Medicaid Issues

Medicaid Issues —

MEDICAID EXPENDITURES AND COVERAGE

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Issue Statement

North Carolina Medicaid expenditures for all services were over $2 billion in FY92, representing approximately 12 percent of the total State budget. (See Exhibit 1.) This represents a 157 percent increase in expenditures since 1987. The increase in expenditures has been of great concern to State policymakers not only because it is unpredictable, but also because of the State's limited ability to effect control because of federal mandates. The purpose of this paper is to assess issues which affect Medicaid expenditures.

Background

The increase in expenditures can be attributed to several factors, including:

- Growth in the number of recipients
- Increase in the scope of services available to Medicaid recipients
- Increase in the cost of services due to price inflation

In an effort to control Medicaid expenditures, states have considered options to reduce the number of program recipients, reduce the scope of services available under the Medicaid program, or limit the units of services to program recipients (for example, physician visits to two per month). Changes are often made in the reimbursement methodologies for various program areas, in efforts to obtain the most cost-effective care for Medicaid recipients. To further reduce costs, many states charge recipients a copayment for each unit of service.

Although these options may provide cost savings for the Medicaid program, ultimately these changes may not provide the control needed in the long term to constrain the growth of program expenditures.

States have broad discretion in determining which segment of the population their Medicaid programs will cover and the financial criteria for Medicaid eligibility. To receive federal funds for services provided to Medicaid recipients, states must cover certain groups of individuals. The following groups are required by federal law to be covered under the Medicaid program:

- AFDC recipients, specifically families with unemployed parents, pregnant women with no other eligible children and children under 18
- Deemed recipients of AFDC, including families losing AFDC because of child or spousal support, and children in foster care who are Title IV-E recipients

EXHIBIT 1

TOTAL NORTH CAROLINA MEDICAID PROGRAM EXPENDITURES

Fiscal Year	Expenditures	Percent Change	Recipients*	Percent Change	Expenditures Per Recipient	Percent Change
1987	860,100,826	N/A	3,765,516	N/A	228.42	N/A
1988	980,315,295	14.0	4,062,547	7.8	241.42	5.7
1989	1,206,619,794	23.1	4,687,156	15.4	257.43	6.6
1990	$1,453,870,674	20.5	5,566,923	18.8	261.16	1.5
1991	$1,831,233,958	26.0	6,665,610	19.7	274.73	5.2
1992	$2,208,462,969	21.0	8,481,694	27.2	260.38	(5.2)
		156.77		125.2		14.0

* Duplicated Count

Source: DMA Gross Expenditure Reports

- Qualified pregnant women and children who would qualify for AFDC if their child was already born

- Newborns of Medicaid eligible women for one year after birth

- Other non-cash recipients, including

    - Qualified Medicare beneficiaries
    - Qualified Disabled Working Individuals
    - Individuals receiving mandatory state supplement

- Aged, blind or disabled individuals who receive Supplemental Security Income. States can elect to use a more restrictive financial eligibility requirement or definition of disability. These are 209(b) states.

During FY92, 514,220 individuals were eligible to receive Medicaid in North Carolina through the mandatory coverage requirements. Expenditures for this population totaled $1.2 billion, or approximately 70 percent of total Medicaid expenditures. The average Medicaid expenditure for mandatory recipients was $2,248.

In FY92, there was a significant increase in the number of AFDC eligibles due to changes in federal law. Additionally, Medicaid covered more long-term care residents than in previous years. For these reasons, the total Medicaid budget was underprojected by approximately $78 million. This shortfall was covered primarily by funds targeted for other programs within the Department of Human Resources.

Federal law also allows states to cover various groups in addition to federal mandated eligibles. Often these groups are considered medically needy because their income or resources are above the federal limits established for mandatory groups. North Carolina has elected to cover the following groups of individuals:

- Pregnant women and infants with income below 185 percent of the federal poverty level

- HMO enrollees for minimum enrollment periods

- Individuals in home- and community-based waiver programs

- Individuals meeting AFDC, SSI income and resource test but receiving no cash payment

- Financially eligible children in
    - Foster homes
    - Private institutions
    - Subsidized adoptions
    - Nursing facilities
    - Inpatient psychiatric facilities
- Optional State supplement recipients who are aged, blind or disabled, and who were in rest homes

In FY92, 71,801 recipients received services under an optional Medicaid program category. Total FY92 expenditures for optional recipients were $662.5 million, or approximately $9,227 per person. Seventy-two percent of all expenditures for optional recipients were to aged or disabled individuals.

In addition to requiring states to cover certain eligibility groups, the Health Care Financing Authority (HCFA) requires states to provide certain services as a condition for receiving federal Medicaid matching funds. Mandated services a state must provide include:

- Hospital inpatient
- Hospital outpatient
- Physician services
- Nursing home services
- Laboratory and X-Ray services
- Family planning
- Durable medical equipment
- Home health

In FY92, approximately $1.3 billion, close to 63 percent of the total Medicaid budget, was expended for mandated services to all recipients. Almost one-half of these expenditures was for inpatient hospital care. Expenditures for services provided in nursing facilities accounted for approximately 33 percent of mandatory service expenditures.

States may also receive federal matching funds from Medicaid if they elect to provide services from a designated list of 32 optional services developed by HCFA. States vary in the number of optional services provided to Medicaid eligibles. For instance, the Alabama and Georgia Medicaid programs offer only 14 optional services to Medicaid recipients, while the Wisconsin and California Medicaid programs offer 30 optional services. Currently, North Carolina's State Medicaid plan includes 23 optional services, including:

- Private duty nursing
- Dental services
- Prescribed drugs
- Diagnostic and screening services
- Mental health rehabilitation services
- Intermediate care facilities for the mentally retarded
- Hospice
- Case management
- Personal care services
- Services provided in an institute for mental disease (IMD), for person 65 and older
- Home- and community-based services provided under the Medicaid Waiver

In FY92, North Carolina expended over $600 million for optional services. Over 40 percent of expenditures for all optional services were for services provided in ICFs/MR. Expenditures for prescription drugs accounted for 24 percent of total expenditures for optional services.

In an effort to control Medicaid expenditures for optional services, states have considered reducing the number of services provided under their Medicaid state plan. Several states have recently eliminated several optional services to reduce Medicaid expenditures. For instance, Oklahoma has recently eliminated expenditures for dental and podiatry care for Medicaid recipients. Michigan discontinued rehabilitative services for substance abusers.

Many states contain health care expenditures by placing limitations on the scope of the services covered by their Medicaid programs. The service limits are intended to control inappropriate service use and, therefore, contain program costs.

Certain service limitations may provide savings in the short-term, but have the potential to shift costs to other areas in the longterm. For example:

- Limiting the number of covered physician visits can provide savings in the short-term, but can also shift the cost to emergency rooms in the longterm as recipients use the emergency room for primary care once they reach their limits for physician services.

- Limiting the number of prescriptions per recipient can provide savings in the short-term. If the limit is too stringent, people with serious prescription drug requirements may remain or become ill. The cost of treating these people will be shifted to the inpatient, outpatient and/or emergency room setting in the longterm.

When selecting service limitations, the potential consequences for health quality and cost shifting must be considered.

Service areas generally targeted for cost containing limitations include:

- Inpatient hospital days
- Outpatient hospital visits
- Physician office visits
- Prescription drugs and refills

In each of these service areas, several limitations may be applied, either by themselves or in combination. Examples of service limits for these four service areas include:

- Inpatient hospital - Length-of-stay based on diagnosis, days covered, surgical procedures covered (e.g., organ transplants, etc.)

- Outpatient hospital - Number of visits covered, non-emergent emergency room visits covered, prior authorization requirements for specific services

- Physician - Number of office, hospital, and nursing home visits covered; the types of ancillary services covered, prior authorization requirements for specific services

- Prescription drugs - Number of prescriptions covered per month, days of prescribed drug, required generic drug substitution

A review of Medicaid State Plans indicates that 13 states place a discrete limit on inpatient days. Some of the states that have day limits allow for additional days upon review (e.g., New York), others (e.g., Virginia) do not allow additional days no matter what the reason. Exhibit 2 indicates that day limits range from a low of 12 per year in Alabama to a high of 45 per year in Florida. North Carolina places no limits on the number of inpatient hospital days covered by Medicaid.

States with absolute limitations indicate that the great majority of days/recipients are covered even though such limits are in place. There is no doubt, however, that placing such limitations on inpatient hospital stays contains expenditures.

When evaluating day limits, there are two key issues for consideration. First, access to care is a concern. If day limits are placed on inpatient stays, and Medicaid recipients are in need of hospitalization, they may find it difficult to gain admission to a hospital for

EXHIBIT 2

DAY LIMITS* - INPATIENT

Alabama	12 days/year
Arkansas	25 days/year
California	30 days/year
Florida	45 days/year for all patients in a non-disproportionate share hospital are excluded from this limitation.
Kentucky	14 days per admission
Louisiana	15 days/calendar year unless prior approval is granted for additional days
Mississippi	15 days/fiscal year
New York	20 days per stay unless additional days are prior authorized
Oklahoma	20 days/fiscal year
Oregon	18 days/fiscal year unless prior authorization for additional days
Tennessee	Coverage is for duration of inpatient hospital care, however, for days exceeding 20, only 60 percent of the per diem is paid
Texas	30 days/year, an additional 30 days is allowed for organ transplants
Virginia	14 days/year

Source: Commerce Clearing House, Medicaid State Charts

* Day limits cannot apply to children covered under EPSDT.

routine admissions. Second, in the cases where individuals receive care that exceeds the day-limit threshold, the cost of that care is not reimbursed by Medicaid. Such costs are eventually shifted to other payors.

A number of states place limitations on the use of outpatient hospital visits. At the extremes, Alabama limits outpatient visits to three per year; and Ohio allows four visits per month. As shown in Exhibit 3, 12 other states fall somewhere in between. North Carolina limits ambulatory visits, including outpatient hospital physician, podiatry, optometry and chiropractry visits to 24 per State Fiscal Year. Still other states place limits only on "special" services provided in the outpatient hospital department. Connecticut, for example, pays for only one therapy visit per day.

A few states also limit coverage for emergency room services. Idaho, for example, limits emergency room visits not resulting in an inpatient admission to six per year. Louisiana limits emergency room visits to three per year. Mississippi limits emergency room visits to six per year. Some states allow additional visits in excess of the limit if medical necessity is demonstrated.

States limit physician visits in a number of ways. They place restrictions on physician office visits, on visits to patients who are hospital inpatients, and on visits to patients in nursing homes.

A number of states place limits on ambulatory visits: Alabama, Arkansas, Georgia and Kansas limit visits to 12 per year. Other states' limits range from 14 per year (New York) to one per day (Massachusetts and Mississippi). Exhibit 4 describes limitations in place.

A number of states place absolute limits on the number of prescriptions per month (Exhibit 5). Oklahoma and South Carolina, for example, allow three per month; Mississippi allows four per month; Missouri and Nevada allow five per month; Arkansas, Georgia, and Tennessee allows seven per month. Some states with limits place no limitations on recipients in nursing homes, other states implement limits, but at different (higher) levels. In addition, a number of states place limitations on the number of refills allowed; most that do place a limitation of five refills within six months.

North Carolina has set limits on physician and outpatient clinic visits and prescription drugs. Currently, North Carolina limits visits to physicians, podiatrists, optometrists, chiropractors and all clinic visits to 24 a year. Prescriptions are limited to 6 prescriptions per month including refills.

Another approach used by states to control utilization and costs is the imposition of copayments for services. Under the copayment program, patients are required to pay a portion of their costs for care, ranging from $.50 to $5 for each outpatient service. For

EXHIBIT 3

OUTPATIENT HOSPITAL VISIT LIMITS*

Alabama	3 visits/calendar year
Arkansas	12 visits/fiscal year for outpatient hospital therapy and physician visits (excludes laboratory and radiology, which have a $500 annual limit. MRI is excluded)
California	2 visits/month for outpatient hospital, podiatrist, chiropractor, P.T., O.T., speech and hearing therapy
Connecticut	1 per day for special services, i.e., P.T., O.T.
Idaho	Limits emergency room visits not resulting in an inpatient admission to 6/year
Iowa	3 visits/week for 12 weeks for cardiac rehabilitation; pulmonary rehabilitation limited to 25 treatment days
Louisiana	3 emergency room visits/year; other outpatient visits - 12/year
Mississippi	6 emergency and 6 non-emergency visits/year
Missouri	2 visits/recipient/month
New Hampshire	12 visits/year
North Carolina	24 visits/year; includes outpatient hospital, physicians, podiatrists, optometrists, chiropractors
Ohio	4 visits/recipient/month
South Carolina	18 visits/recipient/fiscal year
Tennessee	30 visits/fiscal year

Source: Commerce Clearing House, Medicaid State Charts.

* Visit limits cannot apply for children covered under EPSDT.

EXHIBIT 4

PHYSICIAN VISIT LIMITS*

Alabama	12/year, 12 additional when medically necessary during 12 covered inpatient days
Alaska	Nursing home visits limited to 1 every 30 days
Arkansas	12/year
Connecticut	Routine nursing home visits limited to 4/year
Georgia	12 visits/year, 12 nursing visits/year, 1 hospital visit/day
Hawaii	2 nursing home visits/month
Indiana	4 office visits/month or 20/year unless prior authorized
Kansas	12 visits/year; 1 hospital visit per month; 1 consultation in 60 days; 1 inpatient consultation/10 days unless medical necessity dictates otherwise
Kentucky	1 initial or extensive visit per patient in a 12 month period
Massachusetts	1 home or office visit/day; 1 nursing home visit/month; 1 inpatient hospital visit/day; one comprehensive consultation per case episode
Mississippi	1/day or 2/day; if intensive or coronary care, up to allowed hospital days
Nevada	5 visits per month, with no more than 3 visits to the same provider, unless prior authorized
New Hampshire	18 outpatient or ambulatory visits per year (excluding laboratory and radiology, which are limited to 15/year)
New Mexico	2 hospital visits/day
New York	Up to 14 physician and clinic encounters in a benefit year

Source: Commerce Clearing House, Medicaid State Charts.

EXHIBIT 4 (Continued)

PHYSICIAN VISIT LIMITS*

North Carolina	24 visits/year; includes outpatient hospital, physicians, podiatrists, optometrists, chiropractors
Oklahoma	4/month, 2/month in nursing home
South Carolina	18/year (includes outpatient hospital and physician); 1 hospital visit per physician/day; 1 nursing home visit every 30 days for level 2 patients; 1 nursing home visit every 60 days for level 1 patients
Tennessee	24 visits/fiscal year; 20 inpatient visits/year
Washington	2 nursing home visits/month, 1 hospital visit/ day
Wisconsin	1 nursing home visit/month

Source: Commerce Clearing House, Medicaid State Charts.

* Visit limits cannot apply to children covered under EPSDT.

EXHIBIT 5

LIMITS ON NUMBER OF PRESCRIPTIONS

Arkansas	6/month
Connecticut	5 refills, or 6-month supply of controlled substances
Georgia	6/month
Illinois	2 refills within 3 months
Kentucky	No more than 5 refills
Louisiana	No more than 5 refills
Maine	5 refills within 6 months
Maryland	2 refills within 100 days
Massachusetts	5 refills within 6 months
Minnesota	5 refills within 6 months
Mississippi	4/month
Missouri	5/month
Nevada	5/month
New Hampshire	5 refills within 6 months
New Jersey	5 refills within 6 months
North Carolina	6/month
Oklahoma	3/month
Oregon	6/month; 5 refills per month
South Carolina	3/month
Tennessee	7/month
Texas	5 refills within 6 months

Source: Commerce Clearing House, Medicaid State Charts

the first day of care. Recently, Vermont implemented a $50 copayment for each inpatient stay. This fee is collected by the provider and is deducted from the amount the provider receives in reimbursement from the Medicaid program. States may not impose coinsurance or deductible charges on the following Medicaid eligibles and services:

- Children under 18 (or up to 21 at the state's option)
- Services related to pregnancy
- Institutionalized individuals under certain eligibility conditions
- Emergency, family planning or hospice services

Copayments have been implemented to reduce States' share of health care expenditures by requiring recipients to share in the costs of services. The evidence is inconclusive, however, in determining whether savings accrue due to a reduction in service utilization. Twenty-four states have implemented a copayment for services provided to Medicaid recipients. Most of these states require copayments for hospital, professional, clinic visits or prescription drugs. Recently, six states have changed their copayment policy. Most of these changes were related to prescription drugs and professional visits. Most states have increased copayment amounts for prescription drugs, with some states charging as high as $4.00 per refill. One state, Vermont, added a $1 copayment for physician visits.

North Carolina has implemented copayments for several services. These services and their corresponding copayments are presented in Exhibit 6.

Finally, states can control Medicaid expenditures by implementing reimbursement methodologies which reimburse providers equitably, control annual increases to an appropriate inflation index and create incentives for appropriate utilization. Reimbursement strategies for major program areas are dealt with in subsequent issue papers.

Findings

Finding 1: Although North Carolina has experienced significant increases in Medicaid program expenditures in recent years, most of this change can be attributed to federally mandated increases in the number of Medicaid eligibles.

North Carolina has experienced significant growth in Medicaid expenditures over the last six years; however, most of this growth was due to federal program changes which increased categories of individuals that states were required to cover in their Medicaid in plan. Mandated recipients account for almost 90 percent of all Medicaid recipients in North Carolina. This is higher than other states, where mandatory groups account for only 75 percent of Medicaid recipients. These states increased the number of optional recipients under their Medicaid program. Over the last few years, however, states including Maryland, Oklahoma, and Alabama have discussed or implemented options to eliminate

EXHIBIT 6

NORTH CAROLINA CURRENT COPAYMENT PROGRAM

Service	Copayment Amount
Chiropractor Services	$1 per visit
Clinics	$3 per visit
Dental Services	$3 per service
Hospital Outpatient	$3 per service
Physician Services	$3 per service
Podiatrist Services	$2 per service
Optical Supplies	$2 per item
Optometrist	$2 per service
Prescription Drugs	$1 per prescription

optional Medicaid recipient groups to control program costs. These options would decrease optional recipients to 12-15 percent of total Medicaid recipients.

North Carolina examined the impact of eliminating optional eligibility groups in FY92. A report issued by the Department of Human Resources (DHR) indicated that eliminating optional eligibility groups would initially save the State approximately $189.6 million in state revenue. However, North Carolina chose not to eliminate optional eligibles based on the following considerations:

- Optional eligible recipients would continue to need health care. The costs for providing services of these clients would have been shifted to other payors including the State, through State-operated health facilities.

- Elimination of Medicaid as a payor would have a negative financial impact on certain providers who are dependent on Medicaid for large proportions of their service revenue.

In addition, North Carolina is a 209(b) state which has more restrictive Medicaid eligibility for SSI recipients than most other states.

The scope of optional services included in North Carolina's Medicaid State Plan is consistent with the average number of services under most state plans. Currently, North Carolina includes 23 optional Medicaid services; the national average for the number of optional services provided under all state plans is also 23.

North Carolina has considered eliminating or reducing expenditures for various optional services. In FY91, the State estimated that elimination of all optional services would result in State savings of $288 million. Despite this potential savings, North Carolina did not eliminate optional services. A DHR briefing paper cited several reasons including following:

- Reducing State funds would have cost the State over $813 million in federal matching funds. A significant amount of these federal funds were supporting State institutions or local public programs.

- Eliminating ICF/MR services would have resulted in a loss of the federal share of State ICF/MR facilities as well as funding for ICF/MR group homes. Residents in group homes would have likely sought admission to State facilities.

- Eliminating Mental Health Clinics would not have reduced the State budget because the non-federal match was provided by the local mental health authority.

- Eliminating prescription drugs would have likely resulted in more illness, more hospitalizations and institutionalizations at a significantly higher cost per recipient. Physicians may have used hospital outpatient, emergency room or even inpatient placement as a means of providing necessary drugs to their patients.

In North Carolina, 64 percent of expenditures for all optional services is for two programs: ICFs/MR and prescription drugs. Currently, the State is developing options to change the reimbursement system for private ICFs/MR and developing plans to reduce expenditures for public ICFs/MR by downsizing these facilities. The State has taken steps to reduce expenditures for prescription drugs by imposing higher copayments. Another issue paper further discusses options North Carolina may consider to reduce expenditures for prescription drugs.

North Carolina has implemented service limits to control Medicaid expenditures for several mandatory services. The current limit of 24 visits annually for outpatient clinics, physicians and other practitioners is near the median limits imposed by other states. North Carolina's limits of 6 prescriptions per month is consistent with other states limits which range from 4 to 7 a month. The North Carolina current copayment program is presented in Exhibit 7.

Finding 2: In general, the Division of Medical Assistance has accurately projected the State Medicaid budget.

The FY92 underestimate of expenditures was the first time Medicaid had a shortfall. Underestimates of the number of AFDC eligibles, the amount of long-term care covered by Medicaid and the impact of the recession were the major causes of the shortfall. In recent years, several states have experienced substantial cost overruns for similar reasons.

North Carolina DMA develops its projections based on historical costs per eligible. Other factors, including economic forecasts, infant birth data and changes in State and federal laws are incorporated into the projections. Other states use similar methodologies to estimate budgets. Approximately one-third of the states base projections on costs per recipient rather than cost per eligible. Others use more sophisticated, computer-based projection models. The accuracy of these varying methods is mixed. Virginia has historically been highly accurate using cost per recipient; others such as Maryland, have not.

Most states base projections on historical trend data. Some states, including North Carolina, supplement historical data with economic and demographic projections. States which base projections on historical data include Alabama, Arkansas, Mississippi, Kentucky and Florida. Many states which use historical data in projecting expenditures have experienced variances between actual and projected program costs. The State of Kentucky experienced shortfalls in the last two years ranging from seven to ten percent. Alabama, Arkansas and Georgia base projections on historical trend data. Arkansas has experienced projection difficulties in recent years. Arkansas, like North Carolina, is required to project program expenditures over

two-year periods.

Various departments within the State of Wisconsin develop cost projections, using various projection techniques. Department staff then compare and reconcile projections to form one projection. Kansas employs a similar, consensus-building process.

Approximately fifteen states use regression analysis or more sophisticated projection models in order to project Medicaid expenditures. Regression models develop projections by forecasting changes in variables identified to affect program costs and utilization. The State of Ohio uses regression analysis to estimate program growth. Additionally, representatives of various state agencies develop forecasts. Agency representatives then meet in order to develop expenditure projections. Other states use more sophisticated techniques to estimate caseloads. Eight states use Auto Regressive Integrated Moving Average (ARIMA), a curve-fitting model which bases projections on historical trends and past forecasting errors. Regression models are effective forecasting tools, provided accurate and reliable projections of demographic and economic data are available.

While most states use trend analysis in order to project expenditures, other states have developed models which estimate the number of eligible individuals based on economic and demographic data collected from a sample population. Data collected often includes factors such as income, size of family, employment status, sex and age.

Based on a sample survey, a microsimulation model is developed, estimates of total program costs are calculated using average cost per person, by age and sex. Microsimulation models are helpful in projecting the utilization of recently added categories of eligibles.

Considering the volatility of health care costs and the economy and the far-reaching impact of federal mandates in recent years, the DMA methodology has proven relatively accurate over the past several years. Some states, including North Carolina, face additional challenges in projecting Medicaid expenditures due to the fact that state budgets are prepared on a biannual basis. Consequently, these states must project Medicaid enrollment, service utilization and health costs over a two-year time frame.

Finding 3: North Carolina does not require a copayment by Medicaid recipients for inpatient hospital and other services, for which copayments may be applied.

Under federal law, states may require a copayment amount for any non-institutional service provided to Medicaid recipients (except those excluded under federal law). Federal law also limits the maximum copayment chargeable to a recipient based on state payment for the service.

North Carolina does require copayments on nine services. However, some states have imposed copayments on other services that North Carolina has not required such copayments for. These services include:

- Home health visits
- Inpatient hospital
- Durable medical equipment
- Personal care services

Finding 4: ***While much of the growth in the North Carolina Medicaid Program can be attributed to the increase in eligibles mandated by Federal law, reimbursement methodologies can be structured to more aggressively limit rates of increase in expenditures, as well as the overall level of expenditures.***

Additional issue papers present findings regarding reimbursement and other issues that impact the Medicaid budget in the following program areas:

- Inpatient hospital
- Outpatient hospital
- Nursing facility
- Physician and other practitioner services
- Health care for the developmentally disabled and mentally retarded
- Certificate of Need program
- Managed care
- State purchase of health services

Recommendations

Recommendation 1: ***North Carolina should develop more creative strategies for controlling Medicaid expenditures and should only eliminate eligible groups and optional services, or impose restrictive service limits, as options of last resort.***

In recent months, Medicaid agencies in other states have taken drastic measures to reduce the level of Medicaid expenditures. Eliminating eligibles and services, and imposing restrictive service limits provide short-term cost savings to state Medicaid programs. In the long-term, however, reducing or eliminating eligibles or services does not decrease the demand for services. The cost of care provided to ineligible clients may be shifted to other payors as hospitals and other providers attempt to recover the costs of uncompensated care. Eliminating services that allow individuals to remain at home would eventually increase utilization and costs of more expensive facility-based care. Finally, eliminating coverage of primary care services results in many individuals postponing care, so that eventually more expensive, institutional services are needed. Thus, expenditures for health

care may ultimately increase. By shifting costs to other payors, the State is increasing the "tab" for health care expenditures because the federal matching funds are also lost.

Developing more creative strategies for controlling Medicaid expenditures may produce the desired outcome without adversely affecting recipients or providers. One such strategy, development of a managed care program for Medicaid recipients, is discussed in a separate issue paper.

Recommendation 2: The Medicaid budget projection methodology should be enhanced by building a consensus among agency and legislative staff.

The State should develop a formal communications process among State staff in order to develop and monitor Medicaid budget projections. Currently DMA staff are meeting with the Department of Human Resources, Office of Budget Analysis staff in order to review and revise projections. Legislative staff also should be included.

Implications:

- The accuracy of budget projections will improve.
- Meetings with all involved staff will allow potential concerns to be identified early on, enabling agencies to make adjustments.
- Agencies and legislative staff are encouraged to work together to accommodate variations.

Recommendation 3: Impose copayments for inpatient hospital and other services for Medicaid recipients.

Most states that impose copayments for services include copayments for each inpatient hospitalization, home health care and durable medical equipment. Under federal law, states may impose a maximum of one-half the cost for the first day of inpatient care. Maximums for other services depend on the cost of the service. Imposing a copayment for inpatient hospital stays and other services would continue to reduce the cost to the state for inpatient hospital care and other services. Exhibit 7 provides information on services suggested for copayments, copayment levels and anticipated savings of $5.3 million for the first year.

EXHIBIT 7

NORTH CAROLINA
IMPLEMENT COPAYMENTS ON SERVICES

Service	Units (1,2)	Expenditures	Copayment	Total Copayments	State Share
Home Health	1,447,291	$19,248,973	$0.75	$1,085,468	$336,495
Hospital Inpatient - General	216,568	$233,210,516	$50.00	$10,828,400	$3,356,804
Ambulatory Surgical Center	4,104	$918,747	$3.00	$12,313	$3,817
Personal Care Services	5,830,074	$13,467,470	$0.75	$4,372,555	$1,355,492
Durable Medicaid Equipment	458,022	$5,075,487	$2.00	$916,044	$283,974
Totals				$17,214,872	$5,336,587

(1) Gross Expenditures Report 1992

(2) Units of services were based on assumption that 52 percent of utilization is attributable to children and pregnant women, who were excluded from copayments.

Implications:

- Providers would be responsible for additional billing activities for all Medicaid patients.

- Hospitals and other providers would receive reduced payment rates per Medicaid hospital visit or service if they were not able to collect the copayment for the recipient.

Cost Savings

The cost savings for alternative reimbursement strategies are discussed in other issue papers.

Imposing copayments for additional services would reduce payments to facilities and practitioners by $17.2 million. The number of units of services were based on the units of services that were provided in non-emergent situations and services that were provided to individuals who are excluded from copayments under federal law. HCFA 2082 data indicate that approximately 52 percent of all Medicaid recipients were children or pregnant women, for whom copayments cannot be assessed.

First year savings in State dollars by imposing additional copayments totalled $5.3 million. Total ten year savings equaled $73.1 million. Exhibit 8 provides additional cost savings information.

The cost savings were based on the following assumptions:

- The growth in the number of units for the next ten-years would be consistent with previous six-year growth.

- The cost per unit would increase by the average increase in cost per unit experienced over the last six years.

- The level of copayments would remain constant over the ten-year period.

Systemic solutions to control expenditures require the State to:

- Give incentives to providers to render the most cost-effective care in the most appropriate setting.

- Become more aggressive in controlling levels of expenditures for all services.

- Address the issue of the supply of services and how supply affects expenditures

EXHIBIT 8

COST SAVINGS FOR COPAYMENTS ($ MILLIONS)

Fiscal Year	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Current	$271.9	$290.9	$311.3	$333.1	$356.4	$381.6	$408.3	$436.9	$467.5	$500.0
Proposed	$254.7	$272.5	$291.6	$312.0	$333.9	$357.2	$382.2	$409.0	$437.6	$468.3
State Savings	$5.3	$5.7	$6.1	$6.5	$7.0	$7.6	$8.1	$8.7	$9.3	$9.8
Cumulative Savings	$5.3	$11.0	$16.1	$22.6	$29.6	$37.2	$45.3	$54.0	$63.3	$73.1

Notes: @ Inflation Factor Average Payment Per Recipient 1987-1992
* Based on Three Percent Savings Estimate