Alabama Medicaid Agency

FY 1994 Annual Report

Jim Folsom, Jr.
Governor
State of Alabama

David G. Toney
Commissioner
Alabama Medicaid Agency

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FY 1994 Annual Report
October 1, 1993 - September 30, 1994

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JIM FOLSOM
Governor

DAVID G. TONEY
Commissioner

December 1, 1994

The Honorable Jim Folsom, Jr.
Governor of the State of Alabama
Alabama State Capitol
Montgomery, Alabama 36130

Dear Governor Folsom:

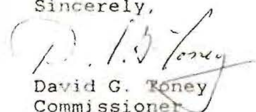
It is my pleasure to transmit to you the twenty-second annual report of the Alabama Medicaid Agency. The report covers activities for the fiscal year that began October 1, 1993, and ended September 30, 1994.

During the year, Medicaid paid for health care for more than 620,000 Alabamians, all of them people with low incomes. Among those who depend on Medicaid for health care are children and pregnant women, as well as elderly and disabled people in their own homes and in nursing homes. Besides meeting critical needs for care, Medicaid contributes substantially to the economy of the state. For many rural and inner city health care providers, the program offers the only reimbursement available.

In no small part because of Medicaid, the state's infant mortality has dropped significantly. Contributing to the better health of Alabama's mothers and babies are a number of Medicaid initiatives, including programs to educate pregnant women in the importance of prenatal care and expansions of eligibility to cover more children and pregnant women. With the aim of giving every Alabama baby the opportunity for a healthy start in life, Medicaid continues to work closely with state and local health and social service agencies, health care providers and advocacy groups throughout the state.

The Alabama Medicaid Agency is committed to ensuring the highest quality of care at an economical cost to the taxpayers who fund the program. Improving Medicaid, so that it becomes an even more efficient and effective program, continues to be a top priority. With this goal in mind, it is my privilege to serve the people of Alabama, and you as Governor, in administering the Medicaid program in our great state.

Sincerely,



David G. Toney
Commissioner

DGT/jsb

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 Financial Planning/Analysis Division of the Alabama Medicaid Agency.

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HIGHLIGHTS

INTRODUCTION

On July 20, 1994 the Administrative Offices and the Montgomery District Office of the Alabama Medicaid Agency moved to a new location. The offices are now located in the newly renovated Lurleen B. Wallace State Office Building at 501 Dexter Avenue, Montgomery. As one can imagine, coordination of the move was a challenge. Because of careful advance planning by Agency staff, the move was accomplished with minimal interruption of work. The new location enables staff to function more efficiently since the entire Agency is now located under one roof. The move is part of an effort to get more state offices into state owned buildings.

Fiscally, the Agency continued its recovery from Congress' action of November 1991 when it limited states' use of provider specific taxes. Last fiscal year, after discussions with members of the legislature and different provider groups, a settlement was reached. Through the Disproportionate Share program, this settlement has provided the Medicaid Agency with the money needed to avoid shortfalls in FY 1993 and FY 1994. The Disproportionate Share program increases Medicaid's state funding by transferring governmental funds from state owned hospitals. These funds are then matched by the federal government. The providers, in return, receive their original contribution plus some additional money to help cover the cost of uncompensated care.

While the Agency had to work through financial challenges, there were also successes during the year. Among the successes was the expansion of the Agency's Maternity Waiver program. This program, long known for its valuable, cost efficient service to Medicaid eligible pregnant women, expanded into three additional counties. The expansion brought the total to 45 counties participating in the waiver — two-thirds of Alabama's counties. Those added were Baldwin, Madison, and Russell Counties. There were other successes...

INFANT MORTALITY REDUCED

During the year it was announced that the state's infant mortality dropped significantly in 1993 to the lowest rate in several years. After peaking at 13.3 deaths per 1,000 live births in 1983, the state's infant mortality rate has declined over the last decade. During calendar year 1993, there were 10.5 deaths per 1,000 live births, compared to a rate of 11.2 deaths in 1992. During the past few years, outreach efforts in the state have helped to reduce the infant mortality rate. Efforts by the Medicaid Agency, Department of Public Health, advocacy groups, physicians, and a variety of health care organizations to educate women on the importance of early prenatal care and healthy lifestyles during pregnancy are credited with the reduction.

FEDERAL GRANT AWARDED

Medicaid received continuation approval of a federal grant that, in its first year, gave almost 1,000 low-income mothers and children easier access to a number of health and social services. The grant, which could total more than $864,000 over four years, provides funding for a "one-stop shopping" project in Dallas County and Wilcox County. The one-stop shopping concept gets its name because individuals can go to one location to apply for a variety of health and social service programs.

The project began in January, 1993 when Medicaid placed an eligibility worker and the Alabama Department of Public Health placed a social worker in George Washington Carver public housing neighborhood located in Selma. The workers enter women and their children into a coordinated health care system of referral and follow-up and ensure those eligible have access to all available health and social services. Also included in the grant is a transportation system to enhance access to services.

The concept of one-stop shopping is helpful to recipients. Going to one location lessens the hardships and frustration often experienced by the low-income population when traveling to several places applying for a variety of health and social services. This is the first grant of its type to be awarded anywhere in the state of Alabama. Out of 217 applications submitted to the U.S. Public Health Service, only 32 grants were awarded nationwide.

The grant allowed the hiring of seven staff members which include a project coordinator, a Medicaid eligibility worker, a public health social worker, a van driver, and clerical support.

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 used to show the percentage of payments made on behalf of people ineligible for Medicaid. The most recent estimate of annual payment error rates released in April 1994 shows that Alabama's rate was .6281 The state in our region with the next lowest rate was Georgia with an estimate of .9604 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 financial sanctions by the federal government.

Third Party Savings

Medicaid is a secondary payor to all third party resources, i.e., insurance companies, liability insurance carriers, absent parent medical support, and others. For FY 1994, approximately 12 percent of Medicaid eligibles were identified as covered by third party resources.

During the 1994 fiscal year, Medicaid's Third Party Division collected $4.6 million from third parties, and $2 million from estates of Medicaid recipients, and approximately $500,000 was recouped from recipients as a result of eligibility related issues. Provider-reported collections from third parties saved Medicaid an additional $7.7 million.

In addition to these savings, Medicaid returned to providers claims totaling in excess of $43 million because of potential health insurance resources. It is estimated these claims represent an additional $7 million in cost avoided savings never reported to Medicaid because third parties paid the claim in full.

Medicaid also returned claims totaling $36 million to providers for submission to Medicare, the primary payor. In FY 1994 Medicaid also recouped $236,000 from providers who had received payment from both Medicaid and a third party.

In FY 1994 the Alabama Medicaid Agency expanded its role of paying premiums for cost effective health insurance plans. In addition to paying premiums for approximately 6,500 Qualified Medicare Beneficiaries who enrolled in a Humana insurance plan, the Agency also paid employer-related group health insurance premiums for 27 individuals who had high cost medical conditions. Payment of these employer-related group health plans resulted in an average savings of $3,500 per recipient.

Managed Care

There was a major push to implement managed care during FY 1994. Plans were made and the Agency negotiated with health maintenance corporations, met with health care providers, and worked with the Health Care Financing Administration towards getting managed care implemented. During FY 1995, there will continue to be concentrated efforts to implement managed care.

Post-Hospital Extended Care Program

During the year, the Agency became increasingly aware of Medicaid recipients who were in acute care hospitals but were no longer in need of that level of care. These patients needed to be placed in a nursing home but for reasons such as the lack of an available bed, or the level of care needed being such that they could not be accommodated currently by an area nursing home, the patient was forced to remain in the hospital. In response to this problem, the Agency initiated the Post-Hospital Extended Care Program (PEC). Patients in this program remain in the hospital, but they receive services ordinarily provided in a nursing home. For these patients the hospital is reimbursed a daily rate equal to the average daily rate paid to nursing homes in the state. The hospital is obligated to actively seek nursing home placement for these patients. The program became effective August 1, 1994.

Looking Ahead

Effective October 1, 1994 Medicaid will enter a contractual arrangement with 53 public hospitals in the state. Under this contract the hospitals agree to transfer public funds to Medicaid, and Medicaid agrees to make funds available for distribution to Disproportionate Share Hospitals. To qualify as a DSH, a hospital must be either a rural hospital, a public hospital, an urban hospital with 100 or fewer beds, a state owned teaching hospital, or meet certain federal minimum requirements. In addition, it must meet certain requirements concerning the provision of maternity services.

ALABAMA'S MEDICAID PROGRAM

HISTORY

Medicaid was created in 1965 by Congress along with a sound-alike sister program, Medicare. *Medicare* is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. *Medicaid* is jointly financed by the state and federal governments and is designed to provide health care to low income individuals. 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, it was renamed the Alabama Medicaid Agency.

A STATE PROGRAM

Unlike the Medicare 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, limitations on services, and reimbursement levels.

FUNDING FORMULA

The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because the average income in Alabama is relatively low, its federal match is one of the largest. During FY 1994, the formula was approximately 71/29. For every $29 the state spent, the federal government contributed $71.

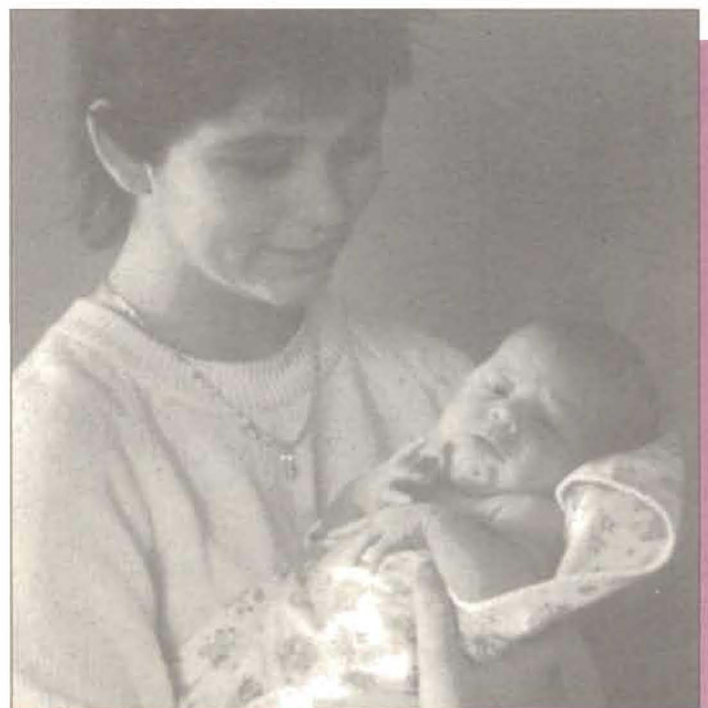
ELIGIBILITY

Persons must fit into one of several categories and must meet necessary criteria before eligibility can be granted. 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 category.
- 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.
- Children under six years of age and certain pregnant women, whose family incomes are under 133 percent of the federal poverty level and who do not receive an AFDC cash payment, and foster children in the custody of the state. Also covered are all other children born after September 30, 1983 who live in families with annual incomes below the 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 coinsurance paid by Medicaid. 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 most of these eligibility categories may be eligible for retroactive Medicaid coverage if any medical bills had been incurred during the three months prior to the time of applying for Medicaid.



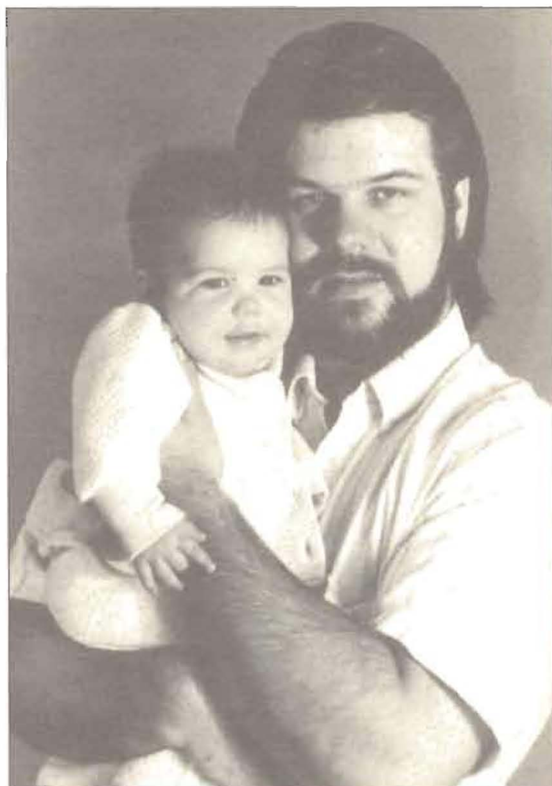
Some persons in eligibility categories are protected by federal law from losing their Medicaid benefits. One of those categories includes Pickle (or Continued Medicaid) cases. Persons in this category receive Social Security and would also receive SSI if the cost of living raises did not push them above 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.

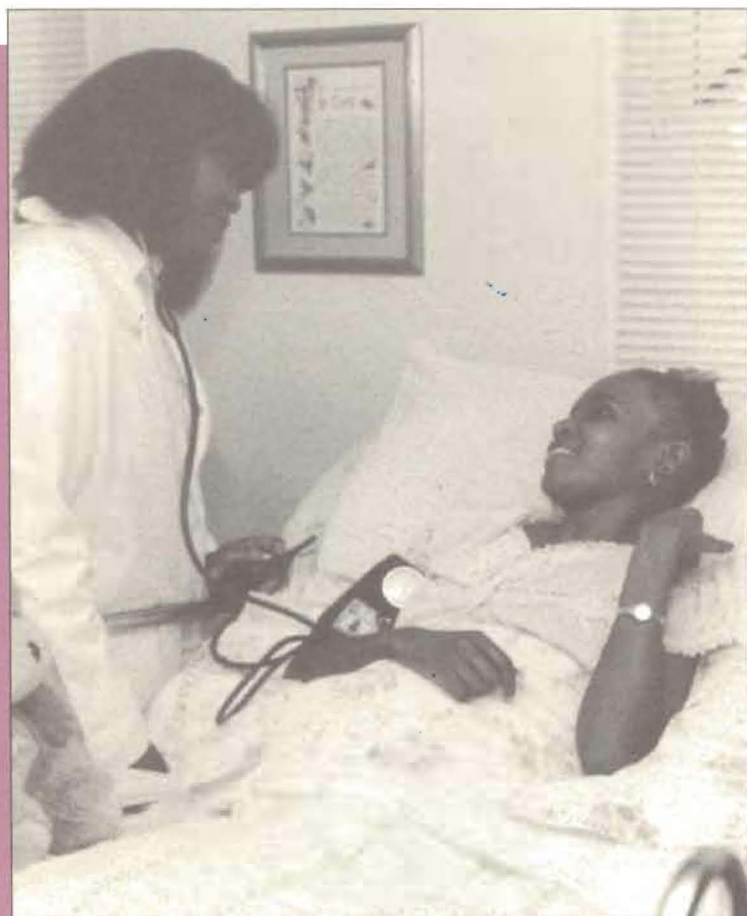
Covered Services

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.

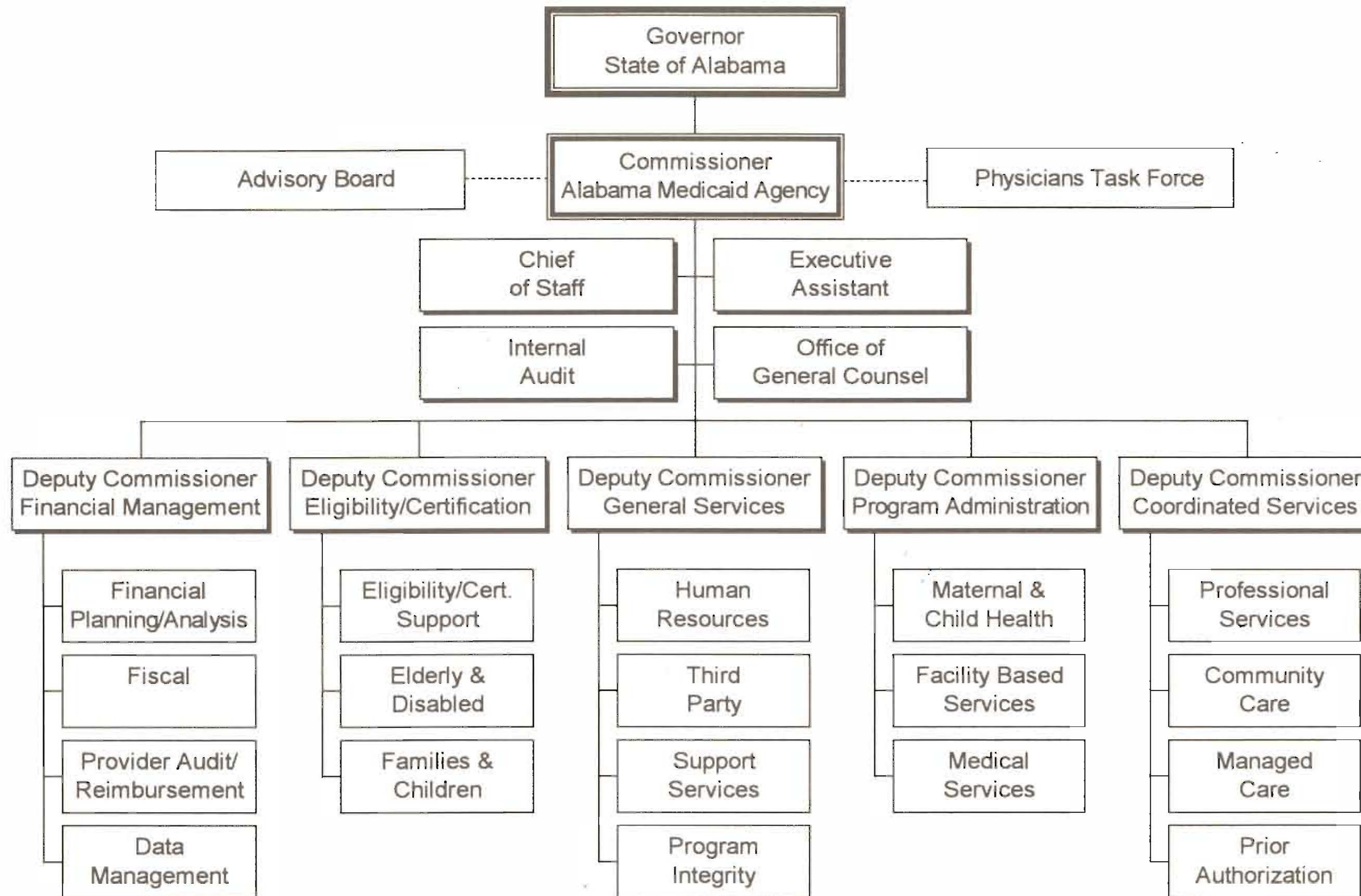
How The Program Works

For many years Medicaid recipients were issued monthly paper cards signifying their eligibility. In November 1992, the Agency converted to plastic cards that are issued on a more permanent basis. It is the option of providers to accept Medicaid recipients as patients, and it is 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.





ALABAMA MEDICAID AGENCY



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 over one million 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 1994, Medicaid paid over $1 billion to providers on behalf of persons eligible for the program. The federal government paid approximately 71 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 $3 billion worth of business in Alabama in FY 1994.

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 Medicaid patients.

FY 1994
COUNTY IMPACT
Year's Cost Per Eligible

County	Benefit Payments	Eligibles	Payment Per Eligible	County	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$7,423,486	4,874	$1,523	Houston	$19,729,848	12,411	$1,590
Baldwin	$20,996,448	10,883	$1,929	Jackson	$14,553,626	6,832	$2,130
Barbour	$10,572,691	5,534	$1,910	Jefferson	$193,593,404	85,384	$2,267
Bibb	$5,355,661	3,025	$1,770	Lamar	$5,628,558	2,217	$2,539
Blount	$9,798,061	4,843	$2,023	Lauderdale	$22,507,397	9,532	$2,361
Bullock	$5,359,916	3,297	$1,626	Lawrence	$8,621,313	4,649	$1,854
Butler	$9,400,243	4,713	$1,995	Lee	$17,918,864	10,184	$1,760
Calhoun	$31,190,897	16,264	$1,918	Limestone	$12,804,196	6,977	$1,835
Chambers	$12,122,515	6,034	$2,009	Lowndes	$4,325,584	3,976	$1,088
Cherokee	$5,580,385	2,446	$2,281	Macon	$10,773,827	5,803	$1,857
Chilton	$9,701,467	4,963	$1,955	Madison	$41,490,635	29,048	$1,428
Choctaw	$6,088,310	3,411	$1,785	Marengo	$10,045,330	5,294	$1,897
Clarke	$10,821,479	6,898	$1,569	Marion	$10,090,636	3,830	$2,635
Clay	$5,585,164	2,043	$2,734	Marshall	$25,542,776	10,759	$2,374
Cleburne	$3,429,508	1,805	$1,900	Mobile	$133,796,688	65,119	$2,055
Coffee	$13,548,522	5,433	$2,494	Monroe	$7,582,070	4,288	$1,768
Colbert	$15,388,270	6,983	$2,204	Montgomery	$64,257,568	36,489	$1,761
Conecuh	$6,440,581	3,385	$1,903	Morgan	$44,481,482	11,465	$3,880
Coosa	$2,678,925	1,606	$1,668	Perry	$7,746,046	4,372	$1,772
Covington	$14,854,105	6,495	$2,287	Pickens	$9,515,047	4,657	$2,043
Crenshaw	$6,211,871	2,745	$2,263	Pike	$11,996,699	6,318	$1,899
Cullman	$23,456,909	8,735	$2,685	Randolph	$7,527,061	3,374	$2,231
Dale	$13,531,649	7,211	$1,877	Russell	$13,708,212	9,005	$1,522
Dallas	$23,659,651	15,121	$1,565	St. Clair	$11,920,212	6,543	$1,822
Dekalb	$18,810,034	7,692	$2,445	Shelby	$12,743,703	6,183	$2,061
Elmore	$25,085,652	6,756	$3,713	Sumter	$7,167,522	4,584	$1,564
Escambia	$12,133,925	6,059	$2,003	Talladega	$27,781,339	14,154	$1,963
Etowah	$35,715,437	14,891	$2,398	Tallapoosa	$18,072,975	6,793	$2,661
Fayette	$5,473,552	2,719	$2,013	Tuscaloosa	$75,527,024	21,303	$3,545
Franklin	$11,908,794	4,707	$2,530	Walker	$26,115,599	10,779	$2,423
Geneva	$8,752,954	4,043	$2,165	Washington	$5,833,097	3,751	$1,555
Greene	$5,567,520	3,299	$1,688	Wilcox	$6,849,491	5,232	$1,309
Hale	$8,019,132	3,949	$2,031	Winston	$10,885,008	3,732	$2,917
Henry	$5,434,724	2,852	$1,906	Other	$152,540	96	$1,589

REVENUE AND EXPENDITURES

FY 1994 SOURCES OF MEDICAID REVENUE

	Dollars
Federal Funds	$1,289,332,882
State Funds	$525,446,434
Total Revenue	$1,814,779,316

FY 1994 COMPONENTS OF FEDERAL FUNDS

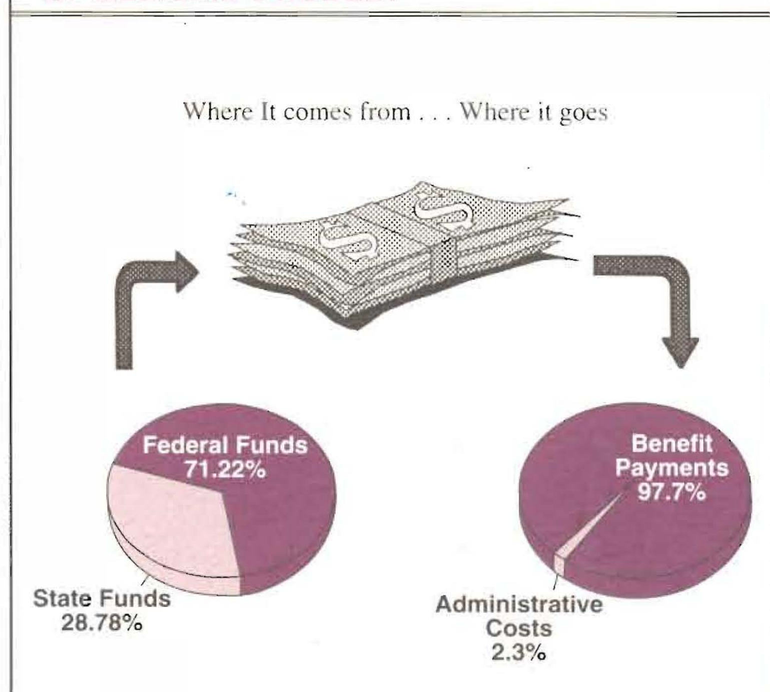
(net)	Dollars
Family Planning Administration	$83,933
Professional Staff Costs	$13,072,762
Other Staff Costs	$13,003,753
Other Provider Services	$1,254,106,168
Family Planning Services	$9,066,266
Total	$1,289,332,882

FY 1994 COMPONENTS OF STATE FUNDS

(net)	Dollars
Encumbered Balance Forward	$483,562
Basic Appropriations	$139,511,494
Public Hospital Transfers and Alabama Health Care Trust Fund	$331,614,944
Other State Agencies	$62,528,403
Interest Income From Fiscal Agent	$66,626
UAB (Transplants)	$393,891
Miscellaneous Receipts	$114,196
Subtotal	$534,713,116
Encumbered	$9,266,682
Total	$525,446,434

In FY 1994, Medicaid paid $1,772,661,670 for health care services to Alabama citizens. Another $42,117,646 were expended to administer the program. This means that almost 98 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 1994 COMPOSITION AND DISBURSEMENT OF MEDICAID'S BUDGET



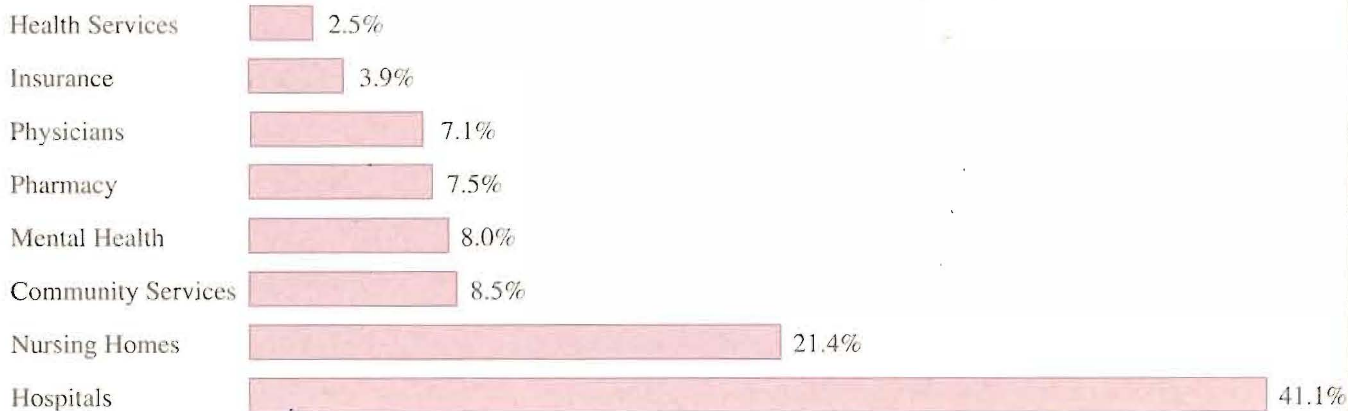
FY 1993-1994 BENEFIT PAYMENTS BY FISCAL YEAR IN WHICH OBLIGATION WAS INCURRED

	FY'93	FY'94
Nursing Homes	$328,960,536	$379,717,111
Hospitals	$708,661,246	$729,300.733
Physicians	$117,721,621	$126,604,472
Insurance	$54,759,962	$68,617,435
Drugs	$118,216,546	$131,979,275
Health Services	$37,341,791	$43,897,563
Community Services	$143,217,212	$149,288,085
Total Medicaid Service	$1,508,878,914	$1,629,404,674
Mental Health	$134,787,821	$143,256,996
Total Benefits	$1,643,666,735	$1,772,661,670

FY 1994
EXPENDITURES
By Type of Service (Net)

Service	Payments	Percent of Total Payments
Hospitals:	$729,300,733	41.14%
Disproportionate Share	$415,766,973	23.45%
Inpatient	$259,565,144	14.64%
Outpatient	$37,266,820	2.10%
FQHC	$15,552,093	0.88%
Rural Health Clinics	$1,149,703	0.06%
Nursing Homes	$379,717,111	21.42%
Waivered Services:	$142,265,927	8.03%
Pregnancy Related	$86,744,190	4.89%
Elderly & Disabled	$28,730,754	1.62%
Mental Health	$25,540,630	1.44%
OBRA '87	$603,240	0.03%
Homebound	$472,961	0.03%
SCCLA	$174,152	0.01%
Pharmacy	$131,979,275	7.45%
Physicians:	$126,604,472	7.14%
Physicians	$97,618,434	5.51%
Physician's Lab and X-Ray	$17,349,894	0.98%
Clinics	$6,580,814	0.37%
Other Practitioners	$5,055,330	0.29%
MR/MD:	$91,148,517	5.14%
ICF-MR	$78,984,574	4.46%
NF-MD/Illness	$12,163,943	0.69%
Insurance:	$68,617,435	3.87%
Medicare Buy-In	$68,090,910	3.84%
Humana QMB Plan	$495,312	0.03%
Catastrophic Illness Insurance	$31,213	0.00%
Health Services:	$43,897,563	2.48%
Screening	$17,233,302	0.97%
Laboratory	$10,366,824	0.58%
Dental	$8,348,965	0.47%
Transportation	$3,484,597	0.20%
Eye Care	$2,660,186	0.15%
Eyeglasses	$1,297,571	0.07%
Hearing	$324,063	0.02%
Preventive Education	$182,055	0.01%
Community Services:	$36,760,506	2.07%
Home Health/DME	$19,109,863	1.08%
Family Planning	$10,073,629	0.57%
Targeted Case Management	$6,459,868	0.36%
Hospice	$1,117,146	0.06%
Mental Health Services	$22,370,131	1.26%
Total For Medical Care	$1,772,661,670	100.00%
Administrative Costs	$42,117,646	
Net Payments	$1,814,779,316	

FY 1994
BENEFIT PAYMENTS
Percent Distribution



POPULATION

The population of Alabama grew from 3,893,888 in 1980 to 4,040,587 in 1990. In 1994, Alabama's population was estimated to be 4,099,303. Because of increases in Medicaid coverage in recent years, the segment of the population eligible for Medicaid services has risen from 10.4% in FY 1990 to 15.1% in FY 1994.

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 1970 to 1990. 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 2000 there will be 570,814 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, Medicaid's costs per eligible have been higher for this group than for other groups of eligibles.

FY 1992-1994
POPULATION
Eligibles as a Percent of Alabama Population by Year

	Population	Eligibles	Percent
1992	4,070,312	551,151	13.5%
1993	4,084,898	595,769	14.6%
1994	4,099,303	620,847	15.1%

FY 1994

COLLECTIONS AND MEASURABLE COST AVOIDANCE

COLLECTIONS	
DRUG REBATE PROGRAM The collection of rebates by the Fiscal Division from drug manufacturers for the utilization of their products.	$29,643,798
THIRD PARTY LIABILITY Includes collections by the Third Party Division and the providers, as well as retroactive Medicare recoupments and recoupments from health insurance.	$16,887,066
OTHER RECOUPMENTS Includes recoupments originating from monthly audits of 25 percent of Medicaid admissions in delegated hospitals and random audits of other hospitals.	$366,544
PROGRAM INTEGRITY DIVISION Provider Recoupments	$158,675
FISCAL AGENT LIAISON OFFICE Claim Corrections	$21,937
TOTAL COLLECTIONS	**$47,078,020**
MEASURABLE COST AVOIDANCE	
PRIOR APPROVAL AND PREPAYMENT REVIEW Results from denials in nondelegated hospitals	$193,673
PRIOR APPROVAL AND PREPAYMENT REVIEW Results from denials in psychiatric hospitals participating in Medicaid's Under 21 Psychiatric program	$480,793
THIRD PARTY CLAIM COST AVOIDANCE - MEDICARE Claims denied and returned to providers to file Medicare.	$36,324,968
THIRD PARTY CLAIM COST AVOIDANCE - OTHER Claims denied and returned to providers to file health casualty insurance.	$42,974,072
WAIVER SERVICES COST AVOIDANCE - ELDERLY AND DISABLED	$96,029,001
WAIVER SERVICES COST AVOIDANCE - PREGNANCY RELATED	$3,074,500
WAIVER SERVICES COST AVOIDANCE - OBRA '87	$1,652,688
WAIVER SERVICES COST AVOIDANCE - HOMEBOUND*	$3,488,436
WAIVER SERVICES COST AVOIDANCE - MR/DD	$98,616,768
TOTAL MEASURABLE COST AVOIDANCE	**$282,834,899**
GRAND TOTAL	**$329,912,919**

* This is an estimated figure based on FY 1993 and FY 1994 figures.

ELIGIBLES

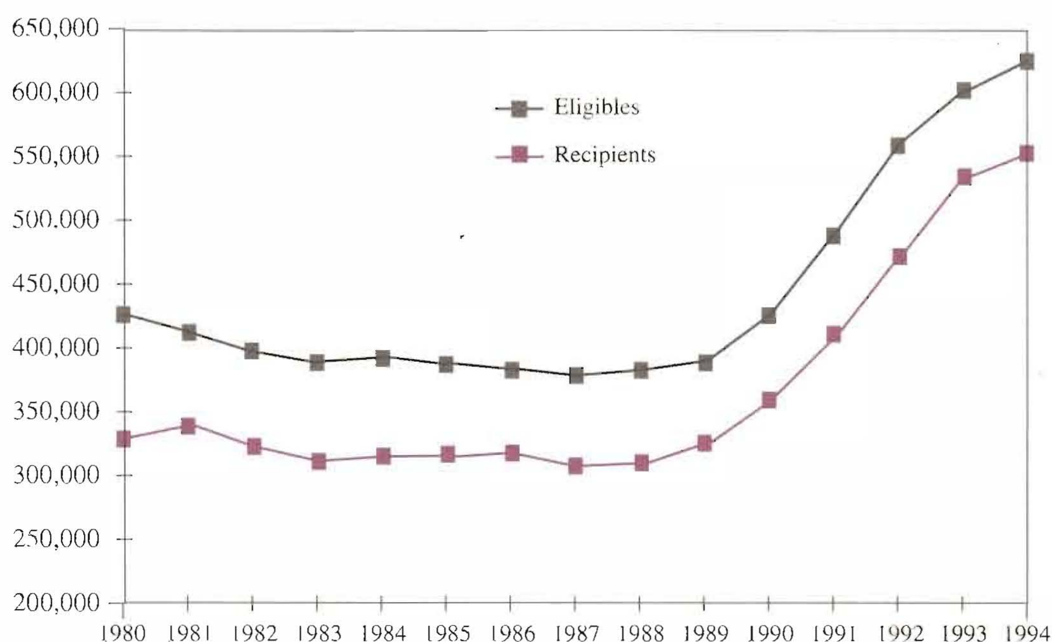
During FY 1994, there were 620,847 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 491,354. The monthly average is the most useful measure of Medicaid coverage because it takes into account length of eligibility.

Although 620,847 people were eligible for Medicaid in FY 1994, only 79 percent were eligible for the entire year. The length of time the other 21 percent of Medicaid eligibles were covered ranged from one to eleven months.

FY 1994 ELIGIBLES MONTHLY COUNT

Month	Count
October '93	487,768
November	484,879
December	484,989
January '94	488,466
February	489,153
March	493,775
April	492,822
May	492,598
June	492,758
July	494,151
August	496,704
September	498,183

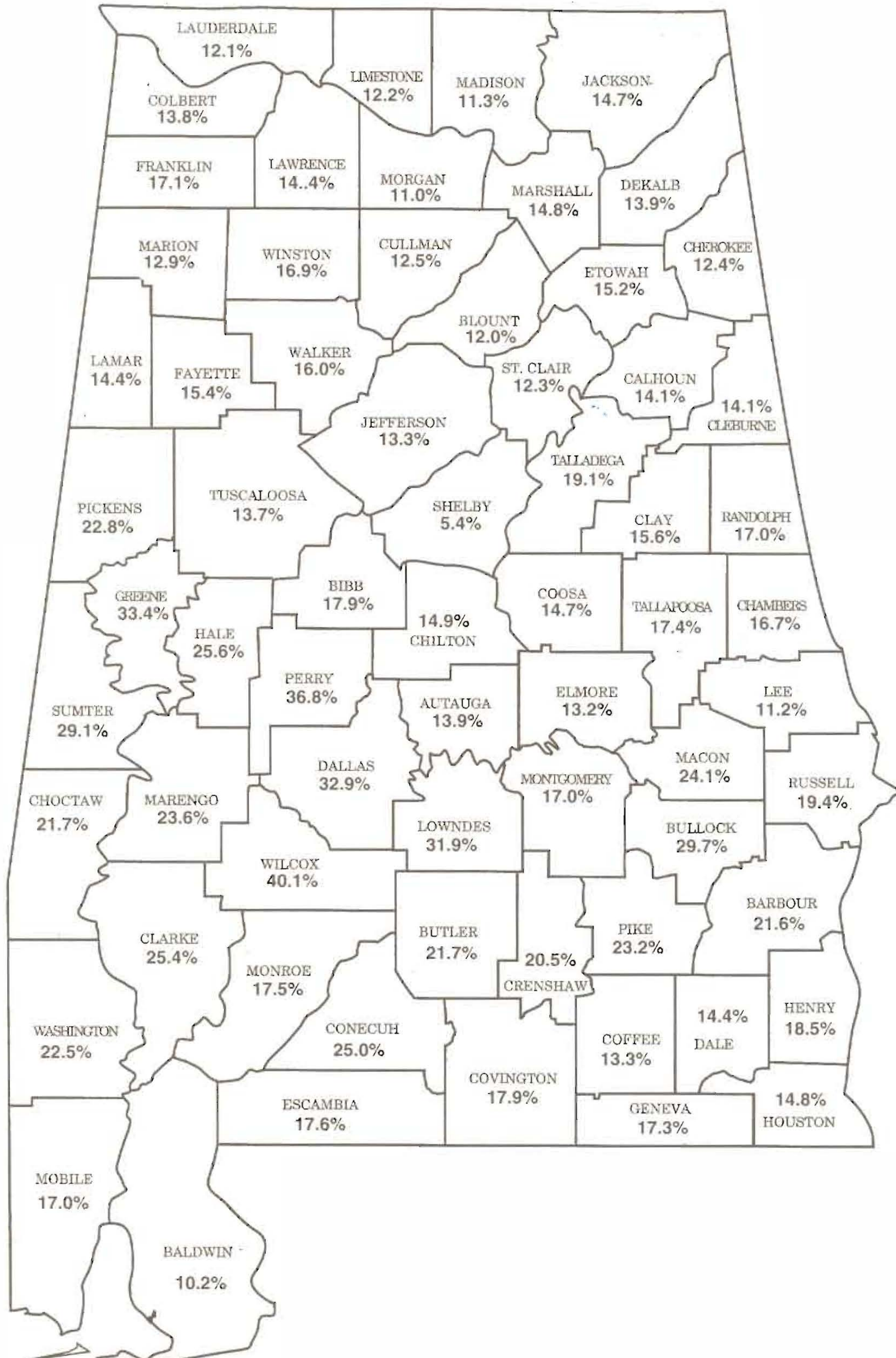
FY 1980 - 1994 MEDICAID ELIGIBLES AND RECIPIENTS



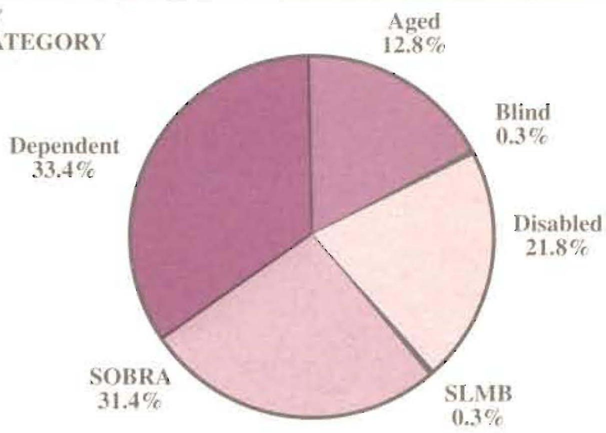
FY 1994
MEDICAID ELIGIBLES BY CATEGORY

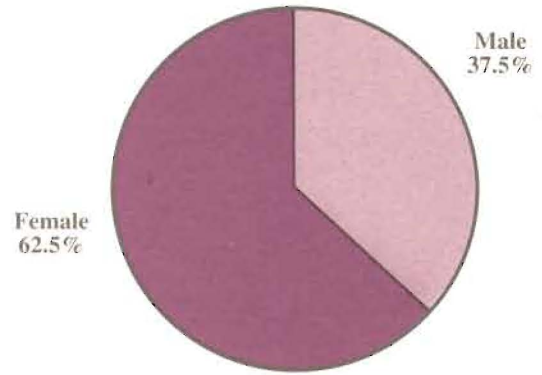
COUNTY	AFDC	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	TOTAL
Autauga	1,371	412	1,020	1,930	125	11	5	4,874
Baldwin	2,322	974	2,297	4,913	305	32	40	10,883
Barbour	1,686	783	1,340	1,522	160	25	18	5,534
Bibb	535	311	782	1,282	98	4	13	3,025
Blount	1,051	610	893	2,078	189	6	16	4,843
Bullock	1,241	455	656	865	65	9	6	3,297
Butler	1,299	740	1,008	1,485	151	15	15	4,713
Calhoun	5,348	1,424	3,945	5,000	426	79	42	16,264
Chambers	2,146	718	1,020	1,876	225	30	19	6,034
Cherokee	512	350	522	904	129	5	24	2,446
Chilton	1,317	550	976	1,894	190	18	18	4,963
Choctaw	1,102	512	734	962	77	12	12	3,411
Clarke	3,079	655	1,383	1,599	156	15	11	6,898
Clay	353	342	430	781	117	10	10	2,043
Cleburne	444	233	374	659	80	5	10	1,805
Coffee	1,399	790	1,083	1,883	242	12	24	5,433
Colbert	740	746	1,504	3,707	240	21	25	6,983
Conecuh	1,134	421	680	1,026	102	15	7	3,385
Coosa	452	164	436	496	47	7	4	1,606
Covington	1,505	905	1,320	2,393	320	15	37	6,495
Crenshaw	753	511	647	697	110	10	17	2,745
Cullman	1,232	1,439	2,077	3,579	347	23	38	8,735
Dale	2,406	701	1,338	2,502	216	19	29	7,211
Dallas	6,295	1,554	3,739	3,187	278	37	31	15,121
Dekalb	1,199	1,338	1,671	3,117	311	22	34	7,692
Elmore	1,918	716	1,602	2,332	160	12	16	6,756
Escambia	2,006	680	1,161	2,007	174	15	16	6,059
Etowah	3,285	1,703	3,924	5,222	632	46	79	14,891
Fayette	691	451	604	869	92	5	7	2,719
Franklin	869	632	1,103	1,856	210	12	25	4,707
Geneva	931	664	924	1,275	202	13	34	4,043
Greene	1,182	443	685	928	48	10	3	3,299
Hale	1,073	687	821	1,286	63	9	10	3,949
Henry	972	431	580	703	133	15	18	2,852
Houston	3,695	1,264	2,646	4,291	414	30	71	12,411
Jackson	1,283	840	1,740	2,553	345	31	40	6,832
Jefferson	34,641	6,732	19,866	22,023	1,704	222	196	85,384
Lamar	287	432	498	873	107	12	8	2,217
Lauderdale	1,821	1,176	2,167	3,935	369	14	50	9,532
Lawrence	918	577	1,035	1,919	168	11	21	4,649
Lee	2,876	903	1,974	4,111	259	30	31	10,184
Limestone	2,208	863	1,440	2,194	210	36	26	6,977
Lowndes	1,554	367	925	1,047	60	8	15	3,976
Macon	3,021	595	951	1,130	84	19	3	5,803
Madison	14,918	1,848	4,708	6,872	581	67	54	29,048
Marengo	1,901	721	1,068	1,471	114	14	5	5,294
Marion	694	663	802	1,450	193	8	20	3,830
Marshall	2,423	1,543	2,521	3,743	428	30	71	10,759
Mobile	27,762	4,104	12,424	19,383	1,207	109	130	65,119
Monroe	1,356	479	893	1,437	105	10	8	4,288
Montgomery	14,169	2,858	8,713	9,928	666	79	76	36,489
Morgan	2,531	1,322	2,821	4,358	364	42	27	11,465
Perry	1,826	541	874	1,066	55	5	5	4,372
Pickens	1,599	698	1,090	1,135	103	15	17	4,657
Pike	1,938	850	1,449	1,887	151	30	13	6,318
Randolph	891	511	635	1,162	144	16	15	3,374
Russell	3,378	916	1,646	2,754	255	26	30	9,005
St. Clair	2,138	521	1,100	2,571	185	14	14	6,543
Shelby	1,589	449	1,208	2,680	210	19	28	6,183
Sumter	2,059	560	878	1,001	61	14	11	4,584
Talladega	4,297	1,108	3,414	4,796	389	102	48	14,154
Tallapoosa	2,113	867	1,360	2,191	220	19	23	6,793
Tuscaloosa	6,987	1,992	5,104	6,659	441	52	68	21,303
Walker	2,296	982	2,961	4,200	271	19	50	10,779
Washington	1,399	381	738	1,127	81	14	11	3,751
Wilcox	2,016	619	1,522	955	85	20	15	5,232
Winston	575	588	892	1,509	140	8	20	3,732
Other	87	3	2		4			96
STATEWIDE	207,094	62,918	135,344	195,226	16,593	1,739	1,933	620,847

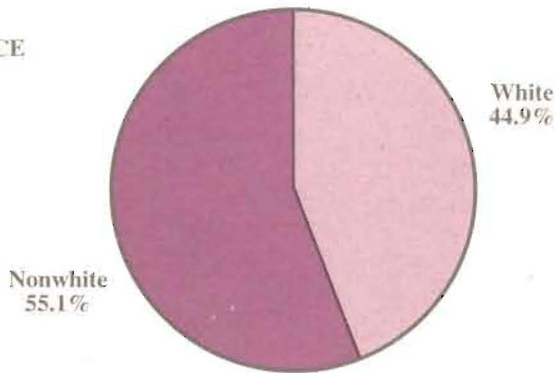
FY 1994
ELIGIBLES
Percent of Population Eligible for Medicaid

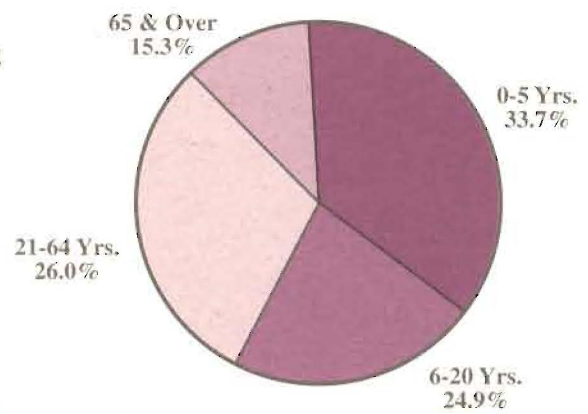


FY 1992 ELIGIBLES Percent Distribution









RECIPIENTS

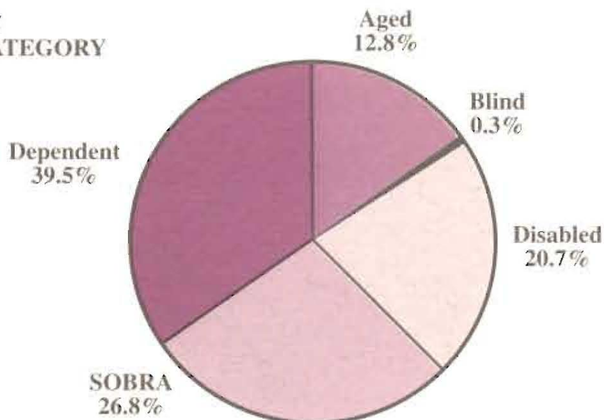
Of the 620,847 persons eligible for Medicaid in FY 1994, about 88 percent actually received care for which Medicaid paid. These 545,348 persons are called recipients. The remaining 75,499 persons incurred no medical expenses paid for by Medicaid.

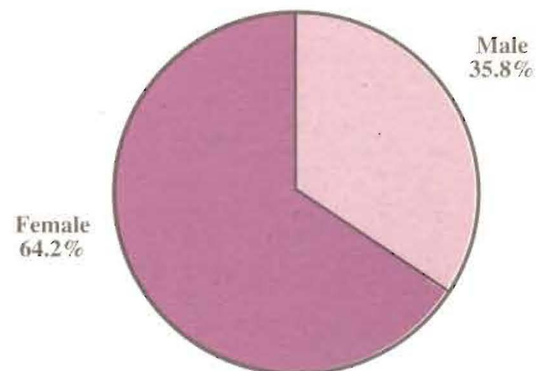
The total number of recipients is an unduplicated count. Recipients may be qualified under more than one category during the year. A recipient who receives services under more than one basis of eligibility is counted in the total for each of those categories, but is counted only once in the unduplicated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

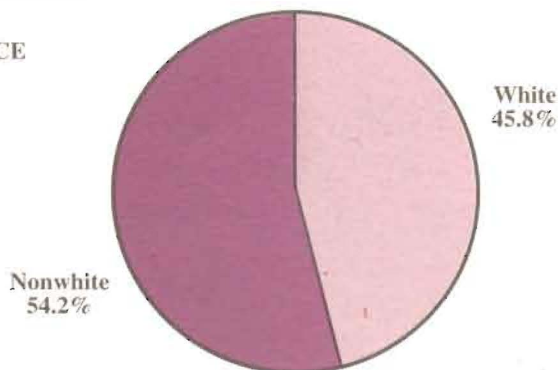
FY 1994
RECIPIENTS
Monthly Averages and Annual Total

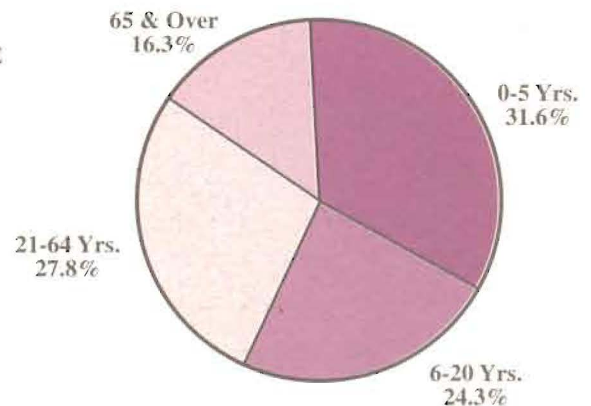
Category	Monthly Average	Annual Total
Aged	46,564	78,678
Blind	1,120	1,630
Disabled	83,831	127,665
Dependent	71,067	242,954
SOBRA	70,661	164,871
All Categories (unduplicated)	276,529	545,348

FY 1994
RECIPIENTS
Percent Distribution









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 payments for services by the total number of persons eligible during the year.

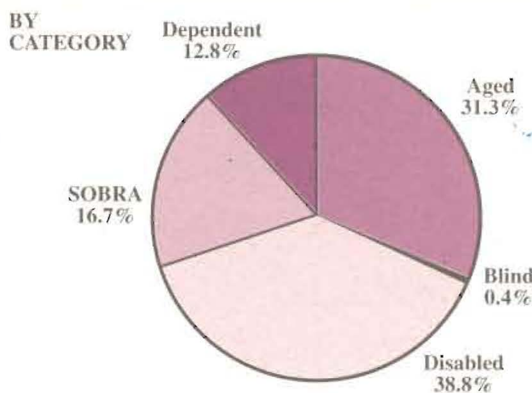
Statistics reveal that certain groups are much more expensive to the Medicaid program than others. The reason for the difference is that some groups tend to need more expensive services. Any Medicaid eligible receives, within reasonable limitations, medically necessary services.

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 1994 was $64. The yearly average number of days for recipients of this service was 274. 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.

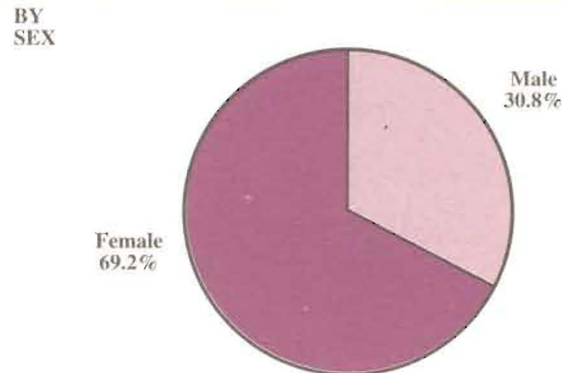
Some low income Medicare beneficiaries are eligible to have their Medicare premiums, deductibles, and coinsurance covered by Medicaid. For this coverage, Medicaid in FY 1994 paid a monthly buy-in fee to Medicare of $41.10 per eligible Medicare beneficiary. The Medicaid Agency also paid from $245.00 to $269.50 per month Part-A buy-in premiums for certain Medicare eligibles. Medicaid paid a total of $63 million in Medicare buy-in fees in FY 1994. Paying the buy-in fees is cost effective for Medicaid because, otherwise, the Agency would incur the full payment for medical bills instead of only the premiums, deductibles, and coinsurance.

FY 1994
PAYMENTS
Percent Distribution

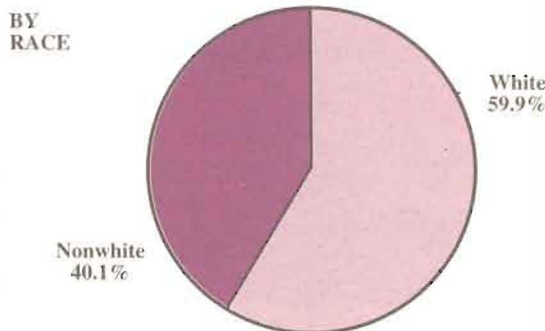
BY CATEGORY



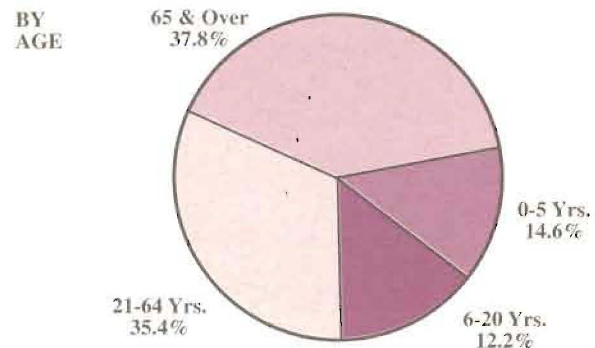
BY SEX



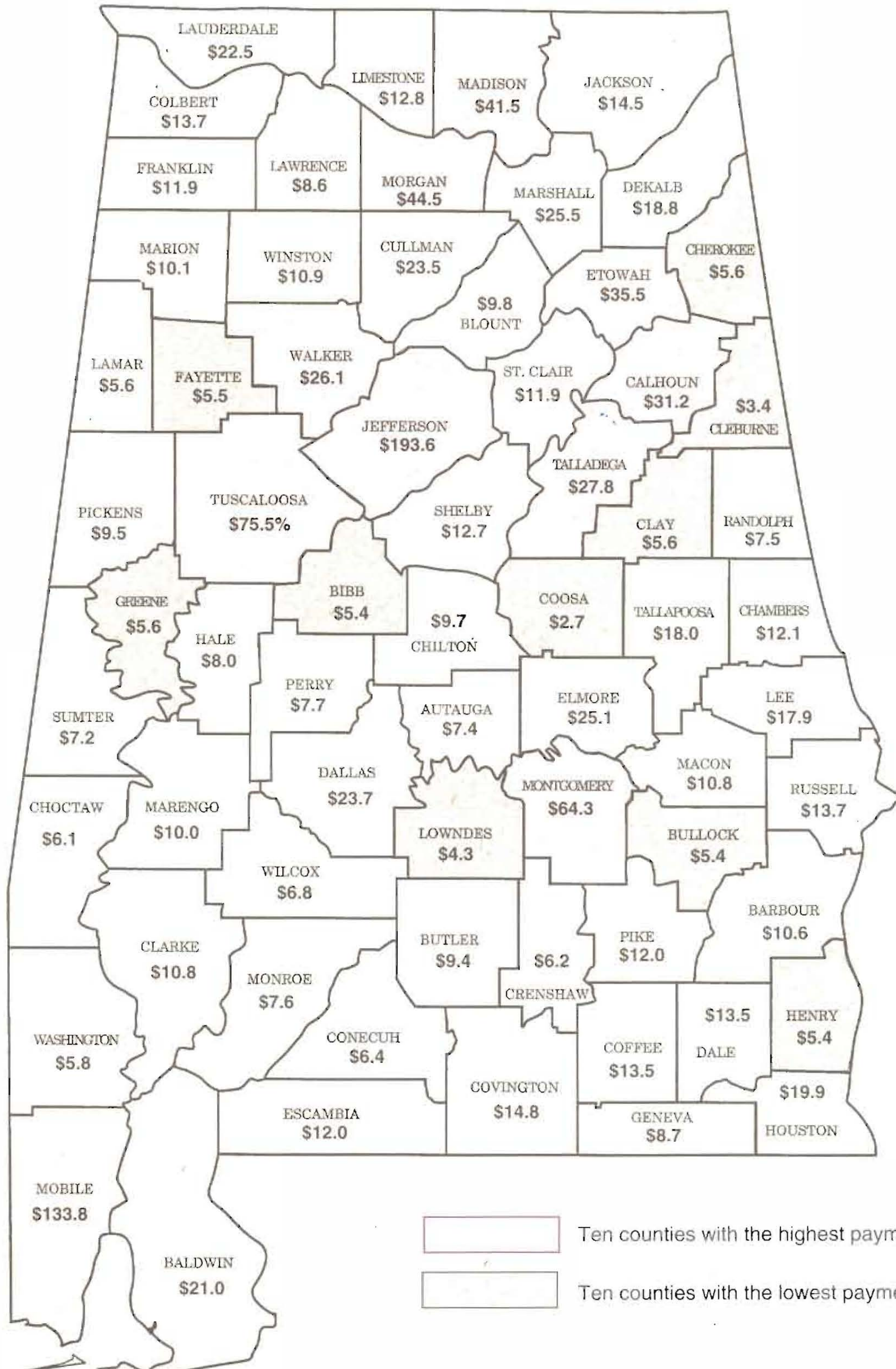
BY RACE



BY AGE



FY 1994
TOTAL PAYMENTS
By County of Recipient (in millions of dollars)



FY 1994
COST PER ELIGIBLE
By Category, Sex, Race, and Age

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 the Quality Control Unit, 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 0.6281 percent for the quarter ending September 30, 1994. This projection was based on the actual payment error rate for the previous year. Nationally, Alabama has consistently been among the four or five states with the lowest payment error rates.

In the Provider Surveillance and Utilization Review Unit, computer programs are used to develop comprehensive statistical profiles for revealing health care utilization patterns and identifying potential Medicaid fraud and abuse. During FY 1994, 278 post-payment reviews were conducted on Medicaid providers. Of the providers reviewed, recoupments for the fiscal year totaled $158,674.85. Recommendations for corrective action include education on proper billing procedures, recoupment of funds, and peer review as indicated.

In the Recipient Surveillance and Utilization Review Unit, 585 recipients were reviewed in FY 1994. 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. There were 311 recipients restricted to one physician and one pharmacy in FY 1994. During the same fiscal year, 148 recipients were sanctioned by the Medicaid program for abusing, defrauding, or misusing the benefits of the program. The Investigations Unit uses two specific criminal statutes which allow Medicaid to pursue fraud and abuse cases. One law allows Medicaid to deny or revoke eligibility to 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 makes an intentional false statement or omits material fact in any claim or application for any payment, knowing the same to be false. 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 175 cases opened and 172 cases closed during FY 1994. Of these cases, 17 were referred to local district attorneys for possible prosecution. A number of possible fraud cases involving providers and recipients were referred to the appropriate agencies for action, such as the Attorney General's Medicaid Fraud Control Unit and the Board of Medical Examiners.

The processing and payment of Medicaid claims is monitored through the Claims Processing Assessment System (CPAS). In addition to CPAS claims reviews, the Systems Audit Unit performs targeted reviews of claims when potential systems errors are found, as well as periodic reviews of forced claims, denied claims and suspect duplicate drug claims. More than 6,777 claims were manually reviewed during FY 1994 and $21,936.71 was recouped. Systems Audit also utilizes a process referred to as the Bill Processing Systems Test (BPST). This process uses test claims, test recipients, and test providers to verify that systems edits have been properly implemented or to verify that 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 mission of Nursing Home Audit is to insure that reimbursement is made only for allowable costs. On-site financial audits are conducted, and adjustments to the reported costs are made. This adjustment information is provided to reimbursement specialists, who adjust current payment rates, recoup overpayments and make up for underpayments.

During FY 1994, this unit completed 54 audits. The total includes Home Office and Facility/Provider financial records for the cost report period ending June 30, 1994. In addition, 5 ICF/MR facilities were audited for the period ending September 30, 1993. Both positive and negative adjustments are made to insure that all reimbursable costs are included and that all non-reimbursable costs are removed from provider per diem rates.

Hospital Audit is a part of Provider Audit/Reimbursement. Hospital Audit selectively validates and verifies the accuracy of revenue, expense, and statistical data reported annually by hospital providers in their Medicaid cost reports. The validated cost reports provide the basis for per diem payments during the following year. Fourteen cost report audits were completed during FY 1994 along with seven audits of information on semi-annual Disproportionate Share Reports.

Medicaid Management Information Systems

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

In-house systems staff completed 2,606 software requests in FY 1994 to support the MMIS and aid Agency decision-making. Major projects completed included enhancements to the State Data Exchange (SDX), SOBRA, and third party insurance systems. The long term care system was changed to include the certification of Post-Hospital Extended Care eligibles, and a new mini-COLA (Cost of Living Adjustment) system was implemented for retired federal civil service employees.

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, 1993. 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.

Third Party Liability

In establishing the Medicaid program, Congress intended that the medical expenses of a person eligible for Medicaid would not be paid by Medicaid if there was another source of payment for such care. As a result, Congress included a requirement that each state establish a program to ensure that Medicaid pays secondary to all available third party resources.

Alabama recognized the potential fiscal benefits of a third party recovery program and in 1970 established one of the first third party liability (TPL) programs in the nation. Today, Alabama's Third Party Division continues to oversee a comprehensive TPL program which has been successful in saving millions of dollars for Alabama's taxpayers through cost avoidance and post payment recovery of health and casualty insurance resources, estate recovery, payment of health insurance premiums for recipients when cost effective, and payment of Medicare premiums for qualified Medicare eligibles. In addition, the Division pursues medical support for children of non-custodial parents and recoupment of erroneous payments incurred as a result of eligibility-related issues.

Federal regulations define a third party as an individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance furnished by the Medicaid program. Examples of third party resources which Medicaid pursues include individual and employer-related health plans; indemnity, cancer and accident insurance; Medicare, liability insurance; absent parent medical support; court-ordered restitution, and estates of institutionalized Medicaid recipients. These resources are identified by Medicaid through data matches with various state agencies and insurance companies, through claims processing edits, and through referrals from eligibility caseworkers and providers.

In FY 1994 the Third Party Division's efforts in these areas resulted in documented savings of over $15 million. In addition, claims totaling more than $43 million were returned to providers to file with a primary insurance. Of this amount, it is estimated that approximately $7 million in claims were never resubmitted to Medicaid because the third party paid more than the Medicaid rate. An additional $36 million in claims were returned to providers to file Medicare as the primary payer. Without the oversight of the Third Party Division, Medicaid's expenditures for FY '94 could have increased by an additional $58 million.

Health Insurances Resources

In FY 1994 approximately 12% of Alabama's Medicaid population were covered by some form of health insurance. Savings from these resources are derived from cost avoidance of claims (the provider must file and obtain third party benefits before Medicaid makes payment) and through post payment recovery (the Medicaid Agency bills the third party for reimbursement). FY 1994 savings to Medicaid from cost avoidance is estimated to be $14.7 million while collections by the Medicaid Agency exceeded $3.8 million.

Casualty/Tort Resources

Thousands of Medicaid recipients receive medical care each month as a result of an injury. Medicaid is required to identify those recipients whose injury may have been caused by another party or covered by liability insurance and then pursue recovery of Medicaid's payment from the liable third party. Identification of these resources is done through claims processing edits and referrals from eligibility caseworkers, insurance companies, providers and attorneys. Once a potential third party is identified, claims are filed by Medicaid against the third party. Examples of types of cases which produce recoveries for Medicaid include dog bites, slips and falls, automobile accidents, malpractice, product liability, and assaults. For FY 1994, Medicaid collected over $660,000 as a result of its recovery

efforts in this program. Statistics are not available to document unreported collections by providers from casualty insurance.

MEDICAL SUPPORT

The Omnibus Budget Reconciliation Act (OBRA) of 1993 requires states to enact legislation to ensure the compliance of insurers and employers in carrying out a court or administrative order for medical support. In FY 1994 Governor Folsom signed into law an act which meets the requirements of OBRA '93. This legislation eliminates many of the obstacles which have historically kept children of non-custodial parents (NCPs) from being covered by employer-related health insurance. It addresses enrollment, claims payment, and premium payment issues for this population. Medicaid anticipates that this new statute will, through enforcement of medical support orders by the Department of Human Resources (DHR), result in increased savings to Medicaid due to an increase in the number of children covered by group health insurance.

Currently, Medicaid seeks to identify children who are eligible to enroll in a NCP's group health plan and refers those cases to DHR for medical support endorsement. In some instances a court order is obtained requiring the NCP to enroll a dependent in an available group health plan; in other instances the NCP is ordered to reimburse Medicaid for medical bills paid by Medicaid on behalf of the dependent. In FY 1994 approximately $133,000 were collected by Medicaid from non-custodial parents either through direct payment or tax intercept. These payments represented court ordered reimbursement of medical expenses (primarily birth expenses) paid by Medicaid.

ESTATE RECOVERY

The Omnibus Budget Reconciliation Act (OBRA) of 1993 requires states to recover the costs of nursing facility and other long-term care services from the estates of Medicaid recipients. Alabama is one of only a few states with a successful estate recovery program in operation prior to passage of OBRA '93. Through its TEFRA lien activity, the Agency's collections for FY 1994 totaled slightly over $2 million.

MEDICARE BUY-IN PROGRAM

Some Medicaid eligibles are also eligible for Medicare. To ensure that available Medicare benefits are used as a primary source of payment for medical bills incurred by this group of eligibles, the Third Party Division maintains the state's edits for Medicare coverage as well as monitors payment of Medicare premiums for qualified individuals. In FY 1994, Medicaid's edits for Medicare coverage ensured that over $36 million in claims which were submitted to Medicaid as primary payer were returned to providers to file Medicare.

PREMIUM PAYMENT

In January 1993 Medicaid initiated a program to pay health insurance premiums, when cost effective, for individuals who are high cost users of medical care and who cannot continue payment of their health insurance premium. Since the program's inception, Medicaid has paid premiums for 27 Medicaid recipients. The majority of these recipients have been pregnant women whose employment ended prior to delivery and, therefore, their insurance coverage would not have covered their delivery had Medicaid not picked up and paid their COBRA premium. Medicaid has also paid for several HIV diagnosed recipients as well as others with high cost medical conditions. Savings this year to Medicaid as a result of this program is estimated at $127,000.

Medicaid has also continued to pay premiums for individuals enrolled in a health insurance plan with Humana Insurance Company. Based upon an estimated annual savings of $100 for each of the approximately 6,500 persons enrolled in this program, Medicaid saved $650,000 in FY 1994 as a result of this premium payment initiative.

RECOUPMENTS

The Medicaid Agency recovers funds from individuals who received Medicaid services they were not entitled to receive. In most instances these cases involve individuals who, through neglect or fraud, did not report income or assets. In FY 1994, this recoupments program recovered nearly $500,000 in misspent dollars.

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." This proactive role includes bringing as many private foundation grant dollars and federal dollars into the state as possible to enhance access to quality obstetric and pediatric 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 1994 Medicaid served 195,226 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 adequate medical care. Alabama's infant mortality rate has improved since 1989 when Medicaid created the Maternal and Child Health Division; from 12.1 infant deaths per thousand in 1989 to 10.3 infant deaths per thousand in 1993, the lowest rate in Alabama's history.

PRENATAL CARE

The latest birth statistics revealed the number of births to women aged 10-19 decreased in Alabama from 11,299 in 1992 to 11,019 in 1993. There were 379 births to teenage women under 15 years of age, an increase from 346 births in 1992.

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 are 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). 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. Beginning in 1992, two additional postpartum visits were added 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.

PREVENTIVE HEALTH EDUCATION SERVICES

Medicaid began covering preventive health education classes in October 1991. The preventive health education program is designed to offer expanded educational services to pregnant and postpartum women that go beyond the limited services offered under the existing Medicaid program. These services are provided 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 decision making skills and the consequences of unintended pregnancies.

Last year, 40 providers were enrolled as preventive health education providers. These included hospitals, county health departments, federally qualified health centers, and private

organizations. Currently, the Preventive Health Education Program has an enrollment of over 130 providers which allows access to preventive health services all across the state. As this program expands and becomes more widespread it will serve as 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.

Maternity Waiver Program

The Maternity Waiver Program, implemented September 1, 1988, is aimed at combating Alabama's high infant mortality rate. It assures that eligible pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through a primary provider network. The program operates by directing women to certain caregivers and by augmenting their medical care with care coordination (also known as case management). 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.

Directing the patients to a specific 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.

During FY 1994, there were 45 counties participating in the maternity waiver. Those counties were: Autauga, Baldwin, Bibb, Blount, Bullock, Calhoun, Chilton, Choctaw, Clarke, Colbert, Conecuh, Cullman, Dallas, Elmore, Escambia, Etowah, Fayette, Franklin, Greene, Hale, Henry, Houston, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Mobile, Montgomery, Morgan, Pickens, Russell, Shelby, St. Clair, Sumter, Tuscaloosa, Washington, Wilcox, and Winston. The waiver has expanded each year so that eventually all Medicaid eligible pregnant women can participate in this innovative and successful approach to healthier birth outcomes.

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.

Family Planning

The origin of the Family Planning Program dates back to the time when Medicaid started in Alabama. The Social Security Amendments of 1972 mandated coverage of Family Planning services for the categorically needy individuals of child bearing age, including minors who are sexually active and desire such services. The law also provides for 90 percent federal funding for these services. This is a higher match than for other Medicaid services.

Family planning services are defined as those services that prevent or delay pregnancy. They include office visits, health education, some laboratory screening tests, and pharmaceutical supplies and devices provided for contraceptive purposes.

Family planning services are covered for Medicaid eligible recipients, including SOBRA women, who are 10-55 years of age and desire such services. Recipients have freedom of choice in selecting a contraceptive method and/or a provider of family planning services. Acceptance of family planning services must be without coercion or mental pressure.

Recipients are authorized one annual physical and up to four additional visits per calendar year. A family planning home visit 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. Contraceptive supplies and devices available include pills, foams/condoms, intrauterine devices, diaphragms, implants, and injections. Sterilization procedures are also covered if federal and state regulations are met.

EPSDT

The Early and Periodic Screening, Diagnosis and Treatment Program 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 realizes long term savings by intervening before a medical problem requires expensive acute care.

Although EPSDT is funded by Medicaid, the program's operation requires the cooperation of the State Department of Human Resources and the State Department of Public Health. EPSDT is available to all Medicaid eligible children under 21 years of age. Department of Human Resources workers normally determine AFDC eligibility, make families aware of EPSDT, and refer eligibles to screening providers such as the public health clinics.

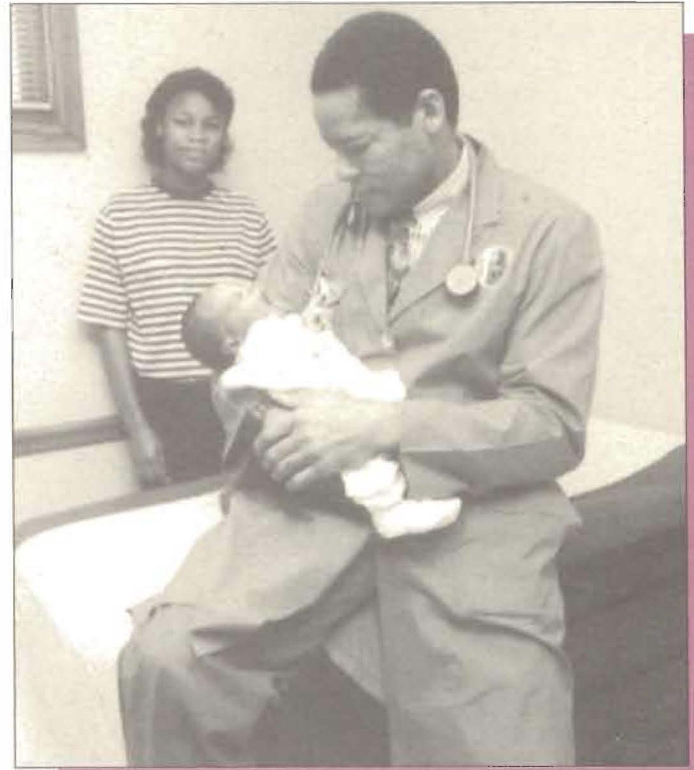
Currently there are more than 987 providers of EPSDT services, including county health departments, community health centers, hospitals, Head Start centers, child development centers, and private physicians. The EPSDT program staff have made great strides in recruiting more private physicians into the program. These services were previously provided mainly by the county health departments.

Since screening is not mandatory, many mothers do not seek preventive health care for their children. Steps have been taken in recent years, however, to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of

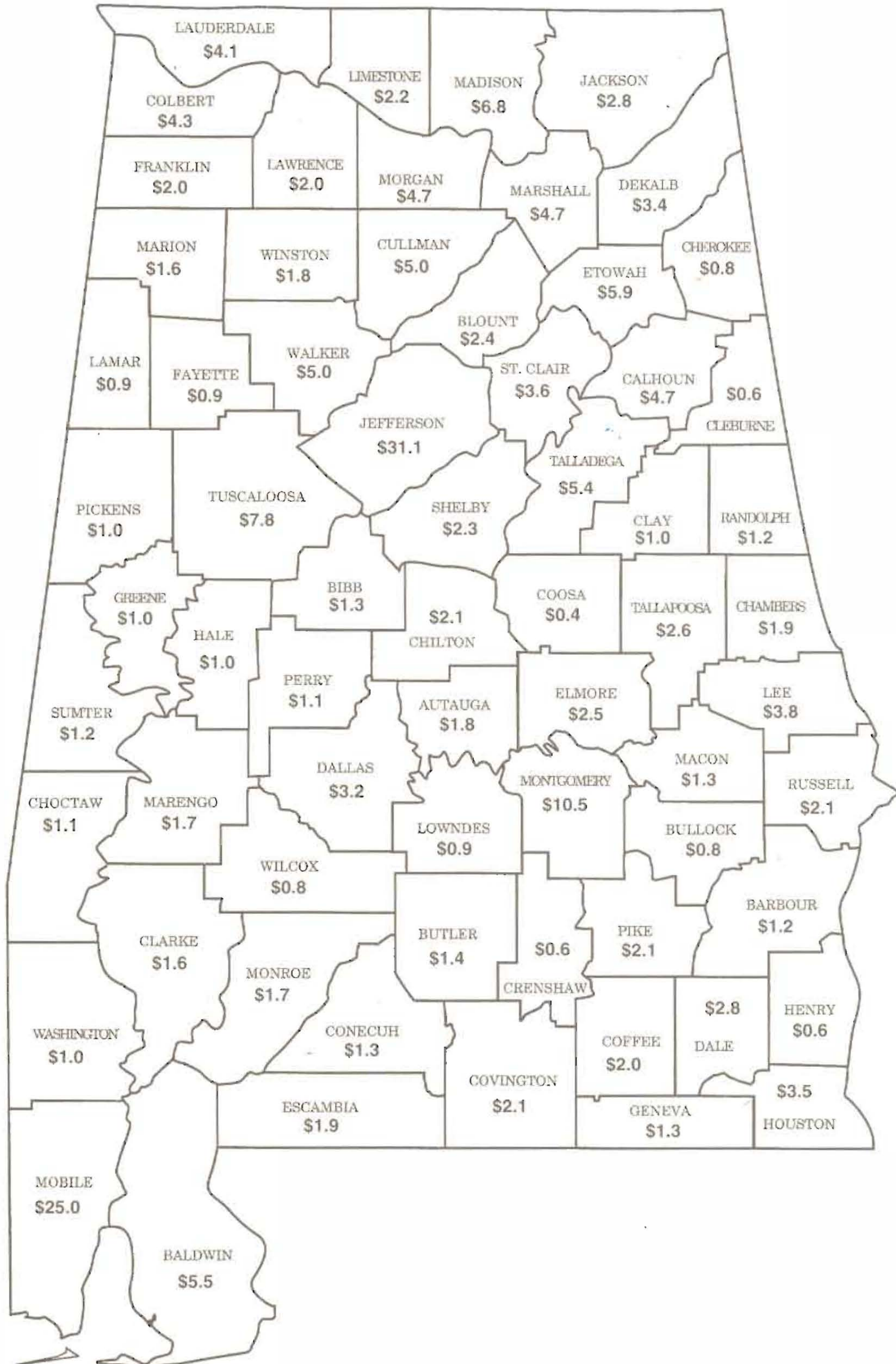
intensive outreach statewide, enhancement of physicians' reimbursement for screening and an increase in the number of screenings for which Medicaid will pay. Because of these added efforts, there have been more screenings performed. A Medicaid goal is to screen all eligible children at 20 intervals between 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 $70 per screening. The cost of treating acute illness is considerably higher.

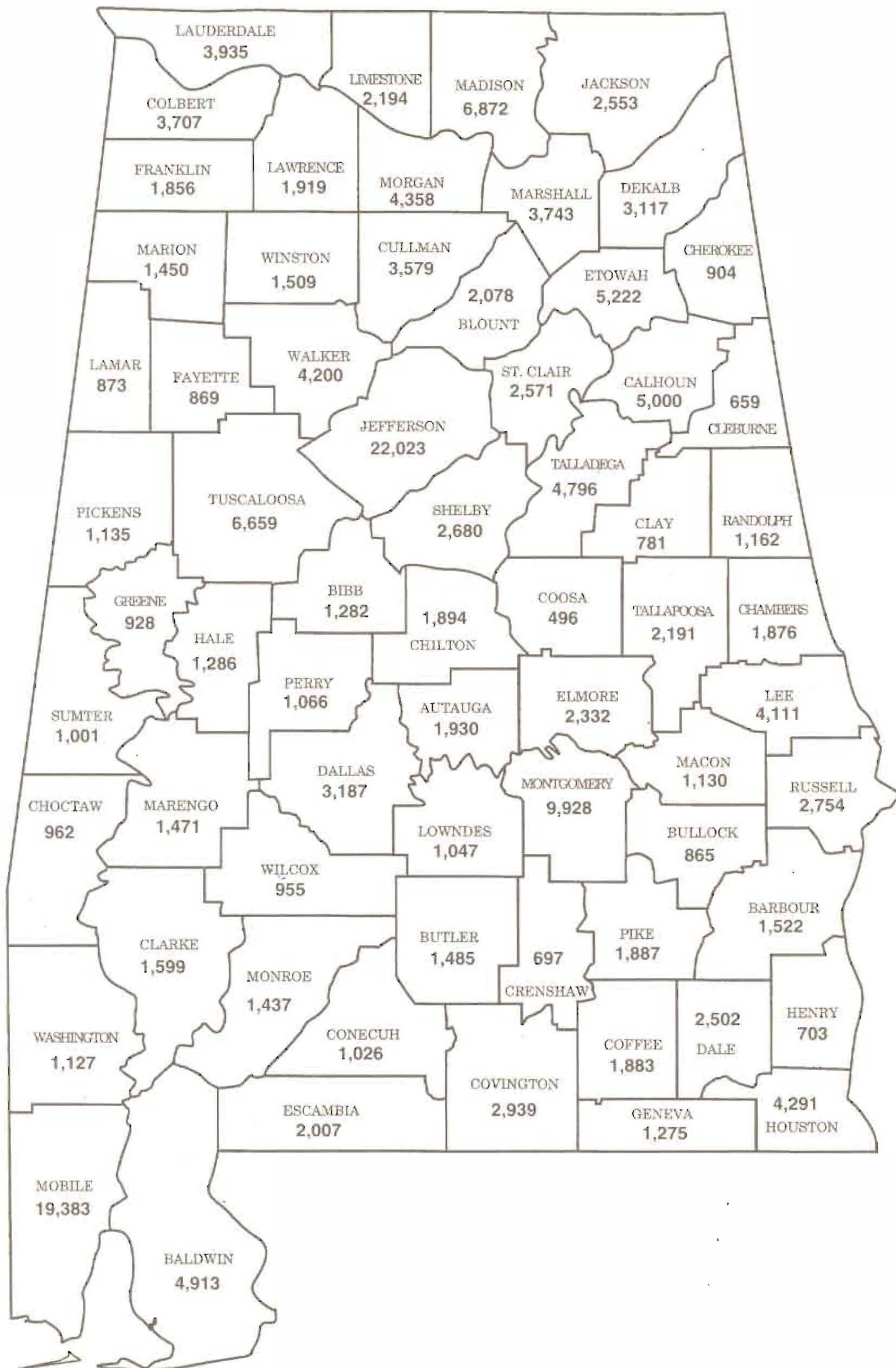
The Medicaid dental program is limited to individuals who are eligible for treatment under the EPSDT program. Dental care under this program is available either as a result of a request or a need by the Medicaid recipient. All Medicaid dental services are provided by licensed dentists. These services 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 1994
MEDICAID PAYMENTS FOR SOBRA ELIGIBLES
By County of Recipient (in millions of dollars)



FY 1994
SOBRA ELIGIBLES



HEALTHY BEGINNINGS

Since 1990, Medicaid's Healthy Beginnings program has promoted the benefits of prenatal care to thousands of expectant women in Alabama. During FY 1994, Alabama experienced its lowest infant mortality rate (10.3) and its highest ever first-trimester entry rates (80 percent), a tribute to the combined efforts of Medicaid, state health care providers and countless others working at the local level.

As the Agency's prenatal care promotion program, Healthy Beginnings is designed to encourage and recognize women who seek prenatal care early and often during pregnancy. During FY 1994, more than 18,000 expectant women — approximately 80 percent of whom were covered by Medicaid or uninsured — enrolled in Healthy Beginnings. To date, more than 80,000 Alabama women have participated in this nationally-recognized health promotion effort.

To encourage women to go for all their checkups, the Healthy Beginnings program provides a free coupon booklet and pregnancy-related information to any pregnant woman in Alabama, regardless of income. Each month following a checkup, a certain number of coupons are validated. Once validated, the coupons for free and/or discounted items at grocery, drug and discount stores may be redeemed.

FY 1994 highlights for Healthy Beginnings include:

* While teens account for 18 percent of all births, 34 percent of all participants were under age 20.

* 58 percent of all participants received prenatal care at a clinic while approximately 42 percent obtained care from a private physician.

* 56 percent of participants were white; 42 percent were black, paralleling the childbearing population in Alabama.

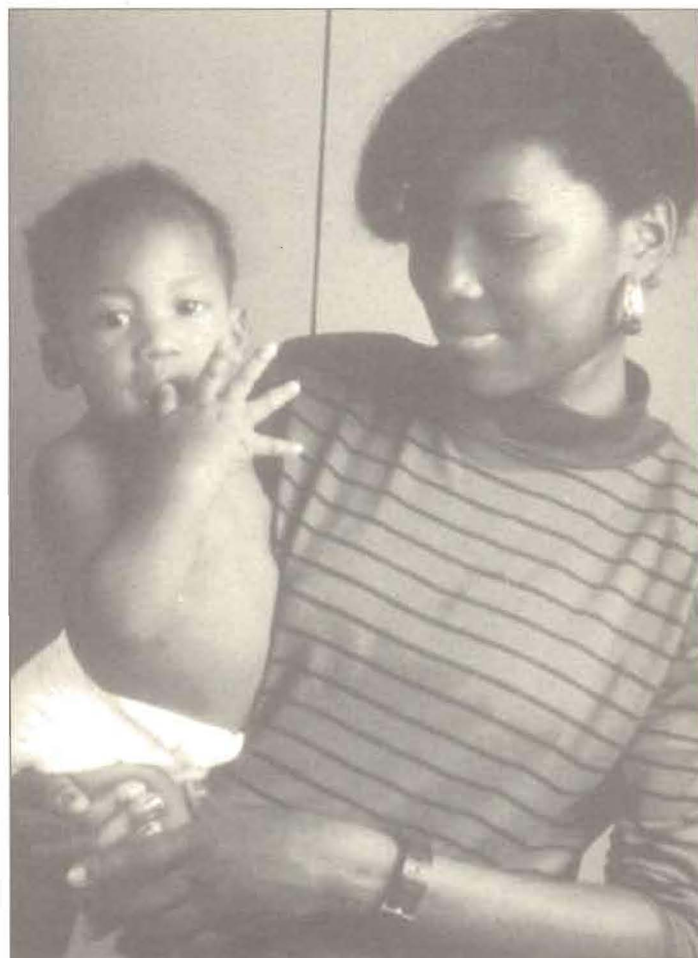
* 38 percent had less than a high school education.

RECIPIENT INQUIRY UNIT

Implemented in late 1992, the Recipient Inquiry Unit has increased recipients' access to the Agency via toll-free telephone service from throughout Alabama. Averaging some 6,000 calls monthly during FY 1994 (more than 70,000 annually), the inquiry unit provides replacements for lost and stolen Medicaid cards to eligible persons while responding to callers' questions about various eligibility, program and other topics.

Each month, approximately one-fourth of all calls deal with card replacement; about 25 percent are information-only calls, while the remaining calls are referred to a certifying agency or worker (Medicaid District Offices, SOBRA workers, Social Security or the Department of Human Resources) or an Agency program office (Hospital, Physicians, and Pharmacy, among others) for action.

The hotline (1-800-362-1504) is open from 8:30 a.m. to 4:30 p.m. Monday through Friday and is staffed with two full time operators and by Agency managerial staff (senior staff, directors and associate directors) who rotate assignments on a daily basis. Additionally, new Medicaid employees spend five days in the unit in order to be more fully acquainted with the Agency and the individuals it serves.



Managed Care

Health care across the nation faces many changes with the advent of health care reform. The shape that this reform will take is yet to be decided on the national level, but the Alabama Medicaid Agency is taking a proactive stance and is preparing for transition into a managed care environment. Managed care systems are planned for selected areas of the state and will be phased in as provider systems are established. The purpose of managed care is to ensure access to appropriate quality health care and promote coordinated care for all Medicaid recipients. Coordinated health care assures a medical home for all recipients and emphasizes prevention and education. Each recipient will have his or her primary care physician. This will reduce the incidence of a recipient depending on hospital emergency rooms or other less appropriate settings for routine care. The primary care physician or case manager will refer the patient for other specialty and hospital care as needed. It is anticipated that a system of coordinated care will result in continuous care that assures access for all recipients. During FY '94 Medicaid began to develop provider networks in Jefferson and Shelby Counties as well as to look at other managed care initiatives in preparation for actual implementation.

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, crisis intervention, 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 24 mental health centers around the state providing these services. On a monthly average during FY 1994, about $1.5 million were spent to provide services to approximately 8,500 clients.

On April 1, 1994, the mental health program was expanded to allow the Department of Human Resources and the Department of Youth Services to provide rehabilitative services to the children and adolescents in their custody. DHR and DYS are presently involved in the process of implementing the provisions of federal court consent decrees (R.C. and A.W., respectively). One of the critical mandates of both suits is the maximization of federal dollars, specifically Medicaid funding. As these state agencies become rehabilitative services providers they will be able to provide a wide array of mental health services to the children in their custody in a cost-effective manner.

Targeted Case Management

The optional targeted case management program assists Medicaid-eligible individuals in gaining access to needed medical, social, educational and other services through coordination, linkage, and referral. The Alabama Medicaid Agency currently serves mentally ill adults (target group 1), mentally retarded adults (target group 2), handicapped children (target group 3), foster children (target group 4), pregnant women (target group 5), AIDS/HIV positive individuals (target group 6), and persons with severe renal disease (target group 7). The expansion of case management services to include adult protective service individuals (target group 8), is anticipated in FY 1995. With the addition of new providers coordinating services for these target groups, a reduction in nursing home placement and hospitalization is expected. It is estimated that over 15,000 Medicaid-eligible recipients will receive targeted case management service this year.

HOME AND COMMUNITY BASED SERVICE WAIVERS

The State of Alabama has developed Home and Community Based Service (HCBS) waivers that provide alternatives to institutionalization for some Medicaid recipients. 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 developmentally disabled, and the homebound. These programs provide quality and cost-effective services to individuals at risk of institutional care.

HCBS WAIVER FOR THE ELDERLY AND DISABLED

This waiver 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. During FY 1994, there were 6,927 recipients served by this waiver at an actual cost of $3,633 per recipient. Serving the same recipients in nursing facilities would have cost the state $17,496 per recipient. This waiver saved the state $13,863 per recipient in FY 1994.

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. This waiver is administered by the Alabama Department of Human Resources and the Alabama Commission on Aging.

HCBS WAIVER FOR THE MENTALLY RETARDED AND THE DEVELOPMENTALLY DISABLED (MR/DD)

This waiver serves individuals who meet the definition of mental retardation or developmentally disabled. 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 re-sponse system, and skilled nursing care. During FY 1994, there were 2,344 recipients served by this waiver at an actual cost of $10,896 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $52,968 per recipient. The MR/DD waiver saved the state $42,072 per recipient in FY 1994.

OBRA '87 HCBS WAIVER

This waiver serves individuals who are inappropriately placed in nursing facilities and was passed by Congress as part of the Omnibus Budget Reconciliation Act of 1987. The services provided under this waiver include case management, personal care, respite care, residential habilitation training, behavior management, day habilitation, prevocational services, supported employment, environmental modification, skilled nursing care, specialized medical equipment and supplies, personal emergency response systems, companion services, physical therapy, occupational therapy, assistive technology, individual and family support, and speech, hearing, and language services. This waiver is administered by the Department of Mental Health and Mental Retardation. During FY 1994, there were 36 persons served by this waiver at a cost of $16,778 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded would have cost the state approximately $62,686 per recipient. The waiver saved the state approximately $45,908 per recipient in FY 1994.

HOMEBOUND WAIVER

This waiver serves disabled adults with specific medical diagnoses who are at risk of being institutionalized. To be eligible an individual must be between the ages of 21-64, and meet the nursing facility level of care. All income categories from SSI to 300% of SSI are included. It is administered by the Department of Education, Division of Vocational Rehabilitation. The services provided under this waiver include case management, personal care, respite care, environmental modification, transportation, medical supplies, personal emergency response system, and assistive technology. During FY 1994, there were 252 recipients served at a cost of $1,880 per recipient. Although FY 1994 figures are not yet available, serving the same recipients in an institution in FY 1993 would have cost the state $15,723. The state saved at least $13,843 per recipient in FY 1994 under the Homebound Waiver.

Home Care Services

The Medicaid home care services program helps people with illnesses, injuries, or disabilities to 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 EPSDT program. This provision of OBRA '89 has greatly increased 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's 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.

This service is not only compassionate but also cost efficient. During FY 1994, the Medicaid Agency served an average of 35 hospice patients each month at an annual total cost of about $800,000. 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 (DME)

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 154 agencies participating in FY 1994.

Up to 104 home health visits per year may be covered by Medicaid in Alabama. During FY 1994, over 6,000 recipients received visits costing a total of approximately $10,500,000.

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 DME services, but all items must be medically necessary and suitable for use in the home. During the fiscal year, over 540 Medicaid DME providers throughout the state furnished services at a cost of approximately $8,000,000.

In-Home Therapies

Physical, speech, and occupational therapy in the home is limited to individuals under 21 years of age who are 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. Private duty nursing services are covered for Medicaid recipients who have medical problems that require education of the primary

caregiver and/or stabilization of the recipient's medical problem or problems. For Medicaid coverage, at least four hours of continuous skilled nursing care are required per day.

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 FY 1994, Medicaid paid approximately $4,300,000 for services provided through 46 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. There are 117 Alabama hospitals that participate in the Medicaid program, and 29 hospitals in neighboring states also participate in Alabama's 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 adverse impact on Medicaid expenditures. Limitations on non-emergency outpatient visits have lessened the problem of abuse, but the number of outpatient visits continues to 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 80 in-state hospitals in Alabama that are considered "delegated" and do their own utilization review; 40 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 1994. 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.

* Children under age seven when in a hospital designated by Medicaid as a Disproportionate Share hospital.

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 chemotherapy, radiation therapy, visits

solely for lab and x-ray services and surgical procedures on the Agency's outpatient surgical list. 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.

Transplant Services

In addition to kidney and cornea transplants, which do not require prior approval, Medicaid benefits cover prior authorized heart transplants, liver transplants, and bone marrow transplants. 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 Medicaid Agency. Eligible recipients requiring heart transplants, liver transplants, bone marrow, or other covered EPSDT-referred 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.

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 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 1994, there were five 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 1992-1994
HOSPITAL PROGRAM
Changes in Use and Cost

Year	Recipients of Inpatient Care	Payments For Services	Medicaid's Annual Cost Per Recipient
1992	71,090	$217,097,579	$3,054
1993	71,017	$235,503,602	$3,316
1994	72,910	$252,868,000	$3,468

FY 1990-1994
HOSPITAL PROGRAM
Outpatients

	FY '90	FY '91	FY '92	FY '93	FY '94
Number of outpatients	115,957	146,358	184,036	214,568	225,586
Percent of eligibles using outpatient services	33%	30%	33%	36%	37%
Annual expenditure for outpatient care	$12,824,623	$19,094,131	$27,864,913	$35,960,064	$40,185,514
Cost per patient$112	$130	$151	$168	$178	

Federally Qualified Health Centers (FQHC)

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, nurse midwives, 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 1994, 16 FQHCs with 54 sites were enrolled as providers, with 64 satellites.

Rural Health Clinics (RHC)

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 physicians program. Independent 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. Independent 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 1994, seventeen independent rural health clinics, (including one out of state), were enrolled as providers in the Medicaid program.

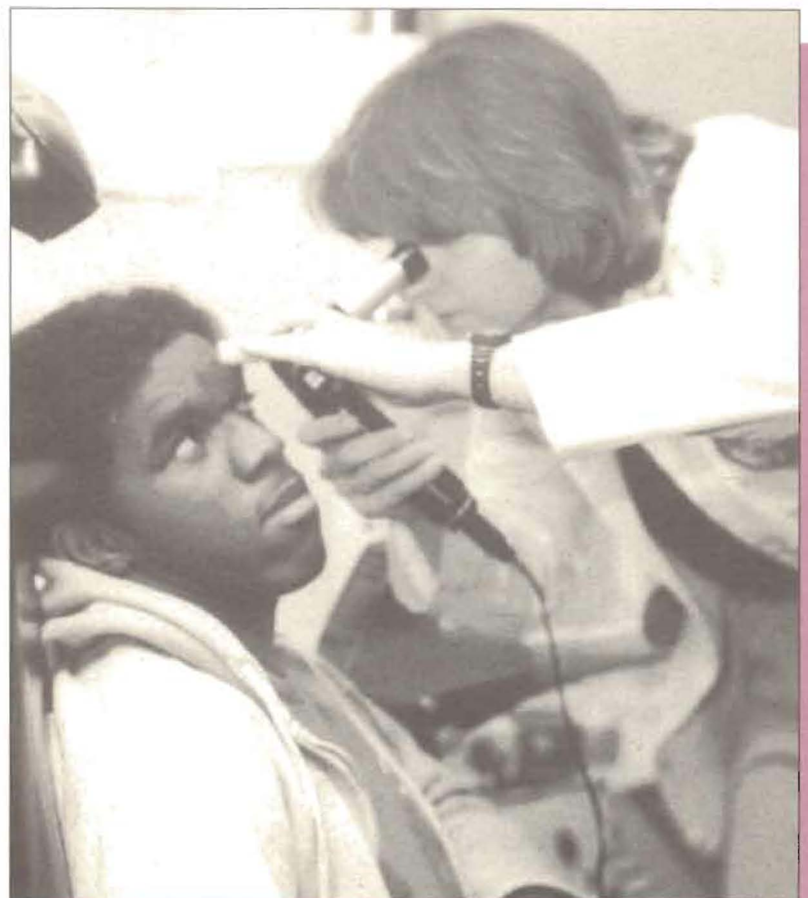
Provider Based Rural Health Center (PBRHC) services were implemented in October 1993. PBRHCs are an integral part of a hospital, skilled nursing facility, or home health agency. Services covered under the program may be provided by a physician, physician assistant, nurse practitioner, certified nurse midwife, and/or specialized nurse practitioner. Visits to a PBRHC are included in the Medicaid-allowed 14 physician office visits per year.

PBRHCs are reimbursed on a percentage of fee-for-service basis based on their yearly cost report. At the beginning of 1994 there were 11 PBRHCs enrolled as providers in the Medicaid Program. There are now 14 PBRHCs enrolled as Medicaid providers.

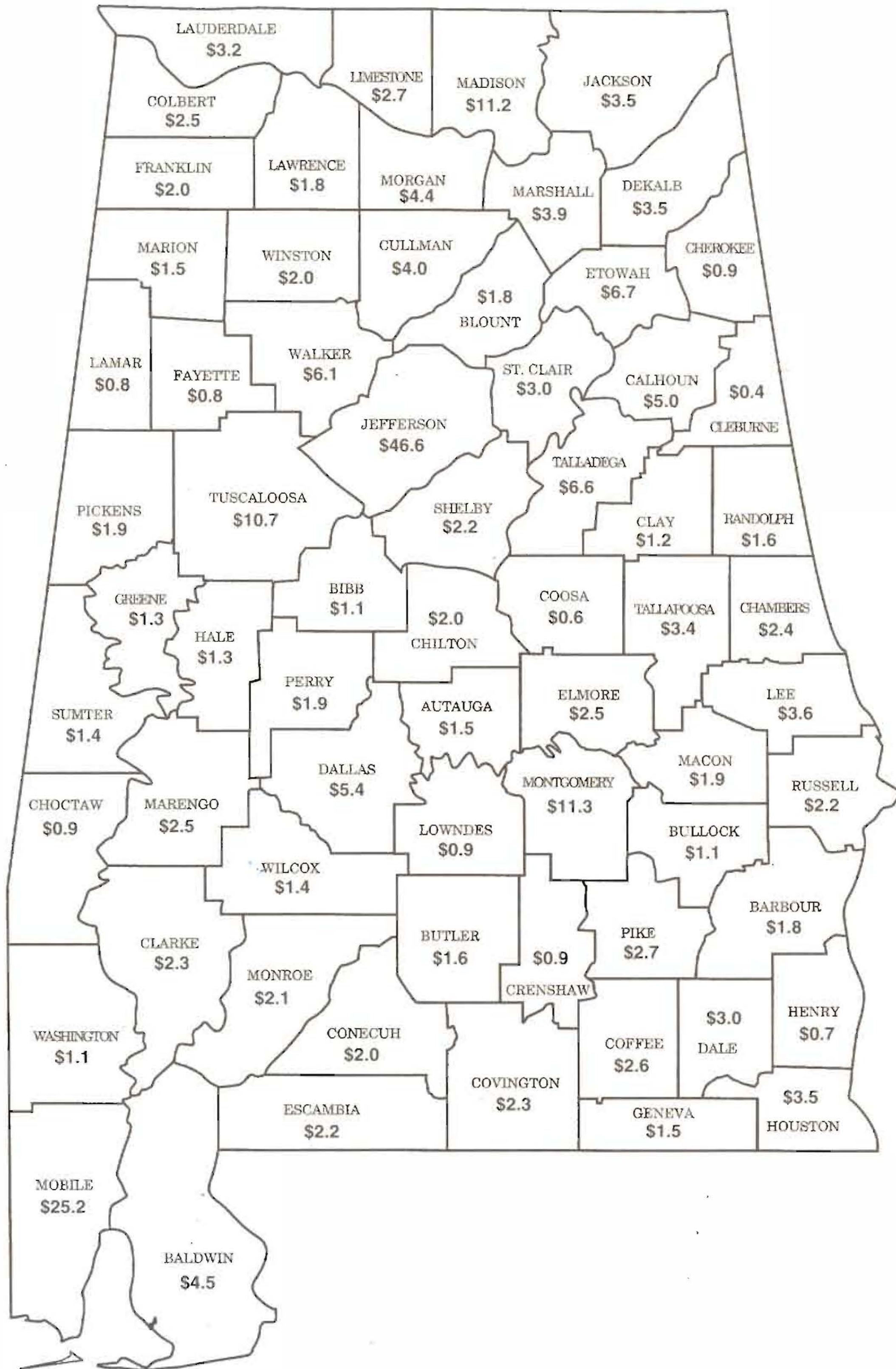
Ambulatory Surgical Centers (ASC)

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 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 approximately 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 1994, 27 ASC facilities were enrolled as providers in this program.



FY 1994
PAYMENTS TO HOSPITALS
By County of Recipient (in millions of dollars)



Medical Services

Physicians Program

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. Service to eligibles, like all other Medicaid programs 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 66 percent of Alabama's Medicaid eligibles received physicians' services in FY 1994.

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 EPSDT program must sign an agreement in order to perform screening for children under the age of 21. 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, Medicaid normally covers the amount of the doctor bill not paid for by Medicare, less the applicable copayment amount.

FY 1990-1994
PHYSICIAN PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
Aged	$5,721,052	56,090	$102
Blind	$464,825	1,360	$342
Disabled	$44,437,836	104,341	$426
Dependent	$65,073,841	289,226	$225
All Categories	$115,697,554	418,096	$277

Eye Care Program

Medicaid's 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. Post-cataract patients may be referred by their surgeon to an optometrist for follow-up management. The OD then receives 20% of the global fee.

In keeping with the Agency's policy of cost containment, eyeglasses are chosen through competitive bidding. During FY 1994, Medicaid extended its eyewear contract for an additional year. 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.

FY 1994
EYE CARE PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
Optometric Service	$2,867,876	58,190	$49
Eyeglasses	$1,070,497	39,343	$27

FY 1992-1994
LAB AND X-RAY PROGRAM
Use and Cost

	Payments	Recipients	Annual Cost per Recipient
1992	$6,973,307	155,184	$45
1993	$8,381,646	175,750	$48
1994	$10,408,331	207,464	$50

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. There are over 160 independent laboratories and over 20 free standing radiology facilities that are enrolled with Alabama Medicaid. Independent laboratories and free-standing facilities must be approved by the appropriate licensing agency within the state in which they reside, be certified as a Medicare provider and sign a contract with the Alabama Medicaid Agency in order to be eligible to receive reimbursement from Medicaid. Laboratory and radiology are unlimited services and if medically necessary can be covered even if other benefit limits have been exhausted.

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 56 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.

Pharmacy 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 1994, pharmacy providers were paid approximately $163 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about seven 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. Effective October 1, 1991 dispensing fees are 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 reimbursable drugs. With the exception of allowable published exclusions, most all drugs are now covered by the Medicaid Agency.

To control drug cost, the Agency operates a Drug Rebate program. This program collects rebates from drug manufacturers based on Medicaid utilization of their drug products in Alabama. During FY 1994, nearly $30 million were collected. This represents a 9.8 percent increase over FY 1993. These rebates are used to offset increasing drug program expenditures. Drug Rebate Program personnel assisted in enhancements to the current Drug Rebate system, aided in the development of a new pc-based rebate system, performed extensive drug file analysis and, utilizing pc-based spreadsheets, focused intensive efforts in drug rebate dispute resolution.

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 Physicians program. The physician may bill for either an office visit or the cost of the drug plus an administration fee.

FY 1994
PHARMACY PROGRAM
Counts of Providers by Type

Type of Provider	Number
Retail	1,304
Institutional	44
Governmental	4
Dispensing Physician	0
Total	**1,352**

FY 1992-1994
PHARMACY PROGRAM
Use and Cost

Year	Number Of Drug Recipients	Recipients As a % Of Eligilbes	Number Of Rx	Rx Per Recipient	Price Per Rx	Cost Per Recipient	Total Cost To Medicaid*
1992	351,293	64%	5,666,482	16.13	$20.42	$329	$115,725,473
1993	397,022	67%	6,533,244	16.46	$22.49	$370	$146,906,501
1994	410,487	66%	6,985,083	17.02	$23.34	$397	$163,041,059

* Does not reflect rebates received by Medicaid from pharmaceutical manufacturers. See table below.

FY 1992-1994
PHARMACY PROGRAM
Cost

	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx	Net Cost Per Recipient
1992	$115,725,473	$17,727,158	$97,998,315	$17.29	$279
1993	$146,906,501	$26,986,514	$119,919,987	$18.36	$302
1994	$163,041,059	$29,643,798	$133,397,261	$19.10	$325

LONG TERM CARE

Care for acutely ill, indigent residents in nursing facilities was mandated in 1965 with the enactment of Medicaid (Title XIX). During the last few years, however, OBRA '87 has made the most significant impact on 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 patients in facilities 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 67 percent of all nursing home care in the state during FY 1994. The total cost to Medicaid for providing this care was $382,487,652. Almost 93 percent of the 221 nursing homes in the state accepted Medicaid recipients as patients in FY 1994. There were also 19 hospitals in the state during FY 1994 that had long term care beds, called swing beds, participating in Medicaid. Swing beds are hospital beds that can be used on an as need basis for either the level of care found in skilled nursing facilities, as in nursing homes, or the level of care found in acute care hospitals. The hospitals providing swing beds must have fewer than 100 beds and must also be located in rural areas.

A regulation issued by the U.S. 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 its reimbursement system effective September 1, 1991. The 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. Swing beds are reimbursed at the average statewide nursing facility rate.

In the past all Medicaid eligibles residing in a nursing facility have had to apply their available income to the basic nursing facility per diem rate; however, effective April 1, 1994, Qualified Medicare Beneficiaries (QMBs) residing in a nursing facility will no longer have to apply any of their income toward the cost of the Medicare coinsurance for nursing home care. The coinsurance will be paid entirely by Medicaid for this group. Also, effective April 1, 1994, medically necessary over-the-counter (non-legend) drug products ordered by a physician will be covered.

FY 1992-1994
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
1992	21,084	273	5,765,840	$55	$315,675,925
1993	21,353	275	5,874,203	$56	$330,829,010
1994	21,862	274	5,999,930	$64	$382,487,652

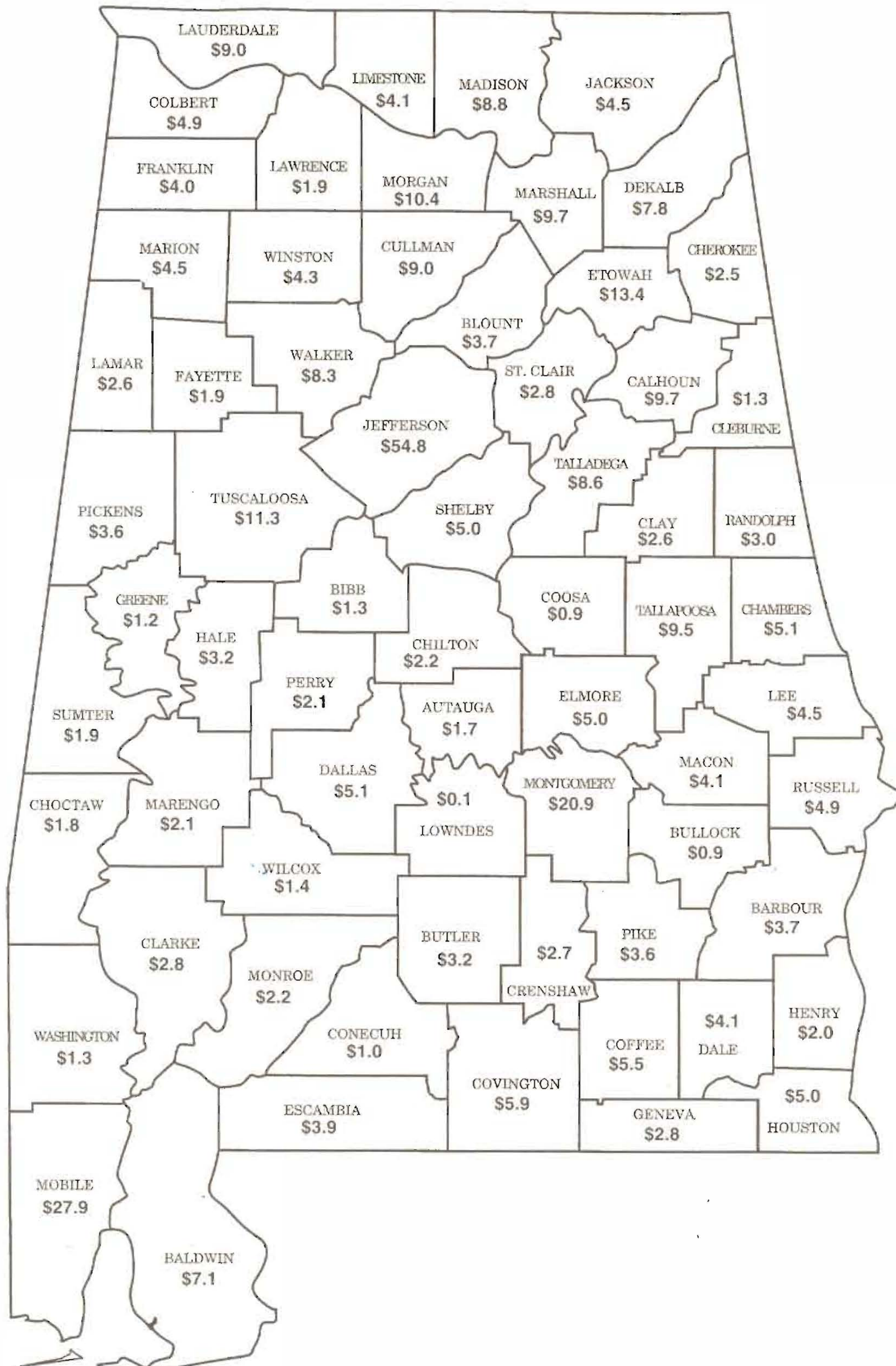
FY 1992-1994
LONG-TERM CARE PROGRAM
Number and Percent of Beds Used by Medicaid

	Licensed Nursing Home Beds	Medicaid Monthly Average	Percent Of Beds Used By Medicaid In An Average Month
1992	22,974	14,732	64.1%
1993	23,357	15,148	64.9%
1994	23,542	15,772	67.0%

FY 1992-1994
LONG-TERM CARE PROGRAM
Recipients and Payments by Sex, Race, and Age

	Recipients	Payments	Cost Per Recipient
By Sex			
Female	16,997	$301,184,503	$17,720
Male	4,865	$81,303,149	$16,712
By Race			
White	17,228	$297,012,435	$17,240
Nonwhite	4,634	$85,475,217	$18,445
By Age			
0-5	19	$586,576	$30,872
6-20	119	$3,617,016	$30,395
21-64	1,738	$34,330,993	$19,753
65 & Over	19,986	$343,953,067	$17,210

FY 1994
PAYMENTS TO NURSING HOMES
By County of Recipient (in millions of dollars)



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. Tarwater 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 statewide reduction of beds in intermediate care facilities for the mentally retarded. 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. In FY 1994 the average payment per day in an institution serving the mentally retarded was approximately $211.82.

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 1994, in cooperation with the Alabama Medicaid Agency, Mental Health was able to match every $29 in state funds with $71 of federal funds for the care of Medicaid-eligible ICF-MR/MD patients.

FY 1994
LONG-TERM CARE PROGRAM
ICF-MR/DD

	ICF/MR	ICF/MD-Aged
Recipients	1,265	462
Total Payments	$79,297,665	$12,178,556
Annual Cost per Recipient	$62,686	$26,361

ALABAMA MEDICAID AND AIDS

During FY 1994, there were 2,870 AIDS cases reported in Alabama. Of this number, 1,006 (41 percent) received services funded by Medicaid. Expenditures for AIDS related cases decreased from $8.3 million in FY 1993 to $6.7 million in FY 1994.

Two new programs aimed at educating the public about AIDS were launched in FY 1994:

Facts From Your Pharmacist: Answers about AIDS - this is a program designed to utilize pharmacies as free, convenient sources of information on HIV prevention and AIDS. Through this program, educational brochures and information is available to the general public in participating pharmacies statewide. Alabama was selected as the national test site for the program. In addition, pharmacists will receive HIV/AIDS continuing education to equip them to answer questions about the disease from customers.

Through an appropriation from the legislature, the Alabama Medicaid Agency entered into an agreement with the AIDS Task Force of Alabama (ATFA) whereby ATFA would provide public service announcements at no cost to the Medicaid Agency.

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.

PHYSICIANS SERVICES

Finding a physician who is familiar with AIDS-related diseases is sometimes difficult for AIDS patients, especially in rural areas. They must frequently travel long distances to get needed care, and transportation can be a problem. Most physicians treating AIDS are located in major urban areas.

INPATIENT HOSPITAL CARE

The largest share of expenditures for services to AIDS patients goes for inpatient hospital care. In 1994, Medicaid provided inpatient care totaling $3,118,574 million. As AIDS progresses, infected patients are more likely to require hospitalization for opportunistic infectious diseases. AIDS patients can easily exhaust their hospital limit of 16 inpatient days per year.

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 1994 rose to $1.6 million, an increase of 8 percent over FY 1993.

HOME AND COMMUNITY BASED WIAVER 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 provides a full range of services to recipients with AIDS under the hospice program.