2004-2005

BLUE RIBBON COMMISSION ON MEDICAID REFORM

MINUTES

BLUE RIBBON COMMISSION
ON
MEDICAID REFORM

2003-2004 Biennium

Co-chairs:

Senator William R. Purcell
Representative Julia Howard
Representative Edd Nye

Staff:

Carol Shaw, Fiscal Research Division
Richard Bostic, Fiscal Research Division
Anne Wilson, Commission Assistant

BLUE RIBBON COMMISSION ON MEDICAID REFORM
2003-2004 INTERIM

MEMBERSHIP LIST

SENATE

Senator William R. Purcell, Co-chair
North Carolina General Assembly
625 Legislative Office Building
Raleigh, NC 27601-2808

Senator Fletcher L. Hartsell, Jr.
North Carolina General Assembly
518 Legislative Office Building
Raleigh, NC 27601-2808

Mr. Daniel C. Hudgins
Durham County Dept. Social Services
818 Anderson Street
Durham, NC 27705

Ms. Pam C. Silberman, JD
Sheps Center for Health Research Services
725 Airport Road, CB 7590
Chapel Hill, NC 27599

Mr. Luckey Welsh
Southeastern Regional Medical Center
300 West 27th Street
Lumberton, NC 28359

Dr. Al Wentzy
Northampton County Dept. Social Services
9467 NC Highway 305
Jackson, NC 27845

HOUSE

Representative Julia Howard, Co-chair
North Carolina General Assembly
1023 Legislative Building
Raleigh, NC 27601-1096

Representative Edd Nye, Co-chair
North Carolina General Assembly
639 Legislative Office Building
Raleigh, NC 27601-1096

Representative Beverly M. Earle
North Carolina General Assembly
535 Legislative Office Building
Raleigh, NC 27601-1096

Mr. William A. Pully
N. C. Hospital Association
P. O. Box 4449
Cary, NC 27519-4449

Dr. Charles F. Willson
Brody School of Medicine
600 Moye Blvd.
Greenville, NC 27834

ADVISORY MEMBERS:

Representative Jeffrey L. Barnhart
North Carolina General Assembly
608 Legislative Office Building
Raleigh, NC 27601-1096

Representative Bob England
P. O. Box 908
Ellenboro, NC 28040

STAFF:

Carol Shaw, Fiscal Research Division
Richard Bostic, Fiscal Research Division

COMMITTEE ASSISTANT:

Anne Wilson

Legislative Authority
for the
Blue Ribbon Commission on Medicaid Reform

BLUE RIBBON COMMISSION ON MEDICAID REFORM

SECTION 6.14A (a) There is established the North Carolina Blue Ribbon Commission on Medicaid Reform (Commission). The Commission shall examine the State's Medicaid program and make comprehensive recommendations for fundamental reform. The Commission shall consider:

(1) Methods to responsibly restrain the growth in Medicaid spending.

(2) Best practices in both the public and private sectors in managing and administering health care.

(3) Options for maximizing existing resources while controlling Medicaid program costs.

(4) Current array of services available within the State Medicaid program to determine the appropriateness of the type, frequency, and duration of those services.

(5) Opportunities for long-term, systemic change in the Medicaid program through the use of federal waivers and other management tools.

(6) How to minimize the State and county share of Medicaid costs and maximize federal participation in Medicaid programs.

(7) The role of Medicaid in the State's economy.

(8) Any other matter relating to reform of the State Medicaid program.

SECTION 6.14A (b) The Commission shall consist of 12 members appointed as follows:

(1) Six members appointed by the Speaker of the House of Representatives, including one member who shall be designated as House Cochair. No more than three may be legislators.

(2) Six members appointed by the President Pro Tempore of the Senate, Including one member who shall be designated as Senate Cochair. No more than three may be legislators.

The appointing officer shall fill vacancies. The Commission shall meet at the call of the Cochairs. Members of the Commission shall receive per diem, subsistence, and travel expenses as provided in G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Commission may contract for consultant services as provided in G.S. 120-32.02. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Commission in its work. Clerical staff shall be furnished to the Commission through the offices of the House of Representatives and Senate Directors of Legislative Assistants. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may exercise all of the powers provided under G.S. 120-19 through G.S. 120-19.4 while in the discharge of its official duties. The funds appropriated by this act to

Legislative Authority
for the
Blue Ribbon Commission on Medicaid Reform

the Reserve for the Blue Ribbon Commission on Medicaid Reform shall be transferred to the Department of Health and Human Services in order to draw down federal match funds to be used to cover the cost of the Commission's work. **SECTION 6.14A.(c)** By April 1, 2004, the Commission shall make an interim report to the 2003 General Assembly. The Commission shall make its final report to the 2005 General Assembly by February 1, 2005, and shall expire upon submitting that report.

Proposed Budget for the Blue Ribbon Commission on Medicaid Reform

I.	Legislative Members Subsistence	$6,500
II.	Non-legislative Members Subsistence	$8,500
III.	Travel Expenses	$5,600
IV.	Clerical Staff	$5,000
V.	Professional Staff	TBD
VI.	Special Travel and Expenses	TBD
VII.	Postage and Telephone	$250
VIII.	Supplies	$250
XI.	Copying and Printing	$1,000
X.	Reserve	$472,900
	Total Proposed Budget	$500,000

Notes: 1. The Commission has a $500,000 budget based on a $250,000 appropriation and $250,000 Medicaid match.

2. Assumes eight meeting days.

ATTENDANCE

Committee: BLUE RIBBON COMMISSION ON MEDICAID REFORM

DATES / NAMES	3/24	4/12															
Sen. William Purcell, Co-chair	✓	✓															
Sen. Fletcher Hartsell	✓	✓															
Rep. Julia Howard, Co-chair	✓	✓															
Rep. Edd Nye, Co-chair	✓	✓															
Rep. Jeffrey Barnhart, Advisory Member		✓															
Rep. Bob England, Advisory Member	✓																
Rep. Beverly Earle	✓	✓															
Mr. Daniel C. Hudgins	✓																
Mr. William A. Pully	✓	✓															
Ms. Pam Silberman	✓	✓															
Mr. Luckey Welsh	✓	✓															
Dr. Al Wentzy	✓	✓															
Dr. Charles F. Willson	✓	✓															
STAFF:																	
Carol Shaw, Fiscal Research Div.	✓	✓															
Richard Bostic, Fiscal Research Div.	✓																
Anne Wilson, Committee Assistant	✓	✓															

STATE OF NORTH CAROLINA
NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

March 3, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

SUBJECT: Meeting Notice

There will be a meeting of the Blue Ribbon Commission on Medicaid Reform:

DAY:	Wednesday
DATE:	March 24, 2004
TIME:	10:00 a.m.
LOCATION:	Room 544, Legislative Office Building

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives (see attached map). The cost for visitor parking is $.50 per hour or $4.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

Please advise Anne Wilson, Committee Assistant, at (919) 733-5707, or e-mail annew@ncleg.net if you will be unable to attend.

Posted: March 3, 2004

cc: Committee Record ✓
Interested Parties

Anne Wilson (Committe Assistant)

From: Anne Wilson (Committe Assistant)
Sent: Wednesday, March 03, 2004 2:54 PM
Subject: Notice of March 24, 2004 Meeting

PLEASE NOTE "SUBJECT" LINE CORRECTION OF MEETING DATE.

March 3, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

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cc: Committee Record ✓
Interested Parties

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — 3/24/04

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Diana Tice	Mecklenburg Co. DSS
Mary Jacobs	Mecklenburg Co. DSS
Millie L. Brown	Duplin County DSS
Bo Nowell	NC DMA, Program Integrity
Mark Benson	Capitol Group
Nancy Reed	SELF
Eddie Finch	NC Dept of Revenue
Robert S. Chase	Robert S. Chase & Associates
Gary Fussell	DMA - DHHS
Jim Bernstein	DHHS

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — 3/24/04

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cressy Sanders	Smith Anderson
Lisa Bateman	DJJDP
Cathy Liverly, CPA	DJJDP
J Cain Thomas	DHHS
Jack Odell	NCCSPC
Jeff Alley	Alley Associates
Steve Mitchell	Novartis
John Mabry	Gov. Office
Lu-Ann Coe	NCPA
Lori Ann Harris	LA Hot
Abby Emanuelson	NMSS

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — 3/24/04

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Starla McKenna	DHHS
Carren Hatter Odom	DHHS
Lindsay Allen	North Carolina Nurses Association
Joanne Stevens	ncna
Janet Shanyac	NC Counsel
Martha Ann McConnell	Carolinas Healthcare Sys
[illegible]	DHHS
Joseph Mahan	MHA-NC
Chip Kelton	Nelson Mullins
Elizabeth Dalton	Bain & Assoc.
John Elder	Swain County

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — 3/24/04

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	P&S
Joint Goodman	Alley Assoc.
Stacy Flannery	NCHCFA
Sam Clark	NCACFP
Rebecca Troutman	NCACC
ADAM SEARING	NC Justice Ctr / HAC
Barbara Canales	NFSS
Jack Cozort	Parker Poe
Debbie Barnes	OSBM

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — 3/24/04

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Martin Phanu	Dept. of Juv. Justice & Delinq. Prev.
Angela Horne	NCMS
Jeffrey Simms	DHHS
Myron Terry	Pfizer
Bill Scoggin	Pfizer
Tom Sri	NCRMH
Peter Young	APPCNE/FRLTC
Patricia Raven	NCACC
Jim Rogers	Home Care & Hospice
DAN CONCHLIN	PIEDMONT AHEAD PROGRESS

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — 3/24/04

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCDS & NCPDA
Phil Telfer	Gov. Policy Office
Andy Ellen	NCRMA
Nancy Henley	DMA

BLUE RIBBON COMISSION ON MEDICIAD REFORM
Wednesday, March 24, 2004
10:00 a.m., Room 544 LOB

Chairmen: Senator William Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

I.	**Opening Remarks and Introductions**	*Chairs*
II.	**Committee Charge**	*Commission Staff*
III.	**Approval of Commission Budget**	*Commission Staff*
IV.	**Medicaid Program Overview**	*Carol Shaw* *Fiscal Research Division*
V.	**NC Medicaid Program – Current Status**	*Gary Fuquay, Director* *Division of Medical Assistance, DHHS*
VI.	**Community Care Of NC**	*Alan Dobson, Chairman of Cabarrus Community Cares*
VII.	**Long-Term Care Insurance Tax Credit**	*Richard Bostic* *Fiscal Research Division*
VIII.	**Impact of Federal Mandates on the NC Medicaid Program**	*Carol Shaw* *Fiscal Research Division*
IX.	**Commission Discussion**	*Chairs*
X.	**Future Meetings and Closing Remarks**	*Chairs*

BLUE RIBBON COMMISSION ON MEDICAID REFORM
Wednesday, March 24, 2004 at 10:00 a.m.
Room 544, Legislative Office Building

MINUTES

The Blue Ribbon Commission on Medicaid Reform met at 10:00 a.m. on Wednesday, March 24, 2004 in Room 544, Legislative Office Building. The following members of the committee were present: Senators William R. Purcell (Co-chair) and Fletcher Hartsell; Representatives Edd Nye, (Co-chair), Julia Howard, (Co-chair) and Beverly M. Earle; public members Daniel C. Hudgins, Pam C. Silberman, Luckey Welsh, Dr. Al Wentzy, William A. Pully and Dr. Charles F. Willson. Senator Purcell presided.

Senator Purcell welcomed members and visitors to this first meeting of the commission and asked members to introduce themselves. He thanked legislative staff for their assistance with the study of issues before the committee. As the first order of business, Senator Purcell asked Carol Shaw of the Fiscal Research Division to review the committee charge and the proposed budget. Ms. Shaw introduced herself as one of the staff members for the commission and said she serves as team leader for the Health & Human Services team within the Division, while her primary responsibility is the Medicaid budget. She reviewed the charge, noting that Section 6.14A (a) describes the commission's responsibility and what the General Assembly wants it to do. She also called attention to Section (c), which calls for an interim report by April 1, 2004 and a final report to the 2005 General Assembly by February 1, 2005.

Ms. Shaw continued with a review of the budget and asked if there were questions. Representative Howard asked if there is a certain number of meetings that can be held within the limits of the budget and Ms. Shaw said there is no required number of meetings. Ms. Shaw said a motion would be required to pass the budget and Representative Howard moved that the budget be approved. Dr. Wentzy seconded the motion, it was approved and the budget was adopted.

Senator Purcell asked Ms. Shaw to present the next agenda item, "Medicaid Program Overview". (See Attachment # 1.) Ms. Shaw said this is a presentation that she typically does during the long session to bring members up to speed on where Medicaid stands and to remind people how Medicaid works. She said Gary Fuquay, the Director of the Division of Medical Assistance (DMA) in the Department of Health and Human Services will talk later about the current state of Medicaid. She said the overview gives the purpose of Medicaid and its impact on the state economy, state budget and on local governments. Also, it lists services that Medicaid provides, both optional and mandatory and who Medicaid recipients are. The final two topics in the overview are about policy changes since 1990 that have major impact on the budget and the most current cost containment efforts. She said North Carolina has had a Medicaid program since 1970 and that the most critical budgeting problems occurred during the early 1990s. She commented on the fact that paying for health care is a big business in North Carolina.

Medicaid alone is much larger, she said, than some other industries, including the tobacco industry and the textile industry. Additional statistics were presented in Handout # 1, which described how Medicaid money is spent.

Senator Purcell recognized Secretary Carmen Hooker Odom of the Department of Health & Human Services (HHS) for comments and an introduction of the next presenter, Mr. Gary Fuquay. Secretary Odom thanked the chairs and members for their work on the commission and said HHS has provided information on Medicaid for members and have actually gone around the state to talk to delegations about the subject because it is so complicated and challenging to figure out ways to support the goals of Medicaid and also to make sure that it is run efficiently and cost-effectively. She said the department has moved into the 21st century in terms of making sure that everything it does is transparent. Secretary Odom said HHS has tried to be as open as possible and expose all the things that need to be done better. She said HHS is trying diligently to be better managers and are thrilled with the development of the new management team at Medicaid. She added that they are eager to work with members of the commission on this very challenging issue and are willing to take every good recommendation to enhance the management of Medicaid as well as to make sure they are serving the people who they are charged to serve in a way that is cost-efficient and continues to benefit across all communities for Medicaid services. Secretary Odom said she was thrilled to be able to present Gary Fuquay. She said he has been in state government for many years, having worked in the Office of State Auditor, with the Division of Mental Health (so he has a good understanding of the issues that intersect between Medicaid and mental health), in the Division of Social Services, and was Medicaid director. In addition, she said Mr. Fuquay was the department's Assistant Controller and then Controller, so he has a wide breadth of experience around management, about fiscal issues and programmatic issues. She concluded by saying that he is available for members' questions, input and suggestions.

Senator Purcell thanked her for her introduction of Mr. Fuquay and said North Carolina is fortunate to have Secretary Odom, Deputy Secretary Lanier Cansler and the outstanding staff they have brought into the Department of Health & Human Services.

Mr. Fuquay said he has been at the Division of Medical Assistance for ten months and said he was asked to give the committee an update of where they are with Medicaid in 2004. He said there are four main areas in his update for members: trends both on expenditures, the units of services consumed and eligibles growth; organizational changes in the division; program integrity, which includes the fraud and abuse section and third party recovery; and prescription drugs.

Mr. Fuquay brought copies of the Annual Report for State Fiscal Year 2003 for the Division of Medical Assistance (See Attachment # 2.), which supports to some degree the overview that Carol Shaw presented earlier. The handout that he used in his presentation is entitled, "Blue Ribbon Commission on Medicaid Reform" (See Attachment # 3.) The charts and graphs in the first section of this report summarize Medicaid services and premiums in January of 2004 as compared to January of 2003. The purpose of this of analysis, he said, is to drill down into the expenditures to "hone in"

on the reason for increases over the past year. He said that, now at the end of March, the check write is at 10.44% above where they were in March of 2003. The budget is based on slightly less than an 11% increase in growth, so he said they are still within the budget. He said a better picture of where Medicaid is going will be available at the end of April. For 2005, he thinks getting through April of this year will give a comfort level of where they are on being within the budget for 2005.

Senator Hartsell said it appears that the disabled category seems to be increasing in any number of ways and he asked what the definition of "disabled" is. Mr. Fuquay said it is defined by the federal government. Ms. Shaw said, from a Medicaid standpoint the person automatically qualifies for Medicaid if they're on SSI because they're disabled. In order to get on SSI, the federal government has to make a determination that the person meets the criteria, which is the same as for Social Security. Senator Hartsell asked if there's an increase in the number of applications for SSI because of the economy and Mr. Fuquay said as increases in SSI are seen, there probably will be increases in Medicaid for the disabled. Ms. Shaw said that, over time, the disabled has grown just as the population has grown. She said she has not been able to make a correlation based on economics. She said it is seen more in the indigent children and AFDC population where there is a direct correlation when the economy declines. She added that it's harder to make a distinction because if they were borderline disabled and couldn't get a job, they might apply for disability, but it can't really be seen it in the numbers.

Representative Nye asked about the prior approval list and, in conjunction with that, said there is a voluntary payment plan where some pharmaceutical companies have been making voluntary payments to expand Carolina Access/Community Care. He said a drug company told him last week it would present a check and the primary reason was that they liked the Community Care of North Carolina program and wanted to help it expand. He asked if the department has any information on that and if the company actually presented the check. Mr. Fuquay replied that they do have a prior approval list and currently have thirteen classes of drugs on the list. With regard to the company actually making a payment – as Representative Nye asked – he said he would have to refer that to Mr. Wade or Mr. Bernstein because the check would not have been presented to Medicaid.

Mr. Fuquay proceeded to an explanation of the section entitled, Organization, in Attachment # 3. He said he has focused on strengthening internal control, management structure and depth of knowledge of the staff since becoming director of the division. He said employees on Division staff are very competent, but more depth of knowledge among the staff is needed. On the financial side, he said they are working to improve internal controls to make sure there is the appropriate segregation of duties. He said DMA has added a number of positions, as listed on Page 3 of the section on Organization. Mr. Fuquay recalled that The Lewin Report to the General Assembly suggested that the division enhance program integrity, including fraud and abuse and third party liability. He said the Assistant Director for Program Integrity, Bo Nowell, would discuss the program, what they are focused on, some of the national projects they are dealing with and also a brief explanation of the sections in the Program Integrity

Division. Another suggestion of the Lewin Report was to increase the number of hearings officers, so without creating additional positions, some positions were re-allocated to strengthen and speed-up recipients' appeals.

Mr. Fuquay said a major focus has been in medical policy or the clinical affairs area where they are in the midst of awarding a new contract for Medicaid Management Information Services (MMIS), which is probably the department's number one priority. He said they will work closely with the vendor, when chosen, to develop a clearly-defined medical policy so that edits and audits work will result in appropriate payments.

Mr. Fuquay said the clinical area has a few people who are extremely knowledgeable, but a greater depth of knowledge is needed. With the Physicians' Advisory Group looking at medical policy, there will be greater assurance that those policies are based on the most appropriate medical and evidence-based practice. So it's important to try to build the depth of knowledge, the information and the evidence-based practices in order to make sure that medical policies are strong. The list of twenty positions on Page 3 of the section on Organization are intended to enhance the clinical affairs area and medical policy documentation, while work on cost containment is going forward. The list of seven positions is identified as non-cost containment.

Mr. Fuquay said the General Assembly allowed the DMA up to $5 million to take on cost containment approaches that Clinical Affairs identified, so the seven positions are in support of the budget and finance area. It has been one of the areas of internal control weakness, so better segregation and depth of knowledge are needed. He said auditors have been added in order to get cost settlement reviews or audits of the hospitals and providers done in a timely manner. He said there may be other re-organizations or realignments of staff as they go forward.

Mr. Fuquay asked Mr. Nowell to present the Program Integrity review. Mr. Nowell referred to that section of Attachment # 3, noting that the Medicaid Division saved almost $1.4 billion through collections and cost avoidance in the state fiscal year 2003. He gave credit for their assistance to the Attorney General's Medicaid Investigation Unit and the one hundred county departments of social services. He said the 99.3% accuracy rate in Medicaid eligibility determinations by county departments of social services and the 98.2% payment accuracy rate as determined by the Office of State Auditor were major factors in this accomplishment. Mr. Nowell reported that thirteen and three-fourths positions are being added to the Program Integrity staff using cost-containment funds so that time spent on investigations can be increased and result in increased recoveries.

Senator Purcell asked if Medicaid fraud and abuse is a big problem in North Carolina and if so, is it attributed to people or the providers. Mr. Nowell said it's difficult to say how much fraud and abuse is in the system. He said he heard it was about 10% so he tracked it down and discovered that the 10% figure is an estimate. He said the difficulty is that fraud is intentional and is usually well concealed. He said he has not seen anything to indicate that there is a big fraud problem in North Carolina because the

division has tools to find most of it. Abuse, which is not intentionally fraudulent, and waste are more of a problem.

Representative Nye said he has heard that some providers that don't have a physical location use post office boxes. He asked if DMA has any means of tracking that kind of situation and Mr. Nowell said they could if sufficient resources are available. He said the division has sent field staff out to check on facilities and do site checks and, when they have found an address was a post office or similar location, that information was reported to the provider enrollment people.

Mr. Fuquay asked Dr. Nancy Henley, Senior Policy Medical Advisor and Acting Assistant Director for Medical Policy in the Division of Medical Assistance to discuss the cost containment initiative DMA is undertaking. (See the Prescription Drugs Section of Attachment #3.) She added that DMA is working closely with the Pharmacy and Therapeutics Committee of the Physician Advisory Group in North Carolina on these clinical and administrative initiatives along with the Community Care Program.

Ms. Silberman asked if Dr. Henley has seen changes in prescribing patterns because of recent changes in the co-pay and dispensing fees. Dr. Henley said that, as best they can tract it, they are seeing a small shift and are continuing to work with the groups discussed and using the Prescription Advantage List (PAL) to try to keep going in that direction. She said brand name advertising is a big factor in prescribing drugs; perhaps advertising for generics is needed.

Representative Earle said she would like to hear a more in depth discussion on prior authorization and evaluation of the program and how it's working, how much the state pays for it, satisfaction rate of physicians and more options for cost savings. Dr. Henley said she would be glad to work on that request.

Representative Nye asked about generic drugs. He said about a year or so ago we started reimbursing pharmacies on the Maximum Allowable Cost List (MAC) that was supposed to saving tens of millions on dollars. Dr. Henley said that was a reimbursement change that was made in 2002. She estimated that $62 million was saved in fiscal year 2003 based on the MAC List. The list is prepared in North Carolina by HHS based on criteria that DMA has developed that uses some information from Electronic Data Systems (EDS) and the federal government. She said that might be something for further discussion.

Senator Purcell asked if there are over the counter medications that Medicaid will pay for and she responded that, at the present time, there are three. Prior to a state plan change made in October, North Carolina Medicaid covered only insulin as an over the counter drug, but since that time, Prilosec and Claritin have been added. Senator Purcell said doctors are put in the position of having to prescribe the more expensive prescription when low-income patients don't have money to pay for over the counter drugs. Dr. Willson said he has had the same kind of experience and now finds that he can prescribe

the over the counter drug in some cases. He noted that it's up to the pharmaceutical companies to develop and market the drugs over the counter rather than as brand names.

Senator Purcell announced a lunch recess from 12:15 to 12:45 p.m.

Senator Purcell called the meeting back to order at 12:45 p.m. and asked Dr. L. Allen Dobson, Chairman of Cabarrus Community Care of North Carolina, formerly known as Access II & III, for a presentation. Dr. Dobson noted that Community Care started out as a pilot program to see if it could make a difference and it has grown to be very important in Cabarrus County. He said he has had an opportunity on a couple of occasions to go to Washington to tell people what North Carolina is doing with regard to disease management and developing networks related to potential savings for Medicaid. Dr. Dobson used a slide presentation to guide the discussion. (See Attachment # 4.) At the end of his review, he said the changes they have made are not done just for Medicaid patients, but are applied also to uninsured and insured patients. It is a basic practice change at the community level and so significant impact should be seen throughout the health care industry. He likened trying to manage Medicaid from Raleigh to sitting in the Pentagon and working out a plan while having no army to carry it out. He said what they are trying to do is build an army for the state to impact care at the local level. As one of several lessons learned in their effort to develop a better system for delivering health care, Dr. Dobson said community involvement rather than a "top down" approach is necessary. He said that, over time, there are indirect quality and cost benefits for everyone and with the work they have going on it is a distinct possibility.

Representative Nye asked if Medicaid wanted to get involved in disease management, would it have any effect on Community Care and Dr. Dobson said it would. He said that is what Community Care does. He added that disease management is identifying the best process for a patient to get, measuring it and trying to make sure every Medicaid patient gets evidence-based medicine and gets handled the same way. Representative Nye said he read that Medicaid has started saying they will contribute to this and asked if they going to help the Community Care program by getting into disease management. Dr. Dobson said he thinks one of the reasons they have said they will get involved in this is because of what North Carolina is doing. He said CMS has taken an interest and we should take full advantage of the federal dollars to enhance what we're already doing.

Dr. Wentzy asked Dr. Dobson to explain the difference between his program and Mecklenburg County's and Dr. Dobson replied that Mecklenburg is currently a part of the Community Care network. He said it was initially a managed care pilot, which contracted for the same program at a fixed cost with several commercial models. These commercial programs have since pulled out and Mecklenburg is now part of the Community Care network. Dr. Henley added the Mecklenburg County program has one remaining HMO with about 10,000 members in addition to being a part of the Community Care network.

Dr. Willson asked, because doctors don't differentiate between Medicaid patients or others, is there any plan to ask commercial carriers if they would like to partner with North Carolina and contribute financially, since we are saving them some money. Dr. Dobson said he thought that was a great idea.

Senator Purcell asked how long a pilot program operates before it is expanded across the state and Dr. Dobson said it depends on the particular pilot. He replied that, generally, a pilot runs for six months. Then, a presentation is made to community directors to get buy-in. It usually takes about eighteen months before things begin to roll out depending on the complexity of the program. Senator Purcell asked what are the main areas on pilots right now and Dr. Dobson said pilots running currently are about getting some control over costs and expansion. He said the PAL list is the major effort and expansion is another. In the future, he said, pilots might include looking at therapy services and others that are not direct patient care, but are a part of patient care.

Ms. Silberman offered congratulations to all who have been involved in the Community Care Program and gave a word of caution, saying that a lot of the cost savings that have been identified have been in communities where doctors have wholeheartedly embraced this notion and come into it. As the program is expanded statewide, she said trying to reach new communities might not yield the save level of participation. She expressed the need for caution when statewide savings are anticipated because the same savings in some of the expansion communities might not be seen. Dr. Dobson said he agrees and is aware that even in communities that are in favor of participating, there are varying levels of commitment and performance.

Dr. Willson said he started a program in Pitt County and now has ten counties involved in the project. He said it's true that communities have strengths, but there are hurdles to overcome as they catch on and get more involved.

Senator Purcell added that one of the motives for a physician is that if you don't help us do this, watch out for your Medicaid reimbursement because something will to be cut. He said Community Care has something to talk to them about.

Senator Purcell called on Richard Bostic, a member of the Fiscal Research staff, to review a report, "Long-Term Care Premium Tax Credit". (See Attachment # 5.) He said while preparing this he discovered long-term care is not just for the elderly. He said the Henry J. Kaiser Foundation found that only 53% of long-term care patients are over age 65. He said the rising cost of long-term care has caused many people to consider long-term care insurance, as evidenced by the fact that in 2002 over 86,000 people in North Carolina had long-term care insurance policies. At that time, the average age for a holder of a long-term care policy was 62.

Mr. Bostic explained that the state tax credit that long-term care policy holders could claim expired at the end of 2003 and will no longer be available unless action is taken during the 2004 legislative session to continue it. He said many taxpayers made errors in trying to claim the credit; the error rate in 2001 was 91%, but dropped to 40% in

2003, an indication that understanding how to apply the credit is improving. He said improved instructions and requiring insurance company information could reduce the error rate further. Mr. Bostic said the cost to the General Fund for continuing the credit is approximately $6 million.

Ms. Silberman asked if there has been a cost/benefit analysis on this credit and Mr. Bostic said he was not able to find direct data for North Carolina. He said other analysts have looked at long-term care policies and their opinions were that the people who would buy them would not be Medicaid eligible, but would be buying them to protect assets.

Mr. Pully said he wanted to point out that the chart on Page 12 would indicate that there are more people in lower income brackets buying the policies and Mr. Bostic agreed the chart is a bit misleading because it shows taxable income rather than gross income.

Dr. Willson said, if his understanding is right, that to get the benefit the policy-holder has to keep paying the premium. He said some people might pay it for a few years and decide to drop it, with the result that they've received a tax credit that the state probably cannot recoup.

Senator Purcell called on Carol Shaw for a presentation on the "Impact of Federal Mandates on the North Carolina Medicaid Program." She said she has divided her presentation into two separate documents, "Medicare Prescription Drug Benefit: Implications for the North Carolina Medicaid Program" (See Attachment # 6.) and "Federal Proposals for Medicaid" (See Attachment # 7.). She differentiated between the two documents, saying that the first document on the prescription drug benefit under Medicare is the law. The impact of this program will happen unless it is changed. The other document includes proposals that are being discussed in the Congress and at CMS, where some administrative activity will take place that could possibly impact North Carolina. She said the voluntary prescription drug benefit for Medicare beneficiaries, which will begin in 2006, would be a new benefit since most of this population does not have supplemental insurance that covers prescription drugs. In addition, that population between now and when that benefits goes into full effect will also get a $600 a year benefit through a Drug Card program. Exact data is not yet available for these programs.

Ms. Shaw said the major impact of the prescription drug benefit will be on dual eligibles – those who are eligible for both Medicare and Medicaid by being both over 65 years of age and poor. Under this new act, in 2006 Medicaid will no longer provide them prescription drug benefits. They will be covered under the Medicare Part D Prescription Drug Benefit. She said states would need to make sure that dual eligibles get signed up so there is no lapse of coverage. The beneficiary does not have a choice to stay on Medicare, nor does the state have a choice to keep them on Medicaid for prescription drugs. They have to participate in this program. The other aspect of it is that cost sharing obligations are similar to Medicaid.

Ms. Shaw said North Carolina's Medicaid Program will receive some fiscal relief over the next ten years, but will be required to make payments to the federal government to help finance the cost of the Medicare prescription drug program for its dual eligibles. She said implications for the program include requiring counties to perform eligibility determinations to enroll dual eligibles and the unknown number of other low-income people who are eligible for the low-income subsidy program. The cost of doing this, she said, will be shared equally between counties and the federal government. Ms. Shaw said she does not see significant savings for the state in 2006 because of the start-up cost of implementing the new responsibility and the limited fiscal relief we will get the first year. She said fiscal relief might be greater in the out years.

Ms. Shaw continued to talk about federal mandates from Washington, including what is being discussed in the president's budget and in Congress, and what is being done administratively by CMS. She discussed the following concerns that could affect the North Carolina Medicaid Program: limiting the use of intergovernmental transfers, prospective budgeting versus retrospective budgeting, budget caps, cost allocation for Medicaid administration, reduced funding for Medicaid Management Information Systems, and the lack of federal fiscal relief.

Representative Earle asked Ms. Shaw to explain where the benefit will be in 2006 when the new prescription drug plan begins. Ms. Shaw said what the federal government is trying to do is start with a base number, 2003, but will build inflation and the state will be paying the drug cost for these people this fiscal year and next fiscal year. North Carolina will spend more on drugs, just because we have in the past. Representative Earle said what the state is implementing now has the potential to save money and if that in fact happens and the $255 million does not increase very much, then do we have the potential not to get anything back. Ms. Shaw said this is a possibility in the short run. She said North Carolina has a generous, but cost-effective prescription drug benefit overall for Medicaid. She said Medicaid will hire private entities to run these programs who will set their own formularies and determine what drugs will be covered. She said it is possible depending on who serves North Carolina that our eligibles might not get as generous a benefit as this money is based on. It will depend on what deals these companies strike with pharmaceutical companies, what the formulary is, etc.

Mr. Pully said the actual cost to the state will be based on the state's experience, so what they "claw-back" will be based on what the state has provided.

Ms. Silberman said her understanding is that under Medicare they are going to inflate our base by the number of dual-eligibles by 16%. If in that same time period Community Care of North Carolina has been able to figure out the magic bullet and for everybody else reduce drug expenditures by 12%, we won't benefit from having that cost containment benefit in North Carolina. We will still be inflated by that national 16%, at least for the foreseeable future. Ms. Shaw said, after the foreseeable future, when the state gets a Medicare prescription drug plan in effect it will be based on how those costs go up. So we will be dependent on the people providing that benefit on how much growth they allow.

Senator Purcell asked members to briefly state what they believe the commission should do to carry out the charge of the General Assembly. Members responded, as follows, and the co-chairs said they would use their ideas as they develop the future work plan for the commission.

Dr. Willson:

1. Divide into committees and look at high costs of things that Medicaid does.
2. Obtain data from other states that addresses these problems.

Dr. Wentzy:

(See Attachment # 8 for further detail.)

1. Consider the breadth of the problem by looking at big pictures of Medicaid expenses across the nation.
2. Consider long-term implications and strategies to try to bring relief.
3. Consider hiring a consultant.
4. Research information available at the legislative level, the Division of Medical Assistance, the N. C. Association of County Directors of Social Services, the NC Association of County Commissioners and other public and private entities involved in health care.
5. Ask that providers of information organize it for tabulation purposes by a) stating a purpose, b) discussing the information provided and c) making a recommendation.

Mr. Welsh:

1. Need more education about what is happening in Medicaid and the impact to the state, so more presentations of information would be helpful.
2. Look at the value received through Medicaid because of the consequences of raising or lowering the standard of health for North Carolinians.

Ms. Silberman:

1. Talk about Medicaid in a broader context through a discussion of the growing number of uninsured people.
2. Look at inflation in Medicaid per eligible.
3. Compare per eligible cost inflation to the commercial market.
4. Consider hiring consultant Vern Smith because he is a former Medicaid director and has collected data about how states have done cost containment.
5. Explore the idea of taking a directive method in trying to reduce prescription drug costs and perhaps get an assessment of what North Carolina could save using that method.

Mr. Pulley:

1. Look at expanding Community Care of North Carolina statewide as quickly as possible.
2. Look at strategies on how to increase participation in the prescription advantage list.
3. Develop strategies to make sure physicians participate in PAL Program.

4. Look at waste in the system of eligible services, optional services and mandated services.
5. Look at administrative simplification.
6. Quantify the state's savings over past several years as a result of maximizing the federal contribution to see how it has affected trend lines.
7. Consider the implications of mental health reform for Medicaid.
8. Address the cost of defensive medicine related to the threat of liability suits.

Mr. Hudgins:
1. Look into best practices of other states to see what we can learn from them about managing Medicaid.
2. Look at the total population of those getting their health care through public sources and the uninsureds, which may include Health Choice.
3. Agreed that administrative simplification needs to be studied.
4. Seconded comment about needing to study effects of mental health reform.
5. Try to determine where savings from maximizing federal Medicaid money have been and how that inflationary cost is also driving Medicaid.

Rep. Howard:
1. Commended Gary Fuquay, Director of the Division of Medical Assistance, and asked him to bring recommendations that he believes will help the commission and benefit the state.

Rep. England:
1. Hear from providers of services to Medicaid recipients, including physicians, hospitals, long-term care facilities, etc.

Rep. Nye:
1. See what short-term work the state can do concerning prescription drugs, as the federal government will "fix" that in two years.
2. Expand Community Care of North Carolina as quickly as possible.

Senator Purcell:
1. Supported the idea of considering Vern Smith to provide consultant services to the commission.

At the conclusion of members' suggestions, Senator Purcell reminded them that an interim report to the 2004 General Assembly and a final report by early February, 2005 are required. He expressed a sense of urgency about the commission's work and said another meet will be held before the 2004 Short Session.

Senator Purcell said the commission discussed briefly the fact that the tax credit for long-term care insurance expired at the end of 2003. In response, Representative Nye moved to submit proposed legislation for consideration during the 2004 Session of the General Assembly that would continue the tax credit for long-term care insurance which

expired at the end of 2003. Representative Howard seconded the motion. The motion passed and staff was directed to prepare a legislative proposal and include this recommendation in the interim report to the 2004 Session of the 2003 General Assembly.

Senator Purcell said members would be notified of the date for the next meeting.

The meeting was adjourned at 2:45 p.m.

Anne B. Wilson, Committee Assistant

Senator William R. Purcell

Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

DEPARTMENT OF HEALTH & HUMAN SERVICES

MEDICAID PROGRAM OVERVIEW

FISCAL RESEARCH DIVISION
March 2004

Attachment # 1

Medicaid Program Overview

- Purpose of Medicaid
- Impact of Medicaid
  - On the State Economy
  - On State Government
  - On the State Budget
  - On Local Government
- Medicaid Services
- Medicaid Recipients
- Policy Changes Since 1990
- Cost Containment Efforts

Medicaid Program

THREE PROGRAMS IN ONE

- HEALTH INSURANCE
- LONG TERM CARE FOR THE ELDERLY
- SERVICES FOR PEOPLE WITH DISABILITIES

Medicaid Program

MEDICAID VS. MEDICARE

Medicaid is health care for certain groups of poor persons, including single parent families, persons over age 65 and the disabled. Coverage is based on a person falling into one of the target groups and passing income and resources tests. Medicaid is administered by states and counties and financed with federal, state and county funds.

Medicare is health care for persons over age 65 and for the disabled who receive Social Security payments. Medicare is administered by the Centers for Medicare & Medicaid Services and financed by employer/employee contributions to the Social Security Trust Fund.

Medicaid Program

ENTITLEMENT STATUS

Medicaid is a federal entitlement program. Entitlement means that any individual who is found eligible for Medicaid has a legal right to receive services under the Medicaid Program and cannot be denied coverage.

Implications for State Government

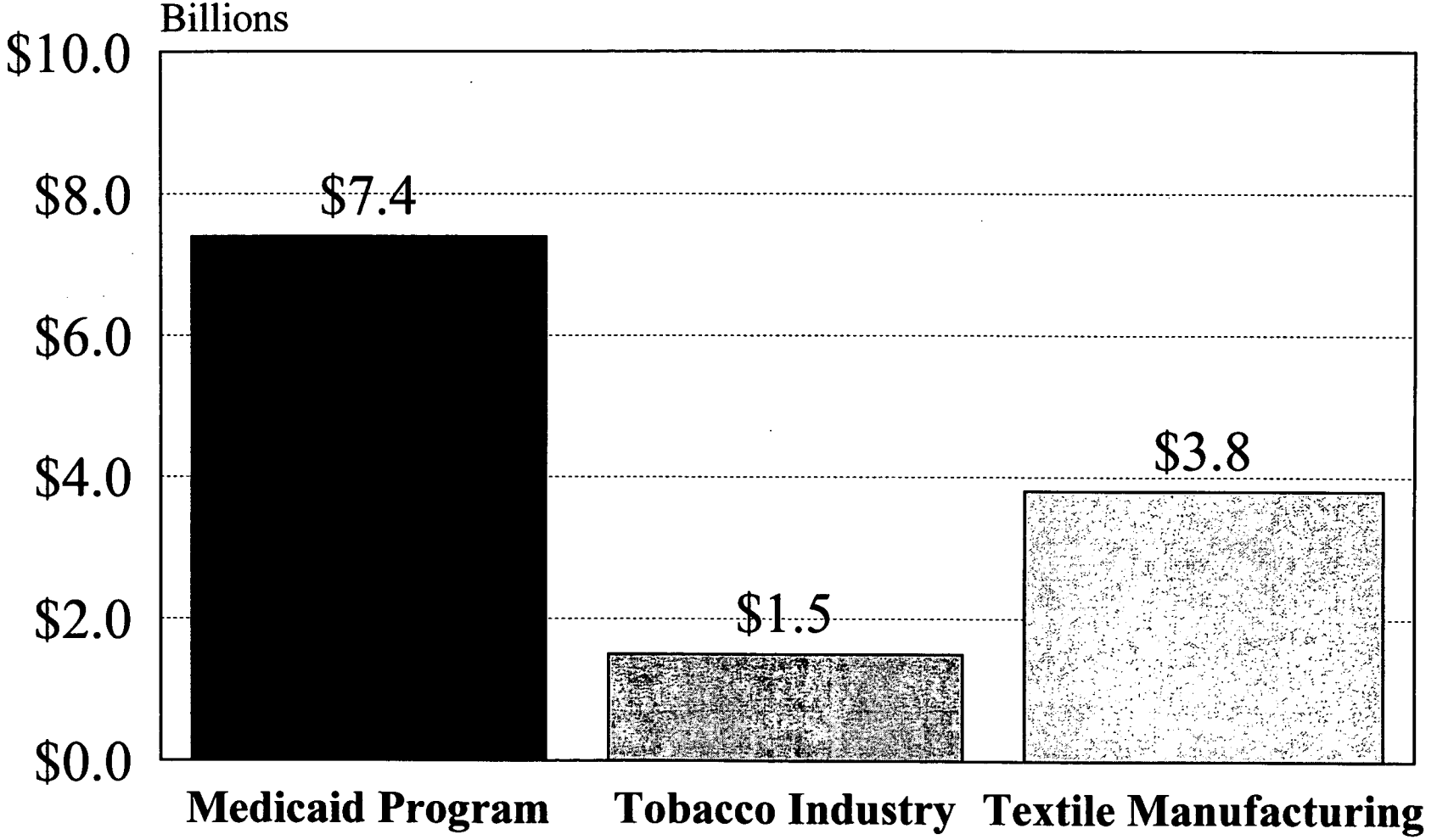
- ✓ **All eligible persons who apply for Medicaid must be served.**
- ✓ **The medical bills for Medicaid eligibles must be paid.**
- ✓ **If the appropriations for the Medicaid Program are inadequate, eligible persons must be served even if the funding must come from other areas of State government.**

IMPACT OF MEDICAID

- ✓ On the State Economy
- ✓ On State Government
- ✓ On the State Budget
- ✓ On Local Government

Medicaid Program

ROLE IN STATE ECONOMY



NOTE: Tobacco Industry includes the value of the 2002 crop and the estimated 2002 salaries and wages for tobacco manufacturing. Textile Manufacturing includes the estimated salaries and wages for the industry for 2002.

Medicaid Program

OTHER COMPARISONS

- The SFY 2002 Medicaid Program expenditures are equal to the estimated total income of the citizens of Cumberland County for 2000.

- Assuming an average private sector salary of $31,621 for 2002, SFY 2002 Medicaid expenditures would pay the salary of 232,950 employees in the private sector.

Medicaid Program

N. C. MEDICAID SNAPSHOTS

- Covered 1.45 Million state residents in SFY 2003 -- 17% of N.C.'s population
- Covered over 826,000 children during SFY 2003 - 57.1% of Medicaid eligibles
- Covers 45% of the babies born each year
- 29.3% of recipients consume 69.6% of resources -- includes aged, blind, and disabled

Medicaid Program

N. C. MEDICAID SNAPSHOTS

- Inpatient care consumes 42.6% of expenditures for services -- includes hospitals, nursing homes, residential high risk intervention services and mental retardation centers.

- Expenditures for drugs were $1.2 Billion in SFY 2003.

- 66.5% of the state's 40,000 nursing home beds are funded through Medicaid.

- 14% of N. C. hospital charges are paid by Medicaid -- 49% are paid by Medicare.

Medicaid Program

IMPACT ON STATE AND LOCAL AGENCIES

- The Medicaid Program supplies significant support to State and Local agencies that provide medical services to Medicaid recipients -- 12% of Medicaid expenditures support State and Local agencies.

- The following State and Local Agencies receive reimbursement from Medicaid: Mental Retardation Centers, State Psychiatric Hospitals, Special Care Center, UNC Hospitals, Area Mental Health Agencies, Alcohol and Drug Treatment Centers, Public Health Departments, Social Services Departments, County Owned Home Health Agencies, County Owned Ambulance Services and Local Education Agencies.

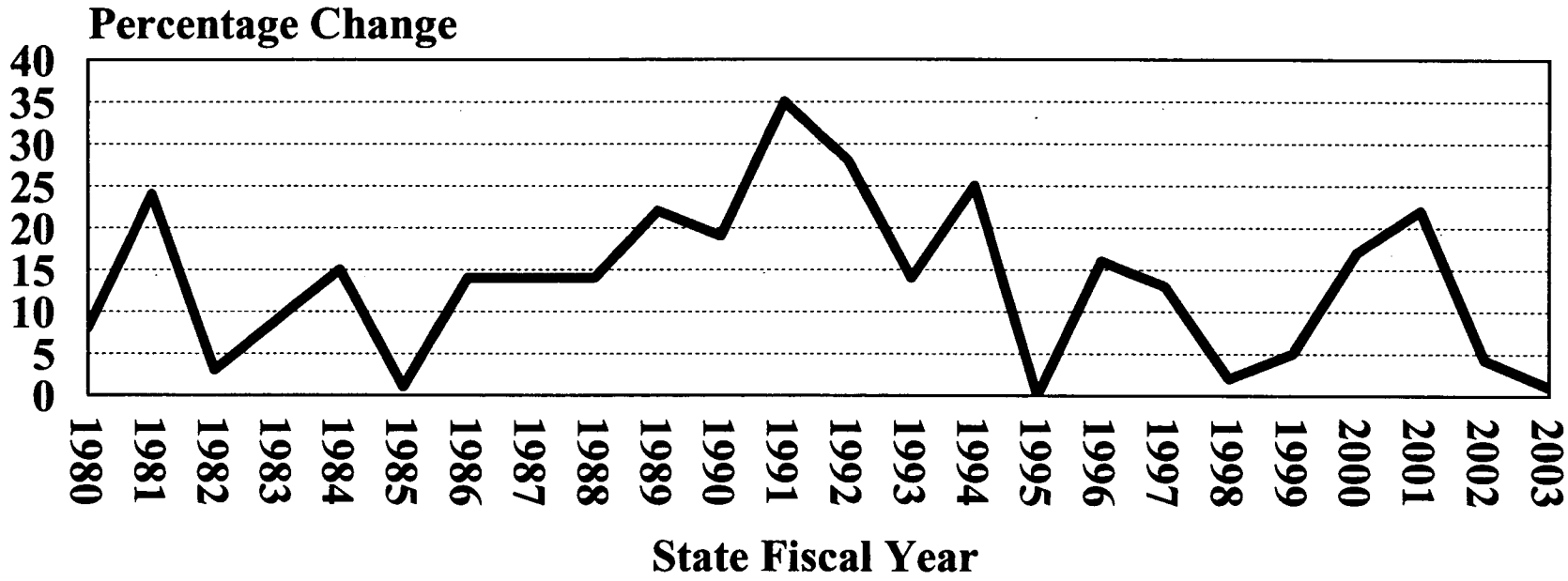
Medicaid Program

HISTORY OF TOTAL EXPENDITURES

STATE FISCAL YEAR	TOTAL EXPENDITURES
1979-80	$410,053,625
1989-90	$1,427,672,567
1999-00	$5,789,133,085
2002-03	$7,439,757,929

Medicaid Program

RATE OF GROWTH

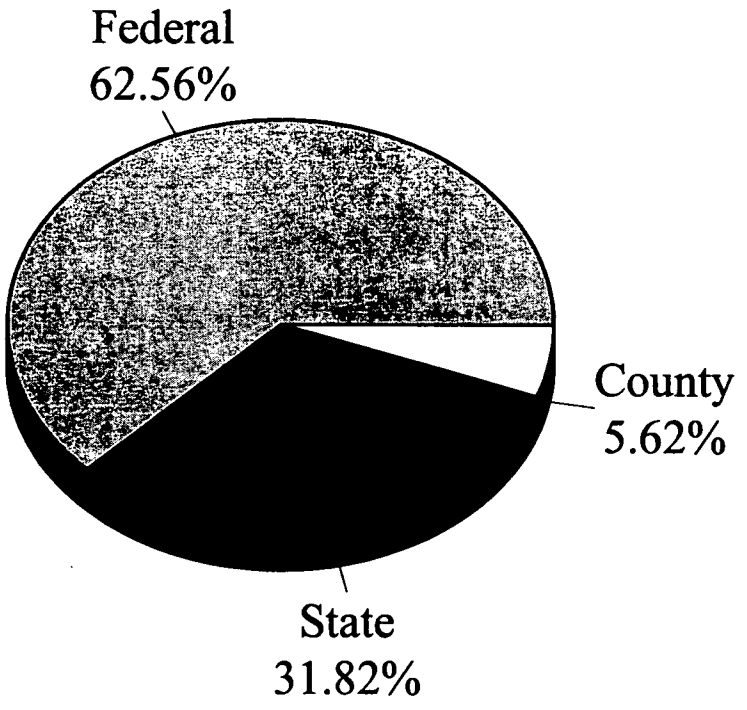


- ✓ During the past twenty years, the rate of growth for Medicaid expenditures has varied considerably - ranging from 0% to 35%.
- ✓ Higher rates of growth have occurred during years of economic distress or when major Medicaid expansions have been authorized.
- ✓ Lower rates of growth have occurred during years when the Medicaid population has been stable or declining.

Medicaid Program

FEDERAL FINANCIAL PARTICIPATION

Medical Benefits



SFY 2003

Other Matching Rates

Family Planning

Federal	90%
State	8.5%
County	1.5%

Administration - Skilled Medical Personnel & MMIS

Federal	75%
NonFederal	25%

Administration - All Other

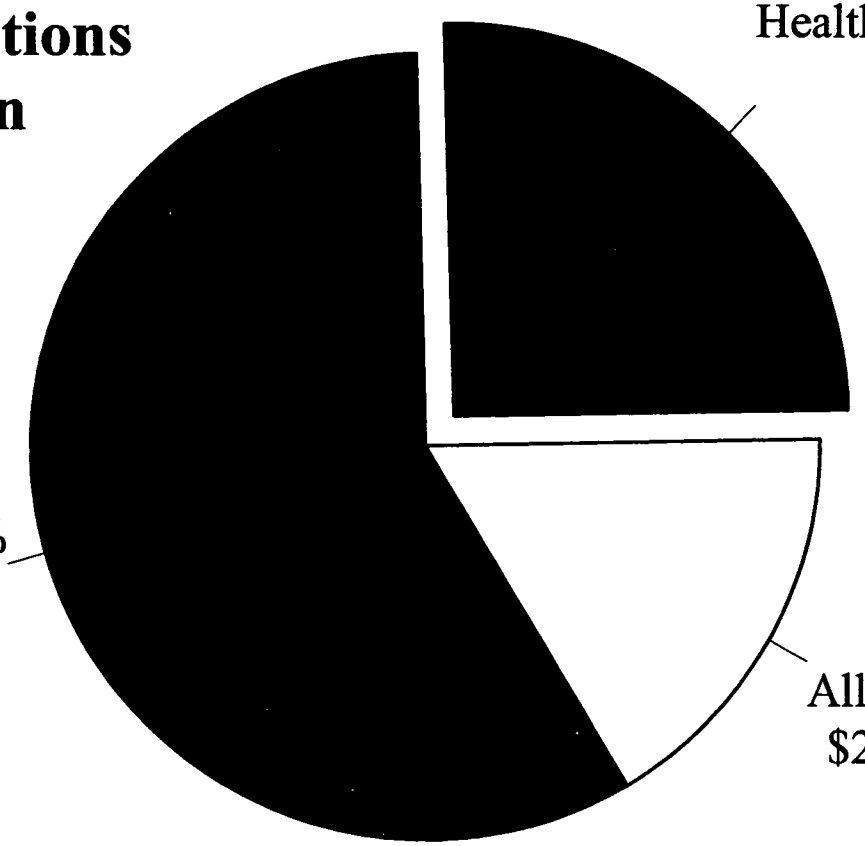
Federal	50%
NonFederal	50%

Medicaid Program

HHS SHARE OF GENERAL FUND APPROPRIATIONS

SFY 2003

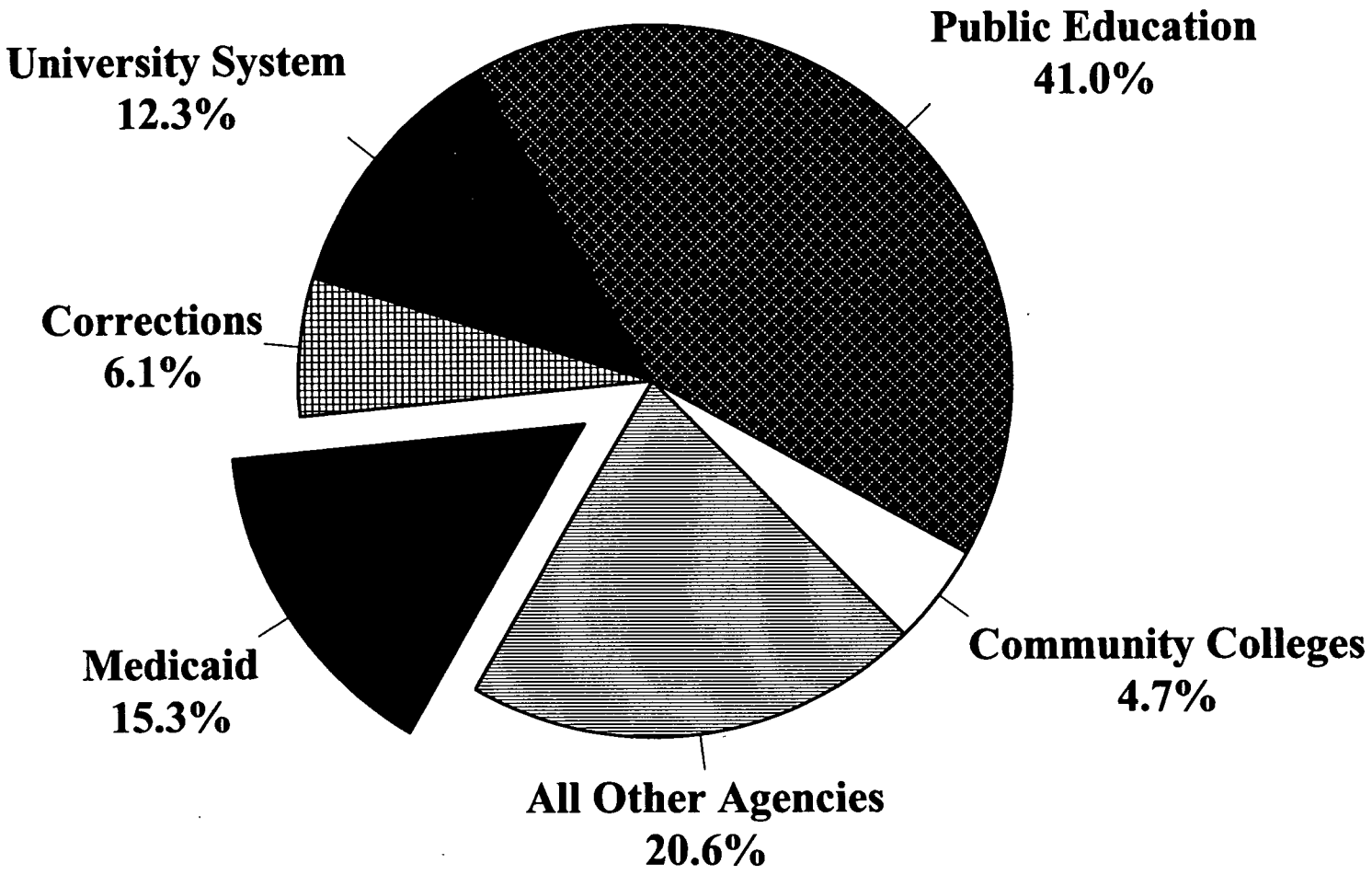
Total Appropriations
$14.35 Billion



Source: NC General Fund Operating Appropriations SFY 2003

Medicaid Program

GENERAL FUND APPROPRIATIONS BY MAJOR PROGRAM AREA
SFY 2003



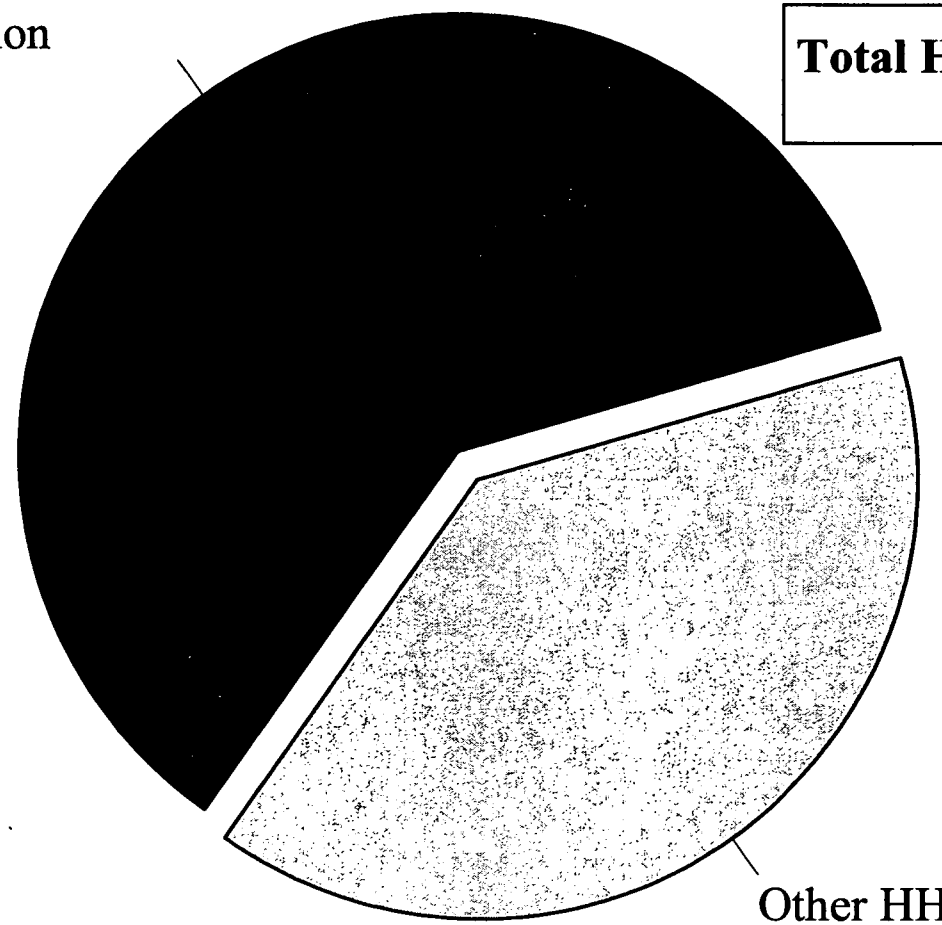
Source: NC General Fund Operating Appropriations SFY 2003

Medicaid Program

MEDICAID'S SHARE OF HHS GENERAL FUND APPROPRIATIONS FOR SFY 2003

Medicaid Program 60.8%
$2.19 Billion

Total HHS Appropriations
$3.6 Billion



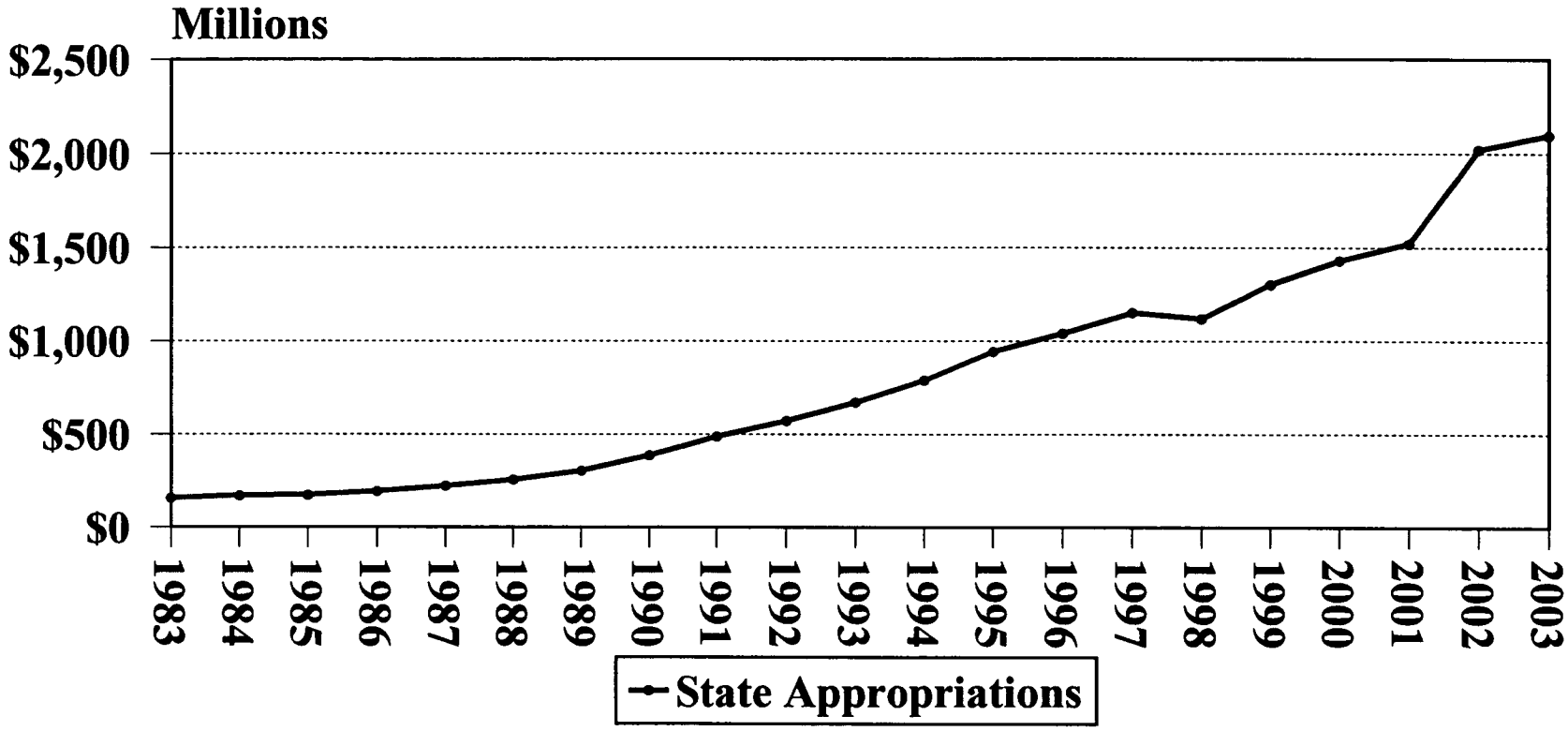
Other HHS Programs 39.2%
$1.41 Billion

Source: NC General Fund Operating Appropriations SFY 2003

Fiscal Research Division 2/03

Medicaid Program

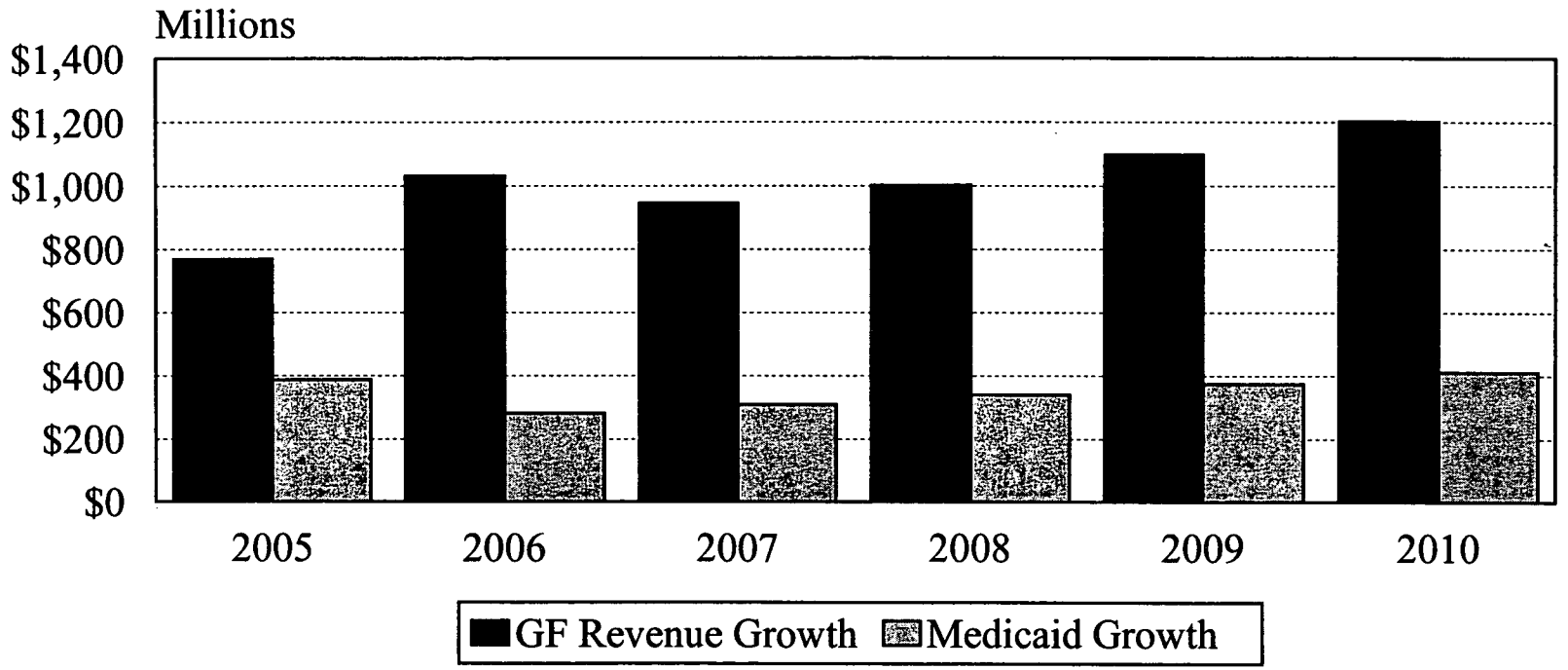
HISTORY OF STATE APPROPRIATIONS



- ✓ 10 years ago, Medicaid was 8.2% of the General Fund operating budget; today it is 15.3%.
- ✓ A 1% increase in the Medicaid Budget equals an $22 Million increase in General Fund requirements.

Medicaid Program

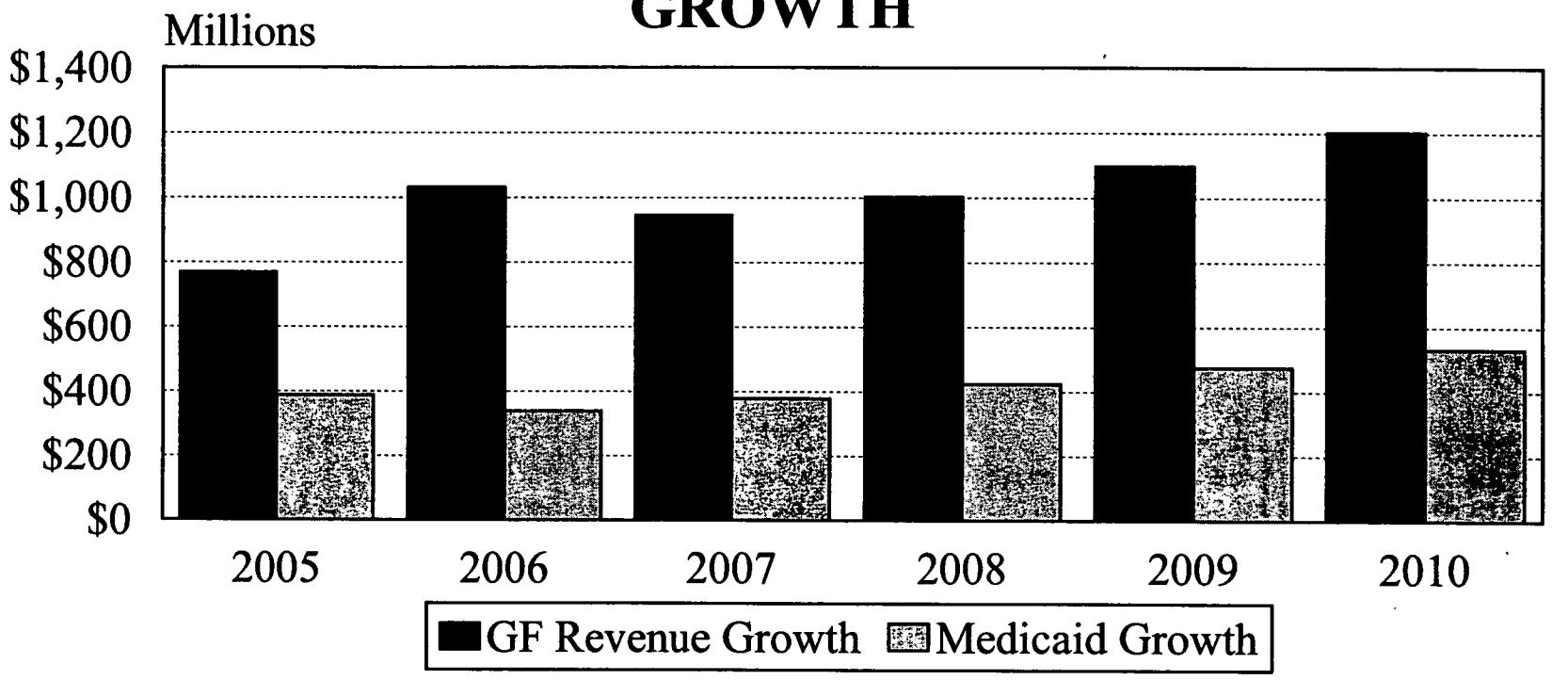
MEDICAID GROWTH VS. GENERAL FUND REVENUE GROWTH



If Medicaid expenditures increase 10% annually, growth in General Fund expenditures for Medicaid will consume 34% of new General Fund revenues by SFY 2010.

Medicaid Program

MEDICAID GROWTH VS. GENERAL FUND REVENUE GROWTH



If Medicaid expenditures increase 12% annually, growth in General Fund expenditures for Medicaid will consume over 44% of new General Fund revenues by SFY 2010.

Medicaid Program

IMPACT ON COUNTIES

- State law requires counties to pay 15% of the nonfederal share of Medicaid Services and 100% of the nonfederal share for County Medicaid Administration.

- For SFY 2004, counties are projected to pay $361.5 million for Medicaid Services or 5% of the expenditures for Medicaid Services.

- For SFY 2004, counties are also projected to pay $63 million for County Medicaid Administration or 50% of the expenditures for County Medicaid Administration.

Medicaid Program

COUNTY PARTICIPATION IN OTHER STATES

Nineteen states require county financial participation for paying the administrative and/or service cost of their Medicaid Programs.

- ✓ Three states require county financial participation for paying for the cost of Medicaid administration: Colorado, Indiana, and Wisconsin.
- ✓ Four states require county financial participation for paying for the cost of Medicaid services: Arizona, Florida, Iowa, and Michigan.
- ✓ Eleven states require county financial participation for paying for the cost of Medicaid administration and services: Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Virginia, and Washington.

MEDICAID SERVICES

Medicaid Program

Mandatory Services and Eligibles

Under federal law, all states operating a Medicaid Program are required to provide certain services and serve specific categories of eligibles. The services and eligibles are **mandatory** and must be included in order to receive federal reimbursement.

Medicaid Program

Mandatory Services

- Health Check Services (ESPDT)
- Family Planning Services
- Federally Qualified Health Centers
- Hearing Aids (children)
- Home Health Services (includes Durable Medical Equipment)
- Inpatient Hospital Services
- Outpatient Hospital Services
- Physicians
- Laboratory & X-Ray Services
- Nurse Midwives
- Nurse Practitioners
- Nursing Facilities
- Prenatal Care
- Rural Health Clinics
- Specialty Hospitals
- Transportation
- Vaccines for Children

Medicaid Program

Optional Services and Eligibles

- Current federal law also will provide federal reimbursement for other services and eligibles that are discretionary, but are allowed under federal law. Each state is allowed to choose which optional services it wants to provide and optional categories of eligibles it wants to serve.

- The North Carolina Medicaid Program covers 28 of the 34 optional Medicaid services.

Medicaid Program

Optional Services

- Ambulance Transportation
- Case Management Services
- Chiropractors
- Clinic Services
- Community Alternatives Programs (CAP)
- Dental Care Services (Dentures)
- Diagnostic, Screening, Preventative Services
- Emergency Hospital Services
- Eyeglasses
- Hospice
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Mental Hospitals (Age 65 and over)
- Impatient Psychiatric Care (Under age 21)
- Occupational, Physical, and Speech Therapies
- Optometrists
- Personal Care Services
- Podiatrists
- Prescription Drugs
- Prosthetics (children)
- Private Duty Nursing Services
- Rehab. Services (Mental Health)

Medicaid Program

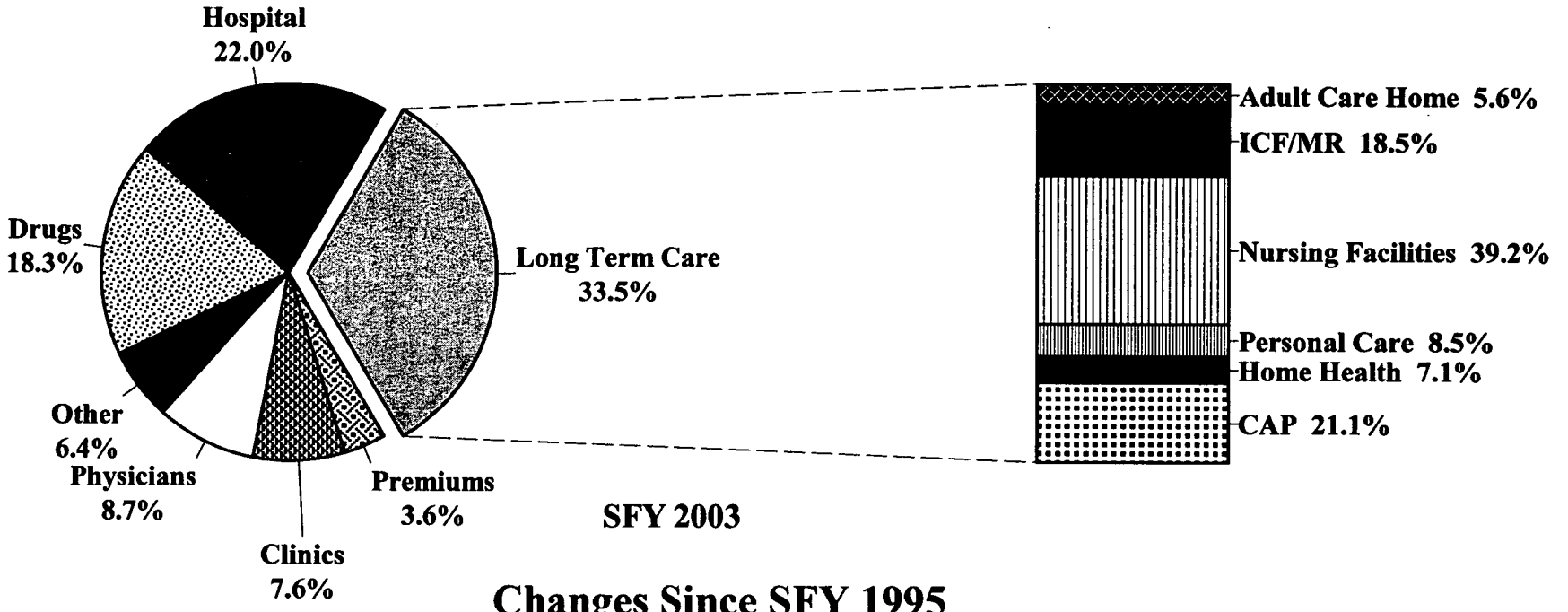
EXPENDITURES FOR SERVICES

- Total expenditures for services and premiums was $6.6 Billion for SFY 2003.

- 96.4% of expenditures for services paid for direct medical services while the remaining 3.6% paid for Medicare and HMO premiums.

Medicaid Program

EXPENDITURES FOR SERVICES

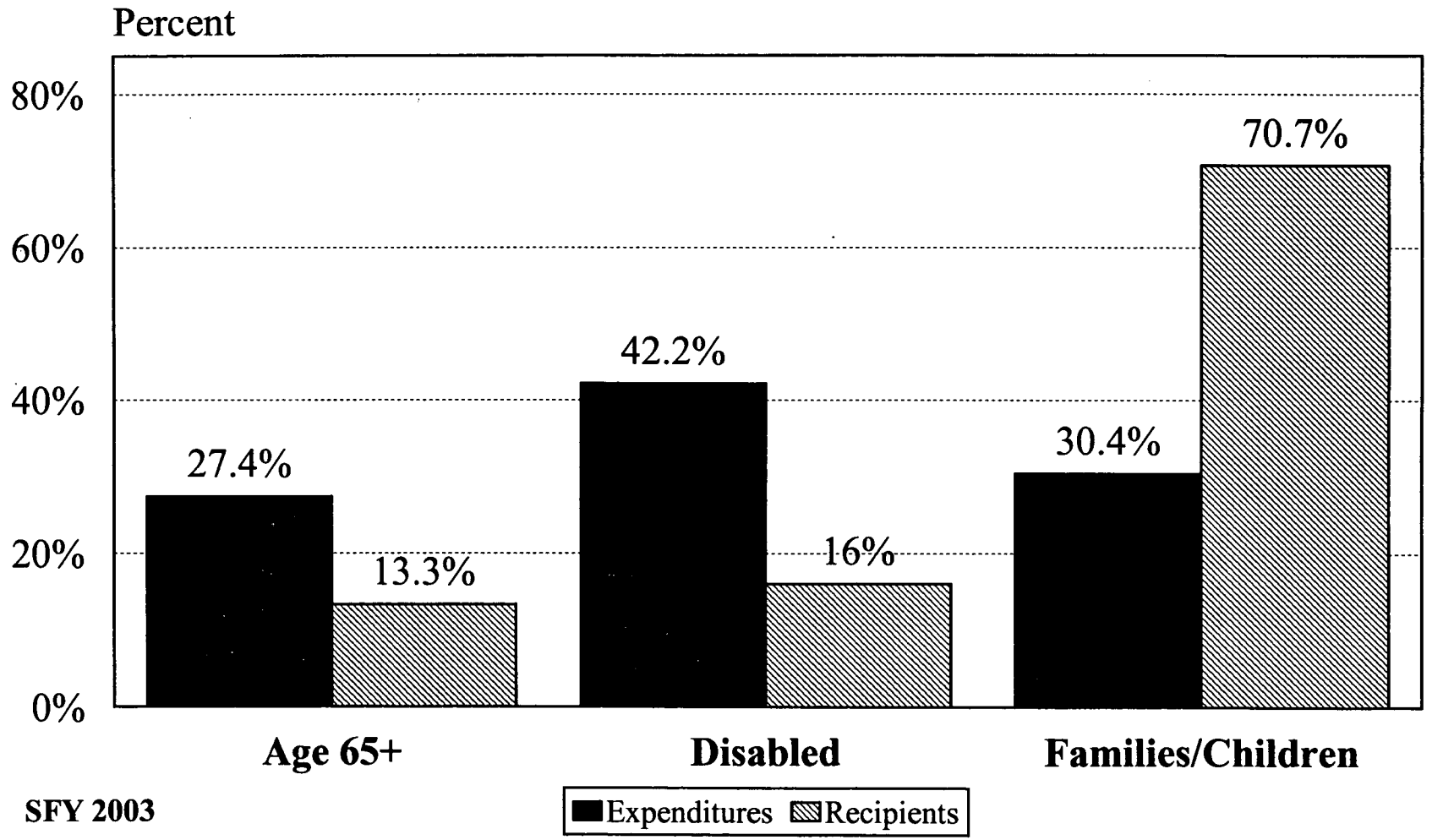


Changes Since SFY 1995

- ✓ Long-Term Care expenditures continue to decline - 40.4% to 33.5%.
- ✓ In-Home Services are an increasing share of Long-Term Care expenditures - 18.5% to 36.7%
- ✓ Hospital expenditures have also declined - 26.9% to 22%.
- ✓ Drug expenditures have doubled - 8.2% to 18.3%

Medicaid Program

EXPENDITURES AND RECIPIENTS



SFY 2003

Medicaid Program

EXPENDITURES AND RECIPIENTS

SFY 2003

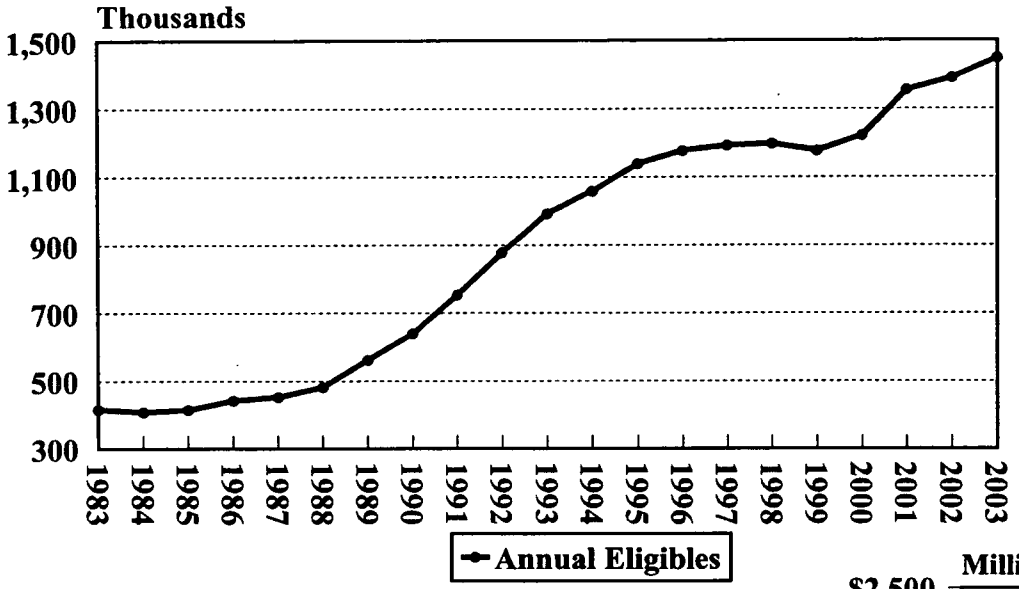
Eligibility Category	Number of Recipients	Expenditures	Annual Cost Per Recipient
Elderly	202,377	$1,807,717,487	$8,932
Aged	162,015	$1,780,878,696	$10,992
Medicare-Aid	40,362	$26,838,791	$665
Disabled	232,166	$2,779,255,514	$11,971
Families & Children	1,003,271	$1,973,688,840	$1,967

NOTE: The Aged and Medicare-Aid categories are subsets of the Elderly category.

MEDICAID RECIPIENTS

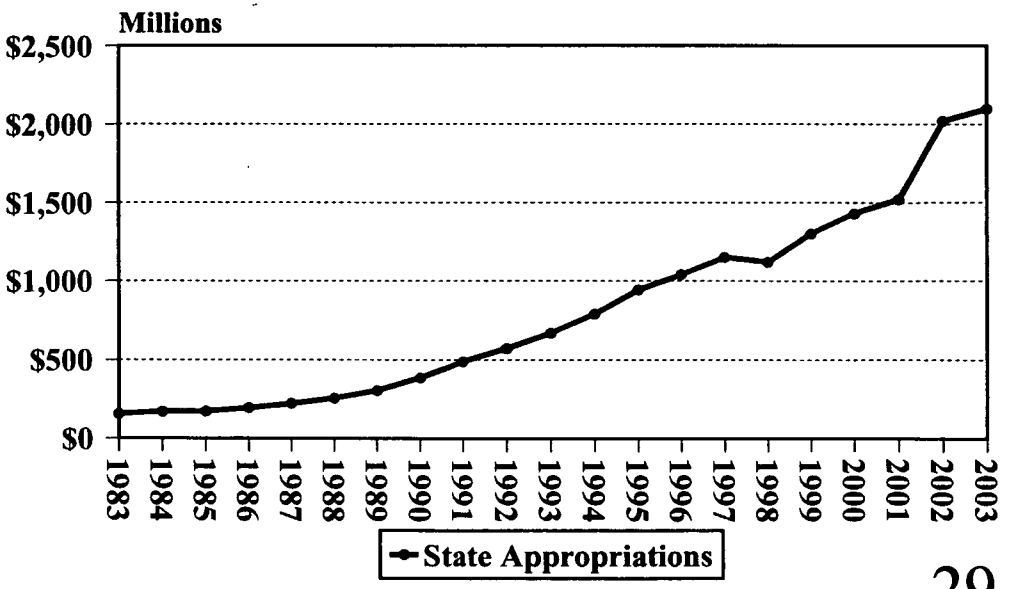
Medicaid Program

GROWTH IN ELIGIBLES AND EXPENDITURES



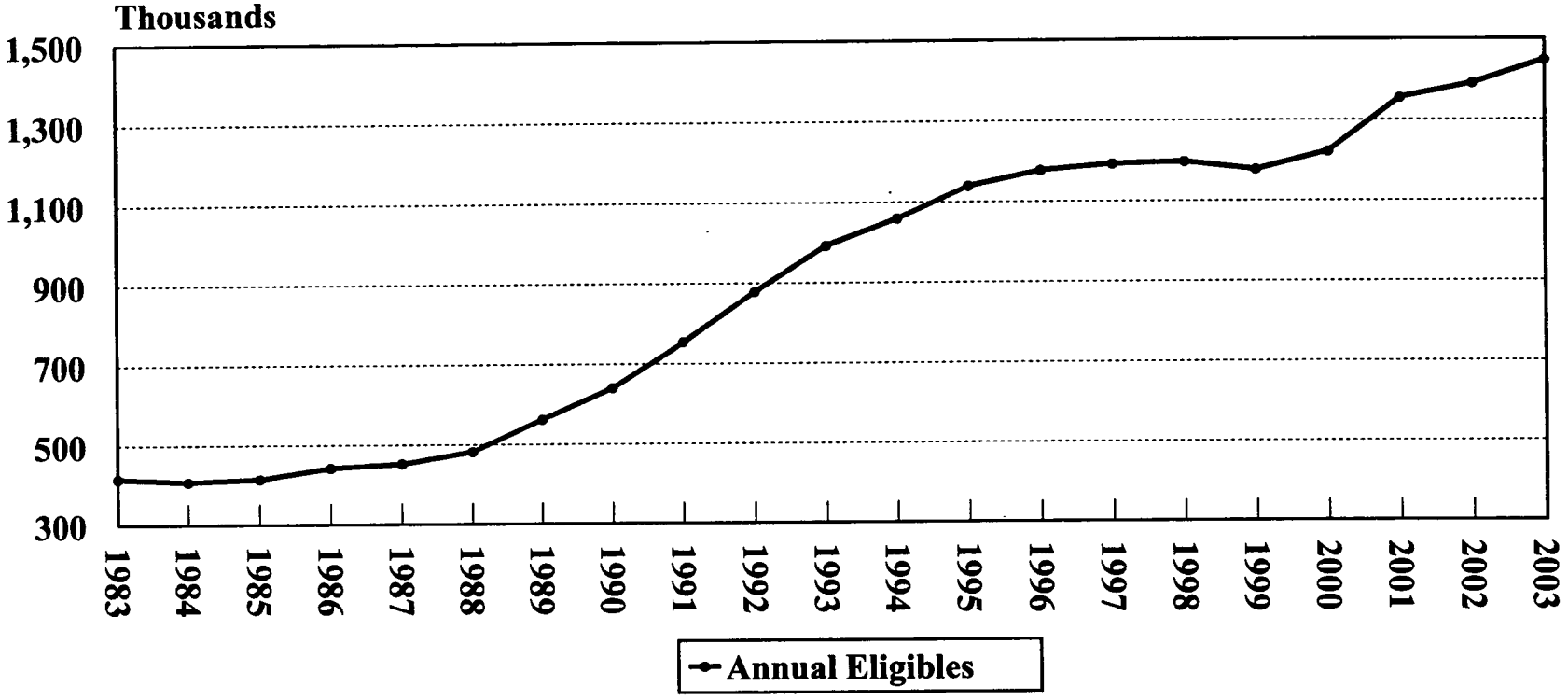
During the early 1980s, the number of eligibles did not grow significantly, and the rate of growth in expenditures for Medicaid was moderate.

Beginning in 1987, a series of mandated and optional eligibility expansions occurred and expenditures for Medicaid began to grow rapidly.



Medicaid Program

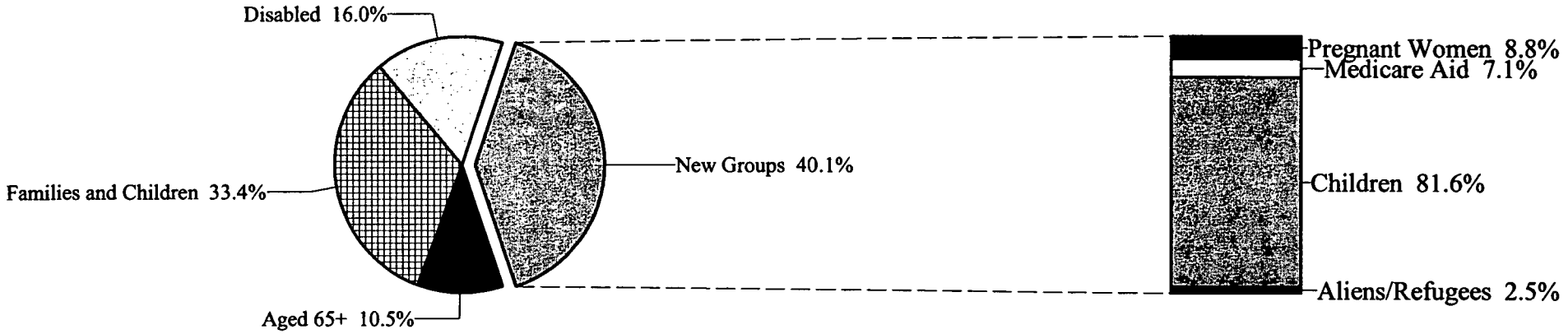
HISTORY OF ANNUAL ELIGIBLES



Growth in the number of annual eligibles began to plateau in SFY 1996 as welfare caseloads began to significantly decline and actually decreased in SFY 1999. The number of annual eligibles grew 11% in SFY 2001 because the decline in welfare caseloads slowed and other eligibility groups continued to grow. Growth in SFY 2002 slowed to 2.6%, but it increased to 4.1% in SFY 2003.

Medicaid Program

NEW GROUPS SINCE 1987



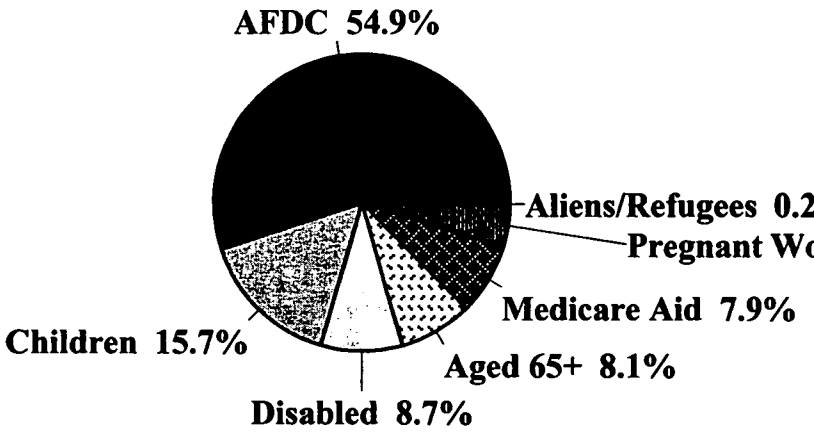
SFY 2003

When Medicaid began, the program focused on providing medical care for the disabled, aged, and families receiving welfare. Since 1987, Medicaid eligibility has been expanded to cover children, pregnant women, qualified Medicare beneficiaries, and aliens/refugees.

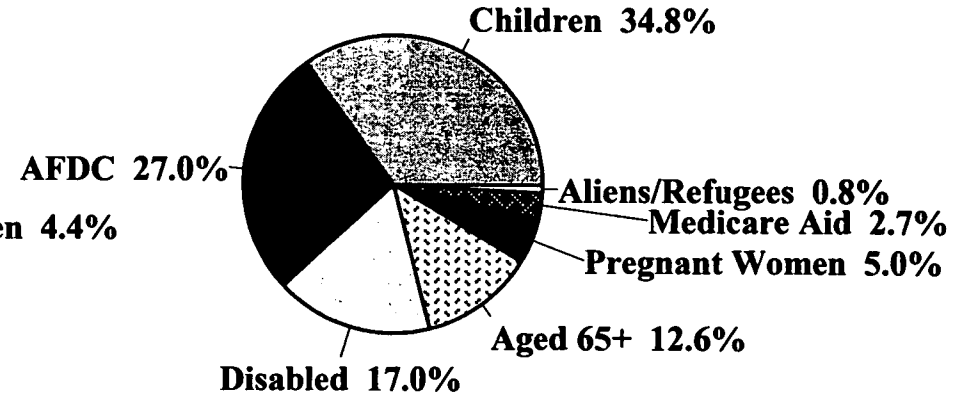
Medicaid Program

MEDICAID ELIGIBLES

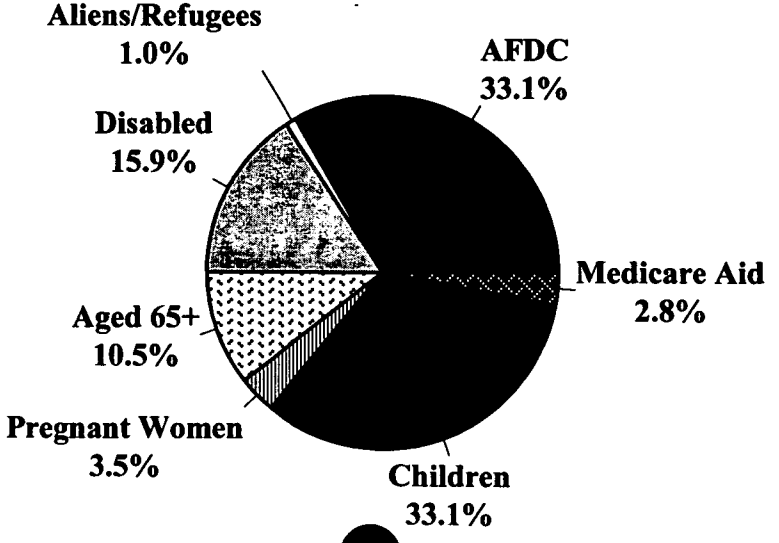
SFY 1994



SFY 2000



SFY 2003



Medicaid Program

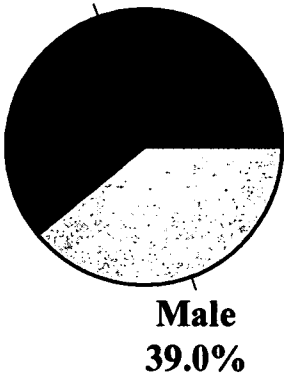
CHANGING MEDICAID ELIGIBLES

- ✓ In SFY 1994, the welfare caseload reached 581,000 people and welfare recipients were the largest group of eligibles.
- ✓ In SFY 2000, welfare reform reduced the welfare caseload to 330,000 people and children became the largest group of eligibles.
- ✓ In SFY 2003, welfare recipients are again the largest group of eligibles due to the poor economy and the expansion of Transitional Medicaid.
- ✓ In SFY 2000, the 1998 expansion of Medicaid to aged, blind, and disabled persons with incomes up to a 100% of the federal poverty level doubled the number of aged, blind and disabled eligibles.
- ✓ In SFY 2003, the number of aged, blind, and disabled eligibles has stabilized and in the case of the aged declined slightly.

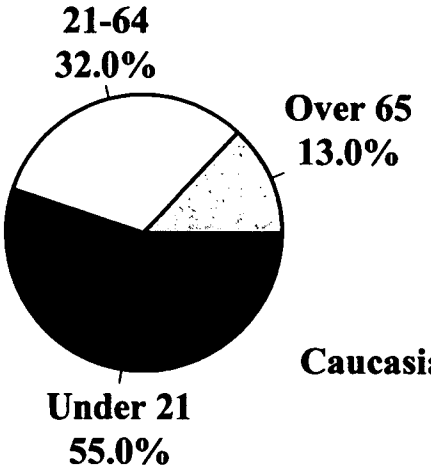
Medicaid Program

RECIPIENT INFORMATION

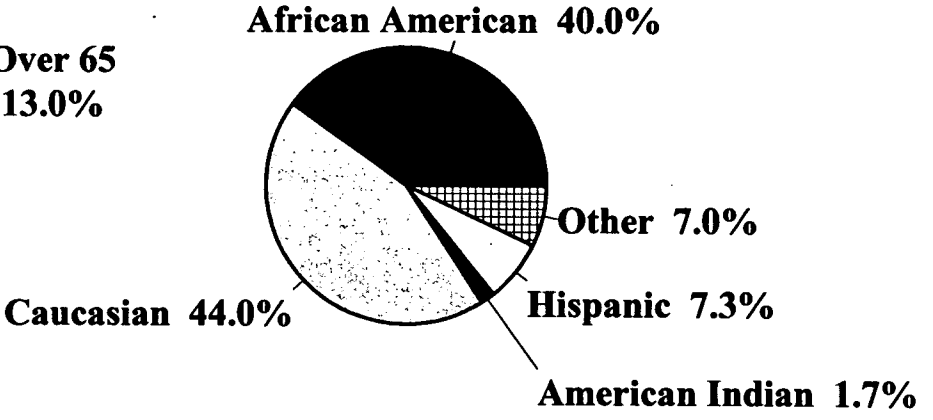
BY GENDER



BY AGE



BY RACE



SFY 2003

Medicaid Program

MANDATORY ELIGIBILITY GROUPS

- Low Income Families and Children (Based on the AFDC State Plan as of July 16, 1996)
- Aged, Blind, and Disabled SSI Recipients
- Infants born to Medicaid eligible women (to 185% of FPL)
- Children under age 6 (to 133% of FPL)
- Pregnant Women (to 150% of FPL)
- All Children born after 9/30/83 (to 100% of FPL)
- Recipients of Adoption Assistance and Foster Care
- Certain Medicare Recipients
  - Dual Eligibles
  - Qualified Medicare Beneficiaries
  - Specified Low-Income Medicare beneficiaries
  - Qualified Disabled and Working Individuals

Note: FPL is the Federal Poverty Level

Medicaid Program

OPTIONAL ELIGIBILITY GROUPS

- Pregnant Women (150% to 185% of FPL)
- Children age 18, 19, and 20 meeting AFDC income standards
- Special Needs Adoptive Children
- Recipients of State/County Special Assistance
- Recipients of State Assistance to the Blind
- Persons receiving care under home and community-based waivers
- Aged, Blind, and Disabled persons presumed eligible for but not receiving SSI
- Aged, Blind, and Disabled persons with non-SSI income (to 100% of the FPL)
- Medically Needy Persons
- Women with Breast and Cervical Cancer (to 185% of FPL)

Note: FPL is the Federal Poverty Level

PROGRAM CHANGES SINCE 1990

Medicaid Program

PROGRAM CHANGES SINCE 1990

Eligibility Expansions

- **Mandated**

  - ✓ Increase children ages 11 to 19 coverage to 100% of FPL - Effective 7/1/94
  - ✓ Increase children ages 1 to 6 coverage to 133% of FPL - Effective 10/1/90

- **Optional**

  - ✓ Increase pregnant women and infant coverage to 150% of FPL - Effective 1/1/90
  - ✓ Increase pregnant women and infant coverage to 185% of FPL - Effective 10/1/90
  - ✓ Add adoptive children with special rehabilitative needs - Effective 10/1/94
  - ✓ Automatic coverage of SSI eligible aged, blind and disabled persons - Effective 1/1/95
  - ✓ Add non-SSI eligible aged, blind, and disabled persons to 100% of FPL - Effective 1/1/99
  - ✓ Increase transitional TANF coverage from 12 to 24 months - Effective 10/1/99
  - ✓ Add women with breast and cervical cancer coverage to 185% of FPL -Effective 10/1/01

Note: FPL is the Federal Poverty Level

Medicaid Program

PROGRAM CHANGES SINCE 1990

Managed Care Initiatives

- ✓ Carolina ACCESS began implementation - Effective 4//91
- ✓ Carolina Alternatives was implemented - Effective 1/94
- ✓ Health Care Connections was implemented in Meclenburg County -Effective 6/96
- ✓ ACCESS II and ACCESS III demonstration was implemented - Effective 7/98
- ✓ Carolina ACCESS implemented statewide - Effective 12/98
- ✓ Carolina Alternatives terminated - Effective 6/99
- ✓ Health Care Connections terminated and replaced with Carolina ACCESS II - Effective 10/01
- ✓ Carolina ACCESS II and III demonstration expansion began and is ongoing - Effective 11/02

Medicaid Program

PROGRAM CHANGES SINCE 1990

Federal Revenue Maximization Efforts

- ✓ Intermediate Care Facilities for the Mentally Retarded
- ✓ Thomas S program (lawsuit)
- ✓ Willie M program (lawsuit)
- ✓ Adult Care Home Personal Care Services
- ✓ DSH Payments
- ✓ Health Departments & Area Mental Health Programs
- ✓ Health Related Services In Schools

Medicaid Program

COST CONTAINMENT EFFORTS 2001 - 2004

- **Prescription Drugs**
  - ✓ Prior Authorization Program for high cost drugs
  - ✓ State "Maximum Allowable Cost" Drug List
  - ✓ Limit most drugs to a 34-day supply
  - ✓ Increase use of generic drugs
  - ✓ Voluntary Preferred Drug List
  - ✓ Increase copayments for brand name drugs ($1 to $3)
  - ✓ Reduce dispensing fees for brand name drugs ($5.60 to $4.00)
  - ✓ Reguire pharmacists to coordinate pharmacy benefits

- **Provider Rates**
  - ✓ Reduce Physician rates from 100% of Medicare rates to 95%.
  - ✓ Eliminate inflationary increases for SFY 2003 and SFY 2004
  - ✓ Reduce rates by 5% for the following providers: private duty nursing, home infusion therapy, home health supplies, durable medical equipment, optical service, ambulatory surgical centers, and high risk intervention
  - ✓ Reduce hospital payments by .5 %
  - ✓ Limit Medicare crossover claims to Medicaid rates
  - ✓ Apply Medicaid medical policy to Medicare crossover claims

Medicaid Program
COST CONTAINMENT EFFORTS 2001 - 2004

- **Recipients**
  - ✓ Apply federal transfer of asset policies to real property excluded as "income producing" under Title XIX.
  - ✓ Apply transfer of asset policies to persons receiving personal care services while residing in their homes
  - ✓ Adopt the SSI method for considering equity value in income-producing property for aged, blind and disabled persons
  - ✓ Modify policy for determining eligibility for pregnant women coverage for minors by counting parental income
  - ✓ Eliminate twelve month State Transitional Medicaid Coverage for families who are working and no longer receiving welfare payments.

- **Managed Care**
  - ✓ Expand Carolina ACCESS II/III activities including reducing hospital admissions, reducing ER visits, using best prescribing practices, increasing generic prescribing, implementing polypharmacy review, reducing therapy visits, and better management of high risk/high cost patients.

Medicaid Program
COST CONTAINMENT EFFORTS 2001 - 2004

- **Services**
  - ✓Reduce monthly limit for Personal Care Services from 80 hours to 60 hours for most recipients
  - ✓Limit Personal Care Services to 3.5 hours per day
  - ✓Eliminate optional circumcision procedures except in cases of medical necessity
  - ✓Reduce case management services for adults and children by reducing rates, streamlining services, and eliminating duplicated services

- **Federal Fiscal Relief**
  - ✓Receipt of enhanced federal reimbursement allowed NC to reduce State appropriations to the Medicaid Program

Medicaid in North Carolina

Annual Report
State Fiscal Year 2003

Division of Medical Assistance

nc department of health and human services

Michael F. Easely
Governor

Carmen Hooker Odom
Secretary

Gary H. Fuquay
Director

This annual report was produced by the
North Carolina Department of Health and Human Services
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Division of Medical Assistance
Director's Office
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Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

Gary H. Fuquay, Director

Dear Fellow North Carolinians:

I am pleased to present the North Carolina Medicaid Annual Report for State Fiscal Year 2003.

With the economy still in deep recession, it was an extremely challenging year for all of the state governments throughout the nation to sustain their Medicaid programs at existing levels. As the North Carolina SFY 2003 budget was being formulated, our legislature was faced with an estimated shortfall of $1.6 billion. Since state appropriations for the North Carolina Medicaid Program during the previous year were approximately $2 billion out of a total state budget of $14 billion, the Medicaid program was under tremendous scrutiny. Fortunately, when the last vote was cast, an appropriation of $2.2 billion was authorized, meaning that over a million North Carolinians would continue to receive the same level of health care insurance coverage they had in the previous year.

In order to continue to offer our citizens accessible, quality health care it was vital to sustain our on-going cost containment efforts and to expand them under new initiatives. The legislature mandated a variety of cost-saving measures, particularly through the elimination of provider reimbursement rate increases, prescription drug utilization management and the expansion of the Community Care managed care program. Additionally, the dedicated staff of the N.C. Medicaid program took a variety of steps to improve the administration and management of the program.

I invite you to read this report in its entirety in order to gain better insight into the N.C. Medicaid program and its many challenges and accomplishments during the year.

Sincerely,

Gary H. Fuquay, Director

Mission Statement

The mission of the Division of Medical Assistance is to manage the Medicaid program efficiently so that cost effective health care services are available through enrolled providers to all eligible persons across the state.

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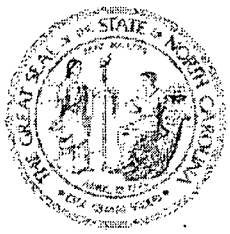

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Policy and Program Changes

State fiscal year 2003 brought a number of policy and program changes that were implemented either as a result of legislative or federal mandates or at the discretion of the Division of Medical Assistance (DMA).

Policy Changes Enacted by Mandates

Asset Policy Change

DMA adopted the Supplemental Security Income (SSI) method for considering equity value in incomeproducing property for aged, blind, and disabled persons. Accordingly, Medicaid no longer excludes the entire equity value of income-producing property for eligibles in the Medically Needy category. Any equity over $6,000 is a countable resource. This change does not affect business property such as an active farm. This policy change applies only to recipients enrolled in Medicaid as of December 1, 2002. Additionally, the General Assembly authorized sanctioning transfers of tenancy-in-common interest in real property. The uncompensated transfer of tenancy-in-common interest in real property results in a sanction unless it is transferred to an
allowable person.

Transfer of Assets Policy for Specified Home Care Services

Effective with dates of service of February 1, 2003 and after, DMA began to apply the federal transfer of asset policies to Medicaid recipients in the aged, blind, disabled and qualified Medicare beneficiaries (MQBQ) eligibility categories receiving the following services: personal care in private residences, home health services (including the supplies provided by home health agencies), durable medical equipment (including the supplies provided by durable medical equipment providers), home infusion therapy, supplies on the home health fee schedule provided by private duty nursing providers to their patients (not including nursing care). This policy change was similar to the transfer of asset requirements currently in place for Medicaid eligibles receiving care at nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR), as well as for those recipients participating in the Community Alternatives Programs. The policy change did not apply to adult care residents receiving State/County Special Assistance, but it does apply to a private pay adult care home resident if the individual is in one of the four eligibility categories.

Drug Utilization Management

Various drug utilization measures were implemented to expand prescription drug cost containment, including expanding the use of generic drugs and a preferred drug list. One such initiative was the pilot ACCESS II and III Prescription Advantage List (PAL). The ACCESS Program's clinical directors developed a voluntary PAL as an educational resource for physicians in the ACCESS II and III programs and, beginning November 1, 2002, a list

of FDA approved drugs was piloted in ACCESS sites. The list placed drugs in the 10 highest cost classes into tiers based solely on their Average Wholesale Price (AWP). This pilot effort was intended to assess physician acceptance of a voluntary list. There was no prior approval process associated with the choice of drugs on the list. Medicaid continued to pay for any medication a physician considered medically necessary for the patient regardless of cost.

Another ACCESS II and III drug utilization initiative, the Nursing Home Polypharmacy Project, was piloted in November 2002. Benefits of the initiative include the potential for use of more appropriate drugs for the elderly and an increase in coordination between pharmacists and physicians. The initiative will be evaluated based on the following aims: decreased prescription drug costs; the preservation or the enhanced quality of prescription-drug related care; and a decrease in other health care service costs.

The Nursing Home Polypharmacy Project represents an effort by the ACCESS Medical Directors team to better manage prescribing practices for a patient population that averages nine prescriptions per month each. The program depends on the interaction and collaboration between the consultant pharmacist and the prescribing physician. Only the physician can authorize the recommended change to a recipient's drug regimen.

The medications in this initiative will be flagged if: 1) they appear on the PAL; 2) they represent a therapeutic duplication; 3) they appear on the Beers list; 4) the length of therapy appears excessive; or 5) the drugs appear on a list developed by a committee of long-term care pharmacists that feature drugs associated with potential significant savings.

Personal Care Services Limitations

The monthly limit for Personal Care Services was reduced from 80 hours per month to 60 hours per month effective with date of service December 1, 2002.

Pregnant Women Coverage for Minors

The N.C. Legislature mandated a policy change, to be effective October 1, 2002, that would have modified the determination of eligibility for pregnant women coverage for minors by the counting of parental income if the minor is residing in the parents' home as long as the minor has not been married, has not served in the military or has not been legally emancipated. The Centers for Medicare and Medicaid Services denied the State Plan amendment submitted by DMA that would have authorized this change, thus the policy was not changed.

Hospital Payments

NC Medicaid payments to hospitals were reduced by 0.5 percent. This was implemented through system and process changes.

Prospective Rates for Home Health Services

A prospective rate payment system was established for home health services. The new system pays for services based on an assessment of the specific needs of the Medicaid recipient. Payment for services is no longer tied to the number of provider visits.

Optional Services

Coverage of routine circumcision procedures were eliminated effective with date of service December 1, 2002.

ACCESS II and III Expansion and Cost Savings

The Medicaid budget was reduced to reflect anticipated savings from the expansion of ACCESS II and III care management activities including reducing hospital admissions, reducing emergency department visits, using best prescribing practices, increasing generic prescribing, implementing polypharmacy review, reducing therapy visits and better management of high risk/high cost patients. The entire NC Medicaid Managed Care Program, consisting of Carolina ACCESS, ACCESS II and III, and HMO's has been renamed "Community Care of North Carolina". Enrollment in ACCESS II and III is anticipated to increase gradually from the current level of 250,000 to 650,000. To encourage the expansion of ACCESS II and III networks, effective April 1, 2003, the monthly case management fee for Carolina ACCESS providers not linked with an ACCESS II and III administrative entity was reduced to $1.00 per member per month, while those linked with ACCESS II and III, and working on care management activities, continued to receive $2.50 per member per month.

Medicare Issues

Effective with dates of service October 1, 2002, Medicaid medical coverage policy was applied to Medicare crossover claims. Crossover claims are those claims that Medicare submits to DMA for health-care services provided to Medicare-Medicaid dual eligible recipients where Medicare is considered to be the primary payer. By March 1, 2005, Medicaid payment of a dual-eligible's Medicare Part B deductible and co-payments will be limited to the amount that would be paid for the rendered Medicaid service using Medicaid rates.

Case Management Services

Case management services for adults and children were reduced by lowering reimbursement rates, streamlining services and eliminating duplicative services.

Reimbursement Rate Reductions

Reimbursement rates for high-risk intervention, optical services and services provided by ambulatory surgical centers were reduced by 5 percent. Reimbursement rates for durable medical equipment and supplies, home health supplies and home infusion therapy were also reduced.

Medicare Coverage in Nursing Facilities

Effective with dates of service December 1, 2002, DMA began requiring nursing facilities to bill NC Medicaid for services only after the appropriate services had been billed to Medicare.

HIPAA Compliance

NC Medicaid implemented Health Insurance Portability and Accountability Act (HIPAA) standard transactions on May 1, 2003. Providers were required to submit electronic claims in the pre-HIPAA format until May 1, 2003. After May 1, 2003, Medicaid began accepting electronic claims in the new HIPAA format and will require the new format after October 16, 2003.

Policy Changes Not Mandated

Change in Carolina ACCESS Override Policy

Effective September 1, 2002, Carolina ACCESS overrides were no longer approved when an enrollee has failed to establish a medical record with the primary care provider designated on the enrollee's Medicaid identification card.

Outpatient Specialized Therapy Services

Beginning October 1, 2002, Medical Review of North Carolina began processing the requests for prior approval of outpatient specialized therapy services provided to all Medicaid recipients. Therapy services encompass all outpatient treatment for physical, occupational, speech, respiratory and audiological therapy regardless of where the services are provided. Additionally, specific medical necessity criteria were incorporated into the Outpatient Specialized Therapies medical coverage policy.

"Medically Necessary" Replaces "Dispense as Written"

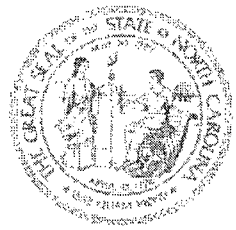
Effective January 1, 2003, the words "medically necessary" written on a prescription were required to dispense a trade or brand name drug, except for antipsychotic drugs and drugs listed in the narrow therapeutic index.

Mental Health Services for HMO Enrollees Provided by Direct-Enrolled Mental Health Providers

Beginning with dates of service on or after February 1, 2003, direct-enrolled mental health providers were allowed to bill Medicaid for services rendered to HMO-enrolled recipients without a referral from the Area Mental Health Authority.

Note: For a brief history of the NC Medicaid Program and a year-by-year record of program and policy changes over the years, please go to the following website:
http://www.dhhs.state.nc.us/dma/publications.htm

Populations, Services and Expenditures



Populations and Eligibility Groups

The estimated population in North Carolina during SFY 2003 was 8,323,375. A total of 1,447,283 North Carolinians, or 17 percent of the total population, were eligible for Medicaid coverage at some time during the year. The monthly average number of eligibles was 1,047,444 or roughly one out of eight people. The number of recipients (i.e., those eligibles who actually received Medicaid services of any kind at some point in the fiscal year) was 1,454,661. This figure is slightly larger than the total number of eligibles because it counts some recipients who were eligible in SFY 2002 for whom claims were paid during SFY 2003. Compared with SFY 2002, the state population rose by 1.7 percent, the number of

Exhibit 1
NC Medicaid Average Monthly Eligibles by Eligibility Group - SFY 2003

Eligibility Group	Number of Eligibles	% of Total Eligibles
Pregnant Women & Children	352,101	33.6%
AFDC-related	339,210	32.4%
Disabled	192,306	18.4%
Aged	127,260	12.1%
Qualified Medicare Beneficiaries	34,040	3.2%
Blind	2,054	0.2%
Aliens & Refugees	473	0.0%
Total	**1,047,444**	**100.0%**

As indicated in **Exhibit 1** above, the largest category of eligibles during SFY 2003 was Pregnant Women and Children with a monthly average of 352,101 individuals, or about 34 percent of total eligibles. The Aid to Families with Dependent Children (AFDC) category was next in size with 339,210 individuals, or about 32 percent of the total eligibles. The AFDC category includes families with children who would have met eligibility criteria for the former AFDC program as of July 1996. As **Exhibit 2** on the next page shows, the AFDC-related population experienced the largest increase of enrollees of 26,691, or 8.5 percent. As was the case during SFY 2002, this relatively large increase was due primarily to the worsening of the economy and an unemployment rate in excess of 6 percent, resulting in a larger number of families qualifying for Medicaid. The Disabled category increased only modestly during SFY 2003 at 6,565, or 3.5 percent, while both the Aged and Blind categories experienced slight decreases.

Exhibit 2

Change in NC Medicaid Average Monthly Eligibles by Eligibility Group
SFY 2002 vs. 2003

Eligibility Group	SFY 2003 Eligibles	Amount of Change	% Change
AFDC-related	339,210	26,691	8.5%
Pregnant Women & Children	352,101	22,467	6.8%
Disabled	192,306	6,565	3.5%
Qualified Medicare Beneficiaries	34,040	2,639	8.4%
Aliens & Refugees	473	193	68.9%
Blind	2,054	(70)	-3.3%
Aged	127,260	(904)	-0.7%
Total	**1,047,444**	**57,581**	**5.8%**

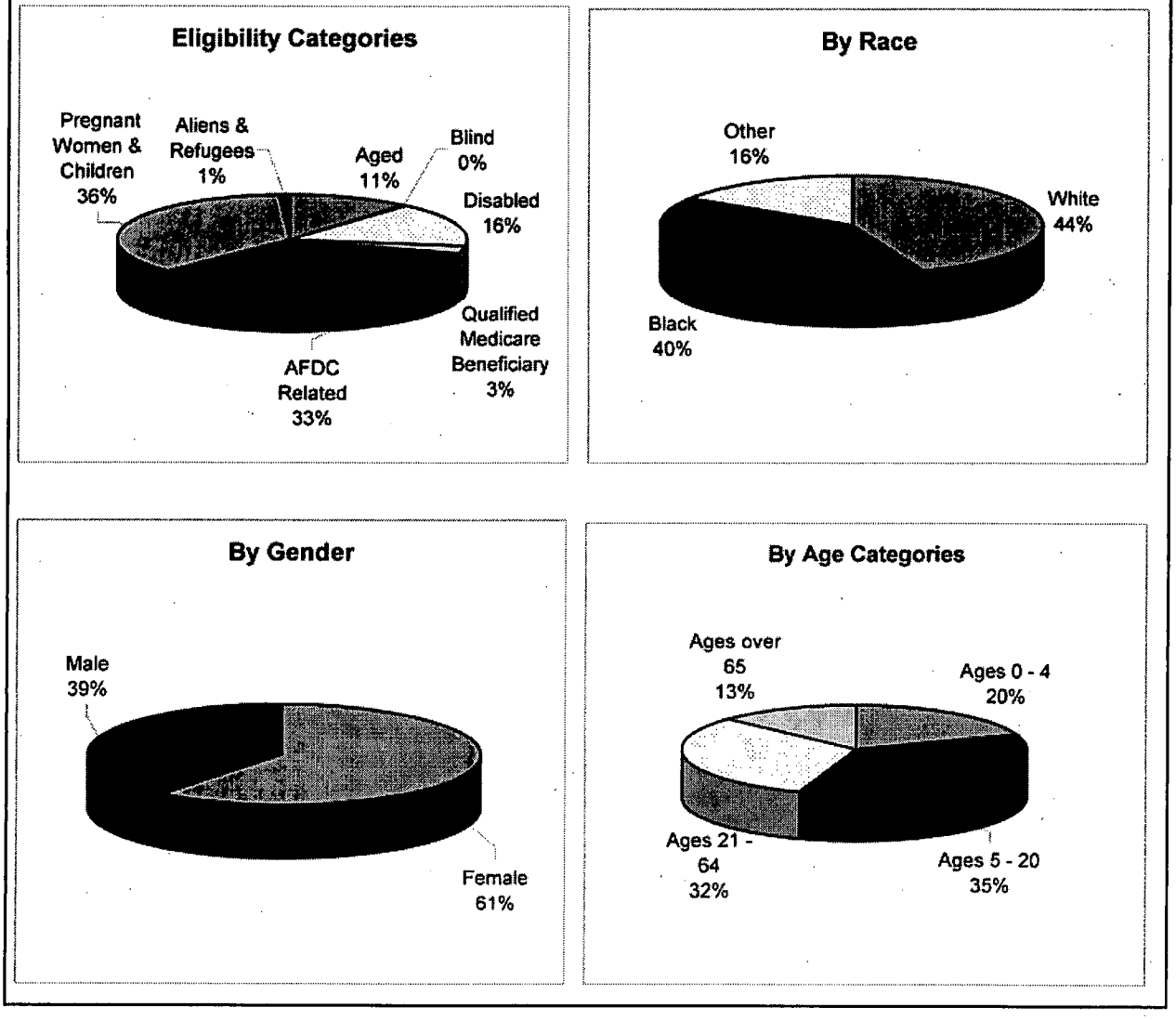
Exhibit 3 on the next page shows the distribution and some of the characteristics of recipients of Medicaid services. The percentage of recipients in each program category approximates the distribution of eligibles shown in **Exhibit 1,** but it varies somewhat because not all eligibles actually become recipients of one or more services in a given year. For instance, Pregnant Women and Children were the largest recipient group and represented almost 36 percent of Medicaid recipients, while they constituted 34 percent of Medicaid eligibles. Forty-four percent of recipients were white, 40 percent were black, and the remaining 16 percent were of other races. A total of 61 percent of recipients were female and 39 percent male. When Medicaid recipients are grouped by age, children ages 5 to 20 constitute the largest group at 35 percent, while adults aged 21 to 64 are the second largest group, followed by young children from birth to 4 (20 percent) and the elderly, ages 65 and older, at 13 percent.

Services and Expenditures

With the continuing stagnation in the national and North Carolina economies, SFY 2003 was an extremely challenging budget year for State government. On the heels of a 2001-02 revenue shortfall exceeding $1.5 billion, which Governor Easley addressed through end-of-year emergency spending cuts, the N.C. Legislature faced an estimated 2002-03 revenue shortfall of $1.6 billion as it passed the final SFY 2003 budget. The final outcome was the passage of a budget that included State appropriations for the NC Medicaid Program in the amount of approximately $2.2 billion. This was a reduction of approximately $35.5 million in the amount that was initially set aside for SFY 2003 in the 2001-03 biennium budget.

The SFY 2003 Medicaid budget included various funding increases and reductions as mentioned above in the "Policy and Program Changes" section. It is noteworthy that in spite of the adverse financial climate, the NC Medicaid program was able to avoid massive reductions in its medical benefit package and, therefore, in related service expenditures; nor were cost savings achieved through restrictions in program eligibility except for the relatively small changes related to assets mentioned in the "Policy and Program Changes" section above. During SFY 2003, many states resorted to applying drastic restrictions in the "optional" eligible population in order to balance their budgets. Such was not the case in North Carolina.

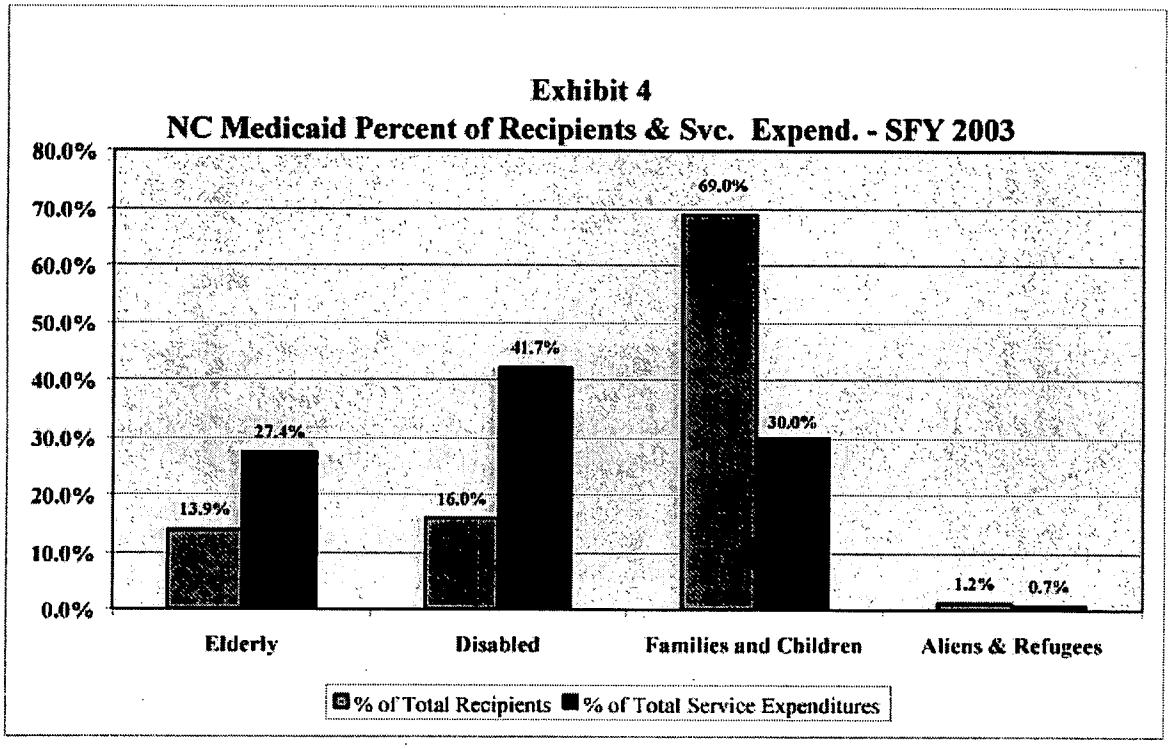
Exhibit 3
NC Medicaid Recipients of Medicaid Services - SFY 2003



As indicated in **Tables 6 and 10** (see the "Medicaid Tables" section at the back of this report), a total of approximately $6.6 billion was spent on health services and premiums for 1,454,661 Medicaid recipients, or $4,530 per recipient during the year. While total service and premium expenditures increased by 6.7 percent, the per recipient increase was a very modest 2.8 percent over SFY 2002. **Exhibits 4** below and **Exhibit 5** on the next page show that Elderly and Disabled recipients numbered 13.9 percent and 16 percent of total recipients respectively. Yet, service expenditures for these two groups amounted to approximately $4.6 billion, or 69.6 percent. These two groups received more services and services that were more expensive per unit than any other group. Recipients from the Families and Children group, on the other hand, represented 69 percent of all recipients, however they accounted for approximately $2 billion, only 30 percent, of total service expenditures. **Exhibit 6** on the next page shows that per recipient expenditures for each of the recipient groups increased between SFY 2002 and SFY 2003 with the exception of Aliens & Refugees, which realized a 2.7 percent decrease.

Exhibit 4

NC Medicaid Percent of Recipients & Svc. Expend. - SFY 2003



As **Table 6 and 7** indicate (again, see "Medicaid Tables"), the grand total of Medicaid and Medicaid-related expenditures in SFY 2003 was $7,439,757,929, an increase of only 1% over SFY 2002. Of this amount, $6,589,067,833 was spent on direct health care services to Medicaid recipients as mentioned above. The balance of approximately $850 million in expenditures was allocated to a variety of categories including adjustments, cost settlements, disproportionate share hospital payments, transfers and State and county administration. Lower expenditures for these items in SFY 2003 offset the 6.7% increase in service and premium expenditures, thus, resulting in the 1 percent increase in the grand total of

Exhibit 5
NC Medicaid Expenditures by Recipient Groups - SFY 2003
(in $ Millions)

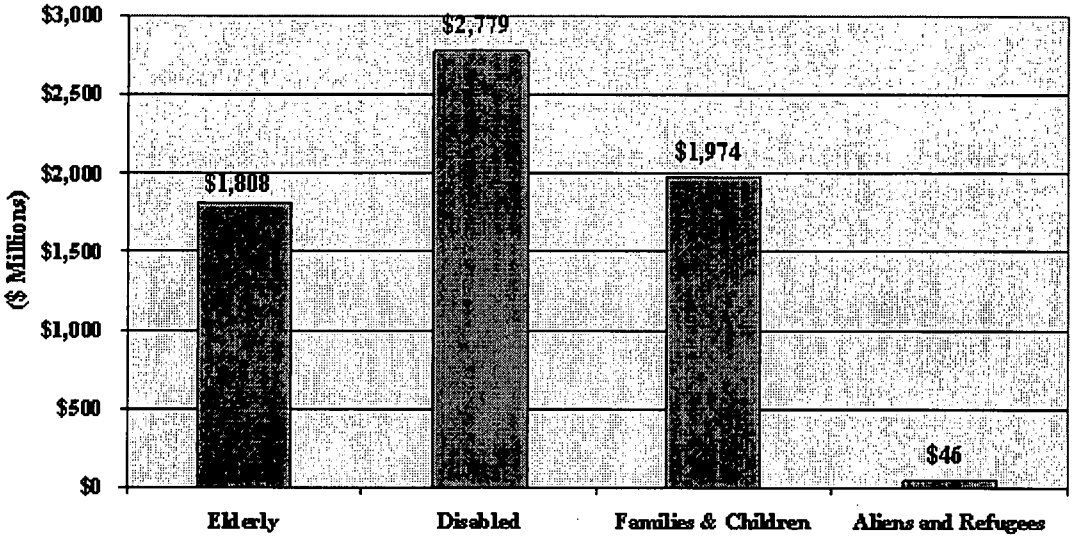
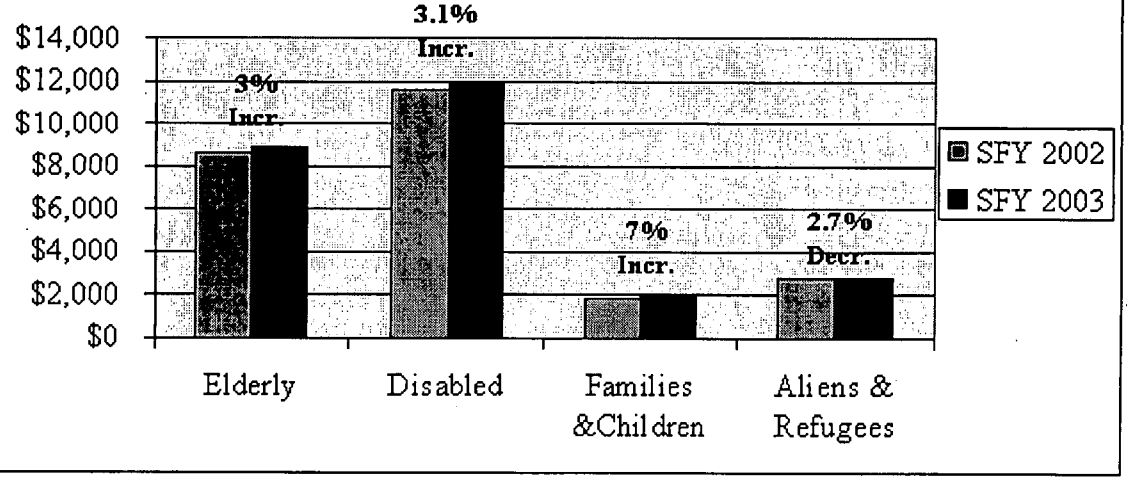


Exhibit 6
NC Medicaid Expenditures Per Recipient
SFY 2002 vs. 2003



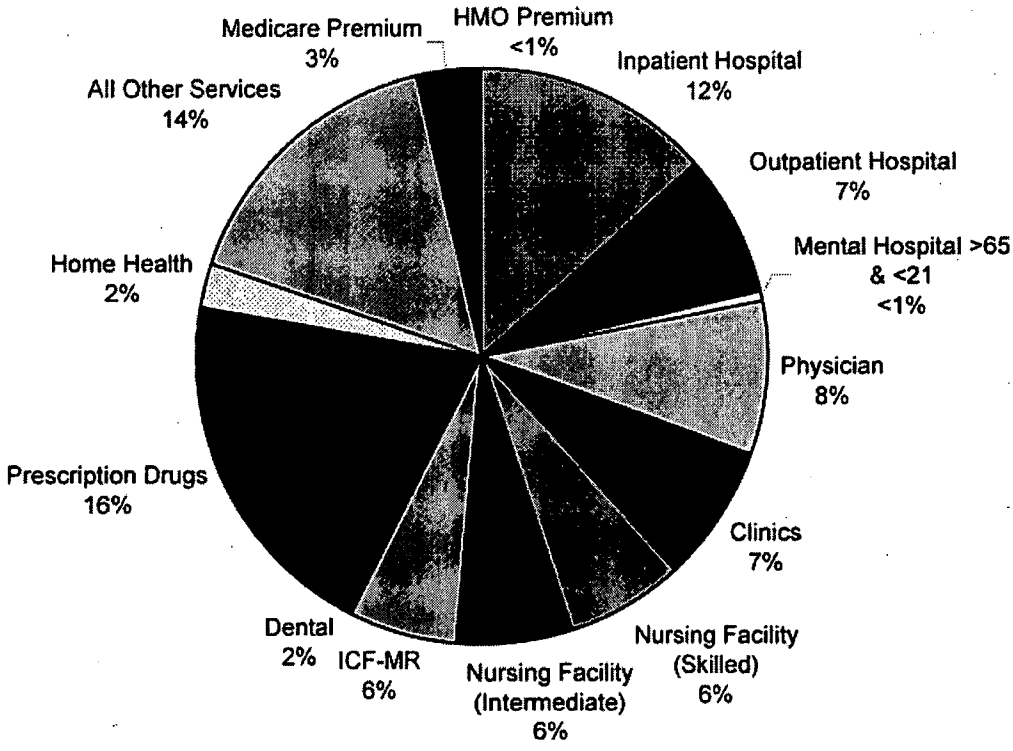
expenditures. DMA spent approximately $310 million or 4.2 percent of total SFY 2003 expenditures on administration. This is a relatively modest amount when compared with Medicaid programs in the other 49 states (source: Federal Fiscal Year 2001 CMS 64 Report; the most recent comparative data). Of all Medicaid services provided, the Prescription Drug service category was the most expensive, at roughly $1.2 billion, or 16.2 percent of all service expenditures as shown in **Table 6** and **Exhibits 7 below and 8** on the next page. This was an increase of roughly $147 million, or 14 percent, over the previous fiscal year. Approximately 51 percent of the increased expenditure was due to the change in the average monthly number of recipients. A total of 35 percent of the Prescription Drug expenditure increase was due to a change in the average amount paid per prescription, due in part to price increases and the type of drugs prescribed. The remaining 14 percent was due to an increase in the average number of prescriptions per recipient. Increased annual expenditures at 14 percent are compelling DMA to continue its intensive prescription drug cost containment efforts during SFY 2004 and beyond. Inpatient hospital services, the second highest category of service expenditures, accounted for approximately $843 million, or 11.8 percent, of total service expenditures. This was an increase of approximately $10 million, or 1.2 percent, mostly attributable to an increase in the number of individuals receiving this service. **Exhibit 7** gives a picture of the growth of DMA's service expenditures from SFY 2002 to SFY 2003, showing the highest categories of non-long term care expenditures, while grouping the long term care expenditures. It is worthwhile noting that while Total Services and Premiums expenditures grew by $411 million, or 6.7 percent, the non-long term care expenditures grew by 9.7 percent while long term care grew by only 1.2 percent.

Exhibit 7
NC Medicaid Highest Categories of Non-Long Term Care Expenditures
SFY 2002 vs. 2003
Sorted on Amount of Change

Category of Service	SFY 2003 Expenditures	Amount of Change	% Change
Prescription Drugs	$1,203,630,913	$147,472,163	14.0%
Outpatient Hospital - General	$339,777,292	$86,972,807	34.4%
Mental Health Clinics	$394,342,036	$79,164,556	25.1%
Outpatient Hospital - ER	$166,031,246	$44,341,161	36.4%
Dental	$129,089,384	$24,701,381	23.7%
Inpatient Hospital	$843,137,417	$9,848,155	1.2%
Physician	$571,538,736	($12,256,273)	-2.1%
Other Non-Long Care Term	$691,978,615	$4,034,051	0.6%
Total Non-Long Care Term	**$4,339,525,639**	**$384,278,001**	**9.7%**
Total Long-Term Care	$2,247,261,944	$26,599,360	1.2%
Total Services & Premiums	**$6,586,787,583**	**$410,877,362**	**6.7%**

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

Exhibit 8
NC MEDICAID SERVICE EXPENDITURES - SFY 2003



As indicated in **Table 10** and in **Exhibit 9**, overall health services costs per recipient rose slightly. The SFY 2003 total annual service expenditures for each recipient were $4,407, a modest 2.8 percent increase over the previous year. Among the service provider groups shown here, per recipient expenditures were the highest for Hospital services ($966 per recipient) and lowest for Medicare Part A and Part B premiums ($145 per recipient). Between SFY 2002 and 2003, the highest per recipient expenditure increase was 9.9 percent for Pharmacy and the largest decrease was 4.8 percent for Institutional services (i.e., non-behavioral health skilled nursing and intermediate care facilities).

As **Exhibit 10** on the next page indicates, approximately 88 percent of North Carolina's Medicaid recipients received services from a physician at least once during SFY 2003

Exhibit 9
NC Medicaid Expenditures Per Recipient - SFY 2003
All Eligibles by Service Provider Group

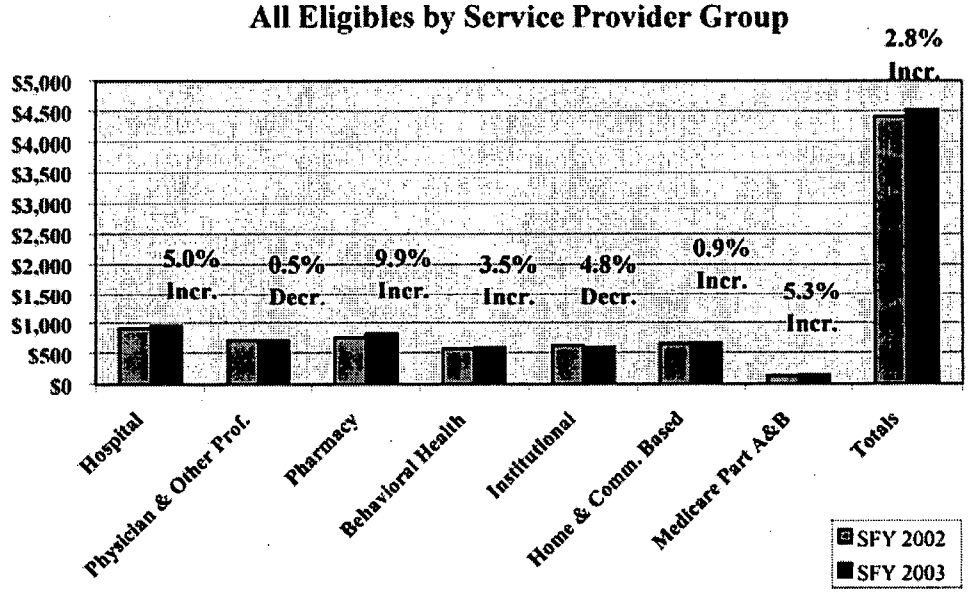
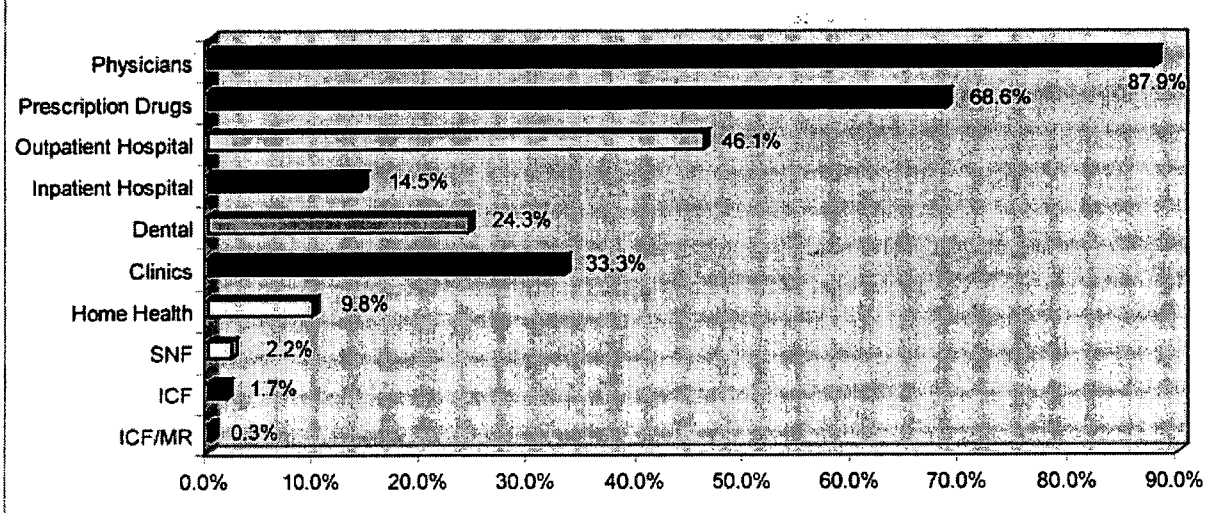


Exhibit 10
State Fiscal Year 2003
Selected Medicaid Services
Percent of Total Users



and 69 percent received at least one prescribed drug. The utilization rate falls off dramatically for other service providers.

Medicaid eligibility and expenditures vary widely among the 100 North Carolina counties, as **Table 9** in the "Medicaid Table" section indicates. The percentage of Medicaid eligibles in the general population is as high as 34 percent in Robeson County and as low as 8.4 percent in Orange County. Expenditures per eligible ranged from a high of $5,889 in Avery County to a low of $3,529 in Cumberland County. Lastly, expenditures per capita were the highest in Bertie County at $1,659 and the lowest in Wake County at $424.

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

Major Accomplishments

Settlement of the Medicaid Dental Lawsuit

In November 2000, a class action lawsuit entitled *McCree et al v. Odom et al* was filed against DMA. The lawsuit focused on improving access to dental care for children (under age 21) enrolled in the NC Medicaid program. In January 2003, the plaintiffs and defendants agreed to a settlement of the lawsuit and on March 6, 2003, Federal District Court Judge Malcolm Howard approved a contingent settlement. The main element of the settlement was an increase in reimbursement rates for 36 dental procedures selected to benefit children. The agreed-upon rates were set at 73 percent of the corresponding UNC-CH Dental Faculty Practice fees current at that time. The original rate increases went into effect on April 1, 2003. Subsequently, the plaintiffs and defendants agreed to several minor modifications of these rates. It is important to note that these increased rates apply to Medicaid recipients of any age for whom the listed procedures are applicable. So it is hoped that this settlement will improve access for adults as well as children.

Even at current levels of access, these new rates have been projected to increase Medicaid dental expenditures by $18.5 million on an annualized basis. This represents an approximately 14 percent increase in Medicaid dental expenditures based on actual spending of $129 million for the 2002-03 state fiscal year.

A second important element of the lawsuit settlement is the establishment of a Medicaid Dental Advisory Committee under the auspices of the NC Physicians Advisory Group (NC PAG). The NC PAG is a non-profit organization of health care providers that the NC General Assembly has charged to provide policy guidance to DMA. Dr. Jasper L. Lewis, Jr. of Greenville has been appointed to serve as the first dentist on the NC PAG Board of Directors. Dr. Cindy Bolton of Reidsville, a member of the North Carolina Dental Society Board of Trustees, has been nominated to chair the Dental Advisory Committee.

Program Integrity Collections and Cost Avoidance

A total of $1,329,538,709 was saved in the NC Medicaid Program through collections and cost avoidance in SFY 2003. The DMA Program Integrity Section worked cooperatively with the Attorney General's Medicaid Investigation Unit, and the 100 county departments of social services to achieve these savings. Recoveries and cost avoidance savings were accomplished through reviews of provider billings and medical records, coordination with other insurers and payers where Medicaid was not the primary payer, through estate recovery, and through legal and civil actions cooperatively with State and local law enforcement. DMA Financial Operations, Audit Section staff also audited provider's financial records.

- Program Integrity's Third Party Recovery Section cost avoided Medicaid payments of $1,026,280,066 for Medicare claims and $214,975,840 for private health insurance.

- Direct recoveries, resulting from casualty, medical insurance and estates, increased to $47 million.
- Program Integrity's four investigative units resulted in the recovery of $11,268,920 in overpayments billed by providers.
- The Attorney General's Medicaid Investigations Unit (MIU) collected $14,000,000 in restitution, fines, penalties, and interest when they concluded criminal and civil cases. Money from the fines went to the State's School Fund as required by the NC Constitution. The MIU also had 31 convictions. PI nursing staff act as consultants to the AGO in many of these cases.
- Recipient fraud investigators in the local departments of social services recovered $1,683,700.98 in overpayments. The State helped the county investigators collect $106,801.45 by intercepting North Carolina income tax refund checks from delinquent debtors.
- Financial Operations auditors recovered $14,330,182 through audits of nursing home and ICF/MR facilities.
- The state continues to have a 99.3 percent accuracy rate in Medicaid eligibility determinations. Program Integrity's Medicaid Eligibility Quality Assurance Unit reviews a sample of all Medicaid cases statewide and provides helpful feedback for corrective action to the county agencies.

The Program Integrity Section operates one of the more unique fraud and abuse detection software systems in the country. Only a handful of states utilize the technology similar to that used by DMA. The accomplishments listed above were made possible through the use of increased automation and effort on the part of staff. The average return per employee is over $1 million.

Program Integrity also assists the Office of State Auditor in determining the Medicaid program accuracy rates for claims billed by providers to Medicaid (see **Exhibit 11**).

Exhibit 11
NC Medicaid - SFY 2003
Annual Error Rates for Claims Billed to Medicaid

	# Of Claims in Sample	Error Rate per OSA	Confidence Level	Sampling Precision
1995-96	283	0.50%	95%	-0.04
1996-97	282	2.20%	95%	-0.04
1997-98	279	1.10%	95%	-0.04
1998-99	274	2.20%	95%	-0.04
1999-00	300	1.50%	95%	-0.04
2000-01	300	0.80%	95%	-0.04
2001-02	270	2.80%	95%	-0.04
2002-03	272	1.80%	95%	-0.04

Medicaid Payment Accuracy Measurement Demonstration Project

DMA Program Integrity received a grant from the Centers for Medicare and Medicaid Services (CMS) to participate in a Medicaid Payment Accuracy Measurement (PAM) demonstration project. The goal of the project is to help CMS determine the feasibility of estimating Medicaid claim payment accuracy for the Medicaid program at the state and national level. This is an effort supported by the U.S. House of Representatives (HR 4878) and the Office of Inspector General (OIG). This was Program Integrity's second PAM grant year. Year three has already been approved for this coming federal fiscal year.

An essential part of this project consists of a review of a stratified sample of Medicaid claims and a review of the corresponding medical records. Program Integrity staff and Medical Review of North Carolina will contact providers whose claims fall in the sample to obtain medical records for the services billed to Medicaid. Samples will be taken from inpatient hospital services, long-term care services, independent practitioners and clinics, prescription drugs, home- and community-based services, and other supplies and services.

Pharmacy

The NC Physician Advisory Group (PAG) and the leadership of the Community Care Program (ACCESS II/III) have partnered with NC Medicaid to further evaluate the pharmacy program and recommend strategies to control costs while maintaining our focus on quality of care for our recipients. When reviewing pharmacy expenditures, we found: (1) the top 15-16 therapeutic drug classes of medications by cost account for almost 60 percent of the total pharmacy cost expenditures, (2) there are opportunities for educating prescribers on the actual drug costs to NC Medicaid program and (3) it would be timely to request "voluntary" help from all of our prescriber community to prescribe less expensive medications whenever appropriate. From the above philosophy, the Prescription Advantage List (PAL) was developed first as a pilot and then for statewide implementation. The PAL list can be found at www.dhhs.state.nc.us/dma/prov.htm under the "Pharmacy" heading. Another initiative that arose from the PAL was the PAG Pharmacy Committee recommendation to DMA to allow coverage for selected OTC medications under a well written policy, which can be located at www.dhhs.state.nc.us/dma/mp/mpindex.htm under A2 OTC. The criteria for coverage are:

- A legend drug is approved by FDA as an OTC drug and, if covered by Medicaid, the cost of the OTC version would result in significant cost savings to Medicaid.
- An efficacious drug is available only as OTC and not legend, and all other legend treatments are significantly (>20 percent) more expensive without a significant increase in effectiveness.
- Coverage for an OTC or a group of OTCs expands treatment options because they have been shown to decrease the total cost of care for certain conditions.

In addition to costs, providers have stated they would like an up-to-date evidenced-based review of literature regarding drug therapy and difference among medications within each class of medication (clinical pearls). North Carolina has partnered with Oregon and currently nine other states to contract with Evidenced-Based Practice Centers (EPCs) to perform comprehensive reviews of selected classes of medications. The full reviews will be made available to NC providers on the Internet. The PAG Pharmacy Committee will be asked to develop key clinical pearls for inclusion in future PAL updates. By providing our NC providers with relative cost and current evidence-based information regarding medications, they will have available the necessary tools to make the best clinically sound, cost-effective choice for their patients.

HIPAA Project

The primary accomplishments of the Health Information Portability and Accountability Act (HIPAA) project during SFY 2003 were in the areas of the business review of transaction and code sets and the subsequent technical development and testing of these requirements. There was an on-going analysis and research effort for HIPAA code conversions culminating in the processing of 23 code conversion requests to EDS, our claims processing contractor. DMA staff training sessions relating to the HIPAA privacy requirements were conducted such that we met the April 16, 2003 deadline. Both code conversion and training have now become an on-going effort.

In addition to the work on HIPAA transactions, other accomplishments were made in several related areas. The cross-walk of Explanation of Benefits (EOB) codes to the HIPAA national codes was completed and loaded to the MMIS + Browser to support the use of the new "835" electronic remittance advice. DMA uses the 835 to respond to a provider's submission of an "837" electronic claim (the 837 replaces the old HCFA 1500 claim form). A draft of the Trading Partner Agreement was submitted for review. The Recipient and Provider Services section continued to receive and process HIPAA questionnaires. Frequently asked questions (FAQ) were published on the DMA HIPAA web site. Education sessions for the provider community were also conducted during the year.

Highlights of Carolina ACCESS Provider Satisfaction Survey

In March through May of 2002, the Division of Medical Assistance (DMA) Managed Care Section conducted a Provider Satisfaction Survey using a random sample of participating Carolina ACCESS primary care providers. The purpose of this survey was twofold: To measure provider satisfaction for submission with the 1915(b) Managed Care waiver renewal and to strengthen the program by identifying potential educational opportunities.

The state is divided into six geographical regions, each region is assigned a Managed Care consultant. The six regional Managed Care Consultants administered the survey by telephone or by office visit. The survey was designed to measure five areas of satisfaction: overall satisfaction with Carolina ACCESS, satisfaction with the referral process, satisfaction with billing/claims, satisfaction with administrative support and education and satisfaction with recipient education.

The results of the survey indicate that overall, the Carolina ACCESS program is meeting its goal of ensuring provider satisfaction. Provider comments and suggestions for improvement have been reviewed to identify strengths and possible areas for improvement within the Carolina ACCESS program. The Managed Care Section will develop policies and strategies to address the provider issues identified in the survey.

Highlights of Carolina ACCESS Contractual Compliance Survey

In the spring of 2002, the Managed Care Section conducted a Contractual Compliance Survey using a random sample of participating Carolina ACCESS primary care providers. The survey results indicate that the majority of providers are meeting their contractual requirements. The programmatic areas surveyed included coordination of care, appointment availability, access to medical advice, office hours, hospital admitting privileges, patient disenrollment and the Women, Infant, and Children Special Supplemental Nutrition Program (WIC). The survey supported DMA's efforts to provide quality care to Medicaid recipients.

Quality and Healthcare Outcome Improvements

The Quality Management (QM) Unit within DMA's Managed Care section continued efforts in quality improvement through initiatives regarding prenatal care, pediatric asthma, Health Check and immunization compliance, HEDIS and other utilization data reporting and follow up, children with ADHD, adults with congestive heart failure and the evaluation of the prescribing of unnecessary antibiotics. Results of completed studies and initiatives may be found under "Publications – Quality Management Initiatives" on the DMA web page at www.dhhs.state.nc.us/dma/ca/qm.htm.

HEDIS

The QM Unit, in conjunction with DMA Information Systems staff, utilized the Health Plan Employer Data and Information Set (HEDIS) to measure and evaluate the quality of care and delivery of services to Medicaid beneficiaries in all systems of care within the Community Care Program (Carolina ACCESS, ACCESS II/III and HMOs) and provide a basis for setting quality standards for ongoing performance.

The analysis for HEDIS CY 2002 data (reporting year 2003) was completed and showed similar results to the HEDIS CY 2001 (reporting year 2002) in the areas of children's

access to primary care practitioners and breast and cervical cancer screenings. There were noted increases in the areas of childhood immunizations (61.16 percent during SFY 2002, up from 58.27 percent in SFY 2001) and diabetic HbA1c testing (31.34 percent during SFY 2002 vs. 27.09 percent in SFY 2001). These increases could be attributed to interventions undertaken by the DMA Managed Care QM Section in these two areas. Re-measures in the future will further confirm the impact of these strategies to improve diabetic care and improve the immunization rate for children. Areas noted for improvement are adolescent immunization rates, which fell below the NCQA Medicaid Mean in all systems of care and prenatal care in the first trimester. The QM Section continues to work collaboratively with the Health Check Program and the Division of Maternal and Child Health to improve the care for these populations. Additionally, the rates for appropriate medications for persons with asthma fell slightly from SFY 2001 data in the three age groups (age 5-9, age 10-17 and age 18-56) by 2.87 percent to 7.92 percent. The QM Section anticipates that these numbers will be improved across all systems of care as strategies are implemented across the state to educate physicians, patients and families with standardized asthma action plans (see "Pediatric Asthma" below). The SFY 2002 HEDIS data indicates a rise in Emergency Department visits (60 visits per 1000 member months as compared to 42.3 visits per 1000 member months during SFY 2001). This increase can be attributed, in part, to the Balanced Budget Act requirement for emergency services. The QM Unit will develop strategies to address this issue through the development of a medical home collaborative in conjunction with the NC Children's Health Initiative Group through UNC-CH. The collaborative will involve educating physicians in the medical home model who in turn will educate patients enrolled in their practice. Physicians are also being encouraged to expand offices hours and provide flexible scheduling to increase access to primary care after normal office hours.

Pediatric Asthma

In an effort to spread asthma quality improvement initiatives across the state, Managed Care staff are working with the North Carolina Center for Children's Healthcare Improvement (formerly known as the Children's Primary Care Research Group or CPCRG) and the National Initiative for Children's Healthcare Quality (NICHQ) to develop and implement site visit tools and protocols to support practice level quality improvement activities for Carolina ACCESS primary care providers. Currently, this project is in test phase for implementation during SFY 2004.

ADHD Collaborative

A learning collaborative focusing on children with Attention Deficit Hyperactivity Disorder was completed during SFY 2003 in cooperation with NCCHI and NICHQ. This collaborative involved approximately 20 North Carolina ACCESS and ACCESS II/III practices with the specific objectives of early identification, diagnosis, appropriate medication and psychotherapeutic intervention, patient and family education and support, and community collaboration particularly with the school systems. Collaborative data indicated improvement in the following process and outcomes measures:

- Percent of patients with the benefits and risks of treatment options explained increased from 45 percent at baseline to 84 percent.

- Percent of patients with a structured diagnostic assessment in the chart from 41 percent at baseline to 75 percent.
- Percent of patients with a written care plan in the chart from 53% at baseline to 91 percent.
- Percent of patients with identified goals documented on their care plan from 38 percent at baseline to 60 percent.
- Percent of patients who maintain an acceptable level or improve functioning by 25 percent or more from 15 percent at baseline to 51 percent.
- Percent of patients who maintain an acceptable symptoms score or improve symptoms score by 25 percent or more from 25 percent at baseline to 56 percent.

Collaborative follow up activities with the NC Department of Public Instruction are scheduled for implementation during SFY 2004.

Congestive Heart Failure

A baseline study on congestive heart failure was completed in early 2001 in conjunction with a national project undertaken by Medical Review of North Carolina, Inc. (MRNC). Quality interventions that were implemented include a medical record flow sheet which was mailed to all physicians for use in care management and a brochure providing disease specific information which was mailed to CHF patients. MRNC completed the second phase of data abstraction to evaluate effectiveness of these interventions. The May 2003 report indicated sustained improvement in assessment of heart function and the use of appropriate medications for the treatment of CHF. The use of patient education materials and practice support were noted to be effective tools for quality improvement.

Utilization Reporting

The Quarterly Utilization Review Report is distributed to Community Care Program (except HMOs) providers to allow a comparison of an individual provider's utilization of services to recipients to the provider's peer group. QM staff, in conjunction with Managed Care Program Operations staff, has implemented a process to identify providers that may benefit from a site visit and medical record review to assess access to care and other quality indicators for improvement opportunities.

Antimicrobial Resistance

North Carolina and the Southeastern United States have among the highest antimicrobial resistance rates for common respiratory tract pathogens in the nation. The excessive use of antibiotics for common outpatient infections is a major contributing factor in the emergence of antibiotic resistant bacteria. QM is participating in a study with Medical Review of North

Carolina (MRNC) to estimate the prevalence of oral antibiotic treatment for acutenonbacterial respiratory tract infections among the adult Medicaid recipients in North Carolina and to promote a pilot project aimed at reducing the prevalence of oral antibiotic treatment among this population. In SFY 2002, an initial measure using paid claims data revealed that, overall, 63 percent of Medicaid recipients filled a prescription for a diagnosis for a nonbacterial respiratory tract infection. A total of 43,709 oral antibiotic prescriptions were filled. More than $1.5 million dollars was paid for these prescriptions. Several interventions have taken place including the administration of "cold kits" of symptom relief measures as a substitute for antibiotic prescriptions. Re-measurement of antibiotic use was completed in SFY 2003 and the report indicated that three of the four practices distributing cold and flu kits demonstrated substantial reduction in oral antibiotic use (-14 percent, -24 percent, -11 percent and +8 percent). The fourth practice indicated that the kits were lost during a move. The study concluded that while many organizations have introduced cold care kits, to our knowledge this is the first reported study of its kind and is highly suggestive that cold care kits may be of use in reducing antibiotic prescriptions. Larger studies are warranted to further assess the efficacy of this intervention and the effects on healthcare costs and on antibiotic resistance.

Prenatal Care

In an effort to improve the identification of cases of low birth weight and infant mortality and to reduce their rates, QM conducted a prenatal study of Medicaid Managed Care enrolled mothers who delivered in 1999. The report of this study was completed during SFY 2003 and included data on demographics, prenatal visits, documentation of prenatal care components, documentation of required tests, low birth weight and premature deliveries and the incidence of sexually transmitted diseases. The results of this study will serve as baseline information for the evaluation of future quality improvement strategies.

Health Check and Immunizations

During SFY 2003, a Health Check/Immunization/Medical Record study was completed in conjunction with Medical Review of North Carolina, Inc. and the North Carolina State Center for Health Statistics. The purpose of the study was to evaluate and compare compliance with the required components and schedules of preventive health visits (Health Check screenings) and immunizations throughout the Community Care Program. This data will be used in future quality initiatives to address identified areas for improvement.

The QM Unit completed the third and final year of participation in the Government Performance and Results Act (GPRA) national initiative to improve the rate of immunizations administered to 2-year-olds in the Medicaid program. The results of the calendar year 2002 HEDIS data showed an overall rate of 61.8 percent indicating improvement exceeding the targeted goal of 10 percent for the project.

Medicaid Tables

Table 1
North Carolina Medicaid
State Fiscal Year 2003
Federal Matching Rates

Benefit Costs
(7/1/02 - 9/30/02)

	Family Planning		All Other
Federal	90.00%	Federal	61.46%
State	8.50%	State	32.76%
County	1.50%	County	5.78%
			100.00%

Benefit Costs
(10/1/02 - 3/31/03)

	Family Planning		All Other
Federal	90.00%	Federal	62.56%
State	8.50%	State	31.82%
County	1.50%	County	5.62%

Benefit Costs
(04/1/03 - 6/30/03)

	Family Planning		All Other
Federal	90.00%	Federal	65.51%
State	8.50%	State	29.32%
County	1.50%	County	5.17%

Administrative Costs
(7/1/02 - 6/30/03)

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

***MMIS-Medicaid Management Information System**

Table 2a
North Carolina Medicaid
State Fiscal Year 2003
Medicaid Financial Eligibility Standards

GROUP	FAMILY SIZE:	1	2	3	4	5
Pregnant Women and Children under age 1	Income Limit:	$1,385/mo	$1,869/mo.	$2,353/mo.	$2,837/mo.	$3,321/mo.
	Resource Limit:	None				
Children age 1 through 5	Income Limit:	$996/mo.	$1,344/mo.	$1,692/mo.	$2,040/mo.	$2,388/mo.
	Resource Limit:	None				
Children age 6 through 18	Income Limit:	$749/mo.	$1,010/mo.	$1,272/mo.	$1,534/mo.	$1,795/mo.
	Resource Limit:	None				
Children age 19 and 20	Income Limit:	$362/mo.	$472/mo.	$544/mo.	$594/mo.	$648/mo.
	Resource Limit:	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Caretaker Relatives - Individuals (usually parents) who live with children under age 19 to whom they are related when one or both of the child's parents are out of the home, dead, incapacitated or working less than 100 hours a month.	Income Limit:	$362/mo.	$472/mo.	$544/mo.	$594/mo.	$648/mo.
	Resource Limit:	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Aged (over age 65), **Blind** or **Disabled** by Social Security standards.	Income Limit:	$749/mo.	$1,010/mo.			
	Resource Limit:	$ 2,000	$ 3,000			
Medicare Beneficiaries - Persons who have Medicare Part A -						
* Medicaid pays for Medicare premiums, deductibles, and co-payments.	Income Limit:	$749/mo.	$1,010/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
* Medicaid pays Medicare Part B premiums only.	Income Limit:	$898/mo.	$1,212/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
* Medicaid pays Medicare Part B premiums only (Federal share of payment is 100%).	Income Limit:	$1,011/mo.	$1,364/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
Deductible/Spendown - Individuals who do not meet the income limits specified above and who have high medical bills may be eligible for Medicaid after meeting a deductible.	The deductible is based on how much the monthly income exceeds this Resource Limit:	$242/mo.	$317/mo.	$367/mo.	$400/mo.	$433/mo.
	Families & Children	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
	Aged,Blind,Disabled	$ 2,000	$ 3,000			

Note: The Federal Poverty Level amounts change each year effective April. The above figures were in effect at the end of SFY 2003

Table2b
Financial Eligibility for Medicaid based on Percentage of Poverty (Annual) SFY 2003

Family Siz	100%	120%	133%	135%	185%	200%	SSI	MNIL	SA
1	$ 8,988	$10,776	$11,952	$12,012	$16,620	$17,964	$6,624	$2,904	$13,524
2	$12,120	$14,544	$16,128	$16,368	$22,428	$24,240	$9,948	$3,804	
3	$15,264		$20,304		$28,326	$30,528			
4	$18,408		$24,480		$34,044	$36,804			
5	$21,540		$28,656		$39,852	$43,080			

Note: The Federal Poverty Level amounts change each year effective April. The above figures were in effect at the end of SFY 2003

Table 3
North Carolina Medicaid
State Fiscal Year 2003
Enrolled Medicaid Providers

Providers	Number
Adult Care Home Providers	2,634
Ambulance Service Providers	407
Chiropractors	1,712
Community Alternatives Program Providers (CAP/C, CAP/AIDS, CAP/DD-MR, CAP/DA)	1,230
Dental Service Providers (Dentists, Oral Surgeons, Pedodontists, Orthodontists)	4,075
Durable Medical Equipment Suppliers	3,266
Health Maintenance Organizations (HMOs)	1
Hearing Aid Suppliers	196
Home Health Agency Providers (Home Infusion Therapy, Private Duty Nursing)	966
Hospice Agency Providers	79
Hospital Providers	888
Independent Laboratory Providers	201
Independent Practitioners (Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, Audiologists)	3,818
Local Education Agencies (LEAs)	105
Mental Health Program Providers	168
Mental Health Providers	3,026
Nursing Facility Providers	1,352
Optical Service Providers and Suppliers (Opticians, Optometrists)	1,880
Other Types of Clinics (Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers)	237
Personal Care Service Providers	793
Pharmacists	2,393
Physician Extenders (Nurse Midwives, Nurse Practitioners, Certified Registered Nurse Anesthetists)	2,326
Physicians	36,869
Podiatrists	513
Portable X-ray Service Providers	27
Psychiatric Facility Providers	551
Public Health Program Providers	616
Rural Health Clinic/Federally Qualified Health Center Providers	353
Total	**70,682**

Note: This is an unduplicated count of any provider enrolled during the year. Physicians may be counted individually and/or as a group. Includes 22,446 providers terminated by 6/30/2003

Table 4
North Carolina Medicaid
State Fiscal Year 2003
Medicaid Covered Services

1 Ambulance Transportation
2 Case Management for:
- Pregnant women
- High risk children (0-5)
- Chronically mentally ill adults
- Emotionally disturbed children
- Chronic substance abusers
- Adults & children at risk of abuse, neglect or exploitation
- Persons with HIV disease

3 Chiropractors
4 Clinic Services
5 Community Alternatives Programs (CAP)
6 Dental Care Services
7 Domicile Care
8 Durable Medical Equipment
9 Health Check Services (EPSDT)
10 Family Planning Services
11 Hearing Aids (for children)
12 HMO Membership
13 Home Health Services
14 Home Infusion Therapy Services
15 Hospice
16 Inpatient & Outpatient Hospital Services
17 Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
18 Laboratory & X-ray Services
19 Mental Hospitals (age 65 & over)
20 Migrant Health Clinics
21 Nurse Midwives
22 Nurse Practitioners
23 Nursing Facilities (NF)
24 Optical Supplies
25 Optometrists
26 Personal Care Services
27 Physical, Occupational and Speech Therapy
28 Physicians
29 Podiatrists
30 Prepaid Health Plan Services
31 Prescription Drugs
32 Private Duty Nursing Services
33 Prosthetics and Orthotics (children)
34 Rehabilitative Services: (under the auspices of area mental health programs)
35 Respiratory Therapy for Children
36 Rural Health Clinics
37 Specialty Hospitals
38 Transportation

Table 5
North Carolina Medicaid
State Fiscal Year 2002 & 2003
Sources of Medicaid Funds

	2002	Percent	2003	Percent
Federal	$ 4,262,533,647	57.87%	$ 4,477,523,570	60.18%
State*	$ 1,967,890,766	26.72%	$ 2,039,415,957	27.41%
Other State	$ 684,135,803	9.29%	$ 458,210,905	6.16%
County	$ 338,293,885	4.59%	$ 350,301,574	4.71%
Admin - Other DHHS Divisions	$ 96,678,025	1.31%	$ 95,494,421	1.28%
Admin - Non-DHHS State Agencies	$ 16,597,304	0.23%	$ 18,811,502	0.25%
Total	**$ 7,366,129,430**	**100.00%**	**$ 7,439,757,929**	**100.00%**

* State Appropriation of funds

Source: BD701, the Authorized Monthly Budget Report for the period ending June 29, 2003
Medicaid Cost Calculation Report, June 2003
NCAS

Table 6
North Carolina Medicaid
State Fiscal Year 2003
Uses of Medicaid Funds

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	$ 874,533,504	11.75%	13.27%	210,463	$ 4,155
Outpatient Hospital	538,024,825	7.23%	8.17%	670,519	802
Mental Hospital >65 & <21	32,781,633	0.44%	0.50%	2,561	12,793
Physician	572,206,549	7.69%	8.68%	1,278,204	448
Clinics	499,919,525	6.72%	7.59%	484,052	1,033
Nursing Facility (Skilled)	448,975,984	6.03%	6.81%	31,666	14,178
Nursing Facility (Intermediate)	419,208,704	5.63%	6.36%	25,027	16,750
ICF-MR	410,557,951	5.52%	6.23%	4,601	89,232
Dental	129,107,695	1.74%	1.96%	353,626	365
Prescription Drugs	1,203,809,178	16.18%	18.27%	998,701	1,205
Home Health	157,985,231	2.12%	2.40%	143,066	1,104
All Other Services	1,067,105,690	14.34%	16.20%	974,975	1,094
Subtotal, Services	**$ 6,354,196,467**	**85.41%**	**96.44%**		
Medicare Premiums:					
(Part A, Part B, QMB, Dually Eligible)	210,394,375	2.83%	3.19%	274,640	
HMO Premium	24,476,991	0.33%	0.37%	34,816	
Subtotal Services	**$ 6,589,067,833**	**88.57%**	**100.00%**	**1,454,661**	**$ 4,530**
Adjustments, Cost Settlements & Transfers	86,455,622	1.16%			
Disproportionate Share Payments**	340,835,304	4.58%			
Transfer to State Treasurer	108,510,735	1.46%			
Transportation-Program County Share	1,199,942	0.02%			
VR DSH Non-federal Share	3,420,366	0.05%			
Title XIX Program - All Dollars	**$ 7,129,489,802**	**95.83%**			
Title XIX Adminstration - All Dollars	310,268,127	4.17%			
Grand Total Medicaid Related Expenditures	**$ 7,439,757,929**	**100.00%**			
Total Recipients (unduplicated)* **				**1,454,661**	
Total Expenditures Per Recipient (unduplicated)					**$ 5,114**

* "Users of Services" is a duplicated count. Recipients using one or more services are counted in each service category.
** Additional payments for hospitals providing services to a higher than average number of Medicaid patients.
*** "Total Recipients" is unduplicated, counting recipients only once during the year regardless of the number or type of services they use. There were 230 unrecognized Medicaid recipients excluded from the total recipients for which the eligibility status could not be established when the claim was paid.

Note: Numbers may not add to the dollar due to rounding.
SOURCE: State 2082 Report -SFY 2003, PER Report YTD June 2003, BD701 Report June 2003, HCFA-64 quarterly reports covering SFY 2003, MCC Report June 2003 r

Note: "Users of Services" in "All Other Services" is obtained from the State History Table by taking an unduplicated count of the number of users.

Table 7
North Carolina Medicaid
A History of Medicaid Expenditures
SFYs 1979-2003

Fiscal Year	Expenditures	Percentage Change
1979	$ 379,769,848	N/A
1980	$ 410,053,625	8%
1981	$ 507,602,694	24%
1982	$ 521,462,961	3%
1983	$ 570,309,294	9%
1984	$ 657,763,927	15%
1985	$ 665,526,678	1%
1986	$ 758,115,890	14%
1987	$ 861,175,819	14%
1988	$ 983,464,113	14%
1989	$ 1,196,905,351	22%
1990	$ 1,427,672,567	19%
1991	$ 1,942,016,092	36%
1992	$ 2,478,709,587	28%
1993	$ 2,836,335,468	14%
1994	$ 3,550,099,377	25%
1995	$ 3,550,468,230	0%
1996	$ 4,113,344,777	16%
1997	$ 4,640,421,917	13%
1998	$ 4,715,733,033	2%
1999	$ 4,934,136,597	5%
2000	$ 5,789,133,085	17%
2001	$ 7,065,354,618	22%
2002	$ 7,366,129,429	4%
2003	$ 7,439,757,929	1%

Table 8
North Carolina Medicaid
State Fiscal Years 1979-2003
A History of Total Unduplicated Medicaid Eligibles

Fiscal Years	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Medicaid Pregnant Women Coverage	Medicaid Indigent Children Coverage	Other Children	Aliens and Refugees	Total	Percent Change
1978-79	82,930	N/A	3,219	59,187	301,218	N/A	N/A	6,620	N/A	453,174	-
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	N/A	455,702	0.56%
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	459,364	0.80%
1981-82	70,010	N/A	2,349	48,266	298,483	N/A	N/A	6,125	N/A	425,233	-7.43%
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	N/A	415,552	-2.28%
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	N/A	407,806	-1.86%
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	N/A	414,353	1.61%
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	N/A	441,930	6.68%
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	N/A	452,025	2.28%
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	N/A	481,326	6.48%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561	561,614	16.68%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	1,011	639,351	13.84%
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	1,675	753,292	17.82%
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	1,955	877,923	16.54%
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	2,437	992,697	13.07%
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	2,330	1,058,603	6.64%
1994-95	127,514	48,373	2,716	155,215	533,300	48,115	216,888	3,808	2,857	1,138,786	7.57%
1995-96	131,496	53,072	2,710	171,204	496,501	52,466	261,525	3,696	3,919	1,176,589	3.32%
1996-97	132,173	58,036	2,593	176,160	462,881	55,838	295,882	3,747	4,823	1,192,133	1.32%
1997-98	131,332	61,032	2,531	180,461	414,853	58,899	337,849	3,905	6,311	1,197,173	0.42%
1998-99	152,582	32,737	2,497	199,523	344,621	60,896	371,986	3,941	8,036	1,176,819	-1.70%
1999-00	154,222	33,302	2,428	205,205	330,113	60,918	421,158	4,063	9,857	1,221,266	3.78%
2000-01	154,284	36,053	2,357	212,798	450,472	57,318	424,436	4,195	12,680	1,354,593	10.92%
2001-02	153,282	39,799	2,334	221,813	456,232	53,009	444,299	4,737	14,523	1,390,028	2.62%
2002-03	151,672	41,030	2,226	228,159	478,842	51,111	474,557	4,881	14,805	1,447,283	4.12%
SFY 2002 Percent Total Eligibles:	11.0%	2.9%	0.2%	16.0%	32.8%	3.8%	32.0%	0.3%	1.0%	100.0%	
SFY 2003 Percent Total Eligibles:	10.5%	2.8%	0.2%	15.8%	33.1%	3.5%	32.8%	0.3%	1.0%	100.0%	

Source: Medicaid Eligibility Report, EJA752-SFY 2003

Table 9
North Carolina Medicaid
State Fiscal Year 2003
Eligibles and Program Payments for Which the County is Responsible for Its Computable Share*

COUNTY NAME	2002 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES**	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% OF MEDICAID ELIGIBLES BY COUNTY, BASED ON 2002 POPULATION
ALAMANCE	136,144	20,426	$ 93,701,732	$ 4,587	$ 688	79	150	15.00%
ALEXANDER	34,224	5,542	23,923,049	4,317	699	75	162	16.19%
ALLEGHANY	10,860	2,030	11,539,974	5,685	1,063	26	187	18.69%
ANSON	25,358	6,778	35,094,593	5,178	1,384	9	267	26.73%
ASHE	24,734	4,850	28,008,196	5,775	1,132	21	196	19.61%
AVERY	17,946	3,120	18,373,807	5,889	1,024	30	174	17.39%
BEAUFORT	45,672	10,781	56,691,681	5,258	1,241	16	236	23.61%
BERTIE	19,807	6,541	32,864,910	5,024	1,659	1	330	33.02%
BLADEN	32,656	10,005	48,890,356	4,887	1,497	5	306	30.64%
BRUNSWICK	79,054	15,533	65,762,821	4,234	832	59	196	19.65%
BUNCOMBE	210,550	34,942	172,167,405	4,927	818	61	166	16.60%
BURKE	89,354	16,095	79,556,589	4,943	890	48	180	18.01%
CABARRUS	140,176	19,996	86,000,764	4,301	614	91	143	14.26%
CALDWELL	78,234	14,079	66,285,844	4,708	847	52	180	18.00%
CAMDEN	7,328	999	5,098,429	5,104	696	77	136	13.63%
CARTERET	60,064	9,091	45,207,717	4,973	753	70	151	15.14%
CASWELL	23,718	4,640	21,948,254	4,730	925	44	196	19.56%
CATAWBA	146,548	23,178	92,498,626	3,991	631	87	158	15.82%
CHATHAM	52,582	6,774	32,659,157	4,821	621	90	129	12.88%
CHEROKEE	25,080	5,630	30,617,295	5,438	1,221	17	224	22.45%
CHOWAN	14,304	3,614	17,142,809	4,743	1,198	18	253	25.27%
CLAY	9,216	1,763	8,873,565	5,033	963	40	191	19.13%
CLEVELAND	97,271	21,106	98,088,834	4,647	1,008	33	217	21.70%
COLUMBUS	54,890	17,388	85,703,863	4,929	1,561	2	317	31.68%
CRAVEN	91,902	16,197	71,620,697	4,422	779	66	176	17.62%
CUMBERLAND	305,851	54,397	191,962,272	3,529	628	88	178	17.79%
CURRITUCK	19,632	2,615	10,032,625	3,837	511	94	133	13.32%
DARE	32,177	3,245	16,384,302	5,049	509	95	101	10.08%
DAVIDSON	150,799	23,878	98,191,706	4,112	651	82	158	15.83%
DAVIE	36,770	4,679	20,788,072	4,443	565	92	127	12.73%
DUPLIN	50,612	12,233	51,422,467	4,204	1,016	32	242	24.17%
DURHAM	233,548	35,153	173,049,084	4,923	741	72	151	15.05%
EDGECOMBE	54,945	17,484	68,753,627	3,932	1,251	15	318	31.82%
FORSYTH	314,853	47,194	202,125,578	4,283	642	84	150	14.99%
FRANKLIN	50,328	9,821	42,007,939	4,277	835	57	195	19.51%
GASTON	191,874	36,661	184,729,733	5,039	963	41	191	19.11%
GATES	10,708	1,947	8,734,574	4,486	816	62	182	18.18%
GRAHAM	8,030	2,247	12,484,152	5,556	1,555	3	280	27.98%
GRANVILLE	51,540	8,289	35,100,324	4,235	681	81	161	16.08%
GREENE	19,471	4,598	19,404,516	4,220	997	35	236	23.61%
GUILFORD	428,794	66,352	267,884,116	4,037	625	89	155	15.47%
HALIFAX	57,105	18,892	77,464,157	4,100	1,357	10	331	33.08%
HARNETT	96,152	19,400	76,077,815	3,922	791	65	202	20.18%
HAYWOOD	55,114	10,373	48,720,488	4,697	884	49	188	18.82%
HENDERSON	92,988	14,119	69,693,888	4,936	749	71	152	15.18%
HERTFORD	23,863	7,384	33,837,194	4,583	1,418	7	309	30.94%
HOKE	36,000	8,394	30,389,413	3,620	844	53	233	23.32%
HYDE	5,846	1,419	7,567,353	5,333	1,294	12	243	24.27%
IREDELL	130,362	19,025	82,634,016	4,343	634	86	146	14.59%
JACKSON	34,132	5,752	25,796,088	4,485	756	69	169	16.85%
JOHNSTON	132,660	23,796	97,306,659	4,089	734	73	179	17.94%
JONES	10,243	2,268	10,858,494	4,788	1,060	27	221	22.14%
LEE	49,810	10,068	39,910,944	3,964	801	64	202	20.21%
LENOIR	59,294	15,484	66,982,445	4,326	1,130	22	261	26.11%

Coninued

Table 9 (Cont.)
North Carolina Medicaid
State Fiscal Year 2003
Eligibles and Program Payments for Which the County is Responsible for its Computable Share*

COUNTY NAME	2003 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES**	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION	% OF MEDICAID ELIGIBLES BY COUNTY, BASED ON 2002 POPULATION
LINCOLN	66,598	10,028	46,393,121	4,626	697	76	151	15.06%
MACON	30,936	5,813	25,881,784	4,452	837	55	188	18.79%
MADISON	19,856	4,206	20,920,288	4,974	1,054	28	212	21.18%
MARTIN	25,082	6,823	34,823,824	5,104	1,388	8	272	27.20%
MCDOWELL	42,960	7,865	38,455,119	4,835	849	51	183	18.31%
MECKLENBURG	734,365	106,699	402,444,677	3,772	548	93	145	14.53%
MITCHELL	15,934	3,119	16,576,326	5,315	1,040	29	196	19.57%
MONTGOMERY	27,282	6,390	25,269,172	3,954	926	43	234	23.42%
MOORE	77,424	11,917	49,824,439	4,181	644	83	154	15.39%
NASH	89,185	18,227	78,067,679	4,283	875	50	204	20.44%
NEW HANOVER	166,072	25,520	128,263,277	5,026	772	68	154	15.37%
NORTHAMPTON	21,773	7,045	33,392,663	4,740	1,534	4	324	32.36%
ONSLOW	152,424	19,879	71,117,478	3,578	467	98	130	13.04%
ORANGE	119,746	10,098	57,054,740	5,650	476	97	84	8.43%
PAMLICO	13,024	2,642	13,281,721	5,027	1,020	31	203	20.29%
PASQUOTANK	35,816	8,440	35,700,807	4,230	997	34	236	23.56%
PENDER	43,135	8,345	36,346,309	4,355	843	54	193	19.35%
PERQUIMANS	11,607	2,633	10,540,651	4,003	908	46	227	22.68%
PERSON	36,764	6,944	35,875,128	5,166	976	38	189	18.89%
PITT	137,901	26,338	114,729,404	4,356	832	58	191	19.10%
POLK	18,866	2,439	13,115,225	5,377	695	78	129	12.93%
RANDOLPH	133,836	22,643	85,633,422	3,782	640	85	169	16.92%
RICHMOND	46,721	13,209	58,481,715	4,427	1,252	14	283	28.27%
ROBESON	125,206	42,622	180,558,193	4,236	1,442	6	340	34.04%
ROCKINGHAM	92,589	18,040	86,963,801	4,821	939	42	195	19.48%
ROWAN	132,921	22,798	94,210,540	4,132	709	74	172	17.15%
RUTHERFORD	63,345	13,679	58,162,831	4,252	918	45	216	21.59%
SAMPSON	61,768	15,983	69,215,419	4,331	1,121	23	259	25.88%
SCOTLAND	35,766	11,476	47,290,154	4,121	1,322	11	321	32.09%
STANLY	58,974	10,142	49,259,734	4,857	835	56	172	17.20%
STOKES	45,355	6,562	30,992,014	4,723	683	80	145	14.47%
SURRY	72,028	13,657	65,115,023	4,768	904	47	190	18.96%
SWAIN	13,287	3,395	14,567,400	4,291	1,096	25	256	25.55%
TRANSYLVANIA	29,400	4,870	22,889,308	4,700	779	67	166	16.56%
TYRRELL	4,170	956	4,655,963	4,870	1,117	24	229	22.93%
UNION	138,928	17,050	69,084,906	4,052	497	96	123	12.27%
VANCE	44,378	14,346	51,172,741	3,567	1,153	19	323	32.33%
WAKE	679,510	68,469	288,150,653	4,208	424	100	101	10.08%
WARREN	20,000	5,584	22,680,808	4,062	1,134	20	279	27.92%
WASHINGTON	13,600	4,133	17,458,676	4,224	1,284	13	304	30.39%
WATAUGA	42,892	3,745	20,009,369	5,343	467	99	87	8.73%
WAYNE	113,844	24,544	94,369,663	3,845	829	60	216	21.56%
WILKES	66,660	13,052	65,118,252	4,989	977	37	196	19.58%
WILSON	75,374	17,548	73,796,901	4,205	979	36	233	23.28%
YADKIN	36,958	5,567	29,634,023	5,323	802	63	151	15.06%
YANCEY	17,944	3,538	17,466,114	4,937	973	39	197	19.72%
STATE TOTAL	8,323,375	1,447,283	$ 6,301,626,561	$ 4,354	$ 757	N/A	174	17.39%

Source: Medicaid Cost Calculation Fiscal YTD June 2003.

Notes:

* Program payments do not include a total of approximately $502 million in Disproportionate Share Hospital for which there is no county share and all administration expenditures.

** Eligibles is a statewide unduplicated count indicating only eligibility in the last county of residence during the fiscal year

Table 10
North Carolina Medicaid
State Fiscal Year 2003
Medicaid Service Expenditures by Recipient Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 2003 Expenditures Per Recipient	SFY 2002 Expenditures Per Recipient	02/03 Percent Change
Total Elderly	**$ 1,807,717,487**	**27.4%**	**202,377**	**13.9%**	**$ 8,932**	**$ 8,671**	**3.0%**
Aged	1,780,878,696	27.0%	162,015	11.1%	10,992	11,086	-0.8%
Medicare-Aid (MQBQ & MQBB & MQBE)	26,838,791	0.4%	40,362	2.8%	665	454	46.4%
Total Disabled	**$ 2,779,255,514**	**42.2%**	**232,166**	**16.0%**	**$ 11,971**	**$ 11,606**	**3.1%**
Disabled	2,750,631,537	41.7%	229,900	15.8%	11,964	11,599	3.2%
Blind	28,623,976	0.4%	2,266	0.2%	12,632	12,294	2.7%
Total Families &Children	**$ 1,973,688,839**	**30.0%**	**1,003,271**	**69.0%**	**$ 1,967**	**$ 1,838**	**7.0%**
AFDC Adults (> 21)	559,308,156	8.5%	204,789	14.1%	2,731	2,491	9.7%
Medicaid Pregnant Women Coverage (MPW)	199,448,052	3.0%	51,889	3.6%	3,844	3,549	8.3%
AFDC Children & Other Children	511,206,017	7.8%	273,233	18.8%	1,871	1,699	10.1%
Medicaid Indigent Children (MIC)	701,446,363	10.6%	473,178	32.5%	1,482	1,417	4.6%
Breast and Cervical	2,280,250	0.0%	182	0.0%	12,529		
Aliens and Refugees	**$ 46,080,274**	**0.7%**	**16,847**	**1.2%**	**$ 2,735**	**$ 2,812**	**-2.7%**
Adjustments Not Attributable to a Specific Category	**$ (17,674,281)**	**-0.3%**					
Total Service Expenditures All Groups	**$ 6,589,067,833**	**100.0%**	**1,454,661**	**100.0%**	**$ 4,530**	**$ 4,407**	**2.8%**

Source: SFY 2003 Program Expenditure Report

Table 11
North Carolina Medicaid
State Fiscal Year 2003
Service Expenditures for Selected Major Medical Services by Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ* Medicaire Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Blind	Disabled	Other Adult**	Breast Cervical	Children***	Alien & Refugees	Adjustments Unattributable to a Specific Category
Inpatient Hospital	$ 874,533,504	13.3%	$ 19,159,016	$ 38,199	$ -	$ 1,831,369	$ 385,724,943	$ 203,821,956	$ 225,326	$ 237,269,155	$ 31,243,980	$ (4,780,450)
Outpatient Hospital	538,024,825	8.2%	34,939,624	114,406	519,939	1,276,835	200,167,849	153,130,520	1,109,155	147,227,607	2,006,212	(2,467,323)
Mental Hospital (> 65)	7,274,997	0.1%	7,262,458	840	-	-	16,740	-		-	-	(5,042)
Psychiatric Hospital (< 21)	25,488,637	0.4%	-	-	-	-	7,080,671	18,945	-	18,405,165	4,318	(22,462)
Physician	572,206,549	8.7%	29,457,183	80,439	232,100	1,156,850	169,798,726	159,205,471	667,813	204,833,285	10,156,101	(3,381,418)
Clinics	499,919,525	7.6%	10,008,226	24,518	41,055	1,038,268	234,799,554	45,860,419	12,751	211,010,466	1,389,770	(4,265,503)
Nursing Facility:												
Skilled Level	448,975,984	6.8%	377,718,999	-	-	1,401,685	69,866,151	239,616	-	58,586	68	(309,129)
Intermediate Level	419,208,704	6.4%	374,603,967	-	-	1,150,280	43,484,669	4,482	-	81,725	2,329	(118,747)
Intermediate Care Facility (Mentally Retarded)	410,557,951	6.2%	22,967,285	-	-	7,092,169	377,809,607	-	-	2,699,346	-	(10,457)
Dental	129,107,695	2.0%	7,479,483	13	-	185,378	23,627,717	25,465,417	18,311	72,272,466	376,565	(317,654)
Prescription Drugs	1,203,809,178	18.3%	360,507,356	-	-	4,135,509	569,595,501	107,395,229	178,264	142,073,303	196,580	(272,565)
Home Health	157,885,231	2.4%	32,474,383	8,978	75,616	953,386	105,013,270	7,965,231	35,297	11,945,040	36,217	(522,168)
CAP/Disabled Adult	184,618,681	2.8%	134,827,369	-	-	1,593,539	48,305,629	-	-	-	-	(107,856)
CAP/Mentally Retarded	259,748,740	3.9%	5,070,250	-	-	2,796,935	249,844,956	-	-	2,498,645	-	(464,046)
CAP/Children	24,027,668	0.4%	-	-	-	277,001	23,071,606	-	-	687,502	-	(8,440)
Personal Care	189,319,390	2.9%	120,690,426	-	-	1,710,230	64,713,508	1,769,829	8,460	538,410	2,043	(113,517)
Hospice	23,799,114	0.4%	13,437,202	-	-	170,949	9,925,921	222,985	4,753	58,114	-	(20,811)
EPSDT (Health Check)	44,468,613	0.7%	444	-	-	5,573	1,201,005	39,116	16	43,309,713	4,271	(71,524)
Lab & X-ray	25,730,285	0.4%	128,568	222	312	47,247	4,902,943	10,978,752	11,866	9,645,234	62,022	(46,880)
Adult Home Care	121,226,198	1.8%	71,922,335	-	-	344,676	48,972,888	13,642	-	15,457	-	(42,800)
High Risk Intervention												
Residential	78,164,707	1.2%	-	-	-	-	18,397,068	-	-	59,665,503	-	(97,864)
Other Services	115,984,294	1.8%	9,634,373	4,661	1,938	213,624	36,250,283	31,652,382	8,236	37,985,432	592,492	(359,128)
Total Services	**$ 6,354,196,467**	**96.4%**	**$ 1,652,288,930**	**$ 272,275**	**$ 870,961**	**$ 27,381,513**	**$ 2,692,671,206**	**$ 747,784,001**	**$ 2,280,260**	**$ 1,202,480,153**	**$ 46,072,965**	**$ (17,805,786)**
Medicare:												
Part A Premiums	41,487,836	0.6%	40,986,004	12,065	(319)	533,061	6,034	-	-	-	-	(49,009)
Part B Premiums	168,906,539	2.6%	87,603,562	449,560	25,234,249	677,494	54,464,353	287,775	-	6,671	2,198	180,677
HMO Premiums	24,476,991	0.4%	201	-	-	31,908	3,589,944	10,684,433	-	10,165,557	5,112	(164)
Total Premiums	**$ 234,871,366**	**3.6%**	**$ 128,589,767**	**$ 461,625**	**$ 25,233,930**	**$ 1,242,464**	**$ 58,060,331**	**$ 10,972,207**	**-**	**$ 10,172,227**	**$ 7,310**	**$ 131,505**
Grand Total Services and Premiums	**$ 6,589,067,833**		**$ 1,780,878,696**	**$ 733,900**	**$ 26,104,891**	**$ 28,623,976**	**$ 2,750,831,537**	**$ 758,756,209**		**$ 1,212,652,380**	**$ 46,080,274**	**$ (17,674,281)**

* Reflects expenditures for those who were eligible as QMBs (Medicare-covered services only) at the end of the year. As a result, expenditures include more services than are available through QMB coverage.

** Includes individuals covered under SOBRA Pregnant Women policies or individuals age 21 & over under TANF or AFDC-related coverage.

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

Note: Grand total expenditures do not include adjustments processed by DMA, settlements, disproportionate share costs and State and county administration costs and certified public funds in other agencies.

Note:you can get column I from PER by adding AFCD adult >21 with sobra pregnant women

NOTE: TOTAL SERVICE=SUM(VAR 10:VAR 30)
TOTAL PREMIUM=SUM(VAR33:VAR35)
GRAND TOTAL =SUM(VAR31,38)

Table 12
North Carolina Medicaid
State Fiscal Year 2003
Expenditures for the Elderly

Type of Service	Aged	Percent of Service Dollars	MQBQ Medicare Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Total Qualified Beneficieries	Percent of Service Dollars	Total Elderly Dollars	SFY 2003 % of Total Dollars	SFY 2002 % of Total Dollars	SFY 2001 % of Total Dollars
Inpatient Hospital	$ 19,159,016	1.1%	$ 38,199	$ -	$ 38,199	0.1%	$ 19,197,215	1.1%	1.1%	1.3%
Outpatient Hospital	34,939,624	2.0%	114,406	519,939	634,345	2.4%	35,573,969	2.0%	2.0%	1.8%
Mental Hospital (> 65)	7,262,458	0.4%	840	-	840	0.0%	7,263,298	0.4%	0.4%	0.7%
Physician	29,457,183	1.6%	80,439	232,100	312,539	1.2%	29,769,722	1.6%	1.6%	3.5%
Clinics	10,008,226	0.6%	24,518	41,055	65,573	0.2%	10,073,799	0.6%	0.6%	0.7%
Nursing Facility:										
Skilled Level	377,718,999	20.9%	-	-	-	0.0%	377,718,999	20.9%	20.9%	20.3%
Intermediate Level	374,603,967	20.7%	-	-	-	0.0%	374,603,967	20.7%	20.7%	23.4%
Intermediate Care Facility (Mentally Retarded)	22,967,285	1.3%	-	-	-	0.0%	22,967,285	1.3%	1.3%	1.2%
Dental	7,479,483	0.4%	13	-	13	0.0%	7,479,496	0.4%	0.4%	0.4%
Prescription Drugs	380,507,356	21.0%	-	-	-	0.0%	380,507,356	21.0%	21.0%	18.7%
Home Health	32,474,363	1.8%	8,978	75,616	84,594	0.3%	32,558,958	1.8%	1.8%	1.5%
CAP/Disabled Adult	134,827,369	7.5%	-	-	-	0.0%	134,827,369	7.5%	7.5%	8.7%
CAP/Mentally Retarded	5,070,250	0.3%	-	-	-	0.0%	5,070,250	0.3%	0.3%	0.3%
Personal Care	120,690,426	6.7%	-	-	-	0.0%	120,690,426	6.7%	6.7%	4.8%
Hospice	13,437,202	0.7%	-	-	-	0.0%	13,437,202	0.7%	0.7%	0.4%
EPSDT (Health Check)	444	0.0%	-	-	-	0.0%	444	0.0%	0.0%	0.0%
Lab & X-ray	128,568	0.0%	222	312	534	0.0%	129,101	0.0%	0.0%	0.0%
Adult Home Care	71,922,335	4.0%	-	-	-	0.0%	71,922,335	4.0%	4.0%	3.9%
High Risk Intervention Residential	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Other Services	9,634,373	0.5%	4,661	1,938	6,600	0.0%	9,640,972	0.5%	0.5%	0.7%
Total Services	**$ 1,652,288,930**	**91.5%**	**$ 272,275**	**$ 870,961**	**$ 1,143,236**	**4.3%**	**$ 1,653,432,166**	**91.5%**	**91.5%**	**92.2%**
Medicare:										
Part A Premiums	40,986,004	2.3%	12,065	(319)	11,746	0.0%	40,997,750	2.3%	2.3%	2.3%
Part B Premiums	87,603,562	6.3%	449,560	25,234,249	25,683,809	95.7%	113,287,371	6.3%	6.3%	5.5%
HMO Premiums	201	0.0%	-	-	-	0.0%	201	0.0%	0.0%	0.0%
Total Premiums	**$ 128,589,767**	**8.5%**	**$ 461,625**	**$ 25,233,930**	**$ 25,695,555**	**95.7%**	**$ 154,285,322**	**8.5%**	**8.5%**	**7.8%**
Grand Total Services and premiums	**$ 1,780,878,696**	**100.0%**	**$ 733,900**	**$ 26,104,891**	**$ 26,838,791**	**100.0%**	**$ 1,807,717,487**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers**	**$ 94,684,977**									
Total Elderly Recipients	**162,015**		**713**	**39,649**	**40,362**		**202,377**			
Expenditures Per Recipient*	**$ 10,992**		**$ 1,029**	**$ 658**	**$ 665**		**$ 8,932**			

* Service Expenditure/Recipient amounts do not contain adjustments, settlements or administrative costs.
** Medicare Crossovers are amounts that Medicaid bills Medicare for those Medicaid-eligible people who are also eligible for Medicare.
Source: SFY 2003 Program Expenditure Report

Table 13
North Carolina Medicaid
State Fiscal Year 2003
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	2003 % of Total Dollars	2002 % of Total Dollars
Inpatient Hospital	$ 385,724,943	14.0%	$ 1,831,369	6.4%	$ 387,556,312	13.9%	14.7%
Outpatient Hospital	200,167,849	7.3%	1,276,835	4.5%	201,444,684	7.2%	6.4%
Mental Hospital (> 65)	16,740	0.0%	-	0.0%	16,740	0.0%	0.0%
Psychiatric Hospital (< 21)	7,080,671	0.3%	-	0.0%	7,080,671	0.3%	0.2%
Physician	169,798,726	6.2%	1,156,850	4.0%	170,955,576	6.2%	7.0%
Clinics	234,799,554	8.5%	1,038,268	3.6%	235,837,823	8.5%	7.6%
Nursing Facility:							
Skilled Level	69,866,151	2.5%	1,401,695	4.9%	71,267,846	2.6%	2.6%
Intermediate Level	43,484,669	1.6%	1,150,280	4.0%	44,634,949	1.6%	1.7%
Intermediate Care Facility (Mentally Retarded)	377,809,607	13.7%	7,092,169	24.8%	384,901,776	13.8%	15.0%
Dental	23,627,717	0.9%	185,378	0.6%	23,813,095	0.9%	0.8%
Prescription Drugs	569,595,501	20.7%	4,135,509	14.4%	573,731,010	20.6%	19.3%
Home Health	105,013,270	3.8%	953,386	3.3%	105,966,656	3.8%	3.9%
CAP/Disabled Adult	48,305,629	1.8%	1,593,539	5.6%	49,899,168	1.8%	2.1%
CAP/Mentally Retarded	249,844,956	9.1%	2,796,935	9.8%	252,641,891	9.1%	9.5%
CAP/Children	23,071,606	0.8%	277,001	1.0%	23,348,607	0.8%	0.8%
Personal Care	64,713,508	2.4%	1,710,230	6.0%	66,423,739	2.4%	1.9%
Hospice	9,925,921	0.4%	170,949	0.6%	10,096,871	0.4%	0.3%
EPSDT (Health Check)	1,201,005	0.0%	5,573	0.0%	1,206,577	0.0%	0.1%
Lab & X-ray	4,902,943	0.2%	47,247	0.2%	4,950,190	0.2%	0.2%
Adult Home Care	48,972,888	1.8%	344,676	1.2%	49,317,563	1.8%	1.8%
High Risk Intervention Residential	18,397,068	0.7%	-	0.0%	18,397,068	0.7%	0.4%
Other Services	36,250,283	1.3%	213,624	0.7%	36,463,907	1.3%	1.4%
Total Services	**$ 2,692,571,206**	**97.9%**	**$ 27,381,513**	**95.7%**	**$ 2,719,952,719**	**97.9%**	**97.7%**
Medicare, Part A Premiums	6,034	0.0%	533,061	1.9%	539,095	0.0%	0.0%
Medicare, Part B Premiums	54,464,353	2.0%	677,494	2.4%	55,141,847	2.0%	1.9%
HMO Premiums	3,589,944	0.1%	31,908	0.1%	3,621,853	0.1%	0.4%
Total Premiums	**$ 58,060,331**	**2.1%**	**$ 1,242,464**	**4.3%**	**$ 59,302,795**	**2.1%**	**2.3%**
Grand Total Services & Premiums	**$ 2,750,631,537**	**100.0%**	**$ 28,623,976**	**100.0%**	**$ 2,779,255,514**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 70,107,822**		**$ 774,747**		**$ 70,882,569**		
Number of Disabled/Blind Recipients	**229,900**		**2,266**		**232,166**		
Service Expenditures Per Recipient**	**$ 11,964**		**$ 12,632**		**$ 11,971**		

* Medicare Crossovers are amounts that are billed to Medicare for those Medicaid clients who are also elig

** Service Expenditures Per Recipient does not include adjustments, settlements or administrative c

Source: SFY 2003 Program Expenditure Report

Table 14
North Carolina Medicaid
State Fiscal Year 2003
Expenditures for Families and Children

Type of Service	AFDC Adults	% of Service Dollars	Special Pregnant Women	% of Service Dollars	AFDC Children & Other Children	% of Service Dollars	Indigent Children	% of Service Dollars	Breast Cervical	% of Service Dollars	Total Families & Children Dollars	SFY 2003 % of Total Dollars	SFY 2002 % of Total Dollars
Inpatient Hospital	$ 129,013,007	23.1%	$ 74,808,958	37.5%	$ 63,595,699	12.4%	$173,673,456	24.8%	$ 225,326	9.8%	$ 441,316,447	22.4%	24.9%
Outpatient Hospital	127,684,081	22.8%	25,446,439	12.8%	61,874,202	12.1%	85,353,406	12.2%	1,109,155	48.6%	$ 301,467,283	15.3%	13.4%
Psychiatric Hospital (< 21)	-	0.0%	18,945	0.0%	11,299,580	2.2%	7,105,585	1.0%	-	0.0%	$ 18,424,110	0.9%	0.9%
Physician	106,492,959	19.0%	52,712,512	26.4%	72,190,839	14.1%	132,642,446	18.9%	667,813	29.3%	$ 364,706,569	18.5%	19.4%
Clinics	26,373,714	4.7%	19,486,705	9.8%	125,375,586	24.5%	85,634,880	12.2%	12,751	0.6%	$ 256,883,636	13.0%	12.7%
Nursing Facility:													
Skilled Level	239,616	0.0%	-	0.0%	58,586	0.0%	-	0.0%	-	0.0%	298,202	0.0%	0.0%
Intermediate Level	4,482	0.0%	-	0.0%	80,462	0.0%	1,263	0.0%	-	0.0%	86,207	0.0%	0.0%
Intermediate Care Facility (Mentally Retarded)	-	0.0%	-	0.0%	1,957,357	0.4%	741,988	0.1%	-	0.0%	2,699,346	0.1%	0.2%
Dental	24,393,081	4.4%	1,072,336	0.5%	30,113,092	5.9%	42,159,374	6.0%	18,311	0.8%	97,756,193	5.0%	4.3%
Prescription Drugs	99,922,282	17.9%	7,472,947	3.7%	59,452,114	11.6%	82,621,189	11.8%	178,264	7.8%	249,646,796	12.6%	11.7%
Home Health	6,951,321	1.2%	1,013,910	0.5%	4,520,834	0.9%	7,424,206	1.1%	35,297	1.5%	19,945,569	1.0%	1.0%
CAP/Disabled Adult	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
CAP/Mentally Retarded	-	0.0%	-	0.0%	2,498,638	0.5%	7	0.0%	-	0.0%	2,498,645	0.1%	0.2%
CAP/Children	-	0.0%	-	0.0%	687,502	0.1%	-	0.0%	-	0.0%	687,502	0.0%	0.0%
Personal Care	1,743,778	0.3%	26,051	0.0%	287,211	0.1%	251,200	0.0%	8,460	0.4%	2,316,699	0.1%	0.1%
Hospice	222,985	0.0%	-	0.0%	23,859	0.0%	34,255	0.0%	4,753	0.2%	285,853	0.0%	0.0%
EPSDT (Health Check)	4,971	0.0%	34,146	0.0%	12,071,880	2.4%	31,237,832	4.5%	16	0.0%	43,348,845	2.2%	2.4%
Lab & X-ray	7,106,352	1.3%	3,872,401	1.9%	3,058,393	0.6%	6,586,841	0.9%	11,866	0.5%	20,635,852	1.0%	0.9%
Adult Home Care	13,642	0.0%	-	0.0%	11,225	0.0%	4,231	0.0%	-	0.0%	29,099	0.0%	0.0%
High Risk Intervention Residential	-	0.0%	-	0.0%	36,990,599	7.2%	22,874,905	3.3%	-	0.0%	59,865,503	3.0%	2.1%
Other Services	21,087,417	3.8%	10,564,965	5.3%	19,933,121	3.9%	18,052,311	2.6%	8,236	0.4%	69,646,050	3.5%	3.7%
Total Services	**$ 551,253,686**	**98.6%**	**$196,530,316**	**98.5%**	**$506,080,780**	**99.0%**	**$696,399,373**	**99.3%**	**$2,280,250**	**100.0%**	**$ 1,952,544,405**	**98.9%**	**98.1%**
Medicare, Part A Premiums	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Medicare, Part B Premiums	278,534	0.0%	9,241	0.0%	2,395	0.0%	4,276	0.0%	-	0.0%	294,446	0.0%	0.0%
HMO Premiums	7,775,936	1.4%	2,908,496	1.5%	5,122,843	1.0%	5,042,714	0.7%	-	0.0%	20,849,989	1.1%	1.9%
Total Premiums	**$ 8,054,471**		**$ 2,917,737**		**$ 5,125,238**		**$ 5,046,990**		**-**		**$ 21,144,435**	**0.5%**	**1.9%**
Total Services & Premiums	**$ 559,308,157**		**$199,448,052**		**$511,206,017**		**$701,446,363**		**$2,280,250**		**$ 1,973,688,840**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 814,437**		**$ 60,937**		**$ (18,237)**		**$ (13,946)**				**$ 843,191**		
Number of Family & Child Recipients	**204,789**		**51,889**		**273,233**		**473,178**		**182**		**1,003,271**		
Service Expenditures Per Recipient**	**$ 2,731**		**$ 3,844**		**$ 1,871**		**$ 1,482**		**$ 12,529**		**$ 1,967**		

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

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

Source: SFY 2003 Program Expenditure Report

Table 15
North Carolina Medicaid
State Fiscal Year 2003
Medicaid Copayment Amounts

Service	Copayment Amount
Chiropractor visit	$1.00
Dental visit	$3.00
Optical service	$2.00
Optometrist visit	$2.00
Outpatient visit	$3.00
Physician visit	$3.00
Podiatrist visit	$1.00
Prescription drugs (including refills):	
Generic & Insulin	$1.00
Brand Name	$3.00

How the NC Medicaid Program Works

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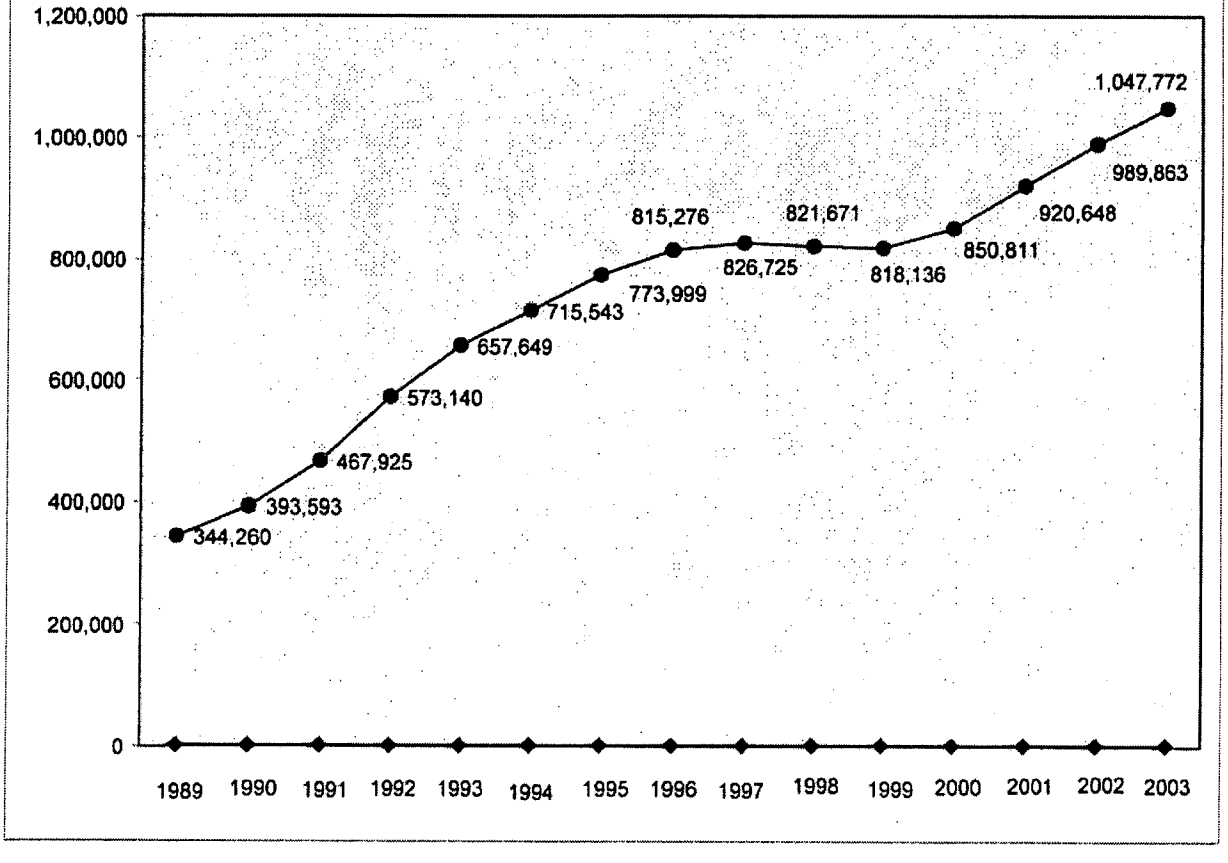
Brief History

The State of North Carolina submitted its Medicaid State Plan to the Health Care Financing Administration in 1969 and received approval that year. North Carolina General Statutes, Chapter 108A is the law that implemented Title XIX in North Carolina, thus beginning the NC Medicaid Program, on January 1, 1970 under the direction of the North Carolina Division of Social Services. G.S. 108A defined certain technical aspects of the North Carolina Medicaid Program not spelled out in federal law. North Carolina Administrative Code, Title 10, Chapter 50 and Chapter 26, provided further definition of North Carolina Medicaid policy not addressed in federal law and regulation nor state law. Each year new legislation that is passed by the North Carolina General Assembly establishes changes to the program and its policies such as eligibility and benefit coverage expansions and contractions, management and administrative mandates, special funding, etc.

Exhibit A-1

The History of Average Monthly Medicaid Eligibles



In 1978, the administration of the NC Medicaid Program was assigned to the newly-created Division of Medical Assistance (DMA), a separate division within the Department of Human Resources, which has since been renamed the Department of Health and Human Services. From 1978 to 2003, the annual number of people eligible for Medicaid has increased from 456,000 to 1,447,283 and Medicaid expendi-tures have grown from approximately $307 million to $7.4 billion. As shown above, the number of average monthly eligibles has increased from 344,260 during SFY 1989 to 1,047,772 during SFY 2003.

In 35 years of operation, the programmatic complexity of Medicaid has paralleled the growth in both program expenditures and number of reci-pients. However, DMA has historically spent a modest percent-age of its budget on administration, which during SFY 2003 was approximately $310 million or 4.2 percent of total expenditures.

Exhibit A-2

"What is Medicaid?"

Title XIX of the Social Security Act is a federal and state entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and services within a state can change during the year.

Source: Centers for Medicare and Medicaid Services

For further general information about the Medicaid Program, eligibility and services, please refer to CMS's article "Medicaid: A Brief Summary" online at: http://cms.hhs.gov/publications/overview-medicare-medicaid/default4.asp

For specific information about the NC Medicaid Program's State Plan and amendments, please refer to CMS's article "Table of Contents for the State of NC" at: http://cms.hhs.gov/medicaid/stateplans/toc.asp?state=NC

Medicaid Eligibility

Medicaid provides funding for health care primarily to individuals who receive some form of financial assistance from the state. In North Carolina, caseworkers at each of the 100 county departments of social services determine an individual's eligibility

Exhibit A-3
Basic Overview of Medicaid Eligibility

Who (coverage group)	Upper Income Limit	Assets *(see explanation below)*
Elderly Aged 65+	$749/month single person ($8,980 annually) $1,010/month couple ($12,120 annually)	$2,000 single person $3,000 couple
Disabled/Blind	Same as elderly	Same as elderly
Medicare Beneficiaries	$1,011 monthly for single person ($12,123 annually) $1,364 monthly for couple ($16,362 annually)	$4,000 $6,000
Pregnant Women and Infants	$2,837 monthly for family of 4 ($34,040 annually)	N/A
Children ages 1 through 5	$2,040 monthly for family of 4 ($24,472 annually)	N/A
Children ages 6 through 18	$1,534 monthly for family of 4 ($18,400 annually)	N/A
Persons aged 19 and 20	$362 per month for single person ($4,344 annually)	$3,000
Parents/Caretakers	$594 monthly for family of 4 ($7,128 annually)	$3,000
Medically Needy (must meet spenddown*)	$242 monthly for single person $317 monthly for couple	$2000 elderly and disabled person $3000 for couple or family

The following items are not counted as assets:

- Burial money
- Home
- Vehicle
  - 1 vehicle for elderly, disabled/blind, and Medicare beneficiaries
  - 1 vehicle per adult for 19 and 20 year olds and parents/caretakers
- clothing, appliances, furniture

In addition to financial requirements, recipients must meet the following general requirements:

- NC resident
- Citizen or "qualified alien"
- Not incarcerated
- Provide information on other health insurance
- Provide Social Security Number

* **Spenddown** is an amount of medical bills equal to the difference between income and the income limit; eligibility begins on day the "incurred" medical bills equal the spenddown amount. Many spenddown recipients are patients in nursing homes

for Medicaid benefits based on policies established by the federal government as implemented by the State. Eligible families and individuals enrolled in the NC Medicaid Program are issued a Medicaid identification card each month. These individuals may receive medical care from providers who enroll in the Medicaid Program. Providers submit claims to DMA for reimbursement of services they render to the Medicaid population.

Medicaid enrollees, applicants, and caretakers who have questions regarding any aspect of the NC Medicaid program may telephone North Carolina's toll free CARE-LINE Information and Referral Service. The CARE-LINE forwards calls regarding covered benefits to the DMA Recipient Ombudsman in DMA's Recipient and Provider Services Section. The Ombudsman ensures that the question is answered in a timely manner. During SFY 2003, the Ombudsman answered questions for approximately 5,000 callers.

Exhibit A-4
Medicaid Eligibility
by Mandatory and Optional Groupings

MANDATORY	OPTIONAL
• Aged, Blind and Disabled receiving SSI • Children ages 1 through 5 up to 133% Federal Poverty Level (FPL) • Foster children and adoptive children under Title IVE • Families with children under the age of 19 who would have been eligible for AFDC on July 1996 • Children ages 6 through 18 up to 100% FPL (mandatory as of October 1, 2001) • Pregnant women and infants (under the age of 1) up to 150% FPL • Medicare beneficiaries up to 100% FPL qualify for Medicare cost-sharing • Medicare beneficiaries between 101% and 135% FPL qualify for payment of Part B premium; however, total enrollment is capped by appropriated federal funds for beneficiaries with income between 121% and 135% FPL	• Aged, Blind and Disabled not receiving SSI, including adult care home residents, 100% of poverty eligibles and medically needy • Non-IVE foster children and/or adoptive children with parents in families not eligible under AFDC rules in July 1996 (medically needy) • Children ages 19 and 20 • Pregnant women and infants up to 185% FPL • Medically needy

Funding the NC Medicaid Program

Federal, state, and local county governments jointly finance Medicaid, with the federal government paying the largest share of Medicaid costs. In North Carolina, the 100 county governments con-tribute 15 percent of the non-federal share of costs. The fed-er-al share of costs for services is established by the Centers for Medicare and Medicaid Services (CMS). CMS calculates the rate based on the most re-cent three-year average per capita income for each state and the national per

capita income. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the State and the counties to increase their share of Medicaid payments.

The established federal matching rates for services are applicable to the federal fiscal year (FFY), which extends from October 1 to September 30. The State's fiscal year (SFY) runs from July 1 through June 30. Because the federal and state fiscal years do not coincide, different federal ser-vice matching rates may apply for each part of the overlapped state fiscal year. The federal match rate for administrative costs does not change from year to year.

Administrative Contracts

Certain functions of the Medicaid program are performed for DMA under contract. Some of these include the following:

EDS Corporation

DMA contracts with EDS to perform many of Medicaid's administrative functions. Currently, EDS processes claims, provides billing guidance and help desk services to enrolled Medicaid providers, , conducts provider education seminars, operates the prior approval system for most Medicaid services, and operates the NC Medicaid Management Information System (MMIS+).

Medical Review of North Carolina (MRNC)

MRNC conducts quality assurance re-views of the services provided to recipients through the Community Alternatives Program for Disabled Adults (CAP/DA), Level of Care reviews for residents in Medicaid-certified nursing facilities, and the Health Maintenance Organization (HMO) contracts. MRNC also works with the DMA Program Integrity Section to 1) evaluate provider DRG coding to identify improper reimbursement maximization and other potentially incorrect billings and 2) assist in a federal Payment Accuracy Grant to determine the accuracy rate of Medicaid claim payments. DMA's participation as one of nine grant states will help develop a process to determine a national model for all states. Payment accuracy measurement has been subsequently mandated in federal law known as the "Improper Payments Reduction Act of 2002" (Ref. HR 4878). Beginning October 1, 2002, MRNC began processing the requests for prior approval of outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech, respiratory and audiological therapy regardless of where the services are provided.

ValueOptions (VO)

DMA contracts with ValueOptions for utilization review of acute inpatient/substance abuse hospital care for recipients through age 64; Psychiatric Residential Treatment Facilities (PRTF); Levels II through IV Residential Treatment Facilities (four beds or more); and outpatient psychiatric services. The contract encompasses all elective and emergency admission reviews, concurrent continued stay reviews and post discharge reviews when applicable.

First Health Services Corporation (FHSC)

DMA contracts with FHSC to perform certain components of the retrospective Drug Use Review (DUR) Program. FHSC generates quarterly recipient and provider profiles from the paid claims computer tapes in accordance with the DUR Board's criteria.

Pharmacy Prior Approval Contract

Beginning March 4, 2002, DMA implemented a prior authorization (PA) process for certain prescription drugs through a contract with ACS State HealtCare in Atlanta, Georgia. These prescription drugs were chosen by a panel of clinical and academic physicians and pharmacists based on cost and the high potential for overuse. Prior authorization allows NC Medicaid to ensure that these prescription drugs are used responsibly and as they are intended.

Optical Contract

Medicaid contracts with the NC Department of Correction's Correctional Enterprises to provide eyeglasses at predetermined rates. In most cases, providers of Medicaid eye care services must obtain eyeglasses through this organization.

Audit Contracts

The DMA Audit Section has contracts with two certified public accountants to conduct onsite compliance audits of nurs-ing facilities and intermediate care facilities for the mentally retarded (ICF-MR) who are enrolled in the Medicaid Pro-gram. These audits supplement DMA's in-house audit activities and verify the accuracy of the providers' cost reports.

In addition, DMA contracts with Blue Cross Blue Shield of Tennessee to perform Medicaid settlement activities for Rural Health Clinics and with Blue Cross Blue Shield of North Carolina to perform Medicaid settlement activities for hospitals and State-operated nursing facilities and ICF-MRs.

Partnerships

Although DMA administers Medicaid, other State and local agencies work closely in partnership with the program and perform important functions:

County Departments of Social Services

The departments of social services in each of North Carolina's 100 counties have the central role in determining Medicaid eligibility for their residents. In ad-dition, counties contribute approximate-ly 5 percent of the cost of ser-vices for Medicaid patients (see Table 5 in the main body of the SFY 2003 Medicaid Annual Report).

NC Division of Social Services (DSS)

The DSS conducts Medicaid recipient appeals when the person making the application contests eligibility denials.

Division of Vocational Rehabilitation Services (DVR)

DVR's Disability Determination Unit determines whether an individual is eligible for Medicaid based on disability. This unit also makes disability deter-minations for two federal programs under a contract with the Social Secur-ity Administration including Title II - Social Security benefits and Title XVI - Supple-mental Security Income.

Division of Mental Health, Develop-mental Disabilities, and Substance Abuse Services (DMH/DD/SAS)

DMA works closely with the DMH/DD/SAS to plan for and monitor community mental health services. These agencies also work cooperatively to operate the Community Alternatives Program for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD), a valuable resource for providing community-based services as a cost-effective alternative to institutional care in an ICF-MR. Under the federal mandate for PASARR, DMH/DD/SAS staff are authorized to make the final determination for service and placement needs for all those individuals identified with MI, MR or RC diagnoses (see the "Nursing Facility Prior Approval and Retrospective Review" section of Addendum A).

Division of Public Health (DPH)

DMA and DPH cooperate in a number of efforts to improve care for people with HIV and AIDS. The AIDS Care Unit in DPH operates HIV Case Management Services (HIV/CMS) and the Community Alternatives Programs for Persons with AIDS (CAP/AIDS). DMA and DPH also cooperate in the provision of pediatric equipment for Medicaid-eligible recipients ages birth through 20 years old.

The Women and Children's Health Section (WCH) within DPH operates a variety of health care programs that are Medicaid-funded. WCH and local health departments also play a central role in the operation of the Baby Love Program, a care coordination pro-gram designed to assure appropriate medical care for pregnant women. It also plays a key role in the Health Check Program, which provides preventive and other health care services for children. Both programs are discussed in more detail in the "Programs" section of this report.

State Center for Health Statistics (SCHS)

The SCHS within DPH supports a variety of NC Medicaid's data needs for program planning and evaluation.

NC Office of Research, Demonstrations, and Rural Health Development

The NC Office of Research, Demonstrations, and Rural Health Development, an agency within DHHS, provides technical assistance to small hospitals and community health centers in rural and medically under-served communities. This agency also recruits health care providers to work in rural and medically under-served communities and provides grants for community health centers and is the lead agency for demonstrations in the delivery and financing of health care for DHHS. Presently, they are working with DMA on the Community Care managed care program.

Division of Aging (DOA)

DMA and DOA staff work together on many issues that are important to the aged population. Jointly, DMA and DOA design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development pro-jects on housing and in-home aide services.

Division of Facility Services (DFS)

DFS has the responsibility for licensing, certifying, and monitoring facil-ities in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a facility.

Department of Public Instruction (DPI)

The Individuals with Disabilities Education Act (IDEA) is the federal law requiring education-related services to be provided to pre-school and school aged children with special needs who are receiving special education services as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, such as speech, physical, audiological and occupational therapies as well as psychological services.

University of North Carolina at Chapel Hill (UNC-CH)

The UNC-CH School of Public Health and the Cecil G. Sheps Center for Health Services Research have collaborated with NC Medicaid on a number of research projects and efforts to support program planning and evaluation.

University of North Carolina at Charlotte (UNC-C)

Faculty within UNC-C have conducted evaluations of patient satisfaction with the Health Care Connection, NC Medicaid's mandatory HMO program in Mecklenburg County. They have also carried out and reported on a primary care provider availability survey for Carolina ACCESS.

Covered Services

NC Medicaid covers a com-pr-ehensive array of preventive and treatment services for eligible enrollees (see Exhibit A-5). Preventive services include one annual physical for adults and child health screenings provided under the Health Check (EPSDT) Program. Treatment services address virtually all acute and chronic illnesses.

Medicaid has certain standard lim-itations on services. These include a limit of 24 ambulatory visits per SFY to prac-titioners, clinics, and outpatient departments and a limit of six pre-scr-iptions per month. There are ex-cep-tions to these limits for preven-tive care to pregnant women, children eligible for Health Check, people with life threatening conditions, participants in the Community Alternatives Programs (CAP), and other selected groups. Some services require nominal co-payments and others require prior approval. Both requirements en-sure that the care received is medically necessary

Providers of Care

During SFY 2003, over 70,000 enrolled Medicaid providers offered a wide variety of services to North Carolina's Medicaid population (see Exhibit A-6). Many providers are enrolled in more than one type of service and participate with a group as well as individually. DMA's Provider Services Unit oversees the enrollment of new providers in the NC Medicaid Program and maintains licensing and credentialing information for providers enrolled with Medicaid.

During 2003, Medicaid began a policy to terminate the enrollment of providers who have not billed the Medicaid Program within the previous 12 months. Providers are notified by mail of DMA's intent to terminate their inactive number and have two weeks to respond if they wish to request that their number not be terminated. These notices are sent to the current mailing address listed in the provider's file. Once terminated, providers are subject to the full re-enrollment process and can experience a period of ineligibility as a Medicaid provider.

This policy also addresses the problem of having an incorrect billing address in the provider's file. If remittance advices and checks cannot be delivered due to an incorrect address, all claims for the provider are suspended and the subsequent remittance advice and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider, the provider has 90 days to submit an address change. If after 90 days the address has not been corrected, claims in suspension deny and the provider's enrollment is terminated.

Exhibit A-5

COVERED SERVICES

MANDATORY	OPTIONAL
• Hospital Inpatient	• Clinical
• Hospital Outpatient	• Diagnostic
• Psychiatric Residential Treatment Facility Services and Residential Services (treatment component only) for under age 21	• Intermediate Care Facilities for the Mentally Retarded
• Other Laboratory and X-ray	• Personal Care
• Nursing Facility	• Prescription Drugs
• Physician	• Dental and Dentures
• Home Health	• Eye Care
• Health Check (EPSDT)	• Mental Health
• Family Planning	• Chiropractor
• Durable Medical Equipment	• Podiatrist
• Nurse Midwife and Nurse Practitioner	• Physical, Occupational and Speech Therapy
• Hearing Aid	• Respiratory Therapy for Children
• Medical Transportation	• Hospice
• Federally Qualified Health Centers & Rural Health Centers	• Private Duty Nursing
	• Home Infusion Therapy
	• Case Management
	• Nurse Anesthetist
	• Preventive
	• Rehabilitative
	• Orthotic and Prosthetic Devices
	• Screening
	• Transportation

Note: All optional services are mandatory for children under age 21

Providers are notified in writing and have 21 days from the date of the letter to respond to DMA Provider Services. If the letter is returned to DMA as undeliverable, the provider's enrollment is terminated.

Exhibit A-6
Enrolled Medicaid Services Providers
State Fiscal Year 2003

Provider Type:	Number
Adult Care Home Providers	2,634
Ambulance Service Providers	407
Chiropractors	1,712
Community Alternatives Program Providers (CAP/C, CAP/AIDS, CAP/DD-MR, CAP/DA)	1,230
Dental Service Providers (Dentists, Oral Surgeons, Pedodontists, Orthodontists)	4,075
Durable Medical Equipment Suppliers	3,266
Health Maintenance Organizations (HMOs)	1
Hearing Aid Suppliers	196
Home Health Agency Providers (Home Infusion Therapy, Private Duty Nursing)	966
Hospice Agency Providers	79
Hospital Providers	888
Independent Laboratory Providers	201
Independent Practitioners (Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech Therapy, Audiologists)	3,818
Local Education Agencies	105
Mental Health Program Providers	168
Mental Health Providers	3,026
Nursing Facility Providers	1,352
Optical Service Providers and Suppliers (Opticians, Optometrists)	1,880
Other Types of Clinics (Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers)	237
Personal Care Service Providers	793
Pharmacists	2,393
Physician Extenders (Nurse Midwives, Nurse Practitioners, Certified Registered Nurse Anesthetists)	2,326
Physicians	36,869
Podiatrists	513
Portable X-ray Service Providers	27
Psychiatric Facility Providers	551
Public Health Program Providers	511
Rural Health Clinic/Federally Qualified Health Center Providers	353
Total	**70,682**

Note: This is an unduplicated count of any provider enrolled during the year. Physicians may be counted individually and/or as a group. Includes 22,446 providers terminated by 6/30/2003.

Rate Setting

Prospective payment rates and fee schedules are very important in controlling Medicaid program costs. Taking into account the leve-l of funding provided by the N.C. General Assembly, payment rates are established accord-ing to federal and state laws and reg-ulations. In-depth analysis of providers' cost of service is required to ensure fair and reasonable reimbursement. DMA reviews, monitors, and adjusts all reimbursement rates.

Program Integrity

DMA's Program Integrity Section is tasked with multiple responsibilities. These include:

Identifying fraud, abuse, waste, and administrative overpayments in Medicaid billings by health care providers

- Coordinating recipient fraud and abuse identification with the county departments of social services
- Determining the accuracy of Medicaid eligibility determinations by the county departments of social services and claim payment accuracy for claims paid by the Medicaid program.
- Collecting money and cost avoiding Medicaid payments when a third party is responsible for paying for the Medicaid service.
- Ensuring, through prospective and retrospective drug use reviews, that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and not likely to result in adverse medical effects.

The efforts of Program Integrity Section promote program fiscal efficiency of Medicaid money spent and the services rendered.

Medicaid Eligibility Error Rate Reduction

Program Integrity's Quality Assurance (QA) Section is responsible for monitoring the accuracy rate of eligibility determinations made by the county departments of social services in each of North Carolina's 100 counties. The QA staff conducts both federally mandated quality control reviews and State-designed targeted reviews. This review process looks at both active and denied cases. Error trends, error-prone cases, and other important error reduction information are communicated quickly to eligibility staff. DMA then works with the counties to promote corrective actions whenever appropriate. County eligibility supervisors then conduct evaluations and training and make the necessary adjustments to eliminate errors and to prevent future mistakes.

North Carolina has never been penalized for exceeding the three percent federal tolerance level for payment error rates. North Carolina's low payment error rate is the result of a successful partnership between DMA and North Carolina's counties.

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

Third Party Recovery (TPR)

Medicaid is, by law, the payer of last resort. As a condition of receiving Medicaid benefits, recipients agree to allow Medicaid to seek payment from avail-able third party health care resources on their behalf. All other third party resources must be used before Medicaid dollars are spent. These resources, such as health and casualty insur-ance and Medicare, are important means of keeping Medicaid costs as low as possible.

Utilization Management

Utilization Management functions ensure optimal health care delivery in a cost effective manner, to Medicaid-eligible individuals who either reside in a nursing facility or live at home. It is a joint effort by DMA and the fiscal agent to reimburse providers for services provided based on needs identified by completion of an FL2 or MR2 and authorized by a physician. The methods of these services are as follows:

Prior Approval

The prior approval function, carried out under a contract with EDS, encompasses medical services, long-term care, specific out-of-state hospital services, and other Medicaid services specified by DMA. Health care providers identify the need for services that require prior approval then complete and submit the state-specified prior approval request form and any applicable supporting documentation. Based on DMA's medical policy, approved medical criteria, and medical judgment, the EDS Prior Approval Unit is authorized to approve, pend or deny the request. Subsequently, the MMIS prior approval files are updated with the information from the request, indicating that the request has been approved, pended for additional information or denied. The claims processing system accesses the prior approval file to validate that the provider's services are consistent with the authorization prior to adjudicating the claim for payment. EDS uses policies developed by DMA to maintain a current medical coverage policy library. In all matters of policy, regulations, and compliance, the EDS Medical Director collaborates closely with DMA.

Prescription Drug Prior Approval

Beginning March 4, 2002, DMA implemented a prior authorization (PA) process for certain prescription drugs through a contract with ACS State Healthcare in Atlanta, Georgia. These prescription drugs were chosen based on cost and the high potential for overuse by a panel of clinical and academic physicians and pharmacists. Prior authorization allows NC Medicaid to ensure that these prescription drugs are used responsibly and as they are intended. They are:

- Drugs used to treat ADHD (for persons 19 and older)
- Procrit, Epogen
- Neupogen
- OxyContin
- Growth hormones
- Provigil

- Rebetron
- Vioxx, Celebrex, Bextra (for persons 59 years of age or younger)
- Enbrel
- Botox, Myobloc, Zyban, Nicotrol, Habitrol
- Synagis, RespiGam (these required prior authorization beginning April 1, 2002)

CAP Utilization Review

CAP/DA cases, randomly selected on a monthly basis from among all lead agencies for CAP, are monitored by MRNC. Quality assurance (QA) reviews determine that clients are classified correctly at either intermediate care or skilled nursing level of nursing facility care. The review also determines that clients have been given the option to choose home care versus nursing home placement, that the plan of care is relevant to the assessed needs of the clients, and that the health, safety, and well-being of clients is reasonably assured by the services provided. Results of the monthly monitorings are reviewed by DMA CAP consultants and shared with the agencies that have been reviewed. The findings enable the agencies to improve the manner in which CAP/DA is operated. The QA review process is not a negative process, but one that leads to the strengthening of programs, enabling agencies to better serve individuals who have nursing facility needs but opt for the range of home care services available through CAP/DA.

Behavioral Health Prior Approval

Prior approval is required for all psychiatric/substance abuse inpatient hospital care, all psychiatric residential treatment facility (PRTF) care for recipients under the age of 21, all residential treatment levels of care II through –IV, after 8 outpatient therapy visits for adults and after 26 outpatient visits for recipients under the age of 21. Medicaid has a contract with ValueOptions to perform utilization review.

Medicaid recipients age 21 and over receiving outpatient mental health services require prior approval after the 8th visit. This includes area mental health programs and private providers. This process replaces the policy of requesting prior approval after the 2nd visit for non-area mental health programs.

The 24-office visit limitation per year was removed and replaced by the requirement for prior approval after the 8th visit for mental health services subject to independent utilization review. Approval is based on medical necessity.

Outpatient Specialized Therapies Prior Approval

Beginning October 1, 2002, prior approval became a requirement for outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech, respiratory and audiological therapy regardless of where the services are provided as well as psychological services in the schools. The prior approval process for services provided in the schools is met by the IEP process. All other prior approval functions are carried out through a contract with MRNC. Based on

DMA's medical policy, approved medical criteria, and medical judgment, the MRNC Prior Approval Unit is authorized to approve or deny the request. Validation reviews are performed by MRNC with review findings sent to DMA on a quarterly basis.

Managed Care Referral Authorization and Utilization Management

Each recipient who is enrolled in either Carolina ACCESS, ACCESS II or ACCESS III (now collectively known as "Community Care of North Carolina) chooses or is assigned to a primary care provider (PCP). The PCP serves as "gatekeeper" for the recipient in achieving the dual goals of improving access to care while reducing unnecessary costs. The PCP is expected to provide 24 hour, 7 day per week access to medical care for enrolled members and to arrange for after hours coverage and authorization for appropriate referrals for specialty care as needed. The PCP provides the referral physician with an authorization number that must appear on the medical claim to ensure Medicaid reimbursement.

From the perspective of the Managed Care Section, utilization management is a process that is used to ensure that appropriate services are delivered to Medicaid enrollees through the identification of aberrant utilization patterns and potential quality of care issues. The process provides the opportunity to identify areas to target for the development of quality improvement activities. Utilization Management also serves to provide the Managed Care Section with cost data based on service utilization, which affords cross-analysis of the efficiency and effectiveness of managed care program types.

Each Carolina ACCESS, ACCESS II, and ACCESS III provider receives quarterly utilization reports and monthly emergency department and referral reports. Data contained in these reports is extracted by EDS from paid claims data. These utilization reports include both inpatient and outpatient utilization statistics and are useful for peer performance comparisons. The Managed Care Quality Management Unit produces internal reports that stratify the data according to provider specialty and the number of enrollees per provider.

Participating managed care organizations (MCOs), of which there is currently only one and it is located in Mecklenburg County, are required by contract to have a written utilization management program that is consistent with federal regulations and includes mechanisms to detect under/over-utilization of services. The written description must address procedures to evaluate medical necessity, the criteria used, information sources, and the process used to review and approve the provision of medical services. MCOs are also required to submit encounter data to EDS within 90 days from the end of the month in which the service was rendered. Additionally, MCOs are required to submit HEDIS data, emergency department visits, inpatient utilization, ambulatory surgical procedures, OB discharges, and newborn data derived from their internal data collection systems to DMA on an annual basis. DMA and EDS continue to work with the sole MCO to develop an encounter reporting process that provides data that accurately reflects the delivery of services to enrollees.

Nursing Facility Prior Approval and Retrospective Review

In order for Medicaid to pay for placement in a nursing facility, an individual must meet both financial and medical eligibility requirements. The county departments of social services have the responsibility of determining financial eligibility. DMA contracts with their fiscal agent, EDS, to determine medical eligibility by utilizing a prior approval process. Prior approval does not guarantee financial eligibility or Medicaid payment.

In addition to the prior approval process for level of care, North Carolina is mandated to perform pre-admission screening – part of the Preadmission Screening and Annual Resident Review (PASARR) process – for all residents applying for, or residing in, a Medicaid-certified nursing facility. This statutory requirement became effective January 1989 as a result of the Omnibus Budget Reconciliation Act (OBRA) of 1987 (P.L. 100-203). This section of OBRA was enacted to assure that recipients with serious mental illness, mental retardation or related conditions entering or residing in Medicaid-certified nursing facilities receive appropriate placement and services. The pre-admission screen (Level I and, if appropriate, Level II) must be completed and the special identification number, known as the **PASARR** number, must be documented on the state-approved FL2 prior approval form before nursing facility level of care will be considered.

North Carolina has two distinct levels of care for nursing facility placement (skilled and intermediate) that are governed by the level of care criteria. The **FL2** form is used to document information specific to the individual including diagnoses, special care needs, requested level of care, and the PASARR number. This information is used to determine the appropriate level of care. The **FL2** must be completed with current information and must be signed and dated by the physician. Prior approval requests are generally initiated via telephone and must be submitted to EDS within ten working days of the telephone review. Requests can also be initiated by written review. Records may be attached to justify the requested level of care.

On January 1, 2001, DMA initiated a change in procedure for consideration of retroactive prior approval requests. If the retroactive request is within 30 days from the telephone prior approval or FL2 criteria review, medical records may not be needed by EDS to make a level of care decision. If the retroactive request is for a time period exceeding 30 days, medical record documentation will be required by EDS to support the retroactive request and level of care decision. Retroactive prior approval will not be granted for time periods exceeding 90 days from the date Medicaid eligibility was determined. In addition, requests exceeding 90 days when unusual circumstances occur must be submitted to DMA for consideration of approval. Certain requests where it can be proven that the provider failed to determine eligibility or follow the prior approval level of care process will be denied. Under these circumstances the resident or family cannot be billed for services provided.

Major Initiatives and Subprograms

Major Sections: **Page**

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The NC Medicaid program has developed a number of initiatives and subprograms to meet federal or state government mandates, to respond to recipient lawsuits, to meet specific medical needs identified among Medicaid recipients or to give recipients better access to care or more care options. Some of these programs are only available to specific groups of recipients, such as pregnant women, and some are available to all. Services under the various subprograms are not necessarily mutually exclusive; a recipient may be eligible to receive services from a number of subprograms.

Managed Care

Managed care options for Medicaid recipients are available in all 100 North Carolina counties. As of June 2003, there were 751,789 Medicaid eligibles enrolled in a managed care plan out of a total of 991,827 average monthly Medicaid managed care eligibles (most, but not all, Medicaid eligibles are eligible for managed care), or approximately 76 percent. Options include Carolina ACCESS, ACCESS II, ACCESS III, and Risk Contracting with state-licensed health maintenance organizations (HMOs). Each of the NC Medicaid managed care program options are now referenced collectively using the umbrella name of "Community Care of North Carolina."

All managed care options operate under the authority of Section 1915(b) of the Social Security Act. Eligibility to participate in a managed care plan is mandatory for a majority of Medicaid recipients in North Carolina. Although recipients of Medicaid who are dually eligible for Medicaid and Medicare are optionally enrolled in Carolina ACCESS, they are not enrolled in HMOs. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan. Managed care options are as follows:

- **Carolina ACCESS** - A primary care case management model (PCCM), characterized by a primary care provider gatekeeper.
- **ACCESS II and ACCESS III** - These programs build on the Carolina ACCESS program by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of health care. ACCESS II and ACCESS III, originally created as a healthcare demonstration project by the NC Office of Research, Demonstrations, and Rural Health Development, are currently a joint collaborative effort between DMA and this office.
- **Healthcare Connection/Risk Contracting** - A program operating in Mecklenburg County requiring the mandatory enrollment in either the HMO, Carolina ACCESS or ACCESS II for a majority of Medicaid recipients in the county. DMA contracts with an HMO in Mecklenburg County to provide and coordinate medical services for certain Medicaid eligibles on a full risk-capitated basis. Recipients may choose between the participating HMO, Carolina ACCESS or ACCESS II. The State must license all HMOs that contract with DMA.

For all of these healthcare models the objectives are:

- cost-effectiveness
- appropriate use of healthcare services
- improved access to primary preventive care

Maternity and Child Health Subprograms

Providing preventive medical services and basic medical care for mothers and children is a continuing priority for the Medicaid program and for the State of North Carolina. Medicaid covered 52,209 of the 117,833, or 44 percent, of all live births in North Carolina during SFY 2002 (the most recent fiscal year for which population data were available). Medicaid coverage is federally mandated for children with family incomes below 100 or 133 percent of the federal poverty level, depending on the age of the child. Over the years, North Carolina has taken advantage of federal options to expand Medicaid coverage to pregnant women and children with incomes ranging up to 185 percent of the poverty level. Since implementing the initiatives and programs described below, North Carolina has experienced many positive outcomes, including reductions in the infant mortality rate and better access to preventive health care for Medicaid recipients and low-income children.

Baby Love

Baby Love was implemented in 1987 and is administered jointly by DMA and the Division of Public Health. The program provides pregnant women with comprehensive care through an expanded Medicaid benefit package which includes childbirth and parenting classes, in-home nursing care for high-risk pregnancies, nutrition counseling, psychosocial counseling, and postpartum/newborn home visits. Specially trained nurses and social workers called Maternity Care Coordinators assist the women in accessing medical care and support services. In addition, Maternal Outreach Workers, who are specially trained to assist at-risk families, are available in 58 counties.

Evaluations of the Baby Love Program have shown that women who receive Maternity Care Coordinator services average more prenatal visits per pregnancy, have a higher participation rate in the WIC program, experience better birth outcomes, and are more likely to receive postpartum family planning services. Likewise, their children are more likely to receive well-child care and WIC services.

Health Check

In 1993, North Carolina expanded the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program to form Health Check. Health Check encourages regular preventive health care and the diagnosis and treatment of any health problem detected during a screening. Medicaid recipients under the age of 21 are automatically eligible for Health Check services.

An integral part of the Health Check program is a special initiative called the Health Check Outreach Project. Specially trained Health Check Coordinators work through this program to reduce barriers and educate families on the importance of preventive health services. Recently, a plan was endorsed by the NC Health Directors' Association to expand Health Check Coordinators statewide. This plan will eventually place Health Check Coordinators in all counties by reallocating existing positions. Health Check Coordinators are located in 76 counties as well as the Qualla Boundary (the reservation of the Eastern Band of Cherokee). DMA's Managed Care Section is the administrative entity for the Health Check Program and coordinators. The Managed Care Section works closely with the Division of Women and Children's Health to provide guidance to the counties.

The Health Check Automated Information and Notification System (AINS) is a computerized system for identifying and following the health care activities of Medicaid-eligible children

It enables Health Check Coordinators to determine which Medicaid-eligible children in their respective counties are receiving regular and periodic Health Check screenings, immunizations, and referrals for special health care problems. AINS generates notices to the parents of Medicaid-eligible children, notifying them of the Health Check Program, scheduled screening appointments, missed appointments, immunizations, and available programs and services. For children enrolled in a Medicaid managed care program, the name of the Carolina ACCESS primary care provider or the HMO appears on letters sent to providers to whom referrals are being made. Access to and utilization of health care services for Medicaid-eligible children and youth have improved since the program was initiated.

Health-Related Services for Children

In order to assure that a comprehensive array of services is accessible to children, Medicaid pays for physical therapy, occupational therapy, audiological services, speech/language services, and psychological services for children in public schools and Head Start programs. These services are provided to eligible children through Local Education Agencies (LEAs) and local Head Start programs. In addition, North Carolina has an Independent Practitioner Program, which enrolls and reimburses individual independent practitioners to provide physical therapy, occupational therapy, respiratory therapy, speech and language therapy, and audiological services to children from birth through 20 years of age.

Practitioner and Clinical Services

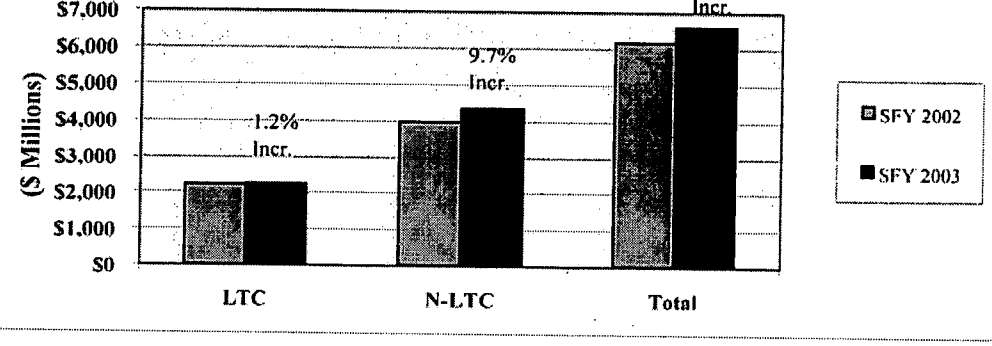
Practitioner and Clinical Services comprises services provided by physicians including injectible drugs given in the physicians office, ambulance services, ambulatory surgery centers, dialysis services, anesthesiology, labs, clinics, birthing centers, radiology services, nurse practitioners, podiatrists and chiropractors. The annual updates of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes occur in this program area. During this fiscal year staff began the intense process of converting local and state created codes to national codes to comply with HIPAA mandates.

Long-Term Care

NC Medicaid spends a large portion of its service dollars (approximately 36 percent) on long-term care. Long-term care includes nursing facility care (both skilled and intermediate levels of care), intermediate care facilities for the mentally retarded (ICF-MR), adult care home personal care services and a variety of home and community-based services. As shown below, total expenditures for long-term care during SFY 2003 were approximately $2.2 billion, a modest increase of 1.2 percent over the previous year.

Exhibit B-1

NC Medicaid Long Term Care vs. Non-Long Term Care Expenditures - SFY 2002 vs. 2003 ($Millions)



Facility Care Services

Nursing Facility Care

There are times when nursing facility care is the best option for Medicaid recipients. All Medicaid-certified nursing facilities are required to provide skilled nursing (SN) and intermediate care (IC). Nursing facility reimbursement rates differ based on whether a resident requires skilled or intermediate level of care. In SFY 2003, a total of 31,666 Medicaid recipients received skilled care in nursing facilities costing $449 million. A total of 25,027 recipients received intermediate care costing $419 million.

All Medicaid recipients must receive prior approval before admission to a nursing facility. Prior approval is given only if recipients meet the State's stringent medical criteria for admission. There is also a federal requirement for preadmission screening and annual resident review (PASARR) to screen and evaluate applicants and residents of Medicaid certified nursing facilities for mental illness, mental retardation, developmental disabilities, and related conditions.

Medicaid allows an individual with a spouse living in a nursing facility to keep a larger portion of the couple's income than normally allowed under Medicaid eligibility rules. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The income of the spouse living at home is considered in determining whether an allowance is budgeted. The total income and resources amount that may be protected for the at-home spouse increases each year.

Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

ICF-MR facilities are long-term care facilities for the mentally retarded/developmentally disabled that meet certain federal criteria. The criteria include the need for active treatment for individuals that have mental retardation or a related condition and who have a severe, chronic disability. ICF-MR facilities must meet certification requirements relating to the provision of habitable services as well as basic intermediate care services. ICF-MRs are paid prospective per diem rates. During SFY 2003, a total of 4,601 recipients were treated in ICF-MRs at a total cost of $411 million.

Adult Care Home Personal Care Services

In 1995, NC Medicaid began covering personal care services for residents in adult care homes who are eligible for Special Assistance for Adults (SA) and Medicaid (see the "Personal Care Services" subsection below for a description of personal care services in the home). In 1996, Medicaid expanded this coverage by creating "enhanced" adult care home personal care and adult care home case management services for residents of adult care homes who met Medicaid criteria for being a "heavy care" resident. A monthly average of 20,515 North Carolinians received personal care services in Adult Care Home settings in SFY 2003 at a total cost of $107 million. Another 3,796 per month on average received enhanced personal care services at a total of $9.7 million. Additionally, a monthly average of 20,140 received transportation services related to the Adult Care Home program at a total expense of $4.5 million.

Home and Community-Based Services

Home and community-based long-term care is a cost-effective and preferable alternative to institutionalization. Medicaid recipients can receive several home-based services such as home health, personal care services, home infusion therapy and hospice.

Home Health Services

Medicaid covers visits provided by certified home health agencies for skilled nursing, physical therapy, speech-language pathology services, occupational therapy and home health aide services when the home is the most appropriate setting for the care. Medical supplies such as adult diapers, disposable bed pads, catheter and ostomy supplies are also covered under home health. Agencies are paid the lower of their customary charge to the general public or a maximum per visit rate established by DMA for each service.

Community Alternatives Program (CAP)

North Carolina operates four Community Alternatives Programs as another option for home and community care as a cost-effective alternative to insti-tutionalization. These are known as "waiver" programs because standard federal program requirements are waived to allow the program to operate. The waiver programs provide some services that otherwise are not covered under Medicaid.

- **Community Alternatives Program for Disabled Adults** (CAP/DA) - CAP/DA provides a package of services to allow adults, age 18 and older, who qualify for nursing facility care, to remain in their private residences. CAP/DA experienced significant growth for many years as DMA pushed its expansion into all counties and fostered the growth of existing county programs. CAP/DA has been the state's primary answer to controlling the growth of nursing facility expenditures while addressing quality of life issues for the expanding frail elderly and disabled adult population. It offers North Carolina the only significant avenue for addressing Olmstead issues for the frail elderly and physically disabled adults. Due to the state budget crisis, participation in the program was frozen in October 2001 through July 2002. Additional support from the legislature enabled the freeze to be lifted. The program served a total of 10,714 citizens in SFY 2003 at a total cost of $185 million.
- **Community Alternatives Program for Persons with Mental Retardation/ Developmental Disabilities (CAP-MR/DD)** - CAP-MR/DD is a special Medicaid home and community-based "waiver" program. It was implemented in 1983 to serve individuals who would otherwise qualify for care in an ICF-MR. It allows these individuals the opportunity to be served in the community instead of residing in an institutional setting. The Medicaid cost for community care must be cost effective in comparison to the cost of ICF/MR care. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services manages the daily operation of the program under an agreement with DMA. The program is available statewide through local area mental health, developmental disabilities and substance abuse programs. CAP-MR/DD served a total of 5,742 people in SFY 2003 at a total cost of $260 million. The average monthly cost per recipient of CAP-MR/DD services was approximately 41 percent of the average cost of care at a state-owned ICF/MR facility and 61 percent of that at a non-state-owned facility.
- **Community Alternatives Program for Children (CAP/C)** - CAP/C provides home-based care for medically fragile children through age 18 who would otherwise require long-term hospital care or nursing facility care. A total of 734 children participated in CAP/C in SFY 2003 at a cost of $24 million. The program contributed to the quality of life for the children and their families/caregivers, while providing care that was cost effective in comparison to a mix of institutional care at either hospital intensive care units (approximately 40 percent of the institutional care, at an average cost of roughly $15,000 and $20,000 per month) or nursing facilities.

- **Community Alternatives Program for Persons with AIDS (CAP/AIDS)** - CAP/AIDS offers a home care alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive with other qualifying conditions. CAP/AIDS is a cooperative effort with the Division of Public Health's AIDS Care Unit. The AIDS Care Unit administers the program with DMA providing oversight. This program began in late 1995 and is still developing statewide. A total of 96 people were served in SFY 2003 at a cost of $947,034 or $9,865 per person, which is a significantly lower cost than the alternative mix of institutional care at hospitals and nursing facilities, thus saving NC Medicaid roughly $30,000 per recipient per year.

Overall, CAP has been very successful in giving individuals an alternative to living in an institution, while containing costs to the Medicaid program. The programs have allowed those who otherwise would be institu-tionalized to remain with their family in familiar surroundings. All of these benefits cost Medicaid less than institutional care.

Personal Care Services (PCS)

PCS covers personal aide services in private residences to perform personal care tasks for recipients who, due to a debilitating medical condition, need help with such basic personal activities as bathing, toileting, and moving about. Aides also monitor the patient's vital signs. Services may also include housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining the patient's basic personal health. PCS is provided for the patient according to a physician's authorized plan of care. Recipients could receive up to 80 hours of PCS in a calendar month for dates of service between July 1 and November 30, 2002 and up to 60 hours per month for dates of service on and after December 1, 2002. During SFY 2003, a total of $189 million was spent on a monthly average of 20,902 PCS recipients.

Home Infusion Therapy (HIT)

HIT is for recipients who live in a private residence or adult care home. Coverage is for self-administration of a drug or nutrition therapy. The recipient or an unpaid caregiver may administer the therapy after appropriate training.

Private Duty Nursing (PDN)

PDN coverage is for recipients who live in a private residence and require substantial and complex continuous nursing care as ordered by the attending physician. PDN must have prior approval, which may include a visit to the recipient's home to verify the medical necessity for the service.

Hospice

Hospice is a package of medical and support services for terminally ill patients with a medical prognosis of a six month or less life expectancy. Services are provided in a private residence, adult care home, hospice residential care facility or a hospice inpatient unit. They may also be provided in a hospital or nursing facility under arrangement with the hospice agency.

Durable Medical Equipment (DME)

Medicaid pays for DME when it is medically necessary for a recipient to function in his home or an adult care home. The list of covered items includes wheelchairs, hospital beds, blood glucose monitors, ambulation devices, enteral formulas, bedside commodes, oxygen

and respiratory equipment and supplies used with DME. Orthotic and prosthetic devices, including braces and artificial limbs, are covered for recipients from birth through age 20. The patient's physician must order DME and document medical necessity on the Medicaid Certificate of Medical Necessity and Prior Approval form. Some items require prior approval. All DME and related supplies have established lifetime expectancies and quantity limitations.

Behavioral Health

NC Medicaid covers a variety of services for behavioral health, some under the rehabilitation option and others under the clinic option. Services provided under the rehabilitation option are provided by Area Mental Health Centers and include Outpatient Therapy, Psychological Testing, Day Treatment, Partial Hospitalization, Psychosocial Rehabilitation, Facility-Based Crisis, and Community-Based services for recipients of all ages and Residential services for recipients under the age of 21. Clinic services include Outpatient Therapy and Psychological Testing provided by directly enrolled providers and LEAs. Medicaid also covers inpatient psychiatric care in psychiatric units for recipients of all ages and in free-standing psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTFs) for recipients under the age of 21. Inpatient services, residential services, and outpatient therapy must go through a prior approval process (see "Behavioral Health Prior Approval" under the Utilization Management section of "How the NC Medicaid Program Works", Addendum A to the NC Medicaid SFY 2003 Annual Report).

DMA also provides services in ICF-MRs, which are long-term care facilities for individuals with mental retardation or a related condition that occurred before the age of 22. Please see the "Intermediate Care Facilities for the Mentally Retarded (ICF-MR)" subsection of the "Long-Term Care" section of this addendum.

Dental Health

NC Medicaid covers most general dental services such as diagnostic exams and radiographs, and preventive services such as dental cleanings, fluoride treatments, and sealants. Restorations, surgeries, and partial and full dentures are covered as well as orthodontic services for children under age 21. Most dental services do not require prior approval. Except where a coverage category is exempted from copays by law, recipients are charged a $3 copayment per visit. A special children's initiative effective February 1, 2001, allowed children from birth to age three to receive special preventive dental services provided by physicians in an attempt to decrease the incidence of early childhood caries and improve access to dental care

Pharmacy

Prescription drugs and insulin (where the manufacturers have signed a rebate agreement with CMS) are covered under the pharmacy program. Recipients may have up to six prescriptions per month and are locked into one pharmacy provider during the month of service. A recipient copayment of $1 applies for generic medications and $3 for brand medications. NC Medicaid does not pay for a drug to be refilled during the same month that the prescription is originally filled. Recipients may have a 34-day supply of their prescription medication and a 3-month supply of birth control pills (BCP) and hormonal replacement

therapy (HRT) dialpaks. The pharmacy reimbursement fee structure is as follows: AWP (average wholesale price) – 10 percent, State MAC, Federal Upper Limit or Usual and Customary, whichever is lower, plus a dispensing fee of $5.60 per generic prescription or $4.00 per brand name prescription.

Drug Use Review Program

NC Medicaid established a Drug Use Review (DUR) Program as required by OBRA of 1990 to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and are not likely to result in adverse medical effects. The DUR program is characterized by the following four major components:

- **DUR Board** - A DUR Board is composed of five licensed and actively practicing physicians, five licensed and actively practicing pharmacists, two other individuals with expertise in drug therapy problems, and the DMA DUR Coordinator. The DUR Board makes recommendations to DMA on DUR policies and procedures.
- **Prospective DUR** - Prospective DUR requires that, prior to dispensing, the pharmacist must screen for potential drug therapy problems and counsel patients about the medications they are taking in order to enhance patient compliance.
- **Retrospective DUR** - Retrospective DUR is an ongoing periodic examination of Medicaid claims data and other records to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients associated with specific drugs or groups of drugs and the appropriate treatment of disease states. These analyses are based on predetermined standards established by the DUR Board. North Carolina contracted with FHSC to provide the computer support for the retrospective DUR.
- **Education** - Education is the key to an effective DUR Program. The DUR Program must provide ongoing outreach programs to educate physicians and pharmacists about common drug therapy problems with the goal of improved prescribing and dispensing practices.

The DUR Program uses a Provider Profiling System to complement the retrospective patient-based drug utilization reviews. This system is designed to be a retrospective characterization of drug use patterns. The Provider Profiling System identifies any prescribing and dispensing practices that deviate from accepted norms. These norms may be defined by the Board, taken from published literature or modified as needed. The Provider Profiling System is criteria driven and accommodates client-specific criteria within any of 12 broad problem types. Since the primary focus of the DUR Program is educating providers about common drug therapy problems to improve prescribing and dispensing practices, the providers who are profiled receive educational letters with profiles of each recipient who receives the medication and prescribing information related to the patient's drug therapy.

Optical Services

The Optical Services Program within the Medical Policy Section of DMA is responsible for the overall administration of visual services covered in the NC Medicaid Program. Medicaid covers routine and medical eye examinations, corrective eyeglasses, medically necessary

contact lenses and some other visual aids. Prior approval is required for all visual aids and is recommended for routine eye examinations. There are limitations regarding the frequency of eye examinations and the number of dispensed visual aids during specific eligibility periods. A $3 copayment is applicable to ophthalmologist visits, while a $2 copayment applies to optical services and supplies. Although a $2 copayment is generally required for new eyeglasses, eyeglass repairs and contact lenses, there are some exemptions.

Medicaid eyeglasses are supplied through a contractual agreement with the North Carolina Department of Correction Enterprise, Nash Optical. Providers must obtain Medicaid eyeglasses through this laboratory. Prior approval for exceptions may be granted under extenuating circumstances.

Hearing Aid Services

Single and binaural hearing aids are covered for recipients under 21 years of age that have received medical clearance from a physician. An ENT specialist, otologist, otolaryngologist, audiologist or hearing aid dealer must submit a prior approval request for the hearing device, audiogram, evaluation report and manufacturer's warranty information. Each prior approval request for replacement hearing aids due to hearing changes, damaged hearing aids or lost hearing aids is reviewed individually for medical necessity. Providers may seek prior approval for FM systems for recipients from birth up to the time of school enrollment. There are no co-payments for hearing aids, hearing aid accessories, or hearing aid services.

Medicare-Aid

In February 1989, North Carolina began a new limited Medicaid program for Qualified Medicare Beneficiaries. The program, known as Medicare-Aid, provides assistance to eligible individuals with Medicare cost-sharing expenses, such as deductibles, premiums, and coinsurance charges. The eligibility income limit for Medicare-Aid is 100 percent of the federal poverty level. This level is adjusted in April of each year.

Effective January 1, 1993, the Medicare-Aid program was expanded to include qualified individuals with income greater than 100 percent of the federal poverty level but not greater than 120 percent. These individuals are referred to as Specified Low-Income Medicare Beneficiaries. Eligible individuals in this group receive assistance with the payment of their Medicare Part B premium only.

In January 1998, the Medicare-Aid program was further expanded to include two new groups of Medicare beneficiaries. Eligible individuals with incomes between 121 percent and 135 percent of the federal poverty level receive assistance with the payment of their Medicare Part B premiums. Funding for these groups is capped and approval of assistance is based on a first-come first-serve basis.

During SFY 2003, a total of 40,362 recipients benefited from Medicare-Aid. Total cost for this coverage was $27 million.

ACKNOWLEDGMENTS

Editorial Panel

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

Sarah Long
Administrative Assistant
Budget & Finance Management

Darlene Creech
Service Consultant
Medical Policy

Bo Nowell
Assistant Director
Program Integrity

Julia McCollum
Human Services Planner/Evaluator
Managed Care

Gina Rutherford
Administrative Assistant
Recipient and Provider Services

Lois Nilson
Public Information Officer
Office of Public Affairs

Contributing Writers

Deborah Bowen
Debbie Chamblee
Darlene Creech
Geoff Elting
Mamta Gentry
Pat Jeter
Beth Karr
Gary Kugler
Sharman Leinwand
Carleen Massey
Julia McCollum
Lou Morton
Bo Nowell
Rhonda Owen
Gina Rutherford
Monica Teasley
Ron Venezie

Data, Tables and Graphics

Emad Attiah
Richard Cobb
Patricia Slaughter

Production

Linda Howard
Teri Reaves

nc department of health and human services

Division of Medical Assistance
2517 Mail Service Center
Raleigh, NC 27699-2517
(919) 857-4011
Gary H. Fuquay, Director

www.dhhs.state.nc.us/dma/

BLUE RIBBON COMMISSION ON MEDICAID REFORM

Gary Fuquay, Director
Division of Medical Assistance
March 24, 2004

Attachment # 3

[redacted]RTMENT OF HEALTH AND HUMAN SERVICES
[redacted]N OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

ALL ELIGIBLES YTD
JANUARY 2004
TOTAL SERVICES & PREMIUMS

PAID			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
4,153,072,645	3,762,982,460	390,090,185	10.37%

UNITS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
199,828,140	187,864,100	11,964,040	6.37%

ELIGIBLES			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
1,088,647	1,037,227	51,420	4.96%

ALL ELIGIBLES YTD

JAN 2003 VS JAN 2004

TOTAL LONG TERM CARE SERVICES & PREMIUMS

PAID			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
$1,329,108,055	$1,319,411,794	$9,696,262	0.73%

UNITS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
116,076,181	116,127,506	(51,325)	-0.04%

AVERAGE MONTHLY RECIPIENTS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
158,593	155,492	3,101	1.99%

Notes:

1) Long term care expenditures of $1,329,108,055 represent 32% of total service and premium expenditures YTD January 2004 .

2) Long term care includes skilled and intermediate care nursing facilities, hospital long term care, home health, durable medical equipment, Community Alternative Programs, home infusion therapy, hospice, personal care services and adult care home services.

3) "Average Monthly Recipients" is a duplicated count; recipients using one or more services are counted in each of the various Long Term Care service categories.

ALL ELIGIBLES YTD
JAN 2003 VS JAN 2004
TOTAL NON-LONG TERM CARE SERVICES & PREMIUMS

PAID			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
$2,823,964,590	$2,443,570,666	$380,393,923	15.57%

UNITS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
83,751,959	71,736,594	12,015,365	16.75%

AVERAGE MONTHLY RECIPIENTS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
1,173,930	1,115,391	58,539	5.25%

Note:

1) Non-long term care expenditures of $2,823,964,590 represent 68% of total service and premium expenditures YTD January 2004 .

2) "Average Monthly Recipients" is a duplicated count; recipients using one or more services are counted in each of the various non-long term care service categories.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

SOURCES OF CHANGE IN YEAR TO DATE AMOUNTS PAID

ALL SERVICES YTD JANUARY 2004 PROGRAM AID CATEGORY	PAID SFY 2004	PAID SFY 2003	INCREASE (DECREASE)	INCREASE (DECREASE) AS PERCENT	PERCENT OF TOTAL CHANGE BY PAC
AGED	1,083,497,031	1,041,603,471	41,893,561	4.02%	10.74%
BLIND	16,426,858	16,804,456	(377,598)	-2.25%	-0.10%
DISABLED	1,735,577,517	1,567,340,517	168,237,000	10.73%	43.13%
AFDC UNDER 21	286,916,733	244,205,738	42,710,995	17.49%	10.95%
AFDC OVER 21	371,900,854	315,260,271	56,640,582	17.97%	14.52%
OTHER CHILDREN	41,891,718	39,019,502	2,872,216	7.36%	0.74%
MPW	121,187,729	118,382,045	2,805,683	2.37%	0.72%
MIC	462,552,230	388,197,591	74,354,639	19.15%	19.06%
MQBQ	376,779	420,042	(43,263)	-10.30%	-0.01%
MQBB	11,196,300	10,083,955	1,112,345	11.03%	0.29%
MQBE	4,978,680	4,456,755	521,925	11.71%	0.13%
LEGAL ALIENS	749,461	419,305	330,156	78.74%	0.08%
ILLEGAL ALIENS	28,202,785	25,551,781	2,651,004	10.38%	0.68%
REFUGEES	344,130	1,026,992	(682,862)	-66.49%	-0.18%
UNRECOGNIZED	(12,726,160)	(9,789,962)	(2,936,199)	0.00%	-0.75%
ALL ELIGIBLES	4,153,072,645	3,762,982,460	390,090,185	10.37%	100.00%

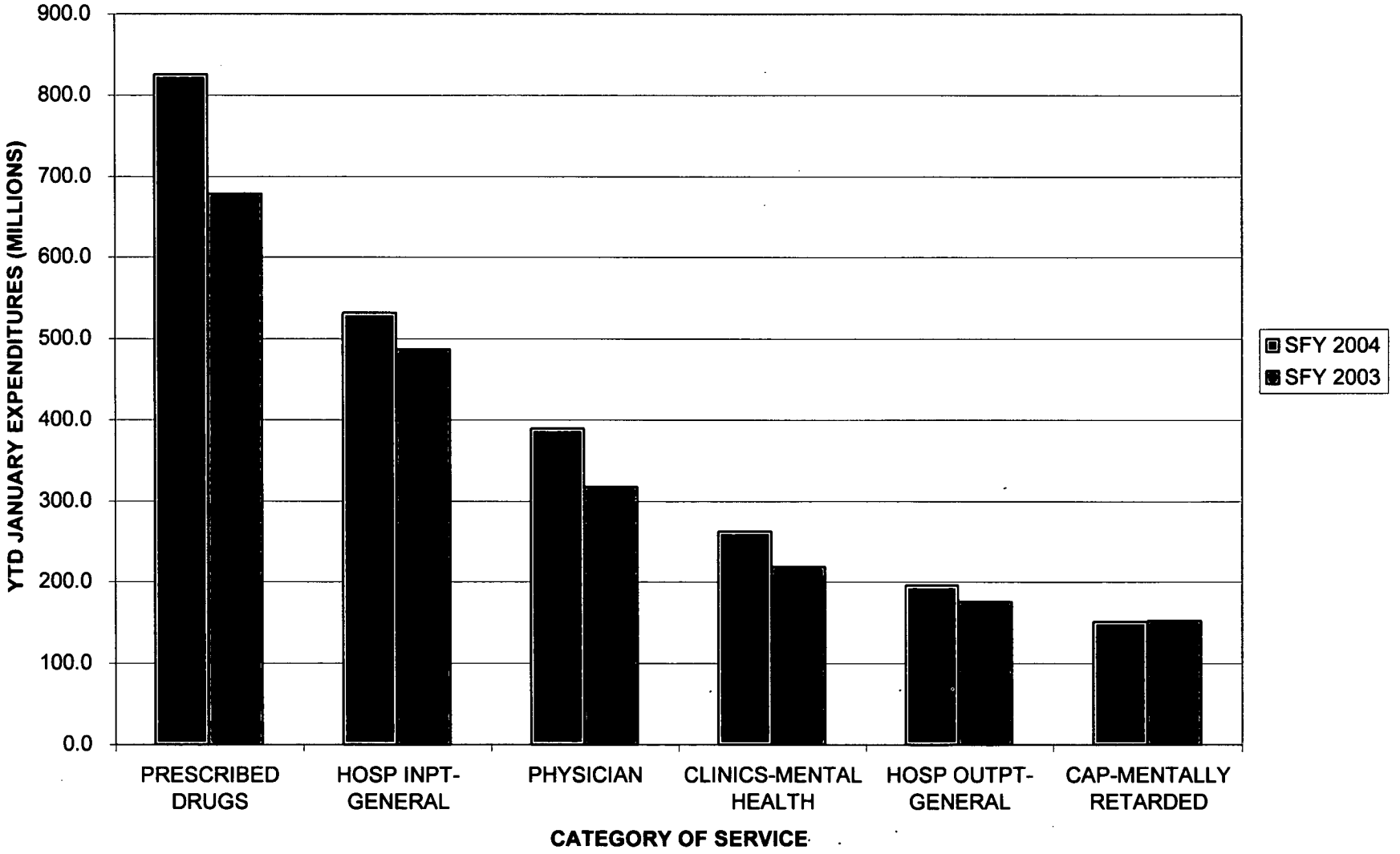
ELIGIBLES AND EXPENDITURES YTD JAN 2004					
	# Eligibles	% Total		Expenditures	% Total
AGED	126,618	11.6%		$1,083,497,031	26.1%
BLIND	2,006	0.2%		$16,426,858	0.4%
DISABLED	199,064	18.3%		$1,735,577,517	41.8%
AFDC UNDER 21	222,246	20.4%		$286,916,733	6.9%
AFDC OVER 21	130,839	12.0%		$371,900,854	9.0%
OTHER CHILDREN	3,686	0.3%		$41,891,718	1.0%
MPW	20,046	1.8%		$121,187,729	2.9%
MIC	347,592	31.9%		$462,552,230	11.1%
MQBQ	566	0.1%		$376,779	0.0%
MQBB	24,688	2.3%		$11,196,300	0.3%
MQBE	10,943	1.0%		$4,978,680	0.1%
LEGAL ALIENS	267	0.0%		$749,461	0.0%
ILLEGAL ALIENS	0	0.0%		$28,202,785	0.7%
REFUGEES	0	0.0%		$344,130	0.0%
UNRECOGNIZED	0	0.0%		($12,726,160)	-0.3%
ALL ELIGIBLES	1,088,647	100.0%		$4,153,072,645	100.0%

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

FIFTEEN MOST EXPENSIVE CATEGORIES OF SERVICE

YEAR TO DATE JANUARY 2004 COS DESCRIPTION	ALL ELIGIBLES			
	PAID		VARIANCE	PERCENT
	SFY 2004	SFY 2003	OVER (UNDER)	CHANGE
PRESCRIBED DRUGS	$825,590,130	$678,560,294	$147,029,836	21.67%
HOSP INPT-GENERAL	$531,353,764	$486,629,988	$44,723,776	9.19%
PHYSICIAN	$389,060,372	$317,821,333	$71,239,040	22.41%
CLINICS-MENTAL HEALTH	$262,207,312	$218,233,429	$43,973,883	20.15%
CAP-MENTALLY RETARDED	$151,110,161	$152,461,117	($1,350,956)	-0.89%
HOSP OUTPT-GENERAL	$195,913,085	$175,400,038	$20,513,047	11.70%
CAP-DISABLED	$112,838,756	$109,580,576	$3,258,180	2.97%
PERSONAL CARE	$120,842,832	$113,086,861	$7,755,971	6.86%
HOSP OUTPT-EMERGENCY ROOM	$99,659,000	$86,435,066	$13,223,934	15.30%
PART B BUY-IN DUAL Q	$76,489,990	$69,050,896	$7,439,094	10.77%
ACH-PCS BASIC	$65,649,098	$63,039,841	$2,609,257	4.14%
DENTAL	$102,646,892	$71,638,191	$31,008,700	43.29%
HOME HEALTH	$55,489,929	$56,421,116	($931,187)	-1.65%
HIGH RISK INTERVENTION	$55,880,851	$41,124,174	$14,756,677	35.88%
DURABLE MEDICAL EQUIPMENT	$36,184,130	$33,282,611	$2,901,519	8.72%
TOTAL FOR THE 15 TOP COS	$3,080,916,302	$2,672,765,532	$408,150,770	15.27%
TOTAL SVC. & PREM. EXPEND.	$4,153,072,645	$3,762,982,460	$390,090,185	10.37%
% TOP 15 COS VS. TOTAL ALL COS	74.2%	71.0%		

SIX HIGHEST COST SERVICE CATEGORIES



COMPONENTS OF 6 NON LONG TERM CARE CATEGORIES OF SERVICE
WITH HIGHEST EXPENDITURE INCREASES
YTD SFY 2004 OVER YTD SFY 2003

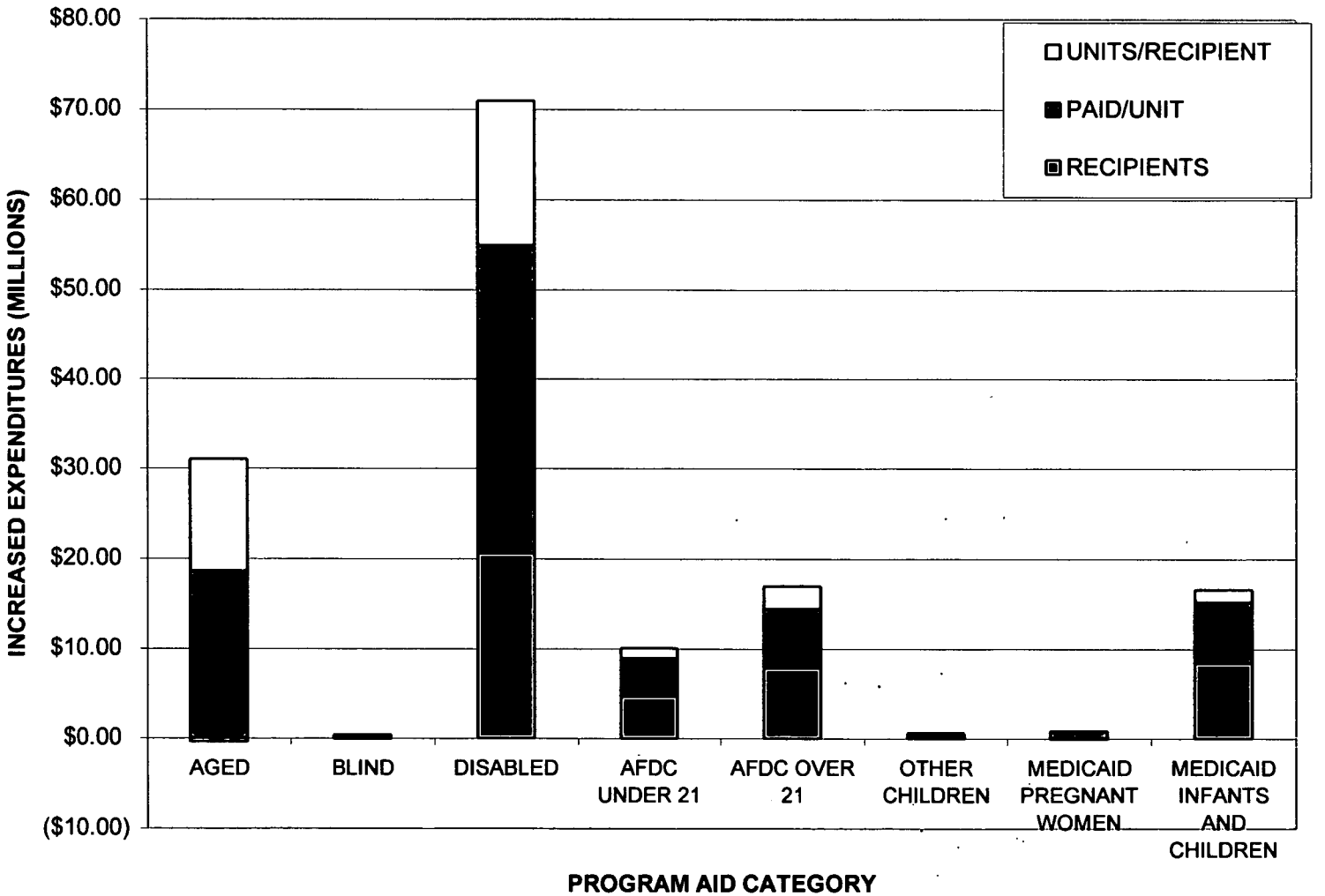
YEAR TO DATE JANUARY 2004 CATEGORY OF SERVICE	CHANGE IN AVERAGE MONTHLY RECIPIENTS	PERCENT OF TOTAL	CHANGE IN AVERAGE MONTHLY AMOUNT PAID PER SERVICE UNIT	PERCENT OF TOTAL	CHANGE IN AVERAGE MONTHLY UNITS CONSUMED PER RECIPIENT	PERCENT OF TOTAL	TOTAL INCREASE EXPENDITURES	PERCENT
PRESCRIBED DRUGS	$58,269,472	39.6%	$71,468,912	48.6%	$17,291,451	11.8%	$147,029,836	100%
HOSP INPT-GENERAL	$74,069,940	165.6%	$5,674,058	12.7%	($35,020,222)	-78.3%	$44,723,776	100%
PHYSICIAN	$45,945,024	64.5%	$19,524,375	27.4%	$5,769,641	8.1%	$71,239,040	100%
CLINICS-MENTAL HEALTH	$7,042,748	16.0%	($8,480,472)	-19.3%	$45,411,608	103.3%	$43,973,883	100%
CAP-MENTALLY RETARDED	($4,150,686)	307.2%	($14,734,410)	1090.7%	$17,534,140	-1297.9%	($1,350,956)	100%
HOSP OUTPT-GENERAL	$35,017,531	170.71%	($18,415,246)	-89.8%	$3,910,763	19.1%	$20,513,047	100%

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

COMPONENTS OF INCREASES IN SFY 2004 YTD EXPENDITURES OVER SFY 2003 YTD EXPENDITURES BY PROGRAM AID CATEGORY

PRESCRIPTION DRUGS YEAR TO DATE JANUARY 2004	INCREASE DUE TO CHANGE IN NUMBER OF RECIPIENTS	PERCENT OF TOTAL INCREASE	INCREASE DUE TO CHANGE IN AMOUNT PAID PER SERVICE UNIT	PERCENT OF TOTAL INCREASE	INCREASE DUE TO CHANGE IN NUMBER OF UNITS USED PER RECIPIENT	PERCENT OF TOTAL INCREASE	TOTAL INCREASES BY PROGRAM AID CATEGORY	TOTAL PERCENT
AGED	($392,984)	-1.28%	$18,555,380	60.54%	$12,489,065	40.75%	$30,651,461	100.00%
BLIND	($70,231)	-23.49%	$234,708	78.49%	$134,551	45.00%	$299,028	100.00%
DISABLED	$20,592,720	29.02%	$34,263,416	48.29%	$16,098,570	22.69%	$70,954,705	100.00%
AFDC UNDER 21	$4,635,250	46.09%	$4,267,166	42.43%	$1,155,030	11.48%	$10,057,446	100.00%
AFDC OVER 21	$7,854,141	46.14%	$6,556,706	38.52%	$2,610,311	15.34%	$17,021,158	100.00%
OTHER CHILDREN	$208,393	31.37%	$395,242	59.49%	$60,737	9.14%	$664,371	100.00%
MEDICAID PREGNANT WOMEN	($42,853)	-5.37%	$691,365	86.58%	$149,977	18.78%	$798,490	100.00%
MEDICAID INFANTS AND CHILDREN	$8,459,698	50.84%	$6,735,970	40.48%	$1,444,580	8.68%	$16,640,248	100.00%

COMPONENTS OF INCREASED PRESCRIPTION DRUG EXPENDITURES
YTD SFY 2004 OVER YTD SFY 2003



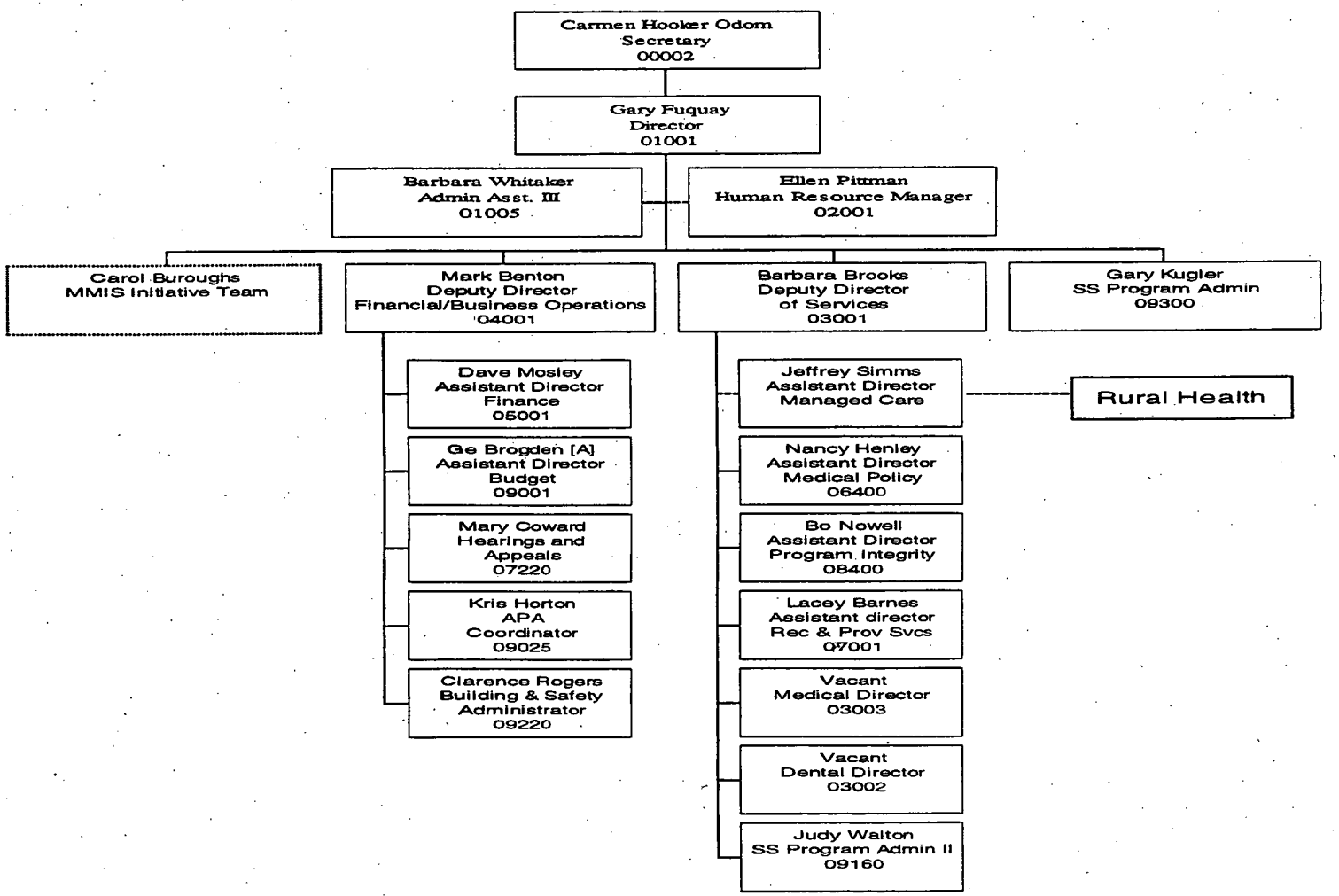
ORGANIZATION

DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Effective Date: February 18, 2004

Gary Fuquay, DMA Director

Date 2/25/04



Summary of New Positions for DMA

04-Jan

	Position Title	Pay Grade	
1.	Pharmacy Manager II	82T	Clinical Affairs
2.	DMA Nurse II	74T	Clinical Affairs
3.	Optician	70	Clinical Affairs
4.	DMA Nurse II	74T	Clinical Affairs
5.	DMA Nurse II	74T	Clinical Affairs
6.	Medicaid Program Services Chief	74T	Clinical Affairs
7.	Dentist II	85	Clinical Affairs
8.	Physician Director III	NG	Clinical Affairs
9.	Medicaid Program Services Chief	74T	Clinical Affairs
10.	Information & Communication Spec	68	Clinical Affairs
11.	DMA Nurse II	74T	Clinical Affairs
12.	DMA Nurse I	72T	Clinical Affairs
13.	DMA Nurse Supervisor	74T	Clinical Affairs
14.	DMA Nurse I	72T	Clinical Affairs
15.	Office Assistant V	61	Clinical Affairs
16.	DMA Nurse II	74T	Clinical Affairs
17.	DMA Nurse II	74T	Clinical Affairs
18.	PH Epidemioligist	73T	Clinical Affairs
19.	DMA Nurse II	74T	Clinical Affairs
20.	Dental Hygentist II	70	Clinical Affairs

Non-Cost Containment Dollar Positions

	Position Title	Pay Grade	
1.	Accountant III	77	Finance
2.	Accountant II	75	Finance
3.	Applications Analyst Program I	76	Budget
4.	Accountant III	77	Budget
5.	Business Officer III	77	Budget
6.	Administrative Officer III	72	Budget
7.	Administrative Assistant II	65	Director's Office

Program Integrity (13 ¾)

03-September

	Position Title	Pay Grade	
1.	Processing Assistant IV	59	Provider Medical Review
2.	DMA Nurse I	72T	Provider Medical Review
3.	DMA Nurse I	72T	Provider Medical Review
4.	DMA Nurse I	72T	Provider Medical Review
5.	DMA Nurse I	72T	Provider Medical Review
6.	DMA Nurse I	72T	Provider Medical Review
7.	Program Integrity Investigator	68	Provider Admin. Review
8.	Program Integrity Investigator	68	Provider Admin. Review
9.	Program Integrity Investigator	68	Provider Admin. Review
10.	Processing Assistant V	61	Provider Admin. Review
11.	Processing Assistant V	61	Provider Admin. Review
12.	DMA Nurse I	72T	Home Care Review
13.	DMA Nurse I	72T	Home Care Review
¾	Pharmacist	77T	Pharmacy Review

PROGRAM INTEGRITY

PAYMENT INTEGRITY ACCOMPLISHMENTS IN MEDICAID

NC Medicaid saved $1,329,538,709 through collections and cost avoidance in SFY 2003. DMA Program Integrity (PI), the Attorney General's Medicaid Investigation Unit, and the 100 county departments of social services worked together to achieve these savings. This was accomplished through a variety of efforts such as: PI reviews of provider billings and medical records, coordination with insurers and payers where Medicaid was not the primary payer, through estate recovery, and through legal and civil actions cooperatively with law enforcement.

- **$47 million in direct recoveries** from casualty, medical insurance and estate recovery activities was collected by Program Integrity's Third Party Recovery Section obtained. TPR also collects when insurance was unreported, authorized retroactively, or the claim was billed with incorrect information.

- **$1,026,280,066 in Medicaid payments was cost** avoided by having Medicare pay first. This is accomplished through pre-payment edits in the MMIS and updating the third party liability Medicare information

- **$214,975,840 in Medicaid payments was cost** avoided by identifying private health insurance polices that should pay before Medicaid. This is accomplished through pre-payment edits in the MMIS and continuously updating of insurance information

- **$11,268,920 was recovered** in overpayments by Program Integrity's four investigative unit efforts.

- **$14,000,000 in fines, penalties, and interest** was collected by the Attorney General's Medicaid Investigations Unit (MIU) when they concluded criminal and civil cases. The MIU gets 80% of their cases from PI investigations and use PI nurses as consultants. Money from the fines went to the State's School Fund as required by the NC Constitution. The MIU also had 31 convictions.

- **$1,683,701 was recovered by recipient fraud investigators** in the 100 county departments of social services. The State helped county investigators collect $106,801 by intercepting North Carolina income tax refund checks from delinquent debtors.

- **$14,330,182** through audits of nursing home and ICF/MR facilities by DMA Financial Operations staff.

- The Medicaid program, thanks to the work by the 100 county departments of social services, has a 99.3% accuracy rate in Medicaid eligibility determinations. Program Integrity's Medicaid Eligibility Quality Assurance Unit reviews a statewide sample of all Medicaid cases and provides feedback for corrective action to the county agencies.

- The Medicaid program has a 98.2% payment accuracy rate for the payment of Medicaid claims as determined by the Office of State Auditor. (See chart.)

MEDICAID PAYMENT ACCURACY MEASUREMENT BY PROGRAM INTEGRITY STAFF

1. **State Auditor Sample**: Program Integrity assists the Office of State Auditor in determining the accuracy rate for claims billed by providers to Medicaid by reviewing the medical records of the sampled claims. The State Auditor selects claims using a stratified sample for a 12-month state fiscal year of paid claims. (The current and historical rates are below.)

NC Medicaid – SFY 2003 Annual Error Rates for Claims Billed to Medicaid				
	# Of Claims in Sample	Error Rate per OSA	Confidence Level	Sampling Precision
1995-96	283	0.50%	95%	-0.04
1996-97	282	2.20%	95%	-0.04
1997-98	279	1.10%	95%	-0.04
1998-99	274	2.20%	95%	-0.04
1999-00	300	1.50%	95%	-0.04
2000-01	300	0.80%	95%	-0.04
2001-02	270	2.80%	95%	-0.04
2002-03	272	1.80%	95%	-0.04

2. **Medicaid Payment Accuracy Measurement (PAM) Demonstration Project:** HR 4878, The Improper Payments Act of 2002 requires payment accuracy measurement for claims paid with federal dollars. CMS expects to issue Payment Error Rate Measurement (PERM) regulations in late 2004 with a mandate for states to comply in 2005.

   For the past 3 years, DMA Program Integrity has participated in a Medicaid Payment Accuracy Measurement (PAM) demonstration project with the Center for Medicaid Services (CMS). The goal of the project is to help CMS determine the feasibility of estimating Medicaid claim payment accuracy for the Medicaid program at a state and national level. NC was chosen because of its long history of payment accuracy measurement activities, which was uncommon in other states.

   This project consists of a review of a stratified sample of Medicaid claims for a quarter. Program Integrity staff request medical records for the services billed to Medicaid and review to determine if the services were appropriately billed by the provider and paid correctly by Medicaid fiscal agent.

NORTH CAROLINA IS ONE OF SIX PILOT STATES SELECTED FOR A SPECIAL FRAUD DETECTION PROJECT

THE MEDICAID/MEDICARE (MEDI-MEDI) FRAUD PROJECT:

In 2003, NC DMA was selected as one of six pilot states in a national project, funded by the FBI, to combine our state's Medicare and Medicaid claims into one central data warehouse -- and then data mine that information to detect fraud and abuse. *"NC was chosen because of its high level of automation and experience dealing with data mining and fraud." (Statement by Paul Miner, CMS, Program Integrity).*

North Carolina was one of the first states to have its Computer Matching Agreement (CMA) approved by CMS and transfer its Medicaid data to the central data warehouse. Data matching is currently underway. Actual sharing and investigation of the findings is expected to start in late April 2004.

Combining claims and eligibility data from Medicare and Medicaid will provide a more complete picture of beneficiary care and provider practices than can be gained by analyzing data from one program in isolation. Such access will enable CMS and DMA to apply tools and technology to look for a wide range of potential fraud and abuse that can best, or only, be found by combining the data from the utilization of benefits across both programs.

This type of analysis will enhance the ability to identify providers "flying below the radar" because their actions in one program do not arouse suspicion, however an aberration will manifest upon analyzing data culled from more than one program. Medicare and the Medicaid programs will benefit from this data matching with the identification, research, development, and referral of fraud and abuse cases to law enforcement for action and recovery of Medicare and Medicaid funds.

The Medi-Medi program is expected to reveal evidence of over-utilization of services or over-billing. Utilizing fraud detection software, the information will then be used to identify patterns of aberrant practices requiring further investigation. We expect to find the following types of aberrant practices that may constitute fraud and abuse by practitioners, providers, and suppliers:

- billing for provisions of more than 24 hours of services in one day,
- providing treatment and services in ways more statistically significant than similar practitioner groups, and
- up-coding and billing for services more expensive than those actually performed.

CMS reports that the initial California pilot project yielded a $20 to $1 return on investment. Most of the investment in this project will be made by CMS. North Carolina's investment will be in staff time used for investigation.

PROGRAM INTEGRITY HAS ADDED STAFF

Thirteen and three quarter positions are being added to Program Integrity. These include: 7 nurses, 5 investigators, 1 support staff and a Pharmacist working 30 hours per month. These positions are being hired using cost containment money.

These additional staff will increase the time spent on investigations. It will increase the number of provider medical records than can be reviewed and thus increase recoveries. These positions will assist in the increased work resulting from the Medi-Medi project and the suspect cases still awaiting investigation.

FRAUD AND ABUSE DETECTION SYSTEMS

In 1999, the DMA Program Integrity Unit was one of the first few states to implement a fraud and abuse detection software system. DMA PI added fraud and abuse detection (FADS) software: The FADS consists of several proprietary software applications running off four years of claims data in Medicaid's data warehouse (DRIVE).

1. **HealthSPOTLIGHT™** - is a fraud and abuse detection and reporting system with a browser-based user interface tool. It was made operational in March 2000. SPOTLIGHT's web browser-based tool allows DMA and Attorney General staff real time access to:

   - 231,495,125 claims,
   - 80,979 enrolled providers, and
   - 2,187,045 recipients who have had Medicaid eligibility at some time.

   The investigators access this data to investigate cases, organize the data, drill-to-detail levels of information, and then export that data to spreadsheets. SPOTLIGHT™ currently has:

   - **31 specific fraud filters** are algorithms that identify aberrant billing behavior. Examples: Excessive recipients per workday. Controlled drugs without an associated physician/dentist visit. Excessive hours billed per day
   - **7 modeling techniques** compare specific types of provider billings to their peers. Examples. A spike detection model looks for suspicious surges in billings. Another model uses neural or learning technology to profile providers based on data driven peer groupings.

2. **OMNIALERT™** - is a utilization review system made operational in March 2001. The software creates peer-to-peer comparisons of provider billings to identify providers billing in patterns that are excessive and unlike their peers. Providers with aberrant billings "except" out for billing above the norms for any service. These are then examined to determine if the billings are normal or improper.

3. **DRIVE – DATA WAREHOUSE** – the third part of the PI Fraud and Abuse Detection System is the Drive system. Using SAS data mining software, PI investigators are able to identify claims and conclude investigations faster.

4. **CONTRACT SERVICES** - PI also contracts with Medical Review of North Carolina for PI investigations and with PCG to assist in identifying health insurance and direct billing private insurance companies. In the coming year, PI will also be exploring more opportunities for contracting with private companies to continue to recover incorrect payments and cost avoidance savings.

ABOUT THE DMA PROGRAM INTEGRITY SECTION

PROGRAM INTEGRITY OVERVIEW

- Program Integrity has **four investigative units** that use fraud and abuse detection, utilization review and other data mining software to detect overpayments. Fraud cases are sent to the Attorney General's Medicaid Investigation Unit (MIU). The PI nurses are then consultants who support the MIU's medical review and case development. PI investigative staff primarily recovers administrative overpayments by providers who bill Medicaid incorrectly or lack documentation to support their billings. They helped to recover $11,268,920 in SFY 2003.

- Program Integrity has **a payment accuracy measurement unit** that determines the accuracy (or error) rate for claims submitted to Medicaid for payment. The majority of the error is due to providers failing to submit or have documentation for the services they billed to Medicaid. This unit also coordinates the fraud and abuse detection system with the 4 investigative units above.

- Program Integrity's **Third Party Recovery section** identifies unreported insurance coverage and obtains money from those sources. It works with attorneys on liability cases to get reimbursed in those settlements. It also complies with the NC Estate Recovery law to obtain reimbursement from deceased recipients. Program Integrity's Third Party Recovery Section cost avoided Medicaid payments of $1,026,280,066 for Medicare claims and $214,975,840 for private health insurance. The unit also obtained $47 million in direct recoveries from casualty, medical insurance and estate recovery activities.

- Program Integrity's **Quality Assurance section** determines the accuracy (error) rate of recipients determined to be eligible by county departments of social services. They are also involved with corrective action for the problems found. This unit also has staff that trains, develops policy and coordinates with the 100 counties for their recipient fraud program investigations.

SPECIFIC DUTIES OF EACH PI SECTION:

The Provider Medical Review Section supervisor nurse has seven registered nurses and one support person. This section performs post payment review of claims billed to determine if the services were medically necessary, were of acceptable quality, and conform to Medicaid coverage and billing policies.

Reviews are performed primarily on physicians and hospitals, but also on other provider types to whom Medicaid makes payments such as ambulance, optometrists, podiatrists, and rural health clinics.

Reviews are initiated from automated reports, the fraud and abuse detection system, referrals from licensing and social service agencies, and complaints from recipients and the general public. Reviews involve examination of claims/payment data, medical record documentation, and research and application of Medicaid coverage policy.

The Home Care Review Section supervisor nurse has five registered nurses and one support staff. They conduct post payment reviews of Medicaid recipients receiving home and community based services. The nurse reviewers determine if Home Health, Personal Care Services, Durable Medical Equipment, Hospice, Home Infusion Therapy, etc. are provided to recipients, medically necessary, appropriate and of high quality. Reviews are often conducted on-site unannounced.

The Pharmacy Review Section includes a registered pharmacist supervisor, three investigators, and one support staff. They conduct post payment reviews of claims on-site, recover overpayments, resolve pharmacy complaint calls and educate providers regarding policy and/or problem areas. This section also provides support and resources to Attorney General's Medicaid Investigations Unit.

The Provider Administrative Review Section (PARS) include the supervisor (a registered Dental Hygienist), three investigators, one Operations Accountant, one Operations Analyst, one Claims Processing Assessment System (CPAS) Supervisor, two CPAS analysts, and two support staff.

PARS Investigative/Operations staff perform post-payment administrative reviews of provider (except Pharmacy) claims and services to determine the

appropriateness of claim submission practices and verify providers' compliance with Medicaid coverage, billing policies and Provider Participation Agreements/contracts. Administrative reviews involve examination of claims/payment data, medical record documentation, and research and application of Medicaid coverage policy. Post payment reviews of Dental Providers include review of clinical services to determine if the services were medically necessary and were of acceptable quality. Reviews of patient personal fund issues by PARS investigator/accountant assure that Medicaid recipients residing in nursing facilities are not incorrectly billed for Medicaid covered services.

The four member Claims Processing Assessment System (CPAS) Unit reviews the claims paid by the fiscal agent to assure that payments are accurate, and that all edit/audit system deficiencies are identified for corrective actions. This unit identifies existing system edits and audits that are not working properly, as well as identifying situations where new edits and audits should be developed to prevent inappropriate payments.

The Third-Party Recovery Section and System Support Section (TPR) is primarily responsible for the recovery of Medicaid payments for services that should have been paid by health insurance plans and liability insurance. TPR is also responsible to ensure that accurate insurance information is on recipient files before Medicaid pays claims. Program Integrity's Third Party Recovery Section cost avoided Medicaid payments of $1,026,280,066 for Medicare claims and $214,975,840 for private health insurance. The unit also obtained $47 million in direct recoveries from casualty, medical insurance and estate recovery activities.

The TPR Section has 31 employees within the following units:

- Casualty Investigations: recovers Medicaid payments from other insurers due to accidental injuries, and product or medical negligence
- Post Payment: handles Credit Balance reports and audits; Estate recoveries; Medical Support Payments (IV-D); Health Insurance Premium Payments (HIPP); Medicare overpayments
- Cost Avoidance: updates recipient files for other insurance; processes claims denied for other insurance; recovers prescription drug payments; oversight of PCG contract
- Systems Support: develops queries to the Medicaid claim data warehouse (DRIVE) to support provider investigations; performs ad hoc reports of provider activities to identify areas of abuse and/or fraud; assists in maintaining the Fraud and Abuse Detection system; provides programming for TPR to use automation in place of manual processes to expedite recovery of money; collects data and provides reports of Program Integrity activities.

The Quality Assurance Section supervisor has 21 staff. Their mission includes determining the Medicaid and Health Choice (the new children's health insurance program) eligibility payment error rates and assisting in correcting problems. They also coordinate the recipient fraud investigations with the counties and handle recipient complaints and investigations of overcharging for Medicaid covered services.

Medicaid Eligibility Payment Error Rate:
The section monitors the accuracy rate of eligibility determinations in the 100 county DSS's by conducting both federally mandated and state-designed targeted reviews of recipient cases. Staff assigned and living near certain counties conducts the case reviews. The results of their reviews are used to determine error trends, identify error prone cases, and recommend corrective action as appropriate. QA data is also used to assist county supervisors and state staff in determining training needs to prevent future errors. The staff also conducts additional Corrective Action Record Reviews for each county to identify potential problem areas in the procedural process of determining eligibility.

Recipient Fraud:
The section has two policy consultants dedicated to the coordination of investigations by county Program Integrity staff of suspected recipient Medicaid fraud and abuse The consultants provide Fraud and Abuse policy, and training on prevention, detection, and recovery of Medicaid overpayments to county staff. They also provide policy for the EPICS data system, used to track all benefits overpayment collections.

Recipient Complaints:
The section also investigates Medicaid claims when the provider has billed Medicaid, and also billed the recipient. The claims investigator serves as a mediator between the recipient and the provider to identify and resolve inappropriate billing issues. If a provider is at fault and unwilling to comply with Medicaid billing requirements, a referral may be made to the Attorney General's office.

THIRD PARTY RECOVERY 5 YEAR REPORT (SFY)

TPR Recoveries	2003	2002	2001	2000	1999
Casualty	14,813,806	14,314,058	11,278,689	9,656,402	9,179,130
Insurance	27,543,971	28,604,553	21,507,279	29,181,323	13,414,456
Estate	4,974,281	3,792,278	2,340,126	1,690,240	1,359,498
Total	**47,332,058**	**46,710,889**	**35,126,094**	**40,527,965**	**23,953,084**
Claims Cost Avoided					
Medicare A & B	1,026,280,066	1,154,449,654	1,044,586,509	937,272,541	858,310,416
Other Insurance	214,975,840	150,835,475	172,035,219	158,002,122	101,375,000
Total	**1,241,255,906**	**1,305,285,129**	**1,216,621,728**	**1,095,274,663**	**959,685,416**
Claims Denied - Insurance					
Medicare	452,929,690	195,472,228	185,420,904	188,379,109	89,108,540
Other Insurance	126,607,140	131,001,965	159,577,884	111,704,144	101,893,406
Total	**579,536,830**	**326,474,193**	**344,998,788**	**300,083,253**	**191,001,946**
Miscellaneous					
Credit Balance Reporting	5,443,186	5,339,910	5,217,695	Not Reported	Not Reported

PRESCRIPTION DRUGS

Prescription Drug Cost Containment Initiatives

- **Prescription Advantage List**
  - Published by Community Care of North Carolina – lists drugs in certain classes that have lower net costs, including rebates, for Medicaid
  - Voluntary
- **Over the Counter Medications**
  - Prilosec 20 mg = $3.78 per unit
  - Prilosec OTC = .57 per unit
- **Reimbursement**
  - Medicaid reimburses brand name drugs at Average Wholesale Price (AWP) minus 10%
  - Reimbursing AWP-10% reflected an annual savings of $113,250,945 over AWP in SFY 2003
  - Drugs with multiple sources and some brands (when generics are available) are reimbursed at the State Maximum Allowable Cost (SMAC), which is typically 150% of the lowest cost source
  - Reimbursing at SMAC reflected a savings of $62,715,200 for SFY 03.
- **Generic Substitutions**
  - Medicaid provides incentives to substitute generic drugs whenever possible
  - Copays: $1 for generic, $3 for brand
  - Dispensing fees: $5.60 for generic, $4.00 for brand
- **Prior Authorization**
  - Medicaid has a contractor which manages the prior authorization process for 13 classes of high cost drugs
  - Prior authorizing these drugs during March-December 2002 resulted in $13,231,988 savings over the same period in
  - Oxycontin savings = $3,592,347
  - Vioxx/Celebrex/Bextra savings = $7,619,269
- **Polypharmacy**
  - Initiatives for managing recipients on multiple medications are being implemented in nursing facilities, physician practices and adult care homes.
- **Drug Utilization Review and Pharmacy and Therapeutics Committees**
  - Medicaid has active committees which advise on pharmacy policy and monitor drug utilization and provider practice patterns
- **Provider Reimbursement** – State MAC was implemented in 2002
- **Utilization Management** - A contract to prior authorize 13 classes of drugs became effective in 2002.

Community Care of North Carolina

ACCESS II & III

PRESENTATION TO:

North Carolina Legislative
Blue Ribbon Commission on Medicaid Reform

March 24, 2004

L. Allen Dobson ,Jr. MD

Attachment # 4

Primary Goals

- *Improve the care of the Medicaid population while controlling costs*
- *Develop Community based networks capable of managing populations*

Goals Achieved By:

- Making Sure People Get Care When They Need It
- Increasing local provider collaboration
- Obtaining Quality Care
- Implementing Best Practice Guidelines
- Managing Medicaid Costs

Options for Medicaid

- State Operated
- Contracted Out
- Locally Run

Basic Operating Premise

- Regardless of who manages Medicaid, the hospitals, physicians and safety net providers in NC serving patients remain the same and must be engaged
- We need to transform Medicaid management from a regulatory function to a health management function
- We must carefully balance cost containment with quality improvement efforts
- Decision making must be driven by data & outcomes monitored

Community Care of North Carolina

Build on ACCESS I

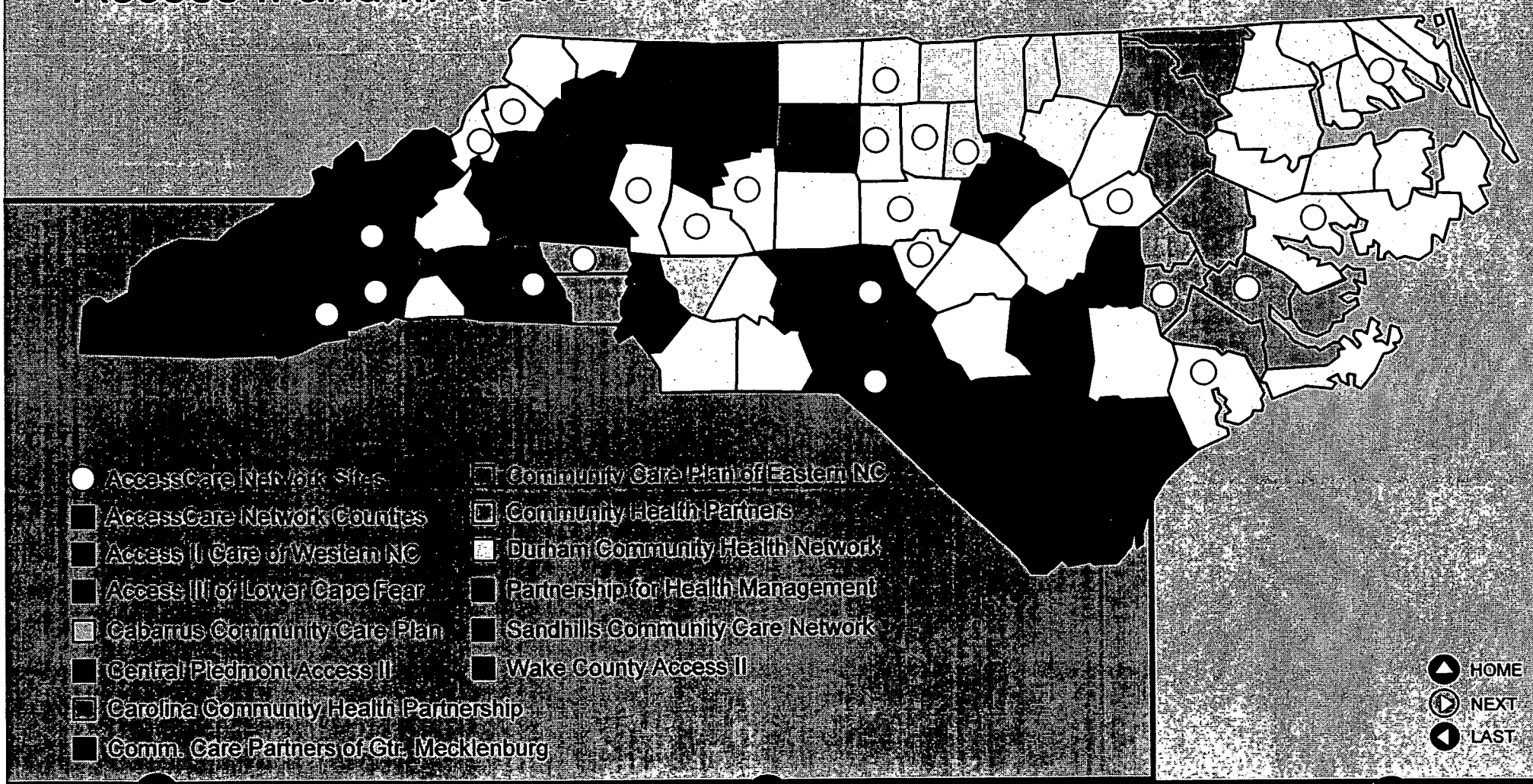
- Joins other community providers (hospitals, health departments and departments of social services) with physicians
- Creates community networks that assume responsibility for managing recipient care

Community Care of North Carolina

- Focuses on improved quality, utilization and cost effectiveness
- 13 Networks with more than 3000 physicians
- 519,000 enrollees

Community Care of North Carolina

Access II and III Networks – 3/04



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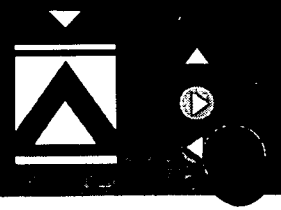
Community Care Networks:

- Non-profit organizations
- Includes all providers including safety net providers
- Steering/Governance committee
- Medical management committee
- Receive $2.50 PM/PM from the State
- Hire care managers/medical management staff

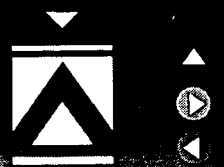
What Networks Do

- Assume responsibility for Medicaid recipients
- Identify costly patients and costly services
- Develop and implement plans to manage utilization and cost
- Create the local systems to improve care & reduce variability
- Implement improved care management and disease management systems



Key Program Areas in Managing Clinical Care:

- Implementing quality improvement — Best practice processes
- Implementing disease management
- Managing high-risk patients
- Managing high-cost services
- Building accountability through monitoring & reporting



Managing Clinical Care

I Clinical Directors Group

- Select targeted diseases/care processes
- Review evidenced-based practice guidelines
- Define the program
- Establish program measures

- ASTHMA
- DIABETES
- PHARMACY
- HIGH-RISK & -COST
- ED

II Local Medical Mgmt. Comm.

- Implement state-level initiatives
- Develop local improvement initiatives

- GASTRO-ENTERITIS
- FEVER
- OTITIS MEDIA
- DEPRESSION
- CHILD DEVELOPMENT
- LOW BIRTH WEIGHT
- ADHD
- ANCILLARY SERVICES

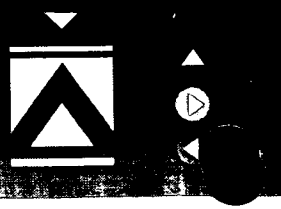
III PRACTICE A | **PRACTICE B** | **PRACTICE C**

Care Managers and Access II and III quality improvement staff support clinical management activities

Improving Quality
"Disease Management"

Current Disease Management Initiatives

- Asthma
- Diabetes
- Pilots in Depression, ADHD, Special Needs Children, Gastroenteritis, Otitis Media and Low Birth Weight

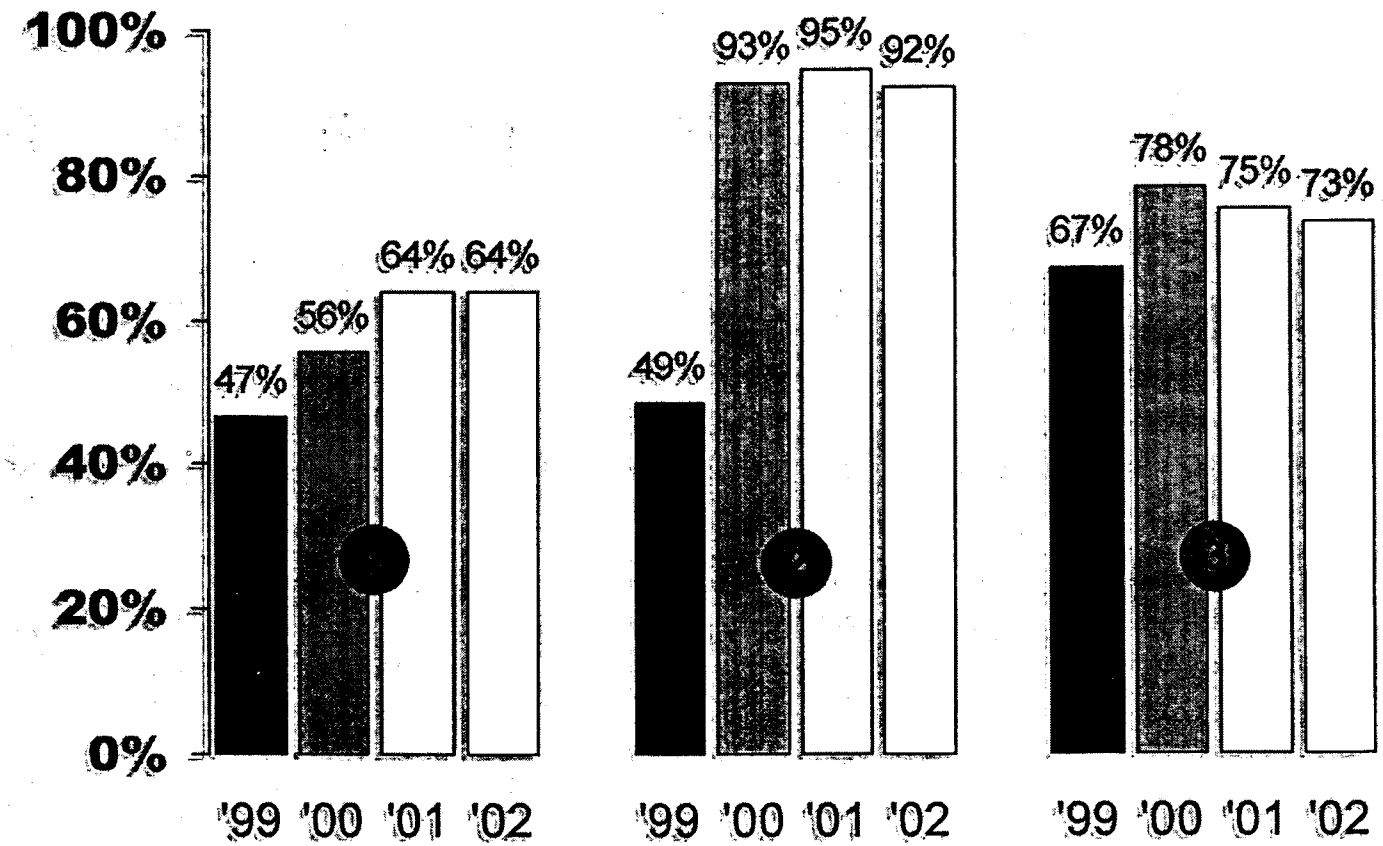


Asthma Initiative

- First program initiative – began Jan. 1999
- Adopted best practice guidelines (NIH)
- Implemented continuous quality improvement processes at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback

Asthma Initiative

Process Measures



Key

1. No. with asthma who had documentation of staging
2. No. staged II – IV on inhaled corticosteroids
3. No. staged II – IV who have an AAP

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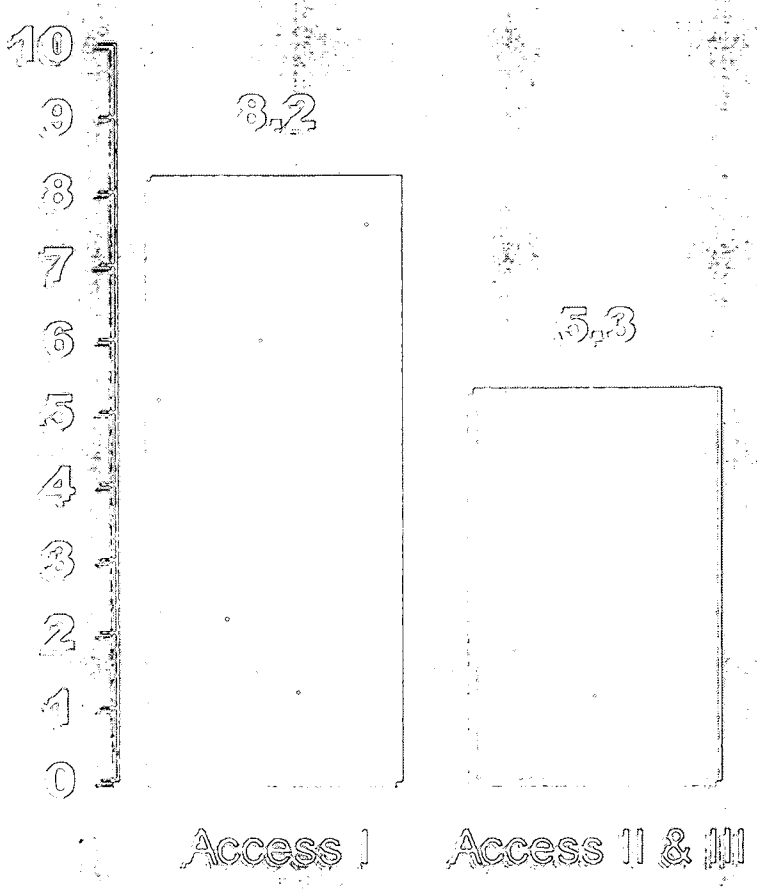
Asthma Initiative

Pediatric Asthma Hospitalization Rates

April 2000 - December 2002



Key

In patient admission rate
per 1000 member months

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SOURCE: February 20, 2004 Sheps Center Report

Evaluation of CCNC Asthma and Diabetes Management Initiative (January 2000 – December 2002)

Asthma DM Findings from Sheps:

- Per member per month (pmpm) costs for CCNC asthma patients consistently lower than Access program
- 2.6%-2.7% lower pmpm costs
- 21%-23% lower hospital admissions

Asthma DM Findings from Sheps:

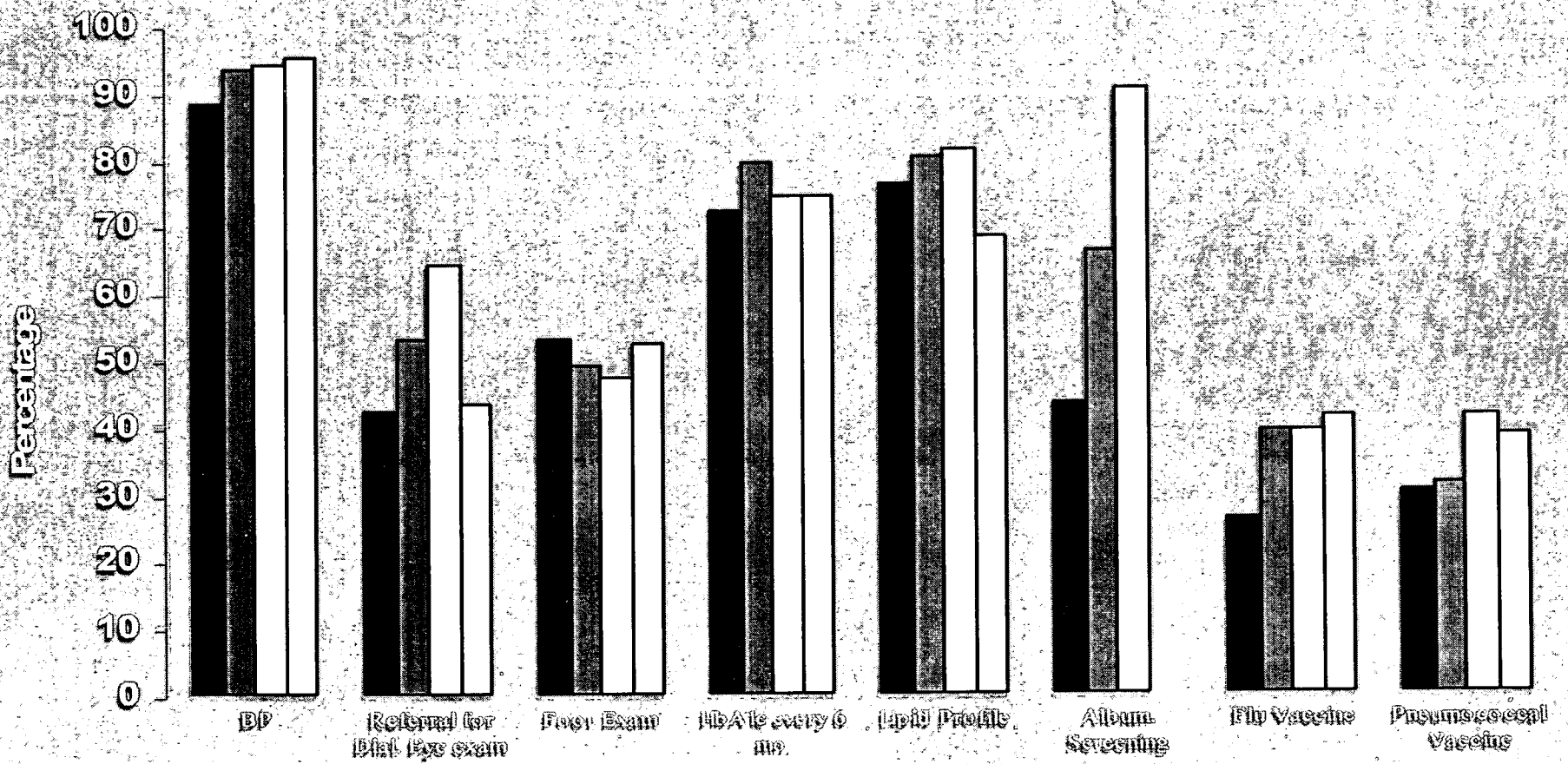
- CY 2000 Annual Savings $ 290,000
- CY 2001 Annual Savings $ 1,470,000
- CY 2002 Annual Savings $ 1,580,000

Diabetes Initiative

- Second program-wide initiative – began July 2000
- Adopted best practice guidelines (ADA)
- Implement continuous quality improvement processes at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback

Diabetes Initiative

ACCESS II-III Diabetes Chart Audit Results



SOURCE: February 20, 2004 Sheps Center Report

Diabetes Disease Management Findings:

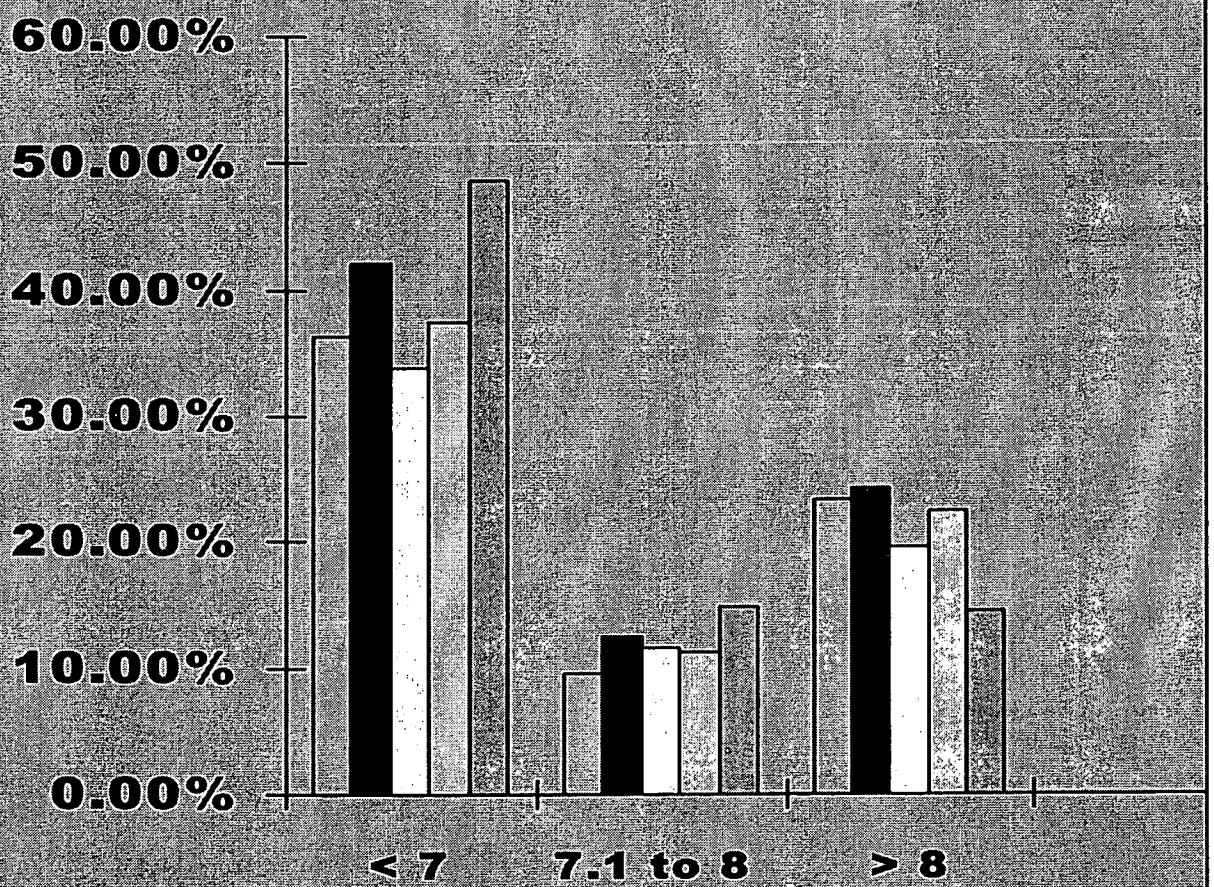
- Overall pmpm costs for CCNC diabetes lower than Access
- 9% lower hospital admissions

Diabetes DM Findings from Sheps:

- Cost savings for diabetes care for 3 year period approximately $2.1 million

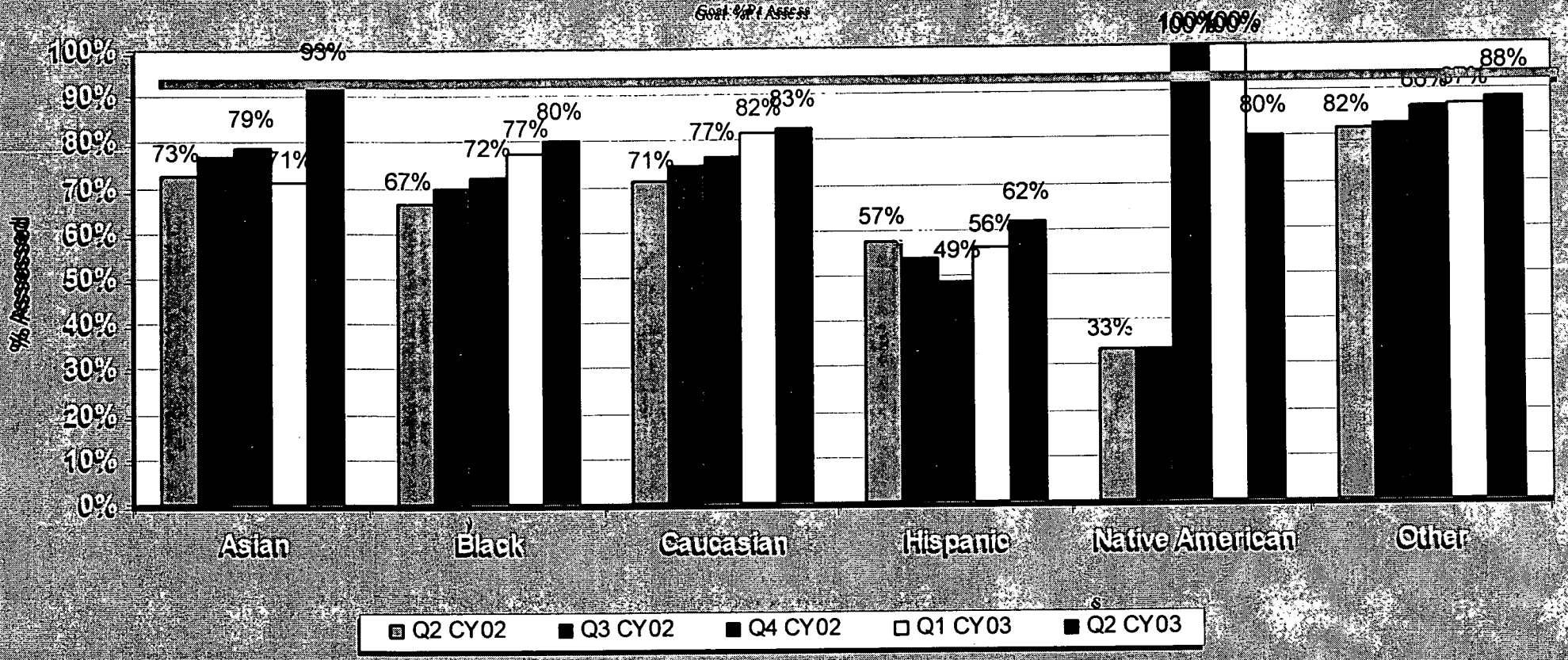
- Potential > $11.3 million total savings in 2003 if CCNC were statewide with asthma and diabetes DM

Cabarrus HbA1C levels



CCNC 2004

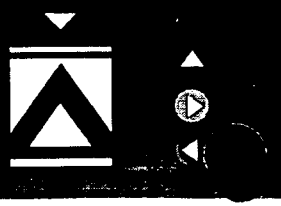
Aspirin Documentation - Comparative by Race



Managing Costs
"Targeted Approach"

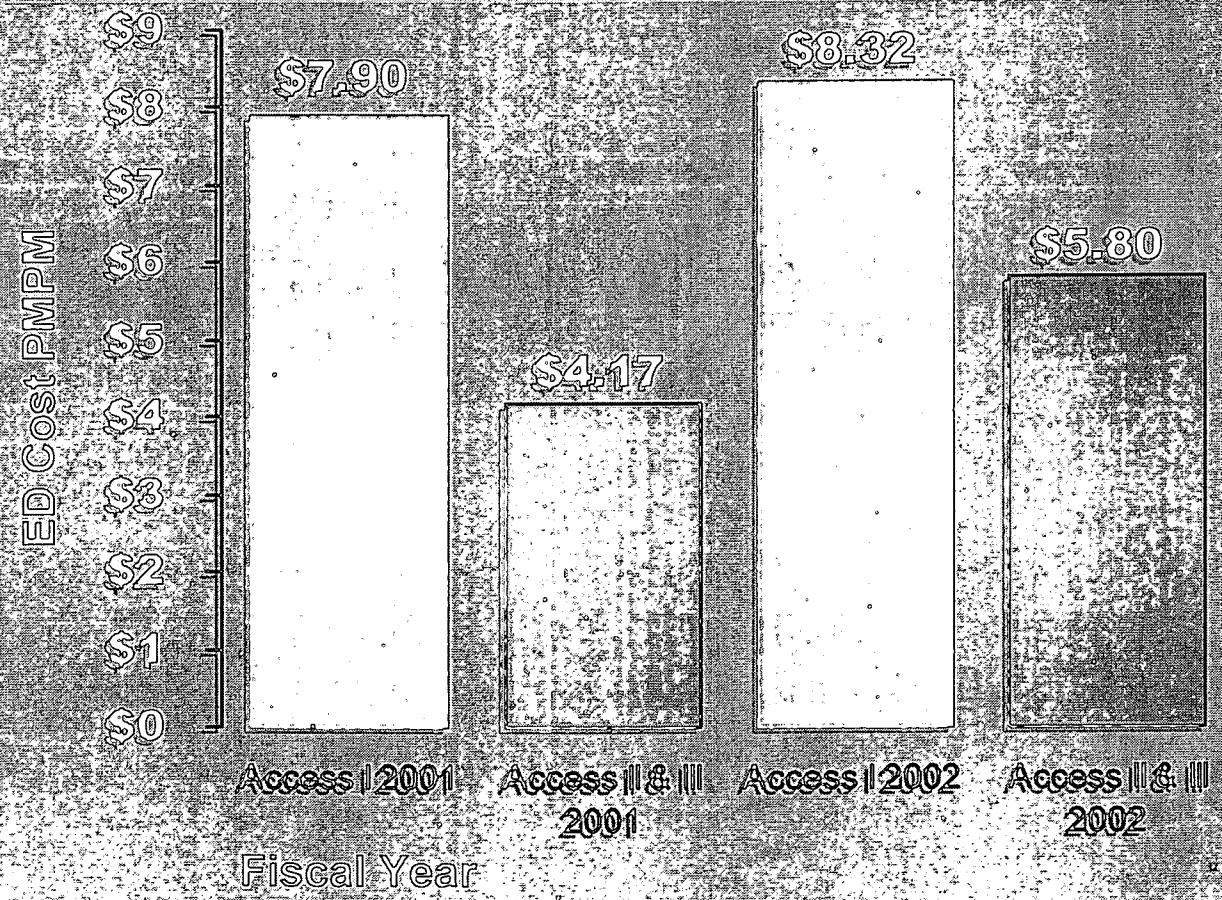
Managing High-Cost Services:

- Pharmacy
  - Nursing home polypharmacy
  - PAL
  - Ambulatory polypharmacy
- Emergency Department
- Ancillary Services
- In-home Care



ED Initiative

ED Cost PMPM – 7/1/01 – 6/30/02 – Children < 21 years



Savings Calculation

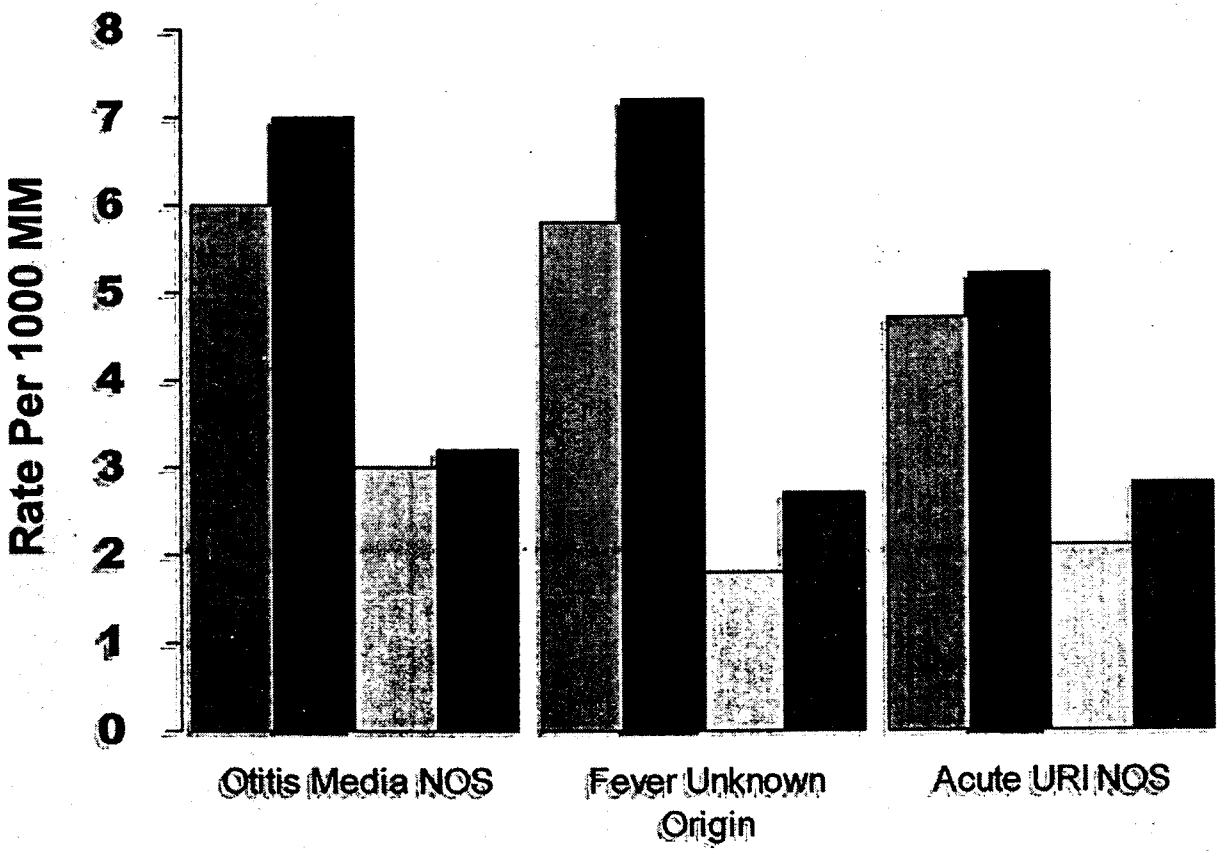
(Access I PMPM – Access II-III) x Access II-III Enrollment

Total Savings – '01-'02

$10,362,190

ED Initiative

Top 3 ED Dx Rates– 7/1/01 – 6/30/02 – Children < 21 years



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Therapies Management Pilot

Project Goals:

- Provide appropriate therapy to meet specific functional deficits
- Decrease delays in services
- Encourage interdisciplinary team approach to care
- Manage medical expenditures more efficiently

Therapies Management Pilot

Preliminary Results – April-August 2003

	# of Requests	Units Saved	Amount Saved
[redacted]	260	955	$14,325
[redacted]	84	184	$2,760
[redacted]	89	206	$3,090
[redacted]	25	19,376	$61,140
[redacted]	458	20,721	$81,315

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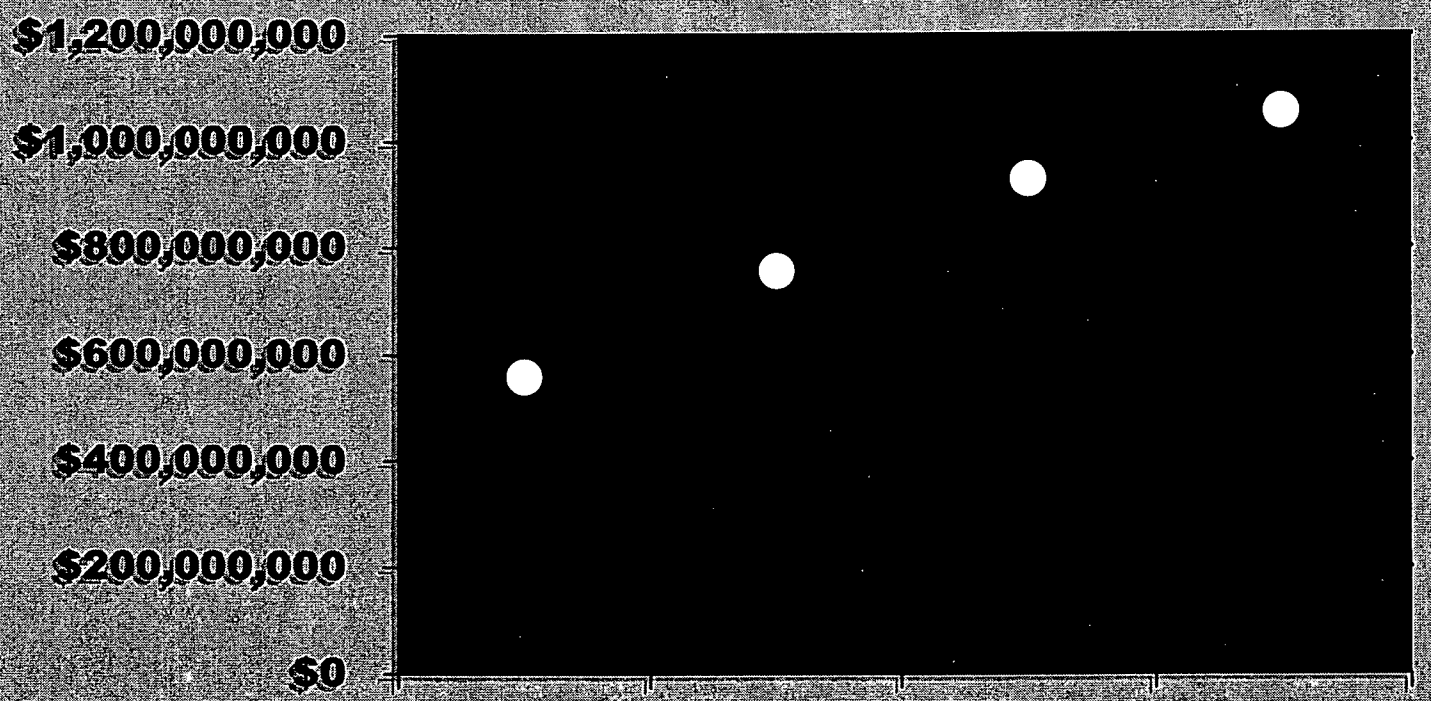
Cost Effective Prescribing 2003

"How to make a difference in rising prescription drug costs!"

NC Medicaid Expenditures: Prescription Drugs



FY99
$557,772,670

FY00
$754,505,194

FY01
$927,240,693

FY02
$1,056,158,750

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Process – PAL

- Pharmacy committee defines drug classes and unit doses
- Medicaid calculates relative drug cost and rank (AWP)
- Inform Access II and III physicians
- Measure changes in prescribing patterns
- State-wide rollout began Nov 2003

PAL — Prescription Advantage List

Access II and III Prescription Advantage List

The Prescription Advantage List (PAL) was developed by the Access II and III Medical Directors' team to improve the effectiveness of prescribing practices within Access II and III networks. By analysis of AWP of medications, the group has identified a series of medicines – rate-centered as tier 1 drugs – that offer potential cost savings for the Access II and III programs.

While this list is voluntary, Access II and III Medical Directors hope you will prescribe Tier 1 drugs whenever possible and medically appropriate.

Updated 11/03

For additional copies of the reference guide, please call the Access II and III office at (919) 715-7575.

For answers to your questions about the reference guide, please call Steve Wegner, M.D. at AccessCare Inc., at (919) 383-4662.

ACE Inhibitors

Drug name	PAL
captopril	1
enalapril	1
lisinopril	1
Lotensin	2
Monopril	2
Univasc	2
Accon	2
Accupril	2
Altace	2
Mavik	2
Prinivil	2
Zestril	2
Capoten	3
Vasotec	3

Macrolides

Drug name	PAL
Erythrocin Stearate Filmtab	1
erythromycin base	1
Ery-tab, E-Mycin	1
erythromycin ethylsuccinate	1
E.E.S.	1
erythromycin delayed-release caps.de	1
erythromycin stearate	1
Zithromax, Z-PAK	2
Biaxin XL	2
Ery-Ped	2
Eryc	2
P.C.E.	2
Biaxin Filmtab	3
Dynabac	3

Fluoroquinolones

Drug name	PAL
Maxaquin	1
Noroxin	1
Cipro	2
Levaquin	2
Tequin	2
Avelox	3
Floxin	3

HMG-CoA Reductase Inhibitors (Statins)

Drug name	PAL
lovastatin	1
Lescol	2
Lescol XL	2
Pravachol	2
Lipitor	3
Mevacor	3
Zocor	3

Inhaled Beta Agonists and Combinations

Drug name	PAL
albuterol MDI	1
albuterol neb. sol'n	1
Combivent MDI	1
Serevent	2
Serevent Diskus	2
Maxair Autohaler	2
Foradil	2
Xopenex	3
Proventil	3
Proventil HFA	3
Ventolin	3
Ventolin HFA	3
Proventil neb. Sol'n	3
AccuNeb	3
Alupent	3
Maxair	3
DuoNeb	3

Inhaled Corticosteroids and Combinations

Drug name	PAL
Pulmicort Turbuhaler	1
Flovent 220mcg MDI	1
Advair	1
Pulmicort Respules	2
Aerobid, Aerobid M	2
Flovent 110mcg MDI	2
Flovent Rotadisk 100mcg	2
Flovent Rotadisk 250mcg	2
Armonair	2
Vancoril	3
Qvar	3
Flovent 44mcg MDI	3
Flovent Rotadisk 50mcg	3

Proton Pump Inhibitors

Drug name	PAL
Protonix	1
AcipHex	2
Prevacid	2
Nexium	3
Prilosec	3

H2 Antagonists

Drug name	PAL
ranitidine	1
famotidine	1
cimetidine	3
Zantac	3
Pepcid	3
Tagamet	3
Axid	3
nizatidine	3

SSRIs

Drug name	PAL
fluoxetine	1
Celexa	2
Paxil	2
Zoloft	2
fluvoxamine	2
Lexapro	2
Paxil CR	2
Prozac	3
Prozac Weekly	3

Non-sedating Antihistamines

Drug name	PAL
Allegra	1
Zyrtec	1
Clarinex	3
Claritin	3
Claritin Reditabs	3

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Preliminary Pilot Findings

- PAL pilot rolled out between December 2002 and January 2003
- Post-rollout period (February-March 2003) – 22% lower expenditures compared to pre-rollout (September – October 2002)
- Actual pilot savings - $640,000

Anticipated Savings

- PAL- $ 30 -40 million annual savings expected
- Other Pharmacy Management/Policy Initiatives:

  Selected Prior Approval

  Selected OTC coverage

  Six Drug Limit Policy revision

Nursing Home Polypharmacy Initiative

Community Care of North Carolina

Intervention

Pharmacist / Physician Teams

- Review drug profiles / medical records of Medicaid patients in nursing homes
- Determine if a drug therapy problem exists
- Recommend a change
- Perform follow-up to determine if change was made

Screening Criteria

- Nursing home residents with . . .
  - >18 drugs used in a 90 day period
- 9208 residents met this criteria
- Medicaid database uses criteria to flag charts

Flagging Criteria

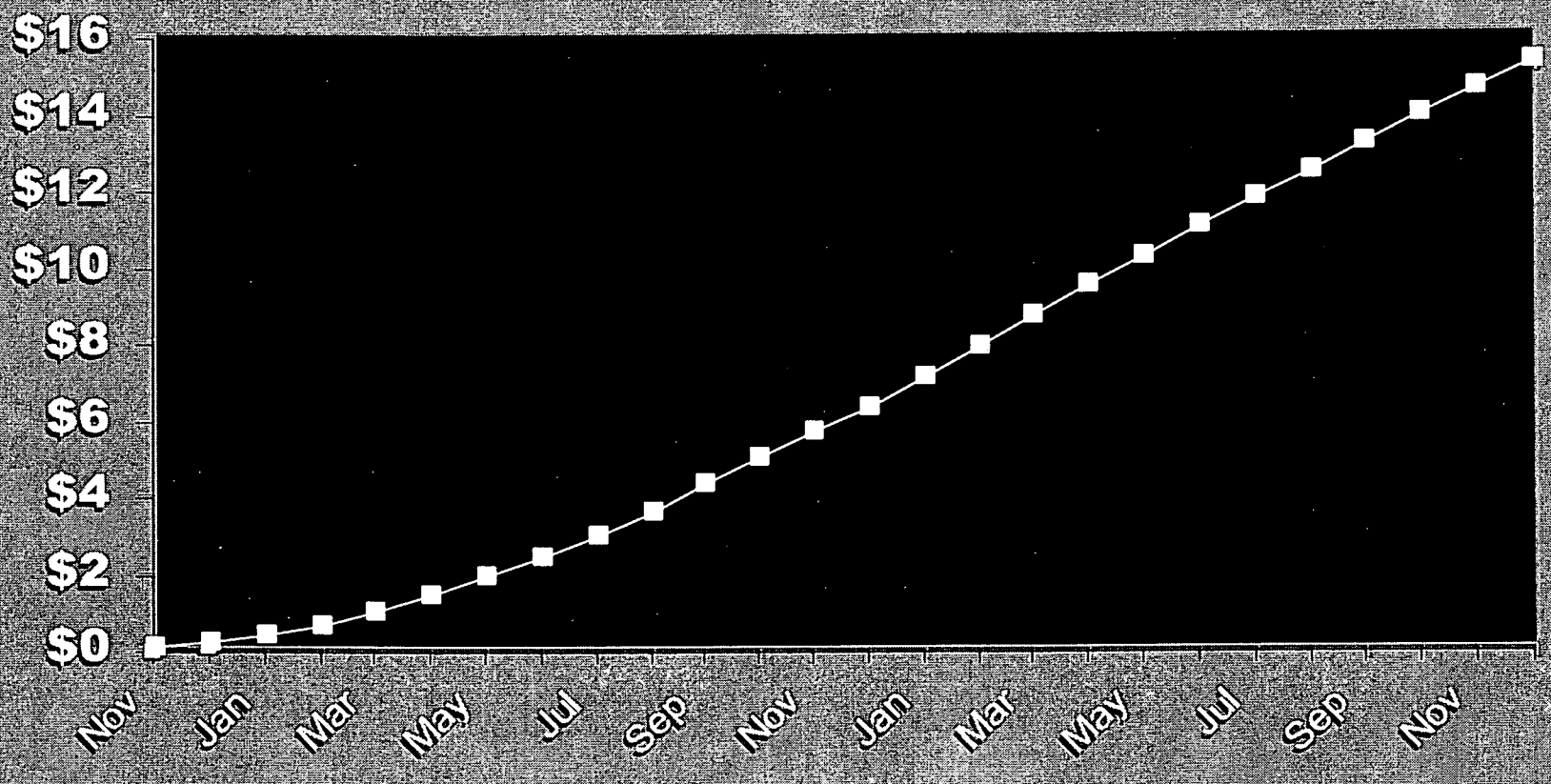
- Inappropriate Rx for the elderly "Beers drugs"
- Drugs used beyond usual time limit
- Drug Use Warnings & precautions
- Prescription Advantage List "PAL"
- Potential Therapeutic Duplication

Preliminary Findings

- Patients reviewed: 9208
- Recommendations made: 8559
  - Unnecessary therapy – 19%
  - More cost effective drug – 56%
  - Wrong dose – 7%
  - Potential adverse reaction – 9%
  - Needs additional therapy – 3%
  - Other – 6%
- Recommendations implemented: 6359 (74%)

Potential Cumulative Savings from Interventions

Dollars in Millions



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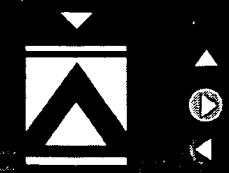
Summary

- Based on findings to date
  - A pharmacist-MD team cuts cost & ups quality
  - The cost savings potential is substantial
  - Further opportunities for drug cost savings:
    - Expand to all NH and assisted living patients in NC
    - Expand the # of medications eligible
  - Evaluation is being conducted by UNC School of Pharmacy



Cost/Benefit Estimates

Community Care of North Carolina

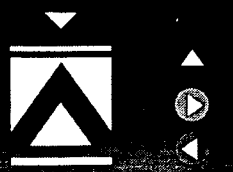
July 1, 2002 – Dec. 31, 2002

- Cost - $4.1 Million

  (Cost of Community Care operation)

- Savings - $12.4 Million

  (Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other)



Initiatives Not Included in Mercer Analysis

- Nursing Home Poly-pharmacy - Round 1 Savings
- Prescription Advantage List (PAL) – Pilot Savings

Pilot Initiatives

- Therapy services
- Low birth weight
- Disparities
- Mental health integration
- Poly-pharmacy in outpatient settings
- Sickle cell
- Community access programs
- Special needs

Initiatives Under Development

- Assisted care living poly-pharmacy
- Statewide rollout of PAL
- Incentive program
- Improved collaboration with public providers (obesity, smoking cessation, diabetes management, low birth weight, depression)
- In-home care
- Targeted disease management (depression, HIV, heart disease)

Potential Savings

- Asthma: $2-4 Million
- Diabetes: $ 5-8 Million
- ED: $10-12 Million
- PAL: $ 30-40 Million
- Poly-pharmacy: $16-20 Million
- Others: Mental Health, In Home, Therapies, High Cost Patients

Local Financial Impact of a Mature Community Program

Per Eligible Cost

	Per Eligible Rates			%Change	
County	SFY 01	SFY 02	SFY 03	SFY 02	SFY 03
CABARRUS	$566.72	$563.43	$528.78	-1%	-7%
ROWAN	$493.70	$524.80	$525.84	6%	0%
STANLY	$573.57	$583.50	$568.84	2%	-3%
STATEWIDE TOTAL	$484.17	$508.99	$510.76	5%	0%

Local Financial Impact of a Mature Community Program

Total Medicaid Costs				
	SFY 01	SFY 02	SFY 03	
CABARRUS(Actual)	$71,963,807.09	$84,879,205.67	$88,956,134.45	
CABARRUS (no AccessIII)*	$71,963,807.09	$89,971,958.01	$95,183,063.86	Total Savings
Savings		$5,092,752.34	$6,226,929.41	$11,319,681.75
* using State-wide % increase				

Local Tax Savings:
$650,000

NCPAG – Medical Leadership in Accountability

- Pharmacy Committee
- Therapy Services Committee
- Dental Committee
- Mental Health Committee
- DME subcommittee
- Vision Task Force
- Transplant Policy Task Force
- Psychiatric Poly-Pharmacy Task Force

Lessons Learned

1. Top down approach is not effective in N.C.
2. Community ownership
3. Can't do it alone - must partner
4. Incentives must be aligned
5. Must develop systems that change behavior
6. Have to be able to measure outcomes
7. Lasting change takes time and reinforcement
8. There are indirect quality and cost benefits

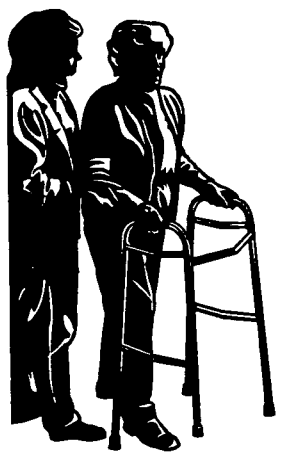
Community Care of North Carolina

Thank You

Long-Term Care Premium Tax Credit

Blue Ribbon Commission on Medicaid Reform

March 24, 2004

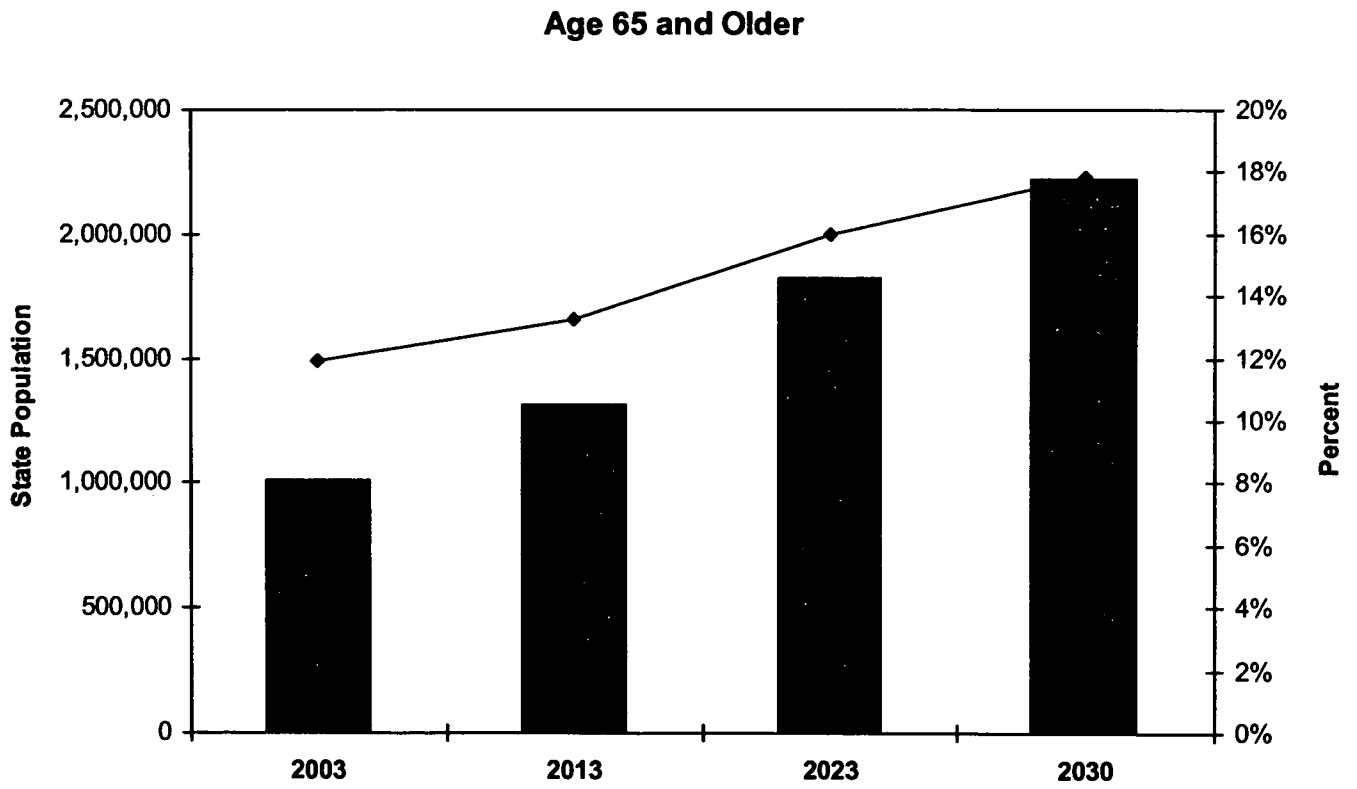


Attachment # 5

Recipients of Long-Term Care Services

- Over age 65 53%
- Working age adults 44%
- Children 3%

Aging Population



In 2010, North Carolina will have:

- **418,400 persons with long-term care needs**
  - **366,700 home-based care (3+ ADLs)**
  - **51,700 institutional care**

The Estimated Annual Cost of Long-Term Care in Charlotte

Home Health Care	**$21,567**
Assisted Living	**$32,244**
Nursing Home	**$49,421**

Federal Long-Term Care Insurance Program.

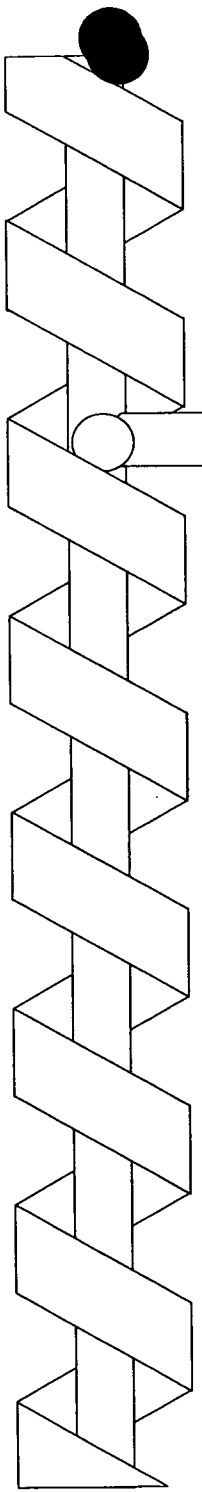
Long-Term Care Insurance

- **7 million policies in the United States in 2002 (4 million active)***
- **86,272 policies in North Carolina****
- **61 companies (4 with 63% of market)****

*Life Plans, Inc.

** NAIC

Cost of LTC Insurance for a Comprehensive Policy



The policy pays:

- **$200/day nursing home**
- **$140/day assisting living**
- **$3,000/month home care**
- **Inflation adjusted and pay lifetime benefits**

The cost is:

- **Age 46 = $1,704/year**
- **Age 56 = $2,868/year**
- **Age 66 = $4,836/year**

North Carolina LTC Tax Credit

- 15% of annual premium
- May not exceed $350 per policy
- Non-refundable/no carry forward
- Cannot claim both medical deduction and credit
- Expired Tax Year 2003

Other States with LTC Credits

- **Colorado-25% of premium up to $75 individual/$150 couple**
- **Minnesota-$100 per person and per policy**
- **New York-10% of premium**
- **North Dakota-25% of premium per policy**

North Carolina LTC Credit Costs

Tax Year	Credits	Tax Returns
1999	$4.2 million	21,029
2000	$6.0 million	29,206
2001	$10.4 million	51,959
2002	$5.7 million	27,516

2002 LTC Credit Amount by Filing Status

Married Filing Jointly/ Widows	**68.7%**
Single	**20.8%**
Head of Household	**9.7%**
Married Separate	**.8%**

2002 LTC Credits by Income Class

0-$10,000	$1.5 million	6,666
$10,001-$30,000	$1.5 million	7,479
$30,001-$50,000	$ .9 million	4,685
$50,001-$75,000	$.65 million	3,564
$75,001-$100,000	$.36 million	1,953
More than $100,000	$ .6 million	2,826

LTC Credit Error Rate

2001 = 91%

- **Claiming credit for regular insurance premiums**
- **Claiming total premium amount**
- **Claiming credit and deduction of medical expense**

LTC Credit Rate Reduced

2003 = 40%

- **Contacted tax preparers making errors**
- **Improved instructions**
- **Improved verbiage in tax preparation software**

Continue Credit?

- **Approximately $6 million General Fund loss each year**
- **Require name of insurance company and policy number on tax credit form**

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
Legislative Services Office
16 W. Jones Street Room 2129
Raleigh, NC 27601-1030 Tel. (919) 733-7044

C. Goldman, Director
Administrative Division
16 W. Jones Street Room 9
Raleigh, NC 27601-1030
(919) 733-7500

Gerry F. Cohen, Director
Bill Drafting Division
300 N. Salisbury St. Rm 401
Raleigh, NC 27603-5925
(919) 733-6660

James D. Johnson, Director
Fiscal Research Division
300 N. Salisbury St. Rm 619
Raleigh, NC 27603-5925
(919) 733-4910

Dennis W. McCarty, Director
Information Systems Division
300 N. Salisbury St. Rm 400
Raleigh, NC 27603-5925
(919) 733-6834

Terrence D. Sullivan, Director
Research Division
300 N. Salisbury St. Rm 545
Raleigh, NC 27603-5925
(919) 733-2578

March 18, 2004

MEMORANDUM

TO: Blue Ribbon Commission on Medicaid Reform

FROM: Richard Bostic RB

SUBJECT: Long-Term Care Insurance Tax Credits

DEMOGRAPHICS

In a 1999 study, the Henry J Kaiser Foundation found that 53% of those receiving long-term care services were over 65 (44% were working age adults and 3% were children). In July 2003, the over age 65 population numbered 1,011,370 in North Carolina and represented 11.92% of the state population of 8.5 million (NC Office of State Budget and Management – State Demographics unit). In the next ten years, the over 65 age group will grow to 13.23% of the population. By 2030, the over 65 age group will increase to 17.85% of the state population.

Year	0 to 5	6 to 17	18 to 64	65 and over	Total
2003	691,299	1,375,376	5,407,757	1,011,370	8,485,802
2013	765,606	1,561,658	6,293,933	1,314,174	9,935,371
2023	866,952	1,735,146	6,988,338	1,826,545	11,416,981
2030	934,608	1,889,202	7,402,317	2,221,470	12,447,597

LONG TERM CARE

What is long-term care? The simplest definition is the care given to individuals who need assistance with activities of daily living because of a health problem. The level of assistance needed is measured by a deficiency in 1) activities of daily living (ADLs) such as bathing, dressing, eating, toileting, getting around the house, and transferring from chair to bed and 2) instrumental activities of daily living (IADLs) that include shopping, meal preparation, light housework, and money management.

In a report prepared for the North Carolina Institute of Medicine in 2000, Millennium Healthcare Solutions, Inc. made the following projection for North Carolina long term care needs in 2010:

- The total number of persons with long term care needs (both at-home and institutional) will increase from 351,600 in 2000 to 418,400 in 2010.
- The number of community dwelling persons with long term care needs will increase from 308,000 in 2000 to 366,700 in 2010. Of this group, those with 3 or more ADLs will increase from 79,800 to 98,400.
- The number of community dwelling persons with 3 or more ADLs and incomes below 100% of poverty will grow from 27,400 in 2000 to 34,000 in 2010.
- The number of residents in institutional care facilities will increase from 42,700 in 2000 to 51,700 in 2010.
- The number of community dwelling persons aged 18 to 64 with disabling mental retardation and/or developmental disability will grow from 34,300 in 2000 to 38,600 in 2010.

The costs for long term care alternatives such as home health care, assisted living and nursing homes are expensive. Two Internet sites provide calculators to estimate the current long term care costs for the major cities in each state. The Federal Long Term Care Insurance Program (www.ltcfeds.com) estimates the following annual costs for Raleigh and Charlotte:

	Raleigh	Charlotte
Home Health Care*	$21,411	$21,567
Assisted Living	$29,453	$32,244
Nursing Home	$45,443	$49,421

*The home health care cost is based on 5 hours a day and 5 visits a week.

The CNNMoney website (cgi.money.cnn.com) offers an annual long term care cost finder based on 2002 average costs derived from the Metlife Mature Market Institute Survey. Home health hours are set at 5 per day in this calculator for comparison to the model above.

	Raleigh	Charlotte
Home Health Care	$29,200	$31,025
Assisted Living	$29,448	$32,244
Nursing Home	$51,830	$54,020

LONG TERM CARE INSURANCE

Given the cost of long term care services, many have chosen to protect their financial assets by purchasing long-term care insurance. Dr. Marc Cohen, President of LifePlans, Inc., presented a paper to the Center for Medicare and Medicaid Services in 2002 that stated 7 million long-term care policies have been sold, but only 4 million are still in-force. He said the target market for long term care policies is 1) middle to upper income elders who would not immediately qualify for Medicaid, 2) those who have few available informal supports (family, friends) or who worry about not having them at the time they need long term care, and 3) younger adults who view long term care insurance as an integral part of retirement planning.

In North Carolina, there were 86,272 long-term care policies reported by 61 companies in 2002 (National Association of Insurance Commissioners, NAIC). In a 2000 NAIC survey, the following four companies insured 63% of those with long term care policies:

General Electric Capital Assurance Co.
Unum
Continental Casualty Co.
Penn Treaty Network American Insurance Co.

The annual cost of a long-term care insurance policy varies by the age of the insured and the type of coverage requested. The California Public Employees' Retirement System (CALPERS) offers an online calculator to estimate your long-term care premium. If you choose a comprehensive policy that 1) pays $200 a day for nursing home, $140 a day for assisted living and $3,000 a month for home care, 2) has built-in inflation adjustments, and 3) provides lifetime benefits, then the annual premium is as follows:

Age 46	$1,704 per year
Age 56	$2,868 per year
Age 66	$4,836 per year

Similarly, the Federal Long Term Care Insurance Program online calculator estimates that a comprehensive policy that offers home and facility care at $150 a day, with an unlimited benefit period, and with inflation protection will cost $1,876 a year for a 50 year old and $3,506 a year for a 65 year old.

NC TAX CREDIT

The long term care insurance tax credit was one of 13 tax provisions included in the budget act for Fiscal Year 1998-99 by the 1998 General Assembly (1998 S.L. chapter 212, SB 1366). The state individual income tax credit equals 15% of the premium paid each year on long-term care insurance, but the credit may not exceed $350 for each policy for which the credit is claimed. The credit may not exceed the amount of tax owed by the taxpayer (nonrefundable), and there is no provision to allow unused portions of the credit to be carried forward. The credit became effective for the taxable year beginning on or after January 1, 1999, and expires for taxable years beginning on or after January 1, 2004.

A taxpayer may claim a credit for policies that provide coverage for either the taxpayer, the taxpayer's spouse, or a family member for whom the taxpayer provides over half of the support and whose income is below an exemption amount. A long term-care insurance policy is one that provides only coverage of long-term care services and that meets the following requirements:

1. Is guaranteed renewable.
2. Does not provide for a cash surrender value.
3. Provides that refunds and dividends may be used only to reduce future premiums or to increase future benefit.
4. Does not pay or reimburse expenses that are reimbursable under Medicare.
5. Satisfies consumer protection laws.

Under federal law, premiums paid on long-term care insurance contracts are treated as deductible medical expenses. Under the medical expense itemized deduction, unreimbursed medical

expenses may be deducted to the extent that the expenses exceed 7.5% of adjusted gross income. To the extent a taxpayer will receive a deduction for long-term care insurance premiums under the Code, the taxpayer will receive a deduction for State income tax purposes as well since North Carolina uses federal taxable income as the starting point for calculating State taxable income. To prevent a double tax benefit in those cases, the credit is limited to those expenses for which a deduction has not been claimed.

STATE TAX INCENTIVES

North Carolina is not alone in offering a tax incentive to those enrolling in long-term care insurance policies. According to a report from the Health Insurance Association of America, the following states allow an income tax deduction for long-term care insurance premiums:

Alabama	Missouri
Hawaii	Montana
Idaho	Ohio
Indiana	Utah
Iowa	Virginia
Kentucky	West Virginia
Maine	Wisconsin

The states listed below allow an income tax credit for the payment of long-term care insurance premiums:

- Colorado – 25% of premiums up to $75 individuals/$150 couples; incomes less than $50,000 single/$100,000 married filing jointly; nonrefundable.
- Louisiana – 10% of premium per policy; enacted but not available to taxpayers until budget is adjusted by legislature for the loss of revenue from credit claims.
- Maryland – 100% of premium up to $240 if age 40 or less, up to $450 if age 41 to 50, or up to $500 if 51 and over; nonrefundable and may not be carried forward.
- Minnesota – $100 per person and per policy.
- New York – 10% of premium, nonrefundable but unused credit may be carried forward.
- North Dakota – 25% of premium per policy
- Oregon – the smaller of 15% of premium paid or $500 nonrefundable and cannot be carried forward.

California and Montana have tax credits for long term care, but are not tied specifically to long-term care insurance policies. California has a $500 nonrefundable tax credit for taxpayers with adjusted gross incomes less than $100,000 who provide long term care to spouse or dependent. Montana has an elderly care tax credit that is a percentage of elder care expenses, but the percentage is based on the taxpayer's adjusted gross income. Long term care insurance premiums are an eligible expense. The credit is limited to $5,000 for a single qualifying family member and $5,000 for a joint return.

FISCAL IMPACT

Tax year 1999 is the first year that taxpayers could claim the long-term care tax credit. In the inaugural year, 21,029 tax returns claimed approximately $4.2 million in credits for an average long-term care insurance credit of $199. The average tax credit claimed per return in the four years of the program has been $202. The total amount of credits claimed each year has been consistent except for 2001, which may be explained by a high error rate (see discussion below).

Tax Year	Number of Returns	Total Long-Term Care Credits	Average Credit Per Return
1999	21,029	$4,181,454	$198.84
2000	29,206	$5,974,615	$204.57
2001	51,959	$10,367,883	$199.54
2002	27,516	$5,652,648	$205.43

The chart below helps explain the type of taxpayer taking the long-term care credit. 61.3% of the tax returns with long term care credits in 2002 were claimed by married couples or widows. This group claimed 68.7% of the total credit amount. The second largest claimant group was single filers with 23.7% of the returns claiming 20.8% of the credits.

The 0 to $10,000 taxable income group had the greatest number of tax credit claims in 2002. This group also had the largest tax credit per return equal to $231. It must be noted that this is taxable income, which is gross income minus deductions and exemptions.

LONG-TERM CARE CREDITS CLAIMED FOR TY 2002

Number of Tax Returns

NC Taxable Income	Single	Married, Joint/Widow	Married, Separate	Head of Household	Total
$0 - $10,000	2,251	2,965	77	1,373	6,666
$10,001 - $20,000	1,274	1,933	73	1,299	4,579
$20,001 - $30,000	950	1,685	61	547	3,243
$30,001 - $40,000	645	1,611	45	277	2,578
$40,001 - $50,000	442	1,528	21	116	2,107
$50,001 - $60,000	295	1,330	28	74	1,727
$60,001 - $75,000	263	1,525	13	36	1,837
$75,001 - $100,000	218	1,688	9	38	1,953
$100,001 or more	194	2,590	14	28	2,826
Total	6,532	16,855	341	3,788	27,516
Percent of Total	23.7%	61.3%	1.2%	13.8%	

Credit amount

NC Taxable Income	Single	Married, Joint/Widow	Married, Separate	Head of Household	Total
$0 - $10,000	$475,235	$847,613	$11,092	$208,656	$1,542,596
$10,001 - $20,000	$229,904	$517,813	$9,069	$193,000	$949,786
$20,001 - $30,000	$152,319	$409,185	$8,787	$79,636	$649,927
$30,001 - $40,000	$97,010	$344,770	$5,437	$32,122	$479,339
$40,001 - $50,000	$69,741	$307,054	$2,656	$15,595	$395,046

$50,001 - $60,000	$45,488	$259,031	$4,697	$8,288	$317,504
$60,001 - $75,000	$35,965	$290,962	$2,355	$4,261	$333,543
$75,001 - $100,000	$36,240	$322,404	$1,158	$4,492	$364,294
$100,001 or more	$34,722	$582,046	$1,630	$2,215	$620,613
Total	$1,176,624	$3,880,878	$46,881	$548,265	$5,652,648
Percent of Total	20.8%	68.7%	0.8%	9.7%	

ERROR RATE

The Department of Revenue has encountered serious taxpayer problems with the long-term care insurance tax credit. Audited tax returns in 2001 showed a 91% error rate for credit. The most common taxpayer error were 1) claiming the credit for regular insurance premiums, 2) claiming the total amount of premiums paid as a credit instead of the $350 limit, and 3) claiming the credit and also claiming the long-term care premium as a medical expense.

The Department of Revenue reports a 40% error rate in audited returns in tax year 2003. Nancy Pomeranz, Director of the Department of Revenue's Personal Taxes Division, credits the reduction in long-term credit errors to the following factors:

1. Tax preparers making errors were contacted.
2. Instructions in the D-400 tax return booklet were improved.
3. Verbiage in the software developers' tax packages was improved.
4. Taxpayers whose credit was disallowed did not make the same mistake.

The high error rate is surprising given that the instructions in Form D-400 TC state "A tax credit is allowed for the qualifying premiums you paid during the taxable year on a qualified long term care insurance contract(s)... **Medical insurance premiums that you pay for general health care, hospitalization, or disability insurance do not qualify as premiums paid for a long term care insurance contract."** The tax form tells you to read the instructions and complete the worksheet to determine the amount of credit owed.

CREDIT FUTURE

The long-term care insurance credit expired with the 2003 tax year. To continue the credit will require the removal of the credit sunset and an adjustment in future General Fund budgets for an annual revenue loss of approximately $6 million. More importantly, to continue the credit will require the elimination of taxpayer error and fraud. North Carolina can follow the practice of Minnesota and require the taxpayer to list the insurance company and policy number of the long-term care policy for which a tax credit is claimed. (see attached tax schedule) The Department of Revenue could work with the Department of Insurance to get the list of companies providing long-term care policies in the state and a computer listing of policy holders to match against the tax credit claims.

MINNESOTA · REVENUE

Schedule M1LTI
Sequence #15

2003 Long-Term Care Insurance Credit

Your first name and initial | Last name | Social Security number

If you (or your spouse, if filing a joint return) paid premiums in 2003 for a qualified long-term care insurance policy, complete this schedule to determine the amount, if any, you can subtract from your tax when you file your Form M1.

To qualify for this credit, your long-term care insurance policy must:

- qualify as a federal deduction (see federal Schedule A of Form 1040), disregarding the 7.5 percent income test, and
- have a lifetime long-term care benefit limit of $100,000 or more.

There are no separate instructions for Schedule M1LTI.

Policy Information

Policy information *(only one qualifying policy per person)*:

	Name of insured	Insurance company	Policy number
#1			
#2			

Determining credit

Provide the information in the appropriate column for each insured person. If you are filing a joint return and both you and your spouse are covered by one policy, use half of the premiums in column A and half in column B (below).

Round amounts to the nearest whole dollar.

		Taxpayer A	Spouse B
1	Total amount of premiums paid in 2003 for the qualifying long-term care insurance policy 1		
2	If you itemized deductions on your federal Form 1040:		
	a Amount of premiums paid on this policy that are included on line 1 of your federal Schedule A 2a		
	b Amount from line 4 of your federal Schedule A (if you and your spouse are claiming premiums paid, enter half of this amount in each column) 2b		
3	Amount from line 2a or line 2b, **whichever is less** 3		
4	Subtract line 3 from line 1 4		
5	Multiply line 4 by 25% (.25) 5		
6	The maximum credit amount per person is $100 6	$100	$100
7	Amount from line 5 or line 6, **whichever is less** 7		
8	Add line 7, columns A and B 8		

Full-year residents: Also enter this amount on line 23 of your Form M1.

Part-year residents and nonresidents

9	Multiply line 8 by line 26 of your Schedule M1NR. Enter the result here and on line 23 of your Form M1 9	

You must include this schedule with your Form M1.

Stock No. 1003160

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

Fiscal Research Division

March 2004

Attachment # 6

Medicare Prescription Drug Benefit:

Implications for the North Carolina Medicaid Program

- The Medicare Modernization Act will provide a voluntary prescription drug benefit for Medicare beneficiaries beginning in 2006 (Medicare Part D).
- "Dual Eligibles" or Medicare beneficiaries with Medicaid are required to receive prescription drug benefits through Medicare effective Jan. 1, 2006.
  - Loss of Medicaid Coverage applies even if dual eligible is not enrolled in a Part D Plan
  - No beneficiary choice
  - No state choice
  - Cost-sharing obligations similar to Medicaid

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

- The North Carolina Medicaid Program will receive some fiscal relief over the next ten years, but the actual relief is lower than expected due the "clawback" provision and new administrative costs.

- Under the 'clawback" provisions, North Carolina is required to make payments to the federal government in perpetuity to finance most of the cost of the Medicare prescription drug coverage for its dual eligibles.

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

- North Carolina's "clawback" payment will be based on three factors:
  - A per capita estimate of the amount the state otherwise would have spent on Medicaid prescription drugs for dual eligibles
    - ***Estimate will be based on 2003 state Medicaid spending on Part D covered drugs per dual eligible trended forward through 2006 by the growth in national per capita prescription drug expenditures and in 2007 and later years by per capita growth in 2007***
  - The number of dual eligibles enrolled in a Part D plan
  - A "takeback" factor set at 90% in 2006, declining to 75% for 2015 and later years.

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

- The Division of Medical Assistance estimates that North Carolina spent $683.1 million on prescription drugs for 220,723 dual eligibles during FFY 2003.
- The State and County share of these FFY 2003 expenditures was $255.8 million or 37.44% of the costs.
- North Carolina's payment in FFY 2006 will be based on these numbers after they are adjusted for inflation.

Medicare Prescription Drug Benefit:

Implications for the North Carolina Medicaid Program

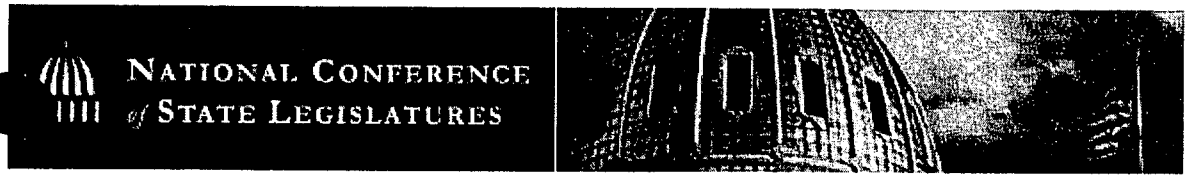
- States have never participated financially in the Medicare program. It has always been financed by employer/employee contributions to the Social Security Trust Fund.
- The "clawback" payments will be a line item in the Medicare budget for Medicare Part D or the Prescription Drug Benefit.
- In the future, Congress could require states to pay a higher percentage of the cost for dual eligibles if the overall cost of the prescription drug benefit grows faster than anticipated.

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

- States are mandated to perform eligibility determinations and to enroll dual eligibles and other low-income people in the Part D low-income subsidy program.
- There is no subsidy for this new administrative burden.
- North Carolina will be reimbursed at the Medicaid administrative cost rates for perform the eligibility determinations.
- In North Carolina, Medicaid eligibility is performed and paid for by counties. The federal government pays 50% and counties pay 50% of the costs associated with eligibility determination.

Federal Proposals for Medicaid

- "Curbing the use of intergovernmental transfers
- Prospective budgeting vs. Retrospective budgeting
- Budget caps
- Cost allocation for Medicaid administration
- MMIS funding reduction
- No Federal fiscal relief



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MEDICAID PROPOSALS UNFAVORABLE TO STATES CONTINUE TO SURFACE

The president's FY 2005 budget proposal includes almost $2 billion in federal savings from the Medicaid program. It proposes to achieve $1.5 billion alone through "curbing" the use of intergovernmental transfers. The reduction would be made by limiting states' ability to set rates for health care providers. The budget also proposes to reduce federal Medicaid payments to states by $261 million through a one-time reduction in Medicaid administrative costs popularly known as "cost allocation." This is an elusive issue related to the 1996 welfare reform law and explained in detail in *Medicaid Cost Allocation: A Backgrounder*, available from the NCSL Washington Office. Finally, the president's budget proposed to reduce the enhanced federal match rate for information and claims management systems from 90 percent to 75 percent, saving the federal government $80 million. This reduction is particularly ill-timed as states prepare for their role in the implementation of the Medicare prescription drug program, which includes eligibility determinations for the Medicare Part D subsidies.

In addition to proposals in the budget, the administration is increasingly depending on regulatory and administrative maneuvers to curb state Medicaid spending. On January 7, the Centers for Medicare and Medicaid (CMS) published in the Federal Register a notice invoking an emergency procedure to change the format and timing of the states' reporting of budget and expenditure information that establishes the basis for entitlement reimbursements to states for Medicaid expenditures. Under current practice, the centers review the information retrospectively. CMS proposed a prospective budget and financial management process that essentially gives CMS authority to "prior approve" mechanisms states use to provide their match and to base state payments on Medicaid budgets "proposed" by governors. States were given only 24 hours to respond. That met with immediate resistance from NCSL and others culminating last week in an announcement that another notice with a 60-day comment period will be published after consultation with governors and state Medicaid directors.

Another technique being used by CMS is to extract concessions from states during negotiations for state plan amendments and waivers. One state seeking an amendment to its nursing facilities operations was told by CMS that the request would not be approved unless the state agreed to, among other things, end all intergovernmental transfers. This raises serious concerns since intergovernmental transfers are allowed under current law, and apparently the intergovernmental transfers in the state complied with federal law. **State legislators are encouraged to share information with NCSL regarding instances where local governments provide part of the state match and specific programs are funded through intergovernmental transfers. State legislators are encouraged to review pending state plan amendments to see if state officials are being told approval is conditioned on termination of intergovernmental transfer use.** In a similar vein, state Medicaid directors and governors are being approached about capping their Medicaid programs as part of waiver applications or as part of ongoing negotiations to address disallowances. Last week two governors expressed interest in pursuing a "block grant" approach for Medicaid using the 1115 waiver approach. Senator Charles Scott (R-Wyoming) has introduced an amendment to the budget bill in Wyoming that would prohibit the state Medicaid agency from agreeing to a Medicaid cap without approval of the state legislature. With much of the action occurring through administrative mechanisms, more states may want to consider this approach.

State legislators should be prepared to share information with their congressional delegation regarding the harm that would occur if the president's budget proposals are enacted. In addition, it is important to share with members of Congress the important role intergovernmental transfers play in supporting the Medicaid program in your state. (NCSL staff contact: Joy Johnson Wilson)

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Denver Office: Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230 | Map
Washington Office: Tel: 202-624-5400 | Fax: 202-737-1069 | 444 North Capitol Street, N.W., Suite 515 | Washington, D.C. 20001

NCSL

National Conference of State Legislatures 444 North Capitol Street, N.W., Suite 515 Washington, D.C. 20001
202-624-5400 202-737-1069 (fax)

February 18, 2004

Proposed Prospective Financial Management Review for the Medicaid Program

Overview

On January 7, 2004, a notice was published in the *Federal Register* by the Centers for Medicare and Medicaid Services (CMS) seeking emergency review by the Office of Management and Budget (OMB) of its proposed revision of the CMS-37 forms[1] and process. Specifically, CMS proposed to:

> "minimize disruption to state operations and the reduction of unnecessary expenditures to the federal government by modifying the collection requirements associated with the CMS-37 budget and expenditure information collection package. In particular, CMS will begin to require the states to submit up-front documentation to support the budget and expenditure information currently captured on the CMS-37 "Medicaid Program Budget Report."

CMS asked that all comments be submitted for review no later than January 8, 2004. This entire process was being pursued as a paperwork reduction activity.

The original plan was to implement the new process for state fiscal year 2005. Neither the substance of the proposed changes, nor the 24-hour comment period was well received by interested parties. As a result, the request for approval and review of the revised forms by OMB will be resubmitted and will not be done on an "emergency" basis. Instead, CMS will consult with state and local government representatives and resubmit the proposed new forms and process for approval by OMB. There will be a 60-day public comment period. Under this revised schedule, the new process would apply to state fiscal year 2006.

What is the proposal? How does it differ from current practices? What will be the impact on state Medicaid programs?

Current Practices

CMS' financial management oversight is currently performed through reviews of historical claims. Funds are advanced to a state at the beginning of each quarter, and CMS reviews expenditures to identify improper payments after a financial management review on the state's quarterly expenditure report is completed. Since these reviews are retrospective, if improper payments are identified, CMS must collect these payments from the states.

Proposed Prospective Financial Management Review Process

CMS is proposing to implement a **prospective financial management review process.** The prospective financial management review process will establish the framework for allowable expenditures for purposes of drawing federal matching payments (FFP). Federal grants will be predicated on the level of expenditures contained in the approved state submissions. **The current process for grant awards, draws of Federal funds, and reporting expenditures will continue to be employed. However, the state will not draw any Federal funds to cover new expenditures, including those that would require a new state plan amendment, waiver amendment or new contracts, unless and until the expenditures are approved and the state funding sources are accepted through the supplemental budget process and applicable state plan or other Federal authorization process.** Current federal cash management protocols will be applicable to the state's draw and use of federal funds.

As part of its prospective review CMS will provide the state with a written determination of any proposed expenditure which it believes lacks outstanding state plan authority, waiver authority or other authority for FFP, or that the expenditure is

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[1] The CMS-37 is a quarterly financial report submitted by the state which provides a statement of the state's Medicaid funding requirements for a certified quarter and estimates and underlying assumptions for two fiscal years -- the current fiscal year and the budget fiscal year. In order to receive federal financial participation, the state must certify that the requisite matching state and local funds are, or will be, available for the certified quarter. This information is supplied to CMS electronically through the Medicaid Budget and Expenditure System (MBES) and is reviewed by CMS. Based on the CMS-37 submission and subsequent review, CMS issues the state a grant award authorizing federal funding to the state for the certified quarter. If at any time in the quarter, the state feels that it's original request for federal funds is insufficient, it may submit a revised CMS-37 through the MBES, justifying its request and recertifying for the quarter. After review and approval, CMS issues a supplemental grant award to the state for the additional federal funds needed.

otherwise not subject to FFP. **If the state continues to believe that there is authority for the proposed expenditure and that it is subject to FFP, the state may retain the expenditure in the Medicaid budget, but CMS will be free to utilize any authority in statute or regulation to question or withhold FFP.**

Under the CMS proposal, beginning with state fiscal year 2006,[2] each state would be required to submit to the appropriate CMS Regional Office, at least 150 days prior to the commencement of each state fiscal year, its preliminary Medicaid budget (i.e. services and administration). At a minimum this submission would include:

- The total budget for medical assistance expenditures of the single state agency (including the identification of Federal and non-Federal funding sources);
- Budgets for medical assistance expenditures made by other state agencies, which will be the basis for claims for Federal matching funds;
- Budgets for medical assistance expenditures made by non-state governmental units (e.g., public hospitals, County Health Departments), which will be the basis for claims for Federal matching funds;
- Budgets for administrative costs either directly charged or allocated to the Medicaid program under approved cost allocation plans; and
- a listing and estimated amounts of all of the state funding sources[3] for the non-Federal share of expenditures pursuant to the Medicaid budget.

All budgets should list expenditures in the same categories that are reported on the CMS-64 forms.[4] In addition, each source of state revenue that meets the definition of a health-care related tax or a provider-related must be separately identified and should be accompanied by documentation that would show it is in compliance with federal law and regulations.

Follow-Up After Submission of the Revised CMS-37 Form

After submission of the new CMS-37 forms, states will be expected to provide additional documentation reasonably requested by CMS to facilitate its review of the state's submission.
Update reports, that will include any significant new expenditure categories or state funding sources under consideration, will be provided every 30 days to CMS on the status of the budget.

Once the final state budget is adopted, the state will submit a final Medicaid budget for CMS review, including the estimated amount of each funding source and a description of each of the funds and funding sources expected to finance the non-Federal share of the Medicaid expenditures. CMS will advise the state no later than 45 days after receipt of the state's submission of its final Medicaid budget of any proposed state-funding source that CMS believes is not allowable under Federal law and regulations.

If necessary, CMS and the state will meet and discuss issues raised with respect to any funding source that CMS had questioned. If after review and negotiation, CMS adheres to a determination that a state funding source is not compliant with Federal law and regulations, CMS will defer and disallow claims related to budget items, including funding sources, that have not been reviewed and accepted by CMS in the financial review process.

Supplemental Budget Amendments

The state plan and waiver submission processes contained in existing statutes and regulations will be utilized. The supplemental budget process will be used for the state to submit the funding sources to cover the non-federal share of the additional expenditures. The state will not claim expenditures under any state plan amendments until they are approved by CMS. The state, however, remains free to pay for services covered by pending state plan amendments with state-only funds, pending approval of the plan amendment and the Medicaid budget amendment by CMS. States will be entitled to draw federal funds for the federal share of all expenditures covered by the approved amendment from the time of its approved effective date.

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[2] Key CMS staff has indicated that the proposal will not be implemented until state fiscal year 2006.

[3] The term "state funding sources" refers to all sources for the non-federal share of Medicaid expenditures. Funding sources can include the state general fund, separately maintained trust funds, other state appropriations and non-state public expenditures. State funding sources also include revenues (whether deposited in the General Fund or other funds) derived from health care providers, or from governmental units on account of health care expenditures, as well as interagency or intergovernmental transfers related to health care expenditures or from an entity related to health care.

[4] The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) is the accounting statement which states must submit each quarter. It shows the disposition of Medicaid grant funds for the quarter being reported and previous fiscal years, the recoupment made or refunds received, and income earned on grant funds. States are not accountable for interest earned on grant money pending disbursement for program purposes. However, states are accountable for the federal share of any interest earned on recoupments or refunds pending their return to the federal government. It is also the vehicle for making adjustments for any identified overpayment and underpayment to states. The amounts reported on Form CMS-64 and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. Form CMS-64 is a statement of expenditures for which states are entitled to federal reimbursement under Medicaid and which reconciles the monetary advance made on the basis of Form CMS-37 filed previously for the same quarter. Consequently, the amount claimed on the Form CMS-64 is a summary of expenditures derived from source documents such as invoices, cost reports and eligibility records.

The supplemental budget amendment may be submitted at any time but would normally be submitted at the same time that a supplemental budget request is made to the state legislature. CMS will approve any supplemental budget amendment provided that it covers allowable expenditures and the state has demonstrated a valid funding source for the non-federal share of the expenditures.

A state may submit to CMS supplemental budget amendments to incorporate any previously unbudgeted expenditure. Supplemental budget amendments may be based on:

- Service utilization changes;
- Increases in eligibles;
- Increases in the number of providers; and
- And/or increases in cost of services or administration.

A state's supplemental budget submission must also show the funding sources from which the non-federal share of the cost of the increased expenditures will be obtained. **CMS will review the non-federal funding sources and notify the state within 45 days of any state funding sources that it believes does not comply with applicable Federal law. CMS will then defer or disallow any claims that are based on unacceptable state funding sources.**

State Impact

It is too early to say with any certainty what the state impact will be. Much of that will depend on exactly how the process is implemented. There are a few things that are certain.

(1) Despite claims to the contrary, this process involves more paperwork and staff time than the current process.
(2) This process calls for the collection of information that CMS probably wants to have, but is not necessary for the administration of the program.
(3) The new process gives CMS the upper hand when there are disputes regarding state funding sources for federal matching payments for Medicaid.
(4) State budget processes vary widely from state to state and developing a one size fits all system that will run smoothly will be difficult.
(5) Finally, there is a general lack of comfort in having federal officials so intimately involved in the state budget process.

NCSL Staff Contact: Joy Johnson Wilson, Health Policy Director, NCSL, Washington, D.C. (Joy.Wilson@ncsl.org)

NCSL

National Conference of State Legislatures 444 North Capitol Street, N.W., Suite 515 Washington, D.C. 20001
202-624-5400 202-737-1069 (fax)

February 11, 2004

MEDICAID COST ALLOCATION---A BACKGROUNDER

THE ISSUE

President Bush submitted his proposed FY 2005 federal budget to Congress on February 4, 2004. Among the many proposals was one to apply "cost allocation" to the Medicaid program, saving the federal government and costing states $300 million in FY 2005. For the uninitiated, Medicaid "cost allocation" is an esoteric concept. This backgrounder attempts to simplify the concept and describe the potential impact of the proposal if enacted.

BACKGROUND

The Personal Responsibility and Work Opportunity Act of 1996 (PWORA) converted the former Aid to Families with Dependent Children (AFDC) entitlement program into the Temporary Assistance to Needy Families (TANF) program, a block grant to states. Each state's TANF funding was based on the higher of: (1) actual state expenditures in either FY 1994 or FY 1995; or (2) an average of state expenditures between FY 1992-FY 1999.

Administrative Cost Allocation

Prior to passage of TANF, states administered the AFDC, Food Stamp and Medicaid programs and the federal government reimbursed them for half of all administrative costs. The largest component of administrative costs was the cost of certifying eligible households. The federal government matched the states' administrative expenses for all of these programs on a 50/50 basis.

Because of the overlap in eligible populations, states often undertake administrative activities that benefit more than one program. For example, when a household applies for TANF, Medicaid, and food stamps, collecting information on the household's income is necessary for all programs and is usually done during a combined eligibility interview. The process of allocating shared administrative costs among various state and federal programs is known as **cost allocation**.

The general rules for allocating costs are prescribed by regulation in OMB Circular A 87. These rules require that costs that are incurred for more than one program be allocated based on the extent to which the various programs benefit from the activity. This is called the "benefiting program" approach. Under this approach, a cost that is equally necessary for more than one program is shared equally by the programs.

The history of the public welfare programs led to an exception to this general cost allocation rule. When Congress created Medicaid and Food Stamps, it assumed that large portions of the administrative work for households that received AFDC was already done for AFDC and that these newer programs could piggy-back on that work. As a result, in the case of AFDC, all costs that were identified as shared costs were allocated to AFDC. This is called the "primary program" approach. For cases that received AFDC, Food Stamps, and Medicaid, the Food Stamp and Medicaid programs paid only the cost of the work that was over and above what was required for AFDC. Because the federal match rate was 50 percent in all three programs, the amount that the federal government paid was the same, regardless of whether it was considered a joint cost and claimed under the AFDC program or a cost allocated to one of the individual programs.

When Congress replaced AFDC with TANF, it failed to specify how shared costs were to be treated under the new program. The funding included in the TANF block grant, based on pre-1996 spending, was predicated on the "primary program" cost allocation method of cost allocation discussed above, where AFDC paid for the administrative costs that benefited all the various programs. Some federal officials believed that states would maximize the administrative costs attributed to Medicaid or Food Stamps, where 50 percent matching funds were still available, and minimize administrative costs allocated to TANF that was no longer eligible for federal matching payments, freeing TANF block grant funds for other purposes.

The Agricultural Research, Extension, and Education Reform Act of 1997 (P.L. 105-185)

In an effort to address the concerns of federal officials who believed states would "maximize" administrative cost reimbursement by shifting costs to the Medicaid and Food Stamp programs, "cost allocation" provisions were included in the Agricultural Research, Extension, and

Education Reform Act of 1997 (P.L. 105-185). The Act required that the Secretary of Health and Human Services (HHS), in consultation with the Secretary of Agriculture (USDA), to determine the costs charged to the former AFDC program in states' TANF base year that could have been allocated to Food Stamps and Medicaid for common administrative costs. The attached chart provides a state-by-state breakdown of the Medicaid "cost allocation" amounts determined through this process. The numbers reflected in the chart are the final determinations after all state appeals had been addressed.

The Act provided that the amounts attributable to Food Stamps were to be deducted from state Food Stamp administrative cost claims for FY 1999-FY 2002. The Act did not require similar treatment for the Medicaid costs identified.

The Farm Security and Rural Investment Act of 2002 (P.L. 107-171)

When the Farm Bill was reauthorized in 2002, cost allocation for the Food Stamp Program was made permanent.

Reauthorization of the Temporary Assistance for Need Families (TANF) Program

In 2002 when the House of Representatives first enacted legislation reauthorizing TANF, H.R. 4737, the Personal Responsibility, Work, and Family Promotion Act of 2002, it proposed to extend the Transitional Medical Assistance (TMA) program and to fund the TMA extension with federal funds obtained through Medicaid "cost allocation." This proposal mirrored a proposal by President Bush in his FY 2003 budget proposal.

Last year, the President did not include the Medicaid "cost allocation" proposal in his FY 2004 budget submission. The House of Representatives passed another TANF reauthorization bill in February 2004, H.R. 4, which continues to include the Medicaid "cost allocation" provision. The FY 2004 Congressional budget resolution provides funding for the TMA extension from the federal general fund, making the "cost allocation" proposal in the House TANF reauthorization bill unnecessary. The Senate Finance Committee reported its version of the TANF reauthorization in September 2003. That bill does not include the Medicaid "cost allocation" provision. As you know final action on the TANF reauthorization bill has not occurred. The program has been temporarily extended until March 31, 2004, pending final action on reauthorizing legislation.

The FY 2005 Federal Budget

Last proposed as part of the FY 2003 budget, the Administration is again proposing to reduce federal reimbursement for Medicaid administrative costs to reflect the share assumed in the TANF block grant. States would be prohibited from using TANF funds to pay these costs during FY 2005. The Congress has not enacted a budget resolution to date.

State Impact

The attached chart (see page 3) provides state-by-state information on the annual Medicaid cost allocation amounts identified according to the provisions of P.L. 105-185. The chart reflects the figures that were finally settled on after states went through an appeals process. While the Medicaid cost allocation provision proposed in the FY 2005 budget is for one year only, it is instructive to remember that the Food Stamp cost allocation provision was also supposed to be a temporary provision.

Laws & Bills

- ***Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193)***
- ***The Agricultural Research, Extension, and Education Reform Act of 1997 (P.L. 105-185)***
- ***The Farm Security and Rural Investment Act of 2002 (P.L. 107-171)***
- ***The Personal Responsibility, Work, and Family Promotion Act of 2002 (H.R. 4737)***
- ***The Personal Responsibility, Work, and Family Promotion Act of 2003(H.R. 4)***

This summary is an information service provided by NCSL's Office of State-Federal Relations. For more up-to-date information on federal health issues, visit our website at:
http://www.ncsl.org/statefed/health/fedhealthissues.htm

NCSL Staff Contacts:

- Joy Johnson Wilson, Health Policy Director
- Rachel Morgan, R.N., Senior Health Policy Specialist

MEDICAID COST ALLOCATION AMOUNTS BY STATE[1]

STATE	Annualized Medicaid Cost Allocation Amounts
ALABAMA	1,370
ALASKA	902
ARIZONA	4,000
ARKANSAS	1,110
CALIFORNIA	68,800
COLORADO	2,403
CONNECTICUT	2,500
DELAWARE	677
FLORIDA	14,409
GEORGIA	961
HAWAII	990
IDAHO	752
ILLINOIS	11,511
INDIANA	3,000
IOWA	-
KANSAS	1,600
KENTUCKY	2,960
LOUISIANA	877
MAINE	760
MARYLAND	5,380
MASSACHUSETTS	9,482
MICHIGAN	8,296
MINNESOTA	2,240
MISSISSIPPI	1,441
MISSOURI	-
MONTANA	445
NEBRASKA	318
NEVADA	1,330
NEW HAMPSHIRE	584
NEW JERSEY	14,200
NEW MEXICO	1,350
NEW YORK	46,340
NORTH CAROLINA	7,978
NORTH DAKOTA	350
OHIO	11,950
OKLAHOMA	4,120
OREGON	3,900
PENNSYLVANIA	-
RHODE ISLAND	1,121
SOUTH CAROLINA	1,479
SOUTH DAKOTA	377
TENNESSEE	2,510
TEXAS	-
UTAH	995
VERMONT	440
VIRGINIA	-
WASHINGTON	6,240
WEST VIRGINIA	563
WISCONSIN	5,570
WYOMING	302
DISTRICT OF COLUMBIA	1,620
UNITED STATES TOTAL	260,503

Source: "Medicaid Reductions for Transitional Medical Assistance," Federal Funds Information for States (FFIS), 2002

[1] The original federal savings was estimated to be $300 million, however, after the state appeals process was completed, the federal savings was reduced to just over $260 million. The state-by-state numbers in the chart reflect the post-appeal amount.

NORTH CAROLINA GENERAL ASSEMBLY
BLUE RIBBON COMMISSION ON MEDICAID REFORM
COURSE OF ACTION

AUTHORITY/PURPOSE/MISSION:

The Blue Ribbon Commission on Medicaid Reform was authorized in the 2003-04 budget bill H397, and engrossed in Section 6.14A.(a) and (b); and, cites: "The Commission shall examine the State's Medicaid program and make comprehensive recommendations for fundamental reform. The Commission shall consider: (1) Methods to responsibly restrain the growth in Medicaid spending; (2) Best practices in both the public and private sectors in managing and administering health care; (3) Options for maximizing existing resources while controlling Medicaid program costs; (4) Current array of services available within the State Medicaid program to determine the appropriateness of the type, frequency, and duration of those services; (5) Opportunities for long-term systemic change in the Medicaid program through the use of federal waivers and other management tools; (6) How to minimize the State and county share of Medicaid costs and maximize federal participation in Medicaid Programs; (7) The role of Medicaid in the State's economy; and, (8) Any other matter relating to reform of the State Medicaid program." Suspense: Feb. 1, 05.

AREAS OF CONSIDERATION AND TESTIMONY:

- **LEGISLATIVE RESEARCH**. Provide research findings on National and State Health Care Costs and Health Care Coverage and provide a historical perspective and macro implications for NC. Need a good "review of the existing literature," consistent with our purpose and mission. How are the other states handling the need to provide health care coverage and what appears to be a crisis in health care costs overall and specifically in the macro view of Medicaid costs? In addition, address each study criteria, 1-8, as appropriate and provide recommendations. (Summarize in written form by purpose, facts, discussion and recommendations.)
- **NC, DHHS, DIVISION OF MEDICAL ASSISTANCE**. Provide a quality review of the historical perspective of the Medicaid Program to include authority; identification of the current cost sharing in place to pay for Medicaid; differentiation of the federal required coverage and optional services elected by the state; identification of different supported subprograms of Medicaid, their trends by $ and % over a representational

number of years by client groups and overall with conclusions; provide a reflection of the attitudes and conclusions of the health care industry as to costs, dealing with Medicaid patients and their associated concerns and recommendations (may desire to solicit representative testimony); provide data and discussion concerning cost containment efforts undertaken to date and their resultant conclusions. In addition, address each study criteria, 1-8, as appropriate and provide recommendations. (Summarize in written form by purpose, facts, discussion and recommendations.)

- **NC ASSOCIATION OF COUNTY DIRECTORS' OF SOCIAL SERVICES.** Provide an understanding of the county delivery of Medicaid services and who pays for what; the degree of oversight responsibilities and audits; automation available and needed; degree of flexibility in providing services; provide a human perspective on services extended by Medicaid to our citizens and gaps in services; address impact of Medicaid services and funds to the county; and, provide recommendations and an understanding of the potential impact in reduction of Medicaid services to the needy. In addition, address each study criteria, 1-8, as appropriate and provide recommendations. (Summarize in written form by purpose, facts, discussion and recommendations.)
- **NC ASSOCIATION OF COUNTY COMMISSIONERS**. Provide an appreciation for the financial impact of Medicaid cost in NC counties reflecting the metropolitan as well as rural county perspectives; brief on work performed to date by NCACC and variances among states and NC counties; and, make applicable recommendations. In addition, address each study criteria, 1-8, as appropriate and provide recommendations. (Summarize in written form by purpose, facts, discussion and recommendations.)
- **LEGISLATIVE RESEARCH**. In addition to requested testimony cited above, be responsible for monitoring all discussions and testimony during the course of the Commission work; summarize the work and assist Commission members in reaching conclusions; and, place in a presentable outcomes paper identifying at a minimum the purpose, facts, discussion and recommendations associated with the Commission's purpose & mission as well as those other factors apparent.
- **OTHER**. Recommend setting aside 21-minutes (3-minute speaking opportunities) for each meeting to allow public or private entities or individuals to address the Commission with discretion by the sitting chair; and, additional agencies and individuals desiring to make full presentations to the Commission should seek approval from the chair and requires a simple majority of the voting members of the Commission.

NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH 27603

March 25, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

SUBJECT: Meeting Notice

The Blue Ribbon Commission on Medicaid Reform will meet. One of the topics for consideration will be the Report to the 2003 Session of the General Assembly.

DAY:	Monday
DATE:	April 12, 2004
TIME:	1:00 p.m.
LOCATION:	Room 544, Legislative Office Building

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives (see attached map). The cost for visitor parking is $.50 per hour or $4.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

Please advise Anne Wilson, Committee Assistant, at (919) 733-5707, or e-mail annew@ncleg.net if you will be unable to attend.

Posted: March 25, 2004

cc: Committee
Record ✓
Interested Parties

Anne Wilson (Committee Assistant)

From: Anne Wilson (Committee Assistant)
Sent: Thursday, March 25, 2004 10:44 AM
Subject: Notice for April 12, 2004 Meeting of the Blue Ribbon Commission on Medicaid Reform

PLEASE NOTE "DATE" CORRECTION IN SUBJECT LINE.

March 25, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

SUBJECT: Meeting Notice

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Please advise Anne Wilson, Committee Assistant, at (919) 733-5707, or e-mail annew@ncleg.net if you will be unable to attend.

Posted: March 25, 2004

cc: Committee Record ✓
Interested Parties

Anne Wilson (Committee Assistant)

From: Anne Wilson (Committee Assistant)
Sent: Thursday, March 25, 2004 9:59 AM
Subject: Notice for April 6, 2004 Meeting of the Blue Ribbon Commission on Medicaid Reform

March 25, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

SUBJECT: Meeting Notice

The Blue Ribbon Commission on Medicaid Reform will meet. One of the topics for consideration will be the Report to the 2003 Session of the General Assembly.

DAY:	Monday
DATE:	April 12, 2004
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LOCATION:	Room 544, Legislative Office Building

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Please advise Anne Wilson, Committee Assistant, at (919) 733-5707, or e-mail annew@ncleg.net if you will be unable to attend.

Posted: March 25, 2004

cc: Committee Record ✓
Interested Parties

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM April 12, 2004

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	ACS
W. H. Potter Jr.	NCDS & NCDTA
	Nelson Mullins
Albert Bell	CORNING
Andy Romanet	NCLM
LANIER CANSLER	DHHS
PEYTON MAYNARD	GPM INC.
John McMillan	NCFAS
Bob Hedrick	NCCSPA

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — April 12, 2004

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Larry Bewley	LBA
Nancy Rees	SELC
Mike Dixon	Capitol Group
Richard C. Hatch	AARP
Adam Searing	NCSCDC - HAR
Karen Gottovi	NCACDSs
Stella McKenney	NC DHHS
John Mellus	GOV OFFICE
Angela Jo Horne	NCMS
John Bourdeau	AstraZeneca
X	

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — April 12, 2004

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daphne Lyon	OSBM
David M. Barnes	Poyner + Spruill
John Goodman	Alley Associates
Doug Miskew	Capstrat
Dana Simpson	Smith Anderson
Abby Emanuelson	Nat'l MS Society
Jenny Gaspard	NCALA
Stacy Flannery	NCHCFA
Evelyn Hawthorne	DHHR
Bill Rustin	ACP

BLUE RIBBON COMISSION ON MEDICAID REFORM
Monday, April 12, 2004
1:00 p.m., Room 544 LOB

Chairmen: Senator William Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

I.	**Opening Remarks**	*Chairs*
II.	**Medicaid Briefing: Best Practices And Innovations**	*Laura Tobler, Program Director Health Care Program, NCSL* *Donna Falkemer, Program Manager Forum for State Health Policy Leader-Ship, NCSL*
III.	**Review of Draft Interim Report and Draft Legislation**	*Commission Staff*
IV.	**Approval of Interim Report**	*Chairs*
IX.	**Commission Discussion**	*Chairs*
X.	**Future Meetings and Closing Remarks**	*Chairs*

BLUE RIBBON COMMISSION ON MEDICAID REFORM
Wednesday, April 12, 2004 at 1:00 p.m.
Room 544, Legislative Office Building

MINUTES

The Blue Ribbon Commission on Medicaid Reform met at 1:00 p.m. on Monday, April 12, 2004 in Room 544, Legislative Office Building. The following members of the committee were present: Senators William R. Purcell (Co-chair) and Fletcher Hartsell; Representatives Julia Howard, (Co-chair), Edd Nye, (Co-chair), Jeffrey L. Barnhart and Beverly M. Earle; public members William A. Pully, Pam C. Silberman, Luckey Welsh, Dr. Al Wentzy, and Dr. Charles F. Willson. Representative Julia Howard presided.

Representative Howard welcomed members and visitors to the meeting and announced that two new members from the House will serve in an advisory capacity on the Commission: Representatives Jeffrey L. Barnhart and Bob England.

Representative Howard asked for consideration of the Minutes of the March 24, 2004 meeting. Senator Fletcher Hartsell moved to approve the Minutes, Dr. Charles Willson seconded the motion and the commission voted unanimous approval.

Representative Howard said that Commission staff had arranged a briefing on Medicaid by Ms. Laura Tobler and Ms. Donna Folkemer, who are associated with the National Conference of State Legislatures (NCSL). Ms. Tobler is NCSL's Program Director with Health Care Programs and Ms. Folkemer is NCSL's Program Manager for Forum for State Health Policy Leadership. Representative Howard called on Ms. Tobler to begin the presentation, "Medicaid Briefing: Best Practices and New Innovations". (See Attachment # 1.)

Ms. Tobler said the health care program and the health policy folks in Washington have been looking at what states are doing to their Medicaid programs through the last two years of trying to accommodate budget crises. She said she and Ms. Folkemer hoped to provide new information and, if not new, at least a refresher of what is happening across the country. She said they would address specific issues as listed in the handout such as long-term care, prescription drugs, nursing home provider taxes in a very small way, waivers, employer premium assistance programs and benefit package design, disease management and evaluation and data collection.

Ms. Tobler started by saying that Medicaid programs are very different, state by state, and because of the nature of Medicaid – it started in 1965 as a program of federal financial support for the states to allow them to provide health coverage for their welfare clients – it has grown into a large program covering three separate programs that operate very differently. It is the nation's largest health care program, having surpassed Medicare at an annual cost for the state and federal contributions of $205 billion in 2002. It is a very costly program, she said, primarily because the clients are sick people who

need a lot of expensive care. Medicaid is the largest source of support to states and creates millions of jobs. She said that the average state's budget for health services shows that over 69% is spent on Medicaid. She reviewed Medicaid's role and explained its broad outreach covering 31% of the U. S. population over 85 years of age, paying nearly half of U.S. nursing home costs, funding about 35% of U.S. births, subsidizing care for the uninsured and subsidizing graduate medical education. She added that research has shown that about 6% of all program spending is optional for the state and that the rate of growth of total Medicaid spending has trended down, while still being above the growth authorized in legislative appropriations for FY 2004.

Ms. Folkemer said the first idea she would offer involves long-term care and she mentioned the attention now occurring in states concerning persons with disabilities and the elderly. She said the Olmstead case decision by the U.S. Supreme Court in 1999 has focused attention on service delivery in the community and its components. She said twenty-nine states have Olmstead plans and what all of them talk about when they discuss the needs of persons with disabilities and the elderly is the need for things that go way beyond what we thought of as traditional health care or traditional long term care in the past. So all those plans say if we're going to provide services in the community then we will have to have things such as transportation, housing, employment for people who are seeking it and ways to involve people in the community. She added that there is considerable agreement across the country on policy goals: reducing reliance on institutional care, promoting consumer choice, responding to unmet needs, containing costs and promoting high quality, optimal outcomes. All of those things are mentioned in Olmstead plans but every state comes at these in a different way and, understandably, the work in this area is incremental and will take a considerable amount of time.

Ms. Folkemer discussed trends across the country, noting that occupancy rates in nursing facilities are down and vary from state to state. She said figures from 2001 show 83% occupancy and analysts suggest a continuing decrease in occupancy rates. She said reimbursement rates in nursing facilities or for other long term care services vary considerably under Medicaid, so a price for a service not only differs in amount, but also in how that price was reached. The average nursing home reimbursement rate, she said, is $124 a day with variations from state to state ranging from $83 to $323. The same kind of variation is seen in community services. So it's difficult to compare rates.

Another trend that Ms. Folkemer said they have seen in the last couple of years is that many states have started using provider taxes, i.e., taxing hospitals, nursing homes, etc., to support facility rates, but there are no good records on how many states have adopted this practice. She said she believes well over half of states use provider taxes now and more states are wanting to start them, particularly on nursing homes, as a way to bring in more state revenue to raise rates or to do other kinds of things in long term care. Ms. Folkemer said she could let members of the Commission know what other states are doing and get names of contacts if something of interest comes along. She said another noticeable change in the functions of nursing facilities and long-term care is the need for short-term admissions, a focus on Alzheimer's and related disorders and the need to adjust to medical advances and consumer preferences.

Ms. Folkemer said the big picture is that residential and assisted living options have doubled in the last decade, many more waivers have been granted for Medicaid home and community based services and changes in federal policy have encouraged community care. In addition, programs to determine the viability of cash/vouchers and consumer directed care using waiver options from CMS are providing for flexibility. She added that many states are planning ahead for long-term care needs and are discussing elements such as family care assisted by county management organizations, growth in community services, guaranteed waiver slots where the money follows the person, and incentives used to alter service mix. She said these are state-specific ideas on how to hold increased spending to a minimum.

Ms. Folkemer discussed prescription drugs and said the important thing to know about prescription drugs is how to manage them – the drug mix, drug prices and drug utilization. So when states look at the mix of drugs, she said, they give attention to generic substitution, therapeutic substitution and to fail-first kinds of programs; when they examine price they look at ingredient costs, dispensing fees, rebates, mail-order pharmacy and maximum allowable costs; when they consider utilization, they look at prior authorization, patient profiling, physician profiling, cost sharing and quantity limitations.

Ms. Folkemer reported that preferred drug lists have become the predominant strategy for improving management of drug programs; twenty-seven states have implemented preferred drug lists and about twelve others have authorized them. She said some states have realized some savings, but formal evaluations of the use of preferred drug lists have not been done. Other states, she said, have combined their drug purchasing power to gain better pricing and still others have used in-state bulk negotiating to gain savings.

Ms. Folkemer also discussed the "340 B Program: State Opportunities" (See Attachment # 2.), a section of public health service law and under this law manufacturers provide discounts on covered drugs to certain kinds of public health service entities and government-sponsored entities. These are things like certain disproportionate share hospitals (DSH), federally qualified health centers, AIDS drug assistance programs, public housing clinics, etc. In addition, state and county prisons are eligible for enrollment consideration in the 340 B Program. Prices for entities meeting the eligibility requirements are lower than Medicaid prices, so when agencies ask about them they are basically asking if there is any way to team up to have access to some of the 340 B prices. She said this is an area where states are doing a lot of exploration and North Carolina might want to consider it. She said a big concern for states is how they are going to relate to the Medicare prescription drug bill. She said twenty-one states have already introduced bills saying how they want to coordinate with the bill.

Ms. Folkemer said there would be dramatic changes in Medicaid and Medicare in 2006 and many challenges, a few of which are: 1) dual-eligible beneficiaries will move from Medicaid to Medicare for drugs; 2) the effect of the clawback provision and

clawback inflation rates (where states will have to pay an amount of money based on their 2003 expenditures for drugs for dual-eligibles and then rising with inflation; 3) new administrative costs for eligibility determinations for low-income assistance; 4) increased Medicaid enrollment due to Part D low-income subsidy applications; 5) use of state funds to wrap-around benefit.

Ms. Folkemer asked if there were questions and Representative Nye asked about the future of disproportionate share (DSH) payments to public hospitals and state hospitals. She said the issue in this regard that she has heard is about inter-governmental transfers (IGT). She said what she has heard from the federal government is that they are concerned that some states are, essentially, using federal money to match federal money. She said they believe some states have structured IGT in such a way that federal money that comes in and is labeled as a match for a payment to an entity is then used by the state as the state match. She said a variety of states have various approaches to this and she heard that this week a report will be issued by CMS which divide states into categories as to their use of IGT and how that fits into federal policy – whether a state's use of IGT is a concern to the federal government. She said what they are hearing is that the president's 2005 budget calls for some savings from Medicaid and that the IGT is an area being looked at by CMS for that purpose. She said they heard at one point that there would be some legislation on this, but she hasn't seen that yet. It is important to note that while the issue of IGT has been a source of tension between the federal government and states for many years, it appears that there is more seriousness about it now at the federal level.

Dr. Willson said most of the uninsured people in our country are adults and asked if those in the elderly and disabled population who have health insurance are less likely to become disabled or enter a nursing home at an early age. Is there a correlation between being insured and being healthy and less likely to be disabled. Ms. Folkemer said she doesn't have specific figures on that, but said people who don't have insurance are less likely to get care and remain healthy later in life.

Dr. Wentzy said he was curious about the study in Arkansas, Florida and New Jersey and asked if there was a gatekeeper involved in the process of providing cash and counseling demos for home health care. Ms. Folkemer responded that the individuals had to meet the same eligibility criteria as somebody who was going to be entering a regular waiver. She said there was a company that would handle the money and case managers were involved. Dr. Wentzy asked if it was her understanding that a case manager would actually verify and validate that the people actually were in need of service and she said the eligibility criteria did not change in the programs.

Mr. Welsh asked if the trend of decreasing occupancy rates for long term care facilities nationwide applies and is true in North Carolina. Ms. Shaw replied that occupancy rates are down in North Carolina, but because our certificate-of-need program tightly controls the number of nursing home beds, North Carolina's occupancy rate is a little higher than the national average.

Representative Nye said it appears that in 2006 when the Medicare prescription drug program takes effect that prior approval, preferred drug lists, rebates and supplemental rebates will all be history. He asked if Ms. Folkemer agreed. She answered that she doesn't know, but has talked with a number of states that believe they will continue to have enough volume in the programs that they will want to continue their preferred drug list program. The other thing of interest here, she said, is the multi-state activity where states join together to strengthen their capacity to manage their programs. The states that are talking about that are those that are using preferred drug lists, etc., so certainly things will change. Representative Nye asked if the clawback procedure would undercut everything Medicaid has been doing on prescriptions, states having to send the federal government 90% of what Medicaid prescription drug bill has been, because this would put the states in a bind. He asked Ms. Folkemer if she has an opinion on this and she responded that some of this has to do with how the federal government sets up the program. She said she has heard people at the state level say they think they might come out about even.

Senator Purcell said the drug companies are required to rebate states' Medicaid programs for the use of brand name drugs, so as we push for more generic drug usage, our rebates will go down. Has anyone looked at whether there's an advantage or disadvantage in doing that and Ms. Folkemer said she said she doesn't know, but thinks generics would be preferred whenever it is possible and appropriate.

Mr. Welsh asked, with regard to utilization of drugs, have there been studies to look at what are the consequences when the use of drugs is decreased. When that happens people get admitted to hospitals and long-term care more often, so you have the unintended consequences of causing more costs than on the other side of that. Ms. Folkemer said she doesn't really know, but in terms of what the states are trying to do, some states have talked about limits on drugs per month and those who say they have limits have an appeals process so that individuals can work through that. She added that what the states have been trying to do is change the mix of drugs and if they move into a preferred drug list, they shift market share to certain preferred drugs and then some other drugs remain available. In general, states are shifting use and bringing down the prices of other drugs by comparing them essentially to the preferred drugs. Mr. Welsh continued, saying he has seen patients who cannot afford prescription drugs end up back in the hospital or in the long term care, so reducing utilization costs should not be done at the expense of higher costs for hospitalizations and other services.

Dr. Wentzy asked if other states or the U. S. Congress have commissions similar to our Blue Ribbon Commission on Medicaid Reform, where discussions of Medicaid reorganization are going on and Ms. Folkemer replied that the U.S. Congress and some other states have similar commissions. Dr. Wentzy continued, asking if there is an entity within the country that is trying to pull all the research together to learn the benefits, what is working and not working – a think tank kind of organization and Ms. Tobler said the federal government and most states have websites where information about programs can be obtained. Ms. Folkemer added that organizations such as NCSL have websites with information about Medicaid Reform.

Mr. Pully said, with regard to the prescription drug act, he knows there are provisions in the bill that increase payments to managed care companies by increasing their rates, incentives to provide care in under-served areas of the country and he said he knows there are tax benefits given to large corporations in order to keep their pension plans in place to cover prescription drug costs, but, he asked, how much in the aggregate is this clawback provision going to cost the State of North Carolina and other states. He asked if we are likely to see this aggregate increasing costs of prescription drugs because of the clawback provision. Ms. Folkemer said she doesn't know, but NCSL is planning an audio-conference with experts talking about this issue. Ms. Folkemer said she has heard federal people describe how they plan to do the clawback, what kinds of data they will use and how they would figure it out because there were many questions from the states about the basic data. She said there are no regulations out on this yet, but there will be. Mr. Pully asked whether there is a public policy behind this, other than the cost-sharing aspects, that was used to develop this clawback provision. Ms. Folkemer replied that the original idea was the states would have some responsibility removed from them, i.e., they would no longer have to or be allowed to cover prescription drugs for Medicaid people who are on Medicare. So, she said, the notion was that since the state wouldn't have to cover that group of people anymore, the states ought to share in the cost.

Ms. Silberman asked what amount of the prescription drug expenses currently paid for non-Medicare folks would include some of the disabled who are not Medicare-eligibles. Carol Shaw replied that of $1.2 billion North Carolina spent in 2003, it's about an equal split; about 50% goes to dual-eligibles and 50% to non-duel-eligibles.

Ms. Tobler returned to the podium for the presentation of information regarding disease management. She said North Carolina is one of the states that other states can look at as an example of a successfully implemented program. The reason disease management has become such a popular topic across the United States is because it is a politically acceptable cost containment strategy, but, she said, disease management was never created solely as a cost containment strategy. She said some relatively small amount of money may be saved and an added benefit is that people like disease management programs because they feel more empowered and involved in their own care. She said they extrapolate that, because they are more involved in their health care, they will be more conscientious about taking care of themselves and in the long run money will be saved. If that assumption is compared to the profile of the average beneficiary, who may be on Medicaid and then off, it's hard to measure. She said folks with disabilities have benefited most from disease management because they tend to be on the program longer.

Ms. Tobler said most states will not save large amounts of money, but many management contractors say that after the initial set-up costs states can expect about a 5% saving. Much of the savings occur because of decreased emergency room use and fewer hospitalizations, though states struggle to prevent administrative costs from eating into the savings. She said twenty-one states are considering legislation to address disease

management and nineteen states have said they are looking at disease management as a strategy for cost savings.

Ms. Tobler discussed the Health Insurance Flexibility & Accountability Initiative (HIFA), which, she said, is basically an 1115 demonstration waiver that was packaged into an initiative by CMS to entice states to look at 1115 waivers in a new way. They were offering the states an opportunity to submit a waiver that would be turned over in less time than previously with the purpose of expanding access to health care to the uninsured. It was targeted to people below 200% of poverty, simplified the application process and changed some of the things that states can do with a waiver. It encouraged states to look at employers as partners, so it was looking at creating a private-public partnership to take advantage of the fact that many uninsured people were employed by companies offering insurance that couldn't afford the premium cost. So, the HIFA initiative was encouraging states to use employer premium assistance programs and to partner with the private sector to maximize the amount of money that would be available to cover the uninsured.

Ms. Tobler said some of the HIFA employer premium assistance programs are very simple and are not waiver programs. They don't really extend out and cover more than the traditional Medicaid population. Some of them have been vehicles to expand to new populations. The idea is that the employer will contribute to the cost of covering an individual and the state gets a discount based on the amount the employer will contribute.

Ms. Tobler said some of the early HIFA programs, such as the one in Massachusetts, were very difficult to set up and were administratively burdensome because of the requirements that CMS had for proving that the insurance Medicaid-eligible employees were getting through their employer was comparable to what they could get through the Medicaid program. She said not all of the HIFA waivers include an employer premium assistance program, but many look at that as a way of covering new lives with less money. Another state, Rhode Island, is saving per member, per month costs with an employer premium assistance program. It has had a HIFA program for several years and individuals working with that program are very happy with the results. They are saving a considerable amount of money on their per member, per month cost for those enrolled and they're trying to roll more people into the program. These programs aren't easy to create or to implement, but states that have done them successfully say once they are in place they take on a life of their own and become less costly and less time-intensive. She said these programs operate differently in each state. Some states pay the employers and some provide a subsidy to the employee to be able to afford the percentage of their premiums that is being subsidized. Ms. Tobler said they have learned that states which have expanded to populations beyond 100% of poverty have saved money through employer premium assistance programs.

Ms. Tobler said the other thing that HIFA allowed states to do was to change the benefit package for certain populations and the populations that were targeted by HIFA were the optional and expansion populations. In the two states that took advantage of that through HIFA, benefit package changes were allowed for optional and expansion

populations, but mandatory populations had to remain the same. For optional populations, the benefit package had to be similar to that provided in the private sector and for expansion populations it just had to include a minimum of basic primary care services.

Ms. Tobler said a good example is the state of Utah, which does not have a HIFA waiver, but does have a 1115 waiver. They wanted to expand coverage to some adults who did not have insurance, but they didn't have the money in their Medicaid budget to do that. They put together a commission that created a program that had "buy-in" from many of the stakeholders and they decided to take a pool of money that was in the state general fund for uncompensated care to support hospitals for costs associated with care deliveries for the uninsured and funneled it into a program that provides services to adults up to 150% of poverty who don't have insurance. They rolled that into their Medicaid program so they could draw down the federal match for these individuals. They only provide primary and preventive services to the expanded group of adults, so individuals that are enrolled in that program are not enrolled in the traditional Medicaid benefit package, which tends to be richer than most private packages. They started planning this in July 2002 and took action, believing that if they had a program to provide primary and preventive services to this group of adults that hospitalizations and emergency room use would go down for that group. The hospital association group and providers involved decided to go forth with this plan even though $12 million was taken from the hospitals' uncompensated care pool. Utah's program serves as a microcosm of research to see whether investing in primary and preventive services will actually, in the end, reduce the uncompensated care dollars that a state needs. From the data they have collected thus far, that is what they are learning. She said this is not a "bare bones" policy, but does cover primary and preventive care, as well as some prescription drugs.

Ms. Tobler briefly discussed Medicaid fraud and abuse and said that Florida and Texas are seen as leaders in monitoring these problems. She said most fraud and abuse occurs in billing for services that were never delivered, billing for unnecessary services, substitutions on generic drugs, kickbacks, and double billing. They created programs to try to bring to light abnormal billing procedures by certain providers. Both states report significant savings after implementation of these fraud and abuse programs.

Ms. Tobler concluded her presentation by discussing evaluation and data collection as an activity that certain states are very quick to fund and others are not. She said what she sees is that having good data to create Medicaid policy is very important in the long run and will probably save money. So, investing in adequate data collection in order to make sound decisions, the research shows, is an important aspect of Medicaid reform. There are a number of states that others can look at as leaders in this – Minnesota being one of the forefront states in data collection. She added that North Carolina is already collecting a lot of data and finding mechanisms to route that data so that it can be useful for more than one purpose.

Dr. Willson commented as a pediatrician involved in the Carolina Access program, which is a disease management/case management program. He said they found

that rather than using a disease management company to come in and tell the physicians what to do, the physicians in Carolina Access have implemented the disease management program through working with medical directors across the state and they have seen significant reductions through managing asthma, reducing emergency room use and reducing the number of hospitalizations. He said they have saved millions of dollars and thinks the key is having providers link together with the state in a partnership to bring the best value and implement the best practices in the doctor's office rather than having another care management program come in to tell them what to do. That is really the great lesson learned in North Carolina.

Senator Hartsell asked for more information on the Utah primary program network and Ms. Tobler said she could get information to him. She suggested that he could access their website that gives the latest statistics on how many people are enrolled and the background of how the program was created.

Representative Howard said members could contact Commission staff if there are additional questions and added that she needs more information on the 340 B program and on the prescription drug savings figures from the three states that were mentioned in the handout.

Representative Howard expressed the Commission's appreciation for the very helpful information presented by Ms. Tobler and Ms. Folkemer.

Representative Howard asked members to refer to the draft of the interim report (See Attachment # 3.) and noted that it was submitted by Carol Shaw of the Fiscal Research Division under the requirements of the committee charge. Referring to Page 6, she reviewed the Commission's recommendation with regard to making the tax credit for long-term care insurance permanent and referred members to the bill draft on the last page of the document. She said this proposed legislation will be introduced on the opening day of session, May 10, 2004, with all legislative members of the Commission serving as co-sponsors. She explained that other items included in this document are copies of presentations to the Commission during its first meeting. She asked if there were questions and comments and, hearing none, asked for a motion with regard to approving the interim report as drafted. Senator Purcell moved to approve the draft of the interim report and Representative Beverly Earle seconded the motion. The motion was unanimously approved.

Proceeding to the next item on the Agenda, "Commission Discussion", Representative Howard said that members who have questions or comments about the information presented to the Commission or new ideas or thoughts should contact staff. She said it is the intent of the chairs to schedule future meetings of the Commission after adjournment of the 2004 Session. She asked for comments from members and Dr. Wentzy asked about the ability of the Commission to actually meet its goal of having a completed recommendation by February, 2005. Would it be appropriate, he asked, to even consider asking the General Assembly to extend the Commission's work even if the work already mandated has been completed. Representative Howard said it would be

possible, in part because the Commission had a late start for its work. She explained that the February date was targeted to comply with the budgetary deadlines for the 2005 Session because it was our mission to try to find some cost savings that would have an effect on the 2005 budget. So, she said, the Commission can work very hard and have another final report, but that would not preclude us from continuing to meet if we have authorization from our leadership. She added that it will probably be the Commission's intent to ask for that because of its late start.

Dr. Willson said that while it is Commission's charge look at state savings, he is concerned about the apparent inequity of having counties provide some of the Medicaid match. He asked if it would be within the purview of the Commission to look at the issue of county match. Representative Howard replied that this probably is one the counties' greatest concerns. The increases in Medicaid costs are hard enough for state budgets but are worse on county budgets because they compete with education and all the other expenditures that counties have. She added that the charge of the Commission does encompass helping counties and it would be the goal of legislators to remove as much of that burden from counties as possible since North Carolina is one of very few states that passes some costs along to local governments. She said she knows the counties would be grateful that they are on our minds with regard to this issue.

Representative Howard said she knows there are a lot of unanswered questions, but the mission of the chairs and staff is to keep abreast of these answers as they are coming down and keep the Commission informed.

Senator Purcell said he commends Commission staff because with only two meetings a 200-page report has been produced.

Representative Nye said we've had great meetings and opened up some doors, which we'll be walking through in the days to come.

Representative Howard thanked members for their participation thus far and adjourned the Commission until further notice. The meeting adjourned at 3:05 p.m.

Anne Wilson, Committee Assistant

Representative Julia Howard, Co-chair

Senator William R. Purcell, Co-chair
Representative Edd Nye, Co-chair

Medicaid Briefing: Best Practices and New Innovations

A Presentation for the North Carolina Blue Ribbon Commission on Medicaid Reform

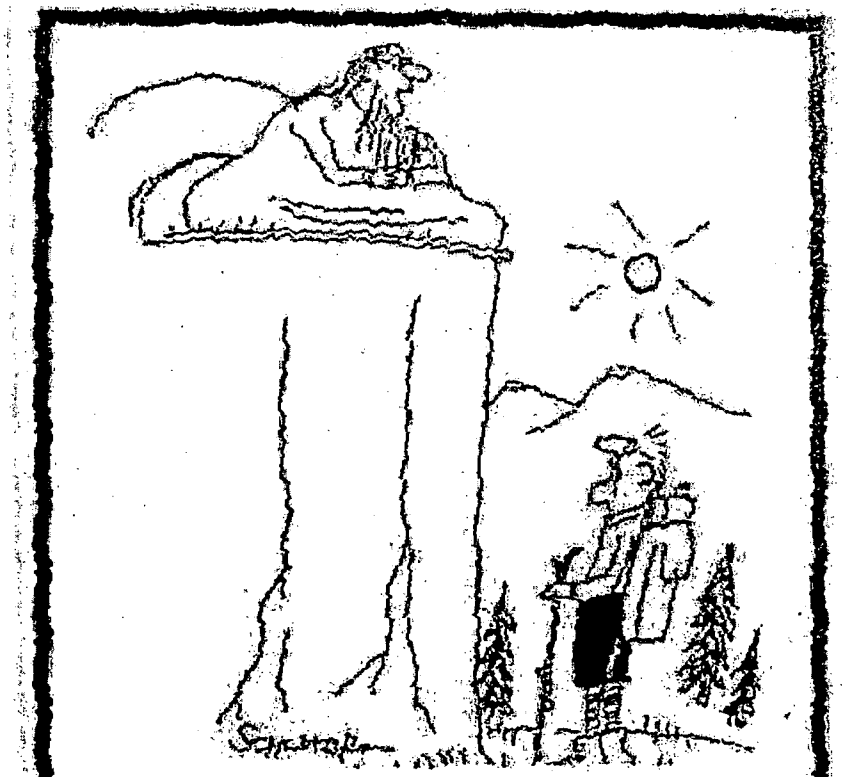
Laura Tobler and Donna Folkemer
National Conference of State Legislatures
laura.tobler@ncsl.org, donna.folkemer@ncsl.org
303/303-364-7700 (Denver), 202-624-5400 (DC)
website: www.ncsl.org/programs/health/health.htm
www.ncsl.org/programs/health/forum/index.htm

Attachment # 1

Presentation Goals: Best Practices and New Initiatives in Medicaid Programs in....

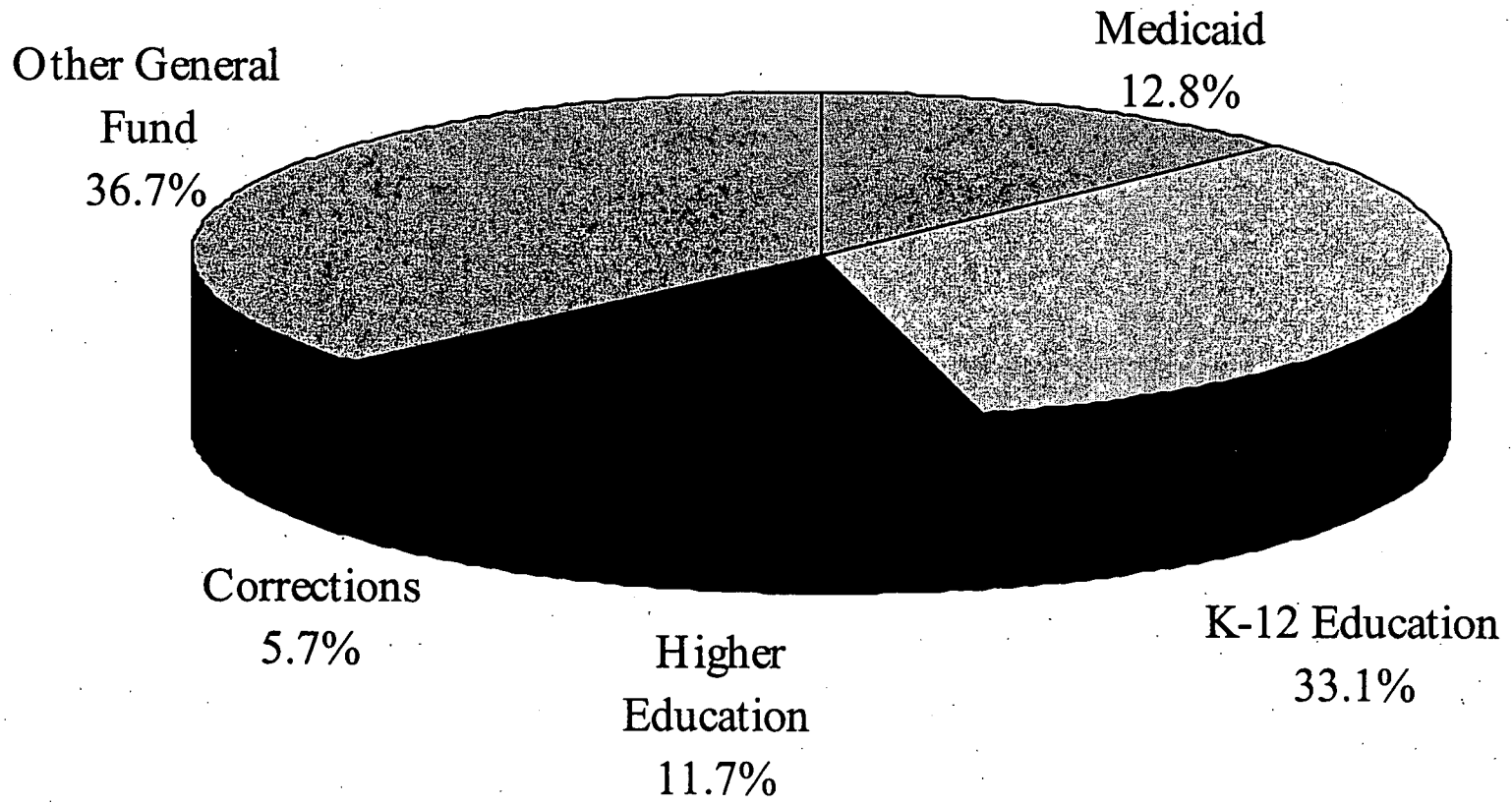
- long-term care
- prescription drugs
- Waivers: employer premium assistance programs and benefit package design
- disease management
- Evaluation and data collection

Describing Medicaid

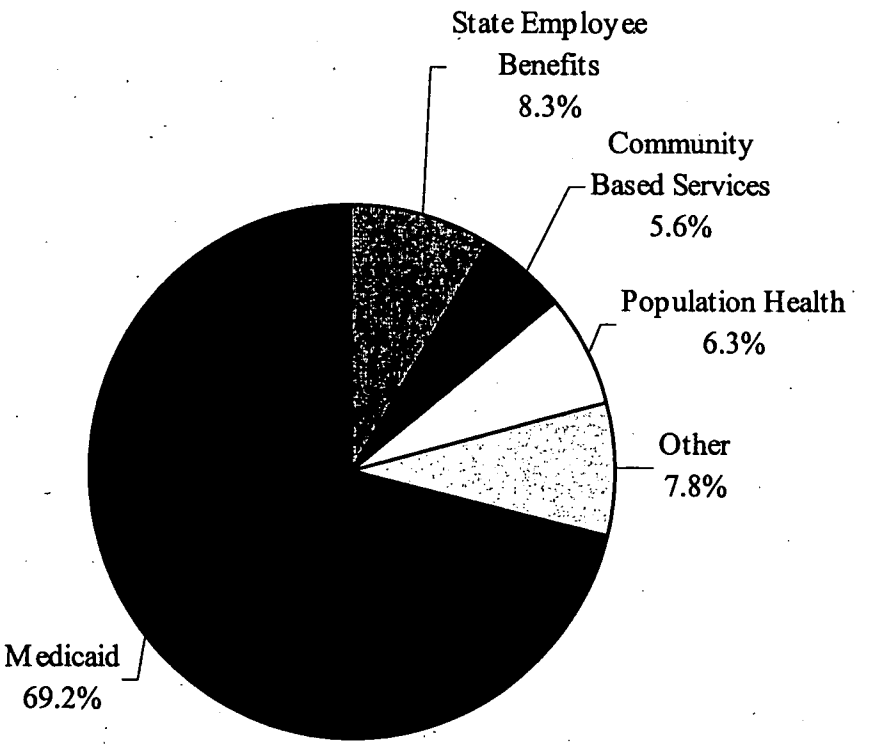


"While I can explain the meaning of life, I don't dare try to explain how the Medicaid system works."

General Fund Spending, FY 2001



Distribution of the Average State's Budget for Health Services, 2001



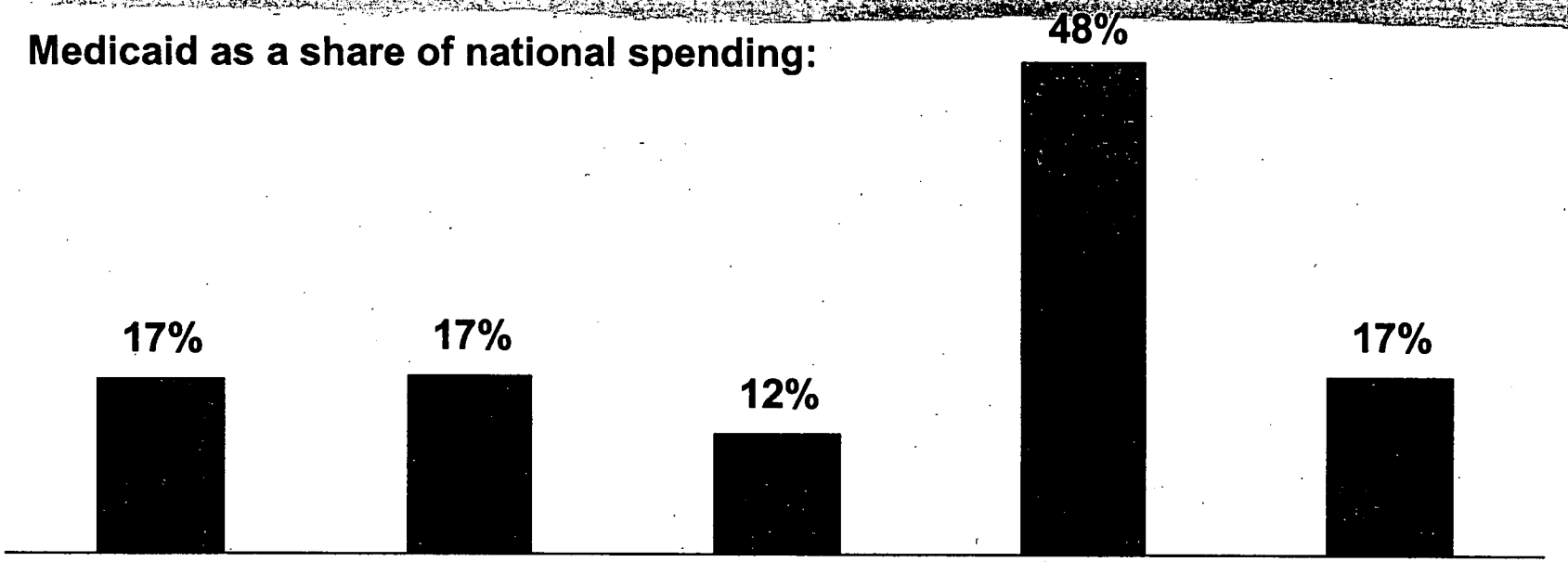
Source: Milbank Memorial Fund, National Association of State Budget Officers and The Reforming States Group, 2000-2001 *State Health Care Expenditure Report* (New York: Milbank Memorial Fund, April 2003), http://www.milbank.org/reports/2000shcer/index.html

Medicaid's Role in System

- Largest financing source for low-income (43% of federal allocations to states)
- Pays nearly half of U.S. nursing home costs
- Pays for about 2/3 of nursing home patients
- Covers 31% of U.S. population 85+
- Funds about 35% of U.S. births
- Subsidizes care for the uninsured
- Subsidizes graduate medical education

Medicaid's Role, 2001

Medicaid as a share of national spending:



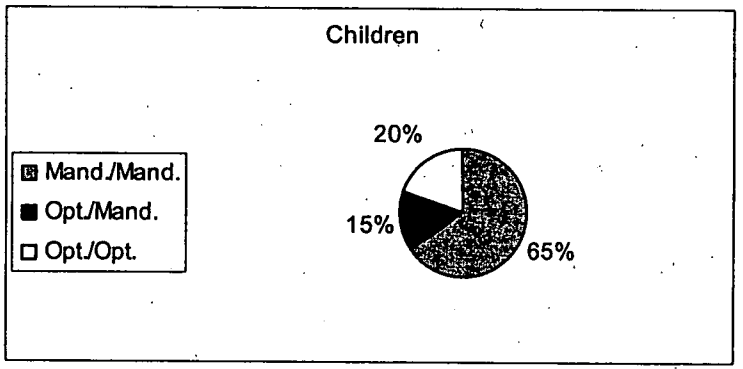
	Total Personal Health Care	Hospital Care	Professional Services	Nursing Home Care	Prescription Drugs
Total National Spending (billions)	$1,236	$451	$462	$99	$141

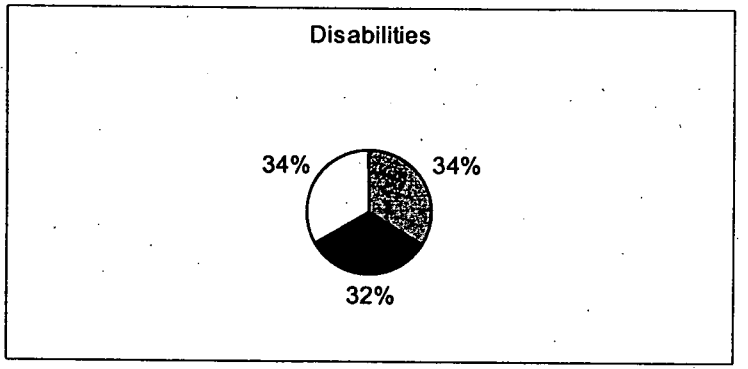
SOURCE: Vernon K. Smith, Health Management Associates, citing Levit, et al, 2003. Based on National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary.

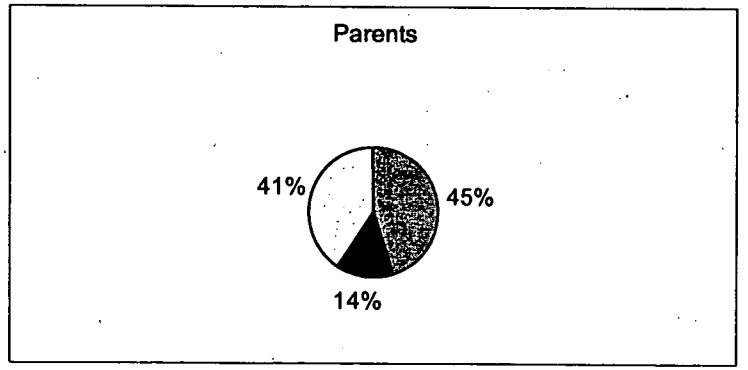
Mandatory & Optional Spending, 1998

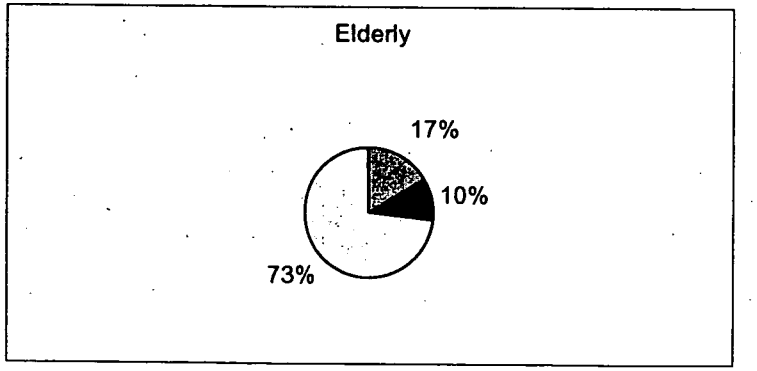
Source: KCMU, July 2001 http://www.kff.org/content/2001/2256/2256.pdf

About 65% of all program spending is at the states option (with variations from state to state.

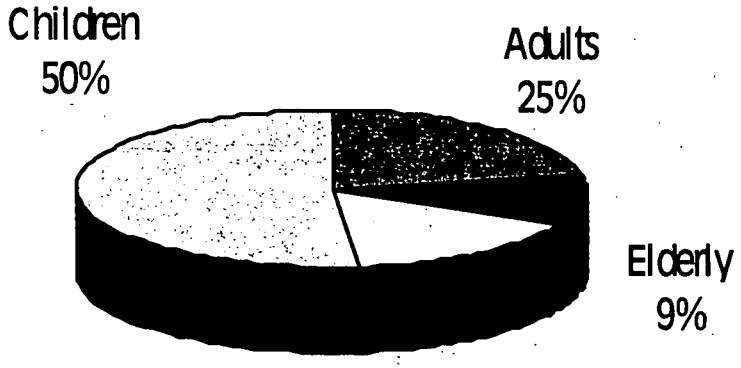






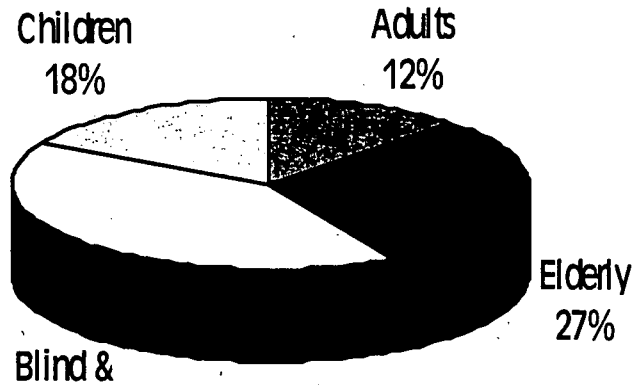


Beneficiaries and Expenditures, 2002



Enrollees

51 million

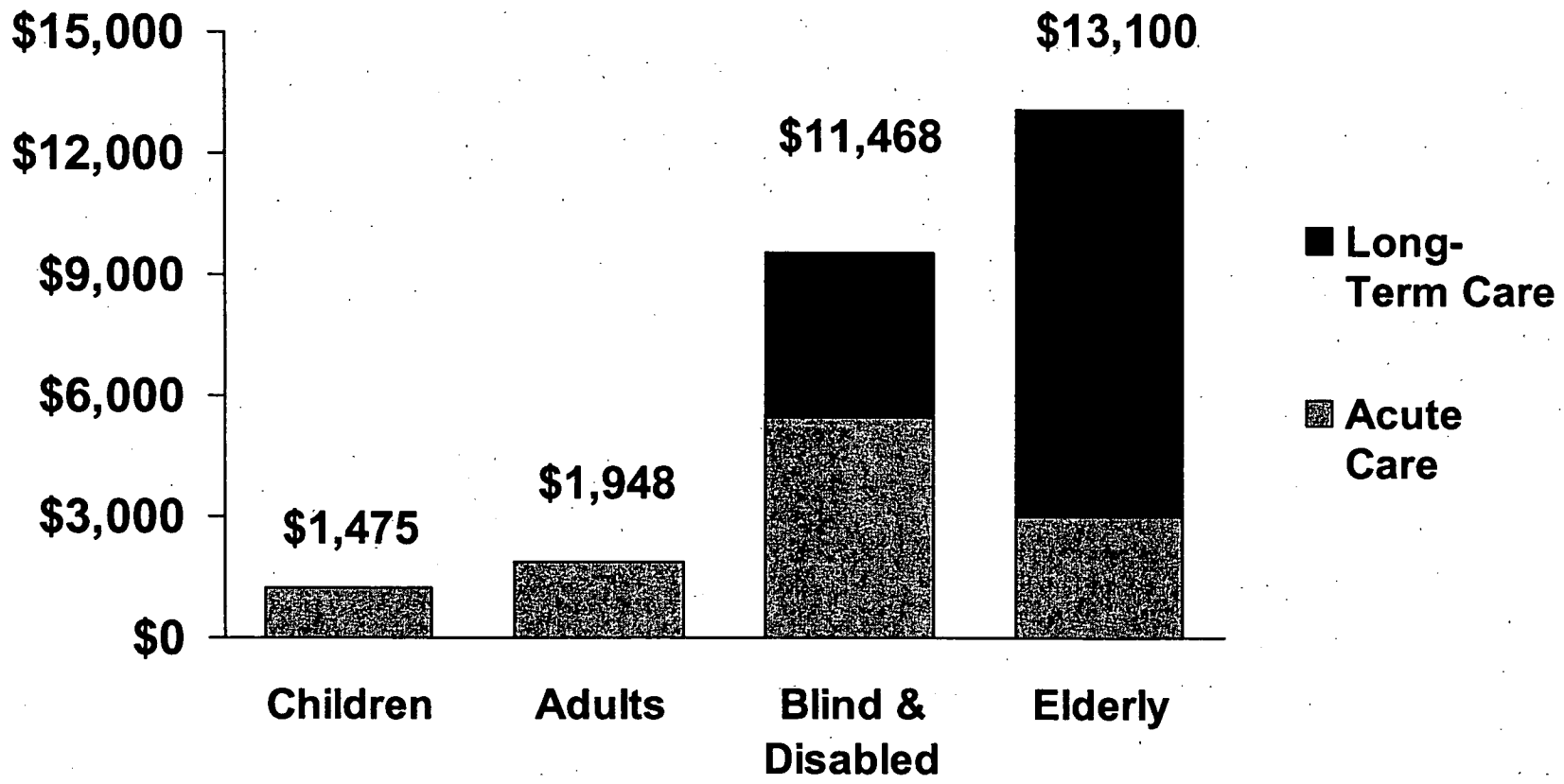


Expenditures*

$210 billion

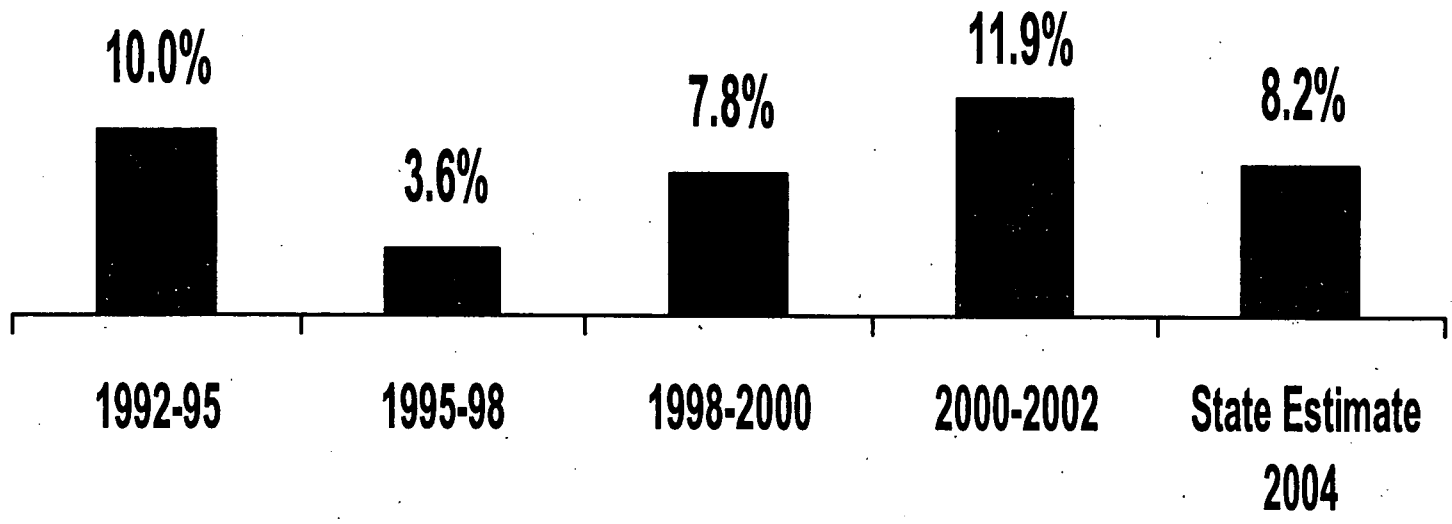
Source: Kaiser Commission on Medicaid and the Uninsured, May 2003, based on CMS and March 2003 CBO data.
* Excludes disproportionate share hospital payments and administrative costs.

Medicaid Expenditures Per Enrollee
(by Acute and Long-Term Care, 2002)



SOURCE: Kaiser Commission on Medicaid and the Uninsured, May 2003

Average Annual Growth Rates of Total Medicaid Spending



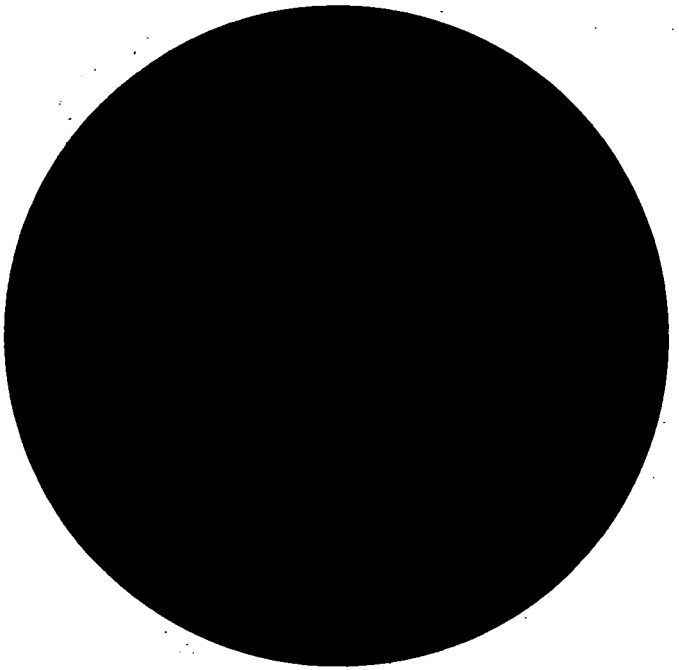
Source: For '92-'02: Urban Institute estimates based on data from Medicaid Financial management Reports.
For '04: Health Management Associates estimates based on estimates provided by state officials.

Medicaid Spending Growth

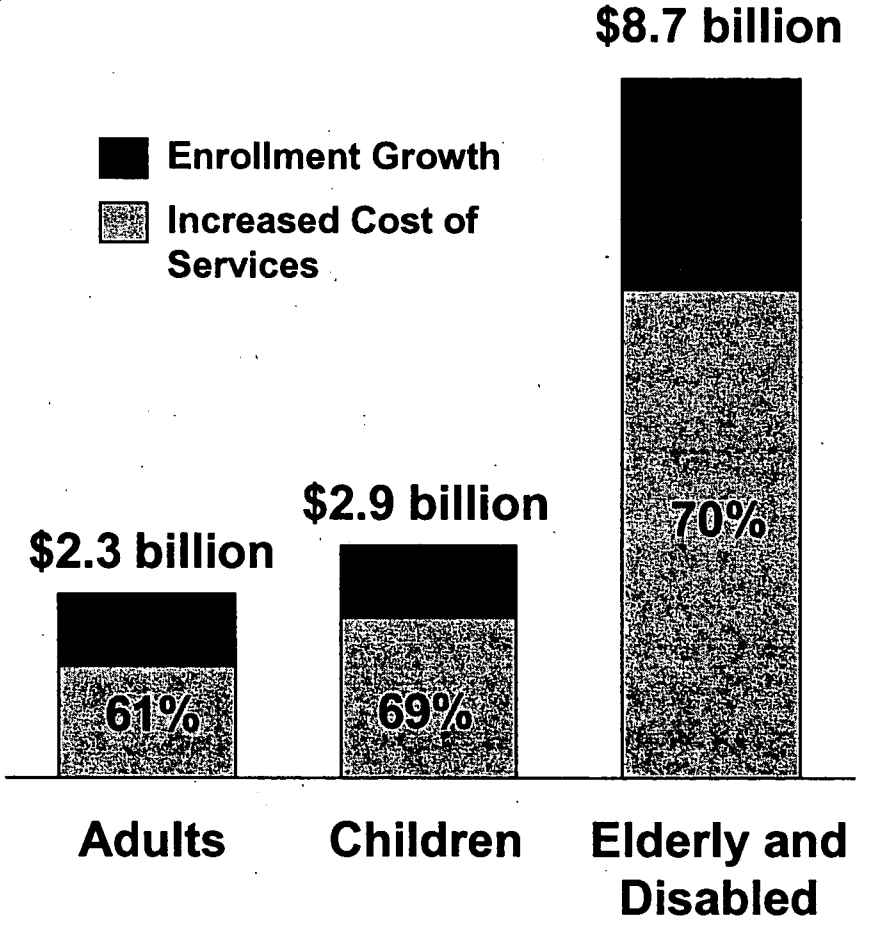
- Total Medicaid spending growth (projected) is down
  - This is a departure in trends with the private insurance market.
  - The 8.2% projection is significantly above the 5.3% growth authorized in legislative appropriation for FY 2004.
- Fiscal Relief
  - As a result of the fiscal relief to states that Congress provided in May 2003, the growth in the state share of Medicaid funding in FY 2004 is now projected to be 3.3 %.
- Fewer states with shortfalls in FY 2004
  - 27 states indicated an expected FY 2004 Medicaid shortfall.
- Enrollment growth
  - The 5.5% rate of growth is lower than in previous years and is the lowest rate of growth the program has had since 2000.
- Cost Containment
  - Many states have implemented strategies to reduce growth.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, Jan. 2004.

Sources of Growth in U.S. Medicaid Expenditures, 2002 to 2003



$14 Billion (Federal) Increase in Cost of Benefits



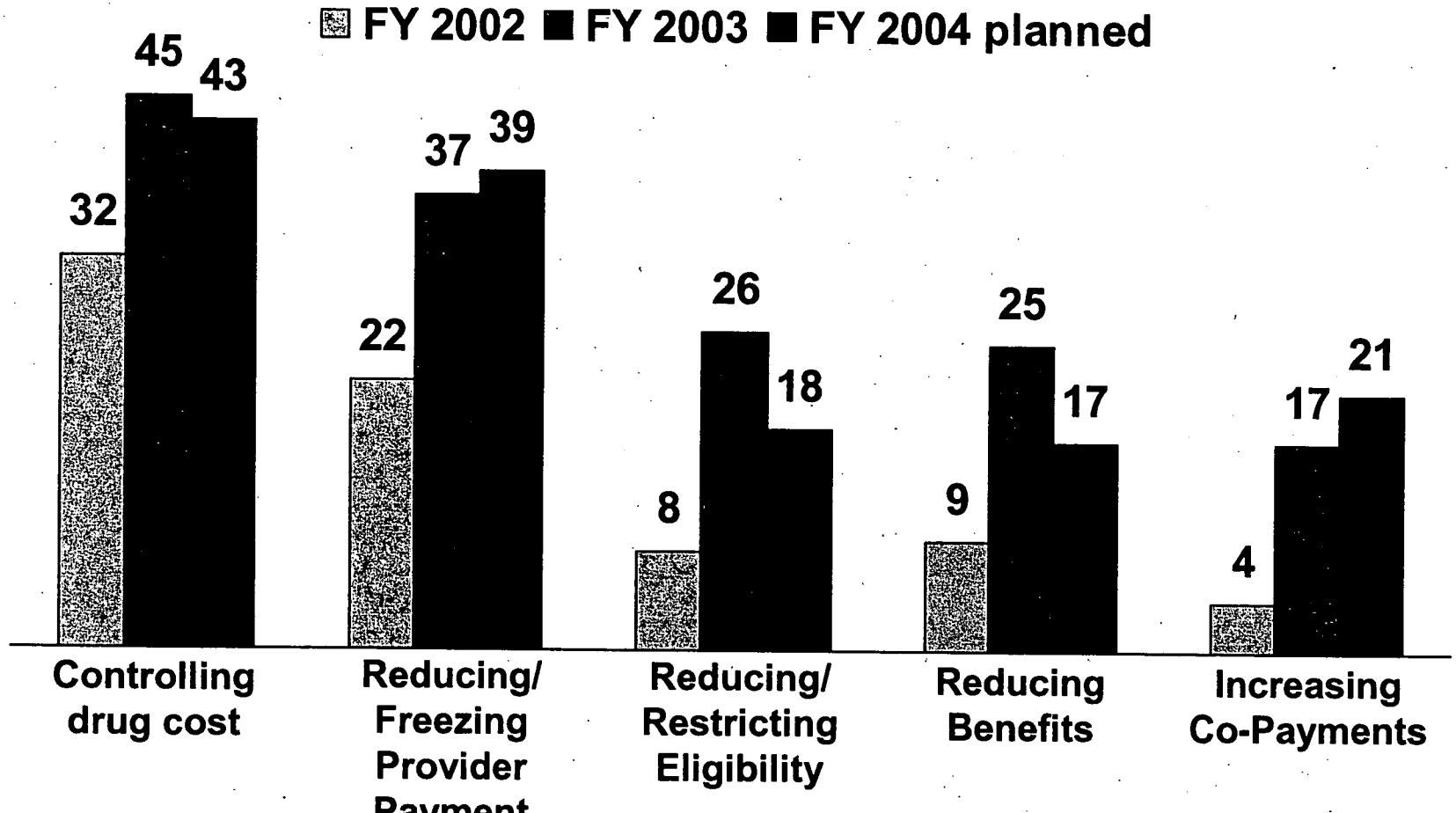
SOURCE: Kaiser Commission on Medicaid and the Uninsured, analysis of the Administration's Medicaid baseline, January 2003. Excludes changes in spending due to DSH, administrative costs, the VFC program, and technical adjustments.

Hospital Spending big factor

- ***Inpatient costs***: up 6.8% in 2002
  (4 th year of increases after 5 years of decreases)
- ***Outpatient costs***: up 14.6% in 2002
  (5th year of double digit increases)
- Hospital prices: up 5.1%, biggest jump since 1994
- Hospital Utilization: up 5.7%, 2nd biggest jump since 1994
- Accounted for 51% of cost growth in 2002
  (Up from just 18 percent in 1997)

Source: Bradley Strunk and Paul Ginsburg, "Tracking Health Care Costs: Trends Stabilize But Remain High in 2002," Health Affairs Web Exclusive, 11Juner2003.

States Undertaking Medicaid Cost Containment Strategies: FY2002 and FY2003



SOURCE: KCMU surveys of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002. SOURCE: Vernon Smith, et.al., *Medicaid Spending Growth: A 50-State Update for Fiscal Year 2003*, Kaiser Commission on Medicaid and the Uninsured. January 2003.

Taking a Look at Long Term Care

- The Olmstead case has focused attention on service delivery in the community and its components.
- Twenty nine states have Olmstead plans. All of them discuss community supports as including assistance with daily tasks, but also transportation, housing, employment and community involvement.

Policy Goals

- Reduce reliance on institutional care.
- Promote consumer choice
- Respond to unmet needs.
- Contain costs.
- Promote high quality and optimal outcomes.

Taking a Look at Long Term Care

- Occupancy rates in nursing facilities down.
  - 90% in 1995, 88% in 1997, 86% in 1999, 83% in 2001. Most analysts predict continued decrease. (Harrington, 2003)

Taking a Look at Long Term Care

- Reimbursement rates and methods (what is included) under Medicaid vary greatly across the country. Hard to compare states.
  - For example, in 2002: Nursing home daily rates ranged from $83 in LA to $323 in AK with an average of $124.
  - Similar variation in community services.
- Increased reliance on provider taxes to support facility rates.

More on Long Term Care Trends

- Function of nursing facility is changing rapidly.
  - More short-term admissions
  - More focus on Alzheimer's and related disorders
  - Change seems to be related to medical advances and consumer preferences

Long Term Care Delivery Changes

- The big picture
  - Doubling of residential and assisted living options in last decade
  - Many more Medicaid home and community based waivers for all populations.
  - Changes in federal policy (but not yet in law) to encourage community care. Some federal law changes proposed to support community care.

Long Term Care in 2004

- New Cash and Counseling Demos to be funded in 2004. Build on successful projects in Arkansas, Florida, and New Jersey.
- Consumer-directed care getting attention. Supported by Independence Plus waiver option from CMS. More flexibility than regular HCBS waiver. FL, NY, SC, LA have Independence Plus.

State Long Term Care Reforms of Interest

- Wisconsin
  - Family Care in 5 counties
  - Key elements: County resource centers, county care management organizations, monthly capitation payment
- Maine
  - Key elements: Universal assessment, continued attention to Medicare coverage, gradual growth in community services, reduction in nursing facility beds with beds "banked", strong data systems, hold $ increases below inflation from year to year.

State Reforms of Interest (continued)

- **Texas**
  - Money follows the person demo. Waiver slots guaranteed for anyone coming out of facility and money follows.
- **Minnesota**
  - Key elements: Changed ltc screening to consultation; used incentives to alter service mix; Set benchmarks for progress (% of dollars spent on community services, beds/1000 elderly, senior housing/1000 elderly, use of nursing facilities for less disabled, use of community services for more disabled).

A Look at Prescription Drugs

- Drug mix, drug price, and drug utilization are key to prescription drug management.
- Mix—Generic substitution, therapeutic substitution, step therapy (fail-first)
- Utilization—DUR, Prior authorization, patient profiling, physician profiling, cost sharing, quantity limitations
- Price—Ingredient costs, dispensing fees, rebates, MACs, mail-order pharmacy.

A Look at Prescription Drugs

- States are working with almost all of the strategies to improve program management.
- Preferred Drug Lists have become predominant strategy during past year.
- Implemented in 27 states
  - With supplemental rebates in 17 states
  - Without supplemental rebates in 10 states
- Authorized in 12+ more

No Consistent Approach to PDLs

- Scope of categories covered
- Category exemptions
- PA process
- Supplemental rebate strategies
- Use of outside vendor for design

A Look at Prescription Drug Issues

- States have released some savings figures and information on shifts in market share. (MI, IL, WA)
- April 2, 2004 Appeals Court ruling upheld Michigan's approach.
- Formal evaluations of PDLs' impact on cost and quality do not yet exist. (That is, formal studies on PA requests, approvals and denials or cost-effectiveness studies.)

Emerging Prescription Drug Strategies

- Multi-state combined purchasing power
  - One example is Medicaid Buying Pool (MI, VT, WI, SC)
- In-state bulk negotiating
  - GA, TX, WA

Impact of Medicare Reform Bill

- In 2006, dual-eligible beneficiaries move from Medicaid to Medicare for drugs.
- Effect of clawback provision and clawback inflation rates?
- New administrative costs for eligibility determinations for low-income assistance?
- Increased Medicaid enrollment due to Part D low-income subsidy applications?
- Use state funds to wrap-around benefit?

Disease Management

- Top 1% of people account for 30% of health spending
- Top 10% of people for 70% of spending
- Bottom 50% of people for 3% of spending

(Source: Scott Leitz, Economist, Minnesota Department of Health)

- Disease management targets people with chronic illness and provides more intensive services
- Common targets: asthma, HIV/AIDS, cardiac diseases, diabetes, hemophilia, depression
- Leaders: FL, MD, MS, NC

Disease Management

- Cost savings?
  - Experts caution states that there is still uncertainty over $$ saved with DM programs. Programs do help people feel more empowered and people like them.
  - ER visits for patients reduced.
  - Hospital costs reduced overall for participants.
  - Asthma initiatives appear to have better returns.
  - Politically acceptable Medicaid cost containment strategy.

Resources:

- http://www.ncsl.org/programs/health/diseasemgmt.htm
- "Contracting for Chronic Disease Management: The Florida Experience" http://www.chcs.org/publications/pdf/ips/CDM-report.PDF

Disease Management Programs

- As of February 2004, 22 states have implemented Disease Management Programs: Alabama, Arkansas, Colorado (pilot), Florida, Georgia, Illinois, Indiana, Maryland, Maine, Minnesota, Missouri, Mississippi, North Carolina, New Jersey, New York (demonstration), Oregon, South Carolina, Tennessee, Texas, Utah, Washington, West Virginia.
- Some of these programs are very small and are components of managed care contracts.
- Six other states have legislation authorizing investigation into disease management or creating programs that have not been implemented yet.

Disease Management: Recent Legislative Activity

- In December 2003, 19 state Medicaid programs reported that they planned to implement or expand disease management programs in FY 2004 according to the Kaiser Commission on Medicaid and the Uninsured.
- During the 2003 legislative session, 8 states introduced legislation promoting the creation of or expansion of existing disease management programs.
- As of February 2004, 21 state legislatures were considering legislation addressing disease management and prevention programs.

Disease Management and CMS

- On February 25, 2004, CMS sent a letter to Medicaid directors urging them to adopt disease management programs.
- Federal match either as a medical service or an administrative function.

"Disease management is not a tool purely for cost savings. If you're putting all your eggs in this basket, you may be in for a big disappointment." Dr. Autumn Galbreath

HIFA

Health Insurance Flexibility & Accountability

Special 1115 demonstration waiver:

- Purpose: to expand health insurance to the uninsured
- Targeted to people below 200% of poverty
- Simple application process & expedited review
- Must be cost neutral
- Flexibility in benefits for optional populations
- Expansion populations - minimum of basic primary care services
- Premium assistance programs can subsidize employer insurance - HIFA emphasis on public/private partnerships.
- 8 approved: AZ, CA,* CO, IL, ME, NM,* NJ, OR

*not implemented

http://www.ncsl.org/programs/health/hifa.htm

Employer Premium Assistance Programs/Health Insurance Premium Payment Programs

- Public insurance subsidizes employer coverage for low-income working beneficiaries: Medicaid or SCHIP.
- 15.states have programs. All very different in intent and scope.
- Can be done through Medicaid (with or without a waiver) or SCHIP.
- Savings will be significant in states that have already expanded eligibility to families above 100% of poverty--lower in states that have expanded eligibility for children only
- visit http://www.ncsl.org/programs/health/buyin03.htm for a list of the states and few details of the programs.

Premium Assistance Programs - HIFA

- HIFA makes Premium Assistance Programs less burdensome.
- More flexibility with benefits and cost-sharing requirements.
- No cost effectiveness test.
- States must monitor aggregate costs to ensure that they are not more expensive.
- State must have a plan to prevent crowd-out.
- Potential to be cost-effective.

Case Study: Rhode Island's RIte Share

- Eligible families who have access to qualified employer health insurance enroll in the employer's health plan. DHS pays the monthly employee share of that coverage, either to the employer or to the employee.
- Working families up to 185% of poverty level. Children and pregnant women up to 250%.
- 12% of the Medicaid population enrolled. 1/3 of all children.
- Rhode Island anticipates saving $1.7M in FY03 and over $5M in FY04 as a result of leveraging employer dollars in RIte Share

RIte Share Cost Savings

- The state saves money by providing coverage for a family in RIte Share rather than RIte Care--an average savings of $70 per RIte Share enrollee per month; or $205 per RIte Share family per month
- For example:
  - ✓ A family enrolled in or eligible for RIte Care may have access to coverage through work, but cannot afford it. Let's say the insurer charges the employer $600 per month for family coverage, and the employer pays 50% or $300. The family has not enrolled because the remaining $300 per month is unaffordable for them, so they have enrolled in RIte Care, at a cost to the state of $500 per month. If coverage is provided for this family by enrollment in RIte Share, the state pays their monthly premium of $300, thus saving $200 per month.

Benefit Package Design post HIFA

- Benefit package changes for optional and expansion populations. Benefits must remain the same for mandatory populations.
- Optional populations - similar to private sector coverage.
- Expansion populations - must include a minimum of basic primary care services.

(Currently, the majority of national Medicaid spending (65%) is for optional populations.)

Case Study: Utah's Primary Care Network an 1115 Waiver program

- First state to offer a very basic benefit package to an expansion population (Adults up to 150%). Implemented July 2002.
- Reduced benefits and increased cost sharing to some mandatory Medicaid clients (TANF parents) to help finance the program.
- Experiment in Utah provides valuable lesson for other states.
  - Does investment in primary care reduce uncompensated care $$? So far, data suggests that it does. ER $$ down.
  - Will people be interested in a very limited benefit package over time? Enrollment steady over time. Just began implementing an employer premium assistance program with the waiver.

Utah's PCN Benefit Package

- Primary/preventive care by physicians and mid-level professionals enrolled in the network.
- Adult immunizations.
- Urgent care & ER visits when appropriate.
- Lab, x-ray, medical equipment, medical supplies, oxygen, ambulance.
- Basic dental, hearing tests, visions screening but not glasses.
- Prescription drugs [Limit of 4 per month].

Other interesting initiatives:

- Maine's Dirigo Health
- Arkansas's Waiver proposal
- New Mexico's approved but not implemented waiver program

Medicaid Fraud and Abuse

- Billing for services not rendered
- Billing for unnecessary services
- substitutions of generic drugs
- Kickbacks
- Double billing
- Other unauthorized billing such as charging a customer for service covered by Medicaid

Case Study: Florida

- Florida: 1996 enacted two laws to strengthen anti-fraud and abuse activities
- Identifies providers with aberrant billing patterns through a specially designed software package.
- Hired "enforcement staff" to conduct provider investigations.
- On-site inspection conducted before Medicaid license is issued.
- Permits Florida's Medicaid Fraud Control Unit to become law enforcement officers
- Florida AG's Office reports the Medicaid Fraud Control Unit recovered $17.5 million in cash and made 158 arrests in 2001.

Case Study: Texas

- 1995 Medicaid Fraud and Prevention Act.
- 1998 collaboration between the Office of Investigations and Enforcement and the Office of the Attorney General, which investigates and prosecutes Medicaid fraud
- Provider exclusion lists
- Inpatient screening criteria
- Medicaid fraud training to health care professionals
- Medicaid fraud and abuse reports
- In the second fiscal quarter of 2003, 1,435 fraud cases identified and $14.5 million was recovered.

Evaluation and Data Collection

- Know what you are paying for.
- Make use of the data that is already being collected by the department.
- Invest in data collection because research suggests that it will save money and improve efficiencies in the long run.
- South Carolina reports saving $22.9 million after an evaluation of the program.

340 B Program: State Opportunities

Excerpts from presentation by
Bill von Oehsen,
Principal, Powers Pyles Sutter and Verville, PC
October 2003.

Section 340B

- Under Section 340B of the Public Health Service Act, manufacturers agree to provide discounts on covered drugs purchased by specified PHS and government-supported facilities known as covered entities.
- Covered entities include certain nonprofit DSH hospitals, FQHCs, AIDS drug assistance Programs, Public housing clinics, and other specified entities.
- Section 340B prices are lower than Medicaid prices.

340 B Opportunities for States: Selected Options

- Encouraging eligible facilities within the state to enroll in 340B
- Using 340B-discounted drugs for state and county prisoners
- Sole source contracts with 340B providers to furnish high-cost chronic care drugs

Encouraging 340 B Participation

- 340B program reduces Medicaid reimbursement for outpatient drugs because 340B providers are required to bill Medicaid substantially below state reimbursement rates to offset state loss of rebates
- For example, according to a recent analysis, 340B hospitals are saving state Medicaid programs an average of almost $300,000 per hospital per year
- Many hospitals, community health centers, and other eligible facilities are not participating in 340B
- By assisting eligible entities with 340B enrollment, states can lower their Medicaid drug expenditures

Extension to Prisons

- States and counties may contract with 340B hospitals or other 340B facilities to provide health care services, including pharmacy services, to correctional populations
- Prisoners must be "patients" of the 340B provider to be eligible to receive discounted drugs
- Texas implemented this approach as a result of legislation passed in 2001 (S.B. 347)
- This partnership strategy is being pursued by state and local governments to extend 340B pricing to mental health populations, and recent Texas legislation (H.B. 2292) specifically encourages this concept

Sole Source Contracts

- To meet patient definition requirements, 340B provider must provide other services than pharmacy – case management and disease management are possibilities
- For Medicaid, a 1915(b) or 1115 waiver is required to waive the patient's freedom of choice
- Utah Medicaid program has a sole source contract with University of Utah for providing factor products and case management services to hemophilia population statewide

BLUE RIBBON COMMISSION ON MEDICAID REFORM

DRAFT DRAFT

INTERIM REPORT TO THE 2004 SESSION OF THE 2003 GENERAL ASSEMBLY OF NORTH CAROLINA

Blue Ribbon Commission On Medicaid Reform

April 15, 2003

To: President of the North Carolina Senate
President Pro Tempore of the North Carolina Senate
Speaker of the North Carolina House of Representatives
Members of the 2003 General Assembly, Regular Session 2003

Attached is an interim report from the Blue Ribbon Commission on Medicaid Reform submitted to you pursuant to Section 6.14A(c) of Chapter 284 of the 2003 Session Laws, which states, "By April 1, 2004, the Commission shall make an interim report to the 2003 General Assembly."

The Blue Ribbon Commission on Medicaid Reform presents to you interim findings and recommendations based on the initial study conducted following the adjournment of the 2001 General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

Senator William R. Purcell	Representative Edd Nye	Representative Julia Howard
Co-Chair	Co-Chair	Co-Chair

Blue Ribbon Commission on Medicaid Reform

2004-2005 Membership List

President Pro Tempore's Appointments

Senator William R. Purcell, Co-Chair

Senator Fletcher L. Hartsell, Jr.

Mr. Daniel C. Hudgins

Ms. Pam C. Silverman, JD

Mr. Luckey Welsh

Dr. Al Wentzy

Speakers' Appointments

Representative Julia Howard, Co-Chair

Representative Edd Nye, Co-Chair

Representative Beverly Earle

Mr. William A. Pully

Dr. David R. Anderson

Dr. Charles F. Wilson

Advisory Members

Representative Bobby F. England

Representative Jeffrey L. Barnhart

Clerk:
Anne Wilson

Staff:
Carol Shaw
Richard Bostic
Fiscal Research Division
919/733-4910

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PREFACE

As outlined in to Section 6.14A(c) of Chapter 284 of the 2003 Session Laws, the Blue Ribbon Commission on Medicaid Reform shall examine the State's Medicaid program and make comprehensive recommendations for fundamental reform. The Commission shall consider:

1. Methods to responsibly restrain the growth in Medicaid spending.
2. Best practices in both the public and private sectors in managing and administering health care.
3. Options for maximizing existing resources while controlling Medicaid program costs.
4. Current array of services available within the State Medicaid program to determine the appropriateness of the type, frequency, and duration of those services.
5. Opportunities for long-term, systemic change in the Medicaid program through the use of federal waivers and other management tools.
6. How to minimize the State and county share of Medicaid costs and maximize federal participation in Medicaid programs.
7. The role of Medicaid in the State's economy.
8. Any other matter relating to reform of the state Medicaid program.

The Commission consists of 12 members. Of these members, the Speakers of the House of Representatives appoint six and the President Pro Tempore of the Senate appoints six.

This interim report represents the work performed by the Blue Ribbon Commission on Medicaid Reform from the conclusion of the 2003 Session of the 2003 General Assembly until the convening of the 2004 Session of the 2003 General Assembly. The Blue Ribbon Commission on Medicaid Reform met on two occasions and has begun examining the North Carolina Medicaid Program.

COMMISSION PROCEEDINGS

March 24, 2004

The Blue Ribbon Commission on Medicaid Reform met at 10:00 a.m. on Wednesday, March 24, 2004, in Room 544, Legislative Office Building. Senator Purcell was the presiding co-chair.

Carol Shaw, Fiscal Research Division, began the meeting by reviewing the committee charge and the proposed budget. She reviewed the charge, noting that Section 6.14A (a) describes the commission's responsibility and what the General Assembly wants it to do. She also called attention to Section (c), which calls for an interim report by April 1, 2004, and a final report to the 2005 General Assembly by February 1, 2005 (Appendix A). Ms. Shaw continued with a review of the budget. Representative Howard moved that the budget be approved. Dr. Wentzy seconded the motion. The motion was approved and the budget was adopted.

Ms. Shaw presented the next agenda item, "Medicaid Program Overview" (Appendix B). She said the overview gives the purpose of Medicaid and its impact on the state economy, government state budget and on local governments. Also, it lists services that Medicaid provides, both optional and mandatory, and who Medicaid recipients are. The final two topics in the overview are about policy changes since 1990 that have major impact on the budget and the most current cost containment efforts. She said North Carolina has had a Medicaid program since 1970 and that the most critical budgeting problems occurred during the early 1990s. She commented on the fact that paying for health care is a big business in North Carolina. She said Medicaid alone is much larger than some other industries, including the tobacco and textile industries. Additional statistics from the overview were presented that described how Medicaid money is spent.

Secretary Carmen Hooker Odom, Department of Health & Human Services (HHS), introduced the next presenter, Mr. Gary Fuquay, Director of the Division of Medical Assistance. Secretary Odom thanked the chairs and members for their work on the commission.

Mr. Fuquay gave the committee an update of where they are with Medicaid in 2004. He said there are four main areas: trends on expenditures, the units of services consumed and eligibles growth; organizational changes in the division; program integrity which includes the fraud and abuse section and third party recovery; and prescription drugs.

Mr. Fuquay brought copies of the Annual Report for State Fiscal Year 2003 for the Division of Medical Assistance, which supports to some degree the overview that Carol Shaw presented earlier. The handout that he used in his presentation is entitled, "Blue Ribbon Commission of Medicaid Reform" (Appendix C). The charts and graphs in the first section of this report summarize Medicaid services and premiums in January 2004 as compared to January 2003. He said the purpose of this of analysis is to drill down into the expenditures to "hone in" on the reason for increases over the past year. At the end of March 2004, the check write is at 10.44% above where it was in March 2003. The budget is based on slightly less than an 11% increase in growth, so they are still within the budget. He said a better picture of where Medicaid is going

would be available at the end of April. For 2005, he thinks getting through April of this year will give a comfort level of where they are on being within the budget for 2005.

Mr. Fuquay next explained the section entitled, "Organization." He said he has focused on strengthening internal control, management structure, and depth of knowledge of the staff since coming in as director of the division. The employees on division staff are very competent, but more depth of knowledge among the staff is needed. On the financial side, they are working to improve internal controls to make sure there is the appropriate segregation of duties. The DMA has added a number of positions. Mr. Fuquay said the Lewin Report that came to the General Assembly suggested that the division enhance program integrity, including fraud and abuse and third party liability. He said the Assistant Director for Program Integrity, Bo Nowell, would discuss the program, its focus, some of the national projects they are dealing with and a brief explanation of the sections in the Program Integrity Division. Another suggestion of the Lewin Report was to increase the number of hearings officers. Without creating additional positions, some positions were re-allocated to strengthen and speed-up recipients' appeals.

Mr. Fuquay said the clinical area has a few people who are extremely knowledgeable, but a greater depth of knowledge is needed. With the Physicians' Advisory Group looking at medical policy, there will be greater assurance that those policies are based on the most appropriate medical and evidence-based practice. It is important to try to build the depth of knowledge, the information, and the evidence-based practices in order to make sure that medical policies are strong. The twenty positions are intended to enhance the clinical affairs area, medical policy documentation, and work on cost containment in going forward. The following seven positions are identified as non-cost containment.

Mr. Fuquay said the General Assembly allowed the DMA up to $5 million to take on cost containment approaches that Clinical Affairs identified. The seven positions are in support of the budget and finance area. It has been one of the areas of internal control weakness; therefore, better segregation and depth of knowledge are needed. He said auditors have been added in order to get cost settlement reviews or audits of the hospitals and providers done in a timely manner. There might also be other re-organizations or realignments of staff as they go forward.

Mr. Fuquay asked Mr. Nowell to present the Program Integrity review. Mr. Nowell noted that the Medicaid Division saved almost $1.4 billion through collections and cost avoidance in the state fiscal year 2003. He gave credit for their assistance to the Attorney General's Medicaid Investigation Unit and the 100 county departments of social services. He said the 99.3% accuracy rate in Medicaid eligibility determinations by county departments of social services and the 98.2% payment accuracy rate as determined by the Office of State Auditor were major factors in this accomplishment. Mr. Nowell reported that thirteen and three-fourths positions are being added to the Program Integrity staff using cost-containment funds so that time spent on investigations can be increased and result in increased recoveries.

Mr. Fuquay asked Dr. Nancy Henley, Senior Policy Medical Advisor and Acting Assistant Director for Medical Policy in the Division of Medical Assistance, to discuss the pharmacy cost containment initiative DMA is undertaking. She added that DMA is working closely with the Pharmacy and Therapeutics Committee of the Physician Advisory Group in North Carolina on these clinical and administrative initiatives along with the Community Care Program.

Dr. L. Allen Dobson, Chairman of Cabarrus Community Care of North Carolina, formerly known as Access II & III, presented next. Dr. Dobson noted that Community Care started out as a pilot program to see if it could make a difference and it has grown to be very important in Cabarrus County and throughout the state (Appendix D). At the end of his review, he said the changes they have made are not done just for Medicaid patients, but are applied to uninsured and insured patients also. It is a basic practice change at the community level and significant impact should be seen throughout the health care industry. He likened trying to manage Medicaid from Raleigh to sitting in the Pentagon and working out a plan while having no army to carry it out. He said what they are trying to do is build an army for the state to impact care at the local level. As one of several lessons learned in their effort to develop a better system for delivering health care, Dr. Dobson said community involvement rather than a "top down" approach is necessary. He said that over time there are indirect quality and cost benefits for everyone, and with the work they have going on it is a distinct possibility.

Richard Bostic, Fiscal Research staff, presented a report called "Long-Term Care Premium Tax Credit" (Appendix E). Mr. Bostic explained that the state tax credit that long-term care policyholders can claim expired at the end of 2003 and will no longer be available unless action to continue it is taken during the 2004 legislative session. He said many taxpayers made errors in trying to claim the credit; the error rate in 2001 was 91%, but dropped to 40% in 2003, an indication that understanding how to apply the credit is improving. He said improved instructions and requiring insurance company information could reduce the error rate further. Mr. Bostic said the cost to the General Fund for continuing the credit is approximately $6 million.

Senator Purcell called on Carol Shaw for a presentation on the "Impact of Federal Mandates on the North Carolina Medicaid Program." She said she has divided her presentation into two separate documents, "Medicare Prescription Drug Benefit: Implications for the North Carolina Medicaid Program" (Appendix F) and "Federal Proposals for Medicaid" (Appendix G). She differentiated between the two documents, saying that the first document on the prescription drug benefit under Medicare is the law. The impact of this program will happen unless it is changed. The other document includes proposals that are being discussed in the Congress and at CMS, where some administrative activity will take place that could possibly impact North Carolina. She said the voluntary prescription drug benefit for Medicare beneficiaries, which will begin in 2006, would be a new benefit since most of this population does not have supplemental insurance that covers prescription drugs. In addition, that population between now and when that benefits goes into full effect will also get a $600 a year benefit through a Drug Card program. Exact data is not yet available for these programs.

Ms. Shaw said the major impact of the prescription drug benefit will be on dual eligibles – those who are eligible for both Medicare and Medicaid by being both over 65 years of age and poor. Under this new act, in 2006 Medicaid will no longer provide them prescription drug benefits. They will be covered under the Medicare Part D Prescription Drug Benefit. She said states would need to make sure that dual eligibles get signed up so there is no lapse of coverage. The beneficiary does not have a choice to stay on Medicare, nor does the state have a choice to keep them on Medicaid for prescription drugs. They have to participate in this program. The other aspect of it is that cost sharing obligations are similar to Medicaid.

Ms. Shaw said North Carolina's Medicaid Program will receive some fiscal relief over the next ten years, but will be required to make payments to the federal government to help finance the cost of the Medicare prescription drug program for its dual eligibles.

She said implications for the program include requiring counties to perform eligibility determinations to enroll dual eligibles and the unknown number of other low-income people who are eligible for the low-income subsidy program. The cost of doing this, she said, will be shared equally between counties and the federal government. Ms. Shaw said she does not see significant savings for the state in 2006 because of the start-up cost of implementing the new responsibility and the limited fiscal relief we will get the first year. She said fiscal relief might be greater in the out years.

Ms. Shaw continued to talk about federal mandates from Washington, including what is being discussed in the president's budget and in Congress, and what is being done administratively by CMS. She discussed the following concerns that could affect the North Carolina Medicaid Program: limiting the use of intergovernmental transfers, prospective budgeting versus retrospective budgeting, budget caps, cost allocation for Medicaid administration, reduced funding for Medicaid Management Information Systems, and the lack of federal fiscal relief.

Senator Purcell asked members to briefly state what they believe the commission should do to carry out the charge of the General Assembly. Members responded and the co-chairs said they would use their ideas as they develop the future work plan for the commission.

At the conclusion of members' suggestions, Senator Purcell reminded them that an interim report to the 2004 General Assembly is due in April 2004 and a final report by early February 2005 are required. He expressed a sense of urgency about the commission's work and said another meeting will be held before the 2004 Short Session.

Senator Purcell said the commission discussed briefly the fact that the tax credit for long-term care insurance expired at the end of 2003. In response, Representative Nye moved to submit proposed legislation for consideration during the 2004 Session of the General Assembly that would continue the tax credit for long-term care insurance, which expired at the end of 2003. Representative Howard seconded the motion. The motion passed and staff was directed to prepare legislation and include this recommendation in the interim report to the 2004 Session of the 2003 General Assembly.

April 12, 2003

The Blue Ribbon Commission on Medicaid Reform met on Monday, April 12, 2004, at 1:00 p.m. in Room 544 of the Legislative Office Building. Members discussed and approved the commission's Interim Report to the 2004 Session of the 2003 General Assembly and heard a report from the National Conference of State Legislatures on Best Practices and Innovations in Medicaid Programs.

COMMISSION RECOMMENDATIONS

The Blue Ribbon Commission on Medicaid Reform makes the recommendation outlined below. The recommendation is followed by background information, and the legislative proposal appears in Appendix H of this report.

Recommendation

The Commission recommends that the tax credit for long-term care insurance be made permanent. In order to reduce the error rate, the Commission also recommends that the Department of Revenue can require that taxpayers claiming the credit must list the insurance company and policy number of the long-term care insurance policy.

Background

North Carolina G.S. 105-151.28 contains the tax credit for long-term care insurance that became effective for tax years beginning on or after January 1, 1999, and expiring for tax years beginning on or after January 1, 2004. According to the Department of Revenue, "the credit is allowed for premiums paid on qualifying long-term care insurance contracts that provide insurance coverage for a taxpayer or a taxpayer's spouse or dependent. The credit is 15% of the premiums paid, not to exceed $350 for each qualified long-term care insurance contract for which a credit is claimed. A long-term care insurance contract is defined in section 7702B of the Internal Revenue Code as any insurance contract under which the only insurance protection provided is for coverage of qualified long-term care services. Qualified long-term care services are those services required by a chronically ill individual and provided under a plan of care prescribed by a licensed health care practitioner."

The Department of Revenue has encountered serious taxpayer problems with the long-term care insurance tax credit. Audited tax returns in 2001 showed a 91% error rate for credit. The most common taxpayer error were 1) claiming the credit for regular insurance premiums, 2) claiming the total amount of premiums paid as a credit instead of the $350 limit, and 3) claiming the credit and also claiming the long-term care premium as a medical expense.

The Department of Revenue reports a 40% error rate in audited returns in tax year 2003. The Department of Revenue's Personal Taxes Division credits the reduction in long-term credit errors to the following factors:

1. Tax preparers making errors were contacted.
2. Instructions in the D-400 tax return booklet were improved.
3. Verbiage in the software developers' tax packages was improved.
4. Taxpayers whose credit was disallowed did not make the same mistake.

The high error rate is surprising given that the instructions in Form D-400 TC state "A tax credit is allowed for the qualifying premiums you paid during the taxable year on a qualified long term care insurance contract(s)... **Medical insurance premiums that you pay for general health care, hospitalization, or disability insurance do not qualify as premiums paid for a long**

term care insurance contract." The tax form tells you to read the instructions and complete the worksheet to determine the amount of credit owed.

Continuing the credit will require the removal of the credit sunset and an adjustment in future General Fund budgets for an annual revenue loss of approximately $6 million. More importantly, continuing the credit will require the reduction of taxpayer error and fraud. North Carolina can follow the practice of Minnesota and require the taxpayer to list the insurance company and policy number of the long-term care policy for which a tax credit is claimed. The Department of Revenue can work with the Department of Insurance to get the list of companies providing long-term care policies in the state and a computer listing of policy holders to match against the tax credit claims.

The Department of Health and Human Services, Division of Aging produced a report entitled, Increasing Personal Responsibility for Long Term Care through Private Long Term Care Insurance. The Division of Aging asserts that individuals purchase long-term care insurance for a variety of reasons including: to avoid spending assets for long-term care, to make sure there are choices regarding the type of care received, to protect family members from having to pay for care, or to decrease the chances of going on Medicaid. The conclusion of the report by the Division of Aging states that, "North Carolina State government has a responsibility to take immediate, sustained and visible action to help North Carolina's baby boomers and younger adults to position themselves to pay privately to meet their long-term care needs to the greatest extent possible. Given the impact aging baby boomers could have on increased demand for publicly funded long-term care services, such an effort is necessary to preserve the future economic security of the state by reducing reliance on publicly funded long-term care services particularly Medicaid. Long-term care insurance holds the greatest promise for positioning a larger segment of the state (and nation's) population to pay privately for future long-term care needs."

The Blue Ribbon Commission on Medicaid Reform agrees with the Division's report which states that, "in addition to the public benefit of having a much larger segment of the adult population positioned to pay privately for long-term care in terms of the state's economic health, consumers and families benefit from the ability to pay privately through increased choice and flexibility in terms of the range of services and settings of care available." Therefore, the Blue Ribbon Commission on Medicaid Reform recommends that the tax credit for long-term care insurance be made permanent, and to insure taxpayer error is reduced, and establishes the legislative intent that the Department of Revenue can require a taxpayer claiming the credit to list the insurance company and policy number for the policy for which a credit is claimed.

APPENDIX A

LEGISLATIVE AUTHORITY FOR THE BLUE RIBBON COMMISSION ON MEDICAID REFORM

BLUE RIBBON COMMISSION ON MEDICAID REFORM

SECTION 6.14A (a) There is established the North Carolina Blue Ribbon Commission on Medicaid Reform (Commission). The Commission shall examine the State's Medicaid program and make comprehensive recommendations for fundamental reform. The Commission shall consider:

(1) Methods to responsibly restrain the growth in Medicaid spending.

(2) Best practices in both the public and private sectors in managing and administering health care.

(3) Options for maximizing existing resources while controlling Medicaid program costs.

(4) Current array of services available within the State Medicaid program to determine the appropriateness of the type, frequency, and duration of those services.

(5) Opportunities for long-term, systemic change in the Medicaid program through the use of federal waivers and other management tools.

(6) How to minimize the State and county share of Medicaid costs and maximize federal participation in Medicaid programs.

(7) The role of Medicaid in the State's economy.

(8) Any other matter relating to reform of the State Medicaid program.

SECTION 6.14A (b) The Commission shall consist of 12 members appointed as follows:

(1) Six members appointed by the Speaker of the House of Representatives, including one member who shall be designated as House Cochair. No more than three may be legislators.

(2) Six members appointed by the President Pro Tempore of the Senate, Including one member who shall be designated as Senate Cochair. No more than three may be legislators.

The appointing officer shall fill vacancies. The Commission shall meet at the call of the Cochairs. Members of the Commission shall receive per diem, subsistence, and travel expenses as provided in G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Commission may contract for consultant services as provided in G.S. 120-32.02. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Commission in its work. Clerical staff shall be furnished to the Commission through the offices of the House of Representatives and Senate Directors of Legislative Assistants. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may exercise all of the powers provided under G.S. 120-19 through G.S. 120-19.4 while in the discharge of its official duties. The funds appropriated by this act to the Reserve for the Blue Ribbon Commission on Medicaid Reform shall be

transferred to the Department of Health and Human Services in order to draw down federal match funds to be used to cover the cost of the Commission's work.

SECTION 6.14A.(c) By April 1, 2004, the Commission shall make an interim report to the 2003 General Assembly. The Commission shall make its final report to the 2005 General Assembly by February 1, 2005, and shall expire upon submitting that report.

APPENDIX B

DEPARTMENT OF HEALTH & HUMAN SERVICES

MEDICAID PROGRAM OVERVIEW

FISCAL RESEARCH DIVISION
March 2004

Medicaid Program Overview

- Purpose of Medicaid
- Impact of Medicaid
  - On the State Economy
  - On State Government
  - On the State Budget
  - On Local Government
- Medicaid Services
- Medicaid Recipients
- Policy Changes Since 1990
- Cost Containment Efforts

Medicaid Program

THREE PROGRAMS IN ONE

- HEALTH INSURANCE
- LONG TERM CARE FOR THE ELDERLY
- SERVICES FOR PEOPLE WITH DISABILITIES

Medicaid Program

MEDICAID VS. MEDICARE

Medicaid is health care for certain groups of poor persons, including single parent families, persons over age 65 and the disabled. Coverage is based on a person falling into one of the target groups and passing income and resources tests. Medicaid is administered by states and counties and financed with federal, state and county funds.

Medicare is health care for persons over age 65 and for the disabled who receive Social Security payments. Medicare is administered by the Centers for Medicare & Medicaid Services and financed by employer/employee contributions to the Social Security Trust Fund.

Medicaid Program

ENTITLEMENT STATUS

Medicaid is a federal entitlement program. Entitlement means that any individual who is found eligible for Medicaid has a legal right to receive services under the Medicaid Program and cannot be denied coverage.

Implications for State Government

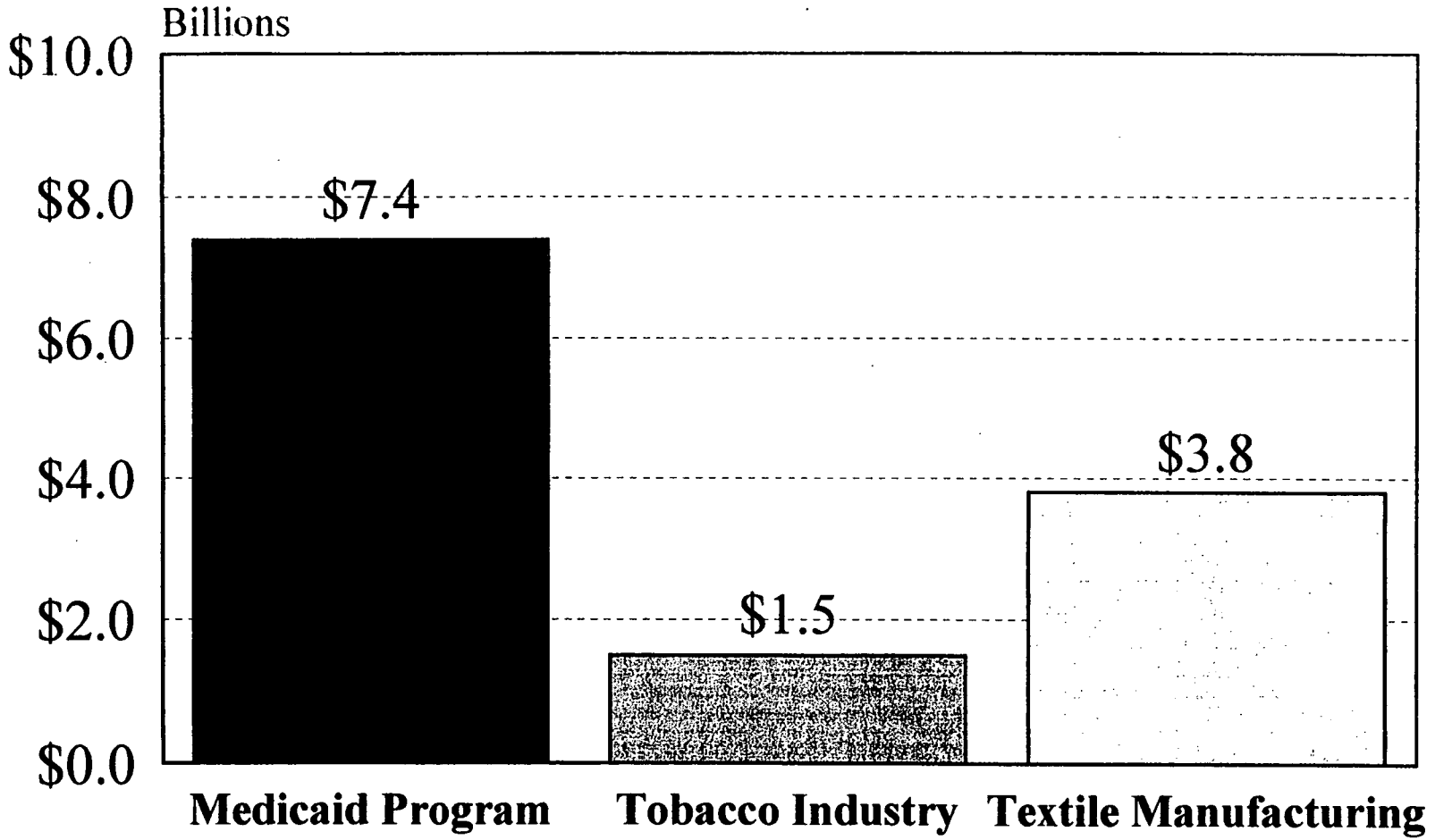
- ✓ **All eligible persons who apply for Medicaid must be served.**
- ✓ **The medical bills for Medicaid eligibles must be paid.**
- ✓ **If the appropriations for the Medicaid Program are inadequate, eligible persons must be served even if the funding must come from other areas of State government.**

IMPACT OF MEDICAID

- ✓ On the State Economy
- ✓ On State Government
- ✓ On the State Budget
- ✓ On Local Government

Medicaid Program

ROLE IN STATE ECONOMY



NOTE: Tobacco Industry includes the value of the 2002 crop and the estimated 2002 salaries and wages for tobacco manufacturing. Textile Manufacturing includes the estimated salaries and wages for the industry for 2002.

Medicaid Program

OTHER COMPARISONS

- The SFY 2002 Medicaid Program expenditures are equal to the estimated total income of the citizens of Cumberland County for 2000.

- Assuming an average private sector salary of $31,621 for 2002, SFY 2002 Medicaid expenditures would pay the salary of 232,950 employees in the private sector.

Medicaid Program

N. C. MEDICAID SNAPSHOTS

- Covered 1.45 Million state residents in SFY 2003 -- 17% of N.C.'s population
- Covered over 826,000 children during SFY 2003 - 57.1% of Medicaid eligibles
- Covers 45% of the babies born each year
- 29.3% of recipients consume 69.6% of resources -- includes aged, blind, and disabled

Medicaid Program

N. C. MEDICAID SNAPSHOTS

- Inpatient care consumes 42.6% of expenditures for services -- includes hospitals, nursing homes, residential high risk intervention services and mental retardation centers.

- Expenditures for drugs were $1.2 Billion in SFY 2003.

- 66.5% of the state's 40,000 nursing home beds are funded through Medicaid.

- 14% of N. C. hospital charges are paid by Medicaid -- 49% are paid by Medicare.

Medicaid Program

IMPACT ON STATE AND LOCAL AGENCIES

- The Medicaid Program supplies significant support to State and Local agencies that provide medical services to Medicaid recipients -- 12% of Medicaid expenditures support State and Local agencies.

- The following State and Local Agencies receive reimbursement from Medicaid: Mental Retardation Centers, State Psychiatric Hospitals, Special Care Center, UNC Hospitals, Area Mental Health Agencies, Alcohol and Drug Treatment Centers, Public Health Departments, Social Services Departments, County Owned Home Health Agencies, County Owned Ambulance Services and Local Education Agencies.

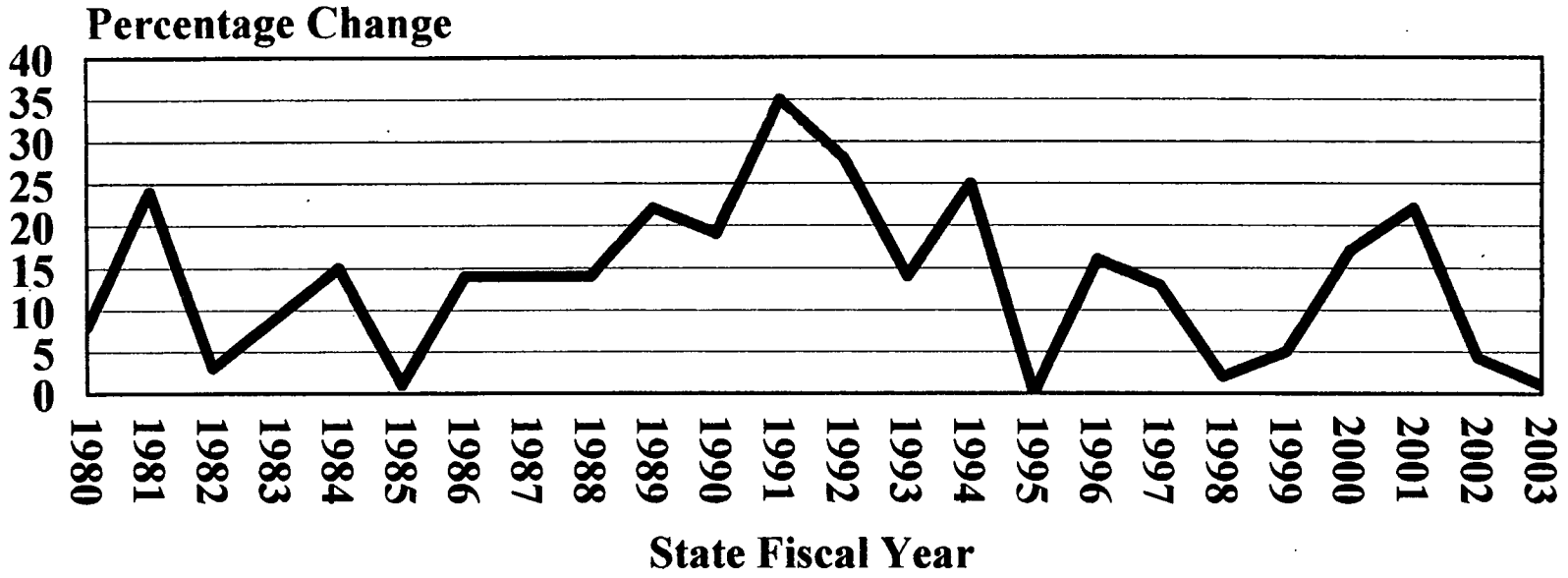
Medicaid Program

HISTORY OF TOTAL EXPENDITURES

STATE FISCAL YEAR	TOTAL EXPENDITURES
1979-80	$410,053,625
1989-90	$1,427,672,567
1999-00	$5,789,133,085
2002-03	$7,439,757,929

Medicaid Program

RATE OF GROWTH

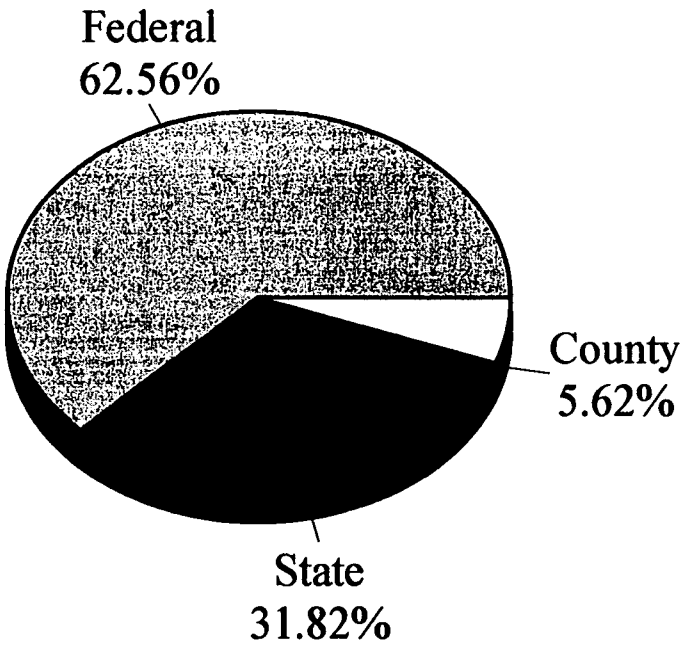


- ✓ During the past twenty years, the rate of growth for Medicaid expenditures has varied considerably - ranging from 0% to 35%.
- ✓ Higher rates of growth have occurred during years of economic distress or when major Medicaid expansions have been authorized.
- ✓ Lower rates of growth have occurred during years when the Medicaid population has been stable or declining.

Medicaid Program

FEDERAL FINANCIAL PARTICIPATION

Medical Benefits



SFY 2003

Other Matching Rates

Family Planning

Federal	90%
State	8.5%
County	1.5%

Administration - Skilled Medical Personnel & MMIS

Federal	75%
NonFederal	25%

Administration - All Other

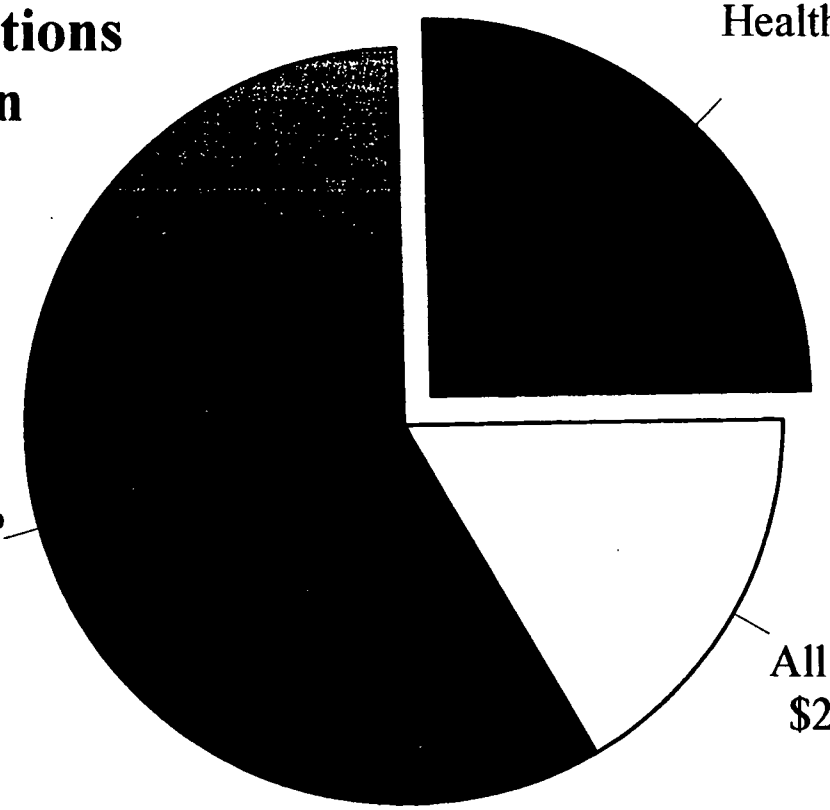
Federal	50%
NonFederal	50%

Medicaid Program

HHS SHARE OF GENERAL FUND APPROPRIATIONS

SFY 2003

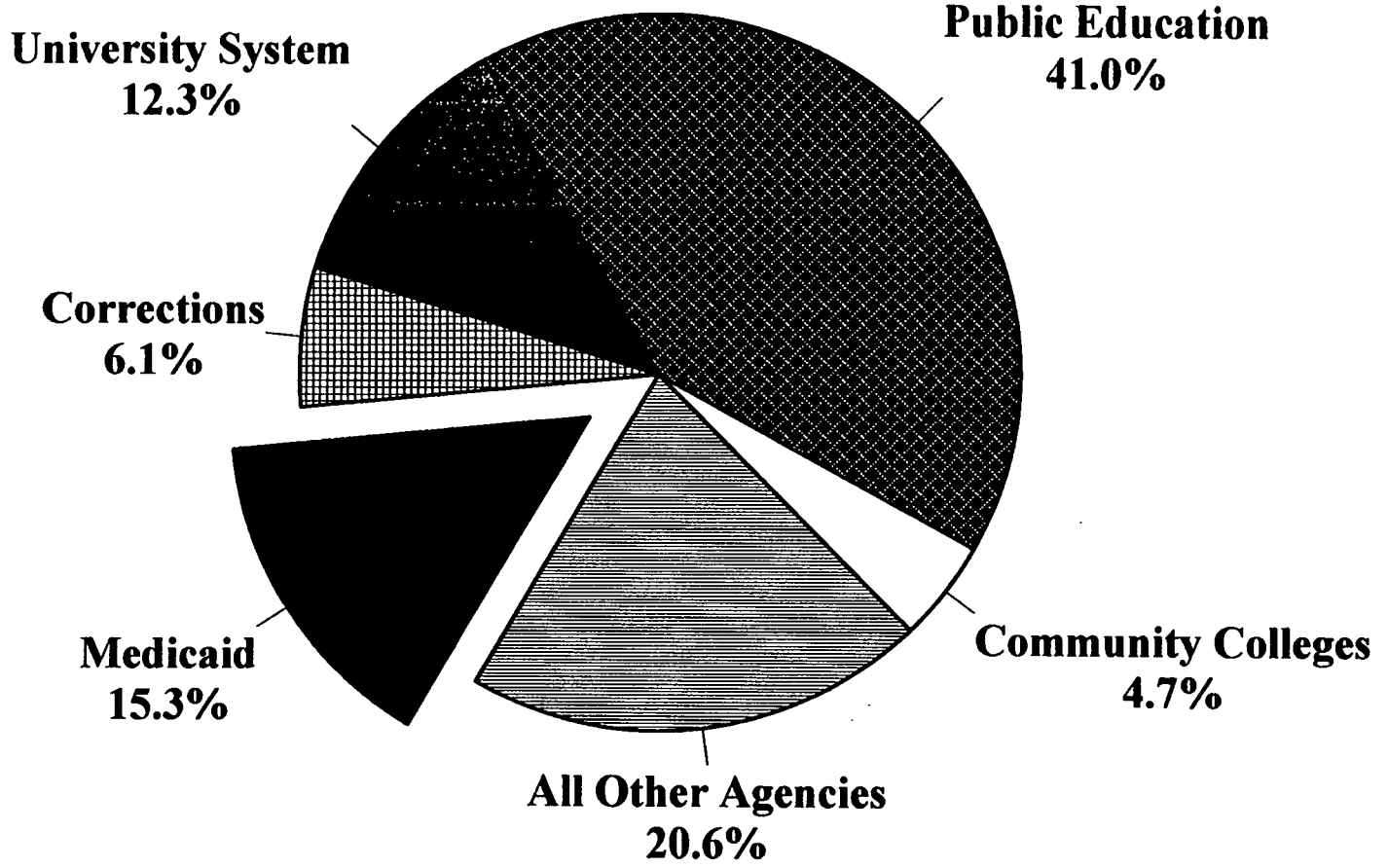
Total Appropriations
$14.35 Billion



Source: NC General Fund Operating Appropriations SFY 2003

Medicaid Program

GENERAL FUND APPROPRIATIONS BY MAJOR PROGRAM AREA
SFY 2003

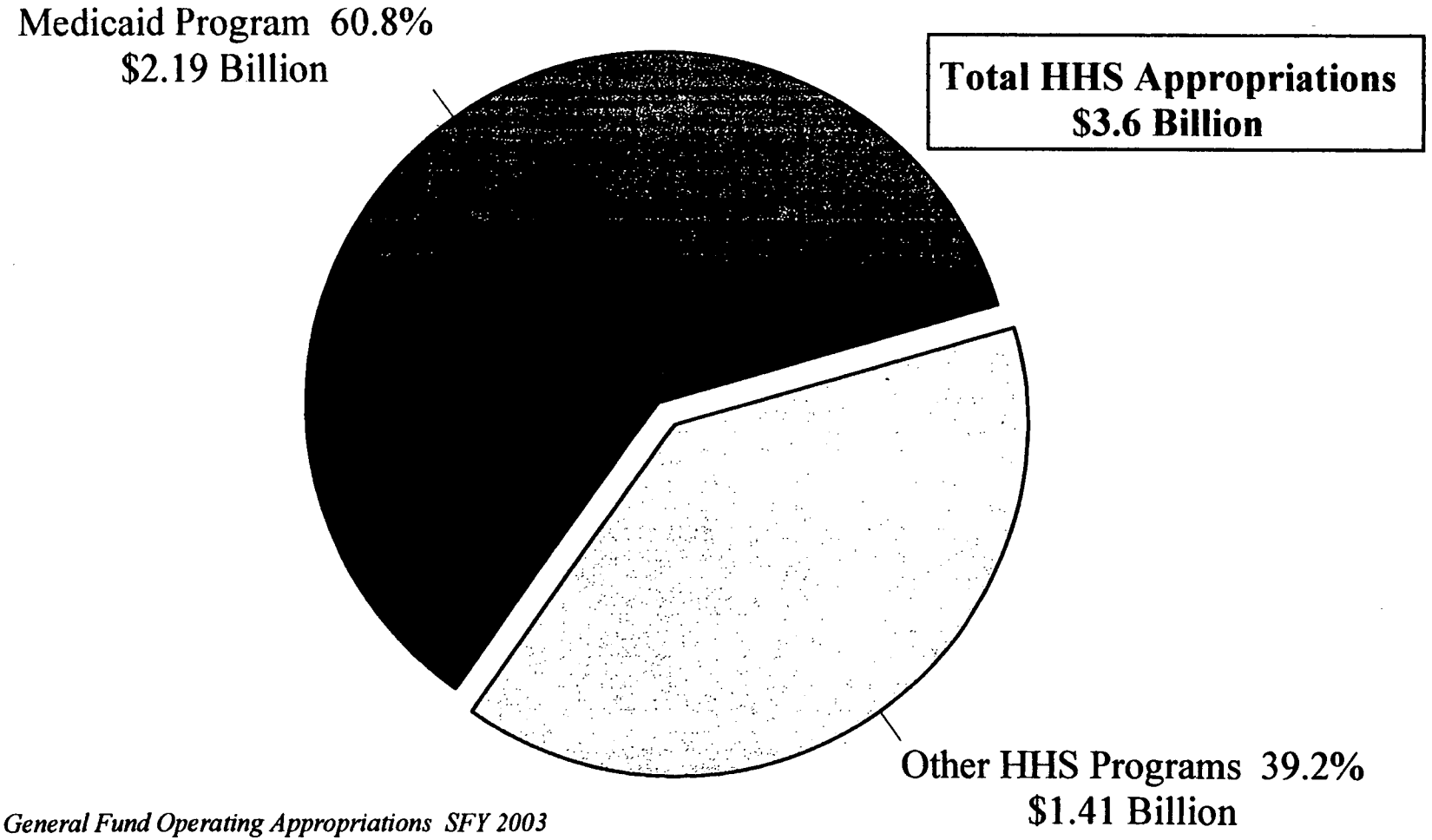


Source: NC General Fund Operating Appropriations SFY 2003

Fiscal Research Division 2/03

Medicaid Program

MEDICAID'S SHARE OF HHS GENERAL FUND APPROPRIATIONS FOR SFY 2003

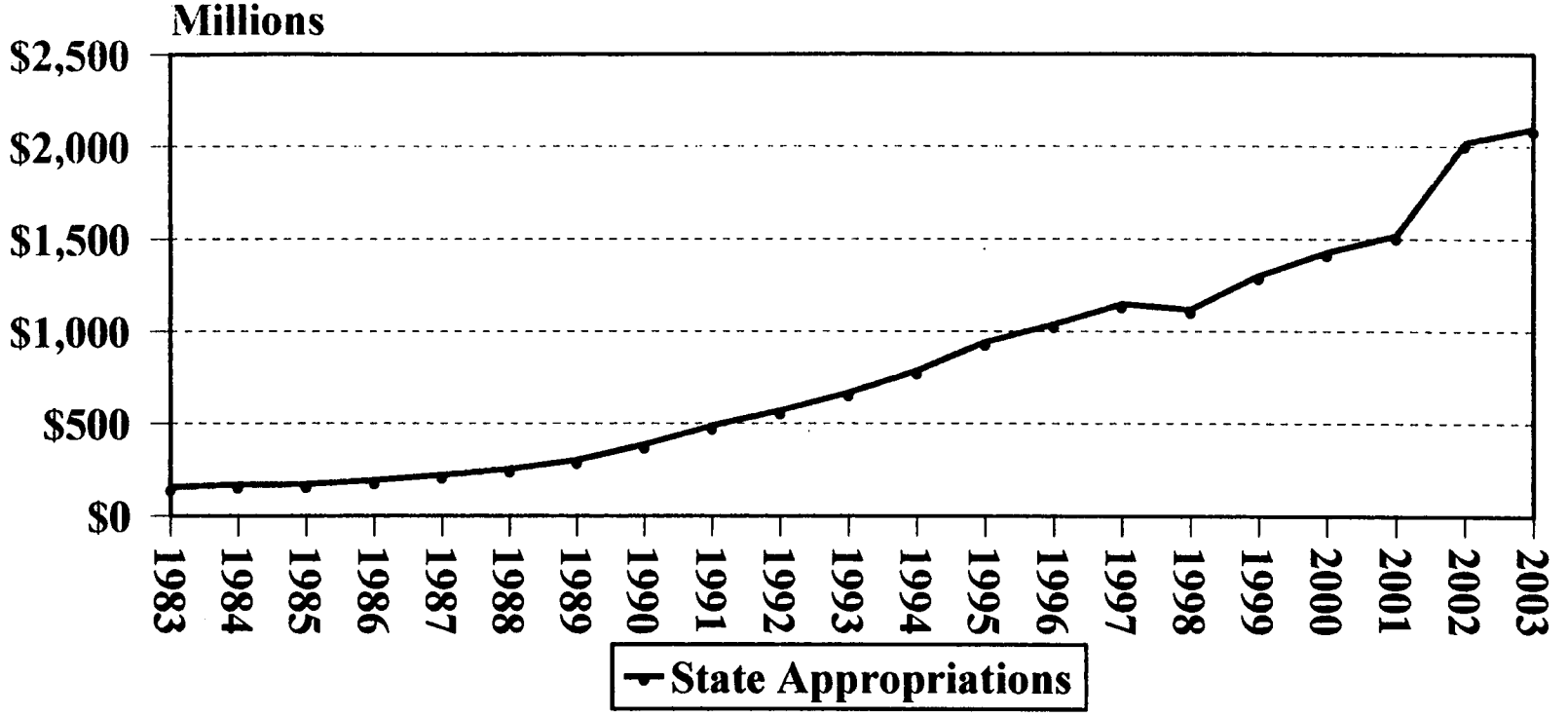


Source: NC General Fund Operating Appropriations SFY 2003

Fiscal Research Division 2/03

Medicaid Program

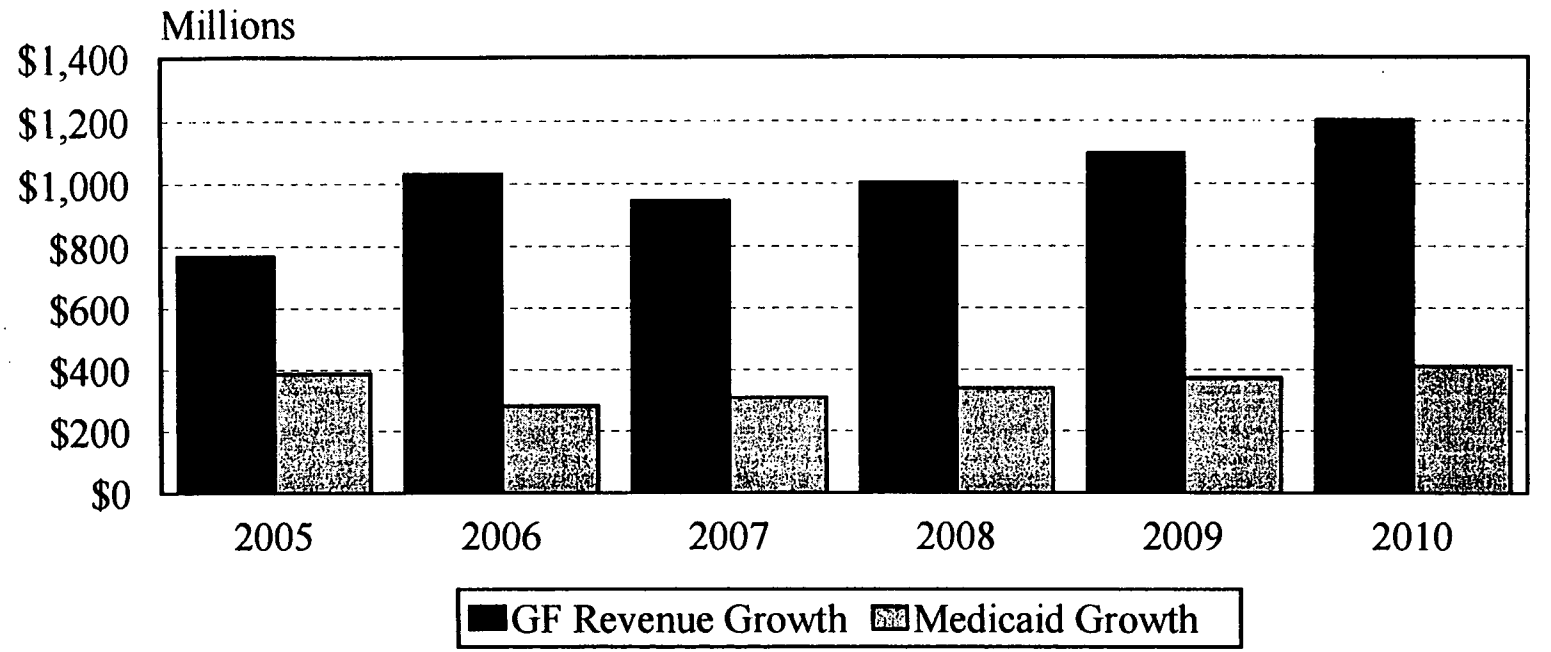
HISTORY OF STATE APPROPRIATIONS



- ✓ 10 years ago, Medicaid was 8.2% of the General Fund operating budget; today it is 15.3%.
- ✓ A 1% increase in the Medicaid Budget equals an $22 Million increase in General Fund requirements.

Medicaid Program

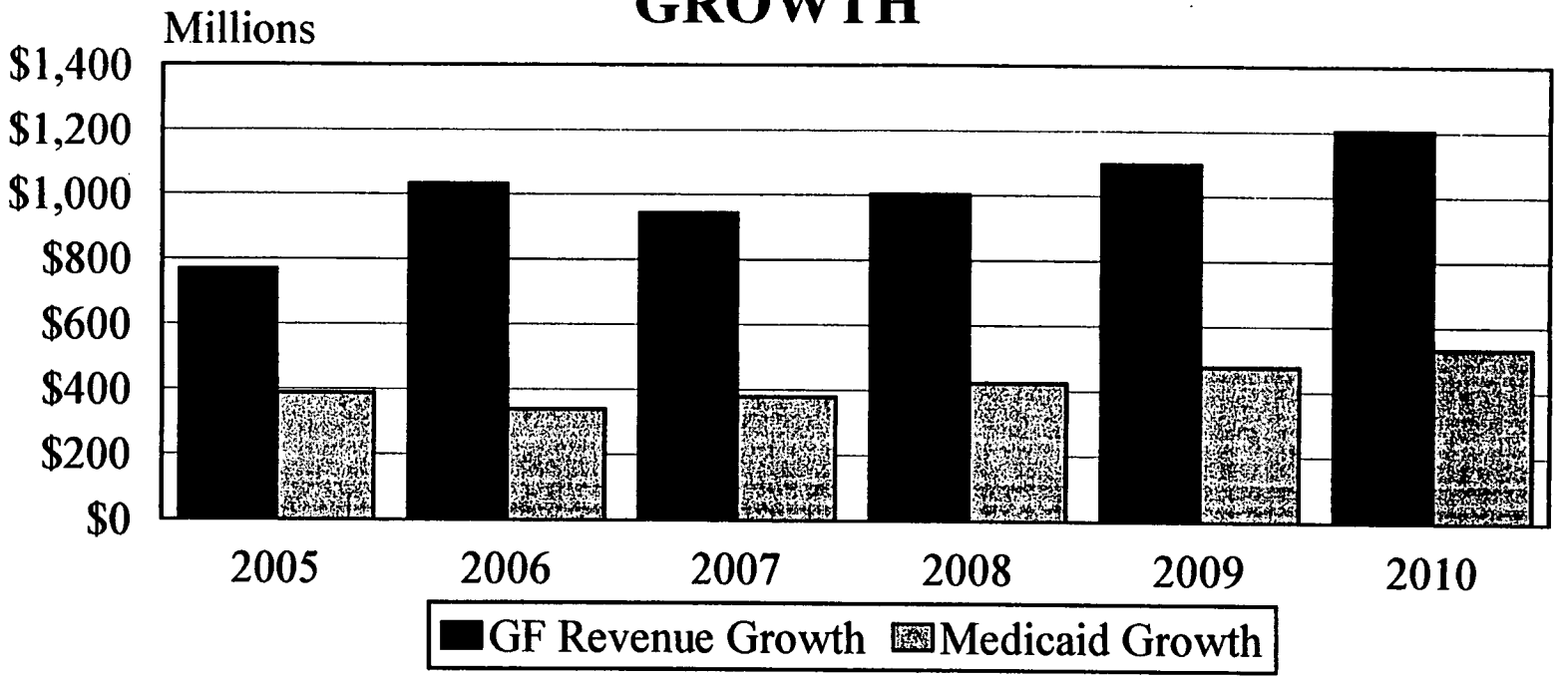
MEDICAID GROWTH VS. GENERAL FUND REVENUE GROWTH



If Medicaid expenditures increase 10% annually, growth in General Fund expenditures for Medicaid will consume 34% of new General Fund revenues by SFY 2010.

Medicaid Program

MEDICAID GROWTH VS. GENERAL FUND REVENUE GROWTH



If Medicaid expenditures increase 12% annually, growth in General Fund expenditures for Medicaid will consume over 44% of new General Fund revenues by SFY 2010.

Medicaid Program

IMPACT ON COUNTIES

- State law requires counties to pay 15% of the nonfederal share of Medicaid Services and 100% of the nonfederal share for County Medicaid Administration.

- For SFY 2004, counties are projected to pay $361.5 million for Medicaid Services or 5% of the expenditures for Medicaid Services.

- For SFY 2004, counties are also projected to pay $63 million for County Medicaid Administration or 50% of the expenditures for County Medicaid Administration.

Medicaid Program

COUNTY PARTICIPATION IN OTHER STATES

Nineteen states require county financial participation for paying the administrative and/or service cost of their Medicaid Programs.

- ✓ Three states require county financial participation for paying for the cost of Medicaid administration: Colorado, Indiana, and Wisconsin.
- ✓ Four states require county financial participation for paying for the cost of Medicaid services: Arizona, Florida, Iowa, and Michigan.
- ✓ Eleven states require county financial participation for paying for the cost of Medicaid administration and services: Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Pennsylvania, South Carolina, Virginia, and Washington.

MEDICAID SERVICES

Medicaid Program

Mandatory Services and Eligibles

Under federal law, all states operating a Medicaid Program are required to provide certain services and serve specific categories of eligibles. The services and eligibles are **mandatory** and must be included in order to receive federal reimbursement.

Medicaid Program

Mandatory Services

- Health Check Services (ESPDT)
- Family Planning Services
- Federally Qualified Health Centers
- Hearing Aids (children)
- Home Health Services (includes Durable Medical Equipment)
- Inpatient Hospital Services
- Outpatient Hospital Services
- Physicians
- Laboratory & X-Ray Services
- Nurse Midwives
- Nurse Practitioners
- Nursing Facilities
- Prenatal Care
- Rural Health Clinics
- Specialty Hospitals
- Transportation
- Vaccines for Children

Medicaid Program

Optional Services and Eligibles

- Current federal law also will provide federal reimbursement for other services and eligibles that are discretionary, but are allowed under federal law. Each state is allowed to choose which optional services it wants to provide and optional categories of eligibles it wants to serve.

- The North Carolina Medicaid Program covers 28 of the 34 optional Medicaid services.

Medicaid Program

Optional Services

- Ambulance Transportation
- Case Management Services
- Chiropractors
- Clinic Services
- Community Alternatives Programs (CAP)
- Dental Care Services (Dentures)
- Diagnostic, Screening, Preventative Services
- Emergency Hospital Services
- Eyeglasses
- Hospice
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Mental Hospitals (Age 65 and over)
- Impatient Psychiatric Care (Under age 21)
- Occupational, Physical, and Speech Therapies
- Optometrists
- Personal Care Services
- Podiatrists
- Prescription Drugs
- Prosthetics (children)
- Private Duty Nursing Services
- Rehab. Services (Mental Health)

Medicaid Program

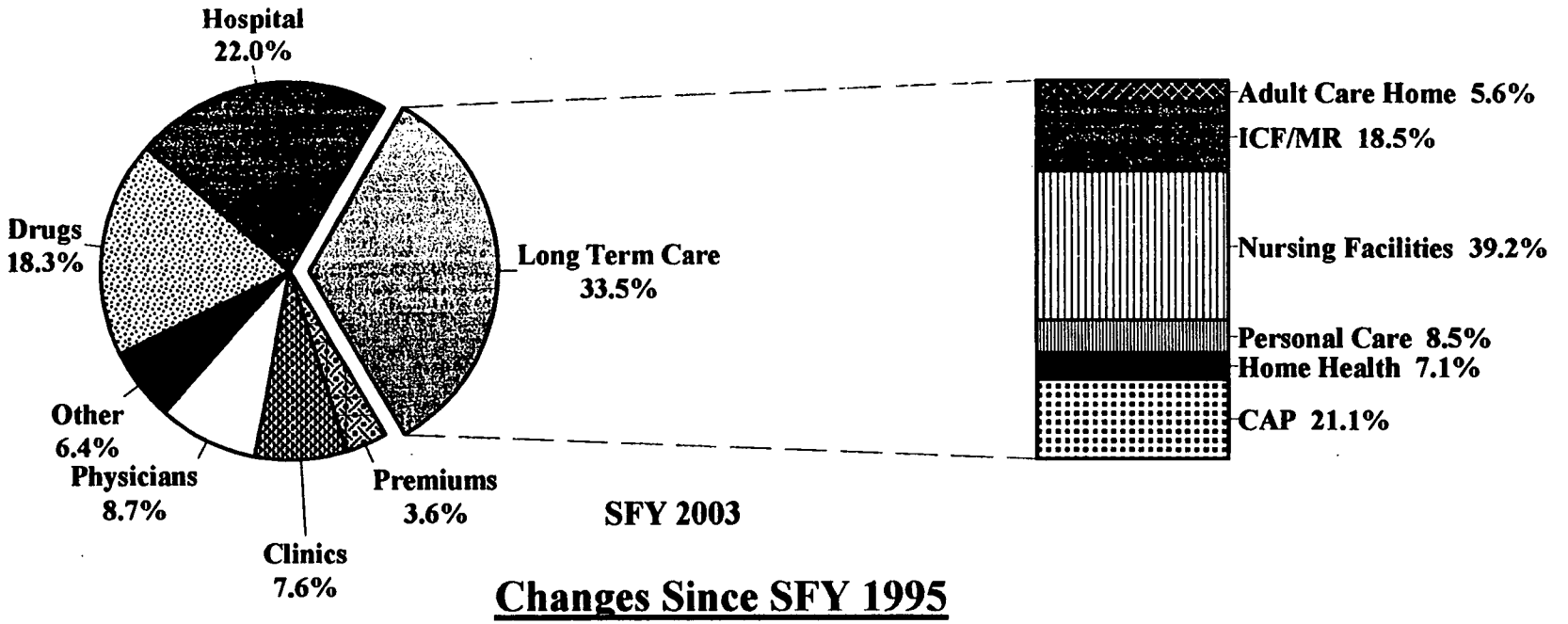
EXPENDITURES FOR SERVICES

- Total expenditures for services and premiums was $6.6 Billion for SFY 2003.

- 96.4% of expenditures for services paid for direct medical services while the remaining 3.6% paid for Medicare and HMO premiums.

Medicaid Program

EXPENDITURES FOR SERVICES

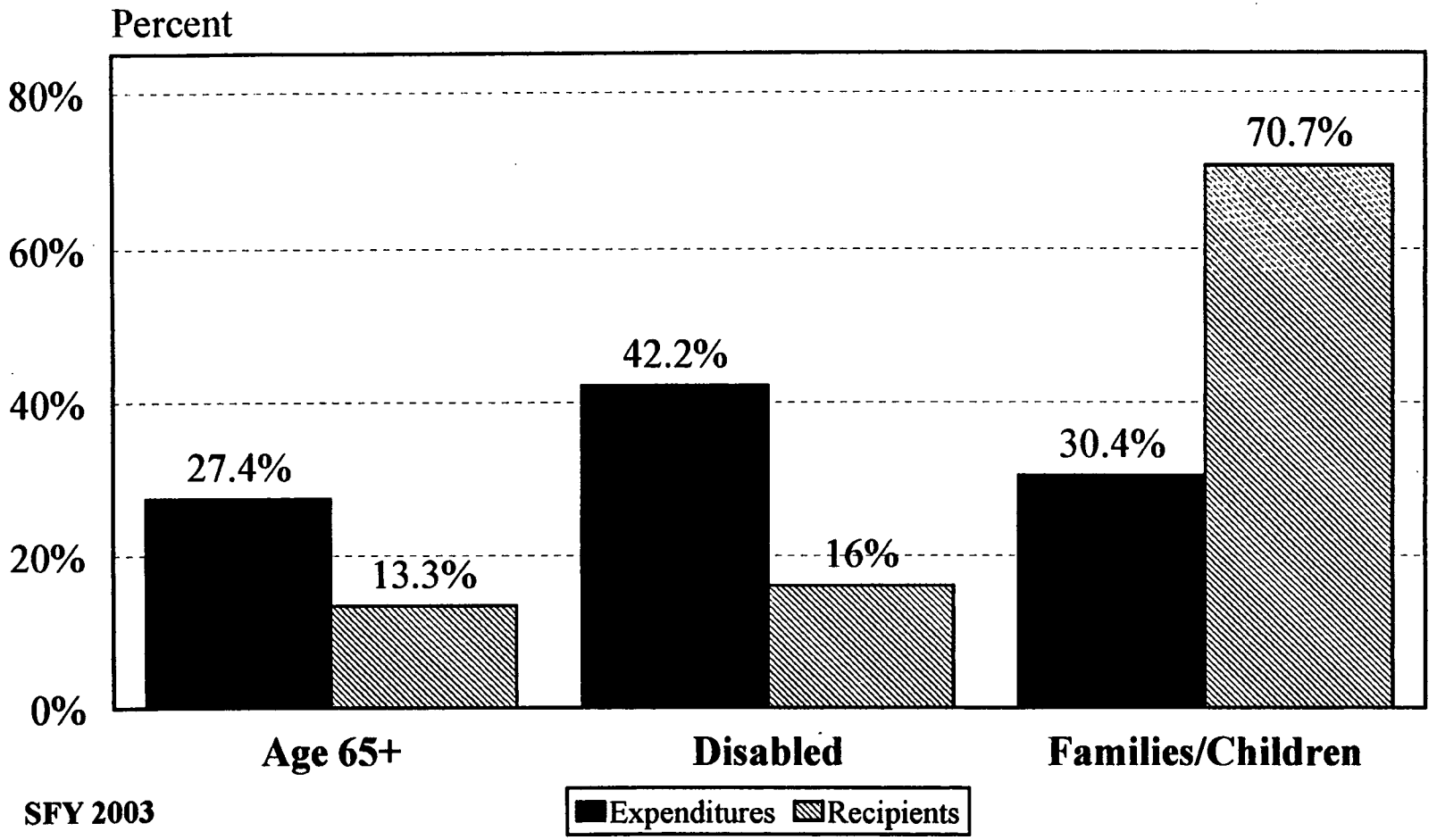


Changes Since SFY 1995

- ✓ **Long-Term Care expenditures continue to decline - 40.4% to 33.5%.**
- ✓ **In-Home Services are an increasing share of Long-Term Care expenditures - 18.5% to 36.7%**
- ✓ **Hospital expenditures have also declined - 26.9% to 22%.**
- ✓ **Drug expenditures have doubled - 8.2% to 18.3%**

Medicaid Program

EXPENDITURES AND RECIPIENTS



SFY 2003

Medicaid Program

EXPENDITURES AND RECIPIENTS

SFY 2003

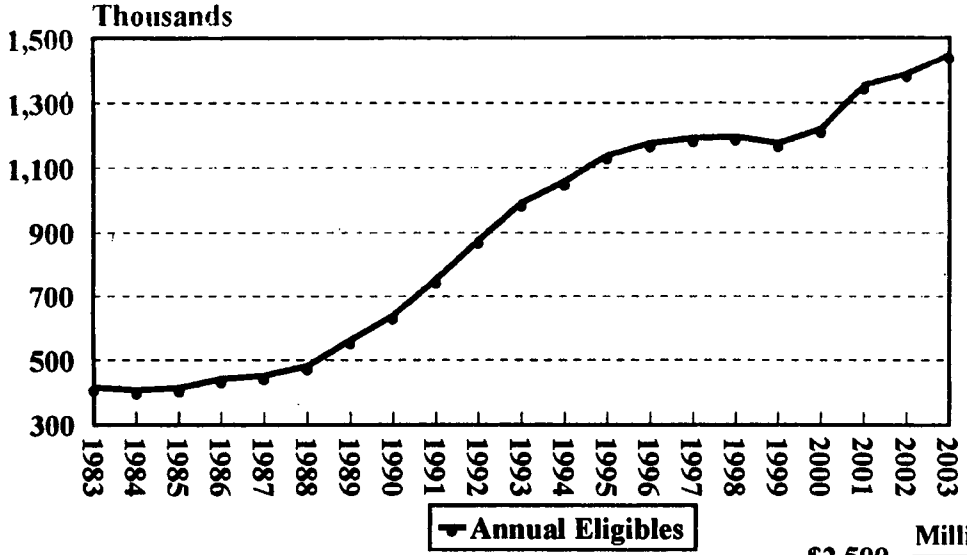
Eligibility Category	Number of Recipients	Expenditures	Annual Cost Per Recipient
Elderly	202,377	$1,807,717,487	$8,932
Aged	162,015	$1,780,878,696	$10,992
Medicare-Aid	40,362	$26,838,791	$665
Disabled	232,166	$2,779,255,514	$11,971
Families & Children	1,003,271	$1,973,688,840	$1,967

NOTE: The Aged and Medicare-Aid categories are subsets of the Elderly category.

MEDICAID RECIPIENTS

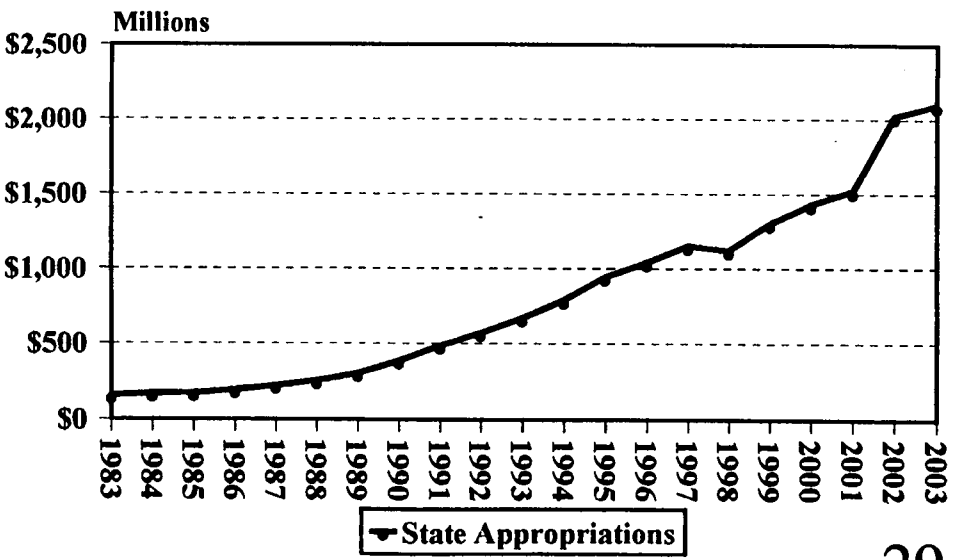
Medicaid Program

GROWTH IN ELIGIBLES AND EXPENDITURES



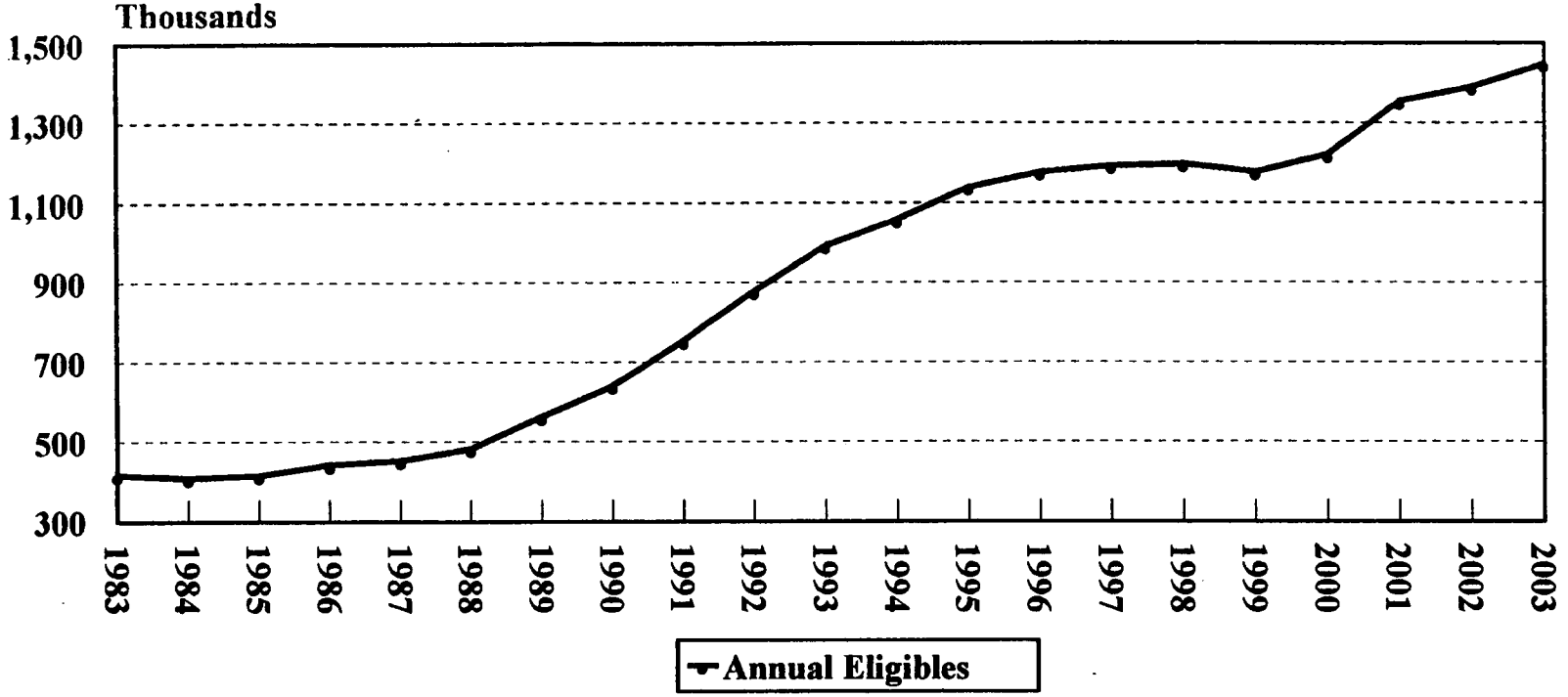
During the early 1980s, the number of eligibles did not grow significantly, and the rate of growth in expenditures for Medicaid was moderate.

Beginning in 1987, a series of mandated and optional eligibility expansions occurred and expenditures for Medicaid began to grow rapidly.



Medicaid Program

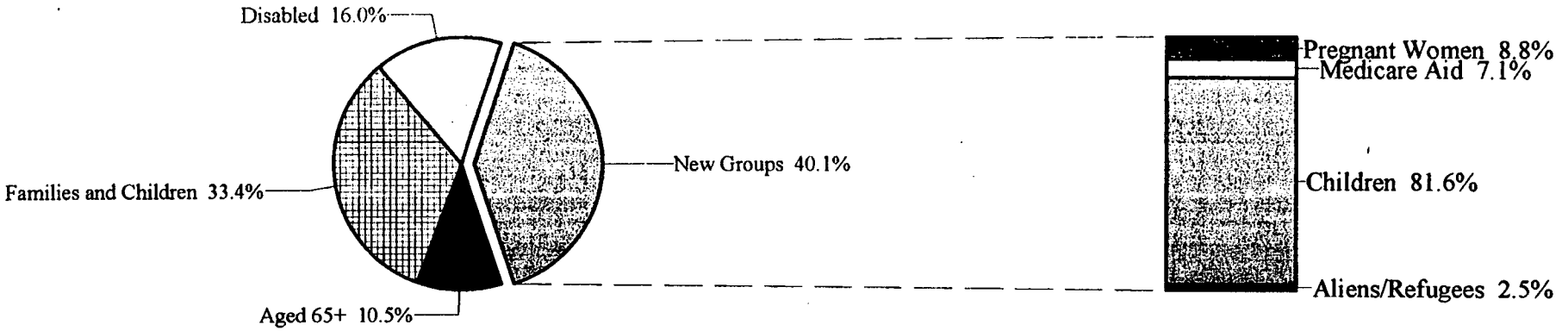
HISTORY OF ANNUAL ELIGIBLES



Growth in the number of annual eligibles began to plateau in SFY 1996 as welfare caseloads began to significantly decline and actually decreased in SFY 1999. The number of annual eligibles grew 11% in SFY 2001 because the decline in welfare caseloads slowed and other eligibility groups continued to grow. Growth in SFY 2002 slowed to 2.6%, but it increased to 4.1% in SFY 2003.

Medicaid Program

NEW GROUPS SINCE 1987



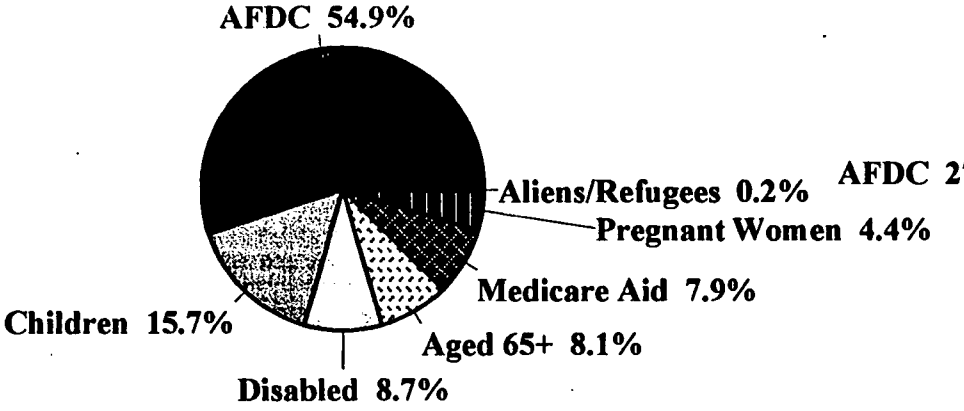
SFY 2003

When Medicaid began, the program focused on providing medical care for the disabled, aged, and families receiving welfare. Since 1987, Medicaid eligibility has been expanded to cover children, pregnant women, qualified Medicare beneficiaries, and aliens/refugees.

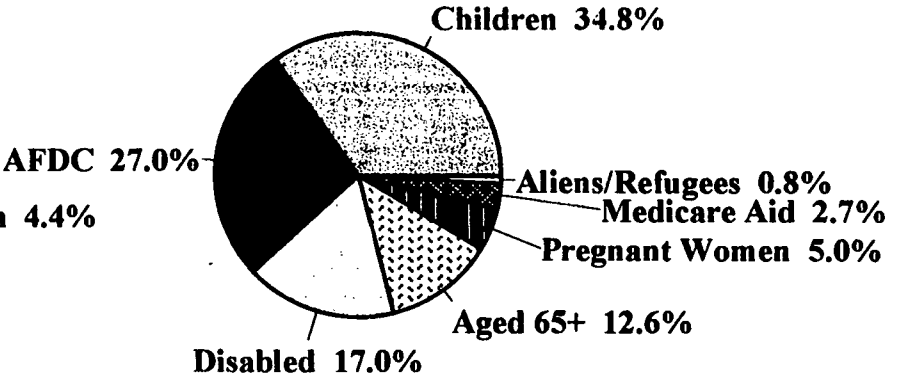
Medicaid Program

MEDICAID ELIGIBLES

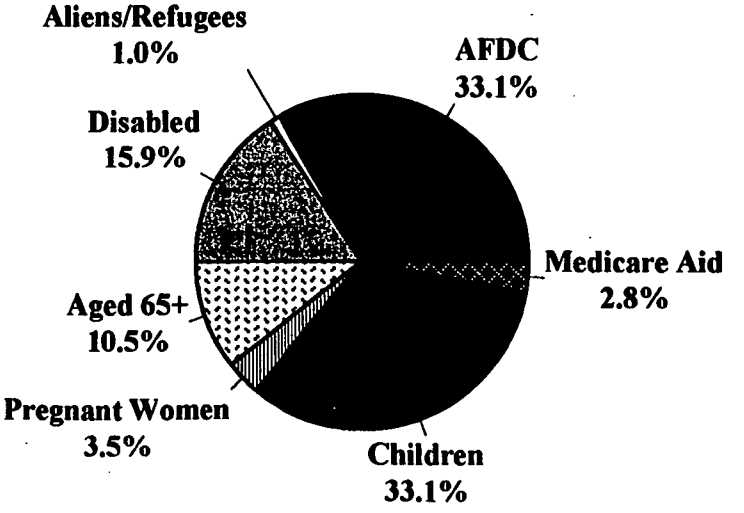
SFY 1994



SFY 2000



SFY 2003



Medicaid Program

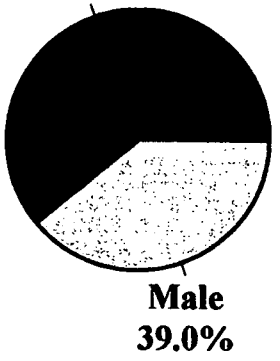
CHANGING MEDICAID ELIGIBLES

- ✓ In SFY 1994, the welfare caseload reached 581,000 people and welfare recipients were the largest group of eligibles.
- ✓ In SFY 2000, welfare reform reduced the welfare caseload to 330,000 people and children became the largest group of eligibles.
- ✓ In SFY 2003, welfare recipients are again the largest group of eligibles due to the poor economy and the expansion of Transitional Medicaid.
- ✓ In SFY 2000, the 1998 expansion of Medicaid to aged, blind, and disabled persons with incomes up to a 100% of the federal poverty level doubled the number of aged, blind and disabled eligibles.
- ✓ In SFY 2003, the number of aged, blind, and disabled eligibles has stabilized and in the case of the aged declined slightly.

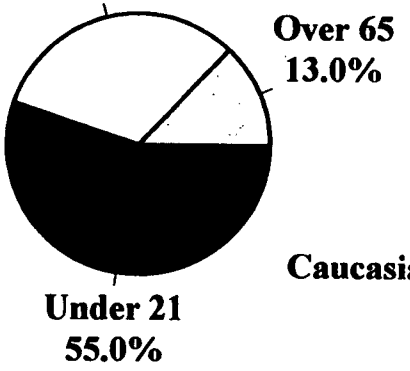
Medicaid Program

RECIPIENT INFORMATION

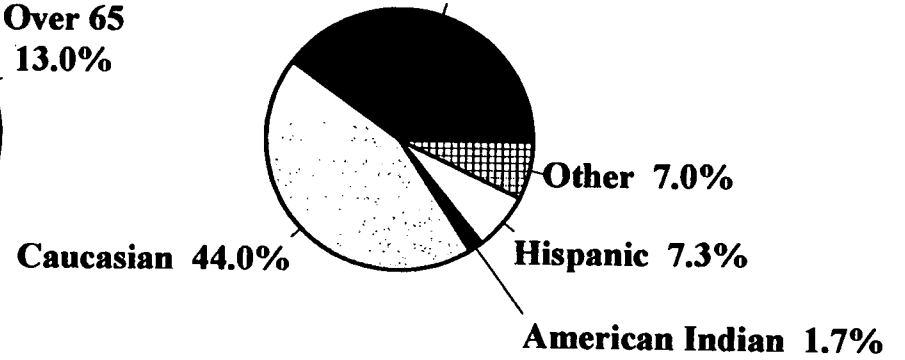
BY GENDER



BY AGE



BY RACE



SFY 2003

Medicaid Program

MANDATORY ELIGIBILITY GROUPS

- Low Income Families and Children (Based on the AFDC State Plan as of July 16, 1996)
- Aged, Blind, and Disabled SSI Recipients
- Infants born to Medicaid eligible women (to 185% of FPL)
- Children under age 6 (to 133% of FPL)
- Pregnant Women (to 150% of FPL)
- All Children born after 9/30/83 (to 100% of FPL)
- Recipients of Adoption Assistance and Foster Care
- Certain Medicare Recipients
  - Dual Eligibles
  - Qualified Medicare Beneficiaries
  - Specified Low-Income Medicare beneficiaries
  - Qualified Disabled and Working Individuals

Note: FPL is the Federal Poverty Level

Medicaid Program

OPTIONAL ELIGIBILITY GROUPS

- Pregnant Women (150% to 185% of FPL)
- Children age 18, 19, and 20 meeting AFDC income standards
- Special Needs Adoptive Children
- Recipients of State/County Special Assistance
- Recipients of State Assistance to the Blind
- Persons receiving care under home and community-based waivers
- Aged, Blind, and Disabled persons presumed eligible for but not receiving SSI
- Aged, Blind, and Disabled persons with non-SSI income (to 100% of the FPL)
- Medically Needy Persons
- Women with Breast and Cervical Cancer (to 185% of FPL)

Note: FPL is the Federal Poverty Level

PROGRAM CHANGES SINCE 1990

Medicaid Program

PROGRAM CHANGES SINCE 1990

Eligibility Expansions

- **Mandated**

  - ✓ Increase children ages 11 to 19 coverage to 100% of FPL - Effective 7/1/94
  - ✓ Increase children ages 1 to 6 coverage to 133% of FPL - Effective 10/1/90

- **Optional**

  - ✓ Increase pregnant women and infant coverage to 150% of FPL - Effective 1/1/90
  - ✓ Increase pregnant women and infant coverage to 185% of FPL - Effective 10/1/90
  - ✓ Add adoptive children with special rehabilitative needs - Effective 10/1/94
  - ✓ Automatic coverage of SSI eligible aged, blind and disabled persons - Effective 1/1/95
  - ✓ Add non-SSI eligible aged, blind, and disabled persons to 100% of FPL - Effective 1/1/99
  - ✓ Increase transitional TANF coverage from 12 to 24 months - Effective 10/1/99
  - ✓ Add women with breast and cervical cancer coverage to 185% of FPL -Effective 10/1/01

Note: FPL is the Federal Poverty Level

Medicaid Program

PROGRAM CHANGES SINCE 1990

Managed Care Initiatives

- ✓ Carolina ACCESS began implementation - Effective 4//91
- ✓ Carolina Alternatives was implemented - Effective 1/94
- ✓ Health Care Connections was implemented in Meclenburg County -Effective 6/96
- ✓ ACCESS II and ACCESS III demonstration was implemented - Effective 7/98
- ✓ Carolina ACCESS implemented statewide - Effective 12/98
- ✓ Carolina Alternatives terminated - Effective 6/99
- ✓ Health Care Connections terminated and replaced with Carolina ACCESS II - Effective 10/01
- ✓ Carolina ACCESS II and III demonstration expansion began and is ongoing - Effective 11/02

Medicaid Program

PROGRAM CHANGES SINCE 1990

Federal Revenue Maximization Efforts

- ✓ Intermediate Care Facilities for the Mentally Retarded
- ✓ Thomas S program (lawsuit)
- ✓ Willie M program (lawsuit)
- ✓ Adult Care Home Personal Care Services
- ✓ DSH Payments
- ✓ Health Departments & Area Mental Health Programs
- ✓ Health Related Services In Schools

Medicaid Program

COST CONTAINMENT EFFORTS 2001 - 2004

- **Prescription Drugs**
  - ✓ Prior Authorization Program for high cost drugs
  - ✓ State "Maximum Allowable Cost" Drug List
  - ✓ Limit most drugs to a 34-day supply
  - ✓ Increase use of generic drugs
  - ✓ Voluntary Preferred Drug List
  - ✓ Increase copayments for brand name drugs ($1 to $3)
  - ✓ Reduce dispensing fees for brand name drugs ($5.60 to $4.00)
  - ✓ Reguire pharmacists to coordinate pharmacy benefits

- **Provider Rates**
  - ✓ Reduce Physician rates from 100% of Medicare rates to 95%.
  - ✓ Eliminate inflationary increases for SFY 2003 and SFY 2004
  - ✓ Reduce rates by 5% for the following providers: private duty nursing, home infusion therapy, home health supplies, durable medical equipment, optical service, ambulatory surgical centers, and high risk intervention
  - ✓ Reduce hospital payments by .5 %
  - ✓ Limit Medicare crossover claims to Medicaid rates
  - ✓ Apply Medicaid medical policy to Medicare crossover claims

Medicaid Program
COST CONTAINMENT EFFORTS 2001 - 2004

- **Recipients**
  - ✓ Apply federal transfer of asset policies to real property excluded as "income producing" under Title XIX.
  - ✓ Apply transfer of asset policies to persons receiving personal care services while residing in their homes
  - ✓ Adopt the SSI method for considering equity value in income-producing property for aged, blind and disabled persons
  - ✓ Modify policy for determining eligibility for pregnant women coverage for minors by counting parental income
  - ✓ Eliminate twelve month State Transitional Medicaid Coverage for families who are working and no longer receiving welfare payments.

- **Managed Care**
  - ✓ Expand Carolina ACCESS II/III activities including reducing hospital admissions, reducing ER visits, using best prescribing practices, increasing generic prescribing, implementing polypharmacy review, reducing therapy visits, and better management of high risk/high cost patients.

Medicaid Program
COST CONTAINMENT EFFORTS 2001 - 2004

- **Services**
  - ✓Reduce monthly limit for Personal Care Services from 80 hours to 60 hours for most recipients
  - ✓Limit Personal Care Services to 3.5 hours per day
  - ✓Eliminate optional circumcision procedures except in cases of medical necessity
  - ✓Reduce case management services for adults and children by reducing rates, streamlining services, and eliminating duplicated services

- **Federal Fiscal Relief**
  - ✓Receipt of enhanced federal reimbursement allowed NC to reduce State appropriations to the Medicaid Program

APPENDIX C

BLUE RIBBON COMMISSION ON MEDICAID REFORM

Gary Fuquay, Director
Division of Medical Assistance
March 24, 2004

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

ALL ELIGIBLES YTD
JANUARY 2004
TOTAL SERVICES & PREMIUMS

PAID			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
4,153,072,645	3,762,982,460	390,090,185	10.37%

UNITS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
199,828,140	187,864,100	11,964,040	6.37%

ELIGIBLES			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
1,088,647	1,037,227	51,420	4.96%

ALL ELIGIBLES YTD

JAN 2003 VS JAN 2004

TOTAL LONG TERM CARE SERVICES & PREMIUMS

PAID			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
$1,329,108,055	$1,319,411,794	$9,696,262	0.73%

UNITS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
116,076,181	116,127,506	(51,325)	-0.04%

AVERAGE MONTHLY RECIPIENTS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
158,593	155,492	3,101	1.99%

Notes:

1) Long term care expenditures of $1,329,108,055 represent 32% of total service and premium expenditures YTD January 2004 .

2) Long term care includes skilled and intermediate care nursing facilities, hospital long term care, home health, durable medical equipment, Community Alternative Programs, home infusion therapy, hospice, personal care services and adult care home services.

3) "Average Monthly Recipients" is a duplicated count; recipients using one or more services are counted in each of the various Long Term Care service categories.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

SOURCES OF CHANGE IN YEAR TO DATE AMOUNTS PAID

ALL SERVICES YTD JANUARY 2004 PROGRAM AID CATEGORY	PAID SFY 2004	PAID SFY 2003	INCREASE (DECREASE)	INCREASE (DECREASE) AS PERCENT	PERCENT OF TOTAL CHANGE BY PAC
AGED	1,083,497,031	1,041,603,471	41,893,561	4.02%	10.74%
BLIND	16,426,858	16,804,456	(377,598)	-2.25%	-0.10%
DISABLED	1,735,577,517	1,567,340,517	168,237,000	10.73%	43.13%
AFDC UNDER 21	286,916,733	244,205,738	42,710,995	17.49%	10.95%
AFDC OVER 21	371,900,854	315,260,271	56,640,582	17.97%	14.52%
OTHER CHILDREN	41,891,718	39,019,502	2,872,216	7.36%	0.74%
MPW	121,187,729	118,382,045	2,805,683	2.37%	0.72%
MIC	462,552,230	388,197,591	74,354,639	19.15%	19.06%
MQBQ	376,779	420,042	(43,263)	-10.30%	-0.01%
MQBB	11,196,300	10,083,955	1,112,345	11.03%	0.29%
MQBE	4,978,680	4,456,755	521,925	11.71%	0.13%
LEGAL ALIENS	749,461	419,305	330,156	78.74%	0.08%
ILLEGAL ALIENS	28,202,785	25,551,781	2,651,004	10.38%	0.68%
REFUGEES	344,130	1,026,992	(682,862)	-66.49%	-0.18%
UNRECOGNIZED	(12,726,160)	(9,789,962)	(2,936,199)	0.00%	-0.75%
ALL ELIGIBLES	4,153,072,645	3,762,982,460	390,090,185	10.37%	100.00%

ALL ELIGIBLES YTD

JAN 2003 VS JAN 2004

TOTAL NON-LONG TERM CARE SERVICES & PREMIUMS

PAID			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
$2,823,964,590	$2,443,570,666	$380,393,923	15.57%

UNITS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
83,751,959	71,736,594	12,015,365	16.75%

AVERAGE MONTHLY RECIPIENTS			
SFY 2004	SFY 2003	VARIANCE OVER (UNDER)	PERCENT CHANGE
1,173,930	1,115,391	58,539	5.25%

Note:

1) Non-long term care expenditures of $2,823,964,590 represent 68% of total service and premium expenditures YTD January 2004 .

2) "Average Monthly Recipients" is a duplicated count; recipients using one or more services are counted in each of the various non-long term care service categories.

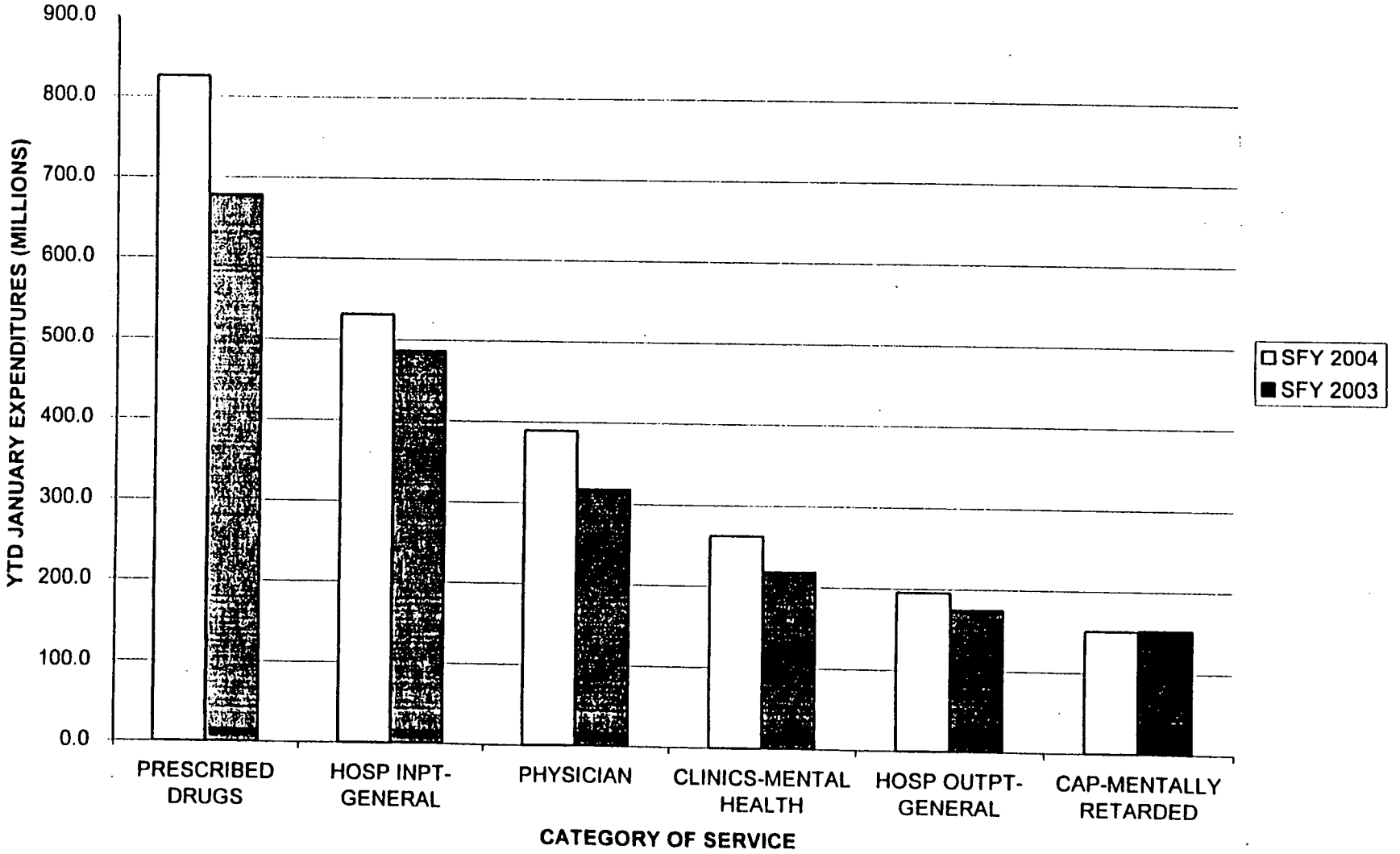
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

FIFTEEN MOST EXPENSIVE CATEGORIES OF SERVICE

YEAR TO DATE JANUARY 2004 COS DESCRIPTION	ALL ELIGIBLES			
	PAID		VARIANCE	PERCENT
	SFY 2004	SFY 2003	OVER (UNDER)	CHANGE
PRESCRIBED DRUGS	$825,590,130	$678,560,294	$147,029,836	21.67%
HOSP INPT-GENERAL	$531,353,764	$486,629,988	$44,723,776	9.19%
PHYSICIAN	$389,060,372	$317,821,333	$71,239,040	22.41%
CLINICS-MENTAL HEALTH	$262,207,312	$218,233,429	$43,973,883	20.15%
CAP-MENTALLY RETARDED	$151,110,161	$152,461,117	($1,350,956)	-0.89%
HOSP OUTPT-GENERAL	$195,913,085	$175,400,038	$20,513,047	11.70%
CAP-DISABLED	$112,838,756	$109,580,576	$3,258,180	2.97%
PERSONAL CARE	$120,842,832	$113,086,861	$7,755,971	6.86%
HOSP OUTPT-EMERGENCY ROOM	$99,659,000	$86,435,066	$13,223,934	15.30%
PART B BUY-IN DUAL Q	$76,489,990	$69,050,896	$7,439,094	10.77%
ACH-PCS BASIC	$65,649,098	$63,039,841	$2,609,257	4.14%
DENTAL	$102,646,892	$71,638,191	$31,008,700	43.29%
HOME HEALTH	$55,489,929	$56,421,116	($931,187)	-1.65%
HIGH RISK INTERVENTION	$55,880,851	$41,124,174	$14,756,677	35.88%
DURABLE MEDICAL EQUIPMENT	$36,184,130	$33,282,611	$2,901,519	8.72%
TOTAL FOR THE 15 TOP COS	$3,080,916,302	$2,672,765,532	$408,150,770	15.27%
TOTAL SVC. & PREM. EXPEND.	$4,153,072,645	$3,762,982,460	$390,090,185	10.37%
% TOP 15 COS VS. TOTAL ALL COS	74.2%	71.0%		

ELIGIBLES AND EXPENDITURES YTD JAN 2004					
	# Eligibles	% Total		Expenditures	% Total
AGED	126,618	11.6%		$1,083,497,031	26.1%
BLIND	2,006	0.2%		$16,426,858	0.4%
DISABLED	199,064	18.3%		$1,735,577,517	41.8%
AFDC UNDER 21	222,246	20.4%		$286,916,733	6.9%
AFDC OVER 21	130,839	12.0%		$371,900,854	9.0%
OTHER CHILDREN	3,686	0.3%		$41,891,718	1.0%
MPW	20,046	1.8%		$121,187,729	2.9%
MIC	347,592	31.9%		$462,552,230	11.1%
MQBQ	566	0.1%		$376,779	0.0%
MQBB	24,688	2.3%		$11,196,300	0.3%
MQBE	10,943	1.0%		$4,978,680	0.1%
LEGAL ALIENS	267	0.0%		$749,461	0.0%
ILLEGAL ALIENS	0	0.0%		$28,202,785	0.7%
REFUGEES	0	0.0%		$344,130	0.0%
UNRECOGNIZED	0	0.0%		($12,726,160)	-0.3%
ALL ELIGIBLES	1,088,647	100.0%		$4,153,072,645	100.0%

SIX HIGHEST COST SERVICE CATEGORIES



DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

COMPONENTS OF INCREASES IN SFY 2004 YTD EXPENDITURES OVER SFY 2003 YTD EXPENDITURES BY PROGRAM AID CATEGORY

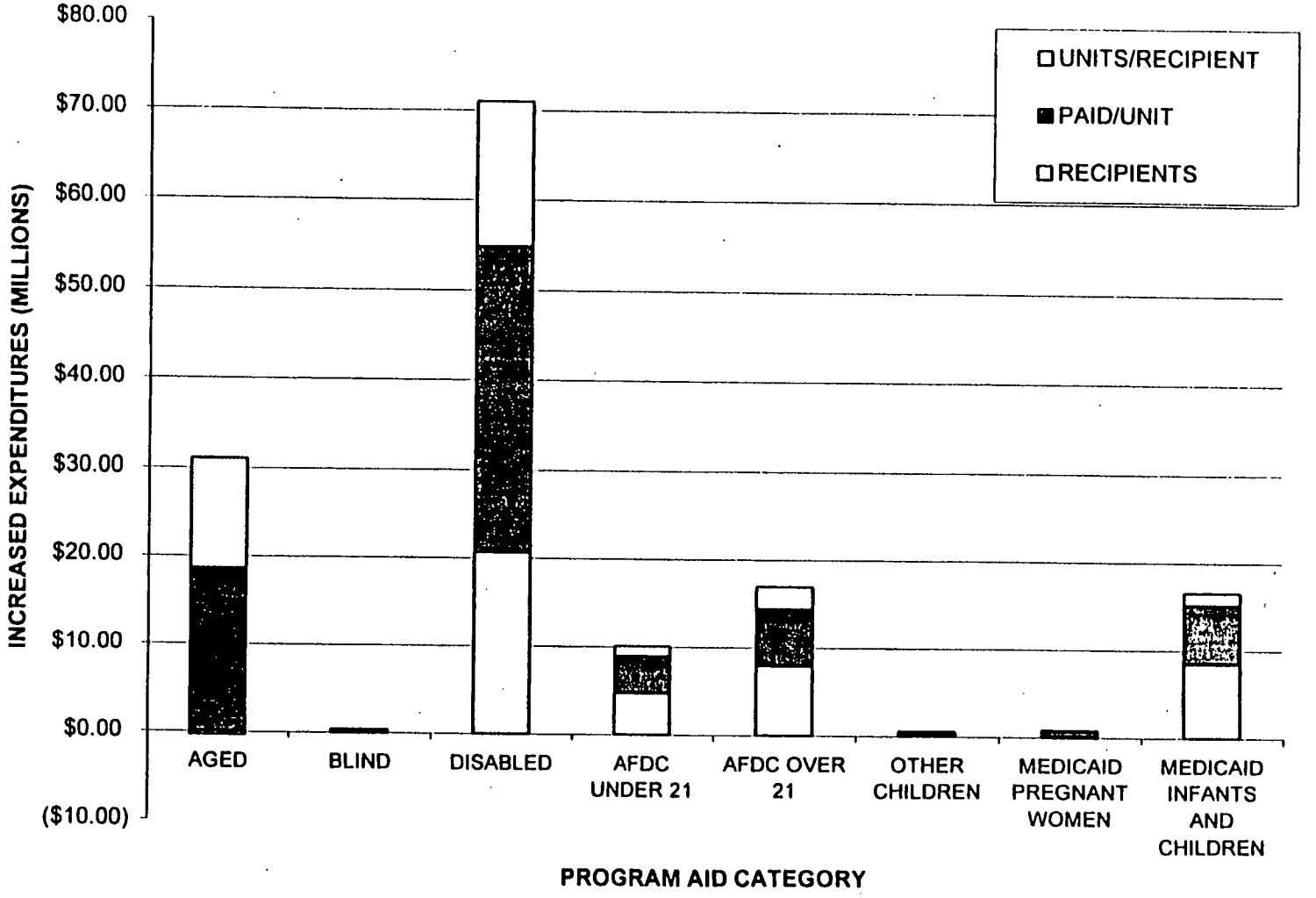
PRESCRIPTION DRUGS YEAR TO DATE JANUARY 2004	INCREASE DUE TO CHANGE IN NUMBER OF RECIPIENTS	PERCENT OF TOTAL INCREASE	INCREASE DUE TO CHANGE IN AMOUNT PAID PER SERVICE UNIT	PERCENT OF TOTAL INCREASE	INCREASE DUE TO CHANGE IN NUMBER OF UNITS USED PER RECIPIENT	PERCENT OF TOTAL INCREASE	TOTAL INCREASES BY PROGRAM AID CATEGORY	TOTAL PERCENT
AGED	($392,984)	-1.28%	$18,555,380	60.54%	$12,489,065	40.75%	$30,651,461	100.00%
BLIND	($70,231)	-23.49%	$234,708	78.49%	$134,551	45.00%	$299,028	100.00%
DISABLED	$20,592,720	29.02%	$34,263,416	48.29%	$16,098,570	22.69%	$70,954,705	100.00%
AFDC UNDER 21	$4,635,250	46.09%	$4,267,166	42.43%	$1,155,030	11.48%	$10,057,446	100.00%
AFDC OVER 21	$7,854,141	46.14%	$6,556,706	38.52%	$2,610,311	15.34%	$17,021,158	100.00%
OTHER CHILDREN	$208,393	31.37%	$395,242	59.49%	$60,737	9.14%	$664,371	100.00%
MEDICAID PREGNANT WOMEN	($42,853)	-5.37%	$691,365	86.58%	$149,977	18.78%	$798,490	100.00%
MEDICAID INFANTS AND CHILDREN	$8,459,698	50.84%	$6,735,970	40.48%	$1,444,580	8.68%	$16,640,248	100.00%

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

COMPONENTS OF 6 NON LONG TERM CARE CATEGORIES OF SERVICE
WITH HIGHEST EXPENDITURE INCREASES
YTD SFY 2004 OVER YTD SFY 2003

YEAR TO DATE JANUARY 2004 CATEGORY OF SERVICE	CHANGE IN AVERAGE MONTHLY RECIPIENTS	PERCENT OF TOTAL	CHANGE IN AVERAGE MONTHLY AMOUNT PAID PER SERVICE UNIT	PERCENT OF TOTAL	CHANGE IN AVERAGE MONTHLY UNITS CONSUMED PER RECIPIENT	PERCENT OF TOTAL	TOTAL INCREASE EXPENDITURES	PERCENT
PRESCRIBED DRUGS	$58,269,472	39.6%	$71,468,912	48.6%	$17,291,451	11.8%	$147,029,836	100%
HOSP INPT-GENERAL	$74,069,940	165.6%	$5,674,058	12.7%	($35,020,222)	-78.3%	$44,723,776	100%
PHYSICIAN	$45,945,024	64.5%	$19,524,375	27.4%	$5,769,641	8.1%	$71,239,040	100%
CLINICS-MENTAL HEALTH	$7,042,748	16.0%	($8,480,472)	-19.3%	$45,411,608	103.3%	$43,973,883	100%
CAP-MENTALLY RETARDED	($4,150,686)	307.2%	($14,734,410)	1090.7%	$17,534,140	-1297.9%	($1,350,956)	100%
HOSP OUTPT-GENERAL	$35,017,531	170.71%	($18,415,246)	-89.8%	$3,910,763	19.1%	$20,513,047	100%

COMPONENTS OF INCREASED PRESCRIPTION DRUG EXPENDITURES
YTD SFY 2004 OVER YTD SFY 2003



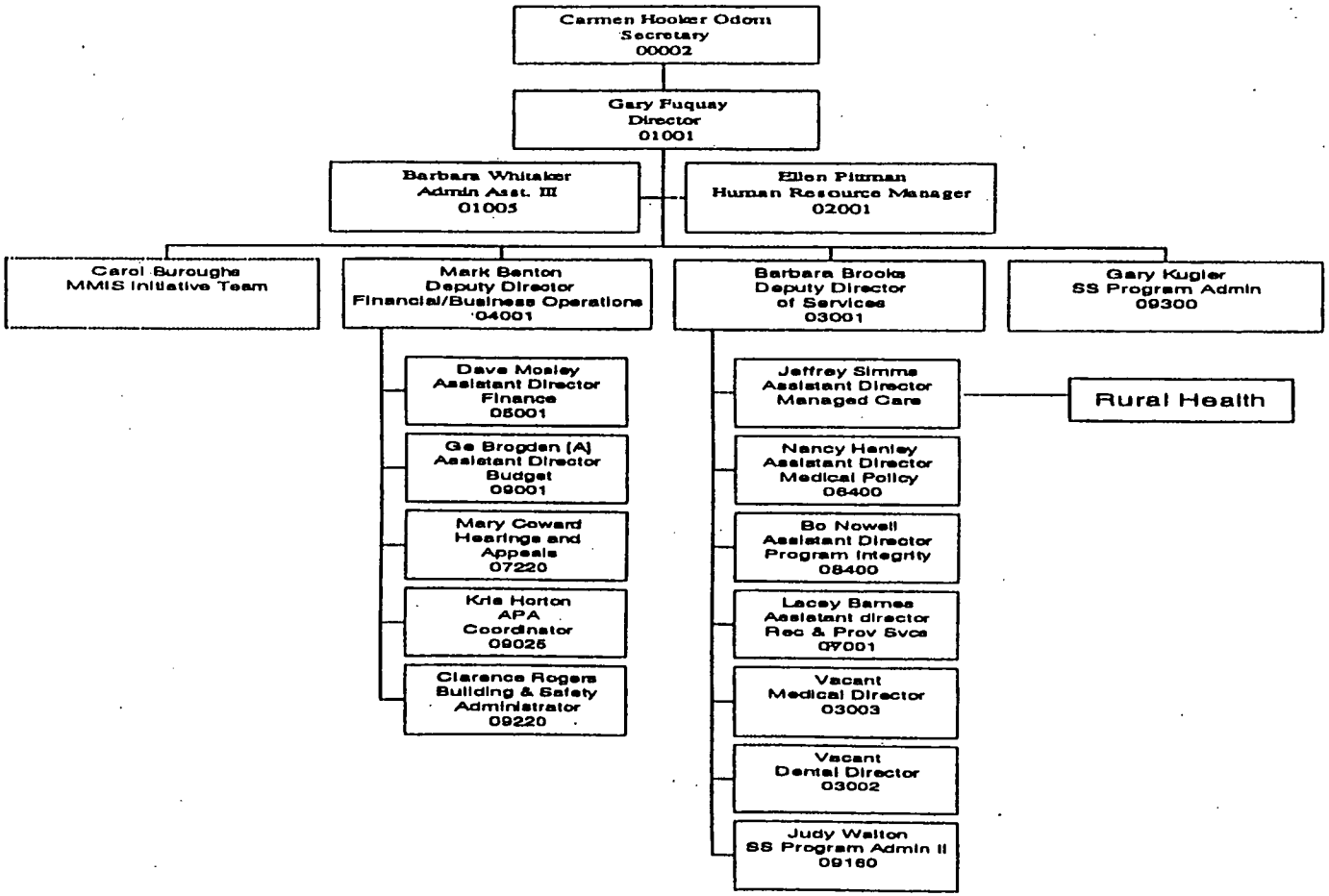
ORGANIZATION

DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

Effective Date: February 18, 2004

Gary Fuquay, DMA Director

Date 2/25/04



Summary of New Positions for DMA

04-Jan

	Position Title	Pay Grade	
1.	Pharmacy Manager II	82T	Clinical Affairs
2.	DMA Nurse II	74T	Clinical Affairs
3.	Optician	70	Clinical Affairs
4.	DMA Nurse II	74T	Clinical Affairs
5.	DMA Nurse II	74T	Clinical Affairs
6.	Medicaid Program Services Chief	74T	Clinical Affairs
7.	Dentist II	85	Clinical Affairs
8.	Physician Director III	NG	Clinical Affairs
9.	Medicaid Program Services Chief	74T	Clinical Affairs
10.	Information & Communication Spec	68	Clinical Affairs
11.	DMA Nurse II	74T	Clinical Affairs
12.	DMA Nurse I	72T	Clinical Affairs
13.	DMA Nurse Supervisor	74T	Clinical Affairs
14.	DMA Nurse I	72T	Clinical Affairs
15.	Office Assistant V	61	Clinical Affairs
16.	DMA Nurse II	74T	Clinical Affairs
17.	DMA Nurse II	74T	Clinical Affairs
18.	PH Epidemioligist	73T	Clinical Affairs
19.	DMA Nurse II	74T	Clinical Affairs
20.	Dental Hygentist II	70	Clinical Affairs

Non-Cost Containment Dollar Positions

	Position Title	Pay Grade	
1.	Accountant III	77	Finance
2.	Accountant II	75	Finance
3.	Applications Analyst Program I	76	Budget
4.	Accountant III	77	Budget
5.	Business Officer III	77	Budget
6.	Administrative Officer III	72	Budget
7.	Administrative Assistant II	65	Director's Office

Program Integrity (13 ¾)

03-September

	Position Title	Pay Grade	
1.	Processing Assistant IV	59	Provider Medical Review
2.	DMA Nurse I	72T	Provider Medical Review
3.	DMA Nurse I	72T	Provider Medical Review
4.	DMA Nurse I	72T	Provider Medical Review
5.	DMA Nurse I	72T	Provider Medical Review
6.	DMA Nurse I	72T	Provider Medical Review
7.	Program Integrity Investigator	68	Provider Admin. Review
8.	Program Integrity Investigator	68	Provider Admin. Review
9.	Program Integrity Investigator	68	Provider Admin. Review
10.	Processing Assistant V	61	Provider Admin. Review
11.	Processing Assistant V	61	Provider Admin. Review
12.	DMA Nurse I	72T	Home Care Review
13.	DMA Nurse I	72T	Home Care Review
¾	Pharmacist	77T	Pharmacy Review

PROGRAM INTEGRITY

MEDICAID PAYMENT ACCURACY MEASUREMENT BY PROGRAM INTEGRITY STAFF

1. **State Auditor Sample**: Program Integrity assists the Office of State Auditor in determining the accuracy rate for claims billed by providers to Medicaid by reviewing the medical records of the sampled claims. The State Auditor selects claims using a stratified sample for a 12-month state fiscal year of paid claims. (The current and historical rates are below.)

NC Medicaid - SFY 2005 Annual Error Rates for Claims Billed to Medicaid				
	# Of Claims in Sample	Error Rate per OSA	Confidence Level	Sampling Precision
1995-96	283	0.50%	95%	-0.04
1996-97	282	2.20%	95%	-0.04
1997-98	279	1.10%	95%	-0.04
1998-99	274	2.20%	95%	-0.04
1999-00	300	1.50%	95%	-0.04
2000-01	300	0.80%	95%	-0.04
2001-02	270	2.80%	95%	-0.04
2002-03	272	1.80%	95%	-0.04

2. **Medicaid Payment Accuracy Measurement (PAM) Demonstration Project:** HR 4878, The Improper Payments Act of 2002 requires payment accuracy measurement for claims paid with federal dollars. CMS expects to issue Payment Error Rate Measurement (PERM) regulations in late 2004 with a mandate for states to comply in 2005.

   For the past 3 years, DMA Program Integrity has participated in a Medicaid Payment Accuracy Measurement (PAM) demonstration project with the Center for Medicaid Services (CMS). The goal of the project is to help CMS determine the feasibility of estimating Medicaid claim payment accuracy for the Medicaid program at a state and national level. NC was chosen because of its long history of payment accuracy measurement activities, which was uncommon in other states.

   This project consists of a review of a stratified sample of Medicaid claims for a quarter. Program Integrity staff request medical records for the services billed to Medicaid and review to determine if the services were appropriately billed by the provider and paid correctly by Medicaid fiscal agent.

PAYMENT INTEGRITY ACCOMPLISHMENTS IN MEDICAID

NC Medicaid saved $1,329,538,709 through collections and cost avoidance in SFY 2003. DMA Program Integrity (PI), the Attorney General's Medicaid Investigation Unit, and the 100 county departments of social services worked together to achieve these savings. This was accomplished through a variety of efforts such as: PI reviews of provider billings and medical records, coordination with insurers and payers where Medicaid was not the primary payer, through estate recovery, and through legal and civil actions cooperatively with law enforcement.

- **$47 million in direct recoveries** from casualty, medical insurance and estate recovery activities was collected by Program Integrity's Third Party Recovery Section obtained. TPR also collects when insurance was unreported, authorized retroactively, or the claim was billed with incorrect information.

- **$1,026,280,066 in Medicaid payments was cost** avoided by having Medicare pay first. This is accomplished through pre-payment edits in the MMIS and updating the third party liability Medicare information

- **$214,975,840 in Medicaid payments was cost** avoided by identifying private health insurance polices that should pay before Medicaid. This is accomplished through pre-payment edits in the MMIS and continuously updating of insurance information

- **$11,268,920 was recovered** in overpayments by Program Integrity's four investigative unit efforts.

- **$14,000,000 in fines, penalties, and interest** was collected by the Attorney General's Medicaid Investigations Unit (MIU) when they concluded criminal and civil cases. The MIU gets 80% of their cases from PI investigations and use PI nurses as consultants. Money from the fines went to the State's School Fund as required by the NC Constitution. The MIU also had 31 convictions.

- **$1,683,701 was recovered by recipient fraud investigators** in the 100 county departments of social services. The State helped county investigators collect $106,801 by intercepting North Carolina income tax refund checks from delinquent debtors.

- **$14,330,182** through audits of nursing home and ICF/MR facilities by DMA Financial Operations staff.

- The Medicaid program, thanks to the work by the 100 county departments of social services, has a 99.3% accuracy rate in Medicaid eligibility determinations. Program Integrity's Medicaid Eligibility Quality Assurance Unit reviews a statewide sample of all Medicaid cases and provides feedback for corrective action to the county agencies.

- The Medicaid program has a 98.2% payment accuracy rate for the payment of Medicaid claims as determined by the Office of State Auditor. (See chart.)

NORTH CAROLINA IS ONE OF SIX PILOT STATES SELECTED FOR A SPECIAL FRAUD DETECTION PROJECT

THE MEDICAID/MEDICARE (MEDI-MEDI) FRAUD PROJECT:

In 2003, NC DMA was selected as one of six pilot states in a national project, funded by the FBI, to combine our state's Medicare and Medicaid claims into one central data warehouse -- and then data mine that information to detect fraud and abuse. *"NC was chosen because of its high level of automation and experience dealing with data mining and fraud." (Statement by Paul Miner, CMS, Program Integrity).*

North Carolina was one of the first states to have its Computer Matching Agreement (CMA) approved by CMS and transfer its Medicaid data to the central data warehouse. Data matching is currently underway. Actual sharing and investigation of the findings is expected to start in late April 2004.

Combining claims and eligibility data from Medicare and Medicaid will provide a more complete picture of beneficiary care and provider practices than can be gained by analyzing data from one program in isolation. Such access will enable CMS and DMA to apply tools and technology to look for a wide range of potential fraud and abuse that can best, or only, be found by combining the data from the utilization of benefits across both programs.

This type of analysis will enhance the ability to identify providers "flying below the radar" because their actions in one program do not arouse suspicion, however an aberration will manifest upon analyzing data culled from more than one program. Medicare and the Medicaid programs will benefit from this data matching with the identification, research, development, and referral of fraud and abuse cases to law enforcement for action and recovery of Medicare and Medicaid funds.

The Medi-Medi program is expected to reveal evidence of over-utilization of services or over-billing. Utilizing fraud detection software, the information will then be used to identify patterns of aberrant practices requiring further investigation. We expect to find the following types of aberrant practices that may constitute fraud and abuse by practitioners, providers, and suppliers:

- billing for provisions of more than 24 hours of services in one day,
- providing treatment and services in ways more statistically significant than similar practitioner groups, and
- up-coding and billing for services more expensive than those actually performed.

CMS reports that the initial California pilot project yielded a $20 to $1 return on investment. Most of the investment in this project will be made by CMS. North Carolina's investment will be in staff time used for investigation.

ABOUT THE DMA PROGRAM INTEGRITY SECTION

PROGRAM INTEGRITY OVERVIEW

- Program Integrity has **four investigative units** that use fraud and abuse detection, utilization review and other data mining software to detect overpayments. Fraud cases are sent to the Attorney General's Medicaid Investigation Unit (MIU). The PI nurses are then consultants who support the MIU's medical review and case development. PI investigative staff primarily recovers administrative overpayments by providers who bill Medicaid incorrectly or lack documentation to support their billings. They helped to recover $11,268,920 in SFY 2003.

- Program Integrity has a **payment accuracy measurement unit** that determines the accuracy (or error) rate for claims submitted to Medicaid for payment. The majority of the error is due to providers failing to submit or have documentation for the services they billed to Medicaid. This unit also coordinates the fraud and abuse detection system with the 4 investigative units above.

- Program Integrity's **Third Party Recovery section** identifies unreported insurance coverage and obtains money from those sources. It works with attorneys on liability cases to get reimbursed in those settlements. It also complies with the NC Estate Recovery law to obtain reimbursement from deceased recipients. Program Integrity's Third Party Recovery Section cost avoided Medicaid payments of $1,026,280,066 for Medicare claims and $214,975,840 for private health insurance. The unit also obtained $47 million in direct recoveries from casualty, medical insurance and estate recovery activities.

- Program Integrity's **Quality Assurance section** determines the accuracy (error) rate of recipients determined to be eligible by county departments of social services. They are also involved with corrective action for the problems found. This unit also has staff that trains, develops policy and coordinates with the 100 counties for their recipient fraud program investigations.

FRAUD AND ABUSE DETECTION SYSTEMS

In 1999, the DMA Program Integrity Unit was one of the first few states to implement a fraud and abuse detection software system. DMA PI added fraud and abuse detection (FADS) software: The FADS consists of several proprietary software applications running off four years of claims data in Medicaid's data warehouse (DRIVE).

1. **HealthSPOTLIGHT™** - is a fraud and abuse detection and reporting system with a browser-based user interface tool. It was made operational in March 2000. SPOTLIGHT's web browser-based tool allows DMA and Attorney General staff real time access to:

   - 231,495,125 claims,
   - 80,979 enrolled providers, and
   - 2,187,045 recipients who have had Medicaid eligibility at some time.

   The investigators access this data to investigate cases, organize the data, drill-to-detail levels of information, and then export that data to spreadsheets. SPOTLIGHT™ currently has:

   - **31 specific fraud filters** are algorithms that identify aberrant billing behavior. Examples: Excessive recipients per workday. Controlled drugs without an associated physician/dentist visit. Excessive hours billed per day
   - **7 modeling techniques** compare specific types of provider billings to their peers. Examples. A spike detection model looks for suspicious surges in billings. Another model uses neural or learning technology to profile providers based on data driven peer groupings.

2. **OMNIALERT™** - is a utilization review system made operational in March 2001. The software creates peer-to-peer comparisons of provider billings to identify providers billing in patterns that are excessive and unlike their peers. Providers with aberrant billings "except" out for billing above the norms for any service. These are then examined to determine if the billings are normal or improper.

3. **DRIVE – DATA WAREHOUSE** – the third part of the PI Fraud and Abuse Detection System is the Drive system. Using SAS data mining software, PI investigators are able to identify claims and conclude investigations faster.

4. **CONTRACT SERVICES** - PI also contracts with Medical Review of North Carolina for PI investigations and with PCG to assist in identifying health insurance and direct billing private insurance companies. In the coming year, PI will also be exploring more opportunities for contracting with private companies to continue to recover incorrect payments and cost avoidance savings.

SPECIFIC DUTIES OF EACH PI SECTION:

The Provider Medical Review Section supervisor nurse has seven registered nurses and one support person. This section performs post payment review of claims billed to determine if the services were medically necessary, were of acceptable quality, and conform to Medicaid coverage and billing policies.

Reviews are performed primarily on physicians and hospitals, but also on other provider types to whom Medicaid makes payments such as ambulance, optometrists, podiatrists, and rural health clinics.

Reviews are initiated from automated reports, the fraud and abuse detection system, referrals from licensing and social service agencies, and complaints from recipients and the general public. Reviews involve examination of claims/payment data, medical record documentation, and research and application of Medicaid coverage policy.

The Home Care Review Section supervisor nurse has five registered nurses and one support staff. They conduct post payment reviews of Medicaid recipients receiving home and community based services. The nurse reviewers determine if Home Health, Personal Care Services, Durable Medical Equipment, Hospice, Home Infusion Therapy, etc. are provided to recipients, medically necessary, appropriate and of high quality. Reviews are often conducted on-site unannounced.

The Pharmacy Review Section includes a registered pharmacist supervisor, three investigators, and one support staff. They conduct post payment reviews of claims on-site, recover overpayments, resolve pharmacy complaint calls and educate providers regarding policy and/or problem areas. This section also provides support and resources to Attorney General's Medicaid Investigations Unit.

The Provider Administrative Review Section (PARS) include the supervisor (a registered Dental Hygienist), three investigators, one Operations Accountant, one Operations Analyst, one Claims Processing Assessment System (CPAS) Supervisor, two CPAS analysts, and two support staff.

PARS Investigative/Operations staff perform post-payment administrative reviews of provider (except Pharmacy) claims and services to determine the

appropriateness of claim submission practices and verify providers' compliance with Medicaid coverage, billing policies and Provider Participation Agreements/contracts. Administrative reviews involve examination of claims/payment data, medical record documentation, and research and application of Medicaid coverage policy. Post payment reviews of Dental Providers include review of clinical services to determine if the services were medically necessary and were of acceptable quality. Reviews of patient personal fund issues by PARS investigator/accountant assure that Medicaid recipients residing in nursing facilities are not incorrectly billed for Medicaid covered services.

The four member Claims Processing Assessment System (CPAS) Unit reviews the claims paid by the fiscal agent to assure that payments are accurate, and that all edit/audit system deficiencies are identified for corrective actions. This unit identifies existing system edits and audits that are not working properly, as well as identifying situations where new edits and audits should be developed to prevent inappropriate payments.

The Third-Party Recovery Section and System Support Section (TPR) is primarily responsible for the recovery of Medicaid payments for services that should have been paid by health insurance plans and liability insurance. TPR is also responsible to ensure that accurate insurance information is on recipient files before Medicaid pays claims. Program Integrity's Third Party Recovery Section cost avoided Medicaid payments of $1,026,280,066 for Medicare claims and $214,975,840 for private health insurance. The unit also obtained $47 million in direct recoveries from casualty, medical insurance and estate recovery activities.

The TPR Section has 31 employees within the following units:

- Casualty Investigations: recovers Medicaid payments from other insurers due to accidental injuries, and product or medical negligence
- Post Payment: handles Credit Balance reports and audits; Estate recoveries; Medical Support Payments (IV-D); Health Insurance Premium Payments (HIPP); Medicare overpayments
- Cost Avoidance: updates recipient files for other insurance; processes claims denied for other insurance; recovers prescription drug payments; oversight of PCG contract
- Systems Support: develops queries to the Medicaid claim data warehouse (DRIVE) to support provider investigations; performs ad hoc reports of provider activities to identify areas of abuse and/or fraud; assists in maintaining the Fraud and Abuse Detection system; provides programming for TPR to use automation in place of manual processes to expedite recovery of money; collects data and provides reports of Program Integrity activities.

THIRD PARTY RECOVERY 5 YEAR REPORT (SFY)

TPR Recoveries	2003	2002	2001	2000	1999
Casualty	14,813,806	14,314,058	11,278,689	9,656,402	9,179,130
Insurance	27,543,971	28,604,553	21,507,279	29,181,323	13,414,456
Estate	4,974,281	3,792,278	2,340,126	1,690,240	1,359,498
Total	**47,332,058**	**46,710,889**	**35,126,094**	**40,527,965**	**23,953,084**
Claims Cost Avoided					
Medicare A & B	1,026,280,066	1,154,449,654	1,044,586,509	937,272,541	858,310,416
Other Insurance	214,975,840	150,835,475	172,035,219	158,002,122	101,375,000
Total	**1,241,255,906**	**1,305,285,129**	**1,216,621,728**	**1,095,274,663**	**959,685,416**
Claims Denied - Insurance					
Medicare	452,929,690	195,472,228	185,420,904	188,379,109	89,108,540
Other Insurance	126,607,140	131,001,965	159,577,884	111,704,144	101,893,406
Total	**579,536,830**	**326,474,193**	**344,998,788**	**300,083,253**	**191,001,946**
Miscellaneous					
Credit Balance Reporting	5,443,186	5,339,910	5,217,695	Not Reported	Not Reported

The Quality Assurance Section supervisor has 21 staff. Their mission includes determining the Medicaid and Health Choice (the new children's health insurance program) eligibility payment error rates and assisting in correcting problems. They also coordinate the recipient fraud investigations with the counties and handle recipient complaints and investigations of overcharging for Medicaid covered services.

Medicaid Eligibility Payment Error Rate:
The section monitors the accuracy rate of eligibility determinations in the 100 county DSS's by conducting both federally mandated and state-designed targeted reviews of recipient cases. Staff assigned and living near certain counties conducts the case reviews. The results of their reviews are used to determine error trends, identify error prone cases, and recommend corrective action as appropriate. QA data is also used to assist county supervisors and state staff in determining training needs to prevent future errors. The staff also conducts additional Corrective Action Record Reviews for each county to identify potential problem areas in the procedural process of determining eligibility.

Recipient Fraud:
The section has two policy consultants dedicated to the coordination of investigations by county Program Integrity staff of suspected recipient Medicaid fraud and abuse The consultants provide Fraud and Abuse policy, and training on prevention, detection, and recovery of Medicaid overpayments to county staff. They also provide policy for the EPICS data system, used to track all benefits overpayment collections.

Recipient Complaints:
The section also investigates Medicaid claims when the provider has billed Medicaid, and also billed the recipient. The claims investigator serves as a mediator between the recipient and the provider to identify and resolve inappropriate billing issues. If a provider is at fault and unwilling to comply with Medicaid billing requirements, a referral may be made to the Attorney General's office.

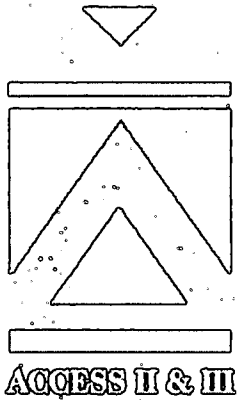
PRESCRIPTION DRUGS

Prescription Drug Cost Containment Initiatives

- **Prescription Advantage List**
  - Published by Community Care of North Carolina – lists drugs in certain classes that have lower net costs, including rebates, for Medicaid
  - Voluntary
- **Over the Counter Medications**
  - Prilosec 20 mg = $3.78 per unit
  - Prilosec OTC = .57 per unit
- **Reimbursement**
  - Medicaid reimburses brand name drugs at Average Wholesale Price (AWP) minus 10%
  - Reimbursing AWP-10% reflected an annual savings of $113,250,945 over AWP in SFY 2003
  - Drugs with multiple sources and some brands (when generics are available) are reimbursed at the State Maximum Allowable Cost (SMAC), which is typically 150% of the lowest cost source
  - Reimbursing at SMAC reflected a savings of $62,715,200 for SFY 03.
- **Generic Substitutions**
  - Medicaid provides incentives to substitute generic drugs whenever possible
  - Copays: $1 for generic, $3 for brand
  - Dispensing fees: $5.60 for generic, $4.00 for brand
- **Prior Authorization**
  - Medicaid has a contractor which manages the prior authorization process for 13 classes of high cost drugs
  - Prior authorizing these drugs during March-December 2002 resulted in $13,231,988 savings over the same period in
  - Oxycontin savings = $3,592,347
  - Vioxx/Celebrex/Bextra savings = $7,619,269
- **Polypharmacy**
  - Initiatives for managing recipients on multiple medications are being implemented in nursing facilities, physician practices and adult care homes.
- **Drug Utilization Review and Pharmacy and Therapeutics Committees**
  - Medicaid has active committees which advise on pharmacy policy and monitor drug utilization and provider practice patterns
- **Provider Reimbursement** – State MAC was implemented in 2002
- **Utilization Management** - A contract to prior authorize 13 classes of drugs became effective in 2002.

APPENDIX D

Community Care of North Carolina



PRESENTATION TO:
North Carolina Legislative
Blue Ribbon Commission on Medicaid Reform
March 24, 2004
L. Allen Dobson ,Jr. MD

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Primary Goals

- *Improve the care of the Medicaid population while controlling costs*
- *Develop Community based networks capable of managing populations*

Goals Achieved By:

- Making Sure People Get Care When They Need It
- Increasing local provider collaboration
- Obtaining Quality Care
- Implementing Best Practice Guidelines
- Managing Medicaid Costs

Options for Medicaid

- State Operated
- Contracted Out
- Locally Run

Basic Operating Premise

- Regardless of who manages Medicaid, the hospitals, physicians and safety net providers in NC serving patients remain the same and must be engaged
- We need to transform Medicaid management from a regulatory function to a health management function
- We must carefully balance cost containment with quality improvement efforts
- Decision making must be driven by data & outcomes monitored

Community Care of North Carolina

Build on ACCESS I

- Joins other community providers (hospitals, health departments and departments of social services) with physicians
- Creates community networks that assume responsibility for managing recipient care

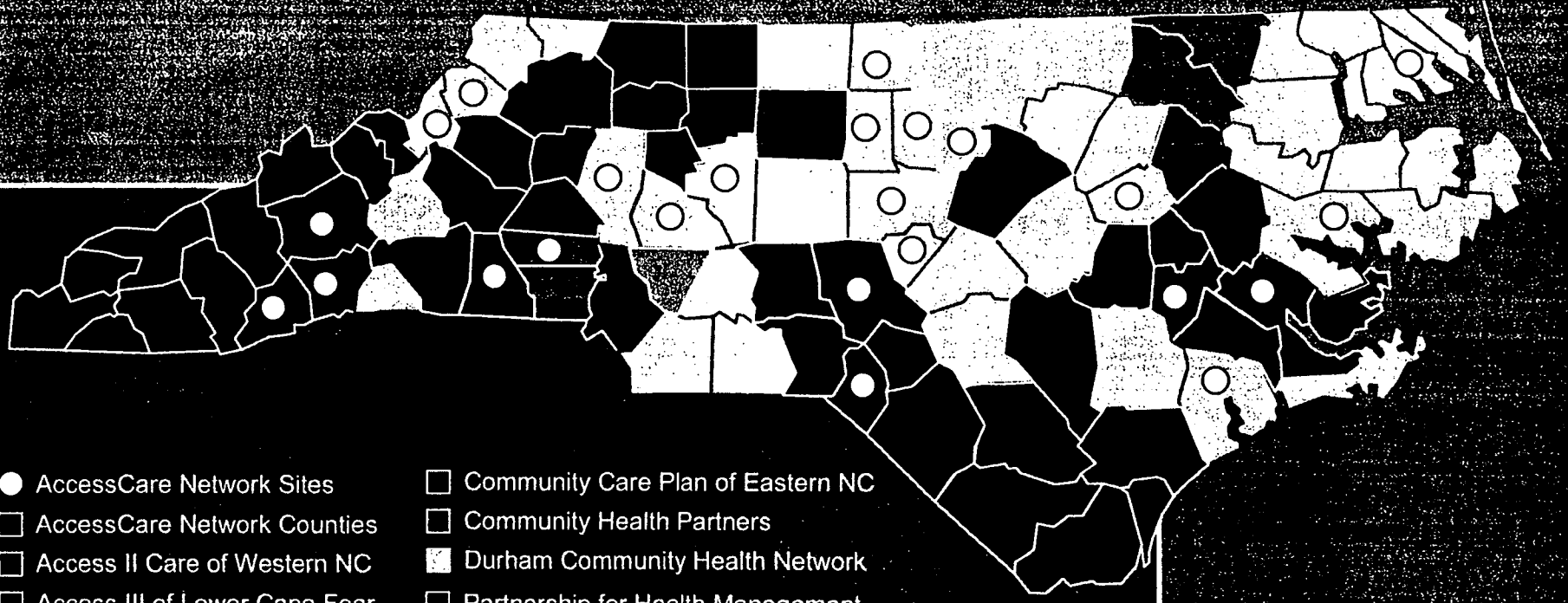
Community Care of North Carolina

- Focuses on improved quality, utilization and cost effectiveness
- 13 Networks with more than 3000 physicians
- 519,000 enrollees

CCNC ♥ 2004

Community Care of North Carolina

Access II and III Networks – 3/04



- AccessCare Network Sites
- AccessCare Network Counties
- Access II Care of Western NC
- Access III of Lower Cape Fear
- Cabarrus Community Care Plan
- Central Piedmont Access II
- Carolina Community Health Partnership
- Community Care Plan of Eastern NC
- Community Health Partners
- Durham Community Health Network
- Partnership for Health Management
- Sandhills Community Care Network
- Wake County Access II

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Community Care Networks:

- Non-profit organizations
- Includes all providers including safety net providers
- Steering/Governance committee
- Medical management committee
- Receive $2.50 PM/PM from the State
- Hire care managers/medical management staff

What Networks Do

- Assume responsibility for Medicaid recipients
- Identify costly patients and costly services
- Develop and implement plans to manage utilization and cost
- Create the local systems to improve care & reduce variability
- Implement improved care management and disease management systems

Key Program Areas in Managing Clinical Care:

- Implementing quality improvement — Best practice processes
- Implementing disease management
- Managing high-risk patients
- Managing high-cost services
- Building accountability through monitoring & reporting

Managing Clinical Care

Clinical Directors Group (I)

- Select targeted diseases/care processes
- Review evidenced-based practice guidelines
- Define the program
- Establish program measures

- ASTHMA
- DIABETES
- PHARMACY
- HIGH-RISK & -COST
- ED

Local Medical Mgmt. Comm. (II)

- Implement state-level initiatives
- Develop local improvement initiatives

- GASTRO-ENTERITIS
- FEVER
- OTITIS MEDIA
- DEPRESSION
- CHILD DEVELOPMENT
- LOW BIRTH WEIGHT
- ADHD
- ANCILLARY SERVICES

(III) **PRACTICE A** | **PRACTICE B** | **PRACTICE C**

Care Managers and Access I and III quality improvement staff support clinical and targeted activities

Improving Quality
"Disease Management"

Current Disease Management Initiatives

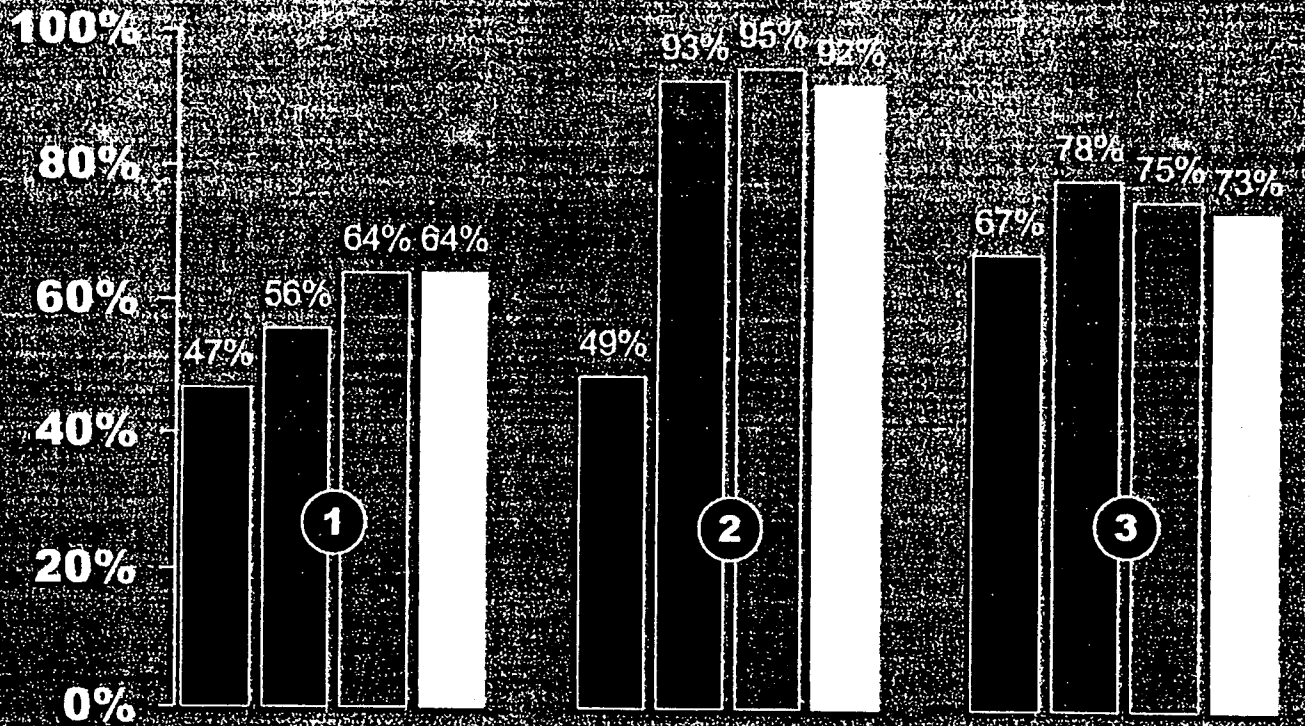
- Asthma
- Diabetes
- Pilots in Depression, ADHD, Special Needs Children, Gastroenteritis, Otitis Media and Low Birth Weight

Asthma Initiative

- First program initiative – began Jan. 1999
- Adopted best practice guidelines (NIH)
- Implemented continuous quality improvement processes at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback

Asthma Initiative

Process Measures



Key

1. No. with asthma who had documentation of staging
2. No. staged II – IV on inhaled corticosteroids
3. No. staged II – IV who have an AAP

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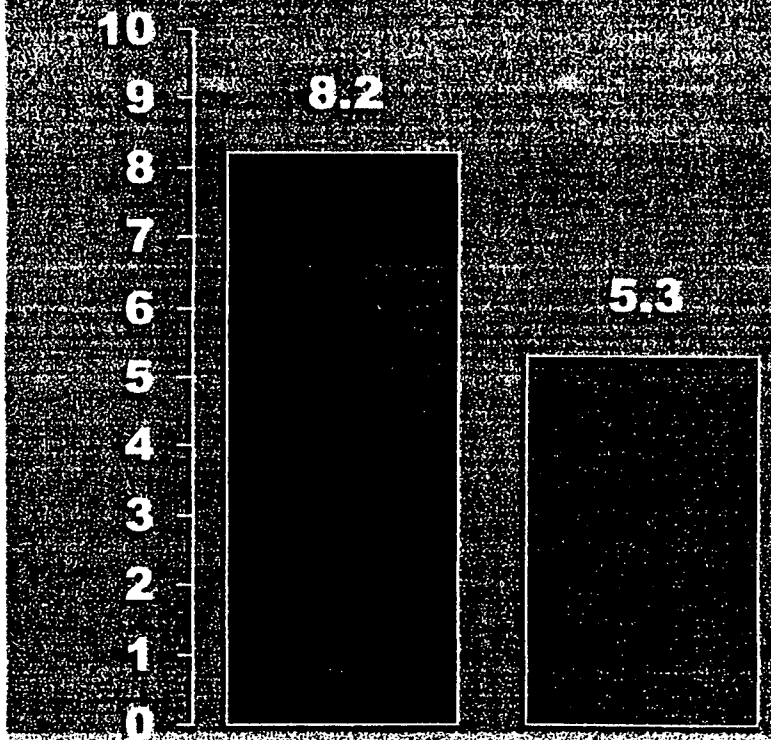
Asthma Initiative

Pediatric Asthma Hospitalization Rates

April 2000 - December 2002



Key

In patient admission rate per 1000 member months

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SOURCE: February 20, 2004 Sheps Center Report

Evaluation of CCNC Asthma and Diabetes Management Initiative (January 2000 – December 2002)

Asthma DM Findings from Sheps:

- Per member per month (pmpm) costs for CCNC asthma patients consistently lower than Access program
- 2.6%-2.7% lower pmpm costs
- 21%-23% lower hospital admissions

Asthma DM Findings from Sheps:

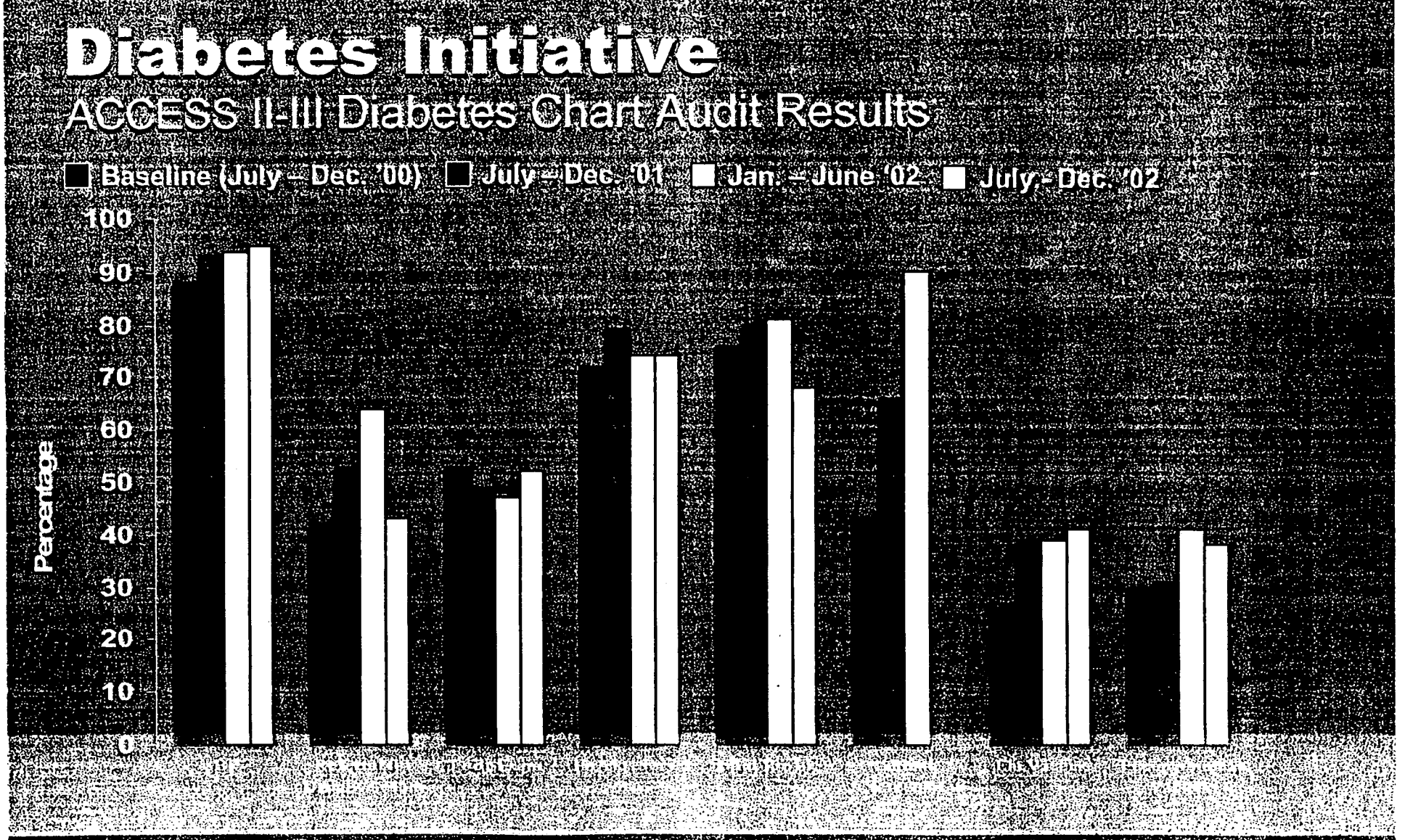
- CY 2000 Annual Savings $ 290,000
- CY 2001 Annual Savings $ 1,470,000
- CY 2002 Annual Savings $ 1,580,000

Diabetes Initiative

- Second program-wide initiative – began July 2000
- Adopted best practice guidelines (ADA)
- Implement continuous quality improvement processes at each practice
- Physicians set performance measures
- Provide regular monitoring and feedback

Diabetes Initiative

ACCESS II-III Diabetes Chart Audit Results



SOURCE: February 20, 2004 Sheps Center Report

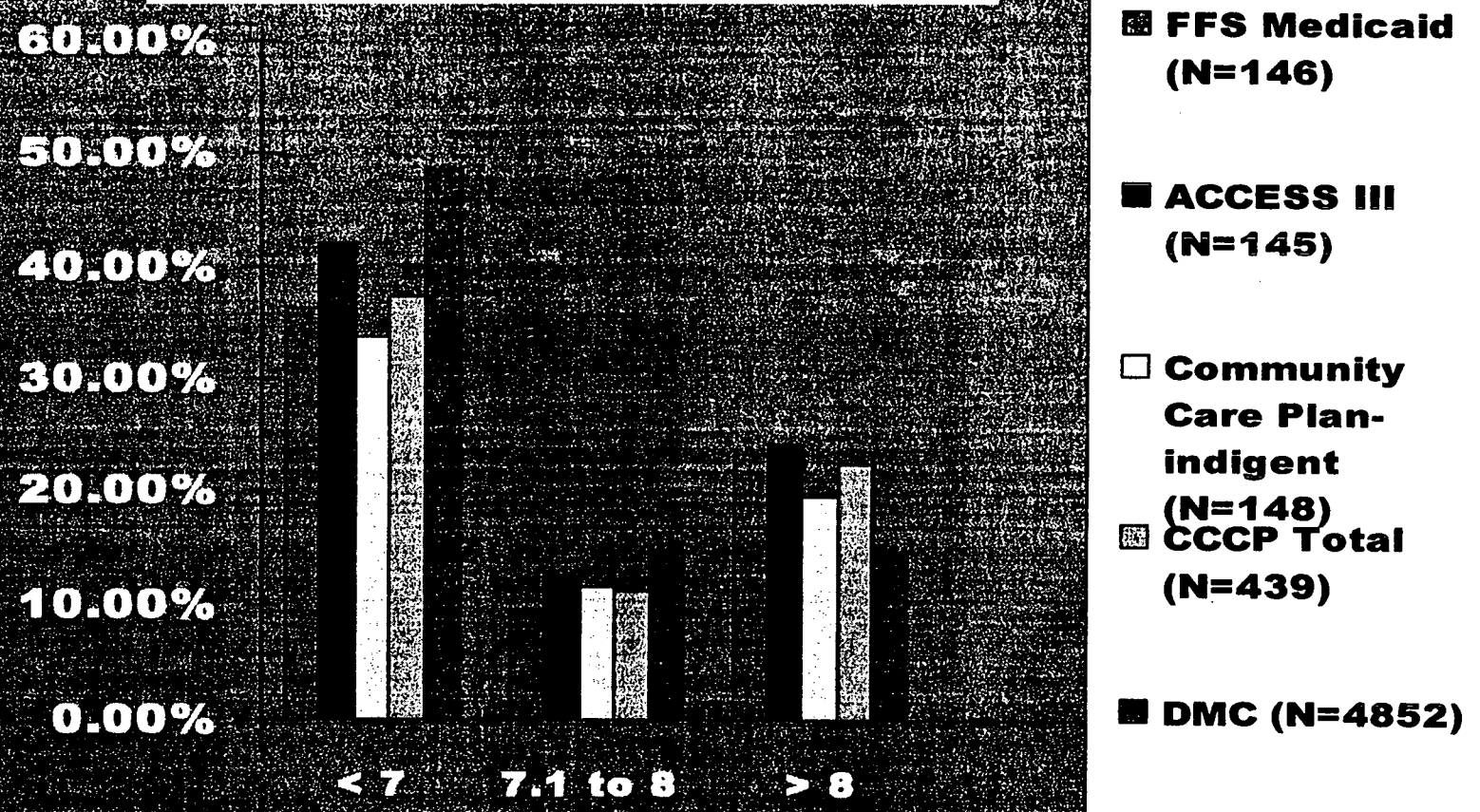
Diabetes Disease Management Findings:

- Overall pmpm costs for CCNC diabetes lower than Access
- 9% lower hospital admissions

Diabetes DM Findings from Sheps:

- Cost savings for diabetes care for 3 year period approximately $2.1 million
- Potential > $11.3 million total savings in 2003 if CCNC were statewide with asthma and diabetes DM

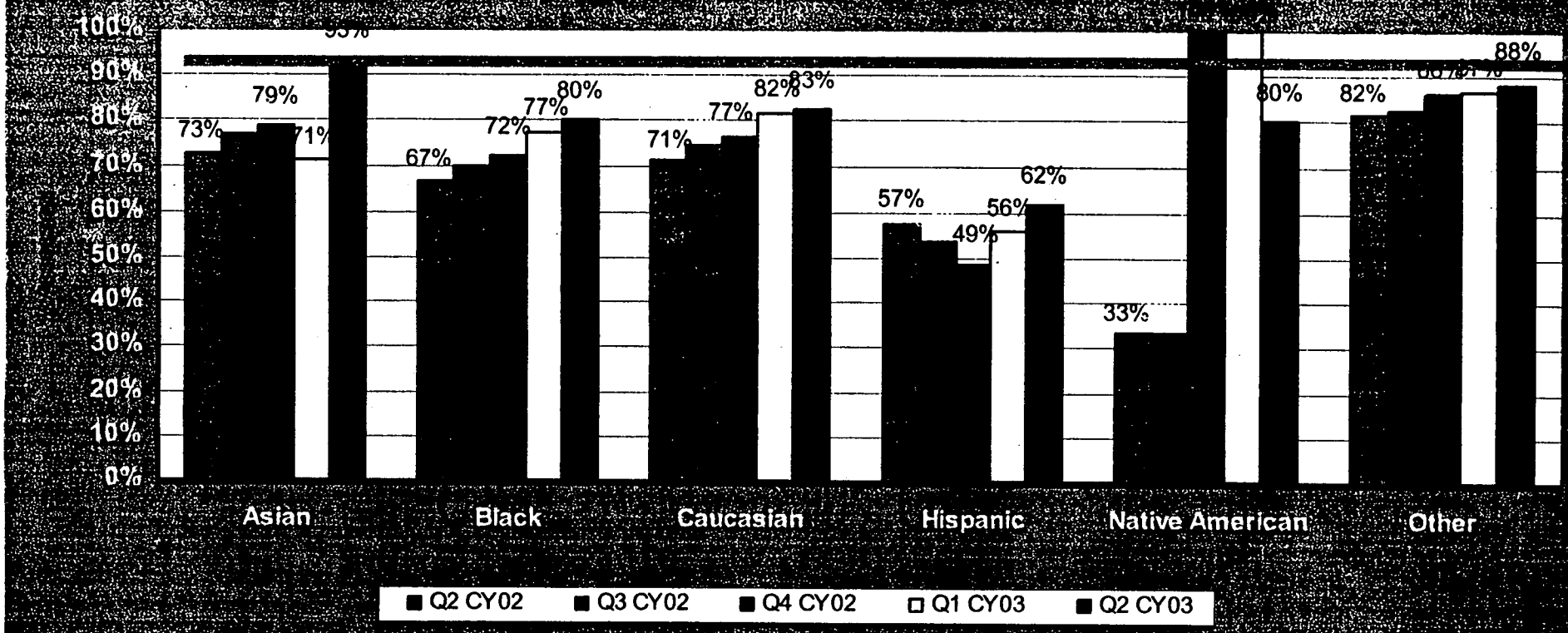
Cabarrus HbA1C levels



Community Care of North Carolina

CCNC ▼ 2004 ▼

Aspirin Documentation - Comparative by Race



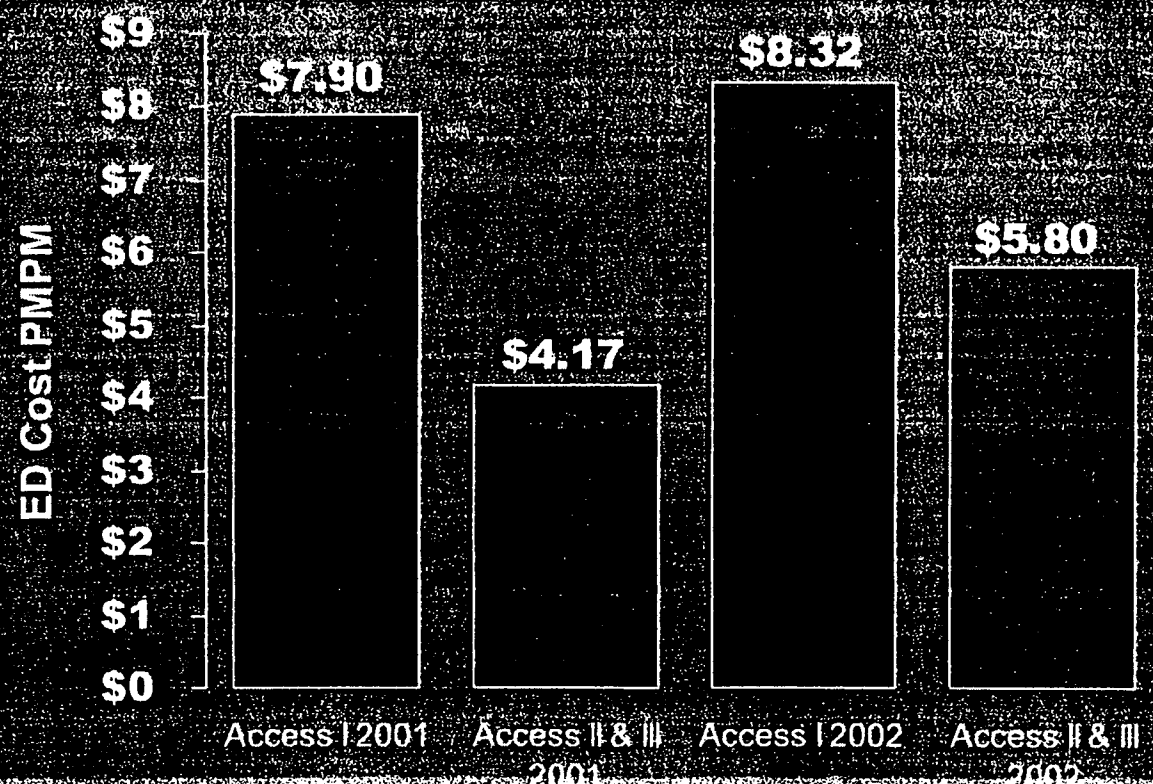
Managing Costs
"Targeted Approach"

Managing High-Cost Services:

- Pharmacy
  - Nursing home polypharmacy
  - PAL
  - Ambulatory polypharmacy
- Emergency Department
- Ancillary Services
- In-home Care

ED Initiative

ED Cost PMPM – 7/1/01 – 6/30/02 – Children < 21 years



Savings Calculation

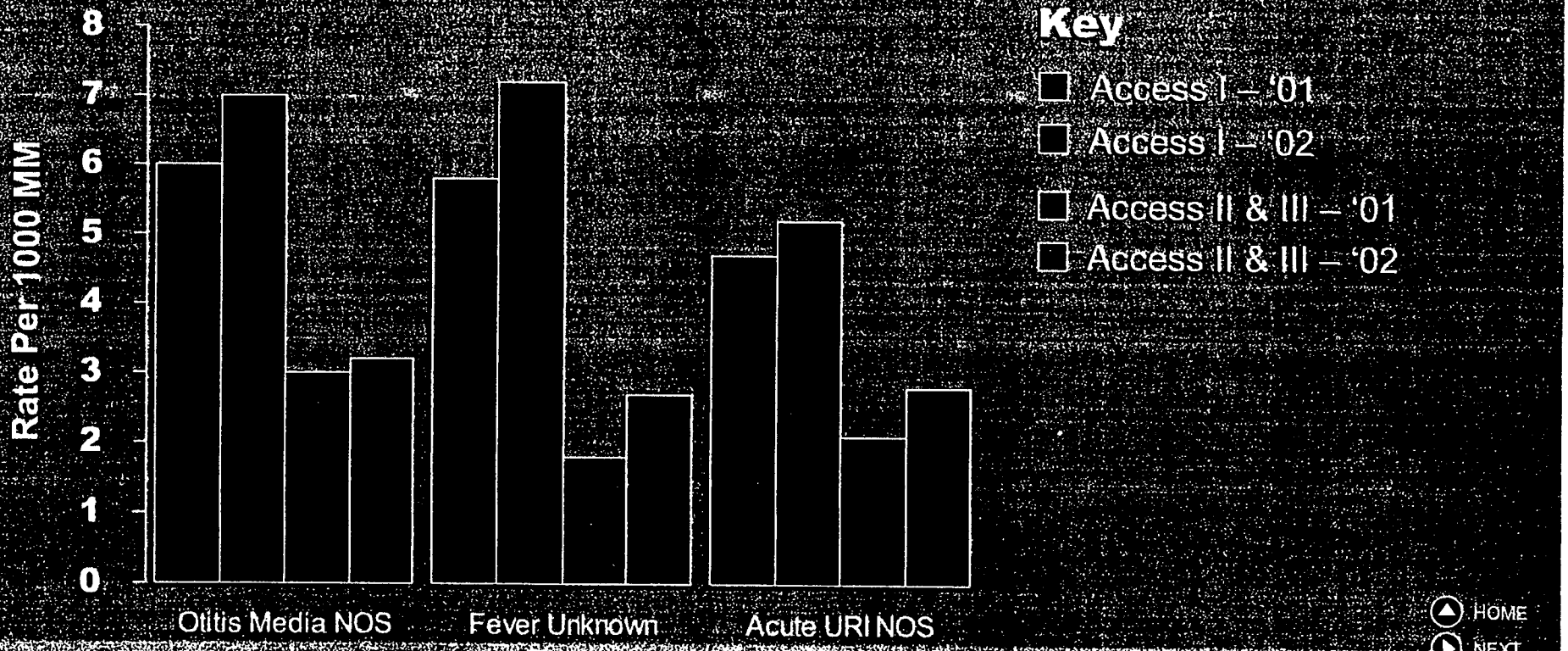
(Access I PMPM – Access II-III) x Access II-III Enrollment

Total Savings – '01-'02

$10,362,190

ED Initiative

Top 3 ED Dx Rates – 7/1/01 – 6/30/02 – Children ≤ 21 years



Therapies Management Pilot

Project Goals:

- Provide appropriate therapy to meet specific functional deficits
- Decrease delays in services
- Encourage interdisciplinary team approach to care
- Manage medical expenditures more efficiently

Therapies Management Pilot

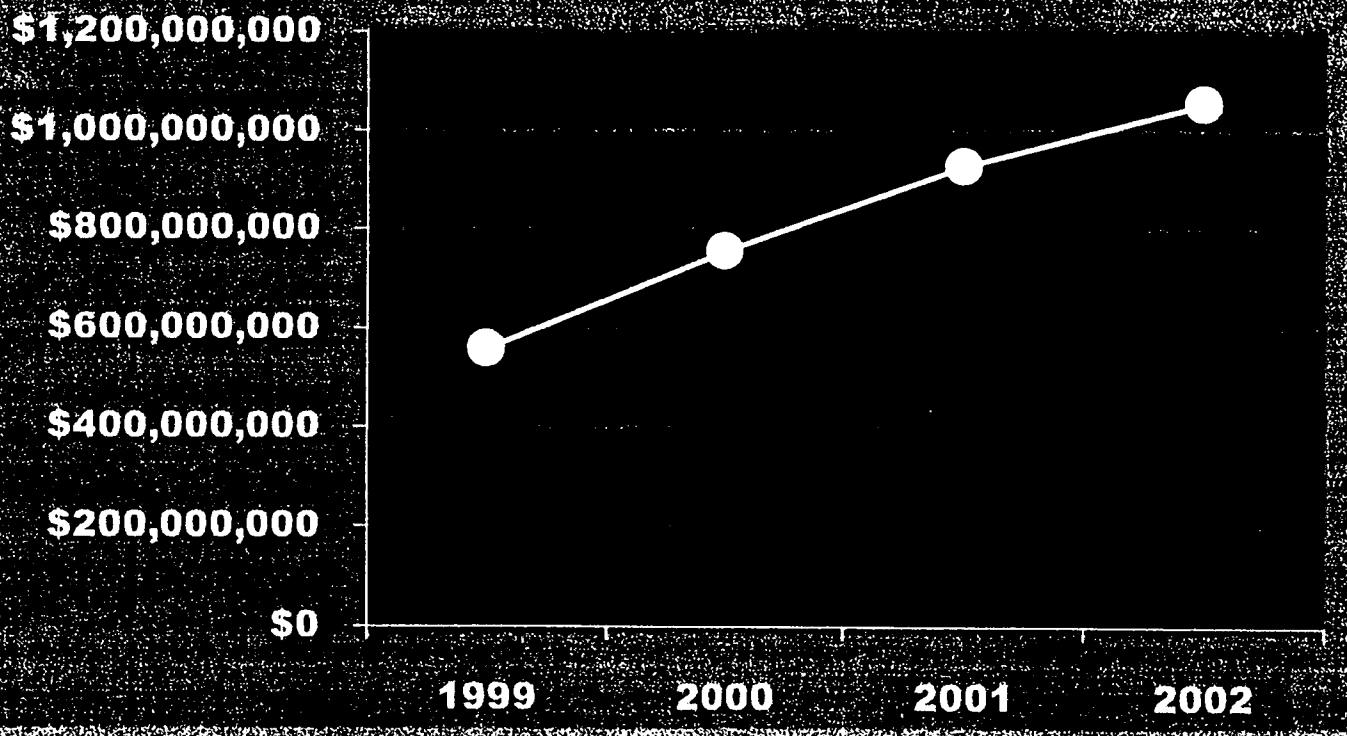
Preliminary Results – April-August 2003

	# of Requests	Units Saved	Amount Saved
Speech	260	955	$14,325
PT	84	184	$2,760
OT	89	206	$3,090
RT	25	19,376	$61,140
Totals Combined	458	20,721	$81,315

Cost Effective Prescribing 2003

"How to make a difference in rising prescription drug costs!"

NC Medicaid Expenditures: Prescription Drugs



FY99
$557,772,670

FY00
$754,505,194

FY01
$927,240,693

FY02
$1,056,158,750

Process – PAL

- Pharmacy committee defines drug classes and unit doses
- Medicaid calculates relative drug cost and rank (AWP)
- Inform Access II and III physicians
- Measure changes in prescribing patterns
- State-wide rollout began Nov 2003

PAL — Prescription Advantage List

Access II and III Prescription Advantage List

The Prescription Advantage List (PAL) was developed by the Access II and III Medical Directors team to improve the outcomes of prescribing practices within Access II and III programs. By analysis of RAP of interactions, the group has identified a series of medications categorized as Tier 1 drugs – that offer a level of cost savings for the Access II and III programs.

While there is voluntary, Access II and III Medical Director hope you will prescribe Tier 1 drugs whenever possible and medically appropriate.

ACE Inhibitors

Drug name	PAL
captopril	1
enalapril	1
lisinopril	1

Macrolides

Drug name	PAL
Erythromycin Stearate Filmtab	1
erythromycin base	1
Erythrocin (Ethylsuccinate)	1
erythromycin ethylsuccinate	1
E.E.S	1
erythromycin delayed release capsule	1
erythromycin stearate	1
Zithromax 3 PAK	3
Biaxin XL	2
Biaxin	2
Ery-Ped	2
Ery-Tab	2
E-Mycin	2
P.C.E.	2
Zithromax	2
Zithromax Tri-Pak	3

Fluoroquinolones

Drug name	PAL
Maxaquin	1
Noroxin	1
Cipro	2
Levaquin	2
Tequin	2

HMG-CoA Reductase Inhibitors (Statins)

Drug name	PAL
lovastatin	1
Lescol	2
Lescol XL	2
Lipitor	2

Inhaled Beta Agonists and Combinations

Drug name	PAL
albuterol MDI	1
albuterol neb. soln	1
Combivent MDI	1
Serevent	2
Serevent Diskus	2
Maxair Autohaler	2
Foradil	2

Inhaled Corticosteroids and Combinations

Drug name	PAL
Pulmicort Turbuhaler	1
Flovent 220mcg MDI	1
Advair	1
Pulmicort Respules	2
Aerobid, Aerobid M	2
Flovent 110mcg MDI	2
Flovent Respules 100mcg	2
Flovent Respules 220mcg	2
Azmacort	2

Proton Pump Inhibitors

Drug name	PAL
Protonix	1
AcipHex	2
Prevacid	2
Nexium	2
Prilosec	2

SSRIs

Drug name	PAL
fluoxetine	1
Celexa	2
Paxil	2
Zoloft	2
Citalopram	2
Lexapro	2
Paxil CR	2

H2 Antagonists

Drug name	PAL
ranitidine	1
famotidine	1
cimetidine	1
Zantac	2
Pepcid	2
Tagamet	2
Axid	2
nizatidine	1

Non-sedating Antihistamines

Drug name	PAL
Allegra	1
Zyrtec	1
Claritex	2
Claritin	2
Claritin Redidose	2

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Preliminary Pilot Findings

- PAL pilot rolled out between December 2002 and January 2003
- Post-rollout period (February-March 2003) – 22% lower expenditures compared to pre-rollout (September – October 2002)
- Actual pilot savings - $640,000

Anticipated Savings

- PAL- $ 30 -40 million annual savings expected
- Other Pharmacy Management/Policy Initiatives:
  - *Selected Prior Approval*
  - *Selected OTC coverage*
  - *Six Drug Limit Policy revision*

Nursing Home Polypharmacy Initiative

Community Care of North Carolina

Intervention

Pharmacist / Physician Teams

- Review drug profiles / medical records of Medicaid patients in nursing homes
- Determine if a drug therapy problem exists
- Recommend a change
- Perform follow-up to determine if change was made

Screening Criteria

- Nursing home residents with . . .
  - >18 drugs used in a 90 day period
- 9208 residents met this criteria
- Medicaid database uses criteria to flag charts

Flagging Criteria

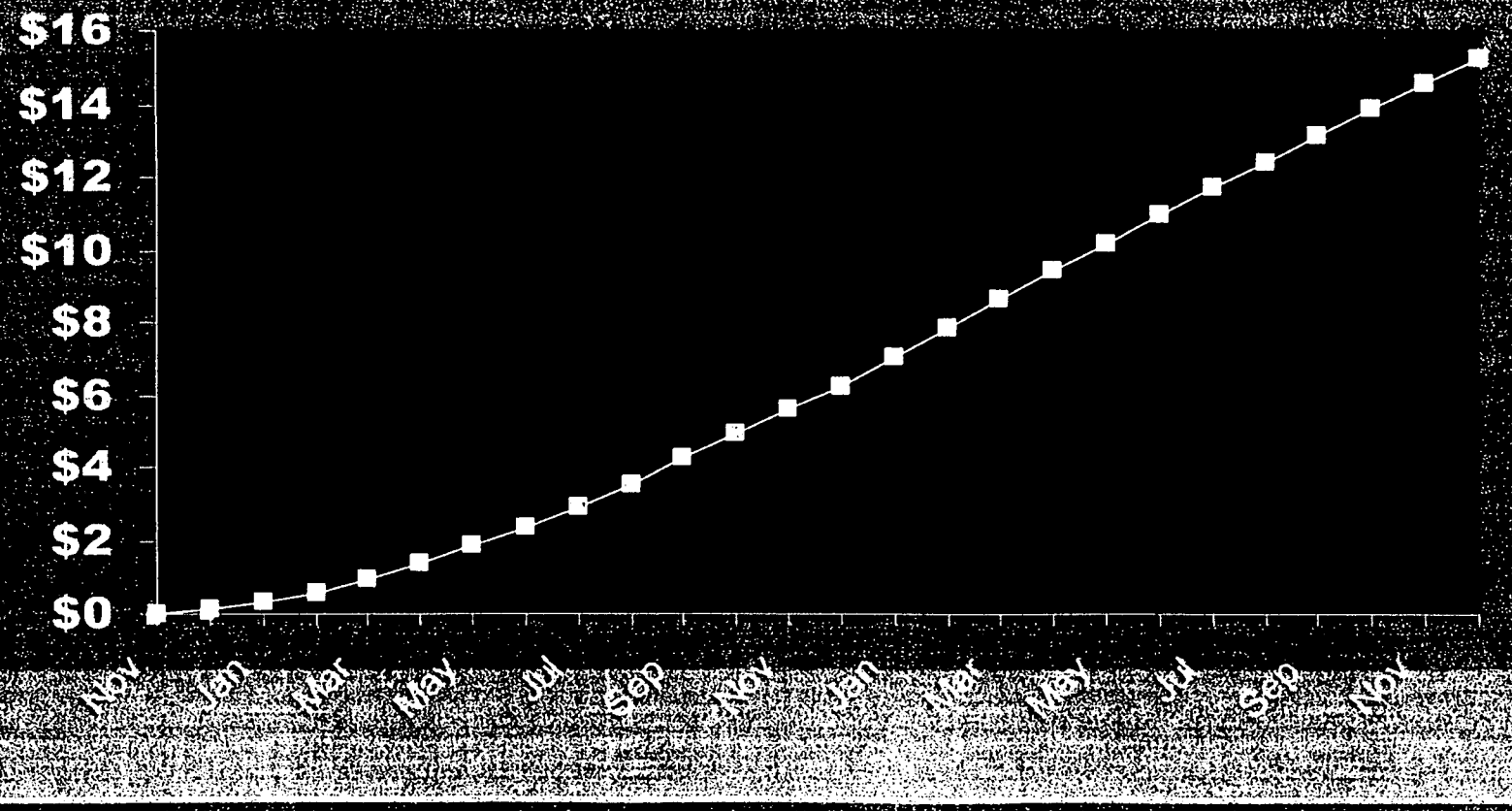
- Inappropriate Rx for the elderly "Beers drugs"
- Drugs used beyond usual time limit
- Drug Use Warnings & precautions
- Prescription Advantage List "PAL"
- Potential Therapeutic Duplication

Preliminary Findings

- Patients reviewed: 9208
- Recommendations made: 8559
  - Unnecessary therapy – 19%
  - More cost effective drug – 56%
  - Wrong dose – 7%
  - Potential adverse reaction – 9%
  - Needs additional therapy – 3%
  - Other – 6%
- Recommendations implemented: 6359 (74%)

Potential Cumulative Savings from Interventions

Dollars in Millions



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Summary

- Based on findings to date
  - A pharmacist-MD team cuts cost & ups quality
  - The cost savings potential is substantial
  - Further opportunities for drug cost savings:
    - Expand to all NH and assisted living patients in NC
    - Expand the # of medications eligible
  - Evaluation is being conducted by UNC School of Pharmacy

Cost/Benefit Estimates

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2003

U D

BILL DRAFT 2003-LCz-187 [v.5] (03/25)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/6/2004 11:10:14 AM

Short Title: Tax Credit for Long-term Care Insurance.	(Public)
Sponsors: Unknown.	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON THE LONG-TERM CARE INSURANCE TAX CREDIT AND MODIFY THE CREDIT.

The General Assembly of North Carolina enacts:

SECTION 1. Section 29A.6(d) of S.L. 1998-212 reads as rewritten:

"(d) Subsection (a) of this section is effective for taxable years beginning on or after ~~January 1, 1999, and expires for taxable years beginning on or after January 1, 2004.~~ January 1, 1999. The remainder of this section is effective when it becomes law. ~~G.S. 105-160.3(b)(7), as enacted by this act, is repealed effective for taxable years beginning on or after January 1, 2004.~~"

SECTION 2. It is the intent of the General Assembly that, to the extent the Department of Revenue can do so without incurring programming, design, or printing costs, the Department require a taxpayer claiming the credit under G.S. 105-151.28 to list the insurance company and policy number of the policy for which a credit is claimed.

SECTION 3. This act becomes effective for taxable years beginning on or after January 1, 2004.

MEDICAID COST ALLOCATION AMOUNTS BY STATE[1]

STATE	Annualized Medicaid Cost Allocation Amounts
ALABAMA	1,370
ALASKA	902
ARIZONA	4,000
ARKANSAS	1,110
CALIFORNIA	68,800
COLORADO	2,403
CONNECTICUT	2,500
DELAWARE	677
FLORIDA	14,409
GEORGIA	961
HAWAII	990
IDAHO	752
ILLINOIS	11,511
INDIANA	3,000
IOWA	-
KANSAS	1,600
KENTUCKY	2,960
LOUISIANA	877
MAINE	760
MARYLAND	5,380
MASSACHUSETTS	9,482
MICHIGAN	8,296
MINNESOTA	2,240
MISSISSIPPI	1,441
MISSOURI	-
MONTANA	445
NEBRASKA	318
NEVADA	1,330
NEW HAMPSHIRE	584
NEW JERSEY	14,200
NEW MEXICO	1,350
NEW YORK	46,340
NORTH CAROLINA	7,978
NORTH DAKOTA	350
OHIO	11,950
OKLAHOMA	4,120
OREGON	3,900
PENNSYLVANIA	-
RHODE ISLAND	1,121
SOUTH CAROLINA	1,479
SOUTH DAKOTA	377
TENNESSEE	2,510
TEXAS	-
UTAH	995
VERMONT	440
VIRGINIA	-
WASHINGTON	6,240
WEST VIRGINIA	563
WISCONSIN	5,570
WYOMING	302
DISTRICT OF COLUMBIA	1,620
UNITED STATES TOTAL	260,503

Source: "Medicaid Reductions for Transitional Medical Assistance," Federal Funds Information for States (FFIS), 2002

[1] The original federal savings was estimated to be $300 million, however, after the state appeals process was completed, the federal savings was reduced to just over $260 million. The state-by-state numbers in the chart reflect the post-appeal amount.

Education Reform Act of 1997 (P.L. 105-185). The Act required that the Secretary of Health and Human Services (HHS), in consultation with the Secretary of Agriculture (USDA), to determine the costs charged to the former AFDC program in states' TANF base year that could have been allocated to Food Stamps and Medicaid for common administrative costs. The attached chart provides a state-by-state breakdown of the Medicaid "cost allocation" amounts determined through this process. The numbers reflected in the chart are the final determinations after all state appeals had been addressed.

The Act provided that the amounts attributable to Food Stamps were to be deducted from state Food Stamp administrative cost claims for FY 1999-FY 2002. The Act did not require similar treatment for the Medicaid costs identified.

The Farm Security and Rural Investment Act of 2002 (P.L. 107-171)

When the Farm Bill was reauthorized in 2002, cost allocation for the Food Stamp Program was made permanent.

Reauthorization of the Temporary Assistance for Need Families (TANF) Program

In 2002 when the House of Representatives first enacted legislation reauthorizing TANF, H.R. 4737, the Personal Responsibility, Work, and Family Promotion Act of 2002, it proposed to extend the Transitional Medical Assistance (TMA) program and to fund the TMA extension with federal funds obtained through Medicaid "cost allocation." This proposal mirrored a proposal by President Bush in his FY 2003 budget proposal.

Last year, the President did not include the Medicaid "cost allocation" proposal in his FY 2004 budget submission. The House of Representatives passed another TANF reauthorization bill in February 2004, H.R. 4, which continues to include the Medicaid "cost allocation" provision. The FY 2004 Congressional budget resolution provides funding for the TMA extension from the federal general fund, making the "cost allocation" proposal in the House TANF reauthorization bill unnecessary. The Senate Finance Committee reported its version of the TANF reauthorization in September 2003. That bill does not include the Medicaid "cost allocation" provision. As you know final action on the TANF reauthorization bill has not occurred. The program has been temporarily extended until March 31, 2004, pending final action on reauthorizing legislation.

The FY 2005 Federal Budget

Last proposed as part of the FY 2003 budget, the Administration is again proposing to reduce federal reimbursement for Medicaid administrative costs to reflect the share assumed in the TANF block grant. States would be prohibited from using TANF funds to pay these costs during FY 2005. The Congress has not enacted a budget resolution to date.

State Impact

The attached chart (see page 3) provides state-by-state information on the annual Medicaid cost allocation amounts identified according to the provisions of P.L. 105-185. The chart reflects the figures that were finally settled on after states went through an appeals process. While the Medicaid cost allocation provision proposed in the FY 2005 budget is for one year only, it is instructive to remember that the Food Stamp cost allocation provision was also supposed to be a temporary provision.

Laws & Bills

- ***Personal Responsibility and Work Opportunity Act of 1996 (P.L. 104-193)***
- ***The Agricultural Research, Extension, and Education Reform Act of 1997 (P.L. 105-185)***
- ***The Farm Security and Rural Investment Act of 2002 (P.L. 107-171)***
- ***The Personal Responsibility, Work, and Family Promotion Act of 2002 (H.R. 4737)***
- ***The Personal Responsibility, Work, and Family Promotion Act of 2003(H.R. 4)***

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NCSL Staff Contacts:

- Joy Johnson Wilson, Health Policy Director
- Rachel Morgan, R.N., Senior Health Policy Specialist

NCSL

National Conference of State Legislatures 444 North Capitol Street, N.W., Suite 515 Washington, D.C. 20001
202-624-5400 202-737-1069 (fax)

February 11, 2004

MEDICAID COST ALLOCATION—A BACKGROUNDER

THE ISSUE

President Bush submitted his proposed FY 2005 federal budget to Congress on February 4, 2004. Among the many proposals was one to apply "cost allocation" to the Medicaid program, saving the federal government and costing states $300 million in FY 2005. For the uninitiated, Medicaid "cost allocation" is an esoteric concept. This backgrounder attempts to simplify the concept and describe the potential impact of the proposal if enacted.

BACKGROUND

The Personal Responsibility and Work Opportunity Act of 1996 (PWORA) converted the former Aid to Families with Dependent Children (AFDC) entitlement program into the Temporary Assistance to Needy Families (TANF) program, a block grant to states. Each state's TANF funding was based on the higher of: (1) actual state expenditures in either FY 1994 or FY 1995; or (2) an average of state expenditures between FY 1992-FY 1999.

Administrative Cost Allocation

Prior to passage of TANF, states administered the AFDC, Food Stamp and Medicaid programs and the federal government reimbursed them for half of all administrative costs. The largest component of administrative costs was the cost of certifying eligible households. The federal government matched the states' administrative expenses for all of these programs on a 50/50 basis.

Because of the overlap in eligible populations, states often undertake administrative activities that benefit more than one program. For example, when a household applies for TANF, Medicaid, and food stamps, collecting information on the household's income is necessary for all programs and is usually done during a combined eligibility interview. The process of allocating shared administrative costs among various state and federal programs is known as **cost allocation**.

The general rules for allocating costs are prescribed by regulation in OMB Circular A 87. These rules require that costs that are incurred for more than one program be allocated based on the extent to which the various programs benefit from the activity. This is called the "benefiting program" approach. Under this approach, a cost that is equally necessary for more than one program is shared equally by the programs.

The history of the public welfare programs led to an exception to this general cost allocation rule. When Congress created Medicaid and Food Stamps, it assumed that large portions of the administrative work for households that received AFDC was already done for AFDC and that these newer programs could piggy-back on that work. As a result, in the case of AFDC, all costs that were identified as shared costs were allocated to AFDC. This is called the "primary program" approach. For cases that received AFDC, Food Stamps, and Medicaid, the Food Stamp and Medicaid programs paid only the cost of the work that was over and above what was required for AFDC. Because the federal match rate was 50 percent in all three programs, the amount that the federal government paid was the same, regardless of whether it was considered a joint cost and claimed under the AFDC program or a cost allocated to one of the individual programs.

When Congress replaced AFDC with TANF, it failed to specify how shared costs were to be treated under the new program. The funding included in the TANF block grant, based on pre-1996 spending, was predicated on the "primary program" cost allocation method of cost allocation discussed above, where AFDC paid for the administrative costs that benefited all the various programs. Some federal officials believed that states would maximize the administrative costs attributed to Medicaid or Food Stamps, where 50 percent matching funds were still available, and minimize administrative costs allocated to TANF that was no longer eligible for federal matching payments, freeing TANF block grant funds for other purposes.

The Agricultural Research, Extension, and Education Reform Act of 1997 (P.L. 105-185)

In an effort to address the concerns of federal officials who believed states would "maximize" administrative cost reimbursement by shifting costs to the Medicaid and Food Stamp programs, "cost allocation" provisions were included in the Agricultural Research, Extension, and

The supplemental budget amendment may be submitted at any time but would normally be submitted at the same time that a supplemental budget request is made to the state legislature. CMS will approve any supplemental budget amendment provided that it covers allowable expenditures and the state has demonstrated a valid funding source for the non-federal share of the expenditures.

A state may submit to CMS supplemental budget amendments to incorporate any previously unbudgeted expenditure. Supplemental budget amendments may be based on:

- Service utilization changes;
- Increases in eligibles;
- Increases in the number of providers; and
- And/or increases in cost of services or administration.

A state's supplemental budget submission must also show the funding sources from which the non-federal share of the cost of the increased expenditures will be obtained. **CMS will review the non-federal funding sources and notify the state within 45 days of any state funding sources that it believes does not comply with applicable Federal law. CMS will then defer or disallow any claims that are based on unacceptable state funding sources.**

State Impact

It is too early to say with any certainty what the state impact will be. Much of that will depend on exactly how the process is implemented. There are a few things that are certain.

(1) Despite claims to the contrary, this process involves more paperwork and staff time than the current process.
(2) This process calls for the collection of information that CMS probably wants to have, but is not necessary for the administration of the program.
(3) The new process gives CMS the upper hand when there are disputes regarding state funding sources for federal matching payments for Medicaid.
(4) State budget processes vary widely from state to state and developing a one size fits all system that will run smoothly will be difficult.
(5) Finally, there is a general lack of comfort in having federal officials so intimately involved in the state budget process.

NCSL Staff Contact: Joy Johnson Wilson, Health Policy Director, NCSL, Washington, D.C. (Joy.Wilson@ncsl.org)

otherwise not subject to FFP. **If the state continues to believe that there is authority for the proposed expenditure and that it is subject to FFP, the state may retain the expenditure in the Medicaid budget, but CMS will be free to utilize any authority in statute or regulation to question or withhold FFP.**

Under the CMS proposal, beginning with state fiscal year 2006,[2] each state would be required to submit to the appropriate CMS Regional Office, at least 150 days prior to the commencement of each state fiscal year, its preliminary Medicaid budget (i.e. services and administration). At a minimum this submission would include:

- The total budget for medical assistance expenditures of the single state agency (including the identification of Federal and non-Federal funding sources);
- Budgets for medical assistance expenditures made by other state agencies, which will be the basis for claims for Federal matching funds;
- Budgets for medical assistance expenditures made by non-state governmental units (e.g., public hospitals, County Health Departments), which will be the basis for claims for Federal matching funds;
- Budgets for administrative costs either directly charged or allocated to the Medicaid program under approved cost allocation plans; and
- a listing and estimated amounts of all of the state funding sources[3] for the non-Federal share of expenditures pursuant to the Medicaid budget.

All budgets should list expenditures in the same categories that are reported on the CMS-64 forms.[4] In addition, each source of state revenue that meets the definition of a health-care related tax or a provider-related must be separately identified and should be accompanied by documentation that would show it is in compliance with federal law and regulations.

Follow-Up After Submission of the Revised CMS-37 Form

After submission of the new CMS-37 forms, states will be expected to provide additional documentation reasonably requested by CMS to facilitate its review of the state's submission.
Update reports, that will include any significant new expenditure categories or state funding sources under consideration, will be provided every 30 days to CMS on the status of the budget.

Once the final state budget is adopted, the state will submit a final Medicaid budget for CMS review, including the estimated amount of each funding source and a description of each of the funds and funding sources expected to finance the non-Federal share of the Medicaid expenditures. CMS will advise the state no later than 45 days after receipt of the state's submission of its final Medicaid budget of any proposed state-funding source that CMS believes is not allowable under Federal law and regulations.

If necessary, CMS and the state will meet and discuss issues raised with respect to any funding source that CMS had questioned. If after review and negotiation, CMS adheres to a determination that a state funding source is not compliant with Federal law and regulations, CMS will defer and disallow claims related to budget items, including funding sources, that have not been reviewed and accepted by CMS in the financial review process.

Supplemental Budget Amendments

The state plan and waiver submission processes contained in existing statutes and regulations will be utilized. The supplemental budget process will be used for the state to submit the funding sources to cover the non-federal share of the additional expenditures. The state will not claim expenditures under any state plan amendments until they are approved by CMS. The state, however, remains free to pay for services covered by pending state plan amendments with state-only funds, pending approval of the plan amendment and the Medicaid budget amendment by CMS. States will be entitled to draw federal funds for the federal share of all expenditures covered by the approved amendment from the time of its approved effective date.

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[2] Key CMS staff has indicated that the proposal will not be implemented until state fiscal year 2006.

[3] The term "state funding sources" refers to all sources for the non-federal share of Medicaid expenditures. Funding sources can include the state general fund, separately maintained trust funds, other state appropriations and non-state public expenditures. State funding sources also include revenues (whether deposited in the General Fund or other funds) derived from health care providers, or from governmental units on account of health care expenditures, as well as interagency or intergovernmental transfers related to health care expenditures or from an entity related to health care.

[4] The Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program (Form CMS-64) is the accounting statement which states must submit each quarter. It shows the disposition of Medicaid grant funds for the quarter being reported and previous fiscal years, the recoupment made or refunds received, and income earned on grant funds. States are not accountable for interest earned on grant money pending disbursement for program purposes. However, states are accountable for the federal share of any interest earned on recoupments or refunds pending their return to the federal government. It is also the vehicle for making adjustments for any identified overpayment and underpayment to states. The amounts reported on Form CMS-64 and its attachments must be actual expenditures for which all supporting documentation, in readily reviewable form, has been compiled and is available immediately at the time the claim is filed. Form CMS-64 is a statement of expenditures for which states are entitled to federal reimbursement under Medicaid and which reconciles the monetary advance made on the basis of Form CMS-37 filed previously for the same quarter. Consequently, the amount claimed on the Form CMS-64 is a summary of expenditures derived from source documents such as invoices, cost reports and eligibility records.

NCSL

National Conference of State Legislatures 444 North Capitol Street, N.W., Suite 515 Washington, D.C. 20001
202-624-5400 202-737-1069 (fax)

February 18, 2004

Proposed Prospective Financial Management Review for the Medicaid Program

Overview

On January 7, 2004, a notice was published in the *Federal Register* by the Centers for Medicare and Medicaid Services (CMS) seeking emergency review by the Office of Management and Budget (OMB) of its proposed revision of the CMS-37 forms[1] and process. Specifically, CMS proposed to:

> "minimize disruption to state operations and the reduction of unnecessary expenditures to the federal government by modifying the collection requirements associated with the CMS-37 budget and expenditure information collection package. In particular, CMS will begin to require the states to submit up-front documentation to support the budget and expenditure information currently captured on the CMS-37 "Medicaid Program Budget Report."

CMS asked that all comments be submitted for review no later than January 8, 2004. This entire process was being pursued as a paperwork reduction activity.

The original plan was to implement the new process for state fiscal year 2005. Neither the substance of the proposed changes, nor the 24-hour comment period was well received by interested parties. As a result, the request for approval and review of the revised forms by OMB will be resubmitted and will not be done on an "emergency" basis. Instead, CMS will consult with state and local government representatives and resubmit the proposed new forms and process for approval by OMB. There will be a 60-day public comment period. Under this revised schedule, the new process would apply to state fiscal year 2006.

What is the proposal? How does it differ from current practices? What will be the impact on state Medicaid programs?

Current Practices

CMS' financial management oversight is currently performed through reviews of historical claims. Funds are advanced to a state at the beginning of each quarter, and CMS reviews expenditures to identify improper payments after a financial management review on the state's quarterly expenditure report is completed. Since these reviews are retrospective, if improper payments are identified, CMS must collect these payments from the states.

Proposed Prospective Financial Management Review Process

CMS is proposing to implement a **prospective financial management review process.** The prospective financial management review process will establish the framework for allowable expenditures for purposes of drawing federal matching payments (FFP). Federal grants will be predicated on the level of expenditures contained in the approved state submissions. **The current process for grant awards, draws of Federal funds, and reporting expenditures will continue to be employed. However, the state will not draw any Federal funds to cover new expenditures, including those that would require a new state plan amendment, waiver amendment or new contracts, unless and until the expenditures are approved and the state funding sources are accepted through the supplemental budget process and applicable state plan or other Federal authorization process.** Current federal cash management protocols will be applicable to the state's draw and use of federal funds.

As part of its prospective review CMS will provide the state with a written determination of any proposed expenditure which it believes lacks outstanding state plan authority, waiver authority or other authority for FFP, or that the expenditure is

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[1] The CMS-37 is a quarterly financial report submitted by the state which provides a statement of the state's Medicaid funding requirements for a certified quarter and estimates and underlying assumptions for two fiscal years -- the current fiscal year and the budget fiscal year. In order to receive federal financial participation, the state must certify that the requisite matching state and local funds are, or will be, available for the certified quarter. This information is supplied to CMS electronically through the Medicaid Budget and Expenditure System (MBES) and is reviewed by CMS. Based on the CMS-37 submission and subsequent review, CMS issues the state a grant award authorizing federal funding to the state for the certified quarter. If at any time in the quarter, the state feels that it's original request for federal funds is insufficient, it may submit a revised CMS-37 through the MBES, justifying its request and recertifying for the quarter. After review and approval, CMS issues a supplemental grant award to the state for the additional federal funds needed.

Prospective Budgeting

- CMS is proposing to implement a prospective financial management review process beginning in SFY 2006 which will be used to to determine allowable expenditures for the purposes of drawing federal matching payments.
- CMS' financial management is currently performed retrospectively through reviews of historical claims.Funds are advanced to each state at the beginning of each quarter, and CMS reviews expenditures to identify improper payments.States must certify that they have required state and local match available at the beginning of each quarter.

Prospective Budgeting

- States will be required to submit their preliminary Medicaid budget 150 days before the beginning of each state fiscal year.
- Detailed budget information must be provided for the total Medicaid budget including a list of all state funding sources

APPENDIX G

Federal Proposals for Medicaid

- Curbing the use of intergovernmental transfers
- Prospective budgeting vs. Retrospective budgeting
- Budget caps
- Cost allocation for Medicaid administration - $8 million
- MMIS funding reduction – 90% to 75%
- No Federal fiscal relief - $191.6 million

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An Information Service of NCSL's Standing Committees

Vol. 11 #10 3/01/04

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MEDICAID PROPOSALS UNFAVORABLE TO STATES CONTINUE TO SURFACE

The president's FY 2005 budget proposal includes almost $2 billion in federal savings from the Medicaid program. It proposes to achieve $1.5 billion alone through "curbing" the use of intergovernmental transfers. The reduction would be made by limiting states' ability to set rates for health care providers. The budget also proposes to reduce federal Medicaid payments to states by $261 million through a one-time reduction in Medicaid administrative costs popularly known as "cost allocation." This is an elusive issue related to the 1996 welfare reform law and explained in detail in *Medicaid Cost Allocation: A Backgrounder*, available from the NCSL Washington Office. Finally, the president's budget proposed to reduce the enhanced federal match rate for information and claims management systems from 90 percent to 75 percent, saving the federal government $80 million. This reduction is particularly ill-timed as states prepare for their role in the implementation of the Medicare prescription drug program, which includes eligibility determinations for the Medicare Part D subsidies.

In addition to proposals in the budget, the administration is increasingly depending on regulatory and administrative maneuvers to curb state Medicaid spending. On January 7, the Centers for Medicare and Medicaid (CMS) published in the Federal Register a notice invoking an emergency procedure to change the format and timing of the states' reporting of budget and expenditure information that establishes the basis for entitlement reimbursements to states for Medicaid expenditures. Under current practice, the centers review the information retrospectively. CMS proposed a prospective budget and financial management process that essentially gives CMS authority to "prior approve" mechanisms states use to provide their match and to base state payments on Medicaid budgets "proposed" by governors. States were given only 24 hours to respond. That met with immediate resistance from NCSL and others culminating last week in an announcement that another notice with a 60-day comment period will be published after consultation with governors and state Medicaid directors.

Another technique being used by CMS is to extract concessions from states during negotiations for state plan amendments and waivers. One state seeking an amendment to its nursing facilities operations was told by CMS that the request would not be approved unless the state agreed to, among other things, end all intergovernmental transfers. This raises serious concerns since intergovernmental transfers are allowed under current law, and apparently the intergovernmental transfers in the state complied with federal law. **State legislators are encouraged to share information with NCSL regarding instances where local governments provide part of the state match and specific programs are funded through intergovernmental transfers. State legislators are encouraged to review pending state plan amendments to see if state officials are being told approval is conditioned on termination of intergovernmental transfer use.** In a similar vein, state Medicaid directors and governors are being approached about capping their Medicaid programs as part of waiver applications or as part of ongoing negotiations to address disallowances. Last week two governors expressed interest in pursuing a "block grant" approach for Medicaid using the 1115 waiver approach. Senator Charles Scott (R-Wyoming) has introduced an amendment to the budget bill in Wyoming that would prohibit the state Medicaid agency from agreeing to a Medicaid cap without approval of the state legislature. With much of the action occurring through administrative mechanisms, more states may want to consider this approach.

State legislators should be prepared to share information with their congressional delegation regarding the harm that would occur if the president's budget proposals are enacted. In addition, it is important to share with members of Congress the important role intergovernmental transfers play in supporting the Medicaid program in your state. (NCSL staff contact: Joy Johnson Wilson)

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Denver Office: Tel: 303-364-7700 | Fax: 303-364-7800 | 7700 East First Place | Denver, CO 80230 | Map
Washington Office: Tel: 202-624-5400 | Fax: 202-737-1069 | 444 North Capitol Street, N.W., Suite 515 | Washington, D.C. 20001

Intergovernmental Transfers

Implications for the North Carolina Medicaid Program

- Like all states, North Carolina routinely asks for state plan changes or waivers based on actions of the General Assembly or other identified needs of the Medicaid Program.
  - NC has requested state plan changes and waivers to implement the new nursing home assessment program and reimbursement plan.
  - NC is also working with CMS to finalize cost settlements for the Non-State Hospital program.
- So far CMS has not asked for concessions on IGTs in order to implement these changes, but concessions requests are a possibility until these proposals have not been approved.

Intergovernmental Transfers

Implications for the North Carolina Medicaid Program

- North Carolina uses intergovernmental transfers to draw down additional DSH and supplemental payments to benefit the state and all acute care hospitals.
- These payments offset the cost of uncompensated care provided by non-state acute care hospitals – 20 to 25% of all Medicaid payments to NC hospitals come from these DSH and supplemental payments.
- Since 1995, non-state acute care hospitals have received over $2 billion from this program.
- NC has also benefited form this program - receiving over $450 million since 1995. The State share of these funds has been placed in a reserve fund and used to pay for cost settlements and to reduce state appropriations to the Medicaid Program.

Intergovernmental Transfers

- The President's budget proposes cost savings based on the intent to curb the use of existing IGTs. The reduction will be made by limiting states' ability to set rates for health care providers.
- CMS is also seeking to end intergovernmental transfers administratively by suggesting that state plan changes or waivers will be approved if a state agrees to terminate all intergovernmental transfers.

Intergovernmental Transfers

- Intergovernmental transfers (IGTs) are a tool that state and local governments use to draw down additional federal dollars to support their Medicaid Programs.
- IGTs are allowed under current federal law.
- Congress and CMS have limited the use of IGTs and other creative financing systems over past decade because they have been concerned that additional federal dollars were not being used to support Medicaid Programs.

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

- States are mandated to perform eligibility determinations and to enroll dual eligibles and other low-income people in the Part D low-income subsidy program.
- There is no subsidy for this new administrative burden.
- North Carolina will be reimbursed at the Medicaid administrative cost rates for perform the eligibility determinations.
- In North Carolina, Medicaid eligibility is performed and paid for by counties. The federal government pays 50% and counties pay 50% of the costs associated with eligibility determination.

Medicare Prescription Drug Benefit:

Implications for the North Carolina Medicaid Program

- States have never participated financially in the Medicare program. It has always been financed by employer/employee contributions to the Social Security Trust Fund.
- The "clawback" payments will be a line item in the Medicare budget for Medicare Part D or the Prescription Drug Benefit.
- In the future, Congress could require states to pay a higher percentage of the cost for dual eligibles if the overall cost of the prescription drug benefit grows faster than anticipated.

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

- The Division of Medical Assistance estimates that North Carolina spent $683.1 million on prescription drugs for 220,723 dual eligibles during FFY 2003.
- The State and County share of these FFY 2003 expenditures was $255.8 million or 37.44% of the costs.
- North Carolina's payment in FFY 2006 will be based on these numbers after they are adjusted for inflation.

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

- North Carolina's "clawback" payment will be based on three factors:
  - A per capita estimate of the amount the state otherwise would have spent on Medicaid prescription drugs for dual eligibles
    - ***Estimate will be based on 2003 state Medicaid spending on Part D covered drugs per dual eligible trended forward through 2006 by the growth in national per capita prescription drug expenditures and in 2007 and later years by per capita growth in 2007***
  - The number of dual eligibles enrolled in a Part D plan
  - A "takeback" factor set at 90% in 2006, declining to 75% for 2015 and later years.

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

- The North Carolina Medicaid Program will receive some fiscal relief over the next ten years, but the actual relief is lower than expected due the "clawback" provision and new administrative costs.

- Under the 'clawback" provisions, North Carolina is required to make payments to the federal government in perpetuity to finance most of the cost of the Medicare prescription drug coverage for its dual eligibles.

Medicare Prescription Drug Benefit:

Implications for the North Carolina Medicaid Program

- The Medicare Modernization Act will provide a voluntary prescription drug benefit for Medicare beneficiaries beginning in 2006 (Medicare Part D).
- "Dual Eligibles" or Medicare beneficiaries with Medicaid are required to receive prescription drug benefits through Medicare effective Jan. 1, 2006.
  - Loss of Medicaid Coverage applies even if dual eligible is not enrolled in a Part D Plan
  - No beneficiary choice
  - No state choice
  - Cost-sharing obligations similar to Medicaid

APPENDIX E

North Carolina General Assembly
Legislative Services Office

George R. Hall, Legislative Services Officer
Legislative Services Office
16 W. Jones Street Room 2129
Raleigh, NC 27601-1030 Tel. (919) 733-7044

Tony C. Goldman, Director
Administrative Division
16 W. Jones Street Room 9
Raleigh, NC 27601-1030
(919) 733-7500

Gerry F. Cohen, Director
Bill Drafting Division
300 N. Salisbury St. Rm 401
Raleigh, NC 27603-5925
(919) 733-6660

James D. Johnson, Director
Fiscal Research Division
300 N. Salisbury St. Rm 619
Raleigh, NC 27603-5925
(919) 733-4910

Dennis W. McCarty, Director
Information Systems Division
300 N. Salisbury St. Rm 400
Raleigh, NC 27603-5925
(919) 733-6834

Terrence D. Sullivan, Director
Research Division
300 N. Salisbury St. Rm 545
Raleigh, NC 27603-5925
(919) 733-2578

March 18, 2004

MEMORANDUM

TO: Blue Ribbon Commission on Medicaid Reform

FROM: Richard Bostic

SUBJECT: Long-Term Care Insurance Tax Credits

DEMOGRAPHICS

In a 1999 study, the Henry J Kaiser Foundation found that 53% of those receiving long-term care services were over 65 (44% were working age adults and 3% were children). In July 2003, the over age 65 population numbered 1,011,370 in North Carolina and represented 11.92% of the state population of 8.5 million (NC Office of State Budget and Management – State Demographics unit). In the next ten years, the over 65 age group will grow to 13.23% of the population. By 2030, the over 65 age group will increase to 17.85% of the state population.

Year	0 to 5	6 to 17	18 to 64	65 and over	Total
2003	691,299	1,375,376	5,407,757	1,011,370	8,485,802
2013	765,606	1,561,658	6,293,933	1,314,174	9,935,371
2023	866,952	1,735,146	6,988,338	1,826,545	11,416,981
2030	934,608	1,889,202	7,402,317	2,221,470	12,447,597

LONG TERM CARE

What is long-term care? The simplest definition is the care given to individuals who need assistance with activities of daily living because of a health problem. The level of assistance needed is measured by a deficiency in 1) activities of daily living (ADLs) such as bathing, dressing, eating, toileting, getting around the house, and transferring from chair to bed and 2) instrumental activities of daily living (IADLs) that include shopping, meal preparation, light housework, and money management.

AN EQUAL OPPORTUNITY/AFFIRMATIVE ACTION EMPLOYER

In a report prepared for the North Carolina Institute of Medicine in 2000, Millennium Healthcare Solutions, Inc. made the following projection for North Carolina long term care needs in 2010:

- The total number of persons with long term care needs (both at-home and institutional) will increase from 351,600 in 2000 to 418,400 in 2010.
- The number of community dwelling persons with long term care needs will increase from 308,000 in 2000 to 366,700 in 2010. Of this group, those with 3 or more ADLs will increase from 79,800 to 98,400.
- The number of community dwelling persons with 3 or more ADLs and incomes below 100% of poverty will grow from 27,400 in 2000 to 34,000 in 2010.
- The number of residents in institutional care facilities will increase from 42,700 in 2000 to 51,700 in 2010.
- The number of community dwelling persons aged 18 to 64 with disabling mental retardation and/or developmental disability will grow from 34,300 in 2000 to 38,600 in 2010.

The costs for long term care alternatives such as home health care, assisted living and nursing homes are expensive. Two Internet sites provide calculators to estimate the current long term care costs for the major cities in each state. The Federal Long Term Care Insurance Program (www.ltcfeds.com) estimates the following annual costs for Raleigh and Charlotte:

	Raleigh	Charlotte
Home Health Care*	$21,411	$21,567
Assisted Living	$29,453	$32,244
Nursing Home	$45,443	$49,421

*The home health care cost is based on 5 hours a day and 5 visits a week.

The CNNMoney website (cgi.money.cnn.com) offers an annual long term care cost finder based on 2002 average costs derived from the Metlife Mature Market Institute Survey. Home health hours are set at 5 per day in this calculator for comparison to the model above.

	Raleigh	Charlotte
Home Health Care	$29,200	$31,025
Assisted Living	$29,448	$32,244
Nursing Home	$51,830	$54,020

LONG TERM CARE INSURANCE

Given the cost of long term care services, many have chosen to protect their financial assets by purchasing long-term care insurance. Dr. Marc Cohen, President of LifePlans, Inc., presented a paper to the Center for Medicare and Medicaid Services in 2002 that stated 7 million long-term care policies have been sold, but only 4 million are still in-force. He said the target market for long term care policies is 1) middle to upper income elders who would not immediately qualify for Medicaid, 2) those who have few available informal supports (family, friends) or who worry about not having them at the time they need long term care, and 3) younger adults who view long term care insurance as an integral part of retirement planning.

In North Carolina, there were 86,272 long-term care policies reported by 61 companies in 2002 (National Association of Insurance Commissioners, NAIC). In a 2000 NAIC survey, the following four companies insured 63% of those with long term care policies:

General Electric Capital Assurance Co.
Unum
Continental Casualty Co.
Penn Treaty Network American Insurance Co.

The annual cost of a long-term care insurance policy varies by the age of the insured and the type of coverage requested. The California Public Employees' Retirement System (CALPERS) offers an online calculator to estimate your long-term care premium. If you choose a comprehensive policy that 1) pays $200 a day for nursing home, $140 a day for assisted living and $3,000 a month for home care, 2) has built-in inflation adjustments, and 3) provides lifetime benefits, then the annual premium is as follows:

Age 46	$1,704 per year
Age 56	$2,868 per year
Age 66	$4,836 per year

Similarly, the Federal Long Term Care Insurance Program online calculator estimates that a comprehensive policy that offers home and facility care at $150 a day, with an unlimited benefit period, and with inflation protection will cost $1,876 a year for a 50 year old and $3,506 a year for a 65 year old.

NC TAX CREDIT

The long term care insurance tax credit was one of 13 tax provisions included in the budget act for Fiscal Year 1998-99 by the 1998 General Assembly (1998 S.L. chapter 212, SB 1366). The state individual income tax credit equals 15% of the premium paid each year on long-term care insurance, but the credit may not exceed $350 for each policy for which the credit is claimed. The credit may not exceed the amount of tax owed by the taxpayer (nonrefundable), and there is no provision to allow unused portions of the credit to be carried forward. The credit became effective for the taxable year beginning on or after January 1, 1999, and expires for taxable years beginning on or after January 1, 2004.

A taxpayer may claim a credit for policies that provide coverage for either the taxpayer, the taxpayer's spouse, or a family member for whom the taxpayer provides over half of the support and whose income is below an exemption amount. A long term-care insurance policy is one that provides only coverage of long-term care services and that meets the following requirements:

1. Is guaranteed renewable.
2. Does not provide for a cash surrender value.
3. Provides that refunds and dividends may be used only to reduce future premiums or to increase future benefit.
4. Does not pay or reimburse expenses that are reimbursable under Medicare.
5. Satisfies consumer protection laws.

Under federal law, premiums paid on long-term care insurance contracts are treated as deductible medical expenses. Under the medical expense itemized deduction, unreimbursed medical

expenses may be deducted to the extent that the expenses exceed 7.5% of adjusted gross income. To the extent a taxpayer will receive a deduction for long-term care insurance premiums under the Code, the taxpayer will receive a deduction for State income tax purposes as well since North Carolina uses federal taxable income as the starting point for calculating State taxable income. To prevent a double tax benefit in those cases, the credit is limited to those expenses for which a deduction has not been claimed.

STATE TAX INCENTIVES

North Carolina is not alone in offering a tax incentive to those enrolling in long-term care insurance policies. According to a report from the Health Insurance Association of America, the following states allow an income tax deduction for long-term care insurance premiums:

Alabama	Missouri
Hawaii	Montana
Idaho	Ohio
Indiana	Utah
Iowa	Virginia
Kentucky	West Virginia
Maine	Wisconsin

The states listed below allow an income tax credit for the payment of long-term care insurance premiums:

- Colorado – 25% of premiums up to $75 individuals/$150 couples; incomes less than $50,000 single/$100,000 married filing jointly; nonrefundable.
- Louisiana – 10% of premium per policy; enacted but not available to taxpayers until budget is adjusted by legislature for the loss of revenue from credit claims.
- Maryland – 100% of premium up to $240 if age 40 or less, up to $450 if age 41 to 50, or up to $500 if 51 and over; nonrefundable and may not be carried forward.
- Minnesota – $100 per person and per policy.
- New York – 10% of premium, nonrefundable but unused credit may be carried forward.
- North Dakota – 25% of premium per policy
- Oregon – the smaller of 15% of premium paid or $500 nonrefundable and cannot be carried forward.

California and Montana have tax credits for long term care, but are not tied specifically to long-term care insurance policies. California has a $500 nonrefundable tax credit for taxpayers with adjusted gross incomes less than $100,000 who provide long term care to spouse or dependent. Montana has an elderly care tax credit that is a percentage of elder care expenses, but the percentage is based on the taxpayer's adjusted gross income. Long term care insurance premiums are an eligible expense. The credit is limited to $5,000 for a single qualifying family member and $5,000 for a joint return.

FISCAL IMPACT

Tax year 1999 is the first year that taxpayers could claim the long-term care tax credit. In the inaugural year, 21,029 tax returns claimed approximately $4.2 million in credits for an average long-term care insurance credit of $199. The average tax credit claimed per return in the four years of the program has been $202. The total amount of credits claimed each year has been consistent except for 2001, which may be explained by a high error rate (see discussion below).

Tax Year	Number of Returns	Total Long-Term Care Credits	Average Credit Per Return
1999	21,029	$4,181,454	$198.84
2000	29,206	$5,974,615	$204.57
2001	51,959	$10,367,883	$199.54
2002	27,516	$5,652,648	$205.43

The chart below helps explain the type of taxpayer taking the long-term care credit. 61.3% of the tax returns with long term care credits in 2002 were claimed by married couples or widows. This group claimed 68.7% of the total credit amount. The second largest claimant group was single filers with 23.7% of the returns claiming 20.8% of the credits.

The 0 to $10,000 taxable income group had the greatest number of tax credit claims in 2002. This group also had the largest tax credit per return equal to $231. It must be noted that this is taxable income, which is gross income minus deductions and exemptions.

LONG-TERM CARE CREDITS CLAIMED FOR TY 2002

Number of Tax Returns

NC Taxable Income	Single	Married, Joint/Widow	Married, Separate	Head of Household	Total
$0 - $10,000	2,251	2,965	77	1,373	6,666
$10,001 - $20,000	1,274	1,933	73	1,299	4,579
$20,001 - $30,000	950	1,685	61	547	3,243
$30,001 - $40,000	645	1,611	45	277	2,578
$40,001 - $50,000	442	1,528	21	116	2,107
$50,001 - $60,000	295	1,330	28	74	1,727
$60,001 - $75,000	263	1,525	13	36	1,837
$75,001 - $100,000	218	1,688	9	38	1,953
$100,001 or more	194	2,590	14	28	2,826
Total	6,532	16,855	341	3,788	27,516
Percent of Total	23.7%	61.3%	1.2%	13.8%	

Credit amount

NC Taxable Income	Single	Married, Joint/Widow	Married, Separate	Head of Household	Total
$0 - $10,000	$475,235	$847,613	$11,092	$208,656	$1,542,596
$10,001 - $20,000	$229,904	$517,813	$9,069	$193,000	$949,786
$20,001 - $30,000	$152,319	$409,185	$8,787	$79,636	$649,927
$30,001 - $40,000	$97,010	$344,770	$5,437	$32,122	$479,339
$40,001 - $50,000	$69,741	$307,054	$2,656	$15,595	$395,046

$50,001 - $60,000	$45,488	$259,031	$4,697	$8,288	$317,504
$60,001 - $75,000	$35,965	$290,962	$2,355	$4,261	$333,543
$75,001 - $100,000	$36,240	$322,404	$1,158	$4,492	$364,294
$100,001 or more	$34,722	$582,046	$1,630	$2,215	$620,613
Total	$1,176,624	$3,880,878	$46,881	$548,265	$5,652,648
Percent of Total	20.8%	68.7%	0.8%	9.7%	

ERROR RATE

The Department of Revenue has encountered serious taxpayer problems with the long-term care insurance tax credit. Audited tax returns in 2001 showed a 91% error rate for credit. The most common taxpayer error were 1) claiming the credit for regular insurance premiums, 2) claiming the total amount of premiums paid as a credit instead of the $350 limit, and 3) claiming the credit and also claiming the long-term care premium as a medical expense.

The Department of Revenue reports a 40% error rate in audited returns in tax year 2003. Nancy Pomeranz, Director of the Department of Revenue's Personal Taxes Division, credits the reduction in long-term credit errors to the following factors:

1. Tax preparers making errors were contacted.
2. Instructions in the D-400 tax return booklet were improved.
3. Verbiage in the software developers' tax packages was improved.
4. Taxpayers whose credit was disallowed did not make the same mistake.

The high error rate is surprising given that the instructions in Form D-400 TC state "A tax credit is allowed for the qualifying premiums you paid during the taxable year on a qualified long term care insurance contract(s)... **Medical insurance premiums that you pay for general health care, hospitalization, or disability insurance do not qualify as premiums paid for a long term care insurance contract."** The tax form tells you to read the instructions and complete the worksheet to determine the amount of credit owed.

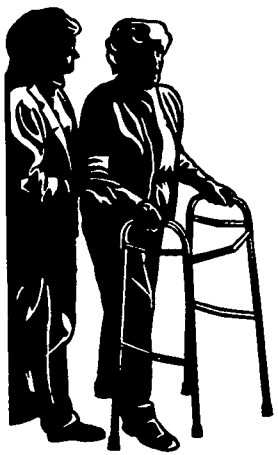
CREDIT FUTURE

The long-term care insurance credit expired with the 2003 tax year. To continue the credit will require the removal of the credit sunset and an adjustment in future General Fund budgets for an annual revenue loss of approximately $6 million. More importantly, to continue the credit will require the elimination of taxpayer error and fraud. North Carolina can follow the practice of Minnesota and require the taxpayer to list the insurance company and policy number of the long-term care policy for which a tax credit is claimed. (see attached tax schedule) The Department of Revenue could work with the Department of Insurance to get the list of companies providing long-term care policies in the state and a computer listing of policy holders to match against the tax credit claims.

Long-Term Care Premium Tax Credit

Blue Ribbon Commission on Medicaid Reform

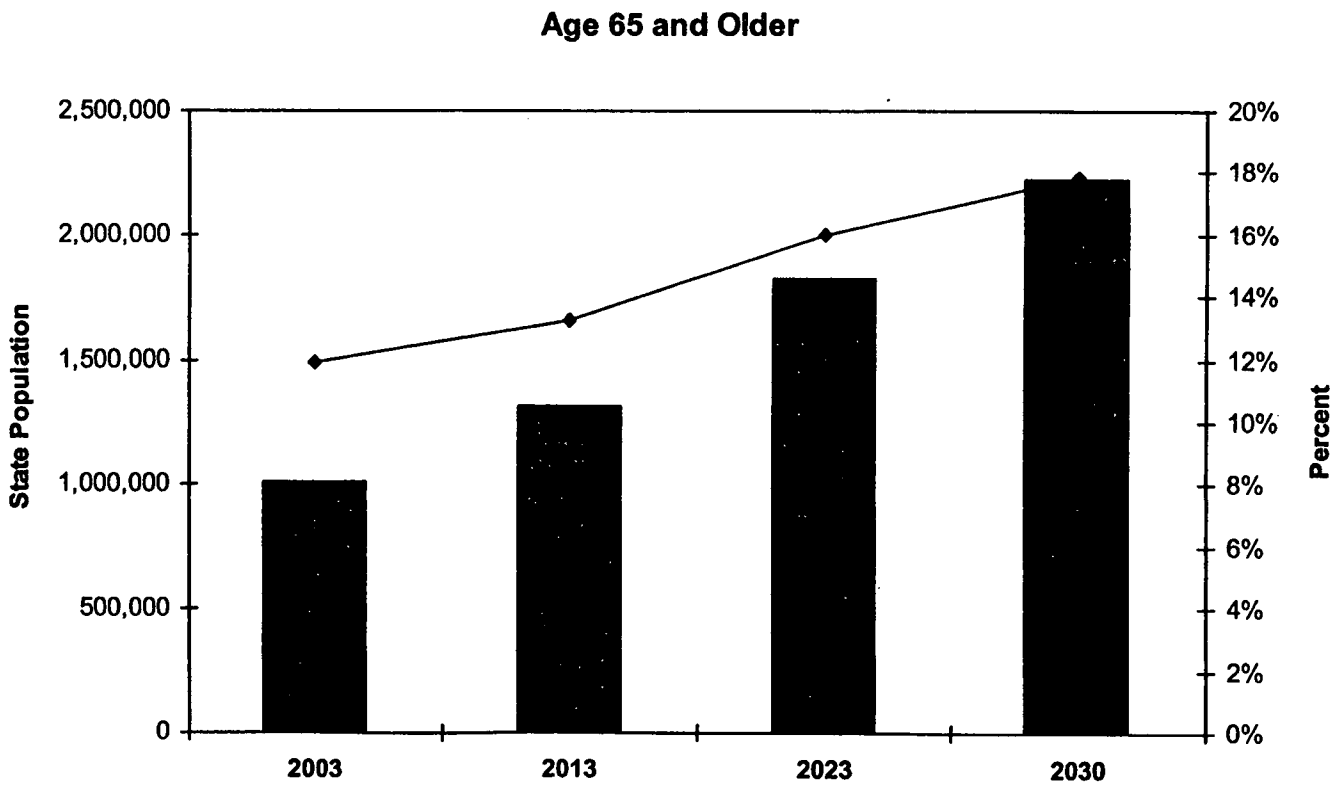
March 24, 2004



Recipients of Long-Term Care Services

- Over age 65 53%
- Working age adults 44%
- Children 3%

Aging Population in NC



In 2010, North Carolina will have:

- **418,400 persons with long-term care needs**
  - **366,700 home-based care (3+ ADLs)**
  - **51,700 institutional care**

The Estimated Annual Cost of Long-Term Care in Charlotte

Home Health Care	**$21,567**
Assisted Living	**$32,244**
Nursing Home	**$49,421**

Federal Long-Term Care Insurance Program.

Long-Term Care Insurance

- **7 million policies in the United States in 2002 (4 million active)***
- **86,272 policies in North Carolina****
- **61 companies (4 with 63% of market)****

*Life Plans, Inc.

** NAIC

Cost of LTC Insurance for a Comprehensive Policy

The policy pays:

- **$200/day nursing home**
- **$140/day assisting living**
- **$3,000/month home care**
- **Inflation adjusted and pay lifetime benefits**

The cost is:

- **Age 46 = $1,704/year**
- **Age 56 = $2,868/year**
- **Age 66 = $4,836/year**

North Carolina LTC Tax Credit

- 15% of annual premium
- May not exceed $350 per policy
- Non-refundable/no carry forward
- Cannot claim both medical deduction and credit
- Expired Tax Year 2003

Other States with LTC Credits

- Colorado-25% of premium up to $75 individual/$150 couple
- Minnesota-$100 per person and per policy
- New York-10% of premium
- North Dakota-25% of premium per policy

North Carolina LTC Credit Costs

Tax Year	Credits	Tax Returns
1999	$4.2 million	21,029
2000	$6.0 million	29,206
2001	$10.4 million	51,959
2002	$5.7 million	27,516

2002 LTC Credit Amount by Filing Status

Married Filing Jointly/ Widows	**68.7%**
Single	**20.8%**
Head of Household	**9.7%**
Married Separate	**.8%**

2002 LTC Credits by Income Class

0-$10,000	$1.5 million	6,666
$10,001-$30,000	$1.5 million	7,479
$30,001-$50,000	$ .9 million	4,685
$50,001-$75,000	$.65 million	3,564
$75,001-$100,000	$.36 million	1,953
More than $100,000	$ .6 million	2,826

LTC Credit Error Rate

2001 = 91%

- **Claiming credit for regular insurance premiums**
- **Claiming total premium amount**
- **Claiming credit and deduction of medical expense**

LTC Credit Rate Reduced

2003 = 40%

- **Contacted tax preparers making errors**
- **Improved instructions**
- **Improved verbiage in tax preparation software**

Continue Credit?

- **Approximately $6 million General Fund loss each year**
- **Require name of insurance company and policy number on tax credit form**

APPENDIX F

Medicare Prescription Drug Benefit:
Implications for the North Carolina Medicaid Program

Fiscal Research Division

March 2004

Community Care of North Carolina

July 1, 2002 – Dec. 31, 2002

- Cost - $4.1 Million

  (Cost of Community Care operation)

- Savings - $12.4 Million

  (Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other)

Initiatives Not Included in Mercer Analysis

- Nursing Home Poly-pharmacy - Round 1 Savings
- Prescription Advantage List (PAL) – Pilot Savings

Pilot Initiatives

- Therapy services
- Low birth weight
- Disparities
- Mental health integration
- Poly-pharmacy in outpatient settings
- Sickle cell
- Community access programs
- Special needs

Initiatives Under Development

- Assisted care living poly-pharmacy
- Statewide rollout of PAL
- Incentive program
- Improved collaboration with public providers (obesity, smoking cessation, diabetes management, low birth weight, depression)
- In-home care
- Targeted disease management (depression, HIV, heart disease)

Potential Savings

- Asthma: $2-4 Million
- Diabetes: $ 5-8 Million
- ED: $10-12 Million
- PAL: $ 30-40 Million
- Poly-pharmacy: $16-20 Million
- Others: Mental Health, In Home, Therapies, High Cost Patients

Community Care of North Carolina

CCNC 2004

Local Financial Impact of a Mature Community Program

Per Eligible Cost

	Per Eligible Rates			%Change	
County	SFY 01	SFY 02	SFY 03	SFY 02	SFY 03
CABARRUS	$566.72	$563.43	$528.78	-1%	-7%
ROWAN	$493.70	$524.80	$525.84	6%	0%
STANLY	$573.57	$583.50	$568.84	2%	-3%
STATEWIDE TOTAL	$484.17	$508.99	$510.76	5%	0%

Local Financial Impact of a Mature Community Program

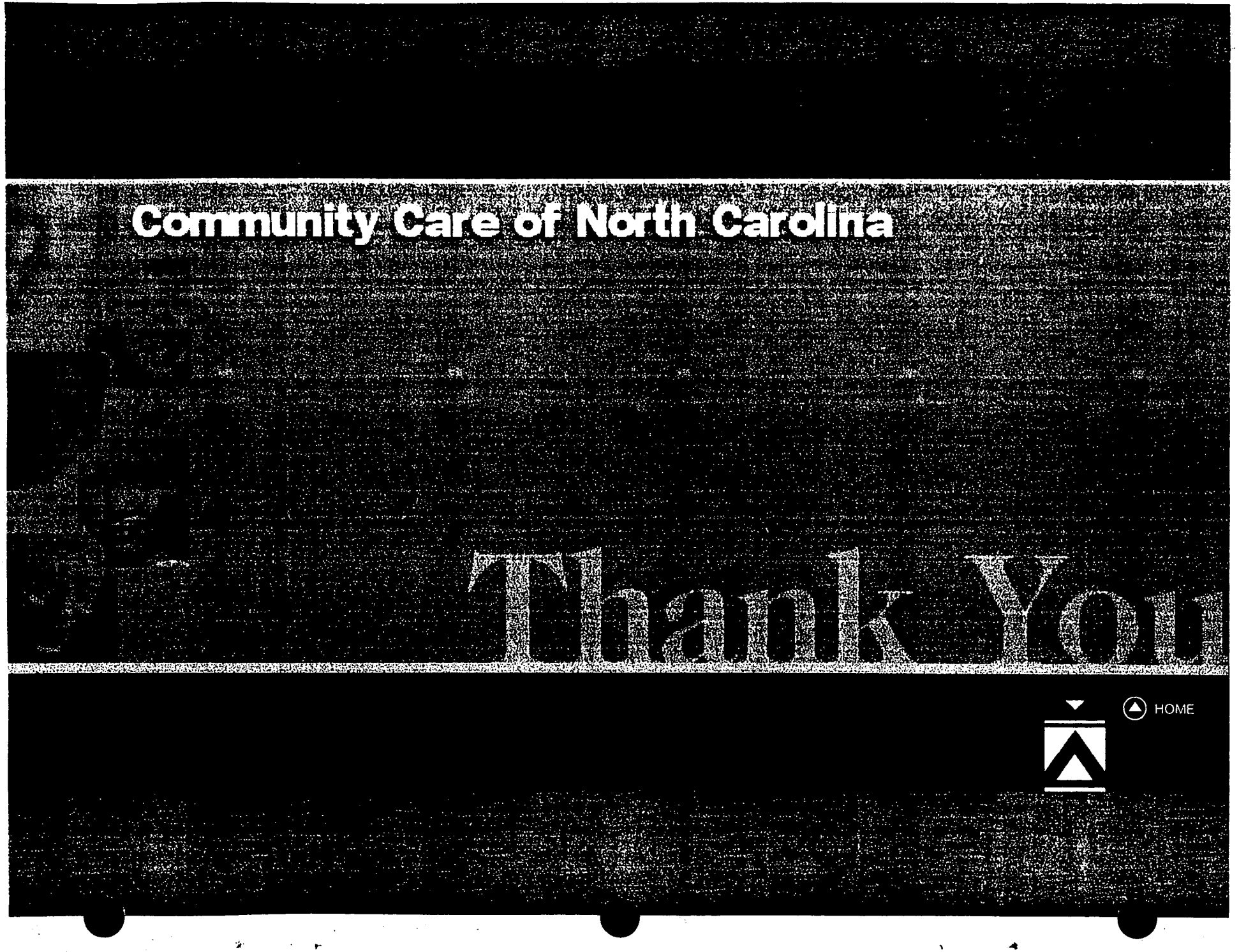
Total Medicaid Costs	SFY 01	SFY 02	SFY 03	
CABARRUS(Actual)	$71,963,807.09	$84,879,205.67	$88,956,134.45	
CABARRUS (no AccessIII)*	$71,963,807.09	$89,971,958.01	$95,183,063.86	Total Savings
Savings		$5,092,752.34	$6,226,929.41	$11,319,681.75
* using State-wide % increase				

NCPAG

- Pharmacy Committee
- Therapy Services Committee
- Dental Committee
- Mental Health Committee
- DME subcommittee
- Vision Task Force
- Transplant Policy Task Force
- Psychiatric Poly-Pharmacy Task Force

Lessons Learned

1. Top down approach is not effective in N.C.
2. Community ownership
3. Can't do it alone - must partner
4. Incentives must be aligned
5. Must develop systems that change behavior
6. Have to be able to measure outcomes
7. Lasting change takes time and reinforcement
8. There are indirect quality and cost benefits


Community Care of North Carolina
Thank You
HOME

BLUE RIBBON COMMISSION
ON
MEDICAID REFORM

2003-2004 Biennium

Co-chairs:

Senator William R. Purcell
Representative Julia Howard
Representative Edd Nye

Staff:

Carol Shaw, Fiscal Research Division

Anne B. Wilson, Commission Assistant

BLUE RIBBON COMMISSION ON MEDICAID REFORM
2003-2004 INTERIM

MEMBERSHIP LIST

SENATE

Senator William R. Purcell, Co-chair
North Carolina General Assembly
625 Legislative Office Building
Raleigh, NC 27601-2808

Senator Charlie S. Dannelly
3167 Dawnshire Avenue
Charlotte, NC 28216

Senator Fletcher L. Hartsell, Jr.
North Carolina General Assembly
518 Legislative Office Building
Raleigh, NC 27601-2808

Mr. Daniel C. Hudgins
UNC School of Social Work
Campus Box 3550
Chapel Hill, NC 27599-3550

Ms. Pam C. Silberman, JD
Sheps Center for Health Research Services
725 Airport Road, CB 7590
Chapel Hill, NC 27599

Mr. Luckey Welsh
Southeastern Regional Medical Center
300 West 27th Street
Lumberton, NC 28359

Dr. Al Wentzy
Northampton County Dept. Social Services
9467 NC Highway 305
Jackson, NC 27845

HOUSE

Representative Julia Howard, Co-chair
North Carolina General Assembly
1023 Legislative Building
Raleigh, NC 27601-1096

Representative Edd Nye, Co-chair
North Carolina General Assembly
639 Legislative Office Building
Raleigh, NC 27601-1096

Representative Jeffrey L. Barnhart
North Carolina General Assembly
608 Legislative Office Building
Raleigh, NC 27601-1096

Representative Beverly M. Earle
North Carolina General Assembly
535 Legislative Office Building
Raleigh, NC 27601-1096

Representative Bob England
P. O. Box 908
Ellenboro, NC 28040

Mr. William A. Pully
N. C. Hospital Association
P. O. Box 4449
Cary, NC 27519-4449

Dr. Charles F. Willson
Brody School of Medicine
600 Moye Blvd.
Greenville, NC 27834

STAFF:

Carol Shaw, Fiscal Research Division

COMMISSION ASSISTANT:

Anne B. Wilson

Legislative Authority
for the
Blue Ribbon Commission on Medicaid Reform

BLUE RIBBON COMMISSION ON MEDICAID REFORM

SECTION 6.14A (a) There is established the North Carolina Blue Ribbon Commission on Medicaid Reform (Commission). The Commission shall examine the State's Medicaid program and make comprehensive recommendations for fundamental reform. The Commission shall consider:

(1) Methods to responsibly restrain the growth in Medicaid spending.
(2) Best practices in both the public and private sectors in managing and administering health care.
(3) Options for maximizing existing resources while controlling Medicaid program costs.
(4) Current array of services available within the State Medicaid program to determine the appropriateness of the type, frequency, and duration of those services.
(5) Opportunities for long-term, systemic change in the Medicaid program through the use of federal waivers and other management tools.
(6) How to minimize the State and county share of Medicaid costs and maximize federal participation in Medicaid programs.
(7) The role of Medicaid in the State's economy.
(8) Any other matter relating to reform of the State Medicaid program.

SECTION 6.14A (b) The Commission shall consist of 12 members appointed as follows:

(1) Six members appointed by the Speaker of the House of Representatives, including one member who shall be designated as House Cochair. No more than three may be legislators.
(2) Six members appointed by the President Pro Tempore of the Senate, Including one member who shall be designated as Senate Cochair. No more than three may be legislators.

The appointing officer shall fill vacancies. The Commission shall meet at the call of the Cochairs. Members of the Commission shall receive per diem, subsistence, and travel expenses as provided in G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Commission may contract for consultant services as provided in G.S. 120-32.02. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Commission in its work. Clerical staff shall be furnished to the Commission through the offices of the House of Representatives and Senate Directors of Legislative Assistants. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may exercise all of the powers provided under G.S. 120-19 through G.S. 120-19.4 while in the discharge of its official duties. The funds appropriated by this act to

Legislative Authority
for the
Blue Ribbon Commission on Medicaid Reform

the Reserve for the Blue Ribbon Commission on Medicaid Reform shall be transferred to the Department of Health and Human Services in order to draw down federal match funds to be used to cover the cost of the Commission's work. **SECTION 6.14A.(c)** By April 1, 2004, the Commission shall make an interim report to the 2003 General Assembly. The Commission shall make its final report to the 2005 General Assembly by February 1, 2005, and shall expire upon submitting that report.

PROPOSED BUDGET FOR THE BLUE RIBBON COMMISSION ON MEDICAID REFORM 2003-2004

I.	Legislative Members Subsistence	$	6,500
II.	Non-legislative Members Subsistence		8,500
III.	Travel Expenses		5,600
IV.	Clerical Staff		5,000
V.	Professional Staff		TBD
VI.	Special Travel and Expenses		TBD
VII.	Postage and Telephone		250
VIII.	Supplies		250
IX.	Copying and Printing		1,000
X.	Reserve		472,900
	TOTAL PROPOSED BUDGET	$	500,000

Notes: 1. The Commission has a $500,000 budget based on a $250,000 appropriation and $250,000 Medicaid match.
2. Assumes eight meeting days.

ATTENDANCE

Committee: BLUE RIBBON COMMISSION ON MEDICAID REFORM

NAMES / DATES	10/06/04	11/16/04	12/15/04	11/18/05												
Sen. William Purcell, Co-chair	✓	✓	✓	✓												
Rep. Julia Howard, Co-chair	✓	✓	✓	✓												
Rep. Edd Nye, Co-chair	✓	✓	✓	✓												
Senator Charlie Dannelly	✓	✓	✓	✓												
Senator Fletcher Hartsell	✓	✓														
Rep. Jeffrey Barnhart		✓	✓	✓												
Rep. Beverly Earle	✓	✓	✓	✓												
Rep. Bob England	✓	✓	✓	✓												
Mr. Daniel C. Hudgins	✓	✓	✓	✓												
Mr. William A. Pully	✓	✓	✓	✓												
Dr. Pam Silberman	✓	✓	✓	✓												
Mr. Luckey Welsh	✓	✓	✓	✓												
Dr. Al Wentzy	✓	✓	✓	✓												
Dr. Charles F. Willson	✓	✓	✓	✓												
STAFF:																
Carol Shaw, Fiscal Research Division		✓	✓	✓												
Jim Klingler, Fiscal Research Division	✓															
Lisa Hollowell, Fiscal Research Division	✓															
Karlynn O'Shaughnessy, Fiscal Research Division			✓	✓												
Anne B. Wilson, Commission Assistant	✓	✓	✓	✓												

NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH 27603

September 10, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

SUBJECT: Meeting Notice

The Blue Ribbon Commission on Medicaid Reform will meet as indicated below. Topics for discussion at the October 6th meeting include an overview of the 2004 Session actions related to the North Carolina Medicaid program and prescription drugs.

DAY: Wednesday

DATE: October 6, 2004

TIME: 10:00 a.m. – 3:00 p.m.

LOCATION: Room 643, Legislative Office Building

In addition, please note that the Commission will meet as follows:

DAY: Tuesday

DATE: November 9, 2004

TIME: 10:00 a.m. – 3:00 p.m.

LOCATION: to be determined

Parking for non-legislative members of the commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives (see attached map). The cost for visitor parking is $.50 per hour or $4.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

Please advise Anne Wilson, Committee Assistant, at (919) 733-5707, or email medicaidca@ncleg.net if you will be unable to attend.

Posted: September 10, 2004
Cc: Committee Record ✓
Interested Parties ____

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM October 6, 2004

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tamara K Hicks	NCACDSS
Howard Rosenberg MD	IPANC
Peter Winston	IPA of North Carolina
Patricia Raeder	
Cora Ann Harris	Cora Harris & Assoc
Rodwyn E Ulm	Rodwyn E Ulm & Associates
Gary Salamido	GSK
John Bowdish	AstraZeneca
Brian Shank	AstraZeneca
Mark Benson	Capitol Impact
Elizabeth Dalton	Bone & Associates

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM October 6, 2004

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McHugh	Gov office
Angie Harris	Maupin Taylor
Emilyn Hawthorne	EH&R
Ed Wooten	N.C. Association of County Commissioners
Andy Ellen	NCRMA
Hugh Tilson	NCHA
Jeffrey Simms	DHHS
Karen T Gean	NCACDSS
Carrie Waller	ECU Pediatrics
Janet Schamgenbach	NIC Council
Betsy Justus	ACS

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM October 6, 2004

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sean McKillion	Nelson Mullins, Raleigh
Tommy Stevens	NCPC
Karen Carpenter	NCPC
Kevin Leonard	WCSR
Mary Taylor	

BLUE RIBBON COMISSION ON MEDICIAD REFORM
Wednesday, October 6, 2004
10:00 p.m., Room 643 LOB

Chairmen: Senator William Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

I.	**Opening Remarks**	*Chairs*
II.	**2004 Session: Changes to Medicaid**	*FRD Staff*
III.	**SeniorCare and Federal Discount Card Program**	*Michael Keough* *Office of Research, Development and Rural Health*
	Implementing Medicare Part D Prescription Drug Benefit: Impact On NC Medicaid	*Barbara Brooks.* *Division of Medical Assistance*
IV.	**Prescription Drug Program for NC Medicaid**	*Dr. Nancy Henley* *Division of Medical Assistance* *Dr. Allen Dobson* *Director, Cabarrus Community Care Network*
V.	**Implementing 340B Pharmacy Program in NC**	*Torlen Wade* *Office of Research, Development and Rural Health*
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VII.	**Commission Discussion**	*Chairs*
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BLUE RIBBON COMMISSION ON MEDICAID REFORM
Wednesday, October 6, 2004 at 10:00 a.m.
Room 643, Legislative Office Building

MINUTES

The Blue Ribbon Commission on Medicaid Reform met at 10:00 a.m. on Wednesday, October 6, 2004 in Room 643, Legislative Office Building. The following members of the committee were present: Senators William R. Purcell (Co-chair) and Charlie Dannelly; Representatives Edd Nye, (Co-chair), Julia Howard, (Co-chair), Beverly M. Earle and Bob England; public members Daniel C. Hudgins, Pam C. Silberman, Luckey Welsh, Dr. Al Wentzy, William A. Pully and Dr. Charles F. Willson. Representative Nye presided.

Representative Nye welcomed members of the committee and guests and asked members to re-introduce themselves, because changes in the membership have occurred since the last meeting. He invited visitors who would make presentations before the committee and staff to introduce themselves.

Representative Nye asked Jim Klingler, Fiscal Research Division, to discuss changes made to the Medicaid program during the 2004 legislative session. (See Handout #1, "Changes to the Medicaid Program".) Mr. Klingler said the document summarizes actions of the 2004 Regular Session with regard to state funding for the Medicaid Program (The Program). In his summary, Mr. Klingler noted that The Program's budget was cut by $90 million for Fiscal Year 2004-05, in addition to the $473 million reduction enacted during the 2003 Session. He said these reductions were the result of an increase in the federal financial participation rate in the amount of $40.2 million and reductions in the projected Medicaid growth rate, an additional transfer from the Medicaid Reserve Fund, and the elimination of coverage for weight loss and weight grain drugs.

Mr. Klingler said the 2004 General Assembly made policy changes to The Program and increased the budget to support the changes as follows:

1. increased funding by $1 million to continue expansion of Community Care of North Carolina (formerly called Carolina ACCESS II and III) to additional counties;
2. increased funding by $900,000 to expand Medicaid coverage of prosthetics and orthotics to adults over 21years of age.

Mr. Klingler said the 2004 General Assembly enacted the following Medicaid policy changes:

1. clarified payment policies for hearing aids and optical supplies;
2. authorized direct enrollment of private mental health service providers to serve adult and child Medicaid recipients of basic mental health services;

3. expanded Medicaid coverage for prosthetics and orthotics to adults over 21 years of age;
4. authorized the Secretary of the Department of Health and Human Services (HHS) to include all types of providers in the development of new medical policies;
5. authorized HHS to implement a Medicaid assessment program for state and private Intermediate Care Facilities for the Mentally Retarded (ICF-MRs);
6. requires HHS to establish and implement pilot programs to test new approaches to the management of access and utilization of health care services to Medicaid recipients;
7. directs HHS to develop a pilot program to implement the Program for All-inclusive Care for the Elderly (PACE) including a pilot in southeastern North Carolina and one in the western part of the state.
8. requires HHS to contract with an independent entity to study whether the North Carolina Medicaid Program has an institutional bias when providing long-term care services.

Representative Nye called on Michael Keough, Department of Health and Human Services, Office of Research, Development and Rural Health, to present the next item on the agenda, "SeniorCare and Federal Discount Card Program". (See Handout # 2.) Mr. Keough said the SeniorCare program has recently undergone dramatic changes as a result of the passage of the Medicare Modernization and Improvement Act in December, 2003, which created an opportunity for North Carolina to make some changes in its SeniorCare program. The intent was to take advantage of the Medicare Discount Card transitional assistance for seniors who are at or below 135% of the federal poverty level (FPL) to see if Medicaid SeniorCare members could be enrolled into that program in order to use federal money to pay for their benefits.

Mr. Keough referred to Handout # 2 and said the federal government provided a free card and a $600 credit at the beginning of the program on June 1, 2004 to any senior who qualified based on income and insurance status. CMS allowed states to automatically enroll seniors who were part of their prescription assistance programs like NC SeniorCare into the federal transitional assistance program of the state's choice. Mr. Keough said DHHS went through a bid process and chose a card called Community Care Rx based on the breadth of pharmacies that participate in the program and based on their willingness to work to develop a single card solution that would provide one card to seniors in this lower income strata that could cover both the Medicare discount card benefit and SeniorCare. He said DHHS wanted to be able to use the federal money to enhance the benefits of SeniorCare for all enrollees, not just people below 135% of poverty. The implications for SeniorCare are that the $600 in federal money would be used first, before any SeniorCare money is spent and that members would have one card and be able to use those benefits. Between 60 and 75% of enrollees are in that income category. Mr. Keough said about 27,000 members have already enrolled. He added that, after receiving legislative approval, DHHS auto-enrolled eligible seniors and gave them an opportunity to opt-out if they choose, as required by CMS. Thus far, he said, only a handful of seniors have chosen to opt-out. They understand the benefits to them of the combination of the two cards and the enriched benefits it has to offer.

Representative Nye recognized Senator Purcell for a question and he asked how the state picked which card to use. Mr. Keough responded that they put out an open bid to the forty cards that were approved by CMS to work in North Carolina. He said HHS also had bidding requirements and they selected Community Care Rx from the approved group of forty cards because it met the state's objectives. The value of one card, he said, is that using one card could assure the state that federal money would be spent first and the state could benefit from the savings and clear coordination.

Mr. Keough explained that the resulting changes to SeniorCare were that restrictions that formerly existed on eligibility or covered drugs based on diagnosis were lifted and benefits increased up to a total of $2400 through the end of 2005. In addition, coinsurance levels were changed to 5% for enrollees at or below 100% of the federal poverty level and 10% for those above it. Further, the federal poverty level for upper income thresholds increased from 200% to 250%, which opened up the program to an additional 150,000 seniors.

Mr. Keough reviewed the eligibility qualifications beginning on Page 2 of the handout and said his office is trying to enroll eligible applicants by the end of this year so the full drug benefit of $2400 can be obtained. He added that the application has been revised to comport with federal requirements so the approval process at CMS would be simpler.

Mr. Keough said recent responses to the SeniorCare program have been dramatic, adding almost 20,000 dual Medicare-Medicaid eligibles in addition to the 27,000 people who were auto-enrolled. He said almost 10,000 calls for information have come into the SeniorCare call center in Henderson and approximately 5,000 individually completed applications have been received. He said DHHS has carried out a mass distribution of applications around the state to pharmacies, physicians' offices, senior centers, health departments, social services departments, etc.

Dr. Willson asked if this plan covers drug benefits for those who now qualify for drugs under Medicaid under the dual-eligible criteria and Mr. Keough replied that it does not. He responded that anyone who is eligible for full Medicaid prescription drug coverage under Medicaid is excluded from SeniorCare and that there would be no cost reduction in Medicaid based on this program. Dr. Willson said Medicaid is paying for over-the-counter Prilosec and great cost savings are occurring and he asked if there is a possibility this program could expand to cover over-the-counter Prilosec and some other drugs that show good cost savings. Mr. Keough said that SeniorCare is trying to track the federal formulary to keep things as clear as possible for seniors.

Ms. Silberman said it is worth noting that this program is only targeted to seniors while there are very poor people with disabilities on Medicare who are under 65 and would get no benefit from this program. She said it was an unfortunate policy choice to exclude people with disabilities when there was the opportunity to expand coverage to include them. She said she appreciates the great work done for seniors but others who

are equally sick and equally poor are not getting any benefit. Mr. Keough responded that the decision to focus on the senior population came from the governor's office.

Representative England asked Mr. Keough if he knows what percentage of those people who were automatically enrolled are actually using the program. Mr. Keough said they know by the increase in September, which was about 2½%, in terms of number of claims and in dollars spent. The early returns indicate that people are aware of it and taking advantage of it.

Representative Nye asked about the income level shown on the first slide, where Mr. Keough said it was 135% of the federal poverty level and later he said it is 250%. Mr. Keough explained that 135% is the dividing line between people who qualify for federal assistance and those who do not and anyone below the 250% level is eligible for SeniorCare that is paid either by the state in full or by the state and federal government combined. Representative Nye asked if other states have a similar program to SeniorCare and if people come to North Carolina to get these cards. Mr. Keough said South Carolina has a senior care program that has a $500 deductible and covers a fair amount after that level and that he is not aware of people crossing the state line to get the cards. He added that there is a residency requirement and DHHS checks against the Department of Revenue database on income and residency. Representative Nye asked how long the call line at Henderson has been open. Mr. Keough said it opened about a year ago and added that the ACS administrator wanted it close to Raleigh and the Triangle because they believed the close proximity would facilitate their efforts to recruit and work with pharmacists to staff the project.

Senator Purcell asked what it would take to add people with disabilities to the program and Mr. Keough said money would be the biggest concern. He said they did consider that possibility in the beginning, but they had a limited amount of money and had to fit a target population into that amount.

Representative Nye asked Mr. Keough to provide an estimate on what the cost would be to add people with disabilities to the program and he responded that he would.

Representative Nye asked Ms. Barbara Brooks to present "Implementing Medicare Part D Prescription Drug Benefit: Impact on NC Medicaid", the next item on the agenda. Ms. Brooks referred to Handout # 3, "Medicare Modernization Act". She said she would talk about the direct implications of the prescription drug benefit to the Medicaid Program and to recipients. She said when the prescription drug benefit law was enacted in December, 2003 the first prescription drug benefit was for the drug discount card, but Medicaid recipients do not qualify for the drug discount card. They continue to receive their prescription drug benefits from Medicaid. DHHS worked with the federal government to develop new data exchanges so the Division could let them know monthly who was a Medicaid enrollee and if that person applied for a drug discount card, as part of the verification check, the federal government would see that in the database. So that activity was completed prior to June, 2004 when the drug discount card was first used. She said the second thing the Division did was look at the bill to

understand that this legislation had enormous and complex consequences for the public and that given all the information that was going to be coming out, the need to work with recipients and educate them. They realized the need to bring together as diverse a group as possible to meet regularly, talk and share information so that one clear message from the Division would be heard. So DHHS created the Medicaid Drug Coordinating Committee, which consists of representatives of AARP, the Health and Human Services Division of Aging, a county director of social services, members of senior pharmacy programs around the state, agricultural health extension representatives, a representative from Social Security Administration, pharmacists, representatives of faith based organizations and just a variety of people. The Senior Health Insurance Program from the Department of Insurance played an important role in this effort.

Ms. Brooks reviewed Medicare Part D, the new prescription drug benefit, which is different than the Part B coverage for drugs (mostly drugs injected in a physician's office) that Medicare has provided in the past. Part D refers to prescription drugs that can be obtained in a pharmacy and is open to all Medicare beneficiaries, seniors and disabled citizens and is voluntary. However, Medicare beneficiaries who sign up after the initial enrollment period may have to pay a late penalty. She said there is a monthly premium, estimated to be about $35.00 per month and an annual deductible of $250 for calendar year 2006. After the deductible, there is a 25% co-pay from the beneficiary to the pharmacy. Medicare will pay a standard benefit of $2,250 before the gap in coverage known as the "doughnut hole" begins. Once $2,250 has been paid by Medicare, she said, no more is paid on prescription drugs until the out-of-pocket expenses reaches $3,600. When a beneficiary reaches this "catastrophic" level, Medicare kicks back in with coverage. So, there is a standard benefit and a catastrophic benefit. Ms. Brooks said Part D will provide risk-bearing entities known as prescription drug plans (PDP) and they will be the entity responsible for tracking out-of-pocket expenses. Beneficiaries will consider the PDPs in their areas and select one for enrollment. She said they have learned from experiences with the drug discount card that this can be a very complex item for beneficiaries and their families. She said beneficiary outreach and education is important leading up to the effective date.

Ms. Brooks said Medicaid Part D would have a formulary, unlike the other parts of Medicaid. The law says that they will establish therapeutic drug classes and a prescription drug plan will have to offer at least 2 drugs in each therapeutic class. However, it may not offer the specific medicine that a person requests when they sign up for Part D.

Ms. Brooks said the basic part of Part D will be open to any Medicare beneficiary and there are out-of-pocket expenses associated with it. To counter that, the law offers what is called a low-income subsidy, which will help beneficiaries with the premium, with the deductible, with the co-pay and with the doughnut hole gap. Basically, she said, some form of low-income subsidy will be available to any Medicare beneficiary whose income is under 150% of the federal poverty level (FPL) and who has assets less than $10,000 for a single person and $20,000 for a couple. So the subsidy, like Medicaid, has both an income test and an asset test. Those eligible will need to apply for the subsidy.

Ms. Brooks discussed how Part D of Medicare will affect the Medicaid program. Beginning in January 2006, she said, when Part D is implemented the Medicaid program will not be able to receive any federal participation for prescription drugs for Medicare beneficiaries. That means Medicaid will not be the prescription drug provider. She said the new terminology entering this program with Part D calls a person who is a Medicare beneficiary who is receiving Medicaid for his prescription drugs is called a full benefit dual eligible. In North Carolina, a Medicare beneficiary who is fully enrolled in Medicaid receives a blue Medicaid card will get all the benefits that Medicaid offers. So, starting in January dual eligibles will not use a Medicaid card to get prescription drugs, but will instead use a Medicare card or a prescription drug discount card. Medicaid will continue to be the carrier of prescription drugs for everyone in the program who is not a dual eligible. She discussed the folks for whom Medicaid pays Medicare premiums, but who don't get all the Medicaid benefits as not being dual eligibles. She said they will have prescription drug coverage from Medicare. She stated that all the dual eligibles will automatically qualify for this low income subsidy, so that will be the bridge the recipient has from the Medicaid card where he had maybe a $1 or $3 co-pay to Medicare Part D, where he will get the low-income subsidy. It means the recipient will not pay the premium or the deductible. His co-pay, instead of being 25% will be $1 or $3. He will not lose coverage in the doughnut hole and will get the catastrophic coverage. The low-income subsidy is a very complex federal plan, but, in general, it says that anyone who gets a Medicaid card is going to have this low-income subsidy benefit to support obtaining prescription drugs from the formulary.

Dr. Willson asked about the out of pocket expense and whether the monthly payment and the co-pays and deductibles are included in the out-of-pocket or is the out-of-pocket above the $225.50. She replied that for the standard Medicare beneficiary who is not on the low-income subsidy, it depends on who pays; if a third party carrier such as an insurance policy pays it is not considered an out-of-pocket expense. She said this issue is still being discussed.

Ms. Brooks continued her review, discussing Medicaid recipients in the counties who have become accustomed to presenting their blue Medicaid card and getting their prescription drugs. With this program, they would automatically qualify for the low-income subsidy, but they must select and enroll in a Part D plan, which means the quarter of a million (roughly) Medicaid recipients in North Carolina are going to have to understand the Part D plans and choose one. So, there is a need for education and outreach.

Ms. Brooks said an even greater concern is that the prescription drug benefit will begin January 1, 2006. People can begin enrolling in November 2005, but the first enrollment period goes until May, 2006. So, with a November to May enrollment period and a January 1 cutoff for those prescription drug plans for recipients, an unresolved major issue for all the states and advocacy groups is how the federal government will handle automatic enrollment of Medicaid recipients into Part D. She said the states are advocating that this be done prior to January so that the recipient knows who his carrier is

and his physician might have an opportunity to look at the drug regimen to see if there are any problems. So that is a big recipient issue that affects state agencies as well as the county departments of social services that work with the recipients. Another issue to consider is that an individual recipient might have to change a drug because it is not a part of the formulary for their carrier. Third issue, a lot of education and outreach will be necessary, which is a state/county consequence, but is also something that directly affects the recipients. The recipients, for example, are going to have to understand that Part B of Medicare is still going to cover some of their drugs, some are covered by Part D and some drugs are not part of Part B or Part D. So, she concluded, there is a myriad of knowledge and information that needs to be worked out with the state's federal partners and other agency partners to help recipients.

Ms. Brooks turned to Page 8 and discussed the state phased down contribution (clawback), which means that the states are responsible for funding a portion of the Part D benefit paid to their dual eligible population. Take note, she said, that this is the first time states have been asked to directly fund a Medicare benefit. She said the formula for the clawback has established calendar year, 2003, as the baseline and states are to establish an average per capita cost for their dual eligibles for that year. So every state will have an individual calculation. The calculation will be based on the number of full-benefit duals (those who receive prescription drugs) and the total amount the state paid for prescription for that population. Roughly half of the state's prescription drug costs go to this group. Once a gross per capita has been established for 2003, it is adjusted for rebates. (See example on Page 9).

Ms. Brooks added that forthcoming detailed information on Part D and included/excluded drugs will be factored into the formula. She noted particular issues the state will confront:

1. the state is going to have to pay for the drug prescription costs for dual eligible recipients;

2. the state is going to have to consider whether through SeniorCare it will wrap around to non-formulary drugs in Part D and whether it is going to cover the drugs that are totally excluded. To make sure of that terminology the state will have a list of Part D included drugs, which are therapeutic classes, and drugs that are excluded from Part B and Part D (examples are barbiturates and valium type drugs);

3. the state will probably see an increase in eligibles because there are any number of people who may qualify for the state to pay the premium, but they have never asked for this kind of assistance. When they go to apply for the low-income subsidy and they are not Medicaid, the Division will be screening their applications to determine whether they qualify. She said some will qualify for limited benefits and others for full Medicaid. So an increase in eligible people, which is a variable in the clawback formula is expected;

4. the state will see changes in administrative areas such as computer programs, printing published policy and training and orientation.

Ms. Brooks said implementation/operational issues for the state are still unclear, since final regulations will not be issued until January 2005. She also said it is unclear what will be state agency responsibilities for low-income subsidy applications, which will

hit directly at the county departments of social services because they take the Medicaid applications. She said the law provides for people to apply with the state or at the Social Security Office. Social Security has offered to process all the applications and the Division of Medical Assistance wants to work with them on that, so their offices are available for intake, but not for the actual determination. She said those areas are still unclear and they are waiting for the federal government to clarify this responsibility. She said states are asking for more flexibility in the clawback formula because the baseline is rigidly 2003 and any change the state implemented in 2003 may not show up until 2004 and because states are constantly making changes this could lock them into an untenable position. She said there is concern about nursing facility patients, a frail population with regard to excluded drugs and the formularies. In addition, she said, there are possible adverse consequences to the disease management programs and other clinical policies because the state will not be paying for prescription drugs for the full benefit dual eligibles. She said they do not know what data will be available about the drug usage, when it will be available or what kind of format it will be in. She said counties are going to feel some programmatic consequences in departments of social services. For example, they may need additional staff because the programs will mean more people going to or calling the Department of Social Services. Also, she said staff in the counties who work with myriad Medicaid coverage groups are going to have a new group to become familiar with and will need additional training in the new regulations.

Ms. Silberman asked if individuals have to enroll in Medicaid if they come in for the low-income subsidy and they are eligible and Ms. Brooks said they do not. She said they can do the low-income subsidy separately because it only subsidizes Medicare. Ms. Silberman said one of the policy questions raised here is whether the state would take all the savings if there is any or would the savings be shared with the county. Mr. Gary Fuquay, Director of the Division of Medical Assistance, answered and said the current legislation only allows county participation for the Medicaid Program. This is not considered a Medicaid Program, but rather a Medicare Program. This is an issue that needs to be taken to the General Assembly in the coming session as to how the state and/or counties will participate in the cost and/or savings.

Mr. Keough asked for a clarification regarding what costs get counted against the deductibles, the out-of-pockets for Medicare and he said he understood that if it is out of the person's pocket it gets counted and if it is from a third party insurer it does not. He asked if there are exceptions to that. She replied that the state pharmacy programs would be an exception. There are exceptions and what CMS is considering is to itemize who the payers might be – the Veterans' Administration, a state pharmacy program, a retirees benefit, etc. – and whether or not as the source of payment that becomes an out-of-pocket expense. That regulation will need to be issued in a very detailed manner.

Ms. Brooks said she hopes there will be at least two PDPs – Prescription Drug Plans – per region that individuals can enroll in. They would select their own formulary. So individuals would need to know what is in the formulary to be able to make an informed decision, which makes the process more complex. On the clawback, she said

the adjustment will be made each year in the amount based on the increase in the prescription drugs and she said it would be indexed.

Representative Nye asked if low-income people would have to go to the Social Services Office to have eligibility established, since Social Security offices are authorized to take these applications. She responded that people could go to Social Services or to the Social Security Office to have an application taken and those applications would all end up at Social Security and they would make the decision on the low-income subsidy. She said she hoped Social Services' offices would only have to screen to see if there is a Medicaid eligibility, not Medicare. She said the dual eligibles applications will be submitted by computer, since those recipients would be known already. She said the pharmacy benefit will be paid by Medicare.

Senator Purcell asked if any effort is being made to simplify this process and Ms. Brooks responded that conversations have taken place regarding the drug discount card and the concern that people will not sign up because of its complexity. She said no one knows whether Congress will make changes to simplify the plan.

Representative Nye said he has been told that the state should not expect to save any money with this plan and Ms. Brooks said variables and new eligibles will affect the clawback, so there is concern about the amount of saving expected. He asked about expected numbers of new eligibles and she said her experience has been that when a benefit is changed, new people come in.

Representative Nye asked Dr. Henley to review the "Prescription Drug Program for NC Medicaid". She used Handout # 4 to give introductory background information on the program and talked about interventions made over several years. She said Dr. Allen Dobson would discuss the prescription advantage list and some interventions made through the Community Care Program. She reviewed information collected since 2001 which related to prescription drug usage and costs involved, comparing North Carolina's reimbursements, dispensing fees, co-pays, etc., with other states. She said the department has worked with pharmacies on various initiatives including the "Generic Conversion Initiative" to engage them on the idea of increasing generic prescribing and the results of that initiative would be included later in the presentation. She explained that in 2003 the department started an emphasis on optimizing the federal 340B program enrollment of various hospital and clinics in North Carolina. She said 340B refers to federal legislation from the early 1990s which offers drug pricing that could be as much as 30% to 40% off the average wholesale price (AWP) to certain hospitals and clinics that meet the criteria of these entities, so the goal has been to enroll as many as possible.

Dr. Henley said the department made an adjustment in 2003 in the number of days fill that would be allowed for generic drugs. The goal was to increase the use of generics and to increase compliance and they heard that this change was well received. Also, in 2003 they expanded over-the-counter coverage for Prilosec OTC and Claritin OTC because they knew it could provide a big financial advantage. This provided significant savings on a per-pill basis.

Dr. Henley highlighted that in 2004, legislation was passed that said weight loss drugs would no longer be a covered benefit and that coverage for weight gain drugs was being studied. Senator Dannelly asked if not covering weight loss drugs was a wise move in view of nationwide concerns about obesity. He asked if the state's action would set up a situation where costs would increase as obesity-related illnesses increase. Senator Purcell responded that few of those particular drugs were used and it is thought that weight loss depends on healthy diets, exercise and lifestyle, so success with these drugs was considered questionable. Representative England added that the basic problem was that the use of so-called appetite suppressants was short-lived in effectiveness and eventually the risks of harmful side effects became known. Senator Dannelly said he wonders why the Federal Trade Commission (FTC) has not taken these drugs off the market if they are ineffective or harmful and Representative Nye said the free market dictates that they remain available. Dr. Willson said the information that accompanies these drugs from the manufacturers say they are not recommended for children and those that have been shown to have serious heart side effects have been taken off the market. Dr. Henley added that within the Division of Public Health there are initiatives to improve diet and exercise and within the Community Care Network, the Access Care Group, a largely pediatric practice, has joint pilot projects with the UNC School of Public Health looking at interventions for pediatric practices to work with obese children.

Dr. Henley said the results of initiatives taken over the past few years regarding generic conversation, joint efforts between a pharmacist and DHHS to move toward generic prescribing, have resulted in total savings for the state of more than $15 million in 2003 and $16 million in 2004. She added that the generic prescription rate has risen from 44.5% to 48.5% and the generic efficiency rate has risen from 87.5% to 94.8%.

Dr. Henley discussed prior authorization drug cost savings and, citing the COX-2 Inhibitor class of drugs as an example, she noted that paid claims dropped from $11.8 million before implementation in 2001 to $4.7 million in 2002.

Representative England asked Dr. Henley for a breakdown of the number of patients for each of the specific drugs listed on Page 6 of Handout IV and she responded that they could provide the number of claims for those drugs and she said it probably would be possible to determine the number of patients requesting them.

Dr. Allen Dobson continued the presentation, specifically discussing "Pharmacy & PAL Update". (See Page 21 of Handout # 4.) He said he would discuss the management initiatives that DHHS and Community Care are using to try to control pharmacy costs. He said there are three main factors involved – what is covered, what is paid for it, and how much it is used. He said he would talk mostly about how much it is used because that is where the cost savings are realized. He said the Prescription Advantage List (PAL) is one tool used and the major advantage of the PAL is the methodology used to look at net cost to the state of individual drugs. Another factor is ranking medications in particular classes from cheapest to most expensive, so that physicians can help by prescribing the cheapest medicine available where appropriate.

He said some savings had been realized, but not at the level expected and he believes one reason is that prescriptions are often written for multiple refills. He referred members to charts starting on Page 24 for a review "PAL Progress" to see how over-the-counter drugs are being prescribed by physicians.

Dr. Dobson discussed management tools for targeting classes where maximum savings are available as outlined in "Opportunities for Managed Pharmacy Utilization/Savings". These tools are: continue targeted approach where criteria and data supports this approach; revise and target specific classes where maximum savings are available; use a specialized disease registry for low patient volume/high cost specialty drugs; target active intervention to support changes in therapy where appropriate.

Senator Purcell said a pharmacist in his district told him that most physicians are cooperative, but he has one physician who absolutely will not write prescriptions for generic drugs, so what options are available for situations such as this. Dr. Dobson said data on that kind of practice should be gathered and once specific information is available on who is not cooperative, peer-to-peer contact may be used to influence behavior. He said he thinks most physicians are doing a good job in helping the state manage this program.

Dr. Willson commented that patients visit their pharmacy much more than their physicians and asked what efforts are being made to use that resource to help manage pharmacy costs. Dr. Dobson replied that when this statewide initiative was begun, they met with the pharmacy associations to enlist their help and they had been very cooperative. He added that active intervention is sometimes needed to influence physicians' behavior. Representative England asked what AWP is, how it is determined and how does it affect the final cost. Dr. Dobson replied that he has learned that the state pays 10% less than the average wholesale prices (AWP) (See formula on Page 7 of the handout.) to the pharmacist and added that Medicaid is complicated because there is also a federal rebate program whereby the state gets money back. Representative England asked if the manufacturer has anything to do with determining AWP and Dr. Dobson replied that he assumes it does. Dr. Willson commented on the chart on Page 3 of the handout where it shows brand vs. generic prescriptions and said he is horrified to see that it looks like doctors are not prescribing generics. He asked Dr. Henley if this indicates that for those medications with brand names used there is no appropriate generic or is it that the physician is not writing on the prescription form that a generic may be substituted. Dr. Henley said state law says that if there is a generic available and the doctor does not write "medically necessary" for the brand, then the generic will be dispensed. She said that numbers on Page 18 show that efficiency data has determined that approximately 48% of prescriptions are for generics and the big difference shown on the bar chart on Page 3 is simply that the brands are much more expensive.

Ms. Silberman said other states also are trying to control Medicaid prescription drug costs and some states are reducing the AWP percentage or reducing their maximum allowable cost (MAC) percentage. She asked how the drug rebate interfaces with the percentage off the AWP. She asked if the state increases the percentage off the AWP,

does that mean we get less for the rebate; do we get a net savings for the state. Dr. Henley responded that the rebate rates are set by the federal government and apply to specific drugs, so we get the rebate and separate from that is the AWP, which we choose as our reimbursement rate. Ms. Silberman asked if the state has looked at what can be saved if there was a higher reduction off AWP and Dr. Henley said they did that last spring.

Representative Nye asked Mr. Torlen Wade, Office of Research, Development and Rural Health, to review the next agenda item, "Implementing 340B Pharmacy Program in NC". (See Handout # 5.) Mr. Wade said this is a federal program that provides pharmacy discounts to certain safety-net providers and the main groups as described in the statutes are public hospitals, disproportionate share hospitals (DSH) that have to have a DSH adjustment rate of 11.75 or greater, community health centers, AIDS Drug Assistance Programs (ADAPs), Family Planning Clinics and AIDS, TB, and STD Clinics. He said the 340B Program in the statutes limits drug assistance to patients of an eligible entity and only applies to out patient drugs. The main beneficiaries of the 340B Program are the safety net providers that are eligible, the Medicaid Program and uninsured patients that now have to pay retail price would pay a much lower price through 340B. A statutory requirement is that the Medicaid Program must be billed at the acquisition rate. Mr. Wade reviewed information presented in the handout and said the 340B program has tremendous potential despite its complexity.

Ms. Silberman said she is aware that Mr. Wade has worked with the Hospital Association to educate hospitals about 340B and asked if he has done any work with either the North Carolina Division of Public Health and local health departments or with North Carolina Community Health Centers Association to do the same kind of education to make sure they are all getting enrolled. Mr. Wade replied that they have had discussions with the Community Health Centers Association. He added that it is more complicated for community health centers that don't have an in-house pharmacy to develop those relationships. He said they have not started working with the Division of Public Health because the opportunities there are limited because of a relatively small number of prescription drugs, but they will be following up with them.

Dr. Willson praised the program and added that there are significant problems with the patient access to this program because many patients who go to the larger hospitals that have this program live a good distance away and when re-fills are needed, it is difficult for them to go back for the prescriptions. In addition, he said, there are issues related to hospitals getting into the outpatient pharmacy business and having the same sorts of hours and availability as retail drug stores. Mr. Wade agreed that this is an issue and in some states, demonstration projects are proposing a network of contract pharmacies in communities. He added that a 340B provider can have a direct buying relationship with a 340B supplier or they can go through a community pharmacy and establish the same arrangement, which is more complex but doable.

Mr. Hudgins commented that the information presented showed prescription drug costs as very high for mental health patients and asked if mental health centers would

have their own pharmacies after the mental health reform effort is completed. He asked if the 340B approach for controlling costs would be available for either state or local mental health institutions. Mr. Wade responded that this issue is under study in some states and DHHS is following those studies with interest.

Senator Dannelly said some patients have difficulties in getting to where their medication is being dispensed and asked why there is a prohibition against allowing a 90-day supply. He said some people have to take a taxi to pick up a prescription twice a month, which can be costly. Representative Nye said the answer is that the budget provision calls for a thirty-four day supply for Medicaid recipients because it is thought that some people take only a part of the medication. Senator Dannelly said he believes most of those who do not take all of their medications are in a small minority compared to people who need medication. Representative Nye said this is probably correct and perhaps the issue should be considered in the long session.

Representative Nye said he has heard that the State of Texas has a central dispensing group that dispenses drugs to the prison population through a FAX and overnight UPS arrangement and he asked Mr. Wade if such an arrangement is being considered in North Carolina. Mr. Wade said the limitation to qualifying for 340B is that the prison population would have to be patients of a 340B provider, but at the present time, there is no such link. Dr. Henley said her understanding of the Texas situation is that the clinical employees of the prison system became employees of the University of Texas, which is a 340B entity. As a result, the prison system gets the drugs under that 340B provider.

Representative Nye called on Dr. Henley to present the final item on the agenda, "Medicaid Durable Medical Equipment and Home Health Supplies". (See Handout # 6.) Dr. Henley said the federal point of view for these types of equipment and supplies is that they are considered a part of the home health services benefit, which is mandatory under federal regulations. Durable medical equipment, she said, includes things like walkers, oxygen, wheelchairs, supplies such as tubing, ostomy covers, incontinence supplies, etc. She reviewed North Carolina's Medicaid Policy on Page 3 of Handout # 6, which she said articulates the federal requirement: in North Carolina these types of equipment and supplies are covered only under certain circumstances, so they must be medically necessary and reasonable for the treatment of the patient's illness or injury. They also have to have a therapeutic or diagnostic purpose and they have to be ordered specifically for a given patient. In addition, she said most medical equipment has established lifetime expectancies, so the state's policy is to state that replacement will occur after a specific length of time and there are quantity limitations for things like supplies.

Dr. Henley continued review of policy issues and expenditures, noting that the cost of durable medical equipment and home health supplies is approximately 1% of total Medicaid service expenditures. She completed the review of the information contained in the handout by highlighting several considerations for improving the Medicaid Durable Medical Equipment and Home Health Supplies Program:

1. expand the criteria for post-payment reviews;

2. expand available codes to reduce the use of the miscellaneous supply code;
3. require providers of power wheelchairs to meet certification requirements to assure proper selection for specific recipient;
4. complete the study of the cost of diapers.

Representative Nye asked if there were further comments or questions.

Dr. Wentzy asked if it is appropriate to ask Fiscal Research staff to consider contracting with an entity to help this commission on specific study questions that are part of the Commission's Charge. He specifically mentioned that the Kaiser Foundation has been instrumental in working with the National Association of Legislatures and he asked if it would be appropriate to check out possible contractors, since that was mentioned at the commission's first meeting. In addition, he asked if the County Commissioners' Association could be invited to make a presentation. He said he is appreciative of today's presentations and added the Association has studied Medicaid cost factors in North Carolina and in other states with regard to how Medicaid impacts budgets. Representative Nye asked Dr. Wentzy to contact staff for further consideration of his suggestion.

Representative Nye announced that the next meeting of the Commission is scheduled for November 9 at 10:00 a.m. and invited members to let him know if additional information is desired on any of the items discussed today.

The meeting adjourned at 1:00 p.m.

Respectfully submitted,

Anne B. Wilson, Commission Assistant

Representative Edd Nye, Co-chair

Handout #1

CHANGES TO THE MEDICAID PROGRAM

During the 2004 Regular Session, the N.C. General Assembly enacted a $8.1 Billion budget for SFY 2004-05. State funding for the Medicaid Program totals $2.4 Billion for SFY 2004-05.

During its deliberations on the budget, the 2004 General Assembly reduced General Fund appropriations for the Medicaid Program by $90 million for SFY 2004-05. This reduction was in addition to the $473 million reduction for SFY 2004-05 that was enacted during the 2003 Session. The most significant reduction resulted from an increase in the federal financial participation rate -- $40.2 million. Other reductions include a one percent reduction in the projected Medicaid growth rate, an additional transfer from the Medicaid Reserve Fund, and the elimination of coverage for weight loss and weight gain drugs.

The 2004 General Assembly also made the following policy changes to the Medicaid Program and increased the budget for the program to support these changes:

- Increased funding by $1 million to continue the expansion of Community Care of North Carolina (Formerly called Carolina ACCESS II and III) to additional counties.
- Increased funding by $900,000 to expand Medicaid coverage of prosthetics and orthotics to adults over 21.

The 2004 General Assembly also enacted other Medicaid policy changes:

- Clarifies payment policies for hearing aids and optical supplies.
- Authorizes direct enrollment of private mental health service providers to provide basic mental health services for adults and children receiving Medicaid services.
- Expands Medicaid coverage for Prosthetics and Orthotics to Adults over 21.
- Authorizes the Secretary of DHHS to include all types of providers in the development of new medical policies.
- Authorized the Department of Health and Human Services to implement a Medicaid assessment program for state and private Intensive Care Facilities for the Mentally Retarded (ICF-MRs)

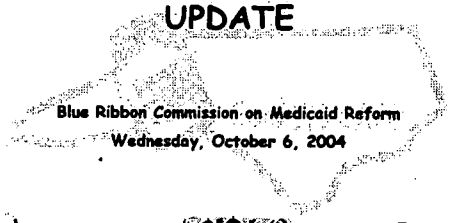
- Requires DHHS to establish and implement pilot programs to test new approaches to the management of access and utilization of health care services to Medicaid recipients.

- Directs DHHS to develop a pilot program to implement the Program for All-Inclusive Care for the Elderly (PACE) including one pilot in the southeastern area of the State and one pilot in western are of the State.

- Requires DHHS to contract with an independent entity to study whether the NC Medicaid Program has an institutional bias when providing long-term care services.

Handout #2

SENIOR CARE PROGRAM UPDATE



Blue Ribbon Commission on Medicaid Reform

Wednesday, October 6, 2004

Medicare Discount Card

- Provided a free card and $600/calendar year to Medicare enrollees at or below 135% of FPL ($12,568/single & $16,862/married)
- CMS allows states to autoenroll seniors eligible for $600 (transitional assistance) from state plan into discount card of state's choice
- NC Legislature allowed Senior Care to autoenroll these TA eligible seniors with chance to opt out into a discount card

Implications for Senior Care

- Federal $600 would be exhausted prior to any state money being spent
- One Card covering both benefits eases confusion among seniors
- Savings of up to $600/eligible enrollee on 62% of enrollees

Implementation

- Selection of Community Care Rx to work with Senior Care
- Implement One Card Solution
- Autoenroll seniors below 135% of FPL

Senior Care Program Changes

·No more restrictions on eligibility or covered drugs based on diagnosis;

·Total benefits of up to $2400 thru 2005 including $1200 thru the end of 2004 when any unused balance is carried over to 2005 when an additional $1200 is available;

·Coinsurance of 5% for enrollees at or below 100% of the Federal Poverty Level (FPL is $9,310 for an individual and $12,490 for a married person) or 10%for those above it;

·Increase from 200% to 250% of the FPL in upper income threshold or to $23,275 for a single person, or $31,225 for a married person;

ELIGIBILITY QUALIFICATIONS

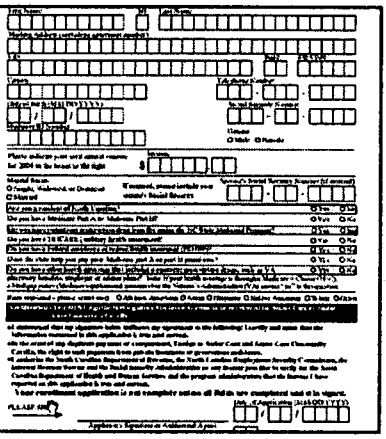
- 65 years of age or older, AND
- A resident of North Carolina, AND

- Your annual household income during 2004 is under 250% of Federal Poverty Level (FPL) ($23,275 if single and $31,225 if married), AND
- You do not have prescription drug insurance through an employee retirement, military retirement or Medicaid plan. Coverage through Medicare + Choice (M+C), a Medicare supplemental insurance, or the Veteran's Administration (VA), does not disqualify an applicant from Senior Care.

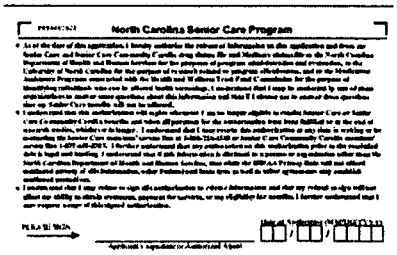
Deadline for 2004 Benefit

- Application must be postmarked on or before December 31, 2004 to get credit for 2004's $1200 benefit credit;
- After that applicants will lose $1200 of the total $2400 available between now and the end of 2005.

Application, Page 1



Application, Page 2

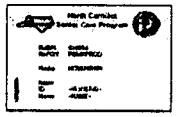


ID Cards

Depending on eligibility qualifications, approved seniors will receive one of two cards:

- Combined Senior Care/CCRx Card
  - Income less than 135% of FPL
  - Senior approved for CCRx card

- Senior Care Only Card
  - Income between 136-250% of FPL
  - Income is less than 135% of FPL, but senior is already enrolled in a another Medicare discount card other than Community Care Rx



COVERED DRUGS

Senior Care covers outpatient prescription drugs, including insulin, EXCEPT for the following:

- Drugs used for weight loss or weight gain, including those for anorexia
- Drugs used to promote fertility
- Drugs used for cosmetic purposes or hair growth
- Drugs used for symptomatic relief of cough or colds
- Prescription vitamins and mineral products (certain fluoride preparations and prenatal vitamins are covered)
- Over-the-counter drugs, (insulin is covered)
- Barbiturates
- Benzodiazepines

Wrap Around Program for the combined Senior Care/CCRx Benefit is Exhausted. . .

Additional benefits of the combined Senior Care/CCRx card (not available to Senior Care only Cardholders):

·Members may receive deep discount pricing on about 300 selected drugs from 8 pharmaceutical manufacturers with copays normally between $10 and $20.

·Members can also receive discounts on drugs not covered under the wrap around program, up to 25% discount.

Contact Information

Senior Care Member Services.....**1-866-226-1388**
(open 24 hrs/day, 7 days a week). Use the **Senior Care Member Services** helpdesk for **All Requests for Applications** and for Senior Care member specific inquiries.

Senior Care/CCRx Member Services.....**1-866-316-6050**
(open Mon-Fri, 8:00am-7:30pm EST). Use the **Senior Care/CCRx Member Services** helpdesk for questions regarding the combined Senior Care/CCRx benefit

Internet Access to Senior Care

- Program information
- FAQ's
- "What's New"
- Send email with questions
- Fill out application online and print out for mailing

* Applications are available online!

http://www.ncseniorcare.com

September Performance

- 44,507 total enrollees as of month's end
- 27,744 (62%) autoenrolled in dual State Card and Medicare Discount Card called Senior Care Community Care Rx
- 18,990 QMBs or dual Medicare-Medicaid eligibles

September Response by Srs

- 3,104 calls received in Henderson Sr Care Call Center requesting applications
- 4,768 completed applications received by Senior Care (monthly average = 1500)
- 160,000 applications distributed to pharmacies, physicians and senior services network

NORTH CAROLINA

SENIOR CARE PROGRAM

Senior Care Member Services:

1-866-226-1388

(TTY 1-877-646-5312

Thank You

Blue Ribbon Commission on Medicaid Reform

Medicare Modernization Act (MMA)

October 6, 2004

Handout #3

MMA Overview

- Medicare Modernization Act enacted by Congress – signed into law December 2003
- Focus on Medicare prescription drug benefits
  - Discount Drug Card as interim solution – June 2003 until December 2005
  - New Medicare Part D prescription drug benefit – begins January 2006

Part D Basics

- Benefits provided thru Prescription Drug Plans (PDPs)
- Enrollment voluntary
- Monthly premium
- Annual deductible & copay
- Initial coverage limit of $2,250
- Coverage gap ('donut hole')
- Catastrophic coverage benefit

Part D basics, con't

- Part D plans can have formularies
  - Must offer 2 drugs in each therapeutic class
- Low Income Subsidy (LIS) for beneficiaries with incomes < 150% fpl
  - Subsidy level based on income
  - There is an income & asset test for subsidy

Part D Benefits & Medicaid

- Effective January 2006, fmap **not available** to Medicaid for 'dual eligible' drug coverage
  - Dual eligibles will receive drugs thru Part D
  - Medicaid continues to provide prescription benefits to all other Medicaid enrollees
- All dual eligibles automatically qualify for the low-income subsidy
- Limited beneficiaries (who receive only Medicare cost sharing/premium payment) also qualify for subsidy

Consequences to Recipients

- Each Medicaid 'dual eligible' must enroll in a Part D plan
  - There will be automatic assignment for those not enrolling
  - ***Unresolved issue: when will the automatic enrollment occur to avoid interruption of benefits on January 1. 2006***

Consequences to Recipients *Cont'd*

- Individual recipients may have to change their prescribed drug within a drug 'class'
  - Part D plans will have formularies
- Recipient education & outreach
  - Part B continues to cover some drugs (as it does now)
  - Part D covers prescription drugs dispensed through 'pharmacy' (referred to as 'outpatient drugs')
  - 'Excluded' drugs not covered under Medicare B or D (e.g. barbiturates)

Consequences to the state - Clawback

- Beginning Jan. 2006, states charged a portion of funding for Part D *('clawback')*
- Payment based on an average 'per capita' prescription cost for state's 'dual eligibles'
  - Baseline per capita calculated from CY 2003 data
  - Monthly clawback payment is a % of charges calculated on non-federal share of 2003 per capita costs (and other factors) multiplied by the # of dual eligibles for the month

Consequences to the State - Clawback

- Example of 'clawback' for NC
  - Average per capita (2003) = $3,188 annual (whole dollars net of rebate)
  - Example annual cost under 'clawback'
    - *Reduce to non-federal share (36.37%)* = $928/person
    - *Assume 20% growth factor from 2003* = $ 1,113 per person
    - Assume 225,000 dual eligibles = $250,000,000 (rounded)
      - State share (85%) = $213 M; county share (15%) = $37 M

State pays 90% (2006 clawback reduction) = $225,000,000(rounded)

**Note: This is an approximate calculation & factors for calculation assumed. These factors will be based on actuals for each payment month.*

Other consequences to State

- Consider 'wrap-around' for Part D non-formulary drugs and/or 'excluded'drugs
  - For 'excluded' drugs, we are confirming whether normal fmap available should state choose to continue providing under Medicaid
- Potential increase in eligibles ('woodwork')
- Administrative costs
  - Changes to computer systems
  - Likely development new data exchanges
  - New policy material & training for county dss's
  - Outreach & education for recipients

Other Consequences to State *con't*

- Many implementation/operational issues still unclear
  - States' role in accepting applications/determining eligibility for Part D 'low income subsidy'
  - CMS has published ***proposed regulations*** and final regulations not due until January 2005
  - States asking for more flexibility in clawback formula
  - Concern about PDP arrangements for institutionalized dual eligibles
  - Possible adverse consequence to state disease management & other clinical initiatives *(prescription drug data & management)*

Programmatic Consequences to County DSS's

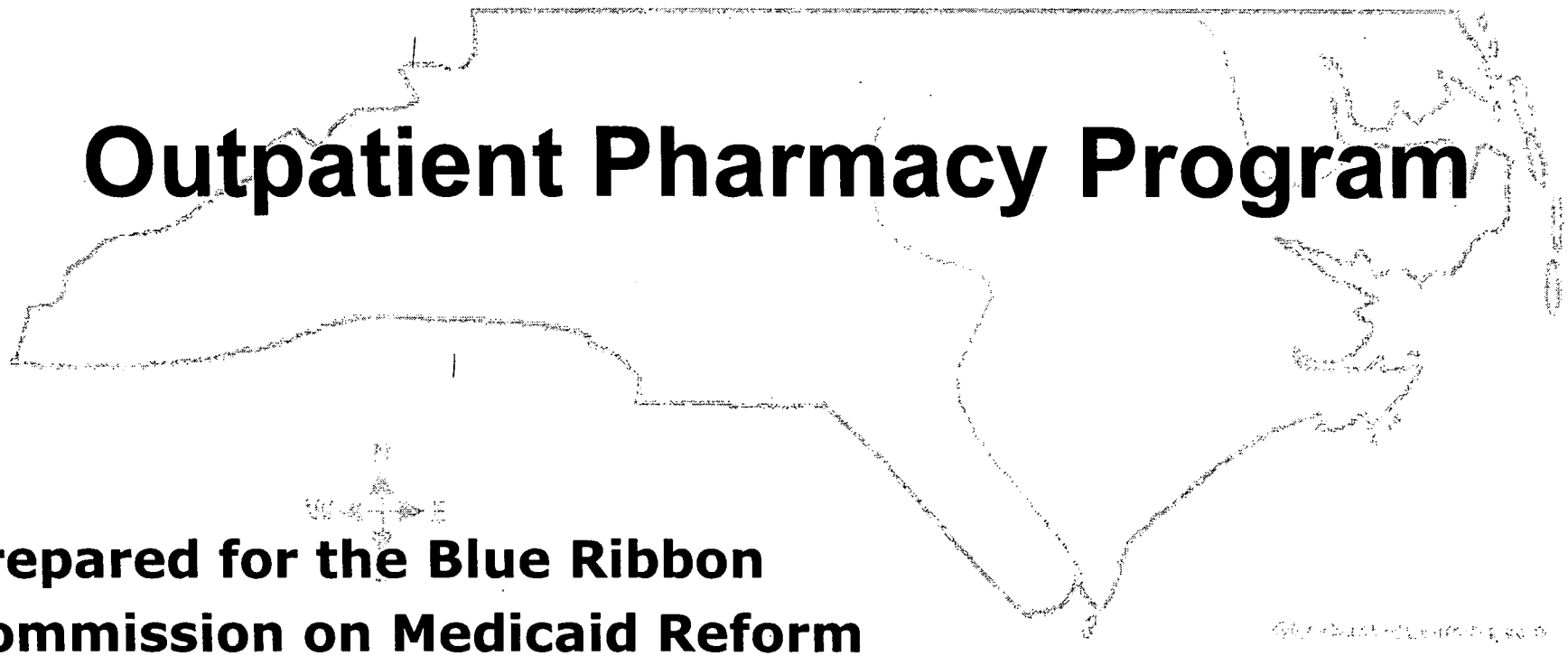
- Potential need for new staff to handle Part D 'low income subsidy' applications
- Screening 'low-income subsidy' applications for Medicaid eligibility
  - Results in increased workload completing the Medicaid eligibility determinations & redeterminations
- Must become familiar with new policy/group (low-income subsidy)
  - Ability to assist recipients/respond to concerns & questions

www.dhhs.state.nc.us/dma/

nc dma

Division of Medical Assistance

dhhs



Outpatient Pharmacy Program

Prepared for the Blue Ribbon Commission on Medicaid Reform

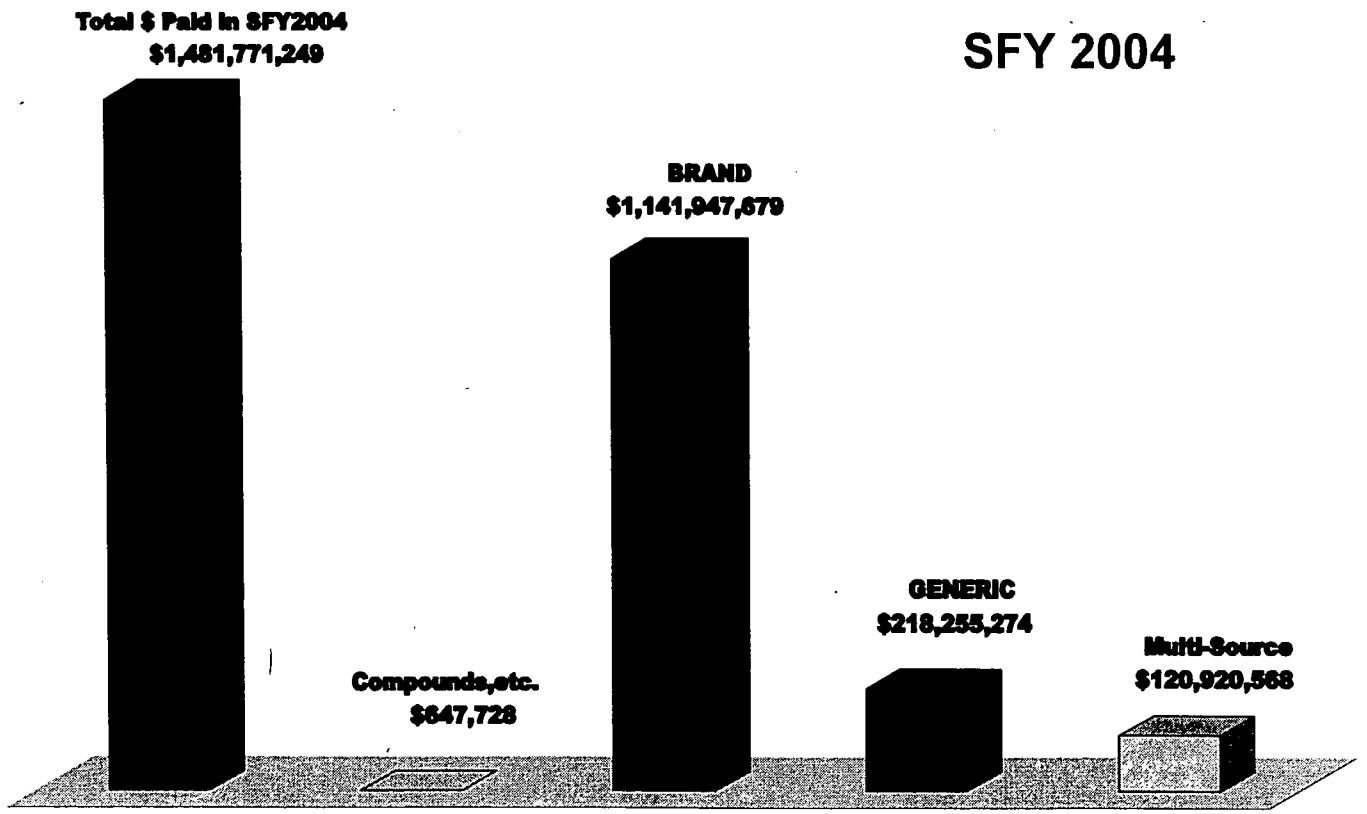
October 6, 2004

Handout #4

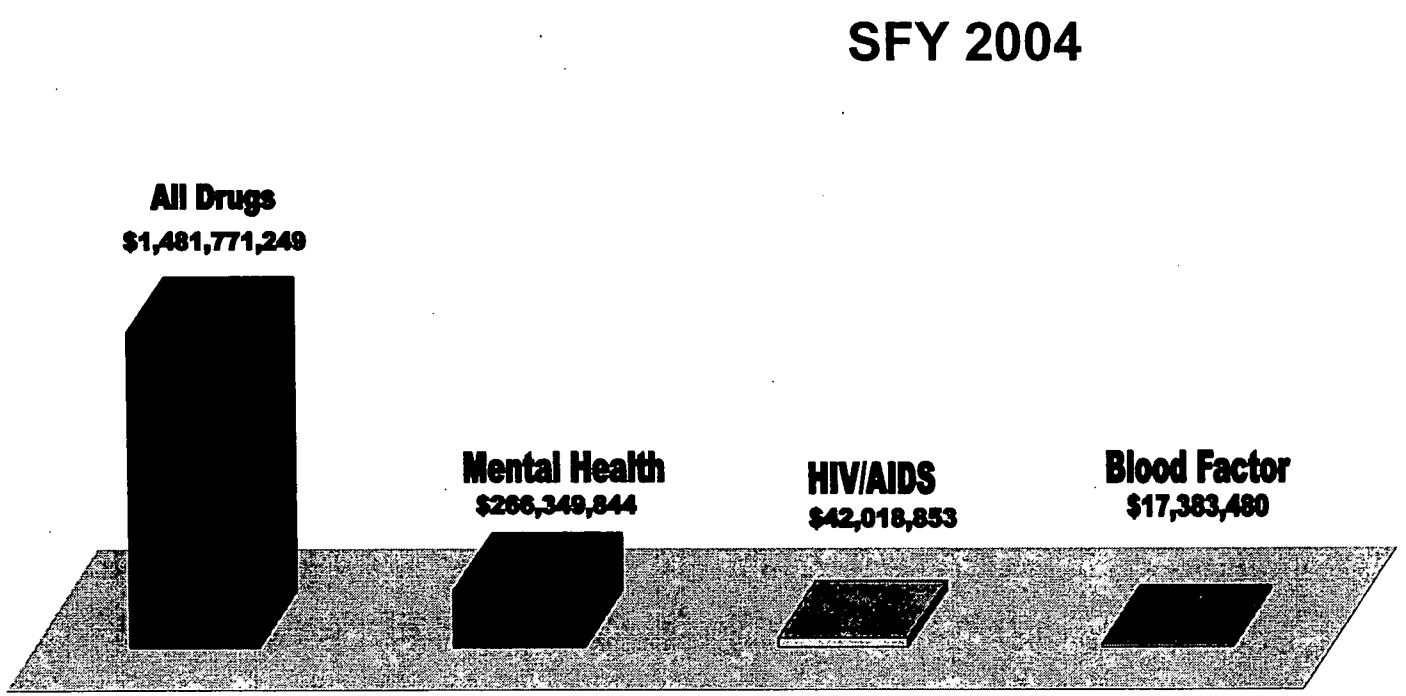
NC Medicaid Pharmacy Program

- The Medicaid Outpatient Pharmacy Benefit is an optional Federal Medicaid service. It is an elective service currently provided by all 50 states for their recipients.
- If the state elects to provide the Pharmacy Benefit to Medicaid recipients, the State must follow the requirements in SS 1927, OBRA 90 and 93.
  - Prospective Drug Use Review
  - Retrospective Drug Use Review
  - Patient Counseling

Medicaid Drug Claims Breakdown by Brand, Generic, and Multi-Source



Medicaid Drug Claims for Mental Health, HIV/AIDS, Blood Factor



Top Current Drug Class Rankings (SFY 2004)

	Drug	Amount Paid ($)
1	ANTIPSYCHOTICS,ATYPICAL,DOPAMINE,& SEROTONIN ANTAGONIST	135,274,991
2	GASTRIC ACID SECRETION REDUCERTS (including Proton Pump Inhibitors)	132,064,823
3	ANTICONVULSANTS	90,736,297
4	ANALGESICS,NARCOTICS	68,126,788
5	LIPOTROPICS (cholesterol lowering drugs)	63,740,923
6	SEROTONIN SPECIFIC REUPTAKE INHIBITORS (SSRIS)	56,693,542

Top Drug Expenditures by Drug Name (SFY2004)

Rank	Drug	Amount Paid ($)
1	PREVACID 30 MG CAPSULE	38,569,328
2	NEXIUM 40 MG CAPSULE	30,910,683
3	PLAVIX 75 MG TABLET	20,290,258
4	PROTONIX 40 MG TABLET	18,215,055
5	OMEPRAZOLE 20 MG CAPSULE	16,767,807
6	ZYPREXA 10 MG TABLET	14,731,048
7	CELEBREX 200 MG CAPSULE	14,557,775
8	SYNAGIS 100 MG VIAL	11,772,059
9	NEURONTIN 300 MG CAPSULE	11,451,632
10	ZYPREXA 5 MG TABLET	10,906,842

Terminology

- AWP- Average Wholesale Price. For NC, this price is calculated by First Data Bank (FDB). FDB updates and sends our drug pricing file weekly to EDS.
- FDB uses the manufacturer's WAC (wholesale acquisition price) to determine AWP. AWP will usually = WAC+20% or WAC +25%.

Current North Carolina Reimbursement

- All prescriptions are reimbursed at the lower of: AWP-10%, State MAC (Maximum Allowable Cost), FUL (Federal Upper Limit) + a dispensing fee or at usual and customary charges + dispensing fee

- Dispensing fees: Brand $4.00 per RX
  Generic and OTC $5.60 per RX

North Carolina Copays

- Copays- Brand $3.00
  Generic and OTC $1.00

- By law, the state cannot charge greater than $3.00 for a copay.

- ** The pharmacy cannot deny the recipient their medication due to a lack of copay funds

Comparison With Other States

State	Reimbursement Rate	Dispensing Fee	Copay	PDL	PA
NC	Lower of:AWP-10%, State MAC, or FUL	Generic & OTC: $5.60 Brand: $4.00	Generic & OTC- $1 Brand:$3	PAL	Yes
AK	AWP-14% (brand) AWP-20% (generic)	$5.51	$.50 $3.00	No	Yes
FL	AWP-13.25%	$4.23	0	Yes	Yes
SC	AWP- 10%	$4.05	$3.00	Yes	Yes
VA	AWP-10.25%	$3.75	$3.00 generic $2.00 (brand)	Yes	Yes

Comparison With Other States

State	Reimbursement Rate	Dispensing Fee	Copay	PDL	PA
MS	AWP – 12%	$3.91	$1.00 $3.00	Yes	Yes
TN	AWP -13%	$2.50	Varies	Yes	Yes
W.Va	AWP – 12 %	$3.50 $4.50	$.50- $3.00	Yes	Yes

Pharmacy Management Initiatives

- October 2001
  - Pharmacy copay changed to $3.00 for brand name drugs. Generic drugs remained $1.00
- December 2001
  - Pharmacy dispensing fee changed to $4.00 for brand name drugs. Dispensing fee for generics remained at $5.60
  - MAC (Maximum Allowable Cost) Initiative Goal: establish a consistent low price for drugs produced by many manufacturers

Pharmacy Management Initiatives

- March 2002
  - Pharmacy Prior Authorization implementation (ACS is our Pharmacy Benefits Manager)
  - Generic Conversion Initiative
- July 2003
  - Optimizing 340B enrollment
- October 2003
  - Medicaid recipients can obtain a 90 day supply of a medication at the discretion of the prescriber if the claim is for a generic, non-controlled maintenance medication (listed on the FUL or SMAC) if the recipient had a previous 30 day fill for the same medication.

Pharmacy Management Initiatives

- October 2003
  - New selected OTC coverage policy to include Prilosec OTC, Claritin OTC, selected loratadine OTC products, along with Insulin
    - Co-pay = $1.00 per RX
    - Dispensing fee = 5.60 per RX
- November 2003
  - Initiated statewide implementation of the PAL (Prescription Advantage List)

Pharmacy Management Initiatives

- July 2004 per 2004 legislation
  - Weight loss drugs no longer covered as of July 1.
  - Weight gain drugs- Seeking advice from NCPAG Pharmacy Committee for clarification

Community Care Network

- PAL: evidenced based review, actual cost analysis, and rollout
- Nursing Home and Adult Care Home polypharmacy
- Diabetes and Asthma initiatives
- High risk case management

Generic Conversion

- Initiative for outpatient pharmacy providers to increase generic dispensing and substitution rates for non-long term care Medicaid recipients

- Implemented in July 2002

- Estimated Total Savings
  - SFY 2003: $15,073,000 (State Share: $5,643,000)
  - SFY 2004: $16,329,000 (State Share: $6,066,000)

Generic Conversion

- **Generic Dispensing Rates (Total Generic scripts/Total Scripts)**
  - Prior to Implementation: 44.5%
  - SFY 2003: 47.7%
  - SFY 2004: 48.5%
- **Generic Efficiency Rates (Rate at which a generic could be and was dispensed by a pharmacist)**
  - Prior to Implementation: 87.7%
  - SFY 2003: 92.3%
  - SFY 2004: 94.8%

Source: Mercer

Maximum Allowable Cost (MAC) List

- **Implemented in December 2001**

- **Estimated Total Net Savings**
  - SFY 2003: $62,715,000 (State Share: $23,481,000)
  - SFY 2004: $63,011,000 (State Share: $23,409,000)

PA Drug Cost Savings for COX-2 Inhibitors (e.g.Celebrex)

- PA implemented in March 2002
- Total amount in paid claims for recipients <59 years old:
  - Prior to PA implementation (Mar. – Dec. 2001): $11,825,979.60
  - After PA implementation (Mar. – Dec. 2002): $4,764,506.46
- **Net calculated savings** (after subtraction of administrative fees) = $7,035,337.04
- **Annualized savings**: $8,442,404.45

Pharmacy & PAL Update

Allen Dobson, MD

Oct 6, 2004

NC Legislature

Prescription Advantage List

- Major contribution is methodology to look at net cost of individual drugs to NC Medicaid
- Voluntary provider education on relative cost of medications to NC Medicaid
- PAL list focuses on 10 of the most expensive classes
- Uses evidenced based approach

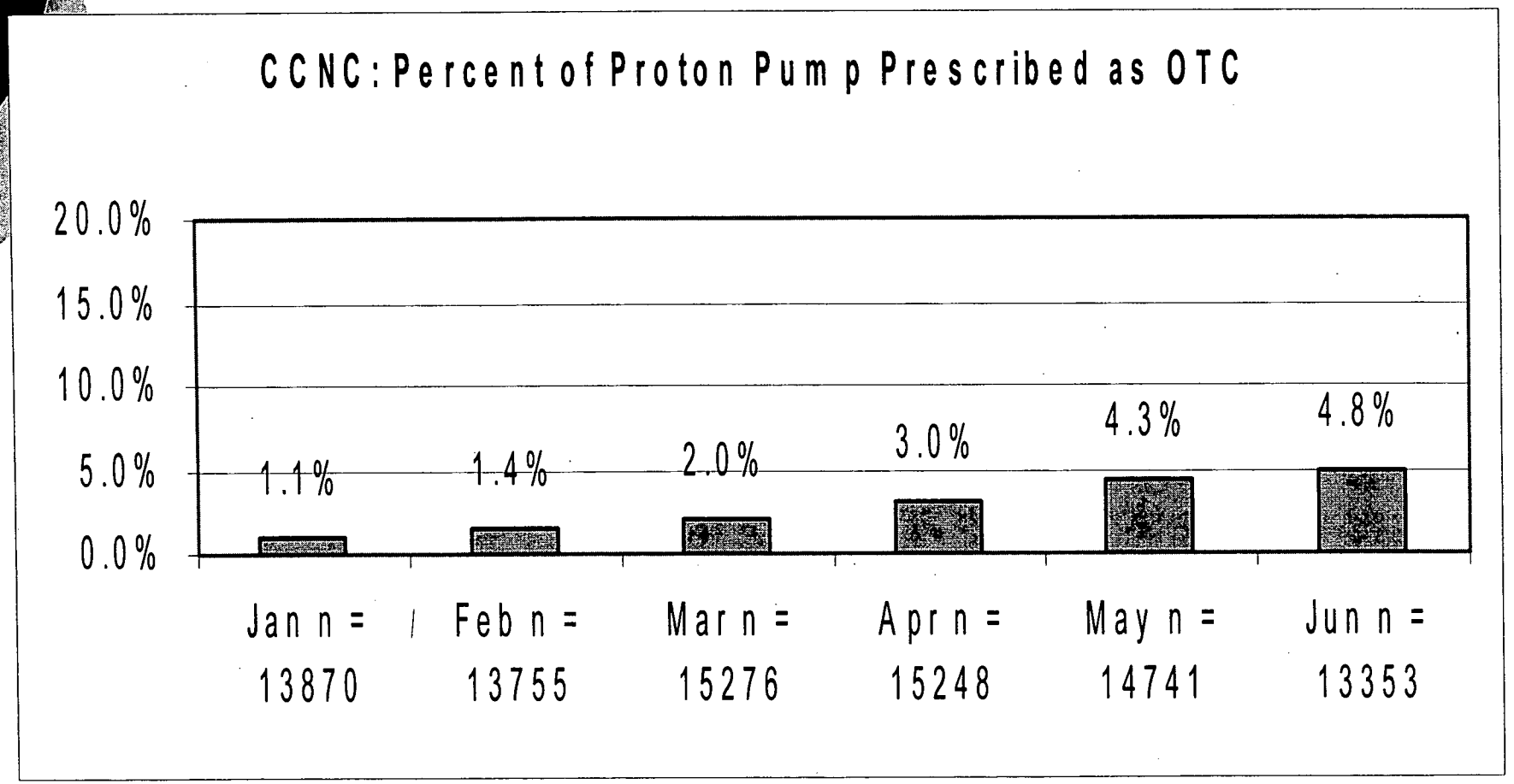
PAL Progress

- Early Saving realized
- Automated reports just now being generated due to MIS re-bid- data lacking
- Slower than expected year to date savings due to:

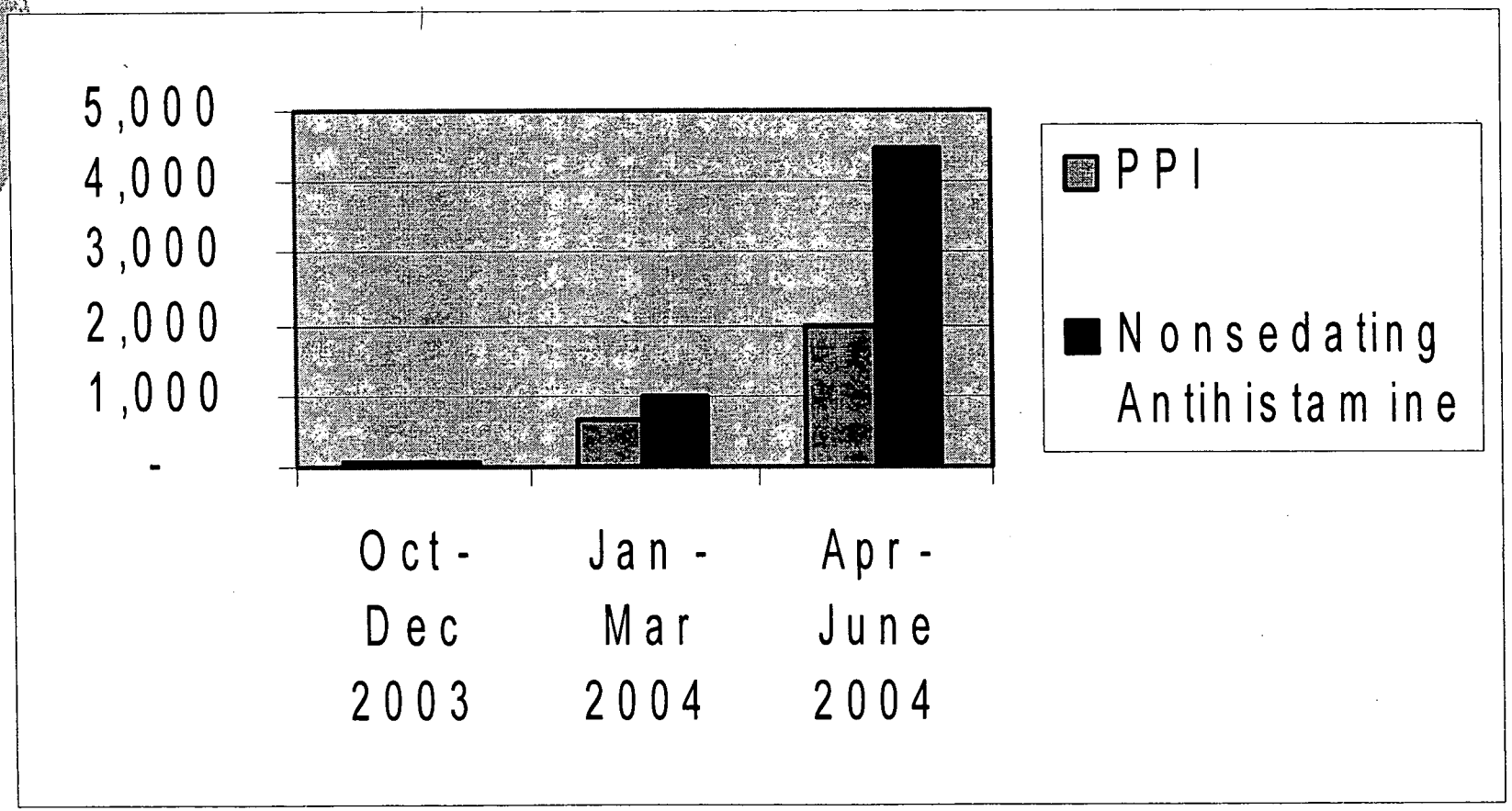
1) Most medications are chronic – multiple refills so lag in opportunity to make change
2) Limited availability of Prilosec OTC

Community Care of NC
" PAL progress"

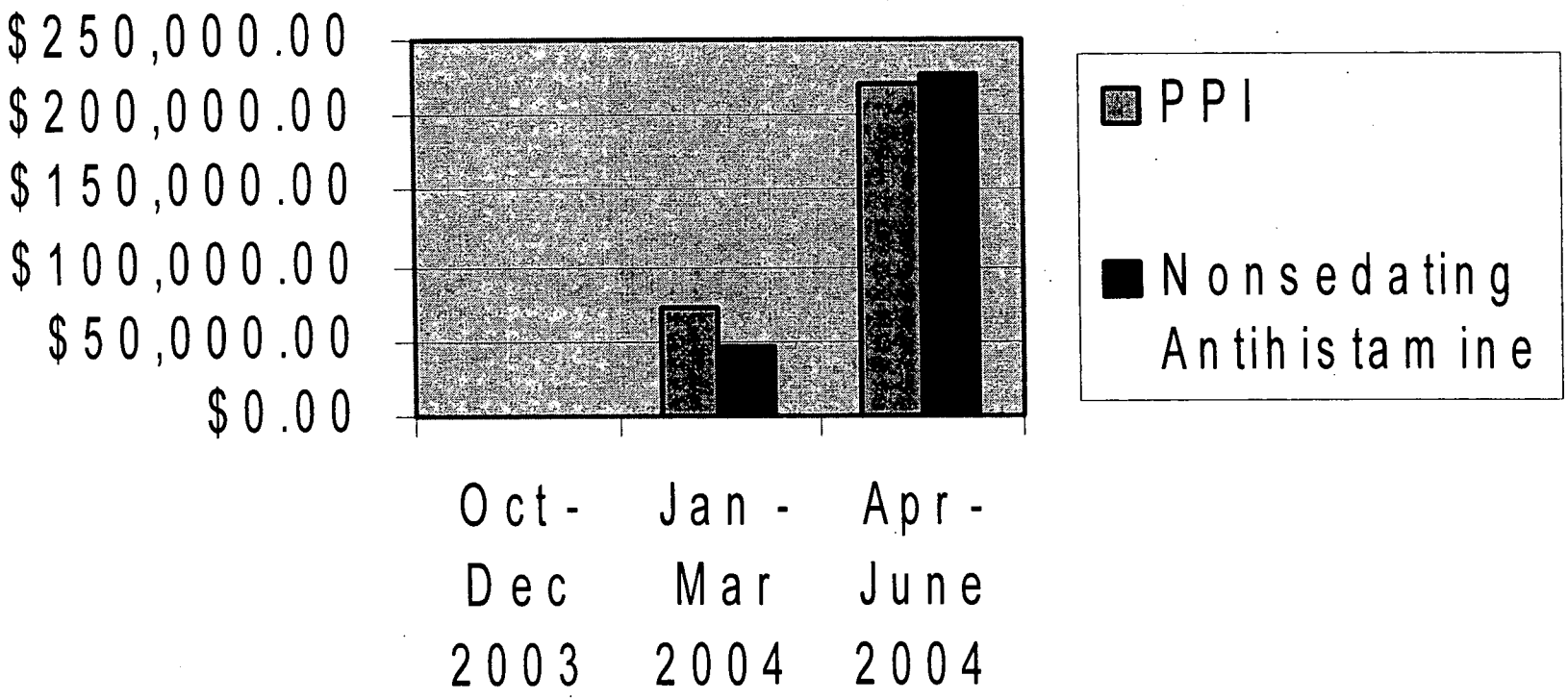
Increasing Utilization of OTCs



CCNC OTC Prescriptions by Quarter



CCNC Savings by Quarter



Opportunities for Managed Pharmacy Utilization/Savings

CCNC & NCPAG

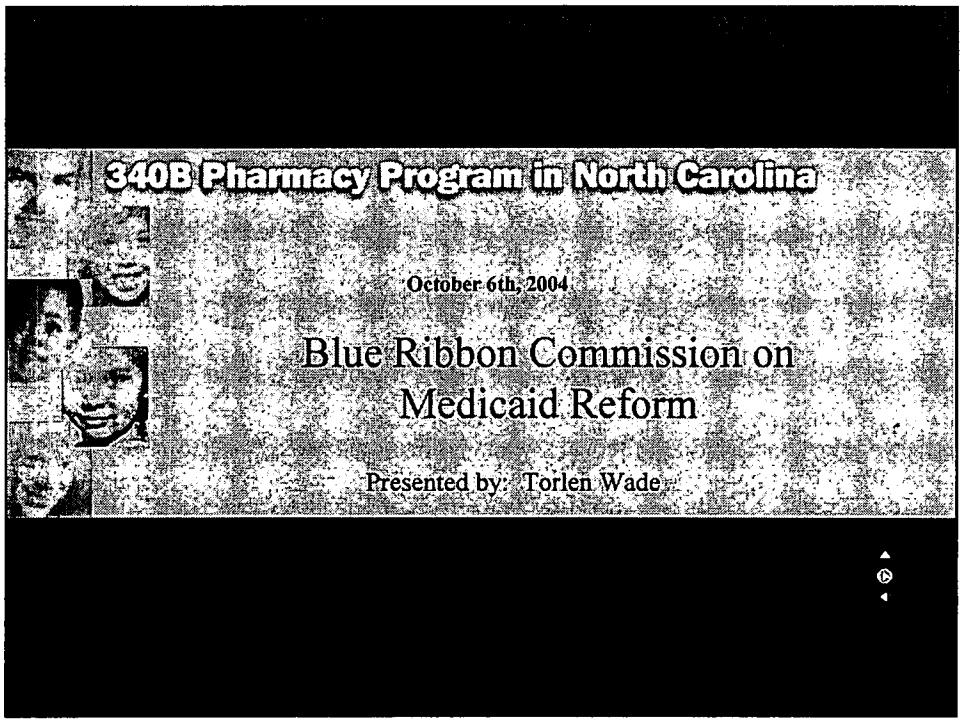
Facts regarding Pharmacy Costs

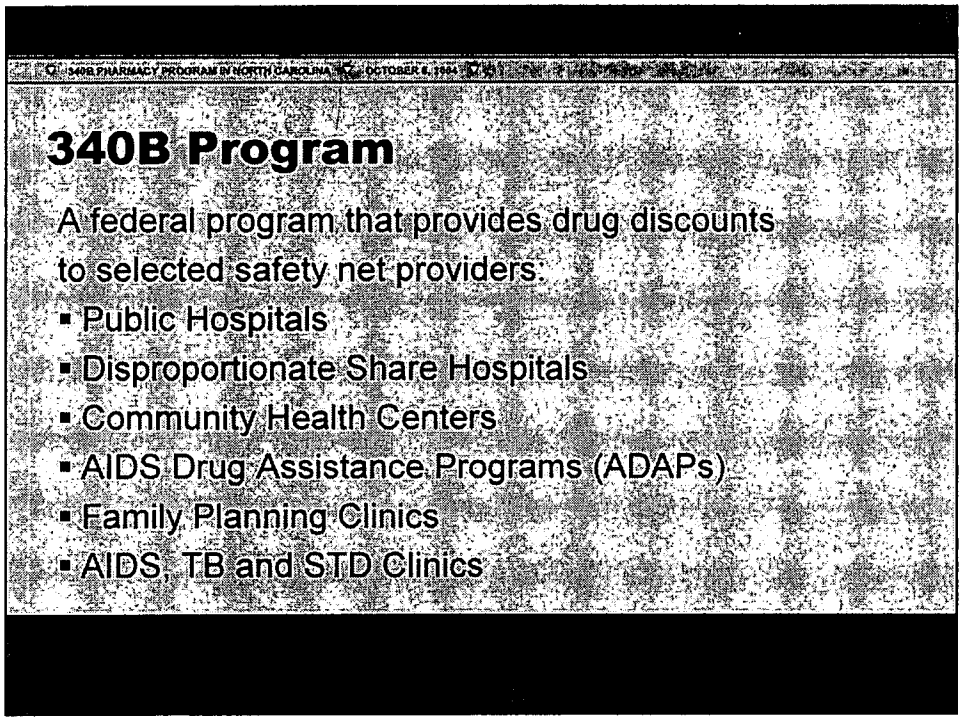
- >25% of Pharmacy Costs are in Behavioral Medicine Drugs (appx. 150 drugs & no current tools to manage)
- Approximately 80% of potential initial PAL savings are in 2-3 classes of medicines (PPIs, nonsedating antihistimines and sleeping pills)- possibly $25- 27 million for FYE 2005
- Additional management tools needed to better manage the pharmacy program

Expanded Management Tools

- PA- continue targeted PA where clear criteria and data supports this approach
- PAL- revise and target specific classes where maximum savings available (include evidenced based medicine pearls)
- *Specialized Disease Registry- for low volume/high cost specialty drugs*
- *Targeted Active Intervention- identify providers and patients where data supports a change in therapy. Uses peer to peer contact to modify behavior (currently done with nursing home pharmacy)*

Handout #5

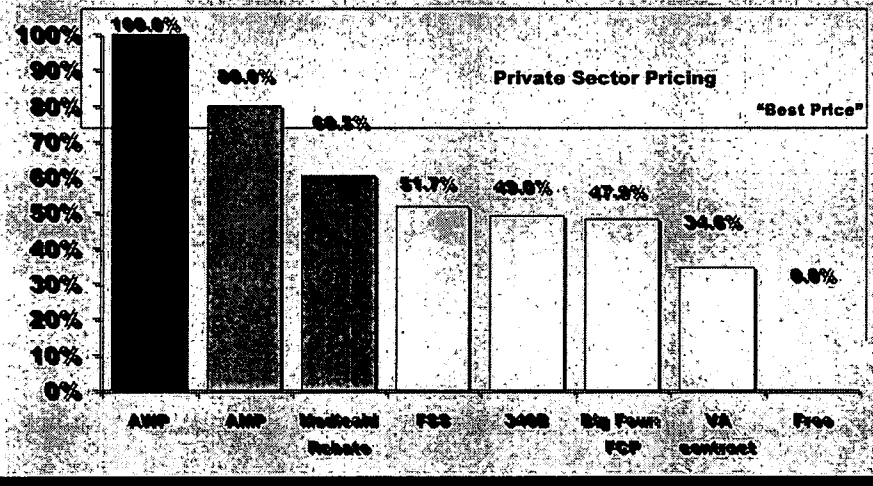

340B Pharmacy Program in North Carolina
October 6th, 2004
Blue Ribbon Commission on Medicaid Reform
Presented by: Torlen Wade


340B PHARMACY PROGRAM IN NORTH CAROLINA
OCTOBER 6, 2004
340B Program
A federal program that provides drug discounts to selected safety net providers:
Public Hospitals
Disproportionate Share Hospitals
Community Health Centers
AIDS Drug Assistance Programs (ADAPs)
Family Planning Clinics
AIDS, TB and STD Clinics

340B Program Overview

- Use of 340B drugs limited to "patients of 340B entity".
- Only applies to outpatient drugs.
- Safety net providers, uninsured patients, and Medicaid benefit most.
- Medicaid must be billed at acquisition cost by 340B entity.
- Medicaid cannot claim rebate on 340B drugs.

How Do 340B Discounts Compare to Other Prices?



340B Opportunities For States

- Reduce Medicaid reimbursement for outpatient drugs because 340B providers bill Medicaid below standard reimbursement rates.
- 340B hospitals are saving state Medicaid programs an average of almost $300,000 per hospital per year.
- Many eligible hospitals, community health centers, and other facilities are not participating in 340B.

DHHS 340B Strategy

- Assist eligible entities with 340B enrollment.
- Explore 340B Alternative Method Demonstration Program opportunities.
- Other

Assisting Eligible 340B Entities

- Joined with NC Hospital Association to sponsor two 340B educational sessions.
- 30 hospitals attended these sessions.
- Developed a 340B participation contract.
- Provided application resources and TA.

Status of Hospital Enrollment Effort

- 8 hospitals participating in 340B program at the start of the project.
- 50 hospitals eligible to participate.
- 32 hospitals now enrolled.
- 2 hospitals with applications pending.
- Nationally 56 rural hospitals are enrolled (19 from North Carolina)

340B Alternative Method Demonstration Program

- Wake County 340B Project:
- Build a provider network around exisiting 340B providers (Wake Med, Wake Health Services and Wake County Health Department).
- The network would provide case management, disease management and pharmacy services to 30,000 Medicaid and indigent patients.
- A complex project requiring significant change to Medicaid systems.
- Further development postponed for one year.

340B Demonstrations in Other States

- Prison patients (Texas)
- Hemophiliac patients (Utah)
- Mental Health patients (Texas)

In each of these demonstrations, a 340B provider agreed to provide health care services, including pharmacy, to these populations.

STATE OF NORTH CAROLINA

NORTH CAROLINA GENERAL ASSEMBLY

STATE LEGISLATIVE BUILDING
RALEIGH, NORTH CAROLINA 27601

October 21, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

SUBJECT: Meeting Notice – Please Note Change of Date from November 9 to November 16, 2004

The Blue Ribbon Commission on Medicaid Reform will meet as indicated below. Topics for discussion at the meeting include financing of the Medicaid Program and its impact on county budgets.

DAY:	Tuesday
DATE:	November 16, 2004
TIME:	10:00 a.m. – 3:00 p.m.
LOCATION:	Room 643, Legislative Office Building

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. The cost for visitor parking is $.50 per hour or $4.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

Please advise Anne Wilson, Committee Assistant, at (919) 733-5707, or e-mail medicaidca@ncleg.net if you will be unable to attend.

Posted: October 21, 2004

cc: Committee Record ✓
Interested Parties

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION, MEDICAID REFORM November 16, 2004
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
NOAH WOODS	ROBESON Co. COMMISSIONER
Lee Ann Coe	NCPA
Tom Sw	NCRMA
Linwood Holmes	NCMS
Steve Keene	NCMS
Hugh Tilson	NCHA
Evelyn Lawrence	EHCR
Myron Terry	Pfizer
Mary Carey	PHS
DAVID BARNES	Poyner + Spruill

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION, MEDICAID REFORM November 16, 2004
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Pearson	
Lori Ann Harris	L.A.H.A
Ben Tyson	NCCHCA
John McKay	Gov office
William A. Potter Jr	NCDS & NCPTA
Zee Lamb	NCACC - Bertie Co.
Norris Keene	NCACC - Alexander Co
Phil Jarrell	NCACC - Alexander Co.
Jimmy B. Clayton	NCACC Person Co.
Raymond Stone	NCACC FRANKLIN CO
HARRY P. MEADOWS	NCACC JONES COUNTY

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION, MEDICAID REFORM November 16, 2004
Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Goodman	Alley Associates
Bob Hedlund	NCCSPC
Patricia Peeler	NCACC
Pearl Burris-Floyd	Gaston County Commission
Anne Burgdorff	Pitt County Attorney
Lanier Cansler	DHHS
Kipling Godwin	Columbus County Commissioner
Jeffrey Simms	DHHS

BLUE RIBBON COMISSION ON MEDICIAD REFORM
Tuesday, November 16, 2004
10:00 p.m., Room 643 LOB

Chairmen: Senator William Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

I.	**Opening Remarks**	*Chairs*
II.	**Impact of Medicaid on County Budgets**	
	NC Association of County Commissioners	*Dr. Breeden Blackwell, Cumberland County Commissioner, President of NCACC*
		David Young, Buncombe County Commissioner, NCACC Steering Committee on Human Resources
	Supporting Comments	*Zee Lamb, Bertie County Manager*
		Pearl Burris-Floyd, Gaston County Commissioner
		Larry ~~Jones~~ Meadows, Jones County Manager
		W. Morris Keever, Chairman Alexander County Commission
		Noah Woods, Robeson County Commissioner
III.	**Options for Reducing the County Share of the NC Medicaid Program**	*Carol Shaw, FRD Staff*

IV.	**Mercer Evaluation of Community Care of North Carolina**	*Jeffrey Simms, Assistant Director Division of Medical Assistance*
V.	**Commission Discussion**	*Chairs*
VI.	**Future Meetings and Closing Remarks**	*Chairs*

BLUE RIBBON COMMISSION ON
MEDICAID REFORM
Tuesday, November 16, 2004 at 10:00 a.m.
Room 643, Legislative Office Building

MINUTES

The Blue Ribbon Commission on Medicaid Reform met at 10:00 a.m. on Tuesday, November 16, 2004 in Room 643, Legislative Office Building. The following members of the committee were present: Senators William R. Purcell (Co-chair), Fletcher Hartsell and Charlie Dannelly; Representatives Edd Nye, (Co-chair), Julia Howard, (Co-chair), Jeffrey Barnhart, Bob England, and Beverly M. Earle; public members Daniel C. Hudgins, William A. Pully, Pam C. Silberman, Luckey Welsh, Dr. Al Wentzy, and Dr. Charles F. Willson. Senator Purcell presided.

Senator Purcell welcomed members and guests and said the floor was open for a motion to approve minutes of the October 6 meeting. Dr. Wentzy moved for approval and Dr. Willson seconded the motion. Members approved the motion.

Senator Purcell announced that presentations and comments by elected and professional representatives of the North Carolina Association of County Commissioners would address Medicaid issues and that the Assistant Director of the North Carolina Division of Medical Assistance would discuss Community Care of North Carolina.

Senator Purcell asked Dr. Breeden Blackwell, Cumberland County Commissioner and President of the North Carolina Association of County Commissioners (NCACC), to present the first agenda item, "Medicaid from the County Perspective". (See Handout # 1.) Dr. Blackwell started by noting that this is the first opportunity county commissioners have had to present their concerns with regard to Medicaid reform and expressed their appreciation for the opportunity. He said counties are in a crisis in their efforts to fund the county share of Medicaid and need immediate relief. He gave special recognition to Dr. Wentzy, a member of the committee who has championed the counties' cause from the local to the national level. He said he wants members to understand the county view of Medicaid funding and will provide background and historical perspective to the crisis. He added that David Young will offer some recommendations to manage this crisis and a few individual counties will relate their own stories to help the committee to understand the impact of its decisions.

Dr. Blackwell said counties pay $71 million a year for Medicaid administration in addition to the Medicaid services provided. Federal and state laws determine who is eligible, but county employees in the departments of social services actually screen and determine who is eligible. Counties pay all employee and administrative expenses and then receive about 50% in federal reimbursement to support these costs. The Task Force looked at this in depth and concluded that counties should continue the administration of the Medicaid program because counties could manage human services programs better than regional Medicaid offices. He said he has heard people say that if counties don't

have a role in funding Medicaid, they have no incentive to control eligibility. He pointed out that, contrary to that notion, federal and state requirements control eligibility. Counties do not. He added that counties have no voice in deciding what services are provided, or how much providers are paid, in addition to having no voice in deciding who is eligible.

Dr. Blackwell said the Medicaid funding crisis is not a new problem and that they have been working for solutions for a number of years, culminating in a vote by the entire NCACC membership in the last biennium to have Medicaid relief as its No. 1 legislative goal. The cost of Medicaid growth was of such importance that they spent a year studying its implications for counties and bringing new recommendations to the General Assembly. Dr. Blackwell said Mr. David Young in the next presentation would look to the future and identify NCACC proposals looking toward the next legislative biennium. Dr. Blackwell suggested naming a county commissioner as a full member or an ex officio member of this Blue Ribbon Commission. He said he appreciated the expertise and professionalism exhibited by the directors of social services who are here today and others who want to augment their contribution with information on general county policy.

Senator Purcell asked Mr. David Young, 3rd Vice President of the NCACC, a Buncombe County Commissioner and member of the NCACC Steering Committee on Human Resources, to present the counties' goals. Mr. Young said Medicaid is an economic driver in communities and is needed. He said, for example, health care is the No. 1 industry in his county. He said the Steering Committee asked counties to submit a list of goals for 2003-04. (See Handout # 1, Page 16.) The first goal was to seek legislation to implement a phase out of county participation in the costs of Medicaid beginning with a cap at current costs in the year 2003. Other goals were listed on Page 17 of the handout. He said they set up these guiding principles based on lengthy deliberation and their conclusions were that all counties need help. He said a cap on growth helps everyone, and counties with high Medicaid eligible populations need special attention with state funding of certain services or client groups. He said the NCACC proposal for 2005-06 is to cap county Medicaid costs at 2004-05 levels beginning 2005-06, target additional relief to counties with high Medicaid populations (The state average is 17.4%) and phase out the county share of Medicaid over some period of time. Mr. Young said the NCACC is open to options and suggestions other than those presented and are basically saying that all counties need help, especially the smaller counties.

Dr. Willson said the commission heard at the first meeting that Medicaid's economic impact on North Carolina, if viewed as an industry, is greater than tobacco and asked if the financial impact of Medicaid spending on these counties has been studied and is there any county sales tax that would benefit through that spending as well. Dr. Blackwell said that analysis has not been done, but that they would get that information.

Senator Hartsell said he and other legislators have considered and proposed legislation in the past that looked for balance in addressing the counties' role in service delivery for the state, particularly in the human services area and asked what would be an

appropriate role for counties in providing for health care services or assistance in their own communities if the state were to eliminate the county requirement for Medicaid funding. Dr. Blackwell said his initial response would be that counties would continue to do the eligibility part of Medicaid. He said they are not asking for relief in that responsibility because counties can do that at a lower cost than the state could, for example, by setting up a Medicaid clinic. Ms. Rebecca Troutman, Director of Research & Public Technology of the N. C. Association of Commissioners added that counties provide health departments locally and are the primary supporters of the health departments where many residents seek direct care. She added that some counties provide some hospital funding and that counties are the direct provider of services through EMS and some other direct care services. Senator Hartsell said he is aware of those services, but the question is what is the appropriate standard for counties in providing health care services to their own constituents, if Medicaid funding were eliminated as a requirement, given the role of counties. He said the real is question is, how far do counties want to go. Mr. Young responded that Buncombe County provides primary care for all citizens through the Health Department, which is unusual for counties. He said counties are providing the administration for Medicaid and should continue to do that. He said counties are asking for help with the cost, because counties have no control over costs or who is eligible.

Senator Dannelly noted that someone said counties have no voice in determining eligibility and asked if counties feel that costs would go down if they were in charge of determining who is eligible for Medicaid. Dr. Blackwell said the counties are already determining eligibility in the DSS and he does not know whether costs would decrease. Ms. Troutman said local county employees are required to follow state and federal law and there is no leeway in that. She said the county cannot influence that and is one reason the counties are asking for relief in paying the service costs. Senator Dannelly asked which way costs would go if counties could influence the process and Dr. Blackwell replied that no one should be denied coverage who needs it. He said he doesn't know whether the number of eligibles or the cost would go up or down. He said he believes counties are doing an admirable job in determining eligibility and the desire of counties is not to neglect the population that needs services. Senator Dannelly said the legislature is concerned about the cost going up also and asked Dr. Blackwell if he thinks the federal government or the state is responsible for the increased costs or are other factors responsible, i.e., cost of drugs, etc. Dr. Blackwell said the county commissioners have discussed this problem with all fifteen of the state's congressional representatives, but he believes probably the best people to answer that question are the frontline people sitting on this commission.

Senator Purcell asked for members' comments on this question and Dr. Wentzy said he would vouch for the fact that the county departments of social services and the county commissioners have absolutely no voice about the eligibility or the expense of Medicaid. He said the rules come down 100% as the "Medicaid bible" and if counties deviate, they are wrong and get an audit finding. He said counties are constantly audited and reviewed and added that if counties were given the option to impact that standard some counties, particularly those with 25%+ of citizens qualifying, would be forced to

make the decisions that this General Assembly has supported, i.e., providing services to our citizens is the top concern. Dr. Wentzy commended the General Assembly for extending all these services to needy citizens and commended the NCACC for recognizing that in the beginning.

Ms. Silberman said she thinks the three basic drivers of Medicaid costs are eligibility, utilization and cost of services, all of which have risen probably as a result of the economic downturn in addition to provider increases given by the General Assembly. She said some rates were increased last year for the first time in three years, so all of these factors drive health care costs for Medicaid and a comparisons of per eligible cost increases are likely to be less in Medicaid than in a commercial plan. She said this is not a new issue to any commission member or the General Assembly and the concern seems to be that the state does not have the money right now to take over the county share of the cost. She suggested that one alternative might be to cap what counties pay at the current amount and advise them not to expect a growing amount in future years. Mr. Young said the cap would be a tremendous help because it would let every county manager and finance director know what their costs are, which would be a good first step.

Mr. Welsh commented that capping is great except for the poorest counties because, generally, utilization does go up across the board because of what is happening in health care. Poor counties with high numbers of uninsured people and a high number eligible for Medicaid are financially challenged by the expectation of providing health care. He said a large percentage of the tax rate has to go to Medicaid, thus reducing the resources available for other needs such as schools. He said he believes capping the counties' share at current levels without some relief for the poorer counties is not the right decision. The commission, he said, must look for some way to reduce counties' costs.

Dr. Blackwell said Medicaid is vital because it covers the poor and medically needy – those whose medical costs are outside their reach. Medicaid covers those patients who would never qualify medically for private insurance regardless of the cost. It is largely used by the elderly through long-term care, prescription drug costs and the disabled, making up only 30% of the clients, but using 69% of the resources. While thousands of children and families are covered their costs are minor, compared to their numbers. Medicaid helps fund services for health departments, public hospitals and mental health programs. If Medicaid were scaled back, he said, it would overwhelm emergency rooms and force counties to support these costs at 100% of local and state funding. Medicaid's economic benefits – an essential economic driver in many communities – cannot be underestimated. While the Medicaid program is critical, the county funding of these services is not working, which is the point being made today. He said counties support Medicaid's essential services and its economic benefits, but county budgets cannot keep pace with the inflationary increases. Each year, the Department of Health and Human Services releases county-by-county Medicaid estimates to help in budget planning. For the current fiscal counties must pay $440 million, a 14% increase over last year alone and a 67% increase in just the last five years. National estimates project a continuing 15% per annum increase. Counties have faced a 10% annual

average increase in Medicaid since 1998, but the property tax base has increased at only 7.7% annually, on average. The only way to manage this revenue expenditure gap without cutting other vital services is to raise property taxes, the major source of funds. Dr. Blackwell said property taxes and Medicaid are a poor fit and does not work. The property tax is only source of income under counties' control and is not keeping pace with Medicaid services costs. Furthermore, poorer counties have lower tax bases to support these costs, which leads to more inequities.

Dr. Blackwell said state law requires a county Medicaid match, but federal law has no requirement. North Carolina state law requires counties to pay 15% of the non-federal share, currently 5.4% of the total of $8.2 billion. Counties pay a portion of the cost for their eligible residents regardless of available resources. While some states require some county funding, the amount varies from none to a percentage approximately in the range of North Carolina. He said a NCACC Fiscal Task Force – with the assistance of Masters students at the University of North Carolina – looked at required Medicaid funding for more than a twelve-month period. In their survey, they found that twenty-eight states out of forty-five responses did not require any county participation and only New York requires its counties to help pay for all Medicaid services. He said fifteen other states had some county participation with South Carolina requiring a relatively small amount – one lump sum of $15 million for all counties in the state. In other states, counties own and operate Medicaid provider facilities such as nursing homes or rest homes. Counties receive the revenue stream for these facilities, so some states require the counties to match those services.

Dr. Blackwell said federal law mandates statewide uniformity. Thus, decisions regarding Medicaid costs are made exclusively by the counties' federal and state partners, leaving counties no control over one of their biggest budget drivers. He said the year long Task Force concluded, after much research, thought and discussion, that county funding for Medicaid services is inappropriate if general guiding principles are applied to determine who pays and who benefits. Dr. Blackwell argued that, generally, local dollars should support local services so citizens can influence what they are willing to pay for. He said no county flexibility is allowed in the system and the requirement to participate in Medicaid implies a statewide uniform tax base, even through the property tax in fact is not a uniform tax base. Medicaid decisions drive county budgets to the detriment of other services that can be targeted to meet unique county needs. Medicaid is a major budget driver for counties and other states have recognized that counties should not be Medicaid funders. The situation is most acute in poorer counties where more of their residents consume Medicaid services. It is the counties' demographics that drive Medicaid costs because a higher number of eligible recipients and a higher number of services equal higher county costs. He said some examples are Anson and Richmond counties with over 25% of their populations eligible for Medicaid, while Scotland County has over 30% eligibility. In addition, Bladen County also has over 30% eligibility, Sampson has more than 25% eligible and both Cleveland and Rutherford have more than 20% of the total population receiving Medicaid services. Dr. Blackwell said these counties are likely to be disadvantaged for a long time and will make it difficult to provide for other county needs such as building and maintaining schools. He said

counties are statutorily required to build and maintain schools and if Medicaid is the biggest budget driver, it impacts on the ability to provide safe and adequate schools. Currently, he said forty-eight counties spend more on Medicaid than on school construction and five counties spend more on Medicaid than on current expenses for schools. He said Cumberland County's Medicaid costs have soared over 56% in the last five years and consumes $.09 on the tax rate. Even with the military health insurance, 18% of Cumberland's population is eligible for Medicaid.

Dr. Blackwell said that Cumberland has a county-owned hospital and presently provides excellent services to the community while primary care clinics throughout the county provide assistance to citizens. He said counties provide health department funding, social services funding and mental health funding and are not trying to abdicate responsibility to citizens regarding health care. Senator Hartsell said his real question is, if the Medicaid requirement is eliminated there needs to be some standard or requirement, because that is the reason for counties' existence. He added that anything counties can do to assist the General Assembly to identify what the requirement might be in an alternative setting, for clinical services or otherwise, would be greatly appreciated. Dr. Blackwell said that counties want to partner with the General Assembly and believes that the NCACC and the General Assembly can form a partnership that will work for the citizens. He added that they are open to suggestions of citizens or the General Assembly. Dr. Blackwell said a cap on the county share of Medicaid would be a good first step, but he hopes there can be a long-range plan, perhaps phased in, for the elimination of the county share.

Dr. Wentzy said, with regard to the direct and/or inferred question as to the degree of responsibility of counties, that he believes the data from other states show that sharing Medicaid costs is not a common policy.

Mr. Pully said he noticed that many of the counties having difficulty with funding Medicaid are agricultural areas and asked if any research has been done to see what kind of impact the tobacco buyout is likely to have on property tax revenue. Ms. Troutman said the Association is working with the Property Tax Division of the Department of Revenue to quantify what impact the quota buyout will have on the tax base. Dr. Blackwell said they would provide that information when it is available.

Dr. England addressed the issue of special assistance to adults, which costs the state about $134 million with counties sharing half of that. He said this is a non-Medicaid funded program, while its recipients are probably 100% Medicaid eligible, and asked where this additional $67+ million will fit in the counties' legislative plan. Mr. Young said it would be hard to ask for expansion of Medicaid while counties are asking for caps and/or reductions in their share costs. It would be a problem because some counties have been hit very hard.

Senator Purcell recognized Mr. Zee Lamb, Bertie County Manager, for comments. Mr. Lamb said he and others are asking for relief on the Medicaid dollars, the 15% passed down to counties. He said they are not asking that the state take over the

administration of services. He said Bertie County supports its health infrastructure, a brand new hospital, thanks to a cooperative effort with Pitt Memorial and East Carolina University. He said Bertie County is putting $120,000 a year into indigent funding and constructing a new health department building, which indicates the county's commitment to health care for its citizens. He said local people should not be involved with setting eligibility criteria, which might create different standards across the state and further the notion of "two North Carolinas". Mr. Lamb said the original intent of the 15% pass-down to the counties was not to hurt low wealth counties, but the notion was that counties would better control the cost of Medicaid if they had some role in controlling who was found eligible. As this discussion has shown, however, the criteria for eligibility has not been set by counties. He said, while the intent was not to hurt small counties, the effect has been to very much hurt the low wealth counties disproportionately because the state spreads 85% of the non-federal share of Medicaid among all the people of the state. He said counties believe that 100% of the costs should be spread among all the people because the 15% pass-down to counties punishes those that are poorest. In Bertie County, 33% of the people are Medicaid eligible, which is twice as much as the state average and four times as much as Orange County. He said 15.7% of Bertie's budget goes toward the Medicaid line item, while Dare County's line item for Medicaid is 1.7%, in Durham County it is 2.1%, in Currituck it is 2.5%, in Mecklenburg it is 2.9%, and in Wake it is 2.9%. In Bertie County, 25% of the entire budget goes to social services and Medicaid and thirty cents on Bertie's tax rate goes toward the cost of Medicaid while the state average is seven cents. The per capita cost of Medicaid in Bertie County is $120 for every man, woman and child while the state average is $54. He said Bertie has been economically challenged by the peanut buyout, the tobacco buyout and the closing of a Wrangler plant last year where 380 jobs were lost. He added that some good things are happening in Bertie – a new prison is being built and will provide 415 jobs. In addition, he said Bertie has its first major (500 lots) subdivision with an Arnold Palmer Golf Course in the plans and an un-typical economic develop project in our regional landfill that brings in trash from more than twenty counties in eastern North Carolina.

Mr. Lamb said Bertie County commissioners are concerned about things other than Medicaid, including education. In the past two years, they have increased the budget for current education expenses by 12% and 5%. This year Bertie has $2.1 million for current education expenses, which is less than the amount for Medicaid. SAT scores in Bertie are more than 200 points lower than the state average. Bertie wants to provide better law enforcement for its communities and grow the new parks and recreation program. But, unfortunately, Bertie will spend more money on Medicaid than for current expense for education. Bertie will spend about the same amount for Medicaid that it gets on the 2½ cents sales tax, while some counties collect ten times or more in sales tax than they spend on Medicaid. The North Carolina School Forum ranked Bertie County at 99th in the ability to pay for education costs two years ago, but the county has progressed to 97th currently. Mr. Lamb said there is a correlation between being first in Medicaid spending and 97th in education and a look at the numbers across the state shows this to be true. He said there are correlations in counties also between high Medicaid costs and a relatively high tax rate. Two years ago, Hertford County did a revaluation as required

every eight years, and was forced to set their new tax rate at $.91 cents. They went from a $1.09 to $.91 at the beginning of the eight-year cycle.

Mr. Lamb said he is aware that bills have been introduced in the General Assembly to look at this issue and believes this is the time to give counties relief. He said he agrees with the NCACC's position to cap spending and urged members of the commission to look at helping poor counties with their heavy loads. Various plans are out there, he said and suggested one called a 20/20 plan: cut the county share by 1% a year and by the year 2020, it will be gone, while other plans would cut 1% this year, 2% next year and 3% each of the next four years. He noted that The Leandro Decision – which involves $220 million – is to be implemented and there is the $440 million that counties will spend this year on Medicaid. Mr. Lamb said Bertie wants to do the right thing for its citizens, but believes it cannot be done with the current pass-down to counties.

Senator Purcell commented, with regard to statements about property tax rates, that his county – Scotland – has a rate of $1.10, which is the highest in North Carolina.

Senator Purcell recognized Ms. Pearl Burris-Floyd, Gaston County Commissioner, for comments. Ms. Burris-Floyd said she represents the 193,000 citizens of Gaston County and shares Medicaid's effects on the people she represents from the property tax point of view and what is happening as a result of the increased costs of Medicaid. She said actual Medicaid payments nearly doubled in five years from $7.1 million in 2000 to $13.9 million in Fiscal Year 2005. This is an average of 20% per year while the state average is around 17%. Interestingly, in Fiscal Year 1991 Medicaid was only $2.2 million in Gaston, which means it has increased by 630% or at a compounded annual rate of 14% per year since 1991. None of Gaston County's revenue has grown at that rate. This has had a tremendous negative effect on economic development and as a result the burden of shouldering county progress rests on the backs of the taxpayers. Ms. Burris-Floyd said Medicaid took 6% of Gaston's combined property and sales taxes ten years and today it takes 11.5%. Over the last five years, Gaston's per capita Medicaid costs increased by 90%. She said Gaston is the seventh largest county in the state and is the second largest in the Charlotte region, but in other Charlotte Metro counties, Union and Cabarrus for example, the per capita increase in Medicaid costs was only 40%. Ms. Burris-Floyd said the very counties that are hardest hit by the economic downtown are forced to pay the most in Medicaid costs, creating a major disincentive for economic development.

Ms. Burris-Floyd said Gaston County has lost over 10,000 jobs during the last six years because of the decline of the textile industry. She said 19% of Gaston's residents are eligible for Medicaid, which translates into 38,000 residents and $.12 on the tax rate. Gaston's current tax rate is $.89 after it went through a revaluation last year and was able to reduce the tax rate by only $.30. Union County, for comparison, has 4% of its citizens eligible for Medicaid and they pay $.04 on their tax rate and in Iredell County, 5.6% of citizens are eligible and pay $.05 on their tax rate.

Ms. Burris-Floyd said Gaston's DSS employees are doing a great job in handling Medicaid cases, although the load has increased significantly. On average, Gaston has 912 Medicaid cases per worker, a tremendous workload, compared with employees in Cabarrus County who handle 550 Medicaid cases, Catawba County employees who handle 580 cases and Iredell County employees who handle 343 cases. Still, this high productivity results in a disproportionate burden on Gaston County taxpayers.

Ms. Burris-Floyd said the economic downturn has caused property tax values to drop at the same time that Medicaid costs are rising. She said Gaston lost $210 million in industrial value over the last two years alone, mostly in personal property as factories have closed and been removed from the industrial production equipment tax rolls. Gaston County has a low total valuation, 43% less in per capita assessed valuation compared to the rest of the Charlotte Metro area because of the large numbers of small mill homes and the large number of mobile homes. She added that residential property now bears 80% of the total taxes, up from 72% just seven years ago. The rapid increase in the mandate of Medicaid costs combined with the loss of industrial valuation has turned Gaston's system upside down. The advent of free trade agreements may make some regions of the country winners and others losers, but without a system of sharing the cost, counties will be affected disproportionately. She said Gaston County is trying to offset this burden in a number of ways: 1) developed a public/private partnership to benefit health care. Gaston Family Health Services and a foundation that is a 501(c)(3) organization helps take care of the indigent population. Gaston is expecting 32% increase because of individuals who were once working in Gaston County making over $50,000 a year from factory jobs are now unemployed. They are now eligible for Medicaid and are too young to receive any other benefits and who cannot maintain their lifestyle working in various service positions; 2) Gaston has begun looking at forming a foundation for the Health Department. The Health Department has not refused to treat any patient who has gone there. Gaston government maintains a strong relationship with Gaston Memorial Hospital and Caremont Health Care; 3) a hospital foundation has been formed and Gaston's citizens have been asked to give and give again and they have continued to do so.

Ms. Burris-Floyd asked for the commission's help – first to cap the Medicaid costs and to follow that by phasing out the county's total responsibility for a share of the cost of Medicaid.

Senator Purcell recognized Mr. Larry Meadows, the Jones County Manager, for comments. Mr. Meadows said Jones County is in rural eastern North Carolina and its largest town, Maysville, has 1,004 citizens. He added that Jones County has fifty-seven manufacturing jobs, the smallest number in any county in North Carolina. He said Jones County's population is 10,381 and is a Tier 1 county, but would be Tier 2 were it not for the rule about being a county with less than 10,500. Jones County covers 497 square miles but one-fourth of the county – Croatan National Forest – is owned by the federal government and N. C. State University owns some land in that vicinity. He said Jones County is 99th in the state for revenue from tourism and in the Eastern Regional Partnership Jones has the smallest property evaluation at $501 million. He said Jones

County's total Social Services budget is $1,358, 811, which is almost $.27 of the $.75 tax rate and that the County pays $779,094 for Medicaid costs which equals to $.153 of the $.75 tax rate. For current expense, he said Jones pays $816,756, which is 16.9% of the tax rate, so they pay almost as much for Medicaid as for current expense.

Mr. Meadows said members probably already know what the problems are that Jones County faces. Since 1996, he said, the reduction of the total tobacco allotment in Jones County has been 60.84%. That is the county's money crop. It builds houses, buys combines, puts up the barns. He said two new schools are needed now – a high school and a middle school – and they have talked with the U.S. Department of Agriculture about a $10 million loan and grant package. He said they cannot afford to make the payments on the $10 million, which would not buy or build even one school. In addition, he said the county was made aware a couple of years ago that it is responsible for the safety and health care of Jones County citizens and, therefore, has a growing need for an EMS system. If the county does not provide the right kind of EMS services, it could be held liable for what happens to the citizens. The EMS system has evolved from a total volunteer service three years ago to six paid employees now and beginning July 1, 2005, it will grow to ten paid employees. Mr. Meadows said this growth will increase the tax rate by $.025.

Mr. Meadows said this has been the most important discussion and request the NCACC has brought before the General Assembly in the last five to ten years. If the commission could help in any way it would take counties toward a "one North Carolina" because now the counties that can least afford it are the ones who have to pay the most for it. County governments would appreciate any help that the General Assembly can provide because it is being done for the citizens. Counties will not cut taxes because of relief given to them, but will put those dollars back into the school systems and services for the people.

Senator Purcell recognized Mr. Morris Keever, Chairman of the Alexander County Commission, for comments. (See Handout # 2.) Mr. Keever said Alexander County's population is approximately 35,000 and is surrounded by Catawba, Iredell, Caldwell and Wilkes counties. He said Alexander County's development into a bedroom community impacts the property tax rate as does the heavy cost of sharing the expense of Medicaid for its eligible citizens. Alexander County's share of Medicaid costs this year is $1,775,000, which is 59% of the county's net cost of providing social services. Medicaid is 30% more than the Sheriff's Department budget and 40% more than the budget for EMS. Medicaid costs are 3.5 times more than the budget to operate the jail and 4.5 times more than the 911 communications budget. Medicaid expenses represent 20% of the current year property tax or 30% of the local option sales tax. Medicaid accounts for 7% of the total county's general fund budget. Mr. Keever said Alexander County's Medicaid cost increased from 2000 to 2005 by 78%, property taxes increased by 21% including the 2002 revaluation and local sales taxes increased by 31%, including a new one-half cent sales tax that went into effect in December 2002.

Mr. Keever said these are some examples of how Medicaid impacts counties. Generally, counties are told to raise taxes, which can be death for a career as a politician. County commissioners are very close to the voters, he noted, and enumerated some of the things Alexander County would do if funds were available: 1) the county would put in 200 miles of water lines to rural areas of the county, so the chicken production industry could expand, in addition to expanding the county-owned water system; 2) the county would increase its appropriation for the school system to increase the local share to 39% so salaries and supplements could be increased; 3) the county could complete a 9400 square foot addition to the social services building and save money on the interest; 4) the county could spend $450,000 for communications equipment needed for Phase 2 compliance without borrowing money; 5) the county could build a new jail with a 5-year loan instead of a 15-year loan and save $1 million in interest. Mr. Keever said these are several examples of how Alexander County would use the money spent on Medicaid sharing and added that several people have stated that they would do something within the counties to help the citizens. He said counties recognize that they are merely an extension of North Carolina government and would like to see a county-state joint effort of working together for a better Medicaid program.

Senator Purcell recognized Mr. Noah Woods, a Robeson County Commissioner for comments. Mr. Woods said Robeson County is expected to spend $11.6 million for Medicaid during this fiscal year and spending this amount on Medicaid will severely impact the needs of education and economic development in Robeson County. He said the tax rate of $0.91 limits the county's expenditures for current expenses and the $4 million for capital outlay for schools. The expenditures for these two areas are sorely needed. Robeson is second only to Duplin County in the percentage of people without medical insurance. He said 34% of Robeson's total population of 123,339 is eligible for Medicaid according to the census in 2000. He said ten percent of its citizens are 65 years of age or older and 25.3% of those elderly fall within the level of poverty. Mr. Woods said 30% of Robeson County children are within the poverty range and unemployment in Robeson County continues to pad the rolls of dependents upon the government for help on their health care bills. According to the North Carolina Employment Security Commission, about 8700 manufacturing jobs were lost between 1993 and 2003. In 2003-04, only 195 jobs were created in Robeson County. He said the county has a very outstanding economic developer who works with county commissioners to cause a lot of good things to happen through the incentives program.

Mr. Woods said they know that their school buildings are rapidly becoming unable to meet the new challenges that the curriculum needs today. The influx of low-wealth money for schools is insufficient to meet the needs of the children in Robeson County. He said 35% of Robeson County's population has less than a high school education and 30% have earned a high school diploma. He said students of color suffer from an achievement gap and added that, as a retired career educator and school administrator, he encourages this commission to give careful consideration to the impact of the lack of adequate health care in our communities for both the young and old. With business and industry moving toward health plans that are limited to employees there will remain a wide gap in health services for families and children. Adequate health care will

impact how well our children perform in school and how well they will perform in the workforce for the future. In Robeson County alone, he said, a one-cent reduction in the amount of tax allocated to Medicaid would generate $350,000 that would help the county to provide a better education of the young people of the county, which will subsequently impact the level of education for workforce development. He said these two economic indicators require the utmost attention as agricultural receipts decline, manufacturing jobs loss continue and families face new challenges in rural Robeson County. He said Robeson will not attract industry if it cannot educate and train dislocated workers and displaced farmers. Robeson cannot keep its children in school if they are not healthy and cannot provide adequate health care for the elderly if county resources are spread too thin. He asked the commission to consider the impact of the increase in Medicaid costs for the large number of children and elderly. He said Robeson County commissioners assure the commission that if the county had the $9 million that was spent last year on Medicaid cost sharing, it would be appropriately placed in education where the needs are.

Representative Nye asked Mr. Woods if recognition of the Lumbees by the federal government would bring any financial relief to the area and Mr. Woods said that based on what he has been told is factual information, the three areas that will be impacted are education, health care and economic development. Representative Nye asked if a casino on I-95 would help and Mr. Woods said a casino is not the issue, but the issue is the recognition of the Lumbees and the needs just mentioned. Representative Nye said he is a neighbor and asked if he could visit Robeson and get one of those Lumbee cards and Mr. Woods said he possibly could get an honorary card.

Senator Purcell commended Dr. Blackwell and the county commissioners for making a clear statement about the effects of Medicaid funding on counties and opened the discussion for questions. Ms. Silberman said she understands that North Carolina is one of the few states that require counties to contribute to Medicaid. She added that, on the other hand, North Carolina does not have a legal requirement that counties contribute to hospital care or to the provision of support for the uninsured. She said there are many ways that counties around the country are required to contribute, one of which is through care of the indigent – she noted that while it is not a legal requirement in North Carolina, some counties do provide this care. She asked if there are comparisons of other contributions that counties make. Ms. Troutman replied that the Association has not ranked counties in their participation in health care across the US. She said North Carolina has been working with the National Association of Counties around Medicaid reform because New York has an extreme burden in Medicaid since they too require it from their counties. Ms. Troutman said they know that counties are large providers of health care nationally. In Los Angeles, for example, counties provide the hospitals, so they are the provider and the recipient of the Medicaid stream. Counties in North Carolina are the provider of local dollars and also the recipient of the federal and state dollars coming back into the community. They have a limited role in hospitals, but are the primary provider of health care through health departments, paying about 80% of those costs, as well as the Medicaid costs. Ms. Silberman asked if there could be a follow-up and see what percentage of health care costs across the nation are paid for by

the counties, just to put it into perspective. Ms. Carol Shaw said that Fiscal Staff can work with the county commissioners' staff to see if there is a source for that information.

Representative Barnhart commented that he appreciates the struggles counties go through and understands the issues they face and added that legislators have tried to find ways to relieve the counties somewhat. He said Medicaid has been called a dinosaur without a leash and the question is how to get it under control in the midst of the state's budgetary problems. He said there is no quick fix and asked about the possibility of swapping some of the state's debt service for writing off public school construction – about $410 million – for the counties' Medicaid share which is about $420 million to $430 million – this would be in the ball park of looking at equals - so the capital school construction cost would go away after it is paid off while Medicaid would continue to increase. He said he threw out the idea as an option without many details and suggested that County Commissioner's Association and legislative staff could come up with a list of the overlaps between the counties and the state for funds and look at the process for any option to consider.

Dr. Blackwell replied that the County Commissioners appreciated Representative Barnhart's comments and will be happy to work with legislative staff to come up with some way to "trade" some program costs.

Dr. Wentzy said for the past four years he has worked, analyzed, studied Medicaid costs and had the pleasure of working with the Commissioners' Association during that period and is appreciative of the fact that they have formed a Medicaid Taskforce, which he was on, and put in a great amount of effort in working with the National Association of Counties about the national perspective of health care costs. He said he is appreciative of the fact that they have worked together and put together an excellent presentation on the actual situation with a group of recommendations. He said the Association has stood firm and above all, "I am absolutely delighted as a social services director with a calling to serve our citizens, that they have not picked away or criticized at any point the relevancy and necessity of the services provided to our citizens and I want to thank them for a job well done. I am personally committed to do all I can and resolved that the General Assembly has to do something to help counties."

Dr. Purcell asked Mr. Pully for comments about a survey conducted by the N. C. Hospital Association concerning support for care for the poor in North Carolina. Mr. Pully said last year the Hospital Association and the N. C. Academy of Family Physicians commissioned a public opinion poll to look at voter attitudes toward the state's Medicaid program and were pleased to learn that there is strong support in both political parties – Democrat and Republican – for bipartisan support of Medicaid spending and also spending for health care in general. He said it was gratifying to see that and he will be happy to share copies of the results of that survey.

Dr. Purcell asked Ms. Carol Shaw, Fiscal Research Division of the North Carolina General Assembly to review "Options for Reducing the County Share of the North Carolina Medicaid Program". (See Handout # 3.) She began by reminding members that

her presentation is about options in which assumptions have been made, particularly on what type of relief is given, and these options should be viewed as a starting point. She briefly reviewed the history of counties' cost sharing of human services in North Carolina because, she said, it is important to talk about how North Carolina became one of only two states that require such comprehensive county cost-sharing on Medicaid. She said about seventeen other states require some cost-sharing – usually administrative costs – which North Carolina does also. Other states tend to have cost-sharing of long-term care and hospitals, aspects of Medicaid where counties used to or still have county operations. She said, when North Carolina's cost-sharing arrangements are viewed from a historical perspective, it will be seen that they go back to the 1930s, long before Medicaid, because that is when the federal government began participating with the states in paying for what used to be called aid to widows, aid to dependent children who have lost a parent, aid to the aged, Aid to Families with Dependent Children (AFDC), food stamps, Supplemental Security Income (SSI), and the Social Security System. At that time, she said, North Carolina was paying 100% of the state's human services costs. Then the federal government came in to help states, North Carolina took on a share, the federal government was paying a share, and counties were asked to continue paying a share. In those years, counties paid 50% of the non-federal share. In the case of state/county special assistance, since that was a state entitlement program separate from anything involving the federal government, the state and counties shared fifty-fifty. Those standards are pretty much still true today, she said, even though AFDC has become Temporary Assistance for Needy Families (TANF) or Work First, through welfare reform.

Ms. Shaw, continuing to review the history, said the story is a little different for Medicaid, which was created in 1965. She said North Carolina did not take this option until 1971. In the 1971 legislative session, Medicaid cost sharing started out at 10% of the non-federal share and later in the session because of long term care, cost increases and the fact that counties still owned a lot of nursing facilities, it was increased to 15% of the non-federal share. It has been at that level since that time. The other interesting aspect of it is, the rate is not in the statutes, but it is in the statutes that there be a cost-sharing arrangement of federal, state and local resources. She said the actual rate the counties pay is set every year in the budget bill – which is referred to as the big Medicaid provision that sets what services are provided at what level. It determines eligibility. It is a one-sentence paragraph in the big special provision. She said as other programs evolved, interestingly, the other final, health-care related program, where the state and the federal share is North Carolina Health Choice, or what was called nationally the State Children's Health Insurance Program (SCHIP). At the time that program was brought to North Carolina and the program was set up, the state made the decision to not require counties to cost-share in that program. So North Carolina has gone from 50% of the non-federal share in the programs that were established in the 1930s to the early 1970s to 15% of the non-federal share to zero.

Ms. Shaw concluded that there is a long history of county participation and the way she would like to end this presentation as the commission considers what to do about Medicaid and the impact it has on counties – and Senator Hartsell may have been trying

to get at this issue earlier in the meeting – is to consider the role counties play in Medicaid financing and the role they play in all of human services financing, because that may be one of the ways to look at how the state will pay for the cost. She said big numbers are involved in paying for more or all or part of the state share of Medicaid and the commission may want to consider it in the context of all human services because counties have burdens there too, but they may consider those not as much of a burden as Medicaid.

Ms. Shaw reviewed "Options for Reducing the County Share of the North Carolina Medicaid Program" (Handout # 3) and concluded it by observing that the state is having budget trouble finding sources for this funding. She said, to cover the cost of the county share there may be the option of looking at how much counties pay for other human services, the option Senator Hartsell suggested about public school financing, some of the debt the state carries and the suggestions about swapping related to state and local taxes. Clearly, she said, anything the state chooses to do with regard to these options or some variation of them is going to cost money and a source will have to be found for that.

Following Ms. Shaw's review, Senator Purcell asked for comments and questions. Senator Hartsell asked if any of the per capita options took into account the existing efforts made to reduce per capita costs in terms of implementation on a broader basis and Ms. Shaw said they did not because she looked at it purely from a financial standpoint. She added there may be a way where certain counties who are more active participants in that effort could reduce the rate of growth of their Medicaid program, so that may be an area where a county could impact their per capita expenditure.

Dr. Willson said, as Community Care (Carolina Access) is expanded, there are some counties that have high rates per capita that are not members of this project and therefore the commission might consider making their reduction contingent upon their providers joining.

Mr. Welsh asked how targeted options vs. statewide options might be received because it could become an issue of "the haves against the have nots", so how would it be perceived to target certain counties vs. the whole state. Senator Purcell said it seems that the control of General Assembly shifted to the larger communities in recent years and Representative Howard said she and Representative Nye have looked at a list of counties that control the budget and where there would be no relief. She said this does not look like a viable option. Representative Earle disagreed and said members represent the whole state and do a good job of looking at how to bring relief to all areas of the state.

Senator Purcell said the Blue Ribbon Commission on Medicaid Reform will end in February 2005 and the commission will meet in December and January, which will allow time to develop proposed recommendations. He suggested that members think about what the commission should do.

Dr. Wentzy proposed that the Division of Medical Assistance assess commission recommendations so information can be available at the next meeting. Ms. Shaw asked if there is another way she could present the issue to develop additional options for consideration. She said she would follow up on the "ability to pay" issue if Fiscal Staff can find a way that would work. Representative Nye said he believes Ms. Shaw has presented a full range of options and he proposed that a listing of the revenue source for the options be developed, for example, revenue sharing that goes to counties. At one time, Representative Nye said, $500 million in revenue sharing was going to counties. Some revenue from the corporate income tax is going to schools and some money is going from other sources to counties. So, if the revenues are going to be re-arranged, the General Assembly needs to know what is coming in and where it is going. Ms. Shaw said she would work with the tax team to see what information is available.

Dr. Wentzy asked if the commission could take a look at the some combinations of the various options and Ms. Shaw said the important piece of information she would need to know is, if counties were capped, would the counties that get targeted relief also be capped. She said it is an important nuance in the analysis, but her analysis did not extend to combining options. She asked if the counties getting the lower rate would also benefit from the cap and Dr. Wentzy asked if he could see both ways analyzed. Ms. Shaw said she would try to do it both ways.

Senator Dannelly said he is interested in what Representative Barnhart implied relative to picking up one cost and counties picking up the others, i.e., school construction. He asked what would happen, if this option were developed, to those counties who presently cannot do any school construction without state help. Those are the same counties that are also struggling with Medicaid, so where would they go from there. He said options need to be further developed before he could decide which is best.

Senator Purcell asked Mr. Jeffrey Simms, Assistant Director of the Division of Medical Assistance in the Department of Health and Human Services to present the next item on the agenda, "Mercer Evaluation of Community Care of North Carolina". (See Handout # 4.) Mr. Simms reviewed the information and took questions from members. Representative Nye commented that Mr. Simms' company was asked to look at long term facilities and at the practice of dispensing drugs to that population. He asked Mr. Simms about the status of that project. Mr. Simms responded that the Poly-Pharmacy Initiation that Representative Nye referred to has gone very well. He said his company is working with the Long Term Care Association to perform a statewide analysis and work with nursing homes across the state as they are looking at ways to expand it to adult care homes. Representative Nye asked if the $6 million savings reported earlier is still accurate and Mr. Simms said he expects it to increase.

Dr. Willson asked Mr. Simms if the savings shown on the analysis on Attachment 2 and Attachment 3 are net savings and Mr. Simms said administrative costs have not been deducted from the totals shown.

Senator Purcell said the chairs and staff have proposed the next meeting of the commission for December 15, 2004 at 9:00 a.m. and suggested that members return with ideas about options for discussion. Dr. Wentzy asked if Ms. Shaw could forward copies of option proposals to members before the next meeting and she replied that she intends to do so.

Mr. Hudgins said he has a question for Ms. Shaw with regard to factoring in long term care as a county decision and said he would like to talk more about that at the appropriate time.

Representative Howard expressed appreciation to the County Commissioners' Association for their presentations and added that legislators understand the impact occurring at the county level with regard to Medicaid cost sharing. She said "one North Carolina" and "one America" have been heard often over recent months and added that the only to fix the cost-sharing burden is to phase it out. It would be a very costly endeavor and what components are used and how it is put together will be at the discretion of budget folks and the recommendations of this commission. Representative Howard said there is an equal utilization system across the state where the state and federal government tell the counties exactly what the criteria is and what the services are and added that the counties don't have equal funding, which is not fair. She said she believes members are committed to rendering the service and need to make the funding commitment as was done with teachers' pay and other things. She said there was a golden opportunity in The Golden Leaf Fund, but the legislature chose not escrow the dollars that should have been directed toward Medicaid as they were in many other states. Instead, she said, the decision was to do economic development in some of the poor counties, anticipating that this use of the Golden Leaf Fund would bring up the income levels that would help solve problems for local governments. Representative Howard suggested other options to raise the needed funds might include a tobacco tax toward a dedicated stream of funding or a Medicaid lottery.

Senator Purcell expressed thanks to the County Commissioners Association for their members' important statements and the staff for helpful information and options for consideration.

The meeting adjourned at 12:45 p.m.

Respectfully submitted,

Anne B. Wilson, Commission Assistant

Senator William R. Purcell, Co-chair

Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

Medicaid from the County Perspective

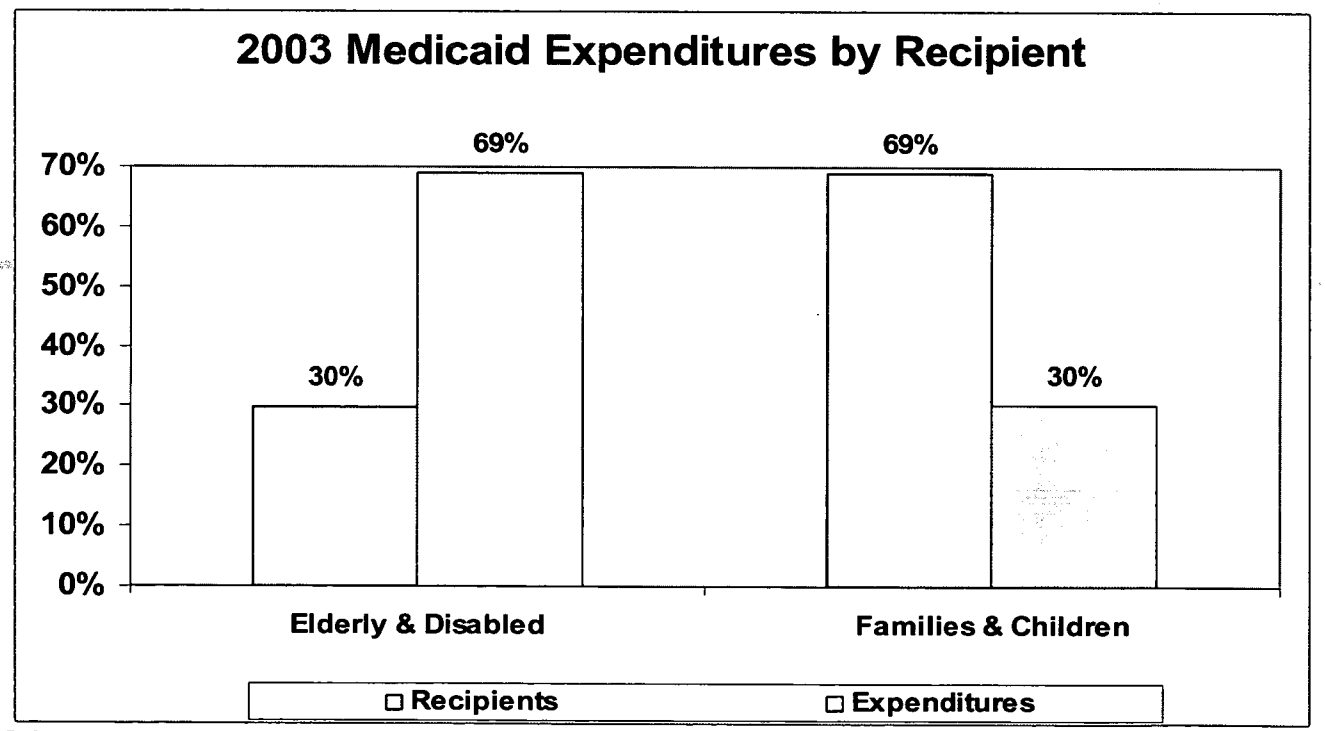
Breeden Blackwell, NCACC President
Cumberland County Commissioner

David Young, NCACC 3rd Vice President
Chair, NCACC Human Resources Steering Committee
Buncombe County Commissioner

Handout #1

Medicaid Critical for NC

- Medicaid covers elderly & disabled, as well as kids & families
- Medicaid covers high-cost care when no private insurance



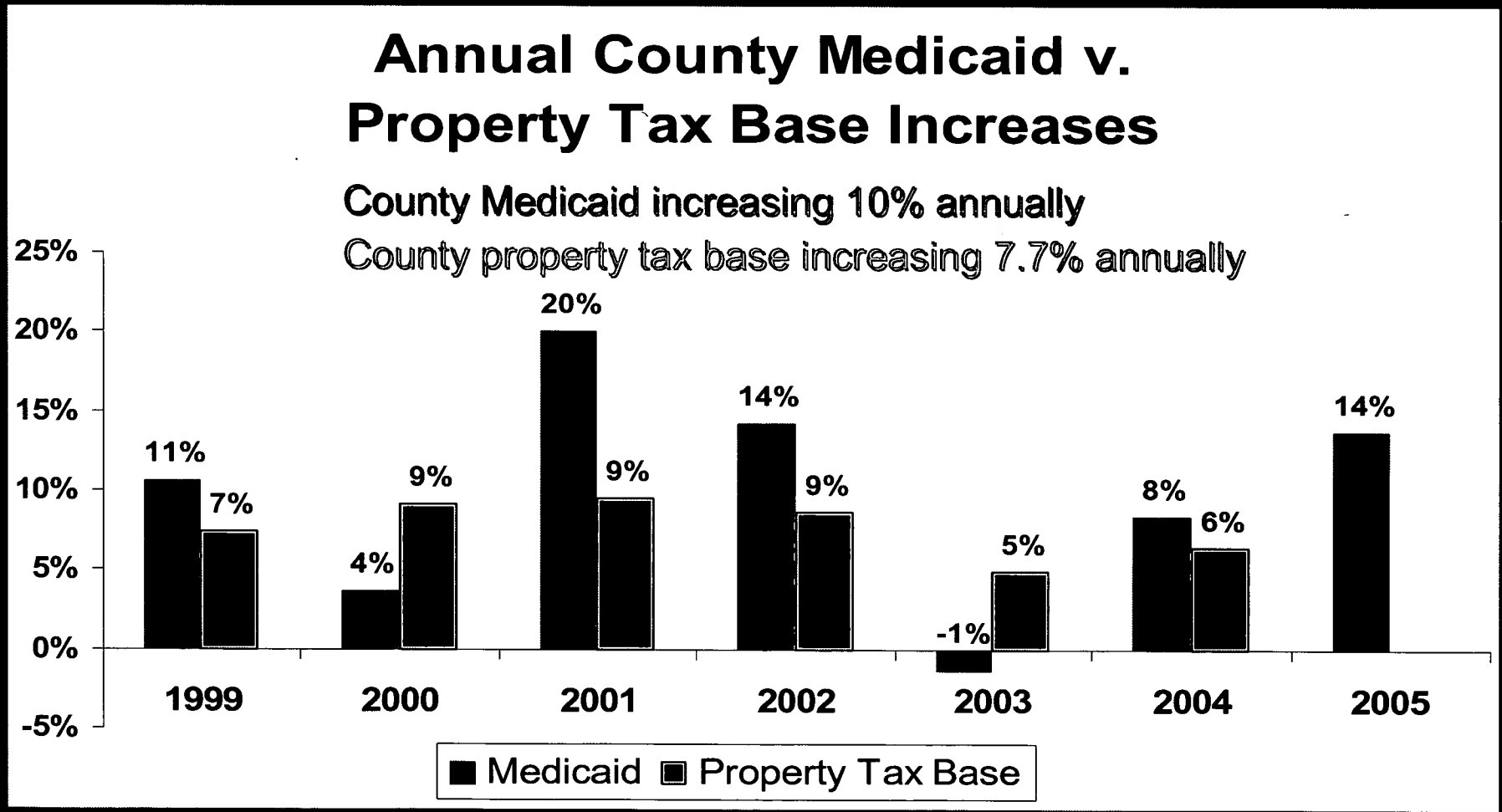
Medicaid Critical for NC

- Medicaid supports public health providers
  - County health departments & public hospitals
  - Without Medicaid, public agencies pay 100%
- Medicaid adds $8.2 billion to NC's economy

Counties Required to Match All Medicaid Services

- 2004-05 state estimates for counties = $440 million
  - 67% increase since 2000
- National estimates project a 15% per annum increase

County Revenues Insufficient for Medicaid



State Requires County Medicaid Funding

- No federal requirement
- State law mandates 15% non-federal share for all services
  - 5.4% of total Medicaid expenditures
  - Counties pay 5.4% for their Medicaid residents receiving services—burden is on individual counties

County Medicaid Funding Unusual

- No federal requirement
- New York only other state requiring county participation in all Medicaid services
  - 15 states require some participation, usually for services in county-owned facilities
- 28 of 45 states reported no county participation

Counties Also Fund Medicaid Administration

- 2004-05 state estimates for counties = $71 million
- State & federal laws determine who is eligible
  - County employees do the work
- Counties pay full non-federal share of Medicaid administration
  - Federal dollars support 50% of admin. costs
- No state support for county admin costs

Counties Can't Influence Medicaid Eligibility

- Eligibility is determined by strict state & federal requirements
- Counties don't set Medicaid policy, eligibility, services, provider rates
  - State & federal decisions alone
  - Must be uniform statewide
- Counties have NO control over biggest county budget driver

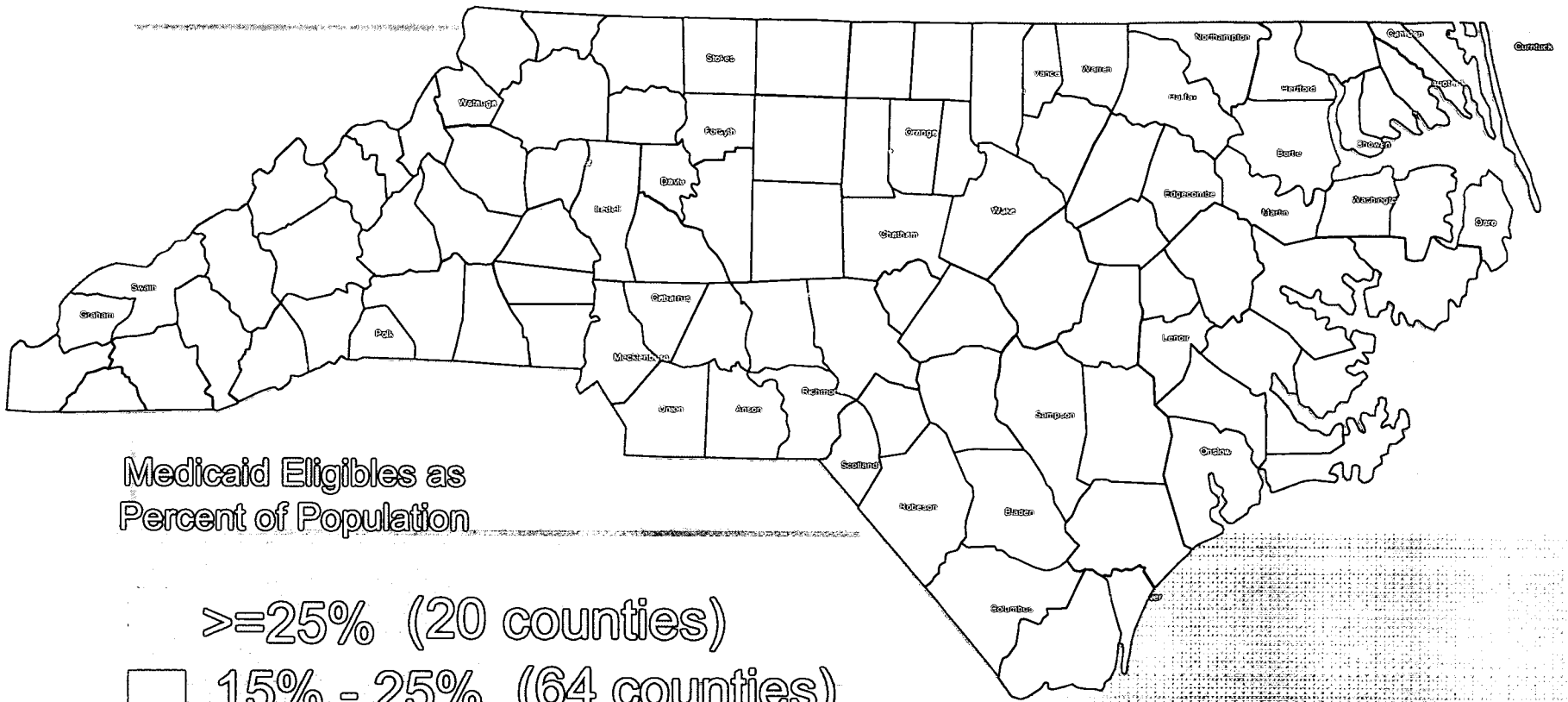
County Medicaid Funding Inappropriate

- Medicaid must be uniform statewide
  - Property taxes most suitable to support flexible service levels
  - Statewide uniformity in services demands statewide uniform tax base
- Counties can't control fastest growing budget line-item
  - Medicaid crowds out education, homeland security, economic development
- NC county requirement an anomaly
- Poorest counties hardest hit with fewest resources

Medicaid Eligibles Determine County Costs

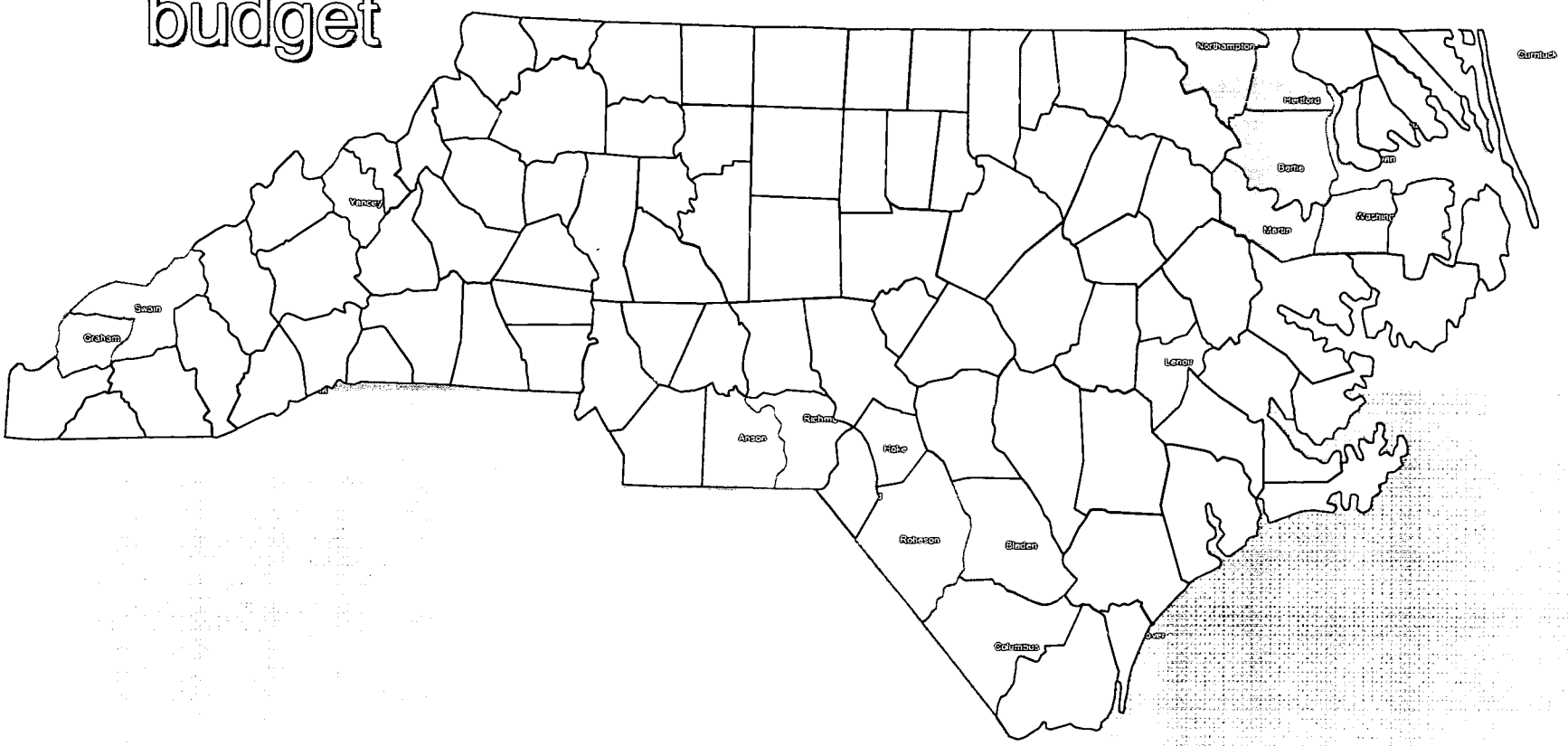
- 40 counties have Medicaid eligibles > 20% population
  - 20 of these have Medicaid eligibles > 25% population
  - 11 of these have Medicaid eligibles > 30%

North Carolina
Medicaid Eligibles Per Capita


Stokes
Surry
Yadkin
Forsyth
Davie
Iredell
Orange
Chatham
Wake
Alamance
Caldwell
Catawba
Rowan
Cabarrus
Stanly
Anson
Union
Mecklenburg
Richmond
Scotland
Moore
Lee
Harnett
Johnston
Sampson
Robeson
Bladen
Columbus
Brunswick
Pender
New Hanover
Onslow
Jones
Pamlico
Carteret
Craven
Lenoir
Greene
Wayne
Duplin
Wilson
Nash
Edgecombe
Halifax
Northampton
Vance
Warren
Franklin
Hertford
Gates
Chowan
Perquimans
Pasquotank
Camden
Currituck
Dare
Hyde
Tyrrell
Washington
Martin
Bertie
Perry
Graham
Clay
Cherokee
Macon
Swain
Jackson
Haywood
Transylvania
Henderson
Buncombe
Madison
Yancey
Mitchell
Avery
McDowell
Polk
Rutherford
Burke
Caldwell
Watauga
Ashe
Alleghany
Wilkes
Alexander
Iredell
Davie
Yadkin
Surry
Stokes
Rockingham
Caswell
Person
Granville
Vance
Warren
Halifax
Northampton
Gates
Chowan
Perquimans
Pasquotank
Camden
Currituck
Dare
Hyde
Tyrrell
Washington
Martin
Bertie
Hertford

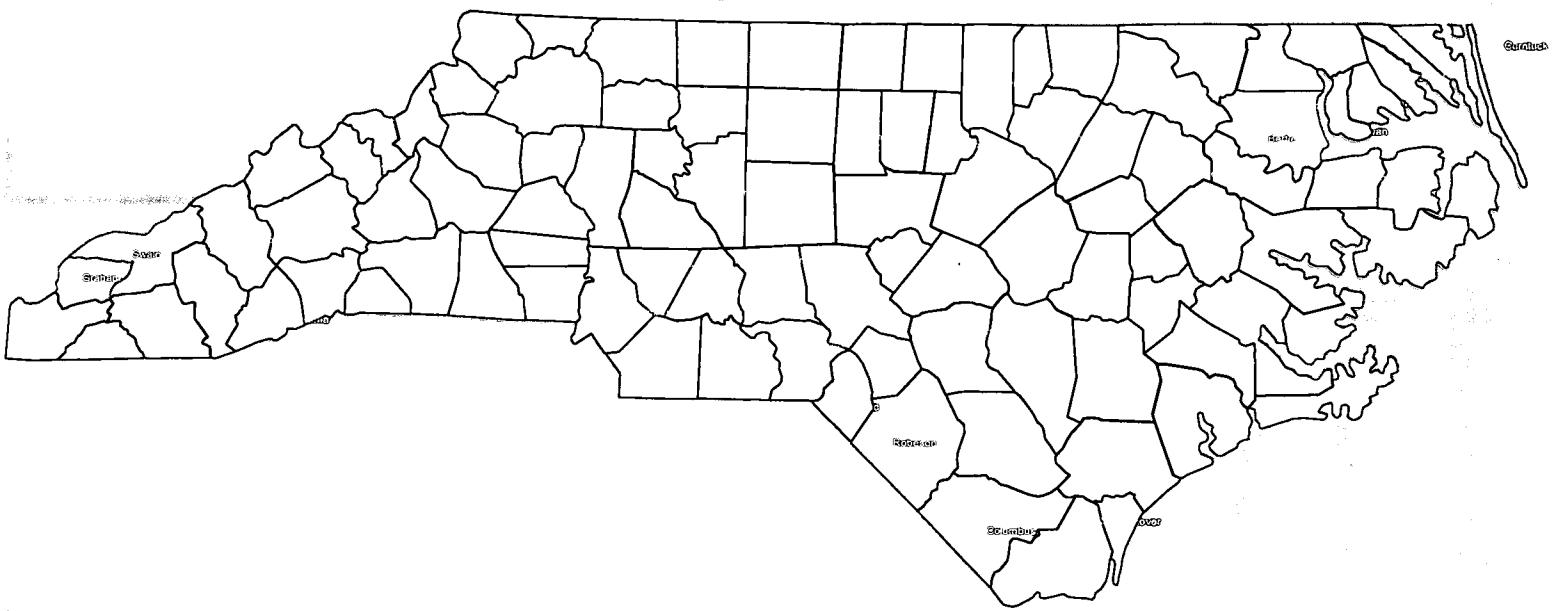
Medicaid Impacts All Counties; *Some More So*

- 15 counties spend more than 10% of budget



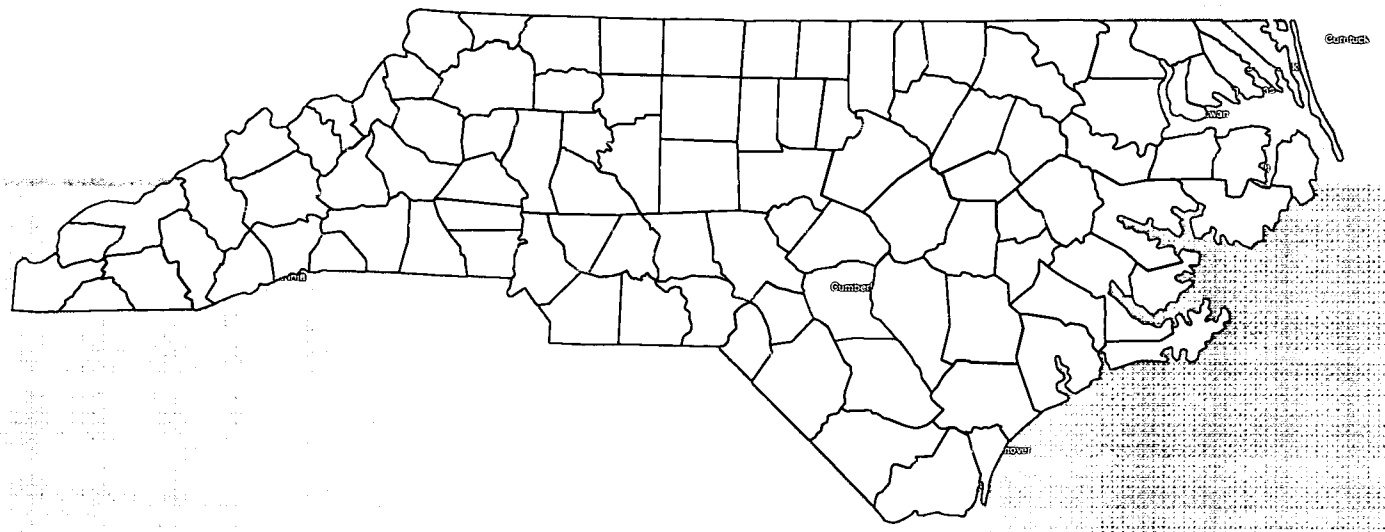
Medicaid Impacts All Counties; *Some More So*

- 48 counties spend more on Medicaid than school construction, renovation, other capital
- 5 of these spend more on Medicaid than school current expense



Cumberland's Story

- 2004-05 County Costs = $12.9 million
  - 56% increase in 5 years
- 18% population Medicaid eligible



Counties Ask For Relief!

- NCACC #1 2003-04 Goal—Medicaid relief
  - *Seek legislation to implement a 6-year phase out of county participation in the costs of Medicaid, beginning with a cap at current costs in the year 2003*
- Medicaid relief goal for 5+ years
- Year-long Fiscal Task Force focus & recommendation

NCACC Committee Considers A Range of Proposals

- Cap, then phase out
- Use "Low wealth" school formula
- Give Supplemental funding
- Phase out over five years
- Phase out over four years
- Phase out over five years with immediate help for Tier 1 Counties

NCACC Committee Conclusions

- ALL counties need help
  - *If Medicaid hurts one county, it hurts all counties*
- A cap on growth helps all
- Targeted assistance for counties with high Medicaid eligible populations

NCACC Committee Recommends Medicaid Relief

- Proposal for 2005-06
  - Cap county Medicaid costs at 2004-05 levels beginning 2005-06
  - Target additional relief to counties with high Medicaid populations
    - State avg = 17.4%
  - Phase out county share of Medicaid

Other Options

- We are open to other ideas
- Every dollar helps

Counties Speak Out

- Alexander County, Norris Keever, Chair
- Gaston County, Pearl Burris-Floyd, Commissioner
- Robeson County, Noah Woods, Commissioner & NCACC Immediate Past President
- Bertie County, Zee Lamb, County Manager
- Jones County, Larry Meadows, County Manager

Handout #2

Alexander County

Administrative Offices

MEMORANDUM

TO: Medicaid Reform Commission

FROM: Norris Keever, Alexander County Board of Commissioners Chairman

SUBJECT: Medicaid Impacts on Alexander County

DATE: November 15, 2004

Alexander County Medicaid Information
Based on 2004-2005 Budget

- $1,775,000 – NC DHHS estimate of Alexander County's share of Medicaid costs
- Medicaid makes up 59% of the County's net cost of providing social services
- Medicaid is 30% more than the Sheriff's Department budget and 40% more than the budget for EMS
- Medicaid costs are 3.5 times more than the budget to operate the Jail and 4.5 times more than the 911 Communications budget
- Medicaid expenses represent 20% of our current year property taxes or 30% of our local option sales taxes
- Medicaid makes up 7% of the County's General Fund budget
- From 2000 to 2005, Medicaid increased by 78% for Alexander County. Property taxes increased 21% (including 2002 revaluation), and local option sales taxes increased by 31% (including new half-cent tax effective 12/1/02).

<u>Other Possible Uses for Funds Currently Spent on Medicaid</u>

1) Almost 18 miles of waterline could be added to the County's system
2) Appropriation to school system could be increased by 39%
3) County could have built the 9,400 square feet addition to the Social Services building without borrowing money. Borrowing $1.2 million for 15 years will cost $274,000 in interest.
4) County could pay $450,000 for communications equipment needed for Phase II compliance without borrowing money, which would save on interest expense.
5) County could borrow $5 million to build a new jail with a 5-year loan instead of a 15-year loan because there would be money available to pay the debt service. Borrowing over 5 years instead of 15 would save approximately $1 million in interest.

621 Liledoun Road, Taylorsville, N.C. 28681
Phone (828) 632-9332 • Fax (828) 632-0059

Options for Reducing the County Share of the NC Medicaid Program

Fiscal Research Division

November 2004

Hamilton #3

Developing Options for Reducing the County Share of Medicaid

- Legislative proposals from previous sessions
- Proposals developed by counties and the NC Association of County Commissioners
- Cost-sharing methodologies used by other states

Developing Options for Reducing the County Share of Medicaid

- Two types of options:
  - Reduce the County share for all 100 counties
  - Target reducing the County share for a subgroup of counties based on need

Reducing the County Share for All 100 Counties

- **Advantage**
  - All 100 counties benefit from the reduction of the County share of Medicaid
- **Disadvantages**
  - Usually more expensive than targeted options
  - Does not consider the impact of Medicaid on a county's budget or a county's ability to pay

Targeting the Reduction of the County Share

- **Advantages**
  - ➢Usually less expensive than options reducing county share for all 100 counties
  - ➢Targets counties based the impact of Medicaid on the county budget and their ability to pay
- **Disadvantages**
  - ➢Some counties may receive no reduction in the county share

Options for Reducing the County Share of Medicaid

- **Reduce the County share for all 100 counties.**
  - Phase-out the County share for total Medicaid expenditures for all counties over a five-year period
  - Phase-out the County share of acute care Medicaid expenditures for all counties over a five-year period. Counties continue to pay a share of long-term care Medicaid expenditures
  - Cap the County share of total Medicaid expenditures at the SFY 2004-05 level over a five-year period. State appropriations cover the annual increase in Medicaid expenditures.

Options for Reducing the County Share of Medicaid

- **Target reducing the County share to a subgroup of counties based on need.**
  - Target reductions over a five-year period to counties where the number of Medicaid eligibles is 25%+ of the county's population
  - Target reductions over a four-year period to counties based on per capita Medicaid expenditures. Counties with per capita Medicaid expenditures greater than the State average pay no more than the State average.
  - Target reductions over a four-year period to counties based on per capita Medicaid expenditures. County share for counties with per capita Medicaid expenditures higher than the Average Per Capita Medicaid Expenditure determined based on how their per capita Medicaid expenditure rate compares to the Average Per Capita Rate.

General Assumptions for All Options

- **Starting Point:** SFY 2004-05 Authorized Budget for the Medicaid Program ($8.17 Billion as of September 1, 2004)
- **Time Period:** Four or Five years – SFY 2005-06 through SFY 2009-2010 (Depends on data availability)
- **Annual Growth Rates:** CMS estimates from the Office of the Actuary -
  - 2006 9.2%
  - 2007 9.2%
  - 2008 9.1%
  - 2009 9.0%
  - 2010 8.8%

General Assumptions for All Options

- **Projected FMAP:** Estimated by the Division of Medical Assistance -
  - 2006 63.37%
  - 2007 63.11%
  - 2008 62.92%
  - 2009 62.67%
  - 2010 62.41%

- State Appropriations replace reduced County share.

Projected Medicaid Expenditures SFY 2005 Through SFY 2010

State Fiscal Year	Projected Medicaid Expenditures	Projected County Share No Change
2005	$8,172,133,335	$448,159,792
2006	$8,923,969,602	$490,327,510
2007	$9,744,974,805	$539,238,181
2008	$10,631,767,512	$591,338,909
2009	$11,588,626,589	$648,905,146
2010	$12,608,425,728	$710,926,085

Option #1

Phase-out the County share for total Medicaid expenditures for all counties over a five-year period.

Phase-Out County Share of Total Medicaid Expenditures

- Eliminates County share of Medicaid expenditures by phasing out the County share over a five-year period.
- County share over the five-year phase-out period:

  - 2005 15% (Current requirement)
  - 2006 12%
  - 2007 9%
  - 2008 6%
  - 2009 3%
  - 2010 0%

Phase-Out County Share of Total Medicaid Expenditures

State Fiscal Year	Projected County Share Under Phase-Out	Additional State Cost
2005	$448,159,792	$0
2006	$392,262,008	$98,065,502
2007	$323,542,909	$215,695,272
2008	$236,535,564	$354,803,345
2009	$129,781,029	$519,124,117
2010	$0	$710,926,085

Option #2

Phase-out the County share of acute care Medicaid expenditures for all counties over a five-year period.

Counties continue to pay a share of long-term care Medicaid expenditures.

Phase-Out County Share of Acute Care Medicaid Expenditures

- Eliminates County share of acute care Medicaid expenditures by phasing out the County share over a five-year period.
- Counties continue paying 15% of the nonfederal share of Medicaid expenditures for institutional and community long-term care Medicaid services.
- Long-term care services defined as follows: nursing facilities, ICF-MRs, Adult Care Home Personal Care Services, Adult Care Home Transportation, CAP-DA, CAP-MR/DD, CAP-Children, CAP-AIDS, Home Health, and Personal Care Services.

Phase-Out County Share of Acute Care Medicaid Expenditures

- Long-term care services share of Medicaid total expenditures:
  - 2005 29% (Current level)
  - 2006 30%
  - 2007 30%
  - 2008 31%
  - 2009 31%
  - 2010 32%

- County share over the five-year phase-out period:
  - 2005 15% (Current requirement)
  - 2006 12%
  - 2007 9%
  - 2008 6%
  - 2009 3%
  - 2010 0%

Phase-Out County Share of Acute Care Medicaid Expenditures

State Fiscal Year	Projected County Share Under Phase-Out	Additional State Cost
2005	$448,159,792	$0
2006	$421,681,658	$68,645,851
2007	$388,251,490	$150,986,691
2008	$346,524,601	$244,814,308
2009	$290,709,505	$358,195,640
2010	$227,496,347	$483,429,738

Option #3

Cap County share of total Medicaid expenditures at the SFY 2004-05 level over a five-year period.

State appropriations cover the annual increase in Medicaid expenditures.

Cap County Share of Total Medicaid Expenditures

- Cap County share of total Medicaid expenditures at the SFY 2004-05 level over a five-year period.

- State appropriations cover the annual increase in Medicaid expenditures.

Cap County Share of Total Medicaid Expenditures

State Fiscal Year	Projected County Share With Expenditure Cap	Additional State Cost
2005	$448,159,792	$0
2006	$448,159,792	$42,167,718
2007	$448,159,792	$91,078,389
2008	$448,159,792	$143,179,117
2009	$448,159,792	$200,745,354
2010	$448,159,792	$262,766,293

Option #4

Target reductions over a five-year period to counties where the number of Medicaid eligibles is 25%+ of the county's population.

Target Counties with Medicaid eligibles 25%+ of the County's Population

- Target reductions over a five-year period to counties where the number of Medicaid eligibles is 25%+ of the county's population.
- Estimates of county Medicaid population are based on a three year average (SFY 2002 through SFY 2004).
- Assumes county share for counties with 25%+ Medicaid population will be 10% of the nonfederal share. All other counties pay 15% of nonfederal share.

Target Counties with Medicaid eligibles 25%+ of the County's Population

- Assumes group of counties with Medicaid eligibles 25%+ of the county population will not change during the five-year period.
- Uses 2005 county share estimates prepared by the Division of Medical Assistance.
- Assumes share of total Medicaid expenditures (15.66%) for counties with Medicaid eligibles 25%+ of the county population will not change during the five-year period.

Counties with Medicaid eligibles 25%+ of the County's Population

County	Medicaid Population	County	Medicaid Population
Robeson	33.9%	Washington	30.6%
Halifax	33.3%	Richmond	28.4%
Bertie	33.1%	Warren	28.0%
Vance	32.4%	Graham	27.7%
Edgecombe	32.3%	Martin	27.3%
Scotland	32.3%	Anson	26.8%
Northampton	32.1%	Lenoir	26.0%
Columbus	31.7%	Sampson	26.0%
Hertford	31.7%	Swain	25.4%
Bladen	30.7%	Chowan	25.1%

Target Counties with Medicaid eligibles 25%+ of the County's Population

State Fiscal Year	Projected County Share With Target Reduction	Additional State Cost
2005	$448,159,792.09	$0.00
2006	$464,730,779.34	$25,596,730.44
2007	$511,088,150.34	$28,150,030.50
2008	$560,469,046.86	$30,869,862.18
2009	$615,030,134.20	$33,875,011.63
2010	$673,813,373.32	$37,112,711.37

Option #5

Target reductions over a four-year period to counties based on per capita Medicaid expenditures.

Assumes counties with per capita Medicaid expenditures greater than the State average pay no more than the State average.

Target Counties Based on Per Capita Medicaid Expenditures

Counties Pay No More Than State Average

- Target reductions over a four-year period to counties based on per capita Medicaid expenditures.
- Assumes counties with per capita Medicaid expenditures greater than the State average will pay no more than the State average.
- Uses County Population Estimates prepared by the NC Data Center for SFY 2005-2009.
- Uses 2005 county share estimates prepared by the Division of Medical Assistance.

Target Counties Based on Per Capita Medicaid Expenditures
Counties Pay No More Than State Average

- Assumes each county's share of total Medicaid expenditures will not change during the four-year period.
- Calculates State Average Per Capita Medicaid Expenditure by dividing the estimated Total Medicaid Expenditure for each State fiscal year by the estimated state population for each State fiscal year.
  - 2005 $51
  - 2006 $55
  - 2007 $60
  - 2008 $65
  - 2009 $70

Target Counties Based on Per Capita Medicaid Expenditures

Counties Pay No More Than State Average

- SFY 2006 Data:
  - State Average Per Capita Medicaid Expenditures- $55
  - Range of Per Capita Medicaid Expenditures – Wake at $28 to Bertie at $133
  - Sixty-five Counties above the State Average Per Capita Medicaid Expenditures
  - Range of Savings for Counties: Brunswick $63,000 to Robeson $6.5 million

- SFY 2007 Data:
  - State Average Per Capita Medicaid Expenditures- $60
  - Range of Per Capita Medicaid Expenditures – Wake at $30 to Bertie at $147
  - Sixty-four Counties above the State Average Per Capita Medicaid Expenditures
  - Range of Savings for Counties: Franklin $82,000 to Robeson $7.1 million

Target Counties Based on Per Capita Medicaid Expenditures
Counties Pay No More Than State Average

- SFY 2008 Data:
  - State Average Per Capita Medicaid Expenditures- $65
  - Range of Per Capita Medicaid Expenditures – Wake at $32 to Bertie at $162
  - Sixty-four Counties above the State Average Per Capita Medicaid Expenditures
  - Range of Savings for Counties: Franklin $56,000 to Robeson $7.8 million

- SFY 2009 Data:
  - State Average Per Capita Medicaid Expenditures- $70
  - Range of Per Capita Medicaid Expenditures – Wake at $34 to Bertie at $178
  - Sixty-four Counties above the State Average Per Capita Medicaid Expenditures
  - Range of Savings for Counties: Franklin $52,000 to Robeson $8.6 million

Target Counties Based on Per Capita Medicaid Expenditures

Counties Pay No More Than State Average

Counties With Per Capita Medicaid Expenditures Above the State Average

- ALLEGHANY
- ANSON
- ASHE
- AVERY
- BEAUFORT
- BERTIE
- BLADEN
- BRUNSWICK (2006 only)
- BUNCOMBE
- BURKE
- CALDWELL
- CASWELL
- CHEROKEE
- CHOWAN
- CLAY
- CLEVELAND
- COLUMBUS
- CRAVEN
- DUPLIN
- EDGECOMBE
- FRANKLIN
- GASTON
- GATES
- GRAHAM
- GREENE
- HALIFAX
- HAYWOOD
- HERTFORD
- HOKE
- HYDE
- JONES
- LENOIR
- MADISON
- MARTIN
- MCDOWELL
- MITCHELL
- MONTGOMERY
- NASH
- NORTHAMPTON
- PAMLICO
- PASQUOTANK
- PENDER
- PERQUIMANS
- PERSON
- PITT
- RICHMOND
- ROBESON
- ROCKINGHAM
- ROWAN
- RUTHERFORD
- SAMPSON
- SCOTLAND
- STANLY
- SURRY
- SWAIN
- TRANSYLVANIA
- TYRRELL
- VANCE
- WARREN
- WASHINGTON
- WAYNE
- WILKES
- WILSON
- YADKIN
- YANCEY

Target Counties Based on Per Capita Medicaid Expenditures

Counties Pay No More Than State Average

Bertie County Calculation for SFY 2006

- Bertie County Per Capita Medicaid Expenditure: **$133**
- State Average Per Capita Medicaid Expenditure: **$ 55**
- Bertie County Estimated Medicaid Expenditures: **$2,602,708**
- Bertie County Estimated Medicaid Expenditures using State Average Per Capita Medicaid Expenditure: **$1,085,657**
- Savings for Bertie County: **$1,517,052**

Target Counties Based on Per Capita Medicaid Expenditures

Counties Pay No More Than State Average

State Fiscal Year	Projected County Share With Target Reduction	Additional State Cost
2005	$448,159,792	$0
2006	$424,761,698	$65,565,812
2007	$466,661,060	$72,577,121
2008	$511,188,385	$80,150,524
2009	$559,141,582	$89,763,564

Option #6

Target reductions over a four-year period to counties based on per capita Medicaid expenditures.

County share for counties with per capita Medicaid expenditures higher than the Average Per Capita Medicaid Expenditure determined based on how their per capita Medicaid expenditure rate compares to the Average per capita rate.

Target Counties Based on Per Capita Medicaid Expenditures

Comparison to the State Average

- Target reductions over a four-year period to counties based on per capita Medicaid expenditures.
- County share for counties with per capita Medicaid expenditures higher than the Average Per Capita Medicaid Expenditure determined based on how their per capita Medicaid expenditure rate compares to the Average per capita rate.
- Uses County Population Estimates prepared by the NC Data Center for SFY 2004-2009.
- Uses 2005 county share estimates prepared by the Division of Medical Assistance.

Target Counties Based on Per Capita Medicaid Expenditures
Comparison to the State Average

- Assumes each county's share of total Medicaid expenditures will not change during the four-year period.
- Calculates Average Per Capita Medicaid Expenditure by adding up the per capita Medicaid expenditure for each of the 100 counties and dividing by 100.

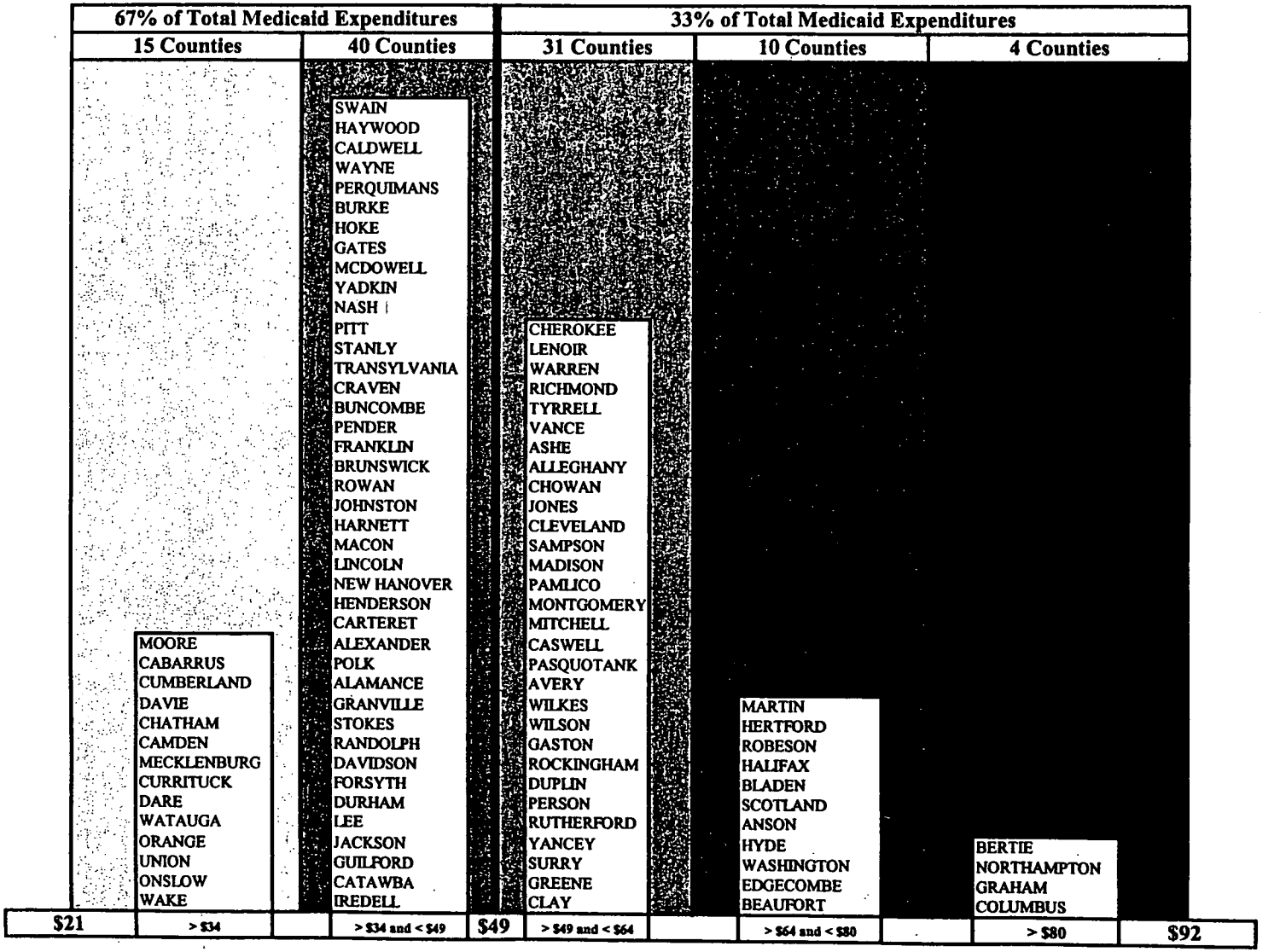
–2004	$49	–2007	$74
–2005	$63	–2008	$81
–2006	$68	–2009	$87

- Distribution of counties is based on SFY 2004 data. Assumes distribution does not change.

Target Counties Based on Per Capita Medicaid Expenditures
Comparison to the State Average

- Counties are distributed across five ranges based on how their per capita Medicaid expenditure rate compares mathematically to the state average.
- Based on SFY 2004 data, 45 counties have per capita Medicaid expenditures below the Sate average. These counties' share of total Medicaid expenditures continues at 15% under this option.
- Based on SFY 2004 data, 55 counties have per capita Medicaid expenditures above the State average. These counties' share of total Medicaid expenditures ranges from 0% to 10% under this option.

Per Capital Medicaid Expenditures
Distribution of Counties for SFY 2004



Target Counties Based on Per Capita Medicaid Expenditures

Comparison to the State Average

State Fiscal Year	Projected County Share With Target Reduction	Additional State Cost
2005	$448,159,792	$0
2006	$411,283,446	$79,044,063
2007	$452,309,391	$86,928,790
2008	$496,011,135	$95,327,774
2009	$544,297,310	$104,607,836

Issues for Discussion

- Statewide options combined with targeted options
- Additional study of county ability to pay for Medicaid based on property tax base
- Administrative considerations by the Division of Medical Assistance
- Consider County cost-sharing for Medicaid and all other Human Services

Handout # 4

Summary of Mercer SFY03 Cost Effectiveness Analysis for CCNC
Presentation to the Medicaid Blue Ribbon Commission
November 16, 2004

The Division of Medical Assistance (DMA) asked Mercer Government Human Services Consulting to analyze the SFY03 cost effectiveness of the State's primary care case management program which includes, Carolina ACCESS, ACCESS II & III, now known as Community Care of North Carolina.

Methodology

- Medicaid claims and eligibility data used from SFY00, SFY01, and SFY02.
- AFDC is the only eligibility category used in this analysis
- Two separate PMPM benchmarks were produced – one reflecting fee for service and CCNC combined, while the other reflects the CCNC program only.
- Actual costs is comprised of claims experience and eligibility data for dates of service July 2002 – June 2003
- Actual costs were compared to the two separate PMPM benchmarks.

Savings

- In comparison to what the FFS and CCNC (Carolina ACCESS, ACCESS II & III) combined would have cost in SFY03 for the number of eligibles in the program, there was approximately $195-$215 million in savings – see Statewide Benchmark Attachment 2 (by Rate Cell)
- In comparison to what the CCNC (Carolina ACCESS, ACCESS II & III) model would have cost in SFY03 without any concerted efforts to control costs, there was approximately $50-$70 million in savings – see ACCESS (CCNC) Only Benchmark Attachment 4 (by Rate Cell)

Next Steps

- Mercer is in the process of receiving data and preparing an analysis for SFY04. The expected completion date is January, 2005.

State of North Carolina

Attachment 2
SFY03 Savings
Using Statewide Benchmark
(by Rate Cell)

AFDC - Specified Categories of Service

Age and Sex Description	Member Months [1]	SFY03 Statewide Benchmark PMPM [2]	SFY03 PMPM [3]	Projected Savings [4]
< 1 year M & F	593,274	$ 372.93	$ 173.14	$ 118,526,635
1 - 13 years M & F	4,205,003	$ 84.06	$ 86.40	$ (9,811,583)
14 - 18 years F	491,393	$ 183.50	$ 148.16	$ 17,366,825
14 - 18 years M	429,759	$ 87.93	$ 85.80	$ 914,630
19 - 44 years F	1,197,580	$ 337.35	$ 290.18	$ 56,483,471
19 - 44 years M	171,349	$ 365.87	$ 246.08	$ 20,525,703
45 years & up M & F	108,552	$ 523.47	$ 445.92	$ 8,418,133
Totals	**7,196,910**	**$ 170.38**	**$ 140.86**	**$ 212,423,814**
Adjustment for Oct. 2002 Inpatient Data Issue				$ (9,000,000)
Adjusted Total				**$ 203,423,814**

1 - ACCESS only member months for SFY03.

2 - The Statewide base SFY03 PMPM was calculated using the historical 36 months of data from SFY00, SFY01, and SFY02. The PMPM shown here is calculated by weighting each rate cell's SFY03 base PMPM with the actual ACCESS member months distribution by rate cell for SFY03.

3 - Calculated using the date of service data for SFY03; represents all ACCESS program (I, II, and III) costs for dates of service from July 2002 through June 2003.

4 - Projected savings calculated using the SFY03 actuals; the benchmark minus the actual, multiplied by the actual SFY03 ACCESS member months, equals the projected savings.

State of North Carolina

Attachment 4
SFY03 Savings
Using ACCESS Only Benchmark
(by Rate Cell)

AFDC - Specified Categories of Service

Age and Sex Description	Member Months [1]	SFY03 ACCESS Only Benchmark PMPM [2]	SFY03 PMPM [3]	Projected Savings [4]
< 1 year M & F	593,274	$ 197.22	$ 173.14	$ 14,285,016
1 - 13 years M & F	4,205,003	$ 88.51	$ 86.40	$ 8,876,953
14 - 18 years F	491,393	$ 161.76	$ 148.16	$ 6,682,123
14 - 18 years M	429,759	$ 84.45	$ 85.80	$ (582,411)
19 - 44 years F	1,197,580	$ 312.03	$ 290.18	$ 26,158,018
19 - 44 years M	171,349	$ 298.82	$ 246.08	$ 9,037,151
45 years & up M & F	108,552	$ 489.45	$ 445.92	$ 4,725,277
Totals	**7,196,910**	**$ 150.48**	**$ 140.86**	**$ 69,182,128**
Adjustment for Oct. 2002 Inpatient Data Issue				$ (9,000,000)
Adjusted Total				**$ 60,182,128**

1 - ACCESS only member months for SFY03.

2 - The Statewide base SFY03 PMPM was calculated using the historical 36 months of data from SFY00, SFY01, and SFY02. The PMPM shown here is calculated by weighting each rate cell's SFY03 base PMPM with the actual ACCESS member months distribution by rate cell for SFY03.

3 - Calculated using the date of service data for SFY03; represents all ACCESS program (I, II, and III) costs for dates of service from July 2002 through June 2003.

4 - Projected savings calculated using the SFY03 actuals; the benchmark minus the actual, multiplied by the actual SFY03 ACCESS member months, equals the projected savings.

NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH 27603

November 22, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

SUBJECT: Meeting Notice – December 15, 2004

The Blue Ribbon Commission on Medicaid Reform will meet as indicated below. The purpose of the meeting is to discuss various legislative proposals for consideration during the 2005 Session.

DAY: Wednesday

DATE: December 15, 2004

TIME: 9:00 a.m. – 12:30 p.m.

LOCATION: Room 643, Legislative Office Building

Parking for non-legislative members of the commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives (see attached map). The cost for visitor parking is $.50 per hour or $4.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

Please advise Anne Wilson, Committee Assistant, at (919) 733-5707, or email medicaidca@ncleg.net if you will be unable to attend.

Posted: November 22, 2004
Cc: Committee Record ✓
Interested Parties

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM 12/15/04

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
NOAH WOODS	NCACC / RALEIGH NC
Ron Mowery	NC Cable TV Assoc.
Mark Pearson	Capitol Group
Karen T Geor[illegible]	NC AC DSS
John Mc[illegible]	Law office
Ron Hancock	County Commissioner
Bruce Ogburn	NC House
David Meredith	N C State Grange
Katherine Miller	Moore & Van Allen
Helen King	Moore & Van Allen
Tim Taylor	self

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM 12/15/04

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Evelyn Hawthorne	EHBA
Jim Rogers	Assoc. for Home & Hospice Care
Sherry Thomas	" " " " "
Kitty Barnes	NC Assoc. of County Commissioners
Rebecca Trantman	NC Assoc County Commissioners
Terry Garrison	NC Assoc. County Commissioners
Breeden Blackwell	NC Assoc. of County Commissioners
Steve Mitchell	Novartis
Amy Jo Horne	NCMS
Stacy Flannery	NCHCFA
Lu-Ann Cox	NCPA

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM 12/15/04

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Poyner + Spruill
	NCLHA
	ACLI

BLUE RIBBON COMISSION ON MEDICIAD REFORM
Wednesday, December 15, 2004
9:00 p.m., Room 643 LOB

Chairmen: Senator William Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

I.	**Opening Remarks**	*Chairs*
II.	**Medicaid Mental Health Services**	
	Mental Health Reform	*Leza Wainwright, Deputy Director DMH/DD/SAS*
	Changes in Medicaid Mental Health Services Required by Mental Health Reform	*Dr. Nancy Henley, Deputy Director for Clinical Affairs, DMA*
	Budget Information	*Mark Benton, Deputy Director for Financial/Business Operations, DMA*
III.	**Medicaid In-Home Personal Care Services Program**	*Lynne Perrin, Chief Facility and Community Care Section, DMA*
IV.	**Division of Medical Assistance Legislative Priorities**	*Gary Fuquay, Director DMA*
V.	**Additional Options for Reducing the County Share of the NC Medicaid Program**	*Carol Shaw, FRD Staff*
VI.	**Topics for Commission Report and Recommendations**	*Chairs*

A. Long-Term Care Tax Credit
B. Prescription Drug Program
C. Community Care Program
D. Mental Health Services
E. Reduce County Share of Medicaid
F. DMA Legislative Priorities

VII. Commission Discussion *Chairs*

VI. Closing Remarks *Chairs*

The next meeting is scheduled for January 18, 2005 at 8:30 am in Room 544. The final commission Report will be approved at this meeting.

BLUE RIBBON COMMISSION ON MEDICAID REFORM
Wednesday, December 15, 2004 at 9:00 a.m.
Room 643, Legislative Office Building

MINUTES

The Blue Ribbon Commission on Medicaid Reform met at 9:00 a.m. on Wednesday, December 15, 2004 in Room 643, Legislative Office Building. The following members of the committee were present: Senators William R. Purcell (Co-chair) and Charlie Dannelly; Representatives Edd Nye, (Co-chair), Julia Howard, (Co-chair), Jeffrey Barnhart, Bob England, and Beverly M. Earle; public members Daniel C. Hudgins, William A. Pully, Dr. Pam C. Silberman, Luckey Welsh, Dr. Al Wentzy, and Dr. Charles F. Willson. Representative Edd Nye presided.

Representative Nye recognized members and staff of the North Carolina Association of County Commissioners, including the president, Dr. Breeden Blackwell of Cumberland County. He also recognized Dr. William Lawrence, the new medical director.

Representative Nye recognized a new staff member of the Fiscal Research Division, Ms. Karlynn O'Shaughnessy, who will team with Ms. Carol Shaw for responsibility for the Division of Medical Assistance in the Department of Health and Human Services. Ms. O'Shaughnessy was formerly with the U.S. Department of Defense and holds the rank of Colonel in the U.S. Army Reserve.

Representative Nye recognized Ms. Leza Wainwright, Deputy Director of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services for a report on the progress of mental health reform. She said MH/DD/SAS and their colleagues from the Division of Medical Assistance have worked closely over the past 12-to-14 months and they will discuss what mental health reform means to them. (See Handout # 1.)

Ms. Wainwright said the first question most folks ask is why mental health reform is taking place and the response is that North Carolina is included in a national effort to make significant changes in the way community services for mental health, development disabilities and substance abuse services are delivered locally. She said pressures for reform at the federal level started when the Supreme Court issued the Olmstead Decision in 1999 in response to a Georgia case, where an individual had been kept in a state institution beyond the period of time considered appropriate. The State of Georgia's defense to the charge was that it did not have sufficient funding for county-based services, but the Supreme Court held that this policy was a violation of the Americans with Disabilities Act. This resulted in an Executive Order in 2001 requiring that federal agencies change their practices to comply with the Olmstead Decision. Ms. Wainwright said a nationwide mental health study in 2003 noted excessive institutionalization, fragmentation, and a significant gap in the implementation of evidence-based best

practices. The study called for nationwide reform and the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services issued an action agenda, which modified all of their funding sources. These changes in mental health services require that a significant amount of federal money be tied to turning in the direction of mental health reform. Ms. Wainwright referred to Handout # 1 and reviewed activities the department has undertaken in recent years.

Dr. Willson expressed concern about the amount of money going to administrative oversight in comparison with the amount going to services for patients and asked if figures were available on what the old system spent and what the new system will have. Ms. Wainwright replied that the old system area administration was limited to thirteen percent of the total cost of services. In the new scenario, the Local Management Entity (LME) function payments this year will be approximately eight or nine percent. The biggest change, she said, is access screening and triage, because that is an LME function. She said as LMEs been divested of services, they have been moving their trained clinicians in one of two places – either into the service management function which is the place where the person-centered plans will be approved, utilization review of division funded dollars and perhaps Medicaid dollars or into the screening and triage function.

Representative England referred to Ms. Wainwright's comment with reference to a patient presenting himself in after-hours circumstances to a time frame when he would actually be in the care of a treating provider and asked if there are guidelines that say how soon a patient will actually be sitting in front of a treating provider. Ms. Wainwright said if a patient calls or presents himself, there is a one-hour window in which the clinician to whom they present is able to decide if it is an emergency situation or routine and a two-hour window for a face-to-face meeting with a treating physician and with an authorization to render that emergency service. If it is an urgent situation but not an emergency the clinician has twenty-four hours to schedule an appointment, but if it is routine they have seven days.

Mr. Pully said he wanted more information about LMEs and how they intend to provide twenty-four hour, seven days a week service and Ms. Wainwright replied that the initial screening is designed to be either in person or by telephone. Then what they will do is, if they are fully divested as part of the new service definition, these comprehensive service providers would be the first responder for the consumers in their care, so if a patient being served by an ACT team goes into a crisis on Saturday night, they or a family member will call the LME, who will call the provider of the ACT team and say this person is in crisis and needs assistance within two hours. If that is not possible, a mobile crisis response team should be able to address the overflow for existing consumers and address new consumers. So if someone is unknown to the system and has a crisis on a Saturday night, the LME staff will get the mobile crisis team to the person in need.

Mr. Pully asked what happens when someone has a crisis who is not already in the system and Ms. Wainwright said if someone has an emergency need and shows up at

a hospital and it is a mental health or substance abuse emergency, doctors on staff might, in their judgment decide to go ahead and do something, but the LME might provide help or authorize the hospital to keep the patient until a provider can intervene. She said emergency room doctors will do what they think is best for the patient. Mr. Pully asked what happens if the LME doesn't send a representative to the hospital and Ms. Wainwright said that all of these practices are still being formulated, but in general the LME would provide the necessary service or be sanctioned for not fulfilling their obligation. If an LME is not providing minimally adequate services and documentation shows they are not providing those emergency services as required, there is statutory language that enables MH/DD/SAS to contract their services out to another management entity or if necessary operate those services from the state level. She said the department does not want to do that, but failsafes are in place.

Mr. Welsh said the department has done an excellent job on very difficult legislation and in his discussions with his hospital employees and others he has heard how difficult it is for them. He said most of the information he has heard in this commission is about administrative types of things and he needs to hear more about inpatient care. He said, speaking from experiences in the hospital he manages, that the proposed changes seem well-intended in getting people back to their communities, but predicted that it will fail if adequate funding is not provided. He said hospitals have discussed this with the involved state agencies and believe they are listening, but he is waiting to see if hospitals can afford it. He said his private, not-for-profit hospital – which is a four-county center – gets no extra funding for this service, but it takes all the poor, all the Medicaid, and all the patients from the four county area, which results in a loss of millions of dollars a year. Mr. Welsh said it would be very difficult for this system to work if state divesture sends all the indigent and Medicaid patients back to the community unless it is adequately funded. He added that it was well-intentioned legislation, but the implementation is scary for hospitals because mental health inpatient care is not a required service for hospitals. He said his hospital provides the service and 95% of the people admitted to their inpatient unit are involuntarily committed, put there by a psychiatrist and the LME. He said he hopes this will work and hospitals will do their best to make it work, but the state has to help. Some hospitals deal with it more than others, but all hospitals will deal with it in the emergency rooms.

Representative Barnhart asked if there were current issues related to service providers that the commission needed to hear. Ms. Wainwright said the primary things members will hear are related to anxiety about the requirements of the new service definitions and that is why DMH/DD/SAS is intent on going out with some training in January. It has been premature up until this point because the definitions were still being written. In some rural areas, she said, it is likely to take quite some time to get a private provider for some specialty services who they believe can succeed, so the division has been cautious in talking with LMEs and advising that they do not divest without having a private provider. Ms. Wainwright said some providers might express anxiety about the rates that will be paid for these services, so the division has tried to put into a place a very thoughtful process with DMA where providers can suggest what the rate should be. She said the division does not want substandard or inadequate care, so they will suggest that

providers bring in some evidence to show why the rate should be changed. The division intends to set a fair and equitable rate that will encourage private providers to come into communities and offer these services for fair compensation.

Dr. Silberman asked if there would be a process in place for retroactive approval of services provided it is later determined that a person would have been eligible for treatment and payment under the LME. She said this would be important if someone needing services goes into an emergency room and the LME cannot be located to do the screening and assessment. Ms. Wainwright said the division does not have funding for non-Medicaid eligibles' visits to emergency rooms. If someone who is eligible cannot get in touch with the LME, it would be a big problem because a primary requirement for LMEs is availability 24 hours a day. She suggested that hospitals should have agreements with LMEs for reimbursement in these types of situations.

Dr. Willson commented that there are positive and exciting aspects about this program and asked what the cost projections are for the new plan in comparison to what the state has already been paying. Ms. Wainwright said they know they are only treating between 10 and 12 % of the target population and she has no idea how much it would cost because they do not know how many have private insurance or are eligible for Medicaid. She said the division has done fiscal impact studies that indicate services will be about the same as they are now at least for the first couple of years. She said area programs in the past were serving approximately 8% of people who do not fall within the target population definition using state funds, but now those funds are reserved for the target populations. One of the responsibilities for the LME will be to connect people to a community service that is not division-funded if they are not eligible for Medicaid or are not in the target population. She added that the question may be, who falls out of target populations. She said when the division has gone back and looked at the people they have been serving, they fall into two primary categories, the mildly mentally ill (mild depression, anxiety) and male substance abusers, such as the working alcoholic and the folks who keep a job but have a significant alcohol problem on weekends. Those people would be a fit for alcoholic anonymous or something like that in the community that would not require a state-funded service.

Mr. Pully emphasized the fact that the hospital emergency room is the last place these patients should receive care and the need for planning and preparations being in place so LMEs will make sure it does not happen. He said he is aware of only two emergency departments in North Carolina with lock-down capacity to treat a seriously ill mental health patient who may be dangerous to himself and to others, noting that there usually is just a thin curtain separating patients in emergency rooms. He said the division needs to must make sure services are available so these people don't show up in emergency rooms.

Mr. Welsh agreed that the emergency room should not be used as a safety net nor as a place to provide mental health services, and he expressed concern about inpatient care. He said hospitals were not involved with LME business planning as they should have been. He said he was repeating his concern about inpatient care because the state

now takes care of indigent patients and uncompensated care in the state psychiatric hospitals, but they want to get out of that business and give it to local hospitals. Again, he said, Medicaid funding is one thing but a re-basing has to happen that takes into account what the local hospitals will take on with the load of the uncompensated care also, since it will no longer be done at state facilities. Ms. Wainwright said that none of the 402 beds that have closed in state psychiatric hospitals have been admission beds. She said the division has not reduced the acute capacity in the state hospitals and recognizes that as that is done, one of the requirements will have to be that a significant portion of the funds that flow to the communities have to flow for purchase of acute care in local hospitals.

Representative Nye recognized Dr. Nancy Henley, Deputy Director for Clinical Affairs in the Division of Medical Assistance, for a presentation, "Changes in Medicaid Mental Health Services Required by Mental Health Reform". (See Handout # 1, Page 12.) She provided background regarding Medicaid as the context for the mental health discussion. She said there are federal requirements for all the services provided under Medicaid which are that the program must be statewide, that the services available must be comparable across the state and that recipients must have freedom of choice among all the enrolled qualified providers of those particular services. She said the freedom of choice piece is very important to DMA and to the mental health program. All the services that are paid for by Medicaid must be medically necessary. She said the Center for Medicare and Medicaid Services feels very strongly that all providers to Medicaid recipients must be enrolled and paid. She said DMA and MH folks have been working over the past year to ensure that this can move forward to meet Medicaid requirements as well and have made changes to meet time lines for delivering services. (These changes, which Ms. Henley reviewed, were listed beginning on Page 12.)

Representative Nye recognized Mr. Mark Benton, Deputy Director for Financial/Business Operations for the Division of Medical Assistance, for a review of budget information related to changes required by mental health reform. (See Handout # 1, Page 18.) The first change was to the method used for paying LMEs, which had been an add-on administrative fee to every rate or payment made to them, He said they stopped doing that on July 1, 2004 and instead of paying a 13% payment add-on, they make an LME payment which is a mixture of funds from Medicaid and funds from the Division of Mental Health. The effect has been to take that overall 13% down to a range of 8 or 9%. The Medicaid share is based on a cost allocation plan, which looks at the sort of mix of Medicaid services vs. non-Medicaid services. He said the division will go back and cost settle with the LME at the end of each year to make sure Medicaid has paid its fair share. The second significant part about payment changes is getting to the actual rates paid to providers, which was done by looking at the existing service array. Most of those, other than stripping out the 13%, stayed the same. A few were increased when there was an access-to-care issue where the rate was not sufficient to get services to the communities, but most of the work was on the new services that are called "enhanced services". Mr. Benton said a variety of work groups solicited input from a number of stakeholders, and asked for comments and feedback about whether they thought the new rate was adequate to provide services. He said that process went well and they sent the proposed rates out

for comment. He said they formed three work groups – one to deal with mental health issues, one to deal with developmental disabilities, and one to work with substance abuse services – and are in the midst of wrapping up the first work group where they received a number of comments from providers on CAP-MR rates. In some cases, he said, the providers felt the rate they set was not adequate because it did not address transportation costs and some other direct service costs. As a result more data was provided, the rates were revised, and the proposed changes were brought to Secretary Carmen Hooker Odom's attention recently. Mr. Benton said they should soon finish this process and be able to send the new service rates out for implementation in the spring and summer.

He said the Division has been working with the North Carolina Hospital Association to try to address the issue of Medicaid funding for inpatient psychiatric care in hospitals. Those rates were based, he said, on a rate established in 1995 and while they have been increased each year for inflation, they have not kept up with actual costs in many cases. He said the psychiatric rates have been revised to more accurately reflect the cost and level of care provided in hospitals and that process should be completed around February or March.

Representative Nye asked for an explanation of the service category, CAP-MR/DD, Level 2 and Ms. Wainwright replied it is for support and habilitation in a group home for a developmentally disabled person. She said there is more activity around the line item HRI Level III Residential 4 Beds or Less, a children's residential group home. Ms Wainwright said much activity is currently focused on revising definitions for children's residential services and the division will come forward with a concurrent administrative rule change around children's residential services. She said they realize this is a hot button issue and one where significant attention is needed. Representative Nye said he was aware the rules have been under review for some time and asked if anyone has considered a moratorium in this area because of the controversy about the practice of setting up group homes and charging $232.00 a day each, for two or three children as occupants. Ms. Wainwright said there has been discussion about a moratorium and, while there are a variety of issues associated with that, they hope to go before the Commission for MH/DD/SAS in January with recommendations on changing the service definition and the rules. She said they hope that doing this will put people on notice that residential level 3 is going away and Representative Nye said it was his opinion it can't be approached quickly enough.

Mr. Welsh asked Ms. Wainwright how she would look at mental health needs and long term care, because his hospital operates a 115-bed, long-term care facility and are aware that many of the residents have mental health needs. He said many are being cared for by the medical director/family practitioner who is probably ill-qualified to deal with mental health issues. He said it is difficult to get mental health involved with long term care and asked if the division would be working with the Long Term Care Facilities Association and hospitals that operate long-term care to help address this. She replied that this year they have assessed how many people in adult care homes have mental illnesses. There is a baseline for our skilled nursing facilities – an assessment that is done at the time a person goes into a facility – and they have been working with the advocacy

groups and mental health folks. Ms. Wainwright said the division has worked for a couple of years on appropriate utilization of medications in the skilled nursing facilities, which may address these issues as well.

Mr. Pully commented that the $1.2 billion cost of the top fifteen Medicaid services is a lot of money and asked how many are receiving services for this amount of money. Mr. Benton said that data is not available today, but that he would provide it.

Dr. Willson asked if the clinical homes would be the equivalent of a medical home for a medical patient and Ms. Wainwright replied this is the idea – that these comprehensive service providers will serve as the clinical home for the consumers. They may receive other types of service, but the comprehensive provider would be responsible for their care.

Representative Nye recognized Ms. Lynn Perrin, Chief of the Facility and Community Care Section of the Division of Medical Assistance, for a presentation on the Medicaid In-Home Personal Care Services Program. (See Handout # 2.) She provided an overview of In-home Personal Care services and reviewed what they are doing to restructure the program, noting that it is a work in progress. She said key recommendations for improving personal care services (PCS) are: 1) develop a new comprehensive functional assessment which identifies deficits in the program; 2) standardize definitions for Activities of Daily Living (ADL); 3) establish minimum criteria for personal care services; 4) strengthen registered nurse certification statement on assessment tool; 5) eliminate need for verbal order to assess a client for personal care services; 6) eliminate need for physician approval for incidental changes on Plan of Care; 7) change requirement for registered nurse to visit client from every 60 days to 90 days; 8) develop a standardized Nursing Supervisory Visit Form; 9) develop nursing supervisory visit standards; 10) allow agencies to use electronic systems to track aide services; 11) ensure that DMA and provider agencies share PCS services in accordance with program policies; 12) develop a Quality Assurance and Utilization Review plan, including self-audit and state level review; 13) review new DMA enrolled providers after six months of Medicaid-billed services; 14) review information systems data by PCS state staff; 15) review state staff desk, other agencies and clients; 16) establish minimum qualifications and training for PCS providers; 17) support legislation for Medical Care Commission authority to set rules for staffing qualifications.

Dr. Silberman asked if some of the recommendations made for training and assessment on the PCS side are going to be carried over to the CAP/DA in-home services and Ms. Perrin said restructuring the Personal Care Services Program will impact other services even though the division calls the CAP/DA In-home Services Program something different, it is still in-home aides. Every program that provides in-home aide services will benefit from the recommendations they have made.

Dr. Willson asked if the personal care workers actually try to train or re-train the recipient to do these services for themselves and Ms. Perrin asked Ms. Sherry Thomas, a nurse who works with the Association for Home and Hospice Care to respond to the

question. Ms. Thomas said this has been an in-home program. She said DMA did some studies a few years ago to look at the type of recipients who receive care and found that the majority are over 75 years of age and have multiple problems and medications, so they believe there can be some limited impact on helping people become more self-sufficient. She said Dr. Willson's question should be considered. The emphasis has mostly been on providing care rather than teaching people to do some of their own care. Ms. Thomas said age and condition impacts whether people can be taught to take care of themselves and whether they live alone or with a caregiver who can be taught some skills. She said her association has recommended a change from one criteria for entering the program to two criteria, because there needs to be more reliance on adaptive equipment in the home, such as bathroom grab bars for getting in and out of a bathtub. She said training of registered nurses for in home care should include emphasis on looking at patients to see if there can be less reliance on aid and more reliance on assistive devices. Those recommendations should depend on the patient's needs.

Dr. Wentzy asked if there has been any discussion with regard to looking at a third-party or gatekeeper case management option and Ms. Perrin said such discussions have occurred, but they decided that doing independent or third-party case management just for PCS was probably not worth the cost of doing it. She added that the Division is looking at doing case management for the broader home and community-based services program, so they are probably working in that direction and trying to figure out the best way to provide that service. She said folks in the division agree that this needs to happen.

Mr. Hudgins asked if personal care is the definition we are using for enhanced care in long-term care facilities, homes for the aged and if so, how do these recommendations affect that. Ms. Perrin replied that this is the reason for the title of this program – Medicaid In-home Personal Care Services. She said they also refer to adult care homes, enhanced care, personal care services and basic personal care services. It falls under the same federal definition, but they try to delineate between the two different programs because of its financial structure and some of the definitions.

Representative England asked what requirements are in place for a provider to do an adequate screening evaluation of the attendant sent into the home and Ms. Perrin said some supervisory nurse visits are required. Ms. Thomas added that licensed home care agencies are required to do criminal background checks and checks of the health care personnel registry to see if the prospective attendant has findings on the registry.

Mr. Pully asked if data is available to show how much is saved by not having these people institutionalized and Ms. Perrin said these figures are not available at the present time because good assessment data on the individuals now being served in the different programs is not available. She said they have been working on a long-term care population study and hope to have considerable information on various long-term care settings fairly soon. She said they are trying to put in good automated assessment tools, so they can compare populations across settings of care and determine the cost savings.

Representative Nye recognized Mr. Gary Fuquay, Director of the Division of Medical Assistance (DMA), for a presentation of the division's legislative priorities. (See Handout # 3.) Mr. Fuquay commented on some of the priorities, which, he said, in no way implies that these are the only things DMA is working on: 1) Medicaid Management Information System (MMIS); 2) Health Choice; 3) Medicare Modernization Act; 4) Community Care; 5) Facility and Community Care; 6) Payment Error Rate Measurement (PERM); 7) Dental Rates; 8) Full Funding of Medicaid contracts; 9) Audit and Rate Setting; 10) SAS Fraud and Abuse. In addition, he said, they are working on a multitude of programs and issues, but probably the most important thing they can do at DMA is to strengthen the programmatic and financial infrastructure of Medicaid. He said it would behoove all involved to focus on appropriate rate-setting, appropriate cost-modeling to ensure that providers are paid appropriately, clinical policies to ensure an appropriate level of care and ultimately the auditing and program integrity section to make sure DMA follows up and delves further into provider cost reports. He said the division needs to make sure it is paying appropriately and enhancing program integrity efforts so the edits and audits are working properly. And if there are potential cases or opportunities for increased fraud and abuse, he said, it would be a reminder to improve that responsibility.

Mr. Fuquay said working on Medicaid is an amazing experience because there is so much to do and everything is a top, needed priority. Mental Health Reform in itself is a worthy, time-consuming process. He said he knows about the legislature's cost-cutting struggles and realizes that he could not present a lot for members to consider in this regard. He added that utilizing the Community Care program and enhancing the infrastructure and clinical policies for the future are methods that he believes will contain growth as much as possible if not control it.

Representative Earle asked if Mr. Fuquay plans to prioritize the list of items he presented which would include the figures attached to his request and he replied that he would provide that information.

Representative Barnhart said Community Care works and it can now be measured to see that it works, but every community is different. It works when people that need to be involved want to make it work. He said the county boards of commissioners, county managements, public health people and local medical communities need to support it. He asked if there is a way to incent these groups of folks to support Community Care as the state seeks to move it across the state. He asked if there might be a way to tie in the county share of Medicaid as Community Care is spread across the state.

Dr. Purcell asked how much money is in abuse of these programs. He said a doctor he knows in a hospital got a stack of emergency room slips on a recent Monday from patients who had been to the emergency room over the weekend and probably 50% to 75% of them were people who'd had colds for several days, but still went to the emergency room on the weekend despite the fact that the doctor's office is open seven days a week and someone is on call 24 hours a day. He said hospital folks get frustrated when people with minor problems go to the emergency room rather than the doctor's

office. Mr. Fuquay agreed that it is a big problem and said that DMA will work with the clients and make sure they understand that they have a clinical home and that they need to use that community care facility first. It is a cultural change for many clients because they have utilized the emergency room and feel it is their first layer instead of the last layer.

Dr. Willson addressed Dr. Purcell's questions said he chaired a taskforce within Community Care of North Carolina and they came out with some new materials that physicians will be discussing with their patients to emphasize the importance of the primary care medical home and the slogan on it is "the right call every time". Unfortunately, he said, under federal law doctors are not allowed to tell patients they can't go to the emergency room for unnecessary things, but building a strong doctor/patient relationship will help influence patient behavior.

Mr. Welsh said he hoped looking at fraud and abuse will help identify those areas that are honest mistakes and those that are fraud. The state should be sensitive to separating fraud from honest mistakes, allowing those situations to be corrected. Mr. Fuquay agreed and said that they are working with SAS to make sure that what they call fraud and abuse is not uninformed errors.

Dr. Silberman asked if the increased use of the emergency room has gone up because of the fact that federal legislation changed prudent law person definitions so states have to reimburse hospitals. She said it was different under the old access program and she wanted to put it into perspective because there have been national studies that show specifically that the commercially-insured population's use of the emergency room is growing even more than the Medicaid or uninsured population.

Representative Nye asked about in-home services, PCS CAP/DA and others, with regard to accountability and said he has heard that if a strict federal audit is done in North Carolina it might have to do some payback because people in the homes are not tracked sufficiently. He asked Mr. Fuquay if his staff has discussed this issue and he replied he has not heard that there is a payback situation, but staff has discussed with him that accountability needs to increase in a number of the in-home programs. He said they have had presentations where CAP/DA and CAP/MR/DD have been discussed and there has been some revealing information that needs to be examined.

Dr. Wentzy asked Mr. Fuquay if he has enough personal assets to do the job that is needed, because some items indicate that very specialized, very smart people will be needed. He said many practitioners or operators in the field think DMA is at skeleton strength although it does a fantastic job for operators in the field as well as the citizens. He said he is concerned that DMA does not have enough people and asked if he has put a package together in that regard. Mr. Fuquay replied he is aware that DMA staffing is insufficient and he considers that as a part of DMA's infrastructure needs. He said another serious consideration is succession planning so expertise is not lost. He said DMA has so much diversity that he is not sure that the division has the right level of

resources – full-time equivalencies or through contractual services. He said this is an ongoing concern, which he has discussed with Secretary Hooker Odom.

Dr. Wentzy asked if it would be possible to put together a list of the primary ways the state could help you help everybody else and still save money and Mr. Fuquay said he could. Representative Nye said Mr. Fuquay did just that in January of 2004 and 27 people were added to his division.

Representative Nye recognized Ms. Carol Shaw, of the Fiscal Research Division, for a review of the options for reducing the county share of the N. C. Medicaid Program. Ms. Shaw reminded members that the additional options have most of the same general assumptions as the presentation at the committee's previous meeting. The starting point for each of these options is state fiscal year 2004-05 authorized budget for the Medicaid Program, the annual growth rates that she used to grow the Medicaid Program over time are ones from the Centers of Medicare/Medicaid Services (CMS) estimates that come from their office of actuaries. She said she had used the federal matching rates that have been projected by the Division of Medical Assistance and assumed in every case that state appropriations replace the reduced county share. Ms. Shaw used Handout # 4 to review the options.

<u>Following is discussion and decisions with regard to the commission's recommendations to the General Assembly:</u>

Representative Barnhart said he requested at the last meeting a list of items paid for by counties that the commission could look at, for example, school capital costs where they are paying about $400 million, in order to do some trading of various county costs. Ms. Shaw said she does not have that information today, but the county folks are also looking at that and the percent of the sales tax that they get. Ms. Rebecca Troutman of the County Commissioners Association said the Department of Revenue administers the sales tax on the county's behalf and is putting together the numbers for 2003-04, compiling their monthly reports into an annual report to show on a county-city basis the different components of the sales tax base. She said the counties pay $900 million annually on school capital needs as well as $2 billion annual for current expense in schools. Representative Nye asked what is the part of the corporate income tax that counties get and she responded that it is about $60 million annually which goes for capital facilities for schools.

Representative Barnhart said he had suggested that the commission consider recommending that Medicaid costs be "traded" for school construction costs, since they are eventually paid off, as a way to gradually reduce and eliminate the counties' 15% share of Medicaid costs. The idea was that school construction costs go away and Medicaid costs increase, so if the state takes Medicaid, counties would see an overall reduction of costs as school construction projects as completed. Senator Purcell asked if that is a realistic option since some counties are always looking for money to build schools.

Representative England asked if it is possible to take present data and project the actual percentage decrease in Medicaid costs if all 100 counties were participating in Community Care and Ms. Shaw said she does have that information. Representative England said if that became an option for counties, they could get a direct reduction on their Medicaid based on dollars saved if they participated in Community Care. Ms. Shaw said what would happen would not be an actual reduction, but rather a reduction in the growth of Medicaid in those counties. How much it would be is a good question, but that could be a carrot or stick to use with counties.

Representative Nye said the commission would agree by consensus on the recommendations to be included in the report to the 2005 session of the General Assembly unless someone objects and would prefer a vote.

1. Representative Howard said there seems to be strong interest in re-enacting the long-term care tax credit and suggested that this be a recommendation of this commission.

2. Representative Howard suggested that legislation should be prepared to expand the Community Care program and she would be open to ideas from others with regard to tying it in with something else.

3. Representative Howard suggested that the commission propose capping the county share of Medicaid with the 3%, five-year phase out.

4. Dr. Silberman said the commission had talked about how the prescription drug program money being used to support people through SeniorCare is going only to recipients who are older adults, but not people with disabilities. She said she recognized that legislative changes with regard to these recommendations would take time with only a couple more months before Medicare Part D would be in effect and she suggested that the commission go on record to say that if the state chooses to continue to provide any kind of subsidy after Medicare Part D becomes effective that it be provided equally to people who are older adults and to people with disabilities who are on Medicare.

5. Dr. Silberman recommended that the commission go on record opposing the potential for a federal Medicaid block grant because that would have significant implications that the state would never be able to make up.

6. Dr. Wentzy said he believes that access to adequate health care should not be determined by geography or where a person lives because the federal government requires that Medicaid be uniformly available across the state. He said it should, therefore, be funded by state and federal revenues that are uniformly applied. He said the General Assembly acknowledges the burden that Medicaid costs pose to counties, so he suggested that the commission adopt a recommendation to the General Assembly to phase out the county cost share over a six-year period.

7. Dr. Wentzy asked for consensus for a recommendation to the General Assembly to cap county Medicaid contributions at 2004-2005 expenditure levels and target supplemental support to those counties with more than 25% of their population eligible for Medicaid.

8. Dr. Willson suggested a recommendation that the state provide adequate funds to prevent a cap on the Health Choice program. Representative Nye said the real problem in that program is federal funds, not state funds, but the commission can make that recommendation. Representative Howard suggested that the commission direct a resolution to the federal government encouraging them to re-authorize funding for Health Choice and stressing the importance of that program for North Carolina.

9. Mr. Welsh said, with regard to mental health issues, he is concerned that there is a clock ticking for getting reform done and that this state is not ready, particularly in the rural areas. He suggested a recommendation to have some extension of time, if it is appropriate, so mental health reform will not be forced onto rural areas before they are ready for it. He said he did not know if the dates for implementation can be extended and Representative Nye replied that the Secretary Carmen Hooker Odom of Health and Human Services has authority to extend the dates.

10. Dr. Silberman said the North Carolina Institute of Medicine has been looking at the safety net that is available to serve the uninsured in North Carolina and one recommendation that they are considering that this commission may want to look at is that if there are savings that come from Community Care of North Carolina, that those savings be used in the community to help expand care of the uninsured. This could provide the incentive that Representative Barnhart was talked about earlier – getting providers involved in local community efforts, knowing that some of that money would stay in the community to help cover other people who do not have insurance coverage.

11. Senator Purcell said all of these proposals are going to cost money, which will have to come from somewhere and he said he noticed that the Speaker of the House is talking about a tobacco tax and everyone has their hand out for a tobacco tax. He said the commission ought to put out our hands too, so if we can get a tobacco tax at least a portion of that money would be used to offset the county share of Medicaid costs.

12. Representative Nye said he heard a report from Colorado on some things they're doing to control drug costs – he suggested that the department develop and implement a program that will allow case managers to handle Medicaid clients who are large users of prescription drugs, as the Colorado program is doing. Representative England suggested that this commission should address these particular areas, types of drugs and the uses for which they're being prescribed – are they truly evidence-based and are there other alternatives that would save a significant amount of money. One of the Colorado cases was about a patient seeing more than one physician and receiving prescriptions that are totally inappropriate and unnecessary. He said physicians have contributed to this problem by producing another addictive patient because there is no method in place to

monitor that patient. (He cited a patient who was taking four different pain medications all very potent drugs and three different anti-depressants. When the patient was finally trapped and place into a disease management program, he ended up writing his own prescriptions and went to jail.)

13. Representative Nye said another suggestion is to recommend that the Department of Health and Human Services (HHS) develop and implement a program to identify all providers that are paid excessive fees and turn this information over to investigators in the fraud divisions of HHS and the Attorney General's Office.

14. Senator Purcell said he mentioned to Gary Fuquay, Director of the Division of Medical Assistance, that his pharmacist back home told him that adults can get up to six prescriptions a month on Medicaid, but if a doctor signs life-threatening illness, they can get any number of prescriptions. He said he mentioned this to Dr. Willson who said he believes that a lot of doctors are not really following this as they should. Senator Purcell said it should be called to the attention of the Medical Society that if doctors really want to help preserve their reimbursement, they need to work on this type of thing and make sure that it is not being abused. Senator Purcell said the pharmacist that made the charge says he is willing to testify that it is being abused and has records to show it. Dr. Willson said they would agree with taking that to the Medical Society and mentioned that within the Community Care of North Carolina at this time, the pharmacy group through the Prescription Advantage List is looking at patients who have more than six prescriptions per month and are working with those physicians as well. Senator Purcell said there is a mechanism for this, but it needs to be effective. Representative Nye said the commission's report would address this issue.

Mr. Pully said he would point out that there might be another perspective on this. A lot of physicians are impacted by the threat of medical liability problems and are not able to limit themselves to five prescriptions if they believe that the patient actually needs six or seven prescriptions. He said unless the medical liability problems are dealt with, it might not be reasonable to expect a physician to be able to limit a patient to five.

Ms. Shaw suggested that the commission can direct the department to develop mechanisms related to this by using the Community Care model. She said she could come up with some language directing the department to increase its efforts in monitoring the sixth prescription over-ride issue.

15. Representative Howard said she agreed with Representative Nye's suggestion to increase support to $2 million for the Community Care program.

16. Dr. Wentzy suggested a recommendation to target counties that are particularly burdened by Medicaid and noted that Carol Shaw had done an option on that, citing counties with 25% or more of their population. Representative Nye reminded Dr. Wentzy that there are many urban counties that might not support targeting this population for additional reductions.

17. Representative Nye proposed including Mr. Fuquay's MMIS program request in its legislative recommendation.

18. Senator Purcell proposed including Mr. Fuquay's suggestion for an increase in dental care rates for children in the commission recommendation because it has been shown to improve access to dental care for children.

19. Representative Nye discussed the Payment Error Rate Measurement (PERM) program and Mr. Fuquay said that when the federal regulations are approved he would have a better idea of what he will need, but believes it will be upwards of 35 staff to support that.

20. Representative Nye discussed the SAS Fraud and Abuse issue and said Mr. Fuquay's handout information indicates that it is being used already. Mr. Fuquay said they began the project, but had not completed the analysis. He said once the pilot on this is done it will guide the division in deciding whether to purchase the software and how to approach it.

21. Dr. Wentzy said he would like to see the commission recommend sending a joint resolution to the federal government to develop a better model for reimbursement to the states that is more consistent with the current economy. He said the federal government is using an "antique" model and the indicators that Ms. Shaw has brought up show that the federal contribution appears to be on a downward sliding scale.

22. Representative England commented on physician provider reimbursements and the need for an inflationary increase, especially in the area of obstetrics. He said there are some areas where 60+% of obstetricians' patients are under Medicaid and if those physicians do not perform the service there is no program. Representative Nye agreed and said they have discussed a supplemental payment because obstetricians have to buy high-cost medical malpractice liability insurance. He asked Mr. Fuquay if he is working on that and he responded that they have asked the Shep's Center for information about the ten counties where a reduction has been seen in the number of available obstetricians. Mr. Fuquay added that he is comparing the situation in North Carolina with other states, mainly in the southeastern United States, to find additional information for staff to use on that issue.

Dr. Willson said he preferred to have the medical liability problem fixed, but until it is, he would support Representative England's suggestion.

Senator Purcell said that the Medicaid reimbursement which Mr. Fuquay addresses in his report (See Handout # 3.) is key because hospitals are necessary for providing obstetrical service and they continue to lose money on the cost of Medicaid.

Mr. Pully emphasized the need for making sure adequate obstetrical services are available in rural areas. For the record, he said, many community hospitals have been saved by being designated as critical access hospitals. Under federal requirements, in

order to get a Medicaid DSH payment, a critical access hospital must have two physicians on the medical staff who are willing to provide obstetrical services. So if the state continues to lose these services in various areas of the states, there could be a tremendous impact on communities and the availability of any hospital service.

Representative Nye said Mr. Pully's comments would be included in the report to the General Assembly so this issue can be addressed.

23. Mr. Hudgins said he has been thinking about the issue of the county share. He said his county, Durham, is urban and would not be helped by targeting the poorer counties and said that hearing the presentation from counties who pay a disproportionate share brought to mind Durham County's budget and the fact that $11 million is spent to match the Medicaid program and $80 million is put into the operations of schools. He said people should know why there is a court decision affecting education in the state when Bertie puts more into its Medicaid budget than to schools. He said he would like to have the commission consider combining the recommendations that came from Representative Howard and those that came from a former colleague from one of those counties, which pays a disproportionate share. He said Page 7 of the presentation made today looks at a six year phase out and targeting a reduction to two-thirds of the amount paid by other counties and noted that the cost for the first year is $103 million. With Representative Howard's recommendation, he said, which is on Page 13 of the original presentation, the amount is about $98 million – not an enormous difference. He said he would the urge counties to look at this from the standpoint of what is best for all North Carolina citizens and that difference in the amount could be justified and defended. He said he would like for the commission to consider the possibility of combining those, acknowledging that he can make that recommendation a bit easier than others might, since he is from an urban county.

Representative Nye asked Representative Howard for a comment on Mr. Hudgins' suggestion and she said she knows that whatever the commission brings out, it will need the votes on the House floor. With all due respect to all the counties, she said, everybody does the best for the entire state, but targeting will face real obstacles. What is put out there in the beginning is out there and if everyone is serious about this and understands the burden it places on counties, particularly the poorer counties, it is a fair issue. If a commitment to find the money is made, not knowing where it will come from, it can be done. She emphasized that she has fear of the targeting aspect.

24. Representative Nye asked for the proposals for a phase-out of counties' Medicaid cost sharing to be repeated so members could vote on their choice. Representative Howard repeated her proposal, which is: to cap the Medicaid expenditures at the 2003-2004 level and begin a phase out in 2005, 3% per year over a five year period. Dr. Wentzy said his proposal is a consolidated one: to adopt a recommendation to the General Assembly to phase out the county cost share of Medicaid over six years and to cap county contributions at 2004-2005 expenditure levels and target supplemental support to those counties with more than 25% of their population eligible for Medicaid. Representative Howard asked if Dr. Wentzy has a reason for proposing a six-year period

and he said he would be happy with five. Mr. Hudgins said his proposal doesn't differ with Dr. Wentzy's. It is a phase down as presented in the recommendation from the staff.

Mr. Welsh said he would support the targeted approach because it is time for the state to realize and look at what is happening to counties because of its basic unfairness in health care, education, etc. He said he is in favor of Dr. Wentzy's proposal. Senator Purcell said he also would support the targeted approach.

Representative Nye reviewed the proposals and members voted. Six members voted to support Dr. Wentzy's proposal and 4 members voted to support Representative Howard's proposal. Representative Nye said Dr. Wentzy's proposal would go forth from the commission.

Ms. Shaw reviewed the preferred option: county share capped at no more than the 2004-2005 fiscal year; phase out over a six year period for all counties; and additional assistance two-thirds of whatever the phase out share is for counties with Medicaid population over 25%.

25. Dr. Silberman raised one other possibility for the North Carolina Health Choice program as a way of keeping it fiscally afloat in terms of not using as much federal funds. She said that one of the proposals the Institute of Medicine made a few years ago was to move children five years old and under into the regular Medicaid program so less would be paid per child, which would save some money over the long haul. She said there was consensus on this proposal from the Medical Society and the Hospital Association at that time. She said that may be one way to look at trying to extend the availability of federal funds for a longer period of time, absent some new federal funds.

Dr. Willson said he sat on the Taskforce that Health and Human Services Secretary Carmen Hooker Odom and Dr. Huff chaired and agreed with this proposal. He said he like the hybrid Health Choice aspect because it included enhanced dental benefits for children. The testimony at the Task Force was that if you could get the children seen by a dentist by the first three-to-four years of life, their overall dental health would be greatly enhanced for a lifetime.

Senator Purcell said he remembered that in the early days of the program, there was a big issue about these people having something that looked like private insurance and not be considered Medicaid. The other aspect of this is if you go to Medicaid for this group of people wouldn't you be shifting some of that cost back to the counties where, right now, the counties don't have to participate in Health Choice. Dr. Purcell said what the Taskforce recommended was that when they are moved into Medicaid, the counties should not be required to pay that part of the cost and there was still cost-savings attached to it. He added that the issue about the Medicaid stigma was largely a reflection of the difference in the cards the people had. He said he understands that when the new MMIS system goes into effect smaller cards will be used, which will help remove the stigma.

Representative Howard said she would be against this idea, because once these children are put into Medicaid it becomes an entitlement and that is the one thing that we have worked so hard against. She said she doesn't think this is the way this body wants to go, because it never was the intent. She said she understands the savings, but hoped that the commission would not go back and contradict what we spoke against on the floor to get this bill passed.

Representative Nye took a vote on Dr. Silberman's proposal with regard to Health Choice. Seven members voted for her proposal and Representative Howard said she hopes those people who supported it will be available to gather support for it when it goes before the General Assembly.

Ms. Shaw reviewed her list of items proposed:

1. Reinstate the long-term care tax credit.
2. Do further expansion of the Community Care Program, recommended $2 million.
4. Include the disabled in the SeniorCare program and not limit it to the elderly if it continues after Medicare Part D goes into effect.
5. Do not cap Health Choice, which the intent is not to close the program.
9. Reinvest savings from the Community Care program in the community.

(That will be a case where DMA would need to be directed to investigate how it could be done and come back with a recommendation, because there are some issues with the federal government. It has been looked at in the past, but it is not something they can do without working with the federal government.)

10. Suggest, as discussed by Representatives Nye and England, consideration of drug prescription program similar to Colorado's with regard to high prescription drug users.
11. Identify all providers that are charging excessive fees and proceed with fraud and abuse investigation of those types of providers.

(Impression is that on the six-drug override, the commission wants the department to continue its work on insuring that the program is being operated properly using the Community Care model.)

12. Prepare a resolution to the federal government on Health Choice funding when the program is re-authorized.
13. Prepare a resolution as it relates to block granting of Medicaid.
14. Ask Congress and the Administration to look at how they determine Medicaid funding relationship between states and federal government (Dr. Wentzy's suggestion).
15. Direct HHS to continue developing ways to keep obstetricians on staff in critical access hospitals in rural areas. Use the reasons Mr. Pully discussed – how the federal government requires that critical access hospitals have two obstetricians on staff in order to maintain the critical access hospital status so that rural areas receiving a lot of the different pots of Medicaid DSH money can remain open. Mr. Pully can help with the intent of this.

Representative Nye said the floor was open for a motion to approve the minutes of the November 16 meeting. Dr. Willson moved for approval and Dr. Wentzy seconded the motion. Members unanimously approved the minutes.

The meeting adjourned at 12:15 p.m.

Respectfully submitted,

Anne B. Wilson, Commission Assistant

Representative Edd Nye, Co-chair

Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair

Reform of the Mental Health, Developmental Disabilities and Substance Abuse Service System

December 15, 2004

Handout #1

Pressures for Reform

- Federal:
  - Olmstead vs. LC (6/22/1999)
  - Executive Order #13217 (6/18/2001)
  - The President's New Freedom Commission on Mental Health (7/2003)
  - SAMHSA "Action Agenda"
- State Studies and Audits
  - Statewide Government Performance Audit (1995)
  - MGT America (1997) – study of state psychiatric hospitals
  - PCG for the Office of the State Auditor (1998) – study of state psychiatric hospitals and overall structure of mh/dd/sa system
  - All studies/audits cited over-reliance on old, costly institution; too few community based alternatives; fragmented system
- Consumer and Advocacy Concerns
- Local government officials concerns – lack of accountability

HB 381 - Phase In Implementation of Mental Health System Reform

Goal: Increase accountability of mh/dd/sa system:

- Emphasizing community-based services that are consumer driven
- Strengthen role and responsibilities of county government
- Outlines core services that State and local governments must provide, within available resources
- Shifts the role of local public MH/DD/SAS agencies from direct service providers to managing and coordinating services

Five year phase in beginning July 1, 2002; proposed completion by 2007

DHHS Requirements:

- Develop a State Business Plan to address:
  - Increased participation by consumers and families
  - Identification and Implementation of Target Populations for Division funded services
  - Utilization of State facilities
  - Increased access to service
- Reduce # of area authorities to ensure economies of scale and scope; minimum population base of 200,000; goal of 20 programs
- Outline requirements for Local Business Plans (LBP), approve LBPs, increase oversight of Area/County Programs

Local Requirements:

- Area Programs to transition from being deliverer of services to Local Management Entity (LME)
- Each county must determine governance structure – Area Authority, County Program, Interlocal agreement
- Prepare a Local Business Plan
  - Input from consumers & families, local governmental leaders, public agencies
  - Assess gaps in service delivery
  - Emphasis on Consumer choice
  - Address Utilization of State facilities

Reform-related legislative actions

- SB 163 & SB 926 increased requirements for monitoring of providers
- Established Mental Health Trust Fund to provide one-time funding to assist in system reform and implementation of community based services
- Assured that funds made available in state institution budgets from downsizing go to the community to fund services

Accomplishments to Date - State

- Developed State Plan for MH/DD/SA services – updated annually
- Identified Target Populations for DMH/DD/SAS funded services
- Reviewed and approved Local Business Plans
- Began paying programs for LME functions based upon a cost model that takes into account population and projected demand for service
- Implemented a performance-based contract between DHHS and each LME
- Created State Consumer and Family Advisory Committee (CFAC)
- Redesigned, in conjunction with DMA, the community service array
- Moved 402 consumers from state psychiatric hospitals to community and closed those beds

Accomplishments to Date - Local

- Developed Local Business Plans
- Established local CFACs
- Divesting of services, recruiting providers
- Implementing 24/7/365 access and screening capacity
- Completed mergers to increase efficiency and economies of scale
- Restructuring organizations to implement LME functions:
  - Administration – including business office, IT, billing function
  - Provider Relations & Support
  - Access, Screening, Triage, and Referral
  - Service Management
  - Consumer Affairs and Satisfaction
  - Quality Improvement & Outcomes Evaluation

Service Philosophy

- Consumers may enter services through a "uniform portal - "no wrong door"
- Consumers most in need will receive new comprehensive services
  - Person Centered Plan
  - "Clinical Home"
- Service descriptions and consumer eligibility are based on national models established through research.
- All consumers have increased access to services

Changes in the Service Array

- Revise services available to reflect evidence-based best practices and emerging best and promising practices – "paying for what works"
- Evidence based best practices – documented to be effective in at least three controlled clinical trials
  - Examples: ACT Team, medication management, supported employment, multi-systemic therapy, functional family therapy
- Designed to reflect a recovery approach to mental illness and substance abuse

Implementation – New Service Array

- Plan to implement new array 7/1/2005 (training to begin in January 2005)
- DHHS has walked through new service array with variety of stakeholders – consumers and families, providers, LMEs, members of Children's Collaborative
- New service definitions have been submitted to the MH subcommittee of the Physicians Advisory Group (PAG)
- Following PAG review, DMA will submit to CMS and post for 45 day public comment

Medicaid Changes Related to Mental Health Reform

- Policy revision and development
- Provider enrollment changes
  - New endorsement process
- Utilization review contract changes
- Increased coordination of patient care
- Payment changes

Policy revision and development

- Updating of outpatient policies to allow
  - Independent practitioners to see adults
  - Additional types of independent practitioners
- Revision of multiple service definitions and addition of new services to cover the evidence based services called for by reform

Provider Enrollment Changes

- More provider types = increased DMA work load
  - Independent practitioners
  - Multiple new provider types for the target pop
- Endorsement by LMEs needed to assure providers meet the requirements of the LMEs as well as DMA
  - Consistent processes for endorsement, monitoring, and withdrawal of endorsement

Utilization review contract changes

- Existing contract covers:
  - All admission and concurrent review for inpatient hospital services
  - Criterion 5//PRTF//Out of state services
  - Outpatient therapy beyond visits limit
  - Other
- Contract expires June 2005 and new contract is required
- RFP went out in Nov and bids are in for review

Utilization review contract changes cont

- RFP for new vendor includes base of statewide services
  - All admission and concurrent review for inpatient hospital services
  - Criterion 5
  - Psychiatric Residential Treatment Facilities
  - Out of state services

Utilization review contract changes -- cont

- LME's who want to perform other UR services will be reviewed by DMH and DMA using criteria based on the RFP requirements
- LME deemed "ready" performs UR function for all *community based* services in its catchment area.

Improved coordination of patient care

- Changes in LME processes, as mentioned
- Care Integration pilots in CCNC Networks
- Coverage of nursing services in schools (State Plan change pending)
- Child Mental Health Plan to include role of primary care physician
- Mental health needs in LT care

Payment Changes

- LME administrative costs -- Medicaid share is cost allocated & settled to actual cost
- Rate changes in response to revisions in Medicaid service definitions – both old & new
  - TAC
  - Provider Workgroups
  - Cost Modeling

Total Expenditures – DMA & DMH

	SFY 2003			SFY 2004		
	MH	DD	SA	MH	DD	SA
Medicaid Total	910,438,663	557,298,591	72,842,033	1,054,403,946	584,789,083	83,517,409
Federal	567,474,893	347,286,101	45,596,560	693,562,132	384,434,758	55,139,015
State	301,563,197	179,382,101	23,615,547	315,636,199	171,331,121	24,435,352
County	41,450,573	30,631,389	3,629,926	45,205,615	29,023,204	3,943,042
DMHDDSAS Total	131,984,790	170,192,690	63,490,974	139,169,184	181,322,103	76,054,722
Federal	11,503,662	25,930,617	31,324,553	10,927,379	13,456,585	40,657,338
State	120,481,128	144,262,073	32,166,421	128,241,805	167,865,518	35,397,384
Grand Total	1,042,473,453	727,491,281	136,333,007	1,193,573,130	766,111,186	159,572,131
Federal	578,978,555	373,216,718	76,921,113	704,489,511	397,891,343	95,796,353
State	422,044,325	323,644,174	55,781,968	443,878,004	339,196,639	59,832,736
County	41,450,573	30,631,389	3,629,926	45,205,615	29,023,204	3,943,042

"Top 15 Medicaid Services"

All - Mental Health, Developmental Disabilities & Substance Abuse Services

Procedure Code	Procedure Code Description	2002	%	2003	%	2004
RC100	ALL-INCLUSIVE R&B PLUS ANCILLARY	$ 543,992,768.55	N/A	$ 518,827,151.59	-4.63%	$ 518,403,977.60
Y2307	DMH CASE MGMT AREA MH 1/4HR	$ 57,192,863.91	N/A	$ 68,192,291.10	19.23%	$ 43,766,022.10
W8183	CAP-MR/DD SUPPORTED LIVING, LEVEL 2	$ 54,696,249.75	N/A	$ 47,651,415.31	-12.88%	
Y2348	HRI LEVEL III RESIDENTIAL 4 BEDS OR LESS	$ 52,107,149.50	N/A	$ 80,290,881.86	54.09%	$ 109,121,658.55
RC120	ROOM & BOARD-SEMI-PRIV GEN CLASS	$ 50,479,999.69	N/A	$ 62,094,828.24	23.01%	$ 76,332,089.98
RC110	ROOM & BOARD-PRIVATE-GEN CLASS	$ 36,301,718.79	N/A	$ 40,776,615.59	12.33%	$ 46,705,927.84
Y2349	HRI LEVEL III RESIDENTIAL 5 BEDS OR MORE	$ 34,198,326.65	N/A	$ 37,073,541.67	8.41%	$ 34,746,393.54
W8188	CAP MR-DD CASE MANAGEMENT, MONTHLY	$ 34,063,282.23	N/A	$ 31,250,295.36	-8.26%	
Y2370	COMMUNITY BASED SERVICES PARAPROFESSIONAL INDIV	$ 33,895,039.49	N/A	$ 85,401,803.75	151.96%	$ 74,152,361.99
W8184	CAP-MR/DD SUPPORTED LIVING, LEVEL 3	$ 32,148,784.84	N/A	$ 31,284,746.43	-2.69%	
W8199	CAP-MR/DD SUPPORTED LIVING, INDIVIDUAL	$ 27,314,182.34	N/A	$ 40,300,821.84	47.55%	
Y2305	DMH OUTPATIENT TREATMENT INDIVIDUAL (15 MINUTES =	$ 25,367,018.31	N/A		N/A	
RC124	ROOM & BOARD-SEMI-PRIV PSYCHIATRIC	$ 22,366,218.89	N/A	$ 24,575,008.62	9.88%	$ 26,895,603.16
Y2362	HRI LEVEL II THERAPEUTIC FOSTER CARE	$ 22,313,982.13	N/A	$ 28,097,109.47	25.92%	$ 35,083,227.62
Y2316	CLIENT BEHAVIOR INTERVENTION, INDIVIDUAL	$ 20,509,416.05	N/A		N/A	
Y2367	COMMUNITY BASED SERVICES ALL OTHER PROFESSIONAL 15 MIN		N/A	$ 54,431,991.44	N/A	$ 52,229,225.62
W8111	CAP-MR/DD WAIVER PERSONAL CARE		N/A	$ 28,203,254.56	N/A	
H0036	COMM PSYCHIATRIC SUPP TREATMENT, FACE-TO-FACE, PER 15 MIN		N/A		N/A	$ 78,140,196.55
S5125	ATTENDANT CARE SERVICES; PER 15 MINUTES		N/A		N/A	$ 34,058,214.08
T2014	HABILITATION, PREVOCATIONAL, WAIVER; PER DIEM		N/A		N/A	$ 31,570,104.01
H2015	COMPREHENSIVE COMMUNITY SUPPORT SERVICES, PER 15 MIN		N/A		N/A	$ 29,829,576.22
T1017	TARGETED CASE MANAGEMENT (ONE UNIT = 15 MIN)		N/A		N/A	$ 28,098,861.34
	Total "Top 15" Expenditures	$ 1,046,947,001.12		$ 1,178,451,756.83		$ 1,219,133,440.20

Questions?

Medicaid In-Home Personal Care Services Program

Presented by Lynne Perrin
Chief, Facility and Community Care
Clinical Policy and Programs
NC Division of Medical Assistance
December 15, 2004

www.dhhs.state.nc.us/dma/
nc dma
Division of Medical Assistance

Handout # 2

In-Home Personal Care Services

- Optional Medicaid Benefit
- Provided to persons living in a private residence and who have medical conditions that require assistance from a personal care aide
- Must be authorized by a physician in accordance with a plan of treatment or otherwise approved by the state

Medicaid Reimbursement

- Medicaid reimburses $14.20 (effective Aug. 2004) per hour for personal care tasks performed by in-home aides.
- The tasks may include
  - Helping patients with bathing, toileting, moving about, keeping track of vital signs; and,
  - Help with housekeeping and home management tasks as a secondary support to maintain one's health.

Amount of Services and Medicaid Benefit Limitations

- Hours of PCS are determined through an assessment performed by the home care agency's RN and authorized by the physician.
- PCS is limited to a maximum of 60 hours per month per patient (3 and ½ hours per day).
- If prior approved by DMA, one may receive up to 80 hours per month under the *PCS Plus* program based on documented need for additional services.

Who Provides PCS Services?

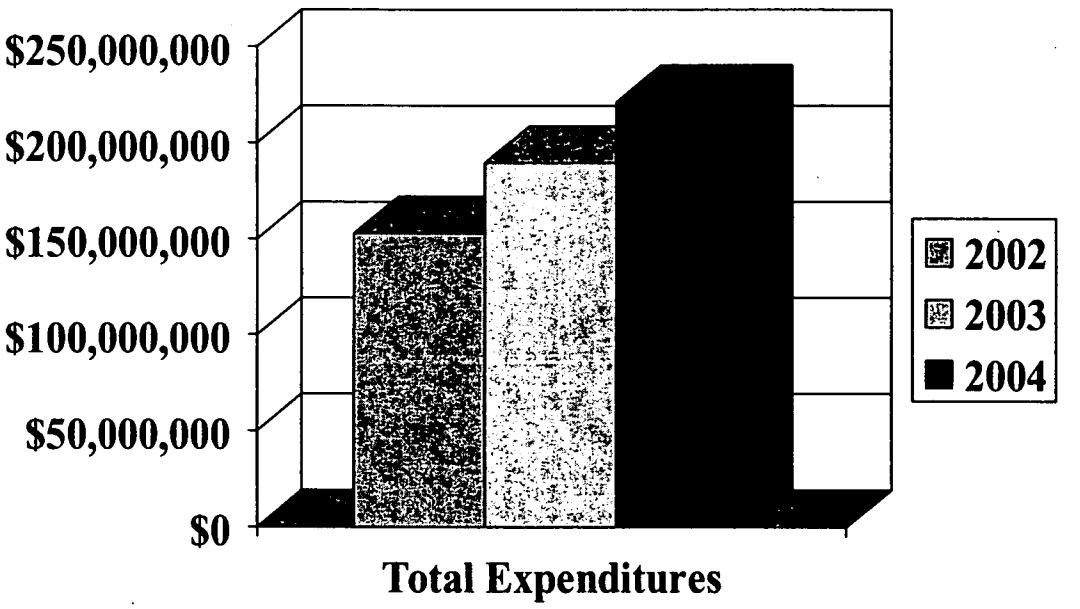
- Home care agencies in North Carolina
  - Licensed by the Division of Facility Services to provide in-home aide services
  - Enrolled in the Medicaid program
- In-home aides must meet the requirements in the Home Care Licensure Rules

Providers Enrolled in Medicaid

- There are currently 685 home care providers* enrolled in the Medicaid Program.

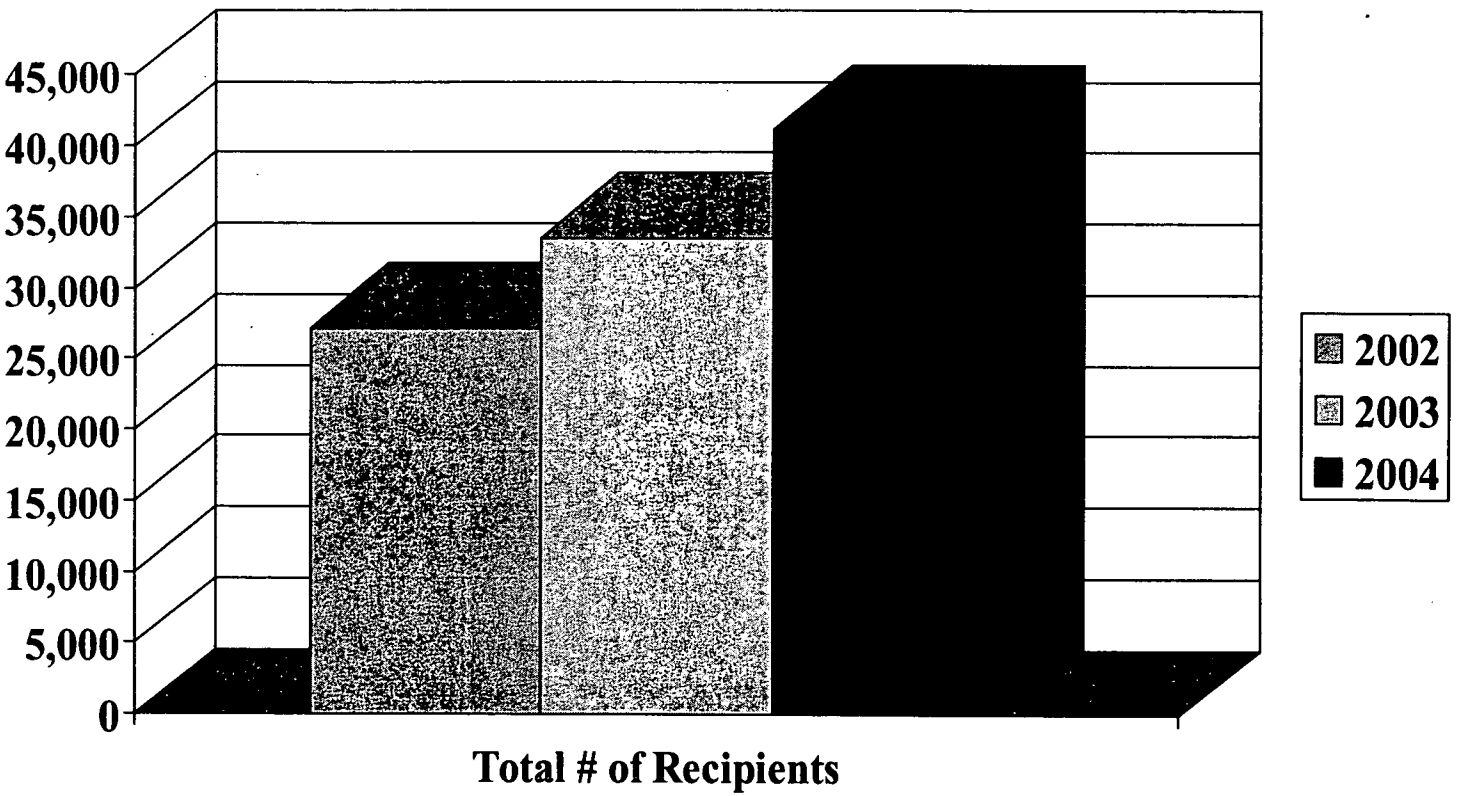
* An agency may have several site locations and each site is treated as a separate provider and not all providers enrolled may actively be billing Medicaid.

Medicaid Expenditures for PCS



SFY 2004
Expenditures:
$220,933,622

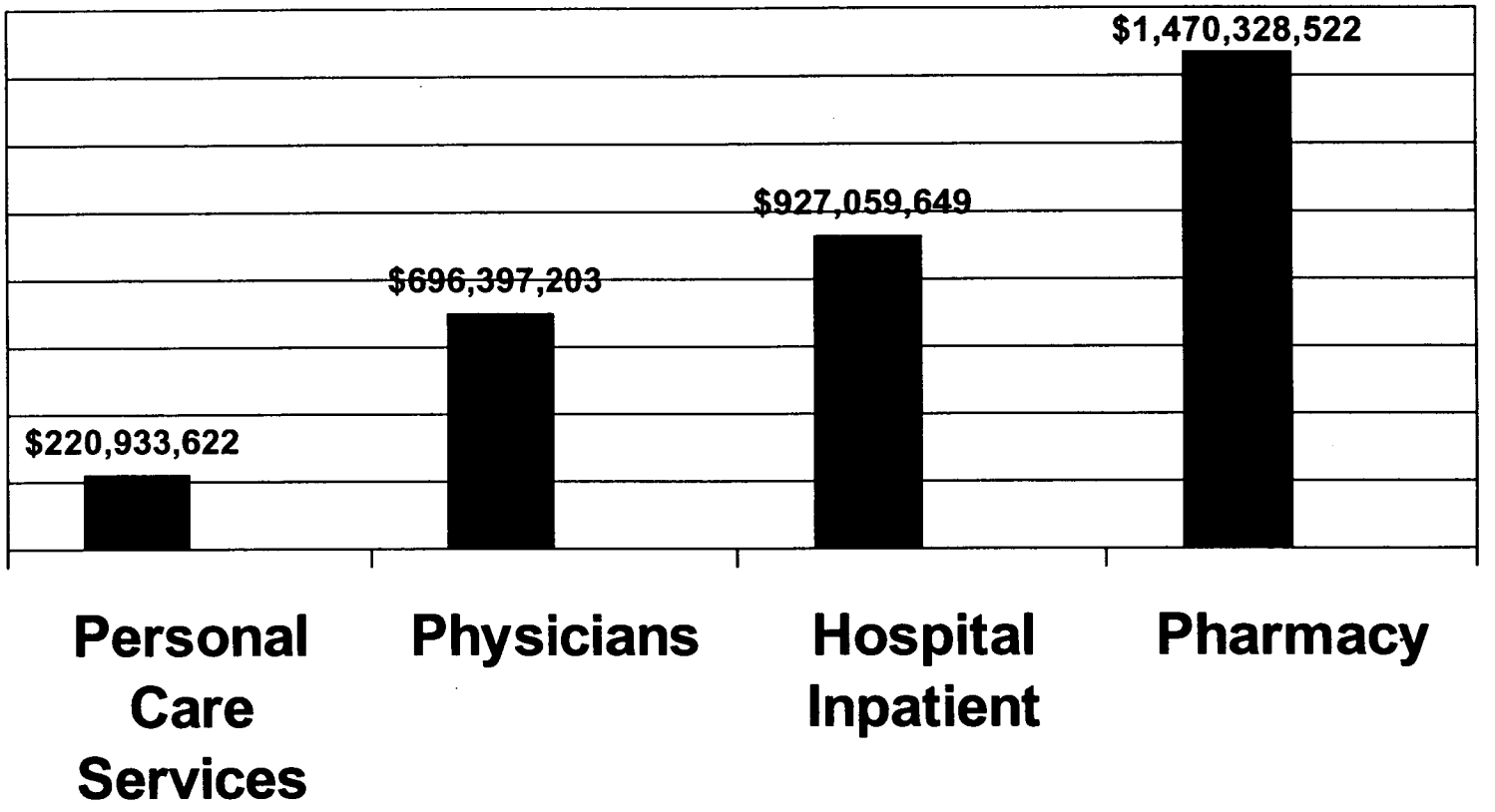
Recipients of PCS



SFY 2004 Recipients:
41,222

PERSONAL CARE SERVICES

Compared to Other Medicaid Expenditures for SFY 2004



Growth in PCS

- Growth in Expenditures
  - 2002 to 2003 was 24%
  - 2003 to 2004 was 17%

- Increase in Recipients
  - 2002 to 2003 was 23%
  - 2003 to 2004 was 23%

Average Expenditures Per Recipient

- Average Annual Per Recipient
  - SFY 2004 $5,360
- Average Monthly Per Recipient
  - SFY 2004 $446

Need for PCS Program Improvements

- PCS is an important program in the NC's long term care system as it supports recipients in their own homes.
- Service has been operating since 1985 with little change in administrative structure or state level oversight.

Need to Restructure PCS Program

- Growth in program expenditures and recipients
- Growth in numbers of providers and appropriate targeting of services
- Quality issues
- Need to refine and clarify medical criteria
- Need for newer improved assessment tools
- Need for provider standards, training and best practices
- Need to improve state level oversight and monitoring functions

PCS Restructuring Initiative

- Restructuring initiated by Association for Home and Hospice Care and DMA in January 2004
- Partnership among PCS providers, DMA staff, and DFS staff
- Established PCS Restructuring Advisory Committee to oversee four work groups
  - Criteria/Documentation
  - Policy/Process
  - Utilization Review
  - Rules Subcommittee

PCS Restructuring Initiative

- Restructuring Advisory Committee met on a monthly basis
- First PCS Kickoff meeting held March 18, 2004
- More than 40 people have participated in the process to date
- Over 30 meetings took place between January, 2004 and October, 2004
- PCS Wrap-Up meeting of work groups held October 27, 2004

PCS Restructuring Goals

- Refine and clarify the Medicaid PCS policy
- Streamline the PCS service delivery process
- Develop a quality assurance and utilization management component
- Strengthen provider compliance with policies
- Establish provider training requirements
- Build strong partnerships with shared goals

PCS Restructuring Advisory Committee

Tom Harmelink, *Provider-Health Force*
Jeff Horton, *DFS*
Azzie Conley, *DFS*
Robyn Reasor, *DMA-Program Integrity*
Kathy Gulick, *DMA-Program Integrity*
Carol Putnam, *DMA-Program Integrity*
Tim Rogers, *AHHC*
Sherry Thomas, *AHHC*
Jim Edgerton, *AHHC*
Dr. Nancy Henley, *DMA-Director's Office*
Pamela Horrell, *DMA-Provider Enrollment*
Frank Dziepak, *DMA-Financial Operations*
Lynne Perrin, *DMA-Clinical Policy*
Rosalie Wachsmuth, *DMA-Clinical Policy*
Donna Steele, *DMA-Clinical Policy*

Criteria/Documentation Work Group

Donna Turlington, *Provider-Liberty HC*
Phyllis Nealey, *Provider-Interim HC*
Tina Glenn, *Provider-Hearthside HC*
Roget Berendes, *Provider-Hearthside Home Care*
Sandra Bridges, *Provider-First Choice HC*
Betty Nance, *Provider-Guardian Angel HC*
Carol Putnam, *DMA-Program Integrity*
Sherry Thomas, *AHHC*
Robyn Reasor, *DMA-Program Integrity*
Donna Steele, *DMA-Clinical Policy*
Rosalie Wachsmuth, *DMA-Clinical Policy*

PCS Policy/Process Workgroup

Beverly Stewart, *DMA-Program Integrity*
Phyllis Burwell, *DMA-Clinical Policy*
Jim Arp, *Provider-Advantage Home & Hospice*
Heather Blank, *Provider-Assisted Care*
Sherry Thomas, *AHHC*
Sandi Massey, *Provider-Good Health Services*
Karen Rowe, *Provider-Carolinas Home Care*
Bonnie McBride, *DMA-Program Integrity*
Kathy Gulick, *DMA-Program Integrity*
Pamela Horrell, *DMA-Provider Enrollment*
Sandi Massey, *Provider-Good Health Services*
Tom Harmelink, *Provider-Health Force*
Nena Reaves, *Provider-Health Services Personnel*
Lloyd Pattison, *DMA-Clinical Policy*
Donna Steele, *DMA-Clinical Policy*
Rosalie Wachsmuth, *DMA-Clinical Policy*

PCS Quality Assurance and Utilization Review Workgroup

Bill Craig, *Provider-Quality Patient Care*
Peggy Mallard, *Provider-Guardian Health Services*
Larry Nason, *DMA-Clinical Policy*
Lynne Perrin, *DMA-Clinical Policy*
Ginger Parrish, *Provider-Albemarle Home Care*
Robyn Slate, *DMA-Rate Setting*
Pat Jeter, *DMA-Rate Setting*
Frank Dziepak, *DMA-Financial Operations*
Sherry Thomas, *AHHC*
Jim Edgerton, *AHHC*
Sheila Alford, *Provider-Home Health & Hospice of Halifax*
Tim Brooks, *Provider-Healthkeeperz Home Health*
Pam Wells, *DMA-Program Integrity*
Peggy Davis, *DMA-Program Integrity*
Robyn Reasor, *DMA-Program Integrity*
Donna Steele, *DMA-Clinical Policy*
Rosalie Wachsmuth, *DMA-Clinical Policy*

Outcomes of the Work Groups

Key Recommendations for Program Improvements

Criteria/Documentation Work Group

- Development of a new comprehensive functional assessment which identifies Activities of Daily Living (ADL) and Instrumental-ADL deficits. It links the recipient's medical condition to their ADL needs on the form. Assessment is based on the MDS instrument used in nursing facilities.
- Standardized ADL definitions and task definitions.
- Establishment of minimum criteria: at least 2 ADL deficits required for PCS. 3-4 ADL deficits for PCS-Plus.
- Strengthened RN Certification statement on assessment tool.

Policy/Process Work Group

- Eliminate the need for agency to obtain a verbal order to assess a client for PCS. The recipient's attending physician will still be required to sign an order to start services.
- Eliminate the need for agency to contact the physician for incidental changes on the Plan of Care. For example, no need to contact the physician if you are changing the day you wash the client's hair. The current policy requires that you must notify the physician in this case.

Policy/Process Work Group (Cont'd)

- Change the current requirement for the RN to visit the client every 60 days to every 90 days. This would make the policy consistent with Home Care Licensure Rules.
- Development of a standardized Nursing Supervisory Visit Form.
- Development of Nursing Supervisory Visit standards for PCS.
- Allow agencies to use electronic systems to track aide services.

Quality Assurance and Utilization Review Work Group

- DMA and provider agencies have a shared responsibility for assuring PCS services are quality-based and are provided in accordance with program policies.
- Development of a Quality Assurance and Utilization Review plan which includes an agency self-audit and a state level review.

Quality Assurance and Utilization Review Work Group (Cont'd)

- PCS Agency Self-Audit
  - Evaluation of Client Records (active and closed)
  - Telephonic surveys with clients
  - Supervisory visits to clients
  - Electronic check-in systems for aides
  - Review of aide service logs
  - Incident/Complaint management
- During state-level review, the auditor may request copy of the agency self-audit, findings and corrective action plan.

Quality Assurance and Utilization Review Work Group (Cont'd)

- New DMA Enrolled Providers (after six months of Medicaid billed service) will receive a state level program review by DMA Program Integrity.

- Does not replace regular DMA Program Integrity audits.

Quality Assurance and Utilization Review Work Group (Cont'd)

- State staff PCS Reviews
  - Targeted Reviews from information systems data. Automated sampling based on identified thresholds. Examples:
    - Pediatrics
    - More than one PCS recipient in the same home
    - Diagnosis targeted audit
- State staff desk reviews and on-site reviews of agencies and clients.

Quality Assurance and Utilization Review Work Group (Cont'd)

- If the findings of the state staff review indicate that the client does not meet PCS criteria, DMA will issue a letter regarding the determination of coverage and take appropriate action.
- Other findings could lead to Program Integrity investigations.

Rules Work Group

- Establishment of minimum qualifications and training requirements for PCS providers. This includes a framework for provider training and competency evaluation.
- Important - PCS Advisory Committee and AHHC support legislation for Medical Care Commission being granted authority to set staffing qualifications through rules.

Impact of PCS Changes on Providers

- Administrative Changes - staff qualification requirements; paper/software changes (mandatory forms, mandatory elements on forms and/or costs associated with electronic entry)
- Training Costs
- Geographical service area impacts (volume impacts on costs)
- More in-depth Utilization Review, more oversight by agency management

Next Steps in the Restructuring Process

- Physician Advisory Group (PAG) input
- DMA development of draft policies, procedures and provider instructions
- DMA internal review of draft policies by all sections in DMA
- Fiscal Impact Analysis by DMA
- Formal Review of policies by PAG and recommendations to DMA
- Preparation of "final" policies and posting on DMA web site for 45 day comment period
- Identify and secure state resources to implement components (utilization management, automation of assessment tools, provider training, etc.)

Next Steps in the Restructuring Process

- Implementation process expected to take from 6-10 months
- Looking at a July 1, 2005 target date for many of the major changes to be implemented
- Information systems changes and contracting for a utilization management program may take longer

Team Effort

- Participation by stakeholders has made the PCS Restructuring products better than they might have been otherwise.
- There is much left to do and many details to be worked out.
- DMA and AHHC remain committed to the process.

Outcome Focus

- To assure PCS continues to be an important service in the state's long term care system; that PCS services are targeted appropriately based on medical need; and, that management systems are in place to ensure quality services and fiscal accountability.

Handout #3

Blue Ribbon Commission on Medicaid
DHHS/Medicaid Priorities
December, 2004

1. **MMIS work efforts.** The development of the new MMIS system is an extremely detail and time consuming process which is requiring a great deal of DMA staff support from both the program and financial sides of DMA. At any given week, we may have between 20 and 40 staff members pulled to work with the MMIS team for the day and weeks at a time. This impacts our ability to maintain existing normal work efforts within DMA, much less time it takes away to implement new program changes. At the same time, **we are quickly approaching a key decision point whereby making modifications to the existing system has to be weighed against awaiting the new system and ensuring the new system has the functionality.** I bring this issue to you so you can have an understanding that our ability to make new changes to the programs of Medicaid and the associated systems changes to support this are better held until the new system is up and running.

2. **Health Choice**- We expect a continued growth of the Health Choice membership through SFY 07 at a rate of 1.2% per month. The current federal funding is authorized though SFY 07 and is up for reauthorization. NC has enjoyed federal funding via NC's regular allotment of Health Choice funds and also redistributed funds not utilized by other states. The redistributed funding received by NC has been reduced by the increased utilization of the other states. Currently we do not have sufficient state funds to support the continued growth and ultimately, unless

Congress appropriates additional federal funds we will find ourselves with insufficient federal funding to support the continued growth in SFY 07.

3. **Medicare Modernization Act**-The new federal regulations will have a major impact on many aspects of the Medicaid program, including Medicaid eligibility policy and process, clinical policies, system development, fiscal, legal and staffing issues. For DMA, the careful understanding and planning for this major change in the Medicare and Medicaid programs is a huge task and priority for us.
4. **Community Care-** As reported at the last meeting, we can now document that the community care efforts provide a savings to Medicaid as compared to the usual Fee for Service model. We seek your support to continue to expand this effort as we move toward statewide implementation of working with local primary care providers to develop and implement quality improvements and cost containment strategies for Medicaid health delivery system. We really do see this approach as the future for disease management in NC.
5. **Facility and Community Care**- As we move to restructure the PCS program, it calls for implementation of new program policies and medical criteria, new management controls and oversight of the program and new assessment and prior approval instruments. **We need to establish appropriate utilization management to ensure PCS is provided based on medical need and ensure the services in the care plans are delivered.** As we move more toward reimbursing facilities based upon the case mix of the clients we need to make sure we have the appropriate level of Quality Improvement in coordination with the increase in the reimbursement.

6. **Payment Error Rate Measurement (PERM)**—CMS has proposed new rules that will require all state Medicaid agencies to establish additional detail reviews of both Medicaid and Health Choice claims. This is a new approach the feds are undertaking to develop national claim payment error rate statistics. The current proposed rules will be extremely staff time consuming and are work efforts over and beyond the existing federal required Quality Assurance requirements. If the proposed rules become final as written, this will place an additional staffing burden on all state Medicaid agencies and additional staffing will be required.

7. **Dental Rates**- as you may be aware; we increased the Dental rates for approximately 30 to 40 procedure codes mostly to improve access to dental services for children under age 21. This action has been successful in assisting to **enroll new providers to care for the dental care for children**. For most dental rates for adults they have not been increased since Jan, 2001. Since this time, the cost of delivery of dental services has risen by approximately 20%. We believe it is important to increase these rates to raise them to a reasonable level and make them competitive, eliminating the excessive variability in the reimbursement procedures and to ensure we maintain and increase provider participation of dental providers and recipient access to care for adults.

8. **Full funding of the Medicaid contracts**—Contracts required to manage the Medicaid program have been under funded since SFY 2000 and as cost increase the difference between what is budgeted and what it takes to run the division grows larger. Historically, DMA is required at year end to transfer available funding from the program/services side over to administration to cover the excess

expenditures over budget for our contracts. We are required to certify the availability of funds prior to entering a new contract or upon issuance of an RFP. With insufficient funding in our contracts administration budget, we are finding ourselves entering into contracts during the year with anticipation of transferring funds out of services at year end. As spending for Medicaid services increases, this is not an appropriate approach to managing the administrative budget

9. **Audit and Rate Setting**- one of the areas within DMA that we believe needs additional resources are in the area of auditing and rate setting. Medicaid has many diverse providers and procedure codes. With the complexity of the program we believe it critical that we strengthen the audit and rate setting section to ensure Medicaid is paying its providers appropriately and that we have sufficient resources to appropriately audit the cost reports and increase the financial oversight of the Medicaid agency.
10. SAS Fraud and Abuse: We are undertaking a new project with SAS to utilize their software and consultative services to find possible additional area of Fraud that Medicaid needs to focus on. This project will affirm our current approach in auditing our MMIS claims for possible fraud and abuse ,but we anticipate will show us additional areas where our Program Integrity Section can enhance their collections. The results of the project will be available in the Spring of 2005 and will guide us on improvements Medicaid will make both in the Program Integrity Section but also will hopefully provide us some valuable insight to possible enhances to our Clinical Policies as well as enhancements in the MMIS edits and audits.

Additional Options for Reducing the County Share of the NC Medicaid Program

Division Fiscal Research

December 2004

Handout # 4

Additional Options for Reducing the County Share of Medicaid

- Phase-out county share for total Medicaid expenditures over a six-year period and target additional reductions to counties where the number of Medicaid eligibles is 25%+ of the county's population.
- Phase-out county share for total Medicaid expenditures over a eight-year period and target additional reductions to counties where the number of Medicaid eligibles is 25%+ of the county's population.
- Phase-out county share for total Medicaid expenditures over a ten-year period and target additional reductions to counties where the number of Medicaid eligibles is 25%+ of the county's population.
- Cap the county share of total Medicaid expenditures at the SFY 2004-05 level over a five-year period and target additional reductions to counties where the number of Medicaid eligibles is 25%+ of the county's population.

Option #7

Phase-out county share for total Medicaid expenditures over a six-year period and target additional reductions to counties where the number of Medicaid eligibles is 25%+ of the county's population.

Six-Year Phase-Out of the County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Phases out the County share for all 100 counties over a six-year period.
- County share over the six-year phase-out period:

  - 2005 15% (Current requirement)
  - 2006 12.5%
  - 2007 10%
  - 2008 7.5%
  - 2009 5%
  - 2010 2.5%
  - 2011 0%

Six-Year Phase-Out of the County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Target additional reductions over a six-year period for counties where the number of Medicaid eligibles is 25%+ of the county's population.
- Assumes county share for counties with 25%+ Medicaid population will be reduced to two-thirds of the phase-out amount.
- Estimates of county Medicaid population are based on a three year average (SFY 2002 through SFY 2004).

Six-Year Phase-Out of the County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Assumes group of counties with Medicaid eligibles 25%+ of the county population will not change during the six-year period.
- Uses 2005 county share estimates prepared by the Division of Medical Assistance.
- Assumes share of total Medicaid expenditures (15.66%) for counties with Medicaid eligibles 25%+ of the county population will not change during the five-year period.

Six-Year Phase-Out of the County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

State Fiscal Year	Projected County Share	Additional State Cost
2005	$448,159,792	$0
2006	$387,277,783	$103,049,727
2007	$340,727,310	$198,510,871
2008	$280,236,067	$311,102,842
2009	$205,011,174	$443,893,972
2010	$112,302,847	$598,623,237
2011	$0	$777,916,164

Option #8

Phase-out county share for total Medicaid expenditures over a eight-year period and target additional reductions to counties where the number of Medicaid eligibles is 25%+ of the county's population.

Eight-Year of the Phase-Out County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Phases out the County share for all 100 counties over a eight-year period.
- County share over the eight-year phase-out period:

➢2005 15% (Current requirement)
➢2006 13.125%
➢2007 11.25%
➢2008 9.375%
➢2009 7.5%
➢2010 5.625%
➢2011 3.75%
➢2012 1.875%
➢2013 0%

Eight-Year of the Phase-Out County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Target additional reductions over a eight-year period for counties where the number of Medicaid eligibles is 25%+ of the county's population.
- Assumes county share for counties with 25%+ Medicaid population will be reduced to two-thirds of the phase-out amount.
- Estimates of county Medicaid population are based on a three year average (SFY 2002 through SFY 2004).

Eight-Year Phase-Out of the County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Assumes group of counties with Medicaid eligibles 25%+ of the county population will not change during the six-year period.
- Uses 2005 county share estimates prepared by the Division of Medical Assistance.
- Assumes share of total Medicaid expenditures (15.66%) for counties with Medicaid eligibles 25%+ of the county population will not change during the five-year period.

Eight-Year Phase-Out of the County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

State Fiscal Year	Projected County Share	Additional State Cost
2005	$448,159,792	$0
2006	$406,641,672	$83,685,838
2007	$383,318,224	$155,919,957
2008	$350,295,084	$241,043,825
2009	$307,516,761	$341,388,385
2010	$252,681,407	$458,244,678
2011	$184,327,602	$593,588,562
2012	$100,658,386	$748,957,020
2013	$0	$926,172,690

Option #9

Phase-out county share for total Medicaid expenditures over a ten-year period and target additional reductions to counties where the number of Medicaid eligibles is 25%+ of the county's population.

Ten-Year of the Phase-Out County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Phases out the County share for all 100 counties over a ten-year period.
- County share over the ten-year phase-out period:

- 2005 15% (Current requirement)
- 2006 13.5%
- 2007 12%
- 2008 10.5%
- 2009 9%
- 2010 7.5%
- 2011 6%
- 2012 4.5%
- 2013 3%
- 2014 1.5%
- 2015 0%

Ten-Year of the Phase-Out County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Target additional reductions over a ten-year period for counties where the number of Medicaid eligibles is 25%+ of the county's population.
- Assumes county share for counties with 25%+ Medicaid population will be reduced to two-thirds of the phase-out amount.
- Estimates of county Medicaid population are based on a three year average (SFY 2002 through SFY 2004).

Ten-Year Phase-Out of the County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Assumes group of counties with Medicaid eligibles 25%+ of the county population will not change during the six-year period.
- Uses 2005 county share estimates prepared by the Division of Medical Assistance.
- Assumes share of total Medicaid expenditures (15.66%) for counties with Medicaid eligibles 25%+ of the county population will not change during the five-year period.

Ten-Year Phase-Out of the County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

State Fiscal Year	Projected County Share	Additional State Cost
2005	$448,159,792	$0
2006	$418,260,005	$72,067,505
2007	$408,872,772	$130,365,409
2008	$392,330,494	$199,008,415
2009	$369,020,113	$279,885,033
2010	$336,908,542	$374,017,542
2011	$294,924,163	$482,992,000
2012	$241,580,125	$608,035,280
2013	$175,565,645	$750,607,046
2014	$95,688,703	$913,896,781
2015	$0	$1,100,464,398

Option #10

Cap the county share of total Medicaid expenditures at the SFY 2004-05 level over a five-year period and target additional reductions to counties where the number of Medicaid eligibles is 25%+ of the county's population

Cap County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Cap County share of total Medicaid expenditures at the SFY 2004-05 level over a five-year period.
- Target additional reductions over a five-year period for counties where the number of Medicaid eligibles is 25%+ of the county's population.
- Assumes county share for counties with 25%+ Medicaid population will be reduced to two-thirds of the phase-out amount.
- Estimates of county Medicaid population are based on a three year average (SFY 2002 through SFY 2004).

Cap County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

- Assumes group of counties with Medicaid eligibles 25%+ of the county population will not change during the six-year period.
- Uses 2005 county share estimates prepared by the Division of Medical Assistance.
- Assumes share of total Medicaid expenditures (15.66%) for counties with Medicaid eligibles 25%+ of the county population will not change during the five-year period.

Cap County Share of Total Medicaid Expenditures and Target Counties with Medicaid eligibles 25%+ of the County's Population

State Fiscal Year	Projected County Share	Additional State Cost
2005	$448,159,792	$0
2006	$424,766,697	$65,560,813
2007	$424,766,697	$114,471,484
2008	$424,766,697	$166,572,212
2009	$424,766,697	$224,138,449
2010	$424,766,697	$286,159,388

NORTH CAROLINA GENERAL ASSEMBLY
STATE LEGISLATIVE BUILDING
RALEIGH 27603

December 30, 2004

MEMORANDUM

TO: Members, Blue Ribbon Commission on Medicaid Reform

FROM: Senator William R. Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

SUBJECT: Notice for January 18, 2005 Meeting

The Blue Ribbon Commission on Medicaid Reform will meet as indicated below. The purpose of the meeting is to consider various legislative recommendations for the 2005 Session.

Those out-of-town members who travel the previous day and spend the night at a hotel should turn in the hotels' itemized bill for reimbursement purposes.

DAY:	Tuesday
DATE:	January 18, 2005
TIME:	8:30 a.m.
LOCATION:	Room 544, Legislative Office Building

Parking for non-legislative members of the committee/commission is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. The cost for visitor parking is $.50 per hour or $4.00 per day and may be reimbursed with a parking receipt submitted with your travel reimbursement form.

Please advise Anne Wilson, Committee Assistant, at (919) 733-5707, or e-mail medicaidca@ncleg.net if you will be unable to attend.

Posted: December 30, 2004

cc: Committee Record ✓
Interested Parties

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — January 18, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lori Ann Harris	CAHA
Debbie Barnes	OSBM
Daphne Lyon	OSBM
[illegible]	Wyeth
Lee Anne [illegible]	Wyeth
John Mackey	Gov office
Nancy Hurley	DMA
AG Horne	NCMS
Gary Fuquay	DMA
John Goodman	Alley Associates

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — January 18, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mark Stephens	Pfizer 1345 Maryland Ave. Charlotte, NC 28209
Dawn Gunter	Pfizer 9801 Devonshire Huntersville, NC 28078
Sherry Hobgood	Accredo 7866 Thornedike Rd. Greensboro, NC 27409
Rick Klusovsky	Accredo 1016 Fairwood Ln Acworth, GA 30101
Dan Datta	HRA 4000 Spring Garden St. Greensboro NC 27407
Jerry Cooper	NCAHA
Evelyn Hawthorne	EHGR
Janet Sigmon	NC Council
Lee Hodge	Kennedy Covington
Sherri Coffee	Abbott
Chris Kennedy	Pfizer 102 Duncroft Ct Apex, NC 27502

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — January 18, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Fontana	Guilford Co. Dept. of Transportation
Lisa Bateman	DJJDP
Don McCorquodale	SAS
Rebecca Troutman	NCACC
Betsy Bailey	NC Public Transportation
[illegible]	NCLHW
John Bowdish	AstraZeneca
Brian Shank	AstraZeneca
Abby Emanuelson	NMSS
Bill [illegible]	[illegible]
Jonathan Beam	Leg. Intern

VISITOR REGISTRATION SHEET

BLUE RIBBON COMMISSION ON MEDICAID REFORM — January 18, 2005

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ben Money	NC Cancer Hosp Cancer Assoc
Kent Earnhardt	NAMI
Chip Killian	Nelson Mullins

BLUE RIBBON COMISSION ON MEDICIAD REFORM
Tuesday, January 18, 2005
8:30 a.m., Room 544 LOB

Chairmen: Senator William Purcell, Co-chair
Representative Julia Howard, Co-chair
Representative Edd Nye, Co-chair

I.	**Opening Remarks**	*Chairs*
II.	**Review of Draft Final Report and Draft Legislation**	*Commission Staff*
III.	**Approval of Final Report**	*Chairs*
IV.	**Closing Remarks**	*Chairs*

BLUE RIBBON COMMISSION ON MEDICAID REFORM
Tuesday, January 18, 2005
Room 544, Legislative Office Building

MINUTES

The Blue Ribbon Commission on Medicaid Reform met at 8:30 a.m. on Tuesday, January 18, 2005 in Room 544, Legislative Office Building. The following members of the committee were present: Senators William R. Purcell (Co-chair) and Charlie Dannelly; Representatives Edd Nye, (Co-chair), Julia Howard, (Co-chair), Jeffrey Barnhart, Beverly M. Earle, and Bob England; public members Daniel C. Hudgins, William A. Pully, Dr. Pam C. Silberman, Luckey Welsh, Dr. Al Wentzy, and Dr. Charles F. Willson. Senator Purcell presided.

Senator Purcell welcomed members and guests to the final meeting of the commission. He called on Ms. Carol Shaw of the Fiscal Research Division to review the first item on the agenda, "Draft Final Report and Draft Legislation". (See Handout #1.) Ms. Shaw said the format for the report is standard and consists of a title page, a letter to the General Assembly leadership, Table of Contents, the Preface, a condensed version of Commission Proceedings and Commission Recommendations. She reviewed each of the recommendations, beginning on Page 8.

Recommendation # 1: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly reinstate the Long-Term Care Income Tax Credit effective January 2005. In order to reduce the error rate, the Commission also recommends that the Department of Revenue can require that taxpayers claiming the credit must list the insurance company and policy number of the long-term care insurance policy.

Ms. Shaw said the Department of Revenue indicated the second sentence of the recommendation is not necessary for implementation of reinstating the tax credit. (See Appendix N of Handout # 1 for draft legislation.)

Representative Howard moved to approve Recommendation #1 as corrected and the commission voted approval.

Recommendation # 2: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly continue the statewide expansion of the Community Care of North Carolina Program, and appropriate $2 million to support the continued expansion.

Senator Dannelly moved to approve Recommendation # 2 and the commission voted approval.

Recommendation #3: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly provide funding to support increased rates for dental services provided for adults.

Ms. Shaw said that the Department of Health and Human Services (HHS) will provide information on the amount of funding needed for increasing this service and it will become a part of the recommendation. Ms. Shaw suggested that the commission direct HHS to study how to handle dental services for adults and to look at case management as a method for delivering this service.

Dr. Silverman moved to approve Recommendation #3 as corrected and the commission voted approval.

Recommendation #4: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly reduce the county share of the North Carolina Medicaid Program as follows: a) Cap the county share for all 100 counties at the FY 2004-05 level. b) Phase-out the county share of Medicaid for all 100 counties over six years beginning in FY 2005-06 by reducing the county share by 2.5% each year until the county share reaches 0% in FY 2010-2011. c) Further reduce the county share of Medicaid for counties where the number of Medicaid eligibles is 25%+ of the county's population by reducing the county share to two-thirds of the phase-out amount.

Dr. Wentzy proposed a change/addition to the background of this recommendation beginning at the last sentence of Paragraph 2. He said the N. C. Association of County Commissioners recently finished its legislative goals agenda which reads, "The Commissioners Association's number one legislative goal for fiscal year 2005-06 is to seek legislation to implement a six-year phase-out of county participation in the cost of Medicaid for the first year, cap county costs at FY 2004-05 level and provide relief by targeting supplemental financial assistance to any county in which more than 25% of the population is eligible for Medicaid."

Dr. Wentzy asked to include this in background material and he moved for approval of the recommendation. The commission voted approval.

Recommendation # 5: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly enact legislation to move children birth through age five with family incomes equal to or less than 200% of the Federal Poverty Guidelines into the Medicaid program. Counties should be held harmless for the costs of moving children into the Medicaid program.

Representative Howard said she would not support this recommendation, even though the concept sounds good, because it skews the focus of Health Choice. She said it goes against the grain of the way Health Choice was set up.

Dr. Silberman moved to approve Recommendation #5. The commission approved the motion with Representative Howard voting against it.

Recommendation # 6: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly require the Division of Medical Assistance (DMA) to develop a case management program for large users of prescription drugs. DMA shall report on the methodology no later than Jan. 1, 2006, to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Representative Nye asked Mr. Gary Fuquay, Director of the Division of Medical Assistance in the Department of Health and Human Services if the commission needs to suggest language that he can use to implement a similar program if he finds that great savings can be obtained. Mr. Fuquay said DMA would want to pursue the program if it were found to be beneficial and would support having appropriate language included. Dr. Willson said the poly-pharmacy initiative in the Community Care of North Carolina program has already moved in the direction of this recommended program and that this proposal would further expand the poly-pharmacy initiative. He suggested substituting the language "users of large numbers of drugs" for "large users of drugs" in the first sentence of the recommendation.

Mr. Hudgins moved to approve Recommendation # 6 as corrected and the commission approved the motion.

Recommendation # 7: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly direct the Division of Medical Assistance (DMA) to develop a methodology for reinvesting savings from the Community Care of North Carolina Program back into the community. DMA shall report on the methodology no later than Jan. 1, 2006, to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Dr. Silberman suggested a word change in the recommendation to clarify that the savings from the Community Care Program would be used to expand care to other underserved populations.

Senator Dannelly moved to approve Recommendation # 7 as corrected and the commission approved the motion.

Recommendation # 8: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly expand Medicaid eligibility under the Ticket to Work and Work Incentives Improvement Act of 1999 to persons who are age 16 through 64 who are disabled but who are working and to persons who have received Medicaid in the first group, who lose eligibility for that group due to medical improvement, but who retain a severe impairment. The Commission also recommends that the General Assembly appropriate funding to support the expansion of eligibility.

Representative Nye referred members to Handout # 2 for a more detailed explanation of this recommendation.

Representative Nye moved to approve Recommendation # 8 and the commission approved the motion.

* * * * * * * *

Ms. Shaw said Recommendations 9 through 13 are directions to the Department of Health and Human Services or the Division of Medical Assistance and added that they do not require legislation because the commission is not asking the General Assembly to do anything.

Recommendation # 9: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services consider expanding coverage under the Senior Care Program to disabled persons receiving Medicare if the Senior Care Prescription Drug Program is continued after the Medicare Part D Program begins in 2006.

Dr. Wentzy moved to approve Recommendation # 9 and the commission approved the motion.

Recommendation # 10: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services develop and implement systems to identify Medicaid providers that are charging excessive fees or for excessive numbers of procedures.

Ms. Shaw suggested a word change to the recommendation, which would direct DMA to streamline and to improve the fraud detection program, focusing on improvements to the system.

Representative Barnhart moved to approve Recommendation # 10 as corrected and the commission approved the motion.

Recommendation # 11: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services study the reduction in the availability of obstetricians in rural areas and determine whether the Medicaid Program can provide supplemental payments to obstetricians in rural areas in order to maintain services.

Mr. Welsh said he is in favor of the recommendation and commented on obstetrical services in rural areas and the 3.4% update on the base-blended rate for Medicaid for hospitals. He said there was no update for Medicaid for the past two years, so when the rebasing is applied and it is averaged over three years, the net effect for his facility, Southeastern Regional Hospital, is a .3% increase over a three-year period. He explained that rebasing obstetrical services for Southeastern Regional meant that 50% of the 3.4% was lost. He said HHS's rebasing has hit especially hard on the obstetrical services area

of many hospitals, as it has Southeastern Regional, since a very high percentage of obstetrics patients in some hospitals are on Medicaid.

Mr. Pully said the North Carolina Hospital Association (NCHA) has done a preliminary analysis of the proposed inflation increase for hospitals and is trying to engage the department to look at the underlying policy with regard to adjustments for Diagnosis Related Groups (DRGs). Mr. Fuquay said DMA is willing to discuss this policy with hospitals and the NCHA to try to address concerns.

Mr. Pully suggested drawing this recommendation as broadly as possible because of implications of medical malpractice liability for doctors.

Representative Barnhart said he agreed with Mr. Pully's comments with regard to medical malpractice insurance as it applies to doctors who are willing to deliver babies.

Representative Earle said she would not support getting into discussions about medical malpractice, since the commission has not addressed that issue. She was it was the intent of this recommendation to encourage doctors to go to underserved areas.

Mr. Welsh commented that, by implication, the commission considered the malpractice issue when it discussed providing supplemental payments to obstetricians in rural areas. He said he understood the commission's intent was to help doctors pay for malpractice and professional liability coverage in order to retain their services.

Dr. Silberman suggested rewording the recommendation as follows: The Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services study the reduction in the availability of obstetrical services in underserved areas and determine whether the Medicaid Program can provide supplemental payments to obstetricians, family physicians and hospitals in order to maintain services in underserved areas.

Senator Dannelly moved to approved Recommendation # 11 as corrected and the commission voted approval.

Recommendation # 12: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services not cap enrollment for the NC Health Choice Program.

Representative Nye moved to approve Recommendation # 12 and the commission voted approval.

Recommendation # 13: The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services develop improved systems through the Community Care Program of North Carolina for monitoring the use of the six-prescription drug over ride.

Representative Nye moved to approve Recommendation # 13 and the commission voted approval.

* * * * * * * * *

Finding # 1: The North Carolina Blue Ribbon Commission on Medicaid Reform recognizes that the development of a new Medicaid Management Information system will make it difficult for the Division of Medical Assistance to make new changes to the Medicaid Program.

Finding # 2: The North Carolina Blue Ribbon Commission on Medicaid Reform recognizes that the new federal requirements for the Payment Error Rate Measurement Program may require that the Division of Medical Assistance hire additional staff to support the new federal requirements.

Senator Dannelly moved to approve Finding # 1 and Finding # 2 and the commission voted approval.

Ms. Shaw asked for a motion from the commission to add the resolutions to the findings.

Dr. Silberman moved to add the resolutions to the findings and the commission voted approval.

Ms. Shaw said Mr. Lanier Cansler of the Department of Health and Human Services advised that the funding for adult dental services in 2005-06 is $2.4M and for 2006/07 is $5.5M. She said she would insert these numbers at the appropriate place in Recommendation # 3.

* * * * * * * *

Senator Dannelly moved to approve the Final Report to the 2005 General Assembly of North Carolina as amended and the commission voted approval.

Representative Nye thanked members for participating in the work of the commission. Representative Howard added comments of appreciation. Senator Purcell thanked members for working to accomplish positive change for the Medicaid Program.

The meeting adjourned at 9:50 a.m.

Respectfully submitted,

Anne B. Wilson, Commission Assistant

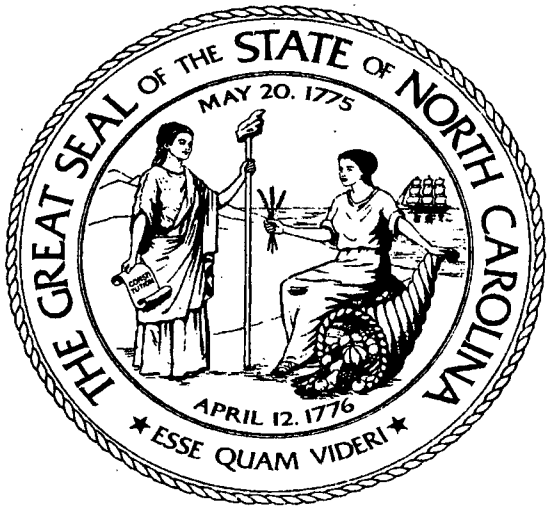
Senator William R. Purcell, Co-chair

Representative Edd Nye, Co-chair
Representative Julia Howard, Co-chair

Handout #1

Draft Report

BLUE RIBBON COMMISSION ON MEDICAID REFORM



FINAL REPORT TO THE 2005 GENERAL ASSEMBLY OF NORTH CAROLINA

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Blue Ribbon Commission On Medicaid Reform

February 1, 2005

To: President of the North Carolina Senate
President Pro Tempore of the North Carolina Senate
Speaker of the North Carolina House of Representatives
Members of the 2005 General Assembly

Attached is the final report from the Blue Ribbon Commission on Medicaid Reform submitted to you pursuant to Section 6.14A(c) of Chapter 284 of the 2003 Session Laws, which states, "By February 1, 2005, the Commission shall make a final report to the 2005 General Assembly."

The Blue Ribbon Commission on Medicaid Reform presents to you final findings and recommendations based on the study conducted following the adjournment of the 2004 Session of the 2003 General Assembly. Proposed legislation is contained within this report.

Respectfully submitted,

Senator William R. Purcell	Representative Edd Nye	Representative Julia Howard
Co-Chair	Co-Chair	Co-Chair

Blue Ribbon Commission on Medicaid Reform

2004-2005 Membership List

President Pro Tempore's Appointments	Speakers' Appointments
Senator William R. Purcell, Co-Chair	Representative Julia Howard, Co-Chair
Senator Charlie Dannelly	Representative Edd Nye, Co-Chair
Senator Fletcher L. Hartsell, Jr.	Representative Jeffrey L. Barnhart
Mr. Daniel C. Hudgins	Representative Beverly Earle
Ms. Pam C. Silberman	Representative Bobby F. England
Mr. Luckey Welsh	Mr. William A. Pully
Dr. Al Wentzy	Dr. Charles F. Wilson

Clerk:
Anne Wilson

Staff:
Carol Shaw
Richard Bostic
Fiscal Research Division
919/733-4910

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December 2004

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PREFACE

As outlined in to Section 6.14A(c) of Chapter 284 of the 2003 Session Laws, the Blue Ribbon Commission on Medicaid Reform shall examine the State's Medicaid program and make comprehensive recommendations for fundamental reform. The Commission shall consider:

1. Methods to responsibly restrain the growth in Medicaid spending.
2. Best practices in both the public and private sectors in managing and administering health care.
3. Options for maximizing existing resources while controlling Medicaid program costs.
4. Current array of services available within the State Medicaid program to determine the appropriateness of the type, frequency, and duration of those services.
5. Opportunities for long-term, systemic change in the Medicaid program through the use of federal waivers and other management tools.
6. How to minimize the State and county share of Medicaid costs and maximize federal participation in Medicaid programs.
7. The role of Medicaid in the State's economy.
8. Any other matter relating to reform of the state Medicaid program.

The Commission consists of 14 members. Of these members, the Speakers of the House of Representatives appoints seven and the President Pro Tempore of the Senate appoints seven.

This final report represents the work performed by the Blue Ribbon Commission on Medicaid Reform from the conclusion of the 2004 Session of the 2003 General Assembly until the convening of the 2005 General Assembly. The Blue Ribbon Commission on Medicaid Reform met on four occasions since it submitted its interim report in April 2004, and the work of the Commission is complete with the submission of its final report.

COMMISSION PROCEEDINGS

October 6, 2004

The Blue Ribbon Commission on Medicaid Reform met at 10:00 a.m. on Wednesday, October 6, 2004 in Room 643, Legislative Office Building. Representative Nye presided.

Representative Nye asked Jim Klingler, Fiscal Research Division, to discuss changes made to the Medicaid program during the 2004 legislative session. (Appendix B) Mr. Klingler said the document summarizes actions of the 2004 Regular Session with regard to state funding for the Medicaid Program.

Representative Nye called on Michael Keough, Department of Health and Human Services, Office of Research, Development and Rural Health, to present the next item on the agenda, "SeniorCare and Federal Discount Card Program". (Appendix C) Mr. Keough said the SeniorCare program has recently undergone dramatic changes as a result of the passage of the Medicare Modernization and Improvement Act in December 2003, which created an opportunity for North Carolina to make some changes in its SeniorCare program. The intent was to take advantage of the Medicare Discount Card transitional assistance for seniors who are at or below 135% of the federal poverty level (FPL) to see if Medicaid SeniorCare members could be enrolled into that program in order to use federal money to pay for their benefits.

Mr. Keough said the federal government provided a free card and a $600 credit at the beginning of the program on June 1, 2004 to any senior who qualified based on income and insurance status. CMS allowed states to automatically enroll seniors who were part of their prescription assistance programs like NC SeniorCare into the federal transitional assistance program of the state's choice. Mr. Keough said DHHS went through a bid process and chose a card called Community Care Rx. He said DHHS wanted to be able to use the federal money to enhance the benefits of SeniorCare for all enrollees, not just people below 135% of poverty. Mr. Keough said about 27,000 members have already enrolled. He added that, after receiving legislative approval, DHHS auto-enrolled eligible seniors and gave them an opportunity to opt-out if they choose, as required by CMS. Thus far, he said, only a handful of seniors have chosen to opt-out. They understand the benefits to them of the combination of the two cards and the enriched benefits it has to offer.

Representative Nye asked Ms. Barbara Brooks to present "Implementing Medicare Part D Prescription Drug Benefit: Impact on NC Medicaid", the next item on the agenda. (Appendix D) She said she would talk about the direct implications of the prescription drug benefit to the Medicaid Program and to recipients.

Ms. Brooks discussed how Medicare Part D affects the Medicaid program. Beginning in January 2006 when Part D is implemented, the Medicaid program will not be able to

receive any federal participation for prescription drugs for Medicare beneficiaries. In North Carolina, a Medicare beneficiary who is fully enrolled in Medicaid receives a blue Medicaid card will get all the benefits that Medicaid offers. Starting in January 2006, dual eligibles will not use a Medicaid card to get prescription drugs, but will instead use a Medicare card or a prescription drug discount card. Medicaid will continue to be the carrier of prescription drugs for everyone in the program who is not a dual eligible.

Ms. Brooks discussed the state phased down contribution (clawback), which means that the states are responsible for funding a portion of the Medicare Part D benefit paid to their dual eligible population. This is the first time states have been asked to directly fund a Medicare benefit. She said the formula for the clawback has established calendar year 2003, as the baseline and states are to establish an average per capita cost for their dual eligibles for that year. Every state will have an individual calculation. The calculation will be based on the number of full-benefit duals (those who receive prescription drugs) and the total amount the state paid for prescription for that population. Roughly half of the state's prescription drug costs go to this group.

Ms. Brooks said implementation/operational issues for the state are still unclear, since final regulations will not be issued until January 2005. She also said it is unclear what will be state agency responsibilities for low-income subsidy applications, which will affect county departments of social services because they take the Medicaid applications. She said the law provides for people to apply with the state or at the Social Security Office. Social Security has offered to process all the applications and the Division of Medical Assistance wants to work with them, so their offices are available for intake, but not for the actual determination. She said those areas are still unclear and they are waiting for the federal government to clarify this responsibility. She said counties are going to feel some programmatic consequences in departments of social services. For example, they may need additional staff because the programs will mean more people will be contacting county departments of social services. Also, she said staff in the counties who work with Medicaid eligibility are going to have a new group to become familiar with and will need additional training in the new regulations.

Representative Nye asked Dr. Henley to review the "Prescription Drug Program for NC Medicaid"(Appendix E). Dr. Henley provided introductory background information on the program and talked about interventions made over several years. Dr. Allen Dobson discussed the prescription advantage list and some interventions made through the Community Care Program

Representative Nye asked Mr. Torlen Wade, Office of Research, Development and Rural Health, to review the next agenda item, "Implementing 340B Pharmacy Program in NC". (Appendix F) Mr. Wade said this is a federal program that provides pharmacy discounts to certain safety-net providers and the main groups as described in the statutes are public hospitals, disproportionate share hospitals (DSH) that have a DSH adjustment rate of 11.75 or greater, community health centers, AIDS Drug Assistance Programs (ADAPs), Family Planning Clinics and AIDS, TB, and STD Clinics. He said the 340B Program in the statutes limits drug assistance to patients of an eligible entity and only applies to

outpatient drugs. The main beneficiaries of the 340B Program are the safety net providers that are eligible, the Medicaid Program and uninsured patients that now have to pay retail price would pay a much lower price through 340B. A statutory requirement is that the Medicaid Program must be billed at the acquisition rate. Mr. Wade reviewed information presented in the handout and said the 340B program has tremendous potential despite its complexity.

Representative Nye called on Dr. Henley to present the final item on the agenda, "Medicaid Durable Medical Equipment and Home Health Supplies". Dr. Henley said the federal view for these types of equipment and supplies is that they are considered a part of the home health services benefit, which is mandatory under federal regulations. Dr. Henley continued review of policy issues and expenditures, noting that the cost of durable medical equipment and home health supplies is approximately 1% of total Medicaid service expenditures. She completed the review of the information contained in the handout by highlighting several considerations for improving the Medicaid Durable Medical Equipment and Home Health Supplies Program:

1. Expand the criteria for post-payment reviews.
2. Expand available codes to reduce the use of the miscellaneous supply code.
3. Require providers of power wheelchairs to meet certification requirements to assure proper selection for specific recipient.
4. Complete the study of the cost of diapers.

November 16, 2004

The Blue Ribbon Commission on Medicaid Reform met at 10:00 a.m. on Tuesday, November 16, 2004 in Room 643, Legislative Office Building. Senator Purcell presided.

Senator Purcell asked Dr. Breeden Blackwell, Cumberland County Commissioner and President of the North Carolina Association of County Commissioners (NCACC), to present the first agenda item, "Medicaid from the County Perspective". (Appendix G) Dr. Blackwell started by noting that this is the first opportunity county commissioners have had to present their concerns with regard to Medicaid reform and expressed their appreciation for the opportunity. He said counties are in a crisis in their efforts to fund the county share of Medicaid and need immediate relief. He said he wants members to understand the county view of Medicaid funding and he provided background information and a historical perspective for the crisis. Dr. Blackwell said the Medicaid funding crisis is not a new problem and that they have been working for solutions for a number of years, culminating in a vote by the entire NCACC membership in the last biennium to have Medicaid relief as its No. 1 legislative goal. The cost of Medicaid growth was of such importance that they spent a year studying its implications for counties and bringing new recommendations to the General Assembly.

Senator Purcell asked Mr. David Young, 3rd Vice President of the NCACC, a Buncombe County Commissioner and member of the NCACC Steering Committee on Human Resources, to present the counties' goals. Mr. Young said Medicaid is an economic

driver in communities and is needed. He said, for example, health care is the No. 1 industry in his county. He said the Steering Committee asked counties to submit a list of goals for FY 2003-04. The first goal was to seek legislation to implement a phase out of county participation in the costs of Medicaid beginning with a cap at current costs in the year 2003. He said they set up guiding principles based on lengthy deliberation and their conclusions were that all counties need help. He said a cap on growth helps everyone, and counties with high Medicaid eligible populations need special attention with state funding of certain services or client groups. He said the NCACC proposal for FY 2005-06 is to cap county Medicaid costs at FY 2004-05 levels beginning FY 2005-06, target additional relief to counties with high Medicaid populations and phase out the county share of Medicaid over some period of time. Mr. Young said the NCACC is open to options and suggestions other than those presented and are basically saying that all counties need help, especially the smaller counties.

The Commission heard testimony from the following counties:

1. Mr. Zee Lamb, Bertie County Manager
2. Ms. Pearl Burris-Floyd, Gaston County Commissioner
3. Mr. Larry Meadows, Jones County Manager
4. Mr. Morris Keever, Chairman of the Alexander County Commission
4. Mr. Noah Woods, a Robeson County Commissioner

Dr. Purcell asked Ms. Carol Shaw, Fiscal Research Division of the North Carolina General Assembly to review "Options for Reducing the County Share of the North Carolina Medicaid Program". (Appendix H) She briefly reviewed the history of counties' cost sharing of human services in North Carolina because it is important to talk about how North Carolina became one of only two states that require such comprehensive county cost sharing on Medicaid. When North Carolina's cost-sharing arrangements are viewed from a historical perspective, it would be seen that they go back to the 1930s when the federal government began to pay for public assistance. At that time, she said, North Carolina was paying 100% of the state's human services costs. When the federal government came in to help states, counties were asked to continue paying a share. Counties paid 50% of the non-federal share. These standards are pretty much still true today, even though AFDC has become TANF through welfare reform.

Ms. Shaw said the story is a little different for Medicaid, which was created in 1965. She said North Carolina did not take this option until 1971. In the 1971 legislative session, Medicaid cost sharing started out at 10% of the non-federal share and later in the session because of long term care, cost increases and the fact that counties still owned a lot of nursing facilities, it was increased to 15% of the non-federal share. It has been at that level since that time. The other interesting aspect of Medicaid county share is that the rate is not in the statutes, but the statutes do establish that there must be a cost-sharing arrangement with federal, state and local resources. She said the actual rate the counties pay is set every year in the budget bill.

Ms. Shaw reviewed "Options for Reducing the County Share of the North Carolina Medicaid Program" (Appendix H).

Senator Purcell asked Mr. Jeffrey Simms, Assistant Director of the Division of Medical Assistance in the Department of Health and Human Services to present the next item on the agenda, "Mercer Evaluation of Community Care of North Carolina". (Appendix I)

Senator Purcell said the Blue Ribbon Commission on Medicaid Reform will end in February 2005 and the commission will meet in December and January, which will allow time to develop proposed recommendations. He suggested that members think about what the commission should do.

December 15, 2004

The Blue Ribbon Commission on Medicaid Reform met at 9:00 a.m. on Wednesday, December 15, 2004 in Room 643, Legislative Office Building. Representative Edd Nye presided.

Representative Nye recognized Ms. Leza Wainwright, Deputy Director of the Division of Mental Health/Developmental Disabilities/Substance Abuse Services for a report on the progress of mental health reform. She said MH/DD/SAS and their colleagues from the Division of Medical Assistance have worked closely over the past 12-to-14 months and they will discuss what mental health reform means to the two programs. Ms. Wainwright presented information on how mental health reform was being implemented in North Carolina. (Appendix J)

Representative Nye recognized Dr. Nancy Henley, Deputy Director for Clinical Affairs in the Division of Medical Assistance, to continue the presentation (Appendix J). She provided background regarding Medicaid as the context for the mental health discussion. She said there are federal requirements for all the services provided under Medicaid, which requires that the program be statewide, that the services available must be comparable across the state, and that recipients must have freedom of choice among all the enrolled qualified providers of those particular services. She said the freedom of choice piece is very important to DMA and to the mental health program. All the services that are paid for by Medicaid must be medically necessary.

Representative Nye recognized Mr. Mark Benton, Deputy Director for Financial/Business Operations for the Division of Medical Assistance, for a review of budget information related to changes required by mental health reform. (Appendix J).

Representative Nye recognized Ms. Lynn Perrin, Chief of the Facility and Community Care Section of the Division of Medical Assistance, for a presentation on the Medicaid In-Home Personal Care Services Program. (Appendix K) She provided on overview of In-home Personal Care services and reviewed what they are doing to restructure the program, noting that it is a work in progress.

Representative Nye recognized Mr. Gary Fuquay, Director of the Division of Medical Assistance (DMA), for a presentation of the division's legislative priorities. (Appendix L)

Representative Nye recognized Ms. Carol Shaw, of the Fiscal Research Division, for a review of additional options for reducing the county share of the N. C. Medicaid Program. (Appendix M)

The commission discussed recommendations for the 2005 General Assembly and directed commission staff to prepare a draft report based on their discussions to be presented at the January 2005 meeting.

January 18, 2005

The Blue Ribbon Commission on Medicaid Reform met on Tuesday January 18, 2005, at 8:30 a.m. in Room 643 of the Legislative Office Building. Members discussed and approved the commission's Final Report to the 2005 North Carolina General Assembly.

COMMISSION RECOMMENDATIONS

The Blue Ribbon Commission on Medicaid Reform makes the recommendations outlined below. Recommendations requiring legislation are followed by background information, and the legislative proposals are located in the Appendices as indicated. Recommendations for the Department of Health and Human Services are also included along with two additional findings by the Blue Ribbon Commission on Medicaid Reform.

Recommendations with Legislation

Recommendation #1

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly reinstate the Long-Term Care Income Tax Credit effective January 1, 2005. In order to reduce the error rate, the Commission also recommends that the Department of Revenue can require that taxpayers claiming the credit must list the insurance company and policy number of the long-term care insurance policy.

Background

North Carolina G.S. 105-151.28 contains the tax credit for long-term care insurance that became effective for tax years beginning on or after January 1, 1999, and expiring for tax years beginning on or after January 1, 2004. According to the Department of Revenue, "the credit is allowed for premiums paid on qualifying long-term care insurance contracts that provide insurance coverage for a taxpayer or a taxpayer's spouse or dependent. The credit is 15% of the premiums paid, not to exceed $350 for each qualified long-term care insurance contract for which a credit is claimed. A long-term care insurance contract is defined in section 7702B of the Internal Revenue Code as any insurance contract under which the only insurance protection provided is for coverage of qualified long-term care services. Qualified long-term care services are those services required by a chronically ill individual and provided under a plan of care prescribed by a licensed health care practitioner."

The Department of Revenue has encountered serious taxpayer problems with the long-term care insurance tax credit. Audited tax returns in 2001 showed a 91% error rate for credit. The most common taxpayer error were 1) claiming the credit for regular insurance premiums, 2) claiming the total amount of premiums paid as a credit instead of the $350 limit, and 3) claiming the credit and also claiming the long-term care premium as a medical expense.

The Department of Revenue reports a 40% error rate in audited returns in tax year 2003. The Department of Revenue's Personal Taxes Division credits the reduction in long-term credit errors to the following factors:

1. Tax preparers making errors were contacted.
2. Instructions in the D-400 tax return booklet were improved.
3. Verbiage in the software developers' tax packages was improved.
4. Taxpayers whose credit was disallowed did not make the same mistake.

The high error rate is surprising given that the instructions in Form D-400 TC state "A tax credit is allowed for the qualifying premiums you paid during the taxable year on a qualified long term care insurance contract(s)... **Medical insurance premiums that you pay for general health care, hospitalization, or disability insurance do not qualify as premiums paid for a long term care insurance contract."** The tax form tells you to read the instructions and complete the worksheet to determine the amount of credit owed.

Continuing the credit will require the removal of the credit sunset and an adjustment in future General Fund budgets for an annual revenue loss of approximately $6 million. More importantly, continuing the credit will require the reduction of taxpayer error and fraud. North Carolina can follow the practice of Minnesota and require the taxpayer to list the insurance company and policy number of the long-term care policy for which a tax credit is claimed. The Department of Revenue can work with the Department of Insurance to get the list of companies providing long-term care policies in the state and a computer listing of policy holders to match against the tax credit claims.

The proposed legislation is located in Appendix N.

Recommendation #2

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly continue the statewide expansion of the Community Care of North Carolina Program, and appropriate $2 million to support the continued expansion.

Background

On March 24, 2004, the Commission heard a presentation from Dr. L. Allen Dobson, Jr. that discussed the benefits of the Community Care of North Carolina Program. The Community Care of North Carolina Program is the primary care case management system used by the Division of Medical Assistance to improve the care of the Medicaid population while controlling costs. The program has the following goals:

- Making sure people get care when they need it
- Increasing local provider collaboration
- Obtaining quality care
- Implementing best practice guidelines
- Managing Medicaid costs

Dr. Dobson discussed the disease management initiatives implemented by Community Care of North Carolina including managing diabetes and asthma. The Program has also

has been managing Medicaid costs by targeting high cost services including prescription drugs, emergency department usage, and in-home care.

On November 16, 2004, the Commission heard from Jeffrey Simms, Assistant Director with the Division of Medical Assistance, who presented the most current Mercer Evaluation of the Community Care of North Carolina Program. The Mercer Evaluation showed that the program was more cost effective when compared to fee-for-service Medicaid.

On December 15, 2004, the Commission heard from Gary Fuquay, director of the Division of Medical Assistance. He said, "We seek your support to continue to expand this effort as we move toward statewide implementation of working with local primary care providers to develop and implement quality improvements and cost containment strategies for Medicaid health delivery system."

The proposed legislation is located in Appendix O.

Recommendation #3

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly provide funding to support increased rates for dental services provided for adults.

Background

On December 15, 2004, Gary Fuquay, director of the Division of Medical Assistance, presented the Department of Health and Human Services priorities for Medicaid In his presentation he said the following, "We increased the Dental rates for approximately 30 to 40 procedure codes mostly to improve access to dental services for children under age 21. This action has been successful in assisting to enroll new providers to care for the dental care for children. Most dental rates for adults have not been increased since January 2001. Since this time, the cost of delivery of dental services has risen by approximately 20%. We believe it is important to increase these rates to raise them to a reasonable level and make them competitive, eliminating the excessive variability in the reimbursement procedures and to ensure we maintain and increase provider participation of dental providers and recipient access to care for adults."

The proposed legislation is located in Appendix P.

Recommendation #4

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly reduce the county share of the North Carolina Medicaid Program:

a. Cap the county share for all 100 counties at the FY 2004-05 level.

b. **Phase-out the county share of Medicaid for all 100 counties over six years beginning in FY 2005-06 by reducing the county share by 2.5% each year until the county share reaches 0% in FY 2010-2011.**
c. **Further reduce the county share of Medicaid for counties where the number of Medicaid eligibles is 25%+ of the county's population by reducing the county share to two-thirds of the phase-out amount.**

Background

On November 16, 2004, the Commission invited the North Carolina Association of County Commissioners (NCACC) to present information on the impact of Medicaid cost sharing on the counties. The Commission heard from Dr. Breeden Blackwell, Cumberland County Commissioner and President of the NCACC; Mr. David Young, 3rd Vice President of the NCACC, a Buncombe County Commissioner and member of the NCACC Steering Committee on Human Resources; Mr. Zee Lamb, Bertie County Manager; Ms. Pearl Burris-Floyd, Gaston County Commissioner; Mr. Larry Meadows, Jones County Manager; Mr. Morris Keever, Chairman of the Alexander County Commission; and Mr. Noah Woods, a Robeson County Commissioner.

The presentations from the counties emphasized that the State and not the federal government requires counties to pay a share of all Medicaid expenditures. Dr. Blackwell said, "Counties are in a crisis in their efforts to fund the county share of Medicaid and need immediate relief", and "Counties have no voice in deciding what services are provided, or how much providers are paid, in addition to having no voice in deciding who is eligible." The counties also noted that the Medicaid funding crisis was not a new problem. They have been working for solutions for a number of years, culminating in a vote by the entire NCACC membership in the last biennium to have Medicaid relief as its No. 1 legislative goal. The cost of Medicaid growth was of such importance that the North Carolina Association for County Commissioners spent a year studying its implications for counties and bringing new recommendations to the General Assembly. The NCACC proposal for FY 2005-06 is to cap county Medicaid costs at FY 2004-05 levels beginning FY 2005-06, target additional relief to counties with high Medicaid populations, and phase out the county share of Medicaid over some period of time.

The proposed legislation is located in Appendix Q.

Recommendation #5

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly enact legislation to move children birth through age five with family incomes equal to or less than 200% of the Federal Poverty Guidelines into the Medicaid program. Counties should be held harmless for the costs of moving children into the Medicaid program.

Background

In February 2003, the North Carolina Institute of Medicine Task Force on the NC Health Choice Program recommended that the General Assembly enact legislation to move the approximately 20,000 NC Health Choice children from birth through age five with family incomes equal to or less than 200% of the Federal Poverty Guidelines into the Medicaid program. The Task Force also recommended that counties be held harmless for the costs of NC Health Choice children who are moved into the Medicaid program, so they would not be required to pay the additional Medicaid costs for covering these children. Older children, six through 18, would remain in the NC Health Choice program administered by the State Employees' Health Plan under this proposal.

This Task Force recommendation was intended to enhance the care of the younger children now covered by NC Health Choice at a lower cost than currently incurred. The savings resulting from lower cost per child could be used to cover additional children through the NC Health Choice Program

The state can move NC Health Choice children into the Medicaid program at a lower cost per child, and still use the enhanced SCHIP federal match rate. The federal State Children's Health Insurance law allows states to use the enhanced federal match rate to expand Medicaid as one of the SCHIP program options. States are also allowed to create combination SCHIP programs. With this change, North Carolina would join other states that have a combination SCHIP program.

The 2003 and 2004 Session of the General Assembly did not enact this proposal. The proposed legislation is located in Appendix R.

Recommendation #6

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly require the Division of Medical Assistance to develop a case management program for large users of prescription drugs. DMA shall report on the methodology no later than Jan. 1, 2006, to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Background

Two members of the Commission, Representatives Edd Nye and Bobby England attended a National Conference of State Legislature's meeting in early December that discussed Medicaid and mental health issues. At this meeting, Dr. Marshall R. Thomas, Vice-President Medical Services and Medical Director for Colorado *Access*, presented information about their case management program that targeted mentally ill Medicaid recipients that were large users of prescription drugs for their mental illnesses and other health issues. By completing a comprehensive review of each Medicaid recipient

medications, Colorado Access was able to eliminate duplicative and medically unnecessary prescription drugs, and save money for the Colorado Medicaid Program.

The proposed legislation is located in Appendix S.

Recommendation #7

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly direct the Division of Medical Assistance (DMA) to develop a methodology for reinvesting savings from the Community Care of North Carolina Program back into the community. DMA shall report on the methodology no later than Jan. 1, 2006, to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Background

During the December 15, 2004 meeting, Ms. Pam Silberman, a member of the Commission said the North Carolina Institute of Medicine has been looking at the safety net that is available to serve the uninsured in North Carolina. The Institute of Medicine is considering whether savings from Community Care of North Carolina can be used in the community to help expand care of the uninsured. Ms. Silberman suggested that getting providers involved in Community Care of North Carolina would be easier that some of the savings would stay in the community to help cover other people who do not have insurance coverage.

The proposed legislation is located in Appendix T.

Recommendations for the Department of Health and Human Services

→ insert

Recommendation #8 9

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services consider expanding coverage under the Senior Care Program to disabled persons receiving Medicare if the Senior Care Prescription Drug Program is continued after the Medicare Part D Program begins in 2006.

Recommendation #9 10

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services develop and implement systems to identify Medicaid providers that that are charging excessive fees or excessive numbers of procedures.

Recommendation #10

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services study the reduction in the availability of obstetricians in rural areas and determine whether the Medicaid Program can provide supplemental payments to rural obstetricians in rural areas in order to maintain services.

Recommendation #11

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services not cap enrollment for the NC Health Choice Program.

Recommendation #12

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the Department of Health and Human Services develop improved systems through the Community Care Program of North Carolina for monitoring the use of the six-prescription drug over ride.

Other Commission Findings

Finding #1

The North Carolina Blue Ribbon Commission on Medicaid Reform recognizes that the development of a new Medicaid Management Information system will make it difficult for the Division of Medical Assistance to make new changes to the Medicaid Program.

Finding #2

The North Carolina Blue Ribbon Commission on Medicaid Reform recognizes that the new federal requirements for the Payment Error Rate Measurement Program may require that the Division of Medical Assistance hire additional staff to support the new federal requirements.

APPENDIX A

Legislative Authority
for the
Blue Ribbon Commission on Medicaid Reform

BLUE RIBBON COMMISSION ON MEDICAID REFORM

SECTION 6.14A (a) There is established the North Carolina Blue Ribbon Commission on Medicaid Reform (Commission). The Commission shall examine the State's Medicaid program and make comprehensive recommendations for fundamental reform. The Commission shall consider:

(1) Methods to responsibly restrain the growth in Medicaid spending.
(2) Best practices in both the public and private sectors in managing and administering health care.
(3) Options for maximizing existing resources while controlling Medicaid program costs.
(4) Current array of services available within the State Medicaid program to determine the appropriateness of the type, frequency, and duration of those services.
(5) Opportunities for long-term, systemic change in the Medicaid program through the use of federal waivers and other management tools.
(6) How to minimize the State and county share of Medicaid costs and maximize federal participation in Medicaid programs.
(7) The role of Medicaid in the State's economy.
(8) Any other matter relating to reform of the State Medicaid program.

SECTION 6.14A (b) The Commission shall consist of 16 members appointed as follows:

(1) Eight members appointed by the Speaker of the House of Representatives, including one member who shall be designated as House Cochair. No more than three may be legislators.
(2) Eight members appointed by the President Pro Tempore of the Senate, Including one member who shall be designated as Senate Cochair. No more than three may be legislators.

The appointing officer shall fill vacancies. The Commission shall meet at the call of the Cochairs. Members of the Commission shall receive per diem, subsistence, and travel expenses as provided in G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Commission may contract for consultant services as provided in G.S. 120-32.02. Upon approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Commission in its work. Clerical staff shall be furnished to the Commission through the offices of the House of Representatives and Senate

Directors of Legislative Assistants. The Commission may meet in the Legislative Building or the Legislative Office Building. The Commission may exercise all of the powers provided under G.S. 120-19 through G.S. 120-19.4 while in the discharge of its official duties. The funds appropriated by this act to

the Reserve for the Blue Ribbon Commission on Medicaid Reform shall be transferred to the Department of Health and Human Services in order to draw down federal match funds to be used to cover the cost of the Commission's work.

SECTION 6.14A.(c) By April 1, 2004, the Commission shall make an interim report to the 2003 General Assembly. The Commission shall make its final report to the 2005 General Assembly by February 1, 2005, and shall expire upon submitting that report.

APPENDIX N

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

U D

BILL DRAFT 2005-LYz-42 [v.3] (1/12)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/13/2005 11:50:32 AM

Short Title: Long-Term Care Insurance Tax Credit.	(Public)
Sponsors: .	
Referred to:	

A BILL TO BE ENTITLED

AN ACT TO REENACT THE PERSONAL INCOME TAX CREDIT FOR PREMIUMS PAID ON LONG-TERM CARE INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 105-151.28 is reenacted.

SECTION 2. This act is effective for taxable years beginning on or after January 1, 2005.

APPENDIX O

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H/S D

BILL DRAFT 2005-LNz-20* [v.2] (1/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/11/2005 5:02:18 PM

Short Title:	Funds to Expand Community Care Program.	(Public)
Sponsors:	Representative Nye./Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO CONTINUE STATEWIDE EXPANSION OF THE COMMUNITY CARE OF NORTH CAROLINA PROGRAM, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of two million dollars ($2,000,000) for the 2004-2005 fiscal year and the sum of two million dollars ($2,000,000) for the 2005-2006 fiscal year. These funds shall be used to continue the statewide expansion of the Community Care of North Carolina Program.

SECTION 2. This act becomes effective July 1, 2005.

APPENDIX P

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S/H D

BILL DRAFT 2005-LNz-23* [v.2] (1/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/11/2005 5:26:39 PM

Short Title:	Funds for Increasing Medicaid Dental Rates.	(Public)
Sponsors:	Senator Purcell./Representative Nye.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO INCREASE DENTAL RATES FOR MEDICAID-ELIGIBLE ADULTS, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of $ for the 2005-2006 fiscal year and the sum of $ for the 2006-2007 fiscal year. These funds shall be used to increase dental rates for dental services provided to Medicaid-eligible adults.

SECTION 2. This act becomes effective July 1, 2005.

APPENDIX Q

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H/S D

BILL DRAFT 2005-LNz-9* [v.8] (12/21)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/11/2005 5:29:40 PM

Short Title:	Medicaid Study/County Phase-Out.	(Public)
Sponsors:	Representative Nye./Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO PHASE-OUT THE COUNTY SHARE OF THE NONFEDERAL SHARE OF MEDICAID COSTS OVER A SIX-YEAR PERIOD, TO PROVIDE THAT THE TOTAL COUNTY SHARE DURING THE PHASE-OUT PERIOD SHALL NOT EXCEED THE COUNTY SHARE PAID BY EACH COUNTY FOR THE 2004-2005 FISCAL YEAR, AND TO FURTHER PROVIDE THAT IN CERTAIN COUNTIES THE COUNTY SHARE SHALL BE FURTHER REDUCED BASED ON THE NUMBER OF MEDICAID ELIGIBLE INDIVIDUALS IN THE COUNTY, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Notwithstanding any other provision of law to the contrary, and except as otherwise provided in subsection (b) of this section, the county portion of the nonfederal share of Medical Assistance Program costs, excluding administrative costs, is reduced by two and one-half percent (2.5%) each fiscal year beginning July 1, 2005, until the county portion of the nonfederal share, excluding administrative costs, equals zero percent (0%). If the reduction in percentage of the county share for each fiscal year under this section results in a higher county share amount than the county share amount paid for the 2004-2005 fiscal year, then the county share for the fiscal year shall be the reduced share or the amount of the county share paid in the 2004-2005 fiscal year, excluding administrative costs, whichever is less. Effective July 1, 2010, the nonfederal share of Medical Assistance Program costs, excluding administrative costs, shall be borne by the State.

SECTION 1.(b) In counties where the number of Medicaid-eligible individuals in a given fiscal year exceeds twenty-five percent (25%) of the county population in that fiscal year, the county's share shall be two-thirds of the reduced share

for each year or the county share paid for the 2004-2005 fiscal year, excluding administrative costs, whichever is less.

SECTION 2. Effective July 1, 2010, G.S. 108A-54 reads as rewritten:

"**§ 108A-54. Authorization of Medical Assistance Program.**

The Department is authorized and empowered to establish a Medical Assistance Program from ~~federal, State and county~~ federal and State appropriations and to adopt rules ~~and regulations~~ under which payments are to be made in accordance with the provisions of this Part. ~~The nonfederal share may be divided between the State and the counties, in a manner consistent with the provisions of the federal Social Security Act, except that the share required from the counties may not exceed the share required from the state. If a portion of the nonfederal share is required from the counties, the boards of county commissioners of the several counties shall levy, impose and collect the taxes required for the special purpose of medical assistance as provided in this Part, in an amount sufficient to cover each county's share of such assistance.~~"

SECTION 3. This act becomes effective July 1, 2005.

.

APPENDIX R

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H/S D

BILL DRAFT 2005-LNz-24* [v.6] (1/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/12/2005 1:26:30 PM

Short Title:	Expand Medicaid Eligibility to Children/200%.	(Public)
Sponsors:	Representative Nye/Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO EXPAND MEDICAID COVERAGE TO CHILDREN AGE BIRTH THROUGH FIVE YEARS WITH FAMILY INCOMES EQUAL TO OR LESS THAN TWO HUNDRED PERCENT OF THE FEDERAL POVERTY LEVEL, AND TO USE NC HEALTH CHOICE STATE AND FEDERAL FUNDS TO FUND THE EXPANSION, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services shall provide coverage under the State Medical Assistance Program to:

(1) Infants under the age of one year whose family income is above one hundred eighty-five percent (185%) through two hundred percent (200%) of the federal poverty level; and

(2) Children age one year through five years whose family income is above one hundred thirty-three percent (133%) through two hundred percent (200%) of the federal poverty level.

Coverage under this section for infants and children age birth to five years shall be paid for from federal funds received under Title XXI of the Social Security Act, and State matching funds, to implement NC Health Choice under Article 8 of Chapter 108A of the General Statutes."

SECTION 2.(a) G.S. 108A-70.21(a)(1) reads as rewritten:

"**§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.**

(a) Eligibility. – The Department may enroll eligible children based on availability of funds. Following are eligibility and other requirements for participation in the Program:

(1) Children must:
a. Be under the age of 19;
b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
c. Be uninsured;
d. ~~Be in a family that meets the following family income requirements:~~ Be age six years through eighteen years and be in a family whose family income is above one hundred percent (100%) through two hundred percent (200%) of the federal poverty level;
~~1. Infants under the age of one year whose family income is from one hundred eighty-five percent (185%) through two hundred percent (200%) of the federal poverty level;~~
~~2. Children age one year through five years whose family income is above one hundred thirty-three percent (133%) through two hundred percent (200%) of the federal poverty level; and~~
~~3. Children age six years through eighteen years whose family income is above one hundred percent (100%) through two hundred percent (200%) of the federal poverty level;~~
e. Be a resident of this State and eligible under federal law; and
f. Have paid the Program enrollment fee required under this Part.
..."

SECTION 2.(b) G.S. 108A-70.21(b) reads as rewritten:

"(b) Benefits. – Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost-sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan, including optional prepaid plans. Prescription drug providers shall accept as payment in full, for outpatient prescriptions filled, ninety percent (90%) of the average wholesale price for the prescription drug or the amounts published by the Centers for Medicare and Medicaid Services plus a dispensing fee of five dollars and sixty cents ($5.60) per prescription for generic drugs and four dollars ($4.00) per prescription for brand name drugs. All other health care providers providing services to Program enrollees shall accept as payment in full for services rendered the maximum allowable charges under the North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan for services less any copayments assessed to enrollees under this Part. No child enrolled in the Plan's self-insured indemnity program shall be required by the Plan to change health care providers as a result of being enrolled in the Program.

In addition to the benefits provided under the Plan, the following services and supplies are covered under the Health Insurance Program for Children established under this Part:

(1) Dental: Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X-rays once every 60 months, supplemental bitewing X-rays showing the back of the teeth once during a 12-month period, fluoride applications twice during a 12-month period, fluoride varnish, sealants, simple extractions, therapeutic pulpotomies, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth. No benefits are to be provided for services under this subsection that are not performed by or upon the direction of a dentist, doctor, or other professional provider approved by the Plan nor for services and materials that do not meet the standards accepted by the American Dental Association.

(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. Optical services, supplies, and solutions must be obtained from licensed or certified ophthalmologists, optometrists, or optical dispensing laboratories. Eyeglass lenses are limited to single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to those made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require prior approval of the Plan. Upon prior approval by the Plan, refractions may be covered more often than once every 12 months.

(3) Hearing: Auditory diagnostic testing services and hearing aids and accessories when provided by a licensed or certified audiologist, otolaryngologist, or other hearing aid specialist approved by the Plan. Prior approval of the Plan is required for hearing aids, accessories, earmolds, repairs, loaners, and rental aids.

~~The Department may provide services to children aged birth through five years enrolled in the Program through the State Medical Assistance managed care program. Services provided through the managed care program shall be paid from Program funds.~~"

SECTION 3. This act becomes effective July 1, 2005.

APPENDIX S

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

S/H D

BILL DRAFT 2005-LNz-21* [v.1] (1/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/11/2005 5:07:51 PM

Short Title:	Reinvestment of Savings Realized/Comm. Care.	(Public)
Sponsors:	Senator Purcell./Representative Nye.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO DEVELOP A METHODOLOGY FOR REINVESTING IN THE COMMUNITY SAVINGS REALIZED FORM THE COMMUNITY CARE OF NORTH CAROLINA PROGRAM, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall develop and implement a methodology for reinvesting savings realized from the Community Care of North Carolina Program back into the community. The Department of Health and Human Services shall report on the methodology not later than January 1, 2006 to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

SECTION 2. This act becomes effective July 1, 2005.

APPENDIX T

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2005

H/S D

BILL DRAFT 2005-LNz-22* [v.2] (1/11)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
1/11/2005 5:25:10 PM

Short Title:	Medicaid Case Management/Prescription Drugs.	(Public)
Sponsors:	Representative Nye./Senator Purcell.	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, TO DEVELOP A CASE MANAGEMENT PROGRAM FOR RECIPIENTS HAVING A LARGE NUMBER OF PRESCRIPTIONS, AS RECOMMENDED BY THE BLUE RIBBON COMMISSION ON MEDICAID REFORM.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall develop a case management program to provide case management services to Medicaid recipients that have a large number of prescriptions. The Department of Health and Human Services shall report on the development of the program not later than January 1, 2006, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 2. This act becomes effective July 1, 2005.

Handout # 2

Proposed Recommendation
for the
Blue Ribbon Commission on Medicaid Reform

Recommendation

The North Carolina Blue Ribbon Commission on Medicaid Reform recommends that the General Assembly expand Medicaid eligibility under the Ticket to Work and Work Incentives Improvement Act of 1999 to

- **Persons who are age 16 through 64 who are disabled but who are working**
- **Persons who have received Medicaid in the first group, who lose eligibility for that group due to medical improvement, but who retain a severe impairment.**

The Commission also recommends that the General Assembly appropriate funding to support the expansion of eligibility.

Background

Under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), states have the option to expand Medicaid coverage to:

- Persons who are age 16 through 64 who are disabled but who are working and
- Persons who received Medicaid in the first group, who lose eligibility for that group due to medical improvement, but who retain a severe impairment.

The state has the option to set any income or resource limit that it chooses. The state also may require the person to pay a fee or premium based on his income to enroll and remain in the covered (Medicaid Buy-In).

Adoption of these coverage groups provides an incentive to persons with disabilities to work without fearing termination of their Medicaid benefits.

There are many disabled persons who, with proper medication and therapy can improve and be able to go to work. However, because of their improvement they cease to be disabled. They then lose eligibility for Medicaid, can no longer pay for the medications and therapies, and their disabilities reappear. The second coverage group of medically improved persons can help these persons maintain their ability to work by assuring that they can purchase their necessary medication and therapy. For example, a

person with a disabling mental disorder may, with proper medication, improve to the point that he can work and is no longer disabled. Without this coverage group he will likely lose his Medicaid coverage and the ability to pay for the medication that he needs. With this coverage he could continue to purchase this treatment and continue to be able to work.

An advisory council, lead by the Division of Vocational Rehabilitation, consisting of representatives from other Department of Health and Human Services' divisions, advocates, and consumers has been studying implementation of a Medicaid Buy-In program, and this group has developed a draft plan.

Based on the experience of the 29 states that have implemented the Ticket to Work program, the initial cost of the program for North Carolina is estimated to cost $1.2 million. After several years of implementation, the program may cost $45 million in health care expenditures for recipients. The actual cost will depend on the participation rate by adults with disabilities.

DRAFT

A Medicaid Buy-In for North Carolina Working Adults with Disabilities
A Plan developed by the Medicaid Buy-In Work Group
North Carolina State Medicaid Infrastructure Grant
Kathleen Thomas, Ph.D., Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, 1-4-05

What is the goal?
To remove the loss of Medicaid as a disincentive to work for adults with disabilities.

What is the buy-in?
North Carolina's Department of Health and Human Services, Division of Vocational Rehabilitation Services, in partnership with the Division of Medical Assistance (DMA), has received a Medicaid Infrastructure Grant from the Centers for Medicare and Medicaid Studies to develop a buy-in. The buy-in is an optional Medicaid program that allows working adults with disabilities to pay a fee to retain Medicaid even if they work enough so that they would otherwise lose their Medicaid coverage.

Who does it affect?
The buy-in is most important for Social Security Disability Insurance (SSDI) recipients currently on Medicaid because they have experience working and as soon as their combined benefits and earnings go above poverty, they are no longer eligible for Medicaid.

What would the buy-in cost?
Most of the 29 states currently providing a Medicaid buy-in have experienced very low participation rates, especially at the beginning. Taking this gradual enrollment into account, the initial cost of the buy-in is estimated at $1.2 million. Based on other states experiences after several years of implementation, the buy-in may cost $45 million in health care expenditures for recipients.

What are potential problems?
This is not the best of times for North Carolina to commit to increased Medicaid expenditures. Although most other states have experienced low participation, setting up a buy-in program commits the state to extending Medicaid coverage to all eligible working adults with disabilities. Full participation could raise the price tag significantly.

What are the benefits?
There are nearly a quarter of a million SSDI beneficiaries in North Carolina. Loss of Medicaid is an important disincentive to work for them. A buy-in program would allow every adult with a disability to work to his or her full potential, with all the accompanying personal and state economic benefits.

How would the buy-in work?
Eligibility based on Disability
1. Basic Group: Adults with disabilities according to the Social Security Administration (SSA) standard disability determination

2. Medically Improved Group: Adults with medically improved disabilities who would otherwise lose Medicaid eligibility because they no longer meet the SSA disability definition. In order to qualify as 'medically improved,' an individual must
    - first be in receipt of coverage through the Basic Group, and
    - *lose* eligibility for that group as a direct and specific result of medical improvement, and
    - a new disability determination must indicate that the individual is no longer disabled but retains a severe medically determined impairment.

Financial Eligibility

1. Minimum earnings:
    - Basic coverage group: $65 per month
    - Medically improved coverage group: ¼ of Substantial Gainful Activity (SGA)
    - A recipient must be engaged in a work activity for which
        1. financial compensation is received, and
        2. all applicable state and federal income and payroll taxes are paid
    - The Department of Social Services (DSS) will conduct reviews quarterly, thereby allowing a 3-month grace period
2. Resource limit of $19,020
   This is the January, 2005 DMA spousal resource limit for recipients in long term care.
3. Spousal income counted according to Supplemental Security Income (SSI) methods
4. Income limits:
    1. Maximum unearned income of $1,276 = 100% FPG + $500 or 164% Federal Poverty Guidelines (FPG)
    2. No limit on earned income

Co-Payment Structure

1. Annual enrollment fee of $50, for those at 150% FPG or above
   Fees go to counties to offset administrative costs as in NC Health Choice.
2. Annual fee set at 5% of total income in place of a cost-based premium, for those at 200% FPG or above. For individuals at higher levels of income the fee will move to a cost-based premium:
    1. For individuals with income 250-450% FPG, the premium will be the maximum allowed: 100% of the cost of the premium or 7.5% of the individual's income, whichever is lower
    2. For individuals with income between 450% FPG ($41,895 in 2004) and $75,000 (indexed), the premium will be the maximum allowed: 100% of the cost of the premium
    3. For individuals with income at $75,000 or above, the state must charge 100% of the cost of the premium, and will not subsidize the premium charge
3. Co-payments on charges:
   These are based on fees in NC Health Choice.
    - $5 per visit (except preventive visits)
    - $6 per prescription
    - $20 for unnecessary use of the emergency room