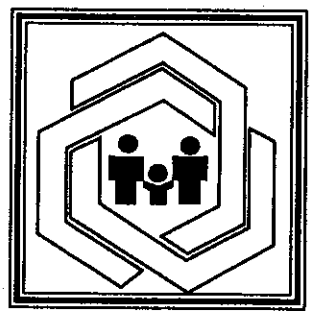

Medicaid in North Carolina
Annual Report
State Fiscal Year 1992

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

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

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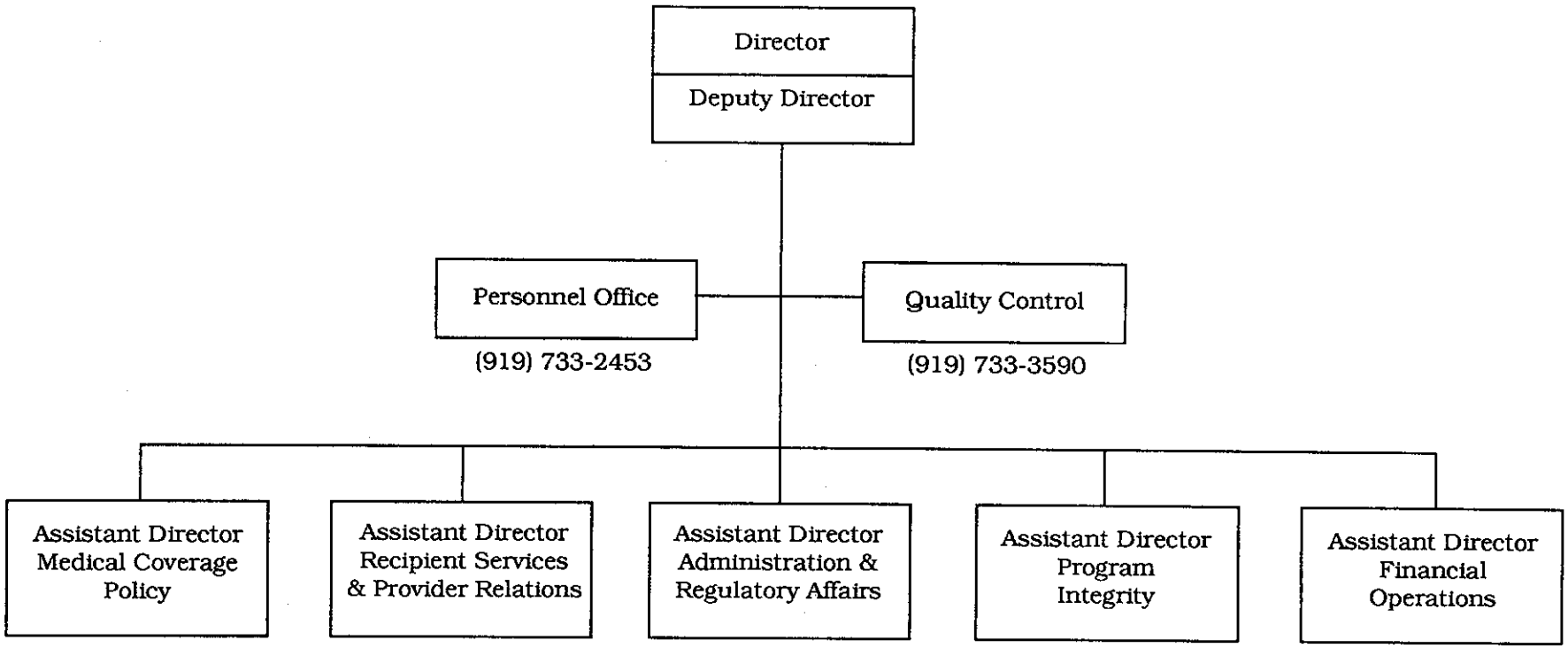

MEDICAID IN NORTH CAROLINA

ANNUAL REPORT
State Fiscal Year 1991-1992

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 1992. During the year, Medicaid eligibles increased by over 16 percent and service costs increased by 28 percent. These increases are due to a combination of factors, including policy changes granting automatic eligibility to some infants, more people applying for benefits, more use of health care services by eligible recipients and continuation of 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 response to increased outreach efforts targeted to pregnant women and young children, the number of pregnant women who were eligible for Medicaid grew by 16 percent over SFY 1991, while the number of children who were eligible for Medicaid grew by 55 percent.

Carolina ACCESS, a primary care coordination demonstration program, has proven to be a highly successful care delivery model. During FY 1992, the program expanded into twelve counties and enrolled 55,705 Medicaid recipients. 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. In addition, an independent evaluation credits Carolina ACCESS with saving $1.5 million annually after its first six months of operation. 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 1992 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) 1992 extends from July 1, 1991 to June 30, 1992. During this time, Medicaid spent $2.5 billion for necessary health care services for 759,975 of North Carolina's neediest citizens. This represents just over 11 percent of North Carolina's population. In SFY 1992, Medicaid was able to serve 20.0 percent more needy recipients than in the year before.

As in past years, the largest proportion (64 percent) of Medicaid's service budget was spent for services to aged, blind and disabled individuals. Thirty-six percent was spent on care for low income families and children. About 36 percent of the service budget was 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. For pregnant women and for infants under one year of age, the income limit to qualify for Medicaid is 185 percent of the federal poverty level. Pregnant women who qualify under this program can receive all services that relate to pregnancy, and young children can receive all necessary Medicaid services. For fiscal year 1992, the General Assembly appropriated funds for counties to purchase transportation services for Medicaid pregnant women and children, and for nutritional counseling , psychosocial counseling, and predelivery and post partum home visits for Medicaid pregnant women. (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. States are required to provide coverage to children ages one to five in families with income below 133 percent of poverty. Also, children ages 6 to 9 in families with incomes under the federal poverty level are covered. These initiatives helped 53,413 pregnant women and 86,643 children.

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 two percent, effective January 1, 1992.

On August 1, 1991, the hourly personal care service rate was increased from $9.00 to $9.36. Effective January 1, 1992, hospice rates increased 4.4 percent.

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 twelve 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 recentlyin 1992, Beaufort, Greene and Pitt counties joined the program. Enrollment in those counties began March 1, 1992. As of August 1, 1992, Carolina ACCESS enrollment reached 55,705 Medicaid recipients--representing approximately 54 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 1993, 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 affected the Medicaid program. Among the most important were:

- 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 requires skilled or intermediate care.

- Nursing facilities must 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.

- Patients' rights were strengthened and made more explicit.

- States were required to develop and maintain a registry of nurse aides and to institute a nurse aide training program in the state. As mandated, North Carolina has instituted a nurse aide training program.

- Nursing facility quality assurance programs were strengthened.

Private Duty Nursing Services

Effective January 1, 1992, North Carolina's Medicaid program opted to directly enroll and reimburse qualified private duty nursing agencies. Prior to that date, private duty nursing services were available only through certified home health agencies.

Nurse Practitioners

North Carolina traditionally covered nurse practitioner services when billed for by the attending physician. OBRA 1989 mandated Medicaid agencies to directly reimburse certified pediatric and family nurse practitioners. Effective December 1, 1991, North Carolina's Medicaid agency began direct enrollment and reimbursement of all specialities of nurse practitioners in an effort to utilize primary care nurse practitioner services as well as nurse practitioner services outside the realm of primary care, in particular, OB-GYN services.

Home Infusion Therapy

Prior to 1992, North Carolina's Medicaid program covered home infusion therapy when arranged for and billed by home health agencies. On January 1, 1992, Medicaid changed this policy and began enrolling and paying qualified home infusion therapy suppliers directly.

Qualified Disabled Working Individuals

Effective July 1, 1991, North Carolina began Medicaid coverage of "Qualified Disabled Working Individuals" as mandated by OBRA 1989. Medicaid coverage is limited to payment of the Medicare Part A premium for those disabled individuals who can work and who meet the income and resources requirements.

Chart 1
SFY 1992
Medicaid Program Changes in Brief

Effective	Policy Change
July 1, 1991	* Cover transportation for Medicaid eligible pregnant women and children
	* Cover Qualified Disabled Working Individuals
	* Expand coverage to children age 7 in families with incomes under 100% of the federal poverty level
August 1, 1991	* Increase personal care services rate from $9.00 to $9.36 per hour
August 15, 1991	* Increase recipient copayments from $.50 to $1.00 for prescription drugs
	* Increase recipient copayments from $.50 to $2.00 for physicians
October 1, 1991	* Coverage of nutritional counseling, psychosocial counseling and predelivery and postpartum home visits for Medicaid pregnant women
	* Expand coverage to children age 8 in families with incomes under 100% of the federal poverty level
December 1, 1991	* Direct enrollment of nurse practitioners
January 1, 1992	* Direct enrollment of private duty nursing agencies
	* Increase pharmacy dispensing fee from $4.85 to $5.60
	* Increase Medicare-Aid income eligibility level from 95% to 100% of federal poverty level
	* DMA given authority to accept an effective date for provider reimbursement plans as date approved by HCFA for the Medicaid State Plan when APA and the State Plan dates cannot coincide
	* Coverage and enrollment of self-administered home infusion therapy agencies

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 1992, Medicaid expenditures and eligibles grew from $307 million to $2.5 billion, and from 456,000 to 876,000, respectively. During this time, DMA staff increased from 121 to 210. 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 1992, 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 the 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 1992.

Table 1
SFY 1992
Federal Matching Rates

Benefit Costs

	Family Planning	All Other
	(7/1/91 - 9/30/91)	
Federal	90.0%	66.60%
State	8.5%	28.39%
County	1.5%	5.01%
	(10/1/91 - 6/30/92)	
Federal	90.0%	66.52%
State	8.5%	28.46%
County	1.5%	5.02%

Administrative Costs

(7/1/91 - 6/30/92)

	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 79.99 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 1992, 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 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 $11,820 to $20,616 (as of January 1, 1992); resource levels range from $13,740 to $68,700 (as of January 1, 1992).

The Omnibus Budget Reconciliation Act of 1989 mandated Medicaid coverage of "Disabled Working Individuals". These individuals have to be determined by the Social Security Administration to be "Working Disabled" , less than 65 years of age and must meet Medicaid income and resources requirements, and they cannot otherwise be eligible for Medicaid. Coverage is limited to Medicaid payment of the Part A Medicare premium. (See Table 2 "Qualified Disabled Working Individuals" column).

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 29,509 providers who are enrolled in the program. Providers then bill Medicaid for their services. In 1992, 14,252 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

Table 2
SFY 1992
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 95% of Poverty	Qualified Medicare Beneficiaries 100% of Poverty	"Spousal Improverishment" Beneficiaries 133% of Poverty	Qualified Disabled Working Individual 200% of Poverty
1	$4,344	$2,900	$2,900	$12,252	$ 8,808	$ 6,624	$6,300	$6,624	$11,820 up a	$13,620
2	5,664	3,800	3,800	16,428	11,820	8,880	8,436	8,880	max. of $20,616	$18,384
3	6,528	4,400	4,400	20,616	14,820	11,148				
4	7,128	4,800	4,800	24,792	17,832	13,404				
5	7,776	5,200	5,200	28,980	20,832	15,660				

Eligibility Resources Limits

1	$1,000	$1,500	$1,500	No resource test applies	No resource test applies	No resource test applies	$4,000	$4,000	$13,740 minimum	$4,000
2	No increment	2,250	2,250				6,000	6,000	$68,700 maximum	$6,000
3	for family size	2,350	2,350							
4		2,450	N/A							
5		2,550	N/A							

Table 3
SFY 1992
Enrolled Medicaid Providers

Providers	Number
Physicians*	19,083
Dentists	2,796
Pharmacists	2,227
Optometrists	900
Chiropractors	631
Podiatrists	299
Ambulance Companies	211
Home Health Agencies**	137
Durable Medical Equipment Suppliers	246
Intermediate Care Facilities-MR	219
Hospitals	194
Mental Health Clinics	114
Nursing Facilities	339
Optical Supplies Company***	1
Personal Care Agencies	140
Rural Health Clinics	60
Nurse Midwives	17
Hospices	55
CAP Providers	380
Other Clinics	69
Other	1,391
Total	**29,509**

* 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.

pays for all patients in intermediate care facilities for the mentally retarded and for 73 percent of all nursing facility days. In SFY 1990, 83 percent of North Carolina's primary care physicians served at least 25 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 17 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 and fulfills many program reporting requirements. Expenditures for EDS-F services were $8.8 million in SFY 1992. EDS-F processed 30,035,172 claim line items during the year.

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

Medical Review of North Carolina (MRNC) - DMA contracts with MRNC to operate Medicaid's preadmission certification program for elective 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, the Community Alternatives Programs (CAP) and nursing facilities.

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. Following competitive bids, MHMA was awarded a contract to review the medical necessity for inpatient psychiatric care for children under 21. Preadmission and post discharge reviews are required in this contract which became effective December 1, 1991. These reviews assure that admissions and lengths of stay are medically necessary and 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. Through cooperative efforts, the divisions have enhanced services offered through the community mental health center network permitting broad Medicaid coverage of community-based services offered by mental health centers.

Division of Aging (DOA) - DMA works cooperatively with DOA staff on issues important to the aged population. In particular, DMA staff routinely participate in policy development projects on in-home aid services, hous-

ing, 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

Table 4
SFY 1992
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 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
Nurse Practitioners
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
Private Duty Nursing Services
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)

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. Consult "Medicaid In Depth" for more information about the payment mechanism that is applicable to each type of service.

Program Efficiency and Effectiveness

Medicaid Error Rate Reduction and Quality Improvement Efforts - The Quality Assurance Section has the goal of monitoring the accuracy rate of eligibility determinations made by the workers in 100 county departments of social services. They also have the responsibility of evaluating the medical claims paid monthly to determine the accuracy of that process.

In order to make sure that health care services are paid only to eligible Medicaid recipients, Quality Assurance staff conduct monthly federally mandated quality control reviews as well as state designed targeted reviews. This review process looks both at active and denied cases and corrective action is taken whenever a problem is found.

Although states can be penalized for exceeding the three percent federal tolerance for payment error rates, North Carolina has never been penalized. North Carolina's low payment error rate is the result of the partnership between DMA and North Carolina's counties to maintain accuracy in eligibility. In this process, error trends, error prone cases and other important error reduction information are communicated

quickly to eligibility staff. Eligibility supervisors than evaluate, train, and make the necessary adjustments to eliminate errors and to prevent future ones. County staff also participate on the Medicaid Error Reduction Committee which designs strategies for improving quality.

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 1992, 4,535 provider reviews were initiated and 1,575 recipient cases were opened. Collections of overpayments amounted to $2,353,602 from providers, and $429,788 from recipients found to be ineligible. In addition, financial audits of long-term care facilities resulted in recovery of $3,103,932 from 332 field audits.

Also during 1992, 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 general inpatient hospital services is operated by MRNC under contract, as is MHMA, to conduct preadmission and concurrent stay reviews of inpatient psychiatric admissions for children 21. 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 1992, funds from a variety of sources defrayed Medicaid expenditures. Insurance paid on patients' behalf amounted to $30,898,307. An additional $69,913,608 in claims were denied because other insurance was thought to be available to pay for services.

Refunds were received from:

Medicare	$ 925,460
Health Insurance	$6,139,621
Casualty Insurance	$3,765,395
Absent Parent	$ 42,088

Medicaid policy is designed to avoid costs that otherwise would be incurred. In SFY 1992, an estimated $447,622,510 in Medicaid expenditures were saved by a policy that requires Medicare to be billed first.

Sources and Uses of Funds

In state fiscal year 1992, Medicaid paid $2,386,854,154 for health care services to North Carolina citizens. This total includes $320,000,000 in additional payments to hospitals serving disproportionately high numbers of Medicaid recipients. Hospitals contributed $107,072,000 to the Medicaid program. In addition, $91,855,433 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 28 percent from SFY 1991 to SFY 1992. The increase is driven by eligibility expansions, inflation, and changes in the mix and use of services.

Chart 2
SFY 1992
Sources of Medicaid Funds, Percent

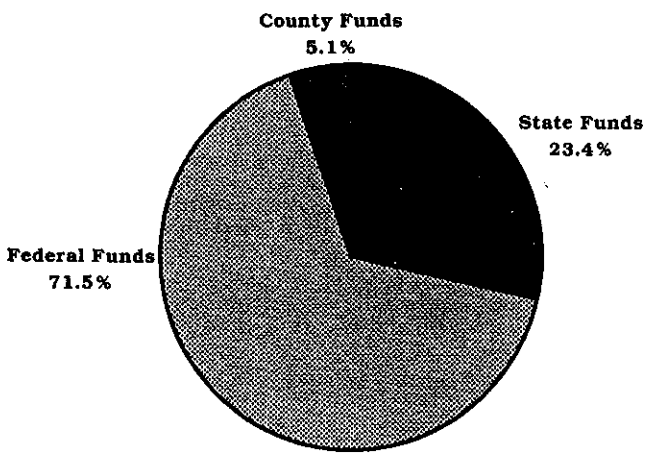


Table 5
SFY 1992
Sources of Medicaid Funds

Federal Funds	$1,770,871,014
State Funds	$ 581,109,604*
County Funds	$ 126,728,969
Total Funds	$2,478,709,587

* Includes $107,072,000 in hospital contributions.

Chart 3
SFY 1992
Users of Medicaid Funds
(percent of total expenditures)

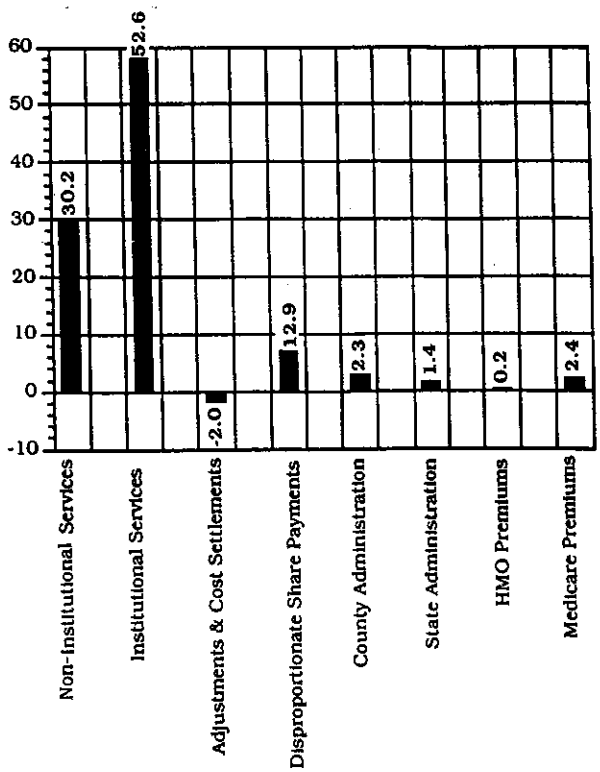


Table 6
SFY 1992
Uses of Medicaid Funds

Type of Service	Total Expenditures	% of Total Dollars	% of Service Dollars	Users of Services*	Cost Per Service User
Inpatient Hospital	$524,286,871	21.1	25.5	177,268	$ 2,958
Mental & Psychiatric Hospital	38,750,934	1.6	1.9	2,668	14,524
Outpatient Hospital	123,911,297	5.0	6.0	409,157	303
Physician	196,682,192	7.9	9.6	621,161	317
Clinics	34,664,262	1.4	1.7	103,832	334
Nursing Facility (Skilled)	258,242,576	10.4	12.6	21,800	11,846
Nursing Facility (Intermediate)	217,077,296	8.8	10.6	18,348	11,831
ICF-MR	264,149,972	10.7	12.9	4,445	59,426
Dental	27,465,689	1.1	1.3	174,846	157
Prescription Drugs	149,478,110	6.0	7.3	529,505	282
Home Health	50,968,808	2.1	2.5	24,902	2,047
Other Services	167,393,730	6.7	8.1	739,583	226
Subtotal, Services	**$2,053,071,737**	**82.8**	**100.0**		
Medicare Premium (Part A, Part B, QMB, Dually Eligible)	60,655,020	2.4			
HMO Premium	4,453,141	0.2			
Adjustments & Cost Settlements	(51,325,744)	(2.0)			
Disproportionate Share Payments	320,000,000	12.9**			
Subtotal Services & Other	**$2,386,854,154**	**96.3**			
Administration (State & County)	91,855,433	3.7			
(State)	33,977,777	1.4			
(County)	57,877,656	2.3			
Grand Total Expenditures	**$2,478,709,587**	**100.0**			
Total Recipients (unduplicated)***				759,975	
Service Expenditures Per Recipient (unduplicated)					$3,262

* "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 sevices they use.

Note: Numbers may not add due to rounding.
Source: SFY 2082 report, SFY 1992; DAS report, SFY 1992

Institutional services, including hospitals and nursing facilities, consume the largest share of the Medicaid service budget (50.6 percent). Spending for intermediate care facilities for the mentally retarded (ICF-MR) was the second highest (12.9 percent) single expenditure, but is used by a very small fraction of the Medicaid population (.6 percent), resulting in expenditures of $59,426 per recipient. The total number of recipients increased by 20.0 percent over SFY 1991. Reflecting the success of eligibility expansions associated with the state's infant mortality initiative, the number of pregnant women and children recipients grew by 20.0 percent and 36.8 percent, respectively.

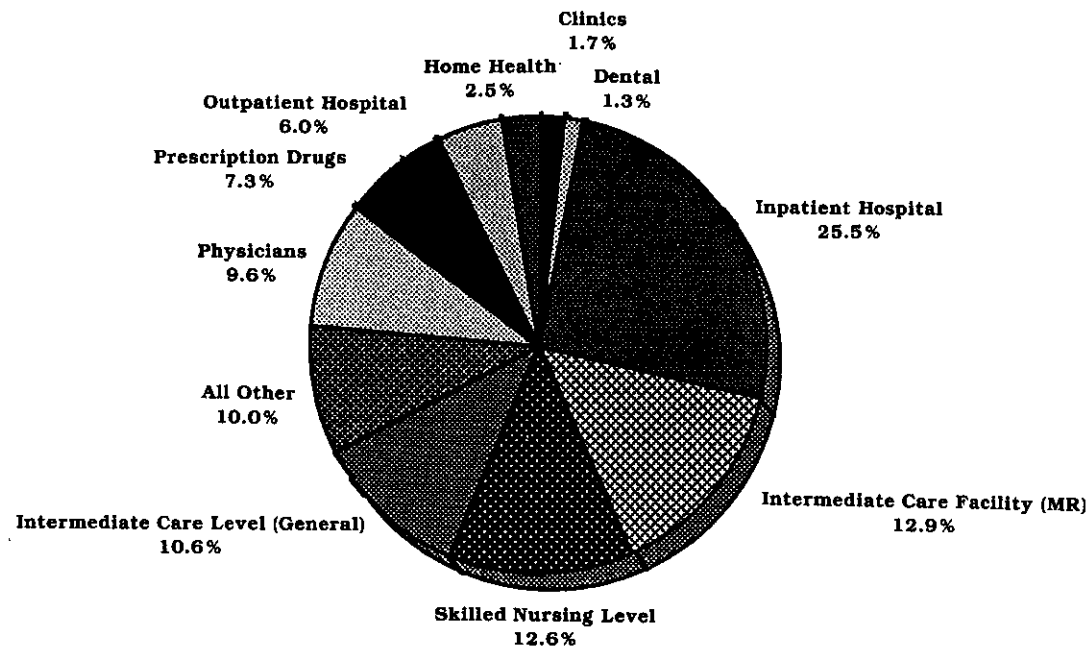
At the same time, the number of recipients whose Medicaid eligibility is linked to AFDC increased at higher rates than in previous years, 21.7 percent. The number of aged recipients increased by 2.9 percent and

Table 7
SFY 1979-1992
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
1992...	2,478,709,587	27.6

Note: Includes vendor payments, administrative costs, refunds, adjustments.
Source: DAS report, SFY 1992

Chart 4
SFY 1992
Medical Service Expenditures, Percent



the number of QMBs grew by almost 40 percent, resulting in a 12.8 percent increase for elderly recipients overall. Continuing a trend seen since 1984, the number of blind recipients declined 6.6 percent.

The increase in expenditures per recipient by eligibility group varied from a high of 13.0 percent for QMBs to a low of -9.9 percent (special coverage children). Per recipient expenditures for the aged, blind and disabled groups grew by 10.4 percent, 6.4 percent and 4.2 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 1992.

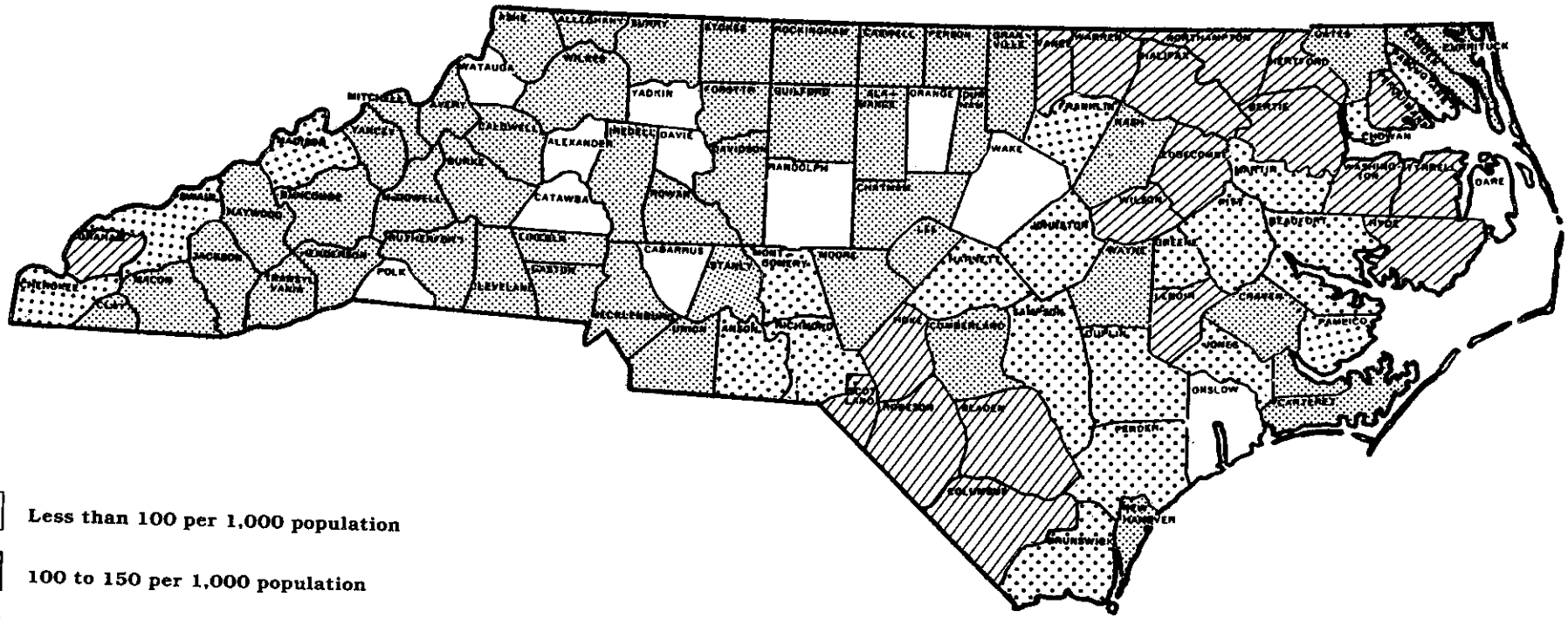
Most eligibles use services and are called recipients. Some eligibles,

Table 8
SFY 1979 - 1992
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
1991-92	83,337	56,871	1,064	79,282	513,023	43,330	94,922	4,139	875,968	16.5
Percent Total Eligibles	9.5%	6.5%	0.1%	9.1%	58.6%	4.9%	10.8%	0.5%	100.0%	

Source: Medicaid Eligibility Report, SFY 1992

Chart 5
SFY 1992
MEDICAID ENROLLMENT PER 1,000 POPULATION BY COUNTY



Less than 100 per 1,000 population

100 to 150 per 1,000 population

150 to 200 per 1,000 population

200 per 1,000 population and above

Table 9
SFY 1992
Total Expenditures and Eligibles by County

County Name	1991 Est. County Population	Number of Medicaid Eligibles	Total Expenditures	Expenditures Per Eligible	Per Capita Expenditures Amount	Rank	Eligibles Per 1,000 Population
Alamance	109,189	10,932	$31,714,718	$2,901	$290.46	73	100
Alexander	27,817	2,437	7,112,909	2,919	255.70	88	88
Alleghany	9,576	1,225	3,087,512	2,520	322.42	59	128
Anson	23,281	4,557	11,902,565	2,612	511.26	5	196
Ashe	22,164	3,269	9,002,461	2,754	406.17	33	147
Avery	14,881	2,051	7,136,505	3,480	479.57	12	138
Beaufort	42,513	7,919	18,817,295	2,376	442.62	21	186
Bertie	20,343	4,893	9,446,046	1,931	464.34	15	241
Bladen	28,491	6,856	14,211,542	2,073	498.81	9	241
Brunswick	52,714	8,049	17,617,824	2,189	334.22	48	153
Buncombe	176,467	20,242	53,179,810	2,627	301.36	68	115
Burke	76,145	8,576	23,240,181	2,710	305.21	66	113
Cabarrus	100,567	9,962	28,206,816	2,831	280.48	79	99
Caldwell	71,083	8,135	22,780,204	2,800	320.47	60	114
Camden	5,926	832	1,732,468	2,082	292.35	70	140
Carteret	53,805	6,170	15,276,140	2,476	283.92	77	115
Caswell	20,703	3,093	8,296,359	2,682	400.73	34	149
Catawba	120,058	10,447	27,259,341	2,609	227.05	92	87
Chatham	39,408	3,956	10,873,784	2,749	275.93	83	100
Cherokee	20,287	3,565	8,373,934	2,349	412.77	30	176
Chowan	13,615	2,653	5,831,733	2,198	428.33	25	195
Clay	7,186	947	2,637,442	2,785	367.03	44	132
Cleveland	84,972	11,938	28,122,317	2,356	330.96	50	140
Columbus	49,415	12,524	28,442,481	2,271	575.58	2	253
Craven	83,093	11,797	25,479,860	2,160	306.64	65	142
Cumberland	278,106	36,990	63,482,100	1,716	228.27	90	133
Currituck	14,051	1,720	3,009,165	1,750	214.16	95	122
Dare	23,897	1,790	4,503,206	2,516	188.44	98	75
Davidson	128,319	13,323	32,540,314	2,442	253.59	89	104
Davie	28,244	2,479	7,971,733	3,216	282.25	78	88
Duplin	39,930	7,867	17,766,826	2,258	444.95	20	197
Durham	186,072	20,687	61,546,440	2,975	330.77	51	111
Edgecombe	56,745	13,564	25,969,844	1,915	457.66	18	239
Forsyth	268,697	30,814	76,784,864	2,492	285.77	76	115
Franklin	37,259	6,020	16,185,873	2,689	434.42	24	162
Gaston	176,792	23,646	55,047,099	2,328	311.37	63	134
Gates	9,372	1,383	3,040,047	2,198	324.38	56	148
Graham	7,195	1,524	2,993,032	1,964	415.99	29	212
Granville	38,929	4,338	11,681,976	2,693	300.08	69	111
Greene	15,299	2,897	6,270,945	2,165	409.89	31	189
Guilford	350,675	37,997	94,400,516	2,484	269.20	84	108
Halifax	55,639	15,512	28,330,811	1,826	509.19	6	279
Harnett	68,835	12,073	27,256,763	2,258	395.97	35	175
Haywood	46,981	6,547	15,358,336	2,346	326.91	55	139
Henderson	70,410	7,416	19,459,741	2,624	276.38	82	105
Hertford	22,485	5,729	11,302,465	1,973	502.67	8	255
Hoke	23,161	5,578	8,976,278	1,609	387.56	38	241
Hyde	5,385	1,266	2,611,800	2,063	485.01	11	235
Iredell	94,340	10,213	27,048,596	2,648	286.71	75	108
Jackson	26,965	3,781	8,878,306	2,348	329.25	52	140
Johnston	82,772	12,853	31,133,662	2,422	376.14	41	155
Jones	9,417	1,788	5,299,835	2,964	562.79	3	190

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

Table 9
SFY 1992
Total Expenditures and Eligibles by County

County Name	1991 Est. Census Population	Number of Medicaid Eligibles	Total Expenditures	Expenditures Per Eligible	Per Capita Expenditures		Eligibles Per 1,00 Populatic
					Amount	Rank	
Lee	41,884	6,055	$ 13,563,242	$2,240	$323.83	57	145
Lenoir	57,012	11,622	28,815,282	2,479	505.42	7	204
Lincoln	51,311	5,244	11,492,995	2,192	223.99	93	102
Macon	23,828	2,993	7,887,737	2,635	331.03	49	126
Madison	16,974	3,027	7,396,243	2,443	435.74	23	178
Martin	24,994	4,896	10,508,364	2,146	420.44	27	196
McDowell	35,737	4,122	10,401,015	2,523	291.04	72	115
Mecklenburg	525,762	59,255	140,743,485	2,375	267.69	86	113
Mitchell	14,416	1,949	6,029,678	2,094	418.26	28	135
Montgomery	23,493	4,082	8,697,668	2,131	370.22	42	174
Moore	59,891	6,413	15,853,320	2,472	264.70	87	107
Nash	77,868	11,573	25,617,050	2,214	328.98	53	149
New Hanover	122,023	17,865	41,638,715	2,331	341.24	47	146
Northampton	20,668	5,431	11,631,428	2,142	562.77	4	263
Onslow	153,100	13,111	23,584,573	1,799	154.05	100	86
Orange	95,994	6,211	19,774,511	3,184	206.00	96	65
Pamlico	11,487	1,868	4,878,753	2,612	424.72	26	163
Pasquotank	31,668	6,151	11,642,616	1,893	367.65	43	194
Pender	29,696	5,192	12,963,535	2,497	436.54	22	175
Perquimans	10,547	2,128	4,106,854	1,930	389.39	37	202
Person	30,338	4,295	13,902,889	3,237	458.27	17	142
Pitt	110,374	18,474	38,589,364	2,089	349.62	45	167
Polk	14,583	1,398	4,189,320	2,997	287.27	74	96
Randolph	108,389	9,238	23,385,518	2,531	215.76	94	85
Richmond	44,526	7,722	17,570,237	2,275	394.61	36	173
Robeson	105,734	27,959	52,170,471	1,866	493.41	10	264
Rockingham	86,349	10,268	27,540,830	2,682	318.95	61	119
Rowan	111,990	12,079	30,126,014	2,494	269.01	85	108
Rutherford	57,329	7,261	17,457,140	2,404	304.51	67	127
Sampson	47,059	9,201	22,307,636	2,424	474.04	13	196
Scotland	33,948	8,348	15,438,035	1,849	454.76	19	246
Stanly	52,185	5,710	15,253,191	2,671	292.29	71	109
Stokes	37,717	3,902	10,488,533	2,688	278.09	81	103
Surry	62,020	7,222	20,019,241	2,772	322.79	58	116
Swain	11,377	2,267	4,321,653	1,906	379.86	40	199
Transylvania	25,714	3,281	8,147,639	2,483	316.86	62	128
Tyrrell	3,838	1,060	2,212,283	2,087	576.42	1	276
Union	86,079	9,757	19,574,950	2,006	227.41	91	113
Vance	39,259	8,095	16,003,407	1,977	407.64	32	206
Wake	438,383	33,575	79,021,340	2,354	180.26	99	77
Warren	17,386	3,622	8,178,037	2,258	470.38	14	208
Washington	13,928	3,236	6,461,988	1,997	463.96	16	232
Watauga	37,282	2,688	7,249,557	2,697	194.45	97	72
Wayne	105,571	15,770	32,530,835	2,063	308.14	64	149
Wilkes	59,415	6,834	20,375,477	2,981	342.93	46	115
Wilson	66,377	13,372	25,390,553	1,899	382.52	39	201
Yadkin	30,739	3,050	8,567,203	2,809	278.71	80	99
Yancey	15,480	2,231	5,086,588	2,280	328.59	54	144
STATE TOTAL	6,721,393	877,923	$2,057,419,813	$2,344	$306.10	N/A	131

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1992.

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

however, do not use services during 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 1992, 875,968 persons were eligible for Medicaid at some time during the year. This represents an increase of almost 124,351 eligibles (or 16.5 percent) over the prior year.

Counties vary greatly in the number of residents who are eligible for Medicaid: from a low of 65 per 1,000 population in Orange County to a high of 279 per 1,000 population in Halifax County. The statewide average is 131 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 1992.

Recipients

Recipients are those who actually use a service during the year. In SFY 1992, Medicaid paid for care for 759,975 recipients. Table 10 displays expenditures for recipients by eligi-

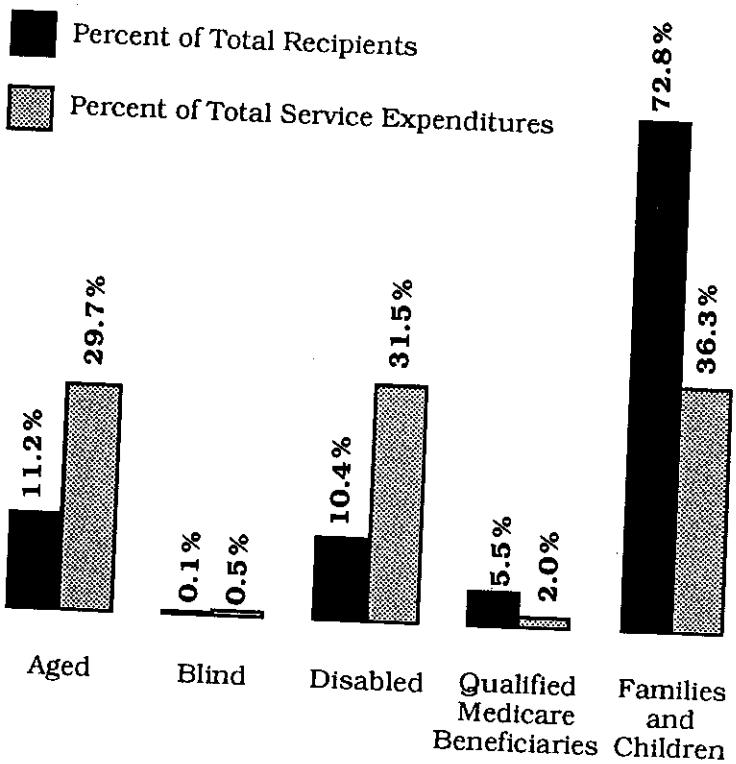
Table 10
SFY 1992
Medcaid Service Expenditures by Eligiblity Group

Eligibility Group	Total Services Dollars	% of Dollars	Total Recipients	% of Recipients	SFY 1992 Expenditures Per Recipient	SFY 1991 Expenditures Per Recipient	Percent Change
Total Elderly	$650,884,662	31.7	127,081	16.7	$5,122	$4,996	2.5
Aged	610,062,711	29.7	85,073	11.2	7,171	6,497	10.4
Medicare-Aid	40,821,951	2.0	42,008	5.5	972	860	13.0
Total Disabled	656,120,075	32.0	80,017	10.5	8,200	7,868	4.2
Disabled	646,989,784	31.5	78,934	10.4	8,197	7,867	4.2
Blind	9,130,291	0.5	1,083	0.1	8,431	7,924	6.4
Total Families And Children	746,067,000	36.3	552,877	72.8	1,349	1,297	4.0
AFDC Adults	227,860,941	11.1	143,107	18.8	1,592	1,455	9.4
Special Pregnant Women Coverage	104,187,463	5.1	53,413	7.0	1,951	1,819	7.3
AFDC Children & Other Children	280,290,989	13.6	269,714	35.6	1,039	989	5.1
Special Children Coverage	133,727,607	6.5	86,643	11.4	1,543	1,712	(9.9)
Total, Service Expenditures All Groups	$2,053,071,737	100.0	759,975	100.0	$2,701	$2,705	(0.1)

Note: Does not include adjustments processed by DMA, settlements, premiums, and state and county administrative costs. These total $425,637,850. See Table 6 for more details.

Source: SFY 2082 report, SFY 1992.

Chart 6
SYF 1992
Medicaid Recipients and Service Expenditures



bility group.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 (73 percent) are families and children including Aid to Families with Dependent Children (AFDC) and special pregnant women and children coverage, and most expenditures were made on their behalf (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 1992
Service Expenditures, Percent Distribution

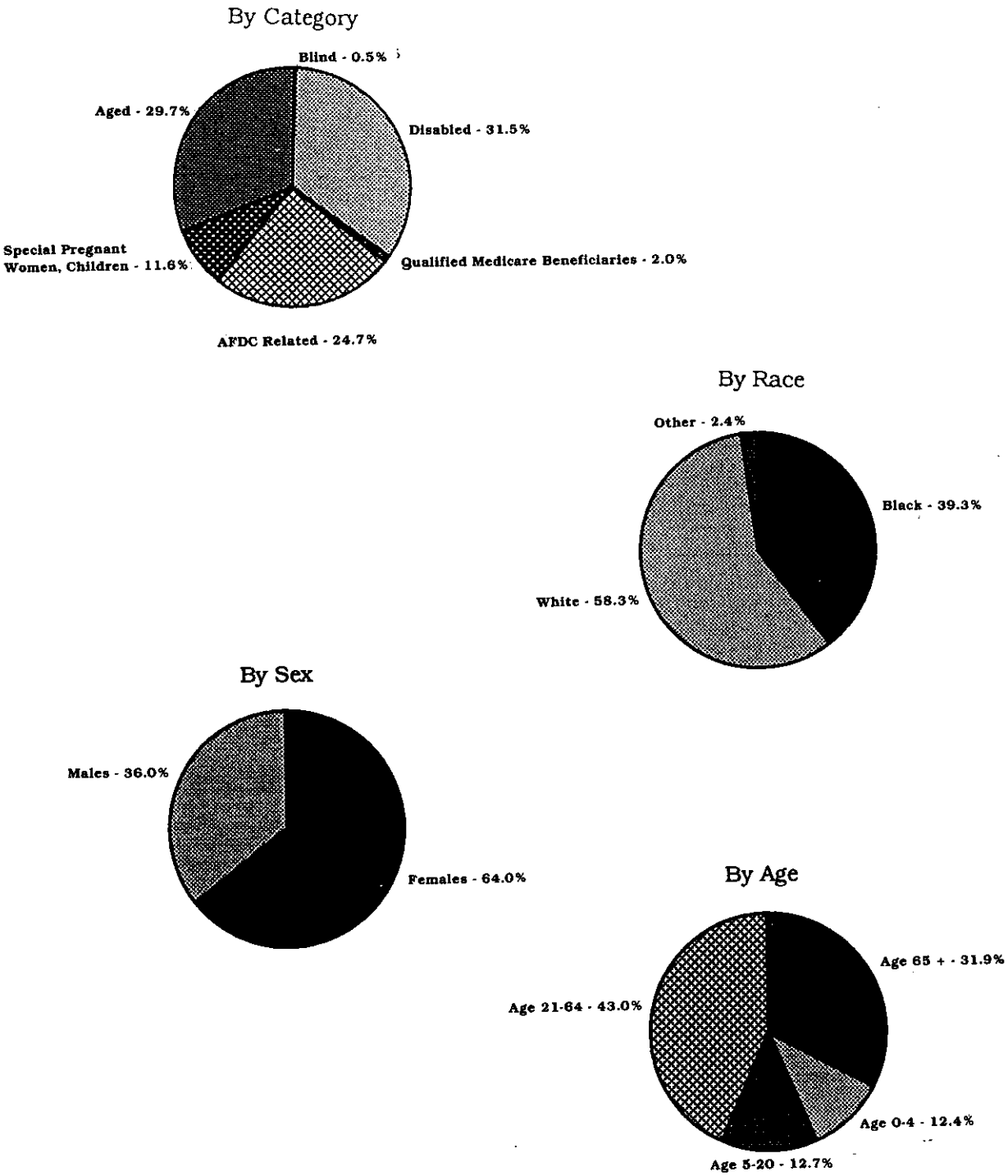
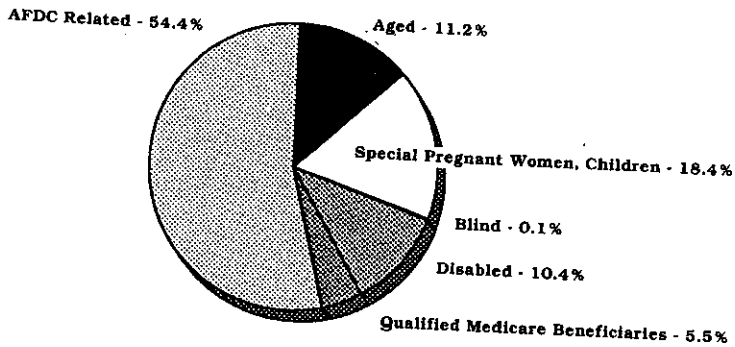
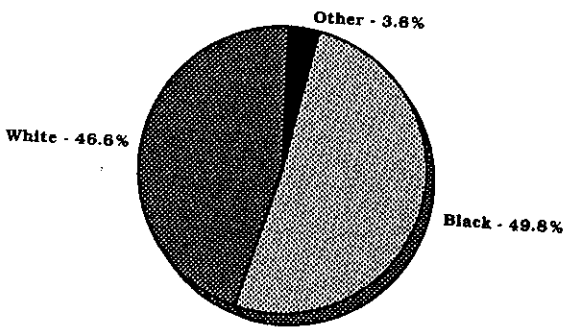


Chart 8
SFY 1992
Recipients, Percent Distribution

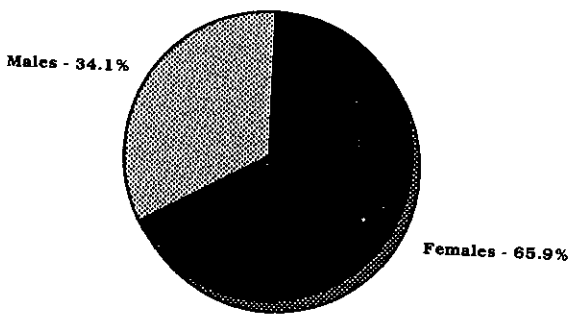
By Category



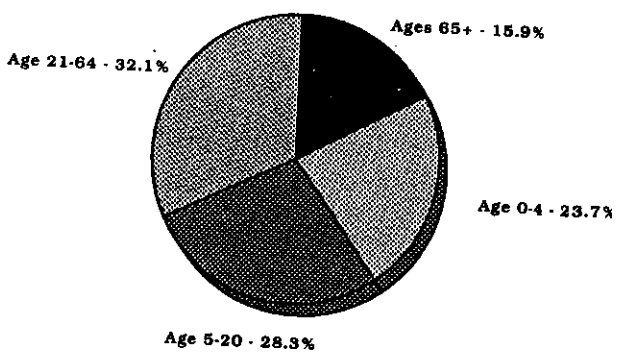
By Race



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, $8,431 and $8,197, respectively.

Male and female adults had similar per recipient costs, although males, on average, cost slightly more than females, $2,854 versus $2,622. 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 ($1,213) overall and those aged 65 and above had the highest ($5,436). (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 1992
Service Expenditures Per Recipient by Selected Characteristics

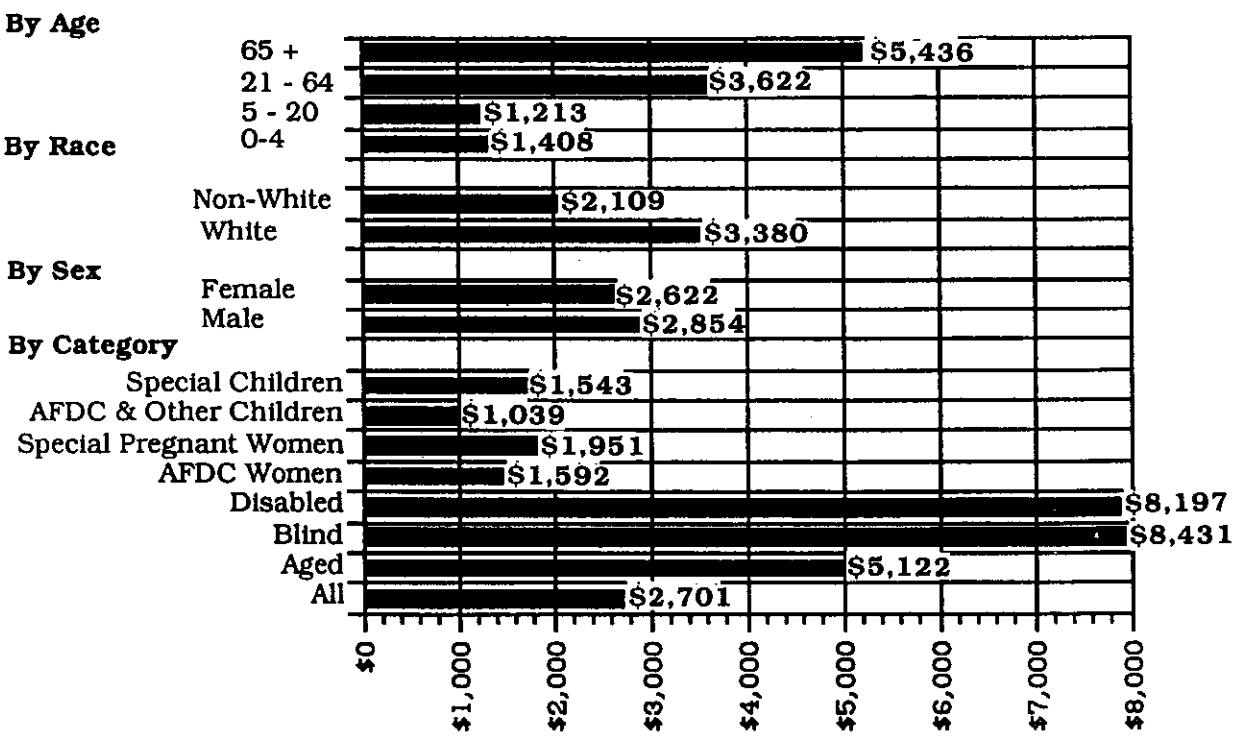


Table 11
SFY 1992
Service Expenditures For Selected Major Medical Services By Program Category

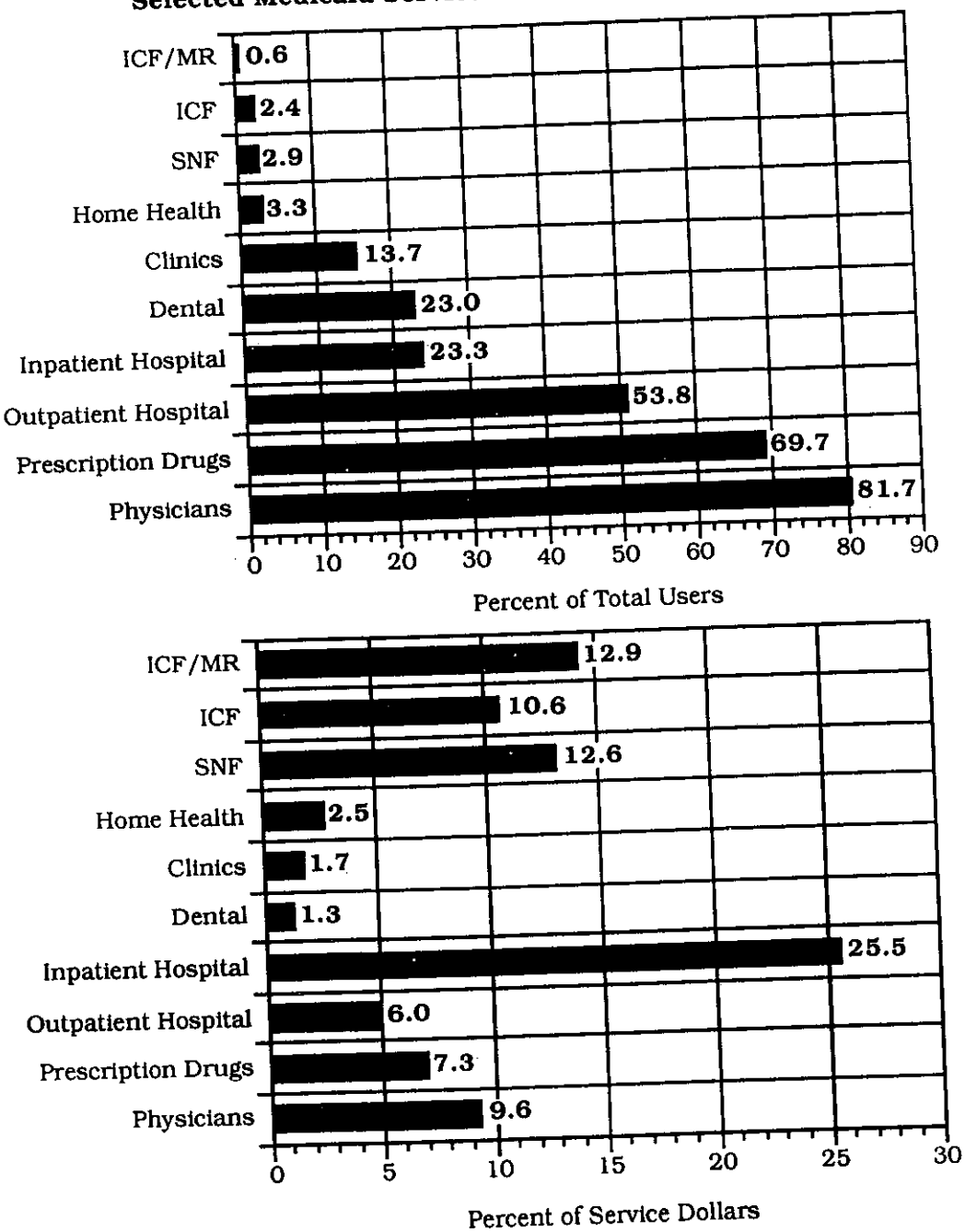
Type of Service	Total	% of Service Dollars	Aged	Qualified Medicare Beneficiaries*	Blind	Disabled	Families and Children — AFDC Adult	Special Pregnant Women	AFDC Child & Other Child	Special Children
Inpatient Hospital	$524,286,871	25.5	$41,510,984	$7,020,187	$678,427	$161,338,442	$82,021,520	$40,742,245	$109,241,355	$81,733,711
Outpatient Hospital	123,911,297	6.0	8,763,341	5,410,890	172,852	27,570,298	34,783,392	11,204,840	26,893,047	9,112,637
Mental Hospital (over 65)	15,925,327	0.8	15,541,268	193,592	4,957	185,510	–	–	–	–
Psychiatric Hospital (under 21)	22,825,606	1.1	–	–	–	996,435	310,497	90,103	21,309,148	119,423
Physician	196,682,192	9.6	15,865,055	8,104,838	284,276	39,207,901	45,632,339	28,644,997	38,131,839	20,810,947
Clinics	34,664,262	1.7	1,208,341	1,403,657	85,639	6,506,734	5,709,970	10,278,088	6,504,971	2,966,862
Nursing Facility:										
Skilled Level	258,242,576	12.6	214,657,609	6,844,971	831,964	34,405,462	647,224	–	855,346	–
Intermediate Level	217,077,296	10.6	192,623,895	4,022,017	928,634	19,431,177	14,311	–	57,262	–
Intermediate Care Facility (Mentally Retarded)	264,149,972	12.9	5,519,549	356,775	4,055,130	231,568,317	912,754	–	21,731,644	5,803
Dental	27,465,689	1.3	2,035,506	168,499	44,866	4,164,389	10,309,950	813,243	8,831,157	1,098,079
Prescription Drugs	149,478,110	7.3	56,546,899	2,673,227	708,689	46,896,656	20,176,345	2,012,414	15,250,642	5,213,238
Home Health	50,968,808	2.5	7,170,973	427,946	430,162	24,353,763	2,682,631	309,667	9,451,683	6,141,983
CAP/Disabled Adult	35,418,774	1.7	24,643,278	1,623,909	211,562	8,854,776	59,821	–	25,428	–
CAP/Mentally Retarded	11,747,897	0.6	40,912	34,994	–	11,163,471	4,677	–	363,729	140,114
CAP/Children	1,356,898	0.1	–	–	–	1,167,723	–	–	28,750	160,425
Personal Care	28,189,742	1.4	18,998,272	640,694	579,724	7,188,033	503,011	13,540	172,292	94,176
Hospice	2,612,279	0.1	359,818	22,561	13,393	1,873,483	279,937	–	56,372	6,715
EPSDT	8,429,008	0.4	–	–	1,409	22,540	13,498	9,282	4,725,015	3,657,264
Lab & X-Ray	18,872,801	0.9	1,403,404	789,320	37,398	5,826,218	5,867,217	1,770,578	2,451,372	727,294
Other Services	60,766,332	2.9	3,173,607	1,083,874	61,209	14,268,456	17,931,847	8,298,466	14,209,937	1,738,936
Total Services	$2,053,071,737	100.0	$610,062,711	$40,821,951	$9,130,291	$646,989,784	$227,860,941	$104,187,463	$280,290,989	$133,727,607

* 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, settlements, premiums, and state and county administration costs.
Source: 2082 Report for SFY 1992.

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 1992
Selected Medicaid Services: Use and Dollars, Percent



The Elderly

The elderly (those 65 or older) comprise 16.7 percent of all Medicaid recipients but account for 32 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 (64.2 percent). Sizable expenditures were also made for inpatient hospital care (7.5 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 9.1 percent of expenditures.

In SFY 1992, 127,081 elderly persons received assistance through the Medicaid program, at an average cost of $5,122 per recipient, an increase of 2.5 percent from SFY 1991. 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 13.0% over SFY 1991.

Table 12
SFY 1992
Expenditures For The Elderly

Type of Service	Aged	% of Dollars	Qualified Medicare Beneficiaries	% of Dollars	Total Elderly Dollars	SFY 1992 % of Total Dollars	SFY 1991 % of Total Dollars
Inpatient Hospital	$41,510,984	6.8	$7,020,187	17.2	$48,531,171	7.5	8.1
Outpatient Hospital	8,763,341	1.4	5,410,890	13.3	14,174,231	2.2	1.8
Mental Hospital (over 65)	15,541,268	2.5	193,592	0.5	15,734,860	2.4	2.5
Physician	15,865,055	2.6	8,104,838	19.9	23,969,893	3.7	3.4
Clinics	1,208,341	0.2	1,403,657	3.4	2,611,998	0.4	0.4
Nursing Facility:							
Skilled Level	214,657,609	35.2	6,844,971	16.8	221,502,580	34.0	34.3
Intermediate Level	192,623,895	31.6	4,022,017	9.9	196,645,912	30.2	29.4
ICF-MR	5,519,549	0.9	356,775	0.9	5,876,324	0.9	1.1
Dental	2,035,506	0.4	168,499	0.5	2,204,005	0.3	0.3
Prescription Drugs	56,546,899	9.3	2,673,227	6.5	59,220,126	9.1	9.2
Home Health	7,170,973	1.2	427,946	1.0	7,598,919	1.2	1.7
CAP/Disabled Adult	24,643,278	4.0	1,623,909	4.0	26,267,187	4.0	4.1
CAP/Mentally Retarded	40,912	*	34,994	*	75,906	*	*
Personal Care Services	18,998,272	3.1	640,694	1.6	19,638,966	3.0	2.9
Hospice	359,818	*	22,561	*	382,379	*	*
Lab and X-Ray	1,403,404	0.2	789,320	1.9	2,192,724	0.3	0.3
Other Services	3,173,607	0.6	1,083,874	2.6	4,257,481	0.8	0.5
Total Elderly Service Expenditures	$610,062,711	100.0	$40,821,951	100.0	$650,884,662	100.0	100.0
Total Elderly Recipients	85,073		42,008		127,081		
Expenditures Per Elderly Recipient	$7,171		$972		$5,122		$4,996

* Less than .1%

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

Source: 2082 Report for SFY 1992.

The Disabled and Blind

Blind and disabled individuals accounted for 32.0 percent of Medicaid expenditures. Most individuals in this group (98.6 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 (44.4 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 $8,200 per recipient for the blind and disabled group. Per recipient expenditures for this group increased 4.2 percent over the figure for 1991. In SFY 1992, 80,017 blind and disabled persons were served by Medicaid.

Table 13
SFY 1992
Expenditures For The Disabled And Blind

Type of Service	Disabled	% of Dollars	Blind	% of Dollars	Total Blind & Disabled Dollars	SFY 1992 % of Total Dollars	SFY 1991 % of Total Dollars
Inpatient Hospital	$161,338,442	24.9	$678,427	7.4	$162,016,869	24.7	23.9
Outpatient Hospital	27,570,298	4.3	172,852	1.9	27,743,150	4.2	3.5
Psychiatric Hospital (under 21)	996,435	0.2	–	–	996,435	0.2	0.2
Physician	39,207,901	6.1	284,276	3.1	39,492,177	6.0	6.0
Clinics	6,506,734	1.0	85,639	0.9	6,592,373	1.0	1.7
Nursing Facility:							
Skilled Level	34,405,462	5.3	831,964	9.1	35,237,426	5.4	5.6
Intermediate Level	19,431,177	3.0	928,634	10.2	20,359,811	3.1	3.2
ICF-MR	231,568,317	35.8	4,055,130	44.5	235,623,447	35.9	38.0
Dental	4,164,389	0.6	44,866	0.5	4,209,255	0.6	0.6
Prescription Drugs	46,896,656	7.2	708,689	7.8	47,605,345	7.3	6.8
Home Health	24,353,763	3.8	430,162	4.7	24,783,925	3.7	4.1
CAP/Disabled Adult	8,854,776	1.4	211,562	2.3	9,066,338	1.4	1.4
CAP/Children	1,167,723	0.2	–	–	1,167,723	0.2	0.2
CAP/Mentally Retarded	11,163,471	1.7	–	–	11,163,471	1.7	1.4
Personal Care Services	7,188,033	1.1	579,724	6.3	7,767,757	1.2	1.0
Hospice	1,873,483	0.3	13,393	0.1	1,886,876	0.3	0.2
Lab & X-Ray	5,826,218	0.9	37,398	0.4	5,863,616	0.9	0.8
Other Services	14,476,506	2.2	67,575	0.8	14,544,081	2.2	1.4
Total Disabled/Blind Service Expenditures	$646,989,784	100.0	$9,130,291	100.0	$656,120,075	100.0	100.0
Total Disabled/Blind Recipients	78,934		1,083		80,017		
Expenditures Per Disabled/Blind Recipient	$8,197		$8,431		$8,200		$7,868

* Less than .1%

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

Source: 2082 Report for SFY 1992.

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 1992, Medicaid expenditures per recipient for all groups were $1,349, 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, 61.1 percent of expenditures was for hospital care following birth. Physician services also account for a large portion of services used by these groups. Outpatient hospital services accounted for 11.0 percent of expenditures. In SFY 1992, 196,520 adults and 356,357 children received services.

Table 14
SFY 1992
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 1992 % of Total Dollars	SFY 1991 % of Total Dollars
Inpatient Hospital	$82,021,520	36.0	$40,742,245	39.1	$109,241,355	39.0	$81,733,711	61.1	$313,738,831	42.1	44.2
Outpatient Hospital	34,783,392	15.3	11,204,840	10.8	26,893,047	9.6	9,112,637	6.8	81,993,916	11.0	9.4
Psychiatric Hospital (under 21)	310,497	0.1	90,103	*	21,309,148	7.6	119,423	0.1	21,829,171	2.9	3.5
Physician	45,632,339	20.0	28,644,997	27.5	38,131,839	13.6	20,810,947	15.6	133,220,122	17.9	18.3
Clinics	5,709,970	2.5	10,278,088	9.9	6,504,971	2.3	2,966,862	2.2	25,459,891	3.4	3.4
Nursing Facility:											
Skilled Level	647,224	0.3	–	–	855,346	0.3	–	–	1,502,570	0.2	0.2
Intermediate Level	14,311	*	–	–	57,262	*	–	–	71,573	*	*
ICF-MR	912,754	0.4	–	–	21,731,644	7.8	5,803	*	22,650,201	3.0	3.9
Dental	10,309,950	4.5	813,243	0.8	8,831,157	3.1	1,098,079	0.8	21,052,429	2.8	2.8
Prescription Drugs	20,176,345	8.9	2,012,414	1.9	15,250,642	5.4	5,213,238	3.9	42,652,639	5.7	5.1
Home Health	2,682,631	1.2	309,667	0.3	9,451,683	3.4	6,141,983	4.6	18,585,964	2.5	2.2
CAP/Children	–	–	–	–	28,750	*	160,425	0.1	189,175	*	*
EPSDT	13,498	*	9,282	*	4,725,015	1.7	3,657,264	2.7	8,405,059	1.1	0.9
Lab & X-Ray	5,867,217	2.6	1,770,578	1.7	2,451,372	0.9	727,294	0.6	10,816,461	1.5	1.4
Other Services	18,779,293	8.2	8,312,006	8.0	14,827,758	5.3	1,979,941	1.5	43,898,998	5.9	4.7
Total Families & Children Service Expenditures	$227,860,941	100.0	$104,187,463	100.0	$280,290,989	100.0	$133,727,607	100.0	$746,067,000	100.0	100.0
Total Families & Children Recipients	143,107		53,413		269,714		86,643		552,877		
Expenditures Per Families & Children Recipient	$1,592		$1,951		$1,039		$1,543		$1,349		$1,297

* Less than .1%

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

Source: 2082 Report for SFY 1992.

MEDICAID IN DEPTH

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

The following discussion describes services, reimbursement methods, limitations and copayment amounts in effect during SFY 1992. (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 - Nursing facility (NF) 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 nursing facility level of care and be approved by Medicaid prior to admission. Nursing facility services are paid a prospective per diem rate.

Physician Services - Physician services are covered subject to an annual 24 visit limit. Selected surgical procedures require prior approval. A $2.00 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 $2.00 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, nurse practitioner services and medical transportation.

Optional Services

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

Intermediate Care Facilities for the Mentally Retarded (ICF-MR) - Services in ICF-MRs are covered for those who are mentally retarded or who have related conditions. ICF-MRs must meet certification requirements relating to provision of habilitation services as well as basic intermediate care services. Intermediate care facilities for the mentally retarded 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 $1.00 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 $5.60 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 1992
Medicaid Copayment Amounts

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

These copayment amounts have been in effect since 1984, as required by the federal Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, except for Physicians and Prescribed Drugs which were increased to $2.00 and $1.00 respectively effective August, 1992. 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 $2.00 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 $2.00 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 reduce North Carolina's high infant mortality rate by improving access to health care and the service delivery system for low income pregnant women and children. The Division Of Medical Assistance and the Division of Maternal and Child Health jointly administer the Baby Love Program in cooperation with the Office of Rural Health and Resource Development.

Through the Baby Love Program, pregnant women can receive comprehensive care from the beginning of pregnancy through the postpartum period. Infants born to Medicaid eligible women continue to be eligible for Medicaid until their first birthday.

Specially trained nurses and social workers called Maternity Care Coordinators are located in all 100 North Carolina counties to assist pregnant women in obtaining medical care and an array of social support services such as transportation, housing, job training and day care. Services provided through the Baby Love Program also include childbirth and parenting classes and in-home skilled nursing care for medically high risk pregnancies.

The most recent efforts of the Baby Love Program to expand outreach efforts include the publication of the Baby Love Keepsake Book (a guide for parenting families), and the implementation of the Baby Love Maternal Outreach Worker Project, funded by the Kate B. Reynolds Health Care Trust and Medicaid. Twenty-four (24) pilot health agencies have a total of 41 Maternal Outrearch Workers who work on a one-to-one basis with Medicaid eligible families to provide social support, encourage healthy behaviors, and to ensure that families are linked with available community resources. The Maternal Outreach Workers have received 60 hours of training to work more effectively with participants in their caseload.

Evaluation of the Baby Love program shows that women who receive the services of a Maternity Care Coordinator average more prenatal visits per pregnancy, have a higher participation in the Women, Infants and Children (WIC) program, and are more likely to receive postpartum/family planning services. Likewise, their children are more likely to receive well-child care and WIC services. Mothers who have a Maternity Care Coordinator have better birth outcomes - more live births and fewer low birthweight babies. In the first two years of the program (1988-1989), maternity care coordination services are estimated to have saved the state of North Carolina $2,174,000.

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.

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. Sixty-two counties choose to participate in CAP/DA and the program served about 4,600 individuals in SFY 1992.

The average daily cost for CAP/DA services at the skilled level was less than 55 percent of the average cost for institutional care at the comparable level. At the intermediate level, CAP/DA services cost less than 70 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 950 individuals in SFY 1992. The area programs decide whether to offer this program. Participants in the CAP-MR/DD were served at approximately 21 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 approximately 58 children in SFY 1992. The cost of CAP services to the children in this program averaged 50 percent or less than that of the comparable level of institutional care.

Overall, the CAP programs have been very successful in giving individuals a choice 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, 42,008 Medicare recipients benefited from Medicare-Aid in SFY 1992. 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 and to 100 percent of the federal poverty level on January 1, 1992.

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 three counties (Mecklenburg, Wake and Durham) and enrolled an average of 3,500 recipients per month in the HMO in SFY 1992.

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.

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