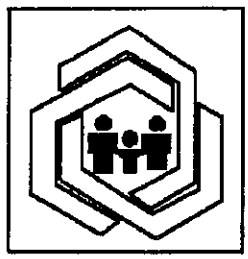

Medicaid in North Carolina
Annual Report
State Fiscal Year 1996

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

January 2, 1997

Dear Fellow North Carolinians,

On the following pages you will find the Annual Report of Medicaid Services for State Fiscal Year 1996.

In State Fiscal Year 1996, Medicaid expenditures topped 4 billion dollars for the first time, of which $3,596,975,336 was spent for Medicaid services. The number of Medicaid recipients in the state for the same time period exceeded 1.1 million people.

Total Medicaid eligibles in the state edged up to 1,176,589, an increase of approximately 38,000 people from the previous fiscal year. **AFDC** Medicaid eligibles decreased for the second straight year, but large increases in the number of **Medicaid Disabled** and **Medicaid Indigent Children** covered were the prime reasons for the overall eligibility increase.

We continued to make strides in the managed care arena. Efforts were focused on expansion of Carolina Access and a special waiver called Health Care Connection was granted for Mecklenburg County.

You are cordially invited to learn more about our managed care efforts and other North Carolina Medicaid programs and initiatives in this report.

Sincerely,

Barbara D Matula

Barbara D. Matula

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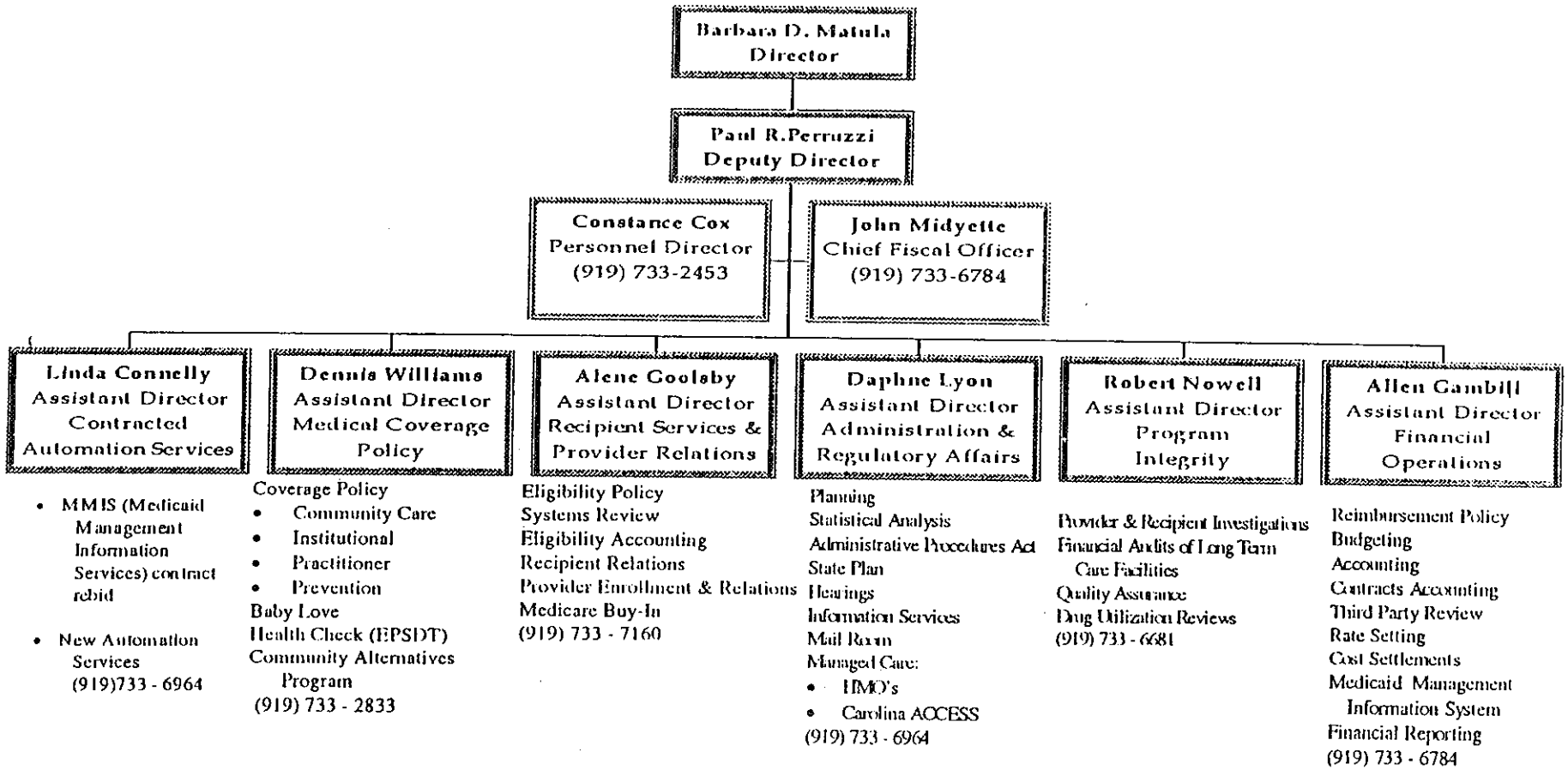

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STATE FISCAL YEAR 1996

HIGHLIGHTS

State Fiscal Year 1996
Medicaid Policy and Legislative Changes in Brief

Effective Date	Policy Change
July 1, 1995	• Creation of a blue ribbon task force by the Legislature to look at the effect of block grant funding and other federal actions on Medicaid in North Carolina.
October 1, 1995	• DMA expanded the Community Alternatives Program for Disabled Adults (CAP/DA) to all counties in the State and obtained Federal approval to increase the potential number of participants by 20 %.
November 1, 1995	• DMA in a cooperative effort with the Division of Health Promotion (DEHNR) to expand services to patients with AIDS implemented the Community Alternatives Program for persons with AIDS (CAP/AIDS).
December 1, 1995	• DMA obtained Federal approval to continue and expand the Community Alternatives Program for Persons with Mental Retardation/Development Disabilities (CAP-MR/DD), increasing the potential number of participants and the type of services available.

Medicaid is an important 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. Also, all children under the poverty level are eligible for Medicaid in North Carolina.

As in past years, the largest proportion (70.7 percent) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. The remainder, 29.3 percent was spent on care for low income families and children.
In SFY 1996, 30 percent of the service budget was spent on nursing facility care and on institutional care for the mentally retarded.

SFY 1996 Synopsis

Total Medicaid Expenditures increased to $4,113,344,777, a 16% increase over SFY 1995. The amount spent for Medicaid services was $3,596,975,336. This represents a 17 % increase in service costs over SFY 1995. See Table 10 on page 32 for a detailed breakdown of these service expenditures.

The total number of Medicaid eligibles in SFY 1996 was 1,176,589. This was a 3% increase in total eligibles over SFY 1995.

There was a total of 1,158,659 Medicaid recipients in SFY 1996. Total recipients increased 8% over state fiscal year 1995.

Martin county had the highest concentration of Medicaid eligibles in SFY 1996 with 359 people per 1,000 of county population on Medicaid. Orange County had the lowest concentration of Medicaid eligibles with 74 per 1,000 of county population on Medicaid

Davie County had the highest Medicaid cost per eligible, $4,006 and Cumberland county had the lowest cost per eligible, $2,192. Statewide, the average cost per eligible was $3,005. Please note that Cost-per-Eligible generally reflects services used.

Once again, Inpatient hospital stays at $691 million was the highest total cost of all Medicaid categories of service rendered for SFY 1996.

Managed Care

Managed care opportunities for Medicaid recipients continued to increase during SFY 1996.

CAROLINA ACCESS, a primary care case management model, characterized by a primary care physician gatekeeper, continued to be the cornerstone of managed care development for North Carolina's Medicaid eligible population (see page 14 in the Medicaid In Depth section for a complete description of **Carolina Access**).

CAROLINA ALTERNATIVES, a prepaid plan for behavioral health continued serving children in 32 North Carolina counties during SFY 1996. Planning has gotten underway to expand the **Carolina Alternatives** program to additional counties and to the adult population (see page 15 in the Medicaid In Depth section for more information on **Carolina Alternatives**).

A major new managed care development program called **HEALTH CARE CONNECTION** started in Mecklenburg County, North Carolina in 1996. **Health Care Connection** links most Medicaid recipients in that county with an HMO. The HMO then offers the Medicaid recipient a comprehensive package of medical benefits. You can read more details about the **Health Care Connection** program on page 3 of this section.

In all of these managed care models, the objectives are:

- Cost effectiveness
- Appropriate use of health care services
- Improved access to primary and preventative care

Health Care Connection[1]

The Division's managed care initiatives began in 1986 with a full risk contract with one HMO, Kaiser-Permanente. Since that time, coverage with Kaiser has been offered on a voluntary basis to Aid to Families with Dependent Children (AFDC) recipients in selected counties. The plan is currently available in Durham, Orange, and Wake counties, with approximately 4,600 recipients choosing this coverage each year.

A project is currently under way in Mecklenburg county to transition most of the Medicaid population from fee-for-service to enrollment in an HMO. Under the authority of a 1915(b) waiver, Medicaid recipients who are not in long term care facilities and those who do not have Medicare coverage, will be required to choose an HMO plan at the time they are certified or re-certified for Medicaid.

Persons immediately eligible for enrollment are:

- **Aid to Families with Dependent Children (AFDC)**
- **AFDC-related without Medicaid deductibles (MAF)**
- **Medicaid for Pregnant Women (MPW)**
- **Medicaid for Infants and Children (MIC) (eligible at the discretion of DDSs and the guardian)**

Persons ineligible for enrollment are:

- **Medicare Qualified Beneficiaries (MQB)**
- **Medicare /Medicaid dual eligibles**
- **Illegal Aliens**
- **Medically Needy (with a Medicaid deductible)**
- **Nursing Facility Residents**
- **Adult Care Home Residents**
- **Residents of Intermediate Care Facilities for Mentally Retarded**
- **Recipients with presumptive eligibility**

Blind and Disabled individuals who are not eligible for Medicare and who are not residents of a long-term care medical facility are expected to become eligible for this service.

An important feature of this project is the use of an independent enrollment counselor, called a Health Benefit Advisor (HBA), to assist recipients with the selection of a plan. The HBA is responsible for initial recipient education, plan selection and enrollment, and some liaison functions with the various HMO plans.

Enrollment for this project began in June, 1996 in Mecklenburg County. Five HMO's currently licensed by the North Carolina Department of Insurance have contracts. These HMO's are:

The Wellness Plan of NC, Inc.
East Blvd. - Suite 204
Charlotte, NC 28303

Kaiser Foundation Health Plan NC
Fairview Road - Suite 114
Charlotte, NC 28210

Optimum Choice Mid-Atlantic Medical
Research Blvd.
Rockville, MD 28250

Maxicare North Carolina, Inc.
77 Center Drive, Suite 380
Charlotte, NC 28217

Atlantic Health Plans
Pineville-Matthews Road
Suite 200
Charlotte, NC 28226

[1] Formerly known as the Mecklenburg Project.

Another feature of this plan is that Medicaid eligibles in Mecklenburg County may choose the C.W. Williams Center Health Care Plan which will offer many of the same benefits of an HMO, but with a "fee-for-service" reimbursement plan.

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

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 1996, Medicaid expenditures grew from $307 million to $4.1 billion, and the count of people eligible for Medicaid increased from 456,000 to 1,158,659. During this time, DMA staff increased from 121 to 299 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 1996, the state administration budget was only 1.5% of total service dollars and the local administration costs consumed just 1.7 % of total service expenditures. The 3.2% of service dollars for administration costs for both governmental entities represents a decrease of .3 percent from SFY 1995 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. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the state and counties to increase their proportionate share of Medicaid costs.

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 in APPENDIX A shows the federal matching rates that apply for State Fiscal Year 1996.

Funding Formula

The federal matching rate for Medicaid services varies from state to state based on per capita income. Nationwide, in SFY 1996, 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 1996, 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, the "Qualified Medicare Beneficiaries" column.)

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.

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 for eligibility is known as the Medicaid deductible or the Medicaid "spenddown." Ironically, these people must "spend down" to levels lower than most eligibility requirements, i.e. to 133% of the AFDC payment level, not to the other income levels such as 185% of poverty, or the SSI payment level, etc. This is a federal requirement.

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 43,300 providers who are currently enrolled in the program. Providers then bill Medicaid for their services. In 1996, 13,632 Medicaid providers billed North Carolina Medicaid for services rendered. Table 3 in Appendix A 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.

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 $16.6 million in SFY 1996.

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

Audit Contracts - The DMA Audit Section contracts with two certified public accountants to conduct on-site compliance audits of nursing facilities(NF's) and intermediate care-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 Blue Cross/Blue Shield 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 NF's and 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 Carolina 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 16 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 (DHP) 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 DHP operates HIV Case Management Services and the Community Alternatives Program for people with AIDS (CAP/AIDS) for DMA.

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.

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 1996) 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 100 counties. 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 recovering 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 1996:

	State Fiscal Year 1996
Provider Activities:	
***Reviews**	**3,269**
***Collected**	**$ 2,874,338**
Recipient Activities:	
***Reviews**	**972**
***Collected**	**$ 742,002**
Long-Term and Primary Health Care Activities:	
***Audits**	**653**
***Collected**	**$4,284,946**

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 1996, insurance coverages and refunds from a variety of sources defrayed Medicaid expenditures.

Insurance paid on patients' behalf amounted to $98,073,438. An additional $104,573,661 in Medicaid claims was denied because other insurance was thought to be available to pay for client services.

Medicaid received refunds from:

- Medicare $ 1,105,078
- Health Insurance 8,274,348
- Casualty Insurance 5,824,933
- Absent Parent 151,362

Medicaid policy is designed to avoid costs that otherwise would be incurred. In SFY 1996, $973,108,394 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 States 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 and copayment amounts in effect during SFY 1996.

STATE FISCAL YEAR 1996
Medicaid Copayment Amounts

SERVICE	COPAYMENT
Chiropractor Visit	$3.00
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 Alternatives 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 at 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 visits provided by certified home health agencies for skilled nursing services, physical therapy, speech-language pathology services, and home health aide services for homebound patients. Under Home Health, Medicaid also pays for medical supplies for these patients. Home Health agencies are paid the lower of their customary charge to the general public or a maximum per visit rate established by DMA for each type of service.

Health Check -- The Health Check program(EPSDT) 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. Health Check services do not count toward the annual 24 visit limitation and no copayment is required. County health departments, Community, Rural, Migrant, and Indian Health Centers all participate as Health Check providers. For a complete description of this program, see Health Check Program on page 17 under "Special Programs".

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 co-payments. FQHCs and RHCs are reimbursed their reasonable 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 met 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. These county transportation costs may be billed as a benefit cost or as an administrative cost, depending on how the service is delivered. Federal and state funds are then used to match the county expenditure. See Table 1 on page 22 for all of 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 habitable 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, cleanings, 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 every 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.

Hearing Aid Services -- Single and binaural hearing aids is a covered service for Medicaid recipients under 21 years of age. Coverage for this service is limited to once every five years. Medical clearance for the fitting of an aid/aids must be documented by an ENT, Otologist or Physician. An audiological report documenting the medical necessity of the service must accompany the request for prior approval of coverage. There is no copayment required for this service.

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.

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 prepaid, 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.

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.

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.

Five counties were selected for a pilot of the program and by July 1996, expanded to 41 counties. There were 262,439 enrollees in Carolina ACCESS as of June 30, 1996. This figure represents approximately 43% of total Medicaid enrollees for these counties as of that date.

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.

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

Alamance (7/95)
Alexander (6/96)
Beaufort (3/92)
Buncombe (3/93)
Burke (9/91)
Caldwell (12/92)
Caswell (8/94)
Chatham (12/94)
Cherokee (10/95)
Cleveland (9/94)
Craven (9/95)
Davidson (8/93)
Duplin (4/96)
Durham (4/91)
Edgecombe (4/91)
Forsyth (2/93)
Gaston (9/95)
Greene (3/92)
Guilford (9/95)
Harnett (5/93)
Haywood (11/92)
Henderson (4/91)
Jackson (1/95)
Lee (12/94)
Lenoir (7/94)
Macon (9/95)
Madison (8/91)
Moore (4/91)
Nash (8/91)
Onslow (10/94)
Orange (11/93)
Person (6/95)
Pitt (3/92)
Rockingham (8/95)
Sampson (3/96)
Scotland (11/93)
Surry (10/93)
Transylvania (6/95)
Wake (3/94)
Wayne (9/91)
Wilson (11/95)

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 Disabilities, 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.

Mortality/Child Health Initiatives

The need for preventive services and basic medical care for North Carolina's

mothers and children are 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 1996 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 any physical or mental condition identified under this program.

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 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 1996, these initiatives helped 79,865 pregnant women and 251,420 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.

On January 1, 1993, a new physician payment system was put in effect. It was 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 under served areas. Under this system, the fee schedule was developed based on a relative value scale (RVS) produced by a research team at Harvard University.

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. Medicaid currently pays 44% of all baby deliveries in North Carolina. Infants born to Medicaid eligible women continue to be eligible until their first birthday.

Specially trained nurses and social workers called Maternity Care Coordinators (MCC's) 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. In state fiscal year 1996, **28,087** pregnant women received MCC services.

In addition to MCC services, Maternal Outreach Workers and specially trained home visitors work one-on-one with at-risk families to provide social support, encourage healthy behaviors, and ensure that families are linked with available community resources. Originally funded by the Kate B. Reynolds Health Care Trust and Medicaid, the Baby Love Maternal Outreach Worker Program has expanded from 21 pilot projects to 66 programs located in various agencies across North Carolina.

The benefit package of covered services has also been enriched through the Baby Love Program to include Childbirth and Parenting Classes, in-home skilled nursing care for high risk pregnancies, nutrition counseling, psychosocial counseling and postpartum/newborn home visits.

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.

The infant mortality rate[1] for Medicaid recipients in North Carolina has fallen from 14.9 in 1987, the year the Baby Love program started, to 10.2 in 1993, the last year for which we have complete data.

The state infant mortality rate including both Medicaid and non-Medicaid births has decreased from 12.6 in 1988 to 9.2 in 1995 (the state's lowest rate ever recorded). This constitutes a 27% decrease in infant mortality during this time period.

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 pays for child health examinations to detect problems early, as well as for the diagnosis, treatment, and referrals necessary to correct any identified health problems. In addition to paying for services, Health Check attempts to ensure that children receive regular health check-ups.

The EPSDT program has been in existence since Medicaid began. With the implementation of the Health Check Program in the fall of 1993, several strategies were initiated to improve the availability and accessibility of comprehensive and continuous preventive and primary health care services for Health Check eligibles. The goal of the Health Check Program 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.

[1] Deaths per 1,000 births. Infant deaths are counted if they occur at birth or anytime during the first year of life.

- 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 and implementation of an automated information and notification system to provide families, caregivers and Health Check coordinators with information regarding program participation.
- Expansion of coverage for specialized services.

All of these efforts will improve Medicaid eligible children's access to and utilization of health care services.

Community Alternatives Program

North Carolina operates four 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.

CAP/DA Program:

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 October 1996, all 100 of North Carolina's counties offered CAP/DA. 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 8,000 people in SFY 1996 at less than 70 percent of the cost of nursing facility care. In State Fiscal Year 1996, the average cost per recipient per month was $1,503.

CAP-MR/DD:

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 3,167 individuals in SFY 1996. Participants in the CAP-MR/DD were served at less than 25 percent of the average Medicaid cost for institutional care. In SFY 1996, the average cost per recipient per month for CAP-MR/DD was $2,464.

CAP/C

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. There were 108 children who participated in CAP/C in SFY 1996 and the average cost per recipient per month was $6,344 for CAP/C for the same time period.

CAP/AIDS:

CAP/AIDS is a new Medicaid program that provides an alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive and meet other criteria. CAP/AIDS is a cooperative effort with the Division of Health Promotion (DHP) in the Department of Environment, Health and Natural Resources. DHP's AIDS Care Branch handles the program operation with DMA personnel providing oversight. The program started in November 1995 and much of this year's efforts have involved implementation activities. CAP/AIDS case management agencies are the entry point; therefore, CAP/AIDS is available where there are CAP/AIDS case management agencies. DHP and DMA have been actively encouraging the participation of appropriate agencies in

the program to develop statewide availability. Since this is a new program, only a total of $5,665 was spent for CAP/AIDS in SFY 1996.

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.

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 for the basic plan. 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. In fact, 42,930 Medicare recipients benefited from Medicare-Aid in SFY 1996. The average cost per recipient was $3,359 for that time period.

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, since December 1, 1993, the Medicaid program 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).

Long-Term Care

Long-Term Care comprises the costliest piece of the Medicaid budget consuming 20% of the State's total service expenditures. In state fiscal year 1996, 50,537 people received long-term care in North Carolina costing a total of $722,454,032. The average cost per recipient was $14,296 for the year.

Nursing Home Reform

Many of the nursing home reform provisions included in 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 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.

Spousal Impoverishment

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. 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 currently ranges from a minimum of $15,348 to a $76,740 maximum.

1996 TABLES and CHARTS

APPENDIX A
MEDICAID TABLES

Table 1
North Carolina Medicaid
State Fiscal Year 1996
Federal Matching Rates

Benefit Costs
(7/1/95 - 9/30/95)

	Family Planning		All Other
Federal	90.0%	Federal	64.71%
State	8.5%	State	30.00%
County	1.5%	County	5.29%

Benefit Costs
(10/1/95 - 6/30/96)

	Family Planning		All Other
Federal	90.0%	Federal	64.59%
State	8.5%	State	30.10%
County	1.5%	County	5.31%

Administrative Costs
(7/1/95 - 6/30/96)

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

*MMIS-Medicaid Management Information System

Table 2
North Carolina Medicaid
State Fiscal Year 1996
Medicaid Financial Eligibility Standards

Eligibility Income Levels
(Annual)

Family Size	* AFDC Related * Groups: Categorically Needy	* AFDC Related * Groups: Medically Needy	Aged, Blind & Disabled: SSI	Aged, Blind & Disabled: Medically Needy	Pregnant Women Infants < 1 Yr. 185% of Poverty	Children Ages 1-5 133% of Poverty	Children Age 6 - 18 100% 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	5,640	2,904	14,328	10,296	7,740	7,740	7,740 - 9,288	Minimum of $15,048	15,480
2	5,664	3,804	8,460	3,804	19,176	13,788	10,368	10,368	10368 - 12432	up to a Maximum of	20,724
3	6,528	4,404		N/A	24,024	17,268	12,984			$23,028	
4	7,128	4,800		N/A	28,860	20,748	15,600				
5	7,776	5,196		N/A	33,708	24,240	18,228				
Eligibility Resource Limits											
1	$1,000	$1,500		$2,000	NO RESOURCE TEST			$4,000	$4,000	$15,348 minimum	$4,000
2	No increment	2,250		3,000	APPLIES			6,000	6,000	$76,740 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. 8/96)

Table 3
North Carolina Medicaid
State Fiscal Year 1996
Enrolled Medicaid Providers

Providers	SFY 1996
Physicians*	25,323
Dentists	3,180
Pharmacists	2,530
Optometrists	910
Chiropractors	926
Podiatrists	339
Ambulance Companies	287
Home Health Agencies**	170
Durable Medical Equip. Suppliers	1,757
Intermediate Care Facilities-MR	528
Hospitals	355
Mental Health Clinics	42
Nursing Facilities	523
Optical Supplies Company***	1
Domicile Care	1,781
Personal Care Agencies	199
Rural Health Clinics	115
CRNA	810
Nurse Midwives	41
Hospices	71
CAP Providers	468
Other Clinics	58
Other	2,886
Total	**43,300**

* 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
North Carolina Medicaid
State Fiscal Year 1996
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
North Carolina Medicaid
State Fiscal Year 1995 & 1996
Sources of Medicaid Funds

		1995		1996
Federal	$	2,221,867,100	$	2,600,855,361
State Appropriated	$	942,583,866	$	1,040,207,046
State, Other	$	198,086,742	$	289,101,309
County	$	187,930,522	$	183,181,061
Total	**$**	**3,550,468,230**	**$**	**4,113,344,777**

Source: DAS report

Table 6
North Carolina Medicaid
State Fiscal Year 1996
Uses of Medicaid Funds

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	691,202,501	16.8%	19.2%	187,285	3,691
Outpatient Hospital	214,340,262	5.2%	6.0%	526,065	407
Mental Hospital >65 & <21	31,013,857	0.8%	0.9%	2,238	13,858
Physician	337,282,703	8.2%	9.4%	912,138	370
Clinics	223,886,598	5.4%	6.2%	333,676	671
Nursing Facility (Skilled)	386,294,858	9.4%	10.7%	28,855	13,387
Nursing Facility (Intermediate)	336,159,174	8.2%	9.3%	23,115	14,543
ICF-MR	355,172,014	8.6%	9.9%	4,992	71,148
Dental	42,318,146	1.0%	1.2%	229,477	184
Prescription Drugs	324,331,335	7.9%	9.0%	756,882	429
Home Health	96,070,494	2.3%	2.7%	58,449	1,644
Other Services	408,677,500	9.9%	11.4%	1,556,924	262
Medicare Premiums:					
(Part A, Part B, QMB, Dually Eligible)	144,203,940	3.5%	4.0%		
HMO Premium	6,021,954	0.1%	0.2%		
Subtotal Services	**3,596,975,336**				
Adjustments & Cost Settlements	103,166,771	2.5%			
Disproportionate Share Payments	280,842,697	6.8% **			
Subtotal Services & Other	**$ 3,980,984,804**	**96.8%**			
Administration (State & County)	132,359,973	3.2%			
(State)	61,073,915	1.5%			
(County)	71,286,058	1.7%			
Grand Total Expenditures	**$ 4,113,344,777**	**100.0%**			
Total Recipients (unduplicated)* **				1,158,659	
Total Expenditures Per Recipient (unduplicated)					$ 3,550

* "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 1996-2082 report, SFY 1996-DAS report, SFY 1996-PER report

Table 7
North Carolina Medicaid
A History of Medicaid Expenditures
SFY 1979-1996

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%
1996	$	4,113,344,777	16%

North Carolina Medicaid
State Fiscal Years 1979-1996
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%
1995-96	131,496	53,072	2,710	171,204	496,501	52,466	261,525	3,696	3,919	1,176,589	3.32%
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%	
SFY 1996 Percent Total Eligibles:	11.2%	4.5%	0.2%	14.6%	42.2%	4.5%	22.2%	0.3%	0.3%	100.0%	

Source: Medicaid Eligibility Report, SFY 1996

Table 9
North Carolina Medicaid
State Fiscal Year 1996
Total Expenditures and Eligibles by County

COUNTY NAME	1996 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 1996 population (Column D / Column C)
ALAMANCE	117,115	14,845	$ 51,484,651	$ 3,468	$ 439.61	74	127	12.68%
ALEXANDER	30,766	4,039	12,561,961	3,110	408.31	87	131	13.13%
ALLEGHANY	9,555	1,514	5,747,568	3,796	601.52	39	158	15.85%
ANSON	23,786	6,444	21,314,352	3,308	896.09	9	271	27.09%
ASHE	23,166	4,219	16,700,561	3,958	720.91	27	182	18.21%
AVERY	15,205	2,760	11,977,395	4,340	787.73	15	182	18.15%
BEAUFORT	43,645	9,965	32,426,330	3,254	742.96	26	228	22.83%
BERTIE	20,701	6,399	19,338,572	3,022	934.19	7	309	30.91%
BLADEN	30,063	8,511	26,152,517	3,073	869.92	8	283	28.31%
BRUNSWICK	62,750	11,888	32,462,591	2,731	517.33	38	189	18.95%
BUNCOMBE	191,798	29,128	96,842,489	3,325	504.92	60	152	15.19%
BURKE	82,866	12,300	40,454,711	3,289	488.19	63	148	14.84%
CABARRUS	113,031	13,498	46,160,624	3,420	408.39	79	119	11.94%
CALDWELL	74,338	10,893	37,761,950	3,467	507.98	55	147	14.65%
CAMDEN	6,445	987	3,027,782	3,068	469.79	75	153	15.31%
CARTERET	58,562	8,200	26,778,671	3,266	457.27	73	140	14.00%
CASWELL	21,311	4,000	12,614,982	3,154	591.95	43	188	18.77%
CATAWBA	127,942	16,657	49,545,880	2,974	387.25	91	130	13.02%
CHATHAM	43,712	5,068	17,895,524	3,531	409.40	76	116	11.59%
CHEROKEE	22,243	4,991	16,059,212	3,218	721.99	23	224	22.44%
CHOWAN	14,140	3,596	11,216,323	3,119	793.23	18	254	25.43%
CLAY	7,862	1,437	5,227,606	3,638	664.92	40	183	18.28%
CLEVELAND	90,053	16,211	46,740,402	2,883	519.03	67	180	18.00%
COLUMBUS	51,556	16,298	48,428,298	2,971	939.33	2	316	31.61%
CRAVEN	86,789	15,361	44,391,516	2,890	511.49	61	177	17.70%
CUMBERLAND	298,810	48,304	105,869,300	2,192	354.30	95	162	16.17%
CURRITUCK	16,257	2,366	5,943,160	2,512	365.58	93	146	14.55%
DARE	26,516	2,579	9,029,824	3,501	340.54	94	97	9.73%
DAVIDSON	138,501	18,045	53,207,802	2,949	384.17	89	130	13.03%
DAVIE	30,203	3,183	12,750,829	4,006	422.17	85	105	10.54%
DUPLIN	43,413	10,271	28,535,001	2,778	657.29	31	237	23.66%
DURHAM	194,685	29,036	96,262,570	3,315	494.45	68	149	14.91%
EDGECOMBE	56,714	17,567	46,202,839	2,630	814.66	16	310	30.97%
FORSYTH	284,157	38,421	117,701,240	3,063	414.21	84	135	13.52%
FRANKLIN	42,605	7,907	25,577,024	3,235	600.33	29	186	18.56%
GASTON	179,018	29,046	92,268,661	3,177	515.42	59	162	16.23%
GATES	9,835	1,902	5,830,710	3,066	592.85	44	193	19.34%
GRAHAM	7,556	1,816	6,163,819	3,394	815.75	17	240	24.03%
GRANVILLE	41,523	6,571	21,320,760	3,245	513.47	56	158	15.82%
GREENE	17,106	3,618	10,303,230	2,848	602.32	34	212	21.15%
GUILFORD	378,067	52,311	165,630,041	3,166	438.10	81	138	13.84%
HALIFAX	57,700	18,521	47,484,046	2,564	822.95	13	321	32.10%
HARNETT	78,967	14,937	43,089,049	2,885	545.66	49	189	18.92%
HAYWOOD	50,443	8,662	27,114,072	3,130	537.52	51	172	17.17%
HENDERSON	77,549	11,328	37,886,203	3,344	488.55	71	146	14.61%
HERTFORD	22,363	7,354	20,640,228	2,807	922.96	4	329	32.88%
HOKE	28,526	6,960	16,056,635	2,307	562.88	41	244	24.40%
HYDE	5,109	1,478	5,201,364	3,519	1,018.08	3	289	28.93%
IREDELL	105,957	14,098	42,973,010	3,048	405.57	83	133	13.31%
JACKSON	29,268	4,863	15,540,753	3,196	530.98	57	166	16.62%
JOHNSTON	98,845	17,180	55,016,651	3,202	556.60	50	174	17.38%
JONES	9,519	2,252	7,377,137	3,276	774.99	10	237	23.66%

North Carolina Medicaid
State Fiscal Year 1996 Cont'd
Total Expenditures and Eligibles by County

COUNTY NAME	1996 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 1996 population (Column D / Column C)
LEE	47,014	8,699	23,010,352	2,645	489.44	65	185	18.50%
LENOIR	59,466	14,847	44,384,043	2,989	746.38	22	250	24.97%
LINCOLN	56,782	7,604	21,465,490	2,823	378.03	86	134	13.39%
MACON	37,696	4,485	13,389,105	2,985	355.19	96	119	11.90%
MADISON	26,757	3,778	11,916,111	3,154	445.35	58	141	14.12%
MARTIN	18,020	6,474	18,967,102	2,930	1,052.56	1	359	35.93%
MCDOWELL	25,895	5,913	18,193,106	3,077	702.57	32	228	22.83%
MECKLENBURG	592,634	76,508	222,670,548	2,910	375.73	88	129	12.91%
MITCHELL	14,864	2,464	8,761,413	3,556	589.44	30	166	16.58%
MONTGOMERY	24,090	5,605	15,911,307	2,839	660.49	45	233	23.27%
MOORE	68,732	9,596	29,252,009	3,048	425.60	78	140	13.96%
NASH	85,588	15,020	44,645,504	2,972	521.63	66	175	17.55%
NEW HANOVER	144,043	22,994	71,796,587	3,122	498.44	54	160	15.96%
NORTHAMPTON	20,714	6,733	18,542,585	2,754	895.17	5	325	32.50%
ONSLOW	150,714	18,513	45,380,844	2,451	301.11	100	123	12.28%
ORANGE	107,992	7,985	30,306,165	3,795	280.63	98	74	7.39%
PAMLICO	11,972	2,177	8,073,967	3,709	674.40	28	182	18.18%
PASQUOTANK	33,501	7,772	20,027,681	2,577	597.82	48	232	23.20%
PENDER	35,773	7,586	22,486,130	2,964	628.58	35	212	21.21%
PERQUIMANS	10,716	2,682	6,512,007	2,428	607.69	46	250	25.03%
PERSON	32,608	5,637	19,297,807	3,423	591.81	33	173	17.29%
PITT	119,276	23,644	72,787,294	3,078	610.24	37	198	19.82%
POLK	15,931	1,966	7,290,365	3,708	457.62	72	123	12.34%
RANDOLPH	117,405	14,896	47,766,483	3,207	406.85	90	127	12.69%
RICHMOND	45,619	11,889	38,537,034	3,241	844.76	19	261	26.06%
ROBESON	111,894	34,751	93,364,271	2,687	834.40	12	311	31.06%
ROCKINGHAM	89,345	14,912	49,103,034	3,293	549.59	52	167	16.69%
ROWAN	121,032	17,127	52,238,158	3,050	431.61	82	142	14.15%
RUTHERFORD	59,479	9,987	30,972,661	3,101	520.73	69	168	16.79%
SAMPSON	51,177	12,501	37,395,030	2,991	730.70	25	244	24.43%
SCOTLAND	34,916	10,311	27,214,074	2,639	779.42	20	295	29.53%
STANLY	54,301	8,498	27,486,026	3,234	506.18	70	156	15.65%
STOKES	42,146	5,319	17,347,063	3,261	411.59	80	126	12.62%
SURRY	66,110	9,752	34,435,007	3,531	520.87	62	148	14.75%
SWAIN	11,662	3,078	8,691,849	2,824	745.31	21	264	26.39%
TRANSYLVANIA	27,447	4,292	13,876,818	3,233	505.59	53	156	15.64%
TYRRELL	3,752	1,111	3,316,603	2,985	883.96	6	296	29.61%
UNION	101,507	12,638	35,189,299	2,784	346.67	92	125	12.45%
VANCE	40,297	11,803	31,578,337	2,675	783.64	14	293	29.29%
WAKE	538,131	47,922	134,956,714	2,816	250.79	99	89	8.91%
WARREN	18,331	4,825	14,497,572	3,005	790.88	11	263	26.32%
WASHINGTON	13,675	3,821	10,207,199	2,671	746.41	24	279	27.94%
WATAUGA	40,607	3,802	13,673,127	3,596	336.72	97	94	9.36%
WAYNE	112,331	20,889	56,968,820	2,727	507.15	64	186	18.60%
WILKES	62,438	10,054	37,330,122	3,713	597.88	47	161	16.10%
WILSON	68,583	16,458	45,096,790	2,740	657.55	36	240	24.00%
YADKIN	34,464	4,390	15,250,588	3,474	442.51	77	127	12.74%
YANCEY	16,278	3,096	10,042,970	3,244	616.97	42	190	19.02%
STATE TOTAL	7,322,317	1,176,589	$3,535,891,597	$3,005	$482.89	N/A	161	16.07%

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1996.
Note: Data reflect only net vendor payments for which the county is billed for its computable share.

Table 10
North Carolina Medicaid
State Fiscal Year 1996
Medicaid Service Expenditures by Eligibility Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 1996 Expenditures Per Recipient	SFY 1995 Expenditures Per Recipient	95/96 Percent Change
Total Elderly	**$ 1,194,882,237**	**33.2%**	**168,125**	**14.5%**	**$ 7,107**	**$ 6,226**	**14.2%**
Aged	1,142,658,568	31.8%	125,195	10.8%	9,127	9,933	-8.1%
Medicare-Aid (MQBQ & MQBB)	52,223,669	1.5%	42,930	3.7%	1,216	1,056	15.2%
Total Disabled	**$ 1,346,698,107**	**37.4%**	**155,864**	**13.5%**	**8,640**	**8,658**	**-0.2%**
Disabled	1,325,740,704	36.9%	153,622	13.3%	8,630	8,630	0.0%
Blind	20,957,403	0.6%	2,242	0.2%	9,348	11,075	-15.6%
Total Families & Children	**$ 1,066,059,581**	**29.6%**	**830,852**	**71.7%**	**1,283**	**1,311**	**-2.1%**
AFDC Adults (> 21)	291,600,199	8.1%	179,988	15.5%	1,620	1,579	2.6%
Medicaid Pregnant Women Coverage	159,950,771	4.4%	79,865	6.9%	2,003	1,760	13.8%
AFDC Children & Other Children	344,491,498	9.6%	319,579	27.6%	1,078	1,146	-5.9%
Medicaid Indigent Children	270,017,113	7.5%	251,420	21.7%	1,074	1,196	-10.2%
Aliens & Refugees	**$ 7,844,365**	**0.2%**	**3,818**	**0.3%**	**2,055**	**1,646**	
Adjustments Not Attributable To A Specific Category	**$ (18,508,954)**	**-0.5%**					
Total Service Expenditures All Groups	**$ 3,596,975,336**	**100%**	**1,158,659**	**100%**	**$ 3,104**	**$ 2,884**	**7.6%**

Note: Total Service Expenditures does not include:

Disproportionate Share payments	$280,842,697
State & county administrative costs	$132,359,973
Adjustments processed by DMA settlements	$103,166,771
HMO premiums	$4,507,752
TOTAL	$ 520,877,193

See Table 6 for more details.
Source: SFY 1996 Program Expenditure Report and 2082 Report.

Table 11
North Carolina Medicaid
State Fiscal Year 1996
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	$ 691,202,501	19.2%	$ 15,954,097	$ 3,956,208	$ -	$ 1,894,938	$ 301,518,887	168,906,962	198,356,993	$ 5,109,480	$ (4,495,064)
Outpatient Hospital	214,340,262	6.0%	18,606,431	7,854,634	-	835,893	73,135,641	58,811,211	56,520,803	194,476	(1,618,827)
Mental Hospital (> 65)	13,718,463	0.4%	13,847,484	27,228	-	60,393	8,205	-	-	-	(224,847)
Psychiatric Hospital (< 21)	17,295,394	0.5%	-	-	-	20,168	4,981,057	46,595	12,325,210	-	(77,636)
Physician	337,282,703	9.4%	35,040,810	10,468,780	-	1,054,837	91,941,047	92,978,859	106,847,351	1,694,638	(2,743,619)
Clinics	223,886,598	6.2%	7,834,446	3,180,156	-	669,954	80,582,810	49,476,594	83,663,049	288,866	(1,809,277)
Nursing Facility:											
Skilled Level	386,294,858	10.7%	343,441,608	93,854	-	1,445,717	45,949,811	62,416	199,892	32,194	(4,930,634)
Intermediate Level	336,159,174	9.3%	308,951,596	44	-	1,428,158	25,710,689	-	201,260	69,841	(202,414)
Intermediate Care Facility (Mentally Retarded)	355,172,014	9.9%	12,384,446	-	-	6,361,843	330,810,168	-	5,661,580	422	(46,445)
Dental	42,318,146	1.2%	5,378,935	3,824	-	133,154	10,244,794	9,664,958	16,805,398	138,361	(51,278)
Prescription Drugs	324,331,335	9.0%	120,388,333	-	-	1,927,373	131,714,576	32,149,412	38,589,793	64,806	(502,958)
Home Health	96,070,494	2.7%	14,535,772	76,043	-	811,695	62,800,211	4,285,296	14,421,555	9,933	(870,011)
CAP/Disabled Adult	86,997,985	2.4%	67,565,741	-		645,278	18,942,572	440	-	-	(156,046)
CAP/Mentally Retarded	56,651,628	1.6%	771,601	-		619,929	54,820,409	-	496,736	-	(57,047)
CAP/Children	3,121,489	0.1%	-	-	-	5,767	3,080,510	-	40,142	-	(4,930)
Personal Care	58,075,382	1.6%	41,134,616	28	-	1,167,180	15,364,300	346,363	160,701	-	(97,806)
Hospice	10,588,771	0.3%	4,198,021	-	-	65,066	6,220,983	121,025	51,819	-	(68,143)
EPSDT (Health Check)	28,219,077	0.8%	179	40	-	6,921	831,660	22,339	27,395,332	8,826	(46,220)
Lab & X-Ray	25,632,155	0.7%	2,211,889	788,768	-	93,180	8,732,481	8,897,932	4,965,040	41,865	(99,000)
Adult Care Home	48,503,112	1.3%	29,183,746	22,062		199,839	19,472,421	549	5,443	-	(380,948)
Other Services	96,909,566	2.7%	6,739,725	622,628	-	174,225	16,187,871	25,456,448	47,792,482	187,701	(251,514)
Total Services	**3,452,771,107**	**96.0%**	**1,048,169,476**	**27,094,297**	**-**	**19,621,508**	**1,303,051,103**	**451,227,399**	**614,500,579**	**7,841,409**	**(18,734,664)**
Part A Premium	38,236,137	1.1%	37,396,079	170,805	-	711,038	12,100	-	-		(53,885)
Part B Premium	105,968,092	2.9%	57,093,013	19,405,073	5,553,494	624,857	22,677,501	323,571	8,032	2,956	279,595
HMO Premium	6,021,954	0.2%	-	-	-	-	-	-	-	-	-
Total Premiums	**144,204,229**		**94,489,092**	**19,575,878**	**5,553,494**	**1,335,895**	**22,689,601**	**323,571**	**8,032**	**2,956**	**225,710**
Grand Total Services and Premiums	**$ 3,596,975,336**		**1,142,658,568**	**46,670,175**	**5,553,494**	**20,957,403**	**1,325,740,704**	**451,550,970**	**614,508,611**	**7,844,365**	**(18,508,954)**

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 Child.

Table 12
North Carolina Medicaid
State Fiscal Year 1996
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 1996 % of Total Dollars	SFY 1995 % of Total Dollars	SFY 1994 % of Total Dollars
Inpatient Hospital	$ 15,954,097	1.4%	$ 3,956,208	$ -	$ 3,956,208	7.6%	$ 19,910,305	1.7%	2.7%	3.8%
Outpatient Hospital	$ 18,606,431	1.6%	7,854,634	-	7,854,634	15.0%	26,461,065	2.2%	2.4%	2.7%
Mental Hospital (>65)	13,847,484	1.2%	27,228	-	27,228	0.1%	13,874,712	1.2%	1.4%	1.5%
Physician	35,040,810	3.1%	10,468,780	-	10,468,780	20.0%	45,509,590	3.8%	3.8%	4.0%
Clinics	7,834,446	0.7%	3,180,156	-	3,180,156	6.1%	11,014,602	0.9%	0.8%	0.8%
Nursing Facility:										
Skilled Level:	343,441,608	30.1%	93,854	-	93,854	0.2%	343,535,462	28.8%	29.5%	32.8%
Intermediate Level:	308,951,596	27.0%	44	-	44	0.0%	308,951,640	25.9%	28.4%	33.3%
Intermediate Care Facility-										
Mentally Retarded	12,384,446	1.1%	-	-	-	0.0%	12,384,446	1.0%	1.0%	1.1%
Dental	5,378,935	0.5%	3,824	-	3,824	0.0%	5,382,759	0.5%	0.3%	0.3%
Prescription Drugs	120,388,333	10.5%	-	-	-	0.0%	120,388,333	10.1%	8.7%	8.9%
Home Health	14,535,772	1.3%	76,043	-	76,043	0.1%	14,611,815	1.2%	1.2%	1.1%
CAP/Disabled Adult	67,565,741	5.9%	-	-	-	0.0%	67,565,741	5.7%	5.0%	5.2%
CAP/Mentally Retarded	771,601	0.1%	-	-	-	0.0%	771,601	0.1%	0.0%	0.0%
Personal Care	41,134,616	3.6%	28	-	28	0.0%	41,134,644	3.4%	2.7%	2.9%
Hospice	4,198,021	0.4%	-	-	-	0.0%	4,198,021	0.4%	0.5%	0.5%
EPSDT (Health Check)	179	0.0%	40	-	40	0.0%	219	0.0%	0.0%	0.0%
Lab & X-Ray	2,211,889	0.2%	788,768	-	788,768	1.5%	3,000,657	0.3%	0.3%	0.3%
Adult Care Home	29,183,746	2.6%	22,062	-	22,062	0.0%	29,205,808	2.4%		
Other Services	6,739,725	0.6%	622,628	-	622,628	1.2%	7,362,353	0.6%	0.6%	0.6%
Service Expenditures	**$ 1,048,169,476**	**91.7%**	**27,094,297**	**-**	**27,094,297**	**51.9%**	**1,075,263,773**	**90.0%**	**89%**	**100%**
Part A Premium	37,396,079	3.3%	170,805	-	170,805	0.3%	37,566,884	3.1%	3.2%	6.0%
Part B Premium	57,093,013	5.0%	19,405,073	5,553,494	24,958,567	47.8%	82,051,580	6.9%	7.6%	0.6%
HMO Premium		0.0%		-	-	0.0%	-	0.0%	0.0%	0.0%
Total Premiums	**$ 94,489,092**	**100%**	**19,575,878**	**5,553,494**	**25,129,372**	**100%**	**119,610,464**			
Total Service & Premiums	**$ 1,142,658,568**		**46,670,175**	**5,553,494**	**52,223,669**		**1,194,882,237**			
Medicare Crossovers**	**$ 93,911,366**									
Total Elderly Recipients	125,195		42,930	8,648	51,578		176,773			
Service Expenditures Per Recipient *	**$ 9,127**		**$ 1,087**	**$ 642**	**$ 1,013**		**$ 6,759**			

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

** Medicare Crossovers are amounts that Medicaid bills Medicare for those Medicaid eligible people who are also eligible for Medicare.

Source: SFY 1996 Program Expenditure Report and 2082 Report

Table 13
North Carolina Medicaid
State Fiscal Year 1996
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	SFY 1996 % of Total Dollars	SFY 1995 % of Total Dollars
Inpatient Hospital	$ 301,518,887	22.7%	$ 1,894,938	9.0%	$ 303,413,825	22.5%	22.2%
Outpatient Hospital	73,135,641	5.5%	835,893	4.0%	73,971,534	5.5%	5.3%
Psychiatric Hospital (>65)	8,205	0.0%	60,393	0.3%	68,598	0.0%	0.0%
Psychiatric Hospital (<21)	4,981,057	0.4%	20,168	0.1%	5,001,225	0.4%	0.2%
Physician	91,941,047	6.9%	1,054,837	5.0%	92,995,884	6.9%	6.9%
Clinics	80,582,810	6.1%	669,954	3.2%	81,252,764	6.0%	4.1%
Nursing Facility:							
Skilled Level:	45,949,811	3.5%	1,445,717	6.9%	47,395,528	3.5%	4.6%
Intermediate Level:	25,710,689	1.9%	1,428,158	6.8%	27,138,847	2.0%	2.4%
Intermediate Care Facility-							
Mentally Retarded	330,810,168	25.0%	6,361,843	30.4%	337,172,011	25.0%	30.6%
Dental	10,244,794	0.8%	133,154	0.6%	10,377,948	0.8%	0.7%
Prescription Drugs	131,714,576	9.9%	1,927,373	9.2%	133,641,949	9.9%	9.0%
Home Health	62,800,211	4.7%	811,695	3.9%	63,611,906	4.7%	4.8%
CAP/Disabled Adult	18,942,572	1.4%	645,278	3.1%	19,587,850	1.5%	1.5%
CAP/Children	54,820,409	4.1%	619,929	3.0%	55,440,338	4.1%	2.5%
CAP/Mentally Retarded	3,080,510	0.2%	5,767	0.0%	3,086,277	0.2%	0.2%
Personal Care	15,364,300	1.2%	1,167,180	5.6%	16,531,480	1.2%	1.3%
Hospice	6,220,983	0.5%	65,066	0.3%	6,286,049	0.5%	0.5%
EPSDT	831,660	0.1%	6,921		838,581	0.1%	0.0%
Lab & X-Ray	8,732,481	0.7%	93,180	0.4%	8,825,661	0.7%	0.8%
Adult Care Home	19,472,421	1.5%	199,839	1.0%	19,672,260	1.5%	
Other Services	16,187,871	1.2%	174,225	0.8%	16,362,096	1.2%	0.7%
Part A Premium	12,100	0.0%	711,038	3.4%	723,138	0.1%	0.1%
Part B Premium	22,677,501	1.7%	624,857	3.0%	23,302,358	1.7%	1.6%
HMO Premium	-	0.0%	-	0.0%	-	0.0%	0.0%
Total Service & Premiums	**$ 1,325,740,704**		**$ 20,957,403**		**$ 1,346,698,107**		
Medicare Crossovers*	**$ 37,561,644**		**$ 1,008,154**		**$ 38,569,798**		
Number of Disabled/Blind Recipients	153,622		2,242		155,864		
Service Expenditures Per Recipient**	**$ 8,630**		**$ 9,348**		**$ 8,640**		

* Medicare Crossovers are amounts that are billed to Medicare for those Medicaid eligible people who are also eligible for Medicare.

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

Source: SFY 1996 Program Expenditure Report and 2082 Report

Table 14
North Carolina Medicaid
State Fiscal Year 1996
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 1996 % of Total Dollars	SFY 1995 % of Total Dollars
Inpatient Hospital	$ 106,338,018	36.5%	$ 62,568,944	39.1%	$ 92,830,504	26.9%	105,526,489	39.1%	$ 367,263,955	34.5%	34.1%
Outpatient Hospital	44,949,147	15.4%	13,862,064	8.7%	33,859,287	9.8%	22,661,516	8.4%	115,332,014	10.8%	11.6%
Psychiatric Hospital (<21)	-	0.0%	46,595	0.0%	8,881,604	2.6%	3,443,606	1.3%	12,371,805	1.2%	1.4%
Physician	55,299,162	19.0%	37,679,697	23.6%	56,275,548	16.3%	50,571,803	18.7%	199,826,210	18.8%	19.4%
Clinics	19,762,640	6.8%	29,713,954	18.6%	59,210,898	17.2%	24,452,151	9.1%	133,139,643	12.5%	8.8%
Nursing Facility:											
Skilled Level:	53,305	0.0%	9,111	0.0%	94,629	0.0%	105,263	0.0%	262,308	0.0%	0.1%
Intermediate Level:	-	0.0%	-	0.0%	120,454	0.0%	80,806	0.0%	201,260	0.0%	0.0%
Intermediate Care Facility-Mentally Retarded	-	0.0%	-	0.0%	4,904,146	1.4%	757,434	0.3%	5,661,580	0.5%	1.7%
Dental	9,232,716	3.2%	432,242	0.3%	10,256,746	3.0%	6,548,652	2.4%	26,470,356	2.5%	2.6%
Prescription Drugs	29,220,148	10.0%	2,929,264	1.8%	21,747,369	6.3%	16,842,424	6.2%	70,739,205	6.6%	6.9%
Home Health	3,581,799	1.2%	703,497	0.4%	8,217,150	2.4%	6,204,405	2.3%	18,706,851	1.8%	3.1%
CAP/Disabled	440		-		-		-				
CAP/Mentally Retarded	-		-		494,926	0.1%	1,810				
CAP/Children	-	0.0%	-	0.0%	40,142	0.0%	-	0.0%	40,142	0.0%	0.0%
Personal Care	335,282	0.1%	11,081	0.0%	90,969	0.0%	69,732	0.0%	507,064	0.0%	0.1%
Hospice	121,025	0.0%	-	0.0%	41,910	0.0%	9,909	0.0%	172,844	0.0%	0.0%
Health Check - EPSDT	234	0.0%	22,105	0.0%	12,522,514	3.6%	14,872,818	5.5%	27,417,671	2.6%	2.2%
Lab & X-Ray	5,965,145	2.0%	2,932,787	1.8%	3,175,830	0.9%	1,789,210	0.7%	13,862,972	1.3%	1.4%
Adult Care Home	549	0.0%	-	0.0%	4,132	0.0%	1,311	0.0%	5,992	0.0%	
Other Services	16,440,877	5.6%	9,015,571	5.6%	31,720,231	9.2%	16,072,251	6.0%	73,248,930	6.9%	5.7%
Total Families & Children Service Expenditures	**$ 291,300,487**	99.9%	**159,926,912**		**344,488,989**		**270,011,590**		**1,065,230,802**		**99%**
Part A Premium	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0%
Total Premiums	**$ 299,712**		**23,859**		**2,509**		**5,523**		**331,603**		
Total Service & Premiums	**$ 291,600,199**		**159,950,771**		**344,491,498**		**270,017,113**		**1,065,562,405**		
Number of Family & Child Recipients	179,988		79,865		319,579		251,420		830,852		
Service Expenditures Per Recipient*	**$ 1,620**		**$ 2,003**		**$ 1,078**		**$ 1,074**		**$ 1,282**		

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

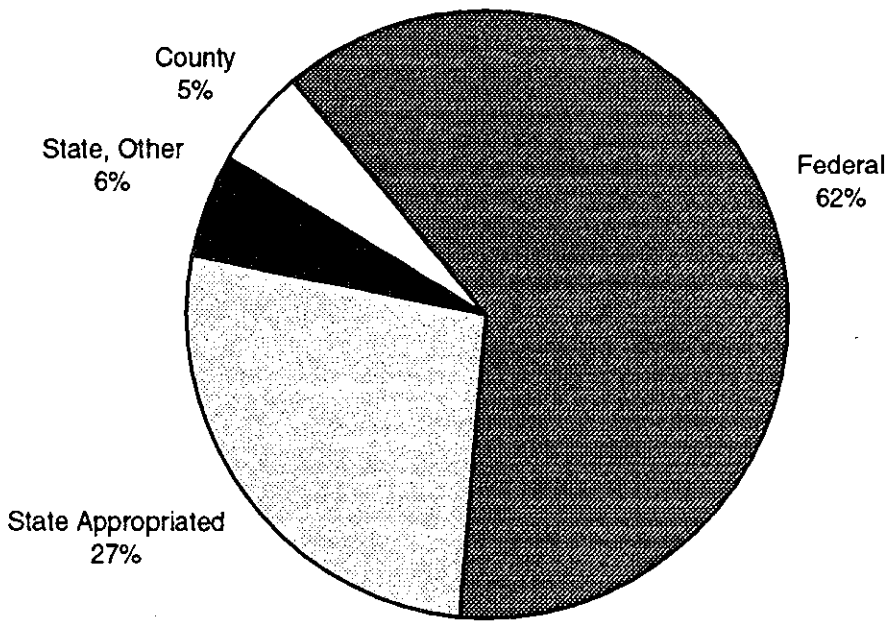
Source: SFY 1996 Program Expenditure Report & 2082 Report

Table 15
North Carolina Medicaid
State Fiscal Year 1996
Medicaid Copayment Amounts

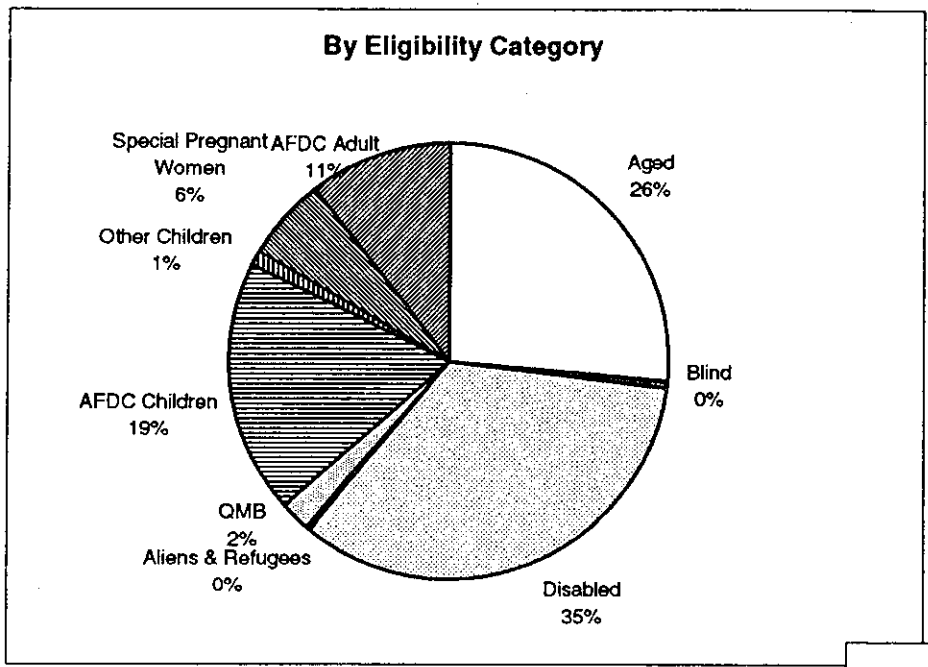
Service	Copayment Amount
Chiropractor visit	$ 1.00
Dental visit	3.00
Optical service	2.00
Optometrist visit	2.00
Outpatient visit	3.00
Physician visit	3.00
Podiatrist visit	1.00
Prescription drug (including refills)	1.00

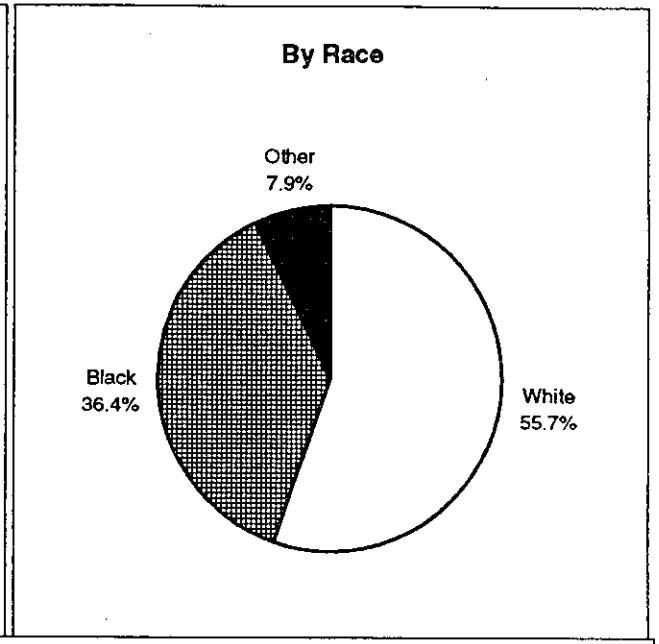
APPENDIX B
MEDICAID CHARTS

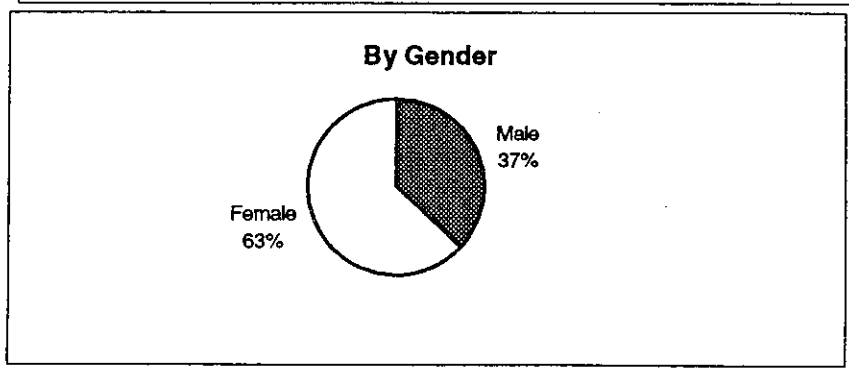
North Carolina Medicaid
State Fiscal Year 1996
Sources of Funds

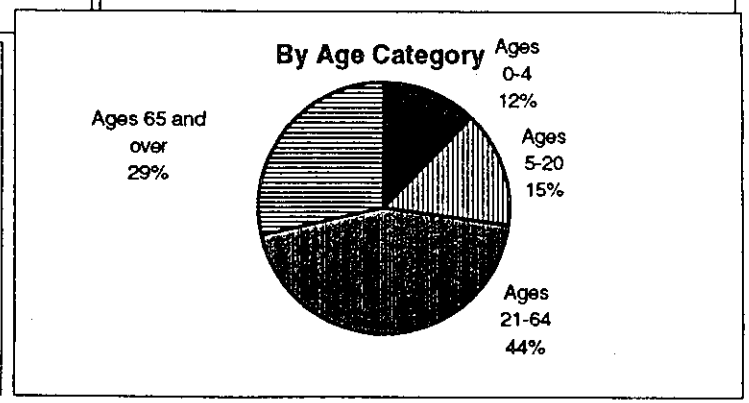


North Carolina Medicaid
State Fiscal Year 1996
Service Expenditures, Percent Distribution



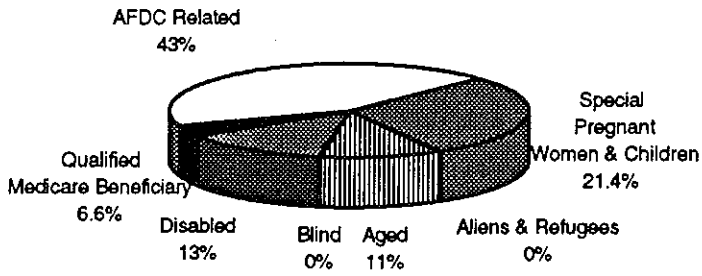




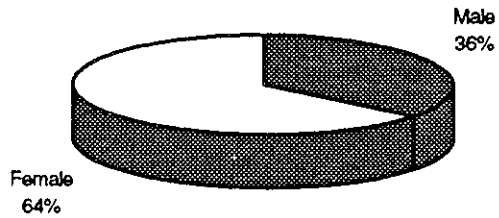


North Carolina Medicaid
SFY 1996
Recipients of Medicaid Services

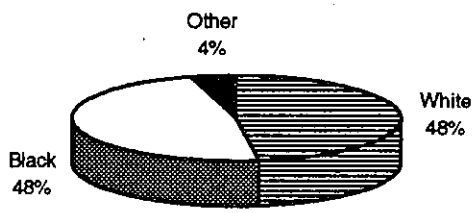
By Eligibility Category



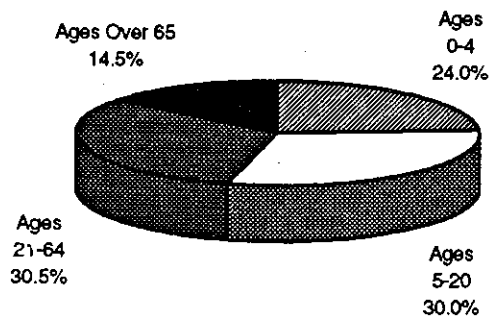
By Gender

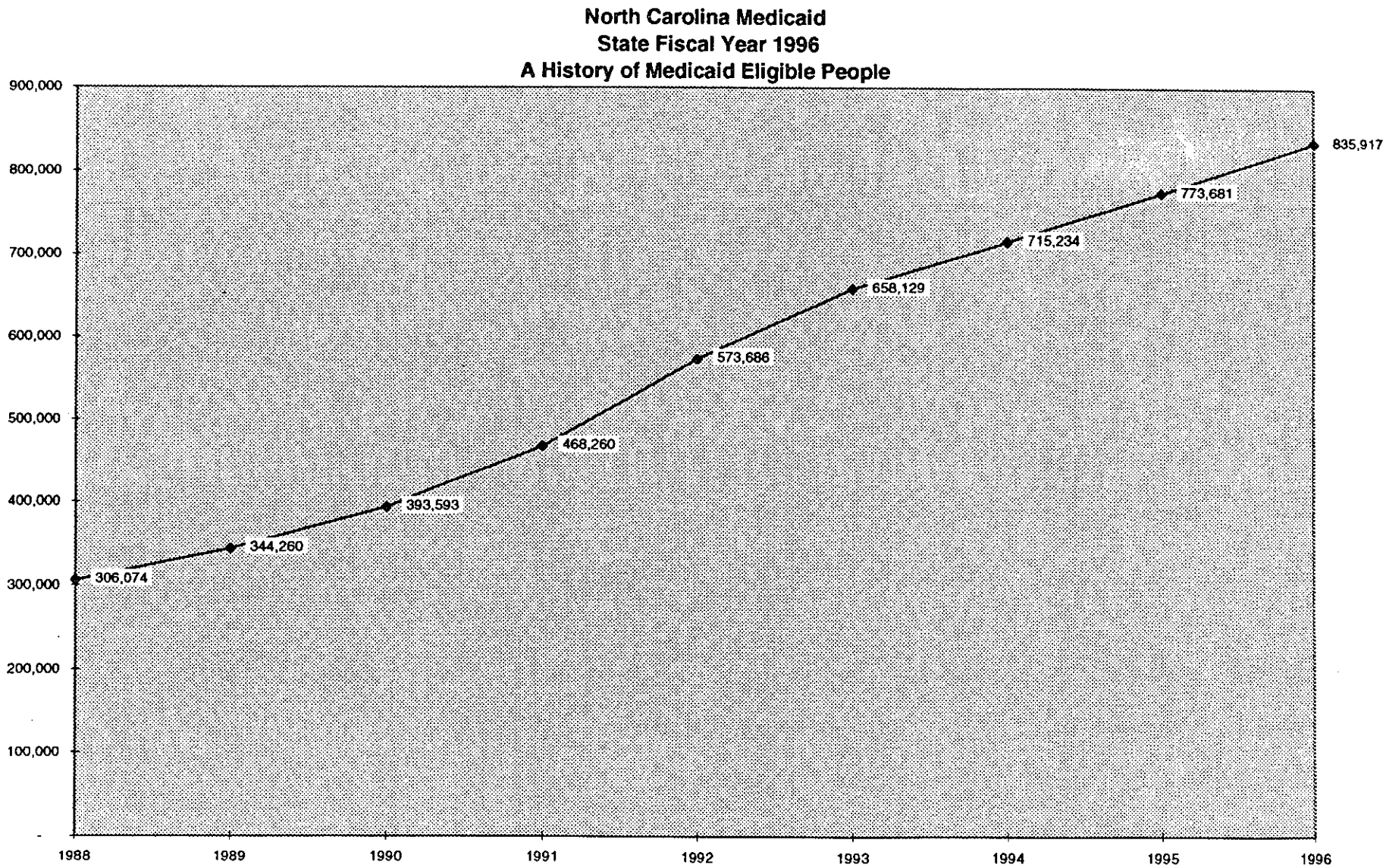


By Race

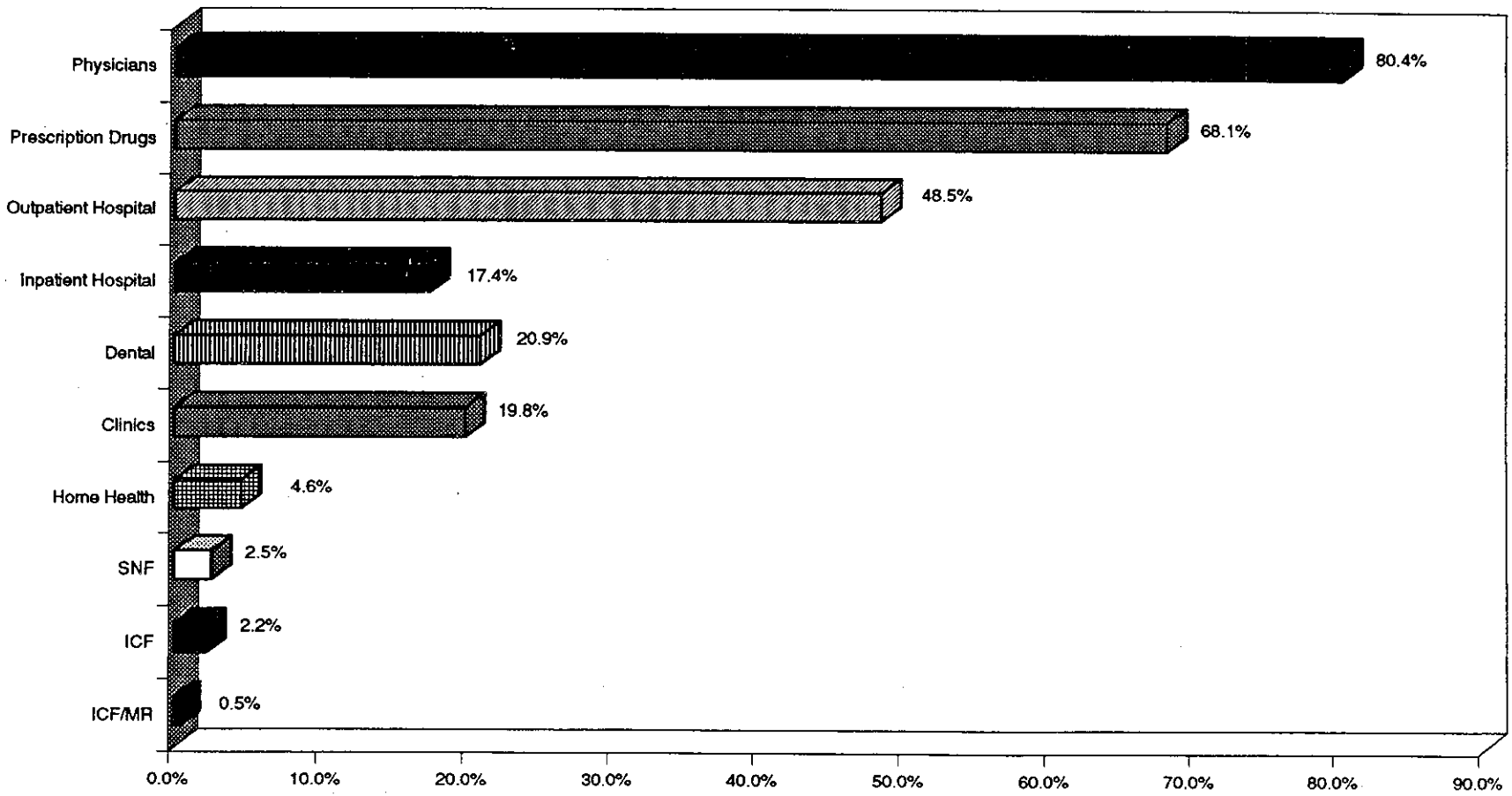


By Age Category

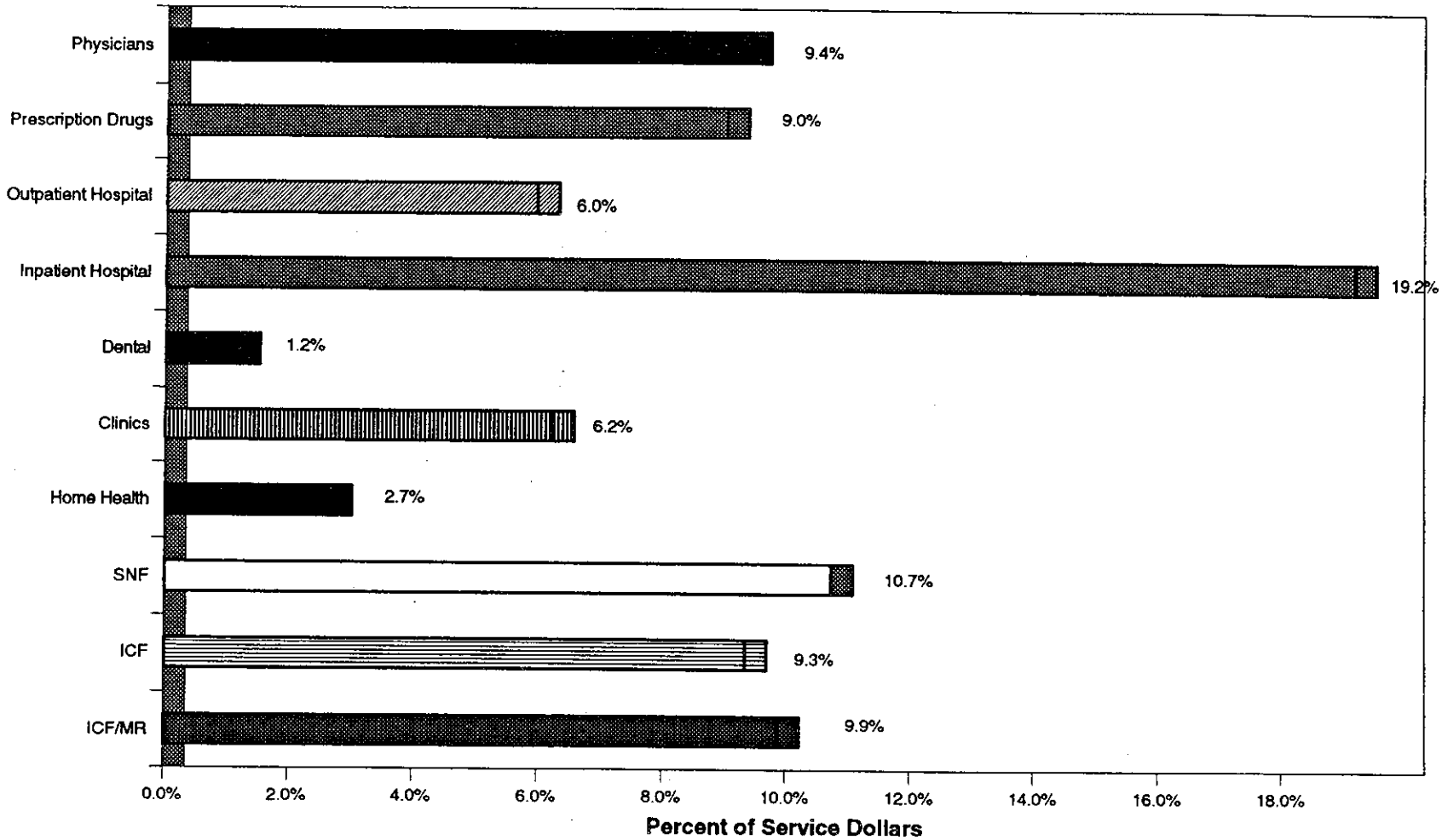



North Carolina Medicaid
State Fiscal Year 1996
A History of Medicaid Eligible People
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
-
306,074
344,260
393,593
468,260
573,686
658,129
715,234
773,681
835,917
1988
1989
1990
1991
1992
1993
1994
1995
1996

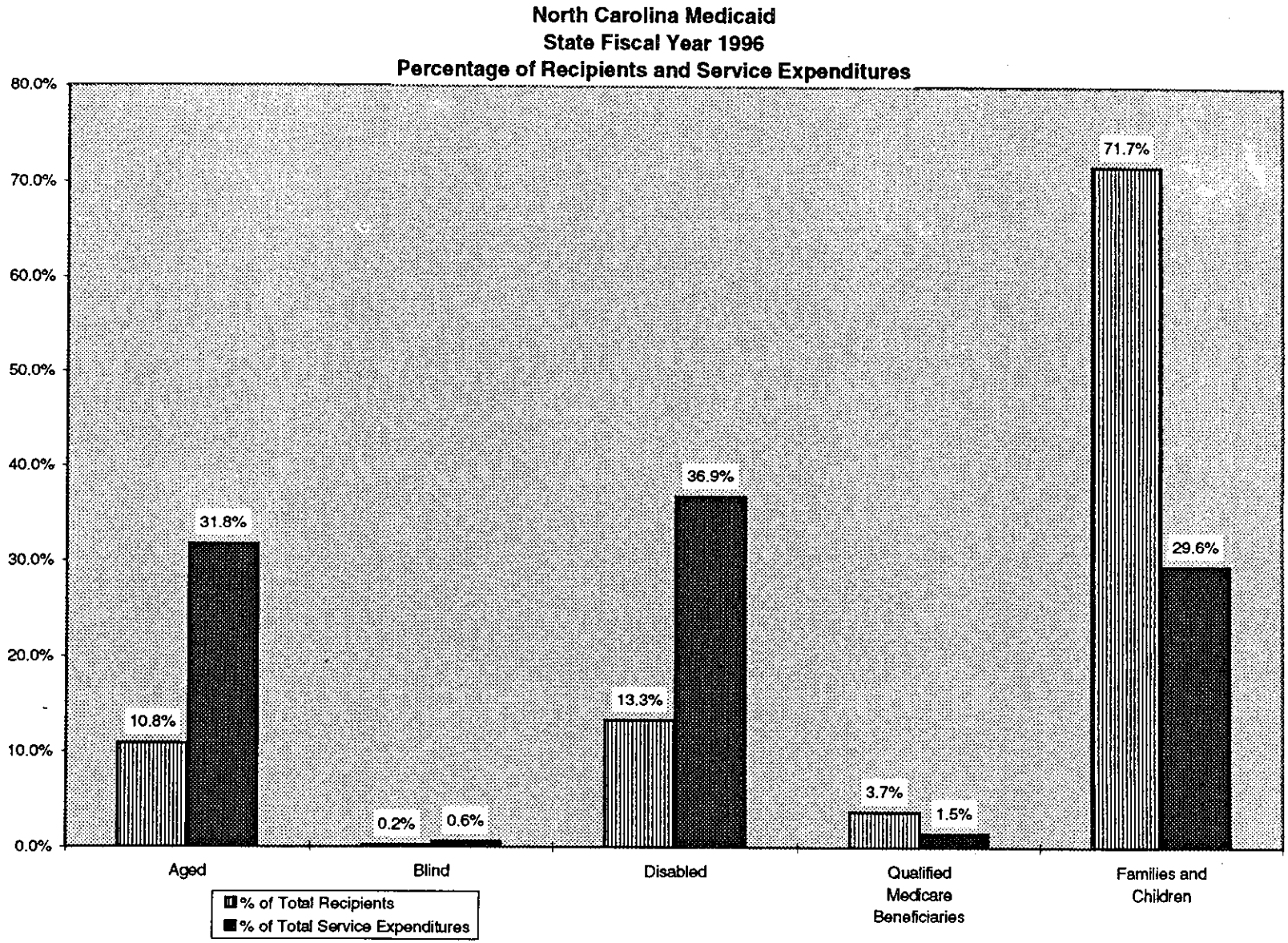
State Fiscal Year 1996
Selected Medicaid Services
Percent of Total Users



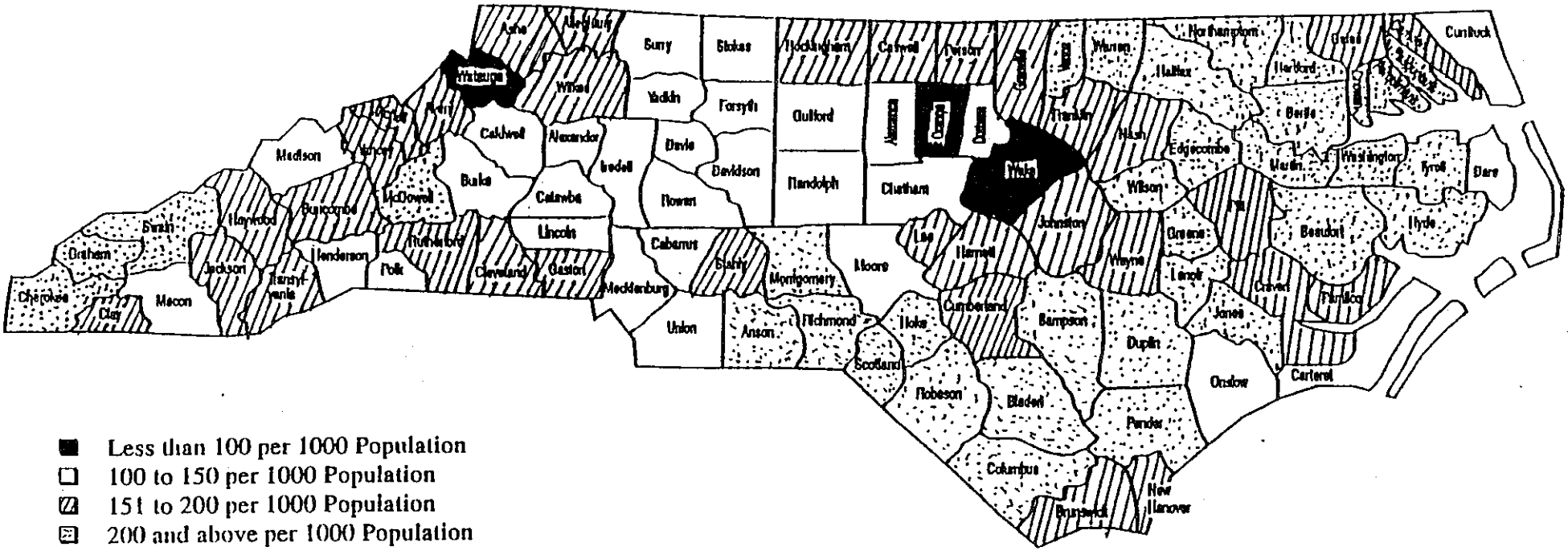
State Fiscal Year 1996
Selected Medical Services
Percent of Service Dollars



33


North Carolina Medicaid
State Fiscal Year 1996
Percentage of Recipients and Service Expenditures
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
10.8%
31.8%
0.2%
0.6%
13.3%
36.9%
3.7%
1.5%
71.7%
29.6%
Aged
Blind
Disabled
Qualified Medicare Beneficiaries
Families and Children
% of Total Recipients
% of Total Service Expenditures

State Fiscal Year 1996
Medicaid Eligibles per 1,000 County Population



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