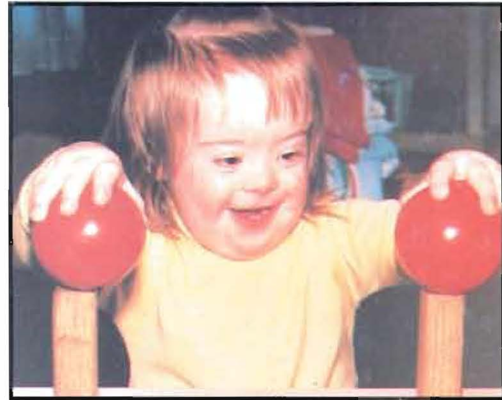

The Alabama Medicaid Agency
1989 Annual Report

Guy Hunt
Governor
State of Alabama

Carol A. Herrmann
Commissioner
Alabama Medicaid Agency

ALABAMA MEDICAID AGENCY
FY 1989 ANNUAL REPORT
OCTOBER 1, 1988 - SEPTEMBER 30, 1989

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 17th Annual Report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1988, and ended September 30, 1989.

During the year, almost 325,000 Alabamians received health care services financed by the Medicaid Agency. Among those who depend on Medicaid to meet their health care needs are low-income pregnant women and their young children, as well as low-income elderly and disabled people in their own homes and in nursing homes. Providing health care services for all eligible recipients cost the state $135 million, with the federal government providing almost $375 million in fiscal year 1989.

Many positive and productive changes in Alabama's Medicaid program have been accomplished this year. By continuing to federally match every state dollar possible, more money has been brought into the program to improve and expand services to our low-income population.

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. In Alabama, the 1988 rate, 12.1 infant deaths per 1,000 live births, improved over the 1987 rate of 12.2 deaths per 1,000 live births. As more initiatives are taken in this area, we should continue to see a decline of infant deaths in this state.

We have not only improved access to care by carefully coordinating with other state agencies, but we also have improved Medicaid's relationship with provider organizations. We created a Physician's Task Force and conducted other outreach efforts in an effort to improve the efficiency of the Agency. By making Medicaid a more "user friendly" program, we can improve access to health care for our beneficiaries.

Your understanding of the needs of Alabama's most vulnerable citizens—the very young and the elderly—is commendable. The Medicaid Agency appreciates your support of our efforts. This Agency looks forward to the continued cooperation among this administration, the Medicaid provider community, and the people of this state. With cooperation, we can assure 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

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HIGHLIGHTS OF THE 1989 FISCAL YEAR

Introduction

During the past three years, Alabama Medicaid has made enormous progress in improving the health care delivery system in the state. Financially, Alabama operates a minimum Medicaid program but by federally matching every available state dollar, additional funds have been brought into the program to improve and expand the services that are offered. Through initiatives to reduce infant mortality as outlined in the Sixth Omnibus Budget Reconciliation Act (SOBRA), eligibility for Medicaid was expanded to more children and pregnant women. As a result of the expansion initiated on July 1, 1988, an additional 15,861 women and 7,320 children were served by the end of the 1989 fiscal year. In other areas, Medicaid has increased services to the elderly and disabled, increased the nursing home income limit, increased hospital days for children and increased the number of recipients for home and community services through waiver programs.

The progress of this agency has been achieved without increasing administrative costs. Ninety-six percent of Medicaid dollars go directly to fund services. But the cost of health care in our state and our nation is increasing much faster than the cost of any other essential service. The Alabama Medicaid Agency is committed to containing costs while assuring a high quality of care and improving services wherever possible. Health care to the most vulnerable—the very young, the elderly, and the poor—is needed in order to stabilize and strengthen the health care system in this state. A strong health delivery system is vital to the economy of Alabama.

Maternity Waiver Program

The Maternity Waiver Program, implemented September 1, 1988, is aimed at combatting Alabama's high infant mortality rate. It assures that low income pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through one primary provider network. The two main components of the waiver are case management and freedom of choice restriction.

Case managers work with the women to set up a plan of care, make appropriate referrals, provide education, follow-up on missed appointments, and assist with transportation as well as other services.

Restricting the patients' freedom of choice in choosing a provider enables Medicaid to set up a primary care provider network. Access to care through one provider eliminates fragmented and insufficient care while assuring that recipients receive adequate and quality attention. Care provided through this network ensures that case managers can track patients more efficiently.

This program has been successful in getting women to begin receiving care earlier and in keeping them in the system throughout their pregnancy. Women in waiver counties receive an average of nine prenatal visits as opposed to only three prenatal visits for women in counties outside the waiver.

In FY 1989, 13 counties participated in the Maternity Waiver Program, with five primary providers coordinating care. The Gift of Life Foundation in Montgomery is the primary provider for Autauga, Elmore, Lowndes, and Montgomery counties. The Etowah Quality of Life serves Etowah County. The Decatur General Hospital serves Lawrence and Morgan counties. West Alabama Health Services, Inc. serves Greene, Hale, and Sumter counties, and Jefferson County Board of Health serves Jefferson, Blount, and Shelby counties.

Physician Fees Increased

In March of 1989, the Alabama Medicaid Agency raised the fee to physicians providing a complete or global package of prenatal care and delivery services. An obstetrician or family physician providing these services is reimbursed $718, up from the previous amount of $675. The national average paid by state Medicaid programs for the same package of services is just under $687, ranking Alabama above the national average for reimbursements of this kind. Medicaid expects to raise the same fee in FY 1990 to $1,000. It is anticipated this increase will bring more delivering physicians into the program.

The rate that the Alabama Medicaid Agency pays nurse midwives for prenatal care and delivery services was similarly increased, from $506.25 to $574.40. The fee for nurse midwives is 80% of the physicians' rate.

Unlimited Hospital Days For Children

Another initiative to improve services to mothers and children began on January 1, 1989, with Medicaid's program of unlimited hospital days for children needing very specialized services such as neonatal intensive care. In the first six months of the program, January through June 1989, more than 400 children benefitted from more than 3,000 additional hospital days that did not include the usual 12 day limit. The cost during the first six months was approximately $2 million. Medicaid was able to provide this benefit through contributions made to the Mothers and Babies Indigent Care Trust Fund.

Dental Coverage Expanded For Children

In February 1989, the Medicaid Agency implemented coverage of dental sealants as a preventive dental service for children up to 21 years of age. In July of the same year, dental care for children up to 21 years of age was further expanded to include coverage for medically necessary orthodontic services.

Governor's Task Force on Infant Mortality

During fiscal year 1989, the Governor's Task Force on Infant Mortality continued to provide valuable guidance to the Governor and the Alabama Medicaid Agency. Its membership, representing public and private health care organizations, education and religious organizations and the state legislature, contributed significant knowledge and ideas from different areas of expertise.

In October and November of 1988, the task force held town meetings throughout the state to gather comments from the public on the serious problem of infant mortality and on actions needed to prevent infant death and disabilities.

In addition to obtaining suggestions from citizens, the town meetings had several other purposes. Through this process, the task force sought to educate the public on the scope of the infant mortality problem and actions already taken to improve maternal and child health, to obtain comments on how well these initiatives are working, and to encourage development of local strategies to prevent infant mortality.

These highly successful meetings, held in nine different cities, were co-sponsored by the March of Dimes. They attracted more than 600 participants, including health care providers, community leaders, representatives from public and private agencies of all kinds, and others.

Raising Nursing Home Income Levels

In January 1989, as in January 1988, the Alabama Medicaid Agency raised the income level for nursing home eligibility. Many nursing home patients would lose Medicaid eligibility each year if the Social Security cost of living adjustment elevated their incomes above the financial limits for Medicaid eligibility. In 1989, 79 patients in Alabama's nursing homes would have become ineligible for Medicaid services because of an adjustment of Social Security benefits.

To eliminate this undue hardship on the elderly, Medicaid raised the income limits placed on Medicaid nursing home patients to $950 per month. If the budget permits, the Alabama Medicaid Agency will continue to raise the income limits of this group yearly to prevent loss of Medicaid eligibility when Social Security benefits are raised.

Transitional Beds

The Alabama Medicaid Agency implemented two new programs in FY 89 that make it possible to provide long term care in rural hospitals.

One type of care, swing beds, may be offered by any hospital with 100 or fewer beds. Swing beds may be used for everyday hospital use or for skilled nursing home care, depending on need and available space.

Transitional beds may be used only as nursing home beds and are available in rural hospitals under 200 beds.

These services benefit rural hospitals and people living in rural areas by offering additional health care services to a growing elderly population while providing a financial alternative for ailing hospitals in rural areas of the state.

Coverage For AIDS Drugs

The Alabama Medicaid Agency began covering more drugs in FY 1989 that are used specifically for the treatment of AIDS, Acquired Immune Deficiency Syndrome. Treatments of Retrovir (AZT) and Aerosolized Pentamidine are covered if prior approved by the agency. By the end of FY 1989, three other AIDS-specific drugs, Cytovene, Roferone-A, and Intron-A also were approved for coverage.

Rural Health Task Force

In February 1989, the Alabama Legislature approved a resolution which created a task force to study the crisis in rural health care. The resolution mandated that the task force identify possible solutions to the many problems which plague the rural health care system, with particular focus on the financial troubles of rural hospitals and the shortage of obstetrical and other health care services in rural areas. Representatives from the Alabama Medicaid Agency served as members of the task force as well as others from health-related organizations, political and advocacy groups, health care providers' associations, the insurance industry, and state and federal governmental agencies.

The Rural Health Task Force met for the first time in April 1989 to begin its search for feasible recommendations to present to the Legislature at a later date.

QMBs

In January 1988, as part of the Medicare Catastrophic Coverage Act of 1988, Medicaid eligibility was extended to some Medicare beneficiaries with very low incomes. Anyone who meets the qualifications needed to become a Qualified Medicare Beneficiary (QMB) may have their Medicare deductibles, coinsurance, and premiums paid by Medicaid.

Only persons who have incomes of no more than 85% of the federal poverty level and who are eligible for Medicare Part A qualify for the program. (During FY 89, 85% of the poverty level was $408 monthly for an individual or $547 monthly for a couple.) In keeping with federal law, the coverage level will rise annually until 1992, when it will reach 100% of the poverty level.

Third Party Recoupments

During the 1989 fiscal year, Medicaid's Third Party Section collected over one million dollars from third parties—insurance companies covering Medicaid recipients, liability insurance carriers, absent parents, and others. The number of recipients identified as having health insurance was just under 10 percent of the total Medicaid recipient population.

Adjustments to Medicaid claims, made possible by identification of third party insurance benefits, impacted claims totaling over $32 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 $1.6 million because of the money providers collected from third party resources. Claims totaling an additional $23 million were denied by Medicaid and returned to providers to collect from recipients' insurance carriers. Many of these claims were paid in full by these insurance carriers. Claims totaling more than $5.6 million were returned to providers for submission to Medicare, the primary payor.

In FY 1989, Medicaid also recouped $116,000 from providers who had received payment from both Medicaid and a third party.

Looking Ahead

The Alabama Medicaid Agency has stood firm this fiscal year to the commitment of providing better access to health care for all groups eligible for the Medicaid program. Significant progress has been made in 1989 with other major improvements planned for 1990.

A collaboration among different state agencies and other entities who furnish services to Medicaid eligibles will channel funds through the Medicaid program in order to obtain the federal match. This match will enable Medicaid to implement much needed expansions and improvements of services for children and others benefiting from Medicaid without requiring additional funding from the taxpayers of Alabama.

A federally mandated expansion is expected in 1990 to raise the coverage level for pregnant women and children in families with incomes up to 133% of the federal poverty level.

The catastrophic health care legislation will continue to impact services provided for the elderly. Provisions allowing the spouse living at home to retain more income and resources while the other spouse is in a nursing home will become effective in 1990.

These measures are a small representation of the initiatives the Alabama Medicaid Agency will be involved in next year to help strengthen the health care delivery system of Alabama's low income citizens. Although federal mandates have caused serious budget restraints recently, and more mandates are expected to affect upcoming budgets, the Alabama Medicaid Agency will not be discouraged in efforts to do everything possible to continue to improve medical services for Medicaid eligibles statewide.

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 1989, the formula was approximately 72/28. 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.
- Some low income Medicare beneficiaries may be eligible to have their Medicare premiums, deductibles, and co-insurance paid by Medicaid as a result of the Catastrophic Coverage Act of 1988.

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 provided 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 a significant way. For instance, during FY '89, Medicaid paid approximately $510 million to providers on behalf of persons eligible for the program. The federal government paid approximately three-quarters of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services and payed taxes in the state. Using the common economic multiplier effect of three, Medicaid expenditures generated over $1.5 billion worth of business in Alabama in FY '89.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. With our current administrative rate, 96% of the Agency's budget goes toward purchasing services for beneficiaries. Medicaid funds are paid directly to the providers who treat the Medicaid patients. Providers may be physicians, dentists, pharmacists, hospitals, nursing homes, medical equipment suppliers and others.

FY 1989
COUNTY IMPACT
Year's Cost per Eligible

Table - 1

County	Benefit Payments	Eligibles	Payment Per Eligible	County	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$2,816,768	2,730	$1,032	Houston	$6,899,490	6,964	$991
Baldwin	$6,815,935	5,452	$1,250	Jackson	$4,733,758	4,182	$1,132
Barbour	$4,613,443	3,869	$1,192	Jefferson	$71,579,428	55,908	$1,280
Bibb	$1,821,036	1,629	$1,118	Lamar	$2,405,196	1,374	$1,751
Blount	$2,914,217	2,291	$1,272	Lauderdale	$7,968,461	5,492	$1,451
Bullock	$2,769,531	2,655	$1,043	Lawrence	$3,572,019	3,008	$1,188
Butler	$4,296,166	3,547	$1,211	Lee	$5,741,659	5,509	$1,042
Calhoun	$11,171,909	9,951	$1,123	Limestone	$4,361,700	3,518	$1,240
Chambers	$4,036,077	3,829	$1,054	Lowndes	$2,237,388	3,176	$704
Cherokee	$1,469,717	1,320	$1,113	Macon	$5,368,040	4,627	$1,160
Chilton	$3,375,820	2,763	$1,222	Madison	$12,934,684	12,827	$1,008
Choctaw	$2,381,946	2,535	$940	Marengo	$4,283,619	4,167	$1,028
Clarke	$4,238,650	4,221	$1,004	Marion	$4,367,216	2,443	$1,788
Clay	$2,108,798	1,353	$1,559	Marshall	$9,181,221	6,438	$1,426
Cleburne	$1,218,763	1,022	$1,193	Mobile	$50,244,401	40,307	$1,247
Coffee	$4,612,719	3,061	$1,507	Monroe	$3,234,783	3,059	$1,057
Colbert	$5,071,031	3,504	$1,447	Montgomery	$25,632,329	23,433	$1,094
Conecuh	$2,161,071	2,124	$1,017	Morgan	$24,837,970	7,084	$3,506
Coosa	$1,050,901	1,047	$1,004	Perry	$2,939,284	3,487	$843
Covington	$5,332,316	3,912	$1,363	Pickens	$4,207,140	3,634	$1,158
Crenshaw	$2,926,406	2,041	$1,434	Pike	$5,054,059	4,411	$1,146
Cullman	$7,327,940	4,486	$1,634	Randolph	$2,850,952	2,102	$1,356
Dale	$5,267,349	3,682	$1,431	Russell	$5,785,782	5,025	$1,151
Dallas	$10,212,710	11,685	$874	Shelby	$4,572,433	3,603	$1,269
Dekalb	$7,182,586	4,623	$1,554	St. Clair	$3,847,087	3,021	$1,273
Elmore	$13,888,642	3,900	$3,561	Sumter	$3,493,080	3,914	$892
Escambia	$4,344,747	3,783	$1,148	Talladega	$9,461,516	8,969	$1,055
Etowah	$12,666,090	8,451	$1,499	Tallapoosa	$7,420,856	4,104	$1,808
Fayette	$2,309,572	1,851	$1,248	Tuscaloosa	$34,454,427	14,561	$2,366
Franklin	$4,779,108	2,975	$1,606	Walker	$9,921,512	6,438	$1,541
Geneva	$3,840,531	2,709	$1,418	Washington	$2,436,024	2,410	$1,011
Greene	$2,262,695	2,829	$800	Wilcox	$3,501,470	4,298	$815
Hale	$3,480,003	3,120	$1,115	Winston	$3,968,689	1,963	$2,022
Henry	$2,012,450	1,839	$1,094	Other	$39,513	107	$369

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 accurately 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. There were 2,002 cases reviewed during FY 1989.

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 17,000 claims were manually reviewed during this fiscal year. The payment and processing 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. The error rate for FY 1989 was .18%. In addition to CPAS, Systems Audit utilizes a process referred to as "Bill Processing Systems Test," (BPST). This process uses test claims, test recipients, and test providers to verify that system edits have been properly implemented or to verify that edits are accomplishing the specified intent. Systems Audit also monitors the financial activities of the Agency's fiscal agent through reconciliations of invoices and bank accounts, as well as analysis of processed provider refunds and claim adjustments.

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 920 new cases in FY '89, and closed 898 cases. Aided by staff from the Legal, Fiscal and Eligibility Divisions, the unit identified $727,468 for recoupment; of this amount, $448,780 was collected.

The Surveillance and Utilization Review (SUR) Unit looks for fraud and abuse and/or misuse in the Medicaid program. Computer programs are used to find unusual patterns of utilization on the part of providers and recipients. During FY '89, Provider SUR opened 266 reviews and closed 273. Recoupments and net adjustments for the fiscal year totaled $69,206. This unit saved the Medicaid program a total of $3,157,000 during FY '89 by identifying irregular Medicaid claims before the payment was made. Recipient SUR opened 365 reviews. 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 '89, URC actions resulted in 154 recipients being terminated from the Medicaid program, 18 provider cases being referred to the Attorney General's Medicaid Fraud Control Unit, two providers being referred to the Board of Medical Examiners, 11 providers or employees of providers being suspended from the Medicaid program, and 181 recipients being locked in to one physician and one pharmacy.

A recipient who abuses Medicaid privileges may be restricted (locked-in) to receiving services from certain providers. This program is one administrative sanction used to control abuse in the Medicaid program. Imputed savings from this program totaled $99,868 in FY '89. The average number of recipients locked-in per month was 130.

A major change to the Recipient SUR System was implemented during FY 1989. This change eliminated recipients of certain ages or certain diagnoses from the exception process in an attempt to identify true abusers in a more timely manner. The benefit of this change will be evident year after year.

Two other units very active in the Program Integrity Division are Pharmacy Audit and Investigations.

The Pharmacy Audit Unit conducts reviews to determine compliance of the Agency's policies and regulations. These reviews act as a deterrent against possible provider fraud and abuse. Violations of such rules and regulations can, in some instances, result in recoupments or other administrative sanctions. During FY 1989, approximately 135 pharmacies were audited, and numerous desk reviews were completed. In addition to the deterrent effect, the audits and reviews resulted in recoupments of $15,800.

Medicaid's investigative staff meets the investigative needs of the entire agency. During FY '89, the Investigative Unit closed 264 cases and opened 451 cases, of which 56 were drug abuse cases. The total identified for recoupment was $188,835. Actual recoupments equalled $28,454. In addition, the staff assisted local authorities with 33 cases involving altered prescriptions, selling drugs for illicit purposes, stolen or loaned Medicaid cards, and recipient fraud cases.

FY '89
PROGRAM INTEGRITY
Closed Case Summary — **Table - 2**

Provider Reviews	Referred to Attorney General	Recoupments Identified	Providers Terminated from the Medicaid Program	Diverted Funds
408	18	$85,006	11	$3,157,000
Recipient Reviews	**Referred to District Attorney**	**Recoupments Identified**	**Recipients Terminated from the Medicaid Program**	**Recipients Locked-In**
1,527	33	$916,303	154	181

MEDICAID MANAGEMENT INFORMATION SYSTEM

The agency's Medicaid Management Information System (MMIS) keeps track of program expenditures, provider and recipient records, and furnishes reports that allow Medicaid administrators to monitor the pulse of the program.

During the past year, agency information systems staff implemented the Medicare Catastrophic Coverage Act of 1988. Changes were made to add Qualified Medicare Beneficiaries (QMBs) to the eligibility files. Adding this new group of eligibles required significant changes in the interface with the Department of Human Resources, printing special eligibility cards for the QMB recipients, numerous changes in statistical reporting programs and creation of a new automated process for Medicare Part A premiums.

Also developed and implemented in 1989 were two new systems to aid in management of the maternity waiver. One system tracks pregnancy outcomes, the other client satisfaction data.

Many of Medicaid's computer functions are performed by the agency's contracted fiscal agent, Electronic Data Systems (EDS). Medicaid first contracted with EDS in October, 1979. The current contract period began October 1, 1988. The company's performance in claims processing has been among the best in the nation.

Electronic Data Systems has always worked closely with the agency to accommodate the MMIS for the many changes made to the Medicaid program. Of great significance was the implementation of various provisions of the Medicare Catastrophic Coverage Act of 1988. EDS is an important partner with the Medicaid Agency. They assist in improving relationships with providers by improving the process of payment to providers.

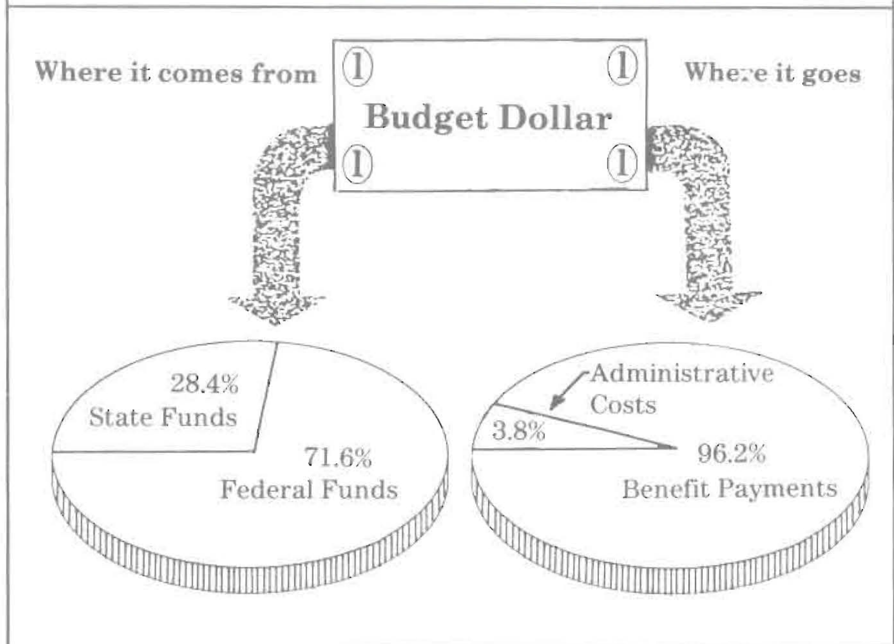
REVENUE, EXPENDITURES, AND PRICES

FY '89 Table - 3
Sources of Medicaid Revenue

Federal Funds	$407,161,805
State Funds	$152,899,410
Total Revenue	$560,061,215

In FY '89, Medicaid paid $539,487,734 for health care services to Alabama citizens. Another $20,573,481 was expended to administer the program. This means that about 96¢ of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY '89 Table - 4
Composition and Disbursement of Medicaid's Budget



FY '89 Table - 5
Components of Federal Funds

(net)	Dollars
Family Planning Administration	$162,927
Professional Staff Costs	$7,384,387
Other Staff Costs	$5,394,411
Other Provider Services	$390,580,032
Family Planning Services	$3,640,048
Total	$407,161,805

FY '89 Table - 6
Components of State Funds

	Dollars
Encumbered Balance Forward	$3,051,677
Basic Appropriations	$114,989,655
Indigent Care Trust Fund	$1,160,000
Other State Agencies	$34,087,112
Interest Income from Fiscal Intermediary	$643,698
Miscellaneous Receipts	$17,593
Subtotal	$153,949,735
Encumbered	$1,050,325
Total	$152,899,410

FY '89 Table - 7
Benefit Cost by Fiscal Year in which Obligation was Incurred

	FY '89	FY '90 (Est.)
Nursing Homes	$150,500,217	$165,200,000
Hospitals	$102,503,994	$311,358,314
Physicians	$47,842,863	$56,186,793
Insurance	$53,246,879	$60,856,361
Drugs	$51,944,705	$60,958,000
Health Services	$10,978,876	$14,074,250
*Community Services	$45,759,944	$59,254,990
Total Medicaid Service	$462,777,478	$727,888,708
Mental Health	$76,710,256	$90,636,947
Total Benefits	$539,487,734	$818,525,655

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

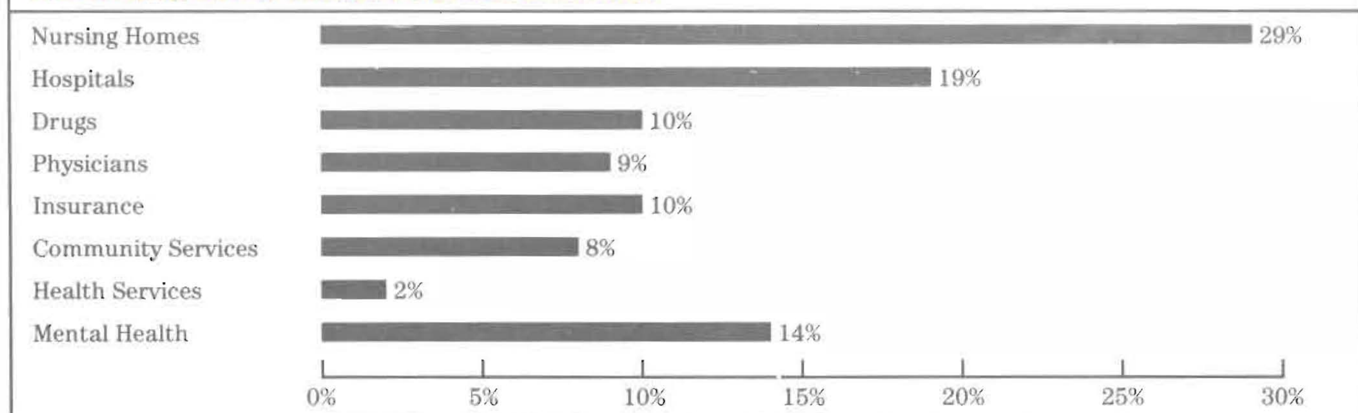
FY '89
EXPENDITURES
By Type of Service (net)

Table - 8

Service	Payments	Percent of Payments by Service FY '89
Pharmacy	$51,944,705	9.63%
Nursing Homes:	$150,500,217	27.90%
SNF	$11,589,624	2.15%
ICF	$138,910,592	25.75%
Hospitals	$102,406,127	18.98%
Inpatient	$94,450,993	17.51%
Outpatient	$7,955,134	1.47%
Buy-In	$33,754,397	6.26%
Physicians	$47,842,863	8.87%
Screening	$1,605,147	0.30%
Dental	$4,592,920	0.85%
Hearing	$112,726	0.02%
Laboratory	$1,584,548	0.29%
Home Health/DME	$8,830,177	1.64%
Eye Care:	$2,293,196	0.43%
Eyeglasses	$573,486	0.11%
Eye Care	$1,719,710	0.32%
Transportation	$790,339	0.15%
Co-Insurance	$17,762,122	3.29%
MR/MD:	$61,562,469	11.41%
ICF-MR	$58,157,694	10.78%
ICF-MD	$3,397,002	0.63%
SNF-MD/Illness	$7,773	0.00%
Mental Health Services	$5,760,770	1.07%
Targeted Case Management	$527,886	0.10%
Waivered Services:	$41,744,400	7.74%
Mental Health	$8,859,131	1.64%
HCBS	$19,289,278	3.58%
Pregnancy Related	$13,595,991	2.52%
Family Planning	$4,044,498	0.75%
Other:	$1,828,227	0.34%
HMO	$1,730,360	0.32%
Rural Health Clinics	$97,868	0.02%
Total For Medical Care	$539,487,734	100.00%
Administrative Costs	$20,573,481	
Net Payments	$560,061,215	

PERCENTAGE DISTRIBUTION OF BENEFIT COSTS INCURRED DURING FISCAL YEAR 1989

Table - 9



POPULATION

The population of Alabama grew from 3,444,165 in 1970 to 3,893,888 in 1980. In 1989, Alabama's population was estimated to be 4,241,653.

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.

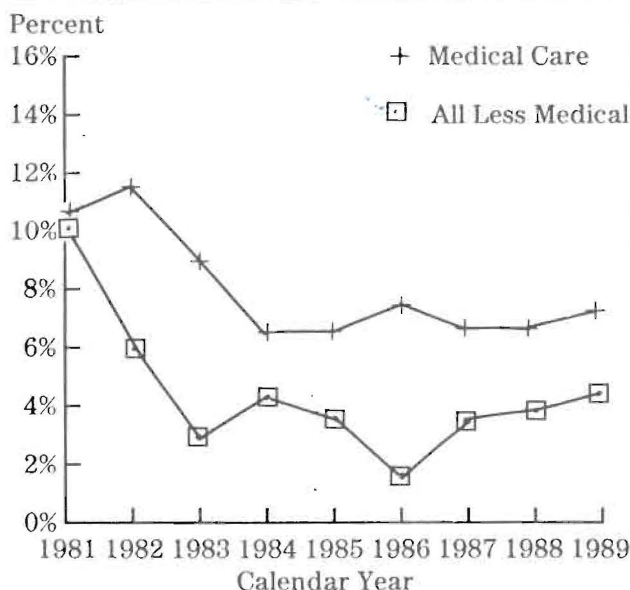
FY '87 - '89 POPULATION — **Table - 11**
Eligibles as Percent of Alabama Population by Year

Year	Population	Eligibles	Percent
1987	4,148,905	364,861	8.8%
1988	4,195,581	367,811	8.8%
1989	4,241,653	386,352	9.1%

PRICES

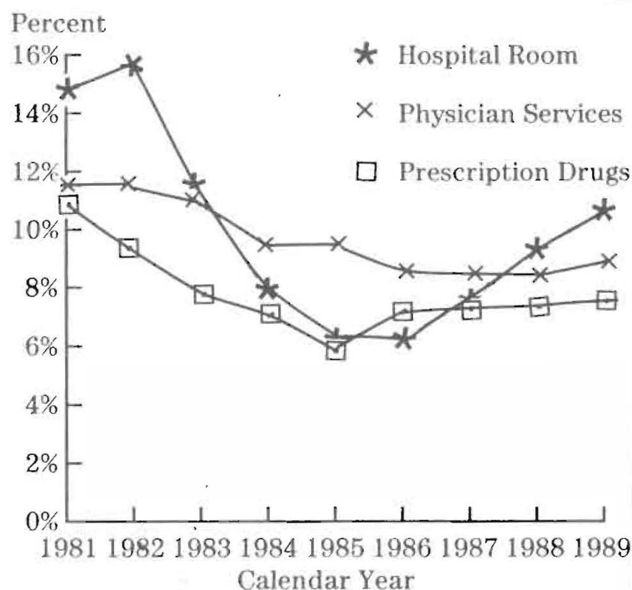
The charts on this page show historical trends in the rate of growth in the Consumer Price Index (CPI). Increases in the CPI are usually reflected in future increases in Medicaid payments to providers.

ANNUAL PERCENT CHANGES In the Consumer Price Index* — **Table - 10**



*For selected items

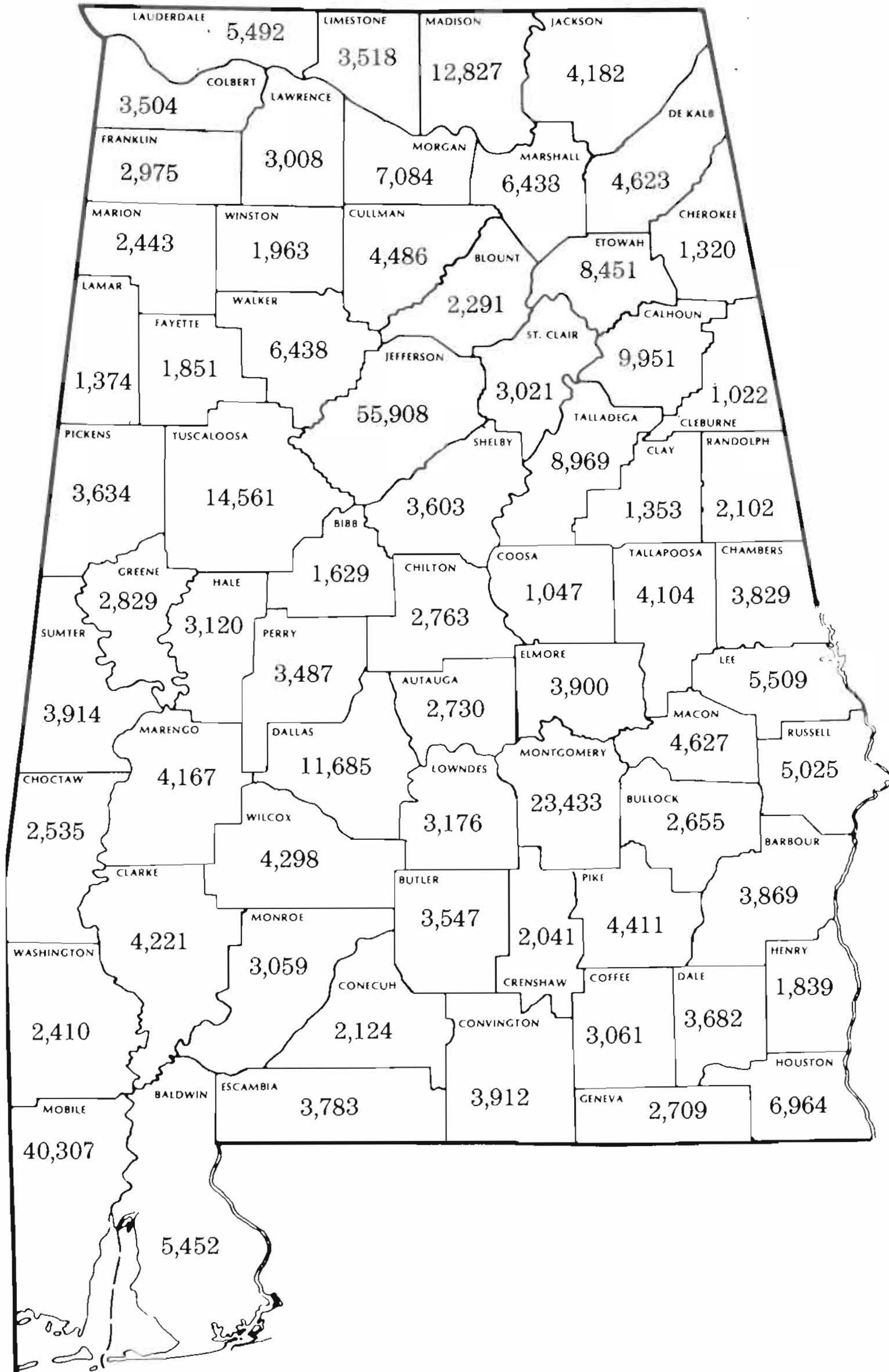
ANNUAL PERCENT CHANGES In the Consumer Price Index* — **Table - 10A**



*For selected items

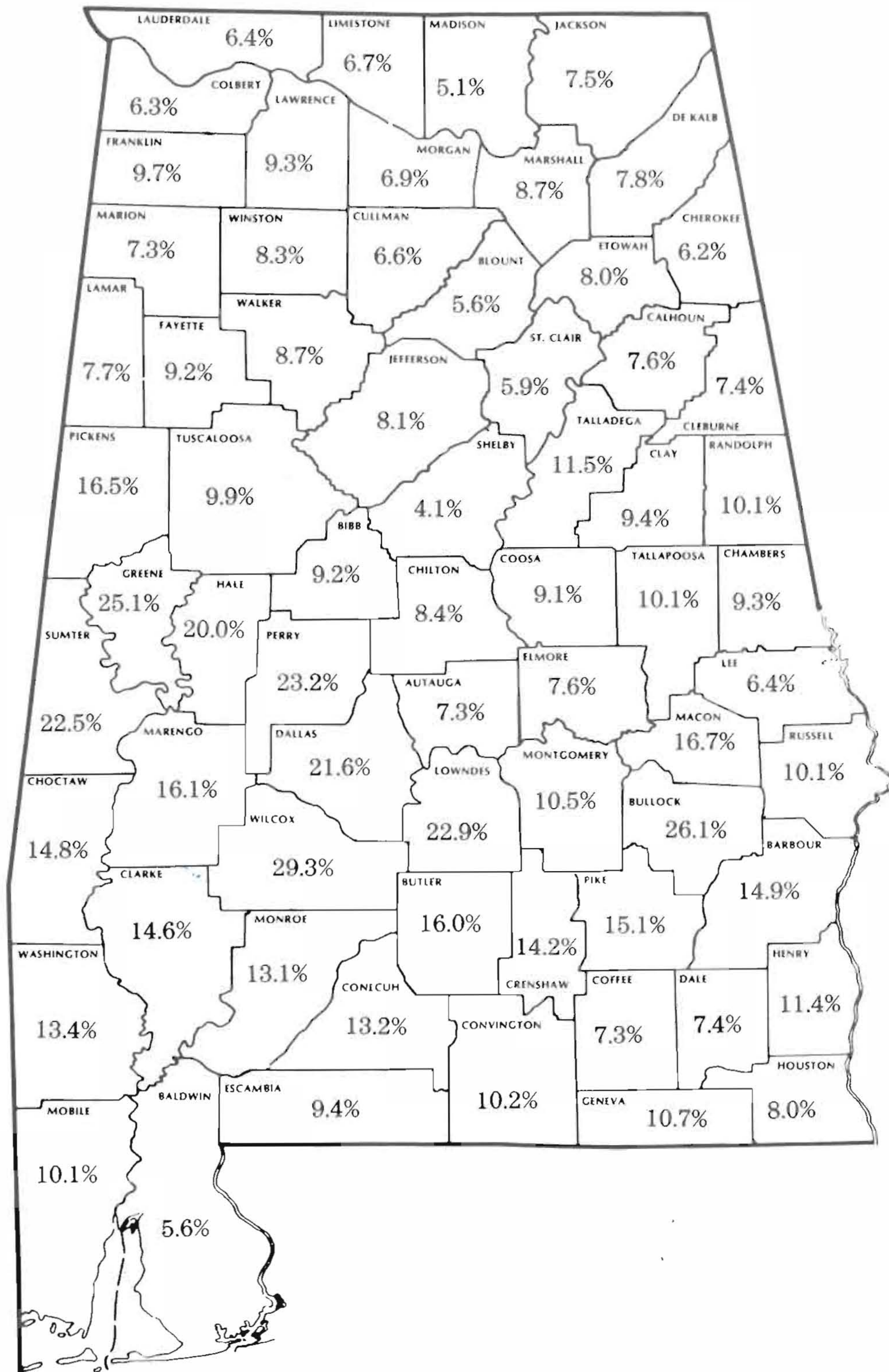
FY '89
ANNUAL UNDUPLICATED TOTAL MEDICAID ELIGIBLES

Table - 12



FY '89
ELIGIBLES
Percent of Population Eligible for Medicaid

Table - 13



ELIGIBLES

During FY '89, 386,352 persons were eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 294,228. The monthly average is the most useful measure of Medicaid coverage because it takes into account length of eligibility.

Although 386,352 people were eligible for Medicaid in FY '89, only about three-fourths were eligible for the entire year. The length of time the other one-fourth of Medicaid eligibles were covered ranged from one to eleven months.

In 1988, Medicaid took advantage of provisions in the Sixth Omnibus Budget Reconciliation Act (SOBRA) to extend Medicaid coverage to pregnant women and children with incomes below the federal poverty level. The expansion of Medicaid coverage to this optional eligibility group will play a significant role in lowering Alabama's infant mortality rate.

FY '89 ELIGIBLES Monthly Count — **Table - 14**

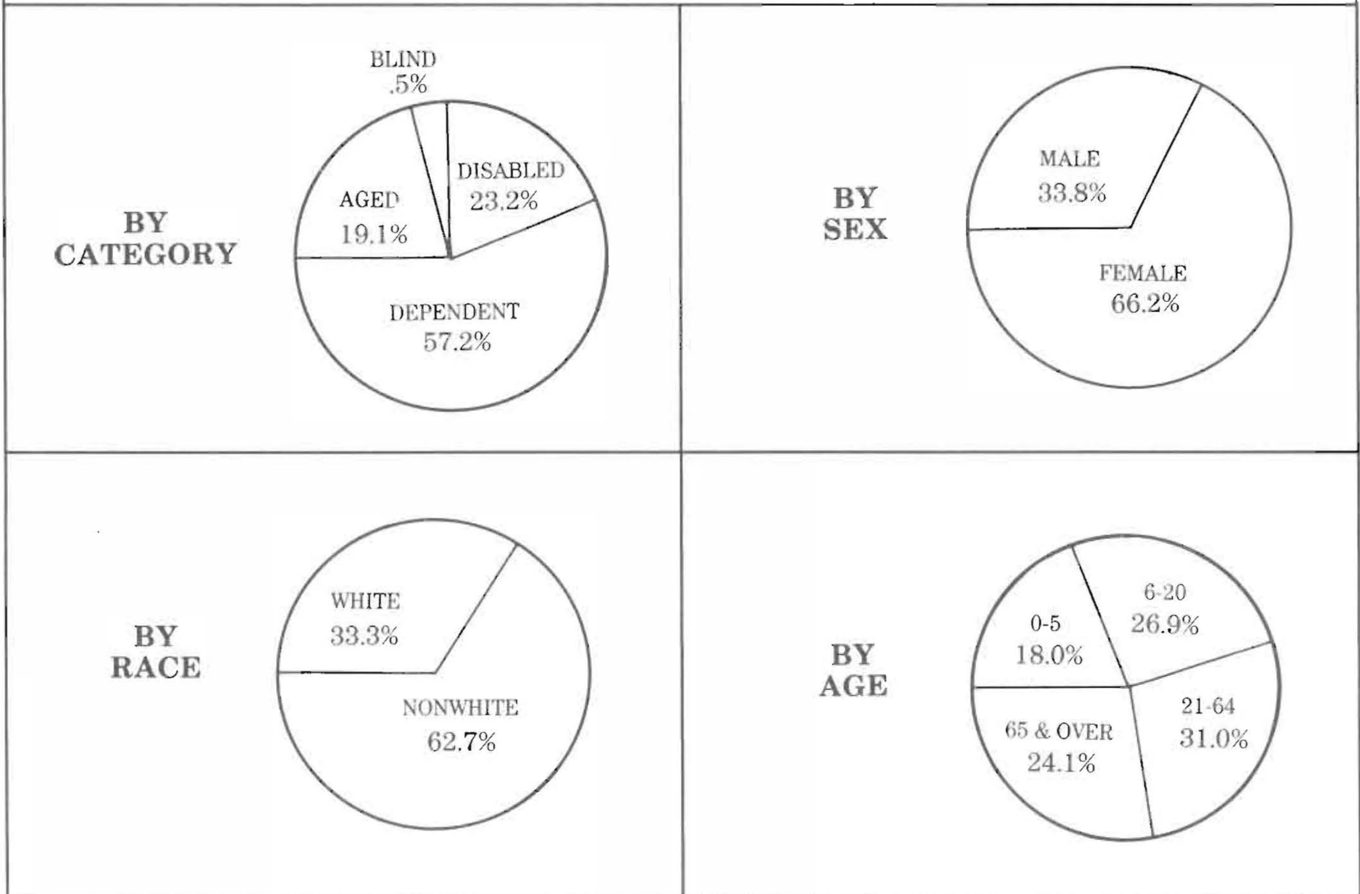
Month	Count
October '88	289,755
November	290,827
December	292,483
January '89	292,148
February	291,022
March	294,732
April	294,728
May	295,223
June	297,493
July	297,280
August	297,633
September	297,408

FY '89 ELIGIBLES By Length of Eligibility — **Table - 15**

Assistance Status/ Basis Of Eligibility	Unduplicated Total	Number Eligible For Full Year	Number Eligible For Partial Year	Number Of Covered Months For Partial Year Eligibles
Categorically Needy, Receiving Assistance	319,772	211,247	108,525	653,034
Aged	58,038	48,463	9,575	57,486
Blind	1,906	1,605	301	1,982
Disabled	87,670	70,311	17,359	110,679
AFDC-Children	121,968	65,305	56,663	334,289
AFDC-Adult	50,189	25,563	24,626	148,597
Other Title XIX	1	0	1	1
Categorically Needy, Not Receiving Assist.	70,725	18,689	52,036	276,809
Aged	14,119	9,264	4,855	28,970
Blind	12	10	2	9
Disabled	2,621	2,127	494	3,306
AFDC-Children	17,407	4,148	13,259	79,628
AFDC-Adult	9,624	1,480	8,144	44,269
Other Title XIX	26,942	1,660	25,282	120,627
Other Coverage	3,670	212	3,458	11,293
Aged	2,167	212	1,955	8,447
Blind	0	0	0	0
Disabled	0	0	0	0
AFDC-Children	0	0	0	0
AFDC-Adult	694	0	694	1,359
Other Title XIX	809	0	809	1,487

FY '89
ELIGIBLES
Percent Distribution

Table - 16



RECIPIENTS

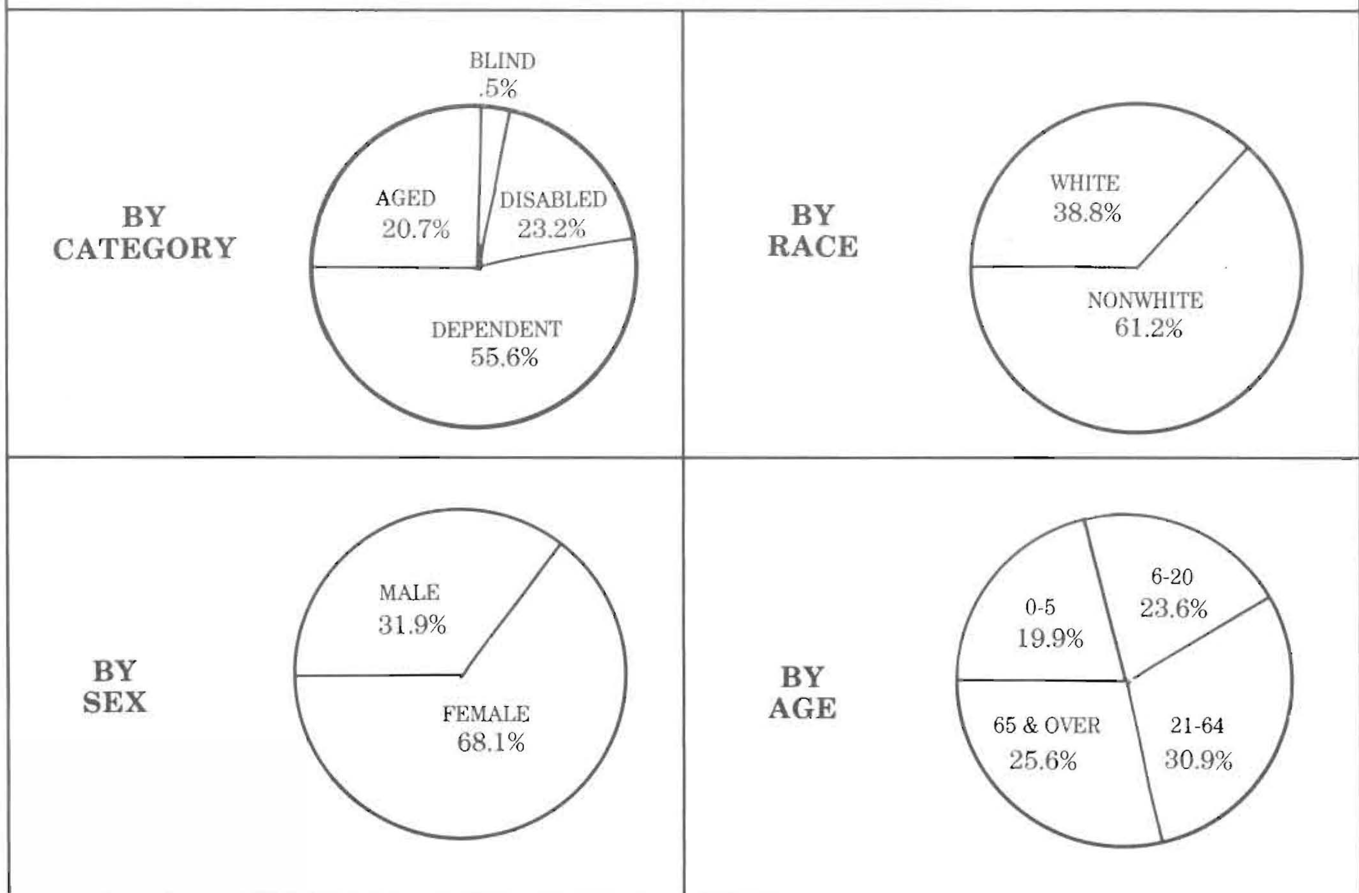
Although there were 386,352 persons eligible for Medicaid in FY '89, only 83 percent of these actually received benefits. These 322,232 persons are called recipients. The remaining 64,120 persons incurred no medical expenses paid for by Medicaid.

The total number of recipients is an unduplicated count. Recipients may be qualified under more than one category 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 does not equal the unduplicated total.

FY '89
RECIPIENTS
Monthly Averages and Annual Total — **Table - 17**

Category	Monthly Average	Annual Total
Aged	46,571	72,147
Blind	1,035	1,644
Disabled	51,797	80,547
Dependent	63,285	193,182
All Categories (unduplicated)	155,784	322,232

FY '89
RECIPIENTS
Percent Distribution — **Table - 18**



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.

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 '89 was $31. The average length of stay for recipients of this service was 260 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.

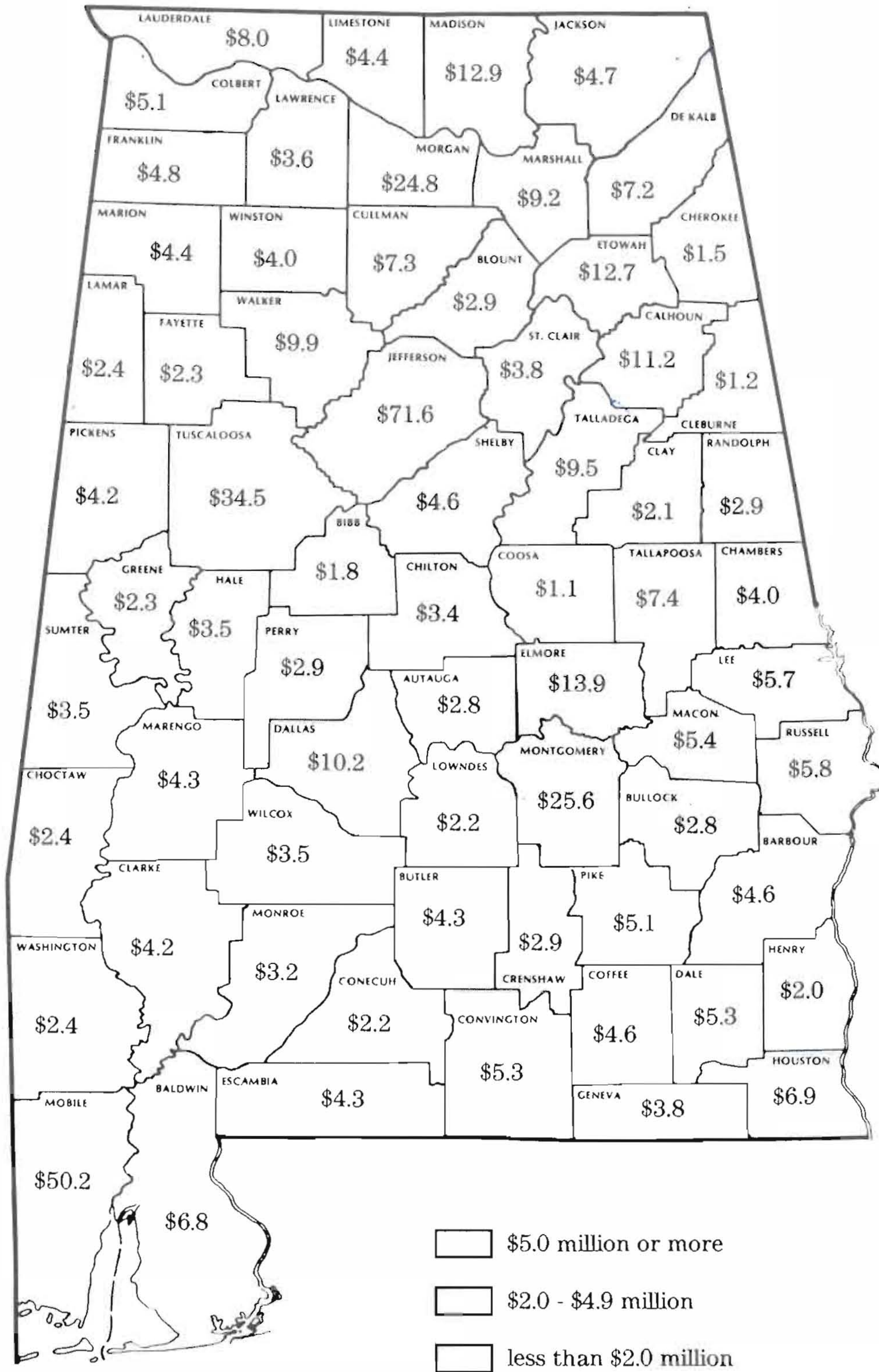
Some low income Medicare beneficiaries are eligible to have their Medicare premiums, deductibles, and co-insurance paid by Medicaid. For this coverage, Medicaid paid a monthly "buy-in fee" to Medicare. On January 1, 1989, this buy-in fee was increased from $24.80 to $31.90. Medicaid paid $33.8 million in buy-in fees in FY '89. 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.

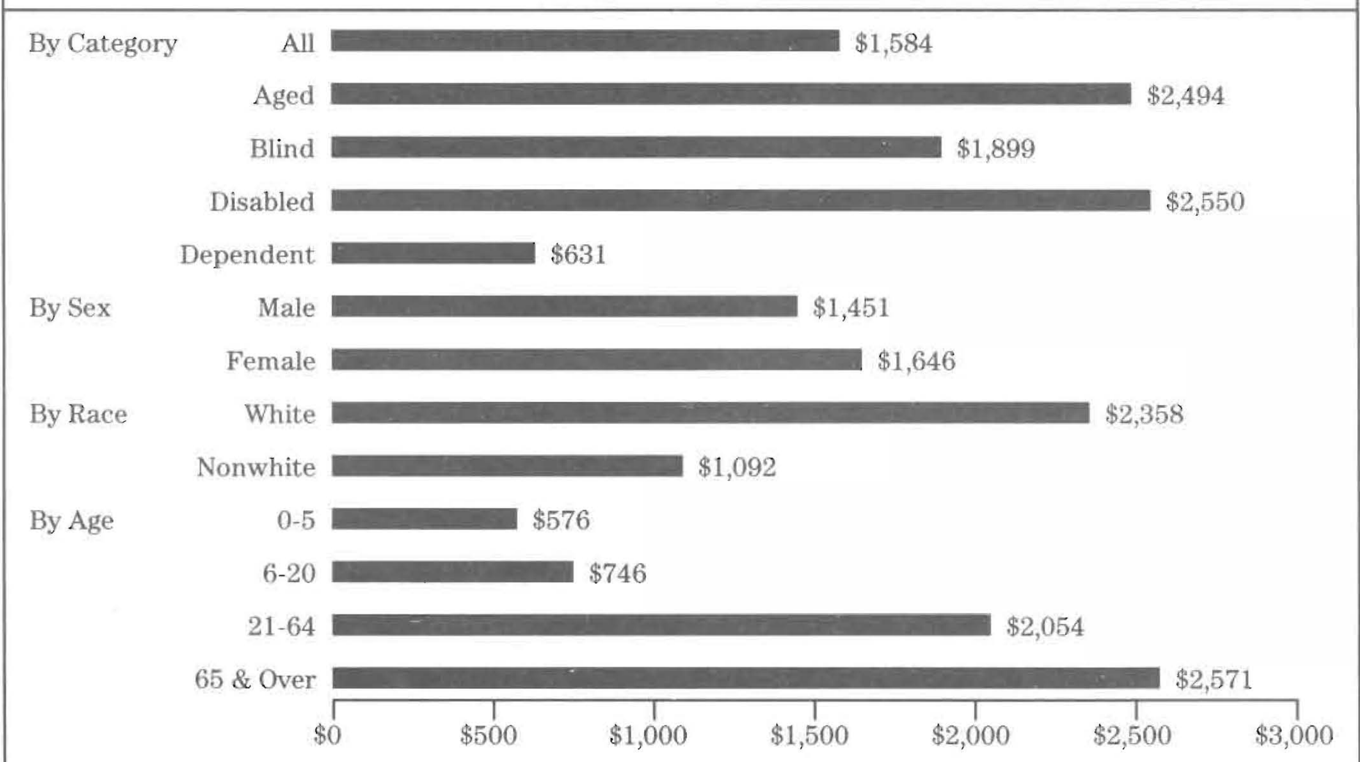
FY '89
PAYMENTS
Percent Distribution

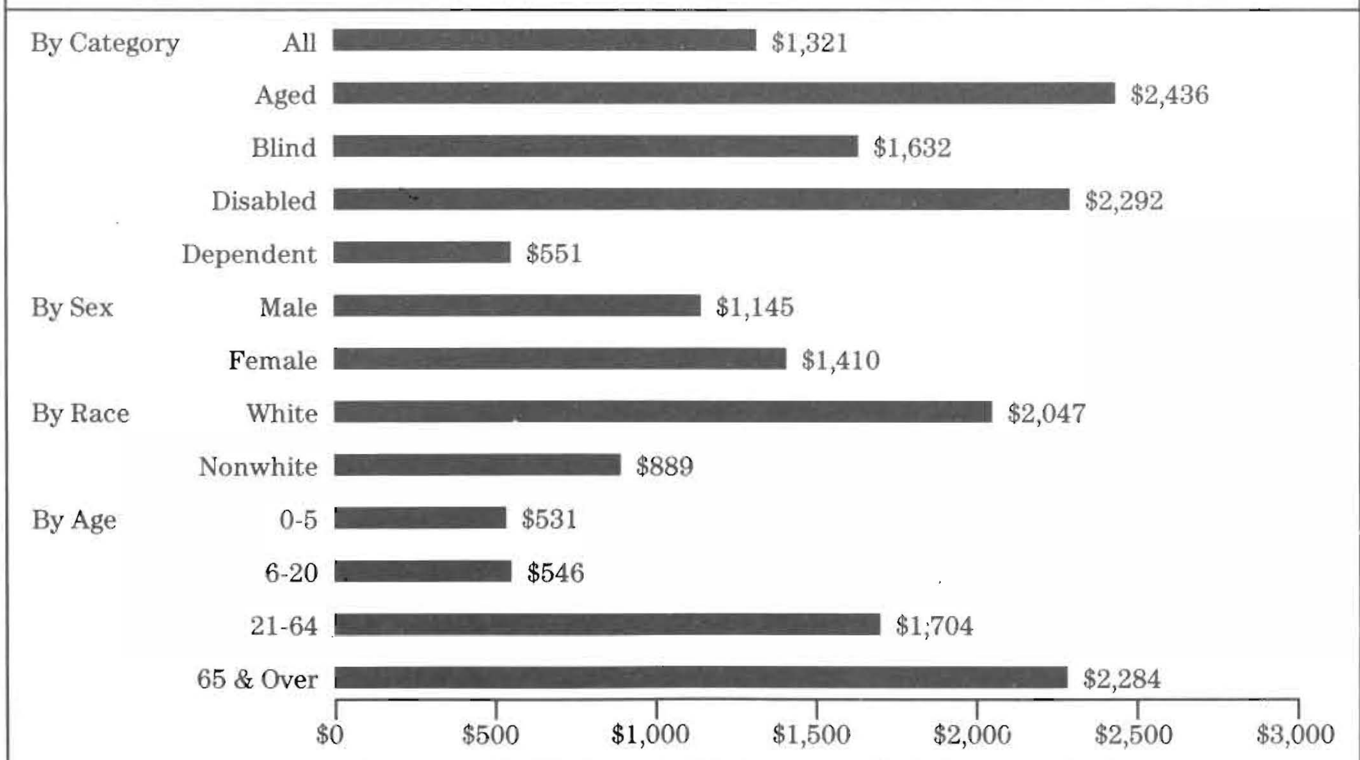
Table - 19

FY '89
PAYMENTS
By County (in millions of dollars)

Table - 20




FY '89 COST PER RECIPIENT
Table - 21
By Category
All
$1,584
Aged
$2,494
Blind
$1,899
Disabled
$2,550
Dependent
$631
By Sex
Male
$1,451
Female
$1,646
By Race
White
$2,358
Nonwhite
$1,092
By Age
0-5
$576
6-20
$746
21-64
$2,054
65 & Over
$2,571
$0
$500
$1,000
$1,500
$2,000
$2,500
$3,000


FY '89 COST PER ELIGIBLE
Table - 22
By Category
All
$1,321
Aged
$2,436
Blind
$1,632
Disabled
$2,292
Dependent
$551
By Sex
Male
$1,145
Female
$1,410
By Race
White
$2,047
Nonwhite
$889
By Age
0-5
$531
6-20
$546
21-64
$1;704
65 & Over
$2,284
$0
$500
$1,000
$1,500
$2,000
$2,500
$3,000

MATERNAL AND CHILD HEALTH CARE

In May 1989, the Alabama Medicaid Office of Maternal and Child Health was created. The mission of this office has been "to take a proactive role in fighting infant mortality and morbidity while enhancing the health of mothers and babies." The proactive role includes bringing as many private foundation grant dollars and federal dollars into the state as possible to enhance access to quality medical care. This office works closely with eligibility specialists and other agency programs to promote to the fullest potential the health of mothers and children. During FY 1989 Medicaid served an additional 15,861 women and 7,320 children through the expanded eligibility group for pregnant women and children called SOBRA (Sixth Omnibus Budget Reconciliation Act). Had it not been for the SOBRA program, these women and children may not have received medical care.

Prenatal Care

In 1988, the number of births to women aged 10-19 increased slightly in Alabama from 10,354 in 1987, to 10,590. Of this number, 6,461 births were to unmarried teenagers. There were 267 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 for health care.

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.

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

Prenatal care for Medicaid eligible recipients is provided through private physicians, hospitals, public health department clinics and rural health clinics. Currently, there are approximately 140 clinics providing prenatal care in the state.

Some of the maternity related benefits covered under the prenatal program are: unlimited prenatal visits, medical services to include physical examinations with ongoing risk assessments, prenatal vitamins, nutritional assessments, counseling and educational services, appropriate medically indicated lab tests and referral services as needed. Referral services include family planning services after delivery and medical services for the newborn under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT or more commonly known as MediKids). Medically indicated procedures such as ultrasound, non stress tests and amniocentesis are examples of other services covered by Medicaid. In order to complete the pregnancy cycle, one postpartum checkup is covered during the 60-day postpartum period.

In 1988, the Medicaid Agency implemented a policy that would allow pregnant women at 100% of the poverty level to qualify for Medicaid benefits. With this expansion, prenatal care has been made available to more women than ever before. Utilization of Medicaid services can help pregnant women in two ways; the provision of adequate prenatal care to Medicaid eligibles is expected to increase the likelihood of a successful outcome for both mother and child, and the family planning services that are available can help Medicaid eligible women control the size of their families.

Family Planning

Although Medicaid's family planning services include assisting eligibles with fertility problems, most recipients of family planning 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 '89. For family planning services, the federal share is 90 percent.

The Medicaid Agency purchases family planning services from

various clinics such as the State Department of Public Health's Family Health Administration, community health centers, private physicians, and others. 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 for adults 21 years of age or older if certain conditions are met.

In accordance with state and federal law, abortions are not included as family planning services. Medicaid will pay for abortions, under the auspices of the physicians program, only when the life of the mother would be endangered if the fetus were carried to term.

MediKids

The Early and Periodic Screening, Diagnosis and Treatment Program, named MediKids in 1986, is a preventive health program designed to detect and treat diseases that may occur early in a child's life. If properly used, the program can benefit both the child and the Medicaid Agency. Many health problems begin early in life and, if left untreated, can cause chronic illness and disability. When an illness is diagnosed and treated through the screening program, the child benefits through improved health. 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 the 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. Department of 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 Agency is making additional efforts to increase the number of physicians to the program and to increase the number of MediKids eligibles using the screening services. Since screening is not mandatory, many mothers do not seek preventive health care for their children.

Steps have been taken in recent years to increase the number of screening services. These initiatives include increased publicity of the MediKids program, implementation of an intensive outreach project in a number of Alabama counties, an increase in the physicians' reimbursement rate for MediKids screenings and an increase in the number of screenings for which Medicaid will pay. The number of screenings has increased because of these efforts. A Medicaid goal is to screen all eligible children at ten intervals between birth and age 21.

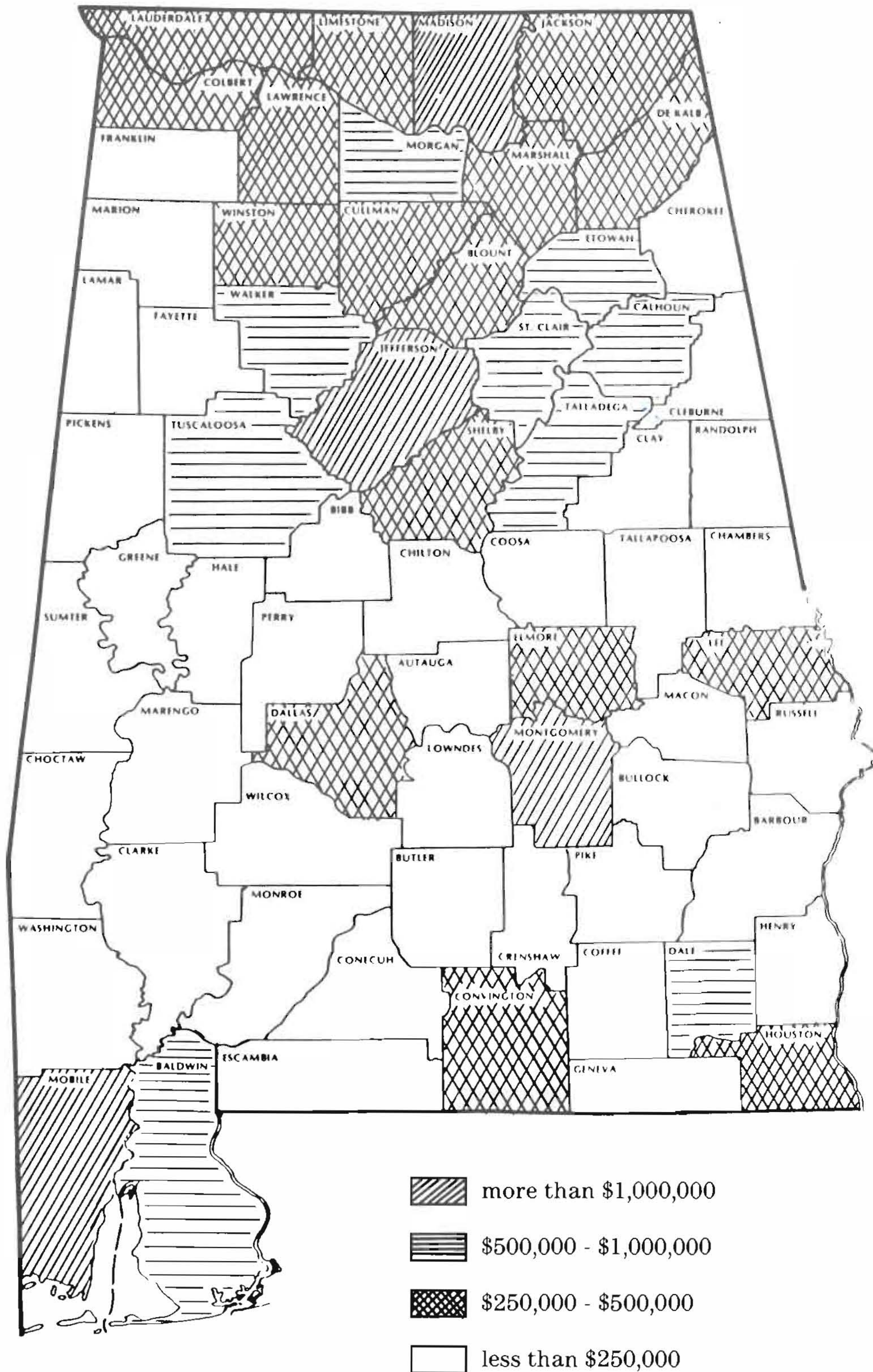
The MediKids screening program can detect many problems before they become acute. Problems such as hypertension, rheumatic fever and other heart conditions, diabetes, neurological disorders, venereal disease, anemia, urinary infections, vision and hearing disorders, and even cases of child abuse have been detected and treated in past years. The cost of screening is relatively small—an average of $31 per screening. The cost of treating acute illness is 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 a request or a 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, and most prosthetic treatments. If justified by the attending dentist, some services may be prior authorized by the Medicaid Agency. These services may include nonsurgical periodontal treatment, third and subsequent space maintainers, general anesthesia and IV sedation, hospitalization and some out-of-state care.

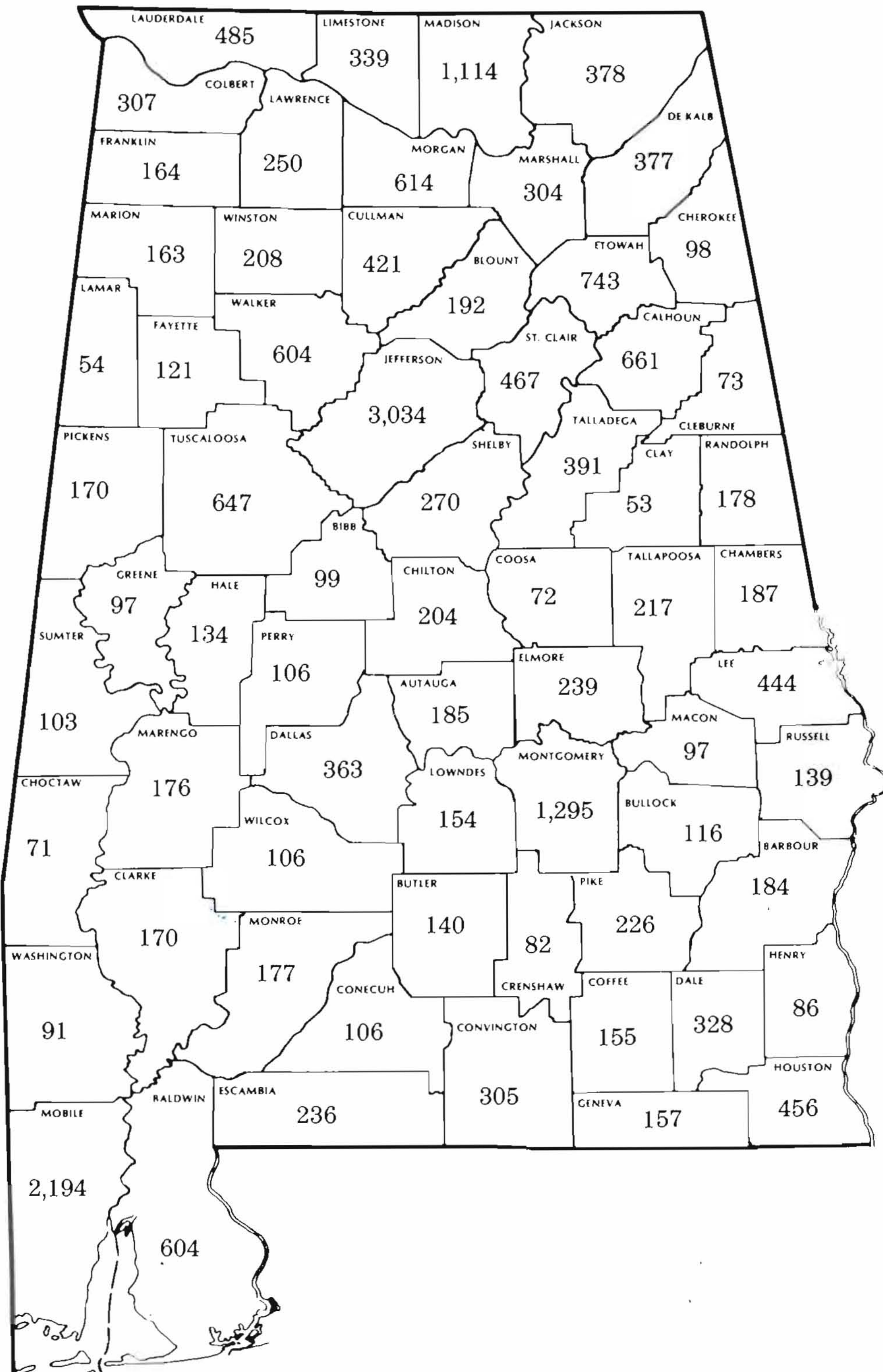
FY '89
MEDICAID PAYMENTS FOR SOBRA ELIGIBLES

Table - 23



FY '89
SOBRA ELIGIBLES

Table - 24



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. Another program offered is the Health Maintenance Organization (HMO), which provides a comprehensive health plan to clients. Each of these programs has been very successful in providing quality health care to various groups of people at great savings to the state of Alabama.

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 helping recipients receive extra services that are not ordinarily covered by the Medicaid program in this state.

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 $8,000 a year to care for a mentally retarded client in the community, whereas institutional care for a single client costs nearly $44,000 a year. During FY '89, about $9 million 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 as of FY '86. More than 4,600 people were served under this waiver during FY '89.

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 '89, about $7 million was spent to provide services to an average of 4,800 clients monthly.

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. Advanced medical technology has made it possible to provide more sophisticated care

and equipment in the home rather than incurring the expense of institutional care. Home health patients may require intravenous therapy, tube feeding, 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 105 agencies participating in FY '89.
- Patients must be homebound (essentially confined to the home because of illness, injury, or disability).
- Patients must be Medicaid eligible.
- 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 104 home health visits per year may be covered by the Medicaid Agency. In FY '89, an average of 3,137 recipients a month received a total of 279,074 visits at a cost of over $8 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 DME providers throughout the state furnished 167,724 units of service at a cost of almost $650,000.

HEALTH MAINTENANCE ORGANIZATION

Medicaid's participation in the Health Maintenance Organization (HMO) Program began in FY '86 when West Alabama Health Services, Inc. received a grant from the Robert Wood Johnson Foundation. The grant helped with the start-up costs for development of an HMO which would encompass 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. Further expansion into Choctaw County began on August 1, 1988 and in Marengo County on January 1, 1989.

Enrollment in an HMO is voluntary for all eligible Medicaid recipients who reside in the five-county geographical area. These recipients may either enroll in the HMO or remain 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 counseling, and non-emergency transportation for health care visits.

To obtain HMO benefits, enrollees must have all their health care provided by the HMO, or they must be referred by the HMO to another provider, except for genuine medical emergencies. Enrollees also must sign an agreement to remain with the HMO for a six-month enrollment period before voluntary disenrollment.

Total HMO enrollment for FY '89 has increased to 2,931 participants within the current geographical areas of Greene, Hale, Choctaw, Sumter, and Marengo counties.

The Health Care Financing Administration (HCFA) has stated that the HMO program in Alabama is one of the best prepaid health care delivery systems in the entire southeast region of the United States.

The Alabama Medicaid Agency is planning expansions in other geographical areas of the state so that Medicaid recipients may reap additional health care benefits from this comprehensive health care system.

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 119 Alabama hospitals that participate in the Medicaid program, and 31 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.

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.

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 71 instate hospitals in Alabama that are considered "delegated" and do their own utilization review; 48 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 '89. 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, additional days are available in the following instances:

- When prior authorized for children under 21 who are receiving specialty care services in qualified EPSDT extended day hospitals,
- When a child is under one year of age, he or she may receive unlimited inpatient days in a hospital that has been designated by Medicaid as a disproportionate share hospital,
- When authorized for deliveries (onset of active labor through discharge).

There were also limitations on outpatient hospital services during this fiscal year. Medicaid will pay for a maximum of three nonemergency outpatient visits per eligible during a calendar year. Exceptions are made for certified emergencies, chemotherapy, and radiation therapy. Additional outpatient visits may be prior authorized if requested by the physician.

Most Medicaid hospital patients are required to pay a copayment for hospital care. The copayments are $50 per inpatient admission and $3 per outpatient visit. Recipients under 18 years of age, nursing home residents, 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.

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. Services performed by an ASC 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.

A listing of more than 1,600 covered surgical procedures is maintained by the Alabama Medicaid Agency and furnished to all ASCs. The list is reviewed and updated quarterly. The agency encourages outpatient surgery whenever possible.

Ambulatory surgical centers have an effective procedure for the immediate transfer to a hospital for 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 '89, 17 ASC facilities were enrolled as providers in this program.

Renal Dialysis Program

The Medicaid renal dialysis program was implemented in 1973. Since that time, enrollment of renal dialysis providers in the Medicaid program has gradually increased to its present enrollment of 34 free-standing facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis, and C.A.P.D. (Continuous Ambulatory Peritoneal Dialysis), as well as training, counseling, drugs, biologicals, and related tests.

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

Rural Health Clinics

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

Rural health clinic services, whether performed by a physician, nurse practitioner or physician assistant, are reimbursable. A physician or nurse practitioner is available to furnish patient care while the clinic operates.

Rural health clinics are reimbursed at the reasonable cost per visit established for the clinics by the Medicare fiscal intermediary. At the end of FY '89, five rural health clinics were enrolled as providers in the Medicaid program.

FY '87 - '89
HOSPITAL PROGRAM
Changes in Use and Cost
Table - 25

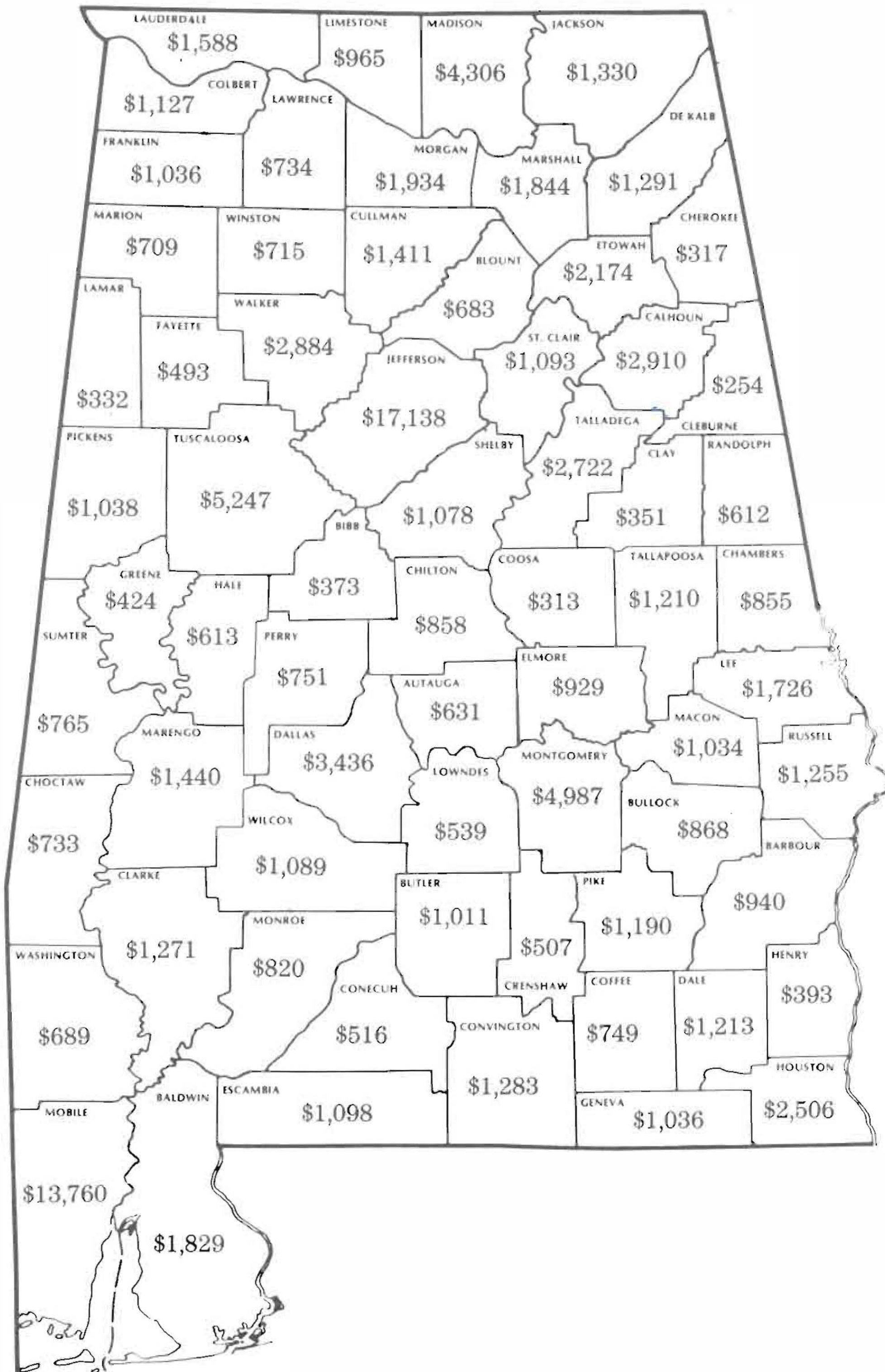
Year	Recipients of Inpatient Care	Payments For Services	Medicaid's Annual Cost Per Recipient
1987	36,508	69,194,337	1,895
1988	46,449	81,541,443	1,756
1989	58,733	105,900,822	1,803

FY '85 - '89
HOSPITAL PROGRAM
Outpatients
Table - 26

	FY '85	FY '86	FY '87	FY '88	FY '89
Number Of Outpatients	91,848	102,082	92,255	92,600	103,665
Percent Of Eligibles Using Outpatient Services	24%	27%	25%	25%	27%
Annual Expenditure For Outpatient Care	$10,186,983	$13,006,467	$6,801,149	$8,258,803	$9,605,911
Cost Per Patient	$111	$127	$74	$89	$93

FY '89
PAYMENTS TO HOSPITALS
By County (in thousands of dollars)

Table - 27



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 eligibles received physicians' services in FY '89.

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.

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.

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.

Optometric Program

The Alabama Medicaid optometric program provides eligibles with continued high quality professional eye care. For children, good eye-sight 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.

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

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.

Since lab and x-ray services are ancillary parts of other services, Medicaid will not pay for lab and x-ray services if the other services performed are not covered.

Laboratory and radiology providers must be approved by the appropriate licensing agency, and each claim serves as a provider contract.

FY '89
PHYSICIAN PROGRAM
Use and Cost

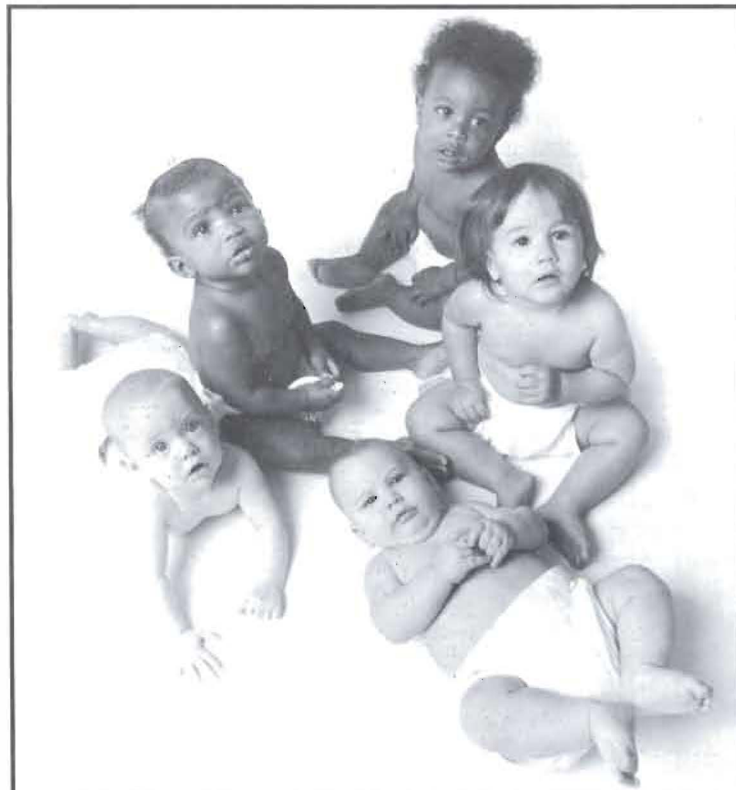
Table - 28

Category	Payments	Recipients	Cost per Recipient
Aged	$3,374,990	51,035	$66
Blind	$372,640	1,410	$264
Disabled	$18,516,617	66,563	$278
Dependent	$30,373,219	148,352	$205
All Categories	$52,637,466	255,008	$206

FY '89
LAB AND X-RAY PROGRAM
Use and Cost

Table - 29

Year	Payments	Recipients	Annual Cost Recipient
1989	$1,626,541	51,097	$32



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. Alabama Medicaid 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 nursing care are furnished skilled 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 1970s. Early in the decade there were more skilled than intermediate care patients, but as the decade progressed the trend gradually was reversed. In FY '89 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 care 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 regulation issued by the Department of Health and Human Services, provides 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 a impose a sanction denying payment for new Medicaid admissions. 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 (UCR) to establish a Medicaid payment rate for a facility. It takes into consideration the nursing facility plant, financing arrangements, staffing, management procedures, and efficiency of operations. The UCR must be completed by each nursing facility and submitted to the Alabama Medicaid Agency by September 15 of each year so that a new rate may be established and implemented by January 1 of the following year. Allowable expenses included in the reimbursement rate are employee salaries, equipment, consultation fees, food service, supplies, maintenance and utilities, as well as other expenses to be incurred in maintaining full compliance with standards required by state and federal regulatory agencies.

Medicaid pays the long-term care facility 100 percent of the difference between the Medicaid-assigned reimbursement rate and the patient's available income.

FY '87 - '89
LONG-TERM CARE PROGRAM
Patients, Months, and Cost

Table - 30

Year	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
1987	20,511	250 Days	5,135,190	28	145,651,321
1988	20,755	251 Days	5,218,730	29	152,068,104
1989	21,272	229 Days	4,877,082	31	152,211,271

FY '87 - '89 **Table - 31**
LONG-TERM CARE PROGRAM
The Number and Percent of Beds Used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	Annual Unduplicated Total Patients	Percent Of Beds Used By Medicaid In An Average Month
1987	22,240	14,019	20,511	63.0%
1988	22,622	14,278	20,755	63.1%
1989	22,293	13,012	21,272	58.4%

FY '89 **Table - 32**
LONG-TERM CARE PROGRAM
Recipients by sex, race, and age

	Skilled	Intermediate	Total
All Recipients	4,057	17,215	21,272
By Sex			
Female	3,032	13,177	16,209
Male	1,025	4,038	5,063
By Race			
White	2,771	13,790	16,561
Nonwhite	1,286	3,425	4,711
By Age			
0-5	50	4	54
6-20	83	73	156
21-64	483	1,721	2,204
65 & Over	3,441	15,417	18,858

FY '89 **Table - 33**
LONG-TERM CARE PROGRAM
Payments by sex, race, and age

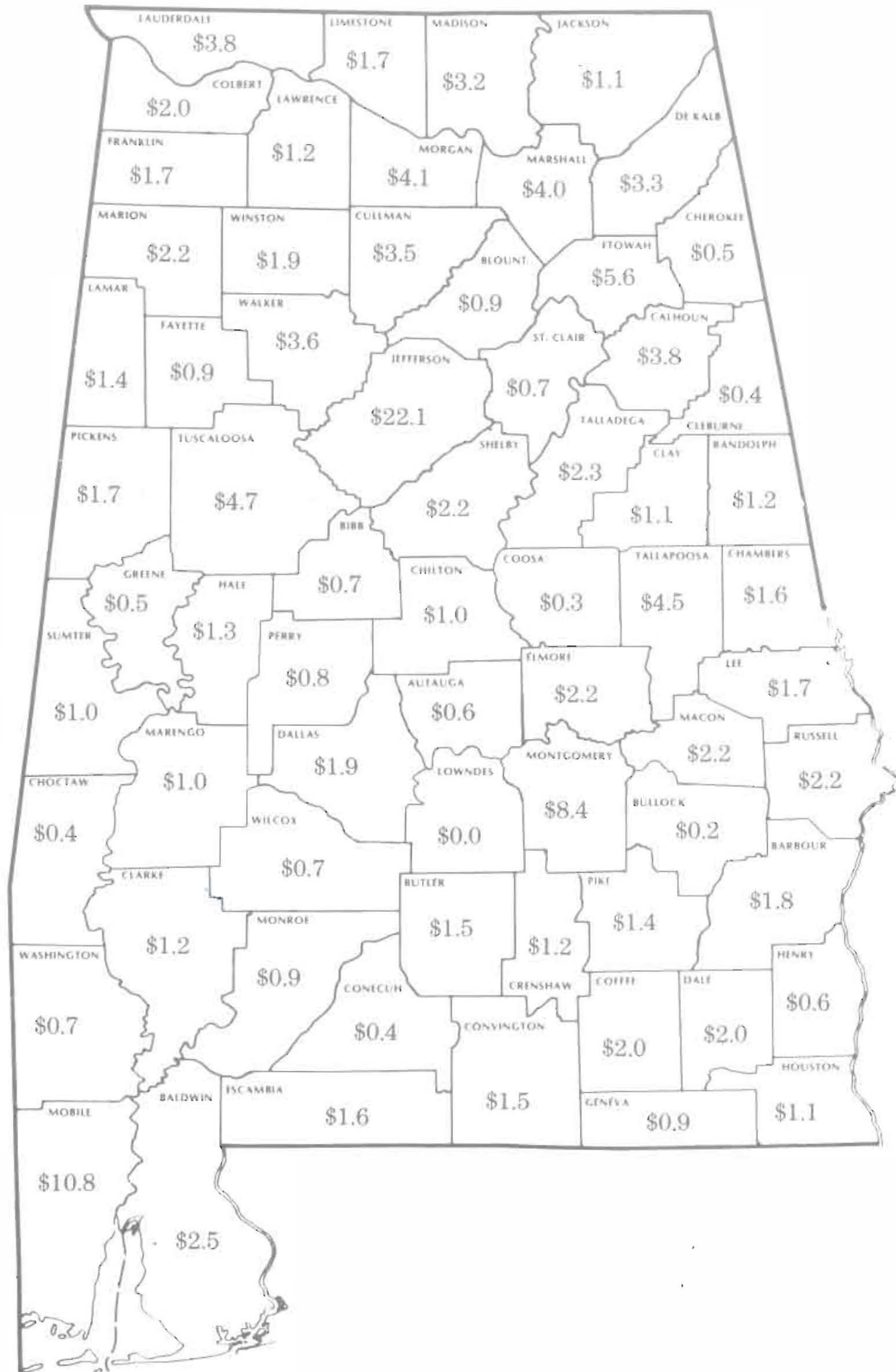
	Skilled	Intermediate	Total
All Recipients	$12,458,947	$139,752,324	$152,211,271
By Sex			
Female	$8,919,787	$107,960,613	$116,880,400
Male	$3,539,160	$31,791,711	$35,330,871
By Race			
White	$8,003,457	$110,802,055	$118,805,512
Nonwhite	$4,455,489	$28,950,269	$33,405,758
By Age			
0-5	$647,974	$15,429	$663,403
6-20	$1,188,090	$945,734	$2,133,824
21-64	$2,133,521	$16,547,829	$18,681,350
65 & Over	$8,489,362	$122,243,332	$130,732,694

FY '87 - '89 **Table - 34**
LONG-TERM CARE PROGRAM
Number of Recipients

	Skilled			Intermediate			Total		
	FY '87	FY '88	FY '89	FY '87	FY '88	FY '89	FY '87	FY '88	FY '89
Monthly Average	1,181	1,150	1,105	12,838	13,128	11,907	14,019	14,278	13,012
Yearly Total	3,213	2,930	4,057	17,298	17,825	17,215	20,511	20,755	21,272
Average Length of Stay	131 days	139 days	99 days	273 days	270 days	258 days	250 days	251 days	229 days

FY '89
PAYMENTS TO NURSING HOMES
By County (in millions of dollars)

Table - 35



LONG TERM CARE MENTAL HEALTH

The Alabama Medicaid Agency, in coordination with the State Department of Mental Health and Mental Retardation, includes coverage for Medicaid-eligible mentally retarded and mentally diseased recipients who require care in an Intermediate Care Facility (ICF). 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.

In recent years there has been a reduction of more than 300 beds in intermediate care facilities for the mentally retarded statewide. This reduction is a cooperative effort by the Department of Mental Health and Mental Retardation and the Alabama Medicaid Agency to deinstitutionalize as many clients as possible and 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. Those facilities include Great Hall-Riverbend Center for Mental Health in Tuscumbia, Volunteers of America #20 in Huntsville, and Volunteers of America #40 in Hartselle. 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 '89 the average payment per day in an institution serving the mentally retarded was approximately $123.

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 through its state appropriation. In FY '89, in cooperation with the Alabama Medicaid Agency, Mental Health was able to match every 28 state dollars with 72 federal dollars for the care of Medicaid-eligible ICF-MR/MD patients.

A home and community-based program for the mentally retarded was implemented by the Alabama Medicaid Agency in FY '83. This is in accordance with the agency's stated policy of using Medicaid funds to pay for effective but less expensive means of treatment. The program is designed for mentally retarded individuals who, without this service, would require institutionalization in an ICF/MR facility. 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 1989
LONG-TERM CARE PROGRAM
ICF-MR/MD **Table - 36**

	ICF/MR	ICF/MD
Recipients	1,370	319
Total Payments	$54,032,001	$2,932,586
Annual Cost per Recipient	$39,439	$9,193

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.

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

In FY '89, pharmacy providers were paid almost $52 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about 10 percent of Medicaid payments for services. The Medicaid Agency reimburses participating pharmacists for dispensing medication that is 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
Government Pharmacy	$1.90
Dispensing Physician	$1.21

Primarily to control overuse, Medicaid recipients must pay a copayment which 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 Medicaid Formulary. On February 28, 1989, the 16th Edition of the formulary went into effect; the formulary 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 either an office visit or for the cost of the drug plus an administration fee.

FY '89 — Table - 37
PHARMACEUTICAL PROGRAM
Counts of Providers by Type

Type of Provider	Number
Retail	1,172
Institutional	31
Governmental	4
Dispensing Physician	2
Total	1,209

FY '87 - '89 — Table - 38
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
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
1989	236,608	61%	3,807,604	16.09	$13.74	$221.10	$52,313,877