



An Information Service of the Division of Medical Assistance

**North Carolina
Medicaid Pharmacy
Newsletter**

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Updated Federal Upper Limit Reimbursement List

There are certain drugs that have been identified for which the Federal Upper Limit (FUL) reimbursement rate does not cover the cost of the drug. Medicaid pharmacy programs are required to reference this reimbursement information when pricing drug claims. In order to receive adequate reimbursement, pharmacy providers may use the DAW1 override to override the FUL reimbursement rate for the drugs listed below until the FUL rate has been adjusted to adequately cover the cost of the drug.

A comment should be entered when the DAW1 override code is used to indicate that the FUL is too low to cover the cost of the drug. If there is an active State Maximum Allowable Cost (SMAC) rate on file, the SMAC rate should be submitted.

Pharmacy providers should report reimbursement issues to the N.C. Medicaid program at 919-855-4300. Use of the **DAWI** override code for overriding FUL rates will continue to be monitored. Pharmacy providers should also monitor the FUL rates and discontinue use of the DAW1 override code once updates to the FUL rates have occurred.

NDC	DRUG NAME
00054302802	ACETYLCYSTEINE 20% VIAL
00093026330	FLUOCINONIDE-E 0.05% CREAM
00093026392	FLUOCINONIDE-E 0.05% CREAM
00093075701	PIROXICAM 20 MG CAPSULE
00093075705	PIROXICAM 20 MG CAPSULE
00168000215	TRIAMCINOLONE 0.5% CREAM
00168000315	TRIAMCINOLONE 0.025% CREAM
00168000380	TRIAMCINOLONE 0.025% CREAM
00168000415	TRIAMCINOLONE 0.1% CREAM
00168000416	TRIAMCINOLONE 0.1% CREAM
00168000480	TRIAMCINOLONE 0.1% CREAM
00168000615	TRIAMCINOLONE 0.1% OINTMENT
00168000616	TRIAMCINOLONE 0.1% OINTMENT
00168000680	TRIAMCINOLONE 0.1% OINTMENT
00168004046	BETAMETHASONE VA 0.1% CREAM
00168005515	BETAMETHASONE DP 0.05% CRM
00168005546	BETAMETHASONE DP 0.05% CRM
00168013460	FLUOCINONIDE 0.05% SOLUTION
00168020230	CLINDAMYCIN PH 1% GEL
00168020260	CLINDAMYCIN PH 1% GEL
00168025815	CLOTRIMAZOLE-BETAMETHASONE C
00168025846	CLOTRIMAZOLE-BETAMETHASONE C
00168031002	DESONIDE 0.05% LOTION
00168031004	DESONIDE 0.05% LOTION
00168038360	METRONIDAZOLE 0.75% LOTION
00185072401	CARISOPRODOL COMPOUND TAB

00185072405	CARISOPRODOL COMPOUND TAB
00228206710	OXAZEPAM 10 MG CAPSULE
00378135501	TRIAMTERENE-HCTZ 75-50
00378135505	TRIAMTERENE-HCTZ 75-50
00378537501	DOXEPIN 75 MG CAPSULE
00378641001	DOXEPIN 100 MG CAPSULE
00378641010	DOXEPIN 100 MG CAPSULE
00472016315	NYSTAIN 100,000 UNIT/GM CREAM
00472016330	NYSTAIN 100,000 UNIT/GM CREAM
00472016615	NYSTAIN 100,000 UNIT 15GMS
00472016630	NYSTAIN 100,000 UNITS 30GMS
00472037915	CLOTRIMAZOLE-BETAMETHASONE CRM
00472037945	CLOTRIMAZOLE-BETAMETHASONE CRM
00472080302	DESONIDE LOTION 0.05%
00472080304	DESONIDE 0.05% LOTION
00527142635	OXYCODONE CONC 20 MG/ML SOLN
00527142636	OXYCODONE CONC 20 MG/ML SOLN
00591578701	NORTRIPTYLINE 25MG CAP
00591578705	NORTRIPTYLINE HCL 25 MG CAP
00591578710	NORTRIPTYLINE HCL 25 MG CAP
00603459315	METHYLPREDNISOLONE 4MG D/P
00603459321	METHYLPREDNISOLONE 4 MG TABL
00603781874	NYSTATIN 100,000
00603781878	NYSTATIN 100,000 UNIT/GM CREAM
00781100801	TRIAMTERENE-HCTZ 75-50
00781100805	TRIAMTERENE-HCTZ 75-50
00781107101	METHAZOLAMIDE 50 MG TABLET
00781196160	CLARITHROMYCIN 250 MG TABLET
00781196260	CLARITHROMYCIN 500 MG TABLET
17478028310	GENTAK 3 MG/ML EYE DROPS
24208058060	GENTAMICIN OPTH SOLN
24208058064	GENTAMICIN 3 MG/ML EYE DROPS
24208067004	SULFACETAMIDE 10% EYE DROPS
29033001301	PIROXICAM 20 MG CAPSULE
29033001305	PIROXICAM 20 MG CAPSULE
45802002146	BETAMETHASONE DP 0.05% LOT
45802004811	NYSTATIN
45802004835	NYSTATIN OINTMENT
45802006405	TRIAMCINOLONE 0.1% CREAM
45802006435	TRIAMCINOLONE 0.1% CREAM
45802006436	TRIAMCINOLONE 0.1% CREAM

45802042235	DESONIDE 0.05% CREAM
45802042237	DESONIDE 0.05% CREAM
48102010101	METHAZOLAMIDE 50 MG TABLET
49884024601	CARISOPRODOL COMPOUND TAB
49884024605	CARISOPRODOL COMPOUND TAB
50111033401	METRONIDAZOLE 500 MG TABLET
50111033402	METRONIDAZOLE 500 MG TABLET
50383026760	CLOBETASOL 0.05% CREAM
51672125301	FLUOCINONIDE 0.05% CREA
51672125302	FLUOCINONIDE 0.05% CREA
51672125303	FLUOCINONIDE 0.05% CREA
51672125304	FLUOCINONIDE 0.05% CREA
51672125903	CLOBETASOL 0.05% OINTMENT
51672126301	NYSTATIN-TRIAMCINOLONE CREAM
51672126302	NYSTATIN-TRIAMCINOLONE CREAM
51672126303	NYSTATIN-TRIAMCINOLONE CREAM
51672127201	NYSTATIN-TRIAMCINOLONE OINT
51672127202	NYSTATIN-TRIAMCINOLONE OINTM
51672127203	NYSTATIN-TRIAMCINOLONE OINTM
51672127304	FLUOCINONIDE 0.05% SOLUTION
51672128003	DESONIDE 0.05% CREAM
51672128202	TRIAMCINOLONE 0.1% CREAM
51672128901	NYSTATIN 100,000 UNIT/GM CRE
51672128902	NYSTATIN 100,000 UNIT/GM CRE
51672129201	HYDROCORTISONE VAL 0.2% OINT
51672129203	HYDROCORTISONE VAL 0.2% OINT
51672129206	HYDROCORTISONE VAL 0.2% OINT
51672404709	CARBAMAZEPINE 100 MG/5 ML SU
51672404801	CLOTRIMAZOLE-BETAMETHASONE CRM
51672404806	CLOTRIMAZOLE-BETAMETHASONE CRM
52152013702	CARISOPRODOL COMPOUND TAB
52152013704	CARISOPRODOL COMPOUND TAB
59746000103	METHYLPREDNISOLONE 4 MG DOSE
59762374301	CLINDAMYCIN PH 1% GEL
59762374302	CLINDAMYCIN PH 1% GEL
60758018805	GENTAMICIN 3 MG/ML EYE DROPS
61314063136	NEOMYC-POLYM-DEXAMET EYE OINTMENT
61314063305	GENTAMICIN 3MG/ML EYE DROPS (3%)
61314064305	TOBRAMYCIN 0.3% EYE DROPS
61314070101	SULFACETAMIDE 10% EYE DROPS
68462034737	OXYCODONE CONC 20 MG/ML SOLN

Roche Provider Rebates – Revised Implementation Date – July 1, 2012

Effective July 1, 2012, all claims for diabetic supplies that meet the requirements for the Roche provider rebate that process and pay with dates of service on or after July 1, 2012, will receive an automated rebate payment in conjunction with their reimbursement from N.C. Medicaid. There will be no action required of providers to receive the provider rebate. Providers should no longer submit provider rebates to Roche for reimbursement for claims with dates of service on or after July 1, 2012.

The rebate payment will be paid one checkwrite after the claim payment is generated and these claims will appear on the Remittance Advice (RA) with an ICN region starting with 81. If a claim is later reversed or adjusted, the rebate claim will also be adjusted in the checkwrite following the claim recoupment (this will appear as a region 90 adjustment for both pharmacy and DME providers). Pharmacy providers will not see this payment on their POS transaction, but the payment will be included on the RA.

If you are not currently enrolled in the Roche rebate program, please log on to <https://rxvp.accu-chek.com> no later than Friday, June 15, 2012 to enroll in the rebate program. With your enrollment, Roche will process your eligible N.C. Medicaid claims for June 2012.

Below are the Roche provider rebates that will be paid by NDC:

Product	Size	NDC #	2012 Roche Provider Rebate Amount
ACCU-CHEK AVIVA STRIPS 50's	50	65702-0103-10	\$26.23
ACCU-CHEK AVIVA PLUS STRIPS 50's	50	65702-0407-10	\$26.23
ACCU-CHEK COMPACT 51's	51	50924-0988-50	\$27.64
ACCU-CHEK SMARTVIEW STRIPS (NANO)	50	65702-0492-10	\$26.23
SOFTCLIX LANCING DEVICE KIT (BLUE)	1	50924-0957-01	\$ 5.08
MULTICLIX LANCING DEVICE KIT	1	50924-0446-01	\$5.08
SOFTCLIX LANCING DEVICE KIT (BLACK)	1	65702-0400-10	\$5.08

Upcoming Policy Implementation: BRANDS Monitoring

On June 5, 2012, the N.C. Division of Medical Assistance (DMA), partnering with Community Care of North Carolina (CCNC), will implement a policy that creates a prior authorization process called BRANDS. Similar to the A+KIDS program, BRANDS (Brand Request-Adverse event Needs Documentation) is a Web-based application available on the Document for Safety Website, www.documentforsafety.org.

The BRANDS program supports the NC Medicaid policy *Prior Approval for Brand-Name Drugs (DAW-1)*. To request a brand name medication for a patient when multiple generic equivalents are available in the marketplace, this policy requires documentation of an adverse event experienced by the patient that was associated with use of a generic equivalent. The BRANDS application allows the provider to request a brand name medication for a patient and document the adverse effect related to the generic equivalent at the same time. All requests must use the BRANDS application; fax requests will not be accepted. In addition to the BRANDS authorization, the words **“Medically Necessary”** must still be written on the face of the prescription in the prescriber’s own handwriting in order for the pharmacy to be able to process the prescription for the brand name drug.

- Authorization of a brand name medication generally includes authorization of any brand product, in any available strength and dosage form, that contains the same generic ingredient(s).
- Medications used for the treatment of seizures and those designated as Narrow Therapeutic Index drugs by the N.C. Board of Pharmacy (e.g., Coumadin, Synthroid), covered OTC products, Federal Upper Limit (FUL) drugs that are overridden due to reimbursement issues and preferred brands that are less costly to the State than their generic equivalent are exempt.
- Adverse event reports created in the Web application may be submitted to the FDA MedWatch program.

Providers who have registered on the Document for Safety Website to use the A+KIDS application, or on the SmartDUR Website to use the Synagis application, do not need to register again; the same User ID and Password will give access to the BRANDS application. Providers without a User ID and Password can go to the Document for Safety Website at any time to register.

Registered providers may start requesting brand medications through the BRANDS application at any time starting on May 10, 2012; however, point-of-sale messaging will not start until June 5. Once the program is implemented, pharmacy providers will receive the following denial message: “Prescriber must complete Adverse Event Report at www.documentforsafety.org for Prior Approval for Brand Name Drugs (DAW-1)”.

Dispense as Written for Medicaid Recipients

Session Law 2011-145 section 10.31(d)(2)(r)(2) and (3) allows all prescriptions that are written for a Medicaid recipient to be orders for the generic medication, even if the prescriber signs the Dispense As Written line. This Session Law also allows Medicaid to establish a prior authorization process for brand-name medications for which the phrase “Medically Necessary” is written on the prescription.

The prior authorization process, called BRANDS, begins June 5th, 2012. Previously, a prescriber only had to write “Medically Necessary” on the prescription in his or her own handwriting in order for a brand to be dispensed. Beginning June 5, the prescriber must complete the prior authorization process and write “Medically Necessary” on the prescription.

On or after June 5th, if a prescription is received for a Medicaid recipient with “Medically Necessary” on the prescription and the prescriber declines or fails to complete the prior authorization, the generic may be dispensed without physician approval. NC Medicaid will require that both the prior authorization and “Medically Necessary” be handwritten on the prescription by the prescriber in order for a brand to be dispensed. If either of these steps is not completed, the prescription is deemed to be written for a generic in accordance with Session Law 2011-145.

The new prior authorization requirement does not apply to narrow therapeutic index drugs, seizure medications, covered OTC products, Federal Upper Limit (FUL) drugs that are overridden due to reimbursement issues or preferred brands that are less costly to the State than their generic equivalent. A prior authorization for a brand name medication has no expiration date and pharmacists should not see a rejection on future prescriptions. These requirements also apply to Health Choice prescriptions.

Remember that the handwritten “Medically Necessary” requirement will still be needed on all future prescriptions and the pharmacy will need to process the prescription using DAW-1. Please note that e-prescriptions do not satisfy the handwritten “Medically Necessary” requirement. The only acceptable form of communicating “Medically Necessary” is through a hard-copy or facsimile of the prescription.

As a reminder, pharmacists may dispense an emergency 72-hour supply for any medication that requires prior authorization under the Medicaid or Health Choice programs while waiting for additional information required from the prescriber.

Point of Sale Overrides for Antipsychotic Programs

It is important for pharmacies to understand the Point-of-Sale override options available for the Antipsychotics – Keeping It Documented for Safety (A+KIDS) and the Adult Safety with Antipsychotic Prescribing (ASAP) programs. While in some aspects, the use of an override code is the same for both programs, there are differences to understand.

Submitting the claim initially without an override should always be considered. The recipient may have a diagnosis exemption (adult program) or active documentation that will allow the claim to process successfully without any action at all. For the ASAP program, if an exempted diagnosis is found by SmartPA within the last 24 months of all paid claims history, the antipsychotic claim can process seamlessly. The pharmacist may not know the diagnosis exists (adult program) or safety documentation has been provided (children/adolescents) if an initial claim submission without an override is not attempted. It is important to keep in mind, when requirements for the antipsychotic programs are met, the claim may deny for other reasons such as DUR alerts. For those occurrences, respond to the DUR alert only. Do not use an override if the claim submission that resulted in the DUR alert did not have an override.

Override Protocol

Code 1 (PA field) or code 2 (submission clarification)

- Applies to the ASAP (adult program) only
- Use when prescriber writes “Meets PA Criteria” in his/her own handwriting on the face of the prescription. “Meets PA Criteria” can be entered in the comment block when e-prescribing.
- No limit to use
- Is subject to DMA Program Integrity audit starting July 1, 2012

Code 11 (submission clarification)

- Applies to ASAP and A+KIDS (adult and child/adolescent programs)
- Consider when point of sale message “safety documentation req...” returns for a denied claim.
- Limit of two per rolling 365 days per recipient. Each override is effective for all antipsychotic claims submitted on same date of service.
- For third override attempt, the message “Override limit exceeded. Prescriber call ACS 866-246-8505” will return to the pharmacy. This message cannot be overridden. Alert indicates requested documentation must be provided for successful processing of the claim.
- Is not subject to DMA Program Integrity audit

Because of the type of diagnoses for which antipsychotics are prescribed, pharmacies may be contacted by phone to follow up on a denied antipsychotic claim. Monitoring of denied claims is managed by Community Care of North Carolina (CCNC). The contact is made to provide assistance with claims processing to ensure recipients receive antipsychotic medications without interruption to therapy. A pharmacy may call 855.272.6576 (CCNC support) or 919.855.4300 (DMA) for help with an antipsychotic medication claim.

N.C. Medicaid Tamper Resistant Prescription Pad Guidance Update

N.C. Medicaid added the following to the list of acceptable features to meet characteristic No. 2 for tamper resistant prescription pads:

g. Dispense and refill number bordered by asterisks and optionally spelled out to prevent modification

The N.C. Medicaid Tamper Resistant Prescription Pads Guidance document was updated on March 2, 2012 to reflect this change.

Maintaining the Security and Accessibility of Records after a Provider Agency Closes

All N.C. Medicaid and N.C. Health Choice (NCHC) providers are responsible for maintaining custody of the records and documentation to support service provision and reimbursement of services by the N.C. Division of Medical Assistance (DMA) for at least six years. See 10A NCAC 22F.0107 and Section 7 of the N.C. Department of Health and Human Services

(DHHS) Provider Administrative Participation Agreement. The Agreement is part of the enrollment application and may be accessed from the [NCTracks Provider Enrollment Webpage](#).

Mental Health, Developmental Disabilities, and Substance Abuse (MH/DD/SA) services records are subject to additional retention and management requirements, including those mandated by S.L. 2009-451 (Section 10.68A(a)(5)(j) and (k) for Community Support and Other MH/DD/SA Services and Section 10.68A(a)(7)(h) and (i) for MH Residential Services). MH/DD/SA providers should refer to guidance from Implementation Updates No. 79, No. 72, No. 62, No. 60, and No. 58 for more information.

Documentation that is required to be maintained by all providers includes clinical service records, billing and reimbursement records, and records to support staff qualifications and credentials (personnel records). Clinical service records include, but are not limited to:

- Diagnostic testing results (X-rays, lab tests, EKGs, psychological assessments, etc.)
- Records from other providers used in the development of care plans
- Nurses' notes or progress notes
- Service orders that authorize treatment and treatment
- Service or treatment plans

Billing and reimbursement records should include recipient demographic information. Providers are **required** to arrange for continued safeguarding of the above-described records in accordance with the record retention guidelines. Failure to protect consumer or staff privacy by safeguarding records and ensuring the confidentiality of protected health information is a violation of the Health Insurance Portability and Accountability Act (HIPAA) and NCGS § 108A-80 and may be a violation of the North Carolina Identity Theft Protection Act. Violations will be reported to the Consumer Protection Section of the N.C. Attorney General's Office, the Medicaid Investigations Unit of the N.C. Attorney General's Office and/or the U.S. DHHS Office of Civil Rights, as applicable. The following sanctions, penalties, and fees may be imposed for HIPAA violations:

- Mandatory investigation and penalties for noncompliance due to willful neglect
- Willful neglect: \$50,000 up to \$1.5 million (\$10,000 up to \$250,000 if corrected within 30 days)
- Enforcement by the State Attorney General along with provisions to obtain further damages on behalf of the residents of the State in monetary penalties plus attorney fees and costs as provided for by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A provider's obligation to maintain the above-described records is independent from ongoing participation in the N.C. Medicaid or NCHC programs and extends beyond the expiration or termination of the Agreement or contract. See 10A NCAC 22F.0107 and Section 8 of the DHHS Provider Administrative Participation Agreement. Provider records may be subject to post-payment audits or investigations after an agency closes. Failure to retain adequate and accessible documentation of services provided may result in recoupment of payments made for those services, termination or suspension of the provider from participation with the N.C. Medicaid or NCHC programs and/or referral to the US DHHS Office of Inspector General for exclusion or suspension from federal and state health care programs.

If another provider takes over the functions of a closing entity, maintenance of the closing entity's records for the applicable recipients may be transferred to the new provider, if the new provider agrees to accept custody of such records in writing and a copy of this agreement is provided to the N.C. Division of Medical Assistance (DMA) upon request. When custody of records is not transferred, the closing providers should send copies of transitional documentation to the providers who will be serving the recipient for continuity of care. Consumer authorization should be obtained as necessary. Copies of records may be provided to the recipient directly for coordination of care.

DMA must be notified of changes in provider enrollment status, including changes in ownership and voluntary withdrawal from participation in the N.C. Medicaid and NCHC programs, as indicated on the [NCTracks Reporting a Provider Change Webpage](#). Providers who anticipate closure are required to develop and implement a records retention and disposition plan. The plan must indicate how the records will be stored, the name of the designated records custodian, where the records will be located, and the process to fulfill requests for records. Information must be included on how recipients will be informed of the contact information and the process to request their records. The plan should also designate retention periods and a records destruction process to take place when the retention period has been fulfilled and there is no outstanding litigation, claim, audit or other official action. The plan should be on file with the records custodian.

Office Relocation: Program Integrity, Finance Management, Hearings

The Program Integrity Unit, Finance Management Unit and Hearings Unit of the N.C. Division of Medical Assistance (DMA) have moved to a new office location effective May 21, 2012. These three units have relocated to 333 East Six Forks Road, Raleigh, North Carolina 27609.

The mailing address and new contact information is listed below:

DMA Program Integrity

New Central Phone Number (919) 814-0000

New Fax Number (919) 814-0035

Mailing Addresses – Remain the Same:

Division of Medical Assistance – Program Integrity
2501 Mail Service Center
Raleigh, NC 27699-2501

Division of Medical Assistance – Program Integrity
Third Party Recovery Section
2508 Mail Service Center
Raleigh, NC 27699-2508

Overnight Delivery Address:

Division of Medical Assistance – Program Integrity
333 East Six Forks Road, **3rd** Floor
Raleigh, NC 27609

DMA Finance Management

New Central Phone Number (919) 814-0000

New Fax Number (919) 814-0031

Mailing Address – Remains the Same:

Division of Medical Assistance – (Rate Setting or Audit)

2501 Mail Service Center

Raleigh, NC 27699-2501

Overnight Delivery Address:

Division of Medical Assistance – (Rate Setting or Audit)

333 East Six Forks Road, 2nd Floor

Raleigh, NC 27609

DMA Hearings

New Central Phone Number (919) 814-0000 / (919) 814-0090

New Fax Number (919) 814-0032

Mailing Address – Remains the Same:

Division of Medical Assistance – Hearings

2501 Mail Service Center

Raleigh, NC 27699-2501

Overnight Delivery Address:

Division of Medical Assistance – Hearings

333 East Six Forks Road, 2nd Floor

Raleigh, NC 27609

DMA Program Integrity / Finance / Hearings

(919) 814-0000

Changes in Drug Rebate Manufacturers

The following changes have been made in manufacturers with Drug Rebate Agreements. It is listed by manufacturer’s code, which are the first five digits of the NDC.

Reinstated Labeler

<i>Code</i>	<i>Manufacturer</i>	<i>Date</i>
10888	Banner Pharmacaps, Inc	05/09/2012

Voluntarily Terminated Labelers

The following labelers have requested voluntary termination effective July 1, 2012:

JS Pharmaceutical, LLC	(Labeler 24839)
Stewart-Jackson Pharmacal, Inc	(Labeler 45985)

Checkwrite Schedule

May 08, 2012	June 12, 2012	July 10, 2012
May 12, 2012	June 19, 2012	July 17, 2012
May 22, 2012	June 28, 2012	July 26, 2012
May 31, 2012		

Electronic Cut-Off Schedule

May 03, 2012	June 07, 2012	July 07, 2012
May 10, 2012	June 14, 2012	July 12, 2012
May 17, 2012	June 21, 2012	July 19, 2012
May 24, 2012		

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date. POS Claims must be transmitted and completed by 12:00 midnight on the day of the electronic cut-off date to be included in the next checkwrite.

Lisa Weeks, PharmD, R.Ph.
 Chief, Pharmacy and Ancillary Services
 Division of Medical Assistance
 NC Department of Health and Human Services

Debbie Pittard
 Acting Assistant Director for Program Integrity
 Division of Medical Assistance
 NC Department of Health and Human Services

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 HP Enterprise Services
