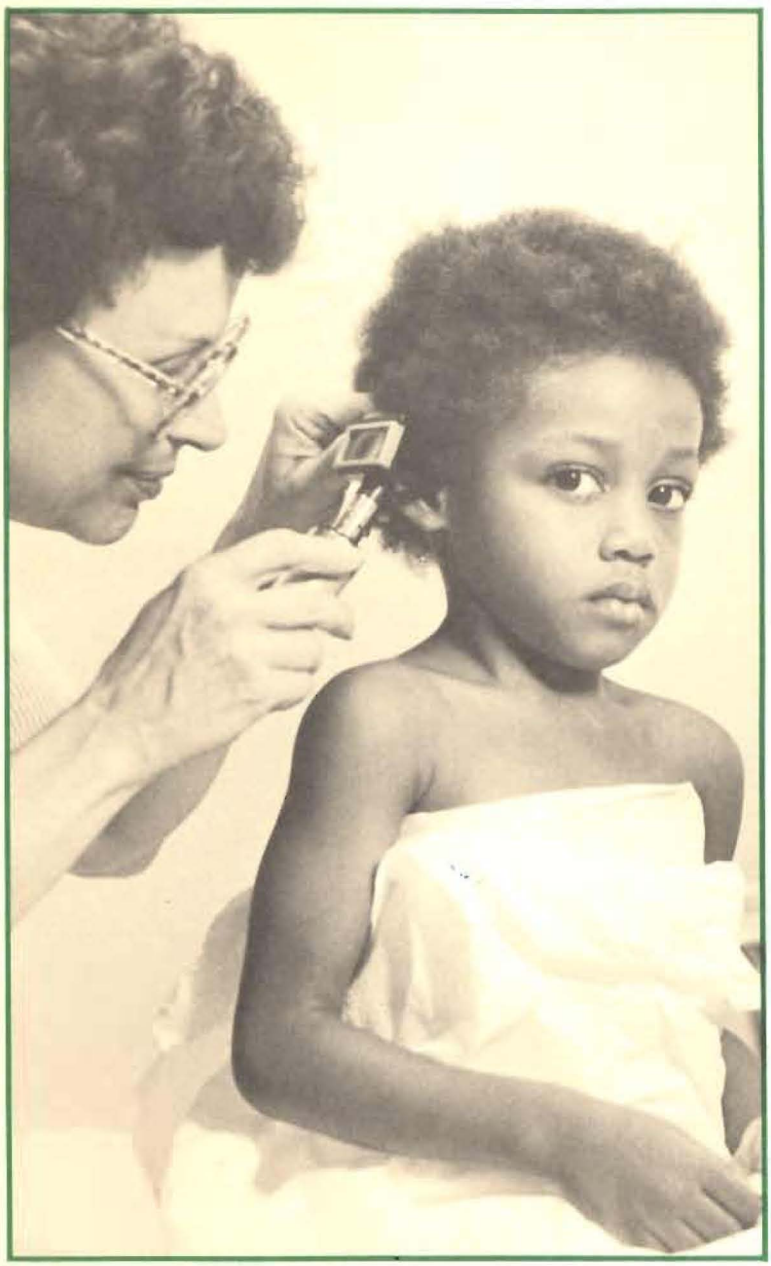
Alabama Medicaid Agency



Eleventh Annual Report

October 1, 1982 - September 30, 1983

George C. Wallace, Governor
State of Alabama

Faye S. Baggiano, Commissioner
Alabama Medicaid Agency

Henry Vaughn, Deputy Commissioner

Harriette Worthington, Deputy Commissioner

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

GEORGE C. WALLACE
Governor

April 10, 1984

FAYE S. BAGGIANO
Commissioner

The Honorable George C. Wallace
Governor of Alabama
State Capitol
Montgomery, Alabama 36130

Dear Governor Wallace:

I am pleased to submit the Eleventh Annual Report of the Alabama Medicaid Agency for the fiscal year which ended September 30, 1983. This report contains a broad range of information which presents an accurate description of the condition and direction of the Alabama Medicaid Program.

Through this program, almost 400,000 needy Alabamians were eligible for medical care which otherwise might have been denied to them. On their behalf, we who administer the program would like to thank you, members of the State Legislature, and the taxpayers of Alabama for continuing to make this care available.

Respectfully submitted,

Faye S. Baggiano

Faye S. Baggiano
Commissioner

FSB:jwh

ALABAMA MEDICAID

FISCAL YEAR 1983

Mike Gibson
Editor

Jim Wright
Statistician

ALABAMA MEDICAID AGENCY

MONTGOMERY, ALABAMA

Faye S. Baggiano, Commissioner

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HIGHLIGHTS OF 1982-83

In October, 1982, the Alabama Medicaid Agency created the **Admissions/Utilization Review Unit** under the Long Term Care Division. AUR determines the medical need of Medicaid nursing home care applicants. The determination of medical need was previously performed by a non-profit organization under contract with the Alabama Medicaid Agency. Since its creation, AUR has proved to be both efficient and cost effective.

Also in October, **Alacaid**, a subsidiary of E.D.S. Federal, began a new contract as fiscal agent of the Medicaid program. Alacaid's low-bid contract was awarded for two years with an Alabama Medicaid Agency option for the third year at the same terms. In February, **Alacaid**, was awarded a one-year contract to review hospital utilization of Medicaid recipients.

In January, 1983, Acting Commissioner **Faye S. Baggiano** was appointed by Governor George C. Wallace as Commissioner of the Alabama Medicaid Agency. Mrs. Baggiano has been Acting Commissioner of the Agency since February, 1982. From November, 1981 through January, 1983, she was also Commissioner of the State Department of Pensions and Security. Also in January, Governor Wallace named **Brenda Emfinger** as Confidential Assistant to the Commissioner of the Medicaid Agency.

It was announced early in 1983 that Medicaid **recipient fraud and abuse convictions** had doubled in the 1982 calendar year over the 1981 calendar year. Health care cost controls, including fraud and abuse detection and the recoupment of erroneous payments and overpayments, resulted in $2 million in savings to the Medicaid program. **The Third Party Unit** continued to be one of the more effective progams of its type in the nation. Collections and cost avoidance efforts of the unit resulted in savings to Medicaid of more than $11 million over the fiscal year.

In March, it became official agency policy to pay **Medicaid providers** once a month rather than twice a month. Because of the General Fund cash flow problems, providers had been paid only once a month for some time.

Also in March, the U.S. Department of Health and Human Services approved a **waiver agreement** between the Alabama Medicaid Agency and the Alabama Department of Mental Health. The agreement allowed the use of Medicaid funds for home and community-based treatment of Medicaid eligible mentally retarded persons at risk of institutionalization. This agreement has proven to be beneficial to both agencies as well as the Medicaid eligibles served by the agencies.

In May, the federal Health Care Financing Administration voided approximately **$2.6 million in proposed sanctions** against the Alabama Medicaid Agency because of significant improvements in the agency's eligibility error rate. The sanctions were originally imposed because of nursing home error rates of about nine percent during two quality control reporting periods in 1979 and 1980. By early 1983, the agency had **reduced its case error rate** to 1.6 percent, the lowest rate in the Southeast and the sixth lowest among all states. The low error rate was accomplished by increasing staff training and improving error detection procedures in the Quality Control Unit.

Major **program changes** became effective in early July. **Inpatient hospital days** allowed Medicaid eligibles were reduced from 15 with a possible five extra days to a maximum of 12 per year. **Physician office visits** were limited to 12 per year, and drug prescriptions and refills were limited to six per month. The drug limitation was dropped in January, 1984. On October 1, 1983, **emergency room visits** by Medicaid eligibles were limited to three per year. This limitation did not apply to bona fide emergencies or radiology, chemotherapy, or dialysis treatments.

A major administrative improvement was effected with the implementation of the **AMAES** (Alabama Medicaid Agency Eligibility System) computer system in July. The development of AMAES required thousands of additional man hours of work, but the system helped streamline computer operations and made the agency's eligibility records compatible with those of the State Department of Pensions and Security.

In August, the Alabama Legislature appropriated **$95.8 million** from the State General Fund for the Medicaid program for the 1983-84 fiscal year. Alabama's federal match was increased effective October 1 from 71 percent to 72 percent, giving the program a total budget of **$408 million.** Despite this record figure, the 1983-84 budget is not sufficient to provide for increases in provider payments until mid-year.

In a major **administrative reorganization** effective October 1, 1983, a second deputy commissioner position was created in the agency. **Harriette Worthington** is now Deputy Commissioner in charge of programs. **Henry Vaughn** is Deputy Commissioner in charge of administration.

Effective September 1, the Medicaid Agency **restricted the enrollment of new providers** into the program. This restriction, which included all providers except physicians, dentists, and optometrists, was imposed to conserve the program's financial resources. It also became the policy of the agency during the fiscal year to call for a **moratorium** on construction of new nursing home beds in the state, and to promote programs, such as home and community-based services, that are more cost-effective than institutionalization.

ALABAMA'S MEDICAID PROGRAM

A State 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, and limitations on services.

History — Medicaid was created in 1965 by the federal government along with a sound-alike sister program, Medicare. Medicaid was designed to provide health care to low income individuals. Medicare is primarily for elderly persons, regardless of income. Medicaid started in Alabama in 1970 as a State Department of Health program. In 1977, the Medical Services Administration was made an independent state agency. In 1981, the agency was renamed the Alabama Medicaid Agency.

Funding Formula — The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because Alabama is a relatively poor state, its federal match is one of the largest. Effective October 1, 1983, the formula became 72/28. For every $28 the state spends, the federal government contributes $72.

Eligibility — Persons must fit into one of three categories in order to qualify for Medicaid in Alabama, and eligibility is determined by one of three different agencies. Eligibles include:

— Persons receiving Supplemental Security Income from the Social Security Administration.

— Persons approved for cash assistance through the State Department of Pensions and Security. Most people in this category receive Aid to Dependent Children or State Supplementation.

— Persons approved for nursing home care by the Alabama Medicaid Agency. Eligibility is determined at one of nine Medicaid District Offices around the state. Nursing home patients approved for Medicaid payments must meet medical as well as financial criteria.

How the Program Works — A family or individual who is eligible for Medicaid is issued an eligibility card, or "Medicaid card," each month. This is essentially good for medical services at one of 8,000 providers in the state. Providers include physicians, pharmacists, hospitals, nursing homes, dentists, optometrists, and others. These providers bill the Medicaid program for their services.

Covered Services — Medical services covered by Alabama's Medicaid program are fewer and less comprehensive than most states'. Alabama's program is essentially a "no frills" program aimed at providing basic, necessary health care to the greatest numbers of people.

Expenditures — For the 1984 fiscal year, the Medicaid budget is approximately $408 million. Over $60 million of this budget will be spent for Mental Health programs.

MEDICAID'S IMPACT

The benefits of the Medicaid program to low-income citizens in Alabama need little elaboration. The general health of Medicaid recipients has improved measurably because of their greater access to quality health care. An example: The Alabama Medicaid program started in 1970. According to State Department of Public Health figures, the infant mortality rate in Alabama dropped from 24.1 per 1000 in 1970 to 14.3 per 1000 in 1979, an improvement of 41 percent. New technology and improved medical techniques were factors in this dramatic improvement, but low-income Alabamians would not have had access to these advances without Medicaid. It is an indisputable fact that Medicaid has been responsible for the good health of hundreds of thousands of state citizens.

The benefits of Medicaid to Alabama citizens who are not eligible for the program are often overlooked. In 1983 $354.5 million was spent on Medicaid in the state. The state provided $102.5 million, and the federal share was $252.0 million. This money was paid not to Medicaid recipients, but directly to some 7,000 Medicaid providers. These providers include physicians, dentists, pharmacists, hospitals, nursing homes, and medical equipment suppliers. The fast-growing health care industry, a cornerstone of many local economies, employs thousands of workers who buy goods and services from thousands more. Using the common multiplier effect of three, the Medicaid program generated more than a billion dollars worth of business in the state in 1983. Health care has proven to be one of the state's most recession-proof industries and Medicaid is vital to that industry.

Medicaid funds provide approximately 75 percent of the state's nursing home revenue and about ten percent of hospital revenue. The more than $40 million a year that Medicaid pays to physicians encourages many physicians to provide services to a segment of the population that might otherwise be excluded from the health care system. Medicaid can also encourage physicians and other health care providers to practice in areas of the state that would be economically marginal if the providers had to rely solely on the ability of their patients to pay.

Alabama Medicaid is essentially a "no frills" program, offering a minimal number of optional services at a relatively low per patient cost. Because the administrative cost of Alabama's program is consistently among the lowest in the nation—three percent—most of the funds go directly to patient care. U.S. Department of Health and Human Services reports indicate that Alabama's Medicaid program is among the most efficiently operated programs in the nation.

Because of the 71 percent funding match for Alabama Medicaid, a loss of $1 million in state funds would have resulted in the loss to the program of an additional $2.4 million. A decrease in Medicaid expenditures would diminish the quality of health care available to low-income citizens, and it would also have an adverse impact on the state's economy.

FY '83 PLATE 1

COUNTY IMPACT

Year's cost per eligible

County	Benefit Payments	Eligibles	Dollars per Eligible
Autauga	$2,182,834	2,878	$758
Baldwin	4,389,556	4,804	914
Barbour	3,416,281	4,016	851
Bibb	1,621,778	1,486	1,091
Blount	2,201,696	2,337	942
Bullock	1,512,263	2,513	602
Butler	2,967,600	3,661	811
Calhoun	8,472,442	9,809	864
Chambers	3,850,853	4,654	827
Cherokee	1,294,748	1,424	909
Chilton	2,104,460	2,566	820
Choctaw	1,846,214	2,860	646
Clarke	3,072,664	4,547	676
Clay	1,462,835	1,256	1,165
Cleburne	866,365	1,025	845
Coffee	2,934,868	3,164	928
Colbert	3,653,264	3,678	993
Conecuh	1,479,061	2,247	658
Coosa	719,729	1,060	679
Covington	3,851,431	3,637	1,059
Crenshaw	2,220,374	2,103	1,056
Cullman	5,126,855	4,308	1,190
Dale	3,174,041	3,025	1,049
Dallas	6,670,252	10,939	610
DeKalb	4,908,352	4,693	1,046
Elmore	7,930,723	3,640	2,179
Escambia	3,012,987	3,708	813
Etowah	8,628,203	8,174	1,056
Fayette	1,505,877	1,724	873
Franklin	3,524,528	3,118	1,130
Geneva	2,087,812	2,719	768
Greene	1,312,142	3,098	424
Hale	2,242,073	3,411	657
Henry	1,456,660	1,908	763
Houston	4,859,913	6,537	743
Jackson	3,264,969	4,097	797
Jefferson	48,200,892	58,808	820
Lamar	1,904,887	1,634	1,166
Lauderdale	4,883,192	5,130	952
Lawrence	2,685,505	2,937	914
Lee	3,306,122	5,360	617
Limestone	3,041,703	3,647	834
Lowndes	1,523,079	3,355	454
Macon	4,121,498	5,194	794
Madison	8,789,865	12,992	677
Marengo	2,922,389	4,351	672
Marion	2,940,709	2,463	1,194
Marshall	6,022,939	5,526	1,090
Mobile	34,014,982	39,377	864
Monroe	1,955,811	2,956	662
Montgomery	17,623,357	20,539	858
Morgan	18,198,487	7,414	2,455
Perry	2,235,443	3,503	638
Pickens	3,290,396	4,323	761
Pike	3,235,695	4,267	758
Randolph	2,538,082	2,291	1,108
Russell	3,894,352	4,917	792
Shelby	3,152,178	2,852	1,105
St. Clair	2,786,349	2,961	941
Sumter	2,585,093	3,739	691
Talladega	7,150,280	10,070	710
Tallapoosa	5,395,059	3,804	1,418
Tuscaloosa	40,658,154	14,326	2,838
Walker	7,266,719	5,909	1,230
Washington	1,817,985	2,417	752
Wilcox	2,214,632	4,373	506
Winston	2,541,190	1,681	1,512

MEDICAID MANAGEMENT INFORMATION SYSTEM

Alabama has operated a certified Medicaid Management Information System (MMIS) since April, 1978. This system allows Alabama to receive 75 percent federal financial participation for all data processing costs related to MMIS.

The MMIS system includes six subsystems; they are outlined below:

Recipient Subsystem

* Maintains identification of all applicants eligible for Medicaid benefits
* Provides timely updating of the eligibility file to include new eligibles and all changes to existing records for eligibles
* Maintains control over all data pertaining to the recipient's eligibility.
* Maintains control over the Medicare Part B buy-in processing for eligibles
* Maintains identification of third party resources for eligibles

Provider Subsystem

* Maintains identification of all Medicaid providers.
* Provides timely processing of provider applications, and maintains control over all data pertaining to provider enrollment
* Maintains a file of provider data to be used for invoice processing, administrative reporting, and surveillance and utilization review.
* Reviews providers on a continuing basis to ensure that they continue to meet eligibility requirements

Claims Processing

* Ensures that all input is captured early and accurately.
* Controls all transactions during their entire processing cycle
* Verifies that providers submitting claims are properly enrolled
* Ensures that recipients for whom claims are submitted were eligible for the service they received.
* Ensures that claims entered into the system are processed completely
* Verifies that charges submitted by providers are reasonable and within acceptable limits
* Ensures that reimbursements to providers are rendered promptly and correctly
* Maintains accurate and complete audit trails.
* Processes approved prior authorization requests
* Processes provider credits and adjustments

FY '80-'83 PLATE 2

MEDICAID SOFTWARE ACTIVITY

	FY '80	FY '81	FY '82	FY '83
# of programs in production at year end	443	714	952	1,205
# of requests received for new programs and for changes to existing programs	808	780	851	886
# of maintenance requests completed	605	522	458	504
# of new programs written	227	271	238	253
# of requests completed	832	793	696	757

Reference File

* Maintains complete and accurate statewide pricing information based on procedure and diagnosis
* Provides information on claims in suspense

Management and Administrative Reporting

* Provides information to assist management in fiscal planning and control
* Provides information required in the review and development of policy
* Monitors the progress of claims processing and provides summary reports on the status of payments
* Reviews provider performance for adequacy and extent of participation and service delivery
* Reports recipient participation in order to analyze usage and develop more effective programs
* Provides information required for federal reports.

Surveillance and Utilization Review

* Develops, a statistical profile of health care delivery and utilization patterns established by providers and recipients.
* Reveals for review potential misutilization to promote correction of actual misutilization of the program.
* Provides information which will reveal and facilitate investigation of potential defects in the level of care or quality of service provided.
* Provides information to assist management in the development and/or revision of policy.

The MMIS software is owned by the state and is made available to contractors wishing to bid on the

Medicaid fiscal agent contract. The successful bidder for a two-year contract which began October 1, 1982, was Alacaid. Alacaid runs 400 state-owned programs in support in the MMIS, economically adjudicating claims faster than any other Medicaid claims processor in the nation. During FY'83, Alacaid processed 6,066,389 claims with an average claims processing time of 3.4 days.

In addition to the 400 programs operated by the fiscal agent, the Alabama Medicaid Agency owns and executes more than 1,000 programs developed and operated by Medicaid data processing personnel in support of the MMIS and the Medicaid Agency. MMIS is a dynamic system requiring constant development and modification to effectively serve recipients and providers and to keep abreast of constantly changing regulations and computer and medical technology. Efforts to maintain a state of the art MMIS are shown in Plate 4. The major project for FY'83 was implementation of an innovative eligibility system which allows for more timely and accurate updates and inquiries.

To receive enhanced federal funding (75% vs. 50%) a state's MMIS must pass a comprehensive System Performance Review (SPR) annually. Alabama's MMIS has passed this review each year with superior scores. For 1983 the Alabama MMIS received an SPR of 771 which included 23 bonus points compared to the minimum required score of 644.

PROGRAM INTEGRITY

The Program Integrity Division has been playing an increasingly effective role in the operation of the Medicaid program. The purpose of the division is to minimize fraud, abuse, and overpayments. The success of the division's efforts were underscored during FY'83 by increases in criminal convictions and administrative sanctions.

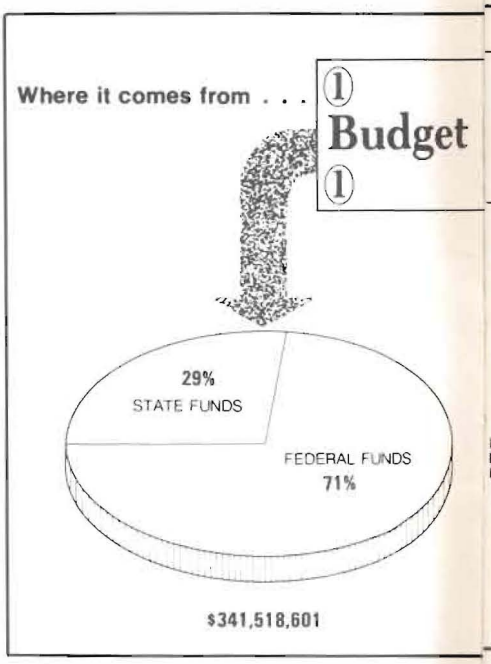
The primary units of the division are Quality Control, Systems Audit, and Surveillance and Utilization Review (SUR). The Quality Control Unit monitors the agency's eligibility operation by systematically sampling eligibility cases. The Systems Audit Unit audits payments to providers to ensure that the payments are correct. SUR uncovers and investigates possible cases of fraud or abuse. While the SUR function for Medicaid recipients is performed by Medicaid agency's employees, provider SUR is done under contract by Alacaid, a private firm. Although fraud and abuse within the program is discovered by several methods, the most common one is the use of computer programs that reveal irregularities in Medicaid utilization.

The total amount of diverted funds for FY'83 — or Medicaid funds that would have been erroneously paid to providers if irregularities had not been discovered by Program Integrity — was $1.7 million.

During the year, complete program integrity reviews were conducted on 350 providers and 404 recipients because of possibilities of fraud or abuse. Twenty-nine suspected provider fraud cases were referred to the attorney general's Medicaid Fraud Control Unit for prosecution. Thirty-three cases of suspected recipient fraud were turned over to local district attorneys for prosecution.

Among the administrative sanctions used to control abuse of the Medicaid program is the lock-in program. During the year, approximately 70 recipients were locked into specific providers. The majority of these recipients were suspected of overutilizing prescription drugs.

REVENUE, EXPENDITURES AND PRICES



SOURCES OF MEDICAID REVENUE	PLATE 4
Federal Funds	$251,948,559
State Funds	102,506,700
Total Revenue	$354,455,259

FY '83
COMPONENTS OF FEDERAL FUNDS

PLATE 5

(Net)	Dollars
Family planning admin.	325,567
Professional staff costs	6,774,996
Other staff costs	1,707,874
Other provider services	239,992,287
Family planning services	3,147,835
TOTAL	$251,948,559

FY '83
COMPONENTS OF STATE FUNDS

PLATE 6

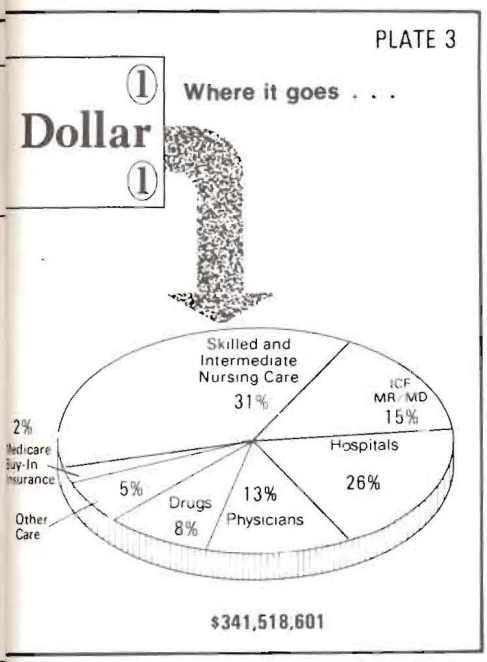
	Dollars
Encumbered balance forward	$7,099,445
Basic Appropriations	76,560,800
Supplemental appropriations	17,484,478
P & S/Mental Health	14,898,162
Interest Income from Fiscal Intermediary	268,620
Miscellaneous Receipts	440,117
	116,751,622
Encumbered	14,244,922
TOTAL	102,506,700

BENEFIT COST BY FISCAL YEAR IN WHICH OBLIGATION WS INCURRED

PLATE 7

	FY'81	FY'82	FY'83	FY'84 (Est)
Nursing Homes	113,107,128	118,477,708	113,558,224	120,000,000
Hospitals	92,938,277	99,601,395	99,275,870	93,800,000
Physicians, Lab & X-Ray	35,365,422	43,503,233	51,305,983	50,000,000
Medicare Buy-In	13,514,393	14,989,169	15,694,900	17,900,000
Drugs	24,232,813	26,756,889	31,609,390	31,200,000
Health Services	8,455,473	10,334,462	12,280,028	14,000,000
Family Planning	2,859,421	3,680,744	4,117,790	3,600,000
Total Medicaid Service	290,472,927	317,343,600	327,842,185	330,500,000
% Increase	7.97	9.25	3.31	.81
Mental Health	18,498,851	36,324,018	58,218,531	63,000,000
Total Benefits	308,971,778	353,667,618	386,060,716	393,500,000

PLATE 3



In FY'83 Medicaid paid $341,518,601 for health care services to Alabama citizens. Another $12,936,658 was expended to administer the program. This means that about 3 cents of every Medicaid dollar did not directly benefit recipients of Medicaid services. Among ALL states, Alabama consistently has one of the lowest rates of expenditures for administrative costs.

FY '83 PLATE 8

EXPENDITURES

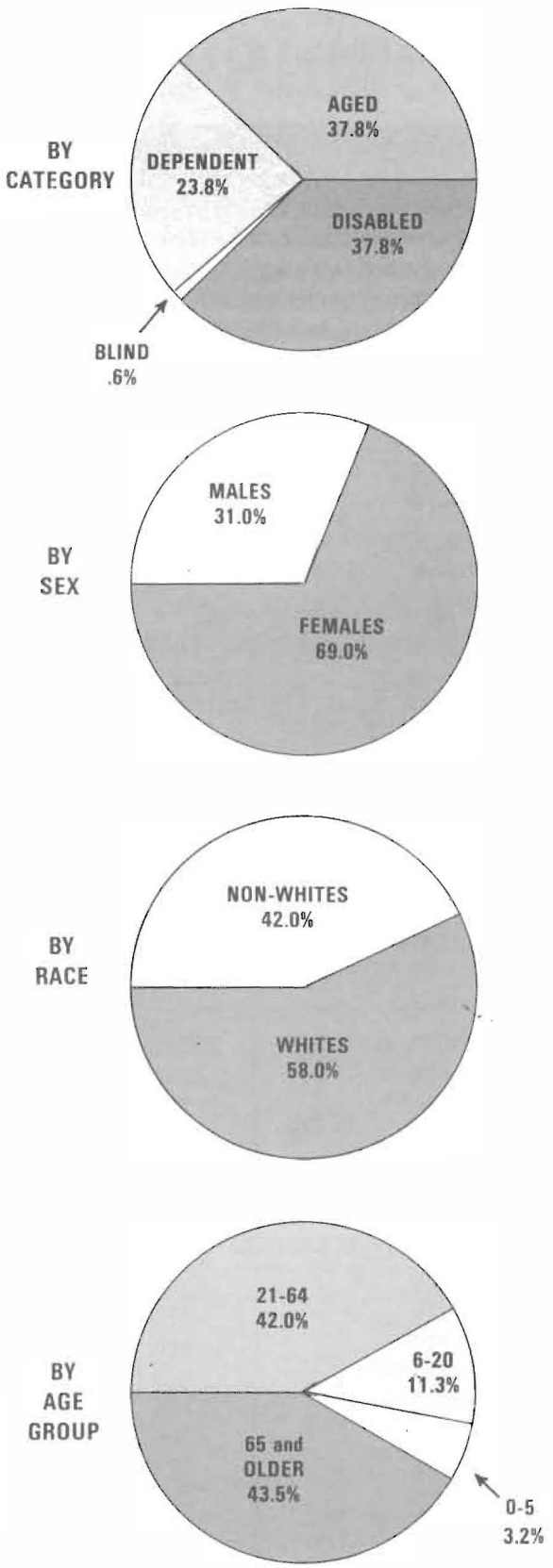
By type of service (net)

Service	Payments	Percent Of Payments by Service FY '83		Percent Of Payments By Service FY '82		Percent Of Payments By Service FY '81	
Intermediate Nursing Care	$98,731,658	28.92%	31.34%	29.67%	33.06%	29.53%	36.76%
Skilled Nursing Care	8,275,651	2.42%		3.39%		7.23%	
Hospital Inpatients	80,028,514	23.44%	25.82%	26.01%	28.39%	26.52%	29.92%
Hospital Outpatients	8,144,617	2.38%		2.38%		3.40%	
ICF-Mentally Retarded & MO	51,162,896	14.98%		9.80%		6.02%	
Physicians' Services	43,603,093	12.77%		10.92%		10.00%	
Drugs	27,235,859	7.97%		7.70%		7.87%	
Medicare Buy-In Insurance	6,631,943	1.94%		4.58%		4.40%	
Dental Services	4,869,808	1.43%		1.44%		1.25%	
Family Planning Care	3,498,119	1.02%		1.12%		.93%	
Home Health	2,527,559	.74%		.62%		.48%	
Waivered Services	2,436,259	.71%		N/A		N/A	
Eye Care	1,904,208	.56%		.56%		.58%	
Lab & X-Ray	1,268,590	.37%		1.47%		1.36%	
Screening	789,783	.23%		.23%		.30%	
Transportation	276,706	.08%		.08%		.07%	
Hearing Care	91,239	.03%		.02%		.02%	
Other Care	42,099	.01%		.01%		.04%	
Total For Medical Care	$341,518,601	100.0%		100.0%		100.0%	
Administrative Costs	12,936,658						
Net Payments	$354,455,259						

FY '83 PLATE 9

PAYMENTS

By category, sex, race, age group



REVENUE, EXPENDITURES, & PRICES

The percent distribution of payments by sex and by race has changed very little from one year to the next. However, there has been a significant change in the percentage of money spent on the disabled category and the 21-64 age group since FY'80. In FY'83 disabled recipients accounted for 37.8 percent of Medicaid payments compared to 28.2 percent in FY'80. During the same period, the percentage of payments for the 21-64 age group rose from 31.11 percent to 42.01 percent. The reason for these increases was the expansion of the ICF-MR/MD Program. The majority of the recipients in this program are in the disabled category and the 21-64 age group.

The relative amount of money Medicaid spends in each county changes little from year to year. (See Plate 10.)

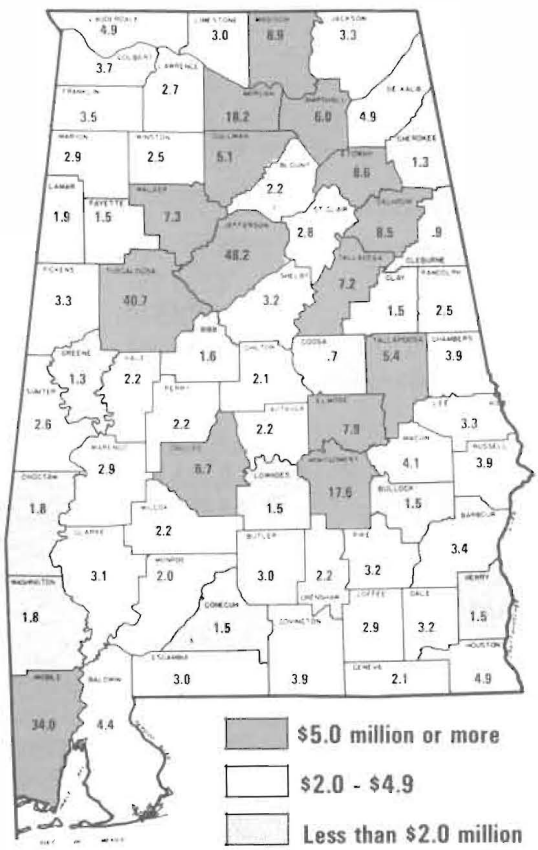
The twelve counties where the most money was spent last year were the top twelve this year. The four counties where the least was spent in FY'82 are still the least expensive this year.

Inspection of the map in Plate 10 shows that with a few exceptions, counties with or near the most populated cities have the most money paid for their recipients.

FY '83 PLATE 10

PAYMENTS

By county (in millions)



PRICES

One of the many different factors which contribute to rising medical care costs is the price of each unit of medical service. Plate 11 shows the average unit price per quarter and year of each of the six major health care services paid for by Medicaid. Also depicted are the percent changes from FY'82 to this year.

All unit prices per service climbed during FY'83. Inpatient days, prescriptions, and outpatient services showed increases of over 10 percent.

Note that during the year, the price for an ICF day was lower than the price for a SNF day. There are only two institutions which provide skilled nursing care exclusively and only 19 institutions which provide intermediate care exclusively. The other nursing homes providing services to Medicaid recipients are certified for both skilled and intermediate care. Medicaid follows a policy of paying the same price per day for skilled and intermediate care in dually certified facilities. Although the rate per day for these facilities is the same for ICF beds as well as Skilled beds, the rate is not identical from one nursing home to another. Some nursing homes cost more than others. When homes whose rates are below average have more ICF beds than Skilled beds, the statewide average for intermediate care is lower than that for skilled care.

FY '83 PLATE 11

PRICES

Unit price per service, by quarter

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	FY '83	Change From Previous Year
Nursing Home Days						
Skilled	$25.82	$26.94	$26.33	$26.83	$26.49	+8.4%
ICF*	22.94	22.93	22.38	22.35	22.64	+4.6%
Inpatient Days	226.84	237.06	241.41	237.25	236.23	+10.8%
Physicians' Procedures	16.89	18.29	18.51	17.27	17.78	+3.1%
Prescriptions	9.39	9.56	9.87	10.35	9.83	+11.6%
Outpatient Services	24.15	26.52	27.80	26.63	26.42	+13.3%

*Excludes ICF-MR/MD

POPULATION AND ELIGIBLES

Population

The population of Alabama grew from 3,444,165 in 1970 to 3,893,000 in 1980. In 1983 Alabama's population was estimated at 4,094,000.

More significant to the Medicaid program was the rapid growth of the elderly population. Census data shows that in the United States the 65 and over population grew twice as fast as the general population from 1960 to 1980. This trend was reflected in Alabama's population statistics. From 1970 to 1980 the entire state's population grew at a rate of 13 percent while the number of persons over 64 years of age increased at a rate of 35 percent. Population projections published by the Center for Business and Economic Research at the University of Alabama reveal that by 1988 there will be almost 540,000 persons 65 years of age and over in the state. Historically, cost per eligible has been higher for this group than other categories of eligibles.

FY '76 - '83 PLATE 12

POPULATION

Eligibles as percent of Alabama population by year

Year	Population	Monthly Average Eligibles	Percent
1976	3,653,000*	324,920	8.89
1977	3,690,000*	331,891	8.99
1978	3,742,000*	332,999	8.90
1979	3,769,000*	338,847	8.99
1980	3,893,888	339,417	8.72
1981	3,920,000*	336,266	8.58
1982	3,943,000*	317,386	8.05
1983	4,094,000**	311,466	7.61

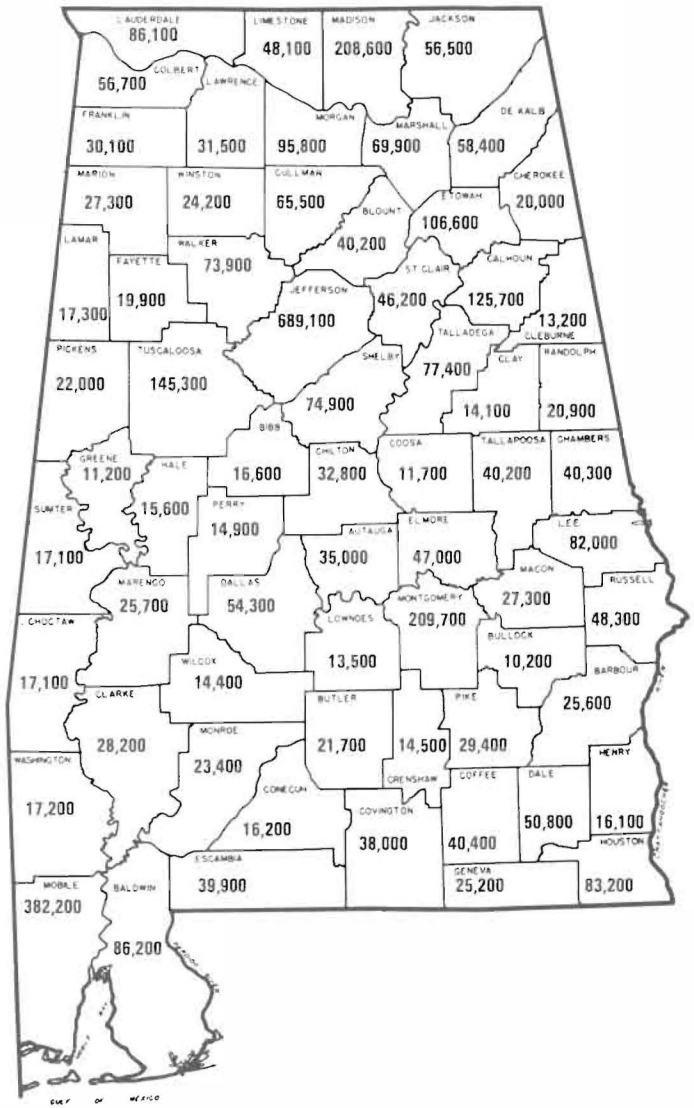
*U.S. Bureau of Census official estimate.

**Estimate by CENTER FOR BUSINESS AND ECONOMIC RESEARCH

CY '83 PLATE 13

POPULATION

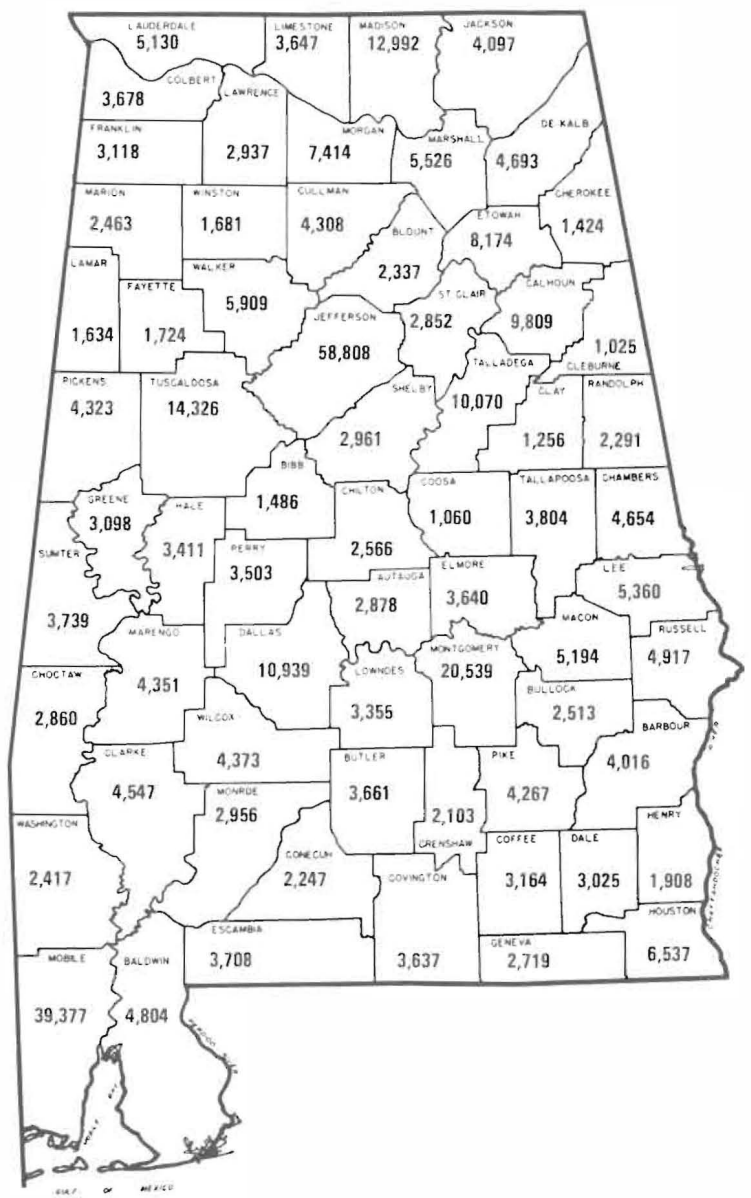
1983 Population Estimates



FY '83 PLATE 14

ELIGIBLES

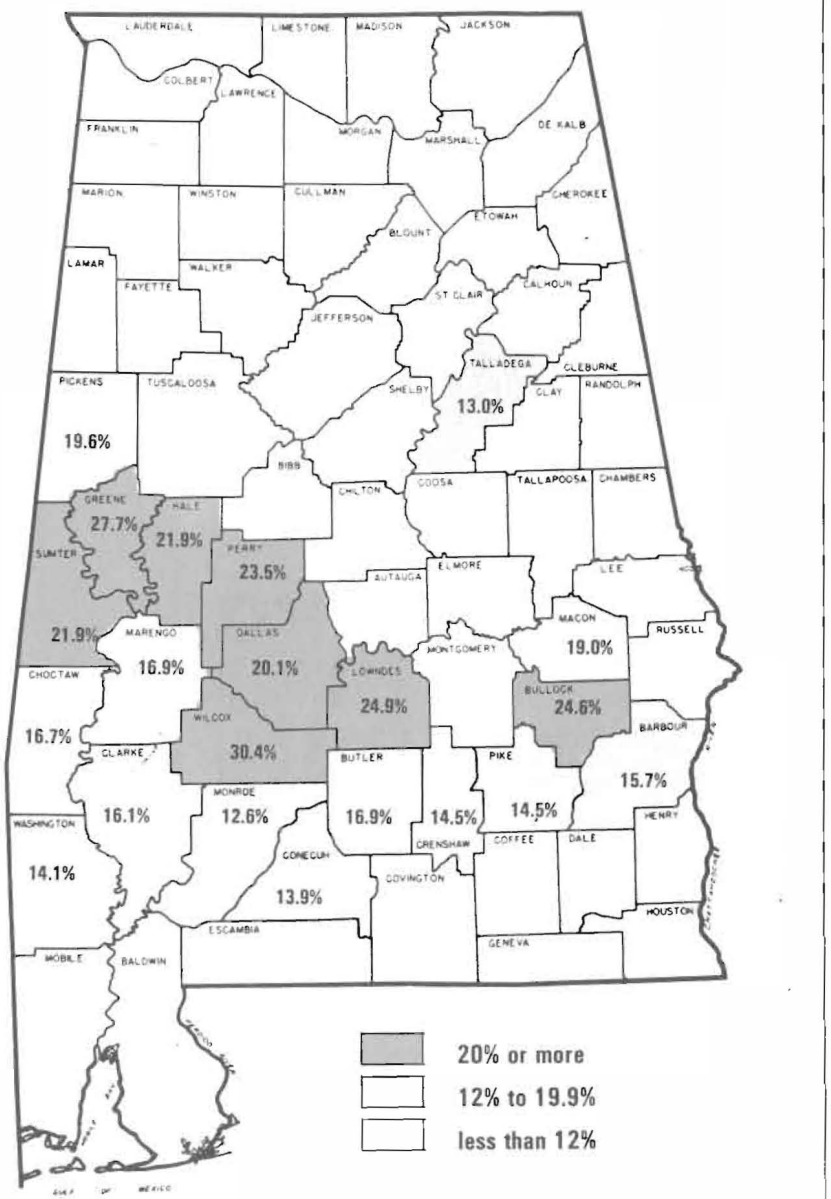
Number of Medicaid eligibles by county



FY '83 PLATE 15

ELIGIBLES

Percent of population eligible for Medicaid, by county



FY '83 PLATE 16

ELIGIBLES

Monthly Count

	Monthly Count
October '82	314,007
November	313,922
December	316,576
January '83	311,760
February	313,398
March	310,964
April	309,604
May	311,957
June	311,263
July	310,945
August	312,926
September	314,108

ELIGIBLES

For a complete picture of eligibility, one needs to make three types of counts:

Monthly counts
Total counts
Average counts

Monthly counts are the actual number of eligibles enrolled at the end of each month (Plate 16). Total counts are the total unduplicated counts of eligibles enrolled at the end of the year, i.e. 383,940 persons were eligible for at least one month during FY'83 (Plate 17).

The most useful and informative count is the average number per month for the entire year (Plate 17). This number should be used for making comparisons between eligibles in different states or different years. The monthly average for FY'83 was 311,466, a decrease of almost 6,000 from the previous year's average of 317,386.

FY '83 PLATE 17

ELIGIBLES

By category, sex, race, age
Total number for year
Average number per month

	First Month	Number Added During Year	Total Number For Year	Number Dropped During Year	Final Month	Average Number Per Month	Annual Turnover Rate
ALL CATEGORIES	314,922	69,018	383,940	79,191	304,749	311,466	23.3%
AGED	81,446	6,149	87,595	10,007	77,588	79,320	10.4%
BLIND	1,999	122	2,121	176	1,945	1,975	7.4%
DISABLED	62,335	7,540	69,875	7,190	62,685	62,471	11.9%
DEPENDENT,	169,142	55,207	224,349	61,818	162,531	167,700	33.8%
MALES	108,284	24,829	133,113	29,501	103,612	106,655	24.8%
FEMALES	206,638	44,189	250,827	49,690	201,137	204,811	22.5%
WHITES	110,942	27,469	138,411	32,906	105,505	109,508	26.4%
NONWHITES	203,980	41,549	245,529	46,285	199,244	201,958	21.6%
AGE 0-5	41,657	21,533	63,190	16,655	46,535	44,934	40.6%
AGE 6-20	88,570	21,559	110,129	29,149	80,980	85,414	28.9%
AGE 21-64	86,887	19,725	106,612	22,102	84,510	85,995	24.0%
AGE 65 & Over	97,808	6,201	104,009	11,285	92,724	95,123	9.3%

Plate 17 shows how this year's eligibles were divided in regard to category, sex, race, and age. The average and cumulative counts allow three measures to be calculated for each group:

number of new eligibles in the year,
number of old eligibles dropped in the year,
the turnover rate.

Annual Turnover Rate: There is a constant turnover among Medicaid eligibles which, in Alabama, has averaged about 23 percent per year. The annual turnover measures the rate at which "old" eligibles are replaced by "new" eligibles. Each category, sex, race, and age group has a different turnover rate, as shown in Plate 17.

Annual Changes in the Number of Eligibles: The total number of Alabama citizens eligible for Medicaid decreased by 10,965 in FY'83. Plate 19 shows how the number of eligibles has changed each year during the past five years. Since FY'81 both monthly averages and yearly totals have generally shown modest declines.

The number of aged individuals is decreasing, as shown by both monthly averages and yearly totals, even though their numbers are rising in the general population. The dependent category also showed a decrease in monthly average and yearly total counts of eligibles. The most significant factor in these declines was recent legislative reforms of federal government cash entitlement programs.

FY '83 PLATE 18
ELIGIBLES
Year's total
Distribution by category, sex, race and age

	Number	Percent
All Categories	383,940	100.0%
Aged	87,595	22.8%
Blind	2,121	0.5%
Disabled	69,875	18.2%
Dependent	224,349	58.5%
Males	133,113	34.7%
Females	250,827	65.3%
White	138,411	36.1%
Nonwhites	245,529	63.9%
Age 0-5	63,190	16.5%
Age 6-20	110,129	28.6%
Age 21-64	106,612	27.8%
Age 65 & Over	104,009	27.1%

FY '79 - '83 PLATE 19
ELIGIBLES
By category
Monthly average
Annual number

		FY '79	FY '80	FY '81	FY '82	FY '83
MONTHLY AVERAGES	AGED	98,284	96,667	88,704	83,626	79,320
	BLIND	1,998	1,962	2,006	2,019	1,975
	DISABLED	57,467	58,386	61,356	62,407	62,471
	DEPENDENT	181,098	182,402	184,200	169,334	167,700
	ALL CATEGORIES	338,847	339,417	336,266	317,386	311,466
YEARLY TOTALS	AGED	108,534	109,314	97,400	91,693	87,595
	BLIND	2,215	2,230	2,186	2,173	2,121
	DISABLED	67,260	69,264	68,666	68,917	69,875
	DEPENDENT	235,796	242,223	241,176	232,122	224,349
	ALL CATEGORIES	413,805	423,031	409,428	394,905	383,940

FY '83 PLATE 20

ELIGIBLES

By category, sex, race, and age
Total MME used by each group
Average MME used by each person

	Total MME Used In Year	Average MME Per Person
ALL ELIGIBLES	3,737,592	9.7
AGED	951,840	10.9
BLIND	23,700	11.2
DISABLED	749,652	10.7
DEPENDENT	2,012,400	9.0
MALES	1,279,860	9.6
FEMALES	2,457,732	9.8
WHITES	1,314,096	9.5
NONWHITES	2,423,496	9.9
AGE 0-5	539,208	8.5
AGE 6-20	1,024,968	9.3
AGE 21-64	1,031,940	9.7
AGE 65 & Over	1,141,476	11.0

Man-Months and Expected Duration of Eligibility: Although 383,940 people were eligible for Medicaid in FY'83, only about three-fourths were eligible all year. The others ranged from one to eleven months.

To find the total amount of time all these people were eligible in FY'83 one should add the total number of eligibles in each of the twelve months. Thus, the total number of man-months of eligibility (MME) used by the entire group all year was used to produce an average MME per person.

Plate 20 shows the total number of MME used by each category, sex, race, and age group, and gives the average number of MME used by each group.

RECIPIENTS

Of the 383,940 people deemed eligible for Medicaid in FY'83, only 81 percent actually received Medicaid benefits. These 311,348 people are called recipients. The remaining 72,592, though eligible for benefits, incurred no medical expenses paid for by Medicaid. The total figure of 311,348 is an unduplicated count, and comparison with various recipient categories and percent of eligibles will reflect some variation. This is due to the transfer of recipients from one category to another during the course of a year.

Plate 21 shows the monthly count of recipients as well as the monthly percentage of eligibles. Monthly fluctuations occur due to seasonal factors and claims processing cycles. The plate shows that in a typical month almost 46 percent of eligibles received Medicaid service.

FY '83 PLATE 21

RECIPIENTS

Monthly Counts
Percent of eligibles

	Monthly Recipients	Percent of Eligibles
October '82	75,331	24.0%
November	155,801	49.8%
December	137,860	44.3%
January '83	145,442	46.7%
February	154,063	49.4%
March	148,073	47.8%
April	147,143	47.3%
May	146,403	46.7%
June	136,392	43.7%
July	135,786	42.9%
August	170,340	54.3%
September	152,472	48.6%
Monthly Average	142,092	45.6%

FY'83 PLATE 22

RECIPIENTS

By category
Monthly counts
Year's total
MMS per category, and per recipient

	Recipients First Month	Recipients Final Month	Recipients Average Month	Total Man-Months of Medical Service	Total Recipients During Year	MMS Per Recipient
AGED	33,586	56,421	53,183	638,200	86,496	7.38
BLIND	559	1,093	1,024	12,287	1,782	6.90
DISABLED	20,472	40,718	36,994	443,925	61,951	7.17
DEPENDENT	20,724	58,251	52,780	633,358	178,148	3.56
ALL CATEGORIES (unduplicated)	75,331	152,472	141,842	1,702,106	311,348	5.47

A unit of measure called man-months of service (MMS) is used to determine the frequency with which recipients availed themselves of Medicaid services. The total number of MMS that Medicaid pays for in a month is equal to the number of recipients for that month, regardless of the dollar amount spent on each recipient. The sum of MMS for each of the twelve months gives the yearly total of Medicaid-paid MMS. The total MMS used by the 311,348 recipients in FY'83 was 1,702,106. MMS per recipient was 5.47, up by 2.6 percent over FY'82.

FY'82 - '83 PLATE 23

RECIPIENTS

By category, sex, race, age and percent of eligibles

	FY'82	FY'83	Percent of Eligibles (FY'83)
AGED	91,401	86,496	N/A
BLIND	1,903	1,782	84.0%
DISABLED	62,520	61,951	88.7%
DEPENDENT	184,252	178,148	79.4%
MALES	105,738	101,725	76.4%
FEMALES	216,030	209,623	83.6%
WHITES	124,758	118,794	85.8%
NONWHITES	197,010	192,554	78.4%
AGE 0-5	40,191	40,367	63.9%
AGE 6-20	86,047	78,981	71.7%
AGE 21-64	91,096	92,320	86.6%
AGE 65 & OVER	104,434	99,680	95.8%
ALL CATEGORIES	321,768	311,348	81.1%

USE AND COST

FY '81-'83 PLATE 24
USE
Utilization rate by category

	FY '81	FY '82	FY '83
AGED	N/A	N/A	N/A
BLIND	84.5%	87.6%	84.0%
DISABLED	89.8%	90.7%	88.7%
DEPENDENT	86.1%	79.4%	79.4%
ALL CATEGORIES	80.7%	81.5%	81.1%

FY '81-'83 PLATE 25
USE
MMS per **Recipient**
Frequency-of-service rate

	FY '81	FY '82	FY '83
AGED	6.97 MMS	7.38 MMS	7.38 MMS
BLIND	6.49 MMS	6.65 MMS	6.90 MMS
DISABLED	6.69 MMS	6.91 MMS	7.17 MMS
DEPENDENT	3.02 MMS	3.28 MMS	3.56 MMS
ALL CATEGORIES	5.21 MMS	5.33 MMS	5.47 MMS

FY '83 PLATE 26
USE
MMS per eligible

AGED	7.29 MMS
BLIND	5.79 MMS
DISABLED	6.35 MMS
DEPENDENT	2.82 MMS
ALL CATEGORIES	4.43 MMS

Use

Three measures of use are significant:
utilization rate
frequency of service rate,
ratio of actual use to potential use.

Utilization Rate: This rate is calculated by dividing the number of recipients by the number of eligibles. The result is the percent of the eligibles who received medical care during the year. This year the rate was approximately four persons out of five, or exactly 81.1 percent. (See Plate 24.)

Frequency-of-Service Rate: Adding the number of recipients from each of the months in the fiscal year gives the number of man-months of Medicaid service. Then, dividing the total MMS by the year's unduplicated count of recipients gives the frequency-of-service rate. (See Plate 25.)

MMS figures measure the number of months in which service was used rather than the number of services used. This year's rate of 5.47 indicates that the average recipient received medical care during 5.47 months.

Ratio of Actual Use to Potential Use: This measure is the ratio of total man months of medical service to total man months of eligibility. If every eligible asked for medical care every month, the maximum demand for medical care would exist. However, only 81 percent of Medicaid's eligibles became recipients in FY'83. These recipients asked for medical care on an average of 5.47 months each. A more precise measure of potential use is provided by calculating the MMS per eligible. Subsequently, the actual demand for care is about 37% of the potential demand.

Cost

Cost per person can be measured by cost per eligible or cost per recipient. Cost per recipient is measured in all states and is the figure used to compare Alabama's costs to similar costs elsewhere.

Other states do not measure cost per eligible so this measurement cannot be used for comparison. However, it is useful for budgeting purposes. Data on cost per eligible help predict how much money will be needed as the number of eligibles changes each year.

Cost Per Eligible: Plate 27 shows the variation from one group to another. For example, an aged person costs Medicaid approximately 8 times as much as a young eligible. In addition to using services more often and using more expensive services, the aged person remains eligible longer than the child. The variations in cost per eligible can be attributed to the fact that different groups use different kinds of services in different amounts.

Plate 27 shows the yearly cost per eligible for the past two years. In FY'83 all groups of eligibles showed a rise in costs. The disabled category showed the largest increase while age 65 and over exhibited the smallest

rise in annual cost. Because the number of persons eligible for Medicaid decreased steadily during FY'83, total expenditures increased at a slower rate than cost per eligible for most groups.

Cost Per Recipient: The group with the highest cost per recipient in both FY'82 and FY'83 was the disabled (Plate 28). This is due to the inclusion of ICF-MR/MD patients in this category. The institutional care provided to these patients is much more expensive than the other services covered by the Medicaid program. Dependents in the age group 0-5 had the lowest cost per recipient for these two years. A reason for this small cost per recipient is that these groups primarily utilize services with a low cost per unit such as dental care, family planning, and screening for preventative medical care (Plate 29).

Section 3 of Plate 29 discloses that Medicaid averaged paying $1,775 for each disabled person who became a hospital patient, but only $543 for each aged inpatient. The average cost per aged inpatient was low because Medicare paid a major part of the bill.

Over 90 percent of the aged people on Medicaid were also eligible for Medicare. Smaller percentages of Medicaid's blind and disabled qualified for Medicare.

For hospital care, Medicare paid more than half of each bill. For four other services listed in Plate 29 Medicare also paid significant, but smaller, fractions of each bill, thus saving Medicaid millions of dollars. For this coverage Medicaid paid to Medicare a monthly "buy-in" fee or premium for each Medicaid eligible who was also on Medicare. The fee is currently $14.60 per month. Medicaid's total payment to Medicare for buy-in premiums in FY'83 was $15,694,896. Medicare spent considerably more than this amount for partial payment of medical bills incurred by Alabama citizens on Medicaid.

FY '82-'83 PLATE 27
COST
Annual changes in cost per **Eligible**

	FY '82	FY '83	CHANGE FROM FY '82
DISABLED	$1,715	$1,992	+16.2%
AGED	1,494	1,591	+6.5%
WHITES	1,388	1,546	+11.4%
AGE 65 & OVER	1,444	1,541	+6.7%
AGE 21-64	1,247	1,453	+16.5%
BLIND	1,062	1,138	+7.2%
FEMALES	928	1,015	+9.4%
ALL ELIGIBLES	856	960	+12.1%
MALES	724	858	+18.5%
NONWHITES	554	630	+13.7%
DEPENDENTS	347	391	+12.7%
AGE 6-20	334	378	+13.2%
AGE 0-5	167	189	+13.2%

FY '82-'83 PLATE 28
COST
Annual Changes in Cost Per **Recipient**

	FY '82	FY '83	CHANGE FROM FY '82
DISABLED	$1,890	$2,247	+18.9%
WHITES	1,591	1,801	+13.2%
AGE 21-64	1,463	1,677	+14.6%
AGED	1,499	1,612	+7.5%
AGE 65 & OVER	1,484	1,608	+8.4%
BLIND	1,212	1,355	+11.8%
FEMALES	1,098	1,214	+10.6%
ALL RECIPIENTS	1,051	1,184	+12.7%
MALES	955	1,123	+17.6%
NONWHITES	708	804	+13.6%
AGE 6-20	459	527	+14.8%
DEPENDENTS	438	492	+12.3%
AGE 0-5	259	296	+14.3%

FY '83

USE AND COST

Year's cost per service by category

Year's total number of recipients by service and category

Year's cost per recipient by service and category

Utilization rates by service and category

		SERVICES WHOSE COSTS ARE SHARED WITH MEDICARE							
		Physicians' Services	Lab & X-Ray	Hospital+ Inpatients	Hospital Outpatients	Rural Health	Home Health	Drugs	Nursing Homes, Skilled++
SECTION 1 YEAR'S COST	ALL CATEGORIES	$43,289,827	$6,727,426	$85,582,354	$13,813,699	$63,768	$2,844,851	$31,616,230	$9,630,619
	Aged	6,908,170	778,761	12,045,032	1,903,023	13,907	1,700,467	16,458,127	6,152,054
	Blind	348,374	57,820	851,208	109,086	683	52,584	301,677	74,472
	Disabled	14,972,526	2,622,873	31,006,819	5,233,864	12,944	1,064,558	11,345,243	3,396,109
	Dependent Children	9,824,149	1,374,564	18,965,587	3,676,306	19,676	6,542	1,268,626	2,850
	Dependent Adults	11,236,608	1,893,408	22,713,708	2,891,420	16,558	20,700	2,242,557	5,134
SECTION 2 YEAR'S TOTAL NUMBER OF RECIPIENTS	ALL CATEGORIES**	242,104	115,051	67,703	110,196	1,640	3,387	222,713	3,658
	Aged	66,534	28,593	22,184	24,521	334	1,852	74,135	3,257
	Blind	1,499	681	474	704	9	59	1,487	19
	Disabled	50,521	27,304	17,473	23,685	280	1,435	50,735	785
	Dependent Children	84,008	34,466	13,344	39,968	695	30	62,151	2
	Dependent Adults	46,674	25,713	14,758	22,795	354	93	41,114	5
SECTION 3 YEAR'S COST PER RECIPIENT	ALL CATEGORIES	$ 179	$ 58	$1,264	$ 125	$ 39	$840	$ 142	$ 2,633
	Aged	104	27	543	78	42	918	222	1,889
	Blind	232	85	1,796	155	76	891	203	3,920
	Disabled	296	96	1,775	221	46	742	224	4,326
	Dependent Children	117	40	1,421	92	28	218	20	1,425
	Dependent Adults	241	74	1,539	127	47	223	55	1,027
SECTION 4 UTILIZATION RATES PERCENT OF ELIGIBLES	ALL CATEGORIES	63.06%	29.97%	17.63%	28.70%	.43%	88%	58.01%	.95%
	Aged	75.96%	32.64%	25.33%	27.99%	.38%	2.11%	84.63%	3.72%
	Blind	70.67%	32.11%	22.35%	33.19%	.42%	2.78%	70.11%	.90%
	Disabled	72.30%	39.08%	25.01%	33.90%	.40%	2.05%	72.61%	1.12%
	Dependents	58.25%	26.82%	12.53%	27.98%	.47%	.05%	46.03%	***

+Includes patients in mental hospitals

++A small part of the cost of skilled care is paid by Medicare, but the amount is insignificant.

*Not Available

**Unduplicated count

***Less than 0.01 Percent

****Includes buy-in premiums for the blind

Plate 29

SERVICES WHOSE COSTS ARE NOT SHARED WITH MEDICARE								ALL SERVICES		
Nursing Homes, ICF	ICF MR/MD	Dental Care	Family Planning	Other Practi-tioners	Other Care	Screening	Medicare Buy-In	Total Of Unshared Costs	Medicaid's Total Part Of Shared Costs	Medicaid's Totals
$108,072,556	$51,636,961	$5,122,200	$5,744,315	$1,409,325	$2,236,100	$924,898	$15,694,896	$234,932,951	$149,477,074	$384,410,025
88,435,958	3,629,063	505	3,357	456,041	919,048	0	11,583,165	129,337,785	21,648,893	150,986,678
530,315	32,549	7,907	16,374	6,882	23,794	363	0	1,046,917	1,367,171	2,414,088
19,103,907	47,975,349	244,484	874,792	360,183	949,143	25,051	4,111,731****	89,450,550	53,849,026	143,299,576
965	0	4,448,164	759,328	330,469	175,507	882,211	0	7,874,662	33,860,282	41,734,944
1,411	0	421,140	4,090,464	255,750	168,608	17,273	0	7,223,037	38,751,702	45,974,739
16,878	1,615	41,571	34,741	31,990	40,414	33,915	N/A*	N/A*	N/A*	311,348
16,877	211	13	210	9,897	17,652	0	N/A*	N/A*	N/A*	86,496
68	2	45	111	143	282	13	0	N/A*	N/A*	1,782
2,816	1,540	1,982	3,993	7,916	11,786	915	N/A*	N/A*	N/A*	61,951
1	0	37,911	10,497	8,036	5,758	32,365	0	N/A*	N/A*	119,166
4	0	2,011	21,565	6,044	5,355	655	0	N/A*	N/A*	58,982
$ 6,403	$ 31,973	$ 123	$ 165	$ 44	$ 55	$ 27	N/A*	N/A*	N/A*	$1,235
5,240	17,199	39	16	46	52	0	N/A*	N/A*	N/A*	1,746
7,799	16,275	176	148	48	84	28	0	N/A*	N/A*	1,355
6,784	31,153	123	219	46	81	27	N/A*	N/A*	N/A*	2,313
965	0	117	72	41	30	27	0	N/A*	N/A*	350
353	0	209	190	42	31	26	0	N/A*	N/A*	779
4.40%	N/A*	10.83%	9.05%	8.33%	10.53%	8.83%	N/A*	N/A*	N/A*	81.09%
19.27%	N/A*	.01%	.24%	11.30%	20.15%	**	N/A*	N/A*	N/A*	N/A
3.21%	N/A*	2.12%	5.23%	6.74%	13.30%	.61%	0	N/A*	N/A*	84.02%
4.03%	N/A*	2.84%	5.71%	11.33%	16.87%	1.31%	N/A*	N/A*	N/A*	88.66%
***	N/A*	17.79%	14.29%	6.28%	4.95%	14.72%	0	N/A*	N/A*	79.41%

LONG-TERM CARE

In terms of people served, the nursing home program is small. This year one eligible in 18 used nursing home care.

In terms of expenditures, it is Medicaid's largest program. This year 31 percent of Medicaid Provider payments went for long-term care.

With the enactment of Medicaid (Title XIX) in 1965, Congress mandated the assurance of care to acutely ill, indigent patients in skilled nursing homes. This care was included in federal law as a mandatory service—one that all states must include in their Medicaid programs. Alabama has provided skilled nursing care since its Medicaid program began in 1970. Contemporary long-term care consists of skilled care and intermediate care. Skilled care is furnished for patients who are sick enough to require around-the-clock professional nursing care. Intermediate care is provided for patients with chronic medical conditions who are not well enough for independent living and require professional nursing care at a less intense level than that of skilled-care recipients. The Alabama Medicaid program began offering this optional service in 1972. In terms of expenditures, these two types of nursing home care comprise the largest service offered by the program.

Throughout the 1970's, the demand for Medicaid nursing home care increased due to a number of social and economic factors. Some of these include:

— Population growth.
— Longer lifespans, resulted in larger numbers of people in older age categories.
— Advances in medical science and technology extended the lives of persons with chronic medical conditions, such as cardiovascular diseases.
— Increasing urbanization, which reduced both the size of homes and the number of nonworking family members available to care for the elderly.

This increase in overall utilization coincided with a change in the pattern of intermediate care and skilled care utilization during the decade. In the early 1970's there were more skilled patients than intermediate patients. This situation reversed itself as the decade progressed. For instance, in FY'77, there were more than 15,000 skilled patients compared to just over 9,000 intermediate patients. By FY'83, there were only about 3,600 skilled patients compared to more than 17,000 intermediate care patients. One factor in this change was the move toward dual certified facilities, or facilities certified to treat both skilled and intermediate patients. Currently, two specialized facilities in the state treat skilled patients only and 19 treat ICF only. Another factor was the advent of combination reimbursement. Nursing homes are reimbursed at a single corporate rate based on their allowed costs, and not the level of care provided to individual patients.

Beginning in FY'82, however, Medicaid nursing home utilization began to show a small decline overall. In FY'83, the decline was significant — eleven percent. Some of the probable reasons for this unprecedented decline were:

— The expansion of the Home Health Care program, which provides intermediate care in a patient's home.
— Financial eligibility determination became more efficient due to better Medicaid management information and increased training for Medicaid eligibility employees.

FY '81-'83 PLATE 30

LONG-TERM CARE PROGRAM

Patients, months, and cost

	Number Of Nursing Home Patients* (Year's Unduplicated Total)	Average Length of Stay During Year	Total Patient-Days Paid For By Medicaid*	Average Cost Per Patient Per Day to Medicaid*	Total Cost To Medicaid*
1981	23,291	228 Days	5,317,655	$21	115,237,891
1982	22,884	236 Days	5,389,977	23	123,790,282
1983	20,536	250 Days	5,135,060	23	117,703,176

*Excludes patients in institutions operated by the Mental Health Department

FY '81-'83 PLATE 31

LONG-TERM CARE PROGRAM

The number and percent of beds used by Medicaid

	Nursing Home Beds Certified For Federal Program Participation*	Medicaid Patients		Percent Of Beds Used By Medicaid**	Number Of Beds Not Used By Medicaid In Average Month
		Monthly Average**	Yearly Unduplicated Total**		
1981	20,460	14,309	23,291	70%	6,151
1982	20,986	14,565	22,884	69%	6,421
1983	20,813	13,676	20,536	66%	7,137

*Excludes ICF-MR Facilities

**Excludes Patients in Institutions Operated by the Mental Health Department

— Revised medical criteria continue to insure that patients who are admitted to the program have genuine medical needs requiring professional care and not just the need for assistance with the tasks of daily living.

Payments to long-term care providers declined by five percent in FY'83. The factors influencing this decline in payments included fewer recipients and stable utilization patterns.

In light of these and other factors, the Alabama Medicaid Agency has taken the position that no new nursing home beds are needed in the state at this time. Some reasons include:

— Two-thirds of all nursing home patients in Alabama are Medicaid patients.

— The number of Medicaid nursing home patients is declining.

— In early 1983, 300 nursing home beds were under construction in the state. At the same time, the overall occupancy rate for all nursing home beds was significantly less than 100 percent.

— In Alabama, there is a high ratio of nursing home beds to persons over 65 years of age in relation to other Southeastern states.

State & Rank	Persons 65* & Older	Beds Per 1,000**
1. Georgia	515,164	58.0
2. Alabama	440,003	46.9
3. Mississippi	288,742	42.4
4. South Carolina	288,214	41.6
5. Tennessee	517,572	41.9
6. Florida	1,687,112	21.4

— Any increase in the number of nursing home beds could result in significant economic problems for the Medicaid program and reduce the financial resources available for other vital services. Based on current utilization, an increase of 100 nursing home beds would result in an increase in Medicaid expenditures of approximately $1 million.

— In 1983 the State Board of Health relaxed its rules for licensing domiciliaries. Since that time the number of beds in these institutions has increased from 650 to 1,100. These facilities provide a supervised environment for elderly persons in need of custodial care. Although Medicaid does not pay for this service, the expansion of the number of domiciliaries in the State should reduce

*U.S. Bureau of Census, 1980 Official Estimates

** U.S. National Center for Health Statistics, 1980 Data

FY '83 PLATE 32

LONG-TERM CARE PROGRAM

Recipients, by sex, by race, by age

	Skilled	ICF*	Total*	Percent
All Recipients	3,658	16,878	20,536	100%
By Sex				
Female	2,579	12,561	15,140	73.7%
Male	1,079	4,317	5,396	26.3%
By Race				
White	2,793	13,594	16,387	79.8%
Nonwhite	865	3,284	4,149	20.2%
By Age				
65 & Over	3,032	14,888	17,920	87.3%
21-64	494	1,889	2,383	11.6%
6-20	98	101	199	.9%
0-5	34	0	34	.2%

*Excludes patients in institutions operated by the Mental Health Department

FY '83 PLATE 33

LONG-TERM CARE PROGRAM

Payments: by sex, by race, by age

	Skilled	ICF*	Total*	Percent
All Recipients	$9,630,620	$108,072,556	$117,703,176	100%
By Sex				
Female	6,657,181	82,060,771	88,717,952	75.4%
Male	2,973,439	26,011,785	28,985,224	24.6%
By Race				
White	7,164,104	86,088,307	93,252,411	79.2%
Nonwhite	2,466,516	21,984,249	24,450,765	20.8%
By Age				
65 & Over	6,584,870	93,259,550	99,844,420	84.8%
21-64	1,699,275	13,899,676	15,598,951	13.3%
6-20	950,252	877,090	1,827,342	1.6%
0-5	396,223	36,240	432,463	0.3%

*Excludes Patients in Institutions Operated by the Mental Health Department

any future needs for nursing home beds. — There is a federal initiative underway encouraging states to use Medicaid funds to pay for effective but less expensive means of caring for the needs of indigents with chronic medical problems. Such means would include home and community-based services—the provision of necessary services that would allow patients to live at home rather than in an institution. The Alabama Medicaid Agency is in agreement with this initiative and is currently developing nursing home alternatives.

Nursing Home Reimbursement: Alabama uses the Uniform Cost Report (UCR) system to establish a Medicaid payment rate for a facility. It takes into consideration the nursing facility plant, financing arrangements, staffing, management procedures, and efficiency of operations. The UCR must be completed by each nursing facility and submitted to the Alabama Medicaid Agency by September 15 of each year so that a new rate may be established and implemented by January 1 of the following year. Allowable expenses included in the reimbursement rate are employee salaries, equipment, consultation fees, food service, supplies, maintenance, utilities, etc., as well as any other expenses to be incurred in maintaining full compliance with standards required by the state and federal regulating agencies.

Medicaid pays to the long-term care facility 100 percent of the difference between the Medicaid-assigned reimbursement rate and the patient's available resources. The maximum amount of income that a patient may have and still be eligible for nursing home care under the Medicaid Program was increased to $852.90 in FY'83. All personal income above $25.00 a month, with the exception of health insurance premiums, must be applied by the patients to reduce the monthly Medicaid charge for nursing home service.

Patient Characteristics and Length of Stay: Plates 32 and 33 show who the recipients were this year in terms of sex, race, and age and the amount spent on each group.

Plate 34 shows average monthly recipients and the annual total of recipients in the Long-Term Care program. Also calculated are the annual turnover rate and average length of stay. It must be emphasized that these two measures are averages. Although the average patient stays 250 days per year, there are recipients who live several years in nursing homes. Information is needed on whether the number of permanent residents is declining or increasing. The answer will have a large impact on Medicaid's expenditures in coming years because of the relative size of the program in terms of recipients served.

FY '81-'83 PLATE 34

LONG-TERM CARE PROGRAM

Number of Recipients

	Skilled*			ICF*			Total*		
	FY '81	FY '82	FY '83	FY '81	FY '82	FY '83	FY '81	FY '82	FY '83
Monthly Average	3,031	1,576	1,105	12,571	12,989	11,865	15,602	14,565	12,970
Yearly Total	6,971	4,181	3,658	16,320	18,703	16,878	23,291	22,884	20,536
Annual Turnover Rate	130%	165%	231%	30%	44%	42%	49%	57%	58%
Average Length of Stay	146 Days	125 Days	99 Days	263 Days	260 Days	283 Days	228 Days	236 Days	250 Days

*Excludes Patients in Institutions Operated by the Mental Health Department

FY '83 PLATE 35

PAYMENTS TO NURSING HOMES

By County (in millions of dollars)

LONG-TERM CARE MENTAL HEALTH

1,615 institutionalized recipients and 1,057 recipients of home and community based services were cared for with the assistance of 72 percent federal matching funds through Medicaid-Mental Health agreements.

The Alabama Medicaid Agency negotiated agreements with the State Department of Mental Health to include coverage for Medicaid-eligible ICF/Mentally Retarded recipients in 1977, and for coverage of ICF/Mentally Diseased recipients over 65 years old in 1978. Eligiblity for these programs is determined by categorical, medical, and/or social requirements specified in Title XIX. The programs provide treatment which includes training and habilitation services intended to aid the intellectual, sensorimotor, and emotional development of a resident.

Since its inception the program has grown steadily. The total number of recipients grew from 458 in FY'79 to 1,615 in FY'83. During the same period, payments increased from $1.6 million to $51.6 million. The reason for the dramatic effect on payments of a relatively small number of recipients is the high price of a day of care, which was $86 in FY'83, and the average length of stay, which was almost a year in FY'83.

Judging from the above statements, it would appear that the ICF-MR/MD program is an extremely costly component of the Alabama Medicaid program. In terms of total Medicaid dollars expended and the average monthly payment per patient, this is certainly true. 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 would be responsible for the total funding of this care entirely out of its state appropriation. Through its relationship with the Alabama Medicaid Agency, Mental Health is able to match every 28 state dollars with 72 federal dollars for the care of Medicaid-eligible ICF-MR/MD patients. Due to the inclusion of ICF-MR/MD in Medicaid's range of services, $36 million of its cost came from federal instead of state revenues in FY'83.

A home and community-based Mental Health program was implemented by the Alabama Medicaid Agency in FY'83. This is in accordance with the agency's stated policy of using Medicaid funds to pay for effective but less expensive means of treatment. The program is designed for mentally retarded individuals who, without this service, would require institutionalization in an ICF/MR. Services offered at this time are those of habilitation, which insure optimal functioning of the mentally retarded within a community setting.

FY '82-'83 PLATE 36

LONG-TERM CARE PROGRAM

ICF-MR/MD

	FY '82	FY '83
Recipients	1,592	1,615
Annual Expenditures	$36,093,722	$51,636,961
Average Annual Cost Per Recipient	$22,672	$31,973
Average Monthly Recipients	1,164	1,505
Average Monthly Cost Per Recipient	$2,584	$2,859

Tarwater Mental Health Facility, Wetumpka

HOME HEALTH

Of every nine Medicaid patients in need of continuous care, eight live in nursing homes. The other one receives home health care.

The Home Health Care Program, one of the Medicaid services made mandatory by federal rules, is intended as an alternative to nursing home care. The service provides health care to Medicaid eligibles in their own homes rather than in institutions. These persons are home bound because of illnesses, disabilities, or injuries, and meet the Medicaid criteria for nursing home care.

Under contract with the Alabama Medicaid Agency, home health providers go into recipients' homes and provide nursing services, personal care, observation, and evaluation in accordance with the attending physician's plan of treatment. The nurse acts as a liaison between hospital, physician, and patient. Home health aides provide personal care under the direction of a registered nurse. Visits by both nurses and aides are provided as required. The normal limit on visits is 100 per calendar year, but additional visits may be provided with Medicaid approval. The Medicaid Agency has contracts with 94 certified home health agencies.

Federal reports indicate that home health care is the fastest growing service covered by Medicaid. State Medicaid administrators foresee the development of a wide variety of home-based services with an emphasis on case management. Plate 37 indicates how the number of chronically ill patients has increased each year since 1977, and the division each year of these patients into two groups—one at home, and the other in nursing homes.

At least three factors have contributed to the program's growth. One of these has been an increase in the number of providers. Need has increased because of earlier hospital discharges, stricter nursing home admission criteria, changes in Medicare levels of care, and the desire of recipients to remain in their homes.

In FY'83, 3,387 persons received 113,958 visits at a cost to Medicaid of $2,844,851. The most common conditions treated were diabetes, hypertension, cerebrovascular accidents, orthopedic and skin problems, and respiratory and urinary infections.

Providers reimbursement is made on a per visit basis, regardless of services rendered during the visit. The maximum per visit payment of $27 was established by the Medicaid Agency in FY'83. The average payment was about $25.

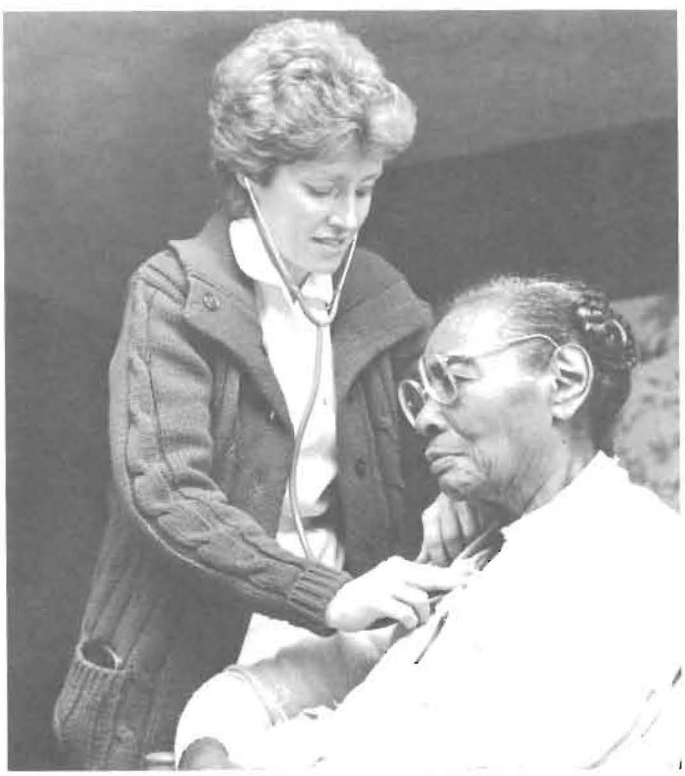
Durable medical equipment and certain suppliers and appliances are available to Medicaid eligibles for at home use. These items help minimize more expensive institutionalization. Covered items are supplied under the order and supervision of attending physicians and are provided through suppliers under contract with the agency. The program has 245 contract equipment suppliers. They supplied 75,879 units of service at a cost of $1,224,329, an average cost of $16.14 per unit.

FY '77-'83 PLATE 37

HOME HEALTH CARE

Number of aged patients using home health care compared to the number using nursing home care.

Year	Home Health Care	Nursing Home Patients
1977	2,234	24,351
1978	2,846	24,267
1979	3,924	24,624
1980	3,389	24,441
1981	3,486	24,065
1982	3,238	24,476
1983	3,387	22,151



HOSPITAL PROGRAM

18 percent of Medicaid eligibles became hospital inpatients during this fiscal year; 29 percent became outpatients.

Outpatients continue to outnumber inpatients.

Inpatient Care: In FY'83 the cost of inpatient care exceeded $85 million. This was second only to the Long-Term Care program in expenditures within the Medicaid program. The specific figures on Hospital program costs are shown in Plate 38.

Although the consumer price index's medical care component showed a moderate rise in FY'83, the increase in total cost to the inpatient hospital program was relatively small. This is explained by the fact that the number of recipients and the units of service used by these recipients declined.

FY '81-'83 PLATE 38

HOSPITAL PROGRAM

Changes in use and costs

Year	Eligibles	*Recipients of Inpatient Care	Payments** for Inpatient Care	Medicaid's Annual Cost Per Recipient
1981	409,428	74,321	$65,916,918	$ 887
1982	394,905	71,130	83,323,150	1,171
1983	383,940	67,699	85,596,571	1,264

*Includes Inpatients covered by both Medicaid and Medicare

**Includes deductibles and co-insurance payments for inpatients covered by both Medicaid and Medicare and excludes cost settlements

FY '82 PLATE 39

HOSPITAL PROGRAM

Cost for Medicaid patients compared to costs for other hospital patients

	Cost per Day	Days per Stay	Cost per Stay
All U.S. Hospital Patients*	$327	7.6	$2,485
All Alabama Hospital Patients (FY '82)	$327	6.7	$2,191
Alabama Medicaid Patients (FY '82)	$263	5.7	$1,499

*1983 Data Not Available

FY '82*

PLATE 40

HOSPITAL PROGRAM

Medicaid eligibles compared to all Alabama residents in regard to use of hospital beds

	Total Number	Hospital Admissions	Patient Days	Admissions per 1000 People	Average Days per Stay
Medicaid Eligibles	394,905	56,924	325,826	144	5.7
All Alabama Residents	3,943,000	762,111	5,091,629	193	6.7

*1983 Date Not Available

Medicaid Patients Compared to Private Patients: Plate 39 shows that for the nation as a whole, the cost per day for hospital care is now up to $327, and that the cost per stay was $2,485. Although the cost to Medicaid for these items is much lower than these national averages, it must be remembered that the $263 per day Medicaid paid for hospital care represents only a part of the cost of Medicaid patients. A third of Medicaid's hospital patients are covered by both Medicaid and Medicare. For these patients, Medicare pays most of the hospital bills. We do not have figures that will tell us the total hospital cost paid by both Medicaid and Medicare for these patients. It has been suggested that the combined payments of Medicaid and Medicare now equal a cost per day larger than that paid by private patients.

As shown in Plate 40 the hospital admission rate for the Alabama population was higher than the rate for Medicaid eligibles. Medicaid's admission rate was 25 percent lower than the rate for Alabama as a whole. Medicaid's length of stay was also below the average for the state.

Outpatient Care: The Outpatient Program was created to enable people to use hospital facilities without staying overnight. When it is used for this purpose, it reduces the cost of medical care. Some people, however, use outpatient care when all they need or want is a visit to a doctor's office.

An outpatient visit costs more than twice as much as a visit to a doctor. Nevertheless, some Medicaid patients frequently use this expensive service rather than the less expensive one, and hospitals rarely refuse to cooperate in this abuse. Plate 41 shows how use and cost of the outpatient program have grown in five years. The number of patients has increased 4 percent. The cost per patient has increased 62 percent. Higher unit prices, stable utilization patterns, and fewer recipients were the main factors influencing the cost of outpatient care in FY'83.

Alabama's Supply of Hospital Beds: According to State Health Planning and Development Agency figures, the number of existing hospital beds has exceeded the number of needed beds since 1978. 1982 data shows a surplus of 1,619 beds. Because of this surplus, Alabama hospitals presumably will not be issued Certificates of Need to expand until the need for beds catches up with the supply (except in rare circumstances). Even if no new Certificates of Need are issued, the construction of new beds may continue. The reason is that many hospitals hold unused "assurances of need" which were issued to them before 1975. These assurances are equivalent to permission to expand. They cannot be revoked and, therefore, can still be used.

Plates 43 and 44 show distribution and occupancy rates of hospital beds by county. Beds per 1,000 people range from 9.04 in Houston County to no hospitals in Coosa and Lowndes counties. Occupancy rates range from 85 percent in Lee and Winston Counties to 22 percent in Bullock County.

FY '79-'83

PLATE 41

HOSPITAL PROGRAM

Outpatients

	FY '79	FY '80	FY '81	FY '82	FY '83
Number of outpatients	105,507	110,774	115,393	112,333	110,196
Percent of eligibles using outpatient service	25%	26%	28%	28%	29%
Annual expenditure of outpatient care	$8,084,542	$11,568,775	$13,109,707	$12,655,314	$13,813,699
Cost per patient	$77	$104	$114	$113	$125

FY '75-'82*

PLATE 42

HOSPITAL PROGRAM

Hospital use and need for all Alabama

	Alabama's Population	Hospital Admissions	Patient Days in Hospitals	Needed Beds	Existing Hospital Beds	Surplus Beds
1975	3,615,000	609,381	4,190,450	16,989	18,278	1,289
1976	3,653,000	642,452	4,445,930	17,316	18,189	873
1977	3,690,000	689,558	4,673,207	N/A	17,652	N/A
1978	3,742,000	728,465	4,902,517	17,339	20,114	2,775
1979	3,769,000	727,292	4,897,995	17,795	20,199	2,404
1980	3,893,888	743,447	4,975,576	17,982	20,420	2,438
1981	3,920,000	748,764	5,055,548	18,690	20,441	1,751
1982	3,943,000	762,111	5,091,629	18,778	20,397	1,619

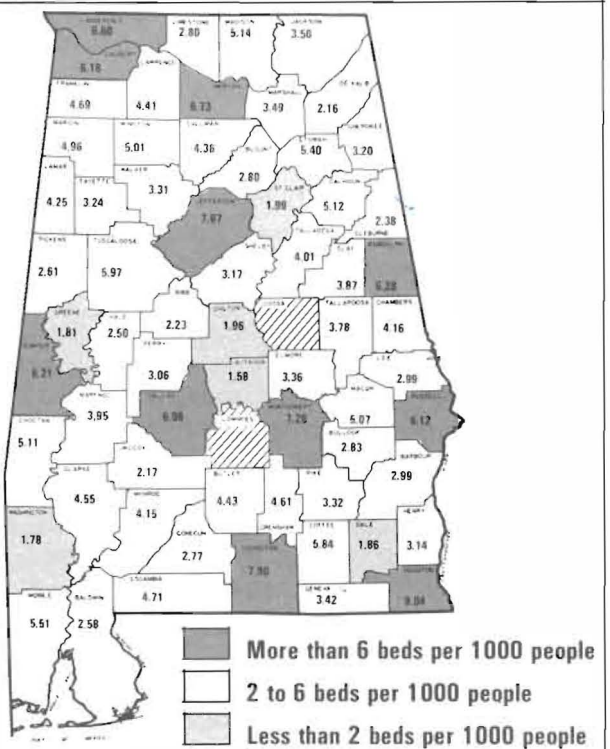
*1983 Data Not Available

1982*

PLATE 43

HOSPITAL PROGRAM

Beds per 1,000 people



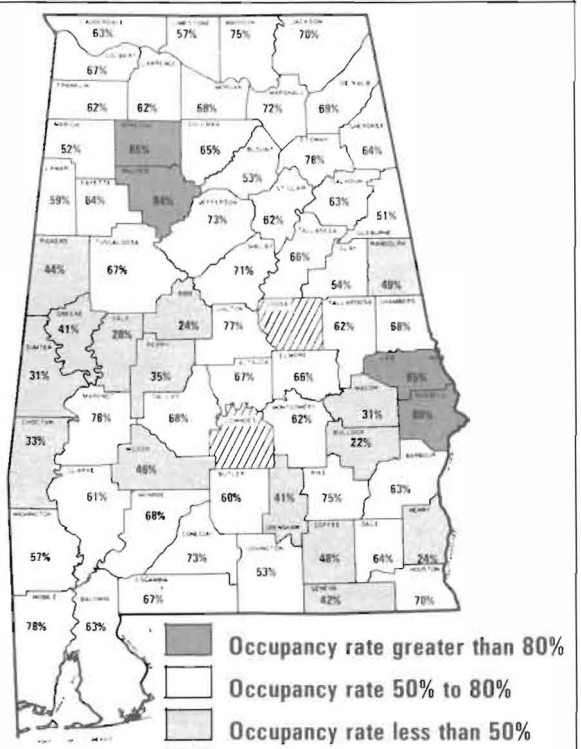
*1983 Data Not Available

1982*

PLATE 44

HOSPITAL PROGRAM

Hospital Occupancy Rate (%)



*1983 Data Not Available

FAMILY PLANNING

Expenditures for family planning services totalled $5,744,315 for FY '83.

Alabama Medicaid purchases family planning services provided by the Statewide Family Planning Project, Bureau of Maternal and Child Health, State Health Department, in clinics under its supervision. These services include physical examinations, Pap smears, pregnancy and V.D. testing, counseling, oral contraceptives, other drugs, supplies and devices, and referral for other needed services. The Medicaid Family Planning Program cooperates with the Statewide Family Planning Project and the Bureau of Nursing in training programs designed to upgrade quality and quantity of services available through the clinics. Medicaid also pays for family planning services provided by physicians, pharmacists, hospitals, and other private providers.

In March 1973, federal law made family planning services a required part of all Medicaid programs. To insure that the new family planning programs be given priority, the federal government agreed to pay 90 percent of the cost. Using the additional funds, Alabama launched its full-scale family planning program, including clinic services, counseling, patient education, supplies and devices, sterilization, and abortion.

In February 1979, federal regulations concerning Medicaid payment for sterilizations required that (1) the individual be at least 21 years old at the time consent is obtained; (2) the individual has voluntarily given informed consent in accordance with all requirements; and (3) at least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.

An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since she gave informed consent for the sterilization. In case of a premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

In August 1977, DHEW issued a policy statement regarding payment for abortions for Medicaid recipients. Basically, this policy states that payment can be made for abortions: (1) when the attending physician has certified that it is necessary because the life of the mother would be endangered if the fetus were carried to term; (2) when severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term; and (3) for treatment of rape and incest victims if reported to a law enforcement agency within sixty days of the incident.

As of February 19, 1980, Alabama Medicaid began receiving federal financial participation for all abortions that are considered medically necessary in the professional judgment of the pregnant woman's physician, exercised in the light of all factors — physical, emotional, psychological, familial, and the woman's age — relevant to the health related well-being of the pregnant woman.

Effective October 6, 1980, Alabama Medicaid could only pay for abortions when the life of the mother would be endangered if the fetus were carried to term and for victims of promptly reported rape and incest.

As of February 23, 1981, Alabama Medicaid could only pay for abortions when the life of the mother would be endangered if the fetus were carried to term and for victims of rape reported within 72 hours to a law enforcement agency.

Effective July 1, 1981, the Alabama Medicaid Program can only pay for abortions when the life of the mother would be endangered if the fetus were carried to term.

FY '81-'83 PLATE 45

FAMILY PLANNING PROGRAM

Recipients by sex, race, and age

	FY '81	FY '82	FY '83
Total	27,013	29,983	34,741
Male	659	1,418	3,771
Female	26,354	28,565	30,970
White	4,512	5,738	8,079
Nonwhite	22,501	24,245	26,662
Age 0-5	0	0	0
Age 6-20	13,320	13,517	15,039
Age 21-64	13,693	16,466	19,702
Age 65 & over	0	0	0

PHYSICIAN PROGRAM

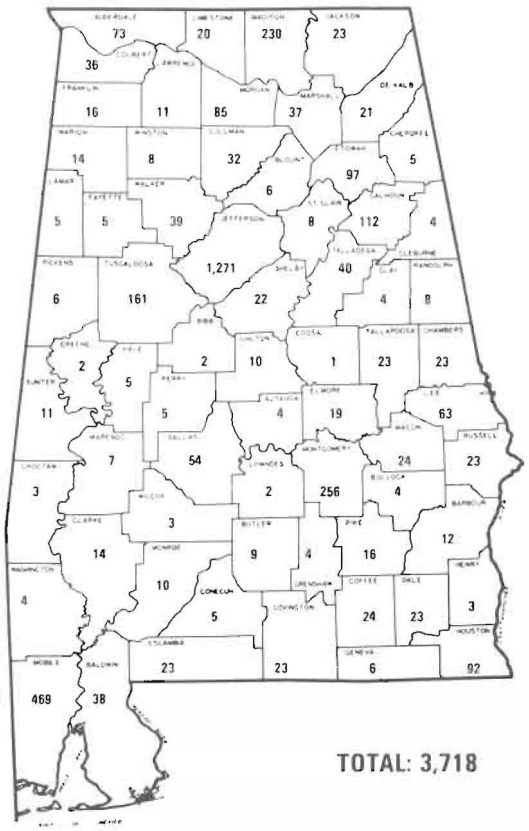
Among Medicaid eligibles, 6 persons in 10 saw a physician this year.

Medicaid paid physicians an average of $179 for each patient.

FY '82 PLATE 46

PHYSICIAN PROGRAM

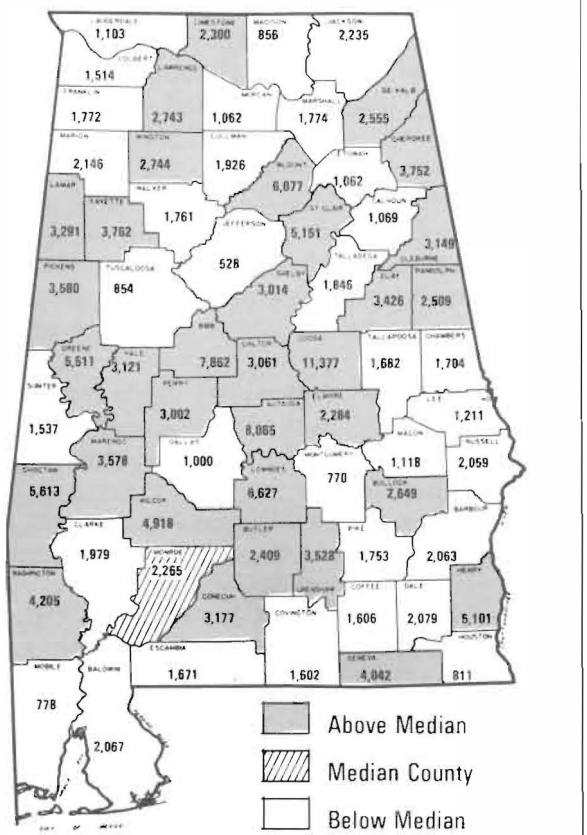
Number of physicians providing direct patient care, by county



FY '82 PLATE 47

PHYSICIAN PROGRAM

Number of people per physician, by county



In Alabama doctors of medicine or osteopathy initiate most medical care. They either provide it directly or prescribe or arrange for additional health benefits. These benefits may include drugs, nursing care, laboratory tests or devices. Physicians may also admit patients to medical institutions and direct the medical care therein. According to the Alabama Health Data System there were 3,718 doctors offering direct patient care in Alabama as of March, 1982. This figure does not include physicians in teaching, research, public health, administration, etc.

Physicians in Alabama may participate in the Medicaid program as general practitioners or specialists. In the EPSDT program, agreements which limit charges per screening must be signed by physicians before they can provide child screening services; however, in the other programs, physicians are not required to sign agreements. They may provide medically necessary care to any eligible person. During FY'83 over three-quarters of the Medicaid recipients in Alabama received physicians' services.

Medicaid physicians' care costs less per person for the aged than it costs for most other categories. (See Plate 48.) This surprising situation is explained by the fact that 90 percent of Medicaid's aged also have Medicare coverage. Medicare pays the larger part of their bills for physicians' care.

The total number of recipients of physicians' care increased by about 2 percent from the previous year. The cost of the program rose from $38,115,673 in FY'82 to $43,289,827 in FY'83.

FY '79-'83 PLATE 48

PHYSICIAN PROGRAM

Use and cost

	COST PER RECIPIENT PER YEAR, FOR PHYSICIANS' SERVICES				
	FY '79	FY '80	FY '81	FY '82	FY '83
Aged	$ 59	$ 76	$ 83	$104	$104
Blind	$202	$176	$179	$232	$232
Disabled	$215	$187	$205	$243	$296
Dependent Children	$ 88	$ 79	$ 84	$ 99	$117
Dependent Adults	$215	$194	$178	$229	$241
ALL CATEGORIES	$128	$120	$132	$160	$179
	NUMBER OF MEDICAID RECIPIENTS TREATED BY PHYSICIANS				
	FY '79	FY '80	FY '81	FY '82	FY '83
Aged	67,071	72,159	71,452	69,831	66,534
Blind	1,439	1,415	1,491	1,549	1,499
Disabled	42,648	45,101	47,386	48,824	50,521
Dependent Children	80,888	77,432	83,019	79,478	84,008
Dependent Adults	45,447	44,328	49,536	46,945	46,674
ALL CATEGORIES	237,503	240,435	240,655*	238,519*	242,104*
	PERCENT OF ELIGIBLES WHO BECAME RECIPIENTS OF PHYSICIANS' CARE				
	FY '79	FY '80	FY '81	FY '82	FY '83
Aged	61.8%	66.0%	73.4%	76.2%	76.0%
Blind	65.0%	63.5%	68.2%	71.3%	70.7%
Disabled	63.4%	65.1%	69.0%	70.8%	72.3%
Dependents	53.6%	50.3%	55.0%	54.5%	58.2%
ALL CATEGORIES	57.4%	56.8%	58.8%	60.4%	63.1%

(*unduplicated count)

PHARMACEUTICAL PROGRAM

An increase of 11 percent in price per prescription was the main factor influencing payments to pharmacy providers in FY'83.

FY '81-'83 PLATE 49
PHARMACEUTICAL PROGRAM
Counts of providers by type and year

Type of Provider	Number		
	FY '81	FY '82	FY '83
In-State Retail Pharmacies	1,008	1,047	1,061
Institutional Pharmacies	41	42	39
Dispensing Physicians	4	4	2
Out-of-State Pharmacies	36	49	44
Health Centers and Clinics	3	3	3
TOTAL	1,092	1,145	1,149

Modern medical treatment relies heavily on the use of drugs. Drugs are used against pain, infection, allergies, chemical imbalances, dietary deficiencies, muscle tension, high blood pressure, vascular diseases, and many other health problems. Illnesses which cannot be treated by drugs usually require hospitalization or surgery. Drugs have advantages over these alternative treatments, and modern medicine has been very successful in finding medications which make the more expensive alternatives unnecessary.

FY '81-'83 PLATE 50
PHARMACEUTICAL PROGRAM
Recipients, expenditures, and claims

	All Categories	Aged	Blind	AFDC/Other	Disabled
RECIPIENTS (Per Year)					
FY '81	223,538	84,832	1,514	104,021	50,271
FY '82	222,109	77,545	1,587	98,220	50,637
FY '83	222,713	74,135	1,487	117,822	50,735
EXPENDITURES (Per Year)					
FY '81	$24,242,873	$13,504,865	$216,208	$2,461,328	$8,060,472
FY '82	28,268,860	15,384,231	269,269	2,839,726	9,775,634
FY '83	31,616,230	16,458,128	301,677	3,511,182	11,345,243
# of Rx (Per Year)					
FY '81	3,171,150	1,782,521	27,500	374,740	986,389
FY '82	3,213,290	1,754,213	29,233	382,291	1,047,553
FY '83	3,230,037	1,685,597	29,268	428,427	1,086,745
Rx PER RECIPIENT (Per Year)					
FY '81	14.2	21.0	18.2	3.6	19.6
FY '82	14.5	22.6	18.4	3.9	20.7
FY '83	14.5	22.7	19.7	3.6	21.4
COST PER RECIPIENT (Per Year)					
FY '81	$108	$159	$143	$24	$160
FY '82	127	198	170	29	193
FY '83	142	222	203	30	224

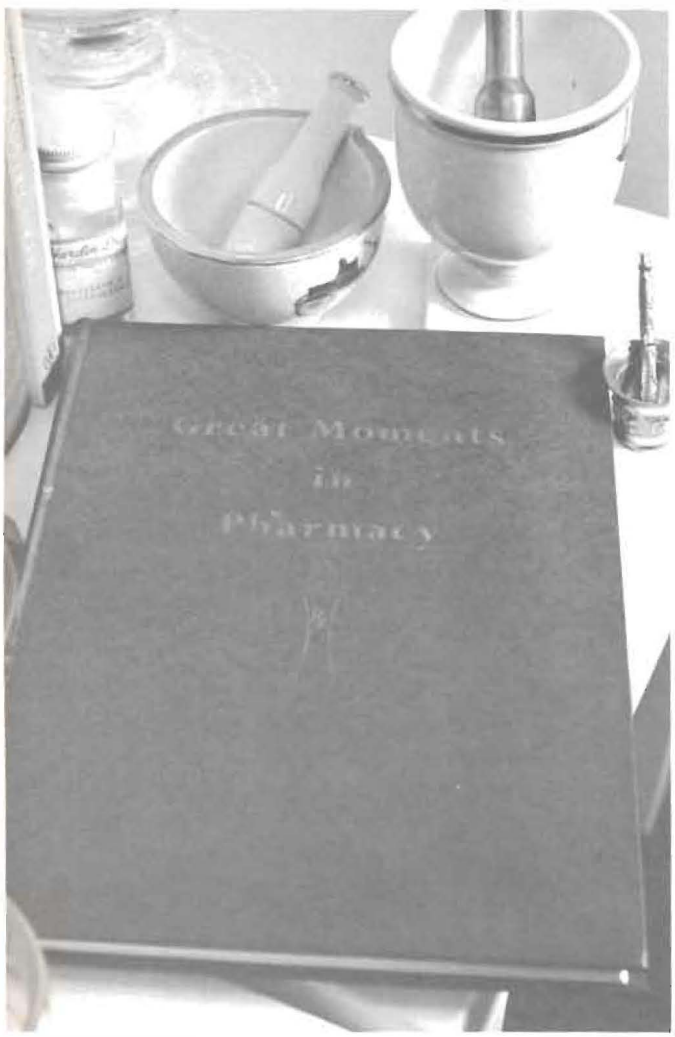
FY '83 PLATE 51

PHARMACEUTICAL PROGRAM

Use and cost

Month	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
October '82*	43,793	14%	90,035	2.06	$9.33	$19.18	$839,814
November	102,474	33%	309,108	3.02	$9.36	$28.24	$2,894,269
December	91,818	30%	247,773	2.70	$9.39	$25.34	$2,326,687
January '83	100,307	32%	294,924	2.94	$9.42	$27.71	$2,779,053
February	105,360	34%	319,480	3.03	$9.57	$29.01	$3,056,317
March	100,776	33%	282,502	2.80	$9.68	$27.15	$2,735,954
April	95,561	31%	258,760	2.71	$9.80	$26.53	$2,534,873
May	97,960	31%	273,131	2.79	$9.84	$27.44	$2,687,631
June	90,593	29%	247,275	2.73	$9.97	$27.21	$2,464,670
July	89,100	28%	234,181	2.63	$10.14	$26.66	$2,375,439
August	117,467	37%	429,335	3.65	$10.35	$37.82	$4,442,318
September	102,181	33%	288,973	2.83	$10.53	$29.78	$3,042,447
ALL YEAR	222,713	58%	3,230,037	14.50	$9.79	$141.96	$31,616,230

*Revised claims processing cycle



This year, as in all previous years, over 50 percent of Alabama's Medicaid eligibles had at least one prescription filled. The only other medical service used by as many eligibles was physicians' care.

Physicians writing prescriptions for Medicaid patients have a choice of approximately 8,000 drug code numbers in more than 50 drug classes. These drugs are listed in the Alabama Drug Code Index (ADCI). The principal purpose of the Index is to identify those drugs which are approved for payment under the program. Every effort is made to assure that the ADCI does not restrict the physician's choice of formulary in justified situations. The pharmaceutical program prior approves products for those Medicaid eligibles who require specific drugs in the course of treatment. In many cases, this enables the patients to return to their own homes rather than remain in an institutional setting. Southeastern states spend more per year per recipient on drugs than do states in other parts of the country. The reason is not known, but opinion among qualified people is that drugs are more often used as an alternative to institutional care in the Southeast.

The relationship of expenditures for drug benefits to total Medicaid program expenditures has remained stable for several years. Since FY'79 the drug program has accounted for 7 percent to 9 percent of total Medicaid payments.

The average price for a prescription in FY'83 increased 11 percent from $8.80 to $9.79 (Plate 51). The number of prescriptions per recipient remained stable, while the cost per recipient rose from $127 in FY'82 to $142 in FY'83 (Plate 50).

FY '83 PLATE 51

PHARMACEUTICAL PROGRAM

Use and cost

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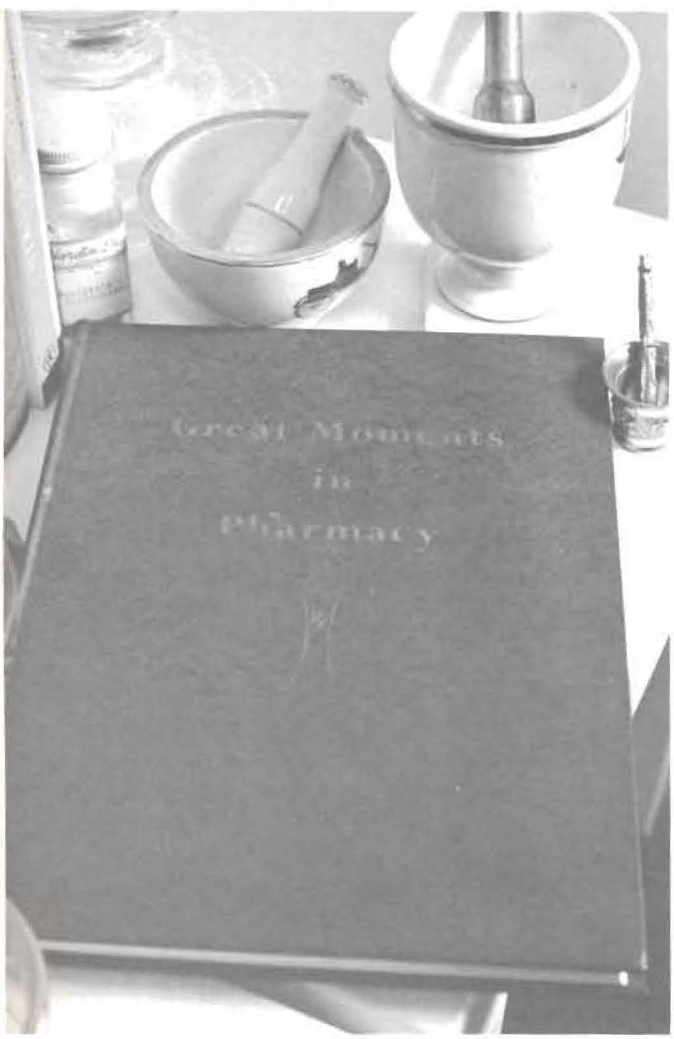

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EPSDT PROGRAM

80 percent of the children screened in Alabama need treatment.

Approximately 42,000 persons received dental care as an integral part of the EPSDT Program.

EPSDT (Early and Periodic Screening, Diagnosis, and Treatment), often called screening, is one of the Alabama Medicaid Agency's mandatory programs. Although it is funded through Medicaid, the program requires the cooperation of two other state agencies — the State Department of Pensions and Security and the State Department of Public Health. EPSDT eligibles are persons under age 21 in either the Aid to Dependent Children or Supplemental Security Income programs, although most are ADC clients. Pensions and Security workers normally determine ADC eligibility, make families aware of EPSDT, and refer eligibles to EPSDT providers. About half of all EPSDT providers, and the providers that conduct about 80 percent of the screenings, are county health departments. In addition to funding the program, the Medicaid Agency keeps track of which eligibles have been screened and which eligibles are due for screenings.

A long-term problem with the program has been underutilization. Eligibles are not required to be screened if they do not want to be. Only about 20 percent of eligible children participate in the program. Health screening benefits the eligible children, and it is also a cost-effective service. Early detection of medical conditions can help alleviate complications that require more costly treatment. Both Pensions and Security and the Department of Health provide educational programs to tell eligible families about the importance of screening. The Medicaid Agency sends educational letters to newly-eligible families who initially refuse screening appointments. A project currently operating in Talladega shows promise for increasing utilization. In cooperation with a local housing authority, a private provider is conducting a mobile EPSDT program for public housing tenants.

The goal of the Medicaid program in FY'84 is to increase EPSDT participation. The Medicaid Agency and Pensions and Security are working together to educate the mothers of EPSDT eligibles as to the importance of screening.

Another shortcoming of the program is that there are very few EPSDT physician providers. Children screened by health departments must be referred to physicians for any needed treatment. This increases the possibility of no-shows. Better continuity of care is possible if a child is both screened and treated by a physician.

In addition to county health departments and physicians, screenings are performed by community health centers, Head Start Centers, and child development centers. These organizations have made significant contributions to the EPSDT program. The De-

FY '82-'83 PLATE 53
DENTAL PROGRAM
Recipients by sex and age

	FY '82	FY '83
Total	42,988	41,571
Male	19,787	19,013
Female	23,201	22,558
Age 0-5	11,338	11,875
Age 6-20	31,650	29,696

FY '81-'83 PLATE 52
EPSDT PROGRAM
Eligibles, recipients, by age
Payments

	FY '81	FY '82	FY '83
TOTAL ELIGIBLES FOR EPSOT PROGRAM	190,285	180,721	173,319
Age:			
0-5	65,766	62,606	63,190
6-20	124,519	118,115	110,129
RECIPIENTS OF SCREENING	37,811	35,131	33,915
Age:			
0-5	15,316	14,664	14,638
6-20	22,495	20,467	19,277
TOTAL PAYMENT FOR SCREENINGS	$928,853	$842,524	$924,898
AVERAGE PAYMENT FOR A SCREENING	$24.57	$23.98	$27.27

partment of Pensions and Security has made a tremendous contribution to the program through outreach program, person-to-person contacts, provision of social services, and help with follow-up of referrals that help assure that eligibles who need care receive it.

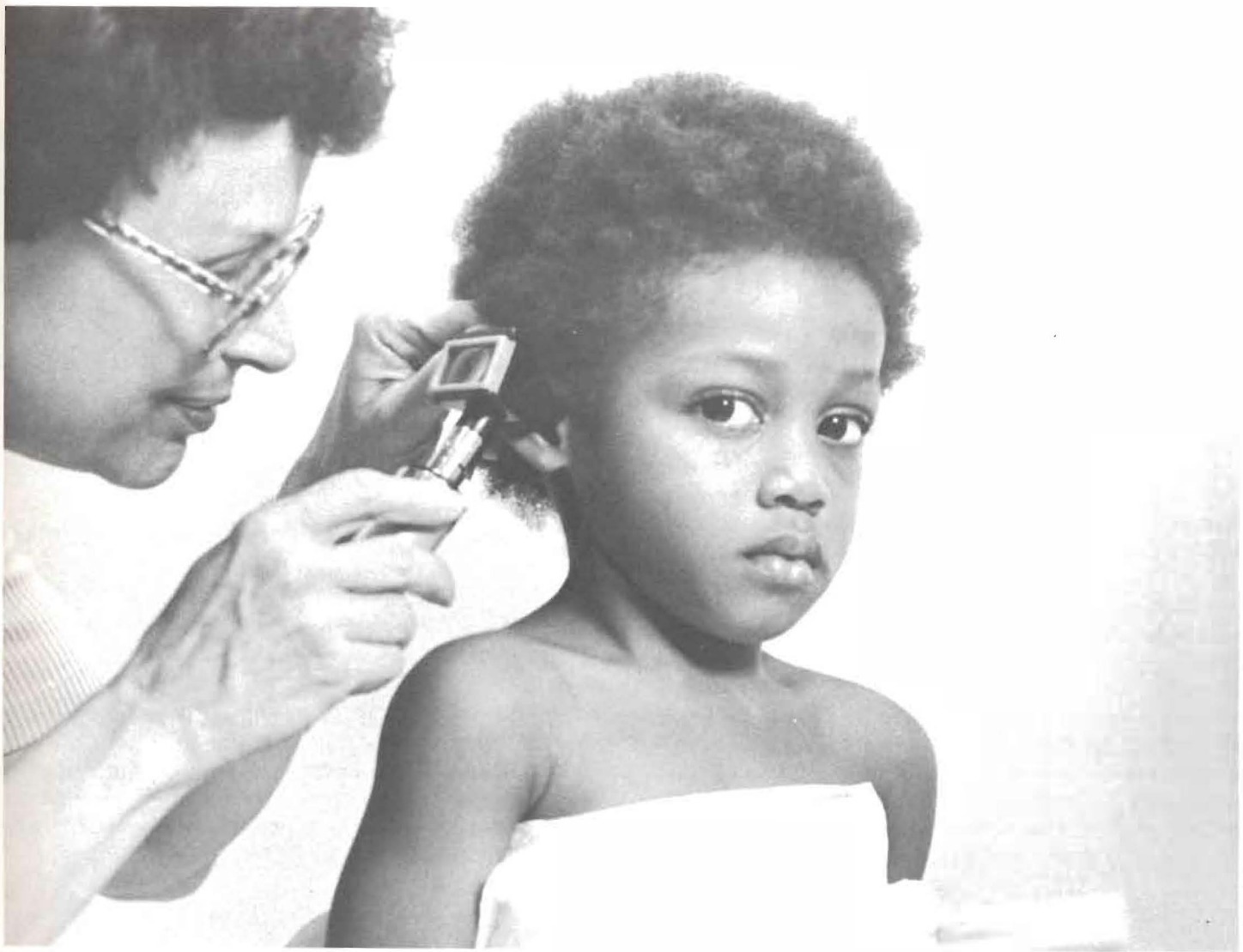
For the past 12 years, the number of EPSDT eligibles has remained constant at about 175,000. A Medicaid goal is to screen eligibles at eight intervals between birth and age 21. During FY'83, about two of five children screened were in the infant to age five group. The rest were in the 6-20 group. Problems discovered and treated included hypertension, rheumatic fever, other heart conditions, diabetes, neurological disorders, venereal disease, skin problem, anemia, urinary infections, vision and hearing problems, and child abuse.

The cost of screening is relatively small—an average of $27.27 per screening. The cost of treating illness is usually considerably higher. Payments for screenings in FY'83 rose by 10 percent over the previous year. During FY'83, a total of 33,915 screenings were performed. This is a decrease of 3 percent compared to FY'82. About 80 percent of screenings resulted in referrals to physicians due to uncovered or suspected medical conditions.

Medicaid Dental Program is provided as part of the EPSDT program. With some exceptions, dental care is available only to EPSDT eligibles who have been referred by a screening agency. These include emergencies, institutionalized eligibles under a physician's care, or eligibles who have a definite health care plan in a program such as Crippled Children's Service.

All Medicaid dental services are provided by licensed dentists. These services are limited to those which are customarily available to most persons in the community. Examples of dental services not covered by Medicaid include surgical periodontal, orthodontic, and most prosthetic treatment. If justified by the attending dentist, some services may be prior authorized by the Medicaid Agency. These services may include non-surgical periodontal treatment, third and subsequent space maintainers, general anesthesia, hospitalization, and some out-of-state care.

During FY'83, about 82,589 claims were paid to dental providers at an approximate cost of $5.1 million.



OPTOMETRIC PROGRAM

In FY'83 expenditures for optometric services and eyeglasses totalled $1.9 million.

The Optometric Program of Alabama Medicaid was established in 1974, with eye examinations provided by ophthalmologists and optometrists licensed to practice in the state that the service is rendered. If eyeglasses are prescribed, recipients who are twenty-one years old or older are authorized one pair each two calendar years and recipients who are under twenty-one years of age are authorized one pair each calendar year. The same limitation applies to fitting and adjusting of the eyeglasses. Medicaid does not replace eyeglasses due to loss or breakage.

Medicaid's eyeglasses are provided through bulk purchase. It is the only bulk program provided by Alabama Medicaid. Purchase of lenses and frames are done through competitive bidding, and a contract awarded the lowest bidder for one year. It has been highly successful on a financial level as the average price per pair of eyeglasses furnished during the recently expired contract period (July 1, 1982 - June 30, 1983) was approximately $15.42, and the average price per pair over the past five years has been $14.96.

In addition to eyeglasses, contact lenses may be provided following cataract surgery or for Keratoconus treatment, when prior authorized by Medicaid.

During FY'83, 34,052 claims were paid to providers for optometric eye care services, at an approximate cost of $1.4 million. During the same period, 41,494 claims were paid to providers for eyeglass service, at an approximate cost of $500 thousand.

LABORATORY AND RADIOLOGY PROGRAM

In FY'83 the Lab and X-Ray Program served over 100,000 recipients at a cost of $6.7 million.

The Laboratory and Radiology Program has been an ancillary part of the Physicians Program and the Hospital Program, but effective May 4, 1983, the Laboratory and Radiology Program became a separate unit.

Medically necessary lab and radiology services are available to Medicaid recipients when recommended by physicians or dentists as part of the diagnosis and treatment of recipients. Because lab and radiology services are ancillary parts of other programs, Medicaid will not pay for them if other services are not available to recipients. For instance, if a recipient's hospital days and physicians visits are exhausted for the year, the recipient can no longer receive lab or radiology services.

The Alabama Medicaid Agency recognizes the following types of laboratory and radiology facilities:

— independent laboratories

— laboratory and x-ray facilities in a physician's office

— private laboratory and x-ray facilities owned and operated by a group of physicians exclusively for their own use

— hospital-based laboratory and x-ray facilities

Independent labs and independent commercial x-ray facilities must enter into contracts with the Alabama Medicaid Agency. Other laboratory and radiology providers must be approved by the appropriate licensing agency, with each submitted claim serving as a provider contract.

Appendix

TERMINOLOGY

MEDICAID and MEDICARE

Medicaid and Medicare are two governmental programs which exist to pay for health care for two different, but overlapping, groups of Americans.

Medicaid buys medical care for several low-income groups, including people of all ages.

Medicare buys medical care for most aged people as well as some disabled people. Many aged people who have low incomes are eligible for both and can get both a Medicaid card and a Medicare card. For these people Medicare pays most of their medical bills, and the balance, or most of it, is paid by Medicaid.

Medicaid is administered by the state governments, and thus there is not one Medicaid program, but 54 (Puerto Rico, Guam, the Virgin Islands, and Washington, D.C., run the total to 54). All 54 programs are different.

Medicare is administered by the federal government and the coverage provided is uniform throughout the nation.

ELIGIBLES and RECIPIENTS

Eligibles, in this report are people who have Medicaid cards and thus are eligible for health care service paid for by Medicaid.

Recipients, in this report are people who used their Medicaid eligibility this year, and actually received one or more medical services for which Medicaid paid all or part of the bill.

PROVIDERS

All physicians, dentists, hospitals, nursing homes, and other individuals or businesses that provide medical care are called providers.

CATEGORY

In normal usage the word "category" is used interchangeably with "kind" or "type". In Medicaid's usage, "Category" has a special meaning. In Medicaid there are eight major bases for eligibility, and the eligibles in each of the resulting groups form a "Category" with a capital C. In this book when eligibles are grouped by age, race, or sex, the divisions that result are spoken of as different groups of eligibles or different kinds of eligibles but never as different Categories. The eight major Categories are:

Category 1 — aged people with low incomes.
Category 2 — blind people with low incomes.
Category 3 — low-income families with dependent children.
Category 4 — disabled people with low incomes.
Category 5 — Cuban-Haitian entrants.
Category 6 — refugees with low incomes.
Category 7 — dependent children in foster care.
Category 8 — other children in foster care.

PAYMENTS, CHARGES EXPENDITURES, PRICES, and COST

A **charge** is the amount of money the provider asks for a service when he submits his bill to Medicaid.

A **payment** is the amount Medicaid pays for a service. Medicaid rules limit payments, so sometimes a provider cannot be paid as much as he asks.

Price, in this report, means "average unit price" or the average price Medicaid paid this year for a unit of care, such as:

1 day in a hospital	$236.23
1 day of skilled nursing care	26.49
1 physician service	17.78
1 prescription	9.83

Cost, in this report, means "average cost per person." Examples of different contexts in which this term is used include:

average cost per eligible for hospital care per month
average cost per recipient for hospital care per month
average cost per eligible for prescriptions per year.

Expenditures, in this report, is a more inclusive term than payments. Payments, as stated above, means the amount paid for medical care. The term expenditure also includes money spent for administration.

HEALTH CARE SERVICES

Medicaid pays for the following health care services:

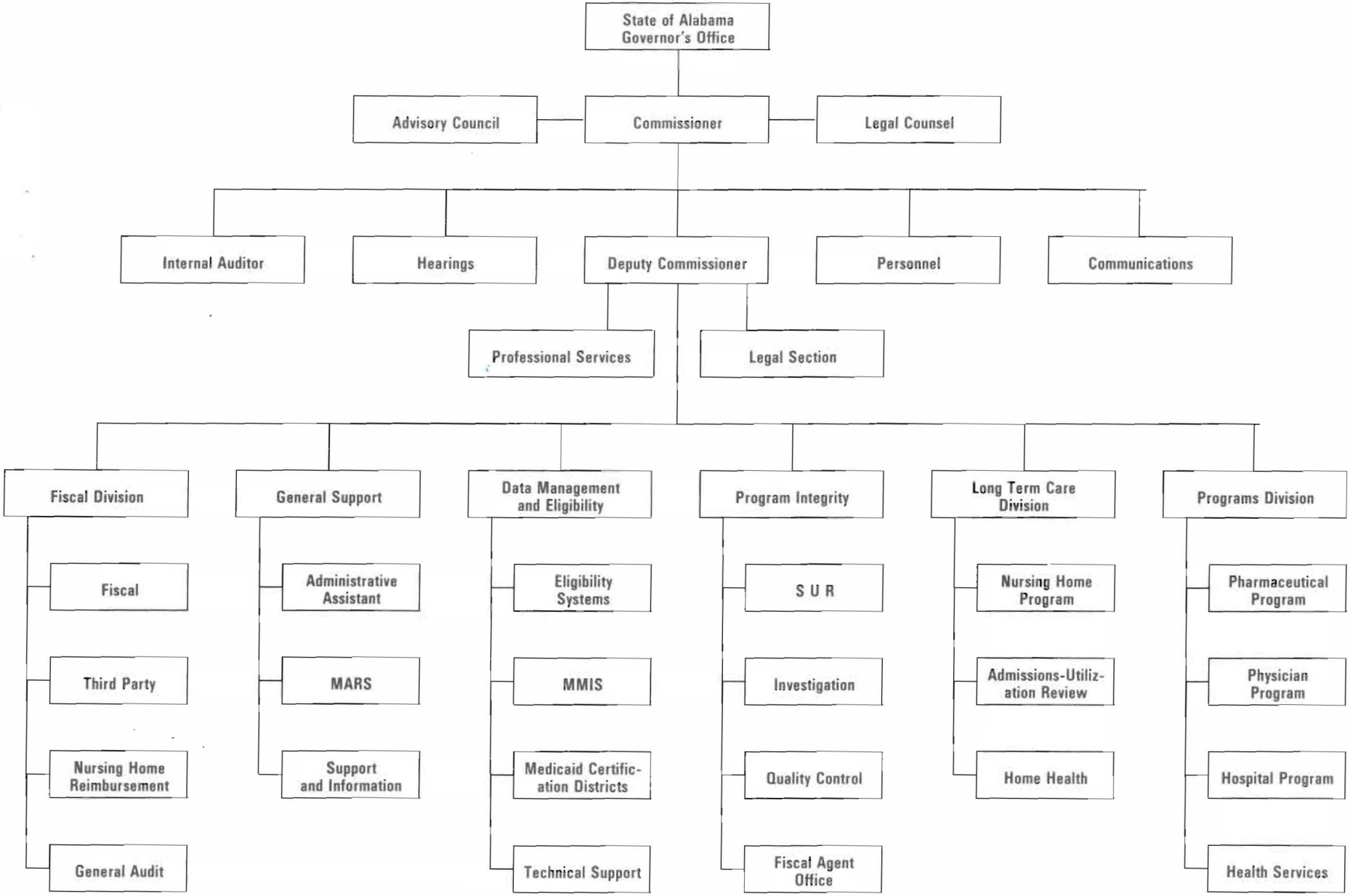
nursing home care,
physicians' services,
eye care, including glasses,
drugs,
family planning services,
home health care,
screening and referral services (EPSDT),
hospital care,
dental services,
hearing care, including hearing aids,
laboratory work and X-rays,
transportation required for medical purposes.

BUY-IN INSURANCE

Many Medicaid eligibles are also eligible for Medicare. As Medicare eligibles they get Medicare hospital insurance without payment. Medicare insurance to cover physicians' bills, however, must be paid for. It costs $14.60 a month. Medicaid buys this insurance for all Medicaid eligibles whose applications are approved by Social Security. Medicaid calls this insurance "buy-in insurance."

MEDICARE CROSSOVER PAYMENTS

Medicare crossover payments are the payments of deductibles and co-insurance charges made by the Alabama Medicaid Agency for those recipients who have both Medicare and Medicaid. These amounts would otherwise be the responsibility of the patient if he were not eligible for Medicaid.



APPROVED Jay D. Baggiano

DATE October 1, 1983