Major Accomplishments

Settlement of the Medicaid Dental Lawsuit

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

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

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

Program Integrity Collections and Cost Avoidance

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

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

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

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

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

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

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

Medicaid Payment Accuracy Measurement Demonstration Project

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

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

Pharmacy

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

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

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

HIPAA Project

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

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

Highlights of Carolina ACCESS Provider Satisfaction Survey

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

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

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

Highlights of Carolina ACCESS Contractual Compliance Survey

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

Quality and Healthcare Outcome Improvements

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

HEDIS

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

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

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

Pediatric Asthma

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

ADHD Collaborative

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

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

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

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

Congestive Heart Failure

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

Utilization Reporting

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

Antimicrobial Resistance

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

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

Prenatal Care

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

Health Check and Immunizations

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

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