Alabama Medicaid Agency

FY 2000 Annual Report

October 1, 1999 – September 30, 2000

Table of Contents

Highlights

New Fiscal Agent Contract

On October 1, 1999, Medicaid implemented a new claims processing system under contract with its fiscal agent Electronic Data Systems (EDS). The Alabama Medicaid Agency and EDS worked together to develop a new system that provides better service to the provider community and will carry the Alabama Medicaid Program into the 21st Century. The new system is live and features enhanced claims processing capability, new claims submission software for providers, and electronic billing enhancements. During the implementation of this new system extra time was devoted to training providers, vendors, and Medicaid staff.

Patient 1st Operating in 67 Counties

With the addition of Mobile County in FY 2000, Patient First now operates in all 67 counties. With statewide expansion complete, the focus during FY 2000 was on education of providers and beneficiaries. The focal point of the beneficiary education is understanding the system and how the system can enhance and benefit the physician-patient relationship. Provider education is aimed at understanding the Patient 1st system and identifying ways the Agency can better help its providers manage their patients.

Alabama's Medicaid Program

History

Medicaid was created in 1965 by Congress along with a sound-alike sister program, Medicare. *Medicare* is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. *Medicaid* is jointly financed by the state and federal governments and is designed to provide health care to low income individuals. *Medicaid* started in Alabama in 1970 as a Department of Public Health program. In 1977, the Medical Services Administration was made an independent state Agency. In 1981, it was renamed the Alabama Medicaid Agency.

A State Program

Unlike the Medicare program, Medicaid is a state-administered health care assistance program. All states, the District of Columbia, and some territories have Medicaid programs. Medicaid is governed by federal guidelines, but state programs vary in eligibility criteria, services covered, limitations on services, and reimbursement levels.

Funding Formula

The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because the average income in Alabama is relatively low, its federal match is one of the largest. During FY 2000, the formula was approximately 70/30. For every $30 the state spent, the federal government contributed $70.

Eligibility

Persons must fit into one of several categories and must meet necessary criteria before eligibility can be granted. The Medicaid Agency, the Department of Human Resources, and the Social Security Administration determine eligibility for Medicaid in Alabama.

- Persons receiving Supplemental Security Income (SSI) from the Social Security Administration are automatically eligible for Medicaid in Alabama. Children born to mothers receiving SSI payments may be eligible for Medicaid until they reach one year of age. After the child's first birthday, Medicaid will make a determination as to whether the child qualifies for another Medicaid program.
- Persons approved for "Medicaid for Low Income Families" (MLIF) through the Department of Human Resources are eligible for Medicaid. Low-income families may apply for cash assistance, Medicaid, or both through the Department of Human Resources. Medicaid may be approved if the children are deprived of parental support due to absence, divorce, separation, death, or unemployment of the primary wage earner. Also, foster children under custody of the state may be eligible for Medicaid.
- Pregnant women and children under six years of age with family income which does not exceed 133% of the federal poverty level are covered by Medicaid. Also covered are children up to age 19 who live in families with family income at or below the federal poverty level. Medicaid eligibility workers in county health departments, federally qualified health centers, hospitals, and clinics determine their eligibility through a program called SOBRA Medicaid. Once children under 19 years of age are determined eligible for Medicaid through any program, they receive twelve months of continuous eligibility without regard to changes in income or family situation as long as they live in Alabama.
- Persons who are residents of medical institutions (nursing homes, hospitals, or facilities for the mentally retarded) for a period of 30 continuous days and meet very specific income, resource and medical criteria may be Medicaid eligible. Persons who require institutional care but prefer to live at home may be approved for a Home and Community Based Service Waiver and be Medicaid eligible. Medicaid District Offices determine eligibility for persons in these eligibility groups.
- Qualified Medicare Beneficiaries (QMBs) have low income. Persons in this group may be eligible to have their Medicare premiums, deductibles, and coinsurance paid by Medicaid. Medicaid District Offices determine eligibility for QMBs.
- Specified Low-income Medicare Beneficiaries (SLMBs) and Qualifying Individuals-1 (QI-1) have low income above the QMB limit. Persons in this group may be eligible to have their Medicare Part B premiums paid by Medicaid. Medicaid District Offices determine eligibility for these programs.
- The Qualifying Individual-2 (QI-2) program assists with a small portion of the Medicare premium for people with incomes below 175% of the federal poverty level. This program has limited funds and is provided on a first come first served basis. Medicaid District Offices determine eligibility for the QI-2 program.
- Qualified Disabled Working Individuals (QDWIs) are individuals who have limited income and resources and who have lost disability insurance benefits because of earnings and who are also entitled to enroll for Medicare Part A. Medicaid will pay their Medicare Part A premiums. Medicaid Central Office determines eligibility for QDWIs.
- Disabled widows and widowers between ages 50 and 64 who are not eligible for Medicare Part A and who have lost SSI because of receiving widows/widowers benefits from Social Security can qualify for Medicaid. Medicaid District Offices determine eligibility for this group.

Persons in most categories may receive retroactive Medicaid coverage if medical bills were incurred in the three months prior to the application for Medicaid or in the two months prior to eligibility for SSI and if they meet all requirements for that category in those months (exceptions are: QMB and HCBS waiver beneficiaries).

Some persons in eligibility categories are protected by federal law from losing their Medicaid benefits:

- Continuous Medicaid (sometimes referred to as the Pickle program) keeps people on Medicaid who lose SSI eligibility because of a cost of living increase in the Social Security benefit and continue to meet all other SSI eligibility factors. The Medicaid District Offices processes applications for Continuous Medicaid.
- Disabled Adult Children (DAC) may retain Medicaid eligibility if they lose eligibility because of an entitlement or increase in a child's benefit, providing they meet specific criteria and continue to meet all other SSI eligibility factors. Medicaid District Offices process applications for DAC cases.

Covered Services

Medical services covered by Alabama's Medicaid program traditionally have been fewer and less comprehensive than most states'. In recent years, however, federal mandates and the Agency's own initiatives have expanded and improved the overall program. Alabama's program is aimed at providing the best possible health care to the greatest number of low-income people at the most affordable cost to the taxpayers.

How the Program Works

For many years Medicaid recipients were issued monthly paper cards signifying their eligibility. In November 1992, the Agency converted to plastic cards that are issued on a more permanent basis. It is the option of providers to accept Medicaid recipients as patients, and it is the responsibility of the providers to verify eligibility when delivering care to recipients. Providers include physicians, pharmacies, hospitals, nursing homes, dentists, optometrists, and others. These providers bill the Medicaid program for their services.

Medicaid's Impact

Since its inception in 1970, Alabama's Medicaid program has had a significant impact on the overall quality of health care in the state. Medicaid has provided over two million citizens access to quality health care they could not otherwise afford.

Citizens who are not eligible for Medicaid also benefit from the program. Health care is one of the state's most important industries, and Medicaid contributes to that industry in a significant way. For instance, during FY 2000, Medicaid paid $2.7 billion to providers on behalf of persons eligible for the program. The federal government paid approximately 70 percent of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services and paid taxes in the state. Using the common economic multiplier of three, Medicaid expenditures generated over $8.1 billion worth of business in Alabama in FY 2000.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. With the current administrative rate, over 97 percent of the Agency's budget goes toward purchasing services for beneficiaries.

FY 2000

COUNTY IMPACT

Year's Cost Per Eligible

County	Benefit Payments	Eligibles	Payment Per Eligible	County	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$11,969,142	5,231	$2,288	**Houston**	$43,585,229	15,728	$2,771
Baldwin	$37,335,280	13,077	$2,855	**Jackson**	$24,304,327	7,765	$3,130
Barbour	$16,369,372	6,240	$2,623	**Jefferson**	$279,944,390	83,938	$3,335
Bibb	$8,702,473	3,428	$2,539	**Lamar**	$11,392,461	2,773	$4,108
Blount	$18,433,678	5,753	$3,204	**Lauderdale**	$39,487,349	11,188	$3,529
Bullock	$10,074,749	3,467	$2,906	**Lawrence**	$14,072,218	4,708	$2,989
Butler	$16,585,825	5,633	$2,944	**Lee**	$35,238,342	11,915	$2,957
Calhoun	$59,317,865	19,386	$3,060	**Limestone**	$21,667,463	7,530	$2,877
Chambers	$19,603,296	6,442	$3,043	**Lowndes**	$7,385,661	4,029	$1,833
Cherokee	$11,994,382	3,809	$3,149	**Macon**	$17,074,134	5,670	$3,011
Chilton	$14,324,670	5,267	$2,720	**Madison**	$75,535,875	25,576	$2,953
Choctaw	$9,774,188	3,647	$2,680	**Marengo**	$15,544,360	5,773	$2,693
Clarke	$17,390,248	7,121	$2,442	**Marion**	$16,640,931	4,384	$3,796
Clay	$9,982,779	2,583	$3,865	**Marshall**	$42,666,819	13,962	$3,056
Cleburne	$6,563,080	2,259	$2,905	**Mobile**	$192,458,809	65,332	$2,946
Coffee	$24,298,786	6,725	$3,613	**Monroe**	$12,730,654	4,896	$2,600
Colbert	$25,854,418	8,666	$2,983	**Montgomery**	$109,654,052	40,140	$2,732
Conecuh	$10,726,141	3,961	$2,708	**Morgan**	$64,249,815	13,067	$4,917
Coosa	$4,741,085	1,944	$2,439	**Perry**	$12,276,495	4,530	$2,710
Covington	$27,162,555	7,563	$3,592	**Pickens**	$15,626,833	4,939	$3,164
Crenshaw	$10,260,570	3,080	$3,331	**Pike**	$19,406,948	7,166	$2,708
Cullman	$40,374,540	11,098	$3,638	**Randolph**	$14,631,754	4,271	$3,426
Dale	$24,349,088	7,990	$3,047	**Russell**	$25,414,373	9,906	$2,566
Dallas	$39,158,461	16,062	$2,438	**St. Clair**	$24,004,689	7,696	$3,119
Dekalb	$36,046,392	10,404	$3,465	**Shelby**	$19,336,384	6,109	$3,165
Elmore	$28,598,442	7,559	$3,783	**Sumter**	$12,360,124	5,028	$2,458
Escambia	$18,808,124	6,783	$2,773	**Talladega**	$46,250,508	15,022	$3,079
Etowah	$64,119,086	16,256	$3,944	**Tallapoosa**	$29,446,646	7,551	$3,900
Fayette	$11,234,283	2,984	$3,765	**Tuscaloosa**	$118,203,941	24,252	$4,874
Franklin	$20,155,511	5,734	$3,515	**Walker**	$47,720,209	12,625	$3,780
Geneva	$15,705,229	5,042	$3,115	**Washington**	$10,071,392	3,571	$2,820
Greene	$8,701,188	3,018	$2,883	**Wilcox**	$11,885,881	5,442	$2,184
Hale	$13,533,888	4,578	$2,956	**Winston**	$15,572,567	4,152	$3,751
Henry	$9,732,275	3,156	$3,084	**Other**	$770,351	358	$2,152

Revenue, Expenditures, and Prices

In FY 2000, Medicaid paid $2,771,084,876 for health care services to Alabama citizens. Another $76,707,377 was expended to administer the program. This means that over 97 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 2000
EXPENDITURES
By type of service (net)

Service	Payments	Percent of Total Payments
Hospitals:	$1,003,652,182	36.22%
Disproportionate Share	$356,475,492	12.86%
Inpatient	$563,471,057	20.33%
Outpatient	$60,734,747	2.19%
FQHC	$17,061,464	0.62%
Rural Health Centers	$5,909,422	0.21%
Nursing Facilities	$659,372,205	23.79%
Waiver Services:	$137,161,796	4.95%
Elderly & Disabled	$38,565,844	1.39%
Mental Health	$95,817,278	3.46%
Homebound	$2,778,674	0.10%
Pharmacy	$328,877,280	11.87%
Physicians:	$133,682,276	4.82%
Physicians	$93,243,060	3.36%
Physician's Lab and X-Ray	$19,953,631	0.72%
Clinics	$16,206,492	0.58%
Other Practitioners	$4,279,093	0.15%
MR/MD:	$83,392,194	3.01%
ICF-MR	$63,926,639	2.31%
NF-MD/Illness	$19,465,555	0.70%
Insurance:	$97,355,633	3.51%
Medicare Buy-In	$86,881,071	3.14%
Managed Care	$47,891	0.00%
PCCM	$9,761,339	0.35%
Medicare HMO	$432,976	0.02%
Catastrophic Illness Insurance	$232,356	0.01%
Health Services:	$60,296,793	2.18%
Screening	$21,315,583	0.77%
Laboratory	$11,413,541	0.41%
Dental	$10,776,385	0.39%
Transportation	$11,309,767	0.41%
Eye Care	$3,172,778	0.11%
Eyeglasses	$1,737,385	0.06%
Hearing	$427,379	0.02%
Preventive Education	$143,975	0.01%
Community Services:	$182,871,900	6.60%
Maternity Program	$94,458,311	3.41%
Home Health/DME	$34,844,061	1.26%
Family Planning	$6,955,568	0.25%
Targeted Case Management	$34,401,643	1.24%
Hospice	$12,212,317	0.44%
Mental Health Services	$84,422,617	3.05%
Total For Medical Care	$2,771,084,876	100.00%
Administrative Costs	$76,707,377	
Net Payments	$2,847,792,253	

Population

The population of Alabama grew from 3,893,888 in 1980 to 4,040,587 in 1990. In 2000**,** Alabama's population was estimated to be 4,419,280. Because of increases in Medicaid coverage in recent years, the segment of the population eligible for Medicaid services has risen from 10.4% in FY 1990 to 15.3% in FY 2000**.**

More significant to the Medicaid program now and in the future is the rapid growth of the elderly population. Census data show that, in the United States, the 65 and older population grew twice as fast as the general population from 1970 to 1990. This trend is reflected in population statistics for Alabama. Population projections published by the United States Census Bureau reveal that between the year 2000 and the year 2025, the over 65 population will grow from 582,000 to 1,069,000 in Alabama. The Center for Demographic and Cultural Research at Auburn University at Montgomery reports that white females 65 years of age and older account for almost one-half of the elderly population in the state. Historically, Medicaid's costs per eligible have been higher for this group than for other groups of eligibles.

Eligibles

During FY 2000 there were 676,938 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 540,381**.** The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

FY 2000

ELIGIBLES
Monthly Count

October ''99	532,090
November	531,603
December	530,048
January '00	541,074
February	533,448
March	538,957
April	541,363
May	541,616
June	542,816
July	546,570
August	550,872
September	554,117

FY 2000

MEDICAID ELIGIBLES BY CATEGORY

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	TOTAL
Autauga	1,129	313	1,175	2,211	253	8	142	5,231
Baldwin	912	782	2,832	7,440	582	31	498	13,077
Barbour	968	555	1,545	2,692	288	18	174	6,240
Bibb	292	242	936	1,656	162	4	136	3,428

FY 2000

MEDICAID ELIGIBLES BY CATEGORY

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	TOTAL
Blount	603	471	1,092	3,004	317	4	262	5,753
Bullock	521	364	801	1,604	115	6	56	3,467
Butler	586	521	1,173	2,840	297	14	202	5,633
Calhoun	2,777	1,114	4,639	9,236	915	68	637	19,386
Chambers	1,295	597	1,295	2,614	356	22	263	6,442
Cherokee	489	303	669	1,942	200	10	196	3,809
Chilton	497	406	1,188	2,531	360	11	274	5,267
Choctaw	482	369	842	1,636	176	5	137	3,647
Clarke	1,607	558	1,558	2,845	308	10	235	7,121
Clay	174	285	451	1,368	166	7	132	2,583
Cleburne	245	164	487	1,094	138	3	128	2,259
Coffee	806	637	1,405	3,237	383	10	247	6,725
Colbert	232	602	1,851	5,082	472	17	410	8,666
Conecuh	1,030	266	821	1,547	168	4	125	3,961
Coosa	207	129	560	840	105	4	99	1,944
Covington	874	730	1,499	3,644	466	13	337	7,563
Crenshaw	268	392	677	1,405	208	1	129	3,080
Cullman	579	1,190	2,259	5,613	791	22	644	11,098
Dale	1,453	591	1,714	3,623	347	14	248	7,990
Dallas	3,149	1,212	4,446	6,162	628	31	434	16,062
Dekalb	1,143	1,051	2,010	5,139	608	15	438	10,404
Elmore	597	553	1,976	3,928	293	12	200	7,559
Escambia	448	501	1,342	3,938	312	9	233	6,783
Etowah	1,461	1,385	4,402	7,273	934	34	767	16,256
Fayette	422	319	710	1,212	183	3	135	2,984
Franklin	617	486	1,186	2,770	394	4	277	5,734
Geneva	511	486	1,111	2,331	319	9	275	5,042
Greene	381	335	782	1,347	103	7	63	3,018
Hale	523	494	1,034	2,195	163	7	162	4,578
Henry	412	354	650	1,324	236	9	171	3,156
Houston	1,750	1,107	3,449	7,959	782	24	657	15,728
Jackson	560	658	1,778	3,813	542	25	389	7,765
Jefferson	17,254	5,340	22,924	33,570	2,667	168	2,015	83,938
Lamar	269	291	602	1,262	187	9	153	2,773
Lauderdale	904	915	2,623	5,572	662	12	500	11,188
Lawrence	602	430	1,067	2,054	340	7	208	4,708
Lee	1,628	706	2,551	6,236	460	24	310	11,915
Limestone	872	654	1,685	3,639	396	22	262	7,530
Lowndes	872	259	938	1,779	117	6	58	4,029
Macon	1,480	448	1,178	2,318	167	10	69	5,670
Madison	5,052	1,616	5,597	11,549	1,013	51	698	25,576
Marengo	1,028	513	1,317	2,521	231	13	150	5,773
Marion	290	495	940	2,040	344	8	267	4,384
Marshall	1,372	1,213	2,914	7,147	722	20	574	13,962
Mobile	13,634	3,547	14,658	30,136	1,955	102	1,300	65,332

FY 2000

MEDICAID ELIGIBLES BY CATEGORY

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	TOTAL
Monroe	590	377	977	2,570	193	7	182	4,896
Montgomery	8,330	2,327	9,683	17,735	1,309	70	686	40,140
Morgan	1,096	1,115	3,125	6,523	688	35	485	13,067
Perry	1,184	406	1,054	1,660	145	5	76	4,530
Pickens	759	523	1,317	2,030	182	8	120	4,939
Pike	1,069	590	1,631	3,416	241	22	197	7,166
Randolph	681	375	773	2,053	238	12	139	4,271
Russell	2,069	698	2,047	4,362	452	18	260	9,906
St. Clair	936	467	1,505	4,130	358	9	291	7,696
Shelby	708	472	1,588	2,798	296	11	236	6,109
Sumter	1,621	425	1,078	1,687	126	11	80	5,028
Talladega	2,319	889	4,162	6,348	721	75	508	15,022
Tallapoosa	930	744	1,732	3,504	366	13	262	7,551
Tuscaloosa	2,990	1,777	6,085	11,799	847	40	714	24,252
Walker	889	844	3,445	6,542	479	23	403	12,625
Washington	655	273	806	1,551	154	10	122	3,571
Wilcox	1,159	428	1,686	1,870	184	17	98	5,442
Winston	269	463	1,028	1,899	292	4	197	4,152
Youth Svcs.	9	0	0	349	0	0	0	358
STATEWIDE	103,520	50,142	159,061	311,744	29,602	1,337	21,532	676,938

.

Use and Cost

The percent distribution of Medicaid payments has changed very little since last year. Most payments are made on behalf of recipients in the aged or disabled categories, females, whites and persons 65 years of age or older. A useful way to compare costs of different groups of Medicaid eligibles and predict how changes in eligibility and utilization will impact Medicaid is to measure cost per eligible. This measure is determined by dividing total payments for services by the total number of persons eligible during the year.

Statistics reveal that certain groups are much more expensive to the Medicaid program than others. The reason for the difference is that some groups tend to need more expensive services. Any Medicaid eligible may receive, within reasonable limitations, medically necessary services.

A good example of this is the pattern of use of long-term care. This type of care has a high cost per unit of service, and recipients of long-term care have a high frequency-of-service rate. The average Medicaid payment for a day of long-term care in FY 2000 was $84. The yearly average number of days for recipients of this service was 298. Most recipients of long-term care are white females who are categorized as aged or disabled and are 65 years of age and over. It is not surprising that these groups have a large percentage of Medicaid payments made on their behalf.

Some low-income Medicare beneficiaries are eligible to have their Medicare premiums, deductibles, and coinsurance covered by Medicaid. Medicaid paid a total of $87 million in Medicare buy-in fees in FY 2000. Paying the buy-in fees is cost effective for Medicaid because, otherwise, the Agency would incur the full payment for medical bills instead of only covering the premiums, deductibles, and coinsurance.

Cost Avoidance and Recoupments

Program Integrity

The Program Integrity Division of the Alabama Medicaid Agency is tasked with identifying fraud and abuse of Medicaid benefits by both health care providers and recipients. Computer programs are used to identify unusual patterns of utilization of services. Medical desk reviews are conducted on those providers and recipients whose medical practice or utilization of services appears outside established norms. Additionally, the division performs follow-up on referrals made from many internal and external sources, including calls made to the Medicaid Fraud Hotline.

In the Provider Review Unit, statistical computer programs are used to identify patterns of potential overbilling or program abuse. Specially trained nurses then examine providers' Medicaid claims using computer programs and review of patient medical records. Both quality and quantity of services are examined. The primary purpose of this review process is to recover overpayments and identify potential Medicaid fraud and abuse. Corrective actions include recoupment of funds, education on proper billing procedures, and peer review by appropriate licensing authorities. Intentional fraud cases are referred to the Attorney General's Medicaid Fraud Control Unit for legal action.

When a recipient review indicates a pattern of over or misutilization of Medicaid benefits, the recipient is placed in the Agency's Restriction Program for management of his medical condition. The recipient is locked in to a physician who is responsible for primary care. Referrals to specialists are allowed if they are made by the recipient's primary care physician. The recipient is also restricted to one pharmacy for obtaining medications. Additional limitations may be placed on the recipient's ability to obtain certain drugs. Follow-up reviews are performed annually.

Code of Alabama, 1975, Section 22-6-8, requires that cases of suspected fraud, abuse, and/or misuse of Medicaid benefits be referred to a Medicaid Utilization Review Committee. The Committee may recommend that a recipient's eligibility be suspended for one year and until repayment of misspent funds is made.

Through the Quality Control Unit, the Medicaid Agency makes sure eligibility determinations are as accurate as possible. In-depth reviews of eligibility determinations are performed on a random sample of Medicaid eligibles. If a state's payment error rate exceeds three percent, the Health Care Financing Administration (HCFA) may impose a financial sanction. The Agency's most recent error rate was within a comfortable margin below the three- percent maximum for the six-month period from October 1999 to March 2000. Nationally, Alabama has consistently been among those states with the lowest payment error rates.

Prior Authorization Program

The mission of the Prior Authorization Program is to ensure that only medically necessary services are provided in a cost-effective manner. The program constantly reviews its scope of responsibility in order to maximize efficient use of the resources of the program and the agency.

The scope of this program has been significantly enlarged to include prior authorization functions for newly covered services and for those services previously handled by other programs within the agency. New areas include prior authorization functions for oxygen services for adults, breast reconstruction surgeries for cancer patients, various other surgeries, and diagnostic procedures.

While continuing to perform PA functions, this unit is moving towards performing Quality Assurance functions on services that have been approved.

Third Party Liability

Medicaid's Third Party Liability (TPL) Program is responsible for ensuring that Medicaid pays only when there is no other source (third party) available to pay for a recipient's health care. To do this Medicaid uses a combination of data matches, diagnosis code edits, and referrals from providers, caseworkers, and recipients to identify available third party resources such as health and liability insurance. The TPL Program also ensures that Medicaid recovers any costs incurred when available resources are identified through its liens and estate recovery programs as well as seeks reimbursement from recipients when Medicaid payments were made erroneously as a result of eligibility-related issues. In addition, the TPL Program provides alternative sources of health care coverage for recipients by purchasing Medicare coverage as well as coverage through individual and group health plans when cost effective.

Alabama's Third Party Division oversees a comprehensive TPL Program, which has been successful in saving Alabama taxpayers over $500 million since 1988. This has been done through a combination of cost avoidance of claims where providers file with the primary payor first, direct billing of third party payors for reimbursement to Medicaid, and continuation of private health insurance coverage for certain Medicaid beneficiaries. Medicaid recovers other costs through estate recovery and liens activity, monitoring of Medicare edits, and recoupments from beneficiaries of incorrectly paid claims due to ineligibility.

Health Insurance Resources

In FY 2000, approximately 14% of Medicaid recipients under the age of 65 had other health insurance coverage. The majority of these recipients were covered by group health plans through their own employers or those of parents or spouses. A significant number of the plans offered by these employers require their insured to use participating providers and obtain precertification of certain services, resulting in substantial savings to Medicaid. For individuals age 65 and older, approximately 15 percent were covered by a Medicare supplement or other health plan.

System edits ensure that claims are submitted to the primary payer before Medicaid makes payment. In situations where primary coverage is identified after Medicaid makes payment, Medicaid seeks reimbursement from the other coverage.

Medicare Buy-In

Medicaid purchases Medicare Parts A and B for eligible beneficiaries. The Third Party Division oversees the payment of premiums for this coverage and ensures that Medicare benefits are used as a primary resource to Medicaid.

Medical Support

Many Medicaid eligible children are also eligible for coverage of their medical care through a non-custodial parent's (NCP) health insurance. In addition to identifying those children with existing coverage, Medicaid uses data matches and referrals from caseworkers to identify those who are not covered by the NCP's health plan but could be. These children are referred to the Department of Human Resources (DHR) to obtain and enforce a court order requiring the NCP to enroll the child in the NCP's health plan. Where health insurance is not

available, an NCP may be under a court order to reimburse Medicaid for medical bills paid by Medicaid on behalf of the dependent.

Casualty/Tort Resources

When Medicaid identifies a recipient whose claims for treatment of an injury were paid by Medicaid, the Third Party Division is required to look for other sources that may pay for the recipient's medical care. Other sources of payment may include homeowner's, automobile, malpractice, or other liability insurance as well as payment by individuals such as restitution ordered by a court. Once a potential third party payor is identified, Medicaid must seek reimbursement of payment for related medical bills paid by Medicaid.

Recoupments

The Medicaid Agency recovers funds from individuals who received Medicaid services for which they were not entitled. In most instances these cases involve individuals who, through neglect or fraud, did not report income or assets to their eligibility caseworkers. The Third Party Division's Recoupments Unit identifies these cases from complaint reports submitted by the individual's caseworker.

Estate Recovery and Liens

State Medicaid Programs are required to recover the costs of nursing facility and other long-term care services from the estates of Medicaid recipients. In FY 2000, the division's Liens Program collected over $2.8 million. In addition, Medicaid's Estate Recovery Program initiated collection against estates and income trusts of individuals to recover Medicaid's costs. Through the efforts of this program, approximately approximately $50,0000 was collected.

Premium Payment

When cost effective, Medicaid has the option of paying health insurance premiums on behalf of individuals who are unable to continue payment of their premiums because of loss of job or high cost of premiums. Many of the individuals enrolled in this program have lost employment and cannot afford to pay the high cost of COBRA premiums. This is a very effective program as it allows individuals with high cost medical conditions to continue to receive health care through their established providers, and at the same time it provides substantial savings to the Medicaid program. In FY 2000, premiums were paid for an average of 100 individuals each month resulting in savings to Medicaid of over $500,000. Individuals who have benefited from this program include pregnant women, accident victims and recipients diagnosed with hemophilia, cancer and HIV.

Agency Audit

Fiscal Agent/Systems Audit

The Fiscal Agent Liaison Division monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews of forced claims, denied claims, processed refunds and adjustments are also performed. In addition, targeted reviews of claims are performed when potential systems errors are found. During this fiscal year, approximately 3,050 claims were manually reviewed and $4,523 was identified for recoupment.

Provider Audit/Reimbursement

The mission of the Provider Audit/Reimbursement Division is to monitor Agency expenditures in the major program areas (nursing facilities, alternative services, managed care plans, health maintenance organizations and other prepaid health plans) to ensure that only allowable costs are reimbursed. Provider Audit has three branches: Nursing Home Audit, Alternative Services Audit, and Quality Assurance/Reimbursement.

Nursing Home Audit conducts on-site financial audits and makes necessary adjustments to the reported costs. This adjustment information is provided to reimbursement specialists who adjust current payment rates, recoup overpayments and make up for underpayments. An in-depth, on-site audit of all nursing home facilities, home offices, and all ICF/MR facilities is completed as necessary. During FY 2000, this unit completed 50 audits. Both positive and negative adjustments are made to insure that all reimbursable costs are included and that all non-reimbursable costs are removed from provider per diem rates. If it is determined that a provider may be intentionally filing a fraudulent cost report, or if the provider continues to claim known unallowable costs in the reimbursement cost total, the Nursing Home Audit section provides the Attorney General's Medicaid Fraud Control Unit with the information.

Quality Assurance/Reimbursement performs annual desk reviews/audits of nursing home and ICF/MR costs and makes adjustments to set nursing home reimbursement rates, recomputes reimbursement rates due to audit findings, and computes over/underpayments based on audits, additional information, etc. The unit also analyzes data necessary for determining capitated rates for managed care plans, health maintenance organizations and other prepaid health plans and reviews all audits performed by nursing home auditors and alternative services auditors for compliance with generally accepted accounting principles and systems, and state/federal regulations.

The Alternative Services Audit section performs limited scope financial audits of providers in selected waiver programs. This section verifies revenue, expense, and other data reported by providers through their cost reports. The data from these cost reports is used to set rates for each service provider in the Elderly and Disabled Waiver, the Mentally Retarded/Developmentally Disabled Waiver, and the Homebound Waiver. This section also sets rates for federally qualified health centers, provider based rural health clinics, targeted case management (adult protective services and foster children), children's specialty clinic services, and the Hospice Program using the providers' cost reports. Providers always have the right to appeal audit findings.

Medicaid Management Information System

The Agency's Medicaid Management Information System (MMIS) maintains provider and recipient eligibility records, processes all Medicaid claims from providers, keeps track of program expenditures, and furnishes reports that allow Medicaid administrators to monitor the pulse of the program.

Major in-house projects (not assigned to the fiscal agent) completed in FY 2000 to support the MMIS and aid Agency decision making included the enlargement of the Eligibility File to include the expanded aid category data for current and retroactive eligibility in order to increase the accuracy of claim processing and payment. A monthly data reconciliation process with our fiscal agent was created. Family planning, a new waiver group, was developed to provide family planning services to non-pregnant Alabama women from 19 to 44 years of age who would not normally qualify for Medicaid. Measures were taken to increase the Agency's security on its online computer systems by creating new protection features for all online users and new policy regulations regarding hardware and software usage were developed.

Revisions and enhancements were made to several online systems, including the Buy-in and Provider Reviews' Ad Hoc Query Database Systems. Other modifications included the incorporation of new fund codes in the accounting system, addition of the Commission on Aging to our clearing house process for state agencies

claim processing, and changes to our software to speed up end of month processing. New developments included the Purchase Requisition and Voucher Log System for Office Services and Provider SUR database system.

The Agency's contracted fiscal agent, Electronic Data System (EDS), performs many of Medicaid's computer functions. Medicaid first contracted with EDS in October of 1979. In June 1998, the Alabama Medicaid Agency and EDS signed a contract for a new Y2K compliant MMIS. The MMIS was operational on October 1, 1999.

Maternal and Child Health Services

During FY 2000, Medicaid served 311,744 women and children through the expanded eligibility group for pregnant women and children called SOBRA (Sixth Omnibus Budget Reconciliation Act). Coverage of this group has contributed to an improvement in Alabama's infant mortality rate since 1989, from 12.1 infant deaths per thousand births to 9.8 deaths per thousand in 1999.

In 1988, the Medicaid Agency implemented a policy that would allow pregnant women at or below 100 percent of the poverty level to qualify for Medicaid benefits. In April 1990, Medicaid expanded eligibility for pregnant women to 133 percent of the federal poverty level. With this expansion Medicaid has been made available to more women than ever before

Prenatal Care

Competent, timely prenatal care has proven to result in healthier mothers and babies. Timely care can also reduce the possibility of premature, underweight babies. Studies consistently show that for every dollar spent on prenatal care, approximately $3 is saved in the cost of caring for low birth weight babies.

Prenatal care for Medicaid recipients is provided through private physicians, hospitals, public health department clinics and federally qualified health centers. Some of the maternity-related benefits covered under the prenatal program are unlimited prenatal visits, medical services to include physical examinations with risk assessments, prenatal vitamins, nutritional assessments, counseling and educational services, appropriate medically indicated lab tests, and referral services as needed. Referral services include family planning services after delivery and medical services for the newborn under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Medically indicated procedures such as ultrasound, non-stress tests, and amniocentesis are examples of other services covered by Medicaid. In order to complete the pregnancy cycle, one postpartum checkup is covered during the 60-day postpartum period. Two additional postpartum visits may be provided for recipients with obstetrical complications such as infection of surgical wounds.

Adolescent Pregnancy Prevention Education

Adolescent Pregnancy Prevention Education was implemented in October 1991. The program is designed to offer expanded medically related education services to teens. The program curricula are designed to teach disease and disability prevention and to prolong life and promote physical and mental health. These classes go beyond the limited service and information offered under existing Medicaid programs. Physicians or other licensed practitioners of the healing arts who present detailed adolescent pregnancy material provide these services.

The pregnancy prevention services include a series of classes teaching male and female adolescents about decision-making skills and the consequences of unintended pregnancies. Abstinence is presented as the preferred method of choice. Currently there are approximately 16 providers of adolescent pregnancy prevention services. These include hospitals, county health departments, FQHCs, and private organizations.

VACCINES FOR CHILDREN

In an effort to increase the number of Alabama children who are fully immunized by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program in October 1994. This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations, if they obtain vaccines from a federally qualified health center or rural health clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 360,000 of Alabama's children are Medicaid eligible. Medicaid has taken the previous vaccines and administration fee costs to calculate an equivalent reimbursement fee of $8 per injection. When multiple injections are given on the same day, Medicaid will reimburse for each injection. When injections are given in conjunction with an EPSDT screening visit or physician office visit, an administration fee of $8 will also be paid.

Providers may charge non-Medicaid VFC participants an administration fee. The fee is an interim rate set by the Health Care Financing Administration based on charge data. No VFC-eligible participant should be denied services because of inability to pay.

The Department of Public Health is the lead agency in administering this program.

FAMILY PLANNING

The origin of the Family Planning Program dates back to the time when Medicaid started in Alabama. The Social Security Amendments of 1972 mandated coverage of Family Planning services for categorically needy individuals of childbearing age, including minors who are sexually active and desire such services. The law also provides for 90 percent federal funding for these services. This is a higher match than for other Medicaid services.

Family planning services are defined as those services that prevent or delay pregnancy. They include office visits, health education, some laboratory screening tests, and pharmaceutical supplies and devices provided for contraceptive purposes.

Family planning services are covered for Medicaid eligible women, including SOBRA women 10-55 years of age and men of any age who desire such services. Recipients have freedom of choice in selecting a contraceptive method and/or a provider of family planning services. Acceptance of family planning services must be without coercion or mental pressure.

Recipients are authorized one annual physical and up to four additional visits per calendar year. These visits do not count against other benefit limits. A family planning home visit is available for newly delivered mothers. This allows recipients to begin the birth control of their choice prior to the postpartum visit in the clinic. An extended contraceptive-counseling visit is also covered on the same day as the postpartum visit. Contraceptive supplies and devices available for birth control purposes include pills, foams/condoms, intrauterine devices, diaphragms, implants, and injections. Sterilization procedures are also covered if federal and state regulations are met. HIV pre and post testing counseling services are also available if performed in conjunction with a family planning visit.

Providers include county health departments, federally qualified health centers, rural health clinics, private physicians and Planned Parenthood of Alabama. Family planning providers are available statewide.

EPSDT

The Early and Periodic Screening, Diagnosis and Treatment Program is a preventive health program designed to detect and treat diseases that may occur early in a child's life. If properly used, the program can benefit both the child and the Medicaid Agency. Many health problems begin early in life and, if left untreated, can cause chronic illness and disability. When an illness is diagnosed and treated through the screening program, the child benefits through improved health. All medically necessary services to correct or improve the condition are unlimited if the condition was identified during or as a result of a screening. The Medicaid program realizes long term savings by intervening before a medical problem requires expensive acute care.

The EPSDT screening program can detect many problems before they become acute. Problems such as hypertension, rheumatic fever and other heart conditions, diabetes, neurological disorders, venereal disease, anemia, urinary infections, vision and hearing disorders, and even cases of child abuse have been detected and treated in past years. The cost of screening is relatively small - an average of $70 per screening. The cost of treating acute illness is considerably higher.

The EPSDT program is a Medicaid-funded program available to all Medicaid eligible children under 21 years of age. The success of the program is fostered by the cooperation of the Alabama Medicaid Agency, the Department of Human Resources, the Department of Public Health, and Medicaid providers. Medicaid beneficiaries are made aware of EPSDT and referred to screening providers by eligibility workers at the Department of Human Resources, Medicaid District Office eligibility specialists, and SOBRA Medicaid outstationed workers located in health departments, hospitals, federally qualified health centers, and clinics throughout the state. The Medicaid Agency sends information to the parent or guardian of each child under 21, notifying them of the availability and benefits of the EPSDT program. Medicaid providers such as public health clinics also inform patients about the program.

Currently there are more than 1,620 providers of EPSDT services, including county health departments, federally qualified health centers, provider-based rural health clinics, independent rural health clinics, hospitals, private physicians and some nurse practitioners. With statewide implementation of the Patient 1st program, primary care providers are obligated to ensure that all Medicaid recipients under 21 years of age receive screenings on time.

In 1995, Medicaid added an off-site component of the EPSDT program. This allows providers who met specific enrollment protocols to offer EPSDT screening services in schools, housing projects, Head Start programs, day care centers, community centers, churches and other unique sites where children are frequently found.

Since screening is not mandatory, many mothers do not seek preventive health care for their children. Steps have been taken in recent years, however, to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of intensive outreach statewide, enhancement of physicians' reimbursement for screening, and an increase in the number of screenings for which Medicaid will pay. Because of these added efforts, there have been more screenings performed. A Medicaid goal is to screen all eligible children at the appropriate intervals between birth and age 21.

The Medicaid dental program is limited to individuals who are eligible for treatment under the EPSDT program. Dental care under this program is available either as a result of a request or a need by the Medicaid recipient. Licensed dentists provide all Medicaid dental services. These services are limited to those that are customarily available to most persons in the community. Examples of dental services not covered by Medicaid include surgical periodontal and most prosthetic treatments. If justified by the attending dentist, some services may be

prior authorized by the Medicaid Agency. These services may include nonsurgical periodontal treatment, third and subsequent space maintainers, hospitalization and some out-of-state care.

Recipient Inquiry Unit

Implemented in late 1992, the Recipient Inquiry Unit has increased recipients' access to the Agency via toll-free telephone service from throughout Alabama. Averaging 24,532 calls monthly during FY 2000 (more than 294,381 annually), the inquiry unit provides replacements for lost and stolen Medicaid cards to eligible persons, while responding to callers' questions about various eligibility, program and other topics.

Each month, approximately one third of all calls deal with Primary Care Case Management (PCCM) provider assignment and about one-fourth are information-only calls. About 10 percent of calls deal with Medicaid card replacement and the remaining calls are referred to a certifying agency or worker (Medicaid District Offices, SOBRA workers, Social Security or the Department of Human Resources) or an Agency program office (Hospital, Physicians, and Pharmacy, among others) for action.

The hotline (1-800-362-1504) is open from 8 a.m. to 4:30 p.m. Monday through Friday. In FY 2000 the unit was staffed with four full time operators and 10 temporary operators.

Managed Care

Partnership Hospital Program

Hospitals remain a critical link in providing medically necessary health care to Alabama Medicaid recipients. A managed care initiative called the Partnership Hospital Program (PHP) changed the way hospital days are reimbursed in Alabama. The PHP is a two-year waiver that was implemented October 1, 1996. Through this program, the state is divided into eight districts. Medicaid pays each PHP a per member, per month fee for inpatient hospital care to most Medicaid patients living in the district. While Medicaid patients are automatically enrolled in the district where they live, the patient may be admitted to any hospital that accepts Medicaid as payment. The PHP covers 112 Alabama hospitals in 66 counties. Not included in the PHP are Mobile county residents, 28 hospitals in neighboring states, four Under Age 21 Psychiatric hospitals, and one Over Age 65 Psychiatric hospital. Plans are to include Mobile County residents with the renewal of the PHP waiver.

The objective of this managed care initiative is to provide inpatient hospital services to eligible Medicaid beneficiaries through arrangements that:

- Assure access to delivery of inpatient care.
- Promote continuous quality improvement.
- Include utilization review.
- Manage overall inpatient hospital care and efficiency.

Inpatient hospital days were limited to 16 per calendar year in FY 2000. However, additional days are available in the following instances:

- When a child has been found, through an EPSDT screening, to have a condition that needs treatment.
- When authorized for deliveries (onset of active labor through discharge).

There are some instances when inpatient days are unlimited:

- Children under one year of age.

- Children under age seven when in a hospital designated by Medicaid as a disproportionate share hospital.

PATIENT 1ST

The Patient 1st program expanded during FY 2000 into a total of 67 counties serving approximately 350,000 beneficiaries. The Patient 1st Program is a primary care case management system that links each participating Medicaid beneficiary with a Primary Medical Provider (PMP). The PMP is responsible for providing care directly or through referral. Additional responsibilities include 24-hour day/7 days a week coverage, coordination of EPSDT and immunizations, and coordination of medical needs.

The program has been successful in meeting its goal of creating medical homes for Medicaid beneficiaries. Access to a PMP has resulted in medical doctor shopping, more appropriate utilization of services, and reduced expenditures for primary care in an emergency room setting.

With the expansion of Patient 1st completed, the focus during FY 2000 continued to be patient and provider education. A video presentation for providers to show patients in their waiting rooms which explains the Patient 1st program was developed. This video includes information about how to access medical care, when to go to the emergency room, and instructions on contacting their PMP before going to other physicians or places for medical care. In addition to the video, new Patient 1st beneficiaries also receive a welcome packet with helpful information about how the program works.

MATERNITY CARE PROGRAM

Since 1988, the Medicaid Agency has been providing care to pregnant women in an effort to combat Alabama's high infant mortality rate through a 1915b waiver called the Maternity Waiver Program. This program has been very successful in getting women to begin receiving care earlier and in keeping them in a system of care throughout the pregnancy. The end result has been increased numbers of prenatal visits and fewer neonatal intensive care days, which has resulted in healthier babies and decreased expenditures for the Agency.

The Balanced Budget Act of 1997 provided Medicaid the authority to convert the Maternity Waiver Program into a State Plan based program. Although the program has changed from a waiver to an operational program, many of the same components are present under the Maternity Care Program.

The program will continuous to ensure that eligible pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through a network established by Primary Contractors. Under this program, women are allowed to choose the Delivering Healthcare Provider of their choice to provide their delivery care. Care Coordinators work with the women to set up a plan of care, make appropriate referrals, provide education, follow-up on missed appointments, assist with transportation, and provide other needed services.

The Maternity Care Program has been expanded statewide with the exception of Mobile County. The state has been divided into 13 districts with one primary Contractor responsible for each district. It is anticipated that the program will serve approximately 27,000 women each year. Plans are to include Mobile County in June of 2001.

The program was implemented in phases with the first district starting in June of 1999 and the last ones starting in October of 1999. The Agency anticipates that this program will continue to be successful and further increase the number of good birth outcomes in the State of Alabama.

Managed Care Quality Assurance Program

The Managed Care Quality Assurance Program is responsible for monitoring and oversight of Quality Assurance Activities for Medicaid's Managed Care initiatives. During fiscal year 2000, Medicaid's Managed Care Initiatives included:

- PHP (Partnership Hospital Program)
- PCCM (Primary Care Case Management)
- MCP (Maternity Care Program)

Each Managed Care initiative is mandated to have an active Quality Assurance System with reporting requirements. Administrative aggregate systematic data collection of performance and patient results is a requirement. The System must provide for the interpretation of this data to the practitioners and provide for making needed changes. Each Plan's reports are monitored and reviewed by Medicaid on an ongoing basis. Findings may initiate a need for further review of areas of interest, potential utilization and quality concerns. The System must also provide for review by appropriate health care professionals.

At a minimum, each Plan is required to designate an active Quality Assurance Committee within established guidelines. The Committee is formally delegated the responsibility to review potential quality concerns identified through the Quality Assurance Process and initiate appropriate corrective/preventative action. The Committee must track/follow potential and positive concerns until resolution is established. Complaints and grievances are reviewed and followed by the Committee with guidelines. Utilization Management issues are addressed and followed as well. The Quality Assurance monitoring and review process is an ongoing assessment that promotes quality improvements over time.

In addition to monitoring and oversight functions, Medicaid's Managed Care Quality Assurance Program must perform formal Annual Medical Audits to assure the Quality Assurance System activities are effective, meet standards, and within guideline compliance. The areas reviewed include administration, utilization management, quality activities, corrective actions, continuity/coordination of care, and complaints and grievances.

Medicare HMOs and CMPs

Medicaid continued a program in which health maintenance organizations (HMOs) and competitive medical plans (CMPs) may enroll with the Medicaid agency to receive capitated per member per month payments to cover, in full, any premiums or cost sharing for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of medical cost sharing.

The HMO or CMP must have an approved Medicare risk contract with HCFA to enroll Medicare beneficiaries and other individuals and groups. The HMO or CPM must deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to Medicare enrollees. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. The HMO or CMP must offer all services covered by Medicare at no cost to the beneficiary. The HMO or CMP may offer additional services to the beneficiary, such as hearing exams, annual physical exams, eye exams, etc. Services covered by Medicaid, but not Medicare, are not included. The beneficiary is given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

Mental Health Services

Through mental health centers under contract with the Department of Mental Health and Mental Retardation, Medicaid provides services for eligible mentally ill adults and emotionally disturbed children. These services include day treatment, crisis intervention, medication check, diagnostic assessment, pre-hospitalization screening,

and psychotherapy for individuals, groups and families. The program serves people with primary psychiatric and substance abuse diagnoses. There are 24 mental health centers around the state providing these services

On April 1, 1994, the mental health program was expanded to allow the Department of Human Resources and the Department of Youth Services to provide rehabilitative services to the children and adolescents in their custody. DHR and DYS are presently involved in the process of implementing the provisions of federal court consent decrees (R.C. and A.W., respectively). One of the critical mandates of both suits is the maximization of federal dollars, specifically Medicaid funding. DHR has become an active provider. Since May 1998, DYS has been an active provider. A wide array of mental health services is provided to children in state custody in a cost-effective manner.

Targeted Case Management

The optional targeted case management program assists Medicaid-eligible individuals in gaining access to needed medical, social, educational and other services through coordination, linkage, and referral. The Alabama Medicaid Agency currently serves mentally ill adults (target group 1), mentally retarded adults (target group 2), handicapped children (target group 3), foster children (target group 4), pregnant women (target group 5), AIDS/HIV positive individuals (target group 6), adult protective service individuals (target group 7), and medically at risk (target group 8). With the addition of new providers coordinating services for these target groups, there was a reduction in nursing home placement and hospitalization. Approximately 22,000 Medicaid beneficiaries received targeted case management service this year at a cost of $24 million.

Home and Community Based Service Waivers

The State of Alabama has developed Home and Community Based Service (HCBS) waivers that provide alternatives to institutionalization for some Medicaid recipients. The waiver programs are aimed at helping recipients receive extra services not ordinarily covered by Medicaid in this state. Home and Community Based waiver programs serve the elderly and disabled, mentally retarded and developmentally disabled, and disabled adults with specific medical diagnoses. These programs provide quality and cost-effective services to individuals at risk of institutional care.

HCBS Waiver for the Elderly and Disabled

This waiver provides services to persons who might otherwise be placed in nursing homes. The five basic services covered are case management, homemaker services, personal care, adult day health, respite care, and companion services. During FY 2000, there were 5,795 recipients served by this waiver at an actual cost of $6,379 per recipient. Serving the same recipients in nursing facilities would have cost the state $24,900 per recipient. This waiver saved the state $18,521 per recipient in FY 2000.

People receiving services through Medicaid HCBS waivers must meet certain eligibility requirements. Those served by the waiver for the elderly and disabled are recipients of Supplemental Security Income (SSI) or State Supplementation who meet the medical criteria for nursing home care financed by the Medicaid program. This waiver is administered by the Alabama Department of Public Health and the Alabama Commission on Aging.

HCBS Waiver for the Mentally Retarded and the Developmentally Disabled (MR/DD)

This waiver serves individuals who meet the definition of mental retardation or developmental disability. The waiver provides residential habilitation training, day habilitation, prevocational training, supported employment, occupational therapy, speech and language therapy, physical therapy, behavior management, companion service, respite care, personal care, environmental accessibility adaptations, medical supplies, assistive technology, and

skilled nursing care. During FY 2000 there were 4,037 recipients served by this waiver at an actual cost of $26,720 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $71,559 per recipient. The MR/DD waiver saved the state $44,839 per recipient in FY 2000.

Homebound Waiver

This waiver serves disabled adults with specific medical diagnoses who are at risk of being institutionalized. To be eligible an individual must be age 18 or above, and meet the nursing facility level of care. All income categories from SSI to 300% of SSI are included. The waiver is administered by the Department of Rehabilitative Services. The services provided under this waiver include case management, personal care, respite care, environmental modification, medical supplies, personal emergency response system, and assistive technology.

Home Care Services

The Medicaid home care services program helps people with illnesses, injuries, or disabilities to receive the quality of care they need at home. Through the utilization of registered nurses, licensed practical nurses, home health aides/orderlies/homemakers, physical therapists, occupational therapists, speech therapists, respiratory therapists, medical equipment and supplies, orthopedists, prosthetists, physicians, and hospices, recipients are provided services that are needed for them to remain at home and maintain their highest level of independence at a cost savings to Medicaid.

Home care services to Medicaid eligibles under the age of 21 have been greatly expanded because of the Omnibus Budget Reconciliation Act of 1989. This law states that any service necessary to treat or ameliorate a condition must be provided to any Medicaid eligible under 21 years of age as long as the condition is discovered as a result of a medical check-up through the EPSDT program. This provision of OBRA '89 has greatly increased the number of children that are served in the community. Occupational therapy, physical therapy, durable medical equipment, and other services as necessary to maintain Medicaid eligibles in the home have been available to Medicaid eligibles under 21 since April 1, 1990.

Due to changes in the health care delivery system, the demand for home care services has been increasing. Advanced medical technology has made it possible to provide more sophisticated care and equipment in the home rather than incurring the expense of institutional care. In addition, expansions mandated under the EPSDT program have made Alabama Medicaid's home care services one of the most comprehensive medical assistance programs for children in the country.

The Medicaid home care services program is based on the philosophy of family and patient participation in providing patient care. Working together, families and patients are taught care which can reasonably and safely be rendered in the home.

Hospice Care Services

Hospice care is a comprehensive home care program which primarily provides reasonable and necessary medical and support services for terminally ill individuals. The goal of hospice is not to cure a terminal illness, but rather, to provide relief of symptoms.

This service is not only compassionate but also cost efficient. During FY 2000, the Medicaid Agency served 1,526 hospice patients at a total cost of about $13 million. The expense was offset by a reduction in hospital costs for Medicaid.

In adding hospice services for eligible patients, the Medicaid Agency follows the same rules the Medicare program uses. Hospice services must be provided by Medicare certified hospice programs and are available for unlimited days. Hospice care through the Medicaid Agency is provided on a voluntary basis, and when it is chosen, the patient waives the right to any other services that treat the terminal illness. Services included are nursing care, medical social services, physicians services, counseling services, short-term inpatient care, medical appliances and supplies (including drugs and biologicals), home health aide services, homemaker services, physical therapy, occupational therapy, speech language pathology services, and nursing home room and board.

Home Health and Durable Medical Equipment (DME)

Skilled nursing and home health aide services prescribed by a physician are provided to eligible homebound recipients on a part-time or intermittent basis. These services cover preventive, restorative, and supportive care to persons who meet Medicaid home health criteria. Nursing and personal care provided under the home health program must be certified by licensed physicians and provided by home health agencies under contract with Medicaid.

Medicaid in Alabama may cover up to 104 home health visits per year per beneficiary. Medicaid may authorize additional home health visits for beneficiaries under age 21 who have exhausted the home health benefit of 104 nursing visits per calendar year. For approval, the service must be referred from an EPSDT screening and prescribed as medically necessary by a physician.

Supplies, appliances, and durable medical equipment are mandatory benefits under the home health program. Medicaid recipients do not have to receive home health services to qualify for DME services, but all items must be medically necessary and suitable for use in the home.

In-Home Therapies

Physical, speech, and occupational therapy in the home are limited to individuals under 21 years of age that are referred from an EPSDT screening. If certified as medically necessary by a physician, services must be provided through a Medicaid certified home health agency. All therapy services rendered in the home require prior authorization by the Medicaid Agency.

Private Duty Nursing

Private duty nursing services in the home are covered for eligible recipients requiring continuous skilled nursing care. The services are available only for recipients under age 21 and prescribed as a result of an EPSDT screening referral. Private duty nursing care is provided in a recipient's home. The service also may be provided to the recipient in other settings when activities such as school or other normal life activities take him or her away from the home. Private duty nursing services are covered for Medicaid recipients who have medical problems that require education of the primary caregiver and/or stabilization of the recipient's medical problem or problems. For Medicaid coverage, at least four hours of continuous skilled nursing care are required per day.

Private duty nursing services must be prior authorized by Medicaid. All services require monitoring on a regular basis, generally every 60 days, with the physician providing recertification of the continuing need for care.

Medical Services

Outpatient Services

There were limitations on outpatient hospital services during this fiscal year. Medicaid pays for a maximum of three non-emergency outpatient visits per eligible during a calendar year. Exceptions are made for certified emergencies, chemotherapy, radiation therapy, visits solely for lab and x-ray services and surgical procedures on the Agency's approved outpatient surgical list.

Copayments

Most Medicaid hospital patients are required to pay a copayment for hospital care. The copayments are $50 per inpatient admission and $3 per outpatient visit. Recipients under 18 years of age, nursing home residents, and pregnant women are exempt from copayments. A provider may not deny service to a Medicaid eligible due to the recipient's inability to pay the copayment.

Transplant Services

In addition to cornea transplants, which do not require prior approval, Medicaid benefits cover prior authorized bone marrow, heart, heart/lung, lung, liver, liver/small bowel, small bowel, kidney, kidney/pancreas and pancreas transplants. Other medically necessary transplants are also covered for recipients under 21 years of age when the need is identified during an EPSDT screening and is prior authorized by the Medicaid Agency. Eligible recipients' transplants must meet the medical criteria in the Alabama Medicaid Organ Transplant Manual.

Transplant services are limited to in-state providers unless there are no in-state providers available to perform the procedure.

Inpatient Psychiatric Program

The inpatient psychiatric program was implemented by the Medicaid Agency in May 1989. This program provides medically necessary inpatient psychiatric services for recipients under the age of 21 if services are authorized by the Agency and rendered in Medicaid contracted psychiatric hospitals. Only psychiatric hospitals approved by the Joint Commission for Accreditation of Healthcare Organizations and with distinct units and separate treatment programs for children and adolescents can be certified to participate in this program. At the end of FY 2000, there were four hospitals enrolled.

Inpatient psychiatric services for recipients age 65 or over are covered services when provided in a free-standing hospital exclusively for the treatment of persons age 65 or over with serious mental illness. These services are unlimited if medically necessary and if the admission and continued stay reviews meet the approved psychiatric criteria. These hospital days do not count against a recipient’s inpatient day limitation for treatment in an acute care hospital.

Persons participating in the programs must meet certain qualifications and the services performed must be expected to reasonably improve the patient's condition or prevent further regression. Reviews are performed by the Medicaid Agency to determine the medical necessity of admissions and continued need for hospitalization. Admissions to psychiatric hospitals are reviewed and authorized prior to payment to ensure that appropriate criteria have been met.

Ambulatory Surgical Centers (ASC)

Medicaid covers ambulatory surgical center (ASC) services, which are procedures that can be performed safely on an outpatient basis. Services performed by an ASC are reimbursed by means of a predetermined fee established by the Medicaid Agency. A listing of covered surgical procedures is maintained by the Agency and furnished to all ASCs. The Agency encourages outpatient surgery whenever possible.

Ambulatory surgical centers must have an effective procedure for immediate transfer of patients to hospitals for emergency medical care beyond the capabilities of the center. Medicaid recipients are required to pay the designated copayment amount for each visit. At the end of FY 2000 there were 48 ASC facilities enrolled as providers in this program.

Post-Hospital Extended Care Program

This program was implemented August 1, 1994 for Medicaid recipients who were in acute care hospitals but no longer need that level of care. These patients needed to be placed in nursing facilities but for reasons such as lack of an available bed, or the level of care needed was such that they could not be accommodated by an area nursing facility, the patient was forced to remain in the hospital. In response to this problem, the Agency initiated the Post-hospital Extended Care Program (PEC). Patients in this program remain in the hospital, but they receive services ordinarily provided in a nursing facility. For these patients the hospital is reimbursed a daily rate equal to the average daily rate paid to nursing facilities in the state. The hospital is obligated to actively seek nursing home placement for these patients.

Swing Beds

Swing beds are defined as hospital beds that can be used for either hospital acute care or skilled nursing facility care. Hospitals with swing beds are located in rural areas with fewer than 100 total beds. The hospital must be certified as a Medicare swing bed provider. Reimbursement for a Medicaid recipient receiving skilled nursing facility care in a swing bed is at a per diem rate equal to the average per diem rate paid to participating nursing homes.

Federally Qualified Health Centers (FQHC)

The Medicaid federally qualified health centers program was implemented April 1, 1990, as a result of the Omnibus Budget Reconciliation Act of 1989. Certain community health centers, migrant health centers, and health care for the homeless programs are automatically qualified to be enrolled, with others able to be certified as "look alike" FQHCs.

Services covered by the FQHC program include ambulatory services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers employed by the FQHC. Federally qualified health centers are reimbursed using Medicaid’s fee schedule adjusted to reasonable cost. Medicaid establishes reasonable costs by using the centers' annual cost reports. At the end of FY 2000 there were 16 FQHCs enrolled as providers, with 97 satellite clinics.

Rural Health Clinics (RHC)

The Medicaid rural health program was implemented in April 1978. Services covered under the program include any medical service typically furnished by a physician in an office or a home visit. Limits are the same as for the physician program. Independent rural health clinic services, whether performed by a physician, nurse practitioner or physician assistant, are reimbursable. A physician or nurse practitioner is available to furnish patient care while the clinic operates. Independent rural health clinics are reimbursed at the reasonable cost per visit established for the clinics by the Medicare fiscal intermediary. At the end of FY 2000 there were 35 independent rural health clinics enrolled as providers in the Medicaid program.

Provider Based Rural Health Center (PBRHC) services were implemented in October 1993. PBRHCs are an integral part of a hospital, skilled nursing facility, or home health agency. Services covered under the program may be provided by a physician, physician assistant, nurse practitioner, certified nurse midwife, and/or specialized nurse practitioner. Visits to a PBRHC are included in the Medicaid-allowed 14 physician office visits per year.

PBRHCs are reimbursed on a percentage of fee-for-service based on their yearly cost reports. At the beginning of 1994 there were 11 PBRHCs enrolled as providers in Medicaid. There are now 22 PBRHCs enrolled as Medicaid providers.

Physicians Services

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. This service to beneficiaries, as with all other Medicaid programs, is based on medical necessity, with physicians determining the need for medical care. Physicians provide this care directly and prescribe or arrange for additional health benefits. It is the physician who determines what drugs a patient receives, decides when a patient needs nursing facility or inpatient hospital care, and controls the care of the patient in an institution. The majority of licensed physicians in Alabama participate in the Medicaid program.

Recipients visiting a physician are required to pay a $1 copayment per office visit. Recipients under 18 years of age, nursing home residents, and pregnant women are exempt from copayments. Certain physicians' services do not require copayments. These include family planning services, physicians' inpatient hospital visits, physical therapy, and emergencies. Physicians may not deny services due to the recipient's inability to pay the copayment.

Most Medicaid providers must sign contracts with the Medicaid Agency in order to provide services to eligibles. Physicians who participate in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program must sign an agreement in order to perform screening for children under the age of 21. Also, nurse midwives are required to sign contracts in order to participate in the Medicaid program. For other types of physicians' services, the submitted claim is considered a contract as long as the physician is enrolled in the Medicaid program and has a provider number.

In general, the per capita cost of Medicaid services to the aged is higher than for other categories of recipients. One reason is that older people are more likely to have health problems. However, Medicaid physicians' care costs for the aged are lower than for most categories. This is because most of Medicaid's aged recipients also have Medicare coverage. In cases when individuals have both Medicaid and Medicare, Medicaid normally covers the amount of the doctor bill not paid by Medicare, less the applicable copayment amount.

Pharmacy Services

Although the pharmacy program is an optional service under federal Medicaid rules, it is economically vital to the Medicaid program. Treating illnesses with prescription drugs is usually much less expensive and often as effective as alternatives such as hospitalization and/or surgery. For this reason, the pharmacy program represents one of the most cost-effective services.

Realistically, modern medical treatment would be impossible without drugs. In recent years, medical professionals have been very successful in finding medications that make more expensive alternatives unnecessary.

In FY 2000, pharmacy providers were paid approximately $332 million for prescriptions dispensed to Medicaid recipients. This expenditure represents about eight percent of Medicaid payments for services. The Medicaid Agency's reimbursement to participating pharmacists is based on the ingredient cost of the prescription plus a dispensing fee. The dispensing fees and the pricing methodology remain unchanged from previous years.

Primarily to control overuse, Medicaid recipients must pay a copayment for each prescription. The copayment ranges from $.50 to $3.00, depending on drug ingredient cost. The Omnibus Budget Reconciliation Act of 1990 (OBRA) expanded Medicaid coverage of reimbursable drugs. With the exception of allowable published

exclusions, the Medicaid Agency now covers almost all drugs. The OBRA '90 legislation also required states to implement a drug rebate program and a drug utilization review program (DUR).

The Rebate Program collects rebates from drug manufacturers based on Medicaid utilization of their drug products in Alabama. During FY 2000, over $63 million was collected. These rebates are used to offset increasing drug program expenditures.

The drug utilization review (DUR) process involves retrospective reviews conducted by the Alabama Quality Assurance Foundation under contract with the Medicaid Agency. The purpose is for identification of drug usage characteristics of Medicaid recipients in order to prevent or lessen the instances of inappropriate, excessive, or therapeutically incompatible drug use. The DUR process also enhances the quality of care received by Medicaid recipients by educating physicians and pharmacists with regard to issues concerning appropriateness of pharmaceutical care, thereby minimizing expenditures.

Medicaid continues to operate a drug utilization review (DUR) program. The retrospective element of DUR is complemented by a prospective element. Prospective DUR is an on-line, real-time process allowing pharmacists the ability to intervene before a prescription is dispensed, preventing therapeutic duplication, over and underutilization, low or high doses and drug interactions. Medicaid has implemented a prospective DUR system that screens prescriptions for early/late refills, therapeutic duplication, drug interactions, high dose, and product selection (preferred drug status).

The Agency has also implemented a voluntary educational program called the Preferred Drug Program. The program provides educational information to physicians and pharmacists regarding drugs considered superior in their class. This program fosters the most appropriate therapy for Medicaid patients in an efficient and effective manner.

FY 1998-2000
PHARMACEUTICAL PROGRAM
Use and Cost

Year	Number Of Drug Recipients	Recipients As a % Of Eligibles	Number Of Rx	Rx Per Recipient	Price Per Rx	Cost Per Recipient	Total Cost To Medicaid*
1998	397,041	62%	7,932,759	19.98	$29.85	$596	$236,819,290
1999	405,140	61%	8,487,157	20.95	$32.24	$675	$273,603,400
2000	435,680	64%	9,094,375	20.87	$36.55	$763	$332,360,350

*** Does not reflect rebates received by Medicaid from pharmaceutical manufacturers.**

FY 1998-2000
PHARMACEUTICAL PROGRAM
Cost

	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx	Net Cost Per Recipient
1998	$236,819,290	$36,677,093	$200,142,197	$25.23	$504
1999	$273,603,400	$49,522,291	$224,081,109	$26.40	$553
2000	$332,360,350	$63,927,136	$268,433,214	$29.52	$616

Eye Care Services

Medicaid's eye care program provides beneficiaries with continued high quality professional eye care. For children, good eyesight is essential to learning and development. For adults, good vision is critical to self-sufficiency and the maintenance of a high quality of life. Through the optometric program, Medicaid eligibles receive a level of eye care comparable to that of the general public.

The eye care program provides services through ophthalmologists, optometrists and opticians. Adults (21 years of age and older) are eligible for one complete eye examination and one pair of eyeglasses every two calendar years. Recipients under 21 years of age are eligible for an eye examination and one pair of eyeglasses every calendar year or whenever medically necessary. Hard or soft contact lenses are available when prior authorized by the Medicaid Agency for apkakic (post-cataract surgery) patients and for other limited justifications. Post-cataract patients may be referred by their surgeons to optometrists for follow-up management.

In keeping with the Agency's policy of cost containment, eyeglasses are chosen through competitive bidding. The contractor is required to furnish eyeglasses that meet federal, state and Agency standards. The selection of frames includes styles for men, women, teens, and preteens. Eyeglasses furnished locally are reimbursed at contract rates.

Laboratory and Radiology Services

Laboratory and radiology services are essential parts of the Medicaid health care delivery system. Many diagnostic procedures and methods of treatment would be impossible without the availability of these valuable services. Since lab and x-ray services are ancillary parts of other services, Medicaid will not pay for lab and x-ray services if the other services performed are not covered. There are over 116 independent laboratories and over 10 free standing radiology facilities that are enrolled with Alabama Medicaid. Each independent laboratory and free-standing facility must be approved by the appropriate licensing agency within the state in which it resides, be certified as a Medicare provider and sign a contract with the Medicaid Agency in order to be eligible to receive reimbursement from Medicaid. Laboratory and radiology are unlimited services and if medically necessary can be covered even if other benefit limits have been exhausted.

Renal Dialysis Services

The Medicaid renal dialysis program was implemented in 1973. Since that time, enrollment of renal dialysis providers in the Medicaid program has gradually increased to its present enrollment of 64 freestanding facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis and CAPD (Continuous Ambulatory Peritoneal Dialysis) and home treatments, as well as training, counseling, drugs, biologicals, and related tests. Patients are allowed 156 treatment sessions per year, which provides for three sessions per week.

Recipients who travel out of state may receive treatment in that state. The dialysis facility must be enrolled with Medicaid for the appropriate period of time. Although the Medicaid renal dialysis program is small, it is a life-saving service without which many recipients could not survive, physically or financially.

Long Term Care

Care for acutely ill, indigent residents in nursing facilities was mandated in 1965 with the enactment of Medicaid (Title XIX). On October 1, 1990, OBRA '87 was implemented and provided for improvements in health care for residents in nursing facilities. The law included more rights and choices for residents in controlling their lives

and surroundings, and more opportunities for restorative care to help residents reach their full physical potential. As of July 1, 1995, the last major phase of nursing home reform was implemented. On that day, new enforcement regulations took effect to assure high quality care in nursing facilities. Nursing home reform has included a resident "bill of rights" and requirements for individual resident assessments and plans of care, as well as nurse aide training and competency requirements and the establishment of a nurse aide registry.

With the new enforcement regulations, there is wider range of sanctions tailored to different quality problems. Adopting "substantial compliance" as the acceptable standard, the new rules are meant to ensure reasonable regulation while at the same time requiring nursing facilities to correct problems quickly and on a long-term basis. An important goal of the new enforcement plan is to ensure that continuous internal quality control and improvement are performed by the nursing facilities themselves.

The regulations provide for the imposition of civil money penalties and other alternative remedies such as denial of payment for new admissions, state monitoring, temporary management, directed plans of correction, and directed in-service training. Almost all facilities will be given the opportunity to correct the deficiencies and avoid remedies. Only chronically poor performers and facilities with deficiencies that present direct jeopardy to residents will be assessed with an immediate remedy, which may involve termination or civil money penalties.

The total cost to Medicaid for providing long term care in FY 2000 was over $624 million. Almost 96 percent of the nursing homes in the state accepted Medicaid recipients as patients in FY 2000. There were also 20 hospitals in the state during FY 2000 that had long term care beds, called swing beds, participating in Medicaid.

In the past all Medicaid patients residing in a nursing facility have had to apply their available income to the basic nursing facility per diem rate; however, effective April 1, 1994, Qualified Medicare Beneficiaries (QMBs) residing in a nursing facility no longer have to apply any of their income toward the cost of the Medicare coinsurance for nursing home care. The coinsurance is paid entirely by Medicaid for this group. Also, effective April 1, 1994, medically necessary over-the-counter (non-legend) drug products ordered by a physician are covered.

LONG TERM CARE QUALITY ASSURANCE PROGRAM

The Long Term Care Quality Assurance Program is designed to organize and provide direction for quality assurance activities for the purpose of monitoring and improving the quality and appropriateness of care to Medicaid recipients. The Long Term Care Quality Assurance Program provides oversight and monitoring for three Home and Community Based Waivers: the Elderly and Disabled Waiver, the Homebound Waiver and the Mentally Retarded and Developmentally Disabled Waiver.

Quality assurance is the process of monitoring and evaluating delivery of care and services to ensure that they are appropriate, timely, accessible, available and medically necessary. Oversight and monitoring refers to the appropriate implementation of services and evaluating of client satisfaction and optimal outcomes. The key components associated with oversight and monitoring include: 1) Access to care, 2) Community care, 3) Continuity of care, 4) Freedom of choice, 5) Health and welfare, 5) Optimal outcomes 7) Quality improvements, and 8) Client satisfaction. All of these assurances are monitored through annual on-site reviews, recipient satisfaction surveys, provider profiling, complaint and grievance tracking, and review of the administering agency internal quality assurance program. The program also approves any corrective actions for deficiencies that may be cited.

Long Term Care for the Mentally Retarded and Mentally Disabled

The Alabama Medicaid Agency, in coordination with the Department of Mental Health and Mental Retardation, includes coverage for Medicaid-eligible mentally retarded and mentally diseased persons who require care in intermediate care facilities (ICF). Eligibility for these programs is determined by categorical, medical and/or social requirements specified in federal law. The programs provide treatment that includes training and habilitative services intended to aid the intellectual, sensorimotor, and emotional development of residents.

Facilities in which intermediate care for the mentally retarded are provided include the Albert P. Brewer Developmental Center in Mobile, the J. S. Tarwater Developmental Center in Wetumpka, the Lurleen B. Wallace Developmental Center in Decatur, and the W.D. Partlow Developmental Center in Tuscaloosa.

In recent years there has been a statewide reduction of beds in intermediate care facilities for the mentally retarded. This reduction is a cooperative effort by the Department of Mental Health and Mental Retardation and the Medicaid Agency to deinstitutionalize as many clients as possible and serve clients in the least restrictive setting. In 1997, the Glenn Ireland II Developmental Center was closed, with the majority of its residents being transferred to community group homes.

In addition to contributing the federal share of money for care in large residential facilities, Medicaid also covers intermediate care of mentally retarded residents in three small facilities of 15 or fewer beds. Those facilities include Arc of the Shoals in Tuscumbia, Volunteers of America #20 in Huntsville, and Volunteers of America #40 in Hartselle. Institutional care for the mentally diseased (IMD) is provided through Alice Kidd Nursing Facility in Tuscaloosa, Claudette Box Nursing Facility in Mobile, and S. D. Allen Nursing Facility in Northport.

In terms of total Medicaid dollars expended and the average monthly payment per patient, the ICF-MR and IMD program is extremely costly. However, the provision of this care through the Medicaid program is saving the taxpayers of Alabama millions of state dollars. These patients are receiving services in state-operated mental health institutions. If the Medicaid program did not cover the services provided to these patients, the Alabama Department of Mental Health and Mental Retardation would be responsible for the total funding of this care through its state appropriation. In FY 2000, in cooperation with the Medicaid Agency, Mental Health was able to match every $30 in state funds with $70 of federal funds for the care of Medicaid-eligible ICF-MR and IMD patients.