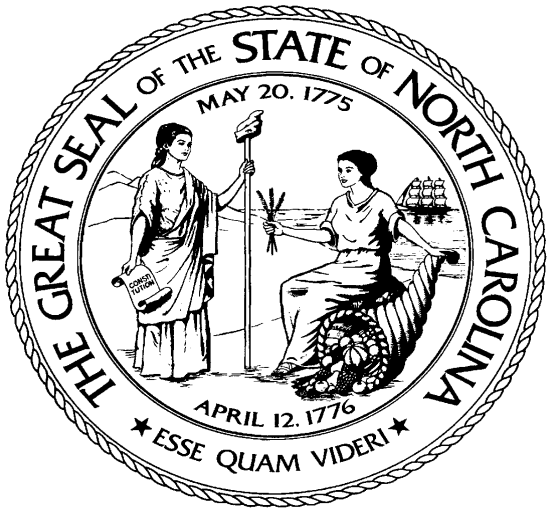
BLUE RIBBON COMMISSION
ON
MEDICAID REFORM



INTERIM REPORT
TO THE 2004 SESSION OF THE
2003 GENERAL ASSEMBLY OF
NORTH CAROLINA

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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
Co-Chair

Representative Edd Nye
Co-Chair

Representative Julia Howard
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.

APPENDICES

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

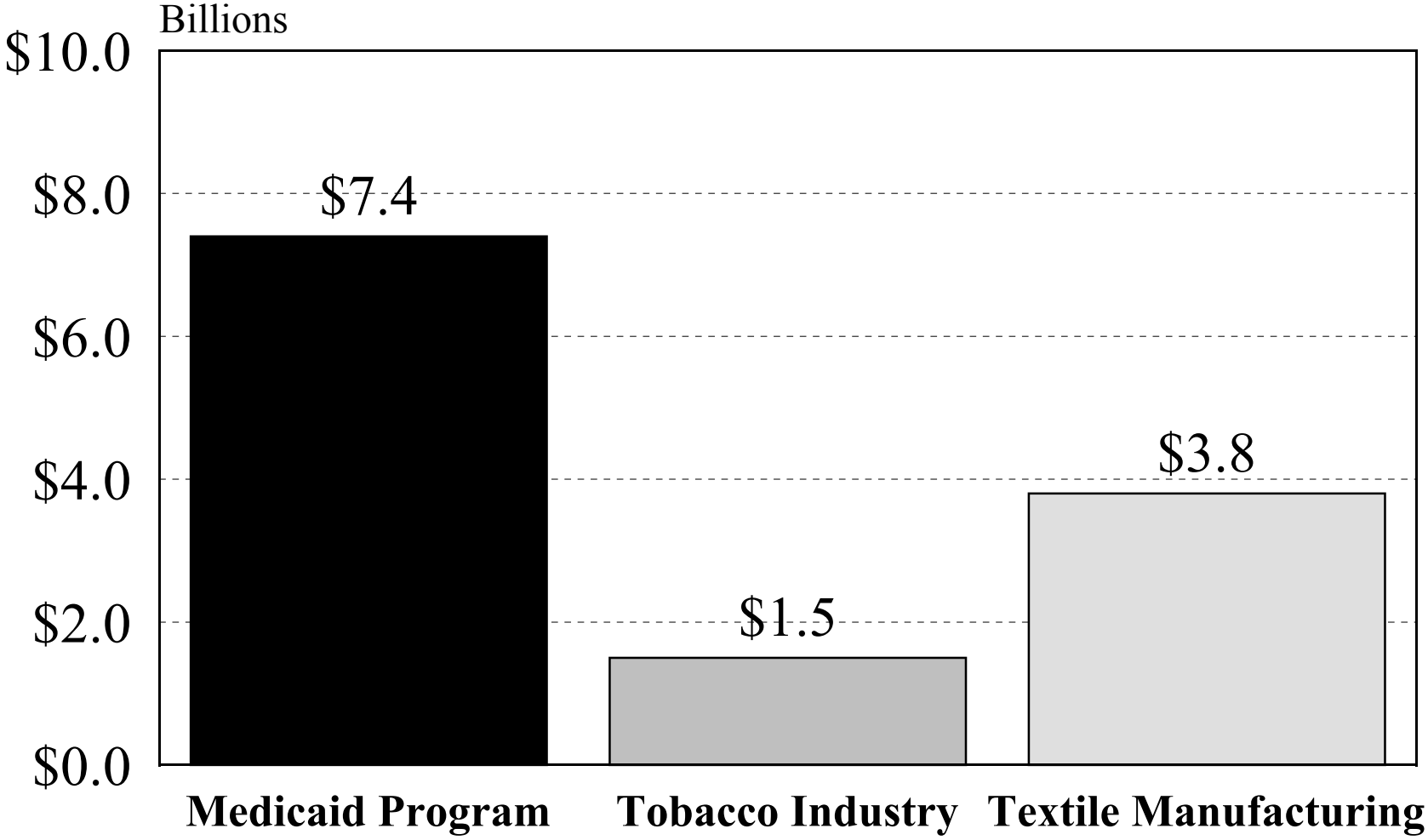
- **All eligible persons who apply for Medicaid must be served.**
- **The medical bills for Medicaid eligibles must be paid.**
- **If the appropriations for the Medicaid Program are inadequate, eligible persons must be served even if the funding must come from other areas of State government.**

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.

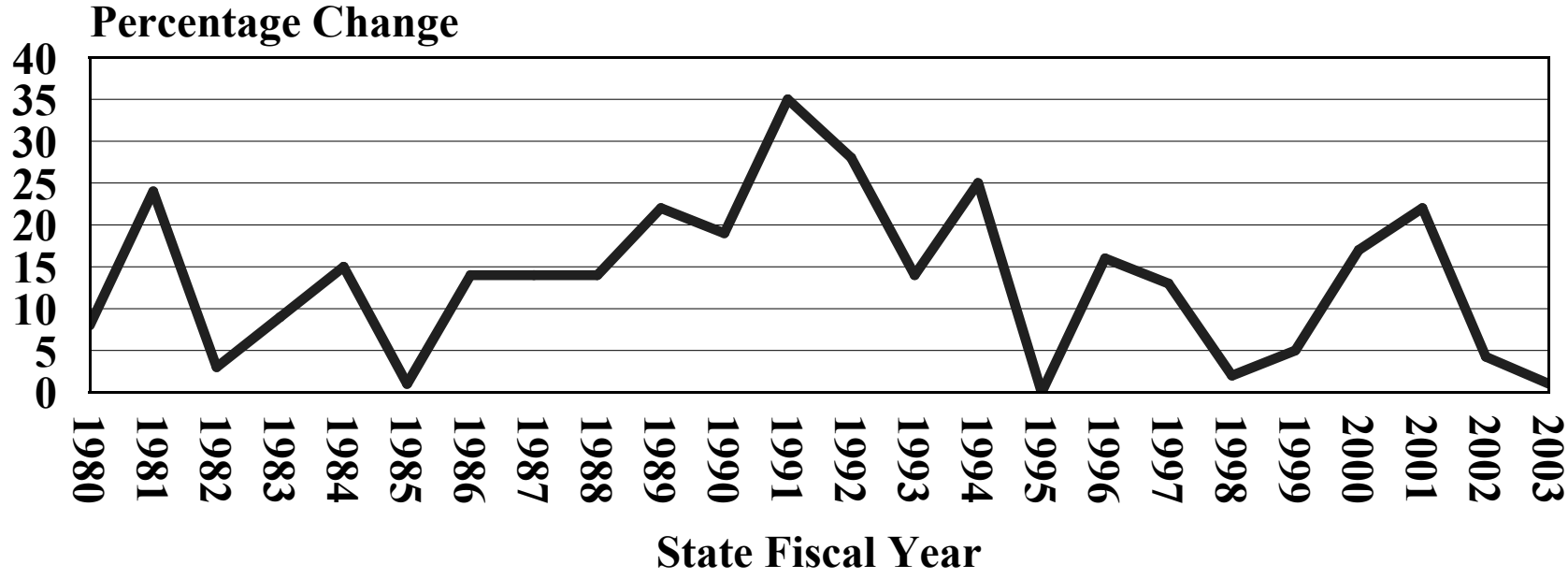
Medicaid Program

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%.

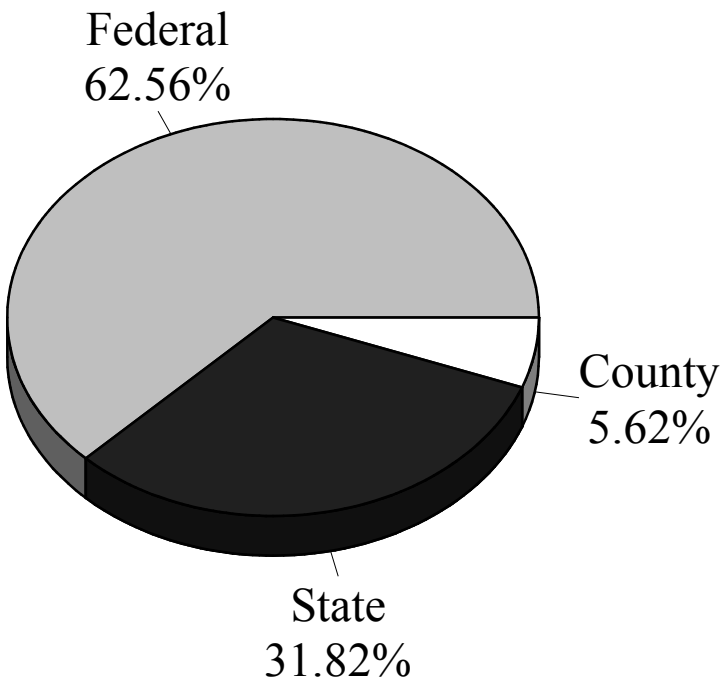
- Higher rates of growth have occurred during years of economic distress or when major Medicaid expansions have been authorized.

- 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

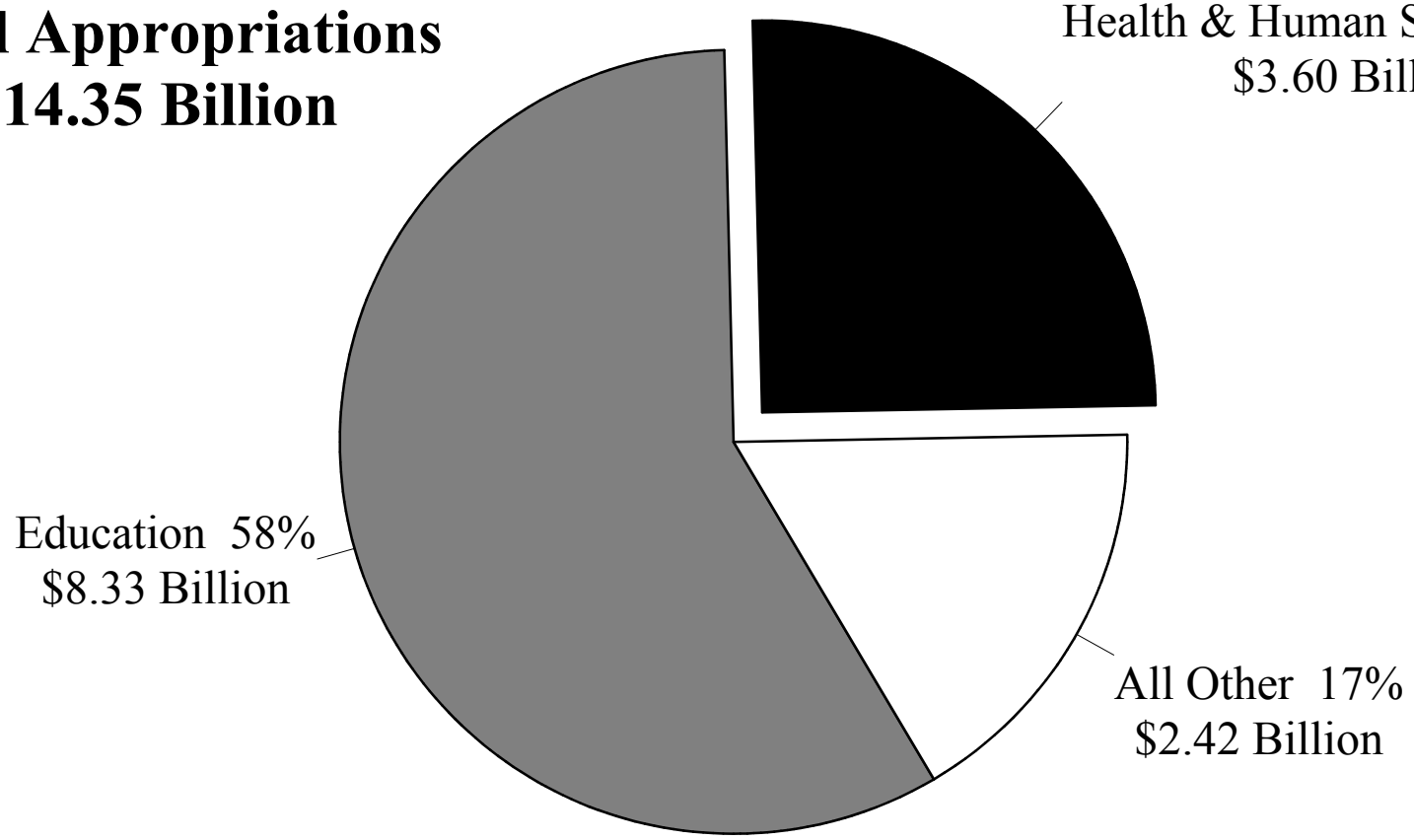
Federal	50%
NonFederal	50%

Medicaid Program

HHS SHARE OF GENERAL FUND APPROPRIATIONS

SFY 2003

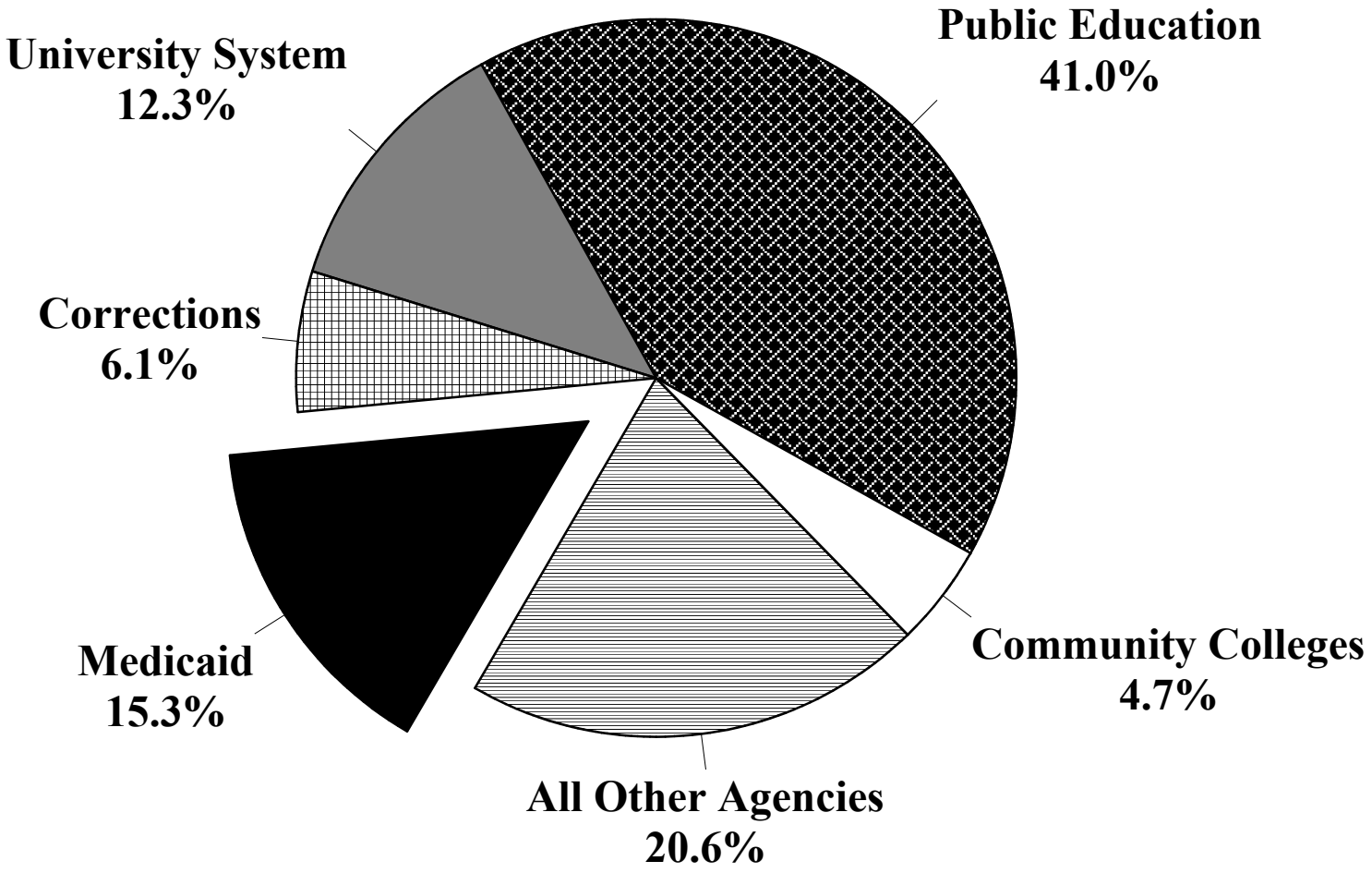
Total Appropriations
$14.35 Billion



Source: NC General Fund Operating Appropriations SFY 2003

Medicaid Program

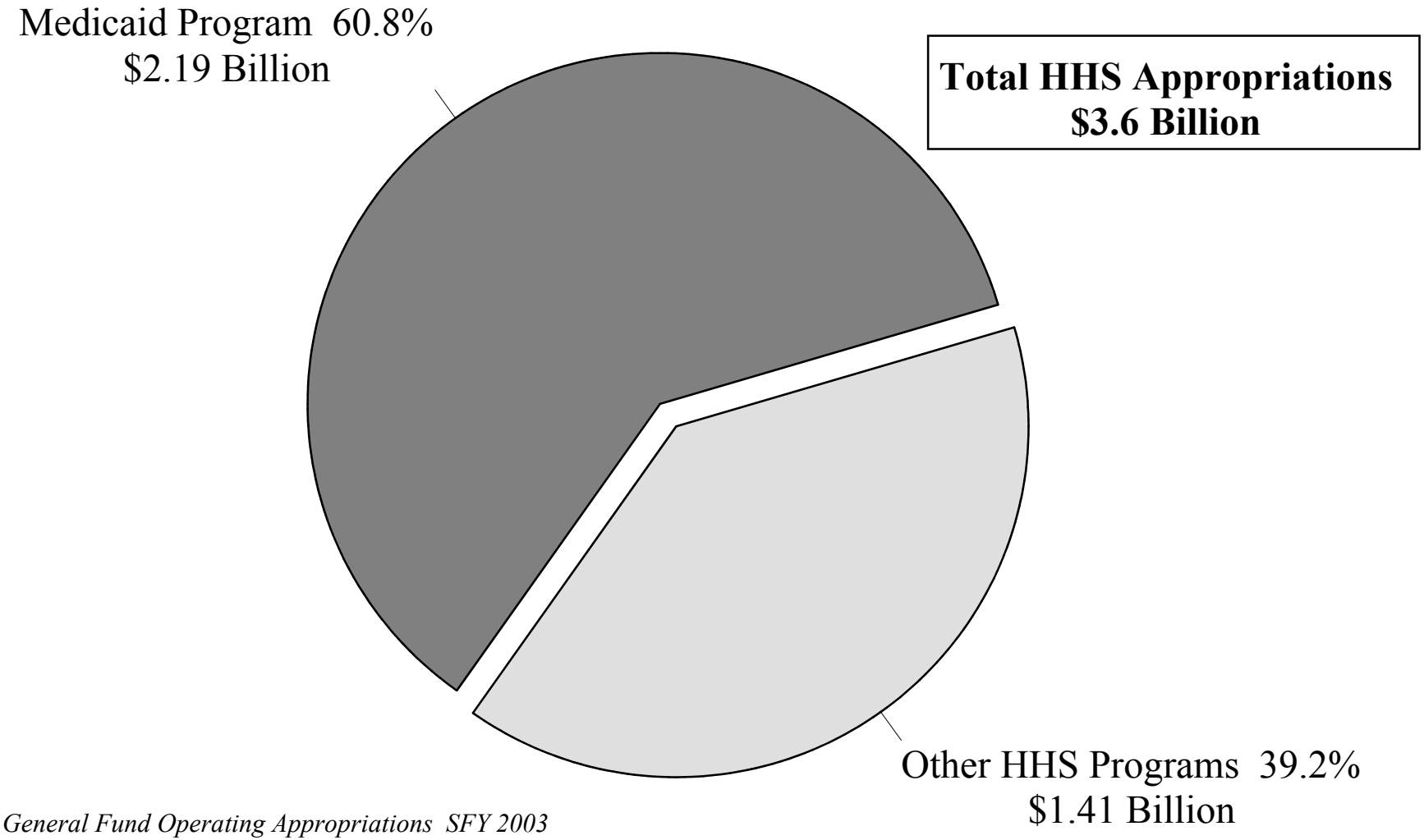
GENERAL FUND APPROPRIATIONS BY MAJOR PROGRAM AREA
SFY 2003



Source: NC General Fund Operating Appropriations SFY 2003

Medicaid Program

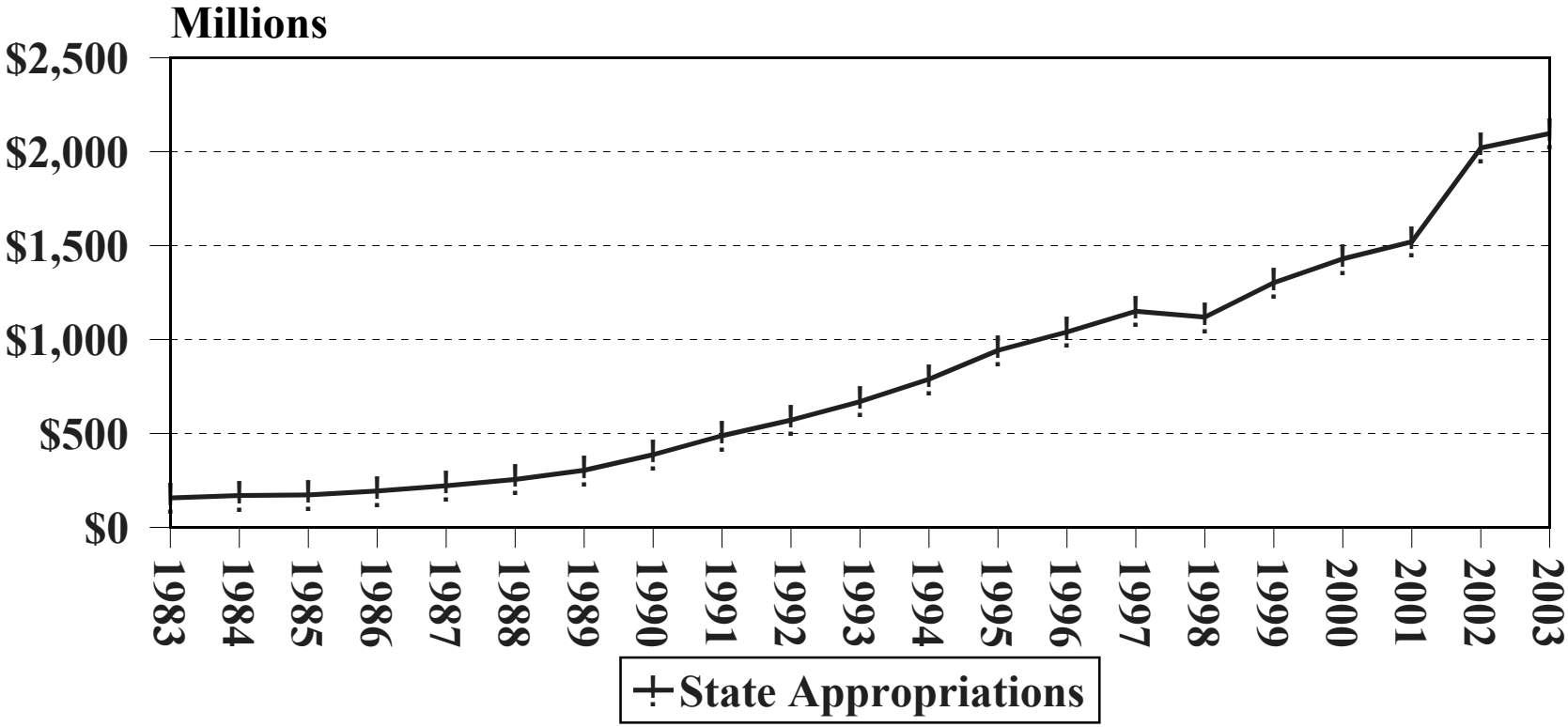
MEDICAID'S SHARE OF HHS GENERAL FUND APPROPRIATIONS FOR SFY 2003



Source: NC General Fund Operating Appropriations SFY 2003

Medicaid Program

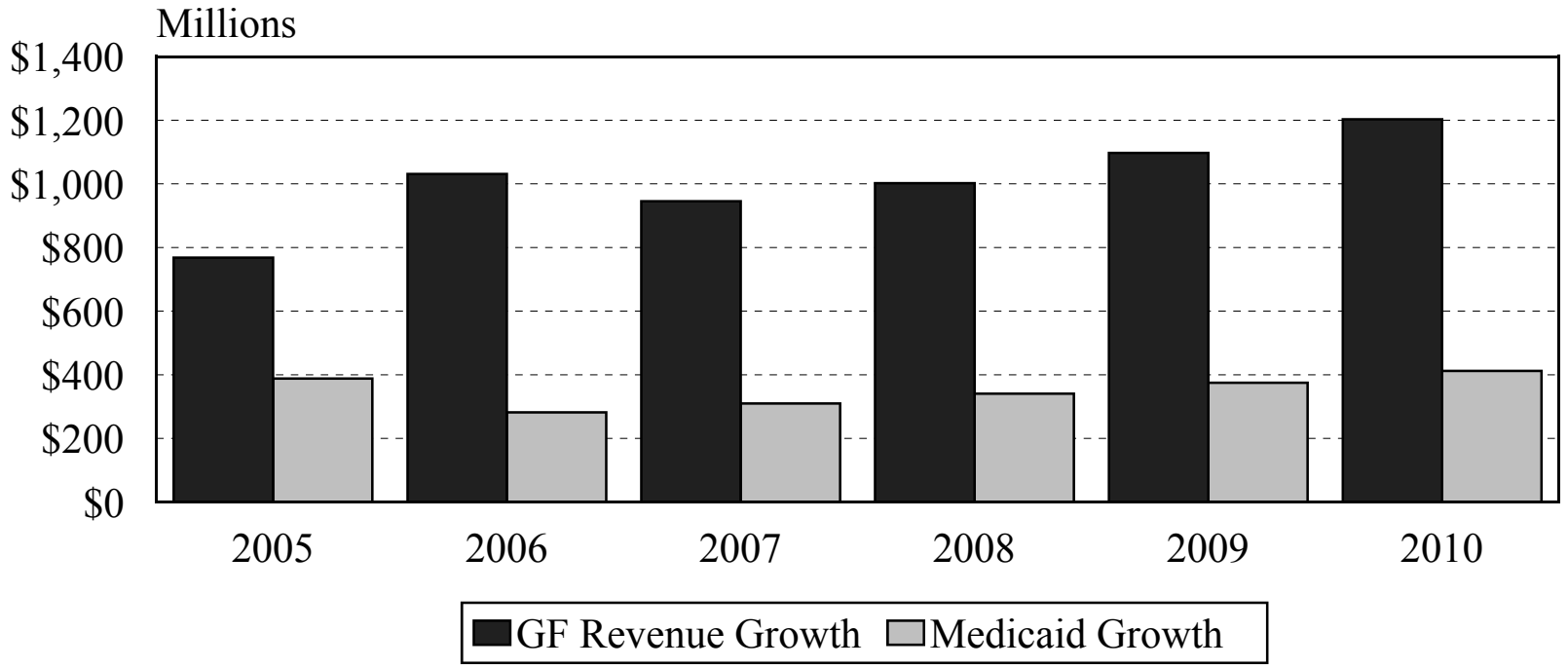
HISTORY OF STATE APPROPRIATIONS



- 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

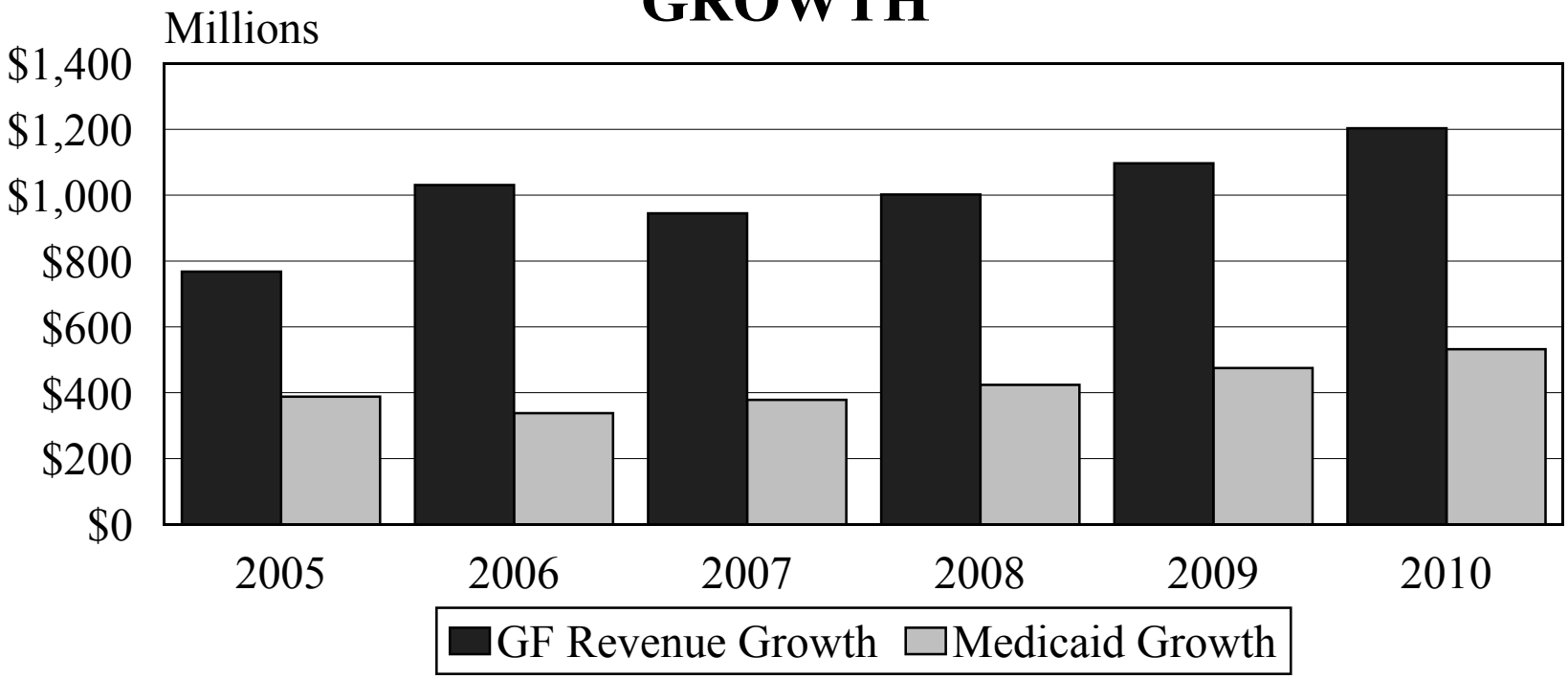
MEDICAID GROWTH VS. GENERAL FUND REVENUE GROWTH



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

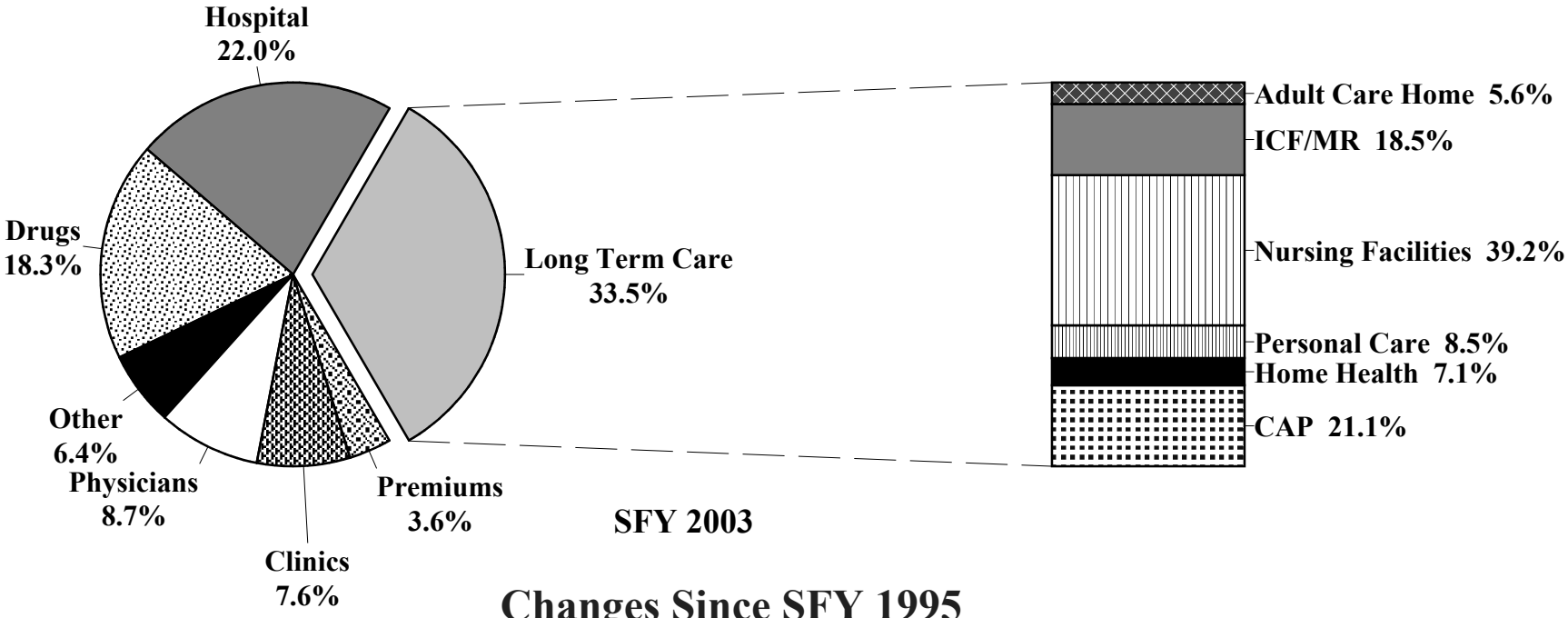
EXPENDITURES FOR SERVICES

- 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

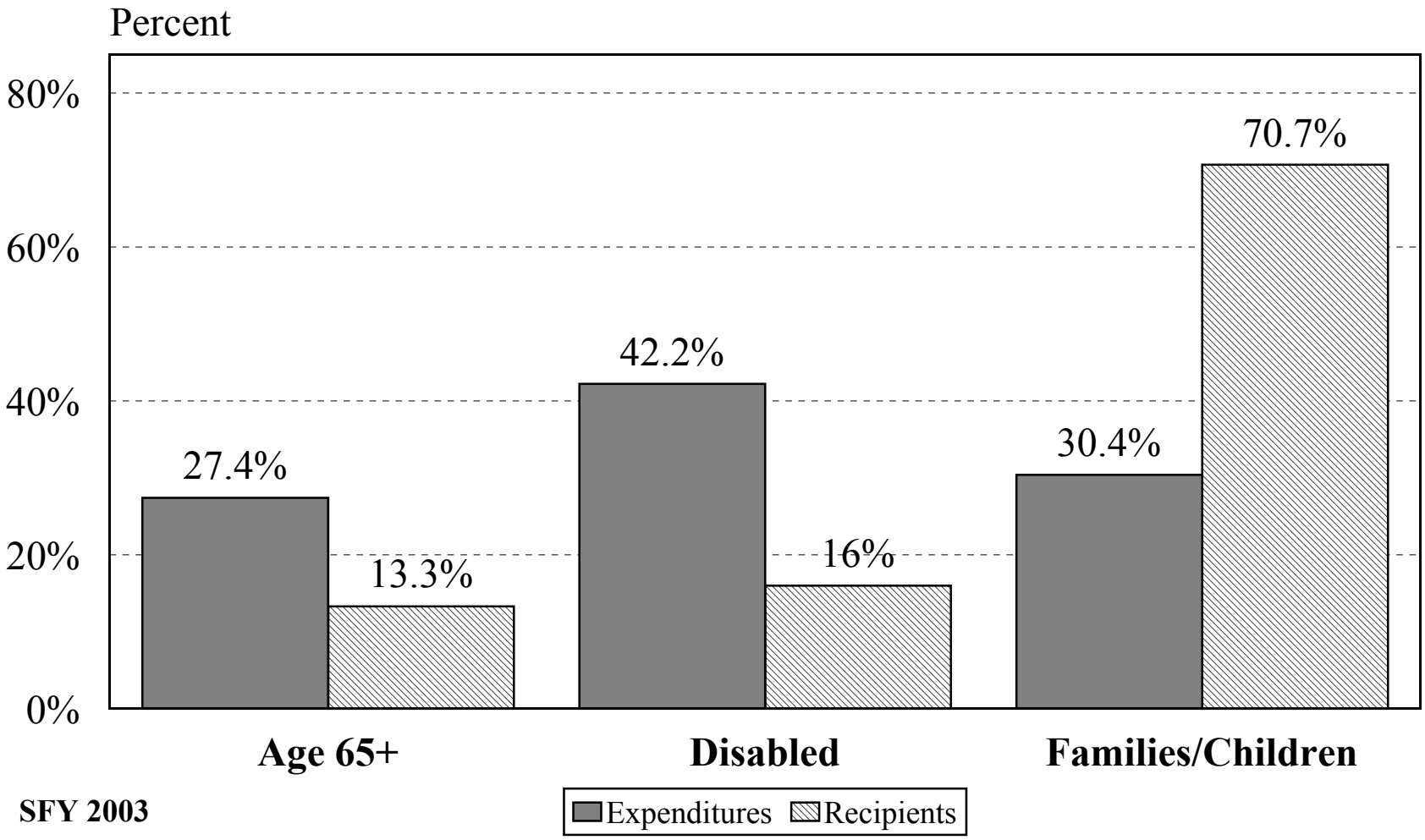


Changes Since SFY 1995

- 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

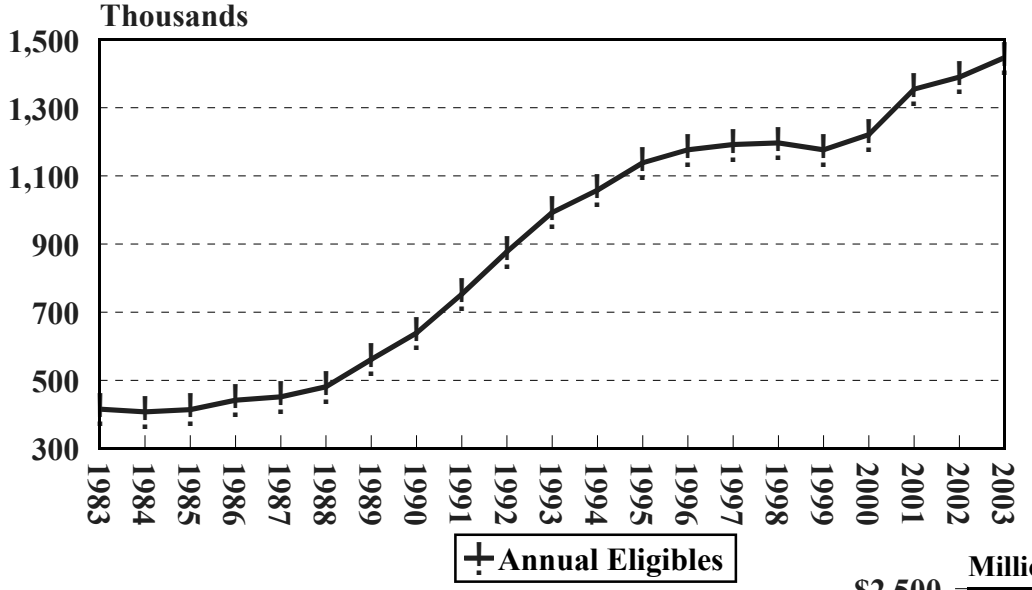
Eligibility Category	Number of Recipients	Expenditures	Annual Cost Per Recipient
Elderly	202,377	$1,807,717,487	$8,932
Aged	162,015	$1,780,878,696	$10,992
Medicare-Aid	40,362	$26,838,791	$665
Disabled	232,166	$2,779,255,514	$11,971
Families & Children	1,003,271	$1,973,688,840	$1,967

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

MEDICAID RECIPIENTS

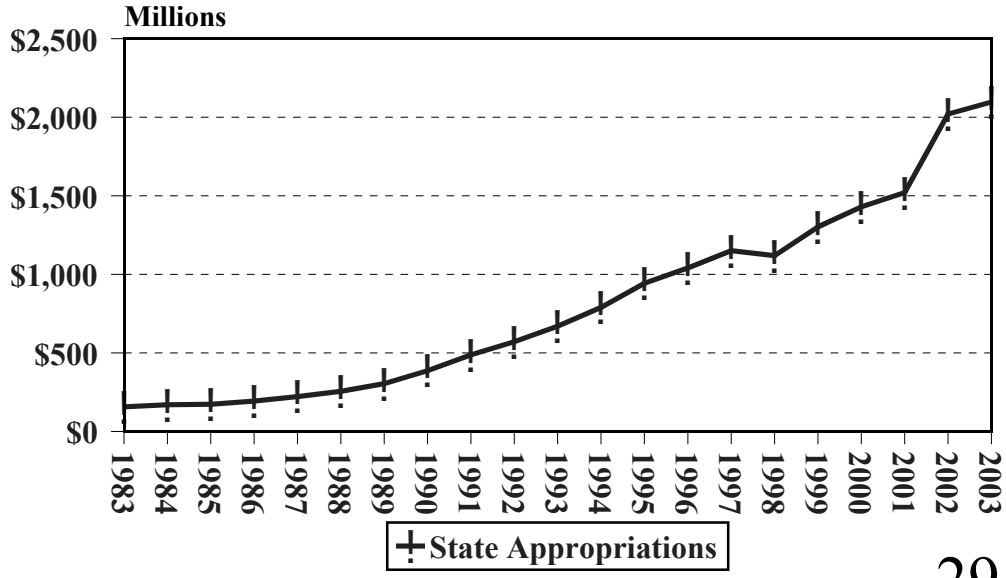
Medicaid Program

GROWTH IN ELIGIBLES AND EXPENDITURES



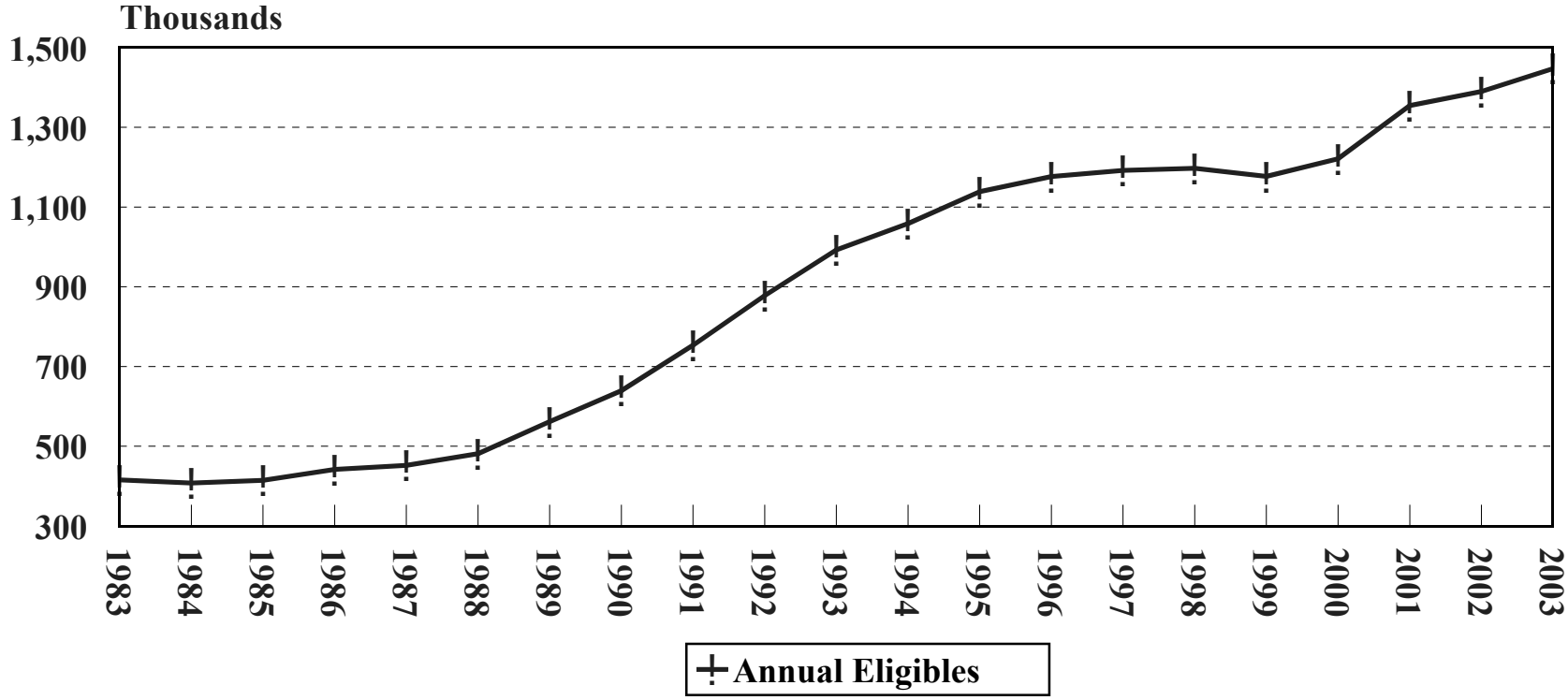
During the early 1980s, the number of eligibles did not grow significantly, and the rate of growth in expenditures for Medicaid was moderate.

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



Medicaid Program

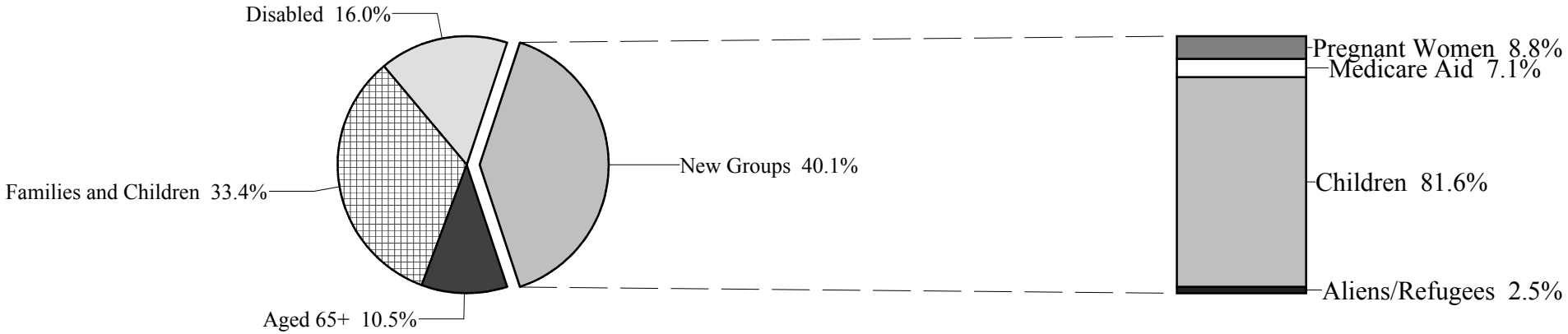
HISTORY OF ANNUAL ELIGIBLES



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



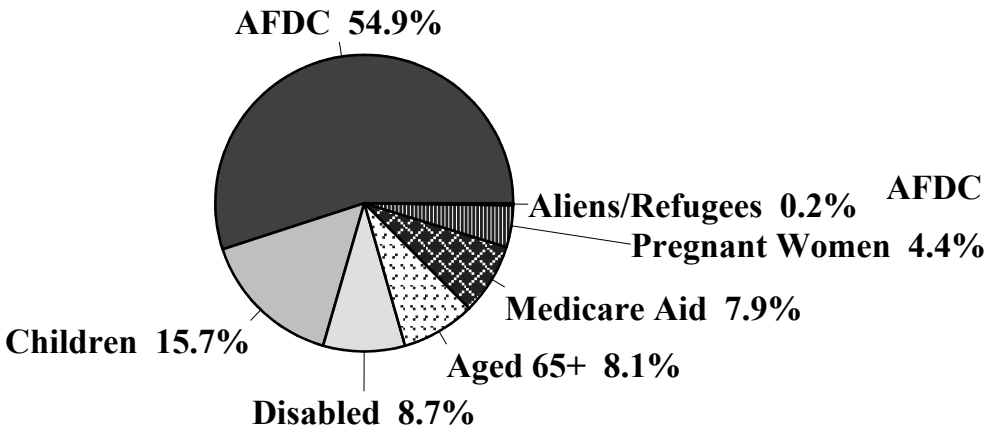
SFY 2003

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.

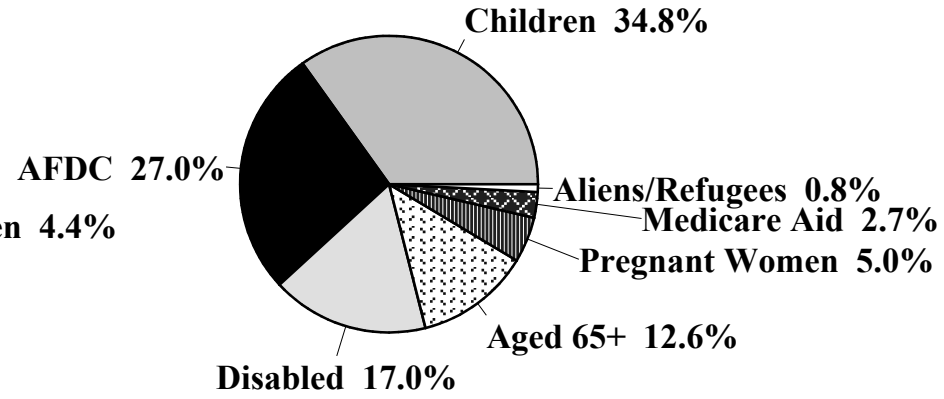
Medicaid Program

MEDICAID ELIGIBLES

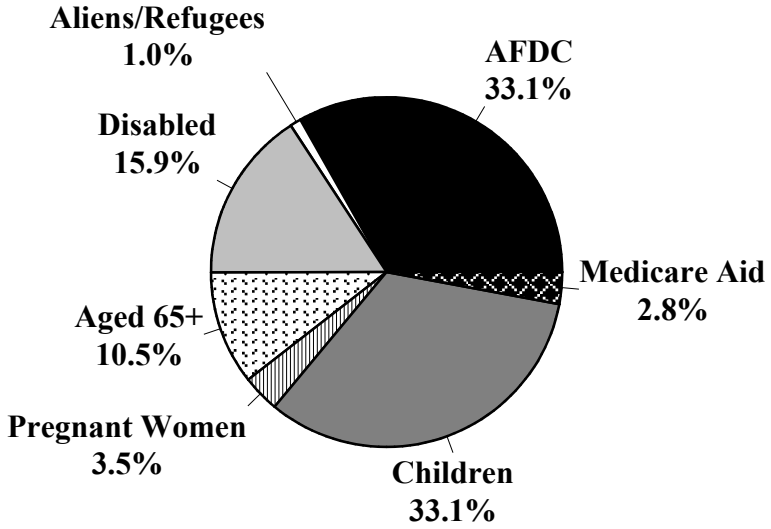
SFY 1994



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.

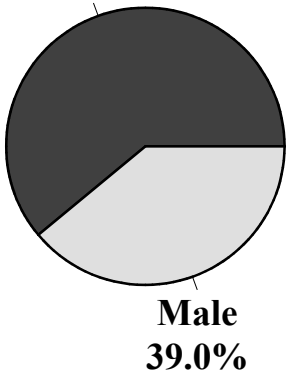
- In SFY 2000, the 1998 expansion of Medicaid to aged, blind, and disabled persons with incomes up to a 100% of the federal poverty level doubled the number of aged, blind and disabled eligibles.

- In SFY 2003, the number of aged, blind, and disabled eligibles has stabilized and in the case of the aged declined slightly.

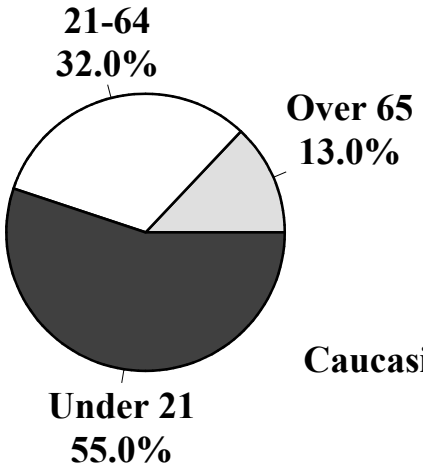
Medicaid Program

RECIPIENT INFORMATION

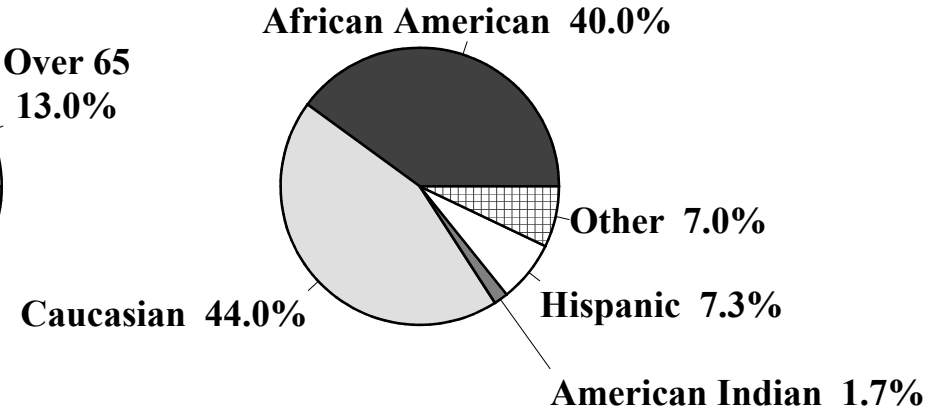
BY GENDER



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

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

) Provider Rates

- 2 Reduce Physician rates from 100% of Medicare rates to 95%.
- 2 Eliminate inflationary increases for SFY 2003 and SFY 2004
- 2 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
- 2 Reduce hospital payments by .5 %
- 2 Limit Medicare crossover claims to Medicaid rates
- 2 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.

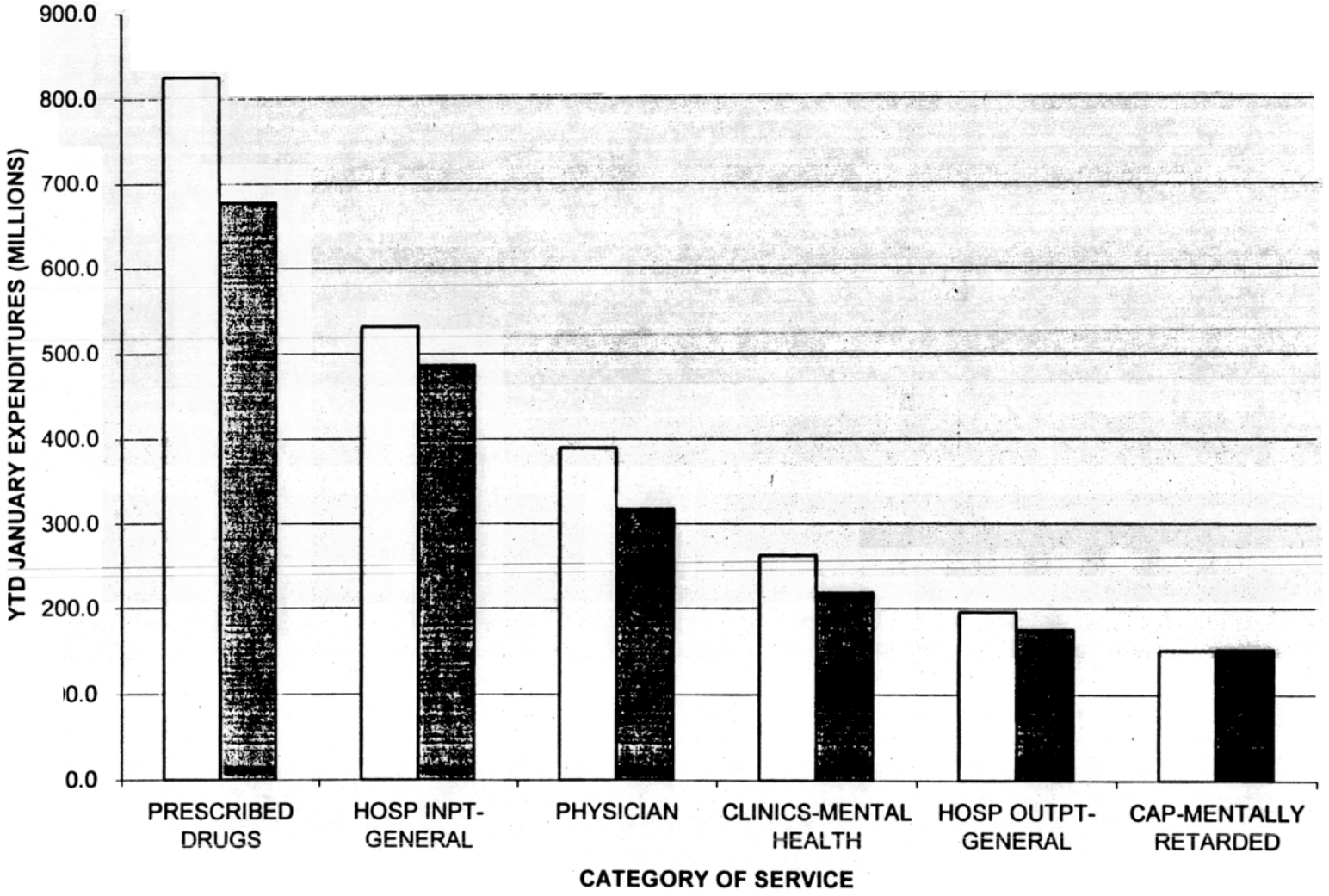
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
BUDGET MANAGEMENT

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%**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YTD JANUARY EXPENDITURES (MILLIONS)
PRESCRIBED DRUGS
HOSP INPT-GENERAL
PHYSICIAN
CLINICS-MENTAL HEALTH
HOSP OUTPT-GENERAL
CAP-MENTALLY RETARDED
CATEGORY OF SERVICE

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

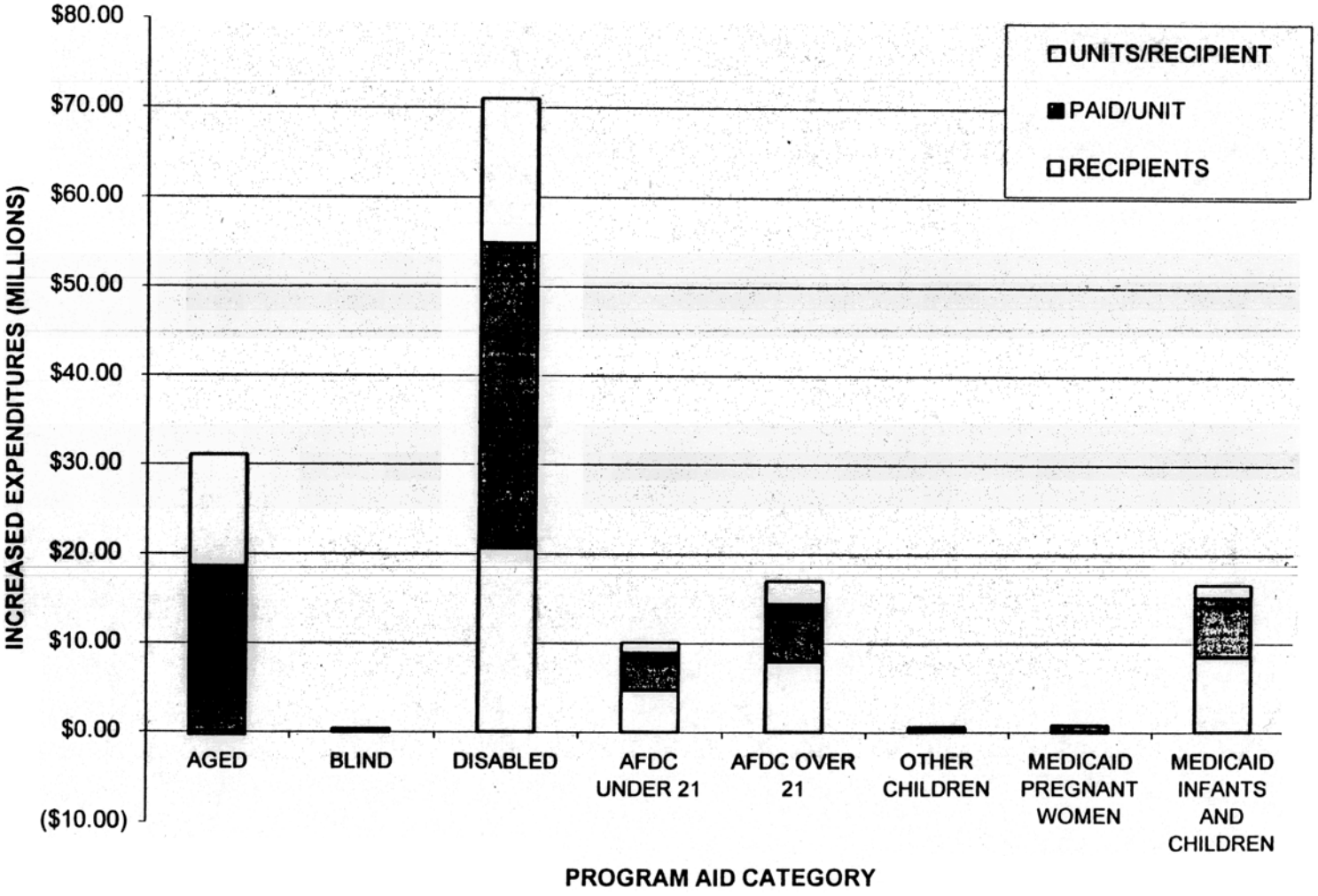
PRESCRIPTION DRUGS YEAR TO DATE JANUARY 2004	INCREASE DUE TO CHANGE IN NUMBER OF RECIPIENTS	PERCENT OF TOTAL INCREASE	INCREASE DUE TO CHANGE IN AMOUNT PAID PER SERVICE UNIT	PERCENT OF TOTAL INCREASE	INCREASE DUE TO CHANGE IN NUMBER OF UNITS USED PER RECIPIENT	PERCENT OF TOTAL INCREASE	TOTAL INCREASES 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	TOTAL INCREASE 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



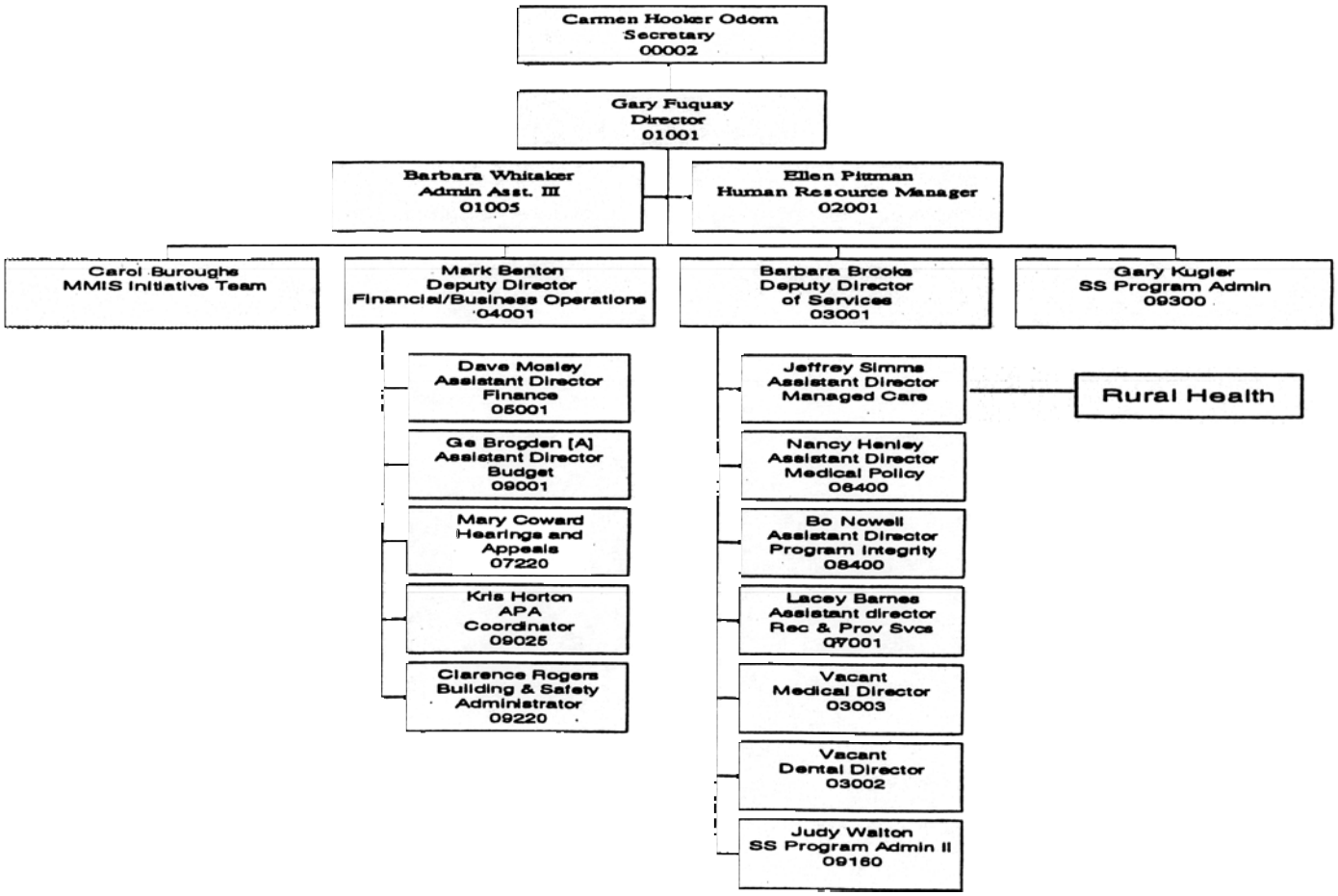
ORGANIZATION

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	
	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		
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

ACCESS II & III

PRESENTATION TO:
North Carolina Legislative
Blue Ribbon Commission on Medicaid Reform
March 24, 2004
L. Allen Dobson ,Jr. MD

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

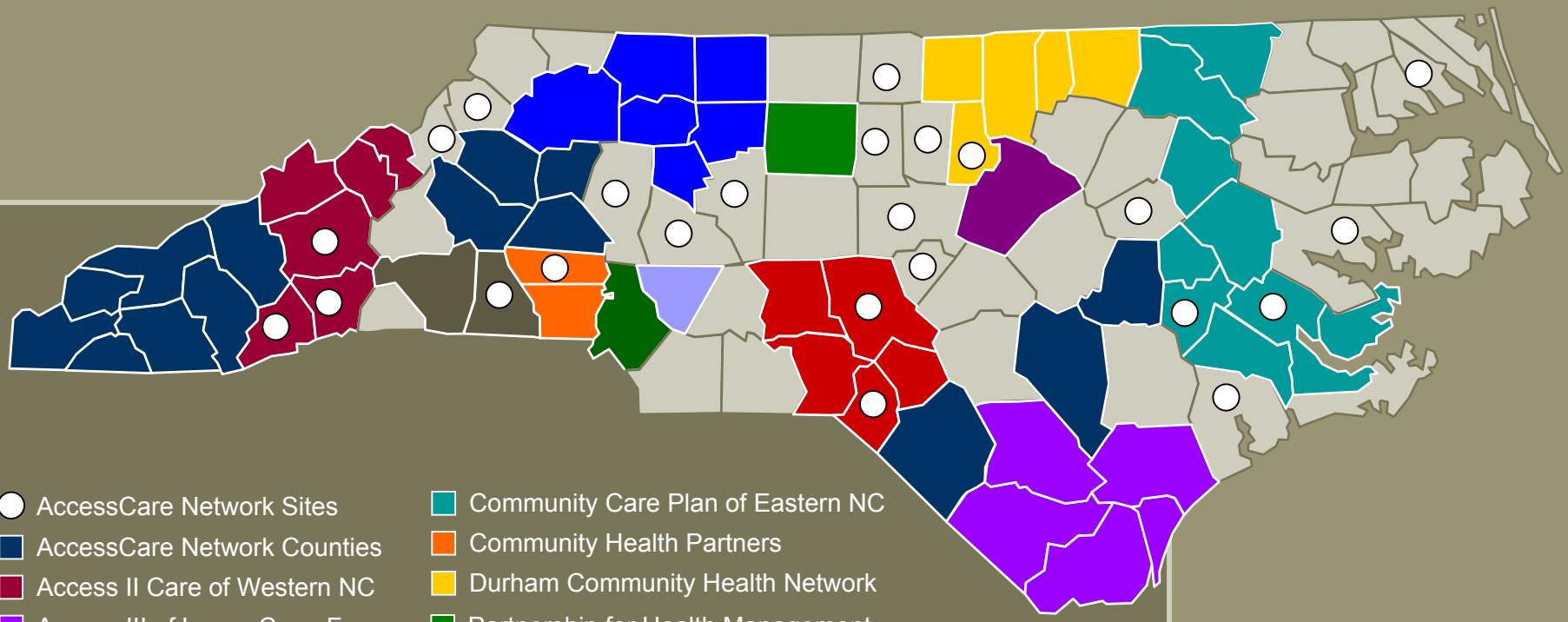
- Joins other community providers (hospitals, health departments and departments of social services) with physicians
- Creates community networks that assume responsibility for managing recipient care

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



- 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
- Comm. Care Partners of Gtr. Mecklenburg
- 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

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
- OTITIS MEDIA
- CHILD DEVELOPMENT
- ADHD
- FEVER
- DEPRESSION
- LOW BIRTH WEIGHT
- 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

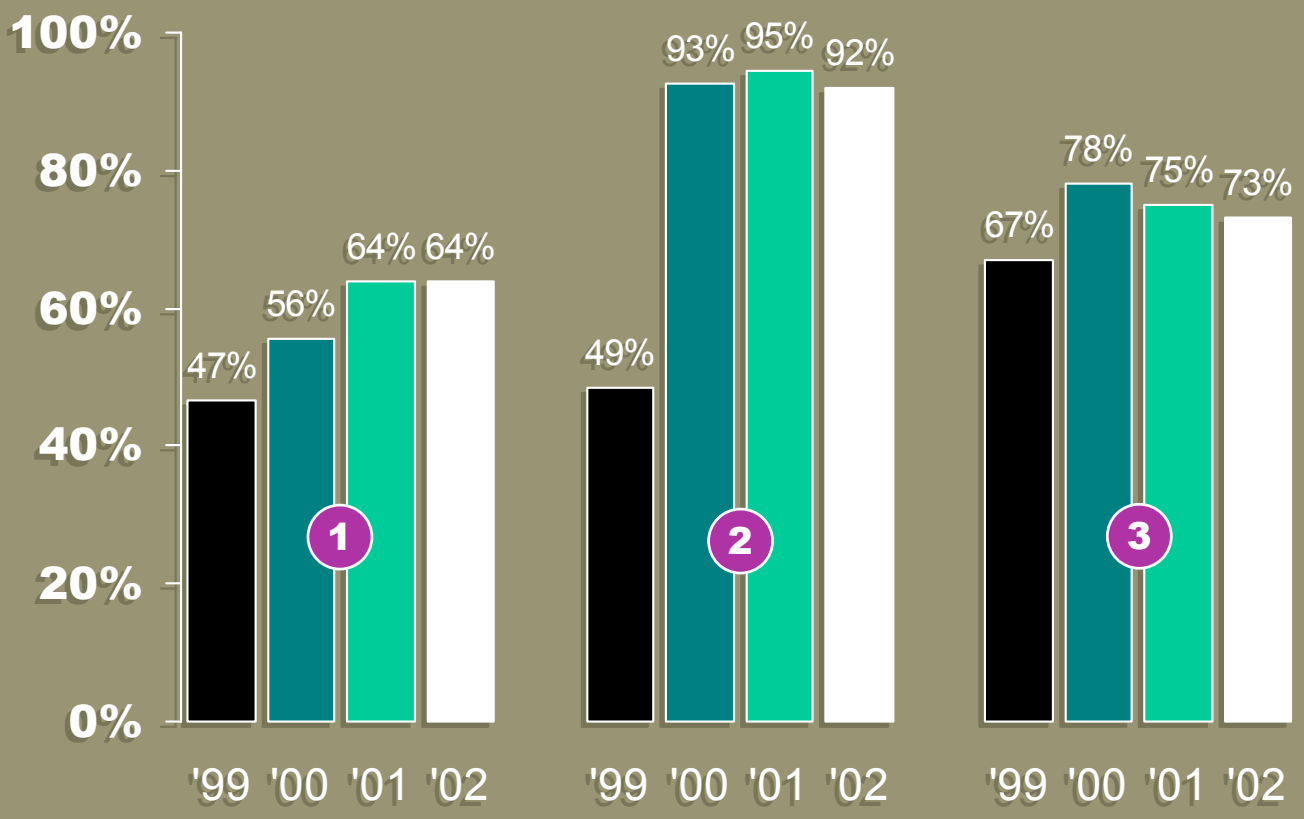
- Asthma
- Diabetes
- Pilots in Depression, ADHD, Special Needs Children, Gastroenteritis, Otitis Media and Low Birth Weight

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

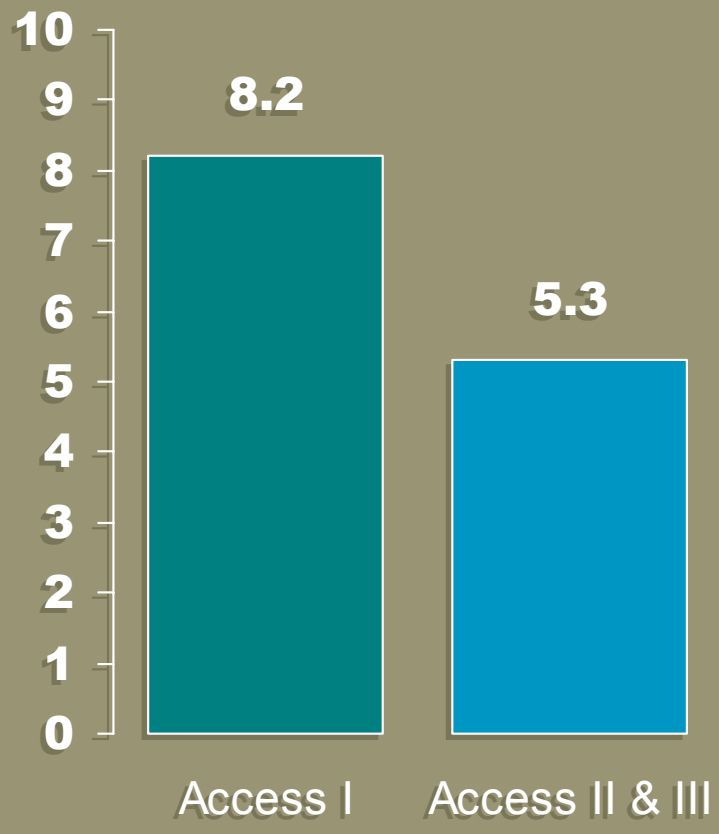
1. No. with asthma who had documentation of staging
2. No. staged II – IV on inhaled corticosteroids
3. No. staged II – IV who have an AAP

HOME
NEXT
LAST

Asthma Initiative

Pediatric Asthma Hospitalization Rates

April 2000 - December 2002



Key

In patient admission rate per 1000 member months

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:

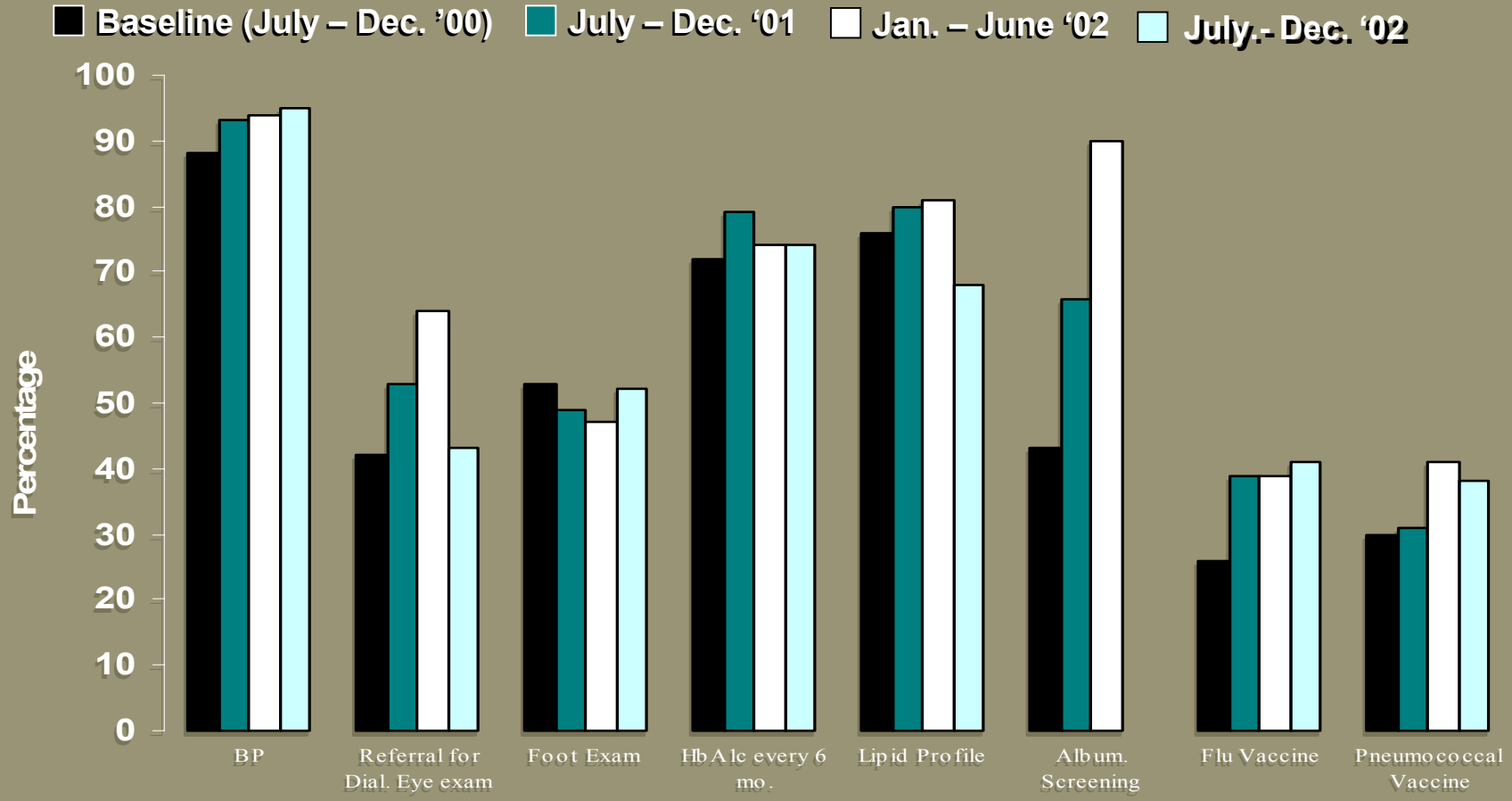
- CY 2000 Annual Savings $ 290,000
- CY 2001 Annual Savings $ 1,470,000
- CY 2002 Annual Savings $ 1,580,000

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

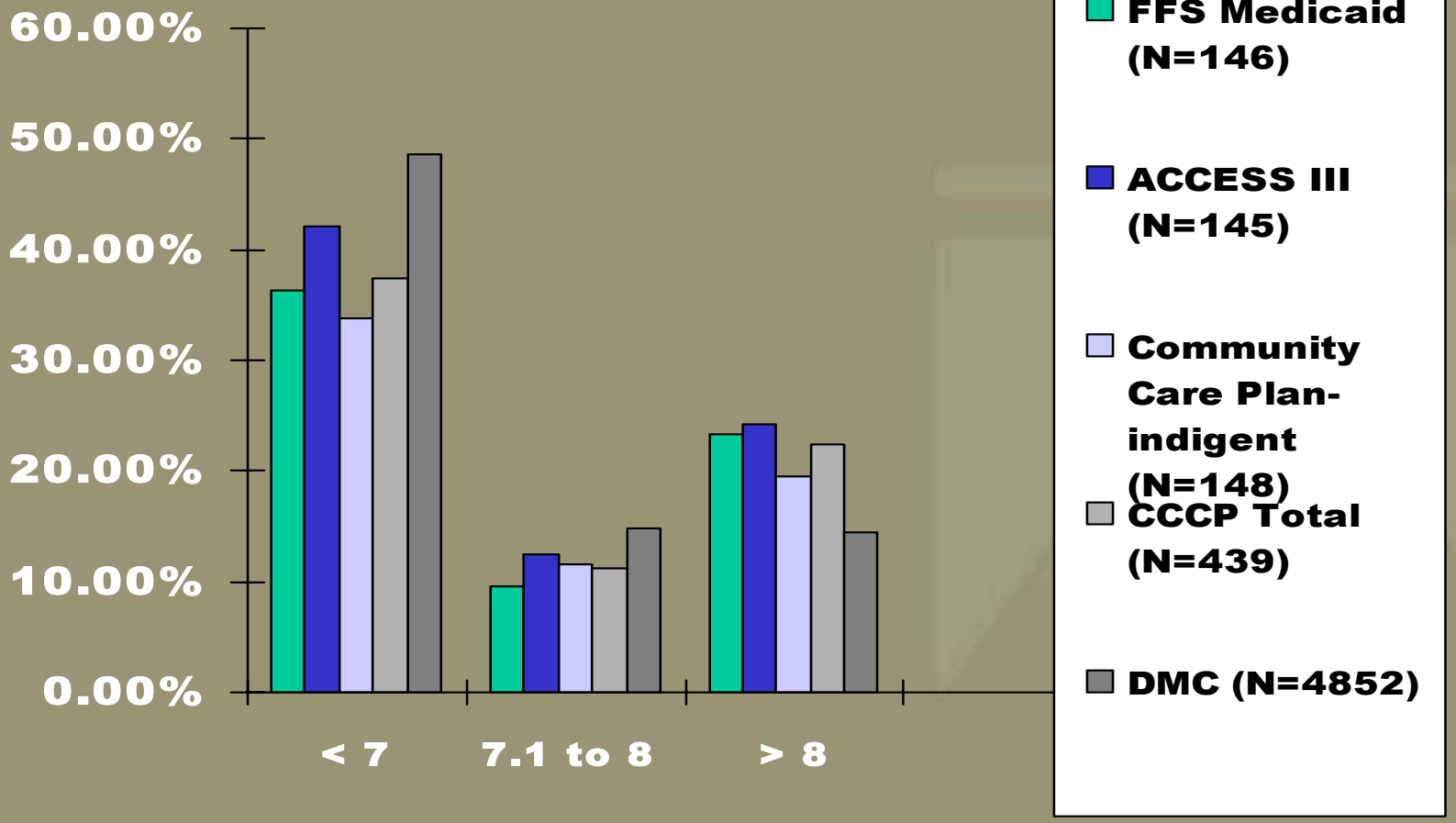
Diabetes Disease Management Findings:

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

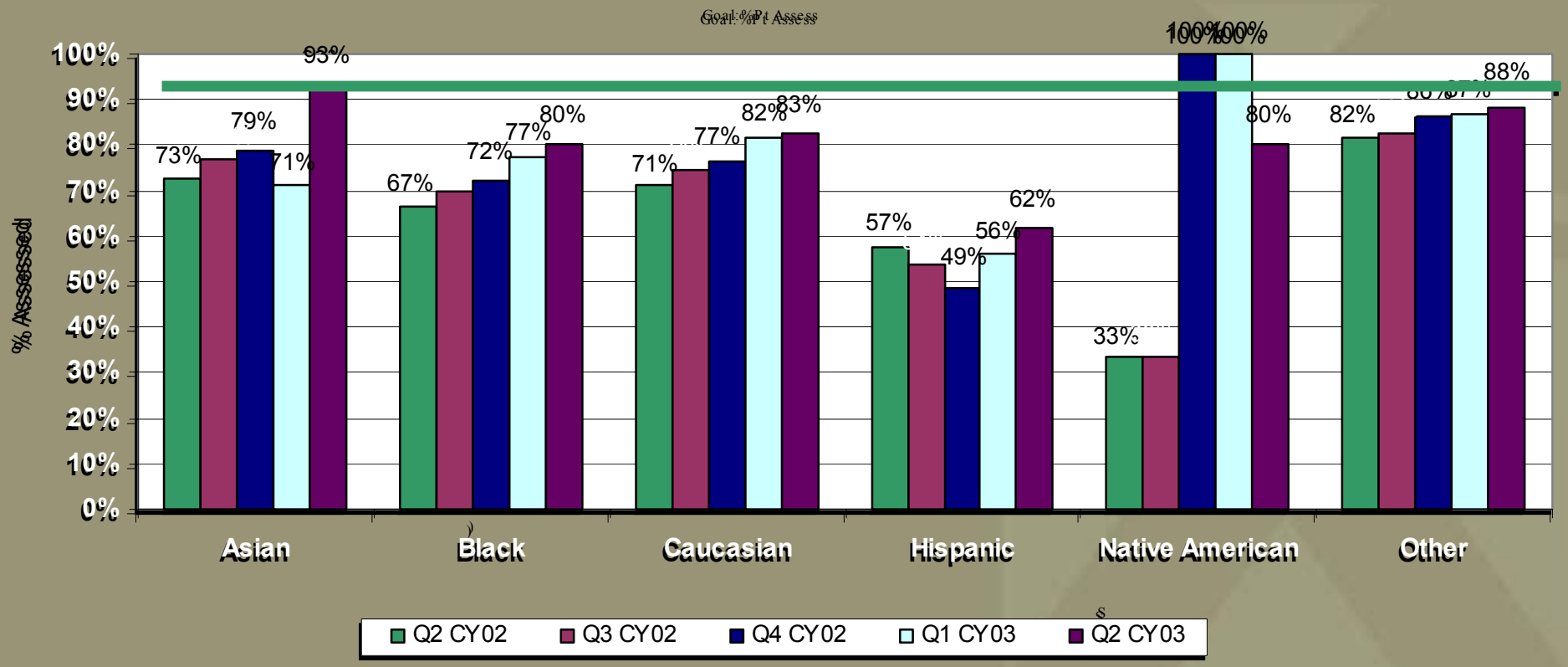
Diabetes DM Findings from Sheps:

- 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



Aspirin Documentation - Comparative by Race



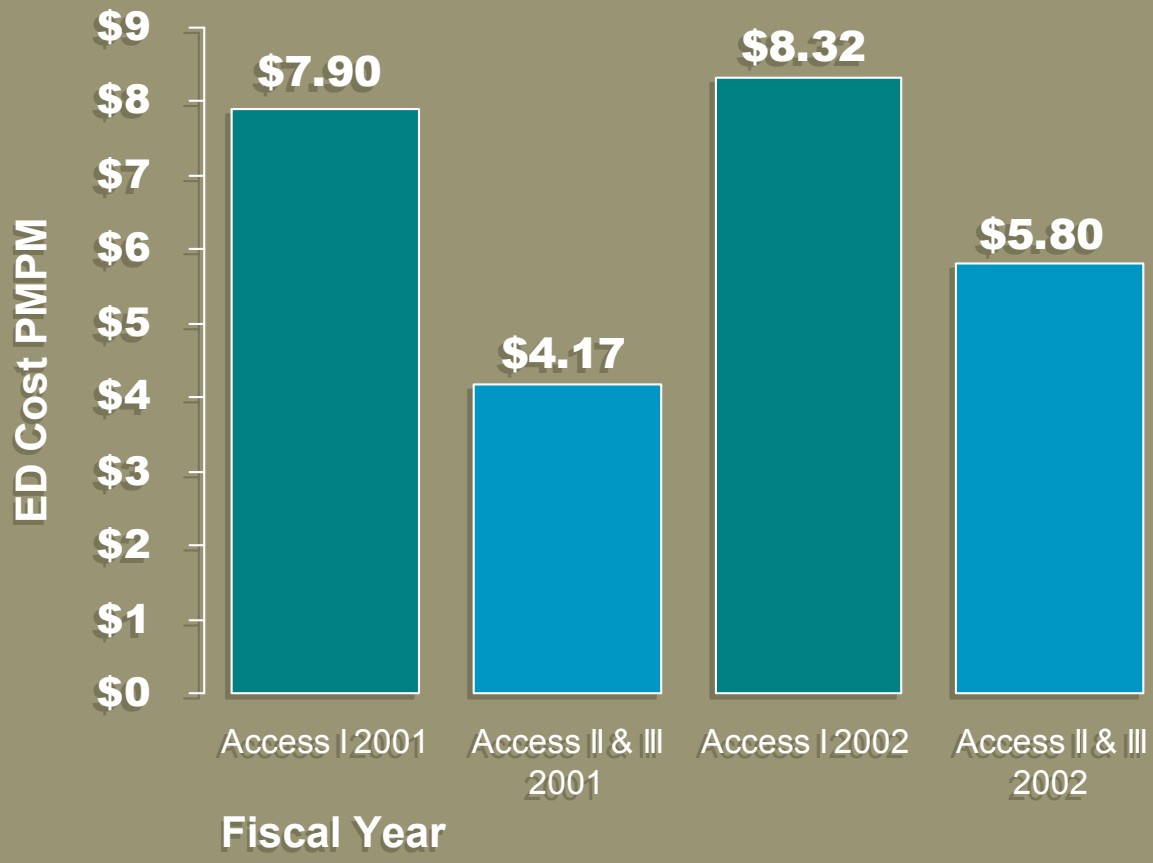
Managing Costs
" Targeted Approach"

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



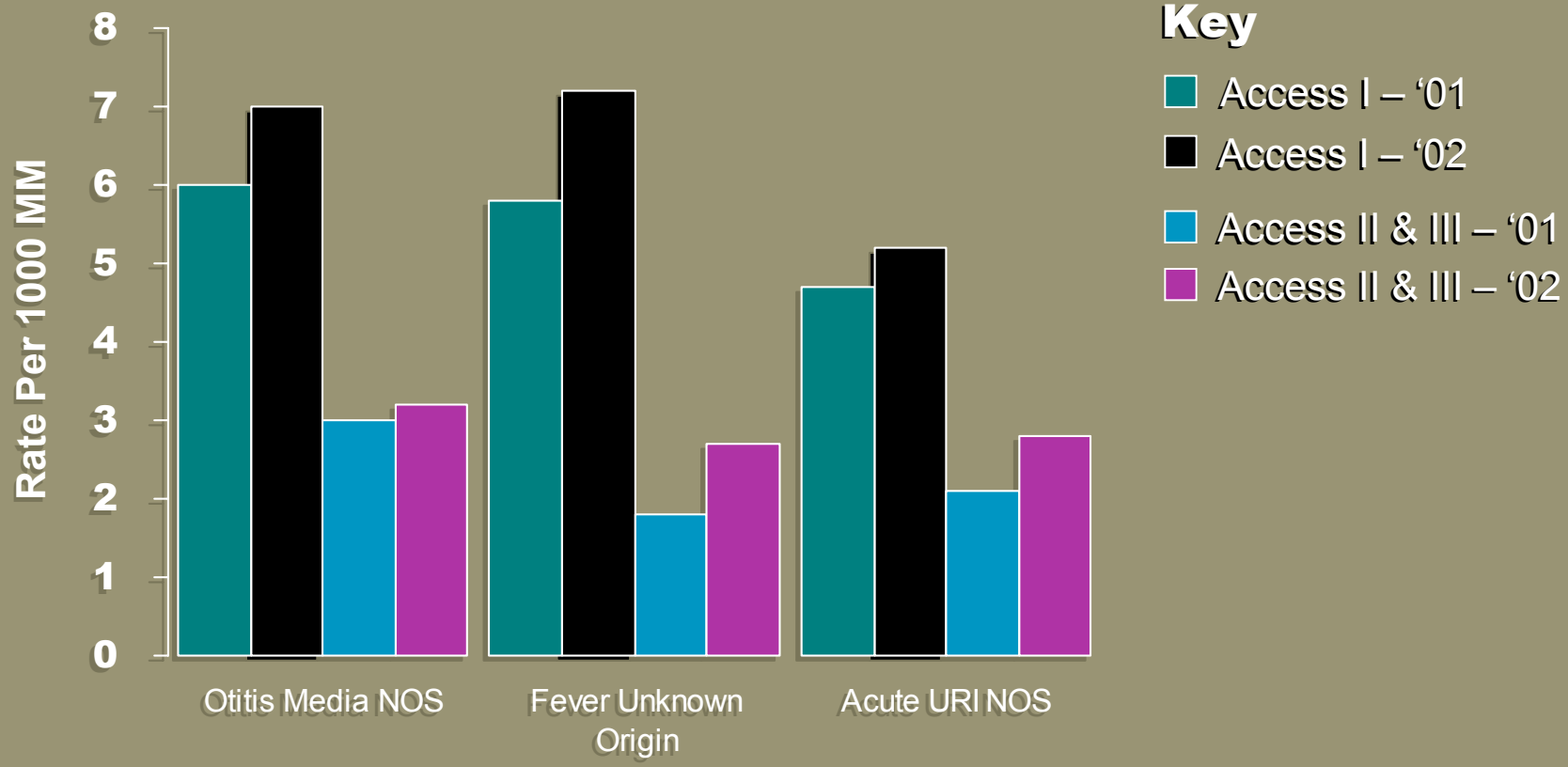
Savings Calculation

(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

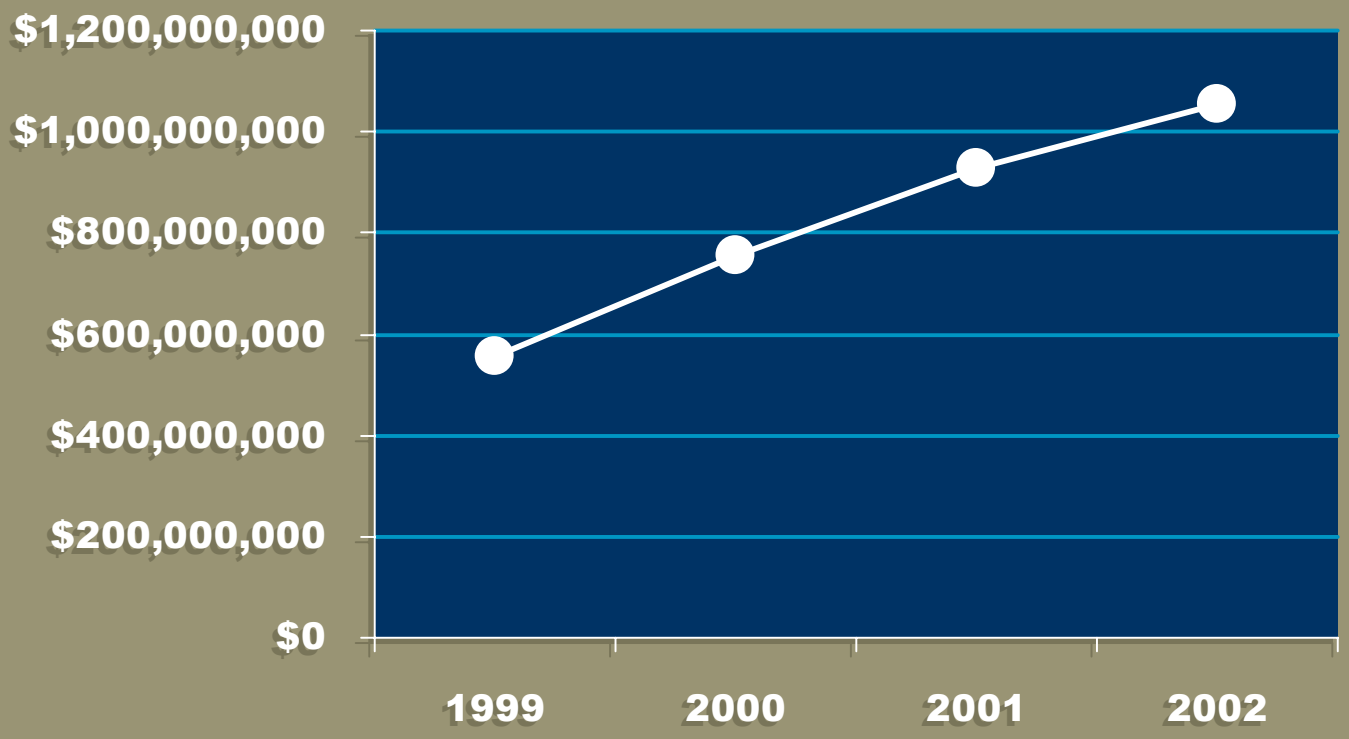
Preliminary Results – April-August 2003

	# 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

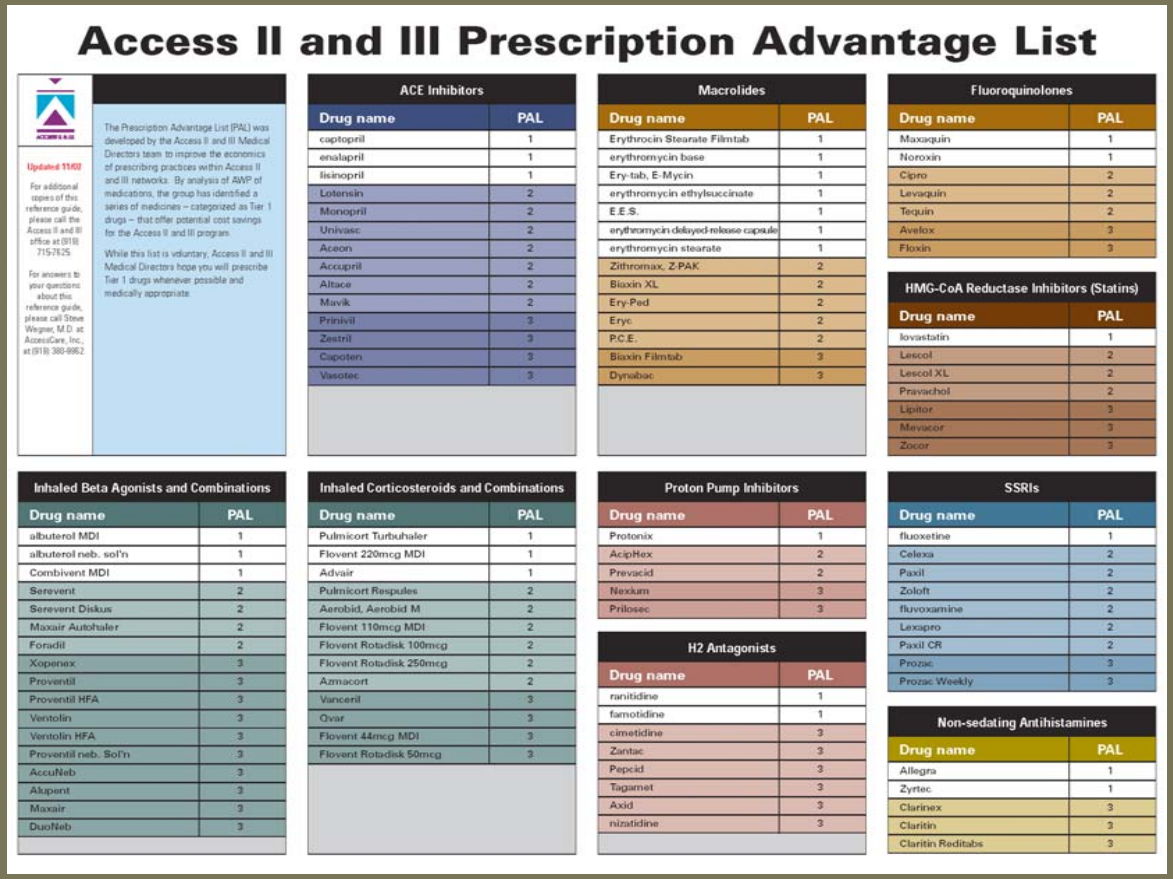
FY02
$1,056.158.750

HOME
NEXT
LAST

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

Updated 11/03

For additional copies of this reference guide, please call the Access II and III office at (919) 715-7625.

For answers to your questions about this reference guide, please call Steve Wegner, M.D. at AccessCare, Inc., at (919) 380-9962.

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

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

ACE Inhibitors

Drug name	PAL
captopril	1
enalapril	1
lisinopril	1
Lotensin	2
Monopril	2
Univasc	2
Aceon	2
Accupril	2
Altace	2
Mavik	2
Prinivil	3
Zestril	3
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 capsule	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
Azmacort	2
Vanceril	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

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

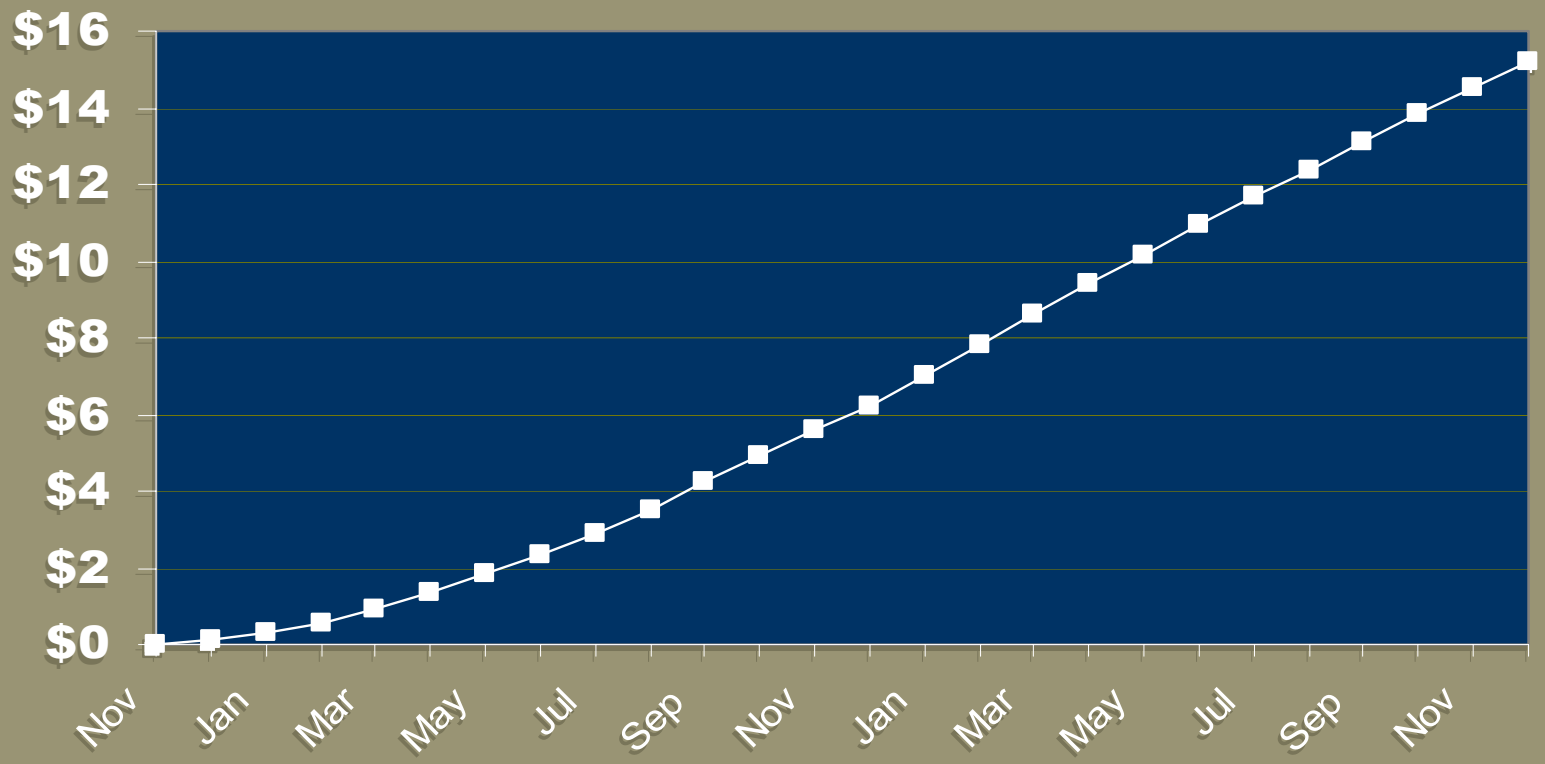
- Inappropriate Rx for the elderly “Beers drugs”
- Drugs used beyond usual time limit
- Drug Use Warnings & precautions
- Prescription Advantage List “PAL”
- Potential Therapeutic Duplication

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



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

- 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

APPENDIX E

North Carolina General Assembly
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(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.

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

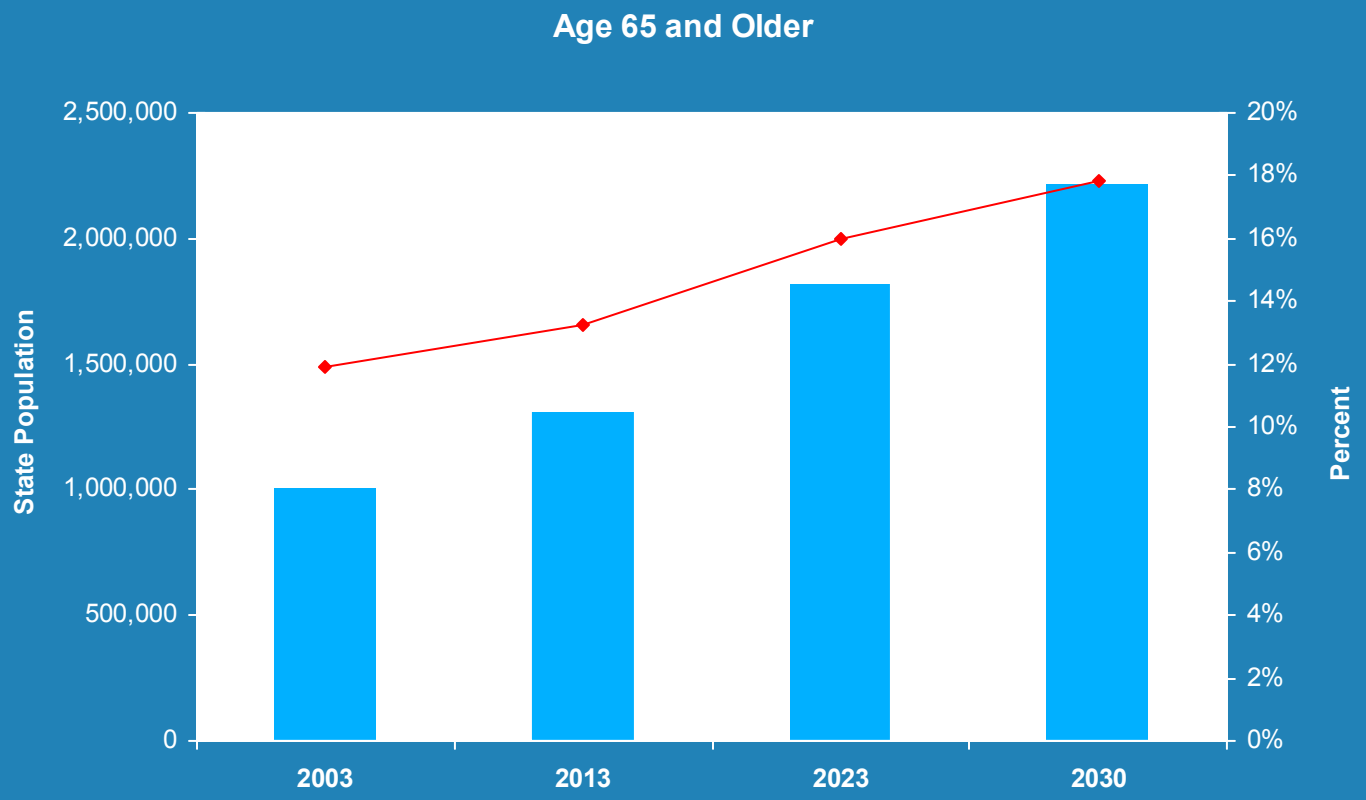
Blue Ribbon Commission on Medicaid Reform

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

Millennium Healthcare Solutions, Inc.

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

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.

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.

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

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

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.

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.

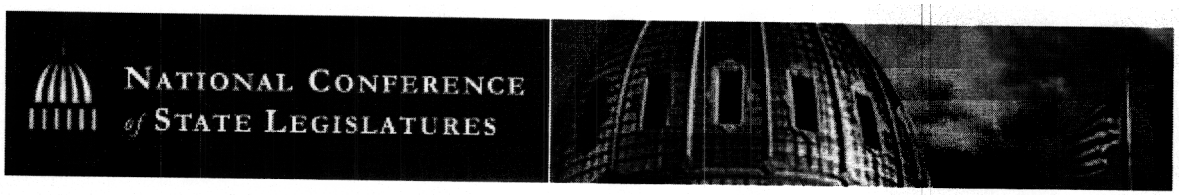
Prospective Budgeting

- 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

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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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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

---

[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.

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

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.

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.

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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

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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
	2,240
	1,441
	-
	445
	318
	1,330
	584
	14,200
	1,350
	46,340
	7,978
	350
	11,950
	4,120
	3,900
	-
	1,121
	1,479
	377
	2,510
	-
	995
	440
	-
	6,240
	563
	5,570
	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

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.

APPENDIX H

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.