina Medicaid physician services are provided by all physician specialties. Also included are the non-physician practitioners like 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.

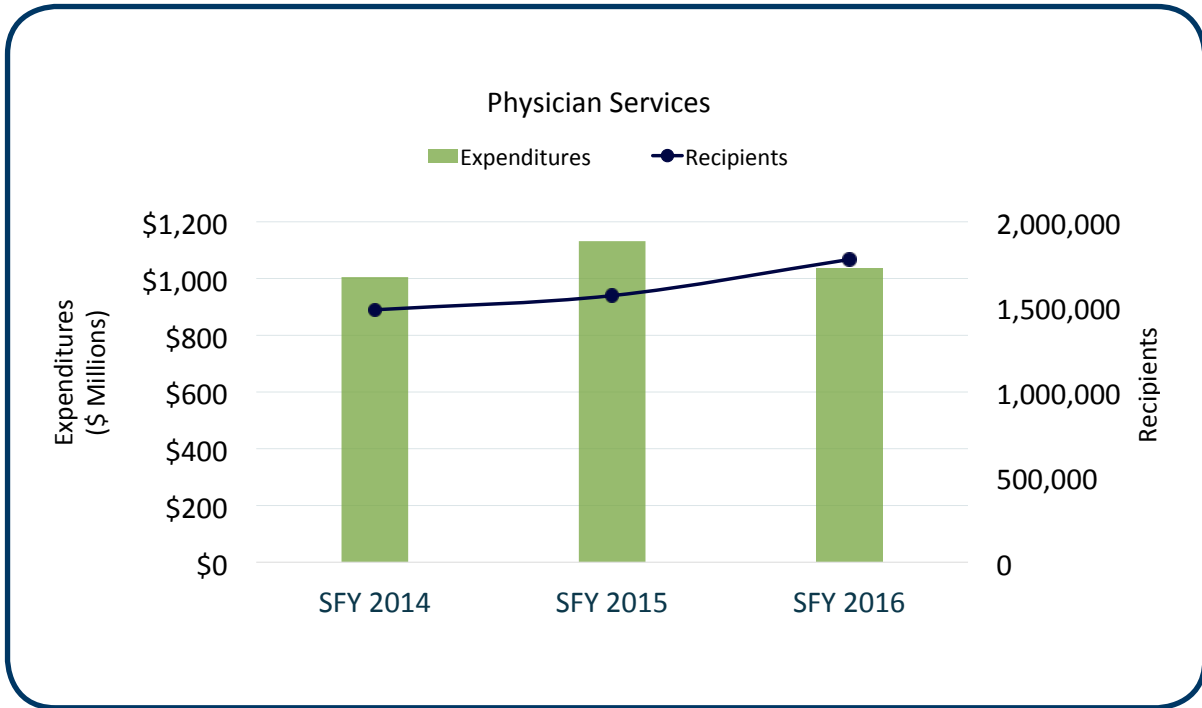
Physician services also include case management, which provides Medicaid recipients with the benefit of a coordinated approach to the management of their health care needs.

SFY 2016 Highlights

While recipients for physician services grew by 13.6% in SFY 2016, expenditures dropped by 8.5%. The decrease in total cost and cost per recipient is attributable to the discontinuation of enhanced payments that were part of the Affordable Care Act.

Starting in SFY 2016, physician assistant and nurse practitioner providers were required through federal regulation to enroll in Medicaid to receive reimbursement for services provided.

EXHIBIT 7



Looking Forward

DMA expects physician services to experience a moderate increase in expenditures in SFY 2017 in line with enrollment trends. DMA efforts to encourage beneficiaries to select a primary care provider may provide an indirect increase in physician service utilization.

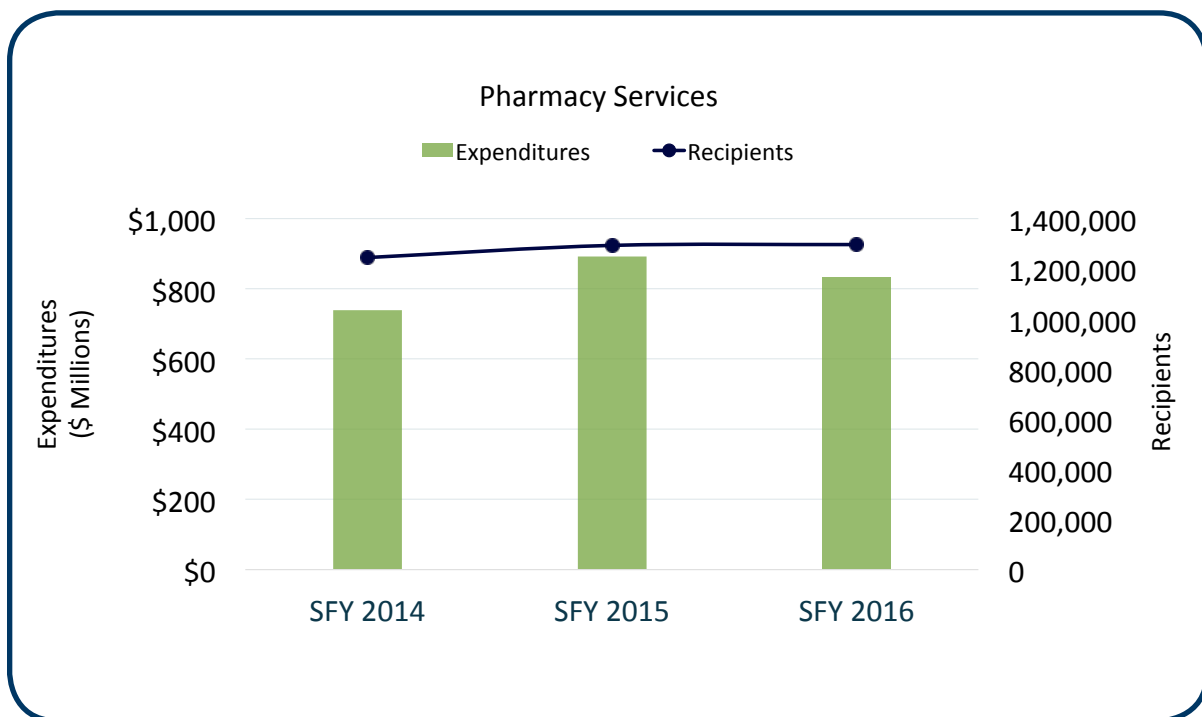
Pharmacy

The North Carolina Medicaid Pharmacy Program provides prescription drug coverage (an optional benefit under federal Medicaid laws) to enrolled Medicaid and NC 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. With over 1.9 million beneficiaries, many with complicated health needs, Medicaid is one of the largest providers of prescription drugs in North Carolina. Due to increasing enrollment and groundbreaking research that continues to lead to new and more effective medications to address a wider range of diseases and the changing health care needs of our beneficiaries, DMA continually works to balance health care outcomes and cost.

The DMA pharmacy program uses a variety of mechanisms, including effective use of drug rebates and careful selection of drugs on a North Carolina Preferred Drug List (NC PDL), to

EXHIBIT 8



ensure access to cost-efficient and medically appropriate drug therapies that maximize patient health outcomes for Medicaid beneficiaries. The result is a pharmacy program that provides the best overall value to beneficiaries, providers and North Carolina.

SFY 2016 Highlights

In SFY 2016, a 7.1% increase in gross drug expenditure was offset by a 21% increase in drug rebate collection, resulting in a 6.7% decrease in net drug expenditure.

Pharmacy program accomplishments in SFY 2016 include:

- Greater than 95% compliance with the NC PDL, which indicates that the NC PDL provides access to medically appropriate drug therapies
- Greater than 99% approval rate for prior authorization requests, which indicates that prescribers are familiar with the NC PDL program
- 2016 NC PDL was updated to prefer two abuse deterrent opioids approved by the Food and Drug Administration (FDA) to align with the North Carolina Opioid Abuse strategic plan
- 2016 NC PDL was updated to prefer the new FDA-approved Narcan nasal spray to align with the statewide naloxone standing order that was unanimously approved by the North Carolina General Assembly

Looking Forward

DMA is planning to make changes to the pharmacy program to align with other state priorities, including:

- Updates to clinical policy and prior authorization criteria for narcotic analgesics to align with the North Carolina Opioid Abuse strategic plan
- Changes in reimbursement policies for immunizing pharmacists providing vaccinations to Medicaid and NC Health Choice beneficiaries within the scope of their practice, which will increase beneficiary access to screening and immunizations. DMA also will transition pharmacy reimbursement methodology to the Centers for Medicare & Medicaid Services-required Average Acquisition Cost cost basis plus a professional dispensing fee determined by a statewide cost of dispensing survey

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.

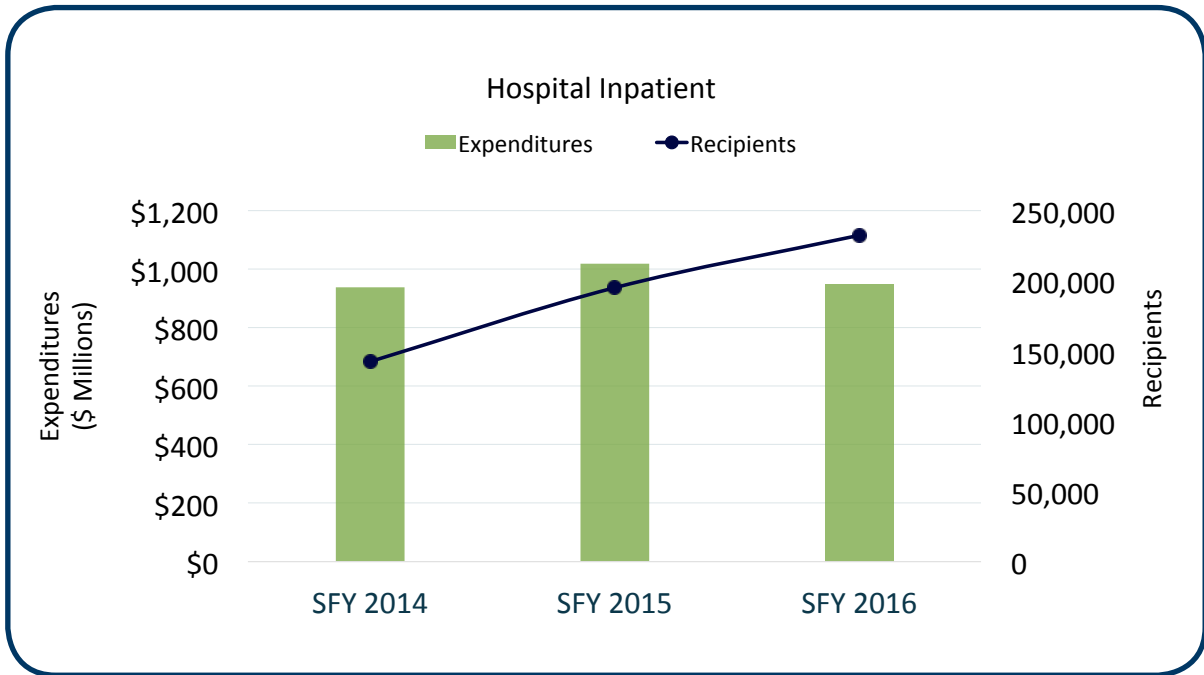
SFY 2016 Highlights

Hospital inpatient service utilization increased in SFY 2016 as the count of unique recipients grew by 19.1%, while costs declined by 7%. The decrease in cost is the result of changes in reimbursement methodology for hospitals regarding Medicare- and Medicaid-eligible beneficiaries.

Looking Forward

DMA is addressing barriers from various stakeholders to increase the dispensing utilization and rates for long-acting reversible contraceptives (LARC). LARC is an intervention that is gaining as a best practice to improve maternal health and infant birth outcomes.

EXHIBIT 9



Medicare Aid Program

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

Seniors and disabled individuals who fall within Medicaid eligibility criteria receive assistance with Medicare costs through this program, providing an extra level of coverage tailored to this dual eligible population and mitigating financial risk to the state. Beneficiaries who fall just outside of full Medicaid income and resource requirements can still receive assistance with some Medicare premiums, copayments and deductibles.

This program offers dual-eligible beneficiaries access to a network of providers who may not necessarily accept patients who have only Medicaid coverage.

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

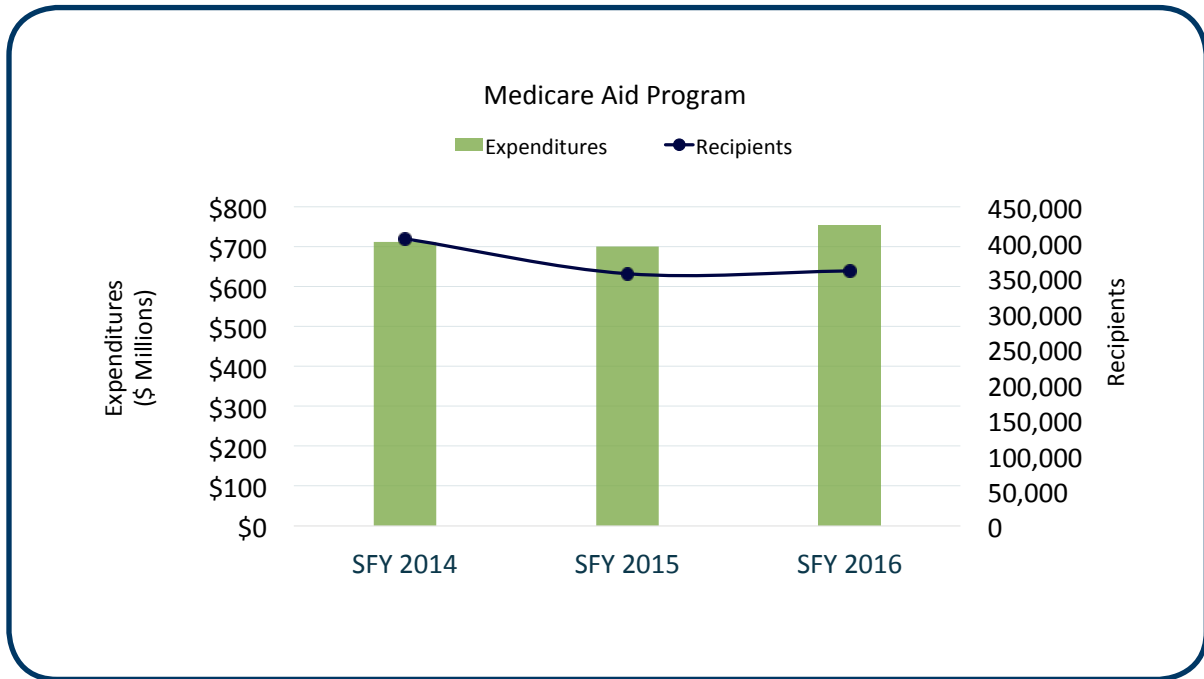
SFY 2016 Highlights

The monthly premium rates paid by DMA for Medicare coverage increased by varying amounts over SFY 2016, contributing to a 6.4% increase in the cost per recipient for Medicare premiums. Enrollment growth among DMA's aged and disabled eligibility groups, some of the primary populations served by Medicare Aid Programs, also contributed to an increase in cost and recipients.

Looking Forward

Rates for Medicare premiums are expected to continue to increase in SFY 2017, combining with the expected growth of the Medicare-eligible population on the Medicaid rolls to result in increased costs.

EXHIBIT 10



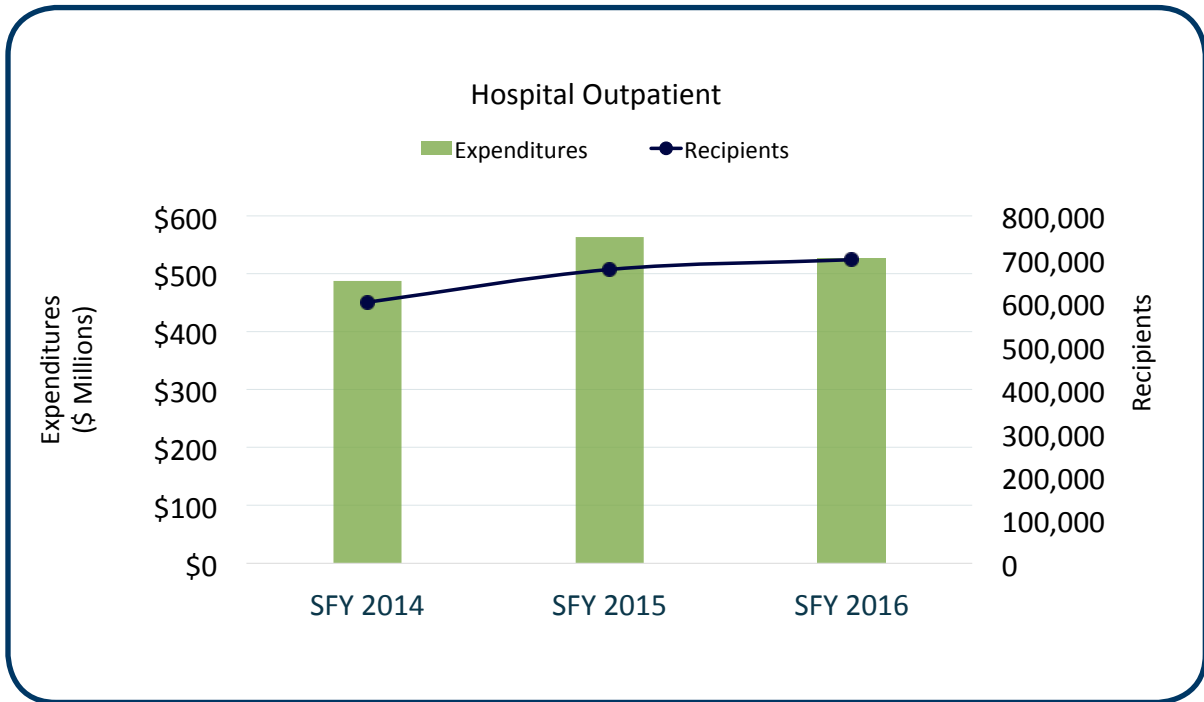
Hospital Outpatient Services

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.

EXHIBIT 11



SFY 2016 Highlights

Like hospital inpatient services, outpatient services also experienced a drop in expenditures while the number of unique recipients increased. This is a function of the changes in reimbursement to hospitals for Medicare crossover claims. The growth of ambulatory surgical center and high-tech imaging service utilization also contributed to the drop in expenditures for hospital outpatient services.

Looking Forward

As ambulatory surgical centers and high-tech imaging services offer a growing range of procedures in settings outside of hospital facilities, hospital outpatient services could continue to see a decline in the utilization and expenditures in the coming years.

Personal Care Services

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

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 2016 Highlights

In SFY 2016, total recipients and expenditures for PCS declined by 4.9% and 1.7%, respectively. PCS began additional oversight and monitoring of the program to ensure providers were offering services in accordance with the clinical coverage policy. The following oversight and monitoring procedures were implemented:

- Custom reviews to help identify potential errors in assessments before being released to providers
- Retraining of independent assessors to ensure all assessments are conducted according to policy

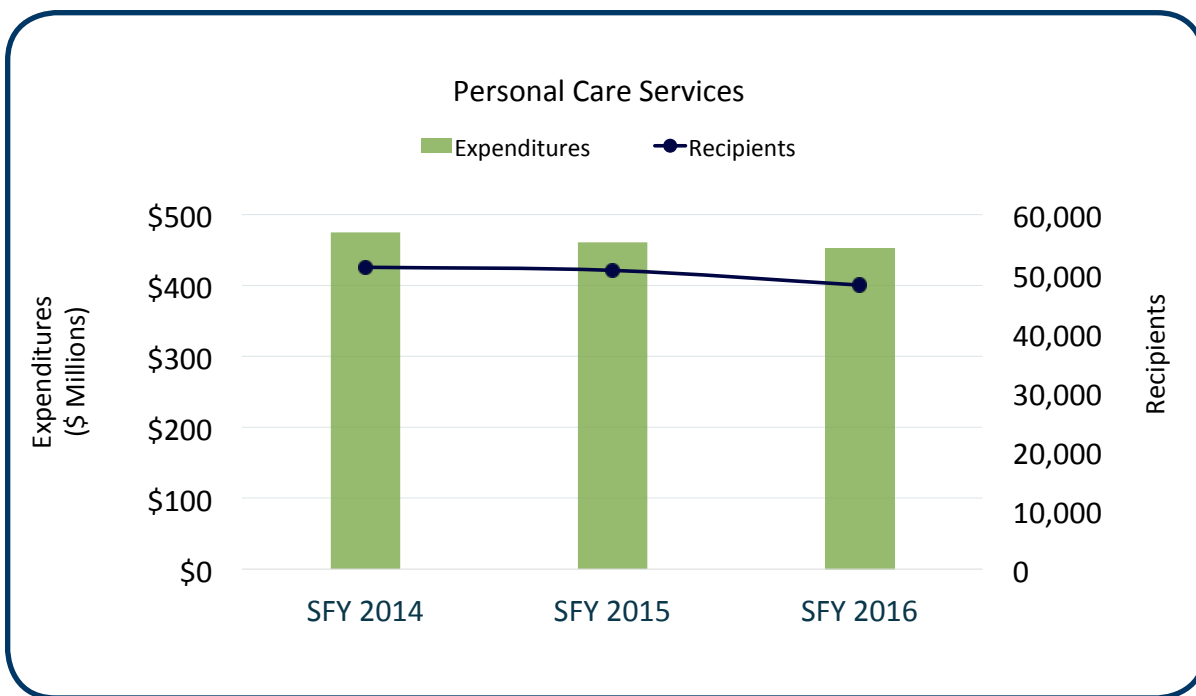
- Implementation of Internal Quality Assurance/Quality Improvement practices to allow DMA staff to monitor practices of PCS providers and independent assessors
- Required ICD-10 transition form to provide updated medical diagnosis information for all beneficiaries seeking reassessment

In addition to these changes, DMA made other programmatic adjustments to ensure comparability across settings in every aspect of the program and offered a reconsideration process for new beneficiaries approved for fewer hours than the program maximum of 80 hours.

Looking Forward

The combined effects of upgraded oversight and monitoring procedures and programmatic changes to the policy will help DMA ensure that quality of service is maintained while utilization is appropriately managed in the coming years..

EXHIBIT 12



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 check-ups, X-rays and cleanings; fillings and extractions; complete and partial dentures; and certain surgery procedures.

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).

Over half of the births in North Carolina are to Medicaid-eligible women.³ Pregnant women with poor oral health are at higher risk for adverse birth outcomes like pre-term and low birth-weight babies, and may more readily transmit bacteria that cause oral disease to their young children.⁴

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. Orthodontic services also are provided to some beneficiaries under age 21 with functionally impaired ability to speak, eat, swallow or chew due to crooked teeth or jaw growth discrepancies.

SFY 2016 Highlights

Dental services grew slightly in terms of both expenditures and recipients in SFY 2016, as was expected given growth in Medicaid enrollment during SFY 2016.

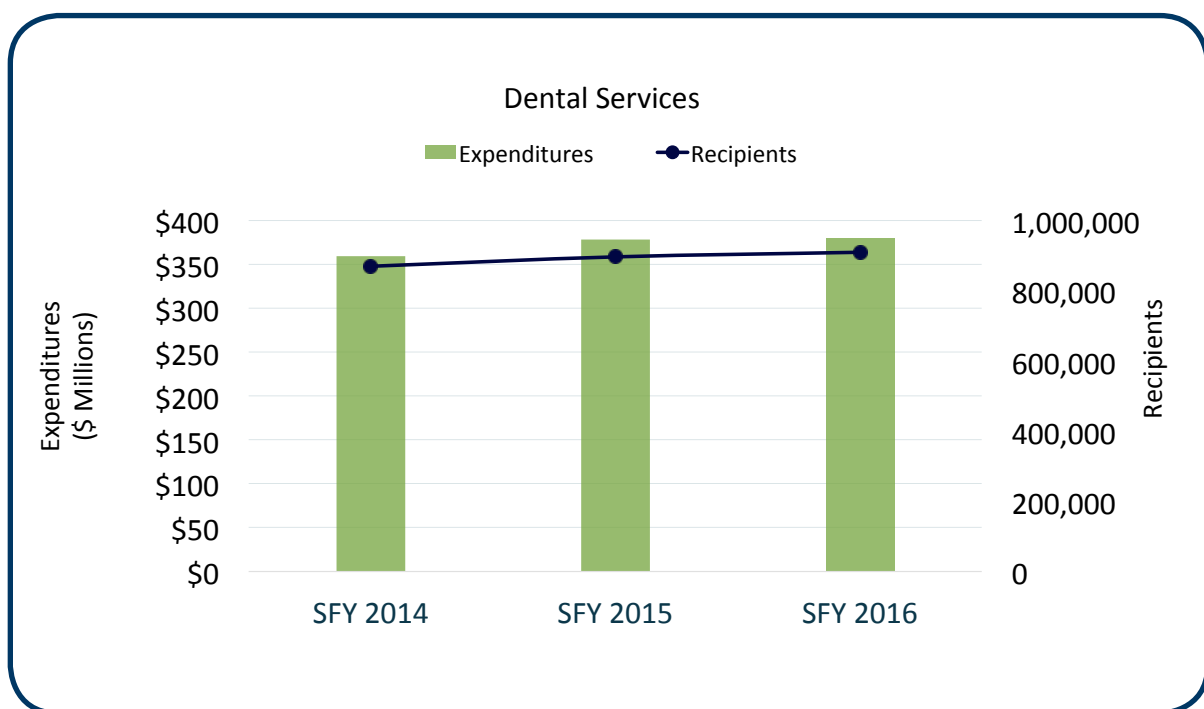
In federal fiscal year (FFY) 2016, approximately 50% of beneficiaries ages 1-20 received a preventive dental service

³ Vernon K. Smith, Kathleen Gifford, Eileen Ellis, and Barbara Edwards, Health Management Associates; and Robin Rudowitz, Elizabeth Hinton, Larisa Antonisse and Allison Valentine, Kaiser Commission on Medicaid and the Uninsured. Implementing Coverage and Payment Initiatives: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2016 and 2017, The Henry J. Kaiser Family Foundation, October 2016. kff.org/medicaid/state-indicator/births-financed-by-medicaid/

⁴ American Academy of Pediatric Dentistry Reference Manual. Guideline on perinatal oral health care. 2011. Vol. 37, No. 6. Pages 15-16. aapd.org/media/policies_guidelines/g_perinataloralhealthcare.pdf

from an enrolled dental provider. The utilization rate for all dental services for children ages 1-20 was 53% in FFY 2016. When including children ages 1-3 who have received oral health services from an enrolled primary medical care provider through Medicaid's "Into the Mouths of Babes" preschool preventive oral health program, the utilization rate of any oral health service for children ages 1-20 jumped to 58%.

EXHIBIT 13



Looking Forward

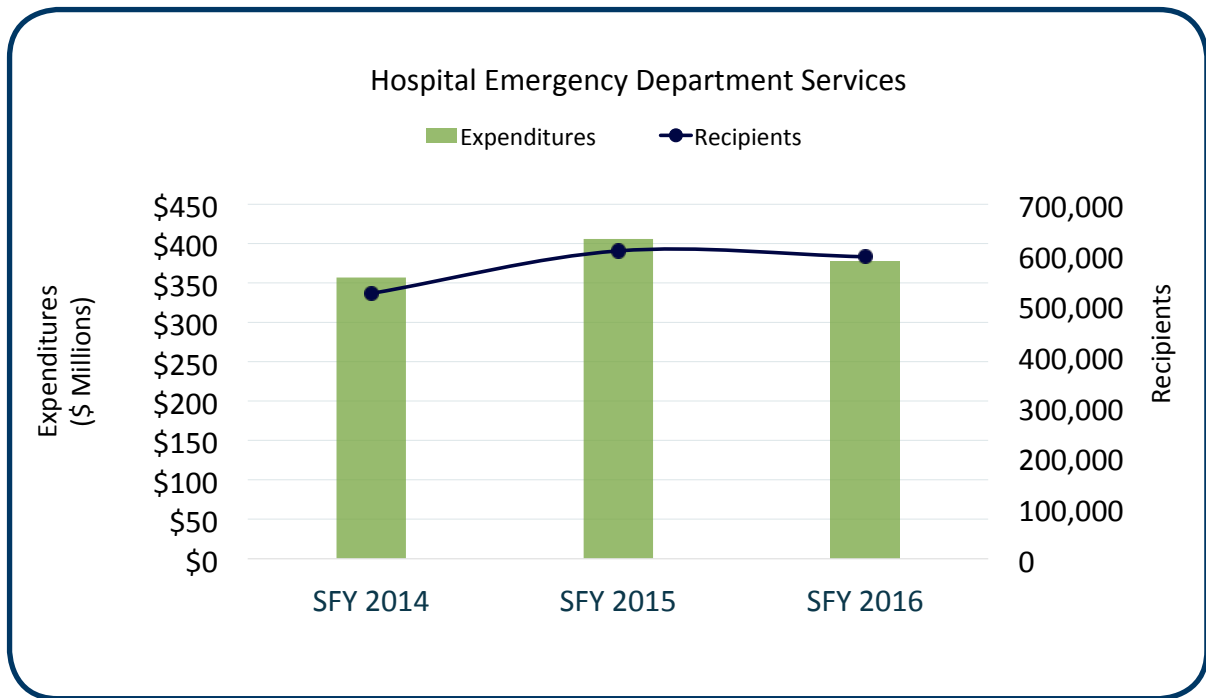
The DMA dental program will begin coverage of therapeutic agents that arrest tooth decay in SFY 2017. In 2014, the FDA approved silver diamine fluoride for use in dental patients. This product's silver component has been shown to effectively stop active tooth decay lesions, and the fluoride component prevents new decay. In populations that are difficult to treat in a dental office under local anesthesia, such as young preschool children, silver diamine fluoride can open new opportunities for improved oral health.

Hospital Emergency Department Services

Hospital emergency departments provide acute care at the sudden onset of a medical condition 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, the burden for emergency care 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 14



SFY 2016 Highlights

Emergency department utilization declined by 1.9% in SFY 2016, while total costs dropped by 7%. Reimbursement methodology changes also impacted this category of service.

Looking Forward

DMA projects a decrease in emergency department utilization as beneficiaries continue to be directed to the proper health care channels by their primary care physicians and LME/MCOs, and as efforts continue to strengthen integration of physical and behavioral health care.

Community Alternatives Program for Disabled Adults

The Community Alternatives Program for Disabled Adults is a home- and community-based services program that makes care at home a real possibility for many people who might otherwise be placed in a nursing home.

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 age 18 and older with disabilities who are at risk of institutionalization. The services provide an alternative to institutionalization for beneficiaries who prefer to remain at home.

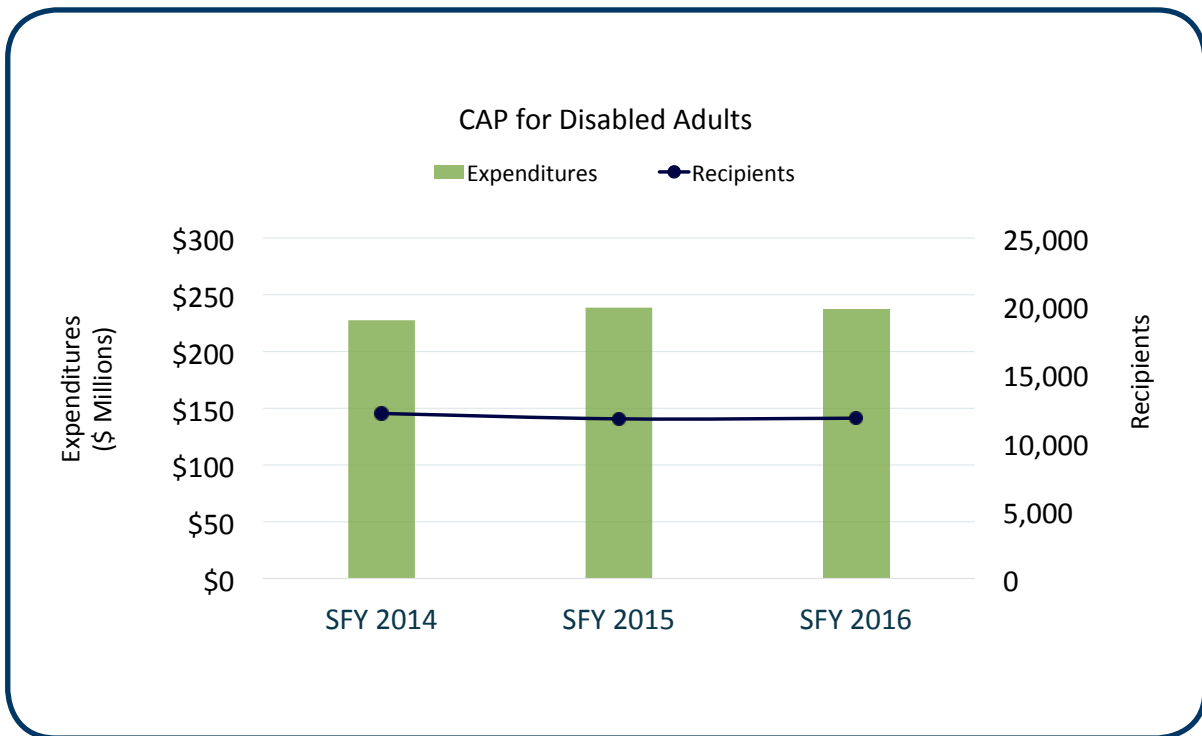
CAP/DA supplements the formal and informal services and supports already available to a beneficiary. The program is intended for situations where no household member, relative, caregiver, landlord, community, agency, volunteer agency or third-party payer is able or willing to meet all medical, psychosocial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

SFY 2016 Highlights

The number of individuals served and total expenditures for CAP/DA were relatively unchanged in SFY 2016. The individuals who can be served at a given time by CAP/DA is capped at 11,214.

The CAP/DA policy of consumer direction allows beneficiaries to negotiate pay rates and service hours. Often, costs and utilization rates are lower for individuals who have greater control over their care.

EXHIBIT 15



Looking Forward

The North Carolina General Assembly has approved an additional 320 slots for CAP/DA, targeting individuals with Alzheimer’s disease or related disorders for this coverage expansion. Changes also are being considered in SFY 2017 that will increase case management hours and add vehicle modification and geriatric nurse aides as waiver services.

Durable Medical Equipment

The durable medical equipment program covers prosthetics, orthotics and other types of durable medical equipment for enrolled Medicaid and NC Health Choice beneficiaries, and to individuals enrolled in both Medicare and Medicaid.

NC Medicaid covers durable medical equipment, prosthetics, orthotics and related supplies (DMEPOS) when medically necessary for beneficiaries to function in their home or adult care home, and ordered by their treating prescriber (physician, physician assistant or nurse practitioner).

Examples of covered equipment include wheelchairs, hospital beds, walkers, canes, crutches, oxygen and respiratory equipment, and glucose monitors. Covered prosthetic and orthotic devices include artificial limbs, and braces for the limbs or spine. Related supplies covered when medically necessary include those used for incontinence, diabetes, ostomy care and tracheostomy care, and tubing, batteries and electrodes. All DMEPOS items have established lifetime expectancies and quantity limitations, and many require prior approval.

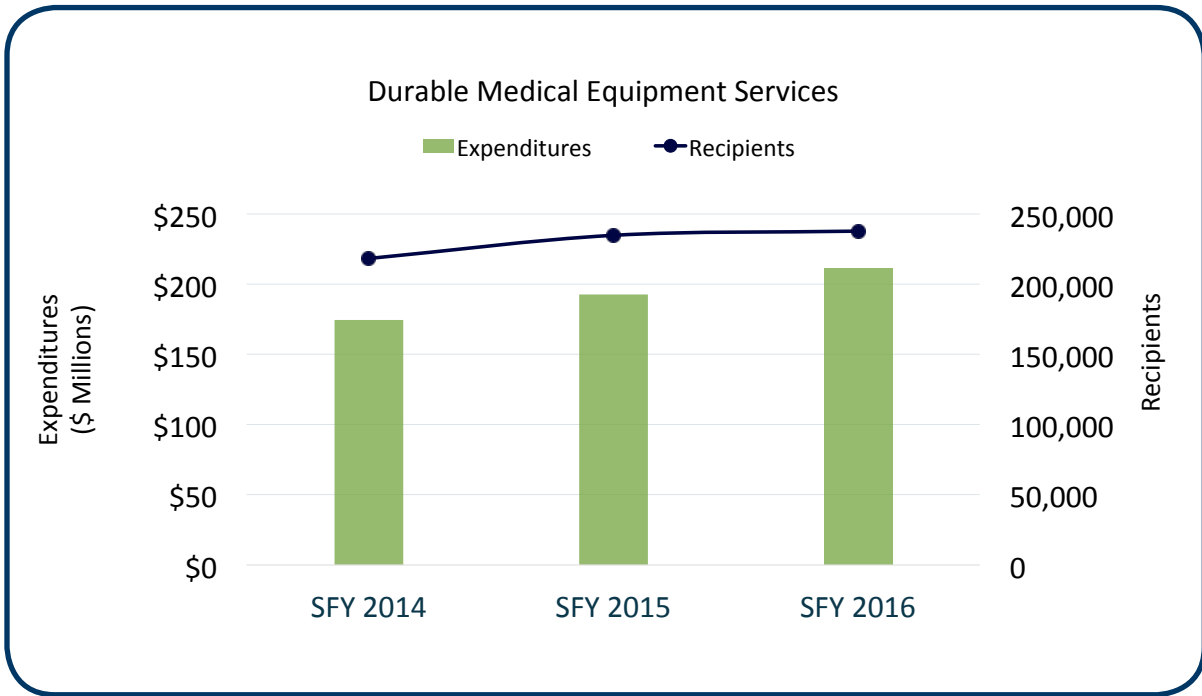
SFY 2016 Highlights

In SFY 2016, DMEPOS expenditures increased by 9.7%, along with a 1.3% increase in recipients.

During SFY 2016, service delivery to beneficiaries was improved:

- Guidance for electronic signatures was developed to increase the efficiency of the prior approval process, allowing beneficiaries more expedient access to the equipment they need
- Process changes were made to simplify the prior approval process for the provision of select DME items on the date of discharge from specified facilities
- Policy language was updated and ICD-10 codes were added to comply with a federal mandate

EXHIBIT 16



Looking Forward

Policy reviews and updates will continue to be a priority to streamline processes, reduce costs and promote efficient distribution of equipment and supplies. The DMEPOS team also will continue to emphasize open communication with providers and beneficiaries through active involvement in stakeholder groups.

Practitioner Non-Physician Services

Practitioner non-physician services are assessments and treatments performed by independent practitioners licensed to provide audiology, occupational, physical, respiratory and speech therapy services. A physician's order and a prior approval is required for these services.

Child development service agencies (CDSAs), home health agencies, outpatient hospitals, physician's offices, local education agencies (LEAs), and single-specialty and multi-specialty group practices provide Medicaid therapy services for specific age groups.

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 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 clinic.

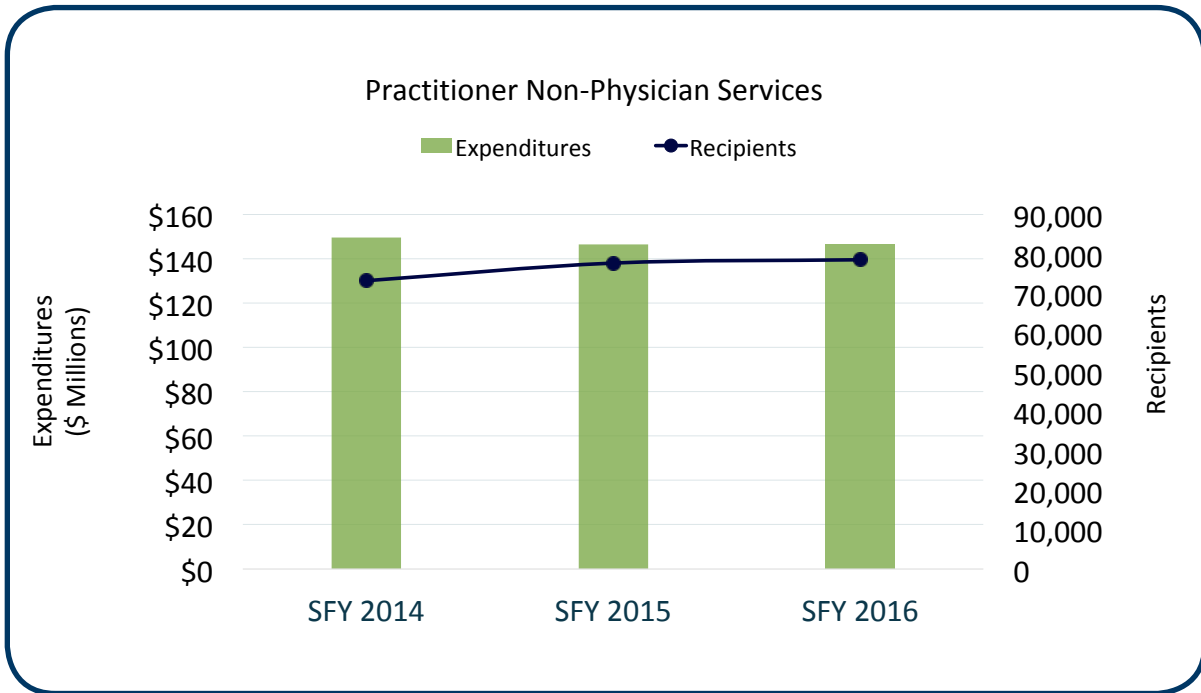
To ensure all adult beneficiaries over age 21 years receive medically necessary therapy to improve recovery from an illness/diagnosis or injury requiring an open surgical procedure, adult beneficiaries can receive therapy through the physician's office, home health agency or through outpatient hospital facility.

SFY 2016 Highlights

Beneficiaries receiving practitioner non-physician services grew slightly while expenditures held steady, resulting in a 1% decrease in the cost per recipient for these services.

Clinical coverage policies related to outpatient specialized therapies and respiratory therapy were updated in SFY 2016 to monitor service utilization, provide clarity regarding billing practices to providers, and provide coverage to NC Health Choice beneficiaries.

EXHIBIT 17



DMA has improved opportunities for early detection of potential deficits in children served by Medicaid and NC Health Choice, and those efforts have resulted in an average of over 22,000 evaluations for specialized therapy needs per year for children ages 4 and under.

Looking Forward

In SFY 2017, DMA plans to update several policies related to these services. These policy changes will provide further clarity and consistency for providers, offer the possibility of coverage to new populations in need of certain therapy services, and ensure children have access to an appropriate level of medically necessary services.

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 of 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 DHHS 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 230 ESRD facilities across the state.

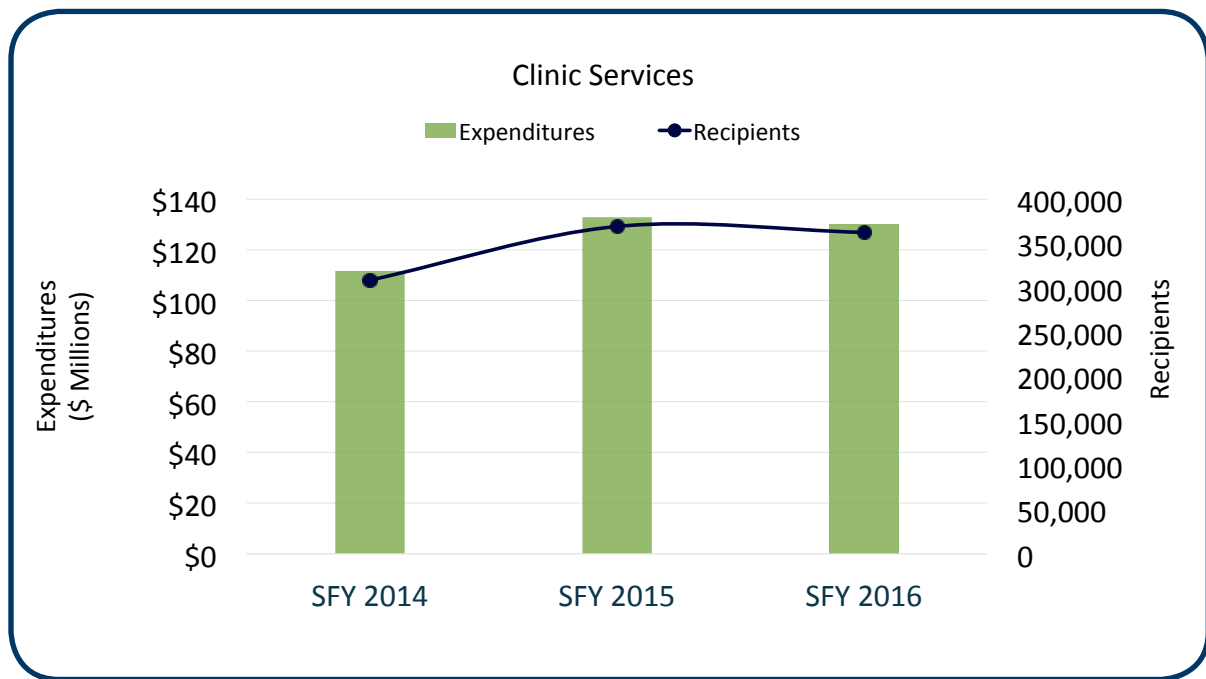
Clinic services provide continued comprehensive medical care for Medicaid beneficiaries unable to find a Medicaid provider due to access or transient care. Moreover, clinics in North Carolina also serve as safety net providers for citizens who have difficulty obtaining medical care because they are either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

SFY 2016 Highlights

In SFY 2016, total expenditures and unduplicated recipients for clinic services each declined by roughly 2%, while cost per recipient held steady. Other highlights:

- More than 50 new ESRD facilities were enrolled
- To improve monitoring and manage utilization of clinic services, system changes were implemented during the year to strengthen oversight regarding services provided to undocumented immigrants through ESRD facilities

EXHIBIT 18



Looking Forward

From 2015 to 2018, the average national growth in spending for physician and clinical services is expected to be 5.5% per year due to increased demand for services associated with continuing coverage expansion.

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 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 provide a cost-effective alternative to 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.

SFY 2016 Highlights

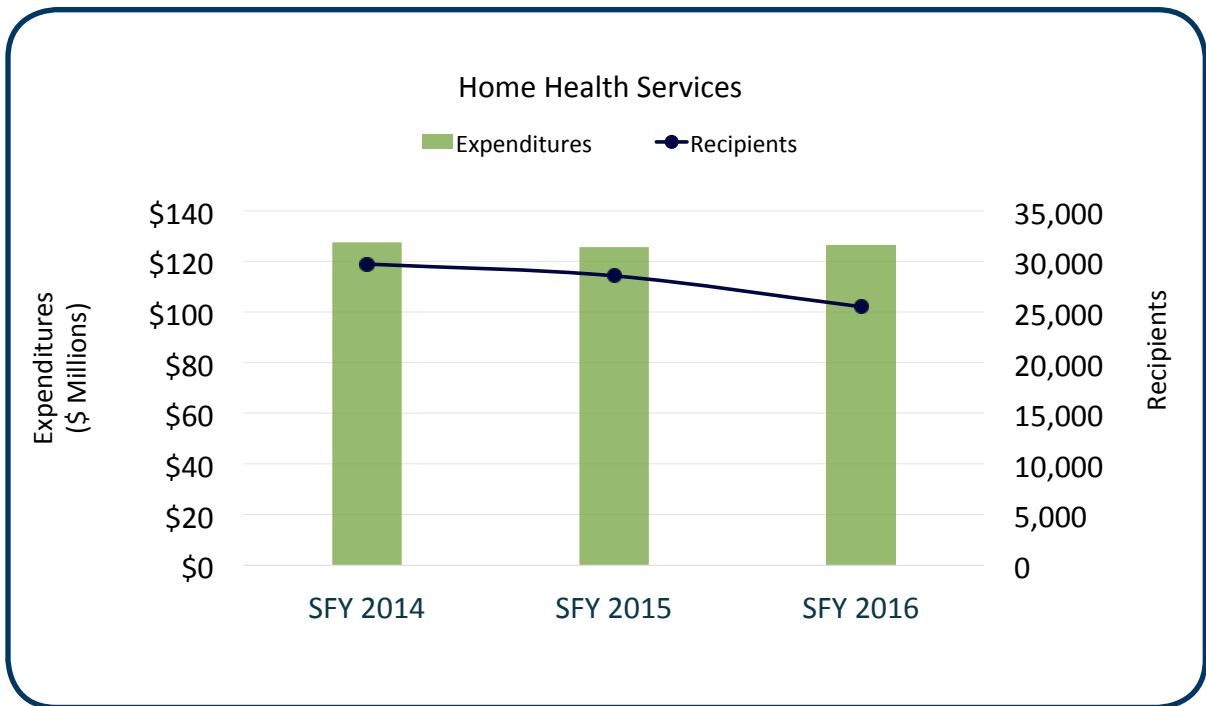
Expenditures for home health services held steady in SFY 2016; however, individuals accessing these services dropped by over 10% compared to the prior year.

The decline in utilization was partially driven by a change in billing policy. This change outlined billing limits and prior approval requirements for certain codes, clarifying the billing process for providers and ensuring proper utilization of resources and access to care for beneficiaries..

Looking Forward

The full implementation of the policy could result in reduced costs and utilization in SFY 2017, but the trend should stabilize as providers become more familiar with new requirements.

EXHIBIT 19



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 2016 Highlights

Lab and X-ray services saw a decline in both expenditures (2.8%) and unique recipients (11.6%). To monitor and manage utilization, and to mirror Medicare coverage and streamline Medicare crossover claims, DMA ended reimbursement for 64 drug screening codes while adding coverage for seven new drug screening codes.

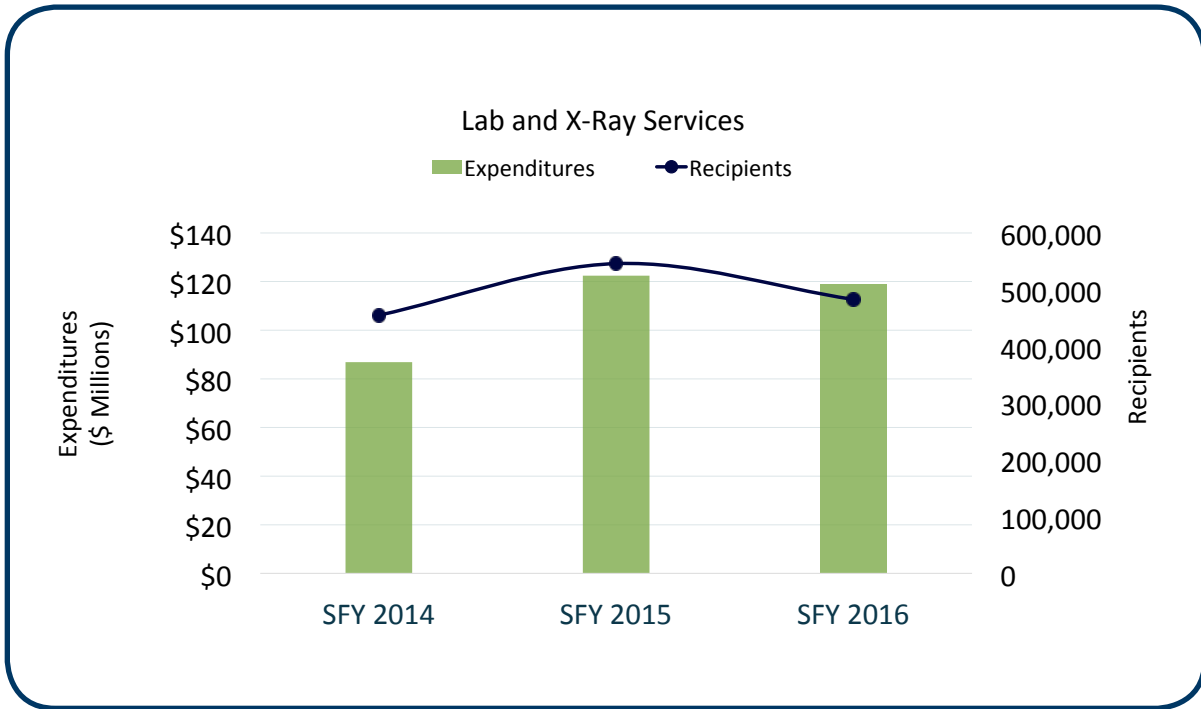


Looking Forward

To further manage utilization, new limitations on urine drug screening will be implemented for SFY 2017.

Potential revisions and additions to coverage of genetic testing procedures may result in policy changes and possible changes in utilization and cost for lab and X-ray services.

EXHIBIT 20



Community Alternatives Program for Children

The Community Alternatives Program for Children is a home- and community-based services program, making care at home a real possibility for many children who face institutional 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 21 who are medically fragile and are at risk of institutionalization. This program provides an alternative to institutionalization for beneficiaries to remain at home.

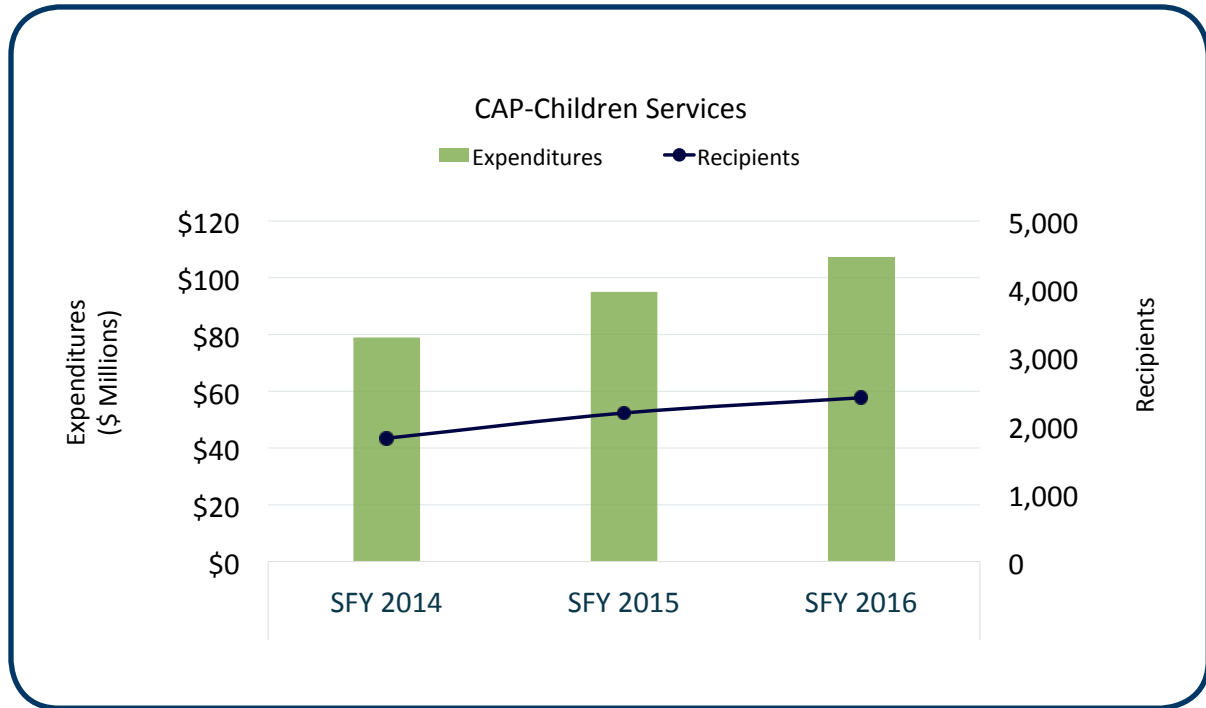
CAP/C supplements the formal and informal services and supports already available to a child. The program is intended for situations where no household member, relative, caregiver, landlord, community, agency, volunteer agency or third-party payer is able or willing to meet all medical, psychosocial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

SFY 2016 Highlights

In SFY 2016, more than 2,400 individuals received services through CAP/C, representing a 10% increase from SFY 2015 and a 33% increase over two years. The increase was partially driven by a higher awareness of the program among providers, which led to more referrals from hospitals, pediatricians and county Department of Social Services offices.

CAP/C staff updated policies in SFY 2016 to streamline the delivery of services and ensure continuity of coverage as beneficiaries are no longer eligible for CAP/C due to age. Workflow processes for participation in the waiver program also were clearly defined, providing beneficiaries and providers with clear communications about program expectations and eligibility.

EXHIBIT 21



Looking Forward

The referral rate for CAP/C is expected to continue increasing due to growing public interest. DMA will expand the capacity of CAP/C to provide services to 4,000 individuals per year by the end of the five-year waiver period.

The rate for nursing services offered within CAP/C will increase by 10% in SFY 2017 to maintain a fair and reasonable pricing structure and provide beneficiaries with adequate access to quality care.

Health Check Early Preventive Health Screening

Health Check is North Carolina's preventive health and wellness 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, 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.

SFY 2016 Highlights

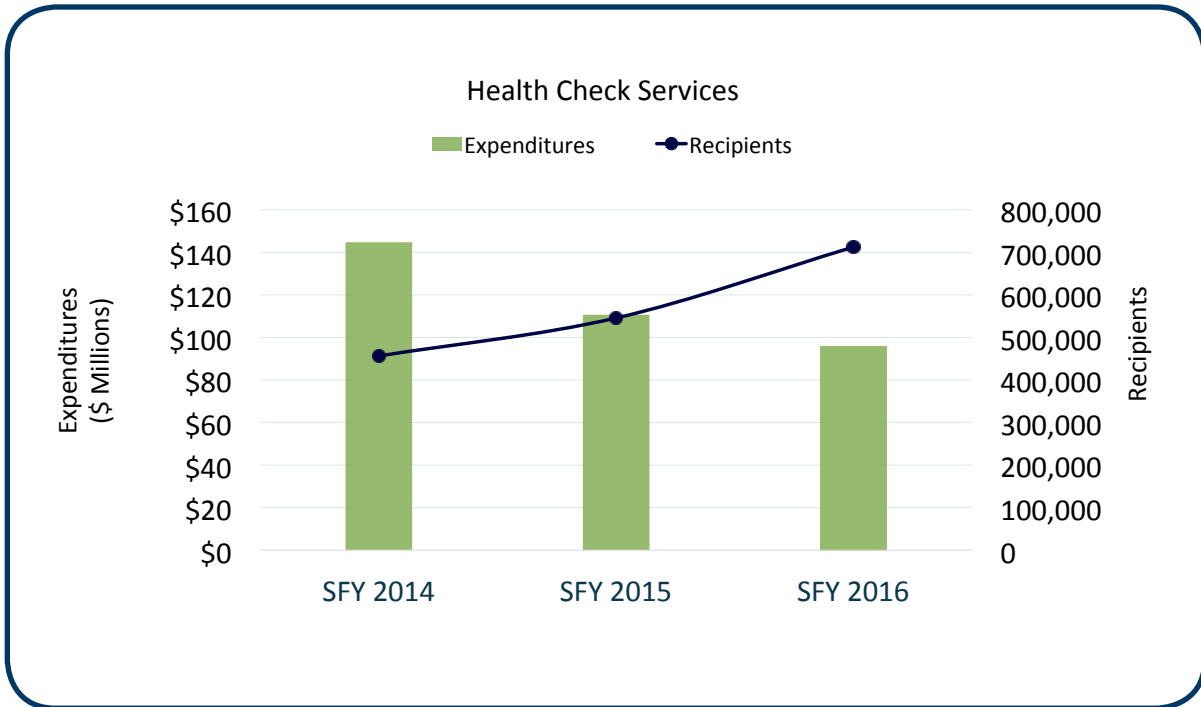
Health Check saw a 30.5% increase in recipients during SFY 2016, but saw a simultaneous 13.3% decline in expenditures. This drop in the cost per recipient for these services is largely due to the expiration of enhanced physician payments through the Affordable Care Act.

Health Check statewide participation in wellness visits is reported to the Centers for Medicare & Medicaid Services (CMS) each federal fiscal year (FFY) using the CMS 416 report. The CMS 416 report for FFY 2015 (Oct. 1, 2015 – Sept. 30, 2016) outlines North Carolina's accomplishments through the Health Check program, including:

- North Carolina children continue to receive wellness screens on par (57%) with the national average (59%)

- Over 93% of North Carolina’s Medicaid enrolled children under age 2 receive their recommended early preventive check-ups and immunizations
- Participation in early periodic screening in high priority populations of pre-teens and teens has increased by nearly 74% since FFY 2011
- Over 600,000 Medicaid enrolled children received preventive dental services in FFY 2015, showing a five-year increase of 40%
- Over 83,000 Medicaid enrolled children received decay-inhibiting sealers on their permanent molars in FFY 2015, an increase of 28% over the past 3 years

EXHIBIT 22



Looking Forward

North Carolina will continue to take the lead nationally to support early preventive screens and delivery of comprehensive health services to its Medicaid enrolled children and youth.

- In early SFY 2017, Medicaid will began reimbursing maternal depression screenings for mothers during the baby's first year of life
- Also in early SFY 2017, Medicaid will enhance access to preventive care by streamlining billing for multiple, medically necessary preventive and treatment services when they are delivered during the same visit
- Medicaid will continue supporting early intervention for emotional challenges, substance use treatment and smoking cessation through reimbursement for easy-to-administer specialized and scientifically validated brief screening tools
- Local Health Check coordinators will continue efforts to strengthen outreach and health education to pre-adolescent and adolescent populations to build a strong foundation for a lifetime of good health habits
 - DMA is working with Health Check coordinators to increase time spent in the field, contacting high-risk, early adolescent populations in high poverty areas through schools, churches and community organizations
 - Health Check coordinators also are responsible for contacting children using emergency room services through the Medicaid program to ensure proper access to preventive screenings

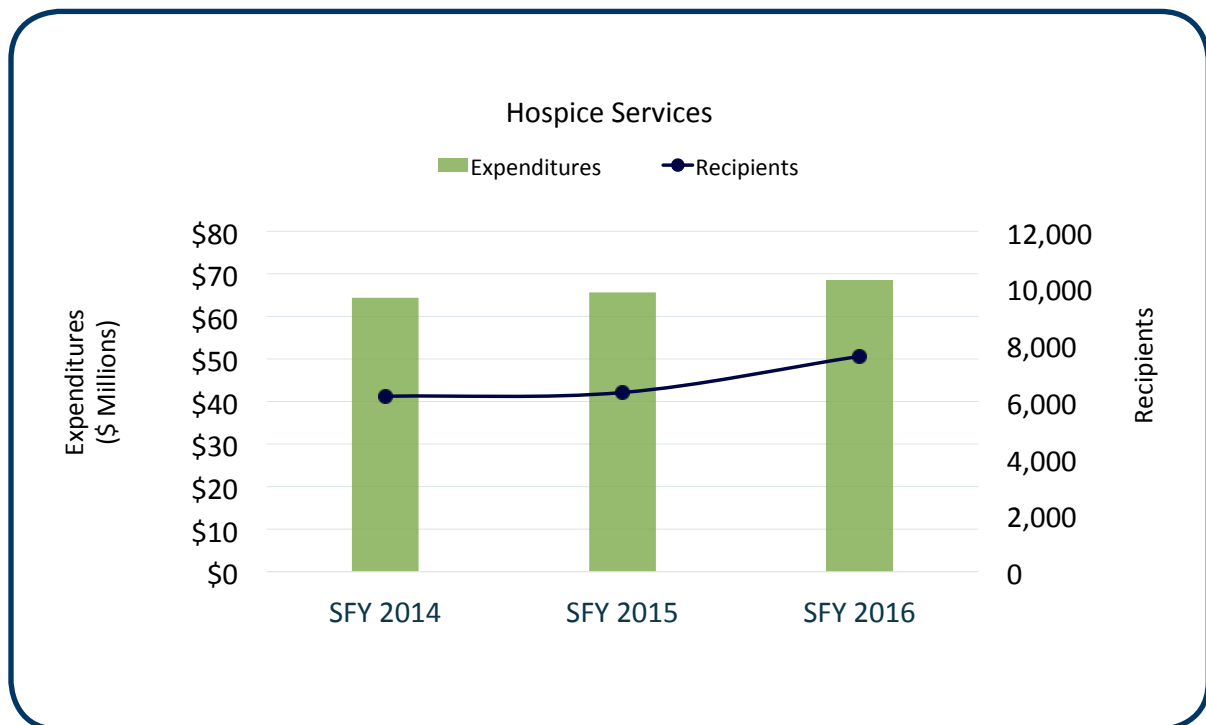
Hospice Services

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.

People 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



SFY 2016 Highlights

Hospice expenditures increased by 4.4% in SFY 2016, while individuals served increased by 20.2%.

The Centers for Medicare & Medicaid Services initiated Hospice Payment Reform effective Jan. 1, 2016, enacting a two-tier payment system where hospice care is reimbursed at a higher rate for the first 60 days and at a lower rate for the remainder of care. Additionally, a Service Intensity Add-on payment is applied for the last seven days of life on top of the routine hospice care rate.

Additionally, a policy change allowing hospice services to be provided at the same time as in-home personal care services was fully implemented Jan. 1, 2016.

Looking Forward

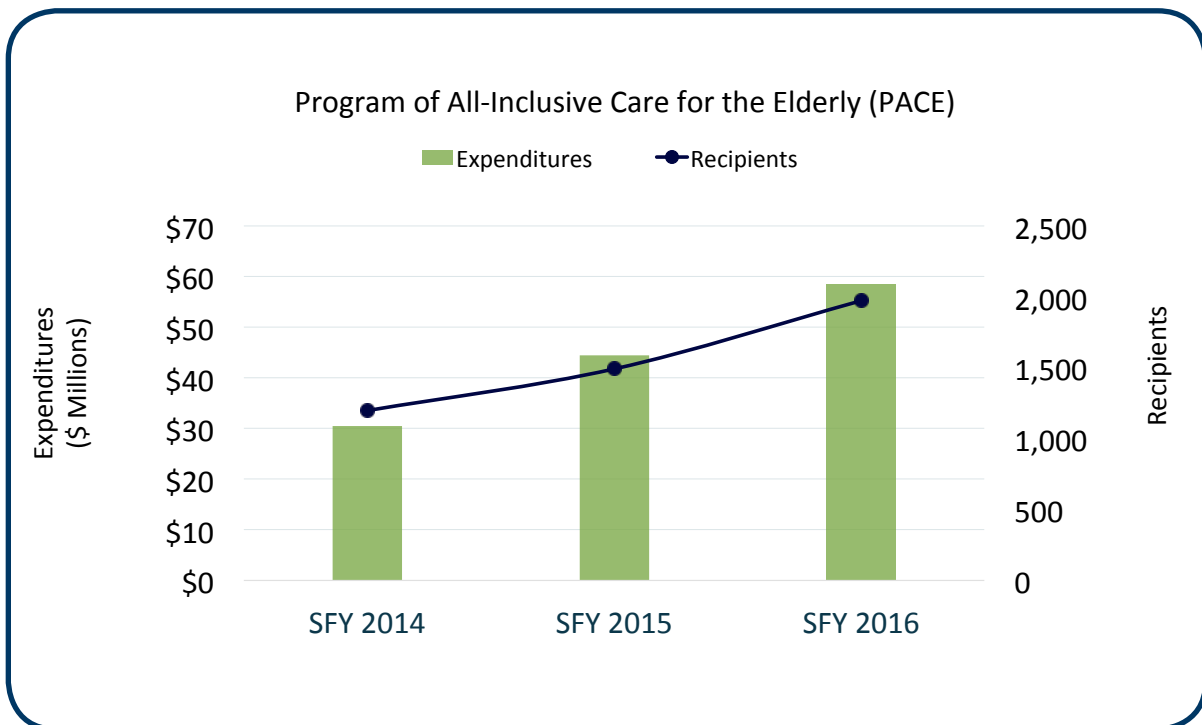
Hospice services should see a continued increase in utilization due to policy changes allowing hospice and in-home PCS to be provided concurrently. Additionally, Hospice Payment Reform should provide for a more efficient billing process for hospice providers.

Program of All-Inclusive Care for the Elderly

Program of All-Inclusive Care for the Elderly 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.

The Program of All-Inclusive Care for the Elderly (PACE) offers a comprehensive array of services including primary health clinics, adult day health programs, areas for therapeutic recreation, personal care, and other acute, emergency care and long-term care services for those enrolled in the program.

EXHIBIT 24



The overarching goals for PACE are:

- Enhance the quality of life and autonomy for older adults
- Enable older adults to live in their homes as long as medically and socially feasible
- Preserve and support the older adult's family unit

SFY 2016 Highlights

Expenditures for PACE services and the people served through these organizations grew in SFY 2016 at the respective rates of 31.8% and 32.3%. The cost of services per recipient held steady. Growth limits capped the net increase in beneficiaries for PACE organizations at either three or six per month, depending on the organization.

In SFY 2016, DMA hired crucial staff to improve oversight and management of the program, including a PACE unit manager to oversee two PACE nurse consultants and two PACE analysts within DMA. The unit manager position is a new position that started February 2016.

Looking Forward

Anticipated changes for SFY 2017 and beyond include continued predictable and modest PACE growth through July 2017 with the allowance of program expansion into counties not currently served. DMA anticipates awarding approval to a limited number of existing North Carolina PACE organizations for service area expansion. Other planned changes include a PACE clinical coverage policy update and the development of a two-way agreement between PACE organizations and DMA, which will provide additional oversight of a PACE organization's financial and programmatic operations.

The trends predicted for PACE within the next state fiscal year include an increase in new participant enrollees with dementia and behavioral health diagnoses.

Training webinars, face-to-face visits and revisions to existing written communications are planned over SFY 2017 to improve communications between DMA and PACE stakeholders, including county Departments of Social Services caseworkers and PACE organizations.

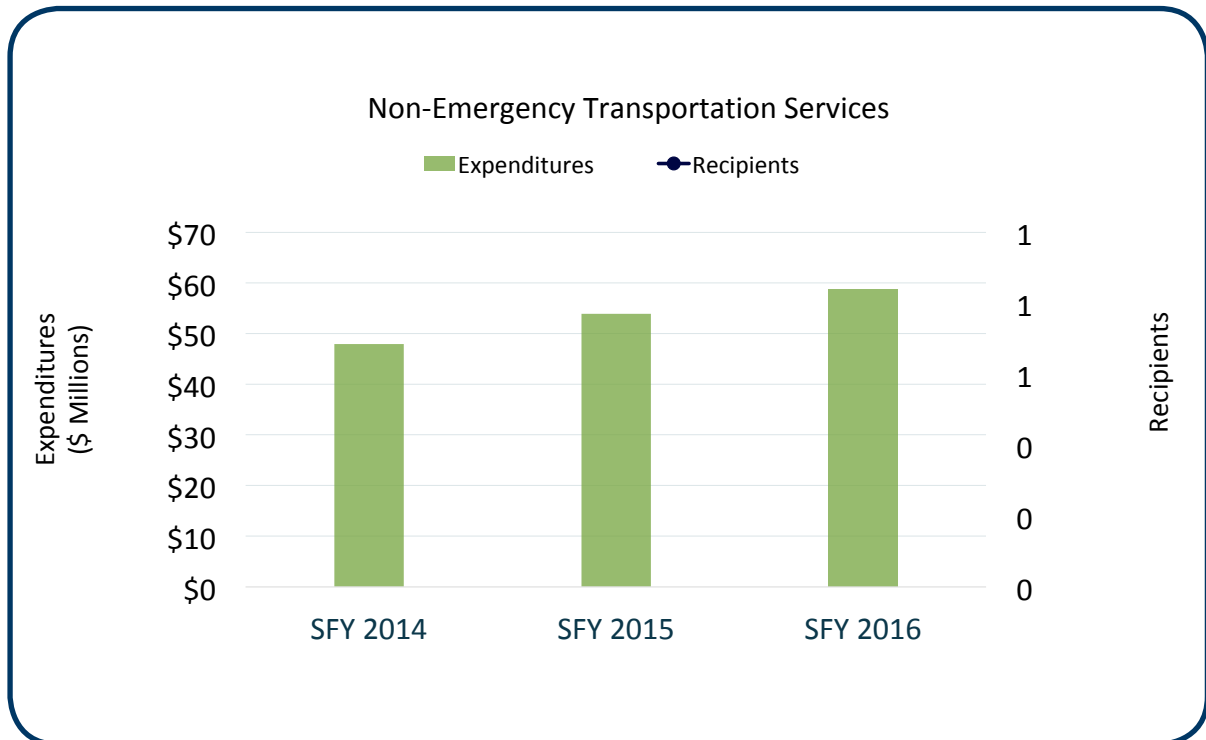
Non-Emergency Medical Transportation Services

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.

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

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

EXHIBIT 25



SFY 2016 Highlights

Spending for NEMT services grew by 8.9% in SFY 2016. NEMT reimbursements are paid directly to counties, which in turn reimburse providers. Therefore, utilization data for NEMT services is currently not available at the beneficiary level.

Looking Forward

A standardized provider enrollment process will be implemented statewide in SFY 2017. As a result, background checks and federal exclusions will be required for NEMT providers during the enrollment process, strengthening compliance with federal safety and risk management guidelines.

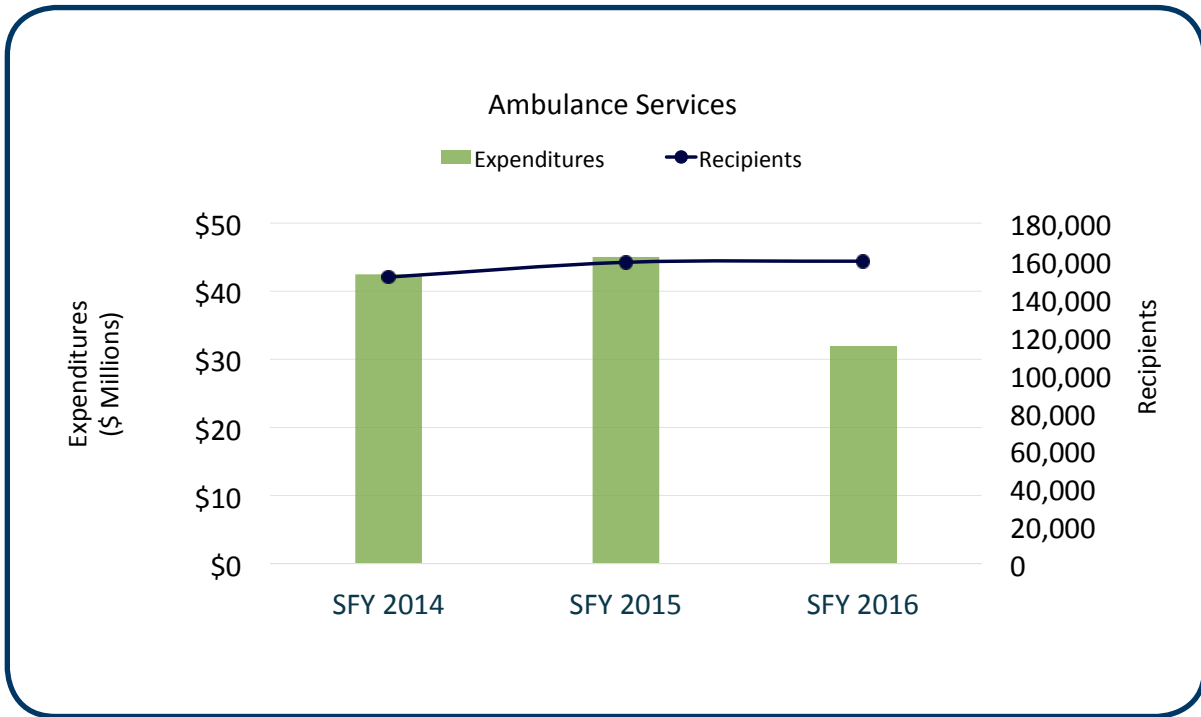
With the implementation of provider enrollment for vendors, providers will begin submitting claims through the NCTracks system. This shift will allow for greater monitoring and analysis of NEMT spending and utilization.

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 26



SFY 2016 Highlights

Total expenditures on ambulance services declined by 29.2% in SFY 2016, while beneficiaries using these services held steady. This decrease in expenditures is in part the result of increased program integrity efforts.

A new ambulance policy was implemented in SFY 2016 that clearly outlined requirements to provide ambulance services to Medicaid beneficiaries and serves as a legally binding document for providers.

Looking Forward

Ambulance service utilization rates are expected to remain constant for the foreseeable future. DMA staff is currently working on an ambulance policy update that will clarify the provider billing and reimbursement guidelines for situations where care is provided by emergency medical personnel upon arrival, but the patient is not in need of emergency transportation.

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, eyeglasses are fabricated by Nash Correctional Institution inmates at Nash Optical Plant, a state-owned and -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.

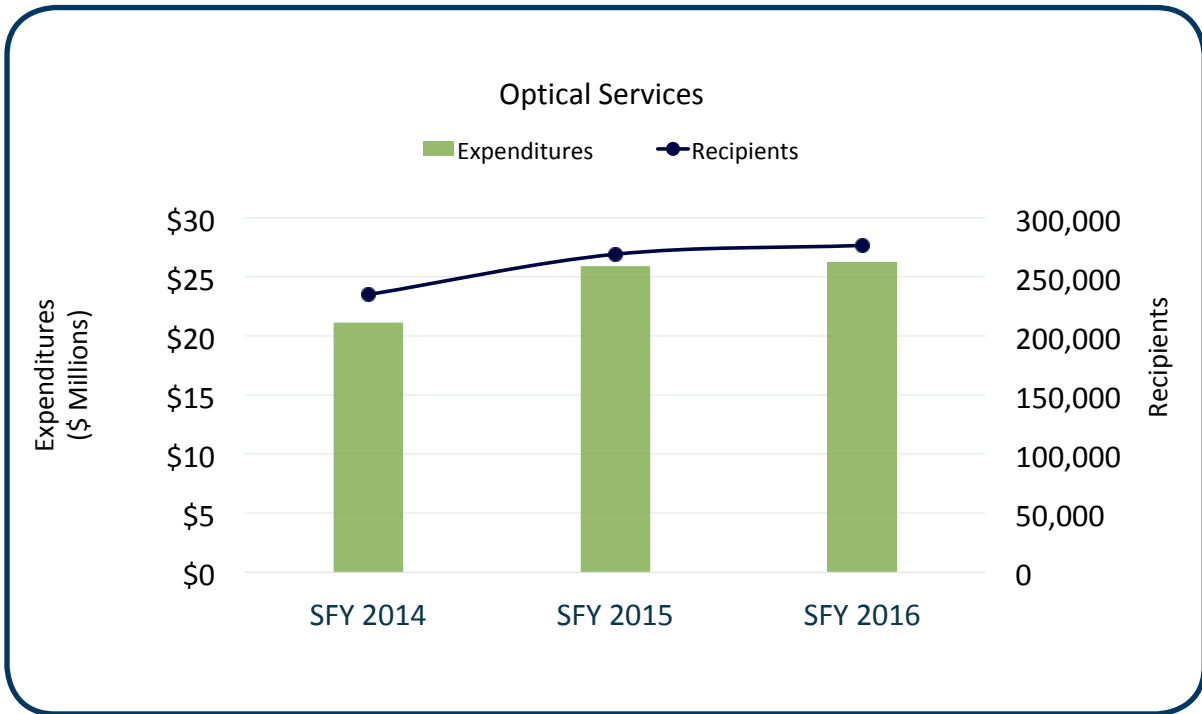
SFY 2016 Highlights

In SFY 2016, over 275,000 individuals received optical benefits through Medicaid and NC Health Choice, an increase of 2.8% over SFY 2015. This increase is approximately in line with enrollment growth and brought a 1.2% increase in the total cost for optical services.

The Nash Optical Plant inmate program resulted in continued savings to Vocational Rehabilitation and Services for the Blind.

In SFY 2016, 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.

EXHIBIT 27



Looking Forward

Although adult optical services were not reinstated in the 2016 budget, DHHS is researching alternative avenues for possible coverage.

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 July 2016, there were 125 ASC providers enrolled in North Carolina Medicaid, with seven new providers to enroll in SFY 2016.

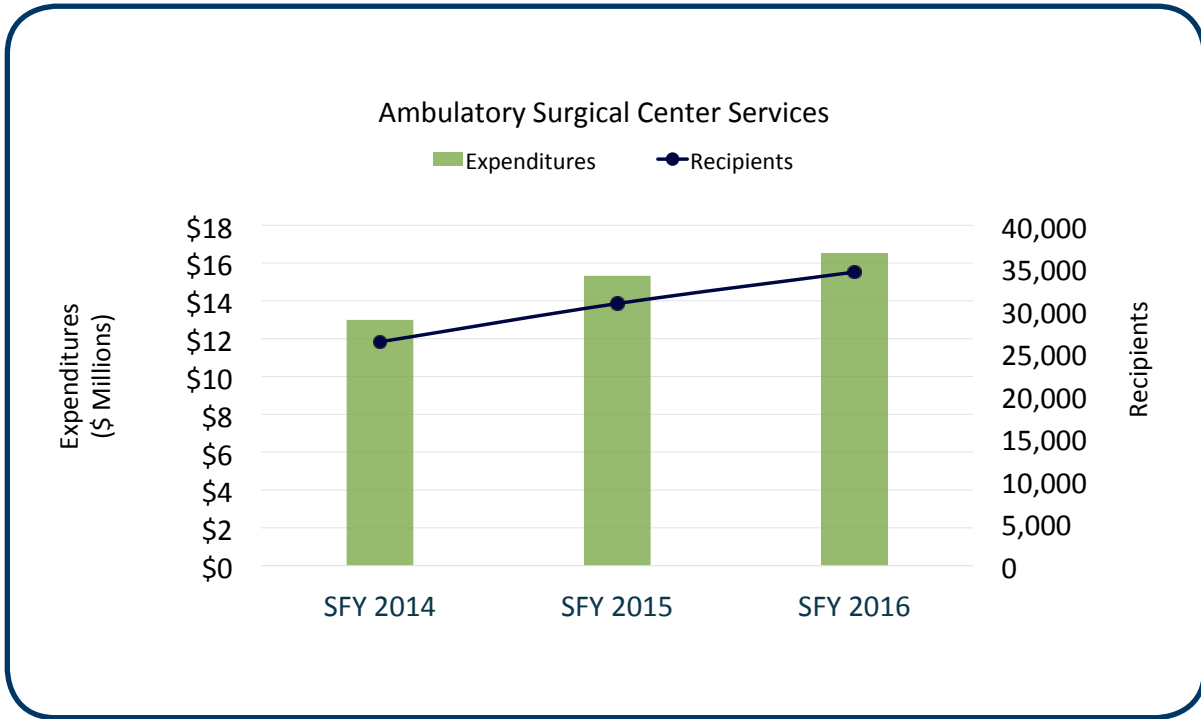
SFY 2016 Highlights

Expenditures for ASC services increased by 7.9% in SFY 2016, while recipients of these services increased by 12%. This resulted in a slight decline (3.6%) in the cost per recipient for providing services in ASC settings.

New procedures offered in these settings have contributed to continued average growth in the use of ambulatory surgical centers. DMA participates in the annual Current Procedural Terminology (CPT) code update, reviewing new procedures that may be covered for Medicaid beneficiaries. In SFY 2016, 50 additional procedures were added to ambulatory surgery including:

- Visualization (scope) of the respiratory and gastrointestinal systems
- Stenting and drainage of the biliary system (liver and gallbladder)
- Stenting and catheter insertion into the urinary system (kidneys and bladder)
- Radiology procedures (X-rays)
- Radiation oncology

EXHIBIT 28



To align with Medicare reimbursement, clinical policy and rate setting staff reviewed the ambulatory surgery fee schedule in 2016 and removed ambulatory surgery centers from 299 codes. The fee schedule was updated to reflect this new information to help providers determine which services are covered in the ambulatory surgery setting.

Looking Forward

It is anticipated that expenditures will continue to grow as Medicaid enrollment increases and new technology allows for additional and more complex procedures to be performed in an ASC setting.



Other Division of Medical Assistance Highlights

Medicaid Reform: Transformation of the North Carolina Medicaid and NC Health Choice Programs

Session Law (S.L.) 2015-245 was signed into law Sept. 23, 2015. Also known as the Medicaid Reform bill, this legislation focuses on the transformation and reorganization of the North Carolina Medicaid and NC Health Choice programs, directing DHHS to design the programs to ensure:

- Budget predictability through shared risk and accountability
- Balanced quality, patient satisfaction and financial measures
- Efficient and cost-effective administrative systems and structures
- A sustainable delivery system by establishing two types of prepaid health plans (PHPs): provider-led entities (PLEs) and commercial plans

Additionally, S.L. 2016-121 was passed at the end of the 2016 session to address administrative and technical changes, thereby amending S.L. 2015-245. Identified by DHHS after conversations with providers, beneficiaries and other stakeholders, and the Centers for Medicare & Medicaid Services, these changes enabled the transformation process to continue to move forward.

SFY 2016 Accomplishments

Since S.L. 2015-245 was enacted, Medicaid reform activities have focused on creating a working platform for the multi-year transformation and reorganization project, meeting federal and state requirements necessary to begin the reform process, and working closely with stakeholders throughout the state to design a program that will improve health and health care throughout North Carolina.

One of the first steps the General Assembly directed was to establish the Division of Health Benefits (DHB) under DHHS to manage the Medicaid transformation project. This included hiring a core project planning team, developing an employment agreement for Division of Medical Assistance (DMA) and DHB employees hired after Oct. 1, 2015 (per S.L. 2015-245), and establishing an accounting structure in the North Carolina Accounting System. Working closely with DHHS, DMA and numerous stakeholders, DHB will use this working platform to design, develop and implement the transition from the current fee-for-service delivery system to managed care.

In SFY 2016, DHHS met all federal- and state-mandated submissions, activities and reporting requirements, including:

- Draft Section 1115 demonstration waiver and other initial program concepts (Joint Legislative Oversight Committee on Medicaid and NC Health Choice (JLOC) report (March 1, 2016)
- North Carolina Health Transformation Center proposed program design JLOC report (May 1, 2016)
- Section 1115 demonstration waiver application (June 1, 2016); CMS formally accepted North Carolina's submission June 16, 2016, with a completeness letter acknowledging that all requirements for submission were met
- Medicaid transformation progress updates to the JLOC from January through April 2016

DHHS is committed to collaborating with stakeholders, such as beneficiaries and their families; health care advocates, providers, businesses and associations; and hospital systems and facilities. In SFY 2016, DHHS reached out to North Carolinians for input to help build the state's approach to Medicaid reform by:

- Holding 12 public hearings, 10 more than required by CMS, across the state on the draft Section 1115 waiver application. The input from the 1,600 attendees was used to develop the final waiver submission
- Collecting 750 written public comments through the DHHS Medicaid Reform website, which also provided input to develop the final waiver submission
- Establishing the Dual Eligibles Advisory Committee to develop recommendations for a long-term strategy to transition dual eligible enrollees to managed care
- Since January 2016, discussing Medicaid reform with stakeholders during more than 100 scheduled meetings

Looking Forward

Over the next several years, DHHS will continue to work closely with stakeholders to build the new Medicaid health care delivery system. In the meantime, the Medicaid and NC Health Choice programs will continue as usual and beneficiaries will receive care the same way they do now.

For SFY 2017, the Transformation Team will:

- Establish and implement a procurement process for technical assistance to support DHHS in the design, development and implementation of the transformed programs
- Develop transformation project status reports for the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and a complete Medicaid transformation work plan
- Engage expert assistance to assist with the launch of the North Carolina Task Force on Health Analytics
- Deliver the first Medicaid transformation annual report to the General Assembly and Office of State Budget Management
- Continue working with the Dual Eligibles Advisory Committee, and use its recommendations to prepare the DHHS proposed plan to transition the dual eligible population to managed care

When Medicaid reform is approved by the federal government, it will be the right health care system for North Carolina – one that puts people first.

Finance Overview

For the third consecutive year, North Carolina's Medical Assistance programs finished the fiscal year with cash on hand through continuous improvement of the forecasting and analysis capabilities of the DMA Finance section.

In SFY 2016, the Finance section continued restructuring efforts that began in SFY 2015. Eight new employees were hired to fill crucial roles on the existing DMA Finance teams, which improved analysis, forecasting and cash management capabilities. Additionally, the DMA Contracts function was moved under the Finance section during the year, improving internal communications and monitoring of contract spending and processes.

Process Improvements

- **Budget.** DMA budget staff members refined the process by which the division's budget is developed, enhancing the quality of data inputs and testing the forecast model against historical scenarios to determine the most accurate predictors of spending patterns. This resulted in strengthened financial planning and reporting for DMA programs, and improved communication with stakeholders.
- **Pharmacy Rebates.** DMA continued to pursue the best possible prices for prescription drugs through rebate negotiations and a preferred drug list. Refining these processes in SFY 2016 contributed to a decrease in cost-per-beneficiary for prescription medications.
- **Cash Management.** Continuation of new practices introduced in SFY 2015, including cash planning meetings and checkwrite reporting, generated improved communications and enabled a more proactive detection and response to potential financial issues as they appear.

Finance Section Functions

The creation of two new units within the Finance section in SFY 2015 and the addition of Contracts as a Finance unit in SFY 2016 has expanded the capacity of the Finance section and helped to contribute to improved financial results.

- The **Audit Unit** audits and reviews 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, and furnish audited data for establishment of 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 ascertain the extent of various types of program risk and to develop appropriate measures and responses to risk.
- The **Provider Reimbursement Unit** primarily establishes reimbursement methodologies that comply with Centers for Medicare & Medicaid Services regulations and legislative authority. Provider Reimbursement develops and establishes reasonable reimbursement rates for the numerous Medicaid covered health care services of North Carolina. This section also administers the financial implementation of the 1915 (b)(c) waiver, including financial monitoring and oversight of the LME/MCOs.
- The **Financial Planning & Analysis Unit** develops 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, media personnel, 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 assist with biennium budget development.
- The **Budget Unit** develops the biennium and continuation budgets. The group also proactively monitors spending versus budget, revises budget amounts based on latest forecasts, and engages with program and service

representatives to understand changes that may impact overall budget results.

- The **Finance & Accounting Unit** is one of the larger units within the Finance Section and maintains accurate financial records, tracks payments and receipts, and manages federal reporting requirements to the Centers for Medicare & Medicaid Services.
- The **Procurement and Contracts Unit** develops and submits requests to procure goods and services required to carry out the responsibilities of the division by vendor sourcing through development and submission of e-Procurement requisitions; strategic sourcing research; requests for proposals, information and quotes; contract development; contract lifecycle management and vendor management; and submission to DHHS agency for issuance of purchase order or approval to award.

Compliance and Program Integrity Overview

The Office of Compliance and Program Integrity (OCPI) ensures compliance, efficiency and accountability by detecting and preventing fraud, waste and abuse. OCPI 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.

OCPI 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 OCPI:

- 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
- Leverage information identified through program reviews, program integrity investigations and from external audits to identify, pursue and implement strengthened controls for the Medicaid program
- 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 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

OCPI receives complaints from patients, their families, 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: dma.ncdhhs.gov/get-involved/report-fraud-waste-or-abuse/complaint-form

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

During SFY 2016, OCPI completed preliminary reviews for more than 4,500 individual complaints through these sources, of which 1,300 cases were referred for further investigation within OCPI. In addition, OCPI made 46 referrals to the North Carolina Attorney General's Office for criminal or civil investigation.

Recoveries from post-payment review activities collected during SFY 2016 totaled \$27,824,030.

Predictive Analytics

To predict and identify fraudulent Medicaid program activities, DHHS uses 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 2016:

- 46 Medicaid providers were referred for suspension of payments and for placement on prepayment billing review (see Prepayment Reviews for additional information on this process)
- 105 providers were referred for investigation of improper Medicaid claim payments
- 11 Medicaid provider applications were referred for additional review or denial of application based on suspicious activity
- 13 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 OCPI 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 or inaccurate billing and fraudulent claiming. 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 1% of the provider population
- Fraudulent claims are more efficiently mitigated by eliminating many of the costs associated with post-payment recoveries
- For SFY 2016, prepayment reviews resulted in denied or reduced claiming representing \$20,552,716 in reduced costs to the state

Clinical Policy and Operations Overview

In SFY 2016, Clinical Policy and Operations staff placed an emphasis on improving customer service; reducing administrative burdens among providers; and engaging staff in various professional development opportunities.

Medicaid's complexity requires focus to retain top performers and subject matter experts throughout DMA, especially in Clinical Policy and Operations. Thus, professional development and organizational redesign were top priorities, and will remain so in SFY 2017. Expanding staff knowledge and competence through targeted professional development curricula from various sources internally and externally will better prepare staff to transition to Medicaid reform.

Reorganization Efforts

In SFY 2016, the alignment of DMA Clinical Policy and DMA Operations sections improved strategic direction and communication across all external services provided to beneficiaries and other stakeholders. The Operations section manages beneficiary eligibility and enrollment, provider services, hearings and appeals, and the DMA Call Center.

Reducing Administrative Burdens

The nationwide transition from the International Classification of Diseases ninth revision (ICD-9) to the tenth revision (ICD-10) required significant planning and energy from North Carolina Medicaid clinical policy staff. On Oct. 1, 2015, the successful transition occurred with relatively few issues, transitioning roughly 12,000 ICD-9 codes into the ICD-10 infrastructure of more than 68,000 codes. This process modernized aspects of the medical billing system to be more applicable for today's health care services and environment.

Improving Customer Service

Under new leadership, the Call Center's focus will expand from primarily providing call center support to beneficiaries regarding eligibility policies to a broader call center serving external callers creating a "no wrong door" concept for callers. The DMA Call Center will relocate to RTP in January 2017, allowing a change in the phone system. This enhanced phone system will provide advanced scripting, call triage, redesigned work flow opportunities and implement performance metrics. This will improve the customer experience, reduce the calls throughout DMA work units and increase staff productivity.

Medicaid Reform

Clinical policy review is underway to prepare for new federal managed care rules, and the implementation of the managed care delivery system. Clinical policy staff will review over 100 policies, the Medicaid and NC Health Choice state plans, and all existing waivers to prepare for additional monitoring and compliance considering these changes, while maintaining certain programs that will remain fee-for-service. DMA will continue to engage various stakeholders and advisory groups such as the North Carolina Physician Advisory Group and the Medical Care Advisory Committee.



Additional Exhibits

Funding Sources, SFY 2015-2016

EXHIBIT 29

Medicaid				
(\$ millions)	2015 Actuals	2015 Budget	2016 Actuals	2016 Budget
Expenditures	\$13,744	\$14,042	\$13,771	\$14,683
Revenues-Federal	8,752	8,866	8,771	9,353
Revenues-Other	1,435	1,489	1,507	1,595
Appropriations	\$3,558	\$3,688	\$3,493	\$3,734

Health Choice				
(\$ millions)	2015 Actuals	2015 Budget	2016 Actuals	2016 Budget
Expenditures	\$175	\$176	\$173	\$199
Revenues-Federal	133	133	161	186
Revenues-Other	1	1	1	1
Appropriations	\$42	\$42	\$11	13

Medicaid & Health Choice				
(\$ millions)	2015 Actuals	2015 Budget	2016 Actuals	2016 Budget
Expenditures	\$13,920	\$14,218	\$13,944	\$14,882
Revenues-Federal	8,884	8,998	8,932	9,539
Revenues-Other	1,436	1,490	1,508	1,596
Appropriations	\$3,599	\$3,730	\$3,504	\$3,747

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

Source: NCAS BD-701

Medicaid Providers by Type, SFY 2016

EXHIBIT 30

North Carolina Medicaid State Fiscal Year 2016 Active Medicaid Providers ¹		
Provider Type	Unduplicated NPI Count (by type)*	NPI Count (with multiple taxonomy codes)**
Agencies	2,066	2,311
Allopathic & Osteopathic Physicians	26,406	37,851
Ambulatory Health Care Facilities	802	904
Behavioral Health & Social Service Providers	2,775	3,118
Chiropractic Providers	384	384
Dental Providers	2,425	2,811
Dietary & Nutritional Service Providers	3	3
Eye and Vision Services Providers	901	903
Group	7,679	8,432
Hospital Units	10	10
Hospitals	765	773
Laboratories	240	240
Managed Care Organizations	36	36
Nursing & Custodial Care Facilities	1,793	2,078
Other Service Providers	3	3
Pharmacy Service Providers	2,400	2,400
Physician Assistants & Advanced Practice Nursing Providers	11,919	14,160
Podiatric Medicine & Surgery Service Providers	255	640
Residential Treatment Facilities	56	56
Respiratory, Developmental, Rehabilitative and Restorative	1,636	1,694
Respite Care Facility	44	44
Speech, Language and Hearing Service Providers	1,572	1,624
Suppliers	1,798	2,606
Transportation Services	287	357
Total	66,255	83,438

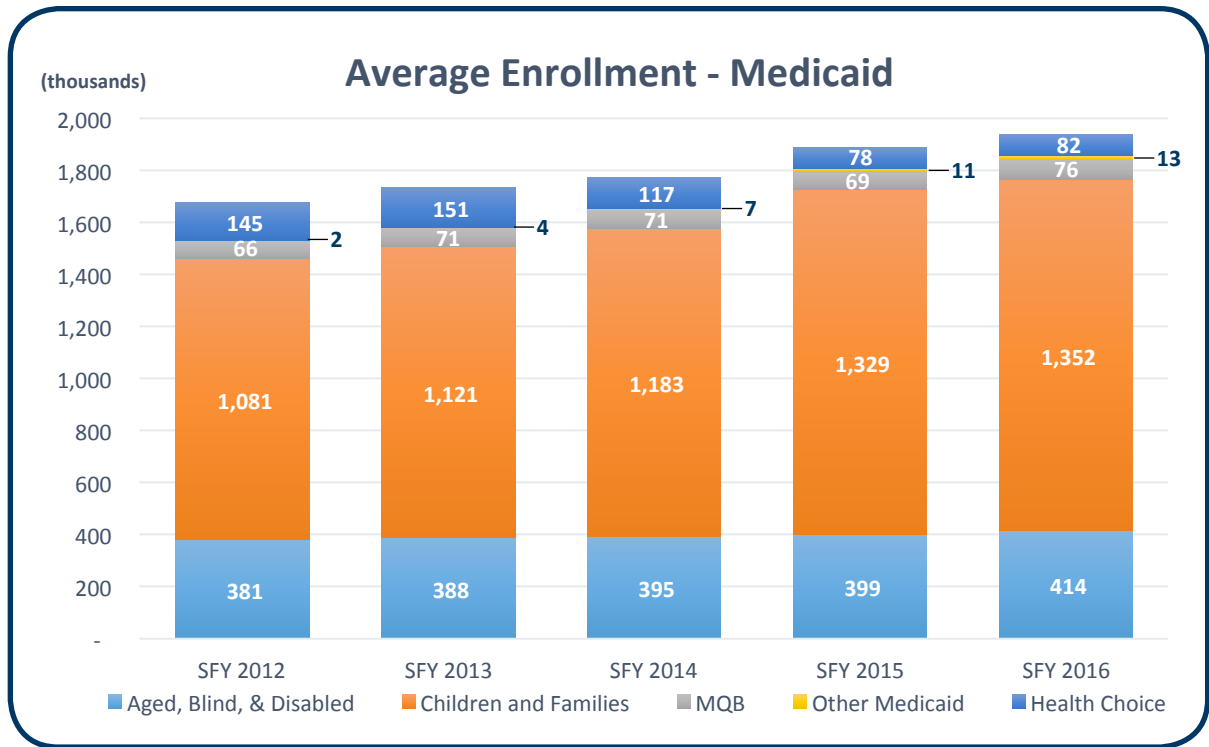
* Total count of NPIs by Level 1 provider taxonomy with a claim in SFY 2016; some providers (such as hospitals) may bill through multiple NPIs as a part of the same entity

** Total count of all NPIs within a given taxonomy with a claim in SFY 2016; some providers (such as hospitals) may bill through multiple NPIs as a part of the same entity

Run Date: 07/21/2016

Average Enrollment by Program Aid Category, SFY 2012-SFY 2016

EXHIBIT 31



Total Expenditure by Category of Service, SFY 2015-SFY 2016

EXHIBIT 32

Service Category	Medicaid + Health Choice (Ranked In Order of SFY2016 Claims Expenditures)						
	SFY 2015			SFY 2016			Cost Per Recipient Variance (vs. SFY 2015)
	Unduplicated Recipients	Claims Expenditure (\$ millions)	Cost Per Recipient	Unduplicated Recipients	Claims Expenditure (\$ millions)	Cost Per Recipient	
LME/MCO	1,793,840	\$2,578.3	\$1,437.3	1,860,507	\$2,612.1	\$1,404.0	-2.3%
Skilled Nursing Facilities	42,316	1,153.6	27,261.4	45,024	1,210.5	26,886.7	-1.4%
Physician Services	1,566,093	1,131.4	722.4	1,778,508	1,034.8	581.8	-19.5%
Pharmacy Services	1,293,145	891.9	689.7	1,296,408	832.0	641.8	-6.9%
Hospital Inpatient	195,033	1,018.5	5,222.1	232,353	947.2	4,076.7	-21.9%
Buy-in/Dual Eligible Services	355,547	700.4	1,969.8	359,523	753.7	2,096.4	6.4%
Hospital Outpatient	676,465	563.3	832.7	698,926	527.2	754.3	-9.4%
Personal Care Services	50,560	461.0	9,118.0	48,070	452.9	9,422.5	3.3%
Dental Services	896,312	378.3	422.0	909,439	379.5	417.3	-1.1%
Hospital Emergency Room Services	607,752	405.8	667.8	596,170	377.3	632.8	-5.2%
CAP for Disabled Adults	11,722	238.6	20,356.2	11,769	237.0	20,139.1	-1.1%
Durable Medical Equipment Services	234,797	192.7	820.6	237,776	211.4	889.1	8.4%
Practitioner Non-Physician Services	77,652	146.5	1,886.7	78,496	146.4	1,865.5	-1.1%
Clinic Services	369,270	132.9	359.9	362,594	130.2	359.0	-0.3%
Home Health Services	28,576	125.6	4,396.9	25,530	126.6	4,958.3	12.8%
Lab & X-Ray Services	545,935	122.4	224.3	482,803	119.0	246.6	9.9%
CAP-Children Services	2,181	95.0	43,561.8	2,405	107.3	44,598.1	2.4%
Health Check Services	545,734	110.7	202.8	712,352	95.9	134.7	-33.6%
Hospice Services	6,316	65.6	10,388.3	7,593	68.5	9,021.9	-13.2%
PACE	1,491	44.4	29,802.7	1,972	58.6	29,703.6	-0.3%
NEM Transport. Services	-	53.9	N/A	-	58.7	N/A	N/A
Ambulance Services	159,290	45.0	282.7	159,872	31.9	199.4	-29.5%
Optical Services	269,149	25.9	96.2	276,616	26.2	94.7	-1.6%
Am. Surgery Center Services	30,794	15.3	497.8	34,494	16.5	479.7	-3.6%
Other Services	2,040,544	142.7	69.9	1,722,071	208.0	120.8	72.8%
Total	2,268,295	\$10,839.8	\$4,778.8	2,312,316	\$10,769.7	\$4,657.5	-2.5%

Notes:

1. Unduplicated recipient data is not available for Non-Emergency Transportation Services as this data is only produced at the County Level.
2. Claims expenditure data is net of drug rebates.

Medicaid Expenditure by Category of Service, SFY 2014-SFY 2016

EXHIBIT 33

Service Category	Medicaid											
	SFY 2014			SFY 2015			SFY 2016			Cost Per Recipient Variance (vs. SFY 2015)		
	Unduplicated Recipients	Claims Expenditure (\$ millions)	Cost Per Recipient	Unduplicated Recipients	Claims Expenditure (\$ millions)	Cost Per Recipient	Unduplicated Recipients	Claims Expenditure (\$ millions)	Cost Per Recipient			
LME/MCO	1,639,112	\$2,394.3	\$1,460.7	1,639,112	\$2,394.3	\$1,460.7	1,860,507	\$2,612.1	\$1,404.0	-2.3%		
Hospital Inpatient	141,313	917.4	6,491.7	141,313	917.4	6,491.7	231,279	933.8	4,037.5	-22.0%		
Skilled Nursing Facilities	40,762	1,158.8	28,429.3	40,762	1,158.8	28,429.3	45,024	1,210.5	26,886.7	-1.4%		
Physician Services	1,354,247	957.2	706.8	1,354,247	957.2	706.8	1,690,276	1,005.4	594.8	-19.7%		
Pharmacy Services	1,142,105	671.7	588.1	1,142,105	671.7	588.1	1,224,360	776.7	634.4	-7.4%		
Buy-in/Dual Eligible Services	404,907	711.7	1,757.6	404,907	711.7	1,757.6	359,523	753.7	2,096.4	6.4%		
Personal Care Services	51,093	474.8	9,292.8	51,093	474.8	9,292.8	48,070	452.9	9,422.5	3.3%		
Hospital Emergency Room Services	497,211	345.1	694.0	497,211	345.1	694.0	577,825	369.8	640.0	-5.2%		
Dental Services	771,677	333.0	431.5	771,677	333.0	431.5	840,947	360.6	428.8	-1.0%		
CAP for Disabled Adults	12,122	227.5	18,766.5	12,122	227.5	18,766.5	11,769	237.0	20,139.1	-1.1%		
Durable Medical Equipment Services	210,199	171.3	814.9	210,199	171.3	814.9	231,749	208.3	898.7	8.7%		
Clinic Services	289,059	108.0	373.6	289,059	108.0	373.6	350,660	127.8	364.4	-0.3%		
Practitioner Non-Physician Services	63,042	119.9	1,901.5	63,042	119.9	1,901.5	69,252	130.3	1,881.2	2.3%		
Home Health Services	29,656	127.5	4,297.8	29,656	127.5	4,297.8	25,488	126.5	4,964.8	12.7%		
Lab & X-Ray Services	435,303	85.3	196.1	435,303	85.3	196.1	469,078	117.9	251.3	10.4%		
Health Check Services	456,040	144.7	317.3	456,040	144.7	317.3	675,394	92.8	137.4	-33.3%		
CAP-Children Services	1,810	79.0	43,627.5	1,810	79.0	43,627.5	2,405	107.3	44,598.1	2.4%		
Hospice Services	6,186	64.4	10,405.0	6,186	64.4	10,405.0	7,591	68.5	9,023.8	-13.2%		
NEM Transport. Services	-	47.9	N/A	-	47.9	N/A	-	58.7	N/A	N/A		
Ambulance Services	149,197	42.1	282.3	149,197	42.1	282.3	158,544	31.7	199.9	-29.5%		
PACE	1,197	30.5	25,457.2	1,197	30.5	25,457.2	1,972	58.6	29,703.6	-0.3%		
Optical Services	204,365	18.3	89.5	204,365	18.3	89.5	253,255	23.9	94.3	-1.7%		
Am. Surgery Center Services	25,438	12.4	\$489.2	25,438	12.4	\$489.2	33,848	16.1	\$476.2	-3.6%		
Hospital Outpatient	572,574	472.6	\$825.4	572,574	472.6	\$825.4	677,605	515.7	\$761.1	-9.3%		
Other Services	1,833,365	145.2	79.2	1,833,365	145.2	79.2	1,721,598	207.9	120.8	64.1%		
Total Medicaid	1,980,641	\$9,860.5	\$4,978.4	2,141,539	\$10,673.2	\$4,983.9	2,194,460	\$10,604.5	\$4,832.4	-3.0%		

NC Health Choice Expenditure by Category of Service, SFY 2014-SFY 2016

EXHIBIT 34

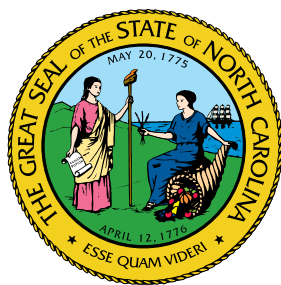
Service Category	Health Choice										
	SFY 2014			SFY 2015			SFY 2016			Cost Per Recipient Variance (vs. SFY 2015)	
	Unduplicated Recipients	Claims Expenditure (\$ millions)	Cost Per Recipient	Unduplicated Recipients	Claims Expenditure (\$ millions)	Cost Per Recipient	Unduplicated Recipients	Claims Expenditure (\$ millions)	Cost Per Recipient		
Pharmacy Services	102,478	\$67.5	\$658.4	68,041	\$52.3	\$769.4	72,048	\$55.3	\$767.8	-0.2%	
Physician Services	128,625	47.5	369.2	79,131	30.1	380.3	88,232	29.4	333.3	-12.3%	
Hospital Inpatient	1,073	20.6	19,225.7	1,045	14.7	14,047.0	1,074	13.4	12,518.2	-10.9%	
Practitioner Non-Physician Services	10,119	29.7	2,934.4	9,125	20.5	2,242.0	9,244	16.2	1,748.2	-22.0%	
Dental Services	97,846	26.4	269.6	62,404	17.3	277.0	68,492	19.0	277.1	0.1%	
Hospital Emergency Room Services	26,356	11.9	451.3	18,954	8.3	436.0	18,345	7.4	404.9	-71%	
Durable Medical Equipment Services	8,099	3.2	396.2	5,489	3.0	545.8	6,027	3.1	519.8	-4.8%	
Optical Services	30,568	2.8	92.9	22,736	2.3	99.1	23,361	2.3	99.4	0.3%	
Clinic Services	19,647	3.7	186.3	12,007	2.2	186.7	11,934	2.4	198.6	6.4%	
Health Check Services	433	0.0	74.3	16,217	1.7	103.1	36,958	3.2	85.3	-17.2%	
Lab & X-Ray Services	19,620	1.5	77.4	13,326	1.2	87.9	13,725	1.2	85.8	-2.3%	
Am. Surgery Center Services	857	0.6	647.7	532	0.4	704.8	646	0.4	661.6	-6.1%	
Ambulance Services	2,272	0.4	162.1	1,302	0.2	157.0	1,328	0.2	142.4	-9.3%	
Home Health Services	88	0.1	1,226.7	60	0.1	1,215.1	42	0.0	1,006.9	-171%	
Hospice Services	-	-	N/A	2	0.0	3,483.8	2	0.0	1,772.2	-49.1%	
Other Services	186,015	3.2	17.0	102,181	0.1	0.5	473	0.2	327.0	64759.6%	
CAP-Children Services	-	-	N/A	-	-	N/A	-	-	N/A	N/A	
Buy-in/Dual Eligible Services	-	-	N/A	-	-	N/A	-	-	N/A	N/A	
CAP for Disabled Adults	-	-	N/A	-	-	N/A	-	-	N/A	N/A	
NEM Transport. Services	-	-	N/A	-	-	N/A	-	-	N/A	N/A	
PACE	-	-	N/A	-	-	N/A	-	-	N/A	N/A	
Personal Care Services	-	-	N/A	-	-	N/A	-	-	N/A	N/A	
Skilled Nursing Facilities	-	-	N/A	-	-	N/A	-	-	N/A	N/A	
Hospital Outpatient	28,371	14.9	526.0	20,329	12.5	613.3	21,321	11.5	540.2	-11.9%	
LME/MCO	-	-	N/A	-	-	N/A	-	-	N/A	N/A	
Total HealthChoice	196,673	\$233.9	\$1,189.5	126,756	\$166.6	\$1,314.6	117,856	\$165.2	\$1,402.0	6.6%	

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North Carolina

Medicaid and NC Health Choice

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July 1, 2015 - June 30, 2016

