A Historical Overview of the Alabama Medicaid Agency

Prepared by the Financial Planning/Analysis Division
Alabama Medicaid Agency
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Introduction

Medicaid traces its origin to July 30, 1965 when Title XIX of the Social Security Act was enacted as part of the federal-state welfare structure to aid America's poor population. Prior to 1965, there was no federal health care assistance for the poor. This responsibility had always been an obligation of state governments. Before the implementation of Medicaid, most health care for the poor was provided as charity care by physicians, either donated or provided on a sliding fee scale. Non-profit, usually religious, hospitals admitted charity cases. Due to the diversity in state budgeting for health care, the types and quality of care provided to the poor varied greatly from state to state. Racial discrimination also posed a problem to the equity of health care access for the poor. The Kerr-Mills Act of 1960, known as Medical Assistance for the Aged, was the forerunner of the Medicaid model and was later incorporated into Title XIX.

Certain basic health services, as set forth in Title XIX, were required of every state Medicaid program:

- Hospital inpatient care
- Hospital outpatient services
- Laboratory and x-ray services
- Skilled nursing facility services for those aged 21 and older
- Home health services for those eligible for skilled nursing facility services
- Physicians' services
- Family planning
- Rural health clinic services
- Early and periodic screening, diagnosis, and treatment (EPSDT) for children under 21 years

States could determine the scope of services offered and provide a number of additional elective services including:

- Drugs
- Eyeglasses
- Intermediate care facility services
- Inpatient psychiatric care for the aged and those under 21 years of age
- Physical therapy
- Dental care

Medicaid operates mainly as a vendor payment program. Providers receive payments directly from a state Medicaid agency for the care rendered to Medicaid eligibles. The methods for reimbursement vary widely among states, but the providers must accept the reimbursement as full payment. As a general rule, Medicaid reimbursement levels are less than Medicare's payments. States may require cost sharing by Medicaid recipients, but they may not require services to be withheld from the categorically eligible because of an inability to pay the co-pay amount. In most states, Medicaid will assume responsibility for the Medicare cost sharing for persons eligible for both programs. States participate in the Medicaid program at their option and administer their individual programs within broad federal guidelines. Considerable discretion is

given to states in determining eligibility, coverage, and provider payment mechanisms. Most states contract with a fiscal agent which is responsible for processing claims from providers and for other functions.

The Medicaid program is financed by the Health Care Financing Administration (HCFA) which is a federal agency that provides the federal matching money to assist the state in funding the Medicaid program. Medicaid is a jointly-funded, state-administered program. Each year HCFA determines the amount of federal matching money which will be available to the state for medical assistance payments on a ratio of the cost of living in the state of Alabama versus the average cost of living for all states in this country. There are also payment rates for administrative costs which vary from 0 to 90% depending on the type of activity that is being financed. Most administrative costs are matched at 50%. Some, such as professional personnel, are matched at 75%, while family planning-related activities and personnel are matched at 90% by HCFA.

The Formative Years

January 1970 - September 1971

Director: Thomas Henry Alphin, M.D.

Dr. Alphin, appointed by Governor Albert Brewer, came to Alabama to establish, organize, and administer the Alabama Medicaid program after his resignation as assistant vice president and medical director of the Equitable Life Assurance Society. Prior to his career with Equitable Life Assurance Society, Dr. Alphin was assistant director and later director of the Washington office of the American Medical Association. Early in his career, he was medical examiner for the Virginia Board of Health.

A native of Maryland, he received his B.S. degree from Washington and Lee University, his M.S. degree from the University of Virginia, and his M.D. degree from the University of Virginia.

Organization and Structure

On June 30, 1967, Executive Order Number 8 as signed by Governor Lurleen B. Wallace began the official formation of Alabama's Medicaid program. This executive order designated the State Board of Health as the single state agency with authority to develop and administer the program, and designated the Department of Pensions and Security as the state agency for determining eligibility for medical assistance and certification. On June 1st of 1968, Dr. Alphin was appointed director of the new program.

Alabama's resulting State Plan for Medical Assistance, effective January 1, 1970, was approved by the federal Department of Health, Education and Welfare (HEW) in the closing hours of 1969. Alabama's Medicaid would be a program directed by the Medical Services Administration (MSA) in the Department of Public Health. It consisted of an administrative division, an operations division, a contracting and fiscal division, and a management systems division. At this time, the Medical Services Administration was under the direct control of the State Health Officer, Dr. Ira Myers, who served at the pleasure of the state Committee of Public Health. Under the direction of the Governor, the State Board of Health held the ultimate authority over the Committee of Public Health.

The Agency's first fiscal agent was Equitable Life Assurance Society and claims processing was done in New York, New York. During this period, the Agency's offices were located in the VFW building located at 304 Dexter Avenue.

Personnel

As of December 30, 1970, MSA had 45 employees. These employees included 3 physicians, 2 pharmacists, 4 nurses, 22 clerical workers, 3 social service workers, 8 administrative personnel, 2 accountants, and 1 messenger position.

Programs

As of January 1, 1970, there were 253,991 Alabamians certified by the Department of Pensions and Security as being eligible for Medicaid. By December 31, 1970, that number had increased to 313,074.

During these early years, Medicaid provided the following services to Alabama's Medicaid population:

- Inpatient and outpatient hospital services
- Laboratory and radiology services
- Pharmaceuticals
- Eyeglasses and optometric care
- Family planning
- Home health care
- Skilled and intermediate nursing care
- Screening services for a variety of conditions such as anemia, eye conditions, otitis, dental health, and hearing and speech problems.

Federal regulations also mandated that states establish a program to identify available third party resources to ensure that Medicaid was "payor of last resort." As a result, on January 1, 1970, Alabama established one of the nation's first third party recovery programs. Mary F. Strait, director of Alabama's Third Party program, was contracted by HCFA to develop a Third Party manual for states to use in developing their own programs.

From January 1, 1970 until May 31, 1971, Medicaid covered 60 inpatient days. This number was reduced to 30 inpatient days during the period from June 1, 1971 until May 31, 1975.

Allowable outpatient days were unlimited from January 1, 1970 through September 30, 1979. Beginning in October of 1972 renal dialysis was provided under Medicaid through the hospital outpatient program.

Medically necessary laboratory and x-ray services were covered beginning in 1970. These services had to be ordered by a physician or licensed practitioner, provided by or under the direction of a physician or licensed practitioner, or in an office or similar facility other than an outpatient department or hospital clinic.

As of January, 1970 there were no limitations on skilled nursing facilities. Treatment at intermediate care facilities was implemented in January, 1972 in accordance with such services under the State Plan under Title I, X, XIV, or Title XIV of the Social Security Act. In January, 1970 federal regulation required the provision of family planning services.

Medically necessary physician services were covered in the patient's home, hospital, or skilled nursing facility beginning in January of 1970. Limitations were placed on stable or chronic illness: one visit per day in hospital; one visit per month for illnesses in skilled nursing facilities; two visits per month in intermediate care facilities. Benefits included eye exams, prosthetic lenses, artificial eyes, the treatment of eye diseases, and contact lenses for cataract surgery patients. Orthoptics was covered with pre-certification.

Beginning in July, 1970 home health services, as provided by an approved agency, were allowable for individuals eligible for skilled nursing facility services. No more than 100 days per calendar year were covered.

In June of 1971 some program cuts were implemented to ease the strain of the financially troubled Medicaid program. As of June 1st, eyeglasses were discontinued, the maximum payment for optometric workup was reduced, payments to physicians were lowered by 10% and the professional fee paid to pharmacists was reduced from $1.50 to $1.40 per prescription. Hospital days were reduced from 60 days to 30 days per calendar year. The Alabama Drug Code Index (ADCI) was revised to delete high-priced drugs when there was an acceptable, lower-priced alternative.

Funding

In the latter half of 1968 a request for approximately $22 million was made to the Alabama legislature to carry out the first year of providing Medicaid services. An actuarial firm underwritten by the state health department gauged benefit cost at $106.6 million for 1970. The federal matching rate determined by HCFA for Alabama's program in 1970 was 78.54 percent, which means that the federal government would match the state's $22 million with approximately $84 million, to total the $106.6 million needed.

In January of 1971, the new Medicaid program was already in a financial crisis. An additional $6.5 million was needed for the current year's expenses and more than a million dollars was needed to pay adjusted bills due the hospitals from 1970.

The Beginning

October 1971 - September 1974

Director: Paul I. Robinson, M.D.

Appointed by Governor George C. Wallace, Dr. Robinson originally joined the State Health Department as assistant to Dr. Alphin after his retirement as vice president and chief medical officer of the Metropolitan Life Insurance Company in New York City. He was appointed director of MSA after Dr. Alphin's resignation in September of 1971. Prior to his career with Metropolitan Life, Dr. Robinson had retired from the U.S. Army with the rank major general after a 30 year career as a medical officer. During his military career he commanded three of the army's largest general hospitals. He received the Distinguished Service Medal and the Legion of Merit with Oak Leaf Cluster.

Dr. Robinson is a graduate of the Washington University School of Medicine and received the university's distinguished alumni award in 1959.

Organization and Structure

The agency continued to grow out of its space. As a result, in the fall of 1972, the Third Party program was moved to 17 South McDonough. Offices were located over a blueprint service. Because of inadequacies of the worksite, including ammonia fumes from the offices below, Third Party staff were relocated to Executive Park. The rest of the Agency followed a year later.

Personnel

In 1973, Alabama Medicaid employed 83 people. By 1974, there were 98 total Medicaid employees.

Programs

Effective October 1, 1971, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of health defects program for Medicaid eligible children under six years of age was implemented.

Medicaid's dental health program was implemented in October, 1972. The screening services were expanded in 1973 to cover children ages 12 to 20. Medicaid also began to provide emergency transportation services to assist eligibles in traveling to receive needed medical care. Medicaid did not cover mental intermediate care facilities or mental hospitals. Further, it did not cover tuberculosis hospitals or provide skilled nursing care to persons under age 21 unless they were categorized as blind or disabled.

In April, 1974 certain requirements became necessary for sterilization procedures, including legally valid informed consent.

Eligibility for Medicaid was initially determined according to one's status in one of the following categories:

- Old Age Assistance (OAP)
- Aid to the Blind (AB)
- Aid to the Permanently and Totally Disabled (APTD)
- Aid to Families with Dependent Children (AFDC)

The enactment of Federal Law 92-603 gave states the option of determining Medicaid eligibility of the aged, blind, and disabled. Alabama elected to have eligibility under these categories determined by the federal government. Since January 1, 1974, the determination of eligibility has been in accordance with the standards of the Supplemental Security Income Program (SSI). By special order of the Governor, the Alabama Department of Pensions and Security, (since renamed the Department of Human Resources), was given the authority of determining eligibility for dependent children and certain special groups.

Funding

The federal matching rate of approximately three to one remained relatively stable throughout this period, while the state appropriation increased steadily. Additional revenue was raised through imprinter rental funds, insurance premium refunds, third party collections, provider overpayment recoveries, and retroactive adjustments.

Funding Crisis

October 1974 - July 1977

Director: Robert Holzworth, M.D.

Governor George C. Wallace appointed Dr. Holzworth director of MSA in October of 1974. Before assuming the position of director, Dr. Holzworth served for two years as deputy director. Prior to his career

with the State Health Department, he served extensively with the U.S. Army. His military career included nine years of administration of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). He also served in Vietnam for one year as a hospital commander. Dr. Holzworth is a graduate of Syracuse University and of Duke University. He was awarded a degree in medicine by Wake Forest College in 1950.

Organization and Structure

A new fiscal agent was awarded the contract for fiscal year 1977. By law, contracts with fiscal agents were awarded for one year to the low bidder. Blue Cross and Blue Shield of Alabama had been the contractor for the past four years, but Electronic Data Systems, Federal, was the lowest bidder.

Personnel

MSA employed 109 employees in 1975 and 119 in 1976.

Programs

During this period the amount of money needed to fund the total Medicaid program was increasing faster than the amount of money being appropriated by the State Legislature. The Medical Services Administration reacted by decreasing the scope of the program as follows:

- The number of days of basic hospitalization allowed per year was reduced from 30 to 20.
- Hospital extensions for adults were limited to 10 days.
- A co-payment of $.50 was required from recipients for each prescription obtained under the drug program.
- Medicaid asked Medicare to pay a portion of the first 100 days of care in nursing facilities.
- The amount of personal income retained by a nursing home patient was reduced from $45 per month to $25.
- The ceiling on the per diem rate for intermediate care beds was reduced from $20.50 per day to $19.35.
- The MSA audit staff was increased to provide in-depth analysis of nursing home cost reports.
- Physician visits for stabilized chronic illness were reduced from two to one per month.
- An upper payment limit was established for home health care at $25 per visit.
- Psychiatric hospital care for recipients under 22 years of age was discontinued because the major provider for these services failed to comply with Medicaid's audit requirements and was therefore terminated.

During 1976, a federal law was passed which prohibited the use of Medicaid funds for abortions. A United States District Court judge issued a preliminary injunction barring enforcement of the ban and directing the Department of Health, Education, and Welfare (DHEW) to continue providing Medicaid reimbursement for abortions. This injunction was dissolved in August of 1977, and DHEW issued a policy statement regarding payment for abortions for Medicaid recipients. The policy stated that payment could be made:

- when the attending physician certified the abortion to protect the life of the mother,
- when the mother would suffer severe and long-lasting physical health damage, or
- in the instance of rape and incest victims when reported to a law enforcement agency within sixty days.

In an effort to detect fraud and abuse, four new steps were taken:

1. MSA began utilizing a Professional Standards and Review Organization (PSRO) to see that institutional care was provided only when needed.
2. Program review teams were organized.
3. MSA implemented computer searches for exceptional prices or practices among providers.
4. Specially-marked Medicaid cards were issued to recipients who were found to be buying excessive drugs or otherwise abusing Medicaid privileges. Recipients with these cards were required to select one pharmacist and one physician and were not allowed to seek services from other providers except in emergencies.

Funding

During the mid-70s, the federal matching rate decreased slightly, culminating in a 2.14 percent drop. State appropriations increased in 1976 to $51 million. However, in 1977, for the first time, the Alabama legislative appropriation for Medicaid was smaller than the previous year.

Expenditures rose only 12 percent in 1976 as compared to 42 percent in 1975. This reduction occurred in spite of the fact that the number of eligibles and recipients remained almost stable and the unit prices of medical services continued to rise. This indicated that Medicaid eligibles used fewer medical services in 1976 than in preceding years.

Reorganization

July 1977 - July 1979

Commissioner: Jack E. Worthington

Mr. Worthington holds the distinction of serving as the first commissioner of the Alabama Medicaid Agency, having been appointed by Governor George C. Wallace. This privilege brought the opportunity to organize, staff and make operational one of the primary elements of state government service to its citizens. Prior to his appointment as Medicaid Commissioner, Mr. Worthington served as a career state employee holding numerous financial management positions in state service, as well as higher education. He holds both a Bachelor of Science and a Masters degree in business administration from Auburn University.

Organization and Structure

In July, 1977 Medicaid was raised to a higher level in the state government hierarchy. Medicaid ceased to be a division of the Department of Public Health and became a separate administrative entity. Medicaid was headed by a Commissioner of Medical Assistance which was a newly created cabinet level post within the Governor's office On November 19, 1978, Henry Vaughn was appointed Deputy Commissioner of MSA.

Personnel

In 1978 the Alabama Medicaid Agency employed 198 people.

Programs

The new Commissioner devised seven new cost containment measures:

1. Rigorous administrative actions were taken.
2. The Medical Care Division of Pensions & Security was transferred to the Medical Services Administration.
3. Payment for Part A Medicare deductibles and co-insurance (2 months only) was discontinued.
4. Automation of third party collections was begun.
5. Validation of Medicare buy-in premiums was initiated.
6. The reimbursement system for drugs was changed from a prospective voucher process to a retrospective claims process.
7. The Medicaid Management Information System (MMIS) was implemented. MMIS has six subsystems; Recipient Subsystem, Claims Processing, Provider Subsystem, Management and Administrative Reporting Subsystem (MARS), Surveillance and Utilization Review Subsystem (S/UR), and Reference Subsystem.

Effective November 1, 1978 all recipients, adults and children, were allowed 30 maximum inpatient hospital days (20 basic days plus 10 additional days when certified by PSRO or prior authorized) per year. However, in November of 1978 it was also determined that children under 21 whose medical necessity was determined through screening and with prior approval by PSRO or MSA should have unlimited hospital days. Beginning in July, 1978 rural health clinic ambulatory services were provided without limitations.

On May 1, 1978 the Medicaid Fraud Control Unit, along with six Medicaid employees, was placed in the Attorney General's office.

In an increased effort to detect and halt fraud and abuse, Medicaid conducted 67 field investigations (up from 27 the preceding year) and 541 routine inspections. Claims totaling $942,000 were filed fraudulently or under questionable circumstances, eleven providers and recipients were indicted and four others were terminated from further participation in the Medicaid program.

A quality control (QC) program was organized in October, 1977 as a part of the eligibility office. In July, 1978 this program became a separate office. The purpose of the program was to ensure that only Medicaid eligibles received Medicaid cards.

Funding

The federal matching rate decreased even further from 1977 to 1978, culminating in a 1.21 percent reduction. State legislative appropriations increased in 1978 and 1979 and transfers of funds were received from the Department of Mental Health, Title II, the Department of Pensions and Security, and the Office of the Attorney General.

The inauguration and certification of the Medicaid Management Information System (MMIS) also occurred during this period. Alabama's financial outlay for the administration of Medicaid had already been cut by approximately $41,000 a month due to enhanced federal funding for the MMIS. Reductions in health care costs were expected to save a much larger amount each month (a five percent savings in this area would amount to nearly $1 million a month).

Another quality control program called the Recipient Explanation of Medicaid Benefits (REOMB) was instituted to check the accuracy of Medicaid payments. REOMB is an MMIS requirement in which letters are sent to the recipients for verification of services. The recipient indicates whether or not the service was provided and sends the letter back to Medicaid.

Full operation of Alabama's PSRO began in April of 1978.

Expanding Services

July 1979 - September 1980

Commissioner: W.H. "Hoke" Kerns

Appointed by Governor Forest "Fob" James, Jr., Mr. Kerns held the dual responsibility of Commissioner of Medicaid and Commissioner for the Commission on Aging. Prior to serving with MSA, Mr. Kerns served as President (Administrator) of Baptist Medical Center, Princeton, in Birmingham, Alabama. He received a B.A. degree in journalism from the University of Florida in 1951.

Personnel

In 1980 the Alabama Medicaid Agency employed 201 people.

Programs

Beginning in October, 1979 Medicaid approved internal life-support prostheses such as pacemakers. Contact lenses, prosthetic lenses and artificial eyes were also included as covered services with prior authorization from Medical Services.

In the late 1970's the provision of nursing home care to Medicaid recipients was consuming a disproportionate share of available Medicaid dollars. In addition to higher costs per nursing home resident, the aged population of Alabama was continuing to grow, and the mores of the people were changing so as to make the placement of the elderly into nursing homes more acceptable. Furthermore, within the general population economics was necessitating that both husband and wife be employed outside the home. Generally this left no one at home to care for the elderly family member(s).

Because of the ever increasing need for nursing home beds, and the spiraling nursing home costs to Medicaid, a conscious decision had to be made to take necessary actions that would center on affordability as opposed to availability of care. The decision was made by the Statewide Health Coordinating Council (SHCC) in 1979 to change the nursing home bed need methodology from a 95% occupancy factor to 97%, and to change the county maximum occupancy level from the state average of less than 40 beds per 1,000 population 65 and older, to a straight 40 beds per 1,000 without reference to the state average. This change resulted in the slowing of those numbers of nursing home beds shown as needed in the Alabama State Health Plan. Even so, the increases in the numbers of nursing home beds and the continuing increases in reimbursements to nursing homes, required further drastic actions.

Previously, the payment rate for nursing home recipients classified for skilled care was higher than that for those classified for intermediate care. Physicians were required to declare it medically necessary that a recipient be classified as 'skilled', but this was desirable to the provider because of the higher payment rate. In 1979 the classifications were assigned the same payment rate. Since the physicians no longer had the incentive to declare patients 'skilled', most were simply declared 'intermediate'. A shift was seen from mostly 'skilled' nursing home recipients before the pay rate change, to mostly 'intermediate' nursing home recipients after the pay rate change.

Funding

The federal matching rate decreased during this period from 72.58 percent to 71.32 percent, while state appropriations continued to rise.

Accelerating Costs

October 1980 - November 1981

Commissioner: Rebecca Beasley

Ms. Beasley was also acting Commissioner of the Department of Pensions and Security during this time period. She began her state government career in the clerical ranks and worked her way into the professional-level accounting series before being appointed the dual commissioner titles in 1980, thus earning the nickname "Superwoman" given her by then Governor Forest "Fob" James. She received her BSBA degree from Auburn University at Montgomery in 1990.

Organization and Structure

On March 2, 1981, Governor Fob James signed the executive order officially changing the Agency's name from the Medical Services Administration to the Alabama Medicaid Agency and the Commissioner of MSA to the Commissioner of Medicaid.

Personnel

Employees of MSA totaled 193 in 1980 and 215 in 1981.

Programs

The fiscal year of 1981 was a milestone in that it marked the beginning of a long period of rapidly increasing health care costs. Providers were paid a total of $284 million in 1980, a 10 percent increase over payments made in 1979. In 1981, the price per day for skilled nursing facility services rose 31.2 percent over the previous year. Nursing home services accounted for 41.4 percent of Medicaid's total costs for the year.

Reimbursement rates for physician visits were previously set on a regional, or profile, basis, a method based on Medicare's reimbursement practices. It was decided that a statewide, "Level III", reimbursement method based on 1979 charges would be much more efficient. This method was implemented November 1, 1981, and increased reimbursement for physician visits from $14.54 in 1981 to $17.25 in 1982. Physical therapy services were covered in 1981, when medically necessary and provided under the supervision of a physician. Finally, this was the seventh consecutive year that outpatient services outnumbered inpatient services in Alabama.

Funding

The federal matching rate continued at 71.32 percent. Long term care consumed $131.5 million of Medicaid's total budget of $317.5 million.

An Interim Period

December 1981 - January 1982

Acting Commissioner: Henry Vaughn

In November of 1981, Commissioner Beasley was named to fill the post of state budget officer with the Finance Department after the post had been made vacant by the April 1981 death of Jimmy Raiford. Mr. Vaughn, then a deputy commissioner at Medicaid, filled in as acting commissioner during the interim period, under Governor Forest "Fob" James, Jr. Mr. Vaughn is a retired Army colonel who brought with him many years of experience as deputy commissioner for the Alabama Medicaid Agency.

Reaching New Levels of Service & Efficiency As Costs Rise

February 1982 - January 1987

Commissioner: Faye S. Baggiano

Dr. Baggiano, appointed by Governor Forest "Fob" James, Jr., held the dual responsibility of Commissioner of Medicaid and Commissioner of Alabama's Department of Pensions & Security. Dr. Baggiano has a master's degree in public administration from Auburn University and a Ph.D. from the University of Alabama.

Personnel

Medicaid employed 215 employees in 1982. By 1987, the agency employed 300 people.

Programs

The 1980's were marked by significantly rising health care costs. These increased costs presented a challenge to Alabama's Medicaid Agency. Costs rose nearly seven percent in 1981 alone which led to the establishment of an expanded variable drug co-payment in February, 1981. Long-term care continued to lead the way in costs with 43 percent of total benefit expenditures going towards nursing home care. Nurse-Midwife services were implemented in 1982 to facilitate access to maternity care. In August 1984 Governor George C. Wallace declared a moratorium on the establishment of any new or additional nursing home beds.

Significant rises in the costs of providing health care to Alabama's medically indigent continued in 1982. To reduce the high costs of long-term care, new criteria were implemented for nursing home admissions. This caused the denial rate to increase from less than one percent to between ten and fifteen percent. In an effort to gain more control of the nursing home admission process, the Admissions/Utilization Review Unit was created in 1982. Also, due to utilization review efforts, the number of fraud and abuse convictions doubled.

A waiver agreement between Medicaid and the Alabama Department of Mental Health was approved by HCFA in March of 1983. This agreement, called the Mentally Retarded and Developmentally Disabled

(MR/DD) waiver, allowed the use of Medicaid funds for home and community based treatment of Medicaid eligible mentally retarded persons at risk of institutionalization.

HCFA previously issued $2.6 million in sanctions against the Medicaid Agency for its excessive error rate in determining eligibility. These sanctions, however, were waived when the agency successfully argued that the method used by HCFA in calculating the error rate was not accurate. In a resulting effort to increase efficiency, the Agency reduced its case error rate to 1.6 percent.

In July, 1983 the Alabama Medicaid Application and Eligibility System (AMAES) was implemented, bringing efficiency to a new level. This is an automated, integrated data file which is a considerable improvement over the old method of using several different files, each of which had to be updated whenever there was a change in a recipient's data. Simultaneously, the Agency began using each recipient's Social Security number as their primary Medicaid number, replacing the old-style county-based Medicaid numbers. The new numbers were consistent with other state agencies' identification numbers.

Continuing the battle against rising health care costs, physician office visits were limited to twelve per year, per person, and emergency room visits to three annually effective July, 1983. In October, 1983 Harriette Worthington was appointed Deputy Commissioner in charge of programs.

Services for the mentally retarded or those with related conditions were covered under the clinic option beginning in 1984 with limitations and prior approval required. The services were provided through community mental health centers. This addition of services was financed through transfers from the Department of Mental Health. Previously, the Department of Mental Health had provided or paid for these programs using all state dollars. Since the programs were optional under Medicaid, it was decided to have MSA take them over with the Department of Mental Health transferring moneys to MSA in order to obtain the federal matching funds. This was a means of maximizing state funds and creating a larger program than would otherwise be possible. The Department of Mental Health also agreed to pay an administrative fee to Medicaid to help offset the cost of operations.

The Medicaid Agency received accolades in 1984 for its efficient operation. The National Conference of State Human Services Finance Officers stated that Alabama spent less on Medicaid administration than any other state: $2.55 per person, compared to the national average of $5.37. These administrative costs accounted for only 3.2% of all Medicaid expenditures. A 1984 audit by the State Examiner of Public Accounts revealed that every Medicaid dollar spent in 1981 and 1982 was fully accounted for.

Attention to rising health care costs continued through the mid -1980's:

- In 1984, the Medicaid Task Force on Preventive Medicine was formed to increase the amount of preventive services received by the State's Medicaid eligibles.
- The Selma and Dadeville district offices were closed during this time to reduce overhead costs.
- A new waiver was approved in December, 1984 allowing Medicaid to provide Home- and Community-Based Services (HCBS) for the elderly and disabled, who would otherwise have required nursing home care, through the Department of Pensions and Security and the Alabama Commission on Aging.
- Effective July 1, 1985, a $3 co-payment for outpatient visits was established, along with a $50 inpatient hospital stay co-payment.
- During 1985, a revised drug code index was issued which emphasized generic drugs and reduced expenditures for certain drugs by seventy percent.
- HCFA renewed the MR/DD waiver, continuing to allow the use of federal funds for state mental health patients.

Despite prolonged financial hardship, Medicaid continued to expand services during these years. The Department of Pensions and Security began accepting applications for a new category of eligibility. For the

first time, families with two able-bodied adults could be eligible for Medicaid benefits. Additionally, new services were extended to foster children of the State Department of Youth Services.

In 1984 Medicaid began covering mental health services under the clinic option. Services were provided through community mental health centers. The state share of the funds for these services was paid for by the Department of Mental Health/Mental Retardation.

The State Medicaid Conference in Montgomery, the first of its kind in the United States, hosted 427 people, mostly providers, for a three day event from January 30 to February 1, 1985. The focus of the conference was the Agency's operations, problems, limitations, and potential.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 extended coverage to pregnant women meeting the criteria for AFDC, regardless of whether the family's principal wage earner was unemployed. COBRA mandated coverage throughout pregnancy and sixty days postpartum and allowed states the option to cover pregnant women and children whose family incomes were above the AFDC eligibility threshold but below the Federal Poverty Level. COBRA allowed states, for the first time in history, to separate Medicaid eligibility from the welfare cash assistance programs' (AFDC and SSI) eligibility requirements.

Service expansion continued in 1986. The Preventive Health Unit was established and the Medicaid Task Force on Preventive Medicine was renamed the Advisory Council on Preventive Health. The MediKids Program, EPSDT, developed a preventive emphasis as the number of eligible screenings increased.

Responding to the national trend toward managed care, Medicaid entered into a cooperative agreement in 1986 with West Alabama Health Services, Inc. to test the concept of a rural health maintenance organization for Medicaid eligibles. This project was piloted in Greene County.

Funding

From 1980 until 1981, there was no change in the federal matching rate of 71.32 percent, however, in 1982 and 1983 the rate decreased to 71.13 percent. To control Medicaid costs, in 1982 the federal government imposed a spending cap for each state. This spending cap set a maximum amount that could be spent and set target expenditure rates for each year that the spending cap was in place. In 1982 this target rate was 3% below the cap. In 1983 it was 4% below and in 1984 it was 4.5% below the ceiling. A penalty would be incurred if the spending cap was exceeded. The federal spending cap was lifted in October, 1984. The Alabama Medicaid Agency had never exceeded the imposed expenditure ceiling, thus never incurring a penalty. In May, 1984 the Medicaid Agency was granted a record $101 million dollar appropriation from the State General Fund for 1985 operations and benefits.

Continuing Progress

January 1987 - November 1988

Commissioner: J. Michael Horsley

Prior to his appointment as Commissioner of the Alabama Medicaid Agency by Governor Guy Hunt, Mike Horsley served for 6 years as an Assistant Attorney General. During that time, he was Director of the Attorney General's Medicaid Fraud Control Unit, which was responsible for prosecuting cases at the trial and appellate levels. Mr. Horsley is a Vietnam veteran, having served in the U.S. Navy for 4 years and is a graduate of the University of Alabama in Huntsville and a cum laude graduate of Cumberland School of Law.

Organization & Structure

Medicaid's Preventive Health Unit became part of the Commissioner's staff under the direct supervision of the Commissioner's Executive Assistant.

The Alabama Management Improvement Plan (AMIP), a comprehensive study of state departments designed to improve the efficiency and effectiveness of their operations, organizational structure, programs and management, completed its study of the Alabama Medicaid Agency in 1987. This study resulted in more than 50 recommendations. Several of the recommendations were implemented during fiscal year 1987 including: bringing the institutional utilization review function back into the agency, within the hospital program division; limiting certain Medicaid-reimbursed prescriptions to no more than a 30-day supply; having Medicaid's utilization review committee (URC) review provider cases (in addition to recipient cases) to determine what sanctions and/or penalties should be imposed when violations of Medicaid policy are found; revising the Medicaid organizational structure; and revising the explanation of payment on outpatient hospital claims to include the reason for disallowed charges for outpatient services.

Personnel

In 1987 and 1988, Alabama Medicaid employed approximately 300 people.

Programs

In 1987, the Health Care Financing Administration approved a 5-year renewal of Medicaid's HCBS Elderly and Disabled waiver. The Mothers and Babies Indigent Care Trust Fund was established in 1987 allowing deposited funds to be used for expansion of coverage in the form of extended hospital days to more young children who were eligible for these services through the EPSDT program.

The fee paid to physicians for a normal delivery was increased in 1987 from $450 to $675. This fee boost was intended to increase the number of obstetricians who would deliver Medicaid babies. Medicaid benefits were increased in 1987 to allow 12 inpatient visits per physician regardless of the number of hospital days utilized by the patient. Moving toward alternative health care delivery and recognizing its cost effectiveness, Medicaid began covering any surgery that could be performed safely on an outpatient basis.

In 1987, the Ward v. Hunt decision ordered that Alabama could no longer count the income of siblings or grandparents in deciding Medicaid eligibility. This allowed some families to qualify for Medicaid who did not qualify for Aid to Families with Dependent Children.

The Medicaid Waiver Program for managed maternity care was implemented in 1988. Now pregnant women in participating counties could go to a single participating provider for coordinated maternity care. Also, Medicaid announced its intention to enhance outreach efforts to children through the MediKids Program (EPSDT).

Beginning in July of 1988, Alabama Medicaid created the extended days program for Medicaid children under 21 which allowed unlimited hospital days for children needing specialized services, such as neonatal intensive care. This was financed via a donation program in which certain hospitals donated funds to the Mother's and Baby's Indigent Care Trust Fund which paid the state share for those services.

The Medicaid Management Improvement team's recommendation to allow the release of recipients' Medicaid numbers to providers was implemented in 1988. This was intended to speed up and ensure

payment to providers and improve relations between the Medicaid Agency and Alabama's Medicaid providers.

Medicaid reinstated its payment of the Medicare hospital deductible for people eligible for both Medicare and Medicaid. This charge increased from $520 to $540 per year. The income limit placed on nursing home residents was increased to $911 per month as the SSI ceiling for resources was increased to $1,900 per individual and $2,850 per couple.

Medicaid eligibility was extended to low income mothers and babies as allowed by SOBRA. Pregnant women and children to age one in families with income equal to or less than the federal poverty level became eligible for Medicaid.

Funding

Consistent with previous years, the federal matching rate continued to remain stable at approximately 2 1/2 to 1.

Unprecedented Expansion

December 1988 - July 1992

Commissioner: Carol Herrmann

Prior to her appointment as Medicaid Commissioner by Governor Guy Hunt, Ms. Herrmann worked in a variety of positions with the Health Care Financing Administration in Washington, D.C. While in Washington, D.C., she also worked for a time at the White House, serving as Assistant to the Special Assistant to the President for Health Policy. Ms. Herrmann has worked with Medicaid on both a national and state level, receiving numerous awards for her work in Alabama. She graduated from Birmingham Southern College in June of 1981 and received her Master of Public Health from University of Alabama in Birmingham in June of 1994.

Organization and Structure

In 1990, a major reorganization converted the Agency from its traditional structure to a matrix structure. This matrix organizational structure concept was executed to encourage more project-oriented, agency-wide teamwork. Each new project would foster its own team of experts that would cut across the Agency selecting appropriate talent as needed. A new emphasis was placed on flexibility and cooperation rather than "turf-protecting" by individual divisions.

Personnel

In 1991, the Agency employed 511 people. This was a significant increase in employees, jumping from approximately 300 people in 1988 to 511 in 1991. This increase is partially explained by the fact that effective September 3, 1991, the Alabama Medicaid Agency began determining Medicaid eligibility for many children and pregnant women whose eligibility had formerly been determined by the Department of Human Resources. A federal mandate had been passed which required outstationed SOBRA workers at disproportionate share hospitals, health facilities, and FQHCs. DHR's contract did not require outstationed workers, so in order to comply with this mandate, the Medicaid Agency hired approximately 100 social workers and placed them at outstationed locations throughout the state.

Programs

As a result of the rampant spread of HIV and AIDs-related illnesses, Medicaid began covering more drugs used in the treatment of AIDS in 1989.

In an effort to reduce the incidence of infant mortality in Alabama, the Office of Maternal and Child Health was established. This office coordinated agency-wide efforts and implemented various initiatives such as Healthy Beginnings hotlines, and obstetrical and pediatric fee increases. The Maternity Waiver Program was extended from thirteen counties in 1989 to sixteen in 1990. In August of 1990 the Healthy Beginnings program was implemented. This program began as an awareness and incentive program to encourage an adequate number of prenatal care visits for expectant women. The program provides a free coupon booklet and pregnancy-related information to any pregnant woman in Alabama, regardless of income.

In 1989, the fee paid to physicians providing a vaginal global package of prenatal care and delivery services was raised to $718 and the amount paid for a C-section global was raised to $750. In 1990 the fee differential between vaginal and C-section deliveries was eliminated and the fee was increased to $1,000 for a global delivery through funds received from the Department of Public Health's perinatal appropriation of $2 million. Again in 1991, this payment was increased. Effective October 1, 1991, the global fee for obstetrical services was increased to $1,700 for rural physicians and $1,300 for urban physicians.

In 1989, children's dental coverage was expanded to include sealants and medically necessary orthodontic services for those under age 21.

To adjust for annual inflation, Medicaid increased the income limit for nursing home patients to $950 per month in 1989. This amount was increased again in 1990 to $1,000 per month.

In January, 1990 the Physicians Task Force was formed. This group was created in order to obtain input from physicians and physician-type providers regarding identification of problems and possible initiatives Medicaid might consider to enhance its relationship with providers.

To attempt to alleviate Alabama's shortage of nursing home beds, Governor Guy Hunt lifted the moratorium on the construction of nursing home beds in 1990. As a result, the construction of 440 new nursing home beds was approved.

In the early 1990's several rural hospitals had closed. At the time, Medicaid was paying the rural hospitals at a 60th percentile ceiling, therefore, 40% of them were not getting payment for full costs. In order to keep the rural hospitals solvent, a contribution system was started in October of 1989 for the disproportionate share rural hospitals. This contribution system allowed Medicaid to lift the 60th percentile payment cap to 100% in May of 1990.

In September of 1991, Medicaid devised a methodology in which most (156 of all 204) Alabama nursing homes were reimbursed for 100% of their allowable costs. This was made possible by the $1,000 per-bed provider tax on nursing homes which took effect in October of 1991. Allowable hospital inpatient days were increased from 12 to 14 days per year in 1990. In 1991, the number of covered inpatient days was increased again to 16. To provide more comprehensive emergency care for Medicaid eligibles, in 1990 the reimbursement of three additional emergency room codes was approved.

In April of 1990 OBRA '89's federally mandated expansion became effective. This mandate contained sweeping changes for maternal and child health. Changes in eligibility included mandatory coverage for pregnant women, infants and children under the age of 6 whose family incomes were below 133% of the federal poverty level (about $14,000 for a family of three).

Effective in July of 1991, the federally mandated OBRA '90 was implemented. This mandate required phased-in coverage for children born after September 30, 1983, if they had attained age 6 but had not attained age 19, and their family income did not exceed 100% of the federal poverty level. The Medicare Catastrophic Coverage Act of 1988 was partially repealed in 1990. Unfortunately for Medicaid, the parts that were repealed were those which had been beneficial to the states. The remaining parts were, overall, detrimental to the states. As a result, Medicaid paid the premiums, deductibles, and coinsurance of some Medicare beneficiaries with limited resources and whose incomes were up to 90 percent of the federal poverty limit (or $7,578 for a family of 2).

In April, 1991 the Specialized Community Care Living Arrangements Model waiver was implemented. This waiver provides care in family foster homes for frail or disabled adults who receive SSI and who meet medical and financial standards for Medicaid covered nursing home care. This program was specifically targeted toward individuals at risk of neglect or abuse.

There was an increase in the number of hospitals qualifying for federally mandated disproportionate share payments. To qualify as a disproportionate share hospital, the provider must have a disproportionate share of Medicaid and/or low income patients. These providers received additional payments above the normal, routine per diem rates. Also, federally mandated coverage was authorized for an unlimited number of hospital days for children in disproportionate share hospitals and for adolescent psychiatric care.

In October, 1991 Medicaid began covering preventive health education classes for pregnant and postpartum women. The Homebound Waiver was implemented in April, 1991 to provide in-home care for persons aged 21 through 64 who were eligible for Medicaid-financed nursing home care. Eligible persons included, among others, those suffering from quadriplegia, traumatic brain injury, multiple sclerosis, muscular dystrophy, or severe arthritis. Consistent with the national trend toward alternative methods of delivering health care and in order to be more cost efficient, Medicaid eliminated restrictions on outpatient surgery in 1991. Further, payment for 23-hour inpatient observation was instated.

OBRA '90, which included a provision known as the Pryor bill, required Medicaid to cover all prescription drugs for any pharmaceutical company who signed a rebate agreement with the Secretary of Health and Human Services. In exchange for covering this more extensive list of brand name drugs, Medicaid collected a rebate from each manufacturer. In 1992 a provider tax was generated in cooperation with the Pharmacy Association to help offset the cost to Medicaid associated with the Pryor Bill. The dispensing fee for pharmacists was increased from $3.75 to $5.40 per Medicaid prescription, and in turn the pharmacists paid a 10 cent provider tax on every prescription. This provider tax saves the general fund approximately $1 million dollars per year.

In February, 1991 the Humana Qualified Medicare Beneficiary Special Care Plan (QMB) was begun. This was an innovative agreement between Medicaid and Humana Insurance Company which offered expanded benefits for thousands of elderly or disabled Alabamians while saving Medicaid money. This program provides Humana insurance coverage for low income Medicare beneficiaries who qualify to have some of their Medicare expenses paid by Medicaid and who wish to join the QMB plan. The program paid the Medicare hospital deductible and coinsurance if enrollees were hospitalized more than 60 days. For QMB's, the monthly income of an individual could not exceed $572 and a couple's monthly income could not exceed $760. Assets were limited to $4,000 per individual and $6,000 per couple.

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

Funding

The federal matching rate declined slightly during this period. The level of state appropriated funding nearly doubled from $152,899,410 in 1989 to $307,184,580 in 1991, however, this increase in funds was mostly self-generated by Medicaid in the form of provider taxes and transfers of funds. Appropriations from the general fund itself actually decreased slightly over this period of time. The total Medicaid budget increased greatly from $560,061,215 in 1989 to $1,106,679,768 in 1991 with administrative costs remaining steady at approximately 3.3 percent.

A Time of Uncertainty

August 1992 - May 1993

Commissioner: Brian Moore

Appointed by Governor Guy Hunt, Mr. Moore brought with him to the position of Commissioner six years experience at the Medicaid Agency. During his tenure with the Agency, Mr. Moore served as Executive Assistant to Carol Herrmann and in a variety of other positions. He also worked in several different Medicaid programs and the Agency's Office of General Counsel. He is a graduate of the University of Alabama and Jones Law School.

Personnel

In 1992, the Agency employed 536 people.

Programs

The Maternity Waiver program was expanded in 1992 to include 20 additional counties. This brought a total of 43 Alabama counties into the program. In 1992, 17 providers were enrolled as preventive health education providers under the program begun in 1991.

The Alabama Medicaid Agency began an incentive program, called the Healthy Beginnings Bonus Program, in June, 1992. This program was designed as a six-month effort to boost the number of women who go for care in the first trimester of pregnancy in 35 Alabama counties and was available for Medicaid-eligible women only. The program was funded by the Southern Triangle Chapter of the March of Dimes and the state Medicaid Agency and was administered by Medicaid and the Montgomery Area Food Bank in conjunction with Second Harvest Food Banks in Montgomery, Mobile, Dothan, Tuscaloosa and Columbus, Georgia. The incentive gift package contained a minimum of ten pounds of food and grocery items along with nutrition and other related information.

In October of 1992 Medicaid received official notice of a federal grant which over a four year period amounts to more than $864,000. The grant provides funding for a "One Stop Shopping" project in Dallas and Wilcox counties. Through this program, individuals can go to one location to apply for a variety of services. 1992 was the first year that awards were made for this grant. Of the 217 applications submitted to the United States Public Health Service that year, the Alabama Medicaid Agency's grant was one of 32 awarded nationwide.

"One Stop Shopping" grant funds have been used to place a Medicaid eligibility worker and a Public Health social worker in George Washington Carver public housing neighborhood in Selma. A clinic has

also opened there. In Wilcox county a school based clinic has been established. The workers enter families into a coordinated system of referral and follow-up and ensure those eligible have access to all available health and social services.

In addition to the Homebound Waiver implemented in 1991, another Home and Community Based Waiver was implemented in 1992 under the Omnibus Budget Reconciliation Act of 1987. This waiver provided care in the home for mentally retarded and developmentally disabled persons residing in nursing homes. To be eligible, the persons could have income levels up to 300 percent of the SSI Federal Benefit Rate.

In November of 1992 Medicaid discontinued the printing of monthly paper Medicaid cards and started issuing permanent plastic cards. These cards have a magnetic stripe which allows providers instant access to the patients' Medicaid eligibility status and other important information. Alabama was one of the first states to utilize this improved technology. Medicaid's fiscal agent, Electronic Data Systems (EDS) worked with Medicaid in this system upgrade. EDS provides the means for providers to check eligibility status. These include the automated voice response system (AVRS), which requires only a touch-tone telephone, and the Medicaid Automated Claims Submission and Adjudication System (MACSAS). MACSAS requires either a point of service device or a personal computer. A Recipient Inquiry Unit with a toll-free number was established to answer recipient's questions concerning their new plastic cards.

The Alabama Medicaid Agency had the lowest payment error rate of HCFA's Region IV states.

Funding

The Alabama Medicaid Agency experienced much uncertainty in 1992. The Health Care Financing Administration issued regulations intended to restrict the states' use of provider taxes. Since the Agency received almost 50 percent of the state share of its budget from the provider tax, the entire program was placed in jeopardy. The federal and state governments reached a compromise in November, 1992 by allowing states to continue using the taxes but with changes in the methods by which they taxed providers. The 1992 Alabama Legislature passed a statute requiring the taxation of all providers in a particular class, such as hospitals or nursing homes, not simply all providers accepting Medicaid.

Under the Humana Qualified Beneficiary Special Care Plan, approximately $300,000 was saved from May 1, 1991 until April 30, 1992. In this year, the plan covered around 6,500 individuals.

Preparing for a Changing Health Care Environment

June 1993 - January 1995

Commissioner: David G. Toney

Mr. Toney is a Birmingham, Alabama native. He holds a bachelor's degree with concentration in accounting from the University of Montevallo, and an M.B.A. from Samford University. Prior to his appointment by Governor Jim Folsom as Medicaid Commissioner, he worked for 21 years with Blue Cross and Blue Shield of Alabama.

Organization and Structure

On January 15, 1994 Commissioner Toney approved a reorganization of the Agency. This reorganization increased the number of Deputy Commissioners from two to five.

In July of 1994 the Agency moved its central offices and the Montgomery district office from 2500 Fairlane Drive to the newly renovated Lurleen B. Wallace State Office Building in the state capitol complex. This state-owned building allows the entire Agency to be located under one roof.

Personnel

As of January 1, 1994 the Agency employed 543 persons.

Programs

In fiscal year 1993, 595,769 Alabamians were certified Medicaid eligibles. That number increased to 620,847 for fiscal year 1994.

The Maternity Waiver program was expanded in fiscal year 1993. Five counties were added to those already participating and one that had previously participated dropped out of the program. Now there were a total of 42 counties participating, up from 38 during fiscal year 1992.

Commissioner Toney saw a need for the Agency to be more in touch with the people that it served. This was addressed by establishing rotations in which Medicaid's associate directors, directors, and senior leadership manned the phone lines in the Recipient Inquiry Unit. New employees also were required to spend time working in the unit as part of their orientation. This unit was initially established with a toll-free number to handle recipients' questions regarding their new plastic eligibility cards but has evolved into a form of "customer service" to answer recipients' general questions regarding their Medicaid eligibility.

There was an intensive effort to implement managed care during fiscal year 1993 and 1994. Plans were made and the Agency negotiated with health care providers, and worked with the Health Care Financing Administration. The majority of the background work necessary to implement a managed care system was completed during this time period, including:

- A review process was coordinated with the Department of Public Health wherein HMOs would be reviewed jointly for approval as a Medicaid managed care provider.
- A capitation methodology was established.
- Managed care manuals were written.
- An extensive reporting system was developed for obtaining necessary statistical information.
- A system was developed with the assistance of EDS for the processing of claims in a managed care environment.

During the year, the Agency became increasingly aware of Medicaid recipients who were in acute care hospitals but were no longer in need of that level of care. These patients needed to be placed in a nursing home, but the patient was forced to remain in the hospital for reasons such as the lack of an available bed or the level of care needed being such that they could not be accommodated currently by an area nursing home. 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 home. For these patients the hospital is reimbursed a daily rate equal to the average daily rate paid to nursing homes in the state. The hospital is obligated to actively seek nursing home placement for these patients. The program became effective August 1, 1994.

Funding

The federal matching rate continued its slight decline during this time. State appropriations experienced a further decline from $129.5 million in 1992 to $128.9 million in 1993 but increased to $139.5 million in 1994. Medicaid's total budget increased in 1993 and again in 1994.

Conclusion

The agency is in the process of developing a strategic plan for the Alabama Medicaid Program. As part of this process, Medicaid staff have adopted the following as its vision, mission, and statement of values.

Statement of Vision

It is our vision that the Alabama Medicaid Agency play a key leadership role in ensuring the availability of and equal access to high quality, appropriate medical care and related services for all citizens of Alabama, regardless of income. We will accomplish this by working with other state and federal agencies to develop and manage a system which, we believe, will result in a healthier, more productive, better educated, and happier citizenry. We will carry out our role in an innovative, caring, and cost effective manner.

Mission Statement

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

Statement of Values

We are a CARING organization and treat our employees, recipients and providers with respect, dignity, honesty and compassion.

We understand that to be effective we must be willing to CHANGE. Therefore, we value new ideas, innovation, and a positive response to change.

We value INTEGRITY and observe the highest ethical standards and obey all laws and regulations. We pledge to be good stewards of the State's resources entrusted to us.

We are committed to EXCELLENCE and the highest standards of quality in all our activities. We are committed to getting better every day in everything we do.

We value TEAMWORK. We encourage team accomplishments over the goals of any one individual. We encourage open discussion of issues, but once a decision is made, commitment is expected from everyone. We understand that the success of our organization relies upon the building and maintenance of effective teams.

Since the U.S. Congress determines Medicaid coverage and service policy, long range planning is difficult even in periods of relative stability. With so much uncertainty in Congress at present, planning for the next five years is a tremendous challenge. The Agency is attempting to overcome this difficulty by examining different scenarios for planning purposes. Once the initial strategic plan is completed in 1995 and the process for keeping it updated is set in motion, the Alabama Medicaid Agency will be better prepared to face whatever challenges await in the Agency's second twenty-five years.