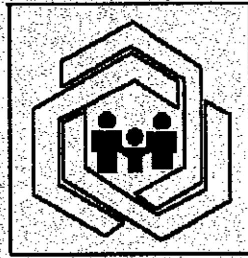

Medicaid in North Carolina
Annual Report
State Fiscal Year 1995

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

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

Barbara D. Matula, Director

May 1, 1996

Dear Fellow North Carolinians,

I am happy to present the Annual Report of Medicaid Services for State Fiscal Year 1995.

During this time period, the number of citizens who received Medicaid services exceeded one million people for the first time. A total of 1,068,907 people received benefits at some time during SFY 1995, which is an increase of over 112,000 from the previous fiscal year.

North Carolina continues to make strides in the managed care arena. A demonstration project has been started in Mecklenburg county that will be used to evaluate the capabilities of HMOs to provide comprehensive, quality services to Medicaid eligible individuals.

You are cordially invited to learn more about the Mecklenburg project and other North Carolina Medicaid programs and initiatives in this annual report.

Sincerely,

Barbara D. Matula

Barbara Matula

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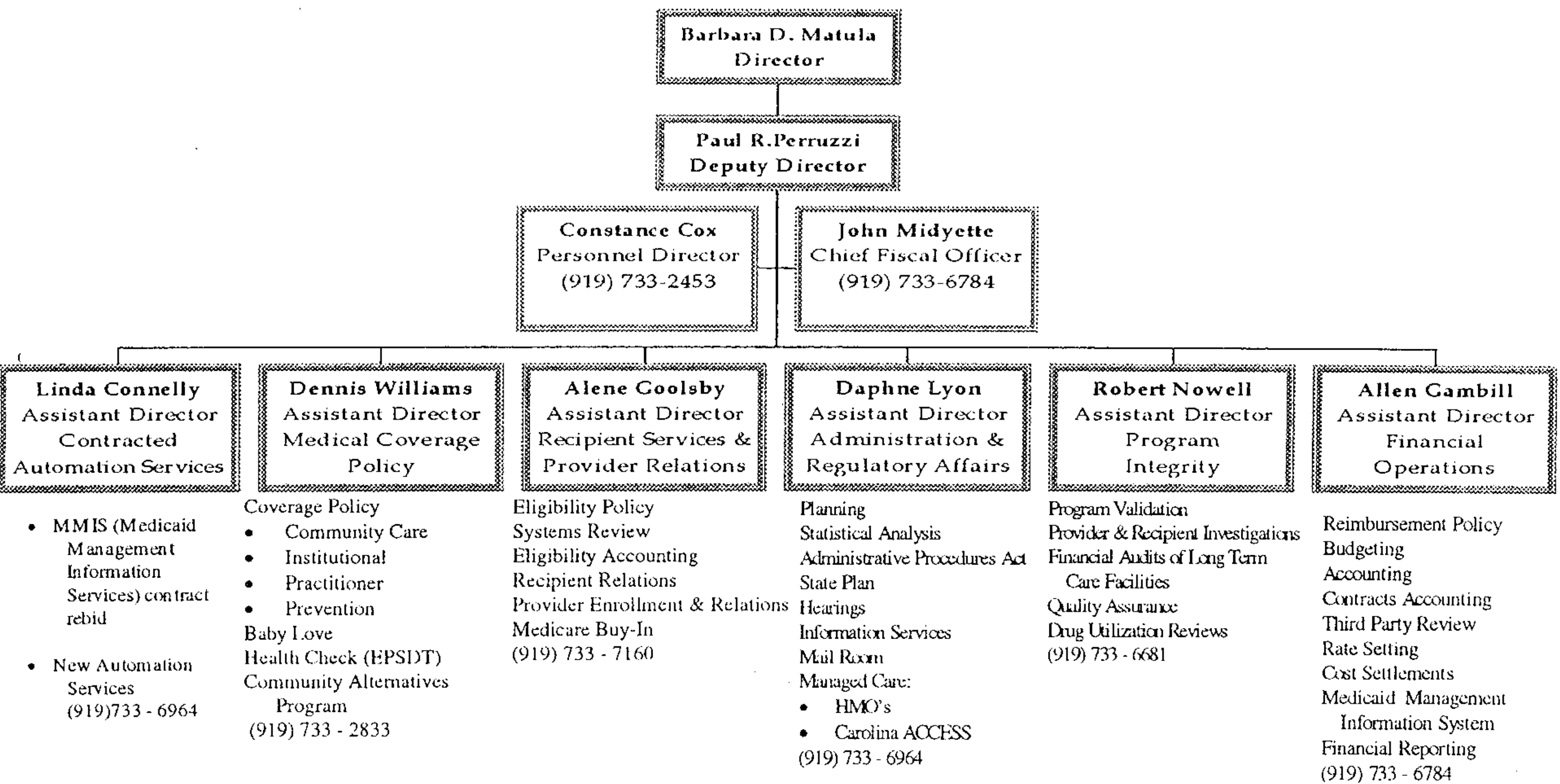

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Highlight's' of the 1995 State Fiscal Year

State Fiscal Year 1995
Medicaid Policy Changes in Brief

Effective Date	Policy Change
October 1, 1994	• The General Assembly authorized recovery of medical payments from the estates of deceased recipients who received nursing care in a facility or under CAP.
October 1, 1994	• The General Assembly expanded Medicaid coverage for children to age 19 in families whose income is below 100% of the Federal poverty level.
October 1, 1994	• The General Assembly expanded coverage to children placed in adoptive homes and who have special needs for medical care or rehabilitation.
January 1, 1995	• The General Assembly authorized Medicaid eligibility for Aged, Blind, and Disabled SSI recipients without a separate Medicaid application or spenddown of income (1634 Status).
January 1, 1995	• DMA implemented Diagnosis Related Group (DRG) reimbursement methodology implemented for acute care inpatient reimbursement.
January 1, 1995	• DMA expanded the number of individuals who may participate in the Community Alternatives Program for Disabled Adults (CAP/DA) to allow an additional 1,175 persons in the program during the year.
January 1, 1995	• DMA increased the number of children who may participate in eligibility for the Community Alternatives Program for Children (CAP/C) from 100 to 200.

Highlight's' of the 1995 State Fiscal Year

Effective Date	Policy Change
January 1, 1995	• DMA increased the number of individuals who may participate in the Community Alternatives Program for Persons with Mental Retardation/Development Disabilities (CAP-MR/DD) to allow an additional 950 persons in the program during the year.
April 1, 1995	• DMA implemented the universal American Dental Association (ADA) claim form for Medicaid Dental Billing and prior approval.
April 1, 1995	• DMA added Coverage of additional dental services under Medicaid for children.

Highlights of the 1995 State Fiscal Year

Medicaid is a central source of health care for North Carolina's most vulnerable citizens: aged, blind, disabled individuals, pregnant women, and low income families who cannot afford to pay their own health care expenses. The state fiscal year (SFY) extends from July 1, to June 30. In SFY 1995, Medicaid spent almost $ 3.6 billion for health care services for 1,138,786 North Carolinians. For 1995, this represents just over 16 percent of North Carolina's population. In SFY 1995, Medicaid was able to serve 7.5 percent more needy recipients than in the year before.

As in past years, the largest proportion (67.1 percent) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. The remainder, 32.9 percent was spent on care for low income families and children. About 28.7 percent of the service budget was spent on nursing facility care and on institutional care for the mentally retarded. The remainder was spent on other types of preventive and acute health care services for other eligible groups and for program administration.

Federal Actions

As Congressional leaders and the President tackled the serious issue of controlling the federal deficit and balancing the budget, Medicare and Medicaid became the most controversial topics in the discussions that have taken place. These programs were targeted because they consume such a large proportion of the federal budget and because the historical rates of expenditure growth far exceeded increases in revenues. But the debate went well beyond issues of budgets, and divergent philosophical opinions overtook the funding debate. The philosophical difference primarily involved whether Medicaid should remain a federal entitlement program with federal guidelines and oversight, or whether a block grant of federal funds should be given to the states and where all coverage decisions would be made.

Changes to Medicaid were not enacted during 1995 and the debate will surely continue in this election year, but nevertheless the attention devoted to the program made all states, including North Carolina, consider how Medicaid must change if it is to remain a health care safety net available for our most vulnerable citizens.

Managed Care

One strategy often proposed was to use Managed Care as a more cost efficient way to deliver quality care. Some states elected to move virtually their entire Medicaid populations into capitated managed care plans. Other states chose less extensive strategies, but most of them made some movement toward getting more Medicaid eligible people into Managed Care.

North Carolina's movement into Managed Care can best be described as cautious. Three specific strategies have been pursued:

- A primary care case management model called **Carolina ACCESS**,
- a prepaid plan for behavioral health called **Carolina Alternatives**, and
- an emphasis on contracting with licensed HMO's.

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 by July, 1995, expanded to 29 counties. There were 191,314 enrollees in Carolina ACCESS (as of July 1995).

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

Beaufort (3/92)	**Henderson (4/91)**
Buncombe (3/93)	**Jackson (1/95)**
Burke (9/91)	**Lee (12/94)**
Caldwell (12/92)	**Lenoir (7/94)**
Caswell (8/94)	**Madison (8/91)**
Chatham (12/94)	**Moore (4/91)**
Cleveland (9/94)	**Nash (8/91)**
Davidson (8/93)	**Onslow (10/94)**
Durham (4/91)	**Orange (11/93)**
Edgecombe (4/91)	**Person(6/95)**
Forsyth (2/93)	**Pitt (3/92)**
Greene (3/92)	**Scotland (11/93)**
Harnett (5/93)	**Surry (10/93)**
Haywood (11/92)	**Wake (3/94)**
	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 infants and 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 in 32 counties with an average of 114,596 participating children monthly. 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 Disabiliites, and Substance Abuse Services; North Carolina Foundation for Alternative Health Programs**; and **The Office of Rural Area Mental Health Programs** all collaborated to develop this program initiative.

Mecklenburg Project[1]

Currently under development is a project to be implemented in Mecklenburg County which will transition the Medicaid population in that county from fee-for-service to enrollment in HMO's. Some of the characteristics of this project are:

- **Standard Contract** - The Division will issue a standard risk-based contract.
- **Pre-Set Cap Rates** - Capitation rates will be pre-set for each distinct coverage group
- **Full Risk Contract** - The contract will cover most Medicaid services.
- **Mandatory Enrollment** - Most recipients not in long term care will be required to choose an HMO.
- **Open Enrollment** - All participating HMO's must enroll all recipients who choose their plan.
- **Any Willing HMO** - All HMO's licensed by the North Carolina Department of Insurance will be invited to contract.

The goals of the project are:

- Cost savings/stabilization
- Cost predictability
- Improved health outcomes through health plan accountability
- Improved access to appropriate health care
- Mainstreaming Medicaid recipients into the health care delivery system
- Maximizing the use of private sector resources in the delivery of quality health care

Additional Risk-Based Contracting

The Division intends to offer HMO options on a voluntary basis where feasible throughout the State. The contract offered in Mecklenburg County will become the model for full risk contracts elsewhere in the State.

Mortality/Child Health Initiatives

The need for preventive services and basic medical care for North Carolina's mothers and children is a continuing priority of the Medicaid program. Several times since 1987, the North Carolina General Assembly has authorized Medicaid to take advantage of options in federal law that expand coverage for pregnant women and children with family incomes up to varying percentages of the federal poverty level. For pregnant women and for infants under one year of age, the income limit to qualify for Medicaid is 185 percent of the federal poverty level.
See Table 2 in Appendix A for a description of 1995 Federal Poverty Level amounts. Pregnant women who qualify under the Baby Love program receive comprehensive maternity health care benefits for the duration of their pregnancy through the postpartum period. The infant automatically qualifies for program benefits and is enrolled in the Health Check program. This program provides for coverage of health screenings, immunizations, vision, hearing and dental check-ups on a regular basis. Participants are also eligible to receive medically necessary care to treat or ameliorate physical or mental conditions for identified problems.

States are required to provide coverage to children ages one to five in families with income below 133 percent of poverty. Also, Federal law mandates Medicaid

[1] This section is taken from the Mecklenburg Managed Care Project Document.

coverage for all children above age 6 and born after September 30, 1983 at 100% of poverty. The North Carolina General Assembly authorized the Division of Medical Assistance to take advantage of an option to cover children under 19 years of age at 100 % of the Federal poverty level. In SFY 1995, these initiatives helped 58,082 pregnant women and 146,791 children.

Improvements for Providers

Health care providers' willingness to serve Medicaid patients is critical to Medicaid's long term effectiveness. Since 1988, the North Carolina General Assembly has authorized a number of changes in Medicaid fees to increase patients' access to services, promote equity among providers and encourage cost effective patterns of care. Increases for some groups are designed to help compensate for years in the early 1980s when no increases were possible.

Most recently, a new physician payment system took effect on January 1, 1993. It is the most significant change in the way the Medicaid program pays physicians since the program began. This 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. Under this system, the fee schedule was developed based on a relative value scale (RVS) produced by a research team at Harvard University.

STATE FISCAL YEAR 1995

HIGHLIGHTS

MEDICAID BACKGROUND/HISTORY

IN

NORTH CAROLINA

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 also contribute to the non-federal share of costs. All states, the District of Columbia and some U.S. territories have Medicaid programs. Medicaid programs are governed by federal guidelines, but vary in eligibility criteria and covered services. In North Carolina, each county determines eligibility for Medicaid benefits.

North Carolina's program began in 1970 under the North Carolina Department of Social Services. A separate Division of Medical Assistance (DMA) was created within the Department of Human Resources in 1978. From 1978 to 1995, Medicaid expenditures grew from $307 million to $3.6 billion, and the count of people eligible for Medicaid grew from 456,000 to 1,138,786. During this time, DMA staff increased from 121 to 282 people. 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 1995, Medicaid state and local administration costs consumed just 3.5 percent of total program dollars. This is an increase of .3 percent over 1994 administrative costs. 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 separate 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). HCFA uses the most recent three year average per capita income for each state and the national per capita income in establishing this rate. The established federal matching rates for services are applicable to the federal fiscal year, which extends from October 1 to September 30. The state's fiscal year (SFY) runs from July through June. Because the federal and state fiscal years do not coincide, different federal service matching rates may apply for each part of the overlapped state fiscal year. The federal match rate for administrative costs does not change from year to year. Table 1 shows the federal matching rates fo for State Fiscal Year 1995... for state fiscal year 1995.

Table 1
State Fiscal Year 1995
Federal Matching Rates

Benefit Costs
(7/1/94 - 9/30/94)

Family Planning		All Other	
Federal	90.0%	Federal	65.14%
State	8.5%	State	29.63%
County	1.5%	County	5.23%

Benefit Costs
(10/1/94 - 6/30/95)

Family Planning		All Other	
Federal	90.0%	Federal	64.71%
State	8.5%	State	29.99%
County	1.5%	County	5.30%

Administrative Costs
(7/1/94 - 6/30/95)

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

*MMIS-Medicaid Management Information System

Funding Formula

The federal matching rate for Medicaid services varies from state to state based on per capita income. Nationwide, in SFY 1995, 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 nonfederal share. During SFY 1995, the federal, state and county shares of total expenditures were approximately 65 percent, 30 percent, and 5 percent, respectively.

Eligibility

Medicaid benefits are available for certain categories of people specified by law, and is based on specific 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 governmental assistance programs or who are specially authorized by law to receive benefits. These include:

- Recipients of Aid to Families with Dependent Children (AFDC) payments, foster care and adoption assistance (Title IV-E) payments, SSI (Supplemental Security Income) payments, state and 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 or persons who are blind or disabled (as defined by the federal Social Security Administration criteria) who qualify for Medicare Part A and have income and assets below federal standards.

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 to become eligible for coverage. Beginning January 1, 1995. North Carolina SSI recipients automatically qualify for Medicaid benefits without any additional financial tests.

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 in Appendix A: "Qualified Medicare Beneficiaries".)

Medicaid pays only the Part B Medicare premium for individuals who meet the requirements for Medicare-Aid except their income is above the Medicare-Aid limit.

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 couple's income when the other spouse requires nursing home care. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The total income and resources amount which may be protected for the at-home spouse increases each year. (See Table 2.) As of January 1, 1996, the amount of annual income that can be protected ranges from a minimum of $15,048 to a maximum of $23,028. The resource protection limit ranges from a minimum amount of $14,548 to a maximum amount of $76,740.

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

How the Program Works

Medicaid operates as a vendor provider payment program. Eligible families and individuals are issued a Medicaid identification card each month. Program eligibles may receive medical care from any of the 38,015 providers who are currently enrolled in the program. Providers then bill Medicaid for their services. In 1995, 16,311 Medicaid providers billed North Carolina Medicaid for services rendered. Table 3 on the following page 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 3
State Fiscal Year 1995
Enrolled Medicaid Providers

Providers	SFY 1995
Physicians*	23,929
Dentists	3,098
Pharmacists	2,345
Optometrists	1,026
Chiropractors	801
Podiatrists	361
Ambulance Companies	261
Home Health Agencies**	160
Durable Medical Equip. Suppliers	138
Intermediate Care Facilities-MR	309
Hospitals	194
Mental Health Clinics	151
Nursing Facilities	417
Optical Supplies Company***	1
Personal Care Agencies	342
Rural Health Clinics	96
Nurse Midwives	19
Hospices	64
CAP Providers	351
Other Clinics	58
Other	3,894
Total	**38,015**

* 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. Some of these are:

EDS Corporation -- DMA contracts with EDS to perform many of Medicaid's administrative functions. Currently, 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 $13 million in SFY 1995. EDS processed 49,642,713 Medicaid claims during SFY 1995, an increase of 9,615,770 over SFY 1994. The primary cause for the increase in processed claims was the increase in Medicaid eligibles in North Carolina during 1995.

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 an additional year was negotiated. The contract has been extended through June 30, 1998.

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) -- DMA contracts with First Mental Health to conduct preadmission and concurrent stay reviews of inpatient psychiatric admissions for children under age 21. They also review the medical necessity for inpatient

psychiatric care for children under age 21. Preadmission and post discharge reviews are required under this contract. 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 Classic Optical from January 1, 1995 through December 31, 1996.

Audit Contract - DMA Accounting contracts with two private firms to conduct on-site compliance audits of nursing facilities and intermediate care for therapy mental retardation facilities (ICF-MR) enrolled in the program. These audits supplement DMA's in-house audit activities and verify the accuracy of the providers' cost reports.

In addition, DMA contracts with BCBS of Tennessee to perform Medicaid settlement activities for rural health clinics, and with BCBS of North Carolina to perform Medicaid settlement activities for hospitals and state-operated ICF-MRs.

Cooperative Arrangements

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

Counties - The Department of Social Services in each of North Carolina's 100 counties have the central role in determining Medicaid eligibility for their residents. In addition, counties contribute approximately 5.2 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 by the person making the application. A disability determination unit of the state's DSS office ascertains whether or not a disabled individual is eligible for Medicaid 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. Many services provided by the community mental health centers are covered by Medicare. The Community Alternatives Program is a pre-paid capitation plan in which DMA pays a monthly capitation fee to DMH/DD/SAS for mental health and substance abuse services of Medicaid eligible children. See the "Special Programs" section on page 19 for more details. 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 Health Promotion in DEHNR - DMA and the Division of 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 the Division of 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 many 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 aide services.

Division of Facility Services (DFS) -- DFS has the 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 if they reside in a long term care facility.

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 and is discussed in more detail in the "Special Programs" section of this report.

Department of Public Instruction(DPI) -- The Individual with Disabilities Education Act (IDEA) is the federal law requiring education related services to pre-school and school aged children with handicapping conditions. DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, for example, speech, physical, and occupational therapy.

Office of Rural Health and Resource Development -- The ORHRD and DMA in collaboration with the North Carolina Pediatric Society, Academy of Family Physicians, and the Society of Internal Medicine, have established a foundation call the Generalist Physician's Medicaid Assistance Program (GPMAP). The function of GPMAP is to recruit primary care physicians to accept Medicaid eligible children for screening and treatment. The impact of this effort has shown that in SFY 93, Health Check screenings were provided by 1,391 primary care physicians. The number of physicians providing these screenings increased to 1,876 in SFY 1994 and 2,279 in SFY 1995.

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 in Appendix A which lists Medicaid services for SFY 1995) 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, participants in the Community Alternatives Program(CAP), and other selected groups.

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

Rate Setting

Prospective payment rates and fee schedules are very important in controlling Medicaid 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 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 Integrity

DMA's program integrity efforts are designed to promote program efficiency and effectiveness. The following are some of the specific efforts toward that goal.

Medicaid Eligibility Error Rate Reduction

The Quality Assurance (QA) Section of DMA has the responsibility of monitoring the accuracy rate of eligibility determinations made by the Department of Social Services in each of North Carolina's. The QA staff conducts both federally mandated quality control reviews and state designed targeted reviews. This review process looks both at active and denied cases. Corrective actions are taken whenever appropriate. 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.

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.

Quality Improvement Efforts -- 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
- evaluating the medical claims processing procedures for accuracy and improvement.

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

Below is a summary of activities for State Fiscal year 1995:

	State Fiscal Year 1995
Provider Activities:	
***Reviews**	**3,945**
***Collected**	**$ 2,558,124**
Recipient Activities:	
***Reviews**	**1,232**
***Collected**	**$ 271,532**
Long Term and Primary Health Care Activities:	
***Audits**	**637**
***Collected**	**$11,954,672**

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.
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 planned care 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 1995, insurance coverages and refunds from a variety of sources defrayed Medicaid expenditures.

Insurance paid on patients' behalf amounted to $71,279,876. An additional $91,811,114 in Medicaid claims was denied because other insurance was thought to be available to pay for client services.

Medicaid received refunds from:

• Medicare	$ 1,367,667.00
• Health Insurance	7,967,922.00
• Casualty Insurance	6,421,499.00
• Absent Parent	136,650.00

Medicaid policy is designed to avoid costs that otherwise would be incurred. In SFY 1995, $793,086,861 in Medicaid expenditures were saved by the policy that requires Medicare to be the primary payer when a person is eligible for both Medicare and Medicaid.

MEDICAID IN DEPTH

Medicaid offers a comprehensive array of services for program eligibles. Federal law requires coverage of some services but state's can elect to cover other service options. All services must be determined to 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 1995.

State Fiscal Year 1995
Medicaid Copayment Amounts

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

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

- Family planning services
- Services to pregnant women
- Community Alternative Program services
- Services to children under age 21
- Services for nursing facility residents and mental hospital patients
- Hospital emergency room services

The state has also elected to exempt the following services (or groups) from copayments:

- Any services to Community Alternatives Program (CAP) participants
- Rural health clinic services
- Non-hospital dialysis treatments
- State-owned mental facility coverage
- 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 mandatory services are provided for Medicaid recipients in North Carolina:

Inpatient Hospital Services --
Medicaid covers hospital inpatient services without a limitation on the length of stay. Selected inpatient procedures require preadmission certification to ensure that the stay is medically necessary and that the procedure is most appropriately performed in an inpatient rather than an outpatient setting. Special restrictions apply to abortions, hysterectomies and Sterilizations. Beginning January 1, 1995, Hospital services are paid on the basis of diagnostic related groupings (DRG's). Prior to this time, hospital inpatient services were 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 which have no limits. A $3.00 per visit copayment applies except for certain exempt groups and services. Hospital outpatient services are paid to the

provider 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 mandatory for recipients aged 21 and older. The state also has chosen a federal option to cover these services for those under age 21. Patients must be certified by a physician to require nursing facility care and be approved by Medicaid prior to admission. Nursing facility services are paid on 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 certain exempt groups 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 as a basis for physician service reimbursement.

Home Health Services -- Medicaid covers all services normally provided through a home health agency, including visiting nurse services and in home therapies. Patients must be home-bound and services furnished under an approved plan of treatment. 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 -- The Health Check (EPSDT) program provides child health examinations as well as necessary diagnosis and treatment. Also, referral for treatment of health problems detected during the screening of a Medicaid recipient 20 years of age or younger is offered. Most Health Check services do not count toward the annual 24 outpatient 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" on page 17.

Family Planning Services -- Medicaid covers family planning 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 particular service.

Federally Qualified Health Centers and Rural Health Centers -- Certain clinics which meet federal requirements are designated as Federally Qualified Health Centers (FQHCs) or Rural Health Centers (RHCs). Services provided by these facilities are not subject to copayments. FQHCs and RHCs are reimbursed their full costs as required by federal law.

Durable Medical Equipment -- Durable medical equipment suitable for use in the home is reimbursed via a fee schedule.

Nurse Midwife Services -- Nurse midwives practicing in accordance with state law are reimbursed at the same rates as physicians for those services they are authorized to perform.

Medical Transportation -- The federal requirement for coverage of transportation to medical care facilities is meet in three ways:

1. Medically necessary Ambulance transportation is a covered benefit.
2. County departments of social services establish a local transportation network which may range from providing bus tokens to using county

employees in county owned vehicles to transport Medicaid recipients. Federal and state funds are then used to match the county expenditure. These county transportation costs may be billed as a benefit cost or as an administrative cost, depending on how the service is delivered. See Table 1 on page 2 for the matching ratios.

3. Residents of nursing facilities and adult care facilities receive transportation (other than Medically necessary ambulance services) from the facilities in which they reside. Medicaid makes a per diem payment to the facility on behalf of each Medicaid eligible resident in order to reimburse the nursing facilities for these transportation costs.

Optional Services

Federal law permits States to cover additional services at their option. 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. The following are optional services North Carolina Medicaid covers:

Intermediate Care Facilities for the Mentally Retarded (ICF-MR) -- Services in ICF-MRs are covered for those who are mentally retarded or who have a related condition. ICF-MR facilities 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 personal aide services in private residences to perform personal care tasks for patients who, due to a debilitating medical condition, need help with such basic personal activities such 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 basic personal 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. During the 1995 legislative session, coverage of personal care services to persons living in adult care homes was authorized to begin in SFY 1996.

Prescription Drugs -- Medicaid covers most prescription drugs as well as insulin for diabetic patients. Drug coverage is limited to six prescriptions per month unless it is shown that additional medication 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 certain exempt groups. Payment for drugs is based on the average wholesale price less 10% plus a $5.60 dispensing fee. The dispensing fee is paid once a month.

Dental Services -- Most general dental services are covered, such as exams, cleaning, fillings, x-rays and dentures. Additional services are covered for children eligible under the Health Check Program. Prior approval is required for some 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 covers corrective lenses, eyeglasses, and other visual aids. Prior approval is required for some optical services, all visual aids, and frequency of visit 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 for new eyeglasses and eyeglass repairs. Copayments do not apply to certain exempt groups.

Medicaid contracts with Classic Optical - Youngstown, Ohio to provide eyeglasses at predetermined rates. The contract was awarded through a competitive bid process and is re-bid ever two years. Providers must obtain eyeglasses through this organization unless extenuating circumstances exist. In such cases, an exception is made to permit a provider to supply lenses or frames.

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 outpatient limit. Area Program centers are paid a negotiated rate, not to exceed costs, for services.

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

Payment is made on a fee schedule basis for outpatient visits. Inpatient state and private mental hospital services are covered for recipients over age 64 or under age 21. Payments to psychiatric hospitals are 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 for the Medicaid client with the expectation that the health screening will prevent serious illness through early detection and treatment of illnesses. Certain components of a health assessment must be included to qualify for payment. The screening applies toward the annual 24 visit outpatient 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 this program.

Other Optional Services -- A variety of other optional services are provided by North Carolina 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 Medicaid eligible 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) has been developed. Additionally, the Baby Love Maternal Outreach Worker Project, funded by the Kate B. Reynolds Health Care Trust and Medicaid was implemented. In this program, 24 health agencies initiated pilot 'home visiting' programs. Maternal Outreach Workers deal 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, **forty-one** 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. Health Check provides child health examinations to detect problems early, and includes the diagnosis, treatment, and physician referral to correct any health problems that are identified. In addition to paying for services, Health Check attempts 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 continued into 1995 to help improve the availability and accessibility of comprehensive and continuous preventive 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.
- Expansion of coverage for specialized services.

Additionally, effective October 1, 1994 Medicaid expanded coverage to children ages 12 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 services.

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 population groups. 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. By the end of the fiscal year, ninety-one counties offered CAP/DA and the remaining nine counties had made a commitment to begin the program. Funding from the Kate B. Reynolds Charitable Trust through the Duke University Long Term Care Resources Program was instrumental in expanding CAP/DA statewide. The program served approximately 6,780 in SFY 1995 at less than 70 percent of the cost of nursing facility care.

The Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (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 area programs. CAP-MR/DD served 1,902 individuals in SFY 1995. Participants in the CAP-MR/DD were served at less than 25 percent of the average Medicaid cost for institutional care.

The Community Alternatives Program for Children (CAP/C) provides cost-effective home care for medically fragile children (through age 18) who would otherwise require long term hospital care or nursing facility care. During SFY 1995, this statewide program was expanded to serve all Medicaid-eligible children. There were 51 children who participated in CAP/C in SFY 1995.

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 their 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, Medicare supplemental insurance premiums and coinsurance charges.

In fact, 70,336 Medicare recipients benefited from Medicare-Aid in SFY 1995. The eligibility income limit for Medicare-Aid is 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 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 about common drug therapy problems with the goal of improved prescribing and dispensing practices.

In SFY 1995, the Drug Use Review Program began using a Provider Profiling System to complement the retrospective patient-based drug utilization reviews. This system is designed to be a retrospective characterization of drug use patterns. The Provider Profiling System identifies any prescribing and dispensing practices which deviate from accepted norms. These norms may be defined by the Board, taken from published literature, or manipulated as needed. The Provider Profiling System is criteria driven and accommodates client-specific criteria within any of 12 broad problem types.

Since the primary focus of the DUR Program is educating providers about common drug therapy problems to improve prescribing and dispensing practices, the providers who are profiled receive educational letters with profiles of each recipient who receives the medication and prescribing information related to the patient's drug therapy.

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, occupational therapy, audiological services, speech/language services, and psychological services provided in the public school system by local education agencies or through local Head Start Programs who are enrolled with the Medicaid program. These services are provided to Medicaid eligible children who receive special education or related services.

Independent Practitioner Program

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, respiration 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) service. 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 nursing facility (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 have their condition reassessed annually.

- Nursing facilities must conduct a comprehensive assessment of each resident to determine the level of 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.

1995 TABLES and CHARTS

APPENDIX A
MEDICAID TABLES

Table 1
State Fiscal Year 1995
Federal Matching Rates

Benefit Costs
(7/1/94 - 9/30/94)

Family Planning		All Other	
Federal	90.0%	Federal	65.14%
State	8.5%	State	29.63%
County	1.5%	County	5.23%

Benefit Costs
(10/1/94 - 6/30/95)

Family Planning		All Other	
Federal	90.0%	Federal	64.71%
State	8.5%	State	29.99%
County	1.5%	County	5.30%

Administrative Costs
(7/1/94 - 6/30/95)

	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 1995
Medicaid Financial Eligibility Standards

Eligibilty Income Levels
(Annual)

Family Size	* AFDC Related * Groups Categorically Needy	Medically Needy	Aged, Blind & Disabled: All Groups	Pregnant Women nfants < 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	13,824	9,936	7,476	7,476	7,476 - 8,964	Minimum of $15,048	14,952
2	5,664	3,804	3,804	18,564	13,344	10,032	10,032	10032 - 12036	up to a Maximum of	20,064
3	6,528	4,404	N/A	23,292	16,752	12,600			$22,452	
4	7,128	4,800	N/A	28,032	20,160	15,156				
5	7,776	5,196	N/A	32,772	23,556	17,712				

Eligibility Resource Limits

Family Size	Categorically Needy	Medically Needy	Aged, Blind & Disabled	Pregnant Women / Infants	Children Ages 1-5	Children Age 6 & Over	Qualified Medicare Beneficiaries	Specified Low-Income Medicare Beneficiaries	"Spousal Impoverishment" Beneficiaries	Qualified Disabled Working Individual
1	$1,000	$1,500	$2,000	NO	RESOURCE	TEST	$4,000	$4,000	$14,964 minimum	$4,000
2	No increment	2,250	3,000		APPLIES		6,000	6,000	$72,820 maximum	6,000
3	for family size	2,350	N/A							
4		2,450	N/A							
5		2,550	N/A							

Source: Income & Reserve Levels (REV. 6/95)

Table 3
State Fiscal Year 1995
Enrolled Medicaid Providers

Providers	SFY 1995
Physicians*	23,929
Dentists	3,098
Pharmacists	2,345
Optometrists	1,026
Chiropractors	801
Podiatrists	361
Ambulance Companies	261
Home Health Agencies**	160
Durable Medical Equip. Suppliers	138
Intermediate Care Facilities-MR	309
Hospitals	194
Mental Health Clinics	151
Nursing Facilities	417
Optical Supplies Company***	1
Personal Care Agencies	342
Rural Health Clinics	96
Nurse Midwives	19
Hospices	64
CAP Providers	351
Other Clinics	58
Other	3,894
Total	**38,015**

* 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.

Table 4
State Fiscal Year 1995
Medicaid Services

1 Ambulance Transportation
2 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
3 Chiropractors
4 Clinic Services
5 Community Alternatives Programs (CAP)
6 Dental Care Services
7 Durable Medical Equipment
8 Health Check Services (EPSDT)
9 Family Planning Services
10 Hearing Aids (for children)
11 Home Health Services
12 Home Infusion Therapy Services
13 Hospice
14 Inpatient & Outpatient Hospital Services
15 Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
16 Laboratory & X-Ray Services
17 Mental Hospitals (age 65 & over)
18 Migrant Health Clinics
19 Nurse Midwives
20 Nurse Practitioners
21 Nursing Facilities (NF)
22 Optical Supplies
23 Optometrists
24 Personal Care Services
25 Physicians
26 Podiatrists
27 Prepaid Health Plan Services
28 Prescription Drugs
29 Private Duty Nursing Services
30 Prosthetics and Orthotics (children)
31 Rehabilitative Services: (under the auspices of area mental health programs)
32 Rural Health Clinics
33 Specialty Hospitals
34 Transportation

Table 5
State Fiscal Year 1994 & 1995
Sources of Medicaid Funds

		1994		1995
Federal	$	2,105,307,078	$	2,221,867,100
State Appropriated	$	788,493,250	$	942,583,866
State, Other	$	489,380,613	$	198,086,742
County	$	166,918,436	$	187,930,522
Total	**$**	**3,550,099,377**	**$**	**3,550,468,230**

Source: DAS report

Table 6
State Fiscal Year 1995
Uses of Medicaid Funds

Type of Service	Total Expenditures	Percent of Total Dollar	Percent of Service Dollar	Users of Services*	Cost Per Service User
Inpatient Hospital	602,289,541	17.0%	19.5%	185,746	3,243
Outpatient Hospital	197,350,933	5.6%	6.4%	518,071	381
Mental Hospital >65 & <21	30,684,349	0.9%	1.0%	2,340	13,113
Physician	308,497,976	8.7%	10.0%	859,156	359
Clinics	142,276,713	4.0%	4.6%	212,072	671
Nursing Facility (Skilled)	355,761,200	10.0%	11.5%	27,172	13,093
Nursing Facility (Intermediate)	322,671,839	9.1%	10.4%	23,365	13,810
ICF-MR	339,722,311	9.6%	11.0%	4,970	68,355
Dental	37,814,255	1.1%	1.2%	223,101	169
Prescription Drugs	254,399,563	7.2%	8.2%	727,931	349
Home Health	92,538,103	2.6%	3.0%	48,699	1,900
Other Services	267,225,022	7.5%	8.6%	1,386,229	193
Medicare Premiums:					
(Part A, Part B, QMB, Dually Elig	131,245,574	3.7%	4.2%		
HMO Premium	8,618,565	0.2%	0.3%		
Subtotal Services	**3,091,095,944**				
Adjustments & Cost Settlements	93,044,363	2.6%			
Disproportionate Share Payments	242,192,743	6.8% **			
Subtotal Services & Other	**$ 3,426,333,050**	**96.5%**			
Administration (State & County)	124,135,180	3.5%			
(State)	53,857,082	1.5%			
(County)	70,278,098	2.0%			
Grand Total Expenditures	**$ 3,550,468,230**	**100.0%**			
Total Recipients (unduplicated)***				**1,068,939**	
Total Expenditures Per Recipient (unduplicated)					**$ 3,321**

* "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.

NOTE: Numbers may not add due to rounding.
SOURCE: SFY 1995-2082 report, SFY 1995-DAS report, SFY 1995-PER report

Table 7
SFY 1979-1995
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%
1995		3,550,468,230	0%

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

SOURCE: DAS Report - SFY

Table 8
State Fiscal Years 1979-1995
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	0.60%
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	459,364	0.80%
1981-82	70,010	N/A	2,349	48,266	298,483	N/A	N/A	6,125	N/A	425,233	-7.40%
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	N/A	415,552	-2.30%
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	N/A	407,806	-1.90%
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	N/A	414,353	1.60%
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	N/A	441,930	6.70%
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	N/A	452,025	2.30%
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	N/A	481,326	6.50%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561	561,614	16.70%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	1,011	639,351	13.80%
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	1,675	753,292	17.80%
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	1,955	877,923	16.50%
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	2,437	992,697	13.10%
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	2,330	1,058,603	6.60%
1994-95	127,514	48,373	2,716	155,215	533,300	48,115	216,888	3,808	2,857	1,138,786	7.60%
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%	
SFY 1995 Percent Total Eligibles:	11.2%	4.2%	0.2%	13.6%	46.8%	4.2%	19.0%	0.3%	0.3%	100.0%	

* Aged, QMB, Blind, Disabled are adjusted figures for 1995.

Source: Medicaid Eligibilty Report, SFY 1994, SFY 1995

Table 9
State Fiscal Year 1995
Total Expenditures and Eligibles by County

COUNTY NAME	1994 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	% of Eligibles on Medicaid by county, based on 1994 population (Column C / Column B)
ALAMANCE	113,670	14,353	$ 46,685,762	$ 3,253	$ 410.71	74	126	12.63%
ALEXANDER	29,649	3,791	10,361,350	2,733	349.47	87	128	12.79%
ALLEGHANY	9,610	1,448	5,357,714	3,700	557.51	39	151	15.07%
ANSON	24,009	5,955	18,351,372	3,082	764.35	9	248	24.80%
ASHE	22,924	4,102	14,088,218	3,434	614.56	27	179	17.89%
AVERY	15,070	2,765	10,549,307	3,815	700.02	15	183	18.35%
BEAUFORT	43,237	9,757	26,645,175	2,731	616.26	26	226	22.57%
BERTIE	20,498	6,139	15,996,638	2,606	780.40	7	299	29.95%
BLADEN	29,478	8,106	22,651,030	2,794	768.40	8	275	27.50%
BRUNSWICK	58,518	11,406	32,903,068	2,885	562.27	38	195	19.49%
BUNCOMBE	185,810	28,006	85,588,045	3,056	460.62	60	151	15.07%
BURKE	79,646	11,626	36,232,179	3,116	454.92	63	146	14.60%
CABARRUS	107,216	13,227	42,259,968	3,195	394.16	79	123	12.34%
CALDWELL	73,079	10,579	35,138,523	3,322	480.83	55	145	14.48%
CAMDEN	6,221	982	2,554,993	2,602	410.70	75	158	15.79%
CARTERET	56,624	8,223	23,484,687	2,856	414.75	73	145	14.52%
CASWELL	21,221	3,923	11,452,541	2,919	539.68	43	185	18.49%
CATAWBA	123,913	15,553	42,207,254	2,714	340.62	91	126	12.55%
CHATHAM	41,959	4,840	16,900,924	3,492	402.80	76	115	11.54%
CHEROKEE	21,452	4,862	13,702,146	2,818	638.74	23	227	22.66%
CHOWAN	13,993	3,527	9,605,049	2,723	686.42	18	252	25.21%
CLAY	7,564	1,419	4,168,946	2,938	551.16	40	188	18.76%
CLEVELAND	87,766	15,610	39,168,155	2,509	446.28	67	178	17.79%
COLUMBUS	51,000	15,783	41,961,414	2,659	822.77	2	309	30.95%
CRAVEN	84,410	15,278	38,813,968	2,541	459.83	61	181	18.10%
CUMBERLAND	291,849	46,731	90,497,720	1,937	310.08	95	160	16.01%
CURRITUCK	15,402	2,470	5,030,427	2,037	326.61	93	160	16.04%
DARE	24,804	2,570	7,808,396	3,038	314.80	94	104	10.36%
DAVIDSON	134,802	17,413	46,561,349	2,674	345.41	89	129	12.92%
DAVIE	29,336	3,104	10,543,569	3,397	359.41	85	106	10.58%
DUPLIN	41,990	9,890	25,317,030	2,560	602.93	31	236	23.55%
DURHAM	191,148	28,072	84,069,000	2,995	439.81	68	147	14.69%
EDGECOMBE	56,372	16,776	39,417,395	2,350	699.24	16	298	29.76%
FORSYTH	276,172	37,700	104,812,629	2,780	379.52	84	137	13.65%
FRANKLIN	40,417	7,541	24,683,497	3,273	610.72	29	187	18.66%
GASTON	177,902	28,510	82,283,777	2,886	462.52	59	160	16.03%
GATES	9,740	1,847	5,155,562	2,791	529.32	44	190	18.96%
GRAHAM	7,420	1,838	5,130,429	2,791	691.43	17	248	24.77%
GRANVILLE	40,479	6,213	19,289,025	3,105	476.52	56	153	15.35%
GREENE	16,396	3,321	9,312,962	2,804	568.00	34	203	20.25%
GUILFORD	365,572	49,979	141,674,595	2,835	387.54	81	137	13.67%
HALIFAX	57,183	18,158	40,438,783	2,227	707.18	13	318	31.75%
HARNETT	74,834	14,668	37,543,904	2,560	501.70	49	196	19.60%
HAYWOOD	49,051	8,214	24,100,750	2,934	491.34	51	167	16.75%
HENDERSON	75,096	10,775	32,216,286	2,990	429.00	71	143	14.35%
HERTFORD	22,430	7,192	17,759,021	2,469	791.75	4	321	32.06%
HOKE	26,618	6,662	14,554,481	2,185	546.79	41	250	25.03%
HYDE	5,270	1,516	4,220,722	2,784	800.90	3	288	28.77%
IREDELL	100,786	13,554	38,407,837	2,834	381.08	83	134	13.45%
JACKSON	28,414	4,744	13,431,826	2,831	472.72	57	167	16.70%
JOHNSTON	91,552	16,510	45,308,478	2,744	494.89	50	180	18.03%
JONES	9,498	2,233	7,111,152	3,185	748.70	10	235	23.51%

State Fiscal Year 1995 Cont'd
Total Expenditures and Eligibles by County

COUNTY NAME	1994 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	% of Eligibles on Medicaid by county, based on 1994 population (Column C / Column B)
LEE	44,818	8,250	20,333,307	2,465	453.69	65	184	18.41%
LENOIR	58,695	14,383	37,506,274	2,608	639.00	22	245	24.50%
LINCOLN	54,740	7,266	19,314,122	2,658	352.83	86	133	13.27%
MACON	36,727	4,298	11,209,388	2,608	305.21	96	117	11.70%
MADISON	25,471	3,741	11,899,023	3,181	467.16	58	147	14.69%
MARTIN	17,598	6,336	15,815,579	2,496	898.71	1	360	36.00%
MCDOWELL	26,058	5,583	15,642,557	2,802	600.30	32	214	21.43%
MECKLENBURG	561,223	75,190	194,865,220	2,592	347.22	88	134	13.40%
MITCHELL	14,458	2,475	8,735,173	3,529	604.18	30	171	17.12%
MONTGOMERY	23,684	5,410	12,535,560	2,317	529.28	45	228	22.84%
MOORE	64,969	9,176	25,689,460	2,800	395.41	78	141	14.12%
NASH	82,788	14,509	37,409,673	2,578	451.87	66	175	17.53%
NEW HANOVER	134,970	22,607	65,274,506	2,887	483.62	54	167	16.75%
NORTHAMPTON	20,611	6,505	16,308,183	2,507	791.24	5	316	31.56%
ONSLOW	147,144	18,275	37,179,504	2,034	252.67	100	124	12.42%
ORANGE	104,668	8,051	29,653,230	3,683	283.31	98	77	7.69%
PAMLICO	11,779	2,175	7,213,802	3,317	612.43	28	185	18.47%
PASQUOTANK	33,287	7,694	16,947,841	2,203	509.14	48	231	23.11%
PENDER	33,588	7,157	19,012,052	2,656	566.04	35	213	21.31%
PERQUIMANS	10,558	2,626	5,580,353	2,125	528.54	46	249	24.87%
PERSON	31,332	5,515	18,119,246	3,285	578.30	33	176	17.60%
PITT	116,088	23,079	65,483,877	2,837	564.09	37	199	19.88%
POLK	15,471	1,844	6,500,350	3,525	420.16	72	119	11.92%
RANDOLPH	112,926	13,960	38,753,538	2,776	343.18	90	124	12.36%
RICHMOND	45,041	10,971	30,432,588	2,774	675.66	19	244	24.36%
ROBESON	109,876	33,796	78,911,821	2,335	718.19	12	308	30.76%
ROCKINGHAM	87,672	14,502	43,066,717	2,970	491.23	52	165	16.54%
ROWAN	116,860	16,338	44,562,385	2,728	381.33	82	140	13.98%
RUTHERFORD	58,628	9,603	25,365,486	2,641	432.65	69	164	16.38%
SAMPSON	49,868	12,139	31,238,207	2,573	626.42	25	243	24.34%
SCOTLAND	34,630	10,053	23,020,993	2,290	664.77	20	290	29.03%
STANLY	53,727	7,959	23,095,434	2,902	429.87	70	148	14.81%
STOKES	40,152	5,061	15,602,078	3,083	388.58	80	126	12.60%
SURRY	64,348	9,338	29,350,656	3,143	456.12	62	145	14.51%
SWAIN	11,504	3,022	7,514,266	2,487	653.19	21	263	26.27%
TRANSYLVANIA	27,041	4,242	13,244,454	3,122	489.79	53	157	15.69%
TYRRELL	3,814	1,100	2,998,176	2,726	786.10	6	288	28.84%
UNION	94,352	12,651	31,583,108	2,496	334.74	92	134	13.41%
VANCE	39,892	11,132	28,035,620	2,518	702.79	14	279	27.91%
WAKE	496,578	46,475	136,222,019	2,931	274.32	99	94	9.36%
WARREN	17,866	4,605	13,174,050	2,861	737.38	11	258	25.78%
WASHINGTON	13,875	3,734	8,854,584	2,371	638.17	24	269	26.91%
WATAUGA	39,364	3,619	11,719,887	3,238	297.73	97	92	9.19%
WAYNE	109,083	20,168	49,621,616	2,460	454.90	64	185	18.49%
WILKES	61,257	9,365	31,679,496	3,383	517.16	47	153	15.29%
WILSON	67,464	16,115	38,110,539	2,365	564.90	36	239	23.89%
YADKIN	32,871	4,221	13,178,694	3,122	400.92	77	128	12.84%
YANCEY	15,986	3,011	8,642,290	2,870	540.62	42	188	18.84%
STATE TOTAL	**7,064,470**	**1,138,786**	**$3,099,716,010**	**$2,722**	**$438.78**	**N/A**	**161**	**16.12%**

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1995.

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

Table 10
State Fiscal Year 1995
Medicaid Service Expenditures by Eligibility Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 1995 Expenditures Per Recipient	SFY 1994 Expenditures Per Recipient	94/95 Percent Change
Total Elderly	**$ 1,048,569,874**	**34.0%**	**168,422**	**15.8%**	**$ 6,226**	**$ 5,455**	**14.1%**
Aged	974,262,525	31.6%	98,086	9.2%	9,933	8,890	11.7%
Medicare-Aid (MQBQ & MQBB)	74,307,349	2.4%	70,336	6.6%	1,056	668	58.2%
Total Disabled	**$ 1,020,752,494**	**33.1%**	**117,903**	**11.0%**	**8,658**	**8,630**	**0.3%**
Disabled	1,006,155,780	32.6%	116,585	10.9%	8,630	8,680	-0.6%
Blind	14,596,714	0.5%	1,318	0.1%	11,075	10,581	4.7%
Total Families & Children	**$ 1,022,760,078**	**33.2%**	**779,895**	**73.0%**	**1,311**	**1,340**	**-2.1%**
AFDC Adults (> 21)	285,715,108	9.3%	180,941	16.9%	1,579	1,482	6.5%
Medicaid Pregnamt Women Coverage	116,857,232	3.8%	66,390	6.2%	1,760	1,770	-0.6%
AFDC Children & Other Children	386,372,333	12.5%	337,117	31.5%	1,146	1,204	-4.8%
Medicaid Indigent Children	233,815,405	7.6%	195,447	18.3%	1,196	1,302	-8.1%
Aliens & Refugees	**$ 4,423,710**	**0.1%**	**2,687**	**0.3%**	**1,646**		
Adjustments Not Attributable To A Specific Category	**$ (13,997,978)**	**-0.5%**					
Total Service Expendatures All Groups	**$ 3,082,508,178**	**100%**	**1,068,907**	**100%**	**$ 2,884**	**$ 2,796**	**3.1%**

Note: Total Service Expenditures does not include:

Disproportionate Share payments	$242,192,743
State & county administrative costs	$124,135,180
Adjustments processed by DMA settlements	$93,964,447
HMO premiums	$8,618,565
TOTAL	$ 468,910,935

See Table 6 for more details.
Source: SFY 1995 Program Expenditure Report and 2082 Report.

Table 11
State Fiscal Year 1995
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
Inpatient Hospital	$ 602,289,541	19.5%	$ 19,898,419	$ 8,102,342	$ -	$ 1,042,260	$ 225,205,561	$ 139,723,279	$ 211,964,455	$ 2,345,070	$ (5,991,845)
Outpatient Hospital	197,350,933	6.4%	13,487,258	11,362,736	-	428,292	54,118,076	59,374,864	59,920,349	167,409	(1,508,051)
Mental Hospital (> 65)	14,221,559	0.5%	14,317,519	42,101	-	98,666	-	-	-	-	(236,727)
Psychiatric Hospital (< 21)	16,462,790	0.5%	-	-	-	895	2,121,437	60,700	14,353,411	-	(73,653)
Physician	308,497,976	10.0%	25,584,421	14,358,794	-	537,212	69,492,976	90,674,791	109,748,875	1,151,266	(3,050,359)
Clinics	142,276,713	4.6%	3,938,310	4,132,776	-	271,090	41,107,698	35,058,269	58,306,470	150,951	(688,851)
Nursing Facility:											
Skilled Level	355,761,200	11.5%	309,345,906	144,783	-	1,282,902	45,579,574	162,364	563,941	90,495	(1,408,765)
Intermediate Level	322,671,839	10.4%	297,849,552	1,242	-	1,231,888	23,646,662	4,609	10,494	121,180	(193,788)
Intermediate Care Facility (Mentally Retarded)	339,722,311	11.0%	10,513,060	-	-	5,410,668	306,483,475	125,345	17,108,834	148,303	(67,374)
Dental	37,814,255	1.2%	3,475,652	2,950	-	76,139	7,281,728	10,542,767	16,395,870	90,748	(51,599)
Prescription Drugs	254,399,563	8.2%	91,456,597	-	-	1,165,395	90,786,807	31,857,203	39,560,205	62,949	(489,593)
Home Health	92,538,103	3.0%	11,924,109	207,679	-	630,996	48,607,279	4,765,069	26,705,653	1,566	(304,248)
CAP/Disabled Adult	67,698,625	2.2%	52,831,831	-		303,371	14,705,351	-	-	-	(141,928)
CAP/Mentally Retarded	26,084,842	0.8%	168,403	-		145,522	25,596,131	-	215,261	-	(40,475)
CAP/Children	1,995,879	0.1%	-	-	-	-	2,001,684	-	-	-	(5,805)
Personal Care	42,471,451	1.4%	28,314,009	-	-	801,808	12,435,367	546,160	484,624	-	(110,517)
Hospice	10,830,484	0.4%	5,019,902	-	-	48,986	5,466,870	322,705	111,344	-	(139,323)
EPSDT (Health Check)	22,514,207	0.7%	601	108	-	2,289	264,576	13,182	22,278,943	4,243	(49,735)
Lab & X-Ray	25,205,697	0.8%	1,614,536	1,194,202	-	55,620	7,604,164	9,379,119	5,416,980	31,340	(90,264)
Other Services	70,423,833	2.3%	5,394,398	1,071,960	-	82,401	7,520,763	19,400,678	36,993,272	53,425	(93,064)
Total Services	**2,951,231,801**	**95.5%**	**895,134,483**	**40,621,673**	-	**13,616,400**	**990,026,179**	**402,011,104**	**620,138,981**	**4,418,945**	**(14,735,964)**
Part A Premium	34,618,848	1.1%	33,099,498	538,429	-	523,796	18,445	261	-		438,419
Part B Premium	96,626,727	3.1%	46,028,544	29,774,284	3,372,963	456,518	16,111,156	560,974	17,956	4,765	299,567
HMO Premium	8,618,565	0.3%					-	2,499,384	6,119,181	-	-
Total Premiums	**139,864,140**		**79,128,042**	**30,312,713**	**3,372,963**	**980,314**	**16,129,601**	**3,060,619**	**6,137,137**	**4,765**	**737,986**
Grand Total and Premiums	**$ 3,091,095,941**		**974,262,525**	**70,934,386**	**3,372,963**	**14,596,714**	**1,006,155,780**	**405,071,723**	**626,276,118**	**4,423,710**	**(13,997,978)**

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

* 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.)

** Includes SOBRA Pregnant Women.

*** Includes SOBRA Child and Other Other Child.

Table 12
State Fiscal Year 1995
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 1995 % of Total Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 19,898,419	2.0%	$ 8,102,342	$ -	$ 8,102,342	10.9%	$ 28,000,761	2.7%	3.8%	4.4%
Outpatient Hospital	13,487,258	1.4%	11,362,736	-	11,362,736	15.3%	24,849,994	2.4%	2.7%	2.3%
Mental Hospital (>65)	14,317,519	1.5%	42,101	-	42,101	0.1%	14,359,620	1.4%	1.5%	1.6%
Physician	25,584,421	2.6%	14,358,794	-	14,358,794	19.3%	39,943,215	3.8%	4.0%	3.6%
Clinics	3,938,310	0.4%	4,132,776	-	4,132,776	5.6%	8,071,086	0.8%	0.8%	0.7%
Nursing Facility:										
Skilled Level:	309,345,906	31.8%	144,783	-	144,783	0.2%	309,490,689	29.5%	32.8%	30.2%
Intermediate Level:	297,849,552	30.6%	1,242	-	1,242	0.0%	297,850,794	28.4%	33.3%	29.4%
Intermediate Care Facility-Mentally Retarded	10,513,060	1.1%	-	-	-	0.0%	10,513,060	1.0%	1.1%	0.9%
Dental	3,475,652	0.4%	2,950	-	2,950	0.0%	3,478,602	0.3%	0.3%	0.3%
Prescription Drugs	91,456,597	9.4%	-	-	-	0.0%	91,456,597	8.7%	8.9%	8.3%
Home Health	11,924,109	1.2%	207,679	-	207,679	0.3%	12,131,788	1.2%	1.1%	1.1%
CAP/Disabled Adult	52,831,831	5.4%	-	-	-	0.0%	52,831,831	5.0%	5.2%	4.3%
CAP/Mentally Retarded	168,403	0.0%	-	-	-	0.0%	168,403	0.0%	0.0%	0.0%
Personal Care	28,314,009	2.9%	-	-	-	0.0%	28,314,009	2.7%	2.9%	2.8%
Hospice	5,019,902	0.5%	-	-	-	0.0%	5,019,902	0.5%	0.5%	0.3%
EPSDT (Health Check)	601	0.0%	108	-	108	0.0%	709	0.0%	0.0%	0.0%
Lab & X-Ray	1,614,536	0.2%	1,194,202	-	1,194,202	1.6%	2,808,738	0.3%	0.3%	0.3%
Other Services	5,394,398	0.6%	1,071,960	-	1,071,960	1.4%	6,466,358	0.6%	0.6%	0.4%
Service Expenditures	**$ 895,134,483**	91.9%	**40,621,673**	**-**	**40,621,673**	54.7%	**935,756,156**	89.2%	**100%**	**91%**
Part A Premium	33,099,498	3.4%	538,429	-	538,429	0.7%	33,637,927	3.2%	6.0%	2.6%
Part B Premium	46,028,544	4.7%	29,774,284	3,372,963	33,147,247	44.6%	79,175,791	7.6%	0.6%	0.5%
HMO Premium		0.0%		-	-	0.0%	-	0.0%	0.0%	0.0%
Total Premiums	**$ 79,128,042**	**100%**	**30,312,713**	**3,372,963**	**33,685,676**	**100%**	**112,813,718**			
Total Service & Premium	**$ 974,262,525**		**70,934,386**	**3,372,963**	**74,307,349**		**1,048,569,874**			
Total Elderly Recipients	98,086		70,336	8,648	78,984		177,070			
Service Expenditures Per Recipient *	**$ 9,933**		**$ 1,009**	**$ 390**	**$ 941**		**$ 5,922**			

* Service Expenditure/Recipient amounts do not contain adjustments, settlements or administrative costs.
Source: SFY 1995 Program Expenditure Report and 2082 Report

Table 13
State Fiscal Year 1995
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	SFY 1995 % of Total Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 225,205,561	22.4%	$ 1,042,260	7.1%	$ 226,247,821	22.2%	22.0%	23.6%
Outpatient Hospital	54,118,076	5.4%	428,292	2.9%	54,546,368	5.3%	5.0%	4.7%
Psychiatric Hospital (>65)		0.0%	98,666	0.7%	98,666	0.0%	0.0%	0.0%
Psychiatric Hospital (<21)	2,121,437	0.2%	895	0.0%	2,122,332	0.2%	0.2%	0.2%
Physician	69,492,976	6.9%	537,212	3.7%	70,030,188	6.9%	6.5%	6.5%
Clinics	41,107,698	4.1%	271,090	1.9%	41,378,788	4.1%	3.0%	3.0%
Nursing Facility:								
Skilled Level:	45,579,574	4.5%	1,282,902	8.8%	46,862,476	4.6%	5.0%	5.0%
Intermediate Level:	23,646,662	2.4%	1,231,888	8.4%	24,878,550	2.4%	2.8%	2.8%
Intermediate Care Facility-Mentally Retarded	306,483,475	30.5%	5,410,668	37.1%	311,894,143	30.6%	33.9%	33.9%
Dental	7,281,728	0.7%	76,139	0.5%	7,357,867	0.7%	0.7%	0.7%
Prescription Drugs	90,786,807	9.0%	1,165,395	8.0%	91,952,202	9.0%	8.2%	7.7%
Home Health	48,607,279	4.8%	630,996	4.3%	49,238,275	4.8%	4.3%	4.2%
CAP/Disabled Adult	14,705,351	1.5%	303,371	2.1%	15,008,722	1.5%	1.4%	1.4%
CAP/Children	25,596,131	2.5%	145,522	1.0%	25,741,653	2.5%	0.2%	0.2%
CAP/Mentally Retarded	2,001,684	0.2%	-	0.0%	2,001,684	0.2%	2.3%	2.0%
Personal Care	12,435,367	1.2%	801,808	5.5%	13,237,175	1.3%	1.4%	1.3%
Hospice	5,466,870	0.5%	48,986	0.3%	5,515,856	0.5%	0.5%	0.5%
EPSDT	264,576	0.0%	2,289		266,865	0.0%	0.0%	0.0%
Lab & X-Ray	7,604,164	0.8%	55,620	0.4%	7,659,784	0.8%	0.8%	1.0%
Other Services	7,520,763	0.7%	82,401	0.6%	7,603,164	0.7%	0.6%	0.4%
Part A Premium	18,445	0.0%	523,796	3.6%	542,241	0.1%		
Part B Premium	16,111,156	1.6%	456,518	3.1%	16,567,674	1.6%		
HMO Premium	-	0.0%	-	0.0%	-	0.0%		
Total Service & Premiums	**$ 1,006,155,780**		**$ 14,596,714**		**$ 1,020,752,494**			
Number of Disabled/Blind Recipients	116,585		1,318		117,903			
Service Expenditures Per Recipient*	**$ 8,630**		**$ 11,075**		**$ 8,658**			

* Service Expenditures/Recipient does not include adjustments, settlements and administrative costs.
Source: SFY 1995 Program Expenditure Report and 2082 Report

Table 14
State Fiscal Year 1995
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 1995 % of Total Dollars	SFY 1994 % of Total Dollars	SFY 1993 % of Total Dollars
Inpatient Hospital	$ 97,754,721	33.9%	$ 41,968,558	35.9%	$ 115,283,407	29.4%	$ 96,681,048	41.3%	$ 351,687,734	34.1%	36.0%	38.7%
Outpatient Hospital	46,967,989	16.3%	12,406,875	10.6%	39,748,202	10.1%	20,172,147	8.6%	119,295,213	11.6%	11.6%	11.8%
Psychiatric Hospital (<21)	-	0.0%	60,700	0.1%	12,443,393	3.2%	1,910,018	0.8%	14,414,111	1.4%	1.7%	2.3%
Physician	58,487,936	20.3%	32,186,855	27.5%	66,927,727	17.1%	42,821,148	18.3%	200,423,666	19.4%	19.4%	19.6%
Clinics	15,499,804	5.4%	16,724,136	14.3%	42,322,817	10.8%	15,983,653	6.8%	90,530,410	8.8%	7.7%	6.8%
Nursing Facility:												
Skilled Level:	162,364	0.1%	-	0.0%	519,086	0.1%	44,855	0.0%	726,305	0.1%	0.1%	0.1%
Intermediate Level:	4,609	0.0%	-	0.0%	10,494	0.0%	-	0.0%	15,103	0.0%	0.0%	0.0%
Intermediate Care Facility-Mentally Retarded	125,345	0.0%	-	0.0%	15,755,395	4.0%	1,353,439	0.6%	17,234,179	1.7%	2.7%	2.5%
Dental	10,157,476	3.5%	385,291	0.3%	11,737,278	3.0%	4,658,592	2.0%	26,938,637	2.6%	2.8%	2.9%
Prescription Drugs	29,364,934	10.2%	2,492,269	2.1%	24,487,384	6.2%	15,072,821	6.4%	71,417,408	6.9%	6.8%	6.5%
Home Health	4,084,704	1.4%	680,365	0.6%	13,554,831	3.5%	13,150,822	5.6%	31,470,722	3.1%	3.2%	2.9%
CAP/Disabled	-		-		-		-					
CAP/Mentally Retarded	-		-		207,722	0.1%	7,539					
CAP/Children	-	0.0%	-	0.0%	30,801	0.0%	-	0.0%	30,801	0.0%	0.0%	0.0%
Personal Care	533,598	0.2%	12,562	0.0%	225,277	0.1%	259,347	0.1%	1,030,784	0.1%	0.0%	0.0%
Hospice	322,705	0.1%	-	0.0%	51,478	0.0%	59,866	0.0%	434,049	0.0%	0.0%	0.0%
Health Check - EPSDT	1,018	0.0%	12,164	0.0%	11,298,484	2.9%	10,980,459	4.7%	22,292,125	2.2%	0.0%	1.3%
Lab & X-Ray	6,521,206	2.3%	2,857,911	2.4%	3,932,639	1.0%	1,484,341	0.6%	14,796,097	1.4%	1.4%	1.5%
Other Services	15,190,997	5.3%	7,044,013	6.0%	27,828,118	7.1%	9,165,154	3.9%	59,228,282	5.7%	6.4%	3.3%
Part A Premium	261	0.0%	-	0.0%	-	0.0%	-	0.0%	261	0.0%		
Part B Premium	535,441	0.2%	25,533	0.0%	7,800	0.0%	10,156	0.0%	578,930	0.1%		
HMO Premium	2,499,384	0.9%	-	0.0%	6,119,181	1.6%	-	0.0%	8,618,565	0.8%		
Total Service & Premium	**$ 288,214,492**		**116,857,232**		**392,491,514**		**233,815,405**		**1,031,163,382**			
Number of Family & Child Recipients	180,941		66,390		337,117		195,447		779,895			
Service Expenditures Per Recipient*	**$ 1,593**		**$ 1,760**		**$ 1,164**		**$ 1,196**		**$ 1,322**			

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

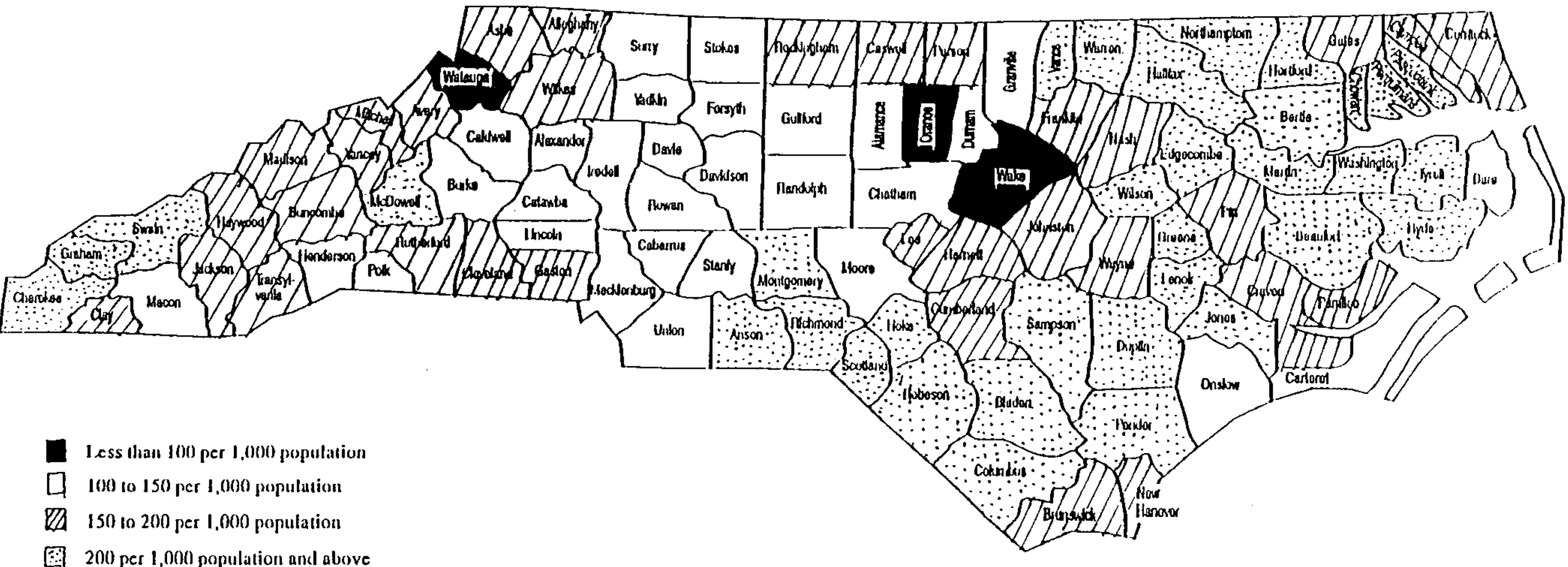
Source: SFY 1995 Program Expenditure Report & 2082 Report

State Fiscal Year 1995
Medicaid Co-payment Amounts

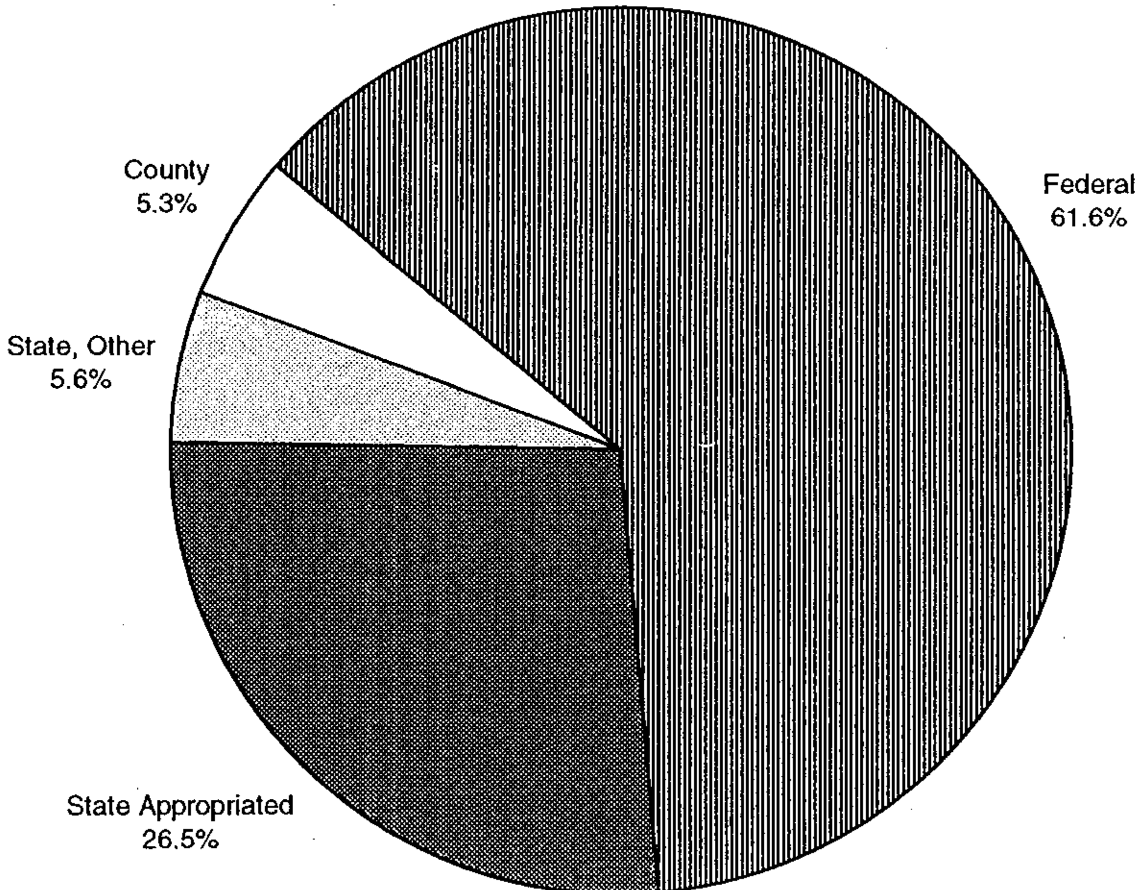
Service	Copayment Amount
Chiropractor	$ 1.00
Dental visit	$ 3.00
Optical Service	$ 2.00
Optometrist	$ 2.00
Outpatient visit	$ 3.00
Physician visit	$ 3.00
Podiatrist visit	$ 1.00
Perscription drug (Including refills)	$ 1.00

APPENDIX B
MEDICAID CHARTS

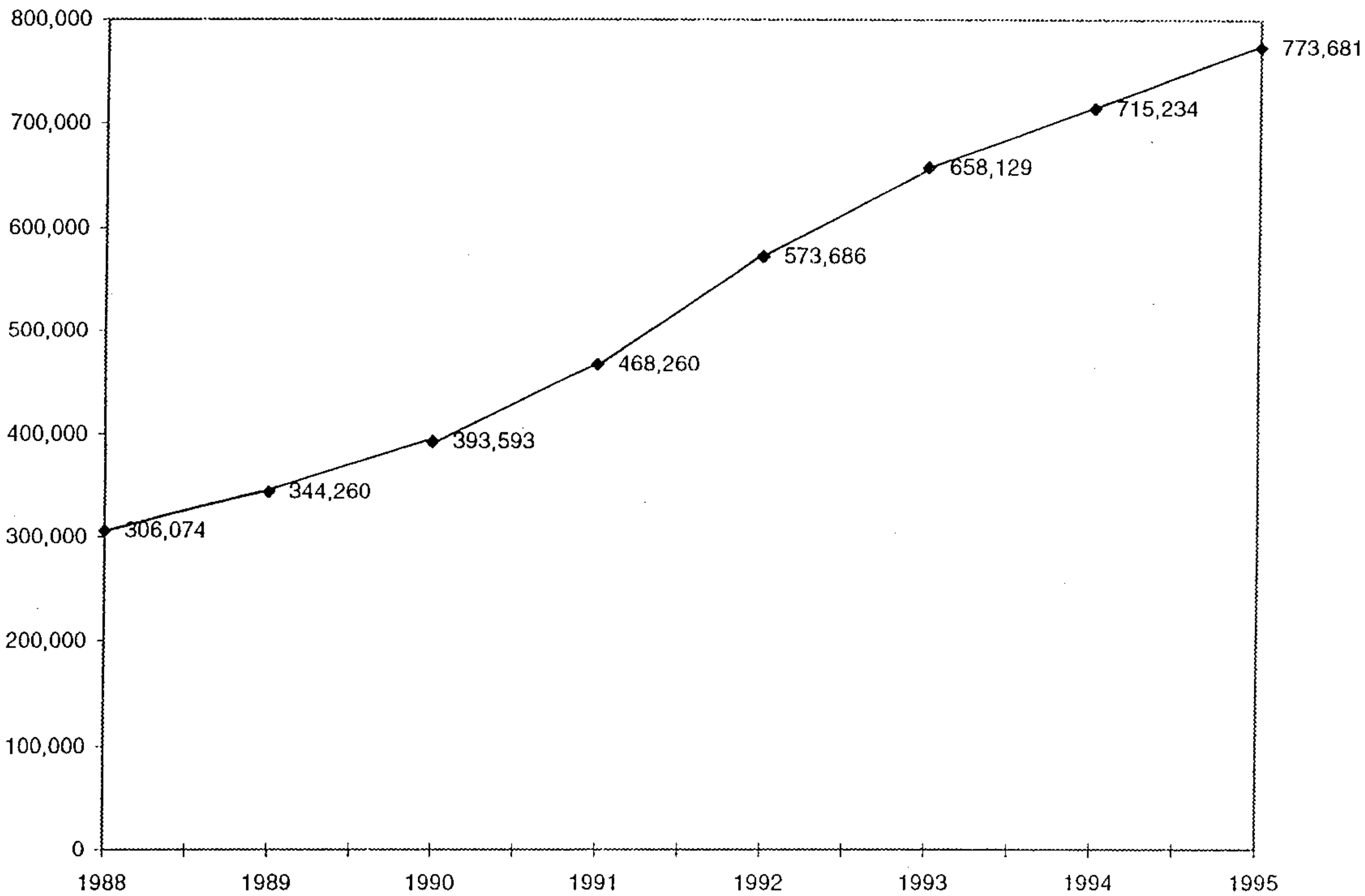
State Fiscal Year 1995
Eligibles per 1,000 Population



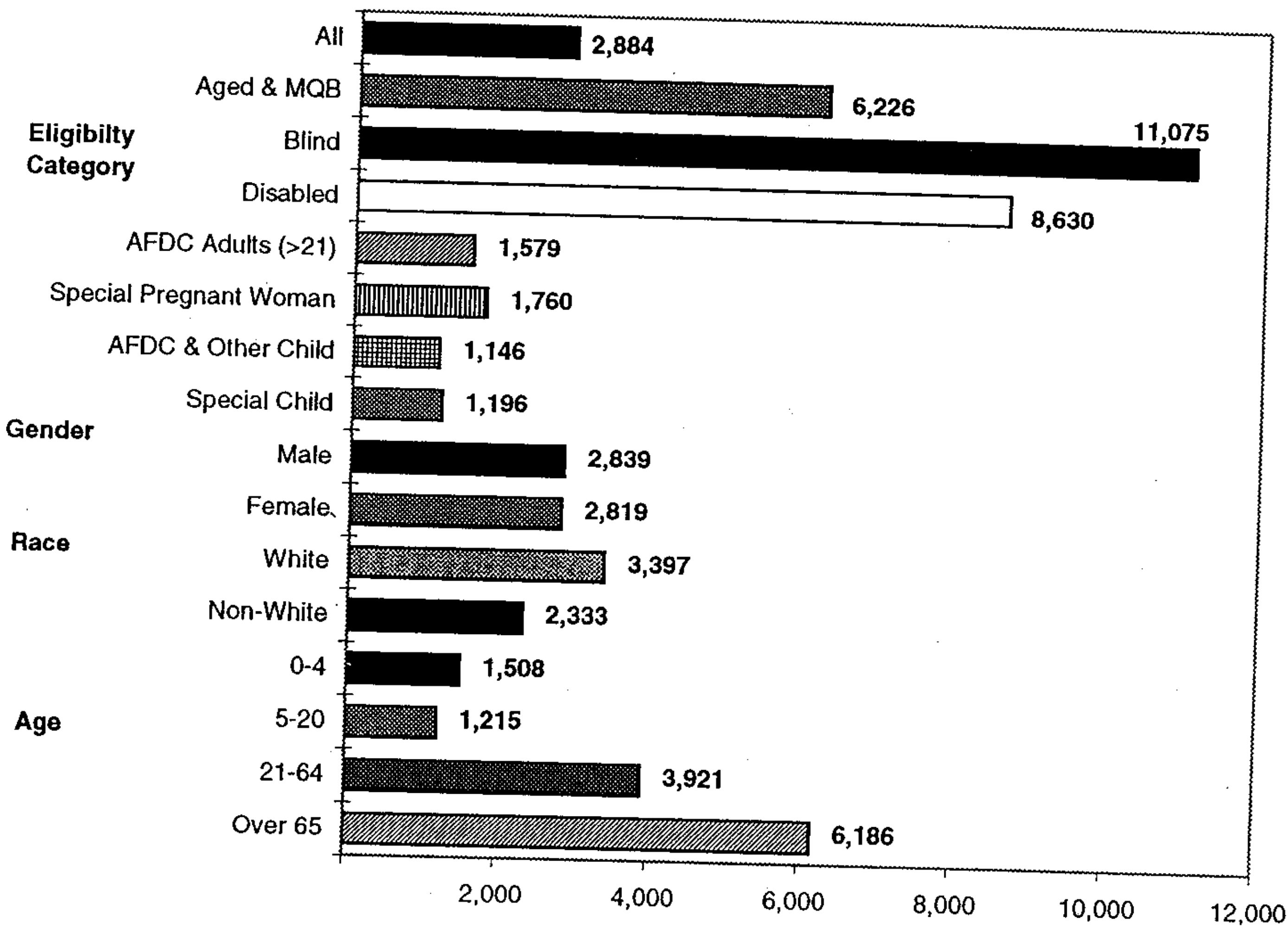
State Fiscal Year 1995
Sources of Medicaid Funds, Percent

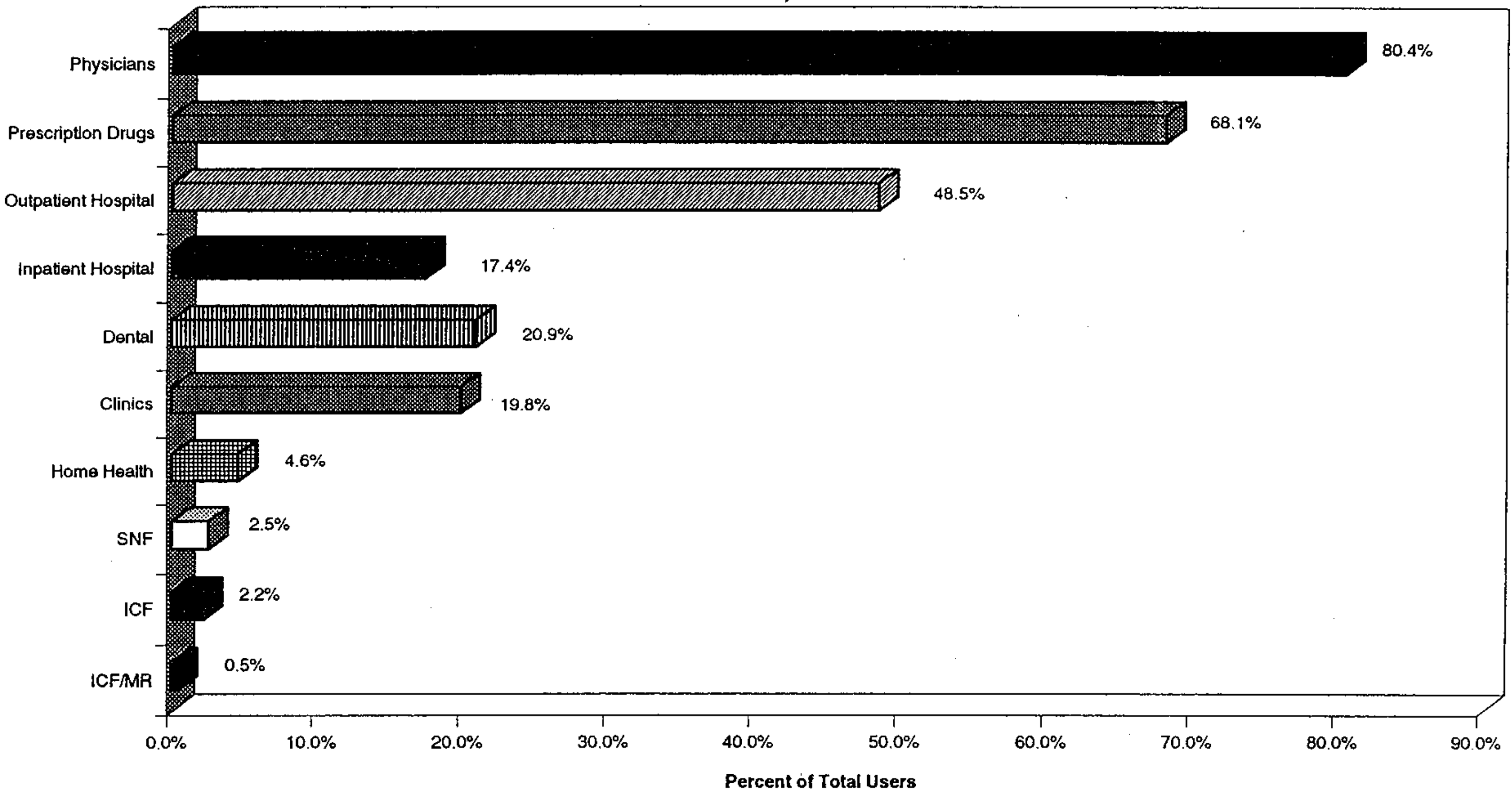


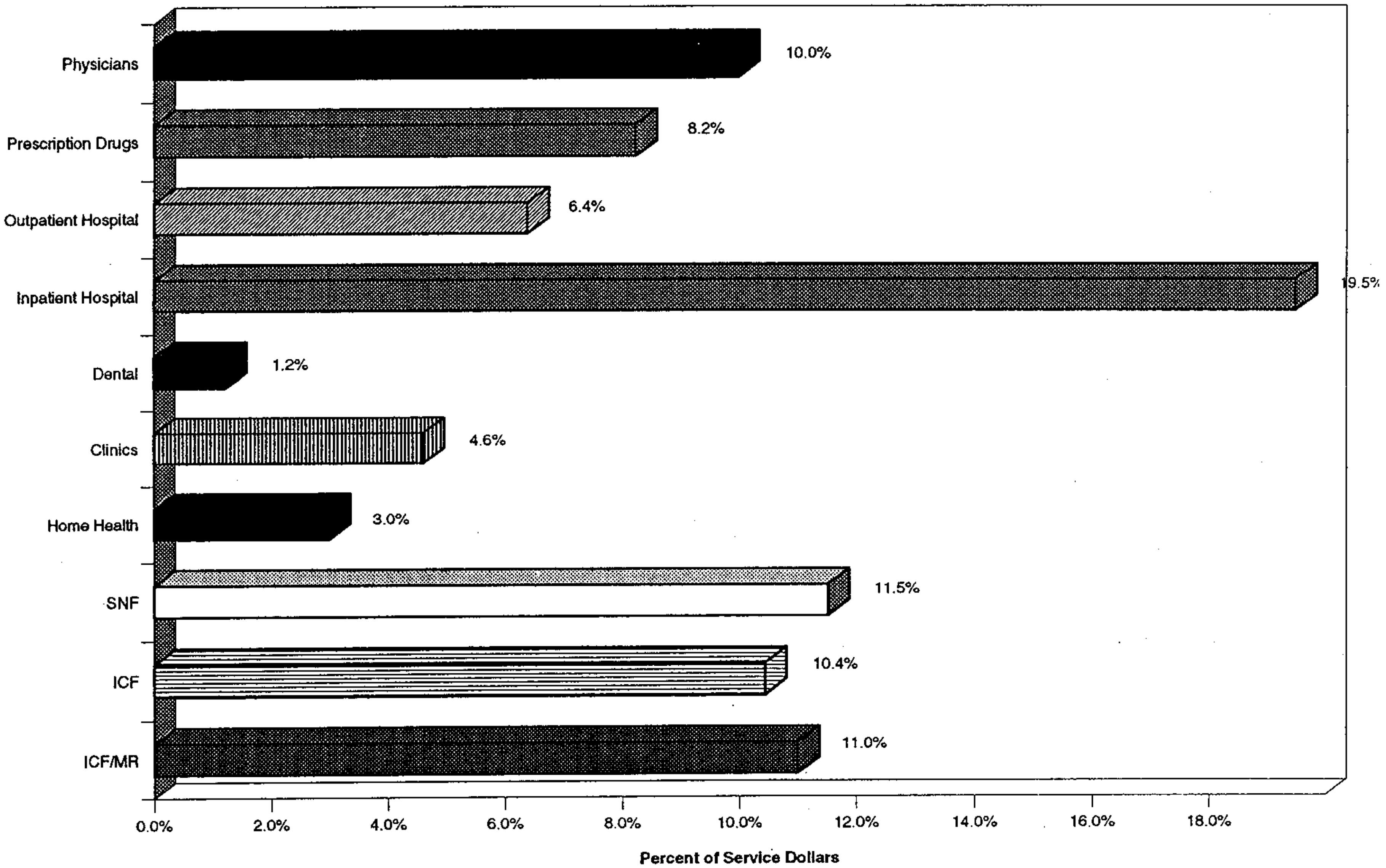
A HISTORY OF MEDICAID ELIGIBLES



State Fiscal Year 1995
Service Expenditures Per Recipient
by Selected Characteristics




State Fiscal Year 1995
Selected Medicaid Services
Use & Dollars, Percent
Physicians
Prescription Drugs
Outpatient Hospital
Inpatient Hospital
Dental
Clinics
Home Health
SNF
ICF
ICF/MR
80.4%
68.1%
48.5%
17.4%
20.9%
19.8%
4.6%
2.5%
2.2%
0.5%
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
90.0%
Percent of Total Users


Physicians
Prescription Drugs
Outpatient Hospital
Inpatient Hospital
Dental
Clinics
Home Health
SNF
ICF
ICF/MR
10.0%
8.2%
6.4%
19.5%
1.2%
4.6%
3.0%
11.5%
10.4%
11.0%
0.0%
2.0%
4.0%
6.0%
8.0%
10.0%
12.0%
14.0%
16.0%
18.0%
Percent of Service Dollars

Medicaid Services
State Fiscal Year 1995

MANDATORY

Durable Medical Equipment

Health Check Services (EPSDT)

Family Planning Services

Hearing Aids (for children)

Home Health Services

Inpatient & Outpatient Hospital Services

Laboratory & X-Ray Services

Nurse Midwives

Nurse Practitioners

Nursing Facilities (NF)

Physicians

Prosthetics and Orthotics (children)

Speciality Hospitals

Transportation

OPTIONAL

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:

* Mental Health
* Public Health
* Rural Health
* Community Health Centers

Community Alternatives Program (CAP)

Dental Care Services

Home Infusion Therapy Services

Hospice

Intermediate Care Facilities for the Mentally Retarded (ICF-MR)

Mental Hospitals (age 65 & over)

Migrant Health Clinics

Optical Supplies

Optometrists

Personal Care Services

Podiatrists

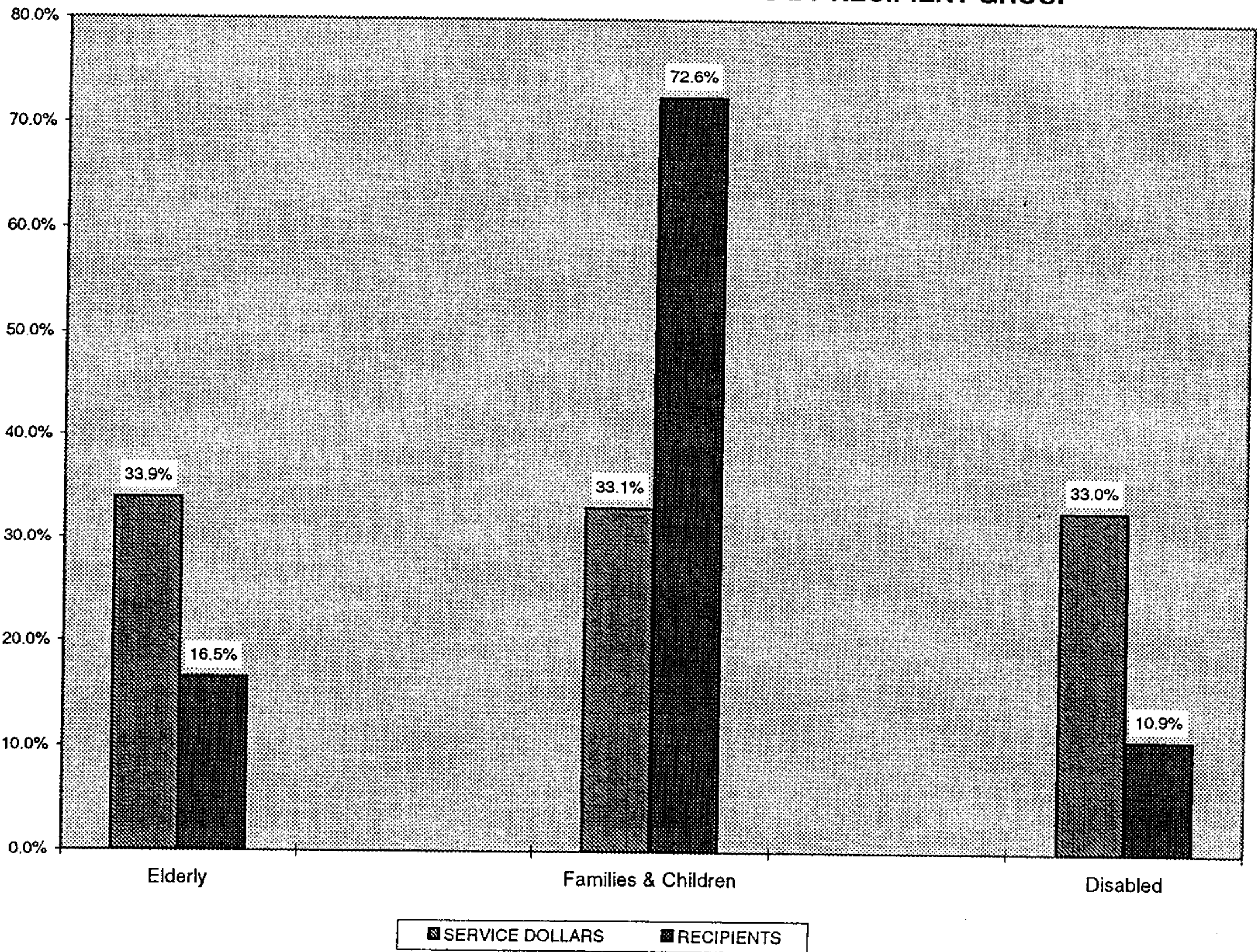
Prepaid Health Plan Services

Prescription Drugs

Private Duty Nursing Services

Rehabilitative Services:
(under auspices of area mental health programs)

Rural Health Clinics


1995 SERVICE EXPENDITURES BY RECIPIENT GROUP
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
33.9%
16.5%
33.1%
72.6%
33.0%
10.9%
Elderly
Families & Children
Disabled
SERVICE DOLLARS
RECIPIENTS

WHO CAN RECEIVE MEDICAID ?

AUTOMATIC COVERAGE	THOSE WHO MUST APPLY
AFDC	Medically Needy * AFDC Related * Aged * Blind * Disabled
SSI * Aged * Blind * Disabled	MPW
SA (Rest Home)	MIC
	MQB
	Foster Care & Adopted Children

Selected Medicaid Services as a Percentage of Total Expenditures

SFY 1995

Long Term Care		
	ICF	10.4%
	SNF	11.1%
	ICF-MR	11.0%
	All Home Based Care	7.7%
	Total LTC	40.2%
Hospital		
	Inpatient	18.6%
	Mental Hospital	1.0%
	Total Hospital	19.6%
Outpatient		
	Clinics	4.2%
	Emergency Room	2.1%
	Other Hospital Outpatient	3.3%
	Physician	8.5%
	Total Outpatient	18.1%
Pharmacy		8.2%
Dental		1.2%
Medicare		7.4%
All Other Services		5.3%

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