Alabama Medicaid Agency

Twelfth Annual Report

October 1, 1983 - September 30, 1984

George C. Wallace, Governor
State of Alabama

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Alabama Medicaid Agency

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GEORGE C. WALLACE
Governor

FAYE S. BAGGIANO
Commissioner

April 16, 1985

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

Dear Governor Wallace:

It is with pleasure and pride that we submit to you the Twelfth Annual Report of the Alabama Medicaid Agency. Covered in the report are highlights and achievements of the fiscal year that ended September 30, 1984.

Alabama's Medicaid program is one of the most efficiently operated in the nation. The program assures the best possible health care for low income Alabamians at the least possible cost to the taxpayers. In addition, Medicaid provides social services that prevent costly institutionalization for many of the state's mentally retarded citizens and for elderly and disabled people who prefer to remain in their own homes. More than 400,000 people benefit from assistance offered by Medicaid in Alabama.

Your work as Governor has contributed significantly to the success of the state's Medicaid program. Also deserving of credit are members of the Alabama Legislature, a staff of dedicated employees and thousands of service providers. In Alabama, we will continue to administer a Medicaid program that is fiscally sound and that maintains the highest standards of service to people.

Sincerely,

Faye S. Baggiano
Commissioner

FSB:jsd

ALABAMA MEDICAID

FISCAL YEAR 1984

Mike Gibson
Editor

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ALABAMA MEDICAID AGENCY

MONTGOMERY, ALABAMA

Faye S. Baggiano, Commissioner

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HIGHLIGHTS OF THE 1984 FISCAL YEAR

• According to a report released by the National Conference of State Human Services Finance Officers in September 1984, **Alabama spends less on Medicaid administrative costs than any state in the nation.** This finding was based on the average cost of administering Medicaid to one person for one month. Alabama's cost was $2.55, which was less than half the national average of $5.37. In a number of studies conducted during recent years, **Alabama's program has consistently ranked among the most efficient in terms of administrative cost.**

• In December 1984, the State Examiners of Public Accounts released the results of an audit of the Medicaid Agency covering FY'81 and FY'82. The audit, conducted for the U.S. Department of Health and Human Services, revealed that the agency had spent nearly **$1 billion during the two-year period and that every penny was properly accounted for.**

• The Agency's efforts to **reduce errors in eligibility determinations paid off** during FY'84. The maximum payment error rate acceptable by the federal government is three percent. States that exceed this error rate are liable for financial penalties. Alabama's error rate for the latest reporting period was only 2.7 percent.

• A program that started in March 1984, **which extends hospital days**, is helping to ease the financial burden of hospitals that treat children with illnesses of long duration. Medicaid patients are normally eligible for a maximum of 12 hospital days a year. If Medicaid patients under 21 years of age exhaust their 12 days and then spend another 30 continuous days in the hospital, they are eligible for an additional 12 Medicaid-paid days. This cycle can be repeated throughout the year.

• The Medicaid Agency was officially notified on October 1, 1984 that the **federal spending cap had been lifted**, but unofficial word of the good news had been received months earlier. The ceiling on spending was instated three years ago by the federal government. States that exceeded the cap were liable for a financial penalty of up to a 4.5 percent reduction in their federal funding ratio. Alabama stayed beneath the cap all three years, primarily by delaying until October the provider payments normally due in September.

• In June 1984, the **Medicaid Task Force on Preventive Medicine** held its organizational meeting. The 20-member group is composed of private practitioners, educators, and members of both public and private organizations. Its purpose is to help the State of Alabama improve its preventive health care efforts, and the group is expected to make recommendations early in the 1985 calendar year. An anticipated by-product of the group's work is improved coordination among all health care organizations in the state.

• In May 1984, the Alabama Legislature approved a **$101 million appropriation** from the State General Fund for Medicaid in FY'85. This appropriation is $6 million more than the previous fiscal year's.

• **The Division of Community Alternative Services** was created in April 1984, to enhance the agency's waivered services activities. With federal approval, the Medicaid Agency can obtain waivers to federal rules in order to spend Medicaid funds for services other than medical care. These services are usually more appropriate and less expensive, and can allow patients to remain at home rather than be treated in institutions. Through a waiver, the Medicaid program provided community-based services to 1,485 mental health patients in FY'84. The cost to the state was $5 million. If these patients had been treated in state mental institutions, **the cost to the state would have been $60 million.** Another waiver received federal approval in December 1984. This waiver will provide social services to help the elderly and disabled stay in their own homes rather than in institutions.

• In August 1984, the agency hired the first auditors of what will be a **new hospital audit unit**. Currently, both Medicare and Medicaid hospital reimbursement rates are based on yearly cost reports submitted by hospitals to Medicare. Beginning with the 1985 calendar year, Medicaid will be using its own cost reports, which will be audited by this unit.

• In a move to reduce costs and consolidate administrative functions, the Medicaid agency's **Selma District Office** was closed in September 1984, and the **Dadeville District Office** was closed in January 1985.

• At least two significant highlights are expected for FY'85. During the latter part of the year, Medicaid will require **copayments** from some recipients for several services. Currently, copayments are required only on prescription drugs. In addition, the Medicaid program will **expand coverage** to new categories of eligibles, to include certain children in two-parent households and c[illegible] pregnant women.

ALABAMA'S MEDICAID PROGRAM

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.

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.

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 seven 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 7,000 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 number of people.

Expenditures — For the 1984 fiscal year, the Medicaid budget was almost $400 million. Over $60 million of this budget was spent for Mental Health programs.

MEDICAID'S IMPACT

Since its implementation in 1970, Alabama's Medicaid program has had a significant impact on the overall quality of health care in the state. Medicaid has given hundreds of thousands of citizens access to quality health care which they could not otherwise afford.

The effect of this access to care is difficult to assess, but there are some indications of the program's effectiveness. When Medicaid started in 1970, the state's infant mortality rate was 24.1 per 1,000 births. Many of these deaths could be traced to mothers who could not afford competent prenatal care. Since 1970, the infant death rate has shown a general decrease. In 1983, the death rate was 13.1 per 1,000. This is actually up slightly from the record low of 12.9 in 1981, and the rate took significant jumps in 1980 and 1982, but the overall trend is consistently downward. Besides access to health care, other factors such as nutrition programs and medical advances have certainly contributed to this improvement, but Medicaid has proven itself to be essential to the good health of thousands of Alabamians.

Medicaid is also important to citizens who are not eligible for the program. Health care is one of the state's most important industries, and Medicaid is vital to that industry. During FY'84, $381 million was spent by Medicaid in Alabama. The state paid only $106 million of the total expenditures, while the federal government provided $275 million, or about three-quarters of the total.

According to a national review conducted during FY'84, Alabama's Medicaid program has the lowest administrative cost per eligible of any program in the nation. Therefore, nearly all of the $381 million expenditure went toward the care and treatment of Medicaid patients. Medicaid funds are paid directly to the 7,000 providers who treat Medicaid patients. These providers include physicians, dentists, pharmacists, hospitals, nursing homes, and medical equipment suppliers all over the state. These funds paid the salaries of thousands of workers, who bought goods and services from thousands more. Using the common economic multiplier effect of three, Medicaid expenditures generated more than $1.2 billion worth of business in the state during FY'84.

Medicaid funds make it possible for citizens to receive quality health care even in rural or economically depressed areas of the state. For instance, Medicaid revenues can allow a physician to practice in an area that might be economically marginal if he had to depend solely on his patients' ability to pay.

Providing quality health care to Medicaid eligibles is important, but the program must also be fiscally responsible. The state's financial resources are not inexhaustible. Because of this, Alabama's Medicaid program is less elaborate than most states'. The philosophy of the Alabama Medicaid Agency is to provide services that will do the most good for the greatest number of people.

FY '84 — PLATE 1

COUNTY IMPACT

Year's cost per eligible

County	Benefit Payments	Eligibles	Payments Per Eligible
Autauga	$2,029,777	2,893	$702
Baldwin	4,407,311	4,916	897
Barbour	3,522,101	3,990	883
Bibb	1,553,109	1,529	1,016
Blount	2,013,026	2,283	882
Bullock	1,816,675	2,675	679
Butler	2,935,064	3,654	803
Calhoun	8,626,809	9,707	889
Chambers	3,653,708	4,512	810
Cherokee	1,116,593	1,379	810
Chilton	2,140,119	2,517	850
Choctaw	1,810,167	2,871	631
Clarke	2,956,863	4,514	655
Clay	1,408,749	1,265	1,114
Cleburne	852,816	1,020	836
Coffee	3,122,287	3,163	987
Colbert	3,638,493	3,520	1,034
Conecuh	1,403,307	2,143	655
Coosa	708,092	1,028	689
Covington	3,715,208	3,466	1,072
Crenshaw	2,370,821	2,052	1,155
Cullman	5,145,793	4,279	1,203
Dale	3,227,453	3,096	1,042
Dallas	6,181,623	11,212	551
DeKalb	5,129,068	4,671	1,098
Elmore	7,887,141	3,719	2,121
Escambia	3,118,337	3,617	862
Etowah	8,849,220	8,115	1,090
Fayette	1,508,980	1,752	861
Franklin	3,486,491	2,954	1,180
Geneva	2,223,030	2,784	799
Greene	1,383,296	3,207	431
Hale	2,112,025	3,334	633
Henry	1,369,352	1,891	724
Houston	4,321,553	6,299	686
Jackson	3,285,372	4,068	808
Jefferson	48,325,013	59,250	816
Lamar	1,833,215	1,552	1,181
Lauderdale	5,083,855	5,007	1,015
Lawrence	2,620,107	2,926	895
Lee	3,516,709	5,436	647
Limestone	3,062,347	3,580	855
Lowndes	1,545,416	3,339	463
Macon	4,153,693	5,198	799
Madison	7,941,592	12,433	639
Marengo	3,002,691	4,294	699
Marion	3,039,697	2,439	1,246
Marshall	6,186,956	5,646	1,096
Mobile	34,992,059	41,638	840
Monroe	1,993,226	2,938	679
Montgomery	17,708,476	21,197	835
Morgan	18,280,412	7,196	2,540
Perry	2,323,825	3,535	657
Pickens	3,575,341	4,263	839
Pike	3,193,226	4,396	726
Randolph	2,354,579	2,238	1,052
Russell	3,820,958	4,967	769
Shelby	2,851,452	2,926	975
St. Clair	2,811,477	2,774	1,014
Sumter	3,069,490	3,755	817
Talladega	6,805,488	9,904	687
Tallapoosa	5,585,323	3,757	1,487
Tuscaloosa	38,460,910	14,368	2,677
Walker	6,747,803	5,881	1,147
Washington	1,744,589	2,568	679
Wilcox	2,210,927	4,278	517
Winston	2,443,362	1,605	1,522

MEDICAID MANAGEMENT INFORMATION SYSTEM

The agency's Medicaid Management Information System (MMIS) keeps track of program expenditures, provider and recipient records, and provides reports that allow Medicaid administrators to monitor the pulse of the program. The MMIS system is divided into six subsystems.

Recipient Subsystem: This subsystem maintains records of eligibles, to include eligibility updates, and the monitoring of third party payment resources and Medicare Part B buy-ins.

Provider Subsystems: This subsystem maintains provider enrollment records.

Claims Processing: This subsystem keeps track of all claims processing from the submission of claims to payment. The process maintains an audit trail and ensures that claims are paid promptly and correctly to properly enrolled providers.

Reference File: This subsystem keeps up with pricing information based on procedure and diagnosis and provides information on claims in suspense.

Management and Administrative Reporting: This subsystem provides a variety of reports that help agency management with planning and developing policy, and preparing federal reports.

Surveillance and Utilization Review (SUR): This subsystem monitors utilization patterns of Medicaid providers and recipients and helps uncover suspected fraud and abuse.

Many of Medicaid's computer functions are done under contract by the agency's fiscal agent, Alacaid. The firm successfully bid for the contract which began in October 1982 and will end in September 1985. Alacaid's performance in claims processing has been among the best in the nation. In FY'84 Alacaid processed 6,529,933 claims in an average time of 3.63 days. The fiscal agent runs about 600 state-owned computer programs in support of MMIS. Medicaid agency employees operate a system that contains more than 1,400 computer programs.

MMIS is a dynamic system that requires constant development and modification to keep pace with changing regulations and medical and computer technology. An important change in FY'84 was the addition of the IBM System 38 computer. This state-of-the-art, user-friendly system has made data processing more accessible to employees who have no extensive computer training.

As in past years, MMIS excelled in the FY'84 federal Systems Performance Review (SPR). Alabama's MMIS received a SPR score of 777, which included 31 bonus points. Federal standards allow a minimum score of 644. Because of this good SPR performance, Alabama gets a federal MMIS match of 75 percent rather than the minimum of 50 percent.

FY '82-'84 PLATE 2
MEDICAID SOFTWARE ACTIVITY

	CY '82	CY '83	CY '84
Number of Programs in production at year end	952	1,205	1,406
Number of Requests received for Software support	851	886	1,528
Number of Requests Completed	696	757	979

PROGRAM INTEGRITY

The purpose of the Program Integrity Division is to minimize fraud, abuse, and waste in the Medicaid program. Increasing emphasis has been placed on program integrity in recent years. This has resulted in an efficient program where every dollar possible goes to providers who render competent, medically necessary care to bona fide eligibles in need of treatment.

The subunits of the Program Integrity Division are Quality Control, Systems Audit, and Surveillance and Utilization Review (SUR). It is Quality Control's job to monitor the agency's eligibility determination accuracy. The Systems Audit Unit checks provider claims to make sure that the correct amount is paid for medical services and that persons who receive services are in fact eligible for Medicaid. SUR is the unit that looks for fraud and abuse in the program, and the unit's primary tool is the computer. Computer programs are used to find unusual patterns of utilization on the part of both providers and recipients. When unusual patterns are found, they are analyzed manually. If aberrations cannot be justified, they may be referred to the Utilization Review Committee (URC), which is composed of a physician and financial experts. The URC may take several types of action, including written warnings and administrative sanctions such as restrictions or terminations from the program and recoupment of funds. Cases of recipient fraud may be referred to local district attorneys for possible criminal prosecution. Suspected provider fraud cases are referred to the Alabama Attorney General's Medicaid Fraud Unit for further investigation and possible prosecution.

Although Eligibility Recoupment is not a unit of the Program Integrity Division, the unit's function is similar to units in that division. Eligibility Recoupment recovers funds from individuals who received Medicaid services but were not in fact eligible for the program. Normally these cases involve nursing home patients who have inaccurately reported their income or assets.

The total amount of diverted funds or Medicaid funds that would have been paid erroneously if irregularities had not been discovered by Program Integrity was $2,341,403 in FY'84.

During the year, complete integrity reviews were conducted on 632 providers and 688 recipients because of possible fraud or abuse. Fifty-six suspected provider fraud cases were referred to the Attorney General's Medicaid Fraud Unit for prosecution. Forty-one cases of suspected recipient fraud were referred to local district attorneys for prosecution.

Among the administrative sanctions used to control the abuse of Medicaid was the lock-in program. During the year, 100 recipients were restricted to specific providers. The majority of these recipients were suspected of overutilizing prescription drugs. Imputed savings from locked-in recipients totaled almost $48,000 FY'84.

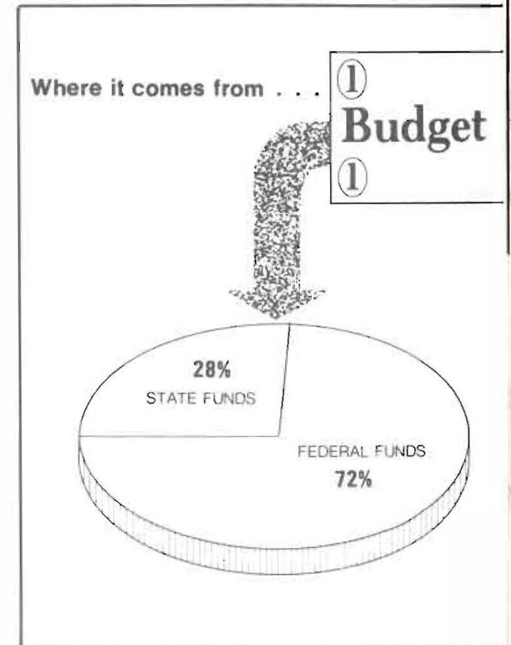
The Medicaid Agency installed a toll-free fraud hotline in March, 1985.

PROGRAM INTEGRITY — PLATE 3

FRAUD and ABUSE REVIEWS Completed in FY '84

Providers Investigated	Referred To Attorney General	Recoupments Identified	Providers Terminated From The Medicaid Program
632	56	$171,757	3
Recipients Investigated	**Referred To District Attorneys**	**Recoupments Identified**	**Recipients Terminated From The Medicaid Program**
688	41	$140,174	131

REVENUE, EXPENDITURES AND PRICES



FY '84 **Sources of Medicaid Revenue**	PLATE 5
Federal funds	$274,835,934
State funds	106,307,903
Total revenue	$381,143,837

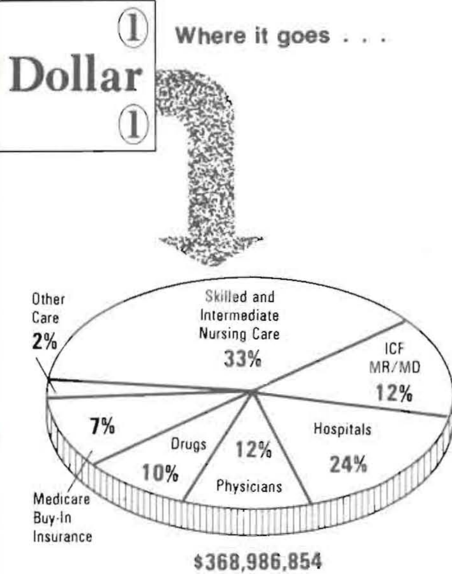
FY '84 **Components of Federal Funds**	PLATE 6
(net)	**Dollars**
Family planning administration	$ 379,701
Professional staff costs	6,661,776
Other staff costs	1,356,995
Other provider services	261,440,736
Family planning services	4,996,726
TOTAL	$274,835,934

FY '84 **Components of State Funds**	PLATE 7
	Dollars
Encumbered balance forward	$ 14,244,922
Basic appropriations	95,819,133
Supplemental appropriations	0
Pensions & Security/Mental Health	15,765,246
Interest incomme from fiscal intermediary	448,527
Miscellaneous receipts	0
	$126,277,828
Encumbered/escrowed	19,969,925
TOTAL	$106,307,903

FY '84 PLATE 8

BENEFIT COST BY FISCAL YEAR IN WHICH OBLIGATION WAS INCURRED

	FY '82	FY '83	FY '84	FY '85 (EST.)
Nursing Homes	$117,183,569	$116,042,218	$125,448,086	$143,200,000
Hospitals	90,706,544	89,320,848	84,146,131	84,000,000
Physicians, Lab & X-Ray	52,828,538	50,652,264	44,958,701	44,100,000
Medicare Buy-In	14,989,169	15,694,900	17,818,490	21,300,000
Drugs	27,023,045	31,602,530	34,998,694	39,000,000
Health Services	10,494,470	11,990,104	12,185,301	13,150,000
Family Planning	3,971,882	4,089,398	5,253,972	4,790,000
Total Medicaid Service	317,197,217	319,392,262	324,809,375	349,540,000
% Increase	9.20	.69	1.70	7.60
Mental Health	36,079,989	47,626,226	53,990,748	63,400,000
Total Benefits	$353,277,206	$367,018,488	$378,800,123	$412,940,000



In FY'84 Medicaid paid $368,986,854 for health care services to Alabama citizens. Another $12,156,983 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 '84 **EXPENDITURES**
By type of service (net)

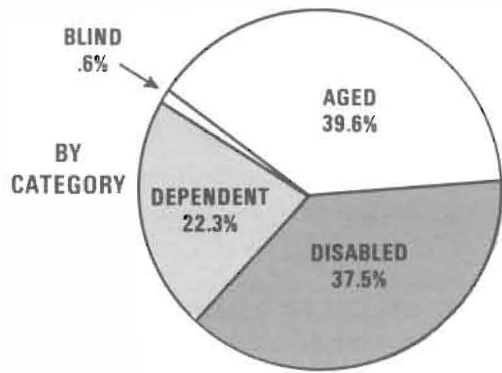
PLATE 9

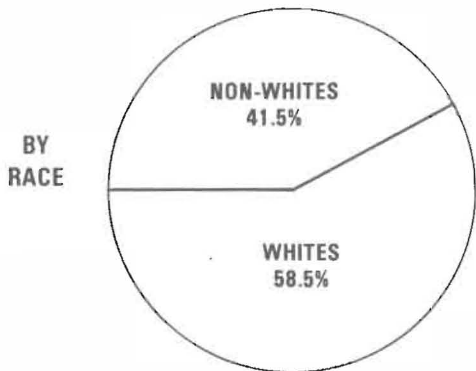
Service	Payments	Percent Of Payments by Service FY '84		Percent Of Payments By Service FY '83		Percent Of Payments By Service FY '82	
Intermediate Nursing Care	$111,769,920	30.29%	32.95%	28.92%	31.34%	29.67%	33.06%
Skilled Nursing Care	9,802,461	2.66%		2.42%		3.39%	
Hospital Inpatients	78,504,305	21.27%	23.96%	23.44%	25.82%	26.01%	28.39%
Hospital Outpatients	9,919,636	2.69%		2.38%		2.38%	
ICF-Mentally Retarded & MD	45,674,214	12.38%		14.98%		9.80%	
Physicians' Services	45,381,261	12.30%		12.77%		10.92%	
Drugs	35,234,150	9.55%		7.97%		7.70%	
Medicare Buy-In Insurance	9,062,953	2.45%		1.94%		4.58%	
Dental Services	5,086,018	1.38%		1.43%		1.44%	
Family Planning Care	5,550,882	1.50%		1.02%		1.12%	
Home Health	4,015,910	1.09%		.74%		.62%	
Waivered Services	4,535,815	1.23%		.71%		N/A	
Eye Care	2,273,456	.62%		.56%		.56%	
Lab & X-Ray	777,915	.21%		.37%		1.47%	
Screening	949,857	.26%		.23%		.23%	
Transportation	297,222	.08%		.08%		.08%	
Hearing Care	97,814	.03%		.03%		.02%	
Other Care	53,065	.01%		.01%		.01%	
Total For Medical Care	$368,986,854	100.0%		100.0%		100.0%	
Administrative Costs	12,156,983						
Net Payments	$381,143,837						

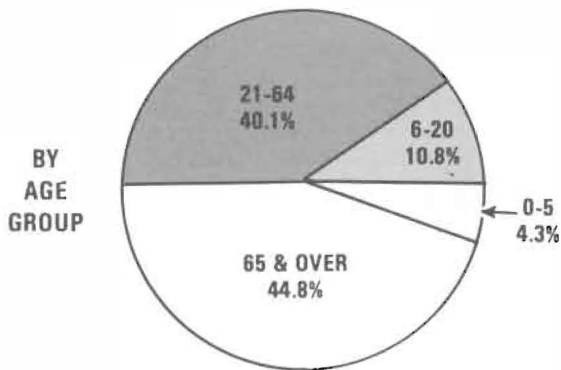
FY '84 PLATE 10

PAYMENTS

By category, sex, race, age







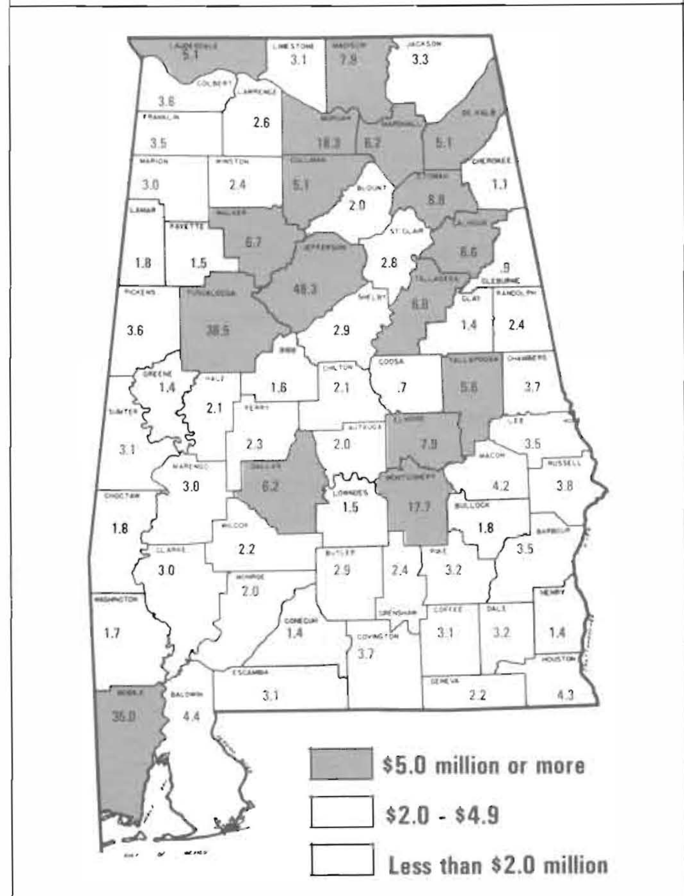
The percent distribution of payments by aid category, by sex, by race, and by age group has changed very little since last year. The majority of Medicaid payments is made to aged and disabled recipients, females, whites, and persons over 65 years of age. A reason for this is the high cost of the Long-Term Care program which accounts for almost 45 percent of Medicaid payments for services. Recipients of long-term care are typically aged or disabled white females over 65 years of age.

The amount of money Medicaid spends in each county has changed very little since last year (see Plate 11). With few exceptions the counties with or near large population centers have the largest amounts of Medicaid payments made on behalf of their residents.

FY'84 PLATE 11

PAYMENTS

By county (in millions)



PRICES

Of the many factors contributing to medical care costs, price per unit of service is highly significant. The decline in the rate of growth in the medical care component of the Consumer Price Index (see Plate 13) is reflected in the decrease in the rate of growth of expenditures in Alabama's Medicaid program during the last two fiscal years.

Plate 12 shows unit prices for selected services. In terms of dollars, the price of a hospital inpatient day rose by the greatest magnitude. When measuring increases by percent changes, prescription drug prices showed the largest increase.

The data in Plate 12 shows two apparent inconsistencies. One of these is the decline in price of a physician's procedure. The other is the difference in price between a day of skilled and intermediate care in a nursing home.

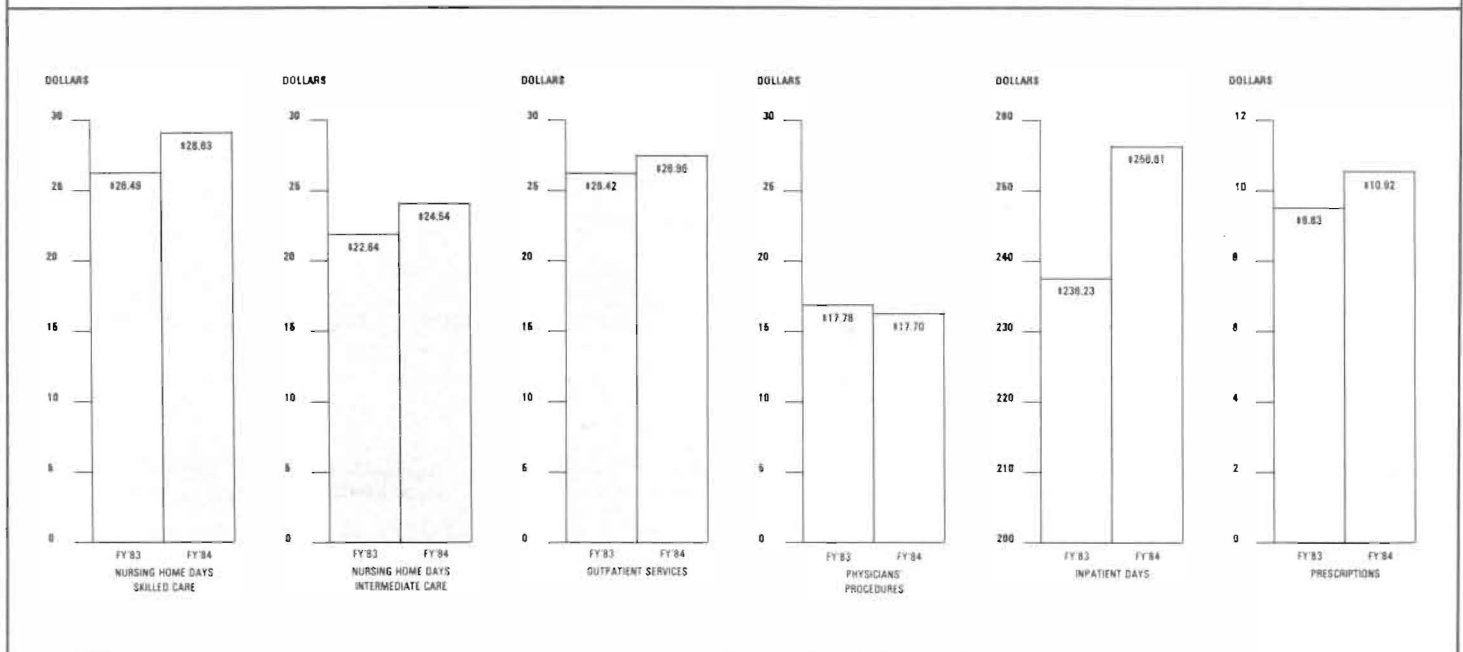
The slight decline in the price of a physician's procedure is due to the limitation of 12 visits per year. When this limitation is exceeded, only the office visit procedure code is denied. Any valid ancillary services on the claim are paid. Office visits are relatively expensive procedures while most ancillary services are relatively inexpensive. This made the average price of a unit of service decline slightly.

Although Medicaid follows a policy of paying the same price per day for skilled and intermediate care in dually-certified nursing home facilities, the average price of a day of skilled care is higher than the average price of a day of intermediate care. While the price per day within the facilities is the same for both levels of care, the rate is not identical from one nursing home to the next. When homes whose rates are below average have more intermediate than skilled beds, the statewide average for intermediate care is lower than that for skilled care.

FY'83-'84 PLATE 12

PRICES

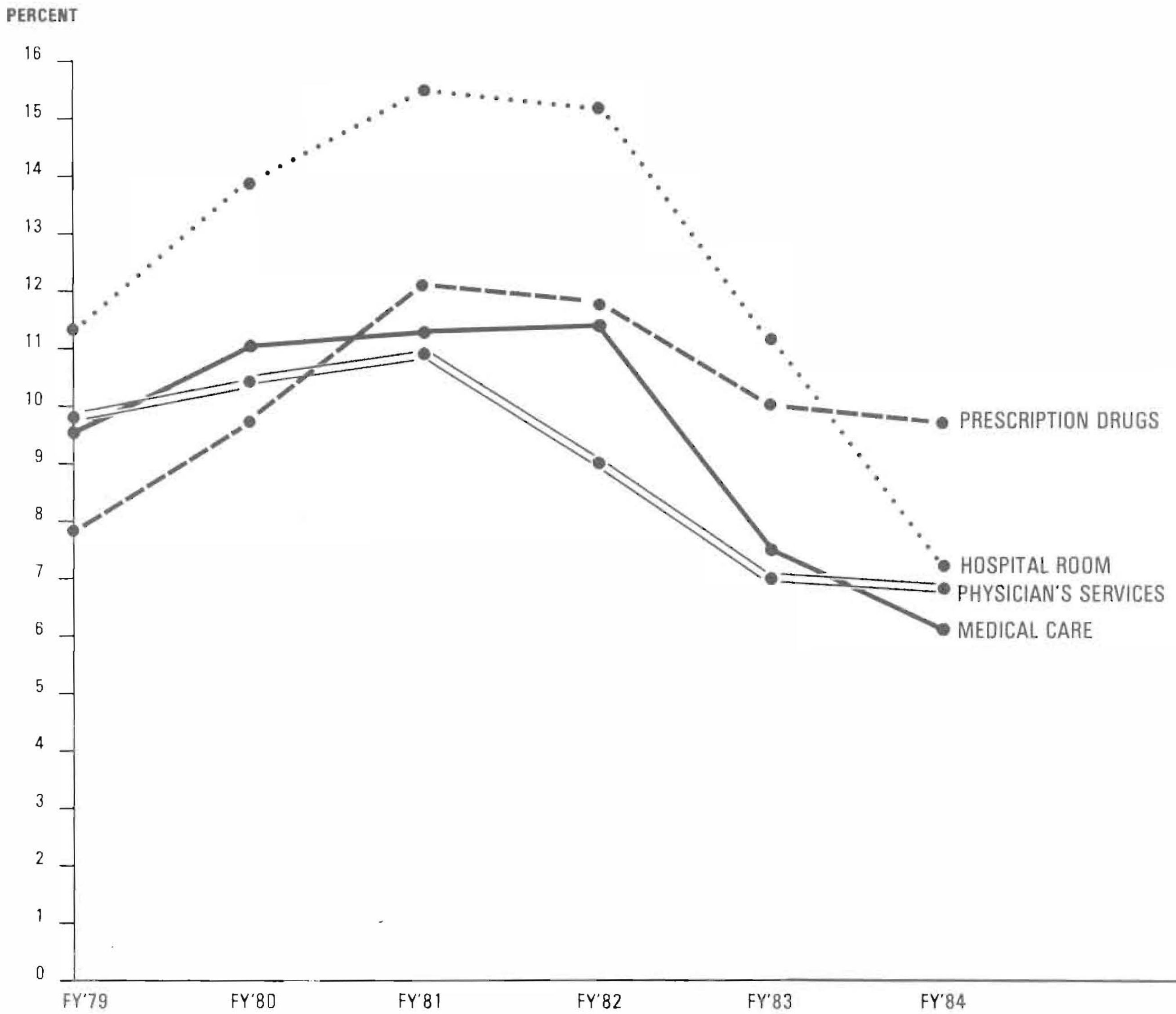
Average unit price per service



FY'79-84 PLATE 13

PERCENT CHANGES IN THE CONSUMER PRICE INDEX

For selected items



POPULATION AND ELIGIBLES

Population

The population of Alabama grew from 3,444,165 in 1970 to 3,893,000 in 1980. In 1984 Alabama's population was estimated at 4,132,400.

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 '77 - '84 Plate 14
POPULATION
Eligibles as percent of Alabama population by year

Year	Population	Total Eligibles	Percent
1977	3,690,000*	413,134	11.20
1978	3,742,000*	403,330	9.28
1979	3,769,000*	413,805	10.98
1980	3,893,888	423,031	10.86
1981	3,920,000*	409,428	10.44
1982	3,943,000*	394,905	10.01
1983	4,093,600*	383,940	10.66
1984	4,132,400**	385,379	9.33

*U. S. Bureau of Census official estimate.

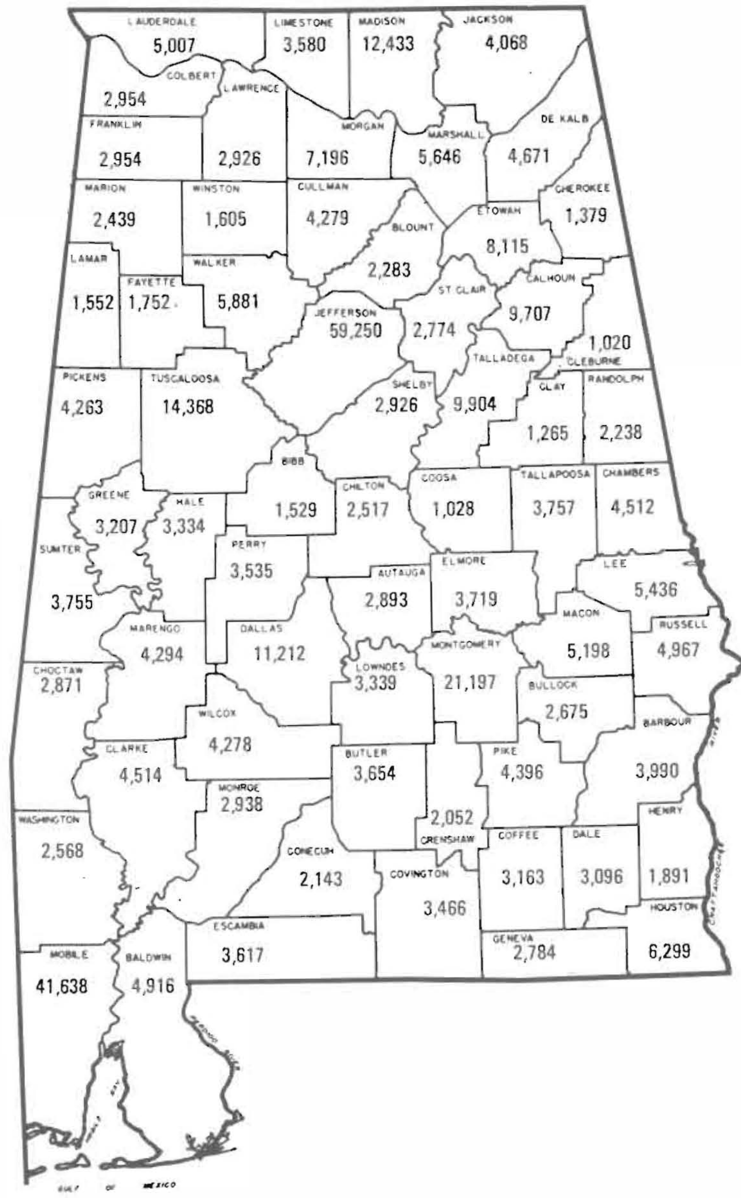
** Estimate by CENTER FOR BUSINESS AND ECONOMIC RESEARCH

FY '84 PLATE 15
POPULATION
1984 population estimates

FY '84 **PLATE 16**

ELIGIBLES

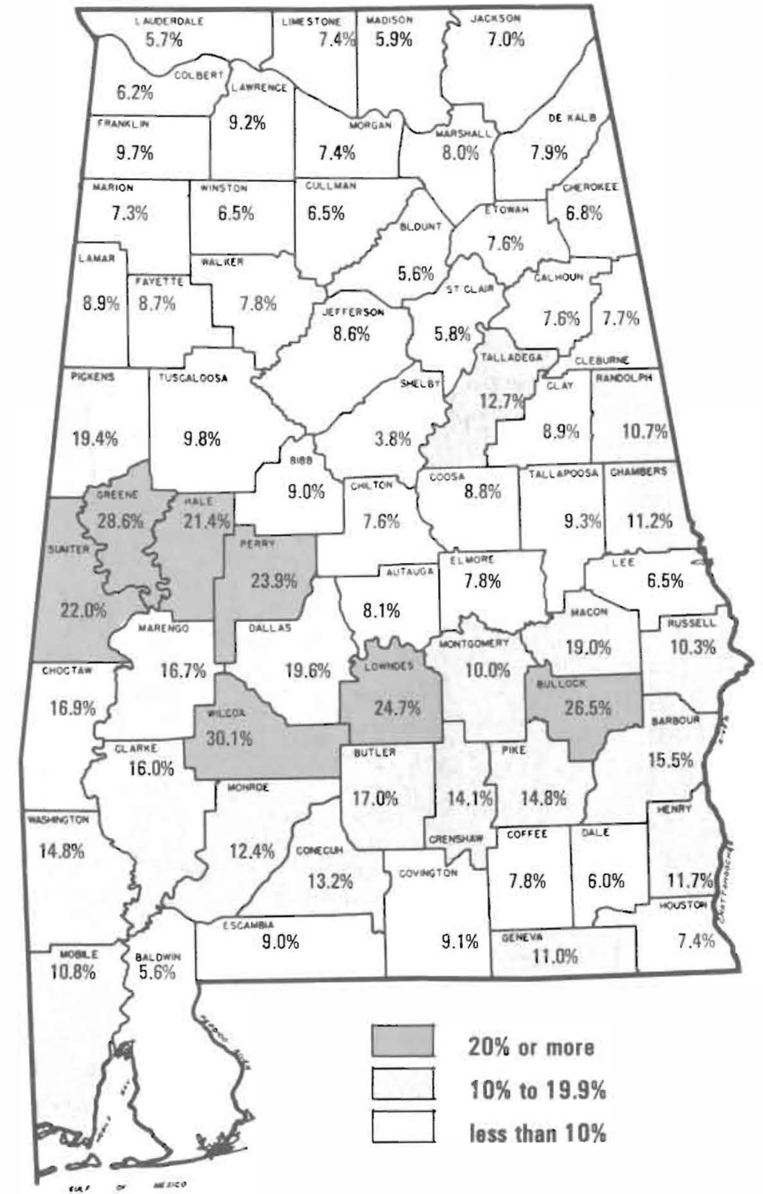
Number of Medicaid eligibles by county



FY '84 **PLATE 17**

ELIGIBLES

Percent of population eligible for Medicaid, by county



Eligibles

During FY'84 there were 385,379 persons eligible for Medicaid in at least one month of the year (see Plate 19). The average number of persons eligible for Medicaid per month was 308,689. The monthly average is the most useful measure for making comparisons between eligibles in different states and different years since it takes into account length of eligibility.

Plate 19 shows how this year's eligibles were distributed in terms of category, sex, race, and age. The average and total counts allow three important measures to be calculated for each group: the number of new eligibles added during the year, the number of old eligibles dropped during the year, and the turnover rate.

The turnover rate measures the frequency at which old eligibles are replaced by new eligibles. This year the rate is 24.8 percent for all eligibles. Each category, sex, race, and age group has a different turnover rate, as shown in Plate 19.

Although 385,379 people were eligible for Medicaid in FY'84, only about three-fourths were eligible all year. The length of eligibility ranged from one to 11 months.

A measure of total eligibility used in a year is called man-months of eligibility (MME). This measure is calculated by adding the total number of eligibles in each of the 12 months of the year to give total MME. Total MME divided the total number of eligibles for the fiscal year yields an average MME per person which is useful in determining the expected duration of eligibility. Plate 21 shows this measure for each category and group.

FY '84 PLATE 18
ELIGIBLES
Monthly Count

	Monthly Count
October '83	307,080
November	311,404
December	305,950
January '84	308,244
February	310,455
March	306,206
April	310,817
May	310,011
June	314,023
July	307,264
August	306,846
September	305,970

FY '84 PLATE 19
ELIGIBLES
By category, sex, race, age
Total number for year
Average number per month

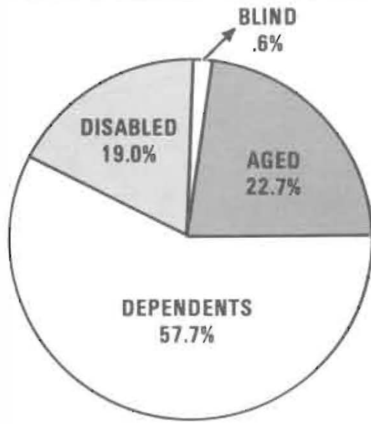
	First Month	Number Added During Year	Total Number For Year	Number Dropped During Year	Final Month	Average Number Per Month	Annual Turnover Rate
ALL CATEGORIES	307,080	78,299	385,379	79,409	305,970	308,689	24.8%
AGED	77,582	10,029	87,611	9,955	77,656	77,453	13.1%
BLIND	1,938	152	2,090	188	1,902	1,930	8.3%
DISABLED	63,075	10,123	73,198	7,873	65,325	64,270	13.9%
DEPENDENT	164,485	57,995	222,480	61,393	161,087	165,036	34.8%
MALES	104,511	28,260	132,771	29,266	103,505	104,877	26.6%
FEMALES	202,569	50,039	252,608	50,143	202,465	203,812	23.9%
WHITES	105,906	30,239	136,145	32,128	104,017	105,737	28.8%
NONWHITES	201,174	48,060	249,234	47,281	201,953	202,952	22.8%
AGE 0-5	40,408	23,089	63,497	18,133	45,364	43,535	45.9%
AGE 6-20	85,355	22,753	108,108	27,225	80,883	84,151	28.5%
AGE 21-64	86,654	22,173	108,827	22,683	86,144	87,029	25.0%
AGE 65 & Over	94,663	10,284	104,947	11,368	93,579	93,974	11.7%

FY '84 PLATE 20

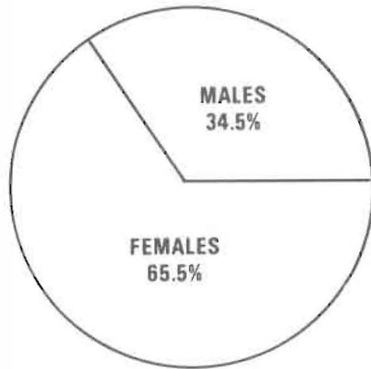
ELIGIBLES

Distribution by category, sex, race, and age

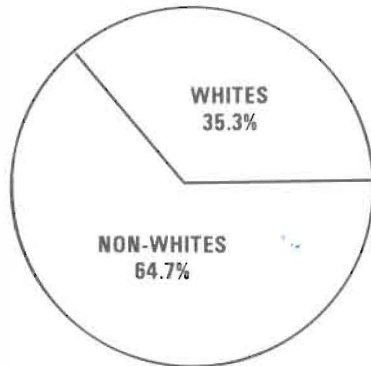
BY CATEGORY



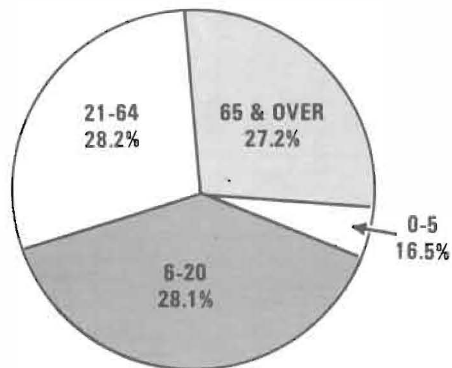
BY SEX



BY RACE



BY AGE

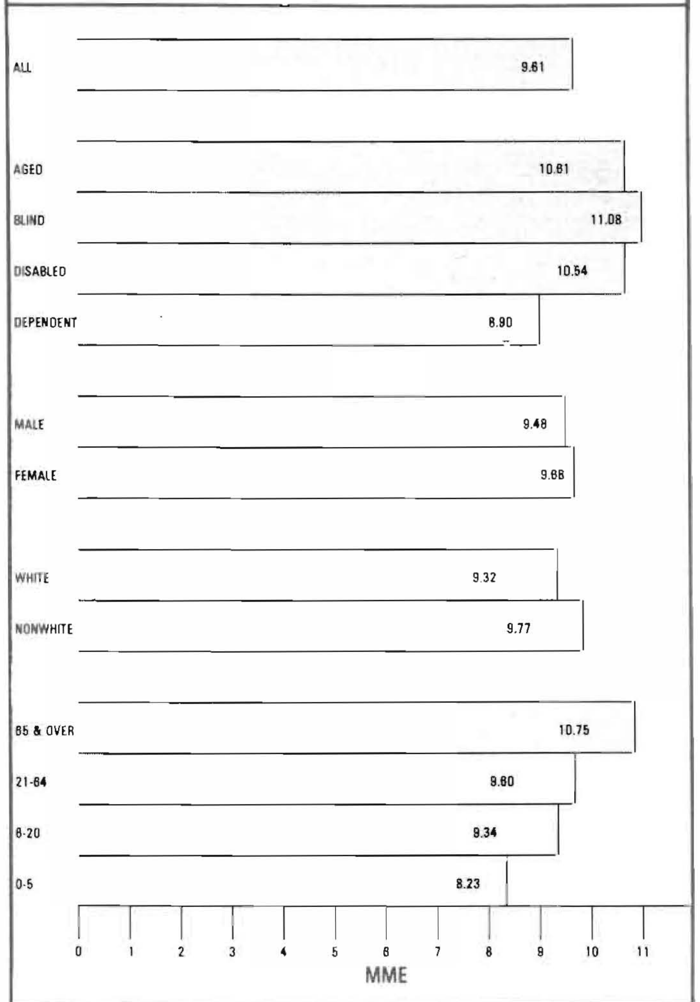


FY '84 PLATE 21

ELIGIBLES

Man-Months of Eligibility

By category, sex, race, and age

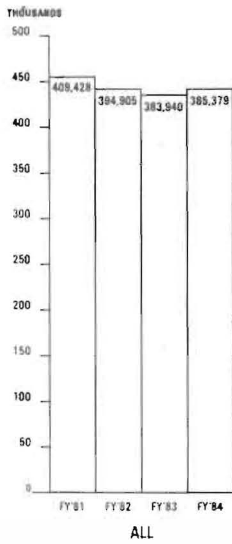


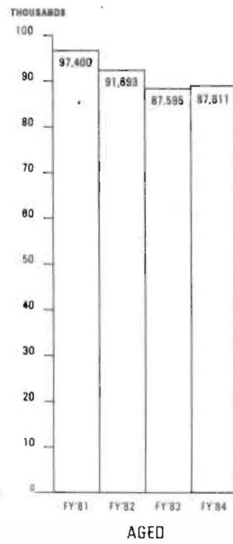
FY'81-'84 PLATE 22

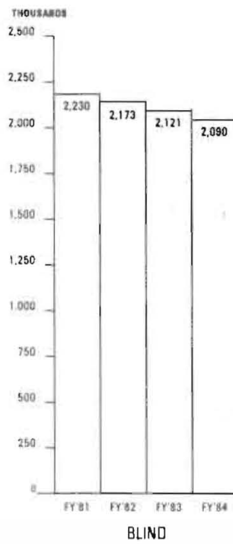
ELIGIBLES

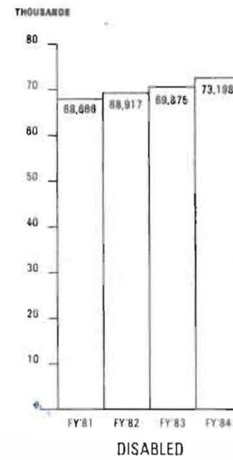
By category

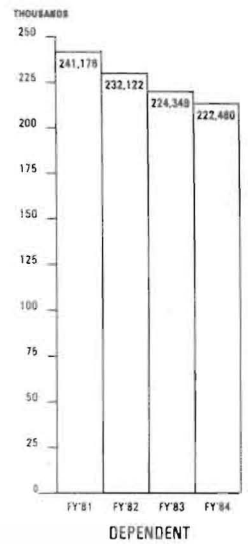
Annual Total









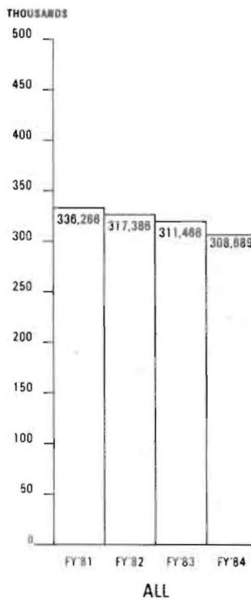


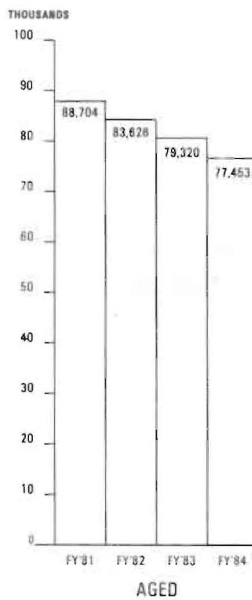
FY'81-'84 PLATE 23

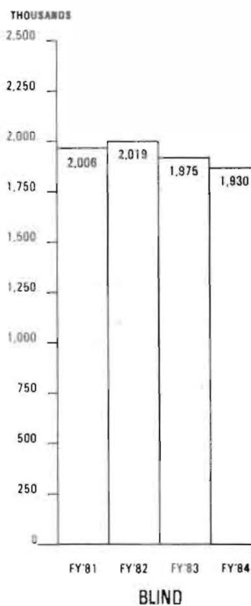
ELIGIBLES

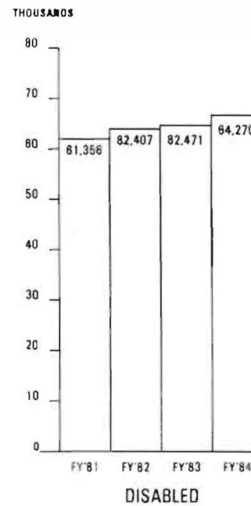
By category

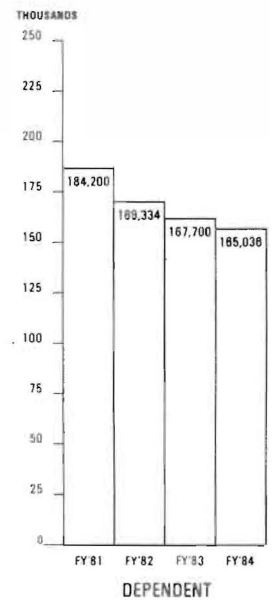
Monthly Average











RECIPIENTS

Of the 385,379 people deemed eligible for Medicaid in FY'84, only 82 percent actually received Medicaid benefits. These 315,666 people are called recipients. The remaining 69,713, though eligible for benefits, incurred no medical expenses paid for by Medicaid. The total figure of 315,666 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 24 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 47 percent of eligibles received Medicaid services.

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 315,666 recipients in FY'84 was 1,729,628. MMS per recipient was 5.4, up by less than 1 percent over FY'83.

FY '84 PLATE 24
RECIPIENTS
Monthly Counts
Percent of eligibles

	Monthly Recipients	Percent of Eligibles
October '83	136,828	44.6%
November	136,502	43.8%
December	147,913	48.3%
January '84	124,574	40.4%
February	150,311	48.4%
March	150,200	49.1%
April	156,584	50.4%
May	146,197	47.2%
June	144,813	46.1%
July	127,695	41.6%
August	168,422	54.9%
September	139,589	45.6%
Monthly Average	144,136	46.7%

FY'84 PLATE 25
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	51,864	51,703	52,454	629,452	85,484	7.36
BLIND	968	1,009	1,032	12,386	1,772	6.98
DISABLED	37,693	39,203	39,230	470,757	64,328	7.32
DEPENDENT	47,393	48,016	52,073	624,879	182,862	3.42
ALL CATEGORIES (unduplicated)	136,828	139,589	144,136	1,729,628	315,666	5.48

USE AND COST

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 year's unduplicated total count of recipients by the total number of persons who were eligible for Medicaid during the year. This gives a percentage of eligibles who received service at least once during the year. This year the rate was approximately four of five persons or 81.9 percent (see Plate 26).

Frequency-of-Service Rate: How often recipients used Medicaid service during the year is measured by this rate. It is derived by adding the number of recipients in each month to give the number of man-months of Medicaid service. Then, total man-months of service is divided by the year's unduplicated total count of recipients to give the frequency-of-service rate (see Plate 27).

Man-months of service measures the number of months in which service was used rather than the number of services used. This year's rate indicates that the average recipient received service in 5.48 months of the year. The fact that every recipient did not receive service in every month of the year is the reason that the annual cost per recipient divided by 12 does not give the average monthly cost per recipient.

Ratio of Actual Use to Potential Use: If every eligible asked for service in every month, the maximum demand for medical care would exist. However, Plate 28 shows that eligibles averaged receiving service in only 4.49 months of the year. Using this figure, it can be shown that the ratio of actual to potential demand is 37 percent. This is calculated by dividing the number of man-months of service per eligible, 4.49, by the number of months in a year.

FY '84 — PLATE 26
USE
Percentage of eligibles who received service
By category

Category	Percentage
AGED	97.6%
BLIND	84.8%
DISABLED	87.9%
DEPENDENT	82.2%
ALL CATEGORIES	81.9%

FY '84 — PLATE 27
USE
Man-months of service per recipient
By category

Category	Man-months
AGED	7.36mms
BLIND	6.99mms
DISABLED	7.32mms
DEPENDENT	3.42mms
ALL CATEGORIES	5.48mms

FY '84 — PLATE 28
USE
Man-months of service per eligible
By category

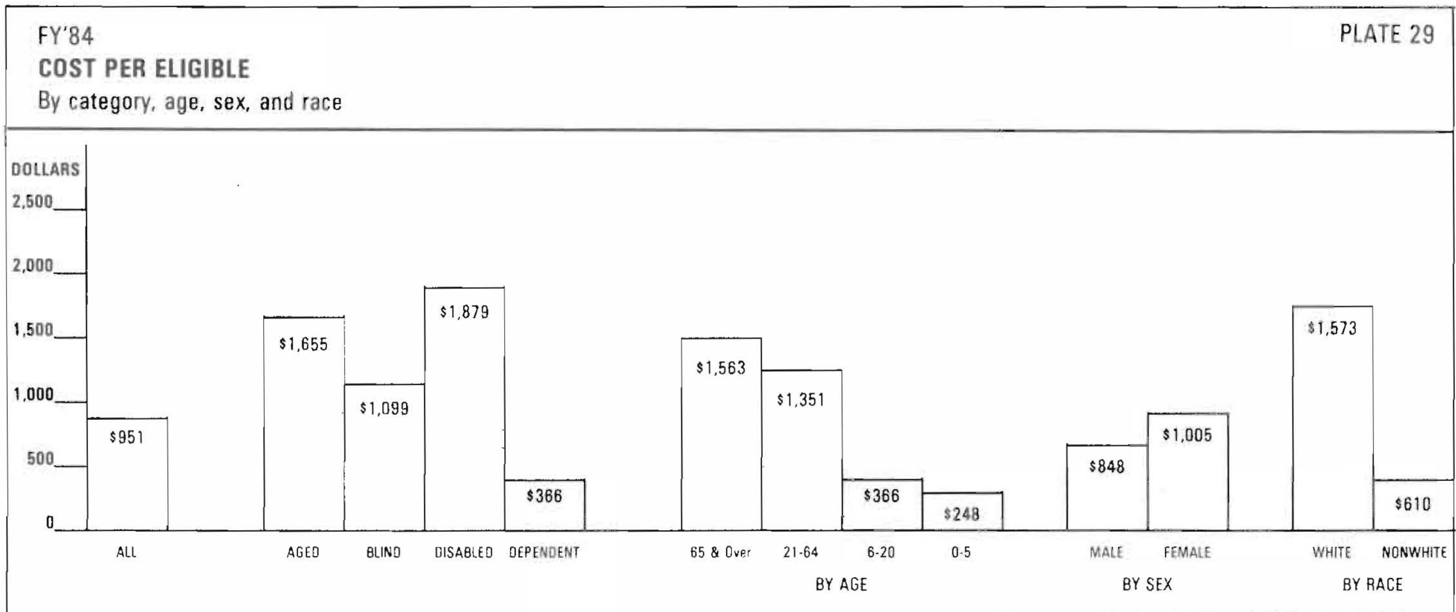
Category	Man-months
AGED	7.18mms
BLIND	5.93mms
DISABLED	6.43mms
DEPENDENT	2.81mms
ALL CATEGORIES	4.49mms

Cost

This report measures cost in two ways—cost per recipient and cost per eligible. Cost per recipient is calculated by dividing payments for services by the year's total unduplicated count of recipients. Cost per eligible is determined by dividing total payments for services by the total number of persons eligible during the year. Both measures are useful for comparing different groups of Medicaid recipients and eligibles and predicting how changes in eligibility and utilization will impact Medicaid's budget.

Plates 29 and 30 examine cost per eligible and recipient by category, age, sex, and race. Relative expense for different groups changes very little from year to year. Historically, costs for the aged and disabled categories have been much higher than cost for the blind and dependent categories.

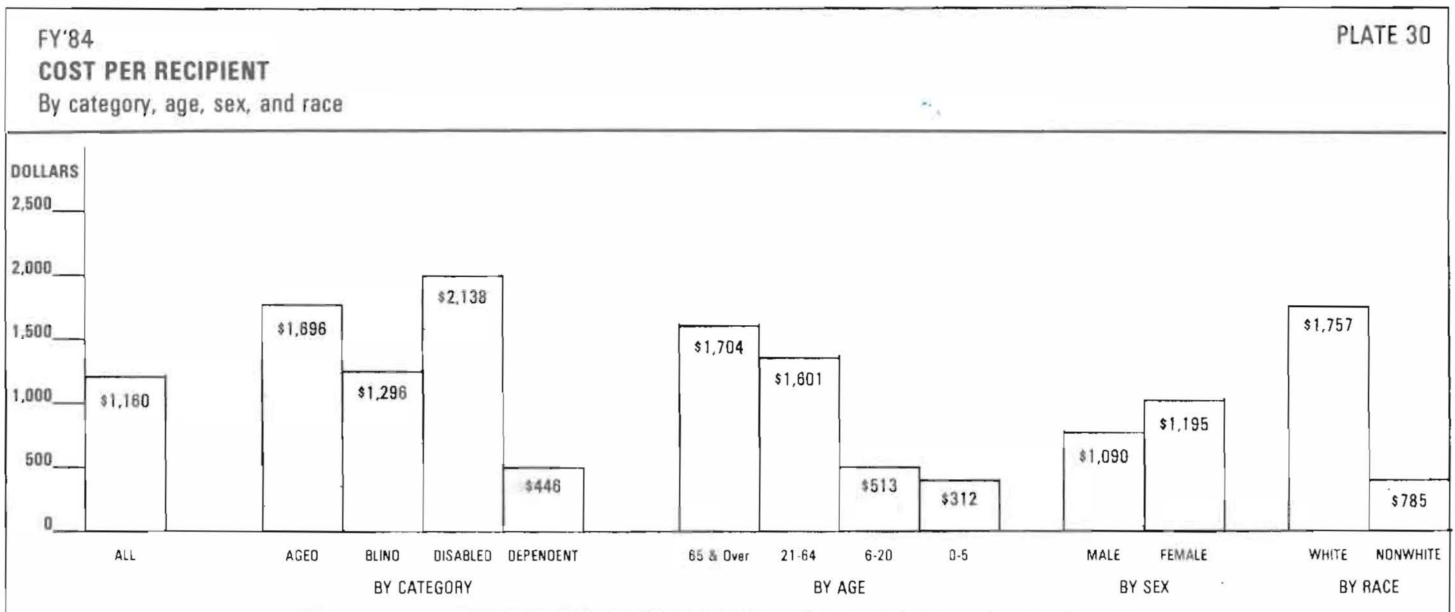
The reason for the differences in cost per person is that specific groups tend to use specific types of services. Medicaid does not budget funds for any particular group. Any eligible receives medically necessary services within reasonable limitations that apply to all eligibles. Plate 31 shows how categories with low cost per person use inexpensive services. For example,



dependent children have high utilization rates for services with low cost per unit such as screening and dental care. Long-term care has a high cost per unit of service and its recipients have a very high frequency-of-service rate. The average length of stay in a nursing home was 247 days in FY'84. Most recipients of long-term care are categorized as aged or disabled, aged 65 and over, and are white females. It is not surprising that these groups have high costs per person.

Also, note on Plate 31 that cost per recipient for services shared with Medicare is much smaller for the aged category. Over 90 percent of aged persons are also covered by Medicare. A smaller percentage of blind and disabled persons are eligible for Medicare coverage. When these Medicare-Medicaid eligibles file a valid claim for medical service, Medicaid pays the deductible and coinsurance and Medicare pays the remaining covered charges. The partial payment made by Medicare is not reflected in Section 1 of Plate 31.

For this coverage Medicaid paid a monthly 'buy-in fee' to Medicare. In FY'84 this fee was $14.60 per month for each Medicaid eligible who was also on Medicare. Medicaid's total bill for this buy-in fee was $17,818,490 in FY'84. This is considerably less than the amount Medicare spent for the partial payment of medical bills incurred by Alabama citizens on Medicaid.



FY '84

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	$37,781,691	$6,407,532	$74,085,082	$12,815,220	$69,804	$8,468,660	$35,266,931	$10,439,919
	Aged	4,888,410	504,413	10,716,547	1,497,453	14,950	2,142,009	18,070,302	6,690,960
	Blind	296,136	48,886	616,083	106,106	344	94,088	326,905	48,791
	Disabled	11,418,310	2,468,731	25,785,012	5,024,857	13,957	6,197,438	12,991,719	3,685,595
	Dependent Children	9,715,570	1,325,428	16,325,639	3,375,447	23,263	5,335	1,405,002	13,264
	Dependent Adults	11,463,265	2,060,074	20,641,801	2,811,357	17,290	29,790	2,473,003	1,309
SECTION 2 YEAR'S TOTAL NUMBER OF RECIPIENTS	ALL CATEGORIES**	244,688	119,166	63,811	108,085	1,714	5,180	226,256	3,743
	Aged	63,078	28,194	19,749	24,218	329	1,842	72,878	3,350
	Blind	1,481	701	410	634	6	69	1,503	14
	Disabled	52,069	28,667	16,805	23,872	289	3,224	52,837	814
	Dependent Children	87,575	35,328	12,596	38,381	752	24	63,675	6
	Dependent Adults	49,029	28,503	14,755	22,967	379	61	42,507	3
SECTION 3 YEAR'S COST PER RECIPIENT	ALL CATEGORIES	$154	$54	$1,161	$119	$41	$1,635	$156	$2,789
	Aged	77	18	543	62	45	1,163	248	1,997
	Blind	200	70	1,503	167	57	1,364	218	3,485
	Disabled	219	86	1,534	210	48	1,922	246	4,528
	Dependent Children	111	38	1,296	88	31	222	22	2,211
	Dependent Adults	234	72	1,399	122	46	488	58	436
SECTION 4 UTILIZATION RATES PERCENT OF ELIGIBLES	ALL CATEGORIES	63.49%	30.92%	16.56%	28.05%	.44%	1.34%	58.71%	.97%
	Aged	72.00%	32.18%	22.54%	27.64%	.38%	2.10%	83.18%	3.82%
	Blind	70.86%	33.54%	19.62%	30.33%	.29%	3.30%	71.91%	.67%
	Disabled	71.13%	39.16%	22.96%	32.61%	.39%	4.40%	72.18%	1.11%
	Dependents	61.40%	28.69%	12.29%	27.57%	.51%	.04%	47.73%	***

+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

***Includes buy-in premiums for the blind

Plate 31

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
$118,147,424	$49,904,573	$4,656,502	$3,710,041	$1,402,989	$2,246,109	$925,760	$17,818,490	$252,987,398	$131,159,329	$384,146,727
95,786,821	3,337,230	260	0	436,508	922,190	0	12,888,321	140,274,601	17,621,773	157,896,374
647,506	74,028	3,571	8,228	7,709	17,501	297	0	1,228,624	1,067,555	2,296,179
21,707,124	46,493,315	242,691	169,074	360,391	957,035	26,686	4,930,169***	97,761,237	44,710,867	142,472,104
0	0	4,048,693	218,542	336,230	177,975	881,438	0	7,086,479	30,765,347	37,851,826
5,973	0	361,287	3,314,197	262,151	171,408	17,339	0	6,636,457	36,993,787	43,630,244
17,206	1,610	39,918	23,226	31,375	41,158	33,508	N/A*	N/A*	N/A*	315,666**
17,279	218	14	0	9,381	17,032	0	N/A*	N/A*	N/A*	85,484
78	2	42	40	153	264	11	0	N/A*	N/A*	1,772
2,957	1,460	2,098	1,259	7,785	12,454	973	N/A*	N/A*	N/A*	64,328
0	0	36,391	4,631	8,055	6,127	31,919	0	N/A*	N/A*	122,281
5	0	1,896	19,040	6,048	5,589	643	0	N/A*	N/A*	60,581
$6,867	$30,997	$117	$160	$45	$55	$28	$N/A*	$N/A*	$N/A*	$1,217
5,544	15,308	19	0	47	54	0	N/A*	N/A*	N/A*	1,847
8,301	37,014	85	206	50	68	27	0	N/A*	N/A*	1,296
7,341	31,845	116	134	48	77	27	N/A*	N/A*	N/A*	2,215
0	0	111	47	42	29	28	0	N/A*	N/A*	310
1,195	0	191	174	43	31	27	0	N/A*	N/A*	720
4.46%	.42%	10.36%	6.03%	8.14%	10.68%	8.69%	N/A*	N/A*	N/A*	81.91%
19.72%	.25%	.02%	.00%	10.71%	19.44%	.00%	N/A*	N/A*	N/A*	97.57%
3.73%	.10%	2.01%	1.91%	7.32%	12.63%	.53%	0	N/A*	N/A*	84.78%
4.04%	1.99%	2 87%	1.72%	10.64%	17.01%	1.33%	N/A*	N/A*	N/A*	87.88%
.00%	.00%	17.21%	10.64%	6.34%	5.27%	14.64%	0	N/A*	N/A*	82 19%

LONG-TERM CARE

This year 34 percent of total Medicaid provider payments went for Nursing Home care.

Care for acutely ill, indigent patients in skilled nursing homes was mandated in 1965 with the enactment of Medicaid (Title XIX). Skilled care is included in federal law as a mandatory service — one that all states must include in their Medicaid programs. This care has been provided by Alabama Medicaid since the program began in 1970.

The current Long-Term Care program consists of skilled and intermediate care. Recipients who are sick enough to require around-the-clock professional nursing care are furnished skilled care. Intermediate care, an optional service, is provided to patients who have chronic medical conditions, are not well enough for independent living, and require care at a less intense level than skilled-care recipients. The Alabama Medicaid Agency has provided intermediate care since 1972.

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

- 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.
- Increased urbanization, which reduced both the size of homes and the number of nonworking family members available to care for the elderly.

The increase in nursing home utilization coincided with a change in the pattern of use of intermediate and skilled care during the 1970's. Early in the decade there were more skilled than intermediate care patients. This situation reversed itself as the decade progressed. By FY'84 only 22 percent of nursing home recipients were receiving skilled care.

A major factor in this change was the move toward dually certified facilities — nursing homes which treat both skilled and intermediate patients. Another reason was the advent of combination reimbursement. Nursing homes are reimbursed at a single corporate rate based on allowed costs and not the level of care provided to individual patients.

Beginning in FY'82, Medicaid nursing home utilization showed a small overall decline. Between FY'82 and FY'83 the average number of nursing home recipients per month declined by over six percent. In FY'84 this trend continued. Average monthly nursing home recipients dropped by 65 persons. Factors contributing to this decline in use were the expansion of the Home Health program which provides care in a patient's home, better management information to make accurate financial eligibility determinations, and the continued application of medical criteria to insure that Medicaid nursing home patients have genuine medical needs requiring professional nursing care.

Moratorium on Certificates of Need: On August 1, 1984, Governor Wallace issued an executive order that placed a moratorium on the acceptance and processing of Certificates of Need (CON) by the State Health Planning Agency. Reasons for this order included the lack of adequate staffing and computerization in the agency, the lack of proper methodologies for evaluating various areas of medical service, and a large volume of CON requests which the CON Review Board, through no fault of its own, could not reasonably

FY '82-'84 PLATE 32

LONG-TERM CARE PROGRAM

Patients, months, and cost

	Number Of Nursing Home Patients (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
1982	22,884	236 Days	5,389,977	$23	$123,790,282
1983	20,536	250 Days	5,135,060	23	117,703,176
1984	20,949	247 Days	5,178,233	25	128,587,343

FY '82-'84 PLATE 33

LONG-TERM CARE PROGRAM

The number and percent of beds used by Medicaid

Year	Nursing Home Beds Certified For Federal Program Participation	Medicaid Monthly Average	Patients Yearly Unduplicated Total	Percent Of Beds Used By Medicaid	Number Of Beds Not Used By Medicaid In Average Month
1982	20,986	14,565	22,884	69%	6,421
1983	20,813	13,676	20,536	66%	7,137
1984	21,132	13,611	20,949	64%	7,521

investigate and act on. This order included CON applications for nursing home beds.

Since 1982, the Alabama Medicaid Agency has taken the position that no new nursing home beds are needed in the state. No significant change has taken place since that time which would alter this position.

In 1983, the most recent year with available data, the statewide nursing home occupancy rate was 91.6 percent. This was a significant decrease from the 93.1 percent rate for the previous year. A rate of less than 100 percent indicates that on an average day there were empty nursing home beds in the state.

Use of nursing home beds by Medicaid patients is also declining. The monthly average of Medicaid nursing home recipients dropped from 14,565 in FY'82 to 13,611 in FY'84. This is important since about two-thirds of the nursing home beds in Alabama are occupied by Medicaid patients.

Any increase in the number of nursing home beds in the state could result in financial problems for the Medicaid program. Based on current utilization, an increase of 100 nursing home beds would cause Medicaid expenditures to rise by about one million dollars.

To conserve financial resources necessary for other vital services, the Alabama Medicaid Agency, as stated in its Administrative Code, will not compute or pay a per diem rate for beds constructed under a CON dated on or after April 1, 1983. Since this policy eliminates a potential source of substantial income, the economic feasibility of any new beds would be in serious question.

In the past, there were few alternatives to nursing home care for people unable to care for themselves. Today, there are adequate alternatives that are less costly and give individuals a greater degree of independence. In 1983, the State Board of Health relaxed its rules for the licensing of domiciliaries. A domiciliary does not provide the level of care available in a nursing home, but it does provide a supervised environment for persons in need of custodial care. Even though Medicaid does not cover care in domiciliaries, the addition of 641 new domiciliary beds since July 1983 should reduce the future needs for nursing home beds in Alabama.

Another alternative to institutional care is a new Medicaid program which will allow indigent patients to receive services in their homes. This program, the Home and Community-Based Waiver for the Elderly and Disabled, is a cooperative effort of the Alabama Medicaid Agency, the State Department of Pensions and Security, and the Alabama Commission on Aging. Services include case management, adult health care, respite care, homemaker services, and personal care. Certain persons who qualify for Medicaid nursing home care will have the opportunity to receive these services in their homes instead of entering a nursing home. The program will begin in February 1985 and will serve up to 3,194 persons during the first year of operation.

Cedar Crest Nursing Home in Montgomery

FY '84 LONG-TERM CARE PROGRAM Recipients, by sex, by race, by age				PLATE 34
	Skilled	ICF	Total	Percent
All Recipients	3,743	17,206	20,949	100.0%
By Sex				
Female	2,707	12,839	15,546	74.2%
Male	1,036	4,367	5,403	25.8%
By Race				
White	2,693	13,786	16,479	78.7%
Nonwhite	1,050	3,420	4,470	21.3%
By Age				
65 & Over	3,119	15,184	18,303	87.4%
21-64	468	1,920	2,388	11.4%
6-20	96	102	198	.9%
0-5	60	0	60	.3%

Nursing Home Reimbursement: Alabama uses a Uniform Cost Report (UCR) 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 other expenses to be incurred in maintaining full compliance with standards required by state and federal regulatory 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 a patient may have and still be eligible for Medicaid in FY'84 was $852.90 a month. All personal income above $25.00 a month, with the exception of insurance premiums, must be applied by the patients to reduce the monthly charge to Medicaid for their nursing home care.

Patient Characteristics and Length of Stay: Plates 34 and 35 show who the nursing home recipients were this year in terms of sex, race, and age of the recipient and the amount of money spent on each group.

Plate 36 shows average monthly recipients and annual totals of recipients in the Long-Term Care program. Note that between FY'83 and FY'84 monthly averages declined while yearly totals increased slightly. The yearly total is an unduplicated count. This means that recipients are counted only once whether they received one day of nursing home care or 365 days of this care. The monthly average takes into account length of service and is a more valid measure of changes in utilization.

FY '84 LONG-TERM CARE PROGRAM Payments: by sex, by race, by age				PLATE 35
	Skilled	ICF	Total	Percent
All Recipients	$10,439,919	$118,147,424	$128,587,343	100%
By Sex				
Female	7,431,251	89,551,988	96,983,239	75.4%
Male	3,008,668	28,595,436	31,604,104	24.6%
By Race				
White	7,243,120	93,886,543	101,129,663	78.6%
Nonwhite	3,196,799	24,260,881	27,457,680	21.4%
By Age				
65 & Over	7,154,055	101,857,166	109,011,221	84.8%
21-64	1,661,075	15,288,338	16,949,413	13.2%
6-20	1,003,906	1,001,920	2,005,826	1.6%
0-5	620,883	0	620,883	0.4%

FY '82-'84

LONG-TERM CARE PROGRAM

Number of Recipients

PLATE 36

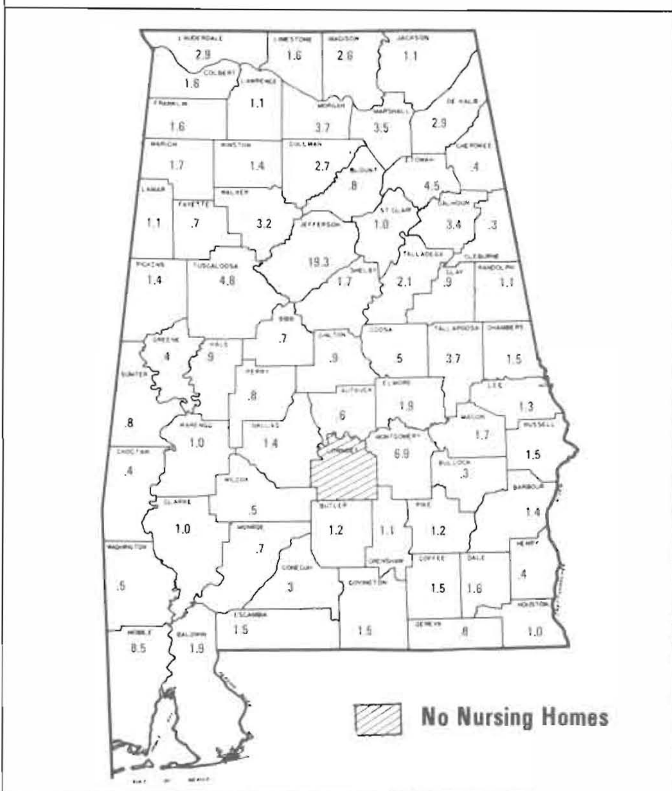
	Skilled			ICF			Total		
	FY '82	FY '83	FY '84	FY '82	FY '83	FY '84	FY '82	FY '83	FY '84
Monthly Average	1,576	1,105	1,065	12,989	12,571	12,546	14,565	13,676	13,611
Yearly Total	4,181	3,658	3,743	18,703	16,878	17,206	22,884	20,536	20,949
Annual Turnover Rate	165%	231%	251%	44%	34%	37%	57%	50%	54%
Average Length of Stay	125 Days	99 Days	97 Days	260 Days	283 Days	280 Days	236 Days	250 Days	247 Days

FY '84

PLATE 37

PAYMENTS TO NURSING HOMES

By County (in millions of dollars)



LONG-TERM CARE MENTAL HEALTH

1,610 institutionalized recipients and 1,485 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 1,610 in FY'84. During the same period, payments increased from $1.6 million to $49.9 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 $89 in FY'84, and the average length of stay, which was almost a year in FY'84.

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'84.

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 '83-'84 PLATE 38

LONG-TERM CARE PROGRAM

ICF-MR/MD

	FY '83	FY '84
Recipients	1,615	1,610
Annual Expenditures	$51,636,961	$49,904,573
Average Annual Cost Per Recipient	$31,973	$30,997
Average Monthly Recipients	1,505	1,501
Average Monthly Cost Per Recipient	$2,859	$2,771

Medicaid eligible receives services at Tarwater Mental Health Facility.

HOME HEALTH

This year the Home Health program furnished services to almost 3,500 persons who might otherwise have required care in an institution.

Home Health Care is an alternative to nursing home care. The service allows homebound persons who meet Medicaid home health criteria to stay at home rather than enter an institution. This nursing and personal care must be certified by a physician and is provided under contract by home health care agencies.

Because of Medicare's Diagnosis Related Groupings and Medicaid's 12-day hospital limit, patients are being discharged earlier than in the past, and the demand for home health care has been increasing. Home health patients may require intravenous therapy and tube feedings, sterile dressing changes, ultraviolet light therapy, and mechanical ventilation.

Medicaid criteria for home health services are:

— Home health agencies must have contracts with the Medicaid Agency. There were 100 agencies participating in FY'84.

— Patients must be Medicaid eligible.

— Patients must be homebound — essentially confined to the home because of illness, injury, or disability.

— Patients must be under the care of a physician.

— Care must be reasonable and necessary on a part-time or intermittent basis.

— Care must be recertified at least once every 60 days by the attending physician. Medicaid staff reviews about 850 recertifications each month.

The maximum reimbursement rate per visit is $27, which is the most prevalent rate. In FY'84 an average of 1,500 persons a month received a total of 125,409 visits at a cost of $3.3 million.

Up to 100 home health visits per year may be authorized by the Medicaid agency. Additional visits may be authorized if the attending physician makes a written report. In FY'84, 2,334 additional visits were authorized for 92 home health patients.

The Supplies, Appliances, and Durable Medical Equipment (DME) program is a mandatory benefit under the Home Health program. Medicaid recipients do not have to receive home health services to qualify for the DME program. Items must be medically necessary and suitable for use in the home.

There are 241 Medicaid Supplies, Appliances, and DME providers throughout the state. These providers supplied 71,663 units of service at a cost of $1.1 million in FY'84.

FY '83-'84
Use and cost of Home Health Care
Compared to Nursing Home Care.

PLATE 39

	Average Number of Recipients Per Month		Average Monthly Cost Per Recipient	
Year	Home Health	Nursing Home	Home Health	Nursing Home
1983	1,181	13,676	$201	$717
1984	1,469	13,611	$201	$787

HOSPITAL PROGRAM

Medicaid paid hospitals $86.9 million for services to 63,000 recipients of inpatient care and 108,000 recipients of outpatient care.

Hospitals are a critical link in the Medicaid health care delivery system. Each year about one-sixth of all Medicaid eligibles receive inpatient care. About one-fourth of all eligibles are treated as hospital outpatients, usually in emergency rooms. There are 130 Alabama hospitals that participate in the Medicaid program, and 42 hospitals in neighboring states also participate in Alabama's Medicaid program.

Reimbursement: Hospitals are reimbursed on a daily rate that varies from hospital to hospital. This per diem is determined by a formula that takes into account many factors, including a hospital's costs, the services provided, and efficiency factors such as occupancy rates. As of October 1, 1984, these rates ranged up to $551 a day. The average per diem rate was $291. This is a 12 percent increase over the previous average per diem rate which had been in effect since April 1, 1984. This is a higher percent increase than the rate of growth of the Consumer Price Index Hospital Room Cost as measured by the percent change in index numbers between September 1983 and September 1984 (see Plate 41).

Use and Cost: Plate 40 shows that total payments for inpatient hospital services declined by $11.5 million during FY'84. This decline was a result of fewer recipients and fewer days of care per recipient. This reflects the statewide trend of reduced use of inpatient beds. The hospital occupancy rate for Alabama dropped by 2.2 percent during the most recent period for which data is available. One reason for this is that increasingly sophisticated medical procedures can be performed in physicians' offices and in an outpatient setting. It is worth noting that if the number of recipients and the patient days used by each recipient had remained constant in FY'84, Medicaid payments for hospital services would have risen by almost $6 million.

FAIR: The system used by Medicaid to monitor hospital inpatient utilization is called FAIR, or Fiscal Agent Inpatient Review. Alacaid, the program's fiscal agent, performs this review function under contract. Utilization review is mandated under federal regulations to ensure that Medicaid eligibles are admitted as inpatients only when medically necessary and that they are released as soon as a lesser level of care will suffice.

The 76 state hospitals that are "delegated" facilities perform their own admission and continued stay reviews, which are systematically monitored by FAIR. FAIR performs all reviews for the 54 "nondelegated" hospitals.

FY '82-'84 PLATE 40

HOSPITAL PROGRAM

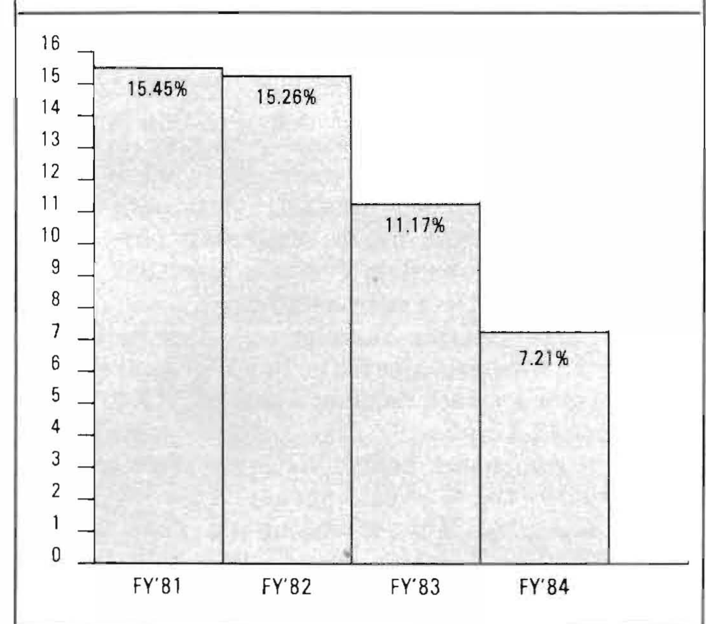
Changes in use and costs

Year	Eligibles	Recipients of Inpatient Care	Payments for Inpatient Care	Medicaid's Annual Cost Per Recipient
1982	394,905	71,130	$83,323,150	$1,171
1983	383,940	67,699	85,596,571	1,264
1984	385,379	63,811	74,085,082	1,161

FY'81-'84 PLATE 41

ANNUAL PERCENT CHANGE

Hospital room cost from the consumer price index



FY '80-'84
HOSPITAL PROGRAM
Outpatients

PLATE 42

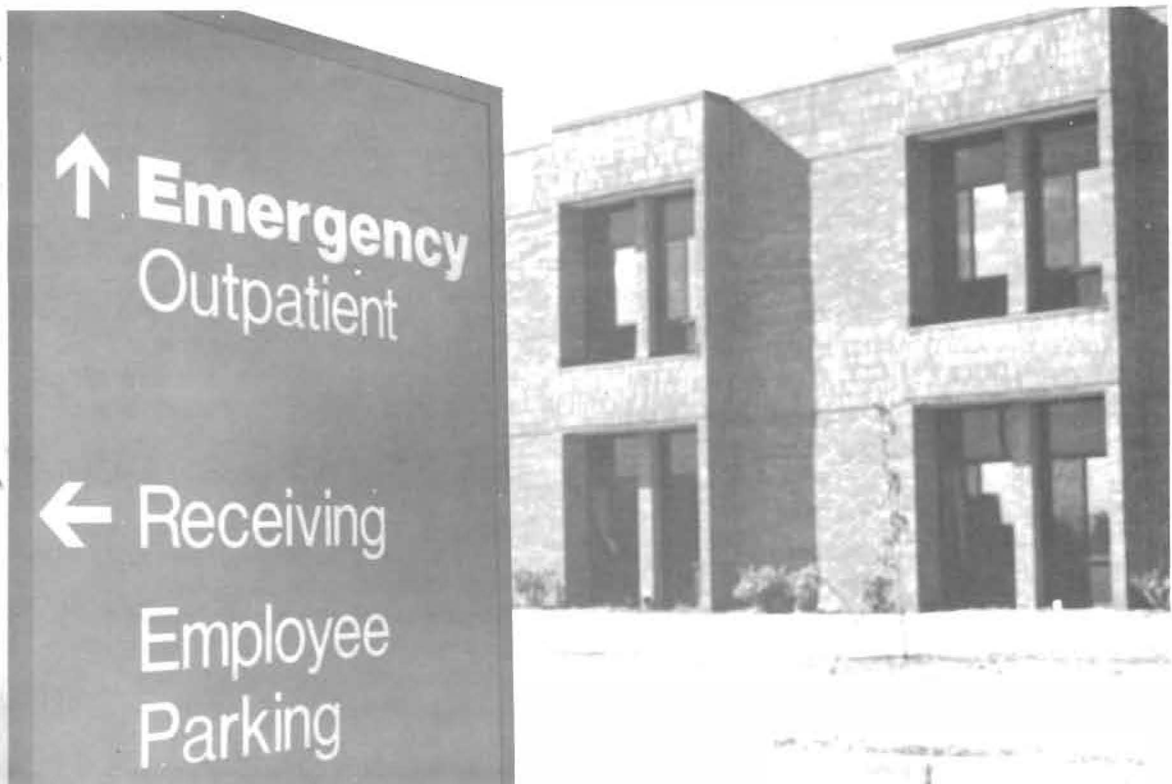
	FY '80	FY '81	FY '82	FY '83	FY '84
Number of outpatients	110,774	115,393	112,333	110,196	108,085
Percent of eligibles using outpatient service	26%	28%	28%	29%	28%
Annual expenditure of outpatient care	$11,568,775	$13,109,707	$12,655,314	$13,813,699	$12,815,220
Cost per patient	$104	$114	$113	$125	$119

Limitations on Services: To control overutilization, the Alabama Medicaid Agency allows eligibles 12 days of inpatient care per calendar year. Beginning in March 1984, an exception was made for children with serious illnesses. After these children exhaust their 12 days and then spend 30 continuous days in the hospital, they are eligible for 12 additional days. This cycle can be repeated throughout the year. These additional days must be prior authorized by Medicaid and based on medical necessity.

Outpatient Care: The Outpatient program was created to enable Medicaid recipients to use hospital facilities without staying overnight. When used for this purpose, the availability of outpatient services reduces the cost of medical care. However, many Medicaid patients use emergency rooms when all they need or want is to see a doctor. This misuse of outpatient facilities is a serious problem for Medicaid. Since an outpatient visit costs about twice as much as a visit to a physician's office, there is a significant impact on Medicaid expenditures. Alabama's hospitals are aware of this problem, but due to potential legal liability and other factors, patients are rarely turned away from emergency rooms.

To control overuse, limitations on outpatient services were implemented during FY'83. Medicaid eligibles are limited to three outpatient visits per calendar year. Certified emergencies, renal dialysis, radiation therapy, and chemotherapy are excluded from this limitation.

Renal dialysis is an outpatient service provided to Medicaid recipients that is not exclusive to hospitals. Currently, Medicaid contracts with 16 freestanding clinics to provide this service. Most renal dialysis patients require service three times a week, 52 weeks a year. Although payments for this service make up a small portion of Medicaid's budget, renal dialysis is very important to these recipients since lack of treatment would threaten their lives.



FY '84 PLATE 43

PAYMENTS TO HOSPITALS

By county (in thousands of dollars)

No hospitals

Hospital Program PLATE 44

HOSPITAL OCCUPANCY RATE (%)

As of September 30, 1983

No hospitals

FAMILY PLANNING

Last year Medicaid paid $3.7 million for Family Planning services, 90 percent of which was paid with federal funds.

During the past 30 years, the number of yearly births in Alabama has dropped from about 82,000 to about 63,000, but during the same period the number of illegitimate births has increased from less than 8,000 per year to more than 14,000. Illegitimacy is a particularly acute problem among younger females. Last year, 4,321 babies were born to girls aged 15 to 17. Of these, 2,791 were illegitimate. Girls under age 15 gave birth to 275 babies last year, and 244 of these babies were illegitimate. Aside from the obvious personal problems faced by these mothers and their children, the young families must usually deal with dependency on public assistance programs and Medicaid.

Although Medicaid's family planning services include assisting eligibles with fertility problems, most recipients of family planning services are people seeking prevention of unwanted pregnancies. Most expenditures for family planning services relate to birth control.

At both the national and state levels, Medicaid family planning services receive a high priority. To ensure this priority, the federal government pays a higher percentage of the cost of family planning than for other services. For most Medicaid services in Alabama, the federal share of costs is 72 percent. For family planning services, the federal share is 90 percent.

The Medicaid agency purchases family planning services from Planned Parenthood of Alabama, Inc. and clinics under the supervision of the Statewide Family Planning Project of the State Department of Public Health's Bureau of Maternal and Child Care.

Services include physical examinations, pap smears, pregnancy and V. D. testing, counseling, oral contraceptives and other drugs, supplies and devices, and referral for other needed services.

Medicaid rules regarding sterilization are based on federal regulations. Medicaid will pay for sterilizations only if certain conditions are met. One is that the Medicaid eligible must be 21 years old at the time consent is given. Also, at least 30 days but not more than 180 days must have passed between the date of informed consent and the date of sterilization. Exceptions to these time limitations are made in cases of premature delivery and emergency abdominal surgery.

Eligibles 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 to the sterilization. In cases of premature delivery, informed consent to the sterilization must have been given at least 30 days before the expected date of delivery.

In accordance with state and federal law, Medicaid will pay for abortions only when the life of the mother would be endangered if the fetus were carried to term.

PRENATAL CARE

Competent, timely prenatal care results in healthier mothers and babies. The prenatal services available to Medicaid eligibles through county health departments and other Medicaid providers have been a significant factor in the overall decline in the state's infant mortality rate during the past decade. Timely care can also reduce the possibility of premature, underweight babies.

Medicaid prenatal care is provided through health departments, private physicians, hospitals, and clinics. Eligibles are allowed prenatal visits whenever they are deemed necessary. Examinations include complete histories and physical examinations, lab tests and pap smears. If an eligible is a high-risk patient, or if she otherwise needs additional care, she may be referred to a specialist.

PHYSICIAN PROGRAM

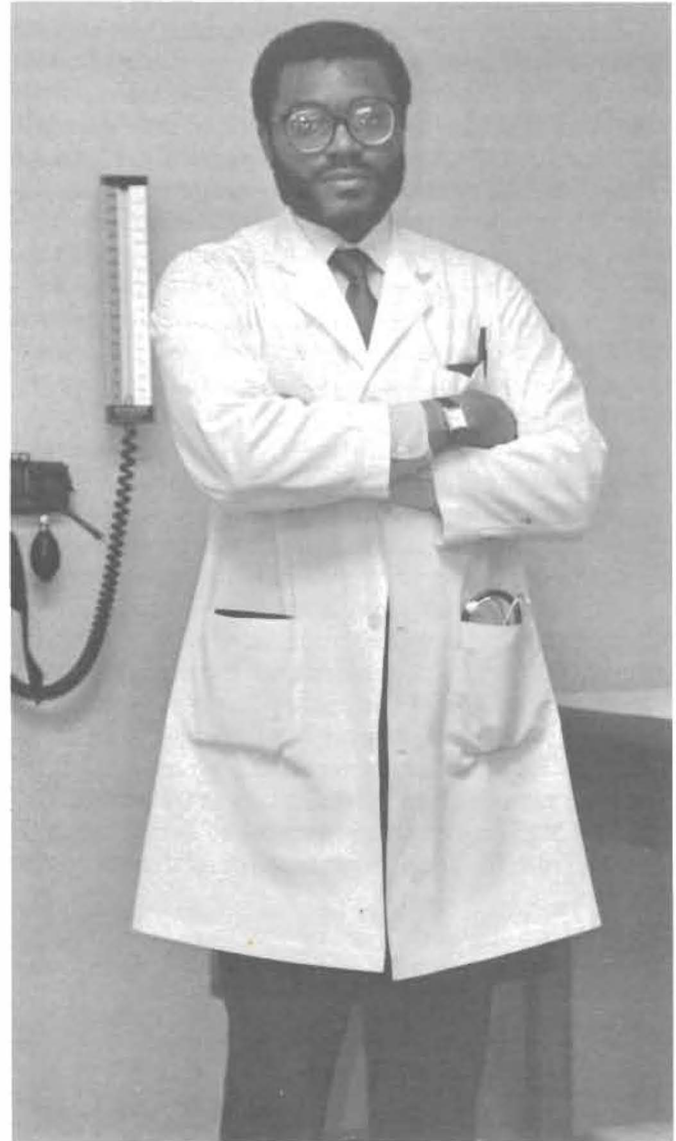
Last year almost 65 percent of Medicaid eligibles received services from a physician.

Physicians are the cornerstone of the Medicaid program. Service to eligibles is based on medical necessity, and it is physicians who determine the need for medical care. Physicians provide this care directly and prescribe or arrange for additional health benefits. It is the physician who determines what drugs a patient receives, decides when and if a patient needs nursing home or inpatient hospital care, and controls the care of the patient in an institution. There are about 5,000 licensed physicians in Alabama. The majority of these physicians participate in the Medicaid program. More than three-fourths of Alabama Medicaid recipients received a physician's service last year.

Significant changes in the Physician program during the year were new limitations in the number of physician visits in a calendar year. Recipients are allowed a total of 12 visits each year in either a hospital outpatient department, a nursing home, or a physician's office. In addition, Medicaid hospital inpatients are allowed one visit per day per physician during their 12 Medicaid-covered hospital days per year.

Most Medicaid providers must sign contracts with the Medicaid agency in order to provide services to eligibles. Physicians who participate in the EPSDT program must sign an agreement limiting charges for screening children. For other types of physician services, the submitted claim is considered a contract.

In general, the per capita cost of Medicaid services to the aged is higher than for other categories of recipients. One reason is that older people are more likely to have health problems. However, Medicaid physicians' care costs for the aged are lower than for most categories (see Plate 45). This is because about 90 percent of Medicaid's aged recipients also have Medicare coverage. In cases when individuals have both Medicaid and Medicare coverage, Medicare pays the larger portion of the physicians' bills.



FY '84 PLATE 45

PHYSICIAN PROGRAM

Use and Cost

	Payments	Recipients	Cost Per Recipient	Percent of Eligibles Treated by a Physician
Aged	$4,888,410	63,078	$78	72.0%
Blind	296,136	1,481	200	70.9%
Disabled	11,418,310	52,069	219	71.1%
Dependents	21,178,835	136,604	155	61.4%
All Categories	37,781,691	244,688	154	63.5%

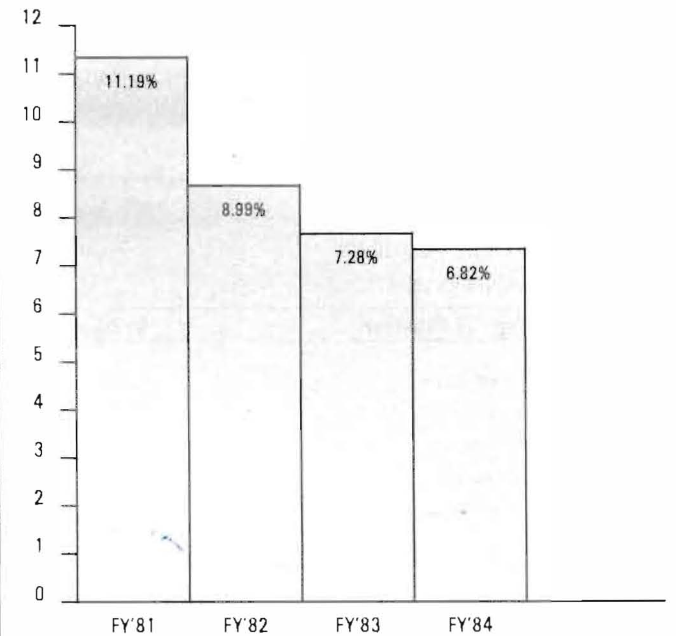
FY '84 PLATE 46

TOTAL LICENSED PHYSICIANS

By county

ANNUAL PERCENT CHANGES PLATE 47

Physician Services cost from the consumer price index

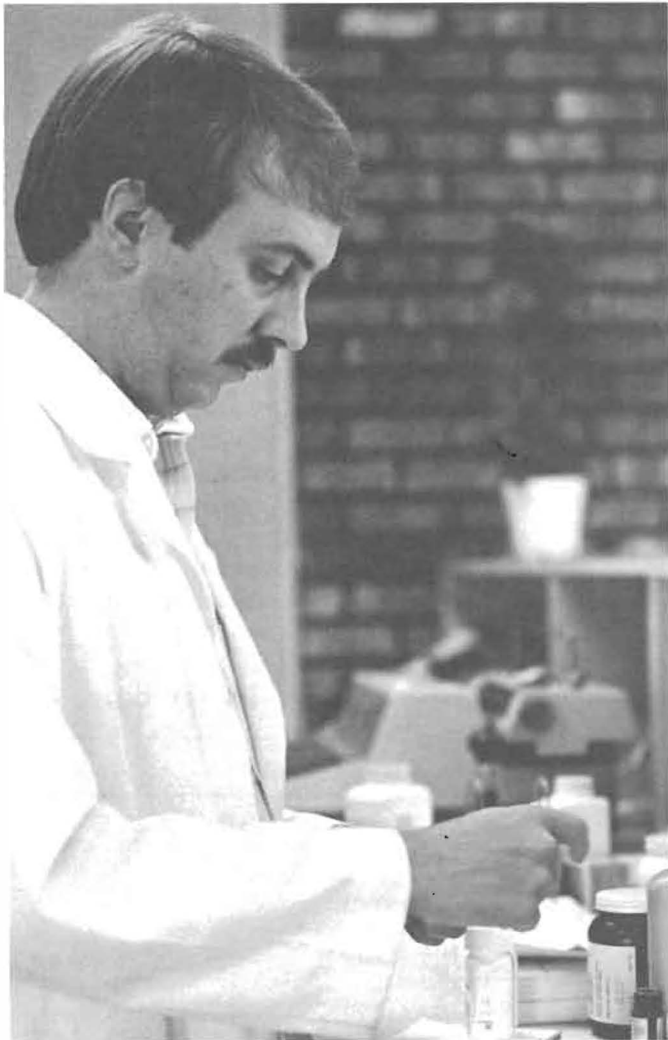


PHARMACEUTICAL PROGRAM

During FY'84, Prescription Drug costs, as measured by the Consumer Price Index, rose by almost ten percent. This increase in price is reflected in Medicaid payments to pharmacy providers.

FY '82-'84 PLATE 48
PHARMACEUTICAL PROGRAM
Counts of providers by type

Type of Provider	Number
In-State Retail Pharmacies	1,199
Institutional Pharmacies	37
Dispensing Physicians	2
Out-of-State Pharmacies	42
Health Centers and Clinics	3
TOTAL	1,283



The provision of prescription drugs is not a mandatory service under federal Medicaid rules, but it is vital to the Medicaid program. The Pharmaceutical program cost more than $35 million last year, but this represented only about nine percent of all Medicaid expenditures. It is perhaps the most cost-effective service the Medicaid program offers. Treating illnesses with prescription drugs is usually much less expensive and often just as effective as alternatives such as hospitalization or surgery.

Realistically, modern medical treatment would be impossible without drugs. Medical practitioners rely heavily on drugs for the treatment of pain, infection, allergies, chemical imbalances, dietary deficiencies, muscle tension, high blood pressure, heart disease, and many other health problems. In recent years, medical professionals have been very successful in finding medication which makes more expensive alternatives unnecessary.

Last year, as in most years, more than half of all Medicaid eligibles had at least one prescription filled. Except for physician's care, the Pharmaceutical program had the highest rate of use of any Medicaid service. Primarily to control overutilization, Medicaid recipients must pay a small portion of the cost of each prescription. This copay varies according to the cost of each prescription and ranges from 50 cents to 3 dollars. In addition, prescribing physicians are limited to the 8,000 drugs listed in the Alabama Drug Code Index. However, every effort is made to avoid restricting a physician's choice of drugs. If a physician can justify the use of a new or special drug that is not on the index, he can usually receive prior approval from the Medicaid Agency to prescribe it.

Primarily because of higher drug ingredient costs and a higher number of drug recipients, total payments for drugs increased significantly last year. New limitations on hospital services and physician's visits during the year could have been factors in the increased use of drug therapy. The price of a prescription rose from an average cost of $9.79 to $10.87 during FY'84. This rise is reflected in the increase in FY'84 of almost 10 percent in the prescription drug segment of the Consumer Price Index. The number of prescriptions per recipient changed very little, as in previous years, while the cost per recipient rose from $141.96 in FY'83 to $155.87 in FY'84.

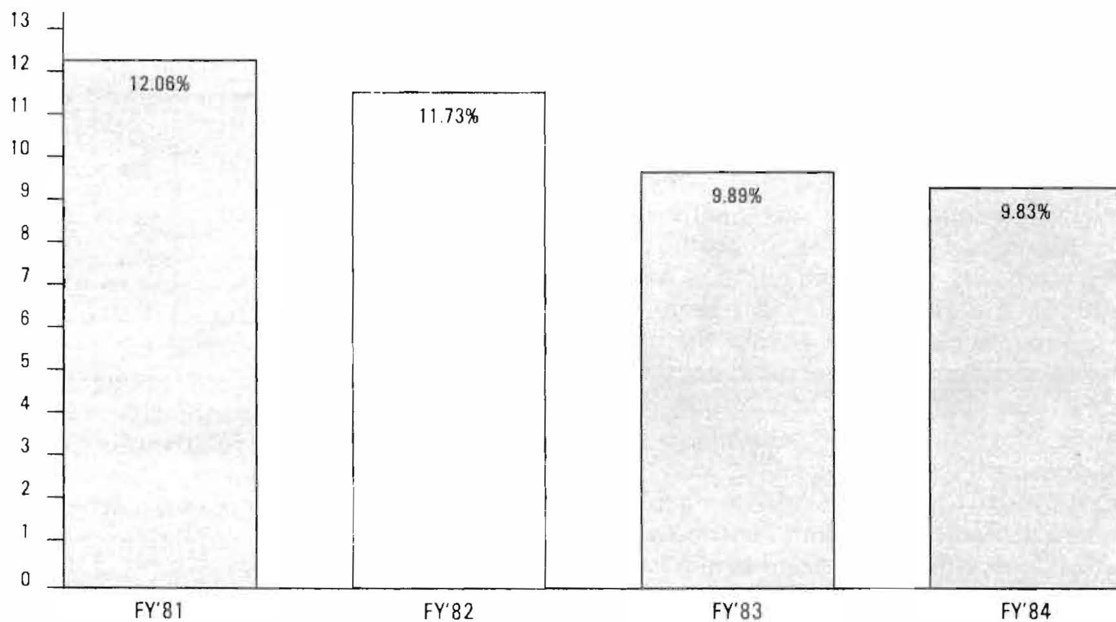
FY '82-'84
PHARMACEUTICAL PROGRAM
Use and cost

PLATE 49

Year	Number of Drug Recipients	Recipients as a % of Eligibles	Number of Rx	Rx per Recipient	Price Per Rx	Cost per Recipient	Total Cost to Medicaid
1982	222,109	56%	3,213,290	14.47	$8.80	$127.27	$28,268,860
1983	222,713	58%	3,230,037	14.50	9.79	141.96	31,616,230
1984	226,256	59%	3,245,359	14.34	10.87	155.87	35,266,931

FY'81-'84
ANNUAL PERCENT CHANGE
Prescription drug cost from
the consumuer price index

PLATE 50



EPSDT PROGRAM

Over 33,000 Medicaid-eligible children received screenings in FY'84. Dental care is provided as an integral part of the screening program.

EPSDT stands for Early and Periodic Screening, Diagnosis, and Treatment. It is often called Medicaid "screening." The purpose of the program is to screen Medicaid-eligible children to discover possible health problems. The program benefits the children by giving them a chance to be healthier. The program also has the potential benefit of long-term savings to Medicaid. Illnesses diagnosed and treated in the early stages are less likely to require expensive acute care.

Although EPSDT is funded by Medicaid, the program's operation requires the cooperation of the State Department of Pensions and Security and the State Department of Public Health. EPSDT eligibles are persons under 21 in either the Aid to Dependent Children or Supplemental Security Income programs. 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 screening.

The major problem with EPSDT is that the program is underused. Screening is not mandatory for eligibles, and less than 23 percent of eligibles are screened each year. Many mothers do not seek health care for their children until the children show symptoms of illness. Taking a child to a physician's office or health department can be a difficult chore. Both Pensions and Security and EPSDT providers have tried to alleviate the no-show problem through educational programs that teach eligible families the importance of screening. The Medicaid Agency sends letters to newly-eligible families who have refused screening appointments. The general public as well as Medicaid eligibles would be better served if more children were screened, but despite the efforts of participating agencies and providers, the number of screening recipients over the past few years has remained relatively constant in relation to the number of eligibles.

FY '83-'84 PLATE 51
DENTAL PROGRAM
Recipients by sex and age

	FY '83	FY '84
Total	41,571	39,918
Male	19,013	18,167
Female	22,558	21,751
Age 0-5	11,875	11,437
Age 6-20	29,696	28,481

FY '83-'84 PLATE 52
EPSDT PROGRAM
Eligibles, recipients, by age
Payments

	FY '83	FY '84
TOTAL ELIGIBLES FOR EPSDT PROGRAM	173,319	171,605
Age:		
0-5	63,190	63,497
6-20	110,129	108,108
RECIPIENTS OF SCREENING	33,915	33,508
Age:		
0-5	14,638	15,929
6-20	19,277	17,579
TOTAL PAYMENT FOR SCREENINGS	$924,898	$925,760
AVERAGE PAYMENT FOR A SCREENING	$27	$27

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

A Medicaid goal is to screen eligibles at eight intervals between birth and age 21. During FY'84, 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 problems, anemia, urinary infections, vision and hearing problems, child abuse, and dental problems.

The cost of screening is relatively small — an average of $27 per screening. The cost of treating illness is usually considerably higher. During FY'84, a total of 33,508 screenings were performed. About 80 percent of screenings resulted in referrals to physicians due to uncovered or suspected medical conditions.

The 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 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'84, about 72,450 claims were paid to dental providers at an approximate cost of $4.4 million.

OPTOMETRIC PROGRAM

In FY'84 payments for optometric services totaled $1.4 million.

Good eyesight is essential to learning and development. For adults, good eyesight is critical to self-sufficiency and quality of life. Medicaid's Optometric program provides eligibles with a level of eye care comparable to that of the general public.

The program provides services through ophthalmologists, optometrists, and opticians. Adults — 21 years of age and older — are authorized one complete eye examination and a pair of eyeglasses every two calendar years. Recipients under 21 are authorized the same service each calendar year. These limitations also apply to fittings and adjustments. Contact lenses are available only when prior authorized by Medicaid for the treatment of keratoconus or following post-cataract surgery.

In keeping with the agency's policy of controlling costs, Medicaid eyeglasses are provided through a central source chosen through competitive bidding. The contractor is required to provide eyeglasses which meet federal, state, and the agency's requirements.

LABORATORY AND RADIOLOGY PROGRAM

In FY'84, the Laboratory and Radiology program served over 100,000 recipients at a cost to Medicaid of $6.4 million.

Laboratory and radiology services are essential parts of the Medicaid health care delivery system. Physicians and dentists would be greatly handicapped without these valuable diagnostic tools.

Lab and x-ray services are available in conjunction with other Medicaid services, such as physician office visits and inpatient hospital care. The services are provided when recommended by a physician or dentist. Because lab and x-ray services are ancillary to other services, Medicaid will not pay for them if other services are not available. For example, if an eligible exhausts his Medicaid hospital days for the year, he also exhausts his eligibility for lab and x-ray services ancillary to inpatient hospital care.

The following types of lab and x-ray facilities provide Medicaid services:

— Independent laboratories

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

— Private and facilities owned and operated by a group of physicians exclusively for their own use

— Facilities in hospitals