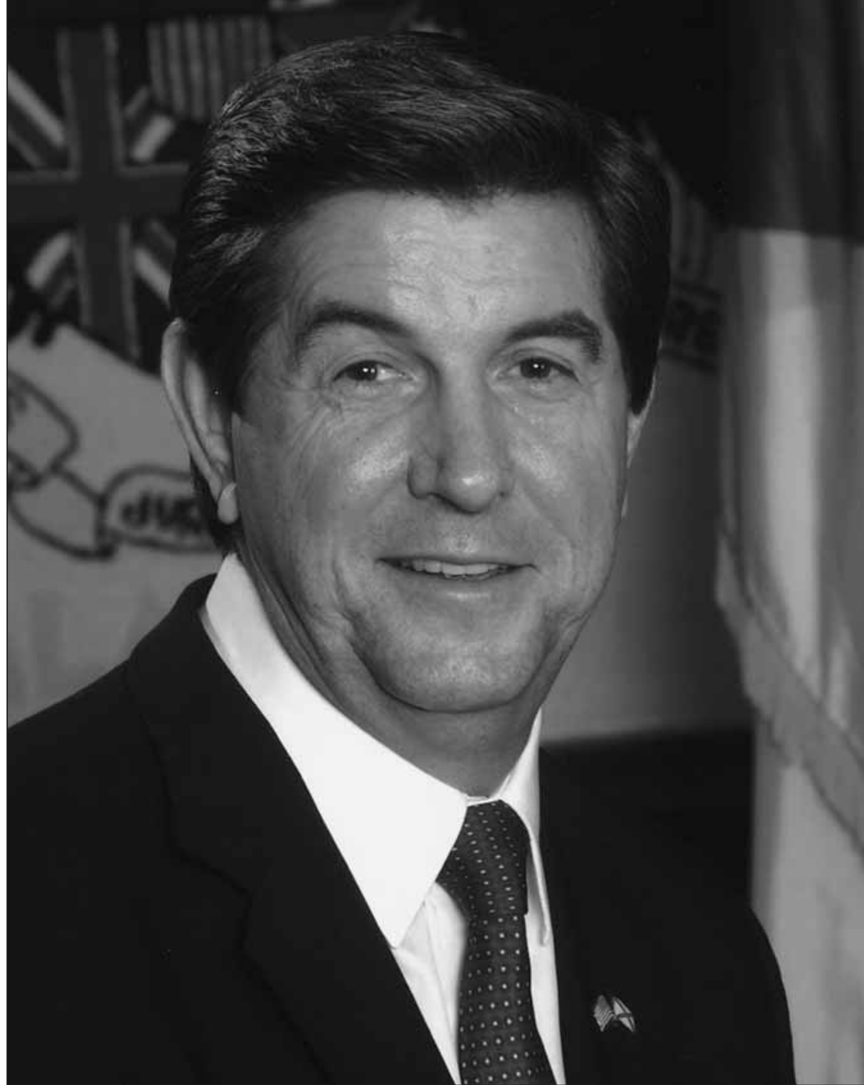
Alabama Medicaid Agency

FY 2004
Annual Report



Bob Riley
Governor
State of Alabama

Alabama Medicaid Agency
FY 2004 Annual Report
October 1, 2003 - September 30, 2004

Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624
www.medicaid.state.al.us
e-mail: almedicaid@medicaid.state.al.us
Telecommunication for the Deaf: 1-800-253-0799
1-800-362-1504 (334) 293-5500

BOB RILEY
Governor

CAROL A. HERRMANN, MPH
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 32nd Annual Report of the Alabama Medicaid Agency. This report covers activities from October 2003 to September 2004.

During the year, over 900,000 Alabamians were eligible for services with approximately 700,000 receiving services financed by the Medicaid Agency. Among those who depend on Medicaid to meet their health care needs are low-income pregnant women and their children, as well as seniors and individuals with disabilities in nursing facilities and in their own homes.

Medicaid continues to improve the quality of care provided to Alabama's Medicaid eligible population and also to ensure the program works as efficiently as possible. This year we have worked to strengthen the care that families receive by improving the Patient 1st program so that every child has a medical home. We also assisted with the development of a joint on-line application for three different programs for health coverage.

Rising health care costs are a challenge affecting both public and private health care financing. Through Medicaid's collection and cost avoidance efforts such as the pharmacy rebate program, third party coordination, prior approval of certain procedures and prescriptions, and avoidance of nursing facility care through home and community based care, Medicaid saves the taxpayers a substantial amount of money each year. This year in addition to these continuing efforts, Program Integrity activities have been enhanced to further reduce fraud and waste in the program and a wide range of additional cost saving programs have been implemented.

Your understanding of the needs of Alabama's most vulnerable citizens – the very young and the elderly – is commendable. The Medicaid Agency appreciates your support. This Agency looks forward to the continued cooperation among this Administration, the Medicaid provider community, and the people of this state. Together, we can ensure the Medicaid Agency manages its limited resources in such a manner as to afford effective and efficient health care services to as many needy Alabamians as possible.

Sincerely,

Carol A. Herrmann, MPH
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 2004 Fiscal Year	5
	Alabama's Medicaid Program	7
	Medicaid's Impact	10
Statistical Topics:	Revenue and Expenditures	11
	Population	13
	Eligibles and Recipients	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 Services	27
	Customer Service	31
	Managed Care	31
	Home and Community Based Service Waivers	33
	Home Care Services	35
	Medical Services	38
	Long-Term Care	42
	Long-Term Care for the Mentally Retarded and Mentally Disabled	45

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	30
Hospital Program:	Outpatients	35
	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	43
	Number and Percent of Beds Used by Medicaid	43
	Recipients and Payments by Gender, Race, and Age	43
	Payments to Nursing Homes by County of Recipient	44
Long-Term Care for the Mentally Retarded & Mentally Disabled:	ICF-MR/MD	45

HIGHLIGHTS OF FISCAL YEAR 2004

During the past year, Alabama Medicaid received approval from the Centers for Medicare and Medicaid (CMS) to re-implement the Patient 1st program to provide a medical home for recipients, assisted with the development of a joint on-line application for three different programs for health coverage, instituted a Preferred Drug List, implemented several initiatives to insure providers were properly paid and continued efforts to improve access to dental care for children. In addition, the Agency is close to resolving funding issues with the Centers for Medicare and Medicaid Services (CMS). All of these efforts will assist the Agency in fulfilling its mission of providing an efficient and effective system of financing healthcare for our beneficiaries.

Patient 1st

After a temporary suspension of the program in February 2004, approval was received from CMS to re-implement the program. Approval was granted in an unprecedented three month period of time from the date Medicaid submitted the request to CMS. The program is designed to create a medical home for Medicaid patients by linking each patient with a primary medical provider (known as a PMP). The patient must either receive services directly from their PMP or receive a referral from their PMP to go to another provider. The goal of Patient 1st is to ensure that patients receive the most appropriate care in the most appropriate setting; areas offering the most opportunity for improvement include inappropriate use of the emergency room and prescribing patterns.

Program enhancements include collaboration with the University of South Alabama to place in-home monitoring equipment for high risk patients with chronic diseases. This equipment will monitor the patient's condition on an on-going basis and will help ensure that the patient's condition does not worsen over time without the appropriate intervention. Daily reports are provided to the patient's PMP, and problems are monitored by 24-hour nursing personnel. Additionally, Medicaid has partnered with Blue Cross Blue Shield (BCBS) to provide physicians with information about medications their patient is receiving. Oftentimes, a physician writes a prescription for a patient, but the patient does not have the prescription filled or may also have other medicines from other physicians. Through this partnership, physicians will have access to paid claims information from BCBS and Medicaid so that they can track all medications being taken by a patient. Both of these initiatives are being provided at no additional cost to the State or to the physicians.

Additionally, Agency staff completed the "**Medical Home/Health Literacy**" project, the Agency's second CD-based continuing education project in its *"Bringing Health to Life"* series. Based on established guidelines and "best practices" regarding medical homes and health literacy, the program is designed to strengthen the physician-patient relationship through the development of medical homes, the expanded use of health literacy programs and resources, and increased understanding of the Medicaid program.

The presentation is also an integral part of the Agency's updated Patient 1st program, supporting primary care physicians in their efforts to provide a medical home for each Medicaid patient. Enrolled primary medical providers (PMPs) who successfully complete the activity will be eligible for an enhanced case management fee once the program is initiated. A companion audiotape, audio CD, and study guide have been produced in addition to the CD presentation, all of which will be distributed to all Alabama physicians in conjunction with the Medical Association of the State of Alabama.

Web Application

Families can now apply on-line for health coverage in Alabama. A joint application for Medicaid, ALL Kids and the Alabama Child Caring Foundation has been developed and can now be filled out and submitted on-line. The on-line web application can be accessed at ***www.insurealabama.org***. The application will make a preliminary determination of eligibility for these programs by pre-screening individuals for Medicaid, ALL Kids, and the Alabama Caring Foundation. Through the use of a password and a unique ID# for each application, an applicant may save information, exit the application, and re-enter the application to add, remove, or change data prior to the final submission of the application. The applicant has 30 days to complete and submit the application on-line. The family must provide a signed signature page to the appropriate agency to complete the process.

Families will be told on-line which program(s) they **appear** to be eligible for, and the application data will be automatically forwarded electronically to the appropriate organization(s) for processing. The eligibility worker will make the final determination for eligibility.

The on-line web application was made possible through a Robert Wood Johnson Grant. This grant reflects collaboration between the Alabama Department of Public Health (grantee agency), Alabama Medicaid Agency, and Alabama Child Caring Foundation. Through this process the state of Alabama hopes to simplify and make the application process more convenient for families, and make the process more efficient for the various agencies. The project was successfully launched statewide in September 2004 after completion of a pilot project in several counties.

Continued Improved Access for Children to Dental Care

The Agency continues its outreach to ensure the Medicaid eligible children are receiving necessary dental care. Much of these efforts include one-on-one training with the dental providers, working with area Headstart agencies and being available to assist parents in locating dental providers. In 1998 there were only 430 dental providers enrolled in Medicaid; 697 dentists are enrolled in the program in 2004. Only 65,088 recipients under 21 years of age received

preventive dental services in 1998; by 2004, 146,957 children received preventive dental services.

Implementation of Preferred Drug List (PDL) and Electronic Prior Authorization (PA)

Legislation was passed in June 2003 that gave Medicaid the authority to implement a Preferred Drug List. The Preferred Drug List is developed in consultation with a Pharmacy and Therapeutics (P&T) Committee consisting of practicing physicians and pharmacists from across Alabama representing various specialties. The P&T Committee conducts in-depth clinical reviews on each class of drug and makes recommendations to Medicaid on which drugs should be on the PDL.

Medicaid began review of drug classes in July 2003 and implemented the first classes in October 2003. Savings have been realized from the implementation of the PDL through greater utilization of the preferred brand and generic drugs. FY 2005 will represent the first full fiscal year for which savings will be achieved.

Although pharmaceutical manufacturers have the opportunity to offer Medicaid supplemental volume discounts, these discounts are not required for a drug to be included in the PDL. Almost 70% of preferred brands were selected when no state discount was offered. Supplemental state drug rebates have been negotiated with pharmaceutical manufacturers in order to obtain preferred status. Negotiations have resulted in a total of $2.1 million being collected to date. This is in addition to the federal drug rebates that are collected on all covered drugs

Other Pharmacy Initiatives

Therapeutic Duplication Edit

Effective February 19, 2004, Medicaid implemented a therapeutic duplication edit for pharmacy claims. Therapeutic duplication is the prescribing of two or more drugs from the same therapeutic class such that the combined daily dose increases the risk of toxicity or incurs additional program costs without additional therapeutic benefit. This edit warns pharmacists when a duplicate claim is submitted. The therapeutic duplication edit takes into consideration the exhaustion of previously dispensed medications by calculating the days supply and the dispensed date. To date the edit has been implemented in four (4) drug classes.

Physician Education

Medicaid Pharmacy Specialists provide educational visits regarding pharmacy initiatives to enrolled physicians. Representatives from seven regional areas of the state conduct a minimum of 1,500 visits per quarter. Information regarding prescribing patterns and the Preferred Drug List is shared with providers in an effort to foster appropriate and cost effective drug therapy.

Enhanced Program Integrity Activities

On July 15, 2004, the Alabama Medicaid Agency contracted with Health Watch Technologies (HWT), a company that helps healthcare payers use their paid claims data to recover overpayments, address fraud and waste, and implement a wide range of other cost savings programs. The contract requires HWT to conduct post payment reviews for all fee-for-service provider programs and to increase the volume of reviews completed. HWT is paid on a contingency fee and the amount of the fee is based on the total dollars of recovery collected and deposited.

To date HWT has conducted post payment reviews of all pharmacy claims data and identified overpayments of $5.9 million. Over 1,000 letters to pharmacy providers have resulted in Medicaid recouping of $1.3 million from these providers.

HWT is in the process of conducting additional post payment reviews for the outpatient hospitals, labs, hospice, DME, and dental program areas.

Improved Administrative Efficiencies

The Public Consulting Group (PCG) is working with Medicaid on a third party “look behind” contract to identify third party resources not previously identified by Medicaid’s Third Party Division. PCG has completed initial data matches with their health plan network, and recently furnished to Medicaid their first file of over 800 potential new third party resources. The Agency will be able to compare these resources to our Third Party database, add verified new resources to this database, and begin using these resources to avoid paying claims covered by these primary payers. PCG will continue to perform data matches with various health plans and furnish new third party data to Medicaid once their verification process has been completed. PCG will also assist the Agency on collection of aged third party accounts receivable, credit balance reviews, and recovery of funds from Medicare for Medicare-covered drugs.

Federal Funding Issues

There were 16 issues outlined by the Center for Medicare and Medicaid Services (CMS) representing differences between CMS and Medicaid, a potential disallowance of $1.4 billion. Alabama is very close to resolving outstanding issues with the federal government, having currently resolved 12 of the 16 issues. Medicaid continues to negotiate with CMS on two issues; the remaining two items involve the Department of Human Resources (DHR) and are being negotiated separately by that Agency. Medicaid anticipates its remaining issues will be resolved without the Agency having to pay back any significant federal funds.

Looking Ahead

Medicaid, in coordination with Health Information Designs will implement an electronic PA system effective December 1, 2004. The design and implementation of this system is in a continuing effort to simplify the drug prior authorization process as much as possible for physicians and pharmacists. The system will electronically review pharmacy claims that require authorization prior to payment against paid medical and pharmacy claims to determine if approvable. If approved, the pharmacy claim will pay, without the need for any paperwork by either the physician or the pharmacist. If the system cannot determine whether all criteria have been met, a prior authorization request form must be completed by the provider and submitted to Medicaid for review.

It is estimated that at least 40% of the current manual prior authorization requests (those requiring interaction with the prior authorization help desk) will be handled electronically upon implementation.

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 2004, 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) which as of April 1, 2003, is determined by the Alabama Medicaid Agency. Low-income families may apply for Medicaid through the Agency's eligibility workers located in county health departments, hospitals and clinics throughout the state. 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 Community Based Service Waiver and be

Medicaid eligible. Medicaid District Offices determine eligibility for persons in these eligibility groups.

- Qualified Medicare Beneficiaries (QMBs) have low income. Persons in this group may be eligible to have their Medicare premiums, deductibles, and coinsurance paid by Medicaid. Medicaid District Offices determine eligibility for QMBs.
- Specified Low-income Medicare Beneficiaries (SLMBs) and Qualifying Individuals-1 (QI-1) have low income above the QMB limit. Persons in this group may be eligible to have their Medicare Part B premiums paid by Medicaid. Medicaid District Offices determine eligibility for these programs.
- 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.

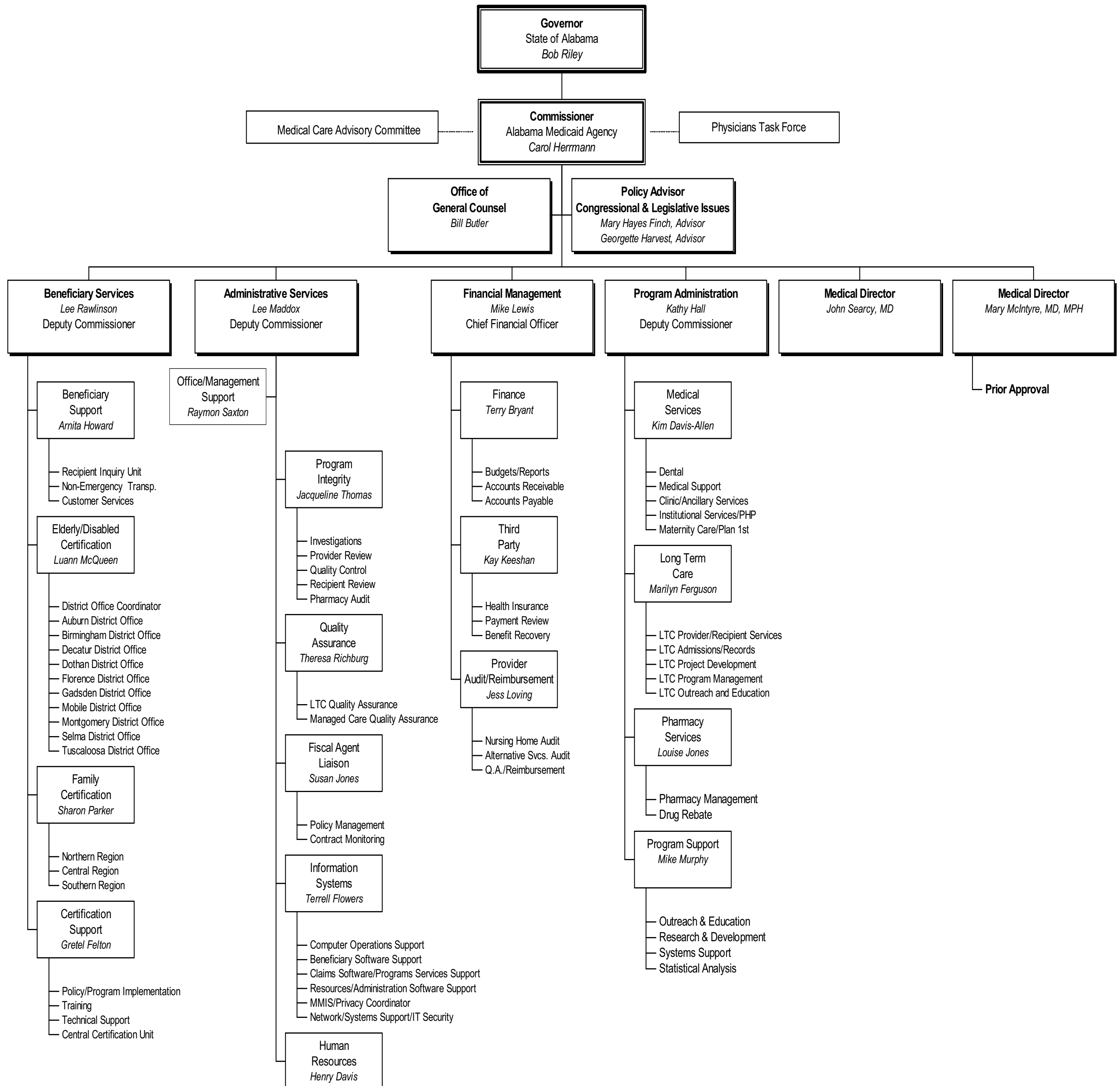
Covered Services

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



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 2004, Medicaid paid over $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 2004.

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 2004
COUNTY IMPACT
Year's Cost Per Eligible

County	Benefit Payments	Eligibles	Payment per Eligible	County	Benefit Payments	Eligibles	Payment per Eligible
Autauga	$18,641,902	7,846	$2,376	**Houston**	$64,066,028	21,655	$2,958
Baldwin	$63,694,260	21,223	$3,001	**Jackson**	$33,901,797	10,766	$3,149
Barbour	$21,376,983	7,714	$2,771	**Jefferson**	$373,181,111	119,526	$3,122
Bibb	$11,312,199	4,797	$2,358	**Lamar**	$14,246,897	3,939	$3,617
Blount	$27,486,448	9,186	$2,992	**Lauderdale**	$57,248,966	16,731	$3,422
Bullock	$11,313,011	4,076	$2,776	**Lawrence**	$19,975,520	6,880	$2,903
Butler	$21,473,928	6,969	$3,081	**Lee**	$46,228,174	18,597	$2,486
Calhoun	$82,064,671	27,108	$3,027	**Limestone**	$32,377,566	11,087	$2,920
Chambers	$25,513,743	8,581	$2,973	**Lowndes**	$11,125,120	4,564	$2,438
Cherokee	$16,979,132	5,427	$3,129	**Macon**	$20,609,414	7,220	$2,854
Chilton	$21,919,817	8,582	$2,554	**Madison**	$109,286,131	37,531	$2,912
Choctaw	$12,469,588	4,463	$2,794	**Marengo**	$19,185,019	6,692	$2,867
Clarke	$21,515,404	8,005	$2,688	**Marion**	$25,301,461	7,285	$3,473
Clay	$12,310,847	3,262	$3,774	**Marshall**	$62,519,487	19,731	$3,169
Cleburne	$9,073,494	3,319	$2,734	**Mobile**	$262,310,704	89,012	$2,947
Coffee	$28,768,704	8,834	$3,257	**Monroe**	$16,882,058	6,107	$2,764
Colbert	$34,947,084	11,922	$2,931	**Montgomery**	$144,570,943	53,661	$2,694
Conecuh	$11,830,439	4,324	$2,736	**Morgan**	$69,833,688	19,824	$3,523
Coosa	$7,568,097	2,525	$2,997	**Perry**	$16,827,120	5,146	$3,270
Covington	$33,357,206	9,856	$3,384	**Pickens**	$20,157,545	6,186	$3,259
Crenshaw	$13,095,395	3,846	$3,405	**Pike**	$25,914,295	8,975	$2,887
Cullman	$56,259,882	15,856	$3,548	**Randolph**	$16,564,021	5,353	$3,094
Dale	$30,080,797	10,580	$2,843	**Russell**	$34,578,484	13,308	$2,598
Dallas	$50,261,210	18,785	$2,676	**St. Clair**	$34,962,681	11,825	$2,957
Dekalb	$54,209,229	16,152	$3,356	**Shelby**	$33,195,665	11,811	$2,811
Elmore	$39,024,176	11,205	$3,483	**Sumter**	$14,593,253	5,670	$2,574
Escambia	$25,862,890	9,691	$2,669	**Talladega**	$61,132,798	20,686	$2,955
Etowah	$84,999,661	22,144	$3,838	**Tallapoosa**	$36,821,327	9,984	$3,688
Fayette	$14,837,307	4,199	$3,534	**Tuscaloosa**	$131,347,468	32,642	$4,024
Franklin	$26,827,970	8,077	$3,322	**Walker**	$61,149,652	16,783	$3,644
Geneva	$20,702,020	6,381	$3,244	**Washington**	$11,527,787	4,361	$2,643
Greene	$9,539,238	3,929	$2,428	**Wilcox**	$16,255,271	6,184	$2,629
Hale	$15,659,026	5,658	$2,768	**Winston**	$22,027,285	6,518	$3,379
Henry	$13,048,726	4,220	$3,092	**Other**	$4,001,038	557	$7,183

Revenue and Expenditures

In FY 2004, Medicaid paid $3,656,032,236 for health care services to Alabama citizens. Another $110,382,239 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 2004 Sources of Medicaid Revenue

	Dollars
Federal Funds	$2,730,989,460
State Funds	$1,040,030,056
Total Revenue	$3,771,019,516

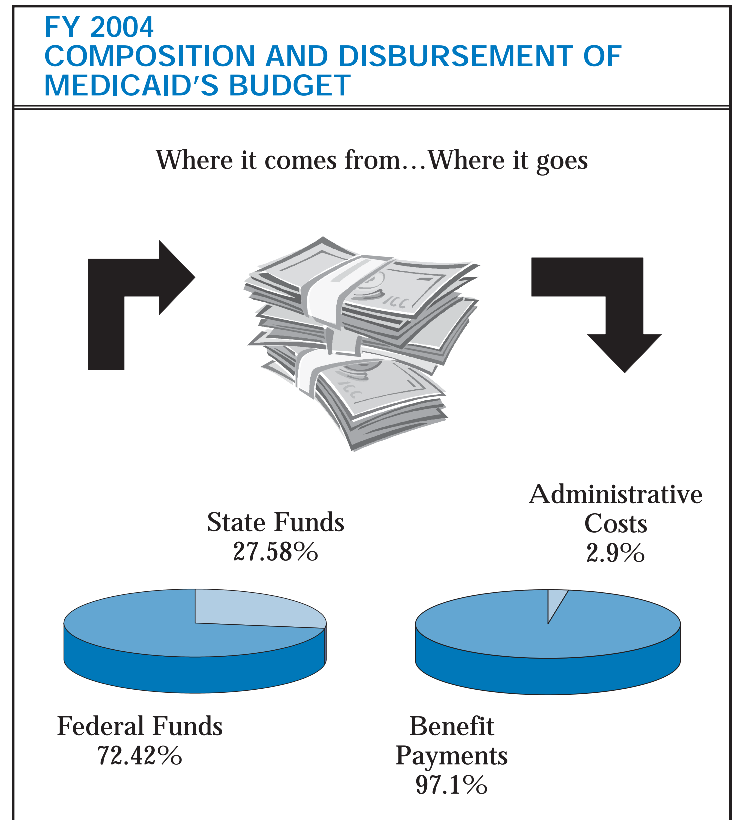
FY 2004 Components of State Funds

(net)	Dollars
General Fund Appropriations	$260,063,045
Public Hospital Transfers and Alabama Health Care Trust Fund	$535,049,232
Other State Agencies	$160,035,612
Drug Rebates	$34,489,956
UAB (Transplants)	$1,929,799
Miscellaneous Receipts	$14,297,412
Medicaid Trust Fund (with interest)	$34,165,000
Total	$1,040,030,056

FY 2004 Components of Federal Funds

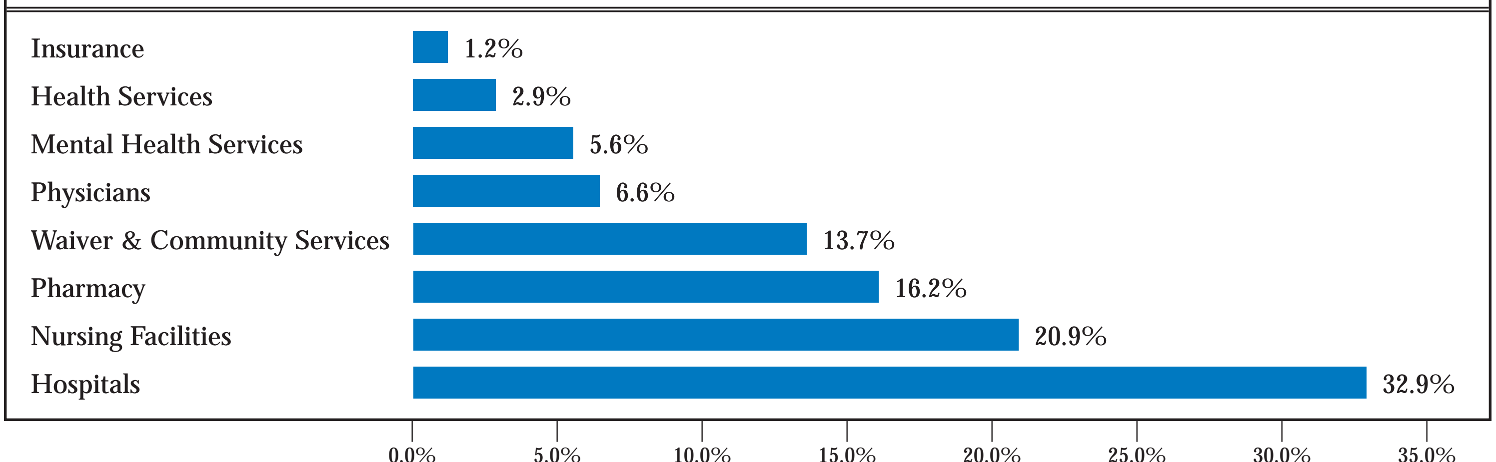
(net)	Dollars
Family Planning Administration	$1,011,745
Professional Staff Costs	$10,008,012
Other Staff Costs	$72,612,258
Other Provider Services	$2,621,710,552
Family Planning Services	$25,646,893
Total	$2,730,989,460

FY 2004 Composition and Disbursement of Medicaid's Budget



FY 2004
EXPENDITURES By type of service (net)

Service	Payments	Percent of Total Payments
Hospitals:	**$1,202,381,125**	32.89%
Disproportionate Share	$409,067,486	11.19%
Inpatient	$635,267,550	17.38%
Outpatient	$124,389,898	3.40%
FQHC	$21,757,136	0.60%
Rural Health Centers	$11,899,055	0.33%
Nursing Facilities	**$764,678,543**	20.92
Waiver Services:	**$235,017,493**	6.43%
Elderly & Disabled	$53,095,614	1.45%
Mental Health	$175,977,155	4.81%
Homebound	$5,944,724	0.16%
Pharmacy	**$593,835,608**	16.24
Physicians:	**$242,964,778**	6.65
Physicians	$175,631,637	4.80%
Physician's Lab and X-Ray	$32,783,545	0.90%
Clinics	$28,203,700	0.77%
Other Practitioners	$6,345,896	0.17%
MR/MD:	**$44,561,281**	1.22%
ICF-MR	$36,698,513	1.00%
NF-MD/Illness	$7,862,768	0.22%
Insurance:	**$42,088,240**	1.15%
Medicare Buy-In	$35,697,911	0.98%
PCCM	$4,698,076	0.13%
Medicare HMO	$1,449,464	0.04%
Catastrophic Illness Insurance	$242,789	0.01%
Health Services:	**$106,628,306**	2.92%
Screening	$27,404,359	0.75%
Laboratory	$14,354,723	0.39%
Dental	$44,152,044	1.21%
Transportation	$9,524,835	0.26%
Eye Care	$7,203,151	0.20%
Eyeglasses	$3,329,896	0.09%
Hearing	$557,814	0.02%
Preventive Education	$27,404,359	0.75%
Community Services:	**$264,214,264**	7.23%
Maternity Program	$117,265,234	3.21%
Home Health/DME	$34,311,616	0.94%
Family Planning	$26,110,218	0.71%
Targeted Case Management	$49,088,198	1.34%
Hospice	$37,438,998	1.02%
Mental Health Services	**$159,662,598**	4.37%
Total For Medical Care	$3,656,032,236	100.00%
Administrative Costs	$110,382,239	
Net Payments	$3,766,414,475	



POPULATION

The population of Alabama grew from 4,040,587 in 1990 to 4,419,280 in 2000. In 2004, Alabama's population was estimated to be 4,603,594. 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 20.3 percent in FY 2004.

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 2002-2004
POPULATION
Eligibles as a Percent of Alabama Population by Year

	Population	Eligibles	Percent
2002	4,526,059	860,107	19.0%
2003	4,564,479	906,948	19.9%
2004	4,603,594	935,539	20.3%

Note: The FY 2004 Eligibles include 131,882 Plan First Eligibles

Eligibles and Recipients

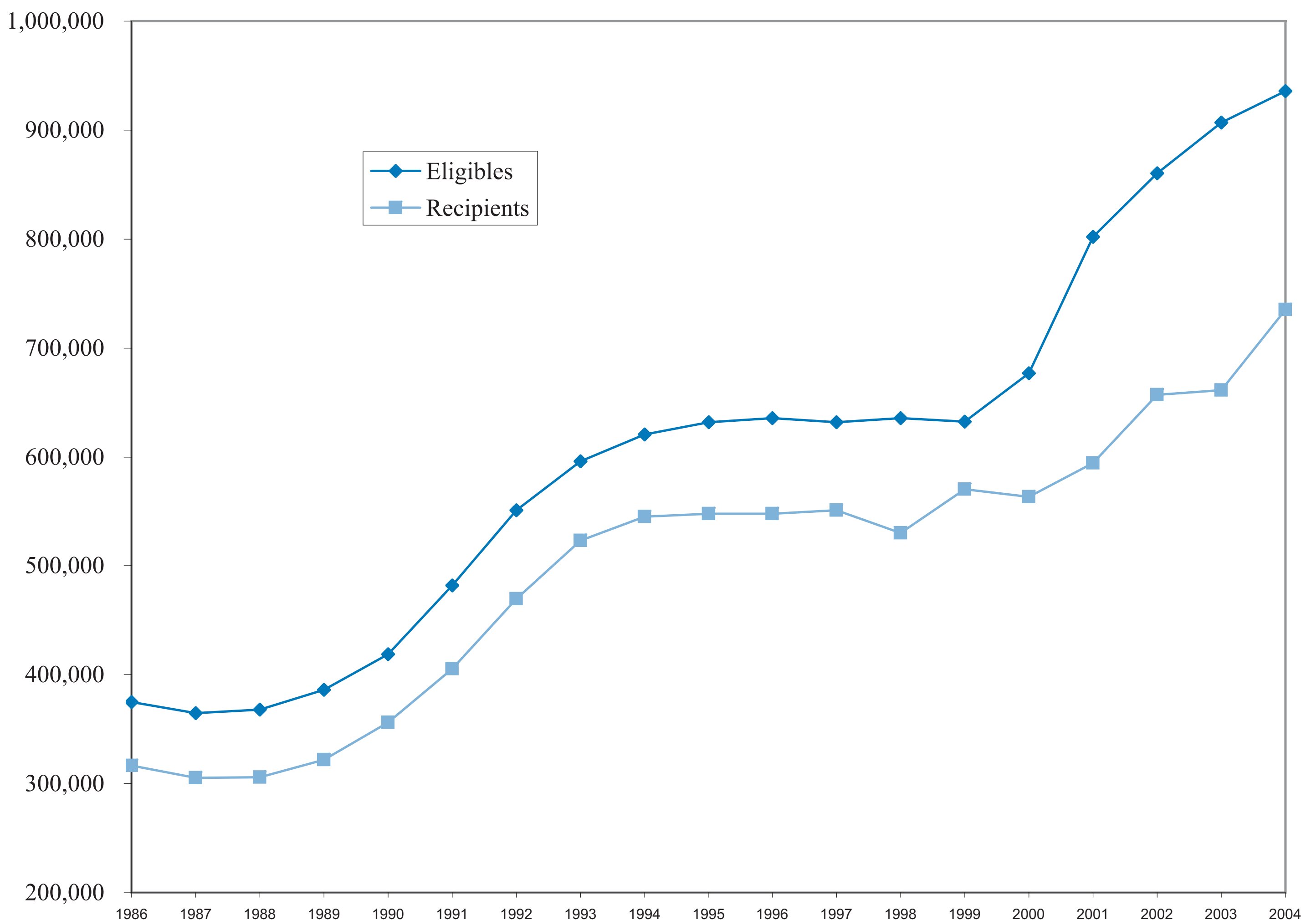
During FY 2004 there were 935,539 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 788,534. The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

Of the 935,539 persons eligible for Medicaid in FY 2004, about 79 percent actually received care for which Medicaid paid. These 734,905 persons are referred to as recipients. The remaining 200,634 persons incurred no medical expenses paid for by Medicaid. Many of these individuals who had no medical expenses paid for by Medicaid were partial eligibles such as Qualified Medicare Beneficiaries (QMBs) only or Specified Low-income Medicare Beneficiaries (SLMBs) only.

FY 2004 ELIGIBLES Monthly Count

Month	Count
October '03	770,938
November	771,567
December	771,340
January '04	777,292
February	783,436
March	789,661
April	793,293
May	796,316
June	800,569
July	796,446
August	804,647
September	806,899

FY 1986 - 2004 MEDICAID ELIGIBLES AND RECIPIENTS



FY 2004
MEDICAID ELIGIBLES BY CATEGORY

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	PLAN FIRST	TOTAL
Autauga	889	260	1,384	3,577	323	11	268	1,134	7,846
Baldwin	1,289	752	3,181	10,545	1,048	31	1,055	3,322	21,223
Barbour	831	412	1,583	3,340	408	14	267	859	7,714
Bibb	238	221	1,050	2,132	250	4	199	703	4,797
Blount	735	421	1,286	4,643	577	6	559	959	9,186
Bullock	352	267	838	1,854	193	4	85	483	4,076
Butler	691	419	1,261	2,991	430	9	327	841	6,969
Calhoun	3,344	929	5,088	11,142	1,337	60	1,116	4,092	27,108
Chambers	1,067	527	1,502	3,469	509	14	479	1,014	8,581
Cherokee	782	276	796	2,274	361	7	329	602	5,427
Chilton	679	335	1,323	3,970	555	9	516	1,195	8,582
Choctaw	600	300	884	1,691	241	4	175	568	4,463
Clarke	945	434	1,640	3,188	429	9	308	1,052	8,005
Clay	166	252	536	1,417	240	3	218	430	3,262
Cleburne	369	141	528	1,459	197	2	221	402	3,319
Coffee	823	573	1,507	3,848	529	9	432	1,113	8,834
Colbert	1,009	470	2,086	5,219	698	11	627	1,802	11,922
Conecuh	859	205	845	1,575	262	4	161	413	4,324
Coosa	167	119	591	1,007	186	2	161	292	2,525
Covington	745	661	1,617	4,260	724	10	634	1,205	9,856
Crenshaw	247	300	683	1,663	281	0	220	452	3,846
Cullman	778	988	2,461	7,400	1,127	18	1,075	2,009	15,856
Dale	1,294	492	2,012	4,619	505	11	380	1,267	10,580
Dallas	2,178	975	4,745	7,333	881	21	565	2,087	18,785
Dekalb	1,595	884	2,173	7,882	1,042	17	810	1,749	16,152
Elmore	1,029	516	2,199	5,138	451	11	353	1,508	11,205
Escambia	986	425	1,469	4,621	450	13	363	1,364	9,691
Etowah	1,490	1,158	4,712	9,336	1,344	30	1,151	2,923	22,144
Fayette	562	260	764	1,597	268	3	222	523	4,199
Franklin	975	412	1,223	3,588	553	2	483	841	8,077
Geneva	507	375	1,179	2,680	505	5	420	710	6,381
Greene	356	235	833	1,700	155	8	85	557	3,929
Hale	357	394	1,176	2,532	241	9	187	762	5,658
Henry	400	310	689	1,742	335	7	234	503	4,220
Houston	1,877	942	3,903	9,989	1,170	21	895	2,858	21,655
Jackson	675	592	1,816	5,011	763	16	583	1,310	10,766
Jefferson	11,237	4,866	25,177	48,921	5,674	149	5,116	18,386	119,526
Lamar	458	244	638	1,486	329	9	221	554	3,939
Lauderdale	1,261	816	2,937	6,956	1,018	13	931	2,799	16,731
Lawrence	633	337	1,145	2,921	459	8	404	973	6,880
Lee	1,993	580	2,911	8,392	695	24	570	3,432	18,597
Limestone	751	563	1,793	5,116	618	17	514	1,715	11,087
Lowndes	719	227	897	1,840	186	6	92	597	4,564
Macon	1,116	330	1,274	2,842	247	6	141	1,264	7,220
Madison	3,516	1,538	6,471	16,855	1,541	45	1,149	6,416	37,531
Marengo	746	400	1,482	2,657	336	7	187	877	6,692
Marion	766	442	1,061	3,012	522	7	460	1,015	7,285
Marshall	1,954	1,004	3,046	9,746	1,038	21	951	1,971	19,731
Mobile	11,963	3,059	14,818	39,966	3,238	103	2,808	13,057	89,012
Monroe	595	324	1,044	2,812	302	6	238	786	6,107
Montgomery	8,018	1,925	10,277	22,557	1,869	63	1,234	7,718	53,661
Morgan	1,475	934	3,443	9,484	1,027	33	805	2,623	19,824
Perry	813	336	1,189	1,853	214	3	115	623	5,146
Pickens	457	410	1,377	2,484	286	7	200	965	6,186
Pike	951	433	1,731	3,689	367	17	326	1,461	8,975
Randolph	536	301	824	2,400	340	11	249	692	5,353
Russell	2,577	575	2,217	5,130	606	20	486	1,697	13,308
St. Clair	1,233	428	1,723	5,642	584	11	631	1,573	11,825
Shelby	968	444	1,830	5,323	666	6	599	1,975	11,811
Sumter	1,066	329	1,142	2,022	203	8	128	772	5,670
Talladega	2,474	768	4,403	8,303	1,173	70	930	2,565	20,686
Tallapoosa	1,045	657	1,983	4,142	573	16	484	1,084	9,984
Tuscaloosa	2,431	1,337	6,836	14,006	1,097	41	967	5,927	32,642
Walker	997	748	3,498	7,416	857	17	821	2,429	16,783
Washington	485	231	821	1,818	215	6	204	581	4,361
Wilcox	711	354	1,682	2,342	245	11	109	730	6,184
Winston	769	368	1,113	2,634	488	4	421	721	6,518
Youth Services	6	0	0	551	0	0	0	0	557
STATEWIDE	96,606	42,540	172,346	405,750	46,581	1,180	38,654	131,882	935,539

FY 2004
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. However, even at 43 percent of all Medicaid Eligibles, the SOBRA group of eligibles accounts for only 22 percent of Medicaid expenditures. Another group that covers parents and their children is Medicaid for Low-Income Families (MLIF).

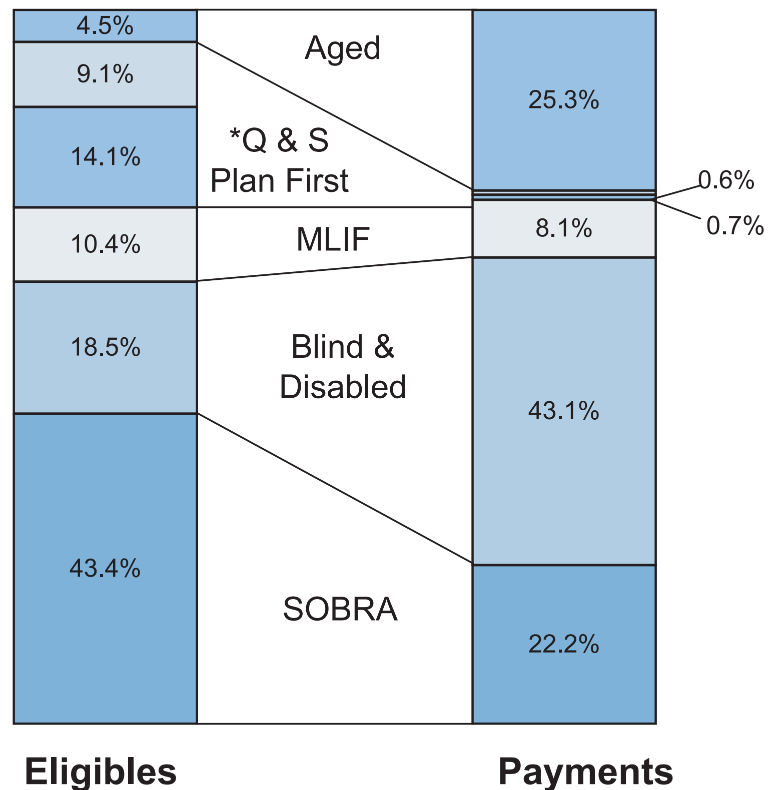
When combined, these two groups that cover families account for 54% of the Medicaid population, but only 30% of the payments. Other eligibles, such as QMB, SLMB, and Plan First comprise a total of over 23% of Medicaid Eligibles, while only a little over one percent of payments for services are made on 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 need of our beneficiaries. For example, pregnant women require prenatal and maternity care, while children require services such as immunizations, well-child care, and primary care services. Children with special needs may also need 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 facility 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 nursing facility care, are not covered by most private health insurance or Medicare.

FY 2004
Eligibles and Payments
Percent Distribution

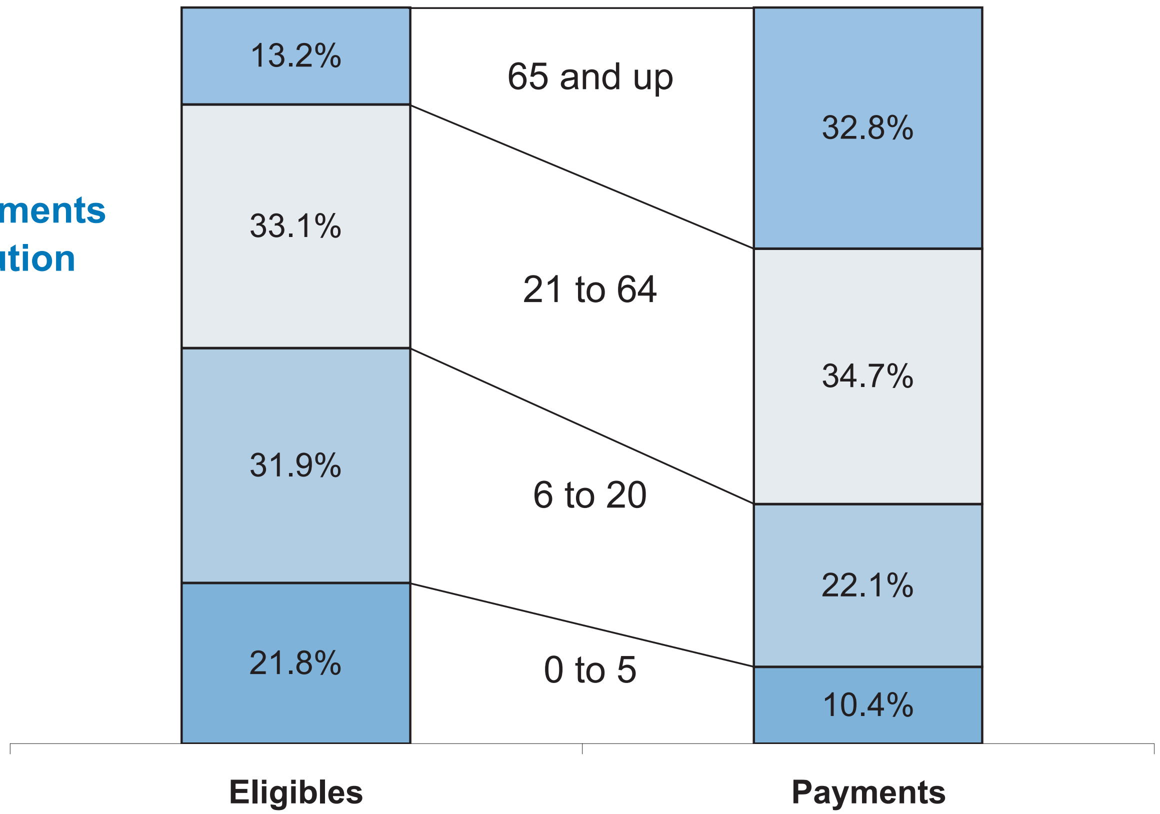
By Category Of Aid

* QMB & SLMB



FY 2004
Eligibles and Payments Percent Distribution

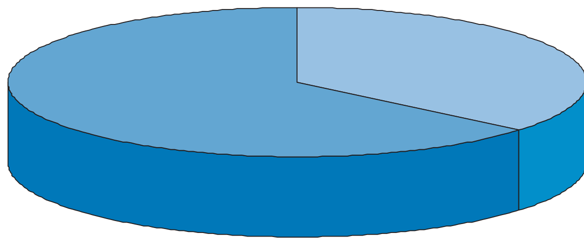
By Age



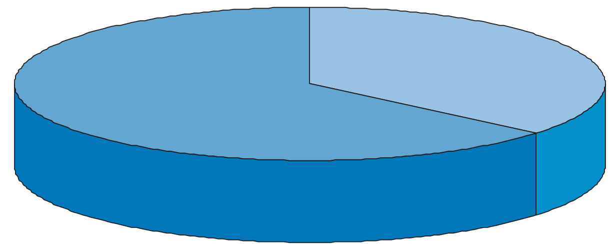
FY 2004 Eligibles and Payments

Percent Distribution by Gender

Eligibles



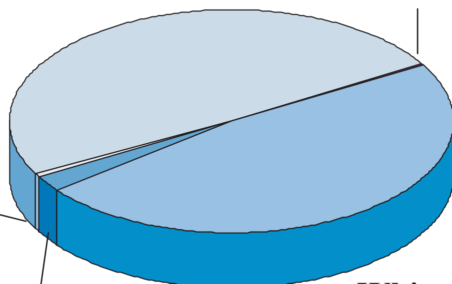
Payments



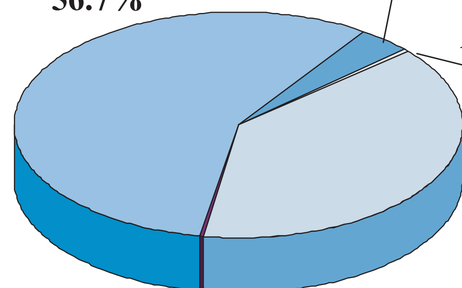
FY 2004 Eligibles and Payments

Percent Distribution by Race

Eligibles



Payments



FY 2004
TOTAL PAYMENTS
By County of Recipient

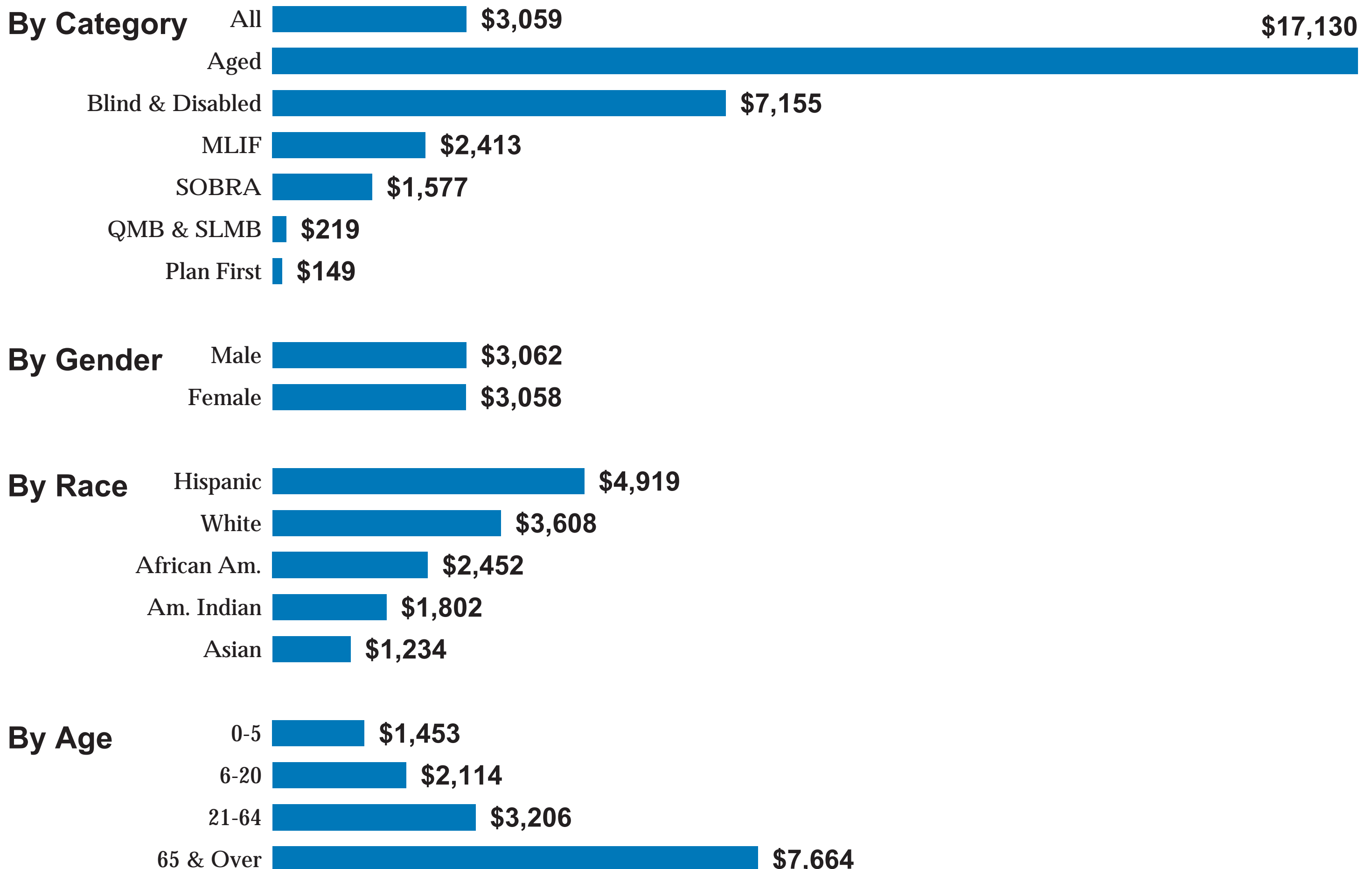
USE AND COST

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 2004 was $96. The yearly average number of days for recipients of this service was 290. 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 high cost per eligible for the year.

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 2004 paid a monthly buy-in fee to Medicare of $66.60 per eligible Medicare beneficiary. The Medicaid Agency also paid from $343 to $377.30 per month Part-A buy-in premiums for certain Medicare eligibles. Medicaid paid over $140 million in Medicare buy-in fees in FY 2004. 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.

The Provider Review Unit uses computer generated statistical reports to identify overbilling or potential fraud and program abuse. The Unit also responds to referrals from other program units, outside agencies, and the Fraud Hotline. Specially trained nurses perform medical audits using specialized computer programs and reviews of patient medical records. Both medical necessity and quality of care are examined. The primary purposes of these reviews are to assure proper claim payment, recovery of overpayments, and to identify Medicaid fraud and abuse.

When problems are identified as the result of a review audit, several corrective actions may be taken: recoupment of funds, education on proper billing procedures, and referral to appropriate oversight Agencies. Suspected fraud cases are referred to the Attorney General's Medicaid Fraud Control Unit for possible legal action.

PROVIDER REVIEWS FY 2004	
Medical Providers	**204**
Medical Provider Recoveries	**$1,578,303**
Pharmacies	**107**
Pharmacy Recoveries	**$57,510**
Potential Recoveries Outstanding	**$1,072,567**

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 2004, 16 previously referred cases were adjudicated along with 201 cases investigated and closed, and five 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.

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 2003 to March 2004. Nationally, Alabama has consistently been among those states with the lowest payment error rates.

Beginning in April 2004, the Pharmacy Audit Unit was established as a separate unit of the Program Integrity Division. The purpose of a pharmacy audit, in general, is to obtain a reasonable assurance that pharmacy providers abide by the rules, regulations, and policies set forth by the Alabama Medicaid Agency and CMS, and in particular, to determine that no Medicaid funds are misspent. Experienced auditors in this unit interpret and apply Medicaid policy regarding the concept of accountability for public resources. Criteria used in selection for audit purposes includes but is not limited to high volume providers, date of last audit, previous audit results, and specific requests or referrals. Examples of discrepancies noted for review and possible recoupment include controlled substances dispensed without an original prescription on file, unauthorized refills, invoice verification, duplicate billing, and unauthorized price overrides. Based on the findings of a desk review or an on-site audit, corrective action is recommended when necessary. If significant fraud or abuse is discovered during the course of an audit, a referral for further investigation is made to the appropriate division or agency.

RECIPIENT REVIEWS FY 2004
Reviews Conducted **424**
Monthly Average # of Restricted Recipients **316**
Cost Avoidance **$124,928**

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.

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.

Third party Coordination of Benefits

Federal regulations require state Medicaid agencies to identify other payers (third party payers) that may be available to pay for the care and services provided to Medicaid recipients and ensure that Medicaid pays secondary to those payers. In Alabama, this effort is conducted by Medicaid's Third Party Division. This coordination of benefits program has been successful in saving Alabama taxpayers hundreds of millions of dollars since its inception in 1970. These savings have been achieved through a combination of cost avoidance of claims where providers file with the primary payer first, direct billing by the Third Party Division to third party payers to obtain health insurance benefits payable for services paid by Medicaid, and continuation of private health insurance which avoids future Medicaid costs. The Third Party Division realizes other program savings through estate recovery and liens activity, establishment and monitoring of Medicare and other third party edits, and recoupments from certain established trusts as well as from beneficiaries of incorrectly paid claims due to ineligibility.

Health Insurance Resources

In FY 2004, the Third Party Division's insurance database indicated over 10% of Medicaid eligibles were covered by health insurance other than Medicare and Medicaid. The Third Party Division is responsible for identification, verification, and documentation of health insurance resources as well as establishment of claims processing edits so that claims are submitted to the primary payer before Medicaid makes payment. When primary coverage is identified after Medicaid makes payment, the Third Party Division seeks reimbursement from the primary coverage. Through a combination of cost avoidance and collection of health insurance benefits (other than Medicare), Medicaid's Third Party Division saved Alabama taxpayers over $140 million in FY 2004.

Trauma Resources

Medicaid also looks for potential third party payers when a Medicaid recipient receives treatment for an injury. Third party sources of payment include homeowner's, automobile, malpractice and other liability insurance as well as court-ordered restitution. Once these resources are identified, the Third Party Division then seeks reimbursement of its payment for medical bills related to a recipient's injury. In FY 2004, Medicaid collected in excess of $2 million from third party payers for trauma-related claims.

Liens / Estate Recovery

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 addition, Medicaid seeks reimbursement of correctly paid claims from estates and income trusts of Medicaid recipients. As a result of the efforts of the Third Party Division's Liens / Estate Recovery Program, Medicaid collected over $6 million in FY 2004.

Recipient Recovery

Medicaid 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 2004, Medicaid received reimbursement of over $1 million from these type cases.

Premium Payment

Federal regulations allow Medicaid to pay health insurance premiums for individuals when it is cost effective to do so. Continuation of an individual's health plan ensures savings to the Medicaid program by deferring costs to the primary payer. Alabama Medicaid's Health Insurance Premium Payment Program (HIPP) accepts applications from individuals who have high cost medical conditions and cannot continue to pay their health plan premiums due to job loss, medical leave, etc. Individuals enrolled in this program include pregnant women, cancer and HIV patients, and low birth weight and preterm babies. In FY 2004, Medicaid paid premiums for approximately 155 individuals each month, resulting in savings to Medicaid of over $2 million.

Medicare Resources

Medicare is also a primary payer to Medicaid, and Medicaid's Third Party Division is responsible for ensuring that Medicare coverage is maximized. Medicaid purchases Medicare Parts A and B coverage for eligible beneficiaries and the Third Party Division monitors the payment of premiums for this coverage. In addition, the Third Party Division ensures that Medicare is a primary payer to Medicaid through establishment and monitoring of Medicare claims processing edits. In FY 2004, system edits denied over $11.2 million in claims that were filed to Medicaid as the primary payer, and Medicaid recouped over $9 million in claims that should have been filed to Medicare as the primary payer. Medicaid costs were further reduced as a result of payments by Medicare to providers in excess of $706 million for Medicaid covered services.

Medicare HMOs

Medicaid has contracts with three HMO Medicare Advantage plans approved by CMS to operate in Alabama. United Healthcare's Medicare Complete operates in 14 counties, Viva's Medicare *Plus* operates in 4

counties and HealthSpring's Seniors First operates in 13 counties. Under the contract terms, Alabama Medicaid pays a capitation fee to the Advantage Plan for QMB eligibles, as well as, recipients who are eligible for both Medicare and full Medicaid benefits. By paying a capitation fee for eligible recipients, Medicaid avoids paying their Medicare coinsurances and deductibles.

At the end of FY 2004, Medicaid paid capitation fees for 8,824 recipients. Medicaid saved about $6.4 million during FY 2004 due to the contract arrangement with the Medicare Advantage plans. With the anticipated expansion of additional counties by all three advantage plans in the next 24 months, Medicaid expects greater savings in the next two years.

Summary

As a result of coordination of benefits efforts by providers and Medicaid's Third Party Division staff in FY 2004, the Alabama Medicaid program saved in excess of $178 million in claims costs by deferring those costs to the appropriate primary payers.

Agency Audit

Fiscal Agent/Contract Monitoring

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 identified. During this fiscal year, approximately 1,116 claims were manually reviewed and $107 million 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 2004, this unit completed 25 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 (FQHCs), Provider Based Rural Health Clinics (PBRHCs), 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 2004
COLLECTIONS AND MEASURABLE COST AVOIDANCE

COLLECTIONS

DRUG REBATE PROGRAM Collection of rebates plus interest from drug manufacturers for the utilization of their products.	$126,717,758
THIRD PARTY LIABILITY Includes reported and estimated third party collections by providers, retroactive Medicare recoupments from providers, and collections due to health and casualty insurance, estate recovery, and misspent funds resulting from eligibility errors.	$29,862,835
PROGRAM INTEGRITY DIVISION	
Provider Recoupments	$1,578,303
Pharmacy Recoupments	$57,510
FISCAL AGENT/SYSTEMS AUDIT DIVISION	
Claim Corrections	$107,005
TOTAL COLLECTIONS	**$158,323,411**

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).	$3,800,792
THIRD PARTY CLAIM COST AVOIDANCE SAVINGS	
Provider Reported Collections - Medicare	$706,050,431
Provider Reported Collections - Health and Casuality Insurance	$26,882,112
Claims denied and returned to providers to file Medicare.	$11,247,027
Claims denied and returned to providers to file health/casualty insurance.	$114,767,354
Health Insurance Premium Payment Cost Avoidance	$2,086,698
WAIVER SERVICES COST AVOIDANCE - ELDERLY AND DISABLED	$164,972,590
WAIVER SERVICES COST AVOIDANCE - HOMEBOUND	$9,814,132
WAIVER SERVICES COST AVOIDANCE - MR/DD	$347,996,180
WAIVER SERVICES COST AVOIDANCE - LIVING AT HOME	$2,219,285
TOTAL MEASURABLE COST AVOIDANCE	**$1,389,836,601**
GRAND TOTAL	**$1,548,160,012**

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 as we all work together to accomplish the Agency's mission.

Major projects completed by the Information Systems Division during FY2004 included continued efforts toward achieving compliance with HIPAA, the Health Insurance Portability and Accountability Act, which requires the national standardization of electronic transactions and code sets for financial and clinical claims processing, protection of confidentiality and security of all health data and the establishment of unique identifiers for all payers, providers, patients and employees. Compliance included ongoing changes to many of Medicaid's computer functions performed by its contracted fiscal agent Electronic Data Systems (EDS) as they process our claims data and coordinate efforts with all healthcare providers and vendors for our recipients throughout the state. However, I/S staff also performed many other tasks independent of the coordination efforts with EDS in order to meet HIPAA compliance requirements. Various data fields, programs and reports were converted to conform to HIPAA specifications. After a new HIPAA-compliant transaction code set was created last year to provide electronic eligibility matching between Medicaid and various state agencies and other outside providers, all incoming files from those outside entities were converted this year. Programs were created and run to generate address and phone number information for Medicaid eligibles and their representatives. In addition, password protection was added to database systems not previously protected, and various summary reports were generated to help identify HIPAA costs. Final testing is in progress for a new Privacy Tracking System to be used as a part of Agency HIPAA compliance.

Other major projects completed this fiscal year by the Information Systems Division included the automation of the Emergency Services Program for aliens. This process allows the ability to identify persons eligible for pregnancy-related emergency services only as well as children and adults eligible for full emergency services. The I/S Division also worked on the further development of the new QDWI (Qualified Disabled Working Individuals) program.

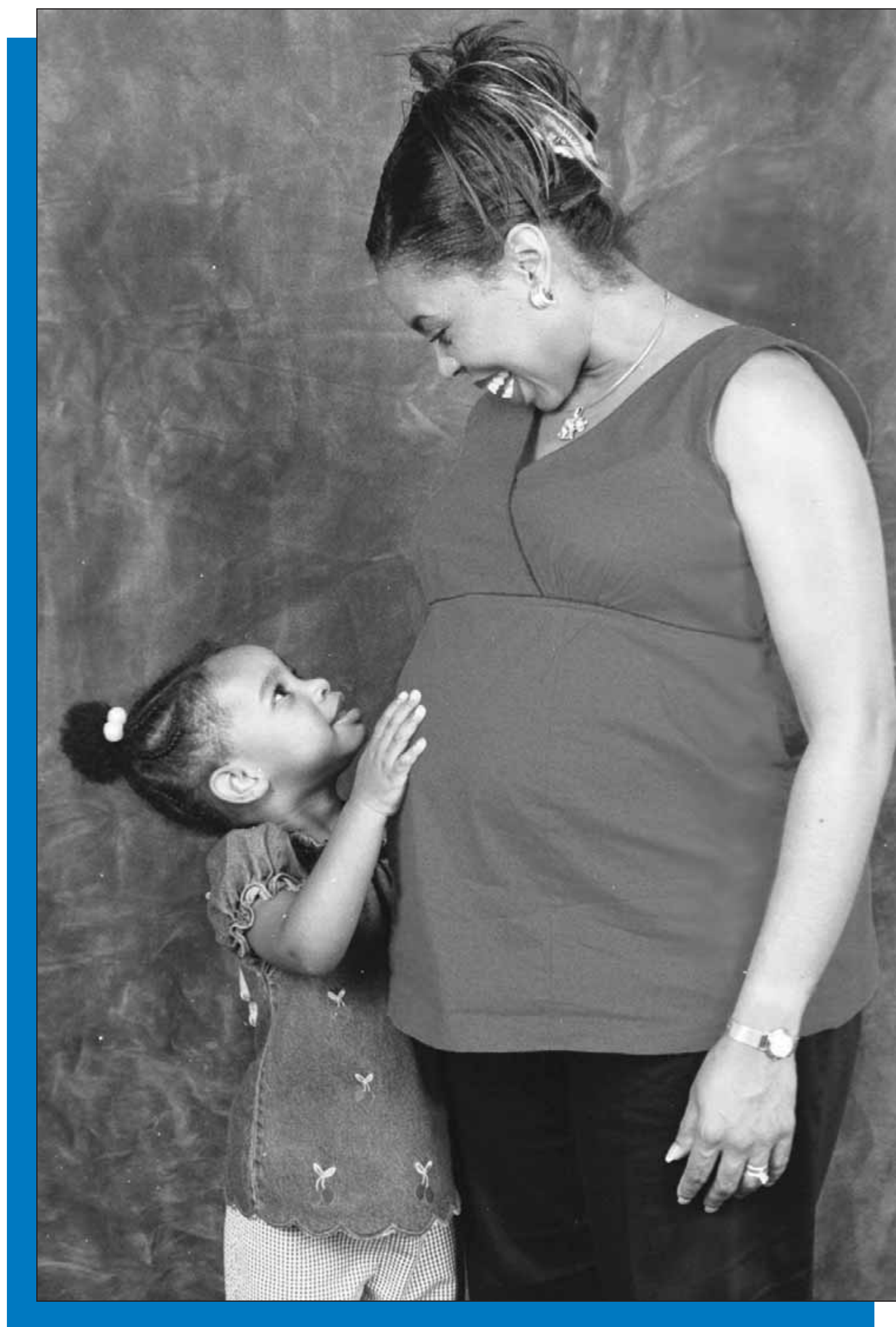
I/S staff assisted the Agency's eligibility divisions and units, including in-house workers and out-stationed SOBRA and District Office workers in various ways, such as modifying the SOBRA Award/Denial online screens. Options were added that allowed the worker to go directly to specific data fields, which in turn allows the system to go to other screens automatically. New reports were provided concerning Medicaid active children in households whose parents/guardians are working and receiving earned income and appropriate employer information for those parents/guardians.

Data processing services and research as needed was provided for other in-house areas and for outside entities such as various hospitals for data matching, several utility companies, specific providers, other state agencies and departments, the state data center (ISD) and the state's Attorney General's Office. Examples of other accomplishments include:

- Creation of new software concerning statistics for PHP enrollment to provide to the Alabama Hospital Association (AlAHA) and our Financial Management Unit,
- Creation of electronic reports from our monthly eligibility update process to provide to other state departments,
- Revision of our online software per ISD specifications to provide quicker access at a more cost effective rate to our users, and
- Provision of quality control and statistical data and research upon request during the year to the Department of Examiners of Public Accounts.

Maternal and Child Health Services

During FY 2004, Medicaid served 405,750 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 8.7 deaths per thousand in 2003.



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.

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. Medically indicated procedures such as ultrasound, non-stress tests, and amniocentesis are examples of other services covered by Medicaid. In order to complete the pregnancy cycle, one postpartum checkup is covered during the 60-day postpartum period.

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.

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 an FQHC or rural health clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 460,000 of Alabama's children are Medicaid eligible. Medicaid has taken the previous vaccines and administration fee costs to calculate an equivalent administration reimbursement fee of $8 per injection. When multiple injections are given on the same day, Medicaid will reimburse for the administration of each injection. When injections are given in conjunction with an EPSDT screening visit or physician office visit, the visit and each administration fee will 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 CMS based on charge data. No VFC-eligible participant should be denied services because of the 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 who 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 enrollees who started with the program. As of September 2004, there were 124,248 women enrolled in the Plan First Program.

EPSDT

The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) 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 treat-

ed 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 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.

Currently there are more than 2000 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.

In 1995, Medicaid added an off-site component of the EPSDT program. This allows providers who meet 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.

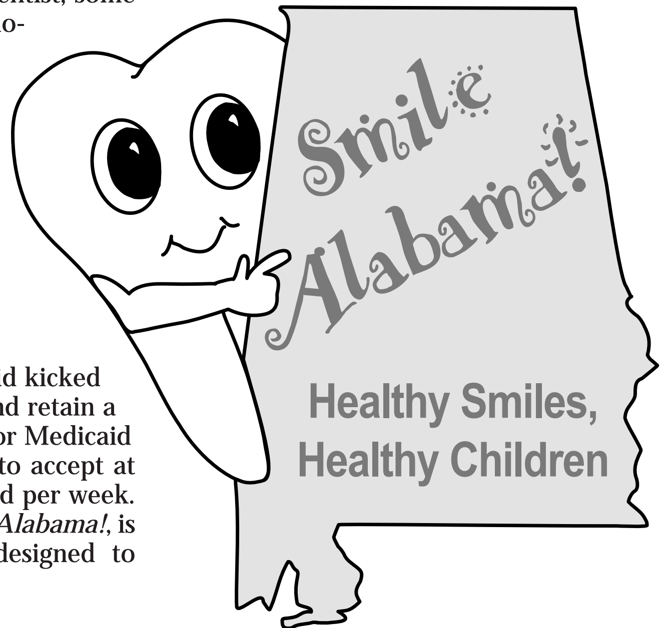
Since screening is not mandatory, many parents do not seek preventive health care for their children. Steps have been taken in recent years, however, to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of intensive outreach statewide, enhancement of physicians' reimbursement for screening, and an increase in the number of screenings for which Medicaid will pay. 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, fillings, 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 2004 the participating dental providers had continued to grow with more than 386 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 almost 166,079 children receiving at least one dental service.



Lauderdale 6,956
Limestone 5,116
Madison 16,855
Jackson 5,011
Colbert 5,219
2,921 Lawrence
3,588 Franklin
9,484 Morgan
Marshall 9,746
7,882 Dekalb
Marion 3,012
2,634 Winston
Cullman 7,400
4,643 Blount
Etowah 9,336
Cherokee 2,274
1,486 Lamar
1,597 Fayette
Walker 7,416
Jefferson 48,921
5,642 St Clair
11,142 Calhoun
1,459 Cleburne
Pickens 2,484
14,006 Tuscaloosa
5,323 Shelby
Talladega 8,303
1,417 Clay
Randolph 2,400
Greene 1,700
2,532 Hale
Bibb 2,132
Chilton 3,970
Coosa 1,007
4,142 Tallapoosa
3,469 Chambers
2,022 Sumter
1,853 Perry
3,577 Autauga
5,138 Elmore
8,392 Lee
2,657 Marengo
Dallas 7,333
Montgomery 22,557
2,842 Macon
5,130 Russell
Choctaw 1,691
Wilcox 2,342
Lowndes 1,840
Bullock 1,854
Barbour 3,340
Clarke 3,188
Monroe 2,812
2,991 Butler
1,663 Crenshaw
Pike 3,689
Washington 1,818
1,575 Conecuh
Coffee 3,848
Dale 4,619
Henry 1,742
Escambia 4,621
Covington 4,260
Geneva 2,680
Houston 9,989
Mobile 39,966
Baldwin 10,545

Customer Service

Medicaid's Information Call Center

In an attempt to provide more efficient service to the Agency's beneficiaries and providers, the Alabama Medicaid Agency implemented an Information Call Center in November 2002. The Agency's recipients can call and get the help they need via a toll-free telephone service throughout Alabama by calling 1-800-362-1504. The caller will be given choices that will connect them to one of the five (5) areas. The areas included in the Call Center are:

Recipient Inquiry Unit, Non-Emergency Transportation, Customer Service, Long Term Care, and District Offices.

With the various automated features of the Information Call Center (1-800-362-1504), more calls can be answered in a timely manner. The Information Call Center lines are open from 8:00 a.m. to 4:00 p.m. Monday through Friday.

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 28,536.17 calls monthly during FY 2004 (more than 342,434 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-third of all calls deal with Primary Care Case Management (PCCM) provider assignments and about one-fourth are information-only calls. About 35 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 4:00 p.m. Monday through Friday. In FY 2004, the unit was staffed with nine (9) full time operators and five (5) 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.

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 Waiver for the Patient 1st Program was not renewed by the State effective February 29, 2004. This was done to allow the State an opportunity to rethink and redesign the program taking advantage of new managed care regulations and new technology. The Patient 1st Program will begin again in FY 2005. 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.

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 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 delivery care. 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 and the Plan First Waiver. During FY 2004, Medicaid's Managed Care Initiatives included:

- MCP (Maternity Care Program)
- PCCM (Primary Care Case Management)
- PHP (Partnership Hospital 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 healthcare 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 that the Quality Assurance System activities are effective, meet standards, and are 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 24 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 technology assisted waiver for adults (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 $45.5 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, disabled adults with specific medical diagnoses, adults who received private duty nursing through EPSDT prior to age 21, and individuals with a diagnosis of HIV, AIDS, and related illnesses who meet the nursing facility level of care. These programs provide quality and cost-effective services to individuals at risk of institutional care.

HCBS Waiver for the Elderly and Disabled

This waiver provides services to persons who might otherwise be placed in nursing homes. The seven basic services covered are case management, homemaker services, personal care, adult day health, respite care, companion services and home-delivered meals. During FY 2004, there were 7,565 recipients served by this waiver at an actual cost of $6,110

per recipient. Serving the same recipients in nursing facilities would have cost the state $27,918 per recipient. This waiver saved the state $21,808 per recipient in FY 2004.

People receiving services through Medicaid Elderly and Disabled waivers must meet certain eligibility requirements. Those served by the waiver are recipients of Supplemental Security Income (SSI) or State Supplementation who meet the medical criteria for nursing facility care financed by the Medicaid program. This waiver is operated by the Alabama Department of Public Health and the Department of Senior Services.

HCBS Waiver for the Mentally Retarded (MR)

This waiver serves individuals who meet the ICF/MR level of care for mental retardation. The services provided by the waiver are residential habilitation training, day habilitation, prevocational training, supported employment, occupational therapy, speech therapy, physical therapy, behavior management, companion service, respite care, personal care, environmental modification, specialized medical equipment and supplies, assistive technology, skilled nursing care, crisis intervention, and community specialist. During FY 2004, there were 5,366 recipients served by this waiver at an actual cost of $31,743 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $96,596 per recipient. The MR waiver saved the state $64,853 per recipient in FY 2004. This waiver is operated by the Alabama Department of Mental Health and Mental Retardation.

Homebound/SAIL Waiver

The State of Alabama Independent Living (SAIL) 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 operated by the Alabama Department of Rehabilitation Services. The services provided under this waiver include case management, personal care, respite care, environmental accessibility adaptations, medical supplies, personal emergency response system, assistive technology personal assistance service, assistive technology, and assistive technology evaluation. During the waiver year of 2004, there were 552 recipients served at a cost of $10,138 per recipient. Serving the same recipients in an institution would have cost the state $27,918 per recipient. During FY 2004, the SAIL Waiver saved the state $17,780 per recipient.

HCBS Waiver for HIV/AIDS

The HIV/AIDS Waiver provides services to individuals age 21 and over with a diagnosis of HIV/AIDS and related illnesses who are at risk for institutionalization. In addition, individuals must meet the nursing facility level of care. All income categories from SSI to 300 percent of SSI are included. The waiver is operated by the Alabama Department of Public Health. Four basic services are offered through the waiver: personal care, respite care, skilled nursing and companion service. Case management services will be provided under the existing Targeted Case Management Program (Target Group 6) as a State Plan service.

Living at Home Waiver (LAH)

The Living at Home Waiver serves individuals living in their own home rather than group homes or other facilities. To be eligible an individual must be age 3 or above and meet the ICF/MR level of care for mentally retarded or related conditions. Financial eligibility is limited to those individuals receiving SSI. The services provided under this waiver include in-home residential habilitation, day habilitation, supported employment, prevocational services, in and out of home respite care, personal care, personal care transportation, physical therapy, occupational therapy, speech therapy, behavior therapy, skilled nursing, environmental accessibility adaptations, specialized medical equipment and supplies, community specialist and crisis intervention. This waiver was approved with an effective date of October 1, 2002 and was implemented in January 2003. During FY 2004, there were 96 recipients served at a cost of $4,800 per recipient. Serving the same recipients in an institution would have cost the state $27,918 per recipient. This waiver saved the state $23,118 per recipient in FY 2004. It is operated by the Alabama Department of Mental Health and Mental Retardation.

Technology Assisted Waiver For Adults

The Technology Assisted Waiver for Adults serves individuals who received private duty nursing services through the EPSDT Program under the Medicaid State Plan and would have lost eligibility for private duty nursing services upon turning age 21. To qualify the individual must meet the nursing facility level of care, have income up to the institutional income limit (FBR X 300%), be receiving private duty nursing services through Medicaid the month prior to their 21st birthday, and continue to medically require these services. Services provided include private duty nursing, personal care/attendant service, medical supplies, assistive technology and targeted case management. During the 2004 waiver year, 3 recipients were served by this waiver. This waiver is administered by the Alabama Medicaid Agency.

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 2004, the Medicaid Agency served 2,810 hospice patients at a total cost of about $30 million.

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, physician's 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 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

FY 2000-2004
HOSPITAL PROGRAM
Outpatients

	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004
Number of outpatients	218,078	245,726	322,818	328,029	365,389
Percent of eligibles using outpatient services	32%	31%	38%	36%	39%
Annual expenditure for outpatient care	$36,141,056	$44,166,407	$50,376,944	$58,034,730	$59,169,313
Cost per patient	$166	$180	$156	$177	$162

by licensed physicians and provided by home health agencies under contract with Medicaid. There were 128 agencies participating in FY 2004.

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 2004, over 6,000 recipients received visits costing a total of approximately $11.5 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 2004, over 752 Medicaid DME providers throughout the state furnished services at a cost of approximately $22.8 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 2004, Medicaid paid approximately $1.7 million for services provided through 46 private duty-nursing providers.

In Millions of Dollars

Excludes public hospital enhancement payments

Medical Services

Outpatient Services

Medicaid pays for visits to the emergency room if they are certified as true emergencies by the doctor at the time of the visit. Benefits include visits for chemotherapy, radiation therapy, lab and x-ray services and approved outpatient surgical procedures.

Hospital Co-payments

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.

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.

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 centers, migrant health centers, and health care for the homeless programs are automatically qualified to be enrolled, with others able to be certified as "look alike" FQHCs.

Services covered by the FQHC program include ambulatory services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers employed by the FQHC. Federally qualified health centers are reimbursed using an all inclusive encounter

rate. Medicaid establishes reasonable costs by using the centers' annual cost reports. At the end of FY 2004, there were 18 FQHCs enrolled as providers, with 111 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 2004, 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. The majority of licensed physicians in Alabama participate in the Medicaid program. Some Medicaid eligibles such as QMB only and SLMB only do not receive any medical services that are paid for by Alabama Medicaid. Of those Medicaid eligibles who do receive medical services paid for by Alabama Medicaid, over 55 percent received physician services in FY 2004.

Recipients visiting a physician are required to pay a $1 copayment per office visit. Recipients under 18 years of age, nursing home residents, and pregnant women are exempt from copayments. Certain physicians' services do not require copayments. These include family planning services, physicians' inpatient hospital visits, physical therapy, and emergencies. Physicians may not deny services due to the recipient's inability to pay the copayment.

Pharmacy Services

Although the pharmacy program is an optional service under federal Medicaid rules, it is economically vital to the Medicaid program. Treating illnesses

FY 2004
PHYSICIAN PROGRAM
Use and Cost

Age	Payments	Recipients	Cost per Recipient
0 to 5	$54,903,631	149,782	$367
6 to 20	$39,778,256	176,233	$226
21 to 64	$70,895,774	130,340	$544
65 and up	$8,682,121	58,989	$147
All Ages	$174,259,782	515,344	$338

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 2004, pharmacy providers were paid $593,835,608 million for prescriptions dispensed to Medicaid recipients. This expenditure represents 16 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 2004, over $126 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 pharmacist with regard to issues concerning appropriateness of pharmaceutical care, thereby minimizing expenditures.

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

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. 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. 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

FY 2002-2004
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*
2002	499,967	64%	10,607,589	21.22	$43.52	$923	$461,617,088
2003	526,058	65%	11,429,977	21.73	$47.93	$1,041	$547,782,433
2004	541,235	60%	11,578,877	21.39	$51.29	$1,097	$593,835,608

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

FY 2002-2004
PHARMACEUTICAL PROGRAM
Cost

	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx	Net Cost Per Recipient
2002	$461,617,088	$85,007,636	$376,609,452	$35.50	$753
2003	$547,782,433	$102,987,398	$444,795,035	$38.91	$846
2004	$593,835,608	$126,717,758	$467,117,850	$40.34	$863

Note: Data for 2002 have been adjusted to reflect updated claims information

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 males, females, teens, and preteens. Eyeglasses furnished locally are reimbursed at contract rates.

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 75 freestanding facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis and CAPD (Continuous Ambulatory Peritoneal Dialysis) and home treatments, as well as training, counseling, drugs, biologicals, and related tests. Patients are allowed 156 treatment sessions per year, which provides for three sessions per week.

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

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. Laboratory and radiology are unlimited services and if medically necessary can be covered even if other benefit limits have been exhausted.

FY 2004
EYE CARE PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
Optometric Service	$7,203,151	91,003	$79
Eyeglasses	$3,270,905	84,546	$39

FY 2002 - 2004
LAB AND X-RAY PROGRAM
Use and Cost

	Payments	Recipients	Annual Cost per Recipient
2002	$42,394,321	395,125	$107.29
2003	$45,318,047	378,882	$119.61
2004	$47,461,916	407,953	$116.34

Note: This includes Physicians Lab and X-Ray

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 2004 was over $744 million. Almost 96 percent of the nursing homes in the state accepted Medicaid recipients as patients in FY 2004. There were also 20 hospitals in the state during FY 2004 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 is part of Medicaid's Quality Assurance Division and is responsible for providing an effective quality assurance system for the Home and Community Based Services (HCBS) waiver programs. The LTC/QA Program provides quality assurance oversight of several operating agencies (OA) that are responsible for the daily operation of the waiver programs. The oversight is to assure that the OA is providing services as outlined in the specific HCBS Waiver document. Quality Assurance for HCBS Waiver programs 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 health and welfare of the participants and to prevent institutionalization

The key components in the process are: 1) Health and safety. 2) Responsiveness of the plan of care. 3) Qualifications of providers. 4) Appropriateness of services. 5) Freedom of choice. 6) Client satisfaction. 7) Complaint and grievance process. 8) Accessibility to waiver services. 9) Availability of other community care options. 10) Continuity of care. 11) Quality improvements. These assurances are through annual review of case management and direct service provider records, visits to participants homes, group homes, adult day care centers, day habilitation worksites, satisfaction survey results, tracking and resolution of participants complaints and grievance, and review of operating agencies internal quality assurance programs and activities.

FY 2002 - 2004
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
2002	27,177	273	7,407,712	$95	$704,151,335
2003	28,056	276	7,749,218	$92	$715,766,681
2004	26,665	290	7,735,215	$96	$744,420,675

FY 2002 - 2004
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	26,687	17,152	64%
FY 2003	27,038	17,467	65%
FY 2004	27,087	17,474	65%

FY 2004
LONG-TERM CARE PROGRAM
Recipients and Payments by Gender, Race and Age

	Recipients	Payments	Cost Per Recipient
By Gender			
Female	19,890	$565,683,708	$28,441
Male	6,775	$178,736,967	$26,382
By Race			
White	19,017	$525,096,568	$27,612
African Am.	7,329	$210,507,959	$28,723
Hispanic	293	$8,195,675	$27,972
Asian	22	$520,079	$23,640
Am. Indian	4	$100,394	$25,099
By Age			
0-5	15	$608,953	$40,597
6-20	106	$5,889,819	$55,564
21-64	3,439	$96,769,564	$28,139
65-74	3,734	$103,558,237	$27,734
75-84	8,345	$232,360,093	$27,844
85 & Over	11,026	$305,234,009	$27,683

FY 2004
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.

Intermediate Care for the mentally retarded is provided through the W.D. Partlow Developmental Center in Tuscaloosa. In 2004 the Albert P. Brewer Developmental Center in Mobile, the J.S. Tarwater Developmental Center in Wetumpka, and the Lurleen B. Wallace Developmental Center in Decatur were closed. In FY 2004, the average reimbursement rate per day in an institution serving the mentally retarded was $450.

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 the Alice Kidd Nursing Facility in Tuscaloosa.

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 2004, 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 2004
LONG-TERM CARE PROGRAM
ICF-MR/DD

	ICF/MR	ICF/MD-Aged
Recipients	384	134
Total Payments	$37,092,674	$7,862,768
Annual Cost per Recipient	$96,596	$58,677

In Memoriam

Lakecia Q. Broadnax

January 28, 1977 – October 30, 2004

Lakecia was a valued co-worker for over three years

Alabama Medicaid Agency
P.O. Box 5624 (501 Dexter Ave.)
Montgomery, AL 36103