# 1998 Annual Report

## Introduction:



## Statistical Topics:



## Topics of Review:

- Prenatal Care
- Adolescent Pregnancy Prevention Education
- Vaccines for Children
- Maternity Waiver
- Family Planning
- EPSDT

## Recipient Inquiry Unit

## Managed Care

- Patient 1st
- BAY Health Plan (HMO)
- Medicare HMOs and CPMs
- Mental Health Services
- Targeted Case Management

## Home and Community Based Service Waivers

- HCBS Waiver for the Elderly & Disabled
- HCBS Waiver for the Mentally Retarded & Developmentally Disabled
- Homebound Waiver

## Home Care Services

- Hospice
- Home Health & Durable Medical Equipment (DME)
- In-Home Therapies
- Private Duty Nursing
- Personal Care Services

## Hospital Program

- Quality Assurance Program
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- Copayments
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- Swing Beds
- Federally Qualified Health Centers (FQHC)
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## Medical Services

- Physicians Services
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- Eye Care Services
- Laboratory & Radiology Services
- Renal Dialysis Services

# 1998 Annual Report
# Highlights

## Introduction

FY 1998 marked another year of successful improvements to make Alabama's Medicaid program more cost efficient and to maintain a high quality of services to Medicaid beneficiaries. Alabama was the first state in the nation to expand services to children through federal legislation that was passed in 1997. Our managed care programs, which began in FY 1997, proved to be successful in FY 1998, and more options were made available to some Alabama residents covered by Medicare and Medicaid. Additional programs were put in place to control costs in the Medicaid program, and the Alabama Legislature enacted bills that will help healthcare providers receive their reimbursement from Medicaid in a more timely fashion.

## Children's Health Insurance Program First In Nation

On February 1, 1998 the Medicaid program in Alabama expanded coverage to include many more teenagers than before. These teens qualify for Medicaid under Phase I of Alabama's participation in the new Children's Health Insurance Program (CHIP). Congress approved CHIP last summer as a part of the 1997 Balanced Budget Act. Alabama was the first state in the United States to receive CHIP approval.

This expansion of Medicaid will assure access to health care for an estimated 34,000 teens aged 14 through 18 throughout the state. Families of these children can apply at more than 100 locations -- including county health departments, some hospitals and some community health centers. Medicaid has hired additional workers to take applications for this group of children and all other low-income children who qualify for Medicaid.

Children eligible through the expansion are those with no health insurance who live in families with incomes at or below the federal poverty level. Currently, that is $1,338 a month for a family of four. This new group of children qualifies for all Medicaid benefits -- regular check-ups and referrals to specialists as needed, hospital care, visits to the doctor, prescription drugs, dental care and many other services. Funding for CHIP in the first year is 78.52 percent federal and 21.48 percent state, as opposed to 69.32 percent federal and 30.68 state for the Medicaid program.

Changes in the federal law that created the Children's Health Insurance Program now allow Medicaid to provide medical care to Department of Youth Services (DYS) teenagers. The program will affect 2,500 DYS teenagers up to age 19 who are at or below 100 percent of the federal poverty level. Prior to CHIP, DYS paid for medical services to these young people exclusively with state dollars. Now DYS wards can receive full Medicaid coverage including mental health services, drug treatment, psychiatric care, inpatient hospital care, as well as preventive care. DYS will provide the state share of the costs for these services, about $415,000 worth, and the remaining $840,000 will be paid with federal Medicaid funds.

## Patient 1st Successful

Patient 1st is a primary care case management program that began in January of 1997. Medicaid announced in December that Patient 1st has improved the level of coordinated health care of Medicaid patients in 26 counties, reduced Medicaid costs, and improved appropriate services to Medicaid beneficiaries. The program's successes will only increase as Patient 1st is expanded throughout the state before an implementation deadline of October 1, 1998. As the program expands to more counties, Medicaid savings will increase, but most important, more patients will benefit from having a doctor coordinate their medical care directly, or when needed, through referrals 24 hours a day, every day of the week.

Alabama received approval for Patient 1st through a waiver of federal Medicaid rules from the Health Care Financing Administration (HCFA). The waiver is one of several initiatives to provide better care to Medicaid beneficiaries in the most cost-effective way to taxpayers. We expect this program to save Medicaid money through more appropriate use of limited health care dollars and valuable medical services. Patients benefit because they no longer have fragmented and uncoordinated health care.

## New Health Care Choice for Medicaid Beneficiaries

In March the Alabama Medicaid Agency announced the start of a new, optional program for residents of Jefferson, Shelby and Mobile counties who are covered by both Medicare and Medicaid. The Medicare Complete program, offered by United HealthCare of Alabama, offers all the benefits of United HealthCare's present Medicare Complete program at no cost to participants. Those eligible include Medicare beneficiaries who have QMB (Qualified Medicare Beneficiary) -only coverage through Medicaid, and those who have full Medicaid along with their Medicare coverage.

The usual Medicare coinsurance and deductibles are covered by Medicare Complete, while Medicaid covers the copayment usually paid by the beneficiary. The Medicaid Agency is responsible for the Medicare coinsurance and deductibles for those persons who are covered by Medicare and Medicaid, as well as the recipient's Medicare Part B premium. In addition to those benefits covered by Medicare and Medicaid, participants will be eligible for unlimited hospital days, coverage for routine annual checkups and hearing exams, dental coverage and other benefits. Participants will not lose any benefits if they decide to join Medicare Complete.

Participants in this voluntary program will be required to use those doctors and hospitals in United HealthCare's network and to follow the program rules regarding referrals. Patients will work with one primary care doctor who will provide or coordinate all care needed.

## Prescription Drug Cost Control Measures Enacted

State Medicaid Commissioner Gwen Williams announced this year the award of a contract to the Alabama Quality Assurance Foundation (AQAF) for administration of the Medicaid pharmacy program. AQAF's proposal was the lowest of six bids submitted. The one-year contract was awarded at a cost of approximately $1.47 million in state and federal funds. The contract has

options for two one-year extensions. AQAF began work on November 10, 1997, and all contract requirements were implemented by January 1, 1998.

Under the contract, Medicaid maintains control over the pharmacy program, monitoring administration, making policy decisions and exercising quality oversight. Medicaid continues to make many policy decisions in consultation with its Pharmacy and Therapeutics Committee, a group of doctors and pharmacists who advise on operation of the pharmacy program.

With this contract, the state is taking an enormous step in slowing the rising cost of prescription drugs for Alabama's more than 630,000 Medicaid beneficiaries. Medicaid's costs for prescription drugs had escalated from $60 million in 1990 to $226 million in fiscal year 1997. Medicaid's pharmacy program is expected to experience more than $30 million in cost avoidance over the contract period because of AQAF's work in expanding initiatives Medicaid already has in place. AQAF has a proven record in planning, developing and managing a variety of medical review and administrative programs, including drug utilization review.

## Recovery for Improper Billing

The Alabama Medicaid Agency worked together with the state Attorney General's office to collect $399,962 from a hospital provider this year. The amount was paid as compensation for improper billing practices. It was the largest recovery ever by the Attorney General 's Fraud Control unit and resulted from a nine-month investigation by that unit and the Alabama Medicaid Agency.

The case demonstrates how important it is for health care providers to make sure they and their employees are knowledgeable about government regulations, and for the state to be vigilant in its oversight of the public treasury. Even though there was no evidence of criminal intent, the hospital was responsible for the full cost to the state for misspending the citizens' money.

## Legislature Passes Bills That Ease Yearly Problem

There were three bills passed during the 1998 Legislative Session that will help ease General Fund cash flow problems historically experienced yearly during the first quarter of the fiscal year. Passage of these bills will help health care providers receive their reimbursement from Medicaid in a much more timely manner. **HB519** (Act #98-498) swapped two payment-due dates for insurance companies' license fees and premium taxes. The total amounts paid by the insurance companies did not change -- only the timing of the two payments. **HB530** (Act #98-503) changed the way payments are made to a trust fund set up for the State Docks. **HB531** (Act #98-499) changed the timing of payments to the Municipal and County Government Capital Improvement Funds. This bill only changed the date of the payments from January 2 to April 15 of each year.

# Alabama's Medicaid Program

## History

Medicaid was created in 1965 by Congress along with a sound-alike sister program, Medicare. Medicare is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. Medicaid is jointly financed by the state and federal governments and is designed to provide health care to low income individuals. Medicaid started in Alabama in 1970 as a Department of Public Health program. In 1977, the Medical Services Administration was made an independent state Agency. In 1981, it was renamed the Alabama Medicaid Agency.

## A State Program

Unlike the Medicare 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, limitations on services, and reimbursement levels.

## Funding Formula

The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because the average income in Alabama is relatively low, its federal match is one of the largest. During FY 1998, the formula was approximately 70/30. For every $30 the state spent, the federal government contributed $70.

## Eligibility

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

- Persons receiving Supplemental Security Income (SSI) from the Social Security Administration are automatically eligible for Medicaid in Alabama. Children born to mothers receiving SSI payments may be eligible for Medicaid until they reach one year of age. After the child's first birthday, Medicaid will make a determination as to whether the child qualifies for another Medicaid program.
- Persons approved for "Medicaid for Low Income Families" through the Department of Human Resources are eligible for Medicaid. Low-income families may apply for cash assistance, Medicaid, or both through the Department of Human Resources. Medicaid may be approved if the children are deprived of parental support due to absence, divorce, separation, death, or unemployment of the primary wage earner. Also, foster children under custody of the state may be eligible for Medicaid.

- Pregnant women and children under six years of age with family income which does not exceed 133% of the federal poverty level are covered by Medicaid. Also covered are children up to age 19 who live in families with family income at or below the federal poverty level. Medicaid eligibility workers in county health departments, federally qualified health centers, hospitals, and clinics determine their eligibility through a program called SOBRA Medicaid.
- Persons who are residents of medical institutions (nursing homes, hospitals, or facilities for the mentally retarded) for a period of 30 continuous days and meet very specific income, resource and medical criteria may be Medicaid eligible. Persons who require institutional care but prefer to live at home may be approved for a Home and Community Based Service Waiver and be Medicaid eligible. Medicaid District Offices determine eligibility for persons in these eligibility groups.
- Qualified Medicare Beneficiaries (QMBs) have low income. Persons in this group may be eligible to have their Medicare premiums, deductibles, and coinsurance paid by Medicaid. Medicaid District Offices determine eligibility for QMBs.
- Specified Low-income Medicare Beneficiaries (SLMBs) and Qualifying Individuals-1 (QI-1) have low income above the QMB limit. Persons in this group may be eligible to have their Medicare Part B premiums paid by Medicaid. Medicaid District Offices determine eligibility for these programs.
- The Qualifying Individual-2 (QI-2) program assists with a small portion of the Medicare premium for people with incomes below 175% of the federal poverty level. This program has limited funds and is provided on a first come first served basis. Medicaid District Offices determine eligibility for the QI-2 program.
- Qualified Disabled Working Individuals (QDWIs) are individuals who have limited income and resources and who have lost disability insurance benefits because of earnings and who are also entitled to enroll for Medicare Part A. Medicaid will pay their Medicare Part A premiums. Medicaid Central Office determines eligibility for QDWIs.
- Disabled widows and widowers between ages 50 and 64 who are not eligible for Medicare Part A and who have lost SSI because of receiving widows/widowers benefits from Social Security can qualify for Medicaid. Medicaid District Offices determine eligibility for this group.

Persons in all categories may receive retroactive Medicaid coverage if medical bills were incurred in the three months prior to the application for Medicaid and if they meet all requirements for that program in those months (exceptions are: QMB and HCBS Waivers).

Persons in most categories may receive retroactive Medicaid coverage if medical bills were incurred in the three months prior to the application for Medicaid or the receipt of the first SSI check and if they meet all requirements for that program in those months (exceptions are: QMB and HCBS waiver beneficiaries).

Some persons in eligibility categories are protected by federal law from losing their Medicaid benefits:

- Continuous Medicaid (sometimes referred to as the Pickle program) keeps people on Medicaid who lose SSI eligibility because of a cost of living increase in the Social Security benefit and continue to meet all other SSI eligibility factors. The Medicaid District Offices processes applications for Continuous Medicaid.
- Disabled Adult Children (DAC) may retain Medicaid eligibility if they lose eligibility because of an entitlement or increase in a child's benefit, providing they meet specific criteria and continue to meet all other SSI eligibility factors. Medicaid District Offices process applications for DAC cases.

## 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 were 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.

# Medicaid's Impact

Since its inception 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 two 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 1998, Medicaid paid $2.4 billion to providers on behalf of persons eligible for the program. The federal government paid approximately 70 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 $7.2 billion worth of business in Alabama in FY 1998.

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 Medicaid patients.

**FY 1998**
**COUNTY IMPACT**
**Year's Cost Per Eligible**

| | Benefit Payments | Eligibles | Payment Per Eligible |
|---|---|---|---|
| **Autauga** | $9,852,171 | 4,810 | $2,048 |
| **Baldwin** | $29,162,766 | 12,175 | $2,395 |
| **Barbour** | $14,407,291 | 6,108 | $2,359 |
| **Bibb** | $6,497,536 | 3,398 | $1,912 |
| **Blount** | $13,971,316 | 5,222 | $2,675 |
| **Bullock** | $7,436,414 | 3,357 | $2,215 |
| **Butler** | $12,799,211 | 5,032 | $2,544 |
| **Calhoun** | $45,219,328 | 17,433 | $2,594 |
| **Chambers** | $15,499,824 | 6,193 | $2,503 |
| **Cherokee** | $8,694,669 | 3,322 | $2,617 |
| **Chilton** | $11,083,802 | 4,807 | $2,306 |
| **Choctaw** | $8,892,912 | 3,581 | $2,483 |

| | | | |
|---|---|---|---|
| **Clarke** | $13,536,023 | 6,802 | $1,990 |
| **Clay** | $8,205,337 | 2,473 | $3,318 |
| **Cleburne** | $5,113,329 | 1,998 | $2,559 |
| **Coffee** | $18,417,388 | 6,053 | $3,043 |
| **Colbert** | $19,259,660 | 7,780 | $2,476 |
| **Conecuh** | $7,876,047 | 3,725 | $2,114 |
| **Coosa** | $3,519,879 | 1,815 | $1,939 |
| **Covington** | $21,385,839 | 6,923 | $3,089 |
| **Crenshaw** | $8,740,654 | 2,913 | $3,001 |
| | **Benefit Payments** | **Eligibles** | **Payment Per Eligible** |
| **Cullman** | $31,786,989 | 9,840 | $3,230 |
| **Dale** | $18,675,795 | 7,497 | $2,491 |
| **Dallas** | $31,198,737 | 15,476 | $2,016 |
| **Dekalb** | $28,177,540 | 9,149 | $3,080 |
| **Elmore** | $25,957,012 | 7,006 | $3,705 |
| **Escambia** | $15,090,301 | 6,250 | $2,414 |
| **Etowah** | $50,540,796 | 15,163 | $3,333 |
| **Fayette** | $8,549,617 | 2,799 | $3,055 |
| **Franklin** | $16,125,138 | 5,204 | $3,099 |
| **Geneva** | $12,244,746 | 4,494 | $2,725 |
| **Greene** | $6,726,129 | 2,895 | $2,323 |
| **Hale** | $10,697,326 | 4,214 | $2,539 |
| **Henry** | $8,096,416 | 2,872 | $2,819 |
| **Houston** | $33,426,004 | 13,694 | $2,441 |
| **Jackson** | $20,614,501 | 7,460 | $2,763 |
| **Jefferson** | $217,718,346 | 81,253 | $2,680 |
| **Lamar** | $9,423,409 | 2,510 | $3,754 |
| **Lauderdale** | $30,111,913 | 10,231 | $2,943 |
| **Lawrence** | $11,109,296 | 4,278 | $2,597 |
| **Lee** | $27,320,187 | 10,991 | $2,486 |

| | | | |
|---|---|---|---|
| **Limestone** | $17,881,878 | 7,522 | $2,377 |
| **Lowndes** | $6,045,215 | 3,882 | $1,557 |
| | **Benefit Payments** | **Eligibles** | **Payment Per Eligible** |
| **Macon** | $13,772,656 | 5,648 | $2,439 |
| **Madison** | $55,985,288 | 25,521 | $2,194 |
| **Marengo** | $11,741,086 | 5,501 | $2,134 |
| **Marion** | $13,073,858 | 4,020 | $3,252 |
| **Marshall** | $34,159,269 | 12,303 | $2,776 |
| **Mobile** | $170,261,378 | 64,144 | $2,654 |
| **Monroe** | $9,789,945 | 4,591 | $2,132 |
| **Montgomery** | $88,138,289 | 38,540 | $2,287 |
| **Morgan** | $53,890,648 | 12,003 | $4,490 |
| **Perry** | $9,584,662 | 4,510 | $2,125 |
| **Pickens** | $12,293,725 | 4,528 | $2,715 |
| **Pike** | $15,390,379 | 6,783 | $2,269 |
| **Randolph** | $10,329,738 | 3,684 | $2,804 |
| **Russell** | $20,493,352 | 9,448 | $2,169 |
| **St. Clair** | $14,737,563 | 6,585 | $2,238 |
| **Shelby** | $17,449,513 | 5,437 | $3,209 |
| **Sumter** | $9,815,905 | 4,961 | $1,979 |
| **Talladega** | $34,455,344 | 14,070 | $2,449 |
| **Tallapoosa** | $22,656,835 | 6,946 | $3,262 |
| **Tuscaloosa** | $96,359,150 | 22,720 | $4,241 |
| **Walker** | $35,685,718 | 11,784 | $3,028 |
| **Washington** | $7,974,771 | 3,472 | $2,297 |
| **Wilcox** | $9,300,333 | 5,124 | $1,815 |
| **Winston** | $12,478,999 | 3,802 | $3,282 |
| **Other** | $688,659 | 764 | $901 |

# Revenue & Expenditures

In FY 1998, Medicaid paid $2,376,032,210 for health care services to Alabama citizens. Another $55,667,950 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 1998**<br>**Sources of Medicaid Revenue** | |
|---|---|
| Federal Funds | $1,682,305,102 |
| State Funds | $755,160,111 |
| Total Revenue | $2,437,465,213 |

| **FY 1998**<br>**Components of Federal Funds (net)** | |
|---|---|
| Family Planning Administration | $269,066 |
| Professional Staff Costs | $5,453,909 |
| Other Staff Costs | $27,063,416 |
| Other Provider Services | $1,643,536,269 |
| Family Planning Services | $5,982,442 |
| Total | $1,682,305,102 |

| **FY 1998**<br>**Components of State Funds (net)** | |
|---|---|
| General Fund Appropriations | $195,677,102 |
| Public Hospital Transfers and Alabama Health Care Trust Fund | $448,811,602 |
| Other State Agencies | $94,232,874 |
| Drug Rebates | $11,209,730 |
| UAB (Transplants) | $457,756 |
| Miscellaneous Receipts | $4,771,047 |
| Total | $755,160,111 |

| **FY 1998**<br>**EXPENDITURES**<br>**By Type of Service (net)** | | |
|---|---|---|
| **Service** | **Payments** | **Percent of Total Payments** |
| **Hospitals:** | $899,695,243 | 37.87% |
| Disproportionate Share | $394,719,036 | 16.61% |

| | | |
|---|---|---|
| Inpatient | $432,807,242 | 18.22% |
| Outpatient | $56,294,846 | 2.37% |
| FQHC | $10,777,072 | 0.45% |
| Rural Health Clinics | $5,097,047 | 0.21% |
| **Nursing Facilities** | $528,989,462 | 22.26% |
| **Waiver Services:** | $194,336,994 | 8.18% |
| Maternity | $72,537,703 | 3.05% |
| Elderly & Disabled | $36,973,696 | 1.56% |
| Mental Health | $82,014,566 | 3.45% |
| Homebound | $2,811,029 | 0.12% |
| **Pharmacy** | $236,904,488 | 9.97% |
| **Physicians:** | $131,031,725 | 5.51% |
| Physicians | $97,004,419 | 4.08% |
| Physician's Lab and X-Ray | $14,799,613 | 0.62% |
| Clinics | $14,763,855 | 0.62% |
| Other Practitioners | $4,463,838 | 0.19% |
| **MR/MD:** | $74,056,199 | 3.12% |
| ICF-MR | $57,075,918 | 2.40% |
| NF-MD Illness | $16,980,281 | 0.71% |
| **Insurance:** | 147,679,298 | 6.22% |
| Medicare Buy-In | $79,304,971 | 3.34% |
| Managed Care | $63,759,369 | 2.68% |
| PCCM | $3,830,786 | 0.16% |
| Human QMB Plan | $491,555 | 0.02% |
| Medicare HMO | $81,030 | 0.00% |
| Catastrophic Illness Insurance | $211,587 | 0.01% |
| **Health Services** | $49,161,803 | 2.07% |
| Screening | $18,025,051 | 0.76% |
| Laboratory | $9,637,667 | 0.41% |
| Dental | $9,439,531 | 0.40% |
| Transportation | $6,777,313 | 0.29% |
| Eye Care | $3,114,517 | 0.13% |
| Eyeglasses | $1,623,676 | 0.07% |

| | | |
|---|---|---|
| Hearing | $295,281 | 0.01% |
| Preventive Education | $248,767 | 0.01% |
| **Community Services:** | $64,147,636 | 2.70% |
| Home Health/DME | $23,520,096 | 0.99% |
| Family Planning | $6,652,222 | 0.28% |
| Targeted Case Management | $28,496,179 | 1.20% |
| Hospice | $5,479,139 | 0.23% |
| Mental Health Services | $50,029,362 | 2.11% |
| **Total for Medical Care** | **$2,376,032,210** | 100.00% |
| Administrative Costs | $55,667,950 | |
| **Net Payments** | **$2,431,700,160** | |

**FY 1998**
**Benefit Payments - Percent Distribution**

# Population

The population of Alabama grew from 3,893,888 in 1980 to 4,040,587 in 1990. In 1998, Alabama's population was estimated to be 4,155,080. Because of increases in Medicaid coverage in recent years, the segment of the population eligible for Medicaid services has risen from 10.4% in FY 1990 to 15.3% in FY 1998.

More significant to the Medicaid program was the rapid growth of the elderly population. Census data show 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 2000 there will be 570,814 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, Medicaid's costs per eligible have been higher for this group than for other groups of eligibles.

**FY 1996-1998**
**POPULATION**
**Eligibles as a Percent of Alabama Population by Year**

| Year | Population | Eligibles | Percent |
|---|---|---|---|
| 1996 | 4,127,562 | 635,568 | 15.4% |
| 1997 | 4,141,341 | 632,472 | 15.3% |
| 1998 | 4,155,080 | 637,489 | 15.3% |

# Eligibles

During FY 1998 there were 637,489 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 499,995. The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

Although 637,489 people were eligible for Medicaid in FY 1998 only 78 percent were eligible for the entire year. The length of time the other 22 percent of Medicaid eligibles were covered ranged from one to eleven months.

| **FY 1998<br>Eligibles<br>Monthly Count** | |
|---|---|
| October '97 | 496,102 |
| November | 493,002 |
| December | 491,452 |
| January '98 | 493,083 |
| Febuary | 496,918 |
| March | 498,829 |
| April | 500,480 |
| May | 500,931 |
| June | 504,492 |
| July | 504,992 |
| August | 508,807 |
| September | 510,847 |

| **FY 1984 - 1998<br>Medicaid Eligibles and Recipients** |
|---|
| |

**Medicaid Eligibles by Aid Category & County**
A Microsoft Excel spreadsheet (14k) showing the number of Medicaid eligibles in each of Alabama's 67 counties broken out by aid category (e.g., aged, disabled, SOBRA, etc.) can be downloaded .

| **FY 1998<br>Eligibles - Percent Distribution** |
|---|

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|---|---|
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| | |

# Recipients

Of the 637,489 persons eligible for Medicaid in FY 1998, about 83 percent actually received care for which Medicaid paid. These 530,128 persons are referred to as recipients. The remaining 107,361 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 1998**
**RECIPIENTS**
**Monthly Averages and Annual Total**

| Category | Monthly Average | Annual Total |
|---|---|---|
| Aged | 48,986 | 85,888 |
| Blind | 967 | 1,390 |
| Disabled | 96,562 | 148,741 |
| Dependent | 36,680 | 111,146 |
| SOBRA | 84,456 | 260,547 |
| All Categories(unduplicated) | 267,258 | 530,128 |
| | | |

# 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 payments 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 may receive, 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 1998 was $79. The yearly average number of days for recipients of this service was 279. 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 Part B coverage, Medicaid in FY 1998 paid a monthly buy-in fee to Medicare of $43.80 per eligible Medicare beneficiary. The Medicaid Agency also paid from $309.00 to $339.90 per month Part-A buy-in premiums for certain Medicare eligibles. Medicaid paid a total of $79 million in Medicare buy-in fees in FY 1998. Paying the buy-in fees is cost effective for Medicaid because, otherwise, the Agency would incur the full payment for medical bills instead of only covering the premiums, deductibles, and coinsurance.

| **FY 1998**<br>**Payments - Percent Distribution** | |
|---|---|
| | |

| | |
|---|---|
| | |

**FY 1998**
**Cost per Eligible**
**by Category, Sex, Race, and Age**

| | |
|---|---|
| By Category | |
| By Sex | |
| By Race | |
| By Age | |

# Cost Avoidance and Recoupments

## Program Integrity

The Program Integrity Division of the Alabama Medicaid Agency is tasked with identifying fraud and abuse of Medicaid benefits by both health care providers and recipients. Computer programs are used to identify unusual patterns of utilization of services. Medical desk reviews are conducted on those providers and recipients whose medical practice or utilization of services appears outside established norms. Additionally, the division performs follow-up on referrals made from many internal and external sources, including calls made to the Medicaid Fraud Hotline.

In the Provider Review Unit, statistical computer programs are used to identify patterns of potential overbilling or program abuse. Specially trained nurses then examine providers' Medicaid claims using computer programs and review of patient medical records. Both quality and quantity of services are examined. The primary purpose of this review process is to recover overpayments and identify potential Medicaid fraud and abuse.

| **FY 1998<br>PROVIDER REVIEWS** | |
|---|---|
| Medical Providers Reviewed | 256 |
| Pharmacies Reviewed | 533 |
| Medical Provider Recoveries | $1,264,723 |
| Pharmacy Recoveries | $95,760 |

Corrective actions include recoupment of funds, education on proper billing procedures, and peer review by appropriate licensing authorities. There were 256 reviews completed in FY 1998 and recoupments for this period totaled nearly $1,265,000.

Intentional fraud cases are referred to the Attorney General's Medicaid Fraud Control Unit for legal action.

Six providers were sanctioned by the Medicaid program for abusive billing practices during fiscal year 1998: three doctors, two hospitals and one dentist.

When a recipient review indicates a pattern of over or misutilization of Medicaid benefits, the recipient is placed in the Agency's Restriction Program for management of his medical condition. The recipient is locked in to a physician who is responsible for primary care. Referrals to specialists are allowed if they are made by the recipient's primary care physician. The recipient is also restricted to one pharmacy for obtaining medications. Additional limitations may be placed on the recipient's ability to obtain certain drugs. Follow-up reviews are performed annually.

| FY 1998<br>RECIPIENT REVIEWS | |
|---|---|
| Reviews Conducted | 829 |
| Monthly Average # of Resticted Recipients | 355 |
| Cost Avoidance | $440,352 |

During FY 1998 Medicaid investigators closed 83 cases. Code of Alabama, 1975, Section 22-6-8, requires that cases of suspected fraud, abuse, and/or misuse of Medicaid benefits be referred to a Medicaid Utilization Review Committee. The Committee may recommend that a recipient's eligibility be suspended for one year and until repayment of misspent funds is made. Since October 1, 1997 Medicaid benefits have been suspended for 352 recipients. At the end of FY 1998, a total of approximately 1,900 recipients are suspended from the Medicaid program for fraud and/or abuse. In addition, 23 recipients were referred to local district attorneys for prosecution, of which 13 indictments or convictions have resulted.

Through the Quality Control Unit, the Medicaid Agency makes sure eligibility determinations are as accurate as possible. In-depth reviews of eligibility determinations are performed on a random sample of Medicaid eligibles. If a state's payment error rate exceeds three percent, the Health Care Financing Administration (HCFA) may impose a financial sanction. The Agency's most recent error rate was within a comfortable margin below the three- percent maximum for the six-month period from April to September 1998. Nationally, Alabama has consistently been among those states with the lowest payment error rates.

The Pharmacy Audit Unit of the Program Integrity Division is responsible for auditing or desk reviewing pharmacy provider records. Audits and desk reviews are performed to determine that claims paid by the Alabama Medicaid Agency for prescription drugs are valid and in compliance with applicable federal and state rules and regulations. Errors discovered by audit or desk review may be corrected through education, recoupment, or adjustment. However, potentially fraudulent practices discovered by audit or desk review are referred to the Investigations Unit of Program Integrity.

The Pharmacy Audit Unit performed 77 audits and 456 suspect duplicate desk reviews during fiscal year 1998. A grand total of nearly $96,000 was recouped or adjusted from provider payrolls during this time period.

## Third Party Liability

Medicaid's Third Party Liability (TPL) Program is responsible for ensuring that Medicaid pays only when there is no other source (third party) available to pay for a recipient's health care. To do this Medicaid uses a combination of data matches, diagnosis code edits, and referrals from providers, caseworkers, and recipients to identify available third party resources such as health and liability insurance. The TPL Program also ensures that Medicaid recovers any costs incurred when available resources are identified through its liens and estate recovery programs as well as seeks reimbursement from recipients when Medicaid payments were made erroneously as a result of eligibility-related issues. In addition, the TPL Program provides alternative sources of

health care coverage for recipients by purchasing Medicare coverage as well as coverage through individual and group health plans when cost effective.

Alabama's Third Party Division oversees a comprehensive TPL Program, which has been successful in saving Alabama taxpayers approximately $53 million in FY 98 and over $420 million since 1988. This has been done through a combination of cost avoidance of claims where providers file with the primary payor first, direct billing of third party payors for reimbursement to Medicaid, and continuation of private health insurance coverage for certain Medicaid beneficiaries. Money is also saved by recovery of Medicaid's costs through estate recovery and liens activity, monitoring of Medicare edits, and recoupments from beneficiaries of incorrectly paid claims due to ineligibility.

## Health Insurance Resources

In FY 1998, some type of health insurance covered approximately 14% of Medicaid recipients under the age of 65. The majority of these recipients were covered by group health insurance through their own employers or those of parents or spouses. A significant number of the plans offered by these employers require their insured to use participating providers and obtain precertification of certain services, resulting in substantial savings to Medicaid. For individuals age 65 and older, approximately 15 percent were covered by a Medicare supplement or other health plan.

In FY 1998, Medicaid's Third Party Division collected over $5 million in reimbursement from health insurance carriers. In addition, Medicaid returned claims to providers totaling almost $39 million due to health insurance edits. From these claims, Medicaid saved $4.3 million which providers reported collecting from health insurance carriers, and it is estimated that Medicaid saved an additional $5.8 million from claims paid in full by the primary payor and never submitted or resubmitted to Medicaid. In all, health insurance resources saved Medicaid, at a minimum, $15 million in FY 98.

## Medicare Buy-In

Medicaid purchases Medicare Parts A and B for eligible beneficiaries. The Third Party Division oversees the payment of premiums for this coverage and ensures that Medicare benefits are used as a primary resource to Medicaid. In FY 1998, Medicaid denied over $29 million in claims that were submitted to Medicaid without first being paid by Medicare. In addition, Medicaid recouped from providers over $4 million in claims which Medicare should have paid as primary payor.

## Medical Support

Many Medicaid eligible children are also eligible for coverage of their medical care through a non-custodial parent's (NCP) health insurance. In addition to identifying those children with existing coverage, Medicaid uses data matches and referrals from caseworkers to identify those who are not covered by the NCP's health plan but could be. These children are referred to the Department of Human Resources (DHR) to obtain and enforce a court order requiring the NCP to enroll the child in the NCP's health plan. Where health insurance is not available, an NCP may

be under a court order to reimburse Medicaid for medical bills paid by Medicaid on behalf of the dependent. In FY 1998 approximately $71,000 was collected by Medicaid from NCP's either through direct payment or tax intercept as a result of court ordered medical support.

## Casualty/Tort Resources

When Medicaid identifies a recipient whose claims for treatment of an injury were paid by Medicaid, the Third Party Division is required to look for other sources that may pay for the recipient's medical care. Other sources of payment may include homeowner's, automobile, malpractice, or other liability insurance as well as payment by individuals such as restitution ordered by a court. Once a potential third party payor is identified, Medicaid must seek reimbursement of payment for related medical bills paid by Medicaid. In FY 1998, Medicaid collected approximately $1.3 million from liable third party payors.

## Recoupments

The Medicaid Agency recovers funds from individuals who received Medicaid services for which they were not entitled. In most instances these cases involve individuals who, through neglect or fraud, did not report income or assets to their eligibility caseworkers. The Third Party Division's Recoupments Unit receives complaint reports from Medicaid and DHR workers. In FY 1998, the unit identified over $1.4 million for collection, and collected over $722,000 in misspent dollars.

## Estate Recovery and Liens

State Medicaid Programs are required to recover the costs of nursing facility and other long-term care services from the estates of Medicaid recipients. In FY 1998, the division's Liens Program recorded over 400 new lien cases and collected $2.4 million. Also, in FY 1998 Medicaid's Estate Recovery Program initiated collection against estates of individuals to recover Medicaid's costs for all claims incurred after the individual reached age 55. Through the efforts of this program, 72 income trusts were recorded and approximately $15,000 was collected.

## Premium Payment

When cost effective, Medicaid has the option of paying health insurance premiums on behalf of individuals who are unable to continue payment of their premiums because of loss of job or high cost of premiums. Many of the individuals enrolled in this program have lost employment and cannot afford to pay the high cost of COBRA premiums. This is a very effective program as it allows individuals with high cost medical conditions to continue to receive health care through their established providers, and at the same time it provides substantial savings to the Medicaid program. In FY 1998, premiums were paid for an average of 82 individuals each month resulting in savings to Medicaid of approximately $500,000. Individuals who have benefited from this program include pregnant women, accident victims and recipients diagnosed with hemophilia, cancer and HIV.

# Agency Audit

## Fiscal Agent/ Systems Audit

The Fiscal Agent Liaison Division monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews of forced claims, denied claims, processed refunds and adjustments are also performed. In addition, targeted reviews of claims are performed when potential systems errors are found. One major target review this year involved overpayments made for duplicate managed care records. During this fiscal year, approximately 10,200 claims were manually reviewed and $284,800 was identified for recoupment.

## Provider Audit/Reimbursement

The mission of the Provider Audit/Reimbursement Division is to monitor Agency expenditures in the major program areas (nursing facilities, alternative services, managed care plans, health maintenance organizations and other prepaid health plans) to ensure that only allowable costs are reimbursed. Provider Audit has three branches: Nursing Home Audit, Alternative Services Audit, and Quality Assurance/Reimbursement.

Nursing Home Audit conducts on-site financial audits and makes necessary adjustments to the reported costs. This adjustment information is provided to reimbursement specialists who adjust current payment rates, recoup overpayments and make up for underpayments. An in-depth, on-site audit of all nursing home facilities and home offices is completed at least once every five years, and for all ICF/MRs, at least once every three years. During FY 1998, this unit completed 52 audits. Both positive and negative adjustments are made to insure that all reimbursable costs are included and that all non-reimbursable costs are removed from provider per diem rates. If it is determined that a provider may be intentionally filing a fraudulent cost report, or if the provider continues to claim known unallowable costs in the reimbursement cost total, the Nursing Home Audit section provides the Attorney General's Medicaid Fraud Control Unit with the information.

Quality Assurance/Reimbursement performs desk reviews/audits of nursing home costs and makes adjustments to set nursing home reimbursement rates, recomputes reimbursement rates due to audit findings, and computes over/underpayments based on audits, additional information, etc. The unit also analyzes data necessary for determining capitated rates for managed care plans, health maintenance organizations and other prepaid health plans and reviews all audits performed by nursing home auditors and alternative services auditors for compliance with generally accepted accounting principles and systems, and state/federal regulations.

Limited scope financial audits of providers in selected waiver programs are performed by the Alternative Services Audit section. This section verifies revenue, expense, and other data reported by providers through their cost reports. The data from these cost reports is used to set rates for each service provider in the Elderly and Disabled Waiver, the Mentally Retarded/Developmentally Disabled Waiver, and the Homebound Waiver. This section also sets rates for federally qualified health centers, provider based rural health clinics, targeted case management (adult protective services and foster children), children's specialty clinic services, and the Hospice Program using the providers' cost reports. Providers always have the right to appeal audit findings.

| **FY 1998**<br>**COLLECTIONS AND MEASURABLE COST AVOIDANCE** | |
|---|---|
| ***COLLECTIONS*** | |
| DRUG REBATE PROGRAM<br>The collection of rebates plus interest by the Fiscal Division from drug manufacturers for the use of their products | $36,677,093 |
| Claim Recoupment/Adjustments | $89,000 |
| THIRD PARTY LIABILITY<br>Includes reported third party collections by providers, retroactive Medicare recoupments from providers, and collections due to health and casualty insurance, estate recovery, and misspent funds resulting from eligibility errors | $14,330,482 |
| OTHER RECOUPMENTS<br>Includes recoupments originating from monthly audits of 25 percent of Medicaid admissions in delegated hospitals and random audits of other hospitals | $228,798 |
| PROGRAM INTEGRITY DIVISION<br>Provider Recoupments | $1,264,723 |
| PROGRAM INTEGRITY DIVISION<br>Tax Intercept Collections | $29,239 |
| FISCAL AGENT/SYSTEMS AUDIT DIVISION<br>Claim Collections | $284,800 |
| TOTAL COLLECTIONS | $52,904,135 |
| ***MEASURABLE COST AVOIDANCE*** | |
| PRIOR APPROVAL AND PREPAYMENT REVIEW<br>Results from denials in psychiatric hospitals participating in Medicaid's Under 21 Psychiatric program | $157,1186 |
| THIRD PARTY CLAIM COST AVOIDANCE - MEDICARE<br>Claims denied and returned to providers to file Medicare | $29,055,151 |
| THIRD PARTY CLAIM COST AVOIDANCE - HEALTH INSURANCE<br>Claims denied and returned to providers to file health casualty insurance | $38,578,768 |
| THIRD PARTY PREMIUM PAYMENT COST AVOIDANCE | $500,000 |
| WAIVER SERVICES COST AVOIDANCE - ELDERLY AND DISABLED | $109,818,915 |
| WAIVER SERVICES COST AVOIDANCE - HOMEBOUND | $4,712,400 |
| WAIVER SERVICES COST AVOIDANCE - MR/DD | $195,409,821 |
| TOTAL MEASURABLE COST AVOIDANCE | $378,232,173 |
| **GRAND TOTAL** | $431,136,308 |

# Medicaid Management Information System

The Agency's Medicaid Management Information System (MMIS) maintains provider and recipient eligibility records, processes all Medicaid claims from providers, keeps track of program expenditures, and furnishes reports that allow Medicaid administrators to monitor the pulse of the program.

Major projects completed during FY 98 included automation of the Pharmacy Audit System to reduce and expedite manual audit procedures, completion of the year 2000 (Y2K) complaint P.C.-based Drug Rebate Audit System, and completion of research and statistics developed to determine the impact of the PHP (Partnership Hospital Program) capitation versus fee-for-service. The SDX system was revised to incorporate new data from the Social Security Administration, and the State Verification & Eligibility System (SVES) was made Y2K compliant. The Third Party Liability (TPL) System was expanded to include new relationship data for policy holders to improve billing procedures and new identification data for pharmacy providers so CHAMPUS and other third party claim processors will pay claims. The annual COLA process was enhanced to expedite Agency workloads, and the Children's Rehabilitation Services State Share Reporting System was changed to calculate state share using pricing for specific dates of service.

The eligibility file was modified this year in response to new federal welfare reform legislation to incorporate two new populations of eligibles, children previously denied eligibility by SSA, and children certified through the Child Health Insurance Program, known as CHIP. The Agency was authorized to certify foster care children through the Department of Youth Services who previously did not qualify for Medicaid coverage. The eligibility file was also revised to award a specific number of months of Medicaid to recipients appealing SSI benefits while Medicaid re-determines eligibility for those recipients. Other changes to the Eligibility System included increases in the income limits for QMB, SLMB and SOBRA recipients, a new program similar to the SLMB Program but with a higher income range, changes to the way Medicaid pays Part B premiums, and changes that grant 12 months of continuous eligibility to all children certified under age 19.

The Drug Pricing File was expanded to include new prior authorization data to ensure specific prescriptions are properly dispensed, and software was developed to place appropriate minimum and maximum units on this file. Changes were made to acquire the Medicare Physician Fee Schedules through the Internet instead of through tapes from Blue Cross/Blue Shield. Federally qualified healthcare center (FQHC) pricing was changed to Level III Pricing with a percentage increase to conform to the pricing methodology used for Rural Health Clinics, with the exception of Patient 1st case management fees, which are excluded from this enhanced rate. The Maternity Waiver Program was expanded to include more Alabama counties.

Many of Medicaid's computer functions are performed by the Agency's contracted fiscal agent, Electronic Data Systems (EDS). Medicaid first contracted with EDS in October 1979, with the current contract period beginning October 1, 1993. In June 1998 the Alabama Medicaid Agency

and EDS signed a contract for a new MMIS. The Y2K compliant MMIS will be operational on October 1, 1999. The new MMIS will be flexible and provide many features that will enhance Medicaid for both providers and recipients.

# Maternal and Child Health Services

During FY 1998, Medicaid served 277,500 women and children through the expanded eligibility group for pregnant women and children called SOBRA (Sixth Omnibus Budget Reconciliation Act). Coverage of this group has contributed to an improvement in Alabama's infant mortality rate since 1989, from 12.1 infant deaths per thousand births to 9.5 deaths per thousand in 1997.

## Prenatal Care

The latest birth statistics revealed the number of births to women aged 10-19 decreased in Alabama from 11,115 in 1996 to 10,724 in 1997. There were 269 births to teenage women under 15 years of age, a decrease from 311 births in 1996.

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 has proven to result in healthier mothers and babies. Timely care can also 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 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). 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. Beginning 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 recipients 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.

## Adolescent Pregnancy Prevention Education

Adolescent Pregnancy Prevention Education was implemented in October 1991. The program is designed to offer expanded medically related education services to teens. The program curricula are designed to teach disease and disability prevention and to prolong life and promote physical and mental health. These classes go beyond the limited service and information offered under existing Medicaid programs. Physicians or other licensed practitioners of the healing arts who present detailed adolescent pregnancy material provide these services.

The pregnancy prevention services include a series of classes teaching male and female adolescents about decision-making skills and the consequences of unintended pregnancies. Abstinence is presented as the preferred method of choice. Currently there are approximately 16 providers of adolescent pregnancy prevention services. These include hospitals, county health departments, FQHCs, and private organizations.

## Vaccines for Children

In an effort to increase the number of Alabama children who are fully immunized by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program in October 1994. This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations, if they obtain vaccines from a federally qualified health center or rural health clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 335,000 of Alabama's children are Medicaid eligible. Medicaid has taken the previous vaccines and administration fee costs to calculate an equivalent reimbursement fee of $8 per injection. When multiple injections are given on the same day, Medicaid will reimburse for each injection. When injections are given in conjunction with an EPSDT screening visit or physician office visit, an administration fee of $8 will also be paid.

Providers may charge non-Medicaid VFC participants an administration fee not to exceed $14.26 per injection. This is an interim rate set by the Health Care Financing Administration based on charge data. No VFC-eligible participant should be denied services because of inability to pay.

The Department of Public Health is the lead agency in administering this program.

## Maternity Waiver

The Maternity Waiver Program, begun September 1, 1988, is aimed at combating Alabama's high infant mortality rate. It assures that eligible pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through a primary provider network. The program operates by directing women to certain caregivers and by augmenting their medical care with care coordination (also known as case management). 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.

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.

During FY 1998, there were 43 counties participating in the maternity waiver. Those counties were: Autauga, Baldwin, Bibb, Blount, Calhoun, Chilton, Choctaw, Clarke, Colbert, Conecuh, Cullman, Dallas, Elmore, Escambia, Etowah, Fayette, Franklin, Greene, Hale, Henry, Houston, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Mobile, Montgomery, Pickens, Russell, Shelby, St. Clair, Sumter, Tuscaloosa, Washington, Wilcox, and Winston. Plans call for an expansion of the waiver so that eventually all Medicaid eligible pregnant women can participate in this innovative and successful approach to improving birth outcomes.

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.

## Family Planning

The origin of the Family Planning Program dates back to the time when Medicaid started in Alabama. The Social Security Amendments of 1972 mandated coverage of Family Planning services for categorically needy individuals of childbearing age, including minors who are sexually active and desire such services. The law also provides for 90 percent federal funding for these services. This is a higher match than for other Medicaid services.

Family planning services are defined as those services that prevent or delay pregnancy. They include office visits, health education, some laboratory screening tests, and pharmaceutical supplies and devices provided for contraceptive purposes.

Family planning services are covered for Medicaid eligible women, including SOBRA women 10-55 years of age and men of any age who desire such services. Recipients have freedom of choice in selecting a contraceptive method and/or a provider of family planning services. Acceptance of family planning services must be without coercion or mental pressure.

Recipients are authorized one annual physical and up to six additional visits per calendar year. These visits do not count against other benefit limits. A family planning home visit 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. An extended contraceptive-counseling visit is also covered on the same day as the postpartum visit. Contraceptive supplies and devices available for birth control purposes include pills, foams/condoms, intrauterine devices, diaphragms, implants, and injections. Sterilization procedures are also covered if federal and state regulations are met. HIV pre and post testing counseling services are also available if performed in conjunction with a family planning visit.

Providers include county health departments, federally qualified health centers, rural health clinics, private physicians and Planned Parenthood of Alabama. Family planning providers are available statewide.

## EPSDT

The Early and Periodic Screening, Diagnosis and Treatment Program 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 realizes long term savings by intervening before a medical problem requires expensive acute care.

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 EPSDT program is a Medicaid-funded program available to all Medicaid eligible children under 21 years of age. The success of the program is fostered by the cooperation of the Alabama Medicaid Agency, the Department of Human Resources, the Department of Public Health, and Medicaid providers. Medicaid beneficiaries are made aware of EPSDT and referred to screening providers by eligibility workers at the Department of Human Resources, Medicaid District Office eligibility specialists, and SOBRA Medicaid outstationed workers located in health departments, hospitals, federally qualified health centers, and clinics throughout the state. The Medicaid Agency sends information to the parent or guardian of each child under 21, notifying them of the availability and benefits of the EPSDT program. Medicaid providers such as public health clinics also inform patients about the program.

Currently there are more than 1,620 providers of EPSDT services, including county health departments, federally qualified health centers, provider-based rural health clinics, independent rural health clinics, hospitals, private physicians and some nurse practitioners. With statewide implementation of the Patient 1$^{st}$ Program and BAY Health in Mobile County, primary care

providers are obligated to ensure that all Medicaid recipients under 21 years of age receive screenings on time. It is anticipated that the number of screenings will increase due to this requirement.

In 1995, Medicaid added an off-site component of the EPSDT program. This allows providers who met specific enrollment protocols to offer EPSDT screening services in schools, housing projects, Head Start programs, day care centers, community centers, churches and other unique sites where children are frequently found.

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 the appropriate intervals between birth and age 21.

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. Licensed dentists provide all Medicaid dental services. These services are limited to those that 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.

# Recipient Inquiry Unit

Implemented in late 1992, the Recipient Inquiry Unit has increased recipients' access to the Agency via toll-free telephone service from throughout Alabama. Averaging 16,099 calls monthly during FY 1998 (more than 193,183 annually), the inquiry unit provides replacements for lost and stolen Medicaid cards to eligible persons, while responding to callers' questions about various eligibility, program and other topics.

Each month, approximately one-fourth of all calls deal with card replacement; about one-third are information-only calls, while the remaining calls are referred to a certifying agency or worker (Medicaid District Offices, SOBRA workers, Social Security or the Department of Human Resources) or an Agency program office (Hospital, Physicians, and Pharmacy, among others) for action.

The hotline (1-800-362-1504) is open from 8 a.m. to 4:30 p.m. Monday through Friday. In FY 1998 the unit was staffed with four full time operators and 16 temporary operators.

# Managed Care

## Patient 1st

The Patient 1st program expanded during FY 1998 into a total of 51 counties serving approximately 200,000 beneficiaries. The Patient 1st Program is a primary care case management system that links each participating Medicaid beneficiary with a Primary Medical Provider (PMP). The PMP is responsible for providing care directly or through referral. Additional responsibilities include 24-hour day/7 days a week coverage, coordination of EPSDT and immunizations, and coordination of medical needs.

The program has been successful in meeting its goal of creating medical homes for Medicaid beneficiaries. Access to a PMP has resulted in medical doctor shopping, more appropriate utilization of services, and reduced expenditures for primary care in an emergency room setting.

Patient 1st will be fully operational in remaining counties in November 1998. This program will not operate in Mobile County, which participates in BAY Health Plan. The state anticipates Patient 1st continuing for an additional two years. During this time, the focus will be education and program refinement.

## BAY Health Plan (HMO)

BAY (Better Access for You) Health Plan represents the first comprehensive managed care program in the state for Medicaid beneficiaries. BAY Health Plan is a program administered by PrimeHealth, an Alabama-based health maintenance organization affiliated with the University of South Alabama. BAY operates under an 1115 research and demonstration waiver approved by the federal Health Care Financing Administration (HCFA) in December 1996. The program became operational in May 1997.

As of September 30, 1998, approximately 39,000 Medicaid beneficiaries were enrolled in BAY Health Plan. The goals of this program are:

- To assure a continuum of care and a stable "medical home" for Medicaid beneficiaries residing in Mobile County through a county-wide health system that preserves and strengthens the existing informal network of traditional providers, while encouraging expanded choice of providers.
- To improve health outcomes and prudent service use among Medicaid beneficiaries through intensive health education and supportive services; and
- To foster maternal and child health through expanded eligibility for post-partum family planning services for women under 133% of the federal poverty level.

Each BAY Health Plan member has:

- A medical home consisting of a primary care provider responsible and accountable for the delivery and/or coordination of his/her health care and services;
- Access to the BAY Health Plan Member Services Department for health care information, assistance in accessing the health care delivery system, and voicing complaints and/or grievances;
- Access to a 24-hour-a-day, 7-day-a-week helpline with registered nurses staffing the telephone after normal business hours and on weekends;
- Access to a Resource Center that includes a host of health education and wellness programs as well as support services; and
- Enhanced health care benefits including, but not limited to, unlimited outpatient visits (under the traditional Medicaid fee-for-services system, physician outpatient visits are limited to 14 per year), enhanced maternity benefits, 24 additional family planning benefits under the CARE Program, and a guaranteed six months of eligibility upon enrollment.

The first year of the program reflected savings of approximately 10 million dollars.

## Medicare HMOs and CPMs

Medicaid continued a program in which health maintenance organizations (HMOs) and competitive medical plans (CMPs) may enroll with the Medicaid agency to receive capitated per member per month payments to cover, in full, any premiums or cost sharing for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of medical cost sharing.

The HMO or CMP must have an approved Medicare risk contract with HCFA to enroll Medicare beneficiaries and other individuals and groups. The HMO or CPM must deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to Medicare enrollees. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. The HMO or CMP must offer all services covered by Medicare at no cost to the beneficiary. The HMO or CMP may offer additional services to the beneficiary, such as hearing exams, annual physical exams, eye exams, etc. Services covered by Medicaid, but not Medicare, are not included. The beneficiary is given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

## 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, crisis intervention, 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 1998, about $3.1 million was spent to provide services to approximately 16,500 clients.

On April 1, 1994, the mental health program was expanded to allow the Department of Human Resources and the Department of Youth Services to provide rehabilitative services to the children and adolescents in their custody. DHR and DYS are presently involved in the process of implementing the provisions of federal court consent decrees (R.C. and A.W., respectively). One of the critical mandates of both suits is the maximization of federal dollars, specifically Medicaid funding. DHR has become an active provider. In May 1998, DYS became an active provider. On a monthly average during FY 1998, about $1 million was spent to provide services to approximately 750 clients. A wide array of mental health services was provided to children in state custody in a cost-effective manner.

## Targeted Case Management

The optional targeted case management program assists Medicaid-eligible individuals in gaining access to needed medical, social, educational and other services through coordination, linkage, and referral. The Alabama Medicaid Agency currently serves mentally ill adults (target group 1), mentally retarded adults (target group 2), handicapped children (target group 3), foster children (target group 4), pregnant women (target group 5), AIDS/HIV positive individuals (target group 6), and adult protective service individuals (target group 8). With the addition of new providers coordinating services for these target groups, there was a reduction in nursing home placement and hospitalization. Over 25,000 Medicaid beneficiaries received targeted case management service this year at a cost of $28 million.

# 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 disabled adults with specific medical diagnoses. 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 1998, there were 6,455 recipients served by this waiver at an actual cost of $5,000 per recipient. Serving the same recipients in nursing facilities would have cost the state $22,013 per recipient. This waiver saved the state $17,013 per recipient in FY 1998.

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 Public Health and the Alabama Commission on Aging.

## HCBS Waiver for the Mentally Retarded and Developmentally Disabled (MR/DD)

This waiver serves individuals who meet the definition of mental retardation or developmental disability. 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 1998 there were 3,579 recipients served by this waiver at an actual cost of $21,387 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $75,986 per recipient. The MR/DD waiver saved the state $54,599 per recipient in FY 1998.

## Homebound Waiver

This waiver serves disabled adults with specific medical diagnoses who are at risk of being institutionalized. To be eligible an individual must be age 18 or above, and meet the nursing facility level of care. All income categories from SSI to 300% of SSI are included. The waiver is administered by the Department of Rehabilitative Services. 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 1998, there were 357 recipients served at a cost of $8,813 per recipient. Serving the same recipients in an institution would have cost the state over $22,013 per recipient. The state saved at least $13,200 per recipient in FY 1998 under the Homebound Waiver.

# Home Care Services

The Medicaid home care services program helps people with illnesses, injuries, or disabilities to 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 EPSDT program. This provision of OBRA '89 has greatly increased the number of children that are served in the community. Occupational therapy, physical therapy, durable medical equipment, and other services as necessary to maintain Medicaid eligibles in the home have been available to Medicaid eligibles under 21 since 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's home care services one of the most comprehensive medical assistance programs for children in the country.

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

## 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.

This service is not only compassionate but also cost efficient. During FY 1998, the Medicaid Agency served 636 hospice patients at a total cost of about $5.5 million. 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 172 agencies participating in FY 1998.

Up to 104 home health visits per year per recipient may be covered by Medicaid in Alabama. During FY 1998, over 6,000 recipients received visits costing a total of approximately $11 million.

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 fiscal year 1998, over 740 Medicaid DME providers throughout the state furnished services at a cost of approximately $12 million.

## In-Home Therapies

Physical, speech, and occupational therapy in the home are 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 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 in other settings 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 FY 1998, Medicaid paid approximately $3 million for services provided through 53 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 remain a critical link in providing medically necessary health care to Alabama Medicaid recipients. A managed care initiative called the Partnership Hospital Program (PHP) changed the way hospital days are reimbursed in Alabama. The PHP is a two-year waiver that was implemented October 1, 1996. Through this program, the state is divided into eight districts. Medicaid pays each PHP a per member, per month fee for inpatient hospital care to most Medicaid patients living in the district. While Medicaid patients are automatically enrolled in the district where they live, the patient may be admitted to any hospital that accepts Medicaid as payment. The PHP covers 112 Alabama hospitals in 66 counties. Not included in the PHP are Mobile county hospitals, 28 hospitals in neighboring states, four Under Age 21 Psychiatric hospitals, and one Over Age 65 Psychiatric hospital.

The objective of this managed care initiative is to provide inpatient hospital services to eligible Medicaid beneficiaries through arrangements that:

- Assure access to delivery of inpatient care.
- Promote continuous quality improvement.
- Include utilization review.
- Manage overall inpatient hospital care and efficiency.

Inpatient hospital days were limited to 16 days per calendar year in FY 1998. 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.
- Children under age seven when in a hospital designated by Medicaid as a disproportionate share hospital.

## Quality Assurance Program

The Quality Assurance Program monitors inpatient hospital services for Alabama Medicaid recipients in accordance with federal regulations and managed care initiatives. Medicaid's Quality Assurance function now monitors the managed care entity's internal Quality Assurance Plan and Committee activities. In part, the monitoring occurs through Semi-Annual Medical Reviews, Reliability Surveys, and Focused Study(ies) Reviews. The Quality Assurance Committee is also responsible for the handling of grievances, appropriate corrective action,

coordination, follow-through and referral. In addition to on-site visits the Quality Assurance Program reviews system generated data based on inpatient days utilized on a statewide basis.

Hospital admission reviews are 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.

## Outpatient Services

There were also limitations on outpatient hospital services during this fiscal year. Medicaid pays 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 approved outpatient surgical list.

**FY 1994-1998**
**Hospital Program**
**Outpatients**

| | FY '94 | FY '95 | FY '96 | FY '97 | FY '98 |
|---|---|---|---|---|---|
| Number of outpatients | 225,586 | 229,622 | 249,712 | 265,030 | 222,375 |
| Percent of Eligibles Using Outpatient Services | 37% | 36% | 39% | 42% | 35% |
| Annual Expenditure for Outpatient Care | $40,185,514 | $42,466,443 | $53,790,133 | $67,965,193 | $38,175,343 |
| Cost Per Patient | $178 | $185 | $215 | $256 | $172 |

## Copayments

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, and pregnant women are exempt from copayments. 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, lung, heart/lung, 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 Medicaid Agency. Eligible recipients' 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 Agency and rendered in Medicaid contracted psychiatric hospitals. Only psychiatric hospitals approved by the Joint Commission for Accreditation of Healthcare Organizations and with distinct units and separate treatment programs for children and adolescents can be certified to participate in this program. At the end of FY 1998, there were four hospitals enrolled.

Inpatient psychiatric services for recipients age 65 or over are covered services when provided in a free-standing hospital exclusively for the treatment of persons age 65 or over with serious mental illness. These services are unlimited if medically necessary and if the admission and continued stay reviews meet the approved psychiatric criteria. These hospital days do not count against a recipient's inpatient day limitation for treatment in an acute care hospital.

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. Reviews are performed by the Medicaid Agency to determine the medical necessity of admissions and continued need for hospitalization. Admissions to psychiatric hospitals are reviewed and authorized prior to payment to ensure that appropriate criteria have been met.

## Ambulatory Surgical Centers (ASC)

Medicaid covers ambulatory surgical center (ASC) services, which are procedures that can be performed safely on an outpatient basis. Services performed by an ASC are reimbursed by means of a predetermined fee established by the Medicaid Agency. A listing of covered surgical procedures is maintained by the Agency and furnished to all ASCs. The Agency encourages outpatient surgery whenever possible.

Ambulatory surgical centers must have an effective procedure for immediate transfer of patients to hospitals for emergency medical care beyond the capabilities of the center. Medicaid recipients are required to pay the designated copayment amount for each visit. At the end of FY 1998 there were 25 ASC facilities enrolled as providers in this program.

## Post-Hospital Extended Care Program

This program was implemented August 1, 1994 for Medicaid recipients who were in acute care hospitals but no longer need that level of care. These patients needed to be placed in nursing facilities but for reasons such as lack of an available bed, or the level of care needed was such that they could not be accommodated by an area nursing facility, the patient was forced to remain in the hospital. In response to this problem, the Agency initiated the Post-hospital Extended Care Program (PEC). Patients in this program remain in the hospital, but they receive services ordinarily provided in a nursing facility. For these patients the hospital is reimbursed a

daily rate equal to the average daily rate paid to nursing facilities in the state. The hospital is obligated to actively seek nursing home placement for these patients.

## Swing Beds

Swing beds are defined as hospital beds that can be used for either hospital acute care or skilled nursing facility care. Hospitals with swing beds are located in rural areas with fewer than 100 total beds. The hospital must be certified as a Medicare swing bed provider. Reimbursement for a Medicaid recipient receiving skilled nursing facility care in a swing bed is at a per diem rate equal to the average per diem rate paid to participating nursing homes.

## Federally Qualified Health Centers (FQHC)

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

Services covered by the FQHC program include ambulatory services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers employed by the FQHC. Federally qualified health centers are reimbursed using Medicaid's fee schedule adjusted to reasonable cost. Medicaid establishes reasonable costs by using the centers' annual cost reports. At the end of FY 1998 there were 16 FQHCs enrolled as providers, with 87 satellite clinics.

## Rural Health Clinics (RHC)

The Medicaid rural health program was implemented in April 1978. Services covered under the program include any medical service typically furnished by a physician in an office or a home visit. Limits are the same as for the physician program. Independent rural health clinic services, whether performed by a physician, nurse practitioner or physician assistant, are reimbursable. A physician or nurse practitioner is available to furnish patient care while the clinic operates. Independent rural health clinics are reimbursed at the reasonable cost per visit established for the clinics by the Medicare fiscal intermediary. At the end of FY 1998 there were 33 independent rural health clinics enrolled as providers in the Medicaid program.

Provider Based Rural Health Center (PBRHC) services were implemented in October 1993. PBRHCs are an integral part of a hospital, skilled nursing facility, or home health agency. Services covered under the program may be provided by a physician, physician assistant, nurse practitioner, certified nurse midwife, and/or specialized nurse practitioner. Visits to a PBRHC are included in the Medicaid-allowed 14 physician office visits per year.

PBRHCs are reimbursed on a percentage of fee-for-service based on their yearly cost reports. At the beginning of 1994 there were 11 PBRHCs enrolled as providers in Medicaid. There are now 26 PBRHCs enrolled as Medicaid providers.

# Medical Services

## Physicians Services

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. This service to beneficiaries, as with all other Medicaid programs, 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 facility 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 61 percent of Alabama's Medicaid eligibles received physicians' services in FY 1998.

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 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program must sign an agreement in order to perform screening 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 by Medicare, less the applicable copayment amount.

**FY 1998**
**PHYSICIAN PROGRAM**
**Use and Cost**

| | Payments | Recipients | Cost Per Recipient |
|---|---|---|---|
| Aged | $7,865,635 | 55,921 | $141 |
| Blind | $372,962 | 1,106 | $337 |
| Disabled | $50,252,137 | 117,802 | $427 |

| | | | |
|---|---|---|---|
| Dependent | $55,767,878 | 246,656 | $226 |
| All Categories | $114,258,611 | 395,973 | $289 |

## Pharmacy Services

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 1998, pharmacy providers were paid approximately $236 million for prescriptions dispensed to Medicaid recipients. This expenditure represents about eight 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. The dispensing fees and the pricing methodology remain unchanged from previous years.

Primarily to control overuse, Medicaid recipients must pay a copayment for each prescription. The copayment ranges from $.50 to $3.00, depending on drug ingredient cost. The Omnibus Budget Reconciliation Act of 1990 (OBRA) expanded Medicaid coverage of reimbursable drugs. With the exception of allowable published exclusions, almost all drugs are now covered by the Medicaid Agency. The OBRA '90 legislation also required states to implement a drug rebate program and a drug utilization review program (DUR).

The Rebate Program collects rebates from drug manufacturers based on Medicaid utilization of their drug products in Alabama. During FY 1998, over $36 million was collected. These rebates are used to offset increasing drug program expenditures.

The drug utilization review (DUR) process involves retrospective reviews conducted by the Alabama Quality Assurance Foundation under contract with the Medicaid Agency. The purpose is for identification of drug usage characteristics of Medicaid recipients in order to prevent or lessen the instances of inappropriate, excessive, or therapeutically incompatible drug use. The DUR process also enhances the quality of care received by Medicaid recipients by educating physicians and pharmacists with regard to issues concerning appropriateness of pharmaceutical care, thereby minimizing expenditures.

Medicaid continues to operate a drug utilization review (DUR) program. The retrospective element of DUR is complemented by a prospective element. Prospective DUR is an on-line, real-time process allowing pharmacists the ability to intervene before a prescription is dispensed, preventing therapeutic duplication, over and underutilization, low or high doses and drug interactions. Medicaid has implemented a prospective DUR system that screens prescriptions for early/late refills, therapeutic duplication, drug interactions, high dose, and product selection (preferred drug status).

The Agency has also implemented a voluntary educational program called the Preferred Drug Program. The program provides educational information to physicians and pharmacists regarding drugs considered superior in their class. This program fosters the most appropriate therapy for Medicaid patients in an efficient and effective manner.

**FY 1996-1998**
**PHARMACEUTICAL PROGRAM**
**Use and Cost**

| Year | Number of Drug Recipients | Recipients as a % of Eligibles | Number of Rx | Rx Per Recipient | Price Per Rx | Cost Per Recipient | Total Cost to Medicaid* |
|---|---|---|---|---|---|---|---|
| 1996 | 412,757 | 65% | 7,612,847 | 18.44 | $26.77 | $494 | $203,794,120 |
| 1997 | 413,981 | 65% | 7,976,383 | 19.27 | $28.40 | $547 | $226,533,080 |
| 1998 | 397,041 | 62% | 7,932,759 | 19.98 | $29.85 | $596 | $236,819,290 |

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

**FY 1996-1998**
**PHARMACEUTICAL PROGRAM**
**Cost**

| Year | Total Payments | Drug Rebates | Net Cost | Net Cost Per Rx. | Net Cost Per Recipient |
|---|---|---|---|---|---|
| 1996 | $203,794,120 | $35,792,661 | $168,001,459 | $22.07 | $407 |
| 1997 | $226,533,080 | $47,170,513 | $179,362,567 | $22.49 | $433 |
| 1998 | $236,819,290 | $36,677,093 | $200,142,197 | $25.23 | $504 |

## Eye Care Services

Medicaid's eye care program provides beneficiaries 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 other limited justifications. Post-cataract patients may be referred by their surgeons to optometrists for follow-up management.

In keeping with the Agency's policy of cost containment, eyeglasses are chosen through competitive bidding. The contractor is required to furnish eyeglasses that meet federal, state and

Agency standards. The selection of frames includes styles for men, women, teens, and preteens. Eyeglasses furnished locally are reimbursed at contract rates.

| **FY 1998**<br>**EYE CARE PROGRAM**<br>**Use and Cost** | | | |
|---|---|---|---|
| | Payments | Recipients | Cost Per Recipient |
| Optometric Service | $3,406,056 | 61,647 | $55 |
| Eyeglasses | $1,381,241 | 42,716 | $32 |

## Laboratory and Radiology Services

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. There are over 116 independent laboratories and over 10 free standing radiology facilities that are enrolled with Alabama Medicaid. Each independent laboratory and free-standing facility must be approved by the appropriate licensing agency within the state in which it resides, be certified as a Medicare provider and sign a contract with the Medicaid Agency in order to be eligible to receive reimbursement from Medicaid. Laboratory and radiology are unlimited services and if medically necessary can be covered even if other benefit limits have been exhausted.

| **FY 1996-1998**<br>**LAB and X-RAY PROGRAM**<br>**Use and Cost** | | | |
|---|---|---|---|
| Year | Payments | Recipients | Annual Cost Per Recipient |
| 1996 | $11,074,885 | 187,349 | $59 |
| 1997 | $10,616,907 | 188,587 | $56 |
| 1995 | $9,520,445 | 158,578 | $60 |

## Renal Dialysis Services

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 64 freestanding facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis and CAPD (Continuous Ambulatory Peritoneal Dialysis) and home treatments, as well as training,

counseling, drugs, biologicals, and related tests. Patients are allowed 156 treatment sessions per year, which provides for three sessions per week.

Recipients who travel out of state may receive treatment in that state. The dialysis facility must be enrolled with Medicaid for the appropriate period of time. Although the Medicaid renal dialysis program is small, it is a life-saving service without which many recipients could not survive, physically or financially.

# Long Term Care

Care for acutely ill, indigent residents in nursing facilities was mandated in 1965 with the enactment of Medicaid (Title XIX). On October 1, 1990, OBRA '87 was implemented and provided for improvements in health care for residents in nursing facilities. The law included 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. As of July 1, 1995, the last major phase of nursing home reform was implemented. On that day, new enforcement regulations took effect to assure high quality care in nursing facilities. Nursing home reform has included a resident "bill of rights" and requirements for individual resident assessments and plans of care, as well as nurse aide training and competency requirements and the establishment of a nurse aide registry.

With the new enforcement regulations, there is wider range of sanctions tailored to different quality problems. Adopting "substantial compliance" as the acceptable standard, the new rules are meant to ensure reasonable regulation while at the same time requiring nursing facilities to correct problems quickly and on a long-term basis. An important goal of the new enforcement plan is to ensure that continuous internal quality control and improvement are performed by the nursing facilities themselves.

The regulations provide for the imposition of civil money penalties and other alternative remedies such as denial of payment for new admissions, state monitoring, temporary management, directed plans of correction, and directed in-service training. Almost all facilities will be given the opportunity to correct the deficiencies and avoid remedies. Only chronically poor performers and facilities with deficiencies that present direct jeopardy to residents will be assessed with an immediate remedy, which may involve termination or civil money penalties.

Medicaid financed 65 percent of all nursing home care in the state during FY 1998. The total cost to Medicaid for providing this care was over $529 million. Almost 96 percent of the 226 nursing homes in the state accepted Medicaid recipients as patients in FY 1998. There were also 20 hospitals in the state during FY 1998 that had long term care beds, called swing beds, participating in Medicaid.

In the past all Medicaid patients residing in a nursing facility have had to apply their available income to the basic nursing facility per diem rate; however, effective April 1, 1994, Qualified Medicare Beneficiaries (QMBs) residing in a nursing facility no longer have to apply any of their income toward the cost of the Medicare coinsurance for nursing home care. The coinsurance is paid entirely by Medicaid for this group. Also, effective April 1, 1994, medically necessary over-the-counter (non-legend) drug products ordered by a physician are covered.

**FY 1996-1998**
**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 |
|---|---|---|---|
| 1996 | 24,305 | 16,112 | 66.3% |
| 1997 | 25,497 | 16,696 | 65.5% |
| 1998 | 25,696 | 16,680 | 64.9% |

**FY 1996-1998**
**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 |
|---|---|---|---|---|---|
| 1996 | 22,755 | 273 | 6,219,387 | $71 | $444,142,454 |
| 1997 | 23,656 | 275 | 6,511,241 | $80 | $523,034,923 |
| 1998 | 24,046 | 279 | 6,719,368 | $79 | $529,335,564 |

**FY 1998**
**LONG-TERM CARE PROGRAM**
**Recipients and Payments by Sex, Race, and Age**

| | Recipients | Payments | Cost Per Recipient |
|---|---|---|---|
| **BY SEX:** | | | |
| Female | 18,613 | $416,740,415 | $22,390 |
| Male | 5,433 | $112,595,149 | $20,724 |
| **BY RACE:** | | | |
| White | 18,410 | $401,753,553 | $21,823 |
| Non-white | 5,636 | $127,582,011 | $22,635 |
| **BY AGE:** | | | |
| 0-5 | 26 | $800,030 | $30,770 |
| 6-20 | 126 | $4,685,244 | $37,184 |
| 21-64 | 1,955 | $46,846,102 | $23,962 |
| 65 & Over | 21,939 | $477,004,188 | $21,742 |

# Long Term Care for the Mentally Retarded and Mentally Disabled

The Alabama Medicaid Agency, in coordination with the Department of Mental Health and Mental Retardation, includes coverage for Medicaid-eligible mentally retarded and mentally diseased persons who require care in intermediate care facilities (ICF). Eligibility for these programs is determined by categorical, medical and/or social requirements specified in federal law. The programs provide treatment that 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. Tarwater Developmental Center in Wetumpka, the Lurleen B. Wallace Developmental Center in Decatur, and the W.D. Partlow Developmental Center in Tuscaloosa. In FY 1998 the average reimbursement rate per day in an institution serving the mentally retarded was $254.25.

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 Medicaid Agency to deinstitutionalize as many clients as possible and serve clients in the least restrictive setting. In 1997, the Glenn Ireland II Developmental Center was closed, with the majority of its residents being transferred to community group homes.

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 Arc of the Shoals in Tuscumbia, Volunteers of America #20 in Huntsville, and Volunteers of America #40 in Hartselle. Institutional care for the mentally diseased (IMD) is provided through Alice Kidd Nursing Facility in Tuscaloosa, Claudette Box Nursing Facility in Mobile, and S. D. Allen Nursing Facility in Northport.

In terms of total Medicaid dollars expended and the average monthly payment per patient, the ICF-MR and IMD 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 1998, in cooperation with the Medicaid Agency, Mental Health was able to match every $30 in state funds with $70 of federal funds for the care of Medicaid-eligible ICF-MR and IMD patients.

| **FY 1998**<br>**Long-Term Care Program**<br>**ICF-MR/DD** | | |
|---|---|---|
| | ICF/MR | ICF/MD-Aged |
| Recipients | 751 | 471 |
| Total Payments | $58,257,867 | $175,434,909 |
| Annual Cost per Recipient | $77,574 | $37,017 |