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NORTH CAROLINA'S MEDICAID PROGRAM: THE EFFECTS OF THE REAGAN-ERA BUDGET REDUCTIONS

KENNETH R. WING*

INTRODUCTION

Following the lead of the Reagan Administration, the 97th Congress drastically reduced federal support for virtually all domestic spending programs.¹ Social welfare programs were among the prime targets scheduled for substantial budget reductions; many were consolidated into block grants at aggregate funding far below previous levels of expenditure; others were eliminated altogether. With the exception of the politically volatile Social Security program, none were spared the impact of the Reagan-inspired funding reductions.²

While Medicaid, the federally financed, state-administered program of medical benefits for the poor,³ survived the budgetary axe, the 97th Congress imposed on the program a series of cost containing limitations.⁴ Most critically, the overall level of federal financial support was scheduled for a series of annual percentage reductions. The net effect was to reduce expected annual federal outlays for Medicaid by nearly \$1 billion beginning in FY 1981 and over \$4 billion by FY 1984.⁵

If these federal Medicaid cuts are followed in subsequent years by additional funding limitations, as prevailing economic and political trends would indicate, there is some question whether a state such as North Carolina can continue to maintain a Medicaid program as it is currently constituted. Even if federal support is stabilized, the impact of the recent federal budget reductions and program limitations will soon embroil the state government, Medicaid service providers, and

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I would like to note the contributions of my research assistants Mike Propst, Barbara Berg, and Terry Kinney.

1. Wing, *The Impact of Reagan-Era Politics on the Federal Medicaid Program*, 33 CATH. U.L. REV. 1 (1983).

2. *See id.* at 28-42.

3. 42 U.S.C. § 1396 (Supp. V 1981). *See* Wing, *supra* note 1, at 3-14.

4. 42 U.S.C. § 1396b (Supp. V 1981).

5. *See* discussion *infra* at notes 8-9.

those people who rely on Medicaid for their health and well-being in difficult legal and political controversies.

At the heart of the difficulties faced by North Carolina lies the problem of rapidly growing Medicaid cost. The total budget for administering Medicaid in North Carolina has inflated from \$94 million for FY 1971 to nearly \$600 million for FY 1983, an increase averaging over 18% a year, becoming one of the largest and most visible parts of the state's social welfare budget.⁶ Prior to the 1981 federal amendments, North Carolina was responsible for approximately 33% of this cost, the remainder being paid by the federal government.⁷ Under the terms of the 1981 amendments, the federal share of the program's cost was reduced by 3% in FY 1982, 4% in FY 1983, and 4½% in FY 1984, unless state program costs could be kept below proscribed limits.⁸ The net result was interpreted in North Carolina to require Medicaid expenditure reductions of over \$25 million in FY 1982 and nearly twice that in FY 1983.⁹

Twenty-five to fifty million dollars Medicaid budget shortfalls can be described as budgetary crises for North Carolina, particularly if juxtaposed to the additional financial burdens which have fallen on state and local government as a result of the Reagan-era domestic spending cuts, stagnating tax revenues, and comparable shortfalls in other, and arguably, more popular state spending programs. Under current circumstances, it is inconceivable that the state legislature will simply increase the state's share of Medicaid costs to fully offset the loss of federal funds. It is not even clear whether North Carolina will be willing or able to maintain its share of the annual Medicaid budget if program expenditures continue to inflate. In the next several years, the state legislature will be under considerable pressure to extract additional cost limitations from the Medicaid program to offset the state's other budgetary problems over and above those required by current or future federal funding reductions. Thus, North Carolina must address the difficult and politically volatile problem of containing the cost of the Medicaid program to meet substantial budget constraints, either by directly or indirectly reducing the program, or by attempting to provide a comparable program more efficiently. This will be no easy task.

So far North Carolina has attempted to steer a middle course between program reduction and program reform. The scope of covered services has been pared; program eligibility has not been directly reduced,¹⁰ although reductions in welfare eligibility have caused some

6. See *infra* Table II.

7. See *infra* notes 111-14.

8. See Wing, *supra* note 1, at 49-50.

9. See *infra* note 116.

10. See *infra* note 119-36.

Medicaid recipients to lose their eligibility.¹¹ The most substantial program changes have been significant revisions of the bases for reimbursement for Medicaid services, particularly inpatient hospital services.¹² North Carolina has also attempted to curtail utilization of Medicaid services by imposing a moratorium on new nursing home bed construction,¹³ and by limiting utilization of prescription drugs, clinic visits, and many other non-institutional services.¹⁴

These initial program reforms have apparently allowed the state to weather the first round of federal Medicaid funding reductions. By FY 1983, the program expenditures had been brought within politically acceptable limits, allowing the state to survive the federally-initiated crisis. Indeed, the state was able to keep program expenditures low enough to avoid the reduction in federal share required by the recent federal amendments. Whether these program changes will be sufficient to meet the fiscal problems of the Medicaid program in the long term, however, can be seriously questioned. More drastic service, eligibility, or reimbursement reductions or more substantial program reform may be required if the program costs continue to inflate or if the political and economic pressures become more critical. Furthermore, even if expenditures for Medicaid are kept within necessary limits, such cost containment measures may resolve only the immediate problems of the state budget; the consequences of these program changes on program providers and program beneficiaries may prove to be as controversial as the impact of Medicaid costs on the state budget.

This article is principally a description of the current program and the legislative and administrative changes made in response to the recent federal budget cuts, an assessment of the state's current cost containment strategy, and an analysis of the options facing North Carolina in the years to come.

I. DESCRIPTION OF THE NORTH CAROLINA MEDICAID PROGRAM

Medicaid is essentially a state-administered, partially federally financed program to underwrite medical care provided to the poor.¹⁵ Originally authorized by Congress in 1965, Medicaid has replaced the "welfare medicine" and private charity programs which were historically the primary source of medical care for the nation's poor.¹⁶ In the last two decades, the Medicaid program has provided millions of indi-

11. See *infra* note 127.

12. See *infra* notes 80-88.

13. See *infra* note 128.

14. See *infra* notes 124-25.

15. For a detailed description of the federal law, see Wing, *supra* note 1, at 3-28.

16. See historical analysis in R. STEVENS & R. STEVENS, *WELFARE MEDICINE IN AMERICA* 5-17 (1974).

gent people with access to the mainstream of American medicine.¹⁷

North Carolina has been a participant in the Medicaid program since 1970.¹⁸ The state's program has grown to provide reimbursement for a wide range of medical services¹⁹ to over 425,000 people²⁰ at a cost of nearly \$600 million a year.²¹ In 1982, as much as 10% of all medical care in the state²² and over 70% of nursing homes services²³ were fi-

TABLE I
TOTAL MEDICAID ELIGIBLES 1977-83

FISCAL YEAR	AGED	BLIND	DISABLED	AFDC	OTHER CHILDREN	TOTAL
1977	83,136	3,933	64,113	300,061	6,139	457,382
1978	82,835	3,616	62,179	300,719	6,425	455,774
1979	82,930	3,219	59,187	301,218	6,620	453,174
1980	82,859	2,878	56,265	307,059	6,641	455,702
1981	80,725	2,656	56,773	315,651	6,559	459,364
1982	70,010	2,349	48,266	298,483	6,125	425,233
1983	67,330	2,000	46,537	293,623	6,062	415,552

Adapted from DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1982-83, at 16 (1984).

17. See Wing, *supra* note 1, at 7-8.

18. Act of June 15, 1969, ch. 807, § 8, 1969 N.C. Sess. Laws 845, 855. The statutory provisions of the North Carolina Medicaid program are codified at N.C. GEN. STAT. §§ 108A-54 through 108A-65 (Cum. Supp. 1983). Note, however, that a considerable portion of the legislative direction of the program is accomplished by special instructions included in the biennial and annual appropriations acts that fund the Medicaid program, some of which are not codified. See, e.g., *infra* note 121.

The bulk of the legal authority for the Medicaid program is found in various administrative rulings and interpretations issued by the Division of Medical Assistance in the Department of Human Resources of the State of North Carolina. In addition to the program regulations (found at 10 N.C. ADMIN. CODE § 32 (1982)), the following sources should also be noted:

- (a) N.C. DEPT. OF HUMAN RESOURCES, STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT, MEDICAL ASSISTANCE PROGRAM (looseleaf; periodically updated) [hereinafter cited as STATE PLAN];
- (b) N.C. DEPT. OF HUMAN RESOURCES, MEDICAID POLICIES MANUAL (looseleaf; periodically updated) [hereinafter cited as POLICY MANUAL];
- (c) N.C. DEPT. OF HUMAN RESOURCES, ELIGIBILITY MANUAL—PART I—MEDICAL ASSISTANCE (looseleaf; periodically updated) [hereinafter cited as ELIGIBILITY MANUAL];
- (d) N.C. DEPT. OF HUMAN RESOURCES, PROVIDER REIMBURSEMENT MANUAL (looseleaf; periodically updated) [hereinafter cited as PROVIDER REIMBURSEMENT MANUAL].

19. See *infra* Table VI.

20. See *infra* Table I.

21. See *infra* Table II.

22. Estimate based on telephone interview with Susan Stone, Division of Facility Services, N.C. Department of Human Resources (October 12, 1983).

23. NORTH CAROLINA HEALTH CARE FACILITIES ASSOCIATION, NURSING HOMES IN NORTH CAROLINA 5 (1982). Experts claim that by 1983 an even higher percentage of nursing home services were paid for by Medicaid funds. Telephone interview with Craig Souza, Executive Director, North Carolina Health Care Facilities Association (October 24, 1983).

TABLE II
TOTAL PROGRAM EXPENDITURES
FISCAL YEARS 1972-1983

FISCAL YEAR	EXPENDITURES	PERCENTAGE CHANGE
1972	105,719,572	—
1973	128,631,312	21.7
1974	141,833,487	10.3
1975	184,606,164	30.2
1976	215,741,299	16.9
1977	273,338,697	26.7
1978	306,691,301	12.2
1979	379,769,848	23.8
1980	410,053,625	8.0
1981	507,602,694	23.8
1982	521,462,961	2.7
1983	570,309,294	9.4

Adapted from DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1981-82, at 10 (1983), DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1982-83, at 15 (1984), and FISCAL RESEARCH DIVISION, N.C. GEN. ASSEMBLY, A LEGISLATOR'S GUIDE TO THE MEDICAID PROGRAM 11 (1983).

nanced through the Medicaid program.

In reviewing the program and its administration in North Carolina, three points deserve particular attention. First, while the scope, size, and cost of the program reflect its importance to program beneficiaries, the limits on program eligibility, service coverage, and reimbursement should not be overlooked. Medicaid does not cover all poor people in the state; nor does it assure access to all necessary medical care or to full reimbursement for services rendered even for those who do qualify. Second, the structure of Medicaid and, in particular, Medicaid eligibility has been determined in large part by the contours of the various welfare cash grant programs to which Medicaid has been affixed. To understand Medicaid, one must have a working understanding of the eligibility standards and payment levels of the cash grant programs available in North Carolina; one must also recognize the political constraints within which welfare programs have been developed at both the state and federal levels. Third, by attempting to provide for the medical needs of the poor principally by providing financial access to mainstream medical care, Medicaid has been necessarily saddled with

many of the problems that have been endemic in medical care delivery during the last few years. The program has been heavily oriented towards expensive and institutionally-based services; it has been wedded to the inflation-inducing, fee-for-service, cost reimbursement principles followed by most private insurance schemes. Perhaps most importantly, the administration of Medicaid is at all times subject to the considerable political power wielded by private medical care providers, an observation that has particular relevance when evaluating the fiscal problems of the program and the prospects for program reform.

The following summary of the Medicaid program and its administration in North Carolina will illustrate these problematic characteristics in greater specificity.

A. *Medicaid Eligibility*

As required by federal law,²⁴ North Carolina offers Medicaid benefits to people defined as "categorically needy."²⁵ This includes all people who receive Aid to Families with Dependent Children (AFDC),²⁶

24. See 42 U.S.C. § 1396a(a)(10)(A) (Supp. V 1981); see generally Wing, *supra* note 1, at 16-26.

25. Roughly speaking, "categorically needy" includes all welfare cash grant recipients (except some SSI and SCSA recipients as explained *infra* note 27) and a few other categories of people that the state is either required or has chosen to treat as "categorically needy." See Wing, *supra* note 1, at 8; see also 42 C.F.R. §§ 435.110-.135 (1982). That is to say, the state is required to offer Medicaid to certain categories of people (the "mandatory eligibles"), but has the option to treat additional people *as if* they were within these categories. Thus, the terms "categorically needy" and "mandatory eligible" are not perfectly synonymous.

Those additional categories currently included as "categorically needy" in North Carolina are described in the ELIGIBILITY MANUAL, *supra* note 18, §§ MA-2300 to -2332 and in the STATE PLAN, *supra* note 18, at Attachment § 2.2-A. Examples include: 1) children who are wards of public agencies or in nursing homes (the so-called "reasonable classifications" under the discretion allowed by 42 C.F.R. § 435.222(b) (1982)); 2) *individuals* who were "grandfathered" into "categorically needy" eligibility (*e.g.*, "essential spouses") because of their Medicaid eligibility prior to 1974; 3) some people who would be eligible for cash grant assistance *but* for a Social Security cost-of-living increase; 4) recipients of state supplemental cash grants.

Parenthetically, because "categorically needy" recipients are in large part determined by their relationship to a welfare program, the terms AFDC-MA (medical assistance to AFDC recipients), AABD-MA or AA-MA, AB-MA and AD-MA (medical assistance to aged, blind, or disabled welfare recipients) are frequently used to describe categorically needy recipients. See ELIGIBILITY MANUAL, *supra* note 18, § MA-2150.

26. ELIGIBILITY MANUAL, *supra* note 18, § 2300. AFDC is a state-administered welfare cash grant program for families with dependent children. See N.C. GEN. STAT. §§ 108A-27 to -39 (Cum. Supp. 1983). For a description of the AFDC program, see 10 N.C. ADMIN. CODE § 31 (1982).

Note that under North Carolina law, "families with dependent children" includes only those families with a single parent or guardian. See N.C. GEN. STAT. § 108A-28 (Cum. Supp. 1983). "Dependent children" includes children under the age of 18 or 18 years old if a full time student. See 10 N.C. ADMIN. CODE §§ 31C.0101, .0201 (1982). For a full description of AFDC eligibility, see 10 N.C. ADMIN. CODE § 31C (1982).

most people who receive Supplemental Security Income (SSI),²⁷ and recipients of other state cash assistance programs.²⁸ North Carolina also opts to provide Medicaid benefits to people defined as "medically needy."²⁹ Those individuals who would qualify for any of the federal

27. SSI is a federally administered program for the indigent blind, aged or disabled. See 42 U.S.C. §§ 1381-1383 (1976 & Supp. V 1981). The SSI program was enacted by the Social Security Amendments of 1972, Pub. L. No. 92-603, § 301, 86 Stat. 1329, 1465-84 as a replacement for the Old Age Security (OAS), Aid to the Blind (AB), and Aid to the Totally Disabled (ATD) welfare programs. Most states extend Medicaid eligibility to all people who are eligible for SSI. However, states are allowed the option of either providing Medicaid to all SSI recipients or applying eligibility standards for those people who are blind, disabled, or that are *no more* restrictive than those applied for the pre-1973 OAS, AB, or ATD welfare programs. See 42 U.S.C. § 1396a(f) (1976). States so opting are called "209(b) states." See Pub. L. No. 92-603, § 209(b), 86 Stat. 1329, 1381 (1972). See also Wing, *supra* note 1, at 8-10.

North Carolina has chosen the restrictive option of applying the pre-1973 income and resource standards for determining AABD-MA, thereby excluding some SSI recipients from automatic Medicaid eligibility. These excluded SSI recipients may become categorically needy by incurring medical expenses in the amount that their incomes exceed the allowable income standard. See 42 C.F.R. § 435.121 (1982); ELIGIBILITY MANUAL, *supra* note 18, §§ MA-2320, 2329. By choosing this more restrictive option, North Carolina has also "grandfathered" some people into the program who have continuously received Medicaid as "essential spouses" since December 1973, but who would not be SSI eligible. See ELIGIBILITY MANUAL, *supra* note 18, § MA-2300.

Note that for purposes of determining Medicaid eligibility, the SSI cash grant is not considered income. See 10 N.C. ADMIN. CODE § 32G (1982). Thus, most SSI recipients are below the pre-1973 income standards and are "categorically needy."

28. See ELIGIBILITY MANUAL, *supra* note 18, § MA-2300. Almost all recipients of State-County Special Assistance (SCSA) and Special Assistance to the Blind (SAB) are considered "categorically needy." SCSA is a state and local program designed to provide support to financially needy aged and disabled people beyond the federal SSI payments. N.C. GEN. STAT. §§ 108A-40 to -47 (Cum. Supp. 1983); 10 N.C. ADMIN. CODE § 33 (1982). When the SSI program was implemented on January 1, 1974, the states were required by federal law to supplement the cash payments of those who had received Aid to the Aged or Aid to the Disabled in December 1973 in order to ensure that no one would receive less money under the new program. All persons receiving this mandatory supplementation are eligible for Medicaid. In addition, North Carolina opted to supplement the income of those financially needy aged or disabled persons who were not receiving Aid to the Aged or Disabled prior to January 1, 1974, and who are residents of domiciliary care facilities. These recipients are also eligible for Medicaid. SCSA payments are also made to disabled adults less than 65 years old, who do not meet SSI's definition of disabled, and who are not in domiciliary care facilities. These recipients are not eligible for Medicaid. See 10 N.C. ADMIN. CODE §§ 33A, 33B, 33N (1982). In fiscal year 1982, there were 10,668 recipients of SCSA receiving an average monthly payment of \$209.61. Telephone interview with Debra Tutor, North Carolina Department of Human Resources, Division of Social Services (June 8, 1983).

The financially needy blind are also eligible for cash supplements and for Medicaid. See N.C. GEN. STAT. §§ 111-13 to -35 (1978 & Cum. Supp. 1983); 10 N.C. ADMIN. CODE § 19E.0101 (1982); ELIGIBILITY MANUAL, *supra* note 18, § MA-2445 V.B.(1). In the last quarter of FY 1983, an average of 278 persons received an average monthly payment of \$226.80 under the SAB program. Interview with Debra Tutor *supra*.

29. See STATE PLAN, *supra* note 18, at Attachment § 2.2-A; see also Wing, *supra* note 1, at 8. States are given the option of maintaining a medically needy program, see 42 U.S.C. § 1396a(a)(10) (Supp. V 1981), and a number of states do not extend their programs to cover such people. See HEALTH CARE FINANCING ADMINISTRATION, HHS, THE MEDICARE AND MEDICAID DATA BOOK, 1981, at 70 (1982) [hereinafter cited as 1981 HHS DATA]. As a "209(b) state", see *supra* note 27, North Carolina is required to allow any aged, blind or disabled individual to become "categorically needy" by incurring enough medical expenses to offset that amount of income above the income standard. See 42 C.F.R. § 435.1(d) (1982). See generally 1981 HHS DATA, *supra*, at 71. Although this requirement is sometimes interpreted as a requirement for a

cash grant programs except for their income or other financial resources³⁰ can become "medically needy" if they incur medical expenses or "spend down"³¹ their excess income or resources.³² Thus Medicaid is limited to people who fall into one of the four federal welfare categories—the blind, the disabled, the aged, or families with dependent children—and who are either receiving welfare benefits or who are extremely poor. Table III summarizes the stringent income and resource ceilings on both the categorically needy and medically needy in North Carolina.³³

medically needy program, coverage of medically needy is an option for "209(b) states." See 42 C.F.R. § 435.330 (1982).

Speaking in rough terms, the medically needy are all those people who fall into one of the categories of people defined as "categorically needy" (with some minor exceptions; e.g., pregnant women can be "medically needy" but can not be "categorically needy") but who are ineligible because they fail to meet the income or resource standards of "categorically needy." Note that the federal law, particularly after the 1981 amendments, gives states considerable flexibility in defining additional standards of eligibility for the medically needy. See Wing, *supra* note 1, at 50-51. Thus far, however, North Carolina has not opted to limit the definition of "medically needy" in any substantial way.

30. E.g., those blind, aged, disabled, or families with dependent children who exclusive of SSI or SCSA payments have incomes above their categorically needy income levels. See *infra* Table III. For a general explanation of medically needy eligibility, see ELIGIBILITY MANUAL, *supra* note 18, §§ MA-2360 to -2387.

31. The application of the "spend down" concept is more complicated than it initially appears. Basically, a person with income and resources exceeding the financial standards for "categorically needy" can qualify for Medicaid (as "medically needy") after incurring sufficient medical expenses, i.e., the "spend down" liability. The amount of this liability is determined by computing net income (as described *infra* note 33) and subtracting the medically needy income standard. See *infra* Table III. Then incurred medical expenses are subtracted from this liability in the following order: health insurance premiums, including Medicare Part B premiums and cost-sharing charges; then necessary medical care not covered by Medicaid; and then services covered by Medicaid. See 42 C.F.R. § 435.831(c) (1982). Once the "spend down" is exceeded, see example *infra* notes 42-43, the applicant becomes "medically needy" and is eligible for all subsequent covered medical expenses for the remainder of the applicable time period. In North Carolina, the applicant must satisfy the "spend down" every six months, except for recipients who are residents of long term care facilities for whom it is done monthly. See 10 N.C. ADMIN. CODE §§ 32L.0101, 32K.0201 (1982).

32. For a summary of the current income and resource standards for the medically needy, see Table III.

Note that the federal law generally requires that the medically needy income level be within 133% of the AFDC income level and no lower than the lowest of the cash grant income levels. 42 C.F.R. §§ 435.811(c)-812(b)(2) (1982). Thus, North Carolina has set the medically needy level at the maximum allowed by federal law. Note also that the federal law allows the state to use different standards for the different categories of medically needy, but that North Carolina uses the same standards for all medically needy groups.

It is also important to note that even though North Carolina uses the maximum allowed level for medically needy eligibility, this is still an extremely low ceiling, as evidenced by the fact that relatively few people "spend down" to Medicaid eligibility. See *infra* note 44 and accompanying text.

33. The ceilings set out in Table III are net figures. Certain kinds of income are disregarded or excluded. 10 N.C. ADMIN. CODE § 32G.0700 (1982); ELIGIBILITY MANUAL, *supra* note 18, §§ MA-2318, -2336, -2367, -2377, -2386, -2470. Similarly, certain kinds of property are also excluded from the resource limits; there are, as well, restrictions on transfer of assets by applicants or

TABLE III
MEDICAID ELIGIBILITY STANDARDS FOR
INCOME AND FINANCIAL RESOURCES
(1983)

MAXIMUM ALLOWABLE ANNUAL INCOME
[excluding disregards]

<u>Family Size</u>	<u>Categorically Needy-AFDC</u>	<u>Other Categorically Needy</u>	<u>All Medically Needy</u>
1	\$1,608	\$1,700	\$2,200
2	2,112	2,200	2,900
3	2,424	2,500	3,300
4	2,652	2,800	3,600
5	2,904	3,000	3,900

MAXIMUM ALLOWABLE RESOURCES [after exclusions]

<u>Family Size</u>	<u>All Categorically Needy</u>	<u>Medically Needy AFDC</u>	<u>Other Medically Needy</u>
1	\$1,000	\$1,500	\$1,000
2	1,100	2,250	1,100
3	1,150	2,350	1,150
4	1,200	2,450	1,200
5	1,250	2,550	1,250

Adapted from Division of Medical Assistance, N.C. DEPT. OF HUMAN RESOURCES, MEDICAID IN NORTH CAROLINA: ANNUAL REPORT 1981-82, at 5 (1983); Act of July 15, 1983, ch. 761, § 60(5), 1983 N.C. Sess. Laws 790, 820.

The specific definition of these categories and the additional eligibility criteria that must be met by Medicaid recipients are extremely complicated and difficult to summarize. The criteria and the methods for applying them vary among the categories of recipients, reflecting the

recipients. 10 N.C. ADMIN. CODE §§ 32F.0100-.0200 (1982); ELIGIBILITY MANUAL, *supra* note 18, §§ MA-2316, -2326, -2335, -2365, -2375, -2385, -2455, -2460.

Note that in determining net income, federal law requires the exclusion of SSI income, income from the state supplement program, and (some) Social Security cost-of-living increases. *See* 42 C.F.R. §§ 435.134, .135, .831 (1982). In effect, federal law parallels the requirements for determining AFDC and SSI eligibility. *See* 42 C.F.R. § 435.845 (1982).

In determining net income and resources, North Carolina follows the various requirements of federal law, *see* STATE PLAN, *supra* note 18, at Attachment § 2.6-A, plus exercises its option to allow additional exclusions for Medicaid eligibility. *See* STATE PLAN, *supra* note 18, at Attachment § 2.6-A & Supplements III, IV, V.

Note that there are slightly different standards and methods for calculating net income for people who are residents of nursing homes. *See* ELIGIBILITY MANUAL, *supra* note 18, §§ MA-2319A, -2329A, -2338, -2369, -2379, -2388.

patchwork nature of the cash grant programs, and Medicaid's linkage to the "deserving poor only" traditions of American welfare programs. It is virtually impossible for anyone outside of the state Medicaid bureaucracy—as well as for some within—to sort through the property and income valuation rules,³⁴ work incentives,³⁵ family unit definitions,³⁶ or other determinants of eligibility and confidently assess eligibility in a particular case or to delineate the entire Medicaid population with any specificity.

The following illustrations should serve as an outline of those eligibility for Medicaid in North Carolina.

—A single parent with three children and no other income would qualify for an AFDC cash grant of \$221 per month as of January 1984³⁷ and all four members of the family would be automatically eligible for Medicaid as categorically needy.³⁸

—A disabled person with no income would qualify as an SSI recipient and as of January 1984 would receive a cash grant of \$284 per month.³⁹ Since SSI income is disregarded for purposes of determining Medicaid eligibility, such a person would be categorically needy and automatically receive Medicaid eligibility upon application.⁴⁰ However, if such a person were to receive \$200 in monthly income, for example, Social Security Disability payments or by holding a low paying job, they would not be automatically eligible for Medicaid, but would have to "spend down" \$100 of income (and any excess resources) during a six month period before receiving Medical eligibility as medically needy for the remainder of the six month period.⁴¹

—A married couple, both over age sixty-five, with a combined monthly Social Security retirement payment of \$400 would not be eligible for Medicaid; if one spouse needed long term care in a nursing home, he or she could spend down to become "medically needy."⁴² However, the excess income and resources that must be spent on medical care would include all of that spouse's available income and liquid

34. See, e.g., extended discussion in ELIGIBILITY MANUAL, *supra* note 18, § MA-2460 relating to valuation of life insurance policies, home sites, personal effects, etc.

35. See, e.g., *id.*, §§ MA-2377 to -2470; or 10 N.C. ADMIN. CODE §§ 32F.0202-.0206 (1982) (work related travel expenses, exempted income, etc.)

36. See 10 N.C. ADMIN. CODE § 32G.0200-.0600 (1982); ELIGIBILITY MANUAL, *supra* note 18, § MA-2329 or § MA-2335.

37. See *supra* Table III.

38. 42 C.F.R. § 435.110 (1982); 10 N.C. ADMIN. CODE § 31K.0102(a) (1982).

39. 47 Fed. Reg. 20,863 (1982).

40. See *supra* note 29.

41. Such a person would have a six-month income of \$200 × 6 or \$1200. The upper limit on "medically needy" eligibility is \$2,200 annually or \$1100 for six months. Hence, the individual would have to spend the difference between \$1200 and \$1100 before eligibility would begin.

42. See ELIGIBILITY MANUAL, *supra* note 18, §§ MA-2375, -2378.

assets subject to only narrowly defined exceptions.⁴³

Obviously, the Medicaid population is limited to the very poor and those linked to the welfare categories. Many adults, some families, and many low income people are excluded by the income, resources, and non-financial eligibility criteria, as well as by the categorical-linkage requirements. Even the allowance for "spending down" income and resources broadens Medicaid eligibility only slightly. Since medically needy eligibility levels are extremely low, only a very small portion of the working poor can actually "spend down" to medically needy levels. Of the 350,000 people who received Medicaid benefits in North Carolina in 1983, only 55,000 were medically needy, although they accounted for 40% of program expenditures.⁴⁴ And while the income and resource criteria for both the medically needy and categorically needy have been periodically raised, they have not been generously expanded, particularly in recent years, and certainly not at a rate comparable to that of inflation. Consequently, the contours of Medicaid eligibility requirements define a safety net that catches only those whose circumstances and poverty make their need for coverage extremely compelling.

Given these limitations, it should not be surprising that the Medicaid population has not been expanding. As Table I indicates, the Medicaid population has been relatively stable, at least since 1977, even at a time when the state population has been increasing.⁴⁵ Moreover, total Medicaid eligibles actually declined following the most recent welfare

43. Under prior state law, the resources and income of the non-institutionalized spouse also had to be "spent down." See Act of June 7, 1979, ch. 838, § 24, 1979 N.C. Sess. Laws 1112, 1131. This practice, known as "deeming," has been the subject of two recent Supreme Court cases as well as a federal district court case in North Carolina. *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981); *Herweg v. Ray*, 455 U.S. 265 (1982); *Foard v. Gibson*, No. 78-319 (W.D.N.C. March 27, 1979). In *Schweiker*, the Supreme Court was asked to decide the constitutionality of federal Medicaid regulations that authorized "deeming" in § 209(b) states such as North Carolina. The Court held that the secretary of HHS had "properly exercised the authority delegated by Congress in promulgating regulations permitting 'deeming' of income between spouses in § 209(b) States." 453 U.S. at 49-50. In *Herweg*, the Supreme Court similarly upheld the propriety of "deeming" in states that had not opted for § 209(b) eligibility. Nonetheless, the political controversy has not ended because HHS has not—as of Sept. 1983—issued regulations fully clarifying current federal policy. See 47 Fed. Reg. 31,899 (1982).

The practice of "deeming" had been suspended pursuant to a district court injunction issued in *Foard*. Although the Supreme Court subsequently held "deeming" constitutional, and the federal administration apparently allows it, North Carolina has done two somewhat contradictory things. First, it has codified a 180 day "deeming" requirement applicable to Medicaid, as well as other social services programs. Act of April 27, 1981, ch. 275, § 1, 1981 N.C. Sess. Laws 239, 255 (codified at N.C. GEN. STAT. § 108A-61 (Cum. Supp. 1983)). However, in the 1983 appropriations bill, it—at least temporarily—prohibited "deeming" for purposes of Medicaid eligibility during the coming fiscal year. See Act of July 15, 1983, ch. 761, § 60(6), 1983 N.C. Sess. Laws 790, 820.

44. See *infra* Table IV & note 52.

45. Note that these figures represent eligibles, presumably those people who have been issued Medicaid cards. The number of recipients is usually much lower. See *infra* Table IV for comparison of eligibles to recipients.

TABLE IV
COST PER RECIPIENT CATEGORY FY 1983

	Number of Recipients	Total Cost of covered services	Cost Per Recipient
All categorical eligible*	298,434	\$286,527,960	\$ 960.10
All medically needy*	55,407	\$196,309,714	\$3,543.05
AFDC			
—child	150,936	\$ 60,396,454	\$ 400.15
—adult	93,990	\$ 74,064,261	\$ 788.00
AB	2,395	\$ 5,700,082	\$2,379.99
AD	53,113	\$185,275,937	\$3,488.34
AA	82,934	\$223,641,239	\$2,696.62
Other child	6,794	\$ 17,914,617	\$2,636.83
Total	353,841	\$566,992,590	\$1,453.22

Adapted from DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1982-83, at 13 (1984). (Excludes cost of administration and other non-service expenditures).

* 1982 figures adapted from FISCAL RESEARCH DIVISION, N.C. GEN. ASSEMBLY, A LEGISLATOR'S GUIDE TO THE MEDICAID PROGRAM 7 (1983).

and Medicaid changes.⁴⁶ It should be noted as well that available data on utilization of services by Medicaid eligibles indicates that the total number of Medicaid recipients (eligibles who receive Medicaid services) has also been declining over the last several years, both in terms of the aggregate number of Medicaid recipients and the number of recipients of major categories of services, with the exception of recipients of ICF-MR services.⁴⁷ Thus, the growth in the aggregate cost of the Medicaid program in recent years cannot be attributed to expanding or inflating eligibility criteria or to a growing Medicaid population, an observation that has obvious significance for the formulation of cost containment strategies.⁴⁸

Another observation which has significance for the current political debates is that Medicaid benefits, by their nature, are not evenly distributed across the Medicaid population. The annual cost per recipient varies considerably by eligibility category, as Table IV shows.⁴⁹ As

46. See *supra* Table I. The total eligibles was lower in 1982 than in 1981, the year of the most recent changes.

47. See *infra* note 50 and Table IX.

48. See discussion *infra* at notes 149-51.

49. Comparable statistics have been reported throughout the history of the program. See,

TABLE V
COST PER RECIPIENT FOR MAJOR SERVICES FY
1981

TYPE OF SERVICE	NUMBER OF RECIPIENTS	AVERAGE SPENT PER RECIPIENT
INPATIENT HOSPITAL	80,866	\$ 1,651.98
OUTPATIENT HOSPITAL	164,879	91.11
MENTAL HOSPITAL	922	8,087.62
SKILLED NURSING HOME	13,022	5,560.70
INTERMEDIATE CARE-GENERAL	13,072	6,063.79
INTERMEDIATE CARE- MENTALLY RETARDED	2,268	26,727.47
PHYSICIAN	268,498	137.35
PRESCRIPTION DRUGS	268,799	128.71
DENTAL	104,847	138.02
SCREENING	56,669	31.65
CLINICS	33,101	277.97
FAMILY PLANNING	29,170	113.59
HOME HEALTH	3,515	623.74
RURAL HEALTH	12,408	56.86
OTHER PRACTITIONERS	48,993	35.38
LABORATORY AND RADIOLOGY	77,921	33.07

Source: DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1980-81 (draft edition) (1982) (more recent data not available).

would be expected, expenditures for recipients who are blind, aged, or disabled, people who are likely to have frequent and serious medical needs, are much higher than expenditures for those who are members of families with dependent children. In FY 1983, for example, disabled recipients represented only 13% of the total Medicaid recipient population in North Carolina, yet they accounted for over 33% of the cost.⁵⁰ On the other hand, families with dependent children were 65% of the Medicaid population, but accounted for only 28% of the cost.⁵¹ For similar reasons, expenditures for recipients who are medically needy are almost four times as great as those for the categorically needy.⁵²

e.g., DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1979-80, at 9 (1981).

50. See also *infra* Tables VII & VIII.

51. *Id.*

52. The most obvious explanation for this is that medically needy individuals only become eligible at the time they incur medical expenses—and “spend down” to eligibility. Some categori-

Moreover, some specific groups of recipients, literally some few thousand individuals, are responsible for a considerable portion of total Medicaid costs. In FY 1981, as indicated on Table V, less than 2300 recipients, recipients of ICF-MR services, were responsible for over \$80 million in costs, almost 15% of the program expenditures.⁵³

While the proportionate share and utilization figures cited above may initially attract the attention of those seeking ways to cut Medicaid costs, the primary significance of these figures should not be ignored. The fact that some individuals, *e.g.*, the institutionalized mentally retarded or the elderly person in need of long term care, are extremely "costly" only underlines their relative need for medical care and their dependence on Medicaid's financial assistance to finance that care. Simply put, some program beneficiaries are more costly to the program because their needs are greater. While the cost of the services they require may be becoming more expensive, as will be discussed in the next subsection, there does not appear to be any eligibility category that has become more expensive because the number of eligibles has been expanding, at least in recent years, with the exception of recipients of ICF-MR services.⁵⁴

The above description of Medicaid eligibility hardly builds a strong argument for a reduction or direct limitation of eligibility in North Carolina as the proper response to the need to control overall program costs. To the contrary, given the somewhat patchwork nature of the current eligibility criteria and the medical needs of the state's poor, strong arguments could be made that the present criteria should be expanded, or at least that the financial criteria should be periodically extended to keep pace with inflation.⁵⁵ How politically feasible such arguments would be under current circumstances is a separate question. It is not surprising, however, that the state legislature has declined to make any direct eligibility reductions or to otherwise change the criteria for Medicaid eligibility in North Carolina even under the considerable pressures to reduce program costs that the state has recently been forced to address.⁵⁶

cally needy individuals, on the other hand, may never use their Medicaid cards, thus lowering the per recipient average cost.

53. Even this figure is understated as it does not include physician and other services to these recipients. See also DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, STATISTICAL REPORT ON MEDICAL CARE: RECIPIENTS, PAYMENTS, AND SERVICES A18 (1982). See discussion of ICF-MR services, *infra* note 150.

54. See *infra* notes 147-51.

55. For a discussion of the inadequacy of North Carolina cash benefit and Medicaid income levels, and a comparison to estimated poverty levels, see OFFICE OF ECONOMIC OPPORTUNITY, N.C. DEPT. OF NATURAL RESOURCES, THE CHANGING FACE OF POVERTY (1983).

56. See discussion *infra* notes 115-36.

TABLE VI
SERVICES PROVIDED ALL MEDICAID RECIPIENTS
AS OF 1983

MANDATORY	OPTIONAL
Hospital inpatient	Prescribed drugs
Hospital outpatient	Chiropractors
Lab and X-ray	Dental
Skilled nursing facilities, over age 21 (SNF)	Intermediate care facilities (ICF)
Home health	Intermediate care facilities for the mentally retarded (ICF- MR)
Early and periodic screening, diagnosis and treatment (EPSDT) (for people under 21)	Clinics
Family planning	Optical supplies
Physicians	Optometrists
Hearing aids for children	Skilled nursing facilities, under age 21 (SNF)
Rural health clinics	Podiatrists
Transportation (ambulance)	Mental health facilities, over age 65
Nurse midwife (categorically needy only)	Psychiatric facilities, under age 22
	Specialty hospitals
	Physical therapy
	Occupational therapy
	Dentures
	Eye glasses
	Prosthetic devices

Source: Adapted from DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1981-82, at 6 (1983).

B. Service Coverage

By opting to participate in Medicaid, North Carolina must offer a specified range of services to the categorically needy.⁵⁷ Federal law has always permitted states some discretion in determining the scope of services offered to the medically needy,⁵⁸ and the recent Reagan-inspired budget cuts expanded this discretion considerably.⁵⁹ Nonetheless, North Carolina covers the same services for both groups and has

57. 42 C.F.R. § 440.210 (1982).

58. See explanation in Wing, *supra* note 1, at 10.

59. *Id.* at 50-52.

gone beyond the federal requirements, offering extended coverage for both the categorically needy and the medically needy.⁶⁰ The services covered as of January 1984 are outlined in Table VI.⁶¹

The coverage of these services is limited in certain regards. Only those services considered to be "medically necessary" are reimbursable.⁶² Prior approval is required from the state Medicaid agency for many services.⁶³ Some inpatient hospital expenses are excluded.⁶⁴ As of 1984, outpatient, physician, and other professional services are limited to a total of twenty-four visits a year (with some exceptions);⁶⁵ and recipients are limited to six prescription drugs per month.⁶⁶ Recipients are also required to make co-payments as a condition of coverage for some services.⁶⁷

The program does not cover routine physical examinations, most forms of preventive care, or personal care services. Even with these

60. See STATE PLAN, *supra* note 18, § 3, at 19-31.

61. For a broader discussion of these services and of the various limitations on the services covered, see *id.* § 3.1-A.1.

62. The POLICY MANUAL, *supra* note 18, sets out a list of services that are either only covered under certain conditions, *e.g.*, abortions are covered only when medically necessary; or that have been determined to be "unnecessary", *e.g.*, incidental appendectomies. See Medical Policy No. 10 & Medical Policy No. 35.

63. *E.g.*, SNF services for people under 22, ICF-MR services, services to people over 65 in mental institutions, eye glasses, non-emergency dental care require prior approval. For a full list, see STATE PLAN, *supra* note 18, at Attachment § 3.1-A.1.

64. *Id.* at Attachment § 3.1-A.1(1).

65. *Id.* at Attachment § 3.1-A.1(2). See *infra* note 134.

66. *Id.* at Attachment § 3.1-A.1(12a)(3). See *infra* note 135.

67. Historically, the federal law has strictly limited the imposition of cost-sharing requirements on Medicaid beneficiaries, although the recent federal amendments expanded the states' authority in this regard. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 131b, 96 Stat. 324, 367-70 (codified at 42 U.S.C. § 13960 (1982)). See also Wing, *supra* note 1, at 68.

North Carolina requires both categorically needy and medically needy Medicaid beneficiaries to share in the cost of some optional services.

(a) Medically needy:	\$2.00 per inpatient hospital day for first 30 days, up to 1/2 the cost of one day service
	\$1.00 per outpatient hospital service
	\$1.00 per physician visit
	\$1.00 per optometrist visit
	\$.50 per chiropractic visit
(b) Categorically needy and medically needy:	\$2.00 per dental visit (people over 21)
	\$.50 per prescription drug
	\$1.00 per clinic visit
	\$2.00 for optical supplies and services

In all cases, the following exceptions are applied (as required by federal law): no co-payment shall be required for services related to pregnancy, family planning, some nursing home services, EPSDT services, Medicare covered services, emergency services, or for children under 18 years of age. See STATE PLAN, *supra* note 18, Attachment §§ 4.18A, 4.18C, at 1-3.

exceptions and limits, however, North Carolina has been generous in its definition of services covered, at least when compared to other states in the Southeast, and has not opted to fully exercise its discretion to limit coverage, impose serious durational or maximum utilization limits, or require substantial cost-sharing on Medicaid recipients. From a beneficiary's point of view, the range of services covered and the cost sharing requirements compare favorably with private health insurance schemes.

While the program's coverage includes a wide range of services, the actual expenditures reflect the heavy orientation of Medicaid's coverage towards institutionally-based medical services. As shown in Table VII, the largest single expenditure in the Medicaid budget in FY 1983 was for inpatient hospital services. However, skilled and intermediate care nursing home services of all types taken together accounted for almost 50% of the Medicaid budget, exclusive of physician services, prescription drugs, and other services rendered to patients in nursing home settings. Services of individual physicians and other primary care providers represented only about 10% of the program in FY 1983, although this percentage may be misleading as physicians control access to other services and therefore affect the expenditure of a much larger share of the Medicaid budget. Dental services, clinic visits of all types, family planning, and the variety of other services covered by Medicaid represent only a small percentage of the Medicaid dollar. Clearly, the Medicaid budget is in large part devoted to two categories of services: expensive, institutionally based medical care, and long term institutionalization of the elderly and the handicapped. These figures reflect national trends both for Medicaid programs⁶⁸ and for the public at large.⁶⁹

The most telling statistics concerning services rendered under the Medicaid program, however, and those most relevant to cost containment strategies are those reflecting changes from year to year, and those reflecting patterns of utilization as well as expenditures of funds. As Table VII indicates, the relative share of the program devoted to the major service categories has fluctuated during the last several years as the overall cost of the program has been expanding. The substantial share of the program devoted to hospital services had been fairly stable until the last several years when it began declining.⁷⁰ A similar pattern has been followed for physician services.⁷¹ On the other hand, the per-

68. 1981 HHS DATA, *supra* note 29, at 24-35.

69. Gibson & Waldo, *National Health Expenditures, 1980*, 3 HEALTH CARE FINANCING REV. 1, 1-10 (1981).

70. For earlier years, see FISCAL RESEARCH DIVISION, N.C. GEN. ASSEMBLY, A LEGISLATOR'S GUIDE TO THE MEDICAID PROGRAM 11 (1983) [hereinafter cited as LEGISLATOR'S GUIDE].

71. *Id.*

TABLE VII
COMPARISON OF MEDICAID COSTS OF PROGRAM
1978-1983

Type of Service	FY 1983 Cost/Percent (in millions)	FY 1981 Cost/Percent (in millions)	FY 1978 Cost/Percent (in millions)
INPATIENT HOSPITAL	\$161.0 (28.2%)	\$133.6 (27.5%)	\$83.2 (30.0%)
OUTPATIENT HOSPITAL	17.1 (3.0%)	15.0 (3.1)	9.9 (3.6)
MENTAL HOSPITAL	9.6 (1.7%)	7.5 (1.5)	10.2 (3.7)
SKILLED NURSING HOME ..	96.1 (16.9%)	72.4 (14.9)	39.5 (14.3)
ICF-GENERAL	92.0 (16.1%)	79.3 (16.3)	44.6 (16.1)
-MENTALLY RETARDED	85.3 (15.0%)	60.6 (12.5)	19.8 (7.2)
PHYSICIAN	37.7 (6.6%)	36.9 (7.6)	28.5 (10.3)
PRESCRIPTION DRUGS	35.5 (6.2%)	34.6 (7.1)	26.7 (9.6)
DENTAL	11.9 (2.1%)	14.5 (3.0)	3.2 (1.2)
BUY IN MEDICARE	6.8 (1.2%)	8.4 (1.7)	7.7 (2.8)
SCREENING	1.7 (.3%)	1.8 (0.4)	1.3 (0.5)
CLINICS	6.4 (1.1%)	9.3 (1.9)	4.7 (1.7)
FAMILY PLANNING	2.7 (.5%)	3.3 (0.7)	1.5 (0.5)
HOME HEALTH	2.9 (.5%)	2.2 (0.5)	0.7 (0.3)
OTHER	- -	7.1 (1.5)	4.6 (1.7)

Adapted from DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1982-83, at 11 (1984); DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1981-82, at 16 (1983), and MEDICAID 1978-1979: AN ANNUAL REPORT AT MEDICAL ASSISTANCE FOR LOW-INCOME RESIDENTS IN NORTH CAROLINA, 6 (1980).

centage share of the program dollar spent on nursing home services of all kinds and, particularly, ICF-MR services has been increasing.⁷²

The exact causes of these shifts in proportionate share of program costs are not clear—although of obvious importance. Public data on utilization are sparse, particularly data that identifies utilization of particular service categories by various recipients. Additionally, all such data are difficult to interpret. Tables VIII and IX attempt to link various increases and decreases in program cost to the number of recipients and their utilization of services. Table IX, in particular, shows a decline in the number of people receiving inpatient hospital and long term care both in FY 1983 and over the previous five years. The exception, again, is ICF-MR recipients, who have continued to increase in number.

72. *Id.*

TABLE VIII
EXPENDITURES FOR SELECTED MAJOR SERVICES
BY PROGRAM CATEGORY FOR FISCAL
YEAR 1983

TYPE OF SERVICE	TOTAL	AGED	BLIND
INPATIENT HOSPITAL	\$161,032,431	\$ 24,255,145	\$ 1,095,358
OUTPATIENT HOSPITAL	17,060,688	2,156,327	122,070
SKILLED NURSING HOME	96,119,578	82,616,518	904,365
INTERMEDIATE CARE-			
GENERAL	92,029,856	81,962,697	1,286,611
MENTALLY RETARDED	85,286,611	1,647,837	1,378,646
PHYSICIAN	37,707,679	3,571,552	229,483
DENTAL	11,898,807	934,650	44,813
PRESCRIPTION DRUGS	35,459,626	17,288,806	431,628
CLINICS	6,437,250	412,223	54,469
TOTAL	566,992,590	223,641,239	5,700,082

TYPE OF SERVICE	DISABLED	AFDC CHILDREN	AFDC ADULTS
INPATIENT HOSPITAL	\$ 61,978,574	\$34,814,703	\$38,888,678
OUTPATIENT HOSPITAL	4,090,619	5,072,789	5,618,783
SKILLED NURSING HOME	12,567,480	1,946	29,269
INTERMEDIATE CARE-			
GENERAL	8,773,821	250	6,609
MENTALLY RETARDED	82,202,524	54,442	3,162
PHYSICIAN	11,442,959	8,939,204	13,578,481
DENTAL	1,785,007	4,099,718	5,034,619
PRESCRIPTION DRUGS	10,718,628	2,278,869	4,741,695
CLINICS	3,486,565	1,127,582	1,356,411
TOTAL	203,190,554	60,396,454	74,064,261

Adapted from DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1982-83, at 10 (1984).

Table IX also indicates a decrease in the number of recipients of other services. Fewer Medicaid recipients visited physicians and other practitioners, and fewer received prescriptions in FY 1982. The number of recipients of dental, family planning, home health, clinic, and lab and x-ray also declined in FY 1982. Yet, while the number of hospital inpatient and SNF recipients was apparently declining, the number of patient days of service for these recipients was remaining about the same from FY 1981 to FY 1982, as Table X indicates. During that same period, the number of recipients of ICF-general services declined, as did utilization of these services, as Tables IX and X show.

TABLE IX

COMPARISON OF MEDICAID RECIPIENTS BY
TYPE OF SERVICE FOR FEDERAL FISCAL
YEARS 1977, 1981 AND 1982

TYPE OF SERVICE	FY 1982 RECIPIENTS	FY 1981 RECIPIENTS	FY 1977 RECIPIENTS
INPATIENT HOSPITAL	67,900	80,866	91,347
OUTPATIENT HOSPITAL	133,433	164,879	127,220
MENTAL HOSPITAL	707	922	1,405
SNF	12,479	13,022	14,886
ICF-GENERAL	12,657	13,072	15,064
-MENTALLY RETARDED	2,594	2,268	1,516
PHYSICIAN	247,935	268,498	263,812
PRESCRIPTION DRUGS	237,621	268,799	272,882
DENTAL	91,777	104,847	74,840
OTHER PRACTITIONERS	40,972	48,993	65,748
CLINICS	30,146	33,101	20,714
RURAL HEALTH CLINICS	10,269	12,408	————*
LAB AND X-RAY	77,855	77,921	33,387
FAMILY PLANNING	27,056	29,170	19,415
HOME HEALTH	3,129	3,515	680
EPSDT	49,553	56,669	————*
OTHER	75,546	56,541	6,807
TOTAL UNDUPLICATED RECIPIENTS	353,841	382,386	368,750

* Data not available for FY 1977.

Source: DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, STATISTICAL REPORT ON MEDICAL CARE: RECIPIENTS, PAYMENTS, AND SERVICES, HCFA Form 2082 (1977); *id.* (1981); *id.* (1982).

This was following a rather significant growth in the use of these services during the preceding four years. In contrast, the growing number of ICF-MR recipients has been a long term trend but has been matched with an increase in average length of stay by these recipients as well.

TABLE X
COMPARISON OF MEDICAID SERVICE
UTILIZATION FOR FEDERAL FISCAL
YEARS 1977, 1981, AND 1982

TYPE OF SERVICE	FY 1982		FY 1981		FY 1977 UTILIZATION
	UTILIZATION	% CHANGE FROM FY 81	UTILIZATION	% CHANGE FROM FY 77	
GENERAL HOSPITAL in days of care	595,065	+1.5%	586,441	-29.1%	826,893
INPATIENT MENTAL HOSP. in days of care	65,114	+20.7%	53,941	-79.9%	268,245
SNF days of care (avg. days recip.)	2,061,499 (165)	+3.1%	2,000,151 (154)	+6.7%	1,874,602 (125)
ICF-GENERAL in days of care (avg. days/recipient)	3,324,391 (263)	-3.1%	3,431,822 (263)	+47.5%	2,326,884 (154)
ICF-MR in days of care (avg. days/recipient)	846,950 (327)	+19.9%	706,417 (311)	+684.0%	90,106 (59)
PHYSICIAN	1,361,999	-9.3%	1,501,447	+116.1%	694,788
RURAL HEALTH CLINIC VISITS	12,353	-62.6%	33,006		—*
HOME HEALTH VISITS	23,534	+9.7%	21,450		—*
PRESCRIPTIONS	2,924,171	-28.1%	4,067,645	+3.9%	3,916,076

* Data not available for FY 1977.

Adapted from DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, STATISTICAL REPORT ON MEDICAL CARE: RECIPIENTS, PAYMENTS, AND SERVICES, HCFA Form 2082 (1977); *id.* (1981); *id.* (1982).

While these data deserve more detailed analysis—an observation that is by itself a critique of the legislative strategies for Medicaid cost containment in North Carolina⁷³—they are at least some indication of the actual causes of inflating program costs and therefore suggest the kind of cost containment measures that North Carolina might pursue successfully. As was made clear in the previous section, there are not more eligibles demanding more services, nor are there more recipients of Medicaid services demanding more, with the exception of the growing ICF-MR population. If the data in Tables VIII-X are accurate in their implications, there does not appear to be an overall trend of more people seeking medical attention more often. To the extent that there

73. See discussion *infra* notes 140-44.

are indications of increased utilization of services covered by the program, there are increases in such figures as number of patient days of hospitalization or the length of stay in a nursing home for some categories of recipients. These utilization figures essentially indicate the same number of patients receiving more care per episode or per provider visit and, therefore, requiring more expenditures through the program.

The major implications of these observations are at least twofold. First, inflation in the cost of North Carolina's program may be linked in part to increased delivery of services to certain kinds of recipients, but not necessarily to more frequent recipient-initiated utilization of those services. Thus, if limits are to be placed on services utilized, it could be argued that some sort of additional or more aggressive review of the necessity or cost-effectiveness of services rendered might be appropriate, or some other means established to affect provider decisions with regard to the length of institutional stays, the intensity of services rendered, or the like. The data do not, however, suggest that more—or the same number of people—are seeking care more often and, therefore, there is little justification for further limits on Medicaid coverage or administrative barriers to utilization, or other recipient-initiated decisions. Moreover, these data more strongly support the assumption that the principal cause of inflation in Medicaid program costs is the inflation in the cost per unit of service, i.e., the inflation in the price of medical care. While good cost data on both Medicaid-funded and privately funded medical care in North Carolina appears to be nonexistent, it would not be surprising if North Carolina reflected national trends: medical care generally has been inflating largely because of an inflation in the price of care.⁷⁴ As will be discussed in the next section, Medicaid reimbursement differs from provider charges to their private patients in some regards, but has historically been based in large part on the same principles. Nor is there little difference between the delivery of services to Medicaid recipients and the pattern of delivery of medical care to the general public. Therefore, Medicaid could hardly avoid the influence of the same factors of inflation that have characterized medical care delivery generally. The implications of these observations for the evaluation of North Carolina's cost containment measures and in predicting the success of the state's attempts to control overall program costs will be discussed further in Section II.

In any event, there is little reason to focus the attention of current debates on either the scope of services covered by the state's program, the number of recipients of those services, or for that matter, the utilization of those services by those recipients unless that attention is rather specifically focused on certain services and, ultimately, on the

74. Gibson & Waldo, *supra* note 69, at 8.

underlying causes of those utilization increases. Nonetheless, when the North Carolina legislature attempted to control the cost of the program in 1981 and 1982, it did impose direct utilization limitations, albeit limits of modest proportions, as discussed earlier. More importantly, it also attempted to effect utilization indirectly by imposing a series of rather substantial changes in the levels of reimbursement for covered services and by attempting to curtail the supply of nursing home beds. The merits of these measures will be discussed more fully in Section II.

C. Reimbursement

Perhaps the most critical determinants of Medicaid's availability to eligible beneficiaries are found in the terms of reimbursement available to the various categories of providers. Payments for services delivered to Medicaid recipients are subject to routine administrative reviews,⁷⁵ various reviews of the appropriateness of the services rendered,⁷⁶ and are limited to an amount determined by state and federal law.⁷⁷

As with eligibility and service coverage, the federal law sets broad guidelines within which each state has considerable discretion to determine the method and bases for reimbursement to the various categories of Medicaid providers. This discretion was further expanded by the 1981 and 1982 federal Medicaid program changes.⁷⁸ North Carolina, like many other states, has grown more willing in recent years to exercise this discretion in attempts to control program costs.⁷⁹ When pressed to reduce state Medicaid expenditures in 1981 and 1982, the state legislature relied most heavily on reimbursement limitations as the primary strategy for containing the growth in the cost of the state's program.

Nonetheless, the reimbursement of Medicaid providers in North Carolina still reflects the cost or charge-based, fee-for-service principles

75. Claims by providers are subject to the requirements of state and federal law regarding the certification of providers for participation in Medicaid, and the compliance with the various conditions on service coverage. For an explanation, see DIVISION OF MEDICAL ASSISTANCE, N.C. DEPT. OF HUMAN RESOURCES, N.C. MEDICAID PROGRAM ANNUAL REPORT 1980-81, at 7 (1981).

76. North Carolina requires that services provided under the Medicaid program be necessary and appropriate. See STATE PLAN, *supra* note 18, § 4.14(a). See also *supra* note 62. All claims submitted by providers are audited by either the state agency or its contractor. See description of reviews, PROVIDER REIMBURSEMENT MANUAL, *supra* note 18, at 1-6.

Institutional Medicaid providers are also subject to various utilization review requirements. Nursing homes, for example, are periodically subjected to on-site review of the quality of care rendered. All institutional providers must maintain in-house utilization review procedures, and in some areas of the state are subject to the review of Professional Standard Review Organizations. For a description, see STATE PLAN, *supra* note 18, at 49-50. North Carolina also maintains a program for the identification of fraud and abuse. See 10 N.C. ADMIN. CODE §§ 26G.0100-.0600 (1982).

77. For a discussion of the federal requirements, see Wing, *supra* note 1, at 11-13.

78. See *id.* at 50-54.

79. See, e.g., *infra* notes 83-88.

typical of most private health insurance programs and preferred by virtually all providers. The methodology and bases for reimbursement vary for each provider category, but in all cases reimbursement of Medicaid services is tied to either an estimate of actual costs of the services delivered or, in the case of professional services, to the fees charged by other providers. In the early years of the programs, reimbursement levels were primarily based on retrospective audits of expenditures actually incurred. In later years, the state has been more willing to exercise its discretion to estimate cost using other factors and on a prospective basis, as well as to impose maximum ceilings on annual increases, to limit reimbursement to a percentage of estimated costs or charges, and to use other means to limit the inflation of reimbursement rates. The result has been a reimbursement structure of some complexity, reflecting the state's objective to control program cost, but also the political resistance of the state's providers to any major departure from cost or charge-based, fee-for-service reimbursement.

Table XI summarizes the bases for provider reimbursement used in North Carolina in FY 1980, prior to the Reagan-era budget cuts, and for FY 1983 following the several rounds of cost cutting measures taken by the state in 1981 and 1982.

The evolution of the current bases for reimbursement of the major Medicaid provider groups is representative of both the complexity of the reimbursement structure and of the political constraints within which Medicaid reimbursement policy has evolved. Until November of 1981, reimbursement for inpatient hospital services, approximately 30% of the Medicaid dollar, was determined on a "reasonable cost" basis.⁸⁰ Essentially, each facility submitted annual cost and utilization reports, and the state Medicaid agency, following an audit of these reports, made per diem payments to each facility based on the actual expenditures by that facility in providing services to Medicaid beneficiaries, subject only to various cost exclusions required by federal and state law.⁸¹ The individually determined rates of reimbursement for hospitals varied greatly from facility to facility; and while the cost exclusions of state and federal law often resulted in Medicaid reimbursement rates below that charged private pay patients, "reasonable cost" reimbursement gave little direct incentive to reduce expenditures or to

80. Under federal law, the state was required to follow the "reasonable cost" principles and methodology used under Medicare (with some minor exceptions) unless it sought specific approval of the federal administration for an alternative scheme. See 42 C.F.R. §§ 405.401, 447.256, 447.272 (1980).

81. Payments were actually made on a periodic basis with an annual adjustment to account for the difference between expected and actual Medicaid utilization. See 42 U.S.C. § 1396(a)(13)(D) (1976), *repealed by* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357, 809.

alter or limit utilization.⁸²

In November of 1981, however, North Carolina instituted a prospective per diem reimbursement scheme for Medicaid hospital inpatient services, a major departure from previous reimbursement policy, although still tying reimbursement of most facilities to their actual expenditures and utilization. Ostensibly exercising the greater flexibility granted to states by Congress in 1981,⁸³ the state initially adopted a plan setting each hospital's FY 1982 per diem rate according to FY 1980 "reasonable" costs, allowing for a fixed percentage increase for some, but not all, costs.⁸⁴ The FY 1982 reimbursement plan was replaced for FY 1983.⁸⁵ Under the new scheme, "reasonable" costs for FY 1981 were calculated for each facility and inflated by 22%.⁸⁶ All facilities with per diem costs below the weighted per diem average (\$262 per day) for all hospitals were assured reimbursement in FY 1983 at their full, prospectively determined rate;⁸⁷ however, facilities above that average were to be fully reimbursed only to 85% of their level of utilization for FY 1981. Beyond that, they would be reimbursed only at the average per diem rate for all facilities *below* the industry wide average (\$200 per day).⁸⁸

82. The North Carolina Hospital Association has estimated that the difference between charges to private patients and Medicaid reimbursement rates was approximately 20%. Interview with Bill Oviatt, North Carolina Hospital Association, in Raleigh, North Carolina (March 9, 1983) [hereinafter cited as Oviatt interview].

83. The new federal standard created in 1981 allows states to reimburse hospitals on a basis that is "reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities." 42 C.F.R. § 447.250 (1982). See Wing, *supra* note 1, at 53. The new standard obviously invites states to develop alternatives for reimbursement, and, in particular, to tie reimbursement of individual hospitals to industry wide costs and to other indicia of relative inflation.

84. The initial plan adopted in November of 1981 (for the remainder of FY 1982) set each hospital's per diem rate by calculating the "allowable" cost of that hospital to provide inpatient services to Medicaid recipients in FY 1980. The state then reduced the FY 1980 costs by 8% for operating costs and inflated the result by 21% (the National Market Basket Index of Inflation for 1981 plus 1982 compounded), reduced by 8% the educational costs and did not inflate it, and did not deflate or inflate capital costs. (It has been reported that the 21% figure was "chosen" by the state to result in \$12 million savings, approximately 50% of the \$24 million state budget reduction required for FY 1982. Oviatt interview, *supra* note 82.) In any event, the result was a total per diem rate increase of approximately 10% over FY 1980 rates, not a sizeable increase given prevailing economic conditions. *Id.* For details, see 10 N.C. ADMIN. CODE § 26H.0202 (1982) (effective Feb. 1, 1982).

85. 10 N.C. ADMIN. CODE § 26H.0200 (1982) (effective July 1, 1982).

86. Oviatt interview, *supra* note 82.

87. To compute a weighted statewide average per diem rate, the state took each hospital's FY 1981 Medicaid utilization level (the number of Medicaid patient days) and multiplied it times a "reasonable rate" (FY 1981 "reasonable costs" as previously calculated plus a 22% inflation factor). The result was considered a "Medicaid budget" for each facility. Adding all of the hospitals' "Medicaid budgets" together and dividing by the number of total Medicaid patient days produced a weighted per diem average cost—\$262.36. *Id.*

88. For example, according to the North Carolina Hospital Association, Duke University would be reimbursed in FY 1983 at a rate of \$510 per day for all Medicaid patients up to 85% of

As a result of these changes, hospitals in North Carolina now have prospectively-determined per diem rates for Medicaid patients, based on their historic costs, but with substantial incentive to maintain aggregate utilization levels for Medicaid patients at or below previous levels. The impact of this scheme will be discussed more fully in Section II.

Medicaid payments to physicians, optometrists, dentists, and other individual providers have been based on their "allowable, usual, or customary charges," annually adjusted and subject to caps and ceilings on rate increases as fixed by the state legislature.⁸⁹ Basically this means that physicians and other individual providers are given a percentage of the lower of their actual or customary charges for a service, or an averaging (e.g., the 75th percentile) of the charges by the other comparable providers.⁹⁰ Prior to 1982, the state legislature generally limited payment to 90% of the "allowable, usual, or customary charge," and had in some years imposed maximum limits on annual rate increases at a fixed percentage of the previous year's rates.⁹¹ In 1981 the state legislature froze the reimbursement rates at the 1980 level;⁹² in 1982 percentage increases were allowed, statewide fee schedules were imposed, and the 90% factor was lifted for some physician services.⁹³ With these modifications, the Medicaid program continues to pay physicians and other individual providers on a fee-for-service basis reflecting their actual charges to private patients.

total Medicaid utilization in FY 1981. Beyond that, reimbursement would be reduced to \$200 per day, the average per diem rate of the state's hospitals with rates below \$262. *Id.* For other hospitals with rates at levels closer to the average, of course, the difference would be far less significant.

89. Historically, federal Medicaid law required only that states pay no more than Medicare. 42 C.F.R. § 447.341 (1980). This ceiling was lifted in 1981. *See* 42 U.S.C. §§ 1396a(a)(30), 1396b(i)(1) (Supp. V 1981).

90. Prior to 1982, payments to physicians were calculated in the following way:

"just before the beginning of each fiscal year the Division of Medical Assistance must review the actual charges billed by physicians during the preceding calendar year. The mid-point of these actual charges by a physician for a service is established as his usual (customary) charge for that service. The prevailing charge is then established at the 75th percentile of all the individual physicians' usual (customary) charges for each service. In effect, the prevailing charge for any service is the amount which is high enough to cover the usual (customary) charges of those physicians whose billings accounted for at least 75 percent of all claims for that service in the locality during the preceding calendar year." PROVIDER REIMBURSEMENT MANUAL, *supra* note 18, at 2-15.

91. *See, e.g.*, Act of June 7, 1979, ch. 838, § 23, 1979 N.C. Sess. Laws 1112, 1129.

92. Act of Oct. 10, 1981, ch. 1127, § 22(1), 1981 N.C. Sess. Laws 1622, 1640.

93. The reimbursement methodology for physicians' fees was modified in 1982 in several regards. Act of June 22, 1982, ch. 1282, § 16(1), 1981 N.C. Sess. Laws 185, 201-02. Principally, the methodology used previously was revised so that fees were no longer determined on an individual basis, but based primarily on a statewide fee schedule (although charges by individual practitioners were still used to compute the level of reimbursement). The new law also eliminated fee differentials between rural and urban areas and between new and established primary care practitioners. And whereas most practitioners would receive 90% of the 75th percentile of the usual (customary) charge, primary care physicians were allowed under the new scheme 100% of the 75th percentile for all services provided on an outpatient basis, presumably an incentive to encourage more primary care in an outpatient setting. *See infra* note 133.

TABLE XI
SUMMARY OF PROVIDER REIMBURSEMENT

<u>Type of service</u>	<u>Basis for reimbursement</u>	
	FY 1980	FY 1984
Hospital inpatient	"allowable costs"	prospective per diem rates (reduced for high utilization)
Outpatient hospital	90% of "allowable costs"	80% of "allowable costs"
Mental specialty hospitals	"allowable costs"	(same)
Skilled nursing homes	"reasonable costs" plus return on equity (except public facilities)	prospectively determined per diem rates
ICF-General facilities		
ICF/MR	"allowable costs"	prospectively determined per diem rates
Prescription drugs	"allowable costs" plus a dispensing fee	(same)
Home health	"allowable cost"	(same)*
Clinic services	(lower of) "reasonable, customary and usual" charges	(same)*
Physicians, optometrists, chiropractors, podiatrists, dentists	90% of 75th percentile of "allowable, usual, and customary"	same (except physicians increased to 100%)**
Ambulance services	100% of "allowable and reasonable"	(same)*
EPSDT services	flat fees (determined by state)	(same)*
Hearing aids	"actual cost" plus dispensing fee	(same)*
Rural health clinics	"reasonable cost"	(same)*
Independent lab and x-ray services	90% of "allowable, usual, and customary"	(same)*
Optical supplies	100% of "reasonable" wholesale cost	(same)
Ambulatory surgical centers	————	negotiated rates*
Mental health clinics	————	negotiated rates*

Source: Derived from Act of June 22, 1982, ch. 1282, § 16, 1981 N.C. Sess. Laws 185, 201-02, and Act of June 7, 1979, ch. 838, § 23, 1979 N.C. Sess. Laws 1112, 1128-29.

* Rates for these services were subject to a 7% ceiling on all increases beginning in June 1982. Act of June 22, 1982, ch. 1282, § 16, 1981 N.C. Sess. Laws 185, 202.

** This increase was initiated by the Department of Human Resources in accordance with the General Assembly's desire to "encourage the participation of primary care physicians in the medical assistance program, and to reduce unnecessary use of inpatient services." Act of June 22, 1982, ch. 1282, § 16, 1981 N.C. Sess. Laws 185, 201-02.

Reimbursement for clinics and other institutional primary care providers has generally tied rates to an estimate of "allowable" costs, also subject to various cost containing limitations.⁹⁴

Since 1980 nursing homes (except ICF-MRs) have been reimbursed for 100% of their "reasonable costs."⁹⁵ According to the terms of the state regulations, this means that nursing homes are limited to per diem rates based on those costs that are "reasonable,"⁹⁶ that are necessary for "normal and efficient provision of services" to Medicaid beneficiaries,⁹⁷ and that are within the maximum ceilings and other cost containing measures imposed by the state on nursing home providers.

As with hospitals, nursing homes report their expenditures on an annual basis;⁹⁸ based on in-house and field audits of these reported costs,⁹⁹ the state Medicaid agency determines a base year annual cost—which may serve as the basis for reimbursement for several years.¹⁰⁰ Annual costs are segregated into direct costs (e.g., nursing salaries) and indirect costs (e.g., depreciation).¹⁰¹ Currently, each facility is limited to a maximum of the 75th percentile of the industry-wide average for direct costs and the 60th percentile of the industry-wide average for indirect costs.¹⁰² The adjusted base year costs are inflated each year by various inflation factors outlined in the state regulations.¹⁰³ Proprietary institutions are also allowed a 14% return on equity; public and non-profit institutions are not.¹⁰⁴

94. Institutionally-based clinics are currently reimbursed on the basis of their "reasonable and customary charges" for the services they render. Independent clinics are reimbursed for all services rendered on a single, per visit rate determined on the basis of their "reasonable cost." A slightly different basis is used for clinics that provide "rural health services." In all cases, the rates are determined prospectively but the rates may be adjusted during the year to account for changes in actual costs. Nonetheless, all clinic services were subject to the freeze imposed in 1981 and the 7% cap on rate increases imposed in 1982. For a more detailed explanation of the determination of rates for clinics, see 10 N.C. ADMIN. CODE § 26B.0113 (1982).

95. These are essentially those costs allowed under the Medicare program with specific exceptions/modifications as outlined in the state regulations. See 42 C.F.R. § 447.251 (1982); 10 N.C. ADMIN. CODE § 26H.0101(g) (1982).

ICF-MRs are reimbursed under the same standard for determining costs and following similar methodology as outlined for nursing homes; however, ICF-MRs are not subject to industry-wide maximum ceilings on costs. For a full explanation, see 10 N.C. ADMIN. CODE § 26H.0303 (1982).

96. According to the state regulations, the basic principle underlying "reasonable" is the "amount that would be acceptable to an independent buyer and seller in the same transaction." 10 N.C. ADMIN. CODE § 26H.0101(e) (1982).

97. "Necessary costs" are those "required for normal, efficient, and continuing provision" of services to Medicaid beneficiaries. *Id.* § 26H.0101(c).

98. *Id.* § 26H.0101(d)-(f).

99. *Id.* § 26H.0102.

100. *Id.* § 26H.0104.

101. *Id.* § 26H.0104(f)(1).

102. *Id.* § 26H.0104(f)(3). Note, however, that providers must return any portion of amounts paid for direct costs over and above actually incurred expenses.

103. *Id.* § 26H.0104(f)(6).

104. *Id.* § 26H.0104(h), (k).

The terms of nursing home reimbursement were not modified during the most recent rounds of state program changes; however, the state legislature opted to effect Medicaid nursing home costs by imposing a partial moratorium on new nursing home construction.¹⁰⁵

Properly matched to the realities of Medicaid utilization and provider practices, the state's Medicaid reimbursement policies can create incentives for both more efficiency in the delivery of services to Medicaid patients and more cost consciousness in decisions to hospitalize, to order diagnostic tests, or to exercise any of the discretionary choices made by Medicaid providers. The result can be significant program savings, without necessarily reducing the availability of necessary medical care.¹⁰⁶ It must also be recognized, however, that Medicaid reimbursement policies can also have the significant yet undesirable effect of discouraging providers from participating in the program at all. Medicaid participation is entirely voluntary: no provider is required by the federal or state Medicaid statutes to accept Medicaid patients or to continue to do so.¹⁰⁷ Yet Medicaid reimbursement, if accepted, must be accepted as payment in full.¹⁰⁸ The difference between Medicaid payment for a covered service and a provider's charges to private patients cannot be billed to the Medicaid patient, unless the provider wants to forego Medicaid reimbursement and demand the entire amount from the patient—who then must pay the entire bill out-of-pocket. As a result, some providers, including some institutional providers, but particularly private physicians, refuse to accept Medicaid or accept only a limited number of Medicaid patients each year.¹⁰⁹ In some areas Medicaid patients must have a difficult time finding any provider willing to accept their Medicaid card. It is not atypical, for example, for Medicaid patients to drive hundreds of miles across the state to attend the clinics at North Carolina Memorial Hospital, the state's major public hospital. In fact, the available data indicates that a few institutional and individual providers see a large proportion of the Medicaid population;¹¹⁰ most providers, it appears, are at least reluctant to accept Medicaid reimbursement.

Obviously provider participation, meaning both the willingness of

105. *See infra* note 128.

106. *See* discussion *infra* notes 160-67.

107. *See* Wing, *supra* note 1, at 13.

108. *Id.*

109. Estimates prepared for this author (based on raw data available through the Division of Medical Assistance), indicated, for example, that only a handful (16) of physicians (or physician groups) provided over 10% of the physician services to Medicaid recipients in 1982. *See* Berg, Provider Participation in the North Carolina Medicaid Program I (1983) (unpublished memo).

110. Similarly, it appears that only two of North Carolina's sixty hospitals provided over 10% of all inpatient hospital care. *Id.* at 4. *See also* discussion *infra* note 168.

providers to participate at all and their willingness to accept additional Medicaid patients, should be given close consideration in tailoring cost containment strategies. Unfortunately, public data on provider participation is virtually nonexistent and the public debates on reimbursement policies, as well as the adequacy of the program in general, generally overlook this important determinant of Medicaid's real impact and availability. While reimbursement limits can be and are important means for controlling program costs, their impact is generally measured in terms of the impact on overall program cost, but not on provider participation or beneficiary utilization.

II. ANALYSIS OF THE CURRENT AND FUTURE COST CONTAINMENT EFFORTS

A. *Political Strategy 1980-83*

Despite North Carolina's attempts to limit reimbursement and to otherwise control program expenditures, Medicaid has become an expensive social commitment for the state and, to a lesser extent, for local governments which share with the state the non-federal costs of the program.¹¹¹ As indicated in Table I, the aggregate cost of the program has been marked by rapid inflation from the inception of the program, fueled initially by the expansion of eligibility and services but in later years, principally by the inflation in the cost of medical services.¹¹² Even with the federal government paying 67% of the total cost,¹¹³

111. Since 1971, the state has paid 85% and the counties have paid 15% of the non-federal share of the program. Act of July 19, 1971, ch. 934, § 2, 1971 N.C. Sess. Laws 1521, 1521-22. One important change in this arrangement, however, has been the splitting of the non-federal costs of providing nursing home services. There have been several different arrangements whereby the state would pay 85% of the non-federal costs of nursing home services up to a certain given amount; the non-federal costs in excess of this amount would then be assumed entirely by the counties. See, e.g., Act of Oct. 30, 1971, ch. 1242, 1971 N.C. Sess. Laws 1809; Act of May 16, 1973, ch. 533, § 7, 1973 N.C. Sess. Laws 801, 809.

In 1978 the legislature mandated that the state would pay only 65% and the counties would pay 35% of the non-federal costs of providing nursing home services to Medicaid recipients, skilled nursing homes, and intermediate care facilities not owned by the state. Act of June 16, 1978, ch. 1219, § 29, 1977 N.C. Sess. Laws 158, 163. This arrangement is still in place. Act of June 22, 1982, ch. 1282, § 16(2), 1981 N.C. Sess. Laws 185, 203.

It should be noted that in years past, however, the legislature has continually appropriated "County Medicaid Relief Funds" to be distributed to the counties to offset the growing costs incurred by the counties. The state has also increased its share of (non-Medicaid) rest home costs from 50% to 70%, as a partial set-off for the counties' increased cost of Medicaid nursing home costs. Currently, the counties pay approximately 8% of the total cost of Medicaid, projected to the \$54 million in FY 1984. For current relief fund appropriations, see Act of July 15, 1983, ch. 761, § 61, 1983 N.C. Sess. Laws 790, 820.

For a full explanation, see LEGISLATOR'S GUIDE, *supra* note 70, at 25.

112. See discussion *supra* note 74 & *infra* notes 150-51.

113. The federal share of the state program costs is determined by a complex formula based on state relative income and other factors. For a full explanation, see Wing, *supra* note 1, at 7.

Medicaid had become a significant portion of the state's budget—growing to nearly 10% of state expenditures by 1980—and inflating at a rate greater than the economy in general and, most importantly, overall state spending.¹¹⁴ As the largest portion of the state's social welfare budget, and second only to education as the largest single item in the state's budget, Medicaid has sparked an annual political debate, growing in significant with each budget cycle and reaching critical proportions even before the Reagan-era budget cuts. Thus, the significance of the federal program changes and budget cuts initiated in 1981 was not that they created a financial dilemma, but that they elevated a growing problem to the level of a political crisis that required immediate attention.

In the spring of 1981, during the state's biennial budget session, the Medicaid program was projected to cost over \$580 million in FY 1982, of which \$194 million would come from state and local government.¹¹⁵ The impact of the federal cuts enacted shortly thereafter was to require either an increase in state expenditures by \$8 million or a reduction in the overall cost of the program by nearly \$25 million for the remaining portion of FY 1982, and by over \$48 million for FY 1983.¹¹⁶ In re-

For the last several years, this share has been 67% of the total state program costs, although since 1981 this share has been subject to the 3%, 4%, and 4½% reductions imposed by Congress in the 1981 federal Medicaid amendments. See *infra* note 116.

114. At the beginning of FY 1983, with total state expenditures approaching \$6 billion, Medicaid expenditures were predicted to exceed \$600 million. OFFICE OF STATE BUDGET AND MANAGEMENT, OVERVIEW: FISCAL AND BUDGETARY ACTIONS BY THE NORTH CAROLINA GENERAL ASSEMBLY FOR THE 1981-83 BIENNIUM 11 (1983). If the expenditures for education were excluded from this figure (nearly \$3 billion), the percentage of state expenditures devoted to Medicaid would be even more impressive.

Inflation in Medicaid expenditures had been erratic but averaging over 15% for previous years, whereas the inflation in the size of the state budget had been declining since 1981 and had averaged approximately 8%. See LEGISLATOR'S GUIDE, *supra* note 70, at 13.

115. See Winner, *Focus on Medicaid: Axing Entitlement Programs*, N.C. INSIGHT, Dec. 1981, at 41, 46.

116. *Id.* at 43, 47. These figures were derived from estimates made during the legislative debates in the summer of 1981. Their computation, as well as their real meaning, require some explanation. First of all, the \$24 million figure understates the immediate impact on the state's program. North Carolina's fiscal year begins on July 1. Thus, the federal cuts, which were to take effect October 1, 1981, only expressed the loss for nine months, not a full fiscal year. The figure is also an aggregate of both federal and state reductions. A 3% reduction of the federal share was estimated to be only an \$8.7 million loss of federal funds. Had the state opted to increase state expenditures by \$8.7 million, no other program changes would have been required.

However, the state legislature was apparently determined not to increase the state share; thus the following calculations:

- 1) federal share (for nine months) = \$290 million (projected) (67% of total cost)
 - 2) state share (for nine months) = \$145 million (projected) (33% of total cost)
 - 3) after the federal cuts \$145 million must equal state share (33% of the program) plus the \$8.7 million, an additional 2%
 - 4) therefore \$145 million must equal 35% of the program
 - 5) 100% of the program must equal \$411 million, effecting a reduction of \$24 million
- The gist of this seeming sleight of hand is that the \$8.7 million absorbed by the state out of state

sponse to these projected budget shortfalls, the state legislature met in the fall of 1981 and amended the FY 1982 state budget to include a series of limitations on Medicaid spending intended to contain the overall cost of the program within acceptable limits.¹¹⁷

The state legislature considered many options, ranging from direct eligibility and service reductions to various reforms in Medicaid financing and delivery.¹¹⁸ Even elimination of medically needy eligibility was discussed. The final program reductions, however, reflected an apparent commitment to retain the basic structure of the program as it had existed, with only modest modifications in the benefit structure and alterations in the terms of provider reimbursement.

As outlined earlier, the legislature in the fall of 1981 mandated that inpatient hospital reimbursement be based on a flat per diem rate; and the Department of Human Resources was required to develop a scheme for the determination of the per diem rates on a prospective basis to be put in effect by July 1982.¹¹⁹ A similar plan for the determination of ICF-MR service reimbursement rates on a prospective basis mandated in 1981 was scheduled for implementation in October 1981.¹²⁰ The rate of reimbursement for physicians, clinics, laboratory and x-ray services, and many other services was "frozen" at the level in effect as of June 1981.¹²¹ Reimbursement for hospital out-patient services was reduced from 90% of "allowable costs" to 80%.¹²²

The 1981 legislation also chose to achieve some cost reductions by imposing various limitations on the utilization of services.¹²³ Most significantly, recipients were limited to a total of eighteen visits (with some exceptions) per year for virtually all individual provider and out-

funds is tantamount to a state reduction in funding. Since each state dollar is matched by two federal dollars, what is on its face a cut of \$8.7 million quickly translates into three times that amount—if the state chooses not to increase funding to offset the loss of federal funds. Thus, the state legislature went beyond the mandated federal cuts and compounded the reduction by its reluctance to appropriate additional funds.

117. Act of Oct. 10, 1981, ch. 1127, § 22(1), 1981 N.C. Sess. Laws 1622, 1638-40. For a brief legislative history, see Winner, *supra* note 115, at 44-48.

118. For a description of those proposals given serious consideration, see Winner, *supra* note 115, at 47.

119. Act of Oct. 10, 1981, ch. 1127, § 22(1), 1981 N.C. Sess. Laws 1622, 1638. See *supra* notes 80-82 for discussion of previous basis for reimbursement of inpatient hospital services prior to 1981. Note that § 22(1) also limited reimbursement for "administrative days" to a maximum of three.

120. See Act of July 8, 1981, ch. 859, § 14(1), 1981 N.C. Sess. Laws 1248, 1266.

121. Act of Oct. 10, 1981, ch. 1127, § 22(1), 1981 N.C. Sess. Laws 1622, 1640. Note that § 22(9) required the state to develop a plan for statewide fee schedules (*i.e.*, uniform rates for each category of provider) for physicians, dentists, chiropractors, optometrists, podiatrists, and clinics. See *supra* notes 90-93 for discussion of reimbursement of physicians and other primary care providers prior to 1981.

122. *Id.* § 22(1), at 1638.

123. *Id.* §§ 22(1)-(8), at 1638-41.

patient services,¹²⁴ and recipients were also limited to a total of four drug prescriptions per month.¹²⁵

While the remaining structure of Medicaid service coverage and eligibility was left relatively unchanged, two related provisions of the 1981 amendments had immediate and significant impact on the program. First, in 1981 the state AFDC program was amended¹²⁶ to comply with various eligibility restrictions imposed by the 1981 federal amendments, effectively limiting as well the Medicaid eligibility of many former AFDC recipients.¹²⁷ Second, the 1981 legislation also amended the provisions of the state certificate of need program to effect a moratorium on the construction of nursing home beds until all beds previously authorized were constructed and all nursing homes operated at least 75% capacity.¹²⁸

By the end of FY 1982 the growth in Medicaid program costs had

124. "Reimbursement is available for up to 18 visits per recipient per year to anyone (sic) or combination of the following: physicians, clinics, hospital outpatient, optometrists, chiropractors, and prodiatrists. Prenatal services, EPSDT screens, and emergency rooms are exempt from the visit limitations contained in this paragraph." *Id.* § 22(1), at 1640.

125. *Id.* § 22(1), at 1639. See also *id.* § 22(8), at 1641-42.

126. *Id.* § 31, at 1645.

127. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, §§ 2301-2321, 95 Stat. 357, 843-60, contained a variety of AFDC-related provisions which served generally to tighten AFDC eligibility requirements or decrease AFDC payments. For implementing regulations, see 45 C.F.R. §§ 205-06, 232-35, 238-39 (1982).

These provisions included stricter rules for disregarding earned income, for allowing work-related expenses to be deducted from income, and for treating non-recurring income; inclusion of the value of food stamps in determining family income; and limitation of eligibility to children under 19 years of age. Although North Carolina opted to exercise the discretion made available under the federal law in favor of broadened eligibility, the net result of the federal and state changes was a marked decrease in the number of families eligible for AFDC and, consequently, for Medicaid as categorically needy. (Some of these people would be able to "spend down" to eligibility however.)

In the year following the implementation of the federally required AFDC eligibility changes in October 1981, roughly 13,000 North Carolina families lost their AFDC eligibility. Telephone interview with Kay Fields, Department of Social Services (July 1, 1983). Note that the total number of Medicaid eligibles experienced a parallel decline following the AFDC cuts and apparently these AFDC restrictions are largely responsible for this decline. *Id.* See *supra* Table 1. Note also that recipient (i.e., the number of people utilizing Medicaid services) data indicate that the number of recipients of all types was declining even before 1981. See *supra* note 47. It is clear, however, that this reduction in the number of recipients or eligibles resulted in significant savings for the program.

128. Act of Oct. 10, 1981, ch. 1127, § 31, 1981 N.C. Sess. Laws 1622, 1645. The 1981 legislation provided that no certificate of need shall be granted after January 1, 1982 for additional or new bed capacity for any existing or proposed skill nursing facility (SNF) or intermediate care facility (ICF) until the total of all previously authorized beds are constructed and are at 75% capacity. The provision further states that no certificate of need for beds which are not constructed on or before October 10, 1981 may be transferred until the conditions of this provision are satisfied.

Note, however that ICF-MR facilities and conversion of beds from rest home to ICF or SNF beds are exempted from the 1981 legislation.

Note also that under the implementing regulations issued by the Department of Human Re-

been kept within the projected budget; indeed, somewhat surprisingly, the 1981-82 program costs were limited to \$521 million, nearly \$19 million short of the legislature's projected budget and representing a modest 2.7% growth in program cost.¹²⁹ As a result, the full impact of the federal share reduction was avoided¹³⁰ and the legislature somewhat relaxed the containment measures adopted in 1981. The FY 1983 Medicaid appropriations legislation reenacted most of the reimbursement policies imposed in 1981;¹³¹ however, the "freeze" on reimbursement levels was lifted. Many non-institutional providers were instead limited to a 7% rate increase for FY 1982.¹³² No ceiling was set for physicians and other individual providers, and a plan for statewide fee schedules previously mandated was instituted, including rather generous terms for some categories of service.¹³³ The utilization restrictions imposed in 1981 were also modified, generally broadening coverage. The eighteen visit maximum was extended to twenty-four visits per

sources, no application for certificates of need is to be accepted or reviewed until the provision is satisfied. 10 N.C. ADMIN. CODE § 3R.0318(c) (1983).

Since this was an amendment to the 1981 budget legislation, it was not codified and would have automatically expired if not re-enacted in 1983. For subsequent re-enactment and amendment, see *infra* note 139.

For the delineation of responsibilities with regard to monitoring occupancy rates and compliance with this legislation, see 10 N.C. ADMIN. CODE § 3R.0318(c) (1983).

129. The \$521 million included \$132 million in state funds. The \$521 million figure represented a \$59 million savings over the original estimate of total Medicaid costs and a saving of state funds of nearly \$19 million. OFFICE OF STATE BUDGET AND MANAGEMENT, 1983-85 CONTINUATION BUDGET V-346 (1983) [hereinafter cited as CONTINUATION BUDGET].

Needless to say, this surplus was unexpected. For a possible explanation, see *supra* note 127. The cuts enacted in 1981 had been estimated to achieve \$27 million in budget reduction (about \$3 million more than necessary to meet the demands created by the federal budget reductions). See LEGISLATOR'S GUIDE, *supra* note 70 at 19.

130. The state avoided the 3% federal share reductions altogether. Under the terms of the 1981 federal reductions, states are allowed a one point offset against the federal reduction if they have a qualified fraud and abuse program. The federal reduction was also to be offset if the state total program costs could be held below a 9% overall increase in FY 1982. Thus, by holding the budget to less than a 3% increase, the state avoided the full impact of the federal 3% reduction in FY 1982 and consequently received an unexpected revenue surplus. See LEGISLATOR'S GUIDE, *supra* note 70, at 21. For full explanation of the federal offsets, see Wing, *supra* note 1, at 49-52.

131. Act of June 22, 1982, ch. 1282, § 16(1), 1981 N.C. Sess. Laws 185, 203.

132. The statutory language reads:

Notwithstanding the schedule for services and payments basis in this section, increases in Medicaid rates for home health services, clinic services, ambulance services, EPSDT screens, hearing aid dispensing fees, rural health clinics, family planning, independent laboratory and x-ray services, ambulatory surgical centers and mental health clinics shall be limited to seven percent (7%).

Id. § 16(1), at 202.

133. *Id.* As adopted by state regulation in November 1982, the new fee schedule for physicians effective on a statewide basis read as follows:

Fees for services other than surgeries performed in a hospital inpatient setting will be established as follows:

- (1) Fees for services will be established using the 75th percentile of usual and customary charges for each specialty as identified in Medicaid's pricing file. Should there be a difference between urban and rural, the higher of the two will be used.

year, and the exemptions from this maximum were expanded to exclude prenatal services, EPSDT screening, emergency room services, and services for which the life of the patient would be threatened without such additional care.¹³⁴ The four drug prescription limitation was extended to a six drug prescription limitation.¹³⁵ With these measures FY 1983 program costs were predicted to be \$614 million.¹³⁶

By the end of the summer of 1983, it appeared that the actual program cost for FY 1983 would be just over \$570 million—again a substantial savings from the estimated cost of the program, representing a 9.4% overall increase in program expenditures.¹³⁷ Although it was not clear whether the impact of the federal share reduction would be again avoided,¹³⁸ there was at least a possibility that the state costs would be below the federal ceiling and that the 4% reduction in the federal share required by the federal amendment would at least be reduced, if not avoided. In any case, the total program cost continued to be much

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- (2) Fees for primary care physicians will be set at 90 percent of the 75th percentile for services performed in a hospital inpatient setting, and at 100 percent of the 75th percentile for services performed in any other setting.
 - (3) Fees for specialists will be set at 90 percent of the 75th percentile.
 Fees for surgeries performed in the inpatient hospital setting will be established as follows:
 - (1) The specialty with the lowest fee and performing at least 10 percent of the surgeries will be used in establishing the inpatient fee.
 - (2) Fees for services will be established using the 75th percentile of usual and customary charges as identified in Medicaid's pricing file. Should there be a difference between urban and rural, the higher of the two will be used.
 - (3) Fees for all physicians will be established at 90 percent of the fee identified in (c)(1) and (2) of this rule.

10 N.C. ADMIN. CODE § 26H.0401 (1982).

134. Act of June 22, 1982, ch. 1282, § 16(1), 1981 N.C. Sess. Laws 185, 203.

135. *Id.* Note that the "life threatening exemption" applies to the six drug limitations as well.

136. Of the \$614 million, state funds were estimated to be \$170 million. CONTINUATION BUDGET, *supra* note 129, at V-346. It is not clear how realistic these estimates were. On their face, they would have represented an increase of nearly 20% in program costs—recreating a budget crisis, particularly with the graduated federal share reduction (4% for FY 1983) and little chance to avoid its impact as the state had the previous year. *See infra* note 138. But even with the relaxed program restrictions, it was at least suspected that the actual program cost for FY 1983 would be much lower as, in fact, it eventually was. Interview with Bob Daughtry, Fiscal Research Division, North Carolina General Assembly, in Raleigh, North Carolina (May 22, 1983).

137. Interview with Bob Daughtry, Fiscal Research Division, North Carolina General Assembly, in Raleigh, North Carolina (July 24, 1983). Of the \$570 million, the state share would be approximately \$13-14 million less than originally estimated.

138. According to the terms of the federal statute, the 4% reduction would be offset one point for maintaining an acceptable fraud and abuse program (which North Carolina apparently has), *see supra* note 76, but also for keeping program cost increases below a target figure determined for FY 1983 by the care expenditures category of the consumer price index of all urban consumers. 42 C.F.R. § 433.217 (1982). For detailed explanation of this computation, see HEALTH CARE FINANCING ADMINISTRATION, HHS, STATE MEDICAID MANUAL, Transmittal No. 19 (January 1984). According to unpublished estimates in March of 1984, North Carolina had been targeted for \$15.9 million in federal budget reductions but that figure had been reduced to \$5.8 million based on the offsets for FY 1983. Telephone interview with Barry Tutska, Chief, Budget Branch, Division of State Agency Financial Management, Health Care Financing Administration, Rockville, Maryland (March 9, 1984).

lower than earlier estimates had indicated and the result was to relieve the immediate political pressure to cut further or reform the existing Medicaid program.¹³⁹

B. *Analysis*

In at least one respect, North Carolina can claim to have weathered the impact of the federal Medicaid budget reductions rather well. The original federally initiated fiscal crisis has been resolved. Medicaid cost inflation was successfully contained in two successive years, at least to an extent necessary to meet the most immediate demands on the state budget. Moreover, this crisis has been resolved during a time marked by extremely trying political and economic circumstances. If North Carolina can find a politically acceptable and administratively workable Medicaid cost containment strategy that survived the pressures created by President Reagan's austere budgeting and the recession of the early 1980's, then the state's ship must be creditably navigated.

Such praise, of course, must be given with considerable qualification. The real test of the state's cost containment strategy will be whether the course adopted continues to be successful in the face of the economic and political conditions that remain unfavorable. Given the cost containment measures adopted by the state, the likelihood of continued success in reducing the inflation of the Medicaid budget can at least be questioned. Equally important, that future success, as well as that of the last few years, should be measured in terms that reflect not only the impact on the state budget but also the impact on the program and program beneficiaries. In particular, given a cost containment strategy that has relied heavily on tightened reimbursement but that has left the basic structural arrangement between providers and the program virtually intact, provider participation and beneficiary utilization should be closely examined, because such a strategy runs a considerable risk of

139. The FY 1984 budget legislation appropriated \$184 million in state funds for Medicaid, based on an estimated program cost for FY 1984 of \$686 million, an increase of over 11%, in the budget recommended to the legislature by the Governor. See Act of July 15, 1983, ch. 761, § 2, 1983 N.C. Sess. Laws 790, 802; CONTINUATION BUDGET, *supra* note 129. Again, it is not clear how realistic these figures were.

Note that the 1983 appropriations legislation also extended the nursing home construction moratorium through June 30, 1985. Act of July 15, 1983, ch. 761, § 74, 1983 N.C. Sess. Laws 790, 824. (See also the temporary extension of this moratorium, Act of June 30, 1983, ch. 655, § 3, 1983 N.C. Sess. Laws 619, 620.)

Note, however, that in the same legislative session, the moratorium was amended in several regards. Act of July 20, 1983, ch. 835, 1983 N.C. Sess. Laws 1045 provided that in counties with a population of 25,000 or more and no licensed nursing home a certificate of need for at least one nursing home could be authorized. Act of July 20, 1983, ch. 836, 1983 N.C. Sess. Laws 1046 added ICF-MR beds to the moratorium (although with an earlier expiration date).

achieving program savings at the expense of de facto program reductions.

1. North Carolina's "Middle Course" Strategy

To characterize the state's success more critically, it is instructive to first note the options that the state has chosen not to pursue. First and most importantly, the state has not opted for direct program reductions. Medicaid eligibility has not been directly limited; no services have been eliminated from the range of services that have been offered in the past, nor have there been major durational limitations or other limits on utilization imposed on program beneficiaries but for those relatively marginal limits discussed in Section I. Even these have been excepted to allow for the most serious hardships. Despite the present financial difficulties facing the state, North Carolina continues to offer a Medicaid program which provides a broad range of services to what can be loosely described as its welfare population, as well as some other people whose medical indigency deserve public assistance—a commitment for which the state should be again given considerable credit. Many other states have been more willing to rely on direct program reductions to contain program costs throughout the history of the program¹⁴⁰ and a number of states immediately responded to the recent federal budget reductions by instituting substantial service or eligibility reductions.¹⁴¹

On the other hand, it must also be noted that North Carolina has neither directly reformed the state Medicaid program in any substantial regard, nor has it indirectly recast the program through any major changes in the delivery of medical care in North Carolina. Some states have reacted to the recent federal cutbacks and to other pressures for program cost containment by more drastically altering their financial arrangements with Medicaid providers or by adopting other innovative reforms of the underlying structure of Medicaid.¹⁴² Other states have

140. For a state-by-state analysis of Medicaid program reductions through the summer of 1982, see generally NATIONAL GOVERNOR'S ASSOCIATION, *MEDICAID PROGRAM CHANGES: STATE-BY-STATE PROFILES* (1982).

141. *MEDICARE & MEDICAID GUIDE* (CCH) ¶ 15,574 (1983).

142. Numerous authorities have argued that the administration of Medicaid programs could be improved or, more importantly, maintained at a more acceptable cost by the implementation of a variety of program reforms ranging from a major overhaul of the methods by which eligibility and reimbursement decisions are made to modifications of the underlying financial structure of Medicaid reimbursement, e.g., prudent buyer arrangements or contracts with closed panels or prepayment plans. See authorities cited in Wing, *supra* note 1, at 68-69. A number of states have reacted to the recent federal program funding reductions by attempting to institute such measures. California, for example, now contracts with hospitals on a competitive basis to provide care to Medicaid recipients in various areas of the state. See CAL. WELF. & INST. CODE §§ 14081-14089 (1982). Arizona is attempting to implement a system where Medicaid services are delivered on a

reacted to these pressures by attempting to re-structure medical care delivery or by imposing some form of public controls over medical care costs.¹⁴³

In contrast to these more vigorous reforms, North Carolina, while avoiding program reductions, has opted for program reforms that could best be described as rather modest adjustments or, at least, program adjustments of rather modest proportions. The notable change effected in the state's medical care delivery system was an amendment to the state's certificate of need program imposing a partial moratorium on nursing home construction. The most significant changes in the program itself were the various modifications in the methods for determining provider payments and the limitations imposed on reimbursement rate increases.

This is not meant to discount completely the program changes established in North Carolina in the last several years. The terms of provider reimbursement certainly have been tightened, as any North Carolina provider participating in Medicaid would most willingly attest. Moreover, the various limits on utilization, however modest they may be in the aggregate or in the abstract, must certainly appear extreme measures for those few people whose needs exceed the maximum limits.¹⁴⁴ Tens of millions of dollars worth of services were not delivered in the last two years or, at least, those dollars were not paid out in reimbursement, at least in part the result of the recent cost containment measures and other program changes.

Nonetheless, the state's strategy for achieving these savings and bringing total program costs below projected expenditures has been rather conservative, steering a middle course between program reform and program reduction, gambling heavily on the modified incentives inherent in restricted reimbursement levels. In doing so, the state continues to buy into a traditionally structured medical care delivery system. It has induced that system, at least temporarily, to reduce its toll on the state Medicaid budget. It has done so, however, principally by tightening, but not changing, a system of reimbursement that relies on charge or cost-based, fee-for-service reimbursement. The problematic

prepaid, capitated basis by providers selected on a competitive bid basis. See Health Care Cost Containment System, ch. 124, § 1, 1983 Ariz. Legis. Serv. 503 (West).

143. Many health policy strategists have argued that states could only achieve substantial savings in the Medicaid program by strengthening regulatory controls over medical care delivery in general. See Wing, *supra* note 1, at 75-81. For example, several states have recently developed mandatory rate setting programs applicable to all medical care providers as well as Medicaid services. See, e.g., Act of June 24, 1983, ch. 579, § 396, 1983 Me. Legis. Serv. 3192, 3210; Executive Budget Bill of 1983, ch. 27, § 410g, 1983 Wis. Legis. Serv. 80, 210 (West).

144. See, e.g., Klopfer, *How Medicaid Cutbacks Hurt*, The North Carolina Anvil, July 16, 1982, at 1, col. 1.

concept of "freedom of choice" remains untouched. There has not been an increase in control or oversight on utilization or patterns of practice; nor has there been any attempt to induce private efforts to do so. It can be argued that there was no need for more radical reforms or further changes in either the program or the medical care delivery system in the state. The modified reimbursement incentives and the other elements of the "middle course" strategy defused the immediate crisis facing the state and the state experienced program savings in FY 1982 and FY 1983 that were within politically acceptable limits. Indeed, unless a more pressing political need could be identified, a sanguine politician might argue that more substantial program reforms would have been politically impossible as well as unnecessary. Nonetheless, whether the political prospects for more systemic reform will increase—or the necessity will become more pressing—are questions not so easily answered. The middle course must stand the test of time, and it must be examined in terms of its impact on the program itself, as well as on the state budget.

2. Long Term Prospects For Continuing Cost Containment

Several factors suggest that the recent Medicaid program modifications in North Carolina have done no more than head off the most immediate political crisis. First of all, as noted in the introduction to this article, even with an improvement in the state's economy, which is hardly a certain prospect, the state faces several years of tight budgeting. The demands of other state-funded programs will continue to produce pressures for additional Medicaid cost control, even in the best of times. Moreover, if the economic picture continues to be gloomy, the large and growing share of the state's budget consumed by Medicaid will continue to be a target of budget-cutting legislators. The state may also face additional rounds of federal budget reductions or limitations over and above those already required. The Reagan domestic welfare strategy has neither resolved the overall budget problems of the federal government nor relieved the other political pressures in Congress to reduce the federal share of Medicaid costs. It is even possible that the initial success of the state's current strategy has been no more than a political "Hawthorne effect;" the willingness of providers to react favorably to the state's pressures may be more of a short term political choice than a true measure of their economic behavior. It is also clear that at least a substantial portion of the savings in FY 1982 and FY 1983 was due to a decline in the number of Medicaid eligibles, a factor unrelated to the state's Medicaid cost containment strategy.¹⁴⁵ More

145. See *infra* notes 169-70.

simply put, the control over program inflation achieved by the modest program changes in the last several years may not represent a successful strategy in future years, even from a point of view that focuses entirely on the state budget.

3. The Appropriateness of the "Middle Course" Strategy

Even if pressures for additional cost savings are not forthcoming in the years ahead, the state will still be faced with the difficult task of maintaining the successful budgetary course that it has thus far charted. While the continuation of that success will obviously be affected by a variety of factors beyond the control of state policymakers, in evaluating the policy choices of the state, the critical question will be whether the state has effected—and will continue to effect—the underlying causes of the inflation in Medicaid program expenditures. Unless the various cost containing measures adopted by the state are appropriately and effectively matched to the actual causes of inflating costs, the state's strategy will eventually fail; or if it is effective in the budgetary sense, it will succeed only at the expense of the program itself.

As indicated in Section I, the actual causes of inflating program expenditures are difficult to specifically delineate given the sparsity of available data. It is at least clear what are not the causes of the state's current financial problems: Medicaid inflation is not a result of either expanding or overly-generous eligibility standards, or of increases in either the number of program eligibles or recipients; nor can it be linked to expanding service coverage.¹⁴⁶ It is also apparent that the inflation in program expenditures during the last several years has not resulted from a general trend of Medicaid recipients seeking out more medical services more often. The available utilization data indicates that recipients of some kinds of services may be receiving more units of care, *e.g.*, some recipients are staying longer in hospitals or other institutions,¹⁴⁷ but even with regard to those services where utilization has increased, there are no indications of a dramatic or overall trend of growing utilization.¹⁴⁸

The major exception to these general observations involves the recent increases in the number of ICF-MR recipients and a corresponding increase in ICF-MR service utilization.¹⁴⁹ Clearly, there are more ICF-MR recipients requiring more services, a trend which, given the expense of those services, stands out as one significant component of the inflation in Medicaid program expenditures and which therefore

146. *See supra* notes 48 & 73-74.

147. *See supra* Table X.

148. *Id.*

149. *Id.*

deserves the careful and deliberate attention of state policymakers.¹⁵⁰ But with this major exception, the clear implication of the available utilization and expenditure data is that the primary causal factor in the inflation in the state's program expenditures is the inflation in the cost per recipient of services of Medicaid-funded medical care. That is to say, the cost of a day in the hospital or in a nursing home bed, or of other units of care, is simply becoming more expensive each year. As a consequence, the overall cost of maintaining the state's Medicaid program at current levels of coverage and eligibility, even apart from any utilization increases, has become increasingly more expensive and likely will continue to be so—unless somehow affected by state policy. This is the heart of the state's Medicaid cost problem.

As indicated earlier, such an observation should hardly be surprising. Inflation in the costs of medical care generally has been fueled by a number of factors, but the principle driving force in recent years has been inflation in the cost per unit of service.¹⁵¹ Medicaid, structurally designed to conform to the mold of the private medical delivery system, particularly with regard to reimbursement principles, could not be expected to be resistant to this same trend. Indeed, inflation in Medicaid program expenditures, paralleling the inflation in medical care costs generally, may well be the inevitable "cost" of a public program that has bought into the traditional medical care delivery system without requiring or effecting any significant variation in the delivery of services or in the terms or patterns of their financing.

Conversely, this outlines the prescription for a successful cost containment strategy for the state's program: cost saving measures must be adopted that will somehow encourage or require changes in the pattern or cost of the services delivered. If not, the state's Medicaid program will continue to be subject to significant inflationary pressures regardless of the future political or economic climate or of other factors influencing the need to reduce or contain expenditures. Other strategies may for a variety of reasons produce temporary budgetary savings, and, of course, program expenditures can always be achieved by reductions in program eligibility or services. But lasting cost containment and equitable social policy can only be achieved if the state's strategy is designed to affect the underlying causes of the program inflation.

150. It must be noted, however, that Medicaid coverage of ICF-MR recipients extends largely to people who are in public institutions; but for Medicaid coverage—for which the state pays only one-third the cost—the state would be bearing the full cost of service to these recipients. Thus the expanding coverage and the increase in the number of this category of recipients is actually a saving to the state budget, and shifts the cost of their care to Medicaid and, in part, to federal funds.

151. See discussion *supra* note 69.

It is in this light that the state's "middle ground" cost containment strategy should be most closely examined and evaluated.

To begin with the most obvious, the coverage limitations imposed on drug prescriptions and on individual provider visits in 1981 and modified in later years seem wholly arbitrary as cost containment measures.¹⁵² They are neither targeted at services for which utilization has been markedly increasing or, for that matter, that involve significant expenditures.¹⁵³ Most importantly, by completely denying reimbursement, they may offer some disincentive to overutilization, *e.g.*, unnecessary visits or prescriptions of marginal value, but they also act to deny services to certain unfortunate recipients who are in need of additional attention. Thus, they are cost containing measures unlikely to result in limits on program expenditures, but which impose a considerable cost on a few arguably faultless beneficiaries.

The partial moratorium on nursing home construction is more difficult to characterize because the actual impact on the nursing home industry in North Carolina is not clear given the terms of the moratorium.¹⁵⁴ Even assuming there is a resulting limitation on the supply of nursing home beds, the effect on the use of those beds by Medicaid recipients is also unclear. Certainly both the costs of nursing home services and the utilization of those services are appropriate, indeed virtually essential, targets for state cost containment efforts.¹⁵⁵ Whether the current moratorium will achieve these objectives, however, is at least questionable. The moratorium, as currently worded, will cause only a delay in the construction of new beds, as all beds previously authorized are constructed.¹⁵⁶ Since nursing homes throughout the state are virtually filled to capacity as soon as they are in operation,¹⁵⁷ once the previously authorized beds are constructed, new

152. *See supra* notes 124-25.

153. *See supra* Table X.

154. *See supra* note 128.

155. *See supra* notes 23 & 68-69.

156. As of November 1, 1981, there were at least 1750 nursing home beds in the state that had been authorized but had not been constructed or licensed. *See* DIVISION OF FACILITY SERVICES AND STATE HEALTH PLANNING SECTION, N.C. DEPT. OF HUMAN RESOURCES, 1981-1982 STATE MEDICAL FACILITIES PLAN 5-7 (1982). Under the terms of the moratorium, these beds would have to be constructed, licensed, and occupied at 75% capacity before any additional certificates of need for nursing home beds could be authorized. According to state officials, the immediate response to the moratorium was to encourage the construction of all these beds. Telephone interview with Barbara Kramer, Division of Facility Services, Department of Human Resources (October 24, 1983) [hereinafter cited as Kramer interview]. Thus, throughout the first several years of the moratorium, the supply of nursing home beds continued to expand. The only real effect of the moratorium would be felt during the period of time after the construction of the 1750 beds—and during the construction of beds delayed by the moratorium and the requirement that no certificate of need applications would be *accepted* until 1750 beds were constructed. *See supra* note 128.

157. Kramer interview, *supra* note 156.

applications for certificates of need will not be affected by the 75% occupancy requirement. Any resulting delay in the growth of the bed supply will only be felt in future years, as additional beds are being constructed following their authorization but prior to their operation.¹⁵⁸

Assuming that there is a temporary limit on the expansion in the supply of nursing home beds in North Carolina, given that Medicaid recipients occupy at least 75% of nursing home beds,¹⁵⁹ the moratorium could have an impact on Medicaid expenditures in the obvious sense that some Medicaid recipients may be denied nursing home services during the interim delay in the availability of new beds. One could even speculate that some nursing homes would attempt to control an adverse impact on program beneficiaries by attempting to make their beds available to those in the most need, and by attempting to be more aggressive in finding alternatives for their patients. But to be more realistic, the influence—if any—of a restricted bed supply is hardly likely to be felt as an incentive by providers for either more efficient delivery of services or more control over the cost of those services. The influence on the nursing home industry is likely to be just the opposite. Thus, the moratorium may result—at some point in time—in reduced program expenditures, largely by restricting access to services for some recipients. It is unlikely to have any real or lasting impact on the delivery of nursing home services to Medicaid beneficiaries, or on the inflating costs of those services; nor is there likely to be a lasting impact on the portion of the inflation in the Medicaid budget which can be traced to its coverage of nursing home services.

The impact, as well as the wisdom, of the reimbursement ceilings and other limitations on provider reimbursement enacted in 1981 and amended in subsequent years can be more specifically assessed.¹⁶⁰ In principle, prospectively determined limits on reimbursement increases, be they fixed ceiling or limits determined by industrywide averaging, could result in incentives for more efficient delivery of services or, at least, shift part of the impact of inflating costs from the Medicaid budget to those providers with charges or costs above the established limits. But such a principle assumes a willingness or a need on the part of providers to continue to provide services to Medicaid beneficiaries under the more restricted terms of reimbursement. As summarized earlier, many individual providers are already reluctant to accept Medicaid patients, in large part because of the levels of reimbursement.

158. It has been estimated that it takes 12 to 18 months from authorization to completion of construction. *Id.*

159. *Id.*

160. *See supra* notes 119-22 & 131.

Since Medicaid participation is voluntary, most individual providers can just as easily react to reduced reimbursement levels by treating fewer Medicaid patients, or even by withdrawing altogether from participation in the program. In reality, therefore, tightening the terms of reimbursement without securing provider participation in an effort to control program costs¹⁶¹ is a gamble and, under the circumstances, not a particularly wise one. The state is gambling that the individual providers affected will continue to provide the same level of services to recipients for less reimbursement, accepting the financial consequences as incentives to render more inexpensive or more efficient care, an outcome that hardly comports with the likely reaction of many providers. Thus, even assuming that the services subjected to the various reimbursement limits are appropriate targets for the state's cost containment strategy,¹⁶² the containment measures adopted are only likely to be successful in the narrow sense that they will reduce program expenditures. But they may likely do so at the expense of beneficiary access to services, affecting de facto reductions in the program.

The limitations imposed on inpatient hospital reimbursement, which is surely an appropriate target for cost containment,¹⁶³ are analytically more complicated, but basically subject to the same criticism: such limits have created a risk of de facto program reductions rather than incentives for more efficient delivery of services.

The recently implemented prospectively determined per diem rate structure is still essentially a fee-for-service, cost-based reimbursement formula.¹⁶⁴ The key ingredient to the new scheme is the "trigger" for lowering the reimbursement rates for high cost hospitals once their total Medicaid patient days exceed 85% of their previous year's level. Clearly, as with all reimbursement limitations, this will discourage the high cost hospitals from accepting Medicaid patients. Indeed, the threat of a greatly reduced reimbursement rate following the "trigger" level may lead these hospitals to build a cushion against unexpected utilization and therefore target their Medicaid admission levels to fall below the "trigger" level. Theoretically, the disincentives for high cost hospitals are offset by the incentives created under the scheme for lower cost hospitals; assuming the reimbursement rate is attractive enough for these hospitals, the high cost hospitals could shift their Medicaid patients to these lower cost hospitals, effecting a kind of systemic efficiency and in theory maintaining the availability of services but at a lower cost to the program.

161. See discussion of provider participation *supra* notes 107-10.

162. See *supra* Tables VIII-X & notes 70-74.

163. See *supra* note 68 & Table VII.

164. See *supra* notes 83-88.

Such a scheme has a certain amount of appeal; it closely parallels some aspects of "preferred provider" schemes that have been advocated by many critics and attempted in some states.¹⁶⁵ It also has several key flaws. First, even if lower cost hospitals are willing to accept additional Medicaid patients, an important and essential key to hospital admission is the availability of physicians to accept those patients, a critical element not addressed by the scheme. Second, it is not clear whether the rates for lower cost hospitals will be sufficiently attractive to encourage their increased services to Medicaid.¹⁶⁶ Thus, the scheme may envision a shifting of Medicaid patients from the high cost to the lower cost hospitals, but, unlike preferred provider agreements, the scheme provides no assurance that the lower cost hospitals will cooperate, only a clear incentive for the "non-preferred" provider to limit Medicaid utilization. Again, cost saving, even if it is achieved, runs a considerable risk of creating de facto program reductions as Medicaid patients are steered away from high cost hospitals and must seek admission elsewhere.¹⁶⁷

Clearly, one critical determinant of the success of the state's "middle course" strategy will be the willingness of Medicaid providers to participate in the program.¹⁶⁸ If the coverage and reimbursement limitations and the other program changes of the last several years have provided incentives for more inexpensive care, the elimination of unnecessary services, or in other ways created more efficiency in the provision of services to Medicaid recipients, then the state truly deserves considerable praise. On the other hand, if the state has not inspired cost containment but merely caused providers to be reluctant to provide services to Medicaid beneficiaries, then the program savings of the last several years have been only de facto program cuts, and future success for that strategy can only be predicted, if at all, in the most limited sense of the term.

Ironically, the state's Medicaid cost containment strategy of the last several years may not have been successful even in that most narrowly defined sense, or at least, its success may have been partially attributable to other factors. The available data from FY 1982 and FY 1983 show a marked decline in both the number of Medicaid eligibles and

165. See *supra* note 142.

166. It should be emphasized that the reimbursement rate for lower cost hospitals is critical. The inflation factor or other factors determining the prospective per diem rate must be attractive enough to encourage these hospitals—and their physicians—to take additional Medicaid patients.

167. It should be noted that the lower cost hospitals may not be geographically available to Medicaid patients and, in any event, there is no requirement for formal arrangements between lower and higher cost hospitals to facilitate transportation or otherwise insure the shift of utilization.

168. See discussion *supra* notes 107-10.

Medicaid recipients.¹⁶⁹ Since Medicaid eligibility is tied directly to welfare eligibility, presumably this reduction is due in large part to the federal changes in eligibility for welfare programs.¹⁷⁰ In any event, this reduction of nearly 30,000 beneficiaries from the Medicaid rolls—and not the state's cost containment strategy—must certainly account for a substantial part of the cost saving that has been achieved by the Medicaid program in recent years.¹⁷¹ This, too, can be best described as a de facto program reduction.

CONCLUSION

Assuming that North Carolina's commitment to the maintenance of a Medicaid program comparable to the one we presently have is genuine, then the state's Medicaid cost containment problem is twofold. The state must attempt to reform or modify the existing program so as to control the inflating cost of Medicaid-funded services, but it must do so without causing a substantial disruption in the availability of providers or the accessibility of Medicaid beneficiaries to necessary care. This is the problem that made the crisis created by the Reagan-inspired federal budget cuts so difficult; this is the problem that clouds the prospects for the future of the program.

Unless something is done to abate the long term trend of inflation in program expenditures—a trend most likely due to inflation in the cost of medical services—the state's Medicaid program as currently constituted will become increasingly expensive and periodically critical, as pressure from both within and without the state fuels the annual Medicaid budget debates. The state extracted sufficient savings from the program in the last several years, by tightening reimbursement and by making other modest adjustments, but the state may well find that the success of this “middle course” between program reduction and program reform was as much fortuitous as a result of sound policy and that it has not permanently resolved the cost containment problem.

Successful long term measures, however they are drawn, are likely to encounter substantial political and administrative difficulties. It almost goes without saying that reform measures affecting the pattern of practice of medical care providers or their financial rewards from participating in the program will be most difficult, even if the cost of the program becomes once again a political crisis. But just such measures

169. See *supra* Table I & notes 46-47.

170. See *supra* note 127.

171. As Table IV indicates, the “average” beneficiary accounted for nearly \$1000 per year in Medicaid expenditures in FY 1982. Comparing the cost per year data in Table IV with the reduction in recipients indicated in Table I, it appears that roughly \$30 million in savings resulted from the change in the number of eligibles (and recipients).

will be needed. Clearly, the inflation in Medicaid program expenditures in North Carolina is tied directly to the rising costs of rendering medical care in the state. No matter how controversial, sooner or later the state's cost containment strategy will have to address these medical care costs. For that matter, the political importance of medical care costs for North Carolinians generally, both as consumers and taxpayers, must at some point become critical. The state will, therefore, eventually have to address medical care costs even if it does not do so in order to salvage the existing Medicaid program.

While it is not the intent of this article to outline a specific legislative agenda for the state's Medicaid cost containment program, the basic principle that should underlie that program is rather clear: whatever measures are adopted should be reasonably calculated to impact on the real causes of Medicaid program inflation and to do so without directly or indirectly effecting program reductions. This will require a more realistic analysis of the program and its history, as well as a careful monitoring of the program as cost containment measures are implemented.

The state's current cost containment strategy would appear to be more sensible public policy if the deliberations concerning that strategy, or at least those that are public and particularly those in the state legislature, took a more explicit accounting of the likely impact on provider participation and a close and continuous accounting of the impact on eligibility and, most importantly, utilization. As emphasized throughout this article, the real measure of a cost containment strategy should not be the apparent cost savings in the short term, or, for that matter, even in the long run; it should be measured in terms of both the savings of program funds and the impact on the program.

If such explicit and public attention is not paid to the impact on the program, then the state risks creating *de facto* program cuts. As argued earlier, this may already be happening; indeed, it may be what state policymakers actually intend. It would be unfortunate, however, if state policy for such an important program were to be set in this manner, just as it would be unfortunate if the underlying commitment to the program were to be conceded or curtailed before a realistic grapple with the causes of Medicaid program inflation actually takes place.

If, over the next several years, the state can somehow affect the cost of medical care services or at least the cost of those services provided to Medicaid beneficiaries within the existing program structure without reducing the scope of the program as currently constituted, then North Carolina does indeed deserve considerable credit. If the current strategy proves to be unworkable, or simply fails to save enough money,

then the crisis that was avoided in the early 1980's will soon recur, and more drastic policy choices will eventually have to be addressed.