nc department of health and human services

Medicaid in North Carolina
Annual Report
State Fiscal Year 1998

Division of Medical Assistance

James B. Hunt, Jr.
Governor

H. David Bruton, M.D.
Secretary

Paul R. Perruzzi
Director

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

November 17, 1998

Dear Fellow North Carolinians,

I am happy to present the Medicaid Annual Report for State Fiscal Year 1998 to you. During the past year, Medicaid expenditures increased to over 4.8 billion dollars and the number of Medicaid recipients exceeded 1.172 million people. For the same period, total Medicaid eligibles edged up to 1,197,173, an increase of approximately 5,000 people from fiscal 1997.

We continue to focus on our managed care efforts. The Access Program has proven to be very successful and there are plans to expand it to 99 of the 100 counties in the state by December 1998.

You are cordially invited to learn more about North Carolina's Medicaid program and initiatives in the annual report that follows.

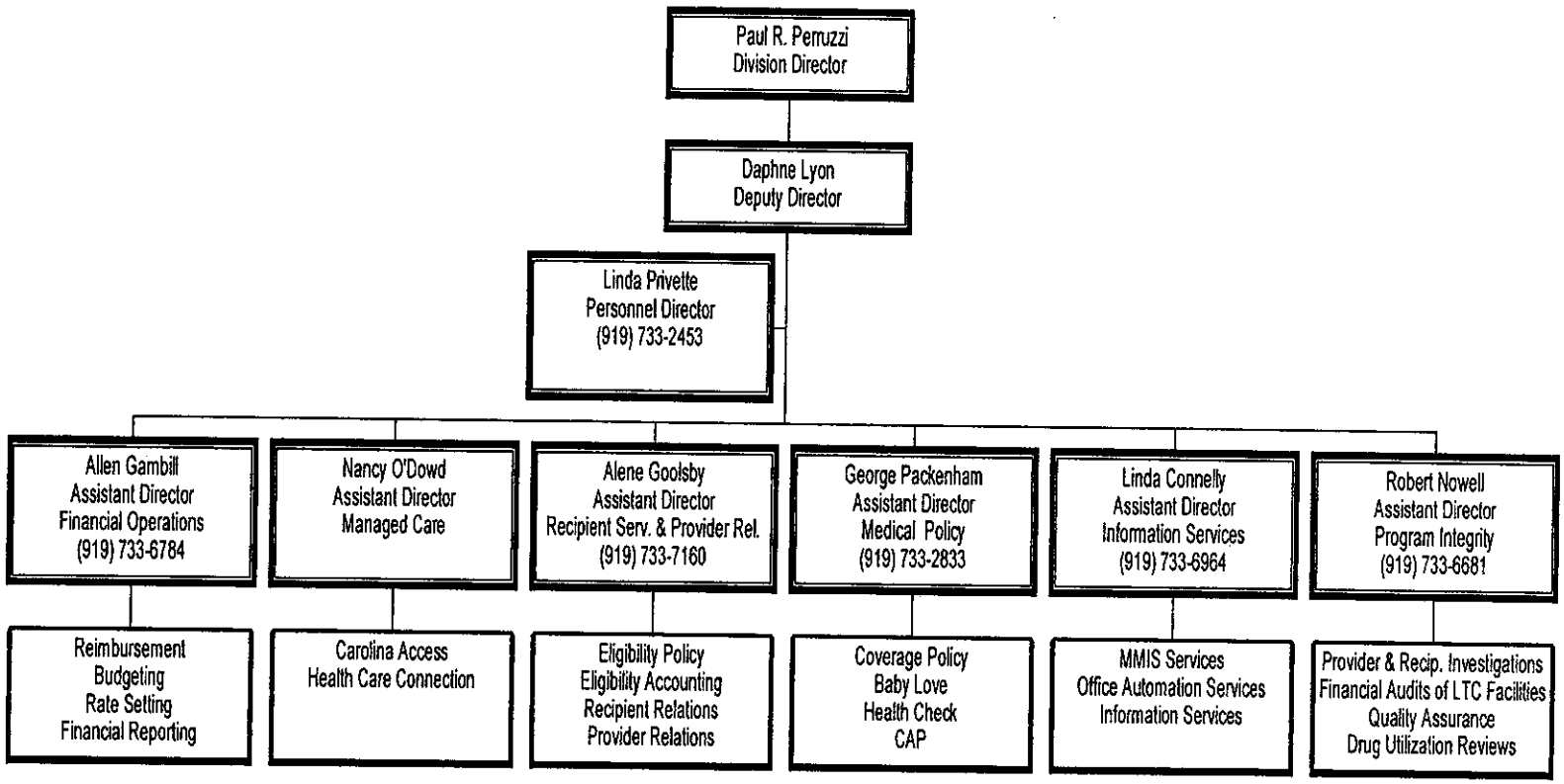
Sincerely,

Paul R. Perruzzi
Director

Division of Medical Assistance

Office of the Director

(919) 733-2060



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Medicaid Policy Changes in Brief

In May 1998, the General Assembly enacted legislation to provide health care coverage to approximately 71,000 children under federal Title XXI of the Social Security Act. The initiative is called the State Child Health Insurance Program. On October 1, 1998, this program, now called **HealthChoice**, began covering children under age 19 in families with income below 200% of poverty.

The Department of Health and Human Services has overall responsibility for administering the program, with the Division of Medical Assistance (DMA*) responsible for eligibility determination and premium payment and the Division of Women and Children's Health responsible for outreach. The Teachers and State Employees Health Plan is responsible for benefit coverage and claim payment.

The General Assembly has also enacted legislation to require DMA to reduce the rate of growth in the Medicaid program to 8% per year by the year 2001. This is to be accomplished by gradually reducing the rate of growth from 10.5% to 9% in state fiscal year 1999**, and then to 8% in 2001.

The General Assembly, upon recommendation of the Governor, transferred all Health Services Divisions from the Department of Environment Health and Natural Resources to the Department of Health and Human Services (formerly the Department of Human Resources). Because DMA works so closely with Health Services sections, this was seen as a move to foster more cooperation between the agencies.

While not directly related to Medicaid coverage, the enactment of federal welfare reform legislation and the implementation of the North Carolina **Work First** welfare reform waiver, have resulted in large reduction in the number in certain categories. The number of Medicaid eligible adults in families has decreased dramatically, and the number of children eligible for Medicaid has also decreased, but not as dramatically as the adults.

Medicaid Annual Report on the Internet

You can now access this report on the Internet. The text is under **Publications** and the tables are under **North Carolina Medicaid Statistics**. The address is:

www.sips.state.nc.us/DHR/DMA/

* DMA is responsible for the administration of the Medicaid program.
** The North Carolina fiscal year runs from July 1 to June 30.

Data Synopsis

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 1998, 28.5 percent of the service budget was spent on nursing facility care and on institutional care for the mentally retarded.

Total Medicaid Expenditures increased to $4,831,721,654, a 4% increase over SFY 1997. The amount spent for program services were $4,197,522,729. This represents a 5 % increase in service costs over SFY 1997. See Table 10 on page 36 for a detailed breakdown of these service expenditures.

The total number of Medicaid eligibles in SFY 1998 was 1,197,173. This was a .42% increase in total eligibles over SFY 1997.

There was a total of 1,172,775 Medicaid recipients in SFY 1998. Total recipients increased 1.5% from state fiscal year 1997.

Hertford county had the highest concentration of Medicaid eligibles in SFY 1998 with 336 people per 1,000 of county population on Medicaid. Orange County had the lowest concentration of Medicaid eligibles with 73 per 1,000 of county population on Medicaid

Alleghany County had the highest Medicaid cost per eligible, $4,566 and Cumberland county had the lowest cost per eligible, $2,503. Statewide, the average cost per eligible was $3,448. Please note that Cost-per-Eligible generally reflects services used.

Inpatient hospital stays at $705 million was the highest total cost of all Medicaid categories of service rendered for SFY 1998 with Prescription Drugs second at $455 million.

In the managed care area, Carolina ACCESS, North Carolina's patient access and coordinated care program was expanded into 77 of the state's 100 counties during the fiscal year. There were 397,694 clients enrolled in the program as of June 30, 1998.

During state fiscal year 1998, the Division of Medical Assistance received almost $81,000,000 in rebates from pharmaceutical companies that deal with the state Medicaid program.

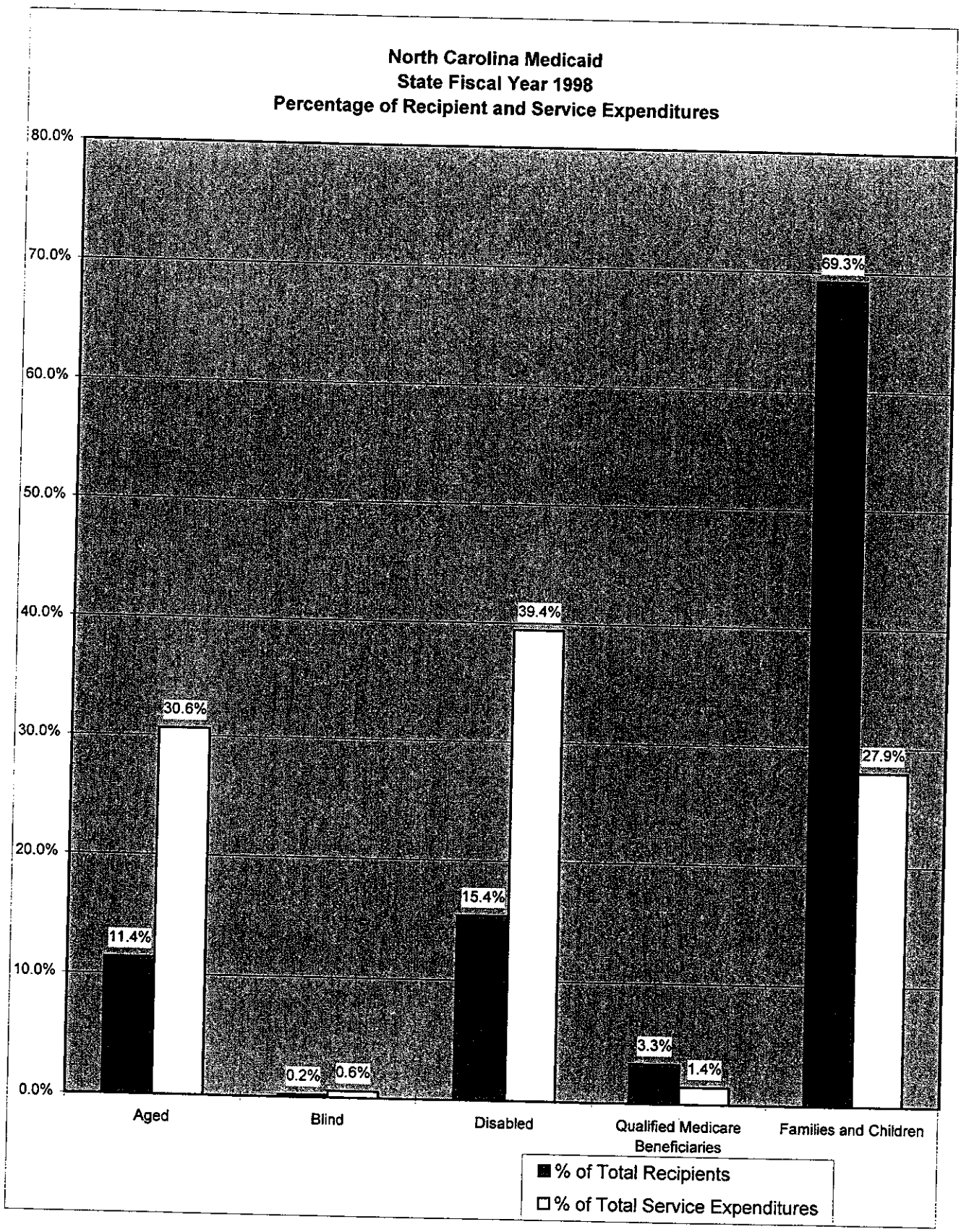
Medicaid Recipients

Of the major Medicaid categories, AGED and DISABLED consumed the most service resources. AGED with 11.5% of the Medicaid recipients used 31.4% of resources and DISABLED with 15% of recipients used 38.1% of Medicaid resources. See the chart on page 3 for full details.

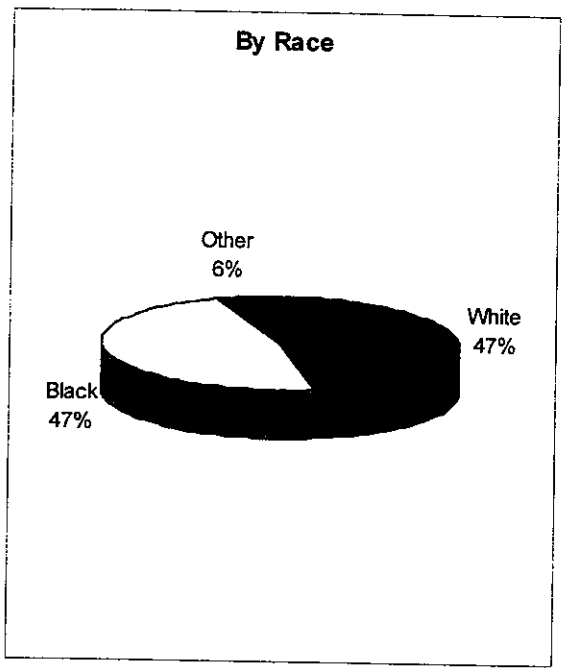
In state fiscal year 1998 the racial breakdown of Medicaid recipients was:

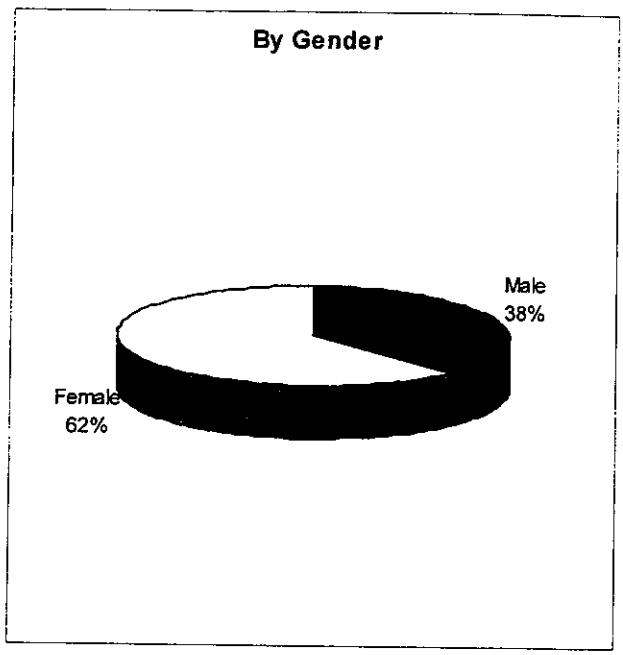
White	517,449
Black	519,112
Other	136,214

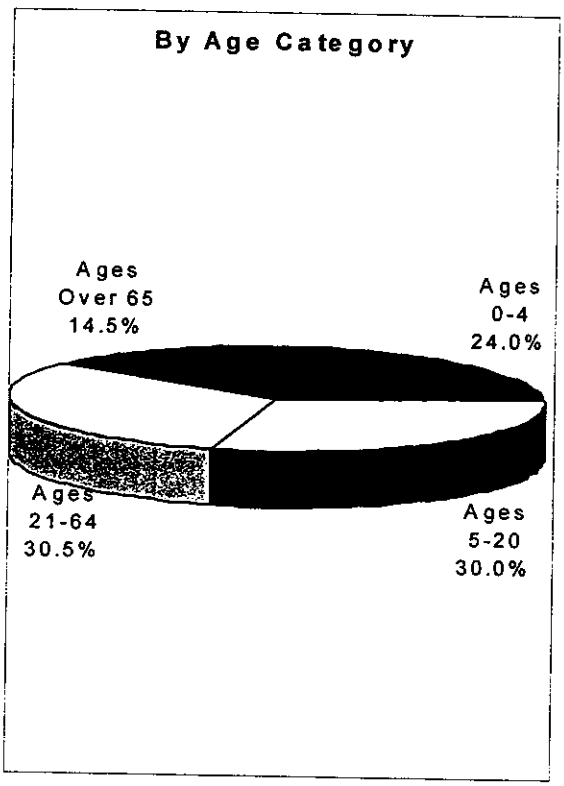
Please turn to page four for more information about Medicaid recipients in North Carolina.

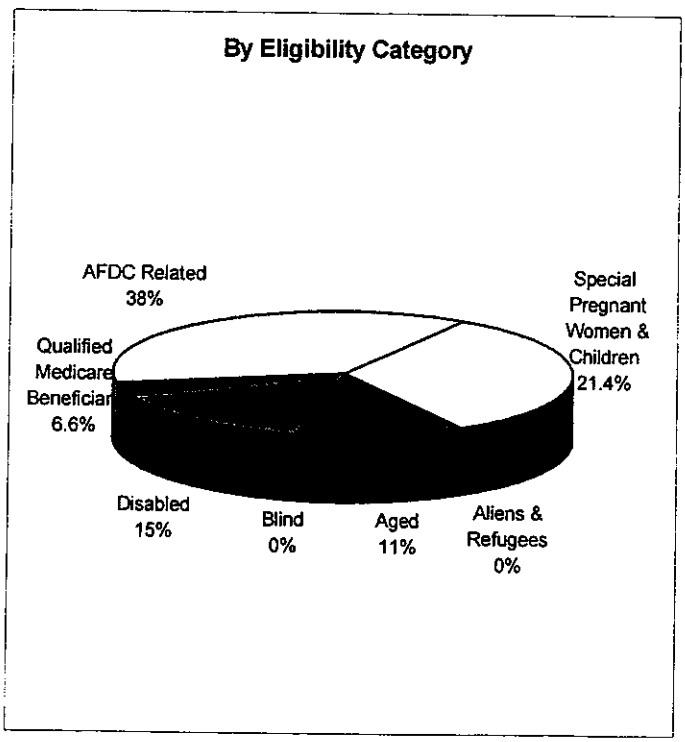

North Carolina Medicaid
State Fiscal Year 1998
Percentage of Recipient and Service Expenditures
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
11.4%
30.6%
0.2%
0.6%
15.4%
39.4%
3.3%
1.4%
69.3%
27.9%
Aged
Blind
Disabled
Qualified Medicare Beneficiaries
Families and Children
% of Total Recipients
% of Total Service Expenditures

Recipients of Medicaid Services









MANAGED CARE

Managed Care

Managed care opportunities for Medicaid recipients continued to increase during SFY 1998. 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**). The program operates under the authority of the 1915(b) waiver of the Social Security Act.

HEALTH CARE CONNECTION started in Mecklenburg County, North Carolina in 1996. Health Care Connection, a mandatory program for certain Medicaid eligibles, links most Medicaid recipients in Mecklenburg 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. The program operates under the authority of the 1915(b) waiver of the Social Security Act.

HMO Option is a Medicaid managed care program whereby the Division of Medical Assistance (DMA) contracts with Health Maintenance Organizations (HMOs) in selected areas to provide and coordinate medical services for certain Medicaid eligibles on a full risk capitated basis. In these areas, recipients may voluntary enroll in an HMO.

For all of these health care models the objectives are:

- Cost effectiveness
- Appropriate use of health care services
- Improved access to primary preventive 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 its contract with the state, opting to serve Medicaid eligibles as a **Carolina ACCESS** provider in three of the four affected counties. In February of 1998, Kaiser ended its participation as 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 eligibles 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 four HMOs serving that county as well as C.W. Williams, the local Federally Qualified Health Center (FQHC) located there. These people have been educated and 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
- Maxicare of North Carolina
- Optimum Choice/Mid-Atlantic Medical
- The Wellness Plan of North Carolina

After two years of operation, enrollment numbered over 31,000 and **Health Care Connection** expanded coverage in Mecklenburg County to blind and disabled eligibles and residents of adult care homes on November 1, 1997.

The **Health Care Connection** program had an 11 percent auto-assignment rate where eligibles were assigned to an HMO if they did not choose one voluntarily, and a 19 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.

HMO Option

Beginning in 1997, HMOs were offered as an option to Medicaid recipients in certain areas outside Mecklenburg County.

Beginning with Gaston County in October of 1997, **Optimum Choice of the Carolinas, Maxicare North Carolina** and **The Wellness Plan** were offered as HMO options to recipients.

The HMO option was then made available in January of 1998 within Chatham, Harnett, Orange Person and Wake counties. Participating HMOs in these counties included: Optimum **Choice of the Carolinas** and **Maxicare North Carolina** in Harnett, Orange, Person and Wake; and **Generations Family Health Plan** in Harnett, Orange Person, Wake and Chatham Counties.

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 for the Kate B. Reynolds Health Care Trust.

Five counties were selected for a pilot of the program and by June 30, 1998, expanded to 76 counties. There were 397,694 enrollees in **Carolina ACCESS** as of June 30, 1998. This figure represents approximately, 70% of total Medicaid enrollees for these counties as of that date.

Expansion to 97 counties by January 1999 is planned. It is anticipated that at least 70

percent of the Medicaid recipients in participating counties will be enrolled in **Carolina ACCESS.**

The following is a list of **Carolina ACCESS** counties and their implementation dates:

Alamance (7/95)
Anson (3/97)
Bladen (6/97)
Burke (9/91)
Caldwell (10/94)
Caswell (7/94)
Chatham (10/94)
Chowan (1/98)
Cleveland (8/94)
Craven (9/95)
Currituck (8/97)
Davie (6/98)
Durham (4/91)
Forsyth (2/93)
Gaston (9/95)
Granville (11/97)
Guilford (9/95)
Harnett (5/93)
Henderson (4/91)
Iredell (9/97)
Johnston (10/96)
Lenoir (7/94)
Macon (9/95)
Moore (4/91)
Northhampton (9/96)
Orange (11/93)
Pasquotank (8/97)
Person (5/95)
Robeson (1/98)
Rowan (2/98)
Sampson (3/96)
Stanly (4/98)
Surry (10/93)
Transylvania (6/95)
Union (12/97)
Wake (3/94)
Washington (6/98)
Wilkes (4/98)
Alexander (6/96)
Beaufort (3/92)
Buncombe (3/93)
Cabarrus (11/97)
Camden (8/97)
Catawba (7/96)
Cherokee (10/95)
Clay (5/98)
Columbus (5/98)
Cumberland (1/98)
Davidson (8/93)
Duplin (4/96)
Edgecombe (4/91)
Franklin (3/98)
Graham (5/98)
Greene (3/92)
Halifax (11/96)
Haywood (11/92)
Hoke (4/98)
Jackson (12/94)
Lee (10/94)
Lincoln (9/96)
Madison (8/91)
Nash (8/91)
Onslow (9/94)
Pamlico (1/98)
Pender (6/97)
Pitt (3/92)
Rockingham (8/95)
Rutherford (12/97)
Scotland (11/93)
Stokes (11/97)
Swain (5/98)
Tyrrell (6/98)
Vance (12/97)
Warren (6/97)
Wayne (9/91)
Wilson (11/95)

Carolina Alternatives Program

Carolina Alternatives is a Mental Health Managed Care model designed to better organize and deliver mental health services to Medicaid eligible infants and children ages 0-17.

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 and is in 32 counties around the state. Currently there are approximately 131,000 children participating monthly in **Carolina Alternatives.**

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.

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 1998, Medicaid expenditures grew from $307 million to $4.8 billion, and the count of people eligible for Medicaid increased from 456,000 to 1,197,000. During this time, DMA staff increased from 121 to 325 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 1998, the state administration budget was only 1.6% of total service dollars and the local administration costs consumed just 2.0 % of total service expenditures. The 3.6% of service dollars administration cost for both governmental entities represents a increase of .4 percent from SFY 1997 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

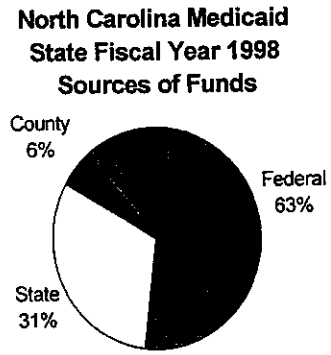
The federal government pays the largest share of Medicaid costs. Federal matching rates for services are established by HCFA, the Health Care Financing Administration.. HCFA uses the most recent three-year average per capita income for each state and the national per capita income in establishing this 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 1998.

Funding Formula

The federal matching rate for Medicaid services varies from state to state based on per capita income. Nationwide, in SFY 1998, the federal match rate varied from a low of 50 percent to a high of 77

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 1998, the federal, state and county shares of total expenditures were approximately 63 percent, 31 percent, and 6 percent, respectively. See Table 1 in Appendix A for a detailed breakdown of these shares.



Eligibility

For the first time in ten years, Medicaid eligibles in North Carolina as of June 30, 1998, the end of the fiscal year dropped. As of June 30, 1997, there were 842,551 people eligible. That figure fell to 820,478 this year. The primary factor causing this drop was the continued decline in AFDC clients. See the chart on page 10 for all details.

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.

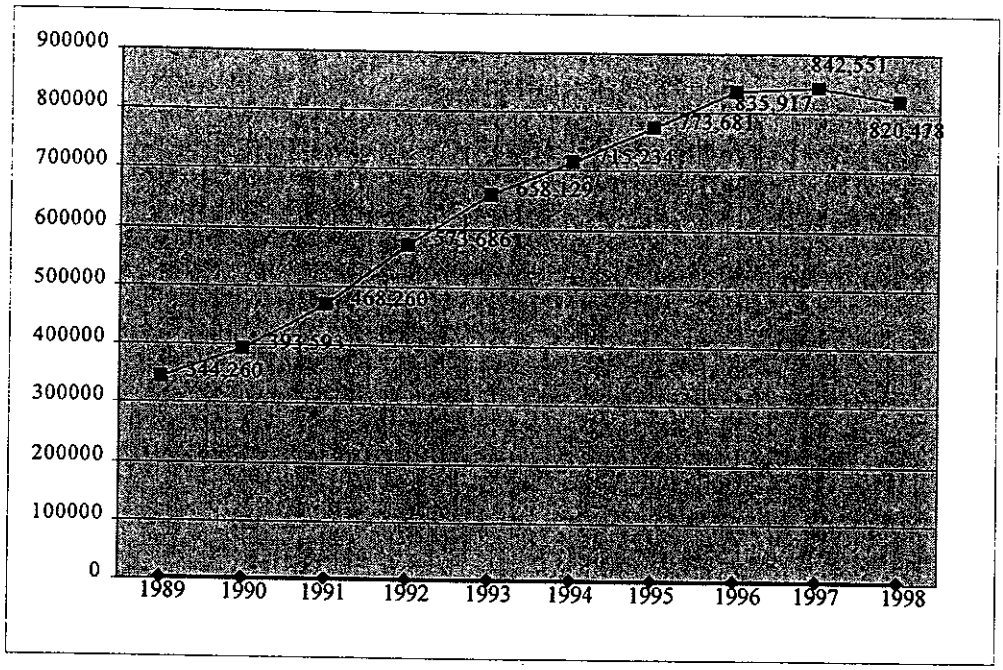
For the aged, blind and disabled, federal regulations permit states either to accept as categorically needy all persons found eligible for the federal Supplemental Security Income (SSI) program or to set categorically needy eligibility criteria that are more restrictive than SSI standards.

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

HISTORY of MEDICAID ELIGIBLES (UNDUPLICATED)



When 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 52,600 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 $24 million in SFY 1998.

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 was been extended through June 30, 1998.

Medical Review of North Carolina (MRNC) -- DMA contracts with MRNC to operate Medicaid's pre-admission 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 pre-admission certification and post discharge reviews of inpatient psychiatric services for children under age 21 and adults. These reviews assure that admissions and lengths of stay are medically necessary and appropriate for this population.

First Health Services Corporation (FHSC) – DMA contracts with FHSC to perform the computerized functions for the retrospective part of the Drug Use Review (DUR) Program. FHSC generates quarterly recipient and provider profiles from the paid claims computer tapes in accordance with the DUR Board's criteria.

FHSC has a therapeutic criteria catalog that the DUR Board can use as is, amend, or make additions. The DUR Board can also elect to create new criteria that FHSC must be able to implement and run. The interventions and responses resulting from the review of these profiles are tracked by FHSC's software. FHSC must provide the data and cost savings for the DUR Annual Report to HCFA. In addition, FHSC provides ad hoc reporting for retrospective DUR projects, studies, and reviews.

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 has 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 the person making the application contests eligibility denials. 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 20 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 Epidemiology in DHHS - DMA and the Division of Epidemiology cooperate in a number of efforts to improve care for people with HIV and AIDS. The AIDS Care Branch in the Division operates HIV Case Management Services (HIV CMS) and the Community Alternatives Programs for Persons 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 lists Medicaid services for SFY 1998.

Some services require nominal co-payments and others require prior approval. Both requirements ensure that care received is medically necessary. Service limitations and co-payment 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 mistakes. County staff also participates 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.

The following chart summarizes activities for the fiscal year:

	State Fiscal Year 1998
Provider Activities:	
Investigations Opened	**2,926**
Overpayment Cases	**861**
Overpayments	**$4,778,443**
Recipient Activities:	
Cases Reported	**1,169**
Overpayments	**$2,191,993**
Health Care Facility Audit Activities:	
Audits	**724**
Collected	**$8,545,084**
Total Collected	**$15,515,520**

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. EDS operate the prior approval system for most services. 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 pre-admission and post payment reviews of inpatient psychiatric admissions for children under 21. In addition, paid claims are reviewed periodically and those that 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 1998, insurance coverage and refunds from a variety of sources defrayed Medicaid expenditures. Medical insurance covered $104,235,058 on behalf of Medicaid patients. Additionally, $79,842,473 in Medicaid claims was denied because it was discovered that other insurance coverage was available to pay for client services.

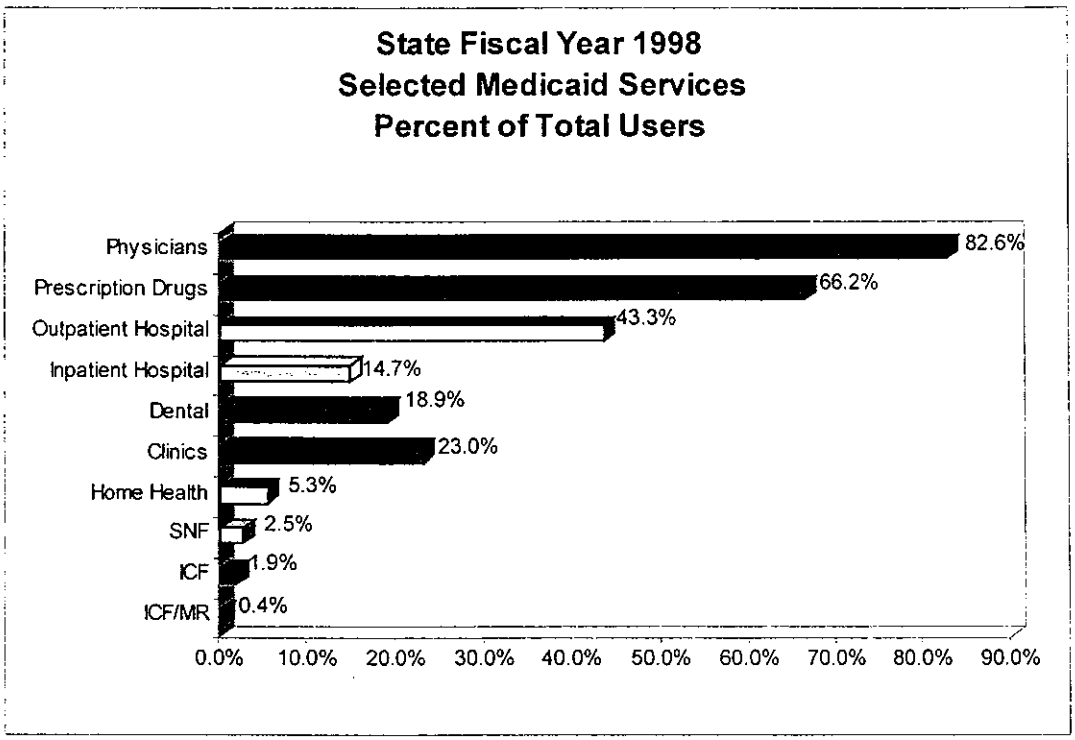
During SFY 1998, Medicaid received refunds from:

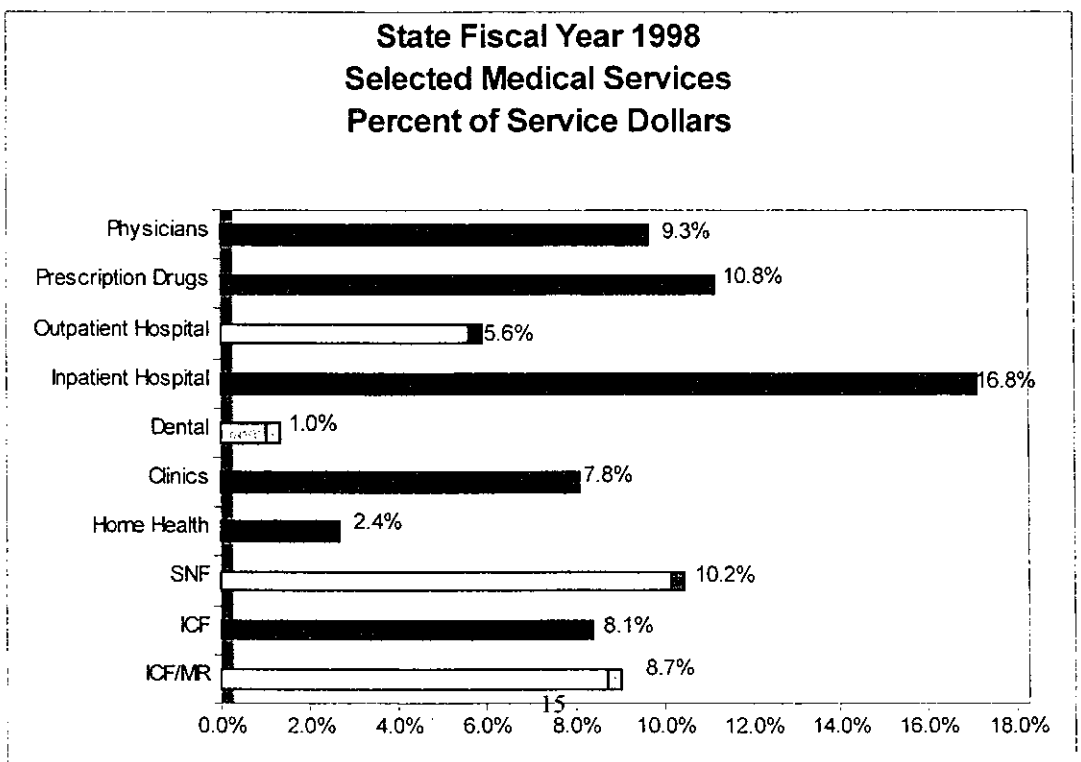
• Medicare	$ 1,910,064
• Health Insurance	$11,986,983
• Casualty Insurance	$9,383,785
• Absent Parent	$222,214
• Estate Recovery	$877,833
	$24,180,879

In SFY 1998, $1,058,199,714 was saved by the policy that requires Medicare to be the primary payer when a person is eligible for both Medicare and Medicaid.

In total, including drug company rebates, the amount of money recovered by DMA in State Fiscal Year 1998 was $304,773,930. This represents approximately 6% of total Medicaid expenditures for the fiscal year.

This amount was $37,000,000 more than the total county contribution to the Medicaid budget and represents a significant contribution to the funding effort for the entire Medicaid program.





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.

Following is a list of services which require a co-payment and the amount of the co-payment.

STATE FISCAL YEAR 1998
Medicaid Copayment Amounts

SERVICE	CO-PAYMENT
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 co-payments are at the federal maximum amount. Co-payment 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
- Mental hospital patients
- Hospital emergency room services

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

- 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 pre-admission 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 a limitation of twentyfour physician visits annually. This limitation does not apply to emergency room visits which have no limits. A $3.00 per visit co-payment 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 Medicaid recipients aged 21 and older. The state also has chosen a federal option to cover NF services for people under age 21. Prospective patients must be pre-certified by a physician in order to receive nursing facility care. 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 co-payment 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 co-payment 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 21 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 in Appendix A 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 habitation 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 in-home aide services in a private residence that perform personal care tasks for the patient who, due to a medical condition, needs help with such activities as bathing, toileting, moving about, and keeping track of vital health signs. The services may only be performed in the patient's residence. While in the patient's home, the aide may also perform essential home management and housekeeping tasks for the patient, though secondary to the personal care tasks necessary for maintaining the person's health. The care is provided according to a plan of care developed by a registered nurse and authorized by the patient's physician.

Medicaid payment is available up to the number of hours authorized on the plan of care, not to exceed 80 hours per month. PCS is provided by licensed home care agencies enrolled with DMA. The agency is paid the lesser of the agency's usual customary charge and the Medicaid maximum allowable rate.

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 co-payment 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 co-payment 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 some frequencies of visit limitations apply. A $3.00 co-payment applies to physician visits; a $2.00 co-payment applies to optometrist visits; and a $2.00 co-payment is charged for new eyeglasses

and eyeglass repairs. Co-payments 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 are covered for Medicaid recipients under 21 years of age. Coverage for this service is limited to once every five years. For this service, the Medicaid client must get prior approval from 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 co-payment 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 twentyfour visit outpatient limit and a $3.00 co-payment 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 available under the North Carolina Medicaid program. Limited services by chiropractors and podiatrists are covered and paid on the basis of a statewide fee schedule. Other optional services available 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

Providing preventive medical services and basic medical care for North Carolina's mothers and children are a continuing priority for 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 maximum income to qualify for Medicaid is 185 percent of the federal poverty level.

See Table 2 in Appendix A for a description of 1998 Federal Poverty Level amounts. Medicaid 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 1998, these initiatives helped 69,446 pregnant women and 314,072 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 49% 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 1998, 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 childcare and WIC services. Mothers who have a Maternity Care Coordinator have better birth outcomes, more live births, and fewer low birth weight 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.

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 teenagers 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 special 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

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

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).

- Families report that they are very satisfied with the assistance provided by Health Check Coordinators.

- Health Check letters represent an effective way of informing families about the program.

Medicaid eligible children and youth access to and utilization of health care services have improved since the initiation of this very important program.

Community Alternatives Program

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

CAP/DA Program:

The Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults (age 18 and older) who qualify for nursing facility care to remain in their private residences. The program is available in all North Carolina counties. The program served approximately 10,000 people in SFY 1998 at far less cost than nursing facility care. The average daily cost of CAP services was less than 75% of the average Medicaid Nursing Facility cost.

CAP-MR/DD:

The Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD) provides community services to individuals of any age who qualify for care in an intermediate care facility for the mentally retarded (ICF-MR). The Division of Mental Health, Developmental Disabilities and Substance Abuse Services manages the daily operation of the program under an agreement with DMA. The program is available statewide through local area mental health, developmental disabilities and substance abuse programs. CAP-MR/DD served approximately 4,000 people in SFY 1998 at an average cost that was less than 35% of the average cost of ICF-MR care.

CAP/C

The Community Alternatives Program for Children (CAP/C) provides cost-effective home care for medically fragile children (through age 18) who would otherwise require long term hospital care or nursing facility care. There were 215 children who participated in CAP/C in SFY 1998. The program contributed to the quality of life for the children and their families/caregivers, while providing care that was cost-effective in comparison to the Medicaid cost for institutional care. The average cost per recipient per month was $5,164.

CAP/AIDS:

The Community Alternatives Program for Persons with AIDS (CAP/AIDS) is a relatively new Medicaid program that offers a home care alternative to nursing facility care for persons with AIDS as well as children who are HIV-positive with other qualifying conditions. CAP/AIDS is a cooperative effort with the Division of Epidemiology's AIDS Care Branch. The AIDS Care Branch administers the program with DMA providing oversight. This program began in late 1995 and is still developing statewide. A total of 27 people were served in SFY 1998 at an average cost of

less than 65% of the average Medicaid cost of nursing facility care.

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

Medicare-Aid

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

The eligibility income limit for Medicare-Aid is 100 percent of the federal poverty level. Effective January 1, 1993, coverage was added to pay the Medicare B premium for individuals who are Medicare-Aid eligible but have incomes too high to qualify for the basic plan. These individuals are called Specified Low-Income Medicare Beneficiaries. To be eligible, their income must be within 101-120 percent of the federal poverty level.

In State Fiscal Year 1998, 38,643 recipients benefited from Medicare-Aid. The average cost per recipient was $1,297

Drug Use Review Program

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

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

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

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

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

- **Education** -- Education is the key for an effective DUR Program. The DUR Program must provide ongoing outreach programs to educate physicians and pharmacists about common drug therapy problems with the goal of improved prescribing and dispensing practices.

In SFY 1995, the Drug Use Review Program began using a Provider Profiling System to complement the retrospective patient-based drug utilization reviews. This system is designed to be a retrospective characterization of drug use patterns. The Provider Profiling System identifies any prescribing and dispensing practices that deviate from accepted norms. These norms may be defined by the Board, taken from published literature, or

manipulated as needed. The Provider Profiling System is criteria driven and accommodates client-specific criteria within any of 12 broad problem types.
Since the primary focus of the DUR Program is educating providers about common drug therapy problems to improve prescribing and dispensing practices, the providers who are profiled receive educational letters with profiles of each recipient who receives the medication and prescribing information related to the patient's drug therapy.

Health Related Services Provided in Public Schools and Head Start Programs

In strengthening the commitment to provide a comprehensive array of services to the children of North Carolina, DMA is reimbursing physical therapy, occupational therapy, audiological services, speech/language services, and psychological services. These services are provided to eligible clients in the public school system by local education agencies or through local Head Start Programs.

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 28.2% of the State's total service expenditures. In state fiscal year 1998, 51,742 people who were not in mental institutions received long-term care in North Carolina costing a total of $77,877,668. The average cost per recipient was $15,034 for the year. In SFY 1998, the percentage of nursing home beds occupied by Medicaid clients increased to 76.3%. See the table on the following page for more information.

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 patient's 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 Pre-admission 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 that they need. The resident assessment is required for all nursing facility patients regardless of payment source.

- Patients' rights were strengthened and made more explicit.
- States were required to develop and maintain a registry of nurse aides and to institute a nurse aide training program in the state. As mandated, North Carolina has instituted a nurse aide program.
- Nursing Facility quality assurance programs were strengthened.

Spousal Impoverishment

The spousal impoverishment provision of the Medicare Catastrophic Coverage Act of 1988 allows a spouse living in the community to keep a larger portion of the couple's income when the other spouse requires nursing home care. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The total income and resources amounts which may be protected for the at-home spouse increases each year. As of January 1, 1998, the annual income that can be protected ranges from $16,284 to $24,228. The resource protection limit currently ranges from $16,152 to $80,760.

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%
1998	43,276	33,038	76.3%

APPENDIX A
MEDICAID TABLES

Table 1
North Carolina Medicaid
State Fiscal Year 1998
Federal Matching Rates

Benefit Costs
(7/1/97 - 9/30/97)

	Family Planning		All Other
Federal	90.0%	Federal	63.89%
State	8.5%	State	30.69%
County	1.5%	County	5.42%
			100.00%

Benefit Costs
(10/1/97 - 6/30/98)

	Family Planning		All Other
Federal	90.0%	Federal	63.09%
State	8.5%	State	31.37%
County	1.5%	County	5.54%
			100.00%

Administrative Costs
(7/1/97 - 6/30/98)

	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 1998
Medicaid Financial Eligibility Standards

GROUP:	FAMILY SIZE:	1	2	3	4	5
Pregnant Women and Children under age 1	Income Limit:	$1,242/mo.	$1,673/mo.	$2,105/mo.	$2,537/mo.	$2,968/mo.
	Resource Limit:	None				
Children age 1 through 5	Income Limit:	$893/mo.	$1,203/mo.	$1,503/mo.	$1,824/mo.	$2,134/mo.
	Resource Limit:	None				
Children age 6 through 18	Income Limit:	$671/mo.	$903/mo.	$1,138/mo.	$1,371/mo.	$1,605/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:	$494/mo.	$741/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:	$671/mo.	$903/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
* Medicaid pays Medicare Part B premiums only.	Income Limit:	$805/mo.	$1,085/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.
	Families & Children	$ 1,500	$ 2,250	$ 2,350	$ 2,450	$ 2,550
	Aged,Blind,Disabled	$ 2,000	$ 5,000			

Table 3
North Carolina Medicaid
State Fiscal Year 1998
Enrolled Medicaid Providers

Providers	Number
Physicians*	30,010
Dentists	3,480
Pharmacists	2,444
Optometrists	1,023
Chiropractors	1,145
Podiatrists	426
Ambulance Companies	330
Home Health Agencies**	178
Durable Medical Equip. Suppliers	3,151
Intermediate Care Facilities-MR	332
HMOs	5
Hospitals	704
Mental Health Clinics	185
Nursing Facilities	564
Optical Supplies Company***	1
Domicile Care	2,209
Personal Care Agencies	522
Rural Health Clinics	163
CRNA	30
Nurse Midwives	40
Hospices	76
CAP Providers	718
Other Clinics	3
Other	4,918
Total	**52,657**

* 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, Occupational Therapies and Home Infusion Therapy services.

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

Table 4
North Carolina Medicaid
State Fiscal Year 1998
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 1997 & 1998
Sources of Medicaid Funds

		1997	Percent		1998	Percent
Federal	$	2,857,833,171	61.6%	$	3,048,333,192	63.09%
State		1,579,540,066	34.0%	$	1,515,711,083	31.37%
County		203,048,680	4.4%	$	267,677,380	5.54%
Total	**$**	**4,640,421,917**		**$**	**4,831,721,654**	

Table 6
North Carolina Medicaid
State Fiscal Year 1998
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		705,744,660	14.6%	16.8%	171,848	$	4,107
Outpatient Hospital		235,445,692	4.9%	5.6%	508,186		463
Mental Hospital >65 & <21		26,890,559	0.6%	0.6%	2,414		11,139
Physician		391,381,088	8.1%	9.3%	968,667		404
Clinics		326,837,731	6.8%	7.8%	269,492		1,213
Nursing Facility (Skilled)		426,076,788	8.8%	10.2%	29,887		14,256
Nursing Facility (Intermediate)		339,255,965	7.0%	8.1%	21,855		15,523
ICF-MR		366,252,026	7.6%	8.7%	4,868		75,237
Dental		43,538,804	0.9%	1.0%	221,163		197
Prescription Drugs		455,379,460	9.4%	10.8%	776,168		587
Home Health		99,502,502	2.1%	2.4%	62,393		1,595
Other Services		594,145,328	12.3%	14.2%	1,438,430		413
				0.0%			
Subtotal, Services	**$**	**4,010,450,603**	**83.0%**	95.5%			
				0.0%			
Medicare Premiums:							
(Part A, Part B, QMB, Dually Eligible)		154,775,583	3.2%	3.7%			
HMO Premium		32,296,543	0.7%	0.8%			
Subtotal Services		**4,197,522,729**					
Adjustments & Cost Settlements		127,633,967	2.6%				
Disproportionate Share Payments		331,081,743	6.9% **				
Subtotal Services & Other	**$**	**4,656,238,439**	**96.4%**				
Administration (State & County)		**175,483,215**	**3.6%**				
(State Share)		78,480,633	1.6%				
(County Share)		97,002,582	2.0%				
Grand Total Expenditures	**$**	**4,831,721,654**	**100.0%**				
Total Recipients (unduplicated)* **					**1,172,775**		
Total Expenditures Per Recipient (unduplicated)						**$**	**4,120**

* "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 1998-2082 report, SFY 1998-PER Report, SFY 1998-BD701 report

Table 7
North Carolina Medicaid
A History of Medicaid Expenditures
SFY 1979-1998

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%
1998	$	4,831,721,654	4%

Table 8

North Carolina Medicaid
State Fiscal Years 1979-1998
A History of Medicaid Eligibles

Fiscal Years	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Medicaid Pregnant Women Coverage	Medicaid Indigent Children Coverage	Other Children	Aliens and Refugees	Total	Percent Change
1978-79	82,930	N/A	3,219	59,187	301,218	N/A	N/A	6,620	N/A	453,174	-
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	N/A	455,702	0.60%
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	459,364	0.80%
1981-82	70,010	N/A	2,349	48,266	298,483	N/A	N/A	6,125	N/A	425,233	-7.40%
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	N/A	415,552	-2.30%
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	N/A	407,806	-1.90%
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	N/A	414,353	1.60%
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	N/A	441,930	6.70%
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	N/A	452,025	2.30%
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	N/A	481,326	6.50%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561	561,614	16.70%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	1,011	639,351	13.80%
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	1,675	753,292	17.80%
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	1,955	877,923	16.50%
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	2,437	992,697	13.10%
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	2,330	1,058,603	6.60%
1994-95	127,514	48,373	2,716	155,215	533,300	48,115	216,888	3,808	2,857	1,138,786	7.60%
1995-96	131,496	53,072	2,710	171,204	496,501	52,466	261,525	3,696	3,919	1,176,589	3.32%
1996-97	132,173	58,036	2,593	176,160	462,881	55,838	295,882	3,747	4,823	1,192,133	1.30%
1997-98	131,332	61,032	2,531	180,461	414,853	58,899	337,849	3,905	6,311	1,197,173	0.42%
SFY 1997 Percent Total Eligibles:	11.1%	4.9%	0.2%	14.8%	38.8%	4.7%	24.8%	0.3%	0.4%	100.0%	
SFY 1998 Percent Total Eligibles:	11.0%	5.1%	0.2%	15.1%	34.7%	4.9%	28.2%	0.3%	0.5%	100.0%	

Source: Medicaid Eligibilty Report, SFY 1998

Table 9
North Carolina Medicaid
State Fiscal Year 1998
Total Expenditures and Eligibles by County

COUNTY NAME	1998 EST. COUNTY POPULATION	NUMBER OF MEDICAID ELIGIBLES	TOTAL EXPENDITURES	EXPENDITURE PER ELIGIBLE	PER CAPITA EXPENDITURE AMOUNT	RANKING	ELIGIBLES PER 1,000 POPULATION	% of Eligibles on Medicaid by county, based on 1998 population (Column C / Column E
ALAMANCE	121,937	14,927	58,956,565	$ 3,950	$ 483.50	81	122	12.24%
ALEXANDER	31,540	4,168	14,122,323	3,388	447.76	85	132	13.21%
ALLEGHANY	9,733	1,525	6,963,270	4,566	715.43	38	157	15.67%
ANSON	23,894	6,589	25,078,996	3,806	1,049.59	7	276	27.58%
ASHE	23,870	4,374	19,184,110	4,386	803.69	27	183	18.32%
AVERY	15,595	2,676	13,410,667	5,011	859.93	22	172	17.16%
BEAUFORT	43,468	9,805	35,211,812	3,591	810.06	26	226	22.56%
BERTIE	20,102	6,548	21,813,295	3,331	1,085.13	3	326	32.57%
BLADEN	30,551	9,010	32,429,399	3,599	1,061.48	6	295	29.49%
BRUNSWICK	67,441	12,261	39,799,093	3,246	590.13	56	182	18.18%
BUNCOMBE	192,459	29,660	111,789,343	3,769	580.85	58	154	15.41%
BURKE	83,996	12,914	52,378,421	4,056	623.58	53	154	15.37%
CABARRUS	119,494	13,508	55,667,985	4,121	465.86	82	113	11.30%
CALDWELL	75,278	11,182	42,563,617	3,806	565.42	63	149	14.85%
CAMDEN	6,320	976	3,404,095	3,488	538.62	72	154	15.44%
CARTERET	59,881	8,079	30,759,414	3,807	513.68	76	135	13.49%
CASWELL	22,396	4,047	15,556,641	3,844	694.62	42	181	18.07%
CATAWBA	131,256	17,609	58,665,659	3,332	446.96	86	134	13.42%
CHATHAM	46,163	5,181	22,956,400	4,431	497.29	78	112	11.22%
CHEROKEE	22,692	5,209	20,289,092	3,895	894.11	19	230	22.96%
CHOWAN	14,325	3,569	13,853,789	3,882	967.11	13	249	24.91%
CLAY	8,206	1,373	5,890,016	4,290	717.77	36	167	16.73%
CLEVELAND	91,410	16,988	58,710,408	3,456	642.28	48	186	18.58%
COLUMBUS	52,261	15,907	57,323,239	3,604	1,096.86	2	304	30.44%
CRAVEN	89,546	14,540	48,572,134	3,341	542.43	68	162	16.24%
CUMBERLAND	295,053	48,803	122,172,395	2,503	414.07	92	165	16.54%
CURRITUCK	16,947	2,319	6,633,639	2,861	391.43	95	137	13.68%
DARE	28,218	2,688	11,507,230	4,281	407.80	93	95	9.53%
DAVIDSON	142,512	18,841	63,110,528	3,350	442.84	87	132	13.22%
DAVIE	31,881	3,390	14,056,853	4,147	440.92	88	106	10.63%
DUPLIN	44,639	10,365	34,251,684	3,305	767.30	29	232	23.22%
DURHAM	200,219	31,160	112,247,981	3,602	560.63	65	156	15.56%
EDGECOMBE	54,872	17,758	51,006,990	2,872	929.56	16	324	32.36%
FORSYTH	290,790	37,644	134,677,380	3,578	463.14	84	129	12.95%
FRANKLIN	44,414	7,950	29,871,133	3,757	672.56	44	179	17.90%
GASTON	181,028	30,003	107,556,989	3,585	594.15	55	166	16.57%
GATES	9,986	1,786	6,958,556	3,896	696.83	41	179	17.89%
GRAHAM	7,536	1,810	8,008,460	4,425	1,062.69	5	240	24.02%
GRANVILLE	43,650	6,685	24,283,965	3,633	556.33	66	153	15.32%
GREENE	18,071	3,837	13,555,535	3,533	750.13	34	212	21.23%
GUILFORD	388,519	54,517	194,608,215	3,570	500.90	77	140	14.03%
HALIFAX	55,182	18,367	54,670,224	2,977	990.73	11	333	33.28%
HARNETT	83,411	15,535	47,297,142	3,045	567.04	61	186	18.62%
HAYWOOD	51,922	8,506	32,924,418	3,871	634.11	50	164	16.38%
HENDERSON	80,562	11,795	43,593,607	3,696	541.12	69	146	14.64%
HERTFORD	21,684	7,294	23,136,347	3,172	1,066.98	4	336	33.64%
HOKE	29,624	7,023	18,800,526	2,677	634.64	49	237	23.71%
HYDE	5,301	1,343	5,901,667	4,394	1,113.31	1	253	25.33%
IREDELL	111,624	14,575	48,440,534	3,324	433.96	90	131	13.06%
JACKSON	29,354	5,016	18,365,271	3,661	625.65	51	171	17.09%
JOHNSTON	106,918	17,733	60,483,557	3,411	565.70	62	166	16.59%
JONES	8,786	2,144	8,349,732	3,894	950.35	15	244	24.40%
LEE	49,456	8,842	26,162,668	2,959	529.01	74	179	17.88%
LENOIR	59,024	14,756	49,454,519	3,351	837.87	23	250	25.00%
LINCOLN	59,121	7,407	24,821,619	3,351	419.84	91	125	12.53%
MACON	28,350	4,486	16,280,217	3,629	574.26	60	158	15.82%

Table 9
North Carolina Medicaid
State Fiscal Year 1998
Total Expenditures and Eligibles by County

COUNTY NAME	1998 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 1998 population (Column C / Column B)
MADISON	18,592	3,758	13,769,522	3,664	740.62	35	202	20.21%
MARTIN	25,545	6,704	22,347,468	3,333	874.83	21	262	26.24%
MCDOWELL	40,457	6,289	21,809,164	3,468	539.07	70	155	15.54%
MECKLENBURG	624,464	76,242	248,553,536	3,260	398.03	94	122	12.21%
MITCHELL	14,716	2,396	10,309,453	4,303	700.56	39	163	16.28%
MONTGOMERY	24,661	5,440	18,722,054	3,442	759.18	31	221	22.06%
MOORE	70,839	10,004	36,957,685	3,694	521.71	75	141	14.12%
NASH	88,469	15,373	49,051,282	3,191	554.45	67	174	17.38%
NEW HANOVER	149,975	22,240	84,236,080	3,788	561.67	64	148	14.83%
NORTHAMPTON	20,837	6,676	21,218,707	3,178	1,018.32	9	320	32.04%
ONSLOW	148,324	18,130	53,985,190	2,978	363.97	98	122	12.22%
ORANGE	108,752	7,968	33,463,367	4,200	307.70	99	73	7.33%
PAMLICO	12,037	2,370	9,059,459	3,823	752.63	32	197	19.69%
PASQUOTANK	35,146	7,572	26,415,485	3,489	751.59	33	215	21.54%
PENDER	38,424	7,328	25,618,878	3,496	666.74	45	191	19.07%
PERQUIMANS	11,040	2,580	7,905,683	3,064	716.09	37	234	23.37%
PERSON	33,330	5,609	23,343,450	4,162	700.37	40	168	16.83%
PITT	123,155	23,833	76,851,585	3,225	624.02	52	194	19.35%
POLK	16,683	2,049	8,989,070	4,387	538.82	71	123	12.28%
RANDOLPH	124,444	16,042	54,724,371	3,411	439.75	89	129	12.89%
RICHMOND	45,791	11,871	44,568,068	3,754	973.29	12	259	25.92%
ROBESON	113,682	36,083	117,005,598	3,243	1,029.24	8	317	31.74%
ROCKINGHAM	89,510	14,892	61,545,867	4,133	687.59	43	166	16.64%
ROWAN	124,687	18,830	60,978,212	3,238	489.05	79	151	15.10%
RUTHERFORD	59,568	10,532	38,615,595	3,667	648.26	47	177	17.68%
SAMPSON	53,631	12,593	44,063,801	3,499	821.61	25	235	23.48%
SCOTLAND	35,196	10,207	35,259,301	3,454	1,001.80	10	290	29.00%
STANLY	55,752	8,409	32,120,558	3,820	576.13	59	151	15.08%
STOKES	43,647	5,402	20,275,907	3,753	464.54	83	124	12.38%
SURRY	67,611	10,184	39,593,650	3,888	585.61	57	151	15.06%
SWAIN	12,200	2,956	10,077,289	3,409	826.01	24	242	24.23%
TRANSYLVANIA	28,205	4,115	14,997,339	3,645	531.73	73	146	14.59%
TYRRELL	3,625	1,031	3,493,861	3,389	963.82	14	284	28.44%
UNION	109,995	12,643	42,362,495	3,351	385.13	96	115	11.49%
VANCE	41,448	12,021	37,715,702	3,137	909.95	18	290	29.00%
WAKE	575,696	50,946	162,318,214	3,186	281.95	100	88	8.85%
WARREN	18,170	5,104	16,658,632	3,264	916.82	17	281	28.09%
WASHINGTON	13,078	3,860	11,483,548	2,975	878.08	20	295	29.52%
WATAUGA	41,160	3,644	15,574,244	4,274	378.38	97	89	8.85%
WAYNE	114,246	21,561	68,586,808	3,181	600.34	54	189	18.87%
WILKES	63,663	10,286	41,960,868	4,079	659.11	46	162	16.16%
WILSON	69,133	16,687	52,830,585	3,166	764.19	30	241	24.14%
YADKIN	35,834	4,519	17,455,209	3,863	487.11	80	126	12.61%
YANCEY	16,474	3,191	12,778,289	4,004	775.66	28	194	19.37%
STATE TOTAL	**7,544,360**	**1,197,173**	**$4,128,190,492**	**$3,448**	**$547.19**	**N/A**	**159**	**15.87%**

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1998.

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 1998
Medicaid Service Expenditures by Recipient Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 1998 Expenditures Per Recipient	SFY 1997 Expenditures Per Recipient	97/98 Percent Change
Total Elderly	**$ 1,344,627,924**	**32.0%**	**172,076**	**14.7%**	**$ 7,814**	**$ 7,691**	**1.6%**
Aged	1,285,294,841	30.6%	133,433	11.4%	9,633	9,443	2.0%
Medicare-Aid (MQBQ & MQBB)	59,333,083	1.4%	38,643	3.3%	1,535	1,525	0.7%
Total Disabled	**$ 1,678,194,921**	**40.0%**	**182,848**	**15.6%**	**9,178**	**8,759**	**4.8%**
Disabled	1,654,940,691	39.4%	180,409	15.4%	9,173	8,755	4.8%
Blind	23,254,230	0.6%	2,439	0.2%	9,534	9,025	5.6%
Total Families & Children	**$ 1,170,956,456**	**27.9%**	**812,283**	**69.3%**	**1,442**	**1,411**	**2.2%**
AFDC Adults (> 21)	280,025,448	6.7%	158,550	13.5%	1,766	1,708	3.4%
Medicaid Pregnant Women Coverage	176,444,200	4.2%	69,446	5.9%	2,541	2,475	2.7%
AFDC Children & Other Children	341,706,224	8.1%	270,215	23.0%	1,265	1,197	5.6%
Medicaid Indigent Children	372,780,584	8.9%	314,072	26.8%	1,187	1,192	-0.4%
Aliens & Refugees	**$ 14,490,306**	**0.3%**	**5,568**	**0.5%**	**2,602**	**2,474**	
Adjustments Not Attributable To A Specific Category	**$ (10,746,878)**	**-0.3%**					
Total Service Expenditures All Groups	**$ 4,197,522,729**	**100%**	**1,172,775**	**100%**	**$ 3,579**	**$ 3,446**	**3.9%**

Note: Total Service Expenditures does not include:

Disproportionate Share payments	331,081,743
State & county administrative costs	175,483,215
Adjustments and cost settlements	127,633,967
TOTAL	$ 634,198,925

See Table 6 for more details.
Source: SFY 1998 Program Expenditure Report and 2082 Report.

Table 11
North Carolina Medicaid
State Fiscal Year 1998
Service Expenditures For Selected Major Medical Services By Program Category

Type of Service	Total	Percent of Service Dollars	Aged	MQBQ* Medicare Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Blind	Disabled	AFDC Adult**	AFDC Child***	Aliens & Refugees	Adjustments Unattributable To A Specific Category
Inpatient Hospital	$ 705,744,660	16.8%	$ 12,167,848	$ 2,700,310	$ -	$ 2,335,222	$ 310,329,293	164,992,975	207,066,794	$ 10,024,575	$ (3,872,357)
Outpatient Hospital	235,445,692	5.6%	$ 20,867,573	9,330,602	8	$ 818,820	$ 87,618,487	58,118,542	59,856,127	355,183	(1,519,650)
Mental Hospital (> 65)	9,704,099	0.2%	9,627,962	31,594	-	44,543	-	-	-	-	-
Psychiatric Hospital (< 21)	17,186,460	0.4%	18,714	-	-	2,893	4,677,947	24,076	12,494,053	-	(31,223)
Physician	391,381,088	9.3%	42,175,628	13,380,784	1,631	1,174,438	114,949,065	99,147,700	119,336,712	3,169,562	(1,954,432)
Clinics	326,837,731	7.8%	13,124,963	3,460,757	117	872,959	165,256,209	36,269,537	108,856,357	278,486	(1,281,654)
Nursing Facility:											
Skilled Level	426,076,788	10.2%	373,610,011	85,975	-	1,609,786	51,115,552	29,168	15,065	74,734	(463,503)
Intermediate Level	339,255,965	8.1%	311,863,168	3,310	-	1,490,501	25,869,890	1,604	96,579	38,321	(107,408)
Intermediate Care Facility (Mentally Retarded)	366,252,026	8.7%	15,074,385	-	-	6,144,914	340,270,798	23,757	4,846,914	-	(108,742)
Dental	43,538,804	1.0%	4,821,573	4,075	-	95,657	10,807,021	8,859,742	18,974,210	146,699	(170,173)
Prescription Drugs	455,379,460	10.8%	160,911,136	-	-	2,382,161	203,185,850	39,789,727	49,203,420	88,874	(181,708)
Home Health	99,502,502	2.4%	14,977,926	119,166	57	843,080	70,181,560	4,421,055	9,306,022	14,908	(361,272)
CAP/Disabled Adult	132,439,114	3.2%	102,319,804	-	-	802,839	29,399,222	-	-	-	(82,751)
CAP/Mentally Retarded	132,422,418	3.2%	3,308,890	-	-	1,503,982	126,637,506	-	1,326,737	-	(354,697)
CAP/Children	7,683,470	0.2%	1,945	-	-	-	7,438,740	-	244,490	-	(1,705)
Personal Care	71,417,814	1.7%	50,714,173	871	-	1,224,737	18,951,442	301,590	382,946	5,325	(163,270)
Hospice	9,029,370	0.2%	4,053,129	-	-	39,551	4,838,869	124,034	11,317	-	(37,530)
EPSDT (Health Check)	31,906,158	0.8%	2,548	17	15	8,243	1,077,962	32,166	30,800,236	9,596	(24,625)
Lab & X-Ray	12,826,381	0.3%	85,574	17,317	-	38,187	3,456,924	6,347,387	2,896,080	22,084	(37,172)
Adult Home Care	65,943,675	1.6%	39,735,287	57,348	11,725	278,839	25,897,400	4,389	9,013	-	(50,326)
Other Services	130,476,927	3.1%	7,649,434	704,065	9	256,029	25,563,749	27,360,595	68,325,262	259,550	(141,732)
Total Services	**4,010,450,602**	**95.5%**	**1,187,111,671**	**29,896,191**	**13,562**	**21,967,381**	**1,627,523,486**	**445,848,044**	**694,048,334**	**14,487,897**	**(10,945,930)**
Medicare:											
Part A Premiums	42,097,130	1.0%	41,287,299	150,335	-	684,893	3,720	-	-	-	(29,117)
Part B Premiums	112,678,454	2.7%	56,895,871	20,695,083	8,577,912	580,571	25,354,926	336,388	7,125	2,409	228,169
HMO Premiums	32,296,543	0.8%	-	-	-	21,385	2,058,559	10,285,216	19,931,383	-	-
Total Premiums	**187,072,127**		**98,183,170**	**20,845,418**	**8,577,912**	**1,286,849**	**27,417,205**	**10,621,604**	**19,938,508**	**2,409**	**199,052**
Grand Total Services and Premiums	**$ 4,197,522,729**		**1,285,294,841**	**50,741,609**	**8,591,474**	**23,254,230**	**1,654,940,691**	**456,469,648**	**713,986,842**	**14,490,306**	**(10,746,878)**

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 1998
Expenditures For The Elderly

Type of Service	Aged	Percent of Service Dollars	MQBQ Qualified Medicare Beneficiary	MQBB+MQBE Part B Premium Only	Total Qualified Beneficiaries	Percent of Service Dollars	Total Elderly Dollars	SFY 1998 % of Total Dollars	SFY 1997 % of Total Dollars	SFY 1996 % of Total Dollars
Inpatient Hospital	$ 12,167,848	0.9%	$ 2,700,310	$ -	$ 2,700,310	4.6%	$ 14,868,158	1.1%	1.4%	1.7%
Outpatient Hospital	20,867,573	1.6%	9,330,602	8	9,330,610	15.7%	30,198,183	2.2%	2.4%	2.2%
Mental Hospital (>65)	9,627,962	0.7%	31,594	-	31,594	0.1%	9,659,556	0.7%	1.0%	1.2%
Physician	42,175,628	3.3%	13,380,784	1,631	13,382,415	22.6%	55,558,043	4.1%	4.1%	3.8%
Clinics	13,124,963	1.0%	3,460,757	117	3,460,874	5.8%	16,585,837	1.2%	1.2%	0.9%
Nursing Facility:										
Skilled Level:	373,610,011	29.1%	85,975	-	85,975	0.1%	373,695,986	27.8%	28.7%	28.8%
Intermediate Level:	311,863,168	24.3%	3,310	-	3,310	0.0%	311,866,478	23.2%	23.9%	25.9%
Intermediate Care Facility-										
Mentally Retarded	15,074,385	1.2%	-	-	-	0.0%	15,074,385	1.1%	1.1%	1.0%
Dental	4,821,573	0.4%	4,075	-	4,075	0.0%	4,825,648	0.4%	0.4%	0.5%
Prescription Drugs	160,911,136	12.5%	-	-	-	0.0%	160,911,136	12.0%	10.7%	10.1%
Home Health	14,977,926	1.2%	119,166	57	119,223	0.2%	15,097,149	1.1%	1.2%	1.2%
CAP/Disabled Adult	102,319,804	8.0%	-	-	-	0.0%	102,319,804	7.6%	6.6%	5.7%
CAP/Mentally Retarded	3,308,890	0.3%	-	-	-	0.0%	3,308,890	0.2%	0.2%	0.1%
Personal Care	50,714,173	3.9%	871	-	871	0.0%	50,715,044	3.8%	3.6%	3.4%
Hospice	4,053,129	0.3%	-	-	-	0.0%	4,053,129	0.3%	0.3%	0.4%
EPSDT (Health Check)	2,548	0.0%	17	15	32	0.0%	2,580	0.0%	0.0%	0.0%
Lab & X-Ray	85,574	0.0%	17,317	-	17,317	0.0%	102,891	0.0%	0.0%	0.3%
Adult Care Home	39,735,287	3.1%	57,348	11,725	69,073	0.1%	39,804,360	3.0%	3.0%	2.4%
Other Services	7,670,093	0.6%	704,065	9	704,074	1.2%	8,374,167	0.6%	0.6%	0.6%
Service Expenditures	**$ 1,187,111,671**	**92.4%**	**29,896,191**	**13,562**	**29,909,753**	**50.4%**	**1,217,021,424**	**90.5%**	**90.4%**	**90.2%**
Part A Premium	41,287,299	3.2%	150,335	-	150,335	0.3%	41,437,634	3.1%	3.1%	3.1%
Part B Premium	56,895,871	4.4%	20,695,083	8,577,912	29,272,995	49.3%	86,168,866	6.4%	6.4%	6.9%
HMO Premium	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Total Premiums	**$ 98,183,170**		**20,845,418**	**8,577,912**	**29,423,330**		**127,606,500**			
Total Service & Premiums	**$ 1,285,294,841**	**100%**	**50,741,609**	**8,591,474**	**59,333,083**	**100%**	**1,344,627,924**			
Medicare Crossovers**	**$ 97,328,628**									
Total Elderly Recipients	133,433		38,643	8,648	47,291		180,724			
Service Expenditures Per Recipient *	**$ 9,633**		**$ 1,313**	**$ 993**	**$ 1,255**		**$ 7,440**			

* 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 1998 Program Expenditure Report and 2082 Report

Table 13
North Carolina Medicaid
State Fiscal Year 1998
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	1998 % of Total Dollars	1997 % of Total Dollars
Inpatient Hospital	$ 310,329,293	18.8%	$ 2,335,222	10.0%	$ 312,664,515	18.6%	20.8%
Outpatient Hospital	87,618,487	5.3%	818,820	3.5%	88,437,307	5.3%	5.5%
Psychiatric Hospital (>65)	-	0.0%	44,543	0.2%	44,543	0.0%	0.0%
Psychiatric Hospital (<21)	4,677,947	0.3%	2,893	0.0%	4,680,840	0.3%	0.3%
Physician	114,949,065	6.9%	1,174,438	5.1%	116,123,503	6.9%	7.0%
Clinics	165,256,209	10.0%	872,959	3.8%	166,129,168	9.9%	7.8%
Nursing Facility:							
Skilled Level:	51,115,552	3.1%	1,609,786	6.9%	52,725,338	3.1%	3.4%
Intermediate Level:	25,869,890	1.6%	1,490,501	6.4%	27,360,391	1.6%	1.8%
Intermediate Care Facility-Mentally Retarded	340,270,798	20.6%	6,144,914	26.4%	346,415,712	20.6%	22.1%
Dental	10,807,021	0.7%	95,657	0.4%	10,902,678	0.6%	7.0%
Prescription Drugs	203,185,850	12.3%	2,382,161	10.2%	205,568,011	12.2%	11.0%
Home Health	70,181,560	4.2%	843,080	3.6%	71,024,640	4.2%	4.3%
CAP/Disabled Adult	29,399,222	1.8%	802,839	3.5%	30,202,061	1.8%	1.6%
CAP/Children	126,637,506	7.7%	1,503,982	6.5%	128,141,488	7.6%	6.6%
CAP/Mentally Retarded	7,438,740	0.4%	-	0.0%	7,438,740	0.4%	0.4%
Personal Care	18,951,442	1.1%	1,224,737	5.3%	20,176,179	1.2%	1.2%
Hospice	4,838,869	0.3%	39,551	0.2%	4,878,420	0.3%	0.4%
EPSDT	1,077,962	0.1%	8,243		1,086,205	0.1%	0.1%
Lab & X-Ray	3,456,924	0.2%	38,187	0.2%	3,495,111	0.2%	0.3%
Adult Home Care	25,897,400	1.6%	278,839	1.2%	26,176,239	1.6%	1.7%
Other Services	25,563,749	1.5%	256,029	1.1%	25,819,778	1.5%	1.6%
Part A Premium	3,720	0.0%	684,893	2.9%	688,613	0.0%	0.0%
Part B Premium	25,354,926	1.5%	580,571	2.5%	25,935,497	1.5%	1.6%
HMO Premium	2,058,559	0.1%	21,385	0.1%	2,079,944	0.1%	0.0%
Total Service & Premiums	**$ 1,654,940,691**		**$ 23,254,230**		**$ 1,678,194,921**		
Medicare Crossovers*	**$ 44,675,078**		**$ 950,451**		**$ 45,625,529**		
Number of Disabled/Blind Recipients	180,409		2,439		182,848		
Service Expenditures Per Recipient**	**$ 9,173**		**$ 9,534**		**$ 9,178**		

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

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

Source: SFY 1998 Program Expenditure Report and 2082 Report

Table 14
North Carolina Medicaid
State Fiscal Year 1998
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 1998 % of Total Dollars	SFY 1997 % of Total Dollars
Inpatient Hospital	$ 95,446,232	34.1%	$ 69,546,743	39.4%	$ 82,630,248	24.2%	124,436,546	33.4%	$ 372,059,769	31.8%	33.1%
Outpatient Hospital	42,055,310	15.0%	16,063,232	9.1%	31,429,285	9.2%	28,426,842	7.6%	117,974,669	10.1%	10.4%
Psychiatric Hospital (<21)	-	0.0%	24,076	0.0%	7,769,501	2.3%	4,724,552	1.3%	12,518,129	1.1%	1.1%
Physician	53,992,090	19.3%	45,155,610	25.6%	52,570,423	15.4%	66,766,289	17.9%	218,484,412	18.7%	18.5%
Clinics	13,566,079	4.8%	22,703,458	12.9%	65,937,365	19.3%	42,918,992	11.5%	145,125,894	12.4%	12.0%
Nursing Facility:											
Skilled Level:	29,168	0.0%	-	0.0%	15,065	0.0%	-	0.0%	44,233	0.0%	0.0%
Intermediate Level:	1,604	0.0%	-	0.0%	96,579	0.0%	-	0.0%	98,183	0.0%	0.0%
Intermediate Care Facility-Mentally Retarded	23,757	0.0%	-	0.0%	4,187,202	1.2%	659,712	0.2%	4,870,671	0.4%	0.4%
Dental	8,323,432	3.0%	536,310	0.3%	9,851,016	2.9%	9,123,194	2.4%	27,833,952	2.4%	2.4%
Prescription Drugs	35,502,086	12.7%	4,287,641	2.4%	23,231,646	6.8%	25,971,774	7.0%	88,993,147	7.6%	7.2%
Home Health	3,554,728	1.3%	866,327	0.5%	4,370,983	1.3%	4,935,039	1.3%	13,727,077	1.2%	1.2%
CAP/Disabled	-		-		-		-				
CAP/Mentally Retarded	-		-		1,326,059	0.4%	678				
CAP/Children	-	0.0%	-	0.0%	173,317	0.1%	-	0.0%	173,317	0.0%	0.0%
Personal Care	295,770	0.1%	5,820	0.0%	174,313	0.1%	149,313	0.0%	625,216	0.1%	0.1%
Hospice	124,034	0.0%	-	0.0%	28,734	0.0%	8,970	0.0%	161,738	0.0%	0.0%
Health Check - EPSDT	117	0.0%	32,049	0.0%	11,928,952	3.5%	19,214,265	5.2%	31,175,383	2.7%	2.6%
Lab & X-Ray	3,224,327	1.2%	3,123,060	1.8%	1,984,074	0.6%	1,172,431	0.3%	9,503,892	0.8%	0.8%
Adult Care Home	4,389	0.0%	-	0.0%	6,833	0.0%	2,846	0.0%	14,068	0.0%	0.0%
Other Services	16,908,401	6.0%	10,452,194	5.9%	34,893,841	10.2%	33,431,421	9.0%	95,685,857	8.2%	8.5%
Total Families & Children Service Expenditures	**$ 273,051,524**	97.5%	**172,796,520**		**332,605,436**		**361,942,864**		**1,139,069,607**	**97%**	**98%**
Part A Premium	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Part B Premium	309,889	0.1%	26,499	0.0%	2,540	0.0%	4,585	0.0%	343,513	0.0%	0.0%
HMO Premium	6,664,035	2.4%	3,621,181	2.1%	9,098,248	2.7%	10,833,135	2.9%	30,216,599	2.6%	1.8%
Total Premiums	**$ 6,973,924**		**3,647,680**		**9,100,788**		**10,837,720**		**30,560,112**		
Total Service & Premiums	**$ 280,025,448**		**176,444,200**		**341,706,224**		**372,780,584**		**1,169,629,719**		
Medicare Crossovers*	**$ 868,753**		**86,071**		**96,962**		**72,375**		**1,124,161**		
Number of Family & Child Recipients	158,550		69,446		270,215		314,072		812,283		
Service Expenditures Per Recipient**	**$ 1,766**		**$ 2,541**		**$ 1,265**		**$ 1,187**		**$ 1,440**		

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

Table 15
North Carolina Medicaid
State Fiscal Year 1998
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**

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