
nc department of health and human services

# Medicaid in North Carolina
# Annual Report
# State Fiscal Year 1997

## Division of Medical Assistance

James B. Hunt, Jr.
Governor

H. David Bruton, M.D.
Secretary

Paul R. Perruzzi
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James B. Hunt, Jr., Governor
H. David Bruton, M.D., Secretary

Paul R. Perruzzi, Director

November 19, 1997

Dear Fellow North Carolinians,

I am happy to present the Medicaid Annual Report for State Fiscal Year 1997 to you. In State Fiscal Year 1997 Medicaid expenditures increased to over 4.6 billion dollars. The number of Medicaid recipients in the state for the same time period was just under 1.2 million people.

Total Medicaid eligibles increased slightly to 1,192,133, an increase of approximately 16,000 people from the previous fiscal year. **AFDC** Medicaid eligibles continued to decrease from the previous fiscal year, and the number of **Medicaid Indigent Children** covered continued to increase from State Fiscal Year 1996.

We continued our effort to expand Carolina ACCESS throughout the State with fifty counties on board by year end. The Health Care Connection project in Mecklenburg County ended its first year and appears to be quite successful. There are plans in the works to expand optional HMO contracts to other counties in the state.

You are cordially invited to learn more about North Carolina's Medicaid program and initiatives in this report.

Sincerely,

Paul R. Perruzzi

# Division of Medical Assistance

## Office of the Director

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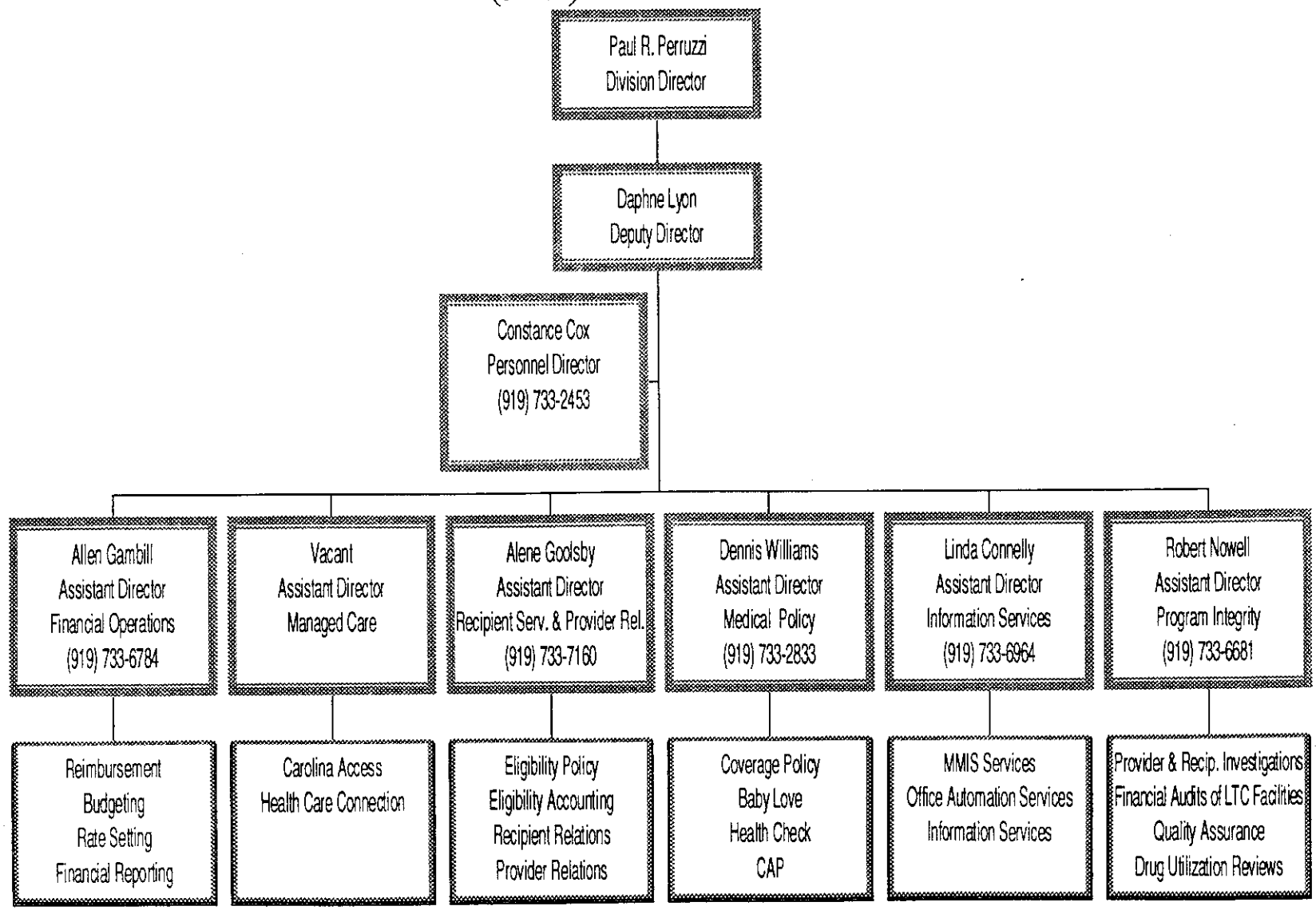

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# STATE FISCAL YEAR 1997

# HIGHLIGHTS

# State Fiscal Year 1997
# Medicaid Policy and Legislative Changes in Brief

| Effective Date | Policy Change |
| --- | --- |
| July 1, 1997 | Under the North Carolina Administrative Code, the Division of Medical Assistance was authorized to begin filing claims against estates of deceased Medicaid recipients in order to recover any expenditures made for long-term care for that individual. This policy is mandated by federal law and affects Medicaid applicants as of October 1, 1994. |

## Highlights of the 1997 State Fiscal Year

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 (71.5 percent) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. The remainder, 28.5 percent, was spent on care for low income families and children. In SFY 1997, 28.5 percent of the service budget was spent on nursing facility care and on institutional care for the mentally retarded.

### SFY 1997 Synopsis

**Total Medicaid Expenditures increased to $4,640,421,917, a 13% increase over SFY 1996. The amount spent for Medicaid services was $3,981,890,683. This represents an 11 % increase in service costs over SFY 1996. See Table 10 on page 32 for a detailed breakdown of these service expenditures.**

The total number of Medicaid eligibles in SFY 1997 was 1,192,133. This was a 1.3% increase in total eligibles over SFY 1996.

**There was a total of 1,155,422 Medicaid recipients in SFY 1997. Total recipients decreased .3% from state fiscal year 1996.**

Martin county again had the highest concentration of Medicaid eligibles in SFY 1997 with 370 people per 1,000 of county population on Medicaid. Orange County had the lowest concentration of Medicaid eligibles with 72 per 1,000 of county population on Medicaid

**Polk County had the highest Medicaid cost per eligible, $4,447 and Cumberland county had the lowest cost per eligible, $2,461. Statewide, the average cost per eligible was $3,260. Please note that Cost-per-Eligible generally reflects services used.**

Again, Inpatient hospital stays at $717 million was the highest total cost of all Medicaid categories of service rendered for SFY 1997.

In the managed care area, nine counties were added to the CAROLINA ACCESS, North Carolina's patient access and coordinated care program and approximately 65% of Medicaid eligibles in those counties were enrolled in a CAROLINA ACCESS program.

# MANAGED CARE

## Managed Care

Managed care opportunities for Medicaid recipients continued to increase during SFY 1997. Some of the Managed Care initiatives that North Carolina is currently implementing are:

**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 below for more details about CAROLINA ACCESS).

**CAROLINA ALTERNATIVES**, a prepaid plan for behavioral health continued serving children in 32 North Carolina counties during SFY 1997. Planning has gotten underway to expand the **Carolina Alternatives** program to additional counties and to the adult population (see page 4 in this section for more details.

**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 in the Risk Contracting section below.

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

## Risk Contracting

Managed Care initiatives in North Carolina began in 1986 when a full risk contract was signed with Kaiser-Permanente to serve AFDC eligible people in Durham, Mecklenburg, Orange and Wake counties. In 1997, Kaiser ended it's contract with the state, opting to serve Medicaid eligible people as a CAROLINA ACCESS provider in three of the four affected counties. Kaiser remains a fully-capitated health plan option in Mecklenburg County.

Risk Contracting was expanded in Mecklenburg county with the **Health Care Connection** project in June, 1996. This project started smoothly and completed a successful year thanks to a well written contract between the state and HMO providers. Through **Health Care Connection**, most of the eligible Medicaid population in Mecklenburg County has been transitioned from fee-for-service to HMO coordinated care.

Medicaid eligible people in Mecklenburg County who are not in long term care facilities and those who do not have Medicare coverage have been informed about the merits of five HMOs serving that county as well as C.W. Williams, the local Federally Qualified Health Center (FQHC) located there. These people have been enrolled in the HMO plan of their choice with the aid of Health Benefits Advisors (HBAs) who are responsible for recipient education and enrollment, as well as some liaison functions with the HMOs. The HMOs participating in Mecklenburg County are:

- **Atlantic Health Plans**
- **Kaiser Foundation Health Plan**
- **Maxicare of North Carolina**
- **Optimum Choice/Mid-Atlantic Medical**
- **The Wellness Plan of North Carolina**

After one year of operation and having enrolled over 90 percent of WFFA (Work First Family Assistance, formerly called AFDC), and other Family and Children's Medicaid population (Over 31,000 people), **Health Care Connection** will expand coverage in Mecklenburg County to blind and disabled eligibles and residents of adult care homes on October 1, 1997.

The **Health Care Connection** program had less than a 10 percent auto-assignment rate where eligibles were assigned to an HMO if they did not choose one voluntarily, and less than a 7 percent rate of change by clients from one HMO to another during the state fiscal year.

Thanks to the success of the **Health Care Connection** project, North Carolina plans to expand Risk Contracts with HMOs to other North Carolina counties where Carolina ACCESS is operational and where HMO enrollment is voluntary.

## 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 June 30, 1997, expanded to 50 counties. There were 314,938 enrollees in Carolina ACCESS as of June 30, 1997. This figure represents approximately 65% 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)**
**Anson (3/97)**
**Beaufort (3/92)**
**Bladen (6/97)**
**Buncombe (3/93)**
**Burke (9/91)**
**Caldwell (12/92)**
**Caswell (7/94)**
**Catawba (7/96)**
**Chatham (10/94)**
**Cherokee (10/95)**
**Cleveland (8/94)**
**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)**
**Halifax (11/96)**
**Harnett (5/93)**
**Haywood (4/96)**
**Henderson (4/91)**
**Jackson (12/94)**
**Johnston (10/96)**
**Lee (10/94)**
**Lenoir (7/94)**
**Lincoln (9/96)**
**Macon (9/95)**
**Madison (8/91)**
**Moore (4/91)**
**Nash (8/91)**
**Northampton (9/96)**
**Onslow (9/94)**
**Orange (11/93)**
**Pender (6/97)**
**Person (5/95)**
**Pitt (3/92)**
**Rockingham (8/95)**
**Sampson (3/96)**
**Scotland (11/93)**
**Surry (10/93)**
**Transylvania (6/95)**
**Wake (3/94)**
**Warren (6/97)**
**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.**

# 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 1997, Medicaid expenditures grew from $307 million to $4.6 billion, and the count of people eligible for Medicaid increased from 456,000 to 1,192,133. During this time, DMA staff increased from 121 to 285 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 1997, 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 1996 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 1997.

## Funding Formula

The federal matching rate for Medicaid services varies from state to state based on per capita income. Nationwide, in SFY 1997, 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 1997, 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 are 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 Work First Family Assistance, formerly AFDC, 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.

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.

Note: Under welfare legislation enacted by Congress in 1997 the criteria for Medicaid eligibility is limited to the

increase in the annual Consumer Price Index (CPI).

## 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 48,800 providers who are currently enrolled in the program. Providers then bill Medicaid for their services. 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 million in SFY 1997.

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(NFs) and intermediate care-facilities for the mentally retarded 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 NFs 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 Division of Vocational Rehabilitation 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 Medicaid. 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 DHHS** - DMA and the Division of Health Promotion Promotion (DHP) in the Promotion 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 Health and Human Services (DHHS), 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 and the Health Check Program which benefits children from birth through age 20. Both programs are 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 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. See Table 4 in Appendix A which lists Medicaid services for SFY 1997.

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 at both 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 the fiscal year:

| | State Fiscal Year 1997 |
|---|---|
| **Provider Activities:** | |
| **Investigations Opened** | **2,432** |
| **Overpayment Cases** | **614** |
| **Overpayments** | **$3,518,995** |
| **Recipient Activities:** | |
| **Cases Reported** | **860** |
| **Overpayments** | **$1,296,263** |
| **Long-Term and Primary Health Care Activities:** | |
| **Audits** | **750** |
| **Collected** | **$9,055,324** |

These amounts do not include loss avoidance from interventions or improvements made to policy or claims payment processes.

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** -- The Division of Medical Assistance 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 make sure that planned care is appropriate for the Medicaid client's needs. The prior approval system for most services is operated by EDS. Prior authorization for general inpatient hospital services is operated by MRNC under contract.

DMA also has contracted to evaluate DRG coding to identify improper optimization and other potentially fraudulent billing practices. 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 1997, insurance coverages and refunds from a variety of sources defrayed Medicaid expenditures.

Insurance paid on patients' behalf amounted to $105,630,555. An additional $102,958,633 in Medicaid claims was denied because other insurance was thought to be available to pay for client services.

Medicaid received refunds from:

- Medicare $ 893,038
- Health Insurance $9,839,949
- Casualty Insurance $7,462,104

- Absent Parent $136,152
- Estate Recovery $311,314

Medicaid policy is designed to avoid costs that otherwise would be incurred. In SFY 1997, $1,134,991,811 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 lists services which require copayment and the amount of copayment in effect during the fiscal year.

**STATE FISCAL YEAR 1997**
**Medicaid Copayment Amounts**

| SERVICE | COPAYMENT |
|---|---|
| Chiropractor Visit | $1.00 |
| Dental Visit | $3.00 |
| Optical Service | $2.00 |
| Optometrist Visit | $2.00 |
| Outpatient Visit | $3.00 |
| Physician Visit | $3.00 |
| Podiatrist Visit | $1.00 |
| Prescription Drug (Including Refills) | $1.00 |

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

- Family planning services
- Services to pregnant women
- Community 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 sterilization. Beginning January 1, 1995, hospital services are paid on the basis of diagnostic related groupings (DRGs). 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 NF services for people 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 screening checks 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. Private Providers, 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. Sterilization, 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 and Nurse Practitioner 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 for medical care services 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 or the usual and customary charge to the public, whichever is less.

**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.

**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 hospice, private duty nursing, ambulance transportation and case management services to meet the needs of specific groups of Medicaid eligible people.

## Maternity/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 1997 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 1997, these initiatives helped 67,836 pregnant women and 278,686 children.

## 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 44.1% of all 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 (MCCs) 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 1997, 23,823 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 9.8 in 1994, the last year for which we have complete data.

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

The state infant mortality rate including both Medicaid and non-Medicaid births has decreased from 12.6 in 1988 to 9.2 in 1996 (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 through age 20. Health Check pays for well child examinations and for the diagnosis, treatment, and referrals necessary to correct any identified health problems.

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, preventive and primary health care services for Health Check eligible children and youths. The goal of the Health Check Program is to assist families in maximizing the health and development of their children. Health Check strategies implemented statewide include:

- Changes in state program administration to help integrate policies and procedures so both financing and service delivery objectives are compatible among state agencies.
- Changes in local administration to improve coordination among local agencies, improve outreach to families and providers and to assist families in obtaining needed health services.
- Recruitment of primary and specialized care providers to increase the accessibility of services.
- Changes in fees and billing processes to increase provider participation.
- Implementation of a statewide outreach campaign and toll free hotline 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.

In addition, a special initiative called the Health Check Outreach Project was developed. In Project counties, specially trained Health Check Coordinators work to reduce barriers and improve access to preventative health services.

A recent evaluation of Health Check was conducted to determine progress made to date. The major findings of this evaluation indicate that:

- Provider recruitment efforts have been successful. There has been an 84% increase in the number of Health Check providers since 1983.
- Statewide awareness of the Health Check Program is high with nearly 75% of Medicaid recipients surveyed reporting knowledge of the program.
- While awareness of the Health Check Program appears to be equal across the state, participation in the program is significantly higher in the 49 counties with Health Check Outreach Projects (52% vs. 43.5% participation in counties with no Outreach Project).
- Over the last four years, the Health Check Outreach Project counties have had significantly higher increases in participation rates than counties without a Health Check Outreach (11.4% vs. 5% increases in those respective counties).

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.

## 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 1997, 52,710 people received long-term care in North Carolina costing a total of $767,308,290. The average cost per recipient was $14,557 for the year. In SFY 1997, the percentage of nursing home beds occupied by Medicaid clients increased to 78.7%. See the table on the following page.

## 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.

# APPENDIX A
# MEDICAID TABLES

# 1997 TABLES and CHARTS

## Nursing Facility - Licensed Beds and Medicaid Usage

| Year | Nursing Facility Licensed Beds | Medicaid NF Avg. Monthly Recipients | Medicaid Use of Licensed Beds |
|---|---|---|---|
| 1995 | 39,686 | 29,879 | 75.3% |
| 1996 | 40,122 | 30,679 | 76.5% |
| 1997 | 40,625 | 31,985 | 78.7% |

- 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, 1997, the amount of annual income that can be protected ranges from a minimum of $15,924 to a maximum of $23,712. The resource protection limit currently ranges from $15,804 to $79,020.

## Table 1
## North Carolina Medicaid
## State Fiscal Year 1997
## Federal Matching Rates

### Benefit Costs
### (7/1/96 - 9/30/96)

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

### Benefit Costs
### (10/1/96 - 6/30/97)

| | Family Planning | | All Other |
|---|---|---|---|
| Federal | 90.0% | Federal | 63.89% |
| State | 8.5% | State | 30.69% |
| County | 1.5% | County | 5.42% |

### Administrative Costs
### (7/1/96 - 6/30/97)

| | 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 1997
## Medicaid Financial Eligibility Standards

| GROUP: | FAMILY SIZE: | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|---|
| Pregnant Women and Children under age 1 | Income Limit: | $1,217/mo. | $1,636/mo. | $2,056/mo. | $2,474/mo. | $2,894/mo. |
| | Resource Limit: | None | | | | |
| Children age 1 through 5 | Income Limit: | $875/mo. | $1,176/mo. | $1,478/mo. | $1,779/mo. | $2,081/mo. |
| | Resource Limit: | None | | | | |
| Children age 6 through 18 | Income Limit: | $658/mo. | $885/mo. | $1,111/mo. | $1,338/mo. | $1,565/mo. |
| | Resource Limit: | None | | | | |
| Children age 19 and 20 | Income Limit: | $362/mo. | $472/mo. | $544/mo. | $594/mo. | $648/mo. |
| | Resource Limit: | $ 1,000 | $ 1,000 | $ 1,000 | $ 1,000 | $ 1,000 |
| **Caretaker Relatives** - Individuals (usually parents) who live with children under age 19 to whom they are related when one or both of the child's parents are out of the home, dead, incapacitated or working less than 100 hours a month. | Income Limit: | $362/mo. | $472/mo. | $544/mo. | $594/mo. | $648/mo. |
| | Resource Limit: | $ 1,000 | $ 1,000 | $ 1,000 | $ 1,000 | $ 1,000 |
| **Aged** (over age 65), **Blind** or **Disabled** by Social Security standards. | Income Limit: | $484/mo. | $726/mo. | | | |
| | Resource Limit: | $ 2,000 | $ 3,000 | | | |
| **Medicare Beneficiaries** - Persons who have Medicare Part A - | | | | | | |
| * Medicaid pays for Medicare premiums, deductibles, and co-payments. | Income Limit: | $658/mo. | $885/mo. | | | |
| | Resource Limit: | $ 4,000 | $ 6,000 | | | |
| * Medicaid pays Medicare Part B premiums only. | Income Limit: | $789/mo. | $1,061/mo. | | | |
| | Resource Limit: | $ 4,000 | $ 6,000 | | | |
| **Deductible/Spendown** - Individuals who do not meet the income limits specified above and who have high medical bills may be eligible for Medicaid after meeting a deductible. | The deductible is based on how much the monthly income exceeds this income limit: | $242/mo. | $317/mo. | $367/mo. | $400/mo. | $433/mo. |

## Table 3
## North Carolina Medicaid
## State Fiscal Year 1997
## Enrolled Medicaid Providers

| Providers | SFY 1996 |
|---|---|
| Physicians* | 28,163 |
| Dentists | 3,323 |
| Pharmacists | 2,820 |
| Optometrists | 981 |
| Chiropractors | 1,047 |
| Podiatrists | 403 |
| Ambulance Companies | 313 |
| Home Health Agencies** | 174 |
| Durable Medical Equip. Suppliers | 2,682 |
| Intermediate Care Facilities-MR | 327 |
| HMOs | 5 |
| Hospitals | 700 |
| Mental Health Clinics | 176 |
| Nursing Facilities | 559 |
| Optical Supplies Company*** | 1 |
| Domicile Care | 2,055 |
| Personal Care Agencies | 460 |
| Rural Health Clinics | 151 |
| CRNA | 19 |
| Nurse Midwives | 31 |
| Hospices | 76 |
| CAP Providers | 549 |
| Other Clinics | 3 |
| Other | 3,820 |
| **Total** | **48,838** |

* 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 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 1997**
**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 Domicile Care
8 Durable Medical Equipment
9 Health Check Services (EPSDT)
10 Family Planning Services
11 Hearing Aids (for children)
12 HMO Membership
13 Home Health Services
14 Home Infusion Therapy Services
15 Hospice
16 Inpatient & Outpatient Hospital Services
17 Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
18 Laboratory & X-Ray Services
19 Mental Hospitals (age 65 & over)
20 Migrant Health Clinics
21 Nurse Midwives
22 Nurse Practitioners
23 Nursing Facilities (NF)
24 Optical Supplies
25 Optometrists
26 Personal Care Services
27 Physicians
28 Podiatrists
29 Prepaid Health Plan Services
30 Prescription Drugs
31 Private Duty Nursing Services
32 Prosthetics and Orthotics (children)
33 Rehabilitative Services:
(under the auspices of area mental health programs)
34 Rural Health Clinics
35 Specialty Hospitals
36 Transportation

**Table 5**
**North Carolina Medicaid**
**State Fiscal Year 1996 & 1997**
**Sources of Medicaid Funds**

| | | 1996 | PerCent | | 1997 | PerCent |
|---|---|---|---|---|---|---|
| Federal | $ | 2,600,855,361 | 63.2% | $ | 2,857,833,171 | 61.6% |
| State Appropriated | | 1,040,207,046 | 25.3% | | 1,150,458,277 | 24.8% |
| State, Other | | 289,101,309 | 7.0% | | 429,081,789 | 9.2% |
| County | | 183,181,061 | 4.5% | | 203,048,680 | 4.4% |
| **Total** | **$** | **4,113,344,777** | | **$** | **4,640,421,917** | |

Source: DAS report

**Table 6**
**North Carolina Medicaid**
**State Fiscal Year 1997**
**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 | | 717,611,668 | 15.5% | 18.0% | 177,596 | 4,041 |
| Outpatient Hospital | | 232,400,142 | 5.0% | 5.8% | 527,352 | 441 |
| Mental Hospital >65 & <21 | | 29,722,808 | 0.6% | 0.7% | 2,472 | 12,024 |
| Physician | | 369,994,473 | 8.0% | 9.3% | 955,648 | 387 |
| Clinics | | 270,204,038 | 5.8% | 6.8% | 261,332 | 1,034 |
| Nursing Facility (Skilled) | | 428,046,638 | 9.2% | 10.7% | 30,416 | 14,073 |
| Nursing Facility (Intermediate) | | 339,261,652 | 7.3% | 8.5% | 22,294 | 15,218 |
| ICF-MR | | 359,316,958 | 7.7% | 9.0% | 4,930 | 72,884 |
| Dental | | 42,476,178 | 0.9% | 1.1% | 226,981 | 187 |
| Prescription Drugs | | 391,239,143 | 8.4% | 9.8% | 778,903 | 502 |
| Home Health | | 94,980,247 | 2.0% | 2.4% | 59,017 | 1,609 |
| Other Services | | 535,975,866 | 11.6% | 13.5% | 1,465,243 | 366 |
| Medicare Premiums: | | | | | | |
| (Part A, Part B, QMB, Dually Eligible) | | 150,234,573 | 3.2% | 3.8% | | |
| HMO Premium | | 20,426,299 | 0.4% | 0.5% | | |
| **Subtotal Services** | | **3,981,890,683** | | | | |
| Adjustments & Cost Settlements | | 185,958,582 | 4.0% | | | |
| Disproportionate Share Payments | | 333,760,618 | 7.2% ** | | | |
| **Subtotal Services & Other** | **$** | **4,501,609,883** | **97.0%** | | | |
| **Administration (State & County)** | | 138,812,034 | 3.0% | | | |
| (State) | | 63,354,988 | 1.4% | | | |
| (County) | | 75,457,046 | 1.6% | | | |
| **Grand Total Expenditures** | **$** | **4,640,421,917** | **100.0%** | | | |
| **Total Recipients (unduplicated)*** ** | | | | | **1,155,422** | |
| **Total Expenditures Per Recipient (unduplicated)** | | | | | | **$ 4,016** |

* "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 1997-2082 report, SFY 1997-DAS report, SFY 1997-PER report

## Table 7
## North Carolina Medicaid
## A History of Medicaid Expenditures
### SFY 1979-1997

| 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% |
| 1997 | $ 4,640,421,917 | 13% |

## Table 9
## North Carolina Medicaid
## State Fiscal Year 1997
## Total Expenditures and Eligibles by County

| COUNTY NAME | 1997 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 1997 population (Column D / Column C) |
|---|---|---|---|---|---|---|---|---|
| ALAMANCE | 118,549 | 14,889 | $ 54,214,076 | $ 3,641 | $ 457.31 | 78 | 126 | 12.56% |
| ALEXANDER | 31,350 | 4,104 | 13,272,374 | 3,234 | 423.36 | 88 | 131 | 13.09% |
| ALLEGHANY | 9,497 | 1,487 | 6,727,476 | 4,524 | 708.38 | 32 | 157 | 15.66% |
| ANSON | 23,875 | 6,566 | 22,976,482 | 3,499 | 962.37 | 11 | 275 | 27.50% |
| ASHE | 23,312 | 4,458 | 18,433,141 | 4,135 | 790.71 | 26 | 191 | 19.12% |
| AVERY | 15,273 | 2,746 | 12,625,430 | 4,598 | 826.65 | 20 | 180 | 17.98% |
| BEAUFORT | 43,848 | 9,854 | 33,604,791 | 3,410 | 766.39 | 28 | 225 | 22.47% |
| BERTIE | 20,766 | 6,514 | 20,709,860 | 3,179 | 997.30 | 4 | 314 | 31.37% |
| BLADEN | 30,313 | 8,781 | 29,423,663 | 3,351 | 970.66 | 9 | 290 | 28.97% |
| BRUNSWICK | 64,770 | 12,160 | 34,959,579 | 2,875 | 539.75 | 63 | 188 | 18.77% |
| BUNCOMBE | 194,545 | 29,538 | 109,189,961 | 3,697 | 561.26 | 57 | 152 | 15.18% |
| BURKE | 84,109 | 12,646 | 47,480,434 | 3,755 | 564.51 | 55 | 150 | 15.04% |
| CABARRUS | 115,108 | 13,283 | 50,286,565 | 3,786 | 436.86 | 83 | 115 | 11.54% |
| CALDWELL | 74,949 | 11,008 | 40,391,654 | 3,669 | 538.92 | 64 | 147 | 14.69% |
| CAMDEN | 6,524 | 1,037 | 3,192,661 | 3,079 | 489.37 | 72 | 159 | 15.90% |
| CARTERET | 59,454 | 8,128 | 28,964,150 | 3,564 | 487.17 | 73 | 137 | 13.67% |
| CASWELL | 21,434 | 4,042 | 13,955,930 | 3,453 | 651.11 | 44 | 189 | 18.86% |
| CATAWBA | 129,566 | 17,425 | 54,636,947 | 3,136 | 421.69 | 89 | 134 | 13.45% |
| CHATHAM | 44,457 | 5,167 | 19,981,421 | 3,867 | 449.46 | 79 | 116 | 11.62% |
| CHEROKEE | 22,616 | 5,261 | 18,241,362 | 3,467 | 806.57 | 23 | 233 | 23.26% |
| CHOWAN | 14,192 | 3,701 | 13,221,782 | 3,572 | 931.64 | 12 | 261 | 26.08% |
| CLAY | 8,006 | 1,387 | 5,573,369 | 4,018 | 696.15 | 37 | 173 | 17.32% |
| CLEVELAND | 90,888 | 17,132 | 54,013,930 | 3,153 | 594.29 | 51 | 188 | 18.85% |
| COLUMBUS | 51,834 | 16,138 | 51,618,962 | 3,199 | 995.85 | 5 | 311 | 31.13% |
| CRAVEN | 87,424 | 15,099 | 47,030,193 | 3,115 | 537.96 | 65 | 173 | 17.27% |
| CUMBERLAND | 303,173 | 48,767 | 120,018,826 | 2,461 | 395.88 | 92 | 161 | 16.09% |
| CURRITUCK | 16,664 | 2,260 | 6,067,339 | 2,685 | 364.10 | 96 | 136 | 13.56% |
| DARE | 27,279 | 2,662 | 10,267,001 | 3,857 | 376.37 | 95 | 98 | 9.76% |
| DAVIDSON | 140,162 | 18,426 | 58,357,082 | 3,167 | 416.35 | 90 | 131 | 13.15% |
| DAVIE | 30,569 | 3,187 | 12,950,198 | 4,063 | 423.64 | 87 | 104 | 10.43% |
| DUPLIN | 43,934 | 10,392 | 31,597,652 | 3,041 | 719.21 | 30 | 237 | 23.65% |
| DURHAM | 196,569 | 30,287 | 103,545,628 | 3,419 | 526.76 | 68 | 154 | 15.41% |
| EDGECOMBE | 56,740 | 18,065 | 47,013,247 | 2,602 | 828.57 | 19 | 318 | 31.84% |
| FORSYTH | 287,468 | 38,043 | 127,021,217 | 3,339 | 441.86 | 81 | 132 | 13.23% |
| FRANKLIN | 43,589 | 8,092 | 28,577,001 | 3,532 | 655.60 | 42 | 186 | 18.56% |
| GASTON | 179,497 | 29,825 | 103,468,767 | 3,469 | 576.44 | 53 | 166 | 16.62% |
| GATES | 9,906 | 1,911 | 6,926,089 | 3,624 | 699.18 | 36 | 193 | 19.29% |
| GRAHAM | 7,623 | 1,808 | 7,590,646 | 4,198 | 995.76 | 6 | 237 | 23.72% |
| GRANVILLE | 42,023 | 6,802 | 22,927,164 | 3,371 | 545.59 | 62 | 162 | 16.19% |
| GREENE | 17,373 | 3,759 | 12,643,918 | 3,364 | 727.79 | 29 | 216 | 21.64% |
| GUILFORD | 383,388 | 53,291 | 179,187,215 | 3,362 | 467.38 | 77 | 139 | 13.90% |
| HALIFAX | 58,016 | 18,548 | 49,972,684 | 2,694 | 861.36 | 18 | 320 | 31.97% |
| HARNETT | 80,918 | 15,473 | 45,565,188 | 2,945 | 563.10 | 56 | 191 | 19.12% |
| HAYWOOD | 50,931 | 8,794 | 30,864,289 | 3,510 | 606.00 | 50 | 173 | 17.27% |
| HENDERSON | 78,837 | 11,608 | 41,190,523 | 3,548 | 522.48 | 70 | 147 | 14.72% |
| HERTFORD | 22,369 | 7,379 | 22,768,848 | 3,086 | 1,017.88 | 3 | 330 | 32.99% |
| HOKE | 29,596 | 6,966 | 18,721,166 | 2,688 | 632.56 | 46 | 235 | 23.54% |
| HYDE | 5,040 | 1,449 | 5,411,585 | 3,735 | 1,073.73 | 2 | 288 | 28.75% |
| IREDELL | 107,981 | 14,447 | 46,789,807 | 3,239 | 433.32 | 84 | 134 | 13.38% |
| JACKSON | 29,603 | 4,867 | 17,301,529 | 3,555 | 584.45 | 52 | 164 | 16.44% |
| JOHNSTON | 101,651 | 17,446 | 56,901,141 | 3,262 | 559.77 | 58 | 172 | 17.16% |
| JONES | 9,539 | 2,227 | 7,705,896 | 3,460 | 807.83 | 22 | 233 | 23.35% |

## North Carolina Medicaid
## State Fiscal Year 1997 Cont'd
## Total Expenditures and Eligibles by County

| COUNTY NAME | 1997 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 1997 population (Column D / Column C) |
|---|---|---|---|---|---|---|---|---|
| LEE | 47,943 | 8,905 | 25,162,507 | 2,826 | 524.84 | 69 | 186 | 18.57% |
| LENOIR | 59,749 | 14,954 | 47,639,537 | 3,186 | 797.33 | 24 | 250 | 25.03% |
| LINCOLN | 57,879 | 7,521 | 24,876,385 | 3,308 | 429.80 | 85 | 130 | 12.99% |
| MACON | 38,059 | 4,547 | 15,789,486 | 3,473 | 414.87 | 91 | 119 | 11.95% |
| MADISON | 27,268 | 3,781 | 13,201,665 | 3,492 | 484.14 | 74 | 139 | 13.87% |
| MARTIN | 18,179 | 6,731 | 21,373,206 | 3,175 | 1,175.71 | 1 | 370 | 37.03% |
| MCDOWELL | 25,990 | 6,128 | 20,633,684 | 3,367 | 793.91 | 25 | 236 | 23.58% |
| MECKLENBURG | 606,368 | 76,300 | 237,236,186 | 3,109 | 391.24 | 93 | 126 | 12.58% |
| MITCHELL | 14,956 | 2,440 | 10,067,426 | 4,126 | 673.14 | 39 | 163 | 16.31% |
| MONTGOMERY | 24,199 | 5,634 | 17,067,326 | 3,029 | 705.29 | 33 | 233 | 23.28% |
| MOORE | 70,358 | 9,847 | 33,635,509 | 3,416 | 478.06 | 75 | 140 | 14.00% |
| NASH | 87,019 | 15,148 | 48,240,494 | 3,185 | 554.37 | 60 | 174 | 17.41% |
| NEW HANOVER | 147,761 | 22,906 | 78,323,107 | 3,419 | 530.07 | 67 | 155 | 15.50% |
| NORTHAMPTON | 20,694 | 6,839 | 20,489,292 | 2,996 | 990.11 | 8 | 330 | 33.05% |
| ONSLOW | 151,770 | 18,422 | 50,813,609 | 2,758 | 334.81 | 98 | 121 | 12.14% |
| ORANGE | 110,093 | 7,904 | 31,895,041 | 4,035 | 289.71 | 99 | 72 | 7.18% |
| PAMLICO | 12,078 | 2,263 | 8,460,073 | 3,738 | 700.45 | 35 | 187 | 18.74% |
| PASQUOTANK | 33,858 | 7,703 | 23,739,974 | 3,082 | 701.16 | 34 | 228 | 22.75% |
| PENDER | 36,945 | 7,603 | 23,727,384 | 3,121 | 642.24 | 45 | 206 | 20.58% |
| PERQUIMANS | 10,792 | 2,635 | 7,195,205 | 2,731 | 666.72 | 41 | 244 | 24.42% |
| PERSON | 33,015 | 5,625 | 22,468,400 | 3,994 | 680.55 | 38 | 170 | 17.04% |
| PITT | 121,233 | 23,841 | 79,348,215 | 3,328 | 654.51 | 43 | 197 | 19.67% |
| POLK | 16,128 | 1,985 | 8,827,620 | 4,447 | 547.35 | 61 | 123 | 12.31% |
| RANDOLPH | 119,306 | 15,549 | 51,054,813 | 3,283 | 427.93 | 86 | 130 | 13.03% |
| RICHMOND | 45,740 | 11,903 | 41,391,756 | 3,477 | 904.94 | 14 | 260 | 26.02% |
| ROBESON | 112,994 | 35,274 | 109,358,191 | 3,100 | 967.82 | 10 | 312 | 31.22% |
| ROCKINGHAM | 89,986 | 14,968 | 55,294,178 | 3,694 | 614.48 | 48 | 166 | 16.63% |
| ROWAN | 122,839 | 17,926 | 57,845,470 | 3,227 | 470.90 | 76 | 146 | 14.59% |
| RUTHERFORD | 59,868 | 10,334 | 36,760,246 | 3,557 | 614.02 | 49 | 173 | 17.26% |
| SAMPSON | 51,760 | 12,431 | 40,491,675 | 3,257 | 782.30 | 27 | 240 | 24.02% |
| SCOTLAND | 35,049 | 10,305 | 31,581,108 | 3,065 | 901.06 | 15 | 294 | 29.40% |
| STANLY | 54,633 | 8,564 | 29,232,858 | 3,413 | 535.08 | 66 | 157 | 15.68% |
| STOKES | 42,956 | 5,455 | 18,868,760 | 3,459 | 439.26 | 82 | 127 | 12.70% |
| SURRY | 66,833 | 10,169 | 37,373,843 | 3,675 | 559.21 | 59 | 152 | 15.22% |
| SWAIN | 11,747 | 3,084 | 10,850,904 | 3,518 | 923.72 | 13 | 263 | 26.25% |
| TRANSYLVANIA | 27,760 | 4,304 | 14,348,236 | 3,334 | 516.87 | 71 | 155 | 15.50% |
| TYRRELL | 3,727 | 1,070 | 3,701,526 | 3,459 | 993.17 | 7 | 287 | 28.71% |
| UNION | 104,459 | 12,492 | 39,561,952 | 3,167 | 378.73 | 94 | 120 | 11.96% |
| VANCE | 40,558 | 12,185 | 35,793,979 | 2,938 | 882.54 | 17 | 300 | 30.04% |
| WAKE | 556,993 | 48,703 | 153,605,100 | 3,154 | 275.78 | 100 | 87 | 8.74% |
| WARREN | 18,523 | 4,920 | 16,482,016 | 3,350 | 889.81 | 16 | 266 | 26.56% |
| WASHINGTON | 13,584 | 3,847 | 11,137,618 | 2,895 | 819.91 | 21 | 283 | 28.32% |
| WATAUGA | 41,142 | 3,718 | 14,855,824 | 3,996 | 361.09 | 97 | 90 | 9.04% |
| WAYNE | 113,410 | 21,571 | 64,475,071 | 2,989 | 568.51 | 54 | 190 | 19.02% |
| WILKES | 62,894 | 10,180 | 39,749,338 | 3,905 | 632.01 | 47 | 162 | 16.19% |
| WILSON | 68,977 | 16,653 | 49,282,745 | 2,959 | 714.48 | 31 | 241 | 24.14% |
| YADKIN | 35,118 | 4,372 | 15,675,074 | 3,585 | 446.35 | 80 | 124 | 12.45% |
| YANCEY | 16,403 | 3,162 | 10,948,110 | 3,462 | 667.45 | 40 | 193 | 19.28% |
| STATE TOTAL | 7,436,690 | 1,192,133 | $3,886,009,561 | $3,260 | $522.55 | N/A | 160 | 16.03% |

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1997.
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 1997**
**Medicaid Service Expenditures by Recipient Group**

| Eligibility Group | Total Service Dollars | Percent of Service Dollars | Total Recipients | Percent of Recipients | SFY 1997 Expenditures Per Recipient | SFY 1996 Expenditures Per Recipient | 96/97 Percent Change |
|---|---|---|---|---|---|---|---|
| **Total Elderly** | **$ 1,306,859,965** | **32.8%** | **169,926** | **14.7%** | **$ 7,691** | **$ 7,107** | **8.2%** |
| Aged | 1,249,493,755 | 31.4% | 132,325 | 11.5% | 9,443 | 9,127 | 3.5% |
| Medicare-Aid (MQBQ & MQBB) | 57,366,210 | 1.4% | 37,601 | 3.3% | 1,526 | 1,216 | 25.5% |
| **Total Disabled** | **$ 1,541,219,057** | **38.7%** | **175,959** | **15.2%** | **8,759** | **8,640** | **1.4%** |
| Disabled | 1,518,764,217 | 38.1% | 173,471 | 15.0% | 8,755 | 8,630 | 1.5% |
| Blind | 22,454,840 | 0.6% | 2,488 | 0.2% | 9,025 | 9,348 | -3.5% |
| **Total Families & Children** | **$ 1,135,651,262** | **28.5%** | **805,077** | **69.7%** | **1,411** | **1,283** | **9.9%** |
| AFDC Adults (> 21) | 289,072,958 | 7.3% | 169,238 | 14.6% | 1,708 | 1,620 | 5.4% |
| Medicaid Pregnant Women Coverage | 167,914,606 | 4.2% | 67,836 | 5.9% | 2,475 | 2,003 | 23.6% |
| AFDC Children & Other Children | 346,371,139 | 8.7% | 289,317 | 25.0% | 1,197 | 1,078 | 11.1% |
| Medicaid Indigent Children | 332,292,559 | 8.3% | 278,686 | 24.1% | 1,192 | 1,074 | 11.0% |
| **Aliens & Refugees** | **$ 11,033,147** | **0.3%** | **4,460** | **0.4%** | **2,474** | **2,055** | |
| **Adjustments Not Attributable To A Specific Category** | **$ (12,872,748)** | **-0.3%** | | | | | |
| **Total Service Expenditures All Groups** | **$ 3,981,890,683** | **100%** | **1,155,422** | **100%** | **$ 3,446** | **$ 3,104** | **11.0%** |

Note: Total Service Expenditures does not include:

| | |
|---|---|
| Disproportionate Share payments | $333,760,618 |
| State & county administrative costs | 138,812,034 |
| Adjustments and cost settlements | $ 185,958,582 |
| TOTAL | $ 658,531,234 |

See Table 6 for more details.
Source: SFY 1997 Program Expenditure Report and 2082 Report.

## Table 11
## North Carolina Medicaid
## State Fiscal Year 1997
## Service Expenditures 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 | $ 717,611,668 | 18.0% | $ 14,801,096 | $ 3,364,937 | $ - | $ 1,918,977 | $ 319,261,748 | 170,392,828 | 205,091,532 | $ 7,462,040 | $ (4,681,490) |
| Outpatient Hospital | 232,400,142 | 5.8% | 22,276,207 | 9,455,229 | 482 | 892,869 | 83,475,941 | 59,696,899 | 57,774,993 | 304,968 | (1,477,446) |
| Mental Hospital (> 65) | 12,439,983 | 0.3% | 12,444,079 | 26,536 | - | 55,897 | - | - | - | - | (86,529) |
| Psychiatric Hospital (< 21) | 17,282,825 | 0.4% | 53,374 | - | - | 10,004 | 5,217,258 | 41,062 | 11,992,773 | 7,410 | (39,056) |
| Physician | 369,994,473 | 9.3% | 41,348,707 | 12,314,299 | 1,455 | 1,150,423 | 106,189,401 | 97,560,121 | 111,956,755 | 2,381,073 | (2,907,761) |
| Clinics | 270,204,038 | 6.8% | 11,470,562 | 3,648,211 | 648 | 763,230 | 118,728,355 | 38,304,593 | 97,878,818 | 237,224 | (827,603) |
| Nursing Facility: | | | | | | | | | | | |
| Skilled Level | 428,046,638 | 10.7% | 375,421,565 | 99,162 | - | 1,824,063 | 50,952,548 | 62,669 | 90,480 | 98,720 | (502,569) |
| Intermediate Level | 339,261,652 | 8.5% | 312,432,007 | 538 | - | 1,292,915 | 25,698,682 | - | 138,483 | 46,439 | (347,412) |
| Intermediate Care Facility (Mentally Retarded) | 359,316,958 | 9.0% | 14,172,717 | - | - | 6,125,538 | 333,956,450 | 22,454 | 5,039,175 | 3,978 | (3,354) |
| Dental | 42,476,178 | 1.1% | 4,934,362 | 2,362 | - | 133,420 | 10,432,340 | 9,197,458 | 17,702,473 | 136,698 | (62,935) |
| Prescription Drugs | 391,239,143 | 9.8% | 140,461,312 | - | - | 2,212,074 | 166,863,216 | 37,020,283 | 45,003,534 | 99,575 | (420,851) |
| Home Health | 94,980,247 | 2.4% | 15,466,388 | 107,776 | - | 817,651 | 65,507,796 | 4,663,020 | 8,690,191 | 9,294 | (281,869) |
| CAP/Disabled Adult | 110,768,008 | 2.8% | 85,761,098 | - | | 731,181 | 24,333,392 | 2,206 | - | 337 | (60,206) |
| CAP/Mentally Retarded | 105,656,284 | 2.7% | 2,575,800 | - | | 1,336,250 | 100,587,943 | - | 1,348,927 | - | (192,636) |
| CAP/Children | 5,938,897 | 0.1% | 72 | - | - | 8,185 | 5,846,635 | - | 173,317 | - | (89,312) |
| Personal Care | 66,644,173 | 1.7% | 47,064,955 | 1,492 | (176) | 1,230,846 | 17,845,864 | 309,297 | 280,327 | - | (88,432) |
| Hospice | 10,245,714 | 0.3% | 4,516,561 | - | - | 56,554 | 5,460,103 | 151,782 | 104,348 | 16,280 | (59,914) |
| EPSDT (Health Check) | 30,115,812 | 0.8% | 1,916 | 67 | 12 | 7,258 | 1,017,671 | 27,533 | 29,074,358 | 13,057 | (26,060) |
| Lab & X-Ray | 13,806,500 | 0.3% | 474,987 | 141,112 | - | 46,592 | 4,059,025 | 5,912,042 | 3,202,483 | 34,124 | (63,865) |
| Adult Home Care | 64,660,069 | 1.6% | 39,372,484 | 45,630 | 13,904 | 303,609 | 25,528,718 | 643 | 12,214 | - | (617,133) |
| Other Services | 128,140,410 | 3.2% | 7,031,448 | 736,843 | 42 | 219,587 | 24,188,656 | 25,789,814 | 70,200,292 | 179,172 | (205,444) |
| **Total Services** | **3,811,229,812** | **95.7%** | **1,152,081,697** | **29,944,194** | **16,367** | **21,137,123** | **1,495,151,742** | **449,154,704** | **665,755,473** | **11,030,389** | **(13,041,877)** |
| Medicare: | | | | | | | | | | | |
| Part A Premiums | 41,718,153 | 1.0% | 40,860,572 | 165,820 | - | 721,760 | 7,778 | - | - | | (37,777) |
| Part B Premiums | 108,516,420 | 2.7% | 56,551,486 | 20,231,868 | 7,007,961 | 595,957 | 23,604,933 | 308,937 | 5,614 | 2,758 | 206,906 |
| HMO Premiums | 20,426,298 | 0.5% | - | - | - | - | (236) | 7,523,923 | 12,902,611 | - | - |
| **Total Premiums** | **170,660,871** | | **97,412,058** | **20,397,688** | **7,007,961** | **1,317,717** | **23,612,475** | **7,832,860** | **12,908,225** | **2,758** | **169,129** |
| **Grand Total Services and Premiums** | **$ 3,981,890,683** | | **1,249,493,755** | **50,341,882** | **7,024,328** | **22,454,840** | **1,518,764,217** | **456,987,564** | **678,663,698** | **11,033,147** | **(12,872,748)** |

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 1997
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 1997 % of Total Dollars | SFY 1996 % of Total Dollars | SFY 1995 % of Total Dollars |
|---|---|---|---|---|---|---|---|---|---|---|
| Inpatient Hospital | $ 14,801,096 | 1.2% | $ 3,364,937 | $ - | $ 3,364,937 | 5.9% | $ 18,166,033 | 1.4% | 1.7% | 2.7% |
| Outpatient Hospital | 22,276,207 | 1.8% | 9,455,229 | 482 | 9,455,711 | 16.5% | 31,731,918 | 2.4% | 2.2% | 2.4% |
| Mental Hospital (>65) | 12,444,079 | 1.0% | 26,536 | - | 26,536 | 0.0% | 12,470,615 | 1.0% | 1.2% | 1.4% |
| Physician | 41,348,707 | 3.3% | 12,314,299 | 1,455 | 12,315,754 | 21.5% | 53,664,461 | 4.1% | 3.8% | 3.8% |
| Clinics | 11,470,562 | 0.9% | 3,648,211 | 648 | 3,648,859 | 6.4% | 15,119,421 | 1.2% | 0.9% | 0.8% |
| Nursing Facility: | | | | | | | | | | |
| Skilled Level: | 375,421,565 | 30.0% | 99,162 | - | 99,162 | 0.2% | 375,520,727 | 28.7% | 28.8% | 29.5% |
| Intermediate Level: | 312,432,007 | 25.0% | 538 | - | 538 | 0.0% | 312,432,545 | 23.9% | 25.9% | 28.4% |
| Intermediate Care Facility-Mentally Retarded | 14,172,717 | 1.1% | - | - | - | 0.0% | 14,172,717 | 1.1% | 1.0% | 1.0% |
| Dental | 4,934,362 | 0.4% | 2,362 | - | 2,362 | 0.0% | 4,936,724 | 0.4% | 0.5% | 0.3% |
| Prescription Drugs | 140,461,312 | 11.2% | - | - | - | 0.0% | 140,461,312 | 10.7% | 10.1% | 8.7% |
| Home Health | 15,466,388 | 1.2% | 107,776 | - | 107,776 | 0.2% | 15,574,164 | 1.2% | 1.2% | 1.2% |
| CAP/Disabled Adult | 85,761,098 | 6.9% | - | - | - | 0.0% | 85,761,098 | 6.6% | 5.7% | 5.0% |
| CAP/Mentally Retarded | 2,575,800 | 0.2% | - | - | - | 0.0% | 2,575,800 | 0.2% | 0.1% | 0.0% |
| Personal Care | 47,064,955 | 3.8% | 1,492 | - | 1,492 | 0.0% | 47,066,447 | 3.6% | 3.4% | 2.7% |
| Hospice | 4,516,561 | 0.4% | - | (176) | (176) | 0.0% | 4,516,385 | 0.3% | 0.4% | 0.5% |
| EPSDT (Health Check) | 1,916 | 0.0% | 67 | 12 | 79 | 0.0% | 1,995 | 0.0% | 0.0% | 0.0% |
| Lab & X-Ray | 474,987 | 0.0% | 141,112 | - | 141,112 | 0.2% | 616,099 | 0.0% | 0.3% | 0.3% |
| Adult Care Home | 39,372,484 | 3.2% | 45,630 | 13,904 | 59,534 | 0.1% | 39,432,018 | 3.0% | 2.4% | |
| Other Services | 7,031,448 | 0.6% | 736,843 | 42 | 736,885 | 1.3% | 7,768,333 | 0.6% | 0.6% | 0.6% |
| **Service Expenditures** | **$ 1,152,028,251** | **92.2%** | **29,944,194** | **16,367** | **29,960,561** | **52.2%** | **1,181,988,812** | **90.4%** | **90.0%** | **89.3%** |
| Part A Premium | 40,860,572 | 3.3% | 165,820 | - | 165,820 | 0.3% | 41,026,392 | 3.1% | 3.1% | 3.2% |
| Part B Premium | 56,551,486 | 4.5% | 20,231,868 | 7,007,961 | 27,239,829 | 47.5% | 83,791,315 | 6.4% | 6.9% | 7.6% |
| HMO Premium | - | 0.0% | - | - | - | 0.0% | - | 0.0% | 0.0% | 0.0% |
| **Total Premiums** | **$ 97,412,058** | | **20,397,688** | **7,007,961** | **27,405,649** | | **124,817,707** | | | |
| **Total Service & Premiums** | **$ 1,249,440,309** | **100%** | **50,341,882** | **7,024,328** | **57,366,210** | **100%** | **1,306,806,519** | | | |
| **Medicare Crossovers**** | **$ 97,328,628** | | | | | | | | | |
| **Total Elderly Recipients** | 132,325 | | 37,601 | 8,648 | 46,249 | | 178,574 | | | |
| **Service Expenditures Per Recipient *** | **$ 9,443** | | **$ 1,339** | **$ 812** | **$ 1,240** | | **$ 7,318** | | | |

* 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 1997 Program Expenditure Report and 2082 Report

## Table 13
## North Carolina Medicaid
## State Fiscal Year 1997
## Expenditures for the Disabled & Blind

| Type of Service | Disabled | Percent of Service Dollars | Blind | Percent of Service Dollars | Total Blind & Disabled Dollars | SFY 1997 % of Total Dollars | SFY 1996 % of Total Dollars |
|---|---|---|---|---|---|---|---|
| Inpatient Hospital | $ 319,261,748 | 21.0% | $ 1,918,977 | 8.5% | $ 321,180,725 | 20.8% | 22.5% |
| Outpatient Hospital | 83,475,941 | 5.5% | 892,869 | 4.0% | 84,368,810 | 5.5% | 5.5% |
| Psychiatric Hospital (>65) | - | 0.0% | 55,897 | 0.2% | 55,897 | 0.0% | 0.0% |
| Psychiatric Hospital (<21) | 5,217,258 | 0.3% | 10,004 | 0.0% | 5,227,262 | 0.3% | 0.4% |
| Physician | 106,189,401 | 7.0% | 1,150,423 | 5.1% | 107,339,824 | 7.0% | 6.9% |
| Clinics | 118,728,355 | 7.8% | 763,230 | 3.4% | 119,491,585 | 7.8% | 6.0% |
| Nursing Facility: | | | | | | | |
| Skilled Level: | 50,952,548 | 3.4% | 1,824,063 | 8.1% | 52,776,611 | 3.4% | 3.5% |
| Intermediate Level: | 25,698,682 | 1.7% | 1,292,915 | 5.8% | 26,991,597 | 1.8% | 2.0% |
| Intermediate Care Facility- | | | | | | | |
| Mentally Retarded | 333,956,450 | 22.0% | 6,125,538 | 27.3% | 340,081,988 | 22.1% | 25.0% |
| Dental | 10,432,340 | 0.7% | 133,420 | 0.6% | 10,565,760 | 0.7% | 8.0% |
| Prescription Drugs | 166,863,216 | 11.0% | 2,212,074 | 9.9% | 169,075,290 | 11.0% | 9.9% |
| Home Health | 65,507,796 | 4.3% | 817,651 | 3.6% | 66,325,447 | 4.3% | 4.7% |
| CAP/Disabled Adult | 24,333,392 | 1.6% | 731,181 | 3.3% | 25,064,573 | 1.6% | 1.5% |
| CAP/Children | 100,587,943 | 6.6% | 1,336,250 | 6.0% | 101,924,193 | 6.6% | 4.1% |
| CAP/Mentally Retarded | 5,846,635 | 0.4% | 8,185 | 0.0% | 5,854,820 | 0.4% | 0.2% |
| Personal Care | 17,845,864 | 1.2% | 1,230,846 | 5.5% | 19,076,710 | 1.2% | 1.2% |
| Hospice | 5,460,103 | 0.4% | 56,554 | 0.3% | 5,516,657 | 0.4% | 0.5% |
| EPSDT | 1,017,671 | 0.1% | 7,258 | | 1,024,929 | 0.1% | 0.1% |
| Lab & X-Ray | 4,059,025 | 0.3% | 46,592 | 0.2% | 4,105,617 | 0.3% | 0.7% |
| Adult Home Care | 25,528,718 | 1.7% | 303,609 | 1.4% | 25,832,327 | 1.7% | 1.5% |
| Other Services | 24,188,656 | 1.6% | 219,587 | 1.0% | 24,408,243 | 1.6% | 1.2% |
| Part A Premium | 7,778 | 0.0% | 721,760 | 3.2% | 729,538 | 0.0% | 0.1% |
| Part B Premium | 23,604,933 | 1.6% | 595,957 | 2.7% | 24,200,890 | 1.6% | 1.7% |
| HMO Premium | (236) | 0.0% | - | 0.0% | (236) | 0.0% | 0.0% |
| **Total Service & Premiums** | **$ 1,518,764,217** | | **$ 22,454,840** | | **$ 1,541,219,057** | | |
| **Medicare Crossovers*** | **$ 44,317,134** | | **$ 1,085,871** | | **$ 45,403,005** | | |
| **Number of Disabled/Blind Recipients** | 173,471 | | 2,488 | | 175,959 | | |
| **Service Expenditures Per Recipient**** | **$ 8,755** | | **$ 9,025** | | **$ 8,759** | | |

* 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 1997 Program Expenditure Report and 2082 Report

Table 14
North Carolina Medicaid
State Fiscal Year 1997
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 1997 % of Total Dollars | SFY 1996 % of Total Dollars |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Inpatient Hospital | $ 102,077,503 | 35.1% | $ 68,315,325 | 41.2% | $ 82,630,248 | 23.5% | 122,461,284 | 37.5% | $ 375,484,360 | 33.1% | 34.5% |
| Outpatient Hospital | 44,341,283 | 15.2% | 15,355,616 | 9.3% | 31,429,285 | 8.9% | 26,345,708 | 8.1% | 117,471,892 | 10.4% | 10.8% |
| Psychiatric Hospital (<21) | - | 0.0% | 41,062 | 0.0% | 7,769,501 | 2.2% | 4,223,272 | 1.3% | 12,033,835 | 1.1% | 1.2% |
| Physician | 55,172,843 | 18.9% | 42,387,278 | 25.6% | 52,570,423 | 14.9% | 59,386,332 | 18.2% | 209,516,876 | 18.5% | 18.8% |
| Clinics | 16,317,067 | 5.6% | 21,987,526 | 13.3% | 65,937,365 | 18.7% | 31,941,453 | 9.8% | 136,183,411 | 12.0% | 12.5% |
| Nursing Facility: | | | | | | | | | | | |
| Skilled Level: | 60,986 | 0.0% | 1,683 | 0.0% | 15,065 | 0.0% | 75,415 | 0.0% | 153,149 | 0.0% | 0.0% |
| Intermediate Level: | - | 0.0% | - | 0.0% | 96,579 | 0.0% | 41,904 | 0.0% | 138,483 | 0.0% | 0.0% |
| Intermediate Care Facility-Mentally Retarded | 22,454 | 0.0% | - | 0.0% | 4,187,202 | 1.2% | 851,973 | 0.3% | 5,061,629 | 0.4% | 0.5% |
| Dental | 8,716,402 | 3.0% | 481,056 | 0.3% | 9,851,016 | 2.8% | 7,851,457 | 2.4% | 26,899,931 | 2.4% | 2.5% |
| Prescription Drugs | 33,343,275 | 11.5% | 3,677,008 | 2.2% | 23,231,646 | 6.6% | 21,771,888 | 6.7% | 82,023,817 | 7.2% | 6.6% |
| Home Health | 3,948,189 | 1.4% | 714,831 | 0.4% | 4,370,983 | 1.2% | 4,319,208 | 1.3% | 13,353,211 | 1.2% | 1.8% |
| CAP/Disabled | 2,206 | | - | | - | | - | | | | |
| CAP/Mentally Retarded | - | | - | | 1,326,059 | 0.4% | 22,868 | | | | |
| CAP/Children | - | 0.0% | - | 0.0% | 173,317 | 0.0% | - | 0.0% | 173,317 | 0.0% | 0.0% |
| Personal Care | 295,249 | 0.1% | 14,048 | 0.0% | 174,313 | 0.0% | 106,014 | 0.0% | 589,624 | 0.1% | 0.0% |
| Hospice | 151,782 | 0.1% | - | 0.0% | 28,734 | 0.0% | 75,614 | 0.0% | 256,130 | 0.0% | 0.0% |
| Health Check - EPSDT | 82 | 0.0% | 27,451 | 0.0% | 11,928,952 | 3.4% | 17,145,406 | 5.2% | 29,101,891 | 2.6% | 2.6% |
| Lab & X-Ray | 3,404,597 | 1.2% | 2,507,445 | 1.5% | 1,984,074 | 0.6% | 1,218,409 | 0.4% | 9,114,525 | 0.8% | 1.3% |
| Adult Care Home | 643 | 0.0% | - | 0.0% | 6,833 | 0.0% | 5,381 | 0.0% | 12,857 | 0.0% | 0.0% |
| Other Services | 15,528,402 | 5.3% | 10,261,412 | 6.2% | 41,163,200 | 11.7% | 29,037,092 | 8.9% | 95,990,106 | 8.5% | 6.9% |
| **Total Families & Children Service Expenditures** | **$ 283,382,963** | 97.3% | **165,771,741** | | **338,874,795** | | **326,880,678** | | **1,113,559,044** | | **100%** |
| Part A Premium | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | - | 0.0% | 0.0% |
| Part B Premium | 285,135 | 0.1% | 23,802 | 0.0% | 2,635 | 0.0% | 2,979 | 0.0% | 314,551 | 0.0% | 0.1% |
| HMO Premium | 7,523,923 | 2.6% | - | 0.0% | 12,902,611 | 3.7% | - | 0.0% | 20,426,534 | 1.8% | 0.8% |
| **Total Service & Premiums** | **$ 291,192,021** | | **165,795,543** | | **351,780,041** | | **326,883,657** | | **1,134,300,129** | | |
| **Medicare Crossovers*** | **$ 939,435** | | **72,352** | | **96,962** | | **72,375** | | **1,181,124** | | |
| **Number of Family & Child Recipients** | 169,238 | | 67,836 | | 289,317 | | 278,686 | | 805,077 | | |
| **Service Expenditures Per Recipient**** | **$ 1,721** | | **$ 2,444** | | **$ 1,216** | | **$ 1,173** | | **$ 1,409** | | |

* Medicare Crossovers are Medicare charges that are billed to Medicaid.

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

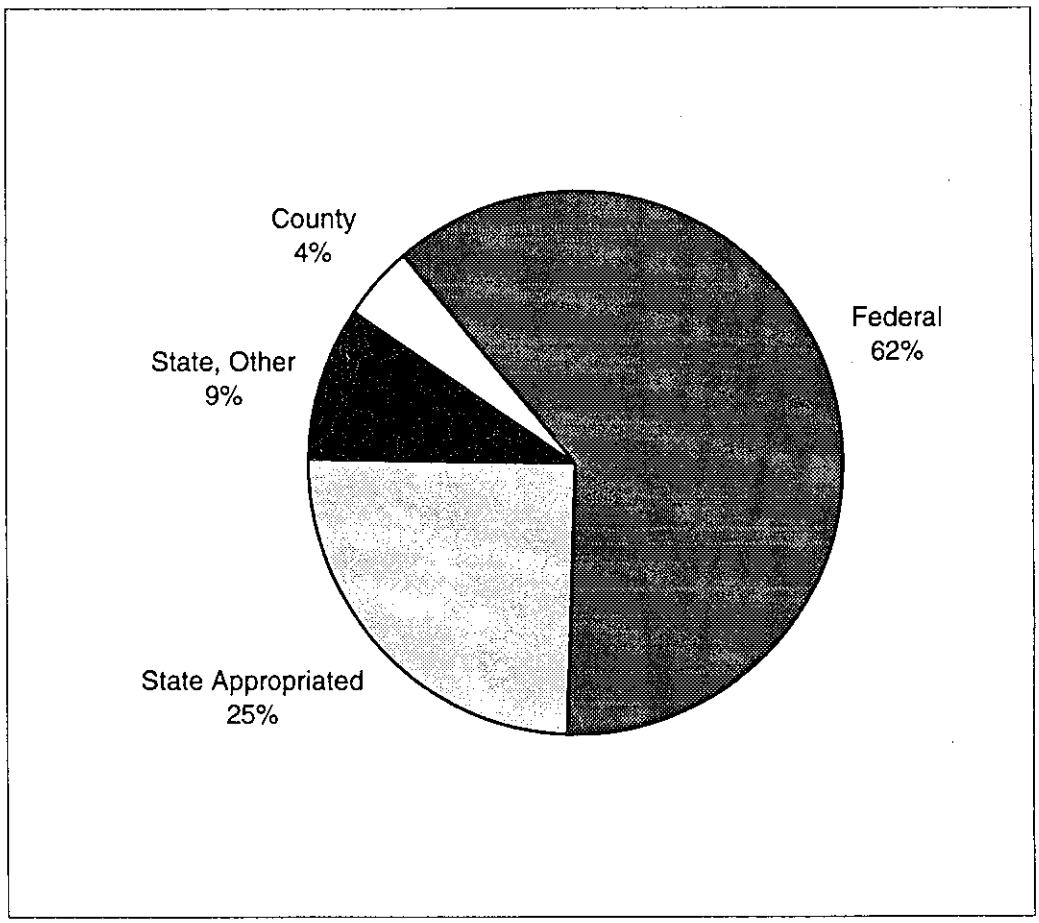
Source: SFY 1997 Program Expenditure Report & 2082 Report

**Table 15**
**North Carolina Medicaid**
**State Fiscal Year 1997**
**Medicaid Copayment Amounts**

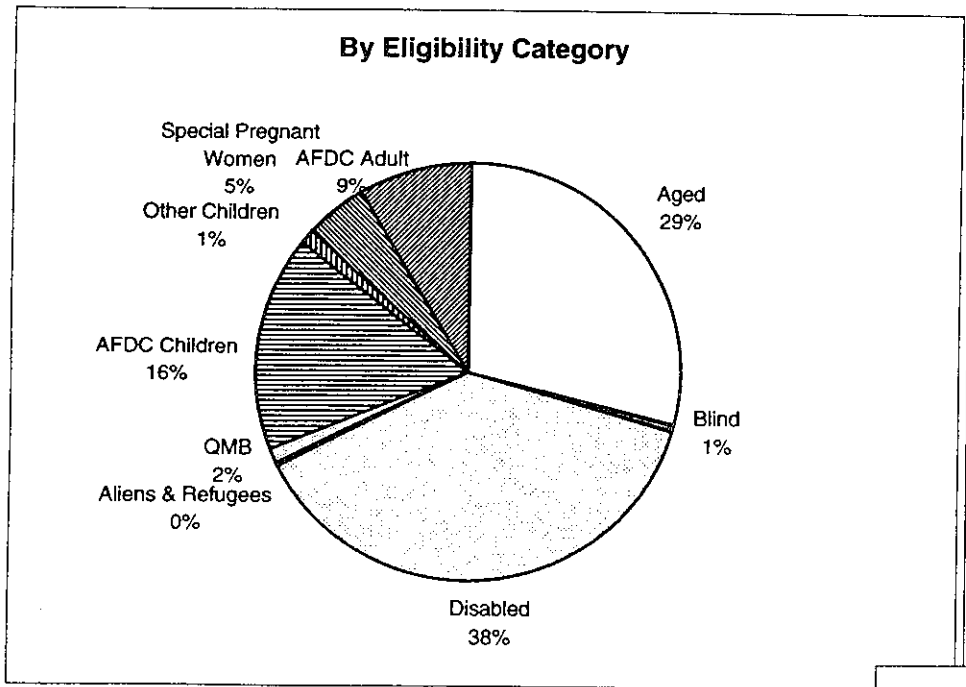
| Service | Copayment Amount |
|---|---|
| Chiropractor visit | $ 1.00 |
| Dental visit | 3.00 |
| Optical service | 2.00 |
| Optometrist visit | 2.00 |
| Outpatient visit | 3.00 |
| Physician visit | 3.00 |
| Podiatrist visit | 1.00 |
| Prescription drug (including refills) | 1.00 |

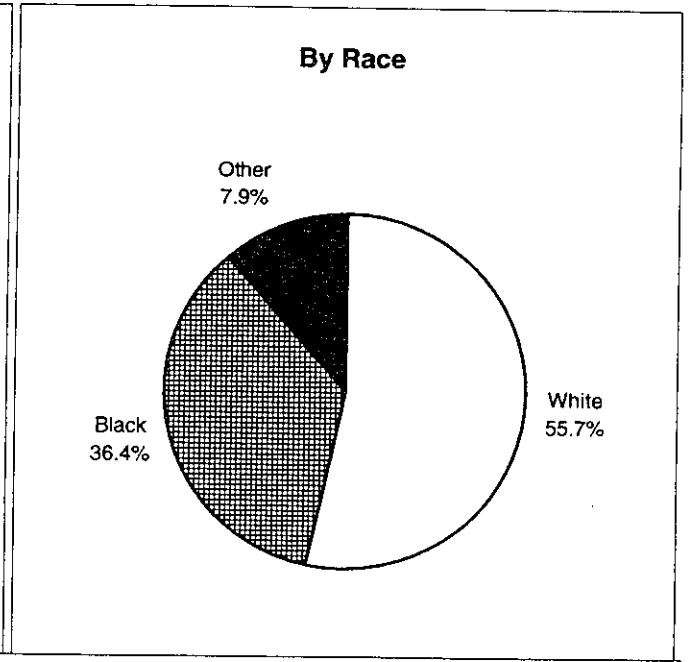
# APPENDIX B
# MEDICAID CHARTS

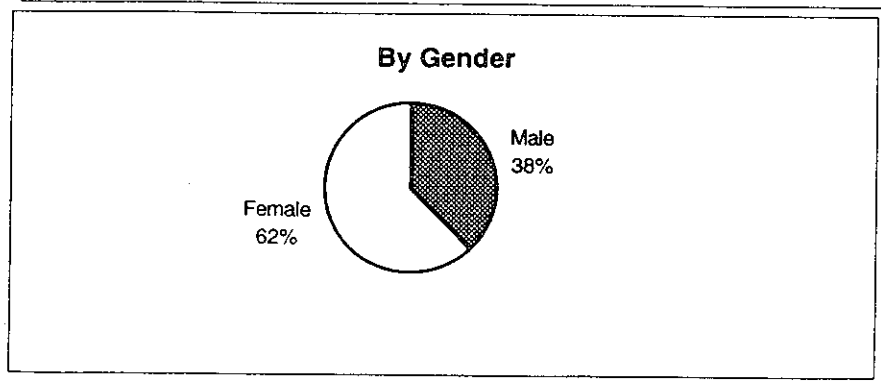
## North Carolina Medicaid
## State Fiscal Year 1997
## Sources of Funds

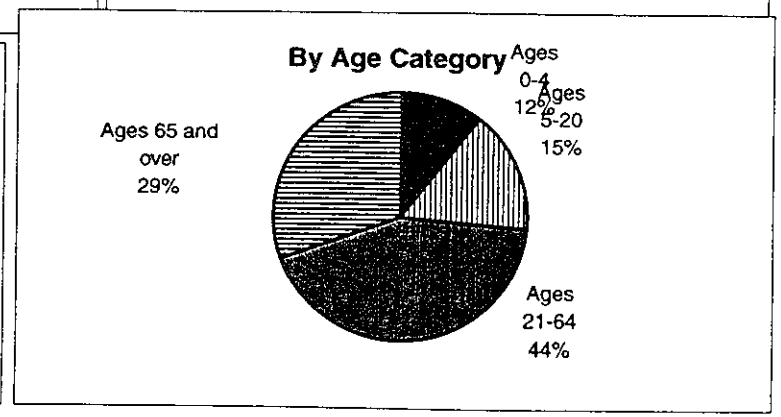


# North Carolina Medicaid
## State Fiscal Year 1997
## Service Expenditures, Percent Distribution



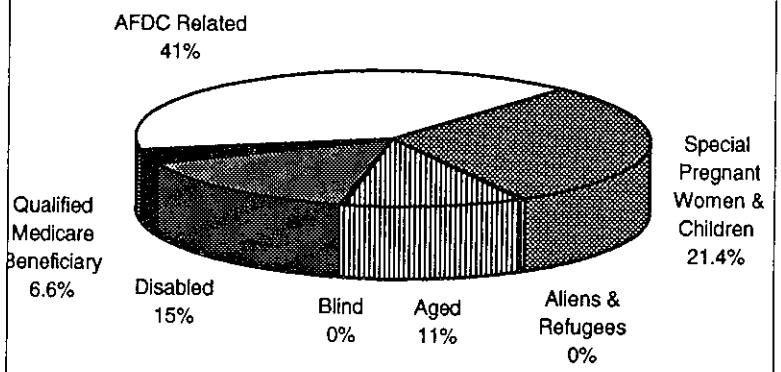



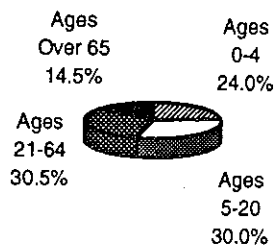



# North Carolina Medicaid
# SFY 1997
# Recipients of Medicaid Services

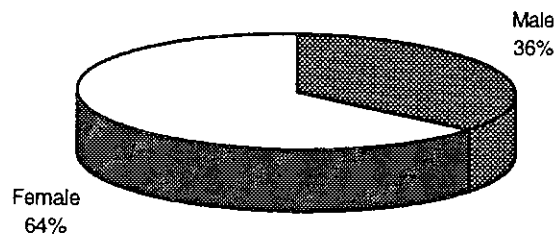
## By Eligibility Category



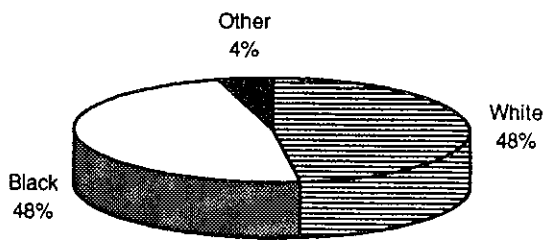

## By Age Category



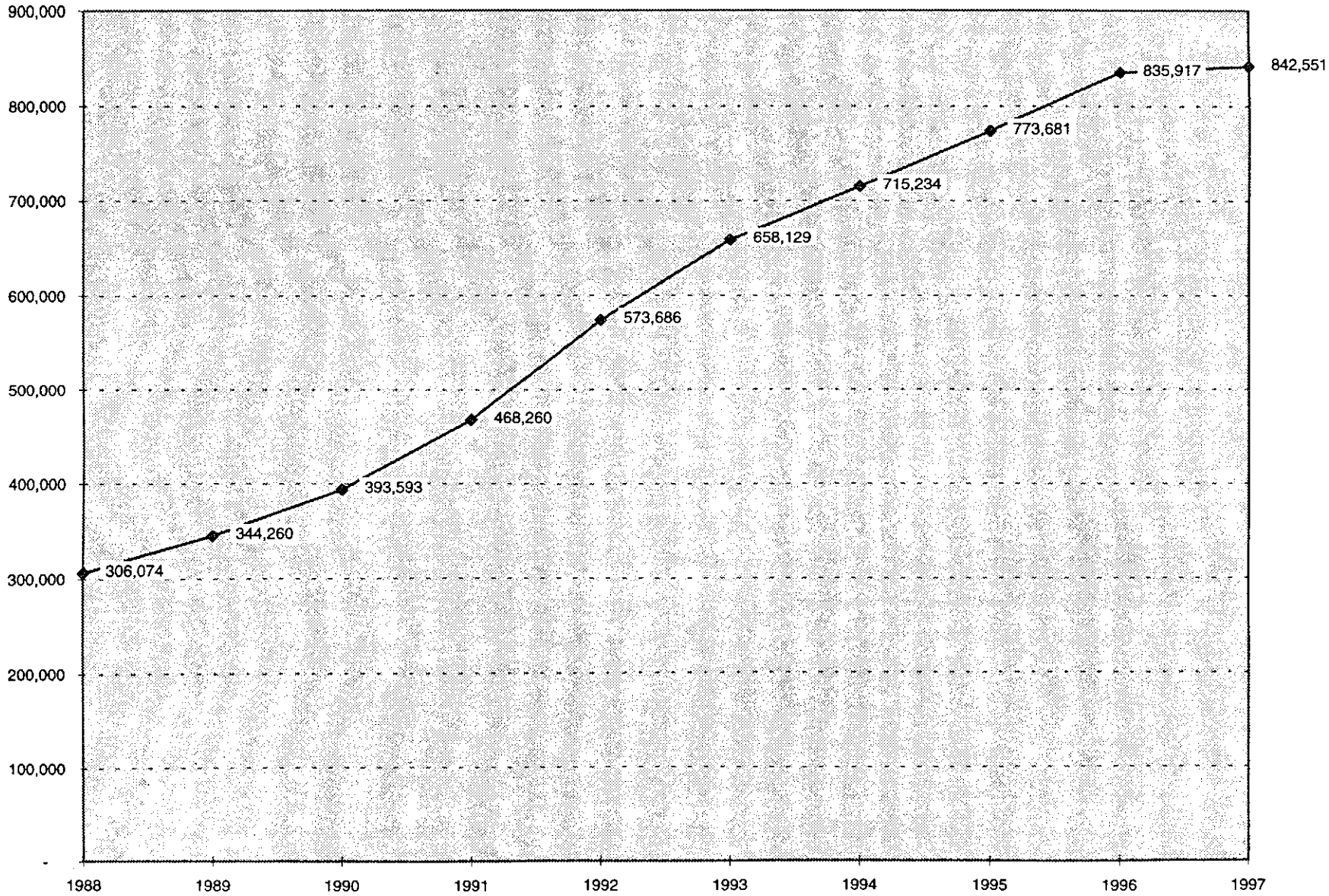

## By Gender



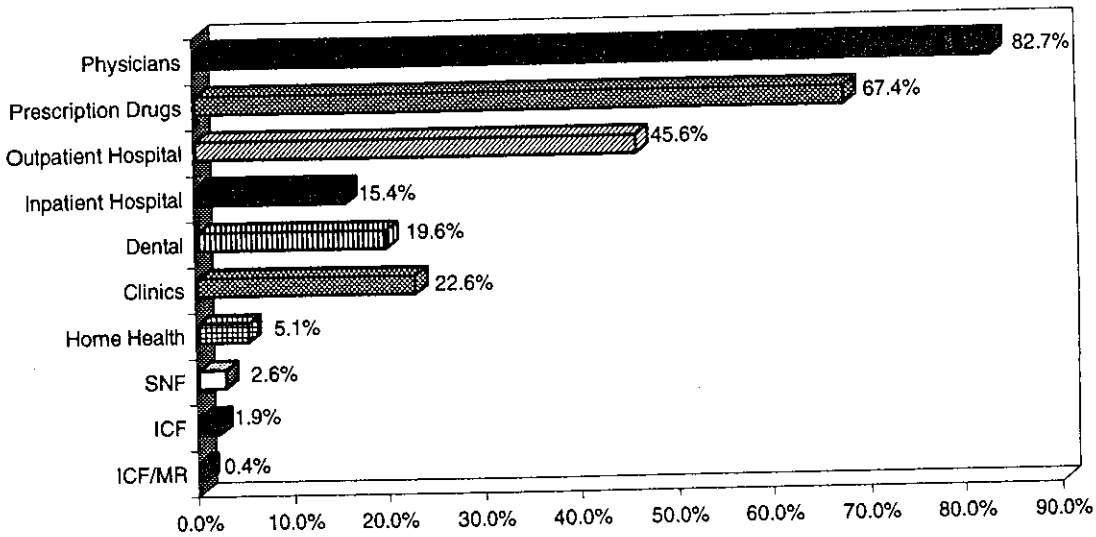

## By Race



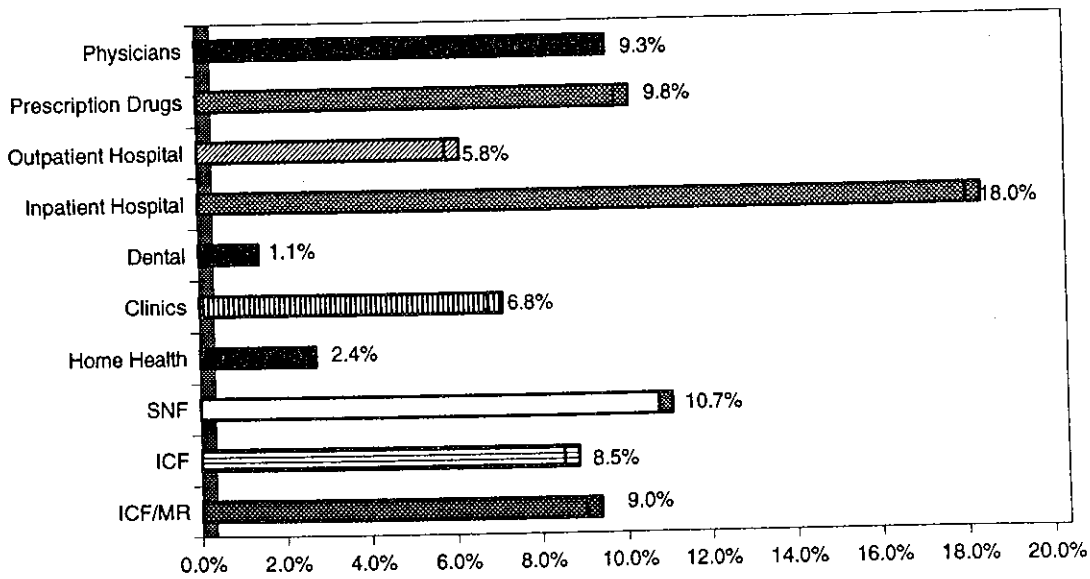
## North Carolina Medicaid
## State Fiscal Year 1997
## Medicaid Eligible People



## State Fiscal Year 1997
## Selected Medicaid Services
## Percent of Total Users




## State Fiscal Year 1997
## Selected Medical Services
## Percent of Service Dollars



# North Carolina Medicaid
## State Fiscal Year 1997
### Percentage of Recipients and Service Expenditures

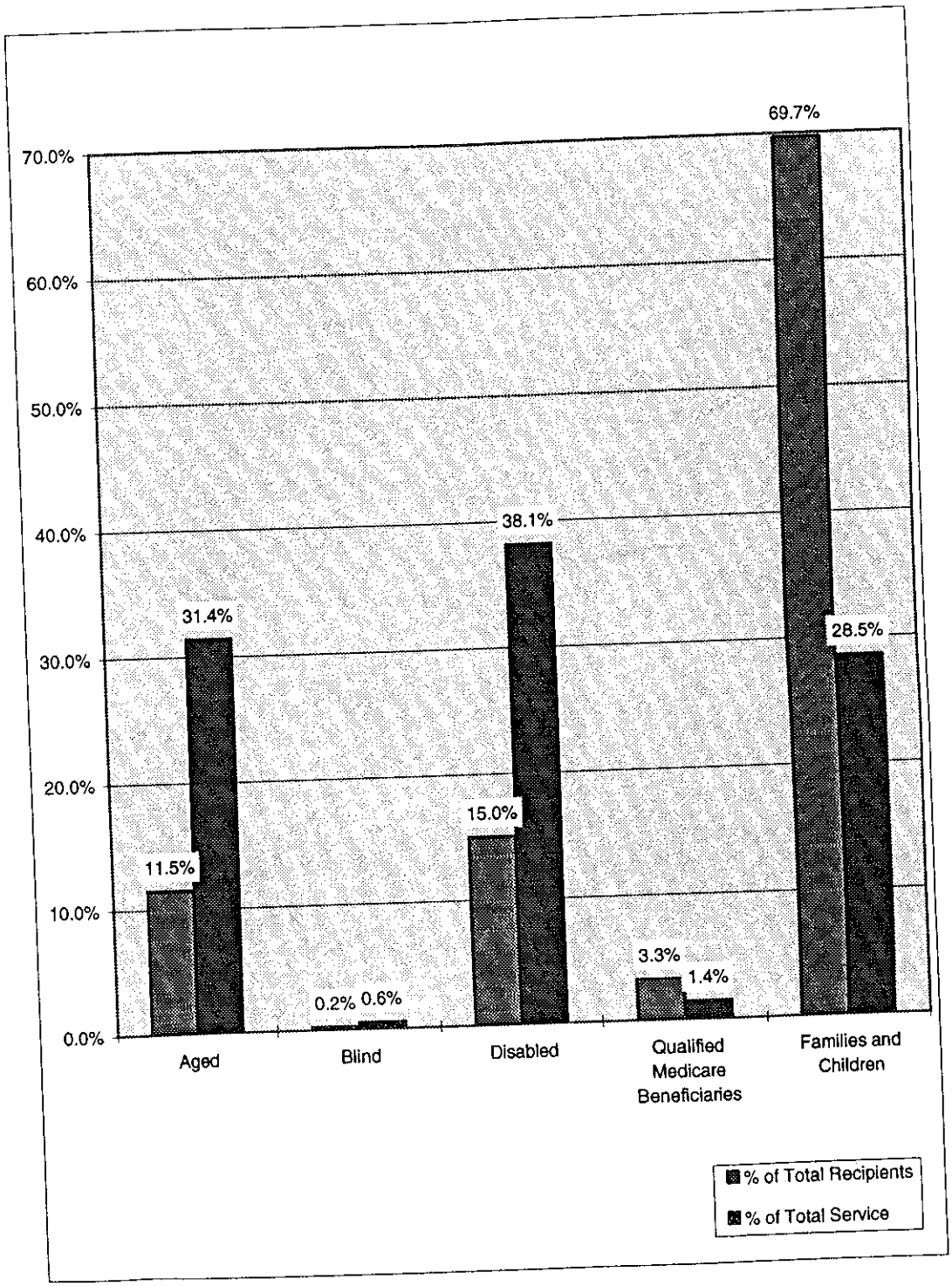


Chart 5
State Fiscal Year 1997
Eligibles per 1,000 Population