— 1990 Annual Report —

THE ALABAMA MEDICAID AGENCY

Guy Hunt
Governor
State of Alabama

Carol A. Herrmann
Commissioner
Alabama Medicaid Agency

ALABAMA MEDICAID AGENCY
FY 1990 ANNUAL REPORT
OCTOBER 1, 1989 - SEPTEMBER 30, 1990

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

GUY HUNT
Governor

CAROL A. HERRMANN
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 18th Annual Report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1989, and ended September 30, 1990.

During the year, a little over 356,000 Alabamians received health care services financed by the Medicaid Agency. Among those who depend on Medicaid to meet their health care needs are low-income pregnant women and their young children, as well as low-income elderly and disabled people in their own homes and in nursing homes. Providing health care services for all eligible recipients cost $217.9 million in total state funds, with the federal government providing almost $585.6 million in fiscal year 1990.

Many positive and productive changes in Alabama's Medicaid program have been accomplished this year. Concerned groups, both in government and in the private sector, have joined forces and have shared a common goal of providing much needed health care to low income Alabamians. We continued to progress in all areas of the program, but especially in the area of maternal and child health. We expanded eligibility, and broadened and improved services provided to that group. Although we have not yet seen a significant decrease in the infant mortality rate, which has remained at 12.1 deaths per 1,000 live births, we are encouraged that our initiatives are working and that we will soon see a positive effect in the rate.

With our operating budget increasing yearly, we have successfully secured alternative funding for the Agency in order to save the state valuable dollars. We are committed to making the wisest use of every state dollar in order to provide needed services to the greatest number of people at the most affordable cost to the state.

Your understanding of the needs of Alabama's most vulnerable citizens—the very young and the elderly—is commendable. The Medicaid Agency appreciates your support of our efforts. This Agency looks forward to the continued cooperation among this administration, the Medicaid provider community, and the people of this state. With cooperation, we can assure the Medicaid Agency manages its limited resources in such a manner as to afford adequate and appropriate health care services to as many needy Alabamians as possible.

Sincerely,

Carol A. Herrmann

Carol A. Herrmann
Commissioner

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HIGHLIGHTS OF THE 1990 FISCAL YEAR

Introduction

During the year, Medicaid continued improving services available through the Agency to the low income citizens in this state. With careful planning and the wisest use of every available state dollar, the Medicaid Agency was able to improve or expand existing services or introduce new services to the program.

Medicaid recipients and providers will benefit from the improvements made in the program during FY 1990. Hospital inpatient days and inpatient doctor visits were both increased from 12 to 14 days per calendar year; and reimbursement for three outpatient emergency room codes was increased.

One area that saw expansion was the Maternity Waiver Program, which was developed in four additional counties in FY 1990. Houston and Henry counties were added in December 1989, with the Houston County Health Department being the primary provider. Calhoun County also was added in December and is served by the Northeast Alabama Regional Medical Center. Mobile County was added in February 1990, and is served by the University of South Alabama Medical Center. Statewide expansion of the program is planned.

The waiver has shown to be very effective in reducing the number of neonatal intensive care admissions and also reducing the number of hospital readmissions during the first year of life for infants in the areas served by the program. The 1989 infant mortality statistics show a lower infant mortality rate during the first 28 days of life in counties where the waiver is operating.

Nursing home residents also benefitted from action taken by Medicaid during FY 1990. In January 1990, as in January of 1989 and 1988, the income limit for Medicaid eligible nursing home residents was increased, saving 111 people from becoming ineligible due to yearly cost of living adjustments. The income limit was raised from $950 to $1,000 a month.

In 1990, Governor Hunt lifted a moratorium on hospital and nursing home construction that was imposed during Governor Wallace's last term. Upon lifting the moratorium, Governor Hunt also approved construction of 440 new nursing home beds statewide, with approximately 500 additional beds being approved for construction at a later date. Roughly $9 million in state and federal Medicaid funds will be expended to provide services to the residents who will occupy the 440 new nursing home beds during the first year of operation.

Improvements in the Alabama Medicaid program and balancing the budget overall could not have been accomplished without an alternative to the traditional appropriation from the state legislature and continued cooperation with other state agencies that provide health care services to Medicaid beneficiaries. These programs have generated over $150 million in state resources.

During the year, the Governor's Task Force on Infant Mortality provided valuable guidance to the Governor and to the Medicaid Agency. Its membership, representing public and private organizations, educational and religious organizations and the state legislature, contributed significant knowledge and ideas from different areas of expertise.

Nursing Homes and Rural Hospitals Reimbursement Increased

The Alabama Medicaid Agency in May 1990 increased the reimbursement rate to nursing homes and rural hospitals. These increases will help to provide more health care services to low income people living in rural areas statewide.

The change in payments to nursing homes meant that 27 additional nursing in the state are paid at 100 percent of their allowable costs. Prior to the change, only 129 out of 204 nursing homes statewide were paid their full allowable costs. Allowable costs are the necessary expenses to run a facility such as equipment, supplies, personnel, etc.

Payments to rural hospitals were increased by eliminating the ceilings on their payments; thus all rural hospitals are now paid at 100 percent of allowable costs. At the same time, the low occupancy adjustment, which penalizes hospitals that fail to maintain a certain occupancy level, was removed. All of the state's 60 rural hospitals will benefit from elimination of the low occupancy adjustment. Thirty-four hospitals will see an increase in their Medicaid rates as a result of lifting the ceiling on payments.

The average rural hospital inpatient rate was increased from $439.70 to $477.79 per day, with the highest rate being approximately $1,000 per day.

Perinatal Appropriation from Public Health

As a result of a collaboration among the Medicaid Agency, the Department of Public Health, and the Alabama Perinatal Advisory Committee, the Department of Public Health's $2 million in annual perinatal funds is now being funneled through the Medicaid Agency for a three-to-one federal match. By matching the state appropriated funds to produce almost $8 million,

the Medicaid Agency has been able to improve services to pregnant women and young children.

With the additional funds, Medicaid raised the global fee for prenatal care and delivery to $1,000, the amount physicians have said would be needed to attract obstetricians back into practice and prevent others from leaving; began providing two very comprehensive assessments in the first year of life for every baby who has been in neonatal intensive care; raised by 45 percent the fees for nine specific critical care services provided by neonatologists and pediatricians; and doubled the fees neonatologists and pediatricians receive for attending high risk deliveries.

SOBRA Expansion

Eligibility for Medicaid was expanded in FY 1990 to pregnant women and children up to age six in families with incomes up to 133 percent of the federal proverty level, or a little more than $14,000 a year for a family of three. Previously, eligibility included pregnant women and children up to age one in families with incomes up to 100 percent of the federal poverty level, or less than $11,000 a year for a family of three. The expansion was federally mandated by the Omnibus Budget Reconciliation Act of 1989 and became effective on April 1, 1990.

The expanded eligibility group of women and children at 100 percent of the federal poverty level, then at 133 percent of the federal poverty level, allowed the Medicaid Agency to serve 21,882 additional pregnant women and 25,325 additional children during fiscal year 1990.

Pregnant women qualify for pregnancy-related services, including prenatal care, delivery and postpartum care for 60 days. Children up to age six qualify for all health care services available through Medicaid.

Iron Chelation Therapy

The Alabama Medicaid Agency began covering iron chelation therapy for patients with sickle cell disease in May of 1990. During the year, approximately 30 patients statewide, most of them children, were able to benefit from the coverage.

The therapy helps eliminate excess iron from the body, thus preventing severe future complications. Therapy of this type is a widely accepted method of treating iron overload which is a serious and common problem among people who have chronic blood transfusions like those with sickle cell disease. The projected annual cost for covering the therapy is $35,000.

Healthy Beginnings

August marked the beginning of a health awareness and incentive program for pregnant women statewide. The program, "Healthy Beginnings: Today's Investment, Tommorrow's Future," is designed to reduce the incidence of low birthweight and ultimately to help reduce the state's high infant mortality rate.

The program encourages expectant women to seek early and continous prenatal care and to maintain healthy lifestyles during pregnancy. A booklet containing health related information and coupons worth more than $300 is sent to each pregnant woman, regardless of income, who calls the program's toll-free hotline. The coupons, which offer free or substantially discounted items, are validated only after a woman visits her doctor or clinic for prenatal care. Businesses throughout the state contributed over $10.5 million to this initiative by donating coupons.

During the first full year of operation, approximately 30,000 pregnant women are projected to receive the booklets.

Physicians Task Force

The Physicians Task Force was formed by the Alabama Medicaid Agency in January, 1990, to improve the working relationship between physicians statewide and the Medicaid Agency. The Task Force was successful in implementing many recommendations throughout the year which helped to improve the Medicaid program and provided continual incentives for physicians to participate in Medicaid.

Recommendations for improvements were suggested during task force meetings and through a survey that was sent to all physicians statewide. Some of the improvements are: shortening the EPSDT form to reduce the amount of paperwork for physicians filing claims; allowing physicians to telephone prescriptions to pharmacists for non-controlled substances; extending the filing limit for physicians submitting claims from 180 days to 365 days; and assigning unborn babies Medicaid numbers.

The Alabama Council on Rural Health Care

The Alabama Council on Rural Health Care and the Office of Rural Health Care were created by Governor Guy Hunt to foster improvement of health care delivery in Alabama's rural areas. The council was created in July of 1990, and the office was organized shortly thereafter to provide resources and staff to facilitate and coordinate activities of the council.

The Council is composed of representatives from the Governor's Administrative Assistant for Agriculture and Rural Development Office, the State Health Planning and Development Agency, the Alabama Medicaid Agency, the Alabama Department of Economic and Community Affairs, the Alabama Department of Human Resources, the Department of Mental Health and Mental Retardation, and the State Health Department.

The functions of the council include working with health care consumers and providers as well as community and business leaders to assist in planning a comprehensive system of health care in rural communities. The Council also creates a forum to ensure that rural Alabamians have a significant role in addressing rural health issues. The Council on Rural Health Care is chaired, as outlined in the Executive Order, by the director of the State Health Planning and Development Agency.

Repeal of the Medicare Catastrophic Coverage Act

In October of 1989, Congress repealed part of the Medicare Catastrophic Coverage Act of 1988. The repeal eliminated provisions that were economical for states, while leaving intact the obligations which are expensive for the states to maintain.

In FY 1990, the Medicaid Agency, as a result of the legislation, was required to pay the premiums, deductibles, and co-insurance of some Medicare beneficiaries who had limited resources and whose incomes were up to 90 percent of the federal poverty level or $7,578 for a family of two. The legislation also provided for the financial protection of the at-home spouse when the other spouse is confined to a skilled nursing home.

In FY 1991, the income limit for QMB's (Qualified Medicare Beneficiaries), will increase to 100 percent of the federal poverty level, or $8,420 for a family of two.

Third Party Recoupments

During the 1990 fiscal year, Medicaid's Third Party Section collected $1.3 million dollars from third parties—insurance companies covering Medicaid recipients, liability insurance carriers, absent parents, and others. The number of recipients identified as having health insurance was 10 percent of the total Medicaid recipient population.

Adjustments to Medicaid claims, made possible by identification of third party insurance benefits, impacted claims totaling over $33 million this fiscal year. In addition to the $1.3 million collected from third party insurance carriers, the Medicaid Agency saw a reduction in Medicaid payments of over $1.6 million because of the money providers collected from third party resources. Claims totaling an additional $20 million were denied by Medicaid and returned to providers to collect from recipients' insurance carriers. Many of these claims were paid in full by these insurance carriers. Claims totaling more than $9 million were returned to providers for submission to Medicare, the primary payor.

In FY 1990, Medicaid also recouped $121,000 from providers who had received payment from both Medicaid and a third party.

Looking Ahead

Great strides were made during FY 1990 to improve and expand services to Medicaid eligible people statewide. The Medicaid program in Alabama no longer resembles the "bare bones" program of several years ago. Federal mandates and many initiatives taken on the state level have enabled more low income people than ever before to receive much needed health care.

More expansions and improvements are scheduled for the upcoming year. The Omnibus Budget Reconciliation Acts of 1989 and 1987 will significantly impact the young and the elderly and both will become effective during FY 1991.

OBRA 87 will provide improvements in health care for residents in nursing homes. The law includes better training for nurse aides, more rights and choices for residents in controlling their lives and surroundings, and more opportunities for restorative care to help residents reach their full physical potential.

OBRA 89 will provide services not ordinarily covered by Medicaid in Alabama for children under 21 years of age. It will also include first time coverage for nurse practitioners and will make the most dramatic changes in the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, also known in Alabama as MediKids. Seminars were conducted during the summer of 1990 to receive recommendations from health care providers statewide on the changes this federal mandate will have on the Medicaid program beginning October 1990. The legislature is expected to cost the state $72 million during the first year for services to children under 21 years of age.

Managed care, with an emphasis on education and preventive health care, will be a top priority in FY 1991 for the Medicaid Agency. A coordinated system of care for all Medicaid eligibles will translate into healthier citizens as well as savings for the State of Alabama.

Technological improvements are also planned for the near future. A computerized system of giving providers immediate access to information concerning recipient eligibility, benefit limitations and other information is being designed. Also being developed is a single form that would allow a person to apply for several different services at one time.

The Medicaid Agency also will be reworking the Physician Program in order to increase physician participation, improve reimbursement, and to continue to make the Agency user friendly for health care providers and recipients.

The Medicaid Agency will continue to improve. The emphasis is no longer only to provide health care to low income people but to provide the best possible health care to the greatest number of people at the most affordable cost to the State of Alabama.

ALABAMA'S MEDICAID PROGRAM

History

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

A State Program

Medicaid is a state-administered health care assistance program. 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 services.

Funding Formula

The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because Alabama is a relatively poor state, its federal match is one of the largest. During fiscal year 1990, the formula was approximately 73/27. For every $27 the state spent, the federal government contributed $73.

Eligibility

Persons must fit into one of several categories and must meet necessary criteria before eligibility can be determined. The Medicaid Agency, the Department of Human Resources, and the Social Security Administration determine eligibility for Medicaid in Alabama.

Eligibles include:

- Persons receiving Supplemental Security Income from the Social Security Administration, which determines their eligibility. Also, children born to mothers receiving Supplemental Security Income (SSI) may be eligible for Medicaid until they reach age one.
- Persons approved for cash assistance through the State Department of Human Resources, which determines their eligibility. Most people in this category receive Aid to Dependent Children or State Supplementation.
- Certain pregnant women and children, including those with incomes under 133 percent of the federal poverty level, who do not receive an ADC cash payment, and foster children in the custody of the state.
- Persons who have been residents or patients of certain medical facilities (nursing homes, hospitals, or state facilities for the mentally retarded) for 30 continuous days and who meet necessary criteria.
- Some low income Medicare beneficiaries may be eligible to have their Medicare premiums, deductibles, and co-insurance paid by Medicaid as a result of the Medicare Catastrophic Coverage Act of 1988.

Some persons in different eligibility categories are protected by federal law from losing Medicaid benefits. Those included are Supplemental Security Income (SSI) recipients whose benefits have stopped because of cost of living adjustments, and those whose SSI has stopped as a result of receiving benefits as a Disabled Adult Child. Also protected are widows and widowers between 60 and 65 years of age who are receiving Social Security but not Medicare Part A and who have lost SSI because of receiving early widow/widowers benefits.

Covered Services

Medical services covered by Alabama's Medicaid program are generally fewer and less comprehensive than most states'. Alabama's program is aimed at providing the best possible health care to the greatest number of low income people at the most affordable cost to the taxpayers.

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.

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 provided hundreds of thousands of citizens access to quality health care they could not otherwise afford.

Citizens who are not eligible for Medicaid also benefit from the program. Health care is one of the state's most important industries, and Medicaid contributes to that industry in a significant way. For instance, during FY 1990, Medicaid paid approximately $611 million to providers on behalf of persons eligible for the program. The federal government paid approximately three-quarters of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services and paid taxes in the state. Using the common economic multiplier effect of three, Medicaid expenditures generated over $1.5 billion worth of business in Alabama in FY 1989.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. With the current administrative rate, 97% of the Agency's budget goes toward purchasing services for beneficiaries. Medicaid funds are paid directly to the providers who treat the Medicaid patients. Providers may be physicians, dentists, pharmacists, hospitals, nursing homes, medical equipment suppliers and others.

FY 1990
COUNTY IMPACT
Year's Cost per Eligible

Table – 1

County	Benefit Payments	Eligibles	Payment Per Eligible	County	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$3,510,165.00	3,067	$1,144	Houston	$8,387,231.00	7,836	$1,070
Baldwin	$8,066,100.00	6,246	$1,291	Jackson	$5,794,555.00	4,476	$1,295
Barbour	$5,102,323.00	4,149	$1,230	Jefferson	$86,316,677.00	60,538	$1,426
Bibb	$2,475,335.00	1,812	$1,366	Lamar	$2,845,288.00	1,542	$1,845
Blount	$3,586,788.00	2,680	$1,338	Lauderdale	$9,424,693.00	6,103	$1,544
Bullock	$2,972,053.00	2,742	$1,084	Lawrence	$3,969,808.00	3,357	$1,183
Butler	$4,855,990.00	3,693	$1,315	Lee	$6,946,986.00	5,990	$1,160
Calhoun	$13,888,530.00	10,693	$1,299	Limestone	$5,024,175.00	3,958	$1,269
Chambers	$4,546,917.00	4,124	$1,103	Lowndes	$2,976,794.00	3,351	$888
Cherokee	$1,851,022.00	1,493	$1,240	Macon	$6,179,560.00	4,852	$1,274
Chilton	$4,265,882.00	3,222	$1,324	Madison	$16,647,601.00	14,523	$1,146
Choctaw	$2,790,755.00	2,646	$1,055	Marengo	$5,050,573.00	4,400	$1,148
Clarke	$5,259,351.00	4,431	$1,187	Marion	$5,176,135.00	2,827	$1,831
Clay	$2,549,252.00	1,370	$1,861	Marshall	$11,130,577.00	6,856	$1,623
Cleburne	$1,610,515.00	1,147	$1,404	Mobile	$58,843,943.00	42,503	$1,384
Coffee	$5,741,017.00	3,334	$1,722	Monroe	$4,450,190.00	3,244	$1,372
Colbert	$6,165,074.00	3,887	$1,586	Montgomery	$31,172,281.00	25,879	$1,205
Conecuh	$2,668,833.00	2,206	$1,210	Morgan	$27,724,421.00	7,786	$3,561
Coosa	$1,290,083.00	1,048	$1,231	Perry	$3,652,015.00	3,641	$1,003
Covington	$6,730,578.00	4,372	$1,539	Pickens	$4,764,559.00	3,711	$1,284
Crenshaw	$3,267,652.00	2,127	$1,536	Pike	$5,950,601.00	4,631	$1,285
Cullman	$9,234,269.00	5,160	$1,790	Randolph	$3,665,960.00	2,409	$1,522
Dale	$6,189,378.00	4,048	$1,529	Russell	$6,384,577.00	5,393	$1,184
Dallas	$12,143,793.00	12,090	$1,004	Shelby	$5,443,063.00	3,983	$1,367
DeKalb	$8,625,689.00	5,185	$1,664	St. Clair	$4,878,788.00	3,457	$1,411
Elmore	$15,437,060.00	4,390	$3,516	Sumter	$4,161,622.00	4,012	$1,037
Escambia	$5,247,994.00	4,052	$1,295	Talladega	$11,765,985.00	9,699	$1,213
Etowah	$14,932,381.00	9,629	$1,551	Tallapoosa	$8,255,447.00	4,444	$1,858
Fayette	$2,940,843.00	2,104	$1,398	Tuscaloosa	$42,438,441.00	15,131	$2,805
Franklin	$5,421,232.00	3,186	$1,702	Walker	$12,565,953.00	7,583	$1,657
Geneva	$4,641,931.00	2,912	$1,594	Washington	$2,821,660.00	2,534	$1,114
Greene	$2,756,278.00	2,820	$977	Wilcox	$3,998,736.00	4,426	$903
Hale	$3,869,604.00	3,198	$1,210	Winston	$4,768,166.00	2,275	$2,096
Henry	$2,520,724.00	1,948	$1,294	Other	$120,478.00	102	$1,181

PROGRAM INTEGRITY

The Program Integrity Division is responsible for planning, developing, and directing Agency efforts to identify, prevent, and prosecute fraud, abuse and/or misuse in the Medicaid program. This includes verifying that medical services are appropriate and rendered as billed, that the services are provided by qualified providers to eligible recipients, and that payments for those services are correct.

One unit within the Program Integrity Division is Quality Control. It is this unit's function to make sure the Medicaid Agency is performing eligibility determinations as accurately as possible. If the Agency's error rate in determining Medicaid eligibility should exceed three percent, the Health Care Financing Administration (HCFA) would impose a financial sanction. The Agency's most recent error rate, as determined by HCFA, is 2.5122 percent. There were 1,817 cases reviewed during FY 1990.

The processing and payment of Medicaid claims is monitored by the Systems Audit Unit through its administration of the Claims Processing Assessment System (CPAS). The unit identifies deficiencies in the management information system that contribute to Medicaid payment errors. More than 17,000 claims were manually reviewed during this fiscal year. The payment and processing error rate cannot exceed one percent and one million misspent dollars. If errors exceed this threshold, the Medicaid Agency is required by HCFA to implement a complicated system with increased reporting requirements. The error rate for FY 1990 was .05 percent. In addition to CPAS, Systems Audit utilizes a process referred to as "Bill Processing Systems Test" (BPST). This process uses test claims, test recipients, and test providers to verify that system edits have been properly implemented or to verify that edits are accomplishing the specified intent. Systems Audit also monitors the financial activities of the Agency's fiscal agent through reconciliations of invoices and bank accounts, as well as analysis of processed provider refunds and claim adjustments.

Recipient Eligibility Review, another unit within the Program Integrity Division, recovers funds from individuals who received Medicaid services while ineligible for the program. In most instances, these cases involve persons in nursing homes who, through neglect or fraud, did not report income or assets. In addition, the unit collects on property liens that are due for collection.

The unit received 1,327 new nursing home, ADC and SSI cases in FY 1990. Aided by staff from other divisions, the unit identified $879,109 for collection and collected $395,688 in misspent dollars in the nursing home and SSI programs. There were $774,015 collected on property liens in FY 1990. There are currently 244 active lien cases.

The Surveillance and Utilization Review (SUR) Unit looks for fraud and abuse and/or misuse in the Medicaid program. Computer programs are used to find unusual patterns of utilization on the part of providers and recipients. During FY 1990, Provider SUR opened 300 reviews and closed 398. Recoupments and net adjustments for the fiscal year totaled $178,140. This unit saved the Medicaid program a total of $4,006,339 during FY 1990 by identifying irregular Medicaid claims before the payment was made. Recipient SUR opened 351 reviews. These cases are determined by analyzing unusual patterns of billing, and, if necessary, are referred to the Utilization Review Committee (URC).

The URC is composed of medical, program, and financial experts who may take several types of action in cases of aberrant utilization. They may give written warnings and administrative sanctions such as restrictions or terminations from the program and recoupment of funds. During FY 1990, URC actions resulted in 329 recipients being terminated from the Medicaid program, nine provider cases being referred to the Attorney General's Medicaid Fraud Control Unit, four providers being referred to the Board of Medical Examiners, 15 providers or employees of providers being suspended from the Medicaid program, and 112 recipients being locked in to one physician and one pharmacy.

A recipient who abuses Medicaid privileges may be restricted (locked in) to receiving services from certain providers. This program is one administrative sanction used to control abuse in the Medicaid program. Imputed savings from this program totaled $93,349 in FY 1990. The average number of recipients locked in per month was 169.

Medicaid's investigative staff meets the investigative needs of the entire Agency. During FY 1990, the Investigative Unit closed 262 cases and opened 320 cases, of which 43 were drug abuse cases. The total identified for recoupment was $171,660. Actual recoupments equalled $32,093. In addition, the staff assisted local authorities with 10 cases involving altered prescriptions, selling drugs for illicit purposes, stolen or loaned Medicaid cards, and recipient fraud.

FY 1990
PROGRAM INTEGRITY
Case Load Summary

Table - 2

Provider Reviews	Referred to Attorney General	Recoupments Identified from Providers	Providers Terminated from the Medicaid Program	Diverted Funds
527	9	$178,140	7	$4,006,339
Recipient Reviews	Referred to District Attorney	Recoupments Identified from Recipients	Recipients Terminated from the Medicaid Program	Recipients Locked-In
1,678	32	$1,824,724	329	189

MEDICAID MANAGEMENT INFORMATION SYSTEM

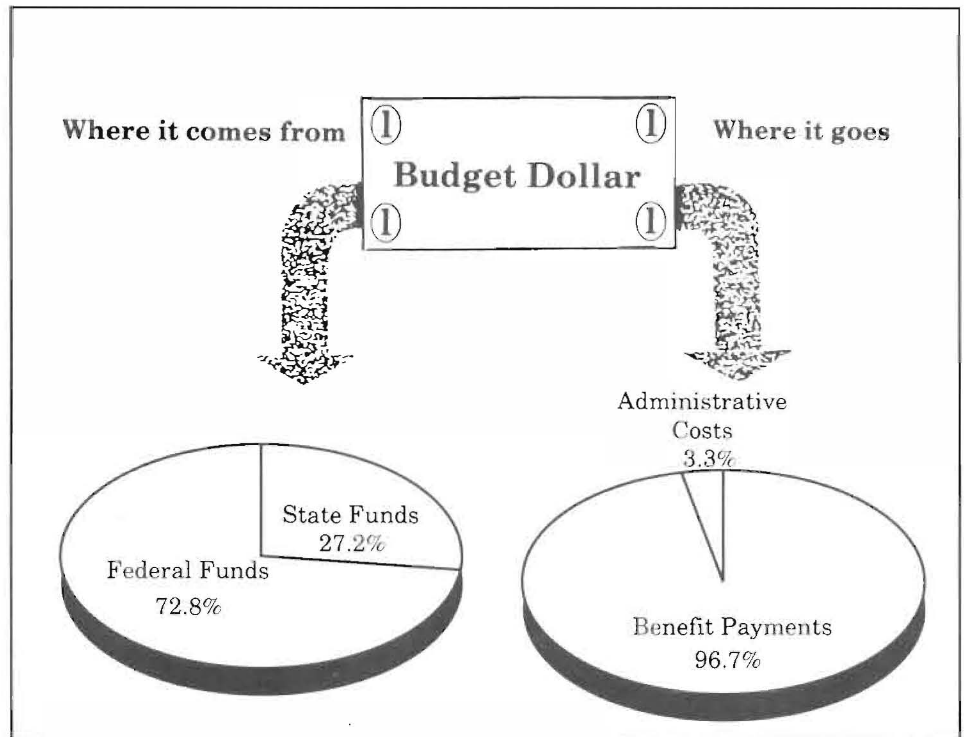
The Agency's Medicaid Management Information System (MMIS) maintains provider and recipient eligibility records, processes all Medicaid claims from providers, keeps track of program expenditures, and furnishes reports that allow Medicaid administrators to monitor the pulse of the program.

Many of Medicaid's computer functions are performed by the Agency's contracted fiscal agent, Electronic Data Systems (EDS). Medicaid first contracted with EDS in October 1979, with the current contract period beginning October 1, 1988. The company's performance in claims processing has been among the best in the nation. EDS is constantly making changes to the MMIS to meet the needs of the program.

REVENUE, EXPENDITURES, AND PRICES

In FY 1990, Medicaid paid $797,759,918 for health care services to Alabama citizens. Another $27,526,431 was expended to administer the program. This means that about 97¢ of every Medicaid dollar went directly to benefit recipients of Medicaid services.

Federal Funds	$600,342,650
State Funds	$224,942,699
Total Revenue	$825,285,349



FY 1990 Table – 5
Components of Federal Funds

(net)	Dollars
Family Planning Administration	$1,051,277
Professional Staff Costs	$8,734,329
Other Staff Costs	6,439,892
Other Provider Services	579,664,741
Family Planning Services	4,452,411
Total	$600,342,650

FY 1990 Table – 6
Components of State Funds

(net)	Dollars
Encumbered Balance Forward	$1,050,328
Basic Appropriations	$122,014,369
Indigent Care Trust Fund	$68,339,630
Other State Agencies	$38,132,226
Interest Income from Fiscal Intermediary	636,956
Miscellaneous Receipts	$15,556
Subtotal	$230,189,065
Encumbered	5,246,366
Total	$224,942,699

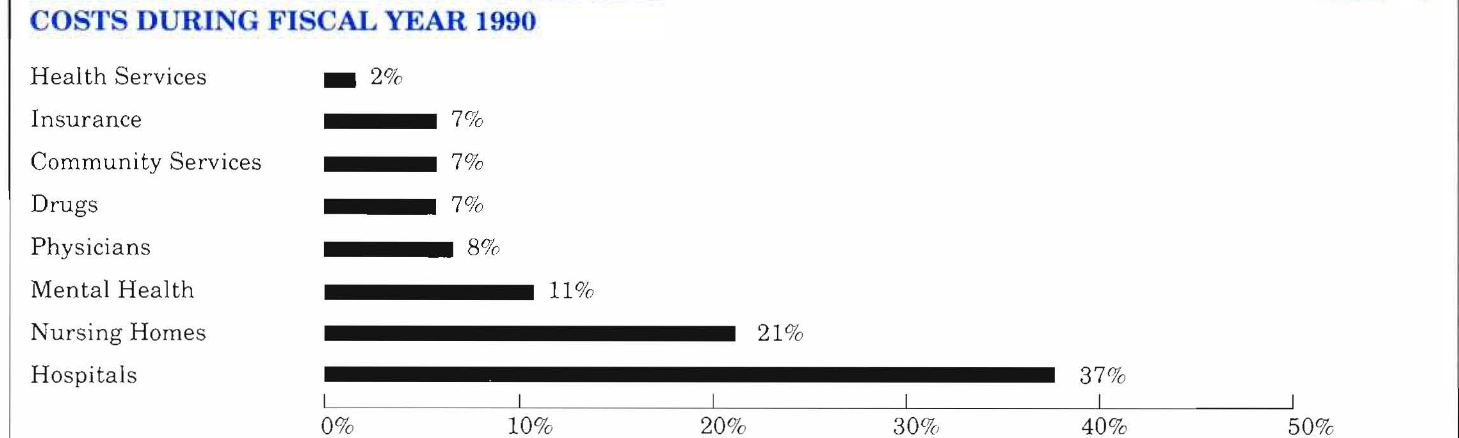
FY 1990 Table – 7
Benefit Cost by Fiscal Year in which Obligation was Incurred

	FY '90	FY '91 (Est.)
Nursing Homes	165,973,378	195,288,000
Hospitals	293,524,452	403,448,000
Physicians	55,471,302	101,612,000
Insurance	58,241,776	74,520,600
Drugs	60,034,079	71,300,000
Health Services	13,649,687	35,330,000
Community Services	62,669,503	98,323,500
Total Medicaid Service	$709,564,177	$979,882,100
Mental Health	88,194,741	123,486,000
Total Benefits	$797,758,918	$1,103,308,100

FY 1990
EXPENDITURES
By Type of Service (net)

Table – 8

Service	Payments	Percent of Payments by Service FY '90
Pharmacy	$60,034,079	7.53%
Nursing Homes:	$165,973,378	20.80%
SNF	$22,604,747	2.83%
ICF	$143,368,631	17.97%
Hospitals	$293,392,430	36.78%
Inpatient	$124,649,186	15.62%
Outpatient	$12,573,244	1.58%
Disproportionate Share Payments	$156,170,000	19.58%
Buy-In	$36,719,722	4.60%
Physicians	$55,452,874	6.95%
Screening	$2,773,289	0.35%
Dental	4,591,759	0.58%
Hearing	92,876	0.01%
Laboratory	2,756,498	0.35%
Home Health/DME	12,934,065	1.62%
Eyecare:	2,442,233	0.31%
Eyeglasses	634,868	0.08%
Eye Care	1,807,365	0.23%
Transportation	993,034	0.12%
Co-Insurance	19,466,359	2.44%
MR/MD:	69,067,424	8.66%
ICF-MR	64,198,146	8.05%
ICF-MD	4,815,870	0.60%
SNF-MD/Illness	53,408	0.01%
Mental Health Services	6,951,198	0.87%
Targeted Case Management	1,144,018	0.14%
Waivered Services:	55,820,416	7.00%
Mental Health Services:	12,176,119	1.53%
HCBS	17,337,635	2.17%
Pregnancy Related	26,306,662	3.30%
Family Planning	4,947,123	0.62%
Other:	2,206,143	0.28%
HMO	2,055,694	0.26%
Rural Health Clinics	132,021	0.02%
Other Practitioners	18,428	0.00%
Total For Medical Care	$797,758,918	100.00%
Administrative Costs	$27,526,431	
Net Payments	$825,285,349	



POPULATION

The population of Alabama grew from 3,444,165 in 1970 to 3,893,888 in 1980. In 1990, Alabama's population was estimated to be 4,284,682.

More significant to the Medicaid program was the rapid growth of the elderly population. Census data shows that, in the United States, the 65 and over population grew twice as fast as the general population from 1960 to 1980. This trend 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 1995 there will be more than 595,399 persons 65 years of age and over in the state. The Center for Demographic and Cultural Research at Auburn University at Montgomery reports that white females 65 years of age and over account for almost one-half of the elderly population in the state. Historically, cost per eligible has been higher for this group than other groups of eligibles.

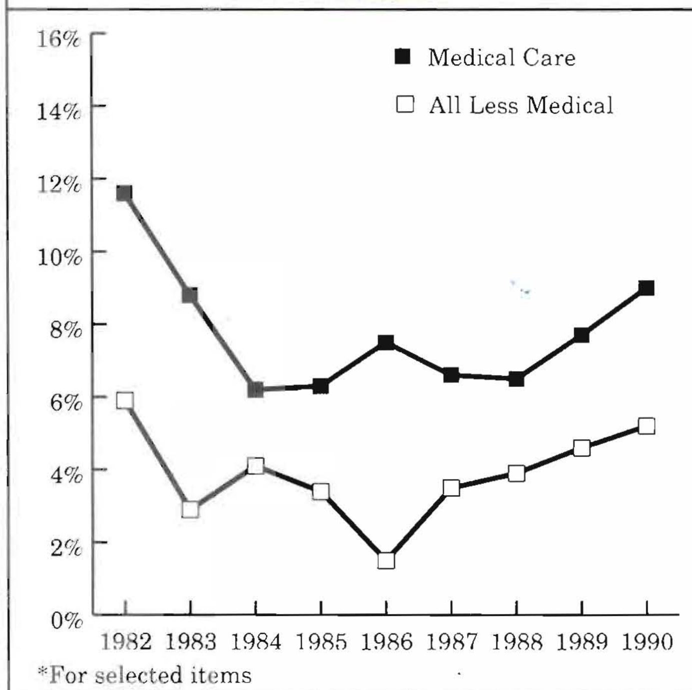
FY 1988-1990 **Table - 10**
POPULATION
Eligibles as Percent of Alabama Population by Year

Year	Population	Eligibles	Percent
1988	4,195,581	367,811	8.8%
1989	4,241,653	386,352	9.1%
1990	4,284,682	418,663	9.8%

PRICES

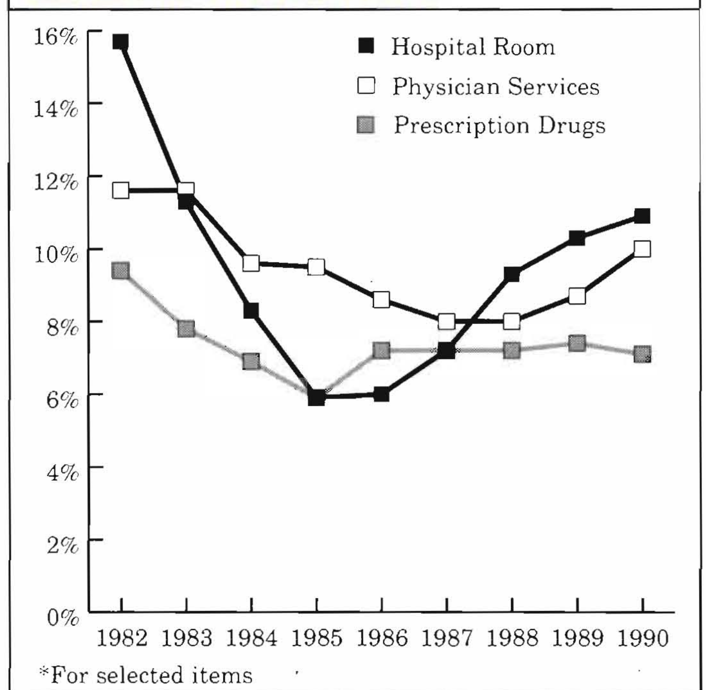
The charts on this page show historical trends in the rate of growth in the Consumer Price Index (CPI). Increases in the CPI are usually reflected in future increases in Medicaid payments to providers.

ANNUAL PERCENT CHANGES In the Consumer Price Index* **Table - 11A**



*For selected items

ANNUAL PERCENT CHANGES In the Consumer Price Index* **Table - 11B**



*For selected items

ELIGIBLES

During FY 1990, 418,663 persons were eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 311,146. The monthly average is the most useful measure of Medicaid coverage because it takes into account length of eligibility.

Although 418,663 people were eligible for Medicaid in FY 1990, only about three-fourths were eligible for the entire year. The length of time the other one-fourth of Medicaid eligibles were covered ranged from one to eleven months.

FY 1990 ELIGIBLES Monthly Count — Table - 12

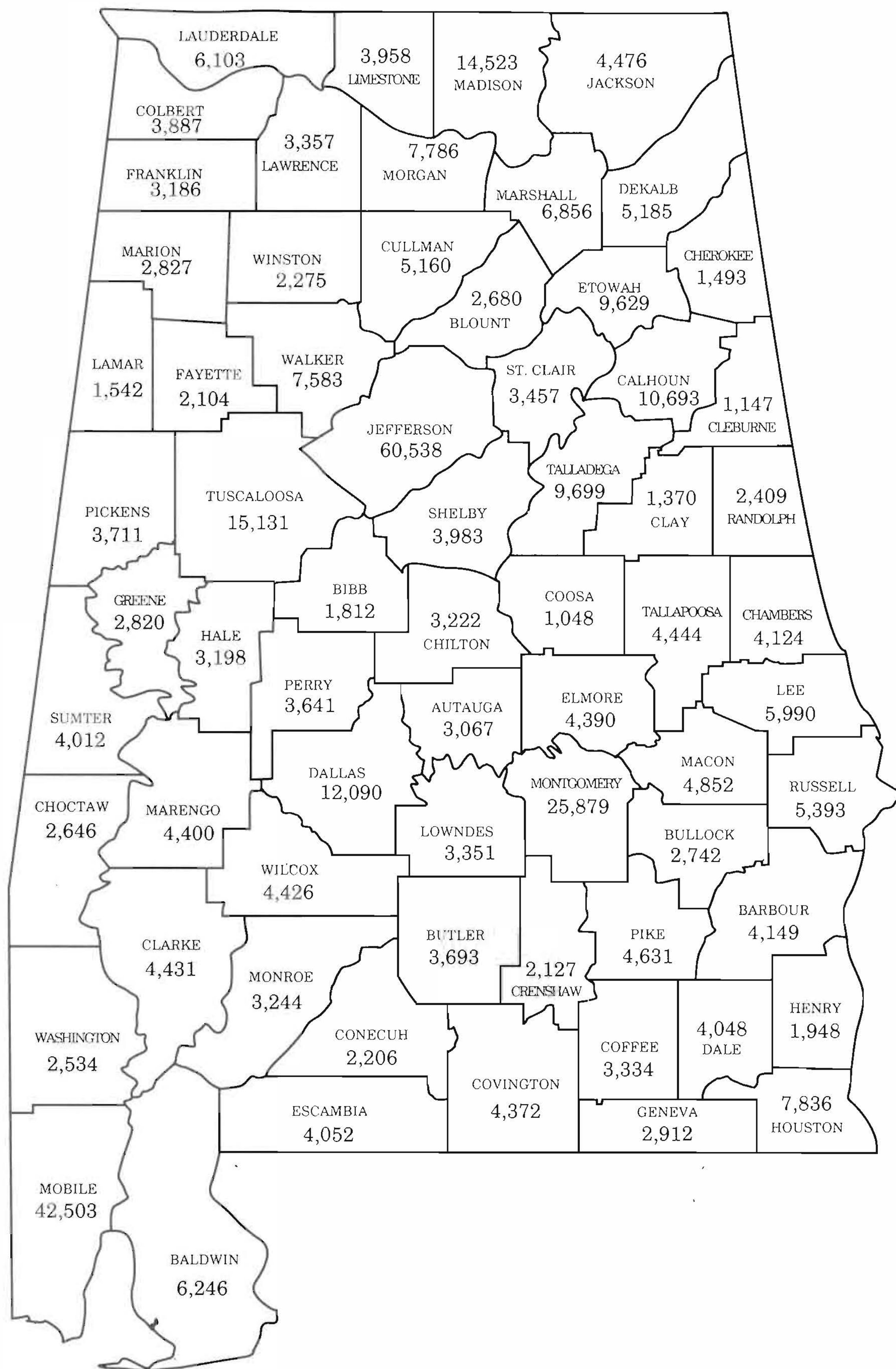
Month	Count
October '89	308,165
November	302,094
December	303,470
January '90	303,402
February	304,769
March	306,313
April	307,100
May	311,222
June	313,631
July	315,469
August	320,607
September	337,513

FY 1990 ELIGIBLES By Length of Eligibility — Table - 13

Assistance Status/ Basis Of Eligibility	Unduplicated Total	Number Eligible For Full Year	Number Eligible For Partial Year	Number Of Covered Months For Partial Year Eligibles
Categorically Needy, Receiving Assistance				
Aged	54,756	46,500	8,256	48,202
Blind	1,849	1,561	288	1,730
Disabled	92,035	73,758	18,277	109,998
AFDC-Children	122,366	65,596	56,770	328,925
AFDC-Adult	50,451	25,566	24,885	147,330
Other Title XIX	2	0	2	5
Categorically Needy, Not Receiving Assistance				
Aged	15,040	9,622	5,418	31,874
Blind	18	11	7	37
Disabled	2,841	2,307	534	3,420
AFDC-Children	18,818	5,759	13,059	75,805
AFDC-Adult	10,102	2,145	7,957	43,069
Other Title XIX	5,397	1,660	3,737	18,624
Other Coverage				
Aged	6,406	2,816	3,590	28,252
Blind	0	0	0	0
Disabled	0	0	0	0
AFDC-Children	28,160	2,544	25,616	115,808
AFDC-Adult	20,497	101	20,396	90,010
Other Title XIX	2,502	1	2,501	3,567

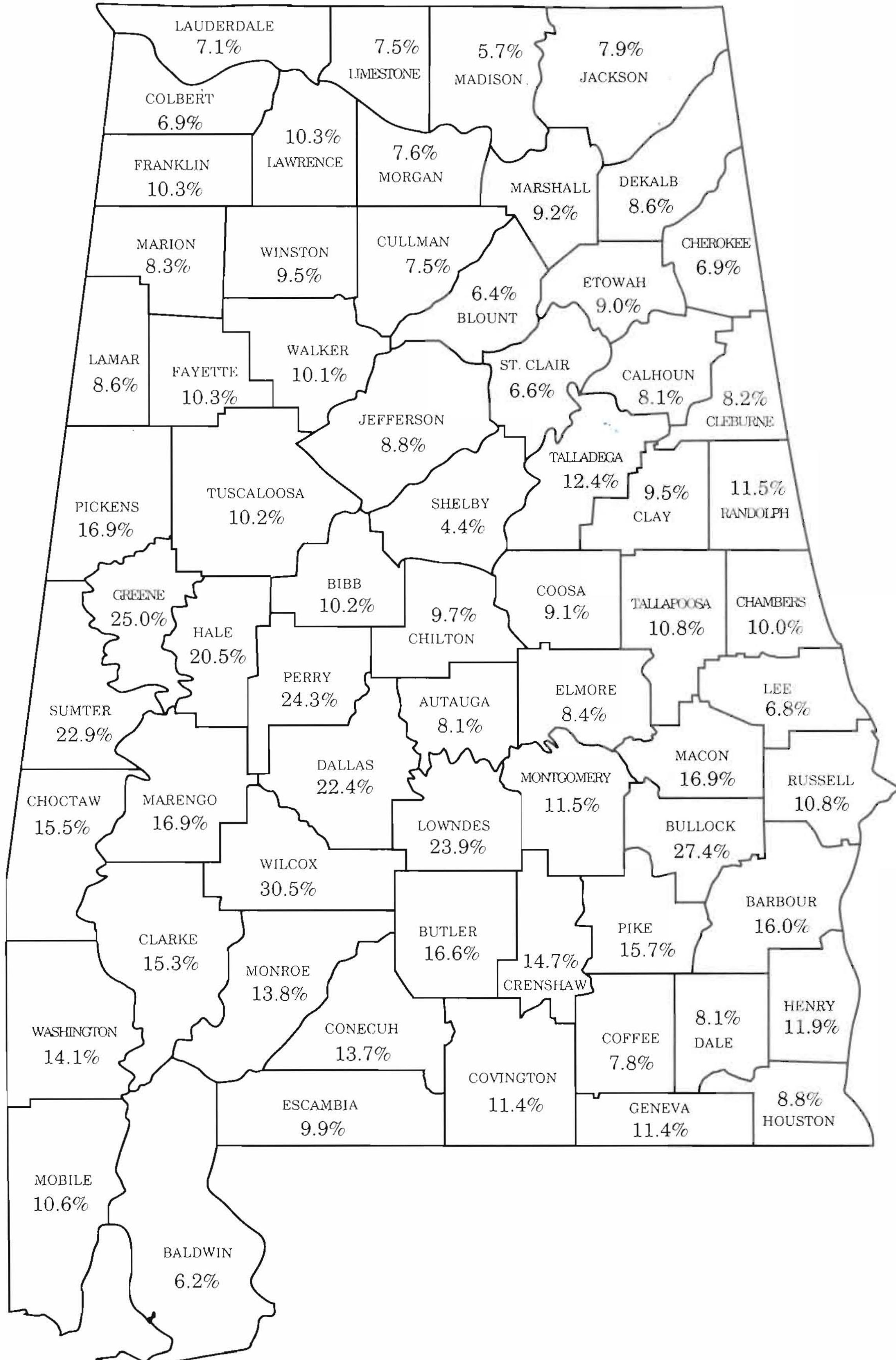
FY 1990 **Table – 14**

ANNUAL UNDUPLICATED TOTAL MEDICAID ELIGIBLES



FY 1990
ELIGIBLES
Percent of Population Eligible for Medicaid

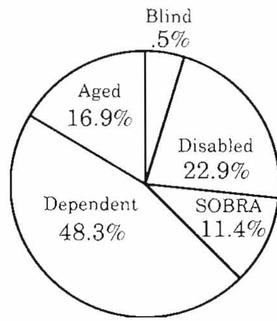
Table – 15



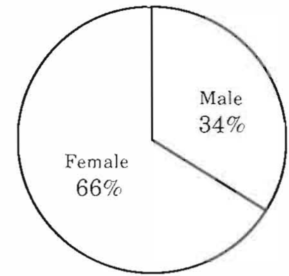
FY 1990
ELIGIBLES
Percent Distribution

Table - 16

BY CATEGORY



BY SEX



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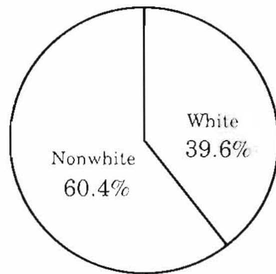
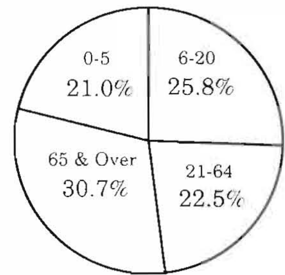


BY AGE



RECIPIENTS

Although there were 418,663 persons eligible for Medicaid in FY 1990, only 85 percent of these actually received benefits. These 356,065 persons are called recipients. The remaining 62,598 persons incurred no medical expenses paid for by Medicaid.

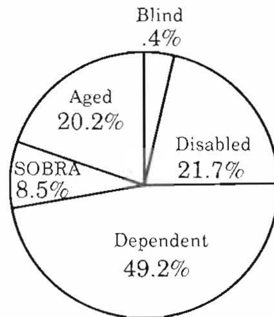
The total number of recipients is an unduplicated count. Recipients may be qualified under more than one category during the year. A recipient who receives services under more than one basis of eligibility is counted in the total for each of those categories, but is counted only once in the unduplicated total. This is the reason that recipient counts by category do not equal the unduplicated total.

FY 1990
RECIPIENTS
Monthly Averages and Annual Total — **Table - 17**

Category	Monthly Average	Annual Total
Aged	47,096	79,194
Blind	1,040	1,621
Disabled	55,097	85,387
Dependent	52,578	193,304
SOBRA	10,952	33,337
All Categories (unduplicated)	169,041	356,065

FY 1990
RECIPIENTS
Percent Distribution — **Table - 18**

BY CATEGORY



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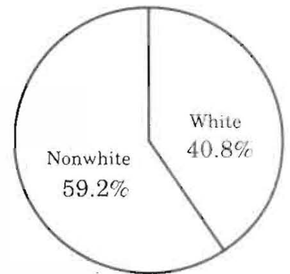

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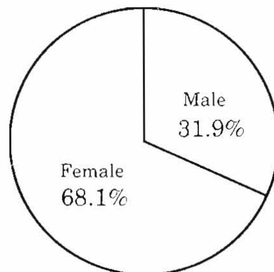
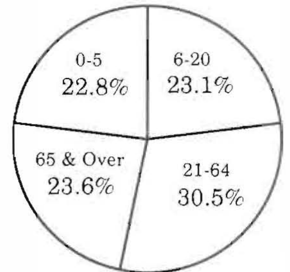


BY AGE



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.

This report measures cost in two ways—cost per recipient and cost per eligible. Cost per recipient is calculated by dividing total payments for services by the year's total unduplicated count of recipients. Cost per eligible is determined by dividing total payments for services by the total number of persons eligible during the year. Both measures are useful for comparing different groups of Medicaid recipients and eligibles and predicting how changes in eligibility and utilization will impact Medicaid.

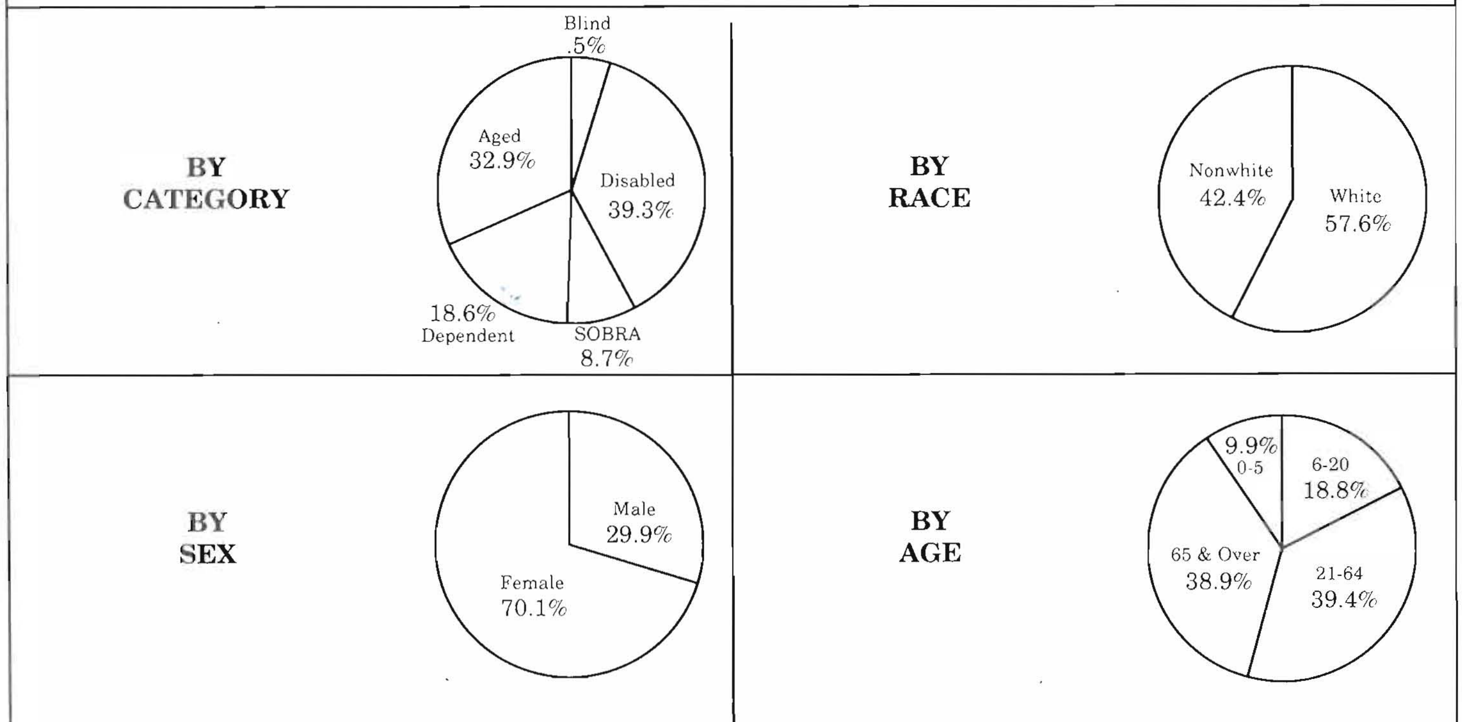
It is obvious from these statistics that certain groups are much more expensive to the Medicaid program than others. The reason for these differences is that specific groups tend to use specific types of services. Any Medicaid eligible receives, within reasonable limitations, medically necessary services.

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 long-term care in FY 1990 was $33. The average length of stay for recipients of this service was 235 days. Most recipients of long-term care are white females who are categorized as aged or disabled and are 65 years of age and over. It is not surprising that these groups have a large percentage of Medicaid payments made on their behalf.

Some low income Medicare beneficiaries are eligible to have their Medicare premiums, deductibles, and co-insurance covered by Medicaid. For this coverage, Medicaid paid a monthly buy-in fee to Medicare which in FY 1990 was $28.60 per eligible Medicare beneficiary. Medicaid paid $36.7 million in buy-in fees in FY 1990. Paying the buy-in fees are very cost effective for Medicaid, because the Agency would incure the full payment of medical bills instead of covering only the premiums, deductibles, and coinsurance.

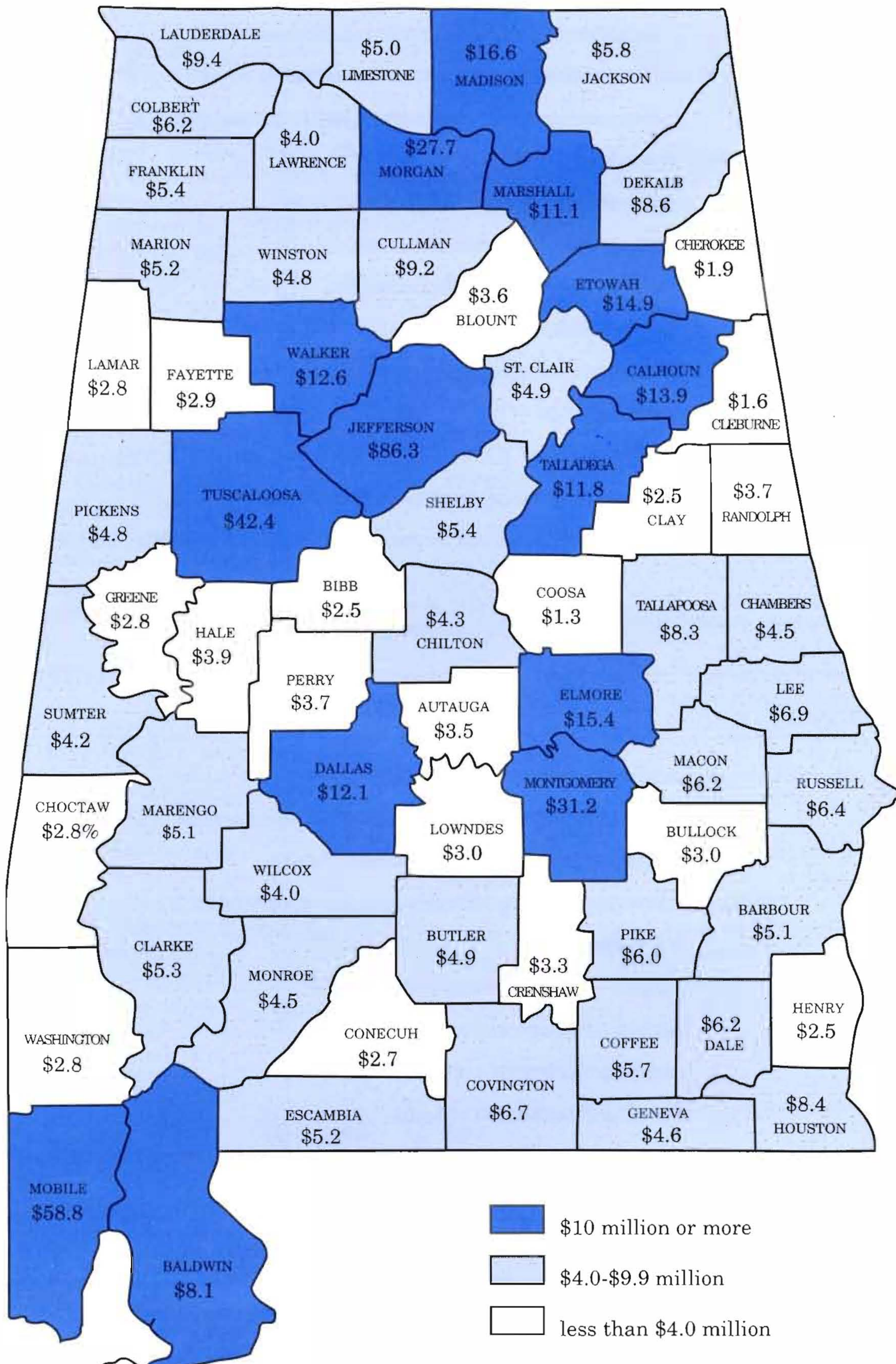
FY 1990
PAYMENTS
Percent Distribution

Table - 19

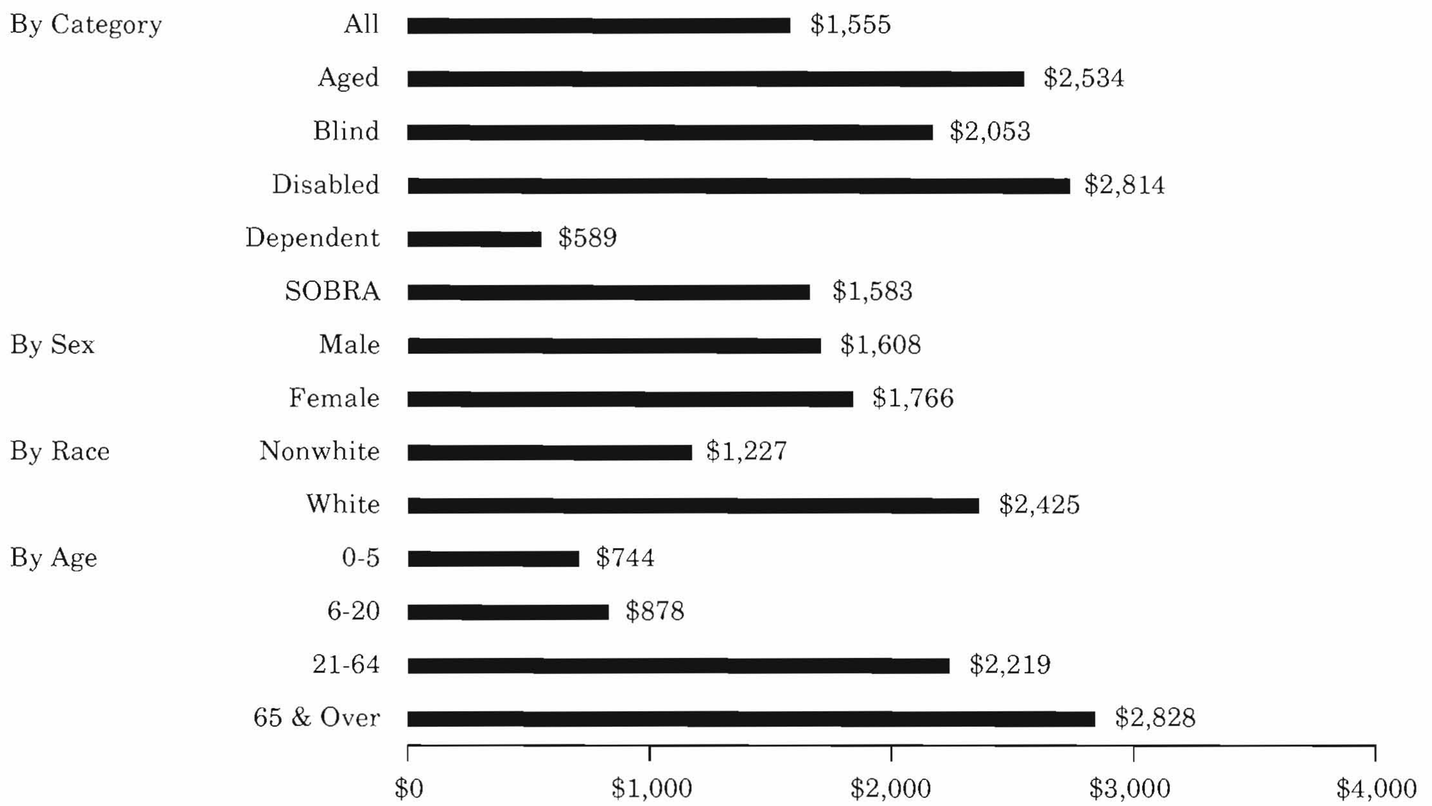


FY 1990
PAYMENTS
By County (in millions of dollars)

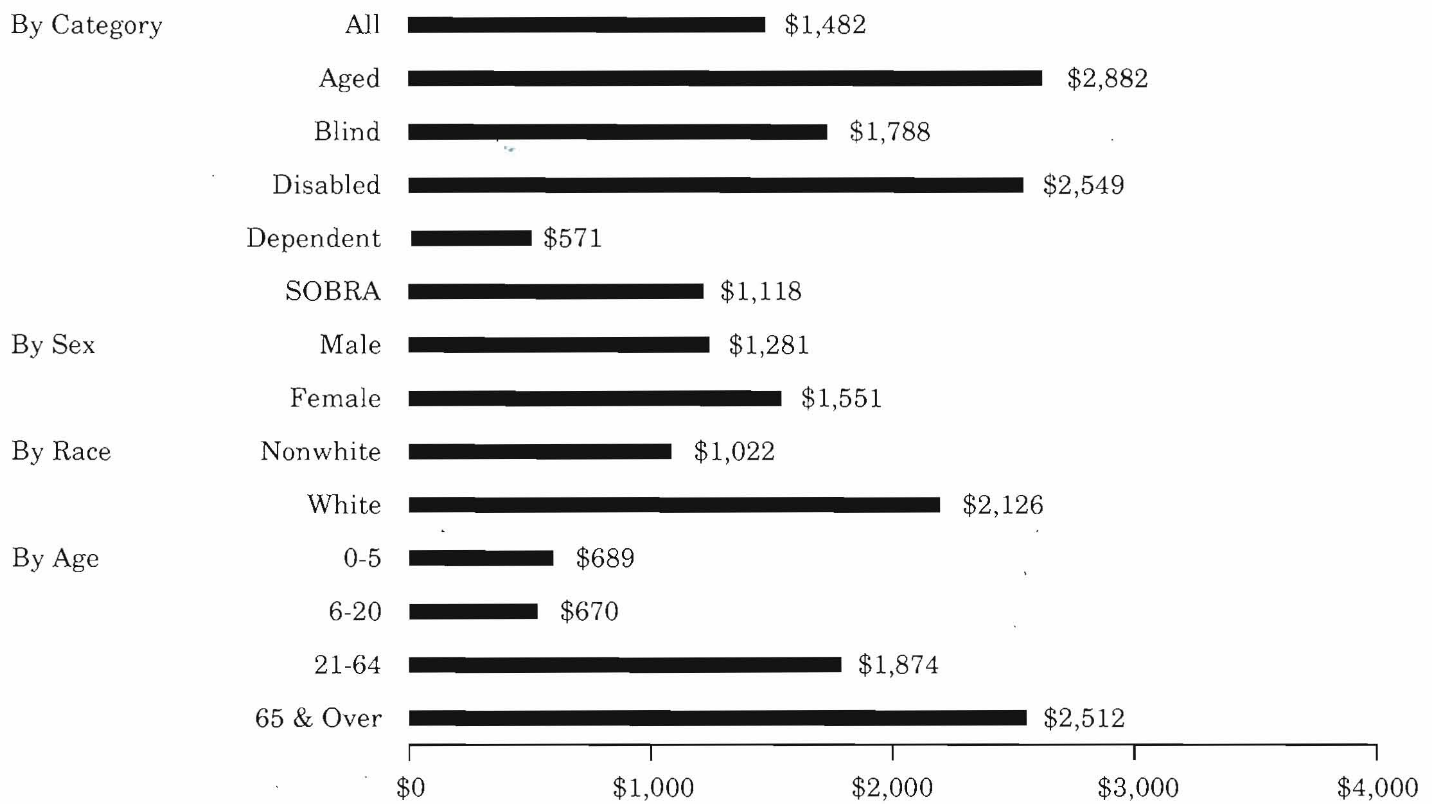
Table – 20



FY 1990 COST PER RECIPIENT — Table - 21



FY 1990 COST PER ELIGIBLE — Table - 22



MATERNAL AND CHILD HEALTH CARE

In May 1989, the Alabama Medicaid Office of Maternal and Child Health was created. The mission of this office has been "to take a proactive role in fighting infant mortality and morbidity while enhancing the health of mothers and babies." The proactive role includes bringing as many private foundation grant dollars and federal dollars into the state as possible to enhance access to quality medical care. This office works closely with eligibility specialists and other agency programs to promote to the fullest potential the health of mothers and children. During FY 1990 Medicaid served an additional 21,882 women and 25,325 children through the expanded eligibility group for pregnant women and children called SOBRA (Sixth Omnibus Budget Reconciliation Act). Had it not been for the SOBRA program, these women and children may not have received medical care.

Prenatal Care

The latest birth statistics compiled revealed that in 1989 the number of births to women aged 10-19 increased slightly in Alabama from 10,590 in 1988, to 11,405. There were 327 births to teenage women under 15 years of age.

Medicaid pays for the deliveries of a large number of these teenage mothers. Usually these young mothers and their families face a number of personal problems and must depend on public assistance programs such as Medicaid for health care.

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 weights and greater health difficulties in later life.

Competent, timely prenatal care results in healthier mothers and babies. Timely care also can reduce the possibility of premature, underweight babies. Studies consistently show that for every dollar spent on prenatal care, approximately $3 is saved in the costs of caring for low birth weight babies.

Prenatal care for Medicaid eligible recipients is provided through private physicians, hospitals, public health department clinics and rural health clinics. Currently, there are approximately 140 clinics providing prenatal care in the state.

Some of the maternity related benefits covered under the prenatal program are: unlimited prenatal visits, medical services to include physical examinations with ongoing risk assessments, prenatal vitamins, nutritional assessments, counseling and educational services, appropriate medically indicated lab tests and referral services as needed. Referral services include family planning services after delivery and medical services for the newborn under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT or more commonly known as MediKids). Medically indicated procedures such as ultrasound, non-stress tests and amniocentesis are examples of other services covered by Medicaid. In order to complete the pregnancy cycle, one postpartum checkup is covered during the 60-day postpartum period.

In 1988, the Medicaid Agency implemented a policy that would allow pregnant women at 100 percent of the poverty level to qualify for Medicaid benefits. In April 1990, Medicaid expanded eligibility for pregnant women to 133 percent of the federal poverty level. With this expansion, prenatal care has been made available to more women than ever before. Utilization of Medicaid services can help pregnant women in two ways; the provision of adequate prenatal care to Medicaid eligibles is expected to increase the likelihood of a successful outcome for both mother and child, and the family planning services that are available can help Medicaid eligible women control the size of their families.

Maternity Waiver Program

The Maternity Waiver Program, implemented September 1, 1988, is aimed at combatting Alabama's high infant mortality rate. It assures that low income pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through one primary provider network. The two main components of the waiver are case management and freedom of choice restriction.

Care coordinators work with the women to set up a plan of care, make appropriate referrals, provide education, follow up on missed appointments, assist with transportation, and provide other services.

Restricting the patients' freedom of choice in choosing a provider enables Medicaid to set up a primary care provider network. Access to care through one provider eliminates fragmented and insufficient care while assuring that recipients receive adequate and quality attention. Care provided through this network ensures that care coordinators can track patients more efficiently.

This program has been successful in getting women to begin receiving care earlier and in keeping them in the system throughout pregnancy. Women in waiver counties receive an average of nine prenatal visits as opposed to only three prenatal visits prior to the waiver. Babies born in waiver counties require fewer neo-

natal intensive care days which translates into not only healthy babies but also reduced expenditures for the Agency.

In FY 1990, 17 counties participated in the Maternity Waiver Program, with eight primary providers coordinating care. The Gift of Life Foundation in Montgomery is the primary provider for Autauga, Elmore, Lowndes, and Montgomery counties. The Etowah Quality of Life serves Etowah County. The Decatur General Hospital serves Lawrence and Morgan counties. West Alabama Health Services, Inc., serves Green, Hale, and Sumter counties. The Jefferson County Board of Health serves Jefferson, Blount, and Shelby counties. The Houston County Health Department serves Houston and Henry counties. The University of South Alabama serves Mobile County, and the Northeast Alabama Regional Medical center serves Calhoun County.

Nurse Midwife Program

The Nurse Midwife Program was implemented in 1982 in order to facilitate access to maternity care for the Medicaid population. Since that time, enrollment of nurse midwives has increased to the current enrollment of 14 providers.

To participate in the program, the nurse midwife must show proof of Alabama RN licensure, Alabama certified nurse midwife licensure, and a written signed agreement between her and her physician supervisor. A contractual agreement with the Medicaid Agency also is required.

Nurse midwife services include global obstetrical deliveries, walk-in deliveries, antepartum care, postpartum care, circumcision of the newborn and individual prenatal office visits. All services are performed under appropriate physician supervision.

Family Planning

Although Medicaid's family planning services include assisting eligibles with fertility problems, most recipients of family planning services seek the prevention of unwanted pregnancies. Most expenditures for family planning 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 costs of family planning than for other services. For most Medicaid services in Alabama, the federal share of costs was 73 percent in FY 1990. For family planning services, the federal share is 90 percent.

The Medicaid Agency purchases family planning services from various clinics such as the State Department of Public Health's Family Health Administration, community health centers, private physicians, federally qualified health centers, and others. Services include physical examinations, pap smears, pregnancy and venereal disease testing, counseling, provision of oral contraceptives, other drugs, supplies and devices, and referral for other needed services. In FY 1990, Medicaid implemented a home visit family planning counseling service for newly delivered mothers. This allows recipients to begin the birth control of their choice prior to the post partum visit in the clinic.

Medicaid rules regarding sterilization are based on federal regulations. Medicaid will pay for sterilizations for adults 21 years of age or older if certain conditions are met.

In accordance with state and federal law, abortions are not included as family planning services. Medicaid will pay for abortions, under the auspices of the Physicians Program, only when the life of the mother would be endangered if the fetus were carried to term.

EPSDT - MediKids

The Early and Periodic Screening, Diagnosis and Treatment Program, named MediKids in Alabama, is a preventive health program designed to detect and treat diseases that may occur early in a child's life. If properly used, the program can benefit 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. The Medicaid program realizes long-term savings by intervening before a medical problem requires expensive acute care.

Although EPSDT is funded by Medicaid, the program's operation requires the cooperation of the State Department of Human Resources and the State Department of Public Health. EPSDT eligibles are persons under 21 years of age who receive assistance through the Aid to Dependent Children or Supplemental Security Income programs. Also included among eligibles are children up to six years old in families with income at or below 133 percent of the federal poverty level. Department of Human Resources workers normally determine ADC eligibility, make families aware of EPSDT, and refer eligibles to providers. The Health Department provides services to many EPSDT eligibles.

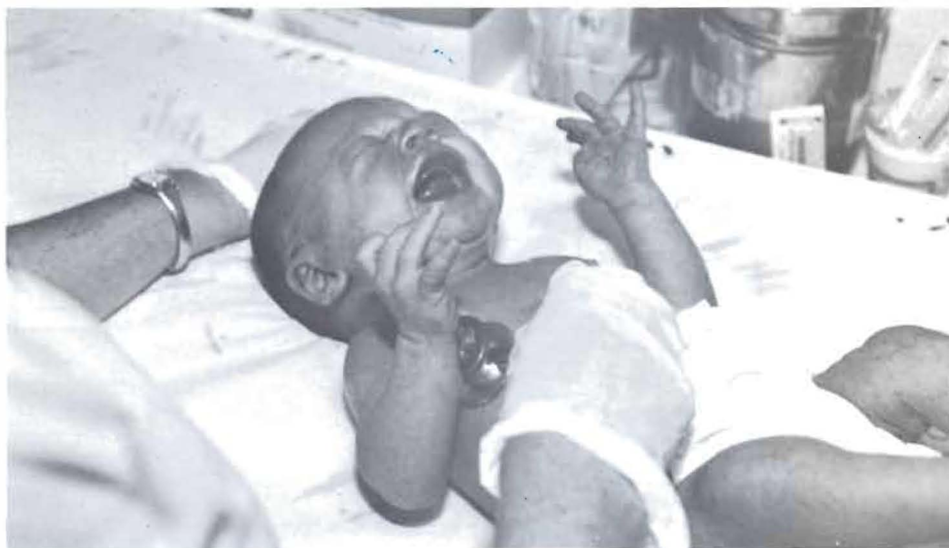
Currently there are more than 350 providers of EPSDT services, including county health departments, community health centers, Head Start Centers, child development centers and private physicians. Efforts are being madeto increase the number of physicians to the EPSDT program and to increase the number of EPSDT eligibles using the screening services. Since screening is not mandatory, many mothers do not seek preventive health care for their children.

Steps have been taken in recent years to increase the number of screening services. These initiatives include increased publicity of the EPSDT program, implementation of intensive outreach statewide, an increase in the physicians' reimbursement rate for EPSDT screenings and an increase in the number of screenings for which Medicaid will pay. The number of screenings has increased because of these efforts. A Medicaid goal is to screen all eligible children at 20 intervals between birth and age 21.

The EPSDT screening program can detect many problems before they become acute. Problems such as hypertension, rheumatic fever and other heart conditions, diabetes, neurological disorders, venereal disease, anemia, urinary infections, vision and hearing disorders, and even cases of child abuse have been detected and treated in past years. The cost of screening is relatively small—an average of $31 per screening. The cost of treating acute illness is considerably higher.

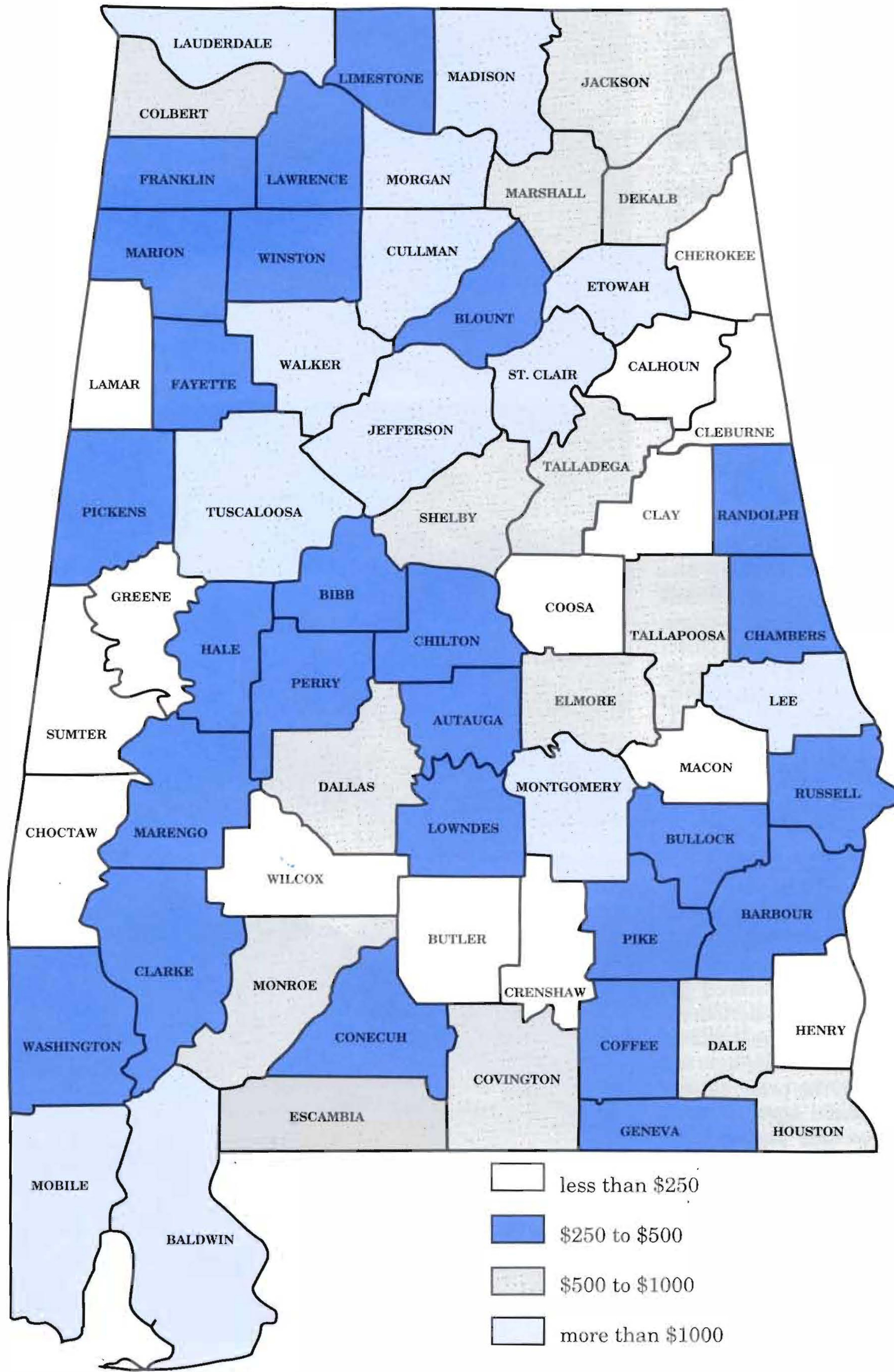
The Medicaid dental program is limited to individuals who are eligible for treatment under the EPSDT program. Dental care under this program is available either as a result of a request or a need by the Medicaid recipient.

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, and most prosthetic treatments. 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, hospitalization and some out-of-state care.



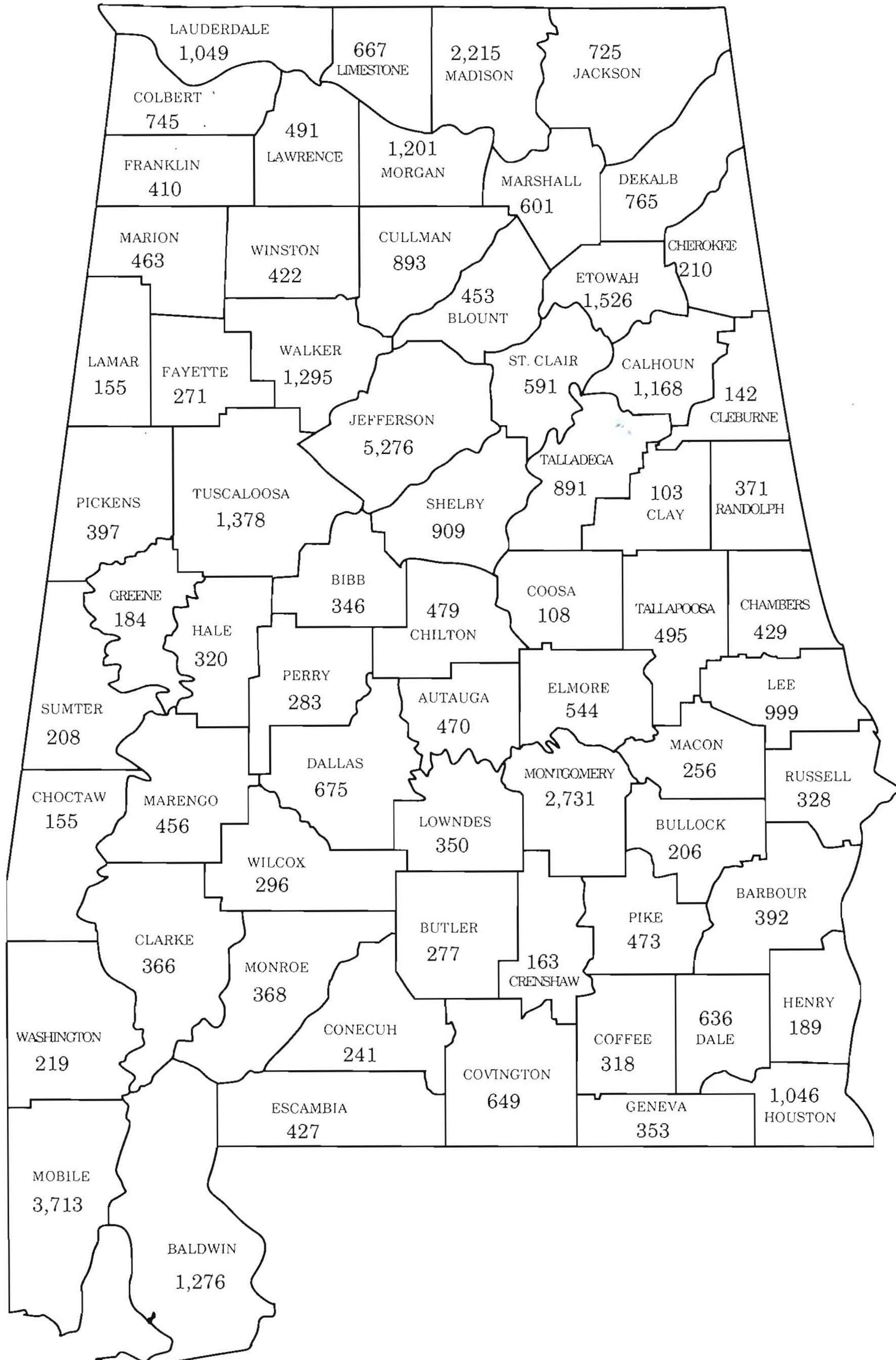
FY 1990
MEDICAID PAYMENTS FOR SOBRA ELIGIBLES
(In Thousands)

Table - 23



FY 1990
SOBRA ELIGIBLES

Table - 24



ALTERNATIVE SERVICES

The Medicaid Agency administers several programs that provide alternatives to institutionalization of Medicaid eligibles. The waiver programs, mental health services program, and the home-care services program serve the elderly and disabled, mentally retarded, and chronically mentally ill Medicaid populations. These programs provide quality and cost-effective services to individuals at risk of institutional care.

The managed care program at Medicaid is exploring different methods of health care delivery. The present "fee for service" system of care does not provide for a coordinated, case managed system of care and does not emphasize preventive care. The goal of the managed care program is to develop a quality, accessible, and cost effective system of care for all Medicaid eligibles.

Managed Care

Many states are redesigning their Medicaid programs from a traditional fee-for-service health care delivery system to a managed care approach. This concept promotes a coordinated and comprehensive system of health care services that emphasizes prevention and education. There is substantial evidence that managed care plans provide quality health care at less cost than fee-for-service. The Alabama Medicaid Agency plans to initiate the managed care concept for all geographical areas of the state over the next five years.

Managed care is a coordinated strategy designed so that a primary health care provider or case manager may provide care directly to patients and authorize all other health care, except true emergencies, that is received by the patient.

With fee-for-service, access to health care services is limited for many Medicaid recipients. Many beneficiaries lack a routine system of coordinated and continuous health care. This lack of care usually results in fragmentation, duplication of services, and indiscriminate "doctor shopping." Under the managed care concept, the patient is directed to use a primary provider, and the unnecessary use of hospital emergency rooms, drug prescriptions, and medical tests are eliminated.

Waiver Services

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. The waiver programs are aimed at helping recipients receive extra services that are not ordinarily covered by the Medicaid program in this state.

The waiver for the mentally retarded provides habilitation services, group home services, supervised community living arrangement services and respite care to Medicaid eligible mentally retarded clients. The Department of Mental Health and Mental Retardation contracts with providers statewide to provide services for the waiver. The services provided through this program prevent needless institutionalization and give support to recipients released from mental retardation facilities.

The difference in cost between services provided under the waiver and institutional services is dramatic. It costs less than $10,000 a year to care for a mentally retarded client in the community, compared to institutional care which costs nearly $50,000 a year. During FY 1990, about $12 million was expended to provide services to 1,732 clients through the MR waiver program. During the same period, almost $60 million was spent in ICF/MR institutions to serve 1,386 clients.

Medicaid's waiver program for the elderly and disabled, which was renewed for a five-year period beginning October 1, 1987, provides services to persons who might otherwise require institutionalization. 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 as of FY 1990.

People receiving services through Medicaid waivers must 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 financed 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.

The waiver services program is working with other state agencies to develop additional programs to serve Medicaid eligibles in the community. The waiver programs have proven that quality, cost effective care can be provided in a community setting.

The Omnibus Budget Reconciliation Act of 1989 greatly expanded the number of home care services to Medicaid eligibles under the age of 21. This law states that any service necessary to treat or ameliorate a condition must be provided to any Medicaid eligible under 21 years of age as long as the condition is discovered as a result of a medical check-up through the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). This provision of OBRA 1989 will greatly increase the number of children that can be served in the community.

Occupational therapy, physical therapy, increased durable medical equipment and other services as necessary to maintain Medicaid eligibles in the home are available to Medicaid eligibles under 21 as of April 1, 1990.

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, prehospitalization screening, and psychotherapy for individuals, groups and families. The program serves people with primary psychiatric and substance abuse diagnoses. There are 25 mental health centers around the state providing these services. On a monthly average during FY 1990, about $1 million was spent to provide services to approximately 6,500 clients.

Targeted Case Management

Since 1988, the Medicaid Agency has offered case management to two target groups, mentally ill adults and mentally retarded adults, as long as the individuals are Medicaid eligible. Case management to these two groups included assessment of the individual's condition, developing a plan of care, coordinating needed services, following up on the individual's progress and reassessment of the condition.

Effective April 1, 1990, as a result of cooperation among the Department of Public Health, Department of Human Resources, Children's Rehabilitation Services, and the Alabama Institute for the Deaf and Blind, case management was expanded to include four additional target groups. Medicaid eligible handicapped children, foster children, pregnant women, and AIDS/HIV positive individuals also may receive the same benefits of case management as mentally ill or mentally retarded individuals. There are a variety of different providers who assist the targeted groups in gaining access to medical, social, educational and other services.

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. Advanced medical technology has made it possible to provide more sophisticated care and equipment in the home rather than incurring the expense of institutional care. Home health patients may require intravenous therapy, tube feeding, sterile dressing changes, catheter installations, or maintenance care.

Medicaid criteria for home health services are:

- Home health agencies must have contracts with the Medicaid Agency. There were 106 agencies participating in FY 1990.
- Patients must be homebound (essentially confined to the home because of illness, injury, or disability).
- Patients must be Medicaid eligible.
- 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.

Up to 104 home health visits per year may be covered by the Medicaid Agency. In FY 1990, an average of 3,475 recipients a month received a total of 312,317 visits at a cost of over $12 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 DME providers throughout the state furnished 262,493 units of service at a cost of almost $766,000.

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 118 Alabama hospitals that participate in the Medicaid program, and 30 hospitals in neighboring states also participate in Alabama's Medicaid program.

Alabama's Medicaid program reimburses hospitals on a daily rate that varies from hospital to hospital. The 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.

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 doctor's office visit, 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.

Utilization review is mandated under federal regulations to ensure that Medicaid inpatient admissions are based on medical necessity. The inpatient utilization review unit of the Alabama Medicaid Agency performs the duties outlined in the regulations. There are 68 in-state hospitals in Alabama that are considered "delegated" and do their own utilization review; 50 hospitals are "non-delegated" and must call the Medicaid Agency for approval of medical necessity for admission and continued stays. Methods for conducting these reviews include admission screening, preadmission review, utilization review conducted by hospital committees, continued stay review, on-site review, and retrospective sampling.

Hospital utilization review is designed to accomplish these goals:

- Ensure medically necessary hospital care to recipients,
- Ensure that Medicaid funds allocated for hospital services are used efficiently,
- Identify funds expended on inappropriate services.

Limitations on hospital services were in effect during FY 1990. Inpatient hospital days are limited to 14 days per calendar year. However, additional days are available in the following instances:

- When a child has been found, through an EPSDT screening, to have a condition that needs treatment,
- When a child is under one year of age, he or she may receive unlimited inpatient days in a hospital that has been designated by Medicaid as a disproportionate share hospital,
- When authorized for deliveries (onset of active labor through discharge).

There were also limitations on outpatient hospital services during this fiscal year. Medicaid will pay for a maximum of three nonemergency outpatient visits per eligible during a calendar year. Exceptions are made for certified emergencies, chemotherapy, radiation therapy, and visits solely for lab and x-ray services. Additional outpatient visits may be prior authorized if requested by the physician.

Most Medicaid hospital patients are required to pay a copayment for hospital care. The copayments are $50 per inpatient admission and $3 per outpatient visit. Recipients under 18 years of age, nursing home residents, pregnant women and others 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.

In January 1989, Medicaid expanded coverage of organ transplants, and as a result, the number of transplants funded by the Agency has increased. In addition to kidney and cornea transplants, which do not require prior approval, Medicaid approved seven liver transplants and eleven bone marrow transplants in FY 1990. Liver transplants are limited to children under 21 years of age.

Ambulatory Surgical Center Services

Medicaid covers ambulatory surgical services, which are procedures that can be performed safely on an outpatient or ambulatory surgical center (ASC) basis. Services performed by an ASC are reimbursed by means of a predetermined fee established by the Alabama Medicaid Agency. Services are limited to three visits per calendar year, with payment made only for procedures on Medicaid's outpatient surgical list.

A listing of more than 1,700 covered surgical procedures is maintained by the Alabama Medicaid Agency and furnished to all ASCs. The list is reviewed and updated quarterly. The Agency encourages outpatient surgery whenever possible.

Ambulatory surgical centers have an effective procedure for the immediate transfer to a hospital for patients requiring emergency medical care beyond the capabilities of the center. Medicaid recipients are required to pay and ambulatory surgery center providers are required to collect the designated copayment amount for each visit. At the end of FY 1990, 17 ASC facilities were enrolled as providers in this program.

Renal Dialysis Program

The Medicaid renal dialysis program was implemented in 1973. Since that time, enrollment of renal dialysis providers in the Medicaid program has gradually increased to its present enrollment of 37 freestanding facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis, and C.A.P.D. (Continuous Ambulatory Peritoneal Dialysis), as well as training, counseling, drugs, biologicals, and related tests.

Although the Medicaid renal dialysis program is small, it is a life-saving service without which many recipients could not survive, physically or financially.

Rural Health Clinics

The Medicaid rural health program was implemented in April 1978. Services covered under the rural health program include any medical service typically furnished by a physician in an office or a 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 or nurse practitioner is available to furnish patient care while the clinic operates.

Rural health clinics are reimbursed at the reasonable cost per visit established for the clinics by the Medicare fiscal intermediary. At the end of FY 1990, eight rural health clinics were enrolled as providers in the Medicaid program.

Federally Qualified Health Centers

The Medicaid Federally Qualified Health Centers Program was implemented April 1, 1990, as a result of the Omnibus Budget Reconciliation Act of 1989. Certain Community Health Centers, Migrant Health Centers, and Health Care for the Homeless Programs are automatically qualified to be enrolled, with others able to be certified as "Look Alike" FQHCs.

Services covered by the FQHC program include ambulatory services provided by physicians, physician assistants, nurse practitioners, clinical psychologists, and clinical social workers employed by the FQHC. Federally Qualified Health Centers are reimbursed by an encounter rate based at 100 percent of reasonable cost. Medicaid establishes reasonable cost by using the centers' annual cost reports.

At the end of FY 1990, 12 FQHCs were enrolled as providers. Additional centers have been certified for enrollment by the Health Care Financing Administration.

Inpatient Psychiatric Program

The Inpatient Psychiatric Program was implemented by the Medicaid Agency in May 1989. This program provides medically necessary inpatient psychiatric services for recipients under the age of 21 if services are authorized by the Alabama Medicaid Agency and rendered in Medicaid contracted psychiatric hospitals. Only psychiatric hospitals which are approved by the Joint Commission for Accrediation of Healthcare Organizations and have distinct units and separate treatment programs for children and adolescents can be certified to participate in this program. At the end of FY 1990, there were two hospitals enrolled.

Persons participating in the programs must meet certain qualifications and the services performed must be expected to reasonably improve the patient's condition or prevent further regression.

An individualized active treatment plan must be developed by the treatment team for each recipient and forwarded to the Medicaid Agency for authorization for services.

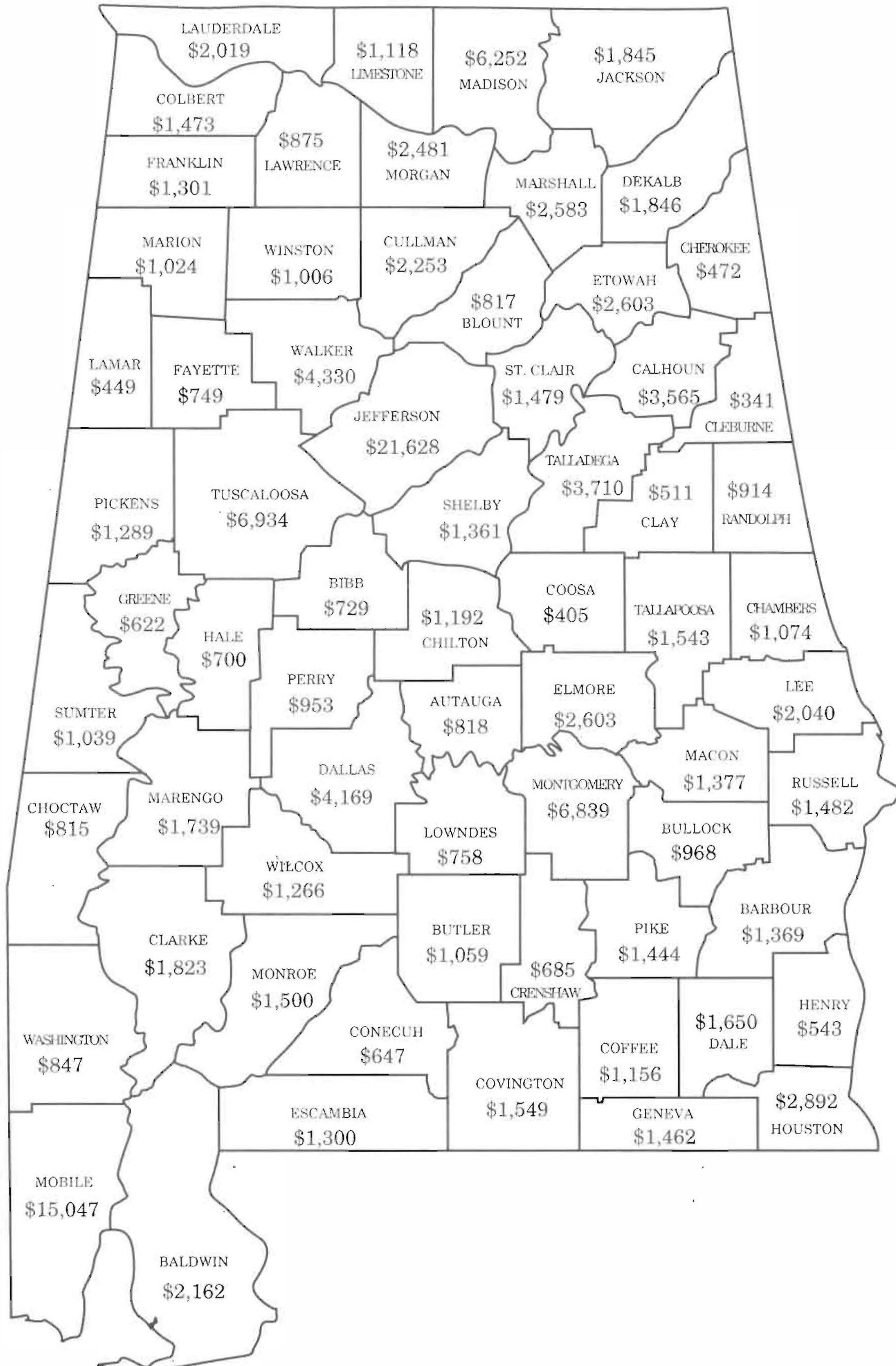
FY 1988-1990
HOSPITAL PROGRAM
Changes in Use and Cost

Table - 25

Year	Recipients of Inpatient Care	Payments For Services	Medicaid's Annual Cost Per Recipient
1988	46,449	81,541,443	1,756
1989	58,733	105,900,822	1,803
1990	60,350	135,255,262	2,241

FY 1990
PAYMENTS TO HOSPITALS
By County (in thousands of dollars)

Table – 26



FY 1986-1990
HOSPITAL PROGRAM
Outpatients

Table - 27

	FY '86	FY '87	FY '88	FY '89	FY '90
Number Of Outpatients	102,082	92,255	92,600	103,665	115,957
Percent of Eligibles Using Outpatient Services	27%	25%	25%	27%	33%
Annual Expenditure For Outpatient Care	$13,006,467	$6,801,149	$8,258,803	$9,605,911	$12,824,623
Cost Per Patient	$127	$74	$89	$93	$112

PHYSICIAN PROGRAM

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. Service to eligibles is based on medical necessity, with physicians determining 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 eligibles received physicians' services in FY 1990.

Recipients visiting a physician are required to pay a $1 co-payment per office visit. The reason for co-payments 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 co-payments. These include family planning services, physician inpatient hospital visits, physical therapy, and emergencies. Physicians may not deny services due to the recipient's inability to pay the co-payment.

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

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 most 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.

Eye Care Program

The Alabama Medicaid eye care program provides eligibles with continued high quality professional eye care. For children, good eye-sight 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 (21 years of age and older) are eligible for one complete eye examination and one pair of eyeglasses every two calendar years. Recipients under 21 years of age are eligible for an eye examination and one pair of eyeglasses every calendar year. However, Medicaid does not replace eyeglasses due to loss or breakage. Hard or soft contact lenses are available when prior authorized by the Medicaid Agency for apkakic (post cataract surgery) patients and for the treatment of keratoconus. Included in this service are the fitting of the lenses and supervision of adaptation.

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

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 services.

Since lab and x-ray services are ancillary parts of other services, Medicaid will not pay for lab and x-ray services if the other services performed are not covered.

Laboratory and radiology providers must be approved by the appropriate licensing agency, and independent labs and x-ray facilities must sign a contract with Medicaid.

FY 1990
PHYSICIAN PROGRAM
Use and Cost

Table - 28

Category	Payments	Recipients	Cost per Recipient
Aged	$3,188,946	53,392	$60
Blind	$399,316	1,386	$288
Disabled	$20,307,394	70,322	$289
Dependent	$37,694,972	171,470	$220
All Categories	$61,590,628	280,280	$220

FY 1989-1990
LAB AND X-RAY PROGRAM
Use and Cost

Table - 29

Year	Payments	Recipients	Annual Cost Per Recipient
1989	$1,626,541	51,097	$32
1990	$2,806,128	71,226	$39

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. Alabama Medicaid has had a skilled nursing program since 1970.

In FY 1990, the long-term care program consisted of skilled and intermediate care. Recipients who are sick enough to require around-the-clock nursing care are furnished skilled care. The Alabama Medicaid Agency has provided intermediate care since 1972.

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, but as the decade progressed the trend gradually was reversed. In FY 1990 only 14 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 that treat both skilled and intermediate care patients. Another reason was the advent of combination reimbursement. Nursing homes are reimbursed at a single corporate rate based on allowed costs rather than 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 patients have genuine medical needs requiring professional nursing care, and a management information system that makes timely and accurate financial eligibility decisions possible.

A regulation issued by the Department of Health and Human Services, provides an alternative to terminating Medicare and Medicaid provider agreements with long term care facilities that are found to be out of compliance with program requirements. In facilities with deficiencies that do not pose immediate jeopardy to the health and safety of patients, Medicaid may impose a sanction denying payment for new Medicaid admissions. The denial of payment sanction provides an option to terminating a facility's provider agreement while still promoting correction of deficiencies.

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

Medicaid pays the long-term care facility 100 percent of the difference between the Medicaid-assigned reimbursement rate and the patient's available income.

FY 1988-1990
LONG-TERM CARE PROGRAM
Patients, Months, and Costs

Table - 30

Year	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
1988	20,755	251 Days	5,218,730	$29	$152,068,104
1989	21,272	229 Days	4,877,082	$31	$152,211,271
1990	21,648	235 Days	5,087,346	$33	$169,195,695

FY 1990 — Table - 31
LONG-TERM CARE PROGRAM
Number and Percent of Beds Used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	Annual Unduplicated Total Patients	Percent of Beds Used By Medicaid In An Average Month
1988	22,622	14,278	20,755	63.1%
1989	22,293	13,012	21,272	58.4%
1990	22,302	13,300	21,648	59.6%

FY 1990 — Table - 32
LONG-TERM CARE PROGRAM
Recipients by sex, race, and age

	Skilled	Intermediate	Total
All Recipients	4,947	16,708	21,655
By Sex			
Female	3,715	12,744	16,459
Male	1,232	3,964	5,196
By Race			
White	3,486	13,484	16,970
Nonwhite	1,461	3,224	4,685
By Age			
0-5	33	1	34
6-20	95	58	153
21-64	513	1,567	2,080
65 & Over	4,306	15,082	19,388

FY 1990 — Table - 33
LONG-TERM CARE PROGRAM
Payments by sex, race, and age

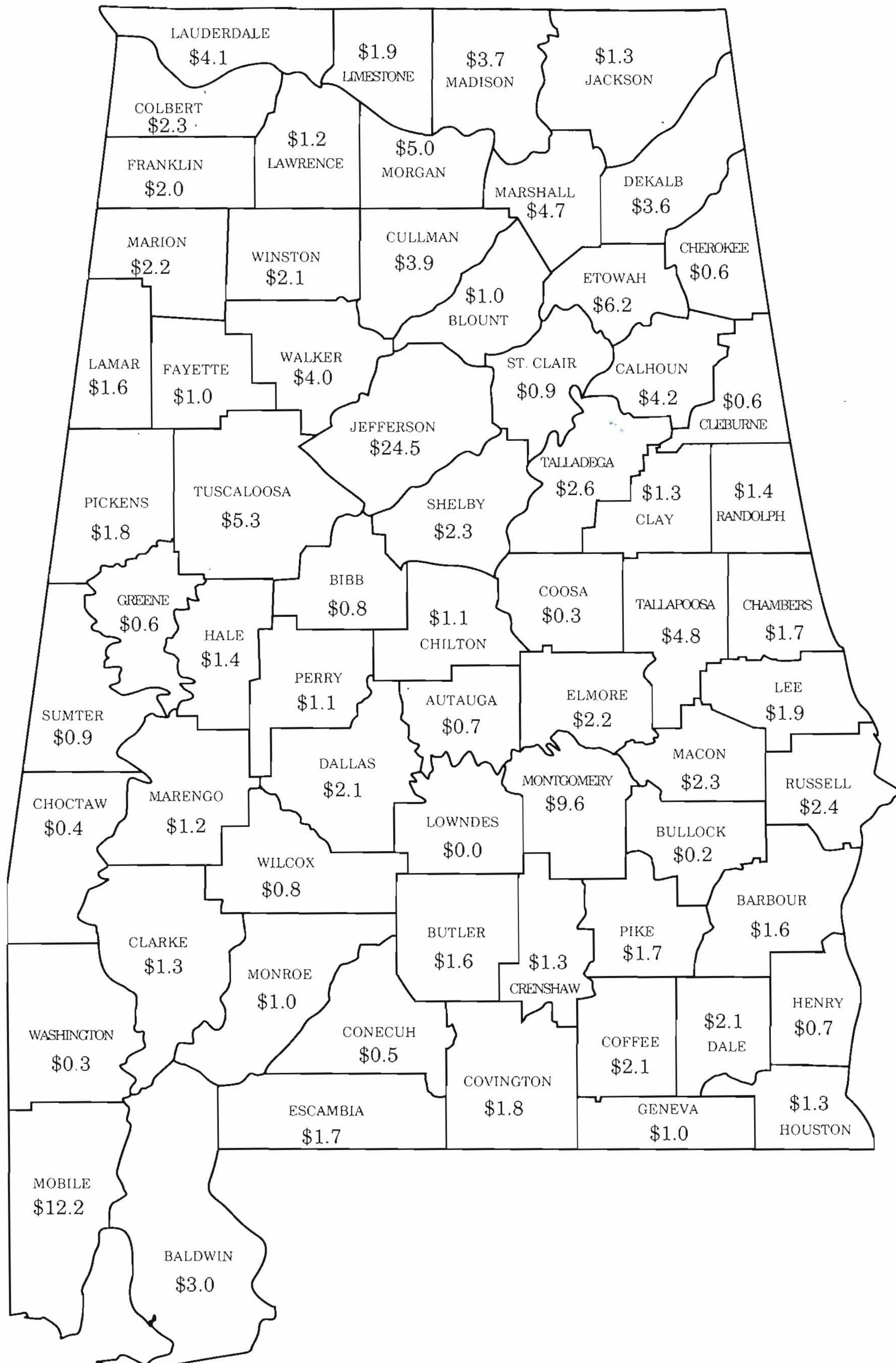
	Skilled	Intermediate	Total
All Recipients	$24,445,239	$144,750,456	$169,195,695
By Sex			
Female	$18,582,305	$111,851,559	$130,433,864
Male	$5,862,934	$32,898,897	$38,761,831
By Race			
White	$16,640,852	$115,372,213	$132,013,065
Nonwhite	$7,804,387	$29,378,243	$37,182,630
By Age			
0-5	$540,516	$6,330	$546,846
6-20	$1,618,484	$876,919	$2,495,403
21-64	$3,520,858	$16,047,489	$19,568,347
65 & Over	$18,765,380	$127,819,718	$146,585,099

FY 1988-1990 — Table - 34
LONG-TERM CARE PROGRAM
Number of Recipients

	Skilled			Intermediate			Total		
	FY '88	FY '89	FY '90	FY '88	FY '89	FY '90	FY '88	FY '89	FY '90
Monthly Average	1,150	1,105	1,865	13,128	11,907	11,443	14,278	13,012	14,278
Yearly Total	2,930	4,057	4,947	17,825	17,215	16,701	20,755	21,272	21,648
Average Length of Stay	139 days	99 days	146 days	270 days	258 days	261 days	251days	229 days	235 days

FY 1990
PAYMENTS TO NURSING HOMES
By County (in millions of dollars)

Table – 35



LONG TERM CARE FOR THE MENTALLY ILL

The Alabama Medicaid Agency, in coordination with the State Department of Mental Health and Mental Retardation, includes coverage for Medicaid-eligible mentally retarded and mentally diseased recipients who require care in an Intermediate Care Facility (ICF). Eligibility for these programs is determined by categorical, medical and/or social requirements specified in Title XIX. The programs provide treatment which includes training and habilitative services intended to aid the intellectual, sensorimotor, and emotional development of a resident.

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.

In recent years there has been a reduction of more than 300 beds in intermediate care facilities for the mentally retarded statewide. This reduction is a cooperative effort by the Department of Mental Health and Mental Retardation and the Alabama Medicaid Agency to deinstitutionalize as many clients as possible and serve clients in the least restrictive setting.

In addition to contributing the federal share of money for care in large residential facilities, Medicaid also covers intermediate care of mentally retarded residents in three small facilities of 15 or fewer beds. Those facilities include Great Hall-Riverbend Center for Mental Health in Tuscumbia, Volunteers of America #20 in Huntsville, and Volunteers of America #40 in Hartselle. 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.

Payments for long-term mental health and mental retardation programs have increased dramatically, from less than $2 million in FY 1979 to more than $60 million in FY 1990. In FY 1989 the average payment per day in an institution serving the mentally retarded was approximately $136.

In terms of total Medicaid dollars expended and the average monthly payment per patient, the ICF-MR/MD program is extremely costly. However, the provision of this care through the Medicaid program is saving the taxpayers of Alabama millions of state dollars. These patients are receiving services in state-operated mental health institutions. If the Medicaid program did not cover the services provided to these patients, the Alabama Department of Mental Health and Mental Retardation would be responsible for the total funding of this care through its state appropriation. In FY 1990, in cooperation with the Alabama Medicaid Agency, Mental Health was able to match every 27 state dollars with 73 federal dollars for the care of Medicaid-eligible ICF-MR/MD patients.

A home and community-based program for the mentally retarded was implemented by the Alabama Medicaid Agency in FY 1983. This is in accordance with the Agency's stated policy of using Medicaid funds to pay for effective but less expensive means of treatment. The program is designed for mentally retarded individuals who, without this service, would require institutionalization in an ICF/MR facility. Services offered are those of habilitation which insure optimal functioning of the mentally retarded within a community setting. Without these community services, more mentally retarded citizens would require institutionalization.

FY 1990
LONG-TERM CARE PROGRAM
ICF-MR/MD — **Table - 36**

	ICF/MR	ICF/MD-Aged
Recipients	1,365	340
Total Payments	$64,176,777	$4,868,805
Annual Cost Per Recipient	$47,016	$14,320

PHARMACEUTICAL PROGRAM

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

Realistically, modern medical treatment would be impossible without drugs. In recent years, medical professionals have been very successful in finding medications that make more expensive alternatives unnecessary.

In FY 1990, pharmacy providers were paid approximately $60 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about 10 percent of Medicaid payments for services. The Medicaid Agency reimburses participating pharmacists for dispensing medication that is based on the ingredient cost of the prescription plus a dispensing fee. Dispensing fees were increased effective April 1, 1988, as follows:

Retail Pharmacy	$3.75
Institutional Pharmacy	$2.77
Government Pharmacy	$1.90
Dispensing Physician	$1.21

Primarily to control overuse, Medicaid recipients must pay a copayment which ranges from 50 cents to $3, depending on drug ingredient cost. In addition, prescribing physicians are limited to the 15,000 drug entities listed on the Alabama Medicaid Formulary. The formulary consists of approximately 70 percent generic drugs. However, every effort is made to avoid restricting a physician's choice of drugs.

The pharmacy program is responsible for maintaining a list of injectable medications that can be administered by physician providers. Reimbursement for these injectables is payable through the physician program. The physician may bill either an office visit or for the cost of the drug plus an administration fee.

FY 1990 — Table - 37
PHARMACEUTICAL PROGRAM
Counts of Providers by Type

Type of Provider	Number
Retail	1,152
Institutional	34
Governmental	5
Dispensing Physician	2
Total	1,192

FY 1988-1990 — Table - 38
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
1988	226,602	62%	3,728,203	16.45	$12.90	$212.30	$48,107,554
1989	236,608	61%	3,807,604	16.09	$13.74	$221.10	$52,313,877
1990	253,457	61%	3,983,206	15.72	$15.19	$238.73	$60,508,220