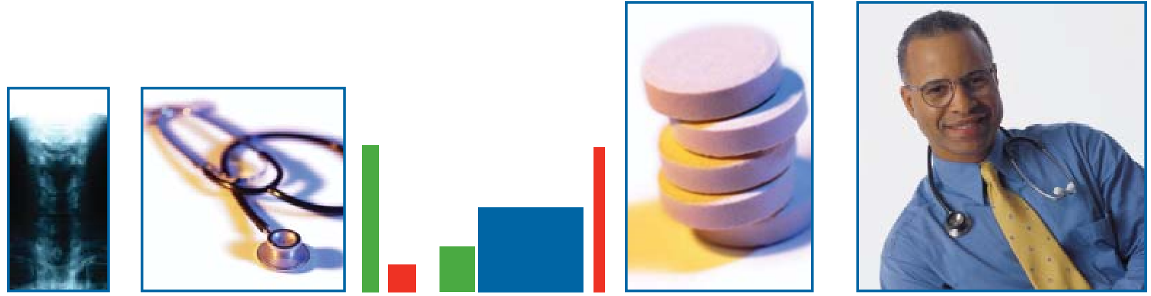
Medicaid

in North Carolina



Annual Report

State Fiscal Year 2005

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Governor

Carmen Hooker Odom
Secretary

L. Allen Dobson, Jr., M.D.
Assistant Secretary for Health Policy and Medical Assistance

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Chief Operating Officer

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This annual report was produced by the

North Carolina Department of Health and Human Services
Division of Medical Assistance

May 2006

Medicaid

in North Carolina

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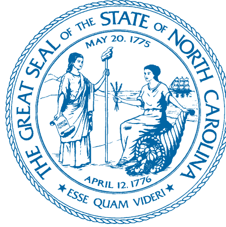
Division of Medical Assistance



North Carolina
Department of Health and Human Services
Division of Medical Assistance
Director's Office
2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
Carmen Hooker Odom, Secretary

L. Allen Dobson, Jr., M.D., Assistant Secretary
for Health Policy and Medical Assistance

May 2006

Dear Fellow North Carolinians:

It is my honor to present you with the enclosed copy of the North Carolina Medicaid Annual Report for State Fiscal Year 2005. The report is a testament to the fine work of the staff of the Division of Medical Assistance. I hope you enjoy reading this report, as I have, and gain additional insight into this complex and vital program.

Sincerely,

L. Allen Dobson, Jr., M.D.

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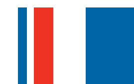

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Mission Statement and Goals

The mission of the Division of Medical Assistance is to provide access to high quality, medically necessary health care for eligible North Carolina residents through cost-effective purchasing of health care services and products.

In order to carry out this mission, DMA's goals for SFYs 2005 – 2007 are:

Budgetary Control *– we will successfully reduce costs and exceed our budgetary targets each year.*

Management rather than Regulation *– we will establish a culture of proactive healthcare management rather than a pure regulatory function for the division.*

Quality Improvement *– we will improve the care provided to Medicaid patients by reducing variability and promoting best practice standards by utilizing and expanding Community Care of North Carolina (CCNC).*

Accountability *– we will establish a culture of accountability within the agency and with provider groups by benchmarking and measuring all key services. We will aggressively eliminate unnecessary utilization of services and fraud.*

Customer Service *– we will identify the populations and groups that we serve and strive to meet or exceed agreed-upon expectations.*

Public Image *– we will improve the public image of the Division and the Medicaid program.*

Job Satisfaction *– we will make the Division a great place to work and will find ways to reward our colleagues.*

Executive Summary

meeting challenges

During State Fiscal Year (SFY) 2005, the North Carolina Medicaid Program successfully met the continued challenges posed by an increasingly uninsured or underinsured population. Coverage was provided to a larger number of eligible citizens, while both the utilization and cost of care were appropriately managed. The anticipated growth rate in the N.C. Medicaid Program decreased from 12.3 percent to 11.3 percent, which corresponded with the national trend for state Medicaid programs.

Approximately 18 percent of the total population of North Carolina was eligible for Medicaid coverage at some time during the year. Compared with the previous year, the state population rose by 1.5 percent; however, the number of Medicaid eligibles increased by 3.4 percent. The number of recipients was 1,585,238. The two largest categories of eligibles during the year were Pregnant Women and Children and Aid to Families with Dependent Children (AFDC), respectively.

Approximately $8.2 billion was spent during the year on health services and premiums, amounting to $5,154 per recipient. While total service and premium expenditures increased by 10.3 percent, the increase per recipient was only 7.3 percent above SFY 2004 expenditures. Within the total increase, non-long-term care expenditures grew by 8.8 percent and long-term care expenditures grew by 13.7 percent. Elderly and Disabled recipients comprised approximately 13 percent and 16 percent of total recipients, respectively; however, service expenditures for these two groups amounted to approximately $5.7 billion, or 70 percent of total Medicaid expenditures. Recipients from the Families and Children group represented approximately 70 percent of all recipients but accounted for approximately $2.4 billion, only 30 percent, of total service expenditures. The Prescription Drugs service category was the most expensive of all services. After deducting manufacturer's rebates, Prescription Drug expenditures totaled roughly $1.25 billion, or about 15.4 percent of total expenditures.

A variety of initiatives were undertaken to enhance the N.C. Medicaid Program. The following are just a few of these:

- *During SFY 2005, DMA received approval from the Centers for Medicare and Medicaid Services (CMS) to implement the N.C. Medicaid Family Planning Waiver for women between the ages of 19 and 55 and men between the ages of 19 and 60 with incomes at or below 185 percent of the federal poverty level.*

- *DMA collaborated with the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to develop and implement a pre-paid mental health managed care plan entitled Piedmont Cardinal Health Plan (PCHP). In April 2005, PCHP was launched as a pilot program in five counties.*

- *Through the activities of the Program Integrity Section, over a billion dollars was saved, recovered or cost avoided during SFY 2005.*

- *Community Care of North Carolina (CCNC), our managed care program, provided a variety of managed care options. As of the end of the fiscal year, 791,240 Medicaid recipients were enrolled in a managed care plan out of a total pool of 1,053,366 Medicaid managed care eligibles, or approximately 75 percent. CCNC improved access to care for recipients by providing a "medical home" while ensuring quality of care and contained health care*

costs. Mercer Human Consulting Group found that the disease and care management activities of CCNC have resulted in savings to the State budget in the amount of $60 million during SFY 2003 and $124 million during SFY 2004. Mercer also found that, through over-the-counter prescribing, CCNC saved the State $941,000 during the first two quarters of SFY 2005.

- *During SFY 2005, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services conducted a drug rebate program audit of the fifty state Medicaid programs in the nation and found that North Carolina is one of only four states with no problems in the billing or collection of drug rebates.*

- *The Quality Management (QM) Unit within the DMA's Managed Care Section continued efforts in quality improvement through studies and initiatives involving asthma care and management, adult preventive services, Health Check, immunizations and access to health care.*

- *N.C. Medicaid was one of only seven pilot states selected by CMS to participate in a national project called "Medi-Medi." The purpose of the project is to build a data warehouse consisting of all Medicare and Medicaid claims that can be data-mined to detect fraud and abuse.*

- *DMA developed a provider sanction process to promptly address instances of provider program abuse.*

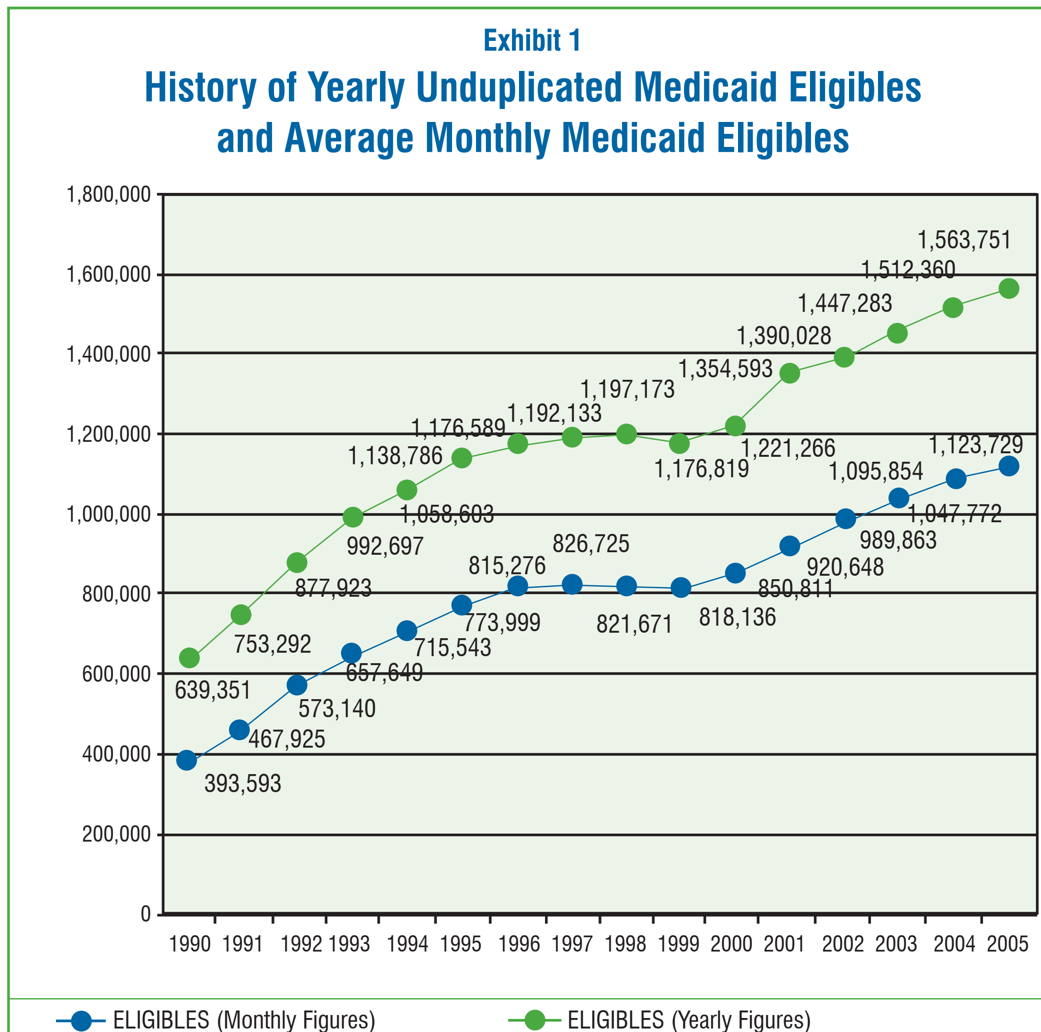
- *Through enhanced provider reimbursement rates and educational outreach efforts, the DMA Dental Unit continued its efforts to increase access to dental care for Medicaid recipients.*

- *The DMA Recipient and Provider Services Section continued its efforts to improve the process for enrolling health care providers into the N.C. Medicaid Program.*

How the N.C. Medicaid Program Works

Brief History

The State of North Carolina submitted its Medicaid State Plan to the Health Care Financing Administration in 1969 and received approval that year. Chapter 108A of the General Statutes is the law that implemented Title XIX in North Carolina on January 1, 1970 under the direction of the North Carolina Division of Social Services. G.S. 108A defined certain technical aspects of the North Carolina Medicaid Program not spelled out in federal law. North Carolina Administrative Code, Title 10A, Chapters 21 and 22, provide further definition of North Carolina Medicaid policy not addressed in federal law and regulation or in state law. Each year, new legislation that is passed by the North Carolina General Assembly establishes changes to the program and its policies such as eligibility and benefit coverage expansions and contractions, management and administrative mandates, special funding, etc.



In 1978, the Department of Human Resources (which has since been renamed the Department of Health and Human Services) created a new division within the department entitled the Division of Medical Assistance (DMA). The Medicaid program was transferred from the Division of Social Services to the new division at that time. From 1978 to 2005, the annual number of people eligible for Medicaid has increased from 456,000 to 1,563,751 and Medicaid service expenditures grew from approximately $307 million to $8.17 billion. As shown in the chart on the preceding page, the number of average monthly eligibles increased from 393,593 during SFY 1990 to 1,123,729 during SFY 2005.

In 35 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

Exhibit 2

What is Medicaid?

Title XIX of the Social Security Act is a federal entitlement program that pays for medical assistance for certain individuals and families with low incomes and resources. This program, known as Medicaid, became law in 1965 as a cooperative venture jointly funded by the federal and state governments (including the District of Columbia and the Territories) to assist states in furnishing medical assistance to eligible needy persons. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Within broad national guidelines established by federal statutes, regulations, and policies, each state (1) establishes its own eligibility standards; (2) determines the type, amount, duration, and scope of services; (3) sets the rate of payment for services; and (4) administers its own program. Medicaid policies for eligibility, services, and payment are complex and vary considerably, even among states of similar size or geographic proximity. Thus, a person who is eligible for Medicaid in one state may not be eligible in another state, and the services provided by one state may differ considerably in amount, duration or scope from services provided in a similar or neighboring state. In addition, Medicaid eligibility and services within a state can change during the year.

Source: Centers for Medicare and Medicaid Services

For further general information about the Medicaid Program, eligibility and services, please refer to CMS's article "Medicaid: A Brief Summary" online at:
http://www.cms.hhs.gov/MedicaidGenInfo/01_Overview.asp#TopOfPage

For specific information about the N.C. Medicaid Program's State Plan and amendments, please refer to CMS's article "Table of Contents for the State of N.C." at:
http://cms.hhs.gov/medicaid/stateplans/toc.asp?state=NC

modest percentage of its budget on administration, which during SFY 2005 was approximately $120 million, or 1.3 percent of total expenditures. The amount of $25.5 million, or 0.3 percent of total expenditures, was spent on DMA staff salaries and benefits.

Note: For a brief history of the N.C. Medicaid Program and a year-by-year record of program and policy changes over the years, please go to the following website:
http://www.dhhs.state.nc.us/dma/publications.htm

Medicaid Eligibility

Medicaid provides funding for health care to individuals who are eligible for one of the Medicaid coverage groups and who have low income and resources. In North Carolina, caseworkers in each of the 100 county departments of social services determine an individual's eligibility for Medicaid benefits based on policies established by the federal and state governments and as implemented by the State. Eligible families and individuals enrolled in the N.C. Medicaid Program are issued a Medicaid identification card each month. These individuals may receive medical care from any provider enrolled in the Medicaid program. Providers submit claims to DMA for reimbursement of services they provide to the Medicaid population.

Medicaid enrollees, applicants and caretakers who have questions regarding the N.C. Medicaid program may call or visit the county department of social services in which they reside or telephone North Carolina's toll free CARE-LINE Information and Referral Service (800-662-7030; TTY 1-877-452-2514). The CARE-LINE forwards calls regarding covered benefits to the appropriate DMA section, which ensures that questions are answered in a timely manner.

Funding the N.C. Medicaid Program

Federal, state and county governments jointly finance the N.C. Medicaid Program, with the federal government paying the largest share of the costs. In North Carolina, the 100 county governments contribute 15 percent of the non-federal share of costs. The federal share of costs for services is established annually by the Centers for Medicare and Medicaid Services (CMS). CMS calculates its share based on the most recent three-year average per capita income for each state and the national per capita income. As North Carolina's per capita income rises, the federal match for Medicaid declines, requiring the State and the counties to increase their share of Medicaid payments.

The established federal matching rates for services are applicable to the federal fiscal year (FFY), which is October 1 to September 30. The State's fiscal year (SFY) is July 1 to June 30. Because the federal and state fiscal years are not the same, 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.

Exhibit 3

N.C. Medicaid Eligibility by Mandatory and Optional Groupings

MANDATORY

- Aged, Blind and Disabled persons receiving SSI
- Medicare beneficiaries up to 100% FPL qualify for Medicare cost-sharing
- Medicare beneficiaries between 101% and 135% FPL qualify for payment of Part B premium; however, total enrollment is capped by appropriated federal funds for beneficiaries with income between 121% and 135% FPL
- Pregnant women and infants (under the age of 1) up to 150% FPL
- Children ages 1 through 5 up to 133% Federal Poverty Level (FPL)
- Children ages 6 through 18 up to 100% FPL (mandatory as of October 1, 2001)
- Families with children under the age of 19 who would have been eligible for AFDC in July 1996
- Foster children and adoptive children under Title IV-E

OPTIONAL

- Aged, Blind and Disabled not receiving SSI, including adult care home residents, 100% of poverty eligibles and medically needy
- Pregnant women and infants up to 185% FPL
- Children ages 19 and 20
- Non-IVE foster children and/or adoptive children with parents in families not eligible under AFDC rules in July 1996 (medically needy)
- Women screened by and enrolled in the N.C. Breast & Cervical Cancer Control Program
- Medically needy

Administrative Contracts

Certain functions of the Medicaid program are performed under contract. Some of the functions contracted include:

EDS Corporation – DMA contracts with EDS, Inc. to process claims, provide billing guidance, provide helpdesk services to enrolled Medicaid providers, conduct provider education seminars, operate the prior approval system for most Medicaid services and operate the N.C. Medicaid Management Information System (MMIS+).

under contract

The Carolinas Center for Medical Excellence, formerly Medical Review of North Carolina (MRNC) – DMA contracts with the Carolinas Center for Medical Excellence (CCME) to conduct quality assurance reviews of the services provided to recipients through the Community Alternatives Program for Disabled Adults (CAP/DA), Level of Care reviews for residents in Medicaid-certified nursing facilities, and the Health Maintenance Organization (HMO) contracts.

CCME also works with the DMA Program Integrity Section to: 1) evaluate provider DRG coding to identify improper reimbursement maximization and other potential incorrect billings and 2) assist in a federal Payment Accuracy Measurement (PAM) grant to determine the accuracy rate of Medicaid claim payments. DMA's participation as one of nine grant states will help develop a process to determine a national model for all states. Payment accuracy measurement has been subsequently mandated in federal law known as the "Improper Payments Reduction Act of 2002" (Ref. HR 4878).

CCME also processes the requests for prior approval of outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech/language, respiratory and audiological therapy regardless of where the services are provided.

Finally, CCME provides day-by-day, retrospective medical reviews of cases in order to determine whether the medical condition of undocumented aliens and legal aliens not qualifying for full Medicaid benefits meets the federal definition of "medical emergency."

Michigan Peer Review Organization (MPRO) – DMA began contracting with MPRO in April 2005 to perform the External Quality Review (EQR) activities for DMA for the health care services provided by Southcare (DMA's health maintenance organization in Mecklenburg County) and Piedmont Cardinal Health Plan according to the Federal requirements established in the Balanced Budget Act of 1997. MPRO performs three mandatory EQR activities following CMS protocols: Validation of Performance Improvement Projects; Validation of Performance Measures; and review of Compliance with State and Federal regulations. Other activities within this contract include Encounter Data Validation and Financial Analysis. MPRO prepares an Annual Technical Report (ATR) summarizing these activities, which is included in the State Quality Strategy.

ValueOptions (VO) – DMA contracts with ValueOptions for utilization review of acute inpatient/substance abuse hospital care, Psychiatric Residential Treatment Facilities (PRTF), Levels II through IV Residential Treatment Facilities (four beds or more), and outpatient psychiatric services. The contract encompasses all elective and emergency admission reviews, concurrent continued-stay reviews, and post-discharge reviews when applicable.

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.

Pharmacy Prior Approval Contract –Since SFY 2002, DMA has continued to utilize a prior authorization process for certain prescription drugs through a contract with ACS State Healthcare in Atlanta, Georgia. These prescription drugs were initially chosen, and are periodically updated, by a panel of clinical and academic physicians and pharmacists based on clinical criteria. Prior authorization allows N.C. Medicaid to ensure that these prescription drugs are used responsibly.

Optical Contract – N.C. Medicaid contracts with the N.C. Department of Correction's Nash Optical Plant to provide eyeglasses at predetermined rates. In most cases, providers of Medicaid eye care services must obtain eyeglasses through this organization.

Audit Contracts – The DMA Audit Unit contracts with several certified public accounting firms, such as Clifton Gunderson and Myers & Stauffer, to conduct onsite compliance audits of Medicaid-enrolled nursing facilities and intermediate care facilities for the mentally retarded (ICF-MR). They also conduct settlement activities for hospitals and state-operated nursing facilities and ICF-MRs. These audits supplement DMA's in-house audit activities and verify the accuracy of the providers' cost reports.

Blue Cross Blue Shield of Tennessee performs Medicaid settlement activities for Rural Health Clinics.

Mercer Government Human Services Consulting provides capitated rates for the Mecklenburg HMO and Piedmont Local Management Entity, as well as support for the pilot PACE Program in the Home-Based and Community Care Unit of DMA. Mercer also provides actuarial services for the Rate Setting Unit of DMA and assists the Pharmacy Unit of DMA with the State Maximum Allowable Cost list of drugs, analysis of the Prior Authorization Program, utilization reviews, and clinical evaluations of drugs and future Pharmacy initiatives.

Navigant Consulting and Myers & Stauffer provide assistance with cost settlement and activities associated with the Disproportionate Share and Supplemental Payment Programs.

Lastly, Clifton Gunderson provides assistance with audits for teaching hospitals, nursing facilities, teaching physicians and inpatient hospitals.

Fraud and Abuse Detection Systems (FADS) Contract with ACS – FADS software assists the Program Integrity Section in fraud and abuse activities by detecting "outliers" in provider practices and recipient usage of Medicaid services and pharmaceuticals.

Decision Support System (DRIVE) Contract with ACS – DRIVE is a data warehouse that mirrors the claims data in the MMIS+ system. This database can be interrogated to pull reports on specific information regarding usage, payments, classes of services, drugs and providers. DRIVE also supports FADS in seeking audit anomalies.

Provider Credentialing Contract with Credential Verification Services (PCVS) – Health care provider credentialing services under this contract ensure that providers who are seeking enrollment with N.C. Medicaid are eligible to participate.

Credit Balance Recovery Contract with Public Consulting Group (PCG) – Under this contract, PCG recovers any credit balance that a Medicaid recipient may have with a Medicaid-enrolled provider.

Partnerships

Although DMA administers Medicaid, other state and local agencies work closely in partnership with the program and perform important functions:

County Departments of Social Services – The department of social services (DSS) in each of North Carolina's 100 counties has the central role in determining Medicaid eligibility for their residents. In addition, counties contribute approximately 5 percent of the cost of services for Medicaid recipients (see Table 5 in the Tables Section of this report).

N.C. Division of Social Services (DSS) – The Division of Social Services conducts Medicaid recipient appeals when the person making the application contests eligibility denials.

N.C. Division of Vocational Rehabilitation Services (DVR) – DVR's Disability Determination Unit 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.

N.C. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) – DMA works closely with the DMH/DD/SAS to plan for and monitor community mental health services. These agencies also work cooperatively to operate the Community Alternatives Program for persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD), a valuable resource for providing community-based services as a cost-effective alternative to institutional care in an ICF-MR. Under the federal mandate for Preadmision Screening and Resident Review (PASARR), DMH/DD/SAS staff are authorized to make the final determination for service and placement needs for all those individuals identified with diagnoses for mental illness, retardation or related conditions (see the "Nursing Facility Prior Approval and Retrospective Review" section of this portion of the annual report).

N.C. Division of Public Health (DPH) – DMA and DPH cooperate in a number of efforts to improve care for

working together

people with HIV and AIDS. The AIDS Care Unit in DPH operates HIV Case Management Services (HIV/CMS) and the Community Alternatives Programs for Persons with AIDS (CAP/AIDS). DMA and DPH also cooperate in the provision of pediatric equipment for Medicaid-eligible recipients ages birth through 20 years old. The Women and Children's Health Section (WCH) within DPH operates a variety of health care programs that are Medicaid-funded. WCH and local health departments also play a central role in the operation of the Baby Love Program, a care coordination program designed to assure appropriate medical care for pregnant women. It also plays a key role in the Health Check Program, which provides preventive and other health care services for children. Both programs are discussed in more detail in the "Major Initiatives and Subprograms" section of this report.

State Center for Health Statistics (SCHS) – The SCHS, within DPH, supports a variety of N.C. Medicaid's data needs for program planning and evaluation.

N.C. Office of Research, Demonstrations, and Rural Health Development – The N.C. Office of Research, Demonstrations, and Rural Health Development, an agency within DHHS, provides technical assistance to small hospitals and community health centers in rural and medically under-served communities. This agency also recruits health care providers to work in these communities and provides grants for community health centers. It is the lead agency for demonstrations in the delivery and financing of health care for DHHS. Presently, the agency is working with DMA on the Community Care of North Carolina managed care program.

N.C. Division of Aging and Adult Services (DOAAS) – DMA and DOAAS staff work together on

many issues that are important to the aged and adult population. Jointly, DMA and DOAAS design a long-range plan of services for the elderly in North Carolina. In particular, DMA staff routinely participate in policy development projects on housing and in-home aide services.

N.C. Division of Facility Services (DFS) – DFS has the responsibility for licensing, certifying and monitoring nursing homes, hospitals and adult care homes in North Carolina. DFS ensures that all patients, including those covered by Medicaid, receive quality care if they reside in a facility.

N.C. Department of Public Instruction (DPI) – The Individuals with Disabilities Education Act (IDEA) is a federal law requiring education-related services to be provided to pre-school and school-aged children with special needs who are receiving special education services as part of an Individualized Education Plan (IEP) or Individualized Family Service Plan (IFSP). DMA works with DPI to provide Medicaid funding for those related services that are medically indicated, such as speech, physical, audiological and occupational therapies, as well as psychological services.

University of North Carolina at Chapel Hill (UNC-CH) – The UNC-CH School of Public Health and the Cecil G. Sheps Center for Health Services Research collaborate with DMA on a number of research projects and efforts to support program planning and evaluation.

University of North Carolina at Charlotte (UNC-C) – Faculty within UNC-C has conducted evaluations of patient satisfaction with the Health Care Connection, N.C. Medicaid's mandatory HMO program in Mecklenburg County. They have also carried out and reported on a primary care provider availability survey for Carolina ACCESS.

N.C. Association of Pharmacists, N.C. Association of Community Pharmacists, Chain Pharmacy Committee of the N.C. Retail Merchants Association, and the Long-Term Care Pharmacy Alliance – These associations have entered into an agreement with DMA to reduce Medicaid drug costs. Under the agreement, pharmacists will help move patients to more cost-effective generic drugs. This will be done by educating prescribing physicians on the cost savings that are possible through use of generic drugs, and working closely with them to attain these savings as appropriate.

Covered Services

N.C. Medicaid covers a comprehensive array of preventive and treatment services for eligible enrollees (see Exhibit A-5). Preventive services include one annual physical for adults and child health screenings provided under the Health Check (Early Periodic Screening and Diagnostic Testing or EPSDT) Program. Treatment services address virtually all acute and chronic illnesses.

Medicaid has certain standard limitations on services. These include a limit on visits per year to practitioners, clinics and outpatient departments. Prenatal services, dental services and mental health services that are subject to independent utilization review are not subject to this limit. Exemptions from this limit include services provided to recipients:

- *with end-stage renal disease;*
- *undergoing chemotherapy and/or radiation therapy for malignancies;*
- *with sickle cell disease;*
- *with hemophilia or other blood clotting disorders;*
- *under the age of 21; or*
- *enrolled in a Community Alternatives Program.*

Medicaid recipients are limited to six prescriptions per month. However, recipients under the age of 21 and recipients enrolled in a Community Alternatives Program are not subject to this limitation. Recipients being treated for one of the conditions listed below may be exempted from the dispensing limitation if it is deemed medically necessary by the recipient's primary prescribing physician:

- *end-stage renal disease;*
- *malignancies requiring chemotherapy and/or radiation therapy;*
- *sickle cell disease;*
- *hemophilia or other blood clotting disorders;*
- *unstable diabetes;*
- *end-stage lung disease; or*
- *terminal stage of any illness or any life-threatening illness.*

Co-payment requirements are indicated in Table 15 in the Tables Section of this report. Co-payments do not apply to recipients who are under the age of 21 or those who are enrolled in a Community Alternatives Program, those receiving services related to pregnancy, or those receiving family planning services.

Some services, procedures and products also require prior approval to verify medical necessity or to ensure that the care that is received is appropriate and efficacious.

Providers of Care

preventive treatment

During SFY 2005, over 54,000 enrolled Medicaid providers offered a wide variety of services to North Carolina's Medicaid population (see Table 3). Many providers are enrolled in more than one type of service and participate with a group as well as individually. DMA's Provider Services Unit oversees the enrollment of new providers in the N.C. Medicaid Program and maintains licensing and credentialing information for providers enrolled with Medicaid.

During 2003, Medicaid began a policy to terminate the enrollment of providers who have not billed the Medicaid Program within the previous 12 months. Providers are notified by mail of DMA's intent to terminate their inactive number and have two weeks to respond if they wish to request that their number not be terminated. These notices are sent to the current mailing address listed in the provider's file. Once terminated, providers are subject to the full re-enrollment process and can experience a period of ineligibility as a Medicaid provider.

This policy also addresses the problem of having an incorrect billing address in the provider's file. If remittance advices and checks cannot be delivered due to an incorrect address, all claims for the provider are suspended and the subsequent remittance advice and/or checks are no longer printed. Automatic deposits are also discontinued. Once a suspension has been placed on the provider, the provider has 90 days to submit an address change. If after 90 days the address has not been corrected, claims in suspension will be denied and the provider's enrollment is terminated.

Providers are notified in writing and have 21 days from the date of the letter to respond to DMA Provider Services. If the letter is returned to DMA as undeliverable, the provider's enrollment is terminated.

Exhibit 4

Services Covered By N.C. Medicaid, By Mandatory And Optional Categories

MANDATORY

- Hospital Inpatient
- Hospital Outpatient
- Psychiatric Residential Treatment Facility Services and Residential Services (treatment component only) for under age 21
- Other Laboratory and X-ray
- Nursing Facility
- Physician
- Home Health
- Health Check (EPSDT)
- Family Planning
- Durable Medical Equipment
- Nurse Midwife and Nurse Practitioner
- Hearing Aid
- Medical Transportation
- Federally Qualified Health Centers & Rural Health Centers

OPTIONAL SERVICES

- Clinical Services
- Community Alternatives
- Diagnostic Testing
- Intermediate Care Facilities for the Mentally Retarded
- Personal Care
- Prescription Drugs
- Dental and Dentures
- Eye Care
- Mental Health
- Chiropractor
- Podiatrist
- Physical and Occupational Therapy and Speech/Language Pathology
- Respiratory Therapy for Children
- Hospice
- Private Duty Nursing
- Home Infusion Therapy
- Case Management
- Nurse Anesthetist
- Preventive Services
- Rehabilitative Services
- Orthotic and Prosthetic Devices
- Screening
- Transportation
- HMO Membership

Note: All optional services are available to children under age 21 if they are medically necessary.

Rate Setting

Payment rates and fee schedules are very important in controlling Medicaid program costs. Taking into account the level of funding provided by the N.C. General Assembly, payment rates are established according to federal and state laws and regulations. In-depth analysis of provider costs is required to ensure fair and reasonable reimbursement of services. DMA reviews, monitors, and adjusts over 500,000 reimbursement rates annually which relate to over 100 different provider types and 100 different provider specialties.

Program Integrity

DMA's Program Integrity Section is tasked with multiple responsibilities. These include:

- *Identifying fraud, abuse, waste, and administrative overpayments in Medicaid billings by health care providers;*
- *Coordinating recipient fraud and abuse identification with the county departments of social services;*
- *Determining the accuracy of Medicaid eligibility determinations by the county departments of social services and claim payment accuracy for claims paid by the Medicaid program;*
- *Collecting money and cost avoiding Medicaid payments when a third party is responsible for paying for the Medicaid service; and*
- *Ensuring, through prospective and retrospective drug use reviews, that outpatient drugs dispensed to Medicaid recipients are appropriate, medically necessary, and not likely to result in adverse medical effects.*

The efforts of the Program Integrity Section promote program fiscal efficiency of Medicaid money spent and the services rendered.

determining accuracy

Medicaid Eligibility Error Rate Reduction and Quality Assurance

Program Integrity's Quality Assurance (QA) Section is responsible for monitoring the accuracy rate of eligibility determinations made by the county departments 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. Error trends, error-prone cases, and other important error reduction information are communicated quickly to eligibility staff. DMA then works with the counties to promote corrective actions whenever appropriate. County eligibility supervisors then conduct evaluations and training and make the necessary adjustments to eliminate errors and to prevent future mistakes.

North Carolina has never been penalized for exceeding the three percent federal tolerance level for payment error rates. North Carolina's low payment error rate is the result of a successful partnership between DMA and North Carolina's counties.

QA also coordinates with the counties on recipient fraud and abuse identification, prevention, detection, training and recovery.

Investigation of provider fraud, abuse or administrative errors

Program Integrity staff use sophisticated computer software in a unique fraud and abuse detection system. The software programs identify unusual patterns of utilization of services by recipients and providers.

Medical desk reviews or site visits are conducted for those providers or recipients whose medical practice or utilization of services appears outside comparative norms. Additionally, the staff investigates fraud complaints and allegations from many internal and external sources, including calls made to the CARE-LINE to report fraud. 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; and*
- *Evaluating the medical claims processing procedures for accuracy and improvement.*

When an administrative overpayment is found, staff recovers it from the provider. When possible fraud or abuse is suspected, the Attorney General's Medicaid Investigations Unit reviews it for criminal or civil prosecution.

DMA operates several other programs directly or under contract to ensure that Medicaid funds are spent appropriately. These programs are designed to prevent and recover incorrect payments. DMA contracts with CCME to evaluate DRG coding to identify improper reimbursement maximization and other potentially fraudulent billing practices. In addition, paid claims are reviewed periodically and those that differ significantly from established norms are analyzed to determine whether the services were medically necessary and appropriate.

Third-Party Recovery (TPR)

Medicaid is, by Federal law, the payor of last resort. As a condition of receiving Medicaid benefits, recipients agree to allow Medicaid to seek payment from available third-party health care resources on their behalf. All other third-party resources must be used before Medicaid dollars are spent. These resources, such as health and casualty insurance and Medicare, are important means of keeping Medicaid costs as low as possible.

Utilization Management and Prior Approval Activities

Utilization Management

Utilization management activities ensure optimal health care delivery in a cost-effective manner to Medicaid-eligible individuals. These activities are conducted jointly by the Division of Medical Assistance (DMA) and the fiscal agent or through a contract with DMA. Utilization management is used to verify medical necessity and to authorize services, including insuring that continuing care is provided appropriately and effectively.

CAP Utilization Review

CAP/DA cases, randomly selected on a monthly basis from among all lead agencies for CAP, are monitored

by CCME. Quality assurance (QA) reviews determine that clients are classified correctly at either intermediate care or skilled nursing levels of nursing facility care. The review also determines that clients have been given the option to choose home care versus nursing home placement; that the plan of care is relevant to the assessed needs of the clients; and that the health, safety, and well-being of clients is reasonably assured by the services provided. Results of the monthly monitoring of each agency are reviewed by DMA CAP consultants and then shared with the agency under review. The findings enable the agencies to improve the manner in which CAP/DA is operated. The QA review process is not a negative process, but one that leads to the strengthening of programs, enabling agencies to better serve individuals who have nursing facility needs but opt for the range of home care services available through CAP/DA.

Prior Approval

Prior approval may be required to verify medical necessity before rendering some services. Health care providers identify the need for services that require prior approval, then complete and submit the state-specified prior approval request form and any applicable supporting documentation. Services requiring prior approval include, but are not limited to:

- *certain prescription drugs;*
- *behavioral health;*
- *outpatient specialized therapies;*
- *managed care referral authorization and utilization management;*
- *certain surgeries, including transplants;*
- *visual aids;*
- *hearing aids;*
- *certain durable medical equipment items;*
- *dental services;*
- *out-of-state services;*
- *nursing facilities;*
- *Community Alternative Programs (CAP);*
- *adult care home enhanced personal care services; and*
- *private-duty nursing.*

optimal delivery

Nursing Facility Prior Approval

In order for Medicaid to pay for placement in a nursing facility, an individual must meet both financial and medical eligibility requirements. The county departments of social services have the responsibility of determining financial eligibility. DMA contracts with its fiscal agent, EDS, to determine medical eligibility by utilizing a prior approval process. Prior approval does not guarantee financial eligibility or Medicaid payment.

In addition to the prior approval process, N.C. Medicaid is federally mandated to perform preadmission screening, as a part of the Preadmission Screening and Annual Resident Review (PASARR) process, for all residents applying for, or residing in, a Medicaid-certified nursing facility. This statutory requirement became effective January 1989 as a result of the Omnibus Budget Reconciliation Act (OBRA) for 1987 (P.L. 100-203). This section of OBRA was enacted to ensure that recipients with serious mental illness, mental retardation or related conditions entering into or residing in Medicaid-certified nursing facilities receive appropriate placement and services. The pre-admission screen (Level I and, if appropriate, Level II) must be completed and the special identification number, known as the PASARR number, must be documented on the state-approved prior approval form (the FL2/FL2e). This must be completed prior to admission to a Nursing Facility.

N.C. Medicaid has one level of care for nursing facilities. The FL2/FL2e form is used to document information specific to the individual including diagnosis, special care needs and the PASARR number. This information is used to determine the appropriate care needs for the individual. The FL2/FL2e must be completed with

current information, signed and dated by the physician, and then sent to EDS for evaluation.

Effective July 1, 2003, providers were permitted to submit FL2 information for nursing facility prior approval authorizations electronically to EDS by using a service developed by ProviderLink, Inc. This company provides web-based communications technology to enable health care providers and payers to manage all of their patient-related external communication through a single browser interface.

Prescription Drug Prior Approval

Beginning March 4, 2002, DMA implemented a prior authorization process through a contract with ACS State Healthcare in Atlanta, Georgia, for certain prescription drugs. These prescription drugs were chosen based on clinical criteria by a panel of clinical and academic physicians and pharmacists. Prior authorization allows N.C. Medicaid to ensure that these prescription drugs are used responsibly and as intended. The prescription drugs that require prior authorization are:

- *Procrit, Epogen, Aranesp;*
- *Neupogen;*
- *OxyContin;*
- *Growth Hormones;*
- *Provigil;*
- *Celebrex (for persons 59 years of age or younger); and*
- *Botox and Myobloc.*

Behavioral Health Prior Approval

Prior approval is required for all psychiatric/substance abuse inpatient hospital care, all psychiatric residential treatment facility (PRTF) care for recipients under the age of 21, all residential treatment Levels of Care II through IV, and all services under the behavioral health rehab options (called enhanced benefit services) after 8 outpatient therapy visits for adults and after 26 outpatient visits for recipients under the age of 21. Either ValueOptions or a DHHS-approved local management entity (LME) performs these utilization reviews.

Medicaid recipients age 21 and over receiving outpatient mental health services require prior approval after the 8th visit. This includes area mental health programs and private providers. This process replaces the policy of requesting prior approval after the 2nd visit for non-area mental health programs.

The 24-office visit limitation per year for services by a private provider was removed and replaced by the requirement for prior approval after the 8th visit for mental health services subject to independent utilization review. Approval is based on medical necessity.

Outpatient Specialized Therapies Prior Approval

Beginning October 1, 2002, prior approval became a requirement for outpatient specialized therapy services provided to Medicaid recipients. Therapy services encompass all outpatient treatment for occupational, physical, speech/language, respiratory and audiological therapy, regardless of where the services are provided, as well as psychological services in the schools. The prior approval process for services provided in the schools is

met by the Individualized Education Program (IEP) process. All other prior approval functions are carried out through a contract with Carolinas Center for Medical Excellence (CCME). Based on DMA's clinical policy, approved medical necessity criteria, and medical judgment, the CCME Prior Approval Unit is authorized to approve, modify or deny the request. Validation reviews are performed by CCME with review findings sent to DMA on a quarterly basis.

Managed Care Referral Authorization and Utilization Management

Each recipient who is enrolled in Community Care of North Carolina either chooses, or is assigned to, a primary care provider (PCP). The PCP serves as "gatekeeper" for the recipient in achieving the dual goals of improving access to care while reducing unnecessary costs. The PCP is expected to provide 24-hour, 7-day per week access to medical care for enrolled members and to arrange for after-hours coverage and authorization for appropriate referrals for specialty care as needed. The PCP provides the referral physician with an authorization number that must appear on the medical claim to ensure Medicaid reimbursement.

From the perspective of the Managed Care Section, utilization management is a process that is used to ensure that appropriate services are delivered to Medicaid enrollees through the identification of aberrant utilization patterns and potential quality of care issues. The process provides the opportunity to identify areas to target for the development of quality improvement activities. Utilization Management also serves to provide the Managed Care Section with cost data based on service utilization, which affords cross-analysis of the efficiency and effectiveness of managed care program types.

Each Carolina Community Care of North Carolina provider receives quarterly utilization reports and

primary care

monthly emergency department and referral reports. Data contained in these reports are extracted by EDS from paid claims data. These utilization reports include both inpatient and outpatient utilization statistics and are useful for peer performance comparisons. The Managed Care Quality Management Unit produces internal reports that stratify the data according to provider specialty and the number of enrollees per provider.

Participating managed care organizations (MCOs) – of which there was only one during SFY 2005, located in Mecklenburg County – are required by contract to have a written utilization management program that is consistent with federal regulations and includes mechanisms to detect under-/over-utilization of services. The written description must address procedures to evaluate medical necessity, the criteria used, information sources, and the process used to review and approve the provision of medical services. MCOs are also required to submit encounter data to EDS within 90 days from the end of the month in which the service was rendered. Additionally, MCOs are required to submit Health Plan Employer Data and Information Set (HEDIS) data, emergency department visits, inpatient utilization, ambulatory surgical procedures, OB discharges, and newborn data derived from their internal data collection systems to DMA on an annual basis. DMA and EDS continue to work with the sole MCO to develop an encounter reporting process that provides data that accurately reflects the delivery of services to enrollees.

Major Initiatives and Subprograms

The N.C. Medicaid program has developed a number of initiatives and subprograms to meet federal or state government mandates, to respond to recipient lawsuits, to meet specific medical needs identified among Medicaid recipients, or to give recipients better access to care or more care options. Some of these programs are only available to specific groups of recipients, such as pregnant women, and some are available to all. Services under the various subprograms are not necessarily mutually exclusive; a recipient may be eligible to receive services from a number of subprograms.

Managed Care

Managed care options for Medicaid recipients are available in all 100 North Carolina counties. Most, but not all, Medicaid-eligibles qualify for managed care. As of the end of SFY 2005, there were 791,240 Medicaid-eligibles enrolled in a managed care plan out of a total of 1,053,366 Medicaid managed care eligibles, or approximately 75 percent. Managed care program options include Carolina ACCESS and Community Care of North Carolina.

Eligibility to participate in a managed care plan is mandatory for the majority of Medicaid recipients in North Carolina. Although recipients of Medicaid who are dually eligible for Medicare and Medicaid 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.

- **Carolina ACCESS** – *A primary care case management model (PCCM), characterized by a primary care provider gatekeeper.*
- **Community Care of North Carolina** – *This program is built 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 health care. This program was originally created as a healthcare demonstration project by the N.C. Office of Research, Demonstrations, and Rural Health Development, and is currently a joint collaborative effort between that office and DMA.*
- **Healthcare Connection/Risk Contracting** – *A program operating in Mecklenburg County requiring a majority of the Medicaid recipients in the county to enroll in either the health maintenance organization (HMO), Carolina ACCESS or Community Care of North Carolina. The recipient is free to choose one of these options. DMA has an existing contract with one HMO in Mecklenburg County to provide and coordinate medical services for certain eligibles on a full risk-capitated basis. The state must license any HMO that contracts with DMA.*

For all of these healthcare models the objectives are:

- *cost-effectiveness;*
- *appropriate use of healthcare services; and*
- *improved access to primary preventive care.*

Maternity and Child Health

Providing preventive medical services and basic medical care for mothers and children is a continuing priority for the Medicaid program and for the State of North Carolina. Medicaid covered 56,701 of the 119,773 live births in North Carolina, or 47.3 percent, during SFY 2004 (the most recent fiscal year for which data were available). Medicaid coverage is federally mandated for children with family incomes below 100 or 133 percent

of the federal poverty level, depending on the age of the child. Over the years, North Carolina has taken advantage of federal options to expand Medicaid coverage to pregnant women and children with incomes ranging up to 185 percent of the poverty level. Since implementing the initiatives and programs described below, North Carolina has experienced many positive outcomes, including reductions in the infant mortality rate and better access to preventive health care for Medicaid recipients and low-income children.

Baby Love

Implemented in October 1987, the Baby Love Program was designed to reduce North Carolina's high infant mortality rate by improving access to health care and the service delivery system for low-income pregnant women and children. Jointly administered by DMA and the Division of Public Health (DPH), the program enables pregnant women up to 185 percent of the federal poverty level to receive comprehensive care through a Medicaid benefit package. This package includes targeted case management services, childbirth education classes, in-home nursing care for high-risk pregnancies, medical nutrition therapy, health and behavior intervention, and postpartum/newborn home visits. Maternity Care Coordination Program (MCCP) staff, including nurses, social workers, and paraprofessionals, assist women in accessing medical care and support services. MCCP services are available in every county in North Carolina. Since the inception of the program, the infant mortality rate in North Carolina has decreased from 14.9 infant deaths per 1,000 live births in 1987 to 8.8 infant deaths per 1,000 live births in 2004; the lowest infant mortality rate recorded was 8.2 infant deaths per 1,000 live births in 2002 and 2003.

Health Check

In 1993, North Carolina expanded the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program to form Health Check. Health Check encourages regular preventive health care and the diagnosis and treatment of any health problem detected during a screening. Medicaid recipients under the age of 21 are automatically eligible for Health Check services.

An integral part of the Health Check program is a special initiative called the Health Check Outreach Project. Specially trained Health Check Coordinators work through this program to reduce barriers and educate families on the importance of preventive health services. Recently, a plan was endorsed by the N.C. Health Directors Association to expand Health Check Coordinators statewide. This plan will eventually place Health Check Coordinators in all 100 counties by reallocating existing positions. Currently, Health Check Coordinators are located in 91 counties as well as the Qualla Boundary (the reservation of the Eastern Band of Cherokee Indians).

DMA's Managed Care Section is the administrative entity for the Health Check Program and coordinators. The Managed Care Section works closely with the Division of Public Health's Women and Children's Health Section to provide guidance to the counties.

The Health Check Automated Information and Notification System (AINS) is a computerized system for identifying and following the health care activities of Medicaid-eligible children. It enables Health Check Coordinators to determine which Medicaid-eligible children in their respective counties are receiving

regular and interperiodic Health Check screenings, immunizations, and referrals for special health care problems. AINS generates notices to the parents of Medicaid-eligible children, notifying them of the Health Check Program, scheduled screening appointments, immunizations, and available programs and services. For children enrolled in a Medicaid managed care program, the name of the Community Care primary care provider or the HMO appears on letters sent to providers to whom referrals are being made. Access to and utilization of health care services for Medicaid-eligible children and youth have improved since the program was initiated.

Local Education Agencies

Medicaid is a critical source of health care coverage for children. Thus, in order to assure that a comprehensive array of services is accessible to the children, Medicaid pays for certain health-related services provided within the public schools and Head Start programs. The school setting provides an opportunity to enroll eligible children in the Medicaid program as well as assist children who are already enrolled in Medicaid to access benefits that may be available to them. Medicaid pays for certain health-related services that are provided to special education children at considerable costs to state and local school districts through their Individualized Education Program (IEP). Direct medical services that are currently available within the LEA setting are audiology, speech/language, occupational therapy, physical therapy, and psychological/counseling services. Nursing, an additional service, is in the process of being added. In addition to providing funding for the direct medical service, Medicaid also provides reimbursement for administrative activities in support of delivering the direct medical service. Providing funding for these services within the school environment improves access of these services to eligible children who otherwise may not be able to obtain these medically necessary services.

Practitioner and Clinical Services

Practitioner and Clinical Services comprise services provided by:

- *ambulance services;*
- *ambulatory surgery centers;*
- *anesthesiology services;*
- *birthing centers;*
- *child services coordination;*
- *chiropractors;*
- *clinic services;*
- *dialysis services;*
- *laboratories;*
- *maternity care coordination services;*
- *nurse midwives;*
- *nurse practitioners;*
- *outpatient hospital services;*
- *physicians;*
- *podiatrists; and*
- *radiology services.*

The annual updates of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes occur in this program area. During this fiscal year, staff completed the intense process of documenting all current policies and provided the necessary input for the construction of the new MMIS+ system.

Long-term Care

The N.C. Medicaid program spends a large portion of its service dollars (approximately 33 percent) on long-term care. Long-term care includes institutional care (all nursing facility and hospital long-term care) and home and community-based care (home health, durable medical equipment, Community Alternatives Programs,

home infusion therapy, hospice, adult care home and personal care services). As indicated in Exhibit 7 on page 42, total expenditures for long-term care during SFY 2005 were approximately $2.7 billion, an increase of 13.7 percent over the previous year.

Facility Care Services:

Nursing Facility Care

There are times when nursing facility care is the best option for Medicaid recipients. Nursing facility reimbursement rates are based on the average state nursing facility per diem rate. The rates are determined by use of the Resource Utilization Groups (RUG)-III, case mix reimbursement system.

Medicaid allows an individual with a spouse living in a nursing facility to keep a larger portion of the couple's income than normally allowed under Medicaid eligibility rules. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The income of the spouse living at home is considered in determining whether an allowance is budgeted. The total income and resources amount that may be protected for the at-home spouse increases each year.

All Medicaid recipients must receive prior approval before admission to a nursing facility. Prior approval is given only if recipients meet the State's medical criteria for admission. There is also a federal requirement for preadmission screening and annual resident review (PASARR) to screen and evaluate applicants and residents of Medicaid-certified nursing facilities for mental illness, mental retardation, developmental disabilities, and related conditions.

In SFY 2005, a total of 43,051 Medicaid recipients received care in nursing facilities at a cost of approximately $1.08 billion.

Intermediate Care Facilities for the Mentally Retarded

Intermediate Care Facilities for the Mentally Retarded (ICF-MR) are long-term care facilities for the mentally retarded/developmentally disabled who meet certain federal criteria. The criteria include the need for active treatment for individuals who have mental retardation or a related condition and who have a severe, chronic disability. ICF-MR facilities must meet certification requirements relating to the provision of habitable services as well as basic intermediate care services. ICF-MRs are paid prospective per diem rates. During SFY 2005, a total of 4,509 recipients were treated in ICF-MRs at a total cost of $408 million.

Home and Community-Based Services

Home and community-based long-term care is a cost-effective and preferable alternative to institutionalization. Medicaid recipients can receive several home-based services such as home health, personal care services, home infusion therapy and hospice.

Adult Care Home Personal Care Services

Since 1995, N.C. Medicaid covers Basic Personal Care Services for residents in Adult Care Homes who are eligible for Special Assistance for Adults (SA) and

Medicaid. With prior approval, Medicaid has covered Enhanced Personal Care Services since 1996 for residents of Adult Care Homes who meet criteria for significant or total assistance with toileting, eating and/or ambulation/locomotion.

In SFY 2005, a monthly average of 19,972 persons received Basic Personal Care Services at an annual cost of $137 million. A monthly average of an additional 3,370 North Carolinians received Enhanced Personal Care Services in Adult Care Home settings at an annual cost of $9 million. And a monthly average of 19,535 persons received non-medical transportation services related to the Adult Care Home program at an annual expense of $4 million.

Home Health

Home health services include medically necessary skilled nursing care, specialized therapies (physical therapy, occupational therapy and speech therapy), home health aide services, and medical supplies needed for diagnosis, treatment or rehabilitation of a recipient's illness in the home setting when provided by a Medicare-certified home health agency. The services may be provided in the recipient's private residence or in an adult care home (exception: home health aide services in the adult care home). The services are considered part-time and intermittent and must be provided under a plan of care authorized by the patient's physician. In SFY 2005, a total of 38,825 (monthly average of 15,729) recipients were served at a cost of $110 million.

Hospice

Hospice, which is elected by the recipient, is a benefit package of medical and support services for terminally ill individuals. An individual is considered terminally ill if he or she has a medical prognosis of a six-month or less life expectancy as certified by a physician. The services include nursing care, medical social services, counseling, the professional care of a physician, in-home aide services, home management services, physical and occupational therapy, speech/language pathology, medical appliances and supplies, drugs and biologicals, and short-term inpatient care (general and respite) when related to the terminal illness. The services are provided in a private residence, an adult care home, a hospice residential care facility, or a hospice inpatient unit. The services also may be provided in a hospital or nursing facility under arrangement with the hospice agency. In SFY 2005, a total of 4,804 (monthly average of 1,157) recipients were served at an annual cost of $42 million.

Home Infusion Therapy

Home Infusion Therapy (HIT) provides for infusion nursing services, pharmacy services, medical equipment, supplies and training. HIT is for self-administration (by the recipient or unpaid caregiver) of a drug or nutrition therapy such as total parenteral nutrition, pain management or antibiotics. The route of administration may be intravenous, enteral, parenteral or epidural. HIT services are available for recipients who live in a private residence or an adult care home. In SFY 2005, a total of 2,271 (monthly average of 479) recipients were served at an annual cost of $7 million.

Private Duty Nursing

Private Duty Nursing (PDN) services are available for recipients who live in a private residence and require substantial, complex and continuous skilled nursing care as ordered by the attending physician. PDN must be prior approved and be supported by a physician's letter of medical necessity. In SFY 2005, a total of 371 (monthly average of 255) recipients were served at an annual cost of $44 million.

Personal Care Services

In-home Personal Care Services (PCS) cover personal aide services in private residences to perform personal care tasks for recipients who, due to a debilitating medical condition, need help with such basic personal activities as bathing, toileting and moving about. Aides also monitor the patient's vital signs. Services may also include housekeeping and home management tasks that are integral, although secondary, to the personal care tasks necessary for maintaining the patient's basic personal health. PCS is provided for the patient according to a physician's authorized plan of care. Recipients are eligible to receive up to 60 hours of PCS per month depending on their needs. Recipients who receive prior approval from DMA may be eligible for an additional 20 hours of PCS if they meet more stringent eligibility criteria. These additional hours are available through the PCS-Plus program. In SFY 2005, a monthly average of 31,589 recipients were served at an annual cost of $277 million.

HIV Case Management

HIV Case Management is a targeted case management program funded by N.C. Medicaid. The program is operated jointly by DMA and the Division of Public Health (DPH). While DMA has administrative oversight of the program, the day-to-day operations are managed by the AIDS Care Unit within DPH. In SFY 2005, a total of 2,614 (monthly average of 1,274) recipients were served at an annual expense of $8 million.

Community Alternatives Program:

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities

Community Alternatives Program for Persons with Mental Retardation/Developmental Disabilities (CAP-MR/DD) is a special Medicaid home and community-based "waiver" program. It was implemented in 1983 to serve individuals who would otherwise qualify for care in an ICF-MR. It allows these individuals the opportunity to be served in the community instead of residing in an institutional setting. The Medicaid cost for community care must be cost-effective in comparison to the cost of ICF/MR care. 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 a monthly average of 5,989 people in SFY 2005 at an annual cost of $266 million. The average monthly cost per recipient of CAP-MR/DD services was approximately 40 percent of the average cost of care at a state-owned ICF/MR facility and 61 percent of that at a non-state-owned facility.

Community Alternatives Program for Children

Community Alternatives Program for Children (CAP/C) is a Medicaid waiver program that provides

home-based care for medically fragile children through age 18. Participants must meet criteria for medical necessity and must be at risk for institutionalization. CAP/C provides skilled nursing or "in-home" aides, case management and other waiver services. The case manager is responsible for developing a plan of care and a budget that is based on the level of care determination. In SFY 2005, a total of 762 (monthly average of 574) recipients were served at an annual cost of $26 million.

Community Alternatives Program for Persons with AIDS

Community Alternatives Program for Persons with AIDS (CAP/AIDS) provides home based care for persons with AIDS. This waiver program is a cooperative effort between DMA and DPH. The AIDS Care Unit, within DPH, handles the program's operation, including approving plans of care, with DMA providing oversight. Local CAP/AIDS case management agencies are the entry point. There is a federal limit on the total unduplicated number of participants each year. The program provides an alternative to nursing home placement. If approved for the program, recipients are potentially eligible for special waiver services in addition to regular Medicaid services. In SFY 2005, a total of 131 (monthly average of 84) recipients were served at an annual expense of $2 million.

Community Alternatives Program for Disabled Adults

Community Alternatives Program for Disabled Adults (CAP/DA) provides a package of services to allow adults (ages 18 and older) who qualify for nursing facility care to remain in their private residences. CAP/DA has been the state's primary answer to controlling the growth of nursing facility expenditures while addressing quality of life issues for the expanding population of frail elderly and disabled adults. CAP/DA offers North Carolina the only significant avenue for complying with the requirements of the Olmstead Act for the frail elderly and physically disabled adults. The program served a total of 13,620 (monthly average of 9,784) citizens in SFY 2005 at a yearly cost of $226 million.

Ancillary Services

Durable Medical Equipment

Medicaid pays for durable medical equipment (DME) when it is medically necessary for a recipient to function in his or her home or an adult care home. The list of covered items includes wheelchairs, hospital beds, blood glucose monitors, ambulation devices, enteral formulas, bedside commodes, oxygen and respiratory equipment, and miscellaneous supplies used with DME. Orthotic and prosthetic devices, including braces and artificial limbs, are also covered. The patient's physician must order the items and document medical necessity on the Medicaid Certificate of Medical Necessity and Prior Approval form. Some items require prior approval. All DME, orthotic and prosthetic, and related supplies have established lifetime expectancies and quantity limitations. During SFY 2005, a monthly average of 45,115 recipients received DME services at annual expense of $75 million.

Independent Practitioner Program

The Independent Practitioner Program enrolls and reimburses individual independent practitioners to provide physical, occupational and respiratory therapy, speech/language pathology and audiological services to children from birth through 20 years of age.

Optical Services

The Optical Services Program is responsible for the overall administration of vision care services covered in the N.C. Medicaid Program. The Optical Services Program covers eye exams and materials and services related to the provision of visual aids, which include corrective eyeglasses, medically necessary contact lenses and other visual aids. Prior approval is required for all visual aids. There are limitations regarding the frequency of eye examinations and the number of dispensed visual aids during specific eligibility periods. Eye examinations in excess of these limitations require prior approval. A $3 copayment is applicable to ophthalmological visits, while a $2 copayment applies to visual aids. Although a $2 copayment is generally required for new eyeglasses, eyeglass repairs and contact lenses, there are some exemptions.

Medicaid eyeglasses are supplied by the Nash Correctional Institution's Optical Plant through a contractual agreement with Correction Enterprise, a division of the N.C. Department of Correction. Providers must obtain Medicaid eyeglasses through this laboratory. Prior approval for exceptions may be granted under extenuating circumstances.

Hearing Aid Services

Monaural and binaural hearing aids are covered for recipients under 21 years of age who have received medical clearance from a physician, preferably an otologist, otolaryngologist or otorhinolaryngologist. Medicaid-enrolled hearing aid providers (ENT doctor, audiologist or hearing aid dealer) must submit a prior approval request for the hearing aid, audiogram, evaluation report and manufacturer's warranty information. Each prior approval request for replacement hearing aids due to hearing changes, damaged hearing aids or lost hearing aids is reviewed individually for medical necessity. Providers may seek prior approval for frequency modulation (FM) systems for pre-school age children. The federal Individuals With Disabilities Education Act (IDEA) requires public schools to provide FM systems for educational purposes for students. There are no co-payments for hearing aids, hearing aid accessories, or hearing aid services.

Behavioral Health

N.C. Medicaid covers a variety of services for behavioral health, some under the rehabilitation option and others under the clinic option. Services provided under the rehabilitation option are provided by area mental health centers and include:

- *outpatient therapy;*
- *psychological testing;*
- *day treatment;*
- *partial hospitalization;*
- *psychosocial rehabilitation;*
- *facility-based crisis;*
- *community-based services for recipients of all ages; and*
- *residential services for recipients under the age of 21.*

Clinic services include outpatient therapy and psychological testing provided by directly enrolled providers, hospitals, health departments, physicians, and local education agencies (LEAs). Medicaid also covers inpatient psychiatric care in community hospitals for recipients of all ages and in free-standing psychiatric hospitals and psychiatric residential treatment facilities (PRTFs) for recipients under the age of 21.

Inpatient services, residential services and outpatient therapy must go through a prior approval process. For additional information, refer to the Behavioral Health Prior Approval subsection of this annual report on page 23.

DMA also provides services in intermediate care facilities for the mentally retarded (ICF-MRs), which are long-term care facilities for individuals with mental retardation or a related condition that occurred before the age of 22. (Refer to the Intermediate Care Facilities for the Mentally Retarded (ICF-MR) subsection of the Long-Term Care section on page 28 for additional information.)

Dental Health

N.C. Medicaid covers most diagnostic and preventive dental services such as exams, radiographs, dental cleanings, fluoride treatments and sealants. Dental restorations, root canals, periodontal services, oral surgeries, and partial and full dentures are also covered. Orthodontic services are covered for children under age 21 with functionally handicapping malocclusions. Most dental services do not require prior approval. Recipients age 21 and older are charged a $3 copayment unless their coverage category is exempted from copayment.
A special children's initiative, "Into the Mouths of Babes," was implemented statewide effective February 1, 2001 to decrease the incidence of early childhood caries. This program allows children from birth to age three to receive a dental screening, application of fluoride varnish, and oral hygiene instructions provided by specially trained physicians and local health departments.

Pharmacy Services

Drug Use Review Program

N.C. 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 in order 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.*
- **Education** – *Education is the key to 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.*

Outpatient Pharmacy Program

Prescription drugs, insulin and selected over-the-counter (OTC) products (where the manufacturers have signed a rebate agreement with CMS) are covered under the pharmacy program. Recipients may have up to six prescriptions per month and are locked into one pharmacy provider during the month of service except for emergency situations. A recipient co-payment of $1 applies for generic drugs, insulin and selected OTC products and $3 for brand-name medications.

Recipients may have a 34-day supply of their prescription medication and a 3-month supply of birth control pills and hormone replacement therapies. Effective October 2003, Medicaid recipients were able to obtain a 90-day supply of a generic, non-controlled maintenance medication at the discretion of the recipient's health care provider if the recipient had a previous 30 days fill for the same medication.

The pharmacy reimbursement fee structure is as follows: average wholesale price (AWP) less 10 percent, state maximum allowable cost (SMAC), federal upper limit (FUL) plus a dispensing fee of $5.60 per generic and selected OTC drugs or $4.00 per brand name drug or usual and customary, whichever is lowest.

In November 2003, the state implemented a statewide Prescription Advantage List (PAL). The PAL's methodology is to take the top 16 most costly therapeutic drug classes and place them in tiers according to their net cost to N.C. Medicaid. This is a voluntary collaborative initiative between the Division of Medical Assistance, Community Care of North Carolina, and the North Carolina Physicians Advisory Group.

Medicare-Aid

In February 1989, the N.C. Medicaid program began a new limited Medicaid program for Qualified Medicare Beneficiaries. The program, known as Medicare-Aid, provides assistance to eligible individuals with Medicare cost-sharing expenses, such as deductibles, premiums and coinsurance charges. The eligibility income limit for Medicare-Aid is 100 percent of the federal poverty level. This level is adjusted in April of each year.

Effective January 1, 1993, the Medicare-Aid program was expanded to include qualified individuals with income greater than 100 percent of the federal poverty level but not greater than 120 percent. These individuals are referred to as Specified Low-Income Medicare Beneficiaries. Eligible individuals in this group receive assistance with the payment of their Medicare Part B premium only.

In January 1998, the Medicare-Aid program was further expanded to include a new group of Medicare beneficiaries. Referred to as "Qualifying Individuals," they have incomes between 121 percent and 135 percent of the federal poverty level and receive assistance with the payment of their Medicare Part B premiums. Funding for this group is capped and approval of assistance is based on a first-come first-served basis.

Highlights

Policy Changes and Reports

Policy Changes Mandated by the North Carolina Legislature

Programmatic Issues:

Expansion of Community Care of North Carolina

Special funding was allocated to continue the statewide expansion of the Community Care (CCNC) of North Carolina Program, DMA's managed care program. CCNC is now available in 94 counties.

Mental Health

Mental Health service coverage for children eligible for EPSDT had included services provided by licensed or certified psychologists, licensed clinical social workers, certified clinical nurse specialists in psychiatric mental health advanced practice, and nurse practitioners certified as clinical nurse specialists in psychiatric mental health advanced practice. Current legislation expanded coverage to include services provided by licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, certified clinical addictions specialists, and certified clinical supervisors, when Medicaid eligible children are referred by the Community Care of North Carolina primary care physician, a Medicaid enrolled psychiatrist, or the area mental health program or local management entity.

The above coverage also applies to Medicaid-eligible adults, except that they may be self-referred.

Until the fiscal impact was determined and the necessary funds were identified, the Division was not allowed to enroll licensed psychological associates, licensed professional counselors, licensed marriage and family therapists, certified clinical addiction specialists, and certified clinical supervisors as Medicaid providers.

PACE Pilot Program

The Division of Medical Assistance was mandated to develop a pilot program to implement the "Program for All Inclusive Care for the Elderly" (PACE). One pilot site was to be planned for the southeastern area of the state and the other for the western area. The program utilizes federal Medicaid and Medicare dollars to provide acute and long-term care services for older patients through the use of interdisciplinary teams. Allowable PACE services include physician visits, drugs, rehabilitation services, personal care services, hospitalization and nursing home care. The PACE pilot program was also allowed to offer social services intervention, case management, respite care or extended home-care nursing. For more information on DMA's implementation of the PACE pilot program, please go to the "Special Studies, Reports and Projects Mandated by N.C. Legislature" subsection below.

Budget and Other Financial Issues:

Medicaid Assessment Program for ICF/MR Facilities

Effective October 1, 2004, DMA implemented a Medicaid assessment program, or "bed assessment," for

intermediate care facilities for the mentally retarded (ICF/MRs). As mandated by the North Carolina General Assembly, funds realized from these assessments are being used to draw down federal Medicaid matching funds and to implement a rate increase for private ICF/MR facility rates. The funds realized from this assessment program will be used to reduce state funds appropriated for public ICF/MR services.

Community Alternatives Programs (CAP)

DMA was directed by legislation not to exceed the budget for the various CAP programs and to ensure that CAP slots were fully allocated and filled in a timely manner. Also, Community Alternatives Programs for Disabled Adults (CAP/DA) services were to be provided for SFY 2005 to any eligible person who entered a nursing facility on or before June 1, 2004 within the existing availability of the county allocation or within the existing availability of services.

Hearing Aids

Payments to providers for hearing aids were changed from actual costs to wholesale costs plus a dispensing fee.

Optical Supplies

In accordance with Federal law, DMA changed its method of reimbursement for optical materials from one hundred percent of reasonable wholesale cost to fees negotiated between DMA and dispensing providers based on industry charges.

Benefit Coverage Issues:

Medically Necessary Prosthetics or Orthotics

Medicaid coverage for medically necessary prosthetics and orthotics had previously been available only to EPSDT-eligible children. The General Assembly expanded coverage to include adults over age 21. Medically necessary prosthetics and orthotics are now subject to prior approval and utilization review. Also, effective July 1, 2005, providers must be board-certified in order to be eligible for reimbursement.

Coverage to Pregnant Women

The income of a pregnant minor's parents is no longer counted in determining her Medicaid eligibility.

Clinical Coverage Policy Development and Amendment

The Division has developed, amended and adopted clinical coverage policy in consultation with the Physician Advisory Group of the North Carolina Medical Society and other professional societies or associations representing physicians, chiropractors, podiatrists, optometrists, dentists, certified nurse midwives and nurse practitioners. This legislation widens the seeking of advice to all providers who are affected by the new clinical coverage policy or amendments to existing clinical coverage policy.

Transfer of Property to Qualify for Medicaid

The existing law related to the transfer of property for purposes of qualifying for medical assistance was changed to eliminate the provision that it only applied to transfers made before July 1, 1988.

Weight Loss and Weight Gain Drugs

Weight loss and weight gain drugs were eliminated from the list of covered benefits.

Policy Changes Not Mandated by the North Carolina Legislature

Programmatic Issues:

Family Planning Waiver

In November 2004, DMA received approval from CMS to implement a Medicaid Family Planning Waiver for women between the ages of 19 and 55 and men between the ages of 19 and 60 with incomes at or below 185% of the federal poverty level. The family planning waiver provides a wide array of related services.

Piedmont Waiver

On April 1, 2005, the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, in collaboration with DMA, implemented a new managed care waiver entitled Piedmont Behavioral HealthCare. For more details on this waiver, please see the "Major Accomplishments" section of this annual report.

Community Alternatives Program - Choice Waiver

On January 1, 2005, the Division of Aging, in collaboration with DMA, implemented the Community Alternatives Program – Choice (CAP-Choice) in order to provide CAP/DA participants or potential participants with a choice between traditional CAP/DA agency-based services and a self-directed option that would allow participants to self-direct, i.e., hire, supervise, and terminate individual care providers. It is being piloted in two counties, Duplin and Cabarrus.

Clinical Policy Changes :

The following clinical coverage and general coverage policies were promulgated through the N.C. Physicians Advisory Group (NCPAG) during SFY 2005:

- ***Breast Surgeries*** – *Coverage of breast surgeries was implemented in January 1974. Coverage of mastectomies in males was originally documented in January 1985. The promulgated policy addresses breast surgeries comprehensively and includes coverage criteria for prophylactic mastectomy, mastectomy for male gynecomastia, reduction mammoplasty and reconstructive surgery.*
- ***Dental Services*** – *This policy was revised to accurately reflect program changes in coverage and limitations implemented since July 2002.*
- ***Durable Medical Equipment*** – *This policy documents the medical necessity criteria, service requirements and limitations for the Durable Medical Equipment program.*
- ***Extracorporeal Shock Wave Lithotripsy*** – *Coverage of this procedure was originally*

documented in October 1985. The promulgated policy addresses revisions to the coverage criteria and to the limitations on coverage.

- **Hyperbaric Oxygenation Therapy** – *Coverage of this procedure was originally documented in July 1988. The amended policy includes coverage criteria for lower extremity wounds due to diabetes.*
- **Mental Health Services** – *Coverage of mental health services was implemented in July 1989. The promulgated policy documents the procedures, service requirements and qualifications that local management entities, contract agencies and direct-enrolled residential treatment providers must follow when providing behavioral health services.*
- **Local Education Agency Services** – *The policy documenting coverage of services provided by local education agencies was amended to include requirements for physicians' orders and for the annual review and revision of service plans.*
- **Neonatal and Pediatric Critical Care Services** – *Coverage of these services was implemented in June 2002. The policy documents the coverage of critical care services for newborns, infants and young children, as well as documenting the age limitations associated with the services.*
- **Outpatient Behavioral Health Services Provided by Direct-Enrolled Providers** – *This policy documents coverage of behavioral health services provided by direct-enrolled therapists who are practicing individually or in a multi-specialty mental health therapist group practice. Coverage of the services was implemented in January 2005 and includes assessment, treatment, family therapy and psychological testing services for Medicaid recipients of all ages.*
- **Outpatient Specialized Therapies** – *The policy documenting coverage of specialized therapies was amended to include requirements for the review and revision of service plans by Local Education Agencies.*
- **Panniculectomy** – *Coverage of this procedure was originally documented in May 1988. The amended policy delineates the medical necessity criteria for the procedure.*
- **Personal Care Services-Plus** – *This policy documents the coverage criteria and requirements for the PCS-Plus program, which was implemented in November 2003.*
- **Prior Authorization for Outpatient Pharmacy Point of Sale Medications** – *This general policy documents the process implemented in March 2002 for designating drugs that require prior authorization.*
- **Psychiatric Residential Treatment Facilities for Children Under the Age of 21** – *Coverage of PRTF services for recipients under the age of 21 was implemented in December 2001. The policy documents the medical necessity criteria, service requirements and limitations on coverage.*
- **Residential Treatment Services** – *Coverage of Residential Treatment Services was implemented in October 2000. The policy documents the medical necessity criteria, service requirements and limitations on coverage.*
- **Screening Laser Glaucoma Tests** – *Coverage of this procedure was implemented in January 1999. The policy documents medical necessity criteria for the procedure and includes limitations relative to visual fields.*
- **Surgery for Clinically Severe Obesity** – *Coverage of this procedure was originally documented in January 1985 as Gastric Bypass Surgery for Obesity. The amended policy was retitled and updated to address both gastric bypass surgery and vertical banded gastroplasty as well as to address medical necessity criteria and coverage requirements.*

Special Studies, Reports and Projects Mandated by N.C. Legislature

PACE Pilot Program Funds

DMA was mandated under the appropriation bill SL 2004 -124 to develop a pilot program to implement the Program for All-Inclusive Care for the Elderly (PACE) and to report to the N.C. General Assembly on its progress by March 1, 2005. One pilot site was to be located in the southeastern part of the state and the other in the western part.

PACE is a national model for a capitated managed care program for the frail elderly. The PACE model is regulated by the Centers for Medicare and Medicaid and, once operational in the state, PACE will combine Medicaid and Medicare funding to serve persons who meet the nursing facility level of care. PACE offers a comprehensive array of services to those persons enrolled in the program. The enrollees receive oversight and intervention from professional staff, frequent and detailed medical reviews, and a wide array of services. The overall goal is to manage all the health and medical needs of this frail population to keep them out of the hospital or a nursing facility for as long as possible. PACE becomes the sole source of services for Medicare- and Medicaid-eligible enrollees.

Responsibility for PACE Program development was assigned to the Facility and Community Care Section of DMA. Presently, the only health care organization in the state that has expressed interest in proceeding with the development of PACE and that has identified the necessary financial backing for PACE is Elderhaus, Inc. in Wilmington. In 2002, Elderhaus, Inc., invested in a PACE feasibility analysis. Elderhaus and the PACE Technical Assistance Center in Columbia, South Carolina plan to update the feasibility study. If PACE is determined to be financially feasible for the Wilmington area, Elderhaus will proceed with the development of a PACE Application to DMA and the Centers for Medicare and Medicaid Services (CMS). To date, no potential PACE organization has been identified for Western North Carolina.

Medicaid Institutional Bias Study

The appropriation bill required DMA to contract with an independent entity to study whether the state's Medicaid program has a bias that favors support for individuals in institutional settings over support for individuals living at home and, if a bias is found, to determine and recommend ways to alleviate the bias. On January 1, 2005, DMA submitted a progress report to the N.C. Legislative Study Commission on Aging. DMA awarded a contract to the Lewin Group to carry out the study. The Lewin Group reported its findings to the Commission on Aging in January 2006, and Division of Medical Assistance staff met with the Commission in March 2006 to answer questions posed by the Commission. The final written report was provided to the Commission in April 2006.

Disease Management Activities

House Bill 1469 "Disease Management Activities" requires DMA to report on activities to address the rising cost of health care provided under the State Medical Assistance Plan. On March 1, 2005, DMA submitted its report to the N.C. General Assembly. For a summary of the requirements of this bill, please see the Major Accomplishments portion of this annual report.

Populations, Services and Expenditures

Populations and Eligibility Groups

North Carolina's population during SFY 2004 was 8,541,263. Approximately 18 percent (or 1,563,751 people) were eligible for Medicaid. Compared with the previous year, the state population rose by 1.5 percent; however, the number of Medicaid eligibles increased by 3.4 percent and the average number of monthly eligibles increased by 2.5 percent.

Exhibit 5

N.C. Medicaid Yearly Unduplicated Eligibles by Eligibility Group - SFY 2005

Eligibility Group	Number of Eligibles	% of Total Eligibles
Pregnant Women & Children	629,616	40.3%
AFDC-related	468,711	30.0%
Disabled	249,921	16.0%
Aged	151,512	9.7%
Qualified Medicare Beneficiaries	44,130	2.8%
Blind	2,130	0.1%
Refugees & Aliens	17,496	1.1%
Breast & Cervical Cancer	235	0.0%
Total	**1,563,751**	**100.0%**

As indicated in **Exhibit 5** above, the largest category of eligibles during SFY 2005 was Pregnant Women and Children with an annual total of 629,616 individuals, or about 40 percent of total eligibles. The Aid to Families with Dependent Children (AFDC) category was second largest with 468,711 individuals, or about 30 percent of the total eligibles. This category includes families with children who would have met eligibility criteria for the former AFDC program, now known as Temporary Assistance to Needy Families or TANF, as of July 1996.

As **Exhibit 6** shows, the Pregnant Women and Children population experienced the largest increase of enrollees – 53,715, or approximately 9 percent. The AFDC-related and Blind categories experienced decreases.

Exhibit 6

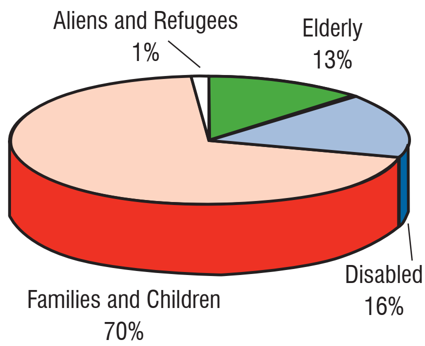
Change in N.C. Medicaid Yearly Unduplicated Eligibles by Eligibility Group SFY 2004 vs. 2005

Eligibility Group	SFY 2005 Eligibles	Amount of Change	% Change
Pregnant Women & Children	629,616	53,715	9.3%
AFDC-related	468,711	-17,145	-3.5%
Disabled	249,921	11,111	4.7%
Aged	151,512	34	0.0%
Qualified Medicare Beneficiaries	44,130	1,717	4.0%
Blind	2,130	-47	-2.2%
Refugees & Aliens	17,496	1,968	12.7%
Breast & Cervical Cancer	235	38	19.3%
Total	**1,563,751**	**51,391**	**3.4%**

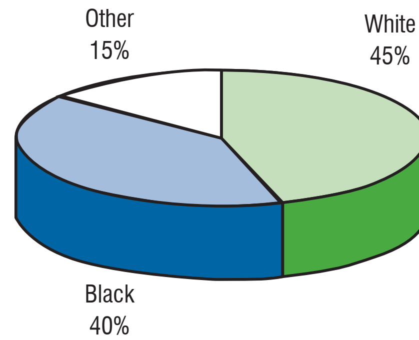
Exhibit 7 on the next page shows the distribution and some of the characteristics of recipients of Medicaid services. The percentage of recipients in each program category approximates the distribution of eligibles shown in **Exhibit 5**, but it varies somewhat. This is due to the fact that not all eligibles actually become recipients of one or more services in a given year. The variance is also attributable to the fact that the recipient count is based upon claims paid during SFY 2005. These paid claims may include claims for services provided the previous year that were carried over for payment in SFY 2005. Forty-five percent of recipients were white, 40 percent were black and the remaining 15 percent were of other races. A total of 60 percent of recipients were female and 40 percent male. When Medicaid recipients are grouped by age, children ages 5 to 20 constitute the largest group (37 percent), while adults aged 21 to 64 are the second largest group (32 percent), followed by young children from birth to 4 (19 percent) and the elderly, ages 65 and older (12 percent).

Exhibit 7
N.C. Medicaid Recipients of Medicaid Services - SFY 2005

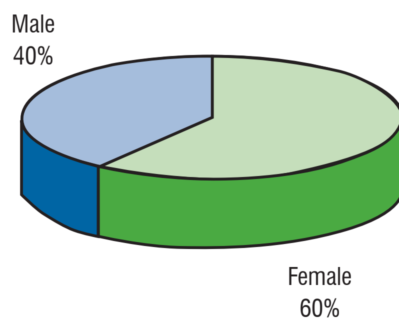
By Eligibility Category



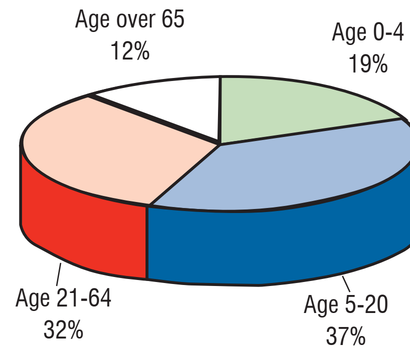
By Race



By Gender



By Age



Services and Expenditures

As indicated in **Table 6** (see the "Medicaid Tables" section of this report), a total of approximately $8.17 billion was spent on health services and premiums for 1,585,238 Medicaid recipients, or $5,154 per recipient during the year. While total service and premium expenditures increased by 10.3 percent, the increase per recipient was only 7.3 percent over SFY 2004.

Exhibit 8 and **Exhibit 9** (two pages forward) show that Elderly and Disabled recipients comprised 13.1 percent and 16.1 percent of total recipients, respectively. Yet, service expenditures for these two groups amounted to approximately $5.7 billion, or 70 percent. These two groups received a greater number of services and services that were more expensive per unit than any other group. Recipients from the Families and Children group, on the other hand, represented approximately 70 percent of all recipients; however, they accounted for approximately $2.4 billion, only 30 percent, of total service expenditures. Exhibit 10 (three pages forward) shows that expenditures per recipient increased during SFY 2005 for each of the recipient groups.

Of all Medicaid services provided, the Prescription Drug service category was the most expensive at roughly $1.6 billion, or 20.2 percent of total expenditures as shown in **Table 6** (see the "Medicaid Tables" section of this report) and **Exhibit 12**. This was an increase of 12.1 percent over the previous fiscal year, as shown in **Exhibit 11**. When manufacturer's rebates of approximately $387 million are applied, the net amount spent on prescription drugs was approximately $1.25 billion, or 15.4 percent of total expenditures. The increase in prescription drug expenditures, as well as a mandate from the N.C. General Assembly, compelled DMA to continue its intensive prescription drug cost containment efforts during SFY 2005. Inpatient hospital services, the second-highest category of service expenditures, accounted for approximately $962 million, or 11.8 percent of total service expenditures. This was an increase of 1.1 percent.

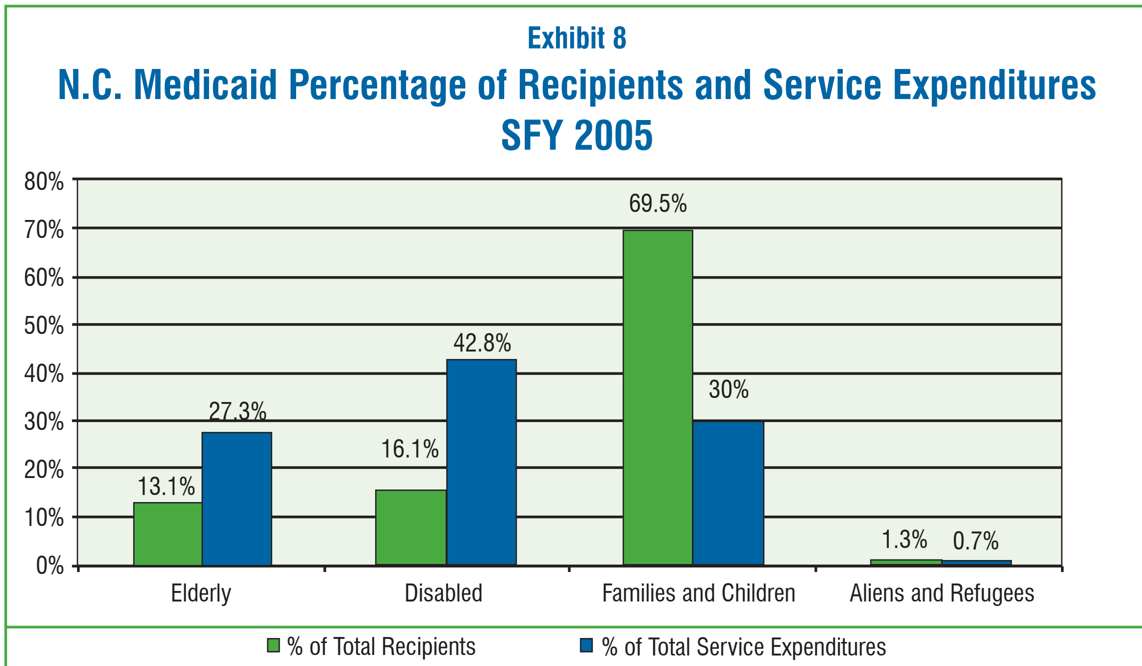


Exhibit 8
N.C. Medicaid Percentage of Recipients and Service Expenditures
SFY 2005
80%
70%
60%
50%
40%
30%
20%
10%
0%
13.1%
27.3%
16.1%
42.8%
69.5%
30%
1.3%
0.7%
Elderly
Disabled
Families and Children
Aliens and Refugees
% of Total Recipients
% of Total Service Expenditures

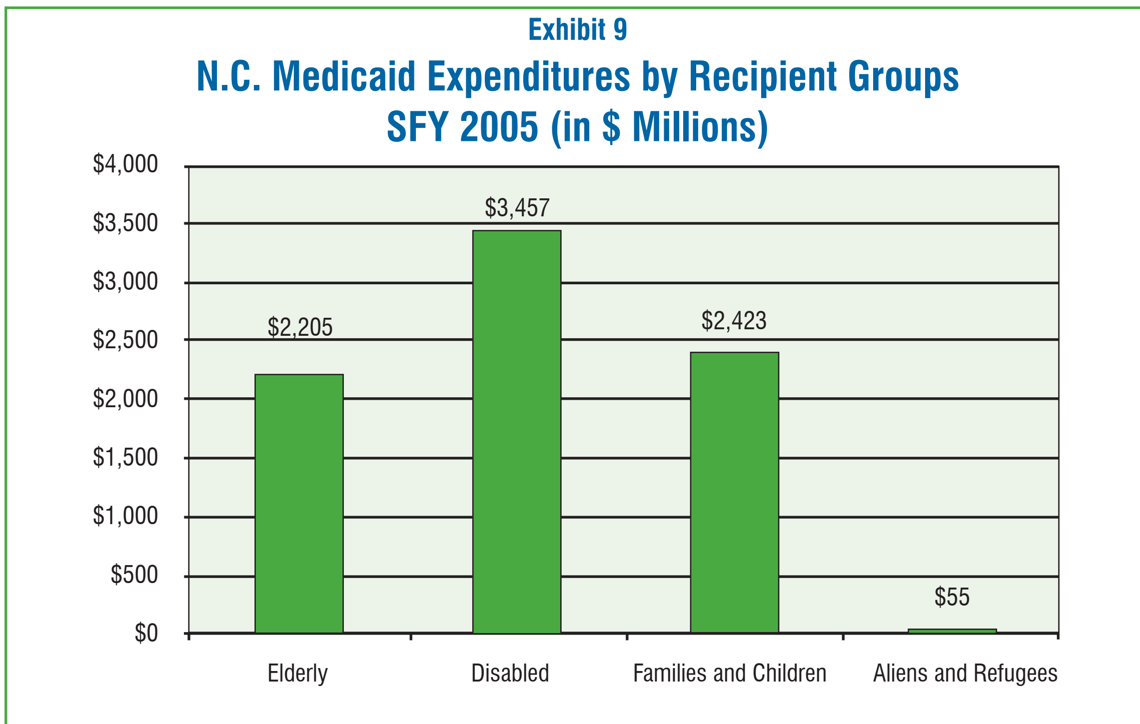
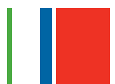


Exhibit 9
N.C. Medicaid Expenditures by Recipient Groups
SFY 2005 (in $ Millions)
$4,000
$3,500
$3,000
$2,500
$2,000
$1,500
$1,000
$500
$0
$2,205
$3,457
$2,423
$55
Elderly
Disabled
Families and Children
Aliens and Refugees



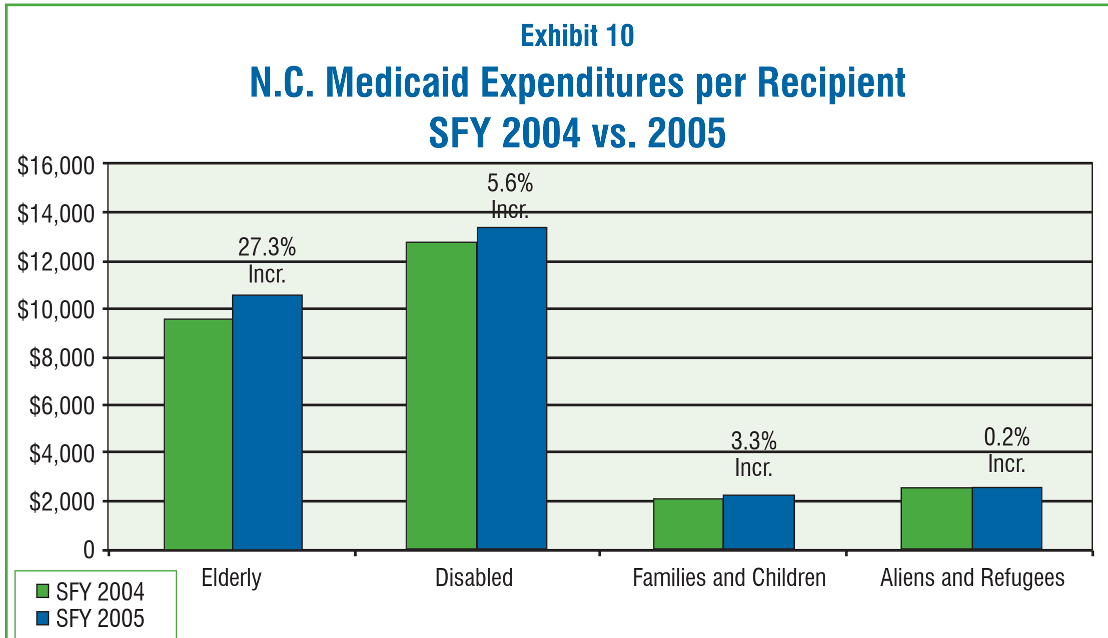


Exhibit 11 depicts the growth of DMA's long-term and non-long-term service expenditures from SFY 2004 to SFY 2005, showing the highest categories of non-long-term care expenditures, while grouping the long-term care expenditures. It is worthwhile noting the non-long-term care expenditures grew by 8.8 percent and long-term care expenditures grew by 13.7 percent.

Exhibit 11

N.C. Medicaid Growth in Long-Term Care and Non-Long-Term Care Expenditures SFY 2004 vs. 2005 Service Expenditures Only - Fund 1310 Sorted by Amount of Non-Long-Term Care Expenditures

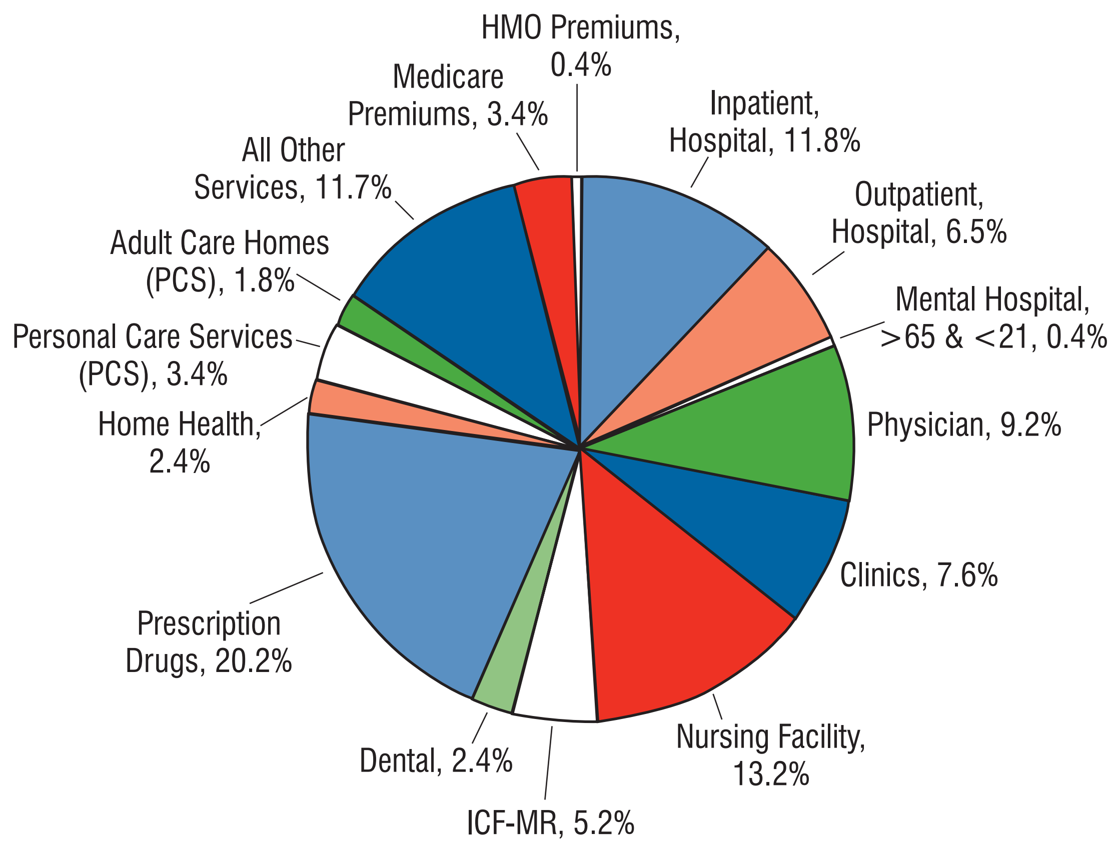
Category of Service	SFY 2005 Expenditures	SFY 2004 Expenditures	% Change
Prescription Drugs	$1,648,039,897	$1,470,497,694	12.1%
Inpatient Hospital	$961,904,185	$951,401,113	1.1%
Physician	$751,474,742	$697,369,742	7.8%
Outpatient Hospital	$533,837,438	$511,730,500	4.3%
Mental Health Clinics	$502,084,896	$476,679,277	5.3%
Medicare Part B Premiums	$219,553,075	$198,092,030	10.8%
Dental	$194,367,043	$179,085,614	8.5%
Other Non-Long-Term	$666,127,163	$551,540,681	20.8%
Total Non-Long-Term	**$5,477,388,439**	**$5,036,396,651**	**8.8%**
Total Long-Term	**$2,692,640,458**	**$2,368,344,773**	**13.7%**

Note: "Long-term care" includes nursing facilities, hospital long-term care, home health, durable medical equipment, Community Alternative Programs, home infusion therapy, hospice, personal care services and adult care home services.

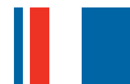
Source: BD-701, June 2004 and 2005

Exhibit 12

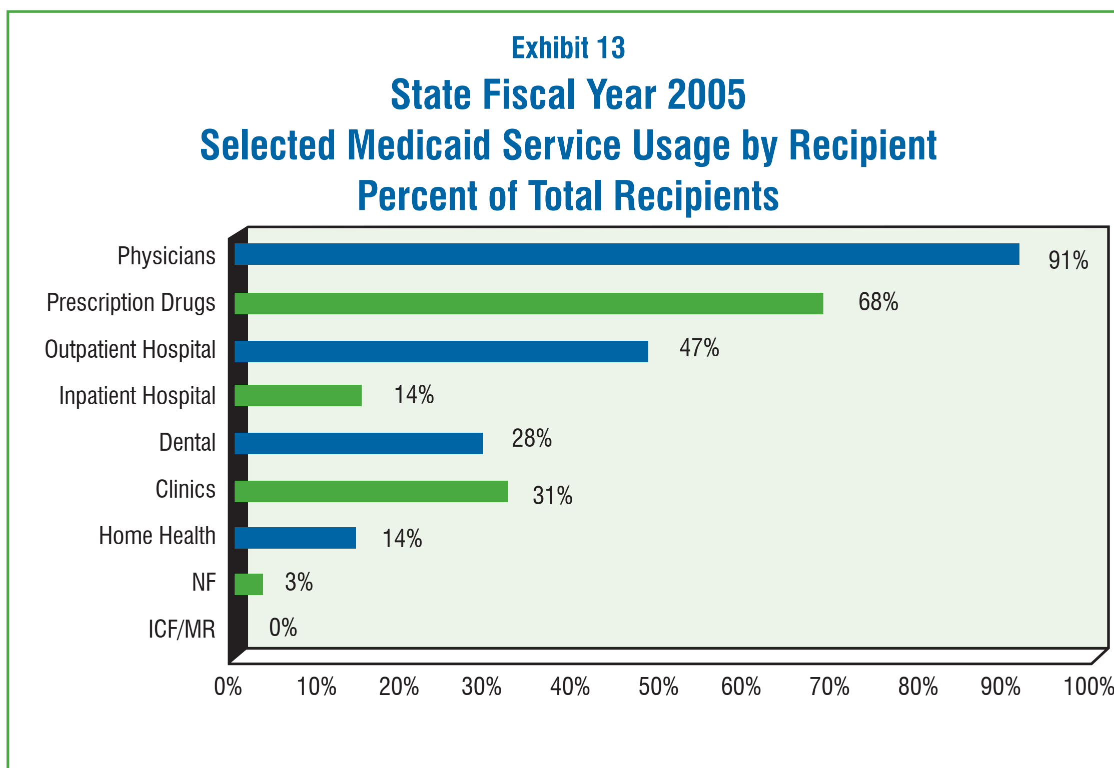
Medicaid Services Expenditures for SFY 2005



As **Exhibit 13** shows, 91 percent of North Carolina's Medicaid recipients received services at least once during SFY 2005 from a physician, 68 percent received at least one prescribed drug and 47 percent received services in a hospital outpatient setting. The utilization rate falls off dramatically for other service providers and locations.



Medicaid eligibility and expenditures vary widely among the 100 North Carolina counties, as **Table 9** in the "Medicaid Table" section demonstrates. The percentage of Medicaid eligibles in the general population was as high as 34.49 percent in Robeson County and as low as 9.38 percent in Orange County. Average expenditures per eligible ranged from a high of $6,711 in Graham County to a low of $3,857 in Cumberland County. Lastly, expenditures per capita were the highest in Bertie County at $2,021 and the lowest in Wake County at $494.



Note: Detailed information regarding expenditures and services is available in the "Medicaid Tables" section of this report.

Major Accomplishments

Numerous operational improvements and special initiatives were either implemented during the past fiscal year or are still in progress.

DMA Budget

DMA came in under budget. The SFY 2005 certified budget for N.C. Medicaid Program Services anticipated to be consumed by Medicaid recipients was $8,175,174,348 (inclusive of federal, county and state funds). The medical needs of Medicaid recipients were met at an actual total cost of $8,170,028,897.

Collections and Cost Avoidance

Over a billion dollars was saved, recovered or cost-avoided in the N.C. Medicaid Program during SFY 2005 through the efforts of the staff in the Program Integrity Section. Recoveries and cost avoidance savings were accomplished through reviews of provider billings and medical records, coordination with other insurers and payers where Medicaid was not the primary payer, through estate recovery, and through legal and civil actions carried out cooperatively by state and local law enforcement.

Recoveries	SFY 2005	SFY 2004	% Change
Medicare	$ 4,864,745	$ 3,852,807	26
Health Insurance	24,242,991	32,638,423	(26)
Casualty Insurance	16,917,611	16,791,951	1
Estate Recovery	8,430,611	5,947,040	42
Totals	**$54,455,958**	**$59,230,221**	**(8)**

Cost Avoidance	SFY 2005	SFY 2004	% Change
Medical Insurance Avoided	$ 207,900,683	$132,128,262	57
Medicare Avoided	578,496,817	558,279,892	4
Insurance Payments Reported on Claims	266,516,819	270,677,854	(2)
Totals	**$1,052,914,319**	**$961,086,008**	**9.6**

Additionally:

- *Efforts by Program Integrity's four provider billing investigative units resulted in the recovery of $12,508,218.*

- *The Medicaid Investigations Unit (MIU) within the Attorney General's Office collected almost $30 million in restitution, fines, penalties and interest, and had 26 convictions when they concluded criminal and civil cases. As required by the North Carolina Constitution, proceeds from the fines went to the individual County School Funds. Program Integrity nursing and pharmacy staff acted as consultants to the Attorney General's Office in many of these cases.*

- *Recipient fraud investigators in the local departments of social services (DSS) recovered $1,626,617 in overpayments. The state assisted county investigators to collect an additional $152,115 by intercepting North Carolina income tax refund checks from delinquent debtors.*

- *The state continues to have a 99.3 percent accuracy rate in Medicaid eligibility determinations. Program Integrity's Medicaid Eligibility Quality Assurance Unit reviews a sample of all Medicaid cases statewide and provides helpful feedback for corrective action to the county agencies.*

With the implementation of a fraud and abuse detection software system, the Program Integrity Section has significantly improved its efficiency in detection, investigation, and recovery. The accomplishments listed above were made possible through the use of increased automation and effort on the part of staff.

Medicaid Error Rate Measurement

Program Integrity assists the Office of State Auditor in determining the Medicaid program accuracy rates for claims billed by providers to Medicaid. In partnership since 1996-97, Program Integrity has annually reviewed a stratified sample of paid claims to determine the accuracy of system payments. In addition to processing claim reviews, nurse reviewers also request provider medical records to substantiate the medical necessity of recipient service(s). Below is a partial chart of the error rate findings for this year and previous years.

Exhibit 14

N.C. Medicaid Annual Error Rates for Claims Billed to Medicaid - SFYs 2001-05

State Fiscal Year	# Claims in Sample	Error Rate per OSA	Confidence Level	Sampling Precision
2000-01	300	0.80%	95%	+/-0.04
2001-02	270	2.80%	95%	+/-0.04
2002-03	272	1.78%	95%	+/-0.04
2003-04	273	3.33%	95%	+/-0.04
2004-05	In Progress			

Effective November 4, 2005, CMS required states to conduct error rate measurements for both Medicaid and SCHIP, in accordance with the Improper Payments Information Act of 2002. CMS is engaging three national contractors to work with states: a statistical contractor for sampling and error rate calculation; a documentation/database contractor to gather medical policy, medical records and other information from states; and a medical records review contractor to use the policies to perform the reviews and provide findings to the statistical contractor. Results will provide the basis for state-specific error rates, upon which a national error rate can be estimated. States will be selected once every three years to sample between 800 and 1,200 fee-for-service claims for both the Medicaid and SCHIP programs. DMA will participate in the 2007 sampling and address any identified claim errors, re-price claims, notify providers, recover claim overpayments, and develop corrective action plans to address causes of improper payments.

Medi-Medi Project

N.C. Medicaid was one of only seven pilot states selected by CMS to participate in a national project called "Medi-Medi." The purpose of the four-year project is to build a data warehouse consisting of all Medicare and Medicaid claims that can be data-mined to detect fraud and abuse. The combined database makes it possible for investigators to observe the manner in which providers bill each program and discover instances of overbilling. For example, providers billing for 22 service hours per day (perhaps 11 hours to Medicare and 11 hours to Medicaid) will be identified. Medicare and N.C. Medicaid investigate and refer potential fraud cases to the appropriate law enforcement entities. During SFY 2005, seven cases were referred to law enforcement by the Medi-Medi Team.

Provider Sanction Process

DMA has developed a provider sanction process to promptly address instances of provider program abuse. The procedures address suspension/termination from program participation and withholding Medicaid payments in conjunction with an investigation of provider abuse. Each incident is evaluated by a Provider Sanction Committee comprised of representatives from DMA and attorneys from the N.C. Department of Justice Medicaid Investigations Unit.

Disease Management Activities

House Bill 1469 "Disease Management Activities" required DMA to report on activities to address the rising cost of health care provided under the State Medical Assistance Plan. The bill mandated that DMA "adopt contractual agreements with providers of services that require and reward use of evidence based practice standards and guidelines for Medicaid and N.C. Health Choice" and to "consider a number of strategies as it develops plans to improve the quality, utilization, and cost effectiveness of the State's Medicaid program." Such strategies included implementation of new disease management initiatives that target costly diseases; collaboration with the Division of Public Health and other community organizations to address obesity, premature birth and smoking cessation; collaboration with local management entities that provide mental health services to care for non-targeted mental illness and substance abuse clients; and use of case management processes to improve the utilization of and access to community-based services. On March 1, 2005, DMA submitted its report to the N.C. General Assembly indicating how DMA fulfilled each of the requirements of the bill. The report is available upon request.

Family Planning Waiver

During SFY 2005, DMA received approval from CMS to implement a Medicaid Family Planning Waiver for women between the ages of 19 and 55 and men between the ages of 19 and 60 with incomes at or below 185 percent of the federal poverty level. Under the waiver, recipients will be eligible to receive the following services:

- *Annual family planning exams;*
- *Most types of birth control;*
- *Testing for pregnancy;*
- *Testing for sexually transmitted infections;*
- *Assistance in planning when to have a baby; and*
- *Voluntary sterilization.*

The goal of the waiver is to reduce unintended pregnancies and improve the well-being of children and families in North Carolina.

Piedmont Waiver

On April 1, 2005, the N.C. Medicaid program implemented a pilot program called Piedmont Cardinal Health Plan (PCHP), in five counties – Cabarrus, Davidson, Rowan, Stanly, and Union – for Medicaid-covered behavioral health services and services for persons with developmental disabilities. The new program represents the collaborative efforts of DMA; the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SA); Piedmont Behavioral Healthcare; and the Centers for Medicaid and Medicare Services (CMS).

PCHP includes all Medicaid-covered mental health and substance abuse services as well as the new Piedmont Innovations waiver program, which replaces the Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP/MR-DD) in the five-county area. PCHP will also include intermediate care facilities for the mentally retarded (ICF-MR) and psychiatric inpatient hospitalizations.

PCHP is a prepaid managed care plan and will be administered by Piedmont Behavioral Healthcare, a public mental health, developmental disabilities, and substance abuse (MH/DD/SA) services organization. In return, Piedmont will develop a comprehensive provider network, assure timely access to care for all Medicaid eligibles in the five-county area, authorize services and pay claims to providers in the network, conduct quality management activities, submit financial reports, submit to audits by DMA and external reviewers contacted by DMA, and submit encounter data to DMA.

N.C. Medicaid Drug Rebate Program

During SFY 2005, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services conducted a drug rebate program audit of the fifty state Medicaid programs in the nation. DMA received a clean audit on its drug rebate program. The audit revealed that North Carolina is one of only four states with no problems in the billing and collection of drug rebates. The Medicaid drug rebate program requires pharmaceutical companies to pay rebates to states in order to have their drugs covered by Medicaid. Under the program, drug makers provide price data to the Centers for Medicare and Medicaid Services (CMS), which administers the Medicaid program. CMS uses the price data to compute the rebate and then supplies states with that information. Then the state bills the drug companies for the rebates. During SFY 2005, North Carolina Medicaid received $370 million in rebates from drug makers.

Provider Enrollment

The DMA Recipient and Provider Services Section continued its efforts to improve the process for enrolling certain health care providers into the N.C. Medicaid Program. Effective January 1, 2005, medical doctors, dentists, osteopaths, chiropractors, optometrists and podiatrists began enrolling directly with Medicaid by completing a new Medicaid Application and Agreement packet. All new health care providers are credentialed through a contracted credentialing agency.

Dental Care

Through enhanced provider reimbursement rates and educational outreach efforts, the DMA Dental Unit increased and improved access to dental care for Medicaid recipients. The number of recipients receiving dental care increased 38 percent between SFY 2002 and SFY 2005.

Community Care of North Carolina (CCNC)

CCNC made significant progress during SFY 2005. Highlights include:

Network and Enrollment Issues:
Carolina Collaborative Community Care of Cumberland County became a new CCNC network; an additional 18 counties were brought on through various networks (88 counties are currently within CCNC); and recipient enrollment increased 18 percent during the year.

Program Activities:
In May 2005, representatives of the National Governors Association visited the CCNC Program office and commented on the program as an exemplary model of state initiative.

CCNC implemented its program priority activities in all expansion counties. These activities included asthma and diabetes disease management, case managing the high-cost and high-risk populations, and managing emergency department and pharmacy utilization.

Preliminary findings in the Diabetes Disparities pilot have been positive. This initiative focuses on community outreach and self-management education targeted towards minority populations in several CCNC networks. Disease registries are being tested in the practices working on the pilot.

Several of the networks are providing case management to the Community Alternatives/Children Program (CAP/C) children in their counties at the request of DMA. The CAP/C program targets the frailest of the children who are eligible for hospital or nursing facility level of care.

A revised Prescription Advantage List (PAL) was introduced in May 2005 that provides further guidance on over-the-counter medications and additional drug classes that have the potential for significant cost savings. PrimeCare, a pilot in Access II Care of Western N.C., demonstrated that a non-specialist case manager could be effective in helping to care for patients with depression within the primary care practice. Expansion of this model is now under way.

Several networks participated in the Sickle Cell Disease Management Program, which was created to address related primary care best practices, emergency department utilization, case management and care coordination.

Performance Indicators:
The results of the first practice-level diabetes audit that

was conducted in the spring of 2004 showed an increase in foot examinations and use of flu vaccines among the CCNC diabetic patient population.

The results of a practice-level asthma audit that was completed in the spring of 2005 showed improvement in the numbers of CCNC patients with action plans who received a flu vaccine. Two networks met the 80 percent benchmark for those Staged II-IV patients with an action plan in their medical record.

During SFY 2005, Tier 1 drug prescriptions increased to over 40 percent of all prescriptions in the CCNC patient population. Tier 1 is the least costly prescription drug price category.

Under a contract with CCNC during SFY 2005, Mercer Management Consulting determined that the program saved the state $124 million during SFY 2004.

Quality and Healthcare Outcome Improvements

The Quality Management (QM) Unit within DMA's Managed Care section continued efforts in quality improvement through studies and initiatives regarding asthma care and management, adult preventive services, improving access to health care, Health Check and immunizations. The QM Unit utilized and reported health outcome data using the nationally-accepted standards of the Health Plan Employer Data and Information Set (HEDIS) and other appropriate means. Results of completed studies and initiatives may be found under Publications – Quality Management Initiatives on the DMA web page at: ***http://www.dhhs.state.nc.us/dma/ca/qm.htm***.

Medicaid Tables

Table 1

North Carolina Medicaid
State Fiscal Year 2005
Federal Matching Rates

Benefit Costs
(7/1/04 - 9/30/04)

	Services except Family Planning	Family Planning
Federal	65.80%	90.00%
State	29.07%	8.50%
County	5.13%	1.50%

Benefit Costs
(10/1/04 - 6/30/05)

	Services except Family Planning	Family Planning
Federal	63.63%	90.00%
State	30.91%	8.50%
County	5.46%	1.50%

Benefit Costs
(10/1/04 - 6/30/05)

	Skilled Medical Personnel & MMIS*	All Other
Federal	75.00%	50.00%
Non-Federal	25.00%	50.00%

**MMIS – Medicaid Management Information System*

Table 2a - North Carolina Medicaid Eligibility during SFY 2005

GROUP	BENEFITS	BASIC REQUIREMENTS[1]						SPECIAL PROVISIONS
		Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit	Resource Limit	Deductible/ Spenddown		
Recipients of Cash Assistance Programs	Full Medicaid coverage	Recipients of the following cash assistance programs are automatically entitled to Medicaid. No separate Medicaid application or Medicaid eligibility determination are required. The cash assistance programs are: • Work First Family Assistance – NC program under the federal Temporary Assistance to Needy Families law that provides cash assistance to families with children. • Supplemental Security Income (SSI) – Federal cash assistance program for the aged, blind, and disabled. • State/County Special Assistance – State cash assistance program for aged and disabled individuals, primarily who are in adult care homes. • Special Assistance to the Blind – State cash assistance program for blind individuals.						
Aged	Full Medicaid coverage	Age 65 or older	Spouse's income and resources if live together	100% of Poverty 1 – $ 798/mo 2 – $1,070/mo	SSI Limits 1 - $2,000 2 - $3,000	Yes	If "yes" and income exceeds income limit and the indicator is "yes" the individual or family may be able to be eligible for Medicaid if he can meet a deductible. See discussion of Medical Deductible on page 2 of this same column. **Individuals in nursing facilities** generally do not have to meet a deductible to be eligible for Medicaid. However, they must pay all of their monthly income, less a $30 personal needs allowance and the cost of medical expenses not covered by Medicaid or other insurance, to the nursing facility. Medicaid pays the remainder of their cost of care.	**Protection of income for spouse at home:** When an individual is in a nursing facility and has a spouse living at home, a portion of the income of the spouse in the facility may be protected to bring the income of the spouse at home up to a level specified by federal law. Currently, that amount is $1,604 and can be as much as $2,378 depending upon at-home spouse's cost for housing. The amount protected for the at-home spouse is not counted in determining the eligibility of the spouse in the nursing facility. **Protection of resources for spouse at home:** Additionally, the countable resources of the couple are combined and a portion is protected for the spouse at home. That portion is ½ the total value of the countable resources, but currently not less than $19,020 or more than $95,100. The amount protected for the at-home spouse is not countable in determining the eligibility of the spouse in the facility. **Transfer of resources:** When a person gives away resources and does not receive compensation with a value at least equal to that of the resources given away, he may be penalized. Medicaid will not pay for care in a nursing facility or care provided under the Community Alternative Placement program or other in-home health services & supplies for a period of time that depends on the value of the transferred resource.
Blind	Full Medicaid coverage	Blind by Social Security Standards	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 798/mo 2 – $1,070/mo	SSI Limits 1 - $2,000 2 - $3,000	Yes		
Disabled	Full Medicaid coverage	Disabled by Social Security Standards	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 798/mo 2 – $1,070/mo	SSI Limits 1 - $2,000 2 - $3,000	Yes		
Qualified Medicare Beneficiaries	Payment of Medicare premiums and deductibles and co-insurance charges for Medicare covered services	Entitled to Medicare Parts A & B	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	100% of Poverty 1 – $ 798/mo 2 – $1,070/mo	2 x SSI Limits 1 - $4,000 2 - $6,000	No		
Specified Low-Income Medicare Beneficiaries	Payment of Medicare Part B premium	Entitled to free Medicare Part A	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	120% of Poverty 1 - $ 957/mo 2 - $1,283/mo	2 x SSI Limits 1 - $4,000 2 - $6,000	No		
Qualifying Individuals	Payment of Medicare Part B Premiums **NOTE:** Total number of eligible individuals is limited to available funds.	Entitled to free Medicare Part A	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	135% of Poverty 1 - $1,077/mo 2 - $1,444/mo	2 x SSI Limits 1 - $4,000 2 - $6,000	No		
Working Disabled	Payment of Medicare Part A premiums	Lost entitlement to free Medicare A due to earnings but still has disabling impairment.	Spouse's income and resources if live together. Parents' income and resources if under age 18 and live with parents.	200% of Poverty 1 - $1,595/mo 2 - $2,139/mo	2 x SSI Limits 1 - $4,000 2 - $6,000	No		

[1] This chart addresses benefits and basic eligibility requirements. Other requirements (such as citizenship/alien status, incarceration, & state residence) which can also affect eligibility or the level of benefits are not reflected on this chart.

Table 2a (cont) North Carolina Medicaid Eligibility during SFY 2005

GROUP	BENEFITS	BASIC REQUIREMENTS: Basic Eligibility Requirement	Whose Income and Resources Count	Income Limit	Resource Limit	Deductible/ Spenddown		SPECIAL PROVISIONS
Families & Children	Full Medicaid Coverage	Parents/Caretaker relatives must be living with and caring for a child to whom they are related who is under age 19. Children must be under age 21.	Spouse's income and resources if live together. Parents' income and resources if under age 21 and live with parents.	1 - $362/mo 2 - $472/mo 3 - $544/mo 4 - $594/mo 5 - $648/mo	$3,000	Yes	If "yes" and income exceeds income limit and the indicator is "yes" the individual or family may be able to be eligible for Medicaid if he can meet a deductible **Medicaid Deductible:** When an individual/family is ineligible for Medicaid due to income over the income limit, they may become eligible by meeting a Medicaid deductible. The deductible is determined by subtracting the Medically Needy Income Limit (MNIL) (see limits below) from the countable monthly income to determine the monthly excess income. Medicaid deductibles are generally determined for 6 months, so the monthly excess income is multiplied by 6 to determine the 6-mo. deductible. Once medical bills are incurred for which they are responsible, they are authorized for the remainder of the 6-mo. period. Medicaid cannot pay for any of the bills applied to the deductible. MNIL: 1 - $242/mo; 2 - $317/mo; 3 - $367/mo; 4 - $400/mo; 5 - $433/mo **Resource limit:** All deductible cases have a resource limit: $3000 for families and children and $2,000 (1) and $3000 (2) for aged, blind and disabled.	Children with special needs who are adopted under state adoption agreements have their eligibility for Medicaid determined without counting the income of the adoptive parents.
Pregnant Women	Coverage is limited to treatment for conditions that affect the pregnancy.	Medical verification of pregnancy.	Count only the income only of the pregnant woman and, if in the home, the father of the unborn.	Preg. Women and children under age 1 185% of Poverty 1 - $1,476/mo 2 - $1,978/mo 3 - $2,481/mo 4 - $2,984/mo 5 - $3,486/mo	No resource limit if eligible with income no more than 185% of poverty.	Yes		When determining the family size for the pregnant woman, the unborn child is included. For example, the family size for a single pregnant woman would be 2.
Children under age 1	Full Medicaid Coverage	Be under age 1.	Parents' income if living in the home.			Yes		
Children age 1 thru age 5	Full Medicaid Coverage	Be over age 1 and under age 6.	Parents' income if living in the home.	133% of Poverty 1 - $1,061/mo 2 - $1,422/mo 3 - $1,784/mo 4 - $2,145/mo 5 – $2,506/mo	No resource limit if eligible with income no more than 133% of poverty.	Yes		
Children age 6 thru 18	Full Medicaid Coverage	Be age 6 thru age 18.	Parents' income if living in the home.	100% of Poverty 1 - $ 798/mo 2 - $1,070/mo 3 - $1,341/mo 4 - $1,613/mo 5 - $1,885/mo	No resource limit if eligible with income no more than 100% of poverty.	Yes		
Title IV-E Children	Full Medicaid Coverage	Be an Title IV-E adoptive or foster child.	Medicaid eligibility is automatic. There is no income or resource determination.			No		
Breast & Cervical Cancer Medicaid	Full Medicaid Coverage	A woman who has been screened and enrolled in the NC Breast &Cervical Cancer Control Program.	Medicaid eligibility is automatic. There is no income or resource determination.			No		To be eligible under the Breast and Cervical Cancer Medicaid program, the woman can have no medical insurance coverage, including Medicaid.
NC Health Choice (NCHC)	Coverage of the NC State Employees Health Plan, plus vision, hearing, & dental	Be an uninsured child under age 19.	Parents' income if living in the home.	200% of Poverty 1 - $1,595/mo 2 - $2,139/mo 3 - $2,682/mo 4 - $3,225/mo 5 - $3,769/mo	No resource limit.	There is no deductible or spenddown provision for NCHC. If a child is ineligible due to too much income, they will be evaluated for Medicaid with a deductible.		

Table2b

Financial Eligibility for Medicaid based on Percentage of Poverty (Annual) SFY 2005

Family Size	100%	120%	133%	135%	185%	200%	SSI	MNIL	SA/ACH	SA/In-Home
1	$ 9,576	$11,484	$12,732	$12,924	$17,705	$19,140	$ 6,948	$ 2,904	$13,794	$9,570
2	$12,840	$15,396	$17,064	$17,328	$23,736	$25,668	$10,428	$ 3,804		
3	$16,092		$21,408		$29,772	$32,184				
4	$19,356		$25,740		$35,808	$38,700				
5	$22,620		$30,072		$41,832	$45,228				

Note 1: The Federal Poverty Level amounts change each year effective April. The above figures were effective April 1, 2005 and remained in effect through the end of SFY 2005.

Note 2: SSI recipients are automatically eligible. Income limits are $6,948 for a family of one and $10,428 for a family of two. Adult care home residents who receive state-county special assistance are also automatically eligible. Income limit for SA/ACH is $13,794 for a family of one. Income limit for SA/In-Home is $9,570 for a family of one.

Note 3: Those with income over the limits are eligible if medical bills are high enough. Medical bills must be equal to or greater than the amount by which their income exceeds the Medically Needy Income Levels (MNIL). The annual 2005 MNIL is $2,904 for a family of one and $3,804 for a family of two (eligibility is determined in six month increments).

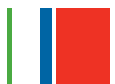


Table 3

North Carolina Medicaid
State Fiscal Year 2005
Enrolled Medicaid Providers

Providers	Number
Adult Care Home Providers	2,086
Ambulance Service Providers	273
Chiropractors	1,064
Community Alternatives Program Providers: CAP/C, CAP/AIDS, CAP/MR-DD, CAP/DA	1,237
Dental Service Providers: Dentists, Oral Surgeons, Pediadontists, Orthodontists	4,234
Durable Medical Equipment Suppliers	2,200
Hearing Aid Suppliers	92
Home Health Agency Providers: Home Infusion Therapy, Private Duty Nursing	414
Hospice Agency Providers	78
Hospital Providers	556
Independent Laboratory Providers	160
Independent Practitioners: Physical, Occupational and Respiratory Therapists, Speech/Language Pathologists and Audiologists	2,258
Managed Care Programs (HMOs)	1
Mental Health Program Providers	132
Mental Health Providers	4,161
Nursing Facility Providers	1,231
Optical Service Providers and Suppliers: Opticians, Optometrists	1,194
Other Types of Clinics: Ambulatory Surgery Centers, Birthing Centers, Dialysis Centers	218
Personal Care Service Providers	822
Pharmacists	2,012
Physician Extenders: Nurse Midwives, Nurse Practitioners, CRNAs	2,141
Physicians	25,547
Podiatrists	373
Portable X-ray Service Providers	28
Psychiatric Facility Providers	683
Public Health Program Providers	497
Rural Health Clinic/Federally Qualified Health Center Providers	344
Community-based Providers	172
Total	**54,208**

Note: This is an unduplicated count of active providers enrolled during SFY 2005. Physicians may be counted individually and/or as a group.

Table 4
North Carolina Medicaid State Fiscal Year 2005 Medicaid-Covered Services

Adult Care Home Personal Care Services
Ambulance & Other Medical Transportation
Targeted Case Management for:
- Pregnant women
- High-risk children (0-5)
- Chronically mentally ill adults
- Emotionally disturbed children
- Chronic substance abusers
- Adults & children at risk of abuse, neglect or exploitation
- Persons with HIV disease

Chiropractors
Clinic Services (Federally Qualified, Rural Health, Health Dept & Mental Health)
Community Alternatives Programs
Dental Care Services
Domicile Care
Durable Medical Equipment
Health Check Services (EPSDT)
Family Planning Services and Prescription Drugs
General and Specialty Inpatient and Outpatient Hospital Services
Hearing Aids (for children)
HMO Membership
Home Health Services
Home Infusion Therapy Services
Hospice
Intermediate Care Facilities for the Mentally Retarded
Laboratory and Radiological Services
Mental Health Services
Migrant Health Clinics
Nurse Anesthetists
Nurse Midwives
Nurse Practitioners
Nursing Facilities
Optical Services and Supplies
Personal Care Services
Physicians
Podiatrists
Prescription Drugs
Preventive Services
Private Duty Nursing Services
Prosthetics and Orthotics (children and adult)
Rehabilitative Services (under Behavioral Health Services)
Screening
Specialized Therapies (Occupational, Physical and Respiratory Therapy,
Speech/Language Pathology and Audiology)

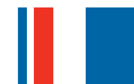


Table 5
North Carolina Medicaid Program
State Fiscal Year 2004 vs. 2005
Fund 1310 - Sources of Medicaid Funds - Services Expenditures Only

	2005	Percent	2004	Percent
Federal	$ 5,168,013,772	63.26%	$ 4,868,510,671	65.75%
State*	$ 2,045,751,219	25.04%	$ 1,869,297,326	25.24%
Other State	$ 529,046,065	6.48%	$ 294,812,636	3.98%
County	$ 427,217,872	5.23%	$ 372,120,792	5.03%
Total	**$ 8,170,028,897**	**100.00%**	**$ 7,404,741,42**	**100.00%**

** State appropriation of funds*

Source: BD701, the Authorized Monthly Budget Report for the periods ending June 29, 2005 and June 29, 2004, respectively. NCAS

This page revised July 14, 2006.

Table 6

North Carolina Medicaid
State Fiscal Year 2005 Program Services Expenditures
Budget Code 14445, Fund 1310

(Division of Medical Assistance Only)

Type of Service	Total Expenditures	Percent of Total Dollars	Percent of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	$ 961,904,185	11.77%	12.30%	218,989	$ 4,392
Outpatient Hospital	533,837,438	6.53%	6.82%	747,667	714
Mental Hospital <21 & >65	34,466,158	0.42%	0.44%	2,501	13,781
Physician	751,474,742	9.20%	9.61%	1,435,159	524
Clinics	619,993,217	7.59%	7.93%	492,310	1,259
Nursing Facilities	1,075,432,318	13.16%	13.75%	43,051	24,980
ICF-MR	426,194,859	5.22%	5.45%	4,509	94,521
Dental	194,367,043	2.38%	2.48%	444,199	438
Prescription Drugs	1,648,039,897	20.17%	21.07%	1,076,722	1,531
Home Health	192,706,554	2.36%	2.46%	214,649	898
Personal Care Services	276,912,131	3.39%	3.54%	50,162	5,520
Adult Care Homes - Personal Care Service	150,675,354	1.84%	1.93%	27,480	5,483
All Other Services	956,772,950	11.71%	12.23%	1,107,823	864
Subtotal, Services	**$ 7,822,766,845**	**95.75%**	**100.00%**		
Medicare Premiums: (Part A, Part B, QMB, Dually Eligible)	273,840,719	3.35%	3.50%		
HMO Premium	34,115,675	0.42%	0.44%		
Transfers	39,295,659	0.48%	0.50%		
Subtotal, Other	**$ 347,252,053**				
Fund 1310 Total Title XIX Services	**$ 8,170,028,897**				
Total Receipients (unduplicated)**				**1,585,238**	
Total Expenditures Per Recepient (unduplicated)					**$ 5,154**

** "Users of Services" is a duplicated count. Recipients using one or more services are counted in each service category.*

*** The word "recipient" refers to an individual who is eligible for Medicaid who actually received at least one service during a given fiscal year. "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 to the dollar due to rounding.

SOURCE: BD-701 Report June 2005

Note: "Users of Services" in "All Other Services" is obtained from the State History Table by taking an unduplicated count of the number of users.

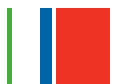


Table 7

North Carolina Medicaid

A History of Medicaid Expenditures - Fund 1310 Program Services Expenditures Only

State Fiscal Year	EXPENDITURES	Increase over Prior Year	FEDERAL	Increase over Prior Year	COUNTY	Increase over Prior Year	STATE	Increase over Prior Year
SFY 1995	3,104,096,450		2,033,890,406		156,970,582		913,235,462	
SFY 1996	3,549,309,272	14.3%	2,319,069,750	14.0%	183,329,798	16.8%	1,046,909,725	14.6%
SFY 1997	3,910,496,650	10.2%	2,558,186,929	10.3%	203,048,680	10.8%	1,149,261,041	9.8%
SFY 1998	4,106,345,835	5.0%	2,694,947,300	5.3%	223,297,504	10.0%	1,188,101,030	3.4%
SFY 1999	4,239,989,114	3.3%	2,726,521,783	1.2%	231,552,651	3.7%	1,281,914,680	7.9%
SFY 2000	4,783,840,430	12.8%	2,998,403,878	10.0%	253,995,385	9.7%	1,531,441,167	19.5%
SFY 2001	5,480,241,286	14.6%	3,430,145,921	14.4%	310,019,848	22.1%	1,740,075,518	13.6%
SFY 2002	6,185,038,224	12.9%	3,827,151,587	11.6%	353,624,465	14.1%	2,004,262,173	15.2%
SFY 2003	6,605,712,421	6.8%	4,172,894,036	9.0%	371,267,939	5.0%	2,061,550,446	2.9%
SFY 2004	7,404,741,424	12.1%	4,868,510,671	16.7%	372,120,792	0.2%	2,164,109,962	5.0%
SFY 2005	8,170,028,897	10.3%	5,168,013,772	6.2%	427,217,872	14.8%	2,574,797,253	19.0%

NOTES:

1. The expenditures in this table are only for Medicaid Program Services paid through the Division of Medical Assistance. Program Services expenditures paid through other DHHS divisions are not included. Adjustments, recoveries and rebates are not included.

2. The 19.0% increase in state dollars contributed in SFY 2005 over SFY 2004 is primarily attributable to the 2.95 percentage points added to the federal participation rate (FMAP) in SFY 2004. Consequently, the SFY 2004 FMAP was 65.94% (28.95% state), followed by 62.85% in SFY 2005 (31.58% state). Expenditures increased 10.34% and state share increased 9.08% in SFY 2005. The provider taxes received in SFY 2005 combined with the drug rebates, transfers from the trust fund, and DSH receipts also offset a significant portion of the increase in appropriations that would have been required to support the 10% growth and dramatic change in FMAP.

Source: BD 701 Budget Reports, Budget Code 14445, Fund 1310.

Table 8
North Carolina Medicaid
State Fiscal Years 1979 - 2005
A History of Unduplicated 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	Breast Cervical Cancer (BCC)	Total	Percent Change
1978-79	82,930	N/A	3,219	59,187	301,218	N/A	N/A	6,620	N/A	N/A	453,174	
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	N/A	N/A	455,702	0.56%
1980-81	80,725	N/A	2,656	56,773	315,651	N/A	N/A	6,559	N/A	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	N/A	425,233	-7.43%
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	N/A	N/A	415,552	-2.28%
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	N/A	N/A	407,806	-1.86%
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	N/A	N/A	414,353	1.61%
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	N/A	N/A	441,930	6.66%
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	N/A	N/A	452,025	2.28%
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	N/A	N/A	481,326	6.48%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561	N/A	561,614	16.68%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	1,011	N/A	639,351	13.84%
1990-91	81,466	42,949	1,116	70,397	451,983	37,200	61,210	4,296	1,675	N/A	753,292	17.82%
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	1,955	N/A	877,923	16.54%
1992-93	85,702	71,120	1,003	87,664	562,661	45,629	132,348	4,133	2,437	N/A	992,697	13.07%
1993-94	86,111	83,460	929	90,889	581,397	46,970	162,417	4,100	2,330	N/A	1,058,603	6.64%
1994-95	127,514	48,373	2,716	155,215	533,300	48,115	216,888	3,808	2,857	N/A	1,138,786	7.57%
1995-96	131,496	53,072	2,710	171,204	496,501	52,466	261,525	3,696	3,919	N/A	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	N/A	1,192,133	1.32%
1997-98	131,332	61,032	2,531	180,461	414,853	58,899	337,849	3,905	6,311	N/A	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	N/A	1,176,819	-1.70%
1999-00	154,222	33,302	2,428	205,205	330,113	60,918	421,158	4,063	9,857	N/A	1,221,266	3.78%
2000-01	154,284	36,053	2,357	212,798	450,472	57,318	424,436	4,195	12,680	N/A	1,354,593	10.92%
2001-02	153,282	39,799	2,344	221,813	456,232	53,009	444,299	4,737	14,523	N/A	1,390,028	2.62%
2002-03	151,672	41,030	2,226	228,159	478,842	51,111	474,557	4,881	14,805	N/A	1,447,283	4.12%
2003-04	151,478	42,413	2,177	238,810	485,856	53,768	517,251	4,882	15,528	197	1,512,360	4.50%
2004-05	151,512	44,130	2,130	249,921	468,711	57,190	567,060	5,366	17,496	235	1,563,751	3.40%
SFY 2004 Percent Total Eligibles:	**10.0%**	**2.8%**	**0.1%**	**15.8%**	**32.1%**	**3.6%**	**34.2%**	**0.3%**	**1.0%**	**0.0%**	**100.0%**	
SFY 2005 Percent Total Eligibles:	**9.7%**	**2.8%**	**0.1%**	**16.0%**	**30.0%**	**3.7%**	**36.3%**	**0.3%**	**1.1%**	**0.0%**	**100.0%**	

Source: Medicaid Eligibility Report, EJA752 – SFY 2005

Table 9
North Carolina Medicaid
State Fiscal Year 2005
Eligibles and Program Payments for which the County is Responsible for Its Computable Share*

COUNTY NAME	2004 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 MEDICAID ELIGIBLES BY COUNTY, BASED ON 2004 POPULATION
ALAMANCE	137,126	22,712	$ 111,884,538	$ 4,926	$816	79	166	16.56%
ALEXANDER	35,140	6,323	29,244,746	4,625	832	76	180	17.99%
ALLEGHANY	10,847	2,287	14,763,887	6,456	1,361	21	211	21.08%
ANSON	25,726	6,867	39,787,864	5,794	1,547	11	267	26.69%
ASHE	25,104	5,214	31,744,060	6,088	1,265	26	208	20.77%
AVERY	18,000	3,224	19,514,505	6,053	1,084	44	179	17.91%
BEAUFORT	45,860	11,000	64,966,160	5,906	1,417	15	240	23.99%
BERTIE	19,717	6,449	39,851,817	6,180	2,021	1	327	32.71%
BLADEN	32,996	9,985	52,356,439	5,244	1,587	9	303	30.26%
BRUNSWICK	85,034	16,629	76,113,172	4,577	895	66	196	19.56%
BUNCOMBE	215,112	38,600	207,914,155	5,386	967	57	179	17.94%
BURKE	88,895	16,914	88,443,343	5,229	995	52	190	19.03%
CABARRUS	146,628	23,021	101,838,445	4,424	695	89	157	15.70%
CALDWELL	78,548	15,674	79,250,374	5,056	1,009	50	200	19.95%
CAMDEN	8,525	1,136	5,253,843	4,625	616	93	133	13.33%
CARTERET	61,870	9,411	49,728,240	5,284	804	81	152	15.21%
CASWELL	23,670	5,119	28,343,931	5,537	1,197	35	216	21.63%
CATAWBA	147,789	25,201	114,428,328	4,541	774	84	171	17.05%
CHATHAM	55,000	7,313	35,693,459	4,881	649	91	133	13.30%
CHEROKEE	25,690	5,719	35,957,956	6,287	1,400	17	223	22.26%
CHOWAN	14,471	3,574	19,178,503	5,366	1,325	23	247	24.70%
CLAY	9,618	1,957	9,914,301	5,066	1,031	47	203	20.35%
CLEVELAND	97,400	23,029	131,392,791	5,706	1,349	22	236	23.64%
COLUMBUS	54,564	17,495	95,570,026	5,463	1,752	4	321	32.06%
CRAVEN	91,980	16,362	85,972,353	5,254	935	62	178	17.79%
CUMBERLAND	310,850	57,442	221,582,195	3,857	713	88	185	18.48%
CURRITUCK	21,876	2,602	13,276,321	5,102	607	94	119	11.89%
DARE	34,248	3,521	20,419,038	5,799	596	95	103	10.28%
DAVIDSON	153,264	26,506	121,896,302	4,599	795	82	173	17.29%
DAVIE	37,927	4,996	24,717,441	4,947	652	90	132	13.17%
DUPLIN	51,482	12,487	59,531,438	4,767	1,156	38	243	24.26%
DURHAM	238,865	38,868	203,480,739	5,235	852	73	163	16.27%
EDGECOMBE	53,916	18,573	84,068,076	4,526	1,559	10	344	34.45%
FORSYTH	320,764	53,087	249,526,887	4,700	778	83	166	16.55%
FRANKLIN	52,882	10,635	50,347,659	4,734	952	59	201	20.11%
GASTON	192,044	40,306	244,920,968	6,077	1,275	25	210	20.99%
GATES	10,986	2,013	10,073,885	5,004	917	64	183	18.32%
GRAHAM	8,074	2,176	14,602,903	6,711	1,809	2	270	26.95%
GRANVILLE	52,942	9,035	44,276,416	4,901	836	75	171	17.07%
GREENE	19,998	4,658	21,890,456	4,700	1,095	42	233	23.29%
GUILFORD	434,693	73,266	321,565,040	4,389	740	87	169	16.85%
HALIFAX	56,476	18,839	95,349,261	5,061	1,688	7	334	33.36%
HARNETT	99,628	19,852	85,178,967	4,291	855	72	199	19.93%
HAYWOOD	56,498	11,071	57,958,639	5,235	1,026	48	196	19.60%
HENDERSON	96,124	15,333	82,565,120	5,385	859	70	160	15.95%
HERTFORD	23,730	7,239	40,281,672	5,565	1,697	5	305	30.51%
HOKE	38,626	8,824	37,662,234	4,268	975	56	228	22.84%
HYDE	5,642	1,367	8,577,706	6,275	1,520	13	242	24.23%
IREDELL	136,008	21,287	100,942,265	4,742	742	86	157	15.65%
JACKSON	35,629	5,850	29,993,914	5,127	842	74	164	16.42%
JOHNSTON	141,391	26,249	124,703,224	4,751	882	67	186	18.56%
JONES	10,241	2,262	12,763,293	5,642	1,246	27	221	22.09%
LEE	50,146	10,680	41,512,271	3,887	828	77	213	21.30%
LENOIR	58,546	15,692	79,885,362	5,091	1,364	20	268	26.80%

Table 9 (Cont.)
North Carolina Medicaid
State Fiscal Year 2005
Eligibles and Program Payments for which the County is Responsible for Its Computable Share*

COUNTY NAME	2004 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 MEDICAID ELIGIBLES BY COUNTY, BASED ON 2004 POPULATION
LINCOLN	68,070	11,185	59,819,649	5,348	879	68	164	16.43%
MACON	31,769	5,959	30,666,834	5,146	965	58	188	18.76%
MADISON	20,204	4,401	24,839,289	5,644	1,229	31	218	21.78%
MARTIN	24,702	6,982	40,826,305	5,847	1,653	8	283	28.26%
MCDOWELL	43,247	8,600	43,640,585	5,074	1,009	49	199	19.89%
MECKLENBURG	768,789	123,387	484,014,781	3,923	630	92	160	16.05%
MITCHELL	15,992	3,271	19,864,266	6,073	1,242	29	205	20.45%
MONTGOMERY	27,153	6,705	31,613,757	4,715	1,164	36	247	24.69%
MOORE	79,342	12,644	61,391,991	4,855	774	85	159	15.94%
NASH	90,712	19,402	85,965,525	4,431	948	60	214	21.39%
NEW HANOVER	174,313	27,233	149,655,081	5,495	859	71	156	15.62%
NORTHAMPTON	21,566	6,926	38,048,419	5,494	1,764	3	321	32.12%
ONSLOW	159,711	20,606	85,334,956	4,141	534	99	129	12.90%
ORANGE	120,965	11,346	69,262,938	6,105	573	96	94	9.38%
PAMLICO	13,074	2,597	14,250,944	5,487	1,090	43	199	19.86%
PASQUOTANK	37,606	8,701	46,347,538	5,327	1,232	30	231	23.14%
PENDER	45,144	8,758	41,580,720	4,748	921	63	194	19.40%
PERQUIMANS	11,840	2,653	12,644,618	4,766	1,068	45	224	22.41%
PERSON	36,985	7,630	41,676,381	5,462	1,127	40	206	20.63%
PITT	141,508	27,951	142,151,071	5,086	1,005	51	198	19.75%
POLK	18,966	2,723	17,343,047	6,369	914	65	144	14.36%
RANDOLPH	135,805	25,356	110,229,005	4,347	812	80	187	18.67%
RICHMOND	46,452	13,598	61,535,839	4,525	1,325	24	293	29.27%
ROBESON	126,554	43,651	214,232,654	4,908	1,693	6	345	34.49%
ROCKINGHAM	92,118	19,550	101,420,768	5,188	1,101	41	212	21.22%
ROWAN	133,134	24,238	116,441,431	4,804	875	69	182	18.21%
RUTHERFORD	63,220	14,471	73,478,942	5,078	1,162	37	229	22.89%
SAMPSON	62,630	16,514	76,990,588	4,662	1,229	32	264	26.37%
SCOTLAND	36,864	12,293	56,769,685	4,618	1,540	12	333	33.35%
STANLY	59,078	10,294	55,547,970	5,396	940	61	174	17.42%
STOKES	45,887	7,589	37,770,179	4,977	823	78	165	16.54%
SURRY	72,276	14,818	77,187,542	5,209	1,068	46	205	20.50%
SWAIN	13,470	3,559	16,777,137	4,714	1,246	28	264	26.42%
TRANSYLVANIA	29,714	5,380	29,093,548	5,408	979	55	181	18.11%
TYRRELL	4,174	985	5,745,022	5,833	1,376	19	236	23.60%
UNION	151,847	19,757	81,557,578	4,128	537	98	130	13.01%
VANCE	43,829	15,079	61,924,176	4,107	1,413	16	344	34.40%
WAKE	723,708	79,458	357,868,072	4,504	494	100	110	10.98%
WARREN	20,074	5,703	27,871,001	4,887	1,388	18	284	28.41%
WASHINGTON	13,480	4,077	19,969,298	4,898	1,481	14	302	30.24%
WATAUGA	42,854	4,073	23,624,678	5,800	551	97	95	9.50%
WAYNE	115,110	25,358	114,468,551	4,514	994	53	220	22.03%
WILKES	66,982	14,070	81,927,687	5,823	1,223	34	210	21.01%
WILSON	76,414	18,318	87,454,337	4,774	1,144	39	240	23.97%
YADKIN	37,054	6,146	36,424,309	5,927	983	54	166	16.59%
YANCEY	18,071	3,825	22,181,819	5,799	1,227	33	212	21.17%
STATE TOTAL	**8,541,263**	**1,563,751**	**$ 7,562,087,434**	**$ 4,836**	**$ 885**		**183**	**18.31%**

*Notes: * Data reflect only net vendor payments for which the county is responsible for its computable share.*

*** Eligibles is a statewide unduplicated count indicating only eligibility in the last county of residence during the fiscal year.*

Source: Medicaid Cost Calculation Fiscal YTD June 2005.

Table 10

North Carolina Medicaid
State Fiscal Year 2005
Medicaid Service Expenditures by Recipient Group

Eligibility Group	Total Service Dollars	Percent of Service Dollars	Total Recipients	Percent of Recipients	SFY 2005 Expenditures Per Recipient	SFY 2004 Expenditures Per Recipient	04/05 Percent Change
Total Elderly	**$ 2,204,972,730**	**27.3%**	**207,511**	**13.1%**	**$ 10,626**	**$ 9,512**	**11.7%**
Aged	2,170,417,066	26.8%	164,863	10.4%	13,165	11,759	12.0%
Medicare-Aid (MQBQ & MQBB & MQBE)	34,555,665	0.4%	42,648	2.7%	810	698	16.1%
Total Disabled	**$ 3,457,431,278**	**42.8%**	**255,084**	**16.1%**	**$ 13,554**	**$ 12,830**	**5.6%**
Disabled	3,427,494,557	42.4%	252,900	16.0%	13,553	12,829	5.6%
Blind	29,936,721	0.4%	2,184	0.1%	13,707	12,977	5.6%
Total Families &Children	**$ 2,422,744,013**	**30.0%**	**1,102,463**	**69.5%**	**$ 2,198**	**$ 2,127**	**3.3%**
AFDC Adults (> 21)	692,763,465	8.6%	224,467	14.2%	3,086	2,947	4.7%
Medicaid Pregnant Women (MPW)	225,105,745	2.8%	57,790	3.6%	3,895	3,701	5.2%
AFDC Children & Other Children	586,237,863	7.2%	252,425	15.9%	2,322	2,149	8.1%
Medicaid Indigent Children (MIC)	914,269,875	11.3%	567,544	35.8%	1,611	1,584	1.7%
Breast and Cervical	4,367,064	0.1%	237	0.0%	18,426	14,652	25.8%
Aliens and Refugees	**$ 55,066,638**	**0.7%**	**20,180**	**1.3%**	**$ 2,729**	**$ 2,722**	**0.3%**

Source: SFY 2005 Program Expenditure Report (PER) and State 2082 Report. Note: Financial data reported in the PER originates from and relates to "claims paid" within MMIS during the fiscal year and is not identical with financial data reported in the BD 107 Budget Reports.

Table 11
North Carolina Medicaid
State Fiscal Year 2005
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	Other Adult**	Breast & Cervical Cancer	Children***	Alien & Refugees	Adjustments Unattributable to a Specific Category
Inpatient Hospital	$ 961,995,047	11.90%	$ 11,917,082	$ 12,124	$ -	$ 1,764,576	$ 439,440,593	$ 229,812,962	$ 436,041	$ 253,580,565	$ 38,316,085	
Outpatient Hospital	534,956,917	6.62%	22,702,108	55,733	-	1,052,428	211,606,757	168,992,235	1,879,682	153,720,927	2,213,894	$ (13,284,982)
Mental Hospital (> 65)	5,916,071	0.07%	5,921,711	-	-	-	-	-	-	-	-	(27,266,848)
Psychiatric Hospital (< 21)	28,550,087	0.35%	-	-	-	1,820	8,935,568	26,595	-	19,601,555	-	(5,640)
Physician	751,919,820	9.30%	46,151,204	121,685	-	1,209,358	233,239,504	202,045,605	1,531,889	260,097,621	11,586,991	(15,451)
Clinics	620,044,328	7.67%	12,472,319	10,873	-	1,370,740	312,222,395	49,163,763	10,895	248,248,919	1,610,554	(4,064,039)
Nursing Facility	1,075,432,263	13.30%	920,451,045	-	531	2,368,366	154,116,813	256,090	-	30,502	-	(5,066,129)
Intermediate Care Facility for												(1,791,085)
Mental Retardation	408,451,420	5.05%	25,254,355	-	-	7,018,548	373,863,905	13,002	-	2,338,562	-	
Dental	194,497,830	2.41%	9,840,721	-	-	213,803	36,376,020	38,199,506	30,830	109,981,521	162,815	(36,952)
Prescribed Drugs	1,637,104,462	20.25%	479,474,918	-	-	5,105,526	800,131,807	151,146,316	325,534	201,122,639	185,198	(307,385)
Home Health	192,708,509	2.38%	35,705,158	9,332	-	1,014,736	126,202,317	12,508,054	81,670	17,700,334	197,181	(387,477)
CAP/Disabled Adult	225,916,136	2.79%	160,368,356	-	-	1,599,902	63,951,260	1,605	-	4,936	23,658	(710,273)
CAP/Mentally Retarded	266,282,024	3.29%	5,288,042	-	-	2,448,548	256,819,412	-	-	2,041,194	-	(33,581)
CAP/Children	25,507,943	0.32%	-	-	-	275,934	24,604,915	-	-	645,313	-	(315,172)
Personal Care	276,912,606	3.42%	147,944,140	-	(3)	2,220,867	119,218,802	5,300,863	22,713	2,432,597	562	(18,218)
Hospice	42,333,330	0.52%	28,366,132	-	-	34,926	13,429,831	499,359	14,997	150,325	-	(227,933)
EPSDT (Health Check)	50,054,144	0.62%	-	-	-	5,830	1,389,061	42,810	14	48,665,724	5,781	(162,239)
Laboratory & Imaging Services	35,435,183	0.44%	491,406	593	-	46,067	6,966,535	16,634,793	17,091	11,264,674	64,214	(55,076)
Adult Home Care	150,560,738	1.86%	85,190,152	-	-	335,751	64,992,791	80,285	114	45,220	-	(50,190)
High-Risk Intervention Residential	118,706,764	1.47%	-	-	-	37,798	27,149,983	3,129	-	91,553,191	-	(83,574)
Other Services	175,007,831	2.16%	14,737,100	5,961	-	293,985	58,990,441	33,893,000	15,150	66,597,510	677,323	(37,337)
Total Services	**$ 7,778,293,451**	**96.2%**	**$ 2,012,275,949**	**$ 216,301**	**$ 528**	**$ 28,419,509**	**$ 3,333,648,709**	**$ 908,619,972**	**$ 4,366,619**	**$ 1,489,823,829**	**$ 55,044,256**	(202,638)
												$ (54,122,220)
Premiums:												
Medicare, Part A Premiums	45,396,172	0.56%	44,828,886	13,706	-	500,281	4,340	-	-	-	-	48,959
Medicare, Part B Premiums	228,588,205	2.83%	112,931,717	482,574	33,842,556	908,822	79,705,505	442,782	-	8,824	13,319	252,106
HMO Premiums	34,115,675	0.42%	380,514	-	-	108,109	14,136,003	8,806,456	445	10,675,085	9,062	-
Total Premiums	**$ 308,100,052**	**3.8%**	**$ 158,141,117**	**$ 496,280**	**$ 33,842,556**	**$ 1,517,212**	**$ 93,845,848**	**$9,249,238**	**$ 445**	**$ 10,683,910**	**$ 22,382**	**$ 301,065**
Program Category Totals			**$ 2,170,417,066**	**$ 712,581**	**$ 33,843,084**	**$ 29,936,721**	**$ 3,427,494,557**	**$ 917,869,210**	**$ 4,367,064**	**$ 1,500,507,738**	**$ 55,066,638**	**$ (53,821,155)**

* *Reflects expenditures for those who were eligible as QMBs (Medicare-covered services only) at the end of the year. As a result, expenditures include more services than are available through QMB coverage.*

** *Includes individuals covered under SOBRA Pregnant Women policies or individuals age 21 & over under TANF or AFDC-related coverage.*

*** *Includes SOBRA Children, individuals under age 21 in TANF or AFDC-related coverages or other children in foster care.*

Source: SFY 2005 Program Expenditure Report

Table 12
North Carolina Medicaid
State Fiscal Year 2005
Expenditures for the Elderly

Type of Service	Aged	Percent of Service Dollars	MQBQ Medicare Qualified Beneficiary	MQBB+MQBE Part B Premium Only	Total Qualified Beneficiaries	Percent of Service Dollars	Total Elderly Dollars	SFY 2005 % of Total Dollars	SFY 2004 % of Total Dollars	SFY 2003 % of Total Dollars
Inpatient Hospital	$ 11,917,082	0.5%	$ 12,124	$ -	$ 12,124	0.0%	$ 11,929,207	0.5%	0.8%	1.1%
Outpatient Hospital	22,702,108	1.0%	55,733	-	55,733	0.2%	22,757,841	1.0%	1.6%	2.0%
Mental Hospital (> 65)	5,921,711	0.3%	-	-	-	0.0%	5,921,711	0.3%	0.4%	0.4%
Physician	46,151,204	2.1%	121,685	-	121,685	0.4%	46,272,889	2.1%	2.3%	1.6%
Clinics	12,472,319	0.6%	10,873	-	10,873	0.0%	12,483,192	0.6%	0.5%	0.6%
Nursing Facility	920,451,045	42.4%	-	531	531	0.0%	920,451,576	41.7%	39.8%	41.6%
Intermediate Care Facility for Mental Retardation	25,254,355	1.2%	-	-	-	0.0%	25,254,355	1.1%	1.3%	1.3%
Dental	9,840,721	0.5%	-	-	-	0.0%	9,840,721	0.4%	0.5%	0.4%
Prescription Drugs	479,474,918	22.1%	-	-	-	0.0%	479,474,918	21.7%	22.8%	21.0%
Home Health	35,705,158	1.6%	9,332	-	9,332	0.0%	35,714,489	1.6%	1.7%	1.8%
CAP/Disabled Adult	160,368,356	7.4%	-	-	-	0.0%	160,368,356	7.3%	7.4%	7.5%
CAP/Mentally Retarded	5,288,042	0.2%	-	-	-	0.0%	5,288,042	0.2%	0.3%	0.3%
Personal Care	147,944,140	6.8%	-	(3)	(3)	0.0%	147,944,136	6.7%	6.6%	6.7%
Hospice	28,366,132	1.3%	-	-	-	0.0%	28,366,132	1.3%	1.0%	0.7%
EPSDT (Health Check)	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Laboratory & Imaging Services	491,406	0.0%	593	-	593	0.0%	492,000	0.0%	0.0%	0.0%
Adult Home Care	85,190,152	3.9%	-	-	-	0.0%	85,190,152	3.9%	4.0%	4.0%
High-Risk Intervention Residential	-	0.0%	-	-	-	0.0%	-	0.0%	0.0%	0.0%
Other Services	14,737,100	0.7%	5,961	-	5,961	0.0%	14,743,060	0.7%	0.5%	0.5%
Total Services	**$ 2,012,275,949**	**92.7%**	**$ 216,301**	**$ 528**	**$ 216,828**	**0.6%**	**$ 2,012,492,777**	**91.3%**	**91.4%**	**91.5%**
Premiums:										
Medicare Part A Premiums	44,828,886	2.1%	13,706	-	13,706	0.0%	44,842,592	2.0%	2.2%	2.3%
Medicare Part B Premiums	112,931,717	5.2%	482,574	33,842,556	34,325,130	99.3%	147,256,847	6.7%	6.5%	6.3%
HMO Premiums	380,514	0.0%	-	-	-	0.0%	380,514	0.0%	0.0%	0.0%
Total Premiums	**$ 158,141,117**	**7.3%**	**$ 496,280**	**$ 33,842,556**	**$ 34,338,836**	**99.4%**	**$ 192,479,953**	**8.7%**	**8.6%**	**8.5%**
Grand Total Services and Premiums	**$ 2,170,417,066**	**100.0%**	**$ 712,581**	**$ 33,843,084**	**$ 34,555,665**	**100.0%**	**$ 2,204,972,730**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 97,104,312**									
Total Elderly Recipients	**164,863**		**597**	**42,051**	**42,648**		**207,511**			
Expenditures Per Recipient**	**$ 13,165**		**$ 1,194**	**$ 805**	**$ 810**		**$ 10,626**			

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

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

Source: SFY 2005 Program Expenditure Report

Table 13
North Carolina Medicaid
State Fiscal Year 2005
Expenditures for the Disabled & Blind

Type of Service	Disabled	Percent of Service Dollars	Blind	Percent of Service Dollars	Total Blind & Disabled Dollars	SFY 2005 % of Total Dollars	SFY 2004 % of Total Dollars	SFY 2003 % of Total Dollars
Inpatient Hospital	$439,440,593	12.8%	$ 1,764,576	5.9%	$ 441,205,169	12.8%	13.5%	13.9%
Outpatient Hospital	211,606,757	6.2%	1,052,428	3.5%	212,659,185	6.2%	6.3%	7.2%
Mental Hospital (> 65)	-	0.0%	-	0.0%	-	0.0%	0.0%	0.0%
Psychiatric Hospital (< 21)	8,935,568	0.3%	1,820	0.0%	8,937,389	0.3%	0.2%	0.3%
Physician	233,239,504	6.8%	1,209,358	4.0%	234,448,863	6.8%	6.8%	6.2%
Clinics	312,222,395	9.1%	1,370,740	4.6%	313,593,135	9.1%	9.1%	8.5%
Nursing Facility	154,116,813	4.5%	2,368,366	7.9%	156,485,179	4.5%	4.0%	4.2%
Intermediate Care Facility for Mental Retardation	373,863,905	10.9%	7,018,548	23.4%	380,882,453	11.0%	12.3%	13.8%
Dental	36,376,020	1.1%	213,803	0.7%	36,589,823	1.1%	1.0%	0.9%
Prescription Drugs	800,131,807	23.3%	5,105,526	17.1%	805,237,334	23.3%	22.6%	20.6%
Home Health	126,202,317	3.7%	1,014,736	3.4%	127,217,054	3.7%	3.6%	3.8%
CAP/Disabled Adult	63,951,260	1.9%	1,599,902	5.3%	65,551,162	1.9%	1.8%	1.8%
CAP/Mentally Retarded	256,819,412	7.5%	2,448,548	8.2%	259,267,959	7.5%	8.3%	9.1%
CAP/Children	24,604,915	0.7%	275,934	0.9%	24,880,848	0.7%	0.7%	0.8%
Personal Care	119,218,802	3.5%	2,220,867	7.4%	121,439,669	3.5%	2.8%	2.4%
Hospice	13,429,831	0.4%	34,926	0.1%	13,464,757	0.4%	0.4%	0.4%
EPSDT (Health Check)	1,389,061	0.0%	5,830	0.0%	1,394,891	0.0%	0.0%	0.0%
Laboratory & Imaging Services	6,966,535	0.2%	46,067	0.2%	7,012,602	0.2%	0.2%	0.2%
Adult Home Care	64,992,791	1.9%	335,751	1.1%	65,328,541	1.9%	1.8%	1.8%
High Risk Intervention Residential	27,149,983	0.8%	37,798	0.1%	27,187,781	0.8%	0.8%	0.7%
Other Services	58,990,441	1.7%	293,985	1.0%	59,284,426	1.7%	1.5%	1.3%
Total Services	**$3,333,648,709**	**97.3%**	**$ 28,419,509**	**94.9%**	**$ 3,362,068,218**	**97.2%**	**97.8%**	**97.9%**
Premiums:								
Medicare Part A Premiums	4,340	0.0%	500,281	1.7%	504,621	0.0%	0.0%	0.0%
Medicare Part B Premiums	79,705,505	2.3%	908,822	3.0%	80,614,327	2.3%	2.1%	2.0%
HMO Premiums	14,136,003	0.4%	108,109	0.4%	14,244,112	0.4%	0.1%	0.1%
Total Premiums	**$93,845,848**	**2.7%**	**$ 1,517,212**	**5.1%**	**$ 95,363,060**	**2.8%**	**2.2%**	**2.1%**
Grand Total Services & Premiums	**$3,427,494,557**	**100.0%**	**$ 29,936,721**	**100.0%**	**$ 3,457,431,278**	**100.0%**	**100.0%**	**100.0%**
Medicare Crossovers*	**$72,774,354**		**$ 630,482**		**$ 73,404,837**			
Total Disabled/Blind Recipients	**252,900**		**2,184**		**255,084**			
Service Expenditures Per Recipient**	**$13,553**		**$ 13,707**		**$ 13,554**			

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

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

Source: SFY 2005 Program Expenditure Report

Table 14
North Carolina Medicaid
State Fiscal Year 2005
Expenditures for Families and Children

Type of Service	AFDC Adults	Percent of Service Dollars	Special Pregnant Women	Percent of Service Dollars	AFDC Children & Other Children	Percent of Service Dollars	Indigent Children	Percent of Service Dollars	Breast/Cervical	Percent of Service Dollars	Total Families & Children Dollars	SFY 2005 % of Total Dollars	SFY 2004 % of Total Dollars
Inpatient Hospital	$ 148,029,231	21.4%	$ 81,783,731	36.3%	$ 60,482,091	10.3%	$ 193,098,474	21.1%	$ 436,041	10.0%	$ 483,829,568	20.0%	21.3%
Outpatient Hospital	141,557,573	20.4%	27,434,662	12.2%	57,497,698	9.8%	96,223,229	10.5%	1,879,682	43.0%	324,592,845	13.4%	13.2%
Psychiatric Hospital (< 21)	-	0.0%	26,595	0.0%	10,958,529	1.9%	8,643,026	0.9%	-	0.0%	19,628,149	0.8%	0.8%
Physician	139,752,164	20.2%	62,293,441	27.7%	80,252,689	13.7%	179,844,932	19.7%	1,531,889	35.1%	463,675,116	19.1%	19.1%
Clinics	28,182,718	4.1%	20,981,044	9.3%	141,965,533	24.2%	106,283,386	11.6%	10,895	0.2%	297,423,576	12.3%	12.8%
Nursing Facility	256,090	0.0%	-	0.0%	30,502	0.0%	-	0.0%	-	0.0%	286,593	0.0%	0.0%
Intermediate Care Facility for Mental Retardation	13,002	0.0%	-	0.0%	1,825,759	0.3%	512,804	0.1%	-	0.0%	2,351,565	0.1%	0.1%
Dental	36,420,398	5.3%	1,779,108	0.8%	39,838,450	6.8%	70,143,070	7.7%	30,830	0.7%	148,211,856	6.1%	6.0%
Prescribed Drugs	140,691,961	20.3%	10,454,355	4.6%	78,041,042	13.3%	123,081,597	13.5%	325,534	7.5%	352,594,489	14.6%	14.0%
Home Health	10,575,705	1.5%	1,932,349	0.9%	5,584,893	1.0%	12,115,441	1.3%	81,670	1.9%	30,290,058	1.3%	1.1%
CAP/Disabled Adult	1,605	0.0%	-	0.0%	4,369	0.0%	567	0.0%	-	0.0%	6,540	0.0%	0.0%
CAP/Mentally Retarded	-	0.0%	-	0.0%	2,041,194	0.3%	-	0.0%	-	0.0%	2,041,194	0.1%	0.1%
CAP/Children	-	0.0%	-	0.0%	645,313	0.1%	-	0.0%	-	0.0%	645,313	0.0%	0.0%
Personal Care	5,240,748	0.8%	60,114	0.0%	1,134,989	0.2%	1,297,608	0.1%	22,713	0.5%	7,756,173	0.3%	0.2%
Hospice	499,359	0.1%	-	0.0%	20,695	0.0%	129,631	0.0%	14,997	0.3%	664,681	0.0%	0.0%
EPSDT (Health Check)	15,524	0.0%	27,286	0.0%	11,629,495	2.0%	37,036,229	4.1%	14	0.0%	48,708,548	2.0%	2.1%
Laboratory & Imaging Services	10,332,454	1.5%	6,302,339	2.8%	3,464,524	0.6%	7,800,150	0.9%	17,091	0.4%	27,916,558	1.2%	1.0%
High Risk Intervention Residential	-	0.0%	3,129	0.0%	53,828,301	9.2%	37,724,890	4.1%	-	0.0%	91,556,320	3.8%	0.0%
Adult Home Care	73,838	0.0%	6,447	0.0%	36,152	0.0%	9,068	0.0%	114	0.0%	125,618	0.0%	3.4%
Other Services	23,670,043	3.4%	10,222,957	4.5%	31,586,180	5.4%	35,011,329	3.8%	15,150	0.3%	100,505,659	4.1%	3.9%
Total Services	**$ 685,312,414**	**98.9%**	**$ 223,307,558**	**99.2%**	**$ 580,868,397**	**99.1%**	**$ 908,955,432**	**99.4%**	**$ 4,366,619**	**100.0%**	**$ 2,402,810,420**	**99.2%**	**99.2%**
Premiums:													
Medicare, Part A Premiums	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	-	0.0%	0.0%
Medicare, Part B Premiums	412,011	0.1%	30,770	0.0%	4,712	0.0%	4,112	0.0%	-	0.0%	451,606	0.0%	0.0%
HMO Premiums	7,039,039	1.0%	1,767,416	0.8%	5,364,754	0.9%	5,310,331	0.6%	445	0.0%	19,481,986	0.8%	0.8%
Total Premiums	**$ 7,451,051**	**1.1%**	**$1,798,187**	**0.8%**	**$ 5,369,466**	**0.9%**	**$ 5,314,444**	**0.6%**	**445**	**0.0%**	**$ 19,933,592**	**0.8%**	**0.8%**
Grand Total Services and Premiums	**$ 692,763,465**	**100.0%**	**$ 225,105,745**	**100.0%**	**$ 586,237,863**	**100.0%**	**$ 914,269,875**	**100.0%**	**$ 4,367,064**	**100.0%**	**$ 2,422,744,013**	**100.0%**	**100.0%**
Medicare Crossovers*	**$ 544,095**		**$ 51,421**		**$ 25,548**		**$ (7,873)**				**$ 613,191**		
Total Family & Child Recipients	**224,467**		**57,790**		**252,425**		**567,544**		**237**		**1,102,463**		
Service Expenditures Per Recipient**	**$ 3,086**		**$ 3,895**		**$ 2,322**		**$ 1,611**		**$ 18,426**		**$ 2,198**		

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

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

Source: SFY 2005 Program Expenditure Report

Table 15

North Carolina Medicaid
State Fiscal Year 2005
Medicaid Copayment Amounts

Service	Copayment Amount
Chiropractor visit	$1.00
Dental visit	$3.00
Optical service	$2.00
Optometrist visit	$2.00
Outpatient visit	$3.00
Physician visit	$3.00
Podiatrist visit	$1.00
Prescription drugs (including refills):	
Generic & Insulin	$1.00
Brand Name	$3.00

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