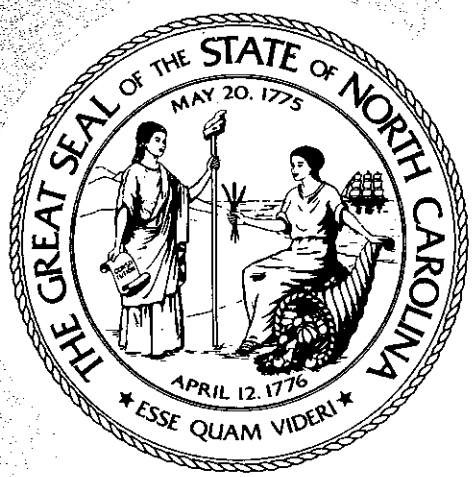
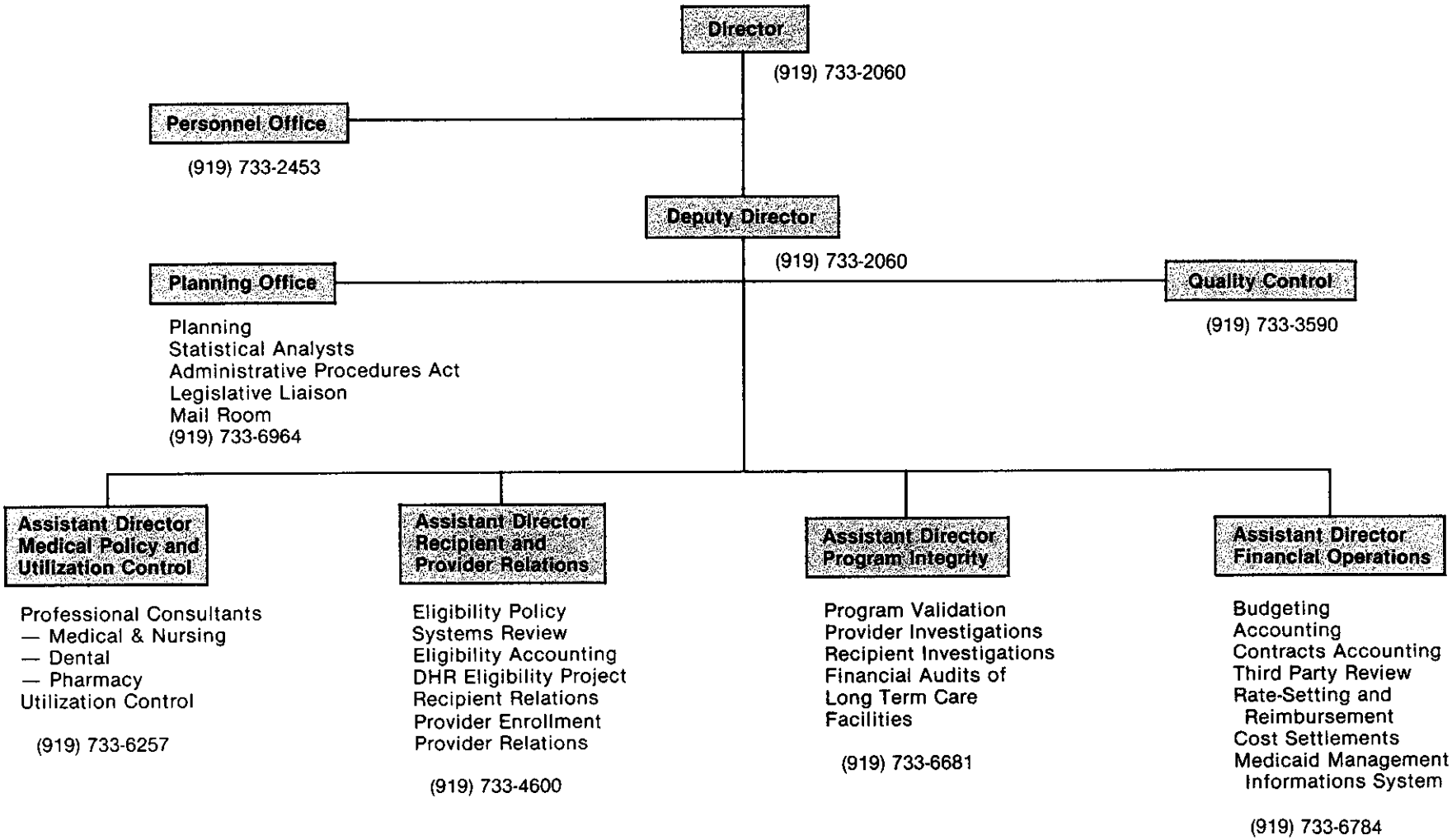


ANNUAL REPORT 1986-1987

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



MEDICAID IN NORTH CAROLINA
ANNUAL REPORT
1986 - 1987

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

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EXECUTIVE SUMMARY . . .

Actions of the 1987 General Assembly in response to Federal legislation enabled pregnant women, infants and young children to qualify for Medicaid based on the federal poverty level and not the traditional AFDC payment level. This initiative is in response to the State's high infant mortality rate and is intended to increase access to prenatal care for low income women and their families.

An overall growth rate of 13.3% in program expenditures created budgetary concerns for program officials. This growth rate was fueled by both increases in the cost of services and increases in the number of people receiving services.

During fiscal year 1987, the number of people who were determined to be Medicaid eligible exceeded 450,000 for the first time since FY 1980-81. A 5% increase in the income eligibility levels in January, 1987 contributed to the growth. The increase in total eligibles over the previous year was 2.3%, but the increase in the number of elderly and disabled was 5.0%, and these two groups are by far the most expensive consumers of Medicaid services.

Pre-admission authorization for all non-urgent, non-emergency hospital admissions was implemented in November, 1986. This major cost containment initiative is expected to save $5.8 million.

PEOPLE SERVED . . .

In state fiscal year 1986-87 the North Carolina Medicaid program paid for the medical care of 385,427 needy people. The 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 receive or are eligible for cash assistance payments. 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, but is not eligible to receive cash assistance payments, 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. This is known as "spenddown."

There are five categories of eligibility within each classification:

1) AFDC or Aid to Families with Dependent Children — A dependent child is one who is deprived of parental support and care because one or both parents is ill, absent, deceased or because the net family income is below state AFDC income standards. Children and their parent(s), or caretakers, who are eligible for cash assistance payments are automatically eligible for Medicaid. Effective January, 1985 coverage under AFDC related classifications was extended to all financially eligible children under age 19 and to pregnant women and children in two-parent households. All financially eligible children include children in two-parent households as well as children in the custody of the county department of social services or children for whom the county has responsibility for placement in medical institutions.

2) AA or Aid to the Aged — Persons age 65 and over who are eligible for AA may be eligible for Medicaid.

3) AD or Aid to the Disabled — Persons between ages birth and 65 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) 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 are more restrictive than SSI standards. North Carolina has elected the more restrictive option, making it a "209(b)" state, so named for the regulatory citation explaining the option.

One of the conditions of eligibility is a means test based on income and resources. With the exception of children under Title IV-E, recipients in all other categories must meet this means test. Resources are real and 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 maximum annual Income and Resource tables used in determining eligibility for the North Carolina Medicaid program in 1987.

INCOME LEVELS (ANNUAL)

Family Size	AFDC, RELATED GROUPS		AGED, BLIND, DISABLED
	Categorically Needy	Medically Needy	All Groups
1	$2,064	$2,800	$2,800
2	2,700	3,600	3,600
3	3,108	4,200	4,200
4	3,396	4,600	4,600
5	3,708	5,000	5,000

RESOURCES

Family Size	AFDC, RELATED GROUPS		AGED, BLIND, DISABLED
	Categorically Needy	Medically Needy	All Groups
1	$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. 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 to 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 staff. A list of Medicaid physicians and agencies providing health care is available at the local department of social services for families needing assistance.

ADULT HEALTH SCREENING PROGRAM

The Adult Health Screening Program provides for annual health screenings for Medicaid recipients over age 21 with the expectation that it will prevent serious illness through early detection and treatment. North Carolina developed the Adult Health Screening Program, effective January 1, 1986, as a result of federal encouragement to states to maximize the availability of preventive services to Medicaid recipients.

The screenings are performed at a local health department and by participating physicians in private practice. Physician's assistants, nurse practitioners and registered nurses who have successfully completed the adult health physical assessment training course are permitted to perform the screenings; however, the private physician or the clinic physician must accept ultimate responsibility for the services provided.

LONG TERM CARE

Medicaid is the primary financier of nursing homes in North Carolina with private paying patients and Medicare being two additional contributors. In fiscal year 1987, expenditures for nursing homes (skilled and intermediate) were $225 million, making it the most expensive service for the year.

Since 1985, nursing home care expenditures in North Carolina have increased by 13.5 percent or approximately $27 million. Because the elderly population is growing rapidly, there is major potential for increased demand for nursing home care in North Carolina. New beds are in various stages of construction and over the next year, approximately 1900 new nursing home beds are expected to be completed. Since 1982, the number of nursing home beds has increased 13.5 percent. There is intense concern over expenditure growth in this area. As a result, there is increasing interest in finding alternatives to nursing home care.

Another category of long term care is intermediate care for the mentally retarded. In 1987, 3202 recipients were served at a cost of approximately $135 million. Since 1985, expenditures have increased 23.7 percent or approximately $26 million.

The North Carolina Medicaid program currently offers three types of care that are alternatives to nursing home care. They are personal care services, home health services and home and community based services. All are in-home services specifically aimed at delaying or preventing institutionalization. Coverage for personal care services began in January, 1986. In only two years, expenditures for personal care services reached $4.9 million in fiscal year 1987. Expenditures for home health services are rapidly increasing. FY 1987 expenditures are up 135.7% over FY 1985. Home and community based services for disabled adults have exhibited the greatest increase in expenditure growth. Since FY 1985, expenditures have increased approximately 400 percent from $1.5 million to $7.5 million.

THE COMMUNITY ALTERNATIVES PROGRAMS

North Carolina has three waiver programs to provide home and community care as a cost-effective alternative to institutionalization. The total cost of in-home care to Medicaid (i.e., the cost of the waiver services plus the home health services the individual receives) must be equal to or less than the average Medicaid reimbursement for the comparable level of institutional care. All services are subject to the approval of the Division of Medical Assistance. The waiver allows the state to determine Medicaid eligibility as if the individual were institutionalized; thereby, eliminating the need to count the income and resources of a spouse or parent.

The Community Alternatives Program for the Disabled Adults (CAP/DA) provides services that allow adults (ages 18 and above) who require care in a skilled nursing facility or intermediate care facility to remain in the community. Thirty-eight of the one hundred counties in the state have the Community Alternatives Program for Disabled Adults. In addition to the regular Medicaid services, the CAP/DA participant may receive screening/assessment, case management, chore services, homemaker services, home mobility aids (e.g., wheelchair ramps and grab bars), one home delivered meal per day, respite care, and telephone alert (emergency response systems). Approximately 1550 individuals participated in CAP/DA during state fiscal year 1986-87.

The Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD) provides services to individuals of any age who normally would require care in an intermediate care facility for the mentally retarded. The program currently is offered by 35 area mental health, mental retardation, and substance abuse programs that cover 82 counties. In addition to regular Medicaid services, the CAP-MR/DD participant can receive screening/assessment, case management, adaptive behavior training, adult day health care, communication training, community skills training, counseling, developmental day care, homemaker services, home mobility aids, medical supplies, personal care, parent/caregiver training, and respite care. Three hundred thirty-one individuals participated in the program in state fiscal year 1986-87.

The Community Alternatives Program for Children (CAP/CC) is different from the other two programs in that it serves children (through age 18) who are normally ineligible for Medicaid due to the parents' income and resources. It is available statewide. The program is often referred to as the "Katie Beckett" program. It is designed to serve medically fragile children in their homes. The child must require the level of care provided by a skilled nursing facility, an intermediate care facility, or in certain instances hospital care. CAP/CC participants may receive case management, screening/assessment, home mobility aids, hourly nursing services, respite care, and personal care services. We can serve fifty children in North Carolina under this program at any one time during the year. In state fiscal year 1986-87, thirty-seven children were served.

In addition to receiving home and community-based services, participants in all of the CAP programs are exempt from limitations and co-payment requirements associated with pharmacy prescriptions and physicians visits.

COST CONTAINMENT INITIATIVES

Preadmission Review Program

The most expensive item in the Medicaid budget in 1987 was inpatient hospital services at nearly $206 million. Since FY 1985, hospital expenditures have increased 38.1%. The rapid expenditure growth in this area prompted DMA to implement preadmission review which is expected to save $5.8 million during its first year.

The preadmission review program began November 1, 1986 for non-urgent, non-emergency hospital admissions. All elective or planned hospital admissions require review prior to admission to the hospital. Proposed admissions are reviewed using clinical criteria developed by physician experts. For procedures defined by the Division of Medical Assistance as being frequently and safely performed on an outpatient basis, approval for hospital admission is contingent upon either an increased surgical risk posed by the condition of the patient, or a lack of outpatient facilities within a reasonable distance. This review process is conducted by Medical Review of North Carolina, Inc. under a contractual agreement with the Division of Medical Assistance.

The objective for this program is not to deny hospitalization but rather to seek less expensive treatment alternatives such as outpatient surgery, preadmission testing, and the reduction of elective weekend admissions.

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 1987 a total of 10,787 providers submitted 12,244,457 claims for payment.

ENROLLED MEDICAID PROVIDERS BY TYPE OF SERVICE

Type of Service	Number of Providers
Physicians	10,977
Radiologists	674
Dentists	2,295
Pharmacists	1,887
Optometrists	675
Chiropractors	393
Podiatrists	175
Ambulance	159
Home Health Agencies	123
ICF-General	201
ICF-MRC	48
Hospitals	182
Mental Health Clinics	89
Optical Suppliers	*
SNF	195
Other	974
Total	19,047

* Single Source Contract effective July 1, 1986.

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 include:

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) hemophilia,
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 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 and orthodontia for children.
7. Admission to SNF, ICF, ICF-MR.
8. Eye Care Services.
9. Durable Medical Equipment.
10. Community Alternatives Program.
11. Organ Transplants.
12. Non-Emergency Admissions to Hospitals.

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 Services	1.00 per visit
Physician	.50 per visit
Podiatrist	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 enrollees 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 costs 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 1986-87 DMA had 153 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 FY 1987 were $2.8 million.

In North Carolina 12,244,457 Medicaid claims were processed in FY 1986-87. 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.

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 efforts in recovering third party resources.

THIRD PARTY RECOVERY ACTIVITY REPORT

SUMMARY		FY 1986-87
A. Insurance Paid to Providers		$ 10,710,644
B. Claims Denied for Other Insurance (EOB 094)*		18,188,393
C. Refunds		
1. Medicare	546,479	
2. Health Insurance	1,702,143	
3. Casualty Insurance	1,862,043	
4. Responsible Relative	1,799	
5. Absent Parent (IV-D)	3,430	
Total Refunds		4,115,894
TOTAL		$33,014,931

COST AVOIDANCE	
A. Medicare A	$123,016,660
B. Medicare B	35,248,024
TOTAL	$158,264,684

* Identified for investigation. Findings may or may not result in a refund.

PROGRAM INTEGRITY

Financial Audits of Long Term Care Facilities

Nursing home financial and Medicaid audits resulted in cost settlement collections totaling $8,706,385.

UTILIZATION REVIEW

Utilization review activity is conducted by the Division of Medical Assistance or via contracts with review agencies. The federal share of expenditures is 75% when a state agency performs these functions.

Retrospective Review of Inpatient Hospital Services

Recoveries initiated by DMA as a result of retrospective review of the medical necessity for inpatient hospital services were $602,995.

Long Term Care Level of Care Review

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 Review

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.

FRAUD AND ABUSE DETECTION

Fraud and abuse detection and deterrence are major concerns of the State's Medicaid administrators. In addition to the Medicaid agency staff, the Office of the Attorney General has staff fully devoted to the criminal investigation and prosecution of Medicaid fraud. In FY 1986-87, 832 provider and 1,184 recipient cases were initiated and recoupments in the total amount of $174,557 (Providers) and $399,100 (Recipients) were collected. Twenty-six (26) cases were referred to the Attorney General for possible fraud prosecution.

In addition to actual cash collections, Program Integrity actions resulted in cost avoidance equal to $19,966,197.

FINANCING MEDICAID

The largest share of Medicaid costs is paid by the federal government. Federal Medicaid matching rates for services 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 coincide, two different federal service matching rates may apply in each state fiscal year. Because federal match for administrative costs are constant, there is only one rate for SFY 1986-87. Following is a table showing the federal matching rates for FY 1986-87.

SERVICE COSTS

	7/1/86 - 6/30/87	
	Family Planning	All Other Services
Federal	90.00	69.18
State	8.50	26.20
County	1.50	4.62

ADMINISTRATIVE COSTS

	7/1/86 - 6/30/87	
	Skilled Medical Personnel & MMIS	All Services
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 receive Medicaid services throughout the year. Counties are required to pay 15% of the non-federal share for medical services, which is about 5% of total costs, and 50% of their administrative costs for eligibility determinations.

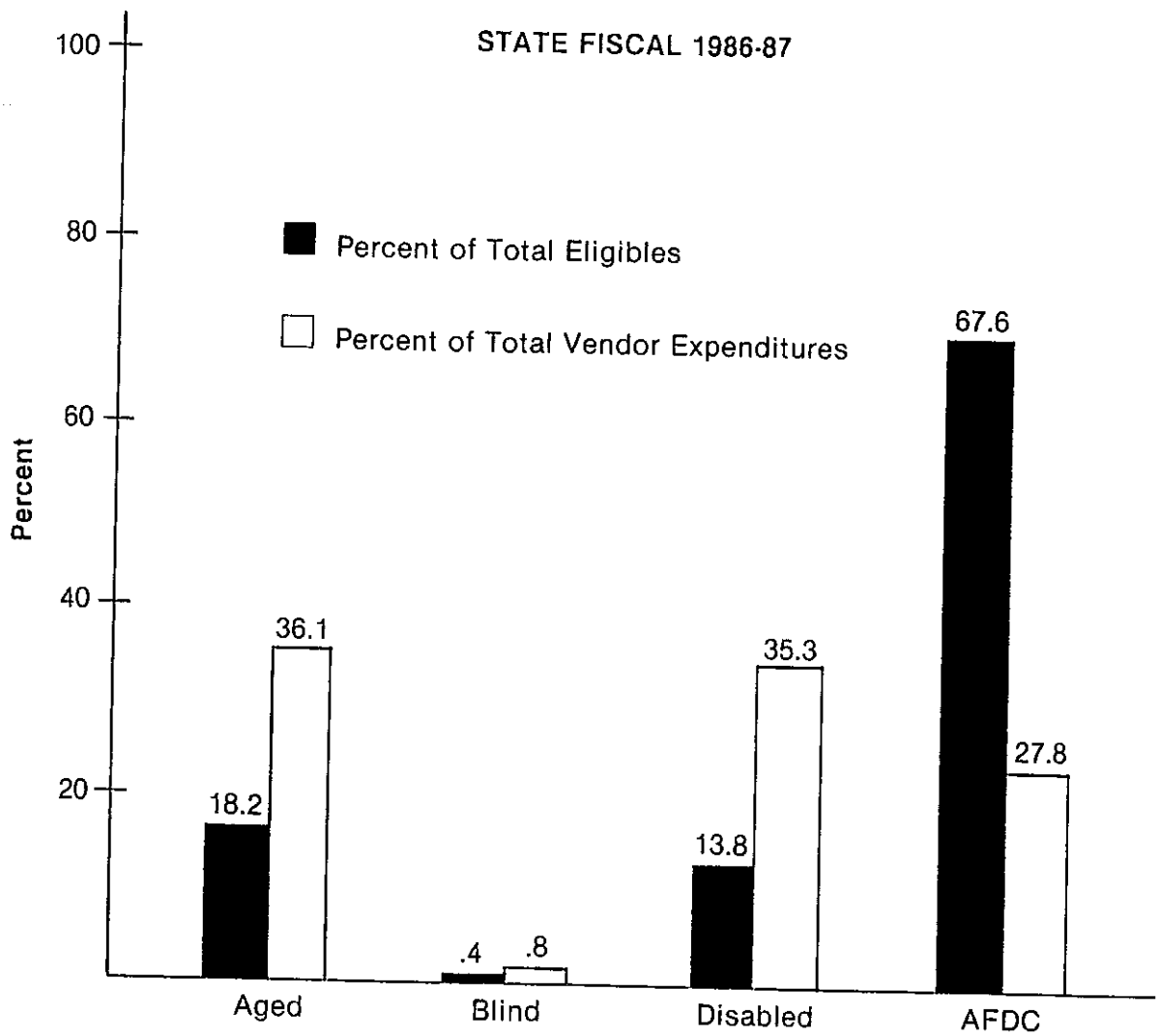
MAJOR POLICY CHANGES

There were several major policy changes in FY 1986-87. Among them were the following:

EFFECTIVE DATE	POLICY CHANGE
July 1986	Pharmacy dispensing fee raised from $3.50 to $3.67
November 1986	Preadmission review required for inpatient hospitalization.
November 1986	Therapeutic leave days for Medicaid recipients in long term care increased from 18 to 60 days in any twelve-month period.
January 1987	Medically Needy Income Standards increased 5%.
Legislative Session February-August 1987	
	The following 1987 legislative actions will be effective in state fiscal year 1987-88.
July 1, 1987	Pharmacy dispensing fee to be raised from $3.67 to $3.85
October 1, 1987	Eligibility expansion under SOBRA options to cover all pregnant women and children under age two with incomes under 100% of the federal poverty guidelines
	Case Management services to be covered, target date October 1, 1987
January 1, 1988	Medically Needy Income Standards to be increased 2.5%, effective January 1, 1988
	Eligibility expansion to cover 19-21 year olds, effective January 1, 1988. Restoration of coverage deleted in SFY82.
	Eligibility expansion to cover intact families when the primary wage earner is unemployed (AFDC-UP), effective January 1, 1988
	Hospice Services to be covered, target date January 1, 1988

EXPENDITURES FOR SELECTED MAJOR MEDICAL SERVICES BY PROGRAM CATEGORY
For Fiscal Year 1987

Type of Service	Total	Aged	Blind	Disabled	AFDC Child Other Children	AFDC Adults
Inpatient Hospital	$205,938,618	$ 26,354,782	$ 818,333	$ 73,614,639	$ 60,586,923	$44,563,941
Outpatient Hospital	20,304,582	2,462,125	96,298	5,736,191	5,546,009	6,463,959
Skilled Nursing Home	120,466,011	102,220,447	898,524	16,782,507	461,446	103,087
Intermediate Care — General	104,913,714	93,461,097	936,693	10,435,575	71,198	9,151
Mentally Retarded	135,840,111	2,027,518	1,838,052	114,652,062	17,322,479	
Physician	57,628,150	7,543,697	249,328	16,381,724	15,080,832	18,372,569
Dental	12,530,538	1,267,296	41,046	2,093,703	4,594,797	4,533,696
Prescription Drugs	61,751,723	29,855,280	542,450	19,550,749	4,271,300	7,531,944
Clinics	9,854,444	557,308	46,567	5,495,043	1,870,961	1,884,565
Total Vendor	$805,001,795	$290,673,618	$6,067,568	$284,036,952	$129,958,456	$94,265,201

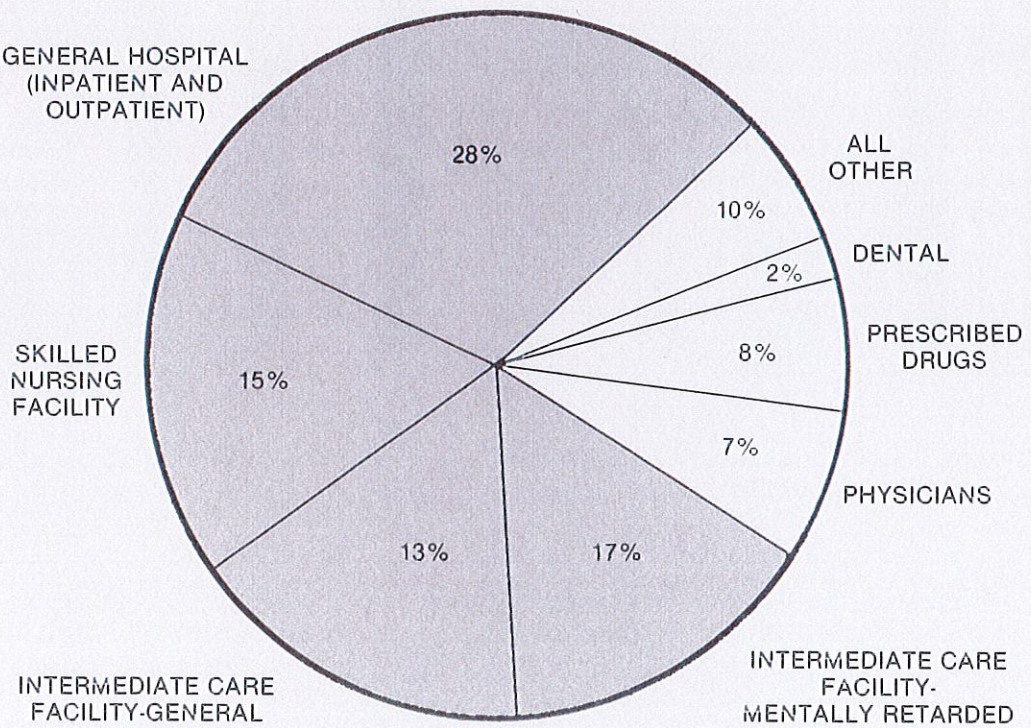


COMPARISON OF MEDICAL EXPENDITURES
For Fiscal Years 1986 and 1987

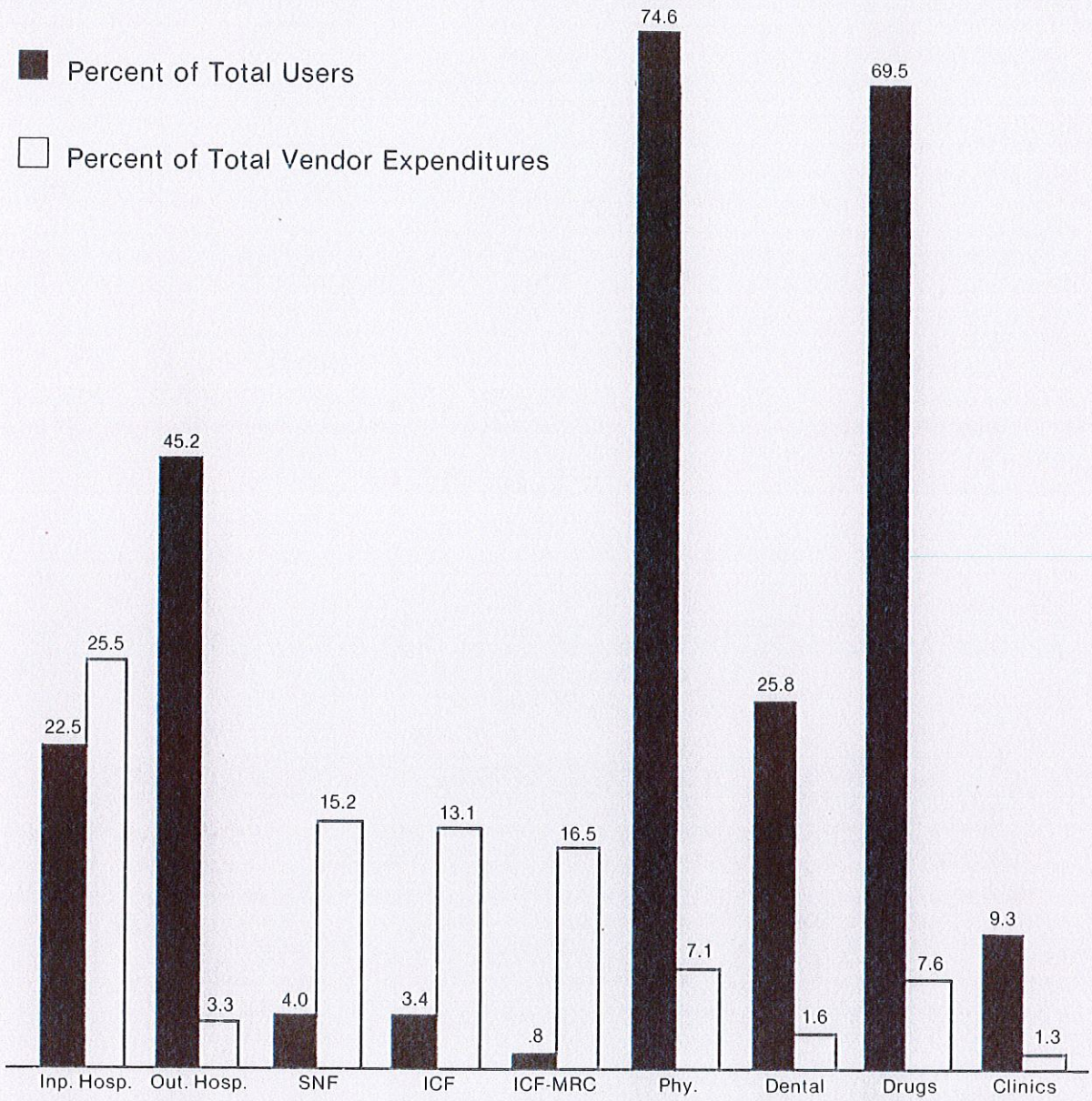
Type of Service	SFY 86 Expenditures	SFY 87 Expenditures	Percentage Change*
Inpatient Hospital	$181,856,407	$205,938,618	13.2
Outpatient Hospital	22,914,355	20,304,582	(11.4)
Mental Hospital	17,955,368	20,641,566	15.0
SNF	111,440,865	120,466,011	8.1
ICF	102,222,291	104,913,714	2.6
ICF-MR	119,968,170	135,840,111	13.2
Physician	49,279,233	57,628,150	16.9
Drugs	52,509,808	61,751,723	17.6
Dental	11,926,749	12,530,538	5.1
Child Screening	2,248,624	2,116,715	(5.9)
Clinics	8,491,171	9,854,444	16.1
Family Planning	4,642,311	4,684,415	0.9
Home Health	10,840,810	15,704,145	44.9
HMO Premiums		263,419	
All Other Services	14,458,530	32,627,063	125.7
Total Vendor Services	710,754,692	805,265,214	13.3
Medicare Part B Premiums	12,181,375	13,963,960	14.6
Total Vendor and Premiums	722,936,067	819,229,174	13.3

* Includes both increases in costs as well as utilization.

PERCENTAGE OF EXPENDITURES FOR SELECTED CATEGORIES OF SERVICE TO TOTAL VENDOR EXPENDITURES
For Fiscal Year 1987



STATE FISCAL 1986-87



TOTAL VENDOR EXPENDITURES FOR MEDICAL SERVICES
TOTAL NUMBER OF RECIPIENTS*
State Fiscal Year 1987

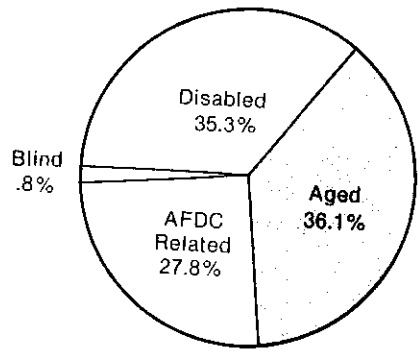
Program Category	Expenditures	Percent of Total	Total No. Recipients	Percent of Total	Average Per Recipient
Aged	$290,673,618	36.1	70,142	18.2	$4,144
Blind	6,067,569	.8	1,456	.4	4,167
Disabled	284,036,952	35.3	53,432	13.8	5,316
AFDC-ADULT	94,265,201	11.7	92,507	24.0	1,019
AFDC-CHILD	99,239,519	12.3	162,917	42.3	609
Other Child**	30,718,936	3.8	4,973	1.3	6,177
Total Vendor	805,001,795	100.0	385,427	100.0	2,089

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

** Includes approximately 432 children in long term care institutions with total costs of approximately $18 million.

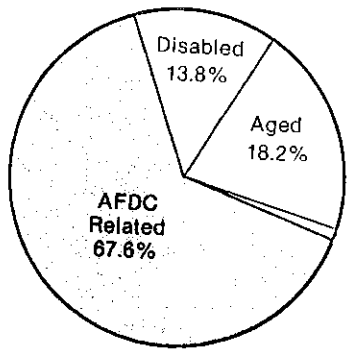
EXPENDITURES AND RECIPIENTS BY AID CATEGORY, SEX, RACE, AGE GROUP
For State Fiscal Year 1987

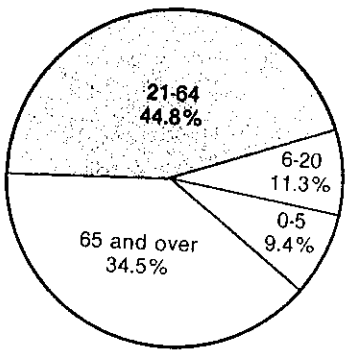
EXPENDITURES



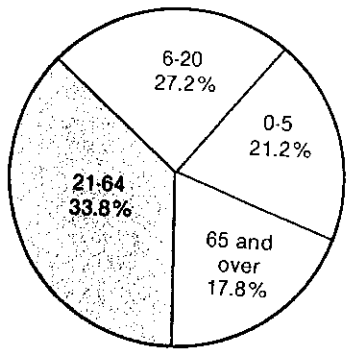
BY AID CATEGORY

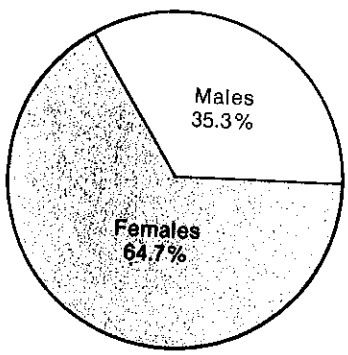
RECIPIENTS



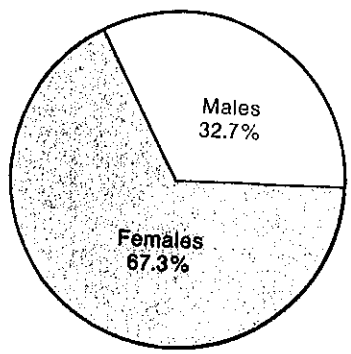


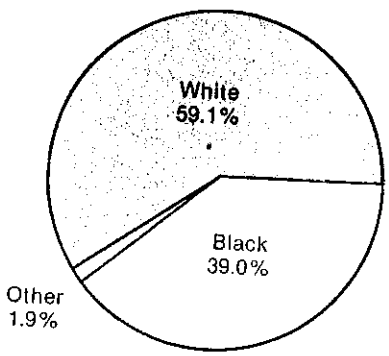
BY AGE GROUP



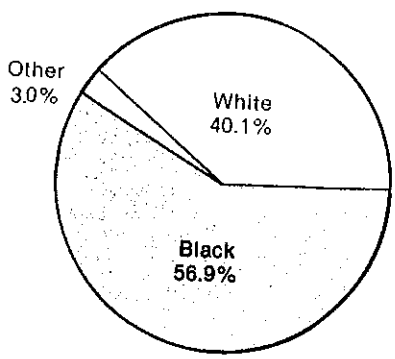


BY SEX





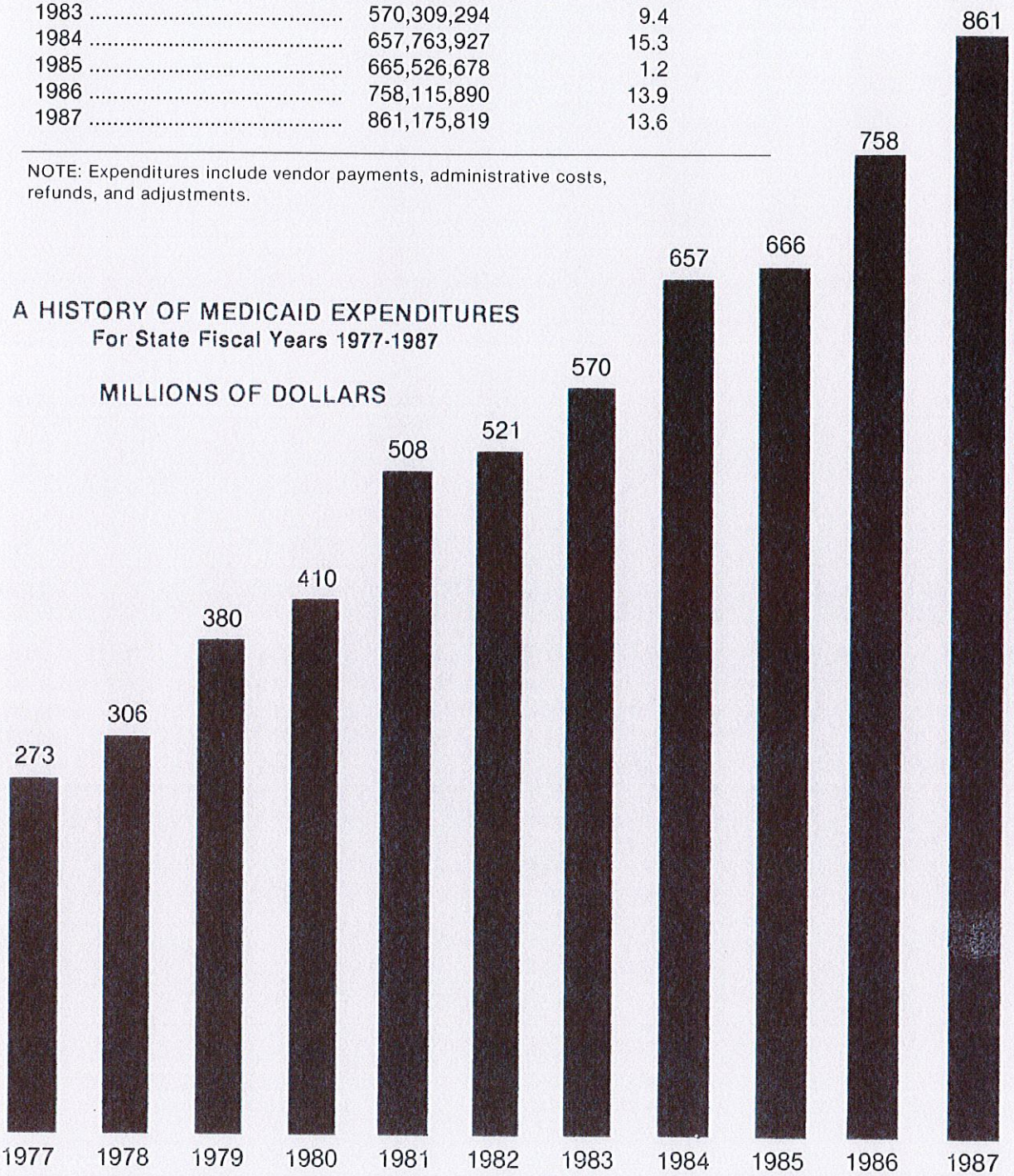
BY RACE



A HISTORY OF TOTAL MEDICAID EXPENDITURES
For State Fiscal Years 1977-1987

Fiscal Year	Expenditures	Percentage Change
1977	273,338,697	
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
1987	861,175,819	13.6

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



A HISTORY OF UNDUPLICATED MEDICAID ELIGIBLES
For State Fiscal Years 1977-1987

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
1986-87	72,295	1,462	54,924	317,983	5,361	452,025

TOTAL VENDOR PAYMENTS AND TOTAL ELIGIBLES BY COUNTY

For State Fiscal Year July 1, 1986 - June 30, 1987

County Name	1986 Est. County Population	Number of Medicaid Eligibles	Total Expenditure	Per Capita Expenditures Amount	Per Capita Expenditures Ranking	Eligibles Per 1,000 Population
Alamance	103,229	4,711	$ 12,011,722	116.36	70	46
Alexander	26,814	934	2,662,855	99.31	90	35
Alleghany	9,722	603	773,734	79.59	97	62
Anson	26,324	2,561	4,824,675	183.28	21	97
Ashe	23,251	1,755	3,388,270	145.73	42	75
Avery	15,028	922	2,154,694	143.38	46	61
Beaufort	43,396	3,658	6,649,356	153.23	35	84
Bertie	21,251	3,078	4,484,681	211.03	7	145
Bladen	30,826	4,154	6,281,732	203.78	10	135
Brunswick	47,797	4,212	6,068,038	126.95	60	88
Buncombe	170,004	7,787	19,016,059	111.86	77	46
Burke	75,990	3,521	8,841,074	116.35	71	46
Cabarrus	92,844	4,492	10,743,466	115.72	72	48
Caldwell	70,146	3,575	8,609,589	122.74	63	51
Camden	5,861	438	813,026	138.72	50	75
Carteret	50,414	2,219	5,347,190	106.07	83	44
Caswell	22,489	1,844	3,006,638	133.69	54	82
Catawba	114,143	4,697	11,577,915	101.43	88	41
Chatham	36,015	1,673	4,414,225	122.57	65	46
Cherokee	20,363	1,447	3,244,475	159.33	32	71
Chowan	13,387	1,302	2,362,743	176.50	24	97
Clay	7,210	493	1,213,490	168.31	29	68
Cleveland	86,216	6,614	12,262,869	142.23	47	77
Columbus	52,292	7,482	11,726,331	224.25	4	143
Craven	80,211	5,814	11,137,226	138.85	49	72
Cumberland	254,943	22,711	27,000,091	105.91	84	89
Currituck	13,366	602	1,005,918	75.26	100	45
Dare	18,705	616	1,719,907	91.95	94	33
Davidson	119,094	5,587	12,092,396	101.54	87	47
Davie	28,415	1,056	3,375,355	118.79	68	37
Duplin	41,685	4,052	7,516,226	180.31	23	97
Durham	165,839	10,814	23,579,815	142.18	48	65
Edgecombe	59,071	8,525	11,250,493	190.46	17	144
Forsyth	260,853	16,593	31,329,044	120.10	66	64
Franklin	34,173	3,036	5,952,565	174.19	26	89
Gaston	171,784	12,582	21,198,940	123.40	62	73
Gates	9,557	818	1,308,713	136.94	52	86
Graham	7,173	669	1,074,941	149.86	40	93
Granville	37,696	2,153	4,026,732	106.82	81	57
Greene	16,586	2,049	3,159,084	190.47	16	124
Guilford	329,862	19,392	40,716,827	123.44	61	59
Halifax	56,030	10,141	12,075,655	215.52	6	181
Harnett	64,009	6,355	10,351,478	161.72	31	99
Haywood	48,469	3,155	5,584,756	115.22	73	65
Henderson	67,222	3,209	6,876,665	102.30	86	48
Hertford	24,046	3,482	4,871,617	202.60	11	145
Hoke	23,135	2,754	3,167,869	136.93	53	119
Hyde	5,909	620	1,073,894	181.74	22	105
Iredell	88,429	4,671	10,035,380	113.49	75	53
Jackson	26,577	1,621	3,404,845	128.11	58	61
Johnston	78,191	5,837	12,374,359	158.26	33	75
Jones	9,814	1,169	2,138,072	217.86	5	119
Lee	41,408	3,315	6,130,204	148.04	41	80

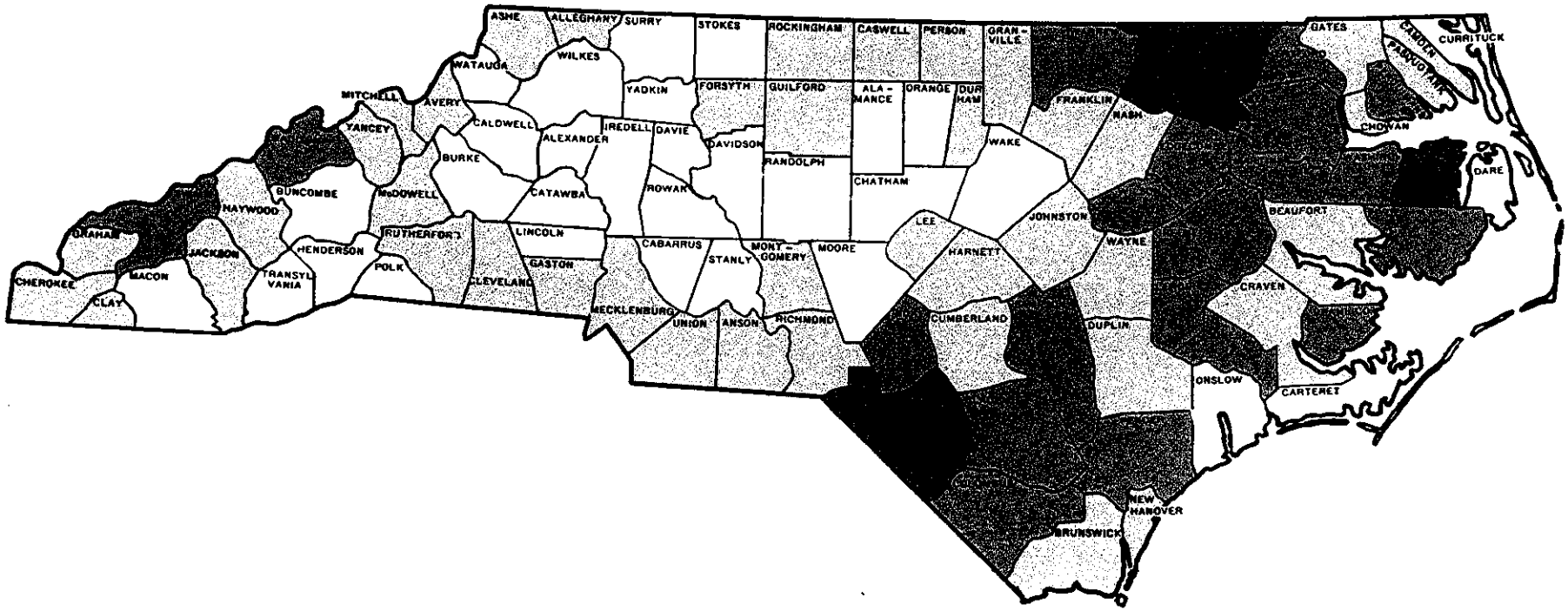
TOTAL VENDOR PAYMENTS AND TOTAL ELIGIBLES BY COUNTY

For State Fiscal Year July 1, 1986 - June 30, 1987

County Name	1986 Est. County Population	Number of Medicaid Eligibles	Total Expenditure	Per Capita Expenditures Amount	Per Capita Expenditures Ranking	Eligibles Per 1,000 Population
Lenoir	60,220	6,605	$12,039,795	199.93	12	110
Lincoln	46,278	2,304	5,000,771	108.06	80	50
Macon	23,085	1,134	2,182,042	94.52	92	49
Madison	17,359	1,960	3,468,429	199.81	13	113
Martin	26,719	2,744	4,323,447	161.81	30	103
McDowell	36,220	2,212	4,683,849	129.32	57	61
Mecklenburg	453,107	29,104	51,424,235	113.49	74	64
Mitchell	14,541	1,078	2,198,294	151.18	38	74
Montgomery	23,852	1,900	3,045,869	127.70	59	80
Moore	56,009	2,619	6,688,871	119.42	67	47
Nash	71,241	6,721	10,778,334	151.29	37	94
New Hanover	114,656	9,893	15,824,810	138.02	51	86
Northampton	22,497	4,124	5,158,836	229.31	2	183
Onslow	125,134	5,418	9,826,079	78.52	99	43
Orange	84,729	2,482	7,079,515	83.55	96	29
Pamlico	11,053	1,118	2,184,009	197.59	15	101
Pasquotank	29,860	2,876	4,480,798	150.06	39	96
Pender	25,199	2,797	4,679,120	185.69	19	111
Perquimans	10,534	1,279	1,838,617	174.54	25	121
Person	30,648	2,629	6,349,578	207.18	8	86
Pitt	97,406	10,485	15,089,164	154.91	34	108
Polk	14,486	568	1,370,334	94.60	91	39
Randolph	99,070	3,012	8,881,814	89.65	95	30
Richmond	46,227	3,612	6,706,051	145.07	43	78
Robeson	106,094	17,195	21,007,305	198.01	14	162
Rockingham	85,516	5,635	12,362,465	144.56	44	66
Rowan	104,523	5,030	11,110,808	106.30	82	48
Rutherford	56,880	3,858	7,371,459	129.60	56	68
Sampson	50,321	5,099	9,262,600	184.07	20	101
Scotland	33,735	5,476	6,960,362	206.32	9	162
Stanley	50,276	2,277	5,653,161	112.44	76	45
Stokes	35,610	1,663	4,167,580	117.03	69	47
Surry	61,546	3,223	6,787,513	110.28	78	52
Swain	10,938	1,151	1,425,771	130.35	55	105
Transylvania	26,132	1,277	3,205,085	122.65	64	49
Tyrrell	4,088	670	1,043,563	255.27	1	164
Union	79,832	4,448	8,017,340	100.43	89	56
Vance	38,740	4,384	6,641,407	171.44	28	113
Wake	366,004	15,128	29,032,415	79.32	98	41
Warren	16,452	2,420	3,698,038	224.78	3	147
Washington	14,541	2,013	2,701,838	185.81	18	138
Watauga	34,479	1,347	3,241,609	94.02	93	39
Wayne	97,410	9,582	14,875,406	152.71	36	98
Wilkes	60,727	3,248	8,757,487	144.21	45	53
Wilson	64,564	8,275	11,242,570	174.13	27	128
Yadkin	29,643	1,264	3,043,804	102.68	85	43
Yancey	15,843	1,118	1,723,069	108.76	79	71
STATE TOTAL	6,331,288	452,025	$816,643,230	128.99	N/A	71

Source: Medicaid Cost Calculation Fiscal Y-T-D June 1987
Data reflects only net vendor payments for which the county is billed for its computable share.

MEDICAID ENROLLMENT PER 1000 POPULATION BY COUNTY
FISCAL YEAR 1987



- Less Than 55 Per 1000 Population
- 55 To 100 Per 1000 Population
- 100 To 150 Per 1000 Population
- 150 Per 1000 Population And Above

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