STATE OF NORTH CAROLINA
DEPARTMENT OF CORRECTION

Division of Prisons

LEGISLATIVE REPORT ON INMATE MEDICAL COST CONTAINMENT

October 1, 2010

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I. INTRODUCTION

The mission of Health Services is to provide access to quality, cost effective healthcare that is rendered by competent healthcare professionals to the inmate population within the North Carolina Department of Correction (DOC). The objectives of Health Services are to uphold the mission and goals of DOC, to view correctional facilities as public health stations that significantly impact the health status of the larger community, to manage the care so as to improve the health status of the inmates and the citizens of North Carolina assuring that the best value is obtained for the tax dollars spent, to provide care consistent with community standards and to focus on the internal and external customers served by DOC.

Inmate healthcare costs have continued to rise across the country. In the last five years, inmate healthcare costs increased 56% within DOC (2005 expenditures of $165M – 2010 expenditures of $258M). Despite on-going efforts by DOC Health Services to better control costs, the costs continue to rise. The actions taken by DOC Health Services listed below represent a sampling of those efforts:

- Collaborated with custody staff to change the mission of some prison facilities with a focus on healthcare.
- Implemented patient acuity system whereby the sickest inmates are housed in designated prisons in an effort to pool resources.
- Incorporated new and ingenious methods into the hiring process resulting in a staffing pattern that includes a combination of medical professionals (nurse assistants v. registered nurses where allowable based on Board of Nursing rules and regulations).
- Instituted infirmary services in at least six prisons to allow for more acute patients to return from outside hospitals earlier.
- Negotiated contracts with favorable rates.
- Implemented $205.2M healthcare facility construction projects at North Carolina Correctional Institution for Women and Central Prison so as to curtail services needed outside the system.

II. LEGISLATIVE DIRECTIVE

INMATE MEDICAL COST CONTAINMENT Section 19.6.(a) through (g) of Senate Bill 897 (Session Law 2010-31) outlines specific directives that DOC should implement in an effort to curtail rising inmate healthcare cost.

Since the passage of Senate Bill 897, DOC has worked hard to implement its various components. Each component of the bill will be highlighted in bold and the current status of that component will follow.

SECTION 19.6.(a) The Department of Correction may reimburse those providers and facilities providing inmate medical services at a rate not to exceed seventy percent (70%) of the amount charged based on the usual and customary charges in effect for all other patients as of July 1, 2010. Usual and customary charges shall be established for each provider or facility based on the schedule of usual and customary charges used for all other patients furnished by that provider or facility providing inmate medical services in effect on July 1, 2010. Information furnished by providers and facilities regarding their usual and customary charges under this section is deemed as a matter of law to meet all the conditions of G.S. 132-1.2(1).

The limitation on payment for inmate medical services under this subsection shall not apply to reimbursement rates the Department of Correction has otherwise contracted for under contracts in effect as of June 30, 2010. This subsection applies to all medical and facility services provided outside the correctional facility, including hospitalizations, professional services, medical supplies, and other medications provided to any inmate confined in a correctional facility.

The Department has notified all contracted and non-contracted providers of this new law. Several inquiries from providers who have concerns with this new law have been received and attempts have been made to address their concerns. Although the Department's medical accounting and billing systems are adapted to handle Medicare rates, the system cannot accommodate the hundreds of rate schedules that would need to be loaded into it for each provider/hospital. It has been a huge challenge to determine how best to implement and assure that the Department is paying no more than 70% of usual and customary rates (UCR). No two hospitals or provider groups have the same rate structure, therefore UCRs vary greatly. The Department has recently purchased a nationally recognized tool which gives costs for various diagnoses in different areas of the country. A workgroup in the Department has reviewed this data and determined how to calculate 70% of UCR for providers/specialty services. The reimbursement rates established by the Department to hospitals and professional medical service providers are as follows:

- For hospitals not under a current contract, the Department is now paying 70% of billed charges.
- For hospitals under contract the Department is honoring the terms of the contract for reimbursement rates.
- For professional services not under contract the Department is reimbursing at 70% of the UCR using the tool described above.
- For professional services under contract the Department is honoring the terms of the contract for reimbursement rates.

Since this provision went into effect the Department has experienced mixed results in its efforts to establish new contracts with hospitals and other medical professional service providers. In some cases, the Department has worked successfully with some vendors to contract at lower rates than previously contracted. There are several service providers who have indicated they do not wish to contract with the Department, and they anticipate receiving 70% of UCR/billed charges as a non-contracted service provider. Additionally, there are numerous contracts in effect prior to the implementation of this legislation where the department has negotiated rates more favorable than seventy percent (70%) of UCR/billed charges. As these contracts expire it has, or will become, more beneficial for the vendor to push for a 70% reimbursement rate during contract negotiations, or simply allow the existing contract to expire and then continue to provide services as a non-contracted provider and receive a 70% reimbursement rate. The Department has also begun adding language in all new contracts which clarifies that the service provider must seek reimbursement from Medicaid for all in-patient services provided to inmates covered by Medicaid. The Department has received a number of inquiries from service providers regarding the impact to their revenue. In some cases where the Department already has contracts for rates more favorable than 70%, the providers have indicated they will need to negotiate new contracts at a higher reimbursement rate (up to 70%) to offset the loss of revenue resulting from Medicaid reimbursement for some inmates.

Contracts in effect as of June 30, 2010 have not been affected by the new reimbursement terms. However, some hospitals and providers have expressed concern regarding the impact the new reimbursement schedule will have on their ability to continue to provide services.

SECTION 19.6.(b) The Department of Correction shall make every effort to contain inmate medical costs by making use of its own hospital and health care facilities to provide health care services to inmates. To the extent that the Department of Correction must utilize other facilities and services to provide health care services to inmates, the Department shall make reasonable efforts to make use of hospitals or other providers with which it has a contract or, if none is reasonably available, hospitals with available capacity or other health care facilities in a region to accomplish that goal. The Department shall make reasonable efforts to equitably distribute inmates among all hospitals or other appropriate health care facilities. With respect to any single hospital, the Department of Correction shall make best efforts to seek admission of the number of inmates representing no more than five percent (5%) of all inmates requiring hospitalization or hospital services on an annual basis, unless the failure to do so would jeopardize the health of an inmate or unless a higher level is agreed to by contract. The Department shall also give preference to those hospitals or other health care facilities in the same county or an adjoining county to the correctional facility where an inmate requiring hospitalization is incarcerated.

The Department has always and continues to make the best use possible of its healthcare facilities within the prison facilities. Six infirmary sites are currently established, with two of these being setup over the past year. These infirmaries are located at Alexander Correctional Institution, Western Youth Institution, Piedmont Correctional Institution, Maury Correctional Institution, North Carolina Correctional Institution for Women, and Central Prison, with Alexander and Maury having been established this past fiscal year. This allows for the return of inmates from outside hospitals sooner and allows the Department to provide a level of care just above outpatient care. The Department uses contracted vendors when available for a needed service in a particular part of the state

The North Carolina Hospital Association offered to poll its hospital members and help the Department determine the location of underutilized hospitals. To date the Department has not received this information. The Department has recently gained access to the North Carolina State Medical Facilities Plan which will come before the legislature in January 2011. This plan clearly outlines the utilization and bed capacity of hospitals across North Carolina. The Health Services Section of DOC has identified underutilized hospitals in each of the five (5) custody regions. Those identified are being contacted to explore their interest in working with the Department and also are being approached with the idea to create a secure ward/area within their hospital. Once the hospital network is established and contracted, DOC will seek contracts with specialty providers connected with a particular hospital. One such arrangement nearing completion is with Heritage Hospital, near Tarboro, North Carolina. The Department is in discussions with Heritage to establish a dedicated, locked ward to provide in-patient services.

DOC has received written notice from WakeMed Hospital, Raleigh, North Carolina that they will only provide emergency care effective October 1, 2010. Through analyses made by WakeMed, they believe that they can achieve the 5% limit by providing only emergency services as needed. Due to the fact that our sickest inmates are located in Raleigh, North Carolina, the Department has been in discussion with UNC to determine the feasibility of partnering with them to provide non-emergent and emergent care in this area. Contract negotiations are continuing, however, it is urgent that DOC establish a location(s) for services that can no longer be obtained at WakeMed. Some of these services will still need to be provided in the Wake County area, especially as it relates to the need for obstetric care for pregnant inmates and unborn children.

SECTION 19.6.(c) The Department of Correction shall consult with the Division of Medical Assistance in the Department of Health and Human Services to develop protocols for prisoners who would be eligible for Medicaid if they were not incarcerated to access Medicaid while in custody or under extended limits of confinement. The Department shall seek reimbursement from Medicaid for those health care costs incurred by the Department in those instances when an inmate's Medicaid eligibility has been temporarily reinstated due to a hospitalization. The Department of Correction shall also work with the Division of Medical Assistance to determine the feasibility of applying for a Medicaid waiver to cover the inmate population.

A workgroup consisting of Department of Health and Human Services (DHHS) and DOC staff members have worked to develop a plan to identify inmates requiring in-patient services at community hospitals who meet the eligibility requirements for Medicaid. DOC staff will assist with the Medicaid application process for submission to the appropriate county Social Services office (inmate's county of residence) for review and approval. The medical service provider (hospital) will be notified by DOC staff that an application is in process and should it be approved the service provider would have to seek reimbursement for services through Medicaid reimbursement procedures. DOC has agreed to reimburse the Division of Medical Assistance the state portion of Medicaid reimbursement (approximately 30%). Implementation of this plan is expected to occur in early October 2010, as soon as the Memorandum of Understanding is finalized and signed by both the Secretary of DOC and the Secretary of DHHS.

SECTION 19.6.(d) The Department of Correction, in consultation with the Office of State Budget and Management, shall study the impact on inmate medical costs resulting from the measures set forth in subsections (a), (b), and (c) of this section. The Department shall present its findings by March 1, 2011, to the Chairs of the House of Representatives and Senate Appropriations Subcommittees on Justice and Public Safety and to the Joint Legislative Corrections, Crime Control, and Juvenile Justice Oversight Committee.

This report is due March 1, 2011 and will outline the further impact on inmate medical costs resulting from Senate Bill 897.

SECTION 19.6.(e) The Department of Correction shall make every effort to explore other cost containment methods not expressly outlined in this section. These methods may include the following:

(1) Contracting with a private third party to manage and provide all inmate medical services;

(2) Partnering with the federal government to allow for treatment of State inmates in federal correctional hospitals; and

(3) Purchasing a fixed number of beds at a hospital.

(1) The Department is in the process of restructuring the specifications of the Request for Proposal (RFP) authorized pursuant to Section 19.20(b) of S.L. 2009-451. The Department at this time is considering expanding the scope of services to allow bids for more comprehensive services, including the management and delivery of all inmate healthcare services. The timeframes for this RFP are discussed in Section 19.6.(f) below.

(2) The Department has contacted the Federal Bureau of Prisons and learned that there is no bed capacity available at its facility in Butner, North Carolina. The Department is exploring the possibility of obtaining some outpatient services (radiologic studies) at the Butner site for DOC prisons located within a fifty (50) mile radius.

(3) The Department is not pursing the purchase of beds at hospitals at this time. However, as noted above, the Department is seeking the establishment of closed wards/areas with some of the hospitals with excess bed capacity. This will allow the Department to avoid cost associated with custody coverage when more than one inmate is located at a particular hospital.

The Department is currently exploring other cost containment efforts which include:

- Purchase of nationally recognized Evidence Based Medicine standards to be used in evaluation of all specialty services prior to approval of service.
- Working to develop healthcare networks within each custody region.
- Making recommendations on possible changes in custody mission at some prisons so as to be able to house inmates where services can be obtained.
- Reorganizing the Utilization Department to expand the role of nurses to include hospital visits and case management.
- Providing education to provider staff based on Evidence Based Medicine to improve the level of primary care provided at the prison facilities.

SECTION 19.6.(f) The Department of Correction shall report to the Joint Legislative Corrections, Crime Control, and Juvenile Justice Oversight Committee no later than October 1, 2010, on:

(1) The Department's progress with the RFP process initiated pursuant to Section 19.20(b) of S.L. 2009-451, as rewritten by Section 15A of S.L. 2009-575, to contract for claims processing, medical management services, and the development and management of a medical professional and facility provider network.

(2) The anticipated effects on medical care provided to inmates as a result of the new hospital at Central Prison and the updated facilities at the North Carolina Correctional Institute for Women, as well as any other new medical services capacity within the Department. Specifically, the Department shall report on:

a. The types and volumes of services that the new and updated facilities
will provide that previously would have been provided by community providers; and
b. The projected types and volumes of services that will still be referred to community providers.

The report shall also address changes in statewide inmate custody that are needed to maximize the utilization of the new facilities and the Department's ability to contract with community providers with the available capacity throughout the State.

(1) Status of the Request for Proposal:

The Department posted the RFP on April 1, 2010 pursuant to Section 19.20(b) of S.L.2009-451, as rewritten by Section 15A of S.L. 2009-575. Over 150 questions were received relative to the RFP. Four bids were received to provide the services outlined in the requirements. However, following review by the North Carolina Department of Administration, Division of Purchase and Contract, it has been determined that neither of these bids meet all specifications outlined in the RFP. It is also important to note that the pricing structure requested in the RFP was not consistent with that as outlined in SB 897. These two factors have led to the reconvening of the RFP writers to restructure the RFP with new cost proposal information consistent with current legislation. The workgroup is also working with the Department's Office of Research and Planning to develop a fair evaluation process of bids relative to cost proposals that may be submitted. For planning purposes, a tentative timeline of Jan. /Feb. 2011 is used as the goal for reposting of the RFP.

The foundation of this RFP was constructed using eight (8) Key Elements. These Key Elements lead to a high-level Statement of Objectives followed by detailed requirements in the RFP. The requirements are not exhaustive, and DOC encourages vendors to propose solutions and innovative approaches to achieve those solutions that are consistent with the objective set forth in the RFP.

Key Elements of the RFP;

Provider Network	Call Center Services
Provider Authorization	Technical
Claims Management	Project Management and Training
Financial Management	Reports

Explanations relative to the key elements are as follows:

Provider Network – The vendor shall provide a managed, stable, high-quality Network or Networks of individual, group, and hospital health care providers to provide **specialty care**

medical services when deemed appropriate and approved by DOC Health Services. At a minimum the RFP details: network size, geographic location of providers and specialties, provider accreditation, industry standard medical practices, tailoring the provider network to fit changes in DOC regional capacities, acuity levels and custody levels, network inadequacies, and continuity of care.

Provider Authorization – The vendor shall provide all DOC facilities with bi-directional web portal access for Prior Authorization. The requests will be submitted to the vendor via the web portal for adjudication and response using DOC Health Services medical policies and procedures. The vendor will evaluate and determine prior authorization adjudication for:

Admissions	Consults
Orthotics	Dental – Endodontic and Oral Surgery
Outpatient Services	Procedures

Claims Management – The vendor shall provide a consolidated claims processing solution resulting in maximized efficiencies and reduced operational costs to DOC. The vendor shall receive and process all medical claims, track all claims, adjustments, and financial transactions from receipt to final disposition. These claims will be adjudicated in accordance with DOC policies and procedures, industry standards, and in relation to Prior Authorization and the Provider Network. At a minimum the RFP details the implementation of edits and audits, attachments, eligibility and prior authorization verification, industry standard coding, fee schedule reimbursement, explanation of benefits (payments) adjudication status, financial reporting, inmate inquiry, internal auditing including third party independent auditing and a claim processing evaluation metric to include at a minimum:

Financial accuracy	Overall accuracy
Payment incidence accuracy	Procedural and coding accuracy

Financial Management – The vendor will maintain all fiscal records in accordance with generally accepted accounting principles (GAAP). The vendor shall maintain accurate control of medical claim payments; perform accounting audits and process provider payments, refund checks, adjustments, and recoupments. At a minimum the RFP details Statement on Auditing Standards (SAS) 70 audit of vendor services, and produces a SAS 70 type 2 report (standard financial audit report), a daily interface to support claim payment reimbursement activities, provides to DOC full detail summary of accounting activities, daily, weekly, monthly and yearly financial reporting and full compliance with IRS and DPR regulations.

Call Center Services – The vendor shall provide Call Center Services for DOC and the Provider Network for questions and inquiries to include but not limited to eligibility inquiries, prior authorization status and verifications, claim and payment status. At a minimum the RFP details: operational hours, technical support for DOC, voice response services, web access, and service requirements.

Technical – DOC requires a technical solution that satisfies all requirements within the RFP while complying with applicable Federal and/or State requirements. At a minimum the RFP details: eligibility interface between DOC and the vendor, prior authorization web portal access between each facility the vendor and DOC, real time transfer of data, rules engine, inmate

demographics, record merging, transmitting and receiving claim and claim payment information, user interface, navigation and workflow requirements, audit trails, online help, search and query, security, system architecture, maintenance, software controls, system availability, reference file requirements, etc.

Project Management and Training – The vendor shall align their project management approach with the projects inherent complexity in order to reach the desired achievement. At a minimum the RFP details: Vendor provided and maintained all inclusive Statement of Work, Integrated Master Plan and Master Schedule (how vendor will do the work and schedule by which the vendor will accomplish it), Risk and Issue Management Plan, Change Management Plan, Security and Business Continuity/Disaster Recovery Plan, Test and Quality Assurance, Deployment/Rollout Plan, project status meeting requirements, DOC staff training, training location, number of sessions and attendance estimates, and documentation.

Reports – Vendor shall provide robust reporting to include standardized reports, flexibility in customized reporting, various sorting options, ad-hoc reports and the capability to download data and reports through secured internet access. The RFP will also include required specific reports to be generated and the frequency.

It is expected that a revised RFP will incorporate additional elements that will permit vendors to submit bids for more comprehensive services, up to and including management of the entire inmate health care delivery system.

(2) Anticipated effects on medical care provided to inmates as a result of the new hospital at Central Prison and the updated facilities at the North Carolina Correctional Institution for Women, as well as any other new medical services capacity within DOC:

The construction of the healthcare facilities at Central Prison and the North Carolina Correctional Institution for Women remains on schedule. Anticipated completion of the facilities is July and May of 2011, respectively. However, it will be a minimum of sixty (60) to ninety (90) days beyond the completion of construction before either of these facilities become operational. The additional time will be needed to conduct the training of medical and custody staff on the appropriate protocols established for these new facilities. It is our plan to provide numerous specialty services on-site at these facilities if providers are willing to contract with DOC and come on-site.

At Central Prison DOC will have the ability to offer the following extended services:

Physical therapy (PT) services (currently very limited):

- One hundred- forty (140) PT evaluations offsite as of 9/13/10
    - Represents four cases for women inmates at the North Carolina Correctional Institution for Women
    - These to be at the North Carolina Correctional Institution for Women
- Eighty evaluations by contracted providers

Chemotherapy on site at Central Prison

- Seven chemotherapy patients 1st three months of current fiscal year
- Extrapolates to 28 for the year

GI procedures (includes endoscopy and colonoscopy)

- Ninety-eight (98) procedures as of 9/13/10
- Seventy-eight (78) done at UNC with current contract
- All could in the future be done at Central Prison
- Extrapolates to 392 for the year

Computerized Tomography Scans (CT Scans)

- One hundred fifty-four (154) done statewide as of 9/13/10
- Represents twenty-nine (29) separate sites for service; eight (8) contracted sites

A full analysis of these services is not yet complete. We need to look at the prisons housing the inmates and determine if it will be more cost effective and efficient to have inmates obtain needed services at Central Prison or at a location near prison.

All Intensive Care Unit hospitalizations and surgeries requiring the opening of body cavities will still be done outside of Central Prison. The new facilities now under construction will not have Intensive Care Unit (ICU) capabilities needed as backup for these types of surgeries.

SECTION 19.6.(g) The Department of Correction shall report to the Joint Legislative Commission on Governmental Operations no later than October 1, 2010, and quarterly thereafter on:

(1) The volume of services provided by community medical providers that can be scheduled in advance and, of that volume, the percentage of those services that are provided by contracted providers; and

(2) The volume of services provided by community medical providers that cannot be scheduled in advance and, of that volume, the percentage of those services that are provided by contracted providers.

To ensure that correct information relative to Section 19.6(g) is reported, the Department sought clarification from the Office of the North Carolina General Assembly Fiscal Research Division. Pursuant to the information provided it is our understanding that the volume of services referenced is for hospitalizations.

As of 9/13/2010, the Department has had 318 hospital admissions statewide. Of these admissions, 263 (83%) were emergent and 55 (17%) were scheduled. These admissions have occurred at forty-four (44) different hospitals, with sixteen (16) of these having current contracts and twenty-eight (28) having no current contract. It is significant to note that nearly all hospitalizations have occurred in the county or neighboring county wherein the prison facility is located. The attached appendixes, based on submitted claims, clearly reveal this information.

III. SUMMARY

The Health Services Section of the North Carolina Department of Correction will continue to implement Senate Bill 897 and make every possible effort to continue to be good stewards of North Carolina taxpayers' money. The Department has taken additional steps to more effectively manage the delivery of health care to the inmates:

1) The Department has recently reorganized the management structure of the Health Services Section of the Division of Prisons and has established a new position as Deputy Director of Prisons for Health Services. This position will not only be responsible for managing the current healthcare delivery system, but also, the new hospital at Central Prison and the new infirmary at the North Carolina Correctional Institution for Women. Management is in the process of recruiting for an experienced professional health care administrator.

2) The Department has recently established a position to report to the Secretary of DOC (Special Assistant to the Secretary for Inmate Medical Cost Containment) with responsibilities for providing guidance and expertise in the development of an effective managed care delivery system, with particular emphasis on contracting services with hospitals and other professional medical service providers. The selected candidate is expected to have extensive experience working in managed care contracting with or for hospitals and/or health insurance companies. The Department is nearing the completion of the selection process to fill this position.

3) The Department is also exploring the possibility of revising the specifications of the RFP to expand the scope of services a third party vendor may offer in managing the delivery of inmate health care.

Appendix A
Non-Scheduled Hospital Admissions
July 1, 2010 – Sept. 13, 2010

HOSPITAL	ADMISSION TYPE	CONTRACT (Y/N)	ADMISSIONS	
BETSY JOHNSON MEM	NON-SCHEDULED (EMERGENCY)	No	4	1.5%
CAROLINAEAST(CRAVEN)	NON-SCHEDULED (EMERGENCY)	No	2	0.8%
CLEVELAND REG MED	NON-SCHEDULED (EMERGENCY)	No	1	0.4%
DUKE RALEIGH HOSP.	NON-SCHEDULED (EMERGENCY)	No	1	0.4%
DUKE UNIV. MED. CTR	NON-SCHEDULED (EMERGENCY)	No	2	0.8%
GRACE HOSPITAL, INC.	NON-SCHEDULED (EMERGENCY)	No	1	0.4%
JOHNSTON MEM. HOSP	NON-SCHEDULED (EMERGENCY)	No	10	3.8%
MEMORIAL MISSION HOS	NON-SCHEDULED (EMERGENCY)	No	3	1.1%
NASH GENERAL HOSPITA	NON-SCHEDULED (EMERGENCY)	No	16	6.1%
NC BAPTIST HOSPITALS	NON-SCHEDULED (EMERGENCY)	No	3	1.1%
NEW HANOVER REG MED	NON-SCHEDULED (EMERGENCY)	No	3	1.1%
ROWAN REG. MED. CTR.	NON-SCHEDULED (EMERGENCY)	No	6	2.3%
SCOTLAND MEM HOSP	NON-SCHEDULED (EMERGENCY)	No	6	2.3%
WAKE MEDICAL CENTER	NON-SCHEDULED (EMERGENCY)	No	60	22.8%
WILKES REG MED CEN	NON-SCHEDULED (EMERGENCY)	No	1	0.4%
1ST HEALTH-MOORE REG	NON-SCHEDULED (EMERGENCY)	Yes	16	6.1%
ALBEMARLE HOSPITAL	NON-SCHEDULED (EMERGENCY)	Yes	2	0.8%
ANNIE PENN MEMORIAL	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
CAPE FEAR VALLEY HOS	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
CAR.MED.CENT.- UNION	NON-SCHEDULED (EMERGENCY)	Yes	7	2.7%
CAROLINAS MEDICAL CE	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
CATAWBA VALLEY MED.	NON-SCHEDULED (EMERGENCY)	Yes	33	12.5%
CENTRAL CAROLINA HOS	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
COLUMBUS REGIONAL	NON-SCHEDULED (EMERGENCY)	Yes	5	1.9%
DUPLIN GENERAL HOSP	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%

FRANKLIN REG MED CEN	NON-SCHEDULED (EMERGENCY)	Yes	2	0.8%
HALIFAX MEMORIAL HOS	NON-SCHEDULED (EMERGENCY)	Yes	6	2.3%
HAYWOOD COUNTY HOSPI	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
KINDRED HOSPITAL	NON-SCHEDULED (EMERGENCY)	Yes	2	0.8%
MARIA PARHAM HOS INC	NON-SCHEDULED (EMERGENCY)	Yes	2	0.8%
MERCY HOSPITAL	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
MOSES H CONE MEM HOS	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
PENDER MEM HOSP INC	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
PITT CO MEM HOSP	NON-SCHEDULED (EMERGENCY)	Yes	33	12.5%
PUNGO DIST HOSP CORP	NON-SCHEDULED (EMERGENCY)	Yes	2	0.8%
RANDOLPH HOSP INC	NON-SCHEDULED (EMERGENCY)	Yes	4	1.5%
S EASTERN REG MED C	NON-SCHEDULED (EMERGENCY)	Yes	6	2.3%
SAMPSON CTY MEM HOSP	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
STANLY REG MED CENT	NON-SCHEDULED (EMERGENCY)	Yes	1	0.4%
UNC HOSPITALS	NON-SCHEDULED (EMERGENCY)	Yes	6	2.3%
WAYNE MEMORIAL HOSP	NON-SCHEDULED (EMERGENCY)	Yes	7	2.7%
TOTAL			**263**	

Percentage of Admissions to Contracted Facilities: **54.8%**
Percentage of Admissions to Non-Contracted Facilities: **45.2%**

Appendix B
Scheduled Hospital Admissions
July 1, 2010 – Sept. 13, 2010

HOSPITAL	ADMISSION TYPE	CONTRACT (Y/N)	ADMISSIONS	% OF TOTAL
DUKE RALEIGH HOSP.	SCHEDULED (NON-EMERGENCY)	No	5	9.1%
DURHAM REGIONAL HOSP	SCHEDULED (NON-EMERGENCY)	No	2	3.6%
WAKE MEDICAL CENTER	SCHEDULED (NON-EMERGENCY)	No	8	14.5%
1ST HEALTH-MOORE REG	SCHEDULED (NON-EMERGENCY)	Yes	2	3.6%
CAR.MED.CENT.- UNION	SCHEDULED (NON-EMERGENCY)	Yes	1	1.8%
CATAWBA VALLEY MED.	SCHEDULED (NON-EMERGENCY)	Yes	6	10.9%
KINDRED HOSPITAL	SCHEDULED (NON-EMERGENCY)	Yes	7	12.7%
LENOIR MEMORIAL HOSP	SCHEDULED (NON-EMERGENCY)	Yes	2	3.6%
MERCY HOSPITAL	SCHEDULED (NON-EMERGENCY)	Yes	1	1.8%
PITT CO MEM HOSP	SCHEDULED (NON-EMERGENCY)	Yes	2	3.6%
RICHMOND MEM HOSPITA	SCHEDULED (NON-EMERGENCY)	Yes	1	1.8%
UNC HOSPITALS	SCHEDULED (NON-EMERGENCY)	Yes	18	32.7%
TOTAL			**55**	

Percentage of Admissions to Contracted Facilities: **72.7%**
Percentage of Admissions to Non-Contracted Facilities: **27.3%**

Appendix C
Scheduled Non-Admission Hospital Services
July 1, 2010 – Sept. 13, 2010

HOSPITAL	ADMISSION TYPE	CONTRACT (Y/N)	PURCHASED CARE	% OF TOTAL
BERTIE MEM HOSP	NON-ADMISSION	No	18	0.7%
BETSY JOHNSON MEM	NON-ADMISSION	No	18	0.7%
CAROLINA GI ASSOC.PC	NON-ADMISSION	No	1	0.0%
CAROLINAEAST(CRAVEN)	NON-ADMISSION	No	25	0.9%
CLEVELAND REG MED	NON-ADMISSION	No	1	0.0%
COMM GEN THOMASVILLE	NON-ADMISSION	No	17	0.6%
DAVIS REG.MED.CENTER	NON-ADMISSION	No	9	0.3%
DUKE RALEIGH HOSP.	NON-ADMISSION	No	24	0.9%
DUKE UNIV. MED. CTR	NON-ADMISSION	No	29	1.1%
DURHAM REGIONAL HOSP	NON-ADMISSION	No	32	1.2%
FORSYTHE MEM HOSP	NON-ADMISSION	No	5	0.2%
GRACE HOSPITAL, INC.	NON-ADMISSION	No	2	0.1%
HERITAGE HOSPITAL	NON-ADMISSION	No	5	0.2%
JOHNSTON MEM. HOSP	NON-ADMISSION	No	20	0.7%
LINCOLN MED. CENTER	NON-ADMISSION	No	2	0.1%
MEMORIAL MISSION HOS	NON-ADMISSION	No	12	0.4%
NASH DAY HOSPITAL	NON-ADMISSION	No	33	1.2%
NASH GENERAL HOSPITA	NON-ADMISSION	No	90	3.3%
NC BAPTIST HOSPITALS	NON-ADMISSION	No	12	0.4%
NEW HANOVER REG MED	NON-ADMISSION	No	10	0.4%
ROWAN REG. MED. CTR.	NON-ADMISSION	No	39	1.4%
SCOTLAND MEM HOSP	NON-ADMISSION	No	28	1.0%
ST.JOSEPH'S HOSPITAL	NON-ADMISSION	No	1	0.0%
WAKE MEDICAL CENTER	NON-ADMISSION	No	351	12.9%
WILKES REG MED CEN	NON-ADMISSION	No	2	0.1%

1ST HEALTH-MOORE REG	NON-ADMISSION	Yes	79	2.9%
ALBEMARLE HOSPITAL	NON-ADMISSION	Yes	22	0.8%
ANNIE PENN MEMORIAL	NON-ADMISSION	Yes	9	0.3%
ANSON COUNTY HOSP	NON-ADMISSION	Yes	45	1.6%
BLADEN COUNTY HOSP	NON-ADMISSION	Yes	4	0.1%
BLUE RIDGE REG HOSP.	NON-ADMISSION	Yes	34	1.2%
CAPE FEAR MEM HOSP	NON-ADMISSION	Yes	1	0.0%
CAPE FEAR VALLEY HOS	NON-ADMISSION	Yes	8	0.3%
CAR.MED.CENT.- UNION	NON-ADMISSION	Yes	15	0.5%
CAROLINAS MED CTR NE	NON-ADMISSION	Yes	6	0.2%
CAROLINAS MEDICAL CE	NON-ADMISSION	Yes	2	0.1%
CARTERET GENERAL HOS	NON-ADMISSION	Yes	7	0.3%
CATAWBA VALLEY MED.	NON-ADMISSION	Yes	214	7.8%
CENTRAL CAROLINA HOS	NON-ADMISSION	Yes	6	0.2%
CHERRY HOSPITAL	NON-ADMISSION	Yes	190	7.0%
COLUMBUS REGIONAL	NON-ADMISSION	Yes	32	1.2%
DUPLIN GENERAL HOSP	NON-ADMISSION	Yes	5	0.2%
FRANKLIN REG MED CEN	NON-ADMISSION	Yes	17	0.6%
FRYE REG. MED. CEN.	NON-ADMISSION	Yes	5	0.2%
GASTON MEM HOSPITAL	NON-ADMISSION	Yes	1	0.0%
HALIFAX MEMORIAL HOS	NON-ADMISSION	Yes	46	1.7%
LENOIR MEMORIAL HOSP	NON-ADMISSION	Yes	29	1.1%
MARIA PARHAM HOS INC	NON-ADMISSION	Yes	54	2.0%
MCDOWELL HOSPITAL	NON-ADMISSION	Yes	13	0.5%
MERCY HOSPITAL	NON-ADMISSION	Yes	6	0.2%
MONTGOMERY MEM HOSP	NON-ADMISSION	Yes	50	1.8%
PENDER MEM HOSP INC	NON-ADMISSION	Yes	29	1.1%
PERSON CO MEM HOSPIT	NON-ADMISSION	Yes	30	1.1%

PITT CO MEM HOSP	NON-ADMISSION	Yes	68	2.5%
PUNGO DIST HOSP CORP	NON-ADMISSION	Yes	13	0.5%
RANDOLPH HOSP INC	NON-ADMISSION	Yes	16	0.6%
REX HOSPITAL	NON-ADMISSION	Yes	2	0.1%
RICHMOND MEM HOSPITA	NON-ADMISSION	Yes	1	0.0%
RUTHERFORD HOSPITAL	NON-ADMISSION	Yes	8	0.3%
S EASTERN REG MED C	NON-ADMISSION	Yes	79	2.9%
SAMPSON CTY MEM HOSP	NON-ADMISSION	Yes	13	0.5%
STANLY REG MED CENT	NON-ADMISSION	Yes	21	0.8%
UNC HOSPITALS	NON-ADMISSION	Yes	736	27.0%
WASHINGTON CTY HO IN	NON-ADMISSION	Yes	10	0.4%
WAYNE MEMORIAL HOSP	NON-ADMISSION	Yes	17	0.6%
WESLEY LONG COM HOSP	NON-ADMISSION	Yes	1	0.0%
TOTAL			2730	

Percentage of Admissions to Contracted Facilities:	**71.2%**
Percentage of Admissions to Non-Contracted Facilities:	**28.8%**