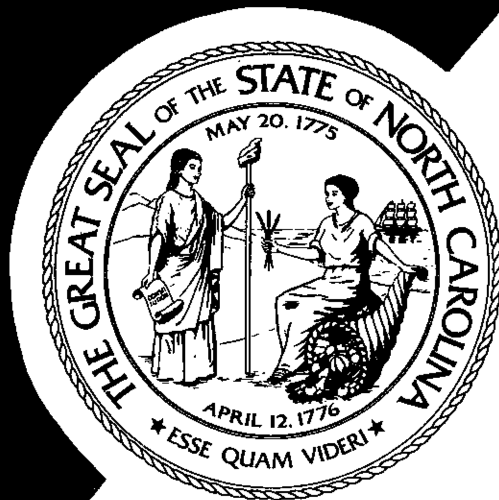
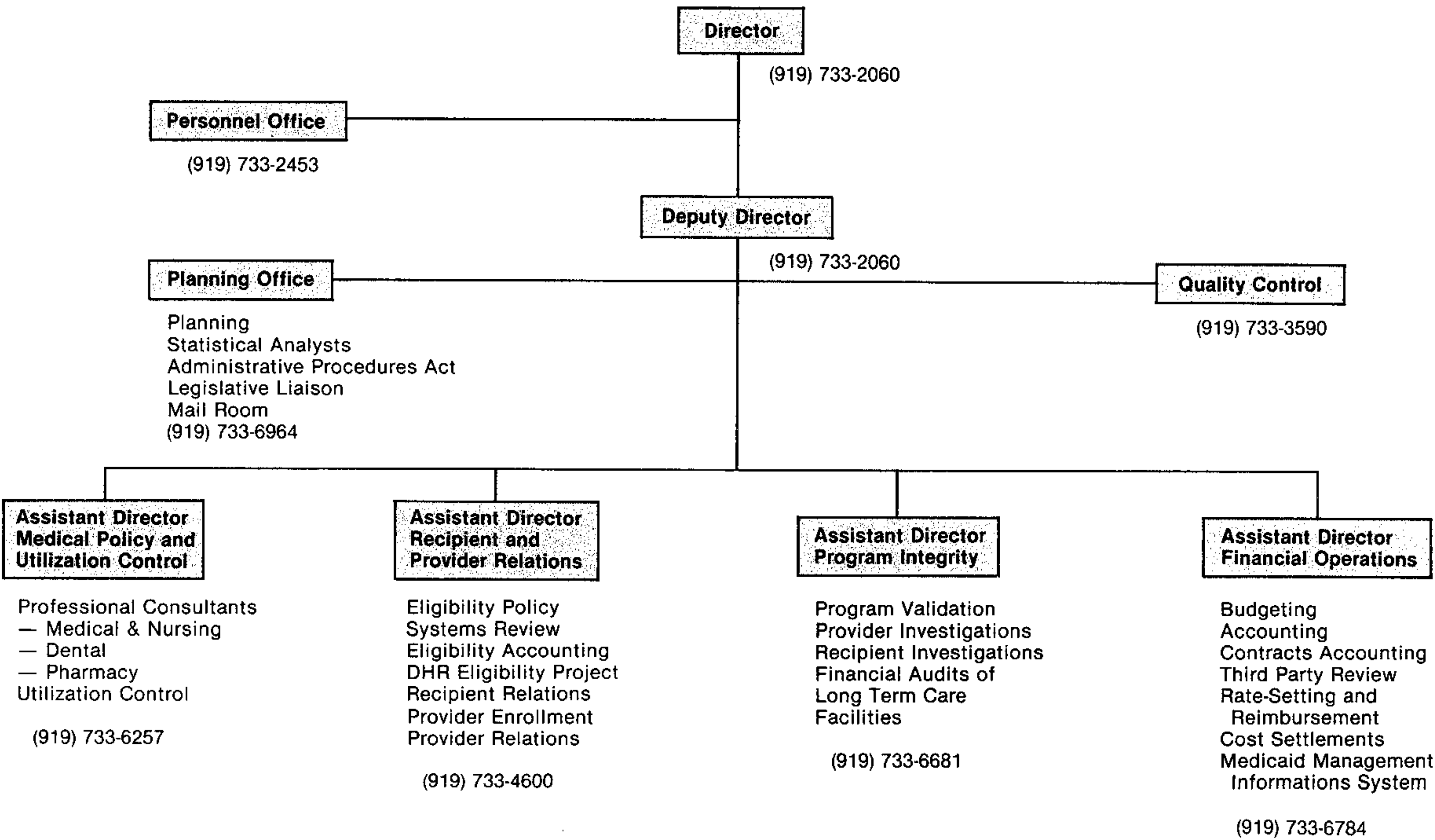
MEDICAID IN NORTH CAROLINA



ANNUAL REPORT 1985-1986

N.C. Department of Human Resources
Division of Medical Assistance

DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MEDICAL ASSISTANCE
OFFICE OF THE DIRECTOR



MEDICAID IN NORTH CAROLINA
ANNUAL REPORT
1985 - 1986

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

Phillip J. Kirk, Jr., Secretary
Department of Human Resources

Barbara D. Matula, Director
Division of Medical Assistance

Daphne O. Lyon, Chief
Planning Section

Patricia C. Slaughter, Editor
Planning Section

One thousand copies of this public document were printed at a cost of $2,385.00 or $2.38 per copy.

North Carolina Department of Human Resources
Division of Medical Assistance
1985 Umstead Drive • Raleigh, North Carolina 27603
James G. Martin, Governor
Phillip J. Kirk, Jr., Secretary
Barbara D. Matula, Director
(919) 733-2060

January 2, 1987

Dear Citizens:

I am pleased to present North Carolina's 1985-86 Annual Report.

In 1985-86 payments for health care services increased 19% over the previous year, but by holding administrative expenditures in check, the total Medicaid budget increased only 13.9%.

A 10% increase in the Medicaid income levels and an increase in resource limits allowed more people to qualify for Medicaid benefits. Even with the increases, the income level for a family of four is 40% of the poverty level.

Personal care services (PCS) in the home is an added benefit as of January 1, 1986. This service is designed to allow elderly and disabled people to live more comfortably in their own homes and to delay institutionalization. PCS and annual adult health screenings, another benefit added in January 1986, had only six months to "gear up" in fiscal 1985-86. However, these two efforts at preventive care for adults make a significant policy statement regarding the goals of Medicaid.

A name change of our child screening program from Early & Periodic Screening, Diagnosis & Treatment (EPSDT) to Healthy Children and Teens Program, also makes a significant policy statement. The new name is to emphasize adolescent and teen health, as well as well-baby care.

Details are provided in the report.

Sincerely,

Barbara D. Matula

Barbara D. Matula
Director

EXECUTIVE SUMMARY . . .

In fiscal year 1985-86 the state Medicaid program spent over $758 million for health care services to over 370,000 needy people. About 5.0% of total Medicaid expenditures went toward administrative costs. Of those expenditures, 31.3% went to local county departments of social services for their efforts in eligibility determinations.

Effective January 1, 1986, adult Medicaid recipients became eligible for an annual health screening. The adult health screening program is patterned after the child health screening program, Healthy Children and Teens. This preventive service is designed to detect health problems, provide early treatment and avoid costly acute services over the longer term. Clients and providers were notified of the availability of the new service, but in the first six months only 300 clients had taken advantage of the service.

Another service added on January 1, 1986, is personal care services. These are services provided in the home designed to assist the patient with activities of daily living and related housekeeping activities. While this service is not limited to persons at immediate risk for institutionalization, it is designed to delay institutionalization and improve the quality of life for the frail elderly and disabled person. During the first six months of operation, $207,000 was spent for this care.

The Medicaid income levels increased by 10% on July 1, 1985, allowing more people to qualify for eligibility.

PEOPLE SERVED . . .

In state fiscal year 1985-86 the North Carolina Medicaid program paid for the medical care of 370,415 needy people. People eligible for Medicaid are divided into two groups: one group is classified as categorically needy and the other as medically needy.

The categorically needy group consists of people who are eligible for public assistance. All state Medicaid programs are required by Federal regulations to include the categorically needy classification. The medically needy classification is included as a state option.

The medically needy must meet the same general qualifications as the categorically needy to be eligible for Medicaid. However, the medically needy individual is not eligible to receive public assistance, primarily because of income or assets. If the medically needy individual's income is higher than the allowable level, he must spend the excess income on medical care before becoming eligible.

There are six categories of eligibility within each classification:

1) AFDC or Aid to Families with Dependent Children — A dependent child is defined as one who is deprived of parental support and care because one or both parents is ill, absent or deceased. Children and their parents, or caretakers, who are eligible for AFDC are eligible for Medicaid. A dependent child is eligible for AFDC Medicaid up to age 19. Effective January 1, 1985, Medicaid coverage under the AFDC medically needy group was extended to pregnant women and children in intact, two parent families.

2) AA or Aid to the Aged — Persons who are age 65 or over and meet financial requirements.

3) AD or Aid to the Disabled — Persons between ages birth and 65 years of age, and who meet the Supplemental Security Income definition of disability may be eligible for Medicaid.

4) AB or Aid to the Blind — Persons of any age who meet the Supplemental Security Income definition of blindness may be eligible for Medicaid.

5) RC or Reasonable Classification of Children under 19 — This category includes children in the custody of the county department of social services or children for whom the county has responsibility for placement in medical institutions. Effective January 1, 1985 coverage was extended to cover children who are in the custody of private adoption/placement agencies.

6) Title IV-E — These children are in foster care or adoptive homes under Title IV-E which means they are automatically eligible for Medicaid.

Recipients of AFDC payments or state/county special assistance payments automatically qualify for Medicaid.

Federal regulations permit states to either accept as categorically needy all persons found eligible for the federal SSI program, or to set categorically needy eligibility criteria which is more restrictive than SSI standards. North Carolina has elected the more restrictive option, making it a "209(b)" state, so named for the regulatory cite explaining the option.

One of the conditions of eligibility is a needs test based on income and resources. With the exception of children under Title IV-E, and those recipients who are automatically eligible, all categories must meet the needs test. Resources are real or personal property, such as land, cash, non-essential automobiles, etc. As long as an applicant, his spouse and/or his dependent children reside in his home, the home is not considered an available resource for purposes of determining eligibility for public assistance or Medicaid.

The following are the annual Income and Resource tables used in determining eligibility for the North Carolina Medicaid program during fiscal year 1985-86. These income eligibility standards reflect a 10% increase which was effective July 1, 1985.

INCOME

Family Size	AFDC, RC Categorically Needy	AFDC, RC Medically Needy	AGED, BLIND, DISABLED All Groups
1	$1,956	$2,700	$2,700
2	2,568	3,500	3,500
3	2,952	4,000	4,000
4	3,228	4,400	4,400
5	3,528	4,800	4,800

RESOURCES

Family Size	AFDC, RC Categorically Needy	AFDC, RC Medically Needy	AGED, BLIND, DISABLED All Groups
1	Flat 1,000	$1,500	$1,500
2	Reserve Limit,	2,250	2,250
3	no increment for	2,350	2,350
4	family size	2,450	NA
5		2,550	NA

SERVICES PROVIDED . . .

Certain services are mandated by federal regulations for all states participating in Medicaid. Other services are optional for states under federal regulation. The North Carolina General Assembly has authorized coverage for the following:

FEDERALLY MANDATED SERVICES

Hospital Inpatient
Hospital Outpatient
Lab and X-Ray
Skilled Nursing Facilities (SNF)
  age 21 and over
Home Health
Early and Periodic Screening
  Diagnosis and Treatment (EPSDT)
Family Planning
Physicians
Hearing Aids for Children
Rural Health Clinics
Transportation
Durable Medical Equipment
  for Home Health Patients

STATE'S OPTIONAL SERVICES

Prescribed Drugs
Chiropractors
Dental
Intermediate Care Facilities (ICF)
Intermediate Care Facilities
  for the Mentally Retarded (ICF-MRC)
Clinics, Including Mental Health Centers
Optical Supplies
Optometrists
Skilled Nursing Facilities,
  under age 21 (SNF)
Podiatrists
Mental Hospitals, age 65 and over
Psychiatric Facilities, under age 21
Specialty Hospitals
Community Alternatives Program
  Aged/Disabled
  Mentally Retarded
  Disabled Children Under 18
Ambulance
Prepaid Health Plans
Personal Care

HEALTHY CHILDREN AND TEENS PROGRAM

The Healthy Children and Teens Program, authorized under the federally mandated EPSDT Program, is a preventive health care program for Medicaid eligible children and teens under the age of 21.

North Carolina selected the title of its program to emphasize the importance of health care to teenagers as well as children. The program is designed to provide comprehensive health care screenings to detect physical and mental health problems which can lead to disabling diseases later in life. Necessary follow-up care to treat, correct and ameliorate the problem is also provided.

Screenings are provided by physicians and certified nurse screeners in public health departments as well as participating private physicians and their staffs. A list of Medicaid physicians and agencies providing health care is available at the local department of social services for families needing assistance.

PROVIDERS OF SERVICE

Medicaid payments are made to participating health care professionals who provide medical services to eligible people. Medicaid recipients have the freedom to choose any enrolled medical provider. Eligible cases are issued a Medicaid identification card each month which lets the provider know that charges should be billed to the Medicaid Program.

During fiscal year 1986 a total of 9,998 providers submitted 9,862,673 claims for payment.

ENROLLED MEDICAID PROVIDERS BY TYPE OF SERVICE

Type of Service	Number of Providers
Physicians	10,270
Radiologists	578
Pharmacists	1,815
Dentists	2,129
Optometrists	607
Chiropractors	359
Podiatrists	158
Ambulance	144
Home Health Agencies	121
ICF-General	199
ICF-MRC	36
Hospitals	181
Mental Health Clinics	88
Optical Suppliers	149
SNF	190
Other	234
Total	17,258

LIMITATIONS ON SERVICES

Twenty-four (24) visits per year are allowed to one or a combination of physicians, clinics, hospital outpatient departments, chiropractors, podiatrists, and optometrists. Exemptions to limitations based on medical necessity included:

a) prenatal care
b) EPSDT,
c) hospital emergency room care,
d) end stage renal disease,
e) chemotherapy and radiation therapy for malignancy,
f) acute sickle cell disease,
g) end stage lung disease,
h) unstable diabetes,
i) hemophelia,
j) terminal stage of any life threatening illness.

Six (6) prescriptions, including refills, are allowed each month. However, the exemptions based on medical necessity listed above also apply to prescriptions.

PRIOR APPROVAL

Prior approval from the Division of Medical Assistance or its designated agent is required for the following services:

1. Reimbursement of hospital inpatient services when a lower level of care is needed, but a bed for the appropriate lower level of care is unavailable.
2. Cosmetic surgery
3. Out of state services that are non-emergency and performed outside a 40 mile radius of North Carolina.
4. More than two outpatient psychiatric visits-except at mental health centers
5. Hearing aids for children.
6. Many non-emergency dental services, including dentures.
7. Admission to SNF, ICF, ICF-MR
8. Eye Care Services
9. Durable Medical Equipment
10. Community Alternatives Program
11. Organ Transplants

CO-PAYMENTS

The following recipient cost sharing (co-payment) amounts became effective April 1, 1984. Co-payment amounts are the same for both categorically needy and medically needy recipients.

Service Category	Co-Payment
Chiropractic	$ .50 per visit
Clinic Services	.50 per visit
Dental Services	2.00 per visit
Legend Drugs and Insulin	.50 per prescription including refills
Optical Supplies	2.00 per visit
Optometric Services	1.00 per visit
Outpatient Hospital	1.00 per visit
Physician	.50 per visit
Podiatrists	1.00 per visit

Certain co-payment exemptions were mandated under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. No co-payment can be charged on the following services:

1. EPSDT
2. Family Planning
3. Services to children under 18
4. Services related to pregnancy
5. Services to residents of ICF, ICF-MR, SNF, and mental hospitals
6. Hospital emergency room

In addition to the federally mandated exemptions, the state exempted the following services from co-payment:

1. Community Alternatives Program (CAP)
2. Services to enrolees of prepaid plans
3. Rural health clinics
4. Non-hospital dialysis facility
5. State-owned mental hospital
6. Services when covered by both Medicare and Medicaid

METHODS OF REIMBURSEMENT

— Hospital Inpatient Services, Long Term Care Facilities: Prospective per diem rates

— Physicians, Other Practitioners, Laboratory and X-Ray: Statewide fee schedule

— Home Health Agencies, Hospital Outpatient Services: Cost based reimbursement

— Rural Health Clinics, Free Standing Clinics, Health Department Clinics: Negotiated rates

— Pharmacy, Hearing Aids: Acquisition Cost Plus Dispensing Fee

— Optical Supplies: Contract Price From Competitive Bid

ADMINISTRATION AND CLAIMS PROCESSING

The Division of Medical Assistance is responsible for administration of the state Medicaid program. During FY 1985-86 DMA had 145 staff positions. EDS Federal Corporation is the fiscal agent contractor for the Medicaid program. EDS-F performs claims processing, provider relations, prior approval, and reporting functions for the state. Expenditures for these services in 1986 were $2.2 million.

In North Carolina 9,862,673 Medicaid claims were processed in FY 1985-86. Each claim was subjected to a series of edits and audits to determine if the recipient was eligible, if the provider was certified, if the procedure was covered, if the service was appropriate for the age and sex of the recipient, if the claim was a duplicate of one previously submitted, and other relevant questions designed to guarantee that Medicaid funds are properly spent. This screening process is more extensive than is used for almost any other third party payor.

UTILIZATION AND INTEGRITY REVIEW

Fraud and abuse detection and deterrence are major concerns of the State's Medicaid administrators. In addition to Medicaid agency staff, the Office of the Attorney General has staff fully devoted to the criminal investigation and prosecution of Medicaid fraud. In FY 1985-86, 889 provider and 1056 recipient cases were initiated and recoupments in the total amount of $306,549 (Providers) and $182,993 (Recipient) were collected. Thirty-seven (37) cases were referred to the Attorney General for possible fraud prosecution.

All utilization review activity is conducted by the Division of Medical Assistance. The federal share of expenditures is 75% when a state agency performs these functions.

Recoveries initiated by DMA as a result of retrospective review of the medical necessity for inpatient hospital services rose to $592,077.

Federally required on-site visits are made annually to each nursing home where the level-of-care needs for each Medicaid patient are reviewed. In 1985, this function was contracted out to the Division of Facility Services (DFS). DFS was already performing nursing home Medicare-Medicaid certification surveys. This contract permits those two functions to be combined. By combining these two on-site inspections into one visit for most nursing homes, the state achieves efficiencies and the nursing homes suffer less disruption.

Paid claims are periodically reviewed and those which differ significantly from established norms are analyzed to ensure that the services are medically necessary and appropriate. Certain services which are very expensive or which may be of questionable necessity under certain circumstances require prior approval before treatment is rendered.

THIRD PARTY LIABILITY

Third party resources for medical care such as health insurance, are an important means of reducing Medicaid costs. When a person accepts Medicaid benefits he, by state law, agrees to assign all third party resources designated for health care to the State Medicaid agency. North Carolina's Medicaid agency has received national recognition for its successful efforts in recovering third party resources.

THIRD PARTY RECOVERY ACTIVITY REPORT

		FY 1985-86
1. SUMMARY		
	A. Insurance Paid to Providers	$ 5,371,436
	B. Claims Denied for Other Insurance (EOB 094)*	17,398,386
	C. Refunds	3,064,006
	TOTAL	$ 25,833,828
2. REFUND DETAIL		
	A. Medicare	$ 573,256
	B. Health Insurance	1,510,745
	C. Casualty Insurance	980,005**
	D. Responsible Relative	--
	TOTAL	$ 3,064,006
3. COST AVOIDANCE BY MEDICARE		
	A. Medicare A	$ 91,078,567
	B. Medicare B	27,640,989
	TOTAL	$118,719,556

* Identified for investigation. Findings may or may not result in a refund.
** Does not include $361,101 undispositioned Casualty Refunds.

FINANCING MEDICAID

The largest share of Medicaid costs is paid by the federal government. Federal Medicaid service matching rates are established by the Department of Health and Human Services using the most recent three year average per capita income for each state and the national per capita income. The established federal matching rates for services are effective for a period of one federal fiscal year. Because the federal fiscal year and the state fiscal year do not exactly coincide, two different federal service matching rates apply in each state fiscal year.

Because federal match for administrative costs are constant, there is only one rate for SFY 1985-86. Following is a table showing the federal matching rates for FY 1985-86.

SERVICE COSTS

	7/1/85 - 9/30/85		10/1/85 - 6/30/86	
	Family Planning	All Other Services	Family Planning	All Other Services
Federal	90.00	69.54	90.00	69.18
State	8.50	25.89	8.50	26.20
County	1.50	4.57	1.50	4.62

ADMINISTRATIVE COSTS

	7/1/85 - 6/30/86	
	Skilled Medical Personnel & MMIS	All Other
Federal	75.00	50.00
Non-federal	25.00	50.00

MMIS — Medicaid Management Information System

THE ROLE OF THE COUNTY IN THE MEDICAID PROGRAM

North Carolina has a state-supervised, county-administered social services system. County social service departments determine eligibility for Medicaid based upon federal and state eligibility requirements. Counties are required by state statute to pay a portion of the costs for Medicaid recipients who reside in their county and recieve Medicaid services throughout the year. Counties are required to pay 15% of the non-federal share for medical services and 50% of their administrative costs for eligibility determinations.

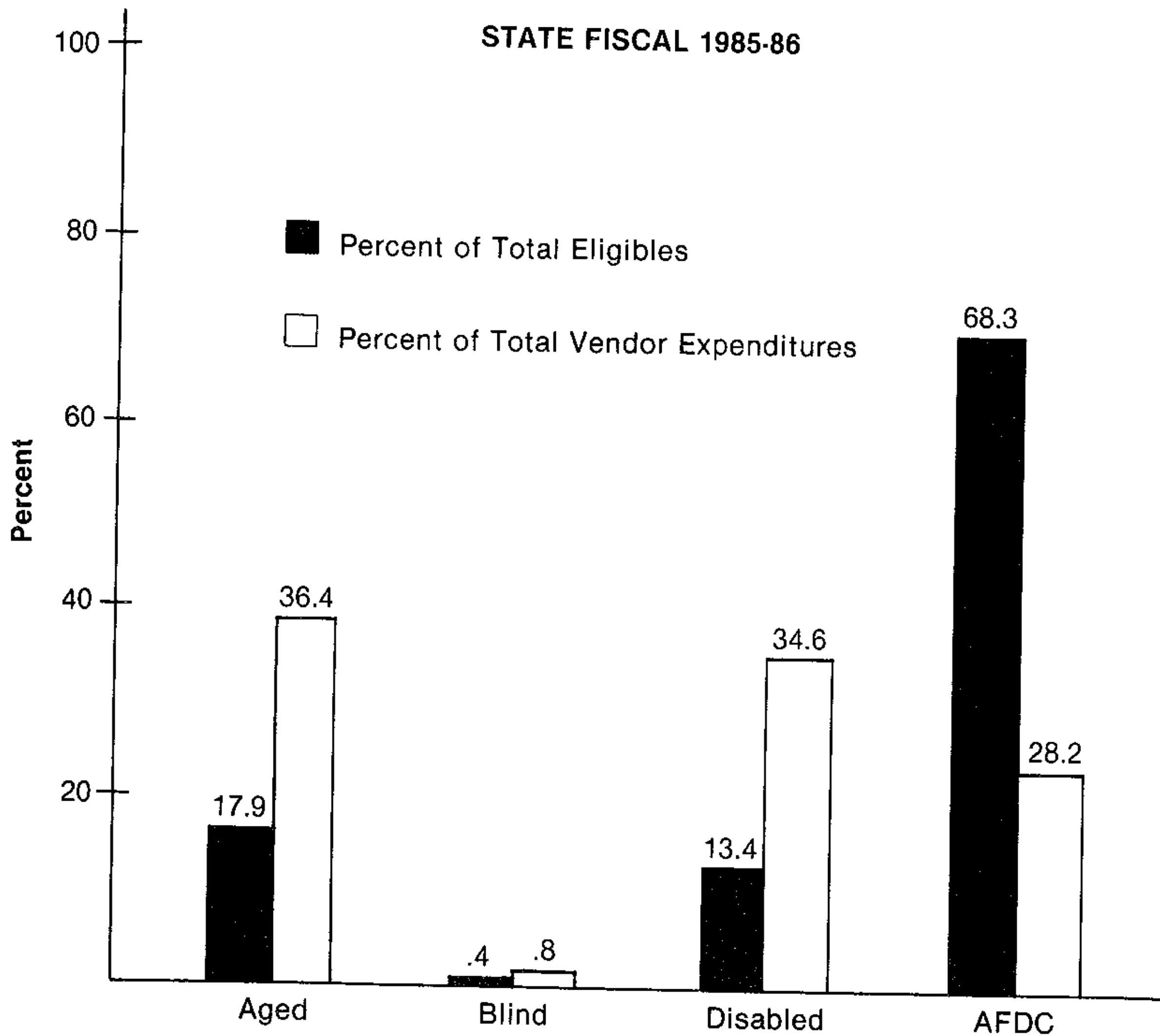
MAJOR POLICY CHANGES

There were several major policy changes during FY 1985-86. Among them were the following:

EFFECTIVE DATE	POLICY CHANGE
July 1985	Pharmacy dispensing fee raised from $3.36 to $3.50
July 1985	Hospital Reimbursement Plan revised to establish a method for setting a reimbursement rate for newly established hospitals and increase per diem rates by 5% to those hospitals serving a disproportionate share of indigent patients.
July 1985	Increase in Resource Limits for the Aged/Blind/Disabled Medically Needy Program.
July 1985	Medically Needy Income Standard increased 10%.
January 1986	Medicaid coverage of Personal Care Services began.
January 1986	Medicaid coverage of Adult Health Screening Services began.
June 1986	The following short session legislative actions will be effective in SFY 1987: Pharmacy dispensing fee raised from $3.50 to $3.67. Medically Needy Income Standards increased 5%, effective January 1, 1987.

EXPENDITURES FOR SELECTED MAJOR MEDICAL SERVICES BY PROGRAM CATEGORY
For Fiscal Year 1986

Type of Service	Total	Aged	Blind	Disabled	AFDC Child Other Children	AFDC Adults
Inpatient Hospital	$181,856,407	$ 20,990,958	$ 778,709	$ 65,623,248	$52,342,093	$42,121,399
Outpatient Hospital	22,914,355	2,680,040	122,775	5,846,277	6,779,556	7,485,707
Skilled Nursing Home	111,440,865	94,691,526	826,000	15,416,729	409,099	97,511
Intermediate Care —						
General	102,222,291	91,021,692	1,095,210	10,031,891	57,142	16,356
Mentally Retarded	119,968,170	2,365,173	1,588,978	100,995,324	15,012,697	5,998
Physician	49,279,233	6,022,563	222,200	13,587,566	13,018,243	16,428,661
Dental	11,926,749	1,105,956	36,818	1,852,820	4,406,838	4,524,317
Prescription Drugs	52,509,808	25,404,350	507,507	16,210,146	3,668,650	6,719,155
Clinics	8,491,171	451,204	26,467	4,549,824	1,773,194	1,690,482
Total Vendor	$710,754,692	$258,877,471	$5,499,109	$245,991,488	$113,365,373	$87,021,251

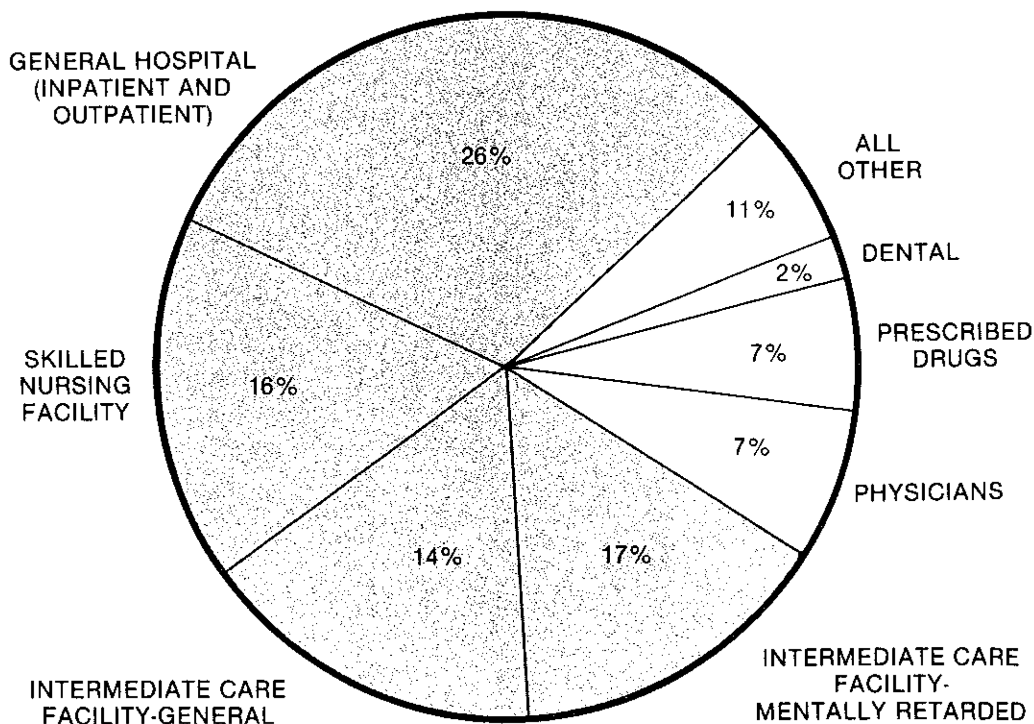


COMPARISON OF MEDICAL EXPENDITURES
For Fiscal Years 1985 and 1986

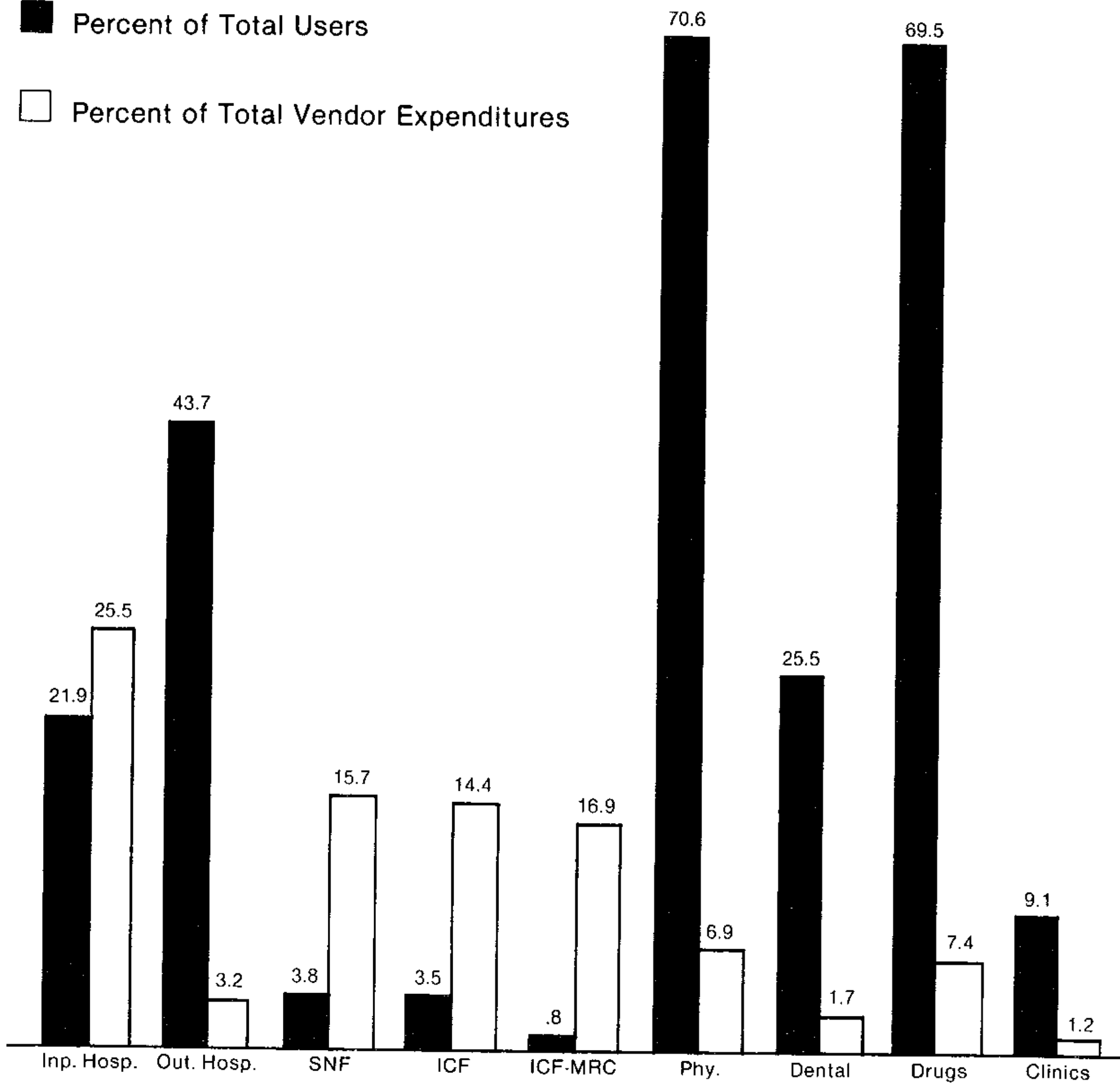
Type of Service	SFY 85 Expenditures	SFY 86 Expenditures	Percentage Change*
Inpatient Hospital	$149,115,221	$181,856,407	22.0
Outpatient Hospital	19,586,562	22,914,355	17.0
Mental Hospital	14,989,617	17,955,368	19.8
SNF	104,256,339	111,440,865	6.9
ICF	94,233,343	102,222,291	8.5
ICF-MR	109,843,333	119,968,170	9.2
Physician	42,520,118	49,279,233	15.9
Drugs	43,390,875	52,509,808	21.0
Dental	10,734,314	11,926,749	11.1
Screening	1,442,184	2,248,624	55.9
Clinics	6,497,521	8,491,171	30.7
Family Planning	2,231,204	4,642,311	108.1
Home Health	6,662,257	10,840,810	62.7
All Other Services	12,521,786	14,458,530	15.5
Total Vendor Services	618,024,674	710,754,692	15.0
Medicare Part B Premiums	10,998,391	12,181,375	10.8
Total Vendor and Premiums	629,023,065	722,936,067	14.9

* Includes both increases in cost as well as utilization.

PERCENTAGE OF EXPENDITURES FOR SELECTED CATEGORIES OF SERVICE TO TOTAL VENDOR EXPENDITURES
For Fiscal Year 1986



STATE FISCAL 1985-86



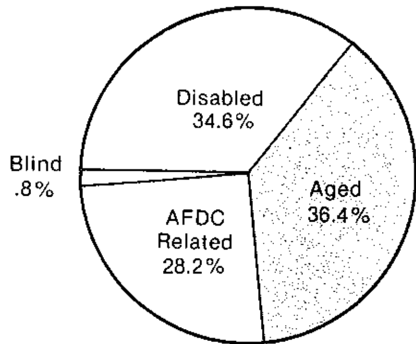
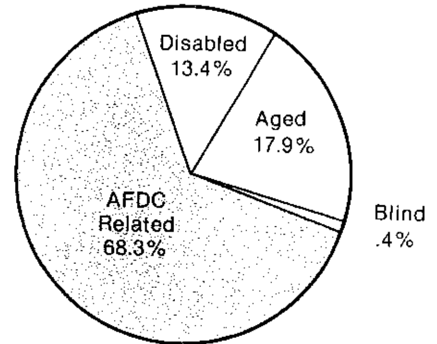
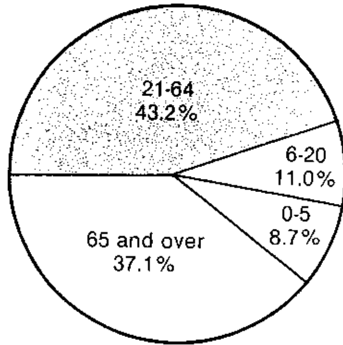
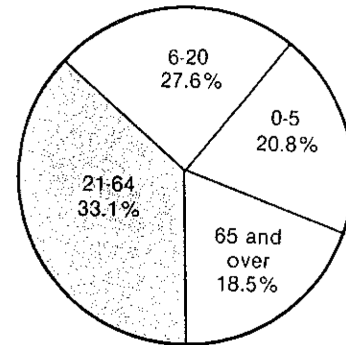
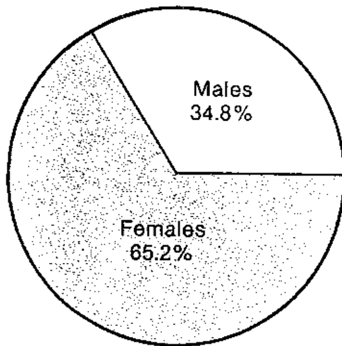
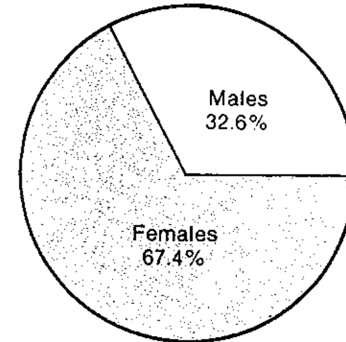
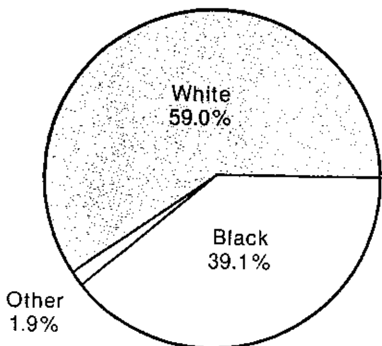
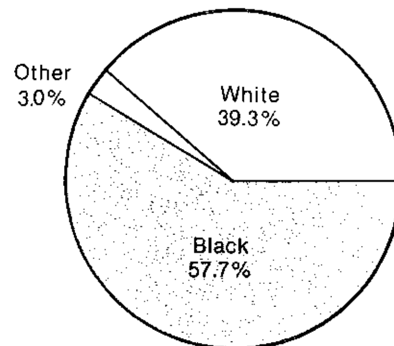
TOTAL EXPENDITURES FOR MEDICAL SERVICES
TOTAL NUMBER OF RECIPIENTS*
State Fiscal Year 1986

Program Category	Expenditures	Percent of Total	Total No. Recipients	Percent of Total	Average Per Recipient
Aged	$258,877,471	36.4	66,194	17.9	$3,911
Blind	5,499,109	.8	1,511	.4	3,639
Disabled	245,991,488	34.6	49,722	13.4	4,947
AFDC-Child	86,112,195	12.1	158,562	42.8	543
AFDC-Adult	87,021,251	12.2	89,440	24.2	973
Other Child**	27,253,178	3.9	4,986	1.3	5,466
Total Vendor	710,754,692	100.0	370,415	100.0	1,919

* A recipient is a Medicaid eligible who has used services.

** Includes approximately 452 children in long term care institutions with total costs of approximately $16 million.

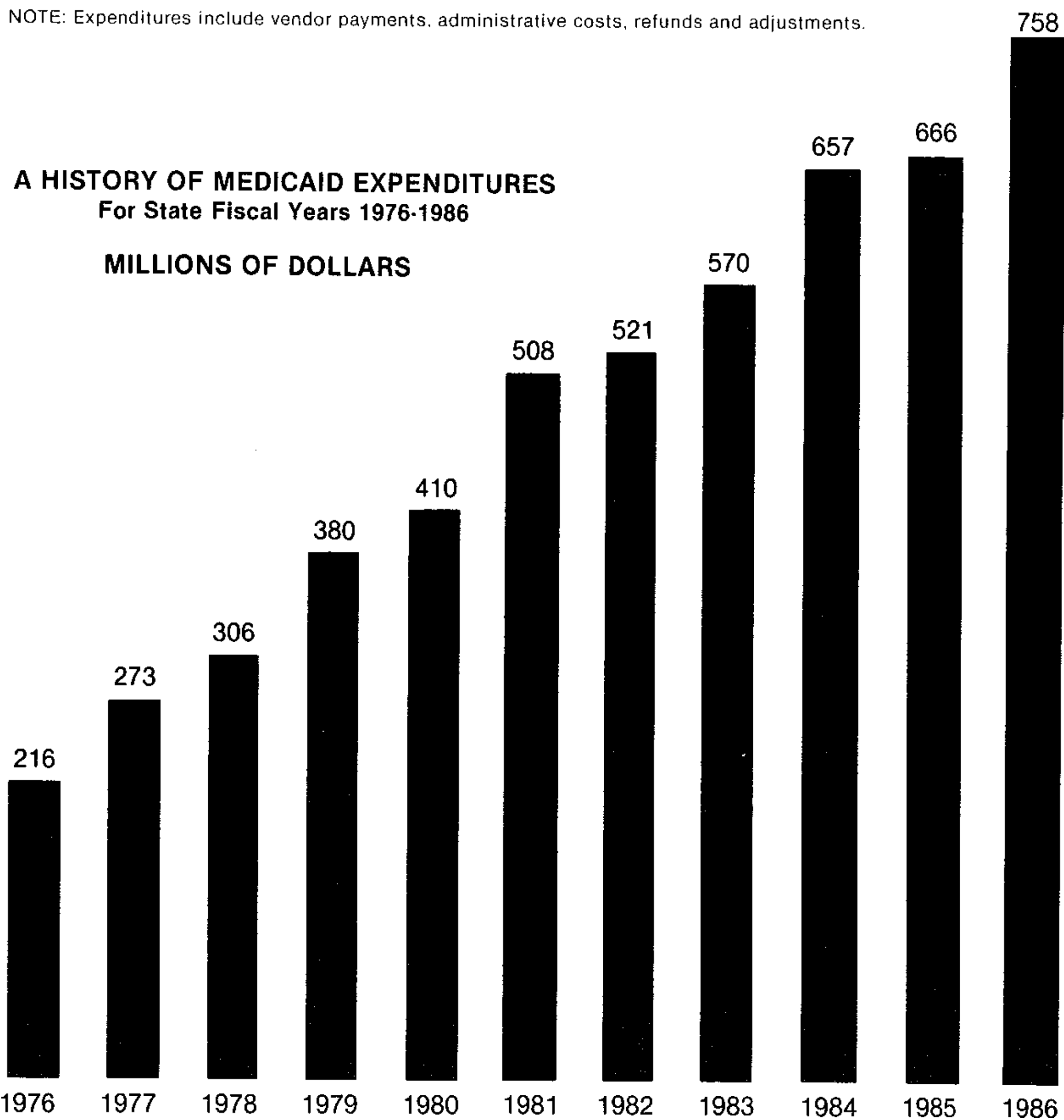
EXPENDITURES AND RECIPIENTS BY AID CATEGORY, SEX, RACE, AGE GROUP
For State Fiscal Year 1986

EXPENDITURES		RECIPIENTS
	BY AID CATEGORY	
	BY AGE GROUP	
	BY SEX	
	BY RACE	

A HISTORY OF TOTAL MEDICAID EXPENDITURES
For State Fiscal Years 1976-1986

Fiscal Year	Expenditures	Percentage Change
1976	215,741,299	
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
1984	657,763,927	15.3
1985	665,526,678	1.2
1986	758,115,890	13.9

NOTE: Expenditures include vendor payments, administrative costs, refunds and adjustments.



A HISTORY OF UNDUPLICATED MEDICAID ELIGIBLES
For State Fiscal Years 1977-1986

Fiscal Year	Aged	Blind	Disabled	AFDC	Other Children	Total
1976-77	83,136	3,933	64,113	300,061	6,139	457,382
1977-78	82,835	3,616	62,179	300,719	6,425	455,774
1978-79	82,930	3,219	59,187	301,218	6,620	453,174
1979-80	82,859	2,878	56,265	307,059	6,641	455,702
1980-81	80,725	2,656	53,773	315,651	6,559	459,364
1981-82	70,010	2,349	48,266	298,483	6,125	425,233
1982-83	67,330	2,000	46,537	293,623	6,062	415,552
1983-84	65,203	1,755	46,728	288,619	5,501	407,806
1984-85	65,849	1,634	48,349	293,188	5,333	414,353
1985-86	69,193	1,554	51,959	313,909	5,315	441,930

TOTAL VENDOR PAYMENTS AND TOTAL ELIGIBLES BY COUNTY

For State Fiscal Year July 1, 1985 - June 30, 1986

County Name	1985 Est. County Population	Number of Medicaid Eligibles	Total Expenditure	Per Capita Expenditures Amount	Per Capita Expenditures Ranking	Eligibles Per 1,000 Population
Alamance	102,256	4,860	$ 10,214,163	99.89	77	48
Alexander	26,619	836	2,153,662	80.91	92	31
Alleghany	9,692	561	721,626	74.46	97	58
Anson	26,235	2,584	4,241,998	161.69	23	98
Ashe	23,423	1,664	2,732,163	116.64	54	71
Avery	14,996	896	1,784,621	119.01	52	60
Beaufort	43,260	3,292	5,528,343	127.79	46	76
Bertie	21,341	3,057	3,817,309	178.87	12	143
Bladen	30,738	4,056	5,648,952	183.78	6	132
Brunswick	45,555	3,964	5,607,477	123.09	49	87
Buncombe	168,281	7,329	16,323,136	97.00	80	44
Burke	75,548	3,484	7,788,674	103.10	71	46
Cabarrus	92,065	4,284	8,593,465	93.34	84	47
Caldwell	70,245	3,438	7,562,240	107.66	68	49
Camden	5,814	409	673,517	115.84	55	70
Carteret	48,734	2,021	4,503,992	92.42	85	41
Caswell	22,443	1,771	2,754,682	122.74	50	79
Catawba	112,602	4,793	10,638,176	94.48	82	43
Chatham	35,363	1,636	4,052,019	114.58	57	46
Cherokee	20,207	1,346	3,005,486	148.73	29	67
Chowan	13,158	1,203	2,160,798	164.22	22	91
Clay	7,026	497	1,220,505	173.71	13	71
Cleveland	86,162	6,727	10,891,425	126.41	47	78
Columbus	52,074	7,238	10,265,065	197.12	5	139
Craven	79,479	5,678	9,275,929	116.71	53	71
Cumberland	256,087	21,649	25,665,091	100.22	76	85
Currituck	12,894	573	899,612	69.77	99	44
Dare	17,243	646	1,322,113	76.68	96	37
Davidson	118,480	5,450	10,714,165	90.43	87	46
Davie	27,679	1,037	2,692,288	97.27	79	37
Duplin	41,588	4,147	6,482,288	155.87	26	100
Durham	161,625	10,636	22,051,308	136.44	38	66
Edgecombe	58,412	8,401	10,122,359	173.29	14	144
Forsyth	258,518	16,852	28,116,904	108.76	65	65
Franklin	32,777	3,008	5,421,992	165.42	21	92
Gaston	171,763	12,283	18,608,747	108.34	66	72
Gates	9,381	836	1,081,029	115.24	56	89
Graham	7,189	605	921,573	128.19	45	84
Granville	36,663	2,248	4,196,915	114.47	58	61
Greene	16,505	2,055	3,018,506	182.88	9	125
Guilford	326,502	19,539	35,738,035	109.46	64	60
Halifax	55,961	10,170	11,520,083	205.86	4	182
Harnett	63,001	6,272	10,127,660	160.75	24	100
Haywood	47,905	3,137	5,379,746	112.30	61	65
Henderson	66,186	2,801	5,856,013	88.48	89	42
Hertford	23,924	3,213	3,999,499	167.18	20	134
Hoke	22,505	2,754	3,147,864	139.87	36	122
Hyde	5,969	617	855,905	143.39	31	103
Iredell	87,252	4,600	8,934,864	102.40	72	53
Jackson	26,967	1,492	2,953,599	109.53	63	55
Johnston	76,817	5,458	10,957,146	142.64	32	71
Jones	9,770	1,208	1,788,094	183.02	8	124

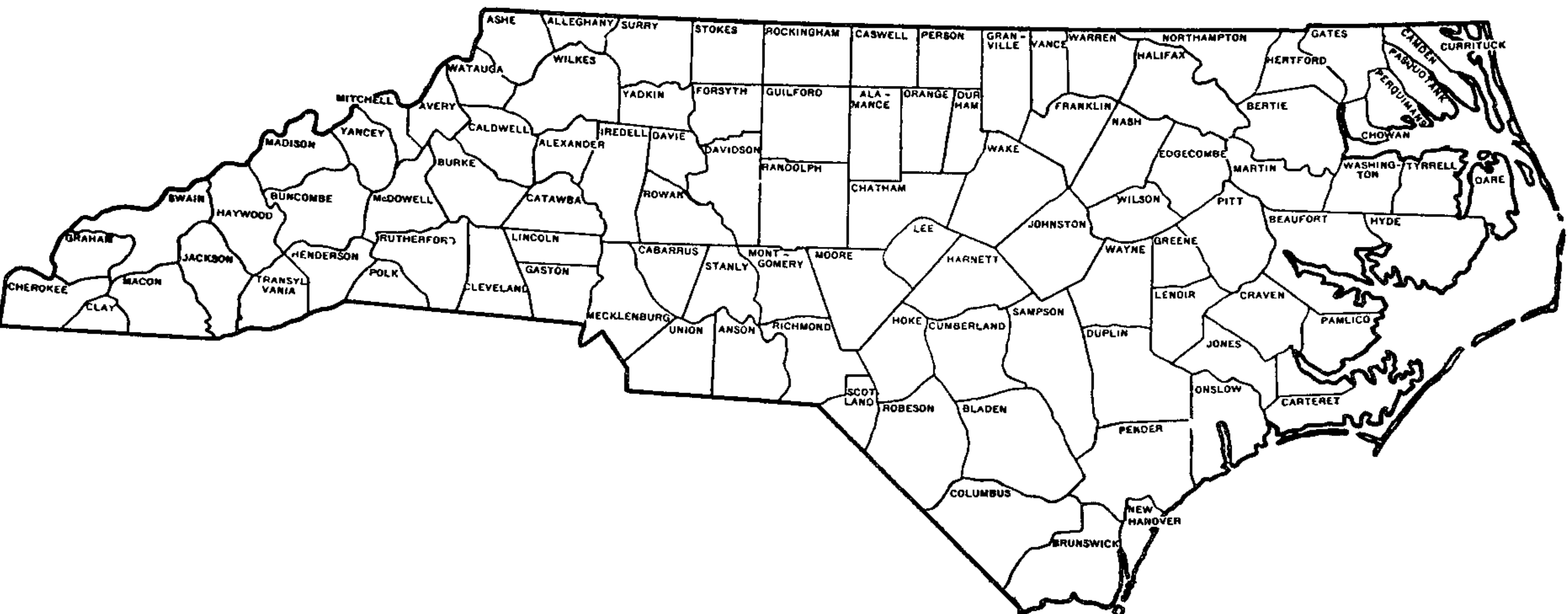
TOTAL VENDOR PAYMENTS AND TOTAL ELIGIBLES BY COUNTY

For State Fiscal Year July 1, 1985 - June 30, 1986

County Name	1985 Est. County Population	Number of Medicaid Eligibles	Total Expenditure	Per Capita Expenditure Amount	Per Capita Expenditure Ranking	Eligibles Per 1,000 Population
Lee	40,548	3,148	$ 5,840,818	144.05	30	78
Lenoir	60,482	6,424	11,101,443	183.55	7	106
Lincoln	45,647	2,216	4,166,975	91.29	86	49
Macon	23,072	977	1,935,875	83.91	91	42
Madison	17,191	1,934	2,955,826	171.94	17	113
Martin	26,653	2,721	3,644,869	136.75	37	102
McDowell	36,281	2,194	4,320,735	119.09	51	60
Mecklenburg	442,498	28,723	43,323,522	97.91	78	65
Mitchell	14,559	984	1,958,946	134.55	40	68
Montgomery	23,763	1,821	2,564,185	107.91	67	77
Moore	54,796	2,633	5,530,719	100.93	75	48
Nash	70,791	6,685	10,058,349	142.09	33	94
New Hanover	112,026	9,412	14,607,049	130.39	43	84
Northhampton	22,360	4,121	4,813,653	215.28	1	184
Onslow	122,502	5,046	8,014,395	65.42	100	41
Orange	82,459	2,459	6,130,736	74.35	98	30
Pamlico	10,976	1,109	1,898,835	173.00	15	101
Pasquotank	29,356	2,728	3,990,968	135.95	39	93
Pender	24,423	2,485	3,464,350	141.85	35	102
Perquimans	10,298	1,190	1,745,084	169.46	19	116
Person	30,253	2,528	5,219,106	172.52	16	84
Pitt	95,862	10,236	13,608,269	141.96	34	107
Polk	14,388	507	1,231,265	85.58	90	35
Randolph	97,233	2,817	7,667,462	78.86	93	29
Richmond	46,150	3,703	5,923,557	128.35	44	80
Robeson	106,025	16,978	19,117,755	180.31	10	160
Rockingham	85,320	5,578	11,183,408	131.08	42	65
Rowan	103,448	4,752	9,717,149	93.93	83	46
Rutherford	56,941	3,655	6,430,191	112.93	59	64
Sampson	50,340	5,074	7,782,545	154.60	27	101
Scotland	33,604	5,367	6,019,172	179.12	11	160
Stanley	50,180	2,212	5,123,066	102.09	73	44
Stokes	35,345	1,619	3,567,276	100.93	74	46
Surry	60,827	3,181	6,440,138	105.88	69	52
Swain	10,699	1,046	1,203,525	112.49	60	98
Transylvania	25,581	1,206	2,867,638	112.10	62	47
Tyrrell	4,127	659	880,290	213.30	2	160
Union	78,117	4,429	6,991,111	89.50	88	57
Vance	38,320	4,558	5,994,912	156.44	25	119
Wake	353,801	14,992	27,453,807	77.60	94	42
Warren	16,399	2,485	3,441,481	209.86	3	152
Washington	14,529	1,928	2,466,907	169.79	18	133
Watauga	34,173	1,309	2,641,482	77.30	95	38
Wayne	98,638	9,294	12,976,260	131.55	41	94
Wilkes	60,802	3,155	7,544,004	124.07	48	52
Wilson	64,349	7,992	9,664,144	150.18	28	124
Yadkin	29,365	1,211	3,103,299	105.68	70	41
Yancey	15,575	1,138	1,493,649	95.90	81	73
STATE TOTAL	6,253,951	441,930	$724,553,021	115.86		71

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1986
Data reflects only net vendor payments for which the county is billed for its computible share.

NORTH CAROLINA'S 100 COUNTIES



STATE OF NORTH CAROLINA
DEPARTMENT OF HUMAN RESOURCES
DIVISION OF MEDICAL ASSISTANCE
1985 UMSTEAD DRIVE
RALEIGH, NORTH CAROLINA 27603