The Alabama Medicaid Agency FY 1992 Annual Report

Jim Folsom
Governor
State of Alabama

Brian W. Moore
Commissioner
Alabama Medicaid Agency

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FY 1992 Annual Report
October 1, 1991 - September 30, 1992

Alabama Medicaid Agency

2500 Fairlane Drive
Montgomery, Alabama 36130

JIM FOLSOM
Governor

BRIAN W. MOORE
Commissioner

The Honorable Jim Folsom
Governor of the State of Alabama
Statehouse
Montgomery, Alabama 36130

Dear Governor Folsom:

You have before you the 20th Annual Report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1991, and ended September 30, 1992.

During the fiscal year, we continued to defend our right to raise additional state revenues through provider taxes. The support from you, the state Legislature, the Congressional delegation, and thousands of Medicaid recipients and advocates helped save the program. The Agency staff has renewed its dedication to providing the most cost effective services possible in the most efficient manner. Providing needed health care services for all eligible recipients cost $424 million in state funds, with the federal government providing more than $1.1 billion in fiscal year 1992.

The Medicaid Agency is a vital and essential part of the health care infrastructure and therefore plays a critical role in the economic development of the state. In many of our rural and inner city urban areas, Medicaid is the sole financial support for the health care system, regardless of income levels.

Although I have been Commissioner for only a short time, I have worked diligently, as others have in the past few years, to move the Medicaid program forward. With an effective Medicaid program, we ultimately enable individuals to be productive to improve the lives of their children and to improve the lives of their family members who are elderly. An investment in the health of our citizens is the greatest investment the state can make for our future.

Sincerely,

Brian W. Moore
Commissioner

Mission Statement

The mission of the Alabama Medicaid Agency is to empower our recipients to make educated and informed decisions regarding their health and the health of their families. We do this by providing a system which facilitates access to necessary, high quality, preventive and acute medical, long term care, health education and related social services to Medicaid eligibles and other needy populations of Alabama. Through teamwork we strive to operate and enhance a cost efficient system by building an equitable partnership with health care providers, both public and private.

This annual report was produced by the Outreach and Education Division of the Alabama Medicaid Agency. Statistical data was produced by the Agency's Planning and Analysis Division.

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Highlights

Introduction: There was much uncertainty surrounding the future of the Alabama Medicaid program during fiscal year 1992. The Health Care Financing Administration (HCFA) issued a regulation designed to severely restrict states' use of provider taxes. The taxes have been widely used to increase the state's share eligible for federal matching funds. The regulation placed Alabama in a precarious situation. Receiving almost 50 percent of the state share from provider taxes, Medicaid was faced with a possible shutdown of the program. A compromise was reached in November 1991 with the federal government allowing states to continue using the taxes but with a change in the methodology of taxing providers.

Even through a time when the future looked bleak, the Medicaid program continued to operate with successes. The maternity waiver program, providing a comprehensive, coordinated, and case managed system of total obstetrical care, expanded into 16 additional counties. The expansion brought to a total of 38 the number of counties participating in the program during FY 1992. Those added were Choctaw, Clarke, Conecuh, Cullman, Dallas, Escambia, Fayette, Lamar, Lee, Marengo, Marion, Marshall, Perry, St. Clair, Washington and Wilcox counties.

The infant mortality rate for 1991 was 11.2 deaths per 1,000 live births. Although up from the 1990 rate of 10.9 infant deaths per 1,000 live births, the 1991 rate was one of the lowest rates in many years. Alabama still ranks above average nationally in the number of infant deaths each year, but as a result of outreach efforts by Medicaid, the Department of Public Health, advocacy groups, physicians, and a variety of health care organizations to educate women on the importance of prenatal care and healthy lifestyles during pregnancy, the state is starting to see improved birth outcomes.

Provider Specific Taxes, Part II: In November 1991, Congress enacted a statute which required the Medicaid Agency to ask the state Legislature during its 1992 session to revise the Agency's provider taxes that were passed the previous year. The Alabama Legislature during its 1991 session passed into law a tax on all pharmacies and on nursing homes and hospitals in the state that accepted Medicaid patients. The taxes would be used to generate revenue for the Medicaid program. The statute issued in November required states, if participating in the provider tax program, to tax all providers in a particular class such as all hospitals and all nursing homes — not just those accepting Medicaid.

With the change in the tax structure came some improvements in the Medicaid program. Since October 1, 1991, physicians delivering babies in rural communities have been reimbursed at a higher rate than their urban counterparts. The rate is $1,700 per global delivery for rural areas and $1,300 per global delivery in urban areas. The higher rate in rural settings is expected to encourage physicians to remain in the rural areas.

Hospitals in rural communities have also seen an adjustment in the way they are reimbursed by Medicaid. Instead of being reimbursed at a limited percentage based on operating costs, rural hospitals are now paid at 100 percent of their operating costs.

Other improvements include an increase in the number of reimbursable inpatient hospital days and inpatient physician services from 14 to 16 days, and visits made to a doctor's office were increased from 12 to 14 per recipient per year.

Pryor Bill Implemented: The Pryor Bill, passed by Congress as part of the Omnibus Budget Reconciliation Act of 1990, provides for an open formulary for Medicaid pharmacy programs across the nation. The bill requires states to cover almost all drugs produced by drug manufacturers that have signed rebate agreements with the Secretary of Health and Human Services. The purpose of the legislation was to pass on to the Medicaid programs the discounts drug manufacturers have traditionally offered their larger clients.

Because of the Pryor Bill, Medicaid recipients have access to more drugs that can be prescribed by their physicians. At the same time, physicians have a greater number of reimbursable drugs to prescribe to their Medicaid patients.

Medicaid budgeted $24 million in state and federal funds for implementation of this federal law during the last four months of FY 1991. The state share of that amount was $6.5 million. Although the law was actually implemented during FY 1991, the Agency did not feel an effect until FY 1992.

Preventive Health Education Services Implemented: Effective October 1991, Medicaid began covering preventive health education classes. The preventive health education program is designed to offer expanded educational services for pregnant and postpartum women that go beyond the limited services offered under the existing Medicaid program. These services are provided in a

classroom setting by a physician or other licensed practitioner of the healing arts who presents detailed preventive health educational material. The program curricula are designed to teach disease and disability prevention and to prolong life and promote physical and mental health.

The educational services covered include the following:

Prenatal parenting (childbirth preparation) - a series of classes teaching pregnant women about the process of pregnancy, healthy lifestyles and the importance of regular prenatal care.

Postnatal parenting - a series of classes designed to help new parents improve their parenting skills by focusing on specific needs of newborns, toddlers, and children up to the age of six.

Adolescent pregnancy prevention - a series of classes teaching male and female adolescents about the consequences of unintended pregnancies and decision making skills.

In FY 1992, 17 providers were enrolled as preventive health education providers. These included hospitals, county health departments, and private organizations. It is believed this program will be a catalyst in helping reduce the number of infant deaths, helping reduce the number of babies being born to adolescents, encouraging healthy lifestyles during pregnancy, encouraging better health care practices for babies and adolescents, and reducing costly medical expenses overall.

"Bonus" Program Started: Citing the number of pregnant women in Alabama who delay prenatal care, the Alabama Medicaid Agency started an incentive program in June, 1992 that is designed to boost the number of women who go for care in the first trimester of pregnancy.

Funded by the Southern Triangle Chapter of the March of Dimes and the Medicaid Agency, the Healthy Beginnings Bonus Program is an intensive six-month effort to increase first trimester care rates in 35 counties in the state. The project is administered by Medicaid and the Montgomery Area Food Bank in conjunction with Second Harvest Food Banks in Montgomery, Mobile, Dothan, Tuscaloosa, and Columbus, Ga.

Women who go for care in the first trimester (12 weeks) of pregnancy are eligible to receive a free incentive gift package containing a minimum of ten pounds of food and grocery items, along with information about nutrition and pregnancy-related topics. The incentive gift packages are distributed through the food banks' distribution network in each county.

The Bonus initiative is an outgrowth of the award-winning Healthy Beginnings incentive and awareness program for pregnant women. Unlike the Healthy Beginnings Program, the Bonus initiative targets Medicaid-eligible women only.

The 35 counties participating include Autauga, Baldwin, Barbour, Bibb, Bullock, Butler, Chilton, Choctaw, Clarke, Coffee, Conecuh, Covington, Crenshaw, Dale, Dallas, Elmore, Escambia, Geneva, Greene, Hale, Henry, Houston, Lee, Lowndes, Macon, Marengo, Mobile, Monroe, Montgomery, Perry, Pike, Russell, Sumter, Washington, and Wilcox.

HCBS Waivers Implemented: During FY 1992, two new Home and Community Based Service (HCBS) waivers were implemented to provide individuals the special care they need at home.

One of the new waivers, called the Homebound Waiver, was implemented in April, 1991 and provides care in the homes of persons ages 21 through 64 who are eligible for Medicaid-financed nursing home care. Individuals eligible for the program include those having primary or secondary diagnoses of quadriplegia, traumatic brain injury, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophies, spinal muscular atrophy, severe arthritis, Parkinson's disease or rare genetic disease. The services are provided but not limited to persons having these diagnoses.

Services offered by the Homebound Waiver include case management, personal care, respite care, environmental modifications, transportation, personal emergency response, and assistive technology.

State funds for the program are provided by the Department of Education, which in previous years administered a similar program under the Rehabilitation Services Division. The Division operated the program, funded only by the state, at a cost $4.1 million in FY 1991. This is the first time Medicaid has entered into an agreement of this kind with the Department of Education.

There will be a phase-in of the Homebound Waiver over a three-year period. During the first year, approximately 450 people will be served at a total cost of $3.4 million, with the state supplying a little over $900,000. The second year, 900 people will be served at a total cost of $6.6 million, and the state will supply $1.8 million. By the third year, a total of $10.2 million will be spent to serve 1,300 people, with the state furnishing approximately $3 million.

The other HCBS waiver implemented during FY 1992 is a result of the Omnibus Budget Reconciliation Act (OBRA) of 1987. Overall, OBRA 1987 mandated higher quality of care and more direct patient care for residents of nursing facili-

ties. The OBRA Waiver provides care in the home for mentally retarded and developmentally disabled individuals who have been residing in nursing facilities.

To be able to participate, individuals may have income levels up to 300 percent of the SSI Federal Benefit Rate. In FY 1992, the SSI Federal Benefit Rate was $1,266 per month. There are no age criteria, but each participating individual must first be discharged from a nursing facility.

Under the OBRA waiver, recipients are able to receive the following services: case management, personal care, respite care, day habilitation, prevocational training, supported employment, environmental modification, skilled nursing care, specialized medical equipment and supplies, personal emergency response systems, companion service, and physical, occupational, speech, language, and hearing therapies.

This waiver will also be less expensive to taxpayers. The cost per recipient on the waiver is estimated at $31,507 compared to $51,937 in an intermediate care facility for the mentally retarded.

The Department of Mental Health and Mental Retardation is the administering state agency. This waiver is limited to 417 slots.

The OBRA Waiver is somewhat similar to another waiver that has been operational for several years. The OBRA Waiver and the Waiver for the Mentally Retarded and Developmentally Disabled both serve mentally retarded individuals, but the Waiver for the Mentally Retarded and Developmentally Disabled is limited to individuals on SSI who are at risk of being institutionalized. The services provided are basically the same.

Low Payment Error Rate: The Alabama Medicaid Agency had the lowest payment error rate of the Health Care Financing Administration's (HCFA) Region IV states. Included in Region IV are Tennessee, Kentucky, Georgia, Mississippi, North Carolina, South Carolina, Florida, and Alabama. Payment error rate is a measure that shows the percentage of payments made on behalf of people ineligible for Medicaid. The most recent error rate, released in September 1992 for the reporting period of October 1990 through September 1991, shows that Alabama's rate was .359 percent. The next lowest state, Florida, had a payment error rate of 1.12 percent.

A low payment error rate reflects efficient management of a state's Medicaid program. States must maintain an error rate of less than three percent to avoid sanctions by the federal government.

Third Party Recoupments: Medicaid is a secondary payor to all third party resources, i.e., insurance companies providing health care for Medicaid recipients, liability insurance carriers, absent parent medical support, and others. For FY 1992, approximately 11 percent of Medicaid eligibles were identified as covered by third party resources.

During the 1992 fiscal year, Medicaid's Third Party Section collected $2.6 million from third parties. Provider-reported collections from third parties saved Medicaid an additional $4.7 million.

In addition to these savings, Medicaid returned to providers claims totaling in excess of $23 million because of potential health insurance resources. It is estimated these claims represent an additional $4 million in cost avoided savings never reported to Medicaid because third parties paid the claim in full.

Medicaid returned claims totaling $14 million to providers for submission to Medicare, the primary payor. In FY 1992 Medicaid also recouped $409,000 from providers who had received payment from both Medicaid and a third party.

During the last fiscal year, the Alabama Medicaid Agency continued in its partnership to pay health insurance premiums of Medicaid eligibles who had enrolled in a health insurance plan with Humana Insurance Company. Savings to Medicaid for the first twelve months (May 1, 1991-April 30, 1992) totaled over $300,000 based on an average of 4,967 enrollees. The savings is based on 1,100 admissions to Humana hospitals and 123 admissions to other hospitals. As of September 30, 1992, Medicaid was paying premiums for approximately 6,500 individuals who had taken out the Humana health plan.

Looking Ahead: Fiscal year 1993 will begin with few changes in Alabama's Medicaid program. After several years of rapid growth and monumental changes, the Agency will have time to stabilize and refine the program. However, the year will not be without accomplishments.

Healthy Beginnings will expand to include a pediatric component to encourage mothers to take their newborn babies in for periodic well-child check-ups during the first year of life.

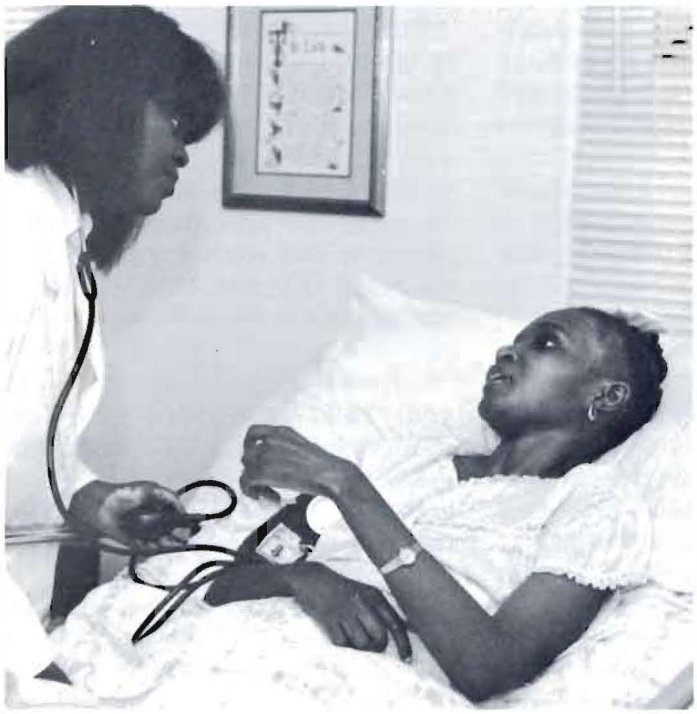
There will be a major change in the cards recipients use to obtain Medicaid-financed health care. In November 1992, Medicaid will change from monthly eligibility cards to more permanent plastic cards. The cards will look similar to credit cards and will have a magnetic stripe on one side that will be encoded with eligibility information.

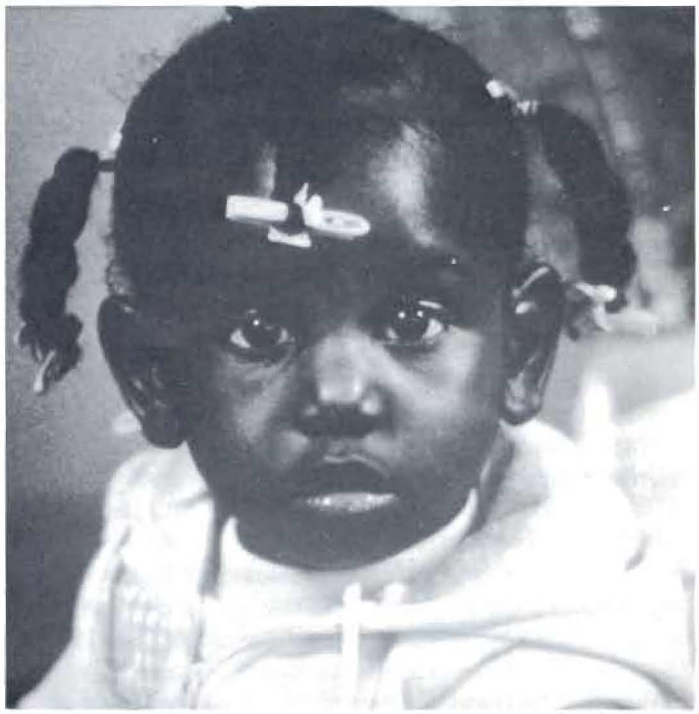
Providers will have access to a new method of verifying eligibility for their Medicaid patients during FY 1993. The Medicaid Automated

Claims Submission and Adjudication System (MACSAS) will become functional during FY 1993. MACSAS will give Alabama Medicaid providers computerized access to recipient eligibiity, third party insurance information, and benefit limitations through a point-of-service device.

The nation will elect a new President during FY 1993 and health care was an issue discussed greatly during the campaign. There are sure to be changes in the program during the months after the election and the Agency will see that Alabama has a voice in those changes.

The Medicaid program is vital to all citizens of the state. It is an essential part of the total health care infrastructure. The Alabama Medicaid Agency will continue in FY 1993 to provide the most effective services in the most cost efficient manner. With a successful Medicaid program, the state's most vulnerable citizens, the young and the very old, have a better chance to have healthy and productive lives. When the state's people are healthy and productive, the state has a better opportunity to be rich and prosperous.





Alabama's Medicaid Program

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

A State Program: Medicaid is a state-administered health care assistance program. All states, 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 1992, 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 (SSI) from the Social Security Administration, which determines their eligibility. Children born to mothers receiving SSI may be eligible for Medicaid until they reach one year of age. After the child's first birthday, it is up to the mother to seek Medicaid eligibility for the child under a different program.

* Persons approved for cash assistance through the State Department of Human Resources, which determines their eligibility. Most people in this category receive Aid to Families with Dependent Children (AFDC) or State Supplementation.

* Certain pregnant women and young children, including those with incomes under 133 percent of the federal poverty level who do not receive an AFDC cash payment, and foster children in the custody of the state. Also covered are children born after September 30, 1983, who have celebrated their sixth birthday, and who live in families with annual incomes up to 100 percent of the federal poverty level. Medicaid eligibility workers determine their eligibility.

* 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. Medicaid District offices determine eligibility for persons in these categories.

* Qualified Medicare Beneficiaries (QMBs) who are low income. Persons in this group 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. Medicaid District Offices determine eligibility for QMBs.

* Disabled widows and widowers between ages 60 and 64 who are not eligible for Medicare Part A and who have lost SSI because of receiving early widows/widowers benefits from Social Security. Medicaid District Offices determine eligibility for this group.

Persons in these eligibility categories may be eligible for retroactive Medicaid coverage if any medical bills had been incurred three months prior to the time of applying for Medicaid.

Some persons in eligibility categories are protected by federal law from losing their Medicaid benefits. One of those categories includes Pickle (or Continued Medicaid) cases. Persons in this category receive Social Security and would also receive SSI if the cost of living raises did not push them above the income limit to receive SSI. Another category protected from losing eligibility are disabled adult children if their SSI stopped because of an increase in or entitlement to Social Security benefits.

Covered Services: Medical services covered by Alabama's Medicaid program traditionally have been fewer and less comprehensive than most states'. In recent years, however, federal mandates and the Agency's own initiatives have expanded and improved the overall program. 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: For many years Medicaid recipients have been issued monthly paper cards signifying their eligibility. In November 1992, the Agency will convert to plastic cards that will be issued on a more permanent basis. It will continue to be the option of providers to accept Medicaid recipients as patients and it will be the responsibility of the providers to verify eligibility when delivering care to recipients. Providers include physicians, pharmacies, 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 low income 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 1992, Medicaid paid over $1.5 billion to providers on behalf of persons eligible for the program. The federal government paid approximately 73 percent 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 of three, Medicaid expenditures generated over $4.2 billion worth of business in Alabama in FY 1992.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. With the current administrative rate, almost 98 percent 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 1992 **Table - 1**
COUNTY IMPACT
Year's cost per eligible

County	Benefit Payments	Eligibles	Payment Per eligible	County	Benefit Payments	Eligibles	Payment Per eligible
Autauga	$5,474,470	4,152	$1,319	Houston	$14,754,046	10,803	$1,366
Baldwin	$16,481,132	9,114	$1,808	Jackson	$10,198,079	5,937	$1,718
Barbour	$7,835,976	5,003	$1,566	Jefferson	$152,300,529	76,517	$1,990
Bibb	$4,057,173	2,438	$1,664	Lamar	$4,383,268	1,970	$2,225
Blount	$6,899,740	3,920	$1,760	Lauderdale	$18,155,080	8,370	$2,169
Bullock	$5,083,562	3,113	$1,633	Lawrence	$7,060,003	4,333	$1,629
Butler	$7,979,004	4,457	$1,790	Lee	$13,792,772	8,701	$1,585
Calhoun	$25,521,572	14,235	$1,793	Limestone	$9,993,350	6,409	$1,559
Chambers	$9,614,992	5,471	$1,757	Lowndes	$3,956,365	3,773	$1,049
Cherokee	$4,480,378	2,106	$2,127	Macon	$9,730,936	5,634	$1,727
Chilton	$7,943,601	4,485	$1,771	Madison	$33,025,364	25,446	$1,298
Choctaw	$4,655,649	3,109	$1,497	Marengo	$7,743,623	4,891	$1,583
Clarke	$8,498,472	6,238	$1,362	Marion	$8,330,633	3,683	$2,262
Clay	$4,362,520	1,803	$2,420	Marshall	$19,960,332	9,005	$2,217
Cleburne	$2,818,924	1,485	$1,898	Mobile	$102,564,751	56,974	$1,800
Coffee	$11,739,590	4,621	$2,540	Monroe	$6,169,738	3,846	$1,604
Colbert	$11,459,749	6,027	$1,901	Montgomery	$51,543,338	32,810	$1,571
Conecuh	$4,960,347	2,967	$1,672	Morgan	$37,873,411	10,182	$3,720
Coosa	$2,124,827	1,387	$1,532	Perry	$6,398,134	4,116	$1,554
Covington	$12,588,001	5,764	$2,184	Pickens	$7,990,052	4,295	$1,860
Crenshaw	$5,214,075	2,542	$2,051	Pike	$9,559,677	5,781	$1,654
Cullman	$18,055,592	7,507	$2,405	Randolph	$6,055,604	3,024	$2,003
Dale	$10,066,233	5,667	$1,776	Russell	$11,105,928	7,444	$1,492
Dallas	$19,460,578	13,888	$1,401	Shelby	$10,141,433	5,482	$1,850
Dekalb	$15,226,665	6,816	$2,234	St. Clair	$8,967,803	5,413	$1,657
Elmore	$22,038,463	6,024	$3,658	Sumter	$6,373,764	4,365	$1,460
Escambia	$9,995,568	5,441	$1,837	Talladega	$22,455,716	12,784	$1,757
Etowah	$28,204,133	13,145	$2,146	Tallapoosa	$14,766,257	6,107	$2,418
Fayette	$4,974,641	2,481	$2,005	Tuscaloosa	$66,539,830	18,582	$3,581
Franklin	$9,686,318	4,281	$2,263	Walker	$20,485,094	9,860	$2,078
Geneva	$7,044,593	3,602	$1,956	Washington	$5,077,729	3,452	$1,471
Greene	$4,785,317	3,165	$1,512	Wilcox	$6,280,818	4,941	$1,271
Hale	$6,957,765	3,789	$1,836	Winston	$8,410,338	3,373	$2,493
Henry	$4,438,538	2,506	$1,771	Other	$271,576	99	$2,743

Revenue, Expenditures, and Prices

FY 1992 **Table – 2**
Sources of Medicaid revenue

	Dollars
Federal Funds	$1,120,364,000
State Funds	$424,086,880
Total Revenue	$1,544,450,880

FY 1992 **Table – 4**
Components of federal funds

(net)	Dollars
Family Planning Administration	$104,426
Professional Staff Costs	$9,156,581
Other Staff Costs	$13,818,546
Other Provider Services	$1,092,047,706
Family Planning Services	$5,236,741
Total	$1,120,364,000

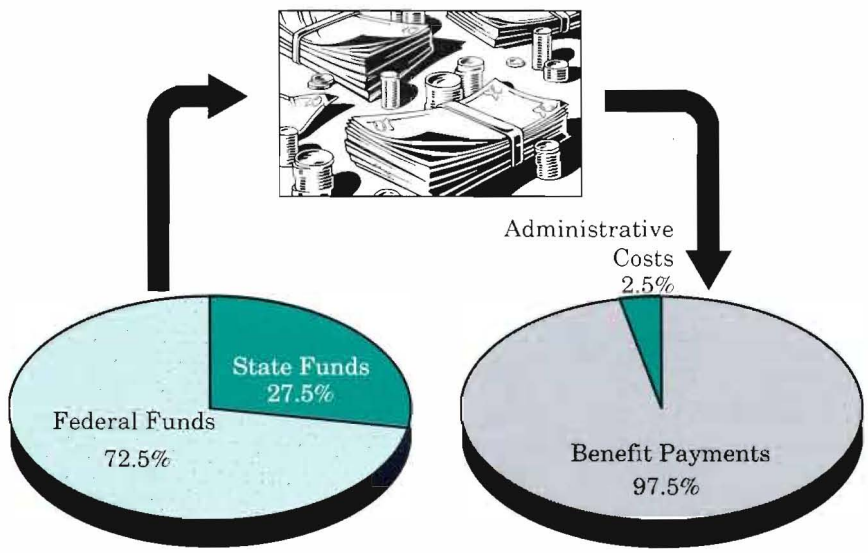
FY 1992 **Table – 5**
Components of state funds

(net)	Dollars
Encumbered Balance Forward	$5,992,949
Basic Appropriations	$129,465,000
Indigent Care Trust Fund	$242,038,936
Other State Agencies	$56,284,829
Interest Income from Fiscal Agent	$453,134
UAB (Transplants)	$36,544
Miscellaneous Receipts	$129,235
Subtotal	$434,400,627
Encumbered	$10,313,747
Total	$424,086,880

In FY 1992, Medicaid paid $1,505,635,016 for health care services to Alabama citizens. Another $38,815,864 was expended to administer the program. This means that almost 98 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 1992 **Table – 3**
Composition and disbursement of Medicaid's budget

Where it comes from . . . Where it goes



FY 1991-1992 **Table – 6**
Benefit Payments by fiscal year in which obligation was incurred

	FY '91	FY '92
Nursing Homes	$226,054,951	$307,246,323
Hospitals	$402,435,413	$663,199,686
Physicians	$70,888,504	$90,003,744
Insurance	$63,820,529	$77,702,123
Drugs	$73,102,595	$97,006,969
Health Services	$19,047,106	$30,119,322
Community Services	$89,659,920	$112,665,904
Total Medicaid Service	$945,009,018	$1,377,944,071
Mental Health	$125,171,838	$127,690,945
Total Benefits	$1,070,180,856	$1,505,635,016

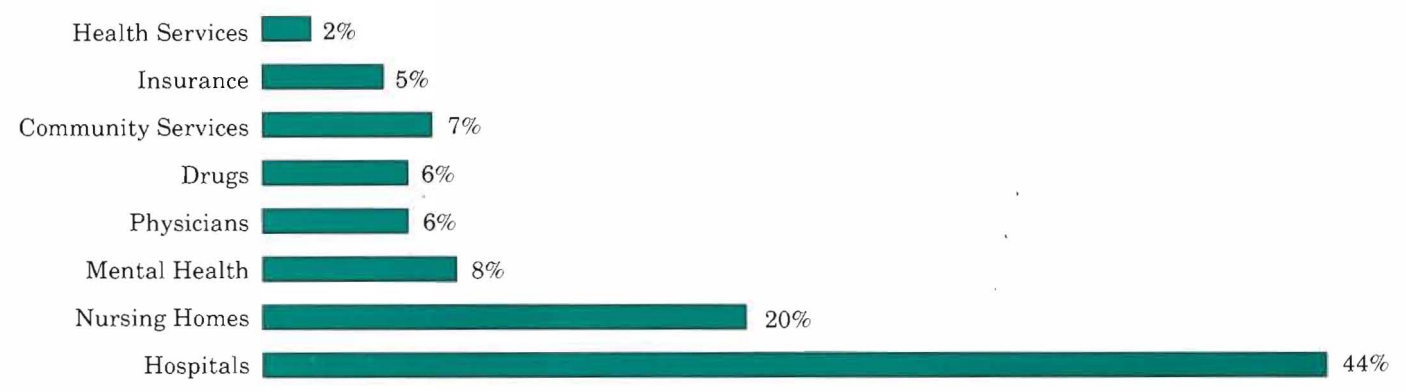
FY 1992
EXPENDITURES
By type of service (net)

Table – 7

Service	Payments	Percent of Total Payments
Hospitals:	$663,199,686	44.05%
Disproportionate Share Payments	$417,457,991	27.73%
Inpatient	$212,617,928	14.12%
Outpatient	$26,951,908	1.79%
FQHC	$6,090,620	0.40%
Rural Health Clinics	$81,239	0.01%
Nursing Homes	$307,246,323	20.41%
Waiver Services:	$105,077,807	6.98%
Pregnancy Related	$59,320,128	3.94%
Elderly & Disabled	$29,191,462	1.94%
Mental Health	$16,473,031	1.09%
SCCLA	$93,186	0.01%
Pharmacy	$97,006,969	6.44%
MR/MD:	$92,875,526	6.17%
ICF-MR	$81,845,070	5.44%
NF-MD/Illness	$10,744,710	0.71%
ICF – MD	$285,746	0.02%
Physicians:	$90,003,744	5.98%
Physicians	$87,505,909	5.81%
Other Practitioners	$2,497,835	0.17%
Insurance:	$77,702,123	5.16%
Medicare Buy-In	$42,765,723	2.84%
Medicare Co-Insurance	$34,350,156	2.28%
Humana QMB Plan	$369,617	0.02%
Managed Care	$215,525	0.01%
Catastrophic Illness Insurance	$1,102	0.00%
Health Services:	$30,119,322	2.00%
Screening	$10,504,353	0.70%
Laboratory	$6,922,791	0.46%
Dental	$6,807,077	0.45%
Eye Care	$2,434,777	0.16%
Transportation	$2,187,848	0.15%
Eyeglasses	$928,706	0.06%
Hearing	$299,982	0.02%
Other Care Services	$33,788	0.00%
Community Services:	$25,714,919	1.71%
Home Health/DME	$14,246,664	0.95%
Family Planning	$5,818,601	0.39%
Targeted Case Management	$5,092,985	0.34%
Hospice	$552,150	0.04%
Preventive Education	$4,519	0.00%
Mental Health Services	$16,688,597	1.11%
Total For Medical Care	$1,505,635,016	100.00%
Administrative Costs	$38,815,864	
Net Payments	$1,544,450,880	

FY 1992 BENEFIT PAYMENTS
Percent distribution

Table – 8



FY 1992
COLLECTIONS AND MEASURABLE COST AVOIDANCE **Table – 9**

COLLECTIONS:	
DRUG REBATE PROGRAM The collection of rebates by the Program Integrity Division from drug manufacturers for the utilization of their products.	$17,727,158
THIRD PARTY LIABILITY Includes collections by the Third Party Division and the providers, as well as retroactive Medicare recoupments and recoupments from health insurance.	$8,495,381
OTHER RECOUPMENTS Includes recoupments originating from monthly audits of 25 percent of Medicaid admissions in delegated hospitals and random audits of other hospitals.	$49,745
PROGRAM INTEGRITY DIVISION Recipient Recoupments	$587,238
PROGRAM INTEGRITY DIVISION Provider Recoupments	$580,072
TOTAL COLLECTIONS	**$27,439,594**
MEASURABLE COST AVOIDANCE:	
PRIOR APPROVAL AND PREPAYMENT REVIEW Results from denials in nondelegated hospitals	$69,250
THIRD PARTY CLAIM COST AVOIDANCE – MEDICARE Claims denied and returned to providers to file Medicare.	$14,197,183
THIRD PARTY CLAIM COST AVOIDANCE – OTHER Claims denied and returned to providers to file health insurance.	$23,394,109
WAIVER SERVICES COST AVOIDANCE – ELDERLY AND DISABLED	$71,585,280
WAIVER SERVICES COST AVOIDANCE – PREGNANCY RELATED	$1,404,974
WAIVER SERVICES COST AVOIDANCE – MR/DD	$96,330,211
TOTAL MEASURABLE COST AVOIDANCE:	**$206,981,006**
GRAND TOTAL:	**$234,420,600**

Population

The population of Alabama grew from 3,444,165 in 1970 to 4,040,587 in 1980. In 1992, Alabama's population was estimated to be 4,075,047.

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 older 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 older in the state. The Center for Demographic and Cultural Research at Auburn University at Montgomery reports that white females 65 years of age and older account for almost one half of the elderly population in the state. Historically, cost per eligible has been higher for this group than for other groups of eligibles.

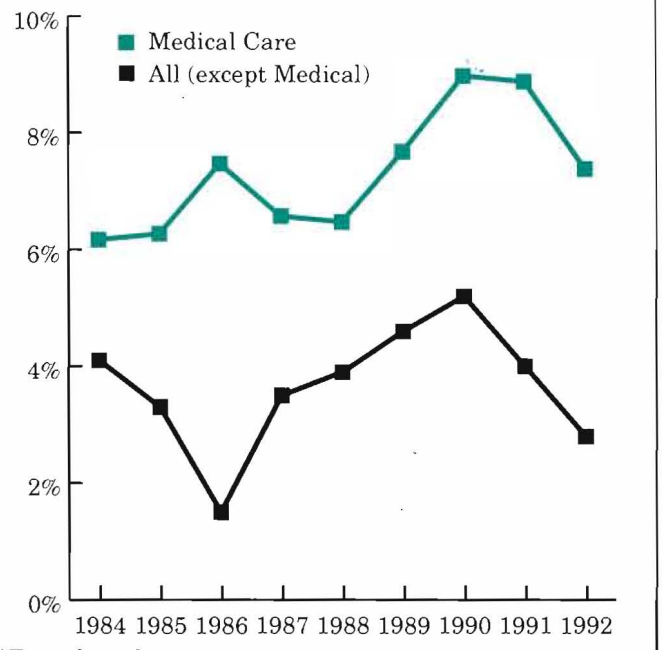
FY 1990-1992 **Table – 10**
POPULATION
Eligibles as a percent of Alabama population by year

Year	Population	Eligibles	Percent
1990	4,040,587	418,663	10.4%
1991	4,057,585	482,104	11.9%
1992	4,075,047	551,151	13.5%

Prices

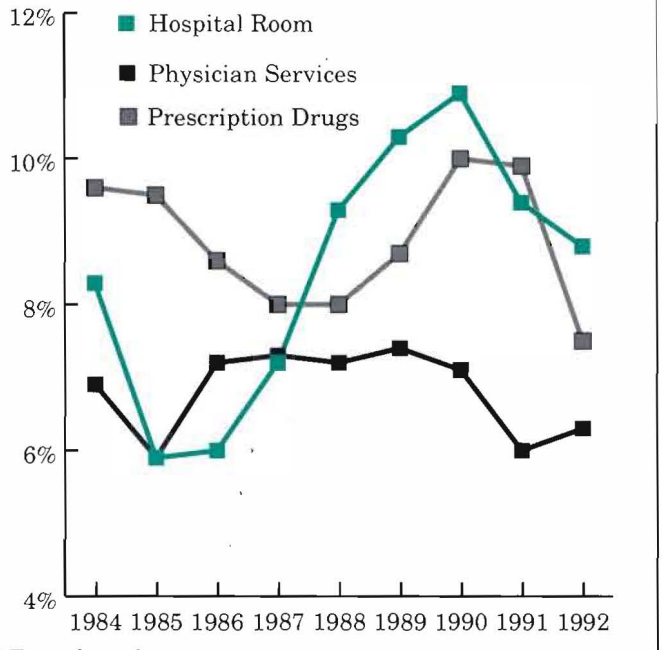
These charts show historical trends in the rate of growth in the Consumer Price Index (CPI). Increases in the CPI are usually reflected in future increases in Medicaid payments to providers.

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



*For selected items 1984-1992

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



*For selected items 1984-1992

Eligibles

During FY 1992, there were 551,151 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 432,734. The monthly average is the most useful measure of Medicaid coverage because it takes into account length of eligibility.

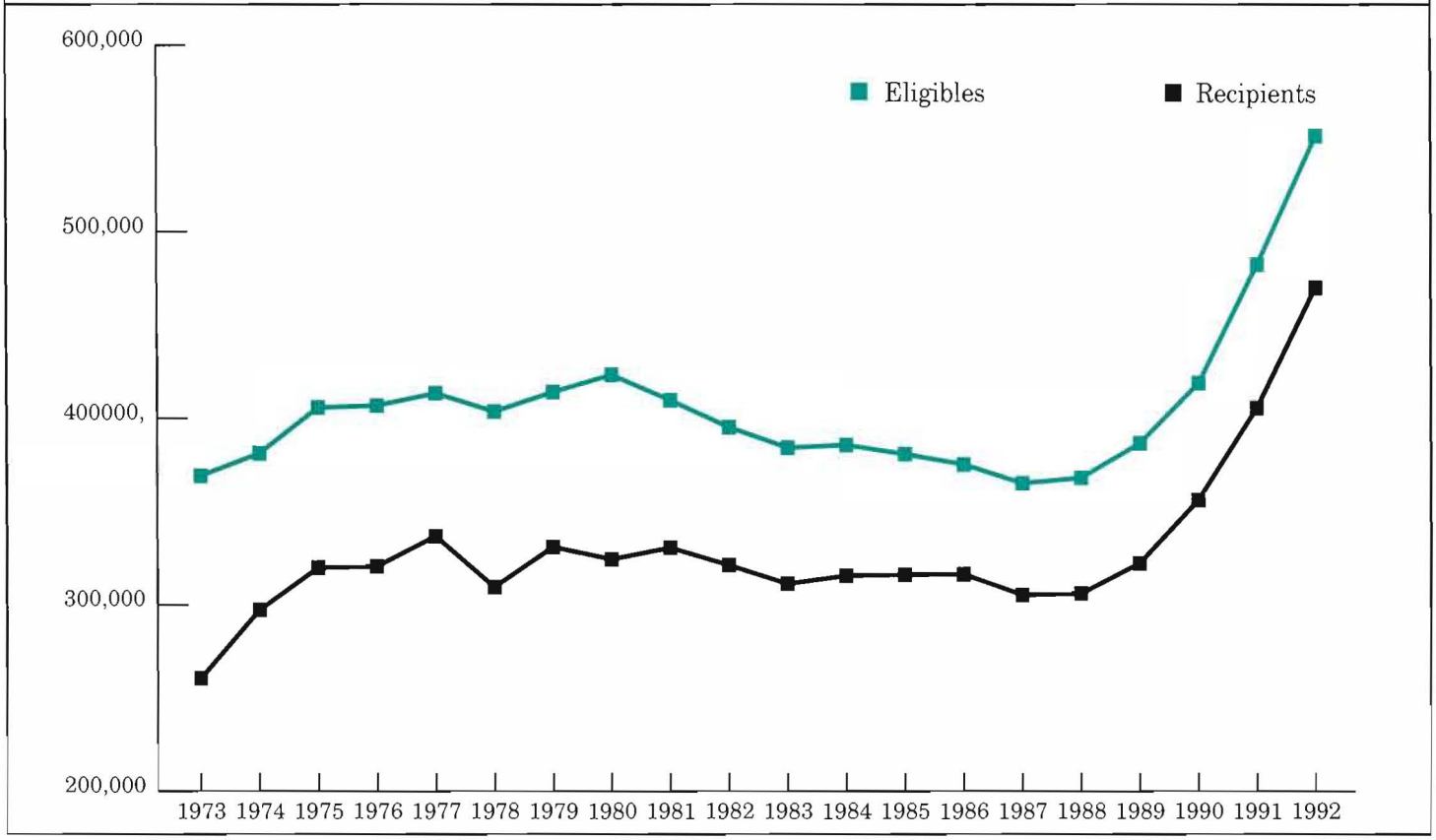
Although 551,151 people were eligible for Medicaid in FY 92, only 78 percent were eligible for the entire year. The length of time the other 22 percent of Medicaid eligibles were covered ranged from one to eleven months.

FY 1992 ELIGIBLES Monthly count — **Table – 12**

October '91	401,578
November	411,255
December	401,938
January '92	417,459
February	430,015
March	438,091
April	439,692
May	440,904
June	444,764
July	455,647
August	455,922
September	455,543

Although the average monthly number of eligibles was 432,734 for FY '92, there was an unduplicated total of 551,151 eligibles during the year. This was due to some clients losing eligibility and some being replaced by others.

FY 1973-1992 Medicaid eligibles and recipients — **Table – 13**



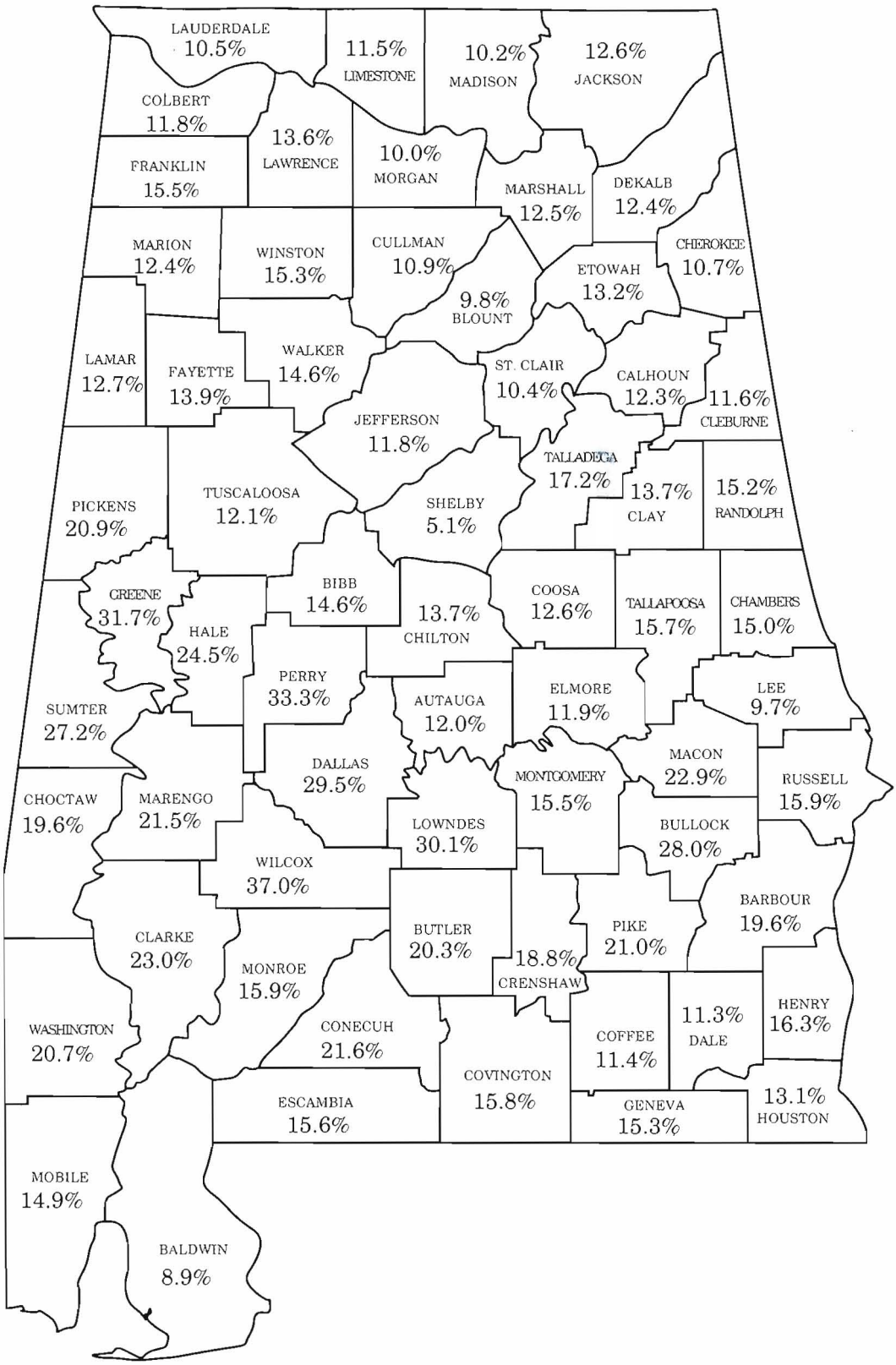
FY 1992
MEDICAID ELIGIBLES BY CATEGORY

Table – 14

COUNTY	AFDC	AGED	DISABLED	SOBRA	QMB	BLIND	TOTAL
Autauga	1,456	456	777	1,349	100	14	**4,152**
Baldwin	2,509	990	1,814	3,569	198	34	**9,114**
Barbour	1,827	838	1,093	1,113	108	24	**5,003**
Bibb	583	333	615	826	75	6	**2,438**
Blount	943	630	746	1,462	133	6	**3,920**
Bullock	1,374	517	562	617	34	9	**3,113**
Butler	1,653	810	805	1,060	116	13	**4,457**
Calhoun	5,297	1,519	3,339	3,699	303	78	**14,235**
Chambers	2,082	763	904	1,546	147	29	**5,471**
Cherokee	483	358	470	702	89	4	**2,106**
Chilton	1,472	593	874	1,389	140	17	**4,485**
Choctaw	1,228	540	598	673	58	12	**3,109**
Clarke	3,019	686	1,132	1,286	101	14	**6,238**
Clay	415	396	378	529	73	12	**1,803**
Cleburne	409	252	324	438	59	3	**1,485**
Coffee	1,483	867	866	1,238	154	13	**4,621**
Colbert	1,065	773	1,278	2,758	135	18	**6,027**
Conecuh	1,052	489	603	751	60	12	**2,967**
Coosa	447	174	385	343	34	4	**1,387**
Covington	1,508	989	1,222	1,798	232	15	**5,764**
Crenshaw	774	554	588	535	81	10	**2,542**
Cullman	1,201	1,506	1,839	2,696	237	28	**7,507**
Dale	1,933	754	1,068	1,748	144	20	**5,667**
Dallas	6,997	1,596	2,907	2,210	137	41	**13,888**
DeKalb	1,479	1,464	1,515	2,134	199	25	**6,816**
Elmore	1,963	741	1,328	1,862	115	15	**6,024**
Escambia	1,791	727	1,009	1,771	121	22	**5,441**
Etowah	3,532	1,707	3,390	4,015	454	47	**13,145**
Fayette	754	472	583	604	60	8	**2,481**
Franklin	1,054	708	1,017	1,345	144	13	**4,281**
Geneva	1,057	707	789	878	158	13	**3,602**
Greene	1,436	495	598	601	23	12	**3,165**
Hale	1,283	718	708	1,025	48	7	**3,789**
Henry	897	456	501	555	83	14	**2,506**
Houston	3,976	1,293	2,222	2,975	307	30	**10,803**
Jackson	1,205	877	1,639	1,966	223	27	**5,937**
Jefferson	35,746	7,101	16,555	15,795	1,063	257	**76,517**
Lamar	382	474	483	558	61	12	**1,970**
Lauderdale	1,950	1,285	1,869	3,016	239	11	**8,370**
Lawrence	1,175	627	901	1,505	109	16	**4,333**
Lee	2,825	974	1,714	3,002	154	32	**8,701**
Limestone	2,249	883	1,228	1,885	125	39	**6,409**
Lowndes	1,860	401	651	805	48	8	**3,773**
Macon	3,144	666	858	885	60	21	**5,634**
Madison	13,720	1,938	3,716	5,599	401	72	**25,446**
Marengo	1,975	768	870	1,196	69	13	**4,891**
Marion	750	720	743	1,321	141	8	**3,683**
Marshall	2,408	1,652	2,203	2,409	303	30	**9,005**
Mobile	28,724	4,214	9,901	13,234	786	115	**56,974**
Monroe	1,363	530	783	1,087	73	10	**3,846**
Montgomery	15,220	3,015	6,617	7,466	398	94	**32,810**
Morgan	2,709	1,428	2,527	3,178	292	48	**10,182**
Perry	2,024	602	651	786	47	6	**4,116**
Pickens	1,590	753	883	978	74	17	**4,295**
Pike	2,139	942	1,248	1,318	107	27	**5,781**
Randolph	871	523	558	952	106	14	**3,024**
Russell	3,305	983	1,500	1,435	194	27	**7,444**
Shelby	1,758	463	1,038	2,084	118	21	**5,482**
St. Clair	1,872	524	954	1,922	130	11	**5,413**
Sumter	2,270	603	721	709	50	12	**4,365**
Talladega	4,887	1,175	2,924	3,460	226	112	**12,784**
Tallapoosa	2,086	922	1,188	1,725	166	20	**6,107**
Tuscaloosa	7,119	2,156	4,277	4,664	308	58	**18,582**
Walker	2,894	1,043	2,548	3,145	207	23	**9,860**
Washington	1,384	402	624	970	57	15	**3,452**
Wilcox	2,239	672	1,202	754	55	19	**4,941**
Winston	615	601	815	1,227	108	7	**3,373**
Other	96	0	0	2	1	0	**99**
TOTAL	214,986	66,788	113,236	143,138	11,159	1,844	**551,151**

FY 1992
ELIGIBLES
Percent of population eligible for Medicaid

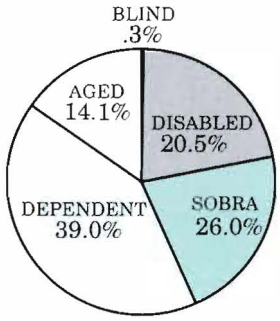
Table – 15



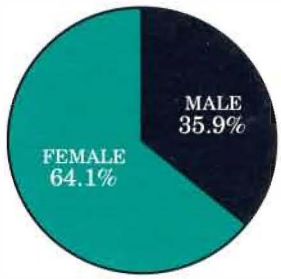
FY 1992
ELIGIBLES
Percent Distribution

Table – 16

BY CATEGORY



BY SEX



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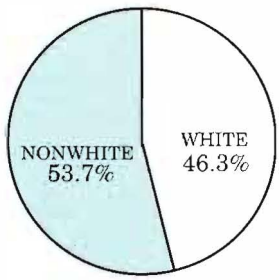
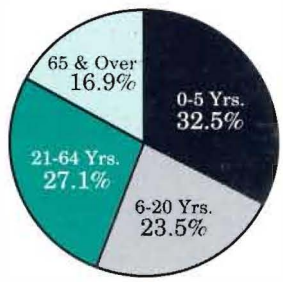


BY AGE



Recipients

Of the 551,151 persons eligible for Medicaid in FY 1992, about 85 percent actually received care financed by Medicaid. These 469,944 persons are called recipients. The remaining 81,207 persons incurred no medical expenses paid for by Medicaid.

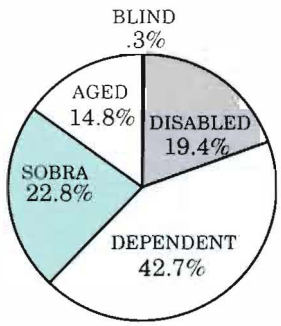
The total number of recipients is an unduplicated count. Recipients may be qualified under more than one category during the year. A recipient who receives services under more than one basis of eligibility is counted in the total for each of those categories, but is counted only once in the unduplicated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

FY 1992 **Table - 17**
RECIPIENTS
Monthly averages and annual total

Category	Monthly Average	Annual Total
Aged	49,068	79,292
Blind	1,071	1,634
Disabled	66,146	103,906
Dependent	67,079	228,590
SOBRA	45,568	121,824
All Categories (unduplicated)	228,477	469,944

FY 1992 **Table - 18**
RECIPIENTS
Percent distribution

BY CATEGORY



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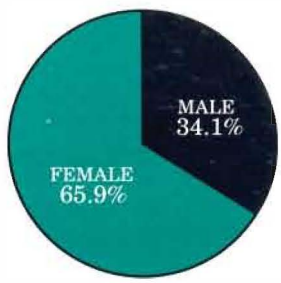

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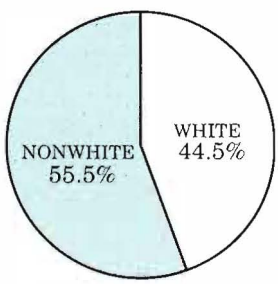

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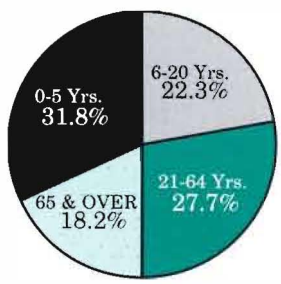


Use and Cost

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.

A useful way to compare costs of different groups of Medicaid eligibles and predict how changes in eligibility and utilization will impact Medicaid is to measure cost per eligible. This measure is determined by dividing total payment for services by the total number of persons eligible during the year.

Statistics reveal that certain groups are much more expensive to the Medicaid program than others. The reason for the difference is that some groups tend to need more expensive services. Any Medicaid eligible receives, within reasonable limitations, medically necessary services.

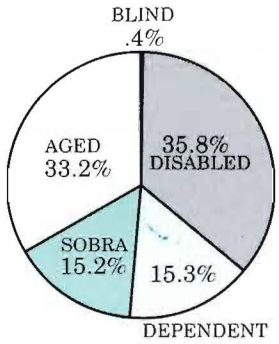
A good example of this is the pattern of use of long-term care. This type of care has a high cost per unit of service, and recipients of long-term care have a high frequency-of-service rate. The average Medicaid payment for a day of long-term care in FY 1992 was $51. The yearly average number of days for recipients of this service was 272. 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 coinsurance covered by Medicaid. For this coverage, Medicaid in FY 1992 paid a monthly buy-in fee to Medicare of $31.80 per eligible Medicare beneficiary. Medicaid paid a total of $42.8 million in Medicare buy-in fees in FY 1992. Paying the buy-in fees is very cost effective for Medicaid because, otherwise, the Agency would incur the full payment for medical bills instead of for only the premiums, deductibles, and coinsurance.

FY 1992
PAYMENTS
Percent distribution

Table – 19

BY CATEGORY



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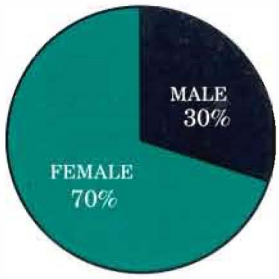

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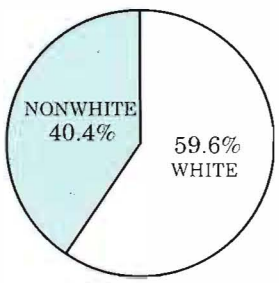

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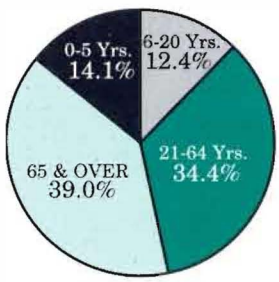
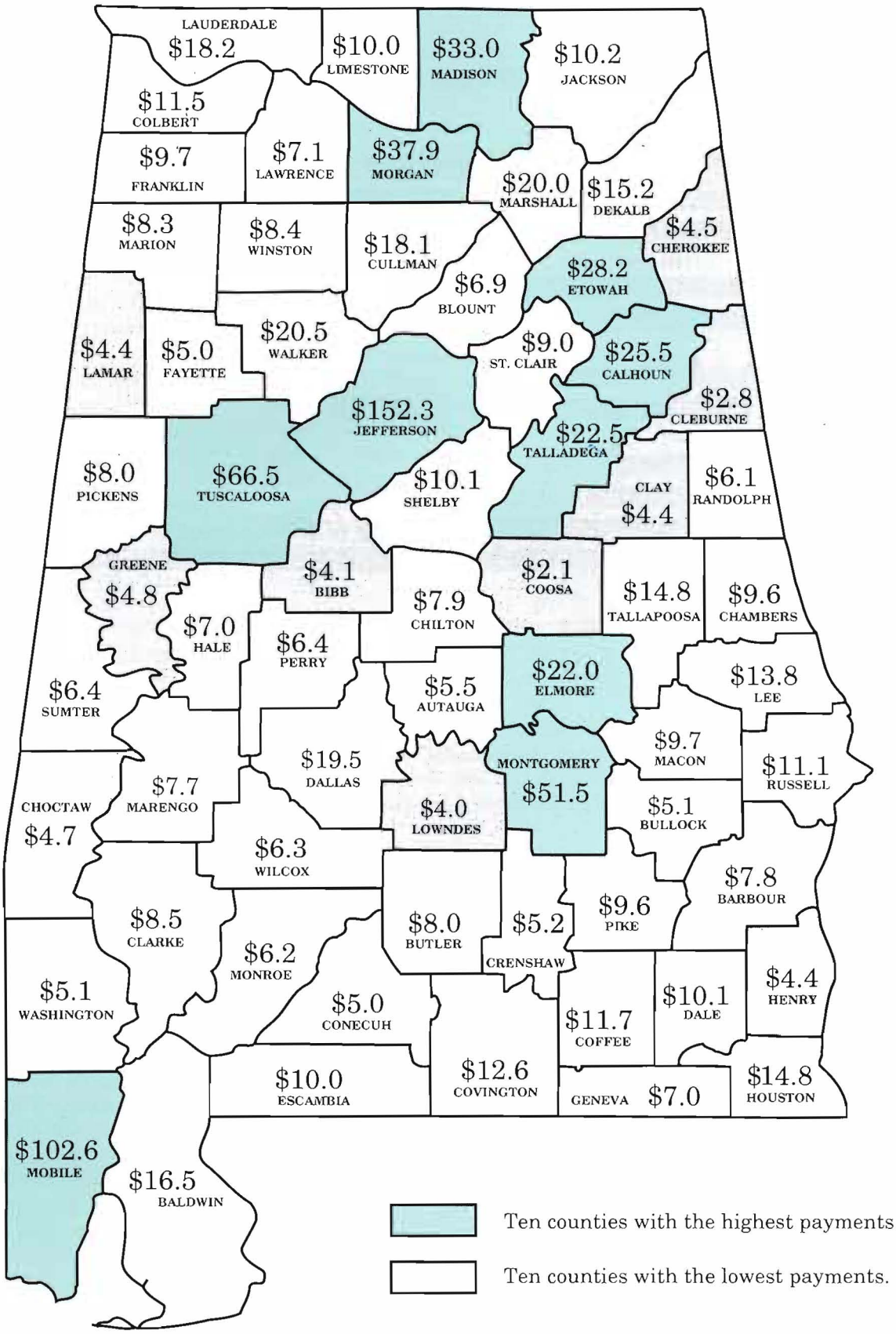


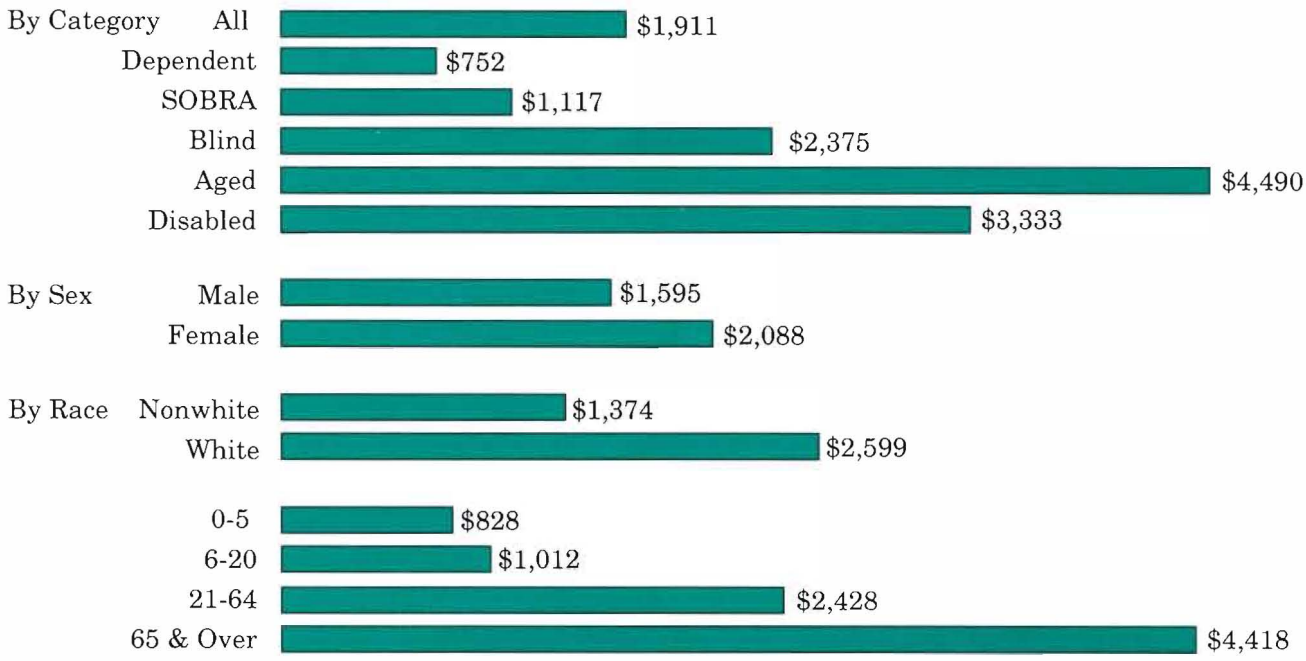
FY 1992
TOTAL PAYMENTS
By county of recipient (in millions of dollars)

Table – 20



FY 1992
COST PER ELIGIBLE
By category, sex, race, and age

Table – 21



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, that payments for those services are correct, and that all funds identified for collection are pursued.

Through quality control, the Medicaid Agency makes sure eligibility determinations are as accurate as possible. This is accomplished by performing in-depth reviews of eligibility determinations on a random sample of Medicaid eligibles. The findings of these reviews are then used to compute a payment error rate. If a state's payment error rate exceeds three percent, the Health Care Financing Administration (HCFA) imposes a financial sanction. The Agency's most recently published error rate was projected to be approximately 0.33 percent for the quarter ending September 30, 1992. This projection was based on the actual payment error rate for the previous year. Nationally, only four other states had lower payment error rates during this period.

The processing and payment of Medicaid claims is monitored through the Claims Processing Assessment System (CPAS). An error rate is determined based on sample reviews of processed claims. Alabama's error rate for FY 1992 was 0.04 percent, which was significantly less than the HCFA target rate of one percent. In addition to CPAS claims reviews, targeted reviews of claims are performed when potential systems errors are found. More than 6,800 claims were manually reviewed during the 1992 fiscal year to verify their accuracy. Another testing process, the Bill Processing Systems Test (BPST), verifies that changes in the bill processing systems have been properly implemented or that existing edits are accomplishing the specified intent. The financial activities of the Agency's fiscal agent are monitored through reconciliations of invoices and bank accounts, as well as analysis of processed provider refunds and claim adjustments.

The Medicaid Agency must recover funds from individuals who received Medicaid services they were not entitled to receive. In most instances these cases involve people who, through neglect or fraud, did not report income or assets. There were 2,059 new cases in FY 1992. Through cooperation with appropriate Agency staff, $858,553.90 in misspent dollars was identified and $587,238.61 was collected.

Computer programs are used to find unusual patterns of utilization on the part of both providers and recipients. During FY 1992, 230 providers were reviewed. Recoupments and net adjustments for the fiscal year totaled $580,072.53. There were 410 recipients reviewed in FY 1992.

There are several types of corrective action that may be taken in cases of aberrant utilization. Such actions range from written warnings to administrative sanctions such as restrictions or terminations from the program and recoupment of funds. A recipient who abuses Medicaid privileges may be restricted to receiving services from certain providers. This is one administrative sanction used to control recipient abuse of the Medicaid program. During FY 1992, 115 recipients were terminated from the Medicaid program, two provider cases were referred to the Attorney General's Medicaid Fraud Control Unit, two providers were referred to the Board of Medical Examiners, and 245 recipients were restricted to one physician and one pharmacy.

The Alabama Legislature has provided two specific criminal statutes which allow Medicaid to be effective in pursuing fraud and abuse cases. One law allows Medicaid to deny or revoke eligibility of persons who have abused, defrauded, or in any way misused the benefits of the program. The other law makes it a felony offense if a recipient or provider knowlingly makes an intentional false statement or omits material fact in any claim or application for any payment. This law also applies penalties for kickbacks or bribery attempts. A recipient or provider convicted of Medicaid fraud under this statute may be fined $10,000 for each count and given a jail sentence of one to five years. Under this statutory authority, there were 376 provider and recipient fraud and abuse cases and 397 cases closed during FY 1992. Of the cases that were opened, 21 were recipient drug abuse cases which were presented to local district attorneys for possible prosecution. In addition, complaints of civil rights violations pertaining to Medicaid recipients or providers were investigated.

During FY 1992, an extensive rebate program on drug products was begun in an effort to control drug program expenditures. This program was mandated by federal legislation passed into law in 1990. During fiscal year 1992, the Drug Rebate Program collected rebates from drug manufacturers based on Medicaid utilization of their drug products in Alabama. These payments have been used as an offset to increasing drug program expenditures. The Agency is continuing to improve the reporting system associated with this function, in order to pursue the collection of these monies and to resolve disputes.

Medicaid Management Information Systems

The Agency's Management Information Systems (MMIS) maintain provider and recipient eligibility records, process all Medicaid claims from providers, keep track of program expenditures, and furnish reports that allow Medicaid administrators to monitor the pulse of the program.

In-house systems staff completed 2,423 software requests in FY 1992 to support the MMIS and aid Agency decision-making. Major projects completed included enhancements to the drug rebate system, an on-line system for outstationed eligibility workers, and the nightly transmission of data to the Agency's fiscal agent for use in the Automated Voice Response and Medicaid Automated Claims Submission and Adjudication Systems (AVRS and MACSAS). A new system was also developed which streamlines ad hoc claims reporting and significantly reduces operational costs.

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.

EDS has recently implemented an automated eligibility verification and claims submission system which allows providers to check Medicaid eigibility, third party liability information and benefit limits, as well as to submit claims via a point-of-service device or personal computer. EDS also introduced in FY 1992 the capability of receiving benefit payments via electronic funds transfer.

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 1992 Medicaid served 143,138 women and 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 1991 the number of births to women aged 10-19 increased slightly in Alabama from 11,557 in 1990 to 11,600. There were 328 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 cost of caring for low birth weight babies.

Prenatal care for Medicaid eligible recipients is provided through private physicians, hospitals, public health department clinics and federally qualified health centers. Some of the maternity-related benefits covered under the prenatal program are unlimited prenatal visits, medical services to include physical examinations with 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 in

Alabama 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 1992, two additional postpartum visits were authorized for recipients with obstetrical complications such as infection of surgical wounds.

In 1988, the Medicaid Agency implemented a policy that would allow pregnant women at or below 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, through one primary provider network, receive comprehensive, coordinated, and case managed medical care appropriate to their risk status. The two main components of the waiver are care coordination (also known as case management) and the direction of women to certain caregivers.

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.

During FY 1992, there were 38 counties participating in the maternity waiver. Those counties were: Autauga, Bibb, Blount, Bullock, Calhoun, Choctaw, Clarke, Conecuh, Cullman, Dallas, Elmore, Escambia, Etowah, Fayette, Greene, Hale, Henry, Houston, Jefferson, Lamar, Lawrence, Lee, Lowndes, Macon, Marengo, Marion, Marshall, Mobile, Montgomery, Morgan, Perry, Pickens, Shelby, St. Clair, Sumter, Tuscaloosa, Washington, and Wilcox. Statewide expansion of the waiver is planned so that all Medicaid eligible pregnant women can participate in this innovative and successful approach to healthier birth outcomes.

Directing the patients to 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 neonatal intensive care days which translates into not only healthy babies but also reduced expenditures for the Agency.

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 30 providers.

To participate in the program, the nurse midwife must show proof of RN licensure and certified nurse midwife licensure and submit a written signed agreement between the nurse midwife and the physician consultant. 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 with appropriate physician consultation.

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 1992. For family planning services, the federal share is 90 percent.

Family planning providers include health department clinics, federally qualified health centers, private physicians, community health clinics, and Planned Parenthood of Alabama. Services include physical examinations, pap smears, pregnancy and venereal disease testing, counseling, provision of oral contraceptives, other drugs, supplies and devices including implants, injections, and referral for needed services. A home visit family planning service is available for newly delivered mothers. This allows recipients to begin the birth control of their choice prior to the postpartum 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. All medically necessary services to correct or improve the condition are unlimited if the condition was identified during or as a result of a screening. The Medicaid program also benefits by realizing 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. Eligibles for the EPSDT program are persons under 21 years of age who receive assistance through the Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) 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 and children born after September 30, 1983 in families with incomes up to 100 percent of the federal poverty level. Department of Human Resources workers normally determine AFDC eligibility, make families aware of EPSDT, and refer eligibles to providers. Medicaid eligibility workers determine eligibility for pregnant women and young children over the income limit for SSI.

Currently there are more than 530 providers of EPSDT services, including county health departments, community health centers, hospitals, Head Start centers, child development centers, and private physicians. Efforts are being made to increase the number of physicians participating in 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.

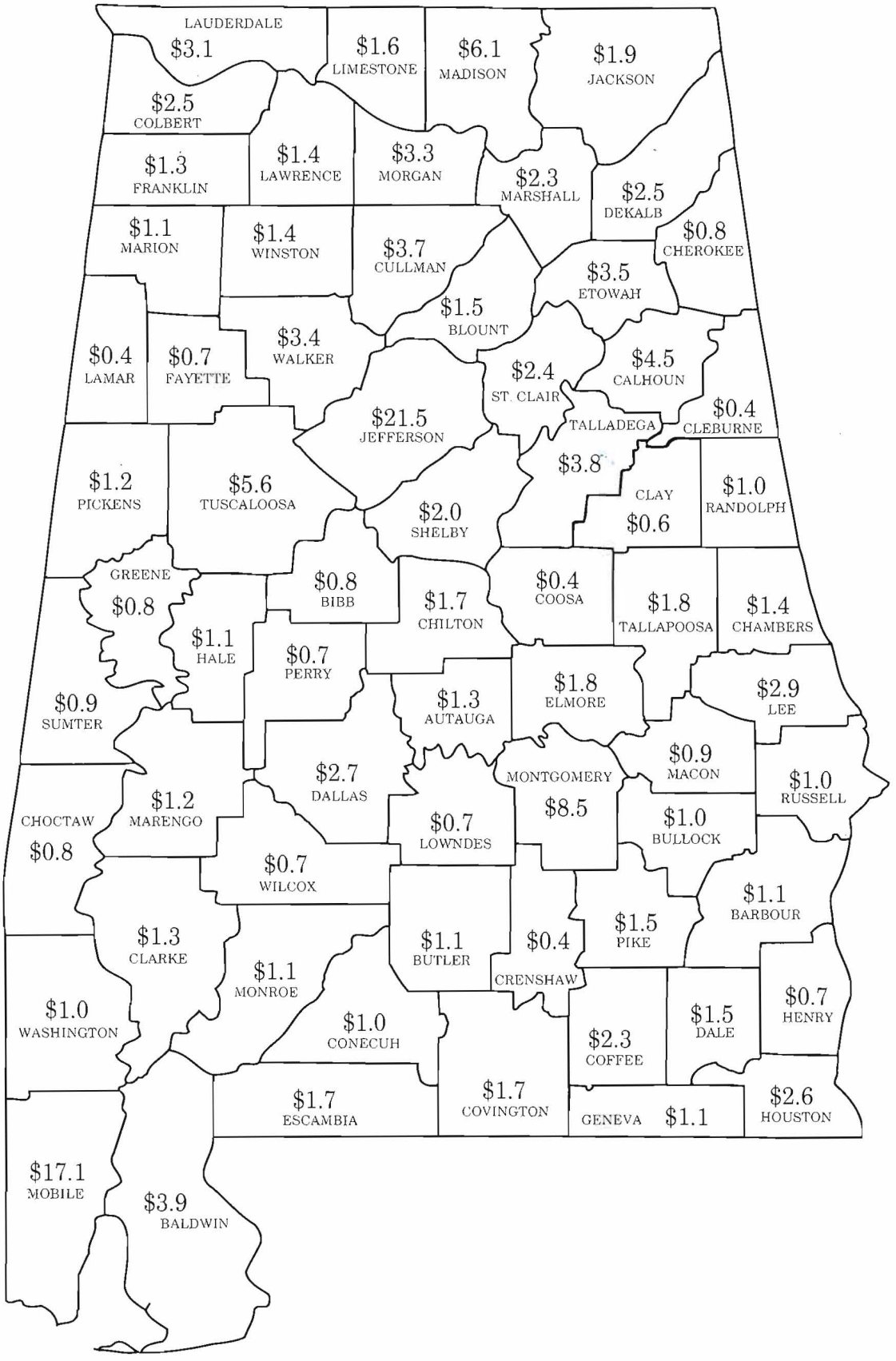
Steps have been taken in recent years to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of intensive outreach statewide, enhancement of physicians' reimbursement for screening and an increase in the number of screenings for which Medicaid will pay. Because of these added efforts, there have been more screenings performed. 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 $50 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.

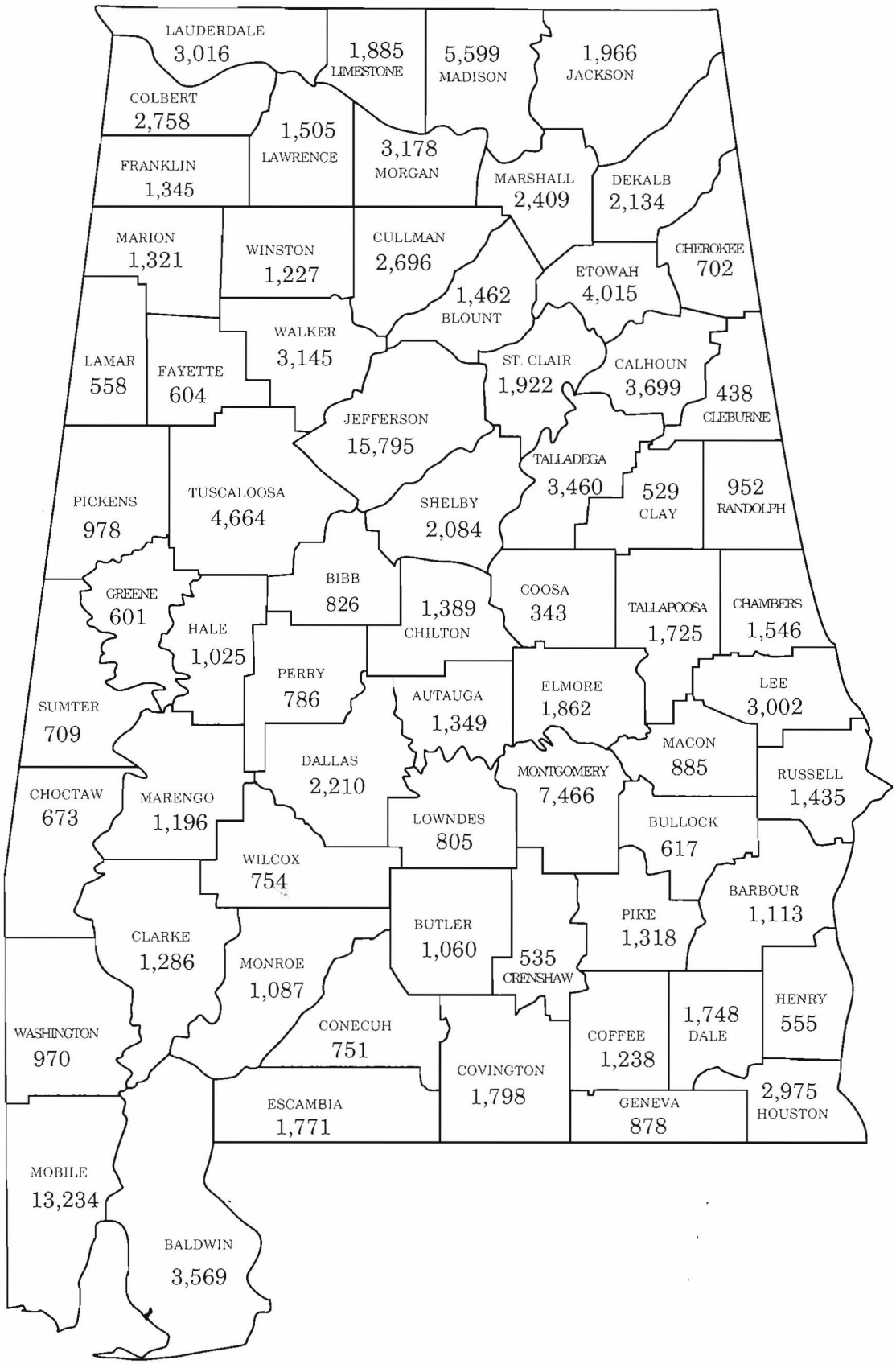
FY 1992
MEDICAID PAYMENTS FOR SOBRA ELIGIBLES
By county of recipient (in millions of dollars)

Table – 22



FY 1992
SOBRA ELIGIBLES

Table – 23



Healthy Beginnings

During FY 1992, the Healthy Beginnings program entered its third year of encouraging all expectant women in Alabama to seek early and continuous prenatal care. The program is based on a booklet of coupons for free or discounted items for mother and baby from a variety of contributors such as drug stores and grocery stores. The booklet also includes pertinent information concerning healthy lifestyles during pregnancy as well as how to qualify for programs such as the special supplemental food program called Women, Infants, and Children (WIC) and Medicaid. Coupons corresponding to the month in a woman's pregnancy are validated each time the woman visits her health care provider for prenatal care. The booklets are obtained by calling the program's toll-free number: 1-800-545-1098.

Healthy Beginnings has been recognized at the local, state, regional and national levels with a variety of awards. Of particular note is the receipt of one of five 1991 National Achievement Awards presented by Healthy Mothers/ Healthy Babies, a coalition of more than 90 organizations which serve as advocates for maternal and child health in the United States. This award was presented at the National Institutes of Health, Bethesda, Maryland, in conjunction with national Child Health Day on October 7, 1991. The FY 1992 program was recognized in 1993 as one of the top health education/promotion programs in Alabama, receiving one of five Governor's Health Education awards.

The program is guided by a 30-member advisory committee comprised of physicians, advocacy group representatives, health professionals, news media, state legislators, and others with an interest in maternal and child health. Healthy Beginnings has been evaluated via focus group studies and a statewide telephone/mail survey conducted by a state university. Survey results are being used to plan future activities and to refine the program to better communicate with women and teens at risk of having low birth weight infants, and to reach them at an earlier point of pregnancy. An expansion of the Healthy Beginnings program is planned to include the first year of life, emphasizing early, preventive care for infants, breastfeeding, positive parenting behaviors, and good nutrition.

Special emphasis has been placed on networking with private organizations to broaden support for improving the infant mortality rate in Alabama. Additionally, Medicaid staff have made numerous presentations to school nurses, guidance counselors and others in an effort to build a coalition in support of preventive care for expectant women and young children.

FY 1992 highlights for Healthy Beginnings include these:

* In the program's first two years, approximately 41,000 calls to the Healthy Beginnings hotline were received from expectant women and teens.

* While teens account for 18 percent of all births in Alabama, 29 percent of all calls are from teenagers.

* Approximately 70 percent of all calls are from Medicaid recipients or from uninsured women.

* There were 339 calls received from women who could not obtain care.

* Sixty percent of callers are receiving care at clinics while 39 percent are receiving care from private physicians.

* Sixty-one percent of all callers are white; 37.8 percent are black, paralleling the general population of the state.

* One-third of all callers have less than a high school education.

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 goal of the Managed Care Program is to develop a quality, accessible, and cost effective system of care for all Medicaid eligibles. The Alabama Medicaid Agency plans to initiate the managed care concept for all geographical areas of the state over the next five years.

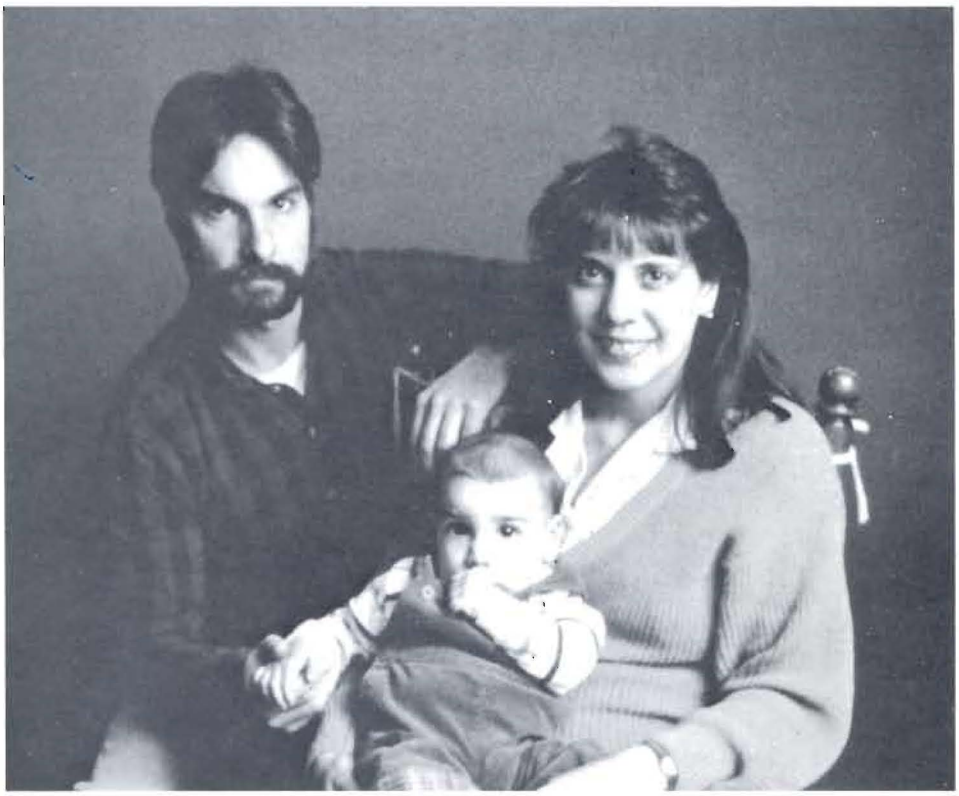
Managed care is a coordinated strategy designed so that a primary health care provider or case manager may provide care directly to patients and authorize all other health care, except true emergencies, that is received by the patient.

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 is eliminated.

Mental Health Services: Through mental health centers under contract with the Department of Mental Health and Mental Retardation, Medicaid provides services for eligible mentally ill adults and emotionally disturbed children. These services include day treatment, medication check, diagnostic assessment, pre-hospitalization 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 1992, about $1.5 million was spent to provide services to approximately 8,500 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 includes assessment of the individual's condition, development of a plan of care, coordination of needed services, follow-up on the individual's progress and reassessment of the condition.

As a result of cooperation among the Department of Public Health, the Department of Human Resources, United Cerebral Palsey, and the Alabama Kidney Foundation, case management was expanded in recent years to include five additional target groups. Medicaid eligible handicapped children, foster children, persons with severe renal disease, pregnant women, and AIDS/HIV positive individuals also may receive the same benefits of case management as mentally ill or mentally retarded individuals. In September 1991, the definition of handicapped children was expanded to include the developmentally delayed. The addition of new providers is anticipated to assist the targeted groups in gaining access to medical, social, educational and other services. On a monthly average during FY 1992, $400,000 was spent serving 4,500 case management clients.



Home and Community Based Service Waivers

Like many other states, Alabama has taken advantage of the provisions of the federal Omnibus Budget Reconciliation Act of 1981 and has developed Home and Community Based Service (HCBS) waivers that provide alternatives to institutionalization. The waiver programs are aimed at helping recipients receive extra services not ordinarily covered by Medicaid in this state. Home and Community based waiver programs 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 HCBS Waiver for the Elderly and Disabled provides services to persons who might otherwise be placed in nursing homes. The five basic services covered are case management, homemaker services, personal care, adult day health and respite care. The program has expanded greatly since its beginning, with all services becoming available statewide as of FY 1986. During FY 1992, there were 6,974 recipients served by this waiver at an average annual cost of $6,072 per recipient. Serving the same recipients in nursing facilities would have cost the state about $16,194 per recipient. Given these figures, the state has estimated saving approximately $70,590,828 in FY 1992, but just as important, the people on the waiver were able to remain in the community to receive the care they needed.

People receiving services through Medicaid HCBS waivers must meet certain eligibility requirements. Those served by the Waiver for the Elderly and Disabled are recipients of Supplemental Security Income (SSI) or State Supplementation who meet the medical criteria for nursing home care financed by the Medicaid program. The administering agencies of this waiver 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.

Another HCBS waiver, the Waiver for the Mentally Retarded and Developmentally Disabled, serves individuals who meet the definition of mental retardation or developmentally disabled. Effective October 1, 1991, this waiver was amended to better identify the habilitation services offered, and incorporate additional services to give support to recipients released from mental retardation facilities. The waiver provides residential habilitation training, day habilitation, prevocational training, supported employment, occupational therapy, speech therapy, physical therapy, individual family support service, behavior management, companion service, respite care, personal care, environmental modification, specialized medical equipment and supplies, assistive technology, personal emergency response system, and skilled nursing care. The program has expanded greatly since its beginning, with all services becoming available statewide as of FY 1992. During FY 1992, there were 1,931 recipients served by this waiver at an average annual cost of $9,207 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $58,998 per recipient. The Waiver for the Mentally Retarded and Developmentally Disabled saved the state an estimated $96,146,421 for FY 1992, and the people on the waiver were able to remain in the community to receive the care they needed.

The Specialized Community Care Living Arrangement model waiver serves individuals who meet the criteria of being at risk of abuse and neglect. The recipients are frail or disabled adults who receive Supplemental Security Income (SSI) or State Supplementation and who also meet medical and financial standards for Medicaid nursing home care.

Under the program, frail adults live in adult foster homes. The foster caregivers provide the adults with food, shelter, and some personal care. More specialized services such as case management, nursing services, respite care, medical supplies and attendant care are available for these individuals by physician's orders.

The Department of Human Resources pays the adult foster caregiver a service fee and also pays for services and medical supplies needed by the adult. The adult in care pays for room and board.

This program is also less expensive to taxpayers. The cost per adult on the waiver is $1,261. Serving the same recipient in a nursing facility would have cost the state $13,751 annually. Providing care in the community for the recipients eligible for this waiver saves the state tremendously.

Home Care Services

The Medicaid home care services program helps people with illnesses, injuries, or disabilities receive the quality of care they need at home. Through the utilization of registered nurses, licensed practical nurses, home health aides/orderlies/homemakers, physical therapists, occupational therapists, speech therapists, respiratory therapists, medical equipment and supplies, orthopedists, prosthetists, physicians and hospices, recipients are provided services that are needed for them to remain at home and maintain their highest level of independence at a cost savings to Medicaid.

Home care services to Medicaid eligibles under the age of 21 have been greatly expanded because of the Omnibus Budget Reconciliation Act of 1989. 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 (EPSDT) Program. This provision of OBRA 1989 will greatly increase the number of children that can be served in the community. Occupational therapy, physical therapy, 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.

Due to changes in the health care delivery system, the demand for home care 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. In addition, expansions mandated under the EPSDT program have made Alabama Medicaid home care services one of the most comprehensive medical assistance programs for children in the country.

The Medicaid home care services program is based on the philosophy of family and patient participation in providing patient care. Working together, families and patients are taught care which can reasonably and safely be rendered in the home.

Hospice Care Services: Hospice care is a comprehensive home care program which primarily provides reasonable and necessary medical and support services for terminally ill individuals. The goal of hospice is not to cure a terminal illness but rather to provide relief of symptoms.

The service is not only compassionate but also cost efficient. During FY 1992, the Medicaid Agency served an average of 30 hospice patients each month at a total cost of about $552,150 in state and federal funds. The expense was offset by a reduction in hospital costs for Medicaid.

In adding hospice services for eligible patients, the Medicaid Agency follows the same rules the Medicare program uses. Hospice services must be provided by Medicare certified hospice programs and are available for unlimited days.

Hospice care through the Medicaid Agency is provided on a voluntary basis, and when it is chosen, the patient waives the right to any other services that treat the terminal illness. Services included are nursing care, medical social services, physicians services, counseling services, short-term inpatient care, medical appliances and supplies (including drugs and biologicals), home health aide services, homemaker services, physical therapy, occupational therapy, speech language pathology services, and nursing home room and board.

Home Health and Durable Medical Equipment: Skilled nursing and home health aide services prescribed by a physician are provided to eligible homebound recipients on a part-time or intermittent basis. These services cover preventive, restorative, and supportive care to persons who meet Medicaid home health criteria. Nursing and personal care provided under the home health program must be certified by licensed physicians and provided by home health agencies under contract with Medicaid. There were 110 agencies participating in FY 1992 and 62 branch office locations.

Up to 104 home health visits per year may be covered by the Medicaid Agency. During FY 1992, 5,000 recipients received visits costing $10,242,145.

Supplies, appliances, and durable medical equipment are mandatory benefits under the home health program. Medicaid recipients do not have to receive home health services to qualify for services, but all items must be medically necessary and suitable for use in the home. During the fiscal year, over 400 Medicaid DME providers throughout the state furnished 428,967 units of service at a cost of $3,735,237.

In-Home Therapies: Physical, speech, and occupational therapy in the home is limited to individuals under 21 years of age referred from an EPSDT screening. If certified as medically necessary by a physician, services must be provided through a Medicaid certified home health agency. All therapy services rendered in the home require prior authorization by the Alabama Medicaid Agency.

Private Duty Nursing: Private duty nursing services in the home are covered for eligible recipients requiring continuous skilled nursing care. The services are available only for recipients under age 21 and prescribed as a result of an EPSDT screening referral. Private duty nursing care is provided in a recipient's home. The service also may be provided to the recipient away from the home when activities such as school or other normal life activities take him or her away from the home. For Medicaid coverage, at least four hours of continuous skilled nursing care are required.

Private duty nursing services must be prior authorized by Medicaid. All services require monitoring on a regular basis, generally every 60 days, with the physician providing recertification of the continuing need for care. During the last fiscal year, Medicaid paid $2,174,480 for services provided to an average of 31 recipients each month through 23 private duty nursing providers.

Personal Care Services: Personal care services are available only for recipients under age 21 who have exhausted the home health benefit of 104 nursing visits per calendar year. The service must be referred from an EPSDT screening and prescribed as medically necessary by a physician. Personal care services are provided through Medicaid contract home health agencies at the recipient's place of residence. Personal care services include but are not limited to bed bath, sponge, tub, or shower bath, shampoo, nail and skin care, oral hygiene, toileting, and elimination.

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 29 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 72 in-state hospitals in Alabama that are considered "delegated" and do their own utilization review; 46 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, pre-admission 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.

Inpatient hospital days were limited to 16 days per calendar year in FY 1992. 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 authorized for deliveries (onset of active labor through discharge).

There are some instances when inpatient days are unlimited. Children under one year of age may receive unlimited inpatient days in any hospital. Children under six years of age may receive unlimited inpatient days in hospitals designated by Medicaid as disproportionate share hospitals.

There were also limitations on outpatient hospital services during this fiscal year. Medicaid will pay for a maximum of three non-emergency 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 April 1991, coverage for transplants was expanded. In addition to kidney and cornea transplants, which do not require prior approval, Medicaid added coverage for prior authorized heart transplants and liver transplants for recipients 21 years of age and above. Other medically necessary transplants are also covered for recipients under 21 years of age when the need is identified during an EPSDT screening and is prior authorized by the Alabama Medicaid Agency. Eligible recipients requiring heart transplants, liver transplants, bone marrow, or other covered transplants must meet the medical criteria in the Alabama Medicaid Organ Transplant Manual.

Transplant services are limited to in-state providers unless there are no in-state providers available to perform the procedure.

Ambulatory Surgical Centers: Medicaid covers ambulatory surgical center (ASC) services, which are procedures that can be performed safely on an outpatient or ambulatory surgical center 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 2,300 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 to immediately transfer patients to hospitals for emergency medical care that is beyond the capabilities of the center. Medicaid recipients are required to pay, and ambulatory surgical center providers are required to collect, the designated copayment amount for each visit. At the end of FY 1992, 18 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 44 freestanding facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis and CAPD (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 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 1992, three 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 on 100 percent of reasonable cost. Medicaid establishes reasonable cost by using the centers' annual cost reports. At the end of FY 1992, 15 FQHCs were enrolled as providers.

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 Accreditation 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 1991, there were six 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 of services.

FY 1990-1992
HOSPITAL PROGRAM
Changes in use and cost

Table – 24

Year	Recipients of Inpatient Care	Payments For Services	Medicaid's Annual Cost Per Recipient
1990	60,350	$135,255,262	$2,241
1991	64,677	$176,397,312	$2,727
1992	71,090	$217,097,579	$3,054

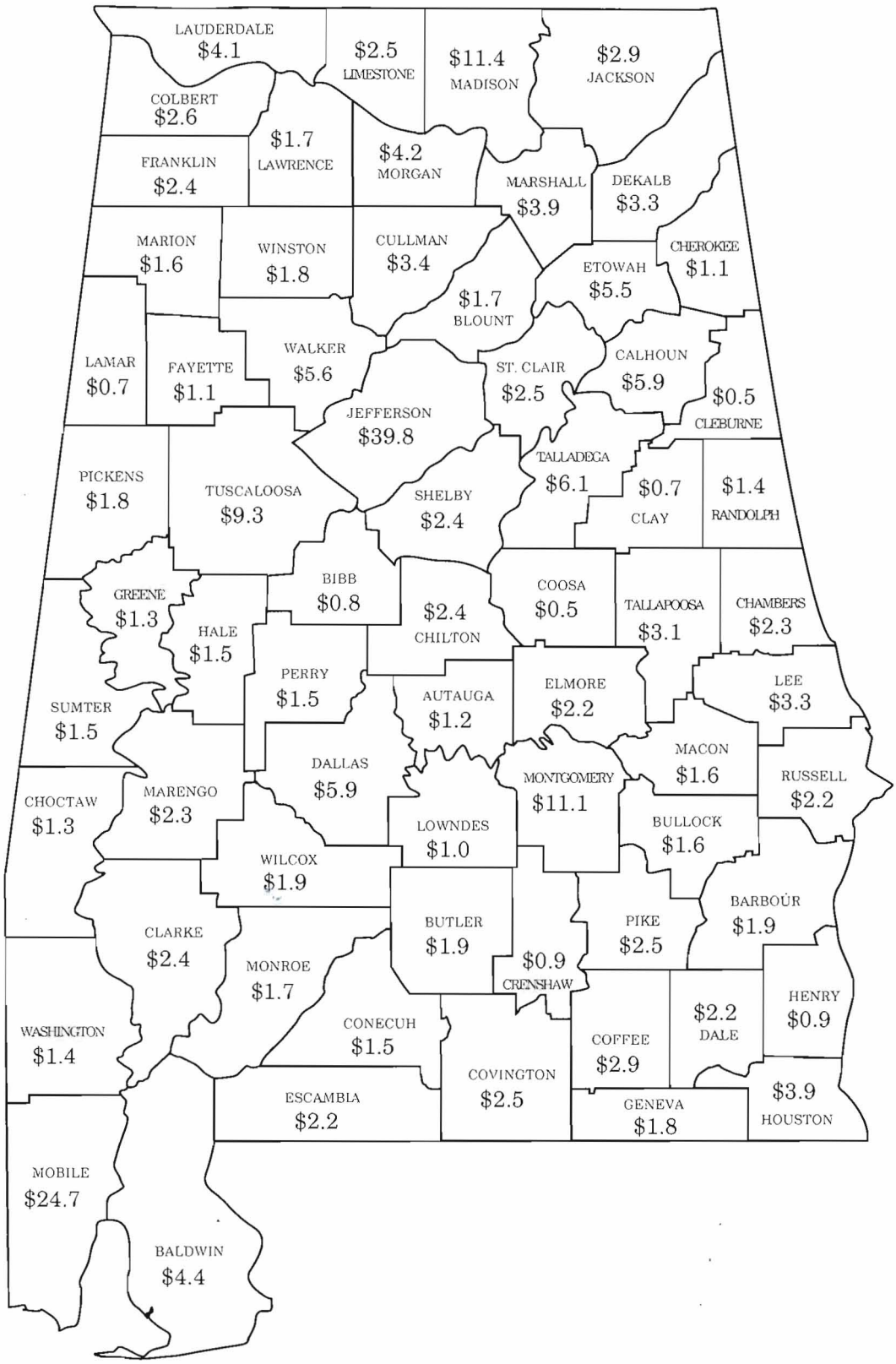
FY 1988-1992
HOSPITAL PROGRAM
Outpatients

Table – 25

	FY '88	FY '89	FY '90	FY '91	FY '92
Number of outpatients	92,600	103,665	115,957	146,358	184,036
Percent of eligibles using outpatient services	25%	27%	33%	30%	33%
Annual expenditure for outpatient care	$8,258,803	$9,605,911	$12,824,623	$19,094,131	$27,864,913
Cost per patient	$89	$93	$112	$130	$151

FY 1992
PAYMENTS TO HOSPITALS
By county of recipient (in millions of dollars)

Table – 26



Physicians 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. A little more than 71 percent of Alabama's Medicaid eligibles received physicians' services in FY 1992.

Recipients visiting a physician are required to pay a $1 copayment per office visit. Recipients under 18 years of age, nursing home residents, and pregnant women are exempt from copayments. Certain physicians' services do not require copayments. These include family planning services, physicians' inpatient hospital visits, physical therapy, and emergencies. Physicians may not deny services due to the recipient's inability to pay the copayment.

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 physician's bills.

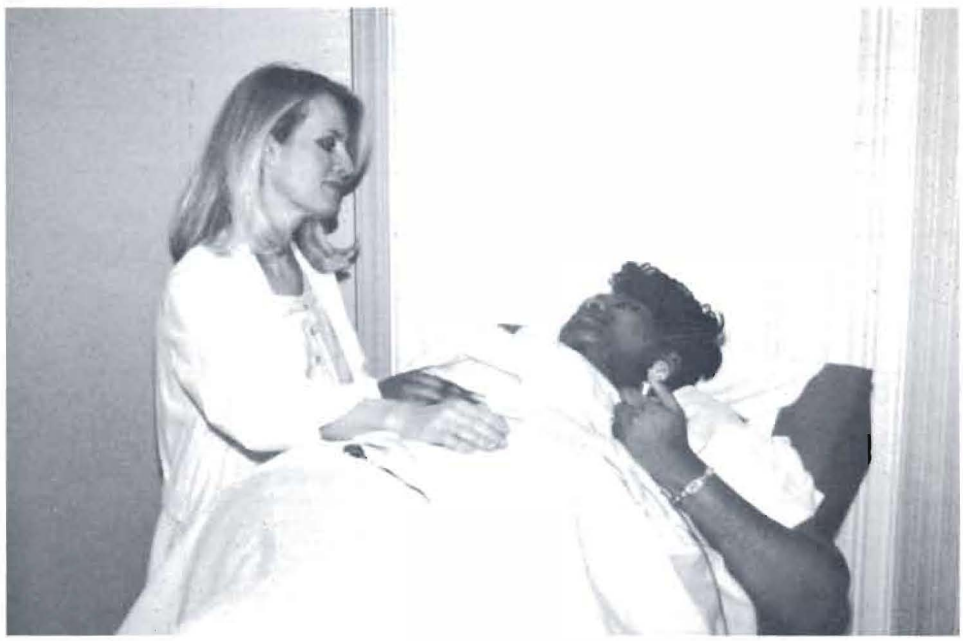
Eye Care Program: The Alabama Medicaid eye care program provides eligibles with continued high quality professional eye care. For children, good eyesight is essential to learning and development. For adults, good vision is critical to self-sufficiency and the maintenance of a high quality of life. Through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

The eye care program provides services through ophthalmologists, optometrists and opticians. Adults (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 or whenever medically necessary. 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.

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 contracts with Medicaid.



FY 1992
PHYSICIAN PROGRAM
Use and cost

Table – 27

Category	Payments	Recipients	Cost Per Recipient
Aged	$4,938,440	56,771	$87
Blind	$421,918	1,345	$314
Disabled	$30,330,252	84,401	$359
Dependent	$61,021,585	249,283	$245
All Categories	$96,712,195	391,800	$247

FY 1990-1992
LAB AND X-RAY PROGRAM
Use and cost

Table – 28

Year	Payments	Recipients	Annual Cost Per Recipient
1990	$2,806,128	71,226	$39
1991	$4,841,269	110,900	$44
1992	$6,973,307	155,184	$45

FY 1992
EYE CARE PROGRAM
Use and cost

Table – 29

Category	Payments	Recipients	Cost Per Recipient
Optometric Service	$2,273,667	48,785	$47
Eyeglasses	$880,616	34,384	$26

Long-Term Care

Care for acutely ill, indigent residents in nursing facilities was mandated in 1965 with the enactment of Medicaid (Title XIX). The Omnibus Budget Reconciliation Act of 1987 (OBRA 87) significantly impacted the nursing facility program. OBRA 87 was implemented October 1, 1990 and provided for improvements in health care for residents in nursing facilities. The law included 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.

During the past several years the elderly population of the state has increased, with the percentage of recipients in nursing facilities increasing at a slower rate. Factors contributing to the stabilization of nursing facility use by Medicaid recipients 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 facility patients have genuine medical needs requiring professional nursing care, and a management information system that makes timely and accurate financial eligibility decisions possible.

Even with the percentage of recipients in nursing homes increasing at a slower rate, Medicaid financed a little over 64 percent of all nursing home care in the state during FY 1992. The total cost to Medicaid for providing this care was $315,675,925. Almost 93 percent of the 221 nursing homes in the state accept Medicaid patients.

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 for terminating a facility's provider agreement while still promoting correction of deficiencies.

Alabama changed reimbursement systems effective September 1, 1991. This new reimbursement system helps to maintain capital formation, improve access for heavy care, promote quality care and achieve cost containment. The system helps provide the best possible health care to our needy elderly at the most affordable cost to the state of Alabama.

Alabama uses a Uniform Cost Report (UCR) to establish a Medicaid payment rate for a facility. Nursing facilities are reimbursed at a single rate based on allowed costs rather than the level of care provided to individual patients. The rate takes into consideration the nursing facility 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 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, consultation fees, dietary service, supplies, maintenance and utilities, as well as other expenses 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 1990-1992 **Table – 30**
LONG-TERM CARE PROGRAM
Patients, months, and costs

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
1990	21,648	235 Days	5,087,346	$33	$169,195,695
1991	21,730	253 Days	5,495,747	$42	$232,088,398
1992	21,084	272 Days	6,213,634	$51	$315,675,925

FY 1990-92 **Table – 31**

LONG-TERM CARE PROGRAM

Number and percent of beds used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	Percent of Beds Used By Medicaid In An Average Month
1990	22,302	13,300	59.6%
1991	22,842	13,973	61.2%
1992	22,974	14,732	64.1%

FY 1992 **Table – 32**

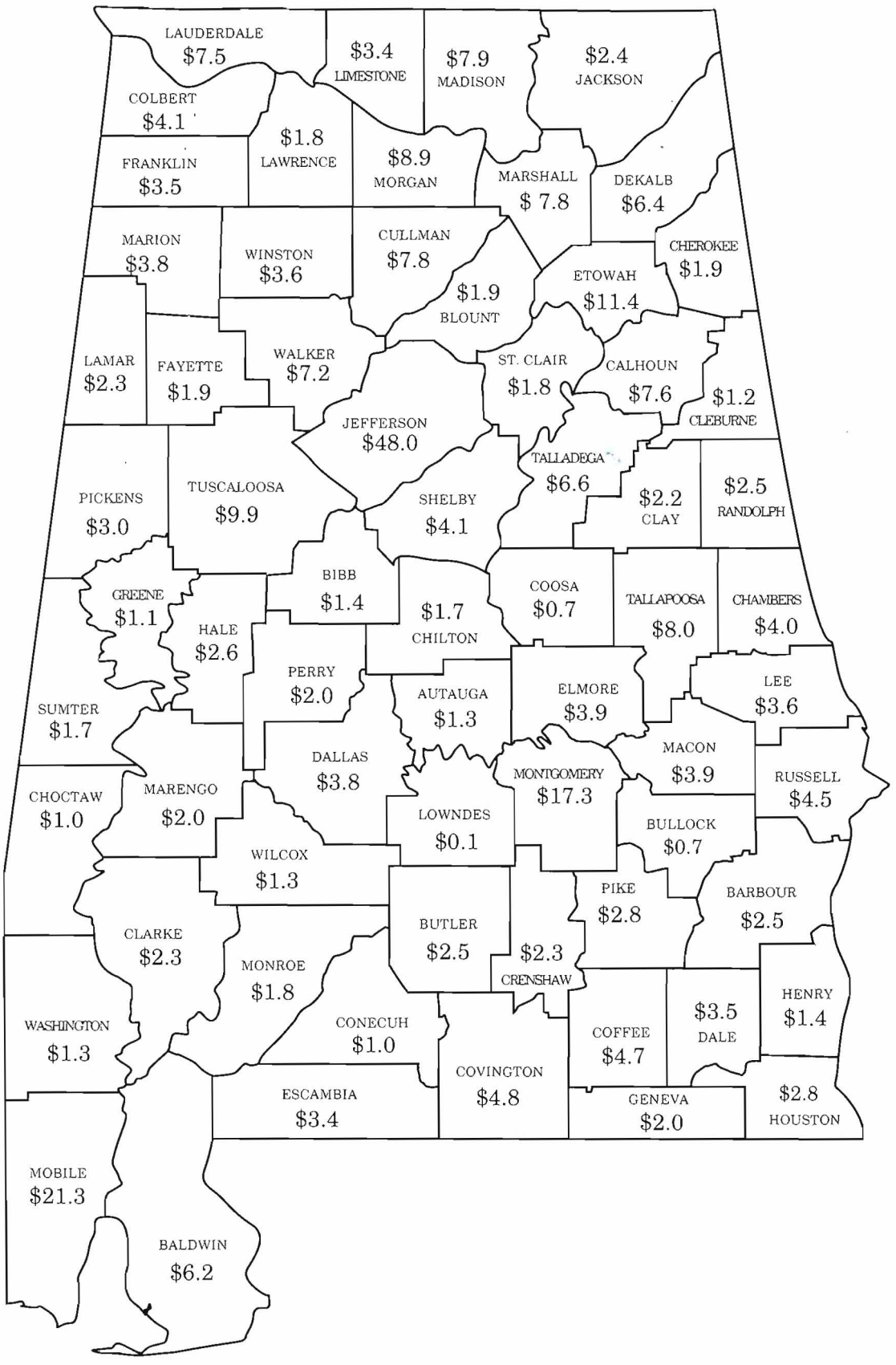
LONG-TERM CARE PROGRAM

Recipients and payments by sex, race, and age

	Recipients	Payments	Cost Per Recipient
By Sex			
Female	16,265	$245,530,443	$15,096
Male	4,819	$70,145,483	$14,556
By Race			
White	16,657	$246,083,398	$14,774
Nonwhite	4,427	$69,592,526	$15,720
By Age			
0-5	23	$515,977	$22,434
6-20	143	$3,554,573	$24,857
21-64	1,893	$32,019,878	$16,915
65 & Over	19,025	$279,585,497	$14,696

FY 1992
PAYMENTS TO NURSING HOMES
By county of recipient (in millions of dollars)

Table – 33



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 residents.

Facilities in which intermediate care for the mentally retarded are provided include the Albert P. Brewer Developmental Center in Mobile, the J. S. Tarwarter Developmental Center in Wetumpka, 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 Muscle Shoals Association for Retarded Citizens 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 Nursing Facility in Tuscaloosa, Claudette Box Nursing Facility in Mobile, and S. D. Allen Nursing 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 approximately $87 million in FY 1992. In FY 1992 the average payment per day in an institution serving the mentally retarded was approximately $183.67.

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 1992, in cooperation with the Alabama Medicaid Agency, Mental Health was able to match every $27 in state funds with $73 of federal funds for the care of Medicaid-eligible ICF-MR/MD patients.

FY 1992
LONG-TERM CARE PROGRAM
ICF-MR/MD

Table – 34

	ICF/MR	ICF/MD-Aged
Recipients	1,301	420
Total Payments	$76,830,747	$10,718,356
Annual Cost Per Recipient	$59,055	$25,520

Pharmaceutical Program

Although the pharmacy program is an optional service under federal Medicaid rules, it is economically 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 1992, pharmacy providers were paid approximately $116 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about 10 percent of Medicaid payments for services. The Medicaid Agency's reimbursement to participating pharmacists is based on the ingredient cost of the prescription plus a dispensing fee. Dispensing fees were increased effective October 1, 1991 as follows:

Retail pharmacy.....$5.40

Institutional pharmacy.....$2.77

Government pharmacy.....$5.40

Dispensing physician.....$1.21

Primarily to control overuse, Medicaid recipients must pay a copayment for each prescription. The copayment ranges from $.50 to $3, depending on drug ingredient cost. The Omnibus Budget Reconciliation Act of 1990 expanded Medicaid coverage of reimburseable drugs. With the exception of allowable published exclusions, almost all drugs are now covered by the Medicaid Agency.

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 for either an office visit or the cost of the drug plus an administration fee.

FY 1992
PHARMACEUTICAL PROGRAM
Counts of providers by type
Table – 35

Type of Provider	Number
Retail	1,283
Institutional	36
Governmental	4
Dispensing Physician	1
Total	1,324

FY 1990-1992
PHARMACEUTICAL PROGRAM
Use and cost
Table – 36

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
1990	253,457	61%	3,983,206	15.72	$15.19	$239	$60,508,220
1991	293,119	61%	4,494,686	15.33	$16.92	$259	$76,028,149
1992	351,293	64%	5,666,482	16.13	$20.42	$329	$115,725,473

Alabama Medicaid and AIDS

Fiscal year 1992 saw a substantial increase in the number of AIDS cases in Alabama and in the number of Medicaid recipients with AIDS. Nationally, Medicaid covers approximately 40 percent of all HIV/AIDS patients and is also the largest payor for health care coverage for those with HIV/AIDS. Of the 1,668 AIDS cases reported in Alabama during FY 1992, 813 (49 percent) received services funded by Medicaid. Payments for AIDS-related care grew from $1.6 million in FY 1990 to more than $5.4 million in FY 1992.

Under federal law, a diagnosis of AIDS is considered a disabling condition and qualifies an individual for all Medicaid benefits. Medicaid eligibles must also meet other financial criteria. The following is a brief summary of some essential services provided to AIDS patients under the Medicaid program.

Physician Services: Finding a physician who is familiar with AIDS-related diseases is sometimes difficult, especially in rural areas. Consequently, AIDS patients must often travel long distances to see a physician who is qualified and willing to see them. The majority of physicians currently treating these Medicaid recipients are located in Mobile and Birmingham.

Inpatient Hospital Care: The largest portion of the costs for HIV/AIDS Medicaid recipients in Alabama continues to be for inpatient hospital care. Medicaid provided inpatient care costing $2,897,086 in FY 1992. AIDS patients frequently require hospitalization for opportunistic infectious diseases. Since Medicaid covers only 16 inpatient days annually for adults, AIDS patients often exhaust their inpatient hospital benefits.

Prescription Drugs: Alabama Medicaid covers AZT and other drugs used to prolong the life and health of AIDS patients. Because of the high cost and the number of drugs available to treat AIDS-related infections, drugs represent the fastest growing expenditure for AIDS recipients. These drug expenditures for FY 1992 rose to $831,972, an increase of 73 percent over FY 1991.

Home and Community Based Waiver Program: Home-based services are provided to AIDS recipients under this waiver program as an alternative to costly nursing home placement.

Targeted Case Management: Case management services are provided to recipients who are HIV positive. These services provide for coordinated access to needed services for AIDS patients not living in a total care environment nor receiving services under a Medicaid waiver program.

Hospice Services: Because AIDS is considered a terminal illness, AIDS patients may need hospice services. Medicaid continues to provide a full range of services to recipients with AIDS under the hospice program.

FY 1989-1992
MEDICAID AIDS EXPENDITURES
(in millions of dollars)

Table – 37