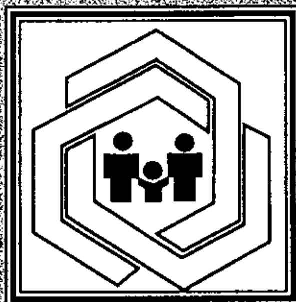

Medicaid in North Carolina Annual Report State Fiscal Year 1990

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

James G. Martin
Governor

David T. Flaherty
Secretary

Barbara D. Matula
Director

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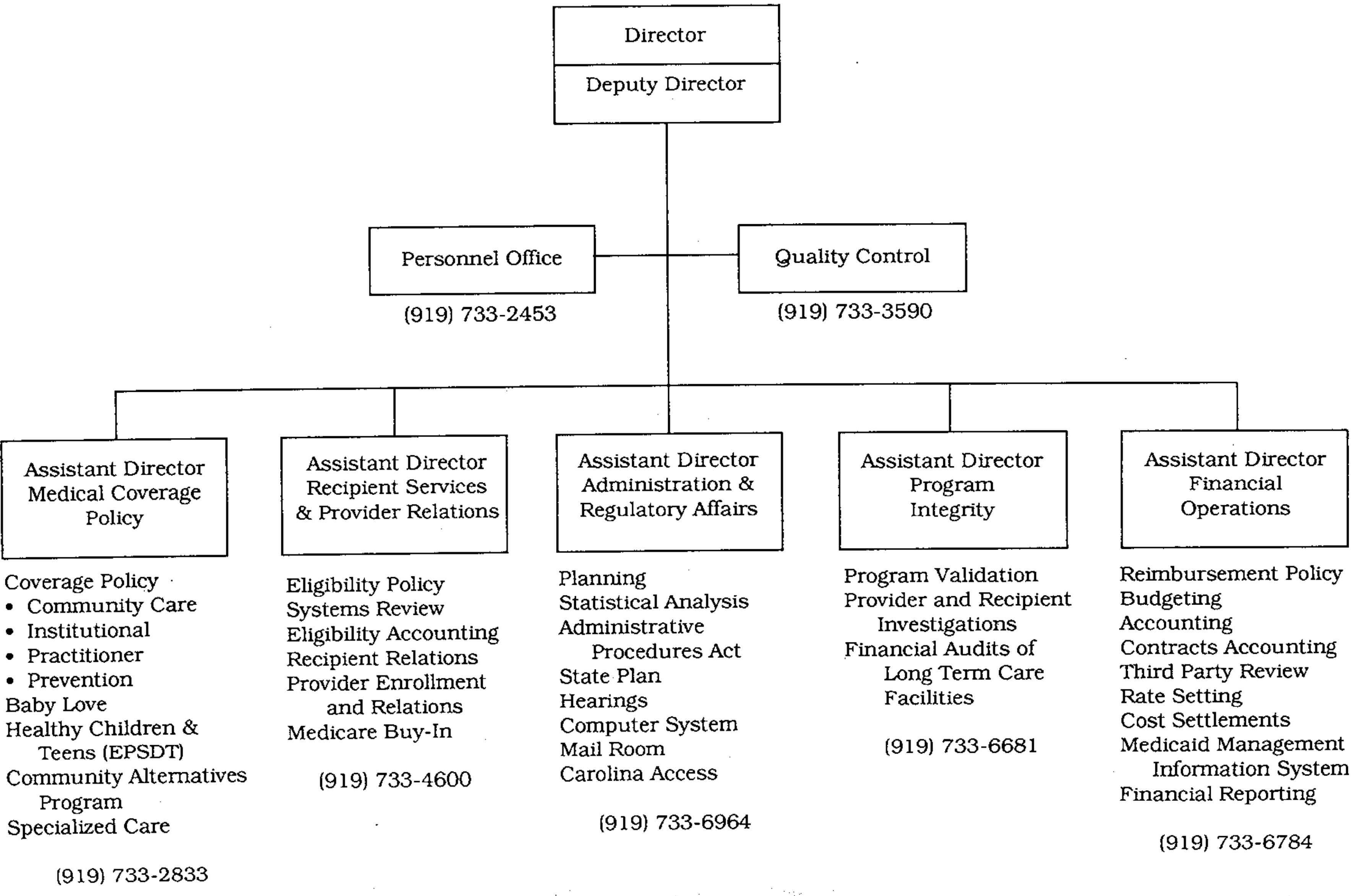

MEDICAID IN NORTH CAROLINA

ANNUAL REPORT
State Fiscal Year 1989-90

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

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Department of Human Resources

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Dear Fellow North Carolinians:

State fiscal year 1990 saw a number of major changes to Medicaid eligibility and payment rates for providers. I am pleased to present the activities of the Medicaid program for the year beginnng July 1, 1989 to June 30, 1990. As in SFY 1989, the Medicaid program expanded to cover greater numbers of the state's disadvantaged population. Low income children up to age six were granted eligibility. Last year, only children up to age three with incomes less than 100% of the federal poverty level were eligible. The income threshhold for pregnant women and infants also increased from 100% to 150% of the federal poverty level. This change is a fundamental element in the state's strategy to significantly reduce infant mortality by covering more prenantal care for pregnant women. According to federal law, the income eligibility threshhold for Medicare-Aid recipients increased from 80% to 85% of the federal poverty level. The Medicare-Aid program pays cost sharing expenses of low income Medicare eligibles.

At the same time, modest increases in provider payment rates were possible. In some cases, increased payments were targeted to maternity care services to support the state's infant mortality initiative. For instance, the global fee for delivery increased from $625 to $925 and the delivery-only fee increased from $350 to $550. Providers of personal care services, hospice care, and drugs also saw payment increases during SFY 1990.

I invite you to read on for more detail about these and other program changes. You may remember that last year we gave this report a new look. Although we like the new format, we discovered that we had inadvertantly left out some very useful items included in previous annual reports. This year we include them again, in most cases with data for both SFY 1989 and 1990.

Thank you for your continued support of the Medicaid program. Please let us know if you have questions, comments or concerns about any of the material offered here.

Sincerely,

Barbara D. Matula

Barbara D. Matula

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Highlights of the 1990 State 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. The state fiscal year (SFY) 1990 extends from July 1, 1989 to June 30, 1990. During this time, Medicaid spent $1.4 billion for necessary health care services for 544,528 of North Carolina's neediest citizens. This represents just over 8 percent of North Carolina's population. In SFY 1990, Medicaid was able to serve 16.2 percent more needy recipients than in the year before.

As in past years, the largest proportion (67 percent) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. Thirty-three percent (33 percent) was spent on care for low income families and children. About 36 percent of the service 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 program administration.

During the year, Medicaid made a number of important changes in eligibility and payment for services.

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 family incomes up to 100 percent of the federal poverty level. As of January 1, 1990, the General Assembly increased the income limit to qualify to 150 percent of the federal poverty level for pregnant women and for infants under one year of age.

Under this program, pregnant women can receive all services that relate to pregnancy and young children can receive all necessary Medicaid services. (See "Baby Love" in the Special Programs section of this report.) To increase the likelihood that young children receive medical care during their formative years, the General Assembly authorized increases in the age limit for children who qualify for this special program: to age three as of October 1, 1988 and to age six as of October 1, 1989. Without this eligibility expansion, the age cut off as of this date would have been age four. In 1990 alone, this program helped 30,688 pregnant women and 37,452 children.

Medicare-Aid

In February 1989, North Carolina began a new program of health care financing assistance to elderly and disabled Medicare beneficiaries. The 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, 21,316 Medicare recipients benefited from Medicare-Aid in SFY 1990. This 300 percent increase in eligibles reflects greatly increased public awareness of Medicare-Aid. As required by federal law, the eligibility income limit for Medicare-Aid was increased from 80 percent to 85 percent of the federal poverty level on January 1, 1990.

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. Increases for some groups are designed to help compensate for years in the early 1980s when no increases were possible.

In 1988, Medicaid eliminated inequitable specialty differentials and began paying the

same fee for a service, regardless of physician specialty. At the same time, physician fees for "cognitive services," including office visits, and consultations were increased, resulting in a 10 percent increase overall. Fees for the most frequently billed dental services were increased by 7 percent.

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

Medicaid also increased payments for maternity care services substantially. The global package payment for a normal delivery increased from $409 in 1987 to $625 in January, 1988 and again to $925 in October, 1989. The fee for a normal delivery 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.

In January 1990, fees for codes for services (other than maternity care) were increased by 4.2 percent.

Hospice rates were increased by 20 percent and the hourly rate for personal care services was increased from $7 to $8 per hour, effective August 1, 1989.

The dispensing fee paid to pharmacists was increased from $4.04 per prescription (excluding refills) to $4.24. on July 1, 1989, and again to $4.85 on October 1, 1989.

Medicaid Error Rate

The Medicaid program works hard to make sure that it pays only for necessary health care services for those who are eligible. As part of this effort, DMA continually conducts quality control reviews of Medicaid eligibility determinations and claims payments.

The federal government mandates this process, setting stringent limits on permissible errors and withholds financial participation from States that exceed the error limits. Penalties are imposed if more than three percent of program payments are 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 lowest of all Medicaid programs nationwide.

In 1990, North Carolina's error rate remained well below the 3 percent limit. North Carolina's 1 percent error rate places the state in the top third of low error rate states.

The state's low error rate results from a longstanding partnership between the Division and North Carolina's 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 correct problems. State and county staff work together on the Medicaid Error Reduction Committee to develop the state's overall plan for error reduction.

Welfare Reform

Beginning April 1, 1990 federal law requires Medicaid to provide a total of 12 months additional coverage for families who lose Aid to Families with Dependent Children (AFDC) benefits because of increased work income. This change was enacted as part of the Family Support Act of 1988 and is designed to smooth families' transition from welfare to work. During the first six-month period, the state may opt to pay a family's premiums, deductibles and coinsurance for employer-sponsored health insurance instead of providing the traditional Medicaid benefit package. During the second six-month period, Medicaid can offer a less than full Medicaid benefit package or enroll the family in a health maintenance organization. Medicaid is permitted to charge a premium for those with incomes between 100 percent and 185 percent of the federal poverty level.

Chart 1 summarizes the major changes that were made in Medicaid in SFY 1990. Note that SFY 1989 changes, not included in the 1989 Annual Report, are also included.

Chart 1
Medicaid Program Changes in Brief

SFY 1989

Effective Date	Policy Change
July 1, 1988	• Coverage of private duty nursing services and nurse midwife services
October 1, 1988	• Coverage of children up to age three in families with income under 100 percent of the federal poverty level
February, 1989	• Implement Medicare-Aid for those with incomes up to 80 percent of the federal poverty level

SFY 1990

Effective Date	Policy Change
July 1, 1989	• Increase dispensing fee for prescriptions (excluding refills) from $4.04 to $4.24
August 1, 1989	• Increase personal care services hourly rate from $7 to $8
	• Increase hospice care rates
October 1, 1989	• Expand coverage of children up to age six in families with incomes under 100 percent of the federal poverty level
	• Increase maternity care rates from $625 to $925 (global fee) and from $350 to $550 (delivery-only)
	• Increase dispensing fee per prescription (excluding refills) $4.24 to $4.85
January 1, 1990	• Increase AFDC-related income levels by 2 percent
	• Increase Medicaid eligibility income level for pregnant women and infants under age one to 150 percent of the federal poverty level
	• Increase eligibility income level for Medicare-Aid from 80 percent to 85 percent of the federal poverty level
April 1, 1990	• Implement welfare reform 12 month transitional Medicaid coverage benefit

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 Division of Social Services program. A separate Division of Medical Assistance (DMA) was created within the Department of Human Resources in 1978.

From 1978 to 1990, Medicaid expenditures and eligibles grew from $307 million to $1.4 billion, and from 456,000 to 638,000, respectively. During this time, DMA staff increased from 121 to 198. In over 20 years of operation, Medicaid's programmatic complexity has paralleled the growth in both program expenditures and recipients. Historically, however, DMA has spent a relatively modest percentage of its budget on administration. In SFY 1990, Medicaid state and local administration costs consumed just 5 percent 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.

Many low income persons qualify for both Medicare and Medicaid. Generally Medicare covers acute care needs, subject to certain benefit limitations. Medicaid coverage fills in many gaps in Medicare's benefit package, especially in the area of long term care services.

Federal Financial Participation

The largest share of Medicaid costs is paid by the federal government. Federal matching rates for services are established by the federal government — the Health Care Financing Administration (HCFA) — 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 applicable to the federal fiscal year, which extends from October 1 to September 30. As mentioned previously, 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 from year to year. Table 1 shows the applicable federal matching rates for SFY 1990.

Table 1
SFY 1990
Federal Matching Rates

	Benefit Costs	
	Family Planning	All Other Services
7/1/89 - 9/30/89		
Federal	90.0%	68.01%
State	8.5%	27.19%
County	1.5%	4.80%
10/1/89 - 6/30/90		
Federal	90.0%	67.46%
State	8.5%	27.66%
County	1.5%	4.88%

	Administrative Costs	
7/1/89 - 6/30/90		
	Skilled Medical Personnel & MMIS*	All Services
Federal	75.0%	50.0%
Non-Federal	25.0%	50.0%

** MMIS - Medicaid Management Information System*

Funding Formula

The federal matching rate for Medicaid services varies from state to state based on per capita income. Nationwide, the federal match rate varies from a low of 50 percent to a high of 79.93 percent. Additionally, states may require counties to participate in the non-federal share of expenditures. In North Carolina, each county contributes 15 percent of the non-federal share. During SFY 1990, the federal, state and county shares were approximately 68 percent, 27 percent, and 5 percent, respectively, of total expenditures.

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;
- infants up to age one;
- children from ages one to 21;
- persons aged 65 and above;
- persons 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 either to accept as categorically needy all persons found eligible for the federal Supplemental Security Income (SSI) program or to set categorically needy eligibility criteria that are more restrictive than SSI standards. North Carolina has elected the latter approach, making it one of 13 "209(b)" states so-named for the regulatory citation explaining the option. What this means is that SSI recipients must make separate application to North Carolina's Medicaid program and meet a more stringent financial means test to become eligible for coverage.

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 through the Medicare-Aid program was effective February 1, 1989. 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 Beneficiaries" column).

The spousal impoverishment provision of the Medicare Catastrophic Coverage Act allows a spouse living in the community to keep a portion of the family's income when the other spouse requires nursing home care. This policy allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The income and resource levels applicable to these individuals are higher than those that apply to other aged persons and increase each year. (See Table 2.) Income levels range from $9,780 to $18,000; resource levels range from $12,000 to $60,000. The spousal impoverishment provision was effective beginning October 1, 1989.

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").

Table 2
SFY 1990 Medicaid Financial Eligibility Standards

Family Size	—AFDC Related Groups— Categorically Needy	Medically Needy	Aged, Blind & Disabled: All Groups	Pregnant Women Infants Aged ·1 150% of Poverty	Children Ages 1-5 100% of Poverty	Qualified Medicare Beneficiaries	Spousal Impoverishment Beneficiaries
Eligibility Income Levels (Annual)							
1	$4,344	$2,900	$2,900	$8,964	$5,976	$5,076	$9,780 up to a max. of $18,000
2	5,664	3,800	3,800	12,024	8,016	6,816	
3	6.528	4,400	4,400	15,084	10,056		
4	7,128	4,800	4,800	18,144	12,096		
5	7,776	5,200	5,200	21,204	14,136		
Eligibility Resources Limits							
1	$1,000	$1,500	$1,500	No resource test applies	No resource test applies	$4,000	$12,000 min. $60,000 max.
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				

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 24,892 providers who are enrolled in the program. Providers then bill Medicaid for their services. In 1989 and 1990, 11,599 and 12,242 providers billed for services, respectively. Table 3 shows the broad range of providers that Medicaid enrolls.

Medicaid provides funding for care that many otherwise would not be able to afford. Eight percent (8 percent) of all North Carolinians receive assistance through Medicaid.

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 72 percent of all nursing home days. In SFY 1990, 83 percent of North Carolina's primary care physicians served at least 25 patients. Statewide 1990 data indicate that about 92 percent of family practitioners and general practitioners, 81 percent of OB/GYN and 92 percent of pediatricians participate in Medicaid. 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 the average, Medicaid accounts for 15 percent of all hospital days, but individual hospitals vary greatly.

Table 3
SFY 1990
Enrolled Medicaid Providers

Providers	*Number*
Physicians	15,739 *
Dentists	2,577
Pharmacists	2,086
Optometrists	797
Chiropractors	509
Podiatrists	244
Ambulance	190
Home Health Agencies	132**
ICF-General	236
ICF-MR	134
Hospitals	197
Mental Health Clinics	95
Optical Supplies	1***
SNF	249
Personal Care Agencies	118
Rural Health Clinics	49
Nurse Midwives	7
Hospices	42
CAP Providers	359
Other Clinics	56
Other	1,075
Total	**24,892**

* The count of physicians reflects each provider number assigned to an individual physician or a group practice of physicians. Most physicians practicing in a group practice have an individual provider number in addition to the group provider number. Also, individual physicians practice in multiple settings and are included in the count once for each practice setting.

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

*** Single source purchase 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 $6.9 million in SFY 1990. EDS-F processed 18,924,662 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 the potential for four 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 five percent of the cost of services for Medicaid patients.

Division of Social Services (DSS) - N.C. 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 a 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 /DD/SAS to finance community mental health services. During SFY 1989 and 1990, the divisions developed a proposal to allow greater Medicaid coverage for mental health services through community mental health centers.

Division of Aging (DOA) - DMA works cooperatively with DOA staff on issues important to the aged population. In particular, DMA staff routinely participate in policy development projects on in-home aid services, housing, and others and in designing 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 and implementing changes brought about by federal nursing home reform legislation. Most elements of nursing home reform are effective October 1, 1990 and will be discussed in depth in the 1991 Annual Report.

Division of Maternal and Child Health (DMCH) - DMCH, within the Department of Environment, Health and Natural Resources (DEHNR), operates a variety of health care programs. Medicaid pays for services offered through DMCH programs and local health departments. DMCH and local health departments also play a central role in the operation of "Baby Love", a care coordination program designed to help pregnant women 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. This program is discussed in more detail in the "Special Programs" section of this report.

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. 99-457 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 screening provided under the Healthy Children and Teens program, reflect Medicaid's commitment to the primary care of North Carolina's citizens. Although North Carolina's program is called the Healthy Children and Teens Program, many providers are accustomed to referring to it by its federal name Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Additional details are discussed in the "Medicaid In Depth" section of this report.

Medicaid imposes certain standard limitations on 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 limits for preventive care to pregnant women, children with life threatening conditions, and other groups.

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".

Table 4
Medicaid Services

Ambulance Transportation
Case Management for pregnant women, chronically mentally ill adults, emotionally disturbed children, and chronic substance abusers
Chiropractors
Clinic Services (including Mental Health Centers)
Community Alternatives Program for aged/ disabled adults, mentally retarded, and disabled children under age 18
Dental Care Services
Durable Medical Equipment (until July 1, 1990 provided through home health agencies)
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program
Family Planning Services
Hearing Aids (for children)
Home Health Services
Home Infusion Therapy under Home Health Services
Hospice
Inpatient and Outpatient Hospital Services
Intermediate Care Facilities (ICF) and Intermediate Care Facilities for the Mentally Retarded (ICF-MRC)
Laboratory and X-Ray Services
Mental Hospitals (for age 65 and over)
Migrant Health Clinics
Nurse Midwives
Optical Supplies
Optometrists
Personal Care Services
Physicians
Podiatrists
Prepaid Health Plan Services
Prescription Drugs
Private Duty Nursing Services
Psychiatric Hospitals (for under age 21)
Rural Health Clinics
Skilled Nursing Facilities (SNF)
Specialty Hospitals
Transportation (through the counties)

Rate Setting

Prospective payment rates and fee schedules are important in controlling program costs. DMA strives to establish rates that are fair to providers. Payment rates are established according to federal and state laws and regulations, taking into account the level of funding provided by the North Carolina General Assembly. The Rate Setting Unit develops rates for a wide array of provider types. The Unit actively reviews, monitors and adjusts fee schedule amounts and works closely with many institutional providers in setting their individual rates. More than 10,000 payment rates were developed during SFY 1990. See "Medicaid In Depth" for more information about the payment mechanism that is applicable to each type of service.

Program Efficiency and Effectiveness

Medicaid has an obligation to North Carolina's taxpayers to ensure that limited funds are spent wisely. Medicaid's low payment error rate is one measure of success in fulfilling this objective.

Program Integrity - DMA's program integrity efforts include: identification of providers and recipients who are abusing or defrauding the Medicaid program; identification and collection of provider and recipient overpayments; education of providers and recipients when errors or abuse are detected; and protection of recipients' rights.

DMA's Program Integrity Section handles these tasks and cooperates 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 1990, 1,000 provider reviews were initiated and 1,500 recipient cases were opened. Collections of overpayments amounted to $440,077 from providers, and $402,441 from recipients found to be ineligible. In addition, financial audits of long term care facilities resulted in recovery of $1,411,933 from 154 field audits and $2,889,989 from 343 desk audits.

Also during 1990, the section used educational letters and consultations to resolve provider questions and billing problems. DMA helped nursing homes interpret and apply Medicaid reimbursement and administration of patients' personal needs funds policies. The second annual *Nursing Home Audit Newsletter* was published in June 1990. In addition, action on complaints resulted in substantial refunds being 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 spent appropriately. 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 for hospital services 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 1990, funds from a variety of sources defrayed Medicaid expenditures. Insurance paid on patients' behalf amounted to $17,147,486. An additional $29,784,164 in claims were denied because other insurance was thought to be available to pay for services.

Refunds were received from:

Medicare	$1,021,179
Health Insurance	$4,723,553
Casualty Insurance	$2,497,298
Absent Parents	$ 14,053

In addition, Medicaid policy is designed to avoid costs that otherwise would be incurred. In SFY 1990, an estimated $301,073,440 in patient expenditures were saved by DMA's policy of requiring billing to other third party payors.

Medicaid Dollars and People

Revenue And Expenditures

In SFY 1990, Medicaid paid $1,357,802,982 for health care services to North Carolina citizens. In addition, $69,869,585 was spent to administer the program at the state and local levels. This means that about 95 percent of the total budget was spent on services. The following Tables and Charts show where Medicaid funds come from and how they are spent.

Medicaid expenditures grew by almost 19 percent from SFY 1989 to SFY 1990. The increase in expenditures is driven by eligibility expansions, inflation, and the mix and use of services.

The total number of recipients increased by 16.2 percent. The largest relative increase occurred in the Medicare-Aid program (309 percent), as enrollment grew from 5,211 to 21,316 persons. SFY 1990 was the first full year of the program which began in February, 1989.

Table 5
SFY 1990
Sources of Medicaid Funds

Federal funds	**$953,572,963**
State funds	**$388,304,091**
County funds	**$85,795,513**
Total Funds	**$1,427,672,567**

Chart 2
SFY 1990
Sources of Medicaid Funds

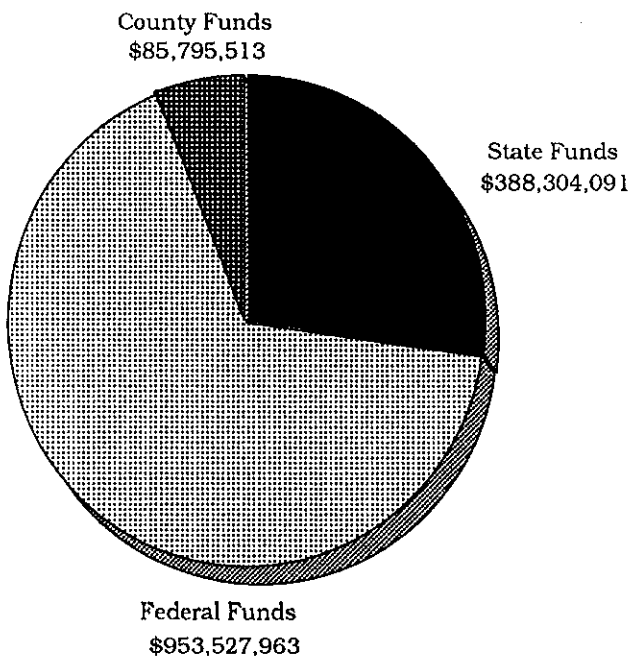


Chart 3
SFY 1990
Uses of Medicaid Funds
(percent of total expenditures)

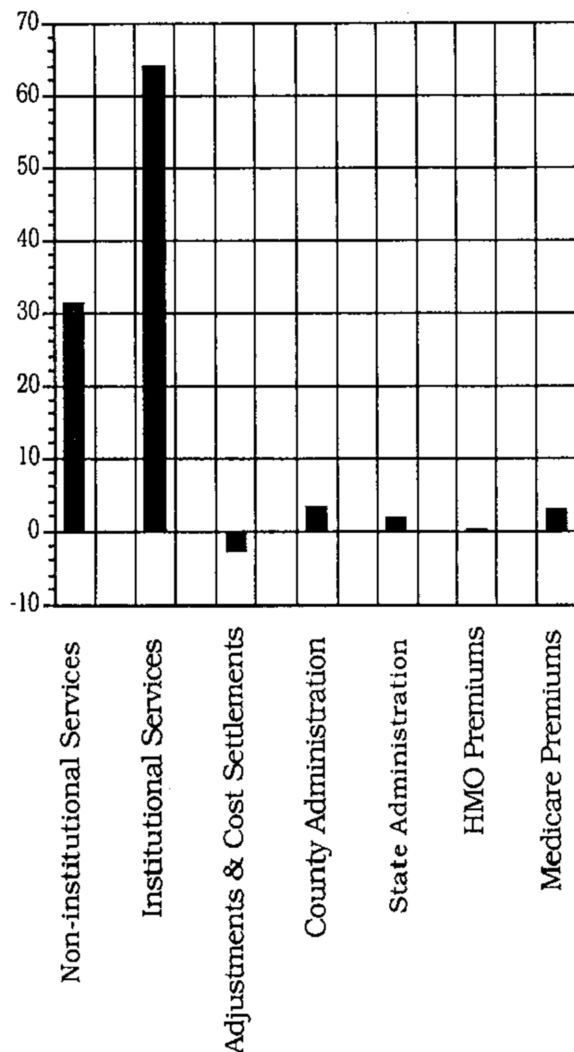


Table 6
SFY 1990
Uses of Medicaid Funds

Type of Service	Total Expenditures	% of Total Dollars	% of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	$363,111,068	25.4	26.7	131,019	$2,771
Mental & Psychiatric Hospital	33,792,038	2.4	2.5	2,325	14,534
Outpatient Hospital	60,257,997	4.2	4.4	271,622	222
Physician	125,272,412	8.8	9.2	421,452	297
Clinics	23,258,687	1.6	1.7	75,385	309
SNF	168,526,244	11.8	12.4	17,075	9,870
ICF-General	149,426,444	10.5	11.0	15,274	9,783
ICF-MR	198,914,582	13.9	14.6	3,902	50,978
Dental	16,772,845	1.2	1.2	116,839	144
Prescirption Drugs	98,743,070	6.9	7.3	372,145	265
Home Health	37,700,423	2.6	2.8	19,694	1,914
Other Services	83,672,239	5.9	6.2	470,012	178
Sub-Total, Service	$1,359,448,049	95.2	100.0		
Medicare Premium (Part A, Part B, QMB, Dually Eligible)	39,340,260	2.8			
HMO Premium	449,181	***			
Adjustments & Cost Settlements	(41,434,508)	(2.9)			
Sub-Total Service & Other	$1,357,802,982	95.1			
Administration (State & County)	69,869,585	4.9			
(State)	25,863,257	1.8			
(County)	44,006,328	3.1			
Grand Total Expenditures	$1,427,672,567	100.0			
Total Recipients (Unduplicated)**				544,528	
Service Expenditures Per Recipient (unduplicated)					$2,497

* "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 2081 report, SFY 1990; DAS report, SFY 1990

Heralding the success of eligibility expansions associated with the state's infant mortality initiative, pregnant women and children recipients grew by 50.1 percent and 117.4 percent, respectively. The numbers of recipients included in traditional eligibility groups—the aged, disabled, AFDC Adults and children, and other children—increased at modest rates: 4.1 percent, 7.1 percent, 7.7 percent, and 8.1 percent, respectively. The number of blind recipients shrank by 4.6 percent from SFY 1989.

Another portion of the increase in expenditures is due to more intensive and extensive use of services and payment increases (or inflation).

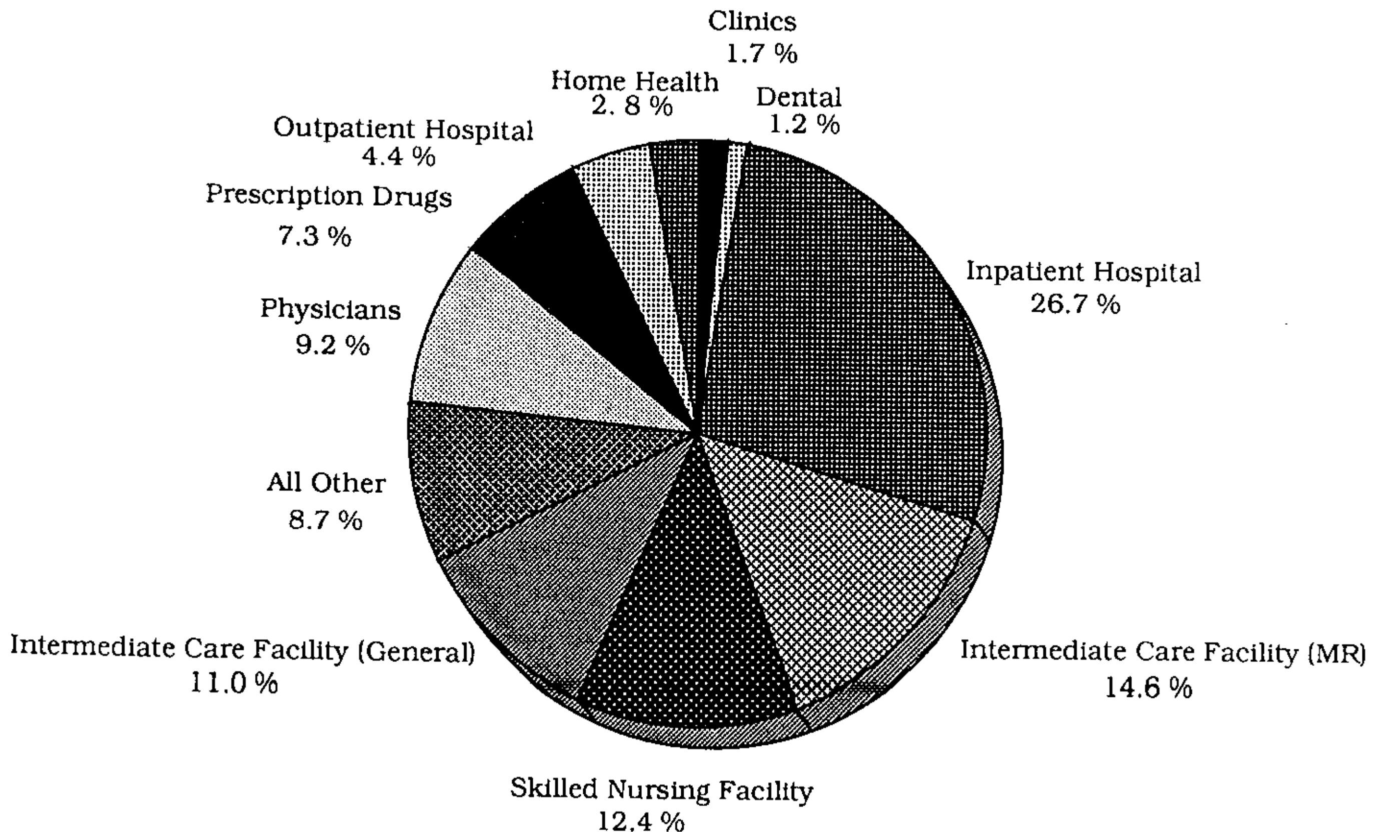
Table 7
SFY 1979-1990
A History of Total Medicaid Expenditures

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
1990	1,427,672,567	19.3

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

Source: DAS report, SFY 1990

Chart 4
SFY 1990
Medicaid Service Expenditures, Percent



The combined effect of these factors is reflected in service expenditures per recipient. Overall, per recipient expenditures increased by 3 percent over SFY 1989, but this measure differed greatly by eligibility category.

Per recipient expenditures for qualified Medicare beneficiaries (QMBs) appear to have increased dramatically, 390 percent since SFY 1989. This increase is illusory, however, because it reflects all service expenditures for those whose eligibility category on the last day of the fiscal year was listed as QMB. Data limitations do not permit exclusion of expenditures for services that these QMBs used when they qualified as, for example, aged individuals entitled to all covered Medicaid services. The increase in per recipient expenditures for most eligibility groups clusters in the 8 percent to 10 percent range, in line with the 8.4 percent increase in the medical component of the Consumer Price Index (CPI) for the same time period. Expenditure increases above inflation likely are accounted for by increased intensity of services and changes in service mix.

The effect of high per recipient expenditure growth rates for some eligibility groups is moderated substantially by the very small rates of growth experienced by the eligibility groups that make up nearly half (43 percent) of all Medicaid recipients, AFDC children and other children, and special coverage children.

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.

Table 8
SFY 1979-1990
A History of Medicaid Eligibles

Fiscal Year	Aged	Qualified Medicare Beneficiaries	Blind	Disabled	AFDC Adults & Children	Special Pregnant Women Coverage	Special Children Coverage	Other Children	Total	Percentage Change
1978-79	82,930	N/A	3,219	59,187	301,218	N/A	N/A	6,620	453,174	
1979-80	82,859	N/A	2,878	56,265	307,059	N/A	N/A	6,641	455,702	0.6%
1980-81	80,725	N/A	2,656	53,773	315,651	N/A	N/A	6,559	459,364	0.8%
1981-82	70,010	N/A	2,349	48,266	298,483	N/A	N/A	6,125	425,233	(7.4)%
1982-83	67,330	N/A	2,000	46,537	293,623	N/A	N/A	6,062	415,552	(2.3)%
1983-84	65,203	N/A	1,755	46,728	288,619	N/A	N/A	5,501	407,806	(1.8)%
1984-85	65,849	N/A	1,634	48,349	293,188	N/A	N/A	5,333	414,353	1.6%
1985-86	69,193	N/A	1,554	51,959	313,909	N/A	N/A	5,315	441,930	6.6%
1986-87	72,295	N/A	1,462	54,924	317,983	N/A	N/A	5,361	452,025	2.3%
1987-88	76,308	N/A	1,394	58,258	323,418	9,842	6,543	5,563	481,326	6.5%
1988-89	80,044	19,064	1,304	62,419	352,321	20,277	19,615	6,009	561,053	16.6%
1989-90	80,266	33,929	1,220	64,875	387,882	28,563	36,429	5,176	638,340	13.8%
% of SFY 1990 Eligibles	12.6%	5.3%	0.2%	10.1%	60.8%	4.5%	5.7%	0.8%	100.0%	

Source: Medicaid Eligibility report, SFY 1990

Table 9
SFY 1990
Expenditures and Eligibles by County

County Name	1989 Est. County Popoulation	Number of Medicaid Eligibles	Total Expenditures	Expenditures Per Eligible	Per Capital Expenditures Amount	Per Capital Expenditures Ranking	Eligibles Per 1,000 Population
Alamance	106,956	7,432	$19,767,155	$2,660	$184.82	77	69
Alexander	28,035	1,485	4,483,763	3,019	159.93	89	53
Allgehany	9,992	862	1,685,197	1,955	168.65	87	86
Anson	26,221	3,373	8,327,656	2,469	317.59	11	129
Ashe	23,486	2,575	6,548,027	2,543	278.81	25	110
Avery	15,505	1,546	4,158,618	2,690	268.21	30	100
Beaufort	42,238	5,772	11,844,607	2,052	280.43	24	137
Bertie	21,009	3,997	6,204,405	1,552	295.32	18	190
Bladen	31,011	5,632	9,932,705	1,764	320.30	10	182
Brunswick	51,535	6,040	11,282,834	1,868	218.94	55	117
Buncombe	175,580	13,750	34,677,037	2,522	197.50	67	78
Burke	77,759	5,656	14,652,509	2,591	188.43	74	73
Cabarrus	97,295	6,811	18,570,501	2,727	190.87	72	70
Caldwell	71,463	5,538	15,681,082	2,832	219.43	54	77
Camden	6,221	621	1,574,853	2,536	253.15	38	100
Carteret	51,464	3,921	9,914,439	2,529	192.65	69	76
Caswell	22,200	2,305	5,578,187	2,420	251.27	40	104
Catawba	118,427	6,696	17,594,080	2,628	148.56	96	57
Chatham	37,456	2,573	7,888,102	3,066	210.60	63	69
Cherokee	21,146	2,575	5,546,488	2,154	262.29	34	122
Chowan	13,584	2,009	3,618,089	1,801	266.35	31	148
Clay	7,191	726	2,114,214	2,912	294.01	20	101
Cleveland	87,762	8,393	18,951,751	2,258	215.94	58	96
Columbus	52,720	9,875	19,088,498	1,933	362.07	4	187
Craven	82,513	8,448	17,433,637	2,064	211.28	62	102
Cumberland	263,515	29,740	43,288,493	1,456	164.27	88	113
Currituck	14,305	969	2,167,417	2,237	151.51	94	68
Dare	22,789	1,000	2,674,503	2,675	117.36	100	44
Davidson	125,632	8,442	119,958,102	2,364	158.86	90	67
Davie	27,886	1,593	5,205,015	3,267	186.65	75	57
Duplin	42,084	5,733	12,213,016	2,130	290.21	23	136
Durham	174,536	15,869	40,020,626	2,522	229.30	51	91
Edgecombe	59,274	10,896	17,483,049	1,605	294.95	19	184
Forsyth	266,721	22,000	49,615,499	2,255	186.02	76	82
Franklin	36,001	4,243	10,450,172	2,463	290.27	22	118
Gaston	174,227	16,374	34,183,498	2,088	196.20	68	94
Gates	9,901	1,066	2,151,431	2,018	217.29	57	108
Graham	7,097	1,071	1,956,073	1,826	275.62	27	151
Granville	39,451	3,039	6,951,345	2,287	176.20	86	77
Greene	16,478	2,203	4,442,281	2,016	269.59	29	134
Guilford	339,109	27,137	64,094,800	2,362	189.01	73	80
Halifax	56,761	12,831	19,461,681	1,517	342.87	5	226
Harnett	67,007	9,063	17,235,410	1,902	257.72	37	135
Haywood	48,026	4,568	10,231,923	2,240	213.05	60	95
Henderson	70,370	5,282	12,695,316	2,404	180.41	82	75
Hertford	23,423	4,732	7,204,378	1,522	307.58	16	202
Hoke	24,249	4,215	6,382,762	1,514	263.22	33	174
Hyde	5,678	955	1,849,104	1,936	325.66	8	168
Iredell	92,552	6,760	17,819,216	2,636	192.53	70	73
Jackson	27,392	2,688	5,662,547	2,107	206.72	64	98
Johnston	81,510	9,386	20,301,270	2,163	249.06	42	115
Jones	9,922	1,435	3,642,863	2,539	367.15	3	145

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

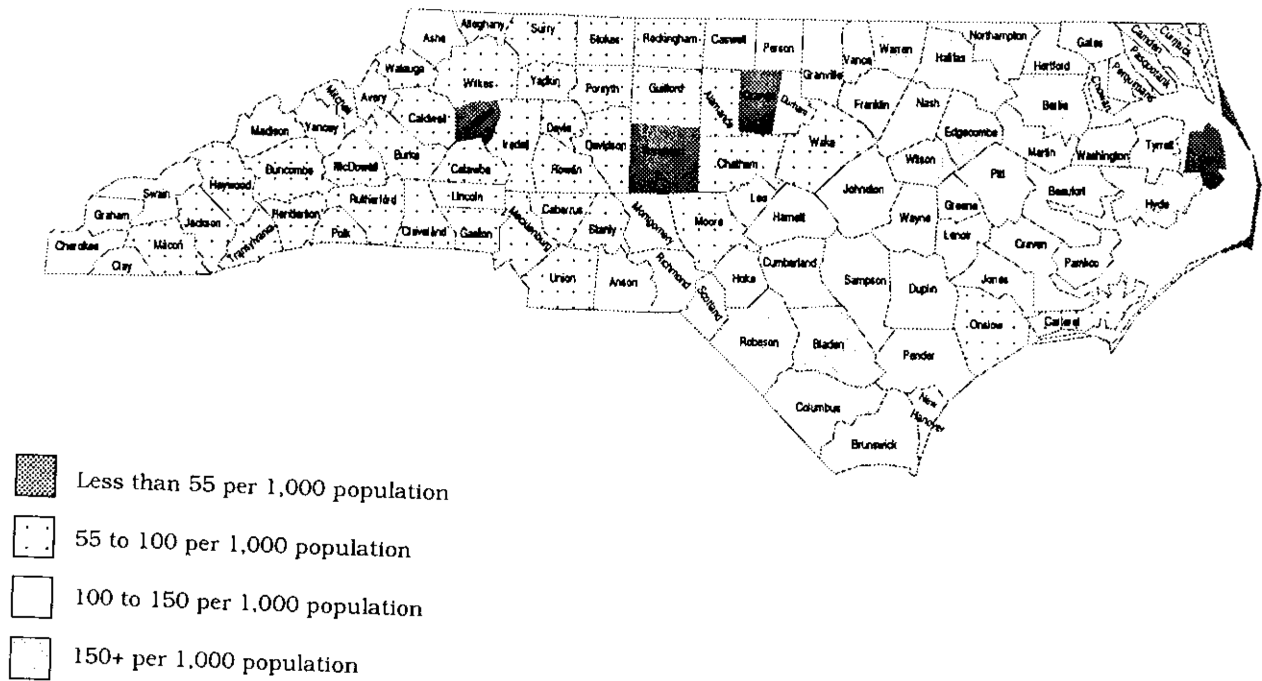
Table 9
SFY 1990
Expenditures and Eligibles by County

County Name	1989 Est. County Popoulation	Number of Medicaid Eligibles	Total Expenditures	Expenditures Per Eligible	Per Capital Expenditures Amount	Per Capital Expenditures Ranking	Eligibles Per 1,000 Population
Lee	42,482	4,393	9,558,105	$2,176	$224.99	52	103
Lenoir	59,996	8,966	19,044,461	2,124	317.43	13	149
Lincoln	49,403	3,425	7,804,088	2,279	157.97	91	69
Macon	23,849	2,192	5,315,795	2,425	222.89	53	92
Madison	17,353	2,379	4,679,531	1,967	269.67	28	137
Martin	26,062	3,856	6,569,404	1,704	252.07	39	148
McDowell	36,429	2,900	7,403,348	2,553	203.23	65	80
Mecklenburg	485,804	38,867	86,594,136	2,228	178.25	84	80
Mitchell	14,615	1,593	3,801,949	2,387	260.14	36	109
Montgomery	24,550	2,905	6,114,787	2,105	249.07	41	118
Moore	60,083	4,377	11,086,072	2,533	184.51	78	73
Nash	73,545	9,212	17,433,931	1,893	237.05	47	125
New Hanover	118,983	13,792	28,308,854	2,053	137.92	46	116
Northampton	21,977	4,556	8,187,552	1,797	372.55	2	207
Onslow	131,526	9,197	16,067,466	1,747	122.16	99	70
Orange	90,922	4,342	13,094,480	3,016	144.02	97	48
Pamlico	10,952	1,498	3,526,457	2,354	321.99	9	137
Pasquotank	31,433	4,677	7,500,674	1,604	238.62	44	149
Pender	27,982	3,713	9,120,143	2,456	325.93	7	133
Perquimans	11,269	1,657	2,642,354	1,595	234.48	48	147
Person	31,426	3,205	9,863,494	3,078	313.86	14	102
Pitt	103,889	14,495	27,082,233	1,868	260.68	35	140
Polk	15,040	922	2,679,054	2,906	178.13	85	61
Randolph	104,380	5,486	15,705,250	2,863	150.46	95	53
Richmond	45,929	5,307	11,208,179	2,112	244.03	43	116
Robeson	107,640	22,354	34,183,155	1,529	317.57	12	208
Rockingham	86,261	7,462	19,830,027	2,657	229.88	50	87
Rowan	108,031	7,648	19,739,074	2,581	182.72	80	71
Rutherford	58,222	5,281	11,186,166	2,118	192.13	71	91
Sampson	50,749	7,133	15,599,787	2,187	307.39	17	141
Scotland	34,385	6,673	10,703,379	1,604	311.28	15	194
Stanly	51,833	3,642	9,399,145	2,581	181.34	81	70
Stokes	37,116	2,426	6,788,440	2,798	182.90	79	65
Surry	62,481	5,159	12,612,134	2,445	201.86	66	83
Swain	11,026	1,681	2,630,930	1,565	238.61	45	152
Transylvania	26,336	2,232	5,580,192	2,500	211.88	61	85
Tyrrell	4,196	844	1,577,426	1,869	375.94	1	201
Union	86,396	6,744	13,234,988	1,962	153.19	93	78
Vance	39,217	6,273	10,850,496	1,730	276.68	26	160
Wake	400,193	23,126	51,720,826	2,230	129.24	98	58
Warren	16,607	2,814	5,493,907	1,952	330.82	6	169
Washington	14,506	2,702	4,242,360	1,570	292.46	21	186
Watauga	35,262	2,039	5,560,674	2,727	157.70	92	58
Wayne	100,311	12,337	23,286,767	1,888	232.15	49	123
Wilkes	61,162	4,889	13,118,451	2,683	214.49	59	80
Wilson	65,961	11,275	17,468,126	1,549	264.83	32	171
Yadkin	30,543	2,170	5,465,164	2,519	178.93	83	71
Yancey	16,005	1,623	3,503,698	2,159	218.91	56	101
SHARE TOTAL	6,568,983	638,340	$1,360,627,333	$2,132	$207.13	N/A	97

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1990.

Data reflects only net vendor payments for which the county is billed for its computable share.

Chart 5
SFY 1990
Medicaid Enrollment Per 1,000 Population by County



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 1990, 638,340 persons were eligible for Medicaid at some time during the year. This represents an increase of almost 78,000 eligibles (or 13.8 percent) over the prior year. The largest portion of the increase is due to eligibility expansions that began in 1989, including coverage of greater numbers of pregnant women and children under the infant mortality initiative and the Medicare-Aid program. Table 8 depicts the growth in Medicaid eligibles since SFY 1979.

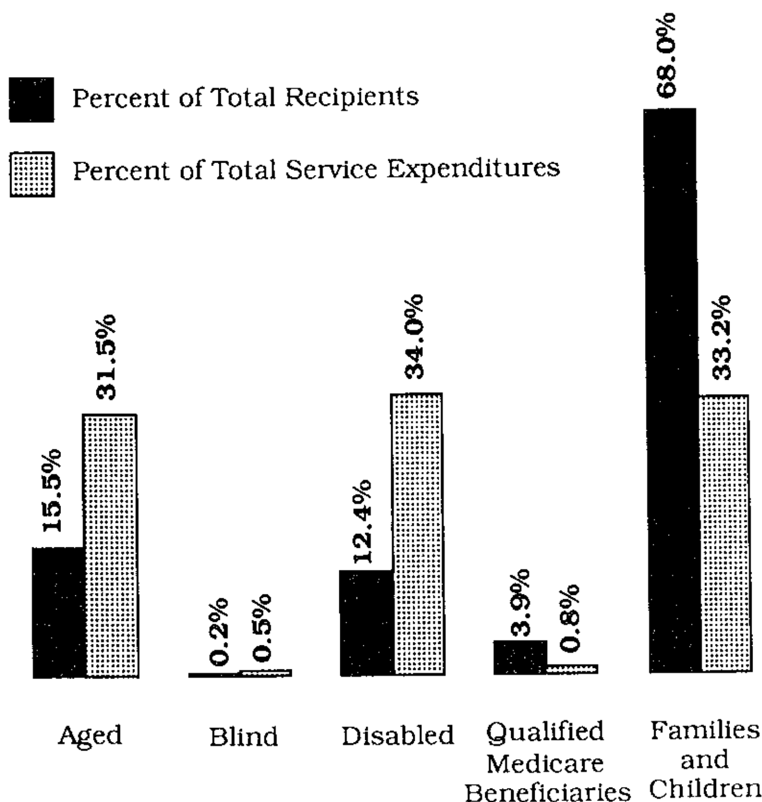
Counties vary greatly in the number of residents who are eligible for Medicaid: from a low of 44 per1,000 population in Dare County to a high of 226 per 1,000 population in Halifax County. The statewide average is 97 per 1,000 population. This variation is due to several factors, including general population density and area poverty rates. Table 9 presents a variety of data on counties, including expenditures, the number of Medicaid eligibles, per eligible expenditures, per capita spending, rank, and Medicaid eligibles per 1,000 population in SFY 1990.

Recipients

Recipients are those who actually use a service during the year. In SFY 1990, Medicaid paid for services to 544,528 recipients. Another 95,812 persons were eligible for Medicaid but either did not receive medical care or received care that Medicaid does not pay for.

During the time that an individual is eligible for Medicaid, his or her basis for eligibility may change, for example from AFDC Adult to Special Pregnant Women coverage. Also, an individual often uses several different types of services. Both these circumstances affect the

Chart 6
SFY 1990
Medicaid Recipients and Service Expenditures



way Medicaid expenditure data for recipients is reported.

Throughout the tables that follow, the number of recipients are counted in two ways in relation to their use of services and their eligibility category during the year: unduplicated and duplicated. The total number of recipients is an unduplicated count, counting an individual only once during the year regardless of services used or changes in eligibility category. Recipient expenditure data are always unduplicated with respect to changes in eligibility category and reported under the eligibility category in which he or she was listed as of the end of the fiscal year.

The recipient count within each type of service, however, 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 10 and the tables that follow.

Spending Patterns

Overall, the percent distribution of Medicaid payments across eligibility groups has changed very little since last year. Most recipients (68 percent) are families and children including Aid to Families with Dependent Children (AFDC) and special pregnant women and children coverage whereas, most expenditures were made on behalf of disabled recipients (34 percent.)

Table 10
SFY 1990
Medicaid Service Expenditures by Eligibility Group

Eligibility Group	Total Services Dollars	% of Dollars	Total Recipeints*	% of Recipients	SFY 1990 Expenditures Per Recipient	SFY 1989 Expenditures Per Recipient	Percent Change
Total Elderly	$439,019,162	32.3	105,911	19.4	$4,145	$4,377	(5.3)
Aged	427,902,526	31.5	84,595	15.5	5,058	4,651	8.7
Medicare-Aid	11,116,636	0.8	21,316	3.9	522	107	387.8***
Total Disabled	469,367,371	34.5	68,516	12.6	6,850	6,254	9.5
Disabled	461,541,421	34.0	67,274	12.4	6,861	6,281	9.2
Blind	7,825,950	0.5	1,242	0.2	6,301	4,928	27.7
Total Families And Children	451,061,516	33.2	370,101	68.0	1,219	1,121	8.7
AFDC Adults	143,415,411	10.6	105,739	19.4	1,356	1,227	10.5
Special Pregnant Women Coverage	47,827,721	3.5	30,688	5.7	1,559	1,434	8.7
AFDC Children & Other Children	194,622,865	14.3	196,222	36.0	992	968	2.5
Special Children Coverage	65,195,519	4.8	37,452	6.9	1,741	1,773	(1.8)
Total Service Expenditure All Groups	$1,359,448,049	100.00	544,528	100.0	$2,497	$2,424	3.0

* A "recipient" is a Medicaid eligible who has used services. "Recipients" is a duplicated count. See text for description of duplicated versus unduplicated count.

** "Total Recipients" is an unduplicated count.

*** Large increase reflects the fact that SFY 1990 was the first full year of the Medicare-Aid program (enrollment began February, 1989). Also includes services used throughout the year by anyone who was classified as MQB on the last day of the fiscal year. Some of these individuals may have qualified under other Medicaid categories during the year and used services that are not covered under Medicaid-Aid benefits.

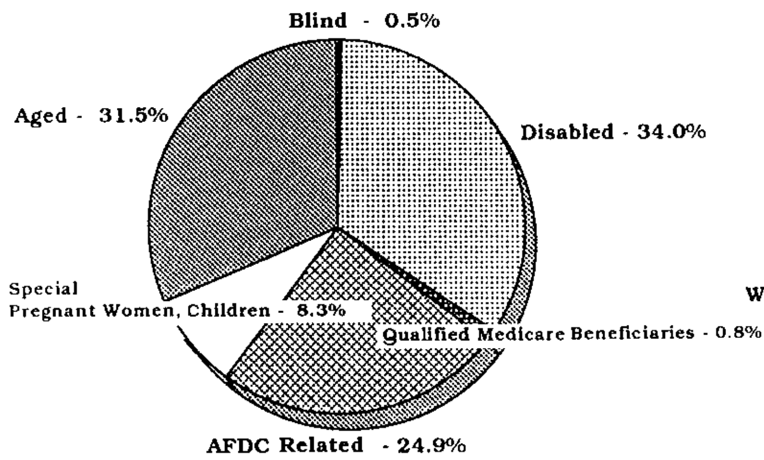
Note: Does not include adjustments processed by DMA, settlements, premiums, and state and county administrative costs. These total $68,224,518. See Table 6 for more details.

Source: SFY 2081 report, SFY 1990.

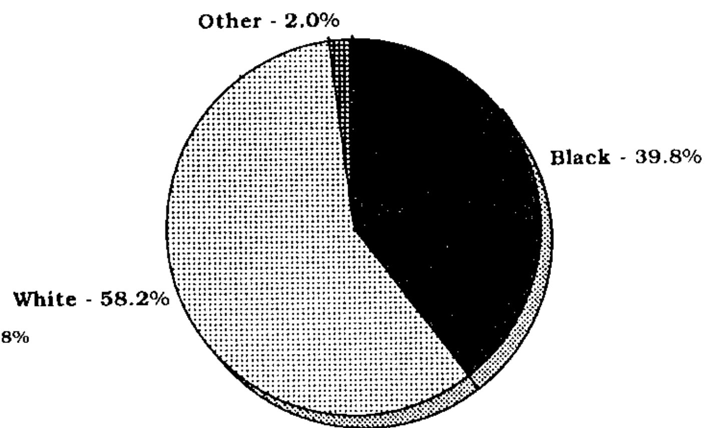
Charts 7 and 8 display service expenditures and recipients by category, sex, race and age.

Chart 7
SFY 1990
Service Expenditures, Percent Distribution

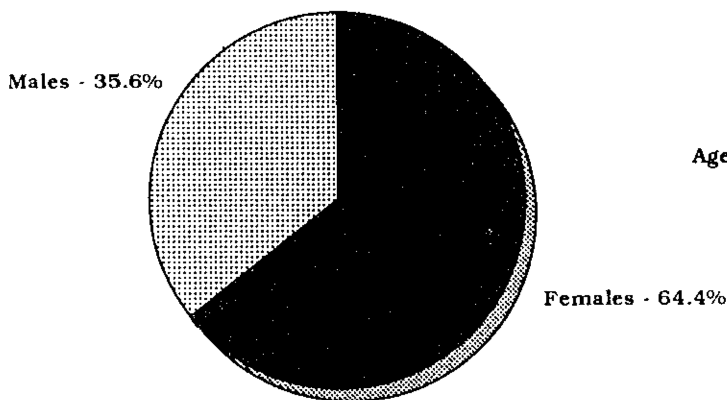
By Category



By Race



By Sex



By Age

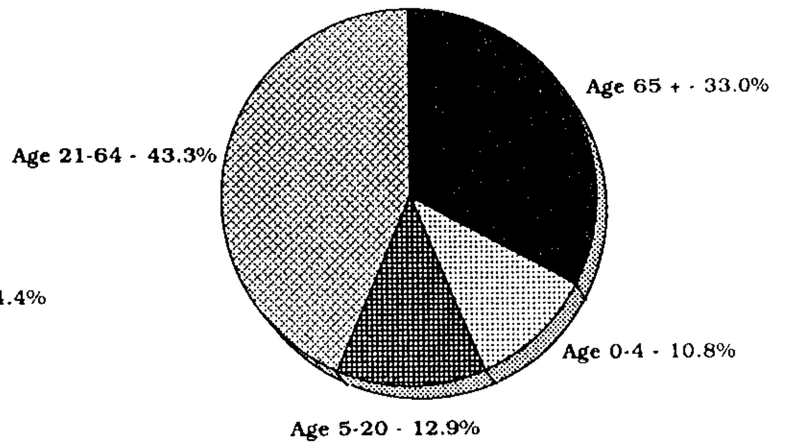
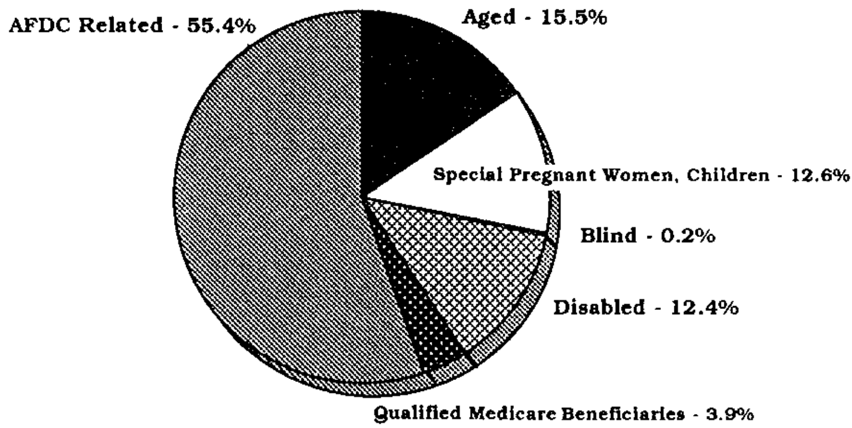
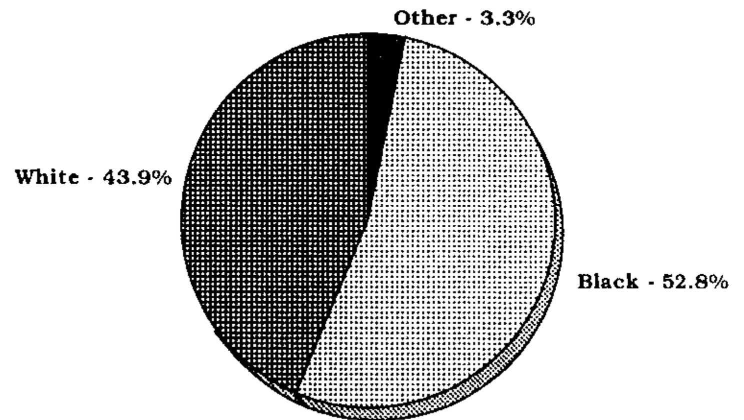


Chart 8
SFY 1990
Recipients, Percent Distribution

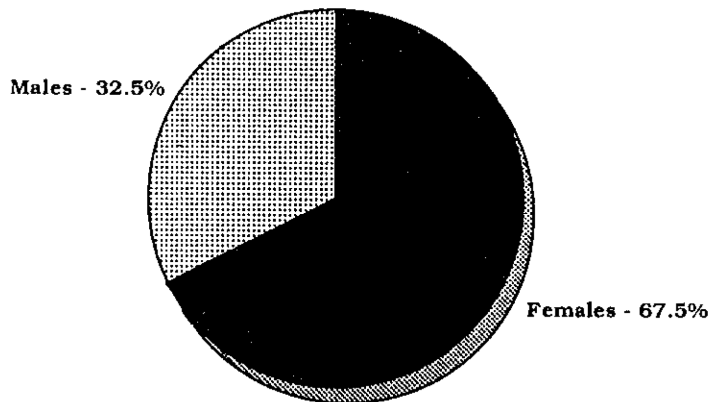
By Category



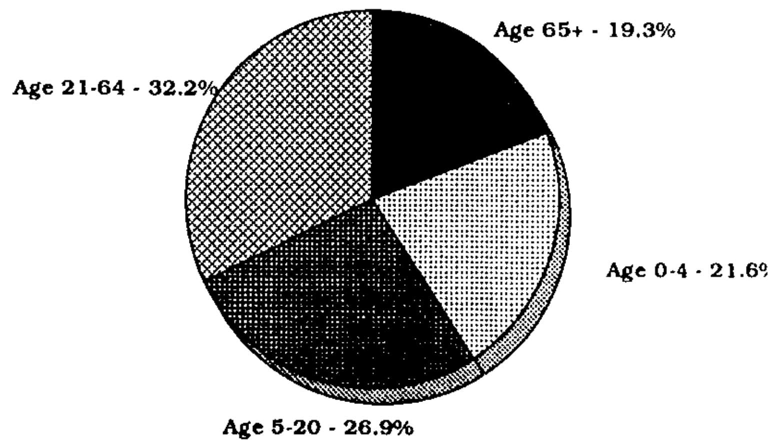
By Race



By Sex



By Age



Service expenditures differ across demographic groups, as shown in Chart 9. As would be expected, disabled individuals demonstrated the highest per recipient cost ($6,861). Males, on average, had a higher recipient cost than females, $2,732 versus $2,383. The per recipient cost for whites ($3,305) was almost double that for non-whites ($1,863). Of all age groups, those aged five to twenty exhibited the lowest cost per recipient ($1,197) and those aged 65 and above had the highest ($4,260). 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 categorized as blind rather than aged, and exhibit a higher per recipient cost than other aged individuals. In addition, the "aged 65 and over" category also includes those whose age is unknown.

The pattern of payments across eligibility groups reflects use of different types of services and the relative cost of these services. Table 11 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 for all eligibility groups. Physician services and prescription drugs are relatively less costly per unit and thus consume smaller shares of the total budget for services despite the fact that they are used heavily by Medicaid recipients (see Chart 10).

Chart 9
SFY 1990
Service Expenditures Per Recipient by Selected Characteristics

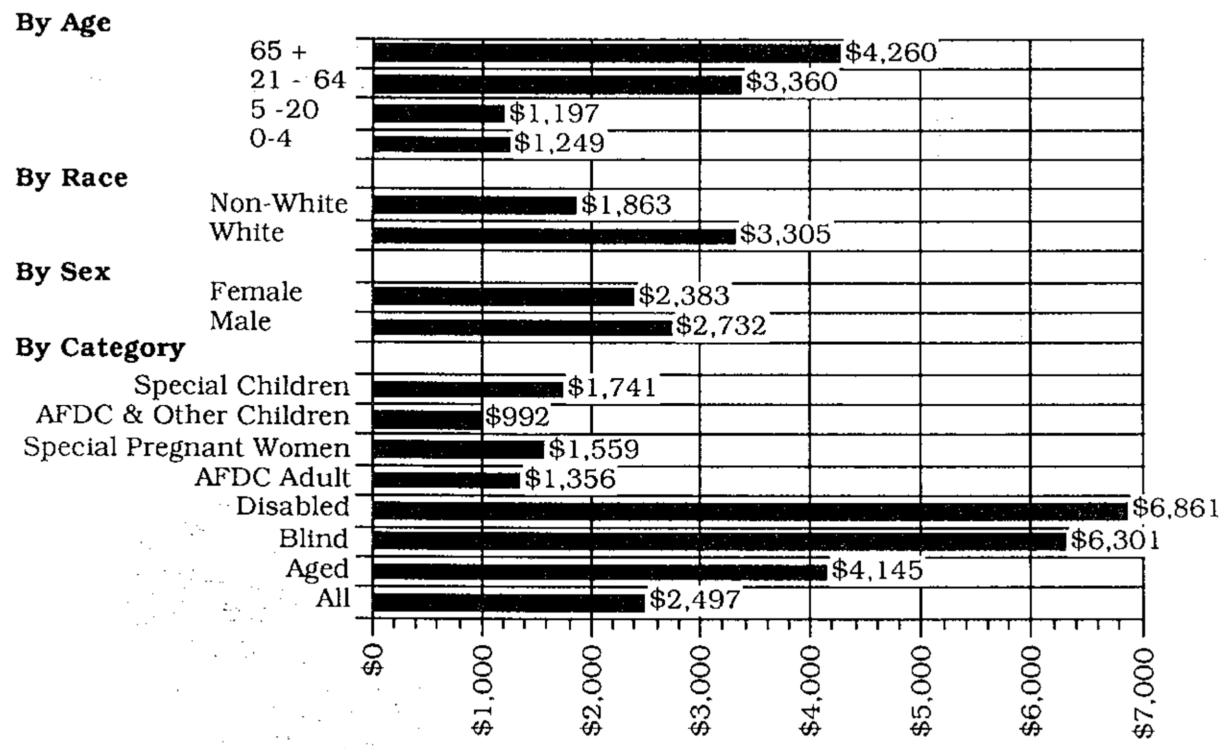


Table 11
SFY 1990
Service Expenditures for Selected Major Medical Services by Program Category

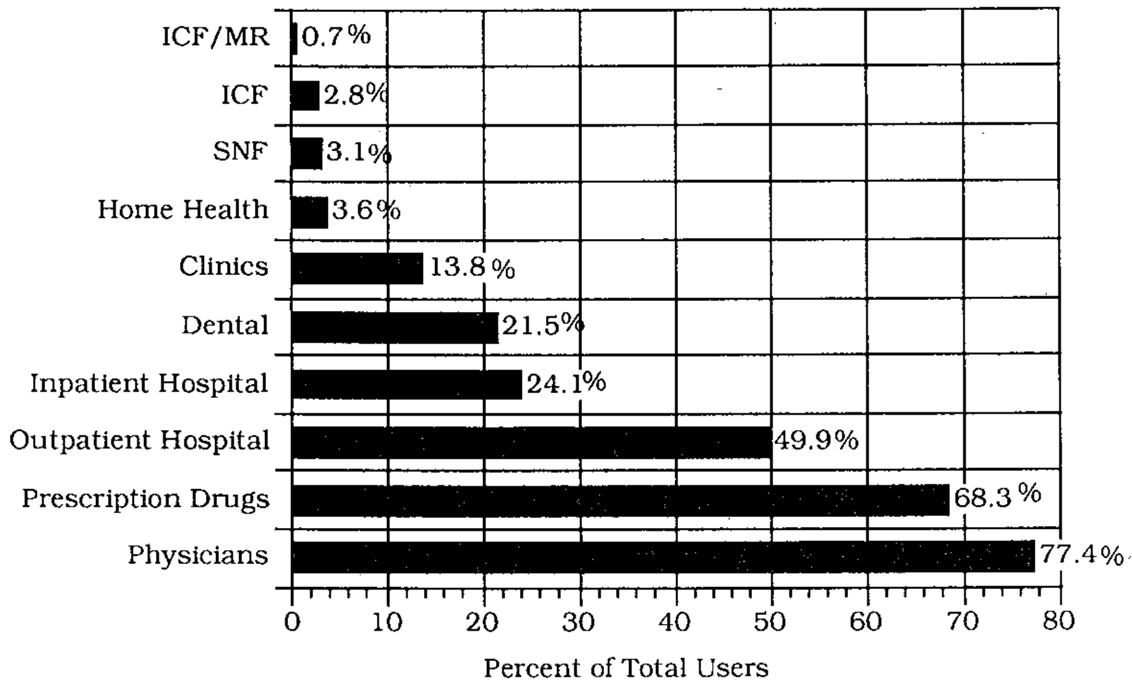
Type of Service	Total	% of Service Dollars	Aged	Qualified Medicare Beneficiaries*	Blind	Disabled	Families and Children: AFDC Adult	Families and Children: Special Pregnant Women	Families and Children: AFDC Child & Other Child	Families and Children: Special Children
Inpatient Hospital	$363,111,068	26.7	$32,652,277	2,397,263	881,615	$116,126,287	$58,583,854	$22,411,126	$79,110,252	$50,948,394
Outpatient Hospital	60,257,997	4.4	5,912,558	1,460,938	139,296	15,561,842	17,205,040	4,191,273	13,796,181	1,990,869
Mental Hospital (> 65)	9,388,902	0.7	9,138,939	40,979	36,244	165,994	6,746	*	*	*
Psychiatric Hospital (<21)	24,403,136	1.8	*	*	*	882,234	235,888	16,043	23,268,889	82
Physician	125,272,412	9.2	13,534,777	3,076,175	284,065	30,276,143	31,514,818	12,035,243	26,652,594	7,898,597
Clinics	23,258,687	1.7	1,159,711	231,122	67,913	9,491,372	3,831,511	3,874,319	4,383,490	219,249
Skilled Nursing Facility	168,526,244	12.4	140,489,812	1,141,406	793,263	25,151,333	304,149	41,832	589,583	14,866
Intermediate Care Facility (General)	149,426,444	11.0	132,966,028	807,243	877,086	14,668,381	2,809	*	85,682	19,215
Intermediate Care Facility (Mentally Retarded)	198,914,582	14.6	4,502,121	7,151	2,893,582	171,137,034	113,450	*	20,261,244	*
Dental	16,772,845	1.2	1,716,137	65,105	40,183	2,979,668	5,911,403	318,017	5,647,433	94,899
Prescription Drugs	98,743,070	7.3	44,274,377	673,146	653,982	32,078,638	11,772,425	697,243	7,723,546	869,713
Home Health	37,700,423	2.8	9,704,071	216,630	504,655	18,430,279	1,384,468	115,307	5,866,568	1,478,445
CAP/Disabled Adult	23,370,938	1.7	16,930,819	224,939	151,543	6,009,172	48,754	*	5,711	*
CAP/Mental Retardation	6,442,432	0.5	25,434	7,829	930	6,097,357	18,035	*	284,633	8,214
CAP/Children	1,116,816	0.1	*	*	6,681	1,089,820	*	*	20,315	*
Personal Care	15,755,016	1.1	11,340,453	109,912	422,525	3,590,445	181,925	*	109,170	586
Hospice	1,111,573	0.1	211,657	*	5,985	759,006	108,757	3,818	1,902	20,448
EPSDT	3,645,409	0.3	*	*	1,105	15,744	11,878	6,269	2,566,296	1,044,117
Lab & X-Ray	11,815,315	0.9	1,397,442	348,229	31,062	4,139,127	3,387,409	672,953	1,536,480	302,613
Other Services	20,414,740	1.5	1,945,913	308,569	34,235	2,891,545	8,792,092	3,444,278	2,712,896	285,212
Total Services	$1,359,448,049	100.0	$427,902,526	$11,116,636	$7,825,950	$461,541,421	$143,415,411	$47,827,721	$194,622,865	$65,195,519

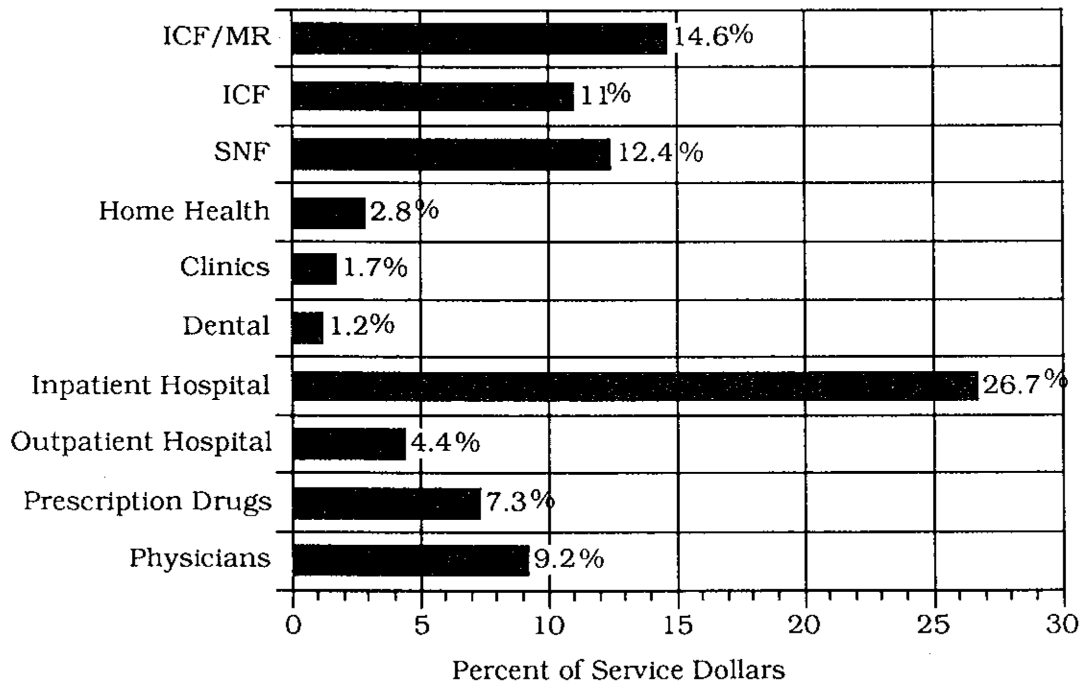
* Reflects expenditures for those who were eligible as QMBs at the end of the year. As a result, expenditures include more services that is available through QMB coverage (Medicare covered services only).

** Less than .1%

Note: Does not include adjustments processed by DMA, settlements, premiums, and state and county administration costs.
Source: 2082 Report for SFY 1990.

Chart 10
SFY 1990
Selected Medicaid Services: Use and Dollars, Percent





The Elderly

The elderly (those 65 or older) comprise 19.4 percent of all Medicaid recipients but account for 32 percent 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 and prescription drugs. Medicaid expenditures reflect these differences in benefits. As Table 12 shows, the lion's share of expenditures for the elderly was for nursing home services (63.9 percent). Sizable expenditures were also made for inpatient hospital care (7.6 percent), 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 percent of expenditures.

In SFY 1990, 105,911 elderly persons received assistance through the Medicaid program, at an average cost of $4,145 per recipient, seemingly a 5.3 percent reduction from SFY 1989. The primary reason for this apparent reduction is that the average figure includes both relatively low cost QMBs and aged persons receiving full Medicaid benefits. When the per recipient cost for the latter group is considered alone and compared to that from SFY 1989, the figure shows an increase of 8.7 percent ($4,651 to $5,058).

Table 12
SFY 1990
Expenditures for the Elderly

Type of Service	Aged	% of Dollars	Qualified Medicare Beneficiaries	% of Dollars	Total Elderly Dollars	SFY 1990 % of Total Dollars	SFY 1989 % of Total Dollars
Inpatient Hospital	$32,652,277	7.6	12,397,263	21.6	$35,049,540	8.0	9.5
Outpatient Hospital	5,912,558	1.4	1,460,938	13.1	7,373,496	1.7	1.3
Mental Hospital (>65)	9,138,939	2.1	40,979	0.4	9,179,918	2.1	2.5
Physician	13,534,777	3.2	3,076,175	27.7	16,610,952	3.8	3.0
Clinics	1,159,711	0.3	231,122	2.1	1,390,833	0.3	0.2
SNF	140,489,812	32.8	1,141,406	10.3	141,631,218	32.2	33.0
ICF-General	132,966,028	31.1	807,243	7.3	133,773,271	30.5	29.5
ICF-MR	4,502,121	1.1	7,151	0.1	4,509,272	1.0	1.1
Dental	1,716,137	0.4	65,105	0.6	1,781,242	0.4	0.4
Prescription Drugs	44,274,377	10.3	673,146	6.0	44,947,523	10.2	10.3
Home Health	9,704,071	2.3	216,630	1.9	9,920,701	2.3	2.6
CAP/Disabled Adult	16,930,819	4.0	224,939	2.0	17,155,758	3.9	3.4
CAP/Mental Retardation	25,434	*	7,829	0.1	33,263	*	*
Personal Care Services	11,340,453	2.6	109,912	1.0	11,450,365	2.6	2.5
Hospice	211,657	0.1	—	—	211,657	0.1	*
Lab and X-Ray	1,397,442	0.3	348,229	3.1	1,745,671	0.4	0.3
Other Services	1,945,913	0.4	308,569	2.7	2,254,482	0.5	0.4
Total Elderly Service Expenditures	$427,902,526	100.0	$11,116,636	100.0	$439,019,162	100.0	100.0
Total Elderly Recipients	84,595		21,316		105,911		
Expenditures Per Elderly Recipient	$5,058		$522		$4,145		$4,377

* Less than .1%

Note: Does not include adjustments processed by DMA, settlements, premiums, or state and county administration expenditures (See Table 6).

Source: 2082 Report for SFY 1990.

The Disabled and Blind

Blind and disabled individuals accounted for 34.5 percent of Medicaid expenditures. Most individuals in this group (98 percent) are classified as disabled, rather than blind. Disabled individuals must wait two years before receiving Medicare benefits if they qualify to receive them. During that waiting period, those who meet Medicaid income and resource criteria may qualify for Medicaid coverage of their health care needs.

As is true with the elderly population, the largest single expenditure for this group was for nursing home care (45.9 percent). Of nursing home expenditures, most was spent for intermediate care services for mentally retarded patients, who constitute only five percent of the total blind and disabled population. Inpatient hospital care was also an important expenditure for this group. On average, Medicaid expenditures were $6,850 per recipient for the blind and disabled group. Per recipient expenditures for this group increased 9.5 percent over the figure for 1989. In SFY 1990, 68,516 blind and disabled persons were served by Medicaid.

Table 13
SFY 1990
Expenditures for the Disabled and Blind

Type of Service	Disabled	% of Dollars	Blind	% of Dollars	Total Blind & Disabled Dollars	SFY 1990 % of Total Dollars	SFY 1989 % of Total Dollars
Inpatient Hospital	$116,126,287	25.1	$881,615	11.3	$117,007,902	24.9	25.7
Outpatient Hospital	15,561,842	3.4	139,296	1.8	15,701,138	3.4	3.0
Psychiatric Hospital (<21)	882,234	0.2	*	*	882,234	0.2	0.2
Physician	30,276,143	6.5	284,065	3.6	30,560,208	6.5	5.9
Clinics	9,491,372	2.1	67,913	0.9	9,559,285	2.0	1.9
SNF	25,151,333	5.4	793,263	10.1	25,944,596	5.5	5.7
ICF-General	14,668,381	3.2	877,086	11.2	15,545,467	3.3	3.3
ICF-MR	171,137,034	37.1	2,893,582	37.0	174,030,616	37.1	37.5
Dental	2,979,668	0.6	40,183	0.5	3,019,851	0.6	0.7
Prescription Drugs	32,078,638	7.0	653,982	8.4	32,732,620	7.0	7.0
Home Health	18,430,279	4.0	504,655	6.4	18,934,934	4.0	4.0
CAP/Disabled Adult	6,009,172	1.3	151,543	1.9	6,160,715	1.3	1.1
CAP/Children	1,089,820	0.2	6,681	0.1	1,096,501	0.2	0.2
CAP/Mentally Retarded	6,097,357	1.3	930	*	6,098,287	1.3	1.2
Personal Care Services	3,590,445	0.8	422,525	5.4	4,012,970	0.9	0.9
Hospice	759,006	0.2	5,985	0.1	764,991	0.2	0.1
Lab & X-Ray	4,139,127	0.9	31,062	0.4	4,170,189	0.9	0.8
Other Services	3,073,283	0.7	71,584	0.9	3,144,867	0.7	0.8
Total Disabled/Blind Service Expenditures	$461,541,421	100.0	$7,825,950	100.0	$469,367,371	100.0	100.0
Total Disabled/Blind Recipients	67,274		1,242		68,516		
Expenditures Per Disabled/Blind Recipient	$6,861		$6,301		$6,850		$6,254

* Less than .1%

Note: Does not include adjustments processed by DMA, settlements, premiums, or state and county administration expenditures (See Table 6).

Source: 2082 Report for SFY 1990.

Families and Children

In strong contrast with the pattern of spending for the elderly, blind and disabled populations, Medicaid spending for families with children reflects the preventive and acute care nature of their health needs. Table 14 displays expenditures for families and children broken down into four groups: AFDC Adults, Special Coverage for Pregnant Women, AFDC Children and Other Children, and Special Coverage Children.

In SFY 1990, total Medicaid expenditures per recipient for all groups combined was $1,219.

For all groups, inpatient hospital care was the largest expenditure. For special coverage children, 78.1 percent of expenditures was for hospital care immediately following birth. Physician services also account for a large portion of services used by these groups, and for AFDC and other children. ICF/MR services accounted for 10.4 percent of expenditures. During SFY 1990, 136,427 adults and 233,674 children received Medicaid services.

Table 14
SFY 1990
Expenditures for Families and Children

Type of Service	AFDC Adults	% of Dollars	Special Pregnant Women	% of Dollars	AFDC Children & Other Children	% of Dollars	Special Children	% of Dollars	Total Families And Children Dollars*	SFY 1990 % of Total Dollars	SFY 1989 % of Total Dollars
Inpatient Hospital	$58,583,854	40.8	$22,411,126	46.8	$79,110,252	40.6	$50,948,394	78.1	$211,053,626	46.8	49.2
Outpatient Hospital	17,205,040	12.0	4,191,273	8.8	13,796,181	7.1	1,990,869	3.1	37,183,363	8.2	7.6
Psychiatric Hospital (<21)	235,888	0.2	16,043	*	23,268,889	12.0	82	*	23,520,902	5.2	5.4
Physician	31,514,818	22.0	12,035,243	25.2	26,652,594	13.7	7,898,597	12.1	78,101,252	17.3	15.1
Clinics	3,831,511	2.7	3,874,319	8.1	4,383,490	2.3	219,249	0.3	12,308,569	2.7	2.5
SNF	304,149	0.2	41,832	0.1	589,583	0.3	14,866	*	950,430	0.2	0.2
ICF-General	2,809	*	–	–	85,682	*	19,215	*	107,706	*	*
ICF-MR	113,450	0.1	–	–	20,261,244	10.4	–	–	20,374,694	4.5	5.1
Dental	5,911,403	4.1	318,017	0.7	5,647,433	2.9	94,899	0.2	11,971,752	2.7	2.9
Prescription Drugs	11,772,425	8.2	697,243	1.5	7,723,546	4.0	869,713	1.3	21,062,927	4.7	4.7
Home Health	1,384,468	1.0	115,307	0.2	5,866,568	3.0	1,478,445	2.3	8,844,788	2.0	1.8
CAP/Children	–	–	–	–	20,315	*	–	–	20,315	*	*
EPSDT	11,878	*	6,269	*	2,566,296	1.3	1,044,117	1.6	3,628,560	0.8	0.8
Lab & X-Ray	3,387,409	2.4	672,953	1.4	1,536,480	0.8	302,613	0.5	5,899,455	1.3	1.2
Other Services	9,156,309	6.3	3,448,096	7.2	3,114,312	1.6	314,460	0.5	16,033,177	3.6	3.5
Total Families & Children Service Expenditures	$143,415,411	100.0	$47,827,721	100.0	$194,622,865	100.0	65,195,519	100.0	$451,061,516	100.0	100.0
Total Families & Children Recipients	105,739		30,688		196,222		37,452		370,101		
Expenditures Per Families & Children Recipient	$1,356		$1,559		$992		$1,741		$1,219		$1,121

* Less than .1%

Note: Does not include adjustments processed by DMA, settlements, premiums, or state and county administration expenditures (See Table 6).

Source: 2082 Report for SFY 1990.

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.

The following discussion describes services, reimbursement methods, limitations and copayment amounts in effect during SFY 1990. (Table 15 displays Medicaid copayment amounts.)

Mandatory Services

At a minimum, all state Medicaid programs must cover a core 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 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 percent of actual operating costs.

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

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 be 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.

In July 1990 (SFY 1991), Medicaid began directly enrolling durable medical equipment suppliers.

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, and/or referral for treatment of health problems detected during the screening of a Medicaid recipient 20 years of age or younger. Most Healthy Children and Teens services do not count toward the annual 24 visit limitation and no copayment is re-

quired. County health departments and private providers may participate in the Healthy Children and Teens program. For a complete description of the EPSDT program, see "Special Programs."

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 or her 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 prescriptions 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 $4.85 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 group 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 $.50 copayment applies to physician visits; a $1.00 copayment applies to optometrist visits; and a $2 copayment is charged on eyeglasses and repairs. Copayments do not apply to the exempt group identified under "Hospital Outpatient Services."

Medicaid contracts with Classic Optical, Inc. to provide eyeglasses at predetermined rates.

Providers must obtain eyeglasses through this company unless extenuating circumstances exist and an exception is made to permit a provider to supply lenses or a frame. The contract was obtained through a competitive bid process and is re-bid every two years.

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 group 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 hospital (tuberculosis or pulmonary), hospice, private duty nursing and ambulance transportation.

Table 15
SFY 1990
Medicaid Copayment Amounts

Service	Copayment Amount
Chiropractor visit	$ .50
Clinic visit	.50
Dental visit	2.00
Outpatient visit	1.00
Physician visit	.50
Podiatrist visit	1.00
Optical service	2.00
Legend drug and insulin prescription (including refills)	.50
Optometrist visit	1.00

These copayment amounts have been in effect since 1984, as required by the federal Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982.

Copayments amounts do not apply to the following:

* EPSDT program services
* Family planning services
* Services to children under age 18
* Services related to pregnancy
* Services to residents of ICF, ICF/MR, SNF facilities and mental hospitals
* Hospital emergency room services

The state elects to exempt the following services (or groups) from copayments:

* Community Alternatives Program (CAP) services
* Rural health clinic services
* Non-hospital dialysis facility services
* State-owned mental facility services
* Services covered by both Medicare and Medicaid
* Services to enrollees of prepaid plans

Special Programs

Baby Love

The Baby Love Program, implemented in October 1987, is designed to help address North Carolina's high infant mortality rate by improving access to health care for low income pregnant women and young children. Through the Baby Love program, pregnant women receive comprehensive, continuous care from the beginning of pregnancy through the postpartum period, and their children continue to receive care even after the mother's coverage has ended.

The Baby Love program is unique in that it was developed cooperatively and is jointly administered by the Divisions of Medical Assistance and Maternal and Child Health, in cooperation with the Office of Rural Health and Resource Development. By extending Medicaid coverage to new populations of low income pregnant women and their young children, more of these individuals have access to the traditional package of medical services. In addition, Baby Love covers childbirth classes, parenting classes, and in-home nursing care needed for medically complex pregnancies. The program created a statewide network of specially trained health care staff called Maternity Care Coordinators who help pregnant women obtain medical care and an array of other support services such as transportation, food and nutrition services, housing, job training and child care.

Outreach efforts were successfully implemented to inform individuals of the need for early prenatal care and services available through the Baby Love program. Coupled with simplification of eligibility requirements and the availability of eligibility determinations on-site at the source of prenatal care, the Baby Love program has been very successful in reaching its target population. 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.

Evaluation of the Baby Love program shows that women who receive the services of a Maternity Care Coordinator average more prenatal visits per pregnancy and better use the Women, Infants and Children (WIC) program, postpartum and family planning services, and well-child care services. Most importantly, these women had more live births and fewer low-birthweight babies.

Healthy Children and Teens Program

The Healthy Children and Teens program (formerly called the Early and Periodic Screening, Diagnosis and Treatment—or EPSDT—Program) provides preventive health care for children and teens from birth up to age 21. Preventive health care, in this context, means the child health examinations necessary to detect problems early, and the diagnosis, treatment, and referral (as indicated) to correct the problems identified.

The EPSDT program has been in existence since Medicaid began. In December 1989, Congress passed legislation (the Omnibus Budget Reconciliation Act of 1989) that includes new provisions designed to further ensure the availability of EPSDT services to Medicaid eligible children. Major changes effective on April 1, 1990 include the following:

- state-established separate periodicity schedules for health, vision, hearing and dental screening services;
- interperiodic screenings —outside the normal schedule —are encouraged whenever a health, developmental or educational professional determines it to be medically necessary or when a diagnosed condition may become worse and require further treatment;
- diagnostic and treatment services that are medically necessary to treat a condition identified during a screen must be covered by Medicaid to the extent permitted by federal law.

In addition to paying for services, EPSDT tries to ensure than children receive periodic and regular health examinations.

Community Alternatives Program

North Carolina operates three 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 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-eight counties choose to participate in CAP/DA and served about 3,325 individuals in SFY 1990.

The average daily cost for CAP/DA services at the skilled level of a nursing facility was 44 percent of the average cost for institutional care. At the intermediate level, CAP/DA services cost 63 percent of that for institutional care.

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-eight counties had access to the CAP-MR/DD program through 40 Mental Health, Mental Retardation, and Substance Abuse program centers and served about 660 individuals in SFY 1990. The area programs decide whether to offer this program. Participants in the CAP-MR/DD were served at approximately 23 percent of the average Medicaid cost for institutional care.

The Community Alternatives Program for Children (CAP/CC) is different from the other two programs because it serves medically fragile children (through age 18) who otherwise would be ineligible for Medicaid. This waiver program is available to all counties and served 60 children in SFY 1990. The cost of CAP services to the children in this program averaged 50 percent or less than that of the comparable level of institutional care.

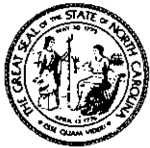
Overall, the CAP programs have been very successful in giving individuals a choice. They have allowed those who otherwise would be institutionalized to remain with family in familiar surroundings. All of this has been accomplished at a cost savings to Medicaid in comparison to the cost of institutional care.

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 (Mecklenburg and Durham) and enrolled an average of 1,246 recipients 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 offers enrollees most benefits available under the regular Medicaid program and may offer others as well. The standard Medicaid service limitations do not apply to HMO enrollees. Any Medicaid benefits not offered by the HMO must continue to be offered by the Medicaid program.

Specialized Care Services

Escalating health care costs, 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.



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