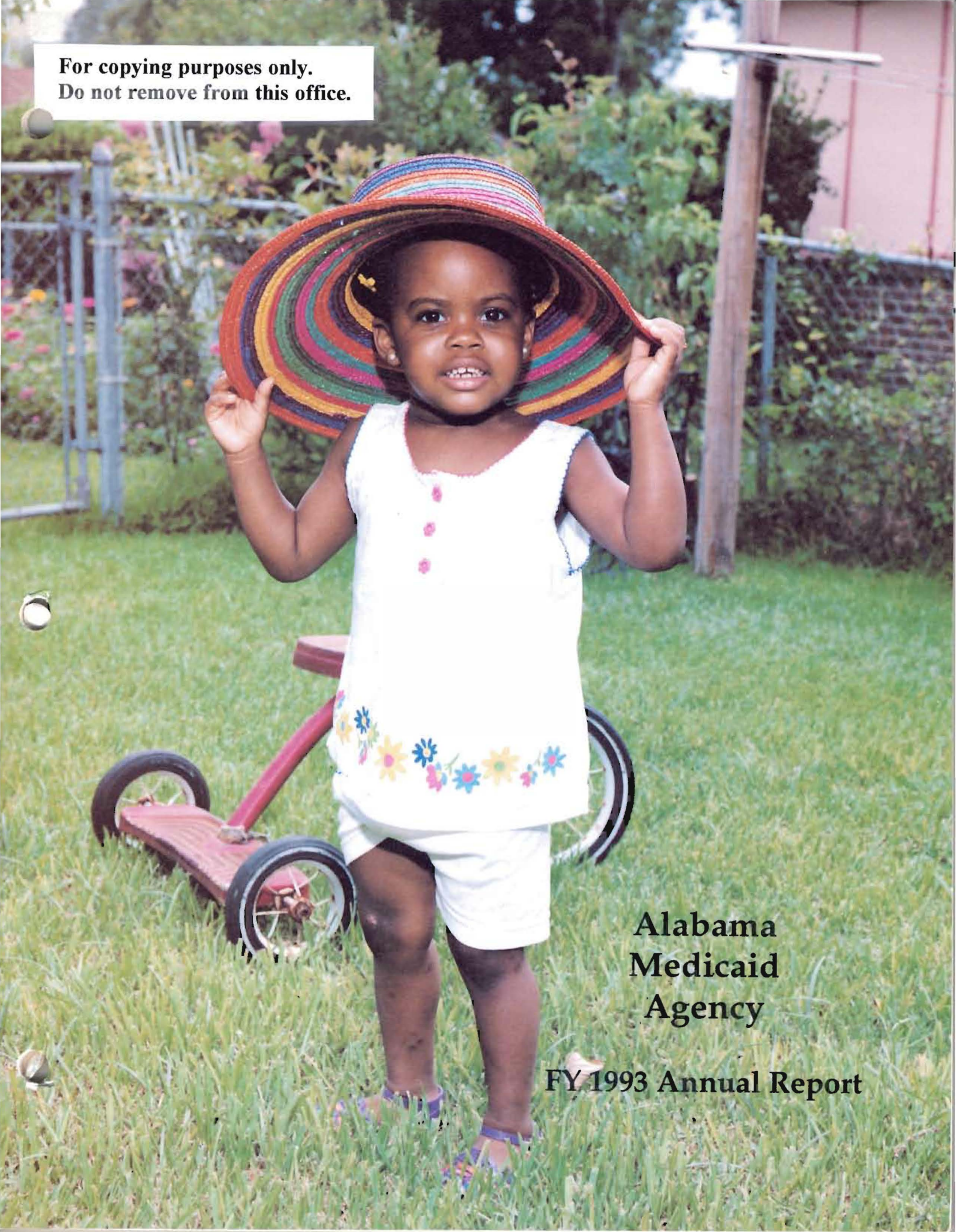

Alabama Medicaid Agency

FY 1993 Annual Report

Jim Folsom, Jr.
Governor
State of Alabama

David G. Toney
Commissioner
Alabama Medicaid Agency

Alabama Medicaid Agency
FY 1993 Annual Report
October 1, 1992 - September 30, 1993

Alabama Medicaid Agency

501 Dexter Ave.
P.O. Box 5624
Montgomery, Alabama 36103

JIM FOLSOM
Governor

David G. Toney
Commissioner

The Honorable Jim Folsom, Jr.
Governor of the State of Alabama
Alabama State Capitol
Montgomery, Alabama 36130

Dear Governor Folsom:

You have before you the twenty-first annual report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1992, and ended September 30, 1993.

The Medicaid program plays an important role in the health care system. For Alabama's low-income population, the Medicaid program is an essential link for a healthy, productive lifestyle. In FY 1993, there were almost 600,000 people eligible for health care services financed by Medicaid. There are almost 637,000 projected to be eligible in the upcoming year. For many of the rural and inner city urban areas, Medicaid is the only reimbursement health care providers receive and therefore plays a critical part in the economic development of the state.

I served as Commissioner only four months in FY 1993 and in those few months, the way was paved for many changes in the Medicaid program. Moving Medicaid to a more effective and cost efficient program is, and will continue to be, a top priority. I will continue to work diligently on the state's behalf in FY 1994 to ensure the Medicaid population receives the highest quality care at an economical cost to the taxpayers.

At Medicaid, we have been working hard to prepare the program for health care reform. President Clinton has made reworking this nation's health care system one of his top priorities. Alabama must be in the best possible position to benefit from the changes that are surely to come and I am proud to be on your team during this time of change.

Sincerely,

David G. Toney

David G. Toney
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 Outreach and Education Division of the Alabama Medicaid Agency. Statistical data was produced by the Agency's Planning and Analysis Division.

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List of Illustrations

Highlights

Introduction: Fiscally, the Agency recovered from Congress' action of November 1991 when it limited states' use of provider specific taxes. Medicaid and providers agreed on a solution that was within the guidelines of the federal government. Then, in February, Medicaid officials found the agency was going to be faced with a possible shortfall by the end of the fiscal year of $20.6 million in state funds. The shortfall was the result of unanticipated increases in the cost and utilization of services, including nursing home care, physicians services, health screening services for children (the Early and Periodic Screening, Diagnosis, and Treatment program), maternity services and expenses Medicaid is required to pay for certain Medicare beneficiaries.

Medicaid officials met with members of the legislature and members of the different provider groups to work out a solution. On April 8, after much discussion, a settlement was reached that, through the Disproportionate Share program, provided the Medicaid Agency with the money needed to avoid the shortfall in FY 1993. The Disproportionate Share program increases the Medicaid's state funding by accepting contributions from different groups of health care providers. The contributions are matched by the federal government. The providers, in return, receive their original contribution plus some additional money to help cover the cost of uncompensated care.

The two teaching hospitals, the University of Alabama at Birmingham and the University of South Alabama agreed to transfer additional money in the Disproportionate Share program that netted the agency the needed funding. Fiscal year 1993 ended with $95,820 carried forward into FY 1994.

While the Agency had to work through financial challenges, there were also successes during the year. Among the successes was the expansion of the agency's Maternity Waiver program. This program, long known for its valuable, cost efficient service to Medicaid eligible pregnant women, expanded into five additional counties. The expansion brought the total to 42 counties participating in the waiver — up from 38 participating counties during FY 1992. Those added were Chilton, Colbert, Franklin, Lauderdale, and Winston counties. Perry County, which started in the waiver in FY 1992, dropped out of the waiver in FY 1993. There were other successes . . .

Infant Mortality Was Reduced: The state's infant mortality rate dropped significantly during 1993 to the lowest rate in several years. During calendar year 1993, there were 10.5 deaths per 1,000 live births, compared to 11.2 deaths per 1,000 live births in calendar year 1992. During the past few years, outreach efforts in the state have helped to reduce the infant mortality rate. Efforts by the Medicaid Agency, Department of Public Health, advocacy groups, physicians, and a variety of health care organizations to educate women on the importance of early prenatal care and healthy lifestyles during pregnancy are credited with the reduction.

The state's infant mortality rate has declined over the last decade. The rate peaked at 13.3 deaths per 1,000 live births in 1983.

Federal Grant Was Awarded: Medicaid received approval of a federal grant that, in its first year, gave almost 1,000 low-income mothers and children easier access to a number of health and social services. The grant, which could total more than $864,000 over four years, will provide funding for a "one-stop shopping" project in Dallas County and later in Wilcox County. The one-stop shopping concept gets its name because individuals can go to one location to apply for a variety of health and social service programs.

The project began in January, 1993 when Medicaid placed an eligibility worker and the Alabama Department of Public Health placed a social worker in George Washington Carver public housing neighborhood located in Selma. The workers enter women and their children into a coordinated health care system of referral and follow-up and ensure those eligible have access to all available health and social services. The project will expand into Wilcox County and other neighborhoods in Dallas County.

The concept of one-stop shopping is helpful to recipients. Going to one location lessens the hardships and frustration often experienced by the low-income population when traveling to several places applying for a variety of health and social services. This is the first grant of its type to be awarded anywhere in the state of Alabama. Out of 217 applications submitted to the U.S. Public Health Service, only 32 grants were awarded nationwide.

The grant allowed the hiring of seven staff members which include a project coordinator, a Medicaid eligibility worker, a public health social worker, a van driver, and clerical support. Also included in the grant is a transportation system to enhance access to services.

Technology Was Improved: During FY 1993, Medicaid initiated a big change in the Medicaid cards recipients use to obtain health care from hospitals, physicians, pharmacists and other providers throughout the state. In November 1992, there was a change to permanent plastic cards for most Medicaid eligibles.

With the change, health care providers now have access to sophisticated new technologies for use in verifying the patient's eligibility for Medicaid, submitting claims for payment of services, and obtaining useful information on the patient.

Previously, Medicaid recipients were mailed a paper card every month to help identify themselves as Medicaid recipients when they obtained health care. The card was good for one month only. If the patient remained eligible for Medicaid, another card was mailed the next month.

The new cards resemble credit cards, complete with a magnetic stripe health care providers can use, with appropriate equipment, to verify the patient's eligibility, learn whether the patient has insurance besides Medicaid, see whether the patient has exhausted benefits such as doctor's visits, and electronically submit claims for payment of services. Alabama was one of the first states to introduce the new technologies into its Medicaid operation.

In making the transition to the new technologies, Medicaid worked closely with Electronic Data Systems (EDS), the company under contract with the agency to process claims from health care providers.

Technologies now available to providers to check the patient's eligibility for Medicaid and obtain other information include EDS's automated voice response system (AVRS), which requires only a touch-tone telephone, and the highly sophisticated Medicaid Automated Claims Submission and Adjudication System (MACSAS).

For MACSAS, health care providers need either a point of service device or a personal computer. Software for use with MACSAS is available free from EDS, which has worked with providers to give them all the information they need to become a part of the MACSAS network.

About 390,000 Medicaid recipients received the new plastic Medicaid cards. Other recipients — including residents of nursing homes and recipients for whom Medicaid has no social security numbers on file — do not receive the new cards.

A Recipient Inquiry Unit was set up specifically to answer recipients' questions about the new cards and replace cards as necessary. The unit's toll-free number for recipients to call if they have questions about new cards is 1-800-362-1504.

Medicaid staff worked with EDS for more than two years to plan for the improvements. The change is a first of its kind in the nation and it is an initiative other Medicaid agencies across the country are watching with interest.

The change to permanent Medicaid cards is saving the state money. Over the next three years, Medicaid should save an estimated one million dollars by not printing and mailing the monthly paper cards.

Low Payment Error Rate Was Announced: The Alabama Medicaid Agency had the lowest payment error rate of the Health Care Financing Administration's (HCFA) Region IV states. Included in Region IV are Tennessee, Kentucky, Georgia, Mississippi, North Carolina, South Carolina, Florida, and Alabama. Payment error rate is a measure used to show the percentage of payments made on behalf of people ineligible for Medicaid. The most recent estimate of annual payment error rates released in October, 1993 for the reporting period of October, 1991 through April, 1992, shows that Alabama's rate was .4276. The state with the next lowest rate was Georgia with an estimate of .8239 percent.

A low payment error rate reflects efficient management of a state's Medicaid program. States must maintain an error rate of less than three percent to avoid sanctions by the federal government.

Third Party Savings: Medicaid is a secondary payor to all third party resources, i.e., insurance companies, liability insurance carriers, absent parent medical support, and others. For FY 1993, approximately 11 percent of Medicaid eligibles were identified as covered by third party resources.

During the 1993 fiscal year, Medicaid's Third Party Section collected $4.1 million from third parties. Provider-reported collections from third parties saved Medicaid an additional $7.4 million.

In addition to these savings, Medicaid returned to providers claims totaling in excess of $30 mil-

lion because of potential health insurance resources. It is estimated these claims represent an additional $5 million in cost avoided savings never reported to Medicaid because third parties paid the claim in full.

Medicaid returned claims totaling $32 million to providers for submission to Medicare, the primary payor. In FY 1993 Medicaid also recouped $423,000 from providers who had received payment from both Medicaid and a third party.

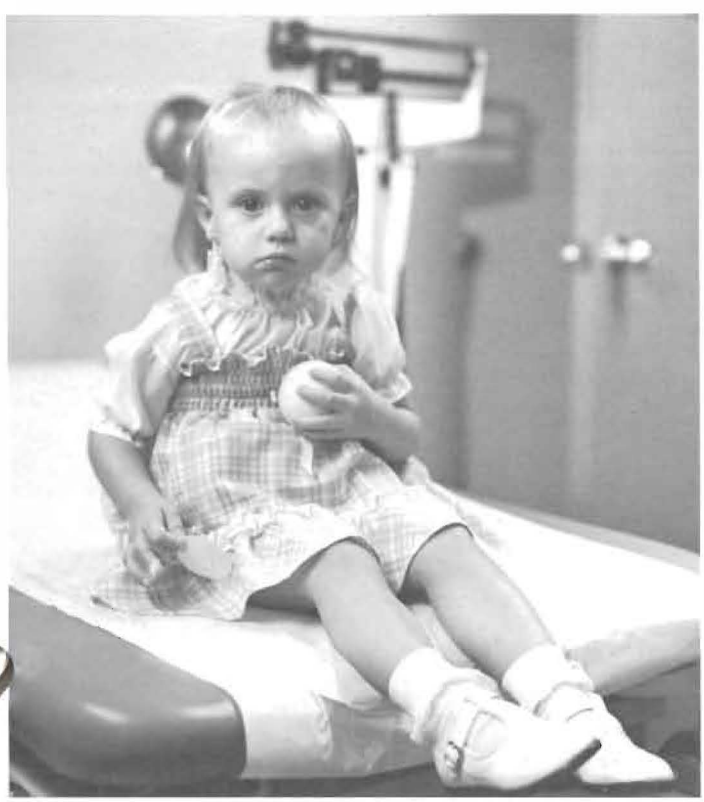
The Alabama Medicaid Agency continued in its partnership to pay health insurance premiums of Medicaid eligibles who had enrolled in a health plan with Humana Insurance Company. As of September 30, 1993, Medicaid was paying premiums for approximately 6,500 individuals who had taken out the Humana health plan.

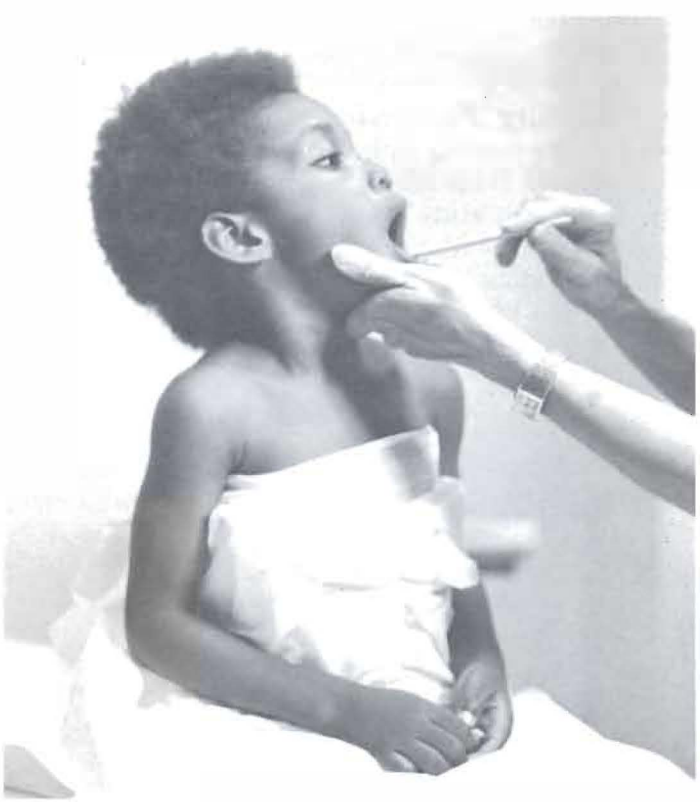
Looking Ahead: There was a major push to implement managed care in Jefferson and Shelby counties during FY 1993. Plans were made and the agency negotiated with health maintenance corporations, met with health care providers, and worked with the Health Care Financing Administration towards getting managed care implemented in the two counties by January 1, 1994. During FY 1994, there will continue to be concentrated efforts to implement managed care. The Jefferson and Shelby county area will not be implemented by the agency-imposed January 1994 deadline, but there will be other areas targeted for implementation.

Changes in the Disproportionate Share program will result in more negotiations with hospitals in the upcoming year. The Federal government will place more restrictions on the Disproportionate Share program effective FY 1995. The restrictions will require Alabama to again change the methodology used in the program in order to increase state funds. The Agency, along with providers, will spend much time working out the details of the new requirements in the upcoming year.

The Medicaid Agency will move its central office to a newly renovated state-owned office building in the state capitol complex in July of 1994. Along with the central office, the Montgomery District Office will also move. This is part of an effort to get more state agencies into state-owned office space.

President Clinton's health care reform package will continue to be debated during FY 1994. The Medicaid Agency will be working towards putting the program in a favorable position to implement the changes that are sure to come.





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. 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 1993, the formula was approximately 73/27. For every $27 the state spent, the federal government contributed $73.

Eligibility: Persons must fit into one of several categories 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. 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, hospitals, 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. Persons in this group may be eligible to have their Medicare premiums deductibles, and coinsurance 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. Medicaid District Offices determine eligibility for this group.

Persons in these eligibility categories may be eligible for retroactive Medicaid coverage if any medical bills had been incurred three months prior to the time of applying for Medicaid.

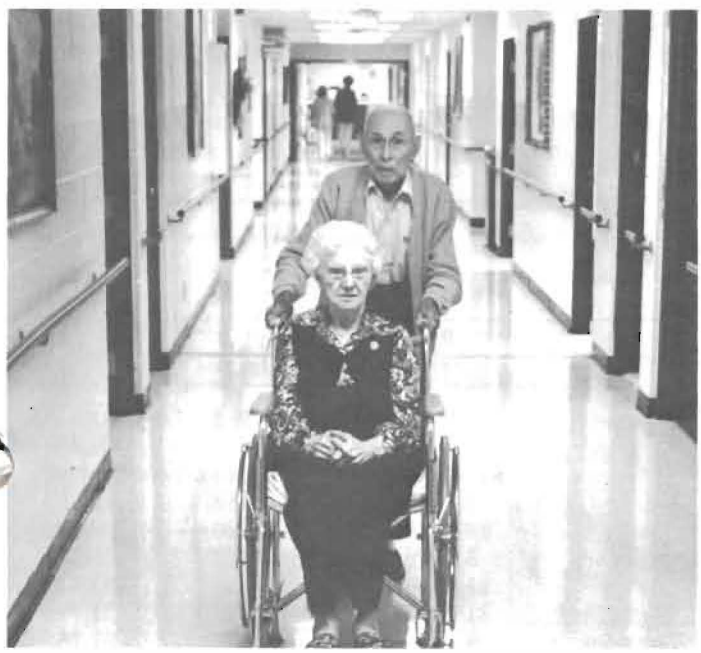
Some persons in eligibility categories are protected by federal law from losing their Medicaid benefits. One of those categories includes Pickle (or Continued Medicaid) cases. Persons in this category receive Social Security and would also receive SSI if the cost of living raises did not push them above 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.

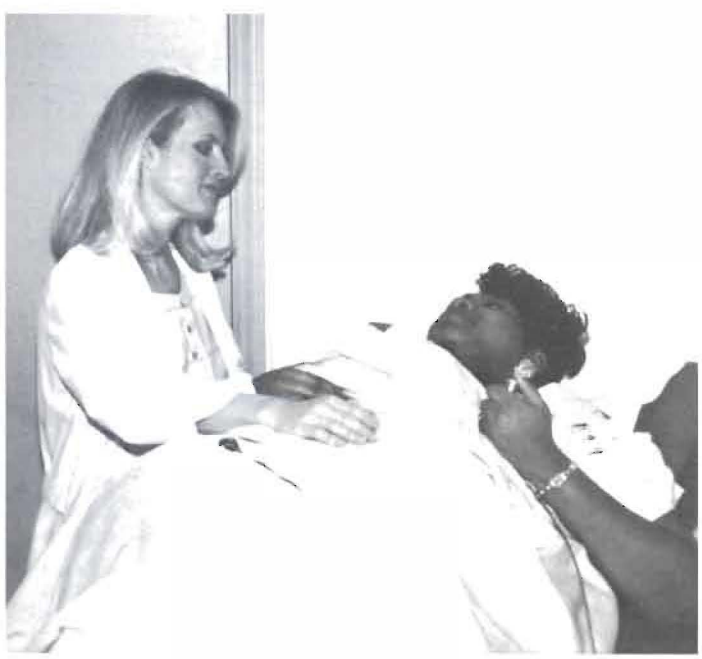
Covered Services: Medical services covered by Alabama's Medicaid program traditionally have been fewer and less comprehensive than most states'. In recent years, however, federal mandates and the Agency's own initiatives have expanded and improved the overall program. Alabama's program is aimed at providing 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: For many years Medicaid recipients have been issued monthly paper cards signifying their eligibility. In November 1992, the Agency converted to plastic cards that are issued on a more permanent basis. It is the option of providers to accept Medicaid recipients as patients and it is the responsibility of the providers to verify eligibility when delivering care to recipients. Providers include physicians, pharmacies, hospitals, nursing homes, dentists, optometrists, and others. These providers bill the Medicaid program for their services.

Recipients: Of the 595,769 persons eligible for Medicaid in FY 1993, about 88 percent actually received care financed by Medicaid. These 523,445 persons are called recipients. The remaining 72,324 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.





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 over one million 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 1993, Medicaid paid over $1.6 billion to providers on behalf of persons eligible for the program. The federal government paid approximately 73 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 of three, Medicaid expenditures generated over $4.8 billion worth of business in Alabama in FY 1993.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. With the current administrative rate, almost 98 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 1993 **Table – 1**
COUNTY IMPACT
Year's cost per eligible

County	Benefit Payments	Eligibles	Payment Per Eligible	County	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$6,806,261	4,591	$1,483	Houston	$18,019,234	11,952	$1,508
Baldwin	$19,514,257	10,269	$1,900	Jackson	$12,829,633	6,479	$1,980
Barbour	$9,854,524	5,342	$1,845	Jefferson	$174,800,594	82,744	$2,113
Bibb	$4,531,830	2,728	$1,661	Lamar	$5,009,011	2,153	$2,327
Blount	$8,001,120	4,451	$1,798	Lauderdale	$20,360,263	9,140	$2,228
Bullock	$4,906,225	3,233	$1,518	Lawrence	$7,679,438	4,620	$1,662
Butler	$8,760,881	4,650	$1,884	Lee	$16,540,798	9,638	$1,716
Calhoun	$28,313,575	15,618	$1,813	Limestone	$11,515,500	6,725	$1,712
Chambers	$10,511,425	5,772	$1,821	Lowndes	$4,427,387	3,877	$1,142
Cherokee	$5,074,071	2,245	$2,260	Macon	$10,487,970	5,820	$1,802
Chilton	$9,011,426	4,808	$1,874	Madison	$35,804,666	27,914	$1,283
Choctaw	$5,010,500	3,297	$1,520	Marengo	$9,057,875	5,124	$1,768
Clarke	$9,616,008	6,709	$1,433	Marion	$9,248,722	3,814	$2,425
Clay	$5,209,847	1,949	$2,673	Marshall	$23,248,117	10,097	$2,302
Cleburne	$2,968,974	1,644	$1,806	Mobile	$122,610,879	62,218	$1,971
Coffee	$12,717,596	5,055	$2,516	Monroe	$7,058,759	4,123	$1,712
Colbert	$13,666,497	6,755	$2,023	Montgomery	$59,917,491	35,183	$1,703
Conecuh	$5,679,836	3,249	$1,748	Morgan	$40,343,463	10,849	$3,719
Coosa	$2,415,115	1,488	$1,623	Perry	$7,166,833	4,330	$1,655
Covington	$13,524,026	6,255	$2,162	Pickens	$8,228,176	4,480	$1,837
Crenshaw	$5,656,703	2,665	$2,123	Pike	$10,614,856	6,206	$1,710
Cullman	$21,330,116	8,356	$2,553	Randolph	$5,943,700	3,124	$1,903
Dale	$12,244,279	6,563	$1,866	Russell	$11,961,622	8,290	$1,443
Dallas	$22,116,988	14,545	$1,521	Shelby	$10,577,567	6,049	$1,749
Dekalb	$16,652,781	7,382	$2,256	St. Clair	$11,535,746	5,972	$1,932
Elmore	$23,452,098	6,498	$3,609	Sumter	$6,802,175	4,492	$1,514
Escambia	$10,800,784	5,885	$1,835	Talladega	$25,165,584	13,641	$1,845
Etowah	$32,276,303	13,947	$2,314	Tallapoosa	$16,041,234	6,613	$2,426
Fayette	$5,475,725	2,599	$2,107	Tuscaloosa	$70,552,258	20,244	$3,485
Franklin	$10,843,115	4,596	$2,359	Walker	$23,073,355	10,342	$2,231
Geneva	$8,282,005	3,946	$2,099	Washington	$5,428,771	3,670	$1,479
Greene	$4,939,634	3,237	$1,526	Wilcox	$6,889,042	5,150	$1,338
Hale	$7,482,222	3,857	$1,940	Winston	$9,584,015	3,707	$2,585
Henry	$5,061,032	2,732	$1,853	Other	$84,682	73	$1,160

Revenue, Expenditures, and Prices

In FY 1993, Medicaid paid $1,643,666,735 for health care services to Alabama citizens. Another $38,978,066 was expended to administer the program. This means that almost 98 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 1993 Sources of Medicaid revenue — Table – 2

	Dollars
Federal Funds	$1,199,009,077
State Funds	$483,635,724
Total Revenue	$1,682,644,801

FY 1993 Components of federal funds — Table – 4

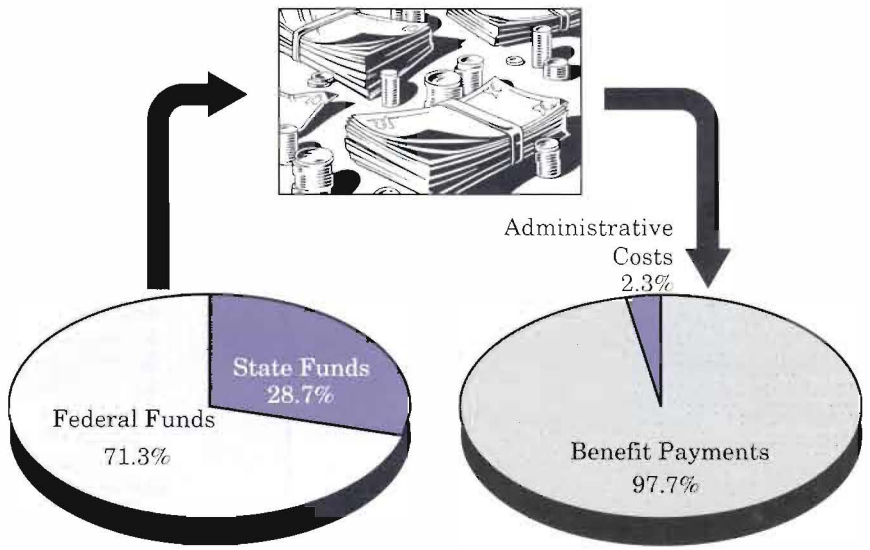
(net)	Dollars
Family Planning Administration	$83,584
Professional Staff Costs	$10,344,696
Other Staff Costs	$13,371,717
Other Provider Services	$1,165,907,345
Family Planning Services	$9,301,736
Total	$1,199,009,077

FY 1993 Components of state funds — Table – 5

(net)	Dollars
Encumbered Balance Forward	$10,313,743
Basic Appropriations	$128,934,767
Indigent Care Trust Fund	$278,010,019
Other State Agencies	$66,480,628
Interest Income from Fiscal Agent	$82,121
UAB (Transplants)	$267,032
Miscellaneous Receipts	$30,975
Subtotal	$484,119,284
Encumbered	$483,560
Total	$483,635,724

FY 1993 Composition and disbursement of Medicaid's budget — Table – 3

Where it comes from . . . Where it goes



FY 1992 & 1993 Benefit Payments by fiscal year in which obligation was incurred — Table – 6

	FY '92	FY '93
Nursing Homes	$307,246,323	$328,960,536
Hospitals	$663,199,686	$708,661,246
Physicians	$90,003,744	$117,721,621
Insurance	$77,702,123	$54,759,962
Drugs	$97,006,969	$118,216,546
Health Services	$30,119,322	$37,341,791
Community Services	$112,665,904	$143,217,212
Total Medicaid Service	$1,377,944,071	$1,508,878,914
Mental Health	$127,690,945	$134,787,821
Total Benefits	$1,505,635,016	$1,643,666,735

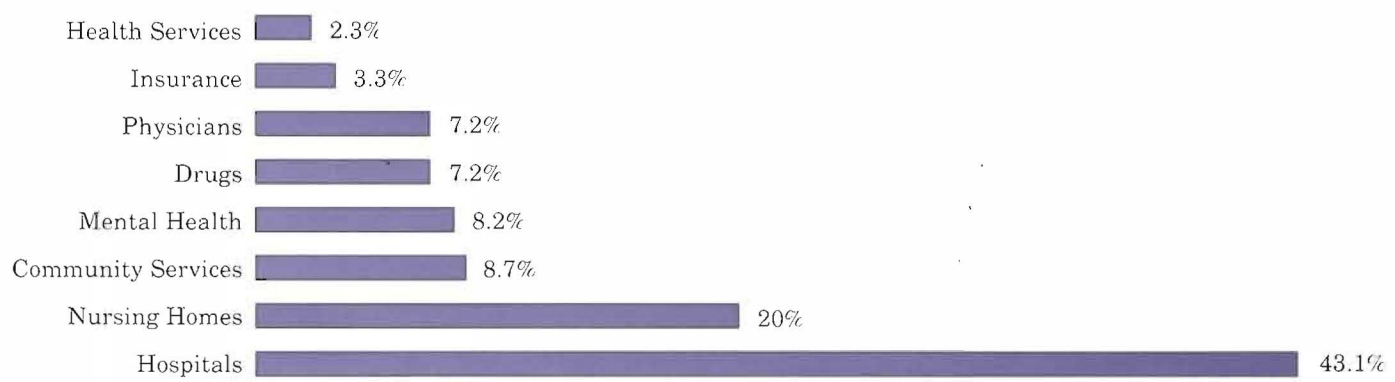
FY 1993
EXPENDITURES
By type of service (net)

Table – 7

Service	Payments	Percent of Benefit Payments
Hospitals:	$708,661,246	43.11%
Disproportionate Share Payments	$419,136,311	25.50%
Inpatient	$243,695,579	14.83%
Outpatient	$32,852,887	2.00%
FQHC	$12,856,853	0.78%
Rural Health Clinics	$119,616	0.01%
Nursing Homes	$328,960,536	20.01%
Waiver Services:	$134,290,602	8.17%
Pregnancy Related	$81,871,216	4.98%
Elderly & Disabled	$29,887,748	1.82%
Mental Health	$21,925,737	1.33%
SCCLA	$288,917	0.02%
OBRA 87	$256,312	0.02%
Homebound	$60,672	0.00%
Pharmacy	$118,216,546	7.19%
Physicians:	$117,721,621	7.16%
Physicians	$89,537,560	5.45%
Other Practitioners	$21,562,003	1.31%
Clinics	$6,622,058	0.40%
MR/MD:	$91,595,777	5.57%
ICF-MR	$79,030,040	4.81%
NF-MD/Illness	$12,565,737	0.76%
Insurance:	$54,759,962	3.33%
Medicare Buy-In	$54,226,687	3.30%
Humana QMB Plan	$525,687	0.03%
Catastrophic Illness Insurance	$7,588	0.00%
Health Services:	$37,341,791	2.27%
Screening	$14,624,182	0.89%
Laboratory	$8,291,766	0.50%
Dental	$7,348,734	0.45%
Transportation	$3,220,690	0.20%
Eye Care	$2,362,514	0.14%
Eyeglasses	$1,175,954	0.07%
Hearing	$255,316	0.02%
Preventive Education	$62,635	0.00%
Community Services:	$33,442,042	2.03%
Home Health/DME	$17,674,964	1.08%
Family Planning	$10,335,260	0.63%
Targeted Case Management	$4,676,270	0.28%
Hospice	$755,548	0.05%
Mental Health Services	$18,676,612	1.14%
Total For Medical Care	$1,643,666,735	100.00%
Administrative Costs	$38,978,066	
Net Payments	$1,682,644,801	

FY 1993 BENEFIT PAYMENTS
Percent distribution

Table – 8



FY 1993
COLLECTIONS AND MEASURABLE COST AVOIDANCE

Table – 9

COLLECTIONS:	
DRUG REBATE PROGRAM The collection of rebates by the Program Integrity Division from drug manufacturers for the utilization of their products.	$26,986,514
THIRD PARTY LIABILITY Includes collections by the Third Party Division and the providers, as well as retroactive Medicare recoupments and recoupments from health insurance.	$12,940,449
OTHER RECOUPMENTS Includes recoupments originating from monthly audits of 25 percent of Medicaid admissions in delegated hospitals and random audits of other hospitals.	$448,026
PROGRAM INTEGRITY DIVISION Claim Corrections	$19,892
PROGRAM INTEGRITY DIVISION Provider Recoupments	$379,812
TOTAL COLLECTIONS	**$40,774,693**
MEASURABLE COST AVOIDANCE:	
PRIOR APPROVAL AND PREPAYMENT REVIEW Results from denials in nondelegated hospitals	$201,319
THIRD PARTY CLAIM COST AVOIDANCE – MEDICARE	$32,513,171
THIRD PARTY CLAIM COST AVOIDANCE – OTHER Claims denied and returned to providers to file health insurance.	$30,004,547
WAIVER SERVICES COST AVOIDANCE – ELDERLY AND DISABLED	$80,249,247
WAIVER SERVICES COST AVOIDANCE – PREGNANCY RELATED	$801,616
WAIVER SERVICES COST AVOIDANCE – MR/DD	$103,389,308
TOTAL MEASURABLE COST AVOIDANCE:	**$247,159,208**
GRAND TOTAL:	**$287,933,901**

Population

The population of Alabama grew from 3,893,888 in 1980 to 4,040,587 in 1990. In 1993, Alabama's population was estimated to be 4,084,898.

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 1970 to 1990. 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.

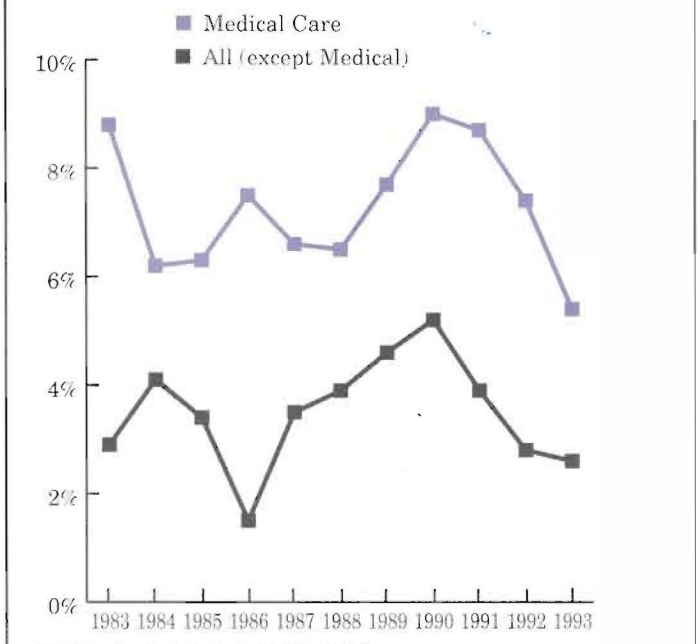
FY 1991-1993 **Table - 10**
POPULATION
Eligibles as a percent of population by year

Year	Population	Eligibles	Percent
1991	4,055,539	482,104	11.9%
1992	4,070,312	551,151	13.5%
1993	4,084,898	595,769	14.6%

Prices

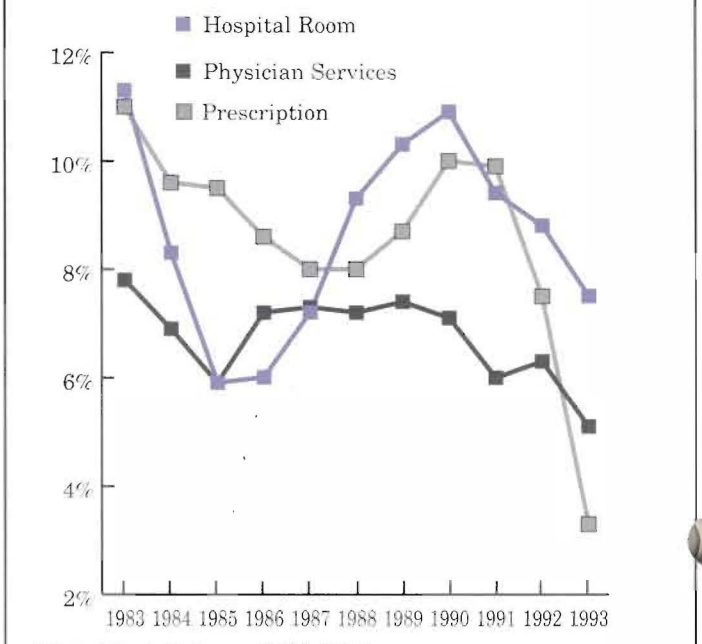
The charts on this page show historical trends in the rate of growth in the Consumer Price Index (CPI). Increases in the CPI are usually reflected in future increases in Medicaid payments to providers.

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



*For selected items 1983-1993

ANNUAL PERCENT CHANGES **Table - 11B**
In the Consumer Price Index*



*For selected items 1983-1993

Eligibles

During FY 1993, there were 595,769 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 471,600. The monthly average is the most useful measure of Medicaid coverage because it takes into account length of eligibility.

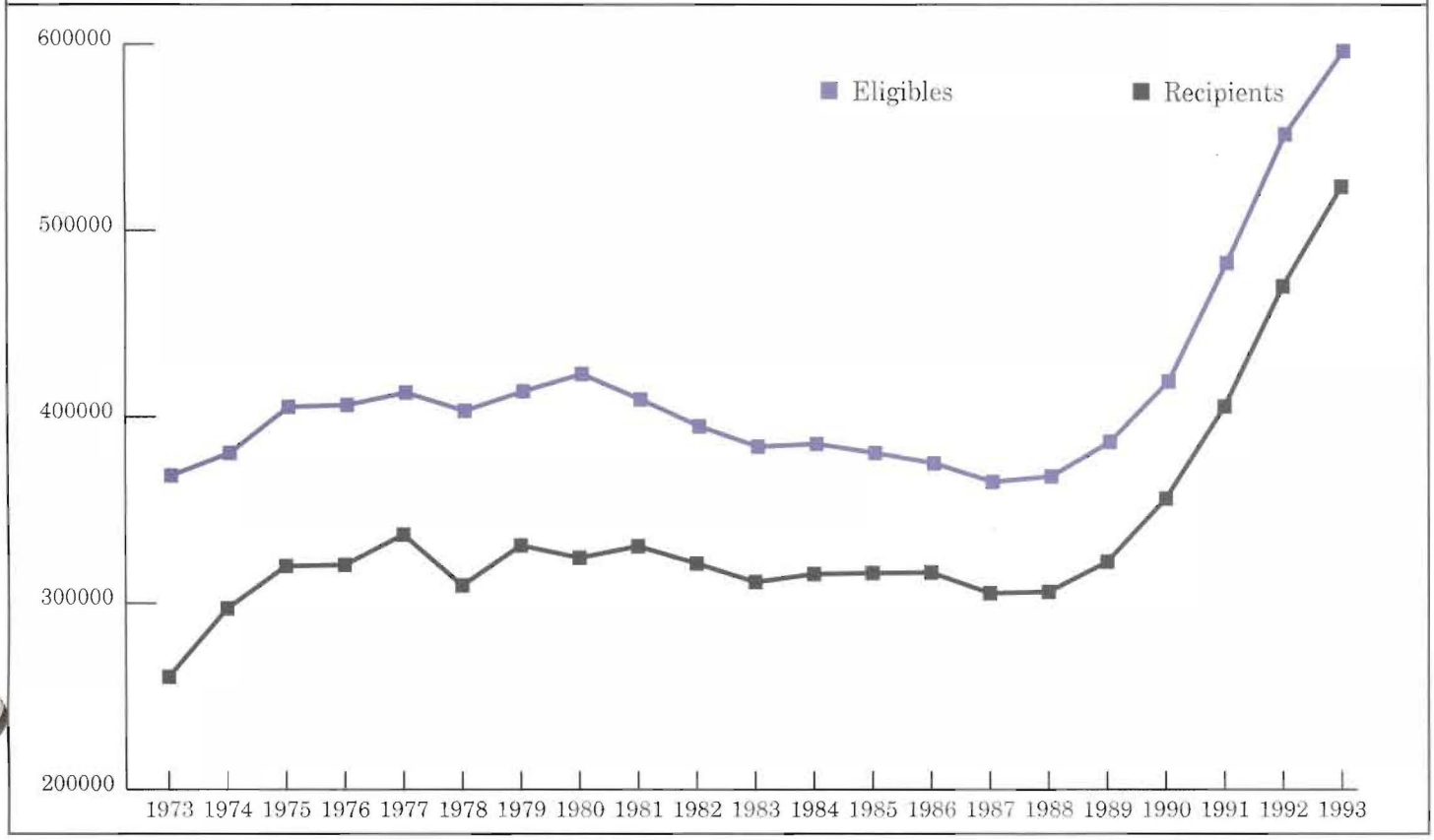
Although 595,769 people were eligible for Medicaid in FY 1993, only 79 percent were eligible for the entire year. The length of time the other 21 percent of Medicaid eligibles were covered ranged from one to eleven months.

FY 1993 **Table – 12**
ELIGIBLES
Monthly count

October '92	462,345
November	462,600
December	462,411
January '93	465,227
February	467,744
March	470,538
April	473,973
May	473,846
June	477,525
July	478,644
August	480,950
September	483,392

Although our average monthly number of eligibles was 471,600 for FY '93, there was an unduplicated total of 595,769 eligibles during the year. This was due to some clients losing eligibility and some being replaced by others.

FY 1973-1993 **Table – 13**
Medicaid eligibles and recipients



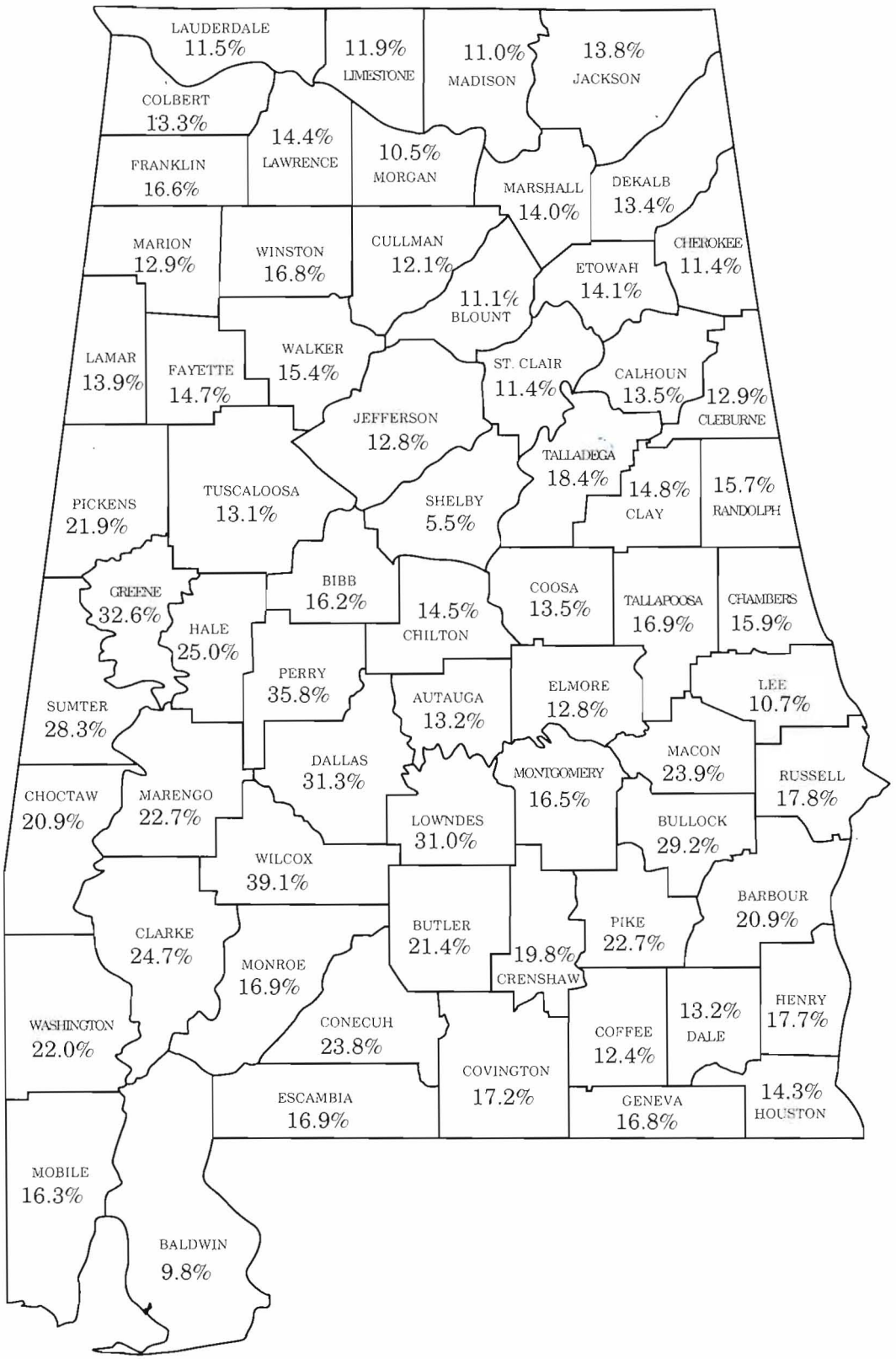
FY 1993
MEDICAID ELIGIBLES BY CATEGORY

Table – 14

COUNTY	AFDC	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	TOTAL
Autauga	1,392	422	896	1,749	119	12	1	**4,591**
Baldwin	2,585	984	2,058	4,361	232	35	14	**10,269**
Barbour	1,779	801	1,239	1,346	141	25	11	**5,342**
Bibb	580	325	718	1,011	85	5	4	**2,728**
Blount	1,004	620	836	1,817	159	7	8	**4,451**
Bullock	1,308	493	626	745	50	9	2	**3,233**
Butler	1,488	777	919	1,300	142	13	11	**4,650**
Calhoun	5,759	1,455	3,728	4,215	363	84	14	**15,618**
Chambers	2,029	744	965	1,797	197	29	11	**5,772**
Cherokee	461	343	511	818	98	5	9	**2,245**
Chilton	1,457	569	951	1,638	165	19	9	**4,808**
Choctaw	1,122	535	672	872	77	11	8	**3,297**
Clarke	3,138	683	1,288	1,452	123	15	10	**6,709**
Clay	382	374	416	670	94	10	3	**1,949**
Cleburne	444	238	352	530	73	4	3	**1,644**
Coffee	1,435	829	990	1,561	208	14	18	**5,055**
Colbert	886	759	1,387	3,500	185	21	17	**6,755**
Conecuh	1,125	459	631	940	74	13	7	**3,249**
Coosa	440	170	427	407	39	4	1	**1,488**
Covington	1,538	936	1,289	2,165	286	17	24	**6,255**
Crenshaw	772	536	624	627	88	9	9	**2,665**
Cullman	1,260	1,480	1,987	3,297	285	26	21	**8,356**
Dale	2,165	742	1,235	2,204	181	19	17	**6,563**
Dallas	6,556	1,579	3,442	2,699	208	42	19	**14,545**
DeKalb	1,399	1,399	1,625	2,698	225	22	14	**7,382**
Elmore	1,979	722	1,489	2,154	134	14	6	**6,498**
Escambia	1,922	701	1,081	2,013	147	19	2	**5,885**
Etowah	3,343	1,693	3,678	4,593	547	51	42	**13,947**
Fayette	743	445	591	742	64	8	6	**2,599**
Franklin	972	686	1,074	1,664	176	13	11	**4,596**
Geneva	1,045	681	914	1,080	189	12	25	**3,946**
Greene	1,288	471	650	780	36	11	1	**3,237**
Hale	1,175	720	765	1,124	56	9	8	**3,857**
Henry	910	460	556	675	107	15	9	**2,732**
Houston	4,108	1,268	2,433	3,709	372	31	31	**11,952**
Jackson	1,236	874	1,700	2,337	276	27	29	**6,479**
Jefferson	35,480	6,900	18,594	20,038	1,367	247	118	**82,744**
Lamar	325	442	504	772	94	11	5	**2,153**
Lauderdale	1,941	1,236	2,063	3,545	318	12	25	**9,140**
Lawrence	1,086	602	980	1,788	141	14	9	**4,620**
Lee	2,938	954	1,849	3,641	210	34	12	**9,638**
Limestone	2,342	870	1,341	1,950	177	35	10	**6,725**
Lowndes	1,611	383	858	944	62	8	11	**3,877**
Macon	3,134	613	904	1,070	75	22	2	**5,820**
Madison	14,996	1,909	4,252	6,178	489	65	25	**27,914**
Marengo	1,923	735	990	1,362	98	14	2	**5,124**
Marion	650	688	807	1,487	161	9	12	**3,814**
Marshall	2,505	1,614	2,398	3,151	359	30	40	**10,097**
Mobile	28,176	4,210	11,398	17,296	978	111	49	**62,218**
Monroe	1,349	502	841	1,327	87	10	7	**4,123**
Montgomery	14,502	2,919	8,022	9,096	533	86	25	**35,183**
Morgan	2,575	1,387	2,686	3,825	316	44	16	**10,849**
Perry	1,906	569	797	993	58	5	2	**4,330**
Pickens	1,589	720	985	1,070	94	16	6	**4,480**
Pike	2,114	899	1,373	1,655	128	27	10	**6,206**
Randolph	882	501	582	1,025	109	17	8	**3,124**
Russell	3,347	932	1,603	2,139	227	28	14	**8,290**
Shelby	1,706	438	1,132	2,578	162	21	12	**6,049**
St. Clair	2,008	543	1,032	2,208	154	17	10	**5,972**
Sumter	2,166	577	802	877	53	12	5	**4,492**
Talladega	4,635	1,158	3,223	4,204	292	104	25	**13,641**
Tallapoosa	2,203	894	1,300	1,984	200	19	13	**6,613**
Tuscaloosa	7,035	2,073	4,728	5,944	375	51	38	**20,244**
Walker	2,588	971	2,792	3,724	225	19	23	**10,342**
Washington	1,377	383	711	1,111	67	14	7	**3,670**
Wilcox	2,171	643	1,413	819	74	20	10	**5,150**
Winston	666	594	875	1,429	126	7	10	**3,707**
Other	68	0	0	0	5	0	0	**73**
TOTAL	213,219	64,832	126,578	174,520	13,815	1,809	996	**595,769**

FY 1993
ELIGIBLES
Percent of population eligible for Medicaid

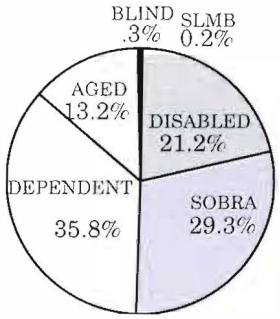
Table – 15



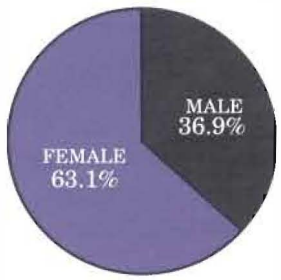
FY 1993
ELIGIBLES
Percent Distribution

Table – 16

BY CATEGORY



BY SEX



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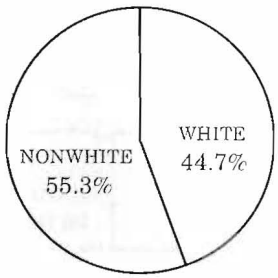
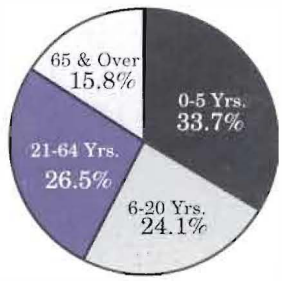


BY AGE



Recipients

Of the 595,769 persons eligible for Medicaid in FY 199, about 88 percent actually received care financed by Medicaid. These 523,445 persons are called recipients. The remaining 72,324 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 1993
RECIPIENTS
Monthly averages and annual total

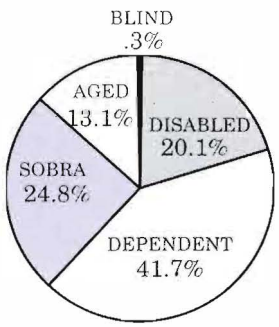
Table – 17

Category	Monthly Average	Annual Total
Aged	49,528	77,755
Blind	1,112	1,660
Disabled	75,112	119,278
Dependent	69,525	246,887
SOBRA	60,588	147,154
All Categories (unduplicated)	255,412	523,445

FY 1993
RECIPIENTS
Percent distribution

Table – 18

BY CATEGORY



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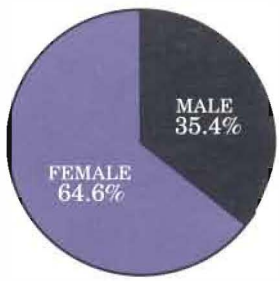

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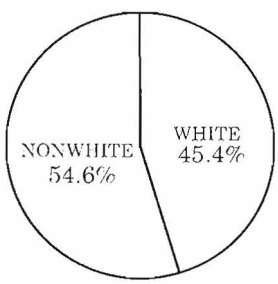

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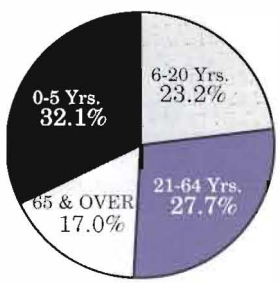


Use and Cost

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 predict 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.

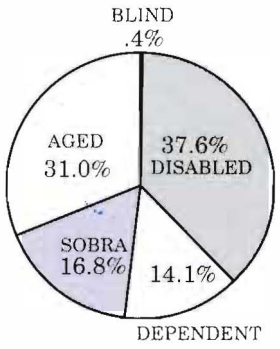
A good example of this is the pattern of use of long-term care. This type of care has a high cost per unit of service, and recipients of long-term care have a high frequency-of-service rate. The average Medicaid payment for a day of long-term care in FY 1993 was $66.91. The yearly average number of days for recipients of this service was 275. 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 in FY 1993 paid a monthly buy-in fee to Medicare of $31.80 per eligible Medicare beneficiary. Medicaid paid a total of $54.2 million in Medicare buy-in fees in FY 1993. 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 1993
PAYMENTS
Percent distribution

Table – 19

BY CATEGORY



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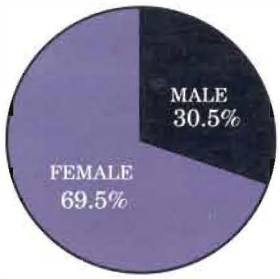

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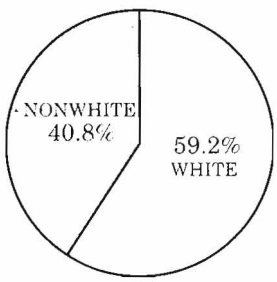

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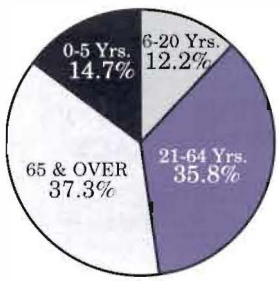
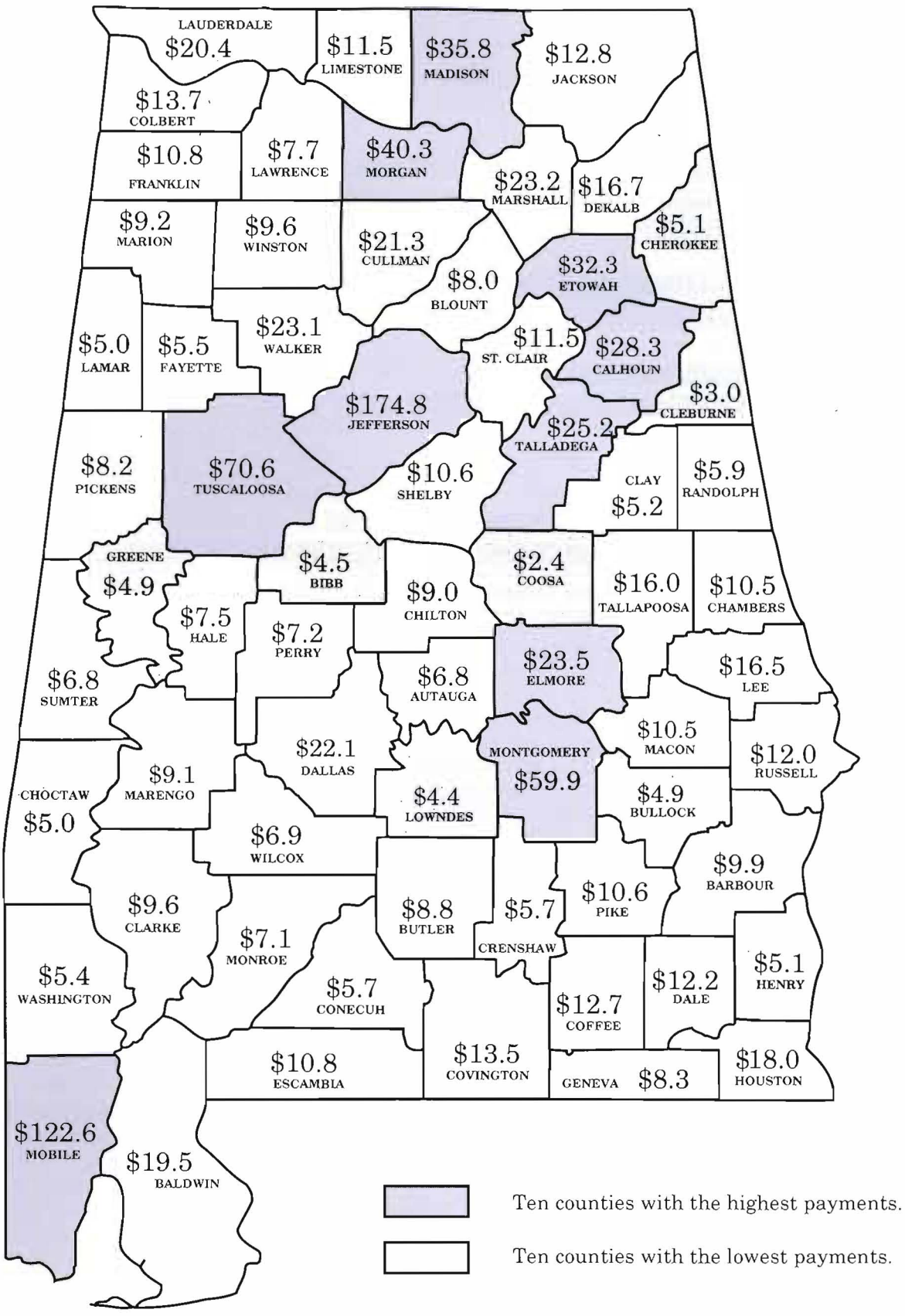


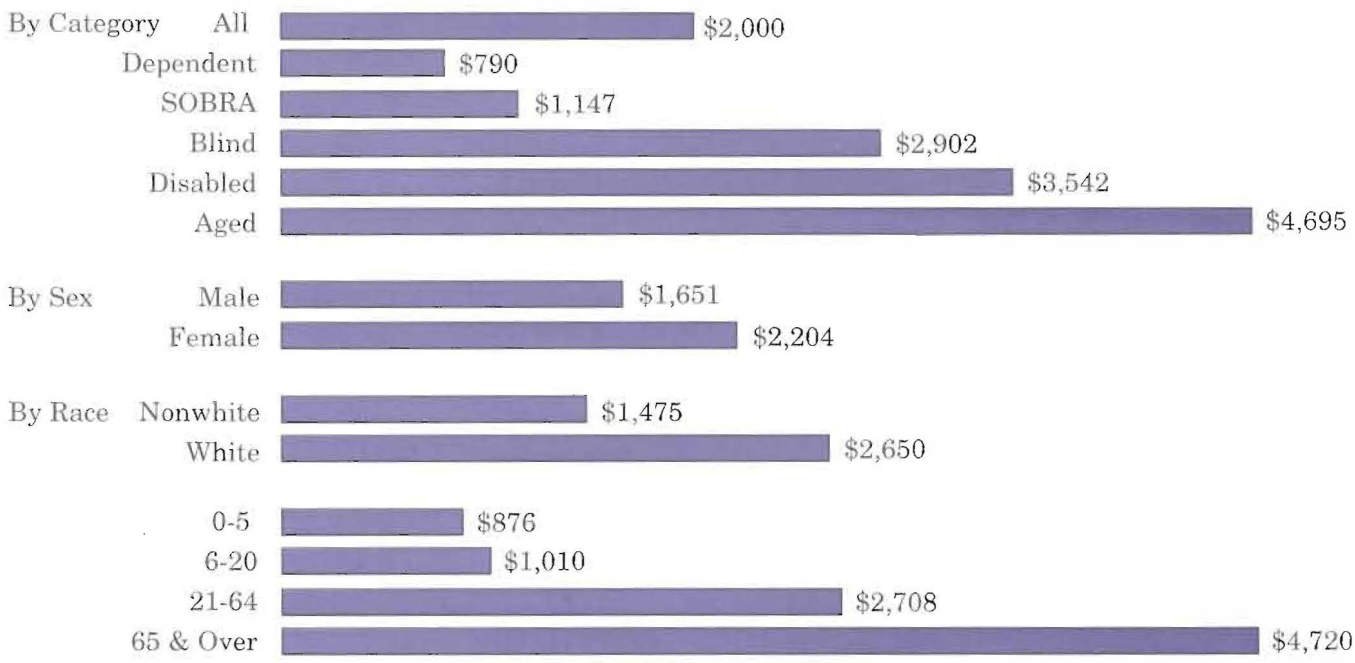
FY 1993
TOTAL PAYMENTS
By county of recipient (in millions of dollars)

Table – 20



FY 1993
COST PER ELIGIBLE
By category, sex, race, and age

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, that payments for those services are correct, and that all funds identified for collection are pursued. These tasks are accomplished by five units which make up the Program Integrity Division.

Through Quality Control Unit, the Medicaid Agency makes sure eligibility determinations are as accurate as possible. This is accomplished by performing in-depth reviews of eligibility determinations on a random sample of Medicaid eligibles. The findings of these reviews are then used to compute a payment error rate. If a state's payment error rate exceeds three percent, the Health Care Financing Administration (HCFA) imposes a financial sanction. The Agency's most recently published error rate was projected to be approximately 0.4376 percent for the quarter ending September 30, 1993. This projection was based on the actual payment error rate for the previous year. Nationally, Alabama has consistently been among the four or five states with the lowest payment error rates.

The processing and payment of Medicaid claims is monitored through the Claims Processing Assessment System (CPAS). In addition to CPAS claims reviews, the Systems Audit Unit performs targeted reviews of claims when potential systems errors are found, as well as periodic reviews of forced claims, denied claims and suspect duplicate drug claims. More than 6,106 claims were manually reviewed during FY 1993 and $19,892.32 was recouped. Systems Audit also utilizes a process referred to as the Bill Processing Systems Test (BPST). This process uses test claims, test recipients, and test providers to verify that systems edits have been properly implemented or to verify that edits are accomplishing the specified intent. The financial activities of the Agency's fiscal agent are monitored through reconciliations of invoices and bank accounts, as well as analysis of processed provider refunds and claim adjustments.

Computer programs are used to find unusual patterns of utilization on the part of both providers and recipients. During FY 1993, 363 providers were reviewed. Recoupments and net adjustments for the fiscal year totaled $379,811.70. There were 495 recipients reviewed in FY 1993.

There are several types of corrective action that may be taken in cases of aberrant utilization. Such 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. There were 276 recipients restricted to one physician and one pharmacy in FY 1993. During the same fiscal year, 171 recipients were sanctioned by the Medicaid program. A number of possible fraud cases involving providers and recipients were referred to the appropriate agencies for action, such as the Attorney General's Medicaid Fraud Control Unit and the Board of Medical Examiners.

The Alabama Legislature has provided two specific criminal statutes which allow 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 if a recipient or provider makes an intentional false statement or omits material fact in any claim or application for any payment knowing the same to be false. 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, there were 253 cases opened and 417 cases closed during FY 1993. Of these cases, 25 were referred to local district attorneys for possible prosecution. In addition, 92 pharmacy reviews, one civil rights investigation and two internal Agency investigations were completed during FY 1993.

During fiscal year 1993, the Drug Rebate Program collected rebates of $26,986,514 from drug manufacturers based on Medicaid utilization of their drug products in Alabama. This represents a 52 percent increase over FY 1992. These rebates are used to offset increasing drug program expenditures. Drug Rebate Program personnel assisted in the development of a drug manufacturer's standard remittance advice report, began utilizating PC-based spreadsheets, assisted in the implementation of the Veteran's Healthcare Act, performed extensive drug file analysis, and focused intensive efforts in drug rebate resolution.

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 2,434 software requests in FY 1993 to support the MMIS and aid Agency decision-making. The most sinificant accomplishment of the past year was implementation of the Medicaid Automated Claims Submission and Adjudication System (MACSAS) project together with nightly transmission of eligibility data to the fiscal agent's on-line transaction processor. Also included in the project was the replacement of monthly paper eligibility cards with permanent plastic magnetic stripe cards. The advanced system has been nationally recognized as leading edge technology for the electronic data interchange of Medicaid data and has resulted in considerable positive publicity for Alabama. Savings over the next three years should exceed $1,000,000. Other major projects included enhancements to the on-line system for outstationed eligibility workers, implementation of on-line eligibility reviews, enhancements to the Personnel System, automation of Inpatient Utilization Review, and statistical reporting to support managed care capitation rate calculations.

Many of Medicaid's computer functions are performed by the Agency's contracted fiscal agent, Electronic Data Systems (EDS). In December 1992, EDS was awarded the contract for the fifth consecutive term. The company's performance in claims processing has been among the best in the nation. EDS is constantly applying new technology and innovative ideas to the MMIS, thereby, making available a more efficient and effective claims processing system.

As part of the new contract, EDS has implemented many enhancements which will assist in the administration of the Medicaid Program. These enhancements include new online inquiry screens with help features, a new provider file with special reporting capabilities, and an online surveillance and utilization review system. Claims filing has been improved with a release of new electronic software, an EMC verification feature, and electronic remittance advices.

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 1993 Medicaid served 174,520 women and 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 the number of births to women aged 10-19 decreased in Alabama from 11,600 in 1991 to 11,299 in 1992. There were 346 births to teenage women under 15 years of age, up from 328 births to this age group in 1991.

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 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 1992, two additional postpartum visits were added 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 or below 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, through one primary provider network, receive comprehensive, coordinated, and case managed medical care appropriate to their risk status. 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 1993, there were 38 counties participating in the maternity waiver. Those counties were: Autauga, Bibb, Blount, Bullock, Calhoun, Choctaw, Clarke, Conecuh, Cullman, Dallas, Elmore, Escambia, Etowah, Fayette, Greene, Hale, Henry, Houston, Jefferson, Lamar, Lawrence, Lee, Lowndes, Macon, Marengo, Marion, Marshall, Mobile, Montgomery, Morgan, Perry, Pickens, Shelby, St. Clair, Sumter, Tuscaloosa, Washington, and Wilcox. 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 specific 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: Nurse midwifery practice is defined as the management of care for normal healthy women and their babies in the areas of prenatal care, labor and delivery service, post partum care, well-woman gynecological services (including family planning services), and normal newborn care. All services are performed with appropriate physician consultation.

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 30 providers.

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

Family Planning: Family planning services prevent or delay pregnancy. Family planning providers include health department clinics, federally qualified health centers, private physicians, nurse midwives, 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, injections, 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.

At both the national and state levels, Medicaid family planning services receive a high priority. To ensure this priority, the federal government pays a higher percentage of the costs of family planning than for other services. For most Medicaid services in Alabama, the federal share of costs was 73 percent in FY 1992. For family planning services, the federal share is 90 percent.

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 750 providers of EPSDT services, including county health departments, community health centers, hospitals, Head Start centers, child development centers, and private physicians. Efforts have been made in recent years to increase the number of physicians participating in the EPSDT program.

Since screening is not mandatory, many mothers do not seek preventive health care for their children. Steps have been taken in recent years, however, to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of intensive outreach statewide, enhancement of physicians' reimbursement for screening and an increase in 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.

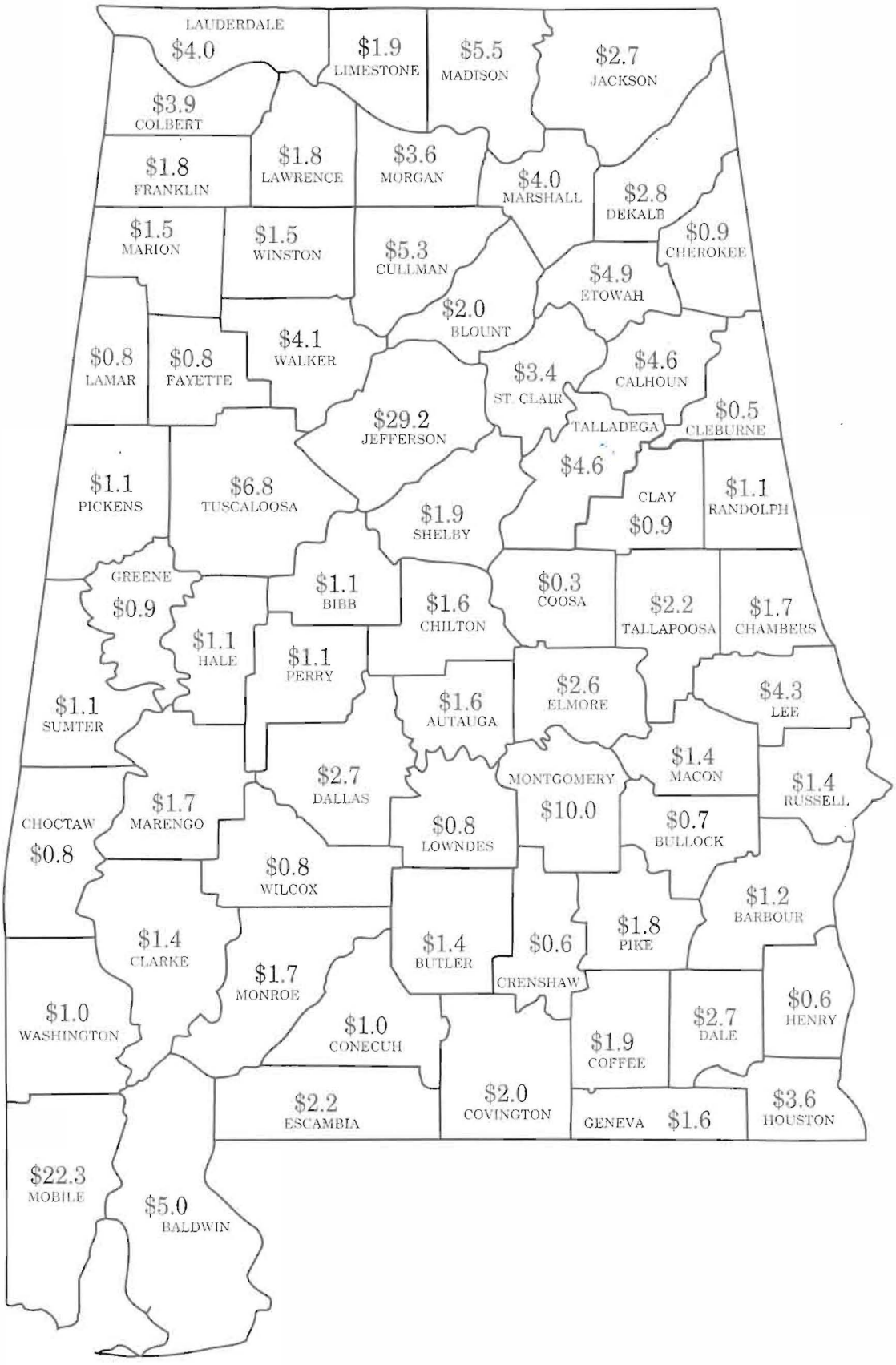
The EPSDT screening program can detect many problems before they become acute. Problems such as hypertension, rheumatic fever and other heart conditions, diabetes, neurological disorders, venereal disease, anemia, urinary infections, vision and hearing disorders, and even cases of child abuse have been detected and treated in past years. The cost of screening is relatively small — an average of $70 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 1993 **Table – 22**

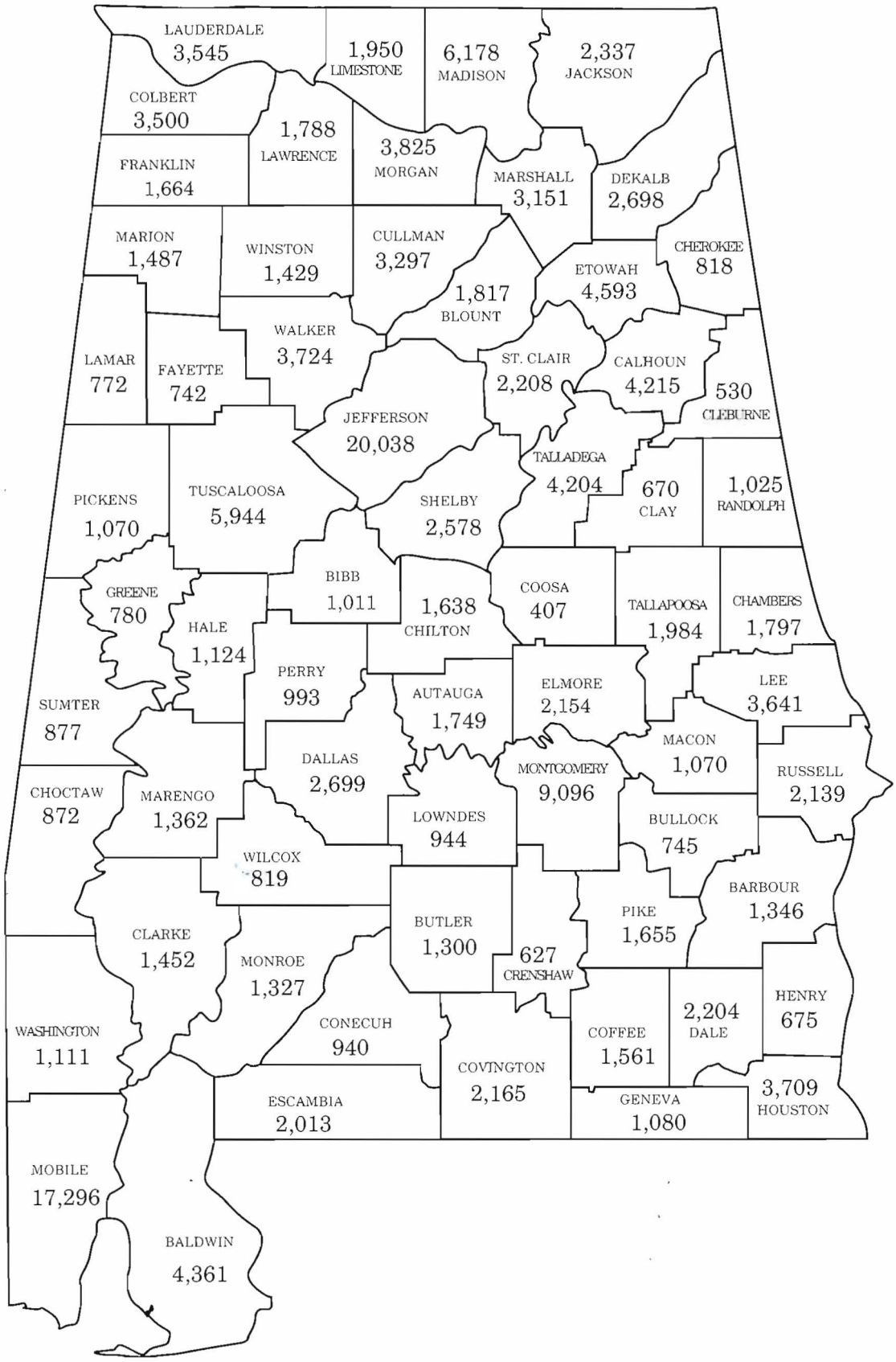
MEDICAID PAYMENTS FOR SOBRA ELIGIBLES

By county of recipient (in millions of dollars)



FY 1993
SOBRA ELIGIBLES

Table – 23



Healthy Beginnings

The Healthy Beginnings program, the Medicaid's Agency's major outreach effort for expectant women and young children began as an awareness and incentive program for expectant women in August, 1990.

Since that time, some 70,000 women, three-fourths of them on Medicaid or uninsured, have participated in this effort which is designed to encourage an adequate number of prenatal care visits. Additionally, in the fall of 1993, the Healthy Beginnings program was expanded to promote well-child checkups and immunizations for all Alabama infants.

To encourage women to go for all their checkups, the Healthy Beginnings (prenatal) program provides a free coupon booklet and pregnancy-related information to any pregnant woman in Alabama, regardless of income. Each month following a checkup, a certain number of coupons are validated. Once validated, the coupons may be used. Each book contains coupons for free and/or discounted items at various grocery, discount and drug stores, among other offers. The program also offers a special incentive gift — an insulated cup — free to women who begin care in the first trimester of pregnancy.

This nationally-recognized program has been credited with helping to increase the number of women who receive an adequate number of prenatal visits.

FY 1993 highlights for Healthy Beginnings include these:

* While teens account for 18 percent of all births in Alabama, 29 percent of all calls were from teenagers.

* Approximately 75 percent of all calls were from Medicaid recipients or from uninsured women.

* Sixty percent of callers were receiving care at clinics while 39 percent were receiving care from private physicians.

* Sixty percent of all callers were white; 39 percent were black, paralleling the general population of the state.

* One-third of all callers had 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.

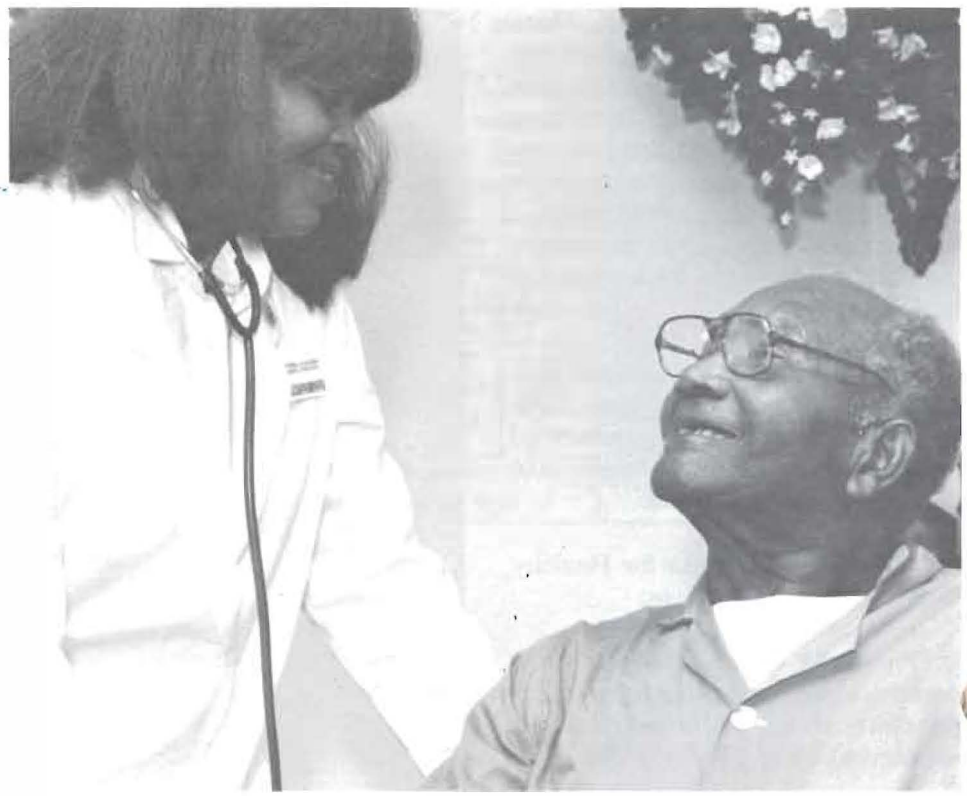
Managed care is a coordinated strategy designed so that a primary health care provider or case manager may provide care directly to patients and authorize all other health care, except true emergencies, that is received by the patient.

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 is 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 1993, about $1.5 million was spent to provide services to approximately 8,500 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, development of a plan of care, coordination of needed services, follow-up on the individual's progress and reassessment of the condition.

As a result of cooperation among the Department of Public Health, the Department of Human Resources, United Cerebral Palsey, and the Alabama Kidney Foundation, case management was expanded in recent years to include five additional target groups. Medicaid eligible handicapped children, foster children, persons with severe renal disease, 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. During FY 1993, $1,310,942 was spent serving an estimated 6,000 case management clients.



Home and Community Based Service Waivers

The State of Alabama has developed Home and Community Based Service (HCBS) waivers that provide alternatives to institutionalization for some Medicaid recipients. The waiver programs are aimed at helping recipients receive extra services not ordinarily covered by Medicaid in this state. Home and Community Based waiver programs serve the elderly and disabled, mentally retarded and developmentally disabled and homebound. These programs provide quality and cost-effective services to individuals at risk of institutional care.

HCBS Waiver for the Elderly and Disabled: This waiver provides services to persons who might otherwise be placed in nursing homes. The five basic services covered are case management, homemaker services, personal care, adult day health, and respite care. During FY 1993, there were 6,791 recipients served by this waiver at an actual cost of $3,846 per recipient. Serving the same recipients in nursing facilities would have cost the state $15,663 per recipient. This waiver saved the state $11,817 per recipient in FY 1993.

People receiving services through Medicaid HCBS 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. This waiver is administered by the Alabama Department of Human Resources and the Alabama Commission on Aging.

HCBS Waiver for the Mentally Retarded and the Developmentally Disabled (MR/DD): This waiver serves individuals who meet the definition of mental retardation or developmentally disabled. The waiver provides residential habilitation training, day habilitation, prevocational training, supported employment, occupational therapy, speech therapy, physical therapy, individual family support service, behavior management, companion service, respite care, personal care, environmental modification, specialized medical equipment and supplies, assistive technology, personal emergency response system, and skilled nursing care. During FY 1993, there were 2,063 recipients served by this waiver at an actual cost of $9,832 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $59,948 per recipient. The MR/DD waiver saved the state $50,116 per recipient in FY 1993.

OBRA '87 HCBS Waiver: This waiver serves individuals who are inappropriately placed in nursing facilities and was passed by Congress as part of the Omnibus Budget Reconciliation Act of 1987. The services provided under this waiver include case management, personal care, respite care, residential habilitation training, behavior management, day habilitation, prevocational services, supported employment, environmental modification, skilled nursing care, specialized medical equipment and supplies, personal emergency response systems, companion services, physical therapy, occupational therapy, assistive technology, individual and family support, and speech, hearing, and language services. This waiver is administered by the Department of Mental Health and Mental Retardation. During FY 1993, there were 18 persons served by this waiver at a cost of $12,913 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded would have cost the state approximately $60,000 per recipient. The waiver saved the state approximately $47,087 per recipient in FY 1993.

Homebound Waiver: This waiver is administered by the Department of Education, Division of Vocational Rehabilitation. The services provided under this waiver include case management, personal care, respite care, environmental modification, transportation, medical supplies, personal emergency response system, and assistive technology. During FY 1993, there were 93 recipients served by this waiver at a cost of $538.98 per recipient. Serving the same recipients in an institution would have cost the state $15,723.70. The state saved $15,184.72 per recipient in FY 1993 under this waiver.

Home Care Services

The Medicaid home care services program helps people with illnesses, injuries, or disabilities receive the quality of 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 and 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 savings to Medicaid.

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 (EPSDT) Program. 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.

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 addition, expansions mandated under the EPSDT program have made Alabama Medicaid home care services one of the most comprehensive medical assistance programs in the country for children.

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.

Hospice Care Services: 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 also cost efficient. During FY 1993, the Medicaid Agency served an average of 30 hospice patients each month at a total cost of about $756,148 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 Medicare certified hospice programs 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.

Home Health and Durable Medical Equipment (DME): 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 licensed physicians and provided by home health agencies under contract with Medicaid. There were 137 agencies participating in FY 1993.

Up to 104 home health visits per year may be covered by the Medicaid Agency. During FY 1993, over 5,000 recipients received visits costing a total of $10,140,509.

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 DME services, but all items must be medically necessary and suitable for use in the home. During the fiscal year, over 400 Medicaid DME providers throughout the state furnished services at a cost of $7,553,453.

In-Home Therapies: Physical, speech, and occupational therapy in the home is limited to individuals under 21 years of age who are 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 skilled nursing care. The services are available only for recipients under age 21 and prescribed as a result of an EPSDT screening referral. Private duty nursing care is provided in a recipient's home. The service also may be provided to the recipient away from the home when activities such as school or other normal life activities take him or her away from the home. Private duty nursing services are covered for Medicaid recipients who have medical problems that require education of the primary caregiver and/or stabilization of the recipient's medical problem or problems. For Medicaid coverage, at least four hours of continuous skilled nursing care are required per day.

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 $4,262,991 for services provided through 30 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.

Hospital Program

Hospitals are a critical link in the Medicaid health care delivery system. There are 117 Alabama hospitals that participate in the Medicaid program, and 29 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 continues to 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 75 in-state hospitals in Alabama that are considered "delegated" and do their own utilization review; 42 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, pre-admission 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 16 days per calendar year in FY 1993. However, additional days are available in the following instances:

* When a child has been found, through an EPSDT screening, to have a condition that 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 age seven 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 non-emergency outpatient visits per eligible during a calendar year. Exceptions are made for certified emergencies, chemotherapy, radiation therapy, visits solely for lab and x-ray services and surgical procedures on the agency's outpatient surgical list. Additional outpatient visits may be prior authorized if requested by the physician.

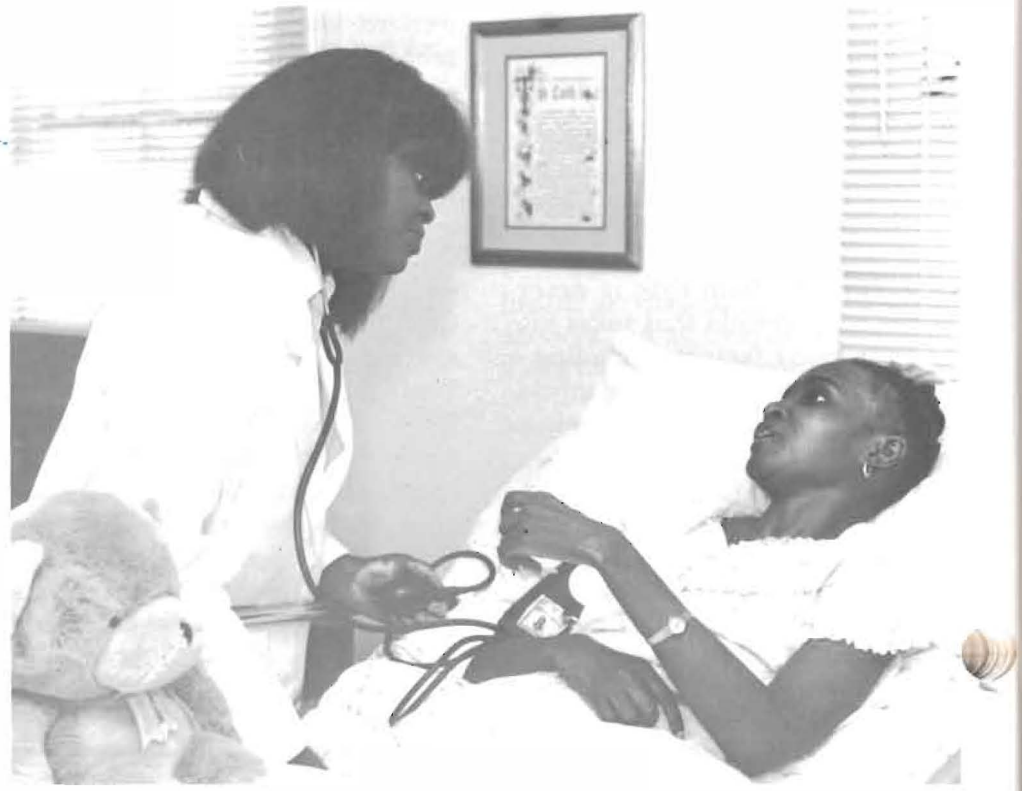
Most Medicaid hospital patients are required to pay a copayment for hospital care. The copayments are $50 per inpatient admission and $3 per outpatient visit. Recipients under 18 years of age, nursing home residents, pregnant women and others are exempt from copayments. (However, a recipient discharged 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.

Transplant Services: In addition to kidney and cornea transplants, which do not require prior approval, Medicaid benefits cover prior authorized heart transplants, liver transplants, and bone marrow transplants. Other medically necessary transplants are also covered for recipients under 21 years of age when the need is identified during an EPSDT screening and is prior authorized by the Alabama Medicaid Agency. Eligible recipients requiring heart transplants, liver transplants, bone marrow, or other covered EPSDT-referred 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.

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 1993, there were five 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 1991-1993
HOSPITAL PROGRAM
Changes in use and cost

Table – 24

Year	Recipients of Inpatient Care	Payments For Services	Medicaid's Annual Cost Per Recipient
1991	64,677	$176,397,312	$2,727
1992	71,090	$217,097,579	$3,054
1993	71,017	$235,503,602	$3,316

FY 1989-1993
HOSPITAL PROGRAM
Outpatients

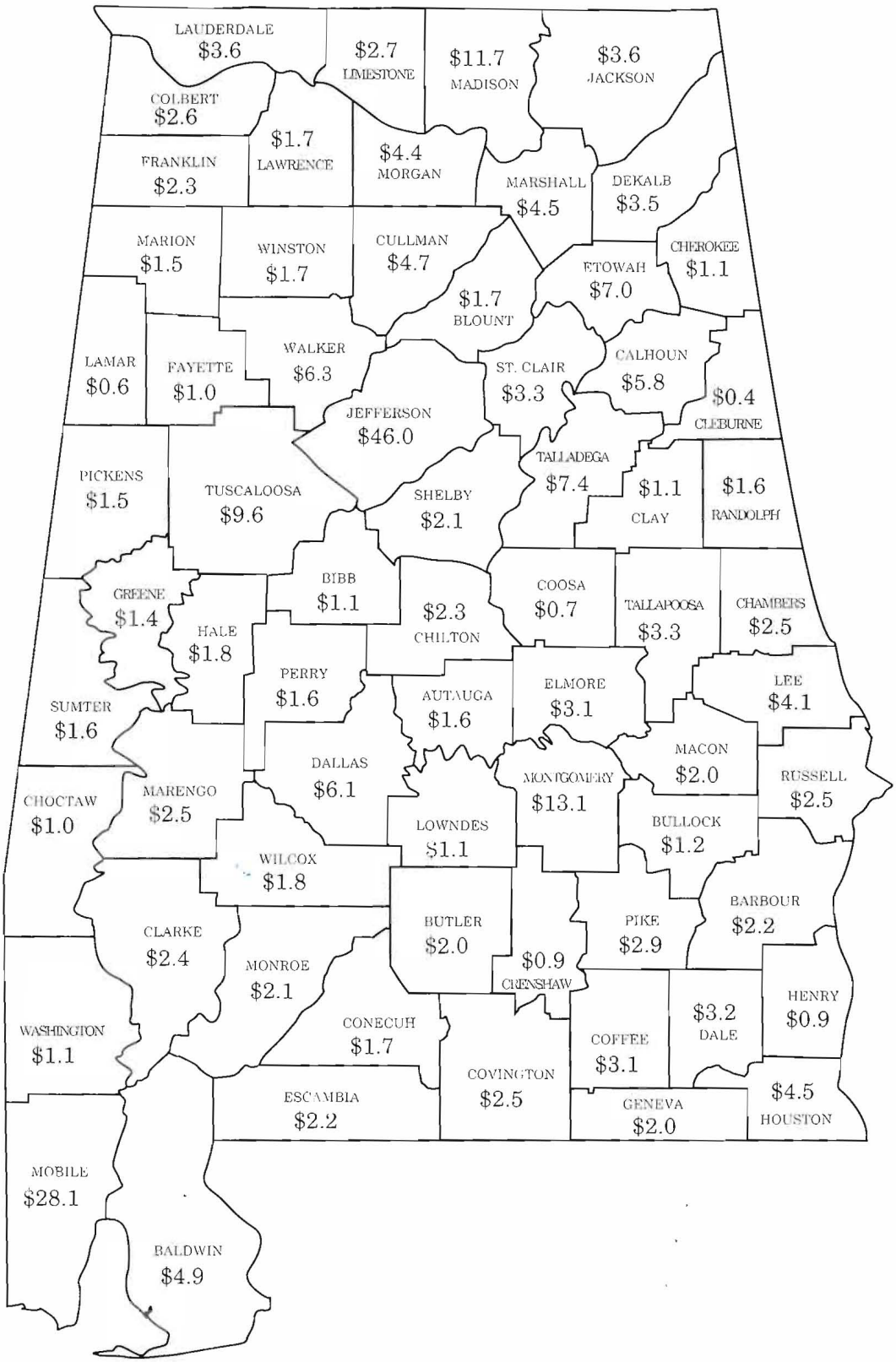
Table – 25

	FY '89	FY '90	FY '91	FY '92	FY '93
Number of outpatients	103,665	115,957	146,358	184,036	214,568
Percent of eligibles using outpatient services	27%	33%	30%	33%	36%
Annual expenditure for outpatient care	$9,605,911	$12,824,623	$19,094,131	$27,864,913	$35,960,064
Cost per patient	$93	$112	$130	$151	$168

FY 1993 **Table – 26**

PAYMENTS TO HOSPITALS*

By county of recipient (in millions of dollars)



*Does not include disproportionate share payments. Inpatient and outpatient services only.

Medical Services

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 more than 66 percent of Alabama's Medicaid eligibles received physicians' services in FY 1993.

Recipients visiting a physician are required to pay a $1 copayment per office visit. 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 in order to perform Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program screens for children under the age of 21. 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, Medicaid normally covers the amount of the doctor bill not paid for by Medicare, less the applicable copayment amount.

Pharmacy Program: Although the pharmacy 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 1993, pharmacy providers were paid approximately $147 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about seven 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 October 1, 1991 as follows:

Retail pharmacy	$5.40
Institutional pharmacy	$2.77
Government pharmacy	$5.40
Dispensing physician	$1.21

Primarily to control overuse, Medicaid recipients must pay a copayment for each prescription. The copayment 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, most 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 for either an office visit or the cost of the drug plus an administration fee.

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.

In keeping with the Agency's policy of cost containment, eyeglasses are chosen through competitive bidding. During FY 1993, Medicaid entered into a new one year eyewear contract period with the option to extend the contract for two additional years. 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 within the state they reside. These facilities must sign a contract with Medicaid in order to be eligible for reimbursement. Laboratory providers must also be certified in order to participate in the Medicaid 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 44 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.

FY 1993
PHYSICIAN PROGRAM
Use and cost

Table – 27

Category	Payments	Recipients	Cost Per Recipient
Aged	$5,277,513	55,494	$95
Blind	$512,990	1,387	$370
Disabled	$38,576,039	96,323	$400
Dependent	$62,388,358	275,331	$227
All Categories	$106,754,900	396,571	$269

FY 1991-1993
LAB AND X-RAY PROGRAM
Use and cost

Table – 28

Year	Payments	Recipients	Annual Cost Per Recipient
1991	$4,841,269	110,900	$44
1992	$6,973,307	155,184	$45
1993	$8,381,646	175,750	$48

FY 1993 **Table – 29**
EYE CARE PROGRAM
Use and cost

Category	Payments	Recipients	Cost Per Recipient
Optometric Service	$2,593,392	54,592	$48
Eyeglasses	$947,968	36,790	$26

FY 1993 **Table – 30**
PHARMACY PROGRAM
Counts of providers by type

Type of Provider	Number
Retail	1,323
Institutional	39
Governmental	4
Dispensing Physician	1
Total	1,367

FY 1991-1993 **Table – 31**
PHARMACY PROGRAM
Use and cost

Year	Number Of Drug Recipients	Recipients As a % Of Eligibles	Number Of Rx	Rx Per Recipient	Price Per Rx	Cost Per Recipient	Total Cost To Medicaid
1991	293,119	61%	4,494,686	15.33	$16.92	$259	$76,028,149
1992	351,293	64%	5,666,482	16.13	$20.42	$329	$115,725,473*
1993	397,022	67%	6,533,244	16.46	$22.49	$370	$146,906,501*

***Does not reflect rebates received by Medicaid from pharmaceutical manufacturers. See Table below.**

FY 1991-1993 **Table – 32**
PHARMACY PROGRAM
Cost

Year	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx	Net Cost per Recipient
1991	$ 76,028,149	--------	$ 76,028,149	$16.92	$259
1992	$115,725,473	$17,727,158	$ 97,998,315	$17.29	$279
1993	$146,906,501	$26,986,514	$119,919,987	$18.36	$302

Long Term Care

Care for acutely ill, indigent residents in nursing facilities was mandated in 1965 with the enactment of Medicaid (Title XIX). During the last few years, however, the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) has made the most significant impact on 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.

During the past several years the elderly population of the state has increased, with the percentage of recipients in nursing facilities increasing at a slower rate. 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 patients in facilities have genuine medical needs requiring professional nursing care, and a management information system that makes timely and accurate financial eligibility decisions possible.

Even with the percentage of recipients in nursing homes increasing at a slower rate, Medicaid financed 65 percent of all nursing home care in the state during FY 1993. The total cost to Medicaid for providing this care was $330,829,010. Almost 93 percent of the 221 nursing homes in the state accepted Medicaid recipients as patients in FY 1993. There were also 16 hospitals in the state during FY 1993 that had long term care beds, called swing beds, participating in Medicaid. Swing beds are hospital beds that can be used on an as need basis for either the level of care found in skilled nursing facilities, as in nursing homes, or the level of care found in acute care hospitals. The hospitals providing swing beds must have fewer that 100 beds and must also be located in rural areas.

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. The new reimbursement system helps to maintain capital formation, improve access for heavy care, promote quality care, and achieve cost containment. The system helps 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 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 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. Swing beds are reimbursed at the average statewide nursing facility rate.

FY 1991-1993 **Table – 33**
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
1991	21,730	253 Days	5,495,747	$42	$232,088,398
1992	21,084	272 Days	6,213,634	$51	$315,675,925
1993	21,353	275 Days	6,327,407	$52	$330,829,010

FY 1991-93 **Table – 34**

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
1991	22,842	13,973	61.2%
1992	22,974	14,732	64.1%
1993	23,357	15,148	64.9%

FY 1993 **Table – 35**

LONG-TERM CARE PROGRAM

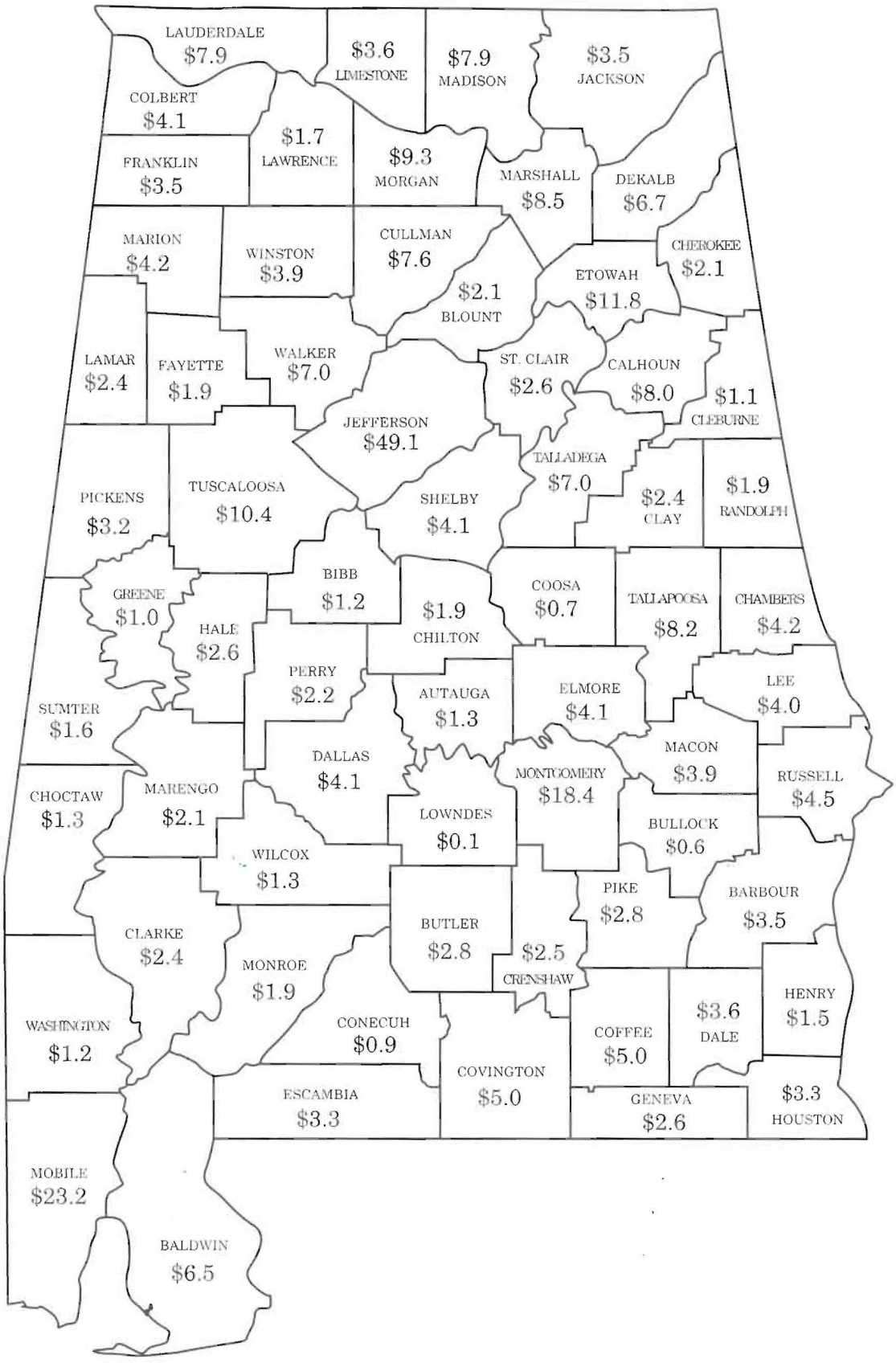
Recipients and payments by sex, race, and age

	Recipients	Payments	Cost Per Recipient
By Sex			
Female	16,509	$258,368,094	$15,650
Male	4,844	$72,460,916	$14,959
By Race			
White	16,867	$258,024,780	$15,298
Nonwhite	4,486	$72,804,230	$16,229
By Age			
0-5	16	$379,507	$23,719
6-20	132	$3,674,620	$27,838
21-64	1,737	$30,913,581	$17,797
65 & Over	19,468	$295,861,302	$15,197

FY 1993 **Table – 36**

PAYMENTS TO NURSING HOMES

By county of recipient (in millions of dollars)



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 residents.

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 statewide reduction of beds in intermediate care facilities for the mentally retarded. 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. In FY 1992 the average payment per day in an institution serving the mentally retarded was approximately $182.78.

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 1993, in cooperation with the Alabama Medicaid Agency, Mental Health was able to match every $27 in state funds with $73 of federal funds for the care of Medicaid-eligible ICF-MR/MD patients.

FY 1993 Table – 37
LONG-TERM CARE PROGRAM
ICF-MR/MD

	ICF/MR	ICF/MD-Aged
Recipients	1,316	456
Total Payments	$79,035,619	$12,565,737
Annual Cost Per Recipient	$60,057	$27,556

Alabama Medicaid and AIDS

During FY 1993, the Center for Disease Control and Prevention adopted an expanded AIDS case definition. This expanded definition increased the number of reported AIDS cases in Alabama in 1993 by 64 percent over the number reported in 1992. There were 2,345 AIDS cases reported in Alabama in 1993, 619 of them new cases. Medicaid provided assistance to 1,079 recipients at a cost of $8.26 million, an increase of 52 percent over 1992 expenditures. Statewide, 46 percent of all reported patients with AIDS received services funded by Medicaid. There were 124 (11.49 percent) children in that number.

The Medicaid Agency continues to work with other state agencies and community based organizations in assessing needs and priorities in dealing with the HIV/AIDS epidemic. The diagnosis of AIDS is considered a disabling condition under federal law and qualifies an individual for Medicaid benefits, providing certain financial criteria are met. The following is a brief summary of services available to HIV/AIDS patients who are Medicaid eligible.

Physician Services: Finding a physician who is familiar with AIDS-related diseases is sometimes difficult for AIDS patients, especially in rural areas. They must frequently travel long distances to get needed care and transportation can be a problem. Most physicians treating AIDS are located in major urban areas.

Inpatient Hospital Care: The largest share of expenditures for services for AIDS patients goes for inpatient hospital care. In 1993, Medicaid provided inpatient care totaling $3.72 million. As AIDS progresses, infected patients are more likely to require hospitalization for opportunistic infectious diseases. AIDS patients can easily exhaust their hospital limit of 16 inpatient days per year.

Prescription Drugs: Alabama Medicaid covers AZT and other drugs used to prolong the life and health of AIDS patients. Because of the high cost and the number of drugs available to treat AIDS-related infections, drugs represent the fastest growing expenditure for AIDS recipients. These drug expenditures for FY 1993 rose to $1.5 million, an increase of 73 percent over FY 1992.

Home and Community Based Waiver Program: Home based services are provided to AIDS recipients under this waiver program as an alternative to costly nursing home placement.

Targeted Case Management: Case management services are provided to recipients who are HIV positive. These services provide for coordinated access to needed services for AIDS patients not living in a total care environment nor receiving services under a Medicaid waiver program.

Hospice Services: Because AIDS is considered a terminal illness, AIDS patients may need hospice services. Medicaid provides a full range of services to recipients with AIDS under the hospice program.

FY 1989-1993 **Table – 38**
MEDICAID AIDS EXPENDITURES
(in millions of dollars)