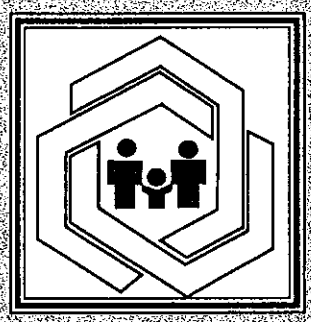

# Medicaid in North Carolina
# Annual Report
# State Fiscal Year 1991


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

James G. Martin
Governor

David T. Flaherty
Secretary

Barbara D. Matula
Director

**N.C. Department of Human Resources**
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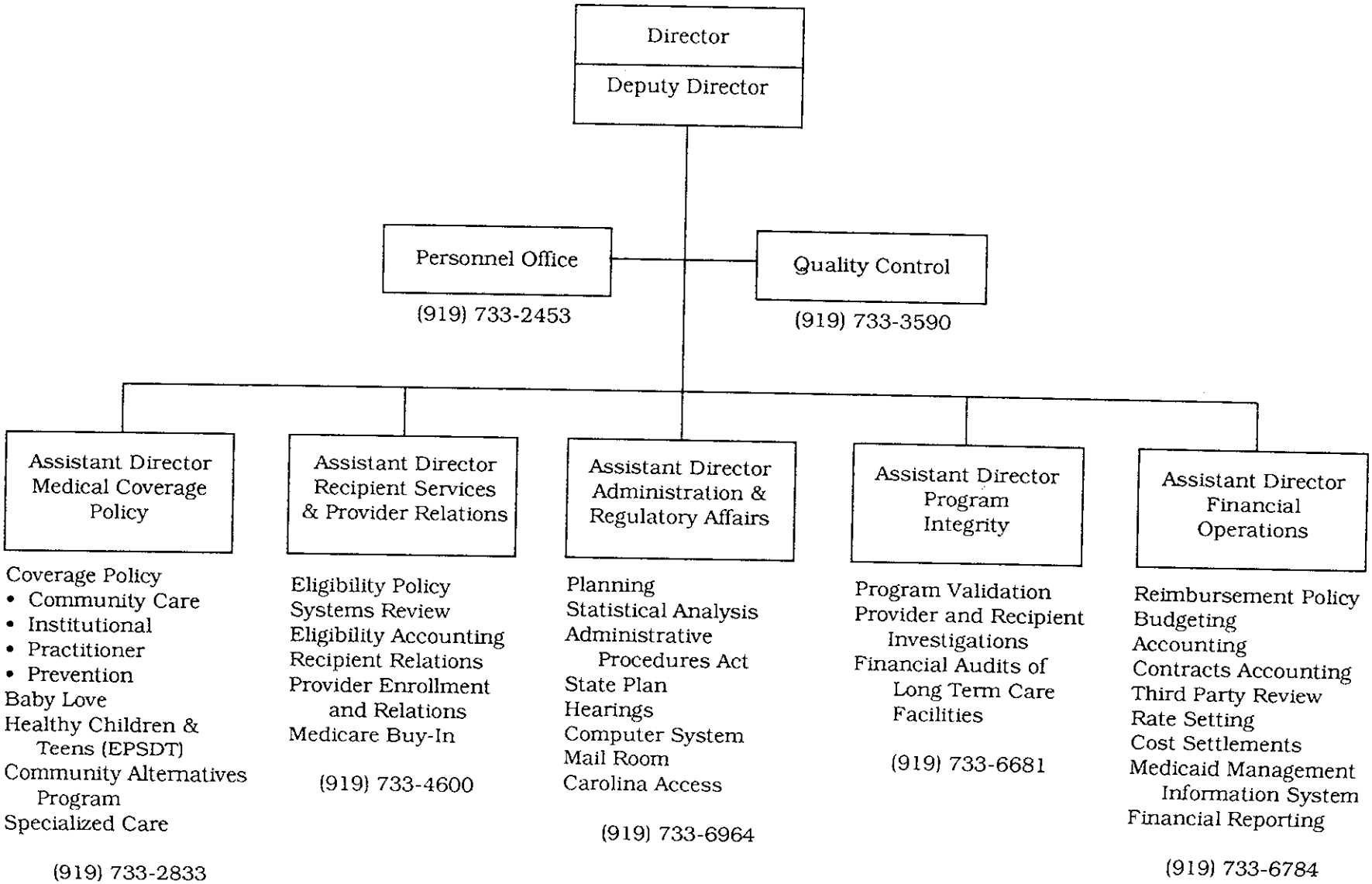

# MEDICAID IN NORTH CAROLINA

## ANNUAL REPORT
### State Fiscal Year 1990-91

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

David T. Flaherty, Secretary
Department of Human Resources

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Dear Fellow North Carolinians:

I am pleased to report on Medicaid program activities during state fiscal year 1991. During the year, Medicaid eligibles increased by over 17 percent and service costs increased by 36 percent. These increases are due to a combination of factors, including eligibility and service expansions mandated by the federal government and erosion of the state's economic health during a nationwide recession.

It is clear that Medicaid is fulfilling its fundamental mission: assuring access to necessary health care services for North Carolina's poorest and most vulnerable citizens. In the face of a slowing economy, the number of individuals qualifying for Medicaid by virtue of their eligibility for Aid to Families with Dependent Children payments increased by 16.5 percent. The number of pregnant women and children who were eligible for Medicaid grew by almost 18 percent over SFY 1990.

Medicaid continues to focus available resources on improving the health of North Carolina's mothers, infants and children. Investment in these populations includes new coverage of case management services for high risk infants and children and increased provider reimbursement for prenatal care, delivery fees and preventive and primary care services. At the same time, Medicaid was able to make improvements in the service delivery system. Carolina ACCESS, a primary care coordination demonstration program, began operation in five counties on April 1, 1991. This program enrolls primary care physicians to serve as patients' gatekeepers to more specialized--and expensive--services. In return, Medicaid pays participating physicians a modest care coordination fee. The goal of the program is to improve access to primary care and reduce fragmented utilization of expensive services. By so doing, Carolina ACCESS is expected to save program costs. Carolina ACCESS has received a favorable reception from participating physicians and patients alike.

I invite you to learn more about North Carolina's Medicaid program in the pages that follow.

Sincerely,

Barbara D Matula

Barbara D. Matula

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# HIGHLIGHTS OF THE 1991 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) 1991 extends from July 1, 1990 to June 30, 1991. During this time, Medicaid spent $1.9 billion for necessary health care services for 633,325 of North Carolina's neediest citizens. This represents just over 9 percent of North Carolina's population. In SFY 1991, Medicaid was able to serve 16.3 percent more needy recipients than in the year before.

As in past years, the largest proportion (66 percent) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. Thirty-four percent was spent on care for low income families and children. About 34 percent of the service budget is spent on nursing facility 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 coverage 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. Several times since 1987, the North Carolina General Assembly has authorized Medicaid to take advantage of options in federal law that expand coverage for pregnant women and children with family incomes up to varying percentages of the federal poverty level.

Most recently, the General Assembly increased the income limit to qualify for Medicaid to 185 percent of the federal poverty level for pregnant women and for infants under one year of age, effective October 1, 1990. This change was mandated by the Omnibus Budget Reconciliation Act (OBRA) 1989. Pregnant women who qualify under this program 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 also authorized increases in the age limit for children who qualify for this special program during the past several years. On October 1, 1990 six year-olds from families with incomes under 100 percent of poverty were covered. At the same time, OBRA 1989 required the state to increase the qualifying family income level from 100 percent to 133 percent for children aged one to five. In 1991 alone, this program helped 44,516 pregnant women and 63,341 children.

The General Assembly took additional steps to make sure that chronically ill and medically fragile infants and children up to age five receive coordinated care. Effective October 1, 1990, case management was covered under Medicaid for this high risk population.

### 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. Most recently, physician and dentist fees were increased four percent, effective January 1, 1991.

As part of its infant mortality initiatives, the Medicaid program also has increased payments for maternity care services substantially. The global package payment for a normal delivery has increased each year since 1987: from $409 to $625 in January, 1988; to $925 in October, 1989; and to $1,100 on October 1, 1990. The fee for a normal delivery-only increased from $308 in 1987 to $350 in 1988, to $550 in 1989, and to $700 on October 1, 1990.

On August 1, 1990, the hourly personal care service rate was increased from $8.00 to $9.00.

### Carolina ACCESS

Carolina ACCESS is a new demonstration program for Medicaid recipients sponsored by the Division of Medical Assistance and the North Carolina Foundation for Alternative Health Programs, funded in part by the Kate B. Reynolds Foundation. The goals of the program are to improve access to primary care and demonstrate more efficient and cost-effective arrangements for delivering care to Medicaid recipients.

Carolina ACCESS encourages more efficient arrangements for delivering care by linking recipients with primary care physicians. The program contracts with primary physicians to deliver and coordinate health care for Medicaid recipients. Each eligible recipient selects the participating physician of their choice. Primary care physicians coordinate their enrollee's health care needs by providing or arranging: primary care services, including prevention, health maintenance, and treatment of illness and injuries; referrals for specialty and other covered services; and after hours coverage.

Carolina ACCESS has been successfully implemented in nine counties across North Carolina. The first five pilot counties began in April 1, 1991: Durham, Edgecombe, Henderson, Moore and Wilson. Additional counties added to the program in 1991 were: Burke, Madison, Nash and Wayne. More recently in 1992, Beaufort, Greene and Pitt counties joined the program. Enrollment in those counties began March 1, 1992. As of January 1, 1992, Carolina ACCESS enrollment reached 35,383 Medicaid recipients--representing approximately 53 percent of total monthly Medicaid eligibles in the demonstration counties. The program anticipates that approximately 60 to 70 percent of the monthly Medicaid eligibles in participating counties will be enrolled in Carolina ACCESS. The program is planning to add 10 to 12

counties in 1992, with a long-range goal of being statewide.

### Nursing Home Reform

Many of the nursing home reform provisions included in the Omnibus Budget Reconciliation Act (OBRA) of 1987 and later amendments became effective on October 1, 1990. Largely devoted to strengthening patients' rights in nursing homes, the OBRA nursing home reform legislation made a number of changes that affect the Medicaid program. Among the most important are:

- Establishing uniform requirements for institutions that formerly were identified as Medicaid skilled nursing facilities (SNFs) and intermediate care facilities (ICFs). Now, all Medicaid SNFs and ICFs are called nursing facilities (NFs) and must provide both skilled nursing (SN) and intermediate care (IC) levels. Reimbursement rates, however, continue to differ based on whether the patient receives skilled or intermediate care.

- Nursing facilities are required to conduct a comprehensive assessment of each resident to determine the services the resident needs. The resident assessment is required for all nursing facility patients regardless of payment source. This change was designed to make sure patients receive services that are most appropriate to their condition. If a patient needs a specialized service, the nursing facility must provide it or arrange for its provision.

- Patients' rights were strengthened and made more explicit.

- States are required to develop and maintain a registry of nurse aides and to institute a nurse aide training program in the state.

- Nursing facility quality assurance programs were strengthened.

### Omnibus Budget Reconciliation Act of 1989

The Omnibus Budget Reconciliation Act (OBRA) of 1989 included many provisions that affected the state's Healthy Children and Teens Program, more often known by its federal acronym EPSDT. Some changes were effective in SFY 1990 and are described in the Special Programs section of this report. OBRA 1989 provisions affecting EPSDT that became effective on October 1, 1990 include the following:

- Coverage of orthotics and prosthetics for EPSDT-eligible children

- Exemption of EPSDT-eligible children from Medicaid service limits of 24 physician visits per year and 6 prescriptions per month

### Durable Medical Equipment

Historically, North Carolina's Medicaid program has covered durable medical equipment. These services were covered, however, only when arranged for and billed by home health agencies. On July 1, 1990, Medicaid changed this policy and began enrolling and paying qualified durable medical equipment suppliers directly.

### Psychiatric Services for Children

Medicaid covers inpatient psychiatric services for children up to age 21. During the past decade, costs for services to these children have grown tremendously. The increased cost re-

flects both greater numbers of children hospitalized for psychiatric reasons and inflation in the cost of services. These dual concerns prompted review of North Carolina's coverage of these services and led to changes in Medicaid's utilization review program for psychiatric services to children. Effective August 1, 1990, DMA contracted with Mental Health Management of America (MHMA) to conduct a strengthened inpatient stay review process.

**Pioneer Project**

Beginning April 1, 1991, Medicaid changed the way it pays for community mental health services. Through a cooperative effort with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), services offered through the community mental health center network were expanded, and for Medicaid purposes, reclassified as rehabilitative services. This program is known as the Pioneer Project. The change permits broader Medicaid coverage of community-based services offered by mental health centers.

Chart 1 summarizes the major changes that were made in Medicaid in SFY 1991.

## Chart 1
## SFY 1991
## Medicaid Program Changes in Brief

| Effective Date | Policy Change |
|---|---|
| **July 1, 1990** | . Begin direct payments to durable medical equipment suppliers |
| **August 1, 1990** | . Increase personal care service rate from $8 to $9 per hour |
| | . Mental Health Management of America contract initiated |
| **October 1, 1990** | . $750,000 appropriation to provide grants to counties to cover the local share of providing transportation services to Medicaid patients |
| | . Increase eligibility income level for pregnant women and infants to 185% of the federal poverty level |
| | . Increase eligibility income level for children ages one to six to 133% of the federal poverty level |
| | . Expand coverage to children age six in families with incomes under 100% of the federal poverty level |
| | . Implement federal nursing home reform requirements |
| | . Increase maternity care rates from $925 to $1,100 (global fee) and from $550 to $700 (delivery-only) |
| | . Cover case management for high risk infants and children under age 5 |
| | . Cover prosthetics and orthotics for EPSDT-eligible children |
| | . Exempt EPSDT-eligible children from the 24 physician visit per year limit and the 6 prescription per month limit |
| **January 1, 1991** | . Increase physician and dentist fees by 4% (excluding maternity care and laboratory fees) |
| | . Increase Medicare-Aid income eligibility level from 85% to 95% |
| **April 1, 1991** | . Carolina ACCESS demonstration program implemented |
| | . Pioneer Project (community mental health center services) implemented |

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

From 1978 to 1991, Medicaid expenditures and eligibles grew from $307 million to $1.9 billion, and from 456,000 to 752,000, respectively. During this time, DMA staff increased from 121 to 207. 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 1991, Medicaid state and local administration costs consumed just four 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. For individuals who qualify for both Medicaid and Medicare, Medicaid pays Medicare cost-sharing amounts and fills in many gaps in Medicare's benefit package, especially in the area of long term care services.

## Federal Financial Participation

The 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 federal matching rates for SFY 1991.

**Table 1**
**SFY 1991**
**Federal Matching Rates**

**Benefit Costs**

| | Family Planning | All Other |
|---|---|---|
| | (7/1/90 - 9/30/90) | |
| Federal | 90.0% | 67.46% |
| State | 8.5% | 27.66% |
| County | 1.5% | 4.88% |
| | (10/1/90 - 6/30/91) | |
| Federal | 90.0% | 66.60% |
| State | 8.5% | 28.39% |
| County | 1.5% | 5.01% |

**Administrative Costs**

(7/1/90 - 6/30/91)

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

* 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 localities to participate in the non-federal share of expenditures. In North Carolina, each county contributes 15 percent of the non-federal share. During SFY 1991, the federal, state and county shares were approximately 67 percent, 28 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).

For the aged, blind and disabled, federal regulations permit states either to accept as categorically needy all persons found eligible for the federal Supplemental Security Income (SSI) program or to set categorically needy eligibility criteria that are more restrictive than SSI standards. North Carolina has elected the latter approach, making it one of 13 "209(b)" states, so-named for the statutory citation explaining the option. What this means is that SSI recipients must make a separate application to North Carolina's Medicaid program and meet more stringent financial means tests (on resources) to become eligible for coverage.

Medicaid's Medicare-Aid program pays for out-of-pocket expenses for Medicare-covered services, such as premiums, deductibles and coinsurance for those who qualify. The income and resource limits that must be met to qualify for Medicare-Aid are higher than those necessary to receive full Medicaid coverage. (See Table 2 "Qualified Medicare Beneficiaries" column).

The spousal impoverishment provision of the Medicare Catastrophic Coverage Act of 1988 allows a spouse living in the community to keep a larger portion of the family's income than otherwise would be permitted when the other spouse requires nursing home care. This allows an institutionalized spouse to receive Medicaid without impoverishing the at-home spouse. The

**Table 2**
**SFY 1991**
**Medicaid Financial Eligibility Standards**

**Eligibility Income Levels**
**(Annual)**

| Family Size | --AFDC Related Groups-- Categorically Needy | Medically Needy | Aged, Blind & Disabled: All Groups | Pregnant Women Infants 0-1 185% of Poverty | Children Ages 1-5 133% of Poverty | Children Age 6 100% of Poverty | Qualified Medicare Beneficiaries | Spousal Impoverishment Beneficiaries |
|---|---|---|---|---|---|---|---|---|
| 1 | $4,344 | $2,900 | $2,900 | $11,628 | $ 8,364 | $ 6,288 | $5,976 | $10,272 up a maximum of $19,944 |
| 2 | 5,664 | 3,800 | 3,800 | 15,588 | 11,208 | 8,424 | 8,004 | |
| 3 | 6,528 | 4,400 | 4,400 | 19,536 | 14,052 | 10,560 | | |
| 4 | 7,128 | 4,800 | 4,800 | 23,496 | 16,896 | 12,708 | | |
| 5 | 7,776 | 5,200 | 5,200 | 27,456 | 19,740 | 14,844 | | |

**Eligibility Resources Limits**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 1 | $1,000 | $1,500 | $1,500 | No resource test applies | No resource test applies | No resource test applies | $4,000 | $13,296 minimum |
| 2 | No increment | 2,250 | 2,250 | | | | 6,000 | $66,480 maximum |
| 3 | for family size | 2,350 | 2,350 | | | | | |
| 4 | | 2,450 | N/A | | | | | |
| 5 | | 2,550 | N/A | | | | | |

income and resources levels applicable to these individuals are higher than those that apply to other aged persons and increase each year. (See Table 2.) Annual income levels to qualify range from $10,272 to $19,944 (as of January 1, 1991); resource levels range from $13,296 to $66,480 (as of January 1, 1991).

**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 27,407 providers who are enrolled in the program. Providers then bill Medicaid for their services. In 1991 13,411 billed for services. Table 3 shows the broad range of provider types that Medicaid enrolls.

Medicaid provides funding for care that many otherwise would not be able to afford. Medicaid is also an ongoing source of both state and federal revenues for North Carolina's health care providers, although its importance varies by provider. Medicaid pays for all patients in intermediate care facilities for the mentally retarded and for 74 percent of all nursing facility days. In SFY 1990, 83 percent of North Carolina's primary care physicians served at least 25

**Table 3**
**SFY 1991**
**Enrolled Medicaid Providers**

| Providers | Number |
|---|---|
| Physicians* | 17,661 |
| Dentists | 2,660 |
| Pharmacists | 2,175 |
| Optometrists | 849 |
| Chiropractors | 567 |
| Podiatrists | 268 |
| Ambulance Companies | 200 |
| Home Health Agencies** | 137 |
| Durable Medical Equipment Suppliers | 267 |
| Intermediate Care Facilities-MR | 178 |
| Hospitals | 192 |
| Mental Health Clinics | 110 |
| Nursing Facilities | 331 |
| Optical Supplies Company*** | 1 |
| Personal Care Agencies | 127 |
| Rural Health Clinics | 58 |
| Nurse Midwives | 10 |
| Hospices | 47 |
| CAP Providers | 372 |
| Other Clinics | 65 |
| Other | 1,132 |
| **Total** | **27,407** |

* 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 number. Also physicians who practice in multiple settings and are included once for each practice setting.

** Includes physical, speech and occupational therapies and home infusion therapy services.

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

Medicaid 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 the proportion at individual hospitals varies greatly.

### 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 many program reporting requirements. Expenditures for EDS-F services were $7.8 million in SFY 1991. EDS-F processed 23,687,271 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 forelective inpatient hospital care. The pre-certification program ensures that Medicaid patients receive medically necessary care in the most appropriate setting. MRNC also conducts quality assurance reviews of prepaid health plan services and the Community Alternatives Programs (CAP).

**Mental Health Management of America (MHMA)** - As of August 1, 1990, DMA contracted with MHMA to conduct preadmission and concurrent stay reviews of inpatient psychiatric admissions for children under 21. These reviews assure that admissions and lengths of stay are medically necessary appropriate for this population.

**Classic Optical** - DMA contracts with Classic Optical to supply all the frames and lenses prescribed by Medicaid providers.

**Audit Contract** - During SFY 1990, DMA contracted with a private audit firm to conduct compliance audits of nursing facilities enrolled in the program. The audits supplement DMA's in-house audit activities and verify the accuracy of providers' cost reports.

### 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)** - NC 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/ Developmental Disabilities/ Substance Abuse Services (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. This culminated in the implementation of the Pioneer Project in April, 1991. See the "Highlights" section of this report.

**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 have worked cooperatively to plan and implement changes contained in federal nursing home reform legislation.

**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 have healthy pregnancies and 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. It requires that states find and serve all eligible children between the ages of three and five 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 on 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, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Additional details are discussed in the "Medicaid In Depth" section of this report.

Medicaid imposes certain standard limitations on services (see 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, EPSDT-eligible children, 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."

## Rate Setting

Prospective payment rates and fee schedules are important in controlling program costs. DMA strives to establish rates that are fair to a wide array of provider types. 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 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 reimbursement rates were developed during SFY 1991. Consult "Medicaid In Depth" for more information about the payment mechanism that is applicable to each type of service.

**Table 4**
**SFY 1991**
**Medicaid Services**

Ambulance Transportation
Case Management for pregnant women, high risk children (0 - 5), chronically mentally ill adults, emotionally disturbed children, and chronic substance abusers
Chiropractors
Clinic Services
Community Alternatives Programs
Dental Care Services
Durable Medical Equipment
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 for the Mentally Retarded (ICF-MR)
Laboratory and X-Ray Services
Mental Hospitals (age 65 and over)
Migrant Health Clinics
Nurse Midwives
Nursing Facilities: Intermediate Care Facilities (ICF) and Skilled Nursing Facilities (SNF)
Optical Supplies
Optometrists
Personal Care Services
Physicians
Podiatrists
Prepaid Health Plan Services
Prescription Drugs
Prosthetics and Orthotics (children)
Psychiatric Hospitals (up to age 21)
Rehabilitative Services (under auspices of area mental health program)
Rural Health Clinics
Specialty Hospitals
Transportation (through the counties)

## Program Efficiency and Effectiveness

**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 consistently has been among the lowest of all Medicaid programs in the nation. In 1991, North Carolina's one percent error rate placed the state in the top quarter of low error rate states.

The state's error rate results from a long-standing partnership between DMA and North Carolina's counties. In this partnership, DMA staff conduct federally mandated and stateinitiated 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.

**Program Integrity** - DMA program integrity efforts include: identification of providers and recipients who abuse or defraud the Medicaid program; identification and collection of provider and recipient overpayments; education of providers or recipients when errors or abuse is 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 1991, 1,441 provider reviews were initiated and 1,576 recipient cases were opened. Collections of overpayments amounted to $4,605,576 from providers, and $536,147 from recipients found to be ineligible. In addition, financial audits of long-term care facilities resulted in recovery of $1,543,381 from 357 field audits and $629,481 from 77 desk audits.

Also during 1991, the section used educational letters and consultation to resolve provider questions and billing problems. DMA furnished guidance to nursing facilities to conform with the nursing home reform section of OBRA 1987. In addition, action on 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 for management.

**Utilization Control and Review** - DMA operates several other programs directly or under contract to make sure that Medicaid funds are spent appropriately. These programs are designed to prevent and recover incorrect payments.

Prior approval and prior authorization for services in advance of their delivery is used to make sure that the care that is planned is appropriate. The prior approval system for most services is operated by EDS-F. Prior authorization for hospital services is operated by MRNC under contract. In addition, 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 1991, funds from a variety of sources defrayed Medicaid expenditures. Insurance paid on patients' behalf amounted to $21,670,513. An additional $43,030,686 in claims were denied because other insurance was thought to be available to pay for services.

Refunds were received from:

| | |
|---|---|
| Medicare | $ 604,423 |
| Health Insurance | $5,822,427 |
| Casualty Insurance | $2,922,791 |
| Absent Parent | $ 28,802 |

Medicaid policy is designed to avoid costs that otherwise would be incurred. In SFY 1991, an estimated $339,748,516 in Medicaid expenditures were saved by a policy that requires Medicare to be billed first.

## MEDICAID DOLLARS AND PEOPLE

### Sources and Uses of Funds

In state fiscal year 1991, Medicaid paid $1,857,726,367 for health care services to North Carolina citizens. This total includes $134,937,513 in additional payments to hospitals serving disproportionately high numbers of Medicaid recipients. Hospitals contributed $45,069,130 to the Medicaid program. In addition, $84,289,725 was spent to administer the program at the state and local levels. In total, 96 percent of the Medicaid 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 36 percent from SFY 1990 to SFY 1991. The increase is driven by eligibility expansions, inflation, and changes in the mix and use of services.

**Chart 2**
**SFY 1991**
**Sources of Medicaid Funds, Percent**

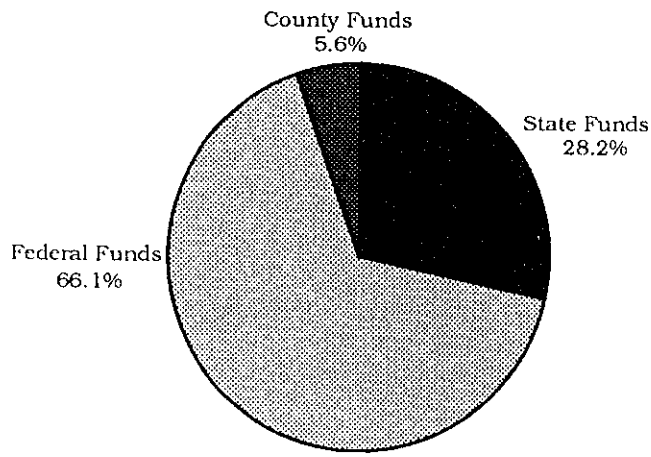



**Table 5**
**SFY 1991**
**Sources of Medicaid Funds**

| | |
|---|---|
| Federal Funds | $1,284,311,751 |
| State Funds | $ 548,161,019* |
| County Funds | $ 109,543,322 |
| Total Funds | $1,942,016,092 |

* Includes $45,069,130 in hospital contributions.

**Chart 3**
**SFY 1991**
**Uses of Medicaid Funds**
**(percent of total expenditures)**

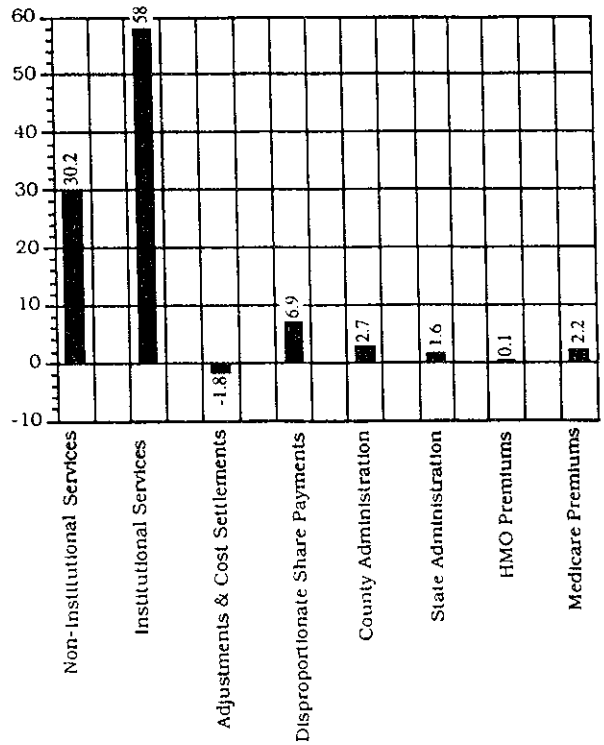


**Table 6**
**SFY 1991**
**Uses of Medicaid Funds**

| Type of Service | Total Expenditures | % of Total Dollars | % of Service Dollars | Users of Services* | Cost Per Service User |
|---|---|---|---|---|---|
| Inpatient Hospital | $ 438,102,471 | 22.6 | 25.6 | 152,014 | $ 2,882 |
| Mental & Psychiatric Hospital | 35,912,956 | 1.8 | 2.1 | 2,380 | 15,089 |
| Outpatient Hospital | 84,789,555 | 4.4 | 4.9 | 323,853 | 262 |
| Physician | 159,887,250 | 8.2 | 9.3 | 510,138 | 313 |
| Clinics | 31,244,639 | 1.6 | 1.8 | 96,725 | 323 |
| Nursing Facility (Skilled) | 225,692,418 | 11.6 | 13.2 | 18,683 | 12,080 |
| Nursing Facility (Intermediate) | 183,351,929 | 9.4 | 10.7 | 16,144 | 11,357 |
| ICF-MR | 244,942,443 | 12.6 | 14.3 | 4,184 | 58,543 |
| Dental | 21,683,521 | 1.1 | 1.3 | 145,634 | 149 |
| Prescription Drugs | 120,266,143 | 6.2 | 7.0 | 437,831 | 275 |
| Home Health | 46,052,821 | 2.4 | 2.7 | 20,757 | 2,219 |
| Other Services | 121,381,408 | 6.3 | 7.1 | 592,579 | 205 |
| Subtotal, Services | **$1,713,307,554** | **88.2** | **100.0** | | |
| Medicare Premium (Part A, Part B, QMB, Dually Eligible) | 42,918,194 | 2.2 | | | |
| HMO Premium | 1,752,499 | 0.1 | | | |
| Adjustments & Cost Settlements | (35,189,393) | (1.8) | | | |
| Disproportionate Share Payments | 134,937,513 | 6.9** | | | |
| Subtotal Services & Other | **$1,857,726,367** | **95.6** | | | |
| Administration (State & County) | 84,289,725 | 4.3 | | | |
| (State) | 31,318,244 | 1.6 | | | |
| (County) | 52,971,481 | 2.7 | | | |
| **Grand Total Expenditures** | **$1,942,016,092** | **100.0** | | | |
| Total Recipients (unduplicated)*** | | | | 633,325 | |
| Service Expenditures Per Recipient (unduplicated) | | | | | **$ 2,705** |

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

** Additional payments for hospitals providing services to a higher than average number of Medicaid patients.

*** "Total Recipients" is unduplicated, counting recipients only once during the year regardless of the number or type of services they use.

Note: Numbers may not add due to rounding
Source: SFY 2082 report, SFY 1991; DAS report, SFY 1991

Institutional services, including hospitals and nursing facilities, consume the largest share of the Medicaid service budget (65.9 percent). Spending for intermediate care facilities for the mentally retarded (ICF-MR) was the second highest (14.3 percent) single expenditure, but is used by a very small fraction of the Medicaid population (.7 percent), resulting in expenditures of $58,543 per recipient. The total number of recipients increased by 16.3 percent over SFY 1990. Reflecting the success of eligibility expansions associated with the state's infant mortality initiative, the number of pregnant women and children recipients grew by 45.1 percent and 69.1 percent, respectively.

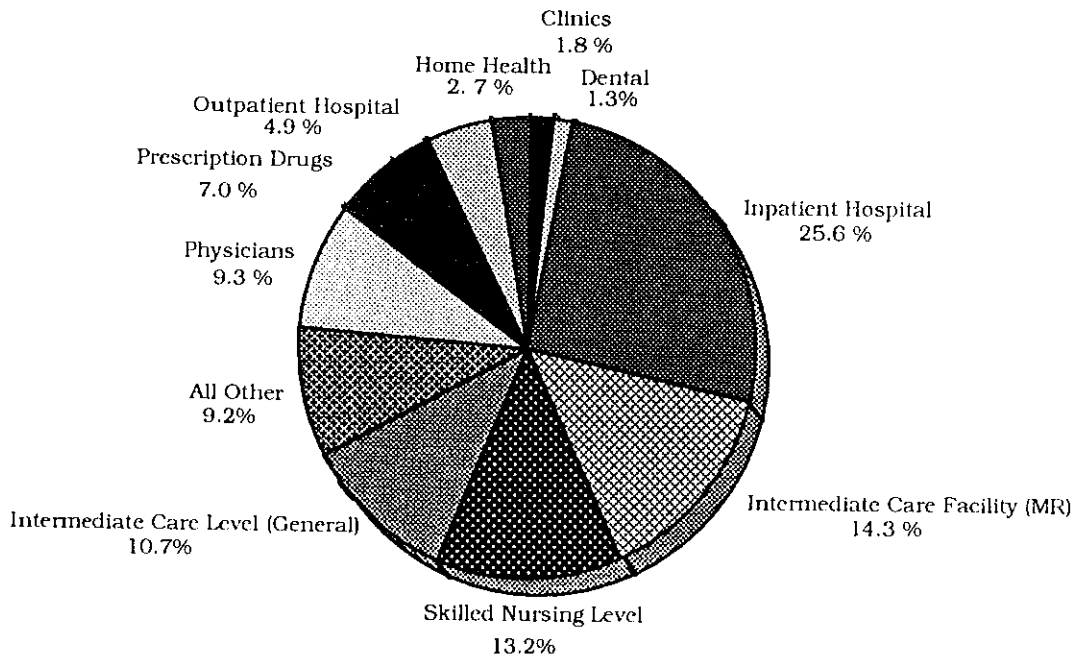
At the same time, the number of recipients whose Medicaid eligibility is linked to AFDC increased at higher rates than in previous years, 12.8 percent. Although the number of aged recipients decreased in absolute terms

**Table 7**
**SFY 1979-1991**
**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 |
| 1991... | 1,942,016,092 | 36.0 |

Note: Includes vendor payments, administrative costs, refunds, adjustments.
Source: DAS report, SFY 1991

**Chart 4**
**SFY 1991**
**Medical Service Expenditures, Percent**



the number of QMBs grew by almost 41 percent, resulting in an 6.3 percent increase for elderly recipients overall. Continuing a trend seen since 1984, the number of blind recipients declined 6.6 percent.

Another portion of the increase in Medicaid expenditures is due to more intensive and extensive use of services and payment increases (or inflation). The combined effect of these factors is reflected in service expenditures per recipient. Overall, per recipient expenditures increased by 8.3 percent over SFY 1990.

The increase in expenditures per recipient by eligibility group varied from a high of 64.8 percent for QMBs to a low of -1.7 percent (special coverage children). Per recipient expenditures for the aged, blind and disabled groups grew substantially, 28.4 percent, 25.8 percent, and 14.7 percent, respectively.

The overall effect of these high per recipient expenditure growth rates within eligibility category is offset considerably by the very small rates of growth experienced by those eligibility groups that make up nearly three-quarters of all Medicaid recipients, AFDC adults and children and special coverage women and 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. Table 8 shows the historical growth in eligibles from 1979 to 1991.

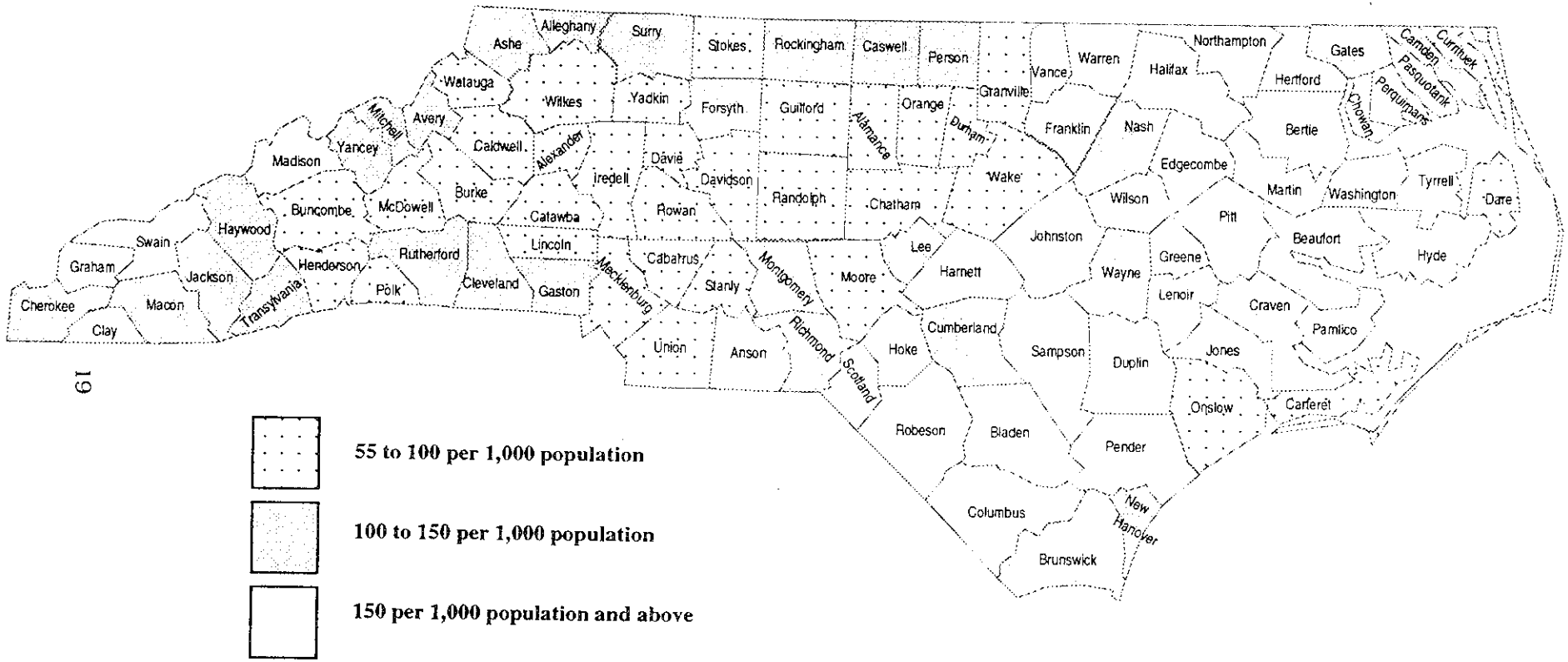
Most eligibles use services and are called recipients. Some eligibles, however, do not use services during

**Table 8**
**SFY 1979 - 1991**
**A History of Medicaid Eligibles**

| Fiscal Year | Aged | QMBs | Blind | Disabled | AFDC Adults & Children | Special Pregnant Women Coverage | Special Children Coverage | Other Children | Total | Percent 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 |
| 1990-91 | 81,466 | 42,949 | 1,116 | 71,397 | 451,983 | 37,200 | 61,210 | 4,296 | 751,617 | 17.7 |
| Percent Total Eligibles | 10.8% | 5.7% | 0.2% | 9.5% | 60.1% | 5.0% | 8.1% | 0.6% | 100.0% | |

Source: Medicaid Eligibility Report, SFY 1991

**Chart 5**
**SFY 1991**
**Medicaid Enrollment per 1,000 Population by County**



# Table 9
# SFY 1991
# Total Expenditures and Eligibles by County

| County Name | 1990 Census Population | Number of Medicaid Eligibles | Total Expenditures | Expenditures Per Eligible | Per Capita Expenditures Amount | Rank | Eligibles Per 1,000 Population |
|---|---|---|---|---|---|---|---|
| Alamance | 108,213 | 9,051 | $25,891,124 | $2,861 | $239.26 | 76 | 84 |
| Alexander | 27,544 | 2,016 | 5,713,254 | 2,834 | 207.42 | 89 | 73 |
| Alleghany | 9,590 | 1,040 | 2,673,861 | 2,571 | 278.82 | 55 | 108 |
| Anson | 23,474 | 3,979 | 10,504,464 | 2,640 | 447.49 | 5 | 170 |
| Ashe | 22,209 | 2,964 | 8,145,604 | 2,748 | 366.77 | 23 | 133 |
| Avery | 14,867 | 1,808 | 5,489,094 | 3,036 | 369.21 | 22 | 122 |
| Beaufort | 42,283 | 6,813 | 15,085,290 | 2,215 | 356.77 | 28 | 161 |
| Bertie | 20,388 | 4,327 | 7,410,643 | 1,713 | 363.48 | 24 | 212 |
| Bladen | 28,663 | 6,279 | 12,482,892 | 1,988 | 435.51 | 6 | 219 |
| Brunswick | 50,985 | 6,860 | 14,749,585 | 2,150 | 289.29 | 48 | 135 |
| Buncombe | 174,821 | 16,786 | 44,867,309 | 2,673 | 256.65 | 68 | 96 |
| Burke | 75,744 | 7,061 | 19,609,493 | 2,777 | 258.89 | 67 | 93 |
| Cabarrus | 98,935 | 8,273 | 24,511,796 | 2,963 | 247.76 | 73 | 84 |
| Caldwell | 70,709 | 6,800 | 19,158,908 | 2,818 | 270.95 | 62 | 96 |
| Camden | 5,904 | 704 | 1,498,318 | 2,128 | 253.78 | 69 | 119 |
| Carteret | 52,556 | 5,103 | 12,511,918 | 2,452 | 238.07 | 78 | 97 |
| Caswell | 22,693 | 2,713 | 6,856,183 | 2,527 | 331.33 | 35 | 131 |
| Catawba | 118,412 | 8,541 | 23,595,251 | 2,763 | 199.26 | 92 | 72 |
| Chatham | 38,759 | 3,202 | 8,703,270 | 2,718 | 224.55 | 86 | 83 |
| Cherokee | 20,170 | 2,997 | 7,242,772 | 2,417 | 359.09 | 27 | 149 |
| Chowan | 13,506 | 2,363 | 4,872,461 | 2,062 | 360.76 | 26 | 175 |
| Clay | 7,155 | 851 | 2,232,289 | 2,623 | 311.99 | 42 | 119 |
| Cleveland | 84,714 | 10,065 | 24,431,197 | 2,427 | 288.40 | 49 | 119 |
| Columbus | 49,587 | 11,134 | 23,782,088 | 2,136 | 479.60 | 3 | 225 |
| Craven | 81,613 | 10,097 | 21,866,877 | 2,166 | 267.93 | 64 | 124 |
| Cumberland | 274,566 | 33,086 | 54,217,906 | 1,639 | 197.47 | 93 | 121 |
| Currituck | 13,736 | 1,336 | 2,565,041 | 1,920 | 186.74 | 95 | 97 |
| Dare | 22,746 | 1,399 | 3,510,710 | 2,622 | 154.34 | 98 | 62 |
| Davidson | 126,677 | 10,854 | 26,980,896 | 2,486 | 212.99 | 88 | 86 |
| Davie | 27,859 | 2,068 | 6,277,747 | 3,036 | 225.34 | 84 | 74 |
| Duplin | 39,995 | 6,899 | 15,060,311 | 2,183 | 376.55 | 20 | 172 |
| Durham | 181,835 | 18,051 | 50,389,617 | 2,792 | 277.12 | 57 | 99 |
| Edgecombe | 56,558 | 12,072 | 22,886,188 | 1,896 | 404.65 | 12 | 213 |
| Forsyth | 265,878 | 26,472 | 63,577,290 | 2,402 | 239.12 | 77 | 100 |
| Franklin | 36,414 | 5,189 | 12,524,924 | 2,414 | 343.96 | 33 | 143 |
| Gaston | 175,093 | 19,797 | 44,119,833 | 2,229 | 251.98 | 70 | 113 |
| Gates | 9,305 | 1,169 | 2,501,766 | 2,140 | 268.86 | 63 | 126 |
| Graham | 7,196 | 1,344 | 2,482,417 | 1,847 | 344.97 | 32 | 187 |
| Granville | 38,345 | 3,728 | 9,567,175 | 2,566 | 249.50 | 72 | 97 |
| Greene | 15,384 | 2,570 | 5,399,687 | 2,101 | 350.99 | 30 | 167 |
| Guilford | 347,420 | 32,333 | 79,362,145 | 2,455 | 228.43 | 83 | 93 |
| Halifax | 55,516 | 14,209 | 23,677,885 | 1,666 | 426.51 | 8 | 256 |
| Harnett | 67,822 | 10,435 | 21,274,555 | 2,039 | 313.68 | 40 | 154 |
| Haywood | 46,942 | 5,537 | 13,292,464 | 2,401 | 283.17 | 51 | 118 |
| Henderson | 69,285 | 6,260 | 16,995,869 | 2,715 | 245.30 | 74 | 90 |
| Hertford | 22,523 | 5,269 | 9,193,305 | 1,745 | 408.17 | 10 | 234 |
| Hoke | 22,856 | 4,766 | 7,801,320 | 1,637 | 341.32 | 34 | 209 |
| Hyde | 5,411 | 1,092 | 2,352,024 | 2,154 | 434.67 | 7 | 202 |
| Iredell | 92,931 | 8,506 | 21,380,654 | 2,514 | 230.07 | 82 | 92 |
| Jackson | 26,846 | 3,232 | 7,379,916 | 2,283 | 274.90 | 60 | 120 |
| Johnston | 81,306 | 11,071 | 26,268,189 | 2,373 | 323.08 | 37 | 136 |
| Jones | 9,414 | 1,642 | 4,649,736 | 2,832 | 493.92 | 2 | 174 |

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

# Table 9
## SFY 1991
## Total Expenditures and Eligibles by County

| County Name | 1990 Census Population | Number of Medicaid Eligibles | Total Expenditures | Expenditures Per Eligible | Per Capita Expenditures Amount | Rank | Eligibles Per 1,000 Population |
|---|---|---|---|---|---|---|---|
| Lee | 41,374 | 5,189 | $ 12,057,619 | $2,324 | $291.43 | 46 | 125 |
| Lenoir | 57,274 | 10,448 | 23,100,753 | 2,211 | 403.34 | 13 | 182 |
| Lincoln | 50,319 | 4,224 | 10,165,797 | 2,407 | 202.03 | 91 | 84 |
| Macon | 23,499 | 2,604 | 6,502,454 | 2,497 | 276.71 | 58 | 111 |
| Madison | 16,953 | 2,645 | 6,418,068 | 2,426 | 378.58 | 19 | 156 |
| Martin | 25,078 | 4,227 | 8,673,768 | 2,052 | 345.87 | 31 | 169 |
| McDowell | 35,681 | 3,524 | 8,933,873 | 2,535 | 250.38 | 71 | 99 |
| Mecklenburg | 511,433 | 47,501 | 112,927,080 | 2,377 | 220.81 | 87 | 93 |
| Mitchell | 14,433 | 1,734 | 5,099,064 | 2,941 | 353.29 | 29 | 120 |
| Montgomery | 23,346 | 3,486 | 7,226,363 | 2,073 | 309.53 | 43 | 149 |
| Moore | 59,013 | 5,339 | 13,944,630 | 2,612 | 236.30 | 79 | 90 |
| Nash | 76,677 | 9,972 | 21,689,229 | 2,175 | 282.86 | 52 | 130 |
| New Hanover | 120,284 | 15,304 | 33,765,383 | 2,206 | 280.71 | 53 | 127 |
| Northampton | 20,798 | 4,977 | 9,461,215 | 1,901 | 454.91 | 4 | 239 |
| Onslow | 149,838 | 10,949 | 20,100,021 | 1,836 | 134.15 | 100 | 73 |
| Orange | 93,851 | 5,236 | 17,613,711 | 3,364 | 187.68 | 94 | 56 |
| Pamlico | 11,372 | 1,726 | 4,227,715 | 2,449 | 371.77 | 21 | 152 |
| Pasquotank | 31,298 | 5,423 | 9,566,497 | 1,764 | 305.66 | 45 | 173 |
| Pender | 28,855 | 4,393 | 11,004,642 | 2,505 | 381.38 | 18 | 152 |
| Perquimans | 10,447 | 1,833 | 3,291,379 | 1,796 | 315.05 | 39 | 175 |
| Person | 30,180 | 3,787 | 12,013,328 | 3,172 | 398.06 | 16 | 125 |
| Pitt | 107,924 | 16,314 | 33,093,026 | 2,029 | 306.63 | 44 | 151 |
| Polk | 14,416 | 1,151 | 3,740,070 | 3,249 | 259.44 | 66 | 80 |
| Randolph | 106,546 | 7,150 | 19,468,110 | 2,723 | 182.72 | 97 | 67 |
| Richmond | 44,518 | 6,521 | 14,048,057 | 2,154 | 315.56 | 38 | 146 |
| Robeson | 105,179 | 24,958 | 42,367,926 | 1,698 | 402.82 | 14 | 237 |
| Rockingham | 86,064 | 8,742 | 23,724,577 | 2,714 | 275.66 | 59 | 102 |
| Rowan | 110,605 | 9,709 | 25,929,935 | 2,671 | 234.44 | 80 | 88 |
| Rutherford | 56,918 | 6,322 | 15,087,192 | 2,386 | 265.07 | 65 | 111 |
| Sampson | 47,297 | 8,055 | 19,726,174 | 2,449 | 417.07 | 9 | 170 |
| Scotland | 33,754 | 7,443 | 13,487,731 | 1,812 | 399.59 | 15 | 221 |
| Stanly | 51,765 | 4,705 | 11,912,320 | 2,532 | 230.12 | 81 | 91 |
| Stokes | 37,223 | 3,155 | 8,982,826 | 2,847 | 241.32 | 75 | 85 |
| Surry | 61,704 | 6,203 | 16,813,442 | 2,711 | 272.49 | 61 | 101 |
| Swain | 11,268 | 2,028 | 3,526,495 | 1,739 | 312.97 | 41 | 180 |
| Transylvania | 25,520 | 2,710 | 7,111,584 | 2,624 | 278.67 | 56 | 106 |
| Tyrrell | 3,856 | 948 | 1,999,978 | 2,110 | 518.67 | 1 | 246 |
| Union | 84,211 | 8,077 | 17,267,349 | 2,138 | 205.05 | 90 | 96 |
| Vance | 38,892 | 7,167 | 14,084,727 | 1,965 | 362.15 | 25 | 184 |
| Wake | 423,380 | 28,259 | 60,668,034 | 2,147 | 143.29 | 99 | 67 |
| Warren | 17,265 | 3,277 | 7,023,330 | 2,143 | 406.80 | 11 | 190 |
| Washington | 13,997 | 2,936 | 5,544,095 | 1,888 | 396.09 | 17 | 210 |
| Watauga | 36,952 | 2,279 | 6,851,918 | 3,007 | 185.43 | 96 | 62 |
| Wayne | 104,666 | 14,127 | 29,359,562 | 2,078 | 280.51 | 54 | 135 |
| Wilkes | 59,393 | 5,728 | 17,022,163 | 2,972 | 286.60 | 50 | 96 |
| Wilson | 66,061 | 12,435 | 21,713,069 | 1,746 | 328.68 | 36 | 188 |
| Yadkin | 30,488 | 2,543 | 6,848,081 | 2,693 | 224.62 | 85 | 83 |
| Yancey | 15,419 | 1,941 | 4,491,376 | 2,314 | 291.29 | 47 | 126 |
| STATE TOTAL | 6,628,637 | 751,617 | $1,719,251,247 | $2,287 | $259.37 | N/A | 113 |

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1991.

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

the year. These are persons who automatically qualified for Medicaid because they were eligible for cash assistance payments, but either 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 1991, 751,617 persons were eligible for Medicaid at some time during the year. This represents an increase of almost 113,277 eligibles (or 17.7 percent) over the prior year.

Counties vary greatly in the number of residents who are eligible for Medicaid: from a low of 56 per 1,000 population in Orange County to a high of 256 per 1,000 population in Halifax County. The statewide average is 113 per 1,000 population. Chart 5 graphically depicts enrollment variation across counties. 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 1991.

## Recipients

Recipients are those who actually use a service during the year. In SFY 1991, Medicaid paid for care for 633,325 recipients. Table 10 displays expenditures for recipients by eligibility group.

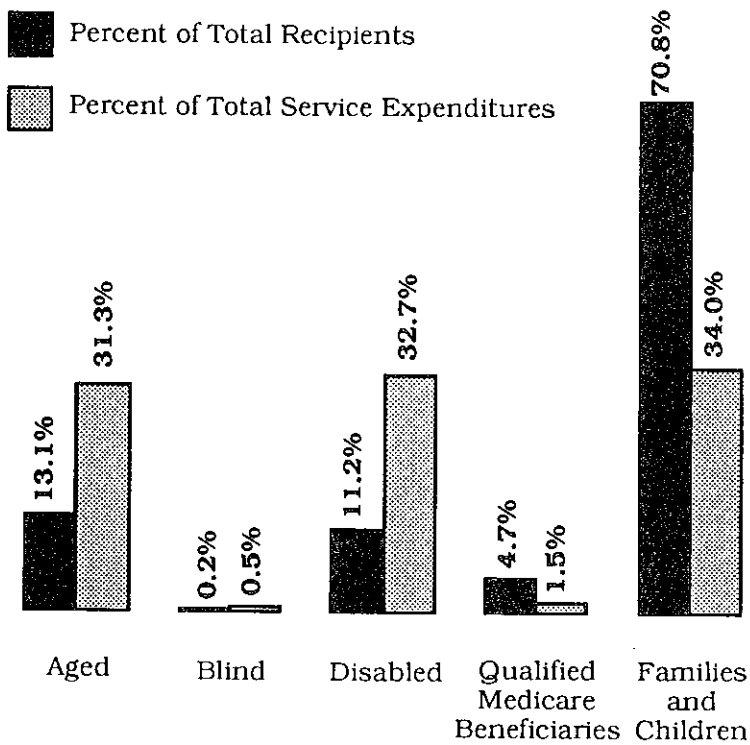
**Table 10**
**SFY 1991**
**Medcaid Service Expenditures by Eligiblity Group**

| Eligibility Group | Total Services Dollars | % of Dollars | Total Recipients | % of Recipients | SFY 1991 Expenditures Per Recipient | SFY 1990 Expenditures Per Recipient | Percent Change |
|---|---|---|---|---|---|---|---|
| Total Elderly | $562,722,232 | 32.8 | 112,639 | 17.8 | $4,996 | $4,145 | 20.5 |
| Aged | 536,919,011 | 31.3 | 82,646 | 13.1 | 6,497 | 5,058 | 28.4 |
| Medicare-Aid | 25,803,221 | 1.5 | 29,993 | 4.7 | 860 | 522 | 64.8 |
| Total Disabled | 568,916,329 | 33.2 | 72,304 | 11.4 | 7,868 | 6,850 | 14.9 |
| Disabled | 559,724,671 | 32.7 | 71,144 | 11.2 | 7,867 | 6,861 | 14.7 |
| Blind | 9,191,658 | 0.5 | 1,160 | 0.2 | 7,924 | 6,301 | 25.8 |
| Total Families And Children | 581,668,993 | 34.0 | 448,382 | 70.8 | 1,297 | 1,219 | 6.4 |
| AFDC Adults | 173,273,302 | 10.1 | 119,078 | 18.8 | 1,455 | 1,356 | 7.3 |
| Special Pregnant Women Coverage | 80,971,592 | 4.7 | 44,516 | 7.0 | 1,819 | 1,559 | 16.7 |
| AFDC Children & Other Children | 219,004,484 | 12.8 | 221,447 | 35.0 | 989 | 992 | (0.3) |
| Special Children Coverage | 108,419,615 | 6.4 | 63,341 | 10.0 | 1,712 | 1,741 | (1.7) |
| Total, All Groups | $1,713,307,554 | 100.0 | 633,325 | 100.0 | $2,705 | $2,497 | 8.3 |

Note: Does not include adjustments processed by DMA, settlements, disproportionate share hospital payments, premiums, and state and county administrative costs. These total $228,708,538. See Table 6 for more details.

Source: 2082 report for SFY 1991.

**Chart 6**
**SFY 1991**
**Medicaid Recipients and Service Expenditures**




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 factors affect the way Medicaid expenditure data are reported. In the tables that follow, the number of recipients are identified in two ways, unduplicated in total and duplicated across service categories. The total number of recipients is an unduplicated count, meaning that an individual is counted only once during the year regardless of the variety of services used. Recipient expenditure data are reported under the category in which the individual was listed as of the end of the fiscal year.

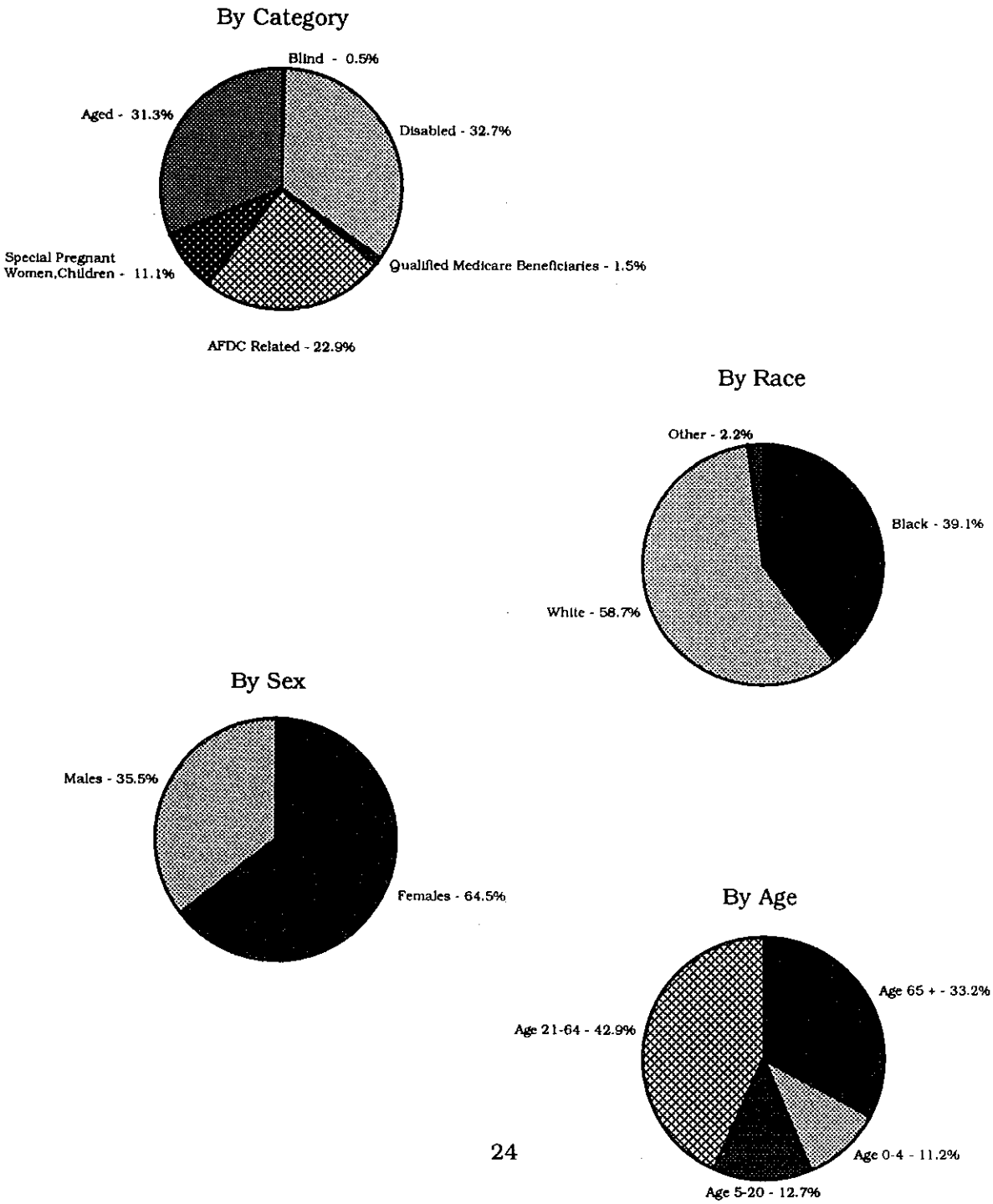
The recipient count across types of services, however, is a duplicated count, meaning that a recipient using two or more different types of services would be counted once in each service category. As a result, the sum of all recipients across service categories does not equal the total unduplicated recipient count, as shown in 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 (71 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 who constitute 11 percent of the Medicaid population. (See Chart 6.)

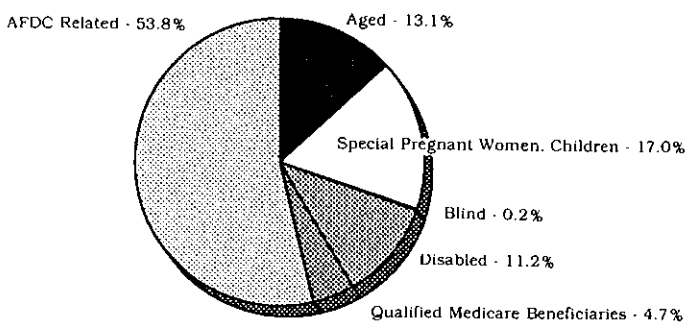
Charts 7 and 8 display service expenditures and recipients by various demographic categories, including sex, race and age, and eligibility group.

**Chart 7**
**SFY 1991**
**Service Expenditures, Percent Distribution**

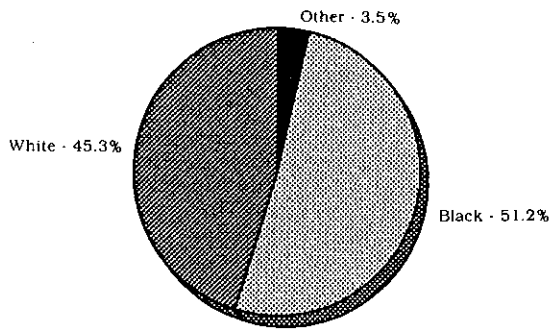


## Chart 8
## SFY 1991
## Recipients, Percent Distribution

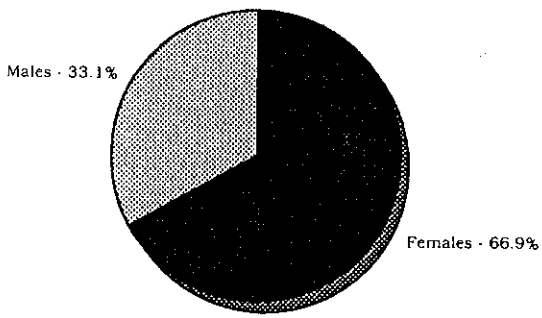
### By Category



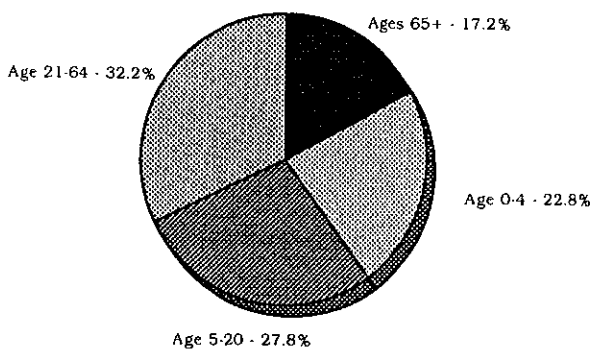

### By Race




### By Sex




### By Age

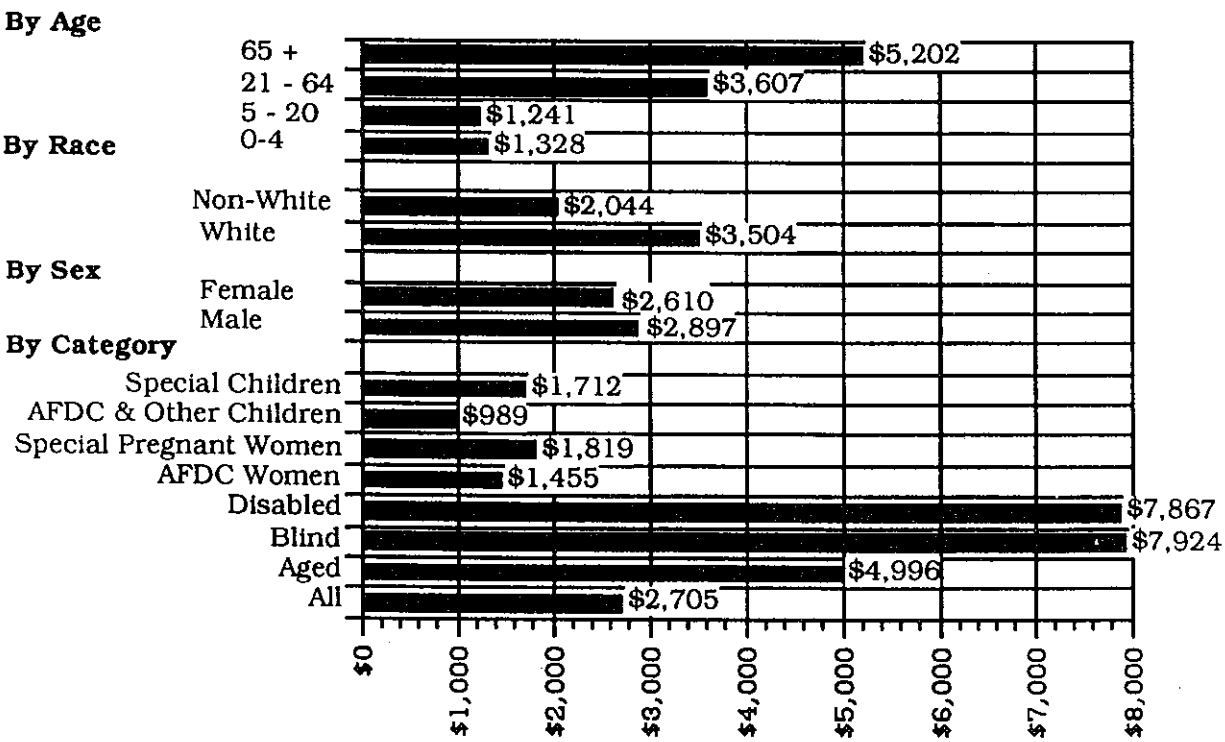


Service expenditures differ across demographic groups in predictable ways. Chart 9 compares per recipient costs by age, race, sex and eligibility category. Reflecting relatively heavy health care needs, blind and disabled individuals have the highest per recipient costs, $7,924 and $7,867, respectively.

Non-disabled male and female adults had similar per recipient costs, although males, on average, cost slightly more than females, $2,897 versus $2,610. The reason for this difference is not clear. One reason may be that the adult female population includes a large proportion of women whose main expenditure relates to pregnancy rather than illness.

Younger recipients (ages 5 to 20) had the lowest cost per recipient ($1,241) overall and those aged 65 and above had the highest ($5,205). (Note that the cost per aged recipient and the cost for those aged 65 and over are not the same. This is because blind persons age 65 and over are categorized as blind rather than aged, and have a higher per recipient cost than other aged individuals. Also, the aged category includes all those whose age is unknown.)

**Chart 9**
**SFY 1991**
**Service Expenditures Per Recipient by Selected Characteristics**



# Table 11
# SFY 1991
## Service Expenditures For Selected Major Medical Services By Program Category

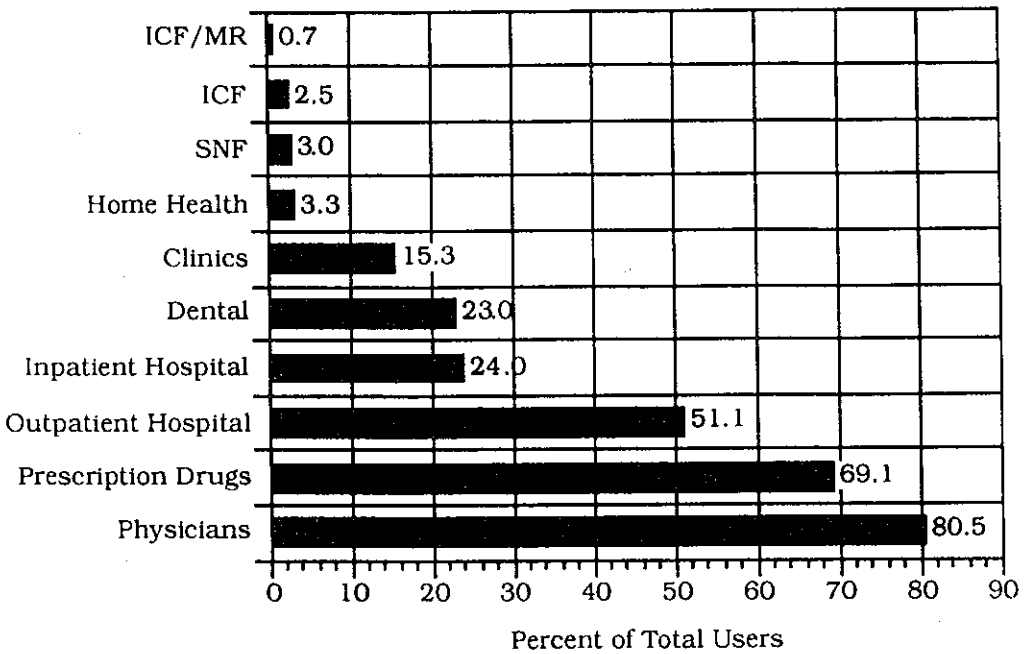
| Type of Service | Total | % of Service Dollars | Aged | Qualified Medicare Beneficiaries* | Blind | Disabled | Families and Children: AFDC Adult | Families and Children: Special Pregnant Women | Families and Children: AFDC Child & Other Child | Families and Children: Special Children |
|---|---|---|---|---|---|---|---|---|---|---|
| Inpatient Hospital | $438,102,471 | 25.6 | $39,420,257 | $6,108,808 | $750,943 | $134,982,866 | $62,791,270 | $33,925,693 | $82,764,802 | $77,357,832 |
| Outpatient Hospital | 84,789,555 | 4.9 | 6,930,392 | 3,068,844 | 159,856 | 19,679,148 | 23,786,256 | 7,841,352 | 18,424,042 | 4,899,665 |
| Mental Hospital (>65) | 14,406,669 | 0.8 | 14,077,133 | 74,357 | 53,220 | 199,239 | 2,720 | – | ... | ... |
| Psychiatric Hospital (<21) | 21,506,288 | 1.3 | – | – | ... | 905,222 | 218,785 | 42,803 | 20,328,818 | 10,660 |
| Physician | 159,887,250 | 9.3 | 13,893,996 | 5,306,159 | 275,518 | 33,998,815 | 38,291,321 | 22,982,351 | 30,210,915 | 14,928,175 |
| Clinics | 31,244,639 | 1.8 | 1,145,793 | 852,164 | 73,994 | 9,502,844 | 4,830,399 | 7,074,109 | 6,505,527 | 1,259,809 |
| Nursing Facility: Skilled Level | 225,692,418 | 13.2 | 188,914,279 | 3,851,349 | 981,255 | 30,914,634 | 314,823 | – | 706,277 | 9,801 |
| Intermediate Level | 183,351,929 | 10.7 | 163,438,765 | 1,845,469 | 1,007,796 | 16,978,272 | 8,889 | – | 72,738 | – |
| Intermediate Care Facility (Mentally Retarded) | 244,942,443 | 14.3 | 6,317,494 | 118,085 | 3,817,345 | 212,134,002 | 708,877 | – | 21,690,404 | 156,236 |
| Dental | 21,683,521 | 1.3 | 1,869,518 | 120,754 | 41,628 | 3,555,416 | 7,790,486 | 642,025 | 7,244,395 | 419,299 |
| Prescription Drugs | 120,266,143 | 7.0 | 49,861,518 | 1,716,421 | 706,868 | 38,259,572 | 15,749,784 | 1,409,354 | 10,171,884 | 2,390,742 |
| Home Health | 46,052,821 | 2.7 | 9,111,732 | 309,406 | 545,638 | 22,992,163 | 1,584,062 | 166,761 | 7,958,127 | 3,384,932 |
| CAP/Disabled Adult | 31,209,441 | 1.8 | 22,302,416 | 813,439 | 211,764 | 7,723,413 | 76,299 | – | 77,619 | 4,491 |
| CAP/Mentally Retarded | 8,420,811 | 0.5 | 71,462 | 39,766 | – | 7,938,053 | 19,769 | – | 316,433 | 35,328 |
| CAP/Children | 1,189,223 | 0.1 | – | – | – | 1,169,438 | – | – | 19,453 | 332 |
| Personal Care | 22,375,265 | 1.3 | 15,809,679 | 414,357 | 479,217 | 5,167,015 | 339,132 | 2,543 | 111,283 | 52,039 |
| Hospice | 1,384,474 | 0.1 | 143,655 | 4,470 | – | 1,107,154 | 77,818 | – | 11,199 | 40,178 |
| EPSDT | 5,397,754 | 0.3 | – | – | 1,742 | 18,571 | 7,550 | 5,105 | 3,163,516 | 2,201,270 |
| Lab & X-Ray | 14,970,319 | 0.9 | 1,283,454 | 533,576 | 41,304 | 4,938,850 | 4,487,264 | 1,287,433 | 1,845,005 | 553,433 |
| Other Services | 36,434,120 | 2.1 | 2,327,468 | 625,797 | 43,570 | 7,559,984 | 12,187,798 | 5,592,063 | 7,382,047 | 715,393 |
| Total Services | $1,713,307,554 | 100.0 | $536,919,011 | $25,803,221 | $9,191,658 | $559,724,671 | $173,273,302 | $80,971,592 | $219,004,484 | $108,419,615 |

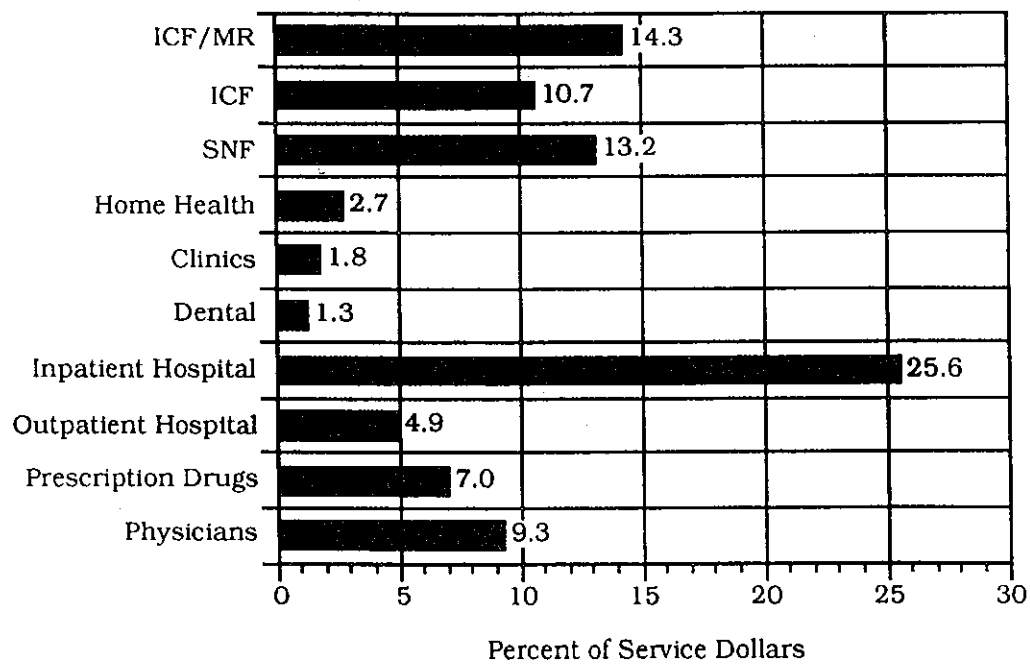
* Reflects expenditures for those who were eligible as QMBs at the end of the year. As a result, expenditures include more services than are available through QMB coverage (Medicare covered services only).

Note: Does not include adjustments processed by DMA, disproportionate share hospital payments, settlements, premiums, and state and county administration costs.
Source: 2082 Report, for SFY 1991.

Expenditure differences across eligibility groups reflect variations in care use. Table 11 displays expenditures for selected types of services by eligibility group. Overall, institutional care consumes the largest share of the Medicaid services budget for all eligibility groups. Physician services and prescription drugs cost less per unit and thus consume smaller shares of the total services budget despite the fact that they are used heavily by Medicaid recipients (see Chart 10).

**Chart 10**
**SFY 1991**
**Selected Medicaid Services: Use and Dollars, Percent**



## The Elderly

The elderly (those 65 or older) comprise 17.8 percent of all Medicaid recipients but account for 33 percent of Medicaid service expenditures. Most elderly persons receive Medicare benefits as well and for these individuals, 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 facility services (63.7 percent). Sizable expenditures were also made for inpatient hospital care (8.1 percent), with Medicaid paying for the Medicare inpatient deductible, coinsurance and days not paid for by Medicare. Prescription drugs, a major need for elderly people but which Medicare does not cover, accounted for 9.2 percent of expenditures.

In SFY 1991, 112,639 elderly persons received assistance through the Medicaid program, at an average cost of $4,996 per recipient, an increase of 20.5 percent from SFY 1990. This figure includes both the relatively low cost QMBs--for whom Medicaid pays premiums, deductibles and coinsurance --and those receiving full Medicaid benefits. The per recipient cost for the latter group increased 28.5% over SFY 1990.

**Table 12**
**SFY 1991**
**Expenditures For The Elderly**

| Type of Service | Aged | % of Dollars | Qualified Medicare Beneficiaries | % of Dollars | Total Elderly Dollars | SFY 1991 % of Total Dollars | SFY 1990 % of Total Dollars |
|---|---|---|---|---|---|---|---|
| Inpatient Hospital | $39,420,257 | 7.4 | $6,108,808 | 23.7 | $45,529,065 | 8.1 | 8.0 |
| Outpatient Hospital | 6,930,392 | 1.3 | 3,068,844 | 11.9 | 9,999,236 | 1.8 | 1.7 |
| Mental Hospital (< 65) | 14,077,133 | 2.6 | 74,357 | 0.3 | 14,151,490 | 2.5 | 2.1 |
| Physician | 13,893,996 | 2.6 | 5,306,159 | 20.6 | 19,200,155 | 3.4 | 3.8 |
| Clinics | 1,145,793 | 0.2 | 852,164 | 3.3 | 1,997,957 | 0.4 | 0.3 |
| Nursing Facility: | | | | | | | |
| Skilled Level | 188,914,279 | 35.2 | 3,851,349 | 14.9 | 192,765,628 | 34.3 | 32.2 |
| Intermediate Level | 163,438,765 | 30.4 | 1,845,469 | 7.2 | 165,284,234 | 29.4 | 30.5 |
| ICF-MR | 6,317,494 | 1.2 | 118,085 | 0.4 | 6,435,579 | 1.1 | 1.0 |
| Dental | 1,869,518 | 0.4 | 120,754 | 0.5 | 1,990,272 | 0.3 | 0.4 |
| Prescription Drugs | 49,861,518 | 9.3 | 1,716,421 | 6.7 | 51,577,939 | 9.2 | 10.2 |
| Home Health | 9,111,732 | 1.7 | 309,406 | 1.2 | 9,421,138 | 1.7 | 2.3 |
| CAP/Disabled Adult | 22,302,416 | 4.2 | 813,439 | 3.1 | 23,115,855 | 4.1 | 3.9 |
| CAP/Mentally Retarded | 71,462 | * | 39,766 | 0.1 | 111,228 | * | * |
| Personal Care Services | 15,809,679 | 2.9 | 414,357 | 1.6 | 16,224,036 | 2.9 | 2.6 |
| Hospice | 143,655 | * | 4,470 | * | 148,125 | * | 0.1 |
| Lab and X-Ray | 1,283,454 | 0.2 | 533,576 | 2.1 | 1,817,030 | 0.3 | 0.4 |
| Other Services | 2,327,468 | 0.4 | 625,797 | 2.4 | 2,953,265 | 0.5 | 0.5 |
| Total Elderly Service Expenditures | $536,919,011 | 100.0 | $25,803,221 | 100.0 | $562,722,232 | 100.0 | 100.0 |
| Total Elderly Recipients | 82,646 | | 29,993 | | 112,639 | | |
| Expenditures Per Elderly Recipient | $6,497 | | $860 | | $4,996 | | $4,145 |

* Less than .1%

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

Source: 2082 Report for SFY 1991.

## The Disabled and Blind

Blind and disabled individuals accounted for 33.2 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.

The largest single expenditure for this group was for nursing facility care (46.8 percent). Of nursing facility 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 $7,868 per recipient for the blind and disabled group. Per recipient expenditures for this group increased 14.9 percent over the figure for 1990. In SFY 1991, 72,304 blind and disabled persons were served by Medicaid.

**Table 13**
**SFY 1991**
**Expenditures For The Disabled And Blind**

| Type of Service | Disabled | % of Dollars | Blind | % of Dollars | Total Blind & Disabled Dollars | SFY 1991 % of Total Dollars | SFY 1990 % of Total Dollars |
|---|---|---|---|---|---|---|---|
| Inpatient Hospital | $134,982,866 | 24.1 | $750,943 | 8.2 | $135,733,809 | 23.9 | 24.9 |
| Outpatient Hospital | 19,679,148 | 3.5 | 159,856 | 1.7 | 19,839,004 | 3.5 | 3.4 |
| Psychiatric Hospital (<21) | 905,222 | 0.2 | – | – | 905,222 | 0.2 | 0.2 |
| Physician | 33,998,815 | 6.1 | 275,518 | 3.0 | 34,274,333 | 6.0 | 6.5 |
| Clinics | 9,502,844 | 1.7 | 73,994 | 0.8 | 9,576,838 | 1.7 | 2.0 |
| Nursing Facility: | | | | | | | |
| Skilled Level | 30,914,634 | 5.5 | 981,255 | 10.7 | 31,895,889 | 5.6 | 5.5 |
| Intermediate Level | 16,978,272 | 3.0 | 1,007,796 | 11.0 | 17,986,068 | 3.2 | 3.3 |
| ICF-MR | 212,134,002 | 37.9 | 3,817,345 | 41.5 | 215,951,347 | 38.0 | 37.1 |
| Dental | 3,555,416 | 0.6 | 41,628 | 0.5 | 3,597,044 | 0.6 | 0.6 |
| Prescription Drugs | 38,259,572 | 6.9 | 706,868 | 7.7 | 38,966,440 | 6.8 | 7.0 |
| Home Health | 22,992,163 | 4.1 | 545,638 | 5.9 | 23,537,801 | 4.1 | 4.0 |
| CAP/Disabled Adult | 7,723,413 | 1.4 | 211,764 | 2.3 | 7,935,177 | 1.4 | 1.3 |
| CAP/Children | 1,169,438 | 0.2 | – | – | 1,169,438 | 0.2 | 0.2 |
| CAP/Mentally Retarded | 7,938,053 | 1.4 | – | – | 7,938,053 | 1.4 | 1.3 |
| Personal Care Services | 5,167,015 | 0.9 | 479,217 | 5.2 | 5,646,232 | 1.0 | 0.9 |
| Hospice | 1,107,154 | 0.2 | – | – | 1,107,154 | 0.2 | 0.2 |
| Lab & X-Ray | 4,938,850 | 0.9 | 41,304 | 0.5 | 4,980,154 | 0.8 | 0.9 |
| Other Services | 7,777,794 | 1.4 | 98,532 | 1.0 | 7,876,326 | 1.4 | 0.7 |
| Total Disabled/Blind Service Expenditures | $559,724,671 | 100.0 | $9,191,658 | 100.0 | $568,916,329 | 100.0 | 100.0 |
| Total Disabled/Blind Recipients | 71,144 | | 1,160 | | 72,304 | | |
| Expenditures Per Disabled/Blind Recipient | $7,867 | | $7,924 | | $7,868 | | $6,850 |

* Less than .1%

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

Source: 2082 Report for SFY 1991.

## Families and Children

In strong contrast with the spending pattern 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 divided into four groups: AFDC adults, special coverage for pregnant women, AFDC children and other children, and special coverage children. In SFY 1991, Medicaid expenditures per recipient for all groups were $1,297, less than one-fifth the average cost of the disabled and about one-fourth that of the elderly.

For families and children, inpatient hospital care was the largest expenditure. For special coverage children, 71.4 percent of expenditures was for hospital care following birth. Physician services also account for a large portion of services used by these groups. ICF/MR services accounted for 9.9 percent of expenditures. In SFY 1991, 163,594 adults and 284,788 children received services.

### Table 14
### SFY 1991
### 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 & Children Dollars* | SFY 1991 % of Total Dollars | SFY 1990 % of Total Dollars |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Inpatient Hospital | $62,791,270 | 36.2 | $33,925,693 | 41.9 | $82,764,802 | 37.8 | $77,357,832 | 71.4 | $256,839,597 | 44.2 | 46.8 |
| Outpatient Hospital | 23,786,256 | 13.7 | 7,841,352 | 9.7 | 18,424,042 | 8.4 | 4,899,665 | 4.5 | 54,951,315 | 9.4 | 8.2 |
| Psychiatric Hospital (<21) | 218,785 | 0.1 | 42,803 | 0.1 | 20,328,818 | 9.3 | 10,660 | * | 20,601,066 | 3.5 | 5.2 |
| Physician | 38,291,321 | 22.1 | 22,982,351 | 28.4 | 30,210,915 | 13.8 | 14,928,175 | 13.8 | 106,412,762 | 18.3 | 17.3 |
| Clinics | 4,830,399 | 2.8 | 7,074,109 | 8.7 | 6,505,527 | 3.0 | 1,259,809 | 1.2 | 19,669,844 | 3.4 | 2.7 |
| Nursing Facility: | | | | | | | | | | | |
| Skilled Level | 314,823 | 0.2 | – | – | 706,277 | 0.3 | 9,801 | * | 1,030,901 | 0.2 | 0.2 |
| Intermediate Level | 8,889 | * | – | – | 72,738 | * | – | * | 81,627 | * | * |
| ICF-MR | 708,877 | 0.4 | – | – | 21,690,404 | 9.9 | 156,236 | 0.1 | 22,555,517 | 3.9 | 4.5 |
| Dental | 7,790,486 | 4.5 | 642,025 | 0.8 | 7,244,395 | 3.3 | 419,299 | 0.4 | 16,096,205 | 2.8 | 2.7 |
| Prescription Drugs | 15,749,784 | 9.1 | 1,409,354 | 1.7 | 10,171,884 | 4.7 | 2,390,742 | 2.2 | 29,721,764 | 5.1 | 4.7 |
| Home Health | 1,584,062 | 0.9 | 166,761 | 0.2 | 7,958,127 | 3.6 | 3,384,932 | 3.1 | 13,093,882 | 2.2 | 2.0 |
| CAP/Children | – | – | – | – | 19,453 | * | 332 | * | 19,785 | * | * |
| EPSDT | 7,550 | * | 5,105 | * | 3,163,516 | 1.5 | 2,201,270 | 2.0 | 5,377,441 | 0.9 | 0.8 |
| Lab & X-Ray | 4,487,264 | 2.6 | 1,287,433 | 1.6 | 1,845,005 | 0.8 | 553,433 | 0.5 | 8,173,135 | 1.4 | 1.3 |
| Other Services | 12,703,536 | 7.4 | 5,594,606 | 6.9 | 7,898,581 | 3.6 | 847,429 | 0.8 | 27,044,152 | 4.7 | 3.6 |
| Total Families & Children Service Expenditures | $173,273,302 | 100.0 | $80,971,592 | 100.0 | $219,004,484 | 100.0 | $108,419,615 | 100.0 | $581,668,993 | 100.0 | 100.0 |
| Total Families & Children Recipients | 119,078 | | 44,516 | | 221,447 | | 63,341 | | 448,382 | | |
| Expenditures Per Families & Children Recipient | $1,455 | | $1,819 | | $989 | | $1,712 | | $1,297 | | $1,219 |

* Less than .1%

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

Source: 2082 Report for SFY 1991.

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 1991. (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.

**Nursing Facility (skilled level)** - 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 level 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 and therapies. Patients must be home-bound and services furnished under a plan of treatment. Certain children under age 21 and disabled adults may be excepted from the home-bound 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, 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 required. 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 that 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, abortions and hysterectomies are permitted under limited circumstances and require special documentation and approval. Payment is made based on the type of provider furnishing the service.

**Other Mandatory Services** - Other mandatory services include rural health center durable medical equipment, other 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.

**Nursing Facilities (intermediate care level) and Intermediate Care Facilities for the Mentally Retarded (ICF-MR)** - Services in nursing facilities (intermediate level) and ICF-MRs are covered for those who are not able to fully care for themselves but do not require the intense level of care provided at the skilled level. ICFs that serve the mentally retarded and disabled population must meet additional certification requirements relating to provision of habilitation services as well as basic intermediate care services. Intermediate care services 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 and insulin. 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 groups. Payment is made on the basis of a statewide fee schedule.

**Table 15**
**SFY 1991**
**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 |
| Optometrist visit | 1.00 |
| Prescription drug (including refills) | .50 |

These copayment amounts have been in effect since 1984, as required by the federal Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Copayment amounts do not apply to the following:

* EPSDT program services
* Family planning services
* Services to children under 19
* Services related to pregnancy
* Services to nursing facility residents and mental hospital patients
* Hospital emergency room services

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

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

**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** - Area Programs for Mental Health, Developmental Disabilities and Substance Abuse Services 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. Area Program centers are paid a negotiated rate, not to exceed costs, 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. Payment is made on a fee schedule basis.

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.

## 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 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. 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 Medicaid

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 of 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 Program, or EPSDT) 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. A number of changes were effective on April 1, 1990. These include:

- 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 my become worse and require further treatment;
- diagnostic and treatment services that are medically necessary to treat a condition identified during a screen.

Other changes were effective on October 1, 1990 and are described in the "Highlights" section of this report.

In addition to paying for services, EPSDT tries to ensure that 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 otherwise are 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 nursing facility to remain in the community. Fifty-two counties choose to participate in CAP/DA and the program served about 3,669 individuals in SFY 1991.

The average daily cost for CAP/DA services at the skilled level was 50 percent of the average cost for institutional care at the comparable level. At the intermediate level, CAP/DA services cost 69 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. All 100 counties had access to the CAP-MR/DD program through 41 Mental Health, Mental Retardation, and Substance Abuse program centers and served about 794 individuals in SFY 1991. 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/C) 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 it served 48 children in SFY 1991. The cost of CAP services to the children in this program averaged 55 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 and holding down costs at the same time. The programs 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 with the cost of institutional care.

## Medicare-Aid

In February 1989, North Carolina began a new program of health care financing assistance to elderly and disabled Medicare beneficiaries. 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, 29,993 Medicare recipients benefited from Medicare-Aid in SFY 1991. As required by federal law, the eligibility income limit for Medicare-Aid was increased from 85 percent to 95 percent of the federal poverty level on January 1, 1991.

## 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 1,382 recipients per month in the HMO in SFY 1991.

Enrollment in the HMO is limited to families who are eligible for Medicaid as a result of receiving 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. 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 technology and growing awareness of quality of care concerns have achieved high visibility during the past decade. In response to these trends, Medicaid created a new unit composed of specialized health care professionals to monitor the care of critcally 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 such as private duty nursing are appropriate.

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