STATE OF NORTH CAROLINA

PERFORMANCE REVIEW

NORTH CAROLINA DEPARTMENT OF HEALTH & HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE

MEDICAID PRESCRIPTION DRUG COSTS

JULY 2005

OFFICE OF THE STATE AUDITOR
LESLIE W. MERRITT, JR., CPA, CFP
State Auditor

Performance Review

of the

North Carolina Department of Health and Human Services
Division of Medical Assistance

MEDICAID PRESCRIPTION DRUG COSTS

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Leslie W. Merritt, Jr., CPA, CFP
State Auditor

2 S. Salisbury Street
20601 Mail Service Center
Raleigh, NC 27699-0601
Telephone: (919) 807-7500
Fax: (919) 807-7647
Internet
http://www.ncauditor.net

July 1, 2005

The Honorable Michael F. Easley, Governor
Members of the North Carolina General Assembly
Secretary Carmen Hooker Odom

Ladies and Gentlemen:

We are pleased to submit this performance review of *Medicaid Prescription Drug Costs*. The program is administered by the Division of Medical Assistance within the Department of Health and Human Services.

This report consists of an executive summary and sections for each of the objectives that contain overview information, discussion of issues and conclusions. The objectives of the review were: 1) to determine why Medicaid prescription drug costs are increasing and 2) whether the cost containment measures initiated by the Division of Medical Assistance are effective. Secretary Hooker Odom has reviewed a draft copy of this report, and her written comments are included as Appendix I, page 47.

We wish to express our appreciation to Secretary Hooker Odom and her staff for the courtesy, cooperation, and assistance provided us during this effort.

Respectfully submitted,

Leslie W. Merritt, Jr.

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State Auditor

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A Performance Review of

NORTH CAROLINA'S MEDICAID PRESCRIPTION DRUG COSTS

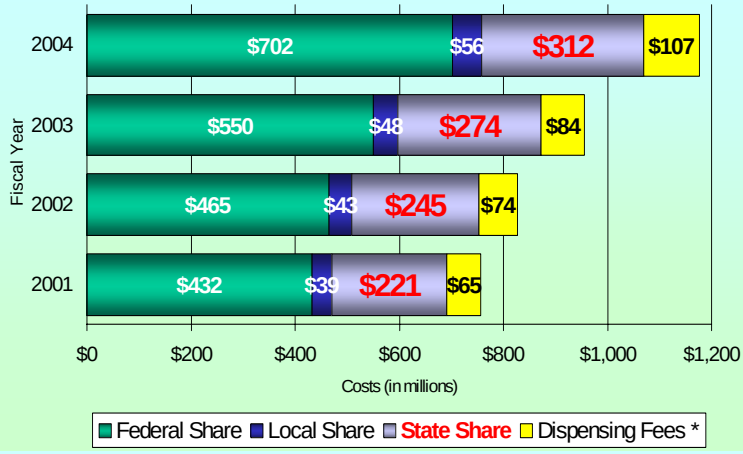
ADMINISTERED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE

OSA Report No. PER-2005-0213
June 2005

Overall Conclusions

North Carolina's prescription drug program is one of the optional programs allowed by the federal Medicaid program. In North Carolina, policy decisions regarding eligibility, services offered, and payment rates have resulted in a prescription drug program that is more generous than other southeastern states. Eligibility, offered services, and payments are three policy levers available to control optional care costs.[1] It will take tough policy decisions by lawmakers and effective cost control measures by the Department of Health and Human Services to control costs.

Exhibit 1
Costs of Prescription Drug Program By Share
(minus Rebates)



Source: Division of Medical Assistance *Dispensing fees paid entirely by the state.

The 2004 total net costs to the state for the prescription drug program are approximately $419 million, including $107 million paid by the state for dispensing fees. See Exhibit 1. Total costs of Medicaid prescription drugs have been increasing over the past four fiscal years, averaging a 24% increase annually for North Carolina (see Exhibit 3 page 5). This increase has resulted from a number of different factors, only one of which is an average annual increase in the actual cost of the drugs of 4.6%.

Program Summary

Medicaid is a federally aided, state operated and administered program that provides medical benefits to low-income people who are aged, blind, disabled, or members of families with dependent children. The program, authorized by Title XIX of the Social Security Act, requires states to provide certain medical services and permits them to provide other services, such as prescription drugs, on an optional basis.

For North Carolina, 56% of the $7.3 billion total costs of the Medicaid program are for optional services. Appendix C, page 33 contains a listing of the mandatory and optional services for North Carolina.

Under the terms of the Medicaid agreement, North Carolina must pay for all Medicaid services upfront and then is reimbursed a pre-determined percentage by the federal government and by local governments. (Appendix B, page 27)

North Carolina's Department of Health and Human Services, Division of Medical Assistance, has been proactive in identifying and testing various cost containment measures for the prescription drug program. A number of the measures used by North Carolina are

[1] "Get Control of Medicaid: Bringing Costs into Line Will Help State Budget", John Locke Foundation, *Spotlight*, No. 248, February 2, 2005.

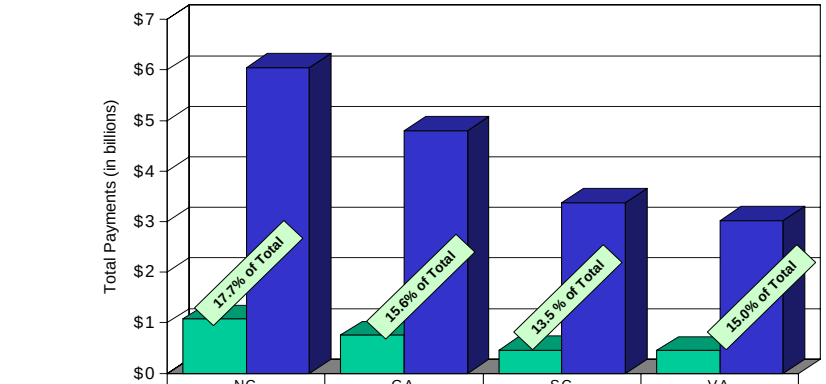
being used as models by other states as they seek to reduce their prescription drug costs.

Direct comparisons of North Carolina's prescription drug program to other states are difficult. Each of the 36 states participating in the optional prescription drug program chooses what services it offers. Additionally, each state decides the group(s) of Medicaid recipients to which the services will be offered. A further factor complicating comparisons is the availability of current program data from other states.

The last data available from the Center for Medicare and Medicaid Services for North Carolina and our neighboring states of Virginia, South Carolina, and Georgia is for federal fiscal year 2002. This data shows prescription drug program costs as a percentage of total Medicaid program costs. The percentages for North Carolina and the other states are: North Carolina, 17.7%; Georgia, 15.5%;, Virginia, 15.0%; and South Carolina, 13.5%.

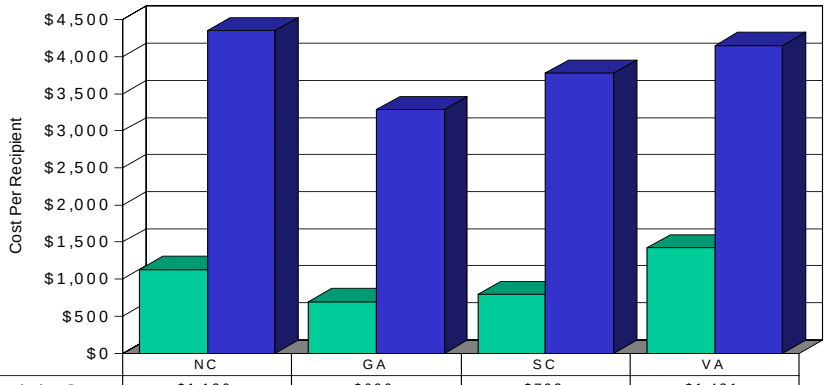
Looking at the cost per recipient for prescription drugs, Virginia is the highest at $1,421, North Carolina is second at $1,126, South Carolina third at $793, and Georgia fourth at $696. This information is presented graphically in Exhibit 2.

Exhibit 2
Comparison of FFY 2002 Costs for Selected States



	NC	GA	SC	VA
Prescription Drugs	$1.07	$0.75	$0.46	$0.45
Total Medicaid	$6.04	$4.80	$3.38	$3.02

Comparison of FFY 2002 Cost Per Recipient for Selected States



	NC	GA	SC	VA
Prescription Drugs	$1,126	$696	$793	$1,421
Total Medicaid	$4,348	$3,286	$3,776	$4,147

Source: Center for Medicare and Medicaid Services

Key Points from Review

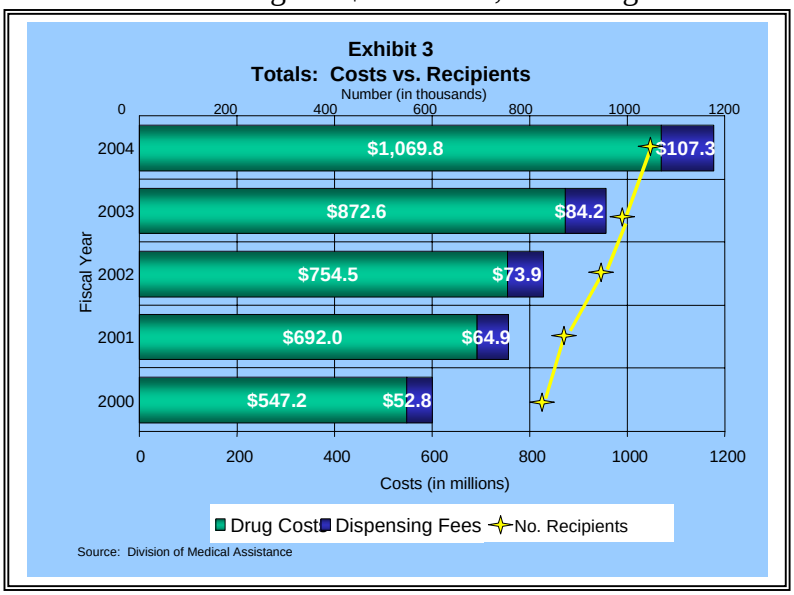
Summary of Objectives, Scope, and Methodology--The audit objectives were to determine (1) why Medicaid prescription drug costs are increasing, and (2) whether the cost containment measures initiated by the Division of Medical Assistance are effective.

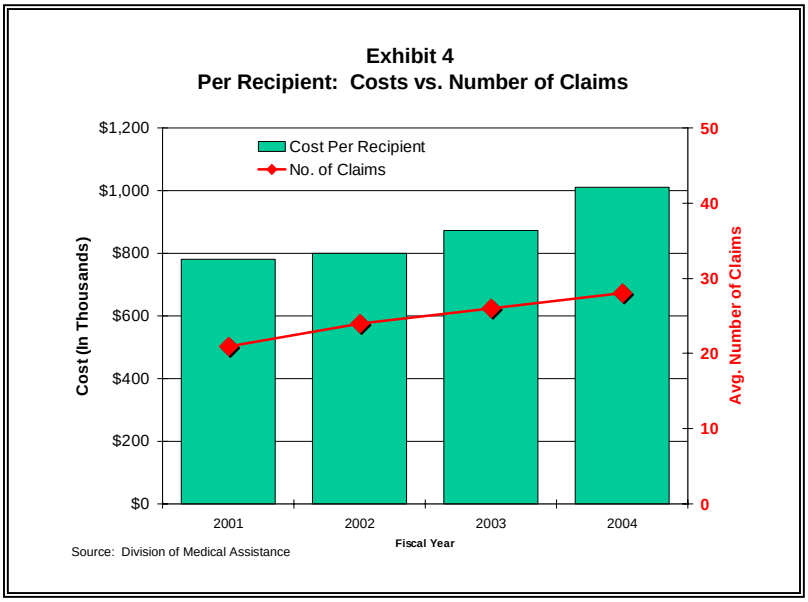
The scope of this audit included the Medicaid prescription drug program for fiscal years 2000 through 2004 as operated by the Division of Medical Assistance within the North Carolina Department of Health and Human Services.

Methodology consisted of selecting, reviewing, and analyzing data at both the state and federal levels for the prescription drug program. Additionally, the State Auditor hosted a series of meetings to discuss the program with professional and advocacy groups whose members are directly affected by the prescription drug program. (Appendix A, page 25)

Objective 1. Cost Increases

Overview: North Carolina's total Medicaid budget is $7.3 billion, with the gross prescription drug cost approximately $1.4 billion, or 20%, of the total. However, the net cost of the drugs to taxpayers is found only after subtracting rebates from drug manufacturers, as well as dispensing fees. This costs includes the federal share, the local share, and the state share. As shown in Exhibit 3, total prescription drug expenditures, less the rebates (see page 8 for discussion) and the number of recipients have been increasing since 2000. The relative rate of increase for that period has averaged 24.0% per year for total costs (drug costs plus dispensing fees) and 7.3% for number of recipients.





However, the cost per recipient has increased a total of 29.7% since 2001 (an average of 7.4% per year), while the average number of claims per recipient has risen from 2001 to 2004, as shown in Exhibit 4. Details are contained in Appendix H, page 45.

To give the reader a frame of reference for the performance of North Carolina's prescription drug program, we present data for our neighboring states of Virginia, South Carolina, and Georgia in Table 1, page 6. In reviewing this data, the reader should be aware that each state chooses the services it wants to offer under the prescription drug program and that the most current data for all states is for federal fiscal year 2002.

Table 1 Comparison of 2002 Data for Selected State Medicaid Programs				
Category	**North Carolina**	**Georgia**	**South Carolina**	**Virginia**
Payments				
Total Medicaid	$6,041,011,008	$4,796,005,361	$3,382,950,504	$3,017,869,649
Prescription Drugs	$1,069,140,895	$749,552,199	$456,976,916	$453,663,058
% Prescription Drugs to Total	17.7%	15.6%	13.5%	15.0%
Recipients				
Total Medicaid Eligible	1,389,455	1,459,631	895,863	727,784
Prescription Drug	949,795	1,076,904	576,136	319,196
% Drug Recipients to Total	68.4%	73.8%	64.3%	43.9%
Cost Per Recipient				
Total Medicaid	$4,348	$3,286	$3,776	$4,147
Total Prescription Drug	$1,126	$696	$793	$1,421
Source: Center for Medicare and Medicaid Services, Federal Fiscal Year 2002				

Discussion of Issues:

1. There are a number of reasons why the total prescription drug costs have increased. As shown in Exhibit 3, the number of eligible recipients for the Medicaid prescription drug program has increased. Along with this increase in total number, there have been significant demographic changes in the recipient population. Specifically, the number of recipients receiving multiple prescriptions due to increased medical problems has increased. In many cases, increased life span has a significant effect on the number and type of medications. Additionally, the number of disabled recipients (aged, blind, mental health, etc.) is also affected by increased life span. As shown in Table 2, the total number of prescriptions increased by 38.7% from fiscal year 2001 to 2004.

Table 2 Total Number of Prescriptions				
Medicaid Program	**2001**	**2002**	**2003**	**2004**
Work First Or TANF	727,432	885,716	990,093	1,483,074
State Foster Child	35,870	43,488	51,561	56,222
IV-E Adoption Assistance	77,805	91,864	104,777	123,716
Medicaid Aid To Aged	5,771,176	6,466,021	6,829,483	7,319,398
Medicaid Aid To Blind	66,252	71,929	74,467	76,502
Medicaid Aid To Disabled	6,157,067	6,951,683	7,602,365	8,514,322
Medicaid Aid To Families	1,630,380	2,052,607	2,466,963	2,486,986
Medicaid Infant & Children/Health Choice	1,569,416	1,688,721	1,946,711	2,235,328
Medicaid For Pregnant Women	249,262	268,616	278,250	296,297
Medicaid Refugee Assistance	810	794	2,094	680
Special Assistance For Blind	1,611	1,984	2,028	2,104
Refugee Cash Assistance	639	825	1,640	766
State/County Special Assistance To Aged	829,931	975,403	1,049,522	1,077,419
State/County Special Assistance To Disabled	558,619	680,510	770,239	851,536
Total	17,676,270	20,180,161	22,170,193	24,524,350
Percentage Change		14.17%	9.86%	10.62%
Source: Division of Medical Assistance				

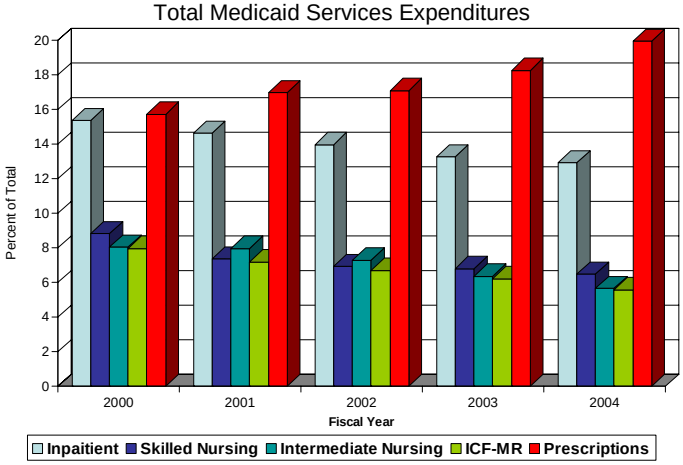
Another major factor in the increase in total prescription drug costs is the continuing development of newer drugs and specialty drugs that have higher costs. Table 3 contains examples of these classes of drugs and shows the changes in the number of prescriptions for them from fiscal years 2001 to 2004.

Table 3
Utilization/Number Of Claims
For the Top Ten Classes of Drugs by Expenditure

	Fiscal Year				
	2001	2002	2003	2004	% Change Since 2001
Antipsychotics, Atypical, Dopamine, & Serotonin	345,984	437,627	512,680	570,500	64.9%
Gastric Acid Secretion Reducers	832,915	969,609	1,081,743	1,214,612	45.8%
Anticonvulsants	617,293	732,085	824,695	939,146	52.1%
Analgesics, Narcotics	1,064,599	1,223,375	1,385,587	1,558,227	46.8%
Lipotropics	368,538	474,801	571,357	708,476	92.2%
Serotonin Specific Reuptake Inhibitor	488,877	597,876	692,531	783,740	60.3%
Nsaids, Cyclooxygenase Inhibitor - Type	696,791	736,896	723,127	772,377	10.8%
Antihistamines	370,279	464,439	531,076	583,190	57.5%
Calcium Channel Blocking Agents	563,985	603,750	601,593	613,100	8.7%
Hypoglycemics, Insulin-Response Enhancer	107,619	147,480	171,818	205,095	90.6%
Source: Division of Medical Assistance					

These drugs offer more therapeutic options for the recipients, and may allow them to remain in their homes rather than having to be institutionalized. Appendix E, page 39, shows that while the percentage of expenditures for prescription drugs have been increasing since fiscal year 2000, the percent of expenditures for inpatient hospitalization, skilled nursing facilities, intermediate nursing facilities, and ICF-MRs have been decreasing. Exhibit 5 depicts the changes in institutional expenditures.

Exhibit 5
Institutional Expenditures As Percent of
Total Medicaid Services Expenditures



Source: Medicaid In North Carolina Annual Reports, 2000-2004

However, information on the impact of drug utilization in regard to decreased hospital stays and delays in admissions to skilled nursing facilities is undetermined. Medications may, in some cases, when combined with comprehensive care, delay admission. In other cases, adverse reactions to drugs often result in deterioration of the condition of patients and may result in admission to these facilities.

Lastly, there has been some general increase in the manufacturers' prices for existing drugs, especially brand-name drugs. According to the federal Government

Accountability Office,[2] 77 drugs generally utilized by Medicare populations increased in costs approximately 21.8% over the four-year period 2000 to 2004. This was an average 4.6% increase for each year. The report also reviewed 79 drugs utilized by non-Medicare populations and found that the increase in drug costs was approximately 22.8% (4.8% annually) over the same period.

2. "Total Prescription Drug Costs" do not reflect the net cost of prescription drugs to the state but rather the gross prescription drug costs. Table 4 shows the rounded net cost of Medicaid prescription drugs to the state to be $312 million or approximately 21% of the total gross costs.

Table 4
Net Medicaid Prescription Drug Costs for Fiscal Year 2004*

	Total	Federal	Local	State
Total Prescription Drug Costs	$1,470,000,000			
Federal share (65.73%)		$ 966,000,000		
Local share (5.14%)			$ 76,000,000	
State share (29.13%)				$ 428,000,000
Less: Rebates (20% of total costs)	($ 293,000,000)			
Federal share (65.73%)		(193,000,000)		
Local share (5.14%)			(15,000,000)	
State share (29.13%)				(85,000,000)
Less: Dispensing Fees	($ 107,000,000)			
Federal share (65.73%)		(71,000,000)		
Local share (5.14%)			(5,000,000)	
State share (29.13%)				(31,000,000)
Net Drug Costs	**$1,070,000,000**	**$ 702,000,000**	**$ 56,000,00**	**$ 312,000,000**

*Totals are rounded

Source: North Carolina Accounting System and Division of Medical Assistance Records

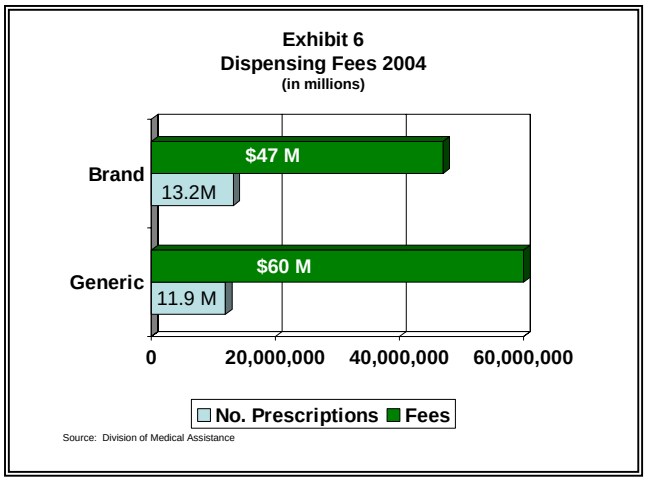
Under the terms of the Medicaid agreement the federal government has with the state, North Carolina must pay the total gross cost of prescription drugs up front, but then is reimbursed a percentage of the gross costs based on the federal financial participation rate (see discussion on page 29). For fiscal year 2004, the federal share of prescription drug costs was 65.73%, the local government share was 5.14%, leaving 29.13% at the state level as shown in Table 4.

Additionally, the federal government has negotiated a rebate from drug manufacturers[3] that is split among the federal government, local governments, and state governments at the same participation rate. Rebates have averaged 20% of the total prescription drug costs over fiscal years 2000 through 2004. These rebates are shown as a credit to the Division of Medical Assistance's general fund, but are not specifically credited against the state's share of the total prescription drug costs.

[2] *Prescription Drugs: Trends in Usual and Customary Prices for Drugs Frequently Used by Medicare and Non-Medicare Enrollees*, GAO-05-104R, United States Government Accountability Office, 2005.

[3] Federal legislation requires drug manufacturers to return rebates at a minimum of 15.1% for brand drugs and 11% for generic drugs of the total prescription drug costs.

Lastly, North Carolina legislation requires set dispensing fees be paid to pharmacies for filling prescriptions for Medicaid recipients. For fiscal year 2004, these fees were set at $4.00 per brand name prescription and $5.60 per generic prescription. Exhibit 6 shows the number of Medicaid prescriptions filled and the dispensing fees paid for generic and brand name prescriptions.



Conclusion: While the total gross costs of Medicaid prescription drugs generally have been increasing, that figure alone does not reflect the effect on state programs. There are a number of factors that play into the increasing costs, only one of which is manufacturers' increases in the price of drugs. Other factors that appear to have more impact on the total costs are related to the increasing number of recipients, the increasing number of prescriptions per recipient, and the increasing use of programs designed to keep recipients out of institutional settings.

Additionally, the "total cost of Medicaid prescription drugs" does not reflect the net cost of the drugs to the state but rather the gross costs to the state. To arrive at the net cost to the state, one must subtract the federal and local governments' reimbursements to the state for their shares of the costs. Further, the state's share of the rebates from manufacturers must be subtracted, as well as the state's share of the mandated dispensing fees paid to pharmacies. Once these factors are taken into account, the state's net total cost of Medicaid prescription drugs is approximately 21% of the total gross cost, or $312 million, for fiscal year 2004. However, the state must continue to budget the total gross costs of prescription drugs since it must pay for the drugs up front before receiving the reimbursements and rebates.

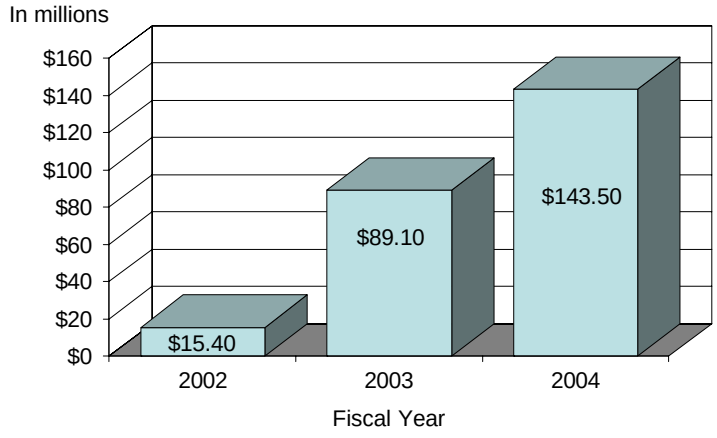
Objective 2: Cost Containment Measures

Overview: Due to continuing increases in the cost of Medicaid services, North Carolina's Division of Medical Assistance has worked to identify cost containment measures to help predict and control those costs. In addition to reviewing data on these measures, the State Auditor hosted a series of meetings with various professional and advocacy groups to discuss cost containment measures. The purpose of these meetings was to solicit input and opinions about the effectiveness of current measures and the viability of different measures being tried in other states.

Discussion of Issues:

1. North Carolina has a number of effective and innovative cost containment measures in place for the Medicaid prescription drug program. Table 5, page 12 summarizes the measures. The meetings hosted by the Auditor, combined with the review of data provided by the Division, identified a number of current measures that we believe Division and Department management should consider expanding. Those measures are highlighted in blue on Table 5. Estimated avoided expenditures for the last three fiscal years, as provided by the Division and reviewed by the audit team, are shown in Exhibit 7. In reviewing efforts in other states, we found that North Carolina is considered a leader in many of its cost containment measures.

Exhibit 7
Estimated Avoided Expenditures
From Cost Containment Measures



Source: Division of Medical Assistance

The Division is continuing to identify other innovative cost containment measures. Currently in the planning stage is an electronic quality prescription management project. The project will implement a wireless handheld drug information database service to high-prescribing Medicaid physicians. The physician will use a cellular device to gather information about each patient's medical history, identify drug therapies initiated by other providers, electronically send prescriptions to pharmacies, review pharmacies used, and identify medications filled and used by patients. The project will be a comprehensive medication management information approach directed toward primary care physicians. Currently, Florida has implemented a similar project. Mississippi will be implementing a similar project in the near future.

Table 5
Analysis of Cost Containment Measures for Medicaid Prescription Drugs
Implemented by Division of Medical Assistance

Cost Containment Measures	Description of Measures	Estimated Savings[a]	Comments/Observations
State Maximum Allowable Cost (SMAC)	Federal regulations require DMA to implement the SMAC Program for generic and multiple source brand drugs. Adequate supplies of covered drugs must be available. The SMAC drugs are priced at 150% of the lowest cost drug, and at least 20% above second lowest cost drug. When only one supplier is available the SMAC price is 20% above the cost of a generic drug.	FY 2003 -- $62.9M FY 2004 -- $66.5M FY 2005 -- $80.4M	There are currently about 450 drugs on the state's SMAC list. Changes in brand/generic status are constantly assessed by DMA's consultant. Drugs are added to the SMAC promptly once they meet criteria.
Average Wholesale Price (AWP) minus 10%	Limits prescription drugs cost to the AWP minus 10%.	Savings not quantified.	42 of 50 states require more than 10% reduction to AWP, ranging from 11% to 35%. Seven states, including North Carolina, have AWP -10% and the rate for one state is less than 10%. Pending legislation may increase North Carolina's AWP to 11%.
Prior Authorization/ Approval (PA)	Mandatory advance approval by ACS, DMA's pharmacy benefits manager, for dispensing high-cost, high-risk, and/or high-use medications. It promotes the use of cost-effective and clinically appropriate drug therapies without compromising patients' health and safety. Intended to decrease inappropriate use of medications, therapeutic duplications, medications frequently abused, medications used off-label, and expensive medications.	FY 2003 -- $12.3M	Currently there are 16 distinct medications that require prior authorization. About 18% of prior approval requests are denied. Total contract payments to ACS in 2004 were $825,879.
Generic Conversion	The General Assembly mandates that pharmacists participating in Medicaid substitute generic drugs for brand name drugs unless the prescriber specifically orders a brand name drug. The Generic Conversion program provides educational resources for physicians and pharmacists to encourage the use of less expensive generic drugs over brand name drugs when medically appropriate.	FY 2003 -- $8.2M FY 2004 -- $16.3 M	Generics are prescribed 95% of the time when a generic drug is available based on a 2004 consultant's report.[4] Of all drugs dispensed, generic prescriptions account for 48.4% in fiscal year 2004.
Prescription Limitation (6 per month)	The limit of six prescriptions per person per month was established by the General Assembly. Exceptions include: the life of the patient is threatened, certain acute illnesses or diseases, Community Alternative Programs, and persons under age 21.	Savings not quantified.	Considered by some to be outdated because many illnesses and diseases are treated with multiple drugs rather than a single drug.
Prescription Advantage List (PAL)	**A list of preferred medications developed by the NC Physicians' Advisory Group and Community Care of NC in cooperation with DMA. A voluntary effort that provides prescribers a guide for selecting less expensive medications for Medicaid recipients in the top 16 drug classes whenever possible and clinically appropriate.**	**No documented evidence of savings.**	**Touted as an alternative to preferred drug lists (PDL) because it is voluntary and therapeutically driven rather than cost-driven. Some interest groups believed that the number of drugs on the PAL should be expanded**

[4] *Generic Conversion Analysis-Results and Methodology*, Mercer Government Human Services Consulting, March 2004.

Table 5 (continued)

Cost Containment Measures	Description of Measures	Estimated Savings[a]	Comments/Observations
34-Day Supply Limit	Denies the early refill of a prescription until at least 70% of the previous refill has been consumed.	Savings not quantified.	
Reduced Dispensing Fees	Previously NC's dispensing fee was $5.60 for both brand and generic drugs. Two-tier dispensing fee implemented: Pharmacists are currently paid $5.60 for generic and selected OTC products and $4.00 for brand drugs.	FY 2002 $7 M	Twenty-four states have lower dispensing fees for brand name drugs than North Carolina. NC has the third highest dispensing fees for generic drugs. An alternative being discussed is to pay pharmacists a fee for switching medications within the two highest cost classes of drugs to the State's lower preferred price drug.
Increased Co-Payment	Two-tier co-payments: Patient co-payments are $1 for generic and selected OTC products and co-payment increased to $3 for brand name drugs.	FY 2002 -- $3.2 M FY 2003 -- $3.6 M	Lower co-pays are to encourage purchasing lower cost generic drugs. A provider may not deny services to any Medicaid patient because of the individual's inability to pay a deductible, co-insurance or co-payment amount. An individual's inability to pay shall not eliminate his or her liability for the cost sharing charge. The provider may open an account for the patient and collect the amount owed at a later date.
Over-the-Counter (OTC)	**New OTC coverage policy implemented to include non-sedating antihistamines, proton pump inhibitors, and insulin. The first two drug classes have a total of two chemical entities with 15 distinct NDC numbers.**	**Saving not quantified**	**DMA is evaluating additional classes of OTC drugs to cover under this cost-containment measure.**
90-Day Supply	Medicaid recipients can obtain a 90-day supply of a medication if the claim is for a generic, non-controlled, maintenance medication for which they have had a previous 30-day fill of the same medication. The claim must also pay at either the Federal or State Maximum Allowable Cost (MAC) rate for a 90-day supply to be allowed. If the product is deleted from the MAC list, then the recipient can only obtain a 34-day supply. This is at the sole discretion of the recipient's health care provider. Only one co-pay is collected and only one dispensing fee is paid for the 90-day supply.	Savings not quantified.	Intended to decrease pharmacy dispensing fees (one fee and one co-payment for 90 day supply), decrease waste, and promote utilization of multisource medications, and encourage generic usage.
340B	A federal program that provides discounts for selected high cost, specialty drugs. The drugs are available to safety-net providers, such as public hospitals, disproportionate share hospitals, community health centers, AIDS drug assistance programs, family planning clinics, and AIDS, TB, and SDT clinics.	247 entities are enrolled, but there is no documentation that identifies cost savings.	The number of medical facilities that can participate in this cost containment measure is controlled by federal statute. Some interest groups believe that it should be expanded to more medical facilities if they meet the eligibility guidelines.

Table 5 (continued)

Cost Containment Measures	Description of Measures	Estimated Savings[a]	Comments/Observations
Community Care of NC/ACCESS II & III (Disease Management)	**Works with primary care providers to implement a generic prescription program to educate providers on the costs of generic drugs versus brand name for certain drugs. Community Care of NC is administered by the Division of Rural Health. Fourteen medical networks (non-profit organizations) with more than 3,000 physicians are members of the program and serve approximately 620,000 Medicaid enrollees..**	**Savings not quantified.**	**These networks that have been established to improve the management of care for Medicaid recipients will plan and test specific provider-led initiatives to improve prescribing practices and the cost-effective use of prescription drugs through the (PAL) Prescription Advantage List.**
Program Integrity Reviews	Program Integrity's Pharmacy Review Section maintains the integrity of the Medicaid program for pharmacy providers by detecting, investigating, reporting, and referring Medicaid fraud and abuse. Cost saving initiatives include: (1) on-site visits to pharmacies and physicians, (2) desk audits, (3) specialized field audits, (4) use of special software to detect aberrant pharmacy providers, (5) post-payment reviews of Medicaid claims to identify inappropriate billings and overpayments, and (6) a number of newly initiated measures (line-item review of claims over $1,000, hospice post-payment reviews, post-season Synagis reviews, on-site audits of long-term care and home infusion pharmacies and working with Clinical Policy Pharmacists to implement certain initiatives).	Actual annual savings: CY 2002 -- $2.1 M CY 2003 -- $2.5 M CY 2004 -- $9.3 M	The potential savings from this cost containment measure are limited by the small number of staff available to perform the reviews.
Hospice Point of Sale Edit	Implemented 2/05. The edits prevent duplicative billing of pharmacy services if the service is eligible under the Hospice Program.	Projected annual savings of $2.4 million for FY2005.	
Nursing Home Polypharmacy Project	**Joint pilot project of drug therapy management services to reduce polypharmacy that focuses on high users of prescription drugs who have potential drug therapy problems. The UNC School of Pharmacy, CCNC/Access Care Inc., Duke University Medical Center, and the UNC Department of Pediatrics participate in the pilot. Includes 6,344 patients. The pilot resulted in prescription changes to lower cost drugs with a mean cost savings of $30.33 per patient per month for the 6,344 patients.**	**2002 cost savings estimated at $1.7 million.**	**Advocacy and professional groups thought this approach to disease management offers the possibility of significant savings based on the pilot.**

[a] Cost savings include the federal, state, and local share of the Medicaid prescription drug program. DMA's estimated savings were based on various analyses conducted for selected time periods between February 2003 and March 2005 and were the most current information that the Division could provide. Program Integrity savings are actual dollars.

Source: Division of Medical Assistance, Pharmacy Section

2. In addition to identifying cost containment measures that should be considered for expansion, the groups also helped identify areas where changes may be needed.

   □ North Carolina's Average Wholesale Price (AWP) formula does not require as much reduction in price as do most other states, as shown in Table 6. A provision in the budget bill now being debated by the General Assembly proposes raising the AWP formula for North Carolina to -11% from -10%.[5] While this would increase the amount of savings from this measure, North Carolina would still be in the bottom tier of states, paying the highest prices for prescription drugs.

Table 6
Average Wholesale Price Formulas by State

NO.	RANK	STATE	AWP BRAND	AWP GENERIC	NO.	RANK	STATE	AWP BRAND	AWP GENERIC
1	1	California	-17%	-17%	26	11	Iowa	-12%	-12%
2	2	New Hampshire	-16%	-16%	27	11	Kentucky	-12%	-12%
3	3	Florida	-15.45%	-15.45%	28	11	Maryland	-12%	-12%
4	4	Michigan	-15.1%	-15.1%	29	11	Mississippi	-12%	-12%
5	5	Arizona	-15%	-15%	30	11	New York	-12%	-12%
6	5	Maine	-15%	-15%	31	11	Oklahoma	-12%	-12%
7	5	Montana	-15%	-15%	32	11	West Virginia	-12%	-12%
8	5	Nevada	-15%	-15%	33	12	Vermont	-11.9%	-11.9%
9	5	Oregon	-15%	-15%	34	13	Minnesota	-11.5%	-11.5%
10	5	Texas	-15%	-15%	35	14	Wisconsin	-11.25%	-11.25%
11	5	Utah	-15%	-15%	36	15	Georgia	-11%	-11%
12	6	Arkansas	-14%	-20%	37	15	Nebraska	-11%	-11%
13	6	Delaware	-14%	-14%	38	15	Wyoming	-11%	-11%
14	6	New Mexico	-14%	-14%	39	16	Hawaii	-10.5%	-10.5%
15	6	Washington	-14%	-50%	40	16	South Dakota	-10.5%	-10.5%
16	7	Colorado	-13.5%	-35%	41	17	Missouri	-10.43%	-10.43%
17	7	Indiana	-13.5%	-20%	42	18	Virginia	-10.25%	-10.25%
18	7	Louisiana	-13.5%	-13.5%	43	19	Alabama	-10%	-10%
19	8	Kansas	-13%	-27%	**44**	**19**	**North Carolina**	**-10%**	**-10%**
20	8	Tennessee	-13%	-13%	45	19	North Dakota	-10%	-10%
21	9	Ohio	-12.8%	-12.8%	46	19	Pennsylvania	-10%	-10%
22	10	New Jersey	-12.5%	-12.5%	47	19	South Carolina	-10%	-10%
23	11	Connecticut	-12%	-40%	48	20	Alaska	-5%	-5%
24	11	Idaho	-12%	-12%	49	N/A	Massachusetts	N/A	N/A
25	11	Illinois	-12%	-25%	50	N/A	Rhode Island	N/A	N/A

Source: Centers for Medicare and Medicaid Services (CMS)

[5] This provision was included in the budget bill as of May 4, 2005, but no final bill had been approved at the time of this writing.

- Dispensing fees in North Carolina are the third highest in the nation for generics, as shown in Table 7. The average is $4.07 for brand and $4.22 for generic. Currently, dispensing fees are set by legislation.[6]

Table 7
Dispensing Fees by State

NO.	RANK	STATE	DISPENSING FEE BRAND	DISPENSING FEE GENERIC	NO.	RANK	STATE	DISPENSING FEE BRAND	DISPENSING FEE GENERIC
1	1	California	$7.25	$7.25	26	24	Missouri	$4.09	$4.09
2	2	Louisiana	$5.77	$5.77	27	25	South Carolina	$4.05	$4.05
3	**3**	**North Carolina**	**$4.00**	**$5.60**	28	26	Colorado	$4.00	$4.00
4	3	North Dakota	$4.60	$5.60	29	26	Pennsylvania	$4.00	$4.00
5	4	Arkansas	$5.51	$5.51	30	27	Mississippi	$3.91	$3.91
6	5	Alabama	$5.40	$5.40	31	28	Utah	$3.90	$3.90
7	6	Washington	$5.20	$5.20	32	28	West Virginia	$3.90	$3.90
8	7	Texas	$5.14	$5.14	33	29	Virginia	$3.75	$3.75
9	8	Georgia	$4.63	$5.13	34	30	New Jersey	$3.73	$3.73
10	9	Massachusetts	$3.50	$5.00	35	31	Ohio	$3.70	$3.70
11	9	Wyoming	$5.00	$5.00	36	32	Maryland	$2.69	$3.69
12	10	Idaho	$4.94	$4.94	37	33	Delaware	$3.65	$3.65
13	11	Indiana	$4.90	$4.90	38	33	Minnesota	$3.65	$3.65
14	12	Wisconsin	$4.88	$4.88	39	33	New Mexico	$3.65	$3.65
15	13	Nevada	$4.76	$4.76	40	34	Connecticut	$3.60	$3.60
16	14	South Dakota	$4.75	$4.75	41	35	Oregon	$3.50	$3.50
17	15	Montana	$4.70	$4.70	42	36	Alaska	$3.45	$3.45
18	16	Hawaii	$4.67	$4.67	43	37	Kansas	$3.40	$3.40
19	17	Illinois	$3.40	$4.60	44	37	Rhode Island	$3.40	$3.40
20	18	Kentucky	$4.51	$4.51	45	38	Maine	$3.35	$3.35
21	19	New York	$3.50	$4.50	46	39	Nebraska	$3.27	$3.27
22	20	Iowa	$4.26	$4.26	47	40	Michigan	$2.50	$2.50
23	21	Vermont	$4.25	$4.25	48	40	Tennessee	$2.50	$2.50
24	22	Florida	$4.23	$4.23	49	41	Arizona	$2.00	$2.00
25	23	Oklahoma	$4.15	$4.15	50	42	New Hampshire	$1.75	$1.75
							Average	$4.07	$4.22

Source: Centers for Medicare and Medicaid Services

- Co-pays may be marginally effective. Medicaid recipients' co-pays are $1 for generics and $3 for brand name drugs. The state pays the co-payment for certain exempt groups.[7] In 2004, the state paid co-payments of $23.9 million for brand name drugs and $7.5 million for generic drugs.

- Approximately 82% of prior authorization calls are initially approved. Data supplied by the division shows that all of the initially denied requests that are appealed are approved by the contractor, bringing the total approval rate to 88%. Table 8, page 17. The average cost of each prior authorization call is $18. Thus, this cost containment measure may no longer be cost beneficial. The prior authorization process is managed by a contracted pharmacy benefits manager, Affiliated Computer Services (ACS). For SFY 2004, North Carolina paid ACS $825,879 for this program.

[6] Session Law 2004-124, House Bill 1414, Section 10.19.(a) (5)

[7] These groups are: 1) Recipients under 21 years of age; 2) Recipients who reside in a nursing home facility, intermediate care facility for individuals with mental retardation (ICR/MR) or a mental health hospital (adult care homes and hospice patients are responsible for co-payment); 3) Recipients who are pregnant; 4) Drugs that are classified as family planning (birth control medications); and, 5) Recipients that are classified as Community Alternatives Program (CAP) recipients.

Table 8
Prior Authorizations for Medicaid Prescription Drugs

Drug/Category	Total Requests	Denied	Percent Denied	Appealed	Percent Appealed	Appealed Denials Overturned *
Vioxx/Celebrex/Bextra	23,534	5,585	23.7%	1,444	25.9%	100%
Synagis	5,704	671	11.8%	137	20.4%	100%
Zyban/Nicotrol/Halbitrol	3,098	52	1.7%	5	9.6%	100%
Oxycontin	15,257	1,901	12.5%	830	43.7%	100%
ADHD Drugs	2,603	496	19.1%	214	43.1%	100%
Provigil	1,005	520	51.7%	230	44.2%	100%
TOTALS	**51,201**	**9,225**	**18.0%**	**2,860**	**31.0%**	

* Federal regulations require Medicaid agencies to dispense any FDA approved drug. Social Security Act, Section 1927 [42 U.S.C. 1396r-8]

Source: DMA statistical reports as of 2003 (Most recent available information.)

3. Other states are using different cost containment measures related to overall medical costs, not necessarily directed at the prescription drug program, as shown in Table 9, page 18. North Carolina may want to consider whether any of these measures would be effective for the prescription drug program.

Table 9
Other States' Cost Containment Measures for Medical Expenses

STATE	PDL			Supp. Rebates			Reimbursement Formula					Dispensing Fees					Co-Payment				MAC Program		Fail First/Step Therapy Programs[1]			Dispensing Limits[1]		
									Description					Description														
	Operating	Enacted (Law or Reg)/Pending	No	Established	Legislation Passed	No	Yes	No	AWP	WAC	Other	Yes	No	Brand	Generic	Other	Yes	No	Amount	Other	Yes	No	Yes	No	Other	Yes	No	Other
Alabama	1			1			1				AWP-10% or WAC+9.2%	1		$5.40			1		$0.50-$3.00	Depending on cost of drug	1				Did not respond to survey			Did not respond to survey
Alaska	1			1			1		-5%			1		$3.45 - $11.46 (based on pharmacy/medicaid volume)			1		$2.00			1	1			1		
Arizona			1			1	1		-15%			1		$2.00				1	N/A			1		1		1			
Arkansas			1			1	1		-14% (Brand); -20% (generic)			1		$5.51	$2.00 (non MAC'd Generics)		1		$0.50-$3.00	Depending on cost of drug	1		1			1		
California	1					1	1		-17%			1		$7.25; $8.00 (Skilled nursing & IC facilities)			1		$1.00		1		1			1		
Colorado		1				1	1		-13.5% (Brand) - 35% (Generic)			1		$4.00 (retail pharmacy); $1.89 (institutional pharmacy)			1		$3.00 (Brand) $0.75 (Generic)		1			1		1		
Connecticut		1				1	1		-12% (Brand) -40% (Generic)			1		$3.15			1		$1.00		1			1		1		
Delaware			1			1	1		-14% (traditional-retail independent & chain) - 16% (non-traditional-LTC & speciality pharmacies)			1		$3.65				1	N/A		1		1			1		
District of Columbia			1			1	1		-10%			1		$4.50			1		$1.00			1	1			1		
Florida	1			1			1				AWP-15.4% or WAC+5.75%, or state MAC or federal MAC or the usual & customary	1		$4.23			1		2.5% of payment up to $300		1			1		1		
Georgia	1			1			1				AWP-11% or most favored price	1		$4.63 (for profit pharm.) $4.33 (not for profit pharm)	$5.13 (for profit pharm.) $4.63 (not for profit pharm)		1		$0.50 (Generic or Preferred brand) $3.00 (All others based on ingredient cost)		1			1		1		

REVIEW RESULTS

Table 9 Continued

STATE	PDL			Supp. Rebates			Reimbursement Formula					Dispensing Fees					Co-Payment				MAC Program		Fail First/Step Therapy Programs[1]			Dispensing Limits[1]		
							Yes	No	Description			Yes	No	Description			Yes	No	Amount	Other	Yes	No	Yes	No	Other	Yes	No	Other
	Operating	Enacted (Law or Reg)/Pending	No	Established	Legislation Passed	No			AWP	WAC	Other			Brand	Generic	Other												
Hawaii		1				1	1		-10.50%			1		$4.67				1	N/A		1		1			1		
Idaho	1			1			1				Lower AWP-12%, SMAC, FUL or U&C	1				$4.94; $5.54 For Unit Dose		1	N/A		1		1			1		
Illinois	1			1			1		-12% (Brand) -25% (Generic)			1		$3.40	$4.60		1		$0.00 (Generic) $3.00 (Brand)		1		1			1		
Indiana	1			1			1		-13.5% (Brand) - 20% (Generic)			1		$4.90			1		$3.00		1				Did not respond to survey			Did not respond to survey
Iowa		1		1			1		-12%			1		$4.26			1		$1.00 (Generic) $0.50-$3.00 (Brand depending on cost of the drug)		1		1			1		
Kansas	1					1	1		-13% (Brand) -27% (Generic)			1		$3.40			1		$3.00		1			1		1		
Kentucky	1					1	1		-12%			1		$4.51			1		$1.00		1		1			1		
Louisiana	1			1			1		-13.5% (Independent pharmacies); -15% (Chain Pharmacies)			1		$5.77			1		$0.50-$3.00 depending on cost of drug		1			1		1		
Maine	1			1			1		-15%			1				$3.35; $4.35 & $5.35 (compounding); $12.50 (insulin syringe)	1		$2.50 (Generic & Brand) Not to exceed $25 per mo.		1		1			1		
Maryland	1			1			1				Lower of AWP -12% or WAC+8% or Direct Price +8% or distributor price +8% when available	1		2.69 $3.69 (Nursing Home)	$3.69 PDL & Generic $4.69 (Nursing Home)	$7.25 (home IV therapy)	1		$1.00 (Generic) $2.00 (Brand)		1			1		1		

REVIEW RESULTS

Table 9 Continued

STATE	PDL			Supp. Rebates			Reimbursement Formula					Dispensing Fees				Co-Payment				MAC Program		Fail First/Step Therapy Programs[1]			Dispensing Limits[1]		
							Yes	No	Description			Yes	No	Description													
	Operating	Enacted (Law or Reg)/Pending	No	Established	Legislation Passed	No			AWP	WAC	Other			Brand	Generic	Other	Yes	No	Amount	Other	Yes	No	Yes	No	Other	Yes	No	Other
Massachusetts	1					1	1				WAC+%5 (equates to approx. AWP -16% for Brands)	1		$3.50	$5.00		1		$1.00 (Generic & non-legend OTC) $3.00 (Brand)	Co-pay cap of $200 per member year	1		1			1		
Michigan	1			1			1		-13.5% (Independent pharmacies); -15.1% (Chain Pharmacies >5 stores)			1		$3.77			1		$1.00		1		1			1		
Minnesota		1		1			1		-11.00%			1		$3.65				1	N/A		1		1			1		
Mississippi	1			1			1		-12%			1		$3.91			1		$1.00 (Generic) $2.00 (Brand on PDL) $3.00 (Brand)			1	1			1		
Missouri		1		1			1				Lower AWP-10.43% or WAC+10%	1		$4.09			1		$0.50-$2.00 (depending on cost of drug)		1		1			1		
Montana	1			1			1		-15%			1		$4.70			1		$1.00			1	1			1		
Nebraska			1			1	1		-11%			1		$3.27-$5.00 (based on service delivery or 3rd. Party payors)			1		$2.00		1		1			1		
Nevada		1		1			1		-15%			1		$4.76			1		$1.00 (Generic) $2.00 (Brand)			1			Did not respond to survey			Did not respond to survey
New Hampshire		1				1	1		-16%			1		$1.75			1		$1.00 (Generic) $2.00 (Brand & Compound)		1		1			1		
New Jersey			1			1	1		-12.50%			1		$3.73 (Additional services)	$4.07			1	N/A			1	1			1		
New Mexico		1				1	1		-14%			1		$3.65				1	N/A		1			1		1		
New York		**See Note***	1			1	1		-12.%			1		$3.50	$4.50		1		$0.50 (Generic) $2.00 (Brand)			1		1		1		
North Carolina		**See Note***	1			1	1		-10%			1		$4.00	$5.60	$0 for refills within same month	1		$1.00 (Generic) $3.00 (Brand)		1			1		1		
North Dakota			1			1	1		-10%			1		$4.60	$5.60		1		$3.00 (Brand)		1			1		1		
Ohio	1			1			1			+9%	Lower of AWP -12.8% or WAC + 9%	1		$3.70			1		$3.00 for non PDL drugs		1				Did not respond to survey			Did not respond to survey
Oklahoma	1			1			1		-12%			1		$4.15			1		$1.00 to $2.00 (depending on cost of Rx)		1		1			1		

REVIEW RESULTS

Table 9 Continued

STATE	PDL			Supp. Rebates			Reimbursement Formula					Dispensing Fees					Co-Payment				MAC Program		Fail First/Step Therapy Programs[1]			Dispensing Limits[1]		
							Yes	No	Description			Yes	No	Description			Yes	No	Amount	Other	Yes	No	Yes	No	Other	Yes	No	Other
	Operating	Enacted (Law or Reg)/Pending	No	Established	Legislation Passed	No			AWP	WAC	Other			Brand	Generic	Other												
Oregon	1			1			1		-15% (Retail) -11% (Institutional)			1		$3.50 (retail) $3.91 (institutional)			1		$2.00 (Generic) $3.00 (Brand)		1				Did not respond to survey			Did not respond to survey
Pennsylvania		1				1	1		-10%			1		$4.00			1		$1.00		1		1			1		
Rhode Island			1			1	1			+5%		1		$3.40 (outpatient) $2.85 (LTC)				1	N/A			1			Did not respond to survey			Did not respond to survey
South Carolina		1		1			1		-10%			1		$4.05 (independent pharm) $3.15 (institutional)			1		$3.00		1		1			1		
South Dakota			1			1	1		-10.50%			1		$4.75 ($5.55 for unit dose)			1		$2.00		1			1		1		
Tennessee	1			1			1		-13%			1		$2.50 (LTC & ambulatory) $5.00 (NH only-if 28 days+)				1	N/A		1				Did not respond to survey			Did not respond to survey
Texas	1			1			1				AWP-15% or WAC+12%	1		$5.14		Variable add on		1	N/A		1			1		1		
Utah		**See Note***	1			1	1		-15%			1				$3.90 Urban; $4.40 Rural	1		$3.00		1		1			1		
Vermont	1			1			1		-15%			1		$4.25			1		$1.00 to $3.00 (depending on cost of Rx)		1		1				1	
Virginia	1					1	1		-10.25%			1		$3.75/$5.00 (unit dose drugs)			1		$1.00		1		1			1		
Washington	1			1			1		-14% (Brand) -50% (if>4 mfg)-19% (brand-mail order) -15% (generic mail order)			1		$4.20-$5.20 (based on 3-tiered pharmacy volume); $3.25 (mail order)				1	N/A		1		1			1		
West Virginia	1			1			1		-12%			1		$3.90 (plus $1.00 for compounding)			1		$0.50 to $3.00 (depending on cost of Rx)			1	1			1		
Wisconsin		1		1			1		-11.25%			1		$4.88			1		$0.50 (OTC); $3.00 (brand) $1.00 (generic)		1			1		1		
Wyoming		**See Note***	1			1	1		-11%			1		$5.00			1		$2.00			1			Did not respond to survey			Did not respond to survey
Totals	26	12	13	27		24	51	0				51	0				40	11			40	11	28	15		42	1	

* Medicaid PDL plan not final. May be delayed or blocked.

1 States that have a fail first program of some kind (per Kaiser Commission's Medicaid Outpatient Prescription Drug Benefit: Findings from a National Survey, 2003)

Source: Compiled by OSA from data obtained on states' web pages.

Conclusions: The North Carolina Division of Medical Assistance has been proactive in identifying and implementing effective cost containment measures for the Medicaid prescription drug program. Several of the Division's initiatives are innovative and other states are developing initiatives based on North Carolina's. While it is difficult to isolate and quantify the effects of some of the measures, those that can be isolated are estimated to have already avoided costs for the state of almost $250 million since fiscal year 2002. As these measures are refined and expanded, those savings can be expected to increase.

Professional and advocacy groups with specific knowledge about the prescription drug program identified several cost containment measures that they felt should be considered for expansion. Those included the Prescription Advantage List, coverage for more over-the-counter drugs, and increased emphasis on disease management programs that included attention to prescription drugs.

Those groups also identified a number of measures that they felt were not effective as currently structured. Those included: North Carolina's average wholesale price formula, the current level set for dispensing fees, and the current level of co-payments. The groups also questioned the cost benefits of the prior authorization program given its approval rate of almost 90%.

APPENDICES

APPENDICES

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APPENDICES

APPENDIX A
Objectives, Scope, And Methodology

North Carolina General Statute 147-64 empowers the State Auditor with authority to conduct performance audits or reviews of any state agency or program, as well as local entities receiving State and federal funds. *Performance audits* are reviews of activities and operations to determine whether resources are being used economically, efficiently, and effectively. *Performance reviews* are more limited in scope, generally identifying major issues surrounding a broad topic that require further study and / or more resources than are available at the time and generally include conclusions, but not detailed findings and recommendations.

This performance review of Medicaid Prescription Drug Costs within North Carolina was undertaken at the discretion of the State Auditor. The State Auditor determined that there was a need to review the issues surrounding the rising costs of prescription drugs in the Medicaid program. These costs account for approximately 20% of the total Medicaid costs to the state. Additionally, the prescription drug program is one of the approved optional Medicaid programs.

The objectives identified by staff were to determine:

1. Why are Medicaid prescription drug costs increasing?
2. Are cost containment measures initiated by the Division of Medical Assistance effective?

During February through April 2005, we conducted on-site work at the Department of Health and Human Services, Division of Medical Assistance. The scope included the Medicaid prescription drug program for fiscal years 2000 to 2004. To answer the initial questions, we employed various techniques, which adhere to the generally accepted standards as promulgated in *Government Auditing Standards* issued by the Comptroller General of the United States. These techniques included:

- Review of existing General Statutes, federal laws, and North Carolina Administrative Codes as they relate to the Medicaid prescription drug program;
- Review of the Division's internal polices and procedures;
- Review of existing audits and reports related to the Medicaid prescription drug program and Medicaid costs in general;
- Review and analysis of prescription drug financial data;
- Interviews with key personnel within the Department of Health and Human Services and the Division of Medical Assistance;
- Review of data on other states' Medicaid prescription drug programs; and
- Meetings with various advocacy groups and professional associations to discuss services offered. Groups included: North Carolina Association of Pharmacists, North Carolina Retail Merchants Association, North Carolina Medical Society, North Carolina

Pharmaceutical Research and Manufacturers, National Association of Mentally Ill, Coalition 2001, and the Mental Health Association in North Carolina.

APPENDIX B
PROGRAM OVERVIEW

Background: Medicaid is a federally-aided, state operated and administered program that provides medical benefits to low income people who are aged, blind, disabled, or members of families with dependent children. The program, authorized by Title XIX of the Social Security Act, requires states to provide certain medical services and permits them to provide other services, such as *prescription drugs* on an optional basis. Appendix C, page 33 contains a listing of the mandatory and optional services for North Carolina. Under the terms of the Medicaid agreement, North Carolina must pay for all Medicaid services upfront and then is reimbursed a pre-determined percentage by the federal government and by local governments. (See "Budget and Funding" below.)

Program Goals: The mission of the Division of Medical Assistance is to manage the Medicaid program efficiently so that cost effective health care services are available through enrolled providers to all eligible persons across the state. While the Division does not have written goals for the prescription drug program, their stated goals are:

- Assist low income citizens in obtaining appropriate drugs at a reasonable price to improve the quality of their lives;
- Through appropriate drug therapies, keep persons with severe diseases out of institutional settings and thereby reduce institutional costs to the state.

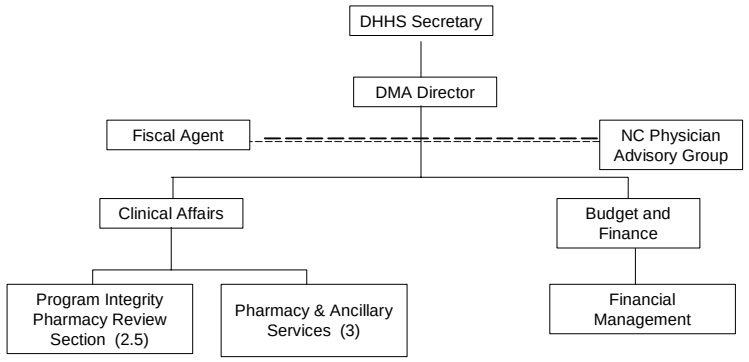
Administration: Federal oversight is the responsibility of the Center for Medicare and Medicaid Services. The North Carolina Division of Medical Assistance is responsible for the overall management of the Medicaid program, including the prescription drug program. Currently, the Pharmacy Program staff consists of a section chief, an office assistant, and two clinical pharmacists who manage the pharmacy program with direction from the Medical Director and the Deputy Director for Clinical Affairs. Other sections within the Division, such as Program Integrity and Rate Setting, also have duties related to the prescription drug program. See Exhibit 8 page 28 for the organization chart.

North Carolina Physicians Advisory Group--This group is an arm of the North Carolina Medical Society and is made up of volunteer physicians, dentists, pharmacists, and an array of other health care professionals. The scope of the group's clinical policy development review covers the review of procedure definitions, product or service reimbursement, and recipient eligibility.

The group works with Division staff to ensure that medical coverage policies are based on national standards or Department-defined best practices, and evidence-based standards. Once the group completes a policy review, it submits recommendations to the Division. Exhibit 9 shows the process and timeline for policy reviews.

APPENDICES

EXHIBIT 8
Division of Medical Assistance
Organizational Chart as of May 2005



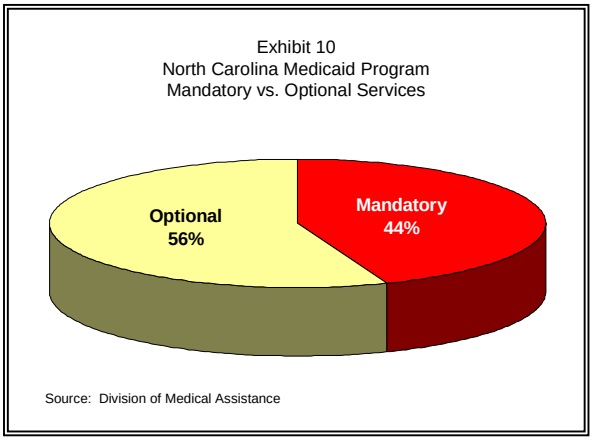
Source: Division of Medical Assistance

Exhibit 9
Time Frame for Processing New and Amended Medical Coverage Policies

Procedures	Timeline
1. DMA Medical Policy initiates, researches, and makes recommendations on medical policy issues	20* – 90 days. *20 days reflects a full time resource dedicated to this process and is the exception
2. Physician Advisory Group of the NC Medical Board or other entity reviews and comments.	2 – 4 weeks
3. DMA Financial Operations performs Fiscal Impact Analysis	2 weeks
4. DHHS reviews and comments on policy and fiscal impact.	2 weeks – 2 months
5. DMA Division Director approves or disapproves recommendations.	1 – 2 weeks
6. DMA notifies providers about new or revised medical coverage policy.	45 days
7. DMA posts policy on website for provider comments	
8. DMA Medical Policy review provider comments and amends policy if necessary	2 weeks
9. DMA Medical Policy re-posts policy on website, if amended.	15 days
10. DMA Medical Policy reviews provider comments and amends policy if necessary	2 – 4 weeks
11. DMA initiates numbered memo to direct EDS to perform file maintenance (2 week average) or CSR (6 month average)	2 weeks to 6 months
12. DMA posts policy on website.	2 months
13. DMA Medical Policy generates Medicaid Bulletin article.	
Total Timeframe	7.5 – 18 months

Source: DMA Report to the Senate and House Appropriations Committee and to Fiscal Research Division dated 2/1/2002 entitled Medicaid Program Management, Attachment II.

Annual reports on the state's entire Medicaid program can be found on the Division's web site http://www.dhhs.state.nc.us/dma/ . These reports detail the various programs, achievements, and expenditures, including information on the Medicaid prescription drug program.



Budget and Funding: The total Medicaid expenditures for services for North Carolina for fiscal year 2004 were $7.3 billion.[1] Appendix C page 33 contains a detailed breakdown of mandatory and optional services. Total optional service expenditures under Medicaid were approximately 56% or $4.1 billion of the total Medicaid service expenditures. Exhibit 10. The gross prescription drug costs were approximately 20% ($1.4 billion) of the total Medicaid expenditures for services in 2004. Under terms of the Medicaid agreement, the state must pay these costs up front and then is reimbursed by the federal government and local governments.

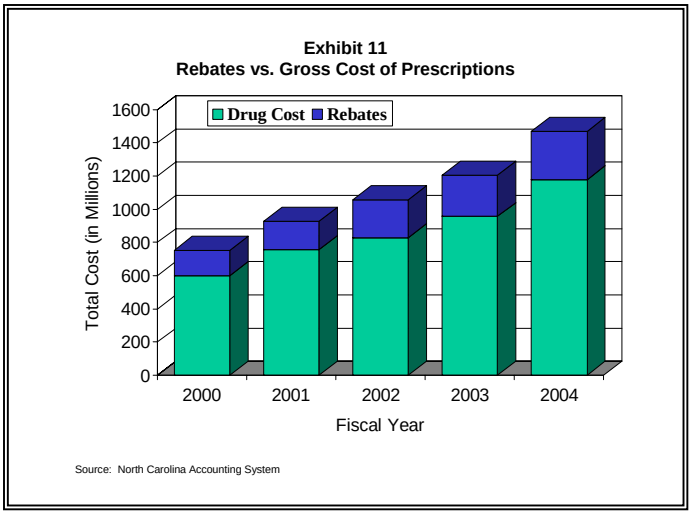
The estimated Federal Financial Participation rate determines the federal, state, and county shares of the Medicaid program. Table 10 shows the computed rate for fiscal years 2000 through 2004.

Table 10
Federal Financial Participation Rate

Fiscal Year	Federal Share	State Share	County Share
2000	62.63%	31.75%	5.60%
2001	62.47%	31.89%	5.63%
2002	61.71%	32.54%	5.74%
2003	63.02%	31.43%	5.55%
2004	65.73%	29.13%	5.14%

Source: Division of Medical Assistance

Additionally, the state participates in the prescription drug rebate program established at the federal level. As shown in Exhibit 11, rebates have averaged 21% ($218.6 million annually) of the total gross price for prescription drugs for fiscal years 2000-2004.[2] The distribution of rebates is the same ratio as the federal financial participation rate.



[1] Does not include various administrative and other non-service expenditures of $1.1 billion. See Appendix C, page 33.

[2] The division is working to identify rebates from injectable drugs under the Physician Drug Program. See Appendix F, page 41.

General Observations: There are two significant changes facing North Carolina's Medicaid program within the next few years, the second pending approval by the North Carolina General Assembly. We briefly describe those below.

1. The Federal Medicare Prescription Drug Improvement and Modernization Act of 2003 Part D program will begin paying for the prescription drug costs of all recipients who are eligible for both Medicaid and Medicare (dual eligibles) beginning January 1, 2006. This will affect recipients who are age 65 and over and disabled individuals who also qualify for Medicaid benefits. The North Carolina Medicaid program will no longer be responsible for paying directly for the prescription drug costs for these dual eligible individuals. The state will be responsible for making monthly payments to the federal government beginning in January 2006 to defray a portion of the Medicare drug expenditures for these individuals. These monthly payments are popularly known as the "clawback." The statutory term is "phased-down state contribution." If the state continued to pay for outpatient prescription drugs through Medicaid on behalf of dual eligible recipients, then the amount of the state's payment, or "clawback," would roughly reflect the expenditures of its own funds that the state would make.

   Table 11 shows the Division's preliminary calculation for the state's portion of the prescription drug costs for the dual eligibles for 2006. Based on this data, the effect of the Act will be to reduce the state's gross Medicaid prescription drug costs by 10% for 2006.

Table 11
Calculation of State's Share of the Dual Eligibles' Prescription Drug Cost

2003 Count	
Total Number of Dual Eligibles	221,292
Total Drug Costs for Dual Eligibles	$671,007,646
Gross Average per Dual Eligibles	$3,032
Baseline Calculations	
Gross Average per Dual from above	$3,032
Assume 21% Rebate reduction	($637)
Net Average per Dual	$2,395
Estimated Reimbursement for 2005	
Reduce net average dual cost per capita to non-Fed share (36.37%)	$871
Adjust above for inflation (use 38.3%)	$1,205
Assume dual eligibles # increase 4%	230,144
Adjusted Average per capita dual eligible	$277,302,242
Reimbursement @ 90% of above [3]	$249,572,018
State share @ 85%	$212,136,215
County share @ 15%	$37,435,803

Source: Division of Medical Assistance

[3] North Carolina Senate Bill 622 Section 10.29 introduced in March 2005 requires the State to pay 85% and the county to pay 15% of the federal Medicare Part D reimbursement payment.

2. **County Share Phase-Out of the Medicaid Program--** Under current state law, county governments pay 15% of the non-federal share of the North Carolina Medicaid program and the state pays the rest of the non-federal share. Legislation introduced in both the House and Senate contains measures to phase out the counties' responsibility of the non-federal share of total Medicaid costs over a five-year period. (Table 12) This legislation was based on the report to the North Carolina General Assembly from the 2005 Blue Ribbon Commission on Medicaid Reform.[4] Table 13 shows the Commission's estimated effect on state and county costs. As of May 6, 2005, this legislation was still pending with different versions in the House and Senate.[5]

Table 12
Proposed County Phase-Out Schedule from Medicaid Payments

Fiscal Year	Percent	Fiscal Year	Percent
2005	15%	2008	6%
2006	12%	2009	3%
2007	9%	2010	0%

Source: *2005 Blue Ribbon Commission Report on Medicaid Reform*

Table 13
Estimated Effect of County Phase- Out on State Costs of Prescription Drugs

Fiscal Year	Projected Total Medicaid Expenditures	Projected Total Medicaid County Share	County Share of Prescription Drugs Cost Shift to State*
2005	$ 8,172,113,335	$ 448,159,792	$ 89,631,958
2006	8,923,969,602	490,327,510	98,065,502
2007	9,744,974,805	539,238,181	107,847,636
2008	10,631,767,512	591,338,909	118,267,782
2009	11,588,626,589	648,905,146	129,781,029
2010	12,608,425,728	710,926,085	142,185,217

Source: *2005 Blue Ribbon Commission Report on Medicaid Reform*

* Assuming prescription drugs remain 20% of total Medicaid expenses based on 2004 data from DMA

For the prescription drug program under Medicaid, the counties' share of costs for all prescription drug expenditures in fiscal year 2004 was approximately $76.1 million. The county share phase-out over the five-year period would result in cost shifting as shown in Table 11 from the county budget to the state budget. Table 11 assumes the projections for total Medicaid expenditures are realistic and the prescription drug costs remain approximately 20% of total Medicaid services: However, as noted above, the Medicare Prescription Drug Improvement and Modernization Act of 2003 should result in changes to the total gross prescription drug costs under Medicaid.

[4]The Blue Ribbon Commission on Medicaid Reform, February 2005, Final Report to the 2005 General Assembly of North Carolina.

[5]Appendix G page 43 lists all pending legislation.

APPENDICES

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APPENDIX C
BREAKDOWN OF MANDATORY VERSUS OPTIONAL SERVICES

Medicaid Eligibility by Mandatory and Optional Groupings	
Mandatory	**Optional**
• Low Income Families and Children (Based on the AFDC State Plan as of 7/16/96 • Transitional Medicaid • 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 • Refugees and Aliens • Certain Medicare Recipients: Dual Eligibles Qualified Medicare Beneficiaries Specified Low-Income Medicare Beneficiaries Qualified Disabled and Working Individuals	• 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)
FPL is the Federal Poverty Level	
Covered Services	
Mandatory	**Optional**
• Inpatient Hospital Services • Outpatient Hospital Services • Physicians • Health Check Services (EPSDT) • Family Planning Service • Federally Qualified Health Centers • Home Health Services (includes Durable Medical Equipment) • Hearing Aids • Laboratory & X-Ray Services • Nurse Midwives • Nurse Practitioners • Nursing Facilities • Prenatal Clinic • Rural Health Clinics • Specialty Hospitals • Transportation • Vaccines for Children	• Prescription Drugs • Intermediate Care Facilities for the Mentally Retarded (ICF-MR) • Rehabilitation Services (Mental Health) • Optometrists • Personal Care Services • Podiatrists • Prosthetics and Orthotics • Private Duty Nursing Services • Occupational, Physical, and Speech Therapies • Inpatient Psychiatric Care (Under age 21) • Mental Hospitals (Age 65 and over) • Hospice • Emergency Hospital Services • Eyeglasses • Diagnostic, Screening, Preventive Services • Dental Care Services • Community Alternative Programs (CAP) • Clinics Services • Chiropractors • Targeted Case Management Services • Ambulance Transportation
Source: North Carolina Fiscal Research Division, February 2005	

APPENDIX C Continued
ANALYSIS OF MANDATORY VS. OPTIONAL MEDICAID SERVICES

MAN-DA-TORY (M) or OPTIONAL (O)	DESCRIPTION	NET PAID 2004	MANDATORY ELIGIBLE[1]/ MANDATORY SERVICE[2]		MANDATORY ELIGIBLE[1] OPTIONAL SERVICE[2]		OPTIONAL ELIGIBLE[1]/ MANDATORY SERVICE[2]		OPTIONAL ELIGIBLE[1]/ OPTIONAL SERVICE[2]	
			NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID
M/O	ACH-PCS BASIC	$123,241,429	$488,438	0.40%	$58,701,272	47.63%	$67,289	0.05%	$63,984,429	51.92%
M/O	ACH-PCS-ENHANCED	$8,910,656	$6,683	0.07%	$3,880,175	43.55%	$150	0.00%	$5,023,648	56.38%
M/O	ACH- TRANSPORTATION	$4,465,010	$17,899	0.40%	$2,136,860	47.86%	$2,428	0.05%	$2,307,823	51.69%
M/O	AMBULANCE	$13,372,825	$3,061,768	22.90%	$6,505,699	48.65%	$189,350	1.42%	$3,616,008	27.04%
M	AMBULATORY SURG CENTER	$6,538,804	$5,573,131	85.23%	$0	0.00%	$965,673	14.77%	$0	0.00%
M/O	CAP-AIDS	$1,384,326	$740,108	53.46%	$45,297	3.27%	$519,176	37.50%	$79,745	5.76%
M	CAP-CHILDREN	$25,057,381	$9,743,340	38.88%	$0	0.00%	$15,314,041	61.12%	$0	0.00%
MID	CAP-DISABLED	$200,854,722	$94,757,340	47.18%	$5,326,908	2.65%	$92,036,820	45.82%	$8,733,655	4.35%
M/O	CAP-MENTALLY RETARDED	$264,897,575	$55,989,781	21.14%	$122,679,643	46.31%	$47,477,938	17.92%	$38,750,213	14.63%
M/O	CASE MANAGEMENT-FSO	$9,946,981	$6,643,391	66.79%	$2,486,087	24.99%	$33,995	0.34%	$783,508	7.88%
M	CASE MANAGEMENT-HIV	$6,904,369	$4,912,827	71.16%	$0	0.00%	$1,991,542	28.84%	$0	0.00%
M	CASE MANAGEMENT-NFP	$45,937	$45,644	99.36%	$0	0.00%	$293	0.64%	$0	0.00%
M/O	CHIROPRACTIC	$2,024,724	$603,114	29.79%	$1,167,967	57.69%	$100,869	4.98%	$152,775	7.55%
M	Clinics-DHS IMMUNIZATIONS	$3,883	$3,620	93.23%	$0	0.00%	$263	6.77%	$0	0.00%
M/O	CLiNICS-FQHC,CORE&AMBULA T	$19,368,023	$15,967,324	82.44%	$1,362,906	7.04%	$1,985,654	10.25%	$52,139	0.27%
M/O	CLINICS-FREE STANDING	$22,255,769	$8,193,538	36.82%	$7,809,910	35.09%	$4,860,340	21.84%	$1,391,982	6.25%
M/O	CLINICS-HEALTH DEPT	$46,577,569	$26,530,477	56.96%	$19,075,464	40.95%	$415,264	0.89%	$556,364	1.19%
M/O	CLINICS-MENTAL HEALTH	$482,858,231	$315,510,344	65.34%	$118,093,623	24.46%	$7,115,124	1.47%	$42,139,140	8.73%
M/O	CLINICS-RURAL HEALTH	$15,718,506	$12,752,178	81.13%	$1,086,200	6.91%	$1,812,612	11.53%	$67,515	0.43%
M/O	DENTAL	$174,173,338	$104,070,480	59.75%	$50,201,125	28.82%	$1,777,567	1.02%	$18,124,167	10.41%
M	DURABLE MEDICAL EQUIPMENT	$63,153,976	$48,479,891	76.76%	$0	0.00%	$14,674,085	23.24%	$0	0.00%
M	FAMILY PLAN-DRUGS	$10,629,730	$10,018,670	94.25%	$0	0.00%	$611,060	5.75%	$0	0.00%
M	FAMILY PLAN-FQHC	$138,706	$131,541	94.83%	$0	0.00%	$7,165	5.17%	$0	0.00%
M	FAMILY PLAN-FREE STANDING	$2,570	$2,260	87.92%	$0	0.00%	$310	12.08%	$0	0.00%
M/O	FAMILY PLAN-HEALTH DEPT	$5,821,425	$5,608,205	96.34%	$1,494	0.03%	$211,726	3.64%	$0	0.00%
M	FAMILY PLAN-HaSP INPT	$1,478	$1,478	100.00%	$0	0.00%	$0	0.00%	$0	0.00%
M	FAMILY PLAN-HOSP OUTPT	$140,391	$135,036	96.19%	$0	0.00%	$5,355	3.81%	$0	0.00%
M	FAMILY PLAN-PHYSICIAN	$3,136,007	$3,026,091	96.50%	$0	0.00%	$109,916	3.50%	$0	0.00%
M	FAMILY PLAN-RURAL HEALTH	$43,078	$41,714	96.83%	$0	0.00%	$1,364	3.17%	$0	0.00%

APPENDIX C Continued

MAN-DA-TORY (M) or OPTIONAL (O)	DESCRIPTION	NET PAID 2004	MANDATORY ELIGIBLE[1]/ MANDATORY SERVICE[2]		MANDATORY ELIGIBLE[1] OPTIONAL SERVICE[2]		OPTIONAL ELIGIBLE[1]/ MANDATORY SERVICE[2]		OPTIONAL ELIGIBLE[1]/ OPTIONAL SERVICE[2]	
			NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID
M	FAMILY PLAN-STERILIZATION	$15,593,259	$15,515,897	99.50%	$0	0.00%	$77,362	0.50%	$0	0.00%
M	HEALTH CHECK-FQHC	$1,900,155	$1,895,435	99.75%	$0	0.00%	$4,720	0.25%	$0	0.00%
M	HEALTH CHECK-HEALTH DEPT	$7,763,025	$7,727,530	99.54%	$156	0.00%	$35,308	0.45%	$31	0.00%
M/O	HEALTH CHECK-OTHER PROVIDEI	$37,022,843	$36,925,834	99.74%	$0	0.00%	$97,008	0.26%	$0	0.00%
M	HEALTH CHECK-RURAL HL TH C	$1,081,054	$1,074,802	99.42%	$0	0.00%	$6,252	0.58%	$0	0.00%
M	HEARING AIDS	$701,159	$669,173	95.44%	$0	0.00%	$31,987	4.56%	$0	0.00%
M	HIGH RISK INTERVENTION	$103,506,893	$102,621,686	99.14%	$0	0.00%	$885,207	0.86%	$0	0.00%
M	HMO PREMIUMS	$21,582,142	$20,575,846	95.34%	$0	0.00%	$1,006,296	4.66%	$0	0.00%
M/O	HOME HEALTH	$97,933,466	$55,588,065	56.76%	$12,919,498	13.19%	$16,502,272	16.85%	$12,923,631	13.20%
M	HOME HEALTH-INDIAN HL TH	$74,748	$41,092	54.97%	$0	0.00%	$33,656	45.03%	$0	0.00%
M/O	HOME INFUSION THERAPY	$6,670,473	$1,806,247	27.08%	$2,578,987	38.66%	$385,913	5.79%	$1,899,326	28.47%
M	HOSP INPT-GEN XOVERS	$15,891,459	$6,578,678	41.40%	$0	0.00%	$9,312,782	58.60%	$0	0.00%
M	HOSP INPT-GENERAL	$906,065,683	$697,210,549	76.95%	$0	0.00%	$208,855,134	23.05%	$0	0.00%
M	HOSP INPT-INDIAN HEALTH	$378,874	$288,756	76.21%	$0	0.00%	$90,118	23.79%	$0	0.00%
M	HOSP INPT-MTL, SO < 21	$9,097,113	$8,496,016	93.39%	$6,027	0.07%	$595,071	6.54%	$0	0.00%
M/O	HOSP INPT-MTL, SO > 65	$6,805,169	$59,150	0.87%	$638,829	9.39%	$87,614	1.29%	$6,019,576	88.46%
M	HOSP INPT-MTL, NSO < 21	$15,345,034	$14,959,228	97.49%	$0	0.00%	$385,805	2.51%	$0	0.00%
M	HOSP INPT-MTL, NSO > 65	$5,851	$3,703	63.28%	$0	0.00%	$2,148	36.72%	$0	0.00%
M	HOSP INPT-SPECIALTY	$6,505,078	$2,868,417	44.10%	$0	0.00%	$3,636,661	55.90%	$0	0.00%
M/O	HOSP LONG TERM CARE	$17,010	$0	0.00%	$10,818	63.60%	$0	0.00%	$6,192	36.40%
M	HOSP OUTPT -EMERGENCY ROOM	$171,100,964	$147,155,560	86.01%	$109	0.00%	$23,945,295	13.99%	$0	0.00%
M	HOSP OUTPT-GEN XOVERS	$3,196	$1,214	37.98%	$0	0.00%	$1,982	62.02%	$0	0.00%
M	HOSP OUTPT-GENERAL	$335,258,943	$254,266,379	75.84%	$0	0.00%	$80,992,563	24.16%	$0	0.00%
M	HOSP OUTPT-INDIAN HEALTH	$1,075,159	$1,006,648	93.63%	$0	0.00%	$68,511	6.37%	$0	0.00%
M	HOSP OUTPT-MTL, SO <21	$7,949	$7,949	100.00%	$0	0.00%	$0	0.00%	$0	0.00%
M	HOSP OUTPT-SPECIALTY	$823,442	$599,651	72.82%	$0	0.00%	$223,790	27.18%	$0	0.00%
M/O	HOSPICE	$32,511,819	$567,745	1.75%	$7,895,328	24.28%	$10,976	0.03%	$24,037,770	73.94%
M	LAB AND X-RAY	$30,320,448	$28,265,242	93.22%	$0	0.00%	$2,055,207	6.78%	$0	0.00%
M	LOCAL EDUCATION AGENCIES-FS	$4,400,262	$4,124,727	93.74%	$0	0.00%	$275,535	6.26%	$0	0.00%
M/O	L TC-ICF MRC, SO	$211,050,576	$2,637,714	1.25%	$49,868,965	23.63%	$712,334	0.34%	$157,831,563	74.78%
M/O	L TC-ICF MRC, NSO	$200,129,292	$30,006,732	14.99%	$75,120,119	37.54%	$7,213,496	3.60%	$87,788,945	43.87%

APPENDIX C Continued

MANDA-TORY (M) or OPTION-AL (O)	DESCRIPTION	NET PAID 2004	MANDATORY ELIGIBLE[1]/ MANDATORY SERVICE[2]		MANDATORY ELIGIBLE[1] OPTIONAL SERVICE[2]		OPTIONAL ELIGIBLE[1]/ MANDATORY SERVICE[2]		OPTIONAL ELIGIBLE[1]/ OPTIONAL SERVICE[2]	
			NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID	NET PAID 2004	% TO TOTAL PAID
M	L TC-ICF SO AND NSO	$421,744,601	$36,512,448	8.66%	$0	0.00%	$385,232,153	91.34%	$0	0.00%
M	L TC-SNF SO AND NSO	$483,037,284	$49,332,537	10.21%	$0	0.00%	$433,704,747	89.79%	$0	0.00%
.M	NF-ICF SWING BEDS	$1,171,786	$135,886	11.60%	$0	0.00%	$1,035,900	88.40%	$0	0.00%
M	NF-INDIAN HEALTH	$1,165,529	$75,872	6.51%	$0	0.00%	$1,089,657	93.49%	$0	0.00%
M	NF-SNF SWING BEDS	$701,093	$126,457	18.04%	$0	0.00%	$574,635	81.96%	$0	0.00%
M	NF-SNF SWING VENT CARE	$632,244	$272,323	43.07%	$0	0.00%	$359,920	56.93%	$0	0.00%
M	NF-VENT LEVEL OF CARE	$6,536,093	$1,117,530	17.10%	$0	0.00%	$5,418,564	82.90%	$0	0.00%
M/O	OPTICAL	$12,099,234	$6,391,774	52.83%	$3,993,161	33.00%	$625,573	5.17%	$1,088,727	9.00%
M/O	OPTICAL SUPPLIES	$7,010,410	$2,769,418	39.50%	$2,656,204	37.89%	$69,480	0.99%	$1,515,307	21.62%
M	OTHER PRACTITIONER	$35,658,116	$34,421,143	96.53%	$0	0.00%	$1,236,973	3.47%	$0	0.00%
M	PART A MEDICARE SUB-TOTAL	$42,643,570	$40,566,815	95.13%	$0	0.00%	$2,076,755	4.87%	$0	0.00%
M	PART B BUY-IN CAT NEEDY	$8,771,784	$3,745,793	42.70%	$0	0.00%	$5,025,991	57.30%	$0	0.00%
M	PART B BUY-IN DUAL B	$3,210,391	$48,101	1.50%	$0	0.00%	$3,162,290	98.50%	$0	0.00%
M	PART B BUY-IN DUAL Q	$135,588,347	$65,136,117	48.04%	$0	0.00%	$70,452,229	51.96%	$0	0.00%
M	PART B BUY-IN MQBB	$19,801,485	$19,193,688	96.93%	$0	0.00%	$607,798	3.07%	$0	0.00%
M	PART B BUY-IN MQBE	$8,088,160	$7,925,521	97.99%	$0	0.00%	$162,639	2.01%	$0	0.00%
M	PART B BUY-IN MQBQ	$420,541	$383,821	91.27%	$0	0.00%	$36,720	8.73%	$0	0.00%
O	PART B BUY-IN NON CASH	$11,547,767	$0	0.00%	$207,519	1.80%	$0	0.00%	$11,340,248	98.20%
M	PART B BUY-IN UNKNOWN	$435	$435	100.00%	$0	0.00%	$0	0.00%	$0	0.00%
M/O	PERSONAL CARE	$220,637,427	$4,342,206	1.97%	$136,910,302	62.05%	$110,320	0.05%	$79,274,599	35.93%
M/O	PHYSICIAN	$686,351,266	$540,656,072	78.77%	$27,788,666	4.05%	$116,902,192	17.03%	$1,004,336	0.15%
M/O	PODIATRY	$3,462,850	$821,371	23.72%	$1,850,049	53.43%	$437,642	12.64%	$353,789	10.22%
MIO	**PRESCRIBED DRUGS**	**$1,461,336,708**	**$241,417,414**	**16.52%**	**$652,850,678**	**44.67%**	**$9,806,308**	**0.67%**	**$557,262,308**	**38.13%**
	TOTALS	**$7,323,907,076**	**$3,231,994,715**	**44.13%**	**$1,375,856,043**	**18.79%**	**$1,587,946,858**	**21.68%**	**$1,128,109,459**	**15.40%**

[1] Eligible refers to a group of qualifying persons as described on page .

[2] Service refers to a commodity or service provided to the eligibility group.

TOTAL MANDATORY ELIGIBLE & MANDATORY SERVICE	**$3,231,994,715**	**44.13%**
TOTAL ALL OPTIONAL (GROUP AND SERVICE)	**$4,091,912,361**	**55.87%**

Source: Division of Medical Assistance

APPENDICES

APPENDIX D
COMPARISON OF MEDICAID EXPENDITURES, NUMBER OF USERS, AND COST PER USER FOR FY 2000 - 2004

	FY 2000			FY 2001			FY 2002			FY 2003			FY 2004		
Type of Service/ Expense	**Total Expenditures**	**Number of Users**	**Cost per User**	**Total Expenditures**	**Number of Users**	**Cost per User**	**Total Expenditures**	**Number of Users**	**Cost per User**	**Total Expenditures**	**Number of Users**	**Cost per User**	**Total Expenditures**	**Number of Users**	**Cost per User**
Inpatient Hospital	$736,135,229	188,441	$ 3,906	$800,302,588	150,654	$ 5,312	$862,769,349	203,894	$ 4,231	$874,533,504	210,463	$ 4,155	$952,315,340	214,478	$ 4,440
Outpatient Hospital	$272,258,247	511,679	$ 532	$341,572,413	478,463	$ 714	$431,017,843	635,226	$ 679	$538,024,825	670,519	$ 802	$517,492,495	741,934	$ 697
Mental Health	$23,063,625	2,547	$ 9,055	$28,309,245	2,052	$13,796	$30,542,240	2,436	$12,538	$32,761,633	2,561	$ 12,793	$33,146,982	2,379	$13,933
Physician	$432,332,656	1,022,362	$ 423	$533,997,448	1,099,082	$ 486	$583,795,009	1,192,979	$ 489	$572,206,549	1,278,204	$ 448	$697,495,106	1,392,685	$ 501
Clinics	$303,962,885	298,971	$ 1,017	$337,196,777	293,323	$ 1,150	$431,812,460	475,128	$ 909	$499,919,525	484,052	$ 1,033	$582,769,700	515,808	$ 1,130
Skilled Nursing Facility	$423,583,541	29,462	$14,377	$403,691,200	26,128	$15,451	$428,768,724	29,374	$14,597	$448,975,984	31,666	$ 14,178	$479,238,470	30,602	$15,660
Intermediate Nursing Facility	$386,455,052	23,627	$16,357	$436,964,073	23,245	$18,798	$450,131,946	25,491	$17,658	$419,208,704	25,027	$ 16,750	$418,220,811	21,505	$19,448
ICF-MR	$382,313,189	4,757	$80,369	$394,535,532	4,678	$84,339	$414,508,021	4,682	$88,532	$410,557,951	4,601	$ 89,232	$412,470,709	4,580	$90,059
Dental	$57,586,942	219,902	$ 262	$76,546,276	267,691	$ 286	$104,388,003	322,168	$ 324	$129,107,695	353,626	$ 365	$179,199,630	415,195	$ 432
Prescription Drugs	$754,505,194	817,779	$ 923	$927,240,693	887,430	$ 1,045	$1,056,158,750	941,491	$ 1,122	$1,203,809,178	998,701	$ 1,205	$1,470,555,037	1,057,239	$ 1,391
Home Health	$120,042,028	81,624	$ 1,471	$123,227,285	82,944	$ 1,486	$146,906,481	119,127	$ 1,233	$157,985,231	143,066	$ 1,104	$170,719,146	154,828	$ 1,103
Medicare Premiums	$165,457,105			$175,275,216			$192,420,319			$210,394,375			$233,031,656		
HMO Premiums	$51,750,006			$63,199,169			$42,181,980			$24,476,991			$21,537,125		
All Other Services	$687,236,522	758,628	$ 906	$826,498,501	711,773	$ 1,161	$1,000,509,096	932,474	$ 1,073	$1,067,105,690	974,975	$ 1,094	$1,204,519,235	1,078,167	$ 1,117
Subtotal of Services Expenditures	$4,796,682,221			$5,468,556,416			$6,175,910,221			$6,589,067,835			$7,372,711,442		
Unduplicated Recipients	$4,796,682,221	**1,200,960**	**$ 3,994**	**$5,458,556,416**	**1,309,955**	**$ 4,175**	**$6,175,910,221**	**1,401,449**	**$ 4,407**	**$6,589,067,835**	**1,454,661**	**$ 4,530**	**$7,372,711,442**	**1,541,450**	**$ 4,783**
Adjustments, Cost Settlements, & Transfers	$283,682,693			$452,020,624			$323,699,394			$86,455,622			$237,401,035		
Disproportionate Share Payments	$374,257,526			$558,227,259			$441,940,322			$340,835,304			$408,120,388		
Transfer to State Treasurer	$106,170,396			$317,329,139			$109,233,788			$108,510,735			$97,144,325		
Transportation--Program County Share							$1,159,123			$1,199,942					
VR DSH Non Federal Share				$89,575,112			$4,713,631			$3,420,366					
Administration	$69,251,716			$89,475,112			$309,472,951			$310,268,127			$360,391,308		
Other Administrative Expenses	$159,657,977			$179,746,067											
Subtotal of Non-Services Expenditures	$993,020,308			$1,686,373,313			$1,190,219,209			$850,690,096			$1,103,057,056		
Total Medicaid Expenditures	$5,789,702,529			$7,154,929,729			$7,366,129,430			$7,439,757,931			$8,475,768,498		

Source: OSA Compilation from Division of Medical Assistance Annual Reports

APPENDICES

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APPENDIX E
Percent of Expenditures by Types of Service for FYs 2000 - 2004

Type of Service	Total FY 2000 Expenditures	Percent of Total	Total FY 2001 Expenditures	Percent	Total FY 2002 Expenditures	Percent	Total FY 2003 Expenditures	Percent	Total FY 2004 Expenditures	Percent
Inpatient Hospital	$736,135,229	15.35%	$800,302,588	14.63%	$862,769,349	13.97%	$874,533,504	13.27%	$952,315,340	12.92%
Outpatient Hospital	$272,258,247	5.68%	$341,572,413	6.25%	$431,017,843	6.98%	$538,024,825	8.17%	$517,492,495	7.02%
Mental Health	$23,063,625	0.48%	$28,309,245	0.52%	$30,542,240	0.49%	$32,761,633	0.50%	$33,146,982	0.45%
Physician	$432,332,656	9.01%	$533,997,448	9.76%	$583,795,009	9.45%	$572,206,549	8.68%	$697,495,106	9.46%
Clinics	$303,962,885	6.34%	$337,196,777	6.17%	$431,812,460	6.99%	$499,919,525	7.59%	$582,769,700	7.90%
Skilled Nursing Facility	$423,583,541	8.83%	$403,691,200	7.38%	$428,768,724	6.94%	$448,975,984	6.81%	$479,238,470	6.50%
Intermediate Nursing Facility	$386,455,052	8.06%	$436,964,073	7.99%	$450,131,946	7.29%	$419,208,704	6.36%	$418,220,811	5.67%
ICF-MR	$382,313,189	7.97%	$394,535,532	7.21%	$414,508,021	6.71%	$410,557,951	6.23%	$412,470,709	5.59%
Dental	$57,586,942	1.20%	$76,546,276	1.40%	$104,388,003	1.69%	$129,107,695	1.96%	$179,199,630	2.43%
Prescription Drugs	$754,505,194	15.73%	$927,240,693	16.96%	$1,056,158,750	17.10%	$1,203,809,178	18.27%	$1,470,555,037	19.95%
Home Health	$120,042,028	2.50%	$123,227,285	2.25%	$146,906,481	2.38%	$157,985,231	2.40%	$170,719,146	2.32%
Medicare Premiums	$165,457,105	3.45%	$175,275,216	3.21%	$192,420,319	3.12%	$210,394,375	3.19%	$233,031,656	3.16%
HMO Premiums	$51,750,006	1.08%	$63,199,169	1.16%	$42,181,980	0.68%	$24,476,991	0.37%	$21,537,125	0.29%
All Other Services	$687,236,522	14.33%	$826,498,501	15.11%	$1,000,509,096	16.20%	$1,067,105,690	16.20%	$1,204,519,235	16.34%
Total of Services	**$4,796,682,221**	**100.00%**	**$5,468,556,416**	**100.00%**	**$6,175,910,221**	**100.00%**	**$6,589,067,835**	**100.00%**	**$7,372,711,442**	**100.00%**

Source: Medicaid in North Carolina Annual Report -- State Fiscal Years 2000 thru 2004.

APPENDICES

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APPENDIX F
DMA Physician Drug Plan—Rebates Due

Under DMA's Physician Drug Plan, Medicaid pays for medications that are administered by a medical professional to a patient in a physician office environment. The medications include injectable drugs and biological products (blood and tissue products) that aren't generally available from retail pharmacies and can't be self-administered. To receive payment for these medications, physicians bill Medicaid using a Healthcare Common Procedures Code (HCPCS). In order for DMA to collect rebates from the manufacturers, staff must identify corresponding National Drug Codes (NDC). Some HCPCS codes do not have corresponding NDC identification numbers; therefore, rebates cannot be obtained from the drug manufacturers. DMA is continuing to work on this issue. The new contract with its fiscal agent, ACS, will address this issue beginning in 2006.

Time Period	Rebates Not Obtained for Single Source Codes	Rebates Not Obtained for Multiple Source Codes	Total*
FY 1999-2000	$1,832,413	$1,976,370	$3,808,783
FY 2000-2001	$1,403,275	$3,083,034	$4,486,309
FY 2001-2002	$1,490,484	$4,239,888	$5,730,372
First 2 Quarters of 2002-2003	$863,314	$2,216,388	$3,079,702
Total	$5,589,486	$11,515,680	$17,105,166
Source: DMA			
*Represents total dollars spent on medications for which rebates may be available from manufacturers. 2002-2003 was the most recent data available.			

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APPENDIX G
List of Pending Legislation that Would Affect the Medicaid Prescription Drug Program

Bill Number	Bill Description	Date Introduced
Senate Bill 105	A bill entitled an act to phase out the non-federal share of Medicaid cost over a five-year period.	February 10, 2005
Senate Bill 931	A bill entitled an act to raise the excise tax on cigarettes and to phase out the county share of Medicaid costs	March 24, 2005
Senate Bill 1128	A bill entitled an act to provide that the Department of Health and Human Services shall not impose prior authorization requirements on certain prescription drugs.	March 24, 2005
House Bill 316	A bill entitled an act to phase out the county share of the nonfederal share of Medical Assistance Program costs.	February 21, 2005
House Bill 149	A bill entitled an act to phase out the county share of the nonfederal share of Medicaid costs over a five-year period, and to provide that the total county share during the phase out period shall not exceed the county share paid by each county for the 2004-2005 fiscal year.	February 9. 2005
House Bill 82	A bill entitled an act to direct the Department of Health and Human Services, Division of Medical Assistance, to develop a case management program for recipients having a large number of prescriptions, as recommended by the Blue Ribbon Commission on Medicaid Reform.	February 7, 2005
House Bill 132	A bill entitled an act to phase out the county share of the nonfederal share of Medicaid costs over a six year period, to provide that the total county share during the phase-out period shall not exceed the county share paid by each county for the 2004-2005 fiscal year, and to further provide that in certain counties the county share shall be further reduced based on the number of Medicaid-eligible individuals in the county, as recommended by the Blue Ribbon commission on Medicaid Reform.	February 9, 2005
Senate Bill 117	A bill entitled an act to phase out the county share of the nonfederal share of Medicaid costs over a six year period, to provide that the total county share during the phase-out period shall not exceed the county chare paid by each county for the 2004-2005 fiscal year, and to further provide that in certain counties the county share shall be further reduced based on the number of Medicaid-eligible individuals in the county, as recommended by the Blue Ribbon commission on Medicaid Reform.	February 14, 2005

Source: Complied by OSA from General Assembly website

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APPENDIX H
Average Number of Medicaid Prescription Drug Claims per Recipient

Program	2001	2002	2003	2004
Work First Or TANF	5	6	6	7
State Foster Child	10	10	12	12
IIV-E Adoption Assistance	8	9	10	11
Medicaid Aid To Aged	44	49	52	56
Medicaid Aid To Blind	34	37	39	42
Medicaid Aid To Disabled	34	37	39	42
Medicaid Aid To Families	8	8	9	9
Medicaid Infant & Children/Health Choice	5	5	6	6
Medicaid For Pregnant Women	5	5	6	6
Medicaid Refugee Assistance	3	3	4	4
Special Assistance For Blind	44	56	54	67
Refugee Cash Assistance	3	3	6	4
State/County Special Assistance To Aged	49	56	62	65
State/County Special Assistance To Disabled	46	53	58	62
Total	**298**	**337**	**363**	**393**
Average per group	21	24	26	28
Percentage change		13.1%	7.7%	8.3%

Source: Division of Medical Assistance

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North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

June 27, 2005

Mr. Leslie W. Merritt, Jr., CPA, CFP
State Auditor
Office of the State Auditor
2 South Salisbury Street
20601 Mail Service Center
Raleigh, North Carolina 27699-0601

Dear Auditor Merritt:

The North Carolina Department of Health and Human Services, Division of Medical Assistance, has reviewed the Performance Review of Medicaid Prescription Drug Costs, OSA Report No. PER-2005-0213. We have found the report to be an accurate overview of the challenges that face this State in identifying and implementing cost containment measures for the prescription drug program.

As noted in your review, North Carolina has implemented a number of measures (that other states are modeling) to reduce costs in the prescription drug program. One such measure is Prior Authorization (PA), which has generated an estimated yearly savings of over $12 million. The largest impact of prior authorization may come from the discouragement of prescribing the medications on the PA list. This cost avoidance may far exceed the estimated yearly savings stated above.

It is also true that North Carolina has been effective in placing cost containment measures into its prescription drug program. Estimated avoided expenditures from these measures exceeded $143 million in SFY 2004. This number represents a 61% increase in avoided expenditures (from cost containment measures) for SFY 2003.

We believe that more innovative cost containment measures will be identified and implemented in the coming years. Your report will be an important part of that effort.

Sincerely,

Carmen Hooker Odom

Carmen Hooker Odom

cc: Dan Stewart
Eddie Berryman
Allyn Guffey
Mark Benton
Jim Slate
Nancy Henley, MD

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July 1, 2005

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