ALABAMA MEDICAID

NINTH ANNUAL REPORT

OCTOBER 1, 1980-SEPTEMBER 30, 1981

ALABAMA MEDICAID AGENCY
State of Alabama

FOB JAMES
Governor

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

Faye S. Baggiano
Acting Commissioner

The Honorable Fob James
Governor
State Capitol
Montgomery, AL 36130

Dear Governor James:

I respectfully transmit the Ninth Annual Report for the fiscal year ending September 30, 1981. The report provides an overview of all programs administered by the Alabama Medicaid Agency. The tables present a comparative view of these programs in order to provide an insight into the availability of medical care to the indigent citizens of this state.

Sincerely yours,

Faye S. Baggiano
Acting Commissioner

FSB:aca

ALABAMA MEDICAID

FISCAL YEAR 1981

Prepared By

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ALABAMA MEDICAID AGENCY

MONTGOMERY, ALABAMA

Faye S. Baggiano, Acting 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 $18 million more in FY'81 than they were in FY'80. This represents an increase of nearly 7 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 $16.8 million higher than they were the previous year. ICF-Mentally Retarded and ICF-Mental Illness accounted for $3.4 million of this increase. For skilled-level nursing home care the payments declined by $14.5 million in FY'81. Taken as a whole, payments to nursing homes rose only $2.3 million, an increase of less than 2 percent.

Two types of service showing large increases in payments were hospital inpatient care and prescriptions with their payments increasing $6.1 million and $4.5 million respectively. Payments for other health care rose $6.5 million for an increase of over 66%. Prenatal care and X-rays accounted for nearly two-thirds of this increase.

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

Plate 2 displays for each type of service the percent change between the current and preceding year for

FY '81 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 '80	FY '81	In Dollars (millions)	In Percent	Attributable to Rising Prices (millions)	Attributable to More Recipients (millions)	Attributable to More Units Per Recipient (millions)
SNF Care	$ 38.3	$ 23.8	$-14.5	-37.9%	$ .5	$-14.4	$- .6
ICF Care	93.1	109.9	16.8	18.0%	-2.0	17.5	1.3
Physician Services	31.6	28.7	-2.9	-9.2%	-1.6	-.7	-.6
Inpatient Hospital	60.0	66.1	6.1	10.2%	16.7	.2	-10.8
Outpatient Hospital	11.6	13.1	1.5	12.9%	1.7	.6	-.8
Prescriptions	20.1	24.6	4.5	22.4%	2.7	2.1	-.3
Other Care	9.8	16.3	6.5	66.3%	3.5	1.5	1.5
TOTAL	$264.5	$282.5	$18.0	6.8%	$21.5	$6.8	$-10.3

these three factors. As shown in this table, the primary factors contributing to the overall increase in payments were the average unit price and the number of recipients, each of which increased about 3 percent in FY'81.

With only two exceptions, all of the major categories of service experienced higher prices. An average day of inpatient care in a hospital exhibited a price increase of 33.7 percent from 1980 to 1981. This was followed closely by a 27.9 percent increase for other care during that period.

The average number of recipients taking advantage of the Medicaid program rose by 2.9 percent during the year. Two types of service, however, which had fewer recipients were skilled nursing home care and physician services. The number of Medicaid eligibles no longer receiving SNF care was almost equal to the number of new ICF patients.

Although the number of recipients of inpatient hospital services remained stable, these recipients were in the hospital 18% fewer days. This was the only significant change in utilization, as measured by the average number of units (days, visits, prescriptions, etc.) per recipient.

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. In the drug program 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'81 would have resulted in an increase of $2.7 million.

Notice in Plate 1 that had it not been for lower utilization of Medicaid services, the total program's payments would have increased by more than $28 million in FY'81 due to a larger number of recipients using more expensive services.

FY '81 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	2.0%	-37.5%	-2.5%
ICF Care	-1.8%	18.8%	1.2%
Physician Services	-6.9%	-2.1%	-2.0%
Inpatient Hospital	33.7%	0.4%	-18.0%
Outpatient Hospital	15.0%	5.7%	-6.7%
Prescriptions	12.4%	10.4%	-1.4%
Other Care	27.9%	N/A	N/A
TOTAL	2.9%	2.9%	0.9%

POSSIBLE EXPLANATION

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 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 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 reduction in utilization of services may also have been the result of a much publicized crackdown on Welfare fraud and Medicaid fraud. This may have caused some recipients to discontinue their over-utilization of the program.

The apparent decline of participation in the physician program is somewhat misleading. Several types of service which had previously been reported as physician services are now correctly being included with Other Care. These services are family planning, prenatal care, EPSDT, X-ray and Laboratory. This would explain the increase of activity and payments in Other Care.

As mentioned before, one of the reasons for the price increases for inpatient care was inflation. Another reason can be found in the very nature of an inpatient stay. Once a recipient becomes a hospital inpatient, a whole range of services, including laboratory work, X-rays, medical supplies, physicians' services, medication, and others may be provided. An increase in these 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. The above might also be true for hospital outpatient visits.

Hopefully, this examination of some of the factors involved in the payment changes from FY'80 to FY'81 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 $296 million expenditure in FY'81 would be expected to create a total payroll for these workers of $323 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.

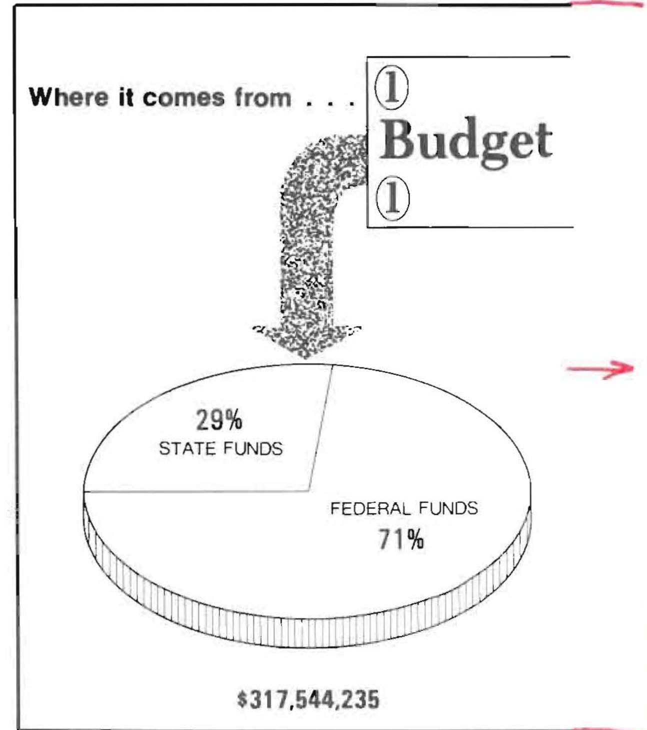
The economic effects of Medicaid are felt in all 67 counties, though it is not spread evenly. Plate 3 shows how much was spent per eligible in each county this year. The median county was Cleburne where Medicaid payments averaged $646 per eligible. In past years, most urban counties have been above the median. This remains true, but a shift is taking place. This year Cleburne County moved up to the median position while two urban counties — Madison and Houston — are below the median.

FY '81 PLATE 3
COUNTY IMPACT
Year's expenditure per eligible

County	Benefit Payments	Eligibles	Dollars per Eligible
Autauga	$1,627,986	2,971	$548
Baldwin	3,612,212	5,168	699
Barbour	2,362,161	4,291	550
Bibb	1,430,216	1,582	904
Blount	1,648,642	2,382	692
Bullock	1,129,989	2,578	438
Butler	2,354,837	3,675	641
Calhoun	7,285,312	11,014	661
Chambers	3,044,826	5,009	608
Cherokee	918,923	1,475	623
Chilton	1,707,945	2,578	663
Choctaw	1,448,502	3,366	430
Clarke	2,381,177	4,834	493
Clay	1,443,884	1,304	1,107
CLEBURNE (median)	686,356	1,062	646
Coffee	2,018,773	3,290	614
Colbert	2,979,226	4,087	729
Conecuh	1,343,990	2,686	500
Coosa	694,134	1,188	584
Covington	3,218,895	3,976	810
Crenshaw	1,957,029	2,513	779
Cullman	4,465,205	4,644	961
Dale	2,328,924	2,926	796
Dallas	5,447,276	11,439	476
DeKalb	3,826,729	4,732	809
Elmore	6,310,429	4,009	1,574
Escambia	2,562,793	4,242	604
Etowah	7,673,213	8,451	908
Fayette	1,351,289	1,843	733
Franklin	2,815,579	3,124	901
Geneva	1,516,903	2,972	510
Greene	1,042,131	3,479	300
Hale	1,828,987	3,692	495
Henry	1,002,036	2,405	417
Houston	3,673,010	7,483	491
Jackson	2,461,383	4,324	569
Jefferson	44,811,917	63,428	707
Lamar	1,806,998	1,712	1,055
Lauderdale	4,498,800	5,515	816
Lawrence	2,288,685	3,407	672
Lee	2,937,823	5,666	519
Limestone	2,473,360	3,811	649
Lowndes	1,373,348	3,930	349
Macon	3,422,741	5,558	616
Madison	7,157,797	13,748	521
Marengo	2,382,637	5,025	474
Marion	1,951,207	2,581	756
Marshall	4,450,584	5,794	768
Mobile	26,427,325	39,564	668
Monroe	1,766,290	3,343	528
Montgomery	14,280,846	21,375	668
Morgan	14,028,962	7,992	1,755
Perry	1,816,066	3,769	482
Pickens	2,784,357	4,591	606
Pike	2,507,835	4,467	561
Randolph	2,046,825	2,503	818
Russell	2,941,452	5,051	582
Shelby	2,905,276	3,742	776
St. Clair	2,823,254	3,209	880
Sumter	2,497,435	4,140	603
Talladega	5,811,648	10,683	544
Tallapoosa	4,909,756	4,524	1,085
Tuscaloosa	10,558,876	14,149	746
Walker	6,106,902	6,524	936
Washington	1,325,430	2,222	597
Wilcox	1,698,427	4,861	349
Winston	2,184,443	1,750	1,248

**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.

REVENUE, EXPENDITURES AND PRICES



SOURCES OF MEDICAID REVENUE	PLATE 5
Federal Funds	$226,004,868
State Funds	91,539,367
Total Revenue	$317,544,235

FY '81 PLATE 6
COMPONENTS OF FEDERAL FUNDS

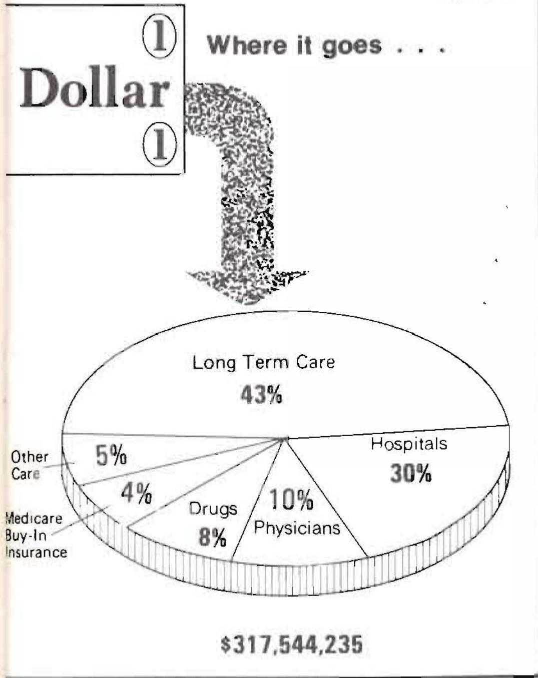
	Dollars	Matching Rate
Absent Parents	40	100.00%
MMIS & Family planning admin.	463,688	90.00%
Professional staff costs	5,465,446	75.00%
Other staff costs	1,156,417	50.00%
Other provider services	216,345,963	71.32%
Family planning services	2,573,314	90.00%
TOTAL	$226,004,868	71.17%

FY '81 PLATE 7
COMPONENTS OF STATE FUNDS

	Dollars
Encumbered balance forward	$4,460,408
Basic Appropriations	66,000,000
Supplemental appropriations	10,000,000
P & S/Mental Health	7,197,474
Interest Income from Fiscal Intermediary	545,341
Miscellaneous Contributions	10
Patient Resources	4,173,164
	$92,376,397
Encumbered	—837,030
TOTAL	$91,539,367

FY '81 PLATE 8
MEDICAID'S PORTION OF TOTAL STATE FUNDS

	Percent of State Funds	State Funds	Federal Funds	Total Current Funds
All Expenditures of Alabama's State Government	100.0%	$5,894,831,654	$1,001,517,626	$6,896,349,280
Medicaid Program	1.6%	91,539,367	226,004,868	317,544,235
All Other Programs	98.4%	$5,803,292,287	$775,512,758	$6,578,805,045



In FY'81 Medicaid paid $307,260,803 for health care services to Alabama citizens. Another $10,283,432 was expended to administer the program. This means that about 3 cents of every Medicaid dollar did not directly benefit recipients of Medicaid services. Only one other state had a lower percentage of expenditures for administrative costs than Alabama.

FY '81
EXPENDITURES
By type of service

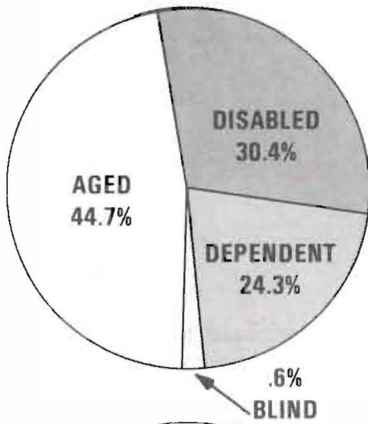
PLATE 9

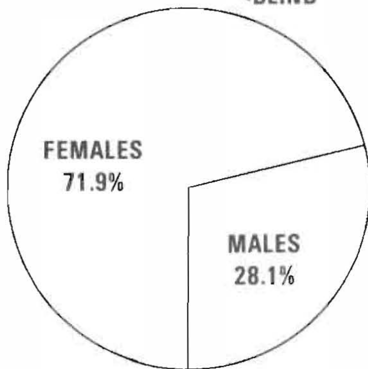
Service	Payments	Percent Of Payments by Service FY '81		Percent Of Payments By Service FY '80		Percent Of Payments By Service FY '79	
Skilled Nursing Care	$22,225,520	7.23%	42.78%	13.24%	46.23%	17.39%	39.48%
Intermediate Nursing Care	109,243,648	35.55%		32.99%		22.09%	
Hospital Inpatients	81,475,682	26.52%	29.92%	24.46%	27.82%	27.58%	30.62%
Hospital Outpatients	10,453,934	3.40%		3.36%		3.04%	
Physicians' Services	30,722,193	10.00%		9.78%		11.39%	
Medicare Buy-In Insurance	13,514,393	4.40%		4.46%		4.53%	
Drugs	24,174,152	7.87%		7.03%		8.38%	
Dental Services	3,827,633	1.25%		1.30%		1.59%	
Lab & X-Ray	4,170,972	1.36%		1.33%		1.45%	
Family Planning Care	2,859,238	.93%		.53%		.49%	
Eye Care	1,771,492	.58%		.56%		.77%	
Screening	919,096	.30%		.33%		.44%	
Home Health	1,482,443	.48%		.50%		.74%	
Transportation	236,817	.07%		.07%		.07%	
Hearing Care	62,696	.02%		.02%		.03%	
Other Care	120,894	.04%		.04%		.02%	
Total For Medical Care	$307,260,803	100.0%		100.0%		100.0%	
Administrative Costs	10,283,432						
Net Payments	$317,544,235						

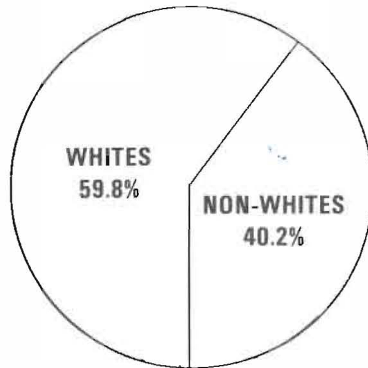
FY '81 PLATE 10

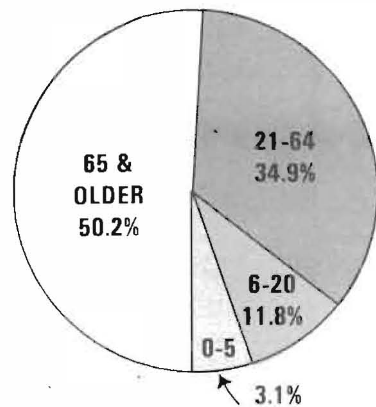
PAYMENTS

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.)

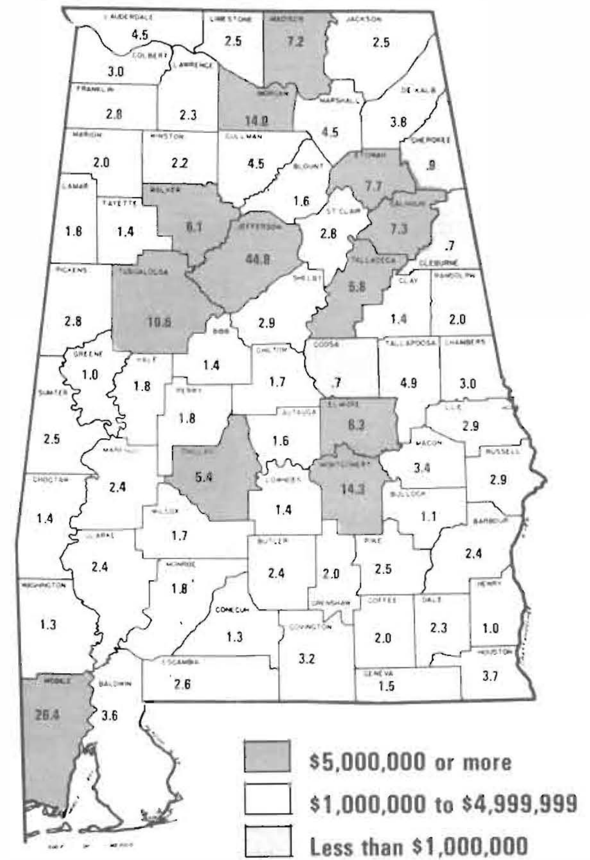
The twelve counties where the most money was spent this year were the top twelve last year. The three counties where the least was spent in FY'80 are still the least expensive this year.

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 '81 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 and year of each of the six major health care services paid for by Medicaid. Also depicted are the percent changes from FY'80 to this year.

With the exception of ICF days and physicians' services, prices climbed from the prior year. The largest jump in prices was seen in the inpatient hospital program with an increase of more than 33%.

Note that as the year ended, the average cost per day for ICF care was lower 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 below average have more ICF beds than skilled beds, then the statewide average for ICF care is lower than that for skilled care.

FY '81 PLATE 12

PRICES

Unit price per service, by quarter

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	FY '81	Change From Previous Year
Nursing Home Days						
Skilled	$23.62	$23.17	$23.12	$22.97	$23.25	+ 2.0%
ICF*	22.11	21.21	21.22	20.78	21.31	−10.2%
Inpatient Days	157.14	192.74	270.56	174.93	198.35	+33.7%
Physicians' Visits	14.00	14.35	15.33	14.47	14.54	− 6.9%
Prescriptions	7.29	7.28	7.93	8.16	7.65	+12.3%
Outpatient Visits	21.24	23.21	24.91	24.40	23.42	+15.0%

*Excludes ICF-MR

POPULATION AND ELIGIBLES

Population

The population of Alabama grew from 3,444,165 in 1970 to 3,890,061 in 1980.

This increase of approximately 12.9% had a significant 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 50.8% of the total. In 1980, this portion had fallen to 46.9%. However, in absolute terms, the over-65 age group had increased by 35% during this period (OSPFP data).

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 '73 - '80 PLATE 13

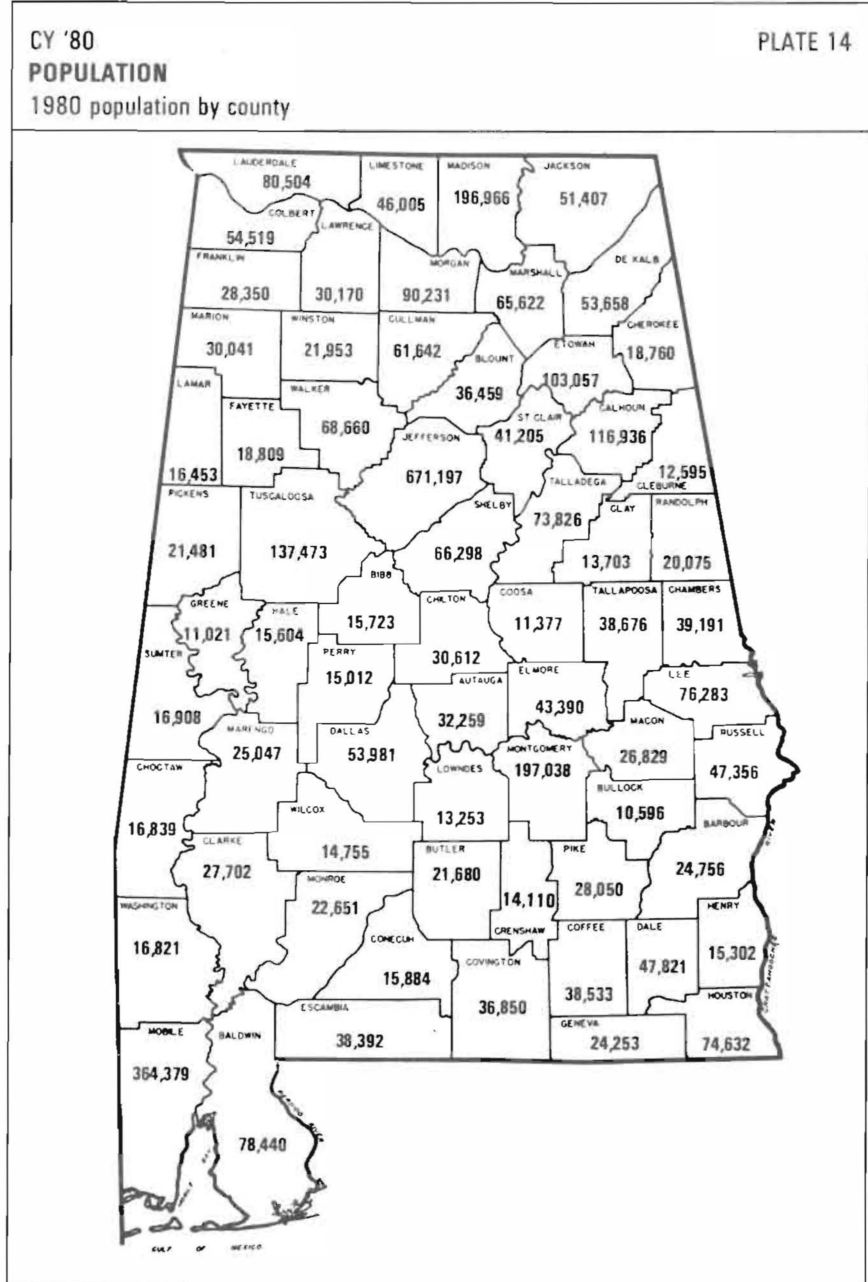
POPULATION

Eligibles as percent of Alabama population by year

Year	Population	Monthly Average Eligibles	Percent
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	3,890,061***	336,266	8.64

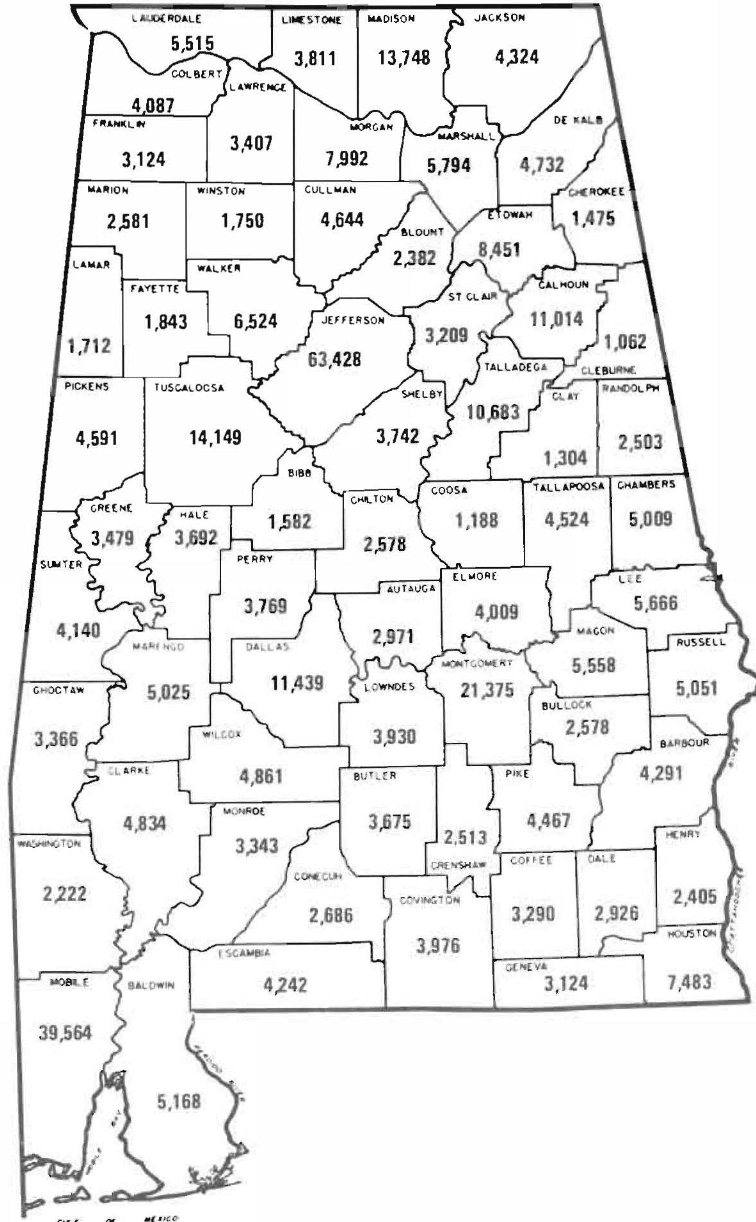
**U.S. Bureau of Census official estimate.

***1981 population estimates not available



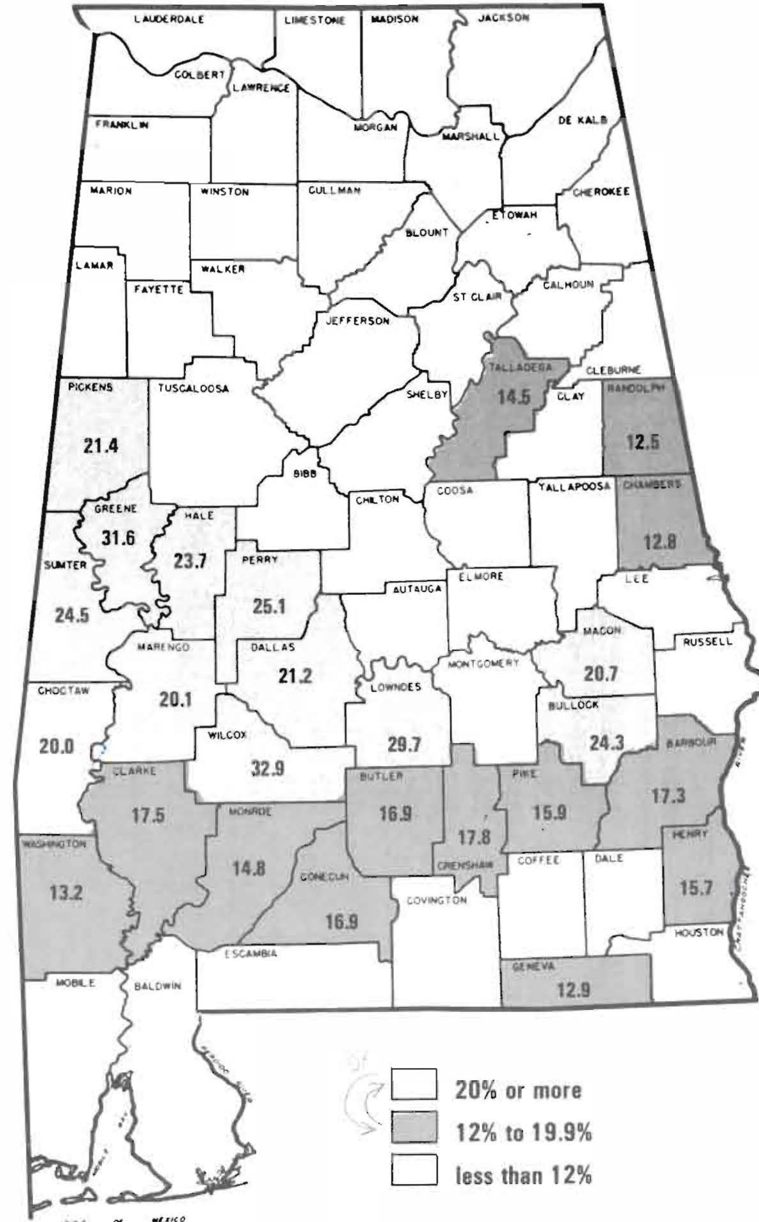
FY '81
ELIGIBLES
Number of Medicaid eligibles by county

PLATE 15



FY '81
ELIGIBLES
Percent of population eligible for Medicaid, by county

PLATE 16



FY '81 **ELIGIBLES** Monthly Count	PLATE 17
	Monthly Count
October '80	336,395
November	337,276
December	335,824
January '81	334,399
February	336,151
March	332,829
April	332,066
May	331,309
June	327,663
July	329,546
August	329,461
September	329,422

ELIGIBLES

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

Monthly Counts
Total Counts
Average Counts

Monthly counts are the actual number of eligibles enrolled at the end of each month (Plate 17). Total counts are the total unduplicated counts of eligibles enrolled at the end of the year, i.e. 409,428 persons were eligible for at least one month during FY'81 (Plate 18).

The most useful and informative count is the average number per month for the entire year (Plate 18). This number should be used for making comparisons between eligibles in different states or different years. The monthly average for 1981 was about 336,266, a decrease of more than 3,000 over the previous year's average of 339,417.

FY '81
ELIGIBLES
By category, sex, race, age
Total number for year
Average number per month
PLATE 18

	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	342,872	66,556	409,428	82,890	326,538	336,266	21.8%
AGED, Category 1	90,932	6,468	97,400	11,252	86,148	88,704	9.8%
BLIND, Category 2	1,992	194	2,186	198	1,988	2,006	9.0%
DISABLED, Category 4	61,169	7,497	68,666	7,782	60,884	61,356	11.9%
DEPENDENT, Categories 3, 5, 6, 7, & 8	188,779	52,397	241,176	63,658	177,518	184,200	30.9%
MALES	119,193	26,487	145,680	31,075	114,605	118,113	23.3%
FEMALES	223,679	40,069	263,748	51,815	211,933	218,153	20.9%
WHITES	125,851	25,353	151,204	34,429	116,775	121,566	24.4%
NONWHITES	217,021	41,203	258,224	48,461	209,763	214,700	20.3%
AGE 0-5	45,531	20,235	65,766	16,593	49,173	47,968	37.1%
AGE 6-20	103,196	21,323	124,519	29,881	94,638	99,429	25.2%
AGE 21-64	88,425	18,456	106,881	23,938	82,943	85,929	24.4%
AGE 65 & Over	105,720	6,542	112,262	12,478	99,784	102,940	9.1%

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 22% 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 decreased by 13,603 in FY'81. Plate 20 shows how the number of eligibles has changed each year during the past five years. The trend has generally been an increase over this period, though FY'81 did show a decrease in both counts.

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 also show a decrease in yearly totals, though the monthly average grew slightly.

FY '81 — PLATE 19
ELIGIBLES
Year's total
Distribution by category, sex, race and age

All Categories	Number 409,428	Percent 100.0%
Aged, Category 1	97,400	23.8%
Blind, Category 2	2,186	.5%
Disabled, Category 4	68,666	16.8%
Dependent, Categories, 3, 5, 6, 7, & 8	241,176	58.9%
Males	145,680	35.6%
Females	263,748	64.4%
White	151,204	36.9%
Nonwhites	258,224	63.1%
Age 0-5	65,766	16.1%
Age 6-20	124,519	30.4%
Age 21-64	106,881	26.1%
Age 65 & Over	112,262	27.4%

FY '77 - '81 — PLATE 20
ELIGIBLES
By category
Monthly average
Annual number

		FY '77	FY '78	FY '79	FY '80	FY '81
MONTHLY AVERAGES	AGED, Category 1	109,856	100,994	98,284	96,667	88,704
	BLIND, Category 2	1,991	1,998	1,998	1,962	2,006
	DISABLED, Category 4	49,153	54,374	57,467	58,386	61,356
	DEPENDENT, Categories 3, 5, 6, 7, & 8	170,891	175, 643	181,098	182,402	184,200
	ALL CATEGORIES	331,891	332,999	338,847	339,417	336,266
YEARLY TOTALS	AGED, Category 1	119,271	111,832	108,534	109,314	97,400
	BLIND, Category 2	2,228	2,180	2,215	2,230	2,186
	DISABLED, Category 4	63,417	62,654	67,260	69,264	68,666
	DEPENDENT, Categories 3, 5, 6, 7, & 8	228,218	226,664	235,796	242,223	241,176
	ALL CATEGORIES	413,134	403,330	413,805	423,031	409,428

FY '81 **ELIGIBLES** By category, sex, race, and age Total MME used by each group Average MME used by each person		PLATE 21
	Total MME Used In Year	**Average MME Per Person**
ALL ELIGIBLES	4,035,198	9.9
AGED, Category 1	1,064,460	10.9
BLIND, Category 2	24,039	11.0
DISABLED, Category 4	736,272	10.7
DEPEDENT, Categories 3, 5, 6, 7, & 8	2,210,427	9.2
MALES	1,417,350	9.7
FEMALES	2,617,848	9.9
WHITES	1,458,795	9.6
NONWHITES	2,576,403	10.0
AGE 0-5	575,610	8.8
AGE 6-20	1,193,143	9.6
AGE 21-64	1,031,151	9.6
AGE 65 & Over	1,235,294	11.0

Man-Months and Expected Duration of Eligibility: Although 409,428 people were eligible for Medicaid in FY'81, only about three-fourths were eligible all year. The others ranged from one to eleven months.

To find the total amount of time all these people were eligible in FY'81, 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 used to produce an average 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.

RECIPIENTS

Of the 409,428 people deemed eligible for Medicaid in FY'81, only 81% actually received Medicaid benefits. These 330,580 people are called "recipients." The other 78,848, though eligible for benefits, incurred no medical bills paid for by Medicaid. The total figure of 330,580 is an unduplicated count, and comparison with the various recipient categories and percent of eligibles will reflect some variation. This is caused by transfer of recipients from one category to another during the course of a year.

Plate 22 shows the monthly count of recipients as well as the monthly percentage of eligibles. The table shows that only 43% of eligibles received Medicaid service in a typical month.

FY '81 PLATE 22
RECIPIENTS
Monthly Counts
Percent of eligibles

	Monthly Recipients	Percent of Eligibles
October '80	154,727	46.0%
November	137,244	40.7%
December	138,451	41.2%
January '81	140,182	41.9%
February	165,085	49.1%
March	140,959	42.3%
April	134,245	40.4%
May	147,278	44.4%
June	152,653	46.6%
July	129,263	39.2%
August	143,805	43.6%
September	139,016	42.2%
Monthly Average	143,576	42.7%

FY '79-'81 PLATE 23
RECIPIENTS
By category, sex, race, age, and percent of eligibles

	FY '79	FY '80	FY '81	PERCENT OF ELIGIBLES (FY '81)
AGED, Category 1	98,837	91,784	98,167	N/A
BLIND, Category 2	1,784	1,759	1,847	N/A
DISABLED, Category 4	55,907	56,973	61,658	N/A
DEPENDENT, Categories 3, 5, 6, 7, & 8	174,472	173,848	207,529	N/A
MALES	110,829	105,911	107,376	73.7%
FEMALES	220,171	218,453	223,204	84.6%
WHITES	122,882	121,361	128,953	85.3%
NONWHITES	208,118	203,003	201,627	78.1%
AGE 0-20	134,537	135,353	131,091	68.9%
AGE 21-64	93,464	84,196	92,009	86.1%
AGE 65 & over	102,999	104,815	107,480	95.6%
ALL CATEGORIES	331,000	324,364	330,580	80.7%

FY '81 PLATE 24

RECIPIENTS

By category
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	61,456	55,235	57,012	684,144	98,167	6.97
BLIND, Category 2	1,067	984	999	11,988	1,847	6.49
DISABLED, Category 4	35,673	34,217	34,350	412,200	61,658	6.69
DEPENDENT, Categories 3, 5, 6, 7, & 8	57,101	49,645	52,231	626,772	207,529	3.02
ALL CATEGORIES (unduplicated)	154,727	139,016	143,576	1,722,912	330,580	5.21

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 330,580 recipients in FY'81 was 1,722,912. MMS per recipient was 5.21, down from 5.24 MMS per recipient in FY'80.

USE AND COST

FY '79-'81 USE Utilization rate by category PLATE 25			
	FY '79	FY '80	FY '81
AGED, Category 1	91.1%	84.0%	N/A
BLIND, Category 2	80.5%	78.9%	84.5%
DISABLED, Category 4	83.1%	82.3%	89.8%
DEPENDENT, Categories 3, 5, 6, 7, & 8	74.0%	71.8%	86.1%
ALL CATEGORIES	80.0%	76.7%	80.7%

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 four persons out of five, with 80.7% being the exact figure. (See Plate 25.)

FY '79-'81 USE MMS per recipient Frequency-of-service rate PLATE 26			
	FY '79	FY '80	FY '81
AGED, Category 1	7.66MMS	7.55MMS	6.97MMS
BLIND, Category 2	6.79MMS	6.58MMS	6.49MMS
DISABLED, Category 4	6.98MMS	6.81MMS	6.69MMS
DEPENDENT, Categories 3, 5, 6, 7, & 8	3.81MMS	3.49MMS	3.02MMS
ALL CATEGORIES	5.49MMS	5.24MMS	5.21MMS

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 26.)

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 5.21 means that the average recipient received medical care during 5.21 months.

FY '81 USE MMS per eligible Ratio of actual use to potential use PLATE 27	
AGED, Category 1	7.02MMS
BLIND, Category 2	5.48MMS
DISABLED, Category 4	6.00MMS
DEPENDENT, Categories 3, 5, 6, 7, & 8	2.60MMS
ALL CATEGORIES	4.21MMS

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 81% of Medicaid's eligibles become recipients of medical services. These recipients ask for medical care on an average of only 5.21 months each. Subsequently, the actual demand for care is about 35% 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 27.)

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 money will be needed as the number of eligibles changes each year.

Cost Per Eligible: Plate 28 shows the variation in cost per eligible from one group to another. An aged person, for example, costs Medicaid six times as much per year as a young eligible. In addition to using services more often and using more expensive services, the aged person remains eligible longer than the child. The variations in cost per eligible can be attributed to the fact that different groups use different kinds of services in different amounts.

Plate 28 shows the yearly cost per eligible for the past three years. All groups of eligibles in FY'81 showed a rise in costs, with only one exception. The average cost of eligibles aged 5 and under declined by 55.5% from the previous year. At the other extreme were the age groups 6-20 and 21-64 with increases of 26% and 22% respectively.

Due in part to a smaller number of total eligibles, the average yearly cost for each rose 10.8% to $690. Plate 29 shows the average cost per month of eligibility.

FY '79-'81 — PLATE 28

COST

Annual changes in cost per eligible

	FY '79	FY '80	FY '81	CHANGE FROM FY '80
AGED, Category 1	$1,167	$1,142	$1,296	+13.5%
AGE 65 & Over	1,080	1,085	1,262	+16.3%
DISABLED, Category 4	995	1,090	1,250	+14.7%
WHITES	1,044	979	1,117	+14.1%
AGE 21-64	869	756	923	+22.1%
BLIND, Category 2	768	683	800	+17.1%
FEMALES	729	696	770	+10.6%
ALL ELIGIBLES	643	623	690	+10.8%
MALES	490	492	545	+10.8%
NONWHITES	423	410	440	+ 7.3%
DEPENDENTS, Categories 3, 5, 6, 7 & 8	300	254	284	+11.8%
AGE 6-20	231	212	268	+26.4%
AGE 0-5	247	299	133	–55.5%

FY '79 - '81 — PLATE 29

COST

Cost per MME

	FY '79	FY '80	FY '81
AGED, Category 1	$107	$108	$119
DISABLED, Category 4	97	108	117
WHITES	108	104	116
AGE 65 & Over	100	101	115
AGE 21-64	92	82	96
FEMALES	74	72	78
BLIND, Category 2	71	64	73
ALL ELIGIBLES	65	65	70
MALES	50	52	56
NONWHITES	43	42	44
DEPENDENTS, Categories 3, 5, 6, 7 & 8	33	28	31
AGE 6-20	24	22	28
AGE 0-5	28	35	15

Cost Per Recipient: Section 3 of Plate 30 discloses that Medicaid averaged paying $1,324 for each disabled person who became a hospital patient, but only $289 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 30 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 $9.60 per month until July 1, when it rose to $10.50. Medicaid's total payment to Medicare for these buy-in premiums in FY'81 was $13,514,393. Medicare spent considerably more than $14 million in partial payment of medical bills incurred by Alabama citizens on Medicaid.

FY '81

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 ~~NOT~~ SHARED WITH MEDICARE							
		Physicians' Services	Lab & X-Ray	Hospital+ Inpatients	Hospital Outpatients	Home Health	Transpor-tation	Drugs	Nursing Homes, Skilled++
SECTION 1 YEAR'S COST	ALL CATEGORIES	$31,650,087	$3,702,368	$65,975,991	$13,109,707	$1,582,490	$352,221	$24,242,873	$23,808,953
	Category 1 Aged	5,806,537	234,794	7,326,310	1,486,957	893,925	11,517	13,504,865	17,859,576
	Category 2 Blind	266,252	34,990	596,128	87,806	39,606	3,946	216,208	101,658
	Category 4 Disabled	9,669,842	1,493,394	23,352,169	4,456,811	624,116	175,336	8,060,472	5,836,224
	Categories 3, 5, 6, 7 & 8 Dependent Children	7,204,376	823,039	14,010,441	3,869,730	8,148	65,407	879,574	6,538
	Categories 3 & 6 Dependent Adults	8,703,080	1,116,151	20,690,943	3,208,403	16,695	96,015	1,581,754	4,957
SECTION 2 YEAR'S TOTAL NUMBER OF RECIPIENTS	ALL CATEGORIES	252,882	84,871	75,220	117,873	3,546	4,882	240,638	7,557
	Category 1 Aged	70,208	14,896	25,386	25,453	2,089	693	84,832	6,265
	Category 2 Blind	1,485	511	502	676	71	48	1,514	29
	Category 4 Disabled	47,187	18,830	17,631	23,045	1,263	2,016	50,271	1,255
	Categories 3, 5, 6, 7 & 8 Dependent Children	85,229	30,406	12,928	42,780	51	855	60,847	4
	Categories 3 & 6 Dependent Adults	48,773	20,228	18,773	25,919	72	1,270	43,174	4
SECTION 3 YEAR'S COST PER RECIPIENT	ALL CATEGORIES	$ 125	$ 44	$ 877	$ 111	$ 446	$ 72	$ 101	$ 3,151
	Category 1 Aged	83	16	289	58	428	17	159	2,851
	Category 2 Blind	179	68	1,188	130	558	82	143	3,505
	Category 4 Disabled	205	79	1,324	193	494	87	160	4,650
	Categories 3, 5, 6, 7 & 8 Dependent Children	85	27	1,084	90	160	76	14	1,635
	Categories 3 & 6 Dependent Adults	178	55	1,102	124	232	76	37	1,239
SECTION 4 UTILIZATION RATES PERCENT OF ELIGIBLES	ALL CATEGORIES	61.76%	20.73%	18.37%	28.79%	0.87%	1.19%	58.77%	1.85%
	Category 1 Aged	72.08%	15.29%	26.06%	26.13%	2.14%	0.71%	87 10%	6 43%
	Category 2 Blind	67 93%	23.38%	22.96%	30.92%	3.25%	2.20%	69.26%	1 33%
	Category 4 Disabled	68 72%	27.42%	25.68%	33.56%	1.84%	2.94%	73.21%	0.01%
	Categories 3, 5, 6, 7 & 8 Dependents	55.56%	20.99%	13.14%	28.49%	0.01%	0.88%	43.13%	**

+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 30

SERVICES WHOSE COSTS ARE NOT SHARED WITH MEDICARE							ALL SERVICES		
Nursing Homes, ICF	Dental Care	Family Planning	Practi-tioners	Other Care	Screening	Medicare Buy-In	Total Of Unshared Costs	Medicaid's Total Part Of Shared Costs	Medicaid's Totals
$109,925,605	$3,832,892	$1,844,187	$1,170,856	$285,238	$931,817	$13,514,393	$179,556,814	$116,372,864	$295,929,678
78,086,575	1,216	846	429,237	125,708	0	10,409,892	120,417,915	15,760,040	136,177,955
389,489	3,188	5,132	4,697	1,536	589	0	722,497	1,028,728	1,751,225
31,443,331	165,264	212,477	291,664	84,596	25,793	3,104,501	49,224,322	39,771,668	88,995,990
6,210	3,197,260	186,442	251,201	41,736	860,671	0	5,429,632	25,981,141	31,410,773
0	465,964	1,439,290	194,057	31,662	44,764	0	3,762,448	33,831,287	37,593,735
18,951	44,621	30,997	30,116	9,418	37,811	N/A*	N/A*	N/A*	330,580
15,770	40	37	10,564	3,877	0	N/A*	N/A*	N/A*	98,167
63	34	76	121	56	23	0	N/A*	N/A*	1,847
3,117	1,956	2,077	7,287	2,351	1,040	N/A*	N/A*	N/A*	61,658
1	39,131	4,884	6,832	1,768	34,937	0	N/A*	N/A*	135,679
0	3,460	23,923	5,312	1,366	1,811	0	N/A*	N/A*	71,850
$ 5,801	$ 86	$ 59	$ 39	$ 30	$ 25	N/A*	N/A*	N/A*	$ 895
4,952	30	23	41	32	0	N/A*	N/A*	N/A*	1,387
6,182	94	68	39	27	26	0	N/A*	N/A*	948
10,088	84	102	40	36	25	N/A*	N/A*	N/A*	1,443
6,210	82	38	37	24	25	0	N/A*	N/A*	232
0	135	60	37	23	25	0	N/A*	N/A*	523
4.63%	10.90%	7.57	7.36%	2.30%	9.24%	N/A*	N/A*	N/A*	80.74%
16.19%	.04%	.04%	10.85%	3.98%	0	N/A*	N/A*	N/A*	*
2.88%	1.56%	3.48%	5.54%	2.56%	1.05%	0	N/A*	N/A*	84.49%
4.54%	2.85%	3.02%	10.61%	3.42%	1.51%	N/A*	N/A*	N/A*	89.79%
**	17.66%	11.94%	5.04%	1.30%	15.24%	0	N/A*	N/A*	86.05%

LONG-TERM CARE

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

In terms of expenditures, it is the largest program. This year 43% of Medicaid funds went for nursing home care.

The AlaMed Nursing Home Program: In 1965 with the enactment of Medicaid (Title XIX), Congress was primarily concerned that the law provide assurance of care to the acutely ill, indigent patients in skilled nursing homes. Since then, the demands for more nursing services have increased due to a number of significant social and economic factors, including the following:

1. Population growth.
2. Increased longevity resulting in larger numbers of people in the older age categories.
3. Increase in chronic disease resulting from an aging population and from advances in medical science and technology.
4. Increasing urbanization, reducing both the size of family domiciles and the number of non-working members available to care for the elderly.
5. Higher average income levels.
6. Increases in the number of Medicaid-eligible mental health patients.

Title XIX requires that any approved Medicaid program have certain required services and allows the states several optional types of services. The Alabama Medicaid Agency provides two basic levels of nursing home care: skilled care, which is a required service; and intermediate care, which is an optional service. Skilled nursing care, the higher level, is for patients who require around-the-clock licensed nursing care. Intermediate nursing care is used by people who have chronic medical conditions which are stable with medication. They do not require around-the-clock nursing care, but are not well enough for independent living.

While skilled nursing care has been a service provided since the inception of Alabama Medicaid in 1970, intermediate nursing care was not provided until 1972. From 1972 until 1976, there were twice as many skilled patients receiving nursing care as intermediate patients. Since then, the trend in the level of care has reversed. In FY 1977 there were 15,261 skilled patients and 9,090 intermediate patients compared to 1981, which showed 6,971 skilled patients and 17,094 intermediate patients. Many factors have contributed to the changing pattern of care utilization. The most significant factors are:

1. DUAL CERTIFIED FACILITIES. On January 1, 1980, AlaMed made it a State condition for all long-term care facilities providing skilled care to provide both skilled and intermediate care services.
2. COMBINATION REIMBURSEMENT RATE. On January 1, 1981, AlaMed adopted a single corporate rate payment methodology that accommo-

FY '77-'81 PLATE 31
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
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
1981	24,065	7.59 months	182,683	738	133,734,558
% Change since 1977	−1%	+18%	+17%	+35%	+58%

FY '76-'81 PLATE 32

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		
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
1981	20,649	14,920	24,065	72%	5,729

dated both skilled and intermediate care patients in the same facility.

3. PROFESSIONAL STANDARDS REVIEW ORGANIZATION (PSRO). On October 1, 1979, a federal grant authorised PSRO to perform periodic medical review for level of care classification of patients without cost to the Medicaid Program. This allows patient reclassifications on a timely basis.
4. INTERMEDIATE CARE FACILITY/ MENTALLY RETARDED (ICF/MR) AND INTERMEDIATE CARE FACILITY/MENTAL DISEASE (ICF/ MD). AlaMed negotiated agreements with the State Department of Mental Health to include coverage for Medicaid-eligible recipients in ICF/MF in 1977 and for coverage to recipients over 65 years old in ICF/MD in 1978.

The Cost of the Nursing Home Program: During FY 1981, Medicaid spent $133.7 million to provide nursing care services for approximately 24,000 patients. While the actual number of recipients receiving services decreased by approximately 400, the cost of the program increased $2.3 million over FY 1980 (Plate 31). Part of the cost rise was caused by higher prices in reimbursement for services rendered by the 210 nursing homes participating in the program. Over the past five years the annual expense for the program has risen from $84.7 million to $133.8 million — an increase of 58%. Plate 31 shows the annual steps by which this increase took place and the factors that caused the increase: patients, months of service, and prices. Most of the increase, however, was due to the high cost of providing services to the ICF/MR recipient. There were 637 ICF/MR patients in 1981 at an average monthly cost per patient of $2,300 (Plate 34). The Long-Term Care Program continues to be the most expensive item in the Alabama Medicaid budget.

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 32 shows the growth rate during the past five years, during which time 1,897 beds were added — an average of 32 per month. Plate 32 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.

FY '81 PLATE 33

LONG-TERM CARE PROGRAM

Recipients, by sex, by race, by age

	Skilled	ICF	Total	Percent
All Recipients	6,971	17,094	24,065	100%
By Sex				
Female	5,182	12,488	17,670	73.4%
Male	1,789	4,606	6,395	26.6%
By Race				
White	5,504	13,732	19,236	79.9%
Nonwhite	1,467	3,362	4,829	20.1%
By Age				
65 & Over	5,896	14,541	20,437	85.0%
21-64	899	2,382	3,281	13.6%
6-20	137	163	300	1.2%
0-5	39	8	47	0.2%

FY '80-'81 PLATE 34

LONG-TERM CARE PROGRAM

ICF-MR

	FY '80	FY '81
Recipients	697	637
Annual Cost	$14,197,620	$17,408,891
Average Cost per Recipient	$20,370	$27,329

FY '81 PLATE 35

LONG-TERM CARE PROGRAM

Payments, by sex, by race, by age

	Skilled	ICF	Total	Percent
All Recipients	$23,808,953	$109,925,605	$133,734,558	100%
By Sex				
Female	18,059,674	76,740,209	94,799,883	70.9%
Male	5,749,279	33,185,396	38,934,675	29.1%
By Race				
White	19,188,357	86,906,768	106,095,125	79.3%
Nonwhite	4,620,596	23,018,837	27,639,433	20.7%
By Age				
65 & Over	18,459,001	80,728,604	99,187,605	74.1%
21-64	3,915,817	26,179,569	30,095,386	22.5%
6-20	1,070,457	2,954,003	4,024,460	3.0%
0-5	363,678	63,429	427,107	0.3%

FY '79-'81 PLATE 36

LONG-TERM CARE PROGRAM

Number of Recipients

	Skilled			ICF			Total		
	FY '79	FY '80	FY '81	FY '79	FY '80	FY '81	FY '79	FY '80	FY '81
Monthly Average	6,464	4,846	3,028	7,938	9,987	11,891	14,402	14,833	14,920
Yearly Total	12,364	9,528	6,971	12,260	14,913	17,094	24,624	24,441	24,065
Annual Turnover Rate	91%	97%	130%	54%	49%	44%	71%	65%	61%
Average Length of Stay	6.3 mo.	6.1 mo.	4.8 mo.	7.8 mo.	8.0 mo.	8.7 mo.	7.0 mo.	7.3 mo.	7.6 mo.
Average Expected Duration of Stay	12 mo.	12.4 mo.	9.2 mo.	20 mo.	24.5 mo.	27.3 mo.	15.5 mo.	18.5 mo.	19.7 mo.

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.

Nursing Home Reimbursement: Alabama uses the Uniform Cost Report (UCR) system to establish a Medicaid payment rate for a facility. It takes into consideration the nursing facility plant, financing arrangements, staffing, management procedures, and efficiency of operations. The UCR must be completed by each nursing facility and submitted to the Alabama Medicaid Agency by September 15 of each year so that a new rate may be established and implemented by January 1 of the following year. Allowable expenses included in the reimbursement rate are employee salaries, equipment, consultation fees, food service, supplies, maintenance, utilities, etc., as well as any other expenses to be incurred in maintaining full compliance with standards required by the state and federal regulating agencies.

Medicaid pays to the long-term care facility 100% of the difference between the Medicaid-assigned reimbursement rate and the patient's available resources. The maximum amount of income that a patient may have and still be eligible for nursing home care under the Medicaid Program was increased twice in 1981. From October, 1980, through March, 1981, the maximum amount was $482. This amount increased in April, 1981, to $600 and again in July, 1981, to $667. All personal income above $25 per month for Medicaid nursing home patients must be applied to reduce the monthly Medicaid charge for covered nursing home services.

Patient Characteristics and Length of Stay: Plates 33 and 35 show who the recipients were this year — in terms of sex, race, and age — and the amount spent on each group.

Plate 36 shows what two particular 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 8 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. The specific figures on cost increases for Alabama Medicaid are shown in Plate 37. During the past four years the following changes occurred:

Number of patients ....+17%
Number of admissions ....+19%
Costs ....+57%

Total costs exceeded $70 million for an average cost per day of $218. The average length of stay was 5.5 days while the number of admissions was 144 per 1,000.

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 are admitted 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.

The data used in Plate 37 was recomputed from previous years to exclude Medicare cross-over claims. This presents a better picture of the actual costs incurred by Medicaid. (NOTE: Comparable figures for FY'80 were not available and the figures provided are not valid for comparison purposes.)

FY '78-'81 PLATE 37
HOSPITAL PROGRAM
Changes in use and costs

Year	Eligibles	Inpatients	Admissions	Admissions per 1000 Eligibles	Days	Length of Stay	Total Cost*	Cost Per Day	Cost Per Stay
1978	403,330	37,782	49,871	124	307,927	6.2	$45,518,783	$148	$ 918
1979	413,805	46,769	63,711	154	337,453	5.3	65,651,013	195	1,033
1980*	423,031	72,350	95,092	225	403,020	4.2	68,201,417	169	710
1981	409,428	44,254	59,123	144	327,363	5.5	71,565,804	218	1,201

*includes Medicare crossovers

FY '81 PLATE 38

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	$245	7.6	$1,862	N/A
All Alabama Hospital Patients (FY '80)	$237	6.7	$1,558	N/A
Alabama Medicaid Patients*	$218	5.5	$1,201	$1,617

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

Medicaid Patients Compared to Private Patients: Plate 38 shows that for the nation as a whole, the cost per day for hospital care is now up to $245, and that the cost per stay is $1,862. The cost to Alabama Medicaid, even though it has increased in the last four years, is still lower than the figure for all U.S. patients. This year Medicaid's cost per day was $218. It must be remembered, however, that the $218 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 that paid by private patients.

As shown in Plate 39 the hospital admission rate for the Alabama population was higher than the rate for Medicaid eligibles. Medicaid's admission rate was 25% lower than the rate for Alabama as a whole. Medicaid's length of stay was also below the average for the state. (NOTE: Plate 39 reflects both 1980 and 1981 data.)

FY '80-'81 PLATE 39

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 (FY '81)	409,428	59,123	327,363	144	5.5
All Alabama Residents (FY '80)	3,890,061	743,447	4,975,576	191	6.7

FY '77-'81

HOSPITAL PROGRAM

Outpatients

PLATE 40

	FY '77	FY '78	FY '79	FY '80	FY '81
Number of outpatients	86,910	94,339	105,507	110,774	115,393
Percent of eligibles using outpatient service	21%	23%	25%	26%	28%
Annual cost of outpatient care	$5,464,123	$5,451,111	$8,084,542	$11,568,775	$13,109,707
Cost per patient	$63	$58	$77	$104	$114

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 40 shows how use and cost of the outpatient program have grown in four years. The number of patients has increased 33%. The price per visit has increased 81%. 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 '73-'81

HOSPITAL PROGRAM

Hospital use and need for all Alabama

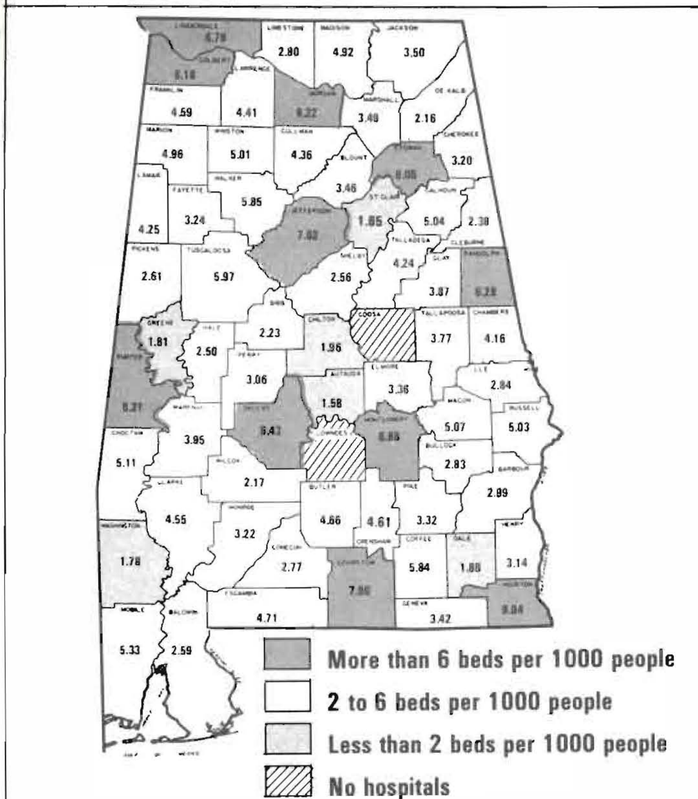
PLATE 41

	Alabama's Population	Hospital Admissions	Patient Days in Hospitals	Existing Hospital Beds	Needed Beds
1973	3,543,789	618,439	4,317,649	18,214	19,270
1974	3,577,000	611,817	4,325,570	18,002	16,170
1975	3,615,000	609,381	4,190,450	18,278	16,989
1976	3,653,000	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	3,769,000	727,292	4,897,995	20,199	17,795
1980	3,890,061	743,447	4,975,576	20,420	17,982

FY '80 PLATE 42

HOSPITAL PROGRAM

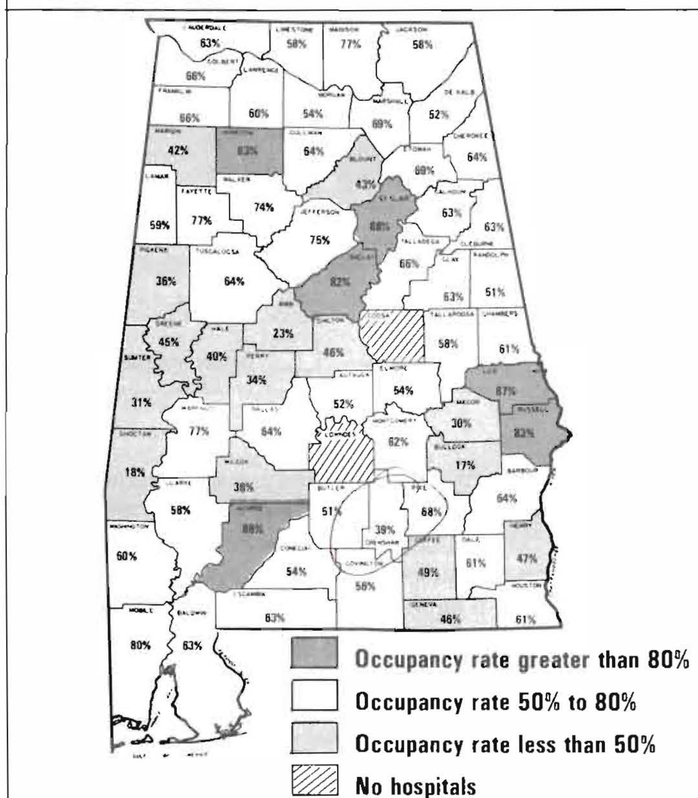
Beds per 1,000 people



FY '80 PLATE 43

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 17,982 which means we now have a surplus of 2,438 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. Plate 42 shows how existing beds are distributed among the counties. The average number of beds per 1,000 people for FY'80 is 5.25 — an increase from 5.19 in FY'79. Plate 43 shows the occupancy rate in each county for FY'80. The average rate has declined from 83% in FY'77 to the FY'80 average of 67.4%. The current efforts to slow expansion cannot lower hospital costs but should retard their growth if the average length of stay remains constant. (NOTE: Plates 42 and 43 reflect FY'80 data.)

PHYSICIAN PROGRAM

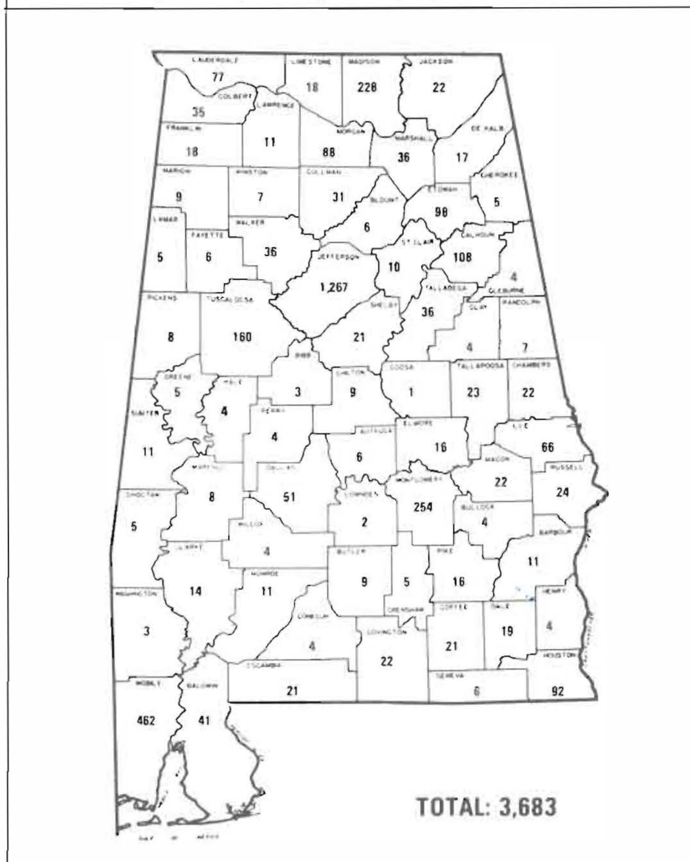
Among Medicaid eligibles, 59 persons in 100 saw a physician this year.

Medicaid paid physicians an average of $132 for each patient.

FY '81 PLATE 44

PHYSICIAN PROGRAM

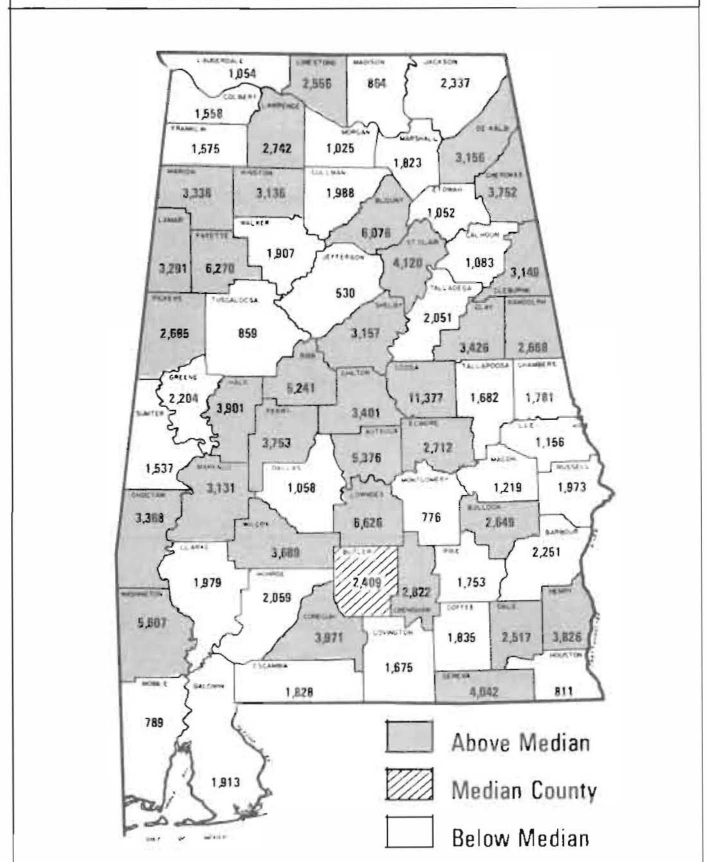
Number of physicians providing direct patient care, by county



FY '81 PLATE 45

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 3,683 doctors offering direct patient care in Alabama as of April, 1981. 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 Alabama Medicaid Agency 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'81 almost three-quarters of the Medicaid recipients in Alabama received physicians' services.

FY '77-'81

PHYSICIAN PROGRAM

Use and cost

PLATE 46

	COST PER RECIPIENT PER YEAR, FOR PHYSICIANS' SERVICES				
	FY '77	FY '78	FY '79	FY '80	FY '81
Aged	$ 51	$ 44	$ 59	$ 76	$ 83
Blind	$135	$133	$202	$176	$179
Disabled	$143	$138	$215	$187	$205
Dependent Children	$ 66	$ 63	$ 88	$ 79	$ 84
Dependent Adults	$140	$153	$215	$194	$178
ALL CATEGORIES	$ 85	$ 87	$128	$120	$132

	NUMBER OF MEDICAID RECIPIENTS TREATED BY PHYSICIANS				
	FY '77	FY '78	FY '79	FY '80	FY '81
Aged	76,287	69,678	67,071	72,159	71,452
Blind	1,416	1,382	1,439	1,415	1,491
Disabled	38,203	39,200	42,648	45,101	47,386
Dependent Children	82,648	69,497	80,888	77,432	83,019
Dependent Adults	33,651	39,063	45,447	44,328	49,536
ALL CATEGORIES	232,205	218,820	237,503	240,435	240,655*

	PERCENT OF ELIGIBLES WHO BECAME RECIPIENTS OF PHYSICIANS' CARE				
	FY '77	FY '78	FY '79	FY '80	FY '81
Aged	64.0%	62.3%	61.8%	66.0%	73.4%
Blind	63.6%	63.4%	65.0%	63.5%	68.2%
Disabled	60.2%	62.6%	63.4%	65.1%	69.0%
Dependents	51.0%	47.9%	53.6%	50.3%	55.0%
ALL CATEGORIES	56.2%	54.3%	57.4%	56.8%	58.8%

(*unduplicated count)

Medicaid physicians' care costs less per person for the aged than it costs for other categories (See Plate 46.) 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 1% from the previous year. The aged category showed a decrease; however, the aged recipients as a percent of eligibles showed a significant increase over the past two years.

PHARMACEUTICAL PROGRAM

More recipients had a larger number of prescriptions for higher-priced drugs than last year. This resulted in a significant rise in the amount that Medicaid paid to pharmacies.

FY '79-'81 PLATE 47
PHARMACEUTICAL PROGRAM
Counts of providers by type and year

Type of Provider	Number		
	FY '79	FY '80	FY '81
In-State Retail Pharmacies	1,130	1,000	1,008
Institutional Pharmacies	37	38	41
Dispensing Physicians	3	3	4
Out-of-State Pharmacies	42	40	36
Health Centers and Clinics	4	4	3
TOTAL	1,216	1,085	1,092

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 '79-'81 PLATE 48
PHARMACEUTICAL PROGRAM
Recipients, expenditures, and claims

	All Categories	Category 1 Aged	Category 2 Blind	Categories 3, 5, 6, 7, & 8 AFDC/Other	Category 4 Disabled
RECIPIENTS (Per Year)					
FY '79	239,654	85,554	1,503	105,927	46,670
FY '80	222,525	80,470	1,443	93,761	46,851
FY '81 (unduplicated)	223,538	84,832	1,514	102,036	50,271
EXPENDITURES (Per Year)					
FY '79	$22,277,146	$12,805,795	$192,029	$2,708,901	$6,570,421
FY '80	19,983,722	11,303,525	171,351	2,151,025	6,357,821
FY '81	24,242,873	13,523,047	216,499	2,432,467	8,072,859
# of Rx (Per Year)					
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
FY '81	3,171,150	1,785,517	27,546	370,040	988,047
Rx PER RECIPIENT (Per Year)					
FY '79	14.5	22.5	19.2	5.3	20.3
FY '80	13.3	20.5	17.2	4.3	18.8
FY '81	14.2	21.0	18.2	3.6	19.6
COST PER RECIPIENT (Per Year)					
FY '79	$ 93	$150	$128	$26	$141
FY '80	90	140	119	23	136
FY '81	108	159	143	24	161

FY '81 PLATE 49

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 '80	105,162	31%	320,592	3.05	$7.09	$21.62	$2,274,114
November	89,424	27%	238,542	2.67	$7.27	$19.38	$1,733,475
December	86,685	26%	233,227	2.69	$7.62	$20.50	$1,777,256
January '81	91,425	27%	254,696	2.78	$7.56	$21.06	$1,925,857
February	104,948	31%	313,723	2.99	$7.61	$22.74	$2,386,026
March	95,101	29%	298,853	3.14	$6.68	$21.00	$1,997,298
April	91,537	28%	249,354	2.72	$7.81	$21.28	$1,948,292
May	91,026	27%	247,045	2.71	$7.98	$21.66	$1,971,277
June	97,708	30%	295,077	3.02	$7.98	$24.11	$2,355,895
July	88,077	27%	238,047	2.70	$8.10	$21.89	$1,928,100
August	89,506	27%	243,698	2.72	$8.23	$22.40	$2,005,373
September	88,778	27%	238,843	2.69	$8.14	$21.89	$1,943,597
ALL YEAR	223,538	68%	3,171,150*	14.19	$7.64	$108.45	$24,242,873*

*less adjustments

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 8,000 drug code numbers in more than 50 drug classes. These drugs are listed in the Alabama Drug Code Index (ADCI). The principal purpose of the Index is to identify those drugs which are approved for payment under the program. Every effort is made to assure that the ADCI does not restrict the physician's choice of formulary in justified situations. Daily the pharmaceutical program approves products for those Medicaid eligibles who require specific drugs in the course of treatment. In many cases, this enables the patients to return to their own homes rather than remain in an institutional setting. 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.

Alabama's expenditures for drug benefits have been a constant portion of the total Medicaid program for several years. This past year only 8% was expended for the program compared with 7% in FY'80 and 8% in FY'79.

The average price for a prescription in FY'81 increased 14% from $6.70 to $7.64 (Plate 49). The number of prescriptions per recipient remained fairly constant, though the yearly cost per recipient increased by 20% from $90 in FY'80 to $108 in FY'81 (Plate 48).

FAMILY PLANNING

Recipients of family planning services this year number 63% more than last year.

FY '79-'81 PLATE 50
FAMILY PLANNING PROGRAM
Recipients by sex, race, and age

	FY '79	FY '80	FY '81
Total	21,269	16,555	27,013
Male	465	89	659
Female	20,804	16,466	26,354
White	2,540	2,014	4,512
Nonwhite	18,729	14,541	22,501
Age 0-5	0	0	0
Age 6-20	9,056	7,515	13,320
Age 21-64	12,213	9,026	13,693
Age 65 & over	0	14	0

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 examinations, 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. 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; and (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 for abortions: (1) when 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 of February 19, 1980, Alabama Medicaid began receiving federal financial participation for all abortions that are considered medically 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 could only pay for abortions when the life of the mother would be endangered if the fetus were carried to term and for victims of promptly reported rape and incest.

As of February 23, 1981, Alabama Medicaid could only pay for abortions when the life of the mother would be endangered if the fetus were carried to term and for victims of rape reported within 72 hours to a law enforcement agency.

Effective July 1, 1981, the Alabama Medicaid Program will only pay for abortions when the life of the mother would be endangered if the fetus were carried to term.

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 '81 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 $24.57 for a recipient. The cost of treatment is considerably higher depending on the condition. Payments for screenings in FY '81 increased 7% from the previous year.

FY '79 - '81 PLATE 51
EPSDT PROGRAM
Recipients by age and payment

	FY '79	FY '80	FY '81
Total Screened	43,378	37,796	37,811
Age:			
0-5	16,328	16,468	15,316
6-20	27,050	21,328	22,495
Total Payment Screenings	$999,696	$870,743	$928,853
Average payment Screenings	$23.05	$23.04	$24.57

During FY '81 a total of 37,811 screenings were made—a slight increase from FY '80. Of those screened, about 70% had referrable conditions uncovered or suspected.

HOME HEALTH

Of every eight Medicaid patients in need of regular and continuous care, seven live in nursing homes. The other one receives home health care.

An Alternative to Nursing Home Care: The Home Health Care Program, which began in Alabama in 1970, is a mandatory, not an optional, program. Its purpose as described in Title XIX of the Social Security Act states that the Home Health Care Program will provide quality medical care for people who are confined to their homes with an illness, disability, or injury. This level of care provides health services to homebound individuals of all ages on an intermittent or part-time basis and is a desirable and less costly alternative to institutionalization. In order for the patient and family to manage their illness/disability, the Alabama Medicaid Agency has contracted with 83 certified home health agencies to provide health care services to these recipients.

Medicaid eligibles receive care from professional registered nurses, licensed practical nurses, orderlies, and home health aides. Nursing services consist of patient observation, evaluation, and treatment in accordance with the attending physician's plan of treatment. The nurse also acts as liaison between hospital, doctor, and patient. Home health aides provide personal services in the form of personal hygiene, ambulation activities, and other supervised services.

Growth of the Program: Plate 52 shows how the number of chronically ill has increased each year since 1975 and the division each year of these patients into two groups — one group at home and one group in nursing homes.

In FY '81 a total of 3,486 recipients received 77,046 visits for a cost to Medicaid in excess of $1,500,000. Primary diagnoses for which these recipients received treatment include diabetes, hypertension, cerebro-vascular accidents, orthopedic and skin problems, and respiratory and urinary infections.

Payment, Service, and Cost: Per visit payments can not exceed the final adjusted rates for Medicare beneficiaries. $25.00 maximum per visit payment was established by the Medicaid program in FY '81 with an increase in the ceiling rate under consideration at this writing. Visits are limited to 100 per calendar year with additional skilled visits available if medically necessary and authorized by AlaMed.

Effective July 1, 1978, certain supplies, appliances, and durable medical equipment became available to Medicaid eligibles in an attempt to minimize institutionalization. These covered items, as a medical necessity, are obtained upon written orders of the attending physician and processed through home health agencies and suppliers under contract with AlaMed.

FY '75-'81 PLATE 52

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
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
1981	3,486	24,065

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 aged people as well as some disabled people. Many aged people who have low incomes are eligible for both and 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 eligibility, and the eligibles in each of the resulting groups form a "Category" with a capital 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	$198.35
1 day of skilled nursing care	23.25
1 physician service	14.54
1 prescription	7.65

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 $10.50 a month. Medicaid buys this insurance for all Medicaid eligibles whose applications are approved by Social Security. Medicaid calls this insurance "buy-in insurance."

MEDICARE CROSSOVER PAYMENTS

Medicare crossover payments are the payments of deductibles and co-insurance charges made by the Alabama Medicaid Agency for those recipients who have both Medicare and Medicaid. These amounts would otherwise be the responsibility of the recipient if he was not eligible for Medicaid.