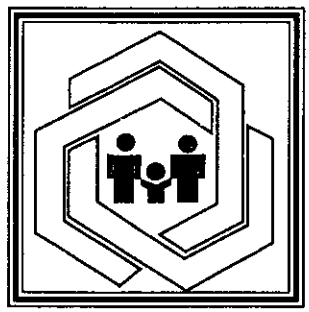
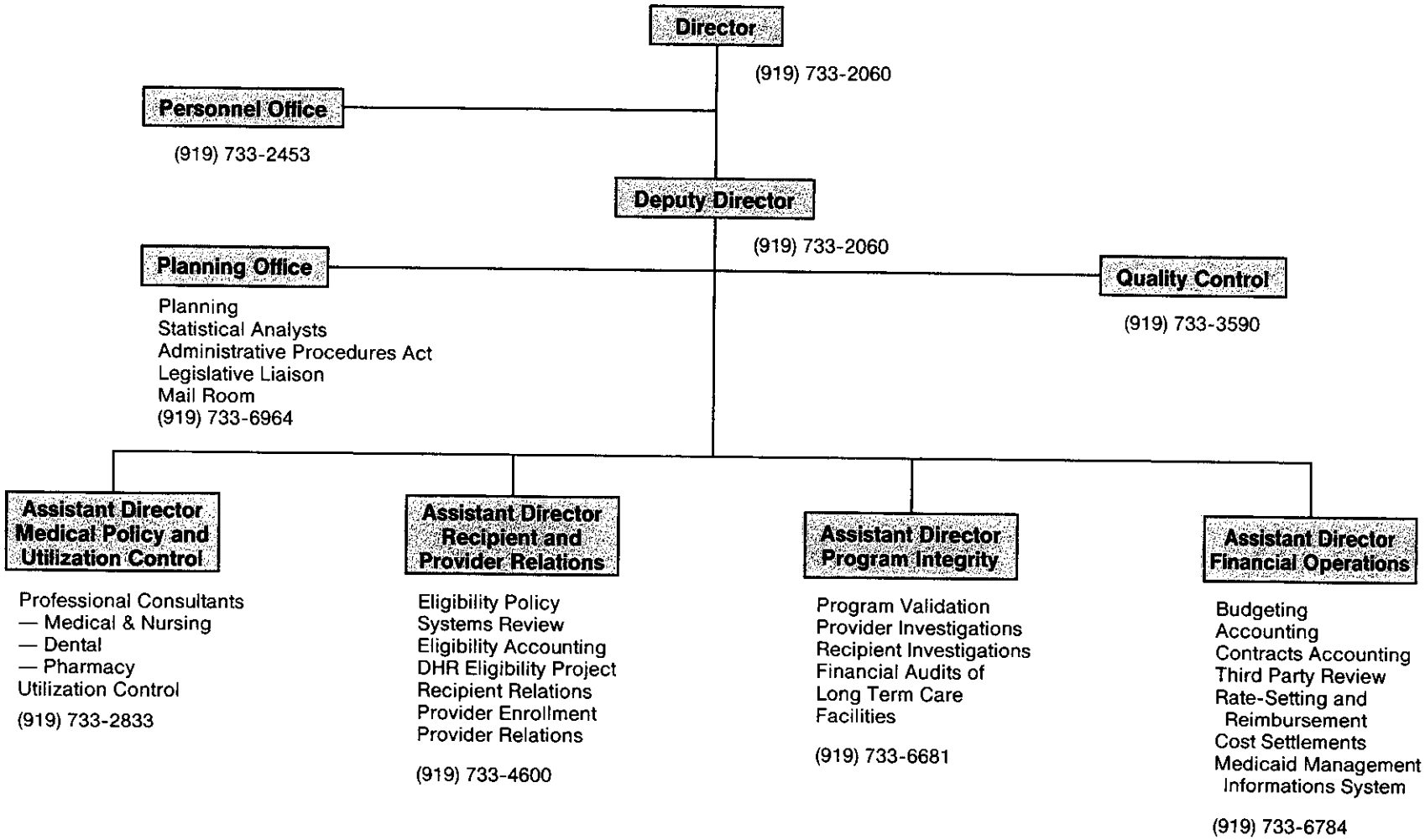


Medicaid in North Carolina
Annual Report
State Fiscal Year 1989

State of North Carolina
Department of Human Resources
Division of Medical Assistance

James G. Martin	David T. Flaherty	Barbara D. Matula
Governor	Secretary	Director

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MEDICAL ASSISTANCE
OFFICE OF THE DIRECTOR



MEDICAID IN NORTH CAROLINA

ANNUAL REPORT
State Fiscal Year 1988 - 1989

The Honorable James G. Martin
Governor of the State of North Carolina

David T. Flaherty, Secretary
Department of Human Resources

Barbara D. Matula, Director
Division of Medical Assistance

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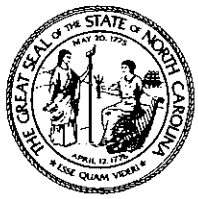

N.C. Division of Medical Assistance

Dear Fellow North Carolinian:

1988-89 has been an exciting year for North Carolina Medicaid, full of changes, challenges and improvements to the program. I am pleased to report on our efforts. Highlights of our activities in state fiscal year 1989 include initiatives to combat infant mortality, creation of a Medicare-Aid program for elderly and disabled persons, addition of nurse midwife and private duty nursing services, and enhanced payment for physician and dental services. At the same time, Medicaid continued to do the best possible job to ensure that taxpayers' dollars are spent wisely. North Carolina Medicaid was recognized for having the lowest payment error rate in the country during the year.

This year we've also given the annual report a new look — one we hope will make it more readable and helpful to you. We have expanded the description of Medicaid services and revised the way facts and figures are presented. We hope you like the new format and invite your suggestions for improvement in coming years.

Sincerely,

Barbara D. Matula

Barbara D. Matula

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HIGHLIGHTS OF THE 1989 FISCAL YEAR

Medicaid is a central source of health care for North Carolina's most vulnerable citizens: aged, blind, disabled individuals and low income families who cannot afford to pay their own health care expenses. During state fiscal year (SFY) 1989, Medicaid spent $1.1 billion for necessary health care services for 468,716 of North Carolina's neediest citizens. This represents just over 7% of North Carolina's population. In SFY 1989, Medicaid was able to serve 16% more needy recipients than in the year before.

As in past years, the largest proportion (69%) of Medicaid's budget was spent for services to aged, blind and disabled individuals. Thirty-one percent (31%) was spent on care for low income families and children. About 40% of the budget is spent on nursing home care and on institutional care for the mentally retarded. The remainder was spent on other types of preventive and acute health care services for other eligible groups and for administration.

During the year, Medicaid made a number of important changes in coverage and payment for services. Medicaid also instituted a new process for monitoring the appropriateness and quality of specialized services provided in the home. Further, Medicaid was recognized for achieving the lowest payment error rate in the nation as a result of its ongoing quality assurance activities.

Infant Mortality Initiatives

The need for preventive services and basic medical care for North Carolina's mothers and children is a continuing priority of the Medicaid program. In 1987, greater coverage of these services became a reality. The North Carolina General Assembly authorized Medicaid to take advantage of several options in federal law that expand coverage for pregnant women and children with incomes up to 100% of the federal poverty level. These include:

- Counting only a pregnant woman's income and not her assets in determining her eligibility for care.

- Allowing a pregnant woman to remain eligible throughout her pregnancy and for 60 days after without regard to changes in her income.

- Permitting certain providers, such as health departments and rural health clinics, to grant temporary eligibility for prenatal care. A "presumptively eligible" woman then has 14 days to apply for Medicaid at her county department of social services.

Under this expanded program, pregnant women can receive all services that relate to pregnancy and more young children can receive all necessary Medicaid services. To increase the likelihood that young children receive medical care during their formative years, the General Assembly authorized several increases in the age limit for children who qualify for this special program: to age 3 as of October 1, 1988 and to age 6 as of October 1, 1989. In 1989 alone, this program helped 20,438 pregnant women and 17,229 children.

Medicare-Aid

In February 1989, North Carolina began a new program of health care financing assistance to elderly and disabled Medicare beneficiaries. The new program, known as "Medicare-Aid", allows Medicaid to pay low income Medicare beneficiaries' cost-sharing expenses, such as deductibles, premiums and coinsurance charges. Although enacted as part of the U.S. Congress' Medicare Catastrophic Coverage Act of 1988 (MCCA), the repeal of this bill in December 1989 did not eliminate Medicare-Aid. In fact, 5,211 Medicare recipients benefited from Medi-

care-Aid in SFY 1989.

Medicare Catastrophic Coverage Act of 1988

In 1988, the U.S. Congress enacted the Medicare Catastrophic Coveraqe Act (MCCA). This act was widely held to be the largest benefit expansion since Medicare's inception in 1965 and included many valuable benefit changes for North Carolina's elderly and disabled citizens. Among the changes were creation of the Medicare-Aid program mentioned above, new drug and home care benefits, reduced beneficiary cost-sharing on some health care services, increased program financing charges, and increased financial protection for spouses of nursing home patients ("spousal impoverishment" provisions).

Due to delayed, but intense, citizen criticism of certain parts of the Act, Congress repealed most of the MCCA in 1989. Both the Medicare-Aid program and spousal impoverishment provisions authorized by the Act survived repeal, however, and they continue to benefit North Carolina's low-income aged and disabled populations.

Other Expanded Services

During SFY 1989, two additional services were added to the Medicaid program. Coverage for nurse midwife and private duty nursing services were made available beginning July, 1988. Both services offer needed alternatives to traditional services. Coverage of nurse midwife services helps alleviate North Carolina's tight physician supply in crucial prenatal care and delivery services. Private duty nursing services allow very ill patients to be cared for in their homes.

Improvements for Providers

Health care providers' willingness to serve Medicaid patients is critical to Medicaid's long-term effectiveness. Since 1988, the North Carolina General Assembly has authorized a number of changes in Medicaid fees to increase patients' access to services, promote equity among providers, and encourage cost effective patterns of care.

- In 1988, Medicaid eliminated inequitable specialty differentials and began paying the same fee for a service, regardless of provider specialty. At the same time, physician fees for "cognitive services", including office visits, hospital visits, nursing home visits, and consultations were increased, resulting in a 10 % increase overall. Fees for the most frequently billed dental services were increased by 7%.

- In 1989, the average maximum fees for 6,700 physician procedures were increased by 10%. Most dental procedures were increased by 5%.

- Medicaid also substantially increased payments for maternity care services. The global package payment for a normal delivery increased from $409 in 1987 to $625 in 1988, and again to $925 in 1989. The fee for a normal delivery only increased from $308 in 1987 to $350 in 1988, then to $550 in 1989. During this same period, historical differences in payments for physician services delivered in inpatient and outpatient settings were eliminated.

Quality Control Error Rate

The Medicaid program is committed to ensuring that it pays only for necessary health care services for those who are eligible. As part of this effort, the Division of Medical Assistance continually reviews Medicaid eligibility and payments to make sure that correct determinations and payments were made.

The federal government monitors this process, setting stringent limits on permissable errors and institutes financial penalties against States who

exceed the error limits. Penalties are imposed if more than 3% of program payments were made in error on an annual basis. Despite the tight error limits, the North Carolina Medicaid program's "error rate" has been consistently among the very lowest of all Medicaid programs nationwide.

In 1989, the federal government recognized North Carolina for achieving the lowest error rate in the nation for a six month period in 1988. North Carolina had the fifth lowest error rate for the prior period and was second lowest in errors for the year.

North Carolina's low error rates result from a longstanding partnership between the Division and the counties. In this partnership, DMA staff conduct federally mandated and state-initiated reviews of county cases to identify problems. County staff use this information to conduct training and implement corrective action. State and county staff work together on the Medicaid Error Reduction Committee to develop the state's overall plan for error reduction.

Specialized Care Services

Escalating health care costs, exciting innovations in home care technology, and growing awareness of quality of care concerns have achieved high visibility during the past decade. In response to these trends, North Carolina's Medicaid program created a new unit , composed of specialized health care professionals to monitor the care of critically ill Medicaid patients who are served in their homes. In the spring of 1989, the Specialized Care Services program began working closely with health care providers, patients and their families to be sure that specialized home care services are appropriate.

NORTH CAROLINA'S MEDICAID PROGRAM

History

Congress created the Medicaid program in 1965. It was designed to be a medical safety net for two categories of low income people receiving cash assistance: mothers and children and elderly, blind and disabled persons. Medicaid is jointly financed by the federal and state governments--in North Carolina, the 100 counties contribute to the non-federal share of costs. All states, the District of Columbia and some territories have Medicaid programs (Arizona's operates under a demonstration authority). Medicaid programs are governed by federal guidelines, but vary in eligibility criteria and covered services. In North Carolina, counties administer eligibility determinations.

North Carolina's program began in 1970 as a Department of Social Services program. It became the Division of Medical Assistance (DMA) within the Department of Human Resources (DHR) in 1978.

DMA has a staff of 177, up from 121 in SFY 1978. During the same time period, Medicaid expenditures and eligibles grew from $307 million to $1.2 billion, and from 456,000 to 561,000, respectively. Over almost 20 years of operation, Medicaid's programmatic complexity has paralleled the growth in both program expenditures and recipients. Historically, however, DMA has spent a relatively modest percentage of its budget on administration. In SFY 1989, Medicaid state and local administration costs consumed just 5% of total program dollars. This level of expenditure is testimony to Medicaid's use of efficient administrative methods and innovative cost control strategies.

Greatly overshadowing Medicaid in 1965, was creation of Medicare, a federally operated health insurance program for elderly, blind and disabled individuals, regardless of income. Composed of two distinct programs (Part A and Part B), Medicare is financed through Social Security payroll taxes, beneficiary premiums and general revenues.

Federal Financial Participation

The largest share of Medicaid costs is paid by the federal government. Federal Medicaid matching rates for services are established by the federal government — the Health Care Financing Administration (HCFA) — using the most recent three year average per capita income for each state and the national per capita income. The established federal matching rates for services are effective for a period of one federal fiscal year (from October through September). The State's fiscal year (SFY) runs from July through June. Because the federal and state fiscal years do not coincide, two different federal service matching rates may apply in each state fiscal year. The federal match rate for administrative costs does not change. As a result, there is only one administrative cost rate for SFY 1989. Table 1 shows the federal matching rates for SFY 1989.

Table 1
SFY 1989
Federal Matching Rates

Benefit costs

	Family Planning	All Other Services
	7/1/88 - 9/30/88	
Federal	90.0%	68.68%
State	8.5%	26.62%
County	1.5%	4.70%
	10/1/88 - 6/30/89	
Federal	90.0%	68.01%
State	8.5%	27.19%
County	1.5%	4.80%

Administrative costs
7/1/88 - 6/30/89

	Skilled Medical Personnel and MMIS*	All Services
Federal	75.00%	50.00%
Non-Federal	25.00%	50.00%

**MMIS - Medicaid Management Information System*

Table 2
SFY 1989
Medicaid Financial Eligibility Standards

ELIGIBILITY INCOME LEVELS
(Annual)

Family Size	AFDC, Related Groups Categorically Needy	AFDC, Related Groups Medically Needy	Aged, Blind, Disabled All Groups	Pregnant Women Indigent Children < 3	Qualified Medicare Beneficiary
1	$ 4,248	$ 2,900	$ 2,900	$ 5,770	$ 4,616
2	5,544	3,700	3,700	7,730	6,184
3	6,384	4,300	4,300	9,690	
4	6,984	4,700	4,700	11,650	
5	7,608	5,100	5,100	13,610	

ELIGIBILITY RESOURCES LIMITS

1	$ 1,000	$ 1,500	$ 1,500	No resources test applies	$ 4,000
2	no increment for family size	2,250	2,250		6,000
3		2,350	2,350		
4		2,450	N/A		
5		2,550	N/A		

Funding Formula

The federal matching rate for Medicaid services varies from state to state based on per capita income. In North Carolina, each county contributes 15% of the non-federal share of expenditures. During SFY 1989, the federal, state and county shares were approximately 68%, 27%, and 5%, respectively.

Eligibility

Medicaid is available for certain categories of people specified by law, based on financial (income and resources) criteria. North Carolina's Medicaid program has two main components, a "categorically needy" program and a "medically needy" program.

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

  - recipients of Aid to Families with Dependent Children (AFDC) payments, foster care and adoption assistance (Title IV-E) payments, state/county Special Assistance payments, or supplemental assistance programs to visually handicapped individuals;
  - pregnant women and infants up to age one;
  - children up through age 21;
  - those aged 65 and above;
  - those who are blind or disabled (as defined by the federal Social Security Administration criteria).

  With respect to the aged, blind and disabled groups, federal regulations permit states to either accept as categorically needy all persons found

eligible for the federal Supplemental Security Income (SSI) program or to set categorically needy eligibility criteria which are more restrictive than SSI standards. North Carolina has elected the more restrictive option, making it one of 13 "209(b)" states, so-named for the regulatory citation explaining the option.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) expanded Medicaid for individuals who are entitled to Medicare Part A, the hospital insurance part of the program. This coverage, the "Medicare-Aid" program, was effective February 1, 1989. As noted previously, Medicaid coverage is in the form of payment for out-of-pocket expenses for Medicare-covered services, such as premiums, deductibles and coinsurance. The income and resource limits that must be met to qualify for Medicare-Aid are higher than those necessary to receive full Medicaid coverage. (See Table 2 "Qualified Medicare Beneficiary" column).

Another provision of the Medicare Catastrophic Coverage Act protects a portion of the income and resources of a married couple for the spouse living in the community when the other spouse requires long term care. This allows the institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. These provisions were effective October 1, 1989.

Persons in the categories listed above must have income and resources (such as savings, automobiles) below a certain level to qualify for Medicaid. These levels are shown in Table 2.

• **Medically Needy.** The medically needy meet the same general requirements as the categorically needy but do not receive cash assistance payments, generally because their income is higher than state standards allow. If the medically needy individual's income is higher than the allowable level, he or she must spend the excess income on medical care before becoming eligible. This is known as the Medicaid deductible (or "spenddown").

How the Program Works

Medicaid operates as a "vendor payment" program. Families or individuals are issued a Medicaid eligibility card each month. Program eligibles may receive medical care from any of the 21,756 providers who are enrolled in the program. Providers then bill Medicaid for their services. Table 3 shows the broad range of providers that Medicaid enrolls.

Table 3
SFY 1989
Enrolled Medicaid Providers

Providers	*Number*
Physicians	**12,782**
Radiologists	**822**
Dentists	**2,456**
Pharmacists	**2,033**
Optometrists	**753**
Chiropractors	**452**
Podiatrists	**220**
Ambulance	**180**
Home Health Agencies	**128 ***
ICF-General	**221**
ICF-MRC	**103**
Hospitals	**194**
Mental Health Clinics	**95**
Optical Supplies	**1 ****
SNF	**232**
Personal Care Agencies	**113**
Rural Health Clinics	**43**
Nurse Midwives	**3**
Hospices	**32**
CAP Providers	**323**
Other Clinics	**48**
Other	522
Total	**21,756**

*** Includes durable medical equipment, physical, speech, occupational therapy.**

**** Single Source Contract effective July 1, 1986.**

Administrative Contracts

Certain functions of the Medicaid program are performed under contract to DMA.

• **Electronic Data Systems-Federal (EDS-F).** DMA contracts with EDS-F to perform many administrative functions of the Medicaid program. EDS-F pays claims, serves as a focal point for questions and problems, trains new providers, operates the prior approval system for most Medicaid services (for example, cosmetic surgery), and fulfills program reporting requirements. Expenditures for EDS-F services were $6.2 million in SFY 1989. EDS-F processed 16,118,595 claim line items during the year.

During 1989, the contract for claims processing services was competitively bid, as required by federal law. EDS-F won the right to continue operating as DMA's fiscal agent for the next four years, plus four potential one-year extensions.

• **Medical Review of North Carolina (MRNC).** DMA contracts with MRNC to operate Medicaid's preadmission certification program for inpatient hospital care. The pre-certification program ensures that Medicaid patients receive medically necessary care in the most appropriate setting.

Cooperative Arrangements

Although DMA administers Medicaid , other agencies, DHR divisions, and state departments work closely with the program and perform significant functions.

• **Counties .** North Carolina's 100 counties have a central role in the Medicaid program. County departments of social services determine Medicaid eligibility for the program. In addition, counties share in approximately 5% of the cost of provider benefit services for Medicaid patients.

• **Division of Social Services (DSS).** The North Carolina DSS conducts Medicaid recipient appeals when eligibility denials are contested. DSS Regional offices in the State provide consultation and technical assistance on Medicaid eligibility to county departments of social services.

Disability determinations for disabled individuals are made by a disability determination unit of the State's DSS. This unit also makes disability determinations for two Federal programs under contract with the Social Security Administration (Title II - Social Security and Title XVI - Supplemental Security Income).

• **Division of Mental Health (DMH/DD/SAS).** DMA works closely with the DMH to finance community mental health services. During SFY 1989, the divisions developed a proposal to allow greater Medicaid coverage for mental health services through community mental health centers. This proposal will come to fruition in SFY 1990.

• **Division of Aging (DOA).** DMA has become more involved during SFY 1989 with DOA activities. DMA staff routinely participate in a number of policy development projects designed to establish a long range plan for services to the elderly in North Carolina.

• **Division of Facility Services (DFS).** DFS has responsibility for certifying and monitoring long term care facilities in North Carolina. In this role, DFS ensures that all patients, including those covered by Medicaid, receive quality care when they are most vulnerable. DMA and DFS work cooperatively in planning for implementation of changes brought about by federal nursing home reform legislation.

• **Division of Health Services (DHS).** DHS, recently transferred from DHR to the Department of Environment, Health and Natural Resources (DEHNR)

operates a variety of health care programs. Medicaid pays for services offered through DHS programs and local health departments. DHS and local health departments also play a central role in the operation of "Baby Love", a care coordination program designed to help pregnant women negotiate the health care system and to have healthy pregnancies and healthy babies. The interagency cooperation exemplified by the Baby Love program has become a national model.

• **Department of Public Instruction (DPI).** P.L. 99-457 is a federal law that provides funding for education and related services to handicapped preschoolers, and requires that states find and serve all eligible children between the ages of three and five. Each state must adopt the provisions of P.L. 99-457 by SFY 1993 or lose all federal funding for educational services to handicapped preschoolers. DMA cooperates with DPI in this effort by providing a representative to the Interagency Coordinating Council, which serves as a planning and advisory body for P.L. 99457 issues.

Covered Services

North Carolina Medicaid covers a comprehensive array of services to treat eligible patients when they become ill. Preventive services in the form of annual physicals for adults and through screenings provided under the Healthy Children and Teens Program (EPSDT), reflect Medicaid's commitment to the primary care needs of North Carolina's citizens.

Medicaid imposes certain standard limitations on the services listed in Table 4, including a limit of 24 visits to practitioners, clinics, and outpatient departments, and a limit of six prescriptions per month. There are exceptions to these for preventive care to pregnant women, children with life threatening conditions, and other groups.

Table 4
Medicaid Services

Ambulance Transportation
Case Management for pregnant women, chronically mentally ill adults, emotionally disturbed children, and chronic substance abusers
Chiropractors
Clinics (including Mental Health Centers)
Community Alternatives Program for aged/ disabled adults, mentally retarded, and disabled children under age 18
Dental
Durable Medical Equipment
Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
Family Planning
Hearing Aids (for Children)
Home Health
Hospice
Inpatient and Outpatient Hospital Services
Intermediate Care Facilities (ICF) and Intermediate Care Facilities for the Mentally Retarded (ICF-MRC)
Lab and X-Ray
Mental Hospitals (for age 65 and over)
Migrant Health Clinics
Nurse Midwives
Optical Supplies
Optometrists
Personal Care
Physicians
Podiatrists
Prepaid Health Plan
Prescribed Drugs
Private Duty Nursing
Psychiatric Hospitals (for under age 21)
Rural Health Clinics
Skilled Nursing Facility (SNF)
Specialty Hospitals
Transportation (through the counties)

Nominal copayments apply to some services and others require prior approval before services are eligible for payment. Both requirements help ensure that care received is medically necessary. Service limitations and copayment requirements are discussed in more detail in "Medicaid In Depth".

Medicaid's Impact

Medicaid spending is an investment in the health and welfare of North Carolina's citizens. Medicaid means that North Carolina's citizens receive the health care they need, but cannot afford. Seven percent of all North Carolinians

Table 5
SFY 1989
Medicaid Expenditures and Eligibiles by County

County Name	Number of Medicaid Eligibles	Total Expenditures
Alamance	6,347	$17,053,349
Alexander	1,250	3,824,615
Alleghany	761	1,364,177
Anson	3,027	6,375,285
Ashe	2,310	5,119,107
Avery	1,289	3,243,934
Beaufort	5,138	9,664,560
Bertie	3,596	5,510,734
Bladen	5,241	9,031,601
Brunswick	5,283	8,873,963
Buncombe	11,389	30,210,058
Burke	4,731	11,940,388
Cabarrus	5,670	15,034,142
Caldwell	4,679	12,747,141
Camden	536	1,029,044
Carteret	3,216	8,229,025
Caswell	2,123	4,508,894
Catawba	5,401	14,662,181
Chatham	2,076	6,028,334
Cherokee	2,192	4,951,711
Chowan	1,732	3,289,223
Clay	646	1,740,794
Cleveland	7,269	16,619,765
Columbus	8,839	17,082,355
Craven	7,396	15,734,535
Cumberland	26,933	38,954,180
Currituck	670	1,645,937
Dare	822	2,250,651
Davidson	6,941	16,768,207
Davie	1,361	4,328,943
Duplin	5,141	10,043,007
Durham	13,247	30,460,768
Edgecombe	9,804	15,606,226
Forsyth	19,606	42,681,759
Franklin	3,656	8,159,854
Gaston	14,669	27,651,945
Gates	956	1,818,631
Graham	1,011	1,972,275
Granville	2,706	5,370,228
Greene	2,136	4,134,450
Guilford	23,838	54,400,330
Halifax	11,783	16,291,501
Harnett	8,047	14,748,543
Haywood	3,885	8,450,603
Henderson	4,374	10,330,660
Hertford	4,277	6,402,912
Hoke	3,694	5,062,545
Hyde	818	1,383,881
Iredell	5,817	14,769,997
Jackson	2,231	4,403,096
Johnston	8,005	17,636,123
Jones	1,358	3,516,368
Lee	3,847	8,333,945
Lenoir	7,940	16,372,802
Lincoln	2,953	7,058,291
Macon	1,788	3,915,356
Madison	2,210	4,436,702
Martin	3,443	5,519,085
McDowell	2,424	6,070,399
Mecklenburg	34,654	69,193,851
Mitchell	1,454	3,141,067
Montgomery	2,488	4,825,910
Moore	3,554	8,469,081
Nash	8,360	14,595,884
New Hanover	12,888	23,133,990
Northampton	4,380	7,099,998
Onslow	7,821	14,165,161
Orange	3,622	10,645,029
Pamlico	1,304	2,853,417
Pasquotank	4,193	6,295,511
Pender	3,373	7,228,783
Perquimans	1,591	2,391,370
Person	2,935	7,771,469
Pitt	12,967	20,783,631
Polk	780	2,239,607
Randolph	4,586	13,729,852
Richmond	4,642	9,783,483
Robeson	20,086	28,754,370
Rockingham	6,663	16,806,880
Rowan	6,592	16,500,688
Rutherford	4,669	9,957,232
Sampson	6,507	13,043,575
Scotland	6,092	8,592,099
Stanley	2,948	8,104,968
Stokes	2,140	5,545,699
Surry	4,302	10,335,499
Swain	1,520	2,094,628
Transylvania	1,829	4,519,764
Tyrrell	769	1,397,568
Union	5,850	10,562,537
Vance	5,500	9,213,521
Wake	19,745	39,401,671
Warren	2,668	5,007,139
Washington	2,432	3,639,866
Watauga	1,751	3,892,283
Wayne	11,110	19,727,908
Wilkes	4,387	10,954,922
Wilson	10,102	15,204,380
Yadkin	1,838	5,071,574
Yancey	1,433	2,614,229
STATE TOTAL	561,053	$1,134,109,209

Source: Medicaid Cost Calculation for SFY 1989. Medicaid Eligibility Report for 1989.

benefit directly from the program. Table 5 shows how expenditures and eligibles are distributed by county.

Medicaid is also an ongoing source of both state and federal revenues for North Carolina's health care providers, although its importance varies by provider. Medicaid pays for all patients in intermediate care facilities for the mentally retarded and for 70% of all nursing home days. In SFY 1989, 83% of North Carolina's primary care physicians served at least 10 Medicaid patients; 70% served at least 25 patients. In many of the state's most rural counties, all primary care physicians participate in the program and Medicaid funding helps make their practices financially viable. On average, Medicaid accounts for 13% of all hospital days, but individual hospitals vary greatly.

Program Efficiency And Effectiveness

Medicaid has an obligation to North Carolina's taxpayers to ensure that limited funds are wisely spent. Medicaid's payment error rate, which has been consistently below the 3% federal tolerance level, is one measure of success in fulfilling this objective. As noted earlier, during the April to September 1988 reporting period, North Carolina had the lowest Medicaid payment error rate in the nation, .02 percent.

• **Program Integrity.** DMA program integrity efforts include: identification of providers and recipients who are abusing and/or defrauding the Medicaid program; determination and collection of provider and recipient overpayments; education of providers and recipients when errors or abuse are detected; and protection of recipients' rights. DMA accomplishes these tasks through the Program Integrity Section of the agency and through cooperation with the State Medicaid Investigations Unit of the Office of the Attorney General and the fraud and abuse staff of county departments of social services.

During 1989, 1,181 provider reviews were initiated and 1,068 recipient cases were opened. Collections of overpayments amounted to $507,299 from providers, and $404,744 from recipients found to be ineligible. In addition, financial audits of long term care facilities resulted in recovery of $3,364,548 from 293 field audits and $2,218,360 from 276 desk audits.

Also during 1989, program integrity efforts resolved provider questions and billing problems through educational letters and consultations. DMA assisted nursing homes in interpreting and applying Medicaid regulations for reimbursement and administration of patients' personal needs funds. One tangible example of this assistance was the publication of the first "Nursing Home Audit Newsletter" in July 1989. In addition, action on numerous recipient complaints resulted in substantial refunds made to recipients who had been billed erroneously or whose personal needs fund had been handled incorrectly.

The Program Integrity Section operates the system DMA uses to identify misspent dollars. The Surveillance and Utilization Review Subsystem (S/URS) of the Medicaid Management Information System (MMIS) identifies providers and recipients whose patterns of practice and use of services fall outside of the norm for their peer groups. These on-going activities also provide useful data to enhance management oversight of the Medicaid program.

• **Utilization Control and Review.** DMA operates other programs to make sure that Medicaid funds are wisely spent. These programs are designed to prevent and recover incorrect payments.

Prior approval and prior authorization for services in advance of their delivery is used to ensure that the care that is planned is appropriate. The prior approval system for most services is operated by EDS-Federal. Prior authorization is operated by MRNC.

Paid claims are reviewed periodically and those which differ significantly from established norms are analyzed to see if the services are medically necessary and appropriate.

• **Third Party Recovery.** By law, Medicaid is designated as the "payor of last resort", with all other resources tapped before Medicaid dollars are spent. Third party resources for medical care, such as health insurance, can be an important means of keeping Medicaid costs as low as possible. As a condition of receiving benefits, recipients agree to permit Medicaid to seek payment from available third party health care resources on their behalf. North Carolina's Medicaid agency has received national recognition for its efforts in recovering these third party resources.

In SFY 1989, funds from a variety of sources defrayed Medicaid expenditures:

- Insurance paid on patients' behalf was $14,536,162 .
- An additional, $28,743,820 in claims were denied because other insurance may be available to pay for services.
- Refunds were received from:

Medicare	$ 728,770
Health Insurance	$ 3,802,179
Casualty Insurance	$ 2,175,910
Absent Parent	$ 19,851

In addition, Medicaid policy is designed to avoid costs that would otherwise be incurred. In SFY 1989, $224,876,408 in patient expenditures were saved by DMA's policy of requiring billing to other third party payers.

MEDICAID DOLLARS AND PEOPLE

Revenue And Expenditures

In SFY 1989, Medicaid paid $1,138,670,194 for health care services to North Carolina citizens. In addition $58,235,157 was spent to administer the program at the state and local levels. This means that about 95% of the total budget was spent on services.

Table 6
SFY 1989
Sources of Medicaid Funds

Federal funds	**$801,966,040**
State funds	**$324,320,351**
County funds	**$ 70,618,960**
Total funds	**$1,196,905,351**

Chart 1
SFY 1989
Sources of Medicaid Funds

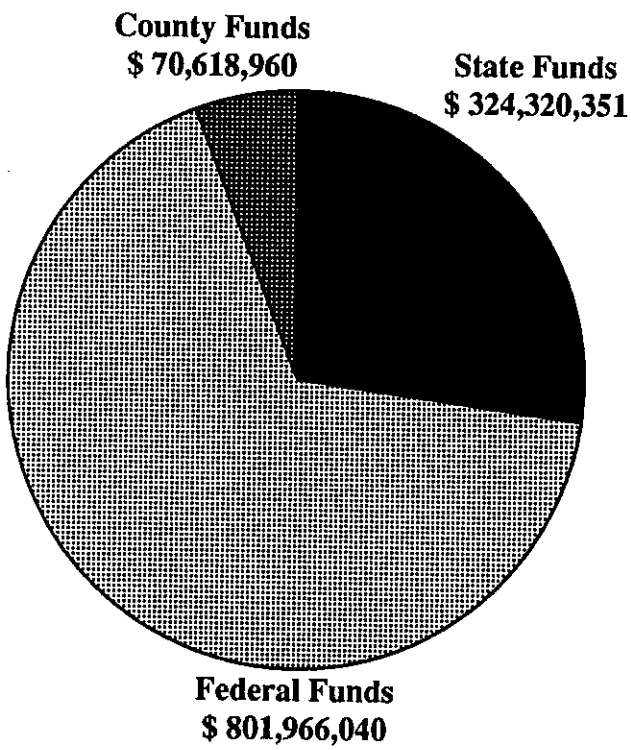


Chart 2
SFY 1989
Uses of Medicaid Funds
(percent of total expenditures)

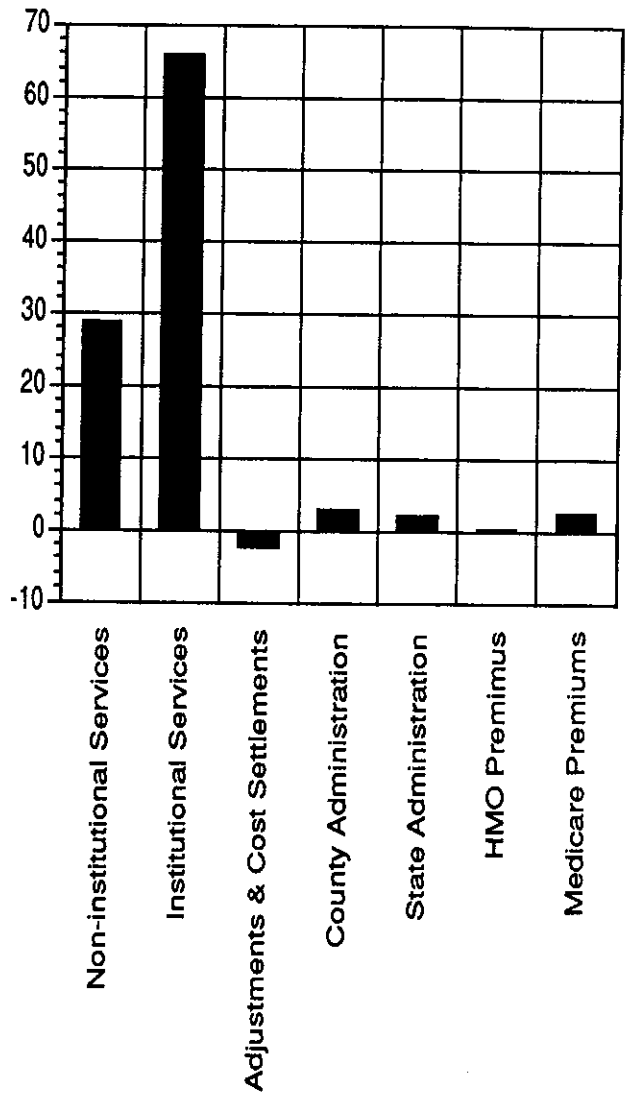


Table 7
SFY 1989
Uses of Medicaid Funds

Type of Service	Total Expenditures	% of Total Dollars	% of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	$314,142,659	26.2	27.7	115,674	$2,716
Mental & Psychiatric Hospital	29,997,829	2.5	2.6	2,152	13,940
Outpatient Hospital	43,900,436	3.7	3.9	227,220	193
Physician	89,002,944	7.4	7.8	365,284	244
Clinics	17,453,821	1.5	1.5	59,210	295
SNF	148,483,473	12.4	13.1	16,020	9,269
ICF-General	124,816,664	10.4	11.0	14,546	8,581
ICF-MR	172,680,331	14.4	15.2	3,662	47,155
Dental	14,485,692	1.2	1.3	107,469	135
Prescription Drugs	83,796,563	7.0	7.4	325,112	258
Home Health	32,264,811	2.7	2.8	15,530	2,078
Other Services	65,030,729	5.4	5.7	398,183	163
Sub-Total, Service	**$1,136,055,952**	**94.8**	**100.0**		
Medicare Premium	29,398,907	2.5			
HMO Premium	863,989	***			
Adjustments & Cost Settlements	(27,648,654)	(2.3)			
Sub-Total, Service & Other	**$1,138,670,194**	**95.0**			
Administration (State & County)	58,235,157	4.9			
(State)	22,292,337	1.9			
(County)	35,942,820	3.0			
Grand Total Expenditures	**$1,196,905,351**	**100.0**			
Total Recipients (unduplicated)**				**468,716**	
Service Expenditures Per Recipient (unduplicated)					**$2,424**

* "Users of Service" is a duplicated count of recipients. A recipient who uses one or more services is counted in each service category.

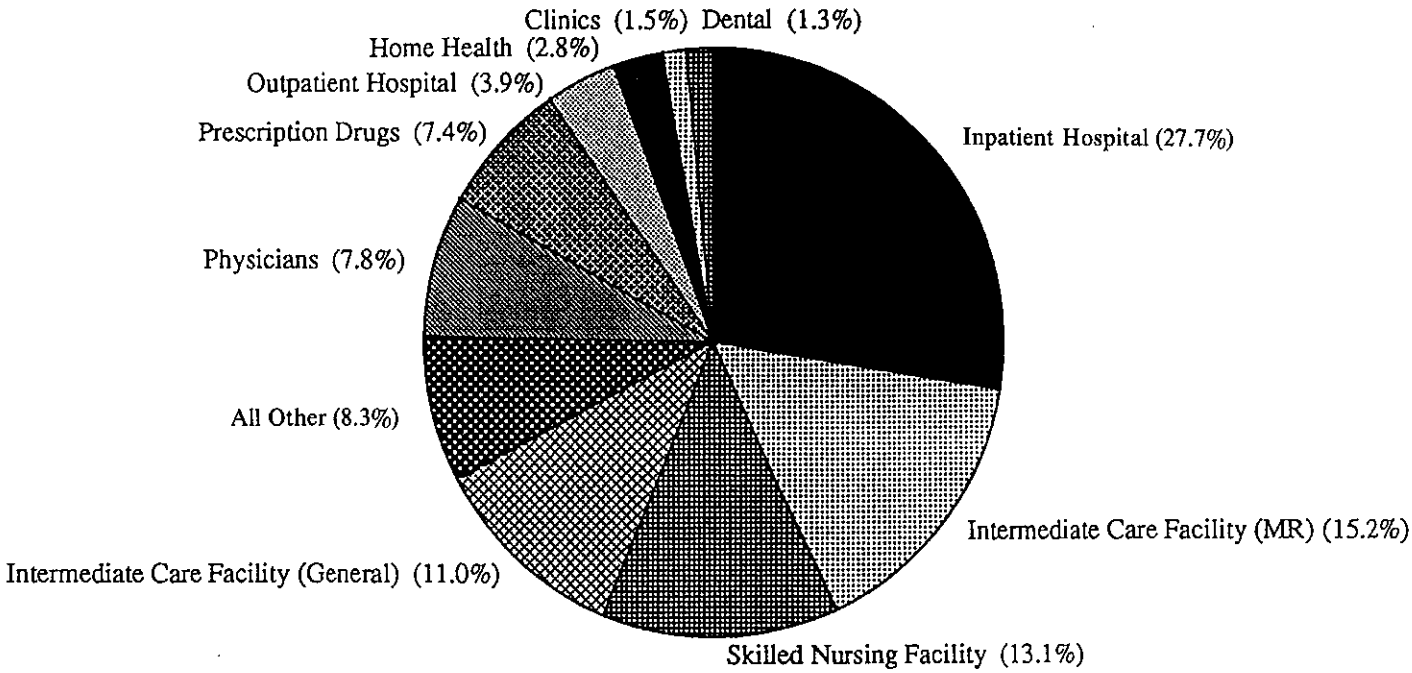
** "Total Recipients" is an unduplicated count, and counts recipients only once during the year regardless of the number and type of services they use.

*** Less than .1%

Note: Numbers may not add due to rounding

Source: SFY 2082 report, SFY 1989; DAS report, SFY 1989

Chart 3
SFY 1989
Medicaid Service Expenditures, Percent



Medicaid expenditures grew by almost 22 % from SFY 1988 to SFY 1989. This represents the largest increase since SFY 1981. The increase is due to four main factors. Eligibility expansions including, pregnant women, infants, children and other recipients, accounted for 33 % of the increase; more intensive use of services accounted for 29%, and rate increases (or inflation) added another 23%. The balance of the change (15%) is due to factors such as more extensive use of services by existing eligibles and changes in service mix.

Table 8
SFY 1979-1989
A History of Total Medicaid Expenditures

Fiscal Year	Expenditures	Percentage Change
1979	379,769,848	
1980	410,053,625	8.0
1981	507,602,694	23.8
1982	521,462,961	2.7
1983	570,309,294	9.4
1984	657,763,927	15.3
1985	665,526,678	1.2
1986	758,115,890	13.9
1987	861,175,819	13.6
1988	983,464,113	14.2
1989	1,196,905,351	21.7

Note: Expenditures include vendor payments, administrative costs, refunds, adjustments.

Source: DAS report, SFY 1989

Eligibles

Medicaid counts the population it serves in two ways: "eligibles" and "recipients". "Eligibles" are those who meet Medicaid's categorical and financial criteria and qualify for Medicaid to pay for medical care on their behalf. Most eligibles use services and are called "recipients". Some eligibles, however, do not use services during the year. These are persons who automatically qualified for Medicaid because they qualified for cash assistance programs, but did not need health care during the year, or used care for which Medicaid did not pay. "Recipients" of services are discussed in the next section of this report.

In SFY 1989, 561,053 persons were eligible for Medicaid at some time during the year. This represents an increase of almost 80,000 eligibles (or 16%) over the prior year. The largest portion of the increase is due to eligibility expansions that began in 1989, including the Medicare-Aid program and coverage of greater numbers of pregnant women and children under the infant mortality initiative. Table 9 depicts the growth in Medicaid eligibles since SFY 1979.

Counties vary greatly in the number of residents who are eligible for Medicaid: from a low of 38 per 1,000 population in Dare county to a high of 207 per 1,000 population in Halifax county. The statewide average is 86 per 1,000 population. This variation is due to several factors, including general population density and area poverty rates. Table 10 presents a variety of data on counties, including expenditures, the number of Medicaid eligibles, per capita spending, rank, and Medicaid eligibles per 1,000 population in SFY 1989.

Table 9
SFY 1979 - 1989
A History of Medicaid Eligibles

Fiscal Year	Aged	Blind	Disabled	AFDC Adults & Children	Other Children	Qualified Medicare Beneficiary	Total
1978-79	82,930	3,219	59,187	301,218	6,620	NA	453,174
1979-80	82,859	2,878	56,265	307,059	6,641	NA	455,702
1980-81	80,725	2,656	53,773	315,651	6,559	NA	459,364
1981-82	70,010	2,349	48,266	298,483	6,125	NA	425,233
1982-83	67,330	2,000	46,537	293,623	6,062	NA	415,552
1983-84	65,203	1,755	46,728	288,619	5,501	NA	407,806
1984-85	65,849	1,634	48,349	293,188	5,333	NA	414,353
1985-86	69,193	1,554	51,959	313,909	5,315	NA	441,930
1986-87	72,295	1,462	54,924	317,983	5,361	NA	452,025
1987-88	76,308	1,394	58,258	339,803	5,563	NA	481,326
1988-89	80,044	1,304	62,419	392,213	6,009	19,064	561,053

Source: Medicaid Eligibility report, SFY 1989

Table 10
SFY 1989
Total Expenditures and Eligibles by County

County Name	1988 Est. County Population	Number of Medicaid Eligibles	Total Expenditures	Per Capita Expenditures		Eligibles Per 1,000 Population
				Amount	Ranking	
Alamance	105,903	6,347	$17,053,349	$161.03	73	60
Alexander	27,563	1,250	3,824,615	138.76	89	45
Alleghany	9,819	761	1,364,177	138.93	88	78
Anson	26,239	3,027	6,375,285	242.97	23	115
Ashe	23,488	2,310	5,119,107	217.95	34	98
Avery	15,254	1,289	3,243,934	212.66	38	85
Beaufort	42,432	5,138	9,664,560	227.77	31	121
Bertie	21,038	3,596	5,510,734	261.94	13	171
Bladen	30,932	5,241	9,031,601	291.98	6	169
Brunswick	50,956	5,283	8,873,963	174.15	59	104
Buncombe	173,198	11,389	30,210,058	174.42	58	66
Burke	77,311	4,731	11,940,388	154.45	80	61
Cabarrus	95,941	5,670	15,034,142	156.70	77	59
Caldwell	71,450	4,679	12,747,141	178.41	54	65
Camden	6,057	536	1,029,044	169.89	62	88
Carteret	51,038	3,216	8,229,025	161.23	72	63
Caswell	22,193	2,123	4,508,894	203.17	43	96
Catawba	117,347	5,401	14,662,181	124.95	94	46
Chatham	36,736	2,076	6,028,334	164.10	67	57
Cherokee	21,186	2,192	4,951,711	233.73	28	103
Chowan	13,695	1,732	3,289,223	240.18	25	126
Clay	7,274	646	1,740,794	239.32	26	89
Cleveland	87,117	7,269	16,619,765	190.78	52	83
Columbus	52,562	8,839	17,082,355	324.99	3	168
Craven	81,589	7,396	15,734,535	192.85	51	91
Cumberland	254,615	26,933	38,954,180	152.99	81	106
Currituck	13,987	670	1,645,937	117.68	96	48
Dare	21,460	822	2,250,651	104.88	99	38
Davidson	124,296	6,941	16,768,207	134.91	91	56
Davie	27,846	1,361	4,328,943	155.46	78	49
Duplin	41,653	5,141	10,043,007	241.11	24	123
Durham	171,483	13,247	30,460,768	177.63	56	77
Edgecombe	59,887	9,804	15,606,226	260.59	14	164
Forsyth	266,353	19,606	42,681,759	160.25	74	74
Franklin	35,445	3,656	8,159,854	230.21	30	103
Gaston	174,194	14,669	27,651,945	158.74	76	84
Gates	9,790	956	1,818,631	185.76	53	98
Graham	7,017	1,011	1,972,275	281.07	8	144
Granville	38,975	2,706	5,370,228	137.79	90	69
Greene	16,386	2,136	4,134,450	252.32	18	130
Guilford	336,837	23,838	54,400,330	161.50	70	71
Halifax	56,840	11,783	16,291,501	286.62	7	207
Harnett	66,286	8,047	14,748,543	222.50	32	121
Haywood	48,269	3,885	8,450,603	175.07	57	80
Henderson	69,258	4,374	10,330,660	149.16	84	63
Hertford	23,669	4,277	6,402,912	270.52	10	181
Hoke	23,973	3,694	5,062,545	211.18	39	154
Hyde	5,677	818	1,383,881	243.77	22	144
Iredell	91,592	5,817	14,769,997	161.26	71	64
Jackson	27,050	2,231	4,403,096	162.78	69	82
Johnston	80,664	8,005	17,636,123	218.64	33	99
Jones	9,847	1,358	3,516,368	357.10	1	138

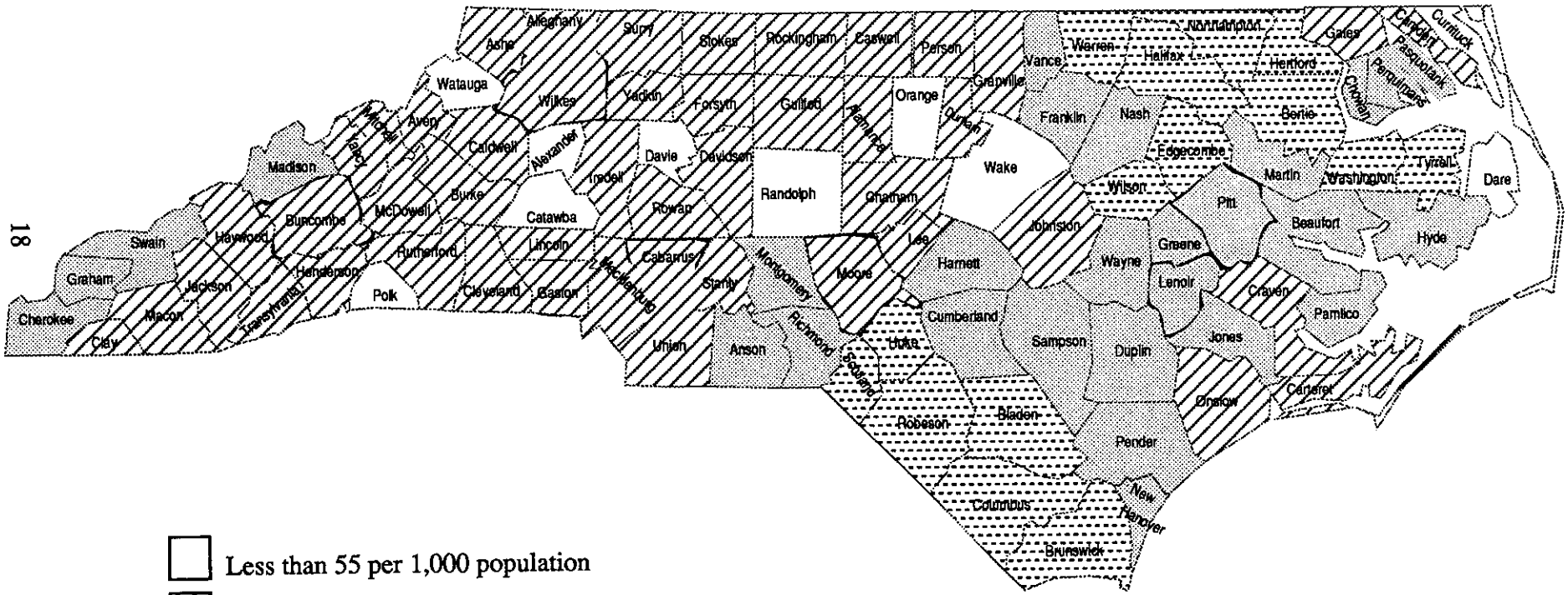
Note: Data reflect only net vendor payments for which the county is billed its computable share.

Table 10 - Continued
SFY 1989
Total Expenditures and Eligibles by County

County Name	1988 Est. County Population	Number of Medicaid Eligibles	Total Expenditures	Per Capita Expenditures		Eligibles Per 1,000 Population
				Amount	Ranking	
Lee	41,939	3,847	8,333,945	198.72	48	92
Lenoir	60,293	7,940	16,372,802	271.55	9	132
Lincoln	48,589	2,953	7,058,291	145.27	86	61
Macon	23,404	1,788	3,915,356	167.29	63	76
Madison	17,232	2,210	4,436,702	257.47	16	128
Martin	26,417	3,443	5,519,085	208.92	40	130
McDowell	36,342	2,424	6,070,399	167.04	65	67
Mecklenburg	476,033	34,654	69,193,851	145.36	85	73
Mitchell	14,699	1,454	3,141,067	213.69	36	99
Montgomery	24,171	2,488	4,825,910	199.66	46	103
Moore	59,317	3,554	8,469,081	142.78	87	60
Nash	72,739	8,360	14,595,884	200.66	44	115
New Hanover	117,417	12,888	23,133,990	197.02	49	110
Northampton	22,108	4,380	7,099,998	321.15	4	198
Onslow	125,506	7,821	14,165,161	112.86	97	62
Orange	88,484	3,622	10,645,029	120.30	95	41
Pamlico	10,980	1,304	2,853,417	259.87	15	119
Pasquotank	30,675	4,193	6,295,511	205.23	41	137
Pender	27,082	3,373	7,228,783	266.92	11	125
Perquimans	11,033	1,591	2,391,370	216.75	35	144
Person	31,422	2,935	7,771,469	247.33	21	93
Pitt	102,006	12,967	20,783,631	203.75	42	127
Polk	14,722	780	2,239,607	152.13	82	53
Randolph	102,753	4,586	13,729,852	133.62	92	45
Richmond	45,860	4,642	9,783,483	213.33	37	101
Robeson	108,017	20,086	28,754,370	266.20	12	186
Rockingham	86,483	6,663	16,806,880	194.34	50	77
Rowan	106,517	6,592	16,500,688	154.91	79	62
Rutherford	57,810	4,669	9,957,232	172.24	61	81
Sampson	50,892	6,507	13,043,575	256.30	17	128
Scotland	34,702	6,092	8,592,099	247.60	20	176
Stanley	51,045	2,948	8,104,968	158.78	75	58
Stokes	36,487	2,140	5,545,699	151.99	83	59
Surry	62,110	4,302	10,335,499	166.41	66	69
Swain	10,518	1,520	2,094,628	199.15	47	145
Transylvania	26,188	1,829	4,519,764	172.59	60	70
Tyrrell	4,095	769	1,397,568	341.29	2	188
Union	84,007	5,850	10,562,537	125.73	93	70
Vance	39,272	5,500	9,213,521	234.61	27	140
Wake	388,502	19,745	39,401,671	101.42	100	51
Warren	16,625	2,668	5,007,139	301.18	5	160
Washington	14,639	2,432	3,639,866	248.64	19	166
Watauga	34,672	1,751	3,892,283	112.26	98	51
Wayne	98,625	11,110	19,727,908	200.03	45	113
Wilkes	61,426	4,387	10,954,922	178.34	55	71
Wilson	65,583	10,102	15,204,380	231.83	29	154
Yadkin	30,322	1,838	5,071,574	167.26	64	61
Yancey	16,011	1,433	2,614,229	163.28	68	90
STATE TOTAL	6,487,438	561,053	$1,134,109,209	$174.82	N/A	86

Sources: Medicaid Cost Calculation, SFY 1989
Medicaid Eligibility report, SFY 1989

Chart 4
SFY 1989
Medicaid Enrollment per 1,000 Population by County



Recipients

"Recipients" are those who use a service during the year. In SFY 1989, Medicaid paid for 468,716 recipients. Another 92,337 persons were eligible for Medicaid but either did not receive medical care or received care that Medicaid does not pay for.

"Recipients" are counted in two ways in relation to their use of services: "unduplicated" and "duplicated." Total recipients is an unduplicated count, enumerating all those individuals who have used one or more types of service. The recipient count for types of service is a duplicated count, meaning that a recipient using two or more different types of service would be counted once in each service category. As a result, the sum of all recipients across service categories does not equal the total unduplicated recipient count, as shown in table 11 and the tables that follow.

Table 11
SFY 1989
Medicaid Service Expenditures by Eligibility Group

Eligibility Group	Total Service Dollars	% of Dollars	Total Recipients*	% of Recipients	Service Expenditures Per Recipient
Total Elderly	$378,580,502	33.3	86,495	18.5	$4,377
Aged	378,022,654	33.2	81,284	17.4	4,651
Medicare-Aid	557,848	0.1	5,211	1.1	107
Total Disabled	400,983,624	35.3	64,121	13.7	6,254
Disabled	394,567,977	34.7	62,819	13.4	6,281
Blind	6,415,647	0.6	1,302	0.3	4,928
Total Families And Children	356,491,826	31.4	318,100	67.8	1,121
AFDC Adults	119,228,964	10.5	97,188	20.7	1,227
Special Pregnant Woman Coverage	29,308,370	2.6	20,438	4.3	1,434
AFDC Children & Other Children	177,412,397	15.6	183,245	39.1	968
Special Children Coverage	30,542,095	2.7	17,229	3.7	1,773
Total Service Expenditures All Groups	**$1,136,055,952**	**100.0**	**468,716 ****	**100.0**	**$2,424**

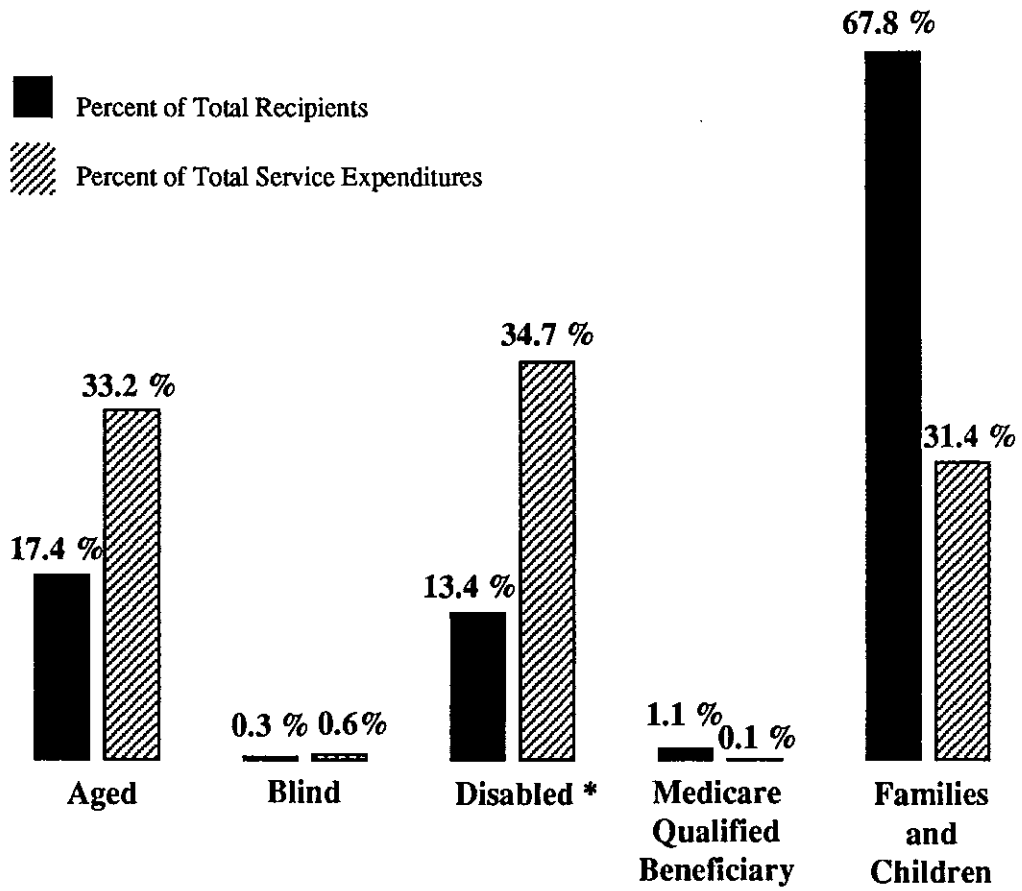
* A "recipient" is a Medicaid eligible who has used services. "Recipients" is a duplicated count.

** "Total Recipients" is an unduplicated count.

Note: Does not include adjustments processed by DMA, settlements, premiums, and state and county administrative costs. These total $60,849,399. See Table 7 for more details.

Source: SFY 2082 report, SFY 1989.

Chart 5
SFY 1989
Medicaid Recipients and Service Expenditures



* includes 396 mentally retarded children in ICF-MRs

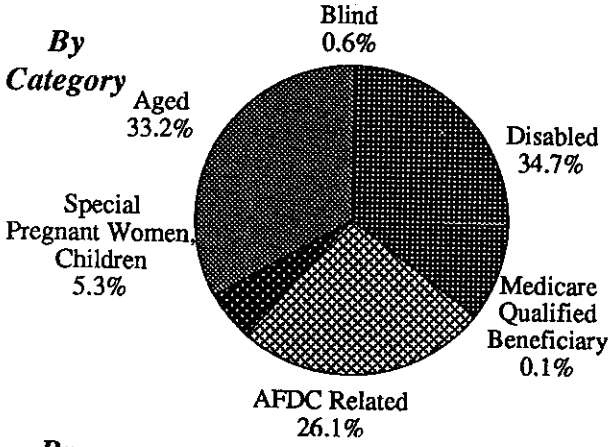
Use And Cost

Overall, the percent distribution of Medicaid payments across eligibility groups has changed very little since last year. Most recipients (67.8%) are associated with the Aid to Families with Dependent Children (AFDC) program whereas, most expenditures were made on behalf of aged and disabled recipients (33.2% and 34.7%, respectively).

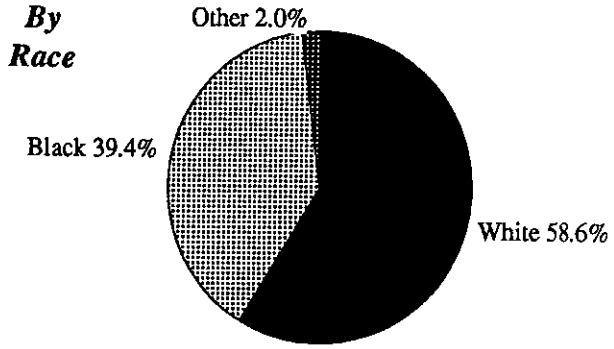
Charts 6 and 7 display service expenditures and recipients by program category, sex, race and age.

Chart 6
SFY 1989
Service Expenditures, Percent Distribution

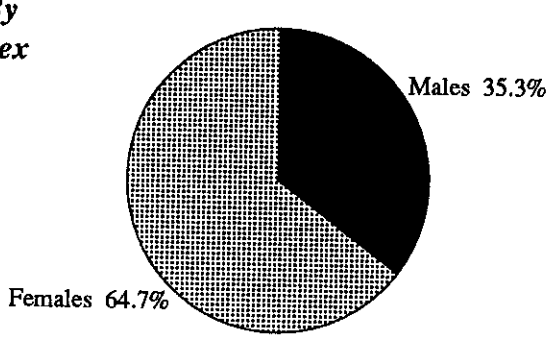
By Category



By Race



By Sex



By Age

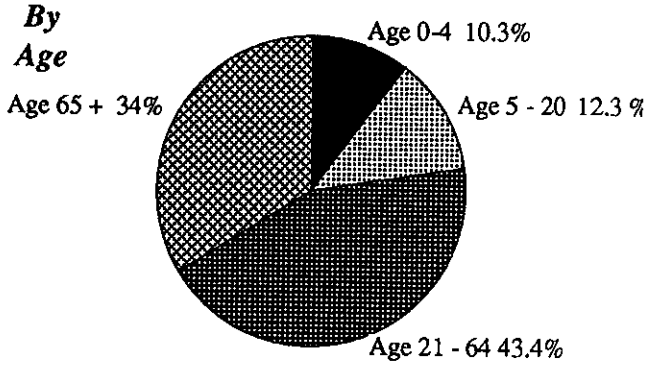
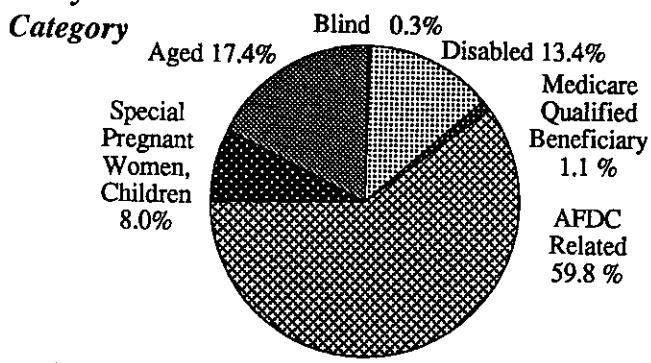
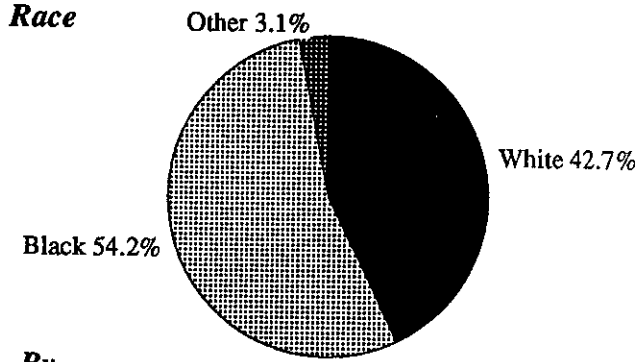


Chart 7
SFY 1989
Recipients, Percent Distribution

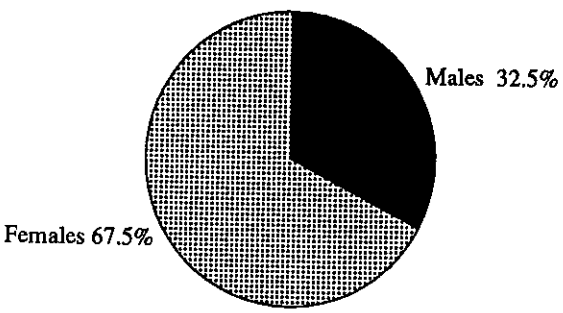
By Category



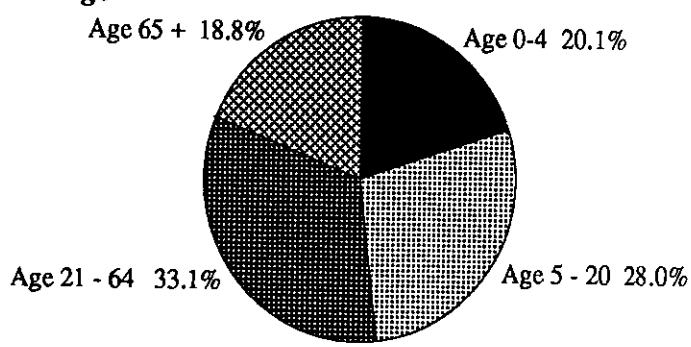
By Race



By Sex

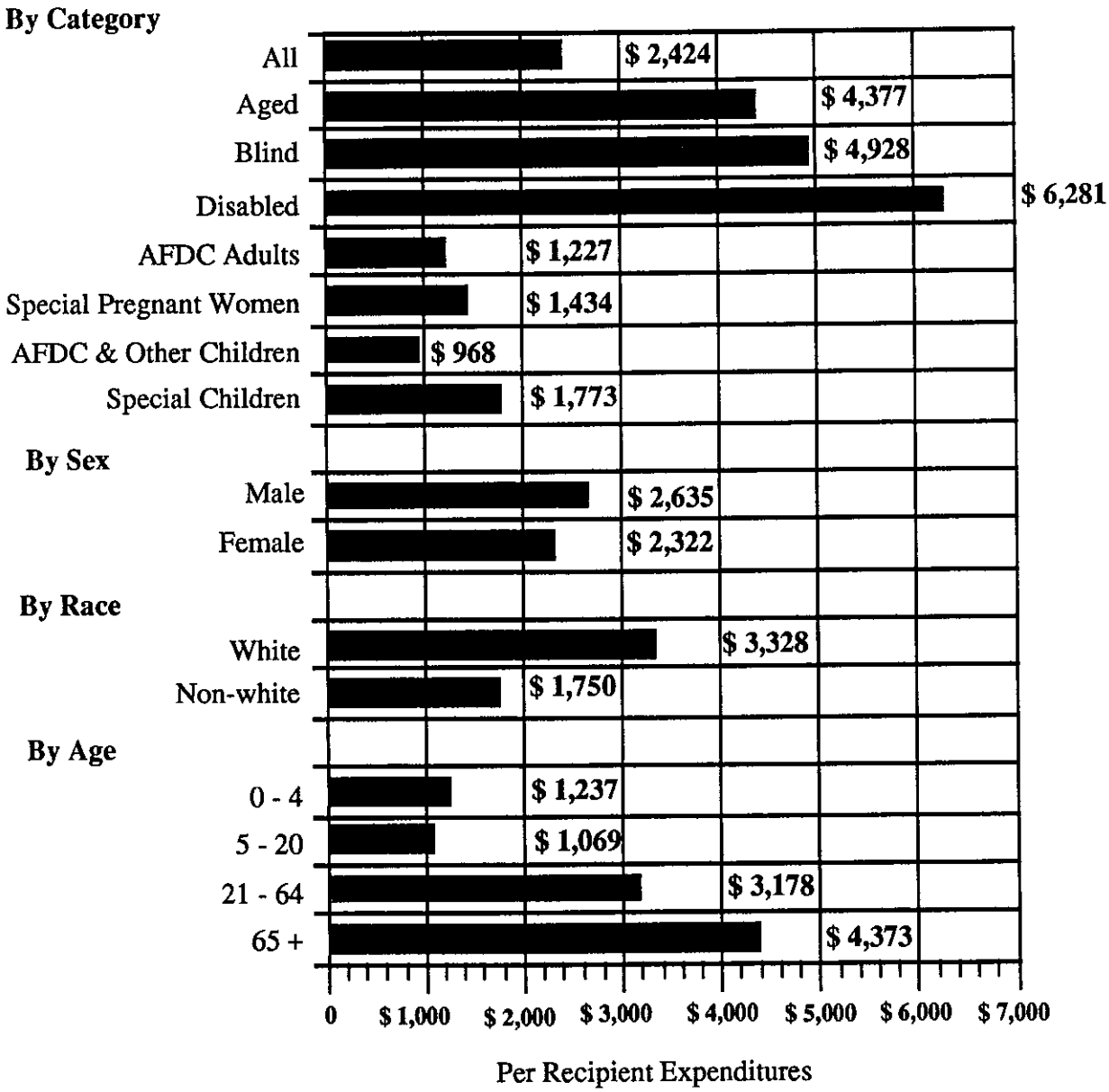


By Age



Service expenditures differ across demographic groups, as shown in Chart 8. Males, on average, had a higher recipient cost than females, $2,635 versus $2,322. The per recipient cost for whites ($3,328) was almost double that for non-whites ($1,750). Of all age groups, those aged five to 20 exhibited the lowest cost per recipient ($1,069) and those aged 65 and above had the highest ($4,373). Note that the cost per recipient values, for the aged and those aged 65 and over do not match exactly. This is because blind persons age 65 and over are catagorized as "blind" rather than "aged".

Chart 8
SFY 1989
Service Expenditures Per Recipient by Selected Characteristics



The pattern of payments across eligibility groups reflects use of different types of services and the relative cost of these services. Table 12 displays expenditures for selected types of services by eligibility group. Overall, institutional care, including hospitals and nursing homes, consume the largest share of the Medicaid services budget. Physician services and prescription drugs are relatively less costly per unit and consume smaller shares of the total budget for services despite the fact that they are used heavily by Medicaid recipients (see chart 9.)

Table 12
SFY 1989
Expenditures for Selected Medical Services by Program Category

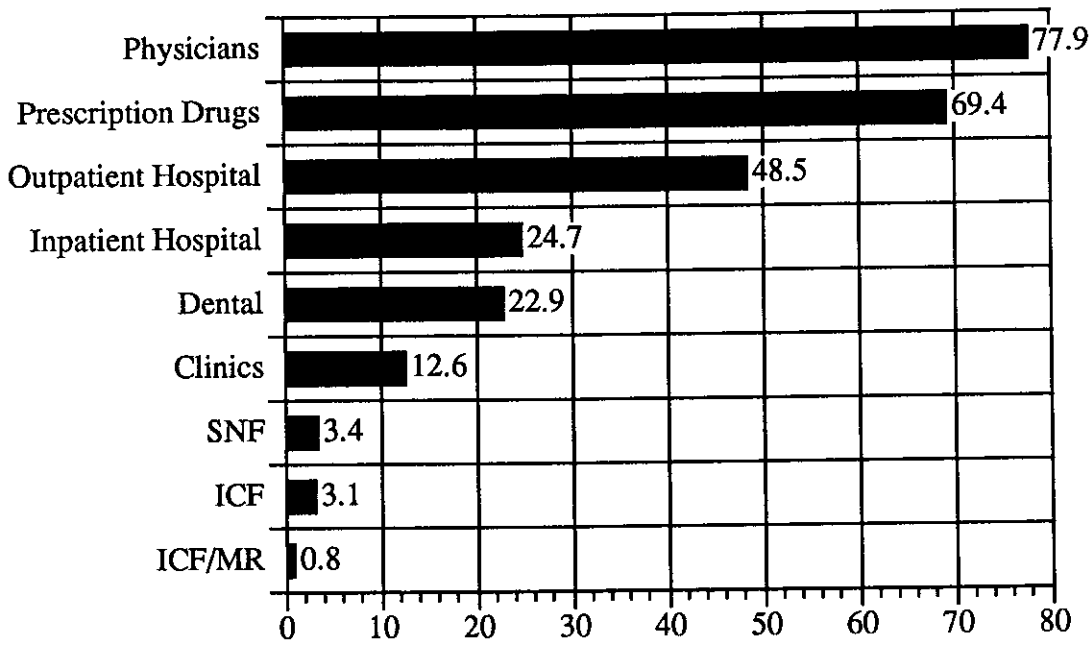
Type of Service	Total	% of Service Dollars	Aged	Blind	Disabled	Qualified Medicare Beneficiary*	— Families and Children — AFDC Child & Other Child	— Families and Children — AFDC Adult
Inpatient Hospital	$314,142,659	27.6	$ 35,669,149	$ 708,689	$102,337,504	$131,827	$107,770,337	$67,525,153
Outpatient Hospital	43,900,436	3.9	4,726,870	133,691	11,947,406	90,866	11,359,218	15,642,385
Skilled Nursing Facility	148,483,473	13.1	124,810,950	740,042	22,105,913	16,840	524,260	285,468
Intermediate Care (General)	124,816,664	11.0	111,576,626	839,094	12,344,841	5,833	20,109	30,161
Intermediate Care Facility (Mentally Retarded)	172,680,331	15.2	4,202,034	2,126,540	148,157,244	—	18,194,513	—
Mental Hospital > 65	9,851,237	0.9	9,604,320	58,638	188,279	—	—	—
Psychiatric Hospital < 21	20,146,592	1.8	—	—	893,567	—	18,975,910	277,115
Physician	89,002,944	7.8	11,113,541	256,713	23,538,153	240,851	23,939,480	29,914,206
Lab & X-Ray	8,570,769	0.8	1,191,271	32,212	3,106,482	25,170	1,317,945	2,897,689
Dental	14,485,692	1.3	1,526,611	39,084	2,627,409	1,759	5,039,118	5,251,711
Prescription Drug	83,796,563	7.4	38,933,882	612,802	27,561,952	9,681	6,516,580	10,161,666
Home Health	32,264,811	2.8	9,845,456	282,939	15,785,248	639	4,971,596	1,378,933
Personal Care Services	13,040,989	1.1	9,332,213	351,442	3,127,518	112	72,089	157,615
CAP/Disabled Adult	17,407,391	1.5	12,945,189	101,696	4,316,684	140	2,813	40,869
CAP/Mental Retardation	4,950,288	0.4	11,509	21,275	4,704,610	—	185,667	27,227
CAP/Children	1,030,161	0.1	—	19,603	957,939	—	52,619	—
Hospice	393,338	Neg.	62,858	—	304,149	—	4,487	21,844
Clinics	17,453,821	1.5	883,984	53,672	7,534,898	6,031	3,710,709	5,264,527
EPSDT	2,918,352	0.3	—	1,619	14,723	—	2,886,899	15,111
Other Services	16,719,441	1.5	1,586,191	35,896	3,013,458	28,099	2,410,143	9,645,654
Total Services	$1,136,055,952	100.0	$378,022,654	$6,415,647	$394,567,977	$557,848	$207,954,492	$148,537,334

* Reflects those who were eligible as QMBs at the end of the year. Some of these persons, however, were eligible under other Medicaid categories during the year. As a result, their expenditures reflect broader coverage than is available for QMBs (Medicare covered services only).

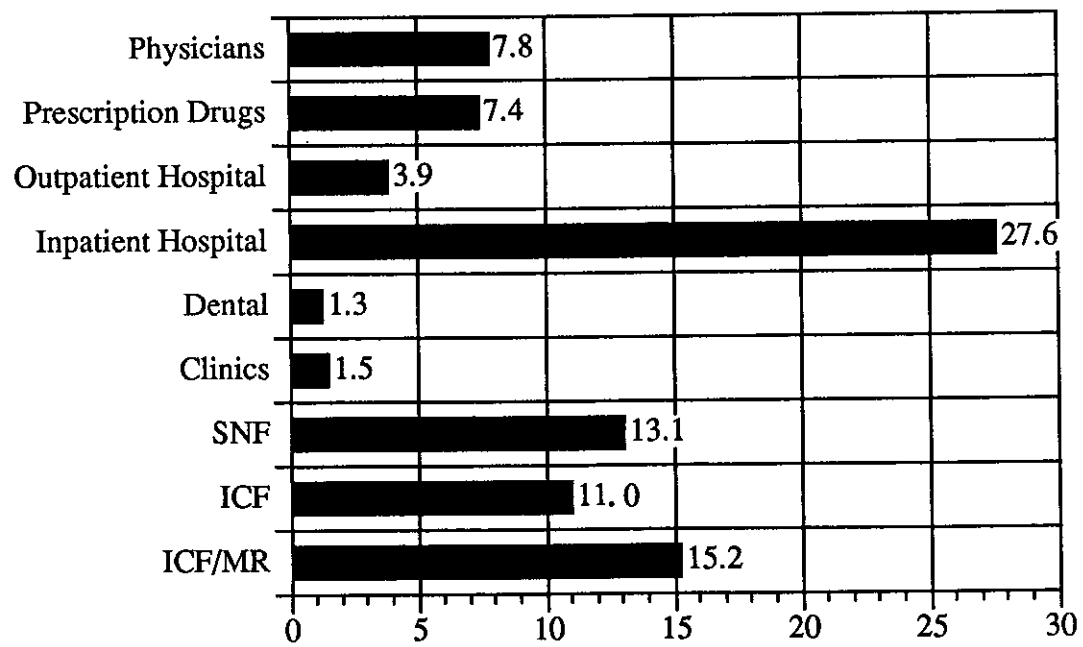
Note: Does not include adjustments processed by DMA, settlements, premiums, and state and county administration costs.

Source: 2082 Report for SFY 1989

Chart 9
SFY 1989
Selected Medicaid Services : Use and Dollars, Percent



Percent of Total Users



Percent of Service Dollars

The Elderly

The elderly (those 65 or older) comprise 18.5% of all Medicaid recipients but account for 33.3% of Medicaid service expenditures. Most elderly persons receive Medicare benefits as well. Medicaid fills in gaps and covers services not paid for by Medicare, for example long term care. Medicaid expenditures reflect these differences in benefits. As Table 13 shows, the lion's share of expenditures for the elderly was for nursing home services (63.6%). Sizeable expenditures were also made for inpatient hospital care (9.5%), with Medicaid paying for the Medicare inpatient deductible, coinsurance and days not paid for by Medicare. Prescription drugs, which Medicare does not cover, accounted for 10.3 % of expenditures. In SFY 1989, 86,495 elderly persons received assistance through the Medicaid program, at an average cost of $4,377 per recipient.

Table 13
SFY 1989
Expenditures for the Elderly

Type of Service	Aged	% of Dollars	Medicare-Aid	% of Dollars	Total Elderly Dollars	% of Dollars
Inpatient Hospital	$ 35,669,149	9.4	$131,827	23.6	$ 35,800,976	9.5
Outpatient Hospital	4,726,870	1.3	90,866	16.3	4,817,736	1.3
Mental Hospital (> 65)	9,604,320	2.6	—	—	9,604,320	2.5
Physician	11,113,541	3.0	240,851	43.2	11,354,392	3.0
Clinics	883,984	0.2	6,031	1.1	890,015	0.2
SNF	124,810,950	33.0	16,840	3.0	124,827,790	33.0
ICF-General	111,576,626	29.5	5,833	1.1	111,582,459	29.5
ICF-MR	4,202,034	1.1	—	—	4,202,034	1.1
Dental	1,526,611	0.4	1,759	0.3	1,528,370	0.4
Prescription Drug	38,933,882	10.3	9,681	1.7	38,943,563	10.3
Home Health	9,845,456	2.6	639	0.1	9,846,095	2.6
CAP/Disabled Adult	12,945,189	3.4	140	Neg.	12,945,329	3.4
CAP/Mental Retardation	11,509	Neg.	—	—	11,509	Neg.
Personal Care Services	9,332,213	2.5	112	Neg.	9,332,325	2.5
Hospice	62,858	Neg.	—	—	62,858	Neg.
Lab and X-Ray	1,191,271	0.3	25,170	4.5	1,216,441	0.3
Other Services	1,586,191	0.4	28,099	5.1	1,614,290	0.4
Total Elderly Service Expenditures	**$378,022,654**	**100.0**	**$557,848**	**100.0**	**$378,580,502**	**100.0**
Total Elderly Recipients	**81,284**		**5,211**		**86,495**	
Expenditures Per Elderly Recipient	**$4,651**		**$107**		**$4,377**	

Note: Does not include adjustments processed by DMA, settlements, premiums, or State and county administration expenditures (See Table 7).

Source: 2082 Report for SFY 1989

The Blind and Disabled

Blind and disabled individuals account for 35.3% of Medicaid expenditures. Disabled individuals must wait two years before receiving Medicare benefits. As is true with the elderly population, the largest single expenditure for this group was for nursing home care (46.5%). Of nursing home expenditures, most was spent for intermediate care services for mentally retarded patients, who constitute only 5% of the total blind and disabled population. Again, inpatient hospital care was also an important expenditure for this group. On average, Medicaid expenditures were $6,254 per recipient for the blind and disabled group. In SFY 1989, 64,121 blind and disabled persons were served by Medicaid.

Table 14
SFY 1989
Expenditures for the Disabled and Blind

Type of Service	Disabled	% of Dollars	Blind	% of Dollars	Total Blind & Disabled Expenditures	% of Dollars
Inpatient Hospital	$102,337,504	25.9	$708,689	11.0	$103,046,193	25.7
Outpatient Hospital	11,947,406	3.0	133,691	2.1	12,081,097	3.0
Mental Hospital < 21	893,567	0.2	—	—	893,567	0.2
Physician	23,538,153	6.0	256,713	4.0	23,794,866	5.9
Clinics	7,534,898	1.9	53,672	0.8	7,588,570	1.9
SNF	22,105,913	5.6	740,042	11.5	22,845,955	5.7
ICF-General	12,344,841	3.1	839,094	13.1	13,183,935	3.3
ICF-MR	148,157,244	37.6	2,126,540	33.2	150,283,784	37.5
Dental	2,627,409	0.7	39,084	0.6	2,666,493	0.7
Prescription Drugs	27,561,952	7.0	612,802	9.6	28,174,754	7.0
CAP/Disabled Adult	4,316,684	1.1	101,696	1.6	4,418,380	1.1
CAP/Children	957,939	0.2	19,603	0.3	977,542	0.2
CAP/Mentally Retarded	4,704,610	1.2	21,275	0.3	4,725,885	1.2
Home Health	15,785,248	4.0	282,939	4.4	16,068,187	4.0
Personal Care Services	3,127,518	0.8	351,442	5.5	3,478,960	0.9
Hospice	304,149	0.1	—	—	304,149	0.1
Lab and X-Ray	3,106,482	0.8	32,212	0.5	3,138,694	0.8
Other Services	3,216,460	0.8	96,153	1.5	3,312,613	0.8
Total Disabled/Blind Service Expenditures	**$394,567,977**	**100.0**	**$6,415,647**	**100.0**	**$400,983,624**	**100.0**
Total Disabled/Blind Recipients	**62,819**		**1,302**		**64,121**	
Expenditures Per Disabled/Blind Recipient	**$6,281**		**$4,928**		**$6,254**	

Note: Does not include adjustments processed by DMA, settlements, premiums, or State and county administration expenditures (See Table 7).

Source: 2082 Report for SFY 1989

Families and Children

In strong contrast with the pattern of spending for the elderly, blind and disabled populations, spending for families with children reflects that Medicaid may be the sole payor of care for the preventive and acute care nature of their health needs. In SFY 1989, Medicaid expenditures per recipient were $1,263 and $1,037 for adults and children, respectively. Both categories include AFDC-related and special coverage individuals. For both adults and children inpatient hospital care was the largest expenditure, 45.5% and 51.8%, respectively. Physician services also account for a large portion of services used by these groups. During SFY 1989, 117,626 adults and 200,474 children received Medicaid services. This includes persons eligible for expanded coverage under Medicaid's infant mortality initiatives.

Table 15
SFY 1989
Expenditures for Families and Children

Type of Service	AFDC Adults*	% of Dollars	AFDC Children* Other Children	% of Dollars	Total Families and Children Expenditures*	% of Dollars
Inpatient Hospital	$ 67,525,153	45.5	$107,770,337	51.8	$175,295,490	49.2
Outpatient Hospital	15,642,385	10.5	11,359,218	5.5	27,001,603	7.6
Psychiatric Hospital (< 21)	277,115	0.2	18,975,910	9.1	19,253,025	5.4
Physician	29,914,206	20.1	23,939,480	11.5	53,853,686	15.1
Clinics	5,264,527	3.6	3,710,709	1.8	8,975,236	2.5
SNF	285,468	0.2	524,260	0.3	809,728	0.2
ICF-General	30,161	Neg.	20,109	Neg.	50,270	Neg.
ICF-MR	—	—	18,194,513	8.8	18,194,513	5.1
Dental	5,251,711	3.5	5,039,118	2.4	10,290,829	2.9
Prescription Drugs	10,161,666	6.8	6,516,580	3.1	16,678,246	4.7
Home Health	1,378,933	0.9	4,971,596	2.4	6,350,529	1.8
CAP/Children	—	—	52,619	Neg.	52,619	Neg.
EPSDT	15,111	Neg.	2,886,899	1.4	2,902,010	0.8
Lab and X-Ray	2,897,689	2.0	1,317,945	0.6	4,215,634	1.2
Other Services	9,893,209	6.7	2,675,199	1.3	12,568,408	3.5
Total Families & Children Service Expenditures	**$148,537,334**	**100.0**	**$207,954,492**	**100.0**	**$356,491,826**	**100.0**
Total Families & Children Recipients	**117,626**		**200,474**		**318,100**	
Expenditures Per Families & Children Recipient	**$1,263**		**$1,037**		**$1,121**	

* Includes special coverage women and children

Note: Does not include adjustments processed by DMA, settlements, premiums, or State and county administration expenditures.

Source: 2082 Report for SFY 1989

MEDICAID IN DEPTH

Medicaid offers a comprehensive array of services for program eligibles. Some services are required by Federal law, others are permitted at the State's option. All services must be medically necessary in order for Medicaid to pay for them.

Mandatory Services

At a minimum, all State Medicaid programs must cover a core set of health services. The following are "mandatory services".

• ***Inpatient Hospital Services.*** Medicaid covers hospital inpatient services without a limitation on the number of days. Selected inpatient procedures require preadmission certification to ensure that the stay is medically necessary and that the procedure is most appropriately performed on an inpatient rather than an outpatient basis. Special restrictions apply to abortions, hysterectomies and sterilizations. Hospital services are paid on the basis of prospective per diem rates.

• ***Hospital Outpatient Services.*** Outpatient services are covered subject to Medicaid's annual 24 physician visit limitation, except for emergency room visits. A $1.00 per visit copayment applies except for certain exempt groups and services. These include Medicare beneficiaries, services related to pregnancy or the Healthy Children and Teens program (EPSDT), SNF, ICF, ICF-MR, mental hospital patients, children under 18, and hospital emergency room services. Hospital outpatient services are paid on the basis of 80% of actual operating costs.

• ***Other Laboratory and X-ray.*** Laboratory and x-ray services are covered when ordered by a physician. These services are covered in a variety of settings. Payment for these services is based on a statewide fee schedule.

• ***Skilled Nursing Facility.*** Skilled nursing facility (SNF) services are required for recipients aged 21 and older. The State has also elected a federal option to cover these services for those under age 21. Patients must be certified to require this level of care and approved by Medicaid prior to admission. SNF services are paid a per diem rate.

• ***Physician Services.*** Physician services are covered subject to an annual 24 visit limit. Selected surgical procedures require prior approval. A $.50 copayment is required on physician services except for the exempt groups identified above under "Hospital Outpatient Services". Payment is made based on the lower of the physician's actual charge or the statewide Medicaid fee schedule amount. Medicaid uses the American Medical Association's Current Procedural Terminology (CPT) coding structure for physician billing.

• ***Home Health Services.*** Medicaid covers all services normally provided through a home health agency, including nursing visits, therapies, limited durable medical equipment, and private duty nursing care in exceptional circumstances. Patients must be homebound and services furnished under a plan of treatment. Private duty nursing and durable medical equipment require prior approval. Certain children under age 21 and disabled adults may be excepted from the homebound requirement. Home health agencies are paid the lower of their customary charge to the general public or a maximum per visit rate established for each type of service.

• ***Preventive Services.*** Medicaid operates two programs specially designed to offer primary preventive care for recipients. The Healthy Children and Teens (EPSDT) program provides child health examinations as well as necessary diagnosis and treatment, or referral for treatment of health problems detected during the screening of a Medicaid recipient 21 years of age or younger. Most Healthy Children and Teens

services do not count toward the annual 24 visit limitation and no copayment is required. County health departments and private providers may participate in the Healthy Children and Teens program

The Adult Health Screening program is not a "mandatory" service, but compliments the Healthy Children and Teens Program for those age 21 and older. The program will cover a comprehensive annual health assessment with the expectation that it will prevent serious illness through early detection and treatment. Certain components of an assessment must be included to qualify for payment. The screening applies toward the annual 24 visit limit, and a $.50 copayment applies. Payment is based on the type of provider who performs the screening; county health departments, clinics, and private physicians may conduct annual screenings under the Adult Health Screening Program.

• ***Family Planning Services.*** Medicaid covers consultation, examination and treatment prescribed by a physician and furnished by or under his supervision. Sterilizations, hysterectomies, and abortions are permitted under limited circumstances and require special documentation and approval. Payment is made based on the type of provider furnishing the service.

• ***Other Mandatory Services.*** Other mandatory services include rural health clinics, nurse midwife services, and medical transportation.

Optional Services

Federal law permits States to cover additional services, at their option. Following are the "optional" services North Carolina Medicaid covers.

• ***Intermediate Care Facilities.*** Services in Intermediate Care Facilities (ICF and ICF-MR) are covered for those who are not able to fully care for themselves but do not require the intense level of care provided in SNFs. ICFs that serve the mentally retarded and disabled population must meet additional certification requirements relating to provision of habilitation services as well as basic ICF services. ICFs and ICF-MRs are paid prospective per diem rates.

• ***Personal Care Services.*** Medicaid personal care services (PCS) are covered for those requiring assistance to function safely at home. PCS services must be authorized by a physician and include such tasks as personal hygiene, ambulation, meal preparation, and incidental home management tasks. PCS services are limited to 80 hours per month. PCS payment is on the basis of the lower of each provider's customary charge or a maximum hourly rate established to cover the reasonable cost of the service.

• ***Prescription Drugs.*** Medicaid covers legend drugs, insulin, and oxygen. A legend drug is one that requires a prescription before it can be dispensed. Drug coverage is limited to six perscriptions per month unless it is needed for treatment of a life threatening illness or disease. In addition, recipients may use only one pharmacist per month except in an emergency. A $.50 per prescription copayment applies, except for exempt groups identified under "Hospital Outpatient Services". Payment for drugs is based on the lower of each provider's customary charge or the average wholesale price of the drug plus a $4.04 dispensing fee.

• ***Dental Services.*** Most general dental services are covered, such as exams, cleaning, fillings, x-rays and dentures. Additional services are covered for children eligible for the Healthy Children and Teens Program. Prior approval is required for all dental services except routine examinations and frequency limitations apply for some services, for example, full mouth x-rays are allowed once every five years. A per visit copayment of $2 applies for all recipients, except the exempt groups identified under "Hospital Outpatient Services". Payment is made on the basis of a Statewide fee schedule.

• ***Eye Care Services.*** Medicaid covers medical eye examinations to determine refractive errors and corrective lenses, eyeglasses, and other visual aids. Coverage for services is limited to certain services and practitioner types. Prior approval is required for some services and frequency limitations apply. A $1 copayment applies to physician or optometrist visits; a $2 copayment is charged on eyeglasses and repairs. Copayments do not apply to the exempt groups identified under "Hospital Outpatient Services". Medicaid contracts with Classic Optical, Inc. to provide eyeglasses at predetermined rates. Providers must obtain eyeglasses through this company. The contract was obtained through a competitive bid process and is re-bid periodically.

• ***Mental Health Services.*** Mental Health Centers offer outpatient mental health services, partial hospitalization, and emergency services for patients under a plan of treatment by the Center. Visits do not count against the annual 24 visit limit. A $.50 copayment per visit applies, except for the exempt groups identified under "Hospital Outpatient Services". Mental Health Centers are paid a negotiated rate for services.

Independent psychiatrists and physicians are covered for mental health services, as well. Prior approval is required for outpatient visits after the first two. Visits to a private practice psychiatrist count against the annual 24 visit limit and a $.50 copayment applies, except to the exempt groups noted above. Payment is made on a fee schedule basis, as with all physician services.

Inpatient State and private mental hospital services are covered for recipients over 64 or under age 21. Payment to psychiatric hospitals is based on each hospital's actual allowable and reasonable costs.

• ***Other Optional Services.*** A variety of other "optional" services are provided by Medicaid. Limited services by chiropractors and podiatrists are covered and paid on the basis of a Statewide fee schedule. Other optional services provided by Medicaid include specialty hospitals (tuberculosis or pulmonary), hospices, and ambulance transportation.

Special Programs

Baby Love

The Baby Love Program was first implemented in November 1987. It is designed to help address North Carolina's high infant mortality rate by assisting pregnant women to obtain comprehensive medical care. Through the Baby Love program, pregnant women receive comprehensive, continuous care from the beginning of pregnancy through the postpartum period, and their children receive care up to age three. On October 1, 1989, the age limit was raised to children under six. The age limit will increase to under age 7 as of October 1, 1990.

Baby Love is a unique program designed specially for pregnant women: it offers traditional medical services as well as childbirth and parenting classes. Care coordination services help women obtain other available support services such as food and nutrition services, housing, job training and child care.

In 1989, the General Assembly appropriated funds to design a mass media campaign to encourage women to obtain early prenatal care and to inform them of Baby Love.

Community Alternatives Program

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

The three waiver programs are designed for different populations. The Community Alternatives Program for Disabled Adults (CAP/DA) provides services that allow adults (ages 18 and above) who require care in a skilled nursing facility or an intermediate care facility to remain in the community. Forty-one counties participated in CAP/DA and served about 3,000 individuals in SFY 1989. Counties elect to participate in this program.

The Community Alternatives Program for the Mentally Retarded/ Developmentally Disabled (CAP-MR/DD) provides services to individuals of any age who normally would require care in an intermediate care facility for the mentally retarded. Ninety-three counties have access to the CAP-MR/DD program through 38 Mental Health, Mental Retardation, and Substance Abuse program centers and served about 500 individuals in SFY 1989. The area programs decides whether to offer this program.

The Community Alternatives Program for Children (CAP/CC) is different from the other two programs because it serves Medically fragile children (through 18) who otherwise would be ineligible for Medicaid. This waiver program is available to all counties and served 49 children in SFY 1989.

Prepaid Health Plan Services

Medicaid contracts with the Kaiser-Permanente Health Maintenance Organization (HMO) to offer prepaid services to some Medicaid recipients. Kaiser operates in two counties (Mecklenberg and Durham) and enrolled an average of 1,246 per month in the HMO in SFY 1989. Enrollment in the HMO is limited to families who are eligible for Medicaid because they receive assistance through the Aid to Families with Dependent Children (AFDC) program. For those who elect HMO coverage, Medicaid pays their HMO premium. The HMO must offer enrollees all benefits available under the regular Medicaid program and may offer others as well. The standard Medicaid service limitations do not apply to HMO enrollees.

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