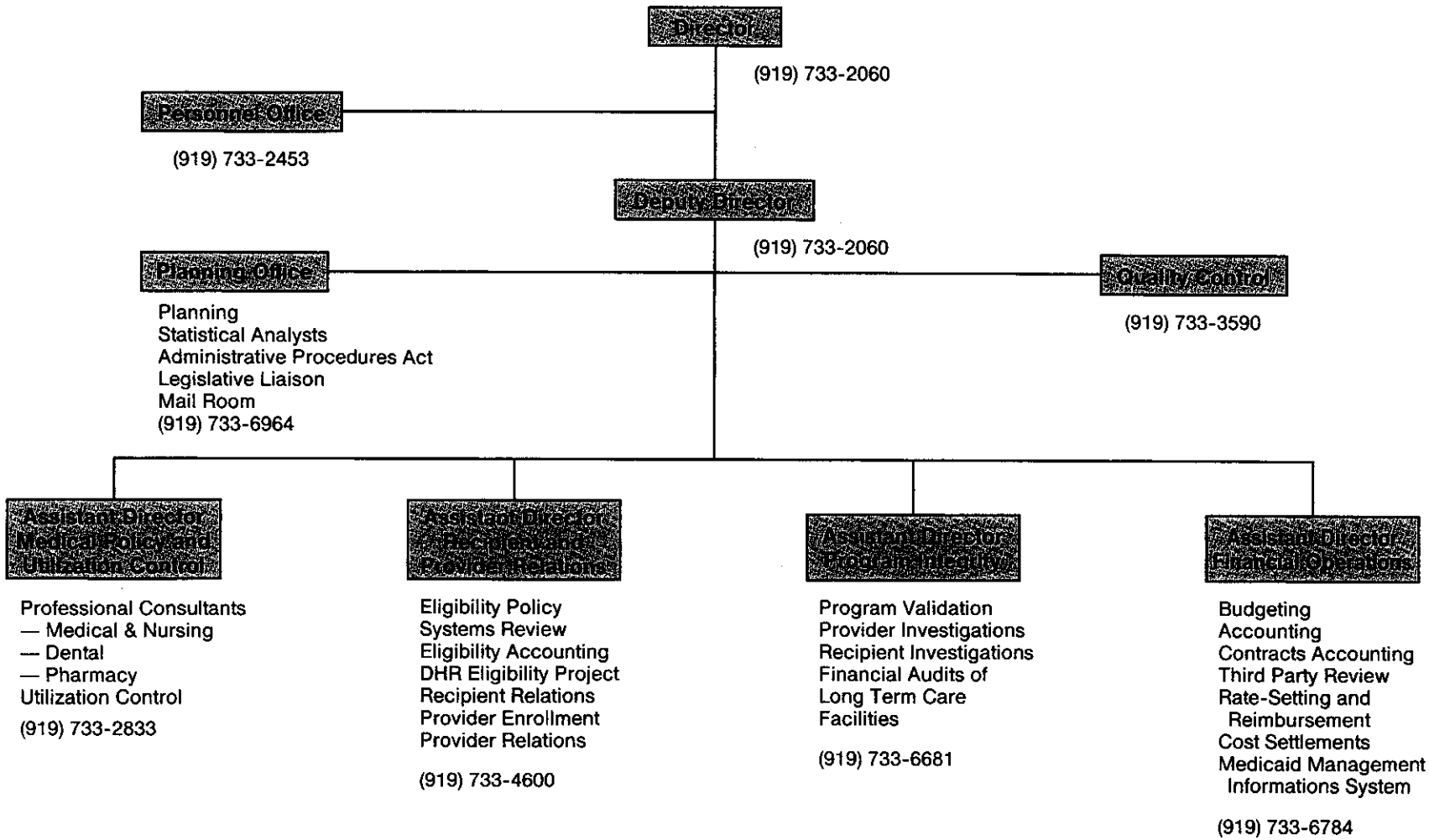
ANNUAL REPORT 1987-1988

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MEDICAL ASSISTANCE
OFFICE OF THE DIRECTOR



MEDICAID IN NORTH CAROLINA
ANNUAL REPORT
1987 - 1988

The Honorable James G. Martin
Governor of the State of North Carolina

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One thousand copies of this publication were printed at a cost of $2437.00 or $2.44 per copy.

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May 26, 1989

Dear Citizens:

In this Annual Report I am pleased to report on our efforts during Fiscal Year 1987-88 to extend the range of Medicaid services to several of our State's most vulnerable populations.

Healthy mothers and babies continue to be critical priorities for the Medicaid Program. During 1988 the Division of Medical Assistance and the Division of Health Services successfully launched the *Baby Love* program. *Baby Love* offers pregnant women and their babies early, continuous and comprehensive health care and other needed support services. Over time, we hope that *Baby Love* will contribute to a reduction in North Carolina's high rate of infant mortality.

Medicaid also expanded coverage for case management for chronically mentally ill persons. This allows the Division of Mental Health, Mental Retardation, and Substance Abuse Services to provide better access to comprehensive mental health services for this vulnerable population.

Both the *Baby Love* and case management programs are noteworthy for the spirit of cooperation between State administrative agencies in delivering needed services. *Baby Love* has gained national recognition for its achievements.

Finally, in 1988 Medicaid coverage was expanded to include hospice services. The hospice program provides alternative services to terminally ill citizens and helps them achieve the highest possible quality of life during their illness.

Although I am proud of the strides we have made in 1988, Medicaid faces additional important challenges in Fiscal Year 1989. I look forward to reporting on our progress in implementing the provisions of the Medicare Catastrophic Coverage Act and elements of nursing home reform. These changes are designed to offer greater financial protection for North Carolina's elderly, blind, and disabled citizens, and to increase the quality of care for nursing home residents.

Sincerely,

Barbara D Matula

Barbara D. Matula

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1. OVERVIEW

EXECUTIVE SUMMARY

In state fiscal year 1987-88, the North Carolina Medicaid program paid providers $915 million to render health care services to 404,118 needy citizens.

Total expenditures for health care services increased 13.7 percent and recipients increased 4.8 percent over state fiscal year 1986-87.

Of these expenditures $659 million (72% of total) was spent to provide services for 132,516 aged, blind, and disabled recipients, or one third of total Medicaid recipients. The remainder, $256 million (28% of total) was spent on services for 271,602 young poor, or two thirds of total recipients.

Forty-three percent of the Medicaid budget is spent for nursing home care and for institutional care for the mentally retarded.

State and county administration costs were $19.9 million and $28.8 million respectively for a total of $48.7 million or 5 percent of total program expenditures.

2. ELIGIBILITY

PEOPLE SERVED . . .

In state fiscal year 1987-88 the North Carolina Medicaid program paid for medical care for 404,118 needy people. Those eligible for Medicaid are divided into two groups, categorically needy and medically needy. All state Medicaid programs are required by Federal regulations to include the categorically needy classification. The medically needy classification is a state option.

The categorically needy group consists of people who receive or are eligible for cash assistance payments. The medically needy meet the same general requirements as the categorically needy but do not receive cash assistance payments, often because their income is too high. If the medically needy individual's income is higher than the allowable level, he must spend the excess income on medical care before becoming eligible. This is known as deductible or "spenddown".

A person must have income and resources below a certain level to qualify for Medicaid. Tables 1 and 2 in the Program Statistics Section show those levels. An applicant's resources must be below the levels in Table 2 or he/she is ineligible. If the applicant's resources are below the established levels and his/her income is above the established levels, he/she may spend down the excess income.

In addition to being poor, a person must also meet certain categorical requirements. The applicant must either be a pregnant woman; a minor child; a caretaker of a dependent child; aged 65 or above; or blind or disabled as defined by Social Security Administration criteria.

Recipients of AFDC payments, Title IV-E payments or State/County Special Assistance payments automatically qualify for Medicaid. Federal regulations permit states to either accept as categorically needy all persons found eligible for the federal SSI program, or to set categorically needy eligibility criteria which are more restrictive than SSI standards. North Carolina has elected the more restrictive option, making it a "209(b)" state, so named for the regulatory citation explaining the option.

3. SERVICES PROVIDED

Certain services are mandated by federal regulations for all states participating in Medicaid; other services are optional. The North Carolina General Assembly has authorized coverage for the following:

FEDERALLY MANDATED SERVICES

Hospital Inpatient
Hospital Outpatient
Lab and X-Ray
Skilled Nursing Facility (SNF)
    age 21 and over
Home Health
Early and Periodic Screening
    Diagnosis and Treatment (EPSDT)
Family Planning
Physicians
Hearing Aids for Children
Rural Health Clinics
Transportation
Durable Medical Equipment
    for Home Health Patients

STATE'S OPTIONAL SERVICES

Prescribed Drugs
Chiropractors
Dental
Intermediate Care Facilities (ICF)
Intermediate Care Facilities
    for the Mentally Retarded (ICF-MRC)
Clinics, including Mental Health Centers
Optical Supplies
Optometrists
Skilled Nursing Facilities,
    under age 21 (SNF)
Podiatrists
Mental Hospitals, age 65 and over
Psychiatric Facilities, under age 21
Specialty Hospitals
Community Alternatives Program
    Aged/Disabled Adults
    Mentally Retarded
    Disabled Children Under 18
Ambulance
Prepaid Health Plans
Personal Care
Hospice
Targeted Case Management for
    Pregnant Women
    Chronically Mentally Ill Adults
    Emotionally Disturbed Children
    Chronic Substance Abusers
Private Duty Nurse Services

4. MEDICAID SPENDING

Ninety-seven percent of program expenditures finance direct health care services for Medicaid eligibles. The remaining three percent pays for enrollees in the Medicare program who also meet Medicaid eligibility standards and for those enrolled in the Medicaid-contracted health maintenance organization (HMO). The bulk of Medicaid direct care expenditures are services in three priority areas: long term care, hospital care, and primary care services.

LONG TERM CARE

Intermediate Care Facilities	$111.5 Million
Skilled Nursing Facilities	130.1 Million
Intermediate Care Facilities For the Mentally Retarded	119.4 Million
Intermediate Care Facilities For the Mentally Retarded — Group Homes	33.5 Million
Home Health	20.5 Million
Community Alternatives Program	15.4 Million
Personal Care Services	8.9 Million

Payments for long term care institutional services (ICF, SNF, and ICF/MR) are the single largest group of services funded by the Medicaid program. Expenditures for these services account for 43 percent of total expenditures and increased 9.3 percent over 1987 to $395 million. SNF expenditures increased by 8 percent, ICF by 6.3 percent, and ICF/MR by 12.6 percent. Relative to overall program growth over 1987 (14.1%), SNF, ICF, and ICF/MR expenditures grew at a more modest pace. Nonetheless, the size of these expenditures is significant. In particular, the increase in ICF/MR has been fueled by the creation of additional small group homes for retarded individuals. 1988 expenditures for group homes increased over 1987 figures at a significantly higher rate (27.8%) than overall program expenditures (14.1%)

Spending for two other components of long term care, home health services and the community alternatives program (CAP) increased to $35.9 million in 1988, a 34 percent jump over 1987 expenditures. Personal Care Services (PCS) became effective January, 1986, and by the end of fiscal year 1988 had increased 82% over 1987. This increase represents a continuing demand for services to allow recipients to remain in their homes rather than in more intensive and expensive nursing home settings.

HOSPITAL CARE

Inpatient Hospitals	$235.1 Million
Mental Hospitals	25.1 Million

Payments for hospital services, including short-term general and mental hospitals, is the second largest Medicaid expenditure, accounting for just over one-quarter of all program payments in 1988 (27.8%). Medicaid expenditures for these services totalled $260.2 million in 1988, a 14.8% increase over 1987, while overall program expenditures in 1988 increased by 14.1%.

PRIMARY CARE SERVICES

Physicians	$66.8 Million
Outpatient Hospitals	23.2 Million
Prescription Drugs	71.4 Million
Clinics	11.6 Million
Dental Care	12.0 Million
Child Health Screening	2.2 Million
Family Planning	5.3 Million

Expenditures for primary care services continue to be a substantial focus of the Medicaid program. Payments for primary care services, including physicians, outpatient hospitals, prescription drugs, clinic services, dental care, child health screening, and family planning, constitute about 21% of total program expenditures ($192.5 million). This proportion was the same in 1987 while 1988 expenditures were up 14% over 1987.

5. SPECIAL PROGRAMS

THE BABY LOVE PROGRAM

The Baby Love Program, implemented in October, 1987, is aimed at combating North Carolina's high infant mortality rate by ensuring that poor pregnant women and young children receive comprehensive medical care. Through the Baby Love Program, pregnant women receive comprehensive medical care from the beginning of pregnancy through the post-partum period and children receive services through age 2. The age limit was increased to age 3 on October 1, 1988. Some of the key features of this program include:

1) Extension of Medicaid coverage to 9,500 more low income pregnant women who are not able to afford the costs of the needed care.

2) Improvement in the package of covered services for pregnant women so that all services required during pregnancy are available. Services include pre and post natal medical check-ups, laboratory and diagnostic testing, medications, transportation, inpatient and outpatient hospital care and treatment for any condition that may complicate the pregnancy. Also, educational classes covering health, labor, delivery and infant care, and specialized in-home nursing care needed for medically complex pregnancies are covered.

3) Creation of a statewide network of specially trained health care staff called Maternity Care Coordinators who help pregnant women obtain medical care covered by the Baby Love program and an array of other support services such as transportation and child care. The coordinators are located in many local health departments and rural health clinics.

4) Implementation of new efforts to reach and inform individuals about the need for early prenatal care and the services available through the Baby Love program. Informational brochures were distributed statewide by public agencies, and local agencies assisted by creating outreach campaigns.

5) Initiation of changes in the process for enrolling new eligibles in the program. Emphasis is being placed on processing the initial application at the site of medical care and in changing federal law to give states more flexibility to eliminate unnecessary requirements. A promising approach called Presumptive Eligibility is available. It allows selected providers to determine a client's eligibility by completing a simple application and an initial decision being made the same day. This process allows access to maternity care immediately and allows sufficient time to provide necessary information to complete enrollment into the Baby Love program while assuring that providers will be reimbursed for the care they render while the enrollment process continues.

HEALTHY CHILDREN AND TEENS PROGRAM

The Healthy Children and Teens Program, authorized under the federally mandated EPSDT Program, is a preventive health care program for Medicaid eligible children and teens under the age of 21.

North Carolina selected the title of its program to emphasize the importance of health care to teenagers as well as children. The program is designed to provide comprehensive health care screenings to detect physical and mental health problems which can lead to disabling diseases later in life. Necessary follow-up care to treat, to correct, and to ameliorate the problem is also provided.

Screenings are provided by physicians and certified nurse screeners in public health departments as well as by participating private physicians and their staff. A list of Medicaid physicians and agencies providing health care is available at the local department of social services for families needing assistance.

During fiscal year 1988, 71,278 child health screenings were performed.

ADULT HEALTH SCREENING PROGRAM

The Adult Health Screening Program provides for annual health screenings for Medicaid recipients over age 21 with the expectation that it will prevent serious illness through early detection and treatment. North Carolina developed the Adult Health Screening Program, effective January 1, 1986, as a result of federal encouragement to states to maximize the availability of preventive services to Medicaid recipients.

The screenings are performed at a local health department and by participating physicians in private practice. Physician's assistants, nurse practitioners and registered nurses who have successfully completed the adult health physical assessment training course are permitted to perform the screenings; however, the private physician or the clinic physician must accept ultimate responsibility for the services provided.

THE COMMUNITY ALTERNATIVES PROGRAMS

North Carolina has three waiver programs to provide home and community care as a cost-effective alternative to institutionalization. The total cost of in-home care to Medicaid (i.e., the cost of the waiver services plus the home health services the individual receives) must be equal to or less than the average Medicaid reimbursement for the comparable level of institutional care. All services are subject to the approval of the Division of Medical Assistance. Waivers allow the state to determine Medicaid eligibility as if the individual were institutionalized; thereby, eliminating the need to count the income and resources of a spouse or parent.

The Community Alternatives Program for Disabled Adults (CAP/DA) provides services that allow adults (ages 18 and above) who require care in a skilled nursing facility or intermediate care facility to remain in the community. Thirty-eight of the one hundred counties in the state participated in the Community Alternatives Program for Disabled Adults in FY 1988. In addition to the regular Medicaid services, the CAP/DA participant may receive screening/assessment, case management, chore services, homemaker services, home mobility aids (e.g., wheelchair ramps and grab bars), one home delivered meal per day, respite care, and telephone alert (emergency response systems). Approximately 2000 individuals participated in CAP/DA during state fiscal year 1987-88.

The Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD) provides services to individuals of any age who normally would require care in an intermediate care facility for the mentally retarded. The program currently is offered by 38 area mental health, mental retardation, and substance abuse programs that cover 93 counties. In addition to regular Medicaid services, the CAP-MR/DD participant can receive screening/assessment, case management, adaptive behavior training, adult day health care, communication training, community skills training, counseling, developmental day care, homemaker services, home mobility aids, medical supplies, personal care, parent/caregiver training, and respite care. Approximately four hundred individuals participated in the program in state fiscal year 1987-88.

The Community Alternatives Program for Children (CAP/CC) is different from the other two programs in that it serves children (through age 18) who are normally ineligible for Medicaid due to the parents' income and resources. It is available statewide. The program is often referred to as the "Katie Beckett" program. It is designed to serve medically fragile children in their homes. The child must require the level of care provided by a skilled nursing facility, an intermediate care facility, or in certain instances hospital care. CAP/CC participants may receive case management, screening/assessment, home mobility aids, hourly nursing services, respite care, medical supplies and personal care services. We can serve fifty children in North Carolina under this program at any one time during the year. In state fiscal year 1987-88, approximately forty nine children were served.

In addition to receiving home and community-based services, participants in all of the CAP programs are exempt from limitations and co-payment requirements associated with pharmacy prescriptions and physicians visits.

6. COST CONTAINMENT

PREADMISSION REVIEW PROGRAM

The most expensive single line item in the Medicaid budget in 1988 was for inpatient hospital services at nearly $235 million, up 14.1 percent over last year. The rapid expenditure growth in this area prompted DMA to implement preadmission review.

The preadmission review program began November 1, 1986 for non-urgent, non-emergency hospital admissions. All elective or planned hospital admissions require review prior to admission to the hospital. Proposed admissions are reviewed using clinical criteria developed by physician experts. For procedures defined by the Division of Medical Assistance as being frequently and safely performed on an outpatient basis, approval for hospital admission is contingent upon either an increased surgical risk posed by the condition of the patient, or a lack of outpatient facilities within a reasonable distance. This review process is conducted by Medical Review of North Carolina, Inc. under a contractual agreement with the Division of Medical Assistance.

The objective for this program is not to deny hospitalization but rather to seek less expensive and more appropriate treatment alternatives such as outpatient surgery, pre-admission testing, and the reduction of elective weekend admissions.

LIMITATIONS ON SERVICES

Twenty-four (24) visits per year are allowed to one or a combination of physicians, clinics, hospital outpatient departments, chiropractors, podiatrists, and optometrists. Exemptions to limitations based on medical necessity or life threatening condition include:

a) pregnancy-related care,
b) EPSDT,
c) hospital emergency room care,
d) end stage renal disease,
e) chemotherapy and radiation therapy for malignancy,
f) acute sickle cell disease,
g) end stage lung disease,
h) unstable diabetes,
i) hemophilia,
j) terminal stage of any life threatening illness.

Six (6) prescriptions, including refills, are allowed each month. However, the exemptions based on medical necessity listed above also apply to prescriptions.

CO-PAYMENTS

The following recipient cost sharing (co-payment) amounts have been in effect since April, 1984. Co-payment amounts are the same for both categorically needy and medically needy recipients.

Service Category	Co-Payment
Chiropractic	$ .50 per visit
Clinical Services	.50 per visit
Dental Services	2.00 per visit
Legend Drugs and Insulin	.50 per prescription including refills
Optical Supplies	2.00 per visit
Optometric Services	1.00 per visit
Outpatient Services	1.00 per visit
Physician	.50 per visit
Podiatrist	1.00 per visit

Certain co-payment exemptions were mandated under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. No co-payment can be charged on the following services:

1. EPSDT
2. Family Planning
3. Services to children under 18
4. Services related to pregnancy
5. Services to residents of ICF, ICF-MR, SNF, and mental hospitals
6. Hospital emergency room

In addition to the federally mandated exemptions, the state exempted the following services from co-payment:

1. Community Alternatives Program (CAP)
2. Services to enrollees of prepaid plans
3. Rural Health clinics
4. Non-hospital dialysis facility
5. State-owned mental hospital
6. Services when covered by both Medicare and Medicaid

PRIOR APPROVALS

Prior approval from the Division of Medical Assistance or its designated agent is required for the following services:

1. Reimbursement of hospital inpatient services when a lower level of care is needed, but a bed for the appropriate lower level is unavailable.
2. Cosmetic surgery.
3. Out of state services that are non-emergency and performed outside a 40-mile radius of North Carolina.
4. More than two outpatient psychiatric visits — except at mental health centers.
5. Hearing aids for children.
6. Many non-emergency dental services, including dentures and orthodontia for children.
7. Admissions to SNF, ICF, ICF-MR.
8. Eye Care Centers.
9. Durable Medical equipment.
10. Community Alternatives Program.
11. Organ Transplants.
12. Non-Emergency Admissions to Hospitals.
13. Private Duty Nursing.

THIRD PARTY LIABILITY

Third party resources for medical care such as health insurance, are an important means of reducing Medicaid costs. When a person accepts Medicaid benefits he, by state law, agrees to assign all third party resources designated for health care to the State Medicaid agency. North Carolina's Medicaid agency has received national recognition for its efforts in recovering third party resources.

THIRD PARTY RECOVERY ACTIVITY REPORT

SUMMARY		FY 1987-88
A. Insurance Paid to Providers		$11,156,393
B. Claims Denied for Other Insurance (EOB 094)*		21,219,447
C. Refunds		
1. Medicare	619,410	
2. Health Insurance	2,011,709	
3. Casualty Insurance	1,599,046	
4. Responsible Relative	—	
5. Absent parent (IV-D)	15,555	
Total Refunds		4,245,720
TOTAL		$36,621,560
COST AVOIDANCE		
A. Medicare A		$133,724,577
B. Medicare B		40,996,445
TOTAL		$174,721,022

*Identified for investigation. Findings may or may not result in a refund.

PROGRAM INTEGRITY

Financial Audits of Long Term Care Facilities

Nursing home financial and Medicaid audits resulted in cost settlement collections totaling $10,679,634.

UTILIZATION REVIEW

Utilization review activity is conducted by the Division of Medical Assistance or via contracts with review agencies. The federal share of expenditures is 75% when a state agency performs these functions.

Retrospective Review of Inpatient Hospital Services

Recoveries initiated by DMA as a result of retrospective review of the medical necessity for inpatient hospital services were $615,026.

Long Term Care Level of Care Review

Federally required inspection of care on-site visits are made annually to each nursing home where the level-of-care needs for each Medicaid patient are reviewed. In 1985, this function was contracted out to the Division of Facility Services as they were already performing nursing home Medicare-Medicaid certification surveys.

Paid Claims Review

Paid claims are periodically reviewed and those which differ significantly from established norms are analyzed to ensure that the services are medically necessary and appropriate. Certain services which are very expensive or which may be of questionable necessity under certain circumstances require prior approval before treatment is rendered.

FRAUD AND ABUSE DETECTION

Fraud and abuse detection are major concerns of the State's Medicaid administrators. In addition to the Medicaid agency, the Office of the Attorney General has staff fully devoted to criminal investigation and prosecution of Medicaid fraud. In FY 1987-88, 935 provider and 1,354 recipient cases were initiated and recoupments in the total amount of $583,158 (Providers) and $785,973 (Recipients) were collected. Nineteen cases were referred to the Attorney General for possible fraud prosecution.

In addition to actual cash collections, Program Integrity actions resulted in cost avoidance equal to $23,671,590.

7. ADMINISTRATION AND FINANCING

METHODS OF REIMBURSEMENT

- Home Health Agencies, Hospital Inpatient Services, Long Term Care Facilities: Prospective per diem rates
- Physicians, Other Practitioners, Laboratory and X-Ray: Statewide fee schedule
- Hospital Outpatient Services: Cost based reimbursement
- Rural Health Clinics, Free Standing Clinics, Health Department Clinics: Negotiated rates
- Pharmacy, Hearing Aids: Acquisition costs plus Dispensing Fee
- Optical Supplies: Contract price for competitive bid.

ADMINISTRATION AND CLAIMS PROCESSING

The Division of Medical Assistance is responsible for administration of the state Medicaid program. During FY 1987-88 DMA had 168 staff positions. EDS-Federal Corporation is the fiscal agent contractor for the Medicaid program. EDS-F performs claims processing, provider relations, prior approval, and reporting functions for the state. Expenditures for these services in FY 1988 were $5.1 million.

In North Carolina 13,298,968 Medicaid claim line items were processed in FY 1987-88. Each claim was subjected to a series of edits and audits to determine if the recipient was eligible, if the provider was certified, if the procedure was covered, if the service was appropriate for the age and sex of the recipient, if the claim was a duplicate of one previously submitted, and other relevant questions designed to guarantee that Medicaid funds are properly spent. This screening process is more extensive than is used for almost any other third party payor.

FINANCING MEDICAID

The largest share of Medicaid costs is paid by the federal government. Federal Medicaid matching rates for services are established by the Department of Health and Human Services using the most recent three year average per capita income for each state and the national per capita income. The established federal matching rates for services are effective for a period of one federal fiscal year. Because the federal fiscal year and the state fiscal year do not coincide, two different federal service matching rates may apply in each state fiscal year. Because federal match for administrative costs are constant, there is only one rate for SFY 1987-88. Following is a table showing the federal matching rates for FY 1987-88.

SERVICE COSTS

	7/1/87 - 9/30/87		10/1/87 - 6/30/88	
	Family Planning	All Other Services	Family Planning	All Other Services
Federal	90.00%	69.18%	90.00%	68.68%
State	8.50	26.20	8.50	26.62
County	1.50	4.62	1.50	4.70

ADMINISTRATIVE COSTS

	7/1/87 - 6/30/88	
	Skilled Medical Personnel & MMIS*	All Services
Federal	75.00%	50.00%
Non-federal	25.00	50.00

***MMIS — Medicaid Management Information System**

THE ROLE OF THE COUNTY IN THE MEDICAID PROGRAM

North Carolina has a state-supervised, county-administered social services system. County social service departments determine eligibility for Medicaid based upon federal and state eligibility requirements. Counties pay about 5 percent of the cost of providing Medicaid services to their residents.

PROVIDERS OF SERVICE

Medicaid payments are made directly to participating health care professionals who provide medical services to eligible people. Medicaid recipients have the freedom to choose any enrolled medical provider. Eligible cases are issued a Medicaid identification card each month which lets the provider know that charges should be billed to the Medicaid Program.

During fiscal year 1988 a total of 11,150 providers submitted 13,298,968 claim line items for payment.

ENROLLED MEDICAID PROVIDERS BY TYPE OF SERVICE

Physicians	11,882
Radiologists	775
Dentists	2,381
Pharmacists	1,972
Optometrists	708
Chiropractors	433
Podiatrists	203
Ambulance	166
Home Health Agencies	134*
ICF-General	208
ICF-MRC	75
Hospitals	188
Mental Health Clinics	90
Optical Supplies	1**
SNF	214
Other	1,063
Total	20,493

*Includes DME, physical, speech, occupational therapy.
**Single Source Contract effective July 1, 1986.

8. MAJOR POLICY CHANGES

There were several major policy changes in FY 1987-88. Among them were the following:

EFFECTIVE DATE	POLICY CHANGE
October 1987	• Case Management services covered for target populations. • Prospective Reimbursement Rate for Home Health Services. • Eligibility expansion under SOBRA options to cover all pregnant women and children under age two with incomes under the federal poverty guidelines.
January 1988	• Medically Needy Income Standards increased 2.5%. • Eligibility expansion to reinstate coverage of 19-21 year olds. • Eligibility expansion to cover intact families when the primary wage earner is unemployed (AFDC-UP).
April 1988	Hospice covered.

Legislative Session June - July 1988

The following 1988 legislative actions became effective in state fiscal year 1988-89.

October 1, 1988	Expansion under SOBRA options to cover children under 3.
January 1, 1989	Implement provisions of the Federal Catastrophic Health Coverage Act of 1988.

9. PROGRAM STATISTICS

Table 1: ELIGIBILITY INCOME LEVELS
(Annual)

1	$ 2,124	$ 2,900	$ 2,900	$ 5,770
2	2,772	3,700	3,700	7,730
3	3,192	4,300	4,300	9,690
4	3,492	4,700	4,700	11,650
5	3,804	5,100	5,100	13,610

Table 2: ELIGIBILITY RESOURCES LIMITS

1	$ 1,000	$ 1,500	$ 1,500	No resources
2	no increment	2,250	2,250	test applies
3	for family size	2,350	2,350	
4		2,450	NA	
5		2,550	NA	

Table 3: EXPENDITURES FOR SELECTED MAJOR MEDICAL SERVICES BY PROGRAM CATEGORY For State Fiscal Year 1988

Inpatient Hospital	$235,057,670	$ 28,977,971	$ 592,818	$ 84,660,803	$ 71,516,397	$ 49,309,681
Outpatient Hospital	23,214,547	2,751,765	75,909	6,623,571	5,939,024	7,824,278
Skilled Nursing Home	130,131,325	110,407,716	763,531	18,491,739	366,329	102,010
Intermediate Care —						
General	111,536,254	99,734,757	859,815	10,846,611	63,838	31,233
Mentally Retarded	152,991,263	3,364,385	1,937,152	130,961,485	16,728,241	-
Physician	66,788,437	8,506,769	224,054	19,209,847	17,268,072	21,579,695
Dental	11,973,085	1,259,445	32,666	2,145,516	4,303,717	4,231,741
Prescription Drugs	71,424,426	34,326,566	587,559	23,164,711	4,972,724	8,372,866
Clinics	11,597,230	696,687	42,952	5,832,888	2,405,962	2,618,741
Total Vendor	$915,438,761	$325,366,462	$5,743,463	$328,328,346	$148,256,378	$107,744,112

Table 4: STATE FISCAL YEAR 1987-88

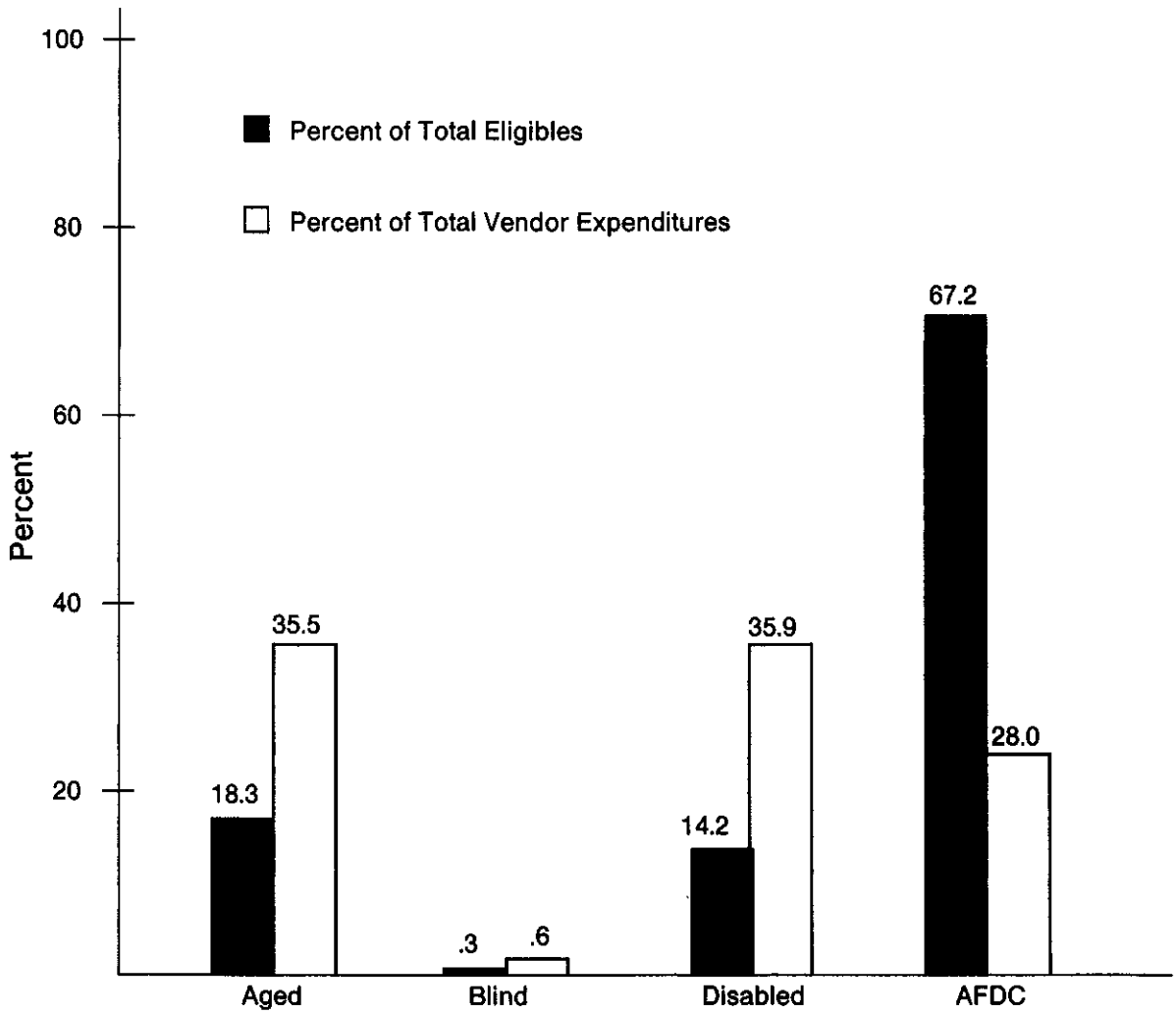


Table 5: COMPARISON OF MEDICAL EXPENDITURES
For State Fiscal Years 1987 and 1988

Type of Service	SFY 87 Expenditures	SFY 88 Expenditures	Percentage Change*
Inpatient Hospital	$205,938,618	$235,057,670	14.1
Outpatient Hospital	20,304,582	23,214,547	14.3
Mental Hospital	20,641,566	25,176,184	22.0
SNF	120,466,011	130,131,325	8.0
ICF	104,913,714	111,536,254	6.3
ICF-MR	135,840,111	152,991,263	12.6
Physician	57,628,150	66,788,437	15.9
Drugs	61,751,723	71,424,426	15.7
Dental	12,530,538	11,973,085	(4.4)
Child Health Screening	2,116,715	2,228,367	5.3
Clinics	9,854,444	11,597,230	17.7
Family Planning	4,684,415	5,301,662	13.2
Home Health	15,704,145	20,561,325	30.9
HMO Premiums	263,419	1,959,230	643.8
All Other Services	32,627,063	45,497,756	39.4
Total Vendor Services	805,265,214	915,438,761	13.7
Medicare Part B Premiums	13,963,960	19,262,785	37.9
Total Vendor and Premiums	819,229,174	934,701,546	14.1

*Includes both increases in costs as well as utilization.

Table 6: PERCENTAGE OF EXPENDITURES FOR SELECTED CATEGORIES OF SERVICE TO TOTAL VENDOR EXPENDITURES
For State Fiscal Year 1988

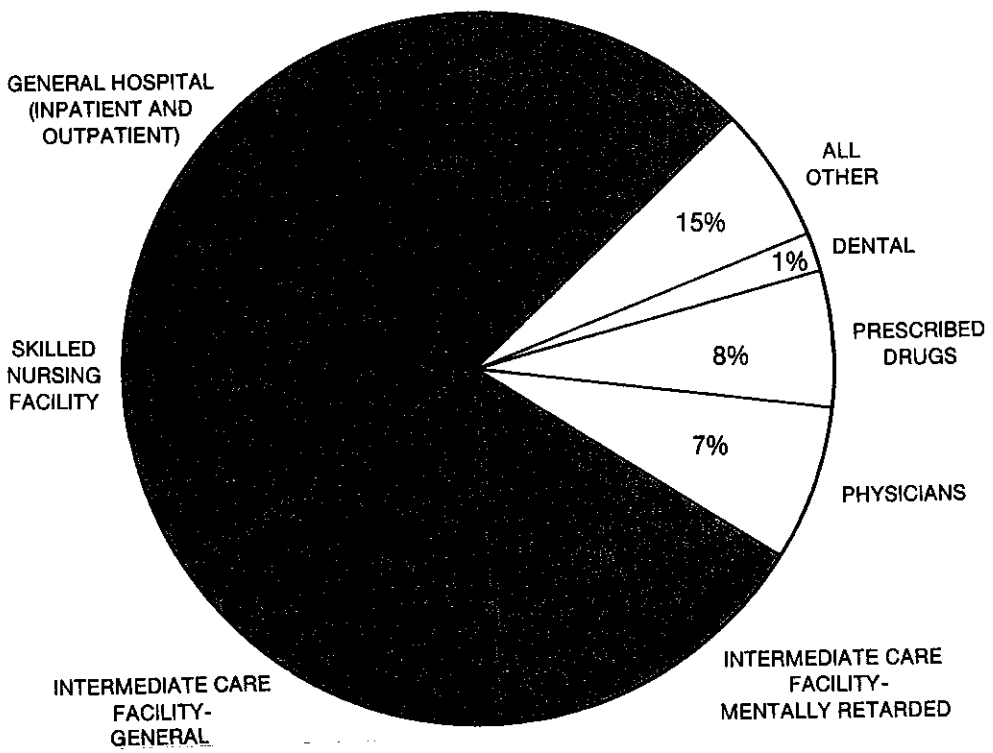


TABLE 6 Errata Are:
General Hospital - 28%
All Other - 13%

Table 7: STATE FISCAL YEAR 1987-88

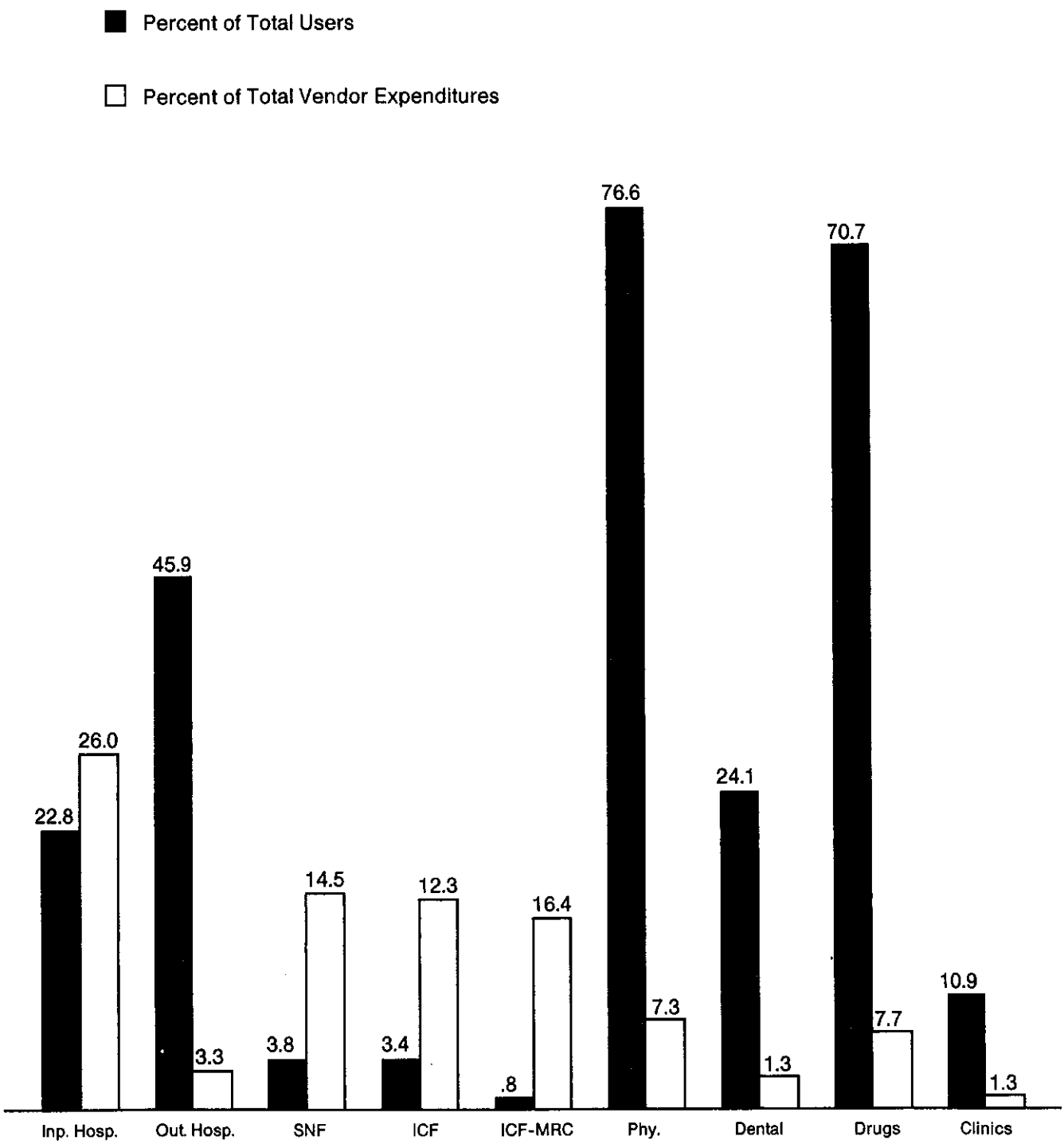


Table 8: TOTAL VENDOR EXPENDITURES FOR MEDICAL SERVICES TOTAL NUMBER OF RECIPIENTS* State Fiscal Year 1988

Aged.....	$325,366,462	35.5	73,923	18.3	$4,401
Blind.....	5,743,463	.6	1,365	.3	4,208
Disabled	328,328,346	35.9	57,228	14.2	5,737
AFDC-ADULT.....	107,744,112	11.8	99,152	24.5	1,087
AFDC-CHILD	116,117,685	12.7	167,312	41.4	694
Other Child**.....	32,138,693	3.5	5,138	1.3	6,255
Total Vendor.....	915,438,761	100.0	404,118	100.0	2,265

*A recipient is a Medicaid eligible who has used services.

**Includes approximately 425 children in long term care institutions with total costs of approximately $17 million.

Table 9: EXPENDITURES AND RECIPIENTS BY AID CATEGORY, SEX, RACE, AGE GROUP For STATE Fiscal Year 1988

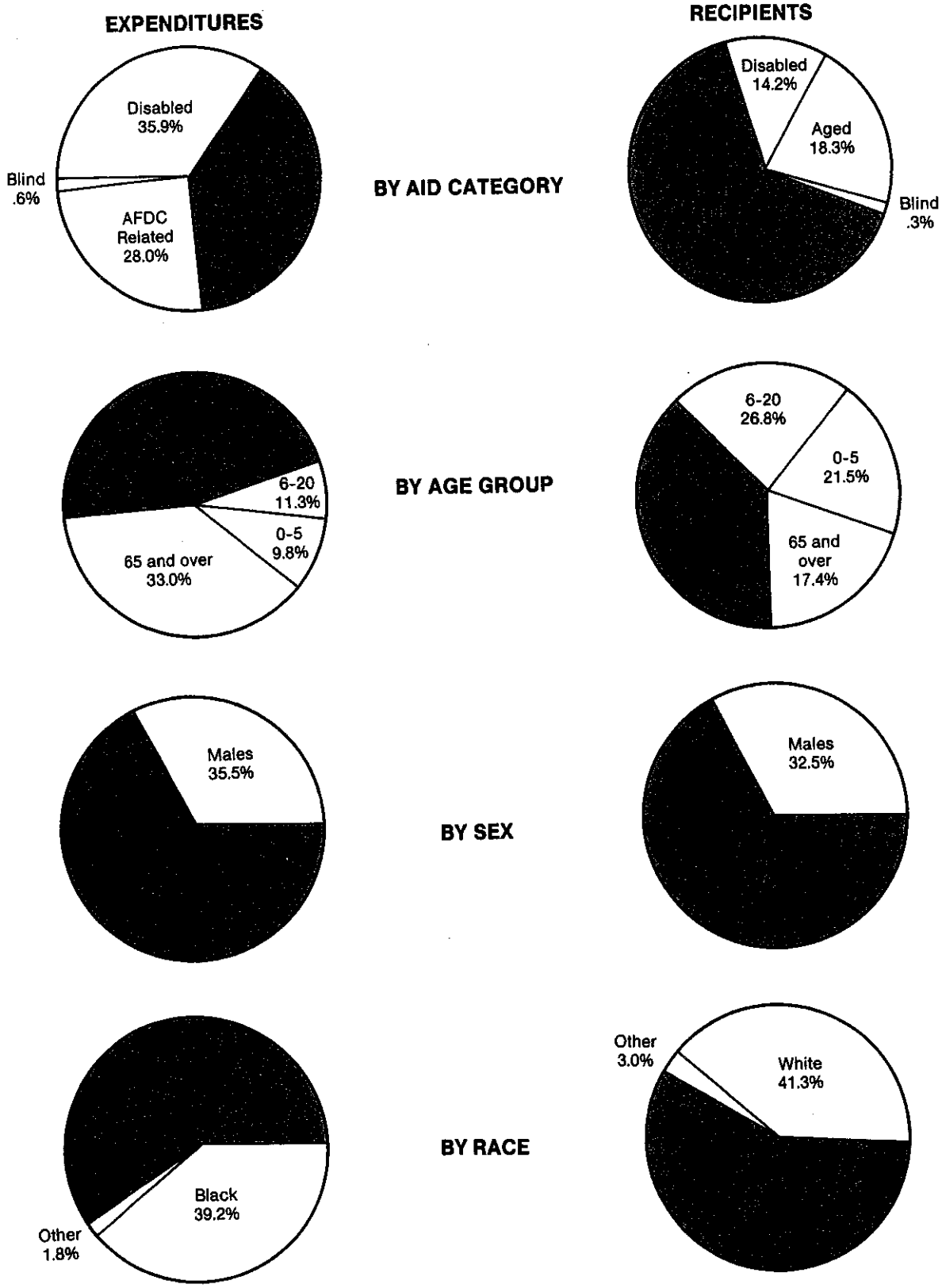


Table 10: A HISTORY OF TOTAL MEDICAID EXPENDITURES For STATE Fiscal Years 1978-1988

1978	$306,691,301	
1979	379,769,848	23.8%
1980	410,053,625	8.0
1981	507,602,694	23.8
1982	521,462,961	2.7
1983	570,309,294	9.4
1984	657,763,927	15.3
1985	665,526,678	1.2
1986	758,115,890	13.9
1987	861,175,819	13.6
1988	983,464,113	14.2

Note: Expenditures include vendor payments, administrative costs, refunds, and adjustments.

Table 11: A HISTORY OF TOTAL MEDICAID EXPENDITURES For STATE Fiscal Years 1978-1988 MILLIONS OF DOLLARS

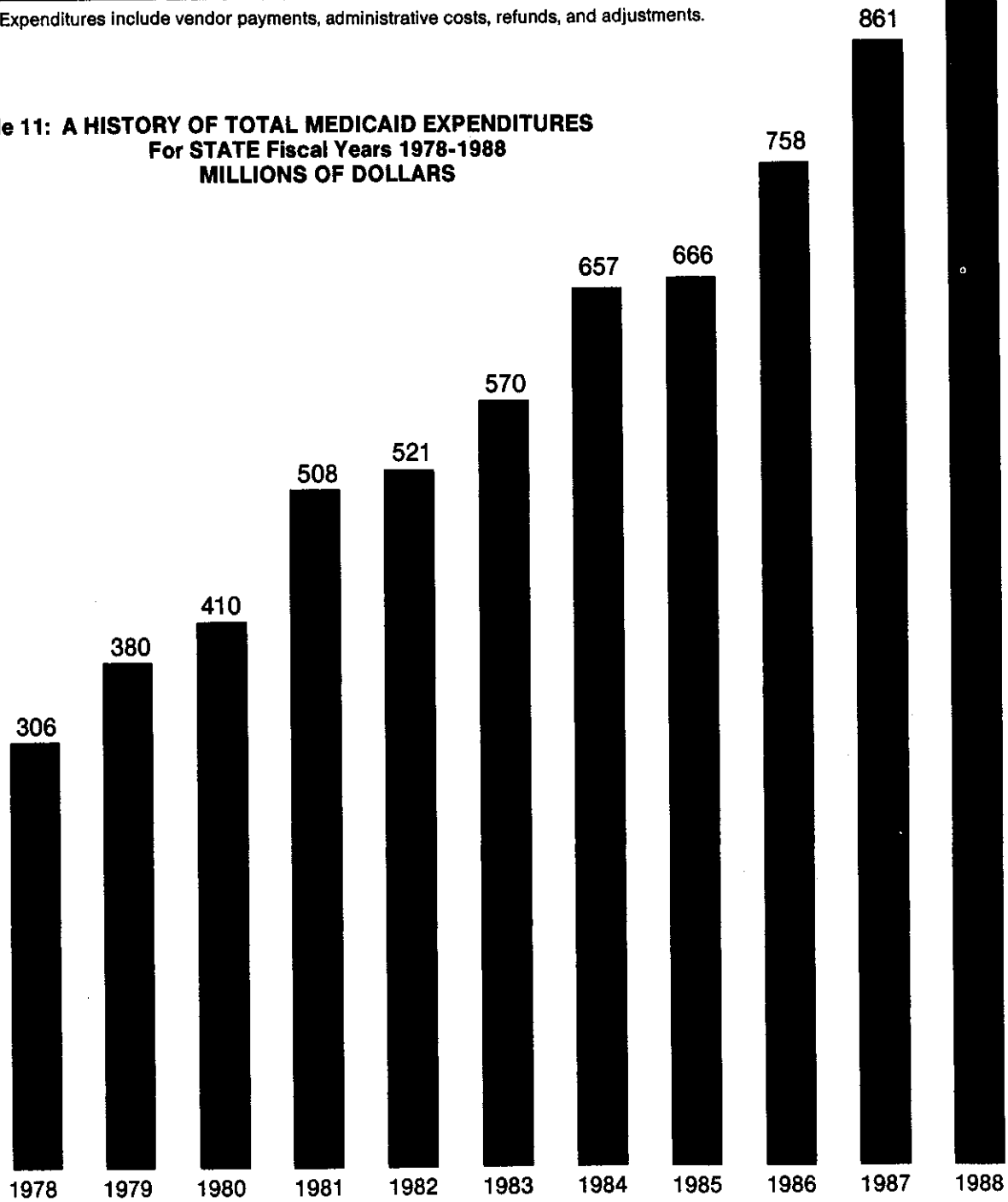


Table 12: A HISTORY OF UNDUPLICATED MEDICAID ELIGIBLES
For STATE Fiscal Years 1978-1988

1977-78	82,835	3,616	62,179	300,719	6,425	455,774
1978-79	82,930	3,219	59,187	301,218	6,620	453,174
1979-80	82,859	2,878	56,265	307,059	6,641	455,702
1980-81	80,725	2,656	53,773	315,651	6,559	459,364
1981-82	70,010	2,349	48,266	298,483	6,125	425,233
1982-83	67,330	2,000	46,537	293,623	6,062	415,552
1983-84	65,203	1,755	46,728	288,619	5,501	407,806
1984-85	65,849	1,634	48,349	293,188	5,333	414,353
1985-86	69,193	1,554	51,959	313,909	5,315	441,930
1986-87	72,295	1,462	54,924	317,983	5,361	452,025
1987-88	76,308	1,394	58,258	339,803	5,563	481,326

Table 13: TOTAL VENDOR PAYMENTS AND TOTAL ELIGIBLES BY COUNTY
For STATE Fiscal Year July 1, 1987 - June 30, 1988

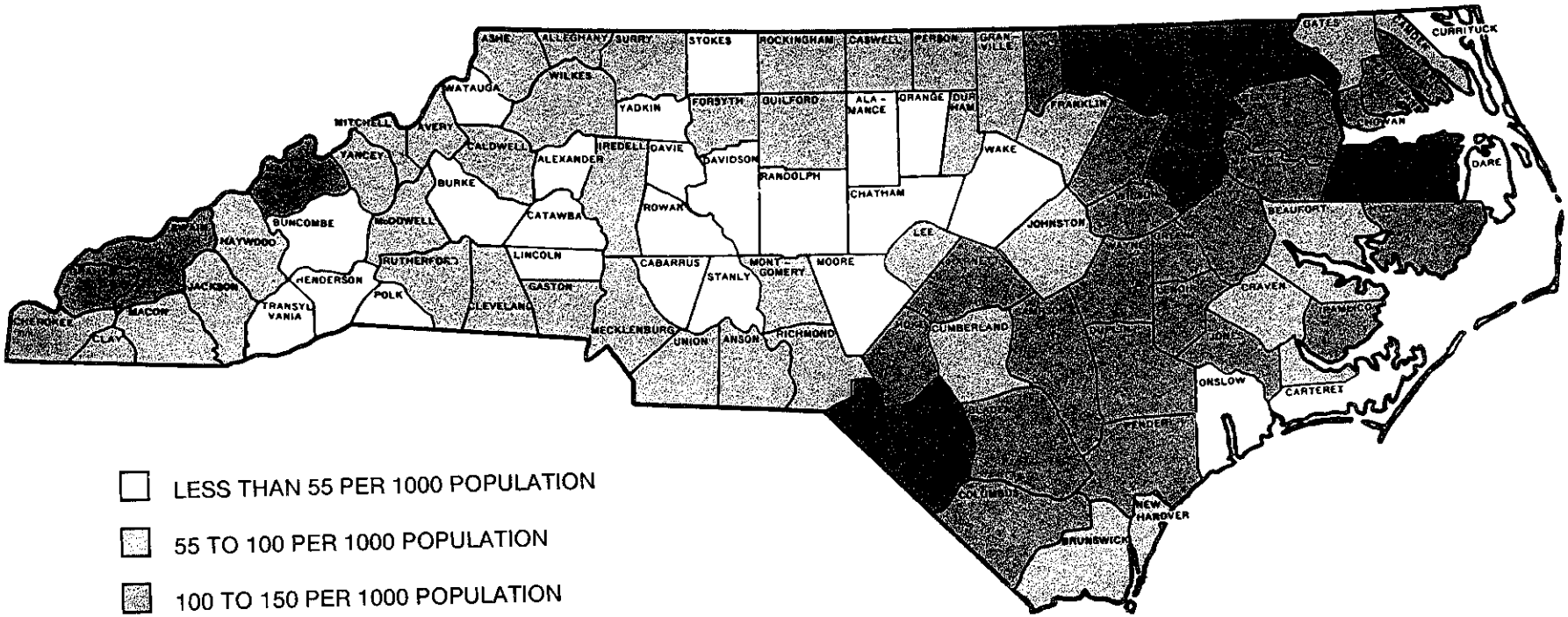
Alamance	103,855	5,113	$ 13,436,981	$129.38	77	49
Alexander	27,104	1,036	2,931,193	108.15	92	38
Alleghany	9,744	592	950,098	97.51	94	61
Anson	26,432	2,568	5,776,340	218.54	18	97
Ashe	23,399	1,963	4,323,832	184.79	34	84
Avery	15,126	1,001	2,546,893	168.38	43	66
Beaufort	43,883	4,280	8,527,944	194.33	28	98
Bertie	21,286	3,123	4,667,376	219.27	16	147
Bladen	30,881	4,531	7,231,893	234.19	8	147
Brunswick	49,718	4,383	6,861,518	138.01	62	88
Buncombe	171,457	8,699	22,518,874	131.34	73	51
Burke	76,548	3,921	9,961,227	130.13	75	51
Cabarrus	93,956	4,826	12,348,888	131.43	72	51
Caldwell	70,530	3,853	10,322,051	146.35	57	55
Camden	5,866	435	883,381	150.59	55	74
Carteret	51,906	2,627	6,371,972	122.76	82	51
Caswell	22,776	1,851	3,498,934	153.62	53	81
Catawba	115,573	4,725	12,610,129	109.11	89	41
Chatham	36,432	1,761	4,491,127	123.27	81	48
Cherokee	20,591	1,685	3,594,012	174.54	40	82
Chowan	13,519	1,467	2,722,659	201.39	26	109
Clay	7,305	516	1,405,671	192.43	29	71
Cleveland	86,662	6,467	13,117,936	151.37	54	75
Columbus	52,493	7,752	13,233,874	252.11	5	148
Craven	81,677	6,207	13,270,463	162.47	45	76
Cumberland	256,189	24,336	32,164,008	125.55	80	95
Currituck	13,731	558	1,196,896	87.17	99	41
Dare	19,558	732	1,737,537	88.84	98	37
Davidson	120,044	5,817	13,292,306	110.73	88	48
Davie	29,026	1,164	3,986,316	137.34	63	40
Duplin	41,801	4,268	8,445,830	202.05	25	102
Durham	168,015	11,394	27,160,983	161.66	47	68
Edgecombe	59,563	8,925	13,046,565	219.04	17	150
Forsyth	263,596	17,135	34,182,054	129.68	76	65
Franklin	34,832	3,253	7,096,547	203.74	23	93
Gaston	173,259	12,813	25,563,037	136.00	66	74
Gates	9,665	809	1,794,381	185.66	33	84
Graham	7,166	799	1,401,353	195.56	27	111
Granville	38,280	2,212	4,164,405	108.79	91	58
Greene	16,661	1,944	3,488,513	209.38	20	117
Guilford	331,897	20,505	45,224,744	136.26	65	62
Halifax	56,184	10,470	14,299,233	254.51	4	186
Harnett	64,719	6,969	12,192,651	188.39	32	108
Haywood	48,783	3,455	7,085,291	145.24	59	71
Henderson	68,605	3,578	7,825,182	114.06	87	52
Hertford	24,155	3,793	5,391,180	223.19	12	157
Hoke	23,575	2,877	3,542,961	150.28	56	122
Hyde	5,915	658	1,349,591	228.16	11	111
Iredell	89,371	4,882	11,813,855	132.19	71	55
Jackson	26,700	1,738	3,697,812	138.49	61	65
Johnston	79,407	6,666	14,086,012	177.39	36	84
Jones	9,830	1,153	2,811,340	286.00	1	117

Table 13: TOTAL VENDOR PAYMENTS AND TOTAL ELIGIBLES BY COUNTY
For STATE Fiscal Year July 1, 1987 — June 30, 1988

Lee	42,158	3,379	$ 6,869,329	162.94	44	80
Lenoir	60,285	6,951	14,015,879	232.49	9	115
Lincoln	46,903	2,414	5,718,022	121.91	84	51
Macon	23,549	1,399	2,776,214	117.89	86	59
Madison	17,446	1,963	3,550,985	203.54	24	113
Martin	26,843	3,050	4,783,590	178.21	35	114
McDowell	36,392	1,992	5,047,311	138.69	60	55
Mecklenburg	460,920	30,792	59,086,985	128.19	79	67
Mitchell	14,560	1,195	2,462,075	169.10	42	82
Montgomery	24,073	2,010	3,706,707	153.98	52	83
Moore	56,889	2,830	7,773,323	136.64	64	50
Nash	71,894	7,221	12,492,494	173.76	41	100
New Hanover	116,446	11,024	18,789,511	161.36	48	95
Northampton	22,545	4,114	5,636,192	250.00	6	182
Onslow	127,109	6,398	12,390,041	97.48	95	50
Orange	85,957	2,819	8,110,874	94.36	96	33
Pamlico	11,158	1,147	2,673,529	239.61	7	103
Pasquotank	30,084	3,459	5,328,755	177.13	37	115
Pender	25,670	2,871	5,417,961	211.06	19	112
Perquimans	10,701	1,338	2,044,940	191.10	30	125
Person	30,885	2,695	7,153,059	231.60	10	87
Pitt	98,567	11,247	17,433,904	176.87	38	114
Polk	14,726	661	1,760,907	119.58	85	45
Randolph	100,312	3,650	10,481,644	104.49	93	36
Richmond	46,347	3,982	7,327,571	158.10	51	86
Robeson	106,811	17,706	23,519,472	220.20	14	166
Rockingham	85,851	5,769	13,946,030	162.44	46	67
Rowan	105,376	5,486	13,767,056	130.65	74	52
Rutherford	57,375	4,097	8,362,346	145.75	58	71
Sampson	50,423	5,526	10,344,729	205.16	21	110
Scotland	33,968	5,425	7,474,885	220.06	15	160
Stanley	50,558	2,463	6,736,986	133.25	69	49
Stokes	36,013	1,762	4,781,322	132.77	70	49
Surry	61,882	3,422	7,957,585	128.59	78	55
Swain	11,042	1,201	1,780,387	161.24	49	109
Transylvania	26,567	1,431	3,605,357	135.71	67	54
Tyrrell	4,106	698	1,144,038	278.63	2	170
Union	81,335	4,678	8,862,977	108.97	90	58
Vance	39,059	4,648	7,439,641	190.47	31	119
Wake	376,337	16,370	31,181,819	82.86	100	43
Warren	16,488	2,470	4,318,953	261.95	3	150
Washington	14,500	2,227	3,211,606	221.49	13	154
Watauga	34,928	1,450	3,118,596	89.29	97	42
Wayne	97,468	10,156	17,017,504	174.60	39	104
Wilkes	61,058	3,645	9,716,936	159.14	50	60
Wilson	64,792	9,062	13,222,955	204.08	22	140
Yadkin	29,836	1,556	3,981,061	133.43	68	52
Yancey	15,988	1,192	1,959,383	122.55	83	75
STATE TOTAL	6,403,426	481,326	$933,929,275	$145.85	N/A	75

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1988
Data reflects only net vendor payments for which the county is billed for its computable share.

TABLE 14: MEDICAID ENROLLMENT PER 1000
POPULATION BY COUNTY - FISCAL YEAR 1988



STATE OF NORTH CAROLINA
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MEDICAL ASSISTANCE
1985 UMSTEAD DRIVE
RALEIGH, NORTH CAROLINA 27603