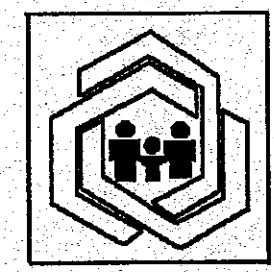


Medicaid in North Carolina
Annual Report
State Fiscal Years 1993 & 1994

State of North Carolina
Department of Human Resources
Division of Medical Assistance

James B. Hunt, Jr.	C. Robin Britt, Sr.	Barbara D. Matula
Governor	Secretary	Director

North Carolina Department of Human Resources
Division of Medical Assistance

P. O. Box 29529 • 1985 Umstead Drive • Raleigh, N.C. 27626-0529 • Courier Service 56-20-06

James B. Hunt Jr., Governor
C. Robin Britt, Sr., Secretary

Barbara D. Matula, Director

December 4, 1995

Dear Fellow North Carolinians:

This Medicaid program report covers state fiscal years 1993 and 1994. During this period there were no major changes in eligibility policy; however, the number of people eligible for Medicaid grew by 20%. The largest growth occurred in the Special Children coverage group. These are children who are in households with income below poverty, but who are not eligible for AFDC. By June, 1994, children were covered up to the age of eleven.

A major objective of the Medicaid program during this period continued to be greater access and improved services for pregnant women and young children. Our Baby Love program and Health Check program are two initiatives designed to achieve these objectives and are highlighted in this report.

Managed Care initiatives were also a focal point for Medicaid during this time. Carolina ACCESS and Carolina Alternatives are two managed care programs designed to improve access to care and to control the rate of growth in costs. They are highlighted in this report.

I invite you to learn more about these and other important health care initiatives in the following pages.

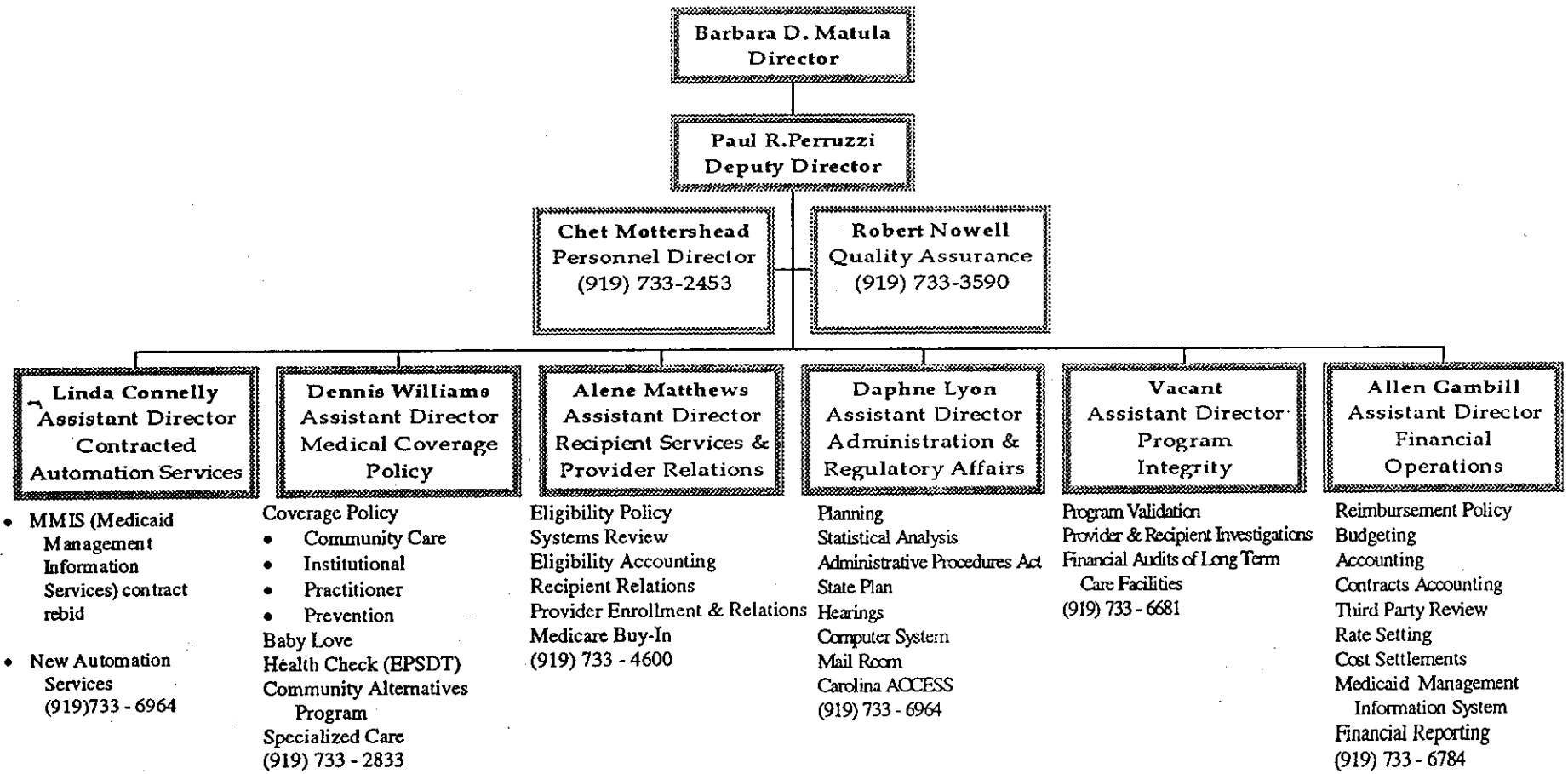
Sincerely,

Barbara D Matula

Barbara D. Matula

BDM/ng

N.C. Department of Human Resources
Division of Medical Assistance
Office of the Director
(919) 733-2060



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Most recently, a new physician payment system took effect January 1, 1993. It is the most significant change in the way the Medicaid program pays physicians since the program began. The new methodology was adopted to address inequities in the old reimbursement system, and was adapted to North Carolina's needs to attract and retain primary care physicians, especially in the rural underserved areas. The new fee schedule was developed based on a relative value scale (RVS) produced by a research team at Harvard University.

Carolina ACCESS

Carolina ACCESS, North Carolina's Patient Access and Coordinated Care Program, was designed to provide a more efficient and effective health care delivery system for Medicaid recipients. Carolina ACCESS brings a system of coordinated care to the Medicaid program by linking each eligible recipient with a primary care provider (PCP) who has agreed to provide or arrange for his or her health care services. By improving access to primary care, and encouraging a stable doctor-patient relationship, the program helps to promote continuity of care, while reducing inappropriate utilization and controlling costs.

The program was implemented as a demonstration project in April 1991 through the cooperative efforts of the Division of Medical Assistance and the North Carolina Foundation for Alternative Health Programs. Partial funding was provided through a grant from the Kate B. Reynolds Health Care Trust.

The program was piloted in five counties, and has expanded to 28 counties. There were 127,042 enrollees in Carolina ACCESS (as of July 1994).

The counties and the dates they became Carolina ACCESS providers are as follows:

Beaufort (3/92)	**Henderson (4/91)**
Buncombe (3/93)	**Jackson (12/94)**
Burke (9/91)	**Lee (10/94)**
Caldwell (12/92)	**Lenoir (7/94)**
Caswell (12/92)	**Madison (8/91)**
Chatham (10/94)	**Moore (4/91)**
Cleveland (8/94)	**Nash (8/91)**
Davidson (8/93)	**Onslow (9/94)**
Durham (4/91)	**Orange (11/93)**
Edgecombe (4/91)	**Pitt (3/92)**
Forsyth (2/93)	**Scotland (11/93)**
Greene (3/92)	**Surry (10/93)**
Harnett (5/93)	**Wake (3/94)**
Haywood (11/92)	**Wayne (9/91)**

Statewide expansion is planned, and it is anticipated that up to 70 percent of the Medicaid recipients in participating counties will be enrolled in Carolina ACCESS.

Carolina Alternatives Program

Carolina Alternatives is a Mental Health Managed Care program designed to better organize and deliver mental health services to Medicaid eligible children ages 0-18. Eligible children are linked to area Mental Health Programs that are responsible for providing and/or arranging for all medically necessary mental health and substance abuse services for these children. Each eligible child in need of care receives an assessment. A care coordinator then locates appropriate community-based services for the child and works with the child's family and the care provider to develop a plan for treatment.

The program began January 1, 1994, through ten area Mental Health Programs covering 32 counties with an average monthly number of 114,596 covered children. The development of the program was made possible through a grant from the Kate B. Reynolds Health Care Trust. The Division of Medical Assistance; Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; North Carolina Foundation for Alternative Health Programs; Office of Rural Health Resources Development and Area Mental Health Programs collaborated to develop this program initiative.

Chart 1
State Fiscal Year 1993 & 1994
Medicaid Policy Changes in Brief

Effective Date	Policy Change
July 1, 1992	• Cover screening mammograms for Medicaid eligible women based on age and risk status
	• Cover case management services for seriously emotionally disturbed children
August 1, 1992	• Increase recipient copayment amounts for Medicaid services to the maximums allowed by federal regulations.
September 1, 1992	• Cover Hepatitis B provided to newborns
October 1, 1992	• Remove prior approval requirements from most dental services
	• Cover case management services for adults and children at risk of abuse, neglect, or exploitation
November 1, 1992	• Implement Lead screening and prevention program for Health Check (EPSDT) eligible children
January 1, 1993	• Implement the physician fee schedule based on the resource based relative value system (RBRVS)
	• Increase in income and resource amounts protected for the at-home spouse of a nursing home patient (Spousal Impoverishment)
	• Cover "Specified Low-Income Medicare Beneficiaries"
	• Implement the Drug Utilization Review Program

Chart 1 (Continued)

Effective Date	Policy Change
July 1, 1993	• Cover physical therapy, occupational therapy, psychological services, audiological services and speech/language services provided by local education agencies
October 1, 1993	• Cover influenza and pneumoccal vaccines for children
January 1, 1994	• Implement Carolina Alternatives, a coordinated-care system for the delivery of child mental health and substance abuse services to children 0-18
February 1, 1994	• Expand coverage in the CAP program for persons with mental retardation or developmental delays to include prevocational services, supported employment, crisis stabilization, personal emergency response systems and augmentative communication devices
April 1, 1994	• Establish targeted case management services for persons with confirmed medical diagnosis of HIV disease, including eligibility requirements, eligible providers and the reimbursement methodology associated with this service
May 1, 1994	• Health Check (EPSDT) introduces a statewide education and outreach program with pilot projects initiated in 21 counties

History

Congress created the Medicaid program in 1965. It was designed to be a medical safety net for two categories of low income people receiving cash assistance: mothers and children and elderly, blind and disabled persons. Medicaid is jointly financed by the federal and state governments -- in North Carolina, the 100 counties contribute to the non-federal share of costs. All states, the District of Columbia and some territories have Medicaid programs. Medicaid programs are governed by federal guidelines, but vary in eligibility criteria and covered services. In North Carolina, counties determine eligibility for Medicaid.

North Carolina's program began in 1970 as a Department of Social Services program. A separate Division of Medical Assistance (DMA) was created within the Department of Human Resources in 1978. From 1978 to 1994, Medicaid expenditures and eligibles grew from $307 million to $3.5 billion, and from 456,000 to 1,058,603, respectively. During this time, DMA staff increased from 121 to 282. In over 20 years of operation, Medicaid's programmatic complexity has paralleled the growth in both program expenditures and recipients. Historically, however, DMA has spent a relatively modest percentage of its budget on administration. In SFY 1994, Medicaid state and local administration costs consumed just 3.2 percent of total program dollars. This level of expenditure reflects Medicaid's use of efficient administrative methods and innovative cost control strategies.

Greatly overshadowing Medicaid in 1965, was the creation of Medicare, a federally operated health insurance program for elderly, blind and disabled individuals, regardless of income. Composed of two distinct programs (Part A and Part B), Medicare is financed through Social Security payroll taxes, beneficiary premiums and general revenues.

Many low income persons qualify for both Medicare and Medicaid. Generally Medicare covers acute care needs, subject to certain benefit limitations. For individuals who qualify for both Medicaid and Medicare, Medicaid pays Medicare cost-sharing amounts and fills in many gaps in Medicare's benefit package, especially in the area of long term care services.

Federal Financial Participation

The largest share of Medicaid costs is paid by the federal government. Federal matching rates for services are established by the federal government -- the Health Care Financing Administration (HCFA) -- 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 applicable to the federal fiscal year, which extends from October 1 to September 30. As mentioned previously, the state's fiscal year (SFY) runs from July through June. Because the federal and state fiscal years do not coincide, two different federal service matching rates may apply in each state fiscal year. The federal match rate for administrative costs does not change from year to year. Table 1 shows the federal matching rates for SFY 1994. (See Appendix for SFY 1993 rates.)

Table 1
State Fiscal Year 1994
Federal Matching Rates

Benefit Costs

	Family Planning		All Other
	(7/1/93 - 9/30/93)		
Federal	90.0%	Federal	65.92%
State	8.5%	State	28.97%
County	1.5%	County	5.11%
	(10/1/93 - 6/30/94)		
Federal	90.0%	Federal	65.14%
State	8.5%	State	29.63%
County	1.5%	County	5.23%

Administrative Costs

(7/1/93 - 6/30/94)

	Skilled Medical Personnel & MMIS	All Other
Federal	75.0%	50.00%
Non-Federal	25.0%	50.00%

**MMIS-Medicaid Management Information System
**See SFY 1993 Information in Appendix

Funding Formula

The federal matching rate for Medicaid services varies from state to state based on per capita income. Nationwide, in SFY 1994, the federal match rate varied from a low of 50 percent to a high of 78.85 percent. Additionally, states may require localities to participate in the non-federal share of expenditures. In North Carolina, each county contributes 15 percent of the non-federal share. During SFY 1994, the federal, state and county shares were approximately 65 percent, 30 percent, and 5 percent, respectively, of total expenditures.

Eligibility

Medicaid is available for certain categories of people specified by law, based on financial (income and resources) criteria. North Carolina's Medicaid program has two main components, a categorically needy program and a medically needy program.

Categorically Needy - The categorically needy group consists of people who receive or are eligible to receive cash assistance payments under other assistance programs or who are specially authorized by law. These include:

- recipients of Aid to Families with Dependent Children (AFDC) payments, foster care and adoption assistance (Title IV-E) payments, state/county Special Assistance payments, or supplemental assistance programs to visually handicapped individuals
- pregnant women
- infants and children up to age 19
- persons aged 65 and above
- persons who are blind or disabled (as defined by the federal Social Security Administration criteria).

For the aged, blind and disabled, federal regulations permit states either to accept as categorically needy all persons found eligible for the federal Supplemental Security Income (SSI) program or to set categorically needy eligibility criteria that are more restrictive than SSI standards.

Until January 1, 1995, North Carolina elected the latter approach, making it one of 13 "209(b)" states, so-named for the statutory citation explaining the option. What this meant is that SSI recipients had to make a separate application to North Carolina's Medicaid program and meet more stringent financial means tests (on resources) to become eligible for coverage. After January 1, 1995, North Carolina SSI recipients will automatically be qualified for Medicaid benefits.

Medicaid's Medicare-Aid program pays for out-of-pocket expenses for Medicare-covered services, such as premiums, deductibles and coinsurance for those who qualify. The income and resource limits that must be met to qualify for Medicare-Aid are higher than those necessary to receive full Medicaid coverage. (See Table 2: "Qualified Medicare Beneficiaries".) Effective January 1, 1993, DMA began coverage of the Part B premium for individuals who meet the requirements for Medicare-Aid, but whose income is high enough to preclude coverage. (See Table 2.)

The spousal impoverishment provision of the Medicare Catastrophic Coverage Act of 1988 allows a spouse living in the community to keep a larger portion of the family's income than otherwise would be permitted when the other spouse requires nursing home care. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The income and resources amount which can be protected for the at-home spouse increase each year. (See Table 2.) As of January 1, 1994, the amount of annual income that can be protected ranges from a minimum of $14,148 to a maximum of $21,804 and resource protection ranges from a minimum of $14,532 to a maximum of $72,660.

Medically Needy - The medically needy meet the same general requirements as the categorically needy but do not receive cash assistance payments, generally because their income is higher than state standards allow. If the medically needy individual's income is higher than the allowable level, he or she must spend the excess income on medical care before becoming eligible. This is known as the Medicaid deductible or "spenddown."

How the Program Works

Medicaid operates as a vendor payment program. Families or individuals are issued a Medicaid identification card each month. Program eligibles may receive medical care from any of the 34,249 providers who are enrolled in the program. Providers then bill Medicaid for their services. In 1994, 16,311 providers billed for services. Table 3 shows the broad range of provider types that Medicaid enrolls.

Medicaid provides funding for care that many otherwise would not be able to afford. Medicaid is also an ongoing source of both state and federal revenues for North Carolina's health care providers, although its importance varies by provider.

Table 2
State Fiscal Year 1994
Medicaid Financial Eligibility Standards

Eligibilty Income Levels
(Annual)

Family Size	* AFDC Related * Groups: Categorically Needy	* AFDC Related * Groups: Medically Needy	Aged, Blind & Disabled: All Groups	Pregnant Women Infants < 1 Yr. 185% of Poverty	Children Ages 1-5 133% of Poverty	Children Age 6 & Over 100% of Poverty	Qualified Medicare Beneficiaries 100% of Poverty	Specified Low-Income Medicare Beneficiaries 101-120% of Poverty	"Spousal Impoverishment" Beneficiaries 150% of Poverty	Qualified Disabled Working Individual 200% of Poverty
1	4,344	2,904	2,904	13,620	9,792	7,368	7,368	7,368 - 8,100	Minimum of $14,148	14,724
2	5,664	3,804	3,804	18,204	13,092	9,840	9,840	9,840 - 10,824	up to a Maximum of	19,680
3	6,528	4,404	4,404	22,800	16,392	12,324			$21,804	
4	7,128	4,800	N/A	27,384	19,692	14,808				
5	7,776	5,196	N/A	31,968	22,992	17,280				

Eligibility Resource Limits

1	$1,000	$1,500	$1,500	No resource	No resource	No resource	$4,000	$4,000	$14,532 minimum	$4,000
2	No increment	2,250	2,250	test applies	test applies	test applies	6,000	6,000	$72,660 maximum	6,000
3	for family size	2,350	2,350							
4		2,450	N/A							
5		2,550	N/A							

Source: Income & Reserve Levels (REV. 8/94)

**See Appendix for SFY 1993 Table 2 data.

Table 3
State Fiscal Years 1993 & 1994
Enrolled Medicaid Providers

Numbers	SFY 1993	SFY 1994
Physicians*	20,393	22,103
Dentists	2,916	3,007
Pharmacists	2,291	2,371
Optometrists	947	994
Chiropractors	674	722
Podiatrists	319	335
Ambulance Companies	233	238
Home Health Agencies**	149	155
Durable Medical Equip. Suppliers	227	266
Intermediate Care Facilities-MR	259	288
Hospitals	195	194
Mental Health Clinics	126	136
Nursing Facilities	351	365
Optical Supplies Company***	1	1
Personal Care Agencies	166	251
Rural Health Clinics	68	68
Nurse Midwives	17	18
Hospices	58	62
CAP Providers	402	459
Other Clinics	77	92
Other	1,868	2,124
Total	**31,737**	**34,249**

* The count of physicians reflects each provider number assigned to an individual physician or a group practice of physicians. Most physicians practicing in a group practice have an individual provider number in addition to the group number. Also physicians who practice in multiple settings are included once for each practice setting.

**Includes physical, speech and occupational therapies and home infusion therapy services

***Single source purchase contract effective October 1, 1990.

Administrative Contracts

Certain functions of the Medicaid program are performed for DMA under contract.

Electronic Data Systems Corporation (EDS) -- DMA contracts with EDS to perform many Medicaid administrative functions. EDS pays claims, serves as a focal point for provider questions and problems, trains new providers, operates the prior approval system for most Medicaid services and operates the North Carolina Medicaid Management Information System (MMIS). Expenditures for EDS services were $10.1 million in SFY 1993 and $11.3 million for SFY 1994. EDS processed 34,878,078 claim line items during SFY 1993 and 40,026,943 line items during SFY 1994.

During 1989, the contract for claims processing services was competitively bid, as required by federal law. EDS won the right to continue operating as DMA's fiscal agent for the next four years, plus the potential for four one year extensions. Since that time, all extension options were exercised and the contract is extended through June 30, 1997.

Medical Review of North Carolina (MRNC) -- DMA contracts with MRNC to operate Medicaid's preadmission certification program for elective inpatient hospital care. The pre-certification program ensures that Medicaid patients receive medically necessary care in the most appropriate setting. MRNC also conducts quality assurance reviews of prepaid health plan services, the Community Alternatives Programs (CAP), nursing facilities and the Health Maintenance Organization contract.

First Mental Health (FMH) -- As of August 1, 1990, DMA contracted with First Mental Health to conduct pre-admission and concurrent stay reviews of inpatient psychiatric admissions for children under age 21. Following competitive bids, FMH was awarded a contract to review the medical necessity for inpatient psychiatric care for children under age 21. Preadmission and post discharge reviews are required in this contract which became effective December 1, 1991. These reviews assure that admissions and lengths of stay are medically necessary and appropriate for this population.

Optical Contracts - Through competitive bid, Winston-Salem Industries for the Blind was awarded a contract to provide eyeglasses to all Medicaid providers for a period from November 1, 1992 through October 31, 1994. This contract was canceled on February 10, 1994, and a new contract was awarded to Classic Optical until a proper Invitation For Bid (IFB) could be developed and issued. The IFB resulted in the award of a contract to Classical Optical for a period from January 1, 1995 through December 31, 1996.

Audit Contract - DMA also has contracts with two private audit firms to conduct compliance audits of nursing facilities enrolled in the program. The audits supplement DMA's in-house audit activities and verify the accuracy of providers' cost reports.

Cooperative Arrangements

Although DMA administers Medicaid, other agencies, DHR divisions, and state departments work closely with the program and perform significant functions.

Counties - North Carolina's 100 counties have a central role in the Medicaid program. County departments of social services determine Medicaid eligibility for the program. In addition, counties share in approximately 4.7 percent of the cost of services for Medicaid patients.

Division of Social Services (DSS) -- NC DSS conducts Medicaid recipient appeals when eligibility denials are contested. A disability determination unit of the state's DSS office ascertains whether or not a disabled individual is eligible. This unit also makes disability determinations for two federal programs under a contract with the Social Security Administration (Title II - Social Security and Title XVI - Supplemental Security Income.)

Division of Mental Health/ Developmental Disabilities/ Substance Abuse Services (DMH/DD/SAS) -- DMA works closely with the DMH/DD/SAS to finance community mental health services. The community mental health center network permits broad Medicaid coverage for services offered by mental health centers.

DMA and DMH/DD/SAS also work cooperatively to offer the Community Alternatives program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD). This program is a valuable resource for providing community-based services as a cost-effective alternative to institutional care.

Division of Adult Health Promotion in DEHNR - DMA and the Division of Adult Health Promotion in the Department of Environment, Health and Natural Resources (DEHNR) cooperate in a number of efforts to improve care for persons with HIV and AIDS. The AIDS Care Branch in Adult Health Promotion operates HIV Case Management Services for DMA and works with DMA on other initiatives.

Division of Aging (DOA) -- DMA and DOA staff work together on issues important to the aged population. Jointly DMA and DOA design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development projects on housing and in-home aid services.

Division of Facility Services (DFS) -- DFS has responsibility for certifying and monitoring long term care facilities in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care when they are most vulnerable.

Division of Maternal and Child Health (DMCH) -- DMCH, within the Department of Environment, Health and Natural Resources (DEHNR), operates a variety of health care programs. Medicaid pays for services offered through DMCH programs and local health departments. DMCH and local health departments also play a central role in the operation of Baby Love, a care coordination program designed to help pregnant women. The Baby Love program has become a national model is discussed in more detail in the "Special Programs" section of this report.

Department of Public Instruction (DPI) -- P. L. 99-457 is a federal law that provides funding for education and related services to handicapped preschoolers. It requires that states find and serve all eligible children between the ages of three and five by SFY 1993 or lose all federal funding for educational services to handicapped preschoolers. DMA provides a representative to the Interagency Coordinating Council, which serves as a planning and advisory body on P. L. 99-457 issues.

Covered Services

North Carolina Medicaid covers a comprehensive array of services to treat eligible enrollees when they become ill. Preventive services include annual physicals for adults and child health screenings provided under the Health Check program. Although North Carolina's program is called Health Check, many providers are accustomed to referring to it by its federal name, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Additional details are discussed in the "Medicaid In Depth" section of this report.

Medicaid imposes certain standard limitations on services (see Table 4), including a limit of 24 visits to practitioners, clinics, and outpatient departments, and a limit of six prescriptions per month. There are exceptions to these limits for preventive care to pregnant women, Health Check eligible children, people with life threatening conditions and other selective groups.

Some services require nominal copayments and others prior approval. Both requirements ensure that care received is medically necessary. Service limitations and copayment requirements are discussed in more detail in "Medicaid In Depth."

Table 4
State Fiscal Years 1993 & 1994
Medicaid Services

Ambulance Transportation
Case Management for:
- * Pregnant women
- * High risk children (0-5)
- * Chronically mentally ill adults
- * Emotionally disturbed children
- * Chronic substance abusers
- * Adults & Children at risk of abuse, neglect, or exploitation
- * Persons with HIV Disease

Chiropractors
Clinic Services
Community Alternatives Programs (CAP)
Dental Care Services
Durable Medical Equipment
Health Check Services (EPSDT)
Family Planning Services
Hearing Aids (for children)
Home Health Services
Home Infusion Therapy Services
Hospice
Inpatient & Outpatient Hospital Services
Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
Laboratory & X-Ray Services
Mental Hospitals (age 65 & over)
Migrant Health Clinics
Nurse Midwives
Nurse Practitioners
Nursing Facilities (NF)
Optical Supplies
Optometrists
Personal Care Services
Physicians
Podiatrists
Prepaid Health Plan Services
Prescription Drugs
Private Duty Nursing Services
Prosthetics and Orthotics (children)
Rehabilitative Services:
(under the auspices of area mental health programs)
Rural Health Clinics
Specialty Hospitals
Transportation

Rate Setting

Prospective payment rates and fee schedules are important in controlling program costs. Taking into account the level of funding provided by the North Carolina General Assembly payment rates are established according to federal and state laws and regulations. DMA actively reviews, monitors and adjusts fee schedule amounts. See "Medicaid In Depth" for more information about the payment mechanism that is applicable to each type of service.

Program Efficiency and Effectiveness

Medicaid Error Rate Reduction and Quality Improvement Efforts --

The Quality Assurance (QA) Section has the goal of monitoring the accuracy rate of eligibility determinations made by the workers in 100 county departments of social services. QA also has the responsibility of evaluating the medical claims processing procedures for accuracy.

To ensure that health care services are paid only to eligible Medicaid recipients, Quality Assurance staff conducts federally mandated quality control reviews as well as state designed targeted reviews. This review process looks both at active and denied cases. Corrective action is taken whenever appropriate.

North Carolina has never been penalized for exceeding the three percent federal tolerance levels for payment error rates. North Carolina's low payment error rate is the result of the partnership between DMA and North Carolina's counties to maintain accuracy in eligibility. In this process, error trends, error prone cases and other important error reduction

information are communicated quickly to eligibility staff. Eligibility supervisors then evaluate, train, and make the necessary adjustments to eliminate errors and to prevent future ones. County staff also participate on the Medicaid Error Reduction Committee which designs strategies for improving quality.

Program Integrity -- DMA Program Integrity efforts include:

- identifying providers and recipients who abuse or defraud the Medicaid program
- identifying and collecting provider and recipient overpayments
- educating providers or recipients when errors or abuse is detected
- protecting recipients' rights

DMA's Program Integrity Section cooperates with the State Medicaid Investigations Unit of the Office of the Attorney General and the fraud and abuse staff of the 100 county departments of social services to handle these tasks.

Below is a summary of activities for State Fiscal years 1993 and 1994:

	State Fiscal Years	
	1993	1994
Provider Activities:		
*Reviews	3,250	4,299
*Collected	$ 2,220,083	$ 974,302
Recipient Activities:		
*Reviews	1,283	1,484
*Collected	$ 304,120	$ 245,437
Long Term Care Activities:		
*Audits	187	213
*Collected	$ 6,196,018	$14,468

Individual provider consultation and education letters are used to resolve provider questions and billing problems. DMA furnishes guidance to nursing facilities to conform with the nursing home reform section of OBRA 1987. Investigations of complaints has resulted in substantial refunds to recipients who were billed erroneously or whose personal needs fund were mishandled.

This section also operates the S/URS system. The Surveillance and Utilization Review Subsystem (S/URS) of the Medicaid Management Information System (MMIS) identifies providers and recipients whose patterns of practice and use of services fall outside of the norm for their peer groups. These on-going activities also provide useful data for management.

Utilization Control and Review -- DMA operates several other programs directly or under contract to make sure that Medicaid funds are spent appropriately. These programs are designed to prevent and recover incorrect payments. Prior approval and prior authorization for services makes sure that the care that is planned for is appropriate. The prior approval system for most services is operated by EDS. Prior authorization for general inpatient hospital services is operated by MRNC under contract. First Mental Health is under contract to conduct preadmission and post payment reviews of inpatient psychiatric admissions for children under 21. In addition, paid claims are reviewed periodically and those which differ significantly from established norms are analyzed to see if the services are medically necessary and appropriate.

Third Party Recovery - By law, Medicaid is designated as the payer of last resort, with all other resources tapped before Medicaid dollars are spent. Third party resources for medical care, such as health insurance, can be an important means of keeping Medicaid costs as low as possible. As a condition of receiving benefits, recipients agree to allow Medicaid to seek payment from available third party health care resources on their behalf. North Carolina's Medicaid agency has received national recognition for its efforts in recovering these third party resources.

In SFY 1994, refunds from a variety of sources defrayed Medicaid expenditures. Insurance paid on patients' behalf amounted to $51,872,477. An additional $70,503,994 in claims were denied because other insurance was thought to be available to pay for services.

Refunds were received from:

- Medicare $ 2,344,498.00
- Health Insurance 10,119,814.00
- Casualty Insurance 4,773,559.00
- Absent Parent 106,089.00

Medicaid policy is designed to avoid costs that otherwise would be incurred. In SFY 1994, an estimated $661,095,063 in Medicaid expenditures were saved by a policy that requires Medicare to be billed first.

Sources and Uses Of Funds

In state fiscal year 1994, Medicaid paid $3,437,505,205 for health care services to North Carolina citizens. This total includes $464,269,749 in additional payments to hospitals serving disproportionately high numbers of Medicaid recipients. For SFY 1994, $112,594,172 was spent to administer the program at the state and local levels. In total, 96 percent of the Medicaid budget was spent on services. The following tables and charts show where Medicaid funds come from and how they are spent.

Medicaid expenditures grew by 25 percent from SFY 1993 to SFY 1994. The increase is driven by eligibility expansions, inflation, and changes in the mix and use of services.

Table 5
State Fiscal Year 1993 & 1994
Sources of Medicaid Funds

		1993		1994	
Federal	$	1,868,300,718	$	2,105,307,078	
State, Appropriated	$	503,523,214	$	788,493,250	
State, Other	$	315,893,833	$	489,380,613	
County	$	148,617,702	$	166,918,436	
Total	**$**	**2,836,335,467**	* **$**	**3,550,099,377**	**

* Includes $ 26,784,000 in hospital contributions for SFY 1993

** Includes no hospital contributions for SFY 1994.

Chart 2
State Fiscal Year 1994
Sources of Medicaid Funds, Percent

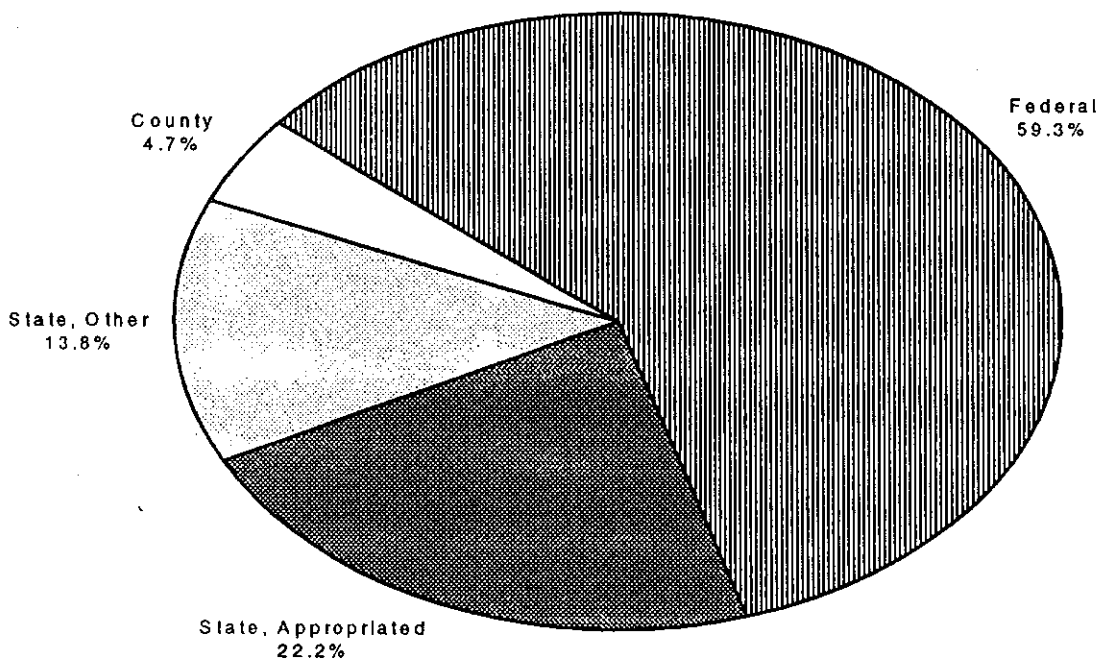


Chart 3
State Fiscal Year 1994
Users of Medicaid Funds
(%of Total Expenditures)

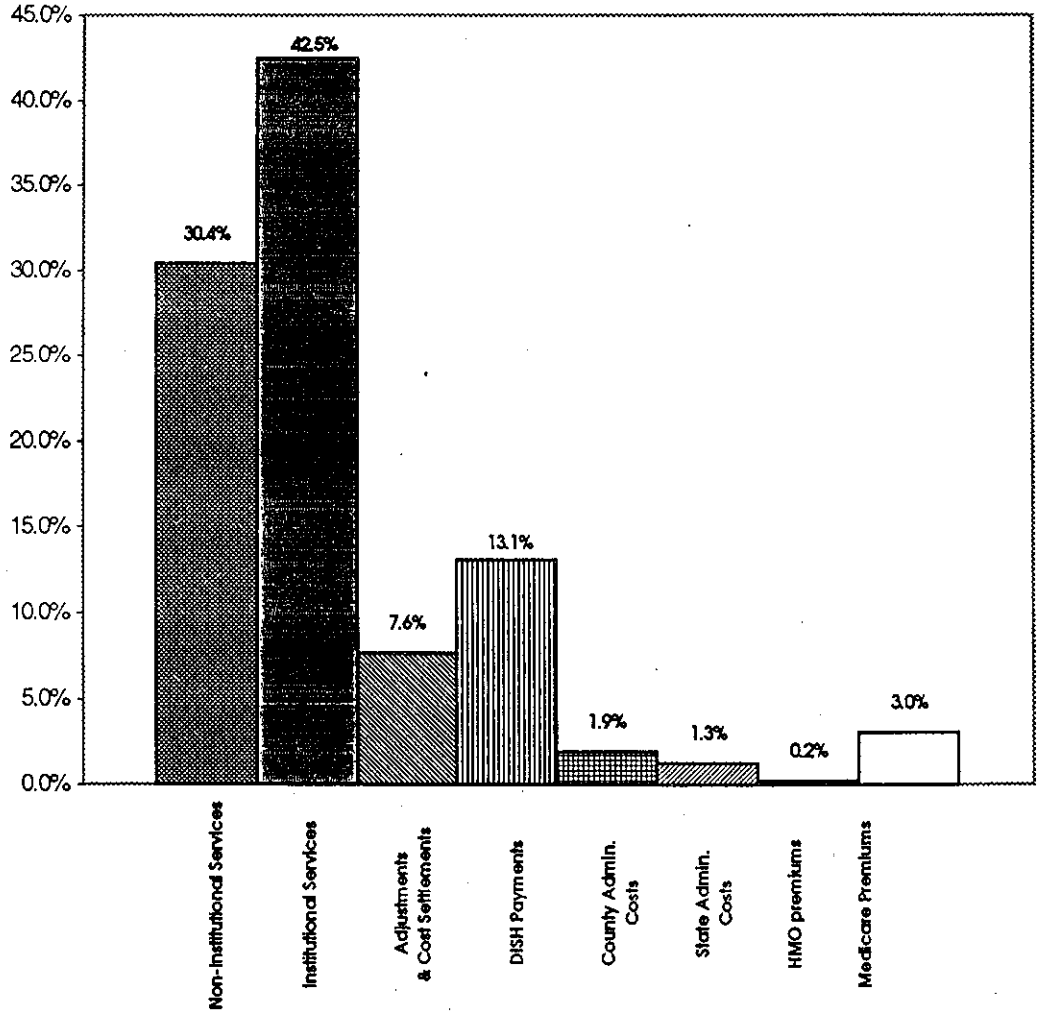


Table 6
State Fiscal Year 1993
Uses of Medicaid Funds

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	546,416,595	19.3%	22.3%	186,875	2,924
Mental & Psychiatric Hospital	34,008,493	1.2%	1.4%	2,535	13,416
Outpatient Hospital	157,429,705	5.6%	6.4%	469,041	336
Physician	247,266,807	8.7%	10.1%	728,167	340
Clinics	87,316,542	3.1%	3.6%	123,930	705
Nursing Facility (Skilled)	286,444,490	10.1%	11.7%	24,306	11,785
Nursing Facility (Intermediate)	261,930,539	9.2%	10.7%	21,127	12,398
ICF-MR	289,275,339	10.2%	11.8%	4,742	61,003
Dental	32,972,654	1.2%	1.3%	198,657	166
Prescription Drugs	183,334,740	6.5%	7.5%	608,309	301
Home Health	65,877,853	2.3%	2.7%	33,449	1,970
Other Services	170,826,537	6.0%	7.0%	884,822	193
Medicare Premiums:					
(Part A, Part B, QMB, Dually Eligible)	82,890,582	2.9%	3.4%		
HMO Premium	5,408,453	0.2%	0.2%		
Subtotal Services	**2,451,399,328**				
Adjustments & Cost Settlements	(36,275,723)	-1.3%			
Disproportionate Share Payments	320,719,000	11.3% **			
Subtotal Services & Other	**$ 2,735,842,605**	**96.5%**			
Administration (State & County)	100,492,862	3.5%			
(State)	36,909,385	1.3%			
(County)	63,583,477	2.2%			
Grand Total Expenditures	**$ 2,836,335,467**	**100.0%**			
Total Recipients (unduplicated)***				**874,936**	
Total Expenditures Per Recipient (unduplicated)					**$ 3,242**

* "Users of Service" is a duplicated count. Recipients using one or more services are counted in each service category.

** Additional payments for hospitals providing services to a higher than average number of Medicaid patients.

*** "Total Recipients" is unduplicated, counting recipients only once during the year regardless of the number or type of services they use.

Table 6
State Fiscal Year 1994
Uses of Medicaid Funds

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	547,989,426	15.4%	20.3%	184,976	2,962
Mental & Psychiatric Hospital	29,953,602	0.8%	1.1%	298	100,515
Outpatient Hospital	173,117,326	4.9%	6.4%	481,888	359
Physician	269,911,597	7.6%	10.0%	783,969	344
Clinics	105,605,482	3.0%	3.9%	174,577	605
Nursing Facility (Skilled)	314,178,144	8.8%	11.6%	25,463	12,339
Nursing Facility (Intermediate)	299,467,133	8.4%	11.1%	22,562	13,273
ICF-MR	316,360,102	8.9%	11.7%	4,905	64,497
Dental	34,239,791	1.0%	1.3%	205,652	166
Prescription Drugs	207,071,852	5.8%	7.7%	647,148	320
Home Health	74,518,557	2.1%	2.8%	39,314	1,895
Other Services	214,397,890	6.0%	7.9%	1,094,066	196
Medicare Premiums: (Part A, Part B, QMB, Dually Eligible)	108,149,578	3.0%	4.0%		
HMO Premium	8,046,245	0.2%	0.3%		
Subtotal Services	**2,703,006,725**				
Adjustments & Cost Settlements	270,228,731	7.6%			
Disproportionate Share Payments	464,269,749	13.1% **			
Subtotal Services & Other	**$ 3,437,505,205**	**96.8%**			
Administration (State & County)	112,594,172	3.2%			
(State)	44,524,399	1.3%			
(County)	68,069,773	1.9%			
Grand Total Expenditures	**$ 3,550,099,377**	**100.0%**			
Total Recipients (unduplicated)***				956,881	
Total Expenditures Per Recipient (unduplicated)					**$ 3,710**

* "Users of Service" is a duplicated count. Recipients using one or more services are counted in each service category.

** Additional payments for hospitals providing services to a higher than average number of Medicaid patients.

*** "Total Recipients" is unduplicated, counting recipients only once during the year regardless of the number or type of services they use.

Institutional services, including hospitals and nursing facilities, consume the largest share of the Medicaid service budget (44.1 percent). Spending for intermediate care facilities for the mentally retarded (ICF-MR) was the second highest single expenditure (11.7 percent), but is used by a very small fraction of the Medicaid population (.5 percent). This results in expenditures of $ 64,497 per recipient. The total number of recipients increased by 9.36 percent over SFY 1993. Intensive outreach efforts targeted toward pregnant women and children resulted in recipient populations of 6.1 percent and 15.3 percent, respectively.

The number of aged recipients increased by 1.2 percent and the number of QMBs grew by 18.4 percent, resulting in a 7.7 percent increase for elderly recipients overall. Continuing a trend seen since 1984, the number of blind recipients has declined or stayed a small percentage of the total recipient population. In SFY 1994, blind recipients constituted only .1 percent of the total recipients.

In SFY 1994, the increase in expenditures per recipient by eligibility group varied from a high of $ 11,204 for the Blind category to a low of $ 1,204 for AFDC Children & Other children. The Medicare-Aid category showed a comparable expenditure per recipient amount at $1,245. Per recipient expenditures for the aged, blind and disabled groups grew by 10.6 percent, 10.8 percent and 1.9 percent, respectively over 1993.

The overall effect of these high per recipient expenditure growth rates within these eligibility categories is offset considerably by the very small rates of growth experienced by those eligibility groups that make up nearly three-quarters of all Medicaid recipients, AFDC adults and children and special coverage women and children.

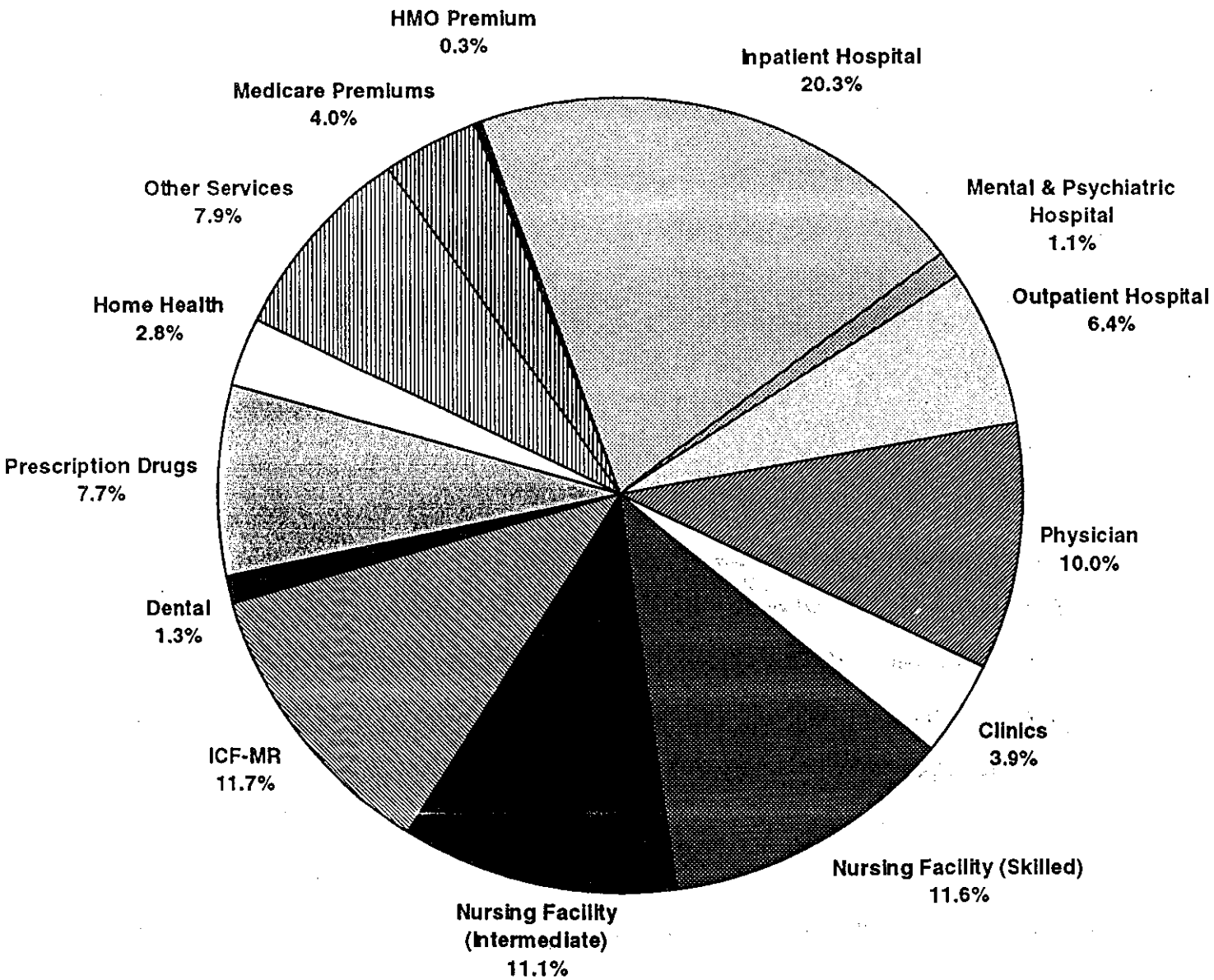
Table 7
SFY 1979-1994
A History of Medicaid Expenditures

Fiscal Year	Expenditures	Percentage Change
1979	$ 379,769,848	N/A
1980	410,053,625	8%
1981	507,602,694	24%
1982	521,462,961	3%
1983	570,309,294	9%
1984	657,763,927	15%
1985	665,526,678	1%
1986	758,115,890	14%
1987	861,175,819	14%
1988	983,464,113	14%
1989	1,196,905,351	22%
1990	1,427,672,567	19%
1991	1,942,016,092	36%
1992	2,478,709,587	28%
1993	2,836,335,468	14%
1994	3,550,099,377	25%

NOTE: Include vendor payments, Administrative costs, Refunds, adjustments, & Disproportionate share hospital payments.

SOURCE: DAS Report - SFY

Chart 4
State Fiscal Year 1994
Medicaid Service
Expenditures



Eligibles

Medicaid counts the population it serves in two ways: eligibles and recipients. Eligibles are individuals who meet Medicaid's categorical and financial criteria and are determined to be eligible for Medicaid by the local Department of Social Services. They receive a Medicaid eligibility card to use to obtain medical care. Table 8 shows the historical growth in eligibles from 1979-1994. The number of Medicaid eligibles was characterized by unprecedented growth from 1989 through 1993. This extraordinary growth was caused by an economic downturn, coupled with state and federal mandates to expand medical coverage to pregnant women and children, and to certain aged, blind and disabled individuals. In 1994 the rate of growth returned to lower levels.

Table 8
State Fiscal Years 1979-1994
A History of Medicaid Eligibles

Fiscal Years	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Medicaid Pregnant Women Coverage	Medicaid Indigent Children Coverage	Other Children	Aliens and Refugees	Total	Percent Change
1978-79	82,930	N/A	3,219	59,187	301,218	N/A	N/A	6,620	N/A	453,174	--
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	N/A	455,702	0.6%
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	459,364	0.8%
1981-82	70,010	N/A	2,349	48,266	298,483	N/A	N/A	6,125	N/A	425,233	-7.4%
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	N/A	415,552	-2.3%
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	N/A	407,806	-1.9%
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	N/A	414,353	1.6%
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	N/A	441,930	6.7%
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	N/A	452,025	2.3%
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	N/A	481,326	6.5%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561	561,614	16.7%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	1,011	639,351	13.8%
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	1,675	753,292	17.8%
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	1,955	877,923	16.5%
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	2,437	992,697	13.1%
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	2,330	1,058,603	6.6%
SFY 1993 Percent Total Eligibles	8.6%	7.2%	0.1%	8.8%	56.7%	4.6%	13.3%	0.4%	0.2%	100.0%	
SFY 1994 Percent Total Eligibles	8.1%	7.9%	0.1%	8.6%	54.9%	4.4%	15.3%	0.4%	0.2%	100.0%	

Source: Medicaid Eligibilty Report, SFY 1993, SFY 1994

Most Medicaid eligibles use services and are called recipients. Some eligibles, however, do not use services during the year. These are persons who automatically qualified for Medicaid because they were eligible for cash assistance payments, and perhaps did not need health care during the year.

In SFY 1994, 1,058,603 persons were eligible for Medicaid at some time during the year. This represents an increase of almost 65,906 eligibles (or 6.6 percent) over the prior year. (See Table 8.) In an average month 88,217 persons were eligible for Medicaid. Counties vary greatly in the number of residents who are eligible for Medicaid: from a low in Orange county of 75 per 1,000 population to a high of 299 per 1,000 population in both Hertford and Northampton counties. The statewide average is 152 per 1,000 population. Chart 5 on one of the following pages geographically depicts enrollment variation across counties. This variation is due to several factors, including general population density and area poverty rates. Table 9 presents a variety of data on counties, including expenditures, per capita spending, per capita ranking, and Medicaid eligibles per 1,000 population in SFY 1994. (See Appendix for SFY 1993 data.)

Recipients

Recipients are those Medicaid eligibles who actually use a service during the year. In SFY 1994, Medicaid paid for care for 956,881 recipients. Table 10 displays expenditures for recipients by eligibility group. During the time that an individual is eligible for Medicaid, the basis for his or her eligibility may change; for example, from special pregnant women coverage to AFDC adult. In addition, an individual often uses several different types of services.

Both factors affect the way Medicaid expenditure data are reported. In the tables that follow, the number of recipients are identified in two ways: unduplicated in total and duplicated across several categories. The total number of recipients is an unduplicated count, meaning that an individual is counted only once during the year regardless of the variety of services used. Recipient expenditure data are reported under the category in which the individual was listed as of the end of the fiscal year.

The recipient count across types of services, however, is a duplicated count, meaning that a recipient using two or more different types of services would be counted once in each service category. As a result, the sum of all recipients across service categories does not equal the total unduplicated recipient count, as shown in the tables that follow.

Chart 6
Comparison of Recipients and Service Expenditures
State Fiscal Years 1993 and 1994

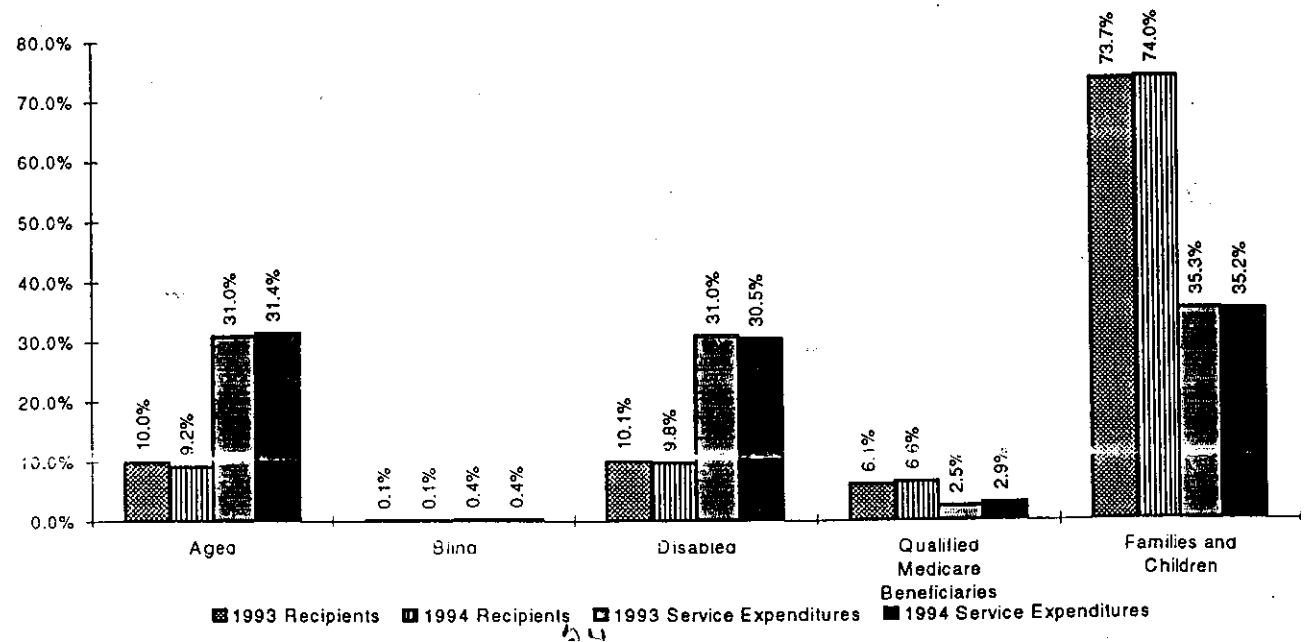


Table 9
State Fiscal Year 1994
Total Expenditures and Eligibles by County

COUNTY NAME	1993 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION
ALAMANCE	112,523	13,056	$ 39,852,698	$ 3,052	$ 354.17	80	116
ALEXANDER	29,042	3,401	8,545,985	2,513	294.26	93	117
ALLEGHANY	9,526	1,293	4,048,838	3,131	425.03	49	136
ANSON	23,862	5,503	16,010,219	2,909	670.95	7	231
ASHE	22,486	3,843	11,803,524	3,071	524.93	30	171
AVERY	15,025	2,557	9,254,883	3,619	615.97	13	170
BEAUFORT	42,758	9,089	22,866,279	2,516	534.78	25	213
BERTIE	20,412	5,592	13,652,145	2,441	668.83	8	274
BLADEN	29,423	7,983	19,769,746	2,476	671.91	6	271
BRUNSWICK	56,896	10,361	25,269,167	2,439	444.13	47	182
BUNCOMBE	182,267	25,709	71,977,964	2,800	394.90	66	141
BURKE	78,513	11,001	31,316,738	2,847	398.87	63	140
CABARRUS	104,785	12,129	37,778,709	3,115	360.54	75	116
CALDWELL	72,310	9,887	28,967,929	2,930	400.61	61	137
CAMDEN	6,005	951	2,277,771	2,395	379.31	72	158
CARTERET	56,046	7,549	18,953,376	2,511	338.18	82	135
CASWELL	21,211	3,815	9,677,525	2,537	456.25	43	180
CATAWBA	122,627	14,107	36,572,013	2,592	298.24	91	115
CHATHAM	41,049	4,656	15,089,082	3,241	367.59	73	113
CHEROKEE	21,232	4,564	11,254,195	2,466	530.06	27	215
CHOWAN	13,824	3,214	8,149,673	2,536	589.53	16	232
CLAY	7,528	1,232	3,720,655	3,020	494.24	38	164
CLEVELAND	87,188	14,483	35,018,417	2,418	401.64	58	166
COLUMBUS	50,198	14,504	35,523,269	2,449	707.66	2	289
CRAVEN	83,964	14,550	32,829,817	2,256	391.00	67	173
CUMBERLAND	292,517	43,691	79,492,835	1,819	271.75	95	149
CURRITUCK	14,755	2,335	4,416,013	1,891	299.29	90	158
DARE	24,003	2,420	6,113,796	2,526	254.71	97	101
DAVIDSON	130,709	16,397	39,776,045	2,426	304.31	89	125
DAVIE	28,775	2,963	9,548,073	3,222	331.82	84	103
DUPLIN	41,426	9,553	21,666,189	2,268	523.01	31	231
DURHAM	189,171	25,342	77,643,343	3,064	410.44	54	134
EDGECOMBE	56,771	15,714	33,993,440	2,163	598.78	15	277
FORSYTH	271,680	35,241	87,480,462	2,482	322.00	88	130
FRANKLIN	39,407	7,150	20,216,801	2,828	513.03	33	181
GASTON	176,856	27,345	71,808,182	2,626	406.03	56	155
GATES	9,515	1,715	4,677,263	2,727	491.57	39	180
GRAHAM	7,372	1,740	3,937,705	2,263	534.14	26	236
GRANVILLE	40,221	5,487	16,127,932	2,939	400.98	59	136
GREENE	15,903	3,221	7,910,683	2,456	497.43	36	203
GUILFORD	360,551	46,251	122,576,144	2,650	339.97	81	128
HALIFAX	56,969	17,000	36,276,162	2,134	636.77	10	298
HARNETT	72,559	14,127	32,335,734	2,289	445.65	45	195
HAYWOOD	48,912	7,501	19,349,660	2,580	395.60	65	153
HENDERSON	73,356	9,754	26,029,728	2,669	354.84	79	133
HERTFORD	22,373	6,679	14,681,610	2,198	656.22	9	299
HOKE	24,442	6,299	12,735,155	2,022	521.04	32	258
HYDE	5,391	1,431	3,757,197	2,626	696.94	3	265
IREDELL	98,452	12,482	33,289,505	2,667	338.13	83	127
JACKSON	27,828	4,433	11,484,709	2,591	412.70	53	159
JOHNSTON	88,520	15,029	41,009,558	2,729	463.28	42	170
JONES	9,439	2,166	6,760,729	3,121	716.25	1	229

Table 9
State Fiscal Year 1994
Total Expenditures and Eligibles by County

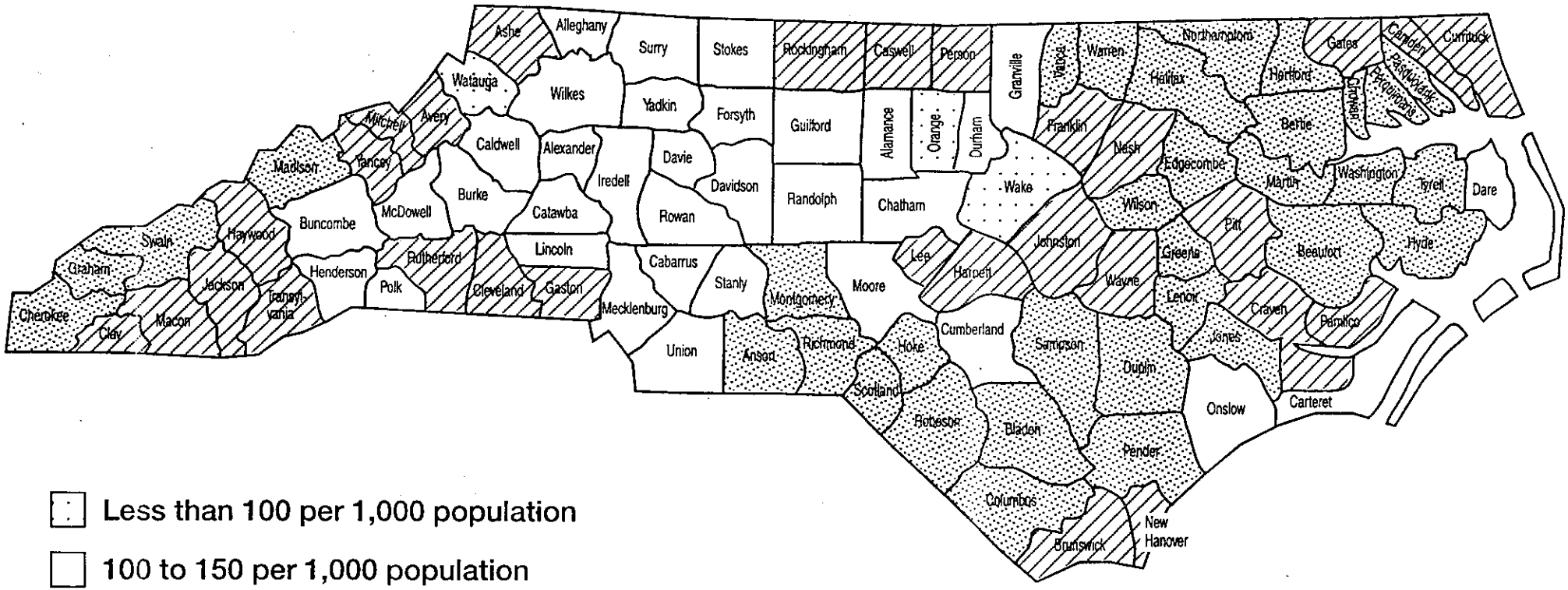
COUNTY NAME	1993 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	PER CAPITA EXPENDITURE RANKING	ELIGIBLES PER 1,000 POPULATION
LEE	43,877	7,478	17,979,172	2,404	409.76	55	170
LENOIR	58,665	13,582	34,191,425	2,517	582.82	17	232
LINCOLN	53,075	6,886	17,450,937	2,534	328.80	85	130
MACON	24,982	3,982	9,907,327	2,488	396.58	64	159
MADISON	17,243	3,566	9,898,104	2,776	574.04	21	207
MARTIN	25,482	5,907	14,086,588	2,385	552.81	22	232
MCDOWELL	36,238	5,106	12,963,229	2,539	357.72	78	141
MECKLENBURG	547,982	71,816	178,725,378	2,489	326.15	86	131
MITCHELL	14,510	2,322	6,759,746	2,911	465.87	40	160
MONTGOMERY	23,342	4,944	11,674,012	2,361	500.13	34	212
MOORE	62,467	8,308	22,644,103	2,726	362.50	74	133
NASH	80,554	13,162	32,282,179	2,453	400.75	60	163
NEW HANOVER	130,590	21,033	54,090,421	2,572	414.20	52	161
NORTHAMPTON	20,491	6,137	14,059,887	2,291	686.15	4	299
ONSLOW	150,713	17,155	32,043,067	1,868	212.61	100	114
ORANGE	101,599	7,597	27,293,179	3,593	268.64	96	75
PAMLICO	11,577	2,113	6,226,766	2,947	537.86	24	183
PASQUOTANK	32,684	7,262	14,267,546	1,965	436.53	48	222
PENDER	32,568	6,539	16,212,034	2,479	497.79	35	201
PERQUIMANS	10,565	2,441	4,796,900	1,965	454.04	44	231
PERSON	30,763	5,128	16,228,282	3,165	527.53	29	167
PITT	115,120	21,213	51,275,366	2,417	445.41	46	184
POLK	15,127	1,696	5,841,071	3,444	386.14	70	112
RANDOLPH	112,684	12,602	31,545,152	2,503	279.94	94	112
RICHMOND	44,782	9,787	23,656,049	2,417	528.25	28	219
ROBESON	108,557	31,590	69,044,652	2,186	636.02	11	291
ROCKINGHAM	86,897	13,075	36,254,553	2,773	417.21	51	150
ROWAN	114,731	15,315	41,279,167	2,695	359.79	77	133
RUTHERFORD	57,919	9,010	22,404,960	2,487	386.83	69	156
SAMPSON	49,352	11,395	28,644,699	2,514	580.42	18	231
SCOTLAND	34,063	9,513	19,767,837	2,078	580.33	19	279
STANLY	52,740	7,357	20,341,651	2,765	385.70	71	139
STOKES	39,033	4,822	14,071,387	2,918	360.50	76	124
SURRY	63,265	8,543	25,329,101	2,965	400.37	62	135
SWAIN	11,299	2,830	6,087,439	2,151	538.76	23	250
TRANSYLVANIA	26,816	4,150	10,862,046	2,617	405.06	57	155
TYRRELL	3,764	1,090	2,548,028	2,338	676.95	5	290
UNION	90,848	12,089	26,948,569	2,229	296.63	92	133
VANCE	39,839	9,897	22,913,510	2,315	575.15	20	248
WAKE	479,271	41,897	112,686,759	2,690	235.12	99	87
WARREN	17,601	4,207	11,043,155	2,625	627.42	12	239
WASHINGTON	13,776	3,634	8,453,044	2,326	613.61	14	264
WATAUGA	38,703	3,365	9,266,612	2,754	239.43	98	87
WAYNE	108,364	18,506	42,064,925	2,273	388.18	68	171
WILKES	61,086	8,407	25,901,462	3,081	424.02	50	138
WILSON	67,116	14,870	33,229,324	2,235	495.10	37	222
YADKIN	32,107	3,916	10,445,300	2,667	325.33	87	122
YANCEY	15,695	2,868	7,284,385	2,540	464.12	41	183
STATE TOTAL	6,949,095	1,058,603	$2,668,245,755	$2,521	$383.97	N/A	152

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1994.

Note: Data reflect only net vendor payments for which the county is billed for its computable share.

***See Appendix for SFY 1993 Table 9 data.

Chart 5
State Fiscal Year 1994
Medicaid Enrollment Per 1,000 Population By County



- Less than 100 per 1,000 population
- 100 to 150 per 1,000 population
- 150 to 200 per 1,000 population
- 200 per 1,000 population and above

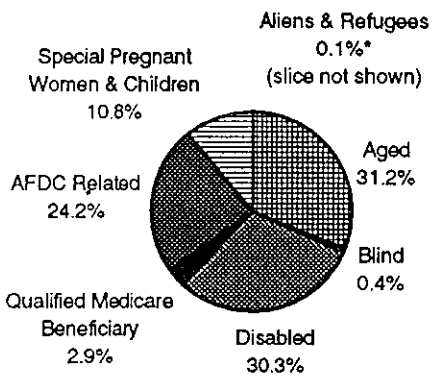
Spending Patterns

Overall, the percent distribution of Medicaid payments across eligibility groups has changed very little in the past two years. Most recipients (74 percent) are families and children including Aid to Families with Dependent Children (AFDC) and special pregnant women and children coverage. Most expenditures were made on the behalf of these groups. (See Chart 6 and Table 10.)

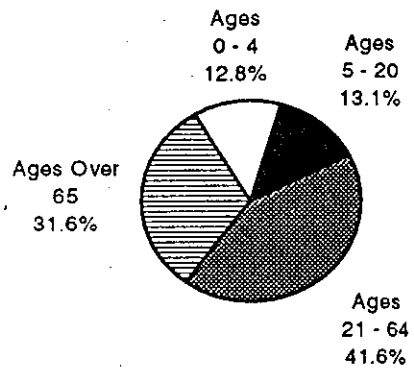
Charts 7 and 8 display service expenditures and recipients by various demographic categories, including gender, race, age, and eligibility group. (See Appendix pages 58 & 59 for 1993 demographic data.)

Chart 7
State Fiscal Year 1994
Service Expenditures, Percent Distribution

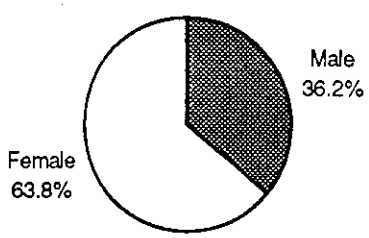
By Eligibility Category



By Age Category



By Gender



By Race

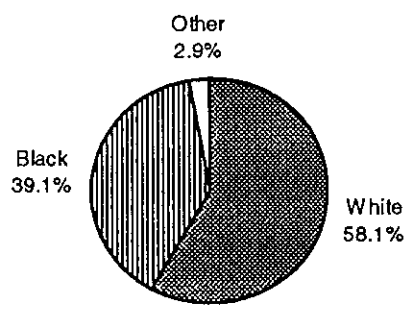
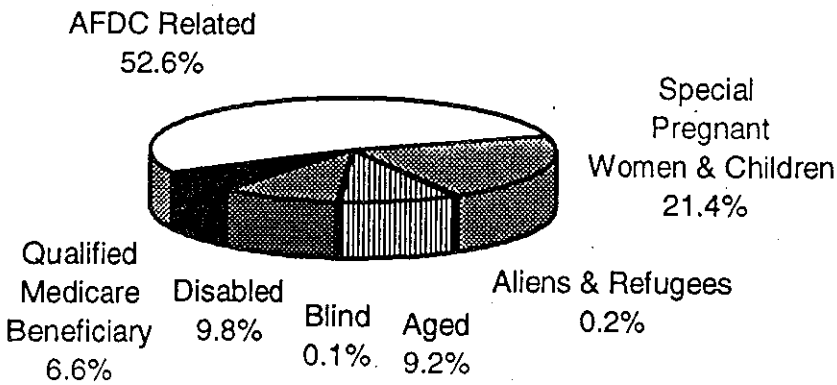
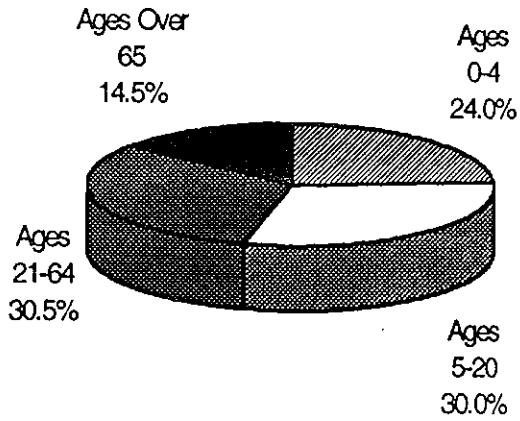


Chart 8
State Fiscal Year 1994
Recipients, Percent Distribution

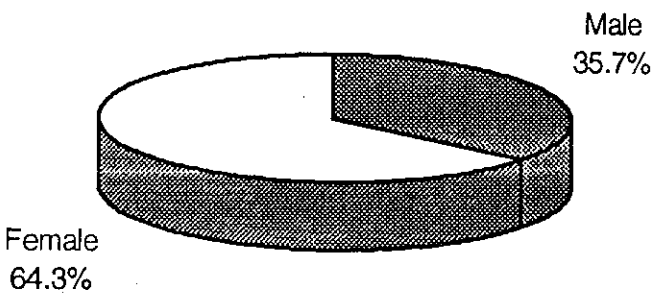
By Eligibility Category



By Age Category



By Gender



By Race

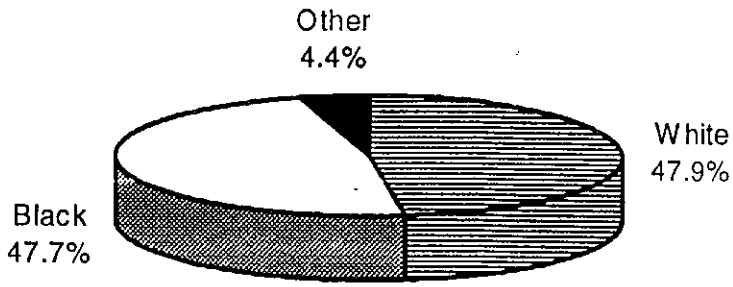


Table 10
State Fiscal Year 1994
Medicaid Service Expenditures by Eligibility Group

Eligibility Group		Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 1994 Expenditures Per Recipient	SFY 1993 Expenditures Per Recipient	Percent Change
Total Elderly	**$**	**926,077,866**	**34.4%**	**151,796**	**15.9%**	**$ 6,101**	**$ 5,804**	**5.1%**
Aged		847,115,143	31.4%	88,373	9.2%	9,586	8,670	10.6%
Medicare-Aid (MQBQ & MQBB)		78,962,723	2.9%	63,423	6.6%	1,245	1,129	10.3%
Total Disabled	**$**	**832,603,435**	**30.9%**	**94,618**	**9.9%**	**8,800**	**8,630**	**2.0%**
Disabled		821,960,052	30.5%	93,668	9.8%	8,775	8,613	1.9%
Blind		10,643,383	0.4%	950	0.1%	11,204	10,114	10.8%
Total Families & Children	**$**	**949,223,157**	**35.2%**	**708,152**	**74.0%**	**1,340**	**1,340**	**0.0%**
AFDC Adults (> 21)		262,525,453	9.7%	176,948	18.5%	1,484	1,490	-0.4%
Medicaid Pregnant Women Coverage		102,853,027	3.8%	58,082	6.1%	1,771	1,679	5.5%
AFDC Children & Other Children		392,778,954	14.6%	326,331	34.1%	1,204	1,195	0.7%
Medicaid Indigent Children		191,065,724	7.1%	146,791	15.3%	1,302	1,342	-3.0%
Aliens & Refugees	**$**	**2,920,270**	**0.1%**	**2,315**	**0.2%**	**1,261**		
Adjustments Not Attributable To A Specific Category	**$**	**(15,864,250)**	**-0.6%**					
Total Service Expenditures All Groups	**$**	**2,694,960,478**	**100%**	**956,881**	**100%**	**$ 2,816**	**$ 2,796**	**0.7%**

Note: Total Service Expenditures does not include adjustments processed by DMA, settlements ($270,228,731), HMO premiums ($ 8,046,245), state & county administrative costs ($ 112,594,172), and Disproportionate Share payments ($ 464,269,749). These costs total $ 855,138,898. (See Table 6 for more details.) See Appendix for SFY 1993 Table 10 data.

Source: SFY 1994 Program Expenditure Report and 2082 Report.

Service expenditures differ across demographic groups in predictable ways. Below, Chart 9 compares per recipient costs by age, race, gender and eligibility category for fiscal year 1994. Reflecting relatively heavy health care needs, blind and disabled individuals have the highest per recipient costs, $ 11,204 and $ 8,775, respectively. Male and female adults had similar per recipient costs, although males, on average, cost slightly more than females, $2,806 versus $2,743. (State Fiscal Year 1993 Chart can be found in the Appendix.) The reason for this difference is not clear. One reason may be that the adult female population includes a large proportion of women whose main expenditure relates to pregnancy rather than illness.

Looking at the recipient breakdown by age categories, younger recipients (ages 5 to 20) had the lowest cost per recipient ($1,208) overall and those aged 65 and above had the highest ($6,018). (When looking at recipients by the aged eligiblity category and not by age breakdown the cost per recipient is $ 9,586.) The cost per recipient for the elderly which includes the Medicare-Aid and the aged eligiblity group, is $ 6,101.

Expenditure differences across eligibility groups reflect variations in care use. Table 11 displays expenditures for selected types of services by eligibility group. Overall, institutional care consumes the largest share of the Medicaid services budget for all eligibility groups. Physician services and prescription drugs cost less per unit and thus consume smaller shares of the total services budget despite the fact that they are used heavily by Medicaid recipients. (See Chart 10.)

Chart 9
State Fiscal Year 1994
Service Expenditures Per Recipient
by Selected Characteristics

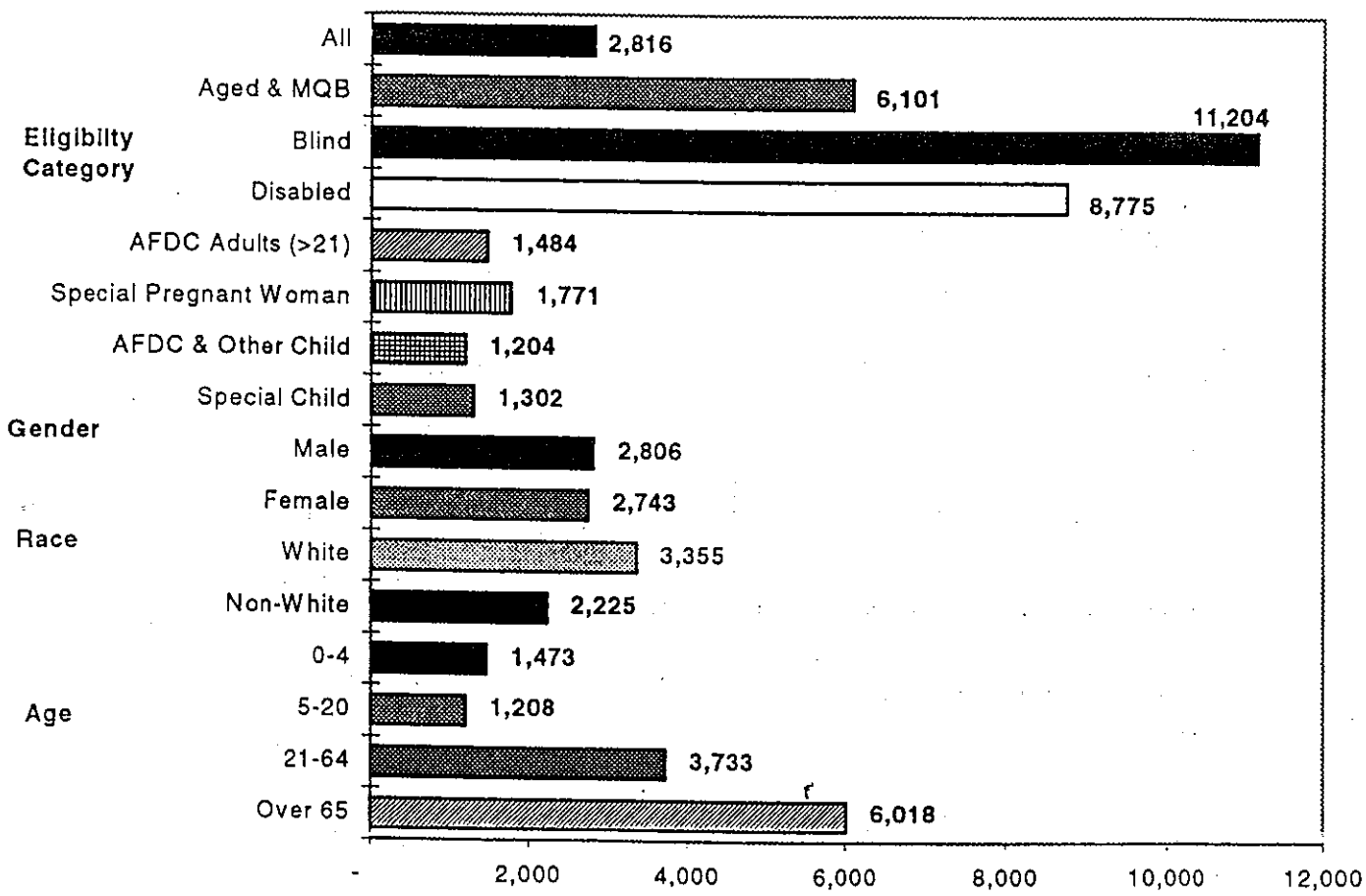


Table 11
State Fiscal Year 1994
Service Expenditure For Selected Major Medical Services By Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ** Medicare Qualified Beneficiary	MQBB Part B Premium Only	Blind	Disabled	AFDC Adult	AFDC Child	Aliens & Refugees	Adjustments Unattributable To A Specific Category
›atient Hospital	$ 547,989,426	20.2%	$ 21,915,412	$ 9,190,215	$ -	$ 361,625	$ 182,952,370	$ 121,581,001	$ 220,342,913	$ 1,223,421	$ (9,577,531)
itpatient Hospital	173,117,326	6.4%	10,992,717	11,727,547	-	180,672	41,099,932	54,628,196	55,648,918	141,976	(1,302,630)
›ntal Hospital (> 65)	12,342,683	0.5%	12,331,117	38,430	-	49,110	1,435	-	-	-	(77,409)
›ychiatric Hospital (< 21)	17,610,919	0.6%	-	405	-	-	1,270,454	41,830	16,327,791	-	(29,561)
›ysician	269,911,597	9.9%	19,174,468	14,322,090	-	267,821	53,943,835	83,395,520	101,092,661	799,094	(3,083,891)
inics	105,605,482	3.9%	2,875,471	4,144,466	-	109,878	25,255,306	28,845,262	44,582,363	106,619	(313,882)
›rsing Facility:											
Skilled Level	314,178,144	11.6%	271,522,752	205,478	-	1,133,013	40,798,575	157,274	643,650	79,039	(361,636)
›ntermediate Level	299,467,133	11.0%	275,704,512	856	-	1,162,240	22,541,201	7,471	67,339	226,754	(243,239)
›rmediate Care Facility											
(Mentally Retarded)	316,360,102	11.6%	8,752,337	-	-	4,592,992	277,600,304	222,959	25,129,861	84,747	(23,097)
›ntal	34,239,791	1.3%	2,411,792	4,341	-	35,013	5,389,551	11,388,353	14,984,123	80,888	(54,271)
›scription Drugs	207,071,852	7.6%	74,105,570	-	-	758,018	67,487,846	29,808,605	35,077,451	62,218	(227,856)
›me Health	74,518,557	2.7%	8,793,228	224,948	-	562,489	35,087,180	4,133,182	26,003,750	10,188	(296,409)
AP/Disabled Adult	55,302,416	2.0%	43,400,285	-	-	203,053	11,713,092	-	-	-	(14,013)
AP/Mentally Retarded	19,884,423	0.7%	182,475	-	-	15,051	19,411,957	-	309,989	-	(35,049)
AP/Children	1,426,024	0.1%	-	-	-	-	1,428,032	-	-	-	(2,008)
›rsonal Care	36,691,086	1.4%	24,324,331	-	-	533,930	10,824,399	512,790	579,518	-	(83,882)
›spice	9,442,668	0.3%	4,416,504	-	-	4,301	4,531,338	368,944	158,461	1,852	(38,732)
PSDT (Health Check)	15,106,812	0.6% *	-	-	-	574	42,075	1,105	15,076,079	4,078	(17,099)
›b & X-Ray	22,750,081	0.8%	1,304,432	1,282,873	-	30,206	6,613,146	8,915,323	4,713,751	37,090	(146,740)
›ther Services	68,543,350	2.5%	3,458,206	1,200,089	8	52,444	5,043,739	21,029,839	37,797,932	60,381	(99,291)
›rt A Premium	31,634,968	1.2%	30,464,521	779,118	-	364,331	6,977	-	-	-	20,021
›rt B Premium	76,514,610	2.8%	30,985,014	33,729,097	2,112,763	227,198	8,958,449	341,931	25,177	5,953	129,029
MO Premium	8,046,245	0.3%	-	-	-	-	-	-	-	-	-
›rand Total and Premiums	**$ 2,717,755,695**		**847,115,143**	**76,849,952**	**2,112,771**	**10,643,957**	**822,001,192**	**365,379,585**	**598,561,727**	**2,924,298**	**(15,879,176)**

›ote: Grand Total Expenditures do not include adjustments processed by DMA, settlements, Disproportionate Share Costs and State and County Administration costs.

Percentages denoted with and * are less than .1%.

Reflects expenditures for those who were eligible as QMBs at the end of the year. As a result, expenditures include more services than are available through QMB coverage. (Medicare covered services only.)

** Please see the Appendix for SFY 1993 Table 11 data.

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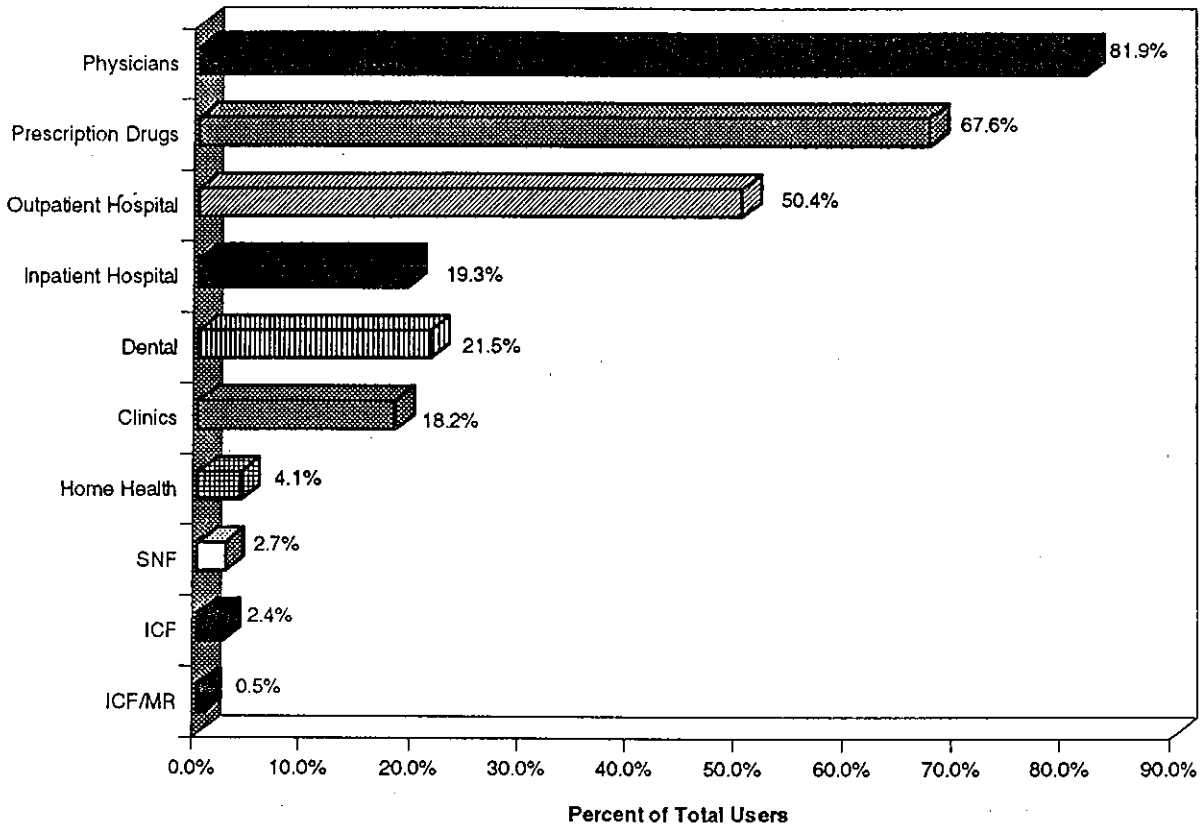
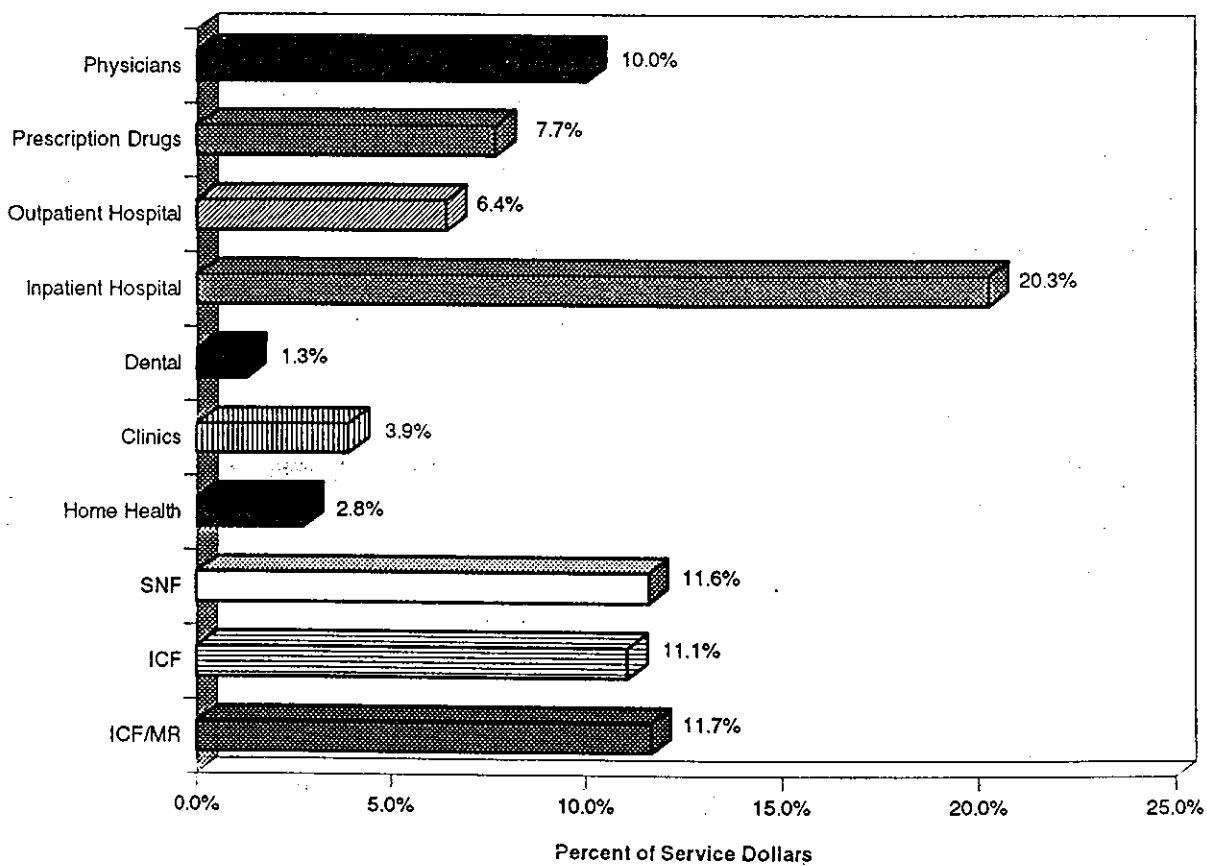
Chart 10, State Fiscal Year 1994
Selected Medicaid Services
Use & Dollars, Percent





The Elderly

(See Table 12.)

The elderly (those 65 or older who meet the "aged" eligibility criteria) comprise 15.9 percent of all Medicaid recipients but account for 34.4 percent of Medicaid service expenditures. Most elderly persons receive Medicare benefits in addition to Medicaid. Medicaid fills in gaps and covers services not paid for by Medicare. Long term care and prescription drugs are two examples. Some Medicaid beneficiaries receive full Medicaid benefits in addition to Medicare, while others (QMB) do not. Medicaid expenditures reflect these differences in benefits. As Table 12 shows, the lion's share of expenditures for the elderly was for nursing facility services - Skilled and Intermediate care and ICF-MR (60 percent). Sizable expenditures were also made for inpatient hospital care (3.4 percent), with Medicaid paying for the Medicare inpatient deductible, coinsurance and days not paid for by Medicare. Prescription drugs, a major need for elderly people but which Medicare does not cover, accounted for 8.0 percent of expenditures.

In SFY 1994, 151,796 elderly persons received assistance through the Medicaid program, at an average cost of $6,101 per recipient, an increase of 5.1 percent from SFY 1993. This figure includes both the relatively low cost QMBs -- for whom Medicaid pays premiums, deductibles and coinsurance -- and those receiving full Medicaid benefits. The per recipient cost for the Medicare-Aid group increased 10.3% over 1993.

The Disabled & Blind

(See Table 13.)

Disabled and Blind individuals accounted for 30.9 percent of Medicaid expenditures. Most individuals in this group (30.5 percent) are classified as disabled rather than blind. Disabled individuals must wait two years before receiving Medicare benefits if they qualify to receive them. During that waiting period, those who meet Medicaid income and resource criteria may qualify for Medicaid coverage of their health care needs. The largest single expenditure for this group was for nursing facility care (41.7 percent).

Of nursing facility expenditures, most was spent for intermediate care services for mentally retarded patients at 33.9%. Inpatient hospital care was also an important expenditure for this group at 22.0%. On average, Medicaid expenditures were $8,800 per recipient for the disabled and blind group. Per recipient expenditures for this group increased 2.0 percent over the figure for 1993. In SFY 1994, 94,618 disabled and blind persons were served by Medicaid.

Families and Children

(See Table 14.)

In strong contrast with the spending pattern for the elderly, blind and disabled populations, Medicaid spending for families with children reflects the preventive and acute care nature of their health care needs. Table 14 displays expenditures divided into four groups: AFDC adults, special coverage for Medicaid pregnant women, AFDC children and other children, and special coverage for Medicaid Indigent children. In SFY 1994, Medicaid expenditures per recipient for all groups was $1,340.

For families and children, inpatient hospital care was the largest expenditure at $341,923,914. For indigent children, 46.4 percent of expenditures was for inpatient hospital care and for Medicaid pregnant women 28.0% of expenditures were for physician services.

Physician services also account for a large portion of services used by the other groups. Outpatient hospital services accounted for 11.6 percent of expenditures for all groups. In SFY 1994, 235,030 adults and 473,122 children received services.

Table 12
State Fiscal Year 1994
Expenditures For The Elderly

Type of Service	Aged	Percent of Service Dollars	MQBQ Qualified Medicare Beneficiary	MQBB Part B Premium Only	Total Qualified Beneficiaries	Percent of Service Dollars	Total Elderly Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 21,915,412	2.6%	$ 9,190,215	$ -	$ 9,190,215	11.6%	$ 31,105,627	3.4%	4.4%
Outpatient Hospital	10,992,717	1.3%	11,727,547	-	11,727,547	14.9%	22,720,264	2.5%	2.3%
Mental Hospital (>65)	12,331,117	1.5%	38,430	-	38,430	0.0% *	12,369,547	1.3%	1.6%
Physician	19,174,468	2.3%	14,322,090	-	14,322,090	18.1%	33,496,558	3.6%	3.6%
Clinics	2,875,471	0.3%	4,144,466	-	4,144,466	5.2%	7,019,937	0.8%	0.7%
Nursing Facility:									
Skilled Level:	271,522,752	32.1%	205,478	-	205,478	0.3%	271,728,230	29.3%	30.2%
Intermediate Level:	275,704,512	32.5%	856	-	856	0.0% *	275,705,368	29.8%	29.4%
Intermediate Care Facility-Mentally Retarded	8,752,337	1.0%	-	-	-	0.0%	8,752,337	0.9%	0.9%
Dental	2,411,792	0.3%	4,341	-	4,341	0.0% *	2,416,133	0.3%	0.3%
Prescription Drugs	74,105,570	8.7%	-	-	-	0.0%	74,105,570	8.0%	8.3%
Home Health	8,793,228	1.0%	224,948	-	224,948	0.3%	9,018,177	1.0%	1.1%
CAP/Disabled Adult	43,400,285	5.1%	-	-	-	0.0%	43,400,285	4.7%	4.3%
CAP/Mentally Retarded	182,475	0.0% *	-	-	-	0.0%	182,475	0.0% *	0.0% *
Personal Care	24,324,331	2.9%	-	-	-	0.0%	24,324,331	2.6%	2.8%
Hospice	4,416,504	0.5%	-	-	-	0.0%	4,416,504	0.5%	0.3%
Lab & X-Ray	1,304,432	0.2%	1,282,873	-	1,282,873	1.6%	2,587,305	0.3%	0.3%
Other Services	3,458,206	0.4%	1,200,494	8	1,200,502	1.5%	4,658,707	0.5%	0.4%
Part A Premium	30,464,521	3.6%	779,118	-	779,118	1.0%	31,243,639	3.4%	2.6%
Part B Premium	30,985,014	3.7%	33,729,097	2,112,763	35,841,860	45.4%	66,826,875	7.2%	6.5%
HMO Premium	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%
Total Service & Premiums	**$ 847,115,143**		**76,849,952**	**2,112,771**	**78,962,723**		**926,077,867**		
Total Elderly Recipients	88,373		63,423		63,423		151,796		
Service Expenditures Per Recipient **	**$ 9,586**		**$ 1,245**		**$ 1,245**			**$ 6,101**	**$ 5,804**

Note: Other Services include amounts from Psychiatric Hospital (<21), CAP-Children & Health Check Categories (See Table 11).

* Percentages denoted with and * are less than .1%.

** Service Expenditure/Recipient amounts do not contain adjustments, settlements or administrative costs.

*** State Fiscal Year 1993 data can be found in the Appendix Table 12.

Source: SFY 1994 Program Expenditure Report and 2082 Report

Table 13
State Fiscal Year 1994
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 182,952,370	22.3%	$ 361,625	3.4%	$ 183,313,995	22.0%	23.6%
Outpatient Hospital	41,099,932	5.0%	180,672	1.7%	41,280,603	5.0%	4.7%
Psychiatric Hospital (<21)	1,270,454	0.2%	-	0.0%	1,270,454	0.2%	0.2%
Physician	53,943,835	6.6%	267,821	2.5%	54,211,656	6.5%	6.5%
Clinics	25,255,306	3.1%	109,878	1.0%	25,365,184	3.0%	3.0%
Nursing Facility:							
Skilled Level:	40,798,575	5.0%	1,133,013	10.6%	41,931,587	5.0%	5.0%
Intermediate Level:	22,541,201	2.7%	1,162,240	10.9%	23,703,442	2.8%	2.8%
Intermediate Care Facility-							
Mentally Retarded	277,600,304	33.8%	4,592,992	43.2%	282,193,295	33.9%	33.9%
Dental	5,389,551	0.7%	35,013	0.3%	5,424,564	0.7%	0.7%
Prescription Drugs	67,487,846	8.2%	758,018	7.1%	68,245,864	8.2%	7.7%
Home Health	35,087,180	4.3%	562,489	5.3%	35,649,669	4.3%	4.2%
CAP/Disabled Adult	11,713,092	1.4%	203,053	1.9%	11,916,145	1.4%	1.4%
CAP/Children	1,428,032	0.2%	-	0.0%	1,428,032	0.2%	0.2%
CAP/Mentally Retarded	19,411,957	2.4%	15,051	0.1%	19,427,008	2.3%	2.0%
Personal Care	10,824,399	1.3%	533,930	5.0%	11,358,329	1.4%	1.3%
Hospice	4,531,338	0.6%	4,301	0.0% *	4,535,639	0.5%	0.5%
Lab & X-Ray	6,613,146	0.8%	30,206	0.3%	6,643,351	0.8%	1.0%
Other Services*	5,046,108	0.6%	101,554	1.0%	5,147,663	0.6%	0.4%
Part A Premium	6,977	0.0% *	364,331	3.4%	371,308	0.0% *	0.0% *
Part B Premium	8,958,449	1.1%	227,198	2.1%	9,185,646	1.1%	1.0%
HMO Premium	-	0.0%	-	0.0%	-	0.0%	0.0%
Total Service & Premiums	**$ 821,960,052**		**10,643,383**		**832,603,435**		
Total Disabled/Blind Recipients	93,668		950		94,618		
Service Expenditures Per Recipient**	**$ 8,775**		**$ 11,204**			**$ 8,800**	**$ 8,630**

Note: Other Services include amounts from Health Check and Mental Hospitals (>65) Categories (See Table 11).

* Percentages denoted with and * are less than .1%.

** Service Expenditures/Recipient does not include adjustments, settlements and administrative costs.

*** State Fiscal Year 1993 can be found in the Appendix Table 13

Source: SFY 1994 Program Expenditure Report and 2082 Report

Table 14
State Fiscal Year 1994
Expenditures for Families and Children

Type of Service	AFDC Adults	% of Service Dollars	Special Pregnant Women	% of Service Dollars	AFDC Children & Other Children	% of Service Dollars	Indigent Children	% of Service Dollars	Total Families & Children Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 86,460,767	32.9%	$ 35,120,234	34.1%	$ 131,636,752	32.9%	$ 88,706,161	46.4%	$ 341,923,914	35.7%	38.7%
Outpatient Hospital	43,288,170	16.5%	11,340,025	11.0%	39,791,272	9.9%	15,857,646	8.3%	110,277,114	11.5%	11.8%
Psychiatric Hospital (<21)	-	0.0%	41,830	0.0% *	15,340,437	3.8%	987,354	0.5%	16,369,621	1.7%	2.3%
Physician	54,630,448	20.8%	28,765,072	28.0%	66,807,223	16.7%	34,285,438	18.0%	184,488,182	19.3%	19.6%
Clinics	13,695,711	5.2%	15,149,551	14.7%	34,418,496	8.6%	10,163,867	5.3%	73,427,625	7.7%	6.8%
Nursing Facility:											
Skilled Level:	157,274	0.1%	-	0.0%	636,664	0.2%	6,986	0.0%	800,924	0.1%	0.1%
Intermediate Level:	7,471	0.0% *	-	0.0%	67,339	0.0% *	-	0.0%	74,810	0.0% *	0.0% *
Intermediate Care Facility-Mentally Retarded	222,959	0.1%	-	0.0%	23,585,691	5.9%	1,544,171	0.8%	25,352,820	2.6%	2.5%
Dental	10,998,118	4.2%	390,236	0.4%	12,082,375	3.0%	2,901,747	1.5%	26,372,476	2.8%	2.9%
Prescription Drugs	27,534,927	10.5%	2,273,677	2.2%	23,584,360	5.9%	11,493,090	6.0%	64,886,055	6.8%	6.5%
Home Health	3,700,690	1.4%	432,492	0.4%	13,284,420	3.3%	12,719,330	6.7%	30,136,932	3.1%	2.9%
CAP/Children	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Health Check - EPSDT	68	0.0%	1,036	0.0%	7,954,113	2.0%	75,797	0.0%	8,031,014	0.8% *	1.3%
Lab & X-Ray	6,329,374	2.4%	2,585,950	2.5%	3,714,110	0.9%	999,642	0.5%	13,629,075	1.4%	1.5%
Other Services*	15,187,812	5.8%	6,723,761	6.5%	27,600,627	6.9%	11,245,273	5.9%	60,757,473	6.3%	3.3%
Part A Premium	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Part B Premium	311,732	0.1%	30,199	0.0% *	13,767	0.0% *	11,410	0.0% *	367,107	0.0% *	0.0% *
HMO Premium	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Total Service & Premiums	**$ 262,525,521**		**102,854,063**		**400,517,647**		**190,997,910**		**956,895,141**		
Total Families & Children Recipients	**176,948**		**58,082**		**326,331**		**146,791**		**708,152**		
Service Expenditures Per Recipient**	**$ 1,484**		**$ 1,771**		**$ 1,227**		**$ 1,301**			**$ 1,351**	**$ 1,340**

Note: Other Services include amounts from Mental Hospital (>65), CAP/Disabled Adult, CAP/Mentally Retarded, Personal Care Services & Hospice categories (See Table 11).

* Percentages denoted with and * are less than .1%.

** Service Expenditures/Recipient does not include adjustments, settlements and administrative costs.

*** State Fiscal year 1993 can be found in the Appendix Table 14.

Source: SFY 1994 Program Expenditure Report & 2082 Report

Medicaid offers a comprehensive array of services for program eligibles. Federal law requires coverage of some services but state's can elect other service options. All services must be medically necessary in order for Medicaid to pay for them.

The following describes services offered, reimbursement methods, limitations and copayment amounts in effect during SFY 1994. (Table 15 displays Medicaid copayment amounts.)

Table 15
State Fiscal Year 1993 &1994
Medicaid Copayment Amounts

Service	Copayment Amount
Chiropractor visit	$ 1.00
Clinic visit	0.50
Dental visit	3.00
Outpatient visit	3.00
Physician visit	3.00
Podiatrist visit	1.00
Optical service	2.00
Optometrist visit	2.00
Prescription drug (including refills)	1.00

These copayments are at the federal maximum amount. Copayment amounts do not apply to the following:

- Health Check (ESPDT) program services
- Family planning services
- Services related to pregnancy
- Services to nursing facility residents and mental hospital patients
- Hospital emergency room services

The state elects to exempt the following services (or groups) from copayments:

- Community Alternatives Program (CAP)
- Rural health clinic services
- Non-hospital dialysis facility
- State-owned mental facility
- Services covered by both Medicare and Medicaid
- Services to enrollees of prepaid plans

Mandatory Services

At a minimum, all State Medicaid programs must cover a core of health services. The following are mandatory services.

Inpatient Hospital Services --
Medicaid covers hospital inpatient services without a limitation on the number of days. Selected inpatient procedures require preadmission certification to ensure that the stay is medically necessary and that the procedure is most appropriately performed on an inpatient rather than an outpatient basis. Special restrictions apply to abortions, hysterectomies and sterilizations. Hospital services are paid on the basis of prospective per diem rates.

Hospital Outpatient Services --
Outpatient services are covered subject to Medicaid's annual 24 physician visit limitation, except for emergency room visits. A $3.00 per visit copayment applies except for certain exempt groups and services. Hospital outpatient services are paid on the basis of 80 percent of actual operating costs.

Other Laboratory and X-ray -- Laboratory and x-ray services are covered when ordered by a physician. These services are covered in a variety of settings. Payment for these services is based on a statewide fee schedule.

Nursing Facility -- Nursing facility (NF) services are required for recipients aged 21 and older. The state has also elected a federal option to cover these services for those under age 21. Patients must be certified to require nursing facility level of care and be approved by Medicaid prior to admission. Nursing facility services are paid a prospective per diem rate.

Physician Services -- Physician services are covered subject to an annual 24 visit limit. Selected surgical procedures require prior approval. A $3.00 copayment is required on physician services except for the exempt groups identified above under "Hospital Outpatient Services." Payment is made based on the lower of the physician's actual charge or the statewide Medicaid fee schedule amount. Medicaid uses the American Medical Association's Current Procedural Terminology (CPT) coding structure for physician billing.

Home Health Services -- Medicaid covers all services normally provided through a home health agency, including nursing visits and therapies. Patients must be home-bound and services furnished under a plan of treatment. Certain children under age 21 and disabled adults may be excepted from the home-bound requirement. Home health agencies are paid the lower of their customary charge to the general public or a maximum per visit rate established for each type of service.

Health Check -- Medicaid operates two programs specially designed to offer primary preventive care for recipients. The Health Check (EPSDT) program provides child health examinations as well as necessary diagnosis and treatment, and/or referral for treatment of health problems detected during the screening of a Medicaid recipient 20 years of age or younger. Most Health Check services do not count toward the annual 24 visit limitation and no copayment is required. County health departments and private providers may participate in the Health Check program. For a complete description of the EPSDT program, see "Special Programs."

Family Planning Services -- Medicaid covers consultation, examination and treatment prescribed by a physician. Sterilizations, abortions and hysterectomies are permitted under limited circumstances and require special documentation and approval. Payment is made based on the type of provider furnishing the service.

Other Mandatory Services -- Other mandatory services include rural health centers, durable medical equipment, other health clinics, nurse midwife services, nurse practitioner services and medical transportation.

Optional Services

Federal law permits States to cover additional services, at their option. Following are the optional services North Carolina Medicaid covers. Where these services are categorized as optional, they must be provided to all children under age 21 when the medical necessity of such services are confirmed through a Health Check screening.

Intermediate Care Facilities for the Mentally Retarded (ICF-MR) -- Services in ICF-MRs are covered for those who are mentally retarded or who have related conditions. ICF-MRs must meet certification requirements relating to provision of habilitation services as well as basic intermediate care services. Intermediate care facilities for the mentally retarded are paid prospective per diem rates.

Personal Care Services -- Medicaid Personal Care Services (PCS) cover aide services in private residences to perform personal care tasks for patients who, due to a medical condition, need help with such activities as bathing, toileting, moving about, and keeping track of vital signs. It may also include housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining the patient's health. PCS is provided for the patient according to a physician authorized plan of care. A patient may receive up to 80 hours of PCS in a calendar month. The PCS provider is paid the lower of the provider's customary charge for the service or the Medicaid maximum allowable rate.

Prescription Drugs -- Medicaid covers legend drugs and insulin. A legend drug is one that requires a prescription before it can be dispensed. Drug coverage is limited to six prescriptions per month unless it is needed for treatment of a life threatening illness or disease. In addition, recipients may use only one pharmacist per month except in an emergency. A $1.00 per prescription copayment applies, except for exempt groups identified under "Hospital Outpatient Services." Payment for drugs is based on the lower of each provider's customary charge or the less than average wholesale price of the drug plus a $5.60 dispensing fee.

Dental Services -- Most general dental services are covered, such as exams, cleaning, fillings, x-rays and dentures. Additional services are covered for children eligible for the Health Check program. Prior approval is required for only a few dental services. A per visit copayment of $3.00 applies for all recipients, except for the exempt groups. Payment is made on the basis of a statewide fee schedule.

Eye Care Services -- Medicaid covers medical eye examinations to determine refractive errors and corrective lenses, eyeglasses, and other visual aids. Coverage for services is limited to certain services and practitioner types. Prior approval is required for some medical services, and all visual aids and frequency limitations apply. A $3.00 copayment applies to physician visits; a $2.00 copayment applies to optometrist visits; and a $2.00 copayment is charged on eyeglasses and repairs.

Copayments do not apply to the exempt group identified under "Hospital Outpatient Services." Medicaid contracts with Classic Optical - Youngstown, Ohio to provide eyeglasses at predetermined rates. Providers must obtain eyeglasses through this organization unless extenuating circumstances exist and an exception is made to permit a provider to supply lenses or a frame. The contract was obtained through a

competitive bid process and is re-bid every two years.

Mental Health Services -- Patients that have a plan of treatment developed by and on file with an area program center, are offered outpatient mental health services, partial hospitalization, and emergency services through Mental Health, Developmental Disabilities and Substance Abuse Services. Visits do not count against the annual 24 visit limit. Area Program centers are paid a negotiated rate, not to exceed costs, for services.

Independent psychiatrists and physicians are covered for mental health services, as well. Prior approval is required for outpatient visits after the first two. Visits to a private practice psychiatrist count against the annual 24 visit limit and a $3.00 copayment applies, except to the exempt groups.

Payment is made on a fee schedule basis. Inpatient state and private mental hospital services are covered for recipients over 64 or under age 21. Payment to psychiatric hospitals is based on each hospital's actual allowable and reasonable costs.

Adult Health Screening Program-- The Adult Health Screening Program is not a mandatory service, but compliments the Health Check program for those age 21 and older. The program covers a comprehensive annual health assessment with the expectation that it will prevent serious illness through early detection and treatment. Certain components of an assessment must be included to qualify for payment. The screening applies toward the annual 24 visit limit, and a $3.00 copayment applies. Payment is based on the type of provider that performs the screening; county health departments, clinics, and private physicians may conduct annual screenings under the Adult Health Screening Program.

Other Optional Services -- A variety of other optional services are provided by Medicaid. Limited services by chiropractors and podiatrists are covered and paid on the basis of a statewide fee schedule. Other optional services provided by Medicaid include specialty hospital (tuberculosis or pulmonary), hospice, private duty nursing, ambulance transportation and case management services to meet the needs of specific groups of people.

Special Programs

Baby Love

The Baby Love Program, implemented in October 1987, is designed to help reduce North Carolina's high infant mortality rate by improving access to health care and the service delivery system for low income pregnant women and children. The Division Of Medical Assistance and the Division of Maternal and Child Health jointly administer the Baby Love Program in cooperation with the Office of Rural Health and Resource Development.

Through the Baby Love Program, pregnant women can receive comprehensive care from the beginning of pregnancy through the postpartum period. Infants born to Medicaid eligible women continue to be eligible until their first birthday.

Specially trained nurses and social workers called Maternity Care Coordinators are located in all 100 North Carolina counties to assist pregnant women in obtaining medical care and an array of social support services such as transportation, housing, job training and day care. Additionally, services provided through the Baby Love Program include childbirth and parenting classes and in-home skilled nursing care for medically high risk pregnancies.

To expand outreach efforts of the Baby Love Program a publication called the Baby Love Keepsake Book (a guide for parenting families) was developed. Additionally, the Baby Love Maternal Outreach Worker Project, funded by the Kate B. Reynolds Health Care Trust and Medicaid was implemented, in which 24 health agencies initiated pilot "home visiting" programs. Maternal Outreach Workers work on a one-to-one basis with at risk Medicaid eligible families to provide social support, encourage healthy behaviors, and to ensure that families are linked with available community resources. As of 1995, twenty-two additional sites have been funded through the Kate B. Reynolds trust and Medicaid.

Evaluation of the Baby Love program shows that women who receive the services of a Maternity Care Coordinator average more prenatal visits per pregnancy, have a higher participation in the Women, Infants and Children (WIC) program, and are more likely to receive postpartum family planning services. Likewise, their children are more likely to receive well-child care and WIC services. Mothers who have a Maternity Care Coordinator have better birth outcomes -- more live births and fewer low birthweight babies.

Health Check Program

The Health Check Program (formerly called the Early and Periodic Screening, Diagnosis and Treatment Program, or EPSDT) provides preventive health care for children and teens from birth up to age 21. Preventive health care, in this context, refers to the child health examinations used to detect problems early, and includes the diagnosis, treatment, and referral to correct the problems identified. In addition to paying for services, Health Check tries to ensure that children receive regular health examinations.

The Health Check (EPSDT) program has been in existence since Medicaid began. Several strategies were initiated in the fall of 1993 and in 1994 to help improve the availability and accessibility of comprehensive and continuous preventative and primary health care services for Health Check eligibles. The goal of this initiative is to assist families to maximize the health and development of their children. The strategies include:

- Changes in state administration of the program to help integrate policies and procedures so both financing and service delivery objectives are compatible among state agencies.
- Changes in local administration to improve coordination among local agencies, improve outreach to families and providers and to assist families in obtaining needed health services.
- Recruitment of primary and specialized care providers to increase the accessibility of services.
- Changes in fees and billing processes to increase provider participation.
- Implementation of a statewide outreach campaign to educate parents about the availability of services and the importance of regular care.
- Design of an automated information and notification system to collect and provide families, caregivers and Health Check coordinators with information regarding program participation.
- Expanded coverage of specialized services.

Additionally, effective July 1994 Medicaid expanded coverage to children ages 6 through 18 years of age at 100% of the federal poverty level. All of these efforts will improve Medicaid eligible children's access to and utilization of health care.

Community Alternatives Program

North Carolina operates three programs to provide home and community care as a cost-effective alternative to institutionalization. These are known as "waiver" programs because standard program requirements are waived to allow the program to operate. The waiver programs provide some services that otherwise are not covered under Medicaid.

The waiver programs are designed for different populations. The Community Alternatives Program for Disabled Adults (CAP/DA) provides services that allow adults (ages 18 and above) who require care in a nursing facility to remain in the community. Eighty-four counties chose to participate in CAP/DA and the program served about 5,741 individuals in SFY 1994.

The average daily cost for CAP/DA services at the skilled level was less than 68 percent of the average cost for institutional care at the comparable level. At the intermediate level, CAP/DA services cost less than 69 percent of that for institutional care.

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. All 100 counties had access to the CAP-MR/DD program through 41 Mental Health, Mental Retardation, and Substance Abuse program centers and served 1,278 individuals in SFY 1993. Participants in the CAP-MR/DD were served at approximately 25 percent of the average Medicaid cost for institutional care.

The Community Alternatives Program for Children (CAP/C) is different from the other two programs because it serves medically fragile children (through age 18) who otherwise would be ineligible for Medicaid. This waiver program is available in all counties and 59 children were served in SFY 1993. The total Medicaid cost for home care did not exceed the comparable Medicaid cost for institutional care.

Overall, the CAP programs have been very successful in giving individuals a choice and holding down costs at the same time. The programs have allowed those who otherwise would be institutionalized to remain with family in familiar surroundings. All of this has been accomplished at a cost savings to Medicaid in comparison with the cost of institutional care.

Medicare-Aid

In February 1989, North Carolina began a new program of health care financing assistance to elderly and disabled Medicare beneficiaries, as mandated by federal law. The program, known as Medicare-Aid, allows Medicaid to pay low income Medicare beneficiaries' cost-sharing expenses, such as deductibles, premiums and coinsurance charges.

In fact, 63,423 Medicare recipients benefited from Medicare-Aid in SFY 1994. The eligibility income limit for Medicare-Aid was increased to 100 percent of the federal poverty level. Effective January 1, 1993, coverage was added to pay the Medicare B premium for individuals who are Medicare-Aid eligible but have incomes too high to qualify. These individuals are called Specified Low-Income Medicare Beneficiaries. To be eligible, their income must be within 101-120 percent of the federal poverty level.

Prepaid Health Plan Services

Medicaid recipients in Durham, Orange, Mecklenburg, and Wake counties may elect to be covered under a prepaid health plan instead of the usual fee-for-service coverage under Medicaid. This option is available to recipients in the Aid to Families with Dependent Children (AFDC) category.

The Division Of Medical Assistance contracts with the Kaiser-Permanente Health Maintenance Organization to provide most covered services at a pre-paid, monthly capitated rate. Medicaid services that are not covered under the Kaiser plan are available to recipients on the usual fee-for-service basis.

Recipients who choose the HMO option may receive some services not otherwise covered by Medicaid. In addition, they are not subject to the usual copayments, prescriptions and visit limitations.

Drug Use Review Program

North Carolina Medicaid established a Drug Use Review (DUR) Program as required by (OBRA) of 1990 to ensure that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and are not likely to result in adverse medical effects.

The DUR program is characterized by the following four major components:

- **DUR Board** - A DUR board is composed of five licensed and actively practicing physicians, five licensed and actively practicing pharmacists, two other individuals with expertise in drug therapy problems and the DMA DUR Coordinator. The DUR Board makes recommendations to DMA on DUR policies and procedures.

- **Prospective DUR** -- Prospective DUR requires that, prior to dispensing, the pharmacist must screen for potential drug therapy problems and counsel patients about the medications they are taking to enhance patient compliance.

- **Retrospective DUR** -- Retrospective DUR is an ongoing periodic examination of Medicaid claims data and other records to identify patterns of behavior involving physicians, pharmacists, and individual Medicaid recipients or patterns associated with specific drugs or groups of drugs. These analyses are based on predetermined standards established by the DUR Board. North Carolina contracted with First Health Inc., to provide the computer support for the retrospective DUR.

- **Education** -- Education is the key for an effective DUR Program. The DUR Program must provide ongoing outreach programs to educate physicians and pharmacists on common drug therapy problems with the goal of improving prescribing and dispensing practices. During 1993, the Board elected to use intervention letters and educational articles in the Medicaid bulletins to all prescribers and pharmacists. In 1994 the educational articles were shared with the professional organizations for inclusion with their publications which are disseminated to their members.

Health Related Services provided in Public Schools and Head Start programs:

To strengthen the commitment to provide a comprehensive array of services to the children of North Carolina, DMA began reimbursement of physical therapy, audiological services and speech/language services provided in the public school system by local education agencies or through local Head Start Programs which are enrolled with the Medicaid

program. These services are provided to Medicaid eligible children who receive special education or related services.

In addition to the above, effective 12/1/93, the Medicaid program also began the enrollment and reimbursement of Independent practitioners who provide physical therapy, occupational therapy, speech and language therapy, and audiological services to children (birth through 20 years old).

Nursing Home Reform

Many of the nursing home reform provisions included the Omnibus Budget Reconciliation Act (OBRA) of 1987 and later amendments became effective on October 1, 1990. Largely devoted to strengthening patients' rights in nursing homes, the OBRA nursing home reform legislation made a number of changes that affected the Medicaid program. Among the most important were:

- Established uniform require- requirements for institutions that formerly were identified as Medicaid skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Now, all Medicaid SNFs and ICFs are called NFs and must provide both skilled nursing (SN) and intermediate care (IC) levels. Reimbursement rates, however, continue to differ based on whether the patient requires skilled or intermediate care.

- HCFA's final regulations for Preadmission Screening and Annual Resident Review (PASARR) became effective January 1993. This program requires that every applicant in a Medicaid certified NF be screened for evidence of mental illness (MI) and mental retardation (MR) to determine appropriate placement and service needs. Individuals in a NF with MI or MR must be reassessed annually.

- Nursing facilities must conduct a comprehensive assessment of each resident to determine the services the resident needs. The resident assessment is required for all nursing facility patients regardless of payment source.

- Patients' rights were strengthened and made more explicit.

- States were required to develop and maintain a registry of nurse aides and to institute a nurse aide training program in the state. As mandated, North Carolina has instituted a nurse aide program.

- Nursing facility quality assurance programs were strengthened.

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Appendix

1993 Tables & Charts

Table 1
State Fiscal Year 1993
Federal Matching Rates

Benefit Costs

	Family Planning		All Other
	(7/1/92 - 9/30/92)		
Federal	90.0%	Federal	66.52%
State	8.5%	State	28.46%
County	1.5%	County	5.02%
	(10/1/92 - 6/30/93)		
Federal	90.0%	Federal	65.92%
State	8.5%	State	28.97%
County	1.5%	County	5.11%

Administrative Costs

(7/1/92 - 6/30/93)

	Skilled Medical Personnel & MMIS	All Other
Federal	75.0%	50.00%
Non-Federal	25.0%	50.00%

**MMIS-Medicaid Management Information System

Table 2
State Fiscal Year 1993
Medicaid Financial Eligibility Standards

Eligibilty Income Levels (Annual)

Family Size	* AFDC Related * Groups Categorically Needy	Medically Needy	Aged, Blind & Disabled: All Groups	Pregnant Women Infants < 1 Yr. 185% of Poverty	Children Ages 1-5 133% of Poverty	Children Age 6 & Over 100% of Poverty	Qualified Medicare Beneficiaries 100% of Poverty	Specified Low-Income Medicare Beneficiaries 101-110% of Poverty	"Spousal Impoverishment" Beneficiaries 150% of Poverty	Qualified Disabled Working Individual 200% of Poverty
1	4,344	2,904	2,904	12,900	9,276	6,972	6,972	6,972 - 7,688	Minimum of $13,788	13,944
2	5,664	3,804	3,804	17,448	12,552	9,432	9,432	9,432 - 10,380	up to a Maximum of	18,864
3	6,528	4,404	4,404	22,008	15,816	11,892			$21,228	
4	7,128	4,800	4,800	26,556	19,092	14,352				
5	7,776	5,196	5,196	31,104	22,368	16,812				

Eligibility Resource Limits

1	$1,000	$1,500	$1,500	No resource	No resource	No resource	$4,000	$4,000	$14,148 minimum	$4,000
2	No increment	2,250	2,250	test applies	test applies	test applies	6,000	6,000	70,740 maximum	6,000
3	for family size	2,350	2,350							
4		2,450	N/A							
5		2,550	N/A							

Source: Income & Reserve Levels (REV. 4/94)

Table 9
SFY 1993
Total Expenditures and Eligibles by County

COUNTY NAME	1992 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	RANKING	ELIGIBLES PER 1,000 POPULATION
ALAMANCE	109,978	12,291	36,080,181	$2,935	$328.07	74	112
ALEXANDER	28,076	2,984	7,831,018	$2,624	$278.92	91	106
ALLEGHANY	9,884	1,312	3,738,504	$2,849	$378.24	55	133
ANSON	23,543	5,149	14,531,022	$2,822	$617.21	3	219
ASHE	22,434	3,695	10,918,912	$2,955	$486.71	29	165
AVERY	14,999	2,355	7,845,835	$3,332	$523.09	19	157
BEAUFORT	42,841	8,736	20,869,674	$2,389	$487.14	28	204
BERTIE	20,508	5,306	11,111,043	$2,094	$541.79	12	259
BLADEN	28,647	7,566	17,324,079	$2,290	$604.74	4	264
BRUNSWICK	54,519	9,441	20,716,300	$2,194	$379.98	53	173
BUNCOMBE	180,223	23,529	65,486,613	$2,783	$363.36	64	131
BURKE	76,901	10,033	29,289,340	$2,919	$380.87	51	130
CABARRUS	103,917	11,571	32,624,590	$2,820	$313.95	85	111
CALDWELL	71,829	9,240	26,687,204	$2,888	$371.54	59	129
CAMDEN	5,952	915	2,201,960	$2,407	$369.95	60	154
CARTERET	55,159	6,986	17,618,321	$2,522	$319.41	80	127
CASWELL	20,956	3,540	9,051,263	$2,557	$431.92	39	169
CATAWBA	121,418	12,753	33,580,950	$2,633	$276.57	92	105
CHATHAM	40,725	4,441	12,505,264	$2,816	$307.07	87	109
CHEROKEE	20,726	4,225	9,933,849	$2,351	$479.29	31	204
CHOWAN	13,973	3,013	6,818,774	$2,263	$488.00	27	216
CLAY	7,184	1,082	2,917,216	$2,696	$406.07	46	151
CLEVELAND	85,976	13,442	33,272,174	$2,475	$386.99	49	156
COLUMBUS	50,134	13,694	32,455,166	$2,370	$647.37	1	273
CRAVEN	83,709	13,669	30,653,859	$2,243	$366.20	63	163
CUMBERLAND	283,405	41,303	75,408,768	$1,826	$266.08	94	146
CURRITUCK	14,566	2,146	4,192,984	$1,954	$287.86	89	147
DARE	23,260	2,203	5,954,191	$2,703	$255.98	95	95
DAVIDSON	132,259	15,218	38,199,477	$2,510	$288.82	88	115
DAVIE	28,869	2,745	9,173,326	$3,342	$317.76	83	95
DUPLIN	41,066	9,075	20,731,338	$2,284	$504.83	22	221
DURHAM	187,911	23,675	71,422,051	$3,017	$380.08	52	126
EDGECOMBE	56,642	14,805	30,531,215	$2,062	$539.02	13	261
FORSYTH	269,678	33,757	85,839,237	$2,543	$318.30	82	125
FRANKLIN	38,794	6,909	19,093,048	$2,764	$492.16	26	178
GASTON	176,874	26,488	64,119,114	$2,421	$362.51	65	150
GATES	9,558	1,552	3,959,033	$2,551	$414.21	45	162
GRAHAM	7,115	1,641	3,661,308	$2,231	$514.59	20	231
GRANVILLE	39,713	5,007	13,606,528	$2,718	$342.62	70	126
GREENE	15,987	3,091	7,305,390	$2,363	$456.96	35	193
GUILFORD	354,477	43,097	112,366,881	$2,607	$316.99	84	122
HALIFAX	56,638	16,403	31,583,604	$1,925	$557.64	10	290
HARNETT	70,820	13,359	31,248,795	$2,339	$441.24	37	189
HAYWOOD	48,323	7,104	17,812,711	$2,507	$368.62	61	147
HENDERSON	72,294	8,833	24,167,392	$2,736	$334.29	72	122
HERTFORD	22,280	6,323	12,996,940	$2,056	$583.35	7	284
HOKE	23,594	6,134	10,796,522	$1,760	$457.60	34	260
HYDE	5,379	1,393	3,017,597	$2,166	$561.00	9	259
IREDELL	96,865	11,563	30,982,316	$2,679	$319.85	79	119
JACKSON	27,537	4,221	10,654,826	$2,524	$386.93	50	153
JOHNSTON	86,515	14,363	36,679,460	$2,554	$423.97	42	166
JONES	9,461	2,072	6,057,204	$2,923	$640.23	2	219
LEE	43,133	6,836	15,418,271	$2,255	$357.42	66	158

Table 9
SFY 1993
Total Expenditures and Eligibles by County

COUNTY NAME	1992 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	RANKING	ELIGIBLES PER 1,000 POPULATION
LENOIR	58,351	13,015	31,184,942	$2,396	$534.44	17	223
LINCOLN	51,999	6,429	14,830,467	$2,307	$285.21	90	124
MACON	24,656	3,568	8,502,171	$2,383	$344.83	69	145
MADISON	17,230	3,347	9,217,231	$2,754	$534.95	16	194
MARTIN	25,750	5,677	12,703,532	$2,238	$493.34	25	220
MCDOWELL	36,000	4,704	11,803,514	$2,509	$327.88	75	131
MECKLENBURG	536,403	67,272	165,837,250	$2,465	$309.17	86	125
MITCHELL	14,495	2,195	6,733,817	$3,068	$464.56	33	151
MONTGOMERY	23,528	4,497	10,086,374	$2,243	$428.70	41	191
MOORE	61,417	7,664	19,810,681	$2,585	$322.56	77	125
NASH	79,373	12,715	28,116,779	$2,211	$354.24	67	160
NEW HANOVER	127,928	19,893	48,000,284	$2,413	$375.21	58	156
NORTHAMPTON	20,732	5,794	12,509,196	$2,159	$603.38	5	279
ONSLOW	144,004	15,644	27,411,759	$1,752	$190.35	100	109
ORANGE	99,674	7,124	23,873,489	$3,351	$239.52	97	71
PAMLICO	11,449	2,076	5,737,355	$2,764	$501.12	24	181
PASQUOTANK	31,994	6,826	13,309,300	$1,950	$415.99	44	213
PENDER	30,950	6,070	15,015,273	$2,474	$485.15	30	196
PERQUIMANS	10,436	2,347	4,491,221	$1,914	$430.36	40	225
PERSON	30,769	4,859	15,421,329	$3,174	$501.20	23	158
PITT	113,147	20,235	44,956,595	$2,222	$397.33	48	179
POLK	15,085	1,627	5,026,895	$3,090	$333.24	73	108
RANDOLPH	109,227	11,217	27,429,347	$2,445	$251.12	96	103
RICHMOND	45,204	8,966	21,522,178	$2,400	$476.11	32	198
ROBESON	107,294	30,334	60,866,389	$2,007	$567.29	8	283
ROCKINGHAM	86,206	11,929	32,466,103	$2,722	$376.61	57	138
ROWAN	112,764	14,171	36,854,063	$2,601	$326.82	76	126
RUTHERFORD	57,763	8,505	21,180,801	$2,490	$366.68	62	147
SAMPSON	48,303	10,641	25,981,386	$2,442	$537.88	15	220
SCOTLAND	34,287	8,960	18,067,811	$2,016	$526.96	18	261
STANLY	53,015	6,653	17,833,816	$2,681	$336.39	71	125
STOKES	38,190	4,415	12,163,415	$2,755	$318.50	81	116
SURRY	62,771	8,067	23,703,639	$2,938	$377.62	56	129
SWAIN	11,244	2,581	5,125,256	$1,986	$455.82	36	230
TRANSYLVANIA	26,338	3,825	9,986,399	$2,611	$379.16	54	145
TYRRELL	3,887	1,090	2,334,074	$2,141	$600.48	6	280
UNION	88,248	11,125	24,292,411	$2,184	$275.27	93	126
VANCE	39,078	9,043	19,854,371	$2,196	$508.07	21	231
WAKE	459,544	38,946	98,270,859	$2,523	$213.84	99	85
WARREN	17,448	3,944	9,583,601	$2,430	$549.27	11	226
WASHINGTON	13,989	3,512	7,535,096	$2,146	$538.64	14	251
WATAUGA	37,760	3,154	8,303,186	$2,633	$219.89	98	84
WAYNE	107,130	17,460	37,644,535	$2,156	$351.39	68	163
WILKES	60,379	7,967	24,426,430	$3,066	$404.55	47	132
WILSON	66,868	14,179	29,026,205	$2,047	$434.08	38	212
YADKIN	31,628	3,581	10,176,889	$2,842	$321.77	78	113
YANCEY	15,813	2,570	6,701,602	$2,608	$423.80	43	163
STATE TOTAL	6,836,977	992,697	$2,418,951,954	$2,437	$353.80	N/A	145

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1993.

Note: Data reflect only net vendor payments for which the county is billed for its computable share.

Table 10
State Fiscal Year 1993
Medicaid Service Expenditures by Eligibility Group

Eligibility Group		Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 1993 Expenditures Per Recipient	SFY 1992 Expenditures Per Recipient	Percent Change
Total Elderly	**$**	**818,001,108**	**33.4%**	**140,943**	**16.1%**	**$ 5,804**	**$ 5,122**	**13.3%**
Aged		757,492,420	31.0%	87,366	10.0%	8,670	7,171	20.9%
Medicare-Aid (MQBQ & MQBB)		60,508,688	2.5%	53,577	6.1%	1,129	972	16.2%
Total Disabled	**$**	**769,491,857**	**31.5%**	**89,165**	**10.2%**	**8,630**	**8,200**	**5.2%**
Disabled		759,408,603	31.0%	88,168	10.1%	8,613	8,197	5.1%
Blind		10,083,254	0.4%	997	0.1%	10,114	8,431	20.0%
Total Families & Children	**$**	**864,329,040**	**35.3%**	**644,828**	**73.7%**	**1,340**	**1,349**	**-0.6%**
AFDC Adults (> 21)		244,537,779	10.0%	164,169	18.8%	1,490	1,592	-6.4%
Medicaid Pregnant Women Coverage		97,599,481	4.0%	58,138	6.6%	1,679	1,951	-14.0%
AFDC Children & Other Children		363,005,764	14.8%	303,862	34.7%	1,195	1,039	15.0%
Medicaid Indigent Children		159,186,016	6.5%	118,659	13.6%	1,342	1,543	-13.1%
Aliens & Refugees	**$**	**2,847,792**	**0.1%**					
Adjustments Not Attributable To A Specific Category	**$**	**(8,678,921)**	**-0.4%**					
Total Service Expenditures All Groups	**$**	**2,445,990,876**	**100%**	**874,936**	**100%**	**$ 2,796**	**$ 2,701**	**3.5%**

Note: Total Service Expenditures does not include adjustments processed by DMA, settlements ($ <36,275,723>), HMO premiums ($5,408,453), State and County administrative costs ($100,492,862) and Disproportionate share costs ($320,719,000). These costs total $ 390,344,592 (See Table 6 for more details.)

Source: SFY 1993 Program Expenditure Report and 2082 Report (Alien & Refugee recipient count not reported this year).

Table 11

State Fiscal Year 1993

Service Expenditure For Selected Major Medical Services By Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ** Qualified Medicare Beneficiary	MQBB Part B Premium Only	Blind	Disabled	AFDC Adult	AFDC Child	Aliens & Refugees	Adjustments Unattributable To A Specific Category
Inpatient Hospital	$ 546,416,595	22.3%	$ 28,605,429	$ 7,184,302	$ -	$ 554,407	$ 180,791,234	$ 118,073,269	$ 215,995,417	$ 1,184,928	$ (5,972,391)
Outpatient Hospital	157,429,705	6.4%	10,083,760	9,120,868	-	200,800	35,817,969	50,593,248	51,420,250	193,531	(721)
Mental Hospital (> 65)	13,027,608	0.5%	12,912,868	48,930	-	21,397	40,488	-	-	3,925	-
Psychiatric Hospital (< 21)	20,980,885	0.9%	-	354	-	-	1,414,933	65,431	19,499,789	378	-
Physician	247,266,807	10.1%	17,749,064	11,965,995	-	270,188	49,401,802	79,197,328	89,808,283	801,058	(1,926,911)
Clinics	87,316,542	3.6%	2,385,059	3,091,205	-	95,721	22,913,730	24,265,055	34,563,148	92,518	(89,894)
Nursing Facility:					-						
Skilled Level	286,444,490	11.7%	246,787,370	191,753	-	950,730	37,746,850	84,682	732,343	82,242	(131,480)
Intermediate Level	261,930,539	10.7%	240,108,093	440	-	1,103,304	20,669,258	14,260	37,807	72,917	(75,540)
Intermediate Care Facility					-						
(Mentally Retarded)	289,275,339	11.8%	6,979,291	-	-	4,193,518	256,604,748	228,979	21,170,345	98,466	(8)
Dental	32,972,654	1.3%	2,511,198	2,570	-	34,074	5,285,242	11,605,510	13,408,020	136,380	(10,340)
Prescription Drugs	183,334,740	7.5%	67,993,818	-	-	739,249	58,751,290	25,931,922	30,048,858	65,643	(196,040)
Home Health	65,877,853	2.7%	8,793,240	154,912	-	614,103	31,666,418	3,578,557	21,440,217	13,096	(382,690)
CAP/Disabled Adult	46,051,324	1.9%	35,396,249	-	-	221,892	10,433,021	824	-	19	(681)
CAP/Mentally Retarded	15,332,885	0.6%	98,744	-	-	34,083	14,984,244	-	215,116	1,323	(625)
CAP/Children	1,714,017	0.1%	-	-	-	-	1,714,046	-	-	-	(29)
Personal Care	33,604,667	1.4%	22,978,706	(599)	-	520,307	9,215,688	476,188	432,291	-	(17,915)
Hospice	6,422,875	0.3%	2,318,444	-	-	12,401	3,753,417	248,665	90,620	-	(673)
EPSDT (Health Check)	11,143,217	0.5%	-	-	-	1,508	34,096	1,364	11,105,114	4,896	(3,761)
Lab & X-Ray	22,879,226	0.9%	1,409,463	1,105,799	-	33,527	7,320,953	8,534,885	4,446,417	35,703	(7,521)
Other Services	33,678,327	1.4%	2,596,989	915,968	-	28,871	3,307,935	19,032,772	7,757,452	57,798	(19,457)
Part A Premium	21,408,136	0.9%	20,666,712	489,733	-	238,906	2,123	-	-	-	10,662
Part B Premium	61,482,446	2.5%	27,117,923	25,878,882	357,576	214,268	7,539,118	204,321	20,293	2,971	147,094
HMO Premium	5,408,453	0.2%	-	-	-	-	-	-	-	-	-
Grand Total Services and Premiums	**$ 2,451,399,328**	**100%**	**757,492,420**	**60,151,112**	**357,576**	**10,083,254**	**759,408,603**	**342,137,260**	**522,191,780**	**2,847,792**	**(8,678,921)**

Note: Does not include adjustments processed by DMA, settlements, and state and county administrative costs.

* Percentages denoted with an * are less than .1%.

** Reflects expenditures for those who were eligible as QMBs at the end of the year. As a result, expenditures include more services than are available through QMB coverage. (Medicare covered services only.)

Source: SFY 1993 Program Expenditure Report and 2082 Report

Table 12
State Fiscal Year 1993
Expenditures For The Elderly

Type of Service	Aged	% of Service Dollars	MQBQ	MQBB Part B Premium Only	Total Qualified Beneficiaries	% of Service Dollars	Total Elderly Dollars	SFY 1993 % of Total Dollars	SFY 1992 % of Total Dollars	SFY 1991 % of Total Dollars
Inpatient Hospital	$ 28,605,429	3.8%	$ 7,184,302	$ -	$ 7,184,302	11.9%	$ 35,789,731	4.4%	7.5%	8.1%
Outpatient Hospital	10,083,760	1.3%	9,120,868	-	9,120,868	15.1%	19,204,628	2.3%	2.2%	1.8%
Mental Hospital (>65)	12,912,868	1.7%	48,930	-	48,930	0.1%	12,961,798	1.6%	2.4%	2.5%
Physician	17,749,064	2.3%	11,965,995	-	11,965,995	19.8%	29,715,059	3.6%	3.7%	3.4%
Clinics	2,385,059	0.3%	3,091,205	-	3,091,205	5.1%	5,476,264	0.7%	0.4%	0.4%
Nursing Facility:										
Skilled Level:	246,787,370	32.6%	191,753	-	191,753	0.3%	246,979,123	30.2%	34.0%	34.3%
Intermediate Level:	240,108,093	31.7%	440	-	440	0.0% *	240,108,533	29.4%	30.2%	29.4%
Intermediate Care Facility-										
Mentally Retarded	6,979,291	0.9%	-	-	-	0.0%	6,979,291	0.9%	0.9%	1.1%
Dental	2,511,198	0.3%	2,570	-	2,570	0.0% *	2,513,768	0.3%	0.3%	0.3%
Prescription Drugs	67,993,818	9.0%	-	-	-	0.0%	67,993,818	8.3%	9.1%	9.2%
Home Health	8,793,240	1.2%	154,912	-	154,912	0.3%	8,948,152	1.1%	1.2%	1.7%
CAP/Disabled Adult	35,396,249	4.7%	-	-	-	0.0%	35,396,249	4.3%	4.0%	4.1%
CAP/Mentally Retarded	98,744	0.0% *	-	-	-	0.0%	98,744	0.0% *	0.0% *	0.0% *
Personal Care	22,978,706	3.0%	(599)	-	(599)	0.0% *	22,978,107	2.8%	3.0%	2.9%
Hospice	2,318,444	0.3%	-	-	-	0.0%	2,318,444	0.3%	0.0% *	0.0% *
Lab & X-Ray	1,409,463	0.2%	1,105,799	-	1,105,799	1.8%	2,515,262	0.3%	0.3%	0.3%
Other Services	2,596,989	0.3%	916,322	-	916,322	1.5%	3,513,311	0.4%	0.8%	0.5%
Part A Premium	20,666,712	2.7%	489,733	-	489,733	0.8%	21,156,445	2.6%	-	-
Part B Premium	27,117,923	3.6%	25,878,882	357,576	26,236,458	43.4%	53,354,381	6.5%	-	-
HMO Premium	-	0.0%	-	-	-	0.0%	-	0.0%	-	-
Total Service & Premiums	**$ 757,492,420**	**100%**	**60,151,112**	**357,576**	**60,508,688**	**100%**	**818,001,108**			
Total Elderly Recipients	87,366		53,577				140,943			
Service Expenditures Per Recipient **	**$ 8,670**		**$ 1,129**		**$ 1,129**			**$ 5,804**	**$ 5,122**	**$ 4,996**

Note: Other Services include amounts from Psychiatric Hospital (<21), CAP-Children & Health Check Categories (See Table 11).

* Percentages denoted with an * are less than .1%.

** Service Expenditures/Recipient does not include adjustments, settlements and administrative costs.

Source: SFY 1993 Program Expenditure Report and 2082 Report

Table 13
State Fiscal Year 1993
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	SFY 1993 % of Total Dollars	SFY 1992 % of Total Dollars	SFY 1991 % of Total Dollars
Inpatient Hospital	$ 180,791,234	23.8%	$ 554,407	5.5%	$ 181,345,641	23.6%	24.7%	23.9%
Outpatient Hospital	35,817,969	4.7%	200,800	2.0%	36,018,769	4.7%	4.2%	3.5%
Psychiatric Hospital (<21)	1,414,933	0.2%	-	0.0%	1,414,933	0.2%	0.2%	0.2%
Physician	49,401,802	6.5%	270,188	2.7%	49,671,990	6.5%	6.0%	6.0%
Clinics	22,913,730	3.0%	95,721	0.9%	23,009,451	3.0%	1.0%	1.7%
Nursing Facility:								
Skilled Level:	37,746,850	5.0%	950,730	9.4%	38,697,580	5.0%	5.4%	5.6%
Intermediate Level:	20,669,258	2.7%	1,103,304	10.9%	21,772,562	2.8%	3.1%	3.2%
Intermediate Care Facility-								
Mentally Retarded	256,604,748	33.8%	4,193,518	41.6%	260,798,266	33.9%	35.9%	38.0%
Dental	5,285,242	0.7%	34,074	0.3%	5,319,316	0.7%	0.6%	0.6%
Prescription Drugs	58,751,290	7.7%	739,249	7.3%	59,490,539	7.7%	7.3%	6.8%
Home Health	31,666,418	4.2%	614,103	6.1%	32,280,521	4.2%	3.7%	4.1%
CAP/Disabled Adult	10,433,021	1.4%	221,892	2.2%	10,654,913	1.4%	1.4%	1.4%
CAP/Children	1,714,046	0.2%	-	0.0%	1,714,046	0.2%	0.2%	0.2%
CAP/Mentally Retarded	14,984,244	2.0%	34,083	0.3%	15,018,327	2.0%	1.7%	1.4%
Personal Care	9,215,688	1.2%	520,307	5.2%	9,735,995	1.3%	1.2%	1.0%
Hospice	3,753,417	0.5%	12,401	0.1%	3,765,818	0.5%	0.3%	0.2%
Lab & X-Ray	7,320,953	1.0%	33,527	0.3%	7,354,480	1.0%	0.9%	0.8%
Other Services	3,382,519	0.4%	51,776	0.5%	3,434,295	0.4%	2.2%	1.4%
Part A Premium	2,123	0.0% *	238,906	2.4%	241,029	0.0% *	-	-
Part B Premium	7,539,118	1.0%	214,268	2.1%	7,753,386	1.0%	-	-
HMO Premium	-	0.0%	-	0.0%	-	0.0%	-	-
Total Service & Premiums	**$ 759,408,603**		**10,083,254**		**769,491,857**			
Total Disabled/Blind Recipients	88,168		997		89,165			
Service Expenditures Per Recipient**	**$ 8,613**		**$ 10,114**			**$ 8,630**	**$ 8,200**	**$ 7,868**

Note: Other Services include amounts from Health Check and Mental Hospitals (>65) Categories (See Table 11).

* Percentages denoted with an * are less than .1%.

** Service Expenditures/Recipient does not include adjustments, settlements and administrative costs.

Source: SFY 1993 Program Expenditure Report and 2082 Report

Table 14
State Fiscal Year 1993
Expenditures for Families and Children

Type of Service	AFDC Adults	% of Service Dollars	Medicaid Pregnant Women	% of Service Dollars	AFDC Children & Other Children	% of Service Dollars	Medicaid Indigent Children	% of Service Dollars	Total Families & Children Dollars	SFY 1993 % of Total Dollars	SFY 1992 % of Total Dollars
Inpatient Hospital	$ 82,837,345	33.9%	$ 35,235,924	36.1%	$ 132,111,194	36.4%	$ 83,884,223	52.7%	$ 334,068,686	38.7%	42.1%
Outpatient Hospital	39,708,168	16.2%	10,885,080	11.2%	38,702,130	10.7%	12,718,120	8.0%	102,013,499	11.8%	11.0%
Psychiatric Hospital (<21)	17,584	0.0% *	47,847	0.0% *	18,903,544	5.2%	596,245	0.4%	19,565,220	2.3%	2.9%
Physician	51,312,103	21.0%	27,885,225	28.6%	61,705,067	17.0%	28,103,216	17.7%	169,005,611	19.6%	17.9%
Clinics	11,632,295	4.8%	12,632,760	12.9%	27,855,438	7.7%	6,707,710	4.2%	58,828,202	6.8%	3.4%
Nursing Facility:											
Skilled Level:	84,682	0.0% *	-	0.0%	722,453	0.2%	9,890	0.0% *	817,026	0.1%	0.2%
Intermediate Level:	14,260	0.0% *	-	0.0%	37,807	0.0% *	-	0.0%	52,066	0.0% *	0.0% *
Intermediate Care Facility-											
Mentally Retarded	228,979	0.1%	-	0.0%	20,919,257	5.8%	251,088	0.2%	21,399,325	2.5%	3.0%
Dental	11,203,344	4.6%	402,166	0.4%	11,357,802	3.1%	2,050,218	1.3%	25,013,530	2.9%	2.8%
Prescription Drugs	23,841,445	9.7%	2,090,477	2.1%	21,473,828	5.9%	8,575,030	5.4%	55,980,779	6.5%	5.7%
Home Health	3,185,481	1.3%	393,076	0.4%	11,831,231	3.3%	9,608,986	6.0%	25,018,774	2.9%	2.5%
CAP/Children	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0% *
Health Check - EPSDT	-	0.0%	1,364	0.0% *	6,295,829	1.7%	4,809,285	3.0%	11,106,478	1.3%	1.1%
Lab & X-Ray	6,469,326	2.6%	2,065,559	2.1%	3,590,372	1.0%	856,045	0.5%	12,981,302	1.5%	1.5%
Other Services	13,817,030	5.7%	5,941,421	6.1%	7,489,952	2.1%	1,005,527	0.6%	28,253,930	3.3%	5.9%
Part A Premium	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-
Part B Premium	185,738	0.1%	18,583	0.0% *	9,860	0.0% *	10,433	0.0% *	224,613	0.0% *	-
HMO Premium	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-
Total Service & Premiums	**$ 244,537,779**		**97,599,481**		**363,005,764**		**159,186,016**		**864,329,040**		
Total Families & Children Recipients	164,169		58,138		303,862		118,659		644,828		
Service Expenditures Per Recipient**	**$ 1,490**		**$ 1,679**		**$ 1,195**		**$ 1,342**			**$ 1,340**	**$ 1,349**

Note: Other Services include amounts from Mental Hospital (>65), CAP/Disabled Adult, CAP/Mentally Retarded, Personal Care Services & Hospice categories (See Table 11).

* Percentages denoted with an * are less than .1%.

** Service Expenditures/Recipient does not include adjustments, settlements, and administrative costs.

Source: SFY 1993 Program Expenditure Report and 2082 Report

Chart 4
State Fiscal Year 1993
Medicaid Service
Expenditures

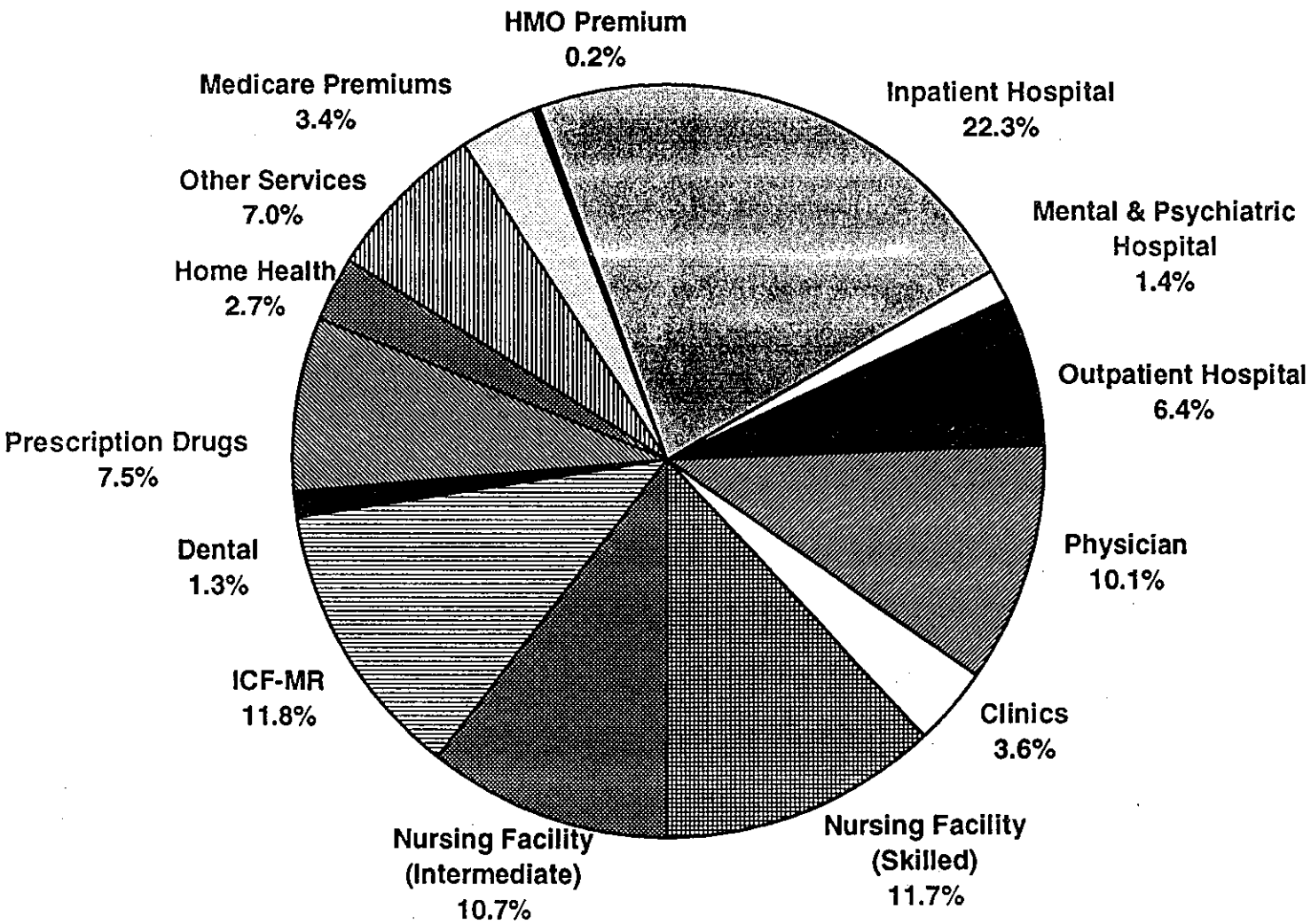


Chart 7 - Data
State Fiscal Year 1993
Service Expenditures, Percent Distribution

Demographic Data Service Expenditures	
By Eligibility Category	
• AFDC Related	24.8 %
• Aged	30.9 %
• Blind	.4 %
• Disabled	30.9 %
• Qualified Medicare Beneficiary	2.5 %
• Special Pregnant Women & Children	10.5 %
• Aliens & Refugees	0.1%
By Age Category	
• Ages 0-4	12.5 %
• Ages 5-20	12.7 %
• Ages 21-64	44.3 %
• Ages Over 65	31.4 %
By Gender	
• Female	64.0 %
• Male	36.0 %
By Race	
• White	58.3 %
• Black	39.1 %
• Other	2.6 %

Chart 8 - Data
State Fiscal Year 1993
Recipients, Percent Distribution

Demographic Data	
Recipients	
By Eligibility Category:	
• AFDC Related	53.5 %
• Aged	10.0 %
• Blind	.1 %
• Disabled	10.1 %
• Qualified Medicare Beneficiary	6.1 %
• Special Pregnant Women & Children	20.2 %
• Aliens & Refugees	N/A
By Age Category:	
• Ages 0-4	24.4 %
• Ages 5-20	28.7 %
• Ages 21-64	31.9 %
• Ages Over 65	15.0 %
By Gender:	
• Female	65.1 %
• Male	35.0 %
By Race:	
• White	47.6 %
• Black	48.4 %
• Other	4.0 %

Chart 9
State Fiscal Year 1993
Service Expenditures Per Recipient
by Selected Characteristics

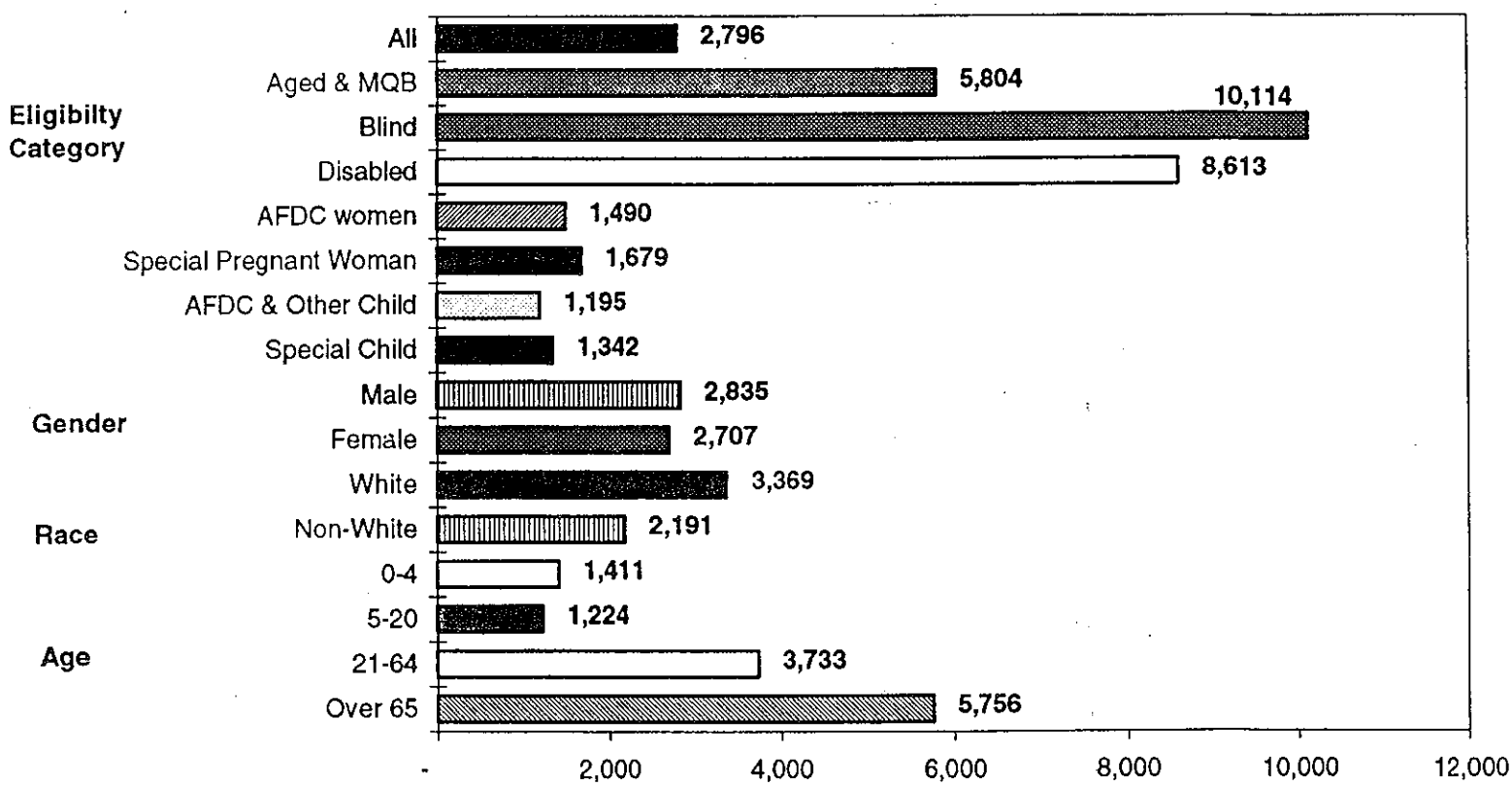
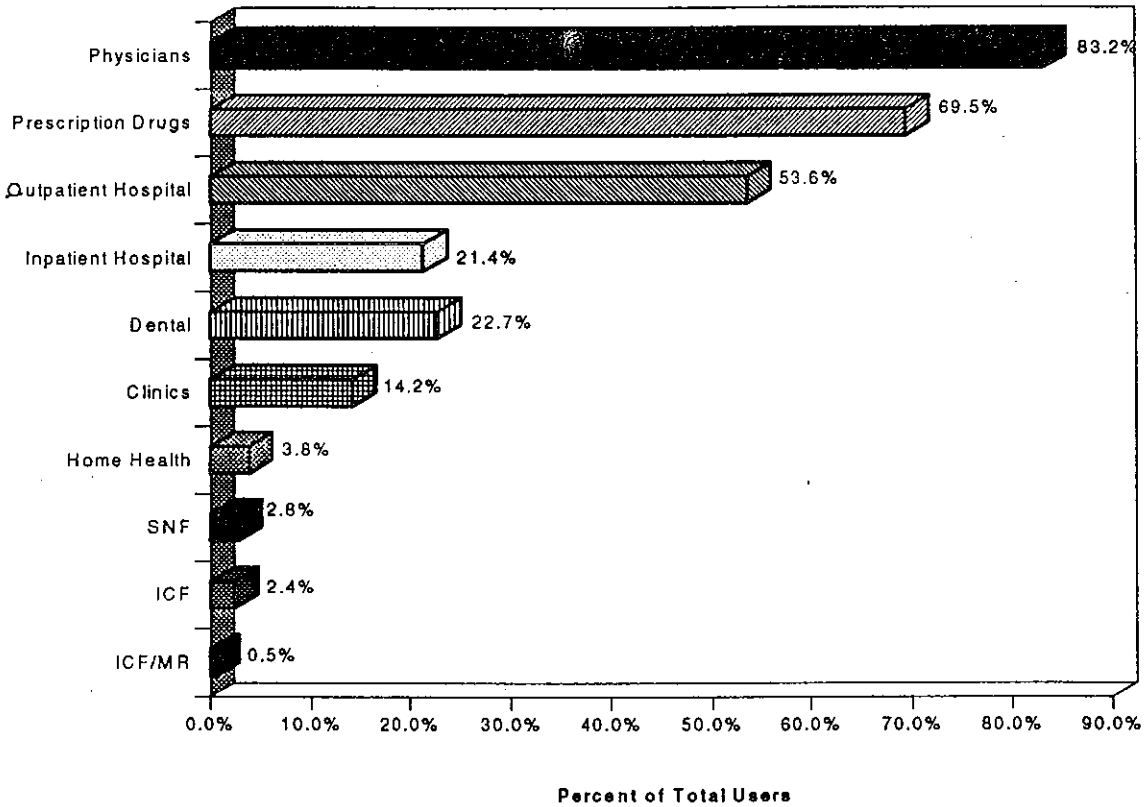
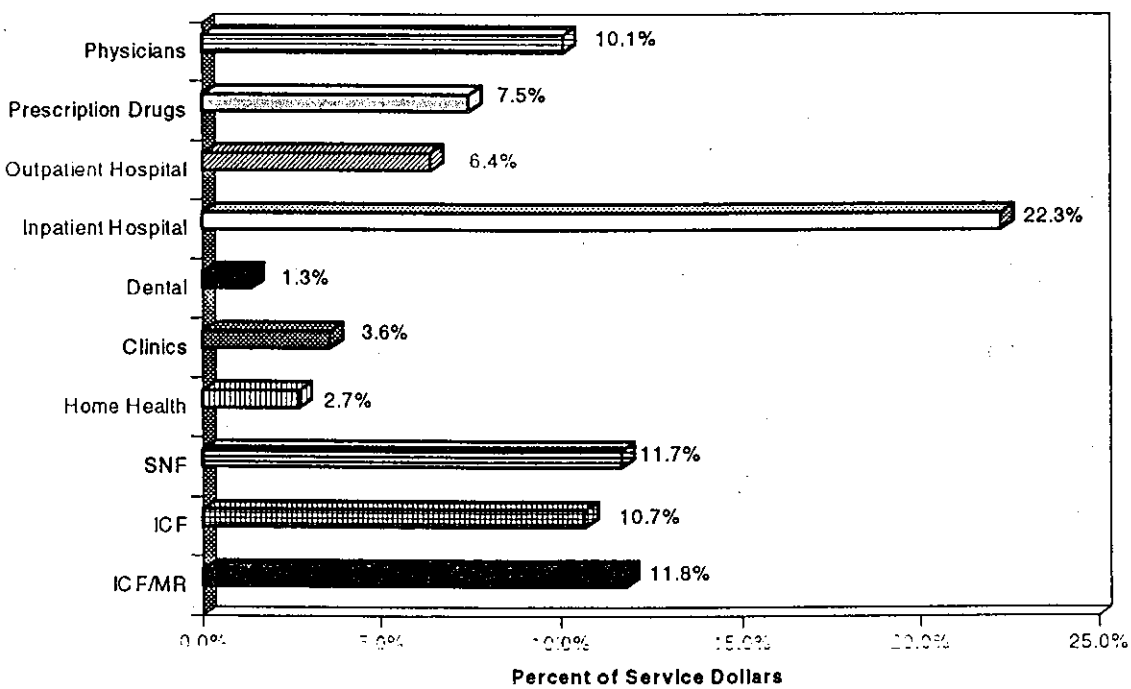


Chart 10, State Fiscal Year 1993
Selected Medicaid Services
Uses & Dollars, Percent





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