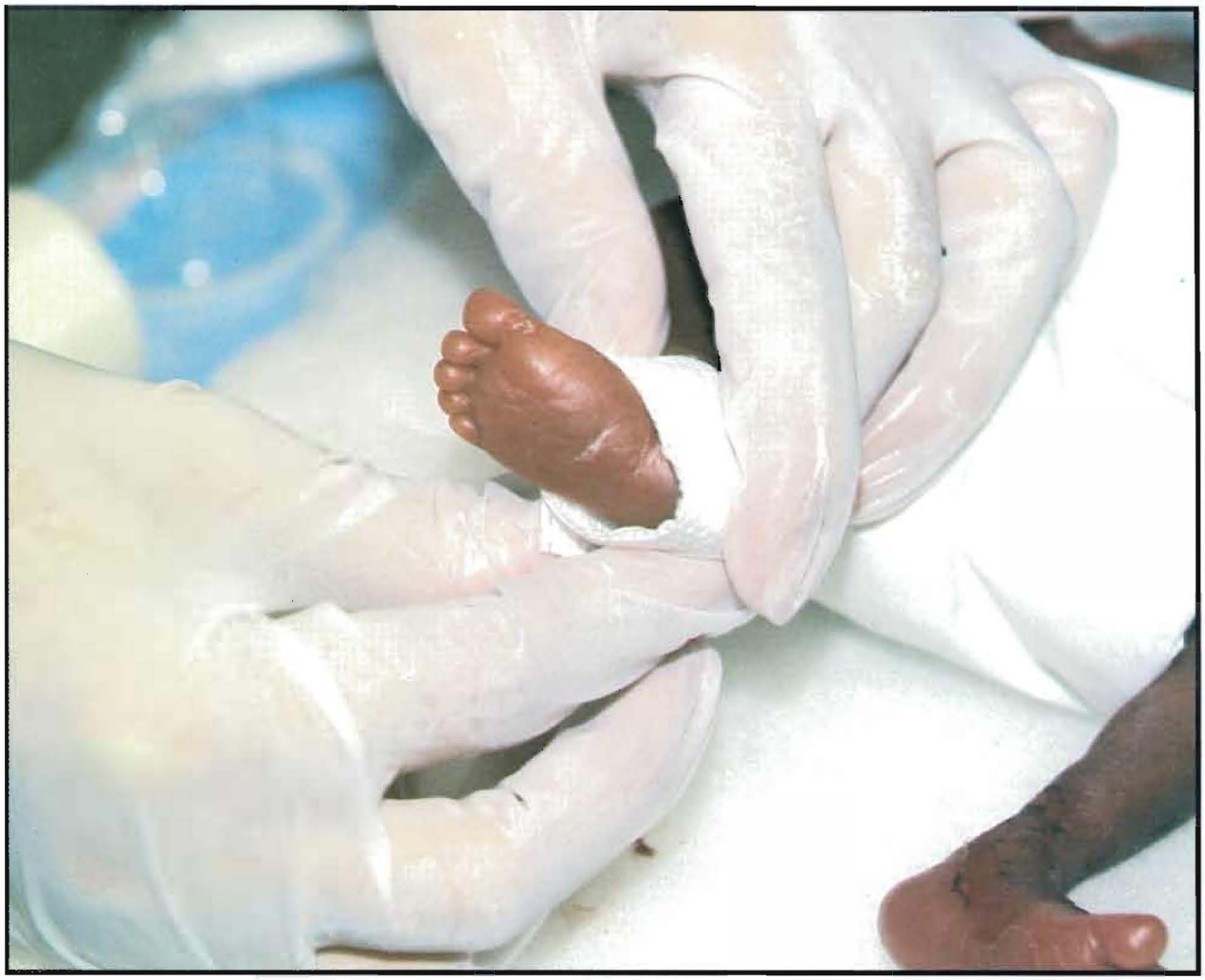


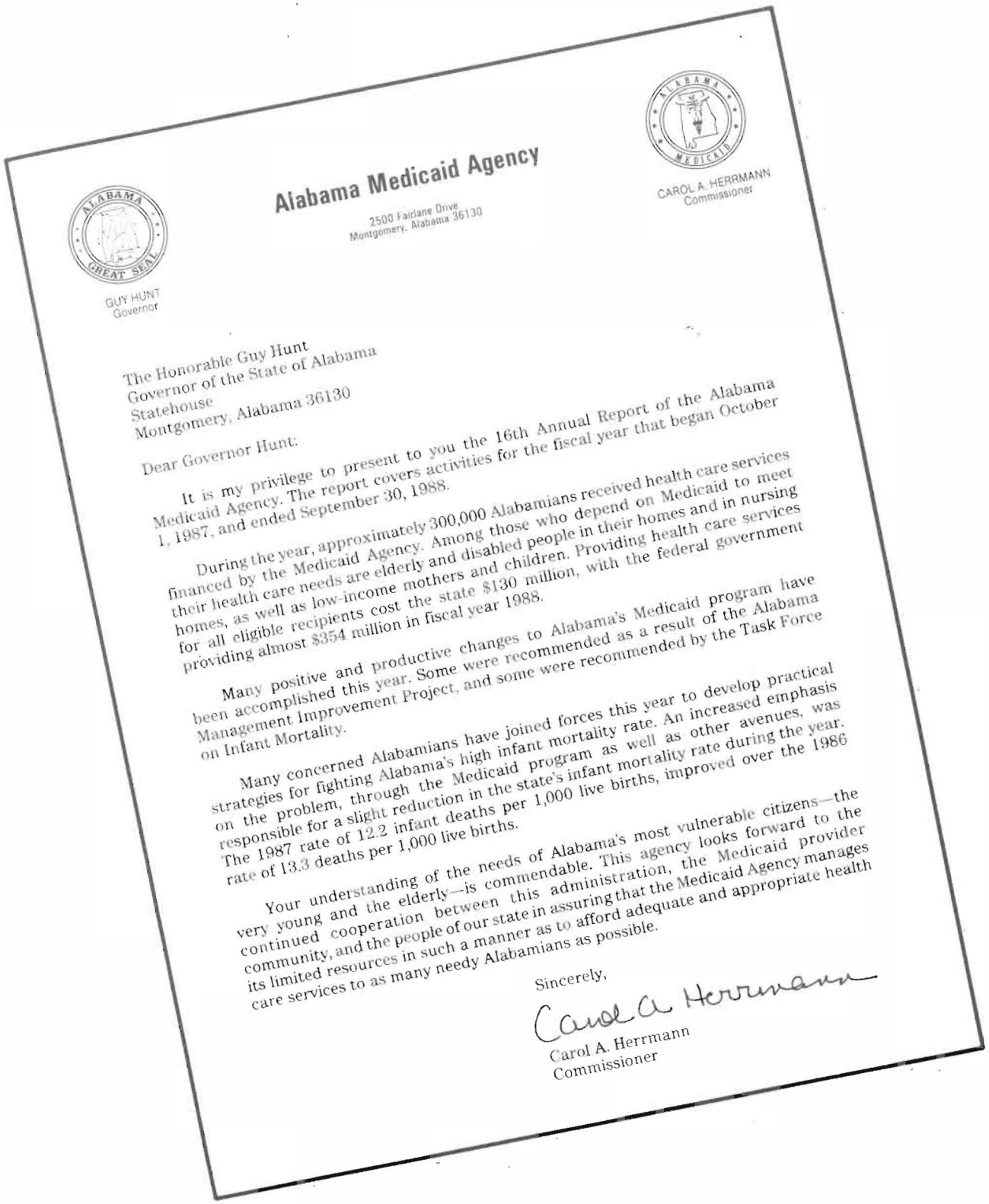
— 1988 Annual Report —

THE ALABAMA MEDICAID AGENCY

Guy Hunt
Governor
State of Alabama

Carol A. Herrmann
Commissioner
Alabama Medicaid Agency

ALABAMA MEDICAID AGENCY
FY 1988 ANNUAL REPORT
OCTOBER 1, 1987 - SEPTEMBER 30, 1988



Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

GUY HUNT
Governor

CAROL A. HERRMANN
Commissioner

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 16th Annual Report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1987, and ended September 30, 1988.

During the year, approximately 300,000 Alabamians received health care services financed by the Medicaid Agency. Among those who depend on Medicaid to meet their health care needs are elderly and disabled people in their homes and in nursing homes, as well as low-income mothers and children. Providing health care services for all eligible recipients cost the state $130 million, with the federal government providing almost $354 million in fiscal year 1988.

Many positive and productive changes to Alabama's Medicaid program have been accomplished this year. Some were recommended as a result of the Alabama Management Improvement Project, and some were recommended by the Task Force on Infant Mortality.

Many concerned Alabamians have joined forces this year to develop practical strategies for fighting Alabama's high infant mortality rate. An increased emphasis on the problem, through the Medicaid program as well as other avenues, was responsible for a slight reduction in the state's infant mortality rate during the year. The 1987 rate of 12.2 infant deaths per 1,000 live births, improved over the 1986 rate of 13.3 deaths per 1,000 live births.

Your understanding of the needs of Alabama's most vulnerable citizens—the very young and the elderly—is commendable. This agency looks forward to the continued cooperation between this administration, the Medicaid provider community, and the people of our state in assuring that the Medicaid Agency manages its limited resources in such a manner as to afford adequate and appropriate health care services to as many needy Alabamians as possible.

Sincerely,

Carol A. Herrmann

Carol A. Herrmann
Commissioner

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HIGHLIGHTS OF THE 1988 FISCAL YEAR

The health care of our nation has been a concern of politicians and advocacy groups for a long time. For years, there has been a growing demand for the expansion of health care but strains have been felt as a result of rising costs and budget limitations.

Three groups—the very young, the elderly and the poor—are probably hit harder than other groups needing medical assistance or other aid.

In 1986, Alabama was recognized as having the highest rate of infant deaths in the nation—13.3 deaths per 1,000 live births. Not only our state, but also the entire nation is facing the problem of infant mortality. In a number of ways, the federal and state governments have banned together to help lessen the incidence of infant deaths.

Statistics show people are living longer now than in the past. With that factor in mind, additional and improved medical care will be needed as we continue to grow older. As medical technology advances, more funding will be needed to pay for better health care. Because of that, federal and state governments have worked diligently to expand coverage to the elderly and poor sectors while having to stay within budget constraints.

Governor's Task Force on Infant Mortality

In October 1987, Governor Hunt asked Medicaid Commissioner Mike Horsley to chair a Governor's Task Force on Infant Mortality and to charge that task force with recommending actions needed to reduce the high incidence of infant mortality and morbidity in Alabama. The charge specified that each recommendation include a separate plan for implementation—one given optimal funding and another given minimal funding.

In November, Governor Hunt officially appointed a 37-member task force that included representatives from public and private health care organizations, education and religious organizations, and the state legislature. Since that time, the full task force has met four times. Work groups formed within the task force, however, have met several times independently. These work groups are Service Delivery, Financing, Education/Awareness, and Research.

In January 1988, the task force submitted a preliminary report of work group recommendations to the Governor. Some of these recommendations were: training health care workers to identify high risk pregnancies; using certified nurse midwives who are recruited from and trained within their local areas; promoting "Storkline," the Health Department's toll free telephone number for maternity and prenatal care information; analyzing health and sex education curricula in public schools with the aim of improving and enhancing such curricula; expanding county health department services to non-Medicaid eligible patients; providing medications to low-income, non-Medicaid eligible children through appropriate outlets; expanding the Medicaid fee currently paid to physicians for global deliveries; establishing case management services in each county health department; and assuring a "medical home" for all children.

Several recommendations made by the task force have already been implemented by Medicaid. These are: allowing maternity patients who have been declared Medicaid-eligible to maintain eligibility throughout their pregnancy and delivery despite minor fluctuations in income; increasing allowed hospital days under Medicaid for maternity patients, infants, and children; adopting and implementing a method of presumptive eligibility for pregnant women; reimbursing pediatricians for attending high-risk births; and increasing fees paid by Medicaid to certified nurse midwives.

Governor's Symposium on Infant Mortality

"Healthy Babies: Everybody's Business" was the theme of the Governor's Symposium on Infant Mortality held in Montgomery January 28, 1988. Governor Guy Hunt, the Southern Governors' Association, the March of Dimes, the Alabama Medicaid Agency, the state Department of Human Resources and the state Health Department sponsored the meeting.

Attending the symposium were approximately 250 business, civic, and political leaders from throughout the state. The agenda was designed to address the economic and social consequences of a high infant mortality rate.

The program included such notables as Governor Hunt and First Lady Helen Hunt and keynote speaker Dr. William R. Roper, administrator of the federal Health Care Financing Administration. Other speakers were Dr. Ted Williams, representing the American Academy

of Pediatrics, Alabama Chapter; William H. Mandy, president of Blue Cross and Blue Shield of Alabama; Honey Alexander, former First Lady of Tennessee; Rae Grad, executive director of the National Commission to Prevent Infant Mortality; and Camille Cunningham, mother of Scott, the 1986 March of Dimes national ambassador.

Film on Teenage Pregnancy

In the summer of 1988, moviegoers around the state began seeing a public service announcement encouraging sexual abstinence among teens. The 2½-minute film, produced by Auburn University's Telecommunications Division, depicts extraterrestrial beings communicating this message: "Don't abuse your power to create life." The film was designed to appeal to teenage audiences. According to the film, abstinence is the most responsible form of birth control.

The production of this video was a cooperative project involving three state agencies—the Alabama Medicaid Agency, the state Health Department, and the state Department of Human Resources. Governor Guy Hunt added his special endorsement of the film.

The primary goal of the film is to reduce the number of teenage pregnancies in the state, thereby reducing numbers of low birthweight babies who may die or be born with severe handicapping conditions.

Medicaid Waiver for Managed Maternity Care

In September 1988, pregnant women in several Alabama counties began receiving managed maternity care from specific providers of pregnancy-related services. In order to begin this program, Medicaid had to apply for and receive from the federal government approval to waive certain sections of the federal Social Security Act. Among these is the section requiring that recipients be allowed freedom of choice in choosing a provider of health care services. Another section deals with "statewideness," which means that all Medicaid recipients statewide must have equal access to all Medicaid covered services.

As a result of this waiver, pregnant women and children in participating counties will now go to a single provider—one that contracts with Medicaid to manage maternity care in specific areas. The pregnant women in the affected counties receive services either from this primary provider or from a provider that subcontracts with the primary provider. The women in these counties have access to quality medical care while receiving the added benefit of case management services. An important part of the program is outreach—working within the community to find the women and children who need care, and bringing them into the system.

MediKids Outreach Efforts

In February 1988, Medicaid announced its intention to enhance outreach efforts to children in the state through its MediKids program. MediKids, known at the federal level as EPSDT—Early and Periodic Screening, Diagnosis, and Treatment—is a health screening program for children. This program provides regular medical examinations of children and referral for treatment if needed. It is a preventive health program designed to detect and treat problems early, before they become more serious and more costly to treat.

As part of this outreach effort, a goal was set to screen 80,000 children over the next year—a figure representing half the children eligible for Medicaid services.

Outreach to mothers and children is a cooperative effort of the Alabama Medicaid Agency, the state Department of Human Resources, and the state Health Department. Human Resources helps in the outreach efforts by emphasizing the MediKids program to families applying for Aid to Dependent Children (ADC). Public Health has a big role in encouraging utilization of the MediKids program. That agency contacts mothers who have chosen not to participate in MediKids, encouraging them to participate and select a provider. They also contact mothers of those children who have not been screened within 18 months.

The primary focus of the project is on children from birth to 12 years of age. Increased emphasis is placed on infants during their first year of life in an effort to impact the state's infant mortality rate.

The outreach project began in 18 counties; the final goal is to conduct outreach efforts in all 67 counties. There is a great need to reach families with the message that preventive health is important for their children now and as they grow into adults.

Implementation of SOBRA

In July 1988, Medicaid eligibility was extended to low-income mothers and babies as allowed by the

federal Sixth Omnibus Budget Reconciliation Act (SOBRA). Through SOBRA, pregnant women and children up to age one in families with incomes equal to or less than the federal poverty level became eligible for Medicaid.

The expansion of health care services to this new eligibility group was a cooperative effort of the Alabama Medicaid Agency, the Department of Human Resources, and the Department of Public Health. The county health department many times is the first point of contact for the women who eventually qualify for these free health care services.

Pregnant women may now be determined presumptively eligible for Medicaid by either the county Health Department, a rural health clinic or a community health center. Final eligibility is determined by the county Department of Human Resources.

Women determined eligible for Medicaid coverage qualify for pregnancy-related services such as prenatal case, delivery, and postpartum care, as well as family planning services following delivery. Eligible children may receive all Medicaid covered services up to the date of their first birthday.

Through September 30, 1988, 4,585 persons had qualified to receive free health care services through the SOBRA program.

Improved Infant Mortality Rate

The infant mortality rate in Alabama dropped from 13.3 deaths per 1,000 live births in 1986 to 12.2 deaths per 1,000 live births in 1987. Although this rate is the state's lowest ever, Alabama still remains among the top five states in terms of high infant mortality rates.

The improvement made in the state's infant mortality rate—from 788 infant deaths in 1986 to 726 deaths in 1987—was accomplished due to many different efforts: extending Medicaid benefits to poverty-level pregnant women and children; increasing concentration on the problem of teenage pregnancy; emphasizing outreach efforts to children through the MediKids program; and increasing awareness of the need to enter early into an organized system of prenatal care.

BENEFITS FOR THE ELDERLY

Reinstatement of Medicare Hospital Deductible

Beginning in January 1988, Medicaid reinstated payment of the Medicare hospital deductible—a benefit Medicaid had discontinued in 1986—for people eligible for both Medicare and Medicaid. This charge increased in January to $540, up from $520.

This change was beneficial to thousands of elderly and disabled people on Alabama. It is estimated that of the approximately 100,000 people in Alabama eligible for both Medicaid and Medicare, nearly 20,000, in a year's time, will benefit from this payment of the Medicare hospital deductible.

Cost of this added benefit was $18 million for the period January 1 through September 30, 1988. The federal government provides 73 percent of this funding.

Changes in Medicaid Eligibility Determination

In January 1988, Medicaid raised the income level for nursing home eligibility. Before that time, Medicaid nursing home patients became ineligible to receive Medicaid benefits if their Social Security cost of living adjustment elevated their incomes above the financial threshold for Medicaid eligibility.

To eliminate this undue hardship on the elderly, Medicaid raised the income limits placed on Medicaid nursing home patients to $911 a month. Prior to this increase, the income level for nursing home eligibility had not been raised in six years.

Another change of benefit to Medicaid nursing home patients was an increase in the Supplemental Security Income (SSI) ceiling for resources to $1,900 for an individual and $2,850 for a couple.

Management Improvement Recommendation Implemented

Effective December 1, 1987, a recommendation of Medicaid's Management Improvement Team was implemented. At that time, the Administrative Code was changed to allow the release of a recipient's Medicaid number to the provider of services. A provider may now fill out a form, send it to the Medicaid office, and receive a recipient's Medicaid number. This should be a very beneficial service to providers, speeding up claims processing, and, many times, assuring a payment they might not otherwise have received.

Third Party Recoupments

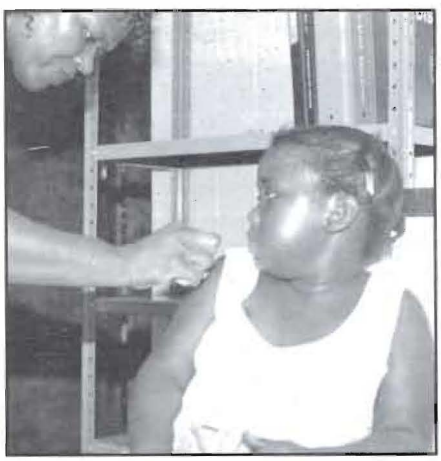
During the 1988 fiscal year, Medicaid's Third Party Section collected over one million dollars from third parties—insurance companies covering Medicaid recipients. This represented the highest amount ever collected. The number of recipients identified as having health insurance was also increased by 15 percent, the number identified the previous fiscal year. By the end of fiscal year '88, just under 10 percent of all Medicaid recipients had been identified as having health insurance.

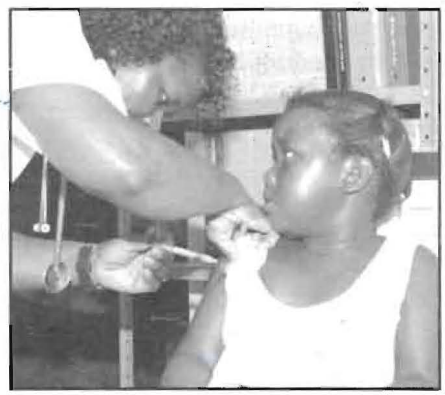
Adjustments to Medicaid claims, made possible by identification of third party insurance benefits, impacted claims totaling over $23 million this fiscal year. In addition to the more than $1 million collected from third party insurance carriers, the Medicaid Agency saw a reduction in Medicaid payments of over $1 million because of the money providers collected from third party resources. Claims totaling additional $15 million were denied by Medicaid and returned to providers to collect from recipients' insurance carriers. Many of these claims were paid in full by the insurance carriers. Claims for more than $4 million were returned to providers for submission to Medicare, the primary payor.

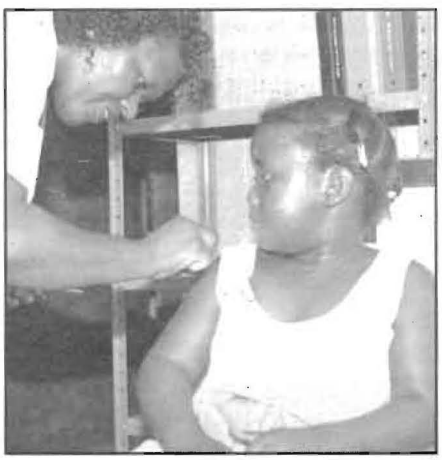
Medicaid was also able to make valuable recoupments from providers; more than $134,000 was recouped from providers who had received payment from both Medicaid and a third party.

Looking Ahead to FY 1989

Though steps have been taken to target groups most likely to produce babies at high risk of dying and to provide upgraded health care to the elderly and poor, more aid will be administered to these people and more consideration given to improve the conditions they face. While vast improvements cannot happen overnight, there has been a decrease in the rate of infant deaths, and the elderly and the poor have benefited from a number of changes in Medicaid. By the end of fiscal year 1989, it is projected that the overall conditions for these groups will improve as more help is made available.







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 1988, the formula was approximately 73/27. For every $27 the state spent, the federal government contributed $73.

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.

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 low income people.

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.

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 they could not otherwise afford.

Citizens who are not eligible for Medicaid also benefit from the program. Health care is one of the state's most important industries, and Medicaid contributes to that industry in significant ways. For instance, during FY '88, Medicaid paid almost $450 million* to providers on behalf of persons eligible for the program. The federal government paid about three-quarters of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services from thousands more. Using the common economic multiplier effect of three, Medicaid expenditures generated over $1.3 billion worth of business in Alabama in FY '88.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. This means that nearly all of Medicaid's budget goes to purchasing services for eligibles. Medicaid funds are paid directly to the providers who treat Medicaid patients. Providers may be physicians, dentists, pharmacists, hospitals, nursing homes, medical equipment suppliers and others.

*Excludes administrative cost and insurance premiums.

FY 1988
COUNTY IMPACT
Year's Cost per Eligible **Table-1**

COUNTY	BENEFIT PAYMENTS	ELIGIBLES	PAYMENT PER ELIGIBLE
AUTAUGA	$2,247,697	2,643	$850
BALDWIN	$5,550,766	4,795	$1,158
BARBOUR	$4,241,672	3,814	$1,112
BIBB	$1,767,371	1,533	$1,153
BLOUNT	$2,612,911	2,020	$1,294
BULLOCK	$2,355,774	2,650	$889
BUTLER	$3,858,306	3,413	$1,130
CALHOUN	$9,585,004	9,668	$991
CHAMBERS	$3,827,776	3,688	$1,038
CHEROKEE	$1,341,261	1,279	$1,049
CHILTON	$2,962,439	2,416	$1,226
CHOCTAW	$1,825,680	2,562	$713
CLARKE	$3,566,324	4,178	$854
CLAY	$2,075,296	1,248	$1,663
CLEBURNE	$1,019,570	948	$1,075
COFFEE	$4,399,032	3,074	$1,431
COLBERT	$4,645,317	3,291	$1,412
CONECUH	$1,851,420	2,061	$898
COOSA	$890,640	997	$893
COVINGTON	$4,420,264	3,541	$1,248
CRENSHAW	$2,769,300	2,014	$1,375
CULLMAN	$6,376,020	4,123	$1,546
DALE	$4,365,400	3,515	$1,242
DALLAS	$8,390,889	11,403	$736
DEKALB	$6,563,444	4,384	$1,497
ELMORE	$12,577,194	3,771	$3,335
ESCAMBIA	$3,860,169	3,550	$1,087
ETOWAH	$11,033,759	7,670	$1,439
FAYETTE	$2,119,274	1,850	$1,146
FRANKLIN	$4,371,245	2,840	$1,539
GENEVA	$3,063,994	2,620	$1,169
GREENE	$2,032,942	2,842	$715
HALE	$3,152,810	3,033	$1,040
HENRY	$1,829,059	1,778	$1,029
HOUSTON	$6,040,938	6,512	$928
JACKSON	$4,212,548	3,907	$1,078
JEFFERSON	$62,102,092	53,433	$1,162
LAMAR	$2,155,297	1,312	$1,643
LAUDERDALE	$6,713,322	5,003	$1,342
LAWRENCE	$2,999,944	2,765	$1,085
LEE	$4,830,326	5,527	$874
LIMESTONE	$3,368,066	3,262	$1,033
LOWNDES	$1,967,106	3,162	$622
MACON	$4,672,575	4,663	$1,002
MADISON	$10,148,555	11,604	$875
MARENGO	$3,765,973	4,074	$924
MARION	$3,878,248	2,275	$1,705
MARSHALL	$8,194,052	6,081	$1,347
MOBILE	$43,656,876	38,907	$1,122
MONROE	$2,638,237	2,949	$895
MONTGOMERY	$21,289,440	21,011	$1,013
MORGAN	$22,103,517	6,465	$3,419
PERRY	$2,767,930	3,607	$767
PICKENS	$3,630,529	3,633	$999
PIKE	$4,260,524	4,255	$1,001
RANDOLPH	$2,618,201	2,091	$1,252
RUSSELL	$5,453,582	4,862	$1,122
SHELBY	$3,984,770	2,804	$1,421
ST. CLAIR	$2,977,657	3,155	$944
SUMTER	$2,994,407	3,921	$764
TALLADEGA	$8,291,271	8,835	$938
TALLAPOOSA	$6,539,842	3,880	$1,686
TUSCALOOSA	$31,144,307	14,143	$2,202
WALKER	$8,546,550	5,910	$1,446
WASHINGTON	$2,090,912	2,362	$885
WILCOX	$2,999,255	4,335	$692
WINSTON	$3,429,495	1,788	$1,918

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 development 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 performed by the agency's contracted fiscal agent, Electronic Data Systems. Medicaid first contracted with EDS in October, 1979. Including that time, EDS has sucessfully bid on the contract four consecutive times.

The fourth contract began October 1, 1988. The company's performance in claims processing has been among the best in the nation.

During the past year, EDS completed several system enhancements that have resulted in a more efficient Management Information System. These enhancements include an improved criteria and parameter file for use in editing claims, and a totally new financial system that will meet new federal reporting requirements. The most significant accomplishment of MMIS this year has been making all the necessary modifications to process claims for a new Medicaid eligibility group—those pregnant women and children currently eligible as allowed by the federal Sixth Omnibus Budget Reconciliation Act (SOBRA). Alabama's MMIS continues to meet the needs of an ever-changing Medicaid program.

FY '86-'88
Medicaid Software Activity

Table - 2

	FY '86	FY '87	FY '88
Number of programs in production at year end	1,737	2,183	2,162
Number of requests received for software support	1,401	1,779	2,283
Number of requests completed	1,173	1,580	1,974

PROGRAM INTEGRITY

The Program Integrity Division is responsible for planning, developing, and directing agency efforts to identify, prevent, and prosecute fraud, abuse and/or misuse in the Medicaid program. This includes verifying that medical services are appropriate and rendered as billed, that the services are provided by qualified providers to eligible recipients, and that payments for those services are correct.

One unit within the Program Integrity Division is Quality Control. It is this unit's function to make sure the Medicaid agency is performing eligibility determinations as acurately as possible. If the agency's error rate in determining Medicaid eligibility should exceed three percent, the Health Care Financing Administration (HCFA) would impose a financial sanction. The agency's most recent error rate, as determined by HCFA, is 2.1105 percent.

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. More than 15,000 claims were manually reviewed during this fiscal year. The error rate cannot exceed one percent and one million misspent dollars. If errors exceed this threshold, the Medicaid Agency is required by HCFA to implement a complicated system with increased reporting requirements. Systems Audit also monitors the financial activities of the fiscal agent. During this fiscal year, a review of the fiscal agent's investment practices revealed additional interest income due the Medicaid Agency of $117,000. Approximately $3,500 more was collected each month following the review.

Recipient Eligibility Review, another unit within the Program Integrity Division, recovers funds from individuals who received Medicaid services while ineligible for the program. In most instances, these cases involve persons in nursing homes who are proven ineligible for Medicaid due to inaccurately reported income or assets. The unit received 579 new cases in FY '88, and closed 1,445 cases. Aided by staff from the Legal, Fiscal and Eligibility Divisions, the unit identified $877,855 for recoupment; of this amount, $502,045 was collected.

The Surveillance and Utilization Review (SUR) Unit looks for fraud and abuse in the Medicaid Program. The unit's primary tool is the computer. Computer programs are used to find unusual patterns of utilization on the part of providers and recipients. During FY '88, Provider SUR opened 340 reviews and closed 441. Recoupments and net adjustments for the fiscal year totaled $113,593. This unit saved the Medicaid program a total of $2,208,000 during FY '88 by identifying irregular Medicaid claims before the payment was made. Recipient SUR opened 365 reviews and closed 201. These cases are determined by analyzing unusual patterns of billing, and, if necessary, are 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. During FY '88, URC actions resulted in 113 recipients being terminated from the Medicaid program, 18 provider cases being referred to the Attorney General's Medicaid Fraud Control Unit, 23 providers or employees of providers being suspended from the Medicaid program, and 148 recipients being locked in to one physician and one pharmacy.

The lock-in program, whereby a recipient who abuses his Medicaid privileges may be restricted to receiving services from certain providers, is one administrative sanction used to control abuse in the Medicaid program. Imputed savings from this program totaled $72,195 in FY '88. The average number of recipients locked-in per month was 110.

Another unit that is very active in the Program Integrity Division is Pharmacy Review, which consists of two sections—Pharmacy Audit and Investigations. The audit staff in Pharmacy Review completed 150 on-site audits during the fiscal year, resulting in recoupments totaling $12,000. Audit activities have created a deterrent effect during the last few years; recoupments and policy violations are down.

Medicaid's investigative staff meets the investigative needs of the entire agency. However, they were placed within the Pharmacy Review Unit last year in an effort to combat the growing drug abuse situation—the use of legitimate Medicaid-covered drugs for illicit purposes. Through the efforts of Investigative and SUR staff, in conjunction with law enforcement authorities

throughout the state, abusive activities are being curtailed. During FY '88, total investigative activity included 286 closed cases with a total of $23,402 being recouped, and 368 assigned cases (out of 1,412 opened cases) with a total amount of $139,944 identified for recoupment. A total of 14 Medicaid fraud cases were referred to local district attorneys. In addition to the fraud cases, the staff assisted local authorities with 30 cases involving altered prescriptions, selling drugs for illicit purposes, and stolen or loaned Medicaid cards.

FY '88 **Table - 3**
PROGRAM INTEGRITY
Closed Case Summary

Provider Reviews	Referred to Attorney General	Recoupments Identified	Providers Terminated from the Medicaid Program	Diverted Funds
591	18	$125,593	23	$2,208,000
Recipient Reviews	**Referred to District Attorney**	**Recoupments Identified**	**Recipients Terminated from the Medicaid Program**	**Recipients Locked-In**
1,932	14	$1,017,799	113	148

REVENUE, EXPENDITURES, AND PRICES

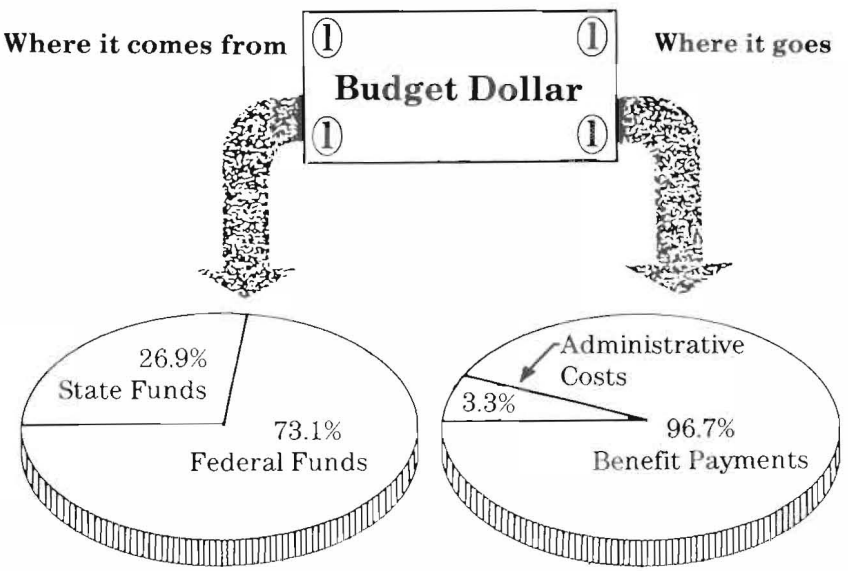
FY '88 Sources of Medicaid Revenue	Table - 5
Federal Funds	$353,839,721
State Funds	$130,302,200
Total Revenue	$484,141,921

FY '88 Components of Federal Funds	Table - 6
(net)	DOLLARS
Family Planning Administration	$ 400,898
Professional Staff Costs	7,108,139
Other Staff Costs	3,017,098
Other Provider Services	340,221,863
Family Planning Services	3,091,723
TOTAL	$353,839,721

FY '88 Components of State Funds	Table - 7
	DOLLARS
Encumbered Balance Forward*	$ 8,394,616
Basic Appropriations	101,600,000
Supplemental Appropriations	91,913
Other State Agencies	22,909,392
Interest Income from Fiscal Intermediary	351,453
Miscellaneous Receipts	6,500
Subtotal	$133,353,874
Encumbered	3,051,674
TOTAL	$130,302,200

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

Table - 5



FY '88 Benefit Cost by Fiscal Year in which Obligation was Incurred	Table - 8	
	FY '88	FY '89 (EST.)
Nursing Homes	$154,292,024	$157,670,500
Hospitals	81,739,660	82,886,500
Physicians	40,479,040	40,769,300
Insurance	38,868,923	46,842,400
Drugs	48,137,237	50,786,800
Health Services	8,670,602	8,941,800
*Community Services	28,037,727	52,717,200
Total Medicaid Service	400,225,213	440,614,500
Mental Health	70,352,260	67,250,000
Total Benefits	$470,577,473	$507,864,500

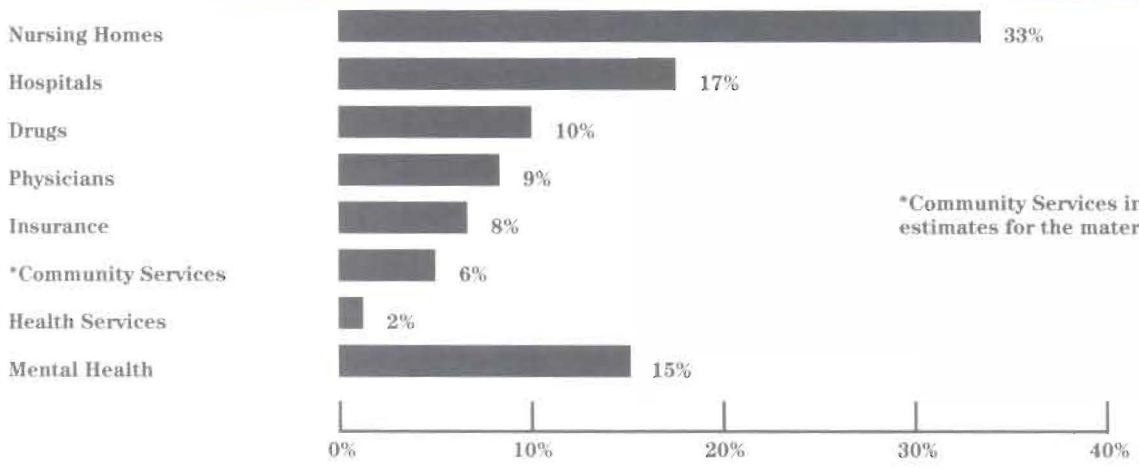
*Community Services includes benefit cost estimates for the maternity waiver program.

In FY '88, Medicaid paid $467,939,786 for health care services to Alabama citizens. Another $16,202,135 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 '88 **Table - 9**
EXPENDITURES
By Type of Service (net)

Service	Payments	Percent of Payments by Service FY '88
Pharmacy	47,765,995	10.21%
Nursing Homes:	153,100,224	32.72%
SNF	12,224,169	2.61%
ICF	140,876,055	30.11%
Hospitals	81,156,191	17.36%
Inpatient	74,809,439	15.99%
Outpatient	6,346,752	1.36%
Buy-In	24,610,231	5.26%
Physicians	40,047,432	8.56%
Screening	1,534,987	0.33%
Dental	4,204,678	0.90%
Hearing	89,701	0.02%
Laboratory	1,432,938	0.31%
Home Health/ DME	7,633,995	1.63%
Eyecare:	2,314,609	0.49%
Eyeglasses	619,675	0.13%
Eye Care	1,694,934	0.36%
Transportation	594,291	0.13%
Co-Insurance	13,247,976	2.83%
ICF MR/MD:	56,946,335	12.17%
ICF-MR	54,013,749	11.54%
ICF-MD	2,932,586	0.63%
Mental Health Services	4,904,514	1.05%
Waivered Services:	23,903,050	5.11%
Waivered Ser. - MH	8,501,160	1.82%
Waivered Ser. - HCBS	15,395,788	3.29%
Waivered Ser. - Preg	6,103	0.00%
Family Planning	3,435,248	0.73%
Other Care Svs:	1,017,392	0.22%
HMO	936,474	0.20%
Rural Health Clinics	80,918	0.02%
Total For Medical Care	$467,939,786	100.00%
Administrative Costs	16,202,135	
Net Payments	$484,141,921	

PERCENTAGE DISTRIBUTION OF BENEFIT COSTS INCURRED DURING FISCAL YEAR 1988 **Table - 10**

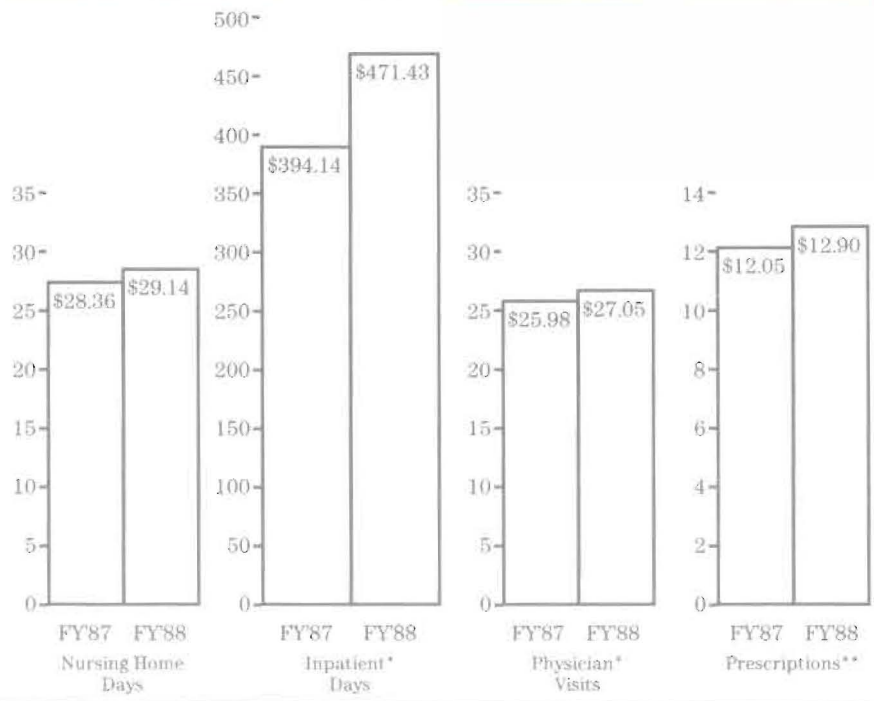


PRICES

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.

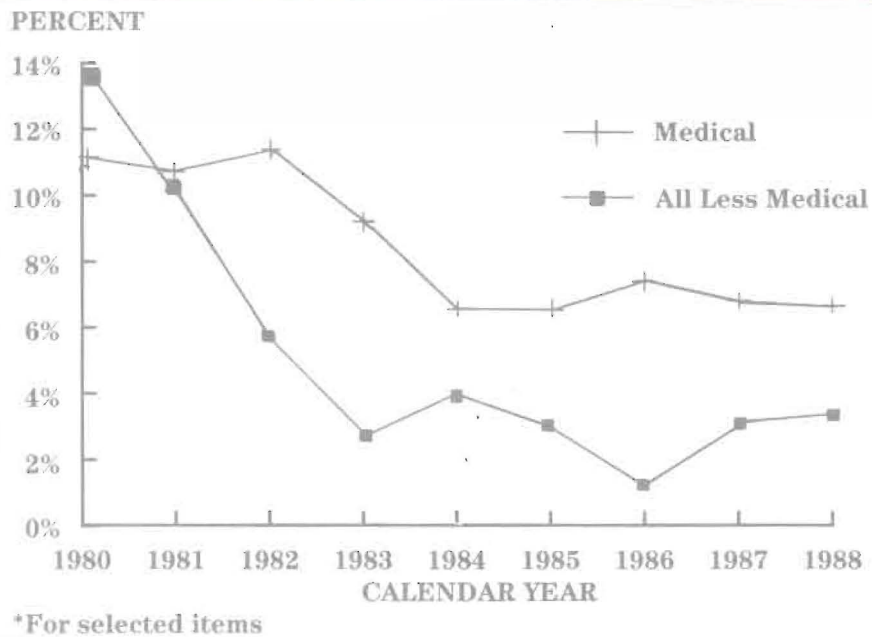
An example of how inflation impacts the Medicaid program is the increase in average prices for a day of nursing care and a day of inpatient hospital care. The Medicaid per diem rates for these services are based on a reimbursement methodology that takes into account an inflation factor. This year the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

FY '87 - '88 **Table - 11**
PRICES
Average Unit Price per Service



*Crossover Claims Excluded
**Family Planning Drugs Excluded

ANNUAL PERCENT CHANGES **Table - 12**
In the Consumer Price Index*



*For selected items

POPULATION

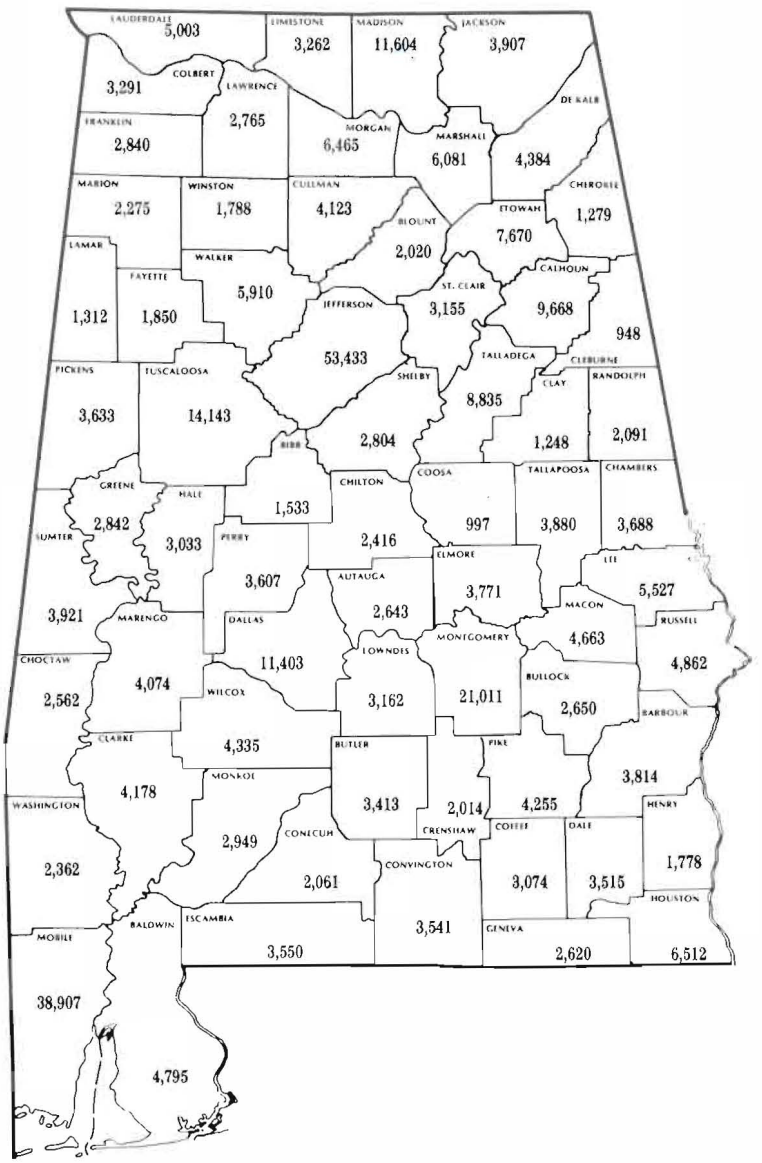
The population of Alabama grew from 3,444,165 in 1970 to 3,893,888 in 1980. In 1988, Alabama's population was estimated to be 4,195,581.

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 1995 there will be more than 595,399 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 '86 - '88 **Table - 13**
POPULATION
Eligibles as Percent of Alabama Population by Year

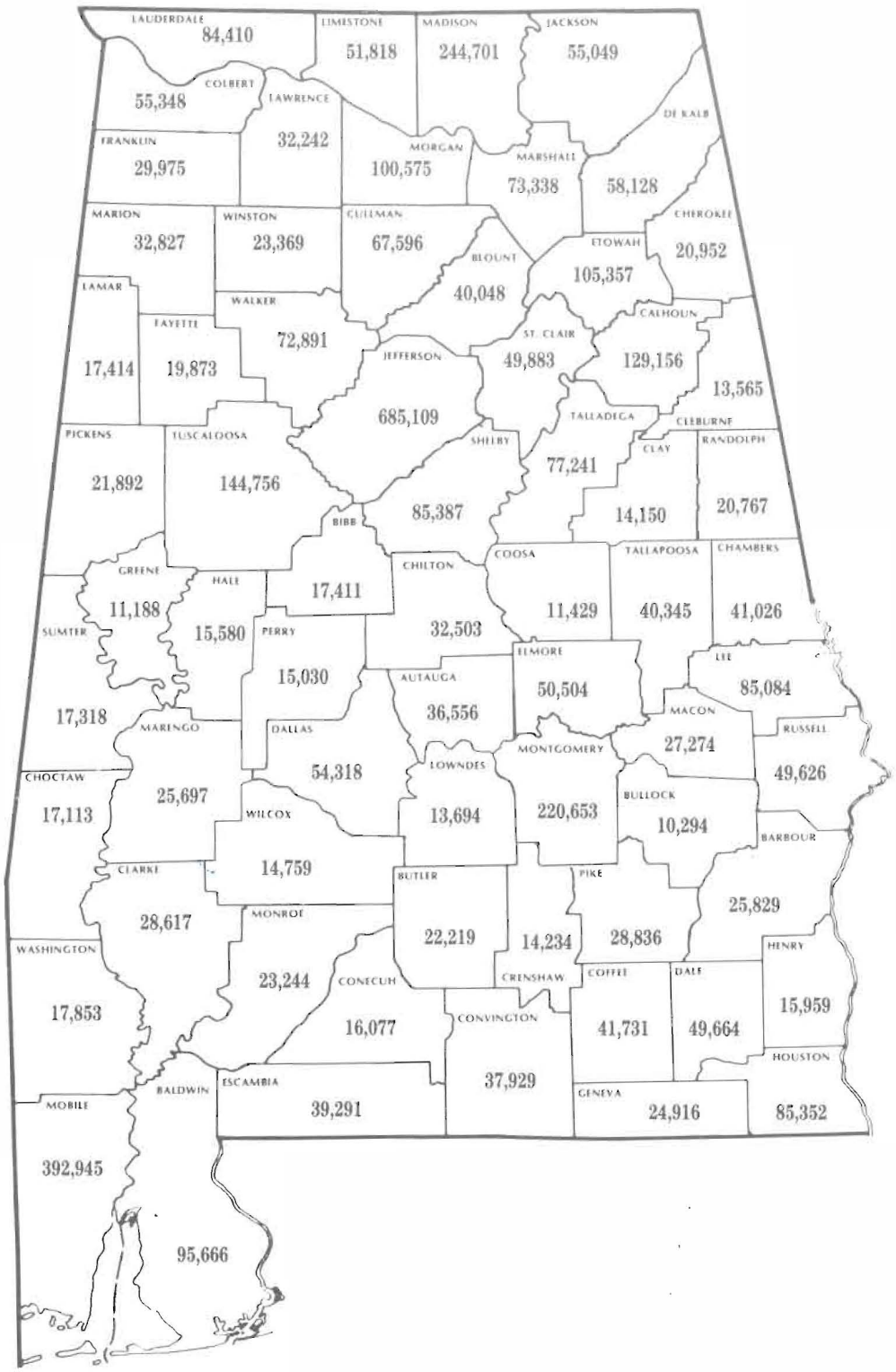
Year	Population	Eligibles	Percent
1986	4,101,507	374,953	9.1
1987	4,148,905	364,861	8.8
1988	4,195,581	367,811	8.8

FY '88 **Table - 14**
ANNUAL UNDUPLICATED TOTAL MEDICAID ELIGIBLES



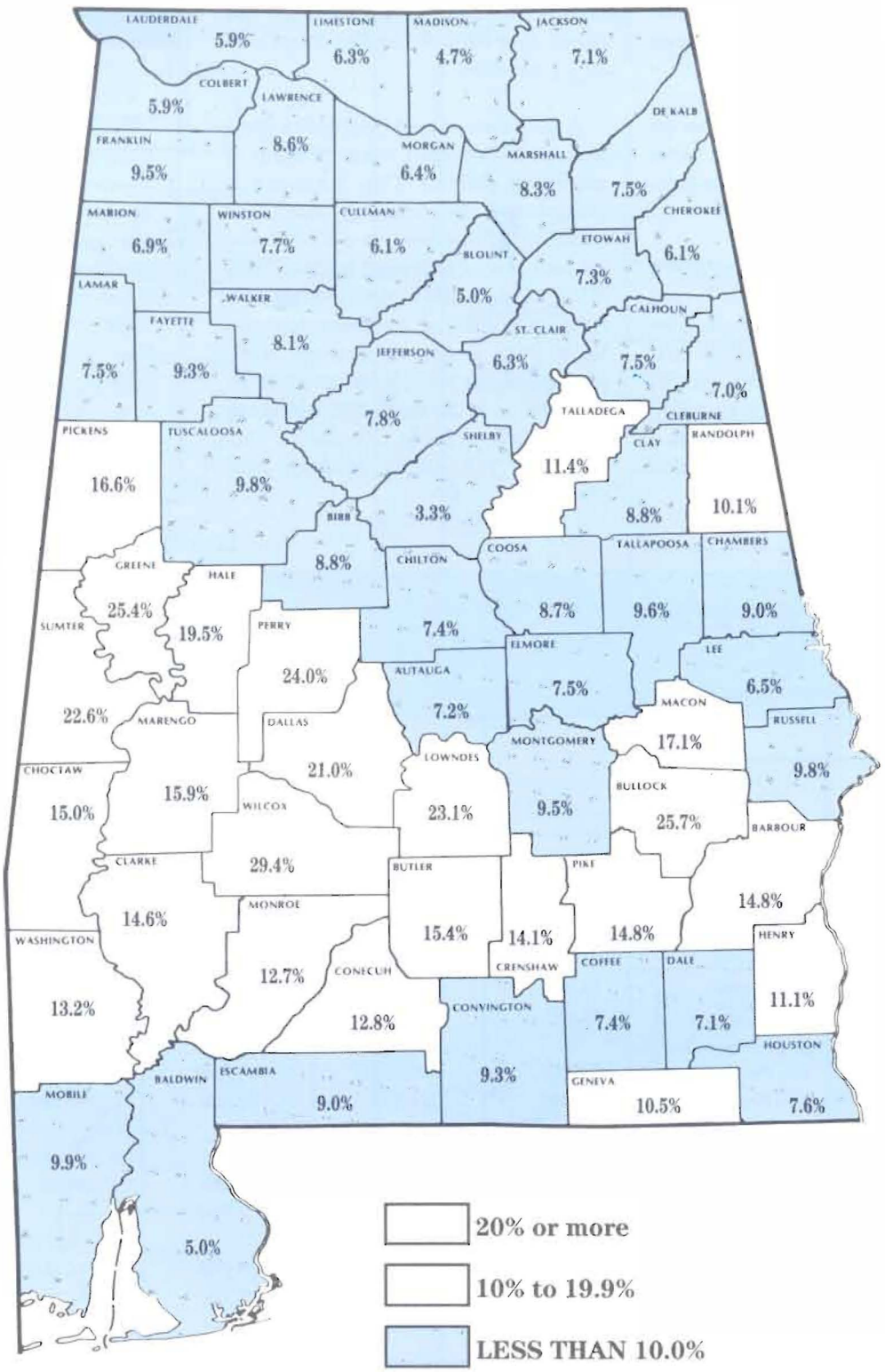
FY '88
POPULATION ESTIMATES

Table - 15



*Estimates by CENTER FOR BUSINESS AND ECONOMIC RESEARCH

FY '88 **Table - 16**
ELIGIBLES
Percent of Population Eligible for Medicaid



ELIGIBLES

During FY '88, there were 367,811 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 288,437. 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 two important measures to be calculated for each group: the number of new eligibles added during the year, and the number of old eligibles dropped during the year.

Although 367,811 people were eligible for Medicaid in FY '88, 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 '88 **Table - 17**
ELIGIBLES
Monthly Count

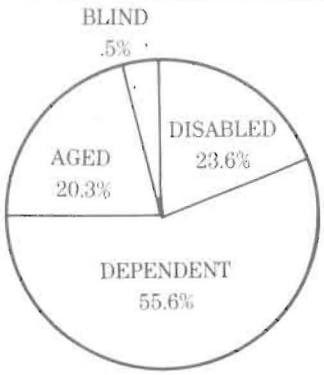
	Monthly Count
October '87	288,573
November	288,896
December	286,360
January '88	288,986
February	288,018
March	286,064
April	292,776
May	287,961
June	284,425
July	286,298
August	293,191
September	289,688

FY '88 **Table - 18**
ELIGIBLES
Total Number for Year
Average Number per Month

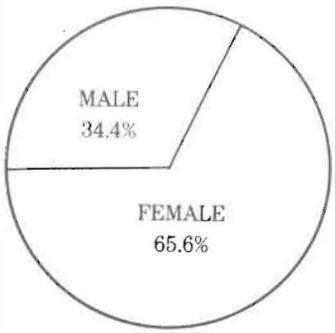
	First Month	Number Added During Year	Total Number for Year	Number Dropped During Year	Final Month	Average Number per Month
All categories	288,573	79,238	367,811	78,123	289,688	288,437
Aged	68,205	6,592	74,797	9,133	65,664	66,739
Blind	1,749	175	1,924	164	1,760	1,757
Disabled	75,352	11,227	86,579	8,604	77,975	76,558
Dependent	143,267	61,244	204,511	60,222	144,289	143,383
Males	99,110	27,478	126,588	27,599	98,989	99,209
Females	189,463	51,760	241,223	50,524	190,699	189,228
Whites	100,037	31,347	131,384	30,243	101,141	100,021
Nonwhites	188,536	47,891	236,427	47,880	188,547	188,416
Age 0-5	43,065	18,127	61,192	17,541	43,651	43,503
Age 6-20	74,105	26,692	100,797	26,512	74,285	74,054
Age 21-64	86,078	25,771	111,849	23,338	88,511	86,809
Age 65 & Over	85,325	8,648	93,973	10,732	83,241	84,071

FY '88 **Table - 19**
ELIGIBLES
Percent Distribution

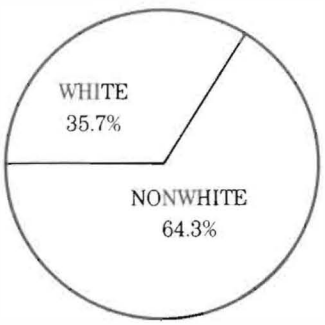
BY CATEGORY



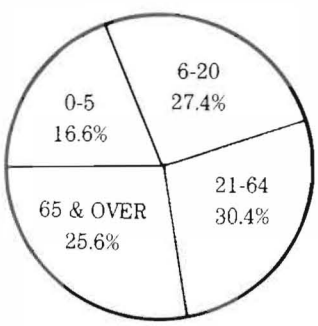
BY SEX



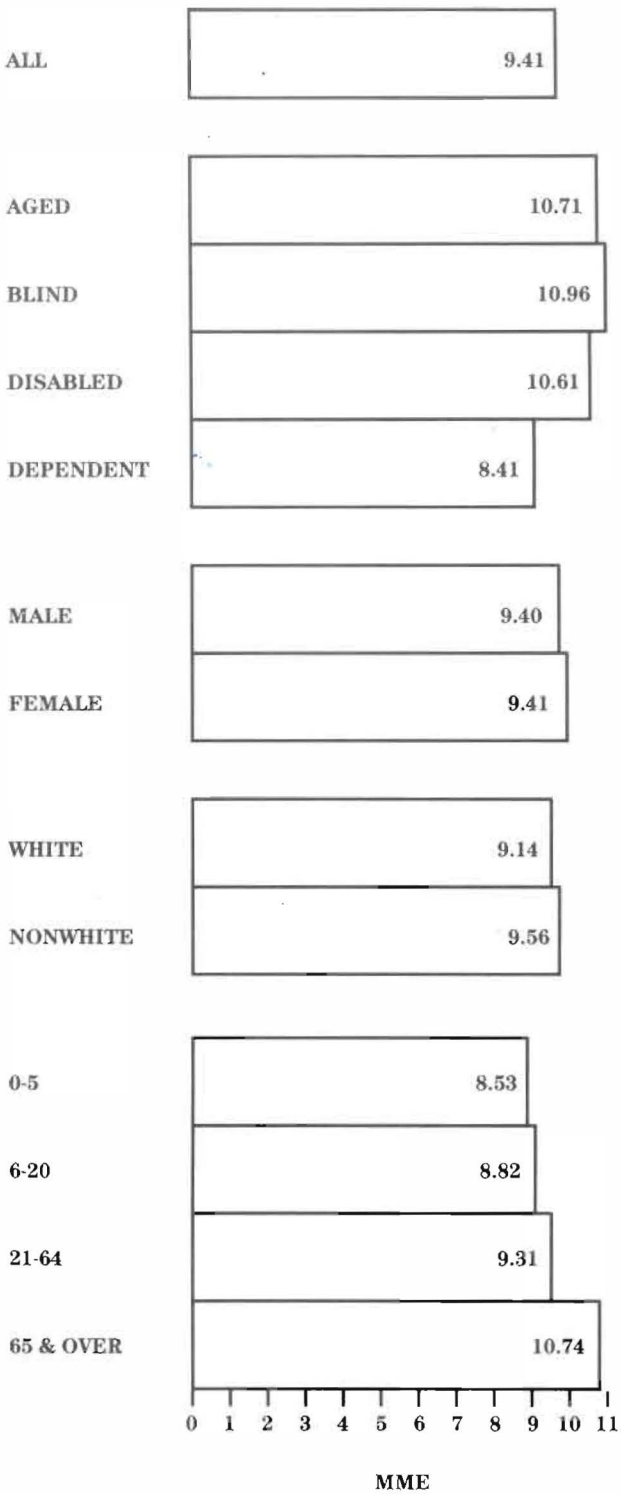
BY RACE



BY AGE

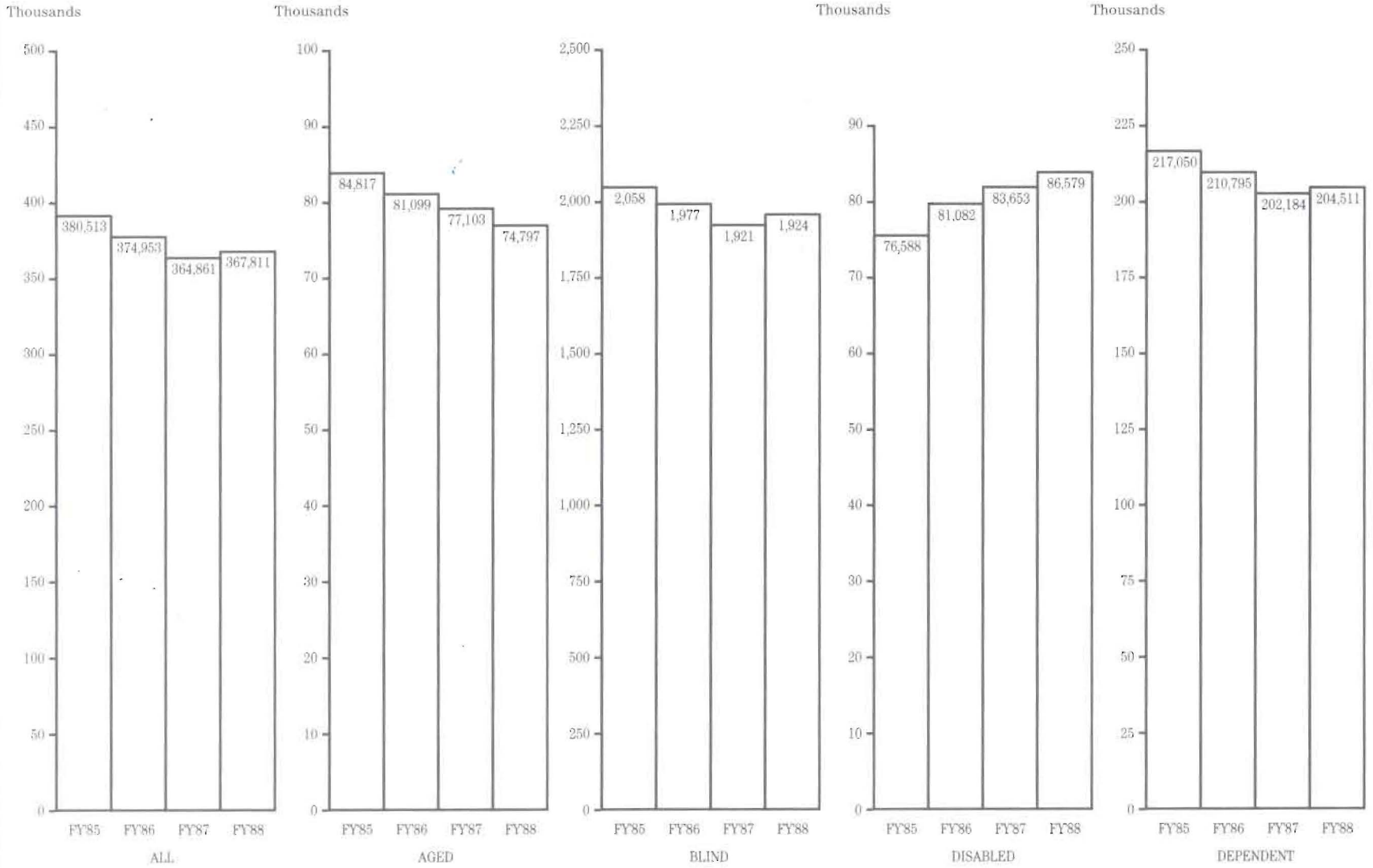


FY '88 **Table - 20**
ELIGIBLES
Man-Months of Eligibility



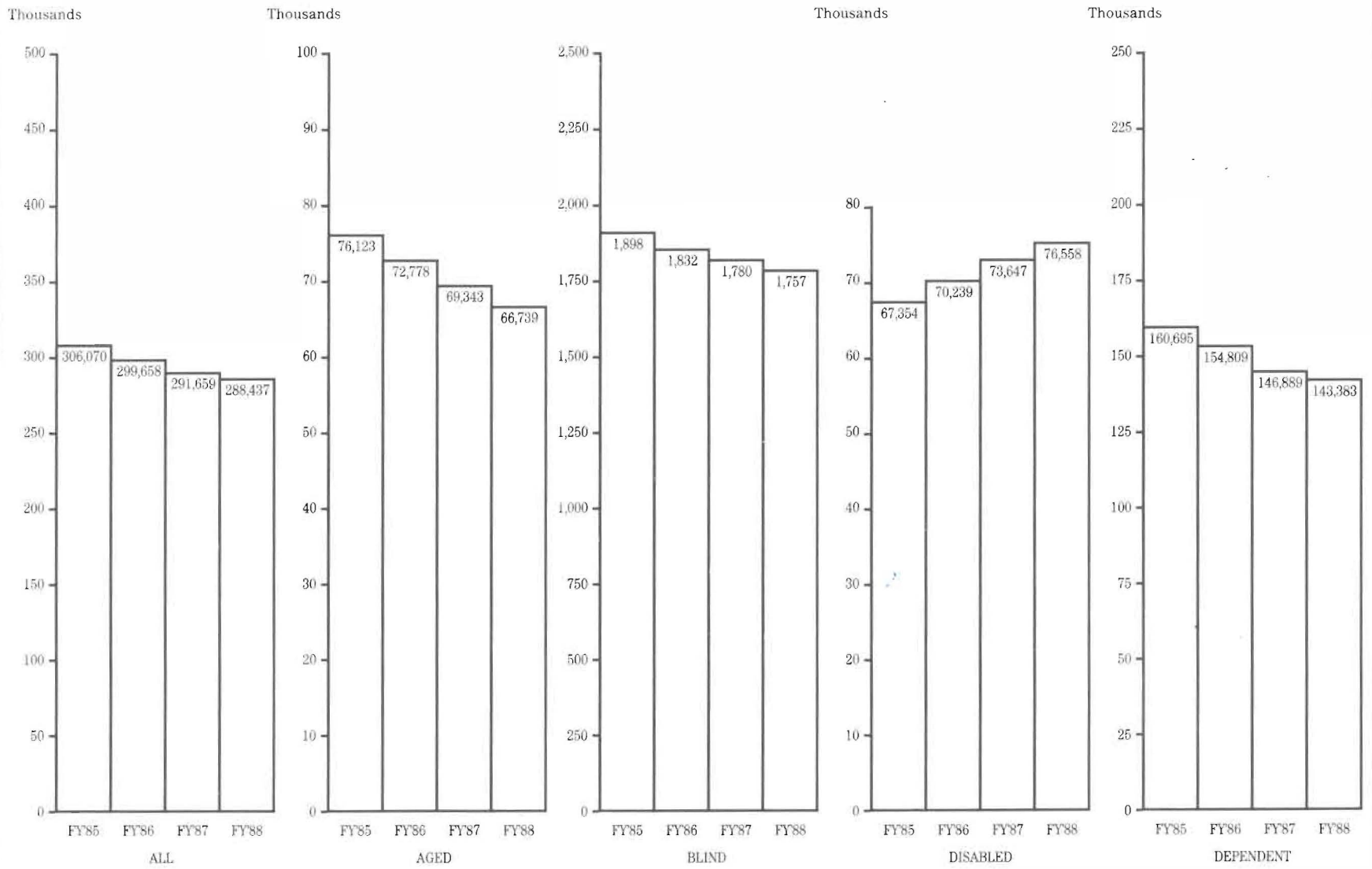
FY '85 - '88
ELIGIBLES
Annual Total

Table - 21



FY '85 - '88
ELIGIBLES
Monthly Average

Table - 22



RECIPIENTS

Although there were 367,811 persons eligible for Medicaid in FY '88, only 83 percent of these actually received benefits. These 306,045 persons are called recipients. The remaining 61,706 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 '88
RECIPIENTS
Monthly Averages and Annual Total

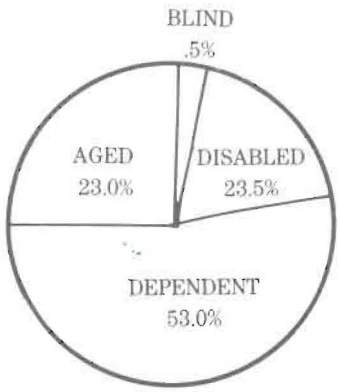
Table - 24

	Monthly Average	Annual Total
Aged	48,302	75,582
Blind	1,013	1,643
Disabled	49,464	77,173
Dependent	51,798	174,004
All Categories (unduplicated)	149,287	306,045

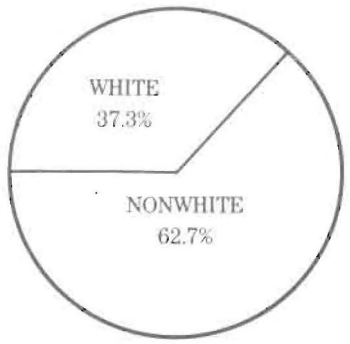
FY '88
RECIPIENTS
Percent Distribution

Table - 23

BY CATEGORY



BY RACE



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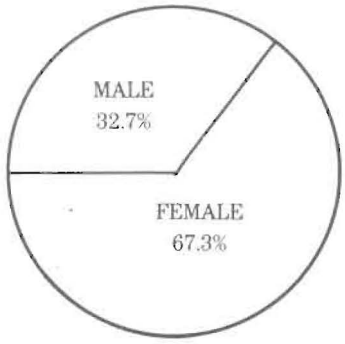
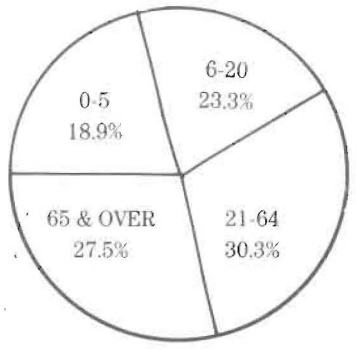


BY AGE



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 '87. 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.

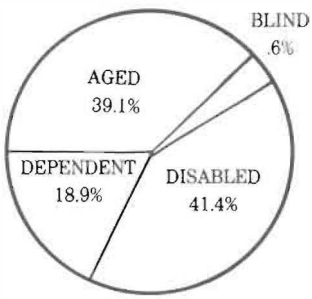
It is obvious from these statistics that certain groups are much more expensive to the Medicaid program than others. The reason for these differences is that specific groups tend to use specific types of services. Any Medicaid eligible receives, within reasonable limitations, medically necessary services.

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 '88 was $29. The average length of stay for recipients of this service was 270 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 '88
PAYMENTS
Percent Distribution

Table - 25

BY CATEGORY



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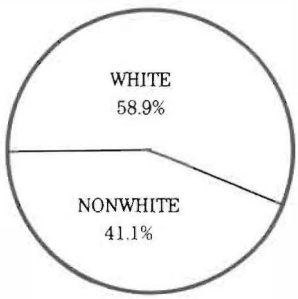

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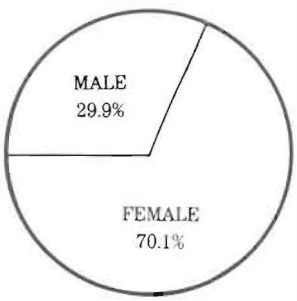

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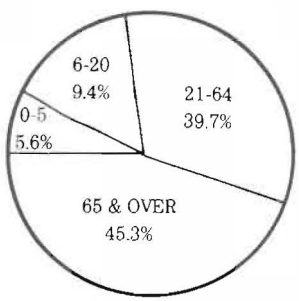
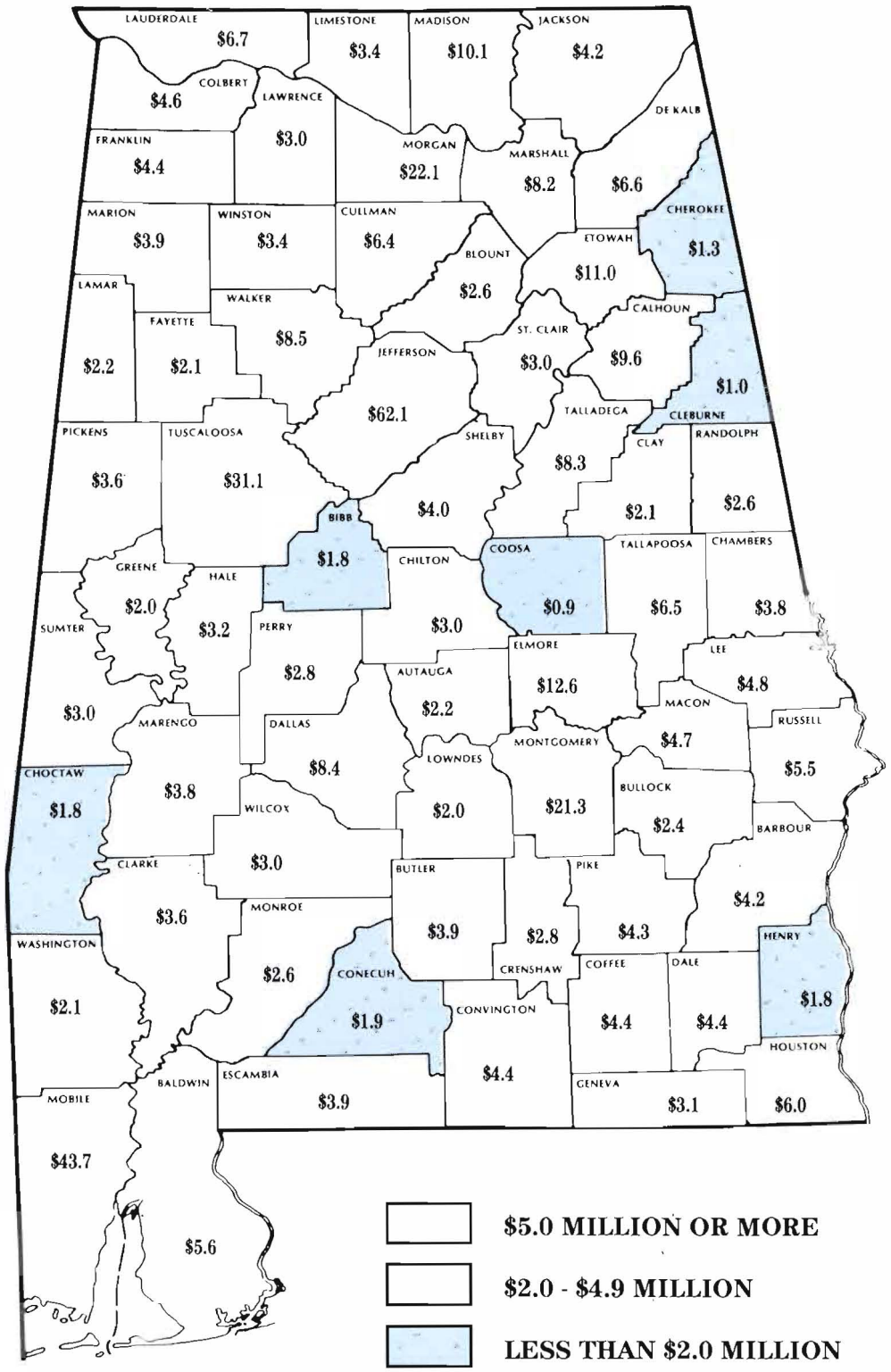


FY '88
PAYMENTS
By County (in millions of dollars)

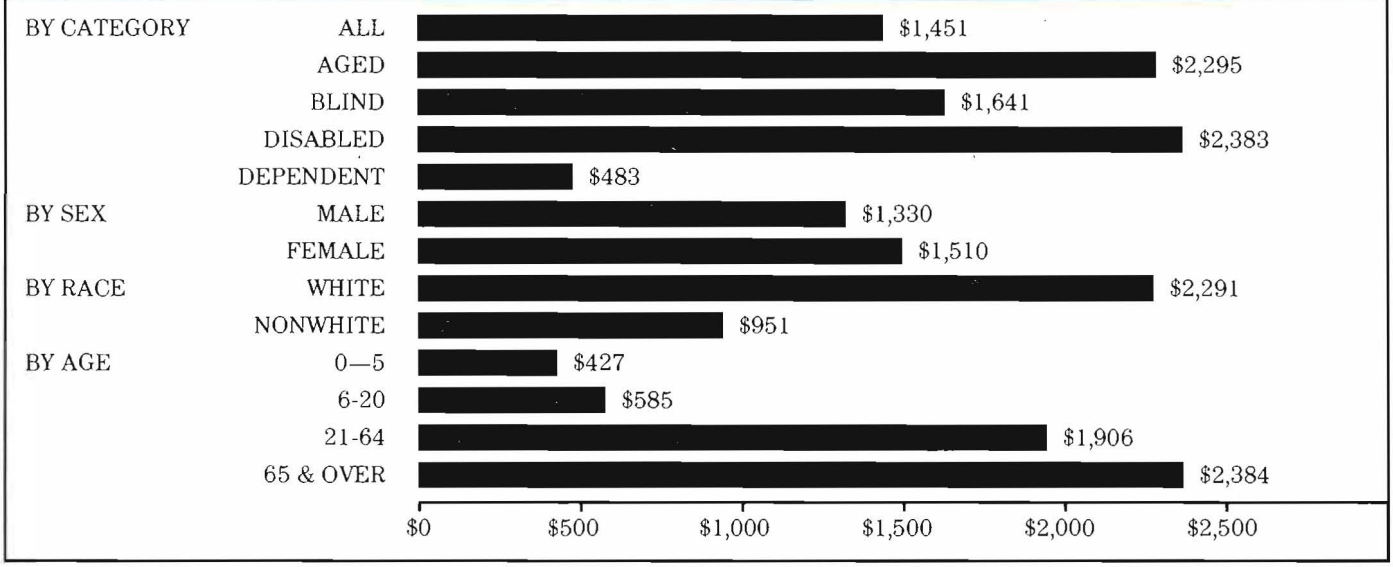
Table - 26



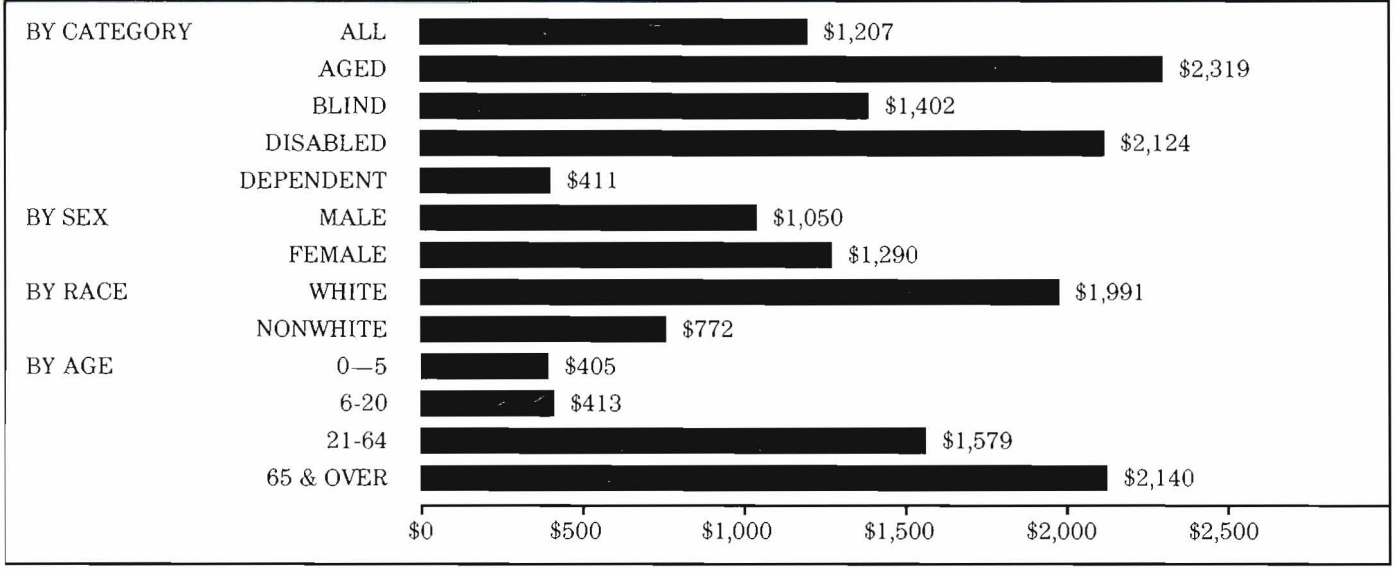
Also, note on Table 29 that cost per recipient for services shared with Medicare is much smaller for the aged category. More than 90 percent of aged persons are also covered by Medicare. A smaller percentage of blind and disabled persons are eligible for Medicare coverage. When these Medicare-Medicaid 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, 1988, this buy-in fee was increased from $17.90 to $24.80. Medicaid paid $24.6 million in buy-in fees in FY '88. 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 '88 COST PER RECIPIENT **Table - 27**



FY '88 COST PER ELIGIBLE **Table - 28**



FY '88 USE AND COST
Year's Cost per Service by Category
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	$45,104,875	$1,477,004	$81,541,443	$8,258,803	$93,988	$31,698,324	$48,107,554	$12,626,689
	Aged	3,576,208	13,899	8,307,794	202,497	10,598	14,351,597	21,651,595	8,371,724
	Blind	336,206	12,901	654,808	63,812	96	401,672	420,530	73,147
	Disabled	16,854,051	696,426	33,705,363	3,781,753	20,756	16,882,742	21,254,562	4,181,818
	Dependent Children	10,174,599	170,400	15,405,164	2,249,421	37,000	30,248	1,959,094	0
	Dependent Adults	14,163,811	583,378	23,468,314	1,961,320	25,538	32,065	2,821,773	0
Section 2 Year's Total Number of Recipients	All Categories***	241,267	54,083	46,449	92,600	1,269	10,960	226,602	2,930
	Aged	54,138	1,414	9,169	5,484	247	5,428	64,999	2,740
	Blind	1,375	300	290	473	1	141	1,411	8
	Disabled	64,084	14,466	14,607	24,838	222	5,327	64,927	672
	Dependent Children	83,484	17,810	8,139	38,555	548	67	63,305	0
	Dependent Adults	48,159	21,196	14,614	25,241	287	89	40,594	0
Section 3 Year's Cost per Recipient	All Categories	$187	$27	$1,756	$89	$74	$2,892	$212	$4,309
	Aged	66	10	906	37	43	2,644	333	3,055
	Blind	245	43	2,258	135	96	2,849	298	9,143
	Disabled	263	48	2,307	152	93	3,169	327	6,223
	Dependent Children	122	10	1,893	58	68	451	31	0
	Dependent Adults	294	28	1,606	78	89	360	70	0
Section 4 Utilization Rates Percent of Eligibles	All Categories	65.60%	14.70%	12.63%	25.18%	0.35%	2.98%	61.61%	0.80%
	Aged	72.38%	1.89%	12.26%	7.33%	0.33%	7.26%	86.90%	3.66%
	Blind	71.47%	15.59%	15.07%	24.58%	0.05%	7.33%	73.34%	0.42%
	Disabled	74.02%	16.71%	16.87%	28.69%	0.26%	6.15%	74.99%	0.78%
	Dependent	64.37%	19.07%	11.13%	31.19%	0.41%	0.08%	50.80%	****

\+ A small part of the cost of skilled care is paid by Medicare.

* Not Available

** Another $24.6 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
$139,441,416	$56,964,588	$4,065,507	$3,174,620	$1,670,856	$3,233,976	$1,669,526	$4,904,490	$307,557,546	$136,476,113	$444,033,659
111,923,988	3,887,704	1,291	0	406,966	641,274	0	69,652	161,305,791	12,110,996	173,416,787
598,219	73,485	2,634	11,408	8,747	22,160	818	16,028	1,628,848	1,067,823	2,696,671
26,919,209	53,003,399	269,149	459,632	539,435	1,438,083	48,877	3,849,217	128,846,123	55,058,349	183,904,472
0	0	3,405,262	180,062	402,225	703,482	1,547,593	677,496	8,905,462	28,036,584	36,942,046
0	0	387,171	2,523,518	313,483	428,977	72,238	292,097	6,871,322	40,202,361	47,073,683
17,825	1,689	37,380	22,534	36,783	45,515	47,031	11,201	N/A*	N/A*	306,045
19,304	356	24	0	9,938	15,421	0	268	N/A*	N/A*	75,582
63	3	42	46	177	322	30	42	N/A*	N/A*	1,643
3,249	1,537	2,540	2,149	11,581	16,439	1,554	7,653	N/A*	N/A*	77,173
0	0	33,187	3,283	8,748	7,618	43,416	2,266	N/A*	N/A*	114,660
0	0	2,380	18,438	6,405	6,407	2,509	1,235	N/A*	N/A*	59,344
$7,823	$33,727	$109	$141	$45	$71	$35	$438	N/A*	N/A*	$1,451
5,798	10,921	54	0	41	42	0	260	N/A*	N/A*	2,294
9,496	24,495	63	248	49	69	27	382	N/A*	N/A*	1,641
8,285	34,485	106	214	47	87	31	503	N/A*	N/A*	2,383
0	0	103	55	46	92	36	299	N/A*	N/A*	322
0	0	163	137	49	67	29	237	N/A*	N/A*	793
4.85%	0.46%	10.16%	6.13%	10.00%	12.37%	12.79%	3.05%	N/A*	N/A*	83.21%
25.81%	0.48%	0.03%	0.00%	13.29%	20.62%	0.00%	0.36%	N/A*	N/A*	N/A*
3.27%	0.16%	2.18%	2.39%	9.20%	16.74%	1.56%	2.18%	N/A*	N/A*	85.40%
3.75%	1.78%	2.93%	2.48%	13.38%	18.99%	1.79%	8.84%	N/A*	N/A*	89.14%
****	0.00%	17.39%	10.62%	7.41%	6.86%	22.46%	1.71%	N/A*	N/A*	85.08%

ALTERNATIVE SERVICES

The Medicaid Agency administers several programs that serve to prevent unnecessary institutionalization of Medicaid eligibles. The home and community-based services program, mental health services program and the home health/durable medical equipment program serve the elderly and disabled, mentally retarded, and chronically mentally ill Medicaid populations.

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. The waiver programs are aimed at keeping Medicaid eligibles out of institutions as long as possible by providing services to them in the community.

The mentally retarded/developmentally disabled waiver 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 $6,000 a year to care for a mentally retarded client in the community, whereas institutional care for a single client costs nearly $39,000 a year. During FY '88, about nine million dollars was expended to provide habilitative services to 1,578 mentally retarded/developmentally disabled clients in the community. During the same period, almost $55 million was spent in ICF/MR institutions to serve 1,386 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 4,600 people were served under this waiver during FY '88.

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 24 mental health centers around the state providing these services. During FY '88, about $5 million was spent to provide services to an average of 4,000 clients monthly.

Health Maintenance Organization

Another cost saving program is the Health Maintenance Organization (HMO) program, which provides a comprehensive health plan to clients. The HMO program began in FY '86 when West Alabama Health Services, Inc. received a grant from the Robert Wood Johnson Foundation to help with start-up costs for a program that would emcompass five rural counties in west Alabama.

The HMO began enrollment in Greene County, expanded into Hale County during FY '87, and into Sumter County during FY '88. Expansion into Choctaw and Marengo counties will begin in FY '89.

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

- long term care,

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

Advantages to HMO enrollment include no copayment for recipients, coverage of preventive health services (such as physical examinations and limited dental care for adults), unlimited covered physician visits, coverage of more hospital inpatient days than allowed by the regular Medicaid program, payment of Medicaid non-covered drugs, nutritional counselling, and non-emergency transportation for health care visits.

Except in bona fide emergencies, participants in the HMO must have all their health care provided by the HMO, or they must be referred by the HMO to another provider. Participants must also sign an agreement to remain with the HMO for a six-month enrollment period.

Total HMO enrollment for Greene, Hale, and Sumter counties during FY '88 was 2,599 participants. According to a 1987 annual review conducted by the Health Care Financing Administration (HMFA), Alabama's HMO program is one of the best rural, prepaid health care delivery systems in the southeast region of the United States.

RURAL HEALTH CLINICS

The Medicaid rural health clinic program was implemented April 1, 1978. Services covered under the 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.

Rural health clinics are reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by the Medicare fiscal intermediary. At the end of FY '88, four rural health clinics were enrolled as providers in the Medicaid program.

RENAL DIALYSIS PROGRAM

The Medicaid renal dialysis program was implemented in 1973. Since that time, enrollment of renal dialysis providers has gradually increased to its present enrollment of 31 free-standing facilities and two hospital-based centers.

Renal dialysis services covered by Medicaid are:

- maintenance hemodialysis (limited to 156 sessions per year, allowing for 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, but who do not require around-the-clock nursing care. The Alabama Medicaid Agency has provided intermediate care since 1972.

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 '88 only 14 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 that 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 rather than 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, 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 income.

FY '86 - '88 **Table - 30**
LONG-TERM CARE PROGRAM
Patients, Months, and Cost

	Number of Nursing Home Patients (Unduplicated Total)	Average Length of Stay During Year	Total Patient-Days Paid for by Medicaid	Average Cost per Patient per Day to Medicaid	Total Cost to Medicaid
1986	20,992	242 Days	5,081,436	$26	$134,199,967
1987	20,511	250 Days	5,135,190	28	145,651,321
1988	20,755	251 Days	5,218,730	29	152,068,104

FY '86 - '88 **Table - 31**
LONG-TERM CARE PROGRAM
The Number and Percent of Beds Used by Medicaid

	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
1986	22,211	13,809	20,992	62.2%	8,402
1987	22,240	14,019	20,511	63.0%	8,221
1988	22,622	14,278	20,755	63.1%	8,344

FY '88 **Table - 32**
LONG-TERM CARE PROGRAM
Recipients by sex, race, and age

	Skilled	Intermediate	Total
All Recipients	2,930	17,825	20,755
By Sex			
Female	2,135	13,582	15,717
Male	795	4,243	5,038
By Race			
White	1,901	14,332	16,233
Nonwhite	1,029	3,493	4,522
By Age			
0-5	47	4	51
6-20	86	84	170
21-64	337	1,819	2,156
65 & Over	2,460	15,918	18,378

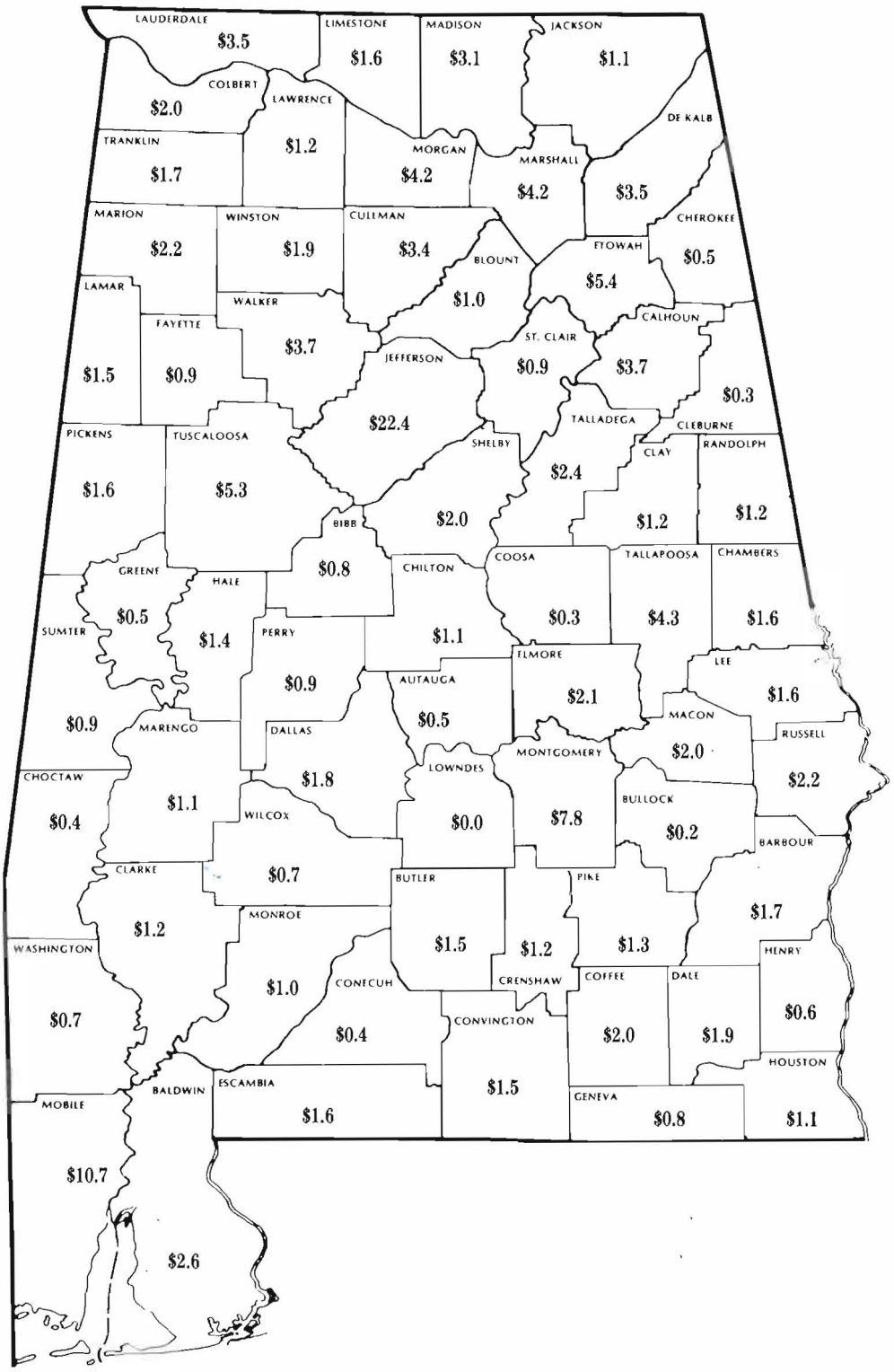
FY '88 **Table - 33**
LONG-TERM CARE PROGRAM
Payments by sex, race, and age

	Skilled	Intermediate	Total
All Recipients	$12,626,688	$139,441,416	$152,068,104
By Sex			
Female	9,007,791	107,782,189	116,789,980
Male	3,618,897	31,659,227	35,278,124
By Race			
White	7,884,582	110,508,681	118,393,263
Nonwhite	4,742,106	28,932,735	33,674,841
By Age			
0-5	677,232	34,260	711,492
6-20	1,118,242	984,613	2,102,855
21-64	1,822,562	16,888,151	18,710,713
65 & Over	9,008,652	121,534,392	130,543,044

FY '86 - '88 **Table - 34**
LONG-TERM CARE PROGRAM
Number of Recipients

	Skilled			Intermediate			Total		
	FY '86	FY '87	FY '88	FY '86	FY '87	FY '88	FY '86	FY '87	FY '88
Monthly Average	1,115	1,181	1,150	12,694	12,838	13,128	13,809	14,019	14,278
Yearly Total	3,594	3,213	2,930	17,398	17,298	17,825	20,992	20,511	20,755
Average Length of Stay	98 Days	131 Days	139 Days	272 Days	273 Days	270 Days	242 Days	250 Days	251 Days

FY '88 **Table - 35**
PAYMENTS TO NURSING HOMES
By County (in millions of dollars)



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 '88, 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 '88, through its relationship with the Alabama Medicaid Agency, Mental Health was able to match every 27 state dollars with 73 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 '87 - '88 **Table - 36**
LONG-TERM CARE PROGRAM
ICF-MR/MD

	FY '87	FY '88
Recipients	1,700	1,689
Total Payments	$53,101,377	$56,964,587
Annual Cost per Recipient	$31,236	$33,727

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 107 agencies participating in FY '88.
- 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.

Up to 100 home health visits per year may be covered by the Medicaid Agency. The maximum reimbursement rate per visit is $27, which is the most prevalent rate. In FY '88, an average of 2,629 recipients a month received a total of 258,951 visits at a cost of almost $7 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 128,420 units of service at a cost of almost $700,000.

FY '87 - '88 **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
1987	1,971	14,019	$222	$866
1988	2,629	14,278	$219	$888

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 125 Alabama hospitals that participate in the Medicaid program, and 33 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.

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

Utilization Review is mandated under federal regulations to ensure that Medicaid inpatient admissions are based on medical necessity. Effective October 1, 1987, the Alabama Medicaid Agency resumed the responsibility, through its Inpatient Utilization Review Unit, for inpatient review, a function that had previously been performed by Medicaid's fiscal agent. There are 74 instate hospitals in Alabama that are considered "delegated" and do their own utilization review; 51 hospitals are "non-delegated" and must call the Medicaid Agency for approval of medical necessity for admission and continued stays. Methods for conducting these reviews include admission screening, preadmission review, utilization review conducted by hospital committees, continued stay review, on-site review, and retrospective sampling.

Hospital utilization review is designed to accomplish these goals:

- Ensure medically necessary hospital care to recipients,
- Ensure that Medicaid funds allocated for hospital services are used efficiently,
- Identify funds expended on inappropriate services.

Limitations on hospital services were in effect during FY '88. 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 children under 21 who are hospitalized for 30 consecutive days after the initial 12 days are exhausted. Then an additional 12 days may be prior authorized (if medically necessary) and the appropriate EPSDT (MediKids) screening has been done. Medicaid may also authorize additional days to maternity patients if 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 '86 - '88 **Table - 38**
HOSPITAL PROGRAM
Changes in Use and Cost

Year	Eligibles	Recipients of Inpatient Care	Payments for Services	Medicaid's Annual Cost per Recipient
1986	374,953	57,323	$80,157,879	$1,398
1987	364,861	36,508	69,194,337	1,895
1988	367,811	46,449	81,541,443	1,756

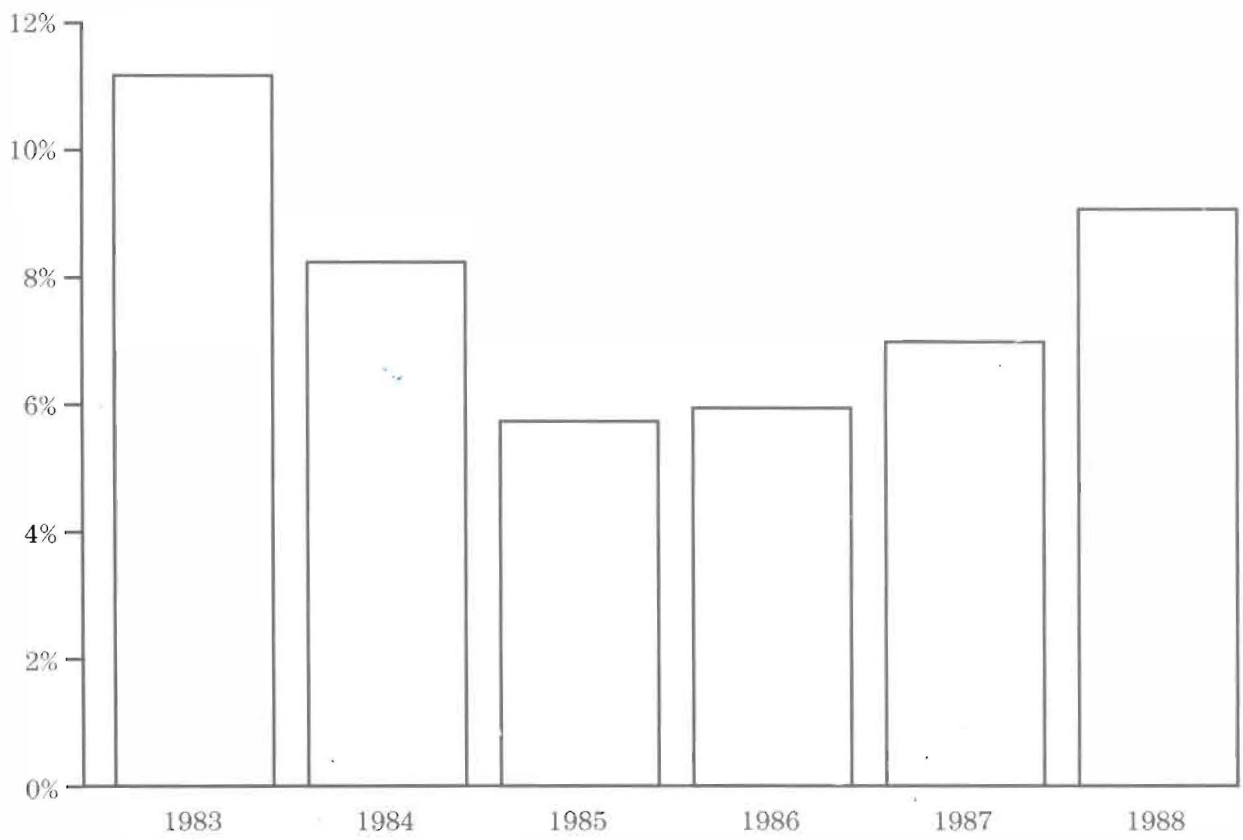
FY '84 - '88
HOSPITAL PROGRAM
Outpatients

Table - 39

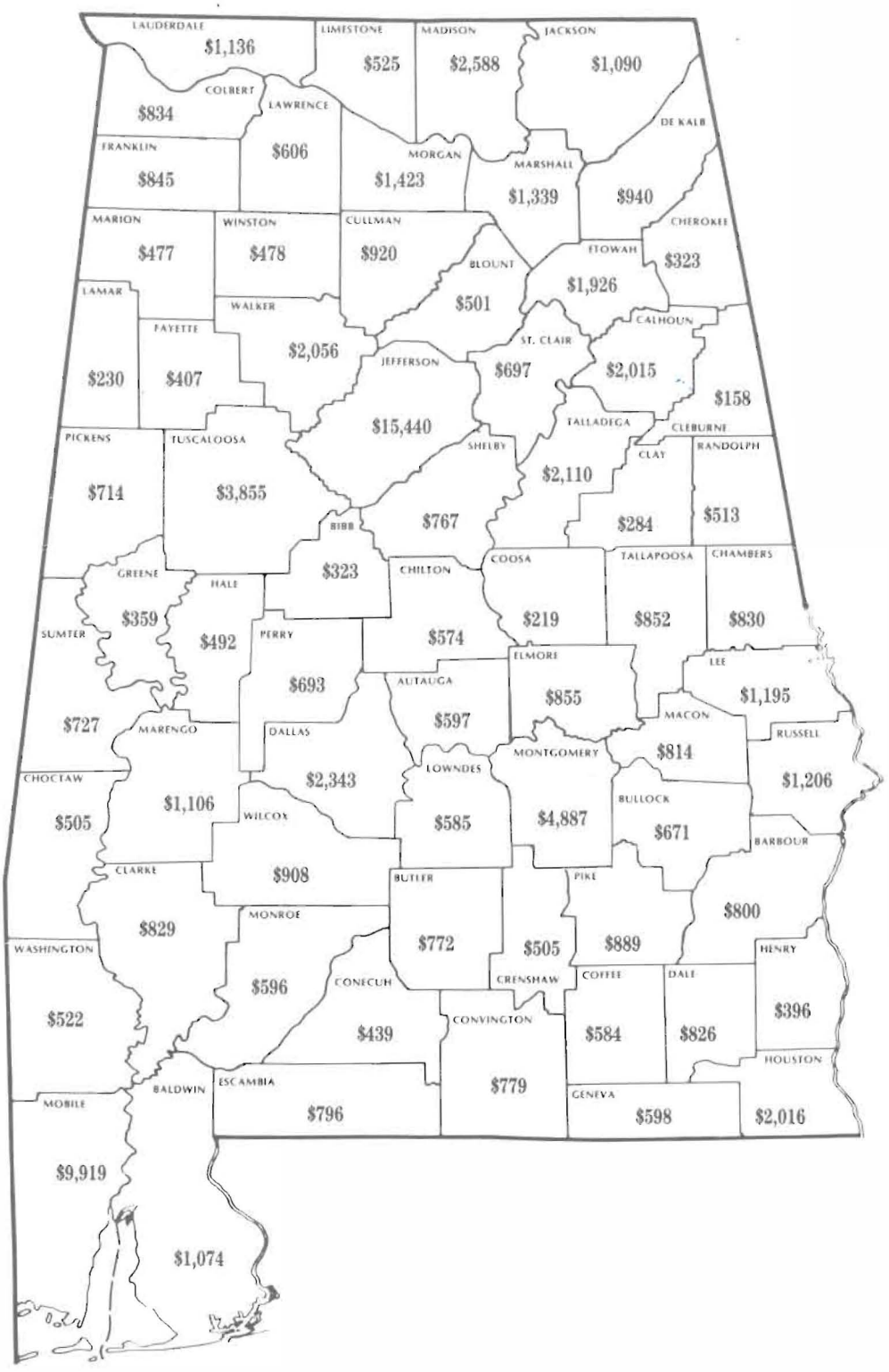
	FY '84	FY '85	FY '86	FY '87	FY '88
Number of Outpatients	108,085	91,848	102,082	92,255	92,600
Percent of Eligibles Using Outpatient Services	28%	24%	27%	25%	25%
Annual Expenditure for Outpatient Care	$12,815,220	$10,186,983	$13,006,467	$6,801,149	$8,258,803
Cost per Patient	$119	$111	$127	$74	$89

CALENDAR YEARS '83 - '88 ANNUAL PERCENT CHANGE
Hospital Room Cost from the Consumer Price Index

Table - 40



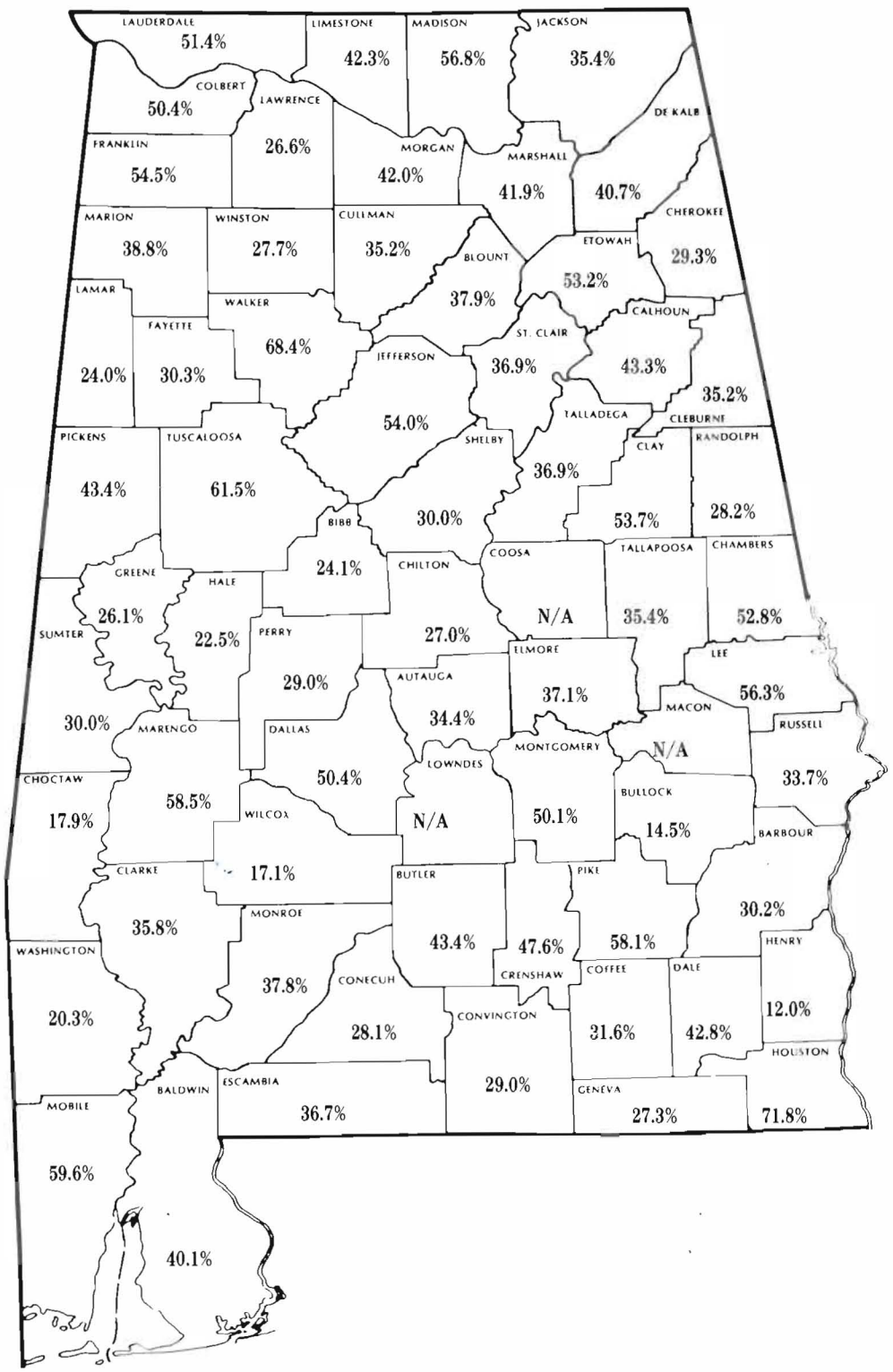
FY '88 **Table - 41**
PAYMENTS TO HOSPITALS
By County (in thousands of dollars)



FY '88 **Table - 42**

HOSPITAL OCCUPANCY RATE (%)

As of September 30, 1987



FAMILY PLANNING

In 1987, the number of births to women aged 10-19 decreased slightly from 1986 to 10,354. Of this number, 6,276 births were to unmarried teenagers. There was a marked increase in births to teenage women under 15 years of age.

Medicaid pays for the deliveries of a large number of these teenage mothers. Usually these young mothers and their families face a number of personal problems and must depend 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 weights and greater health difficulties in later life.

Medicaid services can help pregnant teenage eligibles in two primary ways. Provision of adequate prenatal care to teenage mothers through Medicaid can increase the likelihood of a successful outcome for both mother and child. Family planning services can help Medicaid-eligible women control the size of their families.

Although Medicaid's family planning services include assisting eligibles with fertility problems, most recipients of these services seek the prevention of unwanted pregnancies. Most expenditures for family planning 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 costs of family planning than for other services. For most Medicaid services in Alabama, the federal share of costs was 73 percent in FY '88. For family planning services, the federal share is 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 venereal disease testing, counseling, provision of oral contraceptives, 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 pass between the date of informed consent and the date of sterilization. Exceptions to these time limitations are made in cases of premature delivery and emergency abdominal surgery.

Eligibles may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since giving such informed consent. In cases of premature delivery, informed consent to the sterilization must be 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 will be endangered if the fetus is carried to term.

Prenatal Care

Competent, timely prenatal care results in healthier mothers and babies. Timely care can also 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. With the expansion of Medicaid to cover more pregnant women and young children, prenatal care is now available to more women than ever before.

PHYSICIAN PROGRAM

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. Service to eligibles is based on medical necessity, with physicians determining the need for medical care. Physicians provide this care directly and prescribe or arrange for additional health benefits. It is the physician who determines what drugs a patient receives, decides when a patient needs nursing 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 '88.

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, physical therapy, and emergencies. Physicians may not deny services due to the recipient's inability to pay the copayment.

Although not limited to services performed by a physician, care for Medicaid eligibles furnished by Crippled Children Service is billed through the physician program. Crippled Children Service can submit claims for covered services according to Medicaid's State Plan. About $168,147 was paid by Medicaid to Crippled Children Service for services provided to Medicaid-eligible clients.

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

A significant change in the physician program for FY '88 occurred January 1, 1988, when global obstetrical fees for both physicians and nurse midwives were increased. In addition, prenatal visits were added as a covered nurse midwife service in June 1988, while all nurse midwife fees were increased in August of 1988. During FY '88, eight nurse midwives were enrolled in the Alabama Medicaid program.

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 as long as the physician is enrolled in the Medicaid program and has a provider number.

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

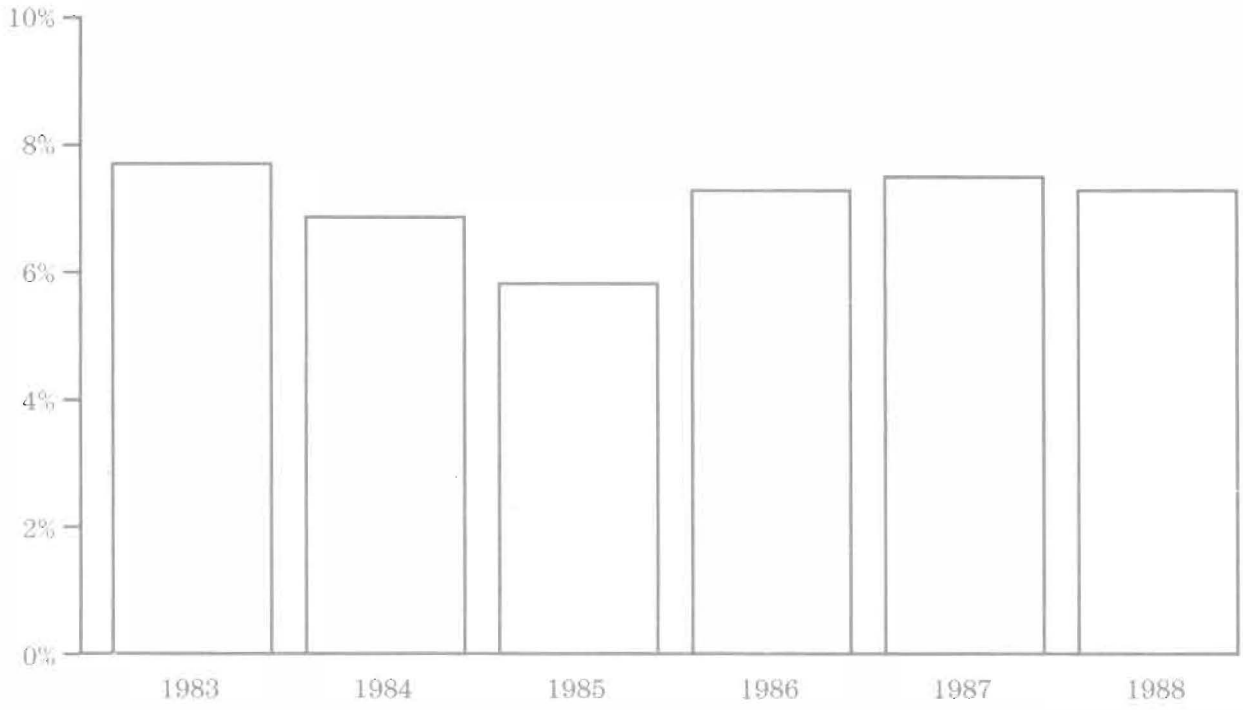
FY '88 **Table - 43**
PHYSICIAN PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
Aged	$3,576,208	54,138	$66
Blind	$336,206	1,375	$245
Disabled	$16,854,051	64,084	$263
Dependent	$24,338,410	131,643	$185
All Categories	$45,104,875	241,267	$187

FY '87 **Table - 44**

ACTIVE LICENSED PHYSICIANS
as of December 31, 1987, by County

CALENDAR YEARS '83 - '88 ANNUAL PERCENT CHANGES **Table - 45**
Physician Services Cost from the Consumer Price Index



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 '88, pharmacy providers were paid almost $50 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about 10 percent of Medicaid payments for services. This fiscal year, the Medicaid Agency reimburses participating pharmacists for dispensing based on the ingredient cost of the prescription plus a dispensing fee. Dispensing fees were increased effective April 1, 1988, as follows:

Retail Pharmacy	$3.75
Institutional Pharmacy	2.77
Governmental Pharmacy	1.90
Dispensing Physician	1.21

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 on the Alabama Drug Code Index. On April 18, 1988, the 15th 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.

The pharmacy program is responsible for maintaining a list of injectable medications that can be administered by physician providers. Reimbursement for these injectables is payable through the physician program. The physician may bill for either an office visit or for the cost of the drug plus an administration fee.

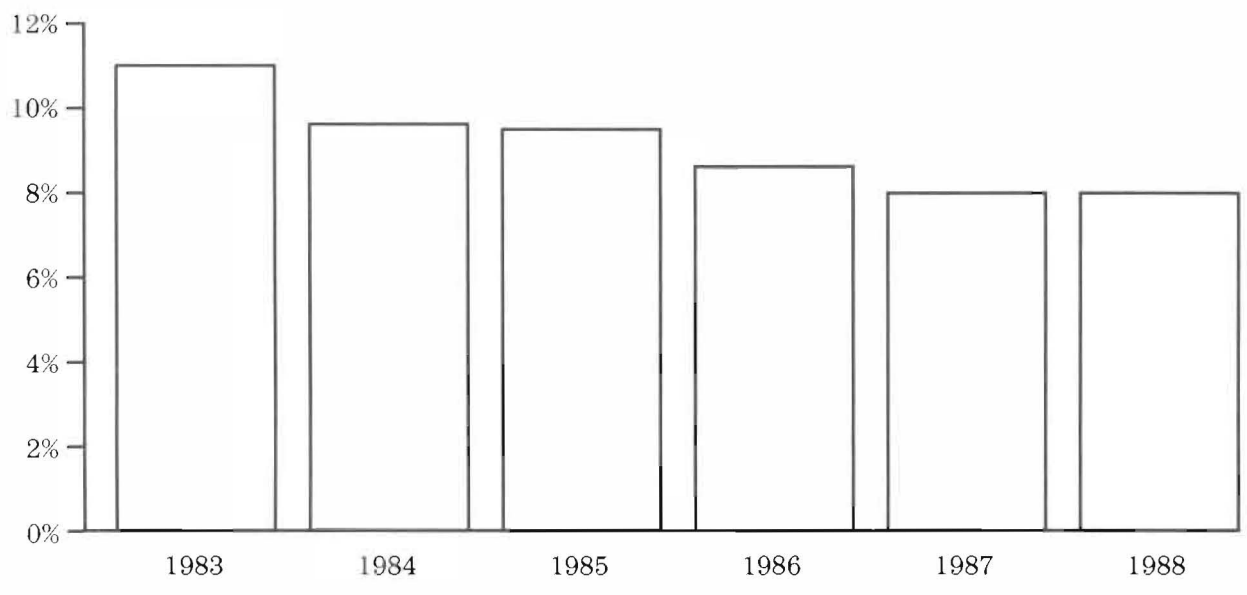
FY '88 **Table - 46**
PHARMACEUTICAL PROGRAM
Counts of Providers by Type

Type of Provider	Number
Retail	1,182
Institutional	37
Governmental	5
Dispensing Physician	2
Total	1,226

FY '86 - '88 **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
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
1988	226,602	62%	3,728,203	16.45	12.90	212.30	48,107,554

CALENDAR YEARS '83 - '88 ANNUAL PERCENT CHANGES **Table - 48**
Prescription Drug Cost from the Consumer Price Index



MEDIKIDS

The Early and Periodic Screening, Diagnosis and Treatment Program, renamed MediKids in 1986, is a preventive health program designed to detect and treat diseases that may occur in a child's early life. If properly used, the program can benefit both the child and the Medicaid Agency. Many health problems begin early in life and, if left untreated, can cause chronic illness and disability. When an illness is diagnosed and treated through the screening program, the child benefits through improved health. The Medicaid program realizes long-term savings by intervening 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. Also included among eligibles are children up to one year old in families with income at or below the federal poverty level. Human Resources workers normally determine ADC eligibility, make families aware of MediKids, and refer eligibles to providers. The Health Department provides services to many MediKids eligibles.

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 1986 succeeded in adding a large number of physicians to the program. The Medicaid program, now, is making efforts to increase the number of MediKids-eligibles using the screening services. Since screening is not mandatory, many mothers do not seek health care for their children until they show signs of illness.

Steps have been taken in recent years to increase screening usage. In addition to the physician recruitment effort, these initiatives include increased publicity of the MediKids program, implementation of an intensive outreach project in a number of Alabama counties, an increase in physicians' reimbursement rate for MediKids screenings and an increase in the number of screenings for which Medicaid will pay. Numbers of screenings have increased because of these efforts. A Medicaid goal is to screen all eligibles at ten intervals between birth and age 21.

The MediKids screening program can detect many problems before they become acute. Problems such as hypertension, rheumatic fever and other heart conditions, diabetes, neurological disorders, venereal disease, anemia, urinary infections, vision and hearing disorders, and even cases of child abuse have been detected and treated in past years. The cost of screening is relatively small—an average of $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 EPSDT 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 '88, more than 37,000 persons received dental treatment at a cost of $4.1 million to the Medicaid program.

FY '87 - '88 **Table - 49**
MEDIKIDS
Screenings and Payments

	FY '87	FY '88
Total Screenings	39,273	55,295
Total Payments for Screenings	$1,208,931	$1,669,526
Recipients of Dental Care	35,593	37,380

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,
- diagnostic or therapeutic services or items directly related to the provision of a surgical procedure,
- administrative, 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 services 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 has been reviewed and updated quarterly since 1986. In September 1988, a master list of all ASC-covered codes with effective dates was compiled. There are over 1600 procedures on the list.

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 designated copayment amount for each visit. At the end of FY '88, 10 ASC facilities were enrolled as providers in this program.

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 covered.

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

- independent laboratories and x-ray facilities,
- laboratory and x-ray facilities owned and operated by physicians for their exclusive use, and
- private laboratory facilities owned and operated by physicians for their exclusive use,
- hospital-based laboratory and x-ray facilities.

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

FY '88 **Table - 50**
LAB AND X-RAY PROGRAM
Use and Cost

Year	Recipients	Payments	Annual Cost per Recipient
1988	54,083	$1,477,004	$27

OPTOMETRIC PROGRAM

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

The eye care program provides services through ophthalmologists, optometrists and opticians. Adults (21 years of age and older) are eligible for one complete eye examination and one pair of eyeglasses every two calendar years. Recipients under 21 years of age are eligible for an eye examination and one pair of eyeglasses every calendar year. However, 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 such as orthoptic training, fundus photography, and external ocular photography are available with prior authorization when medically necessary.

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 '88 **Table - 51**
OPTOMETRIC PROGRAM
Use and Cost

Type of Provider	Average Monthly Recipients	Payments
Dispensing Optician	2,398	$611,735
Optometrist	3,555	$1,670,855
Ophthalmologist	2,112	$1,709,774
Total	8,065	$3,992,364

MEDICAID DISTRICT OFFICES

There are seven Medicaid District Offices around the state. These offices determine financial eligibility for nursing home care.

OFFICE	COUNTIES SERVED	
Birmingham 85 Bagby Drive - Room 305 Birmingham, AL 35209 Phone: 942-9095	Jefferson Shelby	Walker Winston
Decatur 2119 Westmeade Street, S.W. Decatur, AL 35603 Phone: 350-6311	Colbert Cullman Franklin Jackson Lauderdale	Lawrence Limestone Madison Marshall Morgan
Dothan Suite 210 Plaza Two Dothan, AL 36303 Phone: 794-0761	Barbour Coffee Covington Crenshaw Dale	Geneva Henry Houston Pike
Gadsden P. O. Box 35 (412 South 3rd Street) Gadsden, AL 35902 Phone: 547-4907	Blount Calhoun Cherokee Clay Cleburne	DeKalb Etowah Randolph St. Clair Talladega
Mobile 4367 Downtowner Loop North Suite D Mobile, AL 36609 Phone: 342-5169	Baldwin Choctaw Clarke Conecuh	Escambia Mobile Monroe Washington
Montgomery 2388 Fairlane Dr., Bldg. D Montgomery, AL 36130 Phone: 261-4065	Autauga Bullock Butler Chambers Chilton Coosa Dallas Elmore Lee	Lowndes Macon Marengo Montgomery Perry Russell Tallapoosa Wilcox
Tuscaloosa P. O. Box 716 (3716 12th Avenue East) Tuscaloosa, AL 35402 Phone: 553-0613	Bibb Fayette Greene Hale Lamar	Marion Pickens Sumter Tuscaloosa