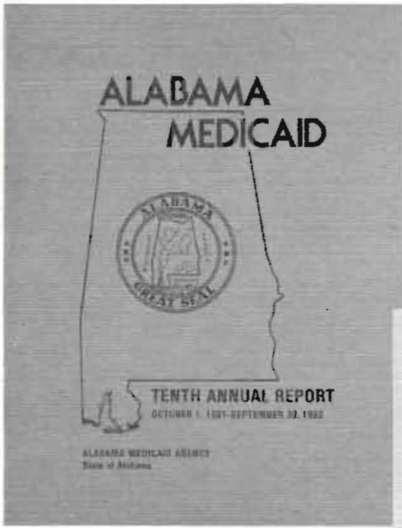
ALABAMA MEDICAID AGENCY



1977-1987
TEN YEARS
OF
DEDICATED
SERVICE

FY 1987
ANNUAL REPORT

GUY HUNT, GOVERNOR
STATE OF ALABAMA

J. Michael Horsley
Commissioner
Alabama Medicaid Agency

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ALABAMA MEDICAID AGENCY
FY 1987 ANNUAL REPORT
OCTOBER 1, 1986 - SEPTEMBER 30, 1987

J. MICHAEL HORSLEY
Commissioner

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

GUY HUNT
Governor

The Honorable Guy Hunt
Governor of the State of Alabama
Statehouse
Montgomery, Alabama 36130

Dear Governor Hunt:

It is my privilege to present to you the 15th Annual Report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1986, and ended September 30, 1987.

During the year, about 365,000 Alabamians benefited from health care delivered through the auspices of the Medicaid program. Among those who depend on Medicaid to meet their health needs are elderly and disabled people in nursing homes and in their own homes, as well as low-income mothers and children. Health care services for the Medicaid population in fiscal year 1987 cost the state and federal governments over $400 million.

Realizing how costly and complex the Medicaid program is, the Alabama Management Improvement Program identified many changes that could be made to existing Medicaid programs that will ultimately save the state's general fund a substantial amount of money. Medicaid staff implemented a number of management improvement recommendations in FY '87, and we look forward to implementing many more in FY '88.

Although the problem of infant mortality did not suddenly surface this year, the agency did begin taking an aggressive approach to reducing Alabama's high infant mortality rate. Doctors, hospital administrators and local government officials throughout the state were contacted during the year in an effort to gain their support for the expansion of Medicaid to more pregnant women and young children as allowed by the federal Sixth Omnibus Budget Reconciliation Act, and to hear their ideas and initiatives for improving health care delivery to these low-income pregnant women and young children.

Alabamians appreciate your support of the Medicaid program, especially your concentration on the needs of mothers and their young children and Alabama's nursing home residents. Along with all the Medicaid staff, I look forward to working with you to strengthen Alabama's Medicaid program, to meet the needs of Alabama's pregnant women and young children, and to foster a spirit of cooperation between all state agencies and the citizens of Alabama.

Sincerely,

J. Michael Horsley
Commissioner

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HIGHLIGHTS OF THE 1987 FISCAL YEAR

As the need for health services and the cost of health care continue to increase, the budgets of many states, including Alabama, have been strained to meet the growing demand for access to care. The trend toward increased health care costs has not changed during the past year, and the number of Alabamians eligible for Medicaid benefits -- about one person in ten -- has remained fairly constant. Because budget restrictions make it necessary to control costs, Alabama's Medicaid program provides basic care but includes few extra or optional services.

Tenth Anniversary

1987 marked the tenth year of the Medicaid Agency's existence as an entity unto itself. Medicaid was created in 1965 by the federal government along with a sister program, Medicare. The Medicaid program was initiated in Alabama in 1970 as a State Department of Health program. In June 1977, the Medical Services Administration was pulled away from the Department of Health by Governor George C. Wallace and placed under the Governor's Office. The name Medical Services Administration was changed to Alabama Medicaid Agency in March 1981 by Executive Order of the Governor.

During the past ten years, five individuals have served as Commissioner of the Medicaid Agency. From June 1977 to August 1979, Jack E. Worthington served as Commissioner; next came William H. (Hoke) Kerns who served from August 1979 to September 1980; then Commissioner Rebecca Beasley served from October 1980 to November 1981; Faye S. Baggiano served as Commissioner from February 1982 to January 1987, when Governor Guy Hunt appointed current Commissioner J. Michael Horsley.

At least 40 employees have been at Medicaid throughout the past ten years and have observed the Medicaid program evolve, growing from a staff of 121 in 1977 to a little less than 300 at the end of FY '87. These employees have been witness to many changes in the program, and have seen the value of Medicaid to the state's economy over the years. During the ten years between October 1, 1977, to September 30, 1987, the Medicaid Agency has paid providers about three and a half billion dollars. Nearly three-quarters of that sum represented federal funds brought into the state.

The Medicaid funds have been spent to provide health care services to 300,000 recipients per year. This means that approximately ten percent of Alabama's population received medical attention that they might not have received if it were not for the Medicaid program.

Another way the Alabama Medicaid program has bolstered the state's economy is through its contribution of federal funds to programs under the Department of Mental Health and Mental Retardation, the Department of Human Resources and the Commission on Aging.

Alabama Management Improvement Program

The Alabama Management Improvement Program (AMIP), a comprehensive study of state departments designed to improve the efficiency and effectiveness of their operations, organizational structure, programs and management, has proven very beneficial to the Alabama Medicaid Agency.

AMIP's study of the Medicaid Agency resulted in more than 50 recommendations, many of which will save the state's general fund a substantial amount of money. Recommendations coming out of the project that were implemented this year include: bringing the institutional utilization review function back into the agency, within the hospital program division; limiting certain Medicaid-reimbursed prescriptions to no more than a 30-day supply; having Medicaid's utilization review committee (URC) review provider cases (in addition to recipient cases) to determine what sanctions and/or penalties should be imposed when violations of Medicaid policy are found; revising the Medicaid organizational structure; and revising the explanation of payment on outpatient hospital claims to include the reason for disallowed charges for outpatient services.

Implementation of the remaining recommendations will continue being made in

the most expedient manner possible. Full implementation should result in marked progress and substantial savings in several Medicaid programs.

Improvements for Providers

In April 1987, the Alabama Medicaid Agency began making payments to health care providers on a twice-a-month schedule. Several thousand providers--physicians, hospitals, nursing homes, pharmacists and others participating in the state Medicaid program--could expect to receive payment for services rendered within 30 days. The change in the payment schedule assisted the Medicaid Agency in adhering to federal requirements for timeliness in payment of claims.

Early in FY '87, Governor Guy Hunt announced plans to increase Medicaid fees paid to physicians for a normal delivery of a baby from the current $450 to $675, a 15 percent increase over the national average. This increase in payment should keep current Medicaid providers in the program as well as provide incentive for other physicians to deliver babies for Medicaid-eligible women.

Physicians, as well as recipents, will benefit from this year's change to the program that allows 12 inpatient visits per physician, regardless of the number of hospital days utilized by the patient.

This year also brought about expanded services Medicaid can provide on an outpatient basis in ambulatory surgical centers. Medicaid will now cover any surgery that can be done safely on an outpatient basis--whether inpatient or outpatient is up to the physician.

Medicaid's Initiatives for the Elderly and Disabled

At the end of September 1987, Alabama's waiver for the elderly and disabled expired. The program continued, however, with no lapse in services when the federal Health Care Financing Administration approved a five-year renewal of Alabama's Medicaid waiver effective October 1, 1987 through September 30, 1992. The waiver renewal will allow Medicaid to serve 4,694 people in FY '88, and the number will increase by 500 people a year over the next five years so that by the fifth year the state will be allowed to serve 6,694 people.

Alabama is fortunate to have one of the largest Medicaid waiver programs in the country. The program helps to prevent the need for expensive nursing home care by providing services at home and in the community. Those eligible include elderly and disabled people who qualify for Medicaid and also meet the medical requirements for nursing home care paid for through Medicaid.

The Alabama Medicaid Agency administers the waiver program, contracting with the Department of Human Resources and the Alabama Commission on Aging for delivery of the services. These agencies also provide the state share of the funding for the program.

In October 1987, the Alabama Medicaid Agency helped sponsor the Fifth Annual National Home and Community-Based Services Conference in Mobile. Attending the meeting were about 250 people from across the United States interested in providing services for the elderly and disabled in their homes and communities.

Preventive Health

This year, in an effort to emphasize the importance of preventive health to the Medicaid program, the preventive health unit became a part of the Commissioner's staff, under the direct supervision of the Commissioner's Executive Assistant.

The Alabama Medicaid Agency also stressed the value of preventive health when it sponsored a health fair for its employees on June 5. The agency's personnel and many health-related organizations participating in the health fair held at the Medicaid offices had access to a variety of tests and measures such as height, weight, blood pressure, cholesterol level, sickle cell anemia, flexibility, percent body fat and vision checks. Information was available on nutrition, cancer, dental health, seat belts, AIDS and smoking cessation.

One important policy to Medicaid's preventive health program was implemented early in 1987. This policy deters smoking by designating only special areas where personnel may smoke.

Plans began in FY '87 for a preventive health conference to be held in Mobile, Alabama May 17-20, 1988. Participants from 11 states are expected at this regional conference entitled, "Getting the Message Out: Prevention Today for a Healthier Tomorrow," which will feature workshops on substance abuse, teenage pregnancy, suicide prevention, AIDS, dental sealants, nutrition, chronic diseases and stress management.

Infant Mortality

Early in 1987, the Medicaid Agency began looking for creative ways to finance an expansion of the program to include pregnant women and children with incomes less than the federal poverty level. Pursuant to this, a bill to establish a Mothers and Babies Indigent Care Trust Fund was passed by the Legislature in 1987. Supported by Governor Guy Hunt, the bill created a fund into which monies could be deposited for expanding Medicaid coverage to more pregnant women and young children. Many local governments and hospitals expressed interest in donating their funds earmarked for uncompensated indigent health care so that the money might be matched by three federal dollars. However, in November 1987, when it became apparent that this plan would take too long to implement, the Governor decided to pursue funding of the medicaid expansion through the state legislature.

Medicaid coverage will soon be extended to all pregnant women in families with incomes below the federal poverty level. When coverage of this new group is implemented, Medicaid will provide prenatal, delivery and postpartum services, along with follow-up family planning services. The plan will also cover young children in families below the poverty level.

Expansion of Medicaid coverage to more pregnant women and children was made possible in April 1987, when provisions of a federal law enacted in 1986 became effective. The Sixth Omnibus Budget Reconciliation Act, known as SOBRA, allows states to expand Medicaid eligibility without expanding eligibility for Aid to Dependent Children. Prior to SOBRA, expansion of Medicaid eligibility meant expansion of eligibility for cash assistance through ADC. The Medicaid Agency's full implementation of SOBRA sometime in 1988 should contribute to a reduced infant mortality rate in Alabama.

In a further effort to reduce the number of infant deaths, Governor Hunt appointed a task force on infant mortality. Medicaid Commissioner Mike Horsley was appointed chairman of this 37-member group charged with making recommendations to the Governor on actions needed to reduce infant mortality and morbidity rates in Alabama.

Along with this stride taken on behalf of Alabama's children, the Governor's Office, in cooperation with the Department of Human Resources, Alabama Medicaid Agency, and Department of Public Health, began planning a symposium on infant mortality. Also cooperating in this effort were the March of Dimes and the Southern Governors' Association.

Eligibility

During the year, Medicaid eligibility was affected by the decision in the case, *Ward v. Hunt*. The U.S. District Court ordered that Alabama could no longer count the income of siblings or grandparents in deciding whether someone is eligible for health care through Medicaid. The ruling, in effect, made it possible for some families to qualify for Medicaid even though ineligible to receive Aid to Dependent Children (ADC).

Fraud and Abuse Conference

In July 1987, the Alabama Medicaid Agency hosted the Southern Regional Fraud and Abuse Conference sponsored by the Health Care Financing Administration (HCFA). Governor Guy Hunt addressed the opening session of the conference.

Representatives from eight southeastern states and HCFA attended the conference in Montgomery where they shared information on state and federal initiatives to combat fraud and abuse in the Medicaid program. The meeting was directed toward administrators and investigators working with state Medicaid agencies and state Medicaid Fraud Control Units.

ALABAMA'S MEDICAID PROGRAM

History

Medicaid was created in 1965 by the federal government along with a sound-alike sister program, Medicare. Medicaid is jointly financed by the state and federal governments and is designed to provide health care to low income individuals. Medicare is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. 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. Almost 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. During fiscal year 1987, the formula was approximately 72/28. For every $28 the state spent, the federal government contributed $72.

Eligibility

Persons must fit into one of several 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, which determines their eligibility,

— persons approved for cash assistance through the State Department of Human Resources, which determines their eligibility. 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.

— certain pregnant women and children who do not receive an ADC cash payment and foster children in the custody of the state.

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 from one of several thousand 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.

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.

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 '87, Medicaid paid about $420 million on behalf of persons eligible for the program. The state paid only $118 million of the total expenditures, while the federal government provided $302 million, or about three-quarters of the total.

Historically, Alabama's Medicaid program has one of the lowest administrative costs per eligible of any program in the nation. This means that nearly all of Medicaid's expenditures went to purchase services for eligibles. Medicaid funds are paid directly to the 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 over $1.2 billion worth of business in the state during FY '87.

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 in 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 '87 COUNTY IMPACT
Year's Cost per Eligible
Table-1

COUNTY	BENEFIT PAYMENTS	ELIGIBLES	PAYMENT PER ELIGIBLE
AUTAUGA	$2,042,982	2,608	$783
BALDWIN	$4,657,299	4,597	$1,013
BARBOUR	$3,936,882	3,803	$1,035
BIBB	$1,768,734	1,560	$1,134
BLOUNT	$2,381,065	2,092	$1,138
BULLOCK	$2,061,990	2,735	$754
BUTLER	$3,250,650	3,292	$987
CALHOUN	$8,734,160	9,423	$927
CHAMBERS	$3,647,126	3,873	$942
CHEROKEE	$1,164,698	1,236	$942
CHILTON	$2,550,736	2,309	$1,105
CHOCTAW	$1,703,675	2,636	$646
CLARKE	$3,192,940	4,069	$785
CLAY	$1,841,244	1,158	$1,590
CLEBURNE	$936,830	923	$1,015
COFFEE	$3,961,386	3,153	$1,256
COLBERT	$4,227,144	3,435	$1,231
CONECUH	$1,682,581	2,068	$814
COOSA	$857,869	1,045	$821
COVINGTON	$3,950,212	3,359	$1,176
CRENSHAW	$2,501,343	2,021	$1,238
CULLMAN	$5,813,817	4,019	$1,447
DALE	$3,781,190	3,371	$1,122
DALLAS	$7,678,490	11,010	$697
DEKALB	$5,898,841	4,306	$1,370
ELMORE	$11,702,315	3,658	$3,199
ESCAMBIA	$3,472,531	3,495	$994
ETOWAH	$10,066,702	7,404	$1,360
FAYETTE	$1,914,434	1,821	$1,051
FRANKLIN	$4,059,122	2,910	$1,395
GENEVA	$2,592,524	2,619	$990
GREENE	$1,881,007	2,910	$646
HALE	$2,807,427	3,036	$925
HENRY	$1,669,375	1,827	$914
HOUSTON	$4,861,426	6,247	$778
JACKSON	$3,418,436	3,872	$883
JEFFERSON	$57,659,161	53,677	$1,074
LAMAR	$2,044,927	1,389	$1,472
LAUDERDALE	$6,271,820	4,899	$1,280
LAWRENCE	$2,893,005	2,836	$1,020
LEE	$4,384,109	5,363	$817
LIMESTONE	$3,127,169	3,174	$985
LOWNDES	$1,680,912	3,026	$555
MACON	$4,545,347	4,758	$955
MADISON	$9,086,260	11,386	$798
MARENGO	$3,643,903	4,040	$902
MARION	$3,648,453	2,213	$1,649
MARSHALL	$7,372,043	5,954	$1,238
MOBILE	$38,055,454	39,158	$972
MONROE	$2,205,167	3,008	$733
MONTGOMERY	$17,983,188	20,446	$880
MORGAN	$20,631,110	6,434	$3,207
PERRY	$2,551,888	3,548	$719
PICKENS	$3,478,651	3,755	$926
PIKE	$3,695,919	4,247	$870
RANDOLPH	$2,486,275	2,195	$1,133
RUSSELL	$5,062,765	5,076	$997
SHELBY	$3,700,587	2,706	$1,368
ST. CLAIR	$2,809,682	2,967	$947
SUMTER	$2,790,610	3,992	$699
TALLADEGA	$7,721,596	8,860	$872
TALLAPOOSA	$6,245,357	3,628	$1,721
TUSCALOOSA	$29,851,870	13,798	$2,163
WALKER	$8,044,386	5,839	$1,378
WASHINGTON	$1,930,916	2,396	$806
WILCOX	$2,598,497	4,336	$599
WINSTON	$3,038,407	1,752	$1,734

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 Subsystem: 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 beginning in October 1979. Alacaid was awarded a third consecutive contract effective October 1, 1985. Alacaid's performance in claims processing has been among the best in the nation. The current fiscal agent contract expires on September 30, 1988.

Governor Hunt signed into law on June 29, 1987, a bill that modified the length of the Alabama Medicaid fiscal agent contract from a three-year period to a five-year period. A ten-member committee comprised of agency staff began working in April 1987 on an invitation to bid for fiscal agent services. This invitation to bid will establish a contract for the period beginning October 1, 1988 and running through September 30, 1991 with the option for two one-year extensions. The fiscal agent market has become extremely competitive in the last few years. It is anticipated that the time and effort spent on this procurement will result in a new contract that will offer expanded and improved service while keeping the overall cost to the State of Alabama to a minimum.

FY '85-'87 Medicaid Software Activity — **Table - 2**

	FY '85	FY '86	FY '87
Number of programs in production at year end	1,560	1,737	2,183
Number of requests received for software support	1,524	1,401	1,779
Number of requests completed	1,367	1,173	1,580

PROGRAM INTEGRITY

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

One unit within the Program Integrity Division is Quality Control. It is the function of this unit to make sure the Medicaid Agency is performing eligibility determinations as accurately as possible.

The processing and payment of Medicaid claims is monitored by the Systems Audit Unit through its administration of the Claims Processing Assessment System (CPAS). The unit identifies deficiencies in the management information system that contribute to Medicaid payment errors.

Recipient Eligibility Review, another unit within Program Integrity, recovers funds from individuals who received Medicaid services but were not eligible for the program. In most instances, these cases involve persons in nursing homes who were actually ineligible for Medicaid because of inaccurately reported incomes or assets.

An addition to the Program Integrity Division during FY '87 was the Pharmacy Review Unit. This unit performs two separate functions-- pharmacy review and investigations. The pharmacy review section assures that providers comply with all applicable Medicaid rules and regulations; the investigations section ensures that quality health care is available to Medicaid recipients through its detection of violations of state and federal regulations governing the Medicaid program. The existence of this section can be a deterrent to such violations.

Surveillance and Utilization Review (SUR) is the unit that looks for fraud and abuse in the program; 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. Unusual patterns are analyzed, and, if necessary, referred to the Utilization Review Committee (URC). The URC is composed of medical, program and financial experts who may take several types of action in cases of aberrant utilization. They may give written warnings and administrative sanctions such as restrictions or terminations from the program and recoupment of funds. Cases of provider fraud may be referred to the Alabama Attorney General's Medicaid Fraud Control Unit for further investigation and possible prosecution.

In FY '87, the Program Integrity Division saved the Medicaid program $2,607,433 --the total amount of Medicaid funds that would have been erroneously spent if irregularities had not been discovered prior to payment.

During the year, complete integrity reviews were conducted on 225 providers and 1,237 recipients suspected of possible fraud or abuse. Thirteen cases of suspected provider fraud were referred to the Attorney General's Medicaid Fraud Control Unit for prosecution, while 15 cases of suspected recipient fraud were referred to local district attorneys.

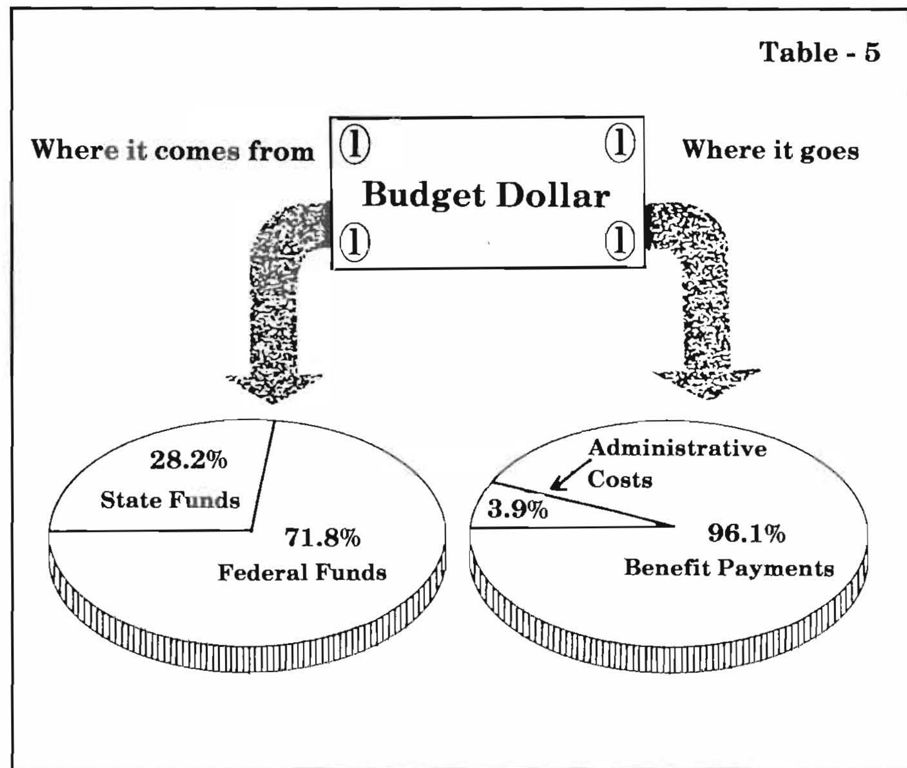
Among the administrative sanctions used to control abuse in the Medicaid program is the lock-in program whereby recipients who abuse the program are locked-in to certain providers. During the year, 391 cases of suspected abuse were reviewed, and 100 recipients were restricted to receiving services from specific providers. The majority of these recipients were suspected of overutilizing prescription drugs. Imputed savings from locked-in recipients totaled almost $40,000 in FY '87.

FY '87 PROGRAM INTEGRITY Closed Case Summary — **Table - 3**

Provider Reviews 321	Referred to Attorney General 13	Recoupments Identified $172,208	Providers Terminated from the Medicaid Program 7
Recipient Reviews 1,237	Referred to District Attorney 15	Recoupments Identified $582,990	Recipients Terminated from the Medicaid Program 112

REVENUE, EXPENDITURES, AND PRICES

FY '87 Table - 5 Sources of Medicaid Revenue	
Federal Funds	$313,925,568
State Funds	$123,478,231
Total Revenue	$437,403,799



FY '87 Table - 6 Disbursement of Federal Funds	
(net)	DOLLARS
Family Planning Administration	$ 143,549
Professional Staff Costs	5,810,486
Other Staff Costs	3,748,771
Other Provider Services	301,226,979
Family Planning Services	2,995,783
TOTAL	$313,925,568

FY '87 Table - 7 Sources of State Funds	
	DOLLARS
Encumbered Balance Forward	$ 1,649,279
Basic Appropriations	94,872,373
Supplemental Appropriations	11,000,000
DHR/Mental Health/ COA/Youth Services	24,005,660
Interest Income from Fiscal Intermediary	334,533
Miscellaneous Receipts	11,000
	$131,872,845
Encumbered*	8,394,614
TOTAL	$123,478,231

*Due to a deficit of Federal funds, this amount was not available for encumbrance. Only $3,932,609 was actually encumbered.

FY '87 Table - 8
Benefit Cost by Fiscal Year in which Obligation was Incurred

	FY '87	FY '88 (EST.)
Nursing Homes	$145,119,021	$152,500,000
Hospitals	75,093,733	79,500,000
Physicians	35,329,249	38,400,000
Insurance	26,594,406	43,000,000
Drugs	44,671,851	47,000,000
Health Services	7,610,527	9,760,000
Community Services	22,342,865	25,240,000
Total Medicaid Service	356,761,652	395,400,000
Mental Health	65,907,861	67,800,000
Total Benefits	$422,669,513	$463,200,000

In FY '87, Medicaid paid $420,388,204 for health care services to Alabama citizens. Another $17,015,595 was expended to administer the program. This means that less than four cents of every Medicaid dollar did not directly benefit recipients of Medicaid services.

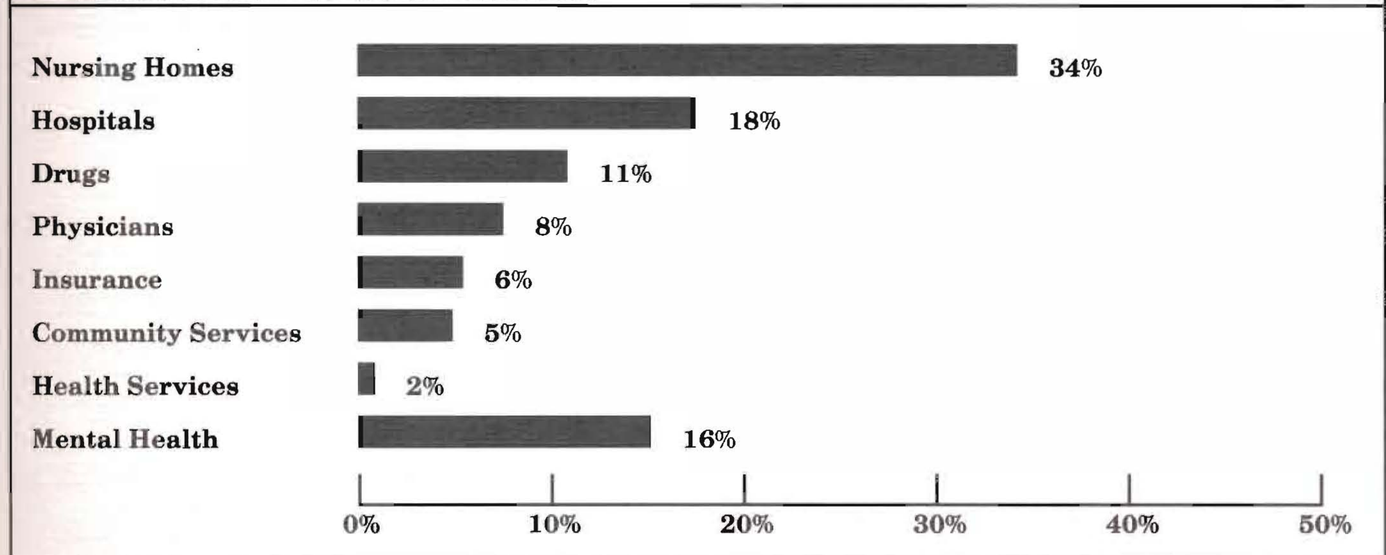
FY '87 EXPENDITURES
By Type of Service (net)

Table - 9

Service	Payments	Percent of Payments by Service FY '87	Percent of Payments by Service FY '86	Percent of Payments by Service FY '85
ICF	132,565,382	31.54%	28.74%	30.02%
SNF	11,720,100	2.79%	2.31%	2.33%
Hospital Inpatient	69,404,636	16.50%	16.19%	15.81%
Hospital Outpatient	5,147,522	1.23%	2.40%	2.00%
ICF-Mentally Retarded & MD	53,104,813	12.63%	12.06%	12.39%
Physicians' Services	34,815,718	8.28%	8.63%	8.79%
Drugs	44,412,818	10.57%	9.47%	9.34%
Medicare Buy-In Insurance	18,987,629	4.52%	4.96%	7.46%
Dental Service	3,649,222	.87%	.85%	1.05%
Family Planning Care	3,328,648	.79%	.88%	1.09%
Home Health	5,671,028	1.35%	1.23%	.91%
Waivered Services	20,588,947	4.90%	5.82%	1.61%
Eye Care	2,427,513	.58%	.62%	.58%
Lab & X-ray	1,050,106	.25%	.25%	.23%
Screening	1,063,048	.25%	.23%	.20%
Transportation	377,592	.09%	.10%	.08%
Hearing	84,348	.02%	.03%	.03%
Mental Health Services	4,477,031	1.06%	.81%	.36%
Co-Insurance	6,989,553	1.66%	4.37%	5.71%
Other Care	522,550	.12%	.05%	.01%
Total For Medical Care	$420,388,204	100.00%	100.00%	100.00%
Administrative Costs	17,015,595			
Net Payments	$437,403,799			

PERCENTAGE DISTRIBUTION OF BENEFIT COSTS INCURRED DURING FISCAL YEAR 1987

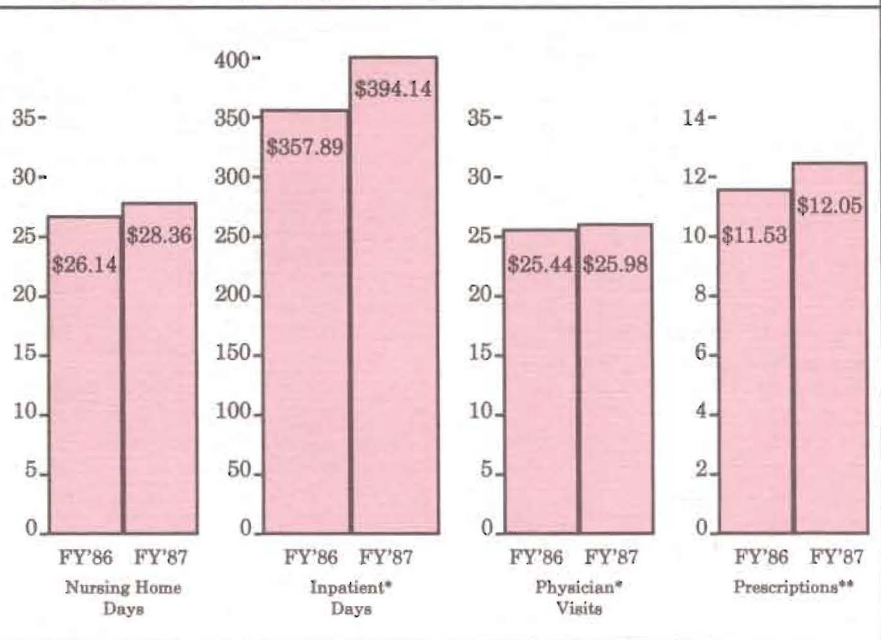
Table - 10



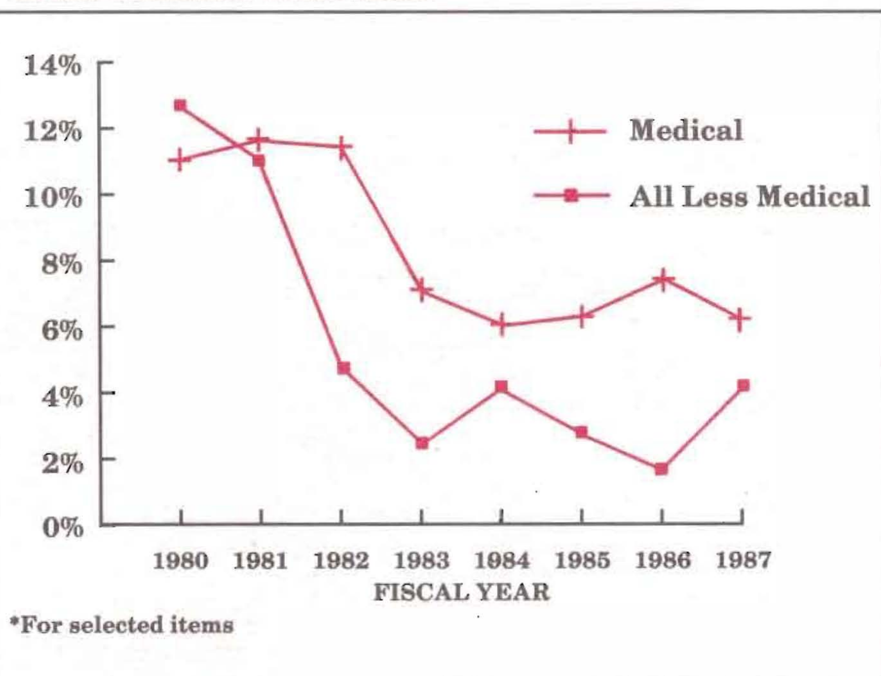
Prices

Price per unit of service is one of the most important factors that influence the cost of medical care. Table 12 shows the rates of growth in the Consumer Price Index's medical care components and all items less medical care. The Consumer Price Index, which is the most widely publicized measure of inflation, is published monthly by the Bureau of Labor Statistics and is generally accepted as an accurate measure of changes in prices. Increases in price levels of medical care components of the Consumer Price Index are usually reflected in increases of future Medicaid payments to providers.

An example of how inflation impacts the Medicaid program is the increase in average prices for a day of nursing care and a day of inpatient hospital care. The Medicaid per diem rates for these services are based on a reimbursement methodology that takes into account an inflation factor. This year the primary factor influencing the increase in average payment per day for these two services was the rate of inflation.



*Crossover Claims Excluded
**Family Planning Drugs Excluded



Population

The population of Alabama grew from 3,444,165 in 1970 to 3,893,888 in 1980. In 1987, Alabama's population was estimated to be 4,148,905.

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 is reflected in population statistics for Alabama. Population projections published by the Center for Business and Economic research at the University of Alabama reveal that by 1990 there will be more than 550,000 persons 65 years of age and over in the state. The Center for Demographic and Cultural Research at Auburn University at Montgomery reports that white females 65 years of age and over account for almost one-half of the elderly population in the state. Historically, cost per eligible has been higher for this group than other groups of eligibles.

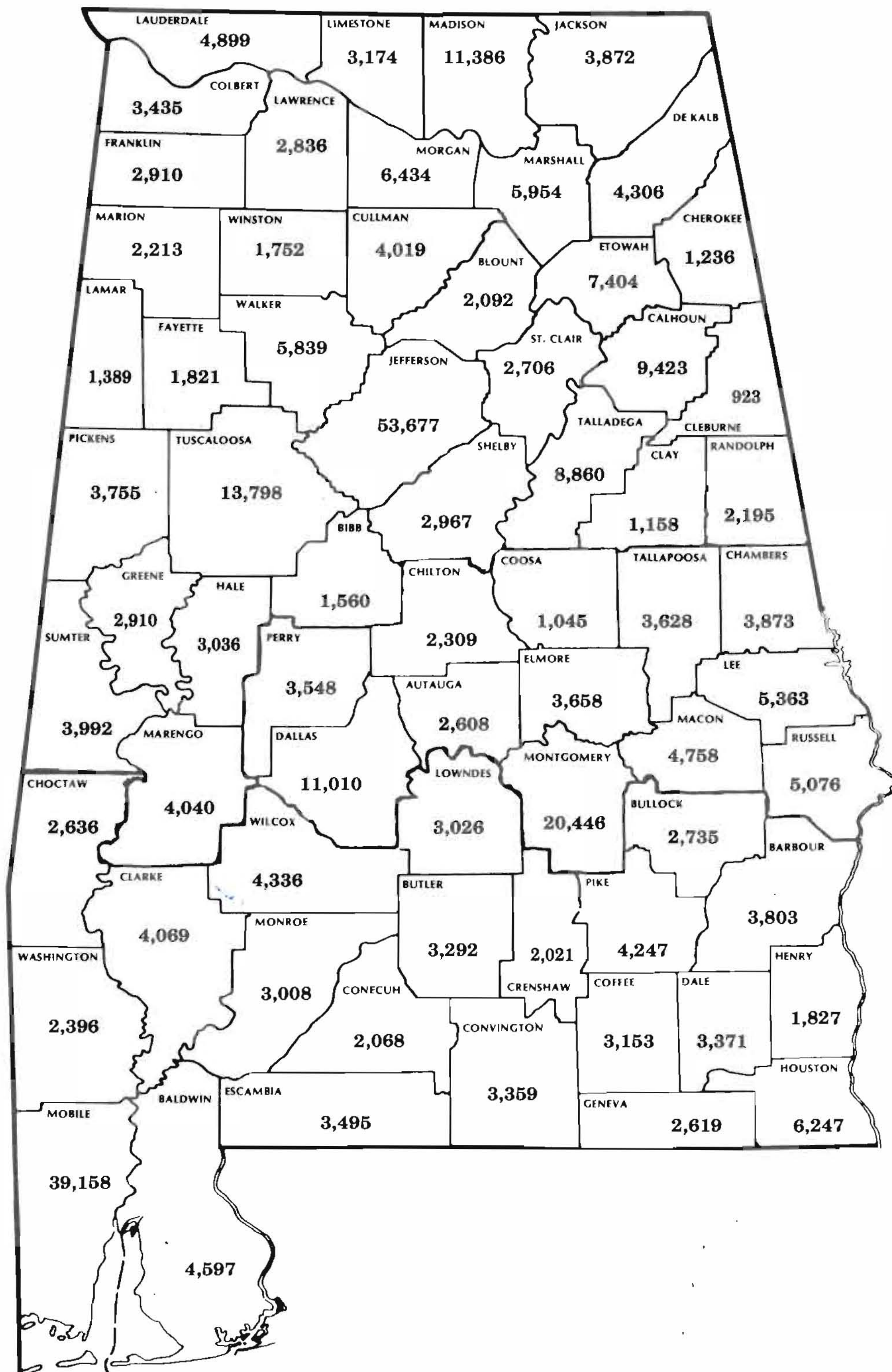
FY '85 - '87 **Table - 13**
POPULATION
Eligibles as Percent of Alabama Population by Year

Year	Population	Eligibles	Percent
1985	4,053,628	380,513	9.4
1986	4,101,507	374,953	9.1
1987	4,148,905	364,861	8.8

FY '87 **Table - 14**
POPULATION ESTIMATES*

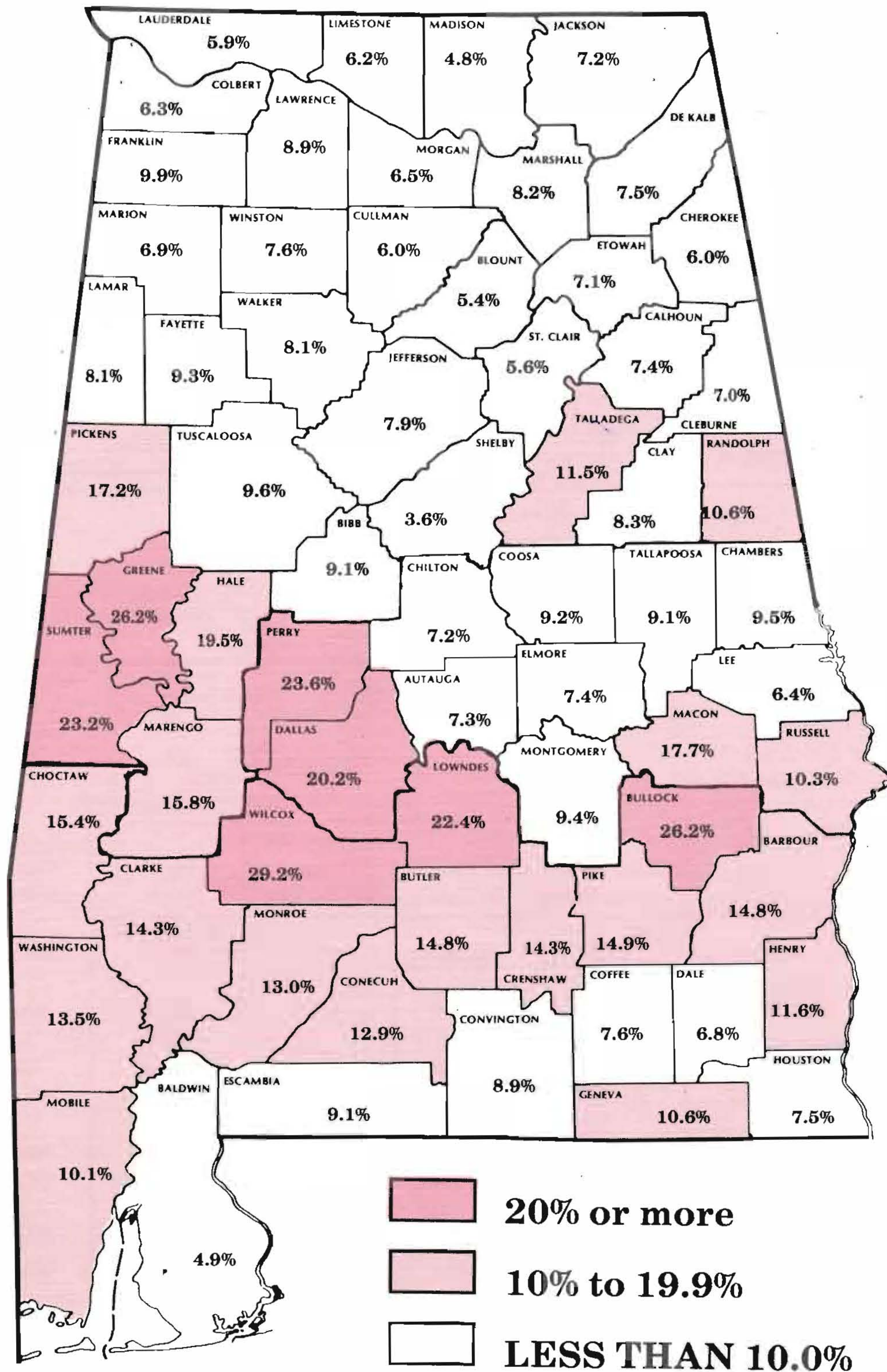
*Estimates by CENTER FOR BUSINESS AND ECONOMIC RESEARCH

FY '87
NUMBER OF MEDICAID ELIGIBLES BY COUNTY **Table - 15**



FY '87
ELIGIBLES
Percent of Population Eligible for Medicaid

Table - 16



ELIGIBLES

During FY '87, there were 364,861 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 291,659. 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.

Table 18 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.

Although 364,861 people were eligible for Medicaid in FY '87, only about three-fourths were eligible all year. The length of eligibility for the other one-fourth 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 by 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. Table 20 shows this measure for each category and group.

FY '87 ELIGIBLES Monthly Count — **Table - 17**

	Monthly Count
October '86	293,933
November	293,626
December	292,543
January '87	293,802
February	292,353
March	292,123
April	293,344
May	291,107
June	289,833
July	291,215
August	289,931
September	286,099

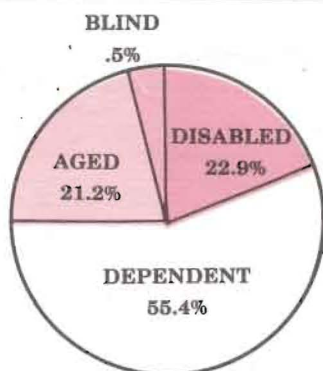
FY '87 ELIGIBLES Total Number for Year Average Number per Month — **Table - 18**

	First Month	Number Added During Year	Total Number for Year	Number Dropped During Year	Final Month	Average Number per Month	Total Turnover Rate
All categories	293,933	70,928	364,861	78,762	286,099	291,659	25.10%
Aged	70,894	6,209	77,103	8,926	68,177	69,343	11.19%
Blind	1,808	113	1,921	170	1,751	1,780	7.92%
Disabled	72,416	11,237	83,653	8,538	75,115	73,647	13.59%
Dependent	148,815	53,369	202,184	61,128	141,056	146,889	37.64%
Males	100,502	26,030	126,532	28,265	98,267	99,979	26.56%
Females	193,431	44,898	238,329	50,497	187,832	191,680	24.34%
Whites	100,707	28,343	129,050	29,792	99,259	100,327	28.63%
Nonwhites	193,226	42,585	235,811	48,970	186,840	191,332	23.25%
Age 0-5	44,431	15,749	60,180	17,860	42,320	44,329	35.76%
Age 6-20	76,185	24,019	100,204	26,863	73,341	75,369	32.95%
Age 21-64	85,849	22,982	108,831	23,578	85,253	85,820	26.81%
Age 65 & Over	87,468	8,178	95,646	10,461	85,185	86,141	11.03%

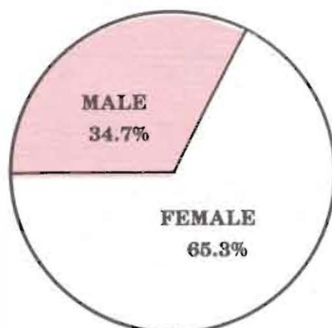
FY '87
ELIGIBLES
Percent Distribution

Table - 19

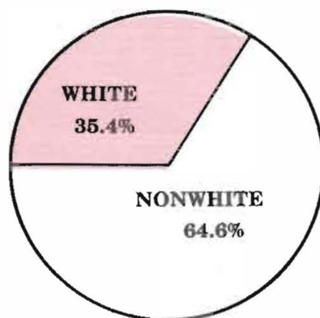
BY CATEGORY



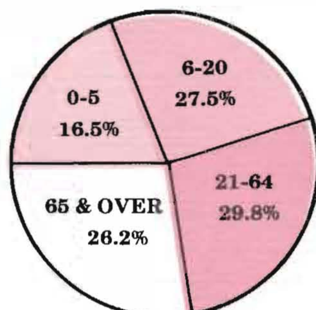
BY SEX



BY RACE



BY AGE



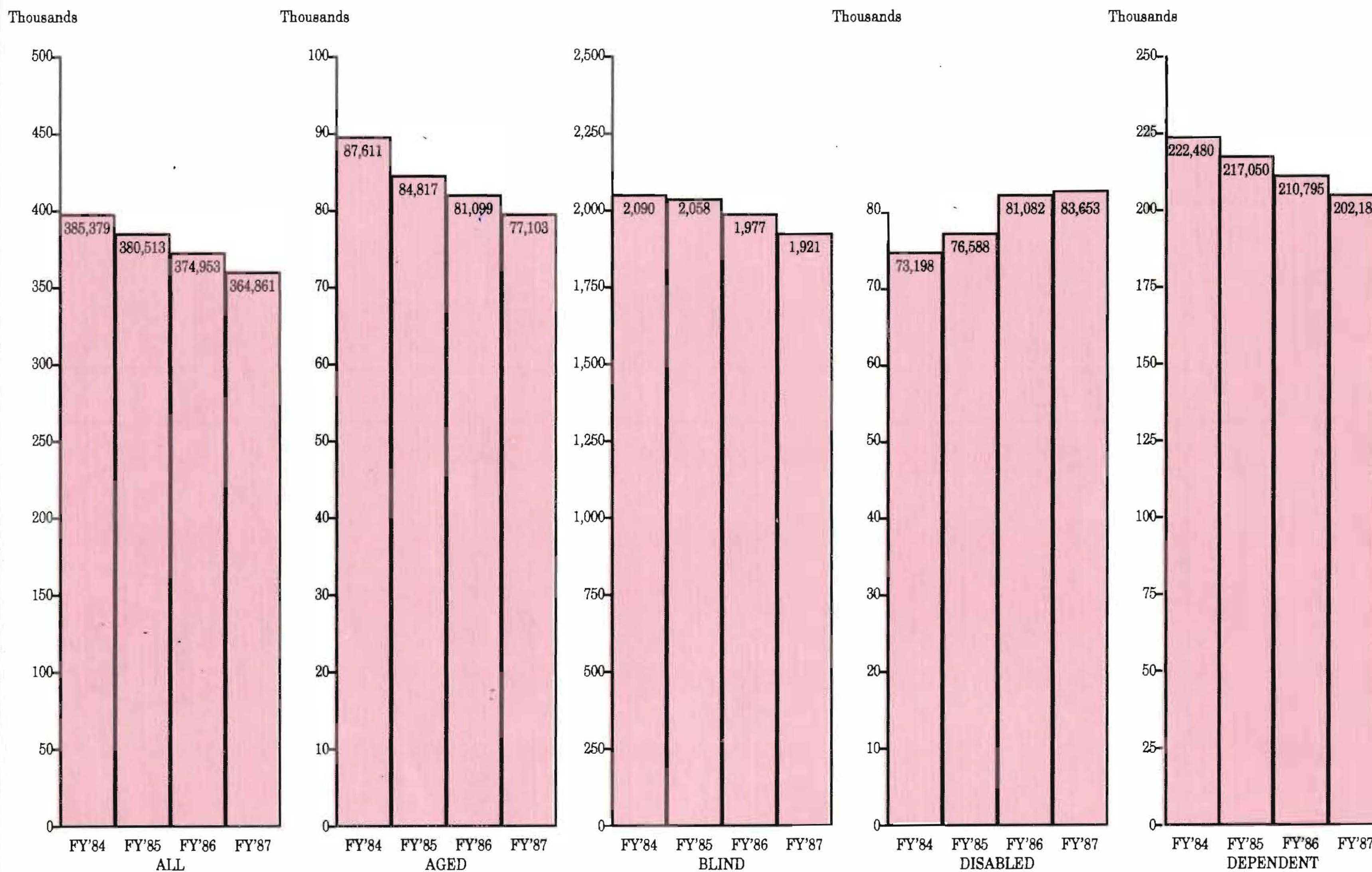
FY '87
ELIGIBLES
Man-Months of Eligibility

Table - 20

	MME
ALL	9.59
AGED	10.79
BLIND	11.12
DISABLED	10.56
DEPENDENT	8.72
MALE	9.48
FEMALE	9.65
WHITE	9.33
NONWHITE	9.74
0-5	8.84
6-20	9.03
21-64	9.46
65 & OVER	10.81

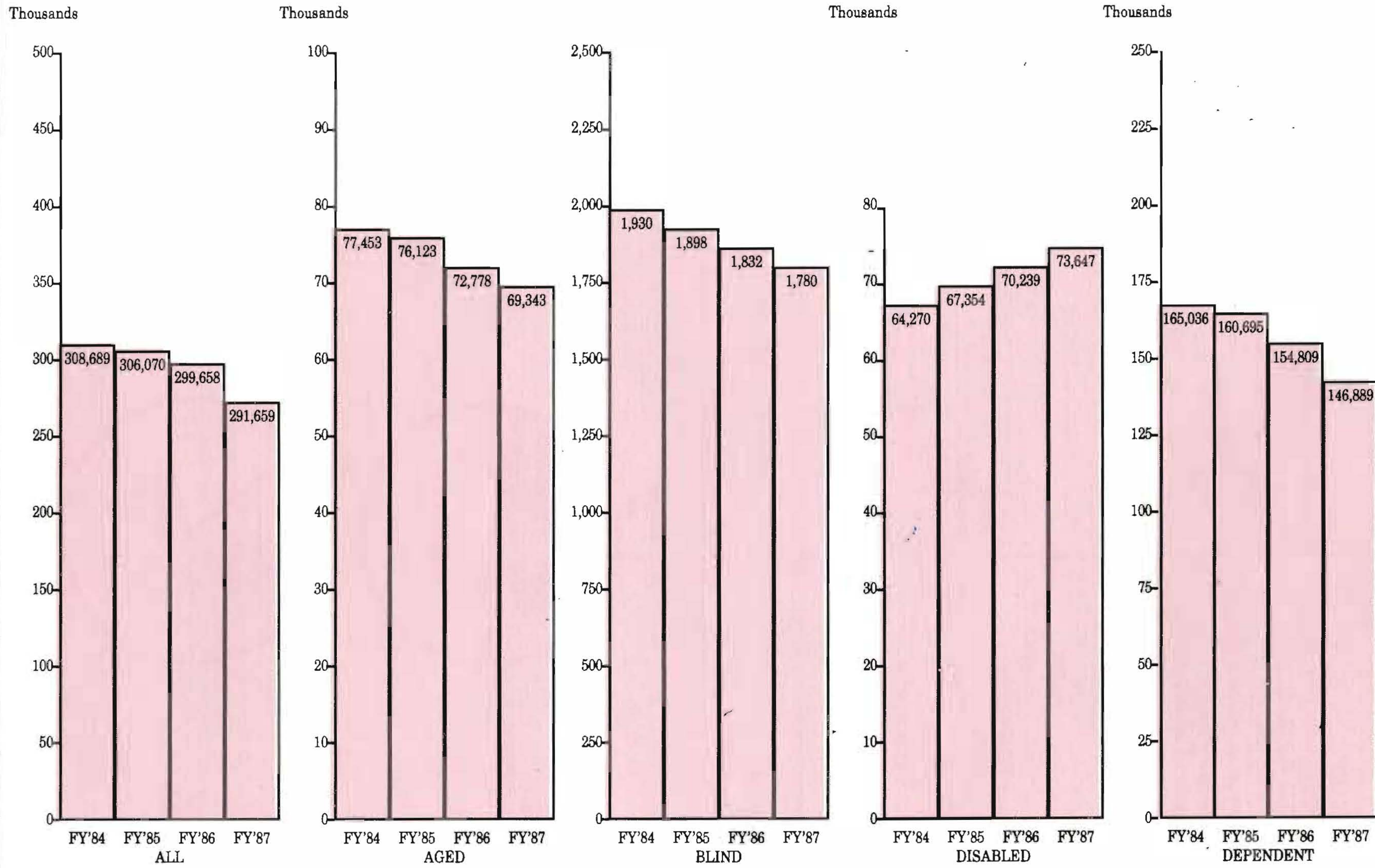
FY '84 - '87
ELIGIBLES
Annual Total

Table - 21



FY '84 - '87
ELIGIBLES
Monthly Average

Table - 22



RECIPIENTS

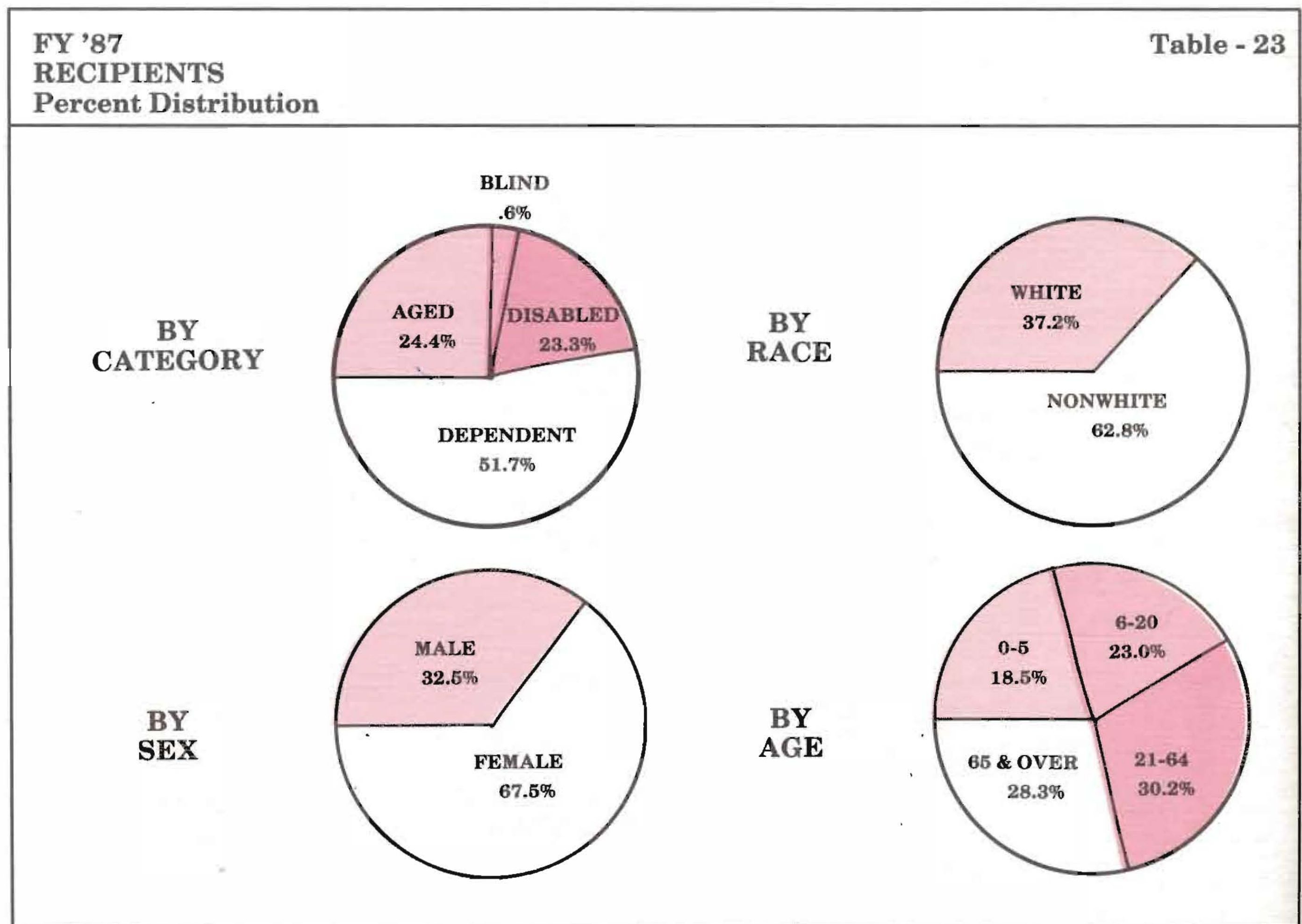
Although there were 364,861 persons eligible for Medicaid in FY '87, only 84 percent of these actually received benefits. These 305,332 persons are called recipients. The remaining 59,529 persons incurred no medical expenses paid for by Medicaid.

The total number of recipients is an unduplicated count. Recipients may be transferred from one category to another during the year. A recipient who receives services under more than one basis of eligibility is counted in the total for each of those categories, but is counted only once in the unduplicated total. This is the reason that recipient counts by category do not add to the unduplicated total.

FY '87 RECIPIENTS Monthly Averages and Annual Total — Table - 24

	Monthly Average	Annual Total
Aged	48,703	78,622
Blind	1,014	1,666
Disabled	46,694	75,250
Dependent	51,308	166,797
All Categories (unduplicated)	145,633	305,332

FY '87 RECIPIENTS Percent Distribution — Table - 23



USE AND COST

The percent distribution of Medicaid payments has changed very little since last year. Most payments are made on behalf of recipients in the aged or disabled categories, females, whites and persons 65 years of age or older.

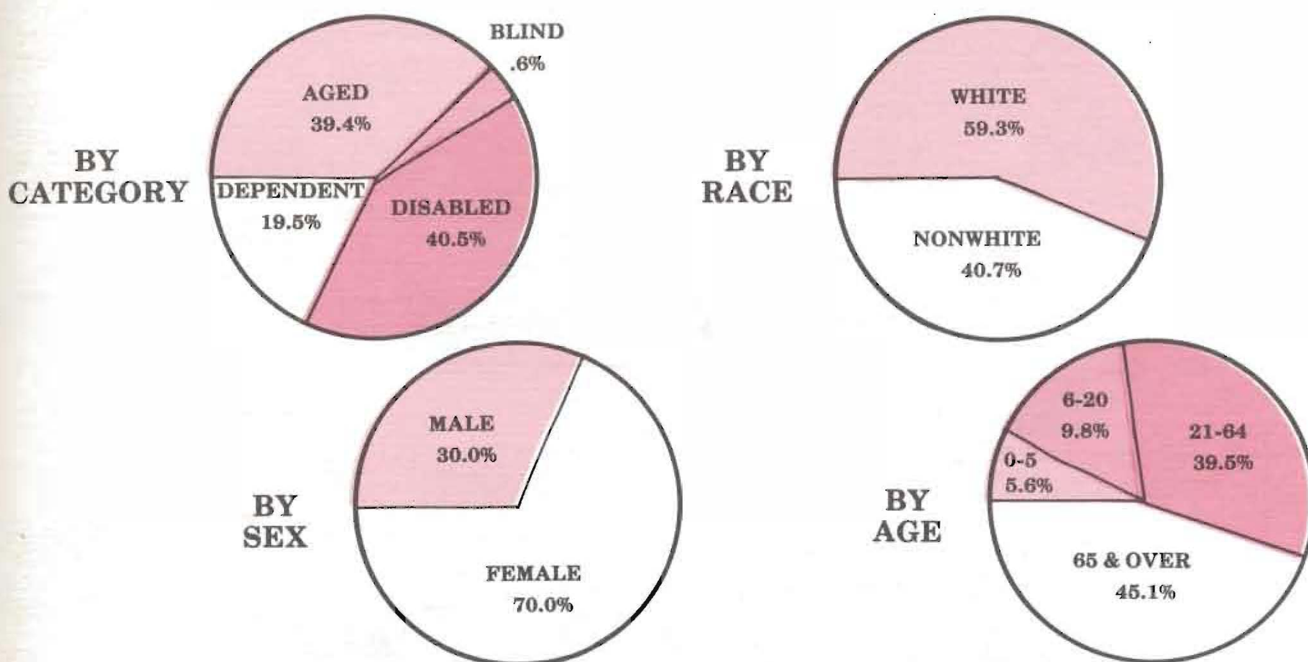
The amount of money Medicaid spends in each county has also shown little change since FY '86. With few exceptions, the counties near large population centers have the largest amount of Medicaid payments made on behalf of their residents. Note the relatively large amount of payments shown in Elmore and Morgan counties. This is due to the location of intermediate care facilities for the mentally retarded in these counties.

This report measures cost in two ways—cost per recipient and cost per eligible. Cost per recipient is calculated by dividing total 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.

It is obvious from these statistics that certain groups are much more expensive to the Medicaid program than others. The reason for these differences is that specific groups tend to use specific types of services. Any Medicaid eligible receives, within reasonable limitations, medically necessary services.

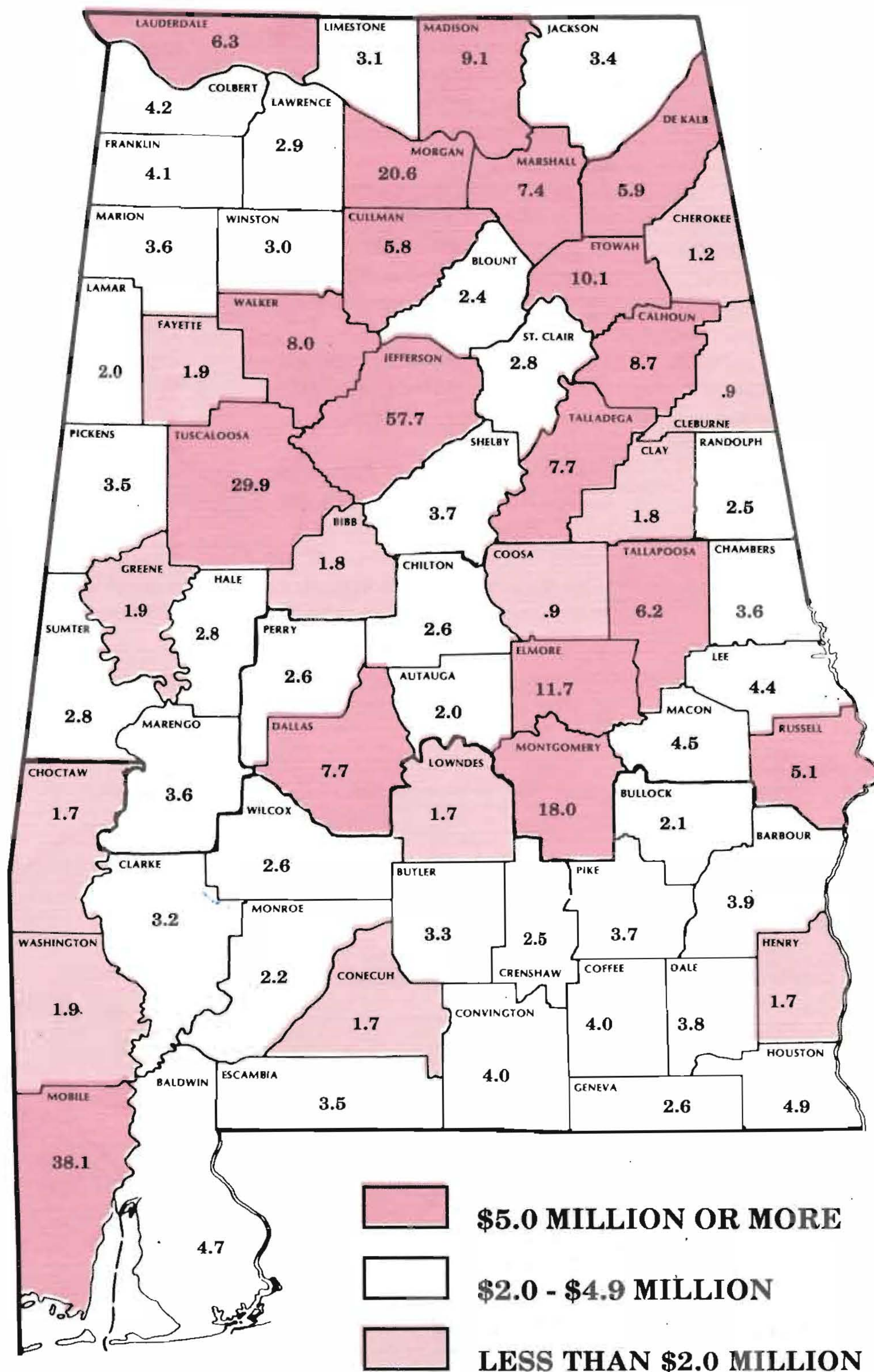
A good example of this is the pattern of use of long-term care. This type of care has a high cost per unit of service, and recipients of long-term care have a high frequency-of-service rate. The average Medicaid payment for a day of intermediate nursing care in FY '87 was $28. The average length of stay for recipients of this service was 273 days. Most recipients of long-term care are white females who are categorized as aged or disabled and are 65 years of age and over. It is not surprising that these groups have a large percentage of Medicaid payments made on their behalf.

FY '87 PAYMENTS Percent Distribution — Table - 25



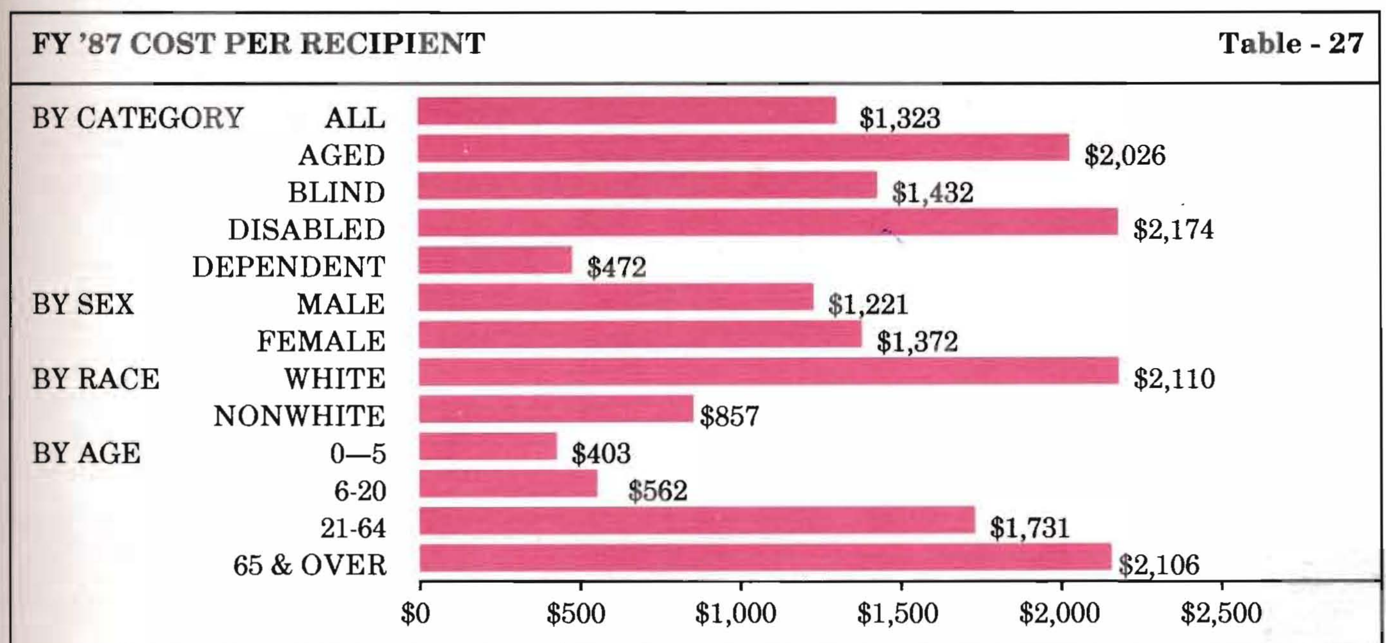
FY '87
PAYMENTS
By County (in millions of dollars)

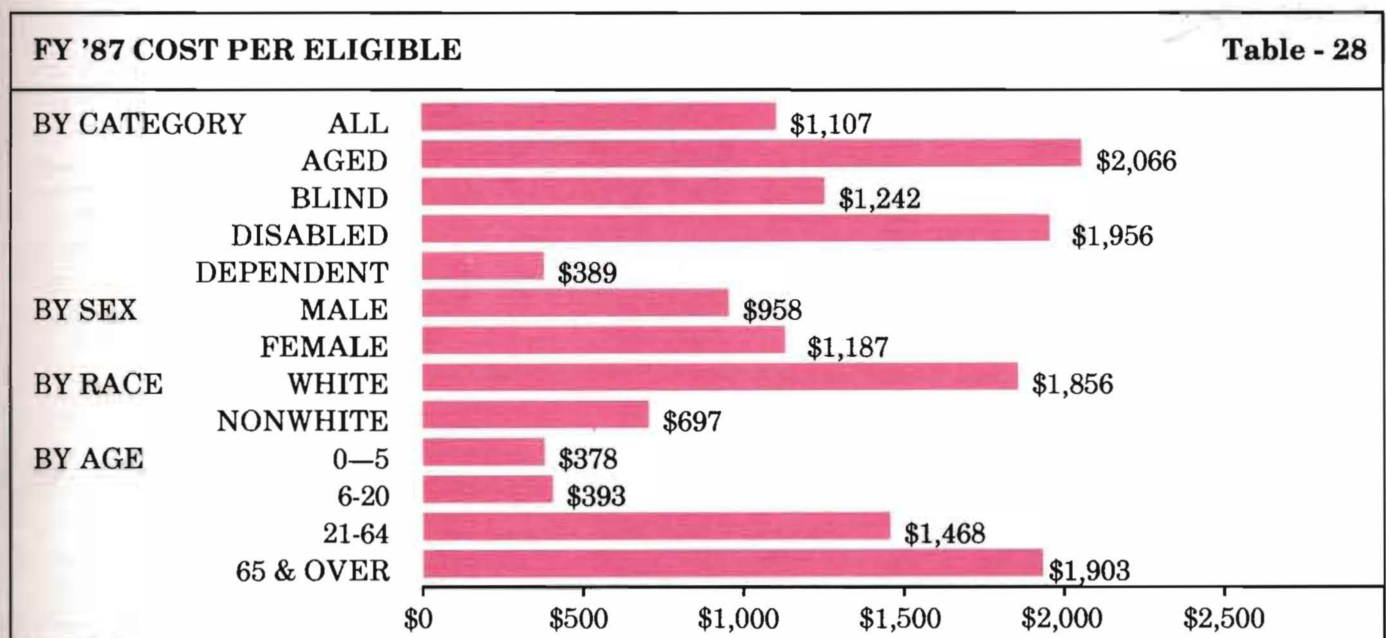
Table - 26



Also, note on Table 29 that cost per recipient for services shared with Medicare is much smaller for the aged category. More than 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 Table 29.

For this coverage Medicaid paid a monthly "buy-in fee" to Medicare. On January 1, 1987, this buy-in fee was increased from $15.50 to $17.90. Medicaid paid $19 million in buy-in fees in FY '87. Medicaid payments for buy-in fees were less than the amount Medicare spent for the partial payment of medical bills incurred by Alabama citizens on Medicaid.





FY '87
USE AND COST
Year's Cost per Service
Year's Total Number of Recipients
Year's Cost per Recipient
Utilization Rates

		SERVICES WITH COSTS 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	$35,932,157	$5,120,634	$69,194,337	$6,801,149	$80,601	$26,889,366	$44,701,304	$12,480,093
	Aged	3,438,600	241,971	3,247,450	265,658	12,321	11,542,314	20,572,261	8,322,910
	Blind	273,886	34,459	498,200	43,579	88	322,432	389,748	66,519
	Disabled	11,435,523	2,101,527	28,025,219	3,196,701	16,669	14,985,603	19,097,101	4,089,310
	Dependent Children	8,830,822	1,029,732	15,504,917	1,761,019	30,371	11,997	1,889,146	1,354
	Dependent Adults	11,953,326	1,712,945	21,918,551	1,534,192	21,152	27,020	2,753,048	0
Section 2 Year's Total Number of Recipients	All Categories***	238,611	108,217	36,508	92,255	1,357	9,917	227,794	3,213
	Aged	55,106	18,345	2,546	6,942	334	4,818	67,239	3,066
	Blind	1,390	662	216	504	2	117	1,420	12
	Disabled	60,936	32,039	11,126	24,060	256	4,939	62,437	724
	Dependent Children	80,334	30,711	8,778	37,531	505	55	62,959	2
	Dependent Adults	47,224	28,026	14,144	24,336	270	80	40,628	0
Section 3 Year's Cost per Recipient	All Categories	$151	$47	$1,895	$74	$59	$2,711	$196	$3,884
	Aged	62	13	1,276	38	37	2,396	306	2,715
	Blind	197	52	2,306	86	44	2,756	274	5,543
	Disabled	188	66	2,519	133	65	3,034	306	5,648
	Dependent Children	110	34	1,766	47	60	218	30	677
	Dependent Adults	253	61	1,550	63	78	338	68	0
Section 4 Utilization Rates Percent of Eligibles	All Categories	65.40%	29.66%	10.01%	25.28%	0.37%	2.72%	62.43%	0.88%
	Aged	71.47%	23.79%	3.30%	9.00%	0.43%	6.25%	87.21%	3.98%
	Blind	72.36%	34.46%	11.24%	26.24%	0.10%	6.09%	73.92%	0.62%
	Disabled	72.84%	38.30%	13.30%	28.76%	0.31%	5.90%	74.64%	0.87%
	Dependent	63.09%	29.05%	11.34%	30.60%	0.38%	0.07%	51.23%	****

+ As of April 11, 1986 Alabama's Medicaid program ceased coverage of the deductible and coinsurance associated with a Medicare hospital stay.

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

* Not Available

** Another $19 million in buy-in premiums was paid for Medicare Part B coverage.

*** Unduplicated count

**** Less than 0.01 percent

Table - 29

SERVICES WITH COSTS NOT SHARED WITH MEDICARE								All Services		
Nursing Homes Intermediate	ICF MR/MD	Dental Care	Family Planning	Other Practi-tioners	Other Care	Screening	Clinic Services	Total of Unshared Costs **	Medicaid's Total Part of Shared Costs	Medicaid's Totals
$133,171,228	$53,101,377	$3,639,576	$3,101,476	$1,553,486	$2,494,275	$1,208,933	$4,476,755	$286,817,869	$117,128,878	$403,946,747
106,794,019	3,764,901	904	0	413,777	575,329	0	74,023	152,060,438	7,206,000	159,266,438
669,198	41,114	2,733	10,817	6,331	14,622	656	10,975	1,535,145	850,212	2,385,357
25,708,011	49,295,362	227,481	374,801	495,126	1,156,207	37,923	3,380,015	118,846,940	44,775,639	163,622,579
0	0	3,275,020	174,598	360,545	459,047	1,156,633	692,456	8,020,796	27,156,861	35,177,657
0	0	133,438	2,541,260	277,707	289,070	13,721	319,286	6,354,550	37,140,166	43,494,716
17,298	1,700	35,593	22,745	35,461	45,222	34,629	10,329	N/A*	N/A*	305,322
18,801	364	37	0	9,828	15,281	0	278	N/A*	N/A*	78,622
68	1	35	46	147	275	23	42	N/A*	N/A*	1,666
3,231	1,549	2,221	1,924	10,965	16,493	1,221	6,950	N/A*	N/A*	75,250
0	0	32,700	3,373	8,265	7,621	33,016	2,067	N/A*	N/A*	109,080
0	0	854	18,334	6,389	5,962	477	1,243	N/A*	N/A*	57,717
$7,699	$31,236	$102	$136	$44	$55	$35	$433	N/A*	N/A*	$1,323
5,680	10,343	24	0	42	38	0	266	N/A*	N/A*	2,026
9,841	41,114	78	235	43	53	29	261	N/A*	N/A*	1,432
7,957	31,824	102	195	45	70	31	486	N/A*	N/A*	2,174
0	0	100	52	44	60	35	335	N/A*	N/A*	323
0	0	156	139	43	48	29	257	N/A*	N/A*	754
4.74%	0.47%	9.76%	6.23%	9.72%	12.39%	9.49%	2.83%	N/A*	N/A*	83.68%
24.38%	0.47%	0.05%	0.00%	12.75%	19.82%	0.00%	0.36%	N/A*	N/A*	N/A*
3.54%	0.05%	1.82%	2.39%	7.65%	14.32%	1.20%	2.19%	N/A*	N/A*	86.73%
3.86%	1.85%	2.66%	2.30%	13.11%	19.72%	1.46%	8.31%	N/A*	N/A*	89.95%
****	0.00%	16.60%	10.74%	7.25%	6.72%	16.57%	1.64%	N/A*	N/A*	82.50%

ALTERNATIVE SERVICES

The Medicaid Agency administers several programs that serve to prevent unnecessary institutionalization of Medicaid eligibles. The home and community-based services and mental health services programs serve the elderly and disabled, mentally retarded, and chronically mentally ill Medicaid populations. Another cost-saving program administered by Alternative Services is the health maintenance organization program, which provides a comprehensive health plan to clients in Hale and Greene counties who choose to participate.

Home and Community-Based Services

Like many other states, Alabama has taken advantage of the provisions of the federal Omnibus Budget Reconciliation Act of 1981 and has developed waivers to federal Medicaid rules. These programs are aimed at keeping Medicaid eligibles out of institutions as long as possible by providing services to them in the community.

The waiver for the mentally retarded/developmentally disabled provides habilitative services to Medicaid-eligible mentally retarded clients. The Department of Mental Health and Mental Retardation contracts with 36 centers statewide to provide habilitative services. These centers instruct clients in the activities of daily living to enable them to live more independently. These services prevent needless institutionalization and give support to recipients released from mental retardation facilities.

The difference in cost between services provided under the waiver and institutional services is dramatic. It costs less than $8,000 a year to care for a mentally retarded client in the community, whereas institutional care for a single client costs nearly $35,000 a year. During FY '87, about seven million dollars was expended to provide habilitative services to 1,572 mentally retarded/developmentally disabled clients in the community. During the same period, almost $50 million was spent in ICF/MR institutions to serve 1,376 clients. The Department of Mental Health and Mental Retardation provided the state's share of the funding.

Medicaid's waiver for the elderly and disabled, which was renewed for a five-year period beginning October 1, 1987, provides services to persons who might otherwise have to enter nursing homes. The five basic services are case management, homemaker services, personal care, adult day health and respite care.

The program has expanded greatly since its beginning, with all services becoming available statewide in FY '86. More than 4,000 people were served under this waiver during FY '87.

People receiving services through Medicaid waivers have to meet certain eligibility requirements. Those served by the waiver for the elderly and disabled are recipients of Supplemental Security Income or State Supplementation who meet the medical criteria for nursing home care paid for by the Medicaid program. Providers of services to this group include the Alabama Department of Human Resources, which delivers services through its 67 county offices, and the Alabama Commission on Aging which contracts with Area Agencies on Aging to deliver services.

Mental Health Services Program

Through mental health centers under contract with the Department of Mental Health and Mental Retardation, Medicaid provides services for eligible mentally ill and emotionally disturbed people. These services include day treatment, medication check, diagnostic assessment, prehospitalization screening, and psychotherapy for individuals, groups and families. The program serves people with primary psychiatric diagnoses. There are 23 mental health centers around the state providing these services. During FY '87, about five million dollars was spent to provide services to an average of 3,700 clients monthly.

Health Maintenance Organization

Health maintenance organizations (HMO'S) offer a promising alternative to the high cost of health care. During FY '86, the Alabama Medicaid Agency entered into a cooperative arrangement with West

Alabama Health Services, Inc., to test the concept of the HMO as a health care delivery system. When established, this pilot project was limited to Greene County, which is located in the rural "Black Belt." Greene County's HMO enrollment in FY '87 was 1,065 enrollees. The program, which expanded into Hale County this year, began enrolling recipients there June 1, 1987 and had a total of 555 Hale-county enrollees at the end of FY '87. Total HMO enrollment for FY '87 was 1,620 participants.

Participation in the West Alabama HMO is entirely voluntary on the part of Medicaid eligibles, who can join the HMO or stay with the regular Medicaid program. All services currently covered by Medicaid are covered by the HMO with the exception of:

- long term care,
- community mental health center services,
- waiver services for the elderly and disabled,
- waiver services for the mentally retarded and developmentally disabled,
- renal dialysis in outpatient setting or freestanding facility,
- organ transplant physician fees, which include surgeon, assistant surgeon and anesthesiologist fees,
- organ transplant inpatient per diem and outpatient surgical fees, and
- eye care provided by an optometrist and eyeglasses provided by a dispensing optician.

Advantages to HMO enrollment include no copayment for HMO eligibles, coverage of preventive services (such as physical check-ups), no limitations on the number of covered physician visits, and coverage of more hospital days than allowed by the regular Medicaid program. In order to benefit from these and other services, enrollees must have all their health care provided by the HMO, or they must be referred by the HMO to another provider.

Medicaid's participation in the HMO pilot project began when West Alabama received a grant from the Robert Wood Johnson Foundation to help with start-up costs. As far as can be determined, Alabama has the only rural HMO in the country that is operated with participation by the Medicaid program.

In the summer of 1987, the Health Care Financing Administration (HCFA) reviewed the entire Medicaid HMO program and reported it one of the best administered HMO's of its type.

RURAL HEALTH CLINICS

The Medicaid rural health program was implemented April 1, 1978. Services covered under the rural health program include any medical service typically furnished by a physician in an office or in a physician home visit. Limits are the same as for the physician program.

Rural health clinic services, whether performed by a physician, nurse practitioner or physician assistant, are reimbursable. A physician, nurse practitioner or physician assistant is available to furnish patient care service at all times the clinic operates. A nurse practitioner or physician assistant is available to furnish patient care service at least 60 percent of the time the clinic operates.

Rural health clinics are reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by the Medicare fiscal intermediary.

RENAL DIALYSIS PROGRAM

The Medicaid renal dialysis program was implemented in 1973. At that time, the Medicaid Agency purchased six renal dialysis machines and leased them to the University of Alabama in Birmingham. In 1976, ownership of the dialysis machines was transferred to the University of Alabama in Birmingham.

Enrollment of renal dialysis providers in the Medicaid program has gradually increased to its present enrollment of 30 free-standing facilities and two hospital-based centers.

Renal dialysis services covered by Medicaid are:

— maintenance hemodialysis (three treatments per week, including routine laboratory tests),

— C.A.P.D. (Continuous Ambulatory Peritoneal Dialysis) (equivalent to three hemodialysis treatments per week, including supplies and routine laboratory tests),

— peritoneal dialysis training and/or counseling up to a maximum of 12 sessions per lifetime,

— medically necessary non-routine drugs and biologicals,

— non-routine tests/procedures such as chest x-ray, EKG, bone survey and nerve conductor velocity test, and

— physician services that are related to dialysis treatments through a monthly capitation payment.

Although the Medicaid renal dialysis program is small, it is a life-saving service without which many recipients could not survive, physically or financially.

LONG-TERM CARE

Care for acutely ill, indigent patients in skilled nursing homes was mandated in 1965 with the enactment of Medicaid (Title XIX). Skilled nursing care is a mandatory service. All states must provide this care in their Medicaid programs. The Alabama Medicaid program has had a skilled nursing program since 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, who are not well enough for independent living, and who do not require around-the-clock nursing care. 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, resulting in larger numbers of people in older age categories,

— medical and technological advances that extended the lives of persons with chronic medical conditions, such as cardiovascular diseases, and

— 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. In FY '87 only 16 percent of nursing home recipients were receiving skilled care.

A major factor in this change was the move toward dually certified facilities or 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.

Since 1983, the average monthly count of nursing home recipients has changed very little. Factors contributing to the stabilization of nursing home use by Medicaid patients include the availability of home health services, the implementation of home and community-based services to prevent institutionalization, the continued application of medical criteria to insure that Medicaid nursing home patients have genuine medical needs requiring professional nursing care, and a management information system that makes timely and accurate financial eligibility decisions possible.

A new regulation was issued by the Department of Health and Human Services effective in December, 1986, to provide an alternative to terminating Medicare and Medicaid provider agreements with long term care facilities that are found to be out of compliance with program requirements. In facilities with deficiencies that do not pose immediate jeopardy to the health and safety of patients, Medicaid may impose a sanction denying payment for new Medicaid

admissions for a period up to 90 days. The denial of payment sanction provides an option to terminating a facility's provider agreement while still promoting correction of deficiencies.

Alabama uses a uniform cost report (URC) 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 URC 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 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.

FY '85 - '87
LONG-TERM CARE PROGRAM
Patients, Months, and Cost

Table - 30

	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
1985	20,741	243 Days	5,049,419	$27	$133,914,679
1986	20,992	242 Days	5,081,436	26	134,199,967
1987	20,511	250 Days	5,135,190	28	145,651,321

FY '85 - '87
LONG-TERM CARE PROGRAM
The Number and Percent of Beds Used by Medicaid

Table - 31

	Licensed Nursing Home Beds	Medicaid Monthly Average	Annual Unduplicated Total Patients	Percent of Beds Used by Medicaid in an Average Month	Number of Beds Not Used by Medicaid in an Average Month
1985	21,776	13,715	20,741	63.0%	8,061
1986	22,211	13,809	20,992	62.2%	8,402
1987	22,240	14,019	20,511	63.0%	8,221

FY '87 Table - 32
LONG-TERM CARE PROGRAM
Recipients

	Skilled	Intermediate	Total
All Recipients	3,213	17,298	20,511
By Sex			
Female	2,324	13,104	15,428
Male	889	4,194	5,083
By Race			
White	2,134	13,902	16,036
Nonwhite	1,079	3,396	4,475
By Age			
0-5	50	3	53
6-20	81	83	164
21-64	378	1,851	2,229
65 & Over	2,704	15,361	18,065

FY '87 Table - 33
LONG-TERM CARE PROGRAM
Payments

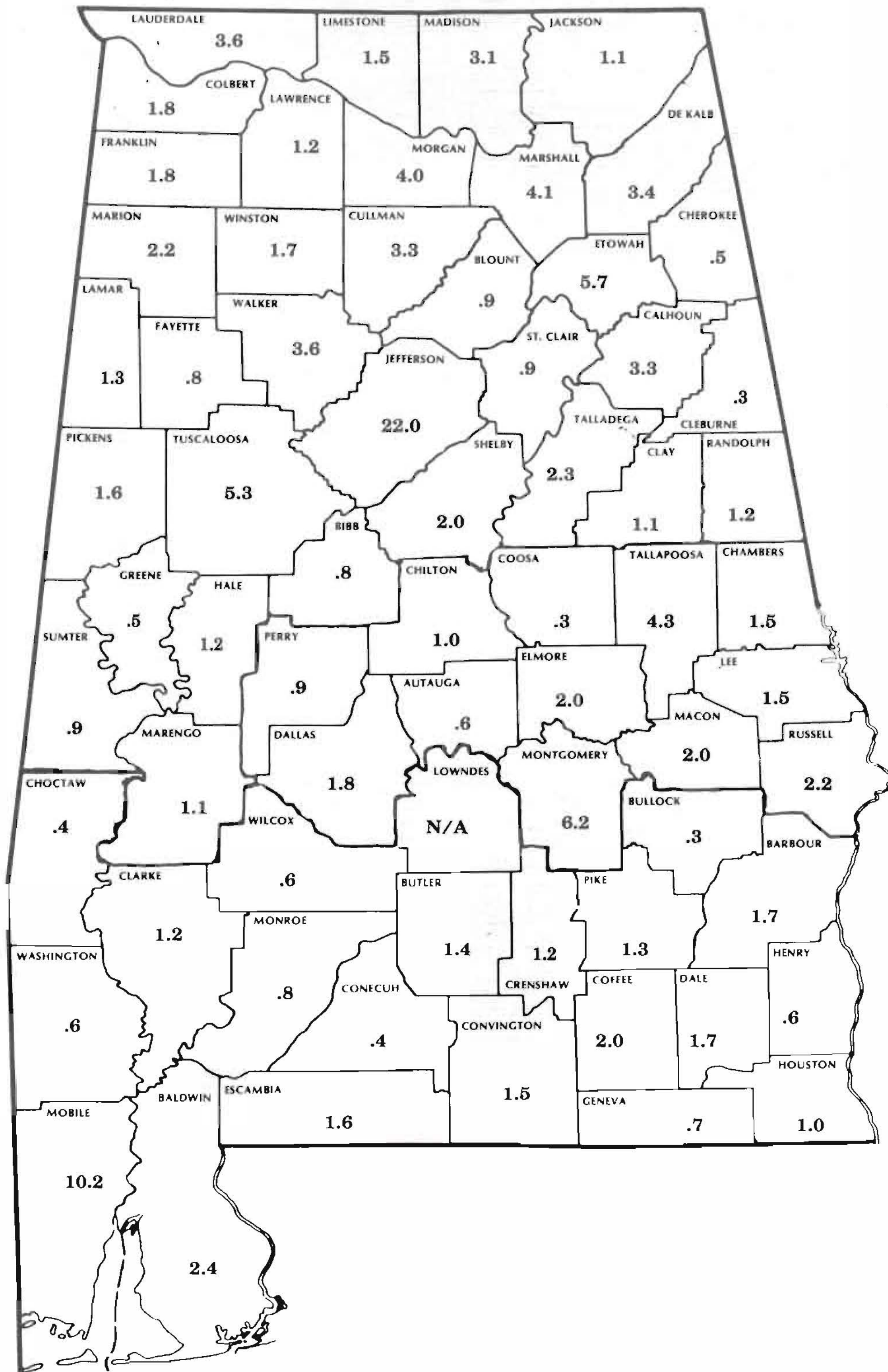
	Skilled	Intermediate	Total
All Recipients	$12,480,093	$133,171,228	$145,651,321
By Sex			
Female	8,805,396	102,118,668	110,924,064
Male	3,674,697	31,052,560	34,727,257
By Race			
White	7,960,009	105,853,988	113,813,997
Nonwhite	4,520,084	27,317,240	31,837,324
By Age			
0-5	748,613	53,276	801,889
6-20	1,107,380	932,957	2,040,337
21-64	1,765,686	16,543,923	18,309,609
65 & Over	8,858,414	115,641,072	124,499,486

FY '85 - '87 Table - 34
LONG-TERM CARE PROGRAM
Number of Recipients

	Skilled			Intermediate			Total		
	FY '85	FY '86	FY '87	FY '85	FY '86	FY '87	FY '85	FY '86	FY '87
Monthly Average	1,048	1,115	1,181	12,667	12,694	12,838	13,715	13,809	14,019
Yearly Total	3,386	3,594	3,213	17,355	17,398	17,298	20,741	20,992	20,511
Average Length of Stay	98 Days	98 Days	131 Days	271 Days	272 Days	273 Days	243 Days	242 Days	250 Days

FY '87
PAYMENTS TO NURSING HOMES
By County (in millions of dollars)

Table - 35



LONG-TERM CARE MENTAL HEALTH

The Alabama Medicaid Agency negotiated agreements with the State Department of Mental Health and Mental Retardation 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. Eligibility for these programs is determined by categorical, medical and/or social requirements specified in Title XIX. The programs provide treatment which includes training and habilitative services intended to aid the intellectual, sensorimotor, and emotional development of a resident.

Facilities in which intermediate care for the mentally retarded are provided include the Albert P. Brewer Developmental Center in Mobile, the J.S. Tarwater Developmental Center in Wetumpka, the Lurleen B. Wallace Developmental Center in Decatur, Partlow State School and Hospital in Tuscaloosa and the Glenn Ireland II Developmental Center near Birmingham. There has been a reduction of 310 in the number of ICF/MR beds statewide. This reduction is a cooperative effort of the Department of Mental Health and Mental Retardation and the Alabama Medicaid Agency. Alabama's goal is to deinstitutionalize as many clients as possible in keeping with its efforts to serve clients in the least restrictive setting.

In addition to contributing the federal share of money for care in large residential facilities, Medicaid also covers intermediate care of mentally retarded residents in three small facilities of 15 or fewer beds. Institutional care for the mentally diseased is provided through Alice Kidd Intermediate Care Facility in Tuscaloosa and S.D. Allen Intermediate Care Facility in Northport.

Payments for long-term mental health and mental retardation programs have increased dramatically, from less than $2 million in FY '79 to more than $50 million annually in recent years. In FY '87, the average per diem rate in an institution serving the mentally retarded was approximately $115.

In terms of total Medicaid dollars expended and the average monthly payment per patient, the ICF-MR/MD program is extremely costly. However, the provision of this care through the Medicaid program is saving the taxpayers of Alabama millions of state dollars. These patients are receiving services in state-operated mental health institutions. If the Medicaid program did not cover the services provided to these patients, the Alabama Department of Mental Health and Mental Retardation would be responsible for the total funding of this care entirely out of its state appropriation. In FY '87, through its relationship with the Alabama Medicaid Agency, Mental Health was able to match every 28 state dollars with 72 federal dollars for the care of Medicaid-eligible ICF-MR/MD patients.

A home and community-based program for the mentally retarded 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 are those of habilitation which insure optimal functioning of the mentally retarded within a community setting. Without these community services, more mentally retarded citizens would require institutionalization.

FY '86 - '87
LONG-TERM CARE PROGRAM
ICF-MR/MD — **Table - 36**

	FY '86	FY '87
Recipients	1,732	1,700
Total Payments	$51,865,695	$53,101,377
Annual Cost per Recipient	$29,946	$31,236

HOME HEALTH AND DME

The Medicaid home health program provides quality medical and personal care in recipients' homes. These services allow homebound persons who meet Medicaid home health criteria to avoid institutionalization or to secure an early discharge from an institution. Nursing and personal care provided under the home health program must be certified by a licensed physician and provided by home health agencies under contract with Medicaid.

Due to changes in the health care delivery system, the demand for home health services has been increasing. Home health patients may require intravenous therapy, tube feedings, sterile dressing changes, catheter installations, or maintenance care.

Medicaid criteria for home health services are:

— Home health agencies must have contracts with the Medicaid Agency. There were 106 agencies participating in FY '87.

— 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 review about 370 certifications and 950 recertifications each month.

Up to 100 home health visits per year may be authorized by the Medicaid Agency. The maximum reimbursement rate per visit is $27, which is the most prevalent rate. In FY '87, an average of 1,971 recipients a month received a total of 196,982 visits at a cost of $5.2 million.

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, but all items must be medically necessary and suitable for use in the home. During the fiscal year, Medicaid supplies, appliances, and DME providers throughout the state furnished 112,671 units of service at a cost of slightly more than $500,000.

FY '86 - '87 **Table - 37**
HOME HEALTH PROGRAM
Use and Cost of Home Health Care Compared to Nursing Home Care

	Average Number Recipients per Month		Average Monthly Cost per Recipient	
Year	Home Health	Nursing Home	Home Health	Nursing Home
1986	1,660	13,809	$245	$810
1987	1,971	14,019	$222	$866

HOSPITAL PROGRAM

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 126 Alabama hospitals that participate in the Medicaid program, and 35 hospitals in neighboring states also participate in Alabama's Medicaid program.

Alabama's Medicaid program reimburses hospitals on a daily rate that varies from hospital to hospital. The per diem rate 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.

During FY '87 the number of recipients of inpatient care and the amount of Medicaid payments for inpatient care declined significantly. The primary reason for the drop in activity of the hospital program was the cessation of Medicaid coverage of deductibles and coinsurance associated with a Medicare hospital stay.

Outpatient Care

Acute medical care in an outpatient setting is much less costly than inpatient care. The proper use of outpatient care reduces medical costs and is convenient for the recipient. However, many Medicaid patients use emergency rooms when all they need or want is to see a doctor. Since an outpatient visit is twice as expensive as a doctor's office visit, the misuse of outpatient services has an impact on Medicaid expenditures. Limitations on outpatient visits have lessened the problem of abuse, but the number of outpatient visits is on the increase because of the trend toward performing more and more procedures on an outpatient basis. On September 1, 1986, the Alabama Medicaid Agency changed the reimbursement methodology for outpatient services from a percentage of billing to procedure code specific billing. This change in reimbursement methods resulted in a significantly lower cost to Medicaid per recipient of outpatient hospital care.

Utilization Controls

FAIR or Fiscal Agent Inpatient Review was the system used by Medicaid to monitor inpatient admissions. Alacaid, the program's fiscal agent, performed this review function under contract. Utilization review is mandated under federal regulations to ensure that Medicaid inpatient admissions are based on medical necessity. Effective October 1, 1987, the inpatient utilization review function will be performed by the Alabama Medicaid Agency.

Limitations on hospital services were in effect during FY '87. The purpose of these limitations is to control the overuse of Medicaid services. Inpatient hospital days are limited to 12 days per calendar year. However, an exception is made for seriously ill children. After these children exhaust their 12 days in the hospital, and then spend an additional 30 continuous days in the hospital, they are eligible for 12 additional Medicaid-paid days. This cycle can be repeated throughout the year. These additional days must be prior authorized and be medically necessary.

There were also limitations on outpatient hospital services during this fiscal year. Medicaid will pay for a maximum of three outpatient visits per eligible during a calendar year. Exceptions are made for certified emergencies, chemotherapy, and radiation therapy.

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

FY '85 - '87 HOSPITAL PROGRAM Changes in Use and Cost — **Table - 38**

Year	Eligibles	Recipients of Inpatient Care	Payments for Services	Medicaid's Annual Cost per Recipient
1985	380,513	58,095	$73,847,525	$1,271
1986	374,953	57,323	80,157,879	1,398
1987	364,861	36,508	69,194,337	1,895

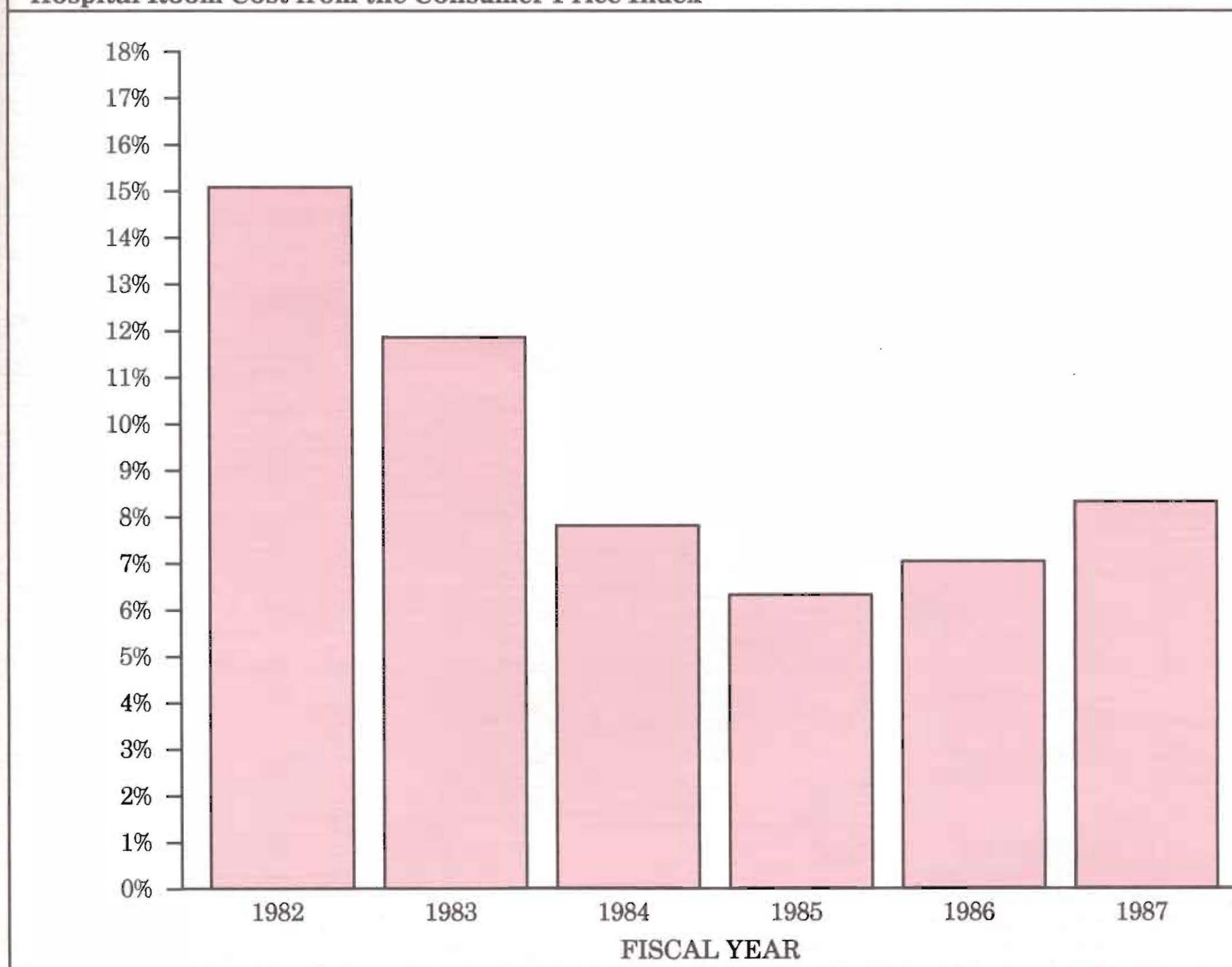
FY '83 - '87
HOSPITAL PROGRAM
Outpatients

Table - 39

	FY '83	FY '84	FY '85	FY '86	FY '87
Number of Outpatients	110,196	108,085	91,848	102,082	92,255
Percent of Eligibles Using Outpatient Services	29%	28%	24%	27%	25%
Annual Expenditure for Outpatient Care	$13,813,699	$12,815,220	$10,186,983	$13,006,467	$6,801,149
Cost per Patient	$125	$119	$111	$127	$74

FY '82 - '87
ANNUAL PERCENT CHANGE
Hospital Room Cost from the Consumer Price Index

Table - 40



FY '87 **Table - 41**

PAYMENTS TO HOSPITALS

By County (in thousands of dollars)

FY '87
HOSPITAL OCCUPANCY RATE (%)
As of September 30, 1986

Table - 42

LAUDERDALE 54.4%
LIMESTONE 47.6%
MADISON 62.7%
JACKSON 38.3%
COLBERT 55.9%
LAWRENCE 37.0%
FRANKLIN 53.9%
MORGAN 45.0%
MARSHALL 43.6%
DE KALB 47.6%
MARION 41.1%
WINSTON 36.6%
CULLMAN 43.9%
BLOUNT 49.7%
ETOWAH 49.8%
CHEROKEE 29.4%
LAMAR 34.9%
FAYETTE 34.6%
WALKER 72.5%
JEFFERSON 58.1%
ST. CLAIR 42.9%
CALHOUN 46.6%
CLEBURNE 30.3%
TALLADEGA 44.2%
CLAY 53.5%
RANDOLPH 30.4%
PICKENS 48.1%
TUSCALOOSA 59.3%
SHELBY 39.4%
BIBB 26.7%
GREENE 24.2%
HALE 24.2%
SUMTER 29.9%
PERRY 17.3%
CHILTON 33.2%
COOSA N/A
TALLAPOOSA 37.3%
CHAMBERS 53.5%
ELMORE 46.1%
LEE 60.8%
AUTAUGA 39.3%
MACON 16.7%
RUSSELL 43.3%
DALLAS 54.1%
MARENGO 67.0%
CHOCTAW 22.5%
WILCOX 22.4%
LOWNDES N/A
MONTGOMERY 55.5%
BULLOCK 22.6%
BARBOUR 41.2%
CLARKE 37.5%
MONROE 43.7%
BUTLER 51.0%
CRENSHAW 45.6%
PIKE 65.1%
HENRY 25.4%
WASHINGTON 25.2%
CONECUH 37.9%
COFFEE 33.8%
DALE 45.8%
CONVINGTON 32.6%
ESCAMBIA 40.6%
GENEVA 36.8%
HOUSTON 69.0%
MOBILE 61.8%
BALDWIN 40.4%

FAMILY PLANNING

Over the past 30 years, the number of yearly births in Alabama has declined while the number of illegitimate births has increased. In Alabama, there were 14,876 illegitimate births in 1985. This is the highest number ever recorded.

The problem of illegitimacy is particularly acute among younger females. This year 40 percent of the illegitimate births in Alabama were to mothers under 20 years of age. Medicaid pays for deliveries of a large number of teenage mothers. Usually these young mothers and their families face personal problems and dependency on public assistance programs such as Medicaid.

There are several health-related problems associated with teenage motherhood. Younger teenage mothers usually do not take advantage of prenatal care. Infants born to these mothers tend to have a high risk of developing health problems. These problems include higher death rates, lower birth rates and greater health difficulties in later life.

Medicaid services can help pregnant teenage eligibles in two primary ways. Since these are high-risk pregnancies, prenatal care paid through Medicaid can increase the likelihood of a successful outcome for both mother and child. Also, young teenage mothers with one child have a higher chance than average of having additional children while they are still teenagers. Family planning services can help Medicaid-eligible women control the size of their familes.

Although Medicaid's family planning services include assisting eligibles with fertility problems, most recipients of family planning services are people seeking the 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 was 72 percent in FY '87. For family planning services, the federal share was 90 percent.

The Medicaid Agency purchases family planning services from Planned Parenthood of Alabama, Inc., clinics under the supervision of the Statewide Family Planning Project of the State Department of Public Health's Family Health Administration, community health centers and private physicians.

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.

An eligible 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. Prenatal services are furnished to Medicaid eligibles through county health departments and other Medicaid providers. Timely care can reduce the possibility of premature, underweight babies.

Medicaid prenatal care is provided through health departments, private physicians, hospitals, and clinics. Examinations include complete histories and physical examinations, lab tests, and pap smears.

PHYSICIAN PROGRAM

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. Services to eligibles are based on medical necessity, with physicians determining the need for medical care. Physicians provide this care directly and prescribe or arrange for additional health benefits. It is the physician who determines what drugs a patient receives, decides when a patient needs nursing home or inpatient hospital care and controls the care of the patient in an institution. The majority of licensed physicians in Alabama participate in the Medicaid program. More than three-fourths of Alabama's Medicaid recipients received physicians' services in FY '87.

Recipients visiting a physician are required to pay a $1 copayment per office visit. The reason for copayments is utilization control. Recipients under 18 years of age, nursing home residents and pregnant women are exempt from copayments. Certain physicians' services do not require copayments. These include family planning services, physician inpatient hospital visits and physician surgery fees for procedures performed in the doctor's office. Physicians may not deny services due to the recipient's inability to pay the copayment.

The physician program also supervises Medicaid services performed by nurse-midwives. These services include global obstetrical care, walk-in deliveries, antepartum care, postpartum care and circumcision. Care by a nurse-midwife must be performed under appropriate physician supervision.

Most Medicaid providers must sign contracts with the Medicaid agency in order to provide services to eligibles. Physicians who participate in the MediKids program must sign an agreement limiting charges for screening children. Also, nurse-midwives are required to sign contracts in order to participate in the Medicaid program. For other types of physicians' services, the submitted claim is considered a contract.

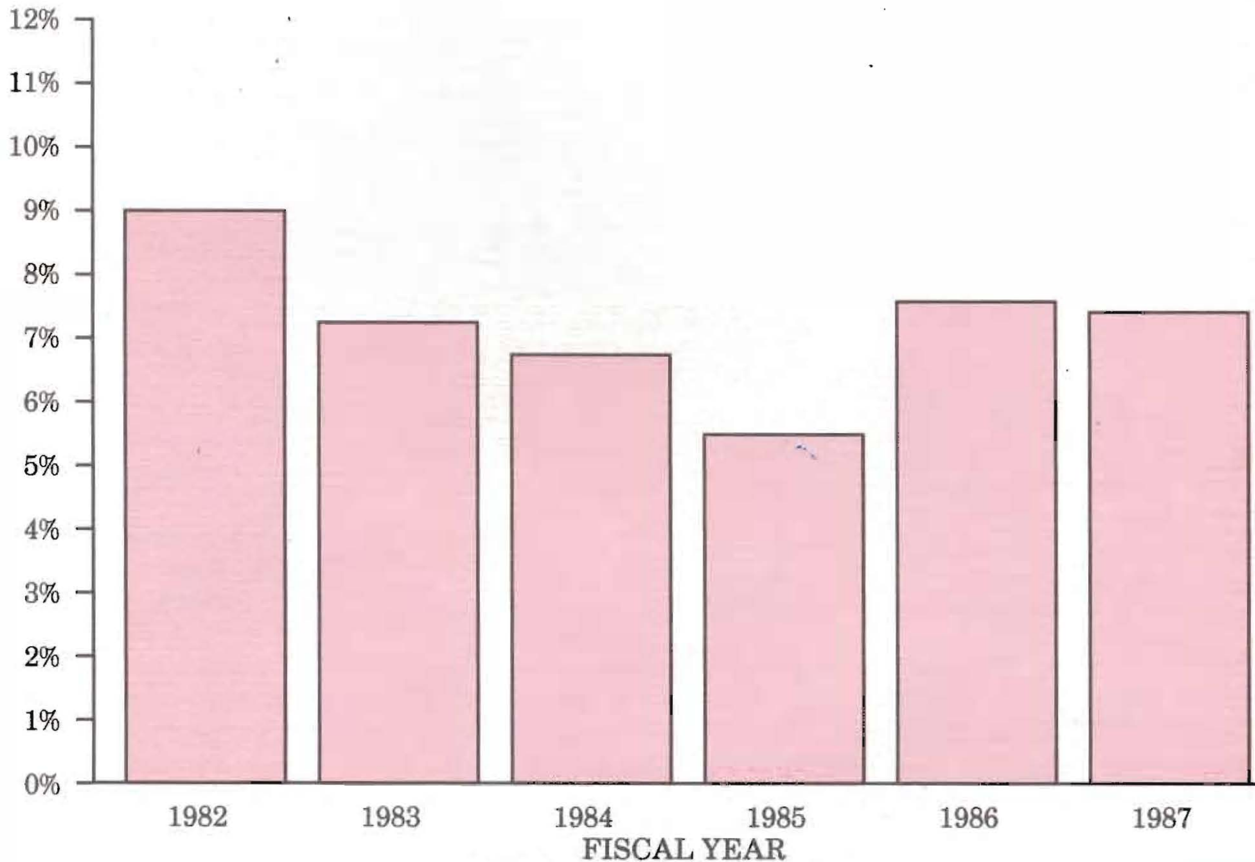
In general, the per capita cost of Medicaid services to the aged is higher than for other categories of recipients. One reason is that older people are more likely to have health problems. However, Medicaid physicians' care costs for the aged are lower than for most categories. This is because about 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 '87
PHYSICIAN PROGRAM
Use and Cost — **Table - 43**

	Payments	Recipients	Cost per Recipient
Aged	$3,438,600	55,106	$62
Blind	$273,886	1,390	$197
Disabled	$11,435,523	60,936	$188
Dependent	$20,784,148	127,558	$163
All Categories	$35,932,157	238,611	$151

FY '87 **Table - 44**

ACTIVE LICENSED PHYSICIANS
as of December 31, 1986, by County



PHARMACEUTICAL PROGRAM

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

Realistically, modern medical treatment would be impossible without drugs. Medical practitioners rely heavily on drugs for the treatment of pain, infection, allergic reactions, 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 medications that make more expensive alternatives unnecessary.

In FY '87, pharmacy providers were paid $44.7 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about 11 percent of Medicaid payments for services. This fiscal year, the pharmaceutical program surpassed physicians' care in percentage of Medicaid payments for services.

The Medicaid Agency reimburses participating pharmacists for dispensing based on

the ingredient cost of the prescription plus a dispensing fee. The dispensing fee, increased to $3.25 per prescription in October 1985, remained the same during FY '87.

Primarily to control overuse, Medicaid recipients must pay a small portion of the cost of their prescriptions. This copayment ranges from 50 cents to $3, depending on drug ingredient cost. In addition, prescribing physicians are limited to the 15,000 drug entities listed in the Alabama Drug Code Index. On October 29, 1987, the 14th Edition of the index went into effect; the index consists of approximately 70 percent generic drugs. However, every effort is made to avoid restricting a physician's choice of drugs.

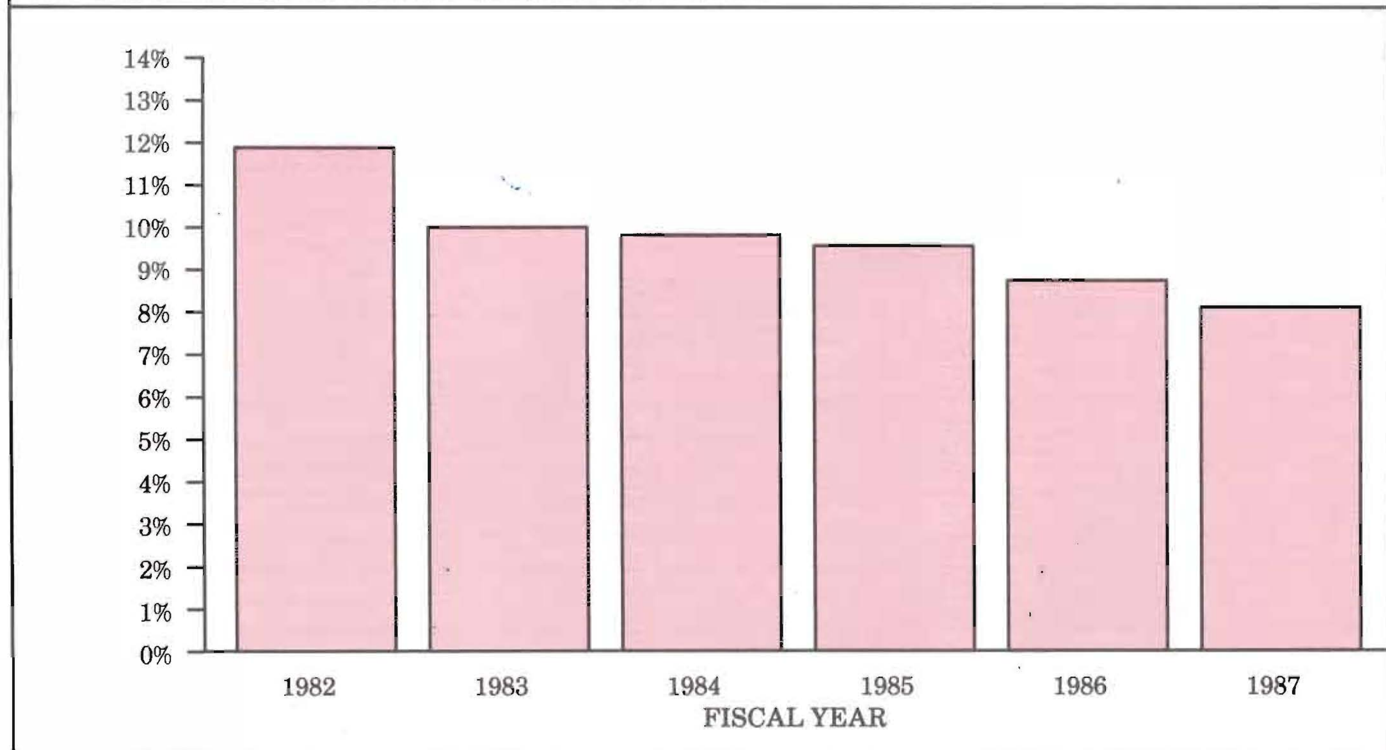
FY '87 — Table - 46
PHARMACEUTICAL PROGRAM
Counts of Providers by Type

Type of Provider	Number
Retail	1,235
Institutional	37
Governmental	4
Dispensing Physician	2
Total	1,278

FY '85 - '87 — Table - 47
PHARMACEUTICAL PROGRAM
Use and Cost

Year	Number of Drug Recipients	Recipients as a % of Eligibles	Number of Rx	Rx per Recipient	Price per Rx	Cost per Recipient	Total Cost to Medicaid
1985	228,136	60%	3,303,229	14.47	$11.46	$165.87	$37,840,727
1986	231,139	62%	3,537,798	15.31	11.53	176.47	40,788,404
1987	227,794	62%	3,710,767	16.29	12.05	196.24	44,701,304

FY '82 - '87 — Table - 48
ANNUAL PERCENT CHANGES
Prescription Drug Cost from the Consumer Price Index



MEDIKIDS

The early and periodic screening, diagnosis and treatment program, renamed MediKids in FY '86, is a preventive health program designed to detect and treat deseases that may occur in a child's early life. If properly utilized, the program can be a benefit to both the child and the Medicaid Agency. Many health problems begin early in life and, if left untreated, can cause chronic illness and disability. When an illness is diagnosed and treated through the screening program, the child benefits through improved health, and Medicaid benefits through long-term savings realized by intervention before a medical problem requires expensive acute care.

Although MediKids is funded by Medicaid, the program's operation requires the cooperation of the State Department of Human Resources and the State Department of Public Health. MediKids eligibles are persons under 21 who receive assistance through Aid to Dependent Children or Supplemental Security Income programs. Human Resources workers normally determine ADC eligibility, make families aware of MediKids and refer eligibles to providers.

Currently there are more than 300 providers of MediKids services, including county health departments, community health centers, Head Start Centers, child development centers and private physicians. An extensive recruitment campaign conducted in FY '86 succeeded in adding a large number of physicians to the program. 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 MediKids is that the program is under-used. Screening is not mandatory for eligibles, and many mothers do not seek health care for their children until the children show symptoms of illness. However, steps taken in recent years to increase screening usage, such as increased publicity of the MediKids program, implementation of an intensive outreach project in a number of Alabama counties, the physician recruitment effort, an increase in the rate paid to physicians for screening and an increase in the number of screenings for which Medicaid will pay, were successful in FY '87.

A Medicaid goal is to screen eligibles at ten intervals between birth and age 21. Problems discovered and treated through MediKids include 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 $31 per screening. The cost of treating illness is usually considerably higher.

The Medicaid dental program is limited to individuals who are eligible for treatment under the MediKids program. Dental care under this program is available either as a result of MediKids referral or as a result of a request/need by the Medicaid recipient.

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 nonsurgical periodontal treatment, third and subsequent space maintainers, general anesthesia and i.v. sedation, hospitalization and some out-of-state care.

During FY '87, approximately 36,000 persons received dental treatment at a cost of $3.6 million to the Medicaid program.

FY '86 - '87 MEDIKIDS Screenings and Payments — **Table - 49**

	FY '86	FY '87
Total Screenings	36,746	39,273
Total Payments for Screenings	$1,012,326	$1,208,931
Recipients of Dental Care	37,431	35,593

AMBULATORY SURGICAL CENTER SERVICES

In September 1986, Medicaid began coverage of ambulatory surgical services, which are procedures typically performed on an inpatient basis but which can be performed safely on an outpatient or ambulatory surgical center (ASC) basis. ASC services are reimbursed by means of a predetermined fee established by the Alabama Medicaid Agency. Services are limited to three visits per calendar year, with payment made only for procedures on Medicaid's approved list.

Ambulatory surgical center services include but are not limited to:

- nursing, technician and related services,
- use of an ambulatory surgery center,
- lab and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances and equipment directly related to the provision of the surgical procedure,
- administration, record keeping and housekeeping items and services, and
- materials for anesthesia.

Ambulatory surgical center services do not include items and services for which payment may be made under other provisions. Ambulatory surgical center services do not include:

- physician services,
- lab and x-ray not directly related to the surgical procedure,
- diagnostic procedures (other than those directly related to performance of the surgical procedure),
- prosthetic devices, except intraocular lens,
- ambulance services,
- leg, arm, back and neck braces,
- artificial limbs, or
- durable medical equipment for use in the patient's home.

A listing of covered surgical procedures is maintained by the Alabama Medicaid Agency and furnished to all ASC's. This list is reviewed and updated on a regular basis by Medicaid.

Ambulatory surgical centers have an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the capabilities of the center. Medicaid recipients are required to pay, and ambulatory surgery center providers are required to collect, the copayment amount for each visit.

LABORATORY AND RADIOLOGY PROGRAM

Laboratory and radiology services are essential parts of the Medicaid health care delivery system. Many diagnostic procedures and methods of treatment would be impossible without the availability of these valuable services.

Medically necessary lab and x-ray services are available in conjunction with other Medicaid services, such as physician office visits, outpatient care, and inpatient care. Since lab and x-ray services are ancillary parts of other services, Medicaid will not pay for lab and x-ray services if other services are not available. For example, if a recipient exhausts his hospital days for the year, he also exhausts his eligibility for lab and x-ray services ancillary to inpatient hospital care.

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

- independent laboratories and x-ray facilities,
- laboratory and x-ray facilities in a physician's office,
- private laboratory facilities owned and operated by physicians for their exclusive use, and
- 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, and each claim serves as a provider contract.

FY '86 - '87 Table - 50
LAB AND X-RAY PROGRAM
Use and Cost

Year	Recipients	Payments	Annual Cost per Recipient
1986	121,433	$6,859,413	$56
1987	108,217	$5,120,634	$47

OPTOMETRIC PROGRAM

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

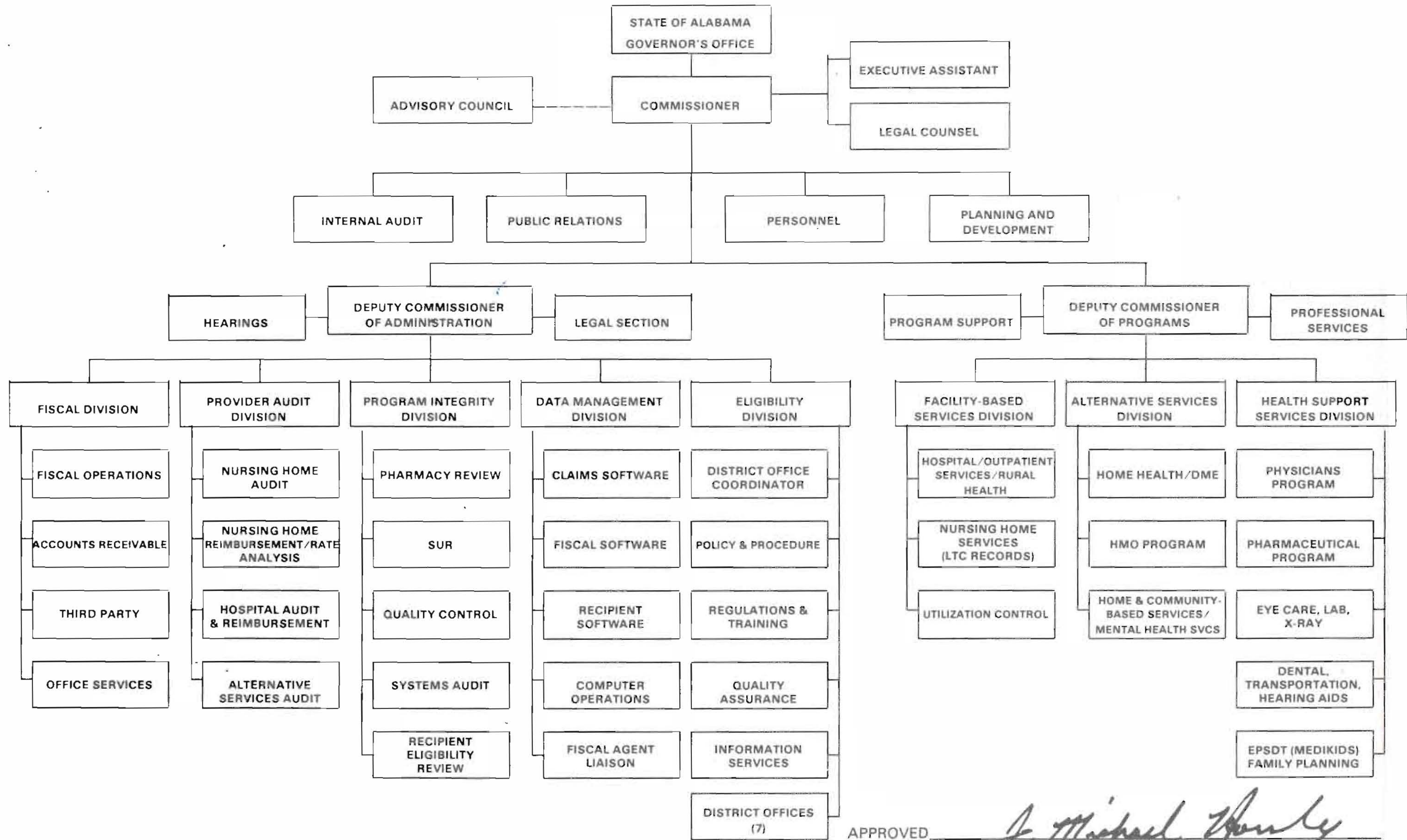
The eye care program provides services through ophthalmologists, optometrists and opticians. Adults (21 years of age and older) are eligible for one complete eye examination and one pair of eyeglasses every two calendar years. Recipients under 21 years of age are eligible for an eye examination and one pair of eyeglasses every calendar year. Medicaid does not replace eyeglasses due to loss or breakage. Hard or soft contact lenses are available when prior authorized by the Medicaid Agency for apkakic (post cataract surgery) patients and for the treatment of keratoconus. Included in this service is the fitting of the lenses and supervision of adaptation. Special optometric services that are provided when medically necessary and that require prior authorization are orthoptic training, tonometry, visual field examinations and fundus photography.

In keeping with the agency's policy of cost containment, Medicaid purchased eyeglasses are provided through a central source chosen through competitive bidding. The contractor is required to furnish eyeglasses that meet federal, state and agency standards. The selection of frames includes styles for men, women, teens and pre-teens.

FY '87 Table - 51
OPTOMETRIC PROGRAM
Use and Cost

Type of Provider	Average Monthly Recipients	Payments
Dispensing Optician	2,511	$675,040
Optometrist	3,549	$1,553,486
Ophthalmologist	2,098	$1,352,490
Total	8,158	$3,581,016

ALABAMA MEDICAID AGENCY



APPROVED J. Michael Horsley
COMMISSIONER
ALABAMA MEDICAID AGENCY

DATE October 1, 1987

Front Cover: The year 1987 marked the tenth year that the Medicaid program in Alabama was administered by an independent state agency totally devoted to its administration. Although the Medicaid program was implemented in Alabama in 1970, it did not become an independent state agency until Governor George Wallace made it so in June 1977. It was then that Medicaid was removed from within the Department of Public Health and placed directly under the Governor's office.

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