ALABAMA MEDICAID AGENCY

FY 2002 ANNUAL REPORT

Governor
State of Alabama
Bob Riley

Mike Lewis
Acting Commissioner
Alabama Medicaid Agency

Alabama Medicaid Agency
FY 2002 Annual Report
October 1, 2001 - September 30, 2002

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BOB RILEY
Governor

MIKE LEWIS
Acting Commissioner

The Honorable Bob Riley
Governor of the State of Alabama
Alabama State Capitol
Montgomery, Alabama 36130

Dear Governor Riley:

It is my privilege to present to you the thirtieth annual Report of the Alabama Medicaid Agency. This report covers activities from October 2001 to September 2002.

During the year, over 860,000 people in the state were eligible for Medicaid benefits. Because of our state's commitment to ensure that all of Alabama's children have access to medical care, Medicaid covered an additional 35,000 children during FY 2002.

Medicaid continues to improve the quality of care provided to Alabama's Medicaid eligible population. During FY 2002, emphasis was placed on the improvement of family planning services, on developing a quality improvement process for the Agency, and on working cooperatively with other state agencies to improve long term care choices for individuals with disabilities and seniors.

The Medicaid Agency is a vital and essential part of the health care infrastructure and, therefore, plays a critical role in the economic development of our state. In many of our rural and inner city urban areas, Medicaid is the main financial support for the health care system regardless of income levels.

Alabamians appreciate your support of the Medicaid program. Along with all Medicaid staff, I look forward to working with you to continue to make improvements that benefit the citizens of this state. With an effective Medicaid program, we ultimately enable individuals to be productive, to improve the lives of their children, and to improve the lives of their family members who are elderly or disabled.

Sincerely,

Mike Lewis
Acting Commissioner

Our Mission - to provide an efficient and effective system of financing health care for our beneficiaries.

Mission Statement

The Mission of the Alabama Medicaid Agency is to provide an efficient and effective system of financing health care for our beneficiaries.

This annual report was produced by the Division of Program Support of the Alabama Medicaid Agency.

This report can be viewed at our web site http: //www.medicaid.state.al.us

Table of Contents

Introduction:	Highlights of the 2002 Fiscal Year	5
	Alabama's Medicaid Program	7
	Medicaid's Impact	10
Statistical Topics:	Revenue and Expenditures	11
	Population	13
	Eligibles	14
	Comparison of Eligibles and Payments	17
	Use and Cost	21
Topics of Review:	Cost Avoidance and Recoupments	22
	Medicaid Management Information System	26
	Maternal and Child Health Care	27
	Recipient Inquiry Unit	32
	Managed Care	32
	Home and Community Based Service Waivers	34
	Home Care Services	35
	Hospital Program	36
	Medical Services	38
	Long-Term Care	43
	Long-Term Care for the Mentally Retarded and Mentally Disabled	46

List of Illustrations

Alabama's Medicaid Program:	Organizational Chart	9
Medicaid's Impact:	County Impact	10
Revenue and Expenditures:	Sources of Medicaid Revenue	11
	Components of Federal Funds	11
	Components of State Funds	11
	Composition and Disbursement of Medicaid's Budget	11
	Expenditures by Type of Service	12
	Benefit Payments by Percent Distribution	12

Population:	Eligibles as Percent of Alabama Population by Year	13
Eligibles and Payments:	Monthly Count	14
	Eligibles and Recipients	14
	Eligibles by Category	15
	Percent of Population Eligible for Medicaid	16
	Eligibles and Payments Percent Distribution by Category of Aid	17
	Eligibles and Payments Percent Distribution by Age	18
	Eligibles and Payments Percent Distribution by Gender	19
	Eligibles and Payments Percent Distribution by Race	19
	Payments By County of Recipient	20
Use and Cost:	Cost per Eligible	21
Cost Avoidance and Recoupments:	Provider Reviews	22
	Recipient Reviews	22
	Collections and Measurable Cost Avoidance	25
Maternal and Child Health Care:	SOBRA Eligibles	31
Hospital Program:	Outpatients	36
	Payments by County	37
Medical Services:	Physicians Program - Use and Cost	39
	Pharmaceutical Program - Use and Cost	40
	Pharmaceutical Program - Cost	40
	Eye Care Program - Use and Cost	41
	Lab and X-Ray - Use and Cost	41
Long-Term Care:	Patients, Days, and Costs	44
	Number and Percent of Beds Used by Medicaid	44
	Recipients and Payments by Gender, Race, and Age	44
	Payments to Nursing Homes by County of Recipient	45
Long-Term Care for the Mentally Retarded & Mentally Disabled:	ICF-MR/MD	46

Highlights

Introduction

Improving the quality of care provided to Alabama's Medicaid-eligible population emerged as a dominant theme at the Alabama Medicaid Agency during FY 2002. Thanks to grant support from the Alabama Chapter of the March of Dimes, the Health Resources and Services Administration (HRSA) and others, emphasis was placed on the improvement of family planning services, on oral health care services provided to children and on developing a quality improvement process for the Agency.

Grant support enables Agency to improve service quality

During the year, the state March of Dimes chapter approved grant support to the Agency for a second year, enabling the Agency to continue its efforts to improve the quality of Medicaid-sponsored services. Agency activities under this grant have centered around increasing the number of providers who adopt some part of the Agency's PT+3 patient education program and providing continued support to enable more providers to use the program to counsel Medicaid-eligible women, particularly in the areas of sexually transmitted infection prevention and contraceptive use. Additionally, the grant provided the impetus to initiate a strategic planning process that will ultimately enable the Agency to respond to new issues and concerns in a strategic and systematic way that maximizes the state's resources to improve health outcomes for mothers and babies in Alabama.

Disease Management Effort Focuses on Asthma

During FY 2002, work began on an interactive CD-ROM project to educate primary care providers regarding best practices and national guidelines regarding the diagnosis, management and treatment of pediatric asthma, now affecting 35,000 Medicaid-eligible children in Alabama. When the project is fully implemented, the Agency hopes to improve health outcomes by increasing the number of children whose asthma is under control. In the longer term, the Agency anticipates changes in prescribing patterns, hospitalization rates and ER visits as the result of this disease management effort.

HRSA Grant To Evaluate Targeted Case Management

The awarding of a new grant in August, 2002, launched a new quality improvement effort at the Agency. The grant, through the Health Resources and Services Administration (HRSA), will be used to evaluate the effectiveness of targeted case management as an intervention to address the problem of poor patient compliance and under utilization of Medicaid covered dental services. The project will focus specifically on increasing the number of parents aware of the importance of oral health prevention and increasing the number of Medicaid patients who receive follow-up care.

Breast and Cervical Cancer Prevention and Treatment Now Covered

On October 1, 2001, Alabama Medicaid began covering a new eligibility group for breast and cervical cancer that was made possible by Federal Legislation passed in 2000. The Breast and Cervical Cancer Act of 2000 allows Alabama Medicaid to cover treatment for women diagnosed with breast or cervical cancer through a federal screening program. Eligible women are not otherwise covered by Alabama Medicaid, have no health insurance that covers their treatment, and are under the age of 65.

Ticket to Work/Medicaid Infrastructure Grant

This grant, awarded to the Agency beginning January 1, 2002 in the amount of $625,000, has enabled Medicaid to establish a consumer-based Policy Consortium. The Policy Consortium meets on a monthly basis to review existing policies relative to Medicaid SAIL Waiver clients who have physical disabilities and have a desire to maintain their employment status or obtain employment with the help of a personal assistant on the job site.

Implementation of the Real Choice Systems Grant Continues

Last year, the Alabama Medicaid Agency received a Real Choice Systems Change Grant from CMS in the amount of $2 million for a three-year period. The State appropriate-

ly titled the proposal Sweet Home Alabama: Under Construction. Other agencies involved in the program are the Alabama Department of Senior Services and the Alabama Department of Mental Health and Mental Retardation.

The grant will be used to develop systems that change the way individuals enter long term care for individuals with disabilities and seniors.

The new systems will ensure that these services are provided in the least restrictive setting. Instead of services being provided based on age and disability, an infrastructure to provide services based on the choice of the consumer will be put in place.

During FY 2002, the Disability/ Aging Policy advisory Group (D/APAG) was established as a mechanism to provide ongoing consumer input in regards to Medicaid long term care policies. Membership consists of four consumers/ family members, two advocates, two providers and representatives from various state agencies. Consumer/ family members, advocates, and providers were selected from nominations submitted by the consumer based Olmstead Core Workgroup. During the membership selection process, special consideration was given to gender, ethnicity, type of disability, individuals to be represented by the member (i.e. seniors and individuals with disabilities), etc to ensure group diversity.

D/APAG held its first meeting on July 24, 2002 and now meets on a bimonthly basis. In September 2002, D/APAG completed the development of the request for proposals that will be used to identify a contractor to conduct a feasibility study of single point of entry within the State.

Outreach and educational activities developed by staff as a part of the grant initiative address the Olmstead Plan, Institutional Deeming, the Auto Approval process, Home Health, and the State Plan. Presentations are made to providers and consumers of long term services. The unit also plans to develop educational presentations of other long term care programs and services, to design a catalog displaying all presentations available through the Outreach and Education Unit, and to create a standard form to be completed and submitted by all organizations requesting presentations by Unit staff.

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) calls for standards of electronic health information to be developed. The overall goal is simplification, but implementation of HIPAA is considered to be more far reaching than preparing for Y2K because it encompasses enterprise-wide business practices and is not strictly information technology.

The primary intent of HIPAA is to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs. Provisions of HIPAA mandate that the U.S. Department of Health and Human Services adopt standards for all healthcare information that is electronically exchanged. HIPAA affects all health plans, not just Medicaid. Medicaid staff along with our fiscal agent, EDS and representatives from CMS will be working together to ensure Alabama Medicaid's compliance with HIPAA.

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 2002, 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" (MLIF) 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 percent 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. Once children under 19 years of age are determined eligible for Medicaid through any program, they receive twelve months of continuous eligibility without regard to changes in income or family situation as long as they live in Alabama.
- Women who are aged 19 - 44, who have not been sterilized, and with family income which does not exceed 133 percent of the federal poverty level are covered by Medicaid for the Plan First Program. This program covers family planning services only.
- 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 Com-

munity 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 percent 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 most categories may receive retroactive Medicaid coverage if medical bills were incurred in the three months prior to the application for Medicaid or in the two months prior to eligibility for SSI and if they meet all requirements for that category 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.

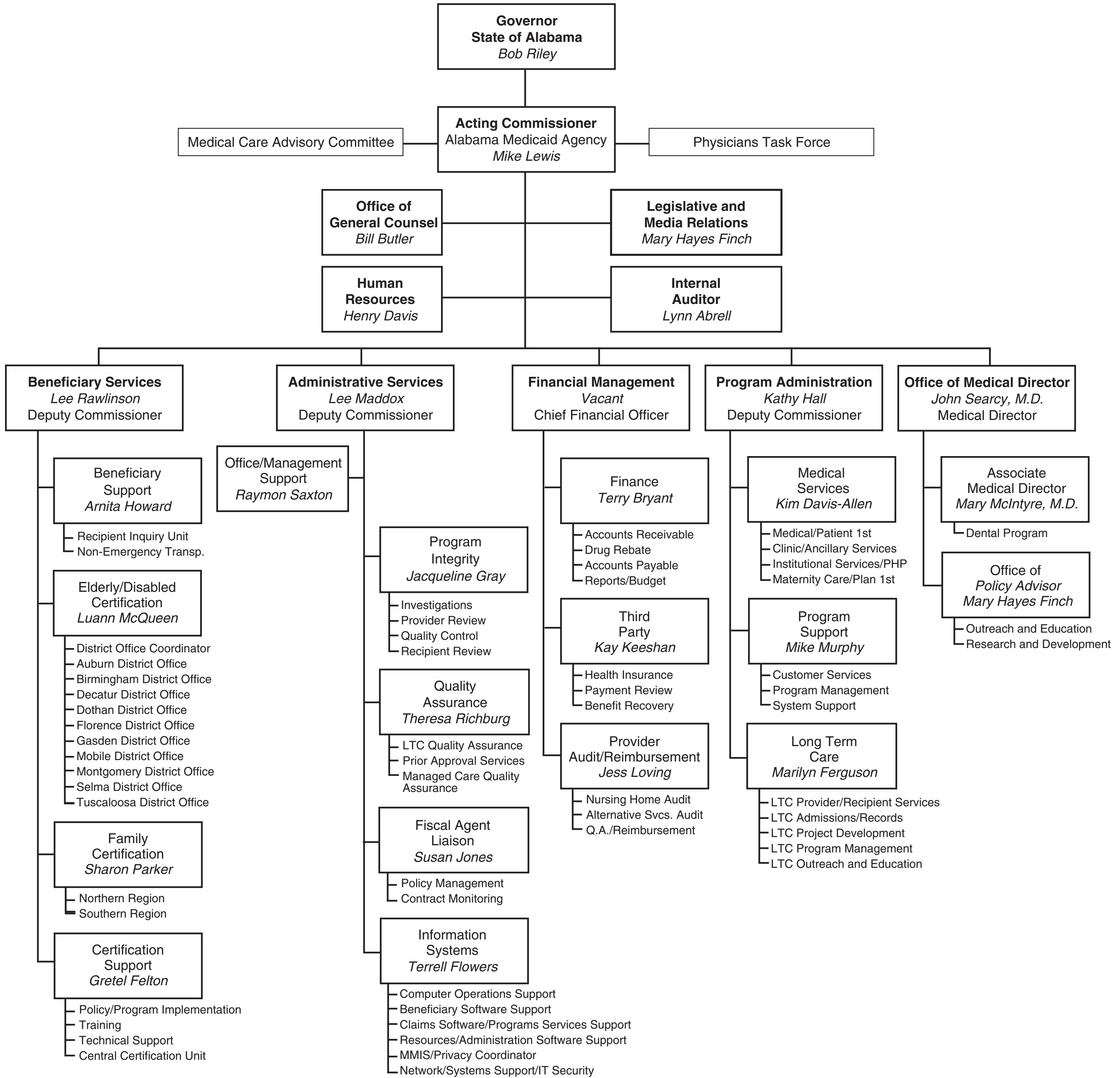
Covered Services

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.

ALABAMA MEDICAID AGENCY



Mike Lewis
Acting Commissioner

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 2002, Medicaid paid $3 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 $9 billion worth of business in Alabama in FY 2002.

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 97 percent of the Agency's budget goes toward purchasing services for beneficiaries.

FY 2002
COUNTY IMPACT
Year's Cost Per Eligible

County	Benefit Payments	Eligibles	Payment per Eligible	County	Benefit Payments	Eligibles	Payment per Eligible
Autauga	$15,034,142	7,034	$2,137	**Houston**	$56,338,609	19,489	$2,891
Baldwin	$56,013,287	17,751	$3,156	**Jackson**	$29,632,433	9,986	$2,967
Barbour	$19,670,035	7,343	$2,679	**Jefferson**	$331,222,821	112,681	$2,939
Bibb	$11,034,017	4,277	$2,580	**Lamar**	$12,784,625	3,615	$3,537
Blount	$22,848,141	7,790	$2,933	**Lauderdale**	$48,165,988	14,750	$3,265
Bullock	$11,439,433	3,927	$2,913	**Lawrence**	$17,645,199	6,108	$2,889
Butler	$19,754,304	6,605	$2,991	**Lee**	$40,354,824	16,559	$2,437
Calhoun	$74,846,710	24,395	$3,068	**Limestone**	$27,147,284	9,791	$2,773
Chambers	$22,897,888	7,951	$2,880	**Lowndes**	$11,411,626	4,690	$2,433
Cherokee	$14,862,505	4,824	$3,081	**Macon**	$20,265,082	6,882	$2,945
Chilton	$18,148,825	7,221	$2,513	**Madison**	$91,875,603	33,614	$2,733
Choctaw	$12,384,030	4,271	$2,900	**Marengo**	$17,853,551	6,507	$2,744
Clarke	$20,322,944	7,949	$2,557	**Marion**	$20,679,071	6,406	$3,228
Clay	$11,406,721	3,097	$3,683	**Marshall**	$52,827,843	17,090	$3,091
Cleburne	$7,990,002	3,008	$2,656	**Mobile**	$255,903,355	81,946	$3,123
Coffee	$26,581,544	8,534	$3,115	**Monroe**	$14,877,109	5,827	$2,553
Colbert	$29,789,904	10,897	$2,734	**Montgomery**	$132,880,867	49,613	$2,678
Conecuh	$11,811,490	4,303	$2,745	**Morgan**	$74,401,479	17,587	$4,230
Coosa	$5,726,162	2,465	$2,323	**Perry**	$14,159,517	5,039	$2,810
Covington	$29,848,076	9,310	$3,206	**Pickens**	$18,207,361	6,095	$2,987
Crenshaw	$11,676,370	3,798	$3,074	**Pike**	$23,816,931	8,557	$2,783
Cullman	$48,532,762	14,901	$3,257	**Randolph**	$15,426,163	5,120	$3,013
Dale	$28,208,669	10,085	$2,797	**Russell**	$30,382,026	11,642	$2,610
Dallas	$44,136,133	18,260	$2,417	**St. Clair**	$26,406,178	10,124	$2,608
Dekalb	$46,822,173	13,758	$3,403	**Shelby**	$29,755,838	9,560	$3,113
Elmore	$37,761,839	10,029	$3,765	**Sumter**	$14,403,608	5,758	$2,501
Escambia	$22,006,811	8,998	$2,446	**Talladega**	$54,074,057	18,464	$2,929
Etowah	$75,020,283	20,800	$3,607	**Tallapoosa**	$33,103,893	8,929	$3,707
Fayette	$12,819,695	3,908	$3,280	**Tuscaloosa**	$129,647,983	30,214	$4,291
Franklin	$23,775,708	7,211	$3,297	**Walker**	$56,770,258	15,822	$3,588
Geneva	$18,022,449	6,174	$2,919	**Washington**	$11,885,818	4,433	$2,681
Greene	$8,886,294	3,738	$2,377	**Wilcox**	$13,927,404	6,273	$2,220
Hale	$15,382,376	5,653	$2,721	**Winston**	$18,926,014	5,829	$3,247
Henry	$11,929,900	4,003	$2,980	**Other**	$1,479,296	839	$1,763

Revenue and Expenditures

In FY 2002, Medicaid paid $3,210,807,182 for health care services to Alabama citizens. Another $95,483,319 was expended to administer the program. This means that almost 97 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 2002 Components of Federal Funds

(net)	Dollars
Family Planning Administration	$956,044
Professional Staff Costs	$8,456,251
Other Staff Costs	$50,823,071
Other Provider Services	$2,231,111,838
Family Planning Services	$23,613,592
Total	$2,314,960,796

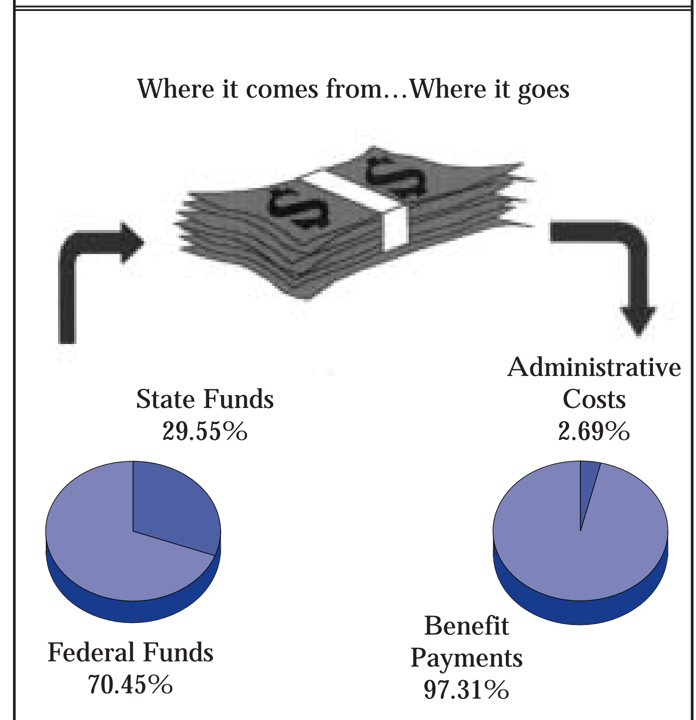
FY 2002 Sources of Medicaid Revenue

Federal Funds	$2,314,963,796
State Funds	$908,476,018
Total Revenue	$3,223,439,814

FY 2002 Components of State Funds

(net)	Dollars
General Fund Appropriations	$231,726,175
Public Hospital Transfers and Alabama Health Care Trust Fund	$464,793,519
Other State Agencies	$137,906,075
Drug Rebates	$25,037,731
UAB (Transplants)	$1,355,252
Miscellaneous Receipts	$16,567,760
Medicaid Trust Fund (with interest)	$31,089,506
Total	$908,476,018

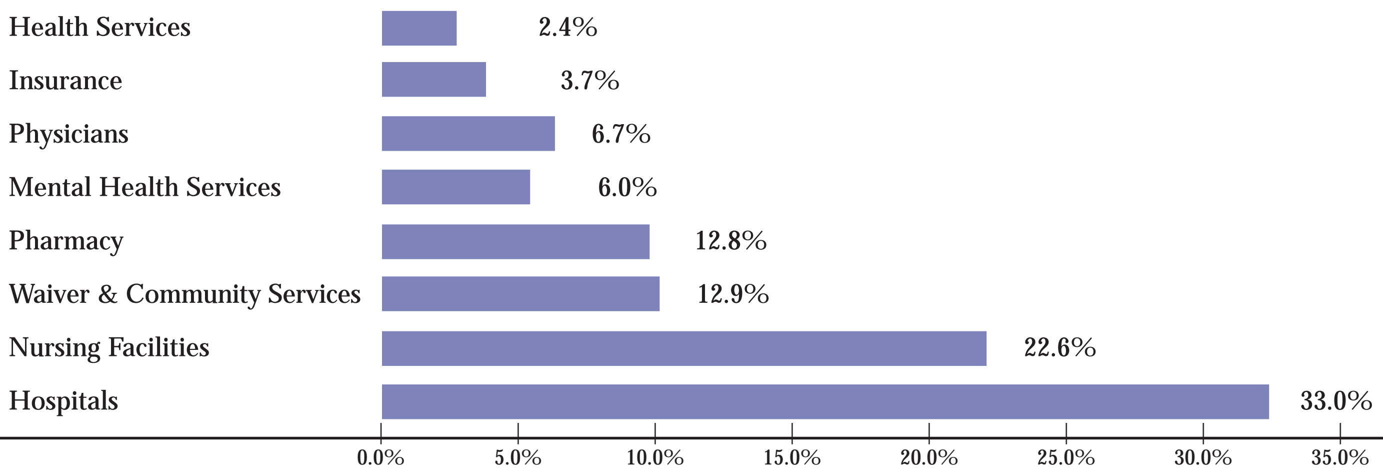
FY 2002 Composition and Disbursement of Medicaid's Budget



FY 2002
EXPENDITURES By Type of Service (net)

Service	Payments	Percent of Total Payments
Hospitals:	**$1,036,930,476**	32.29%
Disproportionate Share	$373,816,436	11.64%
Inpatient	$540,242,762	16.83%
Outpatient	$85,289,917	2.66%
FQHC	$27,706,677	0.86%
Rural Health Centers	$9,874,684	0.31%
Nursing Facilities	**$691,391,675**	21.53%
Waiver Services:	**$183,054,527**	5.70%
Elderly & Disabled	$45,205,645	1.41%
Mental Health	$128,239,244	3.99%
Homebound	$9,609,638	0.30%
Pharmacy	**$450,984,232**	14.05%
Physicians:	**$204,647,364**	6.37%
Physicians	$152,308,995	4.74%
Physician's Lab and X-Ray	$27,159,701	0.85%
Clinics	$19,099,875	0.59%
Other Practitioners	$6,078,793	0.19%
MR/MD:	**$80,960,712**	2.52%
ICF-MR	$60,236,379	1.88%
NF-MD/Illness	$20,724,333	0.65%
Insurance:	**$108,209,220**	3.37%
Medicare Buy-In	$95,508,698	2.97%
PCCM	$10,364,962	0.32%
Medicare HMO	$969,585	0.03%
Catastrophic Illness Insurance	$367,108	0.01%
Health Services:	**$83,871,557**	2.61%
Screening	$16,885,055	0.53%
Laboratory	$14,340,670	0.45%
Dental	$34,446,249	1.07%
Transportation	$8,494,496	0.26%
Eye Care	$6,071,351	0.19%
Eyeglasses	$2,862,188	0.09%
Hearing	$572,680	0.02%
Preventive Education	$198,868	0.01%
Community Services:	**$230,315,961**	7.17%
Maternity Program	$96,992,901	3.02%
Home Health/DME	$43,110,659	1.34%
Family Planning	$26,266,159	0.82%
Targeted Case Management	$44,438,727	1.38%
Hospice	$19,507,515	0.61%
Mental Health Services	**$140,521,458**	4.38%
Total For Medical Care	$3,210,887,182	100.00%
Administrative Costs	$95,483,319	
Net Payments	$3,306,370,501	

FY 2002
BENEFIT PAYMENTS PERCENT DISTRIBUTION



POPULATION

The population of Alabama grew from 4,040,587 in 1990 to 4,419,280 in 2000. In 2002, Alabama's population was estimated to be 4,526,059. Because of increases in Medicaid coverage in recent years, the segment of the population eligible for Medicaid services has risen from 10.4 percent in FY 1990 to 19 percent in FY 2002.

More significant to the Medicaid program now and in the future is 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 United States Census Bureau reveal that between the year 2000 and the year 2025, the over 65 population will grow from 582,000 to 1,069,000 in Alabama. The Center for Demographic Research at Auburn University 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 2000-2002
POPULATION
Eligibles as a Percent of Alabama Population by Year

	Population	Eligibles	Percent
2000	4,419,280	676,930	15.3%
2001	4,486,580	802,215	17.9%
2002	4,526,059	860,107	19.0%

Note: The 2002 Medicaid Eligibles include 105,706 Plan First beneficiaries.

Eligibles and Recipients

During FY 2002 there were 860,107 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 704,155. The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

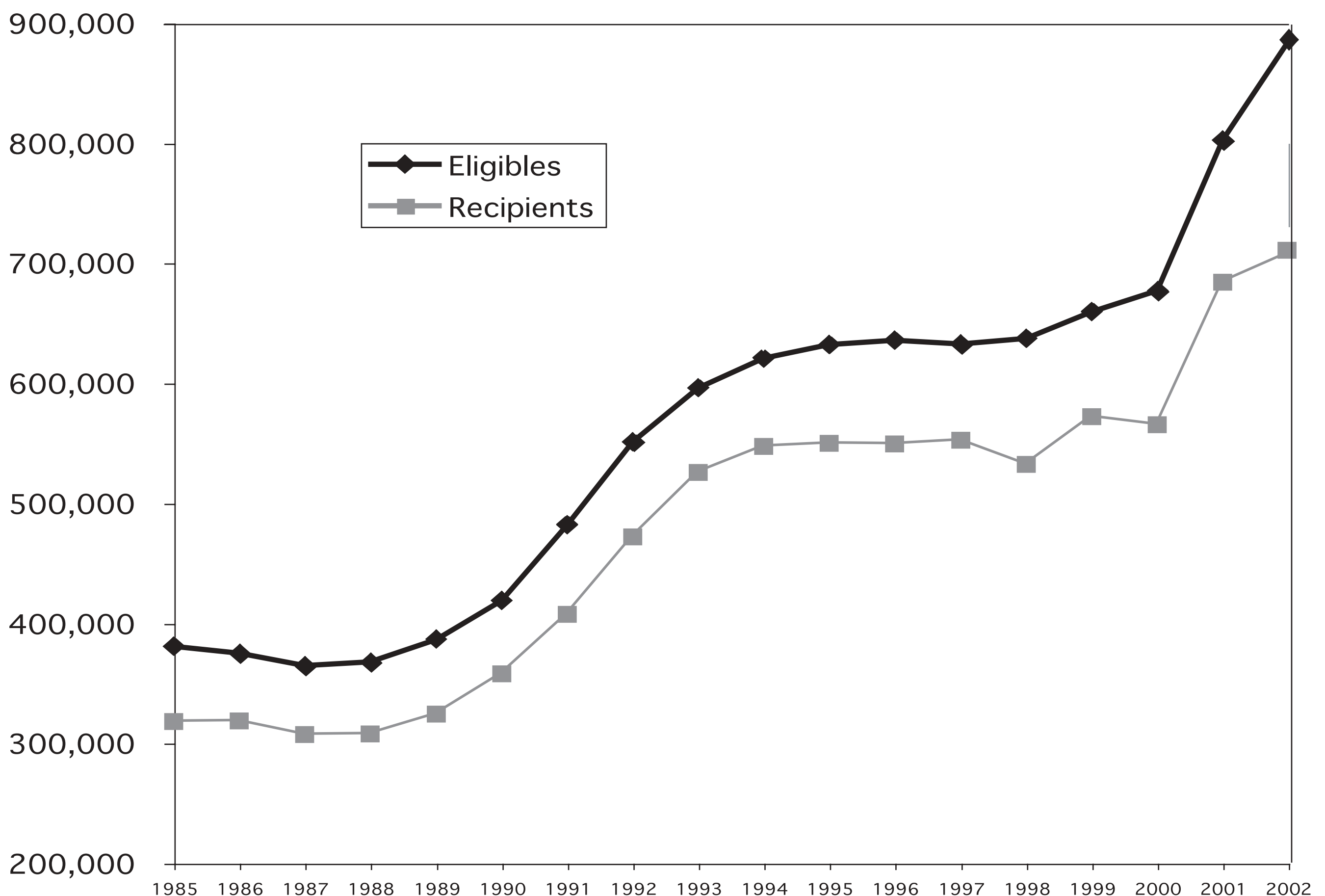
Of the 860,107 persons eligible for Medicaid in FY 2002, about 82 percent actually received care for which Medicaid paid. These 704,062 persons are referred to as recipients. The remaining 156,045 persons incurred no medical expenses paid for by Medicaid.

FY 2002 ELIGIBLES MONTHLY COUNT

Month	Count
October '01	676,529
November	680,151
December	680,706
January '02	688,141
February	694,191
March	699,463
April	706,656
May	711,314
June	716,188
July	722,774
August	732,620
September	741,121

Average Monthly Eligibles FY 2002 - 704,155

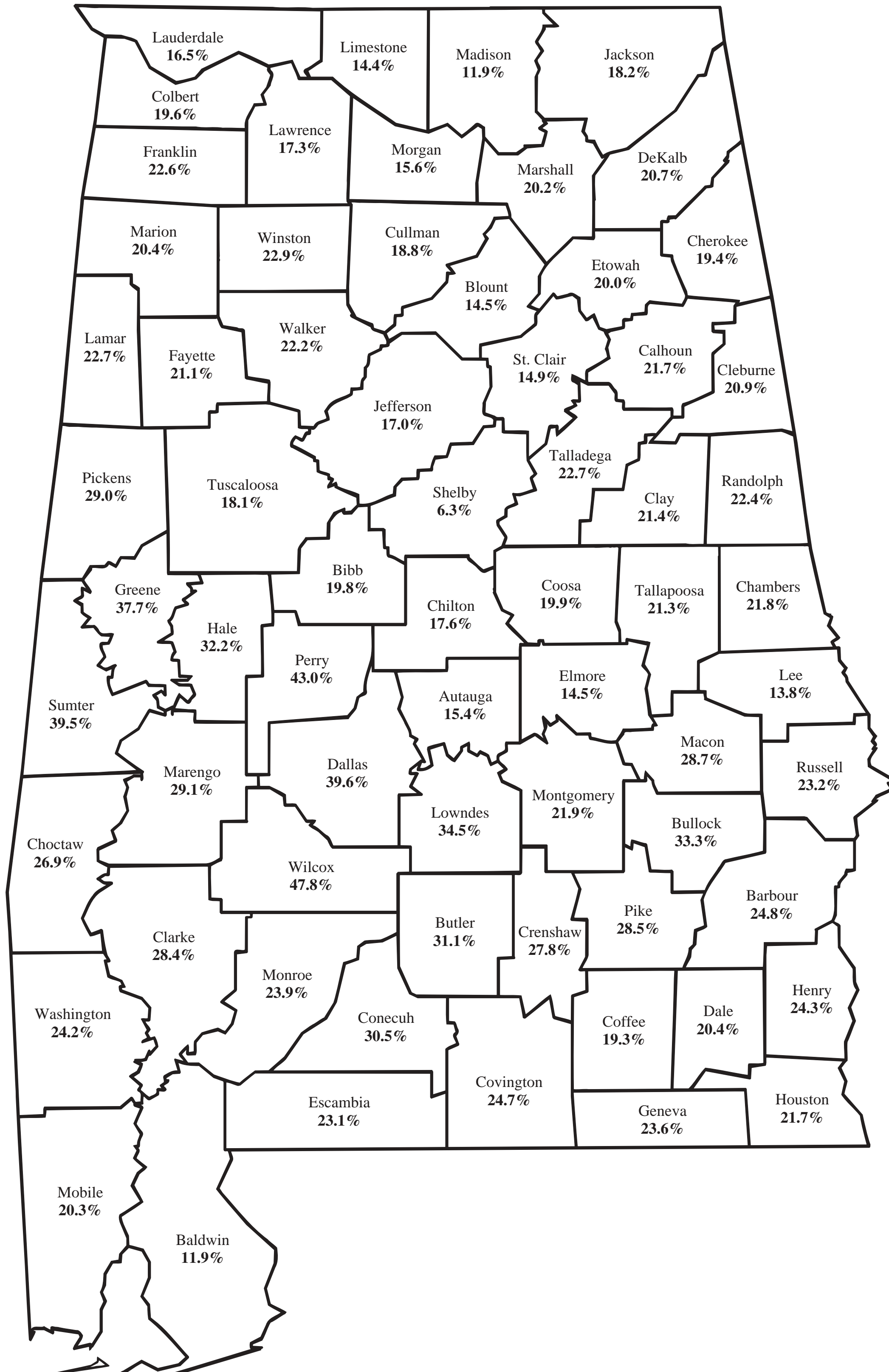
FY 1985 - 2002 MEDICAID ELIGIBLES AND RECIPIENTS



FY 2002
MEDICAID ELIGIBLES BY CATEGORY

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	PLAN FIRST	TOTAL
Autauga	1,247	290	1,289	2,849	279	4	255	821	7,034
Baldwin	948	785	3,126	8,649	819	27	995	2,402	17,751
Barbour	769	482	1,558	3,130	340	15	280	769	7,343
Bibb	324	240	975	1,783	188	5	200	562	4,277
Blount	734	435	1,198	3,686	399	6	507	825	7,790
Bullock	479	318	829	1,644	152	6	96	403	3,927
Butler	536	474	1,233	2,898	366	11	337	750	6,605
Calhoun	2,646	1,022	4,853	10,153	1,121	58	1,129	3,413	24,395
Chambers	1,348	573	1,347	2,968	398	23	504	790	7,951
Cherokee	472	283	725	2,195	279	8	334	528	4,824
Chilton	910	353	1,254	2,974	396	11	439	884	7,221
Choctaw	441	355	879	1,677	189	6	210	514	4,271
Clarke	1,128	489	1,596	3,025	363	11	399	938	7,949
Clay	151	263	513	1,376	214	5	219	356	3,097
Cleburne	355	147	511	1,256	170	2	248	319	3,008
Coffee	812	599	1,487	3,727	466	10	468	965	8,534
Colbert	388	567	1,938	5,284	545	14	635	1,526	10,897
Conecuh	715	247	823	1,716	222	5	199	376	4,303
Coosa	267	137	546	979	143	4	158	231	2,465
Covington	966	679	1,634	3,845	567	11	629	979	9,310
Crenshaw	353	346	664	1,581	221	1	226	406	3,798
Cullman	709	1,055	2,414	6,820	964	20	1,110	1,809	14,901
Dale	1,409	560	1,993	4,180	432	14	433	1,064	10,085
Dallas	2,888	1,104	4,656	6,359	695	27	590	1,941	18,260
Dekalb	1,383	955	2,095	6,420	778	13	796	1,318	13,758
Elmore	916	537	2,121	4,539	344	15	341	1,216	10,029
Escambia	706	456	1,443	4,405	377	12	353	1,246	8,998
Etowah	1,500	1,303	4,564	8,502	1,158	33	1,252	2,488	20,800
Fayette	512	265	736	1,479	224	5	245	442	3,908
Franklin	660	457	1,198	3,300	445	3	445	703	7,211
Geneva	551	424	1,134	2,543	450	7	440	625	6,174
Greene	468	288	841	1,432	131	8	101	469	3,738
Hale	434	430	1,090	2,472	200	8	222	797	5,653
Henry	518	320	673	1,492	289	7	272	432	4,003
Houston	1,960	1,017	3,675	8,661	981	24	975	2,196	19,489
Jackson	757	621	1,784	4,335	635	19	698	1,137	9,986
Jefferson	18,506	5,104	24,500	42,727	3,661	162	4,220	13,801	112,681
Lamar	272	282	617	1,509	238	9	243	445	3,615
Lauderdale	807	879	2,815	6,277	820	12	838	2,302	14,750
Lawrence	500	393	1,098	2,444	374	8	373	918	6,108
Lee	1,529	666	2,843	7,577	604	24	575	2,741	16,559
Limestone	772	612	1,736	4,356	505	20	438	1,352	9,791
Lowndes	733	265	924	1,978	146	6	106	532	4,690
Macon	1,323	391	1,271	2,623	200	5	154	915	6,882
Madison	5,113	1,554	6,081	13,935	1,246	50	1,216	4,419	33,614
Marengo	809	451	1,440	2,592	263	9	209	734	6,507
Marion	383	437	1,009	2,808	418	7	461	883	6,406
Marshall	1,452	1,112	2,996	7,913	887	20	997	1,713	17,090
Mobile	15,144	3,379	14,794	33,341	2,510	100	2,630	10,048	81,946
Monroe	519	332	1,045	2,660	241	10	268	752	5,827
Montgomery	9,218	2,170	9,807	19,712	1,507	65	1,166	5,968	49,613
Morgan	966	1,005	3,310	8,323	837	34	901	2,211	17,587
Perry	942	387	1,155	1,731	170	4	114	536	5,039
Pickens	741	452	1,340	2,232	248	6	249	827	6,095
Pike	1,038	498	1,706	3,506	287	19	332	1,171	8,557
Randolph	765	327	806	2,074	284	9	286	569	5,120
Russell	2,145	624	2,140	4,463	479	19	473	1,299	11,642
St. Clair	1,102	443	1,614	4,794	431	9	492	1,239	10,124
Shelby	823	466	1,707	4,074	439	6	539	1,506	9,560
Sumter	1,583	380	1,107	1,760	168	9	136	615	5,758
Talladega	2,039	830	4,346	7,206	897	76	896	2,174	18,464
Tallapoosa	908	704	1,904	3,522	473	11	516	891	8,929
Tuscaloosa	2,717	1,625	6,440	12,704	938	43	1,130	4,617	30,214
Walker	1,018	818	3,535	6,959	635	21	775	2,061	15,822
Washington	709	247	816	1,703	183	8	221	546	4,433
Wilcox	983	398	1,706	2,186	212	11	109	668	6,273
Winston	347	425	1,099	2,592	377	3	373	613	5,829
Youth Services	7	0	0	832	0	0	0	0	839
STATEWIDE	107,273	46,532	167,102	357,447	36,618	1,253	38,176	105,706	860,107

FY 2002
ELIGIBLES
PERCENT OF POPULATION ELIGIBLE FOR MEDICAID



Comparison of Eligibles and Payments

The percent distribution of Medicaid payments has changed very little from last year. Most payments are made on behalf of eligibles in the aged or disabled categories, females, whites, and persons 65 years of age and older.

The largest group of eligibles is the SOBRA group, which covers low-income pregnant women and children. Alabama Medicaid pays for about one half of all pregnancy-related services in the state, and over 50 percent of children in Alabama less than six years of age are enrolled in the program. Even at 42 percent of all Medicaid Eligibles, the SOBRA group accounts for only a little over 20 percent of Medicaid expenditures. Another group that covers parents and their children is Medicaid for Low Income Families (MLIF).

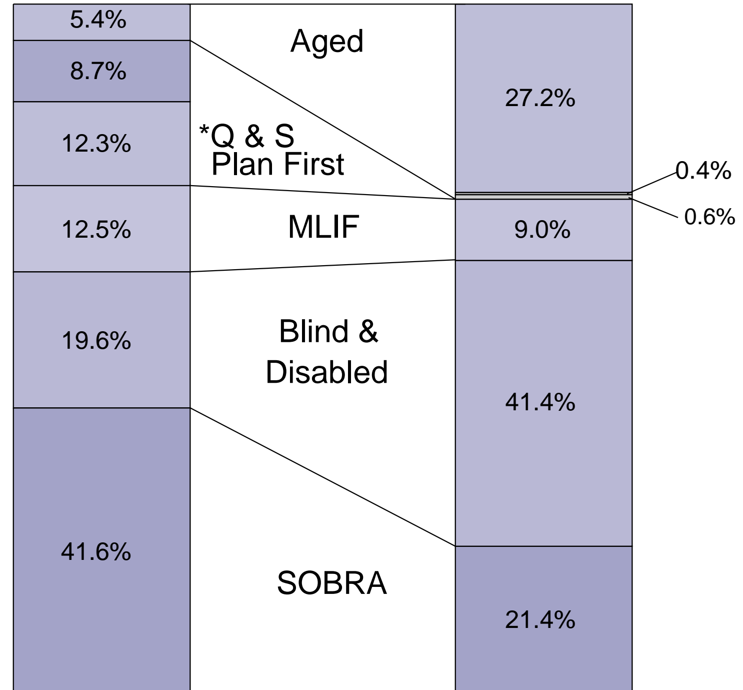
When combined, these two groups that cover families account for almost 55 percent of the Medicaid population, but only 30 percent of the payments. Other eligibles, such as QMB, SLMB and Plan First groups comprise a total of over 20 percent of Medicaid eligibles, while only one percent of payments for Medical Services are made on their behalf. This is because these groups do not receive full Medicaid. QMB's and SLMB's qualify to have their Medicare premiums, deductibles, or coinsurance paid for by Medicaid. Plan First eligibles receive family planning services only.

The structure of Medicaid covered services has been designed to meet the diverse needs of its beneficiaries. For example, pregnant women require prenatal and maternity care, while children require immunizations, lead screening, well-child care and primary care services. Children with disabilities may also need specialty care, home-based care, medical equipment and, in some cases, institutional care. Adults with disabilities may need personal attendants and other supportive services to remain independent. Frail elderly individuals may require home health care or nursing home care. Medicaid covers a broad range of services to meet all these needs. Primary care services and pregnancy related services are much less costly than the specialty care required for disabled or elderly individuals. Many of the services included in the Medicaid program, particularly costly long-term institutional care, are not covered by private insurers or Medicare.

FY 2002
Eligibles and Payments Percent Distribution

By Category Of Aid

* QMB & SLMB



Eligibles

Total = 860,107

Payments

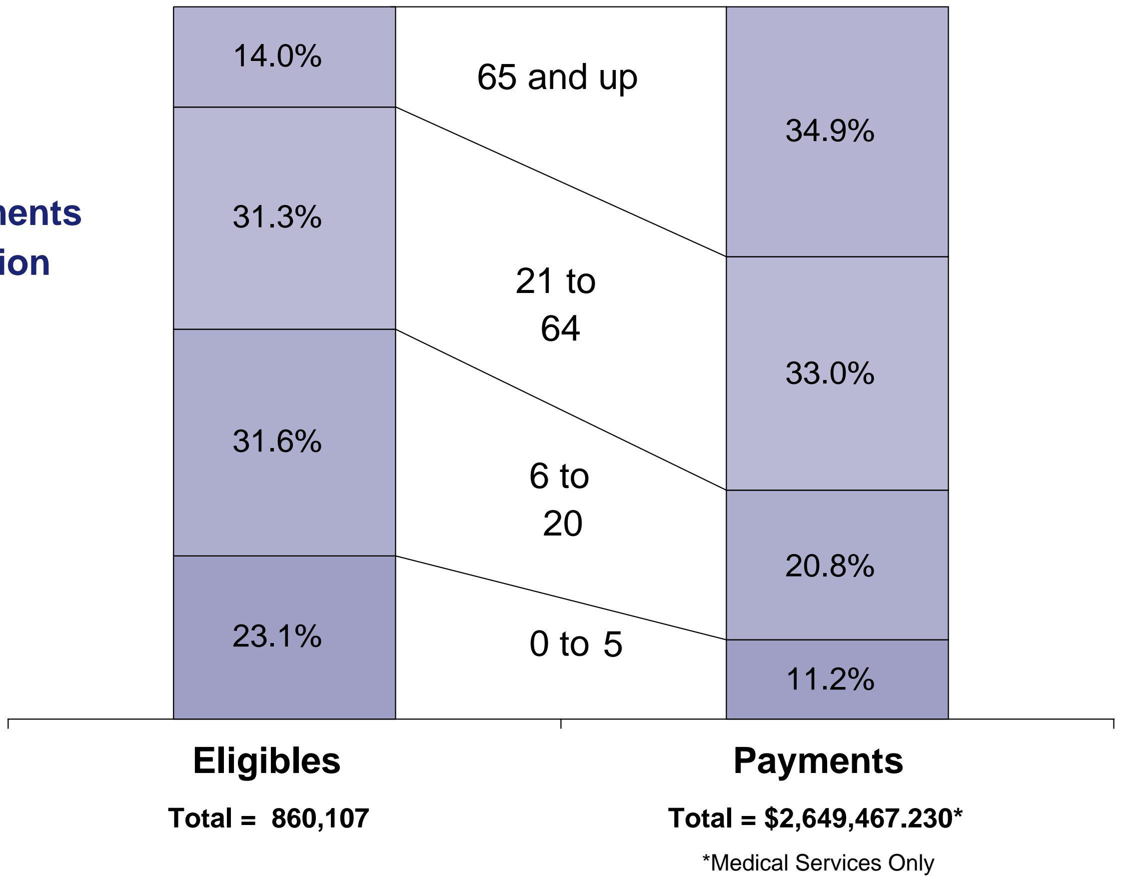
Total = $2,649,467.230*

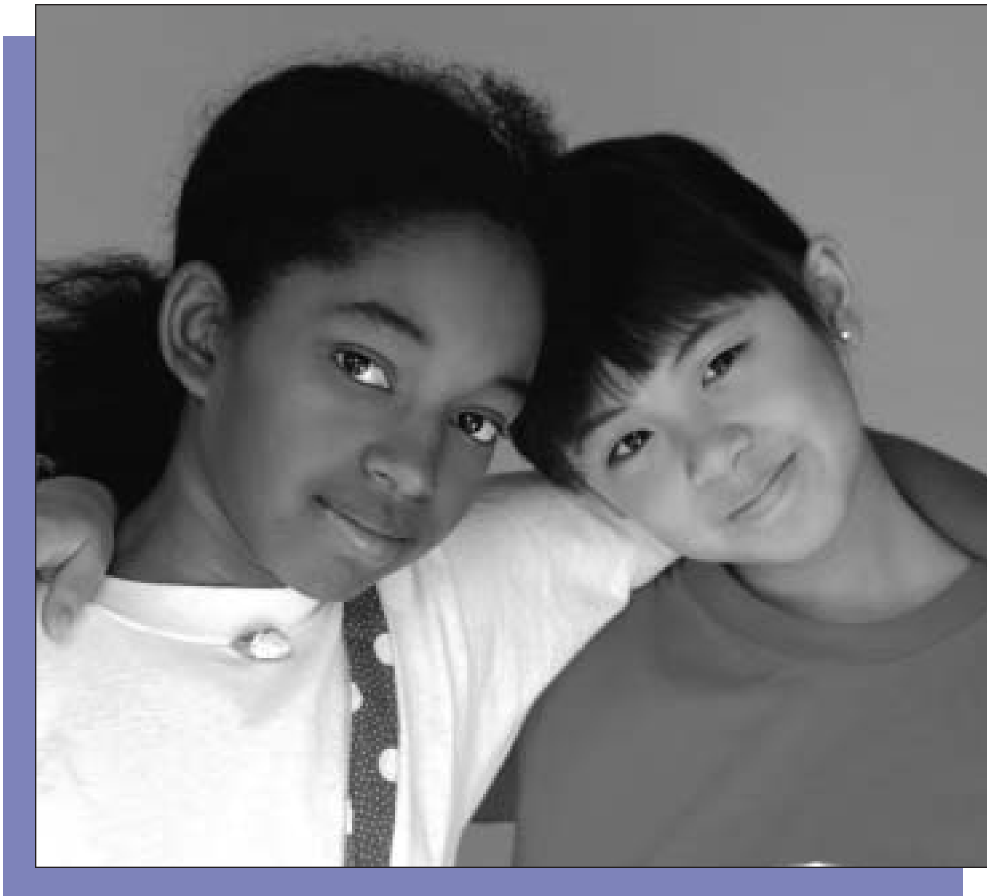
*Medical Services Only

FY 2002

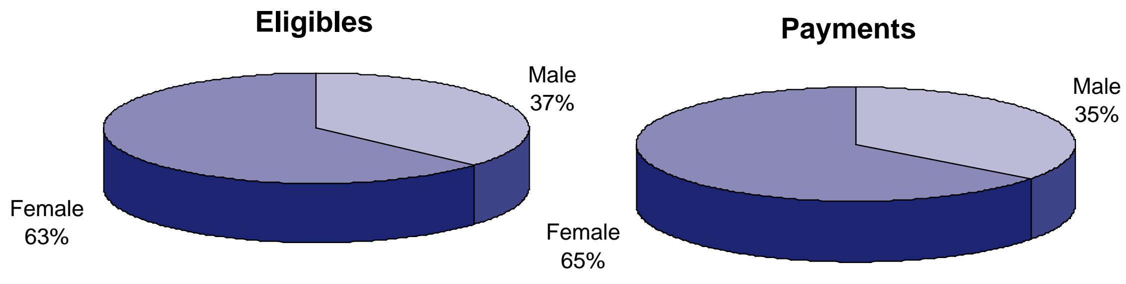
Eligibles and Payments Percent Distribution

By Age

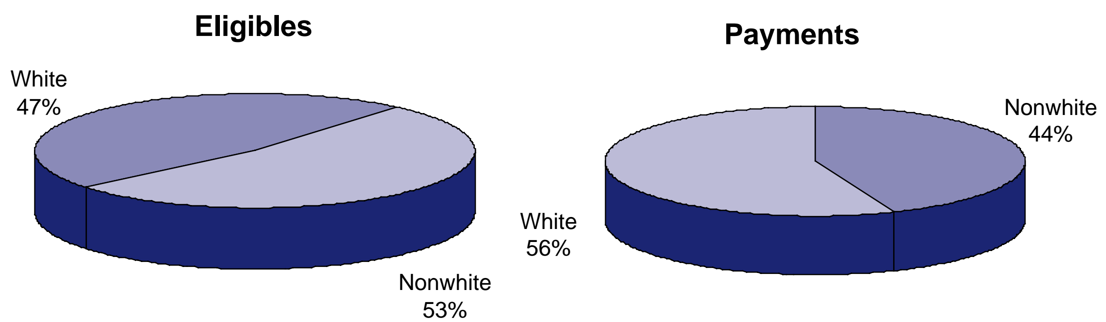




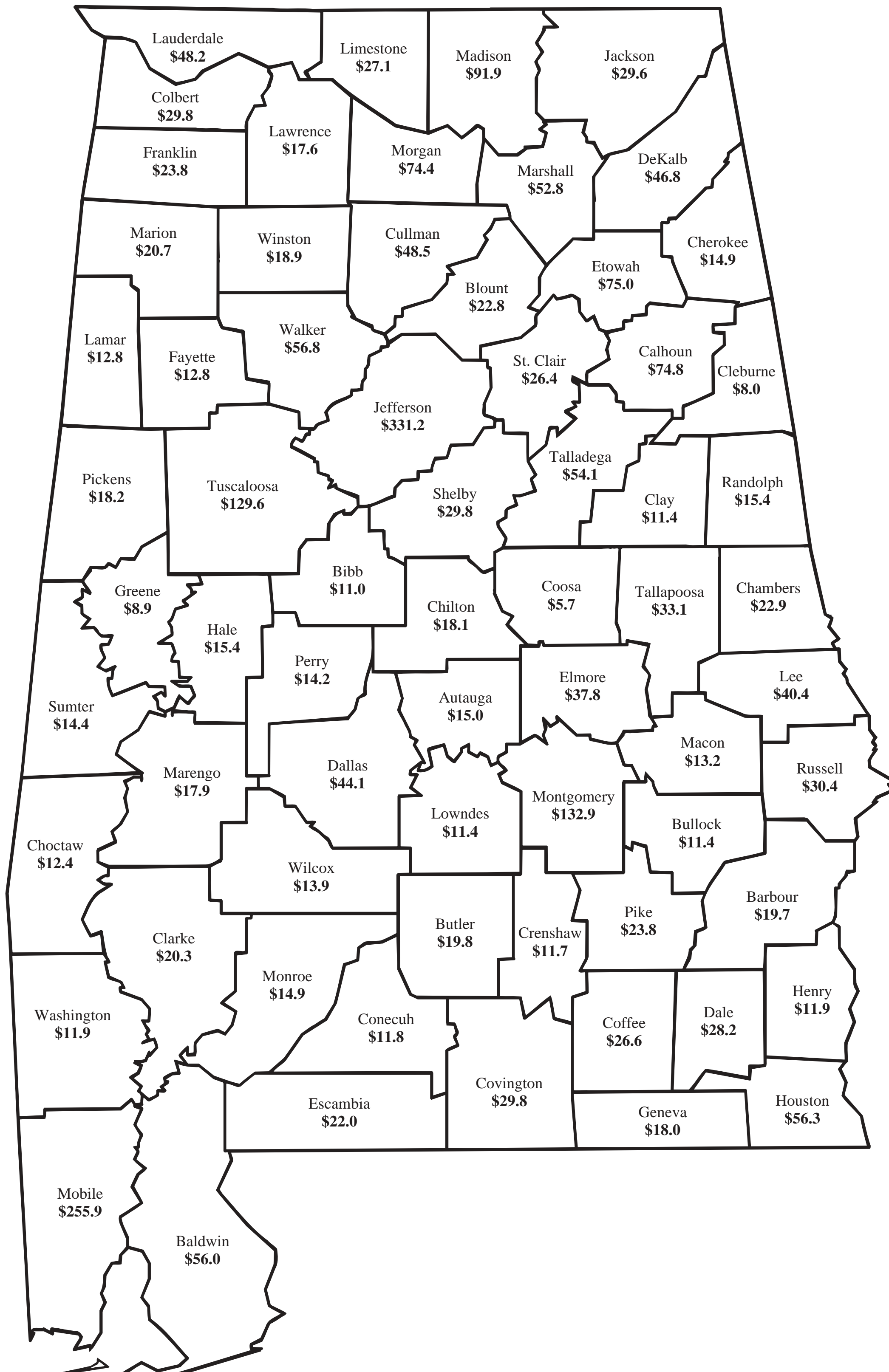
FY 2002 Eligibles and Payments
Percent Distribution by Gender



FY 2002 Eligibles and Payments
Percent Distribution by Race



FY 2002
TOTAL PAYMENTS
By County of Recipient (in millions of dollars)

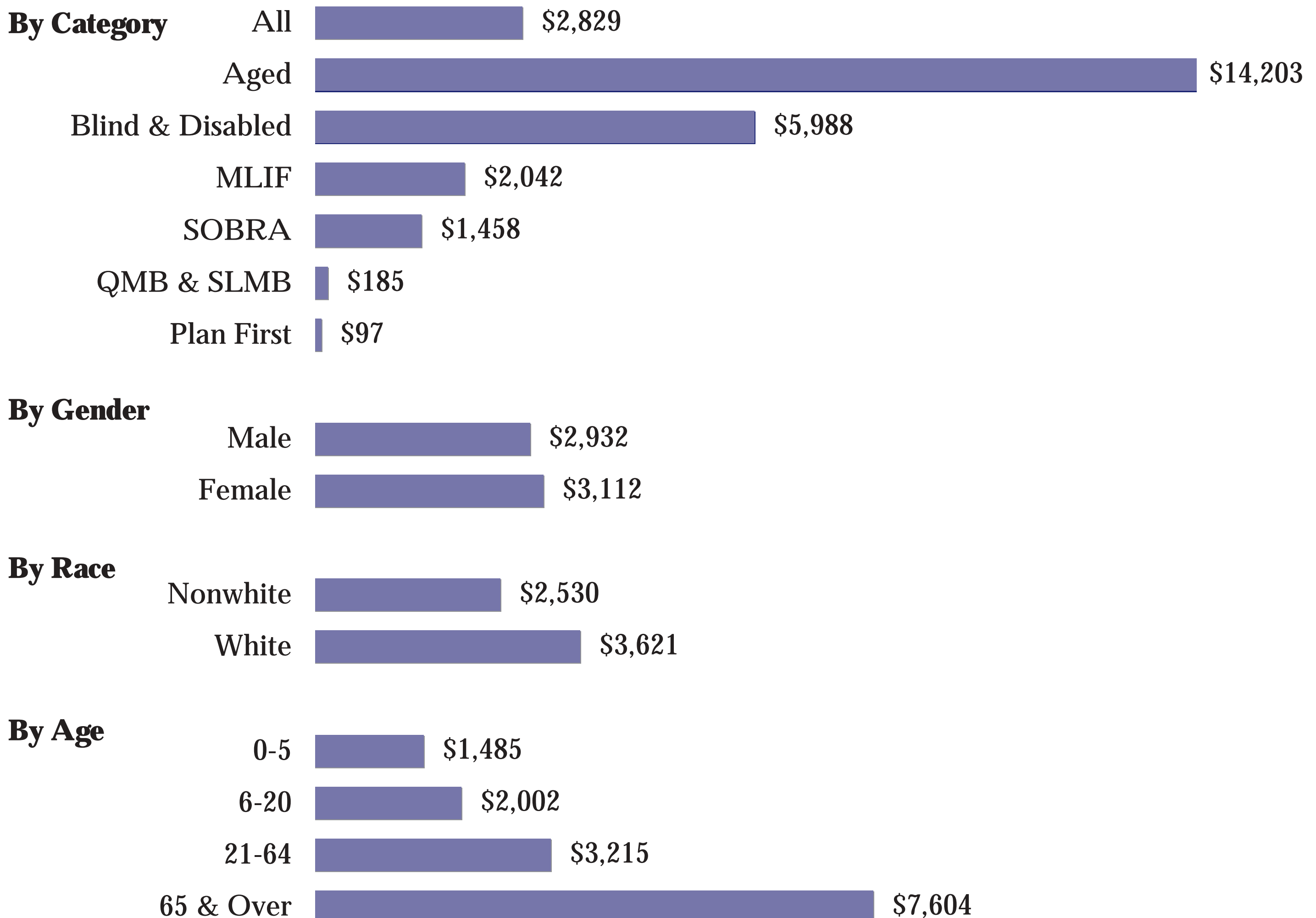


USE AND COST

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 2002 was $95. The yearly average number of days for recipients of this service was 273. 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 2002 paid a monthly buy-in fee to Medicare of $54 per eligible Medicare beneficiary. The Medicaid Agency also paid from $300 to $351 per month Part-A buy-in premiums for certain Medicare eligibles. Medicaid paid a total of $105 million in Medicare buy-in fees in FY 2002. 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.



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 and pharmacy auditors 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.

Corrective actions include recoupment of funds, education on proper billing procedures, and peer review by appropriate licensing authorities. There were 176 reviews completed in FY 2002 and recoupments for this period totaled over $1,141,211.71.

PROVIDER REVIEWS FY 2002

Medical Providers Reviewed	**176**
Pharmacies Reviewed	**411**
Medical Provider Recoveries	**$1,141,212**
Potential Recoveries Identified	**$658,282**

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

The Investigations Unit within the Program Integrity Division is charged with identifying criminal fraud or abuse as related to providers and recipients through on-site investigations, interviews and electronic evidence gathering. Completed cases are then referred to appropriate law enforcement agencies, Medicaid's Utilization Review Committee, or to State Licensing Boards for appropriate action. During FY 2002, twelve previously referred cases were adjudicated along with 102 cases investigated and closed, and eight referrals for prosecution.

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.

Since October 1, 2001 Medicaid benefits have been suspended for 85 recipients. At the end of FY 2002, a total of approximately 2,500 recipients were suspended from the Medicaid program for fraud and/or abuse

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 Centers for Medicare and Medicaid Services (CMS) 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 October 2001 to March 2002. Nationally, Alabama has consistently been among those states with the lowest payment error rates.

RECIPIENT REVIEWS FY 2002

Reviews Conducted **457**
Monthly Average # of Restricted Recipients **305**
Cost Avoidance **$96,195**

Prior Authorization Program

The primary mission of the Prior Authorization Program (PA) is to ensure that only medically necessary services are provided in a cost-effective manner. The program also takes care to ensure that medically necessary services are not denied to recipients. Requests for prior authorization are processed in a timely manner. With rare exceptions, correctly submitted PA requests are processed within two working days of receipt.

Constantly seeking increased efficiency, responsibilities within the unit are reassigned to personnel within the unit. This promotes cross training so that all personnel within the unit may assist all providers.

The program continues to increase its emphasis on quality assurance. Staff makes visits to providers and recipients

to determine the quality and necessity of approved services. Providers are monitored for unusual and inappropriate submission of PA requests. Findings are reported to appropriate units in Medicaid.

The program works with other units in identifying, researching and resolving various issues. Efforts are being made to automate the processing of PA requests for emergency services for illegal aliens.

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 millions of dollars since its inception in 1970. This has been done through a combination of cost avoidance of claims where providers file with the primary payor first, direct billing by Medicaid to third party payors to obtain health insurance benefits payable for services paid by Medicaid, and continuation of private health insurance coverage for certain Medicaid beneficiaries. Medicaid recovers other costs through estate recovery and liens activity, monitoring of Medicare and other third party edits, and recoupments from beneficiaries of incorrectly paid claims due to ineligibility.

Health Insurance Resources

In FY 2002, over 188,000 Medicaid recipients had health insurance coverage other than Medicare or Medicaid. The majority of these recipients were covered by group health plans through their 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 for specific services, resulting in substantial savings to Medicaid. The Third Party Division is responsible for identification, verification, and documentation of health insurance resources and establishment of claims processing edits so that claims are submitted to the primary payor before Medicaid makes payment. In situations where primary coverage is identified after Medicaid makes payment, Medicaid seeks reimbursement from the other coverage. Through a combination of collection from other payors and cost avoidance, these health insurance resources saved Medicaid $68,468,733 in FY 2002.

Medicare Resources

Medicaid purchases Medicare Part B coverage for eligible beneficiaries and Part A coverage for a limited number of eligible beneficiaries. The Third Party Division oversees the payment of premiums for this coverage and ensures that Medicare is a primary payor to Medicaid. In FY 2002, Medicare edits established and maintained by the Agency avoided costs of over $34,425,352 by direct billing to Medicare for reimbursement and by denying or recouping claims submitted to Medicaid as primary payor and instructing providers to file Medicare as the primary payer. Medicaid costs were further reduced as a result of an additional $566,181,678 paid by Medicare for Medicaid covered services.

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.

Casualty/Tort Resources

When Medicaid pays claims for treatment of a recipient's injury, 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, including restitution ordered by a court. Once a potential third party payor is identified, Medicaid seeks reimbursement of payment for related medical bills paid by Medicaid. In FY 2002, Medicaid collected in excess of $1.6 million from liable third party payors for injuries received by Medicaid recipients.

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 identifies these cases from complaint reports submitted by the individual's caseworker. In FY 2002, Medicaid collected over $921,000 in misspent funds, an increase of over $200,000 from the prior fiscal year.

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 2002, an additional staff person was added to the division's Liens Program. This contributed, in part, to a significant increase in collections. In FY 2002, the Liens Program collected $4.3 million compared to $2.2 million in FY 2001.

The division's Estate Recovery Program initiates collection against estates and income trusts of individuals to recover Medicaid's costs. Through the efforts of this program $148,891 was collected in FY 2002.

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 job loss or the high cost of premiums. The Agency saw a steady increase in the number of individuals participating in this program during FY 2002 and a significant increase in the savings to Medicaid. In FY 2002, Medicaid paid premiums for an average of 132 individuals each month as compared to 112 individuals in FY 2001. This resulted in savings to Medicaid of over $1.5 million as compared to $650,000 in FY 2001. Individuals who benefit 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/Contract Monitoring Unit 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. During this fiscal year, approximately 8,387 claims were manually reviewed and $264,150 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, home offices, and all ICF/MR facilities is completed as necessary. During FY 2002, this unit completed 29 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 annual desk reviews/audits of nursing home and ICF/MR 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 2002
COLLECTIONS AND MEASURABLE COST AVOIDANCE

COLLECTIONS

DRUG REBATE PROGRAM The collection of rebates plus interest by the Fiscal Division from drug manufacturers for the utilization of their products.	$85,007,636
THIRD PARTY LIABILITY Includes reported and estimated third party collections by providers, retroactive Medicare recoupment from providers, and collections due to health and casualty insurance, estate recovery, and misspent funds resulting from eligibility errors.	$29,632,983
PROGRAM INTEGRITY DIVISION Provider Recoupments	$1,141,212
PROGRAM INTEGRITY DIVISION Pharmacy Recoupments	$63,758
FISCAL AGENT/SYSTEMS AUDIT DIVISION Claim Corrections	$264,150
TOTAL COLLECTIONS	***$116,109,739***

MEASURABLE COST AVOIDANCE

PRIOR APPROVAL AND PREPAYMENT REVIEW Results from prior authorization denials for various services/items requiring prior approval and not meeting medically needed criteria such as DME, Private Duty Nursing, Inpatient Admissions or continued stays in specialized psychiatric hospitals (under 21 years of age or over age 65).	$3,523,642
THIRD PARTY CLAIM COST AVOIDANCE SAVINGS	
Provider Reported Collections - Medicare	$566,181,678
Provider Reported Collections - Health and Casuality Insurance	$18,723,588
Claims denied and returned to providers toMedicare.	$22,500,798
Claims denied and returned to providers to file health casualty insurance.	$39,069,067
Health Insurance Preium Payment Cost Avoidance	$1,518,019
WAIVER SERVICES COST AVOIDANCE - ELDERLY AND DISABLED	$153,424,050
WAIVER SERVICES COST AVOIDANCE - HOMEBOUND	$6,067,615
WAIVER SERVICES COST AVOIDANCE - MR/DD	$395,665,221
TOTAL MEASURABLE COST AVOIDANCE	***$1,206,673,678***
GRAND TOTAL	**$1,322,783,417**

Medicaid Management Information System

The Agency's Information Systems (I/S) Division maintains recipient eligibility and provider information, keeps track of all Medicaid program expenditures, and furnishes data through reports, charts, graphs, spreadsheets, documents, files and databases to its management and administrators and other outside entities as needed to assist them and to monitor the pulse of the program.

Major projects completed by the Information Systems Division during FY 2002 included a new data extraction process for the S.A.F.E. project and the creation of a new state Aid-category and accompanying reports for the recently implemented Breast and Cervical Cancer program. Another major project was the completion of our Agency's new online Budget and Analysis database system that uses claims data gathered from our contract fiscal agent on provider participation, recipient use and claims paid and denied. With that data, the system monitors Medicaid's program expenses, generating reports and charts for general staff and management to use for analysis. Also, claims research needed for the PHP contract renewal process was performed, and the new ALLKids inquiry system was implemented to provide eligibility workers access to Public Health's ALLKids application status on cases to ensure Alabama's low-income children have access to proper medical care. As a result of the Legislature establishing a new Medicaid Trust Fund, all fiscal reports in the Accounts Payable System were revised to accommodate the trust fund. In addition, revisions and enhancements were made to several online systems this year, including revamping the Eligibility File to add new dates and fields, expansion of the I/S CICS online transactions Log-file to enhance agency security and accountability measures, changes to our billing system to prevent fraud and the addition of security levels for user access to many files and systems.

Programming for the eligibility division included changing the descriptions of the eligibility types on award notices to more closely match the online screens, changing the caseload distributions automatically between the workers when changes occur in staffing and creating reports for newly implemented programs. Also, specifically requested data fields from the eligibility file were added to the nightly fiscal agent transmissions so workers would have more current online access to that information. New telephone area codes were incorporated into files for both recipients and workers throughout the state, existing recipient notices were changed to laser letters to save mailing costs, and new criteria were incorporated for specific limited eligibility programs into existing software. Ongoing recipient award letters were reworded to represent changes in policy and patient account forms were updated as needed. New codes were added to existing software for our Plan First and Breast and Cervical Cancer programs, new standards were added for Medicaid low-income families, and those standards were automatically incorporated into the SOBRA calculations of family income for eligibility determination.

In order to assist users, speed up work processes and increase security other tasks were performed, such as assisting the Non-Emergency Transportation staff with the ITB for the N.E.T. bank contract. For the Third Party Program, two new Buy-in codes were added to existing software programs, logic was incorporated to look for Medicare coverage information on various other systems and files, new reports were created to provide eligibility staff with Third Party Buy-in data to update files with the latest recipient information, and ongoing monthly reports were revised as requested to minimize the number of cases Third Party staff had to research each month.

Several annual processes were completed this year with no problems, such as the annual bit shift process, the annual HCPCS (Health Care Administration Procedure Coding System) process, the annual transfer of account balances in the CROCS System, and production of the annual EPSDT letters to parents of all Medicaid eligible children.

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 of 1979, with the current contract period beginning October 1, 1999. EDS is constantly making changes to the MMIS to meet the needs of the program.

Maternal and Child Health Services

During FY 2002, Medicaid served 357,447 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 9.4 deaths per thousand in 2001.

Prenatal Care

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.

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.

Prenatal care for Medicaid recipients is provided through the Maternity Care Program, which includes private physicians, hospitals, public health department clinics and federally qualified health centers. Some of the maternity-related benefits covered under the Maternity Care 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, pregnancy related referrals to specialty providers 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 check-up is covered during the 60-day postpartum period.

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 practition-

ers 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 20 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 420,000 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 CMS 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.

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 four 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, 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.

Plan First

Plan First, an 1115 waiver, is a collaborative effort between the Alabama Medicaid Agency and the Alabama Department of Public Health. This program extends Medicaid eligibility for family planning services to all women age 19 - 44 with incomes at or below 133 percent of the federal poverty level that would not otherwise qualify for Medicaid. The primary goal of the waiver is to reduce unintended pregnancies.

The great thing about Plan First is that the eligibles are able to receive oral contraceptives directly from their enrolled provider of choice without having to go to a pharmacy to get a prescription filled. All other covered family planning methods are available through the pharmacy.

Also, direct services provided under this program are augmented with psychosocial assessment available to all participants and care coordination for high-risk or at risk women (lack of education, domestic violence,

transportation, multiple pregnancies, first time birth control user). The purpose of these added services is to allow for enhanced education on appropriate use of chosen methods and to encourage correct and continued usage.

Plan First was implemented in October 2000 and at that time there were 61,971 that started with the program. As of September 2002, there were 97,308 women enrolled in the Plan First Program.

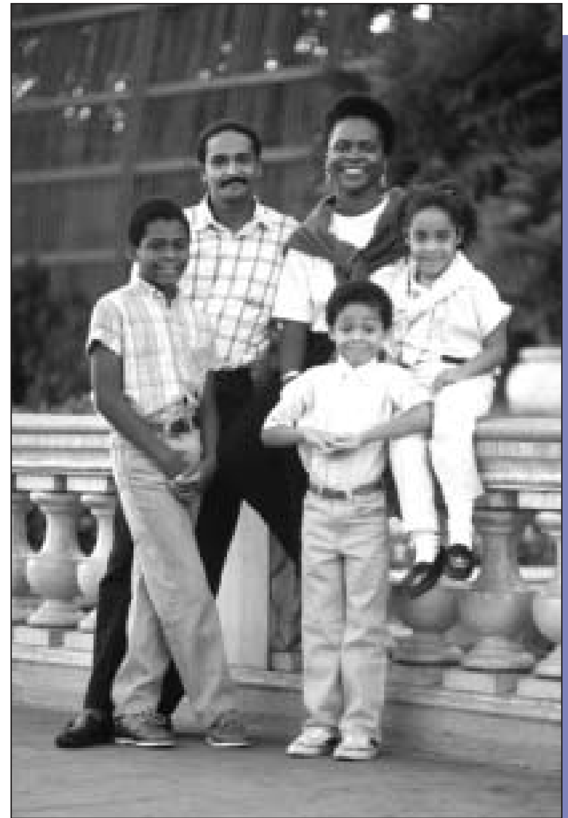
The budget neutrality calculations for this family planning waiver show that the demonstration not only met the budget neutrality requirements in its first year, but that the Medicaid program expended dramatically less on SOBRA pregnant women and infants that it would have in the absence of the waiver. Clearly, Alabama demonstrated budget neutrality during year one of this waiver, saving taxpayers millions of dollars in its initial year.

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 1st Program, primary medical 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.

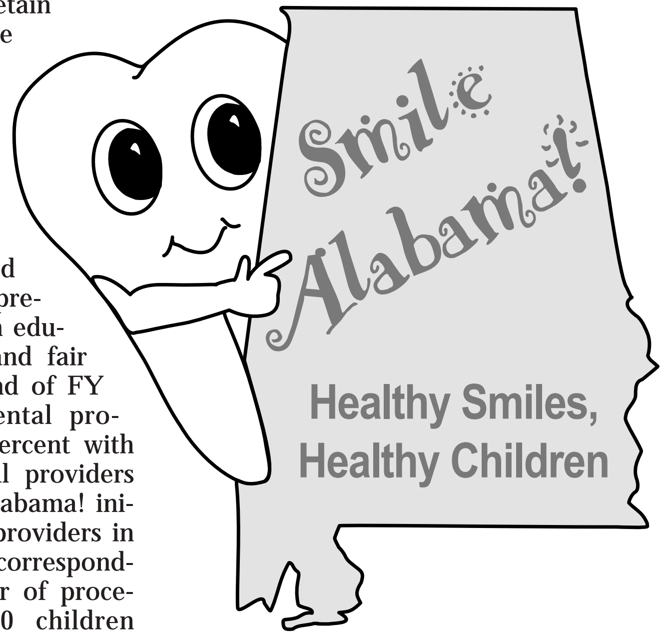
Since screening is not mandatory, many parents do not seek preventive health care for their children. Steps have been taken in recent years, however, to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of intensive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

Dental Services

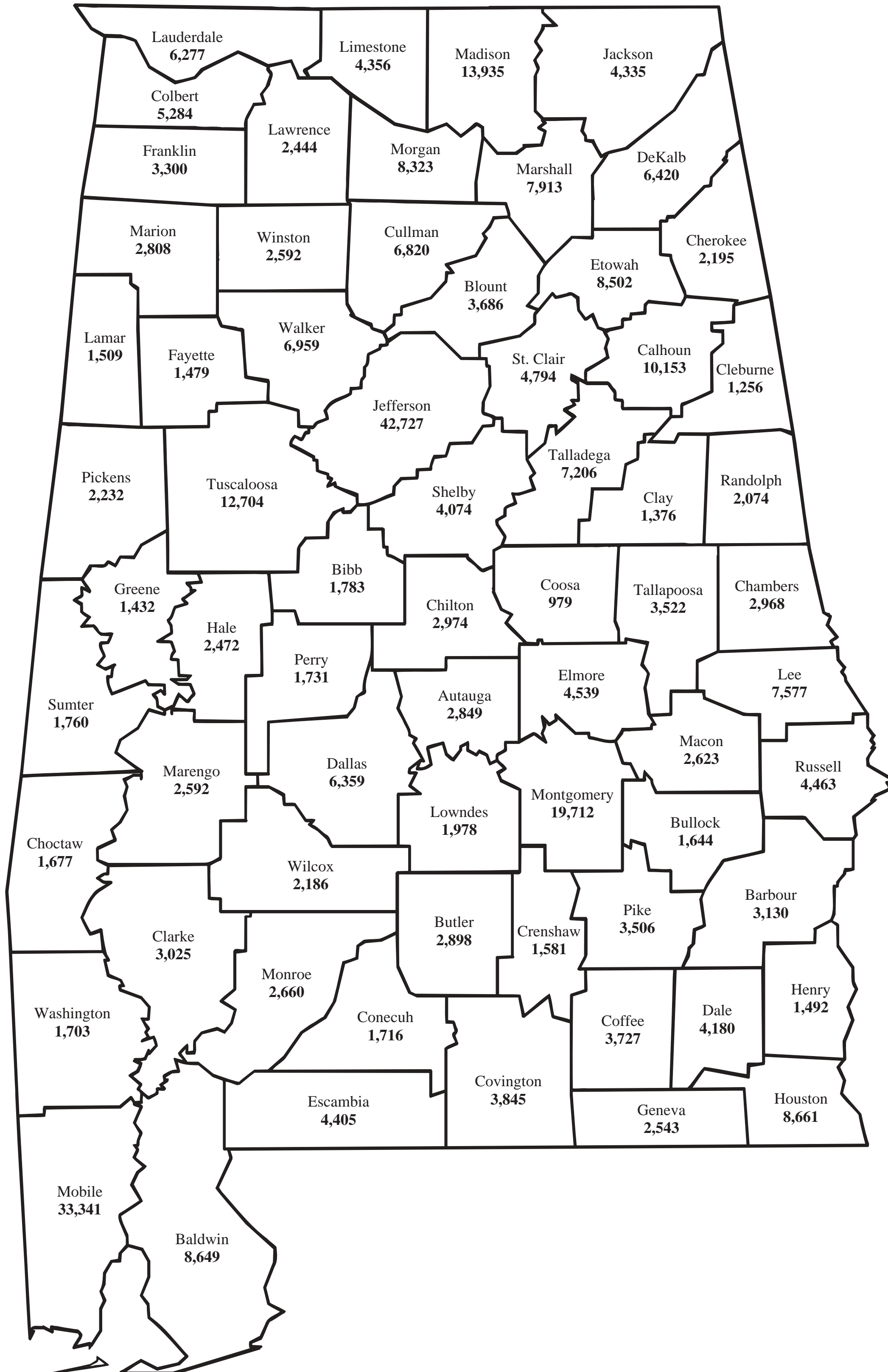
Medicaid pays for routine dental care for children under 21 years of age with full Medicaid eligibility through the EPSDT Program when provided by licensed dentists who are enrolled as Medicaid dental providers. Some of the routine care available includes a cleaning every six months, x-rays, filings, extractions, root canals and crowns. Examples of dental services not covered by Medicaid include surgical periodontal and 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.

Smile Alabama!

In October 2000, Medicaid kicked off an initiative to recruit and retain a solid dental provider base for Medicaid children by asking dentists to accept at least one new Medicaid child per week. The program, named *Smile Alabama*!, is a multifaceted campaign designed to improve access to Medicaid children for routine and preventive dental care through education, provider support, and fair reimbursement. By the end of FY 2002, the participating dental providers had grown by 45 percent with more than 225 new dental providers enrolled since the Smile Alabama! initiative began. With more providers in the state, there has been a corresponding increase in the number of procedures done, with 132,000 children receiving at least one dental service. This is an increase of 30,000 additional children receiving dental services than received services last year.



FY 2002
SOBRA ELIGIBLES



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 25,615 calls monthly during FY 2002 (more than 307,388 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 deals with Primary Care Case Management (PCCM) provider assignments and about one-fifth are information-only calls. About 7 percent of calls deal with Medicaid card replacement and 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 2002, the unit was staffed with four (4) full time operators and eleven (11) temporary operators.

Managed Care

Partnership Hospital Program

Hospitals remain a critical link in providing medically necessary health care to Alabama Medicaid recipients. Implemented in 1996, a managed care initiative called the Partnership Hospital Program (PHP) changed the way hospital days are reimbursed in Alabama. 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 Alabama acute care hospital that accepts Medicaid as payment.

The objective of this managed care initiative is to provide inpatient hospital services to eligible Medicaid recipients 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 are limited to 16 per calendar year. 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.

Patient 1st

The Patient 1st Program is active statewide and serving approximately 410,000 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-hours a 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 reduced doctor shopping, more appropriate utilization of services, and

reduced expenditures for primary care in an emergency room setting.

The focus of Patient 1st is patient and provider education. A video presentation for providers to show patients in their waiting rooms which explains the Patient 1st Program was developed. This video includes information about how to access medical care, when to go to the emergency room, and instructions on contacting their PMP before going to other physicians or places for medical care. In addition to the video, new Patient 1st beneficiaries also receive a welcome packet with helpful information about how the program works. Case management for the medically at risk is available upon referral by a PMP or dentist to assist with various social or environmental needs.

Maternity Care Program

Since 1988, the Medicaid Agency has been providing care to pregnant women in an effort to combat Alabama's high infant mortality rate through a 1915b waiver called the Maternity Waiver Program. This program has been very successful in getting women to begin receiving care earlier and in keeping them in a system of care throughout the pregnancy. The end result has been increased numbers of prenatal visits and fewer neonatal intensive care days, which has resulted in healthier babies and decreased expenditures for the Agency.

The Balanced Budget Act of 1997 provided Medicaid the authority to convert the Maternity Waiver Program into a State Plan based program. Although the program has changed from a waiver to a State Plan based program, many of the same components are present under the Maternity Care Program.

The program will continue to ensure that eligible pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through a network established by Primary Contractors. Under this program, women are allowed to choose the Delivering Healthcare Provider of their choice to provide their prenatal care and delivery. 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 needed services.

The state has been divided into 14 districts with one Primary Contractor responsible for each district. It is anticipated that the program will serve approximately 27,000 women each year.

The Agency anticipates that this program will continue to be successful and further increase the number of good birth outcomes in the State of Alabama.

Managed Care Quality Assurance Program

The Managed Care Quality Assurance Program is responsible for monitoring and oversight of Quality Assurance Activities for Medicaid's Managed Care initiatives. During FY 2002 Medicaid's Managed Care Initiatives included:

- PHP (Partnership Hospital Program)
- PCCM (Primary Care Case Management)
- MCP (Maternity Care Program)

Each Managed Care initiative is mandated to have an active Quality Assurance System with reporting requirements. Administrative aggregate systematic data collection of performance and patient results is a requirement. The System must provide for the interpretation of this data to the practitioners and provide for making needed changes. Each Plan's reports are monitored and reviewed by Medicaid on an ongoing basis. Findings may initiate a need for further review of areas of interest, potential utilization and quality concerns. The System must also provide for review by appropriate health care professionals.

At a minimum each Plan is required to designate an active Quality Assurance Committee within established guidelines. The Committee is formally delegated the responsibility to review potential quality concerns identified through the Quality Assurance Process and initiate appropriate corrective/preventative action. The Committee must track/follow potential and positive concerns until resolution is established. Complaints and grievances are reviewed and followed by the Committee with guidelines. Utilization Management issues are addressed and followed as well. The Quality Assurance monitoring and review process is an ongoing assessment that promotes quality improvements over time.

In addition to monitoring and oversight functions, Medicaid's Managed Care Quality Assurance Program must perform formal annual medical audits to assure the Quality Assurance System activities are effective, meet standards, and within guideline compliance. The areas reviewed include administration, utilization management, quality activities, corrective actions, continuity/coordination of care, and complaints and grievances.

Medicare HMOs and CMPs

Medicaid continued a program in which health maintenance organizations (HMOs) and competitive medical plans (CMPs) for dual eligibles 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 for which Medicaid is responsible for payment of medical cost sharing.

The HMO or CMP must have an approved Medicare risk contract with CMS to enroll Medicare beneficiaries and other individuals and groups. The HMO or CMP 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 checks, diagnostic assessment, pre-hospitalization screening, and psychotherapy. The program serves people with primary psychiatric or substance abuse diagnoses. There are 25 mental health centers around the state providing these services.

The mental health program was expanded in 1994 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. A wide array of mental health services is 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), adult protective service individuals (target group 7), and medically at risk individuals (target group 8). With the addition of new providers coordinating services for these target groups, there was a reduction in nursing home placement, emergency room visits and hospitalization. Dental visits have also increased as a result of case management services. Approximately 40,000 Medicaid beneficiaries received targeted case management service this year at a cost of $44 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 Mentally Retarded and the Developmentally Disabled (MR/DD)

This waiver serves individuals who meet the definition of mental retardation or developmental disability. The services provided by the waiver are residential habilitation training, day habilitation, prevocational training, supported employment, occupational therapy, speech therapy, physical therapy, behav-

ior management, companion service, respite care, personal care, environmental modification, specialized medical equipment and supplies, assistive technology, and skilled nursing care. During FY 2002, there were 4,651 recipients served by this waiver at an actual cost of $28,033 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $113,104 per recipient. The MR/DD waiver saved the state $85,071 per recipient in FY 2002. This waiver is administered by the Alabama Department of Mental Health and Mental Retardation.

Homebound/SAIL 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 percent of SSI are included. The waiver is administered by the Alabama Department of Rehabilitation Services. The services provided under this waiver include case management, personal care, respite care, environmental modification, medical supplies, personal emergency response system, assistive technology and personal assistance service. During the waiver year of 2002, there were 463 recipients served at a cost of $12,805 per recipient. Serving the same recipients in an institution would have cost the state $25,910 per recipient. During FY 2002, the Homebound Waiver saved the state $13,105 per recipient.

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 2002, the Medicaid Agency served 2,572 hospice patients at a total cost of about $24 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 128 agencies participating in FY 2002.

Medicaid in Alabama may cover up to 104 home health visits per year per beneficiary. Medicaid may authorize additional home health visits for beneficiaries under age 21 who have exhausted the home health benefit of 104 nursing visits per calendar year. For approval, the service must be referred from an EPSDT screening and prescribed as medically necessary by a physician. During FY 2002, over 7,000 recipients received visits costing a total of approximately $10.6 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 FY 2002, over 752 Medicaid DME providers throughout the state furnished services at a cost of approximately $21 million.

In-Home Therapies

Physical, speech, and occupational therapy in the home are limited to individuals under 21 years of age that 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.

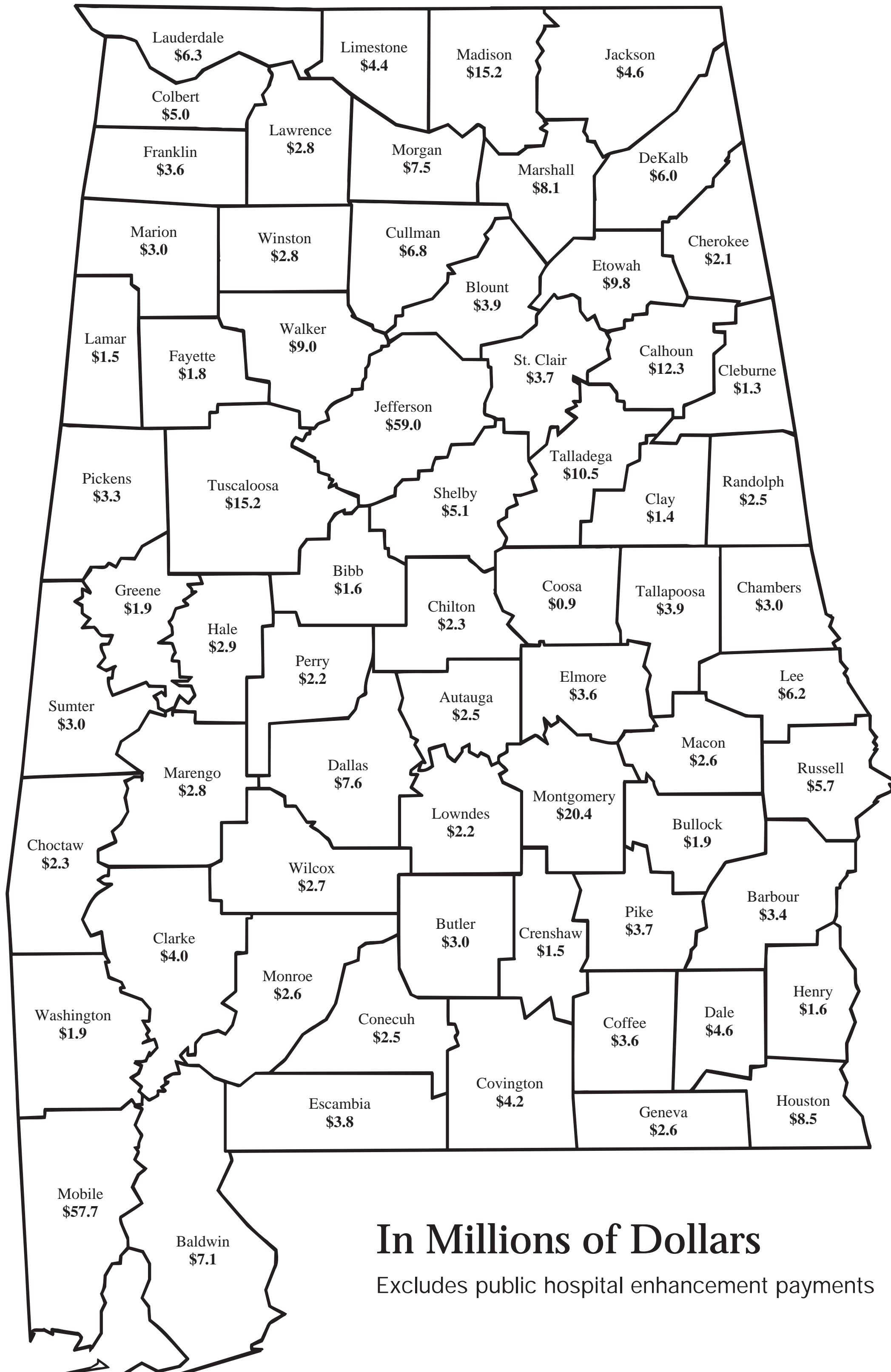
Private Duty Nursing

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 2002, Medicaid paid approximately $2.1 million for services provided through 46 private duty-nursing providers.

FY 1998-2002 HOSPITAL PROGRAM Outpatients

	FY '98	FY '99	FY 2000	FY 2001	FY 2002
Number of outpatients	222,375	190,517	218,078	245,726	322,818
Percent of eligibles using outpatient services	35%	29%	32%	31%	38%
Annual expenditure for outpatient care	$38,175,343	$36,482,841	$36,141,056	$44,166,407	$50,376,944
Cost per patient	$172	$191	$166	$180	$156



In Millions of Dollars

Excludes public hospital enhancement payments

Medical Services

Outpatient Services

Medicaid pays for a maximum of three non-emergency hospital outpatient visits per recipient during a calendar year. Exceptions are made for certified emergencies, chemotherapy, radiation therapy, lab and x-ray services and approved outpatient surgical procedures.

Hospital 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 cornea transplants, which do not require prior approval, Medicaid benefits cover prior authorized heart transplants, lung (both single or double), heart/lung, liver transplants, pancreas, pancreas/small bowel, kidney 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 instate providers unless there are no instate providers available to perform the procedure. All prior authorized transplants must be coordinated through UAB's transplant staff.

Inpatient Psychiatric Program

The inpatient psychiatric program was implemented in May 1989. This program provides medically necessary inpatient psychiatric services for recipients under the age of 21. Services must be authorized by the Agency and rendered in Medicaid contracted psychiatric hospitals. Alabama psychiatric hospitals approved by the Joint Commission for Accreditation of Healthcare Organizations may participate in this program.

Inpatient psychiatric services for recipients age 65 or over are covered when provided in a free-standing hospital exclusively for the treatment of mental illness for persons age 65 or over. 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 Medicaid 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 a fee schedule established by the Medicaid Agency. A listing of covered surgical procedures is maintained in the Provider Billing Manual.

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 responsible for the copayment amount for each visit. At the end of FY 2002, there were 48 ASC facilities enrolled as providers in this program.

Post-Hospital Extended Care Program

This program was implemented in 1994 for Medicaid recipients who were in acute care hospitals but no longer needed 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. 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 cen-

ters, 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 an all inclusive encounter rate. Medicaid establishes reasonable costs by using the centers' annual cost reports. At the end of FY 2002, there were 16 FQHCs enrolled as providers, with 101 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, nurse practitioner or physician assistant 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 2002, there were 38 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 an all inclusive encounter rate based on their yearly cost reports. At the beginning of 1994, there were 11 PBRHCs enrolled as providers in Medicaid. There are now 21 PBRHCs enrolled as Medicaid providers.

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 55 percent of Alabama's Medicaid eligibles received physicians' services in FY 2002.

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

FY 2002
PHYSICIANS PROGRAM
Use and Cost

Age	Payments	Recipients	Cost per Recipient
0 to 5	$55,305,656	143,560	$385
6 to 20	$36,917,105	151,664	$243
21 to 64	$64,713,987	121,792	$531
65 and up	$9,381,407	62,184	$151
All Ages	$166,318,155	479,200	$347

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.

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.

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 2002, pharmacy providers were paid $450,984,232 million for prescriptions dispensed to Medicaid recipients. This expenditure represents 14.05 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 are asked to 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 2002, over $84 million was collected. These rebates are used to offset increasing drug program expenditures.

The DUR process involves retrospective reviews conducted by Health Information Designs, Inc. 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 DUR program. The retrospective

FY 2000-2002
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*
2000	435,680	64%	9,094,375	20.87	$36.55	$763	$332,360,350
2001	465,236	65%	9,719,394	20.89	$39.63	$828	$385,168,230
2002	505,076	59%	10,461,401	20.71	$43.11	$893	$450,984,232

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

FY 2000-2002
PHARMACEUTICAL PROGRAM
Cost

	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx	Net Cost Per Recipient
2000	$332,360,350	$63,927,136	$268,433,214	$29.52	$616
2001	$385,168,230	$76,713,460	$308,454,770	$31.74	$663
2002	$450,984,232	$85,007,636	$365,976,596	$34.98	$725

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.

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 aphakic (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.

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.

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

FY 2002
EYE CARE PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
Optometric Service	$7,312,367	90,954	$80
Eyeglasses	$2,966,827	77,825	$38

FY 2000-2002
LAB AND X-RAY PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
2000	$32,295,622	332,118	$97.24
2001	$37,294,304	357,197	$104.41
2002	$42,394,321	395,125	$107.29

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.

The total cost to Medicaid for providing nursing home care in FY 2002 was over $704 million. Almost 96 percent of the nursing homes in the state accepted Medicaid recipients as patients in FY 2002. There were also 20 hospitals in the state during FY 2002 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.

Long Term Care Quality Assurance Program

The Long Term Care Quality Assurance (LTC/QA) Program provides monitoring and oversight of three waiver programs. There are four operating agencies (OA) that are responsible for the daily operation of specific waivers. The Alabama Department of Mental Health is the OA for the Mental Retardation and Developmentally Disabled (MRDD) waiver. The Alabama Department of Public Health and the Alabama Department of Senior Services are the OAs for the Elderly and Disabled (E/D) waiver, and the Alabama Department of Rehabilitation Services is the OA for the Homebound (SAIL) waiver.

LTC/QA is the process of monitoring and evaluating the delivery of care and services to ensure that they are appropriate, timely, accessible, available and medically necessary to safeguard the health and welfare of the participants and to prevent institutionalization. The LTC/QA program is responsible for the oversight and monitoring of Medicaid's Waiver Program. The key components associated with oversight and monitoring includes: 1) Health and welfare of waiver participants. 2) Responsiveness of the plan of care to the participant's needs. 3) Qualifications of providers who serve waiver participants. 4) Appropriateness of services to the participant's needs. 5) Freedom of choice being offered to participants. 6) Quality improvements. 7) Client satisfaction indicators. 8) Complaint and grievance process. 9) Accessibility to waiver services. 10) Availability of other community care options. 11) Continuity of care. All these assurances are monitored by registered nurses through annual review of case management and direct service provider records, visits to clients homes and day habilitation worksites, recipient satisfaction survey results, tracking and resolution of participants complaints and grievance, and review of operating agencies internal quality assurance programs and activities.

FY 2000-2002
LONG-TERM CARE PROGRAM
Patients, Days, 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
2000	25,096	298	7,481,368	$84	$624,883,481
2001	26,361	280	7,372,715	$90	$666,221,211
2002	27,177	273	7,407,712	$95	$704,151,335

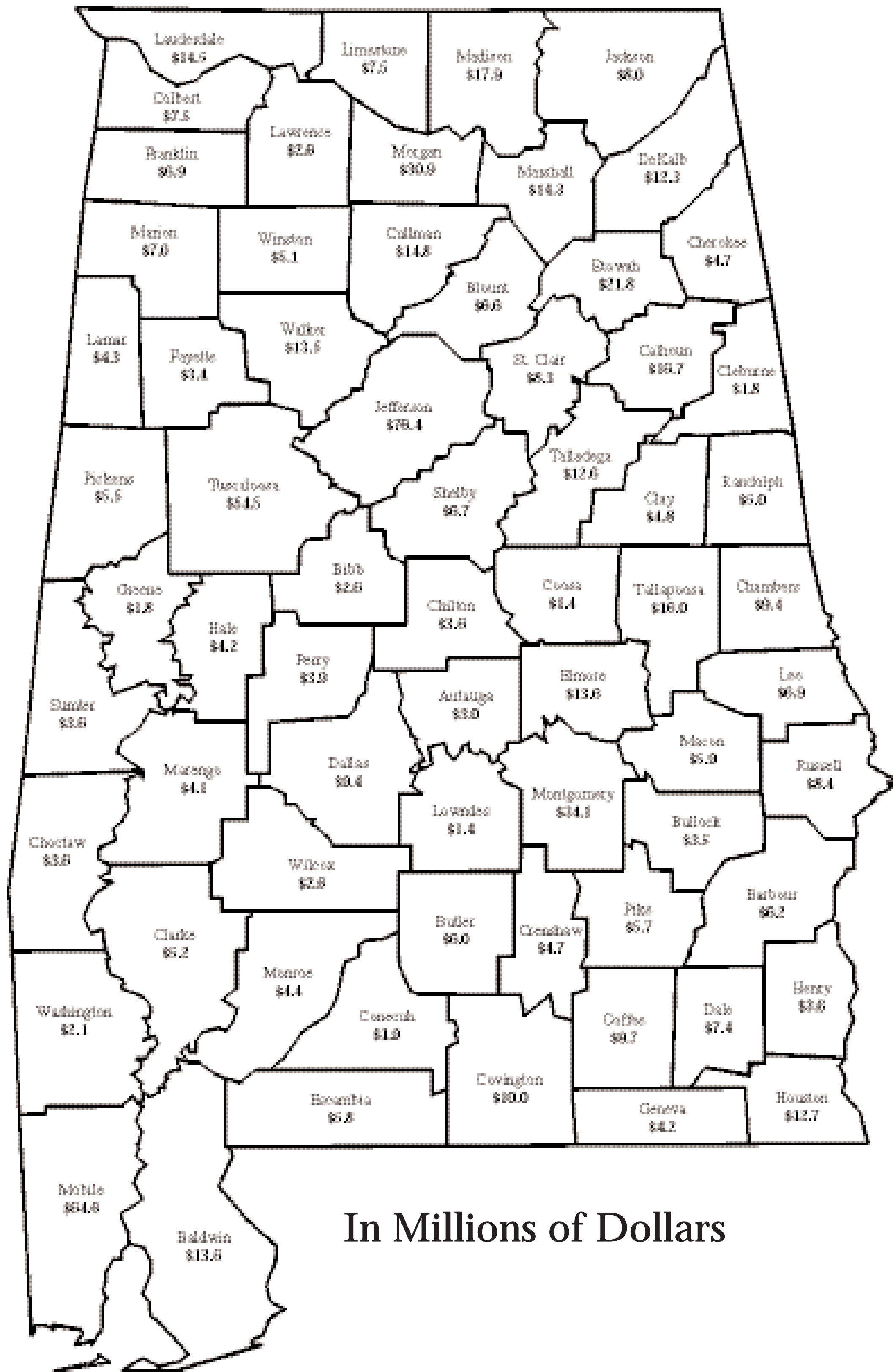
FY 2002
LONG-TERM CARE PROGRAM
Number and Percent of Beds Used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	Percent of Beds Used By Medicaid In An Average Month
FY 2002	26,151	17,152	66%

FY 2002
LONG-TERM CARE PROGRAM
Recipients and Payments by Gender, Race and Age

	Recipients	Payments	Cost Per Recipient
By Gender			
Female	20,131	$543,698,506	$27,008
Male	6,347	$159,609,080	$25,147
By Race			
White	19,216	$504,907,733	$26,275
Nonwhite	7,262	$199,069,256	$27,412
By Age			
0-5	14	$539,422	$38,530
6-20	112	$5,291,083	$47,242
21-64	2,291	$74,966,370	$32,722
65 & Over	23,628	$623,354,460	$26,382

FY 2002
PAYMENTS TO NURSING HOMES
By County of Recipient



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 2002, the average reimbursement rate per day in an institution serving the mentally retarded was $355.

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 2002, 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 2002
LONG-TERM CARE PROGRAM
ICF-MR/DD

	ICF/MR	ICF/MD-Aged
Recipients	573	441
Total Payments	$62,094,107	$21,302,273
Annual Cost per Recipient	$108,367	$48,304

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