MEMORANDUM OF UNDERSTANDING
BETWEEN THE
DIVISION OF MEDICAL ASSISTANCE
AND THE
DIVISION OF PUBLIC HEALTH
DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECTION A: GENERAL

This Memorandum of Understanding (MOU) between the Division of Medical Assistance and the Division of Public Health (the Title V agency within the Department) in the Department of Health and Human Services, outlines the relationship between the parties that is needed to meet our mutual goal of improving the health of Medicaid eligible clients.

SECTION B: DEFINITION OF TERMS

1. Baby Love means the Baby Love Program which targets infant mortality by providing services to Medicaid-eligible pregnant women from the beginning of pregnancy through the postpartum period and infants born to these women until their first birthday.
2. CHIS means the Center for Health Informatics and Statistics in the Division of Public Health, DHHS.
3. CPT means Current Procedural Terminology (as developed by the American Medical Association.)
4. CSHS means Children's Special Health Services Program.
5. DHHS means Department of Health and Human Services.
6. DMA means Division of Medical Assistance.
7. DPH means Division of Public Health.
8. HCFA means Health Care Financing Administration.
9. Health Check means North Carolina's Early, Periodic Screening, Diagnosis and Treatment Program.
11. Local service provider means a local public health department or other provider which has a written agreement with DPH that meets applicable Medicaid participation requirements.
12. MOU means this Memorandum of Understanding between the Division of Medical Assistance and the Division of Public Health in the Department of Health and Human Services.
13. SBHC means a School-Based Health Center.
14. WIC means the USDA Special Supplemental Nutrition Program for Women, Infants and Children.
SECTION C: ARRANGEMENTS FOR COORDINATION/LIAISON

The Assistant Director of Medical Policy in DMA and the Deputy Division Director in DPH shall serve as agency liaisons for purposes of implementing this MOU. They will be responsible for:

a. Co-chairing regular intra-agency meetings to discuss issues of common concern.

b. Assuring participation of administrative and program staff as necessary to address issues covered in MOU.

c. Jointly developing work plans to assure that MOU activities are completed.

DMA and DPH will cooperate in providing consultation, technical assistance, policy and program guidance to local service providers.

SECTION D: JOINT RESPONSIBILITIES

DMA and DPH agree to:

1. Collaborate in:

   a. planning, development, implementation and operation of activities described in this MOU.

   b. provision of consultation, technical assistance, policy and program guidance to local service providers.

   c. development of agreements with other state agencies, programs and providers to facilitate appropriate utilization of services available through DMA and DPH programs.

2. Consult with appropriate professional organizations and societies and develop health services policies and standards in accordance with professionally recognized protocols and standards of care.

3. Administer the Baby Love Program to reduce infant mortality and morbidity among Medicaid recipients. An annual work plan will be developed to determine the tasks to be performed.

4. Promote appropriate access to comprehensive care with an emphasis on reducing the prevalence of disease, disability and mortality. An annual work plan will be developed to determine the tasks to be performed.

5. Assure that joint initiatives employ effective strategies to:

   a. Provide outreach and marketing activities that promote appropriate health services utilization;

   b. Use preventive care and coordination in delivering specialized services to Medicaid-eligible clients.

   c. Develop and utilize public/private partnerships to improve participation in public programs and obtain broad-based support from local service providers.

   d. Identify, quantify and remove barriers that deter appropriate participation by Medicaid-eligible clients in the health care system.

   e. Coordinate and integrate systems and programs to avoid duplication of services.

   f. Track and report the status of system development and program outcomes.
g. Manage program expenditures and reduce unnecessary costs in providing medical services.

h. Share data to support efforts of both agencies in meeting program objectives while respecting the confidentiality and integrity of each agency’s data.

6. Coordinate activities between WIC, Baby Love, Health Check, NC Health Choice, Early Intervention, CSHS, Assistive Technology, Newborn Hearing Screening, CSC and Independent Practitioner Programs to prevent duplication of effort or services.

7. Assure allowable cost reimbursement to the State Laboratory of Public Health consistent with CLIA status for laboratory services, including newborn screening, provided to eligible Medicaid clients.

8. Provide public health specific program guidance as needed through the Medicaid Bulletin and other media efforts.

9. Update and develop program manuals and guidance on an annual basis.

10. Develop a system of local service providers to refer pregnant women and Health Check children under age 5 to the WIC and MCC programs.

11. Determine when changes are needed to the list of covered services, in order to meet the goal of the MOU.

SECTION E: DPH RESPONSIBILITIES

1. Notify local service providers of any substantive change in Title XIX rules, regulations and/or terms of this agreement.

2. Allow DMA to review and approve any manual or other document which cites DMA policy before it is sent to providers.

3. For WIC services:
   A. Provide DMA with a list of WIC coordinators who are local WIC contact persons.
   B. Share WIC outcome data for Medicaid recipients.
   C. Provide WIC outreach materials to DMA.

4. Establish and maintain a system to monitor local service provider compliance with mutually agreed upon, written Medicaid requirements on the amount, duration, scope and medical necessity of services rendered to Medicaid eligibles and to notify DMA Program Integrity when relevant problems are identified.

5. Monitor local service providers compliance with the terms of this agreement and all regulations and policies of the Medicaid Program (see Attachment 8).

SECTION E: DMA RESPONSIBILITIES

1. Provide payment for services covered under this agreement.

2. Negotiate reimbursement rates based on the cost finding process as described in the Medicaid State Plan and obtain HCFA approval as necessary. Facilitate the draw down of federal funds for the administrative activities covered under this MOU (see Section O and Attachment 7.)

3. Provide DPH with Medicaid eligibility information in a manner consistent with Medicaid regulations safeguarding the confidentiality of Medicaid clients.

4. Provide DPH access to Medicaid reimbursement rates.
5. Monitor local service provider compliance with applicable Medicaid fiscal policies/requirements and make referrals to Program Integrity as appropriate.
6. Provide technical assistance in the areas of Medicaid eligibility and Health Check program management.
7. Provide WIC with a list of Health Check contact persons at the local departments of social services.
8. Provide WIC with direct mail access to Medicaid eligible recipients.
9. Enroll eligible local service providers under this Agreement so they may bill for Medicaid-covered services.
10. Review and approve any manual or other document which cites DMA policy before it is sent to providers.

SECTION G: LOCAL SERVICE PROVIDERS REFERENCED IN THIS AGREEMENT INCLUDE:

Local Health Departments

This service entity is operated to provide health care in the form of services which are preventive, diagnostic, therapeutic, supportive, rehabilitative and/or palliative in nature when provided by qualified health care professionals.

A list of covered services which may be billed using codes other than CPT codes, including the service code and description, is included in Attachment 1. The list of covered services which may be billed using codes other than CPT codes will be reviewed at least annually and updated as needed in accordance with standard operating procedures agreed upon by DPH.

The local entity may enter into agreements with physicians and dentists for the provision of services that are to be reimbursed to the agency in accordance with the Medicaid Fee Schedules. When the local entity enters into an agreement, a supplemental provider agreement must be executed between the local health department and physician. The supplemental provider agreement must: 1) be updated annually by the local health department; 2) include a provision for provider (physician or dentist) reassignment of claims to the local entity; and 3) be maintained in files located at local entity and available upon request by DPH or DMA.

Attachment 9 is an agreement which provides for each local health department to be considered a part of this MOU until such time as an individual Medicaid Participation Agreement.

SECTION H: ARRANGEMENTS FOR IMMUNIZATIONS

DPH will purchase all required vaccines on behalf of all North Carolina children through State or Federal contracts, and distribute them to local health departments and private
providers. All North Carolina children are eligible to receive the required vaccines, regardless of insurance status. All local health departments and all participating private providers must have a signed vaccine agreement (Local Health Department Vaccine Agreement, DHHS 837 or Private Provider Vaccine Agreement, DHHS 3451) on file with DPH. The list of vaccines distributed by the NCUCVDP is included as Attachment 2.

DMA agrees to continue with the policy, enacted in March 1995, which requires Medicaid providers to participate in the Division of Public Health’s Universal Childhood Vaccine Distribution Program (NCUCVDP). DMA continues to maintain the right to exclude certain physicians from this policy based on other program criteria and individual circumstances.

SECTION I: ARRANGEMENTS FOR PURCHASE OF MEDICAL CARE SERVICES FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS

DMA shall:
1. Coordinate with Specialized Services Unit in the implementation of services;
2. Provide technical assistance to agencies regarding provider enrollment, claims filing and Medicaid rules and regulations. DMA is the approval authority for all policies, procedures, and activities in this area undertaken by the DPH, Specialized Services Unit (SSU), CSHS Program;
3. Assist in developing training materials and conducting provider training;
4. Collaborate with the SSU to assure that qualified providers are enrolled to deliver appropriate services to Medicaid recipients;
5. Provide DPH with data and reports determined necessary for planning, monitoring and evaluation/management of CSHS, Purchase of Medical Care Services; and
6. Correspond with HCFA regarding Medicaid coverage and provisions and keep the SSU, CSHS Program apprised of the status of such correspondence

DPH will:
1. Support a uniform procedure for review and enrollment of disciplines applying as providers of services. Both DMA and DPH will approve the process and requirements in order to ensure that all providers meet and comply with the established provider qualifications for the program;
2. Coordinate with DMA on operational policies and procedures;
3. Assist in preparation of training materials and in conducting provider training;
4. Keep DMA apprised of developments relative to the CSHS, Purchase of Medical Care Service Program; and
5. Provide technical assistance to agencies on the programmatic aspects of enrollment and on CSIIHS services.
SECTION J: ARRANGEMENTS FOR Health Check

DMA and DPH shall cooperate in administering the Health Check program. The following delineates basic duties and responsibilities as agreed to between the agencies.

DMA shall:
1. Provide local health check coordinators a county listing of persons eligible for Health Check.
2. Share statistical data on program performance and progress toward meeting HCFA participation goals.
3. Implement strategies to allow collaboration between local managed care representative and the health check coordinators to assure eligible children have access to health care.
4. Provide an automated tracking/notification system for use by local health check coordinators.
5. Reimburse for Health Check services provided by public health nurses in local health departments who meet the DHHS criteria to be Rostered Child Health Screeners at the same rate as Health Check screenings performed by physicians and other qualified practitioners in local health departments.
6. Provide technical assistance and training to local health check coordinators through formal training, local and statewide meetings and on-site visits.

DPH shall:
1. Monitor local service providers to assure that Health Check screening services are made available to Health Check eligible clients.
2. Assure that local service providers provide or arrange for the provision of services to clients in need of further diagnosis or treatment.
3. Maintain mechanisms to assure that Health Check screening services are made available statewide.
4. Encourage local service providers to coordinate efforts with county departments of social services to achieve maximum program benefit.

DMA and DPH shall jointly:
1. Develop an annual Health Check work plan.
2. Designate staff within each agency to maintain a continuous liaison for the purpose of meeting objectives of the work plan.

SECTION K: ARRANGEMENTS FOR ROSTERED CHILD HEALTH NURSE SCREENERS

DMA shall reimburse Medicaid enrolled agencies and providers for Health Check screening visits performed by registered nurses who have been rostered through DPH as described in Attachment 3.

DPH shall:
1. Establish, implement and maintain a rostering process for Child Health Nurse Screeners based on the following:
A. Initial Requirements
- Licensure as a Registered Nurse in NC
- Completion of "Introduction to Principles and Practices of Public Health and Public Health Nursing" course (ONLY for non-BSN Registered Nurses employed in a public health setting)
- Completion of one of the following: the Child Health Training Program with documented 60 hours minimum of clinical preceptorship; OR comparable pediatric history and physical examination courses with documented 60 hours minimum of clinical preceptorship and successful completion of the Child Health Training Program Challenge Procedure (written and clinical examinations.)

B. Continuing Requirements
- Biannual submission of statement to the Office of Public Health Nursing & Professional Development (OPHNPD) of continuing performance of Child Health Screening (including history and physical assessment) for a minimum of 200 hours in two (2) years; AND twenty (20) contact hours of relevant continuing education in two (2) years.

2. Maintain a "Roster" (or listing) within the OPHNPD of Registered Nurses who qualify as Child Health Nurse Screeners.
3. Notify Child Health Nurse Screeners of rostered status and continued rostered status upon successful completion and documentation of requirements.
4. Approve and administer renewal requirements for re-rostering as a Child Health Nurse Screener when the nurse has not met the requirements as defined in Attachment 3.
5. Provide a certificate to qualified Child Health Nurse Screeners or other certifiable documentation.

DMA and DPH shall jointly:
1. Promote outreach and marketing strategies for rostering of Child Health Nurse Screeners including providing information through the Medicaid Bulletin to raise awareness and knowledge concerning the process of rostering registered nurses employed in local health departments, Federally-qualified Rural Health Centers and/or Community Health Centers or employed by private sector medical/physician practices.
2. Collaborate on the implementation of the rostering process for Child Health Nurse Screeners as described in Attachment 3.
3. Share data to support efforts of both agencies in meeting program objectives.

SECTION L: ARRANGEMENTS FOR SCHOOL-BASED HEALTH CENTERS

The responsibilities of DMA and DPH for School-Based Health Centers are outlined in a separate MOU (see Attachment 4).
SECTION M: ARRANGEMENTS FOR HIV CASE MANAGEMENT AND AIDS HOME AND COMMUNITY-BASED SERVICES

For HIV CMS, DMA shall:
1. Coordinate the implementation of HIV CMS.
2. Provide technical assistance to agencies regarding provider enrollment, claims filing, and Medicaid rules and regulations. DMA is the approval authority for all policies, procedures and activities undertaken by the DPH AIDS Care Unit in its administration of HIV CMS.
3. Review and approve training materials.
4. Carry out the provider enrollment process of HIV CMS by enrolling HIV CMS providers and issuing a Medicaid provider number to use when billing for the provision of HIV CMS.
5. Process and pay claims submitted for HIV CMS provided to Medicaid recipients. Providers will submit claims directly to EDS, the fiscal agent for DMA. Payments will not exceed the cost of services.
6. Provide DPH with data and reports determined necessary for planning, monitoring, and evaluation and management of HIV CMS.
7. Correspond with HCFA regarding Medicaid coverage and provisions and keep DPH’s AIDS Care Unit apprised of the status of such correspondence.

For HIV CMS, DPH will:
1. Carry out a uniform procedure for review and certification of entities applying to become providers of HIV CMS in order to ensure that all providers meet and comply with the established provider qualifications for the program.
2. Decertify agencies found to be substantially out of compliance with policies and procedures and notify DMA of the decertification by copy of the provider’s notice.
3. Notify DMA after the certification of each provider of HIV CMS by providing a copy of the provider’s notice of certification.
4. Coordinate with DMA on operational policies and procedures for HIV CMS.
5. Prepare training materials and conduct provider training.
6. Keep DMA apprised of developments relative to the HIV CMS program and provide DMA with a copy of any correspondence sent to HIV CMS Providers.
7. Provide technical assistance to agencies on the programmatic aspects of certification and on HIV CMS.
8. Perform ongoing monitoring of participating case management providers, and provide copies of all quality assurance reports, including three-year renewal reports, to DMA.
9. Carry out a provider re-certification process every three years.

For CAP/AIDS, DMA will:
1. Oversee the operation of CAP/AIDS in relation to federal and state guidelines. DMA is the approval authority for all policies, procedures, and activities undertaken by the DPH AIDS Care Unit in its administration of CAP/AIDS.
2. Review a DPH request to amend, renew or replace the existing waiver and submit the request to HCFA when DMA believes that such action is required. DMA will
submit such requests for federal approval and negotiate with HCFA to secure the approval.

3. Negotiate with HCFA on any issues affecting the operation of the waiver program.

4. Develop, publish, and distribute instructions and revisions to a Medicaid provider manual governing the operation of CAP/AIDS to CAP/AIDS case management providers.

5. Develop and implement policies and procedures for the following components of the administration and operation of CAP/AIDS:
   a. Medicaid eligibility;
   b. Reimbursement;
   c. Coordination with other Medicaid home care services; and
   d. Provider enrollment.

6. Provide technical assistance to DPH staff on the components in item 5 (above). The assistance will include participation in DPH-arranged training activities to cover these components and providing guidance in the incorporation of these components into the package used by DPH in performing technical assistance review of CAP/AIDS case management providers.

7. Prepare and submit required federal reports on the waiver program and share the reports with DPH. The annual reports will include information on the number served, service utilization and costs.

8. Conduct a quality review of DPH's plan of care approval actions, notify DPH of its findings and advise on corrective action.

9. Consider DPH requests for changes in rates and individual plan of care limits. Rates and plan of care cost limits will be adjusted when there is sufficient documentation to support an adjustment and DMA determines that there are Medicaid funds available to cover the cost of the adjustment.

10. Inform DPH of all changes to Medicaid regulations, policies or instructions that affect CAP/AIDS.

For CAP/AIDS, DPH will:
1. Supervise the operation of CAP/AIDS by conducting statewide monitoring with annual on-site review of CAP/AIDS case management providers to assure and document that the provision of CAP/AIDS services complies with the intent of the waiver program; DPH standards and client record processes; applicable federal and state laws, regulations, standards and guidelines; and CAP/AIDS policies, procedures and instructions. Each CAP/AIDS case management provider will receive at least one technical assistance review during each twelve month period with more frequent reviews, including follow-up reviews, conducted as needed to ensure proper operation of CAP/AIDS. Reports on technical assistance reviews will be provided to DMA.

2. Provide technical guidance, training and assistance to CAP/AIDS case management provider agencies to ensure proper operation of CAP/AIDS, and to initiate any needed corrective action. DPH will offer a continuous in-service training program to CAP/AIDS case management providers to develop and improve programmatic skills as well as cover the various aspects of program
operation. The technical assistance will include training and guidance as they relate to the operation of CAP/AIDS. Specifically covered are:

a. CAP/AIDS case management provider standards, licensure, and certification regulations and standards as applicable to the provision of services to CAP/AIDS participants, and documentation and recordkeeping requirements;

b. Identification of the target population for CAP/AIDS;

c. Completion of a service needs assessment;

d. Effective development and utilization of CAP/AIDS services as well as other available services (e.g., other AIDS services, educational services, training services, and other Medicaid services) and community resources;

e. Coordination and linkage of other services and resources, including the coordination of CAP/AIDS services with other available services (e.g., other AIDS services, educational services, training services, and other Medicaid services) and community resources;

f. Development and implementation of appropriate plans of care for individual CAP/AIDS participants;

g. Maintenance of the health, safety, and well-being of the client through a continuum of care;

3. Review assessment information and plans of care for CAP/AIDS participation and cooperate with DMA’s review of these activities. The AIDS Care Unit in DPH is the approval authority for all CAP AIDS assessments and plans of care.

4. Provide program evaluation information on an annual basis for inclusion in required federal reports.

5. Prepare a draft amendment for DMA review when requesting changes in the waiver. The draft is to include all information required by HCFA. Justification for the change will be sent to DMA with the draft.

6. Cooperate with DMA in satisfying all federal requirements in obtaining amendments to the existing waiver, the renewal of the existing waiver or the replacement of the existing waiver with a new waiver, federal reviews of waiver operation, and the completion of federal reports for the program.

7. Assume responsibility for resolving federal audit exceptions resulting from incorrect or insufficient direction provided by DPH in its area of responsibility.

SECTION N: EXCHANGE OF DATA
In order to coordinate data reporting and analysis services and promote good health care and utilization of resources:

DMA will:

1. Authorize selected and identified employees of CHIS to access Medicaid eligibility files in order to conduct the activities described in this section.

2. Authorize selected and identified employees of CHIS to access Medicaid paid claims datasets in order to conduct the activities described in this section.

3. Review reports, articles, data tables and other products of analysis of Medicaid data by CHIS, offer comments and suggestions to CHIS regarding such products.
4. Approve or disapprove written requests from CHIS for use of data sets within 30 days of receipt of request.

5. Approve or disapprove written requests for CHIS to publish or release information based in whole or in part on DMA datasets within 30 days of receipt of request.

CHIS will:

1. Use DMA datasets identified in paragraph 1 of this section only for aggregate analysis of data; under no circumstances will CHIS release information which may result in identification of clients or which will violate the requirements for safeguarding information as contained in 42 CFR Subpart F unless such release is approved in writing by appropriate DMA personnel.

2. Provide a copy of reports and tables requiring linkages of vital records and Medicaid program files, including specifically:
   - Annually, report of state births by county of residence, by Medicaid status for all births and for births to mothers under 19 years of age;
   - Annually, report of outcome measures for births by presence of maternity care coordination;
   - Upon request, other reports needed by DMA and agreed upon by CHIS.

3. Obtain formal approval of DMA prior to publication or other release of information based in whole or in part on DMA datasets.

4. Obtain DMA approval for the use of DMA datasets for any purposes not described above.

CHIS will bill Medicaid for work done related to Medicaid data involving projects that have been approved by appropriate DMA personnel. CHIS staff undertake these tasks with written permission from DMA. The billing is based on rates calculated to cover salary, fringe, and administrative costs associated with the work. CHIS staff who are already partially paid from Medicaid funds under different arrangements are not eligible for billing.

Additional arrangements between DMA and CHIS are outlined in Attachment 5.

SECTION Q: ARRANGEMENTS FOR ADMINISTRATIVE FUNDING

DPH may claim Federal Financial Participation (FFP) for administrative activities that are reasonable, necessary and directly necessary for the administration of the Medicaid Program. To claim FFP, DPH must prepare an application, sign an agreement with DMA and meet the requirements specified in Attachment 6. DPH will also assure that any required state match meets all federal requirements and guidelines (see Attachment 6.) Any audit exceptions or disallowances will be the responsibility of the requesting agency.

FFP can be claimed for the programs and activities included as FFP documentation in Attachment 7:
SECTION P: ARRANGEMENTS FOR ACCESS TO COMPUTER DATA/FILES

DMA shall:
1. Authorize DPH access to drug and procedure pricing file.
2. Authorize DPH and local health departments access to Medicaid eligibility data via special files resident at Information Technology Services, Department of Commerce.

DPH shall:
1. Establish and enforce procedures to provide safeguards necessary to prevent unauthorized access to, release of listings of client names and addresses or other unauthorized use of client data.
2. Be responsible for the cost of data transmission or access charges for computer files.

SECTION Q: ARRANGEMENTS FOR PERIODIC REVIEW AND JOINT PLANNING

This MOU and the policies established herein will go into effect on the date this MOU is signed and will remain in effect until terminated by one or both parties. The parties to the agreement will review its contents at least annually, evaluate need for changes and incorporate mutually agreed upon modifications or amendments. In the event the federal and/or state laws should be amended or judicially interpreted so as to render the fulfillment of the MOU, on the part of either party, not feasible or possible, or if the parties of this document shall be unable to agree upon modifying amendments which would be needed to enable substantial continuation of the MOU, both the Division of Medical Assistance and the Division of Public Health shall be discharged from further obligation created under the terms of this Agreement. Equitable settlement of respective accrued claims, adjustments, and payments up to the date of the termination will be made.

_____________________________  ______________________________
Director, Division of Medical Assistance                  Director, Division of Public Health

_____________________________
Date

_____________________________
Date

_____________________________
Effective Date
Signature Page for FFP Agreements

The following FFP Agreements become effective upon signature. These will expire on June 30th of 2004 or until terminated by mutual agreement. All FFP Agreements will be reviewed by DMA and DPH annually. These agreements include (full documentation for these services is included in Attachment 5)

✓ 01. Health Check
✓ 02. Health Choice
✓ 03. Social Work Consultation
✓ 04. WCH Nursing Consultation
✓ 05. Adolescent Parenting Program
✓ 06. School Health Nursing Consultation
  07. Public Health Training and Information Network
  08. HIV Case Management Services (HIV CMS) and AIDS Home and Community-Based Services (CAP/AIDS)
✓ 09. Administrative Consultation
✓ 10. Fetal and Infant Mortality Review Program
  11. Birth Defects Monitoring Program
✓ 12. Physical Therapy Consultation
✓ 13. Community Transition Coordinators
✓ 14. Sickle Cell Program
✓ 15. LTAT Nursing Consultation
  16. Newborn Hearing Screening
✓ 17. POETS/NOETS
  18. Public Health Dentists
✓ 19. First Step Campaign and NC Family Health Resource Line Services
  20. Health Check/Health Choice Toll Free Hotline
  21. Perinatal Smoking Cessation and Infant Mortality Program
  22. Medicaid Administration State Center for Health Statistics
  23. Public Health Dental Hygienists
  24. Medicaid Reimbursement/Cost Study Staff

[Signature]
Director, Division of Medical Assistance

[Signature]
Director, Division of Public Health

Date 3/26/03

Date 3/24/03
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Health Check

The Division of Public Health, hereinafter known as Agency, wishes to claim 50% FFP for administration activities which are reasonable, necessary and directly related to the Medicaid Program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

1. Assistance to DMA in development and implementation of statewide Health Check policies and procedures in collaboration with the Division of Mental health/developmental Disabilities/Substance Abuse Services and the Office of Rural Health;
2. Assistance to DMA in the development of service delivery systems through recruitment of new participants at the local level, and provide site visits, phone calls, annual plan reviews and follow-up consultation reports related to Health Check Program services;
3. Provision of consultations, workshops and in-service training concerning the Health Check Program to health check Outreach project;
4. Assistance to local health departments in the establishment of coordinated service and referral arrangements with other health and human service agencies and private providers that serve Health Check eligible children;
5. Assistance to DMA in the design and implementation of evaluation protocols to measure the impact of Health Check services on healthcare utilization and participation rates;
6. Assistance to DMA in the development of outreach and marketing strategies to promote the use of Health Check services; and
7. Assistance to DMA in the development and updating of health Check Policy and procedure manual for local Health Check outreach coordinators.

The agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.

DMA reimbursement for allowable administrative costs will not exceed $60,000 annually plus indirect costs as approved in the current allocation plan. The level of Agency expenditures for Health Check outreach coordinator positions (two FTE positions and related travel/subsistence expenses) will serve as the basis for claiming FFP. Percent of expenditures attributable to Medicaid clients is 100%. All expenditures are eligible for FFP.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Health Choice

The Division of Public Health, hereinafter known as Agency, wishes to claim the FFP rate approved for SCHIP activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are outlined below.

Provide statewide leadership for the outreach and special needs components of “NC Health Choice,” North Carolina’s children’s health insurance program under Title XXI.

A. DPH is the lead agency for developing and implementing outreach activities including, but not limited to, the following:

1. Maintain an outreach component with representation from state and local governments, health care providers, and family advocacy organizations to provide advice on the development, implementation and evaluation of outreach efforts;
2. Develop, print and distribute outreach materials statewide;
3. Develop media outreach materials (newspaper articles, public service announcements, etc.) and facilitate their distribution;

B. DPH as lead agency for the special needs portion of the program, will manage activities including, but not limited to, the following:

1. Develop policies to successfully implement the special needs service components;
2. Work with DMA to develop and implement all prior authorization mechanisms to assure that claims meet legislative and program requirements;
3. Staff the Commission on Children with Special Health Care Needs established under state law and staff committees established by the Commission to meet its objectives.
4. Maintain a toll-free help line to provide assistance to families of children with special needs.

DMA and DPH mutually agree to:
1. Assign appropriate staff to facilitate implementation of the outreach component.
2. Develop plans to monitor outreach activities and quality assurance for the special needs component.
3. Assign representatives to meet at least quarterly to evaluate overall performance and to revise future plans.

The Agency agrees to follow regulations for SCHIP (Title XXI) activities. One hundred percent of the activities are related to Health Check/NC Health Choice Programs and therefore available to be used as a basis for the match. DMA agrees to assist DPH with regard to the outreach and special needs components of NC Health Choice. DMA will transfer state funds to DPH as a basis for the match to implement the outreach and special needs component of the program. The total amount of funds (state and federal) will not
exceed $650,000 plus indirect cost as approved in the current allocation plan. This FFP supports 2 FTEs in the special needs component. DPH will administer the activities listed above based on level funding from DMA.

Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.

The original date for this FFP was August 1999. The effective date of this new agreement is April 1, 2001.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Social Work Consultants

The Division of Public Health, hereinafter known as Agency, wishes to claim 50% FFP for administration activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

1. Provide social work consultation, technical assistance, and policy and program guidance to local health departments concerning the content, organization and delivery of maternity care coordination, psychosocial counseling and maternal outreach services.

2. Assess the appropriateness and quality of case management, psychosocial and maternal outreach services provided to Medicaid recipients by local health departments, and provide follow-up consultation, technical assistance and training as necessary.

3. Develop in collaboration with DMA all policy statements related to or including reference to DMA reimbursement or other applicable policies.

4. Provide and/or arrange in-service training for local maternity coordinators, clinical social workers, and maternal outreach workers, who serve Medicaid clients.

5. Provide consultation and technical assistance to local health departments in the establishment of coordinated service and referral arrangements with other health and human service agencies that serve Medicaid eligible pregnant women and children.

6. In collaboration with DMA develop the design and implementation of evaluation protocols to measure the impact of case management service utilization and health status.

7. Develop and update for DMA approval service manuals for local case managers who serve Medicaid recipients.

DMA reimbursement for allowable administrative costs covers 7 full-time FTEs and will not exceed $225,000 per year plus indirect cost as approved in the current allocation plan. The level of Agency expenditures for Public Health Social Work Consultation salaries and fringe benefits and travel and the percentage of health department maternity care coordination, maternal outreach and psychosocial services provided to Medicaid-eligible clients will serve as the basis for claiming FFP. The Agency will use FFP to support salaries, fringe benefits and travel-related expenses of Public Health Social Work Consultant staff.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs  
For Medicaid Administration  
WCH Nurse Consultants

The Division of Public Health, hereinafter known as Agency, wishes to claim 75% FFP for administration activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

1. Provide nursing consultation, technical assistance, and policy and program guidance to local health departments on the clinical content, organization and delivery of family planning, maternal health, child health, child service coordination, and specialized pediatric services to Medicaid recipients.

2. Through periodic medical record reviews, assess the appropriateness, scope and quality of maternal health, child health and family planning services – including referral and follow-up services - provided to Medicaid recipients by local health departments, and provide follow-up consultation, technical assistance and training as necessary.

3. Assist DMA in the planning, implementation and evaluation of the Baby Love and Health Check Programs. Such activities include:
   a. Identifying and removing barriers that limit the ability of Medicaid recipients to access health care services.
   b. Conducting provider recruitment to improve private participation in Medicaid and to improve health care access for Medicaid recipients.
   c. Providing and/or arranging training for local staff who have responsibility for providing outreach and direct services to Medicaid clients.
   d. Developing and updating service and program manuals for local health care providers who serve Medicaid clients.
   e. Assisting local health departments in the establishment of coordinated referral arrangements with other primary and specialized health and human service agencies that serve Medicaid clients.
   f. In consultation with professional organizations and societies, developing service policies and standards for Medicaid covered services, in accordance with professionally recognized protocols and standards of care.
   g. Developing outreach and marketing strategies, which promote the use of preventive and primary care such as Health Check, prenatal and family planning services by Medicaid recipients.
   h. Designing and implementing evaluation protocols to measure program impact on service utilization and health status.

DMA reimbursement for allowable administrative costs will not exceed $500,000 per year plus indirect cost as approved in the current allocation plan. The level of Agency expenditures for 17 FTEs for Public Health Nurse Consultation salaries and fringe benefits and travel and the percentage of health department family planning, maternal
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Adolescent Parenting Program

The Division of Public Health, hereinafter known as Agency, wishes to claim 50% FFP for administration activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are related to the Adolescent Parenting Program.

The Adolescent Parenting Program is intended to assist local agencies including local departments of social services, local public health departments and private not-for-profit organizations in strengthening services to pregnant and parenting adolescents that will lead to personal self-sufficiency and economic self-support. The target population is first time pregnant or parenting adolescents who are seventeen years of age or younger. Primary objectives include the provision of preventive services to adolescent parents, including prevention of the adolescent’s second pregnancy, completion of their high school education, and the prevention of abuse/neglect of their children. Independent evaluation has proven that Adolescent Parenting Program participants had less than half the rate of second pregnancies found among adolescents in general in the program counties.

Monthly data collection reports from involved counties are sent to the State APP Consultant and these records are audited according to established “compliance requirements.”

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. DMA reimbursement for allowable administrative costs will not exceed $798,795 plus indirect cost as approved in the current cost allocation plan; this includes support for 1 FTE and will be based on the percentage of total clients who are Medicaid-eligible. Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
health, child health, CSC and CSHS services provided to Medicaid-eligible clients will serve as the basis for claiming FFP. The Agency will use FFP to support salaries, fringe benefits and travel-related expenses of Public Health Nurse Consultant staff.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs

For Medicaid Administration
Regional School Nurse Consultants

The Division of Public Health, Women’s and Children’s Section, hereafter referred to as Agency, wishes to claim 75% FFP for clinical activities that are reasonable, necessary and directly related to the Medicaid Program. The Medicaid activities this Agency provides and for which FFP will be claimed are related to provision of training, consultation and technical assistance provided by regional school nurse consultants to school systems, school nurses, and educators. These school nurse consultants spend a substantial portion of their time working with educators, health providers and families regarding coordination of health care services and in-school care of children with special health care needs.

Based on the level of state funding allocated to support this service we are requesting a FFP to support this program in order to improve services. Specifically we will:

1. Provide orientation and training to each new school nurse in the state;
2. Provide clinical consultation and technical assistance to school nurses and/or other school staff members in schools that do not have a nurse on-site full time;
3. Consult with families, health care providers and others regarding coordination of services to children with special health care needs.

The level of state expenditures for these consultants will be the basis for claiming FFP. The Division of Women’s and Children’s Health will use FFP to support the school health programs in all NC public schools.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowance will be the responsibility of the Agency.

Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $150,000 annually plus indirect cost as approved in the current allocation plan. This request is based on salary, fringe, travel and training expenditures for 9 regional school nurse consultants. The percent of children served who are Medicaid eligible (currently 30% making the net per cent that is eligible for Medicaid Administrative Match against total costs is 22.5%) will be the basis for determining the percentage billed.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Public Health Training and Information Network

The Division of Public Health, hereinafter known as Agency, wishes to claim 50% FFP for administration activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

Developmental and maintenance costs related to the provision of training and consultation to local health department staff through the Public Health Training and Information Network (PHTIN) including: personnel, system maintenance, line charges, equipment purchase and repair and other incidental costs. This agreement applies to the 56% of on-air time which is used for programs/training and consultative sessions that are directly related to Medicaid issues or services. The PHTIN and its backbone the NC Information Highway are an efficient and effective way to offer public health staff the most current and up-to-date information and training necessary to provide quality care to Medicaid recipients.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. DMA reimbursement for allowable administrative costs will not exceed $200,000 plus indirect cost as approved in the current allocation plan. This includes support for 1 FTE plus positions which are a part of a contract with UNC-CH, where the PHTIN hub is located. Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
HIV CMS and CAP/AIDS

The Division of Public Health, hereinafter known as Agency, wishes to claim FFP for administration activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

Administration and program and nursing consultation for the HIV CMS and CAP/AIDS programs to include: two (2) FTE program consultant positions, one (1) nursing consultant position and one (1) administrative support position to meet the responsibilities outlined in Section M of the Intra-Agency Agreement. Funding includes operational costs for the above positions and will be provided contingent upon the following:
- DPH will establish the positions within its budget and may show a Federal Title XIX match for these positions;
- DPH will automatically include direct costs in each billing to DMA in accordance with the approved cost allocation plan;
- DMA will reimburse 50% of the costs of the above cited administrative and program consultant positions and 75% of the costs of the one nurse consultant position with DPH responsible for the remaining costs for the positions with non-federal funding;
- DPH will keep records of the costs associated with these staff positions sufficient to meet federal audit requirements; the records shall substantiate that the duties performed within these positions meet the requirements for Medicaid reimbursement and document the costs related to these positions. DPH accepts financial responsibility related to this expenditure of Medicaid funds.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. DMA reimbursement will not exceed $115,000 per year plus indirect cost as approved in the current allocation plan. Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Administrative Consultation

The Division of Public Health, hereinafter known as Agency, wishes to claim 50% FFP for administration activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

Administration and fiscal, budgetary and accounting consultation to local health departments related to Medicaid-eligible recipients, reimbursable services and appropriate accounting principles for tracking Medicaid billing and revenues as well as the cost of providing services. Funding will include: four (4) FTE administrative consultant positions, one (1) FTE staff development specialist position and one (1) FTE Chief of Local Health Services position based on the percentage of Medicaid clients served by local health departments statewide. For FY2000, this was 45.2%. These positions participate in the monitoring visits to local health departments to assure appropriate accounting of staff time and other expenses related to the cost study to provide for cost-based reimbursement to local health departments. In addition, they work with local health departments to assist them in billing all third party payors and individuals for services in order to comply with the requirements that Medicaid be the payor of last resort. The Chief position supervises the business side of the cost-finding and rate-setting process for local health departments and develops and disseminates written communications with local health departments from DPH and DMA on policy and rate schedules. Funding covers salary, fringe benefits and operational expenses for these positions based on the amount of their time spent in consultation and training related to Medicaid-eligible recipients and reimbursable services. Funding will be provided contingent upon the following:

- DPH will establish the positions within its budget and may show a Federal Title XIX match for these positions;
- DPH will submit to DMA a monthly reimbursement form for allowable Medicaid costs for each of the above cited positions;
- DPH will be responsible for the remaining costs for the positions with non-federal funding;
- DPH will keep records of the costs associated with these staff positions sufficient to meet federal audit requirements; the records shall substantiate that the duties performed within these positions meet the requirements for Medicaid reimbursement and document the costs related to these positions. DPH accepts financial responsibility related to this expenditure of Medicaid funds.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached as a part of this agreement. DMA reimbursement will not exceed $130,000 per year plus indirect cost as approved in the current cost allocation plan. Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs  
For Medicaid Administration  
Fetal and Infant Mortality Review

The Division of Public Health, hereafter known as Agency, wishes to claim 50% FFP for administrative activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid activities this Agency provides and for which FFP will be claimed are:

In collaboration with the Division of Medical Assistance and the State Center for Health Statistics plan, implement and evaluate the National Fetal and Infant Mortality Review Program for pregnant women and their infants, targeting Medicaid recipients. This program is utilized by over 35 states and is endorsed by the American College of Obstetricians and Gynecologists, the March of Dimes Birth Defects Foundation and the federal Maternal and Child Health Bureau.

The Fetal and Infant Mortality Review (FIMR) process is the systematic process of examining the fetal and infant deaths in a community. The Maternal Health Unit administers the program and conducts the FIMR process for all infant and fetal deaths occurring in Mecklenburg, Cleveland, Forsyth, Davie, Davidson, Stokes, Yadkin and Surry county residents. The FIMR process is carried out through contractual arrangements with tertiary hospitals (Carolinas Medical Center, Charlotte and Wake forest University School of Medicine, Winston-Salem). A MHU Nurse Consultant II serves as Program Manager for the program. FIMR will be conducted in six regional sites and one statewide site, beginning with two regional sites.

Fetal and infant deaths are sentinel events, which can serve to identify episodes of poor health care, Perinatal System Care failures and reasons behind such failures. The reasons are reexamined to see if they represent a consistent pattern or an unusual occurrence not easily corrected. Information from this process can be translated to improved birth outcomes for NC families, which will, in the long run, save DMA funds. Although this process looks only at deaths, the findings can be generalized to the larger population of infants that are born either too early, weighing too little, or experiencing birth defects that make them medically fragile. The cost of care for such infants is disproportionately provided by public dollars, including Medicaid funds.

FIMR includes a structured interviews of providers and family members, medical record/chart abstraction, and vital record information; data from this process is entered into a database designed by the national FIMR program. This information is summarized by the Work Group, who then present the information to the review committee. Discussion by this multidisciplinary team of health care professionals is focused on identifying and closing the gaps in the health care system to prevent future deaths. It includes discussion about public policies and assistance programs, accessibility of appropriate services, cultural beliefs concerning health care and parental knowledge or motivation, which may contribute to an adverse outcome. Findings and recommendations and then shared with the Community Coalition for further review and implementation of policies and action steps.

Steps to implement and sustain this program include:

a) Building and maintaining community support.

b) Determining the infant mortality problem from existing information.

c) Completing and updating protocols for the FIMR.

d) Establishing and maintaining review committees.

e) Establishing a system for case identification.

f) Establishing a home interview process.

g) Addressing any confidentiality issues.

h) Establishing and maintaining a record abstraction process.

i) Establishing and maintaining a process for tracking recommendations and actions.

j) Establishing a case summary process.

k) Developing fact sheets documenting the local infant mortality problem.
1) Initiating and continuing the review of cases.
2) Establishing periodic evaluation of FIMR and summary report.
3) Developing system for dissemination of information.

Some examples of systems issues identified and addressed by other state FIMR projects:

1) **Screening for domestic violence**—FIMR has found through their chart reviews that screening for intimate partner violence is less than a standard practice by the majority of maternal care providers. Research has shown that abused women are more likely to be identified during pregnancy. In addition, abuse during pregnancy increases the chance of an infant being born prematurely, which in turn increases the infant's chance of being born low-birth weight, which again impacts the level of care and resources needed to support a less than healthy infant. According to the latest research done by J. Koch on low birth weight infants, children with low birth weights were not more likely to be identified in official reports of child abuse. His hypothesis is that by receiving high risk medical and support services issues and factors associated with child abuse are prevented. The systems approach to improving care would be to integrate risk assessment by: asking and documenting domestic violence in the patient's medical record on an ongoing basis during the pregnancy; provider skill training; and modifying the health care environment to be conducive for patient revelation. Therefore, the P/NOETs are being used to educate the maternal health care providers to better screen and recognize clients who experience domestic violence during pregnancy.

2) **Recognizing signs and symptoms of Urinary Tract Infections (UTIs) and Sexually Transmitted Disease (STDs)**—In reviewing medical records it was noted that many of the fetal/infant deaths occurred in women who delayed seeking medical treatment for UTIs and STDs. Narratives in the records relayed that women were confused about what was normal versus abnormal when it came to some of the common discomforts and symptoms of pregnancy. The intervention was aimed at improving client education about STDs and UTIs and their potential impact on a pregnancy through the development of an easy to read brochure that the local perinatal task forces distributed in local beauty shops, laundry mats, stores and other community locations. Frequent and reoccurring UTIs and untreated STDs are known precursors to preterm labor; and in the case of certain STDs contribute to fetal deaths and congenital abnormalities. Early recognition and treatment of UTIs and STDs is much less costly to manage and yields a much healthier outcome for the fetus/infant and mother.

3) **Improvement in the method for accepting pregnant women into the transport system may reduce the odds of birth occurring at a hospital inappropriately equipped to care for the infant**—One South Carolina FIMR discovered that it was taking rural physicians 6 phone calls and approximately 6-7 hrs. Time to get authorization to transport women to the closest tertiary hospital, however, after the infant was born it only took one phone call to activate the system to transport a very high-risk baby. As a result the Perinatal Region worked with the tertiary care hospitals to revise its protocol for transfer and transformed it into a one-phone call transportation protocol. This facilitated more timely transfer of high risk pregnant women, improved status of infants being delivered at hospitals appropriate for the level of care the would need, and reduced local physician frustration in referring to the tertiary care center and increased the number of appropriate referrals for delivery to the tertiary hospitals. Improvements in this system reduced cost of care and liability to the delivering hospitals and transport systems.

These activities are based upon the **North Carolina Comprehensive Infant Mortality Reduction Initiative**—Section VIII. Promoting Effective Pregnancy Related Care and Section XI. Understanding Birth Outcomes: From Data to Action and the North Carolina Institute of Medicine's Child Health Plan.

The level of Agency expenditures for the Fetal and Infant Mortality Review and the percentage of Medicaid deliveries (currently 44%) will serve as the basis for claiming FFP. DMA reimbursement will not exceed $40,000 per year plus indirect cost as approved in the current allocation plan. The Agency agrees to follow "Guidelines for Requesting Federal Financial Participation for Medicaid Administrative Activities, which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
AGREEMENT TO CLAIM FEDERAL FINANCIAL PARTICIPATION (FFP) COSTS
FOR MEDICAID ADMINISTRATION
Birth Defects Monitoring Program

The Division of Public Health, hereafter known as Agency, wishes to claim 50% FFP for administrative activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid activities this Agency provides and for which FFP will be claimed are as follows:

In collaboration with the North Carolina Birth Defects Monitoring Program (BDMP) within the Division of Public Health, the Agency will design and implement a system for the early identification, counseling, and referral of families of infants diagnosed with birth defects, with a specific focus on the Medicaid population. The major aims of this project are to reduce the incidence of preventable birth defects such as neural tube defects (NTDs), and to improve the physical and developmental outcomes among children born with handicapping conditions in North Carolina.

The BDMP is a state-mandated surveillance program that was created to collect, analyze, and disseminate information related to the incidence and prevention of birth defects in North Carolina. The program operates statewide, covering an annual birth population of over 110,000 infants. Information on infants diagnosed with congenital anomalies within the first year of life is collected through systematic review of hospital medical records and through existing data sources such as hospital discharge records. Data from the various sources are consolidated and maintained in a central registry database. Approximately 5,000 new cases are added to the registry each year. Because infants with birth defects tend to come from economically disadvantaged families, and because of the high medical costs associated with these conditions, at least 50 percent of these infants receive Medicaid.

Due to the high incidence of neural tube defects in the state, the BDMP, in conjunction with the Women’s and Children’s Health Section (WCHS), has established a system for rapid ascertainment of NTDs and providing families of affected infants with information about preventing subsequent occurrences through folic acid education and counseling. This system also provides families with information about available support services to help reduce secondary disabilities and improve their ability to manage the child’s condition. In 1998-99, 60 percent of the families of children with spina bifida were enrolled in Medicaid. Aside from the direct benefits of this program to children with NTDs and their families, the potential economic savings to the state, and the Medicaid program in particular, are substantial. Each year in North Carolina, an estimated $12 million is spent on medical costs for children ages 5 and under with spina bifida. About two-thirds of this amount, or $8 million, is paid by Medicaid.

One limitation of the above project is that it is limited to families of children with neural tube defects. Because NTDs comprise only about 4-5 percent of all serious birth defects, there are many children with other types of birth defects who currently may not be getting the family counseling and support services that they need. This is due, in part, to the fact that the state has not established a systematic means of linking the Birth Defects Monitoring Program with children’s special health services and early intervention programs. As shown in other states, such linkages can provide a very cost-effective and efficient means for ensuring that all children with birth defects are identified and referred to services in a timely manner.

Based on the level of state funding allocated to support the case finding and data collection components of the Birth Defects Monitoring Program, we are requesting an FFP to support an expansion of the program in order to improve the linkage of families identified through the BDMP with available preventive and support services. Specifically, we will:
1. Working with the Birth Defects Monitoring Program's advisory committee and specialists in pediatric genetics, child development, and early intervention, identify a priority list of specific birth defects that require the most intensive level of follow-up care and treatment.

2. Through review of hospital medical records, surveillance specialists with the BDMP will identify infants with the above disorders, flag the records as priority infants, and submit case reports for inclusion in the central registry database. If the mother or infant is enrolled in Medicaid, the Medicaid ID number is entered into the case report. This provides a means of tracking the referrals provided to Medicaid patients.

3. Develop a data-based mechanism and administrative procedures for reporting these infants/families to the Women's and Children's Health Section for follow-up in a timely manner. Because many of these infants will be presenting with complex medical problems and their parents are likely to have numerous questions about their child's condition, the initial contact with the families will be made by a certified genetic counselor within the Genetic Health Care Unit of WCHS.

4. Design and develop a tracking system for WCHS staff to determine the family's specific needs, the referrals that were made for them, and the status of these referrals.

5. Evaluate the referral and tracking system with respect to timeliness of reporting, referrals made/completed, potential gaps or barriers to care that need to be addressed, and satisfaction of the families with the referral process.

The level of Agency expenditures for the Birth Defects Monitoring Program, and the percentage of infants identified by the BDMP who receive Medicaid will serve as the basis for claiming FFP. The Agency agrees to follow "Guidelines for Requesting Federal Financial Participation for Medicaid Administrative Activities", which are attached and are a part of this agreement. DMA reimbursement will not exceed $100,000 plus indirect costs approved in the current cost allocation plan; this includes support for 7 FTEs in State Center for Health Statistics and 1 FTE in Genetics Healthcare Unit. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Regional Physical Therapy Consultants

The Division of Public Health, Women’s and Children’s Section, hereafter referred to as Agency, wishes to claim 75% FFP for activities that are reasonable, necessary and directly related to the Medicaid Program. The Medicaid administrative activities this Agency provides and for which FFP will be claimed are related to training, consultation, and technical assistance services provided by WCHS regional physical therapy (PT) consultants to Medicaid recipients. Pediatric physical therapy and occupational therapy services are essential for children with special health care needs and their families. These professionals are familiar with the causes and treatment of a range of diseases and conditions, and can serve as a needed link between family and providers, and among various health care providers to assure that systems are in place to meet child and family needs in an effective and efficient manner.

Specifically we will:
1. Provide training, consultation and technical assistance to families regarding selection, procurement (primarily through Medicaid) and/or use of equipment and devices designed to increase, maintain or improve development, functioning, learning and/or health status of children from birth to age 21 who have special health care needs.
2. Provide consultation and technical assistance to health care providers and administrative staff regarding policies and procedures for rental or purchase of equipment or devices designed to increase, maintain or improve development, functioning, learning and/or health status of special needs children.
3. Review and authorize requests for purchase of assistive technology devices for Medicaid-eligible children through the DHHS Purchase of Medical Care Services, and otherwise assist DMA in the development, implementation and evaluation of preventive and primary health care services for children with special health care needs.
4. Establish and maintain linkages among early intervention programs, Assistive Technology Resource Centers, Developmental Evaluation Centers, and other local agencies serving this population, including local public health agencies, Head Start programs, child care facilities and others serving Medicaid clients, in order to facilitate family-centered, coordinated care.
5. Provide leadership in the development and dissemination of evidence-based practice guidelines and standards for delivery of services to children with special health care needs.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency including its subcontractor(s). Any audit exceptions or disallowance will be the responsibility of the Agency or sub-contractor(s).

This request is based on salary, fringe, travel and training expenditures for 90% (non-direct service time) of 5 FTE PT consultant positions; the percent of clients who are Medicaid eligible will serve as the basis for the match. Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $300,000 plus indirect cost as approved in the current allocation plan.
An Agreement to Claim Federal Financial Participation (FFP) Costs For Medicaid Administration Community Transition Coordinators

The Division of Public Health, Women's and Children's Section, hereafter referred to as the Agency, wishes to claim FFP for clinical services that are reasonable, necessary and directly related to the Medicaid Program at the rate of 75% for nurses, and 50% for other providers. The Medicaid administrative activities this Agency provides and for which FFP will be claimed are related to in-hospital identification of infants who have, or are at risk for, developmental delay, chronic illness, or handicapping conditions.

Based on the level of state funding allocated to support provision of these services, we are requesting an FFP to support expansion of the program in order to improve services for children with chronic illnesses, handicapping conditions or developmental disabilities. Specifically we will:

1. Screen hospitalized children birth to five years of age for risk conditions that potentially lead to developmental delay/disability, chronic illness or social-emotional disorder, and for a diagnosed developmental delay/disability, chronic illness or social/emotional disorder.
2. Refer identified children birth to five years of age to the Child Service Coordination Program.
3. Refer identified children to the Infant-Toddler Program and other community agencies in compliance with Child Find legislation.
4. Provide follow-up on referrals for children/families to the Child Service Coordination Program and to other community agencies.
5. Provide continuing education activities related to children with special health care needs.
6. Provide education, counseling and outreach services for children birth to 21 years of age who are at risk for or have special needs.

The Agency agrees to follow "Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities" which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency including its subcontractor(s). Any audit exceptions or disallowance will be the responsibility of the Agency or sub-contractor(s).

The CTCs screen all hospitalizations for children from birth to five in their facilities. Based on the scope of work in each contract and activity reports, 90% of CTC time is spent on activities described in this document. The population served (children 0-5) mirrors the state overall proportion of children in this age group that receive Medicaid benefits. This request is based on total funds for Community Transition Coordinator contracts with (currently ten) agencies that use funds for full or partial support for positions (currently 14). (At the time this agreement went into effect 11 (79%) of the positions supported were nurses.)

Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $180,000 plus indirect cost as approved in the current allocation plan.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Sickle Cell Services

The Division of Public Health, Women’s and Children’s Section, hereafter referred to as Agency, wishes to claim 50% FFP for activities that are reasonable, necessary and directly related to the Medicaid Program. The activities this Agency provides and for which FFP will be claimed are sickle cell services including consultation, technical assistance, training and program guidance for providers and families on the organization and delivery of sickle cell health care services to Medicaid recipients. This will include 12 FTEs – 9 FTE’s providing 50% non-direct service and 3 FTEs providing 100% non-direct service.

Based on the level of state funding allocated to support sickle cell health services, we are requesting an FFP to support an expansion of the program in order to improve services to children and families who have or are at risk for having health care needs related to inherited hemoglobinopathies. Staff involved in these activities provide case management services to families whose newborns have been identified as having sickle cell or another hemoglobinopathy disease. They are also responsible for working with health providers in the community, in order to develop and enhance the quality of medical care provided to these families and children. Educating the providers and lay community about sickle cell disease is an integral part of their job. Services delivered through this program assist in ensuring early and needed health care interventions, prevent infant deaths and help improve quality of life. The program collects data on the number of clients served and the type of services provided. Outcome data can be measured by evaluating the data on the number of children on prophylaxis antibiotics and, over time, the decrease in the number of infant deaths due to sickle cell disease. This service targets reductions in the number of medical center visits, emergency room visits and other medical payment requests through the provision of preventive and early intervention services.

Specifically we will:

1. Assist health professionals in case identification and review of patient records and work with families to gather medical and family information;

2. Facilitate re-testing of newborns and assessments of children under 19 years of age with hemoglobinopathy disease on a regular basis;

3. Work with the medical centers to facilitate client services;

4. Provide education and guidance to families of infants identified through the newborn hemoglobinopathy screening program;

5. Provide education to families with sickle cell or other traits when requested;

6. Provide technical assistance and consultation to professionals and communities at large as appropriate;
7. Work as a liaison between families and schools prior to the child entering kindergarten;

8. Develop and distribute materials related to hemoglobinopathies including brochures, fact sheets, and audio visual information;

9. Provide consultation to WCH regional staff, health departments, private providers, hospital personnel, families, individuals and the Division of Medical Assistance;

10. Assist in the establishment of coordinated referral arrangements with primary and specialized health care and human service agencies that serve Medicaid clients; and

11. Provide quality assurance by planning and implementing standards of care for services and interpreting policies and procedures on Medicaid rules and regulations as requested.

Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $250,000 per year plus indirect cost as approved in the current allocation plan. The level of state WCH expenditures for Sickle Cell Program and the percentage of clients (currently 60% for staff and 35% for contracts) who are Medicaid eligible will serve as the basis for claiming FFP. The Division of Public Health will use FFP to support the expansion of sickle cell services.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowance will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
LTAT Nurse Consultants

The Division of Public Health, hereinafter known as Agency, wishes to claim 75% FFP for administration activities which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

1. Provide nursing consultation, technical assistance, and policy guidance to local health departments on the appropriate documentation and coding of clinical services including family planning, maternal health, child health, communicable and sexually transmitted diseases to Medicaid recipients.

2. Through periodic medical record reviews, assess the appropriateness of documentation and coding for services provided to Medicaid recipients by local health departments, and provide follow-up consultation, technical assistance and training as necessary.

The services provided by these consultants will benefit DMA by assuring appropriate coding by local health departments such that that costs of providing service are reflected in appropriate services being billed; this should result in lower “cost settlement” for unreimbursed costs of providing services. DMA reimbursement for allowable administrative costs will include salaries, fringe benefits and operating expenses for five (5) FTEs - the four Public Health Nurse Consultants and the Head of Public Health Nursing and Professional Development - based on the percentage of Medicaid clients served by local health departments statewide (for fiscal year 2000, this was 45.2%). The Agency will use FFP to support salaries, fringe benefits and operating expenses of Public Health Nurse Consultant staff. DPH will submit to DMA a quarterly request for reimbursement for allowable costs for each position cited and will keep records of the costs associated with these positions sufficient to meet federal audit requirements.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached as a part of this agreement. DMA reimbursement will not exceed $200,000 per year plus indirect cost as approved by the current allocation plan. Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Newborn Hearing Screening

The Division of Public Health, Women's and Children's Section, hereafter referred to as Agency, wishes to claim 75% FFP for activities that are reasonable, necessary and directly related to the Medicaid Program. The Medicaid activities this Agency provides and for which FFP will be claimed are related to the NC universal newborn hearing screening program. This program is jointly administered by the Division of Public Health (DPH), and the Division of Early Intervention and Education (DEIE). The Division of Public Health will assure the screening of all newborns for audiological problems, and referral for appropriate follow up. DEIE will provide diagnostic and intervention services for children identified at risk for hearing loss.

DPH activities will be coordinated through a statewide network of WCHS and contractual speech/language pathologists and audiologists. These regional consultants will work in collaboration with Developmental Evaluation Centers, Community Transition Coordinators, WCH Regional Nurse and Social Work Consultants, Child Service Coordinators, birthing hospitals, local health departments and others. A data system for collection of both initial and follow-up information for newborns has been developed to track infants through the screening and follow up process.

Based on the level of state funding allocated to support this service we are requesting a FFP to support this program in order to improve services. Specifically we will:

1. Monitor and supervise birthing facilities and other sites performing hearing screening regarding their performance in screening and reporting of newborn hearing data;

2. Track infants who missed initial or follow-up hearing screening and assure completion of the screening procedures;

3. Consult with families, agencies and professionals dealing with infants and toddlers regarding selection, procurement, and/or repair of equipment and devices related to communication, hearing, and/or cognitive development, which are available through the Assistive Technology (AT) and/or Children’s Special Health Services (CSHS) Programs;

4. Provide assistance to requesting agencies or others regarding completion of documentation, review, or authorization of requests related to communication, hearing, and/or cognitive development to be submitted to Purchase of Medical Care Services (POMCS) for Assistive Technology, Medicaid or CSHS funding;

5. Train, supervise and/or monitor Head Start and health department staff providing hearing screenings;

6. Provide speech, language or hearing screening services for children seen or referred by local health departments, or for children without a source of funding; and for pre-kindergarten children when performed as a special health promotional event;

7. Assist in development of effective and efficient systems for follow up of children with suspected or confirmed communication-related deficits;

8. Provide training, consultation and technical assistance to families and health care providers regarding services available and referral procedures when communication disorders or delays are suspected.

The Agency agrees to follow "Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities" which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency including its subcontractor(s). Any audit exceptions or disallowance will be the responsibility of the Agency or sub-contractor(s).
This request is based on salary, fringe, travel and training for 12 Speech and Hearing positions, and funds allocated to four contracts for the delivery of the services described above. The speech and hearing consultants (employees and contractors) spend 90% of their time on activities described in this document, for a population that mirrors the state overall proportion of children receiving Medicaid benefits.

Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $330,000 plus indirect cost as approved in the current cost allocation plan.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
POETS/NOETS

The Maternal Health Unit of the Women’s and Children’s Health Section, Division of Public
Health, hereafter known as Agency, wishes to claim 75% FFP for administrative activities which
are reasonable, necessary and directly related to the Medicaid program. The goal of the P/NOET
program is to improve the quality of care provided to women and infants by primary perinatal
and neonatal providers at private offices, rural and community health centers, tertiary centers,
and local health departments and thereby reduce infant mortality, morbidity and cost of health
care. The Perinatal/Neonatal Outreach and Education Training program benefits DMA by
assuring that Medicaid reimbursed providers are providing state-of-the art, evidence-based,
quality health care to their Medicaid-eligible clients. Appropriate transfers of the high risk
pregnant woman and infants are facilitated by having well trained educated care providers prior
to delivery with the skills needed to recognize the need for a maternal transfer prior to delivery
and prepared for a successful back transfer of the infant to a lower cost community facility.
Currently 44% of all births are to women receiving Medicaid, many of whom are at high risk for
poor birth outcomes. This program can positively impact the costs, currently 84% of the
funding spent on newborns and infants up to age 1, associated with providing care to sick or
medically fragile newborns.

The Medicaid activities this Agency provides and for which FFP will be claimed utilize master’s
level clinical nurse specialists to:

1. **Improve the access to perinatal care** for Medicaid recipients—especially high risk pregnant
   women and medically fragile newborns by:
   a) Providing consultation, technical assistance, policy and program guidance to local health
departments, tertiary and community hospitals, community health centers, and private
health providers of perinatal care on the clinical content, organization and delivery of
perinatal health services, targeting pregnant and postpartum women and their infants who
are Medicaid recipients.
   b) Implementing and promoting the appropriate use of the statewide Perinatal Care System
   and related programs especially for high-risk women and their infants.
   c) Identifying and removing barriers that limit the ability of Medicaid recipient to access
perinatal health care services.
   d) Conducting provider recruitment to improve private participation in Medicaid and to
   improve health care access for Medicaid recipients.
   e) Improving access to perinatal and preconceptual care services through increasing the
   number of enhanced role nurses by serving as their preceptor and consultant.

2. **Improve the quality of perinatal care** provided by local health departments, tertiary and
community hospitals, community health centers, and private health providers to Medicaid
recipients through implementation of evidence-based practices, clinical education, training,
skills development, preceptorship and evaluation. Clinical areas of concentration include:
High risk perinatal and preconceptual care
Clinical care of HIV infected pregnant women and their infants
Fetal monitoring and infant resuscitation
Thrombocytopenia and pregnancy
Obstetrical legalities and ethical dilemmas in the provision of high risk perinatal care
Monitoring perinatal outcomes
Clinical identification and prevention of Group B Strep infections in the newborn
Clinical identification and management of Pregnancy Induced Hypertension
Clinical management of diabetes
Clinical care of substance abusing pregnant women and their infants
Clinical care and management of tobacco addicted women
Intrapartum assessment and management using the "Intrapartum Assessment and Management Modules"
Epidural analgesia/anesthesia in Obstetrics
Care of low birth weight/preterm infants
Clinical issues in breastfeeding

3. Improve perinatal and preconceptual care programs and services provided to Medicaid recipients, targeting high risk pregnant and postpartum women and their infants. Such activities shall include:

a) Identifying Perinatal Care System gaps that can be addressed by improved evidence based practices from the analysis of fetal, infant, and maternal mortality and morbidity.

b) Collaborating with community health care systems and local community coalitions to address Perinatal Care System gaps.

c) Assisting health care providers in the establishment of coordinated referral arrangements with other primary, community and tertiary health care and human service agencies that serve Medicaid recipients.

d) In consultation with professional organizations and societies, developing perinatal service policies and standards for Medicaid covered services, in accordance with professionally recognized protocols and standards of care.

e) Designing and implementing evaluation protocols to measure program impact on service utilization and health status.

f) Providing professional training, follow-up and technical assistance in the clinical content areas to local health departments, tertiary and community hospitals, community health centers, and private health providers of perinatal care to Medicaid recipients. Maternal Health Unit staff will assure consistency of all the trainers involved in the formulation and implementation of training plans, setting of objectives, follow-up plans and evaluation activities.

g) Publicizing training through activities such as mailing publicity brochures and newsletters to the local contact in each site as well as to other relevant programs, i.e. ACCESS Projects, Adolescent Pregnancy Prevention Projects, Minority Infant Mortality
Reduction Projects, community rural health centers, Project ASSIST Coalitions, hospitals, private physician offices, mental health centers, nurse and social work consultants and interested health care providers in contiguous county health departments.

h) Managing logistics on the day of training, assisting with evaluation of training efforts by assuring completion of pre and post-test surveys, following up with counties and offering further technical assistance.

i) Conducting a needs assessment bi-annually to determine the Perinatal Care System needs in each region. FIMR data from fetal and infant deaths, vital records data, and the NICU database are also utilized to identify gaps in the Perinatal Care System.

The importance and unique role of the P/NOETs has been recognized for over 20 years. The P/NOETs have been in existence since 1980. In 1983, the P/NOETS became an integral part of the Perinatal Care System in response to the legislation (GS 130A-127). This legislation required the Department to establish and administer a perinatal health care program. (See attached). The P/NOETs are the vital links to hospitals (both tertiary and community hospitals) and private providers in providing training toward improving clinical practices and patient outcomes.

Both the recent North Carolina Institute of Medicine’s *Child Health Plan* and the North Carolina *Comprehensive Infant Mortality Reduction Initiative* recommend increased funding for the Perinatal Outreach, Education and Training Program. An expanded Program will play a leading role in educating providers to adopt evidence-based practices.

The level of Agency expenditures for Perinatal Outreach, Education and Training Program and the percentage of Medicaid deliveries (currently 44%) will serve as the basis for claiming FFP. DMA reimbursement will not exceed $400,000 plus indirect cost as approved in the current allocation plan. The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administrative Activities, which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will be the responsibility of the Agency.
A Proposal to Claim Federal Participation (FFP) Costs
For Medicaid Administration
Public Health Dentists

The Division of Public Health, herein known as Agency, wishes to claim 75% FFP for clinical activities, which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

1. Provide public health dentist field services and technical assistance to local health departments, community health centers, school health programs and other public dental clinics to enhance and maximize access to dental and other oral health services for Medicaid clients. A particular emphasis will be placed on access to care for children. Services encompassing prevention of dental disease in children will receive significant emphasis.

2. Through telephone and/or on-site consultation and written communication, assist health directors, community health center administrators, dental directors and other public dental clinic personnel with:
   a. needs assessment of community
   b. dental clinic planning and development
   c. development of dental clinic staff roles and job descriptions
   d. interpretation of applicable dental/dental public health laws and rules, and
   e. provide training in the specialty area of dental public health

3. Assist local health departments, community health centers, school health programs and other public dental clinics with recruitment efforts related to clinic staffing.

4. Serve as the primary liaison between the Agency and locally based public dental clinics with the responsibility for interagency coordination of oral health services for children and adolescents.

5. Identify educational and practice management needs of public dental clinic staff, and participate in the development and implementation of in-service and continuing education training.

The level of Agency expenditures for Public Health Dentist Field Services costs covers nine (7) FTEs(salarics, fringe benefits, travel and a percentage of any school health services provided to Medicaid-eligible clients will serve as the basis for claiming FFP. The Agency will use FFP to support salary and fringe benefits of appropriate Agency staff.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities.” Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exception or disallowance will be the responsibility of the Agency.

Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $175,000 annually plus indirect cost as approved in the current allocation plan. This request is based on salary, fringe, travel and training expenditures for nine regional dentists. The percent of children served who are Medicaid eligible (currently 30% making the net percent that is eligible for Medicaid administrative match against total costs 22.5%) will be the basis for determining the percentage billed.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration

First Step Campaign and North Carolina Family Health Resource Line Services

The Division of Public Health, Women’s and Children’s Section, hereafter referred to as Agency, wishes to claim 50% FFP for activities that are reasonable, necessary and directly related to the Medicaid Program. The activities this Agency provides and for which FFP will be claimed are services related to the First Step Campaign and the North Carolina Family Health Resource Line (Hotline, Resource Line) including public information, education, and advocacy services for providers and families on the organization and delivery of public information and education services to Medicaid recipients.

Based on the level of state funding allocated to the First Step Campaign and the Resource Line services, we are requesting an FFP to support an expansion of the program in order to improve services to children and families who have or are at risk for having poor birth outcomes. Staff involved in these activities provides public information, advocacy, and educational services to women who are pregnant or postpartum, or families with young children. They also work with health providers throughout the state to reduce barriers to services for families in their community. Educating the providers and lay community about prenatal care, parenting skills and other issues related to family and its effect on infant morbidity and mortality is an integral part of their job. Services delivered through this program provide education on domestic violence, substance use prevention and treatment, child abuse, housing, transportation, car seat rentals, and other local resources. Bilingual staff are available to assist Spanish-speaking callers. The program collects data on the number of calls received, types of services provided, and location of calls.

By having a combined campaign and 800 number many benefits are derived, most importantly, a cost-effective and efficient service delivery system has been developed that promotes one stop shopping for North Carolina residents seeking information. This service is part of a comprehensive plan to improve birth outcomes in the state.

Specifically we will:

1) Utilizing the latest research findings, provide public education and information at no charge to North Carolina families by focusing increasing awareness of positive lifestyle choices, behaviors, and available resources that improve the chances of having a healthy pregnancy and a healthy baby by conducting an ongoing comprehensive education campaign to reduce infant mortality and morbidity by:

   a) Developing, producing and distributing educational materials and promotional items regarding family planning, preconception, pregnancy, and parenting (e.g. lactation, infant health, 0-5 years developmental issues) and perinatal substance abuse.
b) Planning and implementing specific educational campaigns (for example, “Back to Sleep” campaign) targeted towards individual causes of infant mortality and morbidity such as SIDS.

2) Provide information and referral for North Carolina families with questions about health and human services for pregnant women, infants, and their families as a part of a comprehensive plan to address the state’s high infant mortality rate by:

a) Operating a toll-free Hotline five days a week (Monday through Friday) except holidays.

b) Providing culturally and linguistically appropriate services to the Hispanic/Latino and the deaf and hard of hearing communities. A minimum of one-person bilingual in English and Spanish will be available to answer calls during all hours of operation of the North Carolina Family Health Resource Line.

c) Answering all incoming calls with trained staff or by receiving an outgoing message giving instructions. This will be verified via monitoring. Between seventy and seventy-five percent of all incoming calls will be answered by a trained staff person. During peak calling times the telephones lines will be monitored, including logging of calls, to insure and verify that all callers are reaching a trained staff person or receiving the instructional message. Documentation will be maintained including a log of unanswered calls and call volume by day and hour.

d) Utilizing clinical back-up provided by the Women’s Health Branch, Maternal Health Unit, Maternal Health Nurse Consultant, as needed, regarding issues of a medical nature, continuing education of staff and quality assurance/monitoring activities.

e) Operating a data retrieval system, which records demographic and service request statistics on Resource Line users. Statistics collected should include, but not be limited to, the type of call, how the caller heard about the hotline, demographic data, information discussed, referrals made, educational materials distributed and missed calls. Statistical reports to be provided on a monthly, quarterly, and fiscal year basis or upon request. A monthly narrative activity report detailing promotional activities, staff changes, special projects, staff in-service training, conferences attended and any significant issues or trends observed, quarterly reports summarizing statistical information and describing trends and activities, and an end of year report.

f) Operating a data retrieval system, which responds with up-to-date, standardized information to health education topic requests. Information database should address basic health and social issues affecting women of reproductive years and children through age 20 including the importance of prenatal care and well child check-ups, and the recommended periodicity schedule; Baby Love; immunization schedules; as well as, population and age appropriate information regarding nutrition, growth and development, injury prevention, violence prevention/safety, parenting skills, dental care, sexuality, sexually transmitted diseases.
g) Providing referral agency information on health and social services available to women of reproductive years and children through age 20 in each county in North Carolina, including scope of service, hours of operation, location, eligibility, and other pertinent information. Referral database should, at a minimum, include information on eligibility, rights, the application process, advocacy and problem resolution with respect to immunizations, prenatal care, WIC, Baby Love, TANF, Food Stamps and other resources, including information regarding the local agencies which administer these programs as specified above. All agencies listed in the referral database will be verified on an annual basis.

h) Providing information on substance abuse counseling and treatment services available in North Carolina for women, infants, and children.

i) Distributing requested educational and other promotional materials to Resource Line callers within two weeks of receiving the call on the following topics; family planning, preconception, pregnancy, parenting issues, perinatal substance abuse, infant care, child and teen health and development in North Carolina.

j) Following-up on requests by callers for assistance through contacts with local service providers, organizations, and other information/referral sources. This advocacy on behalf of the caller may entail problem-solving (assisting the caller in identifying constraints, offering assistance in overcoming those barriers), and repeated contacts as necessary.

k) Coordinating with other hotlines (e.g. CARELINE, Family Support Network) in relation to collaborative planning for the provision of information and referral.

l) Assess consumer satisfaction of the NC Family Health Resource Line’s services and materials.

Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $250,000 per year plus indirect cost as approved in the current allocation plan. The level of state WCH expenditures for the First Step Campaign and Resource Line (Hotline) and the percentage of infants who are Medicaid eligible will serve as the basis for claiming FFP. The Division of Public Health will use FFP to support the expansion of these services.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowance will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Health/Check/Health Choice Toll Free Hotline

The Division of Public Health, hereinafter known as Agency, wishes to claim the FFP rate approved for Health Check/Health Choice activities, which are reasonable, necessary and directly related to the North Carolina Health Choice/Health Check programs. The activities for which FFP will be claimed are delivered through a contractual arrangement to provide a toll free hotline for Health Check/NC Health Choice outreach services.

The hotline will operate five days a week for a minimum of eight hours per day (Monday through Friday), except for holidays observed by the contractor and on the Friday following Thanksgiving. The hotline named the Resource Line will:

1. Provide cultural and linguistically appropriate information for the Hispanic/ Latino and deaf, and hard of hearing communities;

2. Ensure that at least one-person who is bilingual in English and Spanish will be available to answer calls during all hours of operation;

3. Develop and operate a data retrieval system a data retrieval system on Resource Line users. Quarterly and end of year reports summarizing statistical information and describing trends and activities will be submitted to DPH;

4. Respond to requests for health information with up-to-date, standardized information. Topics may include, but are not limited to immigration, eligibility and/or enrollment information, immunization schedules. Topics also include population and age appropriate information regarding nutrition, growth and development, injury prevention, violence prevention / safety, parenting skills, dental care, sexually transmitted diseases, pregnancy prevention, substance use, and Medicaid managed care;

5. Maintain a referral database with information on Health Check/NC Health Choice for Children programs, immunizations, WIC, Baby Love, TANF, Food Stamps; Medicaid managed care, and other resources, including information regarding the local agencies which administer these programs as specified above. Provide appropriate county-specific referrals to families in need of these resources;

6. Coordinate with other hotlines (e.g. CARELINE, Family Support Network) in collaborative planning for the provision of a broad network of information and referral;

7. Coordinate participation in promotional activities and development of all materials with the NC Healthy Start Foundation and DPH to avoid duplication or fragmentation of efforts;

8. Provide client survey information on consumer satisfaction of the Resources Line’s services and materials:

9. Distribute requested education and promotional materials to Resource Line callers within two weeks of receiving a call. These materials include brochures, inserts, posters, and Health Check / NC Health Choice application forms;

10. Submit monthly expenditure and financial reports to DPH. Financial reports will include line item expenditures by category of the agency’ monthly and year-to-date expenses for the contract period.
The Agency agrees to follow Federal Financial Participation regulations for Medicaid activities (Title XIX). Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the contracting agency. Any audit exceptions or disallowances will be the responsibility of the contracting agency.

This request is based on provision of education and outreach for Health Check/NC Health Choice services and will be used in its entirety for a contractual arrangement to provide a toll free hotline service. One hundred percent of the activities are related to Health Check/NC Health Choice Programs and therefore available to be used as a basis for the match. This hotline is to serve as the Resource Line for the Health Check and NC Health Choice programs. Federal reimbursement for allowable costs will not exceed $220,000 plus indirect cost as approved in the current allocation plan.
AGREEMENT OF CLAIM FEDERAL FINANCIAL PARTICIPATION (FFP) COSTS
Perinatal Smoking Cessation and Infant Mortality Program

The Division of Public Health, Women’s and Children’s Section, hereafter referred to as Agency, wishes to claim 50% FFP for activities that are reasonable, necessary and directly related to the Medicaid Program. The activities this Agency provides and for which FFP will be claimed are services related to the Perinatal Smoking Cessation and Infant Mortality Reduction Program including consultation, technical assistance, training, program guidance, and advocacy services for providers and community organizations serving women of childbearing age who are also Medicaid recipients. This Program includes one FTE.

During pregnancy the impact of tobacco use is two-fold. Maternal complications such as placenta previa are more likely. Infants exposed to maternal smoke in utero experience higher rates of infant mortality and morbidity, including low birth weight, preterm birth, SIDS and respiratory conditions. Infants and young children exposed to environmental tobacco smoke during childhood are at higher risk of SIDS and respiratory illnesses such as asthma and wheezing. In 1999 the percent of women giving birth who smoked in the US was 12.3, while in NC the percent was 14.3.

A clinically proven smoking cessation intervention has been identified that can reduce rates of smoking during pregnancy by 30-70%. Offering this proven intervention to pregnant women is the most important thing that can be done to improve the likelihood that babies born in NC survive their first year of life and go on to have a healthy childhood. Together, the Women’s Health and Tobacco Prevention and Control Branches have labored on this problem since 1993, developing the nationally recognized “Guide for Counseling Women Who Smoke” and its companion video, which is now used in various health care settings and disseminated both statewide and nationally. Since 1996, prenatal health care providers across the state have been trained to counsel pregnant smokers to stop smoking initially through funding from an AMCHP Tobacco-Free Futures II Mini-Grant. The training is now institutionalized through use of perinatal nurse educators located in tertiary centers across the state. Progress has been made in small increments, but smoking remains a major cause of infant mortality in North Carolina.

Based on the level of state funding allocated to the Perinatal Smoking Cessation and Infant Mortality Program, we are requesting FFP to support an expansion of the program in order to improve services to women of childbearing age and their families who have or are at risk for having poor birth outcomes. The Women’s Health Branch, in collaboration with the Division of Medical Assistance, the Tobacco Prevention and Control Branch, and the Office of Rural Health, is developing guidance and facilitating the incorporation of the USPHS/Smoke-Free Families smoking cessation intervention into routine clinical health care in North Carolina. There are two major activities: First, the development and implementation of a statewide action plan to promote and develop policy around tobacco use prevention specifically focused on women of childbearing age. Secondly, the development of a statewide system to integrate brief smoking cessation counseling interventions into routine health care in the public and private sector for
Medicaid patients of childbearing age. This Program is part of a comprehensive plan to improve birth outcomes in the state.

The Medicaid activities this Agency provides and for which FFP will be claimed are:

1. Provide consultation, technical assistance, policy and program guidance to physicians, local health departments and other clinical providers of maternity care to Medicaid recipients on the clinical content, organization and delivery of smoking cessation/tobacco use services to Medicaid recipients, targeting women of childbearing age, their children and including all family members.

2. Plan, implement and evaluate smoking cessation/tobacco use services provided to women of childbearing age, especially those who are pregnant, targeting Medicaid recipients. Such activities shall include:

   a) Developing and implementing a statewide smoking cessation action plan with public and private providers.

   b) Developing a system to integrate brief smoking cessation counseling interventions into routine health care for Medicaid recipients of childbearing age in both the public and private sectors.

   c) Promoting tobacco use as a vital sign for all women of childbearing age. Increase awareness of the benefits of quitting smoking to Medicaid recipients and Medicaid providers. Institute a method of documenting tobacco use status in medical records in both Maternal Health and Women’s Preventive Health among all health departments statewide. Support a similar effort among Medicaid providers in the private sector as well.

   d) Updating the “Guide for Counseling Women Who Smoke” with assistance from ACOG nationally and the Smoke-Free Families National Dissemination Center with the Sheps Center for Health Services Research, utilizing their expertise and financial resources to develop it into a “tool kit” for local health department clinicians and other Medicaid providers (OB/GYNs) to use with women who use tobacco products.

   e) Implementing PHS Guideline “Treating Tobacco Use and Dependency: A Clinical Practice Guideline” by revising Guide and incorporating changes into the smoking cessation counseling training program and adding more of a focus on the effects of second hand smoke.

   f) Continuing to identify and support with technical assistance and materials/incentives local health departments and private providers with a high incidence of smoking among its
pregnant clientele and/or communities who identify smoking among pregnant women as a problem.

g) Providing and/or contracting with experienced trainers, at Master's level in nursing, health education or social work, to conduct the smoking cessation counseling trainings using “Guide for Counseling Women Who Smoke” and the PHS Guideline “Treating Tobacco Use and Dependency: A Clinical Practice Guideline”, and to provide follow-up and technical assistance. Maternal Health Unit staff will assure consistency of all the trainers involved in the formulation and implementation of training plans, setting of objectives, follow-up plans and evaluation activities.

h) Continuing to publicize training opportunities by mailing publicity brochures to local contacts in each site as well as to other relevant programs, i.e. ACCESS Projects, Adolescent Pregnancy Prevention Projects, Minority Infant Mortality Reduction Projects, community rural health centers, Project ASSIST Coalitions, hospitals, private physician’s offices, mental health centers, nurse, health education and social work consultants and interested health care providers in contiguous county health departments.

i) Managing logistics on the day of training, assisting with evaluation of training efforts by assuring completion of pre and post-test surveys, following up with counties and offering further technical assistance.

j) Designing and implementing evaluation protocols to measure program impact on service utilization, smoking prevalence and health status.

These activities are based upon both the North Carolina Comprehensive Infant Mortality Reduction Initiative- Section IX, October 2000 and Prenatal Smoking Cessation Initiative and Treating Tobacco Use and Dependence- A Clinical Practice Guideline, US Department of Health and Human Services, June 2000.

Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $100,000 per year plus indirect cost as approved by the current allocation Plan. The level of state WCH expenditures for the Perinatal Tobacco Cessation Program and the percentage of infants who are Medicaid eligible will serve as the basis for claiming FFP. The Division of Public Health will use FFP to support the expansion of these services.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowance will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
State Center for Health Statistics

The Division of Public Health (hereafter referred to as the Agency) wishes to claim FFP for activities of the State Center for Health Statistics (SCHS) that are reasonable, necessary and directly related to the Medicaid Program. The Medicaid administrative activities the SCHS provides and for which FFP will be claimed are detailed below.

1. Ongoing statistical/spatial analyses of desired policy and program issues related to service utilization, cost, and outcomes of Medicaid clients being served in North Carolina.

2. Dissemination of Medicaid reports and data to other state agencies and the public as requested by Division of Medical Assistance (DMA).

3. Ongoing monitoring and evaluative work related to the implementation of systems of care across the Medicaid population.

4. Providing ongoing support for work related to the Health Choice Program in North Carolina.

The State Center is statutorily charged to monitor the health status and health problems/needs of North Carolinians and the impact of services/programs that influence their health and well-being. Staffed with statisticians, epidemiologists, medical geographers, computer programmers/analysts, and having access to an array of health-related data sets, the State Center provides efficient and effective ways for DMA to obtain the most up-to-date analyses and information about the health of Medicaid clients and the quality of service provision to them. It has a long history of providing high quality services and offers continuity of analyses and information at an affordable cost.

The State Center will submit monthly invoices to DMA to claim costs in three categories:

1. The first category is to pay for a proportionate share of salary, fringe, and administrative costs based on time spent on the following:
   a) annually producing specified data reports for DMA Baby Love including the Medicaid birth outcome statistics, costs of low birthweight babies, and Medicaid births by age and county;
   b) providing technical consultation and support in order to monitor and/or evaluate health-related Medicaid program initiatives such as BABY LOVE, Medicaid Managed Care, and the Medicaid LTC project;
   c) responding to special one-time requests from DMA on projects or activities of interest to them;
d) Completing tasks defined in the annual work plan established between DMA and the State Center.

e) Analyzing and reporting on evaluative work carried out to measure programmatic and fiscal efficacy of Access I/II/III managed care programs. This work is done in conjunction with the Office of Research, Demonstration, and Rural Health Development (ORDRHD).

f) Cooperating with DMA's Decision Support Unit in carrying out specific requests from outside agencies using Medicaid data depending on the availability of resources at the SCHS.

2. The second category is the actual or prorated cost to store, process, and print the Medicaid data or reports as follows:

a) Annually producing the composite linked birth, Medicaid, WIC, HSIS file, and in the future, laboratory files for the purpose of evaluating service delivery costs and outcomes for Medicaid versus other clients;

b) ITS charges to produce and/or analyze the Medicaid files and all linked files with Medicaid information used to meet the categories of reports specified above; and

c) The paper/tape costs to run or distribute the reports specified above.

3. The third category is the cost of salary, fringe, and administrative costs to provide a full-time statistician to support the needs of the DMA Managed Care Unit Quality Management (QM) efforts.

Administrative match will be provided by DMA for a Statistician II position to be responsible for data projects related to improving the delivery of health care services to Medicaid recipients in North Carolina. The position will be primarily responsible for analyzing data from all Medicaid Managed Care programs for focused care studies, quality improvement projects and other Medicaid data collection and analysis activities as defined through the Workplan. The positions will assist in identifying study populations through claims and encounter data and will be responsible for gathering and analyzing HEDIS-like data for the Carolina ACCESS, ACCESS II/III and HMO Risk Contract programs from the MMIS and DRIVE systems and from medical record abstraction by the contracted External Quality Review Organization. The position will analyze, interpret, and report findings to the QM team for the development of quality improvement/disease management strategies based on the statistical analysis of all data presented.

DMA will provide the State Center the agreed upon number of user slots in the Medicaid DRIVE data warehouse/query system. The State Center will provide 1) the user
hardware, 2) the non-DRIVE related software required to operate the system, and 3) the LAN/WAN connection to access DRIVE through DMA. The State Center will assure adherence to the user agreements related to DRIVE.

The State Center will adhere to the State and Federal laws and regulations regarding confidentiality of Medicaid data. Information will not be released that could be used to identify individual patients and their health care without the expressed, written consent of DMA. The Medicaid provider numbers will not be contained on any material released by the State Center without the expressed, written consent of DMA.

DMA will receive a copy of all reports prepared by the State Center using Medicaid data.

The extent and cost of activities performed as outlined in the FY 2003 and 2004 Work Plan in Attachment 6 will serve as the basis for claiming FFP.

1. DMA reimbursement for activities described in items 1 and 2 above will not exceed $20,000.00 per fiscal year.

2. The actual salary and fringe benefits, for the 1 FTE described in Category 3 above, based on state classification and pay scale will serve as the basis for claiming FFP. The federal share reimbursing for activities described in item 3 above will not exceed $35,000.00 per fiscal year.

3. The administrative costs associated with supporting the 1 FTE position described in Category 3 above will not exceed $5,000.00 per fiscal year per year plus indirect costs as approved in the current allocation plan.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are attached and are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowance will be the responsibility of the Agency.
An Agreement to Claim Federal Financial Participation (FFP) Costs
For Medicaid Administration
Public Health Dental Hygienists

The Division of Public Health, herein known as Agency, wishes to claim 75% FFP for activities, which are reasonable, necessary and directly related to the Medicaid program. The Medicaid administration activities this Agency provides and for which FFP will be claimed are:

1. Provide public health dental hygienist field services and technical assistance to local health departments, community health centers, school health programs and other public dental clinics to enhance and maximize access to dental and other oral health services for Medicaid clients. A particular emphasis will be placed on access to care for children. Services encompassing prevention of dental disease in children will receive significant emphasis.

2. Through telephone and/or on-site consultation and written communication, assist health directors, community health center administrators, dental directors and other public dental clinic personnel with:
   a. needs assessment of community
   b. developing dental sealant projects
   c. providing oral assessment, referrals and follow-up services for school children
   d. provide oral health educational services

3. Serve as the primary liaison between the Agency and Public Schools to provide dental public health school-based prevention services.

The level of Agency expenditures for Public Health Dental Hygienist Field Services costs covers 49 FTE's (salaries, fringe benefits, travel) and a percentage of any school health services provided to Medicaid-eligible clients will serve as the basis for claiming FFP. The Agency will use FFP to support salary and fringe benefits of appropriate Agency staff.

The Agency agrees to follow “Guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities.” Documentation to support the FFP claim must be in strict compliance with federal requirements and is the sole responsibility of the Agency. Any audit exception or disallowance will be the responsibility of the Agency.

Division of Medical Assistance reimbursement for allowable administrative costs will not exceed $590,000 annually plus indirect costs as approved in the current allocation plan. This request is based on salary, fringe, travel and training expenditures for 49 public health dental hygienists. The percent of children served who are Medicaid eligible (currently 30% making the net percent that is eligible for Medicaid administrative match against total costs 22.5%) will be the basis for determining the percentage billed.
An Agreement to Claim Federal Financial Participation (FFP)
Costs for Medicaid Administration

Medicaid Reimbursement/Cost Study Staff

The Division of Public Health (hereafter referred to as the Agency) wishes to claim FFP for activities of the Medicaid Reimbursement/Cost Study staff that are reasonable, necessary and directly related to the Medicaid program. The Medicaid administrative activities which the Agency provides and for which FFP will be claimed are detailed below.

The two professional staff who work in the Medicaid/Reimbursement/Cost Study area are responsible for designing and implementing annual cost studies and settlements for local public health agencies and DECs (soon to be CDSAs) to insure appropriate cost-based reimbursement. They provide technical assistance, guidance, tools and consultation to local public health agencies, including DECs, to assure compliance with Medicaid policies and procedures. They provide data for supporting the negotiation of appropriate reimbursement rates for services provided by local health departments and DECs. This staff is fully dedicated to activities related to the administration of the Medicaid Program.

The full amount of the salaries, benefits and operating expenses for these two FTE position will serve as the basis for claiming FFP and DMA will reimburse up to 50% of these costs. The maximum amount of reimbursement will not exceed $80,000 per year plus indirect costs as approved in the current allocation plan.

The Agency agrees to follow the “guidelines for Requesting Federal Financial Participation for Medicaid Administration Activities” which are a part of this agreement. Documentation to support the FFP claimed must be in strict compliance with the federal requirements and is the sole responsibility of the Agency. Any audit exceptions or disallowances will also be the responsibility of the Agency.