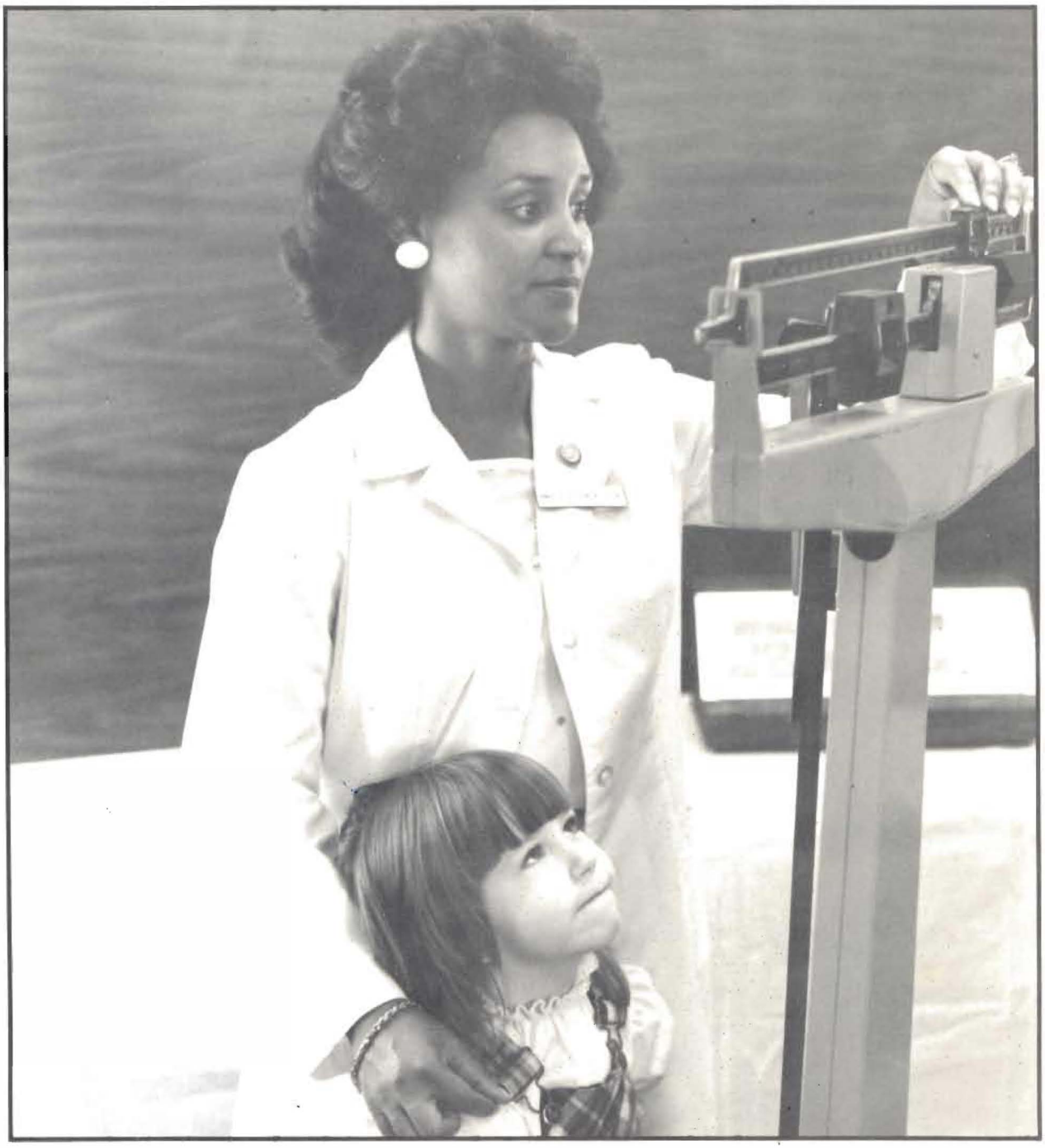
Alabama Medicaid Agency



Fourteenth Annual Report
October 1, 1985 - September 30, 1986

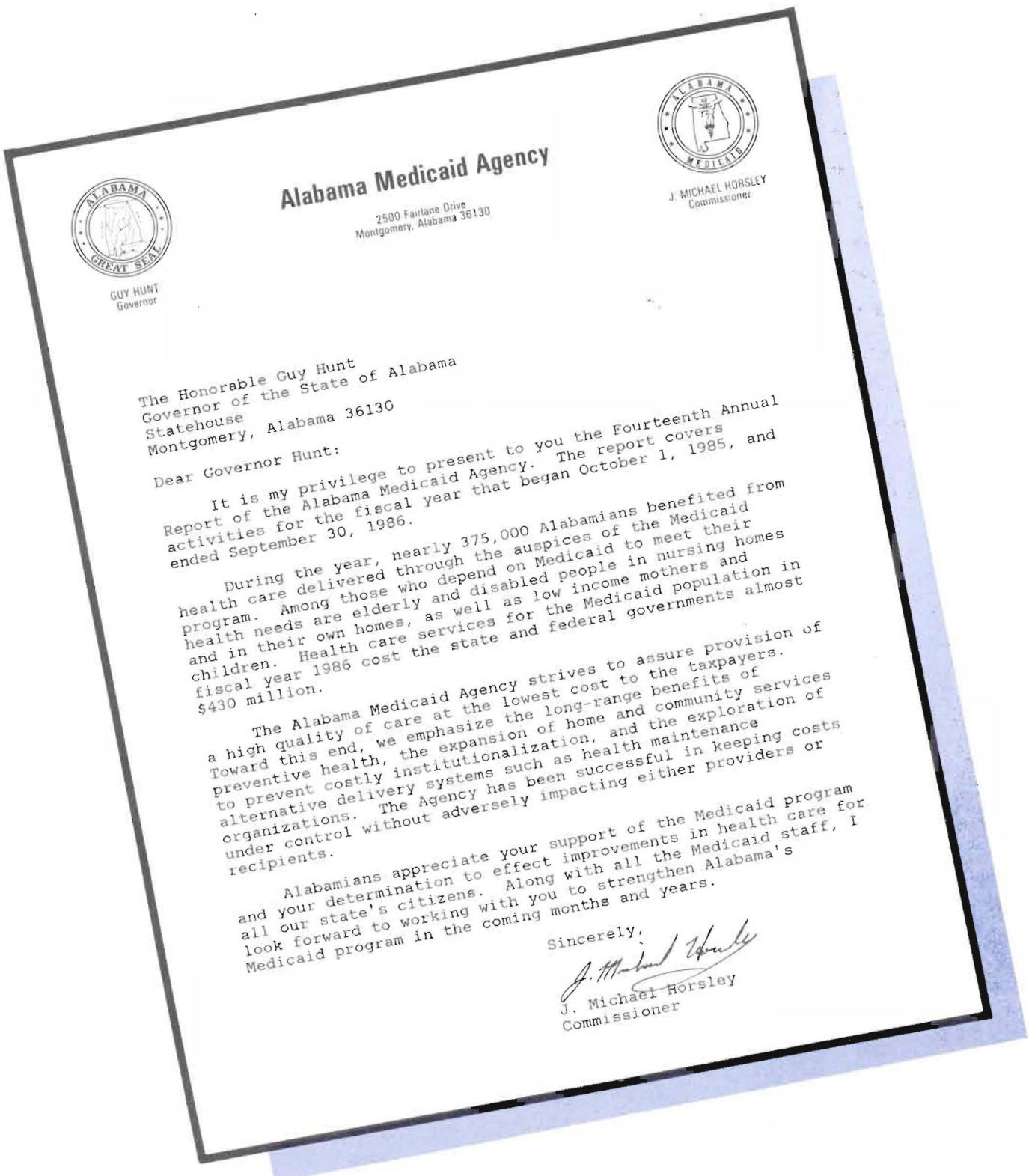
GUY HUNT, GOVERNOR
STATE OF ALABAMA

J. Michael Horsley
Commissioner
Alabama Medicaid Agency

Henry Vaughn
Deputy Commissioner

Harriette Worthington
Deputy Commissioner

Alabama Medicaid Agency
Fourteenth Annual Report
Fiscal Year 1986



Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

GUY HUNT
Governor

J. MICHAEL HORSLEY
Commissioner

The Honorable Guy Hunt
Governor of the State of Alabama
Statehouse
Montgomery, Alabama 36130

Dear Governor Hunt:

It is my privilege to present to you the Fourteenth Annual Report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1985, and ended September 30, 1986.

During the year, nearly 375,000 Alabamians benefited from health care delivered through the auspices of the Medicaid program. Among those who depend on Medicaid to meet their health needs are elderly and disabled people in nursing homes and in their own homes, as well as low income mothers and children. Health care services for low income mothers and fiscal year 1986 cost the state and federal governments almost $430 million.

The Alabama Medicaid Agency strives to assure provision of a high quality of care at the lowest cost to the taxpayers. Toward this end, we emphasize the long-range benefits of preventive health, the expansion of home and community services to prevent costly institutionalization, and the exploration of alternative delivery systems such as health maintenance organizations. The Agency has been successful in keeping costs under control without adversely impacting either providers or recipients.

Alabamians appreciate your support of the Medicaid program and your determination to effect improvements in health care for all our state's citizens. Along with all the Medicaid staff, I look forward to working with you to strengthen Alabama's Medicaid program in the coming months and years.

Sincerely,

J. Michael Horsley

J. Michael Horsley
Commissioner

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HIGHLIGHTS OF THE 1986 FISCAL YEAR

As the need for health services and the cost of health care continue to increase, the budgets of many states, including Alabama, have been strained to meet the growing demand for access to care by more and more people. Care has become more expensive as health costs have increased at a considerably higher rate than costs for goods and services in general. In Alabama, about one person out of every twelve benefits from the Medicaid program, which pays for health care for eligible low income people. Because of the need to control costs in times of dwindling revenues, Alabama has built a Medicaid program that provides basic care but includes few extra or optional services.

Preventive Health

During the fiscal year that began October 1, 1985, the Alabama Medicaid Agency continued pursuit of new approaches and innovations that might decrease costs over the long term and, at the same time, contribute to better health for all Alabamians. With the creation of a preventive health unit, the Agency worked to revitalize the Medicaid Task Force on Preventive Medicine, which was renamed the Advisory Council on Preventive Health. Composed of distinguished health professionals and representatives from interested public and private groups, the Council makes recommendations to the Agency on preventive health initiatives and gives assistance in carrying out its recommendations. Issues of interest to the Council and Medicaid include smoking cessation, teen pregnancy prevention, unhealthly lifestyles, physical fitness of Alabama youth, early identification of children with health problems, accidents, and teenage suicide and homicide. Promotion of a more health-conscious society that strives to prevent problems before they become acute is expected to reduce costs over the long term.

Health Maintenance Organization

Health maintenance organizations offer one promising alternative to the high cost of health care. During FY '86, the Medicaid Agency entered into a cooperative arrangement with West Alabama Health Services, Inc., to test the concept of the HMO as a health care delivery system. As established, this pilot project was limited to Greene County, which is located in the rural Black Belt. Plans were made to expand the HMO to more Black Belt counties if the project proved successful.

An HMO is a prepaid health care delivery system. For a flat monthly payment, each covered individual is eligible for a wide range of health services. Participation in the West Alabama HMO is entirely voluntary on the part of Medicaid eligibles, who can join the HMO or stay with the regular Medicaid program. Advantages to HMO enrollment include coverage of preventive services such as physical checkups, no limitations on the number of covered physician visits, and coverage of more hospital days than allowed by the regular Medicaid program. In order to benefit from these and other services, enrollees must have all their health care provided by the HMO, or they must be referred by the HMO to another provider.

Medicaid's participation in the HMO pilot project began when West Alabama Health Services received a grant from the Robert Wood Johnson Foundation to help with start-up costs. As far as can be determined, Alabama has the only rural HMO in the country that is operated with participation by the Medicaid program. Early results from the innovative project indicate that the HMO is offering a high quality of care at a cost savings to the Medicaid program.

MediKids

One program of prevention that has existed for many years is the Early and Periodic Screening, Diagnosis and Treatment Program, or EPSDT. This health screening program for Medicaid-eligible children under 21 years of age is known as MediKids in Alabama. Screening involves a complete physical examination and referral for any needed treatment. During FY '86, the Alabama Medicaid Agency placed new emphasis on the MediKids program in an effort to increase utilization of the service. One project initiated during the year resulted in the statewide recruitment of more than 100 additional physicians to participate in the program. Other projects involve mailings to new Medicaid mothers to encourage them to have their children regularly screened, distribution of new brochures and posters, and outreach efforts. In FY '86, Medicaid also increased the number of screenings for which the Agency will pay and raised the rate paid to private physicians for screenings they perform. The percentage of children screened increased during the year, and expectations are that it will go up more as emphasis on MediKids continues.

Congressional Actions

Federal legislation enacted in FY '86, and shortly thereafter, had both direct and indirect impacts on the Medicaid program in Alabama and other states as well. Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act, or COBRA, impacted the program directly by extending coverage to more pregnant women, specifically those meeting the income and resource criteria for Aid to Dependent Children, regardless of whether the family's principal wage earner is unemployed. COBRA mandated coverage throughout the pregnancy and the 60-day postpartum period. By the end of the year, more than 150 pregnant women were benefiting from Medicaid coverage as a direct result of COBRA and earlier federal legislation extending coverage to another group during and after pregnancy.

Because of funding limitations, the Alabama Medicaid Agency has not extended coverage to optional groups allowed by COBRA and the Omnibus Budget Reconciliation Act of 1986, which was enacted shortly after the fiscal year ended as Public Law 99-509. Because of these Congressional changes, states for the first time are allowed to separate eligibility levels for Medicaid from eligibility levels for the cash assistance programs of Aid to Dependent Children and Supplemental Security Income. For example, states can now extend coverage to certain pregnant women and children whose family incomes are above the ADC eligibility threshold but below the federal poverty level.

Although Alabama has not covered any of the new optional groups, the Congressional action allowing coverage has had an indirect but significant impact on the state's Medicaid program. Soon after the legislation went into effect, the Medicaid Agency began exploring the possibility of extending coverage to more groups when and if money becomes available. The Agency recognizes the need for coverage, but the question of funding remains.

Good Management

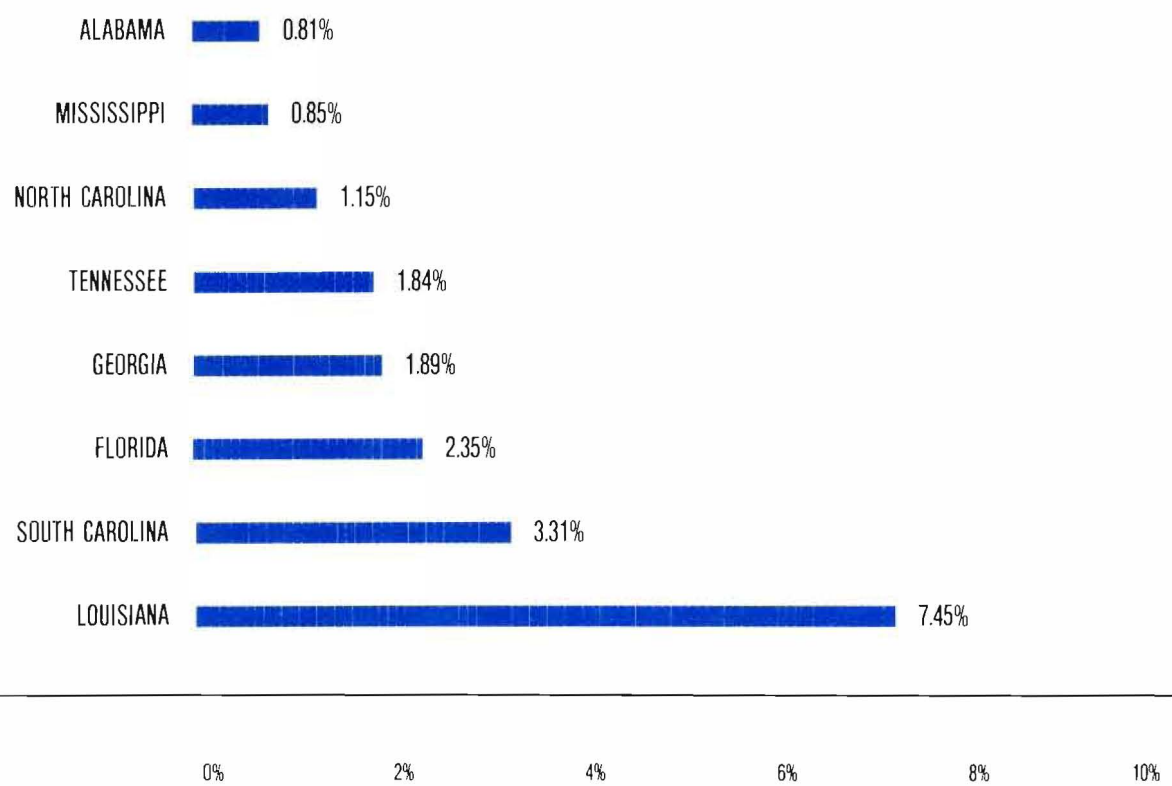
The Alabama Medicaid Agency is proud of its record of extremely low administrative cost. This small administrative cost—3.5 percent in FY '86—assures expenditure of the largest share of the budget for services to recipients. Taxpayer dollars are spent primarily for direct care as opposed to activities indirectly associated with care.

Good management of the Medicaid program in Alabama is reflected in another measure—the payment error rate. This measure shows the percentage of payments made in behalf of people ineligible for Medicaid. Alabama's payment error rate of .81 percent is the lowest in the Southeast. States must maintain an error rate of less than three percent to avoid fiscal sanctions by the federal government, and Alabama's error rate is well below that limit.

During FY '86, the state and federal governments contributed $430 million for health care to people eligible for Medicaid. Every year, the program is literally life-saving for thousands of Alabamians. As the Alabama Medicaid Agency strives toward its goal of delivery of the highest quality of care at the lowest possible cost, continuation of good management practices and exploration of innovative delivery approaches can be expected throughout FY '87 and beyond.

Table - 1

Medicaid Payment Error Rates
For Selected Southeastern States



PROJECTED FOR APRIL 1987

MEDICAID'S IMPACT

Since its 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.

Medicaid is also important to citizens who are not eligible for the program. Health care is one of the state's most important industries, and Medicaid is vital to that industry. During FY '86, Medicaid paid almost $430 million for services to people eligible for the program. The state paid $120 million of this amount, while the federal government provided $310 million, or almost 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 service for eligibles. Medicaid funds are paid directly to the 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 bought goods and services from thousands more. Using the common economic multiplier effect of three, Medicaid expenditures generated over $1.2 billion worth of business in the state during FY '86.

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 revenues 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 1986
County Impact
Year's cost per eligible

Table - 2

COUNTY	BENEFIT PAYMENTS	TOTAL ANNUAL ELIGIBLES	AVERAGE ANNUAL PAYMENT PER ELIGIBLES
Autauga	$ 2,067,831	2,704	$ 765
Baldwin	4,770,871	4,808	992
Barbour	3,907,848	3,879	1,007
Bibb	1,824,459	1,609	1,134
Blount	2,457,724	2,157	1,139
Bullock	2,117,830	2,684	789
Butler	3,426,081	3,429	999
Calhoun	8,965,061	9,376	956
Chambers	3,684,094	4,058	908
Cherokee	1,276,751	1,366	935
Chilton	2,497,195	2,347	1,064
Choctaw	2,105,006	2,734	770
Clarke	3,477,331	4,334	802
Clay	1,759,337	1,211	1,453
Cleburne	1,005,871	993	1,013
Coffee	3,924,105	3,218	1,219
Colbert	4,016,822	3,532	1,137
Conecuh	1,824,365	2,107	866
Coosa	830,256	1,053	788
Covington	4,343,655	3,488	1,245
Crenshaw	2,505,309	2,078	1,206
Cullman	6,097,763	4,126	1,478
Dale	3,671,828	3,301	1,112
Dallas	7,519,706	11,149	674
Dekalb	5,759,181	4,537	1,269
Elmore	11,331,023	3,858	2,937
Escambia	3,489,939	3,686	947
Etowah	9,901,060	7,576	1,307
Fayette	1,907,853	1,788	1,067
Franklin	4,200,353	2,838	1,480
Geneva	2,757,256	2,633	1,047
Greene	1,866,372	3,069	608
Hale	2,938,228	3,279	896
Henry	1,694,386	1,883	900
Houston	4,919,620	6,049	813
Jackson	3,532,374	3,857	916
Jefferson	53,612,185	56,323	952
Lamar	2,044,867	1,407	1,453
Lauderdale	5,766,612	4,942	1,167
Lawrence	2,967,742	2,925	1,015
Lee	4,737,222	5,441	871
Limestone	3,183,272	3,271	973
Lowndes	1,816,914	3,177	572
Macon	4,377,938	4,844	904
Madison	9,419,527	11,608	811
Marengo	3,466,960	4,184	829
Marion	3,574,331	2,244	1,593
Marshall	7,088,672	5,913	1,199
Mobile	40,891,547	40,719	1,004
Monroe	2,398,555	2,998	800
Montgomery	18,360,972	20,830	881
Morgan	19,866,577	6,631	2,996
Perry	2,739,950	3,607	760
Pickens	3,551,147	3,999	888
Pike	3,813,977	4,421	863
Randolph	2,520,880	2,234	1,128
Russell	5,184,103	5,282	981
St. Clair	2,840,607	2,658	1,069
Shelby	3,341,397	2,886	1,158
Sumter	3,136,560	3,968	790
Talladega	7,728,122	9,348	827
Tallapoosa	6,182,878	3,707	1,668
Tuscaloosa	34,782,628	13,896	2,503
Walker	7,784,116	5,984	1,301
Washington	2,198,117	2,471	890
Wilcox	2,738,904	4,335	632
Winston	3,113,668	1,842	1,690

ALABAMA'S MEDICAID PROGRAM

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 Public 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. Almost all states, the District of Columbia, and some territories have Medicaid programs. Medicaid is governed by federal guidelines, but state programs vary in eligibility criteria, services covered, and limitations on service.

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 1986, the formula was 72/28. For every $28 the state spends, the federal government contributes $72.

Eligibility

Persons must fit into one of several 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 Human Resources. 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.

—Certain pregnant women who do not receive ADC and foster children in the custody of the state.

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 from one of several thousand 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 covered in most states. Alabama's program is essentially a "no frills" program aimed at providing basic, necessary health care to the greatest number of people.

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 the monitoring of third party payment resources and Medicare Part B buy-ins.

Provider Subsystem: This subsystem maintains 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 and developing policy, and preparing federal reports.

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

Many of Medicaid's computer functions are performed under contract by the agency's fiscal agent, Alacaid. The firm successfully bid for the contract beginning in October 1979. Alacaid was 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 '86, Alacaid processed 7,099,653 claims in an average time of 4.5 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 1,700 computer programs.

implemented several major system changes in an effort to keep up with changing needs. Among these were modifications to the processing of outpatient claims and changes made in connection with the implementation of a health maintenance organization. In-house projects at the Medicaid Agency included redesign and enhancement of both the Long Term Care System and the Drug Pricing System, further automotation of third party recovery activities, and changes to the Medicare Buy-in process. Implementation of

Table - 3

FY '84-'86
Medicaid Software Activity

	FY '84	FY '85	FY '86
Number of Programs in production at year end	1,406	1,560	1,737
Number of Requests received for Software support	1,528	1,524	1,401
Number of Requests Completed	979	1,367	1,173

MMIS is a dynamic system that requires constant development and modification to keep pace with changing regulations and medical and computer technology. During FY '86, Alacaid and Medicaid personal computers and user-friendly software on the agency's IBM System 38 has reduced the number and increased the complexity of software requests handled by Medicaid's systems staff.

PROGRAM INTEGRITY

The purpose of the Program Integrity Division is to minimize fraud, abuse and waste in the Medicaid program. Increasing emphasis on program integrity has resulted in an efficient program assuring that 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, Systems Audit, 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. Systems Audit monitors the fiscal agent and the claims processing system. 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 medical, financial and administrative personnel. 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 $1,740,000 in FY '86. During the year, complete integrity reviews were conducted on 462 providers and 500 recipients because of possible fraud or abuse. Nineteen suspected provider fraud cases were referred to the Attorney General's Medicaid Fraud Unit for prosecution. Forty-two cases of suspected recipient fraud were referred to local district attorneys for prosecution. Overpayments collected from providers in FY '86 totaled $157,290.26. For fraud or abuse of the program, 240 recipients were terminated during the year.

Among administrative sanctions used to control abuse of Medicaid was the lock-in program. During the year, 81 recipients were restricted to specific providers. The majority of these recipients were suspected of overutilizing prescription drugs. Imputed savings from locked-in recipients totaled almost $30,000 in FY '86.

Table - 4

PROGRAM INTEGRITY
Provider Integrity Reviews
FY '86

Cases Opened	Cases Completed	Overpayments Collected	Cases Referred To Attorney General	Providers Terminated From Medicaid Program
404	462	$157,290	19	2

REVENUE, EXPENDITURES, AND PRICES

Table - 6

FY '86
Source of Medicaid Revenue

Federal Funds	$314,866,532.00
State Funds	129,857,679.00
Total Revenue	$444,724,211.00

Table - 7

FY '86
Components of Federal Funds

(net)	Dollars
Family Planning Administration	$341,633.00
Professional Staff Costs	7,784,249.00
Other Staff Costs	2,240,203.00
Other Provider Services	301,102,270.00
Family Planning Services	3,398,177.00
Total	$314,866,532.00

Table - 8

FY '86
Components of State Funds

	Dollars
Encumbered Balance Forward	$2,785,076.00
Basic Appropriations	103,696,202.00
Supplemental Appropriations	0.00
DHR/Mental Health/COA/Youth Services	24,738,935.00
Interest Income from Fiscal Intermediary	276,542.00
Miscellaneous Receipts	10,200.00
	$131,506,955.00
Encumbered	1,649,276.00
Total	$129,857,679.00

Table - 5

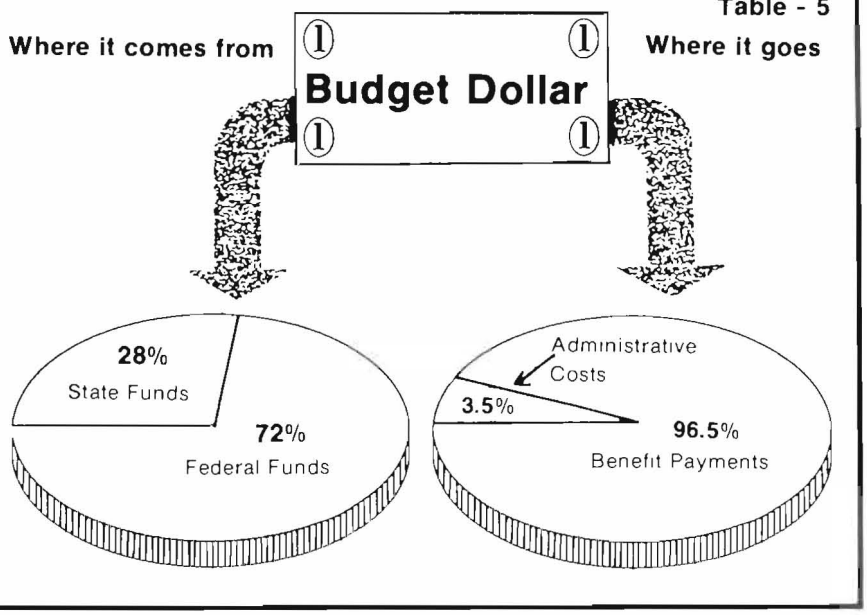


Table - 9

FY '86
Benefit Cost By Fiscal Year In Which Obligation Was Incurred

	FY '86	FY '87 (EST)
Nursing Homes	$133,232,612.00	$140,000,000.00
Hospitals	79,882,989.00	85,000,000.00
Physicians	37,009,572.00	39,000,000.00
Insurance *	40,205,400.00	35,500,000.00
Drugs	40,636,956.00	42,000,000.00
Health	7,864,410.00	8,427,000.00
Community Services	27,275,684.00	34,892,000.00
Total Medicaid Service	$366,107,623.00	$384,819,000.00
% Increase	8.68%	5.11%
Mental Health	62,983,074.00	65,999,950.00
Total Benefits	$429,090,697.00	$450,818,950.00

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

In FY '86, Medicaid paid $429,090,697 for health care services to Alabama citizens. Another $15,633,514 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.

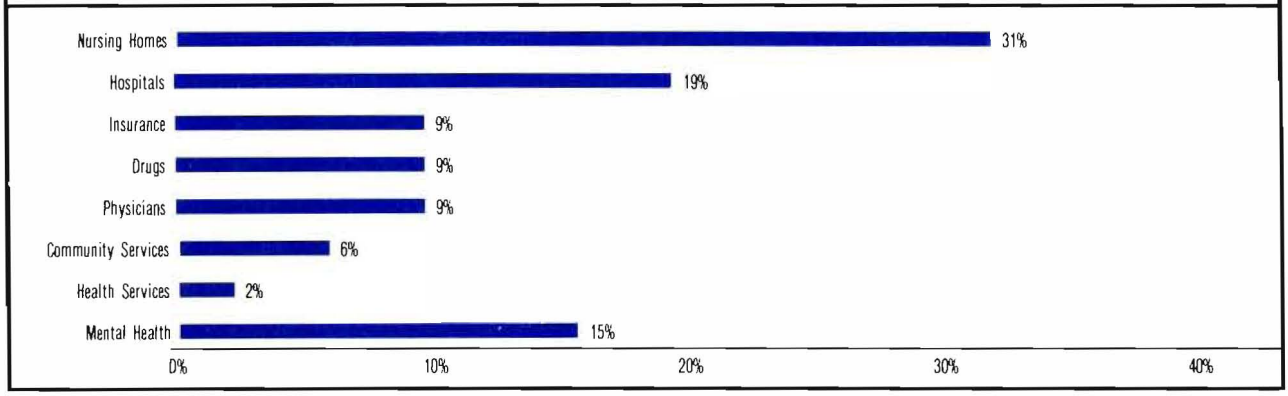
FY '86
EXPENDITURES
By type of service (net)

Table - 10

Service	Payments	Percent of Payments by Service FY '86	Percent of Payments by Service FY '85	Percent of Payments by Service FY '84
Intermediate Nursing Care	123,322,599.00	28.74%	30.02%	30.29%
Skilled Nursing Care	9,910,014.00	2.31%	2.33%	2.66%
Hospital Inpatient	69,483,587.00	16.19%	15.81%	21.27%
Hospital Outpatient	10,324,494.00	2.40%	2.00%	2.69%
ICF-Mentally Retarded & MD	51,748,335.00	12.06%	12.39%	12.38%
Physicians' Services	37,009,572.00	8.63%	8.79%	12.30%
Drugs	40,636,956.00	9.47%	9.34%	9.55%
Medicare Buy-In Insurance	21,301,830.00	4.96%	7.46%	2.45%
Dental Service	3,626,183.00	0.85%	1.05%	1.38%
Family Planning Care	3,775,753.00	0.88%	1.09%	1.50%
Home Health	5,267,677.00	1.23%	0.91%	1.09%
Waivered Services	24,965,946.00	5.82%	1.61%	1.23%
Eye Care	2,645,424.00	0.62%	0.58%	0.62%
Lab & X-Ray	1,059,061.00	0.25%	0.23%	0.21%
Screening	1,007,407.00	0.23%	0.20%	0.26%
Transportation	411,675.00	0.10%	0.08%	0.08%
Hearing Care	122,067.00	0.03%	0.03%	0.03%
Mental Health Services	3,493,641.00	0.81%	0.36%	
Co-Insurance	18,749,306.00	4.37%	5.71%	
Other Care	229,170.00	0.05%	0.01%	0.01%
Total for Medical Care	429,090,697.00	100.00%	100.00%	100.00%
Administrative Costs	15,633,514.00			
Net Payments	444,724,211.00			

Table - 11

Percentage Distribution of Benefit Costs Incurred During Fiscal Year 1986



PRICES

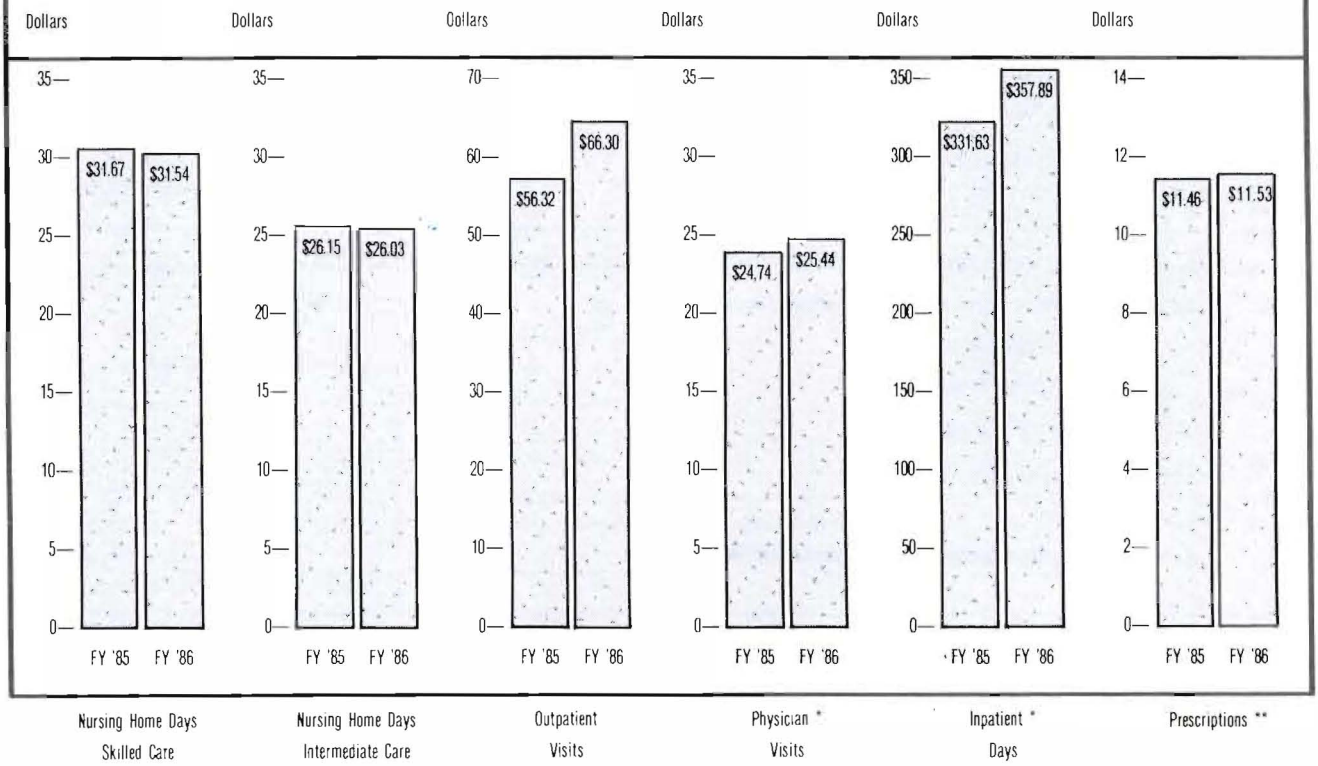
Price per unit of service is one of the most important factors that influence the cost of medical care. Between FY '85 and FY '86, the rate of growth of the Consumer Price Index's medical care component rose, while the rate of growth of all items less medical care declined. If this trend continues, future Medicaid provider payments could reflect this increase.

The average unit price paid by Medicaid for a day of nursing home care declined slightly in FY '86. The primary reason for this decline was the low inflation factor in Medicaid's nursing home reimbursement methodology. Also noteworthy is the increase of only .6 percent in the average price Medicaid paid for a prescription. This small increase is attributable to the adoption of a drug code index primarily consisting of generic drugs.

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 and intermediate care are not the same. Although the price of a day of nursing home 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 of intermediate care is lower than that for a day of skilled care.

Table - 12

FY '85 - '86
PRICES
Average Unit Price Per Service



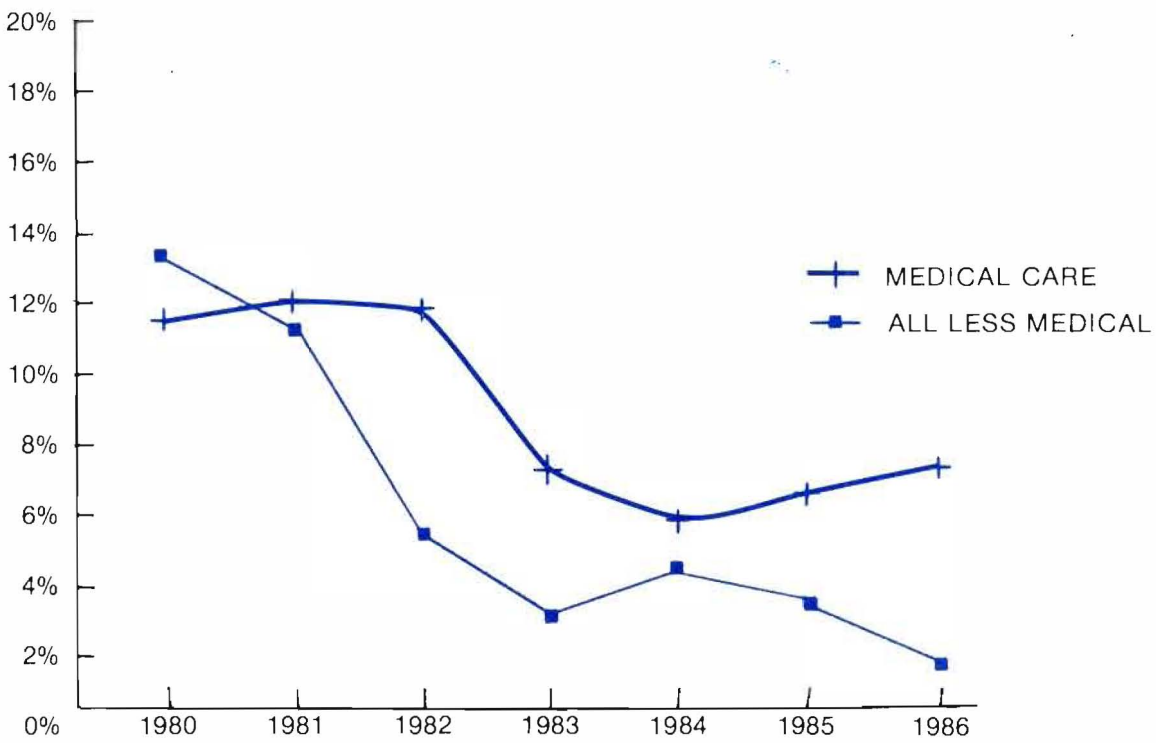
* Crossover Claims Excluded

** Family Planning Drugs Excluded

ANNUAL PERCENT CHANGES

In The Consumer Price Index *

Table - 13



*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 1986, Alabama's population was estimated to be 4,208,600.

More significant to the Medicaid program was the rapid growth of the elderly population. Census data show that from 1960 to 1980, in the United States, the 65 and older population grew twice as fast as the general population. This trend is reflected in population statistics for Alabama. Population projections published by the Center for Business and Economic Research at the University of Alabama reveal that by 1990 there will be 556,080 persons 65 years of age and older in the state. The Center for Demographic and Cultural Research at Auburn University at Montgomery reports that white females 65 years of age and older account for almost one-half of the elderly population in the state. Historically, cost per eligible has been higher for this group than for other groups of eligibles.

Table - 15

FY '86
POPULATION 1986 Population Estimates

Table - 14

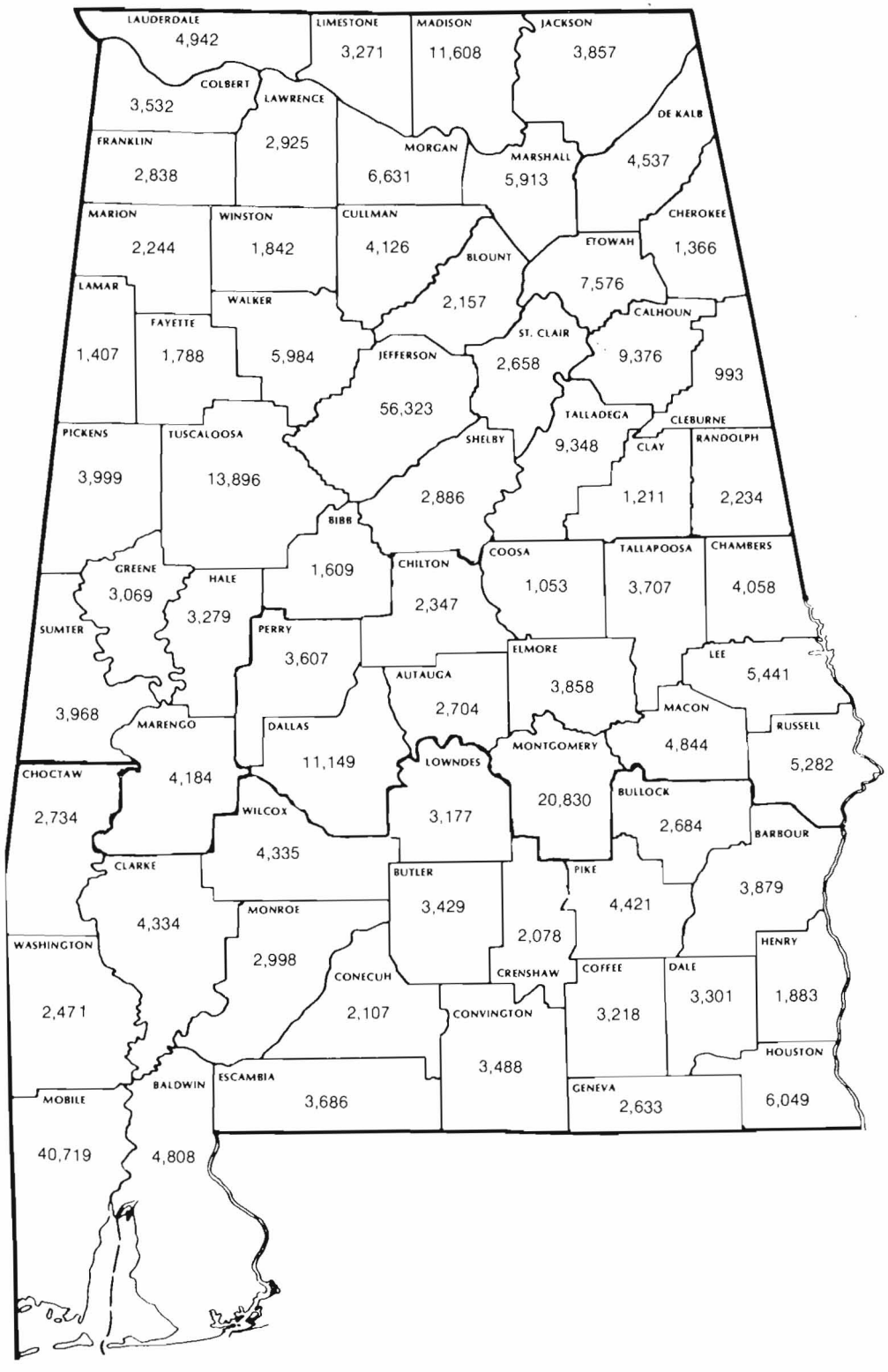
FY '79-'86
POPULATION
Eligibles as percent of Alabama population by year

Year	Population	Total Eligibles	Percent
1979	*3,769,000	413,805	11.0
1980	3,893,888	423,031	10.9
1981	*3,920,000	409,428	10.4
1982	*3,943,000	394,905	10.0
1983	*4,093,600	383,940	9.4
1984	**4,132,400	385,379	9.3
1985	**4,170,100	380,513	9.1
1986	**4,208,600	374,953	8.9

*U.S. Bureau of Census official estimate
**Estimate by CENTER FOR BUSINESS AND ECONOMIC RESEARCH

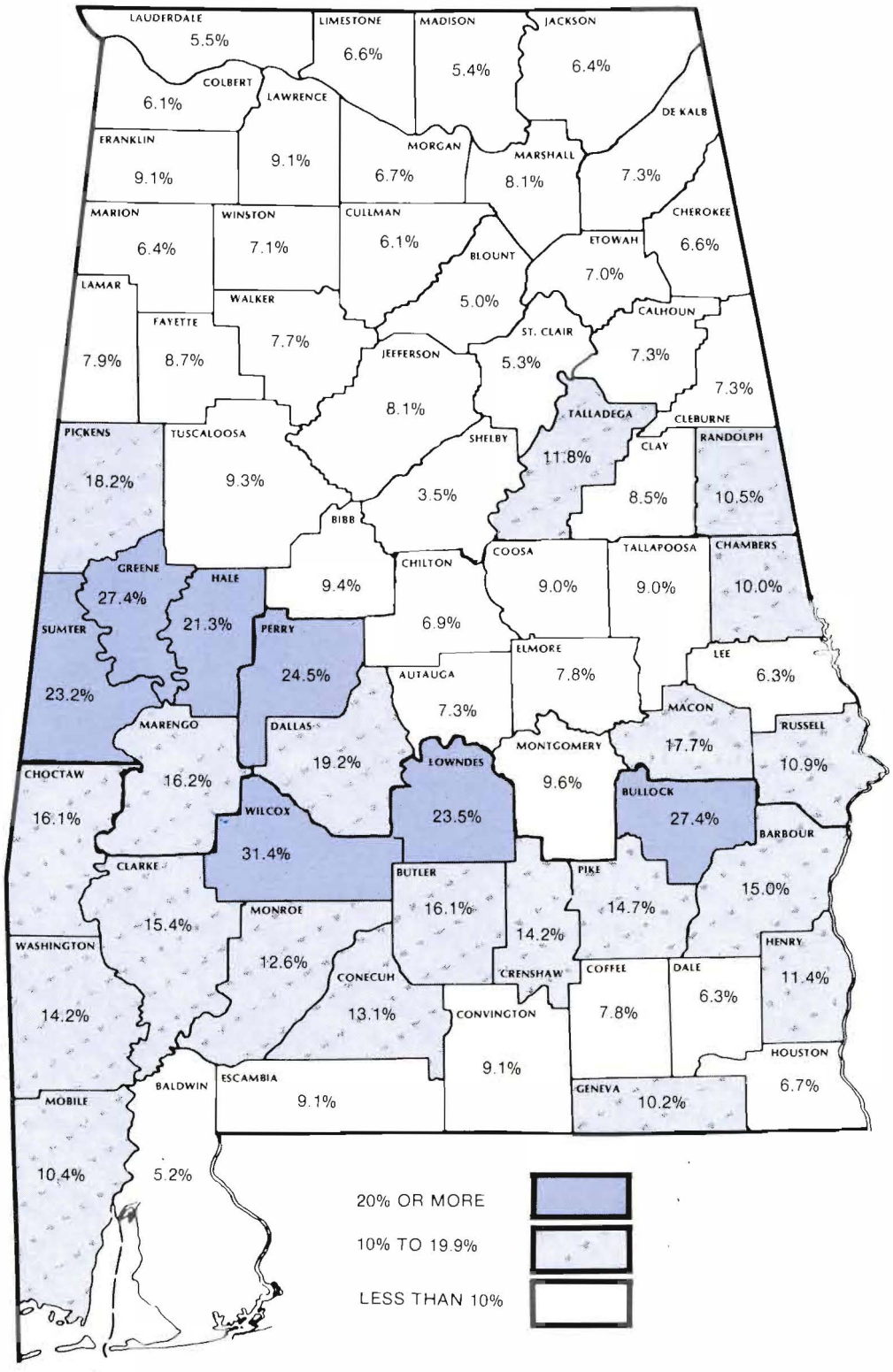
FY '86
Number of Medicaid Eligibles by County

Table - 16



FY '86
ELIGIBLES
Percent of Population Eligible for Medicaid by County

Table - 17



Eligibles

During FY '86, there were 374,953 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 299,658. The monthly average is the most useful measure for making comparisons between eligibles in different states and different years, since the average takes into account length of eligibility.

Table 19 shows how the 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 374,953 people were eligible for Medicaid in FY '86, only about three-fourths were eligible all year. The length of eligibility for the other one-fourth ranged from one to 11 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 of the 12 months 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. Table 21 shows this measure for each category and group.

Table - 18

FY '86
ELIGIBLES
Monthly Count

	Monthly Count
October '85	301,068
November	302,366
December	302,154
January '86	305,297
February	302,011
March	300,193
April	298,668
May	300,255
June	297,582
July	293,360
August	296,927
September	296,009

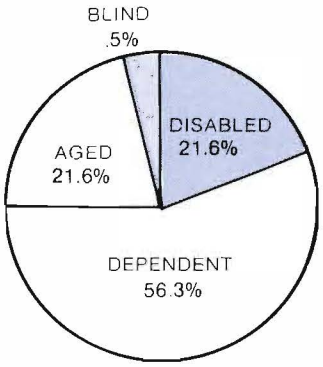
ELIGIBLES
By category, sex, race, age
Total number for year
Average number per month

Table - 19

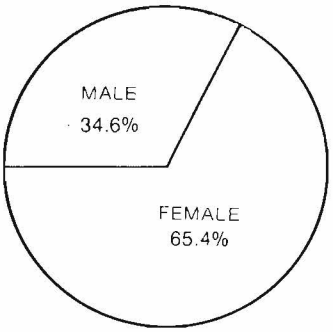
	First Month	Number Added During Year	Total Number For Year	Number Dropped During Year	Final Month	Average Number Per Month	Total Turnover Rate
All Categories	301,068	73,885	374,953	78,944	296,009	299,658	25.1%
Aged	74,595	6,504	81,099	9,989	71,110	72,778	11.4%
Blind	1,854	123	1,977	172	1,805	1,832	7.9%
Disabled	68,696	12,386	81,082	9,035	72,047	70,239	15.4%
Dependent	155,923	54,872	210,795	59,748	151,047	154,809	36.2%
Males	102,447	27,278	129,725	28,465	101,260	102,305	26.8%
Females	198,621	46,607	245,228	50,479	194,749	197,353	24.3%
Whites	102,359	29,482	131,841	30,868	100,973	101,898	29.4%
Nonwhites	198,709	44,403	243,112	48,076	195,036	197,760	22.9%
Age 0-5	46,719	15,282	62,001	16,414	45,587	46,680	32.8%
Age 6-20	78,529	25,505	104,034	27,222	76,812	78,106	33.2%
Age 21-64	85,249	24,560	109,809	23,823	85,986	85,879	27.9%
Age 65 & Over	90,571	8,538	99,109	11,485	87,624	88,993	11.4%

FY '86 **Table - 20**
ELIGIBLES
Distribution by Category, Sex, Race, and Age

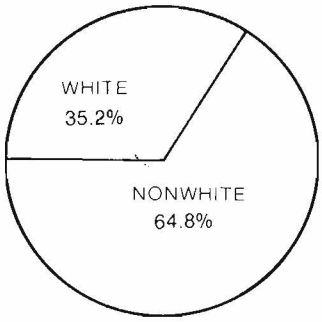
BY CATEGORY



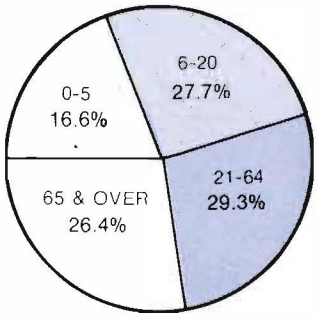
BY SEX



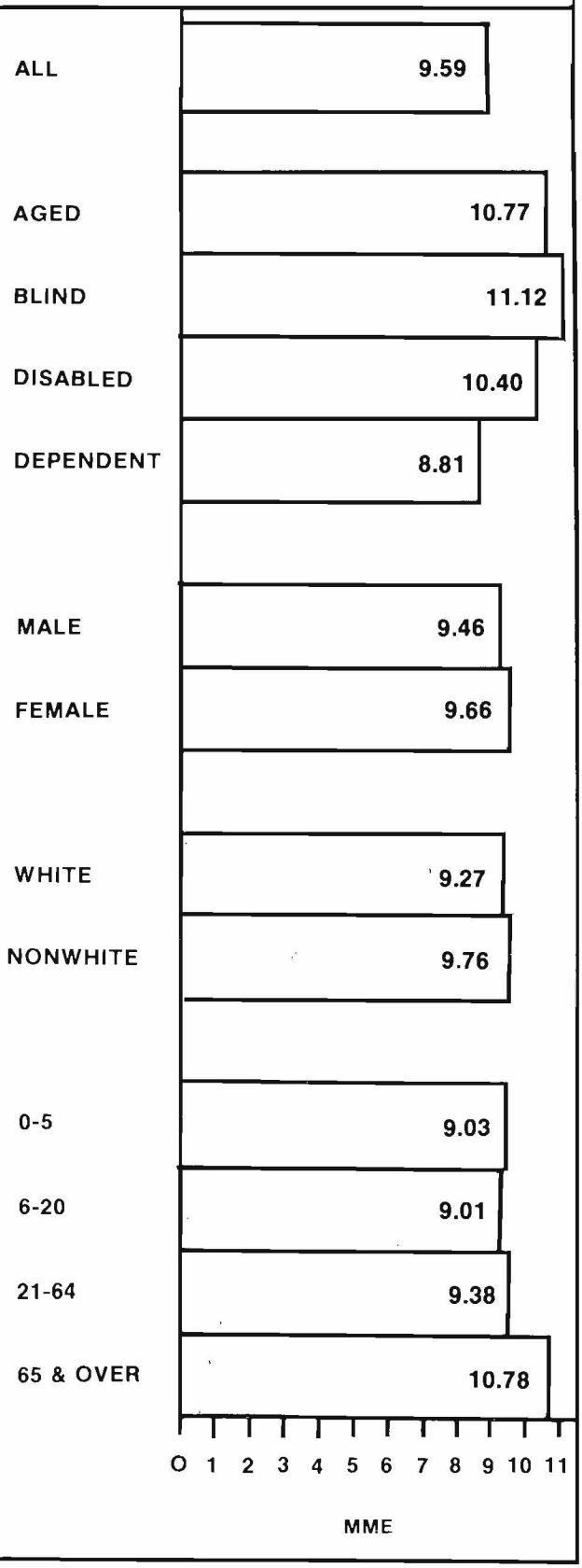
BY RACE



BY AGE

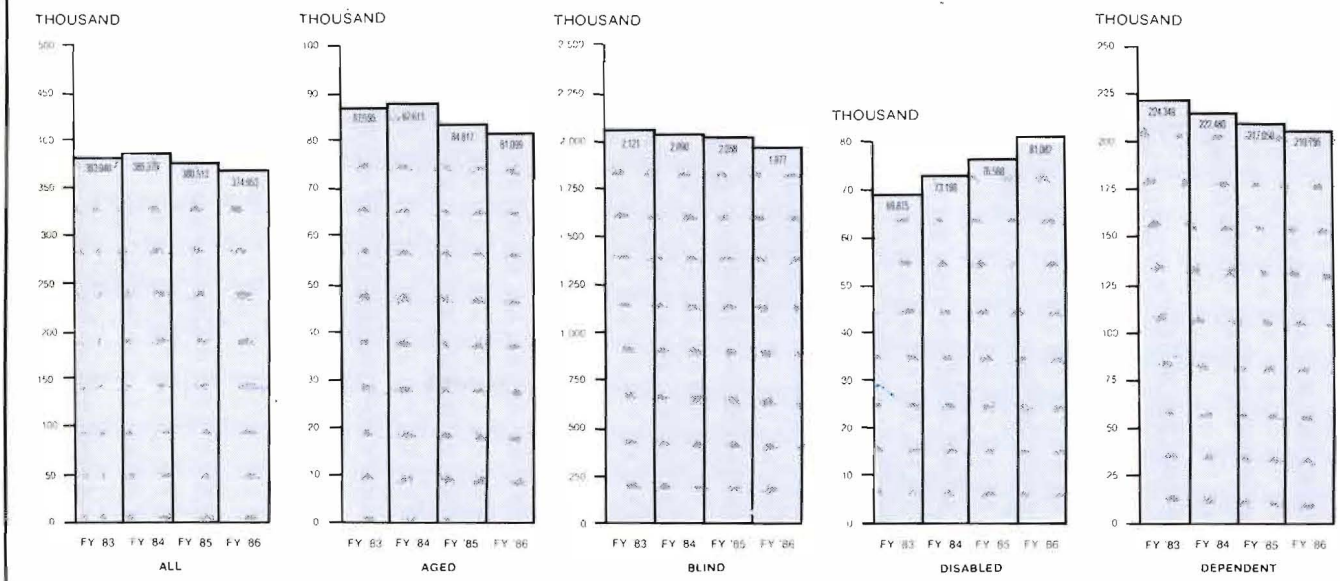


FY '86 **Table - 21**
ELIGIBLES
Man-Months of Eligibility By category, sex, race, and age



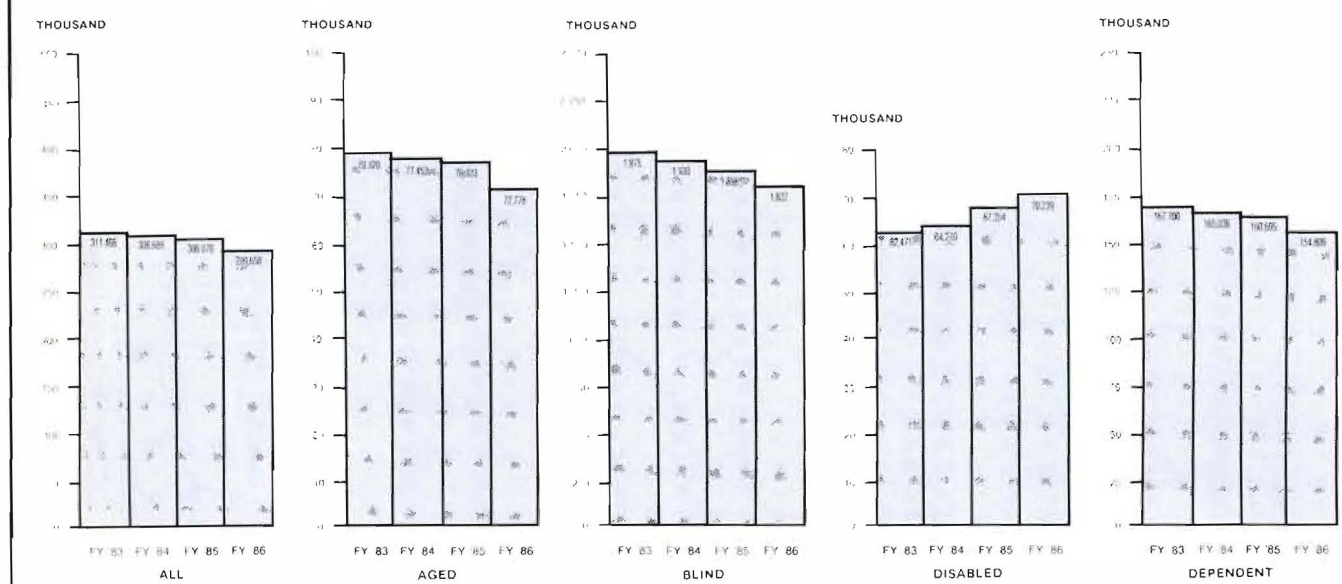
FY '83 - '86
ELIGIBLES
By Category
Annual Total

Table - 22



FY '83 - '86
ELIGIBLES
By Category
Monthly Average

Table - 23



RECIPIENTS

Although there were 374,953 persons eligible for Medicaid in FY '86, only 84 percent of these actually received benefits. These 316,411 persons are called recipients. The remaining 58,542 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 the total for each of those categories, 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.

Table - 25

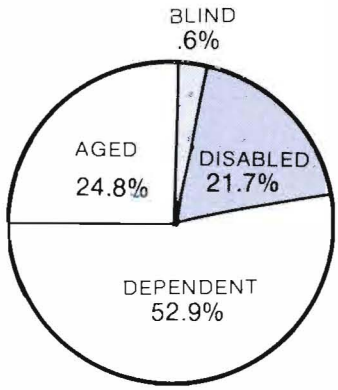
FY '86
RECIPIENTS
Monthly Average and Annual Total

	Monthly Average	Annual Total
Aged	51,441	82,221
Blind	1,037	1,718
Disabled	44,811	71,966
Dependent	52,933	175,710
All Categories (unduplicated)	148,855	316,411

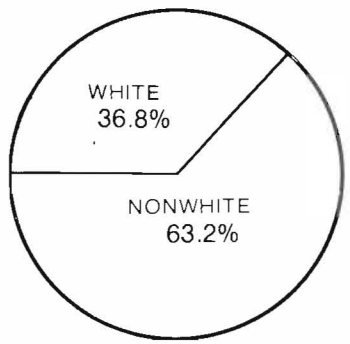
Table - 24

FY '86
RECIPIENTS
Distribution by category, sex, race, and age

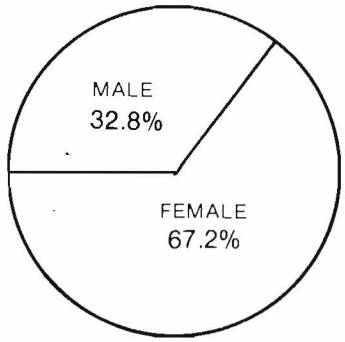
BY CATEGORY



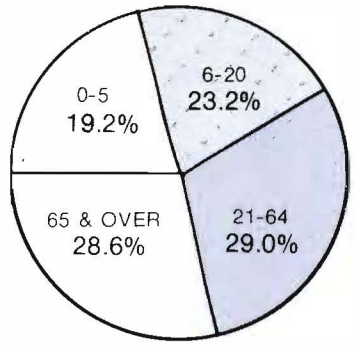
BY RACE



BY SEX



BY AGE



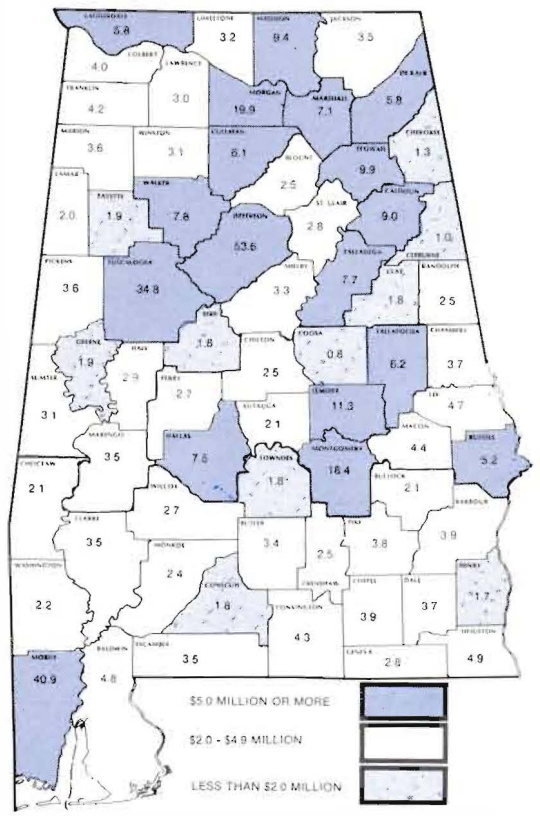
USE AND COST

The percent distribution of Medicaid payments 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 '85. 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.

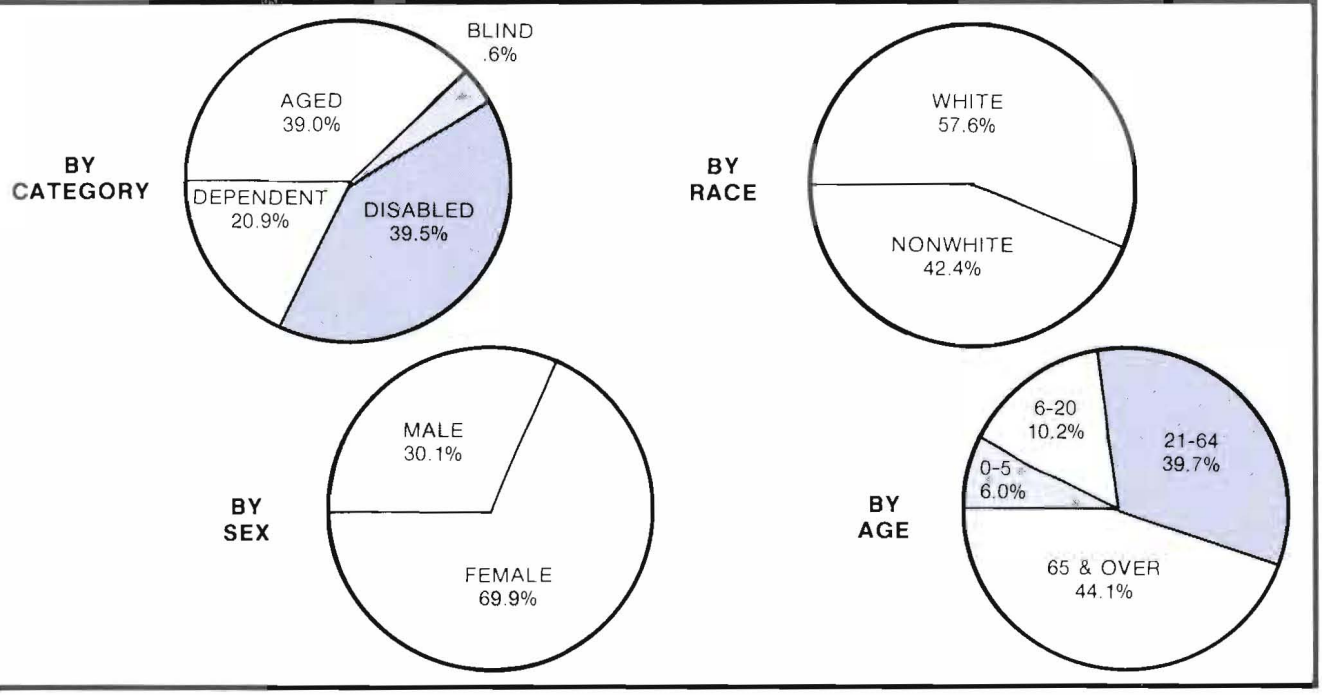
FY '86
PAYMENTS
By county (in millions of dollars)

Table - 27



FY '86
PAYMENTS
Distribution by category, sex, race and age

Table - 26



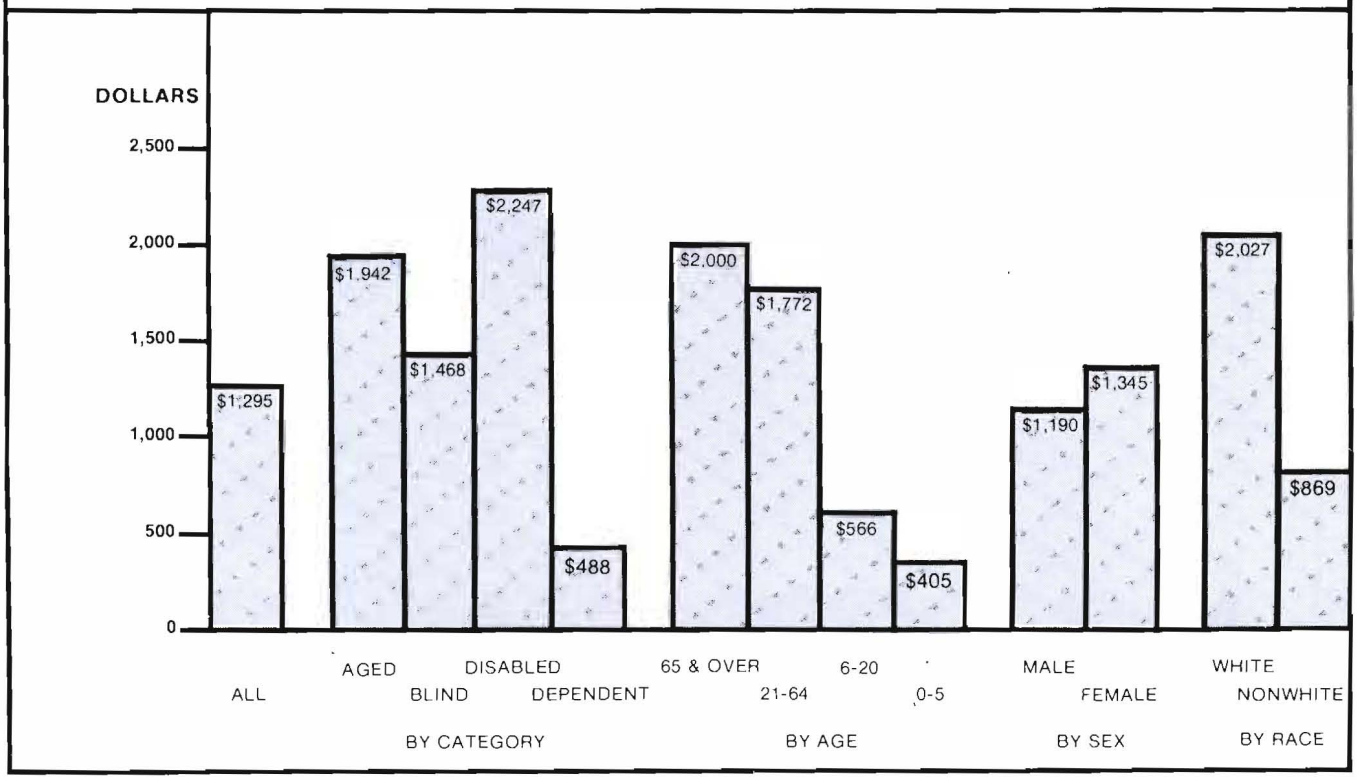
Cost Per Recipient and

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

FY '86
COST PER RECIPIENT
By category, age, sex, and race

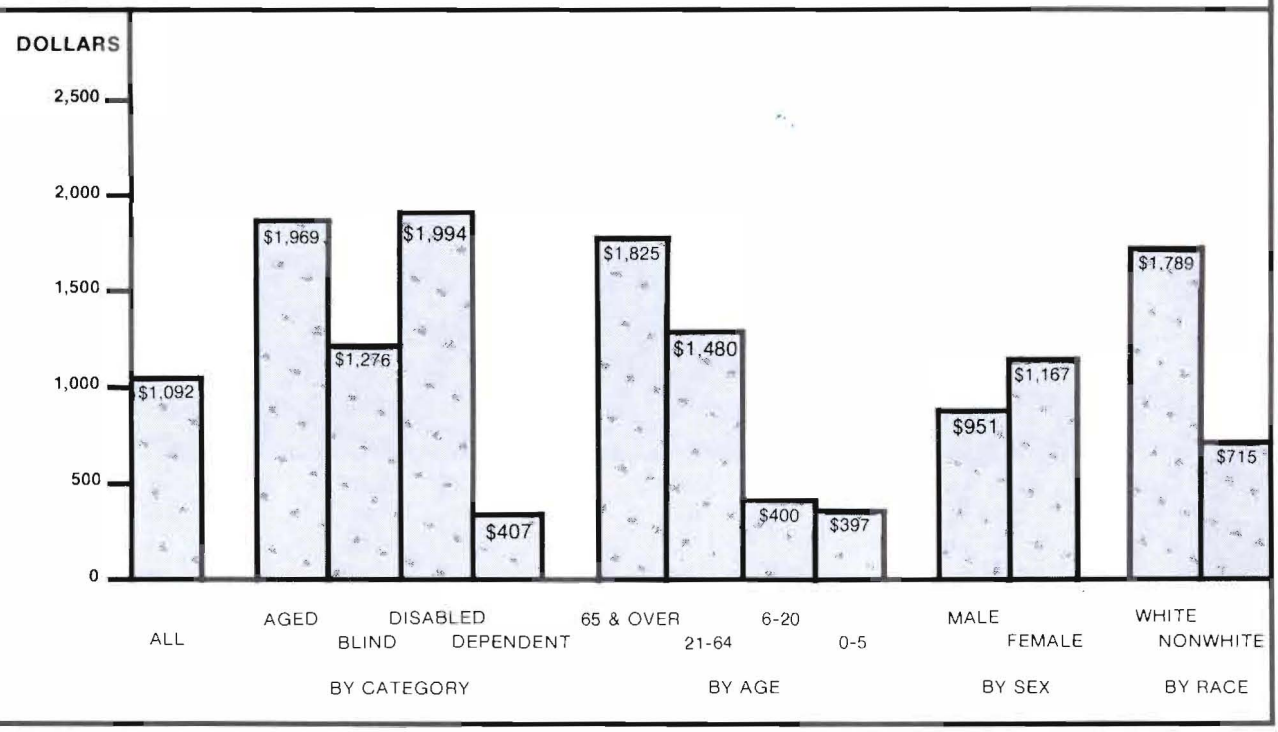
Table - 28



Cost Per Eligible

FY '86
COST PER ELIGIBLE
By category, age, sex, and race

Table - 29



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 payment for a day of intermediate nursing care in FY '86 was about $26. The average length of stay for recipients of this service was 272 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 Table 30 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 percent 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

FY '86
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††
Section 1 Year's Cost	All Categories	$37,762,868	$6,859,413	$80,157,879	$13,006,467	$98,068	$29,408,697	$40,788,404	$11,092,286
	Aged	4,017,384	405,200	9,999,582	606,908	18,088	13,430,816	19,395,580	7,156,078
	Blind	283,543	43,354	573,537	105,723	432	371,335	359,488	83,139
	Disabled	11,839,880	2,802,800	29,870,286	5,540,240	20,402	15,576,622	16,602,608	3,843,080
	Dependent Children	9,980,149	1,431,969	18,260,407	3,821,632	35,399	6,264	1,788,281	8,625
	Dependent Adults	11,641,912	2,176,090	21,454,067	2,931,964	23,747	23,660	2,642,447	1,364
Section 2 Year's Total Number of Recipients	All Categories***	250,058	121,433	57,323	102,082	1,619	9,271	231,139	3,594
	Aged	61,655	25,108	15,100	12,976	351	4,428	69,808	3,174
	Blind	1,433	742	337	589	10	119	1,468	16
	Disabled	59,180	33,472	16,468	25,083	292	4,712	59,084	792
	Dependent Children	88,518	35,538	11,761	41,249	648	35	66,766	5
	Dependent Adults	46,424	28,426	14,195	23,343	333	71	39,833	2
Section 3 Year's Cost Per Recipient	All Categories	$151	$56	$1,398	$127	$61	$3,172	$176	$3,086
	Aged	65	16	662	47	52	3,033	278	2,255
	Blind	198	58	1,702	179	43	3,120	245	5,196
	Disabled	200	84	1,814	221	70	3,306	281	4,852
	Dependent Children	113	40	1,553	93	55	179	27	1,725
	Dependent Adults	251	77	1,511	126	71	333	66	682
Section 4 Utilization Rates Percent of Eligibles	All Categories	66.69%	32.39%	15.29%	27.23%	0.43%	2.47%	61.64%	0.96%
	Aged	76.02%	30.96%	18.62%	16.00%	0.43%	5.46%	86.08%	3.91%
	Blind	72.48%	37.53%	17.05%	29.79%	0.51%	6.02%	74.25%	0.81%
	Disabled	72.99%	41.28%	20.31%	30.94%	0.36%	5.81%	72.87%	0.98%
	Dependent	64.02%	30.34%	12.31%	30.64%	0.47%	0.05%	50.57%	****

† As of April 11, 1986, Alabama's Medicaid Program ceased coverage of the deductible and coinsurance associated with a Medicare hospital stay.

†† A small part of the cost of skilled care is paid by Medicare

* Not Available

** Another $19,511,824 in buy-in premiums was paid for Medicare Part B coverage.

*** Unduplicated count

**** Less than 0.01 percent

made by Medicare is not reflected in Section 1 of Table 30.

For this coverage, Medicaid paid a monthly "buy-in fee" to Medicare. In FY ' 86, this fee was $15.50 per month. Medicaid's total bill for this buy-in fee was $19.5 million. This is less than Medicare spent for the partial payment of medical bills incurred by Medicaid - Medicare eligibles in Alabama.

Table - 30

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
$123,107,681	$51,865,695	$3,644,697	$3,492,047	$1,677,103	$2,153,727	$1,012,326	$3,502,460	$271,745,123	$137,884,695	$409,629,818
99,141,044	4,338,102	205	0	473,961	598,644	0	86,210	144,620,640	15,047,162	159,667,802
616,039	39,317	2,996	7,767	6,638	21,336	783	7,357	1,516,195	1,006,589	2,522,784
23,347,627	47,488,276	198,205	406,183	479,496	1,020,451	31,726	2,620,892	111,615,166	50,073,608	161,688,774
0	0	3,436,439	268,640	408,677	282,917	979,277	456,097	7,635,217	33,529,556	41,164,773
2,971	0	6,852	2,809,457	308,331	230,379	540	331,904	6,357,905	38,227,780	44,585,685
17,398	1,732	37,431	24,621	36,932	44,436	34,383	9,150	N/A*	N/A*	316,411
17,556	385	59	0	10,177	16,895	0	271	N/A*	N/A*	82,221
66	1	36	47	140	307	27	38	N/A*	N/A*	1,718
3,033	1,465	2,180	1,789	10,204	14,709	1,093	6,035	N/A*	N/A*	71,966
0	0	35,177	5,256	9,476	6,955	33,285	1,750	N/A*	N/A*	119,568
4	0	178	18,581	6,987	5,922	20	1,206	N/A*	N/A*	56,142
$7,076	$29,946	$97	$142	$45	$48	$29	$383	N/A*	N/A*	$1,295
5,647	11,268	3	0	47	35	0	318	N/A*	N/A*	1,942
9,334	39,317	83	165	47	69	29	194	N/A*	N/A*	1,468
7,698	32,415	91	227	47	69	29	434	N/A*	N/A*	2,247
0	0	98	51	43	41	29	261	N/A*	N/A*	344
743	0	38	151	44	39	27	275	N/A*	N/A*	794
4.64%	0.46%	9.98%	6.57%	9.85%	11.85%	9.17%	2.44%	N/A*	N/A*	84.39%
21.65%	0.47%	0.07%	0.00%	12.55%	20.83%	0.00%	0.33%	N/A*	N/A*	N/A*
3.34%	0.05%	1.82%	2.38%	7.08%	15.53%	1.37%	1.92%	N/A*	N/A*	86.90%
3.74%	1.81%	2.69%	2.21%	12.58%	18.14%	1.35%	7.44%	N/A*	N/A*	88.76%
****	0.00%	16.77%	11.31%	7.81%	6.11%	15.80%	1.40%	N/A*	N/A*	83.36%

COMMUNITY SERVICES

Community services administered by the Alabama Medicaid Agency include programs that prevent institutionalization of the mentally retarded, the elderly and disabled. Services for mentally ill or emotionally disturbed people are provided by Medicaid through community mental health centers. Community services also encompass a growing emphasis on preventive health to reduce costs over the long term and to contribute to a better health status for all Alabamians.

Home and Community-Based Waivers

Like many 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.

Alabama's waiver for the mentally retarded and developmentally disabled was renewed for a second three-year period at the beginning of FY '86. The habilitative services provided to Medicaid-eligible mentally retarded people under the waiver teach recipients basic living skills that enable them to live more independently. The services, provided by the Department of Mental Health and Mental Retardation, can prevent needless institutionalization and give 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 almost $30,000 a year. During FY '86, about $7 million was spent to provide habilitation services to 1,568 community clients. Mental Health and Mental Retardation provided the state's share of the funding.

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 case management, homemaker services, personal care, adult day health, and respite care.

The program has expanded greatly since its beginning, with all services becoming available statewide in FY '86. More than 3,600 people were served under this waiver during the year. The current waiver for the elderly and disabled is scheduled to end on September 30, 1987, but, with federal approval, it can be extended for another five years.

People receiving services through Medicaid waivers have to meet certain eligibility requirements. Those served by the waiver for the elderly and disabled are recipients of Supplemental Security Income or State Supplementation who meet the medical criteria for nursing home care paid for by the Medicaid program. Providers of services to this group include the Alabama Department of Human Resources, which delivers services through its 67 county offices, and the Alabama Commission on Aging, which contracts with Area Agencies on Aging to deliver services.

Mental Health Services Program

Through mental health centers under contract with the Department of Mental Health and Mental Retardation, Medicaid provides services for eligible mentally ill and emotionally disturbed people. These services include day treatment, medication check, diagnostic assessment, pre-hospitalization screening and psychotherapy for individuals, groups and families. The program serves people with a primary psychiatric diagnosis. There are 23 mental health centers around the state providing these services. During FY '86, about $3.5 million was spent to provide services to almost 10,000 clients.

Preventive Health Services

During FY '86, a Preventive Health Services Unit was created by the Medicaid Agency in response to recommendations of the Medicaid Task Force on Preventive Medicine, which was renamed the Advisory Council on Preventive Health. The Advisory Council hosted a Legislative Fitness Day in 1986, offering legislators detailed health assessments and medical tests at a health fair hosted at the Alabama State House. The health fair was very well attended by both legislators and their executive staffs.

The Medicaid Agency plans to sponsor a conference on preventive medicine and health promotion featuring well known speakers in the preventive medicine field and workshops detailing the many extensive preventive health efforts currently being made in Alabama. In addition, the Agency has launched a Worksite Health Promotion Project to promote better health among Medicaid employees. Alabama Medicaid will continue to support preventive health initiatives across the state, such as implementation of a health curriculum in the schools, support of the Coalition for Tobacco-Free Alabama, and regular fitness testing for young people.

RURAL HEALTH CLINICS

The Medicaid Rural Health Program was implemented April 1, 1978. Services covered under the Rural Health Clinic Progam include any medical service typically furnished by a physician in an office or in a physician home visit. Limits are the same as for the Physician Program.

Rural health clinic services, whether performed by a physician, nurse practitioner, or physician assistant, are reimbursable. A physician, nurse practitioner, or physician assistant is available to furnish patient care service at all times the clinic operates. A nurse practitioner or physician assistant is available to furnish patient care service at least 60 percent of the time the clinic operates.

Rural Health Clinics are reimbursed at the reasonable cost rate per visit (encounter) established for the clinic by the Medicare fiscal intermediary.

RENAL DIALYSIS PROGRAM

The Medicaid Renal Dialysis Program was implemented in 1973. At that time, the agency purchased six renal dialysis machines which were leased to the University of Alabama in Birmingham. In 1976, ownership of the dialysis machines was transferred to UAB, and enrollment of providers had increased to 26 by FY '86 (24 free-standing facilities and two hospitals). The following is a listing of covered dialysis procedures:

- —self-care dialysis in-facility,
- —maintenance hemodialysis with routine laboratory,
- —self-care dialysis training with routine laboratory, and
- —medically necessary non-routine drugs and biologicals.

Although the Medicaid Renal Dialysis Program is relatively small, it is a lifesaving service without which many recipients could not survive.

LONG-TERM CARE

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, resulting in larger numbers of people in older age categories,
- —medical and technological advances that extended the lives of persons with chronic medical conditions, such as cardiovascular diseases, and
- —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 '86 only 17 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 implementation of home- and community-based services to prevent institutionalization, the continued application of medical criteria to insure that Medicaid nursing home paitents have genuine medical needs requiring professional nursing care, and a management information system that makes timely and accurate financial eligibility decisions possible.

FY '84-'86 **Table - 31**
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
1984	20,949	247 Days	5,178,233	$25	$128,587,343
1985	20,741	243 Days	5,049,419	27	133,914,679
1986	20,992	242 Days	5,081,436	26	134,199,967

Table - 32

FY '84-'86
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
1984	21,349	13,611	20,949	63.8%	7,738
1985	21,776	13,715	20,741	63.0%	8,061
1986	22,211	13,809	20,992	62.2%	8,402

Moratorium on Certificates of Need

On August 1, 1984, Governor George C. 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 October 27, 1986, the moratorium on the construction of new nursing home beds was extended until November 1, 1987.

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 to alter this position. The use of nursing home beds by Medicaid patients declined between FY '82 and '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 an average day.

In 1986, the statewide nursing home occupancy rate was 94.6 percent. 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.

Table - 33

FY '86
LONG-TERM CARE PROGRAM
Payments by sex, race, and age

	Skilled	Intermediate	Total	Percent
All Recipients	$11,092,286	$123,107,681	$134,199,967	100.0%
By Sex				
Female	7,820,721	94,250,883	102,071,604	76.1%
Male	3,271,565	28,856,798	32,128,363	23.9%
By Race				
White	6,981,685	97,028,497	104,010,182	77.5%
Nonwhite	4,110,601	26,079,184	30,189,785	22.5%
By Age				
65 & Over	7,560,651	106,290,427	113,851,078	84.8%
21-64	1,728,840	15,785,821	17,514,661	13.1%
6-20	1,073,232	994,277	2,067,509	1.5%
0-5	729,563	37,156	766,719	0.6%

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 certificate of need 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 home and community-based services for the elderly and disabled, and the granting of CON's 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.

In 1983, the State Board of Public 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 123 and the number of domiciliary beds at the end of CY '86 was 2,512. 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.

Table - 34

FY '86
LONG-TERM CARE PROGRAM
Recepients by sex, race, and age

	Skilled	Intermediate	Total	Percent
All Recipients	3,594	17,398	20,992	100.0%
By Sex				
Female	2,579	13,092	15,671	74.7%
Male	1,015	4,306	5,321	25.3%
By Race				
White	2,413	13,955	16,368	78.0%
Nonwhite	1,181	3,443	4,624	22.0%
By Age				
65 & Over	2,979	15,355	18,334	87.3%
21-64	462	1,942	2,404	11.5%
6-20	96	94	190	0.9%
0-5	57	7	64	0.3%

A Medicaid program that is an alternative to institutional care is the home and community-based waiver for the elderly and disabled. Care is furnished in the person's home to foster independence and to take into account the specific needs of the recipient. Services include case management, adult day health care, respite care, homemaker services, and personal care. Certain persons who qualify for Medicaid nursing home care have the opportunity to receive these services instead of entering an institution.

During 1985, the State Health Planning Agency began granting CON's 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 is expected to reduce future needs for an increase of nursing home beds in the state.

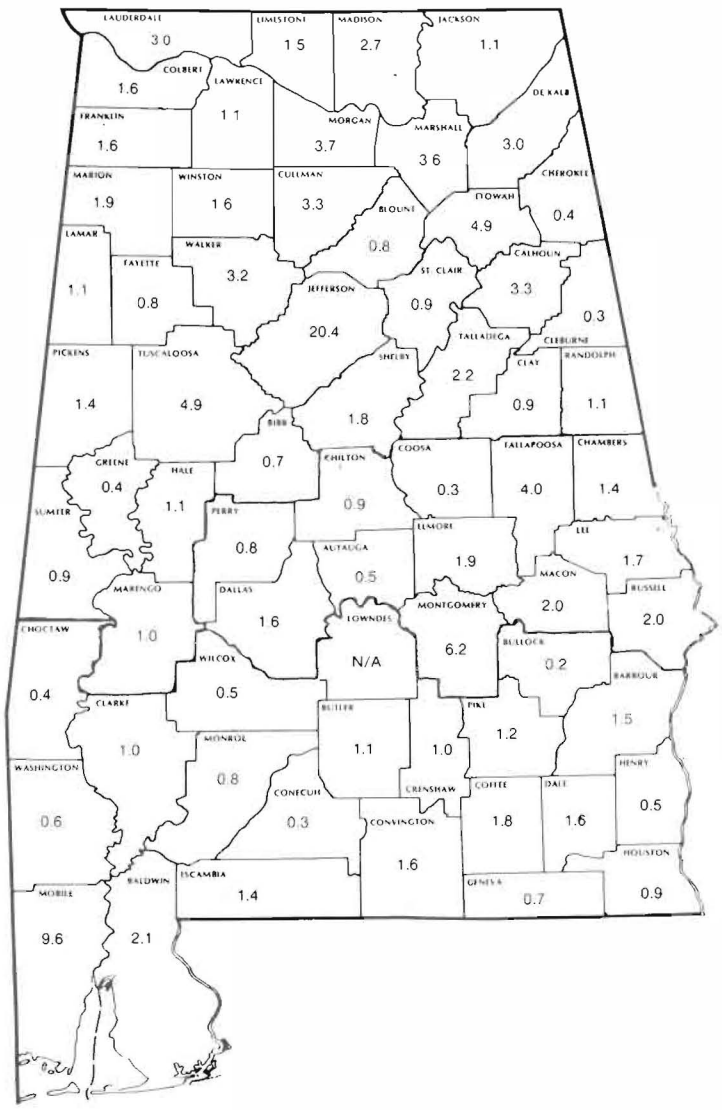
Nursing Home Reimbursement

Alabama uses a Uniform Cost Report (UCR) to establish a Medicaid payment rate for a facility. The cost report takes into consideration the nursing facility plant, financing arrangements, staffing, management proced-

ures, 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 '86 was $852.90 a month. All personal income above $25.00 a month, with the exception of insurance premiums, must be applied by the patient to reduce the monthly charge to Medicaid for nursing home care.

FY '86 **Table - 36**
PAYMENTS TO NURSING HOMES
By county (in millions of dollars)



FY '84-'86 **Table - 35**
LONG-TERM CARE PROGRAM
Number of Recipients

	Skilled			Intermediate			Total		
	FY '84	FY '85	FY '86	FY '84	FY '85	FY '86	FY '84	FY '85	FY '86
Monthly Average	1,065	1,048	1,115	12,546	12,668	12,694	13,611	13,715	13,809
Yearly Total	3,743	3,386	3,594	17,206	17,355	17,398	20,949	20,741	20,992
Average Length of Stay	97 Days	98 Days	98 Days	280 Days	271 Days	272 Days	247 Days	243 Days	242 Days

LONG-TERM CARE MENTAL HEALTH

The Alabama Medicaid Agency negotiated agreements with the State Department of Mental Health and Mental Retardation to include coverage for mentally retarded Medicaid eligibles requiring intermediate residential care in 1977, and for coverage of intermediate care for 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 that includes training and habilitative services intended to aid the intellectual, sensorimotor, and emotional development of residents.

Facilities in which intermediate care for the mentally retarded are provided include the Albert P. Brewer Developmental Center in Mobile, the J.S. Tarwater Developmental Center in Wetumpka, the Lurleen B. Wallace Developmental Center in Decatur, Partlow State School and Hospital in Tuscaloosa, and the Glenn Ireland II Developmental Center near Birmingham. With the opening of the Ireland Center in FY '86, the Department of Mental Health and Mental Retardation began phasing out the Partlow facility, which is expected to close eventually. In addition to contributing the federal share of money for care in these large residential facilities, Medicaid also covers intermediate care of mentally retarded residents in several small facilites of 15 or fewer beds. Institutional care for the mentally diseased is provided through Alice Kidd Intermediate Care Facility in Tuscaloosa and S.D. Allen Intermediate Care Facility in Northport.

Table - 37

FY '85-'86
LONG-TERM CARE PROGRAM
ICF-MR/MD

	FY '85	FY '86
Recipients	1,722	1,732
Total Payments	$51,363,313	$51,865,695
Average Annual Cost Per Recipient	$29,828	$29,946
Average Monthly Recipients	1,530	1,560
Average Monthly Cost per Recipient	$2,798	$2,771

Payments for long-term mental health and mental retardation programs have increased dramatically, from less than $2 million in FY '79 to more than $50 million annually in recent years. In FY '86, the average per diem rate in an institution serving the mentally retarded was approximately $115.

In terms of total Medicaid dollars expended and the average monthly payment per patient, intermediate care for the mentally retarded and the mentally diseased is extremely costly. However, provision of this care through Medicaid is saving the taxpayers of Alabama millions of state dollars. These patients are receiving services in state-operated mental health institutions. If the Medicaid program did not cover the services provided to these patients, the Alabama Department of Mental Health and Mental Retardation would be responsible for the total funding of this care entirely out of its state appropriation. Through its relationship with the Alabama Medicaid Agency, DMH/MR is able to match every 28 state dollars with 72 federal dollars for the care of Medicaid-eligible patients.

A home and community-based program for the mentally retarded was implemented by the Alabama Medicaid Agency and the Department of Mental Health and Mental Retardation in FY '83. This program is in accordance with Medicaid's stated policy of using 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. Services offered 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.

HOME HEALTH AND DME

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 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 these:

- —Home health agencies must have contracts with the Medicaid Agency. There were 101 agencies participating in FY '86.
- —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 370 certifications and 950 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 '86, an average of 1,660 recipients a month received a total of 183,126 visits at a cost of almost $5 million.

The Supplies, Appliances, and Durable Medical Equipment (DME) Program is a mandatory benefit under the Home Health Program. Medicaid recipients do not have to receive home health services to qualify for the DME program, but all items must be medically necessary and suitable for use in the home. During the fiscal year, Medicaid Supplies, Appliances, and DME providers throughout the state furnished 127,310 units of service at a cost of just over $500,000.

Table - 38

FY '85-'86
HOME HEALTH PROGRAM
Use and Cost of Home Health Care Compared to Nursing Home Care

	Average Number of Recipients Per Month		Average Monthly Cost Per Recipient	
Year	Home Health	Nursing Home	Home Health	Nursing Home
1985	1,436	13,715	$219	$814
1986	1,660	13,809	$245	$810

HOSPITAL PROGRAM

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 128 Alabama hospitals that participate in the Medicaid program, and 37 hospitals in 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, 1985, these rates ranged up to $568 a day. The average per diem rate was $311.

During FY '86, a Medicaid-only cost report was implemented. This cost report is used to determine a hospital's per diem rate. The new report should simplify cost-reporting procedures for hospitals participating in the Medicaid program. Formerly, a hospital's Medicaid per diem rate was based on data from its Medicare cost report.

Use and Cost

Table 39 shows that payments for inpatient hospital services went up in FY '86, while the number of recipients of this service decreased slightly. Factors influencing payments for hospital inpatients in FY '86 were fewer recipients, more 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 performing increasingly sophisticated medical procedures in physicians' offices and in hospital outpatient settings.

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. Limitations on outpatient visits have lessened the problem of abuse, but the number of outpatient visits is on the increase because of the trend toward performing more and more procedures on an outpatient basis. On September 1, 1986, the Alabama Medicaid Agency changed the reimbursement methodology for outpatient services from a percentage of billing to procedure code specific billing.

Table - 39

FY '84-'86
HOSPITAL PROGRAM
Changes in use and cost

Year	Eligibles	Recipients of Inpatient Care	Payments for Inpatient	Medicaid's Annual Cost Per Recipient
1984	385,379	63,811	$74,085,082	$1,161
1985	380,513	58,095	73,847,525	1,271
1986	374,953	57,323	80,157,879	1,398

FY '82-'86
HOSPITAL PROGRAM
Outpatients

Table - 40

	FY '82	FY '83	FY '84	FY '85	FY '86
Number of outpatients	112,333	110,196	108,085	91,848	102,082
Percent of eligibles using outpatient service	28%	29%	28%	24%	27%
Annual expenditure for outpatient care	$12,655,314	$13,813,699	$12,815,220	$10,186,983	$13,006,467
Cost per patient	$113	$125	$119	$111	$127

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.

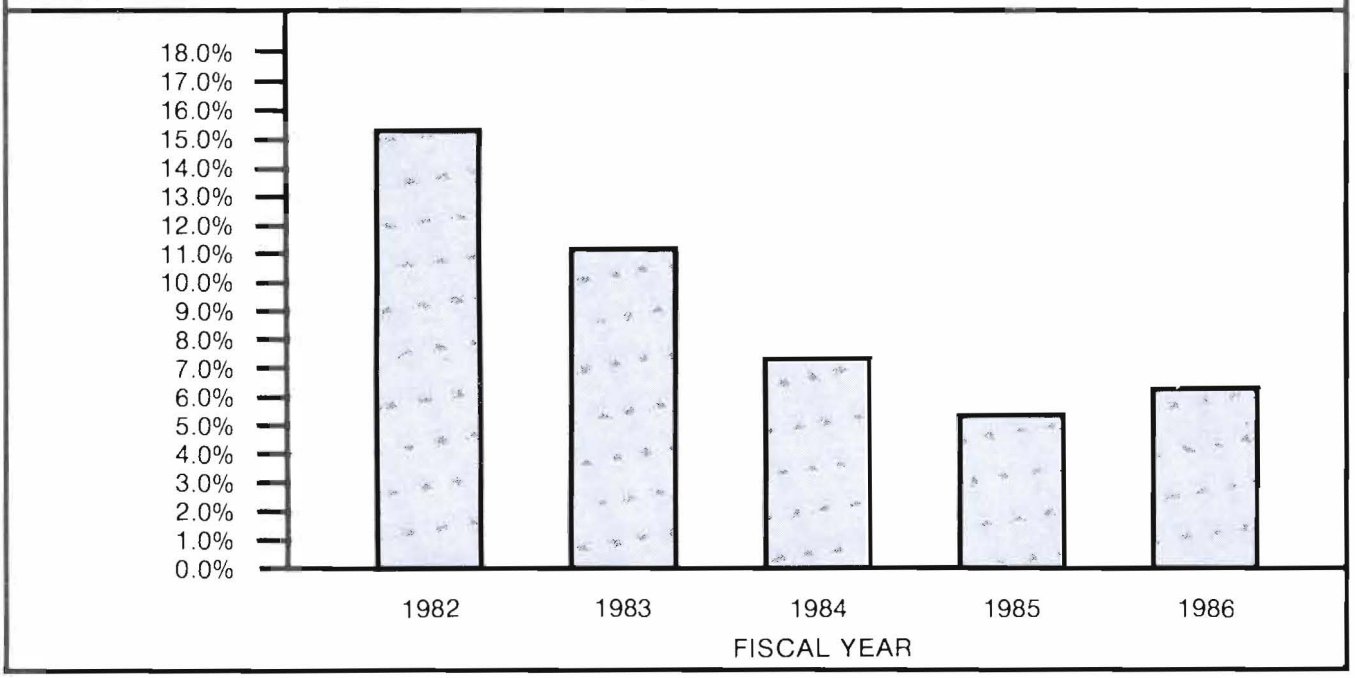
Limitations on hospital services were in effect during FY '86. The purpose of these limitations is to control the overuse of Medicaid services. Inpatient hospital days are limited to 12 days per calendar year. However, an exception is made for seriously ill children. After these children exhaust their 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 three outpatient visits per eligible during a calendar year. Exceptions are made for certified emergencies, renal dialysis, chemotherapy, and radiation therapy.

Most Medicaid hospital patients are 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. (However, a recipient discharged from the nursing home and admitted to the hospital must pay the $50 inpatient copayment.) A provider may not deny service to a Medicaid eligible due to the recipient's inability to pay the copayment.

FY '86
ANNUAL PERCENT CHANGE
Hospital room cost from the consumer price index

Table - 41

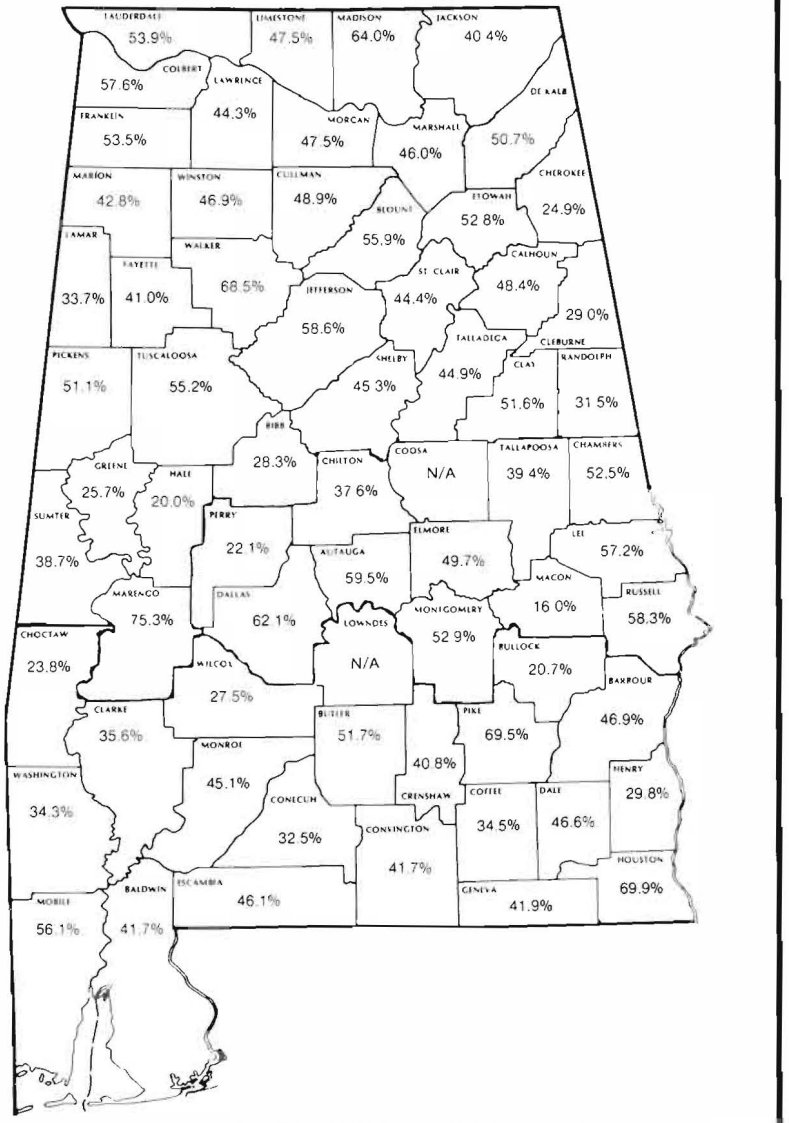


FY '86
PAYMENTS TO HOSPITALS
By county (in thousands of dollars)

Table - 42

HOSPITAL OCCUPANCY RATE (%)
As of September 30,1985

Table - 43



FAMILY PLANNING

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 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 their 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.

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 still 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 the 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 sterilizations 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 cases 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 informed consent was given 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 state and federal law, Medicaid will pay for abortions only when 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. Prenatal services available to Medicaid eligibles are through county health departments and other Medicaid providers. Timely care can reduce the possibility of premature, underweight babies.

Medicaid prenatal care is provided not only through health departments but also through private physicians, hospitals, and clinics. Examinations include complete histories and physical examinations, lab tests, and pap smears.

PHYSICIAN PROGRAM

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. Service to eligibles is based on medical necessity, and physicians 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. The majority of licensed physicians in Alabama participate in the Medicaid program. More than three-fourths of Alabama's Medicaid recipients received physicians' services last year.

Recipients visiting a physician are required to pay a $1 copayment 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.

Although not limited to services performed by a physician, care for Medicaid eligibles furnished by Crippled Children Service is billed through the Physician Program. Crippled Children Service can submit claims for covered services in Medicaid's State Plan. About $230,000 was paid by Medicaid to Crippled Children Service for services provided to 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, or MediKids, program must sign an agreement limiting charges for screening children. Also, nurse-midwives are required

Table - 44

PHYSICIAN PROGRAM
Use and Cost

	Payments	Recipients	Cost Per Recipient	Percent of Eligibles Treated by a Physician
Aged	$4,017,384	61,655	$65	76.0%
Blind	283,543	1,433	198	72.5%
Disabled	11,839,880	59,180	200	73.0%
Dependent	21,622,061	134,942	160	64.0%
All Categories	37,762,868	250,058	151	66.7%

to sign contracts in order to participate in the Medicaid program. For other types of physicians' services, the submitted claim is considered a contract.

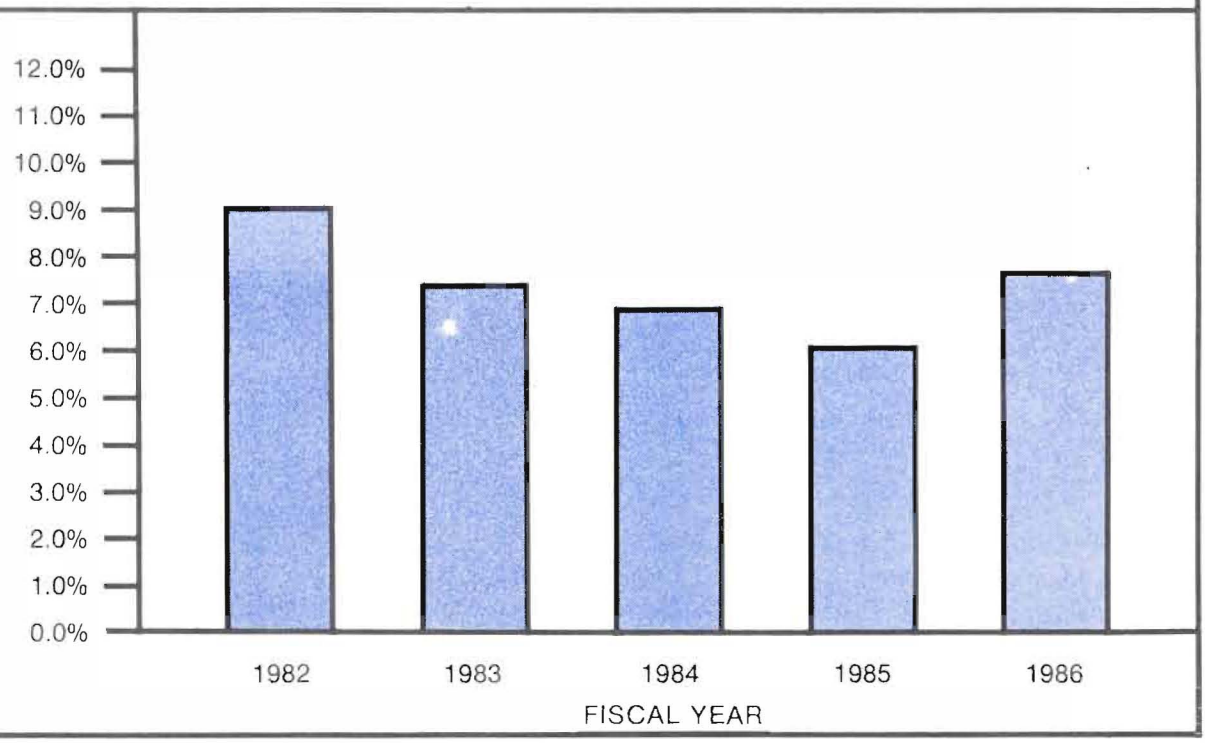
In general, the per capita cost of Medicaid services to the aged is higher than for other categories of recipients. One reason is that older people are more likely to have health problems. However, Medicaid physicians' care costs for the aged are lower than for most categories. This is because about 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 '86
ACTIVE LICENSED PHYSICIANS
as of December 31, 1985
By county

Table - 45

FY '82 - '86
ANNUAL PERCENT CHANGES
Physician services cost from the consumer price index

Table - 46



PHARMACEUTICAL PROGRAM

Although the Pharmaceutical Program is an optional service under federal Medicaid rules, it is vital to the overall 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 represents 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 $40.8 million for prescriptions dispensed to over half of all Medicaid eligibles. This expenditure represents just over nine 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. On October 1, 1985, the dispensing fee increased from $3 to $3.25 per prescription.

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 depending on drug ingredient cost. In addition, prescribing physicians are limited to the 8,000 drugs listed on the Alabama Drug Code Index. On October 1, 1986, the Thirteenth Edition of the index went into effect; the index consists of approximately 70 percent generic drugs. However, every effort is made to avoid restricting a physician's choice of drugs.

Table - 47

FY '86
PHARMACEUTICAL PROGRAM
Counts of providers by type

Type of Provider	Number
In-State Retail Pharmacies	1,220
Institutional Pharmacies	37
Dispensing Physicians	2
Out-of-State Pharmacies	42
Health Centers and Clinics	3
TOTAL	1,304

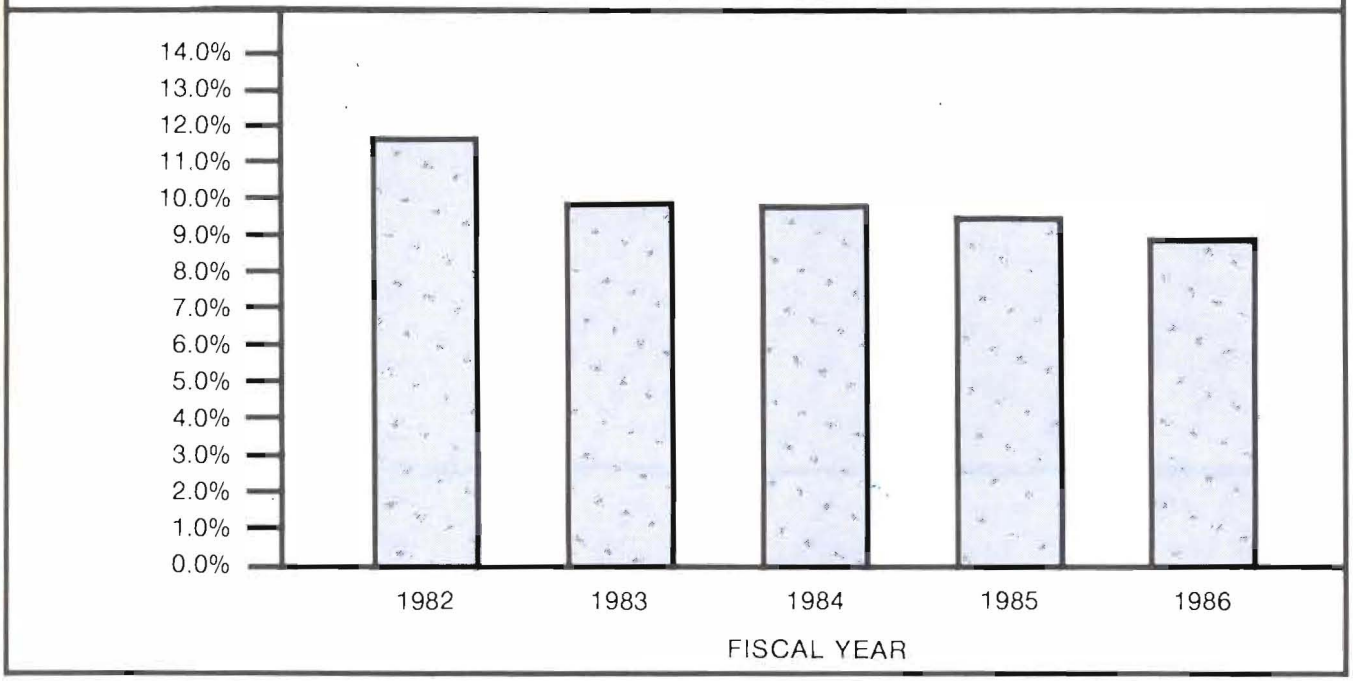
Table - 48

FY '84-'86
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
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
1986	231,139	62%	3,537,798	15.31	11.53	176.47	40,788,404

FY '82 - '86
ANNUAL PERCENT CHANGE
Prescription drug cost from the consumer price index

Table - 49



AMBULATORY SURGICAL CENTER SERVICES

Toward the end of FY '86, Medicaid began coverage of ambulatory surgical services, which are procedures typically performed on an inpatient basis but which can be performed safely on an outpatient or ambulatory surgical center basis. ASC services are reimbursed by means of a predetermined fee established by the Alabama Medicaid Agency. Services are limited to three visits per calendar year, with payments made only for procedures on Medicaid's approved list.

Ambulatory surgical center services include but are not limited to:

- —nursing, technician and related services,
- —use of an ambulatory surgery center,
- —lab and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure,
- —diagnostic or therapeutic services or items directly related to the provision of a surgical procedure,
- —administrative, record keeping, and housekeeping items and services, and
- —materials for anesthesia.

Ambulatory surgical center services do not include items and services for which payment may be made under other provisions. Ambulatory surgical center services do not include:

- —physician services,
- —lab and x-ray services not directly related to the surgical procedure,
- —diagnostic procedures (other than those directly related to performance of the surgical procedure),
- —prosthetic devices (lens implant),
- —ambulance services,
- —leg, arm, back, and neck braces,
- —artificial limbs, or
- —durable medical equipment for use in the patient's home.

A listing of covered surgical procedures is maintained by the Medicaid Agency and furnished to all ASC's. This list is reviewed and updated on a regular basis by Medicaid.

EPSDT PROGRAM - MEDIKIDS

The Early and Periodic Screening Diagnosis and Treatment Program, renamed MediKids in FY '86, 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 MediKids is funded by Medicaid, the program's operation requires the cooperation of the State Department of Human Resources and the State Department of Public Health. MediKids eligibles are persons under 21 who receive assistance through the Aid to Dependent Children or Supplemental Security Income programs. Human Resources workers normally determine ADC eligibility, make families aware of MediKids, and refer eligibles to providers. Providers of MediKids services include county health departments, community health centers, Head Start centers, child development centers and about 125 private physicians. An extensive physician recruitment campaign conducted in FY '86 succeeded in adding a large number of physicians to the program. 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 MediKids is that the program is under-used. Screening is not mandatory for eligibles, and many mothers do not seek health care for their children until the children show symptoms of illness. Medicaid has taken steps to increase the screening rate through increased publicity of the MediKids program, implementation of an outreach project in Montgomery and three nearby counties, the physician recruitment effort, an increase in the rate paid to physicians for screening and an increase in the number of screenings for which Medicaid will pay. About 20 percent of those eligible for MediKids were screened in FY '86, as opposed to a screening rate of 18 percent in FY '85.

A Medicaid goal is to screen eligibles at ten intervals between birth and age 21. During FY '86, about two thirds of 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 $29 per recipient. The cost of treating

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FY '85-'86
DENTAL PROGRAM
Recipients by sex and age

	FY '85	FY '86
Total	43,546	37,431
Male	19,867	17,950
Female	23,679	19,481
Age 0-5	13,097	12,022
Age 6-20	30,449	25,409

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FY '85-'86
EPSDT PROGRAM
Eligibles, recipients, by age payments

	FY '85	FY '86
TOTAL ELIGIBLES FOR EPSDT PROGRAM	169,658	151,245
Age:		
0-5	63,356	62,001
6-20*	106,302	89,244
RECIPIENTS OF SCREENING	28,272	34,383
Age:		
0-5	15,296	19,848
6-20*	12,976	14,535
TOTAL PAYMENTS FOR SCREENING	$785,808	$1,012,326
AVERAGE PAYMENT PER RECIPIENT	$27	$29

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

illness is usually considerably higher.

The Medicaid Dental Program is administered as part of the MediKids program. With some exceptions, dental care is available only to MediKids 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 '86, more than 37,000 persons received dental treatment at a cost of $3.6 million to the Medicaid program.

LABORATORY AND RADIOLOGY PROGRAM

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 conjunction 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, and
—hospital-based laboratory and x-ray facilities.

FY '85-'86
LAB AND X-RAY PROGRAM
Use and Cost

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Year	Recipients	Payments	Annual Cost per Recipient
1985	115,915	$6,154,911	$53
1986	121,433	6,859,413	56

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 must apply for provider numbers from Alacaid, Medicaid's fiscal agent.

OPTOMETRIC PROGRAM

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 or post cataract surgery. Included in this service is the fitting of the lenses and supervision of adaptation. Other optometric services provided when medically necessary and requiring 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. Available frames include styles for men, women, teens, and pre-teens.

FY '86
OPTOMETRIC PROGRAM
Use and Cost

Table - 53

Type of Provider	Average Monthly Recipients	Payments
Dispensing Optician	2,652	$ 684,917
Optometrist	3,370	1,677,101
Ophthalmologist	2,240	1,372,460
TOTAL	8,262	3,734,478