nc department of health and human services

Medicaid in North Carolina
Annual Report
State Fiscal Year 1999

Division of Medical Assistance

James B. Hunt, Jr.
Governor

H. David Bruton, M.D.
Secretary

Paul R. Perruzzi
Director

North Carolina
Department of Health and Human Services
Division of Medical Assistance
Director's Office
1985 Umstead Drive – 2517 Mail Service Center - Raleigh, N.C. 27699-2517
Courier Number 56-20-06

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

Paul R. Perruzzi, Director

Dear Fellow North Carolinians:

I am pleased to present the Medicaid Annual Report for State Fiscal Year 1998-1999. The report covers significant activities during the period of July 1, 1998 through June 30, 1999.

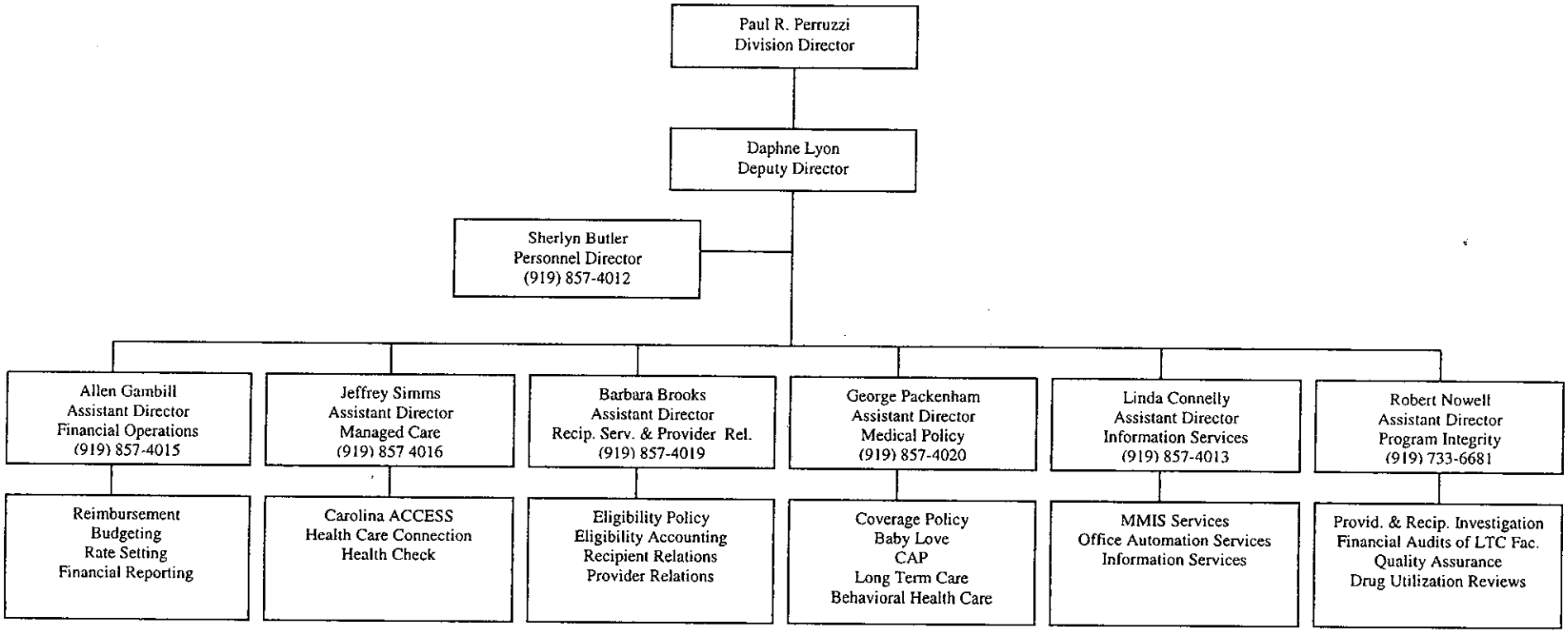
During this time frame, Medicaid expenditures increased by 5% to over 4.9 billion dollars. The total number of Medicaid eligibles decreased 2% from the previous fiscal year to 1,176,819 people. During this year, we completed the expansion of Carolina ACCESS, North Carolina's patient access and coordinated care program, to 99 of the State's 100 counties.

I hope that the information provided in this report will prove to be beneficial to you in your efforts to learn more about North Carolina's Medicaid program.

Sincerely,

Paul R. Perruzzi, Director

Division of Medical Assistance
Office of the Director
(919) 857-4011



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State Fiscal Year 1999 Highlights

Medicaid Policy Changes in Brief

State fiscal year (SFY) 1999 was a successful year for developments in North Carolina's Medicaid program. The Division of Medical Assistance (DMA) continued to improve the program's efficiency and cost-effectiveness while maintaining a high quality of service for Medicaid beneficiaries. Several policy changes supported the pursuit of these goals.

- Responsibility for manufacture of eyeglasses for Medicaid recipients was transferred from an Ohio based private contractor to the N.C. Department of Corrections. The transfer resulted in a number of accomplishments.
  1. Delivery time for eyeglasses was reduced.
  2. Frame selection was increased.
  3. Cost to the Medicaid Program was reduced.
  4. Prison inmates were engaged in meaningful work that targeted skills and work ethic.

- Disproportionate Share Hospital (DSH) payments continued to support hospitals that serve a disproportionate number of Medicare, Medicaid, and indigent patients.

- A major policy change was the expansion of Medicaid coverage to aged, blind, and disabled individuals with incomes below poverty. This change gave full Medicaid coverage to approximately 40,000 people.

- Policy was changed to provide 12 months continuous Medicaid eligibility for children without regard to changes in family income. Previously, changes in income were required to be reported and changes could result in eligibility determination.

- Minor changes in eligibility policies were made to keep consistency between Medicaid policies and changing Work First policies.

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:

http://www.dhhs.state.nc.us/dma/

Data Synopsis

Medicaid is an important source of healthcare for North Carolina's most vulnerable citizens. This includes aged, blind and disabled individuals, as well as pregnant women and low-income families who cannot afford to pay their healthcare expenses. Also, all children under the poverty level, and in some cases, above poverty level, are eligible for Medicaid in North Carolina.

As in past years, the largest proportion (73.7%) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. The remainder, 26.3%, was spent on care for low-income families and children.

In SFY 1999, 27% of the service budget was spent on nursing facility care and on institutional care for persons with mental retardation. The state's fiscal year (SFY) runs from July through June.

Total Medicaid expenditures increased to $4,934,136,597, a 5% increase over SFY 1998. The amount spent for program services was $4,311,798,589. This represents a 3 % increase in service costs over SFY 1998. Table 11 on page 40 gives a detailed breakdown of these service expenditures.

The total number of Medicaid eligibles in SFY 1999 was 1,176,819. This was a 2% decrease in total eligibles from SFY 1998.

There was a total of 1,175,109 Medicaid recipients in SFY 1999. Recipients are eligibles who have used services. Total recipients increased .2% from State fiscal year 1998.

Martin County had the highest concentration of Medicaid eligibles in SFY 1999 with 347 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.

Avery County had the highest Medicaid cost per eligible which amounted to $5,198. Hoke county had the lowest cost per eligible, $2,673. Statewide, the average cost per eligible was $3,542.

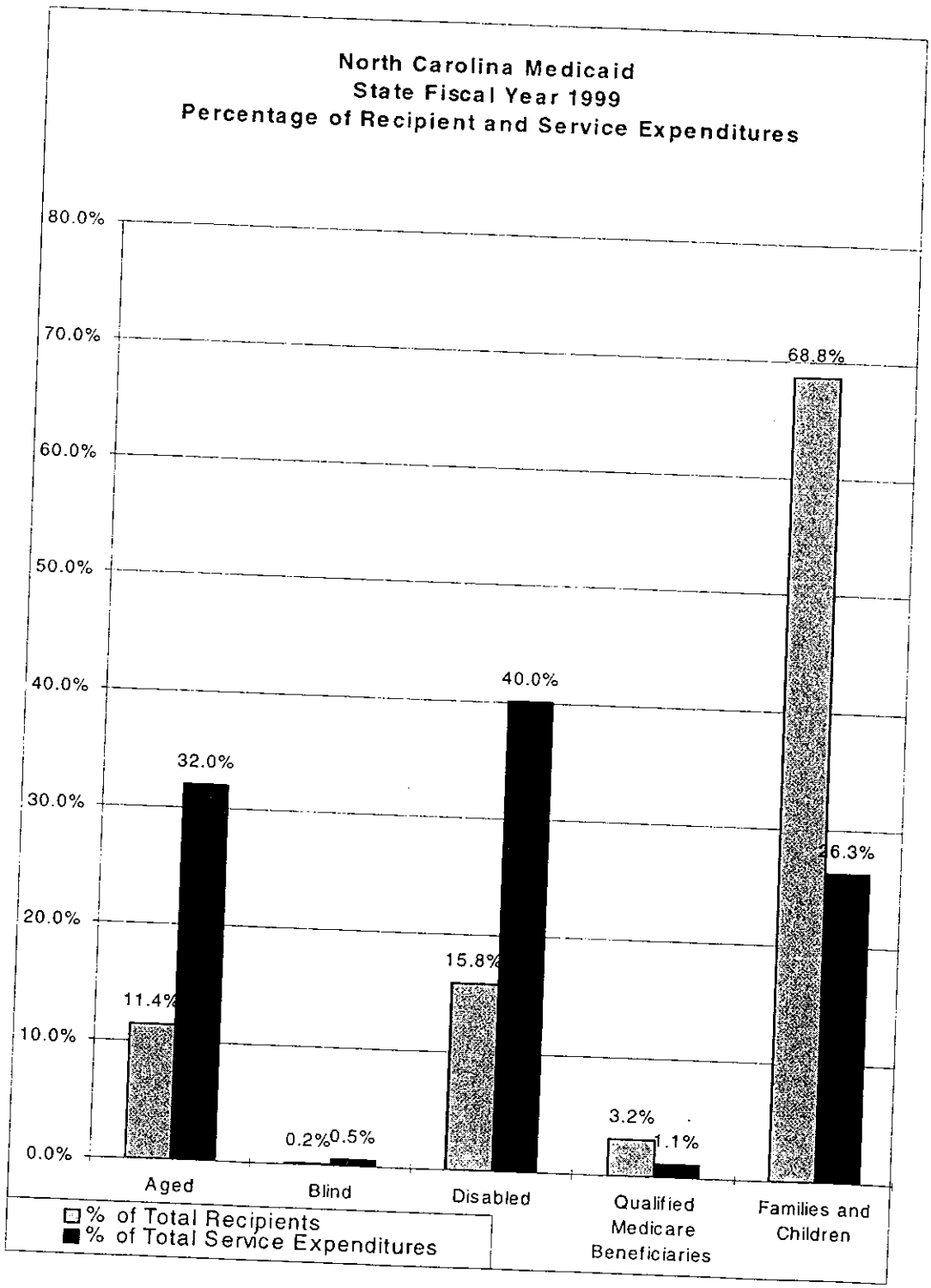
Inpatient hospital stays at $684 million was the highest total cost of all Medicaid categories of service rendered for SFY 1999 with Prescription Drugs second at $558 million.

In the managed care area, Carolina ACCESS, North Carolina's patient access and coordinated care program, was expanded to 99 of the State's 100 counties. (Mecklenburg County does not have Carolina ACCESS). There were 516,513 clients enrolled in the program as of June 30, 1999.

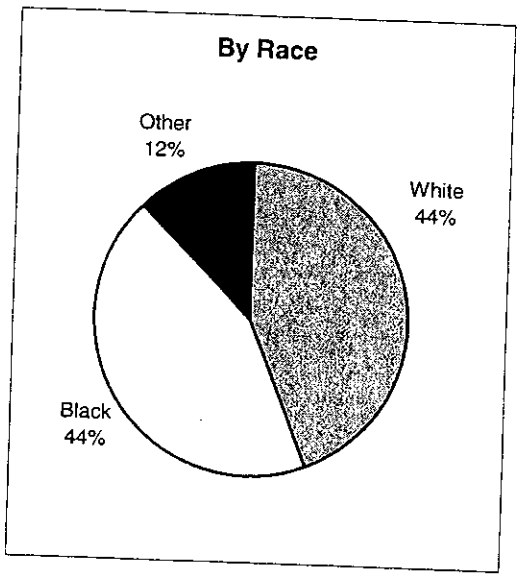
During State fiscal year 1999, the Division of Medical Assistance received almost $108,831,930 in rebates from pharmaceutical companies that contract with the State Medicaid program.

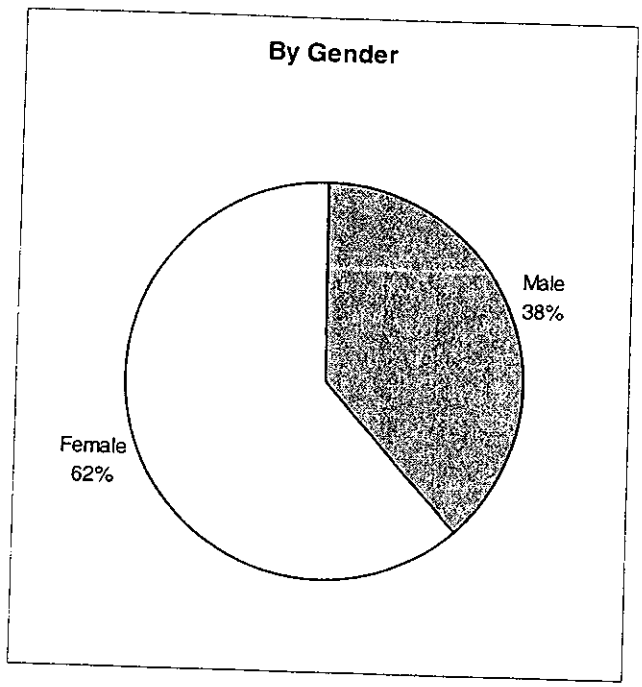
Medicaid Recipients

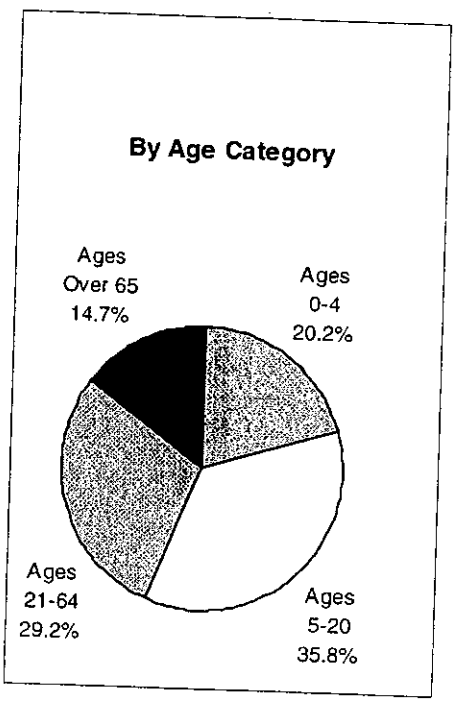
Of the major Medicaid categories, the AGED and DISABLED consumed the most service resources. The AGED category, which consists of 11.4% of the Medicaid recipients, used 32% of resources. The DISABLED, with 15.8% of total recipients, used 40% of Medicaid resources. See the charts on pages 3 and 4 for details.

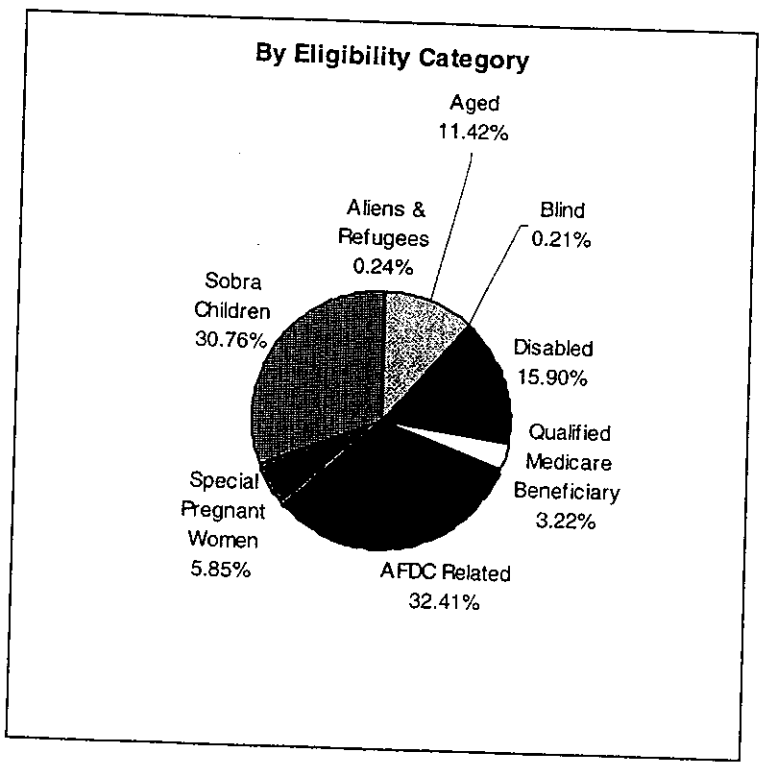

North Carolina Medicaid
State Fiscal Year 1999
Percentage of Recipient and Service Expenditures
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
11.4%
32.0%
0.2%
0.5%
15.8%
40.0%
3.2%
1.1%
68.8%
26.3%
Aged
Blind
Disabled
Qualified Medicare Beneficiaries
Families and Children
% of Total Recipients
% of Total Service Expenditures

Recipients of Medicaid Services









Medicaid Background/History In North Carolina

History

Congress created the Medicaid program in 1965. It was designed as a medical safety net for two categories of low-income people receiving cash assistance:

- mothers and children and
- elderly, blind and disabled persons.

The federal and State governments jointly finance Medicaid. 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 Division of Social Services. A separate Division of Medical Assistance (DMA) was created within the Department of Human Resources in 1978. From 1978 to 1999, Medicaid expenditures grew from $307 million to $4.9 billion, and the number of people eligible for Medicaid increased from 456,000 to 1,176,819. During this time period, DMA staff increased from 121 to 325 people.

In over 20 years of operation, the programmatic complexity of Medicaid has paralleled the growth in both program expenditures and number of recipients. However, DMA has historically spent a relatively modest percentage of its budget on administration. In SFY 1999, the State administration budget was only 2.3% of total service dollars and the local administration costs consumed just 2.2% of total service expenditures. 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 and prescription drugs.

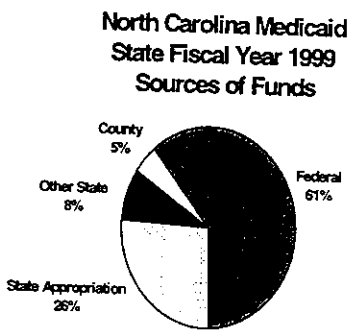
Federal Financial Participation

The federal government pays the largest share of Medicaid costs. Federal matching rates for services are established by the Healthcare Financing Administration (HCFA). HCFA uses the most recent three-year average per capita income for each State and the national per capita income in establishing this rate. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the State and counties to increase their proportionate share of Medicaid costs.

The established federal matching rates for services are applicable to the federal fiscal year, which extends from October 1 to September 30. The State's fiscal year (SFY) runs from July through June. Because the federal and State fiscal years do not coincide, different federal service matching rates may apply for each part of the overlapped State fiscal year. The federal match rate for administrative costs does not change from year to year. Table 1 in APPENDIX A shows the federal matching rates that apply for State Fiscal Year 1999.

Funding Formula

The federal matching rate for Medicaid services varies from State to State based on per capita income. Nationwide, in SFY 1999, 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 1999, the federal, State and county shares of total expenditures were approximately 61 percent, 34 percent, and 5 percent, respectively. See Table 5 in Appendix A for a detailed breakdown of these shares.



Eligibility

For the second year in a row, the average monthly number of Medicaid eligibles in North Carolina dropped. For SFY 1997, there were 826,725 people eligible. That figure fell to 821,671 for SFY 1998 and to 818,136 for SFY 1999. The primary factor causing this drop was the continued decline in WorkFirst clients. See the chart on the following page for more 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.

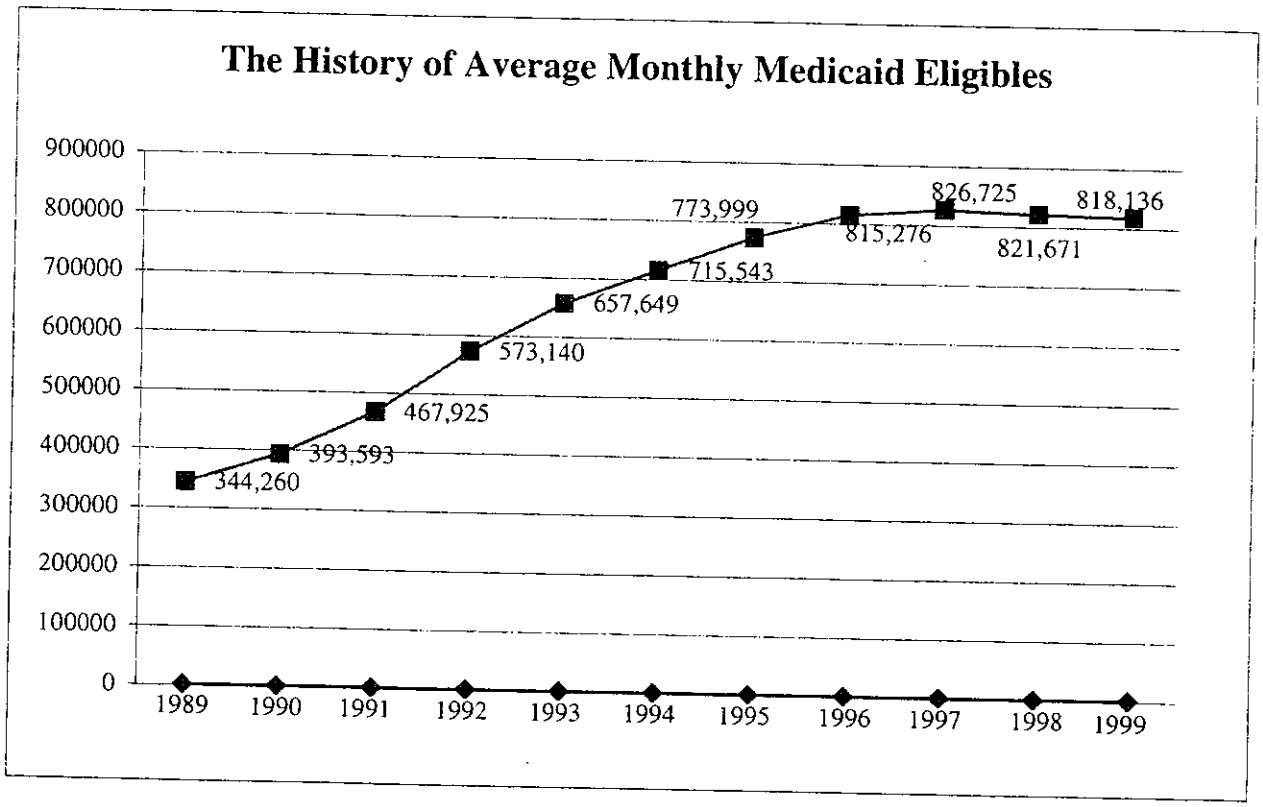
Categorically Needy - The categorically needy group consists of people who receive or are eligible to receive cash assistance payments under other governmental assistance programs or who are specially authorized by law to receive benefits. These include:

- 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 qualified for Medicaid benefits.

Medicaid's Medicare-Aid program pays for out-of-pocket expenses for Medicare-covered services, such as premiums, deductibles and coinsurance for those who qualify. The income and resource limits that must be met to qualify for Medicare-Aid are higher than those necessary to receive full Medicaid coverage.



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 incur medical expenses equal to the excess income before becoming Medicaid eligible.

This criterion for eligibility is known as the Medicaid deductible or the Medicaid "spend down." 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 current income levels such as 185% of poverty, or the SSI payment level.

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 4 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

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 healthcare providers.

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).

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, 2002.

Medical Review of North Carolina (MRNC) -- MRNC 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 certain components of the retrospective 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 the N.C. Department of Corrections, N.C. Corrections Enterprises, to provide eyeglasses at predetermined rates. In most cases, these providers of Medicaid eyecare services, must obtain eyeglasses through this organization.

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. (ICFs-MR) enrolled in the Medicaid 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 ICFs-MR.

Cooperative Arrangements

Although DMA administers Medicaid, other agencies, DHHS divisions, and State departments work closely with the program and perform important 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) -- The 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 determines whether an individual is eligible for Medicaid based on disability. This unit also makes disability determinations for two federal programs under a contract with the Social Security Administration including Title II - Social Security benefits 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. During SFY 1999, DMA and DMH/DD/SAS operated the Carolina Alternatives Program, a pre-paid capitation plan in which DMA paid a monthly capitation fee to DMH/DD/SAS for mental health and substance abuse services of Medicaid eligible children. This program ended June 30, 1999. DMA and DMH/DD/SAS also work cooperatively to operate 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 in an ICF-MR.

Division of Epidemiology - 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 that are 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 participates in policy development projects on housing and in-home aide services.

Division of Facility Services (DFS) -- DFS has the responsibility for certifying and monitoring facilities in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a facility.

Division of Public Health, Women and Children's Health Section (WCH),-- WCH, within the Department of Health and Human Services (DHHS), operates a variety of healthcare programs. Medicaid pays for many of the services which are offered through WCH. WCH and local

health departments also play a central role in the operation of Baby Love, a care coordination program designed to assure appropriate medical care for pregnant women, and the Health Check Program which provides preventive and other healthcare services for children. Both programs are discussed in more detail in the "Special Programs" section of this report.

Department of Public Instruction (DPI) -- The Individuals with Disabilities Education Act (IDEA) is the federal law requiring education-related services to be provided to pre-school and school aged children with physically and mentally challenging conditions. DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, such as speech, physical, and occupational therapies.

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 called the Generalist Physician's Medicaid Assistance Program (GPMAP). The function of GPMAP is to recruit primary care physicians to accept Medicaid eligible children for Health Check 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 and children eligible for Health Check , people with life threatening conditions, participants in the Community Alternatives Programs (CAP), and other selected groups. Table 4 in Appendix A lists Medicaid services for SFY 1999.

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 conduct evaluations and training and make the necessary adjustments to eliminate errors and to prevent future mistakes. County staff also serve on the Medicaid Error Reduction Committee, which designs strategies for quality improvement.

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 are 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 1999	
Provider Activities:	
Investigations Opened	**2,168**
Overpayment Cases	**1,520**
Recoveries	**$8,540,524**
Recipient Activities:	
Cases Reported	**2,053**
Overpayments	**$8,191,993**
Healthcare Facility Audit Activities:	
Audits	**787**
Collected	**$5,767,613**
Total Collected	**$22,500,130**

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 ensure that planned care is appropriate for the Medicaid client's needs. EDS operates the prior approval system for most services.

DMA also has contracted to evaluate DRG coding to identify improper maximization and other potentially fraudulent billing practices. First Mental Health is under contract to conduct pre-admission, concurrent, 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 determine whether 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 healthcare resources on their behalf. North Carolina's Medicaid agency has received national recognition for its efforts in recovering third party resources.

In SFY 1999, insurance coverage and refunds from a variety of sources defrayed Medicaid expenditures. Medical insurance covered $101,375,000 on behalf of Medicaid patients. Additionally, $101,893,406 in Medicaid claims was denied with instructions for the provider to file for other insurance.

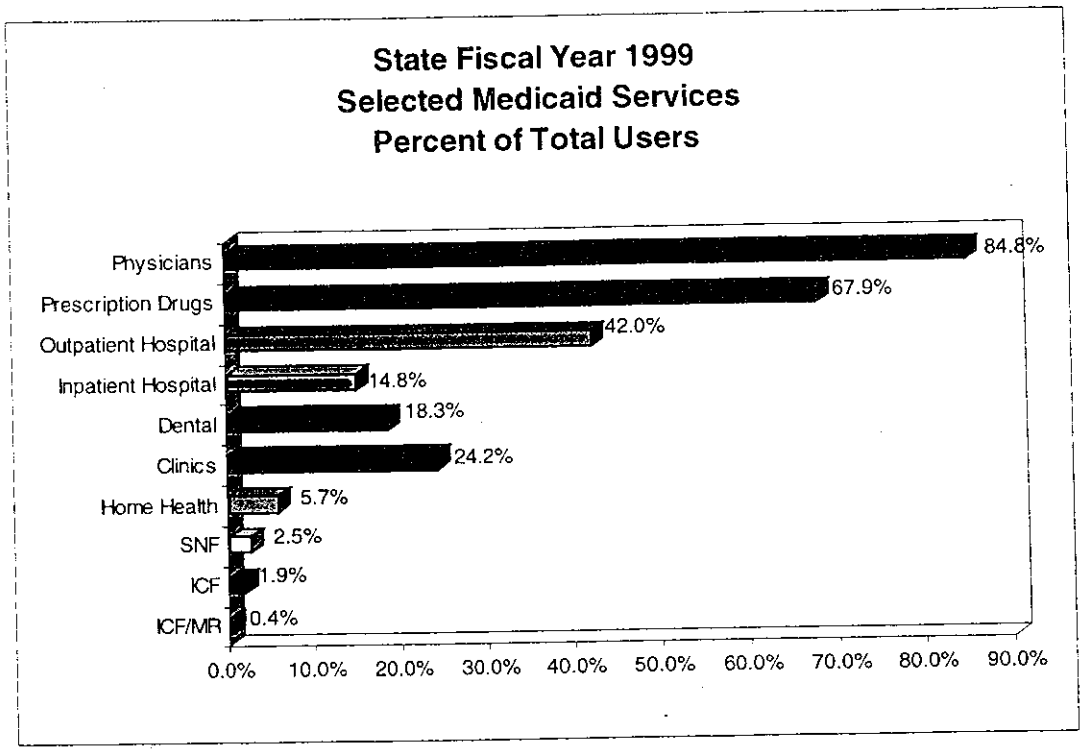
During SFY 1999, Medicaid received refunds from:

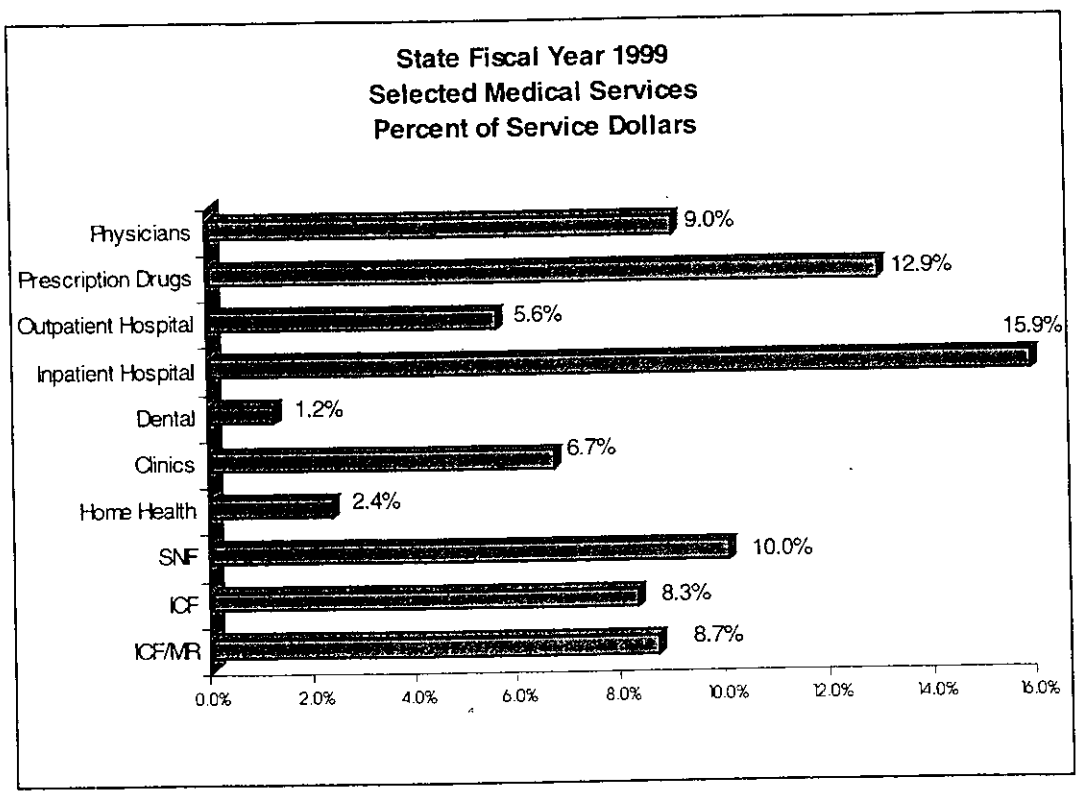
• Medicare	$ 2,408,384
• Health Insurance	$ 10,637,066
• Casualty Insurance	$ 9,179,130
• Absent Parent	$ 369,006
• Estate Recovery	$ 1,359,498
Total	$ 23,953,084

Medicare must be the primary payer when a person is eligible for both Medicare and Medicaid. In SFY 1999, this policy saved $858,310,416.

In total, including drug company rebates, the amount of money recovered by DMA in State Fiscal Year 1999 was $358,553,550. This represents approximately 7% of total Medicaid expenditures for the fiscal year.

This amount was $132,398,099 more than the total county contribution to the Medicaid budget and represents a significant contribution to the funding effort for the entire Medicaid program.


State Fiscal Year 1999
Selected Medicaid Services
Percent of Total Users
Physicians
Prescription Drugs
Outpatient Hospital
Inpatient Hospital
Dental
Clinics
Home Health
SNF
ICF
ICF/MR
84.8%
67.9%
42.0%
14.8%
18.3%
24.2%
5.7%
2.5%
1.9%
0.4%
0.0%
10.0%
20.0%
30.0%
40.0%
50.0%
60.0%
70.0%
80.0%
90.0%


State Fiscal Year 1999
Selected Medical Services
Percent of Service Dollars
Physicians
Prescription Drugs
Outpatient Hospital
Inpatient Hospital
Dental
Clinics
Home Health
SNF
ICF
ICF/MR
9.0%
12.9%
5.6%
15.9%
1.2%
6.7%
2.4%
10.0%
8.3%
8.7%
0.0%
2.0%
4.0%
6.0%
8.0%
10.0%
12.0%
14.0%
16.0%

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 that require a co-payment and the amount of the co-payment.

STATE FISCAL YEAR 1999
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 health 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, based on medical necessity, without a limitation on the length of stay. Special restrictions apply to abortions, hysterectomies and sterilization. Hospital services are paid on the basis of diagnostic related groupings (DRGs).

Hospital Outpatient Services --
Outpatient services are covered subject to a limitation of twenty-four 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 federally mandated and covered for Medicaid recipients aged 21 and older in need of NF level of care. 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 physician's actual charge or the State-wide Medicaid fee schedule amount, whichever is of lesser charge. 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 and necessary diagnosis/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, and abortions 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:

1. Medically necessary ambulance transportation .
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 upon service delivery. 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 ICFs-MR 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 and basic intermediate care services. Intermediate care facilities for the mentally retarded are paid prospective per diem rates.

Personal Care Services in Private Residences -- 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.

Please see page 22 for a review of personal care services in adult care homes.

Prescription Drugs -- Medicaid covers most prescription drugs and 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. Recipients may use only one pharmacist per month, except in the case of 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/customary charge to the public, whichever is less.

Dental Services -- Most routine dental services are covered, such as exams, cleanings, fillings, x-rays and dentures. Additional preventative 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 exempt groups. Payment is made on the basis of a Statewide fee schedule.

Eye Care Services -- Medicaid covers medical eye examinations, corrective eyeglasses, medically necessary contact lenses, and other visual aids. Prior approval is required for all visual aids and various optical services/exams. There are limitations regarding the frequency of doctor visits and the number of dispensed visual aids during specific eligibility periods. A $3.00 co-payment is applicable to opthamologist visits, while a $2.00 co-payment applies to optometrist visits. Although a $2.00 co-payment is generally required for new eyeglasses, eyeglass repairs, and contact lenses, there are some exemptions.

Through a contractual agreement, Medicaid eyeglasses are supplied through the North Carolina Department of Correction's Nash Optical Plant, located in Nashville, North Carolina. Providers must obtain Medicaid eyeglasses through this laboratory unless, due to extenuating circumstances, prior approval is granted.

Hearing Aid Services -- Single and binaural conventional hearing aids are covered once every four years for Medicaid recipients under 21 years of age. An ENT specialist, otologist, or otolaryngologist must submit a prior approval request, accompanied by an audiological report documenting the medical necessity of the hearing aid(s). Exceptional request for replacement/new aids due to breakage not covered by manufacturer warranty, loss of aid, or recipient growth also require prior approval. There are no co-payments for hearing aid/hearing aid services.

Mental Health Services -- Patients that have a plan of treatment developed by and on file with an Area Mental Health Programs, are offered outpatient mental health services, partial hospitalization, and emergency services through Area Programs. Visits do not count against the annual 24-visit outpatient limit. Area Program centers are paid a negotiated service rate.

Visits to independent psychiatrists, physicians, and to PhD and MA psychologists employed and supervised by a physician, are covered for mental health services, also. Prior approval is required for outpatient visits following the first two visits. Private practice psychiatrist visits count against the annual 24-visit outpatient limit and a co-payment applies when applicable.

Payment is made on a fee schedule basis for outpatient visits. Inpatient State and private mental health 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 a serious illness through early detection and treatment of illnesses. Certain components of a health assessment must be included to qualify for payment. The screening applies toward the annual 24-visit outpatient limit and a $3.00 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 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 1999 Federal Poverty Level amounts. Medicaid pregnant women who qualify under the Baby Love program receive comprehensive maternity healthcare 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 coverage for health screenings, immunizations, vision, hearing and dental check-ups on a regular basis. Participants also are 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 1 – 5 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 1999, 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 healthcare and the service delivery system for low-income pregnant women and children. The Division Of Medical Assistance and the Division of Public Health, Women's and Children's Health Section, jointly administer the Baby Love Program in cooperation with the Office of Research, Demonstrations, and Rural Health Development.

Through the Baby Love Program, pregnant women receive comprehensive care from the beginning of pregnancy through the postpartum period. Medicaid currently covers 44% 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 1999, 27,853 pregnant women received MCC services.

In addition to MCC services, Maternal Outreach Workers, 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 Healthcare 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 also has been enriched through the Baby Love Program which includes childbirth and parenting classes, in-home skilled nursing care for high-risk pregnancies, nutrition counseling, psychosocial counseling and postpartum/newborn home visits.

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

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 8.95 in 1996, the last year for which we have complete data.

Health Check Program

North Carolina expanded the federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program (which has been in existence since Medicaid began) to form the Health Check program in 1993. EPSDT serves as the standard for providing healthcare to Medicaid recipients under the age of 21. The purpose of the Health Check program is to facilitate regular preventive medical care and the diagnosis and treatment of any health problem found during a screening. There is no separate enrollment in Health Check. If someone is eligible for Medicaid and is under the age of 21, they automatically receive Health Check services. In SFY 1999, Health Check was integrated with Carolina ACCESS for primary care physicians to focus on the goals and objectives with Health Check.

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.
- 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.

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

An integral part of the Health Check program is a special initiative called the Health Check Outreach Project. Sixty counties participate in this outreach effort by having specially trained Health Check Coordinators work to reduce barriers and improve access to preventive health services. The Managed Care Section in the Division is the administrative entity for the Health Check program and coordinators. The Managed Care Section works in close collaboration with The Division of Women and Children's Health to provide guidance to the project counties.

The Health Check Automated Information and Notification System (AINS) is a computerized system for identifying and following Medicaid-eligible children (birth through 20 years of age) with regard to their activities in the healthcare system. It enables Health Check coordinators across the state to determine which Medicaid-eligible children in their respective counties are receiving regular and periodic Health Check screenings, immunizations, and referrals for special healthcare problems. The system sends notices to the parents of Medicaid-eligible children, notifying them of the Health Check Program, scheduled screening appointments, missed appointments, immunizations and available programs and services. For children enrolled in managed care, the name of the Carolina ACCESS primary care provider appears on the letter, referring the recipient to their doctor for services. For children enrolled in an HMO, the name of the managed care plan appears on the letter.

Access to and utilization of healthcare services for Medicaid eligible children and youth have improved since the initiation of this very important program.

LONG-TERM CARE

Medicaid spends a large portion of its service dollars (38%) on long-term care. Long-term care services comprise nursing facility care, intermediate care facilities for the mentally retarded, adult care home personal care services and a variety of home and community-based services. In SFY 99, 130,746 people received Medicaid long-term care services in North Carolina costing a total of $1,646,098,509. The average cost per recipient was $12,590 for the year.

Many people consider home and community-based long-term care to be a cost-effective and preferable alternative to institutionalization. Therefore, Medicaid recipients can receive several home-based services such as home health, durable medical equipment, and hospice. In addition, North Carolina provides the Community Alternatives Program (described below) as another option for home and community care.

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 and has served approximately 12,000 people in SFY 1999 at less cost than

nursing facility care. The average daily cost of CAP services was less than 70% of the average Medicaid Nursing Facility cost.

CAP-MR/DD:

The Community Alternatives Program for Persons with Mental Retardation or 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 1999 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. Over 200 children participated in CAP/C in SFY 1999. 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.

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 Public Health's AIDS Care Unit. The AIDS Care Unit administers the program with DMA providing oversight. This program began in late 1995 and is still developing Statewide. Approximately 40 people were served in SFY 1999 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 maintaining 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.

Nursing Facility Care

There are times when nursing facility care is the best option for Medicaid recipients. All Medicaid nursing facilities are required to provide skilled nursing (SN) and intermediate care (IC). Nursing facility reimbursement rates differ based on whether a resident requires skilled or intermediate level of care. In SFY 1999, 31,298 Medicaid recipients received skilled care in a nursing facility costing a total of $431,353,967.

In addition, 21,779 recipients received intermediate care costing a total of $334,905,296. In SFY 1999, Medicaid recipients occupied 83.3% of the nursing facility beds in N.C. See the table below. All Medicaid recipients must have prior approval authorization issued for admission to a nursing facility.

There is also a federal requirement for pre-admission screening and annual resident review (PASARR) to screen applicants and residents of Medicaid certified nursing facilities who are suspected of mental illness, mental retardation, or conditions related to mental retardation.

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%
1999	39,361	32,800	83.3%

Adult Care Home Personal Care Services

In the 1995 legislative session of the North Carolina General Assembly, coverage began for personal care assistance provided to residents who are eligible for Special Assistance for Adults (SA) and Medicaid. Beginning January 1, 1996, Medicaid covered "enhanced" adult care home personal care (ACH/PC) and adult care home case management services (ACH/CMS) for certain residents of adult care homes who met the Medicaid criteria for being a "heavy care" resident.

The adult care home personal care services program served 56,712 residents in SFY 1999 for a total expenditure of $72,294,347.

Medicare-Aid

In February 1989, North Carolina began a new program of healthcare 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 January 1998, coverage was expanded to two new groups of Medicare Beneficiaries. Individuals with incomes between 120% and 135% of the federal poverty level can qualify for payment of Medicare Part B premiums. Individuals with incomes between 135% and 175% of the federal poverty level can receive

reimbursement for a portion of the cost of their Part B premium. The reimbursement amount is set annually by HCFA. These new groups are called "Qualifying Individuals." Federal law mandates their eligibility and funding is capped.

In State Fiscal Year 1999, 32,737 recipients benefited from Medicare-Aid. Total cost for this coverage was $21,867,963.

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 & Head Start Programs

In strengthening the commitment to provide a comprehensive array of services to the children of North Carolina, DMA is paying for 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 (LEAs) 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, respiratory therapy, speech and language therapy, and audiological services to children (birth through 20 years old).

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, 1999, the resource protection limit ranges from $16,392 to $81,960. The standard monthly income allowance is $1,359 and can be raised as high as $2,049 depending on shelter cost. (NOTE: The income of the spouse living at home is considered in determining whether an allowance is budgeted).

Managed Care

Managed Care

Managed care options for Medicaid recipients are now available in all 100 counties. There are 540,000 Medicaid recipients enrolled in a managed care plan. Options include Carolina ACCESS (which includes ACCESS II and III) and Risk Contracting with State licensed HMOs. All managed care options operate under the authority of 19151(b) of the Social Security Act. Eligibility to participate in a managed care plan is mandatory for a majority of Medicaid recipients in North Carolina. Although recipients of Medicaid/Medicare are optionally enrolled in Carolina ACCESS, they are not enrolled in HMOs. Medicaid recipients who are in long-term care facilities are not enrolled in any managed care plan. Managed care options are as follows:

- **CAROLINA ACCESS:** A primary care case management model (PCCM), characterized by a primary care physician gatekeeper.
- **ACCESS II & III:** These programs build on the Carolina ACCESS program by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of healthcare
- **HEALTHCARE CONNECTION:** A program operating in Mecklenburg County requiring mandatory enrollment in an HMO for a majority of Medicaid recipients in that county.

RISK CONTRACTING: DMA contracts with 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 choose between a participating HMO and Carolina ACCESS. The State of North Carolina must license all HMOs that contract with DMA.

For all of these healthcare models the objectives are:

- Cost-effectiveness
- Appropriate use of healthcare services
- Improved access to primary preventive care

Carolina ACCESS

Carolina ACCESS, North Carolina's Patient Access and Coordinated Care Program, was designed to provide a more efficient and effective healthcare delivery system for Medicaid recipients. It serves as the foundation managed care program for Medicaid in the State. 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 healthcare services for each enrollee. 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 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 Healthcare Trust.

Five counties were selected for a pilot of the program and by December 1998 expanded to 99 counties. (Mecklenburg County does not have Carolina ACCESS) As of June 1999, there were 516,513 Medicaid recipients enrolled in Carolina ACCESS. This is 73% of all Medicaid recipients eligible to participate.

ACCESS II & III

ACCESS II & III were initiated in July 1998 and aim to build on Carolina ACCESS by working with local providers and networks to better manage the Medicaid population with processes that impact both the quality and cost of healthcare. ACCESS II includes local networks comprised of Medicaid providers who have agreed to work together to develop the care management systems and supports that are needed to manage enrollee care. This model also includes a Statewide network of large Carolina ACCESS practices who have agreed to work together to develop collaborative systems for managing care. ACCESS III includes countywide plans that are community partnerships involving physicians, hospitals, health departments, departments of social services, and other community providers. Networks are assuming responsibility for managing the care of Medicaid eligible populations in the entire county. Plans are distinguished by the following features:

- Local collaboration and community focus to better meet the needs of the Medicaid population
- Population-based and identifying at-risk enrollees
- Implementing targeted care management initiatives
- Developing and measuring defined budget and utilization targets and quality indicators
- Strengthening the community "safety-net" that is in place to serve the expanding indigent population.

Healthcare Connection

Healthcare Connection was implemented in Mecklenburg County in July 1996. It is mandatory for certain Medicaid recipients in Mecklenburg to enroll in an HMO that has contracted with the State. As of June 1999, enrollment in Healthcare Connection stands at 32,423. An evaluation of this program performed by a research team at the University of North Carolina at Charlotte concluded that Healthcare Connection had been cost-effective for the State and county. The evaluation also found patient satisfaction to be high overall with an improved access to general healthcare. In Mecklenburg County, the options for Medicaid recipients are as follows:

- The Wellness Plan
- United Healthcare
- Principle Healthcare
- C.W. Williams (an FQHC which operates on a fee-for-service basis, but also manages patient care much like Carolina ACCESS)

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.

The State has entered into contracts with other HMOs and expanded HMO enrollment opportunities to Gaston County Medicaid recipients in the winter of 1997. HMO options were expanded in the triangle area during the winter of 1998, and the triad area in the fall of 1998. (It is anticipated that, as of October 30, 1999, all HMO options for Medicaid recipients in the triangle area will be discontinued. Carolina ACCESS will be the only managed care option for this region).

Total enrollment in HMOs for the optional counties is 1,287 as of June 1999. The following HMOs have contracted with the state to serve Medicaid recipients as an option with Carolina ACCESS:

- The Wellness Plan
  - Gaston County
- United HealthCare
  - Davidson County
  - Forsyth County
  - Guilford County
  - Rockingham County

Carolina Alternatives Program

Carolina Alternatives was 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 were linked to area Mental Health Programs that were 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 received an assessment. A care coordinator then located appropriate community-based services for the child and worked 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 was in 32 counties around the state. In SFY 1999, there were approximately 131,000 children participating monthly in Carolina Alternatives. The program ended June 30, 1999.

The development of the program was made possible through a grant from the Kate B. Reynolds Healthcare 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.

North Carolina Health Choice

NC Health Choice for Children

NC Health Choice for Children (NCHC) began enrolling children on October 1, 1998. The program is fee-for-service modeled after the NC Teachers and State Employees Comprehensive Major Medical Plan. The base plan is the same as that made available at full premium purchase to the children of State employees and teachers. It is enhanced by vision, dental and hearing benefits and benefits for special needs equivalent to the Medicaid program. The third party administrator of the program is Blue Cross and Blue Shield of North Carolina. Families whose children have been **uninsured for two months** and whose family income is up to **200% of the federal poverty level** are eligible for the program. The leading service filled has been eyeglasses. The program has averaged 32 prescriptions daily for eyeglasses since it began.

As of the June 26,1999, there were 47,457 children enrolled in NCHC. Of these, 70% were from families with income below 150% of the poverty level and 30% were above 150% of the poverty level. The total number of children estimated to be eligible for the program is 71,343.

NC's enrollment rates are among the best in the United States. In fact, NC's efforts have been tagged "cutting edge" by federal officials in HCFA. This is attributed to:

- Active Outreach Coalitions in each of the State's 100 counties
- The county coalition expertise generated in counties through Smart Start
- The commitment on the part of all levels of government to the goal of increasing the numbers of children with health insurance.

Active outreach efforts are underway in all 100 counties. Counties are engaged in outreach in schools, churches, day care centers, minority health clinics, school based health clinics, working with local industry, setting up stations at local discount retailers, billboards, local radio stations and newspapers. Counties have been given target enrollments.

During SFY 2000, the primary initiative must be on outreach targeting both potential new enrollees and those who need to re-enroll. Potential adjustments in other aspects of the program will continue to be studied on an ongoing basis. Quality assessments will begin as the program ends its first year of service.

NC Health Choice for Children

NC Health Choice for Children (NCHC) began enrolling children on October 1, 1998. The program is fee-for-service modeled after the NC Teachers and State Employees Comprehensive Major Medical Plan. The base plan is the same as that made available at full premium purchase to the children of State employees and teachers. It is enhanced by vision, dental and hearing benefits and benefits for special needs equivalent to the Medicaid program. The third party administrator of the program is Blue Cross and Blue Shield of North Carolina. Families whose children have been **uninsured for two months** and whose family income is up to **200% of the federal poverty level** are eligible for the program. The leading service filled has been eyeglasses. The program has averaged 32 prescriptions daily for eyeglasses since it began.

As of the June 26,1999, there were 47,457 children enrolled in NCHC. Of these, 70% were from families with income below 150% of the poverty level and 30% were above 150% of the poverty level. The total number of children estimated to be eligible for the program is 71,343.

NC's enrollment rates are among the best in the United States. In fact, NC's efforts have been tagged "cutting edge" by federal officials in HCFA. This is attributed to:

- Active Outreach Coalitions in each of the State's 100 counties
- The county coalition expertise generated in counties through Smart Start
- The commitment on the part of all levels of government to the goal of increasing the numbers of children with health insurance.

Active outreach efforts are underway in all 100 counties. Counties are engaged in outreach in schools, churches, day care centers, minority health clinics, school based health clinics, working with local industry, setting up stations at local discount retailers, billboards, local radio stations and newspapers. Counties have been given target enrollments.

During SFY 2000, the primary initiative must be on outreach targeting both potential new enrollees and those who need to re-enroll. Potential adjustments in other aspects of the program will continue to be studied on an ongoing basis. Quality assessments will begin as the program ends its first year of service.

Appendix A
Medicaid Tables

Table 1
North Carolina Medicaid
State Fiscal Year 1999
Federal Matching Rates

Benefit Costs
(7/1/98 - 9/30/98)

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

Benefit Costs
(10/1/98 - 6/30/99)

	Family Planning		All Other
Federal	90.0%	Federal	62.49%
State	8.5%	State	31.88%
County	1.5%	County	5.63%
			100.00%

Administrative Costs
(7/1/98 - 6/30/99)

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

*MMIS-Medicaid Management Information System

Table 2
North Carolina Medicaid
State Fiscal Year 1999
Medicaid Financial Eligibility Standards

GROUP:	FAMILY SIZE:	1	2	3	4	5
Pregnant Women and Children under age 1	Income Limit:	$1,271/mo.	$1,706/mo.	$2,140/mo.	$2,575/mo.	$3,010/mo.
	Resource Limit:	None				
Children age 1 through 5	Income Limit:	$914/mo.	$1,226/mo.	$1,539/mo.	$1,851/mo.	$2,164/mo.
	Resource Limit:	None				
Children age 6 through 18	Income Limit:	$687/mo.	$922/mo.	$1,157/mo.	$1,392/mo.	$1,627/mo.
	Resource Limit:	None				
Children age 19 and 20	Income Limit:	$362/mo.	$472/mo.	$544/mo.	$594/mo.	$648/mo.
	Resource Limit:	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
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:	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
Aged (over age 65), **Blind** or **Disabled** by Social Security standards.	Income Limit:	$687/mo.	$922/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:	$687/mo.	$922/mo.			
	Resource Limit:	$ 4,000	$ 6,000			
* Medicaid pays Medicare Part B premiums only.	Income Limit:	$824/mo.	$1,106/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	$ 3,000	$ 3,000	$ 3,000	$ 3,000	$ 3,000
	Aged,Blind,Disable	$ 2,000	$ 3,000			

Table 3
Financial Eligibility for Medicaid
based on
Percentage of Poverty (Annual)
SFY 1999

Family Size	100%	120%	133%	135%	185%	200%	SSI	MNIL	SA
1	$ 8,244	$ 9,888	$ 10,968	$ 11,124	$ 15,252	$ 16,488	$ 6,000	$ 2,904	$ 11,784
2	$ 11,064	$ 13,272	$ 14,712	$ 14,940	$ 20,472	$ 22,128	$ 9,012	$ 3,804	
3	$ 13,884		$ 18,468		$ 25,680	$ 27,768			
4	$ 16,704		$ 22,212		$ 30,900	$ 33,408			
5	$ 19,524		$ 25,968		$ 36,120	$ 39,048			

Table 4
North Carolina Medicaid
State Fiscal Year 1999
Enrolled Medicaid Providers

Providers	Number
Physicians*	32,977
Dentists	3,607
Pharmacists	2,178
Optometrists	1,311
Chiropractors	1,285
Podiatrists	466
Ambulance Companies	349
Home Health Agencies**	201
Durable Medical Equip. Suppliers	3,809
Intermediate Care Facilities-MR	331
HMOs	6
Hospitals	570
Mental Health Clinics	181
Nursing Facilities	967
Domicile Care	2,271
Personal Care Agencies	567
Rural Health Clinics	152
CRNA	45
Nurse Midwives	47
Hospices	71
CAP Providers	845
Other Clinics	11
Other	4,851
Total	**57,098**

* 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.

Table 5
North Carolina Medicaid
State Fiscal Year 1999
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 6
North Carolina Medicaid
State Fiscal Year 1998 & 1999
Sources of Medicaid Funds

		1998	Percent	1999	Percent
Federal	$	2,956,659,567	62.70%	$ 2,988,767,566	60.57%
State*	$	1,119,111,669	23.73%	$ 1,301,768,010	26.38%
Other State	$	423,641,382	8.98%	$ 417,445,570	8.46%
County	$	216,320,416	4.59%	$ 226,155,451	4.58%
Total	**$**	**4,715,733,033**	100.00%	**$ 4,934,136,597**	100.00%

* State Appropriation of funds

Source: BD701, The Authorized Monthly Budget Report for the period ending June 29, 1999

Table 7
North Carolina Medicaid
State Fiscal Year 1999
Utilization 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	683,536,611	13.9%	15.9%	173,906	$ 3,930
Outpatient Hospital	241,551,759	4.9%	5.6%	493,846	489
Mental Hospital >65 & <21	19,432,423	0.4%	0.5%	2,148	9,047
Physician	388,246,446	7.9%	9.0%	995,962	390
Clinics	289,025,038	5.9%	6.7%	284,150	1,017
Nursing Facility (Skilled)	433,076,935	8.8%	10.0%	28,988	14,940
Nursing Facility (Intermediate)	357,114,498	7.2%	8.3%	22,106	16,155
ICF-MR	374,280,119	7.6%	8.7%	4,832	77,459
Dental	52,609,470	1.1%	1.2%	215,196	244
Prescription Drugs	557,772,670	11.3%	12.9%	797,599	699
Home Health	101,392,774	2.1%	2.4%	66,871	1,516
Other Services	609,650,531	12.4%	14.1%	1,397,321	436
Subtotal, Services	**$ 4,107,689,274**	**83.3%**	95.3%		
Medicare Premiums: (Part A, Part B, QMB, Dually Eligible)	160,421,242	3.3%	3.7%		
HMO Premium	43,688,073	0.9%	1.0%		
Subtotal Services	**4,311,798,589**				
Adjustments, Cost Settlements & Transfers	(43,643,618)	-0.9%			
Disproportionate Share Payments	338,644,908	6.9% **			
Transfer to State Treasurer	104,551,863	2.1%			
Subtotal Services & Other	**$ 4,711,351,742**	**95.5%**			
Administration (State & County)	**222,784,855**	**4.5%**			
(State Share)	115,052,374	2.3%			
(County Share)	107,732,481	2.2%			
Grand Total Expenditures	**$ 4,934,136,597**	**100.0%**			
Total Recipients (unduplicated)* **				**1,175,109**	
Total Expenditures Per Recipient (unduplicated)					**$ 4,199**

* "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 1999-2082 report, SFY 1999-PER Report, SFY 1999-BD701 report

Table 8
North Carolina Medicaid
A History of Medicaid Expenditures
SFY 1979-1999

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	$ 4,715,733,033	2%
1999	$ 4,934,136,597	5%

Table 9
North Carolina Medicaid
State Fiscal Years 1979-1999
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%
1998-99	152,582	32,737	2,497	199,523	344,621	60,896	371,986	3,941	8,036	1,176,819	-1.73%
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%	
SFY 1999 Percent Total Eligibles	13.0%	2.8%	0.2%	17.0%	29.3%	5.2%	31.6%	0.3%	0.7%	100.0%	

Source: Medicaid Eligibilty Report, SFY 1999

Table 10
North Carolina Medicaid
State Fiscal Year 1999
Total Expenditures and Eligibles by County

COUNTY NAME	1999 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 1999 population (Column C / Column B)
ALAMANCE	121,664	15,277	$ 61,526,411	$ 4,027	$ 505.71	76	126	12.56%
ALEXANDER	31,902	4,157	$ 13,524,893	3,254	423.95	91	130	13.03%
ALLEGHANY	9,854	1,559	$ 7,615,709	4,885	772.85	32	158	15.82%
ANSON	24,024	6,475	$ 25,087,642	3,875	1,044.27	9	270	26.95%
ASHE	23,698	4,361	$ 20,034,117	4,594	845.39	26	184	18.40%
AVERY	15,319	2,700	$ 14,034,150	5,198	916.13	18	176	17.63%
BEAUFORT	43,544	9,691	$ 37,310,688	3,850	856.85	22	223	22.26%
BERTIE	20,032	6,330	$ 22,392,885	3,538	1,117.86	4	316	31.60%
BLADEN	30,770	8,867	$ 33,626,593	3,792	1,092.84	5	288	28.82%
BRUNSWICK	67,314	12,125	$ 39,357,101	3,246	584.68	60	180	18.01%
BUNCOMBE	193,284	29,435	$ 117,247,472	3,983	606.61	55	152	15.23%
BURKE	84,096	12,806	$ 53,810,474	4,202	639.87	50	152	15.23%
CABARRUS	120,674	13,655	$ 57,353,020	4,200	475.27	80	113	11.32%
CALDWELL	75,404	11,213	$ 44,144,986	3,937	585.45	59	149	14.87%
CAMDEN	6,378	941	$ 3,539,225	3,761	554.91	68	148	14.75%
CARTERET	59,266	7,545	$ 31,253,164	4,142	527.34	72	127	12.73%
CASWELL	22,380	3,974	$ 15,452,101	3,888	690.44	43	178	17.76%
CATAWBA	131,549	17,070	$ 57,350,512	3,360	435.96	89	130	12.98%
CHATHAM	45,938	5,153	$ 21,206,200	4,115	461.63	83	112	11.22%
CHEROKEE	22,782	4,923	$ 20,922,047	4,250	918.36	15	216	21.61%
CHOWAN	14,382	3,401	$ 12,722,864	3,741	884.64	19	236	23.65%
CLAY	8,238	1,380	$ 5,962,484	4,321	723.78	38	168	16.75%
CLEVELAND	91,806	16,307	$ 60,867,015	3,733	663.00	45	178	17.76%
COLUMBUS	52,166	15,611	$ 59,155,460	3,789	1,133.98	2	299	29.93%
CRAVEN	89,008	14,295	$ 49,245,025	3,445	553.27	69	161	16.06%
CUMBERLAND	292,744	47,481	$ 129,558,539	2,729	442.57	86	162	16.22%
CURRITUCK	17,164	2,304	$ 7,016,340	3,045	408.78	93	134	13.42%
DARE	28,140	2,675	$ 10,856,613	4,059	385.81	95	95	9.51%
DAVIDSON	141,374	18,771	$ 63,691,228	3,393	450.52	84	133	13.28%
DAVIE	32,156	3,447	$ 14,220,403	4,125	442.23	87	107	10.72%
DUPLIN	44,250	10,479	$ 34,861,745	3,327	787.84	30	237	23.68%
DURHAM	200,768	29,285	$ 106,858,446	3,649	532.25	71	146	14.59%
EDGECOMBE	54,702	17,154	$ 52,869,494	3,082	966.50	11	314	31.36%
FORSYTH	289,696	36,139	$ 133,950,699	3,707	462.38	82	125	12.47%
FRANKLIN	44,438	7,770	$ 29,057,255	3,740	653.88	47	175	17.49%
GASTON	181,045	29,362	$ 106,913,429	3,641	590.54	58	162	16.22%
GATES	9,993	1,723	$ 6,511,425	3,779	651.60	48	172	17.24%
GRAHAM	7,462	1,856	$ 8,064,490	4,345	1,080.74	6	249	24.87%
GRANVILLE	44,510	6,561	$ 24,759,362	3,774	556.27	67	147	14.74%
GREENE	18,345	3,739	$ 13,251,802	3,544	722.37	39	204	20.38%
GUILFORD	388,103	54,527	$ 190,646,399	3,496	491.23	79	140	14.05%
HALIFAX	55,422	17,783	$ 52,852,541	2,972	953.64	12	321	32.08%
HARNETT	83,590	15,518	$ 50,316,559	3,242	601.94	56	186	18.56%
HAYWOOD	51,618	8,319	$ 32,866,742	3,951	636.73	51	161	16.12%
HENDERSON	80,885	11,553	$ 45,872,943	3,971	567.14	63	143	14.28%
HERTFORD	21,562	6,980	$ 24,381,605	3,493	1,130.77	3	324	32.37%
HOKE	30,038	6,820	$ 18,227,496	2,673	606.81	54	227	22.70%
HYDE	5,741	1,283	$ 5,472,993	4,266	953.32	13	223	22.35%
IREDELL	113,516	14,430	$ 50,841,681	3,523	447.86	85	127	12.71%
JACKSON	29,558	4,998	$ 20,309,388	4,064	687.10	44	169	16.91%
JOHNSTON	107,717	17,508	$ 60,159,891	3,436	558.50	66	163	16.25%
JONES	9,265	2,088	$ 8,495,393	4,069	916.93	17	225	22.54%
LEE	48,758	8,477	$ 27,620,831	3,258	566.49	64	174	17.39%
LENOIR	58,591	14,270	$ 49,791,049	3,489	849.91	24	244	24.36%
LINCOLN	59,084	7,320	$ 25,822,156	3,528	437.04	88	124	12.39%
MACON	40,113	4,516	$ 16,943,382	3,752	422.39	92	113	11.26%
MADISON	28,152	3,632	$ 14,101,658	3,883	500.91	77	129	12.90%
MARTIN	18,792	6,512	$ 23,476,814	3,605	1,249.30	1	347	34.65%
MCDOWELL	25,632	6,266	$ 21,844,910	3,486	852.25	23	244	24.45%
MECKLENBURG	624,527	76,142	$ 246,522,499	3,238	394.73	94	122	12.19%
MITCHELL	14,625	2,454	$ 10,901,208	4,442	745.38	34	168	16.78%

Table 10
North Carolina Medicaid
State Fiscal Year 1999
Total Expenditures and Eligibles by County

COUNTY NAME	1999 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 1999 population (Column C / Column B)
PITT	126,643	23,208	$ 78,626,910	3,388	620.85	53	183	18.33%
POLK	16,667	2,143	$ 8,481,807	3,958	508.90	74	129	12.86%
RANDOLPH	124,142	16,290	$ 54,008,901	3,315	435.06	90	131	13.12%
RICHMOND	45,507	11,787	$ 41,923,612	3,563	921.26	14	259	25.86%
ROBESON	114,430	36,252	$ 121,689,147	3,357	1,063.44	7	317	31.68%
ROCKINGHAM	89,651	14,988	$ 62,640,197	4,179	698.71	42	167	16.72%
ROWAN	124,717	18,344	$ 61,709,787	3,364	494.80	78	147	14.71%
RUTHERFORD	60,056	10,685	$ 38,807,310	3,632	646.19	49	178	17.79%
SAMPSON	53,312	12,817	$ 45,837,034	3,576	859.79	21	240	24.04%
SCOTLAND	35,201	10,156	$ 34,385,593	3,386	976.84	10	289	28.85%
STANLY	55,606	8,197	$ 32,439,161	3,957	583.38	61	147	14.74%
STOKES	43,198	5,156	$ 19,981,402	3,874	462.55	81	119	11.94%
SURRY	67,928	10,403	$ 42,641,257	4,099	627.74	52	153	15.31%
SWAIN	12,168	2,804	$ 10,092,529	3,599	829.43	27	230	23.04%
TRANSYLVANIA	28,316	4,071	$ 15,856,040	3,895	559.97	65	144	14.38%
TYRRELL	3,895	962	$ 3,397,312	3,532	872.22	20	247	24.70%
UNION	110,110	12,736	$ 41,971,459	3,295	381.18	96	116	11.57%
VANCE	41,690	11,816	$ 34,458,660	2,916	826.54	28	283	28.34%
WAKE	574,828	49,224	$ 167,084,274	3,394	290.67	100	86	8.56%
WARREN	18,916	4,971	$ 16,026,645	3,224	847.25	25	263	26.28%
WASHINGTON	13,103	3,744	$ 12,024,648	3,212	917.70	16	286	28.57%
WATAUGA	40,936	3,467	$ 15,394,627	4,440	376.07	97	85	8.47%
WAYNE	113,300	21,528	$ 67,526,223	3,137	595.99	57	190	19.00%
WILKES	63,317	10,314	$ 44,777,716	4,341	707.20	40	163	16.29%
WILSON	69,383	16,156	$ 52,212,152	3,232	752.52	33	233	23.29%
YADKIN	35,657	4,454	$ 18,085,446	4,060	507.21	75	125	12.49%
YANCEY	16,580	3,141	$ 13,074,690	4,163	788.58	29	189	18.94%
STATE TOTAL	**7,547,090**	**1,176,819**	**$4,168,362,844**	**$3,542**	**$552.31**	**N/A**	**156**	**15.59%**

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1999.

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

Table 11
North Carolina Medicaid
State Fiscal Year 1999
Medicaid Service Expenditures by Recipient Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 1999 Expenditures Per Recipient	SFY 1998 Expenditures Per Recipient	98/99 Percent Change
Total Elderly	**$ 1,425,288,282**	**33.1%**	**171,355**	**14.6%**	**$ 8,318**	**$ 7,814**	**6.4%**
Aged	1,379,127,418	32.0%	133,689	11.4%	10,316	9,633	7.1%
Medicare-Aid (MQBQ & MQBB)	46,160,864	1.1%	37,666	3.2%	1,226	1,535	-20.2%
Total Disabled	**$ 1,749,310,431**	**40.6%**	**188,586**	**16.0%**	**9,276**	**9,178**	**1.1%**
Disabled	1,725,904,497	40.0%	186,184	15.8%	9,270	9,173	1.1%
Blind	23,405,934	0.5%	2,402	0.2%	9,744	9,543	2.1%
Total Families & Children	**$ 1,133,238,475**	**26.3%**	**808,078**	**68.8%**	**1,402**	**1,442**	**-2.7%**
AFDC Adults (> 21)	254,281,435	5.9%	155,650	13.2%	1,634	1,766	-7.5%
Medicaid Pregnant Women Coverage	183,534,572	4.3%	68,473	5.8%	2,680	2,541	5.5%
AFDC Children & Other Children	282,768,643	6.6%	223,775	19.0%	1,264	1,265	-0.1%
Medicaid Indigent Children	412,653,825	9.6%	360,180	30.7%	1,146	1,187	-3.5%
Aliens and Refugees	**$ 20,166,770**	**0.5%**	**7,090**	**0.6%**	**2,844**	**2,602**	**9.3%**
Adjustments Not Attributable To A Specific Category	**$ (16,205,369)**	**-0.4%**					
Total Service Expenditures All Groups	**$ 4,311,798,589**	**100%**	**1,175,109**	**100%**	**$ 3,669**	**$ 3,579**	**2.5%**

Note: Total Service Expenditures does not include:

Disproportionate Share payments	338,644,908
State & county administrative costs	222,784,855
Transfer to State Treasurer	104,551,863
Adjustments and cost settlements	(43,643,618)
TOTAL	$ 622,338,008

See Table 6 for more details.
Source: SFY 1999 Program Expenditure Report and 2082 Report.

Table 12
North Carolina Medicaid
State Fiscal Year 1999
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	$ 683,536,611	15.9%	$ 14,358,918	$ 2,355,405	$ -	$ 2,035,961	$ 304,665,733	157,088,633	195,347,560	$ 14,242,153	$ (6,557,752)
Outpatient Hospital	241,551,759	5.6%	$ 24,355,482	7,395,166	263	$ 931,984	$ 96,245,067	56,019,550	58,045,435	406,945	(1,848,133)
Mental Hospital (> 65)	8,094,158	0.2%	8,059,143	8,904	-	9,345	18,143	-	-	-	(1,377)
Psychiatric Hospital (< 21	11,338,265	0.3%	11,834	-	-	2,390	3,533,177	24,625	7,774,353	-	(8,114)
Physician	388,246,446	9.0%	42,081,650	8,561,114	1,185	1,125,719	118,233,224	94,722,859	122,097,622	4,528,483	(3,105,410)
Clinics	289,025,038	6.7%	10,367,331	2,813,362	33	675,496	135,913,570	38,302,997	101,944,022	527,668	(1,519,441)
Nursing Facility:											
Skilled Level	433,076,935	10.0%	378,298,474	79,558	-	1,475,261	53,646,022	37,779	14,660	13,806	(488,625)
Intermediate Level	357,114,498	8.3%	327,315,055	6,660	-	1,424,500	28,687,697	5,302	113,576	2,953	(441,245)
Intermediate Care Facility											
(Mentally Retarded)	374,280,119	8.7%	16,747,921	-	-	6,443,044	347,398,200	3,666	3,670,432	34,799	(17,943)
Dental	52,609,470	1.2%	6,005,552	916	-	117,354	13,839,870	9,021,463	23,538,192	175,841	(89,718)
Prescription Drugs	557,772,670	12.9%	197,799,925	-	-	2,710,590	258,092,098	41,786,846	57,796,394	83,744	(496,927)
Home Health	101,392,774	2.4%	20,978,792	50,532	28	859,472	67,740,128	4,191,816	7,969,587	6,934	(404,515)
CAP/Disabled Adult	150,461,450	3.5%	115,954,074	-	-	1,072,902	33,565,340	472	-	-	(131,338)
CAP/Mentally Retarded	134,482,336	3.1%	3,115,567	-	-	1,482,216	129,057,592	-	1,556,940	-	(729,979)
CAP/Children	10,658,987	0.2%	-	-	-	-	10,277,323	-	385,087	-	(3,423)
Personal Care	73,963,865	1.7%	52,455,811	1,163	-	1,121,493	19,921,839	328,671	217,779	-	(82,891)
Hospice	8,500,466	0.2%	3,677,382	-	-	25,643	4,568,408	208,753	45,016	-	(24,736)
EPSDT (Health Check)	31,498,266	0.7%	831	-	-	7,349	1,051,981	32,378	30,435,894	6,152	(36,319)
Lab & X-Ray	10,449,058	0.2%	53,746	7,262	-	34,636	2,695,857	5,147,304	2,526,440	17,421	(33,608)
Adult Home Care	72,294,345	1.7%	44,009,080	45,678	17,644	270,091	27,973,745	800	10,051	-	(32,744)
Other Services	117,341,758	2.7%	9,362,854	584,680	32	231,367	26,010,084	19,681,219	61,546,816	118,709	(194,003)
Total Services	**4,107,689,274**	**95.3%**	**1,275,009,422**	**21,910,400**	**19,185**	**22,056,813**	**1,683,135,098**	**426,605,133**	**675,035,856**	**20,165,607**	**(16,248,240)**
Medicare:											
Part A Premiums	41,797,853	1.0%	41,162,963	68,073	-	657,369	4,339	-	-	-	(94,891)
Part B Premiums	118,623,389	2.8%	62,955,033	11,682,058	12,481,148	559,605	30,474,506	323,445	8,669	1,163	137,762
HMO Premiums	43,688,073	1.0%	-	-	-	132,147	12,290,554	10,887,429	20,377,943	-	-
Total Premiums	**204,109,315**		**104,117,996**	**11,750,131**	**12,481,148**	**1,349,121**	**42,769,399**	**11,210,874**	**20,386,612**	**1,163**	**42,871**
Grand Total Services and Premiums	**$ 4,311,798,589**		**1,379,127,418**	**33,660,531**	**12,500,333**	**23,405,934**	**1,725,904,497**	**437,816,007**	**695,422,468**	**20,166,770**	**(16,205,369)**

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 availabl

Table 13
North Carolina Medicaid
State Fiscal Year 1999
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 1999 % of Total Dollars	SFY 1998 % of Total Dollars	SFY 1997 % of Total Dollars
Inpatient Hospital	$ 14,358,918	1.0%	$ 2,355,405	$ -	$ 2,355,405	5.1%	$ 16,714,323	1.2%	1.1%	1.4%
Outpatient Hospital	24,355,482	1.8%	7,395,166	263	7,395,429	16.0%	31,750,911	2.2%	2.2%	2.4%
Mental Hospital (>65)	8,059,143	0.6%	8,904	-	8,904	0.0%	8,068,047	0.6%	0.7%	1.0%
Physician	42,081,650	3.1%	8,561,114	1,185	8,562,299	18.5%	50,643,949	3.6%	4.1%	4.1%
Clinics	10,367,331	0.8%	2,813,362	33	2,813,395	6.1%	13,180,726	0.9%	1.2%	1.2%
Nursing Facility:										
Skilled Level:	378,298,474	27.4%	79,558	-	79,558	0.2%	378,378,032	26.5%	27.8%	28.7%
Intermediate Level:	327,315,055	23.7%	6,660	-	6,660	0.0%	327,321,715	23.0%	23.2%	23.9%
Intermediate Care Facility-Mentally Retarded	16,747,921	1.2%	-	-	-	0.0%	16,747,921	1.2%	1.1%	1.1%
Dental	6,005,552	0.4%	916	-	916	0.0%	6,006,468	0.4%	0.4%	0.4%
Prescription Drugs	197,799,925	14.3%	-	-	-	0.0%	197,799,925	13.9%	12.0%	10.7%
Home Health	20,978,792	1.5%	50,532	28	50,560	0.1%	21,029,352	1.5%	1.1%	1.2%
CAP/Disabled Adult	115,954,074	8.4%	-	-	-	0.0%	115,954,074	8.1%	7.6%	6.6%
CAP/Mentally Retarded	3,115,567	0.2%	-	-	-	0.0%	3,115,567	0.2%	0.2%	0.2%
Personal Care	52,455,811	3.8%	1,163	-	1,163	0.0%	52,456,974	3.7%	3.8%	3.6%
Hospice	3,677,382	0.3%	-	-	-	0.0%	3,677,382	0.3%	0.3%	0.3%
EPSDT (Health Check)	831	0.0%	-	-	-	0.0%	831	0.0%	0.0%	0.0%
Lab & X-Ray	53,746	0.0%	7,262	-	7,262	0.0%	61,008	0.0%	0.0%	0.0%
Adult Care Home	44,009,080	3.2%	45,678	17,644	63,322	0.1%	44,072,402	3.1%	3.0%	3.0%
Other Services	9,374,688	0.7%	584,680	32	584,712	1.3%	9,959,400	0.7%	0.6%	0.6%
Service Expenditures	**$ 1,275,009,422**	**92.5%**	**21,910,400**	**19,185**	**21,929,585**	**47.5%**	**1,296,939,007**	**91.0%**	**90.5%**	**90.4%**
Part A Premium	41,162,963	3.0%	68,073	-	68,073	0.1%	41,231,036	2.9%	3.1%	3.1%
Part B Premium	62,955,033	4.6%	11,682,058	12,481,148	24,163,206	52.3%	87,118,239	6.1%	6.4%	6.4%
HMO Premium	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Total Premiums	**$ 104,117,996**		**11,750,131**	**12,481,148**	**24,231,279**		**128,349,275**			
Total Service & Premiums	**$ 1,379,127,418**	**100%**	**33,660,531**	**12,500,333**	**46,160,864**	**100%**	**1,425,288,282**			
Medicare Crossovers**	**$ 95,089,147**									
Total Elderly Recipients	133,689		37,666	22,078	59,744		193,433			
Service Expenditures Per Recipient *	**$ 10,316**		**$ 894**	**$ 566**	**$ 773**		**$ 7,368**			

* 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 1999 Program Expenditure Report and 2082 Report

Table 14
North Carolina Medicaid
State Fiscal Year 1999
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	1999 % of Total Dollars	1998 % of Total Dollars
Inpatient Hospital	$ 304,665,733	17.7%	$ 2,035,961	8.7%	$ 306,701,694	17.5%	18.6%
Outpatient Hospital	96,245,067	5.6%	931,984	4.0%	97,177,051	5.6%	5.3%
Psychiatric Hospital (>65)	18,143	0.0%	9,345	0.0%	27,488	0.0%	0.0%
Psychiatric Hospital (<21)	3,533,177	0.2%	2,390	0.0%	3,535,567	0.2%	0.3%
Physician	118,233,224	6.9%	1,125,719	4.8%	119,358,943	6.8%	6.9%
Clinics	135,913,570	7.9%	675,496	2.9%	136,589,066	7.8%	9.9%
Nursing Facility:							
Skilled Level:	53,646,022	3.1%	1,475,261	6.3%	55,121,283	3.2%	3.1%
Intermediate Level:	28,687,697	1.7%	1,424,500	6.1%	30,112,197	1.7%	1.6%
Intermediate Care Facility-Mentally Retarded	347,398,200	20.1%	6,443,044	27.5%	353,841,244	20.2%	20.6%
Dental	13,839,870	0.8%	117,354	0.5%	13,957,224	0.8%	0.6%
Prescription Drugs	258,092,098	15.0%	2,710,590	11.6%	260,802,688	14.9%	12.2%
Home Health	67,740,128	3.9%	859,472	3.7%	68,599,600	3.9%	4.2%
CAP/Disabled Adult	33,565,340	1.9%	1,072,902	4.6%	34,638,242	2.0%	1.8%
CAP/Children	129,057,592	7.5%	1,482,216	6.3%	130,539,808	7.5%	7.6%
CAP/Mentally Retarded	10,277,323	0.6%	-	0.0%	10,277,323	0.6%	0.4%
Personal Care	19,921,839	1.2%	1,121,493	4.8%	21,043,332	1.2%	1.2%
Hospice	4,568,408	0.3%	25,643	0.1%	4,594,051	0.3%	0.3%
EPSDT	1,051,981	0.1%	7,349		1,059,330	0.1%	0.1%
Lab & X-Ray	2,695,857	0.2%	34,636	0.1%	2,730,493	0.2%	0.2%
Adult Home Care	27,973,745	1.6%	270,091	1.2%	28,243,836	1.6%	1.6%
Other Services	26,010,084	1.5%	231,367	1.0%	26,241,451	1.5%	1.5%
Part A Premium	4,339	0.0%	657,369	2.8%	661,708	0.0%	0.0%
Part B Premium	30,474,506	1.8%	559,605	2.4%	31,034,111	1.8%	1.5%
HMO Premium	12,290,554	0.7%	132,147	0.6%	12,422,701	0.7%	0.1%
Total Service & Premiums	**$ 1,725,904,497**		**$ 23,405,934**		**$ 1,749,310,431**		
Medicare Crossovers*	**$ 52,597,041**		**$ 931,004**		**$ 53,528,045**		
Number of Disabled/Blind Recipients	186,184		2,402		188,586		
Service Expenditures Per Recipient**	**$ 9,270**		**$ 9,744**		**$ 9,276**		

* 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 1999 Program Expenditure Report and 2082 Report

Table 15
North Carolina Medicaid
State Fiscal Year 1999
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 1999 % of Total Dollars	SFY 1998 % of Total Dollars
Inpatient Hospital	$ 84,089,132	33.1%	$ 72,999,501	39.8%	$ 61,380,179	21.7%	133,967,381	32.5%	$ 352,436,193	31.1%	31.8%
Outpatient Hospital	39,165,645	15.4%	16,853,905	9.2%	24,586,077	8.7%	33,459,358	8.1%	114,064,985	10.1%	10.1%
Psychiatric Hospital (<21)	-	0.0%	24,625	0.0%	4,656,577	1.6%	3,117,776	0.8%	7,798,978	0.7%	1.1%
Physician	47,879,674	18.8%	46,843,185	25.5%	43,590,937	15.4%	78,506,685	19.0%	216,820,481	19.2%	18.7%
Clinics	14,913,808	5.9%	23,389,189	12.7%	59,248,240	21.0%	42,695,782	10.3%	140,247,019	12.4%	12.4%
Nursing Facility:											
Skilled Level:	37,779	0.0%	-	0.0%	14,453	0.0%	207	0.0%	52,439	0.0%	0.0%
Intermediate Level:	5,302	0.0%	-	0.0%	113,576	0.0%	-	0.0%	118,878	0.0%	0.0%
Intermediate Care Facility-Mentally Retarded	3,666	0.0%	-	0.0%	2,956,697	1.0%	713,735	0.2%	3,674,098	0.3%	0.4%
Dental	8,354,297	3.3%	667,166	0.4%	9,900,339	3.5%	13,637,853	3.3%	32,559,655	2.9%	2.4%
Prescription Drugs	36,772,769	14.5%	5,014,077	2.7%	23,737,716	8.4%	34,058,678	8.3%	99,583,240	8.8%	7.6%
Home Health	3,313,049	1.3%	878,767	0.5%	2,842,660	1.0%	5,126,927	1.2%	12,161,403	1.1%	1.2%
CAP/Disabled	472		-		-		-				
CAP/Mentally Retarded	-		-		1,556,838	0.6%	102				
CAP/Children	-	0.0%	-	0.0%	383,773	0.1%	1,314	0.0%	385,087	0.0%	0.0%
Personal Care	319,546	0.1%	9,125	0.0%	83,744	0.0%	134,035	0.0%	546,450	0.0%	0.1%
Hospice	208,102	0.1%	651	0.0%	26,417	0.0%	18,599	0.0%	253,769	0.0%	0.0%
Health Check - EPSDT	103	0.0%	32,275	0.0%	9,466,408	3.3%	20,969,486	5.1%	30,468,272	2.7%	2.7%
Lab & X-Ray	2,306,258	0.9%	2,841,046	1.5%	1,305,546	0.5%	1,220,894	0.3%	7,673,744	0.7%	0.8%
Adult Care Home	800	0.0%	-	0.0%	7,621	0.0%	2,430	0.0%	10,851	0.0%	0.0%
Other Services	10,338,700	4.1%	9,342,519	5.1%	28,434,294	10.1%	33,112,522	8.0%	81,228,035	7.2%	8.2%
Total Families & Children Service Expenditures	**$ 247,709,102**	97.4%	**178,896,031**		**274,292,092**		**400,743,764**		**1,100,083,577**	97%	97%
Part A Premium	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Part B Premium	308,861	0.1%	14,584	0.0%	2,768	0.0%	5,901	0.0%	332,114	0.0%	0.0%
HMO Premium	6,263,472	2.5%	4,623,957	2.5%	8,473,783	3.0%	11,904,160	2.9%	31,265,372	2.8%	2.6%
Total Premiums	**$ 6,572,333**		**4,638,541**		**8,476,551**		**11,910,061**		**31,597,486**		
Total Service & Premiums	**$ 254,281,435**		**183,534,572**		**282,768,643**		**412,653,825**		**1,131,681,063**		
Medicare Crossovers*	**$ 886,663**		**84,200**		**225,097**		**52,875**		**1,248,835**		
Number of Family & Child Recipients	155,650		68,473		223,775		360,180		808,078		
Service Expenditures Per Recipient**	**$ 1,634**		**$ 2,680**		**$ 1,264**		**$ 1,146**		**$ 1,400**		

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

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

Source: SFY 1999 Program Expenditure Report & 2082 Repor

Table 10

North Carolina Medicaid

State Fiscal Year 1999

Total Expenditures and Eligibles by County

COUNTY NAME	1999 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 1999 population (Column C / Column B)
ALAMANCE	121,664	15,277	$ 61,526,411	$ 4,027	$ 505.71	76	126	12.56%
ALEXANDER	31,902	4,157	$ 13,524,893	3,254	423.95	91	130	13.03%
ALLEGHANY	9,854	1,559	$ 7,615,709	4,885	772.85	32	158	15.82%
ANSON	24,024	6,475	$ 25,087,642	3,875	1,044.27	9	270	26.95%
ASHE	23,698	4,361	$ 20,034,117	4,594	845.39	26	184	18.40%
AVERY	15,319	2,700	$ 14,034,150	5,198	916.13	18	176	17.63%
BEAUFORT	43,544	9,691	$ 37,310,688	3,850	856.85	22	223	22.26%
BERTIE	20,032	6,330	$ 22,392,885	3,538	1,117.86	4	316	31.60%
BLADEN	30,770	8,867	$ 33,626,593	3,792	1,092.84	5	288	28.82%
BRUNSWICK	67,314	12,125	$ 39,357,101	3,246	584.68	60	180	18.01%
BUNCOMBE	193,284	29,435	$ 117,247,472	3,983	606.61	55	152	15.23%
BURKE	84,096	12,806	$ 53,810,474	4,202	639.87	50	152	15.23%
CABARRUS	120,674	13,655	$ 57,353,020	4,200	475.27	80	113	11.32%
CALDWELL	75,404	11,213	$ 44,144,986	3,937	585.45	59	149	14.87%
CAMDEN	6,378	941	$ 3,539,225	3,761	554.91	68	148	14.75%
CARTERET	59,266	7,545	$ 31,253,164	4,142	527.34	72	127	12.73%
CASWELL	22,380	3,974	$ 15,452,101	3,888	690.44	43	178	17.76%
CATAWBA	131,549	17,070	$ 57,350,512	3,360	435.96	89	130	12.98%
CHATHAM	45,938	5,153	$ 21,206,200	4,115	461.63	83	112	11.22%
CHEROKEE	22,782	4,923	$ 20,922,047	4,250	918.36	15	216	21.61%
CHOWAN	14,382	3,401	$ 12,722,864	3,741	884.64	19	236	23.65%
CLAY	8,238	1,380	$ 5,962,484	4,321	723.78	38	168	16.75%
CLEVELAND	91,806	16,307	$ 60,867,015	3,733	663.00	45	178	17.76%
COLUMBUS	52,166	15,611	$ 59,155,460	3,789	1,133.98	2	299	29.93%
CRAVEN	89,008	14,295	$ 49,245,025	3,445	553.27	69	161	16.06%
CUMBERLAND	292,744	47,481	$ 129,558,539	2,729	442.57	86	162	16.22%
CURRITUCK	17,164	2,304	$ 7,016,340	3,045	408.78	93	134	13.42%
DARE	28,140	2,675	$ 10,856,613	4,059	385.81	95	95	9.51%
DAVIDSON	141,374	18,771	$ 63,691,228	3,393	450.52	84	133	13.28%
DAVIE	32,156	3,447	$ 14,220,403	4,125	442.23	87	107	10.72%
DUPLIN	44,250	10,479	$ 34,861,745	3,327	787.84	30	237	23.68%
DURHAM	200,768	29,285	$ 106,858,446	3,649	532.25	71	146	14.59%
EDGECOMBE	54,702	17,154	$ 52,869,494	3,082	966.50	11	314	31.36%

COUNTY NAME	1999 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 1999 population (Column C / Column B)
FORSYTH	289,696	36,139	$ 133,950,699	3,707	462.38	82	125	12.47%
FRANKLIN	44,438	7,770	$ 29,057,255	3,740	653.88	47	175	17.49%
GASTON	181,045	29,362	$ 106,913,429	3,641	590.54	58	162	16.22%
GATES	9,993	1,723	$ 6,511,425	3,779	651.60	48	172	17.24%
GRAHAM	7,462	1,856	$ 8,064,490	4,345	1,080.74	6	249	24.87%
GRANVILLE	44,510	6,561	$ 24,759,362	3,774	556.27	67	147	14.74%
GREENE	18,345	3,739	$ 13,251,802	3,544	722.37	39	204	20.38%
GUILFORD	388,103	54,527	$ 190,646,399	3,496	491.23	79	140	14.05%
HALIFAX	55,422	17,783	$ 52,852,541	2,972	953.64	12	321	32.09%
HARNETT	83,590	15,518	$ 50,316,559	3,242	601.94	56	186	18.56%
HAYWOOD	51,618	8,319	$ 32,866,742	3,951	636.73	51	161	16.12%
HENDERSON	80,885	11,553	$ 45,872,943	3,971	567.14	63	143	14.28%
HERTFORD	21,562	6,980	$ 24,381,605	3,493	1,130.77	3	324	32.37%
HOKE	30,038	6,820	$ 18,227,496	2,673	606.81	54	227	22.70%
HYDE	5,741	1,283	$ 5,472,993	4,266	953.32	13	223	22.35%
IREDELL	113,516	14,430	$ 50,841,681	3,523	447.88	85	127	12.71%
JACKSON	29,558	4,998	$ 20,309,388	4,064	687.10	44	169	16.91%
JOHNSTON	107,717	17,508	$ 60,159,891	3,436	558.50	66	163	16.25%
JONES	9,265	2,088	$ 8,495,393	4,069	916.93	17	225	22.54%
LEE	48,758	8,477	$ 27,620,831	3,258	566.49	64	174	17.39%
LENOIR	58,591	14,270	$ 49,791,049	3,489	849.81	24	244	24.36%
LINCOLN	59,084	7,320	$ 25,822,156	3,528	437.04	88	124	12.39%
MACON	40,113	4,516	$ 16,943,382	3,752	422.39	92	113	11.26%
MADISON	28,152	3,632	$ 14,101,658	3,883	500.91	77	129	12.90%
MARTIN	18,792	6,512	$ 23,476,814	3,605	1,249.30	1	347	34.65%
MCDOWELL	25,632	6,266	$ 21,844,910	3,486	852.25	23	244	24.45%
MECKLENBURG	624,527	76,142	$ 246,522,499	3,238	394.73	94	122	12.19%
MITCHELL	14,625	2,454	$ 10,901,208	4,442	745.38	34	168	16.78%
MONTGOMERY	24,721	5,164	$ 17,932,264	3,473	725.39	36	209	20.89%
MOORE	70,814	9,741	$ 36,417,189	3,739	514.27	73	138	13.76%
NASH	88,112	15,023	$ 50,498,732	3,361	573.12	62	170	17.05%
NEW HANOVER	148,370	21,483	$ 80,986,166	3,770	545.84	70	145	14.48%
NORTHAMPTON	20,752	6,671	$ 21,988,148	3,296	1,059.57	8	321	32.15%
ONSLOW	149,007	17,183	$ 52,074,254	3,031	349.48	98	115	11.53%
ORANGE	109,288	7,926	$ 35,604,433	4,492	325.79	99	73	7.25%
PAMLICO	12,096	2,367	$ 9,398,791	3,971	777.02	31	196	19.57%
PASQUOTANK	34,766	7,308	$ 25,352,875	3,469	729.24	35	210	21.02%
PENDER	38,114	6,987	$ 27,613,443	3,952	724.50	37	183	18.33%
PERQUIMANS	10,947	2,361	$ 7,242,176	3,067	661.57	46	216	21.57%

COUNTY NAME	1999 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 1999 population (Column C / Column B)
PERSON	33,298	5,416	$ 23,448,188	4,329	704.19	41	163	16.27%
PITT	126,643	23,208	$ 78,626,910	3,388	620.85	53	183	18.33%
POLK	16,667	2,143	$ 8,481,807	3,958	508.90	74	129	12.86%
RANDOLPH	124,142	16,290	$ 54,008,901	3,315	435.06	90	131	13.12%
RICHMOND	45,507	11,767	$ 41,923,612	3,563	921.26	14	259	25.86%
ROBESON	114,430	36,252	$ 121,689,147	3,357	1,063.44	7	317	31.68%
ROCKINGHAM	89,651	14,988	$ 62,640,197	4,179	698.71	42	167	16.72%
ROWAN	124,717	18,344	$ 61,709,787	3,364	494.80	78	147	14.71%
RUTHERFORD	60,056	10,685	$ 38,807,310	3,632	646.19	49	178	17.79%
SAMPSON	53,312	12,817	$ 45,837,034	3,576	859.79	21	240	24.04%
SCOTLAND	35,201	10,156	$ 34,385,593	3,386	976.84	10	289	28.85%
STANLY	55,606	8,197	$ 32,439,161	3,957	583.38	61	147	14.74%
STOKES	43,198	5,158	$ 19,981,402	3,874	462.55	81	119	11.94%
SURRY	67,928	10,403	$ 42,641,257	4,099	627.74	52	153	15.31%
SWAIN	12,168	2,804	$ 10,092,529	3,599	829.43	27	230	23.04%
TRANSYLVANIA	28,316	4,071	$ 15,856,040	3,895	559.97	65	144	14.38%
TYRRELL	3,895	962	$ 3,397,312	3,532	872.22	20	247	24.70%
UNION	110,110	12,736	$ 41,971,459	3,295	381.18	96	116	11.57%
VANCE	41,690	11,816	$ 34,458,660	2,916	826.54	28	283	28.34%
WAKE	574,828	49,224	$ 167,084,274	3,394	290.67	100	86	8.56%
WARREN	18,916	4,971	$ 16,026,645	3,224	847.25	25	263	26.28%
WASHINGTON	13,103	3,744	$ 12,024,648	3,212	917.70	16	286	28.57%
WATAUGA	40,936	3,467	$ 15,394,627	4,440	376.07	97	85	8.47%
WAYNE	113,300	21,528	$ 67,526,223	3,137	595.99	57	190	19.00%
WILKES	63,317	10,314	$ 44,777,716	4,341	707.20	40	163	16.29%
WILSON	69,383	16,156	$ 52,212,152	3,232	752.52	33	233	23.29%
YADKIN	35,657	4,454	$ 18,085,446	4,060	507.21	75	125	12.49%
YANCEY	16,580	3,141	$ 13,074,690	4,163	788.58	29	189	18.94%
STATE TOTAL	**7,547,090**	**1,176,819**	**$4,168,362,844**	**$3,542**	**$552.31**	**N/A**	**156**	**15.59%**

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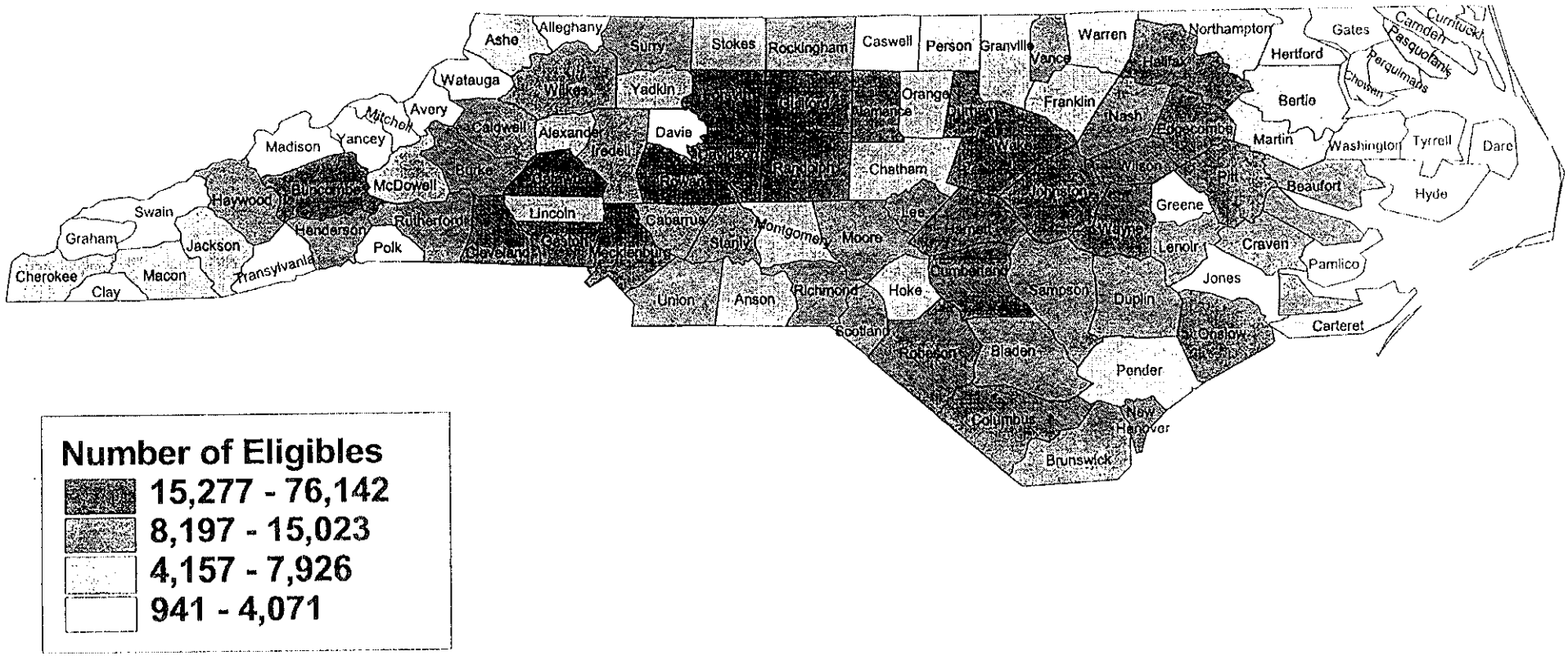
Table 16
North Carolina Medicaid
State Fiscal Year 1999
Medicaid Co-payment Amounts

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

Appendix B
Medicaid Maps

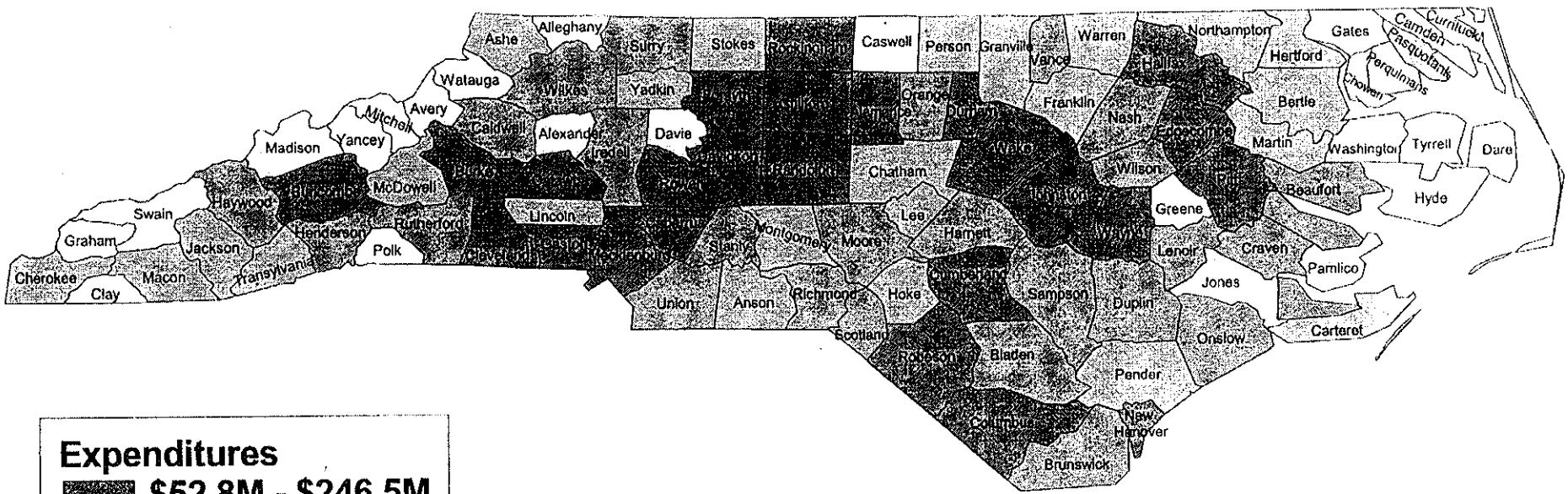
Medicaid Eligibles
SFY 1999



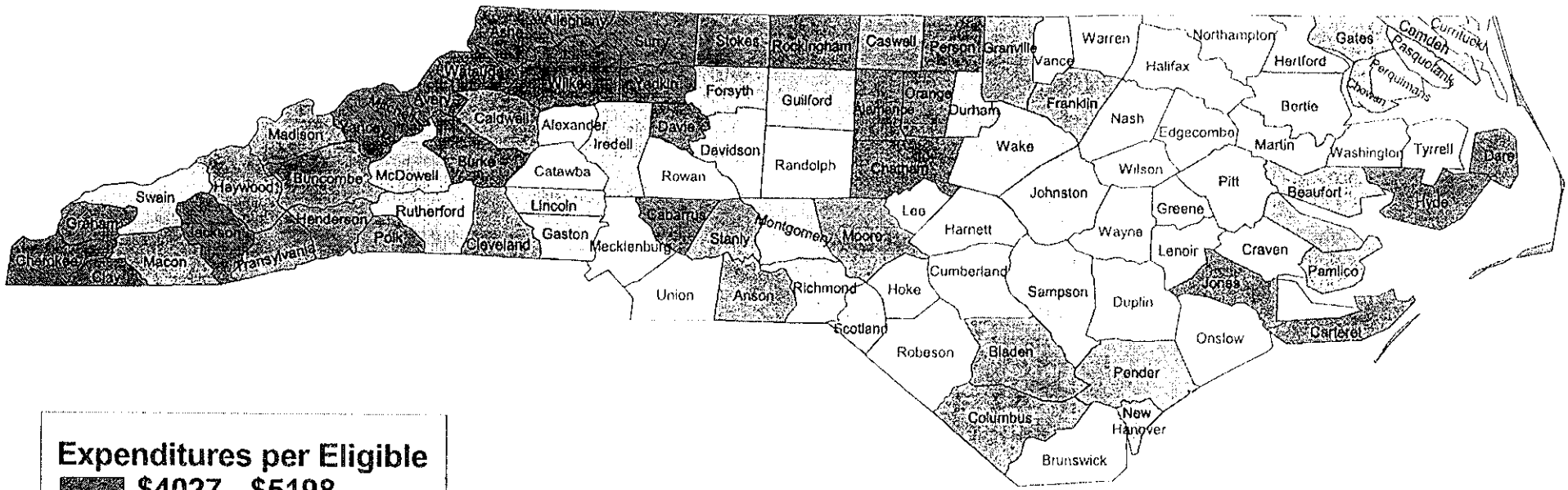
Number of Eligibles

- 15,277 - 76,142
- 8,197 - 15,023
- 4,157 - 7,926
- 941 - 4,071

Medicaid Expenditures
SFY 1999



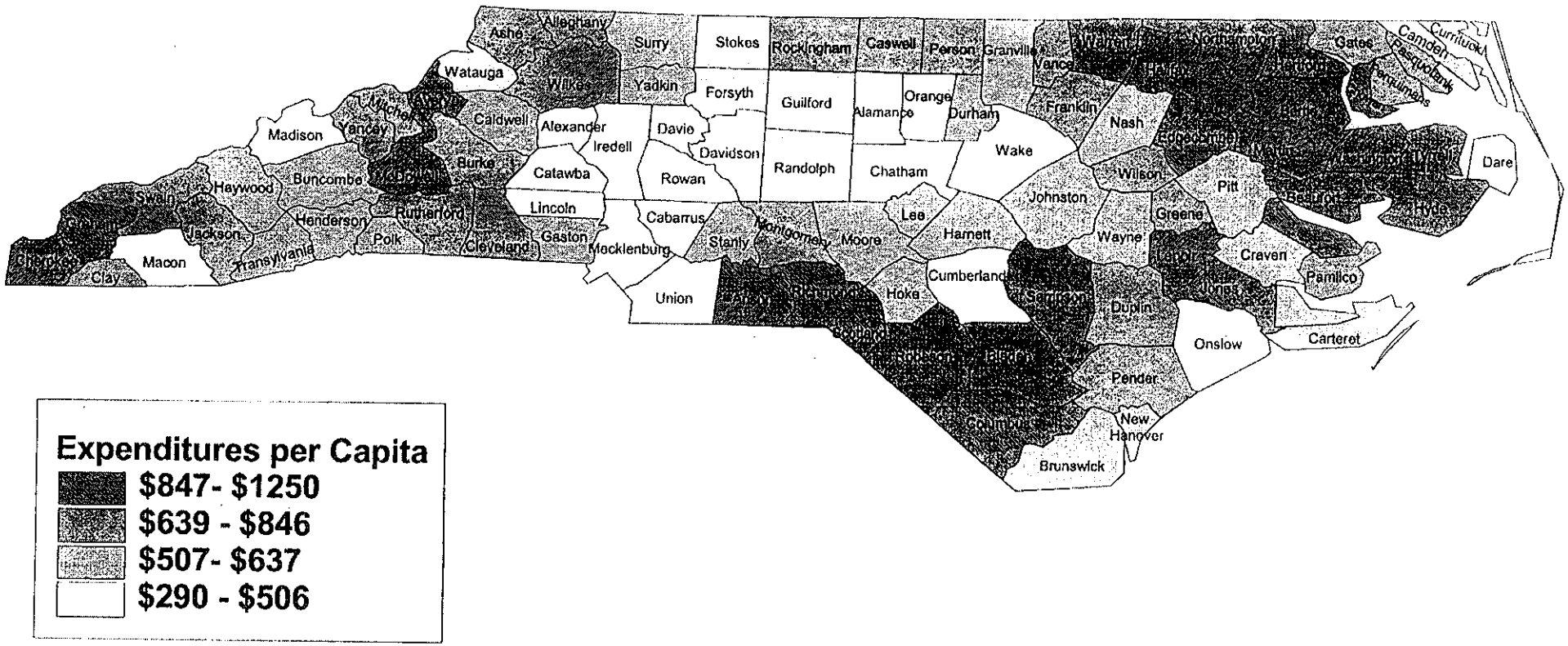
Medicaid Expenditures per Eligible
SFY 1999



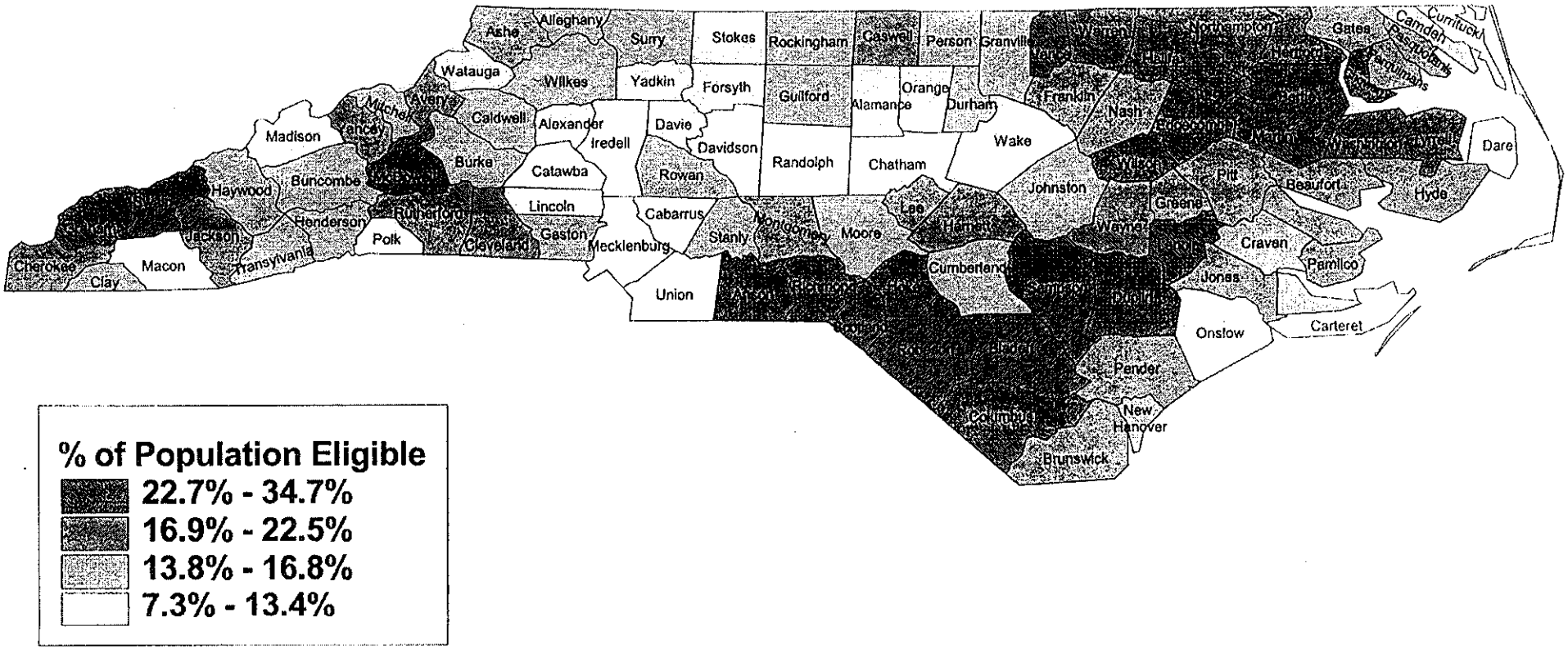
Expenditures per Eligible

- $4027 - $5198
- $3732 - $3984
- $3385 - $3707
- $2672 - $3365

Medicaid Expenditures per Capita
SFY 1999



Percentage of Population Eligible for Medicaid
SFY 1999



% of Population Eligible

- 22.7% - 34.7%
- 16.9% - 22.5%
- 13.8% - 16.8%
- 7.3% - 13.4%

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