ALABAMA MEDICAID

EIGHTH ANNUAL REPORT

October 1, 1979-September 30, 1980

Medical Services Administration
State of Alabama

State of Alabama
Medical Services Administration

FOB JAMES
Governor

2500 Fairlane Drive
Montgomery, Alabama 36130

REBECCA B. BEASLEY
Commissioner

The Honorable Fob James
Governor
State Capitol
Montgomery, Alabama 36130

Dear Governor James:

I am very pleased to submit the Eighth Annual Report of the Alabama Medicaid Agency, formerly the Medical Services Administration, for fiscal year 1979-80.

The report provides a diverse range of data concerning recipients, services, providers and costs of the medicaid program. The graphic overview consists of many charts, graphs and tables. Several tables in the report compare the services and costs of this year's program with those of previous years. We believe that this method of presentation will provide you with a sufficiently detailed account of program operations for an insight into the goal of assuring the availability of quality medical care for the Alabama citizens needing such services. Care has been taken to present an accurate, understandable picture of the present condition and direction of medicaid in this state.

Through your personal efforts and those of the Alabama Legislature, the medicaid program ended the year without a deficit and continued to provide needed medical assistance to recipients. Under the direction of Commissioner W. H. "Hoke" Kerns, many accomplishments were achieved in the areas of cost containment, provider relations and stabilization of the program.

On behalf of approximately 324,000 Alabamians who receive medical assistance through the medicaid program, we take this opportunity to thank you and the Legislature for continuing to make these services available, and Commissioner Kerns for directing the course medicaid followed during fiscal year 1979-80.

Respectfully submitted,

Rebecca B. Beasley

Rebecca B. Beasley
Commissioner

RBB/gd

ALABAMA MEDICAID

FISCAL YEAR 1980

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MEDICAL SERVICES ADMINISTRATION

MONTGOMERY, ALABAMA

Rebecca B. Beasley, Commissioner

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COMPARATIVE ANALYSIS OF PAYMENTS

Since the inception of the Medicaid program in Alabama, there has existed a need for an analysis of the increases or decreases in the amounts paid to health care providers for Medicaid recipients. In order to plan for the future in terms of budgeting and policy changes, a study of the factors which affect payments is required. To better evaluate and control the program, information on three aspects of Medicaid are needed. They are: (1) the extent to which the cost of medical care under the program has changed; (2) the extent to which the number of eligibles in the population taking advantage of the benefits available through Medicaid has changed; and (3) the extent to which various services are being utilized by the individual recipients.

Alabama's Medicaid program was one of the first in the South to obtain a computerized Medicaid Management Information System (MMIS) which provides an extensive claims-processing review and various other data processing functions. One of the review functions is the Management and Administrative Reports Subsystem (MARS), which reports the cost and volume of services provided to Medicaid recipients. It was with the use of the monthly MARS reports that the following analysis was compiled.

TWO YEAR COMPARISON

As shown in Plate 1, providers of Medicaid services were paid a total of $23.4 million more in FY '80 than they were in FY '79. This represents an increase of nearly 10 percent. A further breakdown into the seven major types of service allows a more detailed analysis of this increase. Payments made to nursing homes for intermediate care were $34.3 million higher than they were the previous year. ICF-Mentally Retarded and ICF-Mental Illness accounted for $6 million of this increase. For skilled-level nursing home care the payments declined by $8.3 million in FY '80. Taken as a whole, payments to nursing homes rose $25.9 million, an increase of 24.5 percent. The other two types of service showing increases in payments were hospital inpatient care and physicians' care, although the increase for the latter was insignificant. Were it not for a decline in the remaining program services, Medicaid payments in FY '80 would have risen by more than 15 percent over the prior year.

USE AND COST

In a service oriented program such as Medicaid, the utilization and cost of the services determines the total amount paid to providers. Utilization and cost of services are best analyzed in the Medicaid program by the use of the following measures:

Average payment per unit
Average number of recipients
Average units of service per recipient

FY '80 PLATE 1

COMPARATIVE ANALYSIS OF PAYMENTS

Changes in Medicaid Payments by category of service

	Amounts Paid To Vendors (millions)		Amount Of Increase/Decrease		Relative Contributions To Change in Payments		
	FY'79	FY '80	In Dollars (millions)	In Percent	Attributable to Rising Prices (millions)	Attributable to More Recipients (millions)	Attributable to More Units Per Recipient (millions)
SNF Care	$ 46.7	$ 38.3	$−8.4	−18.0%	$ 5.2	$−11.7	$−1.9
ICF Care	58.8	93.1	34.3	58.3%	20.1	15.3	−1.1
Physician Services	31.4	31.6	.2	.2%	2.3	−3.3	1.2
Inpatient Hospital	62.1	60.0	−2.1	−3.4%	3.4	−3.8	−1.6
Outpatient Hospital	9.4	11.6	2.2	23.4%	1.4	.3	.4
Prescriptions	21.6	20.1	−1.5	−6.9%	1.7	−2.8	−.4
Other Care	11.1	9.8	−1.3	−11.7%	0	−.7	−.6
TOTAL	$241.1	$264.5	$23.4	9.7%	$34.1	−6.7	$−4.0

Plate 2 displays for each type of service the percent change between the current and preceding year for these three factors. As shown in this table, the primary factor contributing to the overall increase in payments was the average unit price, which increased more than 16 percent in FY '80. With only one exception, all of the major categories of service experienced higher prices. An average day of intermediate level care in nursing homes exhibited a price increase of over 27 percent from 1979 to 1980. This was followed by skilled level care and outpatient visits with increases of 15.5 percent and 13.7 percent, respectively, during this period.

The average number of recipients taking advantage of the program declined by 5.7 percent during the year. The two exceptions to this were in intermediate care and outpatient hospital services. With respect to the number of recipients, it is interesting to note that the rate of increase in intermediate nursing home care was almost equal to the rate of decrease in skilled care.

Not only were there fewer recipients of Medicaid; they generally were using the services less often, as measured by the average number of units (days, visits, prescriptions, etc.) per recipient. However, recipients did make more outpatient visits and receive more physicians' services than the year before.

To get the most benefit from these comparisons, a formula was used to translate these rates of change into dollar amounts. The last three columns of Plate 1 reflect the relative contribution each source of variation made to the increase/-decrease in payments for services. For example, if the number of recipients and their utilization rate had remained the same for both fiscal years, then the higher unit price in FY '80 would have resulted in an increase of $1.7 million in the drug program.

Notice that for skilled care, inpatient services, and prescriptions, the savings derived from fewer recipients and their lower utilization rate more than offset the increase which was due to rising prices. Overall, however, the upturn in unit prices was the major contributing factor to the increase in Medicaid payments this year.

FY '80 PLATE 2

COMPARATIVE ANALYSIS OF PAYMENTS

Percent Changes in Use and Cost by category of service

	COST	USE	
		RECIPIENTS	UTILIZATION
	Average Payment Per Unit of Service	Average Number of Recipients	Average Units Per Recipient
SNF Care	15.5%	−25.0%	−5.4%
ICF	27.6%	26.1%	−1.5%
Physician Services	7.9%	−10.6%	4.3%
Inpatient Hospital	6.0%	−6.1%	−2.8%
Outpatient Hospital	13.7%	4.1%	4.0%
Prescriptions	9.2%	−12.9%	−2.0%
Other Care	−0.2%	−.8%	−11.0%
TOTAL	16.1%	−5.7%	0.2%

POSSIBLE EXPLANATIONS

The dramatic jump in Medicaid payments per unit of service mirrors the nationwide increase in health care prices. The medical care component of the Consumer Price Index for the same time period showed a continuation of this significant climb in health care prices across the country. As a direct result of inflation, the increased costs of goods, services, and labor which the provider must purchase are passed on to those who pay for medical care.

The decline in the utilization of Medicaid services had several possible explanations. First, because of funding problems during the year, payments to providers were delayed, sometimes for as long as several weeks. This, coupled with a threatened termination of the program, caused a number of providers to refuse Medicaid cards for payment of their services. Another factor which influenced the rate of utilization was the statewide trend toward fewer days spent in the hospital per admission. This is characterized by patients remaining hospitalized only as long as absolutely necessary. In the nursing home program, as more patients were certified as requiring a lower level of care (intermediate), this lessened the utilization of skilled-care services.

The only major type of service not to exhibit a downturn in use or prices was the outpatient hospital program. The rise in the number of recipients may be attributed to the fact that many people have no personal physician or cannot gain access to one. It is difficult to determine those outpatient visits which were true emergencies and those which could have been handled as a less expensive routine visit by a physician. This problem of access caused by a geographic and specialty maldistribution could account for the higher rate of outpatient visits per patient.

As mentioned before, one of the reasons for the price increases for outpatient care was inflation. Another reason can be found in the very nature of an outpatient visit. Once a recipient becomes a hospital outpatient, a whole range of services, including laboratory work, X-rays, medical supplies, physicians' services, emergency room fees, medication, and others may be provided. An increase in services could stem from the physician's desire to avoid malpractice suits. In addition, the increasing sophistication of new techniques and procedures might lead the practitioner to use more expensive services or tests in the diagnosis of illnesses.

Hopefully, this examination of some of the factors involved in the payment changes from FY '79 to FY '80 pinpoints the areas most costly to the Medicaid program, as well as those areas which helped to curtail the escalating cost of providing medical care to Alabama's needy population.

MEDICAID'S IMPACT

Medicaid not only influences the health of Alabama's citizens, it also produces economic benefits — both direct and indirect.

The direct economic benefits include the jobs and payrolls in health care industries. Indirect benefits include jobs and payrolls in other fields. Increasing the number of health care workers means increased demand for food, clothing, shelter, and all other goods and services.

A widely used study of the multiplier effect in Alabama* provides formulas for estimating the economic impact of both private and public enterprises. The effect of a service industry such as Medicaid, is such that our $271 million expenditure in FY '80 would be expected to create a total payroll for these workers of $296 million a year which is 9% more than the total spent by Medicaid for all purposes.

The two economic benefits cited above
increases in employment
increases in payrolls
in turn, stimulate several other economic benefits
increases in construction work
increases in retail and wholesale sales
increases in taxes collected.

The economic effects of Medicaid are felt in all 67 counties, though it is not spread evenly. Plate 3 shows how much was spent per eligible in each county this year. The median county is Blount where Medicaid payments averaged $588 per eligible. In past years most urban counties have been above this median. This is still true, but a shift is taking place. This year Blount County moved up to the median position, while two other urban counties — Madison and Houston — are below the median.

**The Structure of the Alabama Economy: An Input-Output Analysis*, by Wayne C. Curtis; First Printing February, 1972; published by the Agricultural Experiment Station at Auburn University.

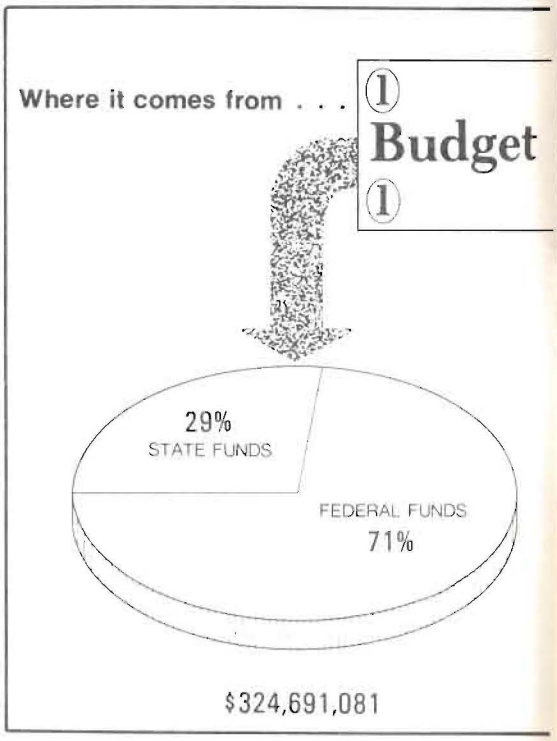
FY '80 PLATE 3

COUNTY IMPACT

Year's expenditure per eligible

County	Benefit Payments	Eligibles	Dollars per Eligible
Autauga	$1,596,370	3,337	$478
Baldwin	3,619,791	5,273	686
Barbour	2,277,238	4,436	513
Bibb	1,337,638	1,605	833
BLOUNT (median)	1,503,521	2,558	588
Bullock	902,684	2,647	341
Butler	2,062,883	3,770	547
Calhoun	6,774,385	11,146	608
Chambers	2,823,897	4,829	585
Cherokee	915,627	1,426	642
Chilton	1,520,898	2,772	549
Choctaw	1,180,860	3,555	332
Clarke	2,037,527	4,747	429
Clay	1,334,405	1,440	927
Cleburne	661,782	1,039	637
Coffee	2,002,247	3,586	558
Colbert	2,883,736	4,336	665
Conecuh	1,292,047	3,101	417
Coosa	690,452	1,335	517
Covington	3,375,577	4,516	747
Crenshaw	1,810,519	2,651	683
Cullman	4,304,407	4,845	888
Dale	2,317,831	3,163	733
Dallas	4,513,668	11,621	388
DeKalb	3,780,157	5,030	752
Elmore	5,928,060	4,398	1,348
Escambia	2,637,893	4,580	576
Etowah	6,856,332	9,162	748
Fayette	1,237,303	1,727	716
Franklin	2,877,267	3,313	868
Geneva	1,192,246	3,289	362
Greene	965,362	3,632	266
Hale	1,866,195	3,694	505
Henry	7,694,423	2,657	299
Houston	3,670,373	7,917	463
Jackson	2,211,368	4,329	511
Jefferson	42,144,333	65,400	644
Lamar	1,664,707	1,955	852
Lauderdale	4,387,636	5,968	735
Lawrence	2,351,462	3,840	612
Lee	2,841,250	5,784	491
Limestone	2,532,944	4,247	596
Lowndes	1,243,656	4,286	290
Macon	2,879,274	5,860	491
Madison	6,923,048	13,583	510
Marengo	2,260,480	5,329	424
Marion	2,350,554	2,617	898
Marshall	4,411,125	6,017	733
Mobile	25,965,539	40,169	646
Monroe	1,491,518	3,415	437
Montgomery	13,375,347	20,767	644
Morgan	11,087,753	7,619	1,455
Perry	1,621,693	3,778	429
Pickens	2,495,525	4,969	502
Pike	2,438,053	4,677	521
Randolph	1,951,523	2,429	787
Russell	2,815,147	5,048	558
Shelby	2,732,435	3,968	689
St. Clair	2,585,258	3,149	821
Sumter	1,916,020	4,350	440
Talladega	5,620,258	10,830	519
Tallapoosa	4,662,231	4,932	945
Tuscaloosa	10,038,392	14,466	694
Walker	5,393,906	7,007	770
Washington	961,879	2,087	461
Wilcox	1,538,737	5,131	300
Winston	2,106,172	1,892	1,113

REVENUE, EXPENDITURES AND PRICES



SOURCES OF MEDICAID REVENUE	PLATE 5
Federal Funds	$230,566,852
State Funds	94,124,229
Total Revenue	324,691,081

FY '80
COMPONENTS OF FEDERAL FUNDS PLATE 6

	Dollars	Matching Rate
Professional staff costs	$4,421,932	75.00%
Family planning administration	118,164	90.00%
Other staff costs	1,353,621	50.00%
Other provider services	223,108,935	71.32%
Family planning services	1,564,200	90.00%
Buy-in fees for "no-money" eligibles	0	0%
	$230,566,852	71.01%

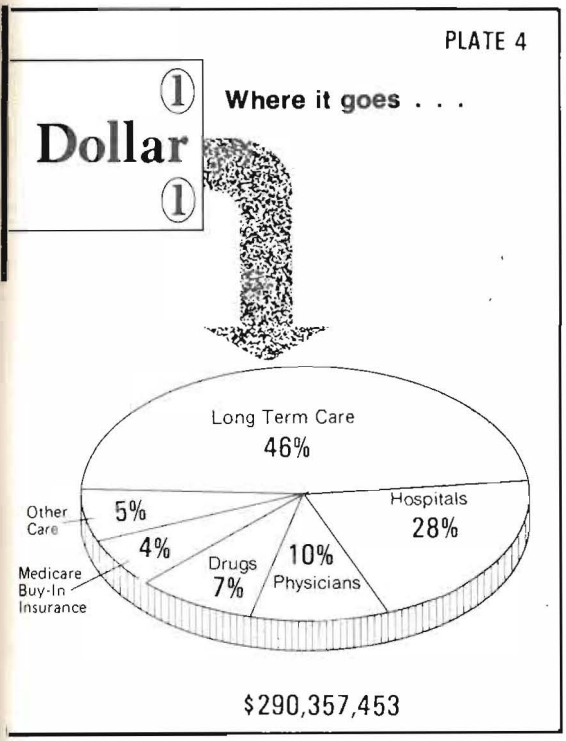
FY '80
COMPONENTS OF STATE FUNDS PLATE 7

	Dollars
Encumbered balance forward	$ 73,815
Basic Appropriations	66,000,000
Supplemental appropriations	27,900,000
Reimbursement from Pensions & Security and Mental Health	4,310,408
Interest Income from Fiscal Intermediary	300,314
Miscellaneous Contributions	100
	$98,584,637
Encumbered	4,460,408
	$94,124,229

FY '80
MEDICAID'S PORTION OF TOTAL STATE FUNDS PLATE 8

	State Funds	Federal Funds	Total Current Funds
All Expenditures of Alabama's State Government	$5,279,144,822	$995,983,818	$6,275,128,640
Medicaid Program	94,124,229	230,566,852	324,691,081
All Other Programs	5,185,020,593	765,416,966	5,950,437,559

PLATE 4



In FY '80, it would appear that Medicaid's revenues exceeded its expenditures.

Revenues from both state and federal sources totalled $324.7 million (See Plates 5 through 8), but expenditures for the year, as shown on Plate 9, came to only $290.4 million. The difference of $34.3 million represents unpaid bills left over from FY '79 which were paid with FY '80 revenues.

FY '80 PLATE 9

EXPENDITURES

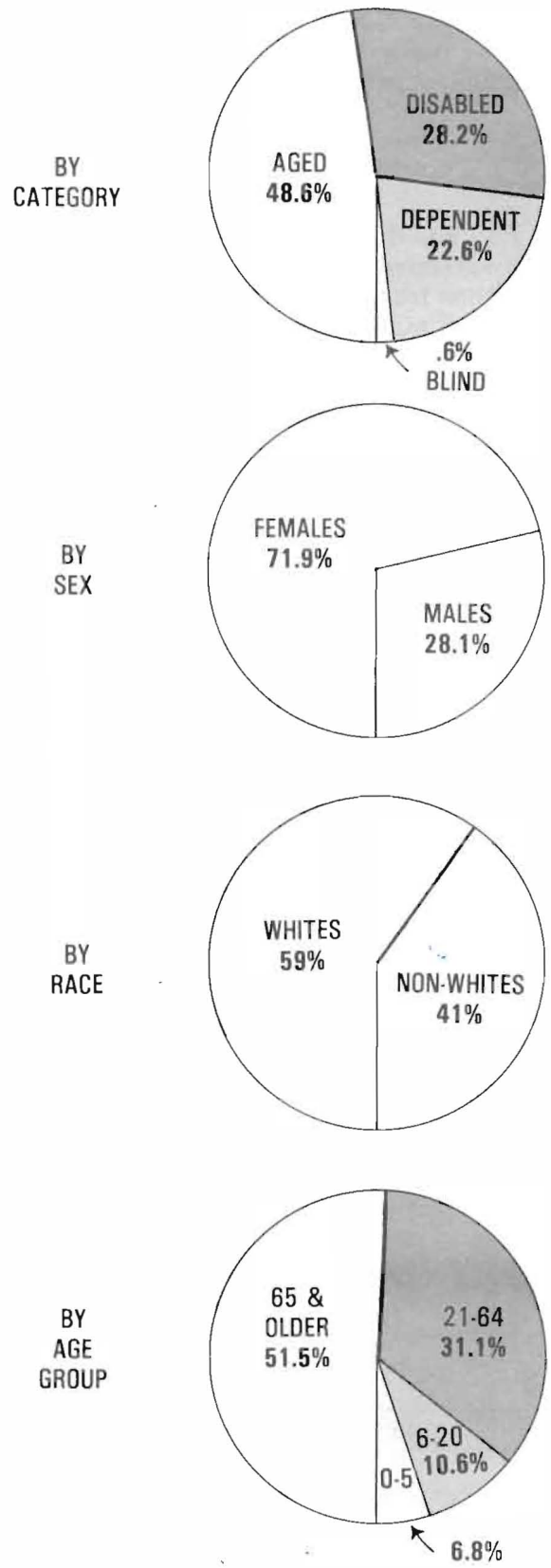
By type of service

Service	Payments	Percent Of Payments By Service FY '80		Percent Of Payments By Service FY '79		Percent Of Payments By Service FY '78	
Skilled Nursing Care	$ 37,342,728	13.24%		17.39%		22.66%	
Intermediate Nursing Care	93,005,441	32.99%	>46.23%	22.09%	>39.48%	21.90%	>44.56%
Hospital Inpatients	68,980,856	24.46%		27.58%		23.84%	
Hospital Outpatients	9,468,488	3.36%	>27.82%	3.04%	>30.62%	2.71%	>26.55%
Physicians' Services	27,575,776	9.78%		11.39%		9.46%	
Medicare Buy-In Insurance	12,572,352	4.46%		4.53%		4.24%	
Drugs	19,812,057	7.03%		8.38%		8.90%	
Dental Services	3,668,533	1.30%		1.59%		1.72%	
Lab & X-Ray	3,752,480	1.33%		1.45%		2.33%	
Family Planning Care	1,488,264	.53%		.49%		0.38%	
Eye Care	1,577,968	.56%		.77%		0.63%	
Screening	924,909	.33%		.44%		0.51%	
Home Health	1,411,594	.50%		.74%		0.62%	
Transportation	207,195	.07%		.07%		0.08%	
Hearing Care	54,298	.02%		.03%		0.03%	
Other Care	104,679	.04%		.02%			
Total For Medical Care	$281,947,619	100.0%		100.0%		100.0%	
Administrative Costs	8,409,834						
Net Payments	$290,357,453						

FY '80 PLATE 10

PAYMENTS

By Category, sex, race, age group



The percentage of the money spent on each category, sex, race, and age group never changes much from one year to the next. The groups that continue to cost the most money are the aged, the females, and the whites. Although the aged and disabled comprised less than one-half of those receiving Medicaid services, more than three-fourths of the total Medicaid payments were made on the behalf of these two categories of eligibles.

The relative amount of money Medicaid spends in each county also changes little from year to year. (See Plate 11.)

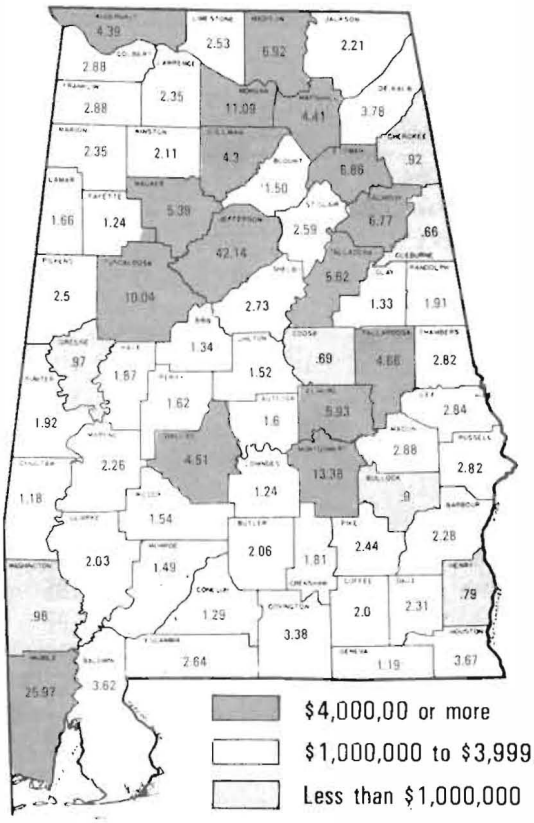
The eight counties where the most money was spent last year are still the top eight this year. The seven counties where the least was spent in FY '79 are still the least expensive this year.

Inspection of the map in Plate 11 shows that with a few exceptions, counties with or near the biggest cities have the most money paid for their recipients.

FY '80 PLATE 11

PAYMENTS

By county



PRICES

One of the many different factors which contribute to rising medical care costs is the price of each unit of medical service. Plate 12 shows the average unit price per quarter of each of the six major health care services paid for by Medicaid. Also depicted are the money and percent changes from the first quarter to the fourth quarter.

As usual, prices climbed each quarter, though this year they climbed more steeply than last year. For example, last year the price per day for SNF care rose 8.3%, while this year the price increased 31.2%.

Note that as the year ended, the average cost per day for ICF care was higher than the cost per day for skilled care. This sounds impossible, particularly since Medicaid now follows a policy of paying the same rate for both skilled care and ICF care. This "same rate policy" means that in any one nursing home Medicaid pays the same price per day for skilled care that it pays for ICF care. But the rate is not identical from one home to another. Some homes charge more than others. When homes whose rates are above average have more ICF beds than skilled beds, then the statewide average for ICF care is higher than that for skilled care.

FY '80 PLATE 12

PRICES

Unit price per service, by quarter

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Change From 1st Qtr.	
					Dollars	Percent
Nursing Home Days						
Skilled	$ 20.16	$ 21.33	$ 24.55	$ 26.46	+$ 6.30	+31.2%
ICF*	20.46	21.99	24.95	26.99	+ 6.53	+31.9%
Inpatient Days	138.97	151.12	149.44	151.86	+ 12.89	+ 9.3%
Physicians' Visits	14.30	15.90	16.55	15.69	+ 1.39	+ 9.7%
Prescriptions	6.71	6.72	6.84	6.95	+ .24	+ 3.6%
Outpatient Visits	18.40	19.87	21.44	21.42	+ 3.02	+16.4%

*Excludes ICF-MR

POPULATION AND ELIGIBLES

Population

The population of Alabama grew from 3,444,165 in 1970 to an estimated 3,827,800 in 1980.

This increase of approximately 11.1% had a discernable effect on the Medicaid program. Specifically, the majority of eligibles come from the dependent portion of the population (those under 21 and over 64 years of age). In 1970 this group represented 41.3% of the total. In 1980 this portion had risen to over 47.6%. The 65-and-over age group contributed most to the growth in that the elderly population increased by 30%.

Economic conditions affect the Medicaid program as well, since slow periods of economic growth contribute to an increase in application for public assistance.

Federal policy has contributed to an increase in eligibles since the definition of disability has been liberalized. Such a change has added an increasingly large number of persons from the non-dependent portion of the population (21-64).

FY '72-'80 PLATE 13

POPULATION

Eligibles as percent of Alabama population by year, 1972 to 1980.

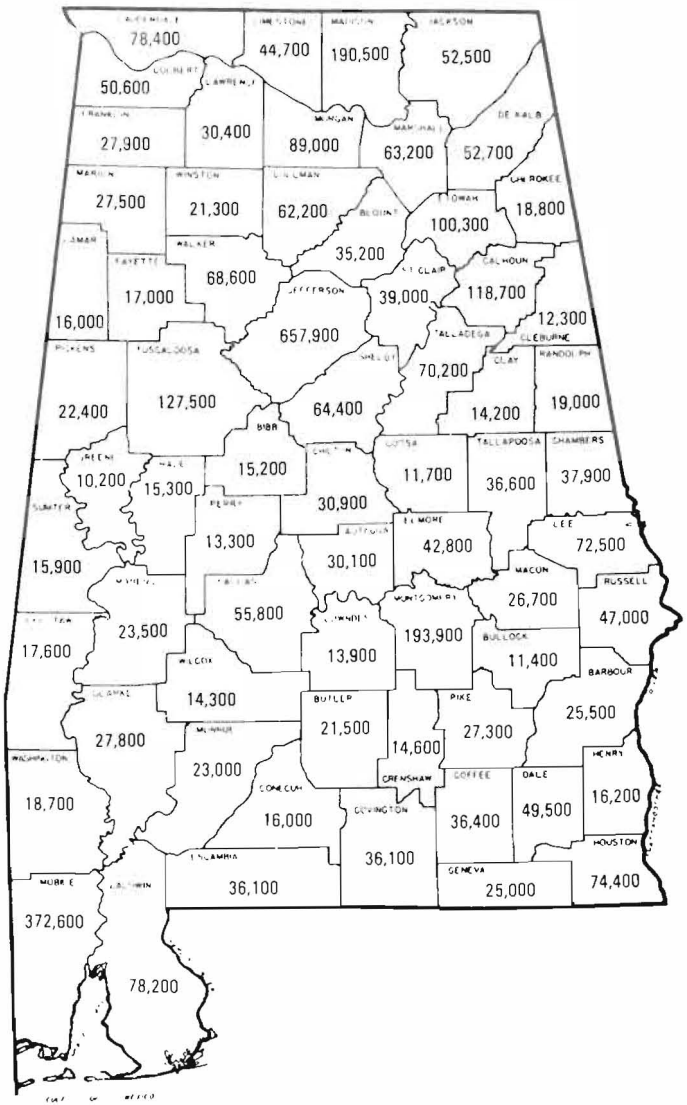
Year	Population	Monthly Average Eligibles	Percent
1972	3,510,581 est.	291,437	8.30
1973	3,543,789 est.	303,344	8.55
1974	3,577,000**	303,310	8.47
1975	3,615,000**	323,887	8.96
1976	3,653,000**	324,920	8.89
1977	3,690,000**	331,891	8.99
1978	3,742,000**	332,999	8.90
1979	3,769,000**	338,847	8.99
1980	3,827,800 est.	339,417	8.87

**U.S. Bureau of Census official estimate.

CY '80 PLATE 14

POPULATION

1980 population estimates, by county

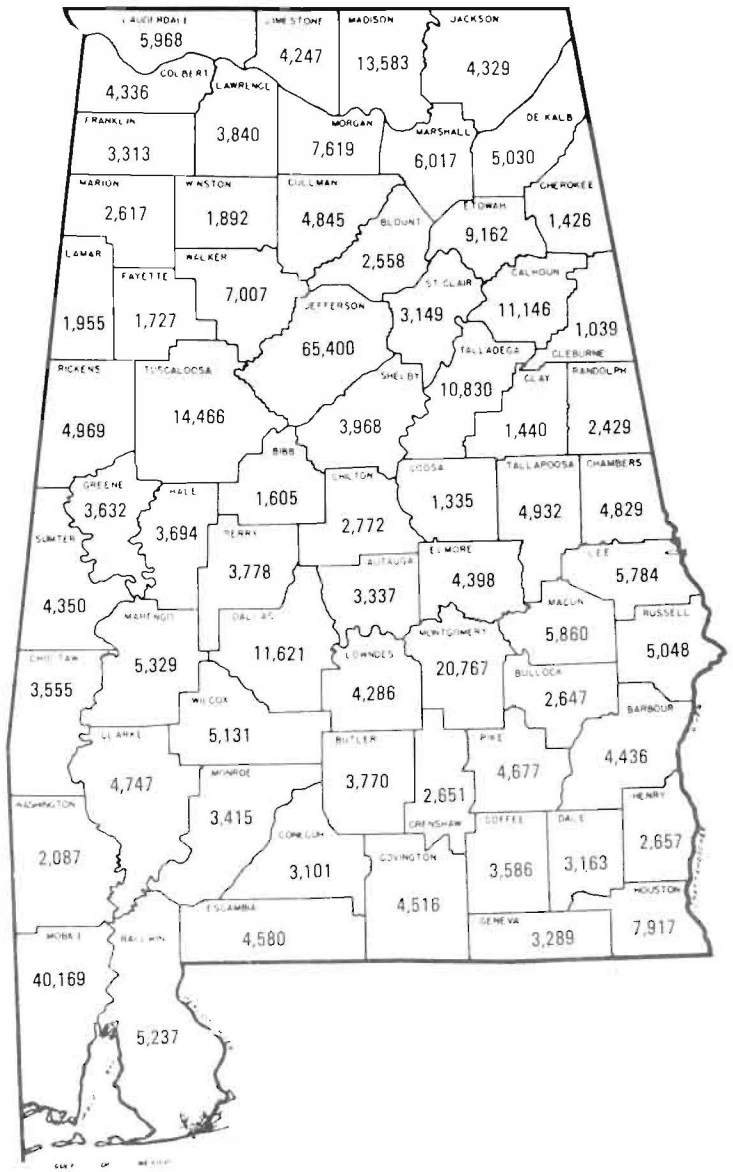


FY '80

PLATE 15

ELIGIBLES

Number of Medicaid eligibles by county

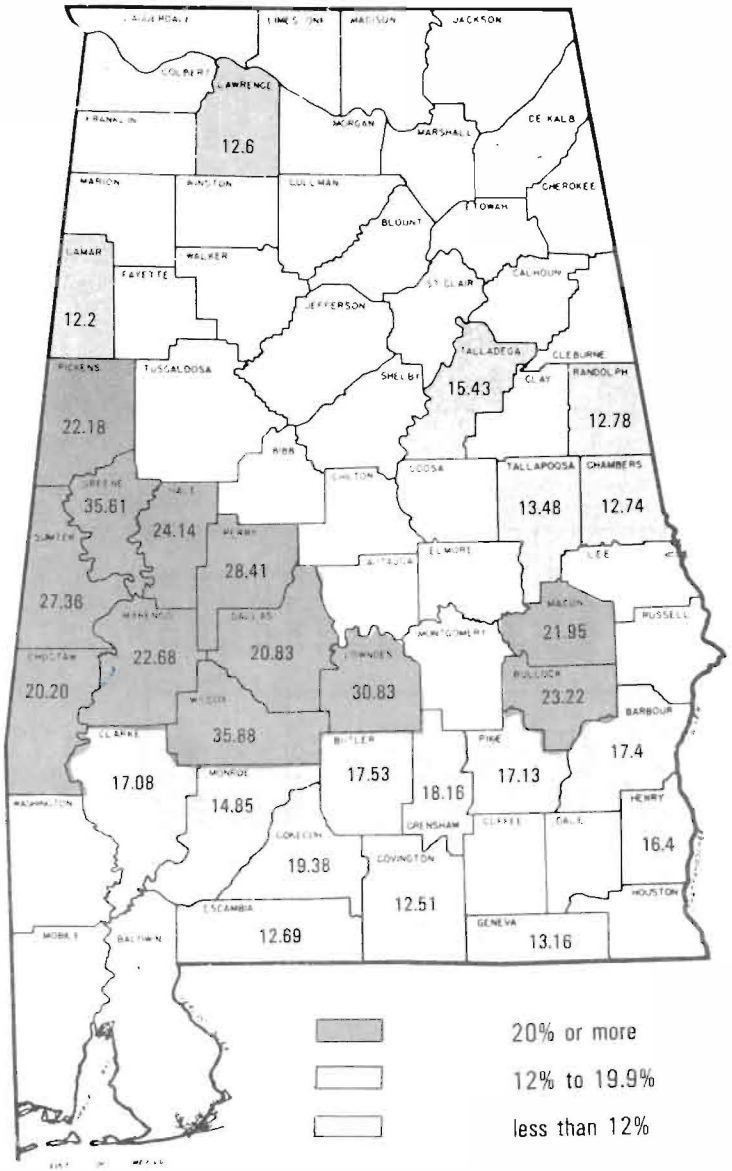


FY '80

PLATE 16

ELIGIBLES

Percent of population eligible for Medicaid by county



FY '80 PLATE 17

ELIGIBLES
All Categories
Three ways to count the number of eligibles

	–1– Current Counts	–2– Cumulative Counts	–3– Monthly Averages
Oct. '79	348,415	348,415	348,415
Nov.	339,335	354,650	343,875
Dec.	337,898	360,888	341,883
Jan. '80	339,790	368,109	341,360
Feb.	340,687	375,067	341,225
Mar.	340,306	382,209	341,072
Apr.	338,252	388,737	340,669
May	337,869	395,403	340,319
June	336,092	402,066	339,849
July	337,318	409,089	339,596
Aug.	338,673	416,302	339,512
Sept.	338,366	423,031	339,417

Eligibles

For a complete picture of eligibility one needs to make three kinds of counts:

current counts,
cumulative counts,
average counts.

Each type of count has a different use with the most useful and informative being the monthly average for the whole year. This is the number that should be used for making comparisons between eligibles in different states or different years. The monthly average for 1980 was about 339,400, an increase of nearly 600 over last year's average of 338,800.

The cumulative count shows that during the year, 423,031 persons were eligible for at least one month. The highest monthly count was 348,415 in October (See Plate 17).

FY '80 PLATE 18

ELIGIBLES
By category, sex, race, age
Total number for year
Average number per month

	First Month	Number Added During Year	Total Number For Year	Number Dropped During Year	Final Month	Average Number Per Month	Annual Turnover Rate
ALL CATEGORIES	348,415	74,616	423,031	84,665	338,366	339,417	24.6%
AGED, Category 1	96,187	13,127	109,314	18,253	91,061	96,667	13.1%
BLIND, Category 2	2,025	205	2,230	236	1,994	1,962	13.7%
DISABLED, Category 4	60,808	8,456	69,264	8,602	60,662	58,386	18.6%
DEPENDENT, Categories 3, 6, 7 & 8	189,395	52,828	242,223	57,574	184,649	182,402	33.8%
MALES	123,094	28,035	151,129	32,211	118,918	119,891	26.1%
FEMALES	225,321	46,581	271,902	52,454	219,448	219,526	23.9%
WHITES	128,050	30,207	158,257	34,338	123,919	124,536	27.1%
NONWHITES	220,365	44,409	264,774	50,327	214,447	214,881	23.2%
AGE 0-5	37,505	20,397	57,902	12,709	45,193	40,961	41.4%
AGE 6-10	106,281	23,759	130,040	28,935	101,105	102,805	26.5%
AGE 21-64	88,139	22,670	110,809	25,763	85,046	85,273	29.9%
AGE 65 & Over	116,490	7,790	124,280	17,258	107,022	110,378	12.6%

Plate 18 shows how this year's eligibles were divided in regard to category, sex, race, and age. The average and cumulative counts allow three measures to be calculated for each group:

number of new eligibles in the year,
number of old eligibles dropped in the year,
the turnover rate.

Annual Turnover Rate: There is a constant turnover among Medicaid eligibles which, in Alabama, has averaged about 23% per year. The annual turnover measures the rate at which "old" eligibles are replaced by "new" eligibles. Each category, sex, race, and age group has a different turnover rate, as shown in Plate 18.

Annual Changes in the Number of Eligibles: The total number of Alabama citizens eligible for Medicaid increased by 9,226 in FY '80. Plate 20 shows that the number of eligibles changed each year during the past 5 years, and between FY '76 and FY '80, the monthly averages rose more rapidly than the yearly totals. Specifically, from FY '76 to FY '80 the monthly average for all categories rose from 324,920 to 339,417, an increase of 4.5%; however, during the same time the yearly totals rose from 406,497 to 423,031 for a 4.1% increase.

FY '80 PLATE 19

ELIGIBLES

Year's total

Distribution by category, sex, race, and age

	Number	Percent
All Categories	423,031	100%
Aged, Category 1	109,314	25.8%
Blind, Category 2	2,230	.5%
Disabled, Category 4	69,264	16.4%
Dependent, Categories 3, 6, 7 & 8	242,223	57.3%
Males	151,129	35.7%
Females	271,902	64.3%
White	158,257	37.4%
Nonwhites	264,774	62.6%
Age 0-5	57,902	13.7%
Age 6-10	130,040	30.7%
Age 21-64	110,809	26.2%
Age 65 & Over	124,280	29.4%

The number of aged individuals is decreasing, as shown by both monthly averages and yearly totals, even though their numbers are rising in the general population. The dependent and disabled categories continued to increase in size.

FY '76-'80 PLATE 20

ELIGIBLES

By category

Monthly average

Annual number

		FY '76	FY '77	FY '78	FY '79	FY '80
MONTHLY AVERAGES	AGED, Category 1	109,108	109,856	100,994	98,284	96,667
	BLIND, Category 2	2,047	1,991	1,998	1,998	1,962
	DISABLED, Category 4	45,846	49,153	54,374	57,467	58,386
	DEPENDENT, Categories 3, 6, 7 & 8	167,919	170,891	175,643	181,098	182,402
	ALL CATEGORIES	324,920	331,891	332,999	338,847	339,417
YEARLY TOTALS	AGED, Category 1	125,648	119,271	111,832	108,534	109,314
	BLIND, Category 2	2,352	2,228	2,180	2,215	2,230
	DISABLED, Category 4	60,111	63,417	62,654	67,260	69,264
	DEPENDENT, Categories 3, 6, 7 & 8	218,386	228,218	226,664	235,796	242,223
	ALL CATEGORIES	406,497	413,134	403,330	413,805	423,031

FY '80 PLATE 21

ELIGIBLES

By category, sex, race, and age
Total MME used by each group
Average MME used by each person

	Total MME Used In Year	Average MME Per Person
ALL ELIGIBLES	4,073,001	9.6
AGED, Category 1	1,160,005	10.6
BLIND, Category 2	23,546	10.6
DISABLED, Category 4	700,628	10.1
DEPENDENT, Categories 3, 6, 7 and 8	2,188,822	9.0
MALES	1,438,695	9.5
FEMALES	2,634,306	9.7
WHITES	1,494,427	9.4
NONWHITES	2,578,574	9.7
AGE 0-5	491,530	8.5
AGE 6-20	1,233,663	9.5
AGE 21-64	1,023,274	9.2
AGE 65 & Over	1,324,534	10.7

Man-Months and Expected Duration of Eligibility: Although 423,031 people were eligible for Medicaid in FY '80, only about three-fourths were eligible all year. The others ranged from one month of eligibility to eleven months.

To find the total amount of time all these people were eligible in FY '80, one should add the total number of eligibles in each of the twelve months. Thus, the total number of man-months of eligibility (MME) used by the entire group all year was 4,073,001, producing an average of 9.6 MME per person.

Plate 21 shows the total number of MME used by each category, sex, race, and age group, and gives the average number of MME used by each group.

The number of months a group takes for 100% turnover also discloses the number of months the average member of that group will remain eligible. Plate 22 shows that the expected duration of eligibility varies from one group to another.

FY '78-'80 PLATE 22

ELIGIBLES

Annual changes in expected duration of eligibility

	EXPECTED DURATION OF ELIGIBLITY			
	Based On Turnover in FY '78	Based On Turnover in FY '79	Based On Turnover in FY '80	Percent Change FY '79 FY '80
ALL ELIGIBLES	57 mo.	54 mo.	49 mo.	−9.3%
AGED, Category 1	112 mo.	115 mo.	92 mo.	−20.0%
BLIND, Category 2	124 mo.	110 mo.	88 mo.	−20.0%
DISABLED, Category 4	79 mo.	71 mo.	64 mo.	−9.9%
DEPENDET, Categories 3, 6, 7 & 8	41 mo.	40 mo.	36 mo.	−10.0%
MALES	54 mo.	52 mo.	46 mo.	−11.5%
FEMALES	59 mo.	56 mo.	50 mo.	−10.7%
WHITES	52 mo.	49 mo.	44 mo.	−10.2%
NONWHITES	60 mo.	57 mo.	52 mo.	−8.8%
AGE 0-5	43 mo.	36 mo.	29 mo.	−19.4%
AGE 6-20	49 mo.	48 mo.	45 mo.	−6.3%
AGE 21-64	49 mo.	45 mo.	40 mo.	−11.1%
AGE 65 & Over	115 mo.	108 mo.	95 mo.	−12.0%

RECIPIENTS

Of the 423,031 people deemed eligible for Medicaid in FY '80, only 77% actually received Medicaid benefits. These 324,364 people are called "recipients." The other 98,667, though eligible for benefits, incurred no medical bills paid for by Medicaid.

Plate 23 shows monthly counts of recipients as well as running monthly averages, with the September figure being the monthly average for FY '80. By comparing this figure of 141,532 to the corresponding figure for FY '79, (151,493), it became apparent that there was a 6.6% decrease in the number of persons receiving Medicaid services each month.

FY '80 PLATE 23

RECIPIENTS

All categories

Monthly and average number of recipients

	Current Counts	Monthly Averages
Oct. '79	124,371	124,371
Nov.	165,275	144,823
Dec.	145,717	145,121
Jan. '80	146,763	145,532
Feb.	134,414	143,308
Mar.	128,151	140,782
Apr.	155,106	142,828
May	136,181	141,997
June	133,303	141,031
July	150,387	141,967
Aug.	137,922	141,599
Sept.	140,793	141,532

FY '80 PLATE 24

RECIPIENTS

By category, sex, race, age

Number of recipients and nonrecipients during year

	Total Recipients in Year	Non-Recipients	Recipients as A Percent of Eligibles
AGED, Category 1	91,784	17,530	84.0%
BLIND, Category 2	1,759	471	78.9%
DISABLED, Category 4	56,973	12,291	82.3%
DEPENDENT, Categories 3, 6, 7 & 8	173,848	68,375	71.8%
MALES	105,911	45,218	70.1%
FEMALES	218,453	53,449	80.3%
WHITES	121,361	36,896	76.7%
NONWHITES	203,003	61,771	76.7%
AGE 0-20	135,353	52,589	72.0%
AGE 21-64	84,196	26,613	76.0%
AGE 65 & Over	104,815	19,465	84.3%
ALL CATEGORIES	324,364	98,667	76.7%

FY '80 PLATE 25

RECIPIENTS

By category, sex, race, age
Monthly counts
Year's total
MMS per category, and per recipient

	Recipients First Month	Recipients Final Month	Recipients Average Month	Total Man-Months of Medical Service	Total Recipients During Year	MMS Per Recipient
AGED, Category 1	53,903	58,837	57,740	692,886	91,784	7.55
BLIND, Category 2	855	975	965	11,574	1,759	6.58
DISABLED, Category 4	28,476	32,827	32,315	387,775	56,973	6.81
DEPENDENT, Categories 3, 6, 7 & 8	41,137	48,154	50,512	606,148	173,848	3.49
MALES	N/A	N/A	N/A	N/A	105,911	N/A
FEMALES	N/A	N/A	N/A	N/A	218,453	N/A
WHITES	N/A	N/A	N/A	N/A	121,361	N/A
NONWHITES	N/A	N/A	N/A	N/A	203,003	N/A
AGE 0-20	N/A	N/A	N/A	N/A	135,353	N/A
AGE 21-64	N/A	N/A	N/A	N/A	84,196	N/A
AGE 65 & Over	N/A	N/A	N/A	N/A	104,815	N/A
ALL CATEGORIES	124,371	140,793	141,532	1,698,383	324,364	5.24

To determine the frequency with which recipients availed themselves of Medicaid services, a unit of measure called man-months of service (MMS) is used. The total number of MMS that Medicaid pays for in a month is equal to the number of recipients for that month, regardless of the dollar amount spent on each recipient. The total MMS Medicaid paid for all year is found by adding the MMS paid for in each of the twelve months.

The total MMS used by the 324,364 recipients in FY '80 was 1,698,383. (See Plate 25.) This represents an average of 5.24 MMS per recipient, down 4.6% from the 5.49 MMS per recipient in FY '79.

USE AND COST

Use

Three measures of use are significant:
utilization rate
frequency of service rate,
ratio of actual use to potential use.

Utilization Rate: This rate is calculated by dividing the number of recipients by the number of eligibles. The result is the percent of the eligibles who received medical care during the year. This year the rate was approximately three persons out of four, with 76.7% being the exact figure. (See Plate 26.)

FY '78-'80 PLATE 26

USE

Utilization rate by category

	FY '78	FY '79	FY '80
AGED, Category 1	90.9%	91.1%	84.0%
BLIND, Category 2	78.7%	80.5%	78.9%
DISABLED, Category 4	83.5%	83.1%	82.3%
DEPENDENT, Categories 3, 6, 7 & 8	67.9%	74.0%	71.8%
ALL CATEGORIES	76.7%	80.0%	76.7%

Frequency-of-Service Rate: Adding the number of recipients from each of the months in the fiscal year gives the number of man-months of Medicaid service. Then, dividing the total MMS by the year's unduplicated count of recipients gives the frequency-of-service rate. (See Plate 27.)

MMS figures measure the number of months in which service was used rather than the number of services used. Therefore, the rate this year of 5.24 means that the average recipient received medical care during 5.24 months.

FY '78-'80 PLATE 27

USE

Frequency-of-service rate (MMS per recipient)

	FY '78	FY '79	FY '80
AGED, Category 1	7.57MMS	7.66MMS	7.55MMS
BLIND, Category 2	6.85MMS	6.79MMS	6.58MMS
DISABLED, Category 4	6.72MMS	6.98MMS	6.81MMS
DEPENDENT, Categories 3, 6, 7 & 8	4.08MMS	3.81MMS	3.49MMS
ALL CATEGORIES	5.69MMS	5.49MMS	5.24MMS

Ratio of Actual Use to Potential Use: The maximum demand for medical care would exist if every eligible person asked for medical care every month. However, only about 77% of Medicaid's eligibles become recipients of medical services. These recipients ask for medical care on an average of only 5.24 months each. Subsequently, the actual demand for care is about 33% of the potential demand. A more precise measure of the ratio of actual use to potential use is provided by calculating the MMS per eligible. (See Plate 28.)

FY '80 PLATE 28

USE

MMS per eligible
Ratio of actual use to potential use

AGED, Category 1	6.34MMS
BLIND, Category 2	5.19MMS
DISABLED, Category 4	5.60MMS
DEPENDENT, Categories 3, 6, 7 & 8	2.50MMS
ALL CATEGORIES	4.01MMS

Cost

Cost per person can be measured in two ways, cost per eligible or cost per recipient. Cost per recipient is measured in all states and is the cost figure needed to compare Alabama costs to similar costs elsewhere.

Cost per eligible is not measured in other states and thus cannot be used for comparison. It is useful, however, for budgeting purposes. Data on costs per eligible help predict how much more money will be needed as the number of eligibles increases each year.

Cost Per Eligible: Plate 29 shows the variation in cost per eligible from one group to another. An aged person, for example, costs Medicaid nearly five times as much per year as a young eligible. The variations in cost per eligible can be attributed to the fact that different groups use different kinds of services in different amounts.

In an aged eligible's period of eligibility, he costs about ten times as much as the young eligible. In addition to using services more often and using more expensive services, the aged person remains eligible longer than the child.

Plate 29 shows the yearly cost per eligible for the past three years. All groups of eligibles in FY '80 showed a decline in costs, with only four exceptions. They were the males, the disabled, the age 0-5 group, and those aged 65 and over. In spite of a larger number of eligibles, the average cost for each was $623, which is a decrease of 3.1% from the previous year. Plate 30 shows cost per period of eligibility.

FY '78-'80 PLATE 29

COST

Annual changes in cost per eligible

	FY '78	FY '79	FY '80	Change From FY '79
AGED, Category 1	$955	$1,167	$1,142	– 2.1%
DISABLED, Category 4	761	995	1,090	+ 9.5%
AGE 65 & Over	923	1,080	1,085	+ .5%
WHITES	807	1,044	979	– 6.2%
AGE 21-64	576	869	756	–13.0%
FEMALES	558	729	696	– 4.5%
BLIND, Category 2	568	768	683	–11.1%
ALL ELIGIBLES	500	643	623	– 3.1%
MALES	397	490	492	+ .4%
NONWHITES	321	423	410	– 3.1%
AGE 0-5	194	247	299	+21.1%
DEPENDENTS, Categories 3, 6, 7 & 8	202	300	254	–15.3%
AGE 6-20	162	231	212	– 8.2%

FY '80 PLATE 30

COST

Cost per eligible

	Cost Per MME	Cost Per Year	Cost Per Period of Eligiblity
AGED, Category 1	$108	$1,142 for 10.6 MME	$9,936 for 92 MME
AGE 65 & Over	101	1,085 for 10.7 MME	9,595 for 95 MME
DISABLED, Category 4	108	1,090 for 10.1 MME	6,912 for 64 MME
BLIND, Category 2	64	683 for 10.6 MME	5,632 for 88 MME
WHITES	104	979 for 9.4 MME	4,576 for 44 MME
FEMALES	72	696 for 9.7 MME	3,600 for 50 MME
AGE 21-64	82	756 for 9.2 MME	3,280 for 40 MME
ALL ELIGIBLES	65	623 for 9.6 MME	3,185 for 49 MME
MALES	52	492 for 9.5 MME	2,392 for 46 MME
NONWHITES	42	410 for 9.7 MME	2,184 for 52 MME
AGE 0-25	35	299 for 8.5 MME	1,015 for 29 MME
DEPENDENT, Categories 3, 6, 7 & 8	28	254 for 9.0 MME	1,008 for 36 MME
AGE 6-20	22	212 for 9.5 MME	990 for 45 MME

Cost Per Recipient: Section 3 of Plate 31 discloses that Medicaid averaged paying $1,287 for each disabled person who became a hospital patient, but only $287 per aged inpatient. The average that Medicaid paid for aged was low because Medicare paid the major part of the bill.

Over 90% of the aged people on Medicaid were also eligible for Medicare. Smaller percentages of Medicaid's blind and disabled qualified for Medicare.

For hospital care, Medicare paid more than half of each bill. For five other services listed in Plate 31 Medicare also paid significant, but smaller, fractions of each bill, thus saving Medicaid millions of dollars. For this coverage Medicaid paid to Medicare a monthly "buy-in" fee or premium for each Medicaid eligible who was also on Medicare. The fee was $8.70 per month until July 1, when it rose to $9.60. Medicaid's total payment to Medicare for these buy-in premiums in FY '80 was $12,572,352. Medicare spent considerably more than $13 million in partial payment of medical bills incurred by Alabama citizens on Medicaid.

FY '80

USE AND COST

Year's cost per service by category
Year's total number of recipients by service and category
Year's cost per recipient by service and category
Utilization rates by service and category

		SERVICES WHOSE COSTS ARE SHARED WITH MEDICARE							
		Physicians' Services	Lab & X-Ray	Hospital+ Inpatients	Hospital Outpatients	Home Health	Transportation	Drugs	Nursing Homes Skilled++
SECTION 1 YEAR'S COST	ALL CATGORIES	$28,926,929	$3,747,015	$59,921,858	$11,568,775	$1,493,896	$207,195	$19,983,722	$38,284,359
	Category 1 Aged	5,497,211	33,092	7,132,198	1,262,591	871,555	6,775	11,303,525	31,304,696
	Category 2 Blind	249,660	35,006	500,731	79,182	23,602	2,321	171,351	126,937
	Category 4 Disabled	8,413,485	1,454,582	20,944,156	3,909,428	573,327	103,142	6,357,821	6,841,160
	Categories 3, 6, 7 & 8 Dependent Children	6,142,092	838,859	13,081,589	3,512,209	6,449	38,476	750,178	7,352
	Category 3 & 6 Dependent Adults	8,624,481	1,385,476	18,263,184	2,805,365	18,963	56,481	1,400,847	4,214
SECTION 2 YEAR'S TOTAL NUMBER OF RECIPIENTS	ALL CATEGORIES	240,435	108,329	73,228	110,774	3,389	2,959	222,525	9,528
	Category 1 Aged	72,159	1,124	24,868	23,090	2,002	420	80,470	8,139
	Category 2 Blind	1,415	684	450	637	57	29	1,443	26
	Category 4 Disabled	45,101	21,521	16,269	20,807	1,221	1,222	46,851	1,356
	Categories 3, 6, 7 & 8 Dependent Children	77,432	50,166	12,672	41,644	43	518	55,421	3
	Category 3 & 6 Dependent Adults	44,328	34,834	18,969	24,596	66	770	38,340	4
SECTION 3 YEAR'S COST PER RECIPIENT	ALL CATEGORIES	$ 120	$ 35	$ 818	$ 104	$ 441	$ 70	$ 90	$ 4,018
	Category 1 Aged	76	29	287	55	435	16	140	3,846
	Category 2 Blind	176	51	1,113	124	414	80	119	4,882
	Category 4 Disabled	187	68	1,287	188	470	84	136	5,045
	Categories 3, 6, 7 & 8 Dependent Children	79	17	1,032	84	150	74	14	2,451
	Category 3 & 6 Dependent Adults	195	40	963	114	287	73	37	1,054
SECTION 4 UTILIZATION RATES PERCENT OF ELIGIBLES	ALL CATEGORIES	56.83%	25.61%	17.31%	26.19%	.80%	.70%	52.60%	2.25%
	Category 1 Aged	66.01%	1.03%	22.75%	21.12%	1.83%	.38%	73.61%	7.45%
	Category 2 Blind	63.45%	30.67%	20.18%	28.57%	2.56%	1.30%	64.71%	1.17%
	Category 4 Disabled	65.11%	31.07%	23.49%	30.04%	1.76%	1.76%	67.64%	1.96%
	Categories 3, 6, 7 & 8 Dependents	50.27%	35.09%	13.06%	27.35%	.04%	.53%	38.71%	**

\+ Includes patients in mental hospitals

++ A small part of the cost of skilled care is paid by Medicare, but the amount is insignificant

* Not Available

** Less than 0.01 Percent

PLATE 31

SERVICES WHOSE COSTS ARE NOT SHARED WITH MEDICARE							ALL SERVICES		
Nursing Homes, ICF	Dental Care	Family Planning	Other Practitioners	Other Care	Screening	Medicare Buy-In	Total Of Unshared Costs	Medicaid's Total Part Of Shared Costs	Medicaid's Totals
$93,108,264	$3,596,696	$683,131	$114,735	$1,823,233	$924,909	$12,572,352	$171,091,401	$105,865,668	$276,957,069
66,586,008	742	186	163	803,523	0	9,861,880	119,860,723	14,803,422	134,664,145
319,780	2,790	757	190	9,820	0	0	631,625	890,502	1,522,127
26,202,476	136,605	25,909	7,661	540,737	0	2,710,472	42,822,841	35,398,120	78,220,961
0	3,021,695	79,200	10,674	266,776	924,909	0	5,060,784	23,619,674	28,680,458
0	434,864	577,079	96,047	202,377	0	0	2,715,428	31,153,950	33,869,378
14,913	42,450	16,555	2,391	39,243	32,521	N/A*	N/A*	N/A*	324,364
12,329	59	13	10	16,154	0	N/A*	N/A*	N/A*	91,784
47	33	23	2	232	0	0	N/A*	N/A*	1,759
2,537	1,611	594	67	9,795	0	N/A*	N/A*	N/A*	56,973
0	37,098	2,366	235	7,369	32,521	0	N/A*	N/A*	116,347
0	3,649	13,559	2,077	5,693	0	0	N/A*	N/A*	57,501
$ 6,243	$ 85	$ 41	$ 48	$ 46	$ 28	N/A*	N/A*	N/A*	$ 854
5,401	13	14	16	50	0	N/A*	N/A*	N/A*	1,467
6,804	85	33	95	42	0	0	N/A*	N/A*	865
10,328	85	44	114	55	0	N/A*	N/A*	N/A*	1,373
0	81	33	45	36	28	0	N/A*	N/A*	247
0	119	43	46	36	0	0	N/A*	N/A*	589
3.53%	10.03%	3.91%	.57%	9.28%	13.43%	N/A*	N/A*	N/A*	76.68%
11.28%	.05%	.01%	**	14.78%	0	N/A*	N/A*	N/A*	83.96%
2.11%	1.48%	1.03%	.09%	10.40%	0	0	N/A*	N/A*	78.88%
3.66%	2.33%	.86%	.10%	14.14%	0	N/A*	N/A*	N/A*	82.25%
**	16.82%	6.57%	.95%	5.39%	13.43%	0	N/A*	N/A*	71.77%

LONG-TERM CARE

In terms of people served, the nursing home program is small. This year 1 eligible in 17 used nursing home care.

In terms of expenditure, it is the largest program. This year 46% of Medicaid funds went for nursing home care.

The Cost of the Nursing Home Program: In the past five years, Medicaid's annual expense for nursing home care has risen from $77.6 million to $131.4 million – an increase of 69%. Plate 32 shows the annual steps by which this increase took place. Plate 32 also shows the factors that caused the increase:

more patients (up 16%)
more months of service (up 18%)
higher prices per month (up 44%)

In terms of dollars, 1980 cost $53.8 million more than 1976. Of this amount, $32.3 million (60%) is attributable to increased use. The other $21.5 million (40%) is attributable to rising prices.

FY '76-'80 PLATE 32

LONG-TERM CARE PROGRAM

Patients, months, and cost

	Number Of Nursing Home Patients (Year's Unduplicated Total)	Average Length Of Stay During Year	Total Months Paid For By Medicaid	Average Cost Per Month To Medicaid	Total Cost To Medicaid
1976	21,094	7.16 months	150,948	$514	$77,576,985
1977	24,351	6.43 months	156,516	541	84,748,904
1978	24,267	6.55 months	159,117	564	89,785,904
1979	24,624	7.29 months	177,887	591	104,995,732
1980	24,441	7.28 months	178,000	738	131,392,623
% Change Since 1976	+16%	+2%	+18%	+44%	+69%

FY '75-'80 PLATE 33

LONG-TERM CARE PROGRAM

The number and percent of beds used by Medicaid

	Nursing Home Beds In Existence At End Of Year	Medicaid Patients		Percent Of Beds Used By Medicaid	Number Of Beds Not Used By Medicaid In Average Month
		Monthly Average	Yearly Unduplicated Total		
1975	18,089	11,360	20,042	63%	6,729
1976	18,752	12,579	21,094	67%	6,173
1977	18,997	13,043	24,351	69%	5,954
1978	19,459	14,225	24,267	75%	5,234
1979	20,498	14,386	24,624	70%	6,112
1980	20,708	14,833	24,441	72%	5,875

Growth of the Nursing Home Industry in Alabama: The nursing home industry has grown rapidly since Medicaid came into existence, and Medicaid has become its principal customer. In Alabama, more than two-thirds of its business comes from Medicaid. Plate 33 shows the growth rate during the past five years, during which time 2,619 beds were added — an average of 44 per month. Plate 33 also shows how many beds Medicaid used each year.

A 1977 survey made by the Alabama Department of Public Health, concluded that the then existing number of 18,997 beds was inadequate and should be increased by 2,610 more beds.

Such surveys are made each year and in recent years it began to look as if no matter how fast beds were built, the gap between supply and demand could not be closed, or even reduced. In late 1971, the need was found to be for 1,602 new beds. By 1977, though 7,648 beds had been built, the shortage had not diminished but had worsened to 2,610.

In 1979, the State Health Planning and Development Agency changed the method it had been using to determine whether to issue certificates of need to nursing homes that applied for permission to expand. The new method includes a new formula for calculating when and where a shortage of nursing home beds exists. It is anticipated that the new formula will show a smaller need for beds than did the old formula. One result should be that henceforth the number of nursing home beds in Alabama will grow less rapidly than it did in the past decade.

FY '80 PLATE 34

LONG-TERM CARE PROGRAM

Recipients, by sex, by race, by age

	Skilled	ICF	Total	Percent
All Recipients	9,528	14,913	24,441	100%
By Sex				
Female	7,220	10,788	18,008	73.6%
Male	2,308	4,125	6,433	26.4%
By Race				
White	7,492	11,648	19,140	78.3%
Nonwhite	2,036	3,265	5,301	21.7%
By Age				
65 & Over	8,335	12,730	21,065	86.2%
21-64	1,019	2,037	3,056	12.5%
6-20	130	139	269	1.1%
0-5	44	7	51	.2%

FY '80 PLATE 35

LONG-TERM CARE PROGRAM

Length of stay, by type of care

Length of Stay	Skilled	ICF	Both
1-6 days	1,218 (12.8%)	186 (1.2%)	1,404 (5.7%)
7-30 days	713 (7.5%)	602 (4.0%)	1,315 (5.4%)
31-60 days	697 (7.3%)	901 (6.0%)	1,598 (6.5%)
61-120 days (2 to 4 months)	1,354 (14.2%)	1,637 (11.0%)	2,991 (12.2%)
121-180 days (4 to 6 months)	1,171 (12.3%)	1,500 (10.0%)	2,671 (11.0%)
181-270 days (6 to 9 months)	1,361 (14.3%)	1,920 (12.9%)	3,281 (13.4%)
271-365 days (9 to 12 months)	3,014 (31.6%)	8,167 (54.8%)	11,181 (45.8%)
	9,528 (100.0%)	14,913 (100.0%)	24,441 (100.0%)

FY '80 PLATE 36

LONG-TERM CARE PROGRAM

Payments, by sex, by race, by age

	Skilled	ICF	Total	Percent
All Recipients	$38,284,359	$93,108,264	$131,392,623	100%
By Sex				
Female	29,772,252	64,440,757	94,213,009	71.7%
Male	8,512,107	28,667,507	37,179,614	28.3%
By Race				
White	30,375,603	71,308,333	101,683,936	77.4%
Nonwhite	7,908,756	21,799,931	29,708,687	22.6%
By Age				
65 & Over	32,232,623	69,334,811	101,567,434	77.3%
21-64	4,714,835	21,538,695	26,253,530	20.0%
6-20	1,031,938	2,204,847	3,236,785	2.5%
0-5	304,963	29,911	334,874	.2%

FY '78-'80 PLATE 37

LONG-TERM CARE PROGRAM

Number of Recipients

	Skilled			ICF			Total		
	FY '78	FY '79	FY '80	FY '78	FY '79	FY '80	FY '78	FY '79	FY '80
Monthly Average	7,235	6,464	4,846	6,988	7,938	9,987	14,225	14,402	14,833
Yearly Total	13,997	12,364	9,528	10,270	12,260	14,913	24,267	24,624	24,441
Annual turnover rate	93%	91%	97%	47%	54.4%	49%	70.6%	71.0%	65%
Average length of stay this year	6.2 mo.	6.3 mo.	6.1 mo.	8.2 mo.	7.8 mo.	8.0 mo.	7 mo.	7 mo.	7.3 mo.
Average expected duration of stay	11.8 mo.	12 mo.	12.4 mo.	23 mo.	20 mo.	24.5 mo.	15.6 mo.	15.5 mo.	18.5 mo.

Patient Characteristics and Length of Stay: Plates 34 and 36 show who the recipients were this year — in terms of sex, race, and age — and show how much was spent on each group.

Plate 35 gives an indication of the number of days recipients spent in nursing homes this year.

Plate 37 shows what these two measures (average length-of-stay and annual turnover rate) turned out to be when calculated. The same plate shows how these two measures have changed in recent years. It should be remembered, however, that these measures are averages. Though it is true that the average patient currently stays only 7 months, there are still large numbers who live permanently in nursing homes, staying five or ten years, or longer. Information is needed on whether the number of permanent residents is declining or increasing. The answer will have a large impact on Medicaid's expenditures in coming years, because of the relative size of the program in terms of recipients served.

HOSPITAL PROGRAM

One eligible in six became a hospital inpatient this year. One in four became an outpatient.

For seven years in a row outpatients have outnumbered inpatients.

Inpatient Care: This year inpatient hospital care was the second most costly single service provided by Medicaid, exceeded only by the Long-Term Care program. Total costs declined by 18%, from $73 million to $59 million dollars, primarily the result of a decline (20%) in the average length of stay and a slight reduction in the number of inpatients admitted during the year.

The cost of hospital care for all patients — private patients as well as Medicaid patients — both in and out of Alabama, has been climbing steeply for years. In the eight years between 1967 and 1975, it doubled. Then in the four years between 1975 and 1979, it doubled again, though in 1980, a reduction was evident.

The specific figures on cost increases for Alabama Medicaid are shown in Plate 38. During the four years since 1976:

Medicaid eligibles rose	4%
The number of patients rose	9%
The number of hospital admissions rose	7%
Costs rose	86%

Note that the number of Medicaid cards issued each year hardly changed. The rising costs were due almost entirely to two things: (1) a larger percent of card holders is now sent to the hospital. This probably means that some illnesses which formerly were treated outside the hospital are now treated inside, and (2) the cost per day for hospital care has increased.

FY '76-'80 PLATE 38

HOSPITAL PROGRAM

Changes in use and costs since 1976

Year	Eligibles	Inpatients	Admissions	Admissions per 1000 eligibles	Days	Length of Stay	Total Cost	Cost Per Day	Cost Per Stay
1976	406,497	67,187	88,438	217	520,502	5.88	$32,215,062	$ 62	$364
1977	413,334	67,842	83,059	201	614,289	7.40	44,721,460	73	538
1978	403,330	66,939	88,356	219	545,554	6.17	48,037,903	88	544
1979	413,805	74,428	101,259	245	536,466	5.30	73,353,242	137	724
1980	423,031	73,228	95,092	225	403,020	4.24	59,921,858	149	631

FY '80 PLATE 39

HOSPITAL PROGRAM

Cost for Medicaid patients compared to costs for other hospital patients

	Cost per Day	Days per Stay	Cost per Stay	Cost per Patient
All U.S. Hospital Patients	$217	7.6	$1,641	N/A
All Alabama Hospital Patients	N/A	6.7	1,412	N/A
Alabama Medicaid Patients	149*	4.24	631*	$818*

*Note: Does not include portion of hospital bills which is paid by Medicare.

Medicaid Patients Compared to Private Patients: Plate 39 shows that for the nation as a whole, the cost per day for hospital care is now up to $217, and that the cost per stay is $1,641. The cost to Alabama Medicaid, even though it has nearly tripled in the last four years, is still lower than the figure for all U.S. patients. This year Medicaid's cost per day was $149. It must be remembered, however, that the $149 a day Medicaid paid for hospital care represents only part of the cost for Medicaid patients. A third of Medicaid's hospital patients are covered by both Medicaid and Medicare. For these patients, Medicare pays most of the hospital bills. We do not have figures that will tell us the total hospital cost paid by both Medicaid and Medicare for these patients. But incomplete evidence suggests that the combined payments of Medicaid and Medicare now equal a cost per day larger than the $217 paid by private patients.

The cost per day for all Alabama hospital patients this year is not available. As shown in Plate 40, the hospital admission rate for the whole population was, as usual, lower than the rate for Medicaid eligibles. Medicaid's admission rate of 225 per thousand is 16% higher than the rate for Alabama as a whole. Last year Medicaid's admission rate was 20% higher. Medicaid's high admission rate was, as usual, partially offset by the fact that Medicaid's length of stay is below average for the state.

FY '80 PLATE 40

HOSPITAL PROGRAM

Medicaid eligibles compared to all Alabama residents in regard to use of hospital beds

	Total Number	Hospital Admissions	Patient Days	Admissions per 1000 People	Average Days per Stay
Medicaid Eligibles	423,031	95,092	403,020	225	4.2
All Alabama Residents	3,827,800	727,292	4,897,995	190	6.7

FY '76-'80 PLATE 41

HOSPITAL PROGRAM

Outpatients

	FY '76	FY '77	FY '78	FY '79	FY '80
Number of outpatients	93,335	86,910	93,229	105,507	110,774
Percent of eligibles using outpatient service	23%	21%	23%	25%	26%
Annual cost of outpatient care	$4,846,291	$5,464,123	$5,451,111	$8,084,542	$11,568,775
Cost per patient	$53	$63	$58	$77	$104

Outpatient Care: The Outpatient Program was created to enable people to use hospital facilities without staying overnight. When it is used for this purpose, it reduces the cost of medical care. Some people, however, use outpatient care when all they need or want is a visit to a doctor's office.

An outpatient visit costs more than twice as much as a visit to a doctor. Nevertheless, some Medicaid patients frequently use this expensive service rather than the less expensive one, and hospitals rarely refuse to cooperate in this abuse. Plate 41 shows how use and cost of the outpatient program have grown in four years. The number of patients has increased 19%. The price per visit has increased 96%. The combined effect of increases in both use and cost has caused the annual cost of the program to more than double in this short time.

Alabama's Supply of Hospital Beds: In recent months, several things have happened which should have a noticeable effect on the number of hospital beds in Alabama and an indirect effect on the cost of hospital care.

The key steps were taken by the State Health Planning and Development Agency (SHPDA) and the Statewide Health Coordinating Council (SHCC) which adopted a revised bed need methodology which would be implemented by both the State Agency and the Health Systems Agencies. The new methodology will (1) indicate a much larger number of surplus or excess hospital beds in the State, and (2) count all licensed beds (including psychiatric) in a facility as actually existing general hospital beds, when in the past a facility could have excluded beds which were not indicated as general hospital beds in their total bed count.

FY '72-'79 PLATE 42

HOSPITAL PROGRAM

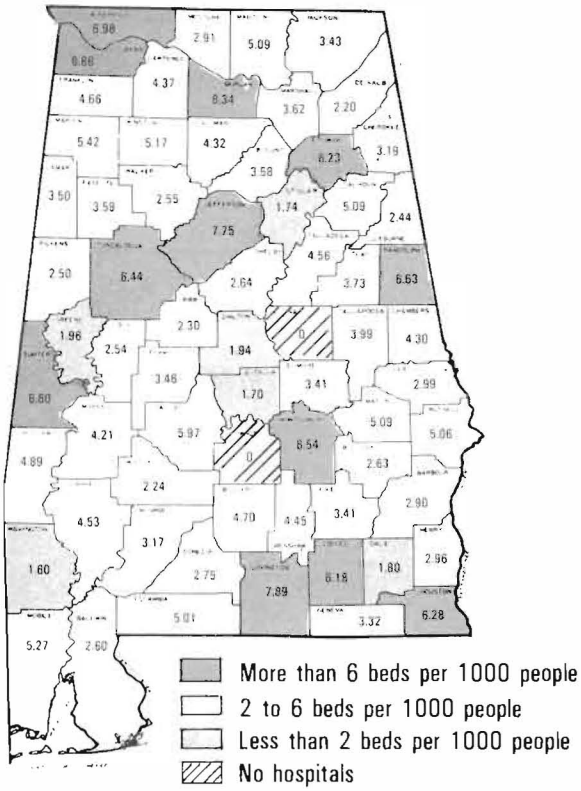
Hospital use and need for all Alabama

	Alabama's Population	Hospital Admissions	Patient Days in Hospitals	Existing Hospital Beds	Needed Beds
1972	3,486,000	584,698	4,175,318	17,705	18,287
1973	3,514,000	618,439	4,317,649	18,214	19,270
1974	3,784,000	611,817	4,325,570	18,002	16,170
1975	3,590,000	609,381	4,190,450	18,278	16,989
1976	3,640,000	642,452	4,445,930	18,189	17,316
1977	3,690,000	689,558	4,673,207	17,652	N/A
1978	3,742,000	728,465	4,902,517	20,114	17,339
1979	3,827,800	727,292	4,897,995	20,199	17,795

FY '79 PLATE 43

HOSPITAL PROGRAM

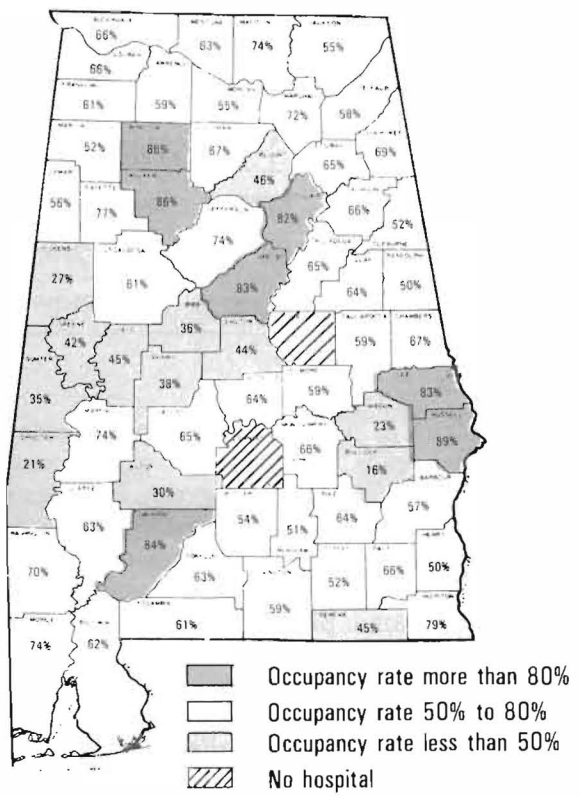
Beds per 1,000 people



FY '79 PLATE 44

HOSPITAL PROGRAM

Hospital occupancy rate (%)



The second change caused the number of hospital beds (or the number of licensed beds) to rise sharply. According to a bed count made in 1976 by the old method, Alabama hospitals had a survey capacity of 18,189 beds. A later count made by the new method showed a total of 20,199 licensed beds. It is doubtful that the actual number of beds increased by nearly 2,000. Much of this difference is probably only the result of the new method of counting.

By the new method of determining bed need, the total needed at present is 17,795, which means we now have a surplus of 2,404 beds. Because of the surplus, Alabama hospitals presumably will not be issued Certificates of Need to expand until our need for beds catches up with our supply (except in very rare circumstances). But even if no new CONs are issued the construction of new beds is expected to continue. The reason is that many hospitals still hold unused "assurances of need" which were issued to them before the old formula was replaced by the new one. These assurances are equivalent to permissions to expand. They cannot be revoked, and therefore can still be used. A recent survey made by SHPDA indicates that when all presently authorized expansions are completed, the excess number of beds in the state will have risen from 2,404 to 3,883.

Plate 43 shows how existing beds are distributed among the counties. The average number of beds per 1,000 people for FY '79 is 5.19; a decline from 5.31 in FY '78. Plate 44 shows the occupancy rate in each county for FY '79. The average rate has declined significantly from 83% in FY '77 to the FY '79 average of 67.5%. The current effort to slow expansion cannot lower hospital costs, but should retard their growth, if the average length of stay (Plate 38) continues to fall. (Note: Plates 43 and 44 reflect FY '79 data.)

PHYSICIAN PROGRAM

Among Medicaid eligibles, 57 persons in 100 saw a physician this year.

Medicaid paid physicians an average of $120 for each patient.

FY '80 PLATE 45

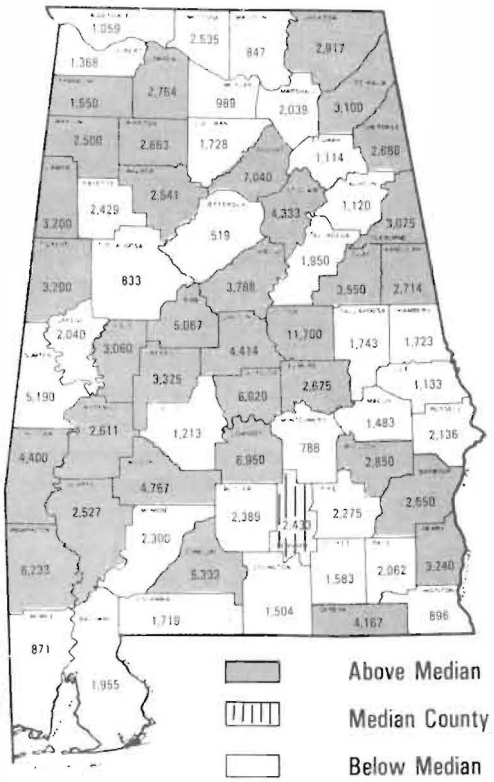
PHYSICIAN PROGRAM

Number of physicians providing direct patient care, by county

FY '80 PLATE 46

PHYSICIAN PROGRAM

Number of people per physician, by county



In Alabama doctors of medicine or osteopathy initiate most medical care. They either provide it directly or prescribe or arrange for additional health benefits. These benefits may include drugs, nursing care, laboratory tests or devices. Physicians may also admit patients to medical institutions and direct the medical care therein. According to the Alabama Health Data System there were 3,583 doctors offering direct patient care in Alabama as of July, 1980. This figure does not include physicians in teaching, research, public health, administration, etc.

Physicians in Alabama may participate in the Medicaid program as general practitioners or specialists. In the EPSDT Program, because of cost limitations, physicians must sign agreements with the Medical Services Administration before they can provide child screening services; however, in the other programs, physicians are not required to sign agreements. They may provide medically necessary care to any eligible person. During FY '80 almost three-quarters of the Medicaid recipients in Alabama received physicians' services.

FY '76-'80 PLATE 47

PHYSICIAN PROGRAM

Use and cost

	COST PER RECIPIENT PER YEAR, FOR PHYSICIANS' SERVICES				
	FY '76	FY '77	FY '78	FY '79	FY '80
Aged	$50	$51	$44	$59	$76
Blind	130	135	133	202	176
Disabled	132	143	138	215	187
Dependent Children	49	66	63	88	79
Dependent Adults	123	140	153	215	194
ALL CATEGORIES	75	85	87	128	120

	NUMBER OF MEDICAID RECIPIENTS TREATED BY PHYSICIANS				
	FY '76	FY '77	FY '78	FY '79	FY '80
Aged	84,428	76,287	69,678	67,071	72,159
Blind	1,505	1,416	1,382	1,439	1,415
Disabled	36,425	38,203	39,200	42,648	45,101
Dependent Children	74,226	82,648	69,497	80,888	77,432
Dependent Adults	39,649	33,651	39,063	45,447	44,328
ALL CATEGORIES	236,233	232,205	218,820	237,503	240,435

	PERCENT OF ELIGIBLES WHO BECAME RECIPIENTS OF PHYSICIANS' CARE				
	FY '76	FY '77	FY '78	FY '79	FY '80
Aged	67.2%	64.0%	62.3%	61.8%	66.0%
Blind	64.0%	63.6%	63.4%	65.0%	63.5%
Disabled	60.0%	60.2%	62.6%	63.4%	65.1%
Dependents	52.1%	51.0%	47.9%	53.6%	50.3%
ALL CATEGORIES	58.1%	56.2%	54.3%	57.4%	56.8%

For Medicaid physicians' care costs less per person for the aged than it costs for other categories (See Plate 47.) This surprising situation is explained by the fact that most of Medicaid's aged also have Medicare coverage. Medicare pays the larger part of their bills for physicians' care.

The total number of recipients of physicians' care increased by about 3,000 from the previous year. The dependent children category, however, showed a decrease.

PHARMACEUTICAL PROGRAM

Recipients had fewer prescriptions for higher-priced drugs. This decline was the result of a sharp drop in the number of participating pharmacies.

FY '78-'80 PLATE 48

PHARMACEUTICAL PROGRAM
Counts of providers by type and year

Type of Provider	Number		
	FY '78	FY '79	FY '80
In-State Retail Pharmacies	1,009	1,130	1,000
Institutional Pharmacies	37	37	38
Dispensing Physicians	6	3	3
Out-of-State Pharmacies	44	42	40
Health Centers and Clinics	3	4	4
TOTAL	1,099	1,216	1,085

Modern medical treatment relies heavily on the use of drugs. Drugs are used against pain, infection, allergies, chemical imbalances, dietary deficiencies, muscle tension, high blood pressure, vascular diseases, and many other health problems. Illnesses which cannot be treated by drugs usually require hospitalization or surgery. Drugs have advantages over these alternative treatments, and modern medicine has been very successful in finding medications which make the more expensive alternatives unnecessary.

FY '78-'80 PLATE 49

PHARMACEUTICAL PROGRAM
Eligibles, expenditures, and claims compared

	All Categories	Category 1 Aged	Category 2 Blind	Categories 3, 6, 7 & 8 AFDC/Other	Category 4 Disabled
ELIGIBLES (Per Year)					
FY '78	403,330	111,832	2,180	226,664	62,654
FY '79	413,805	108,534	2,215	235,796	67,260
FY '80	423,031	109,314	2,230	242,223	69,264
EXPENDITURES (Per Year)					
FY '78	$17,938,531	$10,655,423	$158,113	$2,158,908	$4,966,087
FY '79	22,277,146	12,805,938	192,040	2,708,850	6,570,318
FY '80	19,812,057	11,303,525	171,351	1,979,360	6,357,821
# of RX (Per Year)					
FY '78	3,021,575	1,740,427	25,683	467,136	788,329
FY '79	3,464,102	1,929,156	28,855	557,694	948,397
FY '80	2,958,444	1,653,282	24,880	399,847	880,435
RX PER ELIGIBLE (Per Year)					
FY '78	7.5	15.6	11.8	2.1	12.6
FY '79	8.4	17.8	13.0	2.4	14.1
FY '80	7.0	15.1	11.2	1.7	12.7
COST PER ELIGIBLE (Per Year)					
FY '78	$44	$95	$73	$10	$79
FY '79	54	118	87	11	98
FY '80	47	103	97	8	92

FY '80 PLATE 50

PHARMACEUTICAL PROGRAM

Use and cost

Month	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
October '79	82,315	24%	217,978	2.65	$6.77	$17.95	$ 1,477,526
November	112,482	33%	369,705	3.29	6.69	22.01	2,475,466
December	95,418	28%	262,167	2.75	6.68	18.37	1,752,876
January '80	95,618	28%	261,879	2.74	6.69	18.33	1,752,473
February	70,157	21%	177,166	2.53	6.74	17.05	1,196,161
March	72,307	21%	187,171	2.59	6.73	17.44	1,260,705
April	91,420	27%	272,153	2.98	6.80	20.27	1,853,547
May	82,458	24%	220,147	2.67	6.85	18.30	1,509,029
June	84,588	25%	231,351	2.74	6.86	18.80	1,589,860
July	97,123	29%	289,130	2.98	6.87	20.47	1,988,406
August	89,772	27%	242,783	2.70	7.02	18.96	1,702,511
September	86,943	26%	226,814	2.61	6.97	18.20	1,582,442
ALL YEAR	222,525	53%	2,958,444	13.29	$6.70	$89.03	$19,812,057*

*$328,945 less than sum of column due to adjustments and refunds.

This year, as in all previous years, over 50% of Alabama's Medicaid eligibles had at least one prescription filled. The only other medical service used by as many eligibles was physicians' care.

Physicians writing prescriptions for Medicaid patients have a choice of approximately 6000 drug code numbers in more than 50 therapeutic categories. These drugs are listed in the Alabama Drug Code Index (ADCI). Additions are made to the ADCI periodically to keep the drug list correct and effective.

Southeastern states spend more per year per recipient on drugs than do states in other parts of the country. The reason is not known, but opinion among qualified people is that drugs are more often used as an alternative to institutional care in the Southeast.

The average price per prescription rose 4% from $6.43 to $6.70 (see Plate 50.)

Lower utilization offset higher prices which resulted in the monthly average cost per recipient rising only 1.1% from $18.64 in FY '79 to $18.85 this year.

Alabama's expenditures for drug benefits have been a declining portion of the total Medicaid program for several years. This past year only 7% was expended for the pharmaceutical program, compared with 8% in FY '79 and 9% in FY '78.

FY '80 PLATE 50

PHARMACEUTICAL PROGRAM

Use and cost

Month	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
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January '80	95,618	28%	261,879	2.74	6.69	18.33	1,752,473
February	70,157	21%	177,166	2.53	6.74	17.05	1,196,161
March	72,307	21%	187,171	2.59	6.73	17.44	1,260,705
April	91,420	27%	272,153	2.98	6.80	20.27	1,853,547
May	82,458	24%	220,147	2.67	6.85	18.30	1,509,029
June	84,588	25%	231,351	2.74	6.86	18.80	1,589,860
July	97,123	29%	289,130	2.98	6.87	20.47	1,988,406
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FAMILY PLANNING

Recipients of family planning services this year numbered 22% less than last year. The total costs for these services fell by more than 23%.

FY '80 PLATE 51

FAMILY PLANNING PROGRAM
Recipients by age, sex, and race

	Recipients
Total	16,555
Male	89
Female	16,466
White	2,014
Nonwhite	14,541
Age 0-5	0
Age 6-20	7,515
Age 21-64	9,026
Age 65 & Over	14

Alabama Medicaid purchases family planning services provided by the Statewide Family Planning Project, Bureau of Maternal and Child Health, State Health Department, in clinics under its supervision. These services include physical examination, Pap smears, pregnancy and V.D. testing, counseling, oral contraceptives, other drugs, supplies and devices, and referral for other needed services. The Medicaid Family Planning Program cooperates with the Statewide Family Planning Project and the Bureau of Nursing in training programs designed to upgrade quality and quantity of services available through the clinics. Medicaid also pays for family planning services provided by physicians, pharmacists, hospitals and other private providers.

In March 1973, federal law made family planning services a required part of all Medicaid programs. To insure that the new family planning programs be given priority, the federal government agreed to pay 90% of the cost. Before this time, Alabama Medicaid had offered some family planning services as incidental parts of its pharmaceutical and physician programs, but until then there was no separate program. Using the additional funds, Alabama launched its full-scale family planning program, including clinic services, counseling, patient education, supplies and devices, sterilization, and abortion.

In February 1979, federal regulations concerning Medicaid payment for sterilizations required that (1) the individual be at least 21 years old at the time consent is obtained; (2) the individual has voluntarily given informed consent in accordance with all requirements; (3) at least 30 days, but not more than 180 days have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery.

An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery if at least 72 hours have passed since she gave informed consent for the sterilization. In case of a premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery.

In August 1977, DHEW issued a policy statement regarding payment for abortions for Medicaid recipients. Basically, this policy states that payment can be made: (1) for abortions where the attending physician has certified that it is necessary because the life of the mother would be endangered if the fetus were carried to term; (2) when severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term; and (3) for treatment of rape and incest victims if reported to a law enforcement agency within sixty days of the incident.

As FY '79 ended, no significant policy changes had been made. However, in October 1979, Medicaid funds were prohibited from being used to pay for abortions meeting the second condition above.

As of February 19, 1980, Alabama Medicaid began receiving federal financial participation for all medically necessary abortions that are necessary in the professional judgment of the pregnant woman's physician, exercised in the light of all factors; physical, emotional, psychological, familial, and the woman's age, relevant to the health related well-being of the pregnant woman.

Effective October 6, 1980, Alabama Medicaid will only pay for abortions where the life of the mother would be endangered if the fetus were carried to term and for victims of promptly reported rape and incest.

EPSDT PROGRAM

More than 70% of the children screened in Alabama need treatment.

EPSDT offers persons, from birth through age 20, preventive care with periodic examinations and referral and treatment when needed.

EPSDT (Early and Periodic Screening, Diagnosis and Treatment) is a program of preventive medicine. It is designed to provide preventive health services and early detection and treatment of diseases so that young people can receive medical care before health problems become chronic and disabling. It offers these services to all Medicaid eligibles under age 21.

Each year since FY '72, there have been approximately 175,000 eligibles in this age group. Medicaid's goal is to screen each one at periodic intervals from birth until he reaches age 21 if he remains eligible during all these years. These checkups are scheduled to occur at ages 1, 2, 3, 5, 10, 15 and 19 years.

In FY '80 approximately 2 children of every 5 screened were in age group 0-5 and the remainder were in age group 6-20. Hypertension, rheumatic fever, other abnormal heart conditions, diabetes, neurological disorders, venereal disease, skin problems, anemia, urinary tract infections, visual and hearing problems, and child abuse are among the health problems discovered and treated.

County health departments do most of the screening examinations that Alabama Medicaid pays for. However, several physicians, community health centers, Head Start centers, and child development centers have entered the program and have made significant contributions to the screening program in several counties.

The state and local offices of the Department of Pensions and Security made a tremendous contribution to the EPSDT program during the year through their outreach efforts, person-to-person contacts, provision of social services, and help with follow-up of referrals to assure that children and young people in need of medical or dental services were able to receive them on a timely basis.

The cost of screening is relatively small, an average of $23.04 for a recipient. The cost of treatment is considerably higher depending on the condition. Even so the cost of the total program has declined 13% this year.

FY '78-'80 PLATE 52

EPSDT PROGRAM

Recipients by age, by referral, by payment

	FY '78	FY '79	FY '80
Total Screened	46,059	43,378	37,796
Age:			
0-5	16,062	16,328	16,468
6-20	29,997	27,050	21,328
Condition:			
Referrable	38,062	34,589	27,397
Not referrable	7,997	8,789	10,399
Total Payment For Services	$1,020,360	$999,696	$870,743
Average Payment For Services	$ 22.15	$ 23.05	$ 23.04

During FY '80, a total of 37,796 screenings were made – down 13% from last year. Of those screened, about 72% had referrable conditions uncovered or suspected. We are rapidly approaching the goal set by Congress of seven screenings for each child before his 21st birthday.

HOME HEALTH PROGRAM

Of every 8 Medicaid patients who need regular and continuous care, 7 live in nursing homes. The other 1 stays home and receives home health care.

An Alternative to Nursing Home Care: Medicaid offers two kinds of care for the aged who have chronic health problems and need regular continuous care. One kind is institutional and requires the patient to live in a nursing home. The other kind is non-institutional and permits the patient to remain at home. Institutional care costs 10 times as much as home health care. Medicaid's problem of a continuing money shortage could be largely solved if a way were found to shift large numbers of the chronically ill from institutions to home health care so their families could pay for food, shelter, and other non-medical expenses.

In 1974, there were 17,996 Medicaid patients with chronic illnesses sufficient to warrant continuous regular care. Approximately 93% were put into nursing homes and 7% were treated at home. By 1980, the number of chronically ill had increased to 27,830 and the portion living at home had increased to 12%. They got the medical help they needed from visiting nurses. In absolute terms there were 2,251 more home health patients in 1980 than in 1974. Each patient treated at home this year saved Medicaid $4,935. Total savings on the 2,251 new home health patients was more than $11 million this year.

The possibility of reducing the cost of Medicaid by making more use of home health care has been substantiated by many studies, including one issued by a congressional group headed by Representative Claude Pepper. His report entitled "Home Health — The Need for a National Policy to Better Provide for the Elderly," said "Until older people become greatly or extremely impaired, the cost of nursing home care exceeds the cost of home care, including the value of the general support services provided by family and friends."

Growth of the Program: Plate 53 shows how the number of chronically ill has increased each year since 1974 and the division each year of these patients into two groups — one group at home and one group in nursing homes.

The Home Health Program, which began in Alabama in 1970, is a mandatory, not an optional, program. Its purpose is stated in Title XIX of the Social Security Act which says that the Home Health Care Program is to provide quality medical care for people who are confined to their homes with an illness, disability or injury.

Through utilization of part-time nursing services and home health aide service, people who otherwise could not manage to remain in their homes are able to do so. Some people who enter nursing homes and hospitals go home sooner by being referred to home health care through discharge planning.

Current Medicaid home health care includes restorative, custodial, and supportive services.

In FY '80, there were 77 participating home health agencies serving Medicaid patients in Alabama.

Payment, Service, and Cost: Payment of a provisional rate is renegotiated annually. The maximum payment this year was $25.00 per visit.

Effective July 1, 1978, certain supplies and equipment became available to all Medicaid eligibles as a program benefit under Home Health.

The items are ordered by the attending physician for therapeutic purposes for in-home use, helping to minimize the necessity for hospitalization, nursing home placement, or other institutional care.

These items are obtained through participating Home Health Agencies and contracted suppliers. Durable medical equipment must be authorized by MSA before it is purchased.

The program this year cost $1.49 million to care for nearly 3,400 patients.

FY '74-'80 PLATE 53

HOME HEALTH CARE

Number of aged patients using home health care compared to the number using nursing home care.

Year	Home Health Care	Nursing Home Patients
1974	1,138	16,858
1975	1,844	20,042
1976	1,979	21,094
1977	2,234	24,351
1978	2,846	24,267
1979	3,924	24,624
1980	3,389	24,441

Appendix

TERMINOLOGY

MEDICAID and MEDICARE

Medicaid and Medicare are two governmental programs which exist to pay for health care for two different, but overlapping, groups of Americans.

Medicaid buys medical care for several low-income groups, including people of all ages.

Medicare buys medical care for most people, including some people from all income groups. Many aged people who have low incomes are eligible for both Medicaid and Medicare, and those who are eligible for both can get both a Medicaid card and a Medicare card. For these people Medicare pays most of their medical bills, and Medicaid pays the balance, or most of it.

Medicaid is administered by the state governments, and thus there is not one Medicaid program, but 53 (Puerto Rico, Guam, the Virgin Islands, and Washington, D.C., run the total to 53). All 53 programs are different. Arizona does not have a Medicaid Program.

Medicare is administered by the federal government and the coverage provided is uniform throughout the nation.

ELIGIBLES and RECIPIENTS

Eligibles, in this report, are people who have Medicaid cards and thus are eligible for health care service paid for by Medicaid.

Recipients, in this report are people who used their Medicaid eligibility this year, and actually received one or more medical services for which Medicaid paid all or part of the bill.

PROVIDERS

All physicians, dentists, hospitals, nursing homes, and other individuals or businesses that provide medical care are called providers.

CATEGORY

In normal usage the word "category" is used interchangeably with "kind" or "type". In Medicaid's usage, "Category" has a special meaning. In Medicaid there are eight major bases for eligiblity and the eligibles in each of the resulting groups form a "category" with a capitol C. In this book when eligibles are grouped by age, race, or sex, the divisions that result are spoken of as different groups of eligibles or different kinds of eligibles but never as different categories. The eight major categories are:

Category 1 — aged people with low incomes.
Category 2 — blind people with low incomes.
Category 3 — low-income families with dependent children.
Category 4 — disabled people with low incomes.
Category 5 — Cuban-Haitian entrants.
Category 6 — refugees with low incomes.
Category 7 — dependent children in foster care.
Category 8 — other children in foster care.

PAYMENTS, CHARGES, EXPENDITURES, PRICES, and COST

A **charge** is the amount of money the provider asks for a service when he submits his bill to Medicaid.

A **payment** is the amount Medicaid pays for a service. Medicaid rules limit payments, so sometimes a provider cannot be paid as much as he asks.

Price, in this report, means "average unit price" or the average price Medicaid paid this year for a unit of care, such as:

1 day in a hospital	$148.37
1 day in a skilled nursing home	$ 22.79
1 visit to a physician	$ 15.63
1 prescription	$ 6.81

Cost, in this report, means "average cost per person." Examples of different contexts in which this term is used include:

average cost per eligible for hospital care per month
average cost per recipient for hospital care per month
average cost per eligible for prescriptions per year.

Expenditures, in this report, is a more inclusive term than payments. Payments, as stated above, means the amount paid for medical care. The term expenditure also includes money spent for administration.

HEALTH CARE SERVICES

Medicaid pays for the following health care services:

Nursing home care,
physicians' services,
eye care, including glasses,
drugs,
family planning services,
home health care,
screening and referral services (EPSDT),
hospital care,
dental services,
hearing care, including hearing aids,
laboratory work and X-rays,
transportation required for medical purposes.

BUY-IN INSURANCE

Many Medicaid eligibles are also eligible for Medicare. As Medicare eligibles they get Medicare hospital insurance without payment. Medicare insurance to cover physicians' bills, however, must be paid for. It costs $9.60 a month. Medicaid buys this insurance for all Medicaid eligibles whose applications are approved by Social Security. Medicaid calls this insurance "buy-in insurance."