Alabama Medicaid Agency

Thirteenth Annual Report

October 1, 1984 - September 30, 1985

George C. Wallace, Governor
State of Alabama

Faye S. Baggiano, Commissioner
Alabama Medicaid Agency

Henry Vaughn, Deputy Commissioner

Harriette Worthington, Deputy Commissioner

GEORGE C. WALLACE
Governor

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

FAYE S. BAGGIANO
Commissioner

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

Dear Governor Wallace:

It is my privilege to present to you the Thirteenth Annual Report of the Alabama Medicaid Agency. The report covers activities and accomplishments for the fiscal year that began October 1, 1984, and ended September 30, 1985.

Alabama's Medicaid program benefits thousands of citizens with payments for needed health care. During the year, approximately 385,000 people were eligible for Medicaid. Beneficiaries include the elderly, the disabled and families composed of low income mothers with dependent children.

In an effort to contain costs while improving services, several new strategies were initiated in the 1985 fiscal year. These included a new focus on preventive health, implementation of home and community services for elderly and disabled people who would otherwise require costly institutionalization, and plans for a project to establish a Health Maintenance Organization for Medicaid recipients. All of these initiatives should strengthen services without increasing costs.

Alabama continues to set an example for the nation with its record of delivering a high quality of service at a very low cost for administration. Our success is due in large part to your commitment and your leadership.

Thanks to your support and that of the Legislature, Alabama's Medicaid program remains fiscally sound.

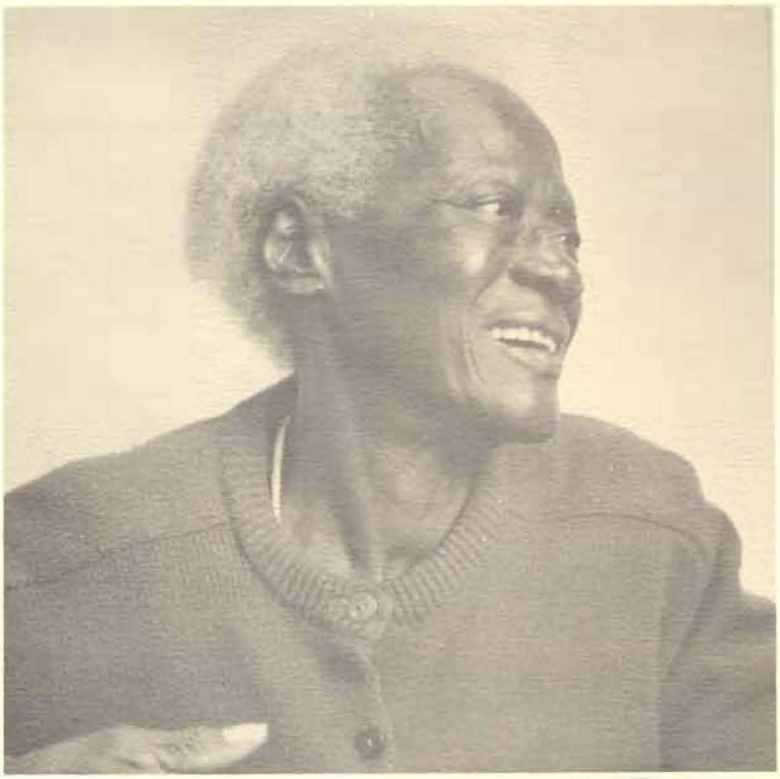
Sincerely,

Faye S. Baggiano
Commissioner

FSB:jsh

Enclosure

The Medicaid program covers a diverse group of people.



ALABAMA MEDICAID

FISCAL YEAR 1985

Published March 1986
by
Planning and Research Division

Best wishes
Jim Wright

ALABAMA MEDICAID AGENCY
MONTGOMERY, ALABAMA

Faye S. Baggiano, Commissioner

Art Composition and Printing
by
Graphics Arts Division
Kilby Correctional Facility
Correctional Industries

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LIST OF ILLUSTRATIONS

HIGHLIGHTS OF THE 1985 FISCAL YEAR

• The **Medicaid Task Force on Preventive Medicine** presented its recommendations to Commissioner Baggiano during July 1985. These recommendations represented a year of effort by a score of respected health care professionals from state government, private institutions, and private practice. The group's work is expected to help the Medicaid Agency as well as other agencies to focus on preventive health care measures in addition to treating the sick. The long term goal of the task force, which will continue to advise the Medicaid Agency, is to promote healthier Alabamians and control health care costs. During FY'86, Medicaid will create a **new preventive health care unit.**

• The agency expanded its recipient **copayment requirements** to include most Medicaid covered services, effective July 1, 1985. Copayments have been required for prescription drugs for several years. The purpose of recipient copayments is to place more responsibility on recipients for controlling their use of Medicaid services. Copayment amounts are only a small fraction of the cost of services. Children, pregnant women, and nursing home residents are exempt, as are certain crucial services such as renal dialysis and cancer treatment.

• The **Medicaid Conference** hosted by the agency January 30 to February 1, 1985, was apparently the first of its kind in the nation. The purpose of the three-day event, held in Montgomery, was to explain to attendees the operation of the state's Medicaid program as well as its problems, limitations, and potential. The majority of the 427 attendees were Medicaid providers.

• **Medicaid expenditures in Alabama,** when expressed as a percentage of the total state budget, are **dropping** faster than in any other state in the eight-state Southeastern region. A report published August, 1985 in the **Southeastern Human Services News** revealed that Medicaid expenditures consumed approximately ten percent of Alabama's budget in FY'82. By FY'84, the percentage had dropped two full points. Two other states in the region, South Carolina and Georgia, showed decreases of less than one-half percent. The other five states showed increases.

• Near the end of FY'85, the Federal Health Care Financing Administration renewed the three-year-old **mental health waiver** for Alabama for another three years. Under this waiver, Medicaid, through the Department of Mental Health and Mental Retardation, provides habilitative services to mentally retarded and developmentally disabled persons at risk of institutionalization. During the three year life of the original waiver, almost $115 million in public funds for institutional care costs were saved, including $39 million during FY'85. The projected cost savings for the next three years is more than $170 million. A waiver for elderly and disabled persons at risk of institutionalization was implemented in February, 1985. By the end of FY'85, about 1,000 persons were being served under this waiver.

• On June 1, 1985, the agency instituted a **revised drug code index** consisting of **70 percent generic drugs.** The primary reason for the change was to control costs. The fastest-growing portion of the Medicaid budget is drugs. Brand name drugs are more expensive than their generic equivalents.

• **A program to treat mentally ill persons** was created at the beginning of FY'85 through a contract between the Medicaid Agency and the Department of Mental Health and Mental Retardation. The Mental Health program is serving nearly 3,000 persons a month at a cost of about $2 million a year.

• The Department of Pensions and Security began taking applications for **new categories of Medicaid eligibles** August 1, 1985, with retroactive eligibility possible to July 1. Although the new categories must meet ADC financial standards, some families with two able-bodied adults may for the first time be eligible for Medicaid.

• Beginning September 1, 1985, Medicaid extended coverage to **State Department of Youth Services foster children.** This coverage has made placement of DYS children in foster family homes easier.

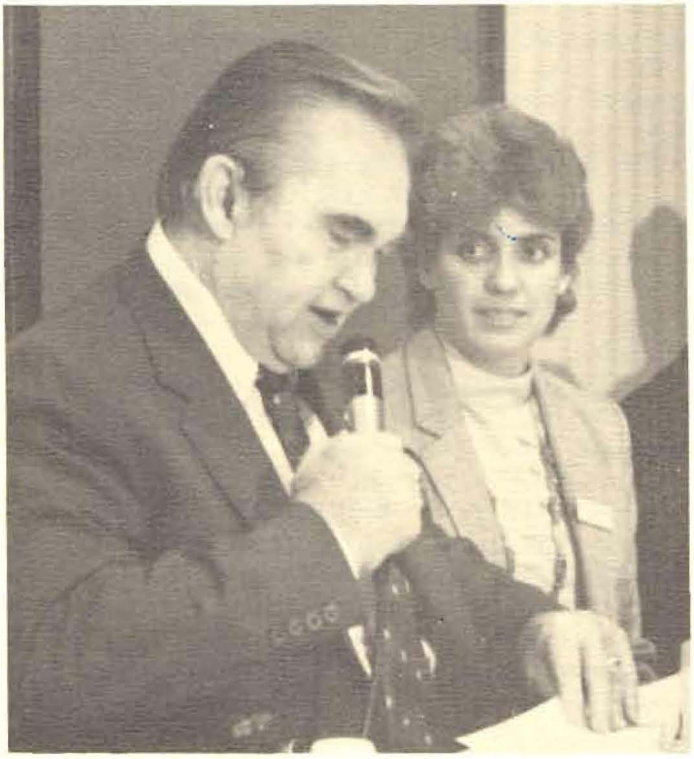
• In the Spring of 1985, the agency's Third Party Section initiated a program to collect **medical support payments from absent ADC parents.** Many of these absent parents have resources such as insurance or cash that can be used to pay medical bills. The potential for taxpayer savings is significant. Third Party activities saved the Medicaid program nearly $17 million in FY'85.

• Throughout the fiscal year, **monthly payrolls to Medicaid providers were made on a timely basis.** In previous years, this was not always the case. The prompt payments in FY'85 were mainly due to full federal and state funding.

• Agency employees worked throughout the fiscal

year toward the implementation of the **West Alabama Health Maintenance Organization project.** If this long-term pilot project is successful, the HMO concept might be applied to the Medicaid program statewide.

- A new **Provider Audit and Reimbursement Division** was organized on April 1, 1985. During its first six months of operation (without a full complement of staff), the unit's cost-avoidance projections were approximately $2 million a year. During FY'86, the unit will implement a Medicaid-only annual cost report methodology for hospitals, which is expected to simplify cost-reporting procedures. Annual cost reports are used in determining the hospital per diem rate. Currently, Medicaid bases its hospital per diem rate on the Medicare cost report.
- In April 1985, **Alacaid** was the successful bidder for the Alabama Medicaid Agency's fiscal agent contract. The primary responsibility of the fiscal agent contract is to process Medicaid claims. The contract, which covers FY'86 and FY'87 with a Medicaid Agency option for a third year, will pay Alacaid about $3 million a year. This is Alacaid's third consecutive fiscal agent contract in Alabama. Alacaid also successfully bid for a Medicaid hospital inpatient review contract in September, 1985. The cost of the contract, which covers FY'86, is $210,000. This price is $148,000 less than the FY'85 contract.



Governor Wallace and Commissioner Baggiano at Medicaid conference

ALABAMA'S MEDICAID PROGRAM

History — Medicaid was created in 1965 by the federal government along with a sound-alike sister program, Medicare. Medicaid is jointly financed by the State and Federal governments and is designed to provide health care to low income individuals. Medicare is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. Medicaid started in Alabama in 1970 as a State Department of Health program. In 1977, the Medical Services Administration was made an independent state agency. In 1981, the agency was renamed the Alabama Medicaid Agency.

A State Program — Medicaid is a state-administered health care assistance program. All states, as well as the District of Columbia and some territories, have Medicaid programs. Medicaid is governed by federal guidelines, but state programs vary in eligibility criteria, services covered, and limitations on services.

Funding Formula — The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because Alabama is a relatively poor state, its federal match is one of the largest. During fiscal year 1985, the formula was 72/28. For every $28 the state spends, the federal government contributes $72.

Eligibility — Persons must fit into one of three categories in order to qualify for Medicaid in Alabama, and eligibility is determined by one of three different agencies. Eligibles include:

- Persons receiving Supplemental Security Income from the Social Security Administration.
- Persons approved for cash assistance through the State Department of Pensions and Security. Most people in this category receive Aid to Dependent Children or State Supplementation.
- Persons approved for nursing home care by the Alabama Medicaid Agency. Eligibility is determined at one of seven Medicaid District offices around the state. Nursing home patients approved for Medicaid payments must meet medical as well as financial criteria.

How the Program Works — A family or individual who is eligible for Medicaid is issued an eligibility card, or "Medicaid Card", each month. This is essentially good for medical services at one of 7,000 providers in the state. Providers include physicians, pharmacists, hospitals, nursing homes, dentists, optometrists, and others. These providers bill the Medicaid program for their services.

Covered Services —Medical services covered by Alabama's Medicaid program are fewer and less comprehensive than services offered by most other states. Alabama's program is essentially a "no frills" program aimed at providing basic, necessary health care to the greatest number of people.

MEDICAID'S IMPACT

Since implementation in 1970, Alabama's Medicaid program has had a significant impact on the overall quality of health care in the state. Medicaid has given hundreds of thousands of citizens access to quality health care which they could not otherwise afford.

The effect of this access to care is difficult to assess, but there are some indications of the program's effectiveness. When Medicaid started in 1970, the state's infant mortality rate was 24.1 per 1,000 births. Many of these deaths could be traced to mothers who could not afford competent prenatal care. Since 1970, the trend in the infant death rate has been consistently downward. In 1984, the death rate was 12.9 per 1,000. This equals the record low rate of 1981. Besides access to health care, other factors such as nutrition programs and medical advances have certainly contributed to this improvement, but Medicaid has proven itself to be essential to the good health of thousands of Alabamians.

Medicaid is also important to citizens who are not eligible for the program. Health care is one of Alabama's most important industries, and Medicaid is vital to that industry. During FY'85, Medicaid eligibles received services totaling $375 million. The state paid only $105 million of the total expenditures, while the federal government provided $270 million, or about three-quarters of the total.

Historically, Alabama's Medicaid program has one of the lowest administrative costs per eligible of any program in the nation. This means that nearly all of Medicaid's expenditures went to purchase services for eligibles. Medicaid funds are paid directly to the 7,000 providers who treat Medicaid patients. These providers include physicians, dentists, pharmacists, hospitals, nursing homes, and medical equipment suppliers all over the state. These funds paid the salaries of thousands of workers, who in turn bought goods and services from thousands more. Using the common economic multiplier effect of three, Medicaid expenditures generated approximately $1.2 billion worth of business in Alabama during FY'85.

Medicaid funds make it possible for citizens to receive quality health care even in rural or economically depressed areas of the state. For instance, Medicaid revenue can allow a physician to practice in an area that might be economically marginal if he had to depend solely on his patients' ability to pay.

Providing quality health care to Medicaid eligibles is important, but the program must also be fiscally responsible. The state's financial resources are not inexhaustible. Because of this, Alabama's Medicaid program is less elaborate than in most states. The philosophy of the Alabama Medicaid Agency is to provide services that will do the most good for the greatest number of people.

FY'85 PLATE 1
COUNTY IMPACT
Year's cost per eligible

County	Benefit Payments	Eligibles	Payments Per Eligible
Autauga	$ 1,899,269	2,714	$ 700
Baldwin	4,484,748	4,798	935
Barbour	3,517,591	3,942	892
Bibb	1,599,632	1,592	1,005
Blount	2,091,518	2,203	949
Bullock	1,772,863	2,716	653
Butler	2,979,873	3,492	853
Calhoun	8,611,763	9,398	916
Chambers	3,496,149	4,233	826
Cherokee	1,045,171	1,343	778
Chilton	2,144,836	2,444	878
Choctaw	1,951,163	2,783	701
Clarke	3,213,901	4,478	718
Clay	1,479,255	1,281	1,155
Cleburne	951,983	1,009	943
Coffee	3,138,679	3,185	985
Colbert	3,759,789	3,511	1,071
Conecuh	1,405,015	2,092	672
Coosa	788,740	991	796
Covington	3,830,441	3,425	1,118
Crenshaw	2,346,540	2,098	1,118
Cullman	5,524,534	4,187	1,319
Dale	3,332,737	3,240	1,029
Dallas	6,306,211	11,123	567
DeKalb	5,128,957	4,573	1,122
Elmore	10,458,600	3,901	2,681
Escambia	3,212,955	3,755	856
Etowah	8,971,522	7,884	1,138
Fayette	1,522,056	1,684	904
Franklin	3,506,072	2,869	1,222
Geneva	2,385,377	2,718	878
Greene	1,501,031	3,173	473
Hale	2,671,243	3,390	788
Henry	1,572,174	1,893	831
Houston	4,856,581	6,045	803
Jackson	3,372,034	3,962	851
Jefferson	47,458,084	58,310	814
Lamar	1,806,928	1,434	1,260
Lauderdale	5,129,864	5,041	1,018
Lawrence	2,522,666	2,873	878
Lee	3,662,872	5,311	690
Limestone	3,116,810	3,294	946
Lowndes	1,731,942	3,291	526
Macon	3,995,136	4,991	800
Madison	8,100,825	11,805	686
Marengo	3,222,185	4,274	754
Marion	3,184,866	2,236	1,424
Marshall	6,412,741	5,778	1,110
Mobile	36,777,648	41,743	881
Monroe	2,119,139	3,002	706
Montgomery	18,915,538	21,282	889
Morgan	19,237,239	6,980	2,756
Perry	2,355,989	3,567	660
Pickens	3,284,798	4,110	799
Pike	3,245,498	4,499	721
Randolph	2,193,339	2,243	978
Russell	4,677,012	5,209	898
St. Clair	3,212,638	2,692	1,193
Shelby	2,466,535	2,897	851
Sumter	3,112,198	3,864	805
Talladega	6,885,391	9,581	719
Tallapoosa	5,905,155	3,707	1,593
Tuscaloosa	36,318,781	13,969	2,600
Walker	6,971,431	5,862	1,189
Washington	1,736,430	2,547	682
Wilcox	2,291,947	4,274	536
Winston	2,536,993	1,722	1,473

MEDICAID MANAGEMENT INFORMATION SYSTEM

The agency's Medicaid Management Information System **(MMIS)** keeps track of program expenditures, provider and recipient records, and provides reports that allow Medicaid administrators to monitor the pulse of the program. The MMIS system is divided into six subsystems.

Recipient Subsystem: This subsystem maintains records of eligibles, to include eligibility updates, and monitors third party payment resources and Medicare Part B buy-ins.

Provider Subsystem: This subsystem maintains the provider enrollment records.

Claims Processing: This subsystem keeps track of all claims processing from the submission of claims to payment. The process maintains an audit trail and ensures that claims are paid promptly and correctly to properly enrolled providers.

Reference File: This subsystem keeps up with pricing information based on procedure and diagnosis and provides information on claims in suspense.

Management and Administrative Reporting: This subsystem provides a variety of reports that help agency management with planning, policy development, and preparing federal reports.

Surveillance and Utilization Review (SUR): This subsystem monitors the utilization patterns of Medicaid providers and recipients and helps uncover suspected fraud and abuse.

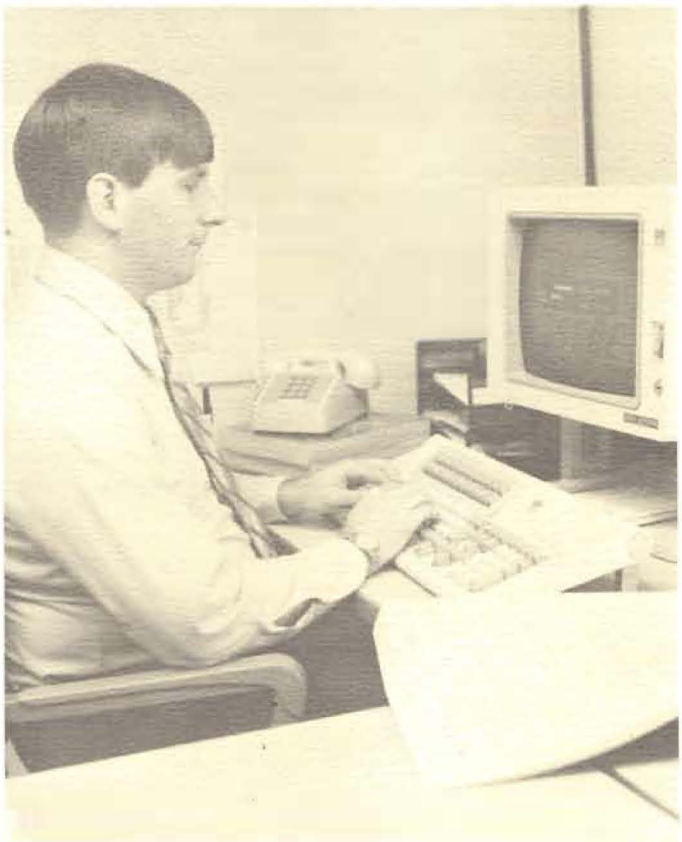
Many of Medicaid's computer functions are done under contract by the agency's fiscal agent, Alacaid. The firm successfully bid for the contract beginning in October 1979. Alacaid has been awarded a third consecutive contract effective October 1, 1985. Alacaid's performance in claims processing has been among the best in the nation. In FY'85, Alacaid processed 6,556,054 claims in an average time of 3.8 days. The fiscal agent runs about 600 state-owned computer programs in support of MMIS. Medicaid agency employees operate a system that contains more than 1,500 computer programs.

MMIS is a dynamic system that requires constant development and modification to keep pace with changing regulations and medical and computer technology. During FY'85, Alacaid implemented major system changes in accordance with federal requirements for a uniform hospital claim form, new outpatient clinical diagnostic laboratory billing procedures, and the HCFA Common Procedure Coding System (HCPCS). An on-line application system for applicants, served by the Medicaid District Offices, was installed by Medicaid during the year.

FY'83-'85 PLATE 2

MEDICAID SOFTWARE ACTIVITY

	FY'83	FY'84	FY'85
Number of Programs in production at year end	1,205	1,406	1,560
Number of Requests received for Software support	886	1,528	1,524
Number of Requests Completed	757	979	1,367



PROGRAM INTEGRITY

The purpose of the Program Integrity Division is to minimize fraud, abuse, and waste in the Medicaid program. Increasing emphasis has been placed on program integrity in recent years. This has resulted in an efficient program where every dollar possible goes to providers who render competent, medically necessary care to bona fide eligibles in need of treatment.

The subunits of the Program Integrity Division are Quality Control, Special Projects, and Surveillance and Utilization Review (SUR). It is Quality Control's job to monitor the agency's eligibility determination accuracy. The Special Projects Unit's primary responsibility is the coordination of the implementation of the West Alabama Health Maintenance Organization project. SUR is the unit that looks for fraud and abuse in the program, and the unit's primary tool is the computer. Computer programs are used to find unusual patterns of utilization on the part of both providers and recipients. When unusual patterns are found, they are analyzed manually. If aberrations cannot be justified, they may be referred to the Utilization Review Committee (URC), which is composed of a physician and financial experts. The URC may take several types of action, including written warnings and administrative sanctions such as restrictions or terminations from the program and recoupment of funds. Cases of recipient fraud may be referred to local district attorneys for possible criminal prosecution. Suspected provider fraud cases are referred to the Alabama Attorney General's Medicaid Fraud Unit for further investigation and possible prosecution.

Although Eligibility Recoupment is not a unit of the Program Integrity Division, the unit's function is similar to units in that division. Eligibility Recoupment recovers funds from individuals who received Medicaid services, but were not in fact eligible for the program. Normally these cases involve nursing home patients who have inaccurately reported their income or assets.

The total amount of diverted funds or Medicaid funds that would have been paid erroneously if irregularities had not been discovered by Program Integrity was $2,300,750 in FY'85.

During the year, complete integrity reviews were conducted on 802 providers and 717 recipients because of possible fraud or abuse. Twenty-six suspected provider fraud cases were referred to the Attorney General's Medicaid Fraud Unit for prosecution. Fifty cases of suspected recipient fraud were referred to local district attorneys for prosecution.

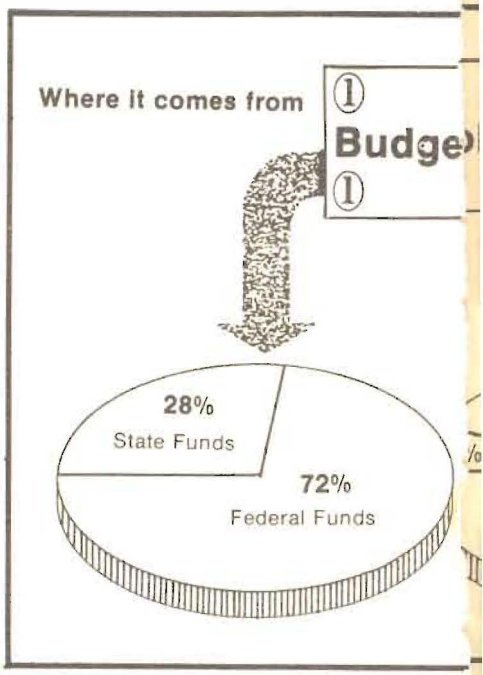
Among the administrative sanctions used to control the abuse of Medicaid was the lock-in program. During the year, 90 recipients were restricted to specific providers. The majority of these recipients were suspected of over-utilizing prescription drugs. Imputed savings from locked-in recipients totaled almost $42,000 in FY'85.

PROGRAM INTEGRITY PLATE 3
FRAUD and ABUSE REVIEWS Completed in FY'85

Providers Investigated	Referred To Attorney General	Recoupments Identified	Providers Terminated From The Medicaid Program
802	26	$137,523	1
Recipients Investigated	Referred To District Attorneys	Recoupments Identified	Recipients Terminated From the Medicaid Program
717	50	$126,229	261

REVENUE, EXPENDITURES, AND PRICES

FY '85 **Sources of Medicaid Revenue**	PLATE 5
Federal funds	$355,070,411
State funds	$139,745,185
Total revenue	$494,815,596



FY '85 **Components of Federal Funds**	PLATE 6
(net)	**Dollars**
Family planning administration	$ 698,119
Professional staff costs	7,942,446
Other staff costs	2,180,863
Other provider services	339,536,799
Family planning services	4,712,184
TOTAL	$ 355,070,411

FY '85 **Components of State Funds**	PLATE 7
	Dollars
Escrowed/Encumbered balance forward	$ 20,289,063
Basic appropriations	101,607,728
Supplemental appropriations	0
Pensions & Security/Mental Health	20,213,588
Interest income from fiscal intermediary	418,982
Miscellaneous receipts	900
	$142,530,261
Encumbered/escrowed	2,785,076
TOTAL	$139,745,185

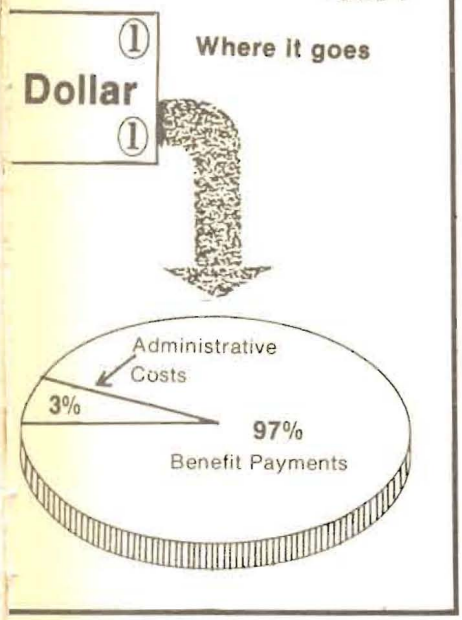
FY '85 PLATE 8

BENEFIT COST BY FISCAL YEAR IN WHICH OBLIGATION WAS INCURRED

	FY '85	FY '86 (EST.)
Nursing Homes	$133,421,135	$140,000,000
Hospitals	74,005,437	76,400,000
Physicians, Lab & X—Ray	35,934,314	39,900,000
Insurance*	39,611,245	48,800,000
Drugs	37,842,621	44,700,000
Health	7,842,635	9,000,000
Community Services	8,202,140	22,000,000
Total Medicaid Service	336,859,527	380,800,000
% Increase	3.71	13.04
Mental Health	59,886,508	66,300,000
Total Benefits	$396,746,035	$447,100,000

*Includes buy-in premiums, coinsurance payments, and deductibles.

PLATE 4



In FY'85, Medicaid paid $478,858,757 for health care services to Alabama citizens. Another $15,956,839 was expended to administer the program. This means that only about three cents of every Medicaid dollar did not directly benefit recipients of Medicaid services. Among ALL states, Alabama consistently has one of the lowest rates of expenditures for administrative costs.

This year, there is a large difference in total expenditures (Plate 9) and total benefits (Plate 8). Total benefits is a measure of obligations incurred during FY'85. Since sufficient federal funds were not available prior to the close of FY'84, two provider payrolls were carried forward from FY'84 to FY'85 and are reflected in the expenditure total for FY'85.

FY '85 PLATE 9

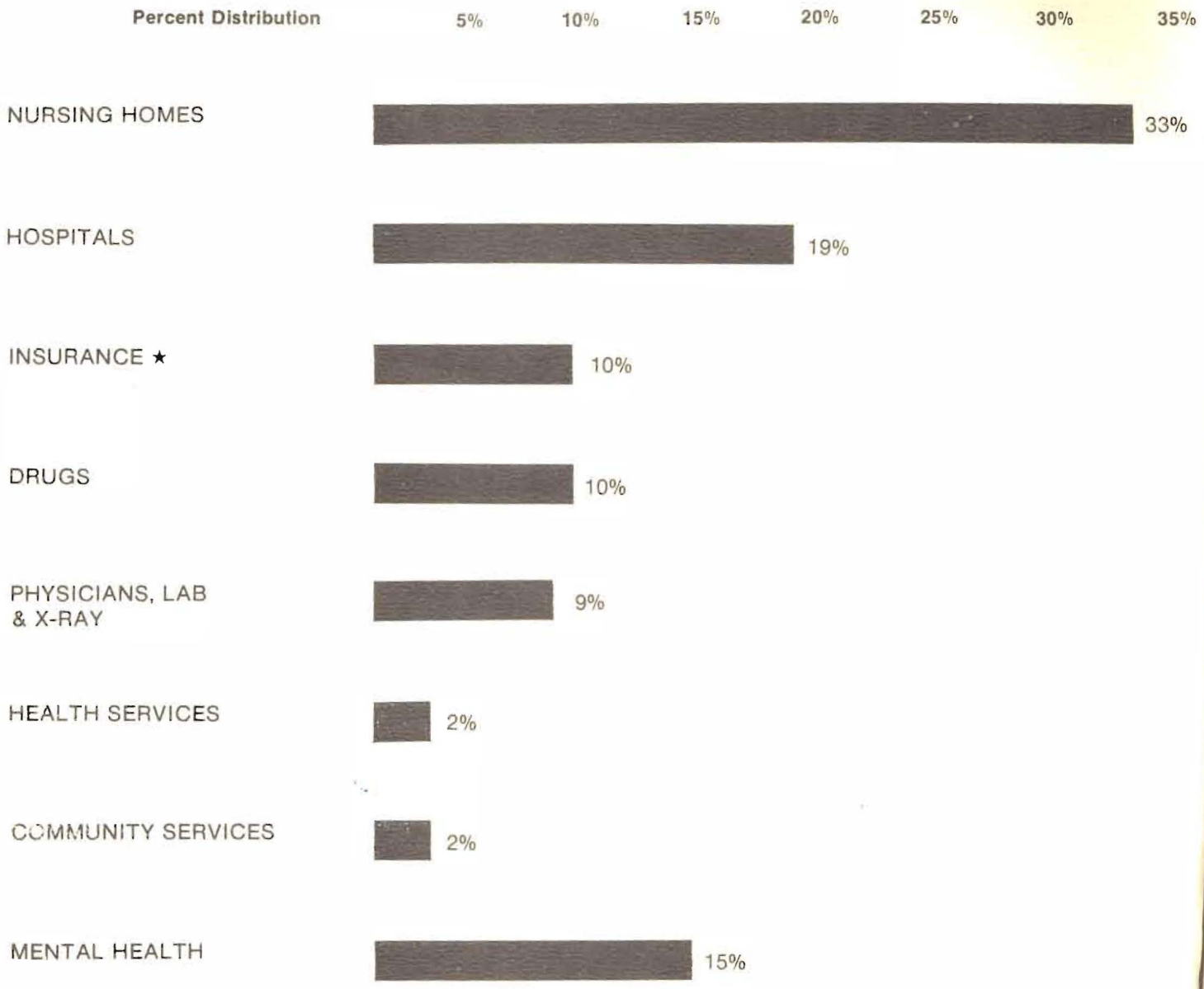
EXPENDITURES

By type of service (net)

Service	Payments	Percent Of Payments by Service FY '85	Percent Of Payments By Service FY '84	Percent Of Payments By Service FY '83
Intermediate Nursing Care	$143,769,388	30.02% > 32.35%	30.29% > 32.95%	28.92% > 31.34%
Skilled Nursing Care	11,138,453	2.33%	2.66%	2.42%
Hospital Inpatients	75,687,836	15.81%	21.27%	23.44%
Hospitals Outpatients	9,597,790	2.00%	2.69%	2.38%
ICF—Mentally Retarded & MD	59,334,547	12.39%	12.38%	14.98%
Physicians' Services	42,070,254	8.79%	12.30%	12.77%
Drugs	44,710,310	9.34%	9.55%	7.97%
Medicare Buy-In Insurance	35,729,402	7.46%	2.45%	1.94%
Dental Services	5,040,702	1.05%	1.38%	1.43%
Family Planning Care	5,235,760	1.09%	1.50%	1.02%
Home Health	4,363,331	.91%	1.09%	.74%
Waivered Services	7,685,846	1.61%	1.23%	.71%
Eye Care	2,778,693	.58%	.62%	.56%
Lab & X—Ray	1,108,408	.23%	.21%	.37%
Screening	962,813	.20%	.26%	.23%
Transportation	372,417	.08%	.08%	.08%
Hearing Care	134,343	.03%	.03%	.03%
Mental Health Services	1,728,117	.36%		
Co-Insurance	27,338,105	5.71%	Prior to FY '85 Cost included in Inpatient Hospital, Skilled Nursing Care, and Physicians' Services.	
Other Care	72,242	.01%	.01%	.01%
Total For Medical Care	$478,858,757	100.0%	100.0%	100.0%
Administrative Costs	15,956,839			
Net Payments	$494,815,596			

PERCENTAGE DISTRIBUTION OF BENEFIT COSTS
Incurred During Fiscal Year 1985

PLATE 10



★ Includes Buy-In Premiums and Payments for Coinsurance and Deductibles

10

35%

33%

PRICES

The price per unit of service is one of the most important factors that influence the cost of medical care. The decline in growth of the medical care component of the Consumer Price Index is shown in Plate 12. This decrease in the rate of growth of the price of medical care is reflected in the small increase of the Alabama Medicaid program's benefit costs during the past fiscal year.

The average unit prices for selected Medicaid services for FY'84 and FY'85 are compared in Plate 11. The service that showed the largest increase over the last fiscal year was an inpatient hospital day. The only decline in a unit price was in outpatient hospital services. This was due to a change in reimbursement methodology and a different method of reporting radiology services associated with an outpatient visit.

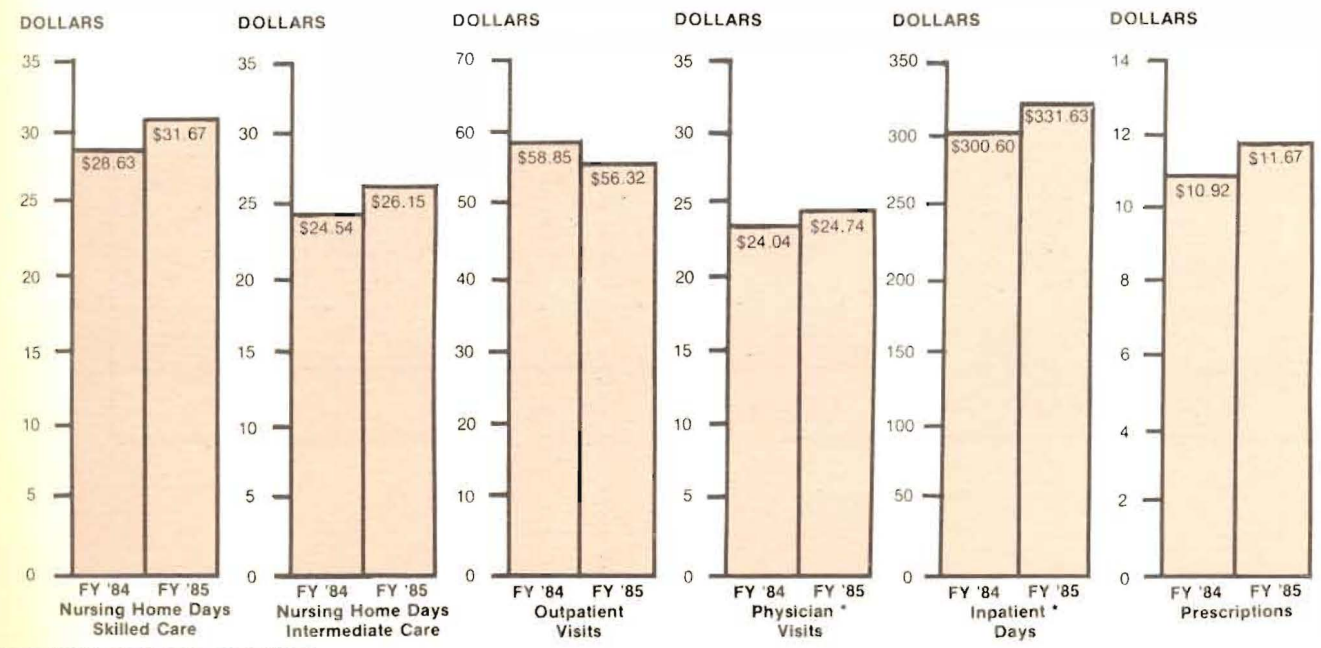
It is Medicaid's policy to pay the same price per day for skilled and intermediate nursing care in dually certified nursing home facilities. However, average unit prices for a day of skilled nursing care and a day of intermediate nursing care are not the same. Although the price of a day of nursing care is the same within a dually certified facility, the per diem rate is not identical from one nursing home to the next. When nursing homes with rates below the statewide average have more intermediate beds than skilled beds, the average price per day of intermediate care is lower than that for a day of skilled care.

FY '84-'85

PLATE 11

PRICES

Average unit price per service



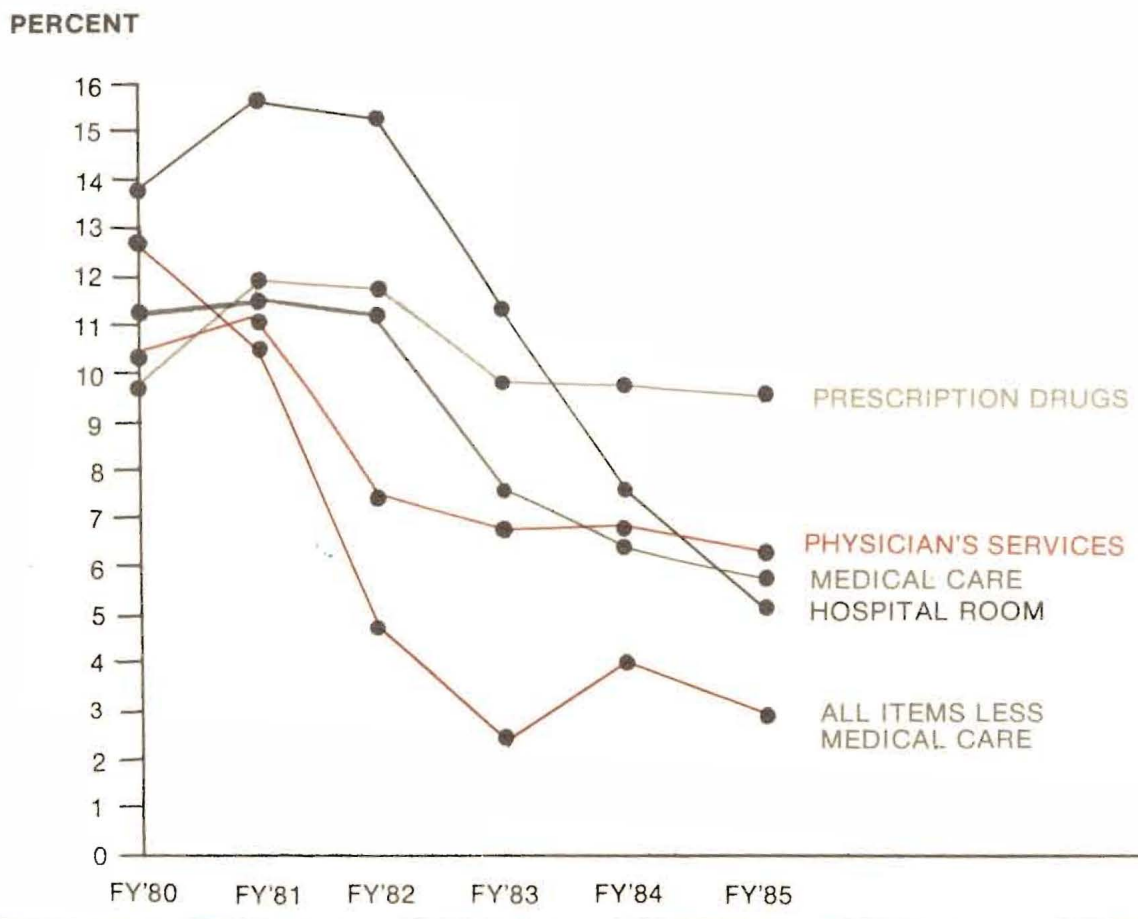
* CROSSOVER CLAIMS EXCLUDED

PLATE 12

FY'80-'85

PERCENT CHANGES IN THE CONSUMER PRICE INDEX

For selected items



POPULATION AND ELIGIBLES

Population

The population of Alabama grew from 3,444,165 in 1970 to 3,893,888 in 1980. In 1985, Alabama's population was estimated at 4,170,100.

More significant to the Medicaid program was the rapid growth of the elderly population. Census data shows that, in the United States, the 65 and over population grew twice as fast as the general population from 1960 to 1980. This trend was reflected in population statistics for Alabama. From 1970 to 1980, the entire Alabama population grew at a rate of 13 percent while the number of persons over 64 years of age increased at a rate of 35 percent. Population projections published by the Center for Business and Economic Research at the University of Alabama reveal that by 1988 there will be almost 540,000 persons 65 years of age and over in the state. Historically, cost per eligible has been higher for this group than other categories of eligibles.

FY '78-'85 PLATE 13

POPULATION

Eligibles as percent of Alabama population by year

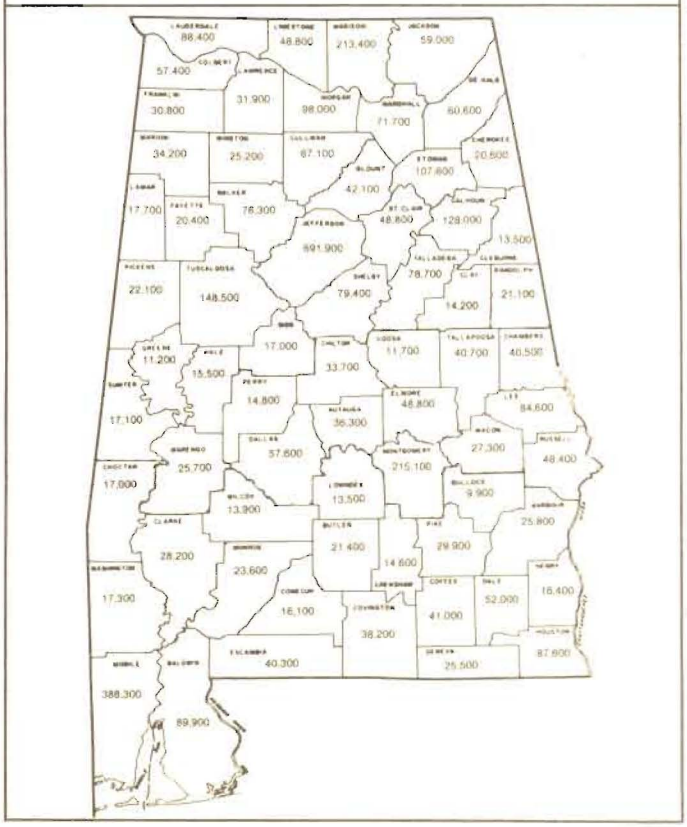
Year	Population	Total Eligibles	Percent
1978	*3,742,000	403,330	9.28
1979	*3,769,000	413,805	10.98
1980	3,893,888	423,031	10.86
1981	*3,920,000	409,428	10.44
1982	*3,943,000	394,905	10.01
1983	*4,093,600	383,940	10.66
1984	**4,132,400	385,379	9.33
1985	**4,170,100	380,513	9.12

* U.S. Bureau of Census official estimate

** Estimate by CENTER FOR BUSINESS AND ECONOMIC RESEARCH

FY'85 PLATE 14

POPULATION 1985 population estimates



FY'85 PLATE 15

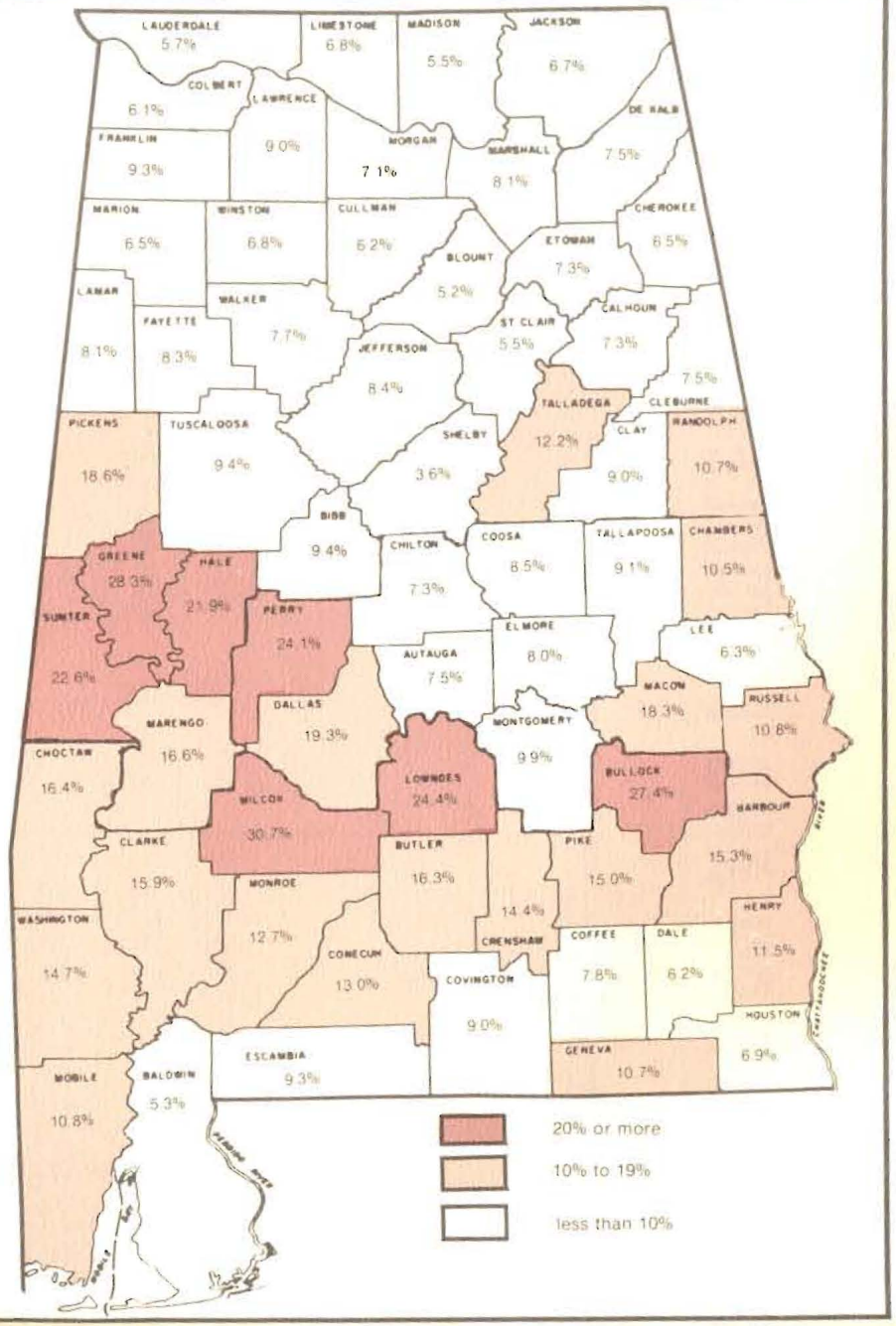
ELIGIBLES

Number of Medicaid eligibles by county

FY'85 PLATE 16

ELIGIBLES

Percent of population eligible for Medicaid, by county



Eligibles

During FY'85, there were 380,513 persons eligible for Medicaid in at least one month of the year (see Plate 18). The average number of persons eligible for Medicaid per month was 306,070. The monthly average is the most useful measure for making comparisons between eligibles in different states and different years since it takes into account length of eligibility.

Plate 18 shows how this year's eligibles were distributed in terms of category, sex, race, and age. The average and total counts allow three important measures to be calculated for each group: the number of new eligibles added during the year, the number of old eligibles dropped during the year, and the turnover rate.

Although 380,513 persons were eligible for Medicaid in FY'85, only about three-fourths were eligible all year. The length of eligibility ranged from one to eleven months.

A measure of total eligibility used in a year is called man-months of eligibility (MME). This measure is calculated by adding the total number of eligibles in each month of the year, to give total MME. Total MME divided by the total number of eligibles for the fiscal year yields an average MME per person, which is useful in determining the expected duration of eligibility. Plate 20 shows this measure for each category and group.

FY '85 PLATE 17

ELIGIBLES

Monthly Count

	Monthly Count
October '84	319,269
November	317,352
December	315,309
January '85	299,988
February	301,355
March	303,294
April	301,900
May	300,805
June	305,055
July	301,410
August	304,966
September	302,135

FY' 85 PLATE 18

ELIGIBLES

By category, sex, race, age

Total number for year

Average number per month

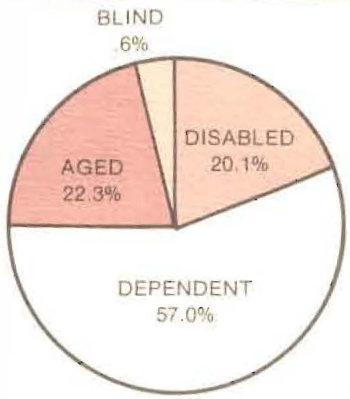
	First Month	Number Added During Year	Total Number For Year	Number Dropped During Year	Final Month	Average Number Per Month	Total Turnover Rate
ALL CATEGORIES	319,269	61,244	380,513	78,378	302,135	306,070	24.3%
AGED	78,543	6,274	84,817	10,119	74,698	76,123	11.4%
BLIND	1,950	108	2,058	191	1,867	1,898	8.4%
DISABLED	68,133	8,455	76,588	8,213	68,375	67,354	13.7%
DEPENDENT	170,643	46,407	217,050	59,855	157,195	160,695	35.1%
MALES	108,691	22,763	131,454	28,695	102,759	104,174	26.2%
FEMALES	210,578	38,481	249,059	49,683	199,376	201,896	23.4%
WHITES	108,595	23,790	132,385	29,750	102,635	104,021	27.3%
NONWHITES	210,674	37,454	248,128	48,628	199,500	202,049	22.8%
AGE 0—5	49,432	13,924	63,356	16,211	47,145	47,959	32.1%
AGE 6—20	84,950	21,352	106,302	27,296	79,006	80,300	32.4%
AGE 21—64	90,379	18,337	108,716	23,376	85,340	85,905	26.6%
AGE 65 & Over	94,508	7,631	102,139	11,495	90,644	91,906	11.1%

FY'85 PLATE 19

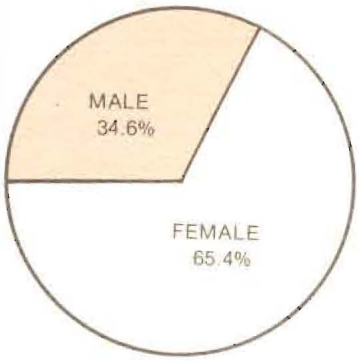
ELIGIBLES

Distribution by category, sex, race, and age

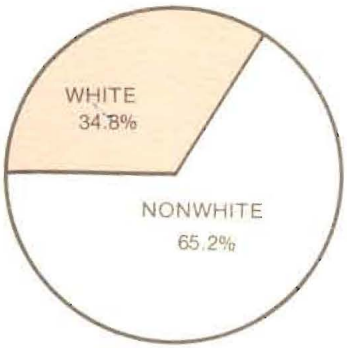
BY CATEGORY



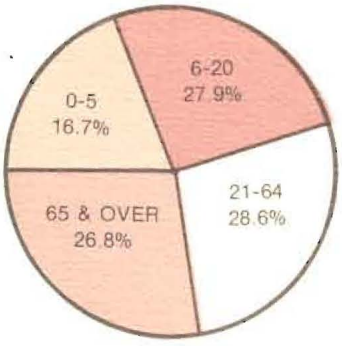
BY SEX



BY RACE



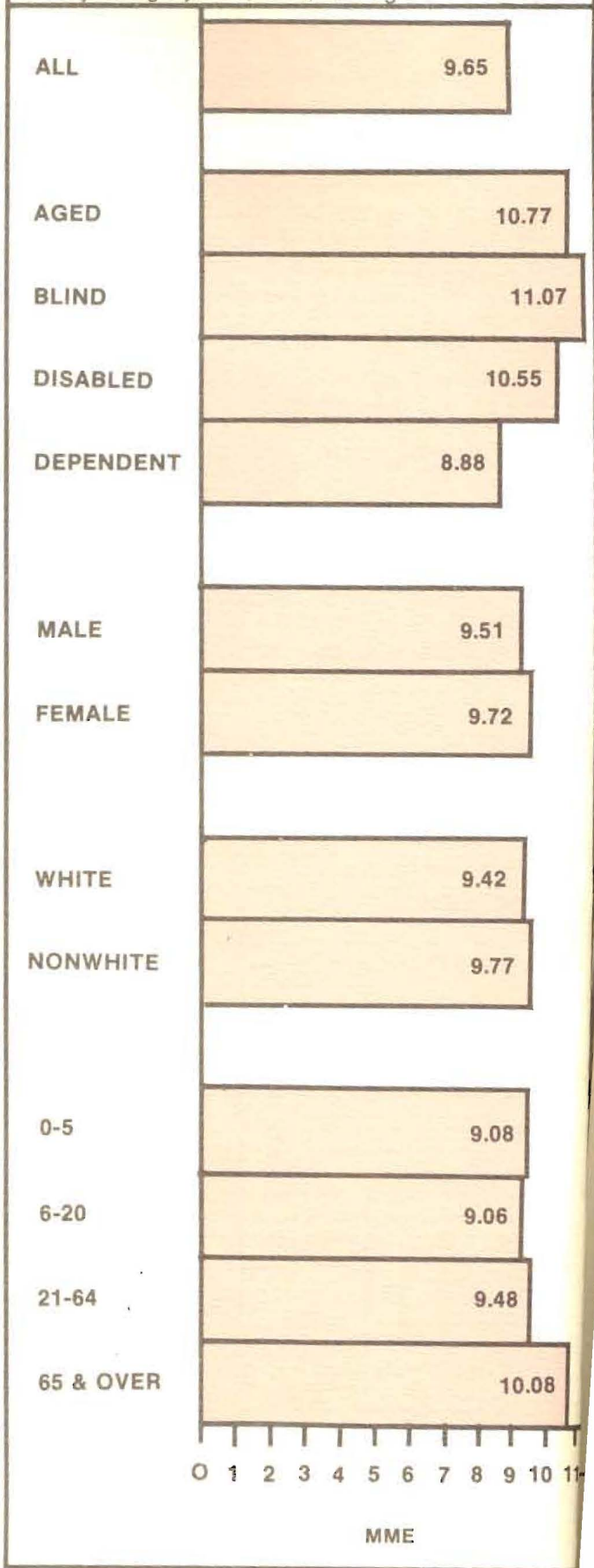
BY AGE



FY'85 PLATE 20

ELIGIBLES

Man-Months of Eligibility
By category, sex, race, and age

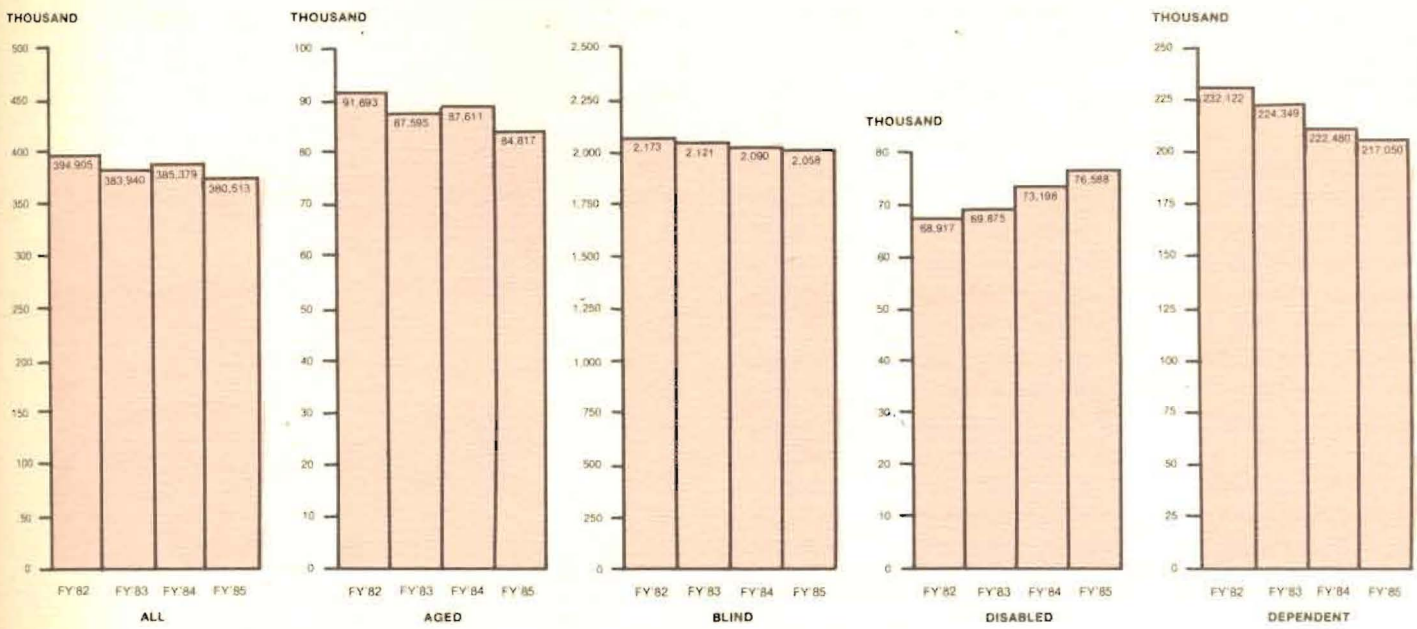


FY'82-'85

ELIGIBLES

By Category
Annual Total

PLATE 21

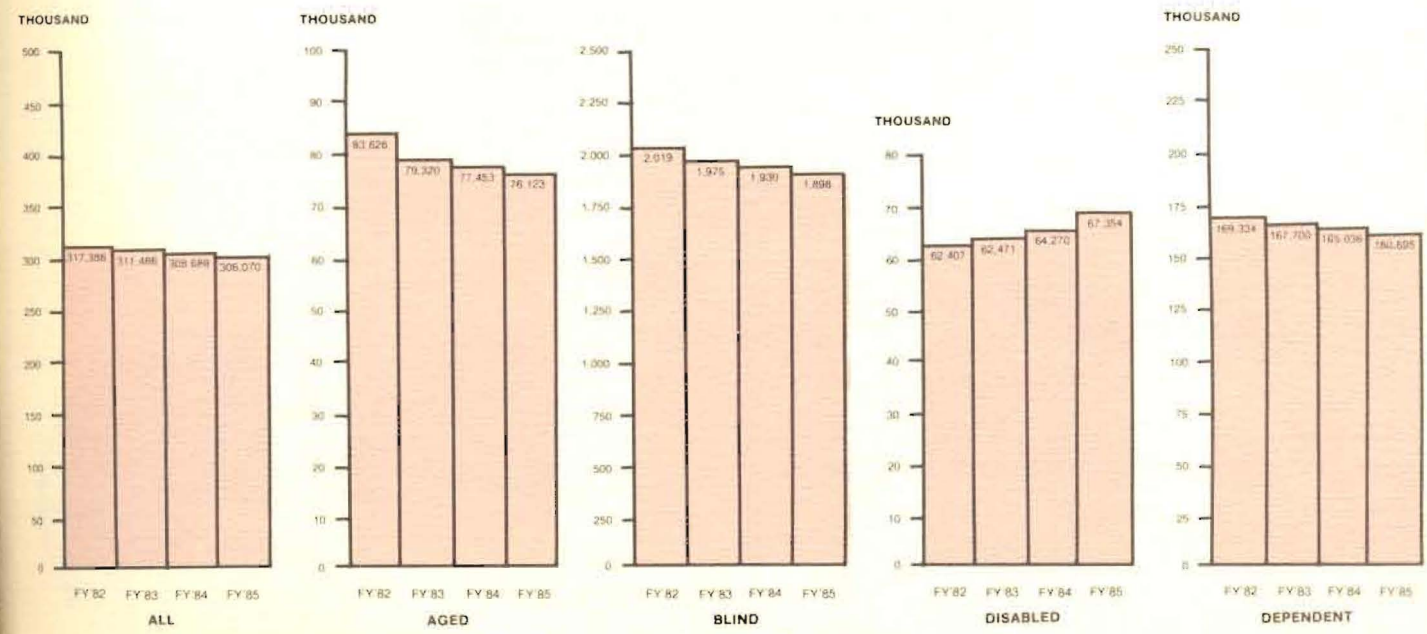


FY'82-'85

ELIGIBLES

By Category
Monthly Average

PLATE 22



RECIPIENTS

There were 380,513 persons eligible for Medicaid in FY'85. Only 83 percent of these eligibles actually received benefits from Medicaid. These 316,159 persons are called recipients. The remaining 64,354 persons incurred no medical expenses paid for by Medicaid.

The total number of recipients is an unduplicated count. Recipients may be transferred from one category to another during the year. A recipient who receives services under more than one basis of eligibility is counted in those different categories' totals, but is counted only once in the unduplicated total. This is the reason that recipient counts by category do not add to the unduplicated total.

Plate 24 shows average monthly recipients, total recipients, and MMS per recipient. MMS or man-months of service is derived by first adding the number of recipients in each month of the fiscal year. This is then divided by the unduplicated annual total of recipients to give MMS per recipient, a measure of the frequency of service.

The total MMS in FY'85 was 1,732,593 which is slightly higher than FY'84. Total recipients increased from 315,666 to 316,159 while MMS per recipient remained 5.48. This means the average recipient received Medicaid service in 5.48 months of the fiscal year.

FY '85 PLATE 24

RECIPIENTS

Monthly Average, Annual Total, and MMS Per Recipient

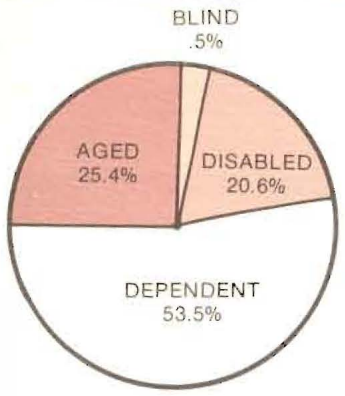
	Monthly Average	Annual Total	MMS Per Recipient
AGED	52,012	84,688	7.37
BLIND	1,038	1,771	7.03
DISABLED	41,686	68,494	7.30
DEPENDENT	52,140	178,290	3.51
ALL CATEGORIES (unduplicated)	144,383	316,159	5.48

FY'85 PLATE 23

RECIPIENTS

Distribution by category, sex, race, and age

BY CATEGORY



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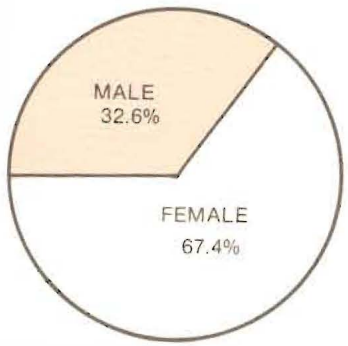
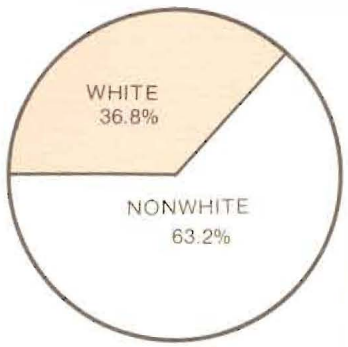
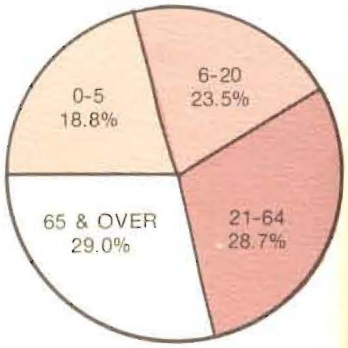


BY RACE



BY AGE

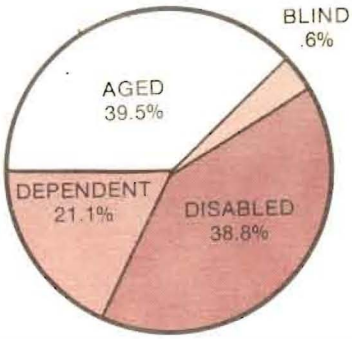


FY'85 PLATE 25

PAYMENTS

Distribution by category, sex, race, and age

BY CATEGORY



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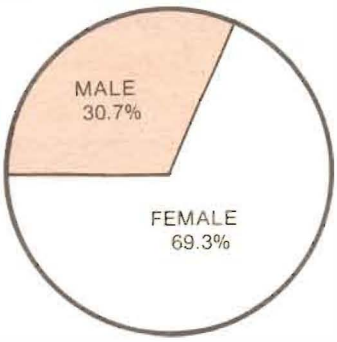

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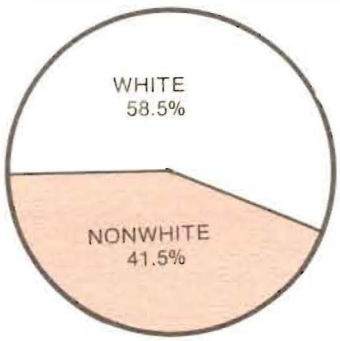

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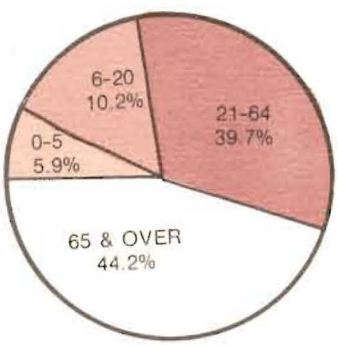


USE AND COST

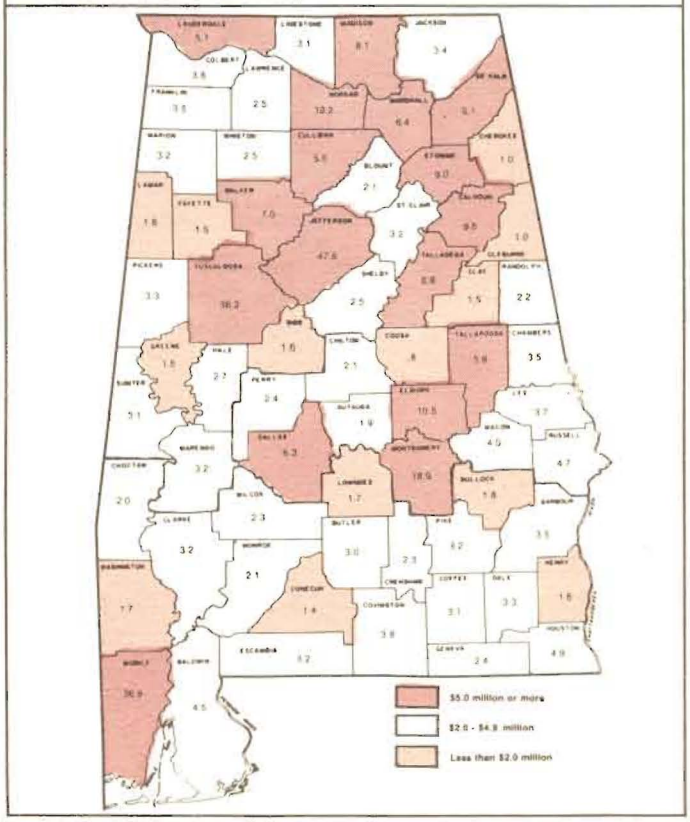
The percent distribution of Medicaid payments, as shown in Plate 25, has changed very little since last year. Most payments are made on behalf of recipients in the aged or disabled categories, females, whites, and persons 65 years of age or older.

The amount of money Medicaid spends in each county also has shown little change from FY'84. With few exceptions, the counties with or near large population centers have the largest amounts of Medicaid payments made on behalf of their residents. Note the relatively large amount of payments shown in Morgan and Elmore counties. This is due to the location of intermediate care facilities for the mentally retarded in these counties.

FY'85 PLATE 26

PAYMENTS

By county (in millions of dollars)



This report measures cost in two ways, cost per recipient and cost per eligible. The cost per recipient is calculated by dividing payments for services by the unduplicated annual total of recipients. Since recipients usually do not receive services in every month of the fiscal year, annual cost per recipient divided by 12 does not give the average monthly cost per recipient. The cost per eligible is determined by dividing total payments for services by the annual total of persons eligible for Medicaid. Both measures are useful for comparing different groups of recipients and eligibles and predicting how changes in utilization and eligibility will impact the Medicaid program.

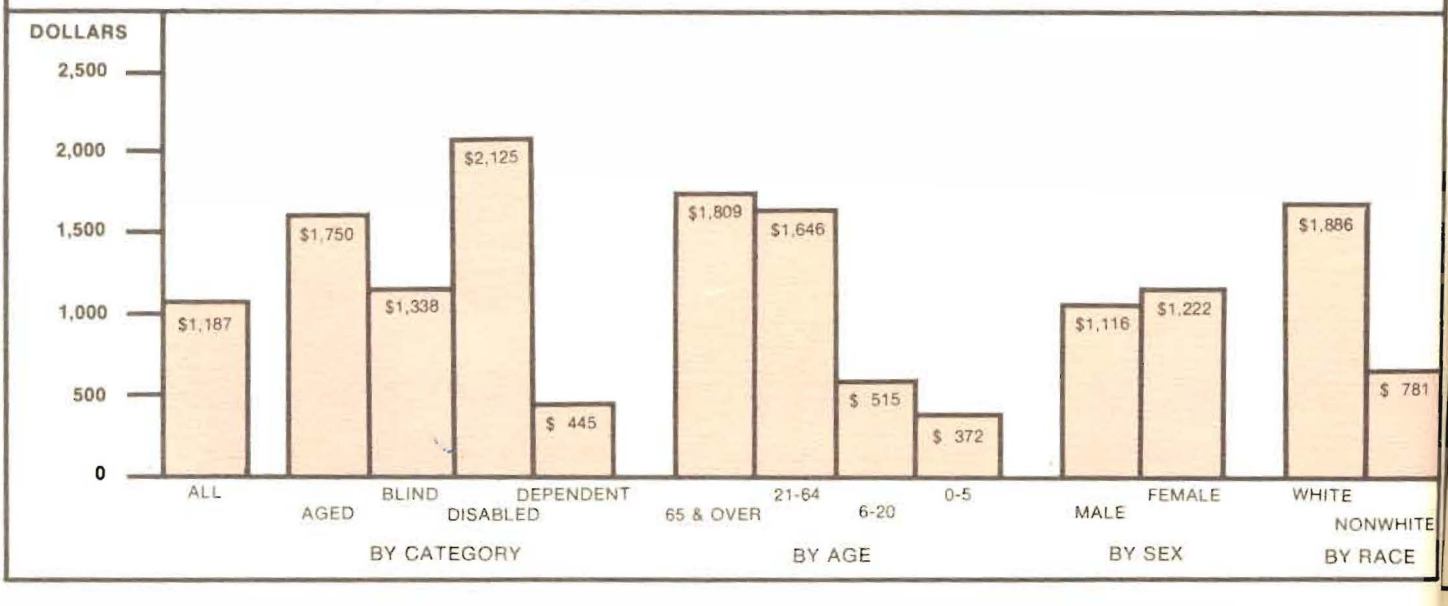
It is obvious from these statistics that certain groups are much more expensive than others. The reason for these differences is that specific groups tend to use specific types of services. Any Medicaid eligible receives, within reasonable limitations, medically necessary services. Medicaid funds are not budgeted for any particular group.

A good example of this is the pattern of use of long-term care. This type of care has a high cost per unit of service, and recipients of long-term care have a high frequency-of-service rate. The average Medicaid

FY'85 PLATE 27

COST PER RECIPENT

By category, age, sex, and race



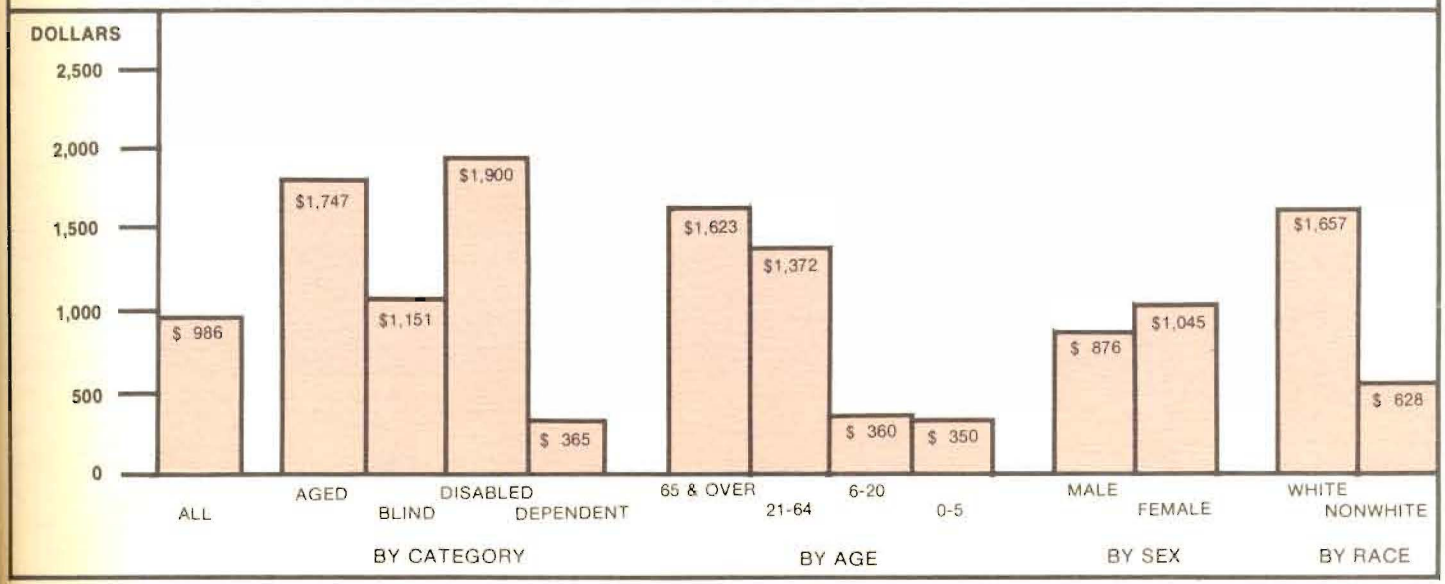
payment for a day of intermediate nursing care in FY'85 was about $26. The average length of stay in a nursing home during this fiscal year was 271 days. Most recipients of long-term care are white females who are categorized as aged or disabled and are over 64 years of age. It is not surprising that these groups have high costs per person and have a large percentage of Medicaid payments made on their behalf.

Also, note on Plate 29 that cost per recipient of services shared by Medicare is relatively small for the aged category. This is due to the fact that about 90% of aged persons are also eligible for Medicare. A smaller percentage of blind and disabled persons are eligible for Medicare coverage. When these Medicare - Medicaid eligibles file a valid claim for medical service, Medicaid pays the deductible and coinsurance, and Medicare pays the remaining covered charges. The partial payment made by Medicare is not reflected in Section 1 of Plate 29.

For this coverage, Medicaid paid a monthly "buy-in fee" to Medicare. In FY'85, this fee was $15.50 per month. Medicaid's total bill for this buy-in fee was $19.6 million. This is less than Medicare spent for the partial payment of medical bills incurred by Medicaid - Medicare eligibles in Alabama.

PLATE 28

FY'85
COST PER ELIGIBLE
By category, age, sex, and race



FY '85

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 WITH COSTS SHARED WITH MEDICARE								
		Physicians' Services	Lab & X-Ray	Hospital Inpatients	Hospital Outpatients	Rural Health	Home Health	Drugs	Nursing Homes Skilled+	Int
SECTION 1 YEAR'S COST	ALL CATEGORIES	$36,355,370	$6,154,911	$73,847,525	$10,186,983	$70,173	$10,586,842	$37,840,727	$10,694,940	
	Aged	4,754,571	411,831	10,285,387	498,634	6,536	2,401,163	18,738,946	6,584,426	
	Blind	282,003	50,199	618,938	105,861	350	107,277	348,118	79,368	
	Disabled	11,213,440	2,406,575	26,738,272	4,341,113	14,945	8,044,909	14,710,872	3,999,149	
	Dependent Children	9,262,722	1,276,479	16,315,251	2,973,882	27,763	6,387	1,558,256	31,439	
	Dependent Adults	10,842,634	2,009,827	19,889,677	2,267,493	20,579	27,106	2,484,535	558	
SECTION 2 YEAR'S TOTAL NUMBER OF RECIPIENTS	ALL CATEGORIES***	247,483	115,915	58,095	91,848	1,493	6,132	228,136	3,386	
	Aged	64,078	25,130	17,641	12,375	290	2,463	72,082	3,011	
	Blind	1,490	743	395	557	5	79	1,500	16	
	Disabled	56,036	30,422	16,211	21,247	266	3,529	55,949	742	
	Dependent Children	85,636	33,381	11,252	37,284	619	29	64,281	6	
	Dependent Adults	47,448	28,309	13,281	21,503	325	61	40,551	2	
SECTION 3 YEAR'S COST PER RECIPIENT	ALL CATEGORIES	$147	$53	$1,271	$111	$47	$1,726	$166	$3,15	
	Aged	74	16	583	40	23	975	260	2,16	
	Blind	189	68	1,567	190	70	1,358	232	4,40	
	Disabled	200	79	1,649	204	56	2,280	263	5,39	
	Dependent Children	108	38	1,450	80	45	220	24	5,24	
	Dependent Adults	229	71	1,498	105	63	444	61	2	
SECTION 4 UTILIZATION RATES PERCENT OF ELIGIBLES	ALL CATEGORIES	65.04%	30.46%	15.27%	24.14%	0.39%	1.61%	59.95%	0.8	
	Aged	75.55%	29.63%	20.80%	14.59%	0.34%	2.90%	84.99%	3.5	
	Blind	72.40%	36.10%	19.19%	27.07%	0.24%	3.84%	72.89%	0.8	
	Disabled	73.17%	39.72%	21.17%	27.74%	0.35%	4.61%	73.05%	0.9	
	Dependents	61.31%	28.42%	11.30%	27.08%	0.43%	0.04%	48.30%	**	

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

* Not Available

** Another $19,576,015 in buy-in premiums was paid for Medicare Part B coverage.

*** Unduplicated count

**** Less than 0.01 percent

PLATE 29

Nursing Homes Skilled+	SERVICES WITH COSTS NOT SHARED WITH MEDICARE								ALL SERVICES		
	Nursing Homes, Intermediate	ICF MR/MD	Dental Care	Family Planning	Other Practi-tioners	Other Care	Screening	Clinic Services	Total Of Unshared Costs**	Medicaid's Total Part Of Shared Costs	Medicaid's Totals
$10,694,940	$123,219,739	$51,363,313	$4,179,328	$4,563,249	$1,534,280	$2,299,821	$785,808	$1,726,584	$248,794,631	$126,614,962	$375,409,593
6,584,426	99,216,284	3,957,941	377	0	454,865	871,405	0	21,612	132,247,019	15,956,959	148,203,978
79,368	664,323	67,379	1,630	14,461	7,481	16,550	810	4,331	1,311,728	1,057,351	2,369,079
3,999,149	23,334,763	47,337,993	236,624	392,090	422,643	1,012,903	28,939	1,285,673	100,806,558	44,714,345	145,520,903
31,439	0	0	3,624,147	307,368	373,495	182,434	738,856	212,822	7,035,204	29,856,097	36,891,301
558	4,369	0	316,550	3,849,330	275,796	216,529	17,203	202,146	7,394,122	35,030,210	42,424,332
3,386	17,355	1,722	43,752	24,928	34,718	43,140	28,272	5,940	N/A*	N/A*	316,159
3,011	17,849	374	50	0	9,924	17,652	0	149	N/A*	N/A*	84,688
18	80	2	36	51	155	266	28	28	N/A*	N/A*	1,771
742	3,064	1,564	2,518	1,871	9,258	13,715	1,047	3,955	N/A*	N/A*	68,494
6	0	0	40,003	4,972	8,958	6,027	26,588	1,037	N/A*	N/A*	119,825
2	2	0	1,871	19,336	6,461	5,860	634	866	N/A*	N/A*	58,465
$3,159	$7,100	$29,828	$96	$183	$44	$53	$28	$291	N/A*	N/A*	$1,187
2,187	5,559	10,583	8	0	46	49	0	145	N/A*	N/A*	1,750
4,409	8,304	33,690	45	284	48	62	29	155	N/A*	N/A*	1,338
5,390	7,616	30,267	94	210	46	74	28	325	N/A*	N/A*	2,125
5,240	0	0	91	62	42	30	28	205	N/A*	N/A*	308
279	2,185	0	169	199	43	37	27	233	N/A*	N/A*	726
0.89%	4.56%	0.45%	11.50%	6.55%	9.12%	11.34%	7.43%	1.56%	N/A*	N/A*	83.09%
3.55%	21.04%	0.44%	0.06%	0.00%	11.70%	20.81%	0.00%	0.18%	N/A*	N/A*	99.85%
0.87%	3.89%	0.10%	1.75%	2.48%	7.53%	12.93%	1.36%	1.36%	N/A*	N/A*	86.05%
0.97%	4.00%	2.04%	3.29%	2.44%	12.09%	17.91%	1.37%	5.16%	N/A*	N/A*	89.43%
....	....	0.00%	19.29%	11.20%	7.10%	5.48%	12.54%	0.88%	N/A*	N/A*	82.14%

COMMUNITY SERVICES

Services provided at home and in the community help to prevent costly institutionalization.

The Community Alternative Services Division was created during FY'85. In general, its function is to develop and administer new, alternative services to Medicaid eligibles. These alternative services tend to be more appropriate than traditional Medicaid services as well as less costly to taxpayers.

Medicaid Waivers

Like several other states, Alabama has taken advantage of the provisions of the federal Omnibus Budget Reconciliation Act of 1981 and has developed waivers to federal Medicaid rules. These programs are aimed at keeping Medicaid eligibles out of institutions as long as possible by providing services to them in the community.

Waiver for Mentally Retarded: Alabama Medicaid's first waiver was three years old at the end of FY'85. The habilitative services provided to Medicaid-eligible mentally retarded people under the waiver teach the recipients to live more independently. They include basic living skills. The services, provided by the Department of Mental Health and Mental Retardation, can prevent needless institutionalization and provide support to recipients who are released from institutions. The difference in cost between community services and institutional care is dramatic. Community care for an individual costs less than $6,000 a year. Institutional care for a mentally retarded patient costs more than $30,000 a year. During FY'85, about $7 million was spent to provide services to 1,535 clients. Mental Health and Mental Retardation provided the state's share of the funding. At the end of FY'85, Medicaid received federal approval to extend the waiver for the mentally retarded another three years.

Waiver for Elderly and Disabled: Medicaid's waiver for the elderly and disabled, which received federal approval in December, 1984, provides services to persons who might otherwise have to enter nursing homes. The five basic services are provided by the State Department of Pensions and Security and the Alabama Commission on Aging. They are case management, homemaker services, personal care, adult day health, and respite care. Because of the newness of the program, only case management and homemaker care were available statewide during FY'85, but the program is expected to expand during FY'86. The program had about 1,300 active cases at the end of the year. Considerable growth in the program is expected during the current fiscal year.

New Programs

Mental Health Program: Through mental health centers under contract with the Department of Mental Health and Mental Retardation, Medicaid provides services for Medicaid-eligible mentally ill and emotionally disturbed people. The services include day treatment, medication check, diagnostic assessment, pre-hospital screening, and psychotherapy for individuals, groups, and families. The program serves people with a primary psychiatric diagnosis.

Preventive Health: A preventive health unit was created October 1, 1985 in response to the recommendation of the Medicaid Task Force on Preventive Health, but staffing had not been completed by November, 1985.

LONG-TERM CARE

Social, economic, and medical factors contributed to a stabilization of nursing home use by Medicaid patients.

Care for acutely ill, indigent patients in skilled nursing homes was mandated in 1965 with the enactment of Medicaid (Title XIX). Skilled nursing care is a mandatory service. All states must provide this care in their Medicaid programs. The Alabama Medicaid program has had a skilled nursing program since 1970.

The current Long-Term Care program consists of skilled and intermediate care. Recipients who are sick enough to require around-the-clock professional nursing care are furnished skilled care. Intermediate care, an optional service, is provided to patients who have chronic medical conditions, who are not well enough for independent living, and who do not require around-the-clock nursing care. The Alabama Medicaid Agency has provided intermediate care since 1972.

Throughout the 1970's, the demand for Medicaid nursing home care increased due to a number of social and economic factors. Some of these included:

— Population growth

— Longer lifespans resulted in larger numbers of people in older age categories.

— Advances in medical science and technology extended the lives of persons with chronic medical conditions, such as cardiovascular diseases.

— Increased urbanization, which reduced both the size of homes and the number of nonworking family members available to care for the elderly.

The increase in nursing home utilization coincided with a change in the pattern of use of intermediate and skilled care during the 1970's. Early in the decade there were more skilled than intermediate care patients. This situation reversed itself as the decade progressed. In FY'85, only 16 percent of nursing home recipients were receiving skilled care.

A major factor in this change was the move toward dually certified facilities or nursing homes which treat both skilled and intermediate patients. Another reason was the advent of combination reimbursement. Nursing homes are reimbursed at a single corporate rate based on allowed costs and not the level of care provided to individual patients.

Since 1983, the average monthly count of nursing home recipients has changed very little. Factors contributing to the stabilization of nursing home use by Medicaid patients include the availability of Home Health services, the continued application of medical criteria which insure that Medicaid nursing home patients have genuine medical needs that require professional nursing care, and a management information system that makes timely and accurate financial eligibility decisions possible.

Moratorium on Certificates of Need: On August 1, 1984, Governor Wallace issued Executive Order Number 28 which placed a moratorium on the acceptance and processing of Certificates of Need (CON) by the State Health Planning Agency. Reasons for this order included the lack of adequate staffing and computerization in the agency; the lack of proper methodologies for evaluating various areas of medical service; and a large volume of CON requests which the CON Review Board, through no fault of its own, could not reasonably investigate and act on. This order included CON applications for nursing home beds. On September 30, 1985, the moratorium on the construction of new nursing home beds was extended until November 1, 1986.

FY'83-'85 PLATE 30

LONG-TERM CARE PROGRAM

Patients, months, and cost

	Number Of Nursing Home Patients (Unduplicated Total)	Average Length of Stay During Year	Total Patient-Days Paid For By Medicaid	Average Cost Per Patient Per Day to Medicaid	Total Cost To Medicaid
1983	20,536	250 Days	5,135,060	$23	$117,703,176
1984	20,949	247 Days	5,178,233	25	128,587,343
1985	20,741	243 Days	5,049,419	27	133,914,679

FY'83-'85 PLATE 31

LONG-TERM CARE PROGRAM

The number and percent of beds used by Medicaid

	Licensed Nursing Home Beds	Medicaid Monthly Average	Annual Unduplicated Total Patients	Percent Of Beds Used By Medicaid In An Average Month	Number of Beds Not Used By Medicaid In An Average Month
1983	21,460	13,676	20,536	63.7%	7,784
1984	21,349	13,611	20,949	63.8%	7,738
1985	21,776	13,715	20,741	63.0%	8,061

Since 1982, the Alabama Medicaid Agency has taken the position that no new nursing home beds are needed in the state. No significant change has taken place since that time which would alter this position.

The use of nursing home beds by Medicaid patients declined between FY'82 and FY'83 and has been stable since FY'83. This is an important factor in establishing the need for new nursing home beds since Medicaid patients occupy almost two-thirds of the nursing home beds in the state on a average day.

In 1984, the statewide nursing home occupancy rate was 92.2 percent. This is slightly higher than the 1983 rate but lower than the occupancy rate in 1982. A rate of less than 100 percent indicates that on an average day there were empty nursing home beds in the state. The accepted standard for optimal cost efficient delivery of services in a nursing home is an occupancy rate of 90 percent.

An increase in the number of nursing home beds in the state could result in financial problems for Alabama's Medicaid program. Based on current use, 100 new nursing home beds certified for Medicaid patients could cost the Medicaid program an additional one million dollars a year.

In order to conserve resources necessary for other vital services, the Alabama Medicaid Agency will not compute or pay a per diem rate for nursing home beds constructed under a CON dated on or after April 1, 1983. Since this policy eliminates a substantial source of income, the economic feasibility of any new nursing home beds is in serious question.

In the past, there have been few alternatives to nursing home care. Recently, there has been a growth of alternative methods of care outside the nursing home. These include the increase in domiciliary beds in Alabama, the implementation of a Medicaid Home and Community-Based Waiver for the Elderly and Disabled, and the granting of CONs for swing beds in rural hospitals in Alabama. Although these alternative care arrangements are not designed to empty nursing home beds, the need for new beds should be reduced.

FY'85 PLATE 32

LONG-TERM CARE PROGRAM

Recipients by sex, race, and age

	Skilled	Intermediate	Total	Percent
All Recipients	3,386	17,355	20,741	100.0%
By Sex				
Female	2,395	12,990	15,385	74.2%
Male	991	4,365	5,356	25.8%
By Race				
White	3,430	13,925	17,355	83.7%
Nonwhite	1,073	2,313	3,386	16.3%
By Age				
65 & Over	2,793	15,344	18,137	87.4%
21-64	437	1,910	2,347	11.3%
6-20	84	101	185	0.9%
0-5	72	0	72	0.4%

In 1983, the State Board of Health relaxed its rules for the licensing of domiciliaries. A domiciliary does not provide nursing care, but it does provide a supervised environment for persons in need of custodial care. Since 1983, the number of domiciliaries has grown from 55 to 106 and the number of domiciliary beds has doubled. Officials at the State Department of Health feel that within two years the number of domiciliaries will increase by 100 percent. Even though Medicaid does not pay for care in a domiciliary, the increase in the availability of domiciliary beds should reduce future needs for nursing home beds.

A new Medicaid program, which is an alternative to institutional care, is the Home and Community-Based Waiver for the Elderly and Disabled. It is a cooperative effort of the Alabama Medicaid Agency, the State Department of Pensions and Security, and the Alabama Commission on Aging. Care is furnished in the person's home. Thus independence is fostered and specific needs of the recipient can be taken into consideration. Services include case management, adult day health care, respite care, homemaker services, and personal care. Certain persons who qualify for Medicaid nursing home care will have the opportunity to receive these services instead of entering an institution. The program began in February 1985. There were 1,300 active cases at the end of FY'85.

During 1985, the State Health Planning Agency began granting CONs for conversion of hospital beds in rural counties in Alabama to swing beds. A swing bed is a licensed hospital bed that can be used for either a hospital or a nursing home patient. Although Medicaid does not cover care in a swing bed, the availability of swing beds should reduce the future need for an increase of nursing home beds in the state.

FY'85 PLATE 33

LONG-TERM CARE PROGRAM

Payments by sex, race, and age

	Skilled	Intermediate	Total	Percent
All Recipients	$10,694,940	$123,219,739	$133,914,679	100%
By Sex				
Female	7,441,893	93,813,391	101,255,284	75.6%
Male	3,253,047	29,406,348	32,659,395	24.4%
By Race				
White	6,942,079	97,375,709	104,317,788	77.9%
Nonwhite	3,752,861	25,844,030	29,596,891	22.1%
By Age				
65 & Over	6,982,543	106,439,113	113,421,656	84.7%
21-64	1,858,929	15,692,978	17,551,907	13.1%
6-20	1,058,316	1,087,648	2,145,964	1.6%
0-5	795,152	0	795,152	0.6%

FY'83-'85 PLATE 34

LONG-TERM CARE PROGRAM

Number of Recipients

	Skilled			Intermediate			Total		
	FY'83	FY'84	FY'85	FY'83	FY'84	FY'85	FY'83	FY'84	FY'85
Monthly Average	1,105	1,065	1,048	12,571	12,546	12,668	13,676	13,611	13,715
Yearly Total	3,658	3,743	3,386	16,878	17,206	17,355	20,356	20,949	20,741
Average Length of Stay	99 Days	97 Days	98 Days	283 Days	280 Days	271 Days	250 Days	247 Days	243 Days

Nursing Home Reimbursement: Alabama uses a Uniform Cost Report (UCR) 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 other expenses to be incurred in maintaining full compliance with standards required by state and federal regulatory agencies.

Medicaid pays to the long-term care facility 100 percent of the difference between the Medicaid-assigned reimbursement rate and the patient's available resources. The maximum amount of income a patient may have and still be eligible for Medicaid in FY'85 was $852.90 a month. All personal income above $25 a month, with the exception of insurance premiums, must be applied by the patients to reduce the monthly charge to Medicaid for their nursing home care.

Patient Characteristics and Length of Stay: Plates 32 and 33 show who the nursing home recipients were this year in terms of sex, race, and age of the recipient and the amount of money spent on each group.

Plate 34 shows average monthly recipients and annual totals of recipients in the Long-Term Care program. Note that between FY'84 and FY'85 monthly averages increased while yearly totals decreased slightly. The yearly total is an unduplicated count. This means that recipients are counted only once whether they received one day of nursing home care or 365 days of this care. The monthly average takes into account length of service. The fluctuations in both measures are relatively small and do not signal any significant changes in the utilization trends by Medicaid nursing home patients.

FY'85 PLATE 35

PAYMENTS TO NURSING HOMES

By County (in millions of dollars)

LONG-TERM CARE MENTAL HEALTH

Medicaid eligibles in institutions for the mentally retarded were helped to develop new capacities.

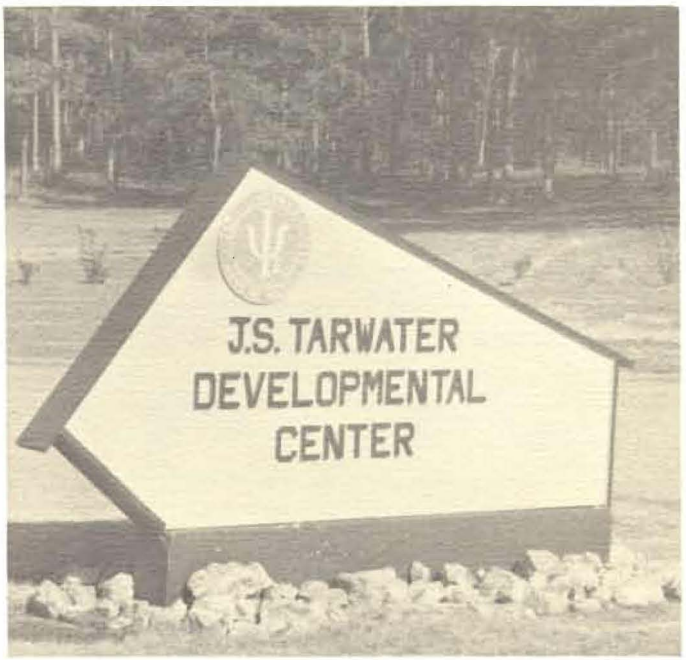
The Alabama Medicaid Agency negotiated agreements with the State Department of Mental Health to include coverage for Medicaid-eligible ICF/Mentally Retarded recipients in 1977, and for coverage of ICF/Mentally Diseased recipients over 65 years old in 1978. Eligibility for these programs is determined by categorical, medical, and/or social requirements specified in Title XIX. The programs provide treatment which includes training and habilitative services intended to aid the intellectual, sensorimotor, and emotional development of a resident.

The program has grown steadily since its inception. The number of recipients grew from 458 in FY'79 to 1,610 in FY'84. This year, there were 1,722 recipients of this service. The reason for this increase was the opening of a new ICF/MD facility which is operated by the State Department of Mental Health.

Payments have grown dramatically since the program began. Payments increased from slightly less than $2 million in FY'79 to over $50 million in FY'85. The reasons that a relatively small increase in recipients can have such a dramatic influence on payments are the high price of unit of service and the length of an average stay in an institution. This year, the average per diem rate in an institution serving the mentally retarded was approximately $100 and the average length of stay was almost a year.

Judging from the above statements, it would appear that the ICF-MR/MD program is an extremely costly component of the Alabama Medicaid program. In terms of total Medicaid dollars expended and the average monthly payment per patient, this is certainly true. However, the provision of this care through the Medicaid program is saving the taxpayers of Alabama millions of state dollars. These patients are receiving services in state-operated mental health institutions. If the Medicaid program did not cover the services provided to these patients, the Alabama Department of Mental Health would be responsible for the total funding of this care entirely out of its state appropriation. Through its relationship with the Alabama Medicaid Agency, Mental Health is able to match every 28 state dollars with 72 federal dollars for the care of Medicaid-eligible ICF-MR/MD patients. Due to the inclusion of ICF-MR/MD in Medicaid's range of services, $37 million of its cost came from federal instead of state revenues in FY'85.

A home and community-based program for the mentally retarded was implemented by the Alabama Medicaid Agency in FY'83. This is in accordance with the agency's stated policy of using Medicaid funds to pay for effective but less expensive means of treatment. The program is designed for mentally retarded individuals who, without this service, would require institutionalization in an ICF/MR facility. Services offered at this time are those of habilitation which insure optimal functioning of the mentally retarded within a community setting. Without these community services, more mentally retarded citizens would require institutionalization.



FY'84-'85 PLATE 36

LONG-TERM CARE PROGRAM

ICF-MR/MD

1468/MR in FY8

	FY'84	FY'85
Recipients	1,610	1,722
Total Payments	$49,904,573	$51,363,313
Average Annual Cost Per Recipient	$30,997	$29,828
Average Monthly Recipients	1,501	1,530
Average Monthly Cost per Recipient	$2,771	$2,798

HOME HEALTH

The Home Health program provides an appropriate and cost-effective alternative to institutional care.

The Medicaid Home Health program provides quality medical and personal care in recipients' homes. These services allow homebound persons who meet Medicaid home health criteria to avoid institutionalization or to secure an early discharge from an institution. Nursing and personal care provided under the Medicaid Home Health program must be certified by a licensed physician and provided by home health agencies under contract with Medicaid.

Due to changes in the health care delivery system, the demand for home health services has been increasing. Home health patients may require intravenous therapy, tube feedings, sterile dressing changes, catheter installations, or maintenance care.

Medicaid criteria for home health services are:

—Home health agencies must have contracts with the Medicaid Agency. There were 101 agencies participating in FY '85.

—Patients must be Medicaid eligible.

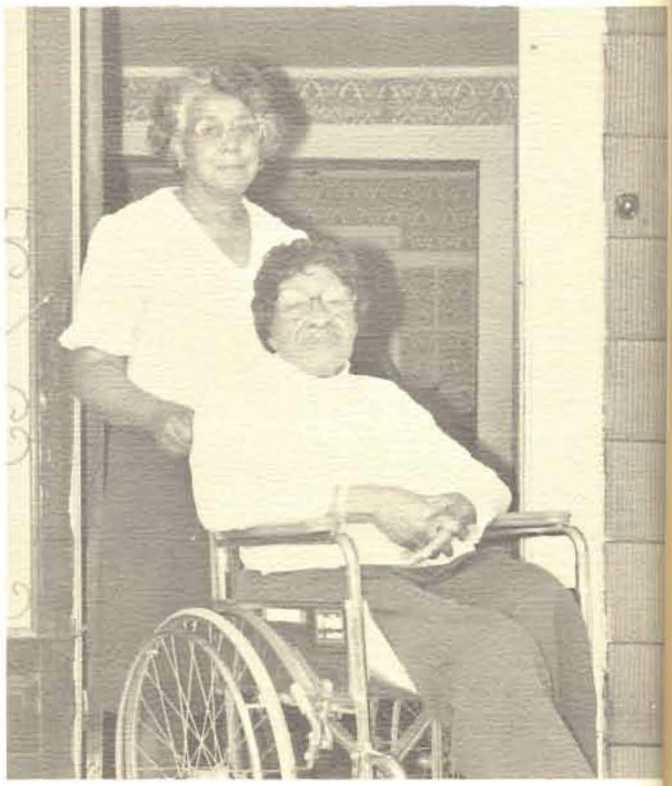
—Patients must be homebound (essentially confined to the home because of illness, injury, or disability).

—Patients must be under the care of a physician.

—Care must be reasonable and necessary on a part-time or intermittent basis.

—Care must be recertified at least once every 60 days by the attending physician. Medicaid staff review about 850 recertifications each month.

Up to 100 home health visits per year may be authorized by the Medicaid Agency. The maximum reimbursement rate per visit is $27, which is the most prevalent rate. In FY '85, an average of 1,400 recipients a month received a total of 141,478 visits at a cost of $3.8 million.



The Supplies, Appliances, and Durable Medic Equipment (DME) program is a mandatory bene under the Home Health program. Medicaid recipien do not have to receive home health services to quali for the DME program, but all items must be medica necessary and suitable for use in the home. During t fiscal year, Medicaid Supplies, Appliances, and DM providers throughout the state furnished 89,731 units service at a cost of $1.1 million.

FY '84-'85
Use and Cost of Home Health Care
Compared to Nursing Home care

PLATE 37

	Average Number of Recipients Per Month		Average Monthly Cost Per Recipient	
Year	Home Health	Nursing Home	Home Health	Nursing Home
1984	1,469	13,611	$201	$787
1985	1,436	13,715	219	814

HOSPITAL PROGRAM

The Hospital program provides acute inpatient and outpatient medical care to Medicaid eligibles.

Hospitals are a critical link in the Medicaid health care delivery system. Each year about one-sixth of all Medicaid eligibles receive inpatient care. About one-fourth of all eligibles are treated as hospital outpatients, usually in emergency rooms. There are 129 Alabama hospitals that participate in the Medicaid program, and 39 hospitals in the neighboring states also participate in Alabama's Medicaid program.

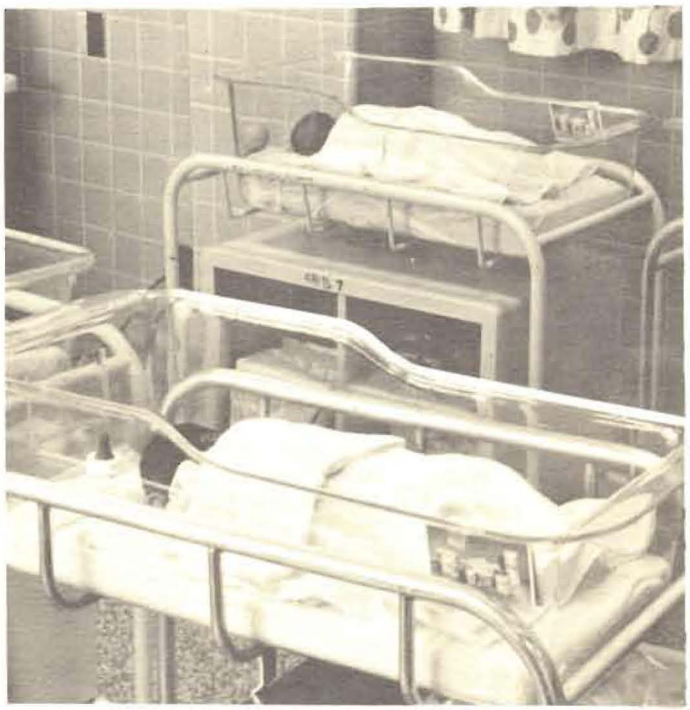
Reimbursement: Hospitals are reimbursed on a daily rate that varies from hospital to hospital. This per diem rate is determined by a formula that takes into account many factors, including a hospital's costs, the services provided, and efficiency factors such as occupancy rates. As of October 1, 1984, these rates ranged up to $551 a day. The average per diem rate was $291.

During FY '86 a Medicaid-only cost report will be implemented. This cost report is used to determine a hospital's per diem for hospitals participating in the Medicaid program. At present, a hospital's Medicaid per diem rate is based on data from its Medicare cost report.

Use and Cost: Plate 38 shows that payments for inpatient hospital services declined slightly while the number of recipients of this service decreased by almost 6,000 persons. The factors influencing payments for hospital inpatients in FY '85 were fewer recipients, fewer days of care, and higher prices for a day of care. Medicaid's inpatient hospital utilization trends are reflected in the statewide use of inpatient beds. Last year, the overall hospital occupancy rate and the number of inpatient days used statewide declined significantly. A reason for this is the trend of increasingly sophisticated medical procedures being performed in physicians' offices and in hospital outpatient settings.

FY '83-'85 PLATE 38
HOSPITAL PROGRAM
Changes in use and cost

Year	Eligibles	Recipients of Inpatient Care	Payments for Inpatient Care	Medicaid's Annual Cost Per Recipient
1983	383,940	67,699	$85,596,571	$1,264
1984	385,379	63,811	74,085,082	1,161
1985	380,513	58,095	73,847,525	1,271



FY '81-'85 PLATE 39
HOSPITAL PROGRAM
Outpatients

	FY '81	FY '82	FY '83	FY '84	FY '85
Number of outpatients	115,393	112,333	110,196	108,085	91,848
Percent of eligibles using outpatient service	28%	28%	29%	28%	24%
Annual expenditure for outpatient care	$13,109,707	$12,655,314	$13,813,699	$12,815,220	$10,186,983
Cost per patient	$114	$113	$125	$119	$111

Outpatient Care: Acute medical care in an outpatient setting is much less costly than inpatient care. The proper use of outpatient care reduces medical costs and is convenient for the recipient. However, many Medicaid patients use emergency rooms when all they need or want is to see a doctor. Since an outpatient visit is twice as expensive as a visit at a doctor's office, the misuse of outpatient services has an impact on Medicaid expenditures. The limitations on outpatient visits have improved this situation as shown by the decline in the number of recipients of outpatient services (see Plate 39).

Utilization Controls: FAIR, or Fiscal Agent Inpatient Review, is the system used by Medicaid to monitor inpatient admissions. Alacaid, the program's fiscal agent, performs this review function under contract. Utilization review is mandated under federal regulations to ensure that Medicaid inpatient admissions are based on medical necessity.

Limitations on hospital services were in effect during FY '85. The purpose of these limitations is to control the overuse of Medicaid services.

Inpatient hospital days are limited to 12 days per calendar year. However, an exception is made for seriously ill children. After these children exhaust their 12 days in the hospital and then spend an additional 30 continuous days in the hospital, they are eligible for 12 additional Medicaid-paid days. This cycle can be repeated throughout the year. These additional days must be prior authorized and be medically necessary.

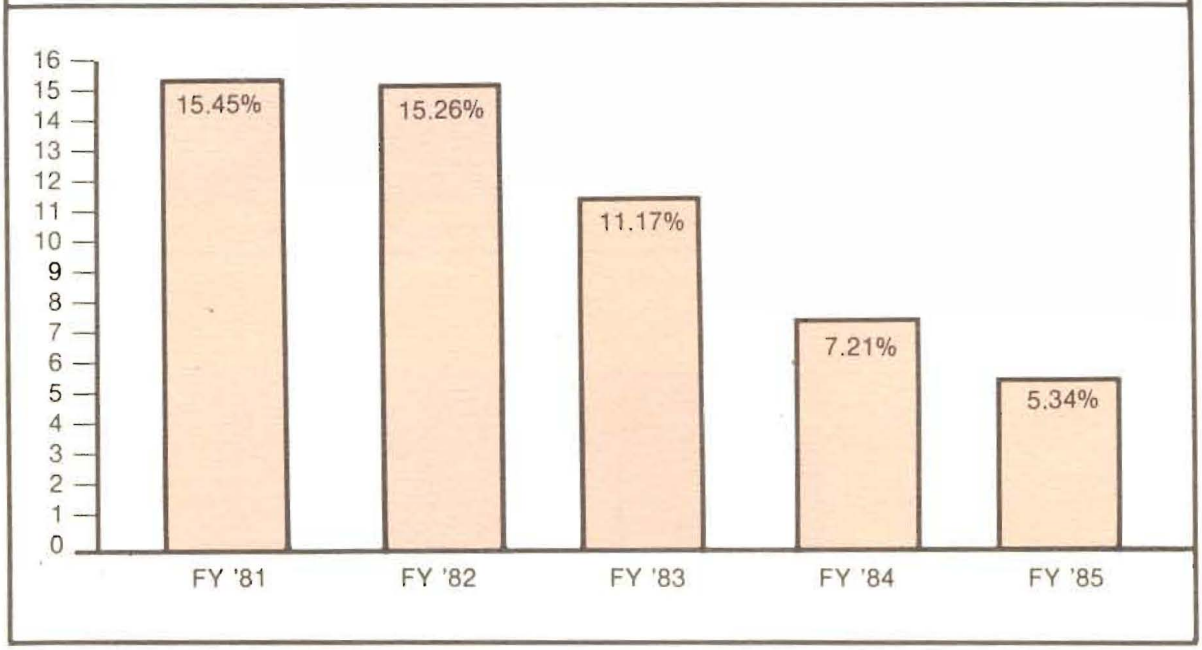
There were also limitations on outpatient hospital services during this fiscal year. Medicaid will pay for a maximum of 3 outpatient visits per eligible during a calendar year. Exceptions are made for certified emergencies, renal dialysis, chemotherapy, and radiation therapy.

Beginning July 1, 1985, most Medicaid hospital patients were required to pay a portion of the cost of hospital care. These copayments are $50 per inpatient admission and $3 per outpatient visit. Recipients under 18 years of age, nursing home residents, and pregnant women are exempt from copayments. A provider may not deny service to a Medicaid eligible due to the recipient's inability to pay the copayment.

FY '81-'85 PLATE 40

ANNUAL PERCENT CHANGE

Hospital room cost from the consumer price index



hospital
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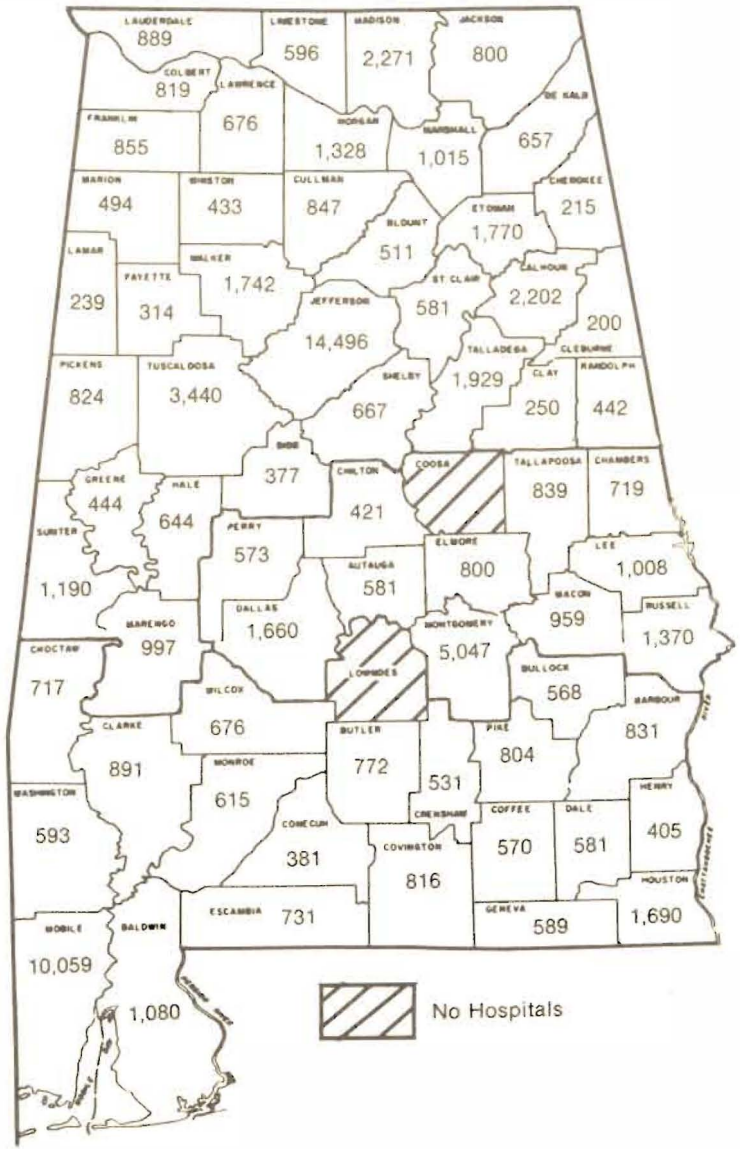
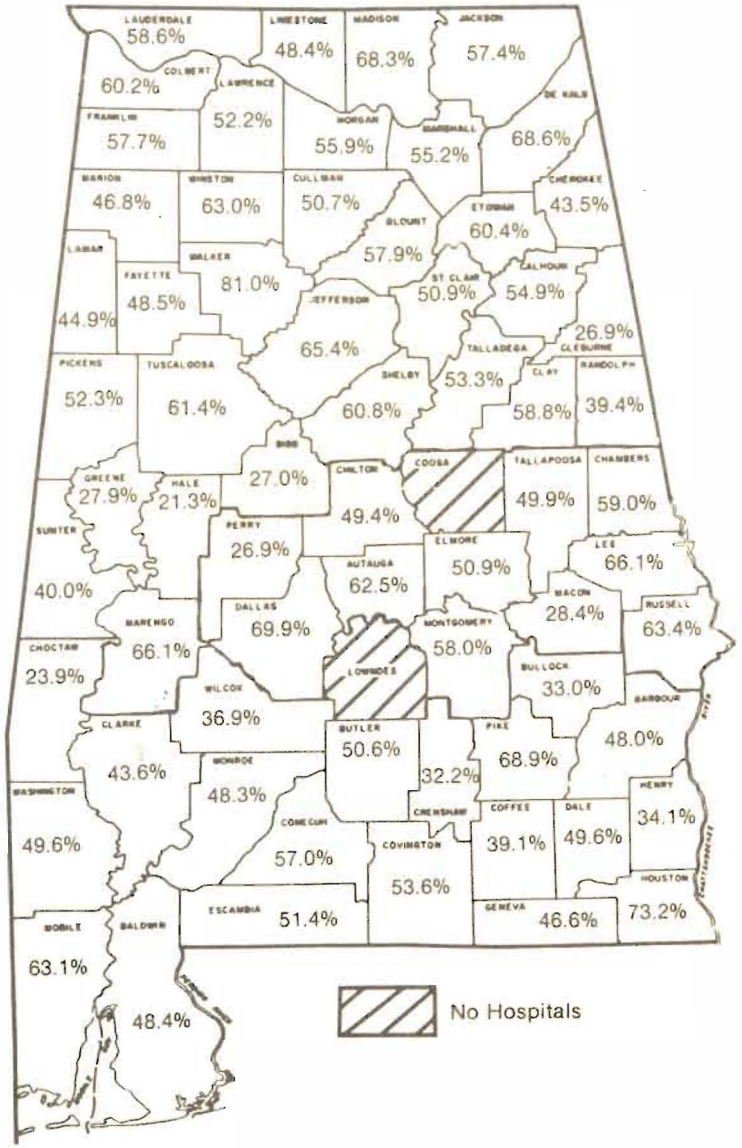
FY '85
PAYMENTS TO HOSPITALS
By county (in thousands of dollars)

PLATE 41



Hospital Program
HOSPITAL OCCUPANCY RATE (%)
As of September 30, 1984

PLATE 42



FAMILY PLANNING

The Family Planning program provides services which allow Medicaid-eligible women to control the size of their families.

Over the past 30 years, the number of yearly births in Alabama has declined while the number of illegitimate births has increased. In Alabama, there were 14,469 illegitimate births in 1984. This is the highest number ever recorded.

The problem of illegitimacy is particularly acute among the younger females. This year 40 percent of the illegitimate births in Alabama were to mothers under 20 years of age. Medicaid pays for the deliveries of a large number of teenage mothers. Usually these young mothers and there families face personal problems and dependency on public assistance programs such as Medicaid.

There are several health-related problems associated with teenage motherhood. Younger teenage mothers usually do not take advantage of prenatal care. Infants born to these mothers tend to have a high risk of developing health problems. These problems include higher death rates, lower birth rates, and greater health difficulties in later life. weights?

Medicaid services can help pregnant teenage eligibles in two primary ways. Since these are high-risk pregnancies, prenatal care paid through Medicaid can increase the likelihood of a successful outcome for both mother and child. Also, young teenage mothers with one child have a higher chance than average of having additional children while they are teenagers. Family planning services can help Medicaid-eligible women control the size of their families.

Although Medicaid's family planning services include assisting eligibles with fertility problems, most recipients of family planning services are people seeking the prevention of unwanted pregnancies. Most expenditures for family planning services relate to birth control.

At both the national and state levels, Medicaid family planning services receive a high priority. To ensure this priority, the federal government pays a higher percentage of the cost of family planning than for other services. For most Medicaid services in Alabama, the federal share of cost is 72 percent. For family planning services, the federal share is 90 percent.

The Medicaid Agency purchases family planning services from Planned Parenthood of Alabama, Inc., clinics under supervision of the statewide Family Planning Project of the State Department of Public Health's Family Health Administration, and private physicians.

Services include physical examinations, pap smears, pregnancy and V.D. testing, counseling, oral contraceptives and other drugs, supplies and devices, and referral for other needed services.

Medicaid rules regarding sterilization are based on federal regulations. Medicaid will pay for sterilization only if certain conditions are met. One is that the Medicaid eligible must be 21 years old at the time consent is given. Also, at least 30 days but not more than 180 days must have passed between the date of informed consent and the date of sterilization. Exceptions to these time limitations are made in case of premature delivery and emergency abdominal surgery.

Eligibles 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 to the sterilization. In cases of premature delivery, informed consent to the sterilization must have been given at least 30 days before the expected date of delivery.

In accordance with the state and federal law, Medicaid will pay for abortions only if the life of the mother would be endangered if the fetus were carried to term.

PRENATAL CARE

Competent, timely prenatal care results in healthier mothers and babies. The prenatal services availible to Medicaid providers have been a significant factor in the overall decline in the state's infant mortality rate during the past decade. Timely care can also reduce the possibility of premature, underweight babies.

Medicaid prenatal care is provided through health departments, private physicians, hospitals, and clinics. Examinations include complete histories and physical examinations, lab tests, and pap smears.

PHYSICIANS PROGRAM

Physicians provide or arrange for most care furnished to Medicaid eligibles.

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. Service to eligibles is based on medical necessity, and it is physicians who determine the need for medical care. Physicians provide this care directly and prescribe or arrange for additional health benefits. It is the physician who determines what drugs a patient receives, decides when a patient needs nursing home or inpatient hospital care, and controls the care of the patient in an institution. There are about 5,000 licensed physicians in Alabama. The majority of these physicians participate in the Medicaid program. More than three-fourths of Alabama's Medicaid recipients received physicians' services last year.

The major change in the Physicians' program during FY '85 was the implementation of copayments. The amount of the copayment is one dollar per office visit. The reason for copayments is utilization control. Recipients under 18 years of age, nursing home residents, and pregnant women are exempt from copayments. Certain physicians' services do not require copayments. These include family planning services, physician inpatient hospital visits, and physician surgery fees for procedures performed in the doctor's office. Physicians may not deny services due to the recipient's inability to pay the copayment.

The Physicians' program also pays for services performed by nurse-midwives. These services include global obstetrical care, walk-in deliveries, antepartum care, postpartum care, and circumcision. Care by a nurse-midwife must be performed under appropriate physician supervision.

A patient of the Crippled Children Service.

FY '85 PLATE 43

PHYSICIAN PROGRAM
Use and Cost

	Payments	Recipients	Cost Per Recipient	Percent of Eligibles Treated By A Physician
Aged	$ 4,754,571	64,078	$ 74	73.1%
Blind	282,003	1,490	189	71.3%
Disabled	11,213,440	56,036	200	76.6%
Dependent	20,105,356	133,084	337	59.8%
All Categories	36,355,370	247,483	147	64.2%

Although not limited to services performed by a physician, care for Medicaid eligibles arranged or furnished by Crippled Children Service is billed through the Physicians' program. Crippled Children Service can submit claims for covered services in Medicaid's State Plan. Almost $300,000 was paid by Medicaid to Crippled Children Service for services provided to their Medicaid-eligible clients.

Most Medicaid providers must sign contracts with the Medicaid Agency in order to provide services to eligibles. Physicians who participate in the EPSDT program must sign an agreement limiting charges for screening children. Also, nurse-midwives are required to sign contracts in order to participate in the Medicaid program. For other types of physicians' services, the submitted claim is considered a contract.

In general, the per capita cost of Medicaid services to the aged is higher than for other categories of recipients. One reason is that older people are more likely to have health problems. However, Medicaid physicians' care costs for the aged are lower than for most categories (see Plate 43). This is because about 90 percent of Medicaid's aged recipients also have Medicare coverage. In cases when individuals have both Medicaid and Medicare coverage, Medicare pays the larger portion of the physicians' bills.

FY '85 PLATE 44

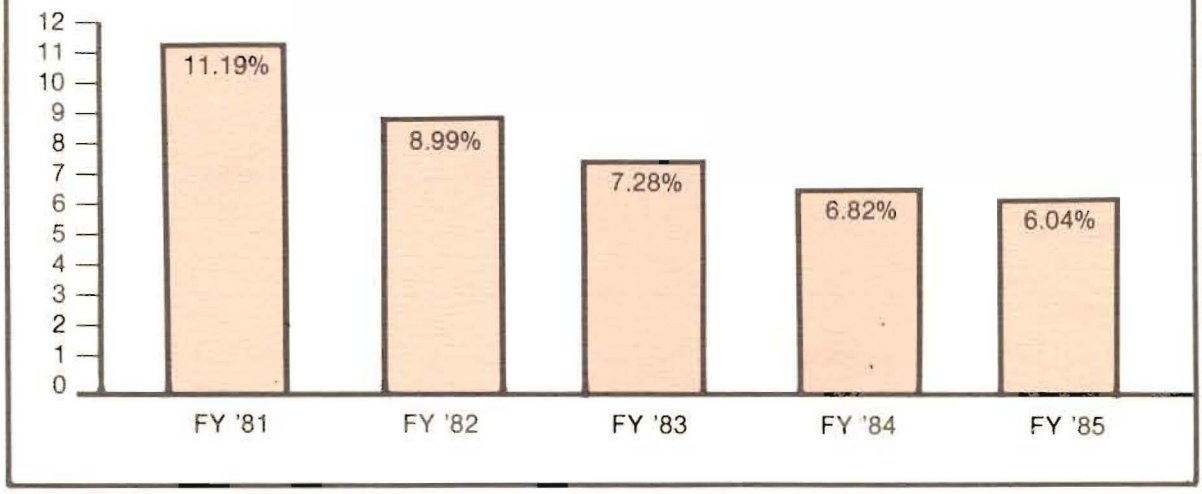
TOTAL LICENSED PHYSICIANS

By county

FY '81-'85 PLATE 45

ANNUAL PERCENT CHANGES

Physician services cost from the consumer price index



PHARMACEUTICAL PROGRAM

Prescription drugs are one of the most cost-effective services offered to Medicaid recipients.

Although the Pharmaceutical program is an optional service under federal Medicaid rules, it is vital to the Medicaid program. Treating illnesses with prescription drugs is usually much less expensive and often as effective as alternatives such as hospitalization and/or surgery. For this reason, the Pharmacy program is one of the most cost-effective services that Medicaid offers.

Realistically, modern medical treatment would be impossible without drugs. Medical practitioners rely heavily on drugs for the treatment of pain, infection, allergic reactions, chemical imbalances, dietary deficiencies, muscle tension, high blood pressure, heart disease, and many other health problems. In recent years, medical professionals have been very successful in finding medications that make more expensive alternatives unnecessary.

Last year, pharmacy providers were paid $37.8 million for prescriptions dispensed to over half of all Medicaid eligibles. This expenditure represents about 10 percent of Medicaid payments for services. Except for physicians' care, the Pharmaceutical program had the highest rate of use of any Medicaid program.

The Medicaid Agency reimburses participating pharmacists for dispensing based on the ingredient cost of the prescription plus a dispensing fee. This dispensing fee was raised from $2.75 to $3.00 on October 1, 1984. On October 1, 1985, the fee was increased from $3.00 to $3.25. At the present time, a cost-to-dispense study is being developed by the Medicaid Agency to be used in determining the average dispensing cost for pharmacists participating in the Alabama Medicaid program.

Primarily to control overuse, Medicaid recipients must pay a small portion of the cost of their prescriptions. This copayment ranges from 50 cents to 3 dollars depending on drug ingredient cost. In addition, prescribing physicians are limited to the 8,000 drugs listed on the Alabama Drug Code Index. The Twelfth Edition of this index, which went into effect on June 1, 1985, consists of 70 percent generic drugs. However, every effort is made to avoid restricting a physician's choice of drugs. If a physician can justify a new or special drug that is not on the index, he can usually receive prior approval from Medicaid to prescribe it.

A comparison of payments to pharmacists between FY '84 and FY '85 shows an increase of $2.5 million. The primary factors influencing this increase were higher drug ingredient costs and more drug recipients. Another factor involved was the trend toward earlier release from institutional care. This led to more recipients on at-home intravenous or injectable drug therapy. These costs are reported under the Pharmacy program instead of being billed as part of institutional or physicians' services.

FY '85 PLATE 46

PHARMACEUTICAL PROGRAM

Counts of providers by type

Type of Provider	Number
In-State Retail Pharmacies	1,098
Institutional Pharmacies	38
Dispensing Physicians	2
Out-of-State Pharmacies	40
Health Centers and Clinics	4
TOTAL	1,182

FY '83-'85 PLATE 47

PHARMACEUTICAL PROGRAM

Use and Cost

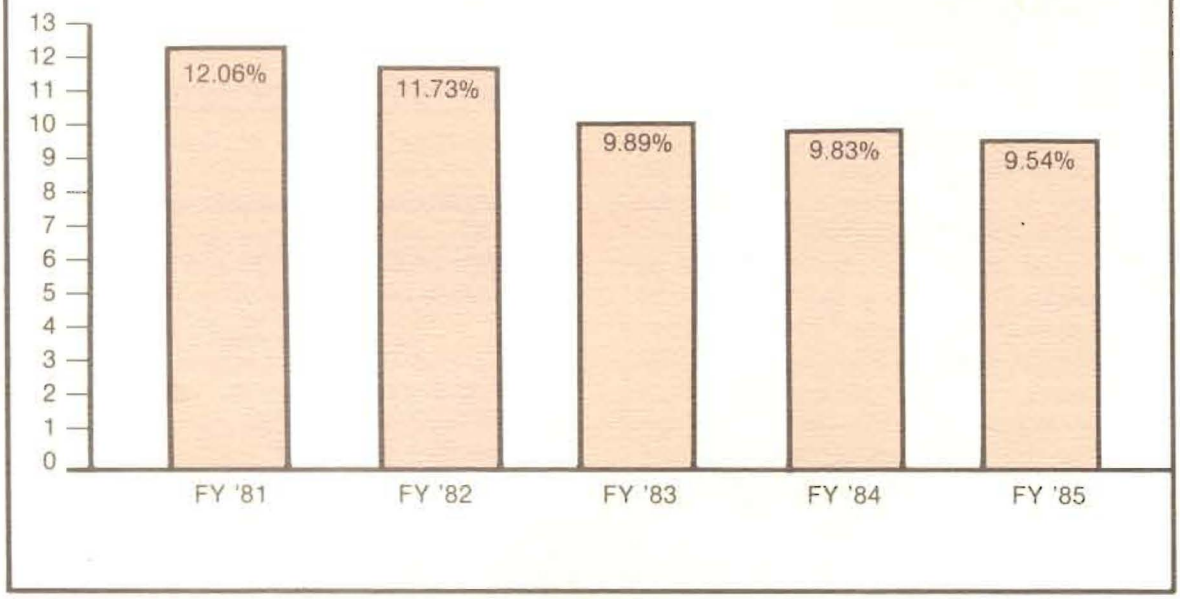
Year	Number of Drug Recipients	Recipients as a % of Eligibles	Number of Rx	Rx Per Recipient	Price Per Rx	Cost per Recipient	Total Cost to Medicaid
1983	222,713	58%	3,230,037	14.50	$ 9.79	$141.96	$31,616,230
1984	226,256	59%	3,245,359	14.34	10.87	155.87	35,266,931
1985	228,136	60%	3,303,229	14.47	11.46	165.87	37,840,727

FY '81-'85

ANNUAL PERCENT CHANGE

Prescription drug cost from the consumer price index

PLATE 48



EPSDT PROGRAM

The Screening program detects problems before they become chronic and expensive to treat.

The Early and Periodic Screening Diagnosis and Treatment program or Medicaid "screening," is a preventive health program designed to detect and treat diseases that may occur in a child's early life. If properly utilized, the program can be a benefit to both the child and the Medicaid Agency. Many health problems begin early in life and, if left untreated, can cause chronic illness and disability. When an illness is diagnosed and treated through the screening program, the child benefits through improved health, and Medicaid benefits through long-term savings realized by intervention before a medical problem requires expensive acute care.

Although EPSDT is funded by Medicaid, the program's operation requires the cooperation of the State Department of Pensions and Security and the State Department of Public Health. EPSDT eligibles are persons under 18 who receive assistance through Aid to Dependent Children or Supplemental Security Income programs. Pensions and Security workers normally determine ADC eligibility, make families aware of EPSDT, and refer eligibles to EPSDT providers. About half of all EPSDT providers, and the providers that conduct about 80 percent of the screenings, are county health departments. In addition to funding the program, the Medicaid Agency keeps track of which eligibles have been screened and which eligibles are due for screening.

The major problem with EPSDT is that the program is underused. Screening is not mandatory for eligibles, and less than 20 percent of eligibles are screened each year. Many mothers do not seek health care for their children until the children show symptoms of illness. Taking a child to a physician's office or health department can be a difficult chore. Both Pensions and Security and EPSDT providers have tried to alleviate the no-show problem through educational programs that teach eligible families the importance of screening. The general public as well as Medicaid eligibles would be better served if more children were screened, but despite the efforts of participating agencies and providers, the number of screening recipients over the past few years has remained relatively constant in relation to the number of eligibles.

In addition to county health departments and physicians, screenings are performed by community health centers, Head Start Centers, and child development centers. These organizations have made

FY '84-'85 PLATE 49
DENTAL PROGRAM
Recipients by sex and age

	FY '84	FY '85
Total	39,918	43,546
Male	18,167	19,867
Female	21,751	23,679
Age 0-5	11,437	13,097
Age 6-20	28,481	30,449

FY '84-'85 PLATE 50
EPSDT PROGRAM
Eligibles, recipients, by age
Payments

	FY '84	FY '85
TOTAL ELIGIBLES FOR EPSDT PROGRAM	171,605	169,658
Age:		
0-5	63,497	63,356
6-20*	108,108	106,302
RECIPIENTS OF SCREENING	33,508	28,272
Age:		
0-5	15,929	15,296
6-20*	17,579	12,976
TOTAL PAYMENTS FOR SCREENING	$925,760	$785,808
AVERAGE PAYMENT FOR A SCREENING	$27	$27

* During FY '85, the age limit for screening eligibility was lowered to 18 years.

significant contributions to the EPSDT program. The Department of Pensions and Security has made a tremendous contribution to the program through an outreach program, person-to-person contacts, provision of social services, and help with follow-up of referrals to assure that eligibles who need care receive it.

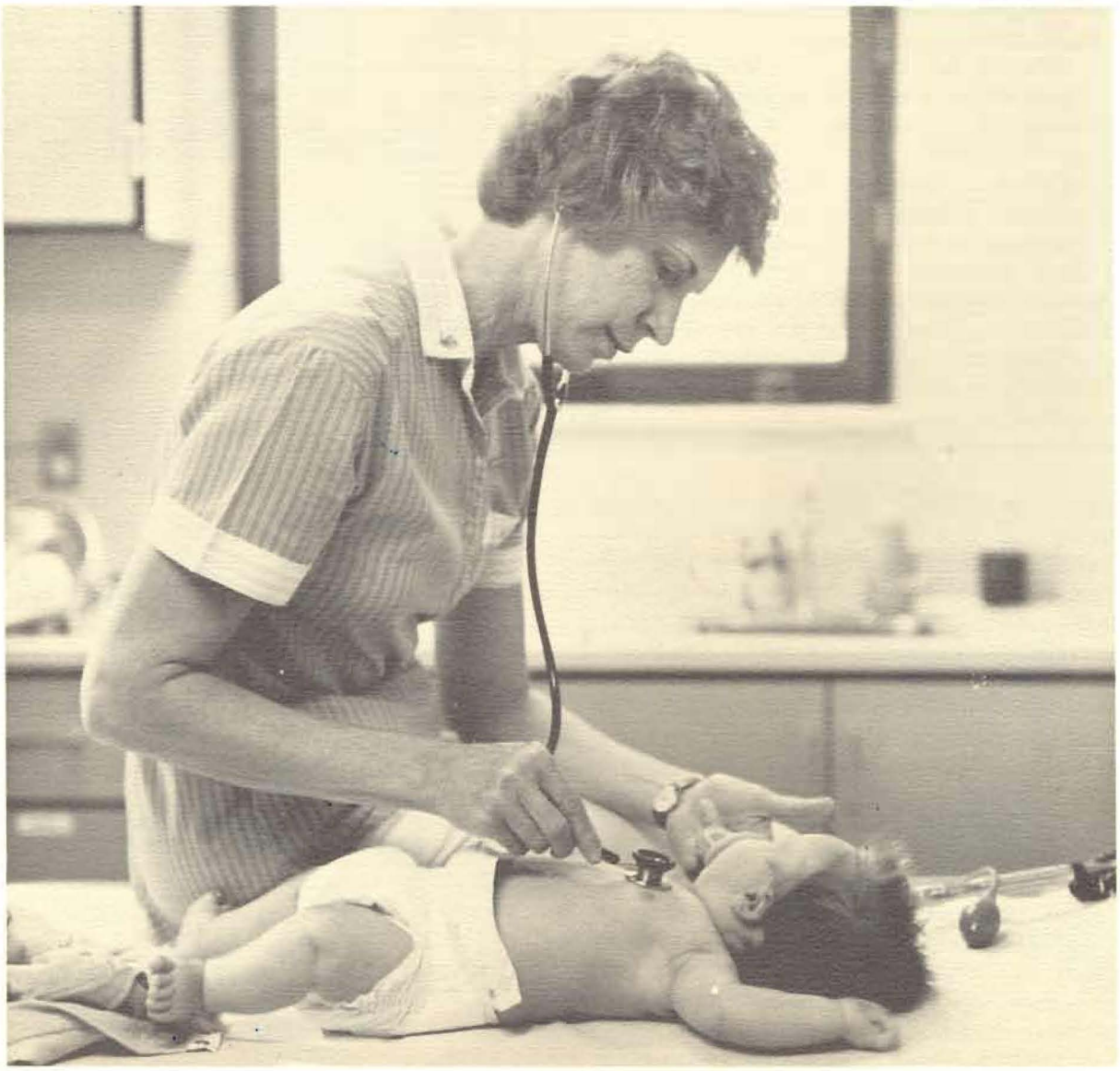
A Medicaid goal is to screen eligibles at eight intervals between birth and age 18. During FY '85, about two of five children screened were in the infant to age five group. The rest were older children. Problems discovered and treated included hypertension, rheumatic fever, other heart conditions, diabetes, neurological disorders, venereal disease, skin problems, anemia, urinary infections, vision and hearing problems, child abuse, and dental problems.

The cost of screening is relatively small-an average of $27 per screening. The cost of treating illness is usually considerably higher. During FY '85, a total of 33,508 screenings were performed. About 80 percent of screenings resulted in referrals to physicians due to uncovered or suspected medical conditions.

The Medicaid Dental program is provided as part of the EPSDT program. With some exceptions, dental care is available only to EPSDT eligibles who have been referred by a screening agency. These include emergencies, institutionalized eligibles under a physician's care, or eligibles who have a definite health care plan in a program such as Crippled Children Service.

All Medicaid dental services are provided by licensed dentists. These services are limited to those which are customarily available to most persons in the community. Examples of dental services not covered by Medicaid include surgical periodontal, orthodontic, and most prosthetic treatment. If justified by the attending dentist, some services may be prior authorized by the Medicaid Agency. These services may include nonsurgical periodontal treatment, third and subsequent space maintainers, general anesthesia, hospitalization, and some out-of-state care.

During FY '85, 43,752 persons received dental treatment at an approximate cost of $4.1 million.



LABORATORY AND RADIOLOGY PROGRAM

The Lab and X-Ray program provides valuable diagnostic tools to providers who treat Medicaid eligibles.

Laboratory and radiology services are essential parts of the Medicaid health care delivery system. Many diagnostic procedures and methods of treatment would be impossible without the availability of these valuable tools.

Medically necessary lab and x-ray services are available in conjuction with other Medicaid services, such as physician office visits, outpatient care, and inpatient care. Since lab and x-ray services are ancillary parts of other services, Medicaid will not pay for lab and x-ray services if other services are not available. For example, if a recipient exhausts his hospital days for the year, he also exhausts his eligibility for lab and x-ray services ancillary to inpatient hospital care.

The Alabama Medicaid Agency recognizes the following types of laboratory and radiology facilities:

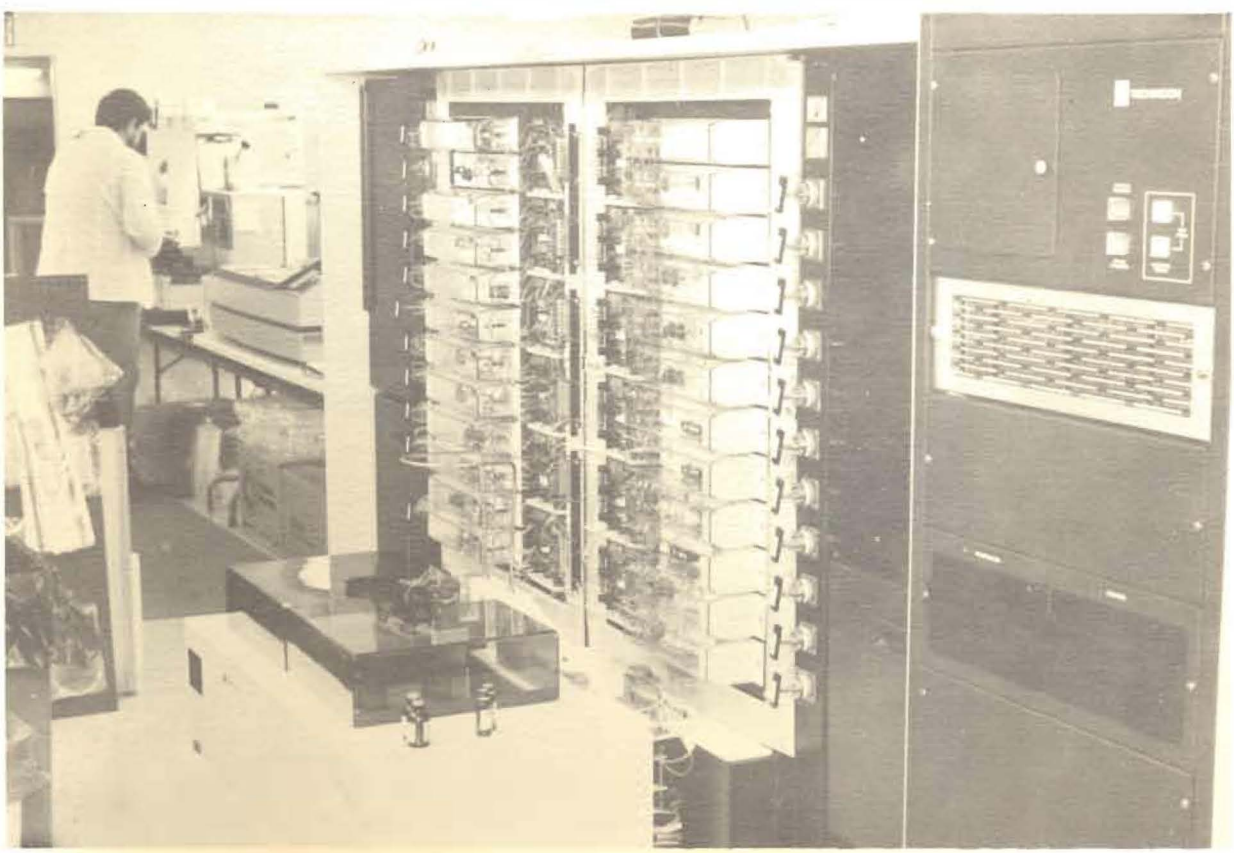
—independent laboratories and x-ray facilities
—laboratory and x-ray facilities in a physician's office
—private laboratory facilities owned and operated by physicians for their exclusive use
—hospital-based laboratory and x-ray facilities

Independent labs and independent commercial facilities must enter into contracts with the Alabama Medicaid Agency. Other laboratory and radiology providers must be approved by the appropriate licensing agency, and each claim serves as a provider contract.

FY '84-'85 PLATE 52

LAB AND X—RAY PROGRAM
USE AND COST

YEAR	RECIPIENTS	PAYMENTS	ANNUAL COST PER RECIPIENT
1984	119,166	$6,407,532	$54
1985	115,915	6,154,911	53



Medicaid eligibles have access to state-of-the-art lab services.

OPTOMETRIC PROGRAM

Through the Optometric program, Medicaid eligibles receive high quality professional eye care.

The Alabama Medicaid Optometric program provides eligibles with high quality professional eye care. For children, good eyesight is essential to learning and development. For adults, good vision is critical to self-sufficiency and the maintenance of a high quality of life. Through the Optometric program, Medicaid eligibles receive a level of eye care comparable to that of the general public.

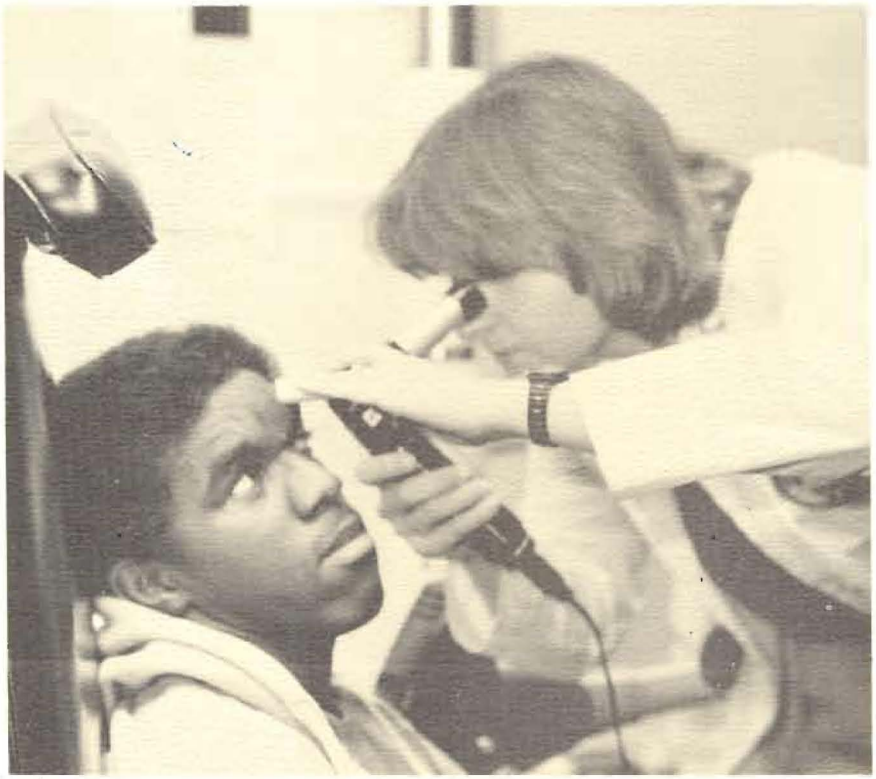
The eye care program provides services through ophthalmologists, optometrists, and opticians. Adults (18 years of age and older) are eligible for one complete eye examination and one pair of eyeglasses every two calendar years. Recipients under 18 years of age are eligible for an eye examination and one pair of eyeglasses every calendar year. Hard or soft contact lenses are available when prior authorized by the Medicaid Agency for the treatment of keratoconus following cataract surgery. Included in this service is the fitting of the lenses and supervision of adaptation. Other optometric services which are provided when medically necessary and which require prior authorization are orthoptic training, tonometry, visual field examinations, and fundus photography.

In keeping with the agency's policy of cost containment, Medicaid purchased eyeglasses are provided through a central source chosen through competitive bidding. The contractor is required to furnish eyeglasses that meet federal, state, and agency standards. The selection of frames includes styles for men, women, teens, and pre-teens.

FY '85 PLATE 53

OPTOMETRIC PROGRAM
USE AND COST

Type of Provider	Average Monthly Recipients	Payments
Dispensing Optician	2,472	$ 571,884
Optometrist	3,089	1,534,280
Opthalmologist	2,207	1,184,457
TOTAL	7,768	3,290,621



Low-Vision clinic at the Alabama Institute for the Deaf and Blind in Talladega.