— 1991 Annual Report —

THE ALABAMA MEDICAID AGENCY

Guy Hunt
Governor
State of Alabama

Carol A. Herrmann
Commissioner
Alabama Medicaid Agency

Alabama Medicaid Agency
FY 1991 Annual Report
October 1, 1990 - September 30, 1991

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

GUY HUNT
Governor

CAROL HERRMANN
Commissioner

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

Dear Governor Hunt:

You have before you the 19th Annual Report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1990, and ended September 30, 1991.

This year has been a year of highs and lows for the Medicaid Agency in Alabama. We served more than 400,000 Alabamians who otherwise would have gone without health care services or would have added to the burden of uncompensated care in our state's hospitals. We fought hard in Washington, D.C., and in the Alabama Legislature to protect our right to raise additional state revenues through provider specific taxes. In this area, and so many others like it, the Alabama Medicaid Agency is now a progressive leader in health care throughout the country. The Agency staff has renewed its dedication to providing the most cost efficient services possible in the most effective manner. Providing needed health care services for all eligible recipients cost $307 million in total state funds, with the federal government providing more than $799 million in fiscal year 1991.

The Medicaid Agency has become a vital and essential part of the health care infrastructure and therefore plays a critical role in the economic development of the state. In many of our rural and inner city urban areas, Medicaid is the sole financial support for the health care system regardless of income levels. We have continued to work to improve the system to make it more cost effective and efficient.

But more important, we have returned the Agency to its original mission of providing a hand up, not a hand out, for the hundreds of thousands of Alabamians facing health problems. We have renewed our commitment to service and respect of our clients. Most of all, we strive every day to meet the directive set out in Matthew 25: 31-40, whereby "the King replied 'I tell you the truth, whatever you did for one of the least of these brothers of mine, you did for me.'"

Many positive and productive changes in Alabama's Medicaid program have been accomplished this year. An accomplishment of which the Agency is most proud is being part of the many groups — public and private — that made a commitment to help improve the lives of mothers and babies. As a result of this commitment, Alabama saw a significant reduction in the infant mortality rate—from 12.1 infant deaths per 1,000 live births in 1989 to 10.9 infant deaths in 1990. As more initiatives are taken in this area, we are encouraged that fewer infants will die before reaching their first birthday. This effort proves what can be accomplished when all Alabamians unite to resolve specific problems.

By improving the Medicaid Agency, we have enabled individuals to return to work, to improve the lives of their children and their family members who are elderly. This investment is the greatest investment a state can make — for its future.

Sincerely,

Carol A. Herrmann

Carol A. Herrmann
Commissioner

Mission Statement

The mission of the Alabama Medicaid Agency is to empower our recipients to make educated and informed decisions regarding their health and the health of their families. We do this by providing a system which facilitates access to necessary, high quality, preventive and acute medical, long term care, health education and related social services to Medicaid eligibles and other needy populations of Alabama. Through teamwork we strive to operate and enhance a cost efficient system by building an equitable partnership with health care providers, both public and private.

This annual report was produced by the Alabama Medicaid Agency's Outreach and Education Division. Statistical data was provided by the Agency's Planning and Analysis Division.

Cover photo by Robertson's Photography, Montgomery

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Highlights

Introduction: Fiscal year 1991 marked another year of vast improvements and expansions in Alabama's Medicaid program. Two major pieces of federal legislation — one affecting children and one affecting nursing home residents — brought about major changes in the long term care and Early and Periodic, Screening, Diagnosis, and Treatment (EPSDT) programs.

The development and passage of a package of state legislation aimed at increasing Medicaid funding was organized by the Agency with vital, significant input and support from the hospital, nursing home, and pharmacy industries. With the increased funding, the Agency was able to expand and improve services in many areas. The future of the program looked bright, but a regulation issued by the Health Care Financing Administration (HCFA) regarding provider specific taxes quickly brought concern in Alabama over the future of this state's health care system. With support of health care providers, advocacy groups, and concerned citizens, Alabama led the attack to change the law concerning the taxes.

In November, Congress intervened and passed legislation that spared states like Alabama from a possible shutdown of the Medicaid program. What resulted from the law passed by Congress were provisions that will become effective in FY 1993 that will change the providers who are taxed.

In other areas, the maternity waiver program, which has shown to be successful in providing a comprehensive, coordinated and care managed system of total obstetrical care expanded into five additional counties, making a total of 22 counties participating in the program during FY 1991. Those added were Bibb, Bullock, Macon, Pickens, and Tuscaloosa counties.

Nursing homes residents benefitted as well from improvements in the program. In January 1991, Medicaid increased the nursing home income limit from $1,158 to $1,221.

Provider Specific Taxes: During the 1991 Legislative session, Medicaid and the hospital, nursing home and pharmeceutical associations were successful in getting taxes placed on all pharmacies statewide and nursing homes and hospitals statewide that accept Medicaid patients or that do a disproportionately high amount of indigent care. The Congressionally passed Omnibus Budget Reconciliation Act of 1990 provided for the use of such taxes — called provider specific taxes — to expand states' share for federal matching funds. By using a methodology agreed upon by the Agency, and the three health care provider groups, Medicaid's state share was increased by $112.7 million with a potential of $416.2 worth of new or enhanced services through the federal match. The provider groups were very supportive of this concept because it helped them regain some of the loss incurred by uncompensated care and historically poor reimbursement by Medicaid.

Improvements in the program spanned a variety of essential services — hospital care, nursing home care, physician services, and others. What follows is a breakdown of how the Agency used the money collected from the participating providers:

Nursing home care — adjustments in reimbursement methodology to place financial emphasis on direct patient care and provide an efficiency incentive for indirect patient care, additional money to pay for new nursing home beds and a continuum of care, and coverage of personal laundry services for residents.

Hospital care — an expansion in the number of hospitals that qualify as serving a disproportionate share of low income patients, an increase in covered inpatient days from 14 to 16 per year, removal of the limit on outpatient surgery, payment for a 23-hour observation period in the hospital, an increase in the ceiling on payments for urban hospitals, coverage of an unlimited number of days for children in disproportionate share hospitals, and coverage of inpatient psychiatric care for adolescents.

Prescription drugs — an increase in the dispensing fee for pharmacists and an increase in the number of prescription drugs covered by Medicaid.

Physicians services — an increase in the limit on office visits from 12 to 14 per year, an increase in the limit on inpatient visits from 14 to 16 per year, and an increase effective October 1, 1991, in the global fee for obstetrical services from $1,000 to $1,700 for physicians practicing in rural areas and $1,300 for physicians in urban centers.

In September, the Health Care Financing Administration (HCFA) issued a regulation severely restricting the use of provider specific taxes as well as voluntary donations. The restriction on voluntary donations did not affect Alabama since that program had been discontinued when the provider specific taxes became effective. With approximately one-half of the total Alabama Medicaid budget at stake, the state moved to take legal action to stop the implementation of the regulation. Hundreds of letters written by governmental officials, recipients,

providers, and advocacy groups and members of the Medicaid Agency were sent to HCFA supporting the Agency and the state's use of the taxes.

With similar widespread support from a number of states, Congress intervened and passed Legislation that gave states the right to continue using provider specific taxes until December 31, 1992. On January 1, 1993, if states want to continue using taxes as a means of expanding their state's share, they must be prepared to implement broad based taxes — or taxes placed on all providers in a particular class. For Alabama, it means all hospitals and nursing homes now must be taxed - not just those that accept Medicaid patients or that deliver a high amount of indigent care. The tax originally placed on pharmacies was unharmed since that tax affected all pharmacies. During the FY 1992 state legislative session, the Medicaid Agency will be working with the Governor's office, the hospitals and nursing homes to devise the best plan of broad based taxes.

Infant Mortality Rate Decreased: In July 1991, it was announced that Alabama's infant mortality rate had dropped significantly during 1990 - from 12.1 infant deaths per 1,000 live births in 1989 to 10.9 infant deaths per 1,000 live births in 1990. In reality, 67 more babies survived to celebrate their first birthday.

In 1986, Alabama had the highest infant mortality rate in the nation, with 13.3 infant deaths for each 1,000 live births. In 1987, the rate dropped to 12.2 and remained at 12.1 in 1988 and 1989.

Improvements, expansions and continued coordination of Medicaid and public health services are largely credited with the reduction. Medicaid's expansion in eligibility brought pregnant women and young children into a system of care who might otherwise have not been eligible for free health care. Outreach efforts by Medicaid, the Department of Public Health, advocacy groups, physicians, and a variety of health care organizations to educate women in the importance of early and continuous prenatal care and healthy lifestyles during pregnancy also played an important role in reducing infant deaths. Medicaid's Healthy Beginnings program helped lead the way in the state's outreach efforts by sending over 20,000 women who called the program's toll-free number a coupon booklet full of free or discounted items, giving them incentives to go for prenatal care. Together, public and private organizations worked to accomplish this goal.

OBRA '89 Implemented: The Omnibus Budget Reconciliation Act of 1989, passed by Congress in December of 1989, mandated a Medicaid expansion that opened Medicaid programs nationwide to provide more medically necessary services to all eligible children under 21 years of age. As a result of the law, Medicaid now covers any health care diagnostic and treatment service that is medically necessary to correct or improve a problem or condition discovered as a result of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) check-up. Because of the legislation, more health care providers such as chiropractors, occupational therapists, physical therapists, podiatrists, and speech and language therapists are able to enroll in the Medicaid program as "EPSDT only" providers and are now eligible to be reimbursed for medical services provided to eligibles under 21 years of age.

Alabama was the first state in the nation to fully implement the provisions of the act by the Congressionally imposed deadline of October 1, 1990. It is expected that OBRA 89 cost approximately $72 million during the first year of implementation.

While still planning the best way to implement the legislation, Agency staff organized several meetings statewide with hundreds of providers affected by the legislation in attendance to gain insight and ideas into introducing the changes to the state.

OBRA 89 brought about the most significant change in the Medicaid program in the history of the Agency. While most changes were directed toward the EPSDT program, there were mandated changes in other program areas, too.

The legislation allows payment for services provided by federally qualified health centers. Certain community health centers, migrant health centers, and health care for the homeless programs are defined as federally qualified health centers. Services from FQHCs eligible for reimbursement include ambulatory services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers employed by individual FQHCs. States are required to reimburse these centers at 100 percent of their operating costs.

Another change brought about by OBRA 89 that affected Medicaid was the coverage of pediatric, family, and neonatal nurse practitioner services whether or not the nurse practitioner is under the supervision of or associated with a physician or other health care provider. The practitioners can bill only certain codes and are paid at 80 percent of what physicians are reimbursed by Medicaid.

OBRA '87 Implemented: On October 1, 1990, the Alabama Medicaid Agency implemented provisions of the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) which assures a higher quality of care and more direct patient care for residents of nursing homes.

OBRA 87 provides for improvements such as stricter requirements for training and evaluating nurse aides and the creation of a state

nurse aide registry to record training, evaluations, and grievances of each state's nurse aides. There also were provisions in the law that required additional social workers and nursing professionals such as registered nurses, licensed practical nurses and nurse aides in order to increase the ratio of nursing professionals to nursing home residents for total, more direct patient care. In addition, Medicaid also is required to help finance the training for nurse aides, and all nursing facilities must now conduct a comprehensive assessment of each resident's functional capacity upon admission, with revisions and re-evaluations regularly. OBRA 87 gave nursing home residents rights and choices in controlling their lives and surroundings, and more opportunities for restorative care to help residents reach their fullest physical and mental potential.

Changes made because of OBRA '87 cost about $6.5 million in state funds and $25 million in state and federal funds during the first full year.

Transfer of Eligibility Determination Responsibility: Effective September 3, 1991, the Alabama Medicaid Agency began determining Medicaid eligibility for many children and pregnant women whose eligibility had formerly been determined by the Department of Human Resources. To accomplish this change, the Medicaid Agency hired approximately 100 social workers and placed them at many hospitals, county health departments, federally qualified health centers, and other health facilities throughout the state.

People affected by the transfer of responsibility are children and pregnant women who qualify for Medicaid solely because of low income — those often called the "SOBRA" group because of expansions in Medicaid that started with the Sixth Omnibus Budget Reconciliation Act.

Included in the group are pregnant women and children through age five in families with incomes up to 133 percent of the federal poverty level, as well as the new eligibility group of six- and seven-year-olds with family incomes up to 100 percent of the federal poverty level.

With the change, families can have eligibility determined through the mail, or if they have questions or need help filling out the form, they can go to any of the sites where Medicaid has an eligibility worker. Applications can be picked up at those sites and at county DHR offices.

Previously, DHR was under contract with the Medicaid agency to determine Medicaid eligibility for many different groups, including some that receive cash assistance and some that do not. With the transfer of responsibility, DHR will continue to determine eligibility for those receiving cash assistance but not for children and pregnant women who need help solely with payment for health care.

Eligibility Expanded: Medicaid eligibility was expanded in July 1991 to include children born after September 30, 1983, who live in families with yearly incomes up to 100 percent of the federal poverty level. In 1991, that meant $11,140 for a family of three. The expansion will extend Medicaid eligibility each year to this group until all children through age 18 who meet eligibility criteria are covered by Medicaid. It is expected about 25,000 children will be served during the first full year ending July 1992.

The Medicaid agency continues to serve children up to age six and pregnant women in families with incomes up to 133 percent of the federal poverty level, or $14,816 a year for a family of three in 1991 figures.

The Alabama Medicaid program first saw eligibility expand in 1988 under the Sixth Omnibus Budget Reconciliation Act which extended eligibility to pregnant women and young children up to age one in families with yearly incomes of 100 percent of the federal poverty level. In April 1990, eligibility was again expanded to include pregnant women and young children up to age six in families with yearly incomes of 133 percent of the federal poverty level.

Humana/QMB Plan: The Medicaid Agency and Humana Insurance Company entered into an innovative agreement during FY 1991 that saves money for the Medicaid program while offering expanded benefits for thousands of elderly or disabled Alabamians.

Through the agreement, Medicaid contracts for insurance coverage from Humana for low income Medicare beneficiaries who qualify to have some of their Medicare expenses paid by Medicaid and who wish to join the Humana Qualified Medicare Beneficiary (QMB) Special Care Plan.

More than 6,000 people signed up for the program during the first seven months of its implementation, exceeding estimates that 5,000 people would enroll during the first full year. The program includes payment of the Medicare hospital deductible and coinsurance if enrollees are hospitalized more than 60 days. Medicaid is required to pay these expenses for Medicare beneficiaries with very low incomes and few assets under the Medicare Catastrophic Coverage Act of 1988.

To qualify for the assistance through the Humana QMB Special Care Plan during FY 1991, the monthly income of a single Medicare beneficiary could not exceed $572, while a couple's income limit was $760 per month. The limit on assets was $4,000 for an individual and $6,000 for a couple during that year. In addition, Medicaid also paid Humana a monthly premium for

each QMB who enrolls in the plan. The plan also includes a wide variety of Humana hospital benefits, health screenings, and discounts not covered by Medicaid.

Medicaid estimates a savings in inpatient hospital care of $83 per member who joins the plan during the first year of implementation. Total savings for the first year should exceed $380,000 in state funds and more than $1.4 million in total state and federal funds.

The Humana plan covers inpatient stays at any Humana hospital in Alabama but also covers true emergencies at other hospitals. There are six Humana Hospitals in Alabama. Humana Hospital-Montgomery and Humana Hospital-East Montgomery, Humana Hospital-Florence, Humana Hospital-Huntsville, Humana Hospital-Russellville, and Humana Hospital-Shoals in Muscle Shoals.

Hospice Services Covered: Effective October 1, 1990, hospice care became a covered service for all eligible Medicaid recipients. Hospice care is a comprehensive home care program which primarily provides reasonable and necessary medical and support services for terminally ill individuals. The goal of hospice is not to cure a terminal illness but rather to provide relief of symptoms.

The service is not only compassionate but cost efficient. During FY 1991, the Medicaid Agency served an average of 16 hospice patients each month at a total cost of about $155,820 in state and federal funds. The expense was offset by a reduction in hospital costs for Medicaid.

In adding hospice services for eligible patients, the Medicaid Agency follows the same rules the Medicare program uses. Hospice services must be provided by a Medicare certified hospice program and are available for unlimited days.

Hospice care through the Medicaid Agency is provided on a voluntary basis, and when it is chosen, the patient waives the right to any other services that treat the terminal illness. Services included are nursing care, medical social services, physicians services, counseling services, short-term inpatient care, medical appliances and supplies (including drugs and biologicals), home health aide services, homemaker services, physical therapy, occupational therapy, speech language pathology services, and nursing home room and board.

New Waiver Implemented: A new program, called the Specialized Community Care Living Arrangements Model Waiver, was implemented in April 1991 and provides care in family homes to frail or disabled adults who receive Supplemental Security Income (SSI) or State Supplementation and who also meet medical and financial standards for Medicaid nursing home care. The program primarily serves individuals at risk of abuse and neglect.

The waiver, with a maximum total of 200 slots, is a three-year pilot program in 12 north Alabama counties including Blount, Cullman, Etowah, Jackson, Jefferson, Lawrence, Limestone, Madison, Marshall, Morgan, Walker, and Winston counties.

Under the program, frail adults live in adult foster homes. The foster caregivers provide the adults with food, shelter, and some personal care. More specialized services such as nursing care can also be provided in the home.

The Department of Human Resources pays the adult foster caregivers a service fee and also pays for services and medical supplies needed by the adult. The adult in care pays for room and board.

In addition to being less impersonal than institutional care, the program also will be less expensive to taxpayers. The cost per adult on the waiver is less than half the approximate $1,700 a month cost of nursing home care.

Technological Advancements: Pursuing the goal of making the Agency more user friendly, Medicaid and its fiscal agent, Electronic Data Systems (EDS), improved communication linking health care providers statewide with Medicaid and EDS.

In June 1991, the Agency and EDS implemented the Automated Voice Response System (AVRS). The system enhances the regular provider inquiry capabilities by allowing providers, through a computerized menu accessible with a touch tone phone, to automatically receive information about recipient eligibility, third party insurance resources, availability of benefits, procedure code information, drug pricing information, claim status and check amounts for reimbursement.

Providers can use the system 18-22 hours per day, seven days per week. An average of 43,411 calls were received each month, allowing for 320,867 transactions.

Third Party Recoupments: During the 1991 fiscal year, Medicaid's Third Party Section collected in excess of $1.8 million 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 ten percent of the total Medicaid recipient population.

In addition to the $1.8 million collected from third party insurance carriers, the Medicaid Agency saw a reduction in Medicaid payments of over $2.8 million because of the money providers collected from third party resources. Claims totaling an additional $21 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 $14 million were returned to providers for submission to Medicare, the primary payor. In FY 1991, Medicaid also recouped $194,000 from providers who had received payment from both Medicaid and a third party.

Looking Ahead: The achievements of a very busy year could not have been accomplished without the coalition and widespread support of those interested in the future of this state's health care system. From positive changes in the program to attacking a program-threatening regulation — supporters became unified to help those who are most vulnerable. The Medicaid Agency appreciates the support that was given during the year and looks forward to a continued working relationship with those who are committed to working toward a healthy and prosperous state.

The Agency will propose two bills to be voted on during the 1992 Legislative session that will change the provider specific tax structure in this state. In devising a workable piece of legislation, the Agency will be met with great opposition from hospitals that are not Medicaid providers.

During FY 1992, the Agency also will prepare itself for another costly federal mandate — the implementation of the Pryor Bill. This piece of legislation basically opens the drug formulary so that Medicaid agencies are paying for a multitude of drugs that were previously not covered.

Another waiver will be introduced in the upcoming year. This one will care for persons in their homes or communities who qualify for nursing home type care. For the first time eligibility won't be linked to Supplemental Security Income (SSI) and persons will be able to have the same income limit as those eligible for nursing home placement.

The state General Fund budget will face proration in the next fiscal year, making funding for state agencies and departments difficult. The Medicaid Agency will continue to work with the other state agencies and departments to maximize state dollars and improve services to this state's most vulnerable citizens.

Because of the hard work and dedication of people across the state, Alabama's health care system is showing signs of improvement. The infant mortality rate is significantly lower than in previous years, more care is being given to pregnant women so healthier pregnancy outcomes can be maintained. Children have more access to health care than ever before so they can live healthier lives. More direct patient care is being given to nursing home residents, and more people are being given much needed care in the comfort of their own homes without being placed in institutions. Alabama has come a long way in providing health care for those who would not have had the opportunities to live healthy lives.

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 1991, the formula was approximately 72/28. For every $28 the state spent, the federal government contributed $72.

Eligibility: Persons must fit into one of several categories and must meet necessary criteria before eligibility can be determined. The Medicaid Agency, the Department of Human Resources, and the Social Security Administration determine eligibility for Medicaid in Alabama.

Eligibles include:

* Persons receiving Supplemental Security Income (SSI) from the Social Security Administration, which determines their eligibility. Some persons in this group are also eligible for retroactive Medicaid if any medical bills had been incurred three months prior to the time of applying for SSI. Children born to mothers receiving SSI may be eligible for Medicaid until they reach one year of age. After the child's first birthday, it is up to the mother to seek Medicaid eligibility for the child under a different program.

* Persons approved for cash assistance through the State Department of Human Resources, which determines their eligibility. Most people in this category receive Aid to Families with Dependent Children (AFDC) or State Supplementation.

* Certain pregnant women and young children, including those with incomes under 133 percent of the federal poverty level who do not receive an AFDC cash payment, and foster children in the custody of the state. Also covered are children born after September 30, 1983, who have celebrated their sixth birthday, and who live in families with annual incomes up to 100 percent of the federal poverty level. Medicaid eligibility workers determine their eligibility.

* Persons who have been residents or patients of certain medical facilities (nursing homes, hospital, or state facilities for the mentally retarded) for 30 continuous days and who meet necessary criteria. Medicaid District offices determine eligibility for persons in these categories.

* Qualified Medicare Beneficiaries (QMBs) who are low income may be eligible to have their Medicare premiums, deductibles, and co-insurance paid by Medicaid as a result of the Medicare Catastrophic Coverage Act of 1988. Medicaid District Offices determine eligibility for QMBs.

* Disabled widows and widowers between ages 60 and 64 who are not eligible for Medicare Part A and who have lost SSI because of receiving early widows/widowers benefits from Social Security may be eligible for Medicaid. Medicaid District Offices determine eligibility for this group.

Some persons in eligibility categories are protected by federal law from losing their Medicaid benefits. One of those categories includes Pickle (or Continued Medicaid) cases. Persons in this category receive Social Security and would also receive SSI if the cost of living raises did not push them above the income limit to receive SSI. Another category protected from losing eligibility are disabled adult children if their SSI stopped because of an increase in or entitlement to Social Security benefits.

Covered Services: Medical services covered by Alabama's Medicaid program traditionally have been generally fewer and less comprehensive than most states'. In recent years, however, federal mandates and the Agency's own initiatives have expanded and improved the overall program. Alabama's program is aimed at providing the best possible health care to the greatest number of low income people at the most affordable cost to the taxpayers.

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 1991, Medicaid paid approximately $611 million to providers on behalf of persons eligible for the program. The federal government paid approximately 75 percent of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services and paid taxes in the state. Using the common economic multiplier effect of three Medicaid expenditures generated over $2.4 billion worth of business in Alabama in FY 1991.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. With the current administrative rate, 97 percent 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 1991
COUNTY IMPACT
Year's Cost per Eligible

Table – 1

County	Benefit Payments	Eligibles	Payment Per Eligible	County	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$4,482,536	3,605	$1,243	Houston	$10,937,592	9,126	$1,199
Baldwin	$11,125,837	7,505	$1,482	Jackson	$7,269,035	5,250	$1,385
Barbour	$6,424,369	4,645	$1,383	Jefferson	$117,896,093	67,785	$1,739
Bibb	$3,217,826	2,009	$1,602	Lamar	$3,431,379	1,673	$2,051
Blount	$5,165,008	3,248	$1,590	Lauderdale	$13,304,467	7,059	$1,885
Bullock	$3,388,375	2,944	$1,151	Lawrence	$5,134,678	3,665	$1,401
Butler	$6,032,542	4,067	$1,483	Lee	$10,292,643	7,153	$1,439
Calhoun	$19,831,241	12,145	$1,633	Limestone	$7,265,533	5,655	$1,285
Chambers	$6,270,722	4,888	$1,283	Lowndes	$3,822,386	3,617	$1,057
Cherokee	$2,988,805	1,862	$1,605	Macon	$7,770,953	5,149	$1,509
Chilton	$5,822,759	3,796	$1,534	Madison	$22,887,196	20,317	$1,127
Choctaw	$3,658,038	2,863	$1,278	Marengo	$6,695,196	4,608	$1,453
Clarke	$7,097,571	5,357	$1,325	Marion	$7,102,222	3,352	$2,119
Clay	$3,309,527	1,518	$2,180	Marshall	$15,112,362	7,698	$1,963
Cleburne	$2,437,198	1,318	$1,849	Mobile	$78,144,097	49,692	$1,573
Coffee	$7,702,379	3,968	$1,941	Monroe	$5,498,911	3,486	$1,577
Colbert	$8,198,290	4,594	$1,785	Montgomery	$40,087,676	29,125	$1,376
Conecuh	$3,584,545	2,554	$1,404	Morgan	$32,696,097	9,074	$3,603
Coosa	$1,799,439	1,200	$1,500	Perry	$5,122,668	3,807	$1,346
Covington	$8,774,628	4,988	$1,759	Pickens	$6,116,135	4,043	$1,513
Crenshaw	$4,007,600	2,323	$1,725	Pike	$7,296,629	5,184	$1,408
Cullman	$12,720,131	6,172	$2,061	Randolph	$4,870,670	2,787	$1,748
Dale	$7,766,612	4,744	$1,637	Russell	$7,898,035	6,307	$1,252
Dallas	$14,952,290	12,995	$1,154	Shelby	$7,431,199	4,872	$1,525
DeKalb	$11,603,026	5,963	$1,946	St. Clair	$6,868,534	4,382	$1,567
Elmore	$19,199,654	5,221	$3,677	Sumter	$5,017,127	4,195	$1,196
Escambia	$7,029,691	4,766	$1,475	Talladega	$15,956,423	11,218	$1,422
Etowah	$20,747,574	11,598	$1,789	Tallapoosa	$11,163,981	5,247	$2,128
Fayette	$3,762,970	2,352	$1,600	Tuscaloosa	$53,545,994	16,639	$3,218
Franklin	$7,078,990	3,658	$1,935	Walker	$16,014,289	8,665	$1,848
Geneva	$5,443,486	3,336	$1,632	Washington	$3,598,923	2,923	$1,231
Greene	$3,601,668	3,026	$1,190	Wilcox	$5,097,081	4,664	$1,093
Hale	$5,034,399	3,449	$1,460	Winston	$6,214,486	2,763	$2,249
Henry	$3,111,249	2,194	$1,418	Other	$58,659	93	$631

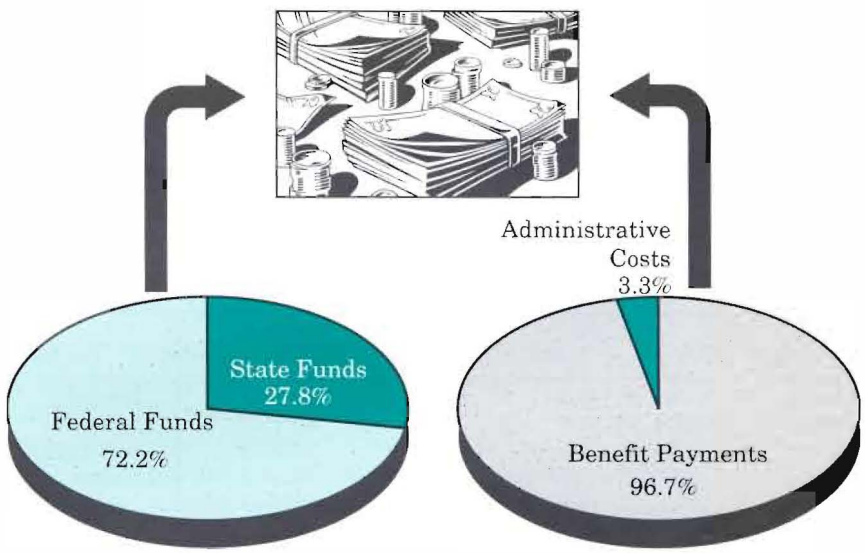
Revenue, Expenditures, and Prices

In FY 1991, Medicaid paid 1,070,180,856 for health care services to Alabama citizens. Another $36,498,914 was expended to administer the program. This means that about 97 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 1991 Table – 2
Sources of Medicaid Revenue

	Dollars
Federal Funds	$799,495,188
State Funds	$307,184,580
Total Revenue	$1,106,679,768

FY 1991 Table – 3
Composition and Disbursement of Medicaid's Budget



FY 1991 Table – 4
Components of Federal Funds

(net)	Dollars
Family Planning Administration	$402,457
Professional Staff Costs	$7,770,389
Other Staff Costs	$13,465,871
Other Provider Services	$773,358,124
Family Planning Services	$4,498,347
Total	$799,495,188

FY 1991 Table – 5
Components of State Funds

(net)	Dollars
Encumbered Balance Forward	$5,246,370
Basic Appropriations	$145,656,637
Indigent Care Trust Fund	$112,200,000
Special Education Trust Fund	$163,625
Other State Agencies	$49,258,497
Interest Income from Fiscal Intermediary	$631,451
Miscellaneous Receipts	$20,948
Subtotal	$313,177,528
Encumbered	$5,992,948
Total	$307,184,580

FY 1991-1992 Table – 6
Benefit Payments by Fiscal Year in which Obligation was Incurred

	FY '91	FY '92 (Est.)
Nursing Homes	$226,054,951	$307,647,000
Hospitals	$402,435,413	$641,166,000
Physicians	$70,888,504	$95,020,000
Insurance	$63,820,529	$81,875,252
Drugs	$73,102,595	$105,775,000
Health Services	$19,047,106	$31,882,000
Community Services	$89,659,920	$114,821,000
Total Medicaid Service	$945,009,018	$1,378,186,252
Mental Health	$125,171,838	$139,477,899
Total Benefits	$1,070,180,856	$1,517,664,151

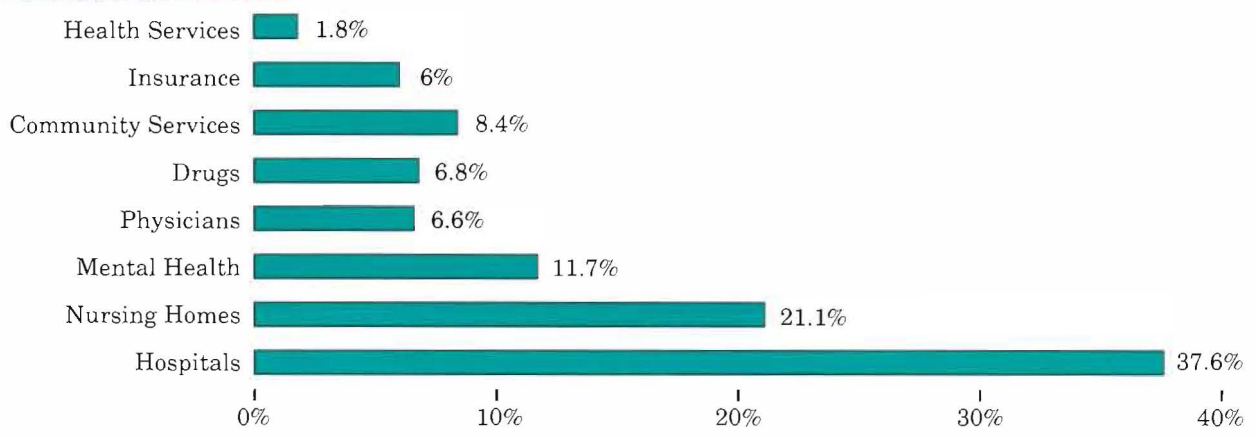
FY 1991
EXPENDITURES
By type of service (net)

Table – 7

Service	Payments	Percent of Total Payments
Pharmacy	$73,102,595	6.83%
Nursing Homes	$226,054,951	21.12%
Hospitals:	$402,435,413	37.60%
Inpatient	$169,076,171	15.80%
Outpatient	$18,708,256	1.75%
Disproportionate Share Payments	$211,544,510	19.77%
Rural Health Clinics	$101,007	0.01%
FQHC	$3,005,469	0.28%
Physicians:	$70,888,504	6.62%
Physicians	$70,836,216	6.62%
Other Practitioners	$52,288	0.00%
Health Services:	$19,047,106	1.78%
Screening	$4,239,708	0.40%
Dental	$5,295,307	0.49%
Hearing	$170,960	0.02%
Laboratory	$4,787,628	0.45%
Eyeglasses	$823,412	0.08%
Eye Care	$2,114,839	0.20%
Transportation	$1,612,644	0.15%
Other Care	$2,608	0.00%
Community Services:	$21,787,974	2.04%
Home Health/DME	$12,128,779	1.13%
Targeted Case Management	$4,491,847	0.42%
Family Planning	$4,998,163	0.47%
Hospice	$169,185	0.02%
Insurance:	$63,820,529	5.96%
Buy-In	$36,997,885	3.46%
Co-Insurance	$26,572,960	2.48%
Humana QMB Plan	$89,915	0.01%
Managed Care	$159,769	0.01%
MR/MD:	$97,865,487	9.14%
ICF-MR	$90,030,607	8.41%
ICF-MD	$603,017	0.06%
NF-MD/Illness	$7,231,863	0.69%
Mental Health Services	$11,634,167	1.09%
Waiver Services:	$83,544,130	7.81%
Mental Health Services:	$14,401,075	1.35%
HCBS	$22,937,851	2.14%
Pregnancy Related	$46,205,204	4.32%
Total For Medical Care	$1,070,180,856	100.00%
Administrative Costs	$36,498,914	
Net Payments	$1,106,679,770	

FY 1991 BENEFIT PAYMENTS
Percent Distribution

Table – 8



FY 91 **Table - 9**

Collections and Measurable Cost Containment

The Agency works to ensure accurate and appropriate payment for services which are monitored by the Systems Audit Unit through its administration of the Claims Proc-essing Assessment System (CPAS).

Program integrity and compliance with state and federal regulations are monitored through reviews, audits and investigations. The Agency makes collections when overpayments are identified.

In FY 91, collections and measurable cost avoidance saved a total of $115,339,959.

Collections - FY 91 Third Party Liability **$7,314,938**

The Agency works with providers and eligibility workers to identify health care insurance coverage recipients may have. Because Medicaid is the payor of last resort, the Agency collects from insurance companies, providers, and sometimes recipients, when there is third party liability for payment of medical bills. Approximately 10 percent of Medicaid eligibles were identified as having health coverage through a third party in FY 91. The Agency collected $194,000 from providers who had already received reimbursement from other third party sources. This figure is included in the amount shown above for total liability.

Other Collections **$267,755**

The Agency collects funds identified through investigations and utilization reviews. Also included in this category are recoupments originating from monthly audits of 25% of Medicaid admissions in delegated hospitals and random audits of other hospitals.

Measurable Cost Avoidance - FY 91 Prior Approval and Prepayment Review **$30,836**

The inpatient Utilization Review unit of the Agency ensures that services are appropriate and medically necessary. 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.

Third Party Claim Cost Avoidance - Medicare **$14,000,142**

Claims for recipients who are covered by both Medicaid and Medicare must first be submitted to Medicare for payment. The Agency avoids cost by ensuring that Medicare pays first.

Third Party Claim Cost Avoidance - Other **$21,649,100**

Claims must go to other insurance or liability sources before being submitted to Medicaid for payment. The Agency avoids costs by identifying those sources and requiring payment by them before Medicaid payment is made.

Waiver Services Cost Avoidance - Elderly and Disabled **$19,304,350**

During FY 91 the Elderly and Disabled program served 5,589 recipients at an average annual cost of $4,154.01 per recipient. If this group of recipients were served in a nursing facility the cost would have been $7,608.00 annually per recipient.

Waiver Services Cost Avoidance - MR/DD **$52,772,838**

The Mentally Retarded and Developmentally Disabled program provided Home and Community Based Service waiver services to 1,363 recipients. The annual program average cost for this group was $8,812.85 per recipient. If this group had been served in an intermediate care or mental retardation facility the annual cost would have been $47,513.00 per individual.

Total Measurable Cost Avoidance and Collections **$115,339,959**

Population

The population of Alabama grew from 3,444,165 in 1970 to 3,893,888 in 1980. In 1991, Alabama's population was estimated to be 4,057,585.

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 older 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 older in the state. The Center for Demographic and Cultural Research at Auburn University at Montgomery reports that white females 65 years of age and older account for almost one half of the elderly population in the state. Historically, cost per eligible has been higher for this group than for other groups of eligibles.

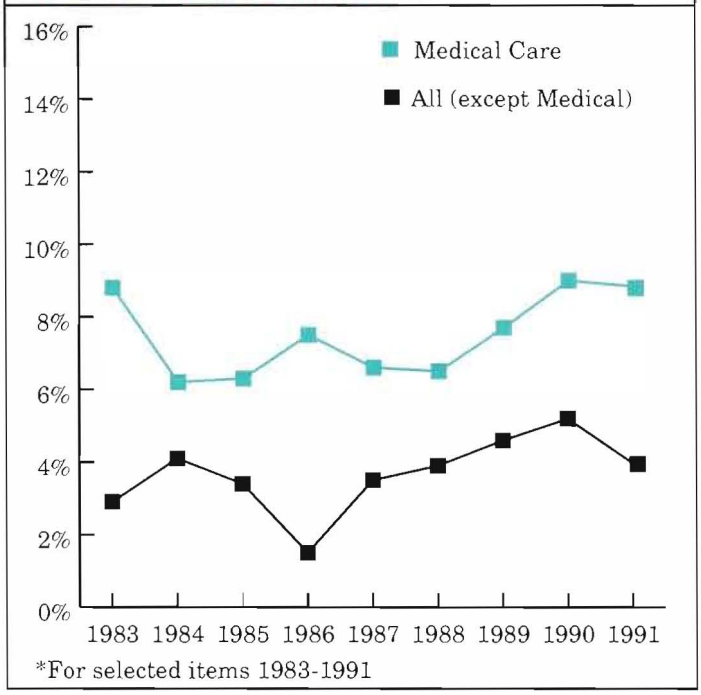
FY 1989-1991 **Table – 10**
POPULATION
Eligibles as a percent of population by year

Year	Population	Eligibles	Percent
1989	4,024,041	386,352	9.6%
1990	4,040,587	418,663	10.4%
1991	4,057,585	482,104	11.9%

Prices

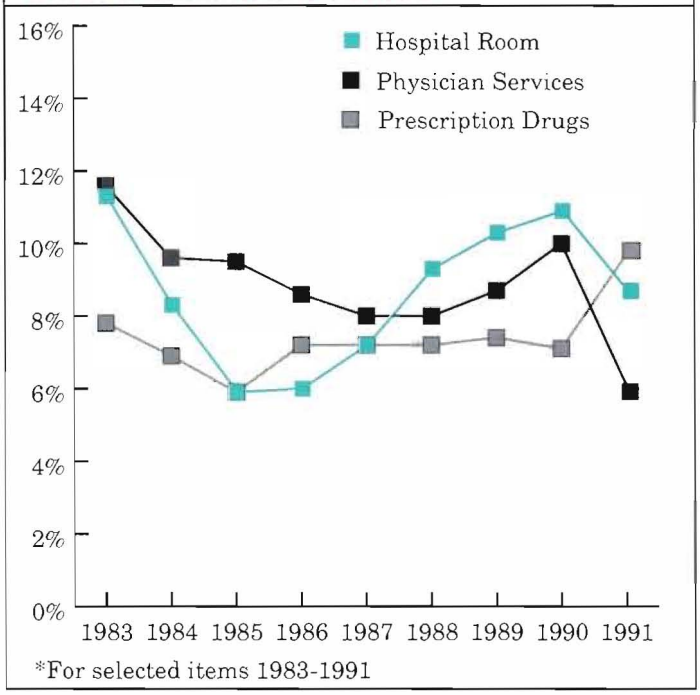
The charts on this page show historical trends in the rate of growth in the Consumer Price Index (CPI). Increases in the CPI are usually reflected in future increases in Medicaid payments to providers.

ANNUAL PERCENT CHANGES **Table – 11**
In the Consumer Price Index*



*For selected items 1983-1991

ANNUAL PERCENT CHANGES **Table – 11A**
In the Consumer Price Index*



*For selected items 1983-1991

Eligibles

During FY 1991, 482,104 persons were eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 370,828. The monthly average is the most useful measure of Medicaid coverage because it takes into account length of eligibility.

Although 482,104 people were eligible for Medicaid in FY 91, 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.

FY 1991 ELIGIBLES Monthly Count — **Table – 12**

October '90	343,496
November	344,760
December	349,618
January '91	357,551
February	364,264
March	370,605
April	376,881
May	380,387
June	383,173
July	389,301
August	393,404
September	396,493

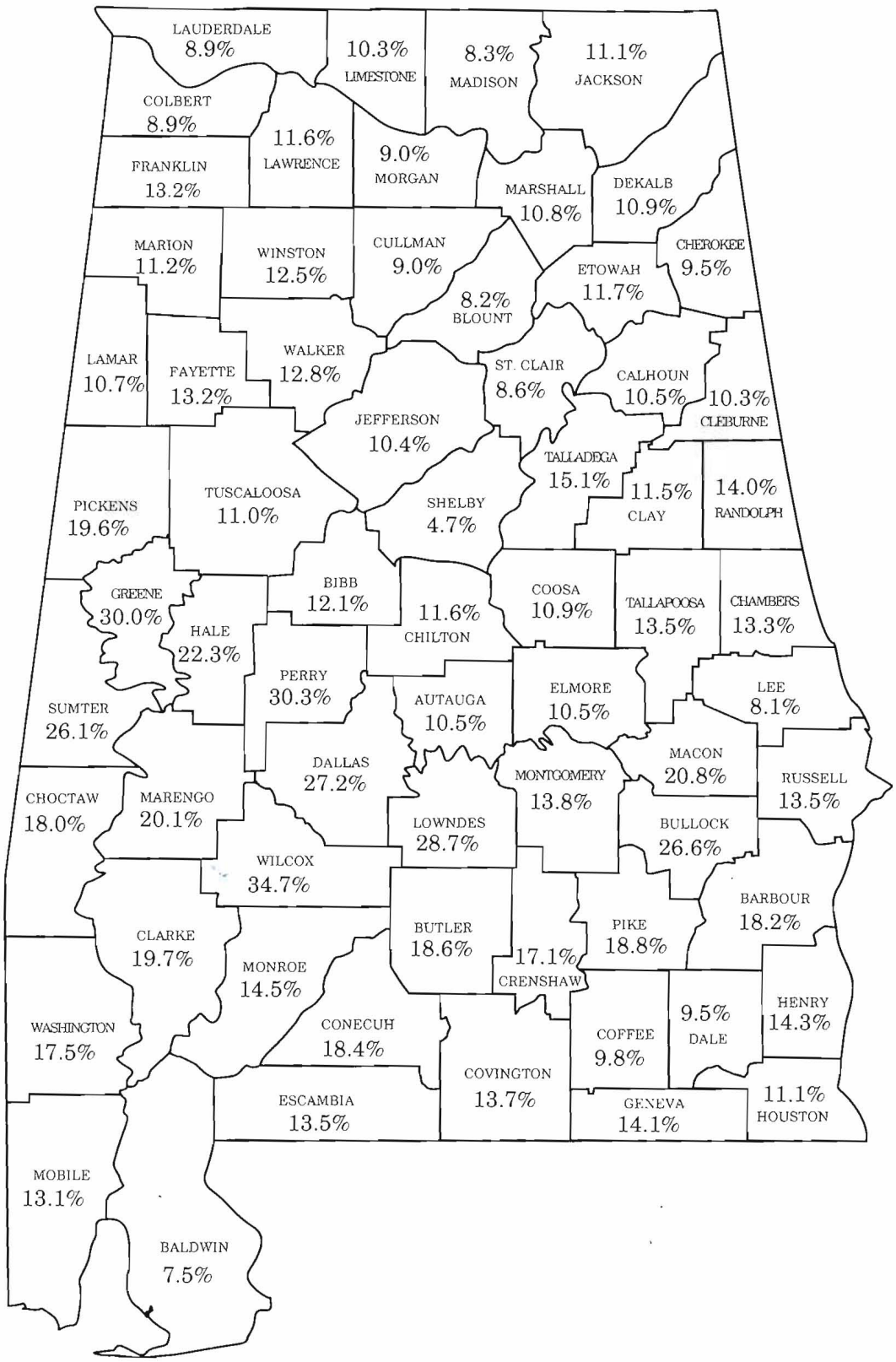
FY 1991 ELIGIBLES By Length of Eligibility — **Table – 13**

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				
Aged	51,613	44,172	7,441	43,170
Blind	1,788	1,536	252	1,544
Disabled	97,082	78,464	18,618	114,282
AFDC-Children	127,103	70,852	56,251	340,734
AFDC-Adult	53,330	26,942	28,388	173,820
Other Title XIX	1	0	1	8
Categorically Needy, Not Receiving Assistance				
Aged	16,823	10,460	6,363	37,829
Blind	27	14	13	88
Disabled	3,905	2,690	1,215	8,776
AFDC-Children	17,670	7,586	10,084	64,992
AFDC-Adult	10,099	2,900	7,199	39,581
Other Title XIX	4,976	1,773	3,203	15,974
SOBRA/QMB				
Aged	7,533	4,499	3,034	15,038
Blind	0	0	0	0
Disabled	0	0	0	0
AFDC-Children	60,225	14,804	45,421	265,733
AFDC-Adult	25,072	309	24,763	122,744
Other Title XIX	1,747	0	1,747	2,504

FY 1991
MEDICAID ELIGIBLES BY CATEGORY

Table – 14

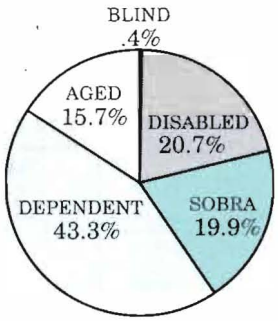
COUNTY	AFDC	AGED	DISABLED	SOBRA	QMB	BLIND	TOTAL
Autauga	1,461	476	667	914	73	14	**3,605**
Baldwin	2,473	982	1,552	2,326	136	36	**7,505**
Barbour	1,929	880	960	760	91	25	**4,645**
Bibb	544	332	522	550	56	5	**2,009**
Blount	830	635	690	992	95	6	**3,248**
Bullock	1,354	542	538	468	32	10	**2,944**
Butler	1,826	810	706	626	85	14	**4,067**
Calhoun	4,832	1,524	2,974	2,534	201	80	**12,145**
Chambers	2,043	787	840	1,103	88	27	**4,888**
Cherokee	496	364	449	502	45	6	**1,862**
Chilton	1,270	605	783	1,020	99	19	**3,796**
Choctaw	1,285	537	550	436	43	12	**2,863**
Clarke	2,707	707	974	866	90	13	**5,357**
Clay	382	394	334	332	62	14	**1,518**
Cleburne	417	267	311	280	40	3	**1,318**
Coffee	1,401	848	756	853	97	13	**3,968**
Colbert	1,120	802	1,177	1,389	89	17	**4,594**
Conecuh	940	508	523	538	34	11	**2,554**
Coosa	454	167	329	220	26	4	**1,200**
Covington	1,439	1,001	1,097	1,283	151	17	**4,988**
Crenshaw	781	573	554	350	55	10	**2,323**
Cullman	1,094	1,536	1,657	1,679	175	31	**6,172**
Dale	1,773	795	915	1,145	95	21	**4,744**
Dallas	7,223	1,617	2,493	1,495	89	38	**12,955**
DeKalb	1,449	1,474	1,463	1,439	114	24	**5,963**
Elmore	2,085	751	1,189	1,104	76	16	**5,221**
Escambia	1,918	743	912	1,089	84	20	**4,766**
Etowah	3,612	1,788	3,101	2,748	307	42	**11,598**
Fayette	801	485	537	486	38	5	**2,352**
Franklin	1,010	728	922	887	95	16	**3,658**
Geneva	1,127	702	723	661	112	11	**3,336**
Greene	1,536	520	522	414	22	12	**3,026**
Hale	1,355	751	646	665	25	7	**3,449**
Henry	852	467	447	350	64	14	**2,194**
Houston	3,518	1,338	1,942	2,105	197	26	**9,126**
Jackson	1,352	895	1,493	1,348	134	28	**5,250**
Jefferson	35,092	7,195	14,443	10,150	672	233	**67,785**
Lamar	359	487	439	339	38	11	**1,673**
Lauderdale	1,988	1,290	1,666	1,927	174	14	**7,059**
Lawrence	1,170	634	838	936	73	14	**3,665**
Lee	2,647	972	1,501	1,913	88	32	**7,153**
Limestone	1,979	927	1,119	1,494	96	40	**5,655**
Lowndes	2,028	421	485	637	37	9	**3,617**
Macon	3,024	698	786	575	47	19	**5,149**
Madison	10,231	1,935	3,210	4,599	269	73	**20,317**
Marengo	2,131	768	790	860	48	11	**4,608**
Marion	851	733	693	990	76	9	**3,352**
Marshall	2,447	1,674	2,023	1,326	201	27	**7,698**
Mobile	27,821	4,280	8,452	8,468	552	119	**49,692**
Monroe	1,353	564	738	748	71	12	**3,486**
Montgomery	15,013	3,039	5,368	5,394	232	79	**29,125**
Morgan	2,824	1,473	2,344	2,166	225	42	**9,074**
Perry	2,063	625	548	532	34	5	**3,807**
Pickens	1,623	787	777	780	59	17	**4,043**
Pike	2,054	964	1,119	932	89	26	**5,184**
Randolph	890	564	525	713	80	15	**2,787**
Russell	2,985	998	1,345	819	126	34	**6,307**
Shelby	1,740	448	940	1,650	74	20	**4,872**
St. Clair	1,704	518	819	1,253	79	9	**4,382**
Sumter	2,395	617	630	505	37	11	**4,195**
Talladega	4,915	1,207	2,629	2,217	139	111	**11,218**
Tallapoosa	2,051	931	1,098	1,030	115	22	**5,247**
Tuscaloosa	7,372	2,181	3,807	2,967	254	58	**16,639**
Walker	2,885	1,047	2,283	2,277	148	25	**8,665**
Washington	1,288	405	544	626	45	15	**2,923**
Wilcox	2,331	700	1,007	575	33	18	**4,664**
Winston	515	627	746	807	61	7	**2,763**
Other	89				4		**93**
TOTAL	208,547	68,040	99,960	96,162	7,591	1,804	**482,104**


LAUDERDALE 8.9%
10.3% LIMESTONE
8.3% MADISON
11.1% JACKSON
COLBERT 8.9%
11.6% LAWRENCE
9.0% MORGAN
FRANKLIN 13.2%
MARSHALL 10.8%
DEKALB 10.9%
MARION 11.2%
WINSTON 12.5%
CULLMAN 9.0%
CHEROKEE 9.5%
ETOWAH 11.7%
8.2% BLOUNT
LAMAR 10.7%
FAYETTE 13.2%
WALKER 12.8%
ST. CLAIR 8.6%
CALHOUN 10.5%
10.3% CLEBURNE
JEFFERSON 10.4%
TALLADEGA 15.1%
PICKENS 19.6%
TUSCALOOSA 11.0%
SHELBY 4.7%
11.5% CLAY
14.0% RANDOLPH
GREENE 30.0%
BIBB 12.1%
COOSA 10.9%
TALLAPOOSA 13.5%
CHAMBERS 13.3%
HALE 22.3%
11.6% CHILTON
PERRY 30.3%
ELMORE 10.5%
LEE 8.1%
SUMTER 26.1%
AUTAUGA 10.5%
MACON 20.8%
DALLAS 27.2%
MONTGOMERY 13.8%
RUSSELL 13.5%
CHOCTAW 18.0%
MARENGO 20.1%
LOWNDES 28.7%
BULLOCK 26.6%
WILCOX 34.7%
BARBOUR 18.2%
BUTLER 18.6%
PIKE 18.8%
CLARKE 19.7%
17.1% CRENSHAW
MONROE 14.5%
HENRY 14.3%
9.5% DALE
WASHINGTON 17.5%
CONECUH 18.4%
COFFEE 9.8%
COVINGTON 13.7%
ESCAMBIA 13.5%
GENEVA 14.1%
11.1% HOUSTON
MOBILE 13.1%
BALDWIN 7.5%

FY 1991
ELIGIBLES
Percent Distribution

Table – 16

BY CATEGORY



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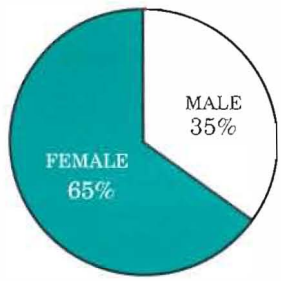

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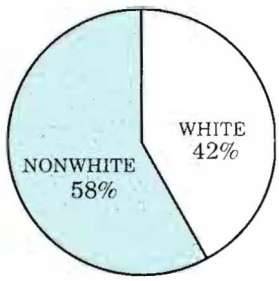

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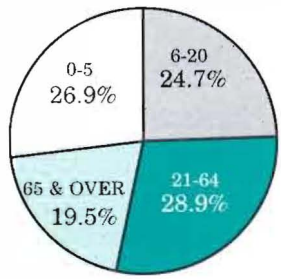


Recipients

Although there were 482,104 persons eligible for Medicaid in FY 1991, only 84 percent of these actually received benefits. These 405,557 persons are called recipients. The remaining 76,547 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 do not equal the unduplicated total.

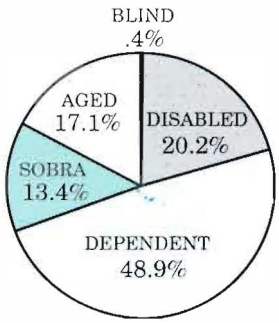
FY 1991 **Table – 17**
RECIPIENTS
Monthly Averages and Annual Total

Category	Monthly Average	Annual Total
Aged*	47,867	78,039
Blind	1,027	1,602
Disabled	59,271	91,764
Dependent	61,101	222,717
SOBRA	24,427	61,115
All Categories (unduplicated)	193,387	405,557

*(includes Qualified Medicare Beneficiaries)

FY 1991 **Table – 18**
RECIPIENTS
Percent Distribution

BY CATEGORY



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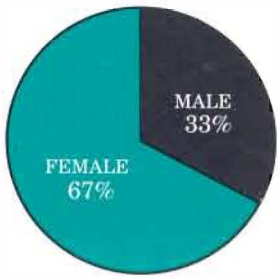

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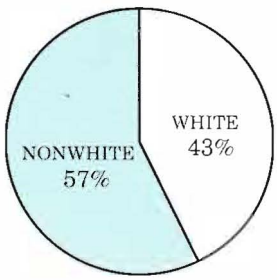

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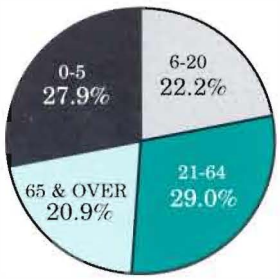


Use and Cost

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.

A useful way to compare costs of different groups of Medicaid eligibles and predicting how changes in eligibility and utilization will impact Medicaid is to measure cost per eligible. This measure is determined by dividing total payment for services by the total number of persons eligible during the year.

Statistics reveal that certain groups are much more expensive to the Medicaid program than others. The reason for the difference is that some groups tend to need more expensive services. Any Medicaid eligible receives, within reasonable limitations, medically necessary services.

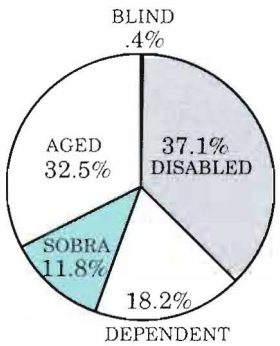
A good example of this is the pattern of use of long-term care. This type of care has a high cost per unit of service, and recipients of long-term care have a high frequency-of-service rate. The average Medicaid payment for a day of long-term care in FY 1991 was $42. The average length of stay for recipients of this service was 253 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 coinsurance covered by Medicaid. For this coverage, Medicaid paid a monthly buy-in fee to Medicare which in FY 1991 was $29.90 per eligible Medicare beneficiary. Medicaid paid $36.9 million in buy-in fees in FY 1991. Paying the buy-in fees is very cost effective for Medicaid because, otherwise, the Agency would incur the full payment for medical bills instead of for only the premiums, deductibles, and coinsurance.

FY 1991
PAYMENTS
Percent Distribution

Table – 19

BY CATEGORY



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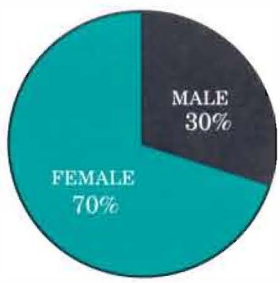

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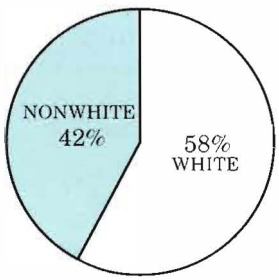

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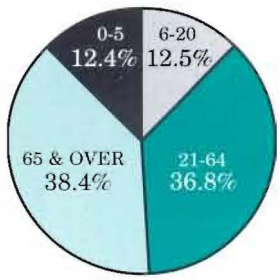
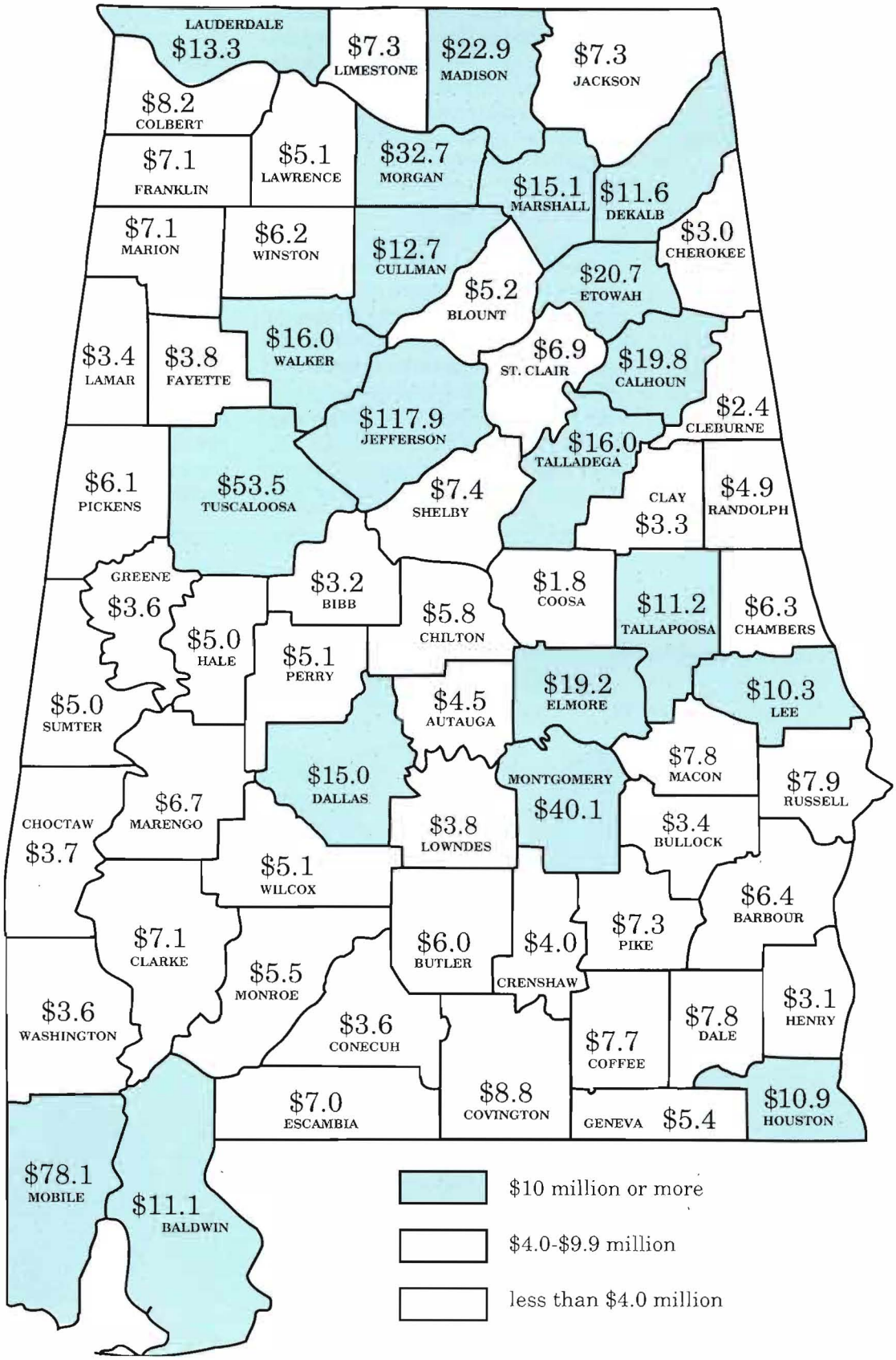


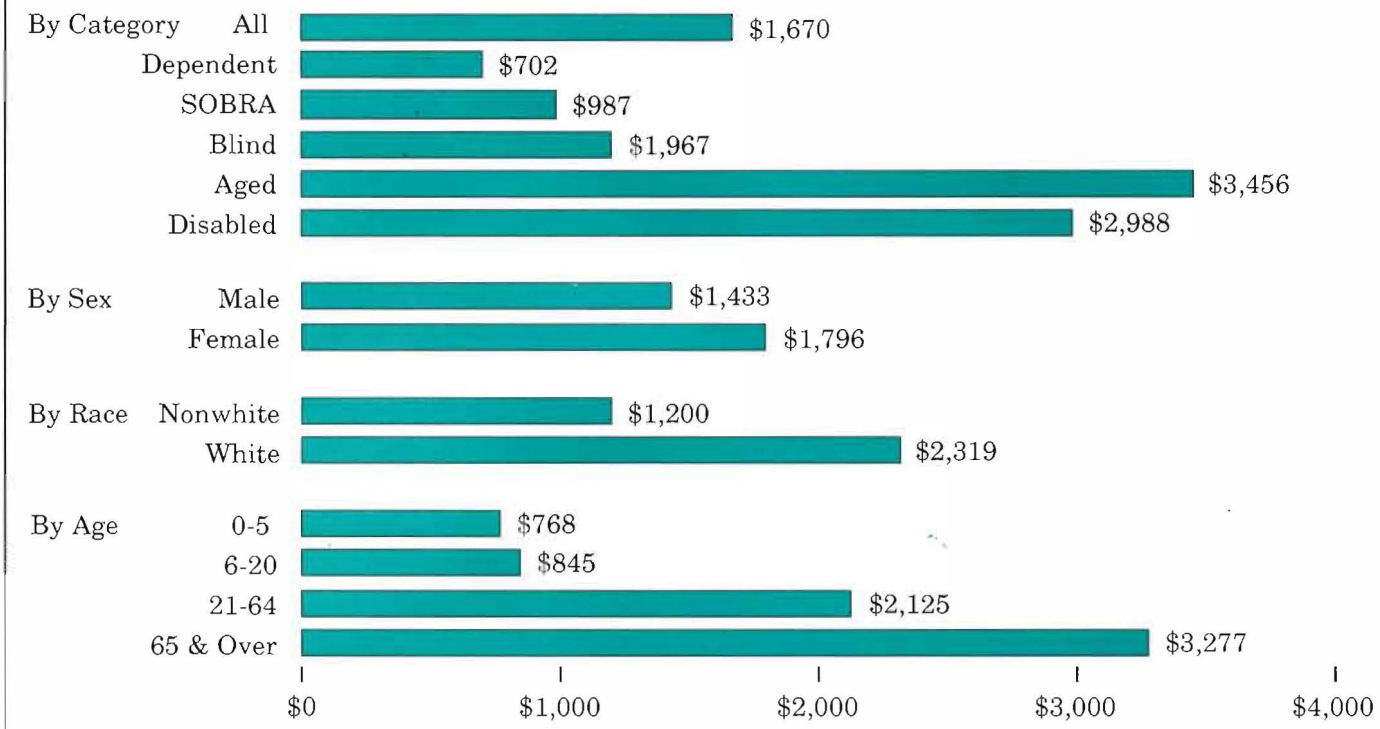
FY 1991
PAYMENTS
By County (in millions of dollars)

Table – 20



FY 1991
Cost Per Eligible

Table – 21



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.

The one function of the Division is to make certain the Medicaid Agency is performing eligibility determinations as accurately as possible. This is accomplished by performing in-depth reviews of eligibility determinations on a sample of Medicaid eligibles. The findings of these reviews are then used to compute an error rate. If a state's error rate in determining Medicaid eligibility exceeds three percent, the Health Care Financing Administration (HCFA) imposes a financial sanction.

Processing and payment of Medicaid claims are monitored through administration of the Claims Processing Assessment System (CPAS). As with quality control, an error rate is determined based upon sample reviews of Medicaid claims processed. The error rate for FY 1991 was 0.06 percent, which was significantly less than the HCFA projected target rate of one percent. In addition to CPAS claims reviews, targeted reviews of claims are performed when potential systems errors are found as well as periodic reviews of forced claims, denied claims and suspect duplicate drug claims. More than 13,000 claims were manually reviewed during the 1991 fiscal year to verify their accuracy. A testing process referred to as Bill Processing Systems Test (BPST) is also utilized to verify that new systems edits have been properly implemented or to verify that existing edits are accomplishing the specified intent. Also monitored are 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 claims adjustments.

The Program Integrity Division also recovers funds from individuals who received Medicaid services they were not entitled to receive. In most instances these cases involve people who, through neglect or fraud, did not report income or assets. The Division received 1,747 new cases in FY 1991. Aided by staff from the legal, fiscal, and eligibility divisions the unit identified $1,108,693.09 and collected $641,841.97 in misspent dollars.

The Program Integrity Division looks for fraud, abuse and/or misuse in the Medicaid program. Computer programs are used to find unusual patterns of utilization on the part of both providers and recipients. During FY 1991, there were 283 providers reviewed. Recoupments and net adjustments for the fiscal year totaled $102,240.70. There were 487 recipients reviewed in fiscal year 1991.

Medical, programmatic, and financial experts are used to recommend several types of corrective action in cases of aberrant utilization. Corrective actions range from written warnings to administrative sanctions such as restrictions or terminations from the program and recoupment of funds. A recipient who abuses Medicaid privileges may be restricted to receiving services from certain providers. This is one administrative sanction used to control recipient abuse of the Medicaid program. The average monthly number of recipients on restriction status during 1991 was 171. During FY 1991, 223 recipients were terminated from the Medicaid program, six provider cases were referred to the Attorney General's Medicaid Fraud Control Unit, eight providers were referred to the Board of Medical Examiners, and 101 recipients were restricted to one physician and one pharmacy.

The Alabama Legislature has provided two specific criminal statutes which enable Medicaid to be effective in pursuing fraud and abuse cases. One law allows Medicaid to deny or revoke eligibility to persons who have abused, defrauded, or in any way misused the benefits of the program. The other law makes it a felony offense for a recipient or provider who knowingly give false information on a claim or application. This law also applies penalties for kickbacks or bribery attempts. A recipient or provider convicted of Medicaid fraud under this statute may be fined $10,000 for each count and given a jail sentence of one to five years. Under this statutory authority, the Program Integrity Division opened 253 cases and closed 312 cases during 1991. During FY 1991, 44 were recipient drug abuse cases which were presented to local district attorneys for possible prosecution. In addition, this unit now investigates complaints of civil rights violations pertaining to Medicaid recipients or providers.

Medicaid Management Information Systems

The Agency's Management Information Systems (MMIS) maintain provider and recipient eligibility records, process all Medicaid claims from providers, keep track of program expenditures, and furnish reports that allow Medicaid administrators to monitor the pulse of the program.

In-house systems staff completed 2,594 software requests in FY 1991 to support the MMIS and aid Agency decision-making. The most significant project undertaken was the establishment of a statewide data network for the outstationed eligibility workers. This network enables direct, real-time updating of all SOBRA applications and eligibles. Another major project was the implementation of the national drug rebate program in Alabama which recovered over $2 million in the last three months of FY 1991.

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, with the current contract period beginning October 1, 1988. The company's performance in claims processing has been among the best in the nation. EDS is constantly making changes to the MMIS to meet the needs of the program.

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 1991 Medicaid served an additional 27,015 women and 69,147 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: The latest birth statistics compiled revealed that in 1990 the number of births to women aged 10-19 increased slightly in Alabama from 11,405 in 1989 to 11,557. There were 312 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 cost of caring for low birth weight babies.

Prenatal care for Medicaid eligible recipients is provided through private physicians, hospitals, public health department clinics and federally qualified health centers.

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 in Alabama 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 1991, two additional postpartum visits were authorized for recipients

with obstetrical complications such as infection of surgical wounds.

In 1988, the Medicaid Agency implemented a policy that would allow pregnant women at 100 percent of the poverty level to qualify for Medicaid benefits. In April 1990, Medicaid expanded eligibility for pregnant women to 133 percent of the federal poverty level. 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.

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 care coordination (also known as case management) and the direction of women to certain caregivers.

Care coordinators work with the women to set up a plan of care, make appropriate referrals, provide education, follow up on missed appointments, assist with transportation, and provide other services.

During FY 1991, there were 22 counties participating in the maternity waiver. Those counties were: Autauga, Bibb, Blount, Bullock, Calhoun, Elmore, Etowah, Greene, Hale, Henry, Houston, Jefferson, Lawrence, Lowndes, Macon, Mobile, Montgomery, Morgan, Pickens, Shelby, Sumter, and Tuscaloosa. Statewide expansion of the waiver is planned so that all Medicaid eligible pregnant women can participate in this innovative and successful approach to healthier birth outcomes.

Directing the patients to 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 care coordinators 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 pregnancy. Women in waiver counties receive an average of nine prenatal visits as opposed to only three prenatal visits prior to the waiver. Babies born in waiver counties require fewer neonatal intensive care days which translates into not only healthy babies but also reduced expenditures for the Agency.

Nurse Midwife Program: The nurse midwife program was implemented in 1982 in order to facilitate access to maternity care for the Medicaid population. Since that time, enrollment of nurse midwives has increased to 16 providers.

To participate in the program, the nurse midwife must show proof of RN licensure, certified nurse midwife licensure, and a written signed agreement between the nurse midwife and the physician consultant. A contractual agreement with the Medicaid Agency also is required.

Nurse midwife services include global obstetrical deliveries, walk-in deliveries, antepartum care, postpartum care, circumcision of the newborn, and individual prenatal office visits. All services are performed with appropriate physician consultation.

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 72.2 percent in FY 1991. For family planning services, the federal share is 90 percent.

Family planning providers include health department clinics, federally qualified health centers, private physicians, community health clinics, and Planned Parenthood of Alabama. Services include physical examinations, pap smears, pregnancy and venereal disease testing, counseling, provision of oral contraceptives, other drugs, supplies and devices including implants, and referral for needed services. A home visit family planning service is available for newly delivered mothers. This allows recipients to begin the birth control of their choice prior to the postpartum visit in the clinic.

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.

EPSDT - MediKids: The Early and Periodic Screening, Diagnosis and Treatment Program,

named MediKids in Alabama, 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. All medically necessary services to correct or improve the condition are unlimited if the condition was identified during or as a result of a screening. The Medicaid program also benefits by realizing long term savings by intervening before a medical problem requires expensive acute care.

Although EPSDT 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. Eligibles for the EPSDT program are persons under 21 years of age who receive assistance through the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) programs. Also included among eligibles are children up to six years old in families with income at or below 133 percent of the federal poverty level and children born after September 30, 1983 in families with incomes up to 100 percent of the federal poverty level. Department of Human Resources workers normally determine AFDC eligibility, make families aware of EPSDT, and refer eligibles to providers. Medicaid eligibility workers determine eligibility for pregnant women and young children over the income limit for SSI.

Currently there are more than 350 providers of EPSDT services, including county health departments, community health centers, Head Start centers, child development centers, and private physicians. Efforts are being made to increase the number of physicians to the EPSDT program and to increase the number of EPSDT eligibles using the screening services. Since screening is not mandatory, many mothers do not seek preventive health care for their children.

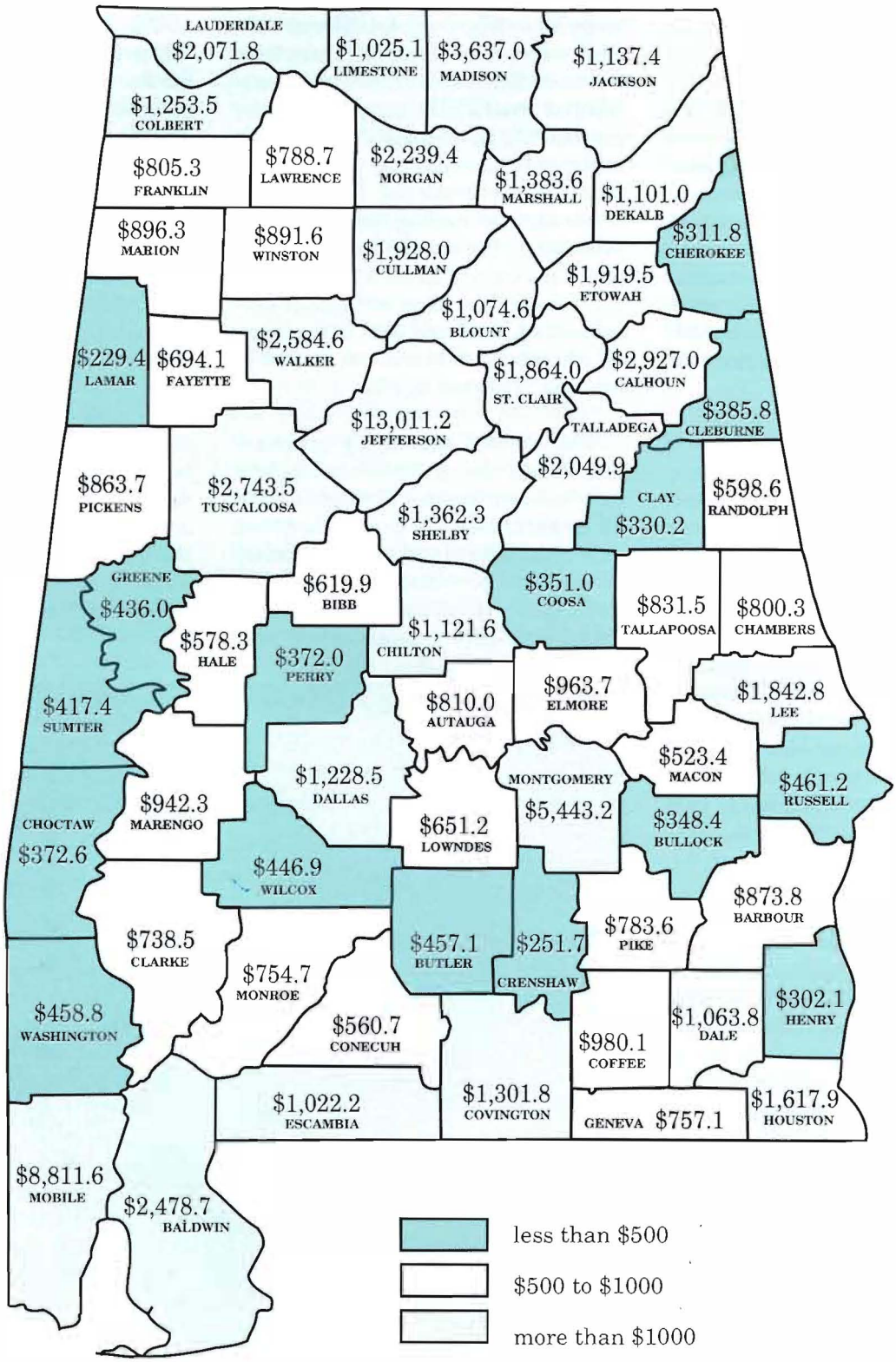
Steps have been taken in recent years to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of intensive outreach statewide, enhancing physicians' reimbursement rate for EPSDT screening and raising the number of screenings for which Medicaid will pay. Because of these added efforts, there have been more screenings performed. A Medicaid goal is to screen all eligible children at 20 intervals between birth and age 21.

The EPSDT 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 EPSDT 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, hospitalization and some out-of-state care.

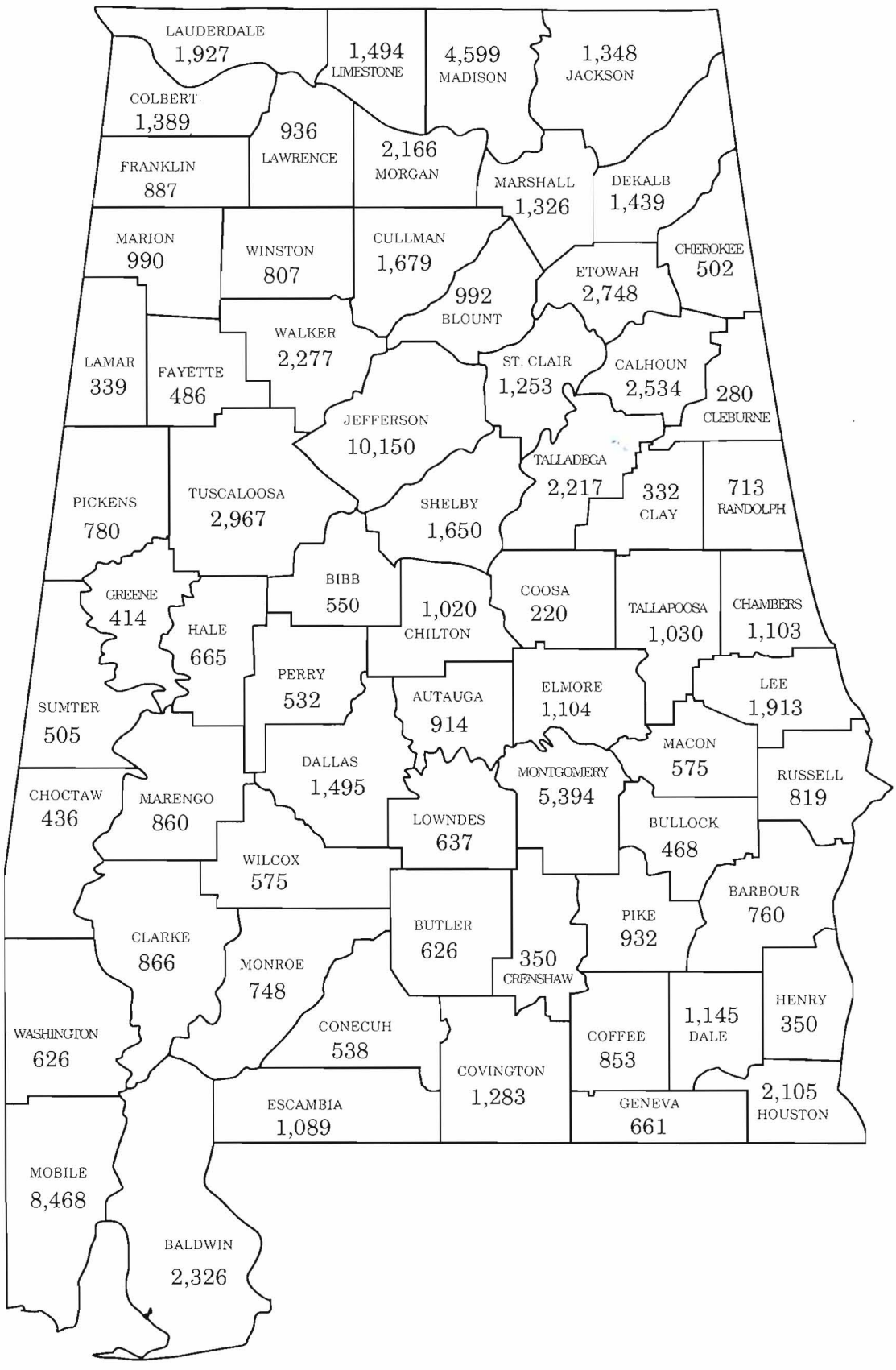
FY 1991
MEDICAID PAYMENTS FOR SOBRA ELIGIBLES
(In Thousands)

Table - 22



FY 1991
SOBRA ELIGIBLES

Table – 23



Healthy Beginnings

During FY 1991, the Healthy Beginnings program entered its second year of encouraging all expectant women in Alabama to seek early and continuous prenatal care. The program is based on a booklet of coupons full of free or discounted items for mother and baby from a variety of contributors such as drug stores and grocery stores. The booklet also includes pertinent information concerning healthy lifestyles during pregnancy as well as how to qualify for programs such as Women, Infants, and Children (WIC) and Medicaid. Coupons corresponding a woman's pregnancy are validated each time the woman visits her health care provider for prenatal care. The booklets are obtained by calling the program's toll-free number: 1-800-545-1098.

Healthy Beginnings has been recognized at the local, state, regional and national levels with a variety of awards in recognition of the program and the television spots produced in conjunction with the project. Of particular note is the receipt of one of five 1991 National Achievement Awards presented by Healthy Mothers/Healthy Babies, a coalition of more than 90 organizations which serve as advocates for maternal and child health in the United States. This award was presented at the National Institutes of Health, Bethesda, Maryland, in conjunction with national Child Health Day on October 7, 1991.

The program is guided by a 30-member advisory committee comprised of physicians, advocacy groups representatives, health professionals, news media, state legislators, and others with an interest in maternal and child health. Healthy Beginnings has been evaluated via focus group studies and a statewide telephone/mail survey conducted by a state university. Survey results are being used to plan future activities and to refine the program to better communicate with women and teens at risk of having a low birth weight infant, and to reach them at an earlier point of pregnancy. An expansion of the Healthy Beginnings program is planned to include the first year of life, emphasizing early, preventive care for infants, breastfeeding, positive parenting behaviors, and good nutrition.

Special emphasis has been placed on networking with private organizations broaden support for improving the infant mortality rate in Alabama. Additionally, Medicaid staff has made numerous presentations regarding the project to mental health professionals, school nurses, and guidance counselors in an effort to build a coalition in support of preventive care for expectant women and young children. Current plans call for working with religious and other private sector groups in the coming year.

First-year program highlights:

* In the program's first year, approximately 22,000 calls were received from expectant women and teens.

* While teens account for 18 percent of all births in Alabama, 30 percent of all calls are from teenagers.

* Seventy-eight percent of all calls are from Medicaid recipients or from uninsured women.

* There were 146 calls received from women who could not obtain care.

* Sixty percent of callers are receiving care at a clinic while 40 percent are receiving care from a private physician.

* Sixty-two percent of all callers are white; 37.5 percent are black, paralleling the general population of the state.

* One-third of all callers have less than a high school education.

Managed Care

Many states are redesigning their Medicaid programs from a traditional fee-for-service health care delivery system to a managed care approach. This concept promotes a coordinated and comprehensive system of health care services that emphasizes prevention and education. There is substantial evidence that managed care plans provide quality health care at less cost than fee-for-service. The goal of the Managed Care Program is to develop a quality, accessible, and cost effective system of care for all Medicaid eligibles. The Alabama Medicaid Agency plans to initiate the managed care concept for all geographical areas of the state over the next five years.

Managed care is a coordinated strategy designed so that a primary health care provider or case manager may provide care directly to patients and authorize all other health care, except true emergencies, that is received by the patient.

With fee-for-service, access to health care services is limited for many Medicaid recipients. Many beneficiaries lack a routine system of coordinated and continuous health care. This lack of care usually results in fragmentation, duplication of services, and indiscriminate "doctor shopping." Under the managed care concept, the patient is directed to use a primary provider, and the unnecessary use of hospital emergency rooms, drug prescriptions, and medical tests are eliminated.

Mental Health Services: Through mental health centers under contract with the Department of Mental Health and Mental Retardation, Medicaid provides services for eligible mentally ill adults and emotionally disturbed children. These services include day treatment, medication check, diagnostic assessment, pre-hospitalization screening, and psychotherapy for individuals, groups and families. The program serves people with primary psychiatric and substance abuse diagnoses. There are 25 mental health centers around the state providing these services. On a monthly average during FY 1991, about $1.5 million was spent to provide services to approximately 6,500 clients.

Targeted Case Management: Since 1988, the Medicaid Agency has offered case management to two target groups, mentally ill adults and mentally retarded adults, as long as the individuals are Medicaid eligible. Case management to these two groups includes assessment of the individual's condition, developing a plan of care, coordinating needed services, following up on the individual's progress and reassessment of the condition.

As a result of cooperation among the Department of Public Health, Department of Human Resources, Children's Rehabilitation Services, and the Alabama Institute for the Deaf and Blind, case management was expanded in recent years to include four additional target groups. Medicaid eligible handicapped children, foster children, pregnant women, and AIDS/HIV positive individuals also may receive the same benefits of case management as mentally ill or mentally retarded individuals. In September 1991, the definition of handicapped children was expanded to include the developmentally delayed. The addition of new providers is anticipated to assist the targeted groups in gaining access to medical, social, educational and other services.

Waiver and Home Care Services

The Medicaid Agency administers several programs that provide alternatives to institutionalization of Medicaid eligibles. The waiver programs, mental health services program, and the home-care services program serve the elderly and disabled, mentally retarded, and chronically mentally ill Medicaid populations. These programs provide quality and cost-effective services to individuals at risk of institutional care.

Waiver Services: Like many other states, Alabama has taken advantage of the provisions of the federal Omnibus Budget Reconciliation Act of 1981 and has developed Home and Community Based Service (HCBS) waivers that provide alternatives to institutionalization. The waiver programs are aimed at helping recipients receive extra services that are not ordinarily covered by the Medicaid program in this state.

The largest HCBS waiver serves elderly and disabled persons at risk of nursing home placement. This waiver offers basic services such as case management, homemaker services, personal care, adult day health and respite care. During FY 1991, there were 5,589 recipients served by the waiver for the elderly and disabled at an average annual cost of $4,154 per recipient. Serving the same recipients in nursing facilities would have cost the state about $7,608 per person. Given these figures, the state saved approximately $19,304,400, but just as important, the people on the waiver were able to remain in the community to receive the care they needed.

People receiving services through Medicaid waivers must meet certain eligibility requirements. Those served by the waiver for the elderly and disabled are recipients of Supplemental Security Income (SSI) or State Supplementation who meet the medical criteria for nursing home care financed 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.

Another HCBS waiver serves individuals who meet the definition of mental retardation or developmentally disabled. The waiver provides habilitation services, group home services, supervised community living arrangement services, and respite care to Medicaid eligible mentally retarded clients. The Department of Mental Health and Mental Retardation contracts with providers statewide to provide services for the waiver. The 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. During FY 1991, it cost an average of $8,813 per recipient to care for the 1,363 recipients on the waiver for the mentally retarded and developmentally disabled. Institutional costs for this group for one year would have been approximately $47,531 per recipient. Providing care in the community for the recipients eligible for this waiver saved the state $52,772,838.

The waiver services program is working with other state agencies to develop additional programs to serve Medicaid eligibles in the community. The waiver programs have proven that quality, cost effective care can be provided in a community setting.

Home care services to Medicaid eligibles under the age of 21 have been greatly expanded because of the Omnibus Budget Reconciliation Act of 1989. This law states that any service necessary to treat or ameliorate a condition must be provided to any Medicaid eligible under 21 years of age as long as the condition is discovered as a result of a medical check-up through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). This provision of OBRA 1989 will greatly increase the number of children that can be served in the community. Occupational therapy, physical therapy, durable medical equipment, and other services as necessary to maintain Medicaid eligibles in the home are available to Medicaid eligibles under 21 as of April 1, 1990.

Home Health and Durable Medical Equipment: Skilled nursing and home health aide services prescribed by a physician are provided to eligible homebound recipients on a part-time or intermittent basis. These services cover preventive, restorative, and supportive care to persons who meet Medicaid home health criteria. 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. There were 110 agencies participating in FY 1991.

Up to 104 home health visits per year may be covered by the Medicaid Agency. In calendar year 1991, 5,898 recipients received a total of 315,205 visits at a cost of over $10,949,384.

Supplies, appliances, and durable medical equipment are mandatory benefits under the home

health program. Medicaid recipients do not have to receive home health services to qualify for services, 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 175,125 units of service at a cost of $1,340,316.

In-Home Therapies:

Physical, speech, and occupational therapy in the home is limited to individuals under 21 years of age referred from an EPSDT screening. If certified as medically necessary by a physician, services must be provided through a Medicaid certified home health agency. All therapy services rendered in the home require prior authorization by the Alabama Medicaid Agency.

Private Duty Nursing:

Private duty nursing services in the home are covered for eligible recipients requiring continuous nursing care. The services are available only for recipients under age 21 prescribed as a result of an EPSDT screening referral. Private duty nursing care is only provided to a recipient in his or her home and must be rendered by a registered nurse or a licensed practical nurse. For Medicaid coverage, at least four hours of continuous skilled nursing care are required.

Private duty nursing services must be prior authorized by Medicaid. All services require monitoring on a regular basis, generally every 60 days, with the physician providing recertification of the continuing need for care.

During the last fiscal year, Medicaid paid $227,123 for services provided to 54 recipients through 14 private duty nursing providers.

Personal Care Services:

Personal care services are available only for recipients under age 21 who have exhausted the home health benefit of 104 nursing visits per calendar year. The service must be

referred from an EPSDT screening and prescribed as medically necessary by a physician. Personal care services are provided through Medicaid contract home health agencies at the recipient's place of residence. Personal care services include but are not limited to bed bath, sponge, tub, or shower bath, shampoo, nail and skin care, oral hygiene, toileting, and elimination.

Home Care Services: The Medicaid home care services program is to help people with an illness, injury, or disability receive the quality care they need at home. Through the utilization of registered nurses, licensed practical nurses, home health aides/orderlies/homemakers, physical therapists, occupational therapists, speech therapists, respiratory therapists, medical equipment supplies, orthopedists, prosthetists, physicians, and hospices, recipients are provided services that are needed for them to remain at home and maintain their highest level of independence at a cost-saving to Medicaid.

Due to changes in the health care delivery system, the demand for home care 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. In additional, expansions mandated under the EPSDT program have made Alabama Medicaid home care services one of the most comprehensive medical assistance programs for children in the country.

The Medicaid home care services program is based on the philosophy of family and patient participation in providing patient care. Working together, families and patients are taught care which can reasonably and safely be rendered in the home.

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 117 Alabama hospitals that participate in the Medicaid program, and 30 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. The inpatient utilization review unit of the Alabama Medicaid Agency performs the duties outlined in the regulations. There are 70 in-state hospitals in Alabama that are considered "delegated" and do their own utilization review; 47 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.

Inpatient hospital days were limited to 14 days per calendar year in FY 1991. However, additional days are available in the following instances:

* When a child has been found, through an EPSDT screening to have a condition tha needs treatment
* When authorized for deliveries (onset of active labor through discharge).

There are some instances when inpatient days are unlimited. Children under one year of age may receive unlimited inpatient days in any hospital. Children under six years of age may receive unlimited inpatient days in hospitals designated by Medicaid as disproportionate share hospitals.

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, radiation therapy, and visits solely for lab and x-ray services. 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.

In April 1991, coverage for transplants was expanded. In addition to kidney and cornea transplants, which do not require prior approval, Medicaid added coverage for prior authorized heart transplants and liver transplants for recipients 21 years of age and above. Eligible recipients requiring heart transplants, liver transplants or bone marrow transplants must meet the medical criteria in the Alabama Medicaid Organ Transplant manual.

Transplant services are limited to in-state providers unless there are no in-state providers available to perform the procedure.

Ambulatory Surgical Centers: Medicaid covers ambulatory surgical center services, which are procedures that 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 outpatient surgical list.

A listing of more than 2,100 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 surgical center providers are required to collect the designated copayment amount for each visit. At the end of FY 1991, 16 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 41 freestanding facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis and CAPD (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 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 1991, three rural health clinics were enrolled as providers in the Medicaid program.

Federally Qualified Health Centers: The Medicaid federally qualified health centers program was implemented April 1, 1990, as a result of the Omnibus Budget Reconciliation Act of 1989. Certain community health centers, migrant health centers, and health care for the homeless programs are automatically qualified to be enrolled, with others able to be certified as "look alike" FQHCs.

Services covered by the FQHC program include ambulatory services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers employed by the FQHC. Federally qualified health centers are reimbursed by an encounter rate based at 100 percent of reasonable cost. Medicaid establishes reasonable cost by using the centers' annual cost reports. At the end of FY 1991, 15 FQHCs were enrolled as providers.

Inpatient Psychiatric Program: The inpatient psychiatric program was implemented by the Medicaid Agency in May 1989. This program provides medically necessary inpatient psychiatric services for recipients under the age of 21 if services are authorized by the Alabama Medicaid Agency and rendered in Medicaid contracted psychiatric hospitals. Only psychiatric hospitals which are approved by the Joint Commission for Accreditation of Healthcare Organizations and have distinct units and separate treatment programs for children and adolescents can be certified to participate in this program. At the end of FY 1991, there were six hospitals enrolled.

Persons participating in the programs must meet certain qualifications and the services performed must be expected to reasonably improve the patient's condition or prevent further regression.

An individualized active treatment plan must be developed by the treatment team for each recipient and forwarded to the Medicaid Agency for authorization of services.

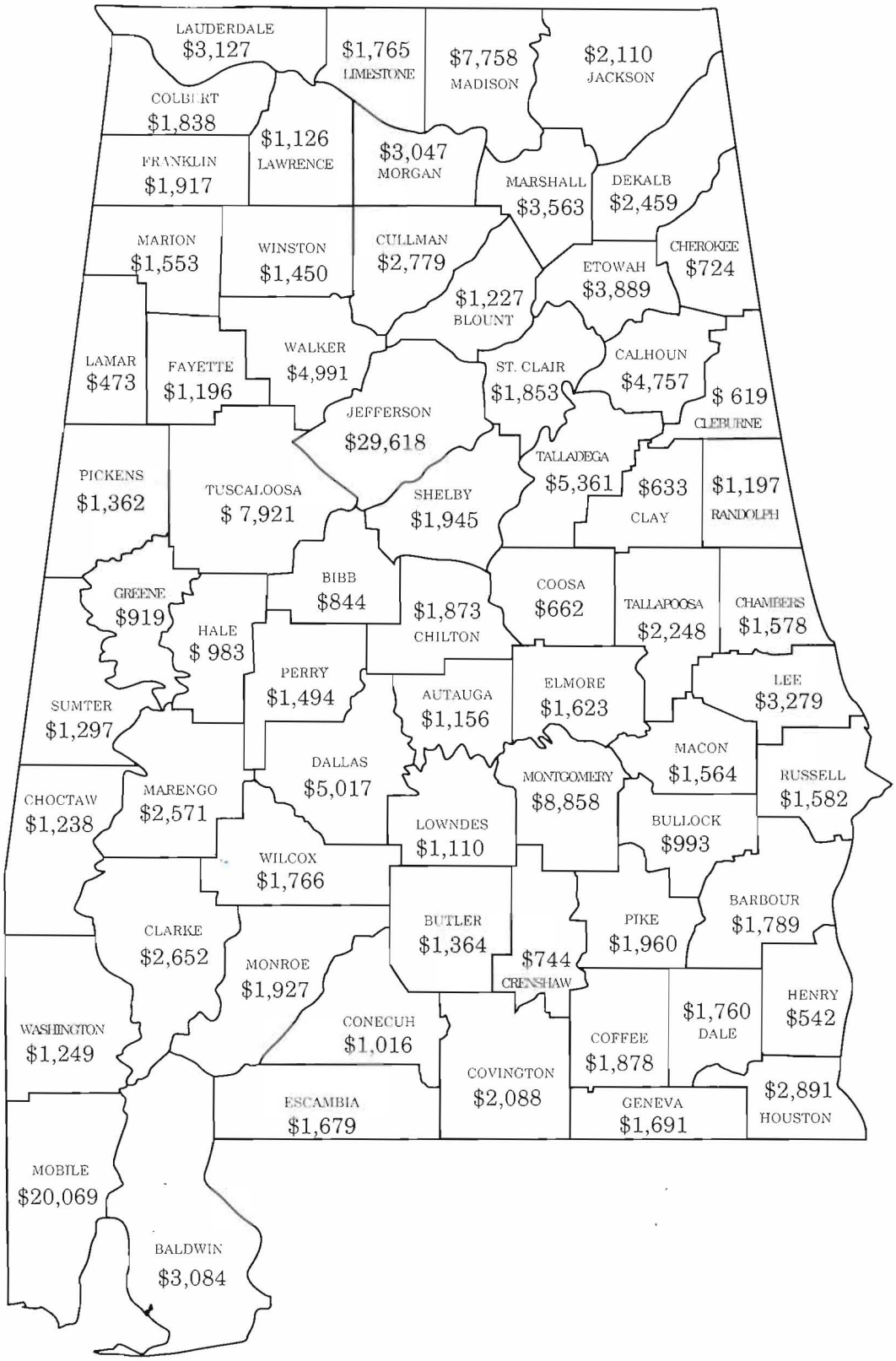
FY 1989-1991
HOSPITAL PROGRAM
Changes in Use and Cost

Table – 24

Year	Recipients of Inpatient Care	Payments For Services	Medicaid's Annual Cost Per Recipient
1989	58,733	$105,900,822	$1,803
1990	60,350	$135,255,262	$2,241
1991	64,677	$176,397,312	$2,727

FY 1990
PAYMENTS TO HOSPITALS
By County (in thousands of dollars)

Table – 25



FY 1987-1991
HOSPITAL PROGRAM
Outpatients

Table – 26

	FY '87	FY '88	FY '89	FY '90	FY '91
Number of outpatients	92,255	92,600	103,665	115,957	146,358
Percent of eligibles using outpatient services	25%	25%	27%	33%	30%
Annual expenditure for outpatient care	$6,801,149	$8,258,803	$9,605,911	$12,824,623	$19,094,131
Cost per patient	$74	$89	$93	$112	$130

Physicians 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. A little less than 75 percent of Alabama's Medicaid eligibles received physicians' services in FY 1991.

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

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.

Eye Care Program: The Alabama Medicaid eye care 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 or whenever medically necessary. 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 are 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 independent labs and x-ray facilities must sign a contract with Medicaid.

FY 1991
PHYSICIAN PROGRAM
Use and Cost

Table – 27

Category	Payments	Recipients	Cost Per Recipient
Aged	$4,237,078	53,402	$79
Blind	$348,496	1,318	$264
Disabled	$24,709,574	75,238	$328
Dependent	$48,039,221	208,619	$230
All Categories	$77,334,369	338,577	$228

FY 1989-1991
LAB AND X-RAY PROGRAM
Use and Cost

Table – 28

Year	Payments	Recipients	Annual Cost Per Recipient
1989	$1,626,541	51,097	$32
1990	$2,806,128	71,226	$39
1990	$4,841,269	110,900	$44

FY 1991
EYE CARE PROGRAM
Use and Cost

Table – 29

Category	Payments	Recipients	Cost Per Recipient
Optometric Service	$805,457	43,318	$19
Eyeglasses	$1,952,907	31,633	$62
TOTAL	$2,758,365	74,951	$37

Long-Term Care

Care for acutely ill, indigent residents in nursing facilities was mandated in 1965 with the enactment of Medicaid (Title XIX). The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) significantly impacted the nursing facility program. OBRA 87 was implemented October 1, 1990 and provided for improvements in health care for residents in nursing facilities. The law included better training for nurse aides, more rights and choices for residents in controlling their lives and surroundings and more opportunities for restorative care to help residents reach their full physical potential.

Since 1983, the average monthly count of nursing facility recipients has changed very little. Factors contributing to the stabilization of nursing facility use by Medicaid recipients 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 facility 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 impose a sanction denying payment for new Medicaid admissions. The denial of payment sanction provides an option for terminating a facility's provider agreement while still promoting correction of deficiencies.

Alabama changed reimbursement systems effective September 1, 1991. This new reimbursement system will help to maintain capital formation, improve access for heavy care, promote quality care and achieve cost containment. This new system will help provide the best possible health care to our needy elderly at the most affordable cost to the State of Alabama.

Alabama uses a Uniform Cost Report (UCR) to establish a Medicaid payment rate for a facility. Nursing facilities are reimbursed at a single rate based on allowed costs rather than the level of care provided to individual patients. The rate takes into consideration the nursing facility 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, consultation fees, dietary 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 1989-1991 **Table – 30**
LONG-TERM CARE PROGRAM
Patients, Months, and Costs

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
1989	21,272	229 Days	4,877,082	$31	$152,211,271
1990	21,648	235 Days	5,087,346	$33	$169,195,695
1991	21,730	253 Days	5,495,747	$42	$232,088,398

FY 1989-91 **Table – 31**

LONG-TERM CARE PROGRAM

Number and Percent of Beds Used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	Percent of Beds Used By Medicaid In An Average Month
1989	22,293	13,012	58.4%
1990	22,302	13,300	59.6%
1991	22,842	13,973	61.2%

FY 1991 **Table – 32**

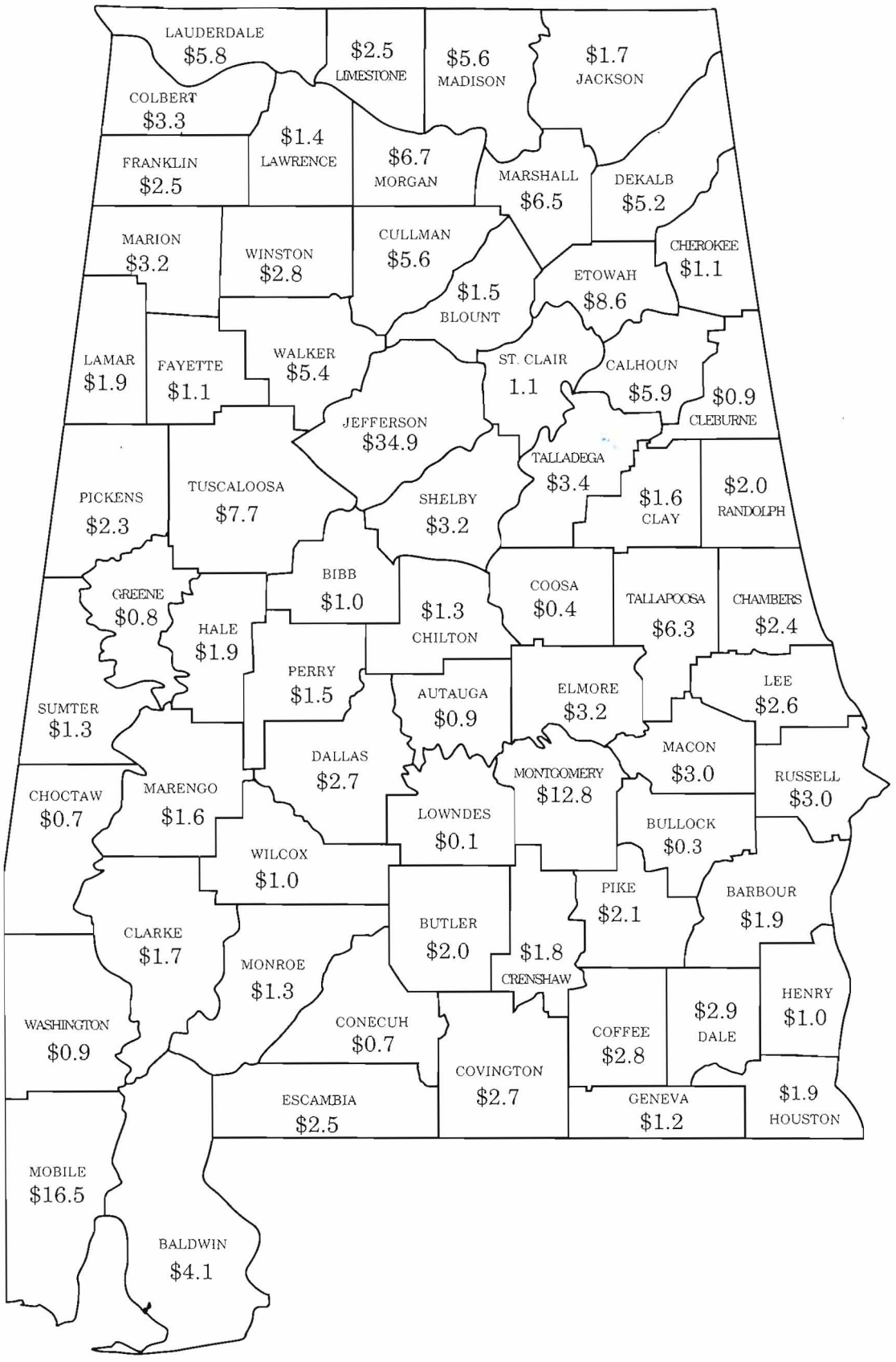
LONG-TERM CARE PROGRAM

Recipients and Payments by sex, race, and age

	Recipients	Payments	Cost Per Recipient
By Sex			
Female	16,157	$180,505,811	$11,172
Male	5,573	$51,582,587	$9,256
By Race			
White	17,076	$181,051,268	$10,603
Nonwhite	4,654	$51,037,130	$10,966
By Age			
0-5	25	$548,490	$21,940
6-20	259	$3,026,577	$11,686
21-64	3,050	$24,902,281	$8,165
65 & Over	18,396	$203,611,049	$11,068

FY 1991
PAYMENTS TO NURSING HOMES
By County (in millions of dollars)

Table – 33



Long-Term Care for the Mentally Ill

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. Tarwarter Developmental Center in Wetumpka, 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 Muscle Shoals Association for Retarded Citizens 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 Nursing Facility in Tuscaloosa, Claudette Box Nursing Facility in Mobile, and S. D. Allen Nursing Facility in Northport.

Payments for long-term mental health and mental retardation programs have increased dramatically, from less than $2 million in FY 1979 to more than $100 million in FY 1990. In FY 1989 the average payment per day in an institution serving the mentally retarded was approximately $136.

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 1991, 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 1983. 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 1991
LONG-TERM CARE PROGRAM
ICF-MR/MD

Table - 34

	ICF/MR	ICF/MD-Aged
Recipients	1,357	334
Total Payments	$72,228,436	$5,934,184
Annual Cost Per Recipient	$53,227	$17,767

Pharmaceutical Program

Although the pharmaceutical program is an optional service under federal Medicaid rules, it is economically 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 1991, pharmacy providers were paid approximately $76 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about 10 percent of MedicaId payments for services. The Medicaid Agency's reimbursement to participating pharmacists 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 to $3, depending on drug ingredient cost. The Omnibus Budget Reconciliation Act of 1990 expanded Medicaid coverage of reimburseable drugs. With the exception of allowable published exclusions, all drugs are now covered by the Medicaid Agency.

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 1991
PHARMACEUTICAL PROGRAM
Counts of Providers by Type

Table – 35

Type of Provider	Number
Retail	1,217
Institutional	35
Governmental	4
Dispensing Physician	1
Total	1,257

FY 1989-1991
PHARMACEUTICAL PROGRAM
Use and Cost

Table – 36

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
1989	236,608	61%	3,807,604	16.09	$13.74	$221	$52,313,877
1990	253,457	61%	3,983,206	15.72	$15.19	$239	$60,508,220
1991	293,119	61%	4,494,686	15.33	$16.92	$259	$76,028,149