ALABAMA MEDICAID

TENTH ANNUAL REPORT

OCTOBER 1, 1981-SEPTEMBER 30, 1982

ALABAMA MEDICAID AGENCY
State of Alabama

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

GEORGE C. WALLACE
Governor

FAYE S. BAGGIANO
Commissioner

April 20, 1983

The Honorable George C. Wallace
Governor of Alabama
State Capitol
Montgomery, Alabama 36130

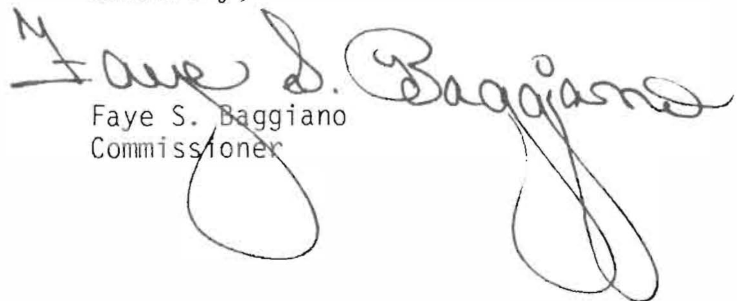
Dear Governor Wallace:

It is with pleasure that I submit the Tenth Annual Report of the Alabama Medicaid Agency covering the fiscal year ending September 30, 1982.

In this report, we have compiled a wide-range of data concerning recipients, providers of service, and expenditures concerned with the Medicaid Program during that year. This information will assist interested parties in understanding the activities and the complexities of Medicaid.

We who administer the program are extremely grateful to you, the State Legislature, and the taxpayers of Alabama for the opportunity to make medical care available each year to over 400,000 Alabama citizens who might otherwise be denied this needed care.

Sincerely,



Faye S. Baggiano
Commissioner

ALABAMA MEDICAID

FISCAL YEAR 1982

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Statistician

ALABAMA MEDICAID AGENCY

MONTGOMERY, ALABAMA

Faye S. Baggiano, 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 \$55.5 million more in FY'82 than they were in FY'81. This represents an increase of nearly 20 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 \$14.1 million higher than they were the previous year. ICF-Mentally Retarded and ICF-Mental Illness accounted for another \$17.6 million increase. For skilled-level nursing home care the payments declined by \$11.1 million in FY'82. Taken as a whole, payments to nursing homes rose \$20.6 million, an increase of more than 15 percent.

Another program having a significant increase was inpatient hospitalization, with payments to hospitals for this type of service climbing \$17.2 million, or 26% over FY'81 levels. Payments for other health care rose \$9.8 million for an increase of over 57%. Dental care, family planning services, and X-rays accounted for approximately one-half 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 these three factors. As shown in this table, the primary factor contributing to the overall increase in payments

FY '82 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 '81	FY '82	In Dollars (millions)	In Percent	Attributable to Rising Prices (millions)	Attributable to More Recipients (millions)	Attributable to More Units Per Recipient (millions)
SNF Care	\$ 23.8	\$ 12.7	\$-11.1	-46.6%	\$ .6	\$-11.4	\$ -.3
ICF Care	91.4	105.5	14.1	15.4%	1.8	13.9	-1.6
ICF-MR/MD	18.5	36.1	17.6	95.1%	5.5	10.2	1.9
Physician Services	27.7	32.9	5.2	18.8%	5.2	1.7	-1.7
Inpatient Hospital	66.1	83.3	17.2	26.0%	5.8	.5	10.9
Outpatient Hospital	13.1	11.9	-1.2	-9.2%	-.1	-.5	-.6
Prescriptions	24.9	28.8	3.9	15.7%	3.3	-.1	.7
Other Care	17.1	26.9	9.8	57.3%	6.5	2.3	1.0
TOTAL	\$282.6	\$338.1	\$55.5	19.6%	\$28.6	\$16.6	\$10.3

was the average unit price which rose more than 14% in FY'82.

With the exception of outpatient hospital care, all of the major categories of service experienced higher prices. The average payment per unit of other care increased the most (31.7%), followed by physician services with an increase of 18.6%.

The average number of recipients taking advantage of the Medicaid program fell by only 1% during the year. Two types of service, however, which had a greater number of recipients in FY'82 were ICF-MR/MD and intermediate nursing home care for all others. The number of Medicaid eligibles no longer receiving SNF care was more than offset by the number of new ICF patients. At the same time, patients of intermediate care facilities for the mentally retarded/mentally diseased increased by almost 55%. Physician services also exhibited a rise in the number of recipients.

Although the number of recipients of inpatient hospital services remained stable, these recipients were in the hospital 16.4% more days. This was the only significant change in utilization, as measured by the average number of units (days, procedures, 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'82 would have resulted in an increase of $3.3 million.

Notice in Plate 1 that higher prices accounted for over one-half of the total program's payment increase for FY'82.

FY '82 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	5.1%	-48.0%	-2.2%
ICF Care	1.7%	15.2%	-1.5%
ICF-MR/MD	18.1%	54.9%	6.7%
Physician Services	18.6%	6.3%	-5.9%
Inpatient Hospital	7.5%	.8%	16.4%
Outpatient Hospital	-.5%	-4.1%	-4.6%
Prescriptions	13.0%	-.4%	2.7%
Other Care	31.7%	N/A	N/A
TOTAL	14.5%	-.9%	5.4%

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 (CPI) 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.

For 1982, health care prices in the United States rose at twice the rate of prices for all other goods and services combined, as measured by the CPI.

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 large jump in payments to physicians was primarily a result of a new pricing structure which went into effect at the beginning of fiscal year 1982. On the average, the amount Alabama Medicaid pays for a physician procedure grew by about 18%. Prior to this, doctors had been reimbursed at the same level for about five years. This new pricing structure affected in large measure the health services lumped together as "other care."

In the middle of fiscal year 1982 tighter medical and financial admission criteria for nursing home patients were instituted. Concurrently, as more patients were certified as requiring a lower level of care (intermediate), this lessened the utilization of skilled-care services.

The rapid growth of ICF-MR recipients was influenced mostly by the addition of two new facilities. Because of the rise in the number of ICF-MR patients and the substantially higher per diem rates associated with providing this type of service, payments for intermediate care experienced the greatest rate of increase of any component in the Alabama Medicaid Program.

This examination of some of the factors involved in the payment changes from FY'81 to FY'82 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

The benefits of the Medicaid program to low-income citizens in Alabama need little elaboration. The general health of Medicaid recipients has improved measurably because of their greater access to quality health care. An example: The Alabama Medicaid program started in 1970. According to State Department of Public Health figures, the infant mortality rate in Alabama dropped from 24.1 per 1000 in 1970 to 14.3 per 1000 in 1979, an improvement of 41 percent. New technology and improved medical techniques were factors in this dramatic improvement, but low-income Alabamians would not have had access to these advances without Medicaid. It is an indisputable fact that Medicaid has been responsible for the good health of thousands of state citizens.

The benefits of Medicaid to Alabama citizens who are not eligible for the program are often overlooked. In 1982, $338 million was spent on Medicaid in the state. The state provided $98.1 million, and the federal share was $240.2 million. This money was paid not to Medicaid recipients, but directly to some 7000 Medicaid providers. These providers include physicians, dentists, pharmacists, hospitals, nursing homes, and medical equipment suppliers. The fast-growing health care industry, a cornerstone of many local economics, employs thousands of workers who buy goods and services from thousands more. Using the common multiplier effect of three, the Medicaid program generated more than a billion dollars worth of business in the state in 1982. Health care has proven to be one of the state's most recession-proof industries, and Medicaid is vital to that industry.

Medicaid funds provide approximately 75 percent of the state's nursing home revenue and about ten percent of hospital revenue. The more than $30 million a year that Medicaid pays to physicians encourages many physicians to provide services to a segment of the population that might otherwise be excluded from the health care system. Medicaid can also encourage physicians and other health care providers to practice in areas of the state that would be economically marginal if the providers had to rely solely on the ability of their patients to pay.

Alabama Medicaid is essentially a "no frills" program, offering a minimal number of optional services at a relatively low per patient cost. Because the administrative cost of Alabama's program is consistently among the lowest in the nation — three percent — most of the funds go directly to patient care. U.S. Department of Health and Human Services reports indicate that Alabama's Medicaid program is among the most efficiently operated programs in the nation.

Because of the 71 percent funding match for Alabama Medicaid, a loss of $1 million in state funds would result in the loss to the program of an additional $2.4 million. A decrease in Medicaid expenditures would diminish the quality of health care available to low-income citizens, and it would also have an adverse impact on the state's economy.

FY '82 PLATE 3
COUNTY IMPACT
Year's cost per eligible

County	Benefit Payments	Eligibles	Dollars per Eligible
Autauga	$1,931,641	2,849	$678
Baldwin	4,144,229	4,900	846
Barbour	3,039,676	4,155	732
Bibb	1,501,415	1,545	972
Blount	1,961,546	2,352	834
Bullock	1,323,980	2,512	527
Butler	2,662,433	3,595	741
Calhoun	8,364,205	10,161	823
Chambers	3,514,705	4,739	742
Cherokee	1,056,227	1,441	733
Chilton	2,077,673	2,464	843
Choctaw	1,661,058	3,029	548
Clarke	2,762,532	4,627	597
Clay	1,523,580	1,291	1,180
Cleburne	898,730	969	927
Coffee	2,815,700	3,315	849
Colbert	3,480,500	3,879	897
Conecuh	1,636,903	2,512	652
Coosa	750,260	1,099	683
Covington	3,802,885	3,750	1,014
Crenshaw	2,206,761	2,234	988
Cullman	4,881,692	4,354	1,121
Dale	2,753,182	2,874	958
Dallas	6,152,117	11,353	542
DeKalb	4,380,116	4,549	963
Elmore	7,046,094	3,705	1,902
Escambia	2,887,802	3,998	722
Etowah	8,541,900	8,342	1,024
Fayette	1,471,503	1,784	825
Franklin	3,361,248	3,124	1,076
Geneva	2,105,744	2,781	757
Greene	1,292,969	3,268	396
Hale	2,302,074	3,562	646
Henry	1,401,630	2,044	686
Houston	4,492,040	7,055	637
Jackson	3,140,583	4,176	752
Jefferson	47,621,880	61,991	768
Lamar	1,991,916	1,590	1,253
Lauderdale	4,964,347	5,165	961
Lawrence	2,640,346	3,106	850
Lee	3,060,489	5,328	574
Limestone	2,877,201	3,730	771
Lowndes	1,493,477	3,573	418
Macon	3,920,306	5,345	733
Madison	8,631,811	13,645	633
Marengo	2,747,008	4,644	592
Marion	2,771,349	2,438	1,137
Marshall	5,306,868	5,699	931
Mobile	30,150,355	38,895	775
Monroe	1,982,825	3,135	632
Montgomery	16,791,623	20,864	805
Morgan	16,850,421	7,665	2,198
Perry	2,224,776	3,646	610
Pickens	3,039,339	4,402	690
Pike	2,930,873	4,260	688
Randolph	2,232,440	2,330	958
Russell	3,754,248	4,908	765
Shelby	3,042,346	3,306	920
St. Clair	2,949,305	3,069	961
Sumter	2,767,506	3,943	702
Talladega	6,457,345	10,341	624
Tallapoosa	5,511,011	4,025	1,369
Tuscaloosa	27,376,555	14,734	1,858
Walker	6,651,452	6,227	1,068
Washington	1,563,337	2,304	679
Wilcox	2,070,602	4,543	456
Winston	2,388,566	1,667	1,433

MEDICAID MANAGEMENT INFORMATION SYSTEM

Realizing the need for more efficient, economical, and effective administration of the Medicaid programs nationwide, Congress in 1972 authorized 90% federal financial participation (FFP) for the design, development, and installation of mechanized claims processing and information retrieval systems, termed Medicaid Management Information Systems (MMIS). In addition, 75% FFP was authorized for the on-going operation of each certified MMIS.

Two years later the Department of Health, Education, and Welfare (HEW) published a five-volume General System Design detailing the six required subsystems of MMIS. In April 1978 Alabama's MMIS, adapted by Blue Cross/Blue Shield of Alabama from the Indiana system, was certified by HEW as meeting the requirements of the General System Design. The six subsystems of MMIS are outlined below:

Recipient Subsystem

- Maintains identification of all applicants eligible for Medicaid benefits
- Provides timely updating of the Medicaid Eligibility File to include new eligibles and all changes to existing records for Medicaid eligibles
- Maintains positive control over all data pertaining to the Medicaid recipient's eligibility
- Maintains control over the Medicare Part B buy-in processing for eligibles
- Maintains identification of third party resources for eligibles

Provider Subsystem

- Maintains identification of all providers qualified to render services under the Medicaid program
- Provides timely processing of provider applications and changes and maintains control over all data pertaining to provider enrollment
- Maintains a computerized file of provider data to be used for invoice processing, administrative reporting, and surveillance and utilization review
- Reviews enrolled providers on a continuing basis to ensure that they continue to meet eligibility requirements

FY '80-'82 PLATE 4
ALAMED SOFTWARE ACTIVITY

	FY '80	FY '81	FY '82
# of programs in production at year end	443	714	952
# of requests received for new programs and for changes to existing programs	808	780	851
# of maintenance requests completed	605	522	458
# of new programs written	227	271	238
# of requests completed	832	793	696

Claims Processing

- Ensures that all input is captured at the earliest possible time and in an accurate manner
- Controls all transactions during their entire processing cycle
- Verifies that all providers submitting claims are properly enrolled
- Ensures that all recipients for whom claims are submitted were eligible for the type of service at the time the service rendered
- Ensures that all claims entered into the system are processed completely
- Verifies that charges submitted by providers are reasonable and within acceptable limits
- Ensures that reimbursements to providers are rendered promptly and correctly
- Maintains accurate and complete audit trails of all processing
- Processes approved prior authorization requests
- Processes provider credits and adjustments

Reference File

- Maintains complete and accurate statewide pricing information based on procedure and diagnosis
- Provides information on claims in suspense

Management and Administrative Reporting

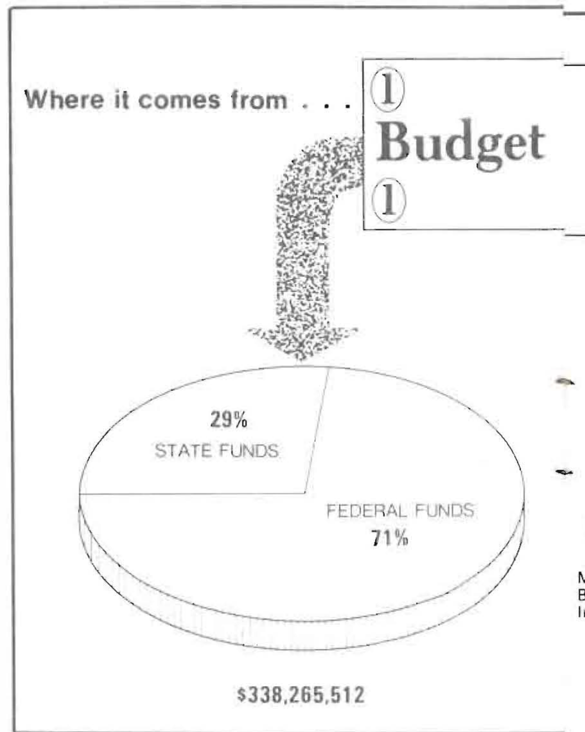
- Provides information to assist management in fiscal planning and control
- Provides information required in the review and development of medical assistance policy and regulations
- Monitors the progress of claims processing activity and provides summary reports which reflect the current status of payments
- Reviews provider performance to determine the adequacy and extent of participation and service delivery
- Reports recipient participation in order to analyze usage and develop more effective programs
- Provides information required to support federal reporting requirements

Surveillance and Utilization Review

- Develops, over time, a comprehensive statistical profile of health care delivery and utilization patterns established by provider and recipient participants in the various categories of service authorized under the Medicaid program
- Reveals for review potential misutilization to promote correction of actual misutilization of the Medicaid program by its individual participants
- Provides information which will reveal and facilitate investigation of potential defects in the level of care or quality of service provided under Medicaid
- Provides information to assist management in the development and/or revision of medical assistance policy

Alabama was one of 38 states operating an approved MMIS during FY'82. The Recipient and Buy-in Subsystem, consisting of over 400 programs, is operated and maintained by AlaMed's data processing staff. In addition, over 500 in-house programs support the other five subsystems which are maintained and operated by a fiscal agent. Alabama's fiscal agent for FY'82 was Electronic Data Systems Federal Corporation d/b/a Alacaid. Alacaid runs 400 Alabama-owned programs in support of MMIS, adjudicating claims faster and more economically than any other Medicaid claims processor in the region.

REVENUE, EXPENDITURES AND PRICES



SOURCES OF MEDICAID REVENUE	PLATE 6
Federal Funds	$240,192,538
State Funds	98,072,974
Total Revenue	$338,265,512

FY '82 PLATE 7
COMPONENTS OF FEDERAL FUNDS

	Dollars	Matching Rate
Absent Parents	93	100.00%
Family planning admin.	120,201	90.00%
Professional staff costs	6,124,730	75.00%
Other staff costs	1,254,996	50.00%
Other provider services	229,381,163	71.13%
Family planning services	3,311,355	90.00%
TOTAL	$240,192,538	71.01%

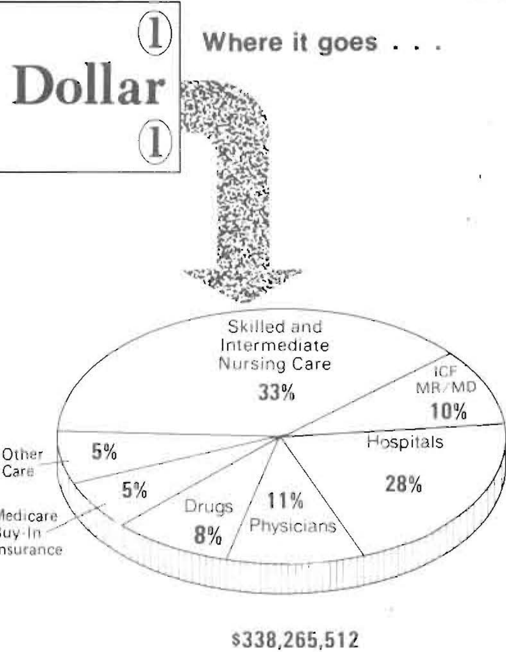
FY '82 PLATE 8
COMPONENTS OF STATE FUNDS

	Dollars
Encumbered balance forward	$837,030
Basic Appropriations	78,400,000
Supplemental appropriations	11,600,000
P & S/Mental Health	13,843,504
Interest Income from Fiscal Intermediary	474,422
Miscellaneous Receipts	17,463
	105,172,419
Encumbered	—7,099,445
TOTAL	$98,072,974

FY '82 PLATE 9
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%	$2,995,114,710	$947,671,349	$3,942,786,059
Medicaid Program	3.3%	98,072,974	240,192,538	338,265,512
All Other Programs	96.7%	$2,897,041,736	$707,478,811	$3,604,520,547

PLATE 5



In FY'82 Medicaid paid $338,265,512 for health care services to Alabama citizens. Another $10,912,283 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 '82
EXPENDITURES
By type of service

PLATE 10

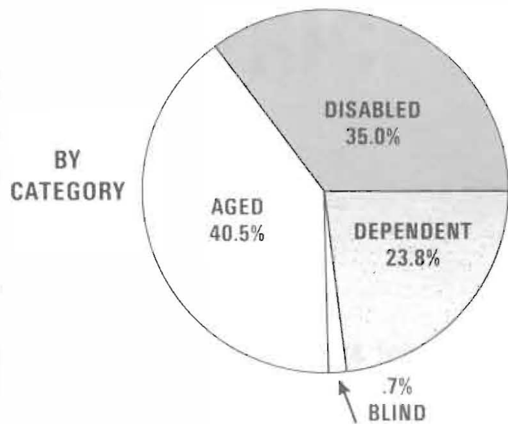
Service	Payments	Percent Of Payments by Service FY '82		Percent Of Payments By Service FY '81		Percent Of Payments By Service FY '80	
Skilled Nursing Care	$11,100,641	3.39%		7.23%		13.24%	
Intermediate Nursing Care	97,138,239	29.67%	42.86%	29.53%	42.78%	27.56%	46.23%
ICF-Mentally Retarded	32,074,943	9.80%		6.02%		5.43%	
Hospital Inpatients	85,153,428	26.01%	28.39%	26.52%	29.92%	24.46%	27.82%
Hospital Outpatients	7,779,205	2.38%		3.40%		3.36%	
Physicians' Services	35,744,933	10.92%		10.00%		9.78%	
Medicare Buy-In Insurance	14,989,170	4.58%		4.40%		4.46%	
Drugs	25,194,464	7.70%		7.87%		7.03%	
Dental Services	4,719,604	1.44%		1.25%		1.30%	
Lab & X-Ray	4,804,548	1.47%		1.36%		1.33%	
Family Planning Care	3,679,284	1.12%		.93%		.53%	
Eye Care	1,825,526	.56%		.58%		.56%	
Screening	764,749	.23%		.30%		.33%	
Home Health	2,023,087	.62%		.48%		.50%	
Transportation	249,538	.08%		.07%		.07%	
Hearing Care	74,747	.02%		.02%		.02%	
Other Care	37,123	.01%		.04%		.04%	
Total For Medical Care	$327,353,229	100.0%		100.0%		100.0%	
Administrative Costs	10,912,283						
Net Payments	$338,265,512						

FY '82 PLATE 11

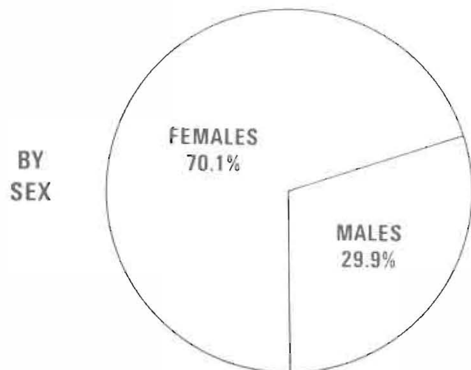
PAYMENTS

By category, sex, race, age group

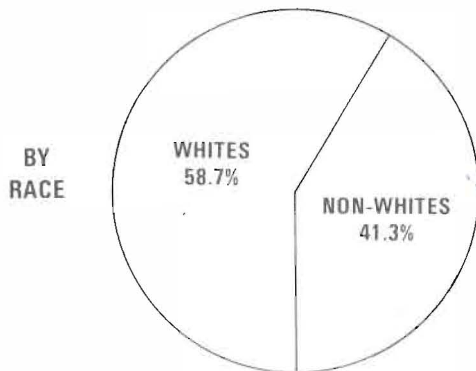
BY CATEGORY



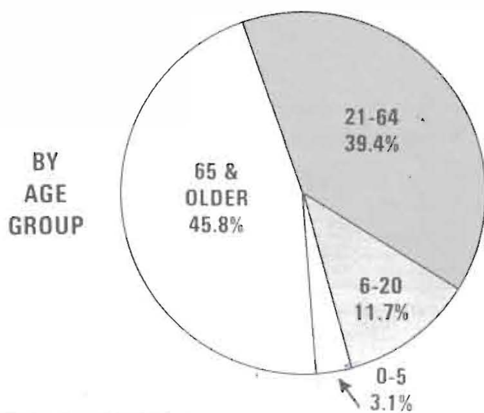
BY SEX



BY RACE



BY 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 12.)

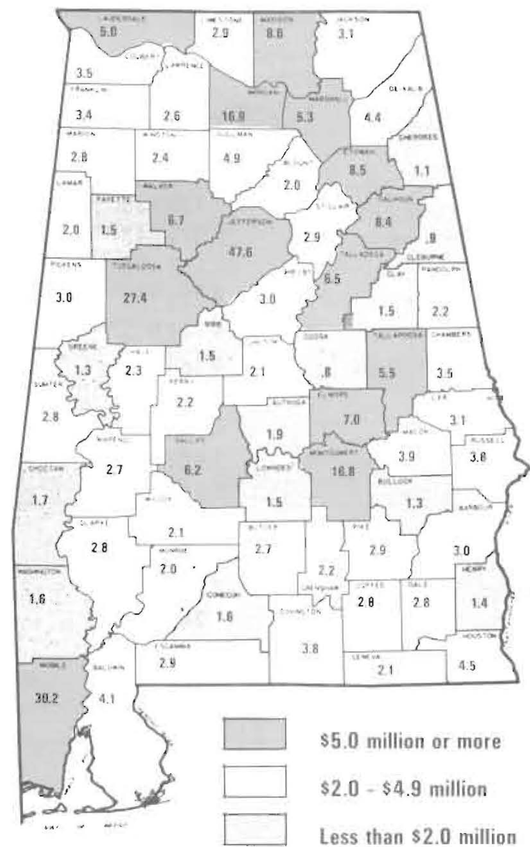
The twelve counties where the most money was spent last year were the top twelve this year. The six counties where the least was spent in FY'81 are still the least expensive this year.

Inspection of the map in Plate 12 shows that with a few exceptions, counties with or near the biggest cities have the most money paid for their recipients.

FY '82 PLATE 12

PAYMENTS

By county (in millions)



PRICES

One of the many different factors which contribute to rising medical care costs is the price of each unit of medical service. Plate 13 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'81 to this year.

With the exception of outpatient hospital services, prices climbed from the prior year. The largest jump in prices was seen in the physicians program with an increase of nearly 19%.

Note that as the year ended, the average cost per day for ICF care was lower than the cost per day for skilled care. 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 '82 — PLATE 13

PRICES

Unit price per service, by quarter

	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	FY '82	Change From Previous Year
Nursing Home Days						
Skilled	$22.75	$23.79	$26.42	$25.84	$24.43	+5.1%
ICF*	20.58	21.60	25.80	22.52	22.69	+6.5%
Inpatient Days	189.04	212.69	224.41	221.14	213.29	+7.5%
Physicians' Procedures	15.18	17.87	18.25	17.26	17.25	+18.6%
Prescriptions	8.41	8.62	8.96	9.23	8.81	+13.0%
Outpatient Services	22.07	23.09	23.98	23.90	23.31	-.5%

*Excludes ICF-MR/MD

POPULATION AND ELIGIBLES

Population

The population of Alabama grew from 3,444,165 in 1970 to 3,893,888 in 1980. This increase of approximately 13% 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). By 1980 there were 440,000 persons over 64 years of age in Alabama's population. This was an increase of 35% since 1970. Historically, cost per eligible has been higher for this group than other categories of eligibles.

FY '75 - '82 PLATE 14

POPULATION

Eligibles as percent of Alabama population by year

Year	Population	Monthly Average Eligibles	Percent
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	3,893,888	339,417	8.72
1981	3,920,000*	336,266	8.58
1982	3,943,000*	317,386	8.05

*U.S. Bureau of Census official estimate.

CY '80 PLATE 15

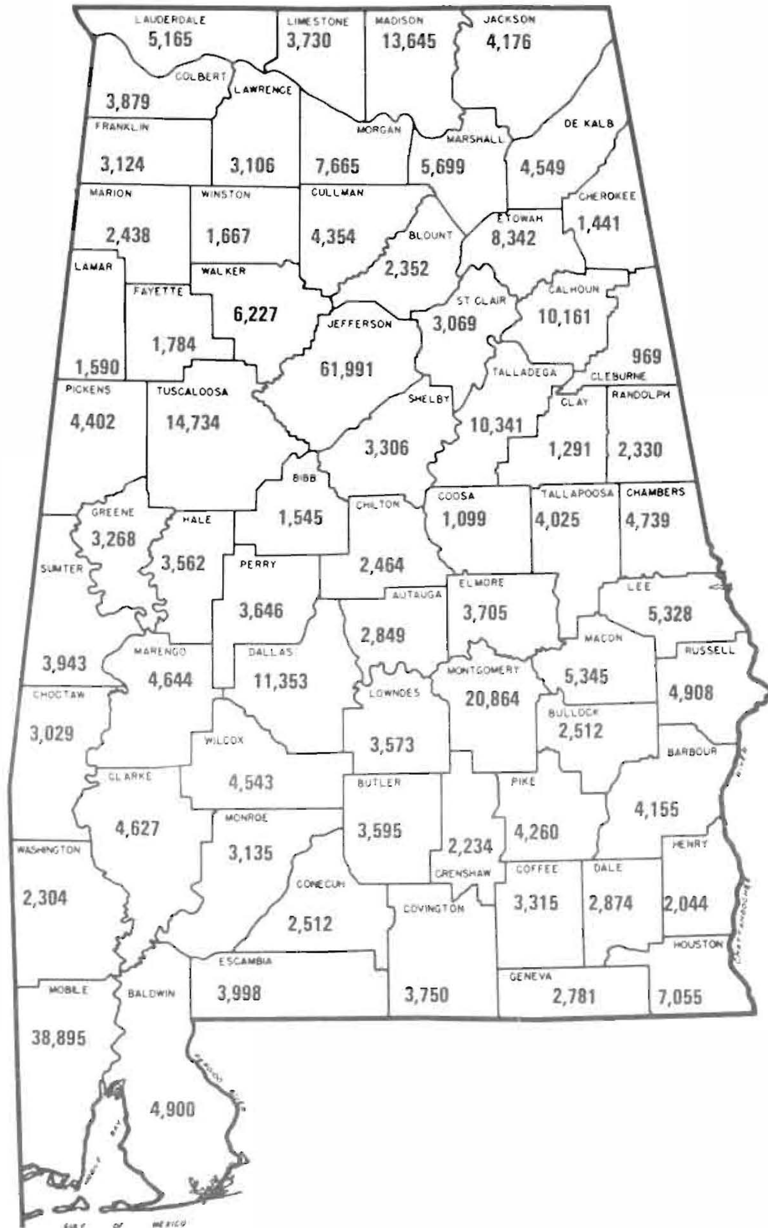
POPULATION

1980 population

FY '82 PLATE 16

ELIGIBLES

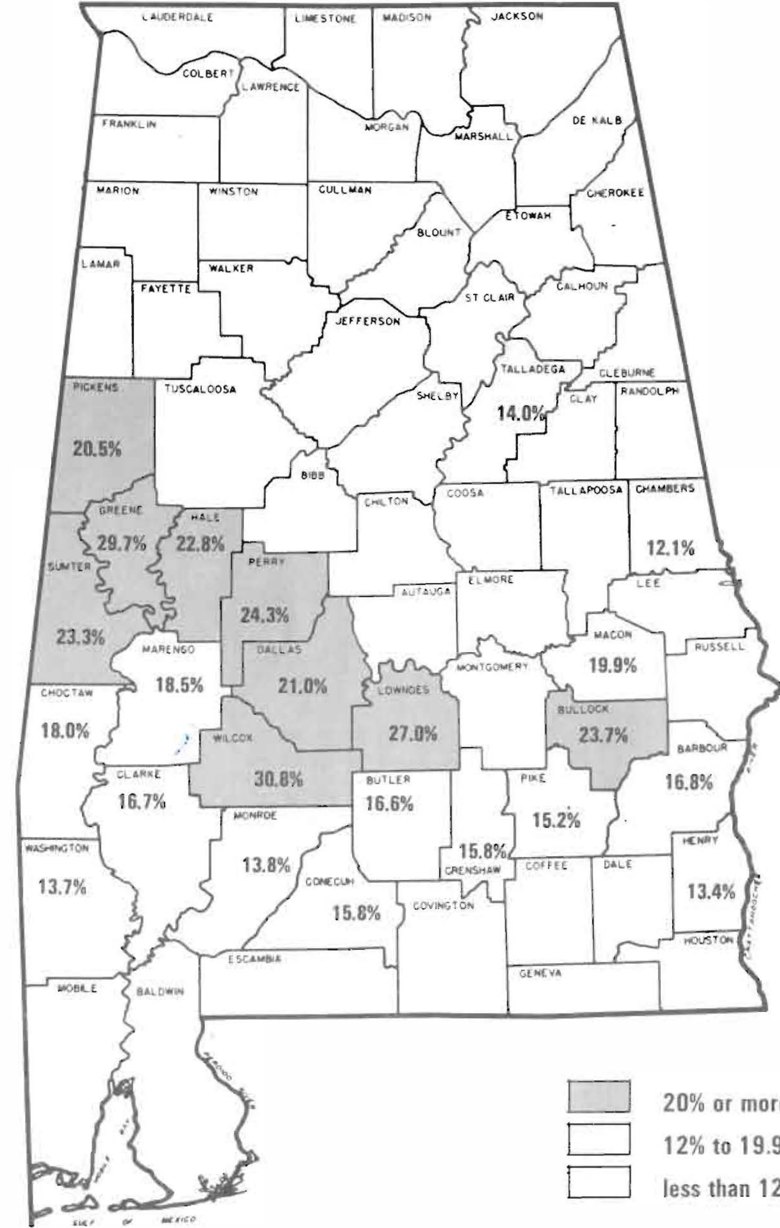
Number of Medicaid eligibles by county

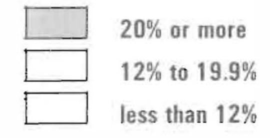


FY '82 PLATE 17

ELIGIBLES

Percent of population eligible for Medicaid, by county





FY '82 **ELIGIBLES** Monthly Count	PLATE 18
	Monthly Count
October '81	328,733
November	324,300
December	322,997
January '82	317,917
February	315,274
March	314,362
April	313,236
May	311,449
June	310,819
July	310,054
August	311,204
September	311,393

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 18). Total counts are the total unduplicated counts of eligibles enrolled at the end of the year, i.e. 394,905 persons were eligible for at least one month during FY'82 (Plate 19).

The most useful and informative count is the average number per month for the entire year (Plate 19). This number should be used for making comparisons between eligibles in different states or different years. The monthly average for 1982 was about 317,386, a decrease of more than 18,000 from the previous year's average of 336,266.

FY '82 — PLATE 19
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	333,471	61,434	394,905	82,863	312,042	317,386	24.4%
AGED	86,285	5,408	91,693	9,671	82,022	83,626	9.7%
BLIND	2,033	140	2,173	159	2,014	2,019	7.6%
DISABLED	62,470	6,447	68,917	6,414	62,503	62,407	10.4%
DEPENDENT	182,683	49,439	232,122	66,619	165,503	169,334	37.1%
MALES	117,520	21,974	139,494	32,265	107,229	109,870	27.0%
FEMALES	215,951	39,460	255,411	50,598	204,813	207,516	23.1%
WHITES	119,256	23,830	143,086	32,844	110,242	112,962	26.7%
NONWHITES	214,215	37,604	251,819	50,019	201,800	204,424	23.2%
AGE 0-5	44,559	18,047	62,606	15,193	47,413	45,748	36.9%
AGE 6-20	99,097	19,018	118,115	34,595	83,520	87,755	34.6%
AGE 21-64	88,003	18,868	106,871	22,302	84,569	85,324	25.3%
AGE 65 & Over	101,812	5,501	107,313	10,773	96,540	98,559	8.9%

Plate 19 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 24% 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 19.

Annual Changes in the Number of Eligibles: The total number of Alabama citizens eligible for Medicaid decreased by 14,523 in FY'82. Plate 21 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'82 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 category also showed a decrease in monthly average and yearly total counts of eligibles.

FY '82 — PLATE 20
ELIGIBLES
Year's total
Distribution by category, sex, race and age

	Number	Percent
All Categories	394,905	100.0%
Aged	91,693	23.2%
Blind	2,173	.5%
Disabled	68,917	17.5%
Dependent	232,122	58.8%
Males	139,494	35.3%
Females	255,411	64.7%
White	143,086	36.2%
Nonwhites	251,819	63.8%
Age 0-5	62,606	15.8%
Age 6-20	118,115	29.9%
Age 21-64	106,871	27.1%
Age 65 & Over	107,313	27.2%

FY '78 - '82 — PLATE 21
ELIGIBLES
By category
Monthly average
Annual number

		FY '78	FY '79	FY '80	FY '81	FY '82
MONTHLY AVERAGES	AGED	100,994	98,284	96,667	88,704	83,626
	BLIND	1,998	1,998	1,962	2,006	2,019
	DISABLED	54,374	57,467	58,386	61,356	62,407
	DEPENDENT	175,643	181,098	182,402	184,200	169,334
	ALL CATEGORIES	332,999	338,847	339,417	336,266	317,386
YEARLY TOTALS	AGED	111,832	108,534	109,314	97,400	91,693
	BLIND	2,180	2,215	2,230	2,186	2,173
	DISABLED	62,654	67,260	69,264	68,666	68,917
	DEPENDENT	226,664	235,796	242,223	241,176	232,122
	ALL CATEGORIES	403,330	413,805	423,031	409,428	394,905

FY '82 ELIGIBLES By category, sex, race, and age Total MME used by each group Average MME used by each person	PLATE 22	
	Total MME Used In Year	**Average MME Per Person**
ALL ELIGIBLES	3,808,632	9.6
AGED	1,003,512	10.9
BLIND	24,228	11.1
DISABLED	748,884	10.9
DEPENDENT	2,032,008	8.8
MALES	1,318,440	9.5
FEMALES	2,490,192	9.7
WHITES	1,355,544	9.5
NONWHITES	2,453,088	9.7
AGE 0-5	548,976	8.8
AGE 6-20	1,053,060	8.9
AGE 21-64	1,023,888	9.6
AGE 65 & Over	1,182,708	11.0

Man-Months and Expected Duration of Eligibility: Although 394,905 people were eligible for Medicaid in FY'82, 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'82, 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 22 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 394,905 people deemed eligible for Medicaid in FY'82, only 81% actually received Medicaid benefits. These 321,768 people are called recipients. The remaining 73,137, though eligible for benefits, incurred no medical expenses paid for by Medicaid. The total figure of 321,768 is an unduplicated count, and comparison with various recipient categories and percent of eligibles will reflect some variation. This is due to the transfer of recipients from one category to another during the course of a year.

Plate 23 shows the monthly count of recipients as well as the monthly percentage of eligibles. Monthly fluctuations occur due to seasonal factors and claims processing cycles. The plate shows that in a typical month only 45% of eligibles received Medicaid service.

FY '82 PLATE 23
RECIPIENTS
Monthly Counts
Percent of eligibles

	Monthly Recipients	Percent of Eligibles
October '81	149,508	45.5%
November	141,880	43.8%
December	109,572	33.9%
January '82	156,496	49.2%
February	151,447	48.0%
March	143,654	45.7%
April	141,466	45.2%
May	141,046	45.3%
June	153,337	49.3%
July	131,093	42.3%
August	139,886	45.0%
September	155,703	50.0%
Monthly Average	142,924	45.0%

FY '81-'82 PLATE 24
RECIPIENTS
By category, sex, race, age, and percent of eligibles

	FY '81	FY '82	PERCENT OF ELIGIBLES (FY '82)
AGED	98,167	91,401	N/A
BLIND	1,847	1,903	87.6%
DISABLED	61,658	62,520	90.7%
DEPENDENT	207,529	184,252	79.4%
MALES	107,376	105,738	75.8%
FEMALES	223,204	216,030	84.6%
WHITES	128,953	124,758	87.2%
NONWHITES	201,627	197,010	78.2%
AGE 0-5	39,713	40,191	64.2%
AGE 6-20	91,377	86,047	72.9%
AGE 21-64	92,009	91,096	85.2%
AGE 65 & OLDER	107,481	104,434	97.3%
ALL CATEGORIES	330,580	321,768	81.5%

FY '82 PLATE 25

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	59,318	58,954	56,226	674,712	91,401	7.38
BLIND	1,062	1,133	1,055	12,658	1,903	6.65
DISABLED	36,593	39,400	36,019	432,233	62,520	6.91
DEPENDENT	53,199	56,723	50,319	603,826	184,252	3.27
ALL CATEGORIES (unduplicated)	149,508	155,703	142,924	1,715,088	321,768	5.33

A unit of measure called man-months of service (MMS) is used to determine the frequency with which recipients availed themselves of Medicaid services. 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 sum of MMS for each of the twelve months gives the yearly total of Medicaid-paid MMS. The total MMS used by the 321,768 recipients in FY'82 was 1,715,088. MMS per recipient was 5.33, up by 2.3% over FY'81.

USE AND COST

FY '80-'82 USE Utilization rate by category PLATE 26			
	FY '80	FY '81	FY '82
AGED	84.0%	N/A	N/A
BLIND	78.9%	84.5%	87.6%
DISABLED	82.3%	89.8%	90.7%
DEPENDENT	71.8%	86.1%	79.4%
ALL CATEGORIES	76.7%	80.7%	81.5%

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, or exactly 81.5%. (See Plate 26.)

FY '80-'82 USE MMS per recipient Frequency-of-service rate PLATE 27			
	FY '80	FY '81	FY '82
AGED	7.55MMS	6.97MMS	7.38MMS
BLIND	6.58MMS	6.49MMS	6.65MMS
DISABLED	6.81MMS	6.69MMS	6.91MMS
DEPENDENT	3.49MMS	3.02MMS	3.28MMS
ALL CATEGORIES	5.24MMS	5.21MMS	5.33MMS

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. This year's rate of 5.33 indicates that the average recipient received medical care during 5.33 months.

FY '82 USE MMS per eligible Ratio of actual use to potential use PLATE 28	
AGED	7.36MMS
BLIND	5.83MMS
DISABLED	6.27MMS
DEPENDENT	2.60MMS
ALL CATEGORIES	4.34MMS

Ratio of Actual Use to Potential Use: This measure is the ratio of total man months of medical service to total man months of eligibility. If every eligible asked for medical care every month, the maximum demand for medical care would exist. However, only 81% of Medicaid's eligibles became recipients in FY'82. These recipients asked for medical care on an average of 5.33 months each. The acutal demand for care is about 45% of the potential demand.

Cost

Cost per person can be measured by cost per eligible or cost per recipient. Cost per recipient is measured in all states and is the figure used to compare Alabama's costs to similar costs elsewhere.

Other states do not measure cost per eligible so this measurement cannot be used for comparison. However, it is useful for budgeting purposes. Data on cost per eligible help predict how much money will be needed as the number of eligibles changes each year.

Cost Per Eligible: Plate 29 shows the variation from one group to another. For example, an aged person costs Medicaid approximately 8 times as much 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 29 shows the yearly cost per eligible for the past two years. In FY'82 all groups of eligibles showed a rise in costs. The disabled category showed the largest increase while age 65 and over exhibited the smallest rise in annual cost. Total expenditures increased at a slower rate than cost per eligibles because the number of eligibles steadily decreased during FY'82.

FY '81-'82 PLATE 29

COST

Annual changes in cost per eligible

	FY '81	FY '82	CHANGE FROM FY '81
DISABLED	$1,250	$1,715	+37.2%
AGED	1,296	1,494	+15.3%
AGE 65 & OVER	1,262	1,444	+14.4%
WHITES	1,117	1,388	+24.3%
AGE 21-64	923	1,247	+35.1%
BLIND	800	1,062	+32.8%
FEMALES	770	928	+20.5%
ALL ELIGIBLES	690	856	+24.1%
MALES	545	724	+32.8%
NONWHITES	440	554	+25.9%
DEPENDENTS	284	347	+22.2%
AGE 6-20	268	334	+24.6%
AGE 0-5	133	167	+25.6%

FY '81-'82
COST
Cost per Recipient

PLATE 30

	FY '81	FY '82	CHANGE FROM FY '81
DISABLED	$1,392	$1,890	+35.8%
WHITES	1,309	1,591	+21.5%
AGED	1,286	1,499	+16.6%
AGE 65 & Over	1,318	1,484	+12.6%
AGE 21-64	1,072	1,463	+36.5%
BLIND	947	1,212	+28.0%
FEMALES	910	1,098	+20.7%
ALL CATEGORIES	854	1,051	+23.1%
MALES	739	955	+29.2%
NONWHITES	563	708	+25.8%
AGE 6-20	395	459	+16.2%
DEPENDENTS	330	438	+32.7%
AGE 0-5	220	259	+17.7%

Cost Per Recipient: The group with the highest cost per recipient in both FY'81 and FY'82 was the disabled (Plate 30). This is due to the inclusion of ICF-MR/MD patients in this category. The institutional care provided to these patients is much more expensive than the other services covered by the Medicaid program. Dependents and the age group 0-5 had the lowest cost per recipient for these two years. A reason for this small cost per recipient is that these groups primarily utilize services with a low cost per unit such as dental care, family planning, and screening (Plate 31).

Section 3 of Plate 31 discloses that Medicaid averaged paying $1,738 for each disabled person who became a hospital patient, but only $464 for each aged inpatient. The average cost per aged inpatient was low because Medicare paid a 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 Mediare 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 is currently $12.20 per month. Medicaid's total payment to Medicare for buy-in premiums in FY'82 was $14,989,169. Medicare spent considerably more than this amount for partial payment of medical bills incurred by Alabama citizens on Medicaid.

FY '82

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	Rural Health	Drugs	Nursing Homes, Skilled++
	ALL CATEGORIES	$38,115,673	$5,357,414	$83,338,441	$12,655,314	$2,212,233	$52,613	$28,268,860	$12,718,961
SECTION	Aged	7,239,487	410,196	10,983,147	1,755,450	1,284,057	9,180	15,384,231	8,332,208
1	Blind	359,938	43,903	825,373	105,383	45,474	408	269,269	102,524
YEAR'S	Disabled	11,859,592	2,210,834	31,176,999	4,691,700	856,233	11,557	9,775,634	4,272,528
COST	Dependent Children	7,898,258	1,083,448	15,311,995	3,244,715	5,347	17,676	947,239	6,380
	Dependent Adults	10,758,398	1,609,033	25,040,927	2,858,066	21,122	13,792	1,892,487	5,321
SECTION	ALL CATEGORIES	238,519	95,783	71,148	112,333	3,238	1,679	222,109	4,181
2	Aged	69,831	19,063	23,648	25,216	1,766	326	77,545	3,644
YEAR'S	Blind	1,549	599	506	730	72	7	1,587	16
TOTAL	Disabled	48,824	22,079	17,939	23,819	1,364	288	50,637	1,003
NUMBER OF	Dependent Children	79,478	31,156	11,732	39,163	25	711	57,409	2
RECIPIENTS	Dependent Adults	46,945	24,221	17,935	25,112	56	369	40,811	2
SECTION	ALL CATEGORIES	$ 160	$ 56	$1,171	$ 113	$ 683	$ 31	$ 127	$ 3,042
3	Aged	104	22	464	70	727	28	198	2,287
YEAR'S	Blind	232	73	1,631	144	632	58	170	6,408
COST	Disabled	243	100	1,738	197	628	40	193	4,260
PER	Dependent Children	99	35	1,305	83	214	25	16	3,190
RECIPIENT	Dependent Adults	229	66	1,396	114	377	37	46	2,661
SECTION	ALL CATEGORIES	60.40%	24.25%	18.02%	28.45%	.82%	.43%	56.24%	1.06%
4	Aged	76.16%	20.79%	25.79%	27.50%	1.93%	.36%	84.57%	3.97%
UTILIZATION	Blind	71.28%	27.57%	23.29%	33.59%	3.31%	.32%	73.03%	.74%
RATES	Disabled	70.84%	32.04%	26.03%	34.56%	1.98%	.42%	73.48%	1.46%
PERCENT OF	Dependents	54.46%	23.86%	12.78%	27.69%	.03%	.47%	42.31%	**
ELIGIBLES									

+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

***Includes buy-in premiums for the blind

Plate 31

SERVICES WHOSE COSTS ARE NOT SHARED WITH MEDICARE								ALL SERVICES		
Nursing Homes, ICF	ICF MR/MD	Dental Care	Family Planning	Other Practi- tioners	Other Care	Screening	Medicare Buy-In	Total Of Unshared Costs	Medicaid's Total Part Of Shared Costs	Medicaid's Totals
$105,479,796	$36,093,722	$5,243,792	$3,975,157	$1,342,081	$2,392,665	$842,524	$14,989,169	$211,346,727	$141,731,688	$353,078,415
83,430,789	2,465,099	951	3,082	472,289	1,169,394	60	11,332,930	126,632,028	21,681,517	148,313,545
469,201	8,574	4,929	16,538	7,175	23,760	410	0	926,424	1,380,479	2,306,903
21,578,762	33,620,049	244,980	726,266	327,832	877,494	23,026	3,656,239***	71,037,771	50,806,915	121,844,686
0	0	4,428,728	394,456	299,453	154,344	791,465	0	7,022,571	27,561,439	34,584,010
1,044	0	564,204	2,834,815	235,332	167,673	27,563	0	5,727,933	40,301,338	46,029,271
18,703	1,592	42,988	29,983	30,823	41,701	35,131	N/A*	N/A*	N/A*	321,768
18,237	216	12	108	10,279	19,706	9	N/A*	N/A*	N/A*	91,401
78	1	40	97	152	291	17	0	N/A*	N/A*	1,903
3,671	1,452	1,957	2,801	7,334	11,465	927	N/A*	N/A*	N/A*	62,520
0	0	38,664	5,761	7,366	5,563	33,164	0	N/A*	N/A*	121,300
2	0	2,936	22,425	5,717	5,141	1,201	0	N/A*	N/A*	62,952
$ 5,640	$ 22,672	$ 122	$ 133	$ 44	$ 57	$ 24	N/A*	N/A*	N/A*	$1,097
4,575	11,412	79	29	46	59	7	N/A*	N/A*	N/A*	1,623
6,015	8,574	123	170	47	82	24	0	N/A*	N/A*	1,212
5,878	23,154	125	259	45	77	25	N/A*	N/A*	N/A*	1,949
0	0	115	68	41	28	24	0	N/A*	N/A*	285
522	0	192	126	41	33	23	0	N/A*	N/A*	731
4.74%	N/A*	10.89%	7.59%	7.81%	10.56%	8.90%	N/A*	N/A*	N/A*	81.48%
19.89%	N/A*	.01%	.12%	11.21%	21.49%	**	N/A*	N/A*	N/A*	N/A*
3.59%	N/A*	1.84%	4.46%	6.99%	13.39%	.78%	0	N/A*	N/A*	87.57%
5.33%	N/A*	2.84%	4.06%	10.64%	16.64%	1.35%	N/A*	N/A*	N/A*	90.72%
**	N/A*	17.92%	12.14%	5.64%	4.61%	14.80%	0	N/A*	N/A*	79.38%

LONG-TERM CARE

In terms of people served, the nursing home program is small. This year one eligible in 16 used nursing home care.

In terms of expenditures, it is Medicaid's largest program. This year 43% of Medicaid provider payments went for long-term care. Payments for ICF MR/MD accounted for almost one-fourth of this amount.

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, (SNF) which is a required service; and intermediate care, (ICF) which is an optional service and includes services provided in an institution for the mentally retarded (ICF/MR) and the mentally diseased (ICF/MD). 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 FY '82, which showed 4,181 skilled patients and 20,295 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 REIMBURSE-

FY '79-'82 — 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 Patient-Days Paid For By Medicaid	Average Cost Per Patient Per Day to Medicaid	Total Cost To Medicaid
1979	24,624	223 Days	5,412,241	$19	104,995,732
1980	24,441	223 Days	5,460,871	24	131,392,623
1981	24,065	231 Days	5,570,029	24	133,734,558
1982	24,476	237 Days	5,808,279	27	154,292,479
% Change since 1979	-0.6%	+6.3%	+7.3%	+42.1%	+47.0%

FY '79-'82 PLATE 33

LONG-TERM CARE PROGRAM

The number and percent of beds used by Medicaid

	Nursing Home Beds Certified For Federal Program Participation	Medicaid Patients		Percent Of Beds Used By Medicaid	Number Of Beds Not Used By Medicaid In Average Month
		Monthly Average	Yearly Unduplicated Total		
1979	19,723	14,386	24,624	73%	5,337
1980	20,708	14,833	24,441	72%	5,875
1981	21,038	14,920	24,065	71%	6,118
1982	22,509	15,587	24,476	69%	6,922

MENT RATE. On January 1, 1981, AlaMed adopted a single corporate rate payment methodology that accommodated both skilled and intermediate care patients in the same facility.

3. 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/MR in 1977 and for coverage to recipients over 65 years old in ICF/MD in 1978.

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 since 1979, during which time 2,786 beds were added — an averge of 56 per month. Also shown is the number of beds used by Medicaid recipients each year.

The Alabama Medicaid Agency has taken the position that no increase in nursing home beds is warranted at this time. Comparisons with neighboring states reveal that the number of beds per thousand elderly in our state exceeds all but one other state. The states rank as follows:

State & Rank	Persons 65* & Older	Beds Per 1,000**
1. Georgia	515,164	58.0
2. Alabama	440,003	46.9
3. Mississippi	288,742	42.4
4. South Carolina	288,214	41.6
5. Tennessee	517,572	41.9
6. Florida	1,687,112	21.4

*U.S. Bureau of Census, 1980 Official Estimates

** U.S. National Center for Health Statistics, 1980 Data

Recent actions by Medicaid which further reduce the advisability of adding nursing home beds are:

1. In April, 1982, Medicaid implemented revised medical criteria for admission to nursing homes. These criteria were developed to help insure that persons admitted under Medicaid have genuine medical needs, and not just the need of assistance with the tasks of daily living or other social needs. Before April, 1982, the denial rate for nursing home care was less than 1 percent. After these criteria were implemented, the denial rate increased to between 10 and 15 percent.
2. Financial eligibility determinations have become more effective due to better management information and increased training for personnel working in this area. This has led to more efficient application of existing financial criteria for nursing home admission.
3. Some months ago, a task force was formed consisting of representatives from the Departments of Pensions and Security, Mental Health, Commission on Aging, and the Alabama Medicaid Agency. This task force has developed a Request for Waiver of Federal Regulations which will soon be ready for forwarding to the Department of Health and Human Services. It is expected that this waiver will make available to persons, who normally enter a nursing home, various services which would enable them to remain in their own homes or in some alternative setting.

The Cost of the Long-Term Care Program: The Long-Term Care program continues to be the most expensive item in the Alabama Medicaid budget. During FY 1982 Medicaid spent $154.3 million to provide nursing home care for approximately 24,500 patients. This is an increase of about 400 recipients since 1981. Expenditures for the program rose by $20.5 million during the same time period. Over the past four years, the annual expense for the Long-Term Care program has risen from $105 million to $154 million —an increase of 47 percent. Plate 32 shows the factors

FY '82 — PLATE 34

LONG-TERM CARE PROGRAM

Recipients, by sex, by race, by age

	Skilled	ICF	Total	Percent
All Recipients	4,181	20,295	24,476	100%
By Sex				
Female	3,054	14,412	17,466	71.4%
Male	1,127	5,883	7,010	28.6%
By Race				
White	3,284	16,128	19,412	79.3%
Nonwhite	897	4,167	5,064	20.7%
By Age				
65 & Over	3,406	16,315	19,721	80.6%
21-64	622	3,668	4,290	17.5%
6-20	115	302	417	1.7%
0-5	38	10	48	0.2%

FY '81-'82 — PLATE 35

LONG-TERM CARE PROGRAM

ICF-MR/MD

	FY '81	FY '82
Recipients	774	1,592
Annual Expenditures	$18,496,667	$36,093,722
Average Annual Cost Per Recipient	$23,898	$22,672
Average Monthly Recipients	685	1,164
Average Monthly Cost Per Recipient	$2,250	$2,584

that led to the increase: patients, days of service, and prices.

Most of the change in expenditures since FY'81 was due to the expansion of the ICF-MR/MD program. With the ICF-MR/MD expenditures excluded, Medicaid payments for long-term care only rose by about $3 million or 3 percent. If ICF-MR/MD recipients were deleted, the total number of nursing home patients actually declined. The reason for the dramatic effect of the addition of a relatively small number of recipients (818) is the high cost of providing services to these patients. Plate 35 shows that the average monthly payment for ICF-MR/MD recipients is nearly $2,600.

Judging from the above statements and figures, it would appear that ICF-MR/MD care is an extremely expensive component of Alabama's Medicaid program. In terms of total Medicaid dollars expended and the average monthly payment per patient, this is certainly true. The provision of this care through the Medicaid program, however, is saving the taxpayers of Alabama millions of State dollars. These MR and MD patients are receiving ICF services in the State-operated mental health institutions. If the Medicaid program did not cover the services provided to these patients, the Alabama Department of Mental Health would be responsible for total funding of their care. With the inclusion of ICF-MR/MD in Medicaid's range of services, the Mental Health Department has agreed to pay the State's portion of the federal financial participation which comprises the other 70 percent of the cost of this care.

FY '82 — PLATE 36

LONG-TERM CARE PROGRAM

Payments, by sex, by race, by age

	Skilled	ICF	Total	Percent
All Recipients	$12,718,961	$141,573,518	$154,292,479	100%
By Sex				
Female	9,227,202	94,771,966	103,999,168	67.4%
Male	3,491,759	46,801,552	50,293,311	32.6%
By Race				
White	9,899,575	110,356,859	120,256,434	77.9%
Nonwhite	2,819,386	31,216,659	34,036,045	22.1%
By Age				
65 & Over	8,840,946	93,502,691	102,343,637	66.3%
21-64	2,540,695	43,142,402	45,683,097	29.6%
6-20	1,046,532	4,870,123	5,916,655	3.9%
0-5	290,788	58,302	349,090	0.2%

FY '80-'82 PLATE 37

LONG-TERM CARE PROGRAM

Number of Recipients

	Skilled			ICF			Total		
	FY '80	FY '81	FY '82	FY '80	FY '81	FY '82	FY '80	FY '81	FY '82
Monthly Average	4,846	3,028	1,627	9,987	11,891	13,960	14,833	14,920	15,587
Yearly Total	9,528	6,971	4,181	14,913	17,094	20,295	24,441	24,065	24,476
Annual Turnover Rate	97%	130%	157%	49%	44%	45%	65%	61%	57%
Average Length of Stay	186 Days	146 Days	125 Days	244 Days	264 Days	260 Days	223 Days	231 Days	237 Days

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 FY'82. From October, 1981, through June, 1982, the maximum amount was $794.10 This amount increased to $852.90 July 1, 1982. All personal income above $25.00 a month, with the exception of health insurance premiums, must be applied by the patients to reduce the monthly Medicaid charge for nursing home service.

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 the amount spent on each group.

Plate 37 shows average monthly recipients and the annual total of recipients in the Long-Term Care program. Also calculated are the annual turnover rate and average length of stay. It must be emphasized that these two measures are averages. Although the average patient stays 237 days per year, there are recipients who live several years in nursing homes. 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

18% of Medicaid eligibles became hospital inpatients during this fiscal year. 28% became outpatients.

For eight years in a row outpatients have outnumbered inpatients.

Inpatient Care: In FY'82 the cost of inpatient care exceeded $71 million. This was second only to the Long-Term Care program in expenditures within the Medicaid program. The specific figures on Hospital program costs are shown in Plate 38. Total cost increased over FY'81 by $14 million. The consumer price index's medical care component showed the same general trend with a substantial rise in FY'82.

The data used in Plate 38 was computed to exclude Medicaid's share of Medicare crossover claims. This presents a better picture of acutal costs incurred by Medicaid. (Note: Comparable figures for FY'80 were not available and the figures provided are not valid for comparison purposes.)

263 for FY'82 was based on rate X days

FY '79-'82 PLATE 38
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
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
1982	394,905	42,514	56,924	144	325,826	5.7	85,549,601	263	1,499

*includes Medicare crossovers

~~228~~ FY'81
~~246~~ FY'82

methodology changed for FY'83

228.14 FY'82
246 FY'83
246 FY'84 est-Mar
259 April-Sept 1984

FY '82 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*	$284	7.6	$2,158	N/A
All Alabama Hospital Patients (FY '81)	$280	6.8	$1,904	N/A
Alabama Medicaid Patients (FY '81)	$218	5.5	$1,201	$1,617

*1981 Data, 1982 Data Not Available

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 $284, and that the cost per stay was $2,158. Although the cost to Medicaid for these items is much lower than these national averages, it must be remembered that the $218 per day Medicaid paid for hospital care represents only a part of the cost of 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. It has been suggested 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 40 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.

FY '82 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	394,905	56,924	325,826	144	5.7
All Alabama Residents	3,943,000	762,111	5,091,629	193	6.7

FY '78-'82
HOSPITAL PROGRAM
Outpatients

PLATE 41

	FY '78	FY '79	FY '80	FY '81	FY '82
Number of outpatients	94,339	105,507	110,774	115,393	112,333
Percent of eligibles using outpatient service	23%	25%	26%	28%	28%
Annual expenditure for outpatient care	$5,451,111	$8,084,542	$11,568,775	$13,109,707	$12,655,314
Cost per patient	$58	$77	$104	$114	$113

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 cost per patient has increased 95%. 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.

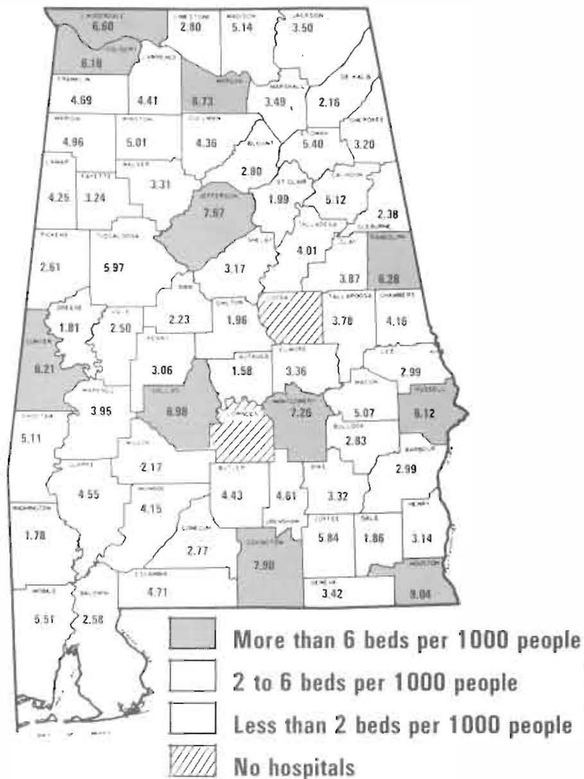
Alabama's Supply of Hospital Beds: According to State Health Planning and Development Agency figures, the number of existing hospital beds has exceeded the number of needed beds since 1978. FY'82 data shows a surplus of 1,619 beds. Because of this surplus, Alabama hospitals presumably will not be issued Certificates of Need to expand until the need for beds catches up with the supply (except in rare circumstances). Even if no new Certificates of Need are issued, the construction of new beds may continue. The reason is that many hospitals hold unused "assurances of need" which were issued to them before 1975. These assurances are equivalent to permission to expand. They cannot be revoked and, therefore, can still be used.

FY '75-'82
HOSPITAL PROGRAM
Hospital use and need for all Alabama

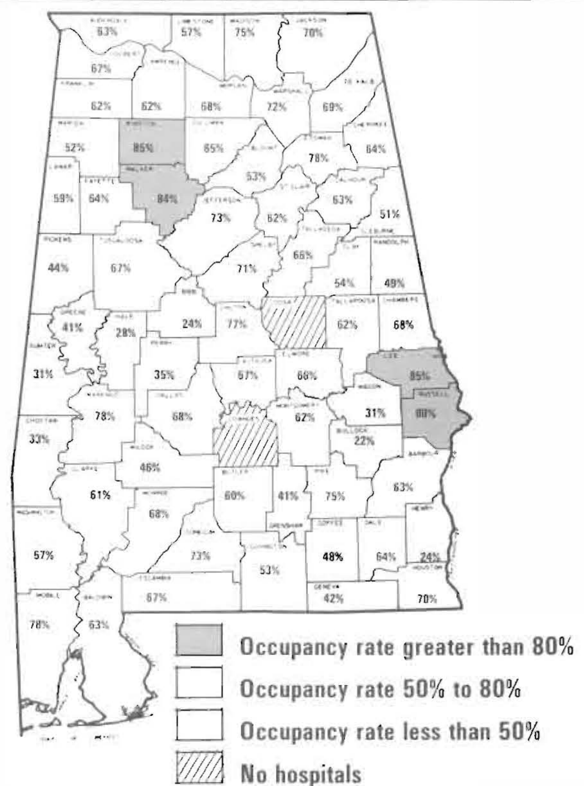
PLATE 42

	Alabama's Population	Hospital Admissions	Patient Days in Hospitals	Needed Beds	Existing Hospital Beds	Surplus Beds
1975	3,615,000	609,381	4,190,450	16,989	18,278	1,289
1976	3,653,000	642,452	4,445,930	17,316	18,189	873
1977	3,690,000	689,558	4,673,207	N/A	17,652	N/A
1978	3,742,000	728,465	4,902,517	17,339	20,114	2,775
1979	3,769,000	727,292	4,897,995	17,795	20,199	2,404
1980	3,893,888	743,447	4,975,576	17,982	20,420	2,438
1981	3,920,000	748,764	5,055,548	18,690	20,441	1,751
1982	3,943,000	762,111	5,091,629	18,778	20,397	1,619

FY '82 PLATE 43
HOSPITAL PROGRAM
Beds per 1,000 people



FY '82 PLATE 44
HOSPITAL PROGRAM
Hospital Occupancy Rate (%)



Plates 43 and 44 show distribution and occupancy rates of hospital beds by county. Beds per 1,000 people range from 9.04 in Houston County to no hospitals in Coosa and Lowndes counties. Occupancy rates range from 85% in Lee and Winston Counties to 22% in Bullock County.

PHYSICIAN PROGRAM

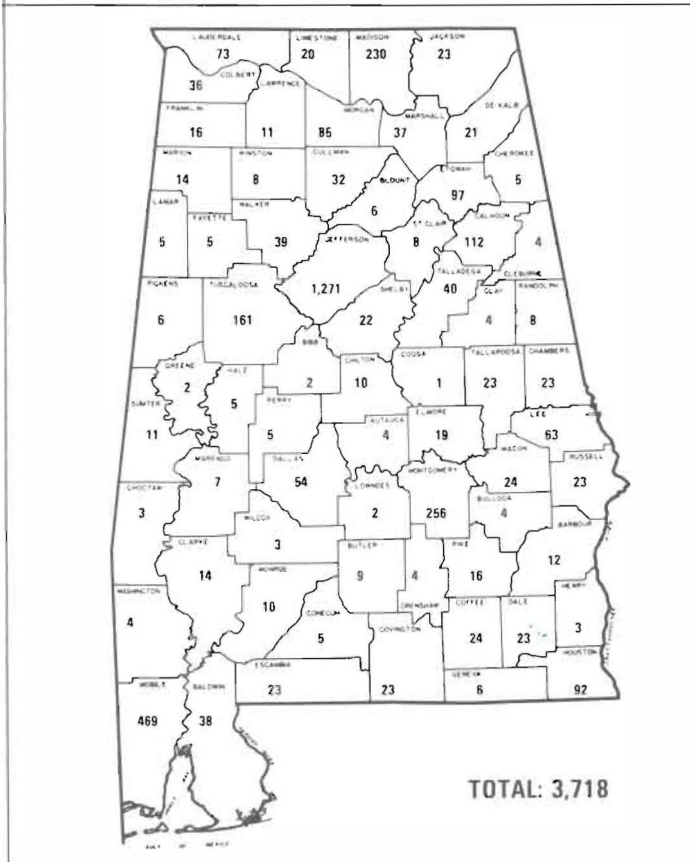
Among Medicaid eligibles, 6 persons in 10 saw a physician this year.

Medicaid paid physicians an average of $160 for each patient.

FY '82 PLATE 45

PHYSICIAN PROGRAM

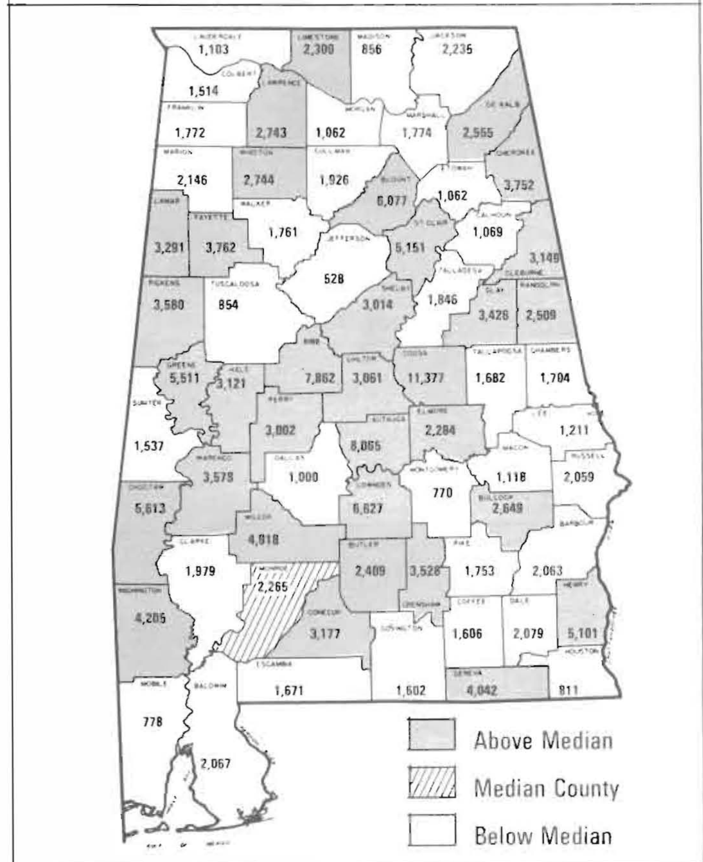
Number of physicians providing direct patient care, by county



FY '82 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 3,718 doctors offering direct patient care in Alabama as of March, 1982. 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, agreements which limit charges per screening must be signed by physicians 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'82 almost three-quarters of the Medicaid recipients in Alabama received physicians' services.

FY '78-'82 PLATE 47

PHYSICIAN PROGRAM

Use and cost

	COST PER RECIPIENT PER YEAR, FOR PHYSICIANS' SERVICES				
	FY '78	FY '79	FY '80	FY '81	FY '82
Aged	$ 44	$ 59	$ 76	$ 83	$104
Blind	$133	$202	$176	$179	$232
Disabled	$138	$215	$187	$205	$243
Dependent Children	$ 63	$ 88	$ 79	$ 84	$ 99
Dependent Adults	$153	$215	$194	$178	$229
ALL CATEGORIES	$ 87	$128	$120	$132	$160

	NUMBER OF MEDICAID RECIPIENTS TREATED BY PHYSICIANS				
	FY '78	FY '79	FY '80	FY '81	FY '82
Aged	69,678	67,071	72,159	71,452	69,831
Blind	1,382	1,439	1,415	1,491	1,549
Disabled	39,200	42,648	45,101	47,386	48,824
Dependent Children	69,497	80,888	77,432	83,019	79,478
Dependent Adults	39,063	45,447	44,328	49,536	46,945
ALL CATEGORIES	218,820	237,503	240,435	240,655*	238,519*

	PERCENT OF ELIGIBLES WHO BECAME RECIPIENTS OF PHYSICIANS' CARE				
	FY '78	FY '79	FY '80	FY '81	FY '82
Aged	62.3%	61.8%	66.0%	73.4%	76.2%
Blind	63.4%	65.0%	63.5%	68.2%	71.3%
Disabled	62.6%	63.4%	65.1%	69.0%	70.8%
Dependents	47.9%	53.6%	50.3%	55.0%	54.5%
ALL CATEGORIES	54.3%	57.4%	56.8%	58.8%	60.4%

(*unduplicated count)

Medicaid physicians' care costs less per person for the aged than it costs for most other categories. (See Plate 47.) This surprising situation is explained by the fact that 90% 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 declined by about 1% from the previous year. The cost of the program rose from $31,650,087 in FY'81 to $38,115,673.

PHARMACEUTICAL PROGRAM

More prescriptions at a higher price per prescription resulted in a significant increase in Medicaid payments to pharmacies.

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 '80-'82 PLATE 48
PHARMACEUTICAL PROGRAM
Counts of providers by type and year

Type of Provider	Number		
	FY '80	FY '81	FY '82
In-State Retail Pharmacies	1,000	1,008	1,047
Institutional Pharmacies	38	41	42
Dispensing Physicians	3	4	4
Out-of-State Pharmacies	40	36	49
Health Centers and Clinics	4	3	3
TOTAL	1,085	1,092	1,145

FY '80-'82 PLATE 49
PHARMACEUTICAL PROGRAM
Recipients, expenditures, and claims

	All Categories	Aged	Blind	AFDC/Other	Disabled
RECIPIENTS (Per Year)					
FY '80	222,525	80,470	1,443	93,761	46,851
FY '81	223,538	84,832	1,514	104,021	50,271
FY '82	222,109	77,545	1,587	98,220	50,637
EXPENDITURES (Per Year)					
FY '80	$19,983,722	$11,303,525	$171,351	$2,151,025	$6,357,821
FY '81	24,242,873	13,504,865	216,208	2,461,328	8,060,472
FY '82	28,268,860	15,384,231	269,269	2,839,726	9,775,634
# of Rx (Per Year)					
FY '80	2,958,444	1,653,282	24,880	399,847	880,435
FY '81	3,171,150	1,782,521	27,500	374,740	986,389
FY '82	3,213,290	1,754,213	29,233	382,291	1,047,553
Rx PER RECIPIENT (Per Year)					
FY '80	13.3	20.5	17.2	4.3	18.8
FY '81	14.2	21.0	18.2	3.6	19.6
FY '82	14.5	22.6	18.4	3.9	20.7
COST PER RECIPIENT (Per Year)					
FY '80	$ 90	$140	$119	$23	$136
FY '81	108	159	143	24	160
FY '82	127	198	170	29	193

FY '82 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 '81	101,279	31%	294,677	2.91	$8.32	$24.22	$2,453,009
November	93,425	29%	253,968	2.72	$8.38	$22.79	$2,128,997
December	65,343	20%	148,512	2.27	$8.47	$19.25	$1,257,930
January '82	104,782	33%	350,484	3.34	$8.57	$28.65	$3,001,956
February	103,792	33%	316,468	3.05	$8.66	$26.42	$2,741,995
March	94,407	30%	255,312	2.70	$8.63	$23.33	$2,202,472
April	92,590	30%	253,433	2.74	$8.72	$23.87	$2,210,318
May	94,040	30%	252,400	2.68	$9.04	$24.26	$2,281,018
June	103,664	33%	315,181	3.04	$9.10	$27.66	$2,867,409
July	89,134	29%	238,012	2.67	$9.17	$24.48	$2,182,011
August	93,386	30%	255,234	2.73	$9.24	$25.25	$2,358,068
September	104,582	34%	328,103	3.14	$9.25	$29.03	$3,036,097
ALL YEAR	222,109	56%	3,213,290*	14.47	$8.80	$127.27	$28,268,860*

*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.

The relationship of expenditures for drug benefits to total Medicaid program expenditures has remained stable for several years. Since FY'79 the drug program has accounted for 7% to 8% of total Medicaid payments.

The average price for a prescription in FY'82 increased 15% from $7.64 to $8.80 (Plate 50). The number of prescriptions per recipient showed a small increase, whild the cost per recipient rose from $108 in FY'81 to $127 in FY'82 (Plate 49).

FAMILY PLANNING

Expenditures for family planning services totalled $3,975,157 for FY '82.

FY '80-'82 PLATE 51
FAMILY PLANNING PROGRAM
Recipients by sex, race, and age

	FY '80	FY '81	FY '82
Total	16,555	27,013	29,983
Male	89	659	1,418
Female	16,466	26,354	28,565
White	2,014	4,512	5,738
Nonwhite	14,541	22,501	24,245
Age 0-5	0	0	0
Age 6-20	7,515	13,320	13,517
Age 21-64	9,026	13,693	16,466
Age 65 & over	14	0	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 80% 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 during the neonate period (first 30 days of life), 1 to 12 months of age, and 1, 2, 3, 5, 10, 15 and 19 years of age.

In FY '82 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 $23.98 per recipient. The cost of treatment is considerably higher depending on the condition. Payments for screenings in FY '82 declined 9% from the previous year.

FY '80-'82 PLATE 52
EPSDT PROGRAM
Eligibles, recipients, by age
Payments

	FY '80	FY '81	FY '82
TOTAL ELIGIBLES FOR EPSDT PROGRAM	187,942	190,285	180,721
Age:			
0-5	57,902	65,766	62,606
6-20	130,040	124,519	118,115
RECIPIENTS OF SCREENING	37,796	37,811	35,131
Age:			
0-5	16,468	15,316	14,664
6-20	21,328	22,495	20,467
TOTAL PAYMENT FOR SCREENINGS	$870,743	$928,853	$842,524
AVERAGE PAYMENT FOR A SCREENING	$23.04	$24.57	$23.98

During FY '82 a total of 35,131 screenings were made—a decrease of 7% from FY '81. Of those screened, about 80% had referrable conditions uncovered or suspected.

HOME HEALTH

Of every nine Medicaid patients in need of continuous care, eight 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 88 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 53 shows how the number of chronically ill has increased each year since 1976 and the division each year of these patients into two groups — one group at home and one group in nursing homes.

In FY '82 a total of 3,238 persons received 94,034 visits for a cost to Medicaid in excess of $2,200,000. 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: Reimbursement is made on a per visit basis regardless of the number of services rendered during the visit. Per visit payments cannot exceed the final adjusted rates for Medicare beneficiaries. The maximum per visit payment of $27.00 was established by the Medicaid program in FY'82. 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 '76-'82 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
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
1982	3,238	24,476

DENTAL AND OPTOMETRIC PROGRAMS

Nearly 43,000 persons received dental care as an integral part of the EPSDT Program.

$1.7 million were expended for optometric services and eyeglasses in FY '82.

Dental Program

The Alabama Medicaid Dental Program is provided as part of the Early and Periodic Screening, Diagnois, and Treatment (EPSDT) of Medicaid eligible individuals under twenty-one (21) years old.

Dental Services are defined as any diagnostic, preventive, or corrective procedure administered by or under the direct supervision of a dentist in the practice of his/her profession. All dental service must be provided by dentists licensed to practice in the state in which the service is rendered. Medicaid requires that such services shall maintain a high standard of quality and shall be within the reasonable limits of those services which are customarily available and provided to most persons in the community with the following limitations and exclusions. A Medicaid eligible in need of dental care must be referred for dental services through the EPSDT Program, with exceptions such as: emergency care, recipients institutionalized under a physician's care, or who have a definite health care plan in a program such as Crippled Children's Service, Head Start, and day care programs. Medicaid does not provide total dental care services. Examples of services not provided by Medicaid are surgical periodontal treatment, orthodontic treatment, and most prosthetic treatment.

Certain dental services may be prior authorized by Medicaid when justified by the attending dentist as being medically necessary. Examples of these services are nonsurgical periodontal treatment, third and subsequent space maintainers, general anesthesia, hospitalization, and some out-of-state care.

During FY'82, approximately 79,178 claims were paid to dental providers for services rendered to Medicaid recipients, at an approximate cost of $4,648,580.

FY '82 PLATE 54
DENTAL PROGRAM
Recipients by Sex and Age

	FY '81	FY '82
Total	44,621	42,988
Male	20,526	19,787
Female	24,095	23,201
Age 0-5	10,964	11,338
Age 6-20	33,657	31,650

Optometric Program

The Optometric Program of Alabama Medicaid was established in 1974, with eye examinations provided by ophthalmologists and optometrists licensed to practice in the state that the service is rendered. If eyeglasses are prescribed, recipients who are twenty-one years old or older are authorized one pair each two calendar years and recipients who are under twenty-one years of age are authorized one pair each calendar year. The same limitation applies to fitting and adjusting of the eyeglasses. Medicaid does not replace eyeglasses due to loss or breakage.

Medicaid's eyeglasses are provided through bulk purchase. It is the only bulk purchse program provided by Alabama Medicaid. Purchase of lenses and frames are done through competitive bidding, and a contract awarded the lowest bidder for one year. It has been highly successful on a financial level as the average price per pair of eyeglasses furnished during the recently expired contract period (July 1, 1981 - June 30, 1982) was approximately $15.00, and the average price per pair over the past five years has been approximately $14.50.

In addition to eyeglasses, contact lenses may be provided following cataract surgery or for Keratoconus treatment, when prior authorized by Medicaid.

During FY'82, approximately 29,248 claims were paid to providers for optometric eye care services, at an approximate cost of $1,199,924. During the same period, approximately 25,121 claims were paid to providers for eyeglass service, at an approximate cost of $455,894.

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 54 (Puerto Rico, Guam, the Virgin Islands, and Washington, D.C., run the total to 54). All 54 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	$213.29
1 day of skilled nursing care	24.43
1 physician service	17.25
1 prescription	8.81

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:

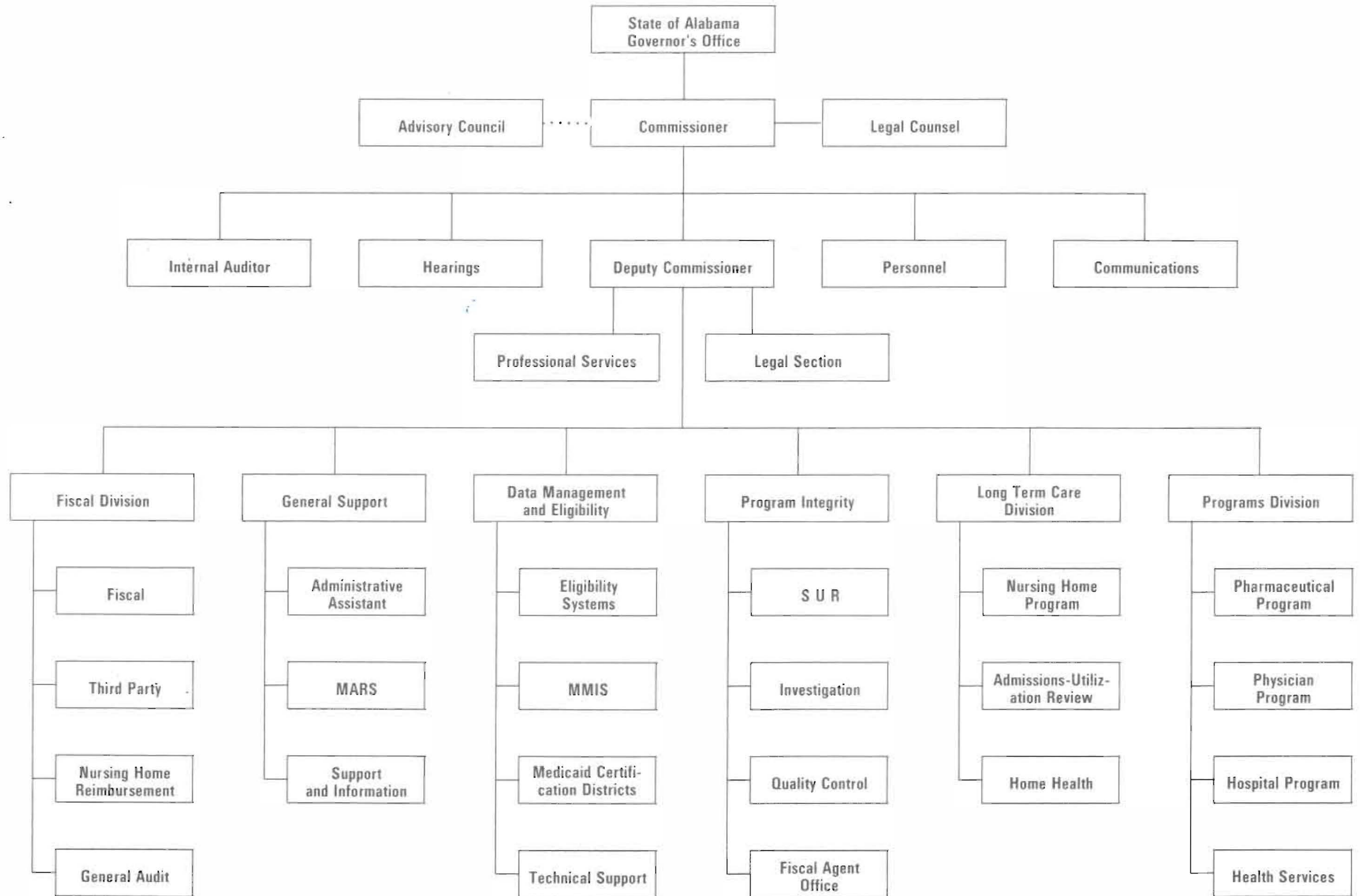
Nursing home care,
physicians' services,
eye care, including glasses,
drugs,
family planning services,
home health care,
screening and referral services (EPSDT),
hospital care,
dental services,
hearing care, including hearing aids,
laboratory work and X-rays,
transportation required for medical purposes.

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 $12.20 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 patient if he were not eligible for Medicaid.


State of Alabama Governor's Office
Advisory Council
Commissioner
Legal Counsel
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Hearings
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Legal Section
Fiscal Division
General Support
Data Management and Eligibility
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General Audit
Administrative Assistant
MARS
Support and Information
Eligibility Systems
MMIS
Medicaid Certification Districts
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Admissions-Utilization Review
Home Health
Pharmaceutical Program
Physician Program
Hospital Program
Health Services