HIGHLIGHTS

As the need for health care services continues to increase, Medicaid's budget has been strained to meet the growing demand for access to care. Because budget restrictions make cost controls a necessity, Medicaid's primary focus in Fiscal Year 1996 was the development of managed health care systems. The promise of managed care is flexibility in administration and operation with the assurance of adequate, cost-effective care.

FUNDING DISPUTE

A major funding dispute with the Health Care Financing Administration (HCFA) was resolved in Fiscal Year 1996. HCFA is the federal agency that regulates the Medicaid program nationwide. Alabama's dispute with HCFA centered on a change made by Medicaid in the methodology for paying hospitals throughout the state. Because the dispute resulted in massive withholding of federal funds, large cuts in the program were planned for Fiscal Year 1997. These cuts would have included reductions in services to beneficiaries and reimbursement to providers. Changes in eligibility for nursing home residents, children and pregnant women would also have been made. Fortunately, a negotiated settlement with HCFA was reached before proposed cuts were implemented. A supportive Congressional delegation played a crucial role in the negotiated settlement.

The long-term solution to this dispute was the approval of the Partnership in Hospital Program (PHP). The PHP is a two-year waiver that was implemented October 1, 1996. Through this program, the state is divided into eight districts. Medicaid pays each PHP a per member, per month fee for inpatient hospital care to most Medicaid patients living in the district. While Medicaid patients are automatically enrolled in the district where they live, the patient may be admitted to any hospital that accepts Medicaid as payment.

MANAGED CARE

Medicaid staff worked throughout the year to develop other managed care programs. Their work was rewarded by federal approval of two waivers set for implementation in 1997. These are a primary care case management (PCCM) system called Patient 1st and BAY (Better Access for You) Health Plan.

Patient 1st is operated under a two-year "freedom of choice waiver." In this program, a physician contractually agrees to deliver and coordinate health care for patients who select, or are assigned to, the physician as their primary medical provider (PMP). PMPs will be paid $3 per patient per month, up to $3,000 per month, for case management and care coordination. Most Medicaid patients will be required to participate in Patient 1st. PMPs will provide primary and preventive care and coordinate referrals to specialists. Marengo County will be the first of the initial 26 counties brought into the system.

BAY Health Plan is a five-year research and demonstration project in Mobile County. It will be implemented in May 1997. Its purpose is to establish a managed care system composed of traditional providers of health care, using the existing health care network to assure a medical home for each Medicaid beneficiary. The plan represents a network that includes the University of South Alabama hospitals and physicians, Franklin Memorial Health Centers, Mostellar Medical Center, the Mobile County Health Department, and other area providers. Each Medicaid patient will select, or be assigned, a primary care physician (PCP). An extensive educational campaign to acquaint patients with the new system will be conducted by BAY Health Plan. A resource center will also be available to assist patients in selecting a primary care physician.

THIRD PARTY SAVINGS

In Fiscal Year 1996 Medicaid realized significant savings from its third party collection activities. Medicaid is a secondary payor to third party resources such as insurance companies, absent parent medical support, and others. Third party collection activity resulted in almost $100 million of savings during the year.

LOW ERROR RATE

The Alabama Medicaid Agency has traditionally had one of the lowest payment error rates in the Health Care Financing Administration's Region IV. Tennessee, Kentucky, Georgia, Mississippi, North Carolina, South Carolina, Florida, and Alabama are included in this region. The most recent payment error rate is about one-fourth of one percent.

A low payment error rate reflects efficient management of a state Medicaid program. If a state's error rate exceeds three percent, the state risks imposition of financial sanctions by the federal government.

HEALTHY BEGINNINGS

After five successful years and more than 100,000 participants, Medicaid's nationally recognized Healthy Beginnings program ended its coupon book incentive program on December 31, 1995. The program's hotline and outreach activities were transferred to the Alabama Department of Public Health. The outreach program has been credited with helping reduce the state's infant mortality rate by encouraging women of all income levels to obtain early and continuous prenatal care.

FAMILY PLANNING

Reducing Alabama's unintended pregnancy rate continues to be the focus of a partnership formed in 1995 by the Alabama Medicaid Agency, the Alabama Department of Public Health, the Auburn University at Montgomery School of Nursing and the Pharmacia and Upjohn Company. Grant funding from Pharmacia and Upjohn has made it possible to develop a variety of counseling materials for use with low-literacy audiences in Alabama.

In addition, a number of promotional materials have been developed to increase awareness about the Info Connection, a toll-free hotline that will provide free information to parents, teachers, counselors and health professionals, as well as teens and adults who want information on a variety of health topics. These include abstinence, family planning, resisting sexual pressure, and talking to your teen (or parents). Callers to this hotline, to be staffed by the Alabama Department of Public Health, will have access to a social worker or on-call nurse. This hotline will become operational in early 1997.

COURT RULINGS

As a result of a court order in a class action suit, Medicaid began coverage of non-emergency medical transportation on January 1, 1996. The program provides assistance and coordination with transportation needs of Medicaid beneficiaries to and from clinics, physicians' offices, hospitals and other places that provide medical services. Payment is made by voucher directly to the recipient. This method of payment is designed to encourage the most cost-effective and appropriate form of transportation.

Court rulings in Haynes v. State of Alabama by a federal court and a companion case in state circuit court resulted in a change in the methodology Medicaid uses to pay the Medicare cost sharing amounts to providers of services to Qualified Medicare Beneficiaries. The change will result in significant increases in Medicaid's future expenditures.

LEGISLATION

The Contract with America Advancement Act of 1996 changed the definition of disability so that drug addiction and alcoholism are no longer considered disabilities for Social Security Disability and Supplemental Security Income (SSI) purposes. Persons receiving SSI automatically qualify for Alabama Medicaid coverage.

The Personal Responsibility and Work Opportunity Act of 1996 made several significant changes to Alabama's Medicaid program. SSI and Medicaid eligibility for certain noncitizens is prohibited. SSI and Medicaid eligibility is denied to persons fleeing to avoid prosecution or custody after a conviction for a felony or a violation of federal or state parole. Also, SSI and Medicaid are denied for ten years to persons convicted of having made a fraudulent claim to residence in two or more states to get SSI or other benefits.

The Personal Responsibility and Work Opportunity Act of 1996 also impacted disability determinations for children applying for SSI. Now a child is considered disabled only if he/she has a medically determinable impairment resulting in marked and severe functional limitations. Maladaptive behavior is no longer a disability for SSI purposes. Currently-eligible children will continue to be eligible until redetermination. Many children who no longer meet the SSI definition of disability will retain Medicaid eligibility through other programs.

The state welfare system was also significantly changed by the Personal Responsibility and Work Opportunity Act of 1996. This act eliminated the Aid to Families with Dependent Children (AFDC) cash assistance program and created the Temporary Assistance to Needy Families (TANF) program. Alabama's TANF program is called Family Assistance. Receipt of Family Assistance is not directly linked to Medicaid eligibility.

Recipients of AFDC cash assistance had automatically qualified for Medicaid. Under the new program receipt of cash assistance no longer qualifies the recipient for Medicaid. The Alabama Department of Human Resources will continue to certify Medicaid eligibility for former AFDC recipients who meet Medicaid eligibility rules that were in effect on July 16, 1996 and for recipients of Family Assistance.

LOOKING AHEAD

The implementation of managed care systems and welfare reform in the upcoming year will be both a challenge and an opportunity for

Alabama's Medicaid Program. Because these changes will allow Medicaid to contain costs while improving services, the future should see a better Medicaid program for our state.

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 1996, the formula was approximately 70/30. For every $30 the state spent, the federal government contributed $70.

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.

Medicaid's Impact

Since its implementation in 1970, Alabama's Medicaid program has had a significant impact on the overall quality of health care in the state. Medicaid has provided 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 1996, Medicaid paid $1.7 billion to providers on behalf of persons eligible for the program. The federal government paid approximately 70 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 $5 billion worth of business in Alabama in FY 1996**.**

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 1996
COUNTY IMPACT
Year's Cost Per Eligible

County	Benefit Payments	Eligibles	Payment Per Eligible	County	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$8,829,167	4,927	$1,792	Houston	$26,846,755	13,189	$2,036
Baldwin	$25,321,426	11,403	$2,221	Jackson	$17,548,463	7,271	$2,413
Barbour	$12,671,796	5,906	$2,146	Jefferson	$213,114,116	85,001	$2,507
Bibb	$5,772,063	3,177	$1,817	Lamar	$6,947,152	2,370	$2,931
Blount	$12,397,719	4,949	$2,505	Lauderdale	$27,053,494	9,703	$2,788
Bullock	$7,033,895	3,436	$2,047	Lawrence	$10,116,735	4,519	$2,239
Butler	$11,222,961	4,746	$2,365	Lee	$21,988,028	10,503	$2,093
Calhoun	$41,136,619	17,241	$2,386	Limestone	$15,317,554	7,420	$2,064
Chambers	$13,881,587	6,143	$2,260	Lowndes	$5,495,632	3,946	$1,393
Cherokee	$7,046,545	2,791	$2,525	Macon	$12,328,855	5,600	$2,202
Chilton	$10,382,081	4,841	$2,145	Madison	$51,343,509	28,476	$1,803
Choctaw	$7,788,660	3,547	$2,196	Marengo	$10,372,718	5,433	$1,909
Clarke	$12,143,362	6,823	$1,780	Marion	$11,341,025	3,830	$2,961
Clay	$6,891,103	2,295	$3,003	Marshall	$29,394,539	11,337	$2,593
Cleburne	$4,518,899	1,962	$2,303	Mobile	$153,576,554	66,513	$2,309
Coffee	$15,855,685	5,965	$2,658	Monroe	$8,022,000	4,277	$1,876
Colbert	$17,956,548	7,393	$2,429	Montgomery	$77,037,540	38,316	$2,011
Conecuh	$7,190,206	3,573	$2,012	Morgan	$48,519,059	11,899	$4,078
Coosa	$3,341,369	1,732	$1,929	Perry	$8,382,223	4,533	$1,849
Covington	$18,078,885	6,716	$2,692	Pickens	$11,443,210	4,556	$2,512
Crenshaw	$7,303,983	2,814	$2,596	Pike	$13,707,721	6,565	$2,088
Cullman	$26,226,925	9,123	$2,875	Randolph	$8,809,560	3,669	$2,401
Dale	$15,979,262	7,519	$2,125	Russell	$17,462,248	9,478	$1,842
Dallas	$27,728,232	15,290	$1,813	St. Clair	$13,415,608	6,325	$2,121
Dekalb	$23,647,639	8,520	$2,776	Shelby	$15,804,658	5,995	$2,636
Elmore	$24,647,400	6,774	$3,639	Sumter	$8,457,254	4,740	$1,784
Escambia	$13,079,890	5,838	$2,240	Talladega	$33,171,995	14,356	$2,311
Etowah	$43,673,420	15,108	$2,891	Tallapoosa	$19,184,356	6,799	$2,822
Fayette	$7,646,976	2,743	$2,788	Tuscaloosa	$84,267,993	22,305	$3,778
Franklin	$13,157,713	4,856	$2,710	Walker	$30,743,686	11,396	$2,698
Geneva	$10,765,516	4,222	$2,550	Washington	$7,520,204	3,647	$2,062
Greene	$6,365,312	3,089	$2,061	Wilcox	$8,664,155	5,224	$1,659
Hale	$9,839,528	4,045	$2,433	Winston	$11,904,139	3,756	$3,169
Henry	$7,804,142	2,938	$2,656	Other	$1,043,268	176	$5,928

Revenue, Expenditures, and Prices

In FY 1996, Medicaid paid $2,038,585,953 for health care services to Alabama citizens. Another $45,942,042 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 1995

Sources of

Medicaid Revenue

	Dollars
Federal Funds	$1,452,133,086
State Funds	$632,394,909
Total Revenue	$2,084,527,995

FY 1995

Components of

Federal Funds

(net)	Dollars
Family Planning Administration	$96,443
Professional Staff Costs	$10,833,443
Other Staff Costs	$16,701,432
Other Provider Services	$1,417,937,182
Family Planning Services	$6,564,586
Total	$1,452,133,086

FY 1995

Components of

State Funds

(net)	Dollars
Encumbered Balance Forward	$2,554,725
Basic Appropriations	$169,294,453
Public Hospital Transfers & Alabama Health Care Trust Fund	$383,639,946
Other State Agencies	$79,173,909
Interest Income From Fiscal Agent	$42,993
UAB (Transplants)	$429,911
Miscellaneous Receipts	$150,977
Subtotal	$635,286,914
Encumbered	$2,892,005
Total	$632,394,909

FY 1995

EXPENDITURES

By type of service (net)

Service	Payments	Percent of Total Payments

Hospitals:	$808.878,776	39.68%
Disproportionate Share	$402,222,645	19.73%
Inpatient	$327,333,974	16.06%
Outpatient	$60,062,551	2.95%
FQHC	$15,132,569	0.74%
Rural Health Clinics	$4,127,037	0.20%
Nursing Homes	$442,911,220	21.73%
Waivered Services:	$184,088,055	9.03%
Pregnancy Related	$88,788,072	4.36%
Elderly & Disabled	$36,694,740	1.80%
Mental Health	$56,459,939	2.77%
OBRA '87	$0	0.00%
Homebound	$2,148,485	0.11%
SCCLA	($3,181)	0.00%
Pharmacy	$165,761,744	8.13%
Physicians:	$132,621,884	6.51%
Physicians	$99,984,939	4.90%
Physician's Lab and X-Ray	$17,823,307	0.87%
Clinics	$9,563,679	0.47%
Other Practitioners	$5,249,959	0.26%
MR/MD:	$83,161,316	4.08%
ICF-MR	$68,010,974	3.34%
NF-MD/Illness	$15,150,342	0.74%
Insurance:	$78,751,563	3.86%
Medicare Buy-In	$77,991,568	3.83%
Humana QMB Plan	$575,615	0.03%
Catastrophic Illness Insurance	$184,380	0.01%
Health Services:	$51,803,056	2.54%

Screening	$20,395,047	1.00%
Laboratory	$11,139,499	0.55%
Dental	$10,043,911	0.49%
Transportation	$4,675,932	0.23%
Eye Care	$3,175,781	0.16%
Eyeglasses	$1,440,563	0.07%
Hearing	$346,627	0.02%
Preventive Education	$585,696	0.03%
Community Services:	$54,466,009	2.67%
Home Health/DME	$20,046,272	0.98%
Family Planning	$7,429,830	0.36%
Targeted Case Management	$23,796,023	1.17%
Hospice	$3,193,884	0.16%
Mental Health Services	$36,142,330	1.77%
Total For Medical Care	$2,038,585,953	100.00%
Administrative Costs	$45,942,042	
Net Payments	$2,084,527,995	

Population

The population of Alabama grew from 3,893,888 in 1980 to 4,040,587 in 1990. In 1996**,** Alabama's population was estimated to be 4,127,562. 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 15.4% in FY 1996**.**

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.

Eligibles

During FY 1996 there were 635,568 persons eligible for Medicaid in at least one month of the year. The average number of persons

eligible for Medicaid per month was 498,844.. The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

Although 635,568 people were eligible for Medicaid in FY 1996 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 1996

MEDICAID ELIGIBLES BY CATEGORY

COUNTY	AFDC	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	TOTAL
Autauga	1,090	389	1,124	2,125	156	11	32	4,927
Baldwin	1,639	927	2,627	5,706	371	33	100	11,403
Barbour	1,609	729	1,475	1,818	198	23	54	5,906
Bibb	436	263	833	1,482	122	4	37	3,177
Blount	1,034	546	918	2,173	219	6	53	4,949
Bullock	1,084	443	734	1,064	94	8	9	3,436
Butler	930	645	1,084	1,859	185	12	31	4,746
Calhoun	4,512	1,306	4,346	6,282	583	81	131	17,241
Chambers	1,774	647	1,166	2176	279	27	74	6,143
Cherokee	501	331	566	1,185	151	6	51	2,791
Chilton	1,021	480	1,112	1,926	232	19	51	4,841
Choctaw	873	473	825	1242	104	7	23	3,547
Clarke	2,498	610	1,526	1,922	214	14	39	6,823
Clay	338	324	474	983	139	6	31	2,295
Cleburne	390	220	415	806	91	5	35	1,962
Coffee	1,411	752	1,245	2,206	258	9	84	5,965
Colbert	520	680	1,692	4,082	304	17	98	7,393
Conecuh	1,090	360	793	1,165	130	11	24	3,573
Coosa	346	145	479	678	63	6	15	1,732
Covington	1,205	818	1,410	2,829	361	11	82	6,716

Crenshaw	557	457	660	947	137	7	49	2,814
Cullman	1,009	1,328	2,208	3,989	447	28	114	9,123
Dale	1,895	655	1,567	3,084	241	17	60	7,519
Dallas	4,919	1,424	4,258	4,184	374	33	98	15,290
Dekalb	1,219	1,245	1,797	3,756	387	21	95	8,520
Elmore	1,499	656	1,794	2,571	192	14	48	6,774
Escambia	1,257	592	1,252	2,446	228	12	51	5,838
Etowah	2,630	1,540	4,185	5,860	685	43	165	15,108
Fayette	527	422	656	982	116	5	35	2,743
Franklin	749	585	1,142	2,032	261	9	78	4,856
Geneva	732	599	1,042	1,531	228	10	80	4,222
Greene	928	391	727	937	78	10	18	3,089
Hale	863	628	894	1,528	92	8	32	4,045
Henry	774	415	623	893	180	12	41	2,938
Houston	2,824	1,223	3,000	5,444	514	27	157	13,189
Jackson	997	793	1,834	3,116	408	32	91	7,271
Jefferson	28,916	6,277	21,965	25,140	2,017	201	485	85,001
Lamar	268	374	544	982	153	11	38	2,370
Lauderdale	1,421	1,101	2,403	4,188	440	13	137	9,703
Lawrence	813	520	1,043	1,869	222	10	42	4,519
Lee	2,474	847	2,278	4,472	317	29	86	10,503
Limestone	1,925	776	1,573	2,750	289	33	74	7,420
Lowndes	1,300	333	977	1,227	81	7	21	3,946
Macon	2,526	520	1,027	1,386	105	14	22	5,600
Madison	12,514	1,785	5,298	7,958	716	59	146	28,476
Marengo	1,685	640	1,174	1,735	162	13	24	5,433
Marion	564	619	926	1,418	218	6	79	3,830

Marshall	1,796	1,447	2,744	4,652	521	23	154	11,337
Mobile	24,215	4,005	14,191	22,277	1,390	107	328	66,513
Monroe	1,128	459	948	1,573	125	8	36	4,277
Montgomery	12,387	2720	9,531	12,511	890	77	200	38,316
Morgan	2,203	1232	2,973	4,905	443	39	104	11,899
Perry	1,556	503	986	1,370	91	5	22	4,533
Pickens	1,174	594	1,175	1,437	132	15	29	4,556
Pike	1,482	763	1,587	2,506	157	28	42	6,565
Randolph	848	459	712	1,427	178	15	30	3,669
Russell	3,130	852	1,895	3,179	332	26	64	9,478
St. Clair	1,475	507	1,266	2,798	212	14	53	6,325
Shelby	1,281	464	1,313	2,596	254	16	71	5,995
Sumter	1,863	527	996	1,223	91	15	25	4,740
Talladega	3,840	1,015	3,724	5,058	509	95	115	14,356
Tallapoosa	1,610	807	1,517	2,501	283	15	66	6,799
Tuscaloosa	5,817	2,002	5,622	8,040	603	42	179	22,305
Walker	1,883	961	3,203	4,838	371	23	117	11,396
Washington	1,171	344	819	1,170	99	12	32	3,647
Wilcox	1,705	541	1,617	1,199	114	17	31	5,224
Winston	492	534	916	1,560	199	9	46	3,756
Other	176	0	0	0	0	0	0	176
STATEWIDE	173,318	58,569	149,426	226,954	20,536	1,601	5,164	635,568

Recipients

Of the 635,568 persons eligible for Medicaid in FY 199**6**, about 86 percent actually received care for which Medicaid paid. These 547,583 persons are called recipients. The remaining 87,985 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.

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 1996 was $71. The yearly average number of days for recipients of this service was 273. 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 1996 paid a monthly buy-in fee to Medicare of $42.50 per eligible Medicare beneficiary. The Medicaid Agency also paid from $289.00 to $317.90 per month Part-A buy-in premiums for certain Medicare eligibles. Medicaid paid a total of $78 million in Medicare buy-in fees in FY 1996. 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.

Cost Avoidance and Recoupments

PROGRAM INTEGRITY

The Program Integrity Division of the Alabama Medicaid Agency is tasked with identifying fraud and abuse of Medicaid benefits by both health care providers and recipients. Computer programs are used to identify unusual patterns of utilization of services. Medical desk reviews are conducted on those providers and recipients whose medical practice or utilization of services appear outside established norms. Additionally, the division performs follow-up on referrals made from many internal and external sources, including calls made to the Medicaid FRAUD HOTLINE.

Provider reviews are conducted by highly trained registered nurses who examine all aspects of a provider's billing practice. With the help of automation, the review staff have doubled the dollars recovered this year compared to last year.

When a recipient review indicates a pattern of over or misutilization of Medicaid benefits, the recipient is placed in the Agency's Restriction Program for management of their medical condition. The recipient is locked into a physician who is responsible for primary care. Referrals to specialists are allowed if they are made by the recipient's primary care physician. The recipient is also restricted to one pharmacy for obtaining their medications. Additional limitations may be placed on the recipient's ability to obtain certain drugs. Follow-up reviews are performed annually.

During FY 1996 Medicaid Investigators closed 116 cases. Code of Alabama, 1975, Section 22-6-8, requires that cases of suspected fraud, abuse, and/or misuse of Medicaid benefits be referred to a Medicaid Utilization Review Committee. The Committee may recommend that a recipient's eligibility be suspended for one year and until

repayment of misspent funds is made. Since October 1, 1995 Medicaid benefits have been suspended for 100 recipients. At the present time, a total of approximately 1,500 recipients are suspended from the Medicaid program for fraud and/or abuse. In addition, eight recipients were referred to local district attorneys for prosecution.

Through the Quality Control Unit, the Medicaid Agency makes sure eligibility determinations are as accurate as possible. In-depth reviews of eligibility determinations are performed on a random sample of Medicaid eligibles. If a state's payment error rate exceeds three percent, the Health Care Financing Administration imposes a financial sanction. The Agency's most recently published error rate was projected to be less than one-half percent for the upcoming fiscal year. 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.

Third Party Liability

Medicaid's Third Party Liability (TPL) Program is responsible for ensuring that Medicaid pays for medical services only when there is no other source (third party) available to pay for a recipient's health care. To do this Medicaid uses a combination of data matches, diagnosis code edits, and referrals from providers, caseworkers, and recipients to identify available third party resources. In addition, the TPL Program provides alternative sources of health care coverage for recipients by purchasing Medicare coverage as well as coverage through individual and group health plans when cost effective. The TPL Program also ensures that Medicaid recovers any costs incurred when available resources are identified through its estate recovery program and when Medicaid payments were made erroneously as a result of eligibility-related issues.

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. As a result of the efforts of this division, Medicaid saved in excess of $58 million in FY 1996 through a combination of cost avoidance of claims (requiring providers to file for third party resources prior to filing Medicaid) and pursuing recovery from third party resources identified after payment by Medicaid. Of the amount saved, the Agency collected $8.3 million, providers reported collections of $4.9 million, $43.7 million in claims were denied or recouped from providers due to other resources (resulting in an estimated final savings of $6.6 million), and $38 million in claims were denied or payment recouped from providers because Medicare was the primary payer.

Significant accomplishments for the TPL Program in FY 1996 included continued expansion of cost avoidance edits for prescription drug claims, increased emphasis in payment of health insurance premiums, and full implementation of electronic submission of claims to Blue Cross-Blue Shield of Alabama.

Health Insurance Resources.

Medicaid's population has increased over the years due to changes in eligibility criteria. Changes in these criteria mean that more eligibles have access to employment-related health plans through their own employer or that of a spouse or parent. Many of the plans chosen by Alabama's eligibles are managed care plans, including HMOs. These plans offer a significant savings to Medicaid when recipients use their plan providers for their medical care. In FY 1996, approximately 14% of Medicaid eligibles were covered by some form of health insurance which resulted in Medicaid collecting $4.2 million from health insurance plans and cost avoiding in excess of $11.5 million.

Medicaid pays the Medicare Part A and/or Part B premiums for those individuals who meet the Medicaid eligibility criteria for this program. The Third Party Division oversees the payment of these premiums and ensures that Medicare benefits are used as a primary resource to Medicaid. In FY 1996 Medicaid denied over $32 million in claims which were submitted to Medicaid without first being paid by Medicare. An additional $6 million in payments were recouped from providers because of retroactive Medicare.

Medical Support.

Many Medicaid eligible children are also eligible for coverage of their medical care through a non-custodial par-

ent's (NCP) health insurance. In addition to identifying those children with existing coverage, Medicaid uses data matches and referrals from caseworkers to identify those who are found to be eligible to enroll in a NCP's health plan. These children are referred to the Department of Human Resources (DHR) to obtain and enforce a court order requiring the NCP to enroll the child in the NCP's health plan. Where health insurance is not available, a NCP may be under a court order to reimburse Medicaid for medical bills paid by Medicaid on behalf of the dependent. In FY 1996 approximately $101,000 was collected by Medicaid from NCP's either through direct payment or tax intercept as a result of court ordered medical support.

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. 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 1996, Medicaid collected approximately $1.1 million as a result of its recovery efforts in this program.

RECOUPMENTS.

The Medicaid Agency recovers funds from individuals who received Medicaid services for which they were not entitled. In most instances these cases involve individuals who, through neglect or fraud, did not report income or assets to their eligibility case worker. The Recoupments Unit received 2,500 complaint reports from Medicaid's District Offices, AFDC or SOBRA workers in FY 1996. The unit identified over $1.2 million for collection and collected over $720,000 in misspent dollars.

ESTATE RECOVERY.

State Medicaid Programs are required to recover the costs of nursing facility and other long-term care services from the estates of Medicaid recipients. In FY 1996, the Estate Recovery Unit recorded over 500 liens and collected in excess of $2.1 million.

PREMIUM PAYMENT.

A relatively new function for Medicaid is payment of health insurance premiums when cost effective for Medicaid eligible individuals who are high cost users of medical care and who cannot continue payment of their health insurance premiums. In FY 1996 premiums for employment-related health insurance were paid for 180 individuals with diagnoses including pregnancy, AIDS, cancer, and hemophilia, resulting in savings to Medicaid of over $532,000. Recent efforts to educate providers, advocacy groups, other state agencies and employers about this program should result in even greater savings for Medicaid in FY 1997.

AGENCY AUDIT

Fiscal Agent/Systems Audit

This division monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews of forced claims, denied claims and suspect duplicate drug claims are also performed. In addition, targeted reviews of claims are done when potential systems errors are found. Approximately 11,729 claims were manually reviewed during FY 1996 and $101,144 were recouped.

Provider Audit/Reimbursement

The mission of the Provider Audit/Reimbursement Division is to monitor Agency expenditures in the major program areas (nursing facilities, hospitals, waiver services) to ensure that only allowable costs are reimbursed. Provider Audit has three branches, Nursing Home Audit, Hospital Audit, and Alternative Services Audit.

Nursing Home Audit conducts on-site financial audits and makes necessary adjustments to the reported costs. This adjustment information is provided to reimbursement specialists, who adjust current payment rates; recoup overpayments and make up for underpayments. An in-depth, on-site audit of all nursing home facilities and home offices are completed at least once every five years, and for all ICF/MRs at least once every three years. During FY 1996, this unit completed 65 audits. The total includes Home Office and Facility/Provider financial records for the cost report period ending June 30, 1996. 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. If it is determined that a provider may be intentionally filing a fraudulent cost report or if the provider continues to claim known unallowable costs in the reimbursement cost total, the Nursing Home Audit section provides the Attorney General's Medicaid Fraud Division with the information.

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. Twelve cost report audits were completed during FY 1996.

Limited scope financial audits of providers in selected waiver programs are performed by the Alternative Services Audit section. This section verifies revenue, expense, and statistical data reported by providers through their cost reports. The data from these cost reports is used to set rates for each service provider in the Elderly and Disabled Waiver, the Mentally Retarded/Developmental Disabled Waiver, and the Homebound Waiver. This section also sets rates for federally qualified health centers, provider based rural health clinics, and the Hospice Program using the provider's cost reports. Providers always have the right to appeal audit findings.

Medicaid Management Information System

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.

Major projects completed during FY 1996 included enhancements to the Preferred Drugs System, CROCS (Comprehensive Recipient On-Line Collection System), Fiscal Financial System, BENDEX (Beneficiary and Earnings Data Exchange), SDX (State Data Exchange), and COLA (Cost of Living Adjustment). Changes were also made to EPSDT Outreach. Conversion of the Buy-In Premium Record to on-line and microfiche was completed. Newly developed were the Agency's On-Line Projects System, a Provider Surveillance & Utilization System, Agency Records Tracking System (in Visual Basic), on-line access by Social Security Administration to Medicaid Inquiry Screens, Non-Emergency Transportation System (NET), Office Management Purchasing System, Maternity Waiver Reporting System, PHP Eligibles Reporting Systems, PHP Capitation Analysis Reporting System for Agency Audit, AS/400 Menu system for EPSDT, Medicare Eligibles Reporting System, and Medicaid Verification Reporting System for Telephone Companies in Alabama.

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.

Maternal and Child Health Services

Services to women and their children are overseen by several divisions including the Physicians program, the Maternity Waiver program, and Preventive Health. During FY 1996, Medicaid served 226,954 women and children through the expanded eligibility group for pregnant women and children called SOBRA (Sixth Omnibus Budget Reconciliation Act). Alabama's infant mortality rate has improved since 1989 when the "old" Maternal and Child Health Division was created; from 12.1 infant deaths per thousand births to 9.8 deaths per thousand in 1995, the lowest rate in Alabama history.

PRENATAL CARE

The latest birth statistics revealed the number of births to women aged 10-19 decreased in Alabama from 11,333 in 1994 to 11,175 in 1995. There were 324 births to teenage women under 15 years of age, a decrease from 339 births in 1994.

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 can also reduce the possibility of premature, underweight babies. Studies consistently show that for every dollar spent on prenatal care, approximately $3 is saved in the cost of caring for low birth weight babies.

Prenatal care for Medicaid eligible recipients is provided through private physicians, hospitals, public health department clinics and federally qualified health centers. Some of the maternity-related benefits covered under the prenatal program are unlimited prenatal visits, medical services to include physical examinations with risk assessments, prenatal vitamins, nutritional assessments, counseling and educational services, appropriate medically indicated lab tests, and referral services as needed. Referral services include family planning services after delivery and medical services for the newborn under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). 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.

ADOLESCENT PREGNANCY PREVENTION EDUCATION

Adolescent Pregnancy Prevention Education was implemented in October 1991. The program is designed to offer expanded medically related education services to teens. These classes go beyond the limited service and information offered under existing Medicaid programs. These services are provided by physicians or other licensed practitioners of the healing arts who present detailed adolescent pregnancy material. The program curricula are designed to teach disease and disability prevention and to prolong life and promote physical and mental health.

The pregnancy prevention services include a series of classes teaching male and female adolescents about decision making skills and the consequences of unintended pregnancies. Abstinence is presented as the preferred method of choice.

Currently there are approximately 33 providers of adolescent pregnancy prevention services. These include hospitals, county health departments, federally qualified health centers, and private organizations.

VACCINES FOR CHILDREN

In an effort to increase the number of Alabama children who are fully immunized by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program in October, 1994. This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations, if they obtain vaccines from a federally qualified health center or rural health clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 259,000 of Alabama's children are Medicaid eligible. Medicaid has taken the previous vaccines and administration fee costs to calculate an equivalent reimbursement fee of $8.00 per in-

jection. When multiple injections are given on the same day, Medicaid will reimburse for each injection. When injections are given in conjunction with an EPSDT screening visit or physician office visit, an administration fee of $8.00 will also be paid.

Providers may charge non-Medicaid VFC participants an administration fee not to exceed $14.26 per injection. This is an interim rate set by the Health Care Financing Administration based on charge data. No VFC-eligible participant should be denied services because of inability to pay.

The Department of Public Health is the lead agency in administering this program.

MATERNITY WAIVER

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 1996, there were 43 counties participating in the maternity waiver. Those counties were: Autauga, Baldwin, Bibb, Blount, 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, 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 women, including SOBRA women, 10-55 years of age and men of any age who 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. An extended contraceptive counseling visit is also covered on the same day as the post partum visit. Contraceptive supplies and devices available for birth control purposes include pills, foams/condoms, intrauterine devices, diaphragms, implants, and injections. Sterilization procedures are also covered if federal and state regulations are met.

Currently there are approximately 1,057 providers. These include county health departments, federally qualified health centers, rural health clinics, private physicians and Planned Parenthood of Alabama.

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 1,419 providers of EPSDT services, including county health departments, federally qualified health centers, provider-based rural health clinics, independent rural health clinics, hospitals, private physicians and some nurse practitioners. 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.

In 1995, Medicaid added an off-site component of the EPSDT program. This allowed providers who met specific enrollment protocols to offer EPSDT screening services in schools, housing projects, head start programs, day care centers, community centers, churches and other unique sites where children are frequently found.

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 appropriate 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.

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 8,692 calls monthly during FY 1996(more than 100,000 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 one-third 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 four 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

Managed Care continued to be a priority of the Alabama Medicaid Agency during FY 1996. Although there were no operational programs, this was a period of increased awareness and planning for initiation of risk based programs. Interest was expressed to the agency by HMOs and traditional providers in anticipation of providing care on a capitated basis. Medicaid has begun structuring the components of a system that will begin the transition to managed care. In the coming year programs will be initiated in parts of the state.

The Health Care Financing Administration (HCFA) has approved the Primary Care Case Management (PCCM) system called Patient 1st. It was approved in late September 1996. The managed health care system for Medicaid patients in Mobile County, called BAY Health Plan, is expected to be approved early in FY 1997.

MEDICARE HMOS AND CPMS

In FY 1996 Medicaid began a program in which health maintenance organizations (HMOs) and competitive medical plans (CMPs) may enroll with the Medicaid agency to receive capitated per member per month payments to cover, in full, any premiums or cost sharing for beneficiaries who enroll in a Medicare HMO or CMP for which Medicaid is responsible for payment of Medical cost sharing.

The HMO or CMP must have an approved Medicare risk contract with the Health Care Financing Administration to enroll Medicare beneficiaries and other individuals and groups. They must deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to Medicare enrollees. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. All services covered by Medicare shall be offered by the HMO or CMP at no cost to the beneficiary. The HMO or CMP may offer additional services to the beneficiary, such as hearing exams, annual physical exams, eye exams, etc. Services covered directly by Medicaid which are not covered by Medicare are not included. The beneficiary is given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

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 25 mental health centers around the state providing these services. On a monthly average during FY 1996, about $2.25 million were spent to provide services to approximately 2,400 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. DHR has become an active provider. On a monthly average during FY 1996, about $459,000 were spent to provide services to approximately 425 clients. A wide array of mental health services were provided to 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), persons with severe renal disease (target group 7), and adult protective service individuals (target group 8). With the addition of new providers coordinating services for these target groups there was a reduction in nursing home placement and hospitalization. It is estimated that over 20,000 Medicaid-eligible recipients received targeted case management service this year. at a projected cost of $24 million.

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 1996, there were 6,513 recipients served by this waiver at an actual cost of $3,978 per recipient. Serving the same recipients in nursing facilities would have cost the state $19,518 per recipient. This waiver saved the state $15,540 per recipient in FY 1996.

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 developmental disablity. The waiver provides residential habilitation training, day habilitation, prevocational training, supported employment, occupational therapy, speech therapy, physical therapy, individual family support service, behavior management, companion service, respite care, personal care, environmental modification, specialized medical equipment and supplies, assistive technology, personal emergency response system, and skilled nursing care. During FY 1996, there were 2,770 recipients served by this waiver at an actual cost of $13,135 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $71,583 per recipient. The MR/DD waiver saved the state $58,448 per recipient in FY 1996.

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 1996, there were 355 recipients served at a cost of $4,572 per recipient. Serving the same recipients in an institution would have cost the state over $7 million. The state saved at least $15,148 per recipient in FY 1996 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 are served in the community. Occupational therapy, physical therapy, durable medical equipment, and other services as necessary to maintain Medicaid eligibles in the home have been available to Medicaid eligibles under 21 since 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 1996, the Medicaid Agency served 627 hospice patients at a total cost of about $3.2 million. 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 169 agencies participating in FY 1996.

Up to 104 home health visits per year per recipient may be covered by Medicaid in Alabama. During FY 1996, over 6,000 recipients received visits costing a total of approximately $11 million.

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 fiscal year 1996, over 600 Medicaid DME providers throughout the state furnished services at a cost of approximately $11 million.

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 the FY 1996, Medicaid paid approximately $3 million for services provided through 48 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 113 Alabama hospitals that participate in the Medicaid program, and 27 hospitals in neighboring states also participate in Alabama's program.

Quality Assurance Program

Utilization management is mandated under federal regulations to ensure that Medicaid inpatient admissions are based on medical necessity. The Quality Assurance Program of the Alabama Medicaid Agency performs the duties outlined in the regulations. There are 141 in-state and border hospitals in Alabama that are considered "delegated" and do their own utilization review. There are 6 Psychiatric

Hospitals for which QA performs 100% of Medicaid admission and continued stay medical necessity reviews. The State has 1 Psychiatric Hospital for persons over age 65, and the QA Program also performs 100% of Medicaid admission reviews for this facility.

Hospital admission reviews are 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 1996. 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.

OUTPATIENTS

There were also limitations on outpatient hospital services during this fiscal year. Medicaid will pay for a maximum of three non-emergency outpatient visits per eligible during a calendar year. Exceptions are made for certified emergencies, chemotherapy, radiation therapy, visits solely for lab and x-ray services and surgical procedures on the Agency's outpatient surgical list.

COPAYMENTS

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. 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 1996, there were six hospitals enrolled.

Inpatient psychiatric services for recipients age 65 or over are covered services when provided in a free-standing hospital exclusively for the treatment of persons age 65 or over with serious mental illness. These services are unlimited if medically necessary and if the admission and continued stay reviews meet the approved psychiatric criteria. These hospital days do not count against a recipient’s inpatient day limitation for treatment in an acute care hospital.

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. Reviews are performed by the Medicaid Agency to determine the medical

necessity of admissions and continued need for hospitalization.

Ambulatory Surgical Centers (ASC)

Medicaid covers ambulatory surgical center (ASC) services, which are procedures that can be performed safely on an outpatient basis. Services performed by an ASC are reimbursed by means of a predetermined fee established by the Medicaid Agency. A listing of covered surgical procedures is maintained by the Alabama Medicaid Agency and furnished to all ASCs. The Agency encourages outpatient surgery whenever possible.

Ambulatory surgical centers must 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 the designated copayment amount for each visit. At the end of FY 1996, 33 ASC facilities were enrolled as providers in this program.

Post-Hospital Extended Care Program

This program was implemented August 1, 1994 for 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.

Swing Beds

Swing beds are defined as hospital beds that can be used for either hospital acute care or skilled nursing facility care. Hospitals with swing beds are located in rural areas with fewer than 100 total beds. The hospital must have been approved by the Department of Health and Human Services and certified as a Medicare swing bed provider. Reimbursement for a Medicaid recipient receiving skilled nursing facility care in a swing bed is at a per diem rate equal to the average per diem rate paid to participating nursing homes.

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 1996, 17 FQHCs were enrolled as providers, with 78 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 physician 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 1996, thirty independent rural health clinics, (including three 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 28 PBRHCs enrolled as Medicaid providers.

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 64 percent of Alabama's Medicaid eligibles received physicians' services in FY 1996

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 Early and Periodic Screening, Diagnosis and Treatment (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.

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 1996, pharmacy providers were paid approximately $204 million for prescriptions dispensed to Medicaid eligibles. This expenditure represents about eight 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. The dispensing fees and the pricing methodology remain unchanged from previous years.

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 (OBRA) expanded Medicaid coverage of reimbursable drugs. With the exception of allowable published exclusions, most all drugs are now covered by the Medicaid Agency. The OBRA ‘90 legislation also required states to implement a Drug Rebate Program and a Drug Utilization Review Program (DUR).

The Rebate Program collects rebates from drug manufacturers based on Medicaid utilization of their drug products in Alabama. During FY 1996, nearly $36 million were collected. This represents an 11 percent increase over FY 1995. These rebates are used to offset increasing drug program expenditures.

The DUR process involves retrospective reviews conducted by a committee of pharmacists and physicians from across the state. The purpose is for identification of drug usage characteristics of Medicaid recipients in order to prevent or lessen the instances of inappropriate, excessive, or therapeutically incompatible drug use. This also enhances the quality of care received by Medicaid recipients by educating physicians and pharmacists with regard to issues concerning appropriateness of pharmaceutical care and to minimize expenditures.

During FY 1996, savings generated from the retrospective DUR process was approximately $1,213,000. The retrospective element of DUR is complimented by a prospective element. Prospective DUR is an on-line, real-time process allowing pharmacists the ability to intervene before a prescription is dispensed, preventing therapeutic duplication, over and underutilization, low or high doses and drug interactions. Medicaid has implemented a prospective DUR system that screens prescriptions for early/late refills, theraputic duplica-

tion, drug interactions, high dose , and product selection (preferred drug status).

The Agency has also implemented a voluntary educational program called the Preferred Drug Program. The program provides educational information to physicians and pharmacists regarding drugs considered superior in their class. This program fosters the most appropriate therapy for Medicaid patients in an efficient and effective manner.

PHARMACEUTICAL PROGRAM
Use and Cost

Year	Number Of Drug Recipients	Recipients As a % Of Eligibles	Number Of Rx	Rx Per Recipient	Price Per Rx	Cost Per Recipient	Total Cost To Medicaid*
1994	410,487	66%	6,985,083	17.02	$23.34	$397	##########
1995	413,076	65%	7,352,754	17.8	$24.62	$438	##########
1996	412,757	65%	7,612,847	18.44	$26.77	$494	##########

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

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 other limited justifications. Post-cataract patients may be referred by their surgeon to an optometrist for follow-up management.

In keeping with the Agency's policy of cost containment, eyeglasses are chosen through competitive bidding. During FY 1996, Medicaid entered into a new contract on July 1, 1996. The contractor is required to furnish eyeglasses that meet federal, state and Agency standards. The selection of frames includes styles for men, women, teens, and preteens.

LABORATORY AND RADIOLOGY PROGRAM

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

Since lab and x-ray services are ancillary parts of other services, Medicaid will not pay for lab and x-ray services if the other services performed are not covered. There are over 116 independent laboratories and over 10 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 64 freestanding facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis and CAPD (Continuous Ambulatory Peritoneal Dialysis) and home treatments, as well as training, counseling, drugs, biologicals, and related tests. Patients are allowed 156 treatment sessions per year, which provides for three sessions per week.

Recipients who travel out of state may receive treatment in that state. The dialysis facility must be enrolled with Medicaid for the appropriate period of time. Although the Medicaid renal dialysis program is small, it is a life-saving service without which many recipients could not survive, physically or financially.

Long Term Care

Care for acutely ill, indigent residents in nursing facilities was mandated in 1965 with the enactment of Medicaid (Title XIX). On October 1, 1990, OBRA '87 was implemented and provided for improvements in health care for residents in nursing facilities. The law included 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.

As of July 1, 1995, the last major phase of nursing home reform was implemented. On that day, new enforcement regulations took effect to assure high quality care in nursing facilities. Nursing home reform has included a resident "bill of rights" and requirements for individual resident assessments and plans of care, as well as nurse aide training and competency requirements and the establishment of a nurse aide registry.

With the new enforcement regulations a wider range of sanctions are available tailored to different quality problems. Adopting "substantial compliance" as the acceptable standard, the new rules are meant to ensure reasonable regulation while at the same time requiring nursing facilities to correct problems quickly and on a long term basis. An important goal of the new enforcement plan is to ensure that continuous internal quality control and improvement is performed by the nursing facilities themselves.

The regulations provide for the imposition of civil money penalties and other alternative remedies such as denial of payment for new admissions, state monitoring, temporary management, directed plans of correction, and directed in-service training. Almost all facilities will be given the opportunity to correct the deficiencies and avoid remedies. Only chronically poor performers and facilities with deficiencies that present direct jeopardy to residents will be assessed with an immediate remedy, which may involve termination or civil money penalties.

House Bill 611 was passed February 17, 1994 to amend certain sections of the Code of Alabama. This amendment provides for an exemption to the certificate of need process, allowing an increase in the number of nursing home beds meeting certain criteria. The beds cannot exceed 10 percent of the total beds of the facility or 10 beds, whichever is greater. The average rate of occupancy of the facility cannot be less than 95 percent for the 24 month period ending on June 30 of the year immediately preceding the application for exemption from the certificate of need review. The aggregate average rate of occupancy for all other facilities in the same county as the facility seeking an exemption must not be less than 95 percent for the 24 month period ending on June 30 of the year immediately preceding the application. In FY 1996, 737 beds were approved under the exemption.

Medicaid financed 66 percent of all nursing home care in the state during FY 1996. The total cost to Medicaid for providing this care was $444,142,454. Almost 94 percent of the 231 nursing homes in the state accepted Medicaid recipients as patients in FY 1996. There were also 21 hospitals in the state during FY 1996 that had long term care beds, called swing beds, participating in Medicaid.

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.

Long Term Care for the Mentally Retarded and Mentally Disabled

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 Developmental Center 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 Arc of the Shoals in Tuscumbia, Volunteers of America #20 in Huntsville, and Volunteers of America #40 in Hartselle. Institutional care for the mentally diseased (IMD) 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 1996 the average rate per day in an institution serving the mentally retarded was approximately $217.21.

In terms of total Medicaid dollars expended and the average monthly payment per patient, the ICF-MR and IMD 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 1996, in cooperation with the Alabama Medicaid Agency, Mental Health was able to match every $30 in state funds with $70 of federal funds for the care of Medicaid-eligible ICF-MR and IMD patients.

Alabama Medicaid and AIDS

During FY 1996, there were 613 new AIDS cases reported in Alabama making a cumulative number of cases reported totaling 4,114. Of this number, 1,106 (27 percent) received services funded by Medicaid. Expenditures for AIDS -related cases decreased from approximately $9 million in FY 1995 to approximately $7 million in FY 1996.

Educating the public about AIDS continues through the Facts From Your Pharmacist: Answers about AIDS. Through this program, educational brochures and information is available to the general public in participating pharmacies statewide. In addition, Alabama will receive educational information and outreach material developed by HCFA for a pilot project targeted at pregnant women and their providers. This program promotes the value of AZT therapy in an effort to reduce the transmission of the HIV virus to infants. Although Alabama was not selected as an official participant of the pilot project, consumer brochures, posters and public service announcements will be made available through the Agency for Health Care Policy and Research.

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

Physician Services

Finding a physician who is familiar with AIDS-related diseases is sometimes difficult 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 for AIDS patients goes for inpatient hospital care. In 1996, Medicaid provided inpatient care totaling 1,3 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. While the number of claims remained fairly stable, drug expenditures increased over $400,000 for the past year.

Home and Community Based Waiver Program

Home based services are provided to AIDS recipients under this waiver program as an alternative to costly nursing home placement.

Targeted Case Management

Case management services are provided to recipients who are HIV positive. These services provide for coordinated access to needed services for AIDS patients who are 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.