1997 Annual Report

Introduction:

Statistical Topics:

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1997 Annual Report

Annual Report 1997
Highlights

Introduction

During FY 1997 Medicaid continued to work toward improving efficiency, containing costs, and maintaining a high quality of service for Medicaid beneficiaries. Significant progress was made in the area of managed care as two innovative programs were put into place. The Agency's third party activities saved taxpayers over $55 million, and cost saving changes were made to Medicaid's prescription drug program. At the same time, plans were put in place to expand coverage to Alabama's teenagers.

Managed Care

Medicaid staff's work to implement managed care was rewarded during FY 1997 by the beginning of two managed care programs for Medicaid beneficiaries in Alabama. One is a primary care case management (PCCM) system called Patient 1st and the other model is called 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 are 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 provide primary and preventive care and coordinate referrals to specialists. Marengo County was the first of 17 counties brought into the system during FY 1997.

BAY Health Plan is a five-year research and demonstration project in Mobile County. It was 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 selects, or is assigned, a primary care physician (PCP). An extensive educational campaign to acquaint patients with the new system was conducted by BAY Health Plan. A resource center has also been made available to assist patients in selecting a primary care physician and obtaining support services.

Governor's Task Force on Medicaid

On January 22, 1997 Governor Fob James signed an executive order which created the Governor's Task Force on Medicaid. The Task Force members were asked to examine the state Medicaid program and recommend improvements in all areas, particularly sources of funding, provider reimbursements methodologies, legislative changes, and methods for increasing efficiency.

After three months of work the task force made recommendations and suggestions concerning nursing home care, pharmacy services, and hospital care. During the remainder of 1997 the Agency began working on implementation of task force recommendations, all of which were directed toward containing costs.

Changes to Medicaid's Prescription Drug Program

As a result of the recommendations made by the Governor's Task Force on Medicaid, changes were implemented in the Medicaid prescription drug program to slow the rising costs of benefits while maintaining a high quality of service for Medicaid beneficiaries. One of the changes involves expansion of prior approval requirements for expensive drugs. With prior authorization, doctors must obtain approval from Medicaid before prescribing certain drugs. Recommendations of drugs for the prior approval list are made by Medicaid's Pharmacy and Therapeutics Committee, a group of doctors and pharmacists who advise the Agency on operation of the prescription drug program.

Other changes to the program include greater use of automation to stop drug misuse and abuse, increased education to doctors and pharmacists identified as having inappropriate prescribing and dispensing habits, case management programs for patients who are high users of drugs, and expansion of use of generic drugs unless the doctor certifies a need for a brand name.

Third Party Savings

Federal regulations require that Medicaid identify resources available to pay for a recipient's health care and ensure that those resources are used. In FY 1997, Medicaid's third party activities saved taxpayers $55 million at a savings to cost ratio of $48 to $1. These savings include collection and cost avoidance activities relating to health and liability insurance, liens, estate recovery, recoupments due to ineligibility, purchase of group health insurance, and medical support. Also included are savings which resulted from edits to identify claims submitted to or paid by Medicaid as primary payor instead of Medicare. The $55 million in savings does not include payments made by Medicare as a primary payor to Medicaid.

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 Info Connection, a toll-free hotline that provides 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, staffed by the Alabama Department of Public Health, have access to a social worker or on-call nurse. The toll-free phone number is 1-800-545-1098.

Legislation

On August 5, 1997 Congress enacted the Balanced Budget Act of 1997 (BBA). This Act created a new Title XXI of the Social Security Act which impacts Medicaid in several of its provisions. Most notable was the approval of a total of nearly $40 billion to be used over the next ten years to fund an expansion in health care coverage of uninsured children. States, including the District of Columbia can use these funds to expand Medicaid eligibility for children, with an enhanced federal match for the expansion population, or to purchase other health coverage, or both. Also included in the BBA were provisions to 1) extend Medicaid coverage for children no longer receiving SSI due to welfare reform, 2) extend Medicaid coverage to disabled individuals with earned income, 3) change Disproportionate Share Hospital allotments, and 4) repeal the Boren Amendment. In addition, the BBA gives states flexibility in establishing the amount of payment for Medicare cost-sharing in their Medicaid State plans and provides a simplified process by which states can extend Section 1115 Medicaid waivers.

Looking Ahead

As the fiscal year came to an end, Medicaid Agency staff were planning an expansion of eligibility that could add an additional 34,000 uninsured teenagers to the Medicaid program. This initiative, part of the BBA, is referred to as the Children's Health Insurance Program (CHIP). As this report goes to press, federal approval of the expansion has been granted, and implementation began February 1, 1998.

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 Department of Public 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 1997, 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.

- Persons receiving Supplemental Security Income (SSI) from the Social Security Administration, are automatically eligible for Medicaid in Alabama. Children born to mothers receiving SSI payments may be eligible for Medicaid until they reach one year of age. After the child's first birthday, a determination will be made by Medicaid as to whether the child qualifies for another Medicaid program.
- Persons approved for “Medicaid for Low Income Families” through the Department of Human Resources are eligible for Medicaid. Low income families may apply for cash assistance, Medicaid, or both through the Department of Human Resources. Medicaid may be approved if the children are deprived of parental support due to absence, divorce,

separation, death, or unemployment of the primary wage earner. Also, foster children under custody of the state may be eligible for Medicaid.

- Pregnant women and children under six years of age with family income which does not exceed 133% of the federal poverty level are covered by Medicaid. Also covered are children born after September 30, 1983, who live in families with family income at or below the federal poverty level. Medicaid eligibility workers in county health departments, federally qualified health centers, hospitals, and clinics determine their eligibility through a program called SOBRA Medicaid.
- Persons who are residents of medical institutions (nursing homes, hospitals, or facilities for the mentally retarded) for a period of 30 continuous days and meet very specific income, resource and medical criteria may be Medicaid eligible. Persons who require institutional care but prefer to live at home may be approved for a Home and Community Based Service Waiver and be Medicaid eligible. Medicaid District Offices determine eligibility for persons in these eligibility groups.
- Qualified Medicare Beneficiaries (QMBs) have low income and few resources. 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.
- Specified Low-income Medicare Beneficiaries (SLMBs) have low income above the QMB limit. These persons may be approved for limited benefits. Persons in this group may be eligible to have their Medicare Part B premiums paid by Medicaid. Medicaid District Offices determine eligibility for SLMBs.
- Qualified Disabled Working Individuals (QDWIs) are individuals who have limited income and resources and who have lost disability insurance benefits because of earnings and who are also entitled to enroll for Medicare Part A. Medicaid will pay their Medicare Part A premiums. Medicaid Central Office determines eligibility for QDWIs.
- 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 can qualify for Medicaid. Medicaid District Offices determine eligibility for this group.

Persons in all categories may receive retroactive Medicaid coverage if medical bills were incurred in the three months prior to the application for Medicaid and if they meet all requirements for that program in those months (exceptions are: QMB and HCBS Waivers).

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 had not pushed them above the income limit to receive SSI. Another category protected from losing eligibility is 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 inception 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 1997, Medicaid paid $2.2 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 $6.6 billion worth of business in Alabama in FY 1997.

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 1997
COUNTY IMPACT
Year's Cost Per Eligible

	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$9,498,228	4,897	$1,940
Baldwin	$28,566,262	11,711	$2,439
Barbour	$14,913,130	5,883	$2,535
Bibb	$6,483,238	3,418	$1,897
Blount	$13,447,623	5,067	$2,654
Bullock	$7,201,565	3,337	$2,158
Butler	$12,510,519	4,807	$2,603
Calhoun	$45,338,193	17,302	$2,620
Chambers	$15,111,832	6,147	$2,458
Cherokee	$8,296,885	3,085	$2,689
Chilton	$11,241,802	4,833	$2,326
Choctaw	$8,248,855	3,611	$2,284
Clarke	$13,228,575	6,756	$1,958
Clay	$7,769,671	2,408	$3,303
Cleburne	$5,001,229	1,929	$2,593
Coffee	$18,195,862	5,919	$3,074
Colbert	$19,456,200	7,450	$2,612
Conecuh	$7,769,671	3,627	$2,142
Coosa	$3,548,505	1,812	$1,958
Covington	$21,079,425	6,840	$3,082
Crenshaw	$8,549,899	2,881	$2,968
	Benefit Payments	**Eligibles**	**Payment Per Eligible**
Cullman	$30,700,796	9,340	$3,287
Dale	$18,052,539	7,407	$2,437

Dallas	$31,457,067	15,272	$2,060
Dekalb	$26,444,873	8,666	$3,052
Elmore	$23,903,976	6,871	$3,479
Escambia	$14,116,509	5,924	$2,383
Etowah	$48,696,644	15,074	$3,231
Fayette	$8,698,441	2,687	$3,237
Franklin	$15,787,355	5,047	$3,128
Geneva	$11,884,633	4,225	$2,813
Greene	$6,721,094	3,064	$2,194
Hale	$10,623,337	4,114	$2,582
Henry	$8,000,871	2,880	$2,778
Houston	$31,528,856	13,277	$2,375
Jackson	$19,990,864	7,372	$2,712
Jefferson	$221,133,686	82,906	$2,667
Lamar	$8,671,723	2,413	$3,130
Lauderdale	$30,229,566	9,657	$3,594
Lawrence	$10,741,435	4,382	$2,451
Lee	$25,081,358	10,490	$2,391
Limestone	$17,803,578	7,524	$2,366
Lowndes	$6,047,109	3,867	$1,564
Macon	$13,233,108	5,646	$2,344
Madison	$56,627,248	27,131	$2,087
Marengo	$11,322,860	5,371	$2,108
Marion	$13,206,434	3,837	$3,442
Marshall	$33,983,589	11,523	$2,949
Mobile	$162,091,259	65,259	$2,484
Monroe	$9,784,975	4,356	$2,246
Montgomery	$85,670,337	38,464	$2,227
Morgan	$52,583,526	11,843	$4,440

Perry	$9,532,122	4,490	$2,123
Pickens	$12,167,606	4,526	$2,688
Pike	$15,145,986	6,517	$2,324
Randolph	$10,227,790	3,695	$2,768
Russell	$19,661,861	9,376	$2,097
St. Clair	$14,377,323	6,364	$2,259
Shelby	$17,740,811	5,720	$3,102
Sumter	$9,299,050	4,886	$1,903
Talladega	$35,012,026	14,123	$2,479
Tallapoosa	$21,495,365	6,710	$3,203
Tuscaloosa	$93,428,885	22,490	$4,154
Walker	$34,720,264	11,532	$3,011
Washington	$7,612,805	3,427	$2,221
Wilcox	$9,183,033	5,132	$1,789
Winston	$13,205,522	3,717	$3,553
Other	$829,922	158	$5,253

Revenue, Expenditures, and Prices

In FY 1997, Medicaid paid $2,203,135,718 for health care services to Alabama citizens. Another $48,394,452 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 1997 **Sources of Medicaid Revenue**	
Federal Funds	$1,560,627,071
State Funds	$690,903,099
Total Revenue	$2,251,530,170

FY 1997 **Components of Federal Funds (net)**	
Family Planning Administration	$203,669
Professional Staff Costs	$2,013,382
Other Staff Costs	$24,865,180
Other Provider Services	$1,527,015,833
Family Planning Services	$6,529,007
Total	$1,560,627,071

FY 1997 **Components of State Funds (net)**	
Encumbered Balance Forward	$2,892,605
Basic Appropriations	$181,294,453
Public Hospital Transfers and Alabama Health Care Trust Fund	$409,141,188
Other State Agency	$95,816,549
Interest Income From Fiscal Agent	$28,031
UAB(Transplants)	$544,895
Miscellaneous Received	$419,478
Subtotal	$690,137,199
Encumbered	$766,500
Total	$689,370,699

FY 1997
EXPENDITURES
By Type of Service (net)

Service	Payments	Percent of Total Payments
Hospitals:	$830,205,817	37.68%
Disproportionate Share	$417,458,000	18.95%
Inpatient	$322,106,019	14.62%
Outpatient	$70,608,365	3.20%
FQHC	$15,197,963	0.69%
Rural Health Clinics	$4,835,470	0.22%
Nursing Homes	$519,147,385	23.56%
Waivered Services:	$193,113,996	8.77%
Pregnancy Related	$83,483,022	3.79%
Elderly & Disabled	$32,867,857	1.49%
Mental Health	$73,925,387	3.36%
Homebound	$2,837,784	0.13%
SCCLA	$54	0.00%
Pharmacy	$177,411,210	8.05%
Physicians:	$151,247,061	6.87%
Physicians	$110,271,269	5.01%
Physician's Lab and X-Ray	$17,768,389	0.81%
Clinics	$18,066,415	0.82%
Other Practitioners	$5,140,988	0.23%
MR/MD:	$74,185,960	3.37%
ICF-MR	$58,291,411	2.65%
NF-MD Illness	$15,894,549	0.72%
Insurance:	100,181,476	4.55%
Medicare Buy-In	$80,642,592	3.66%
Managed Care	$18,245,749	0.83%
PCCM	$625,158	0.03%
Human QMB Plan	$445,539	0.02%
Catastrophic Illness Insurance	$222,738	0.01%

Health Services	$50,509,551	2.29%
Screening	$17,975,981	0.82%
Laboratory	$10,784,657	0.49%
Dental	$10,061,777	0.46%
Transportation	$6,249,521	0.28%
Eye Care	$3,355,460	0.15%
Eyeglasses	$1,454,194	0.07%
Hearing	$358,388	0.02%
Preventive Education	$269,573	0.01%
Community Services:	$65,268,118	2.96%
Home Health/DME	$22,067,664	1.00%
Family Planning	$7,254,452	0.33%
Targeted Case Management	$30,801,100	1.40%
Hospice	$5,144,902	0.23%
Mental Health Services	$41,865,144	1.90%
Total for Medical Care	**$2,203,135,718**	100.00%
Administrative Costs	$48,394,452	
Net Payments	**$2,251,530,170**	

Population

The population of Alabama grew from 3,893,888 in 1980 to 4,040,587 in 1990. In 1997, Alabama's population was estimated to be 4,141,341. 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 15.3% in FY 1997.

More significant to the Medicaid program was the rapid growth of the elderly population. Census data shows that, in the United States, the 65 and older population grew twice as fast as the general population from 1970 to 1990. This trend is reflected in population statistics for Alabama. Population projections published by the Center for Business and Economic Research at the University of Alabama reveal that by 2000 there will be 570,814 persons 65 years of age and older in the state. The Center for Demographic and Cultural Research at Auburn University at Montgomery reports that white females 65 years of age and older account for almost one half of the elderly population in the state. Historically, Medicaid's costs per eligible have been higher for this group than for other groups of eligibles.

FY 1995-1997
POPULATION
Eligibles as a Percent of Alabama Population by Year

Year	Population	Eligibles	Percent
1995	4,113,525	631,916	15.4%
1996	4,127,562	635,568	15.4%
1997	4,141,341	632,472	15.3%

Eligibles

During FY 1997 there were 632,472 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 496,938. The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

Although 632,472 people were eligible for Medicaid in FY 1997 only 78 percent were eligible for the entire year. The length of time the other 22 percent of Medicaid eligibles were covered ranged from one to eleven months.

FY 1997 Eligibles Monthly Count	
October '96	502,008
November	501,095
December	496,506
January '97	497,059
Febuary	499,651
March	500,193
April	499,723
May	499,037
June	497,434
July	494,859
August	479,185
September	496,509

Medicaid Eligibles by Aid Category & County
A Microsoft Excel spreadsheet (13k) showing the number of Medicaid eligibles in each of Alabama's 67 counties broken out by aid category (e.g., aged, disabled, SOBRA, etc.) can be downloaded.

Recipients

Of the 632,472 persons eligible for Medicaid in FY 1997, about 87 percent actually received care for which Medicaid paid. These 550,772 persons are referred to as recipients. The remaining 81,700 persons incurred no medical expenses paid for by Medicaid.

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

FY 1997
RECIPIENTS
Monthly Averages and Annual Total

Category	Monthly Average	Annual Total
Aged	51,073	85,162
Blind	1,022	1,470
Disabled	97,212	146,459
Dependent	48,797	161,687
SOBRA	82,815	229,317
All Categories(unduplicated)	280,496	550,772

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 1997 was $80. The yearly average number of days for recipients of this service was 275. 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 1997 paid a monthly buy-in fee to Medicare of $43.80 per eligible Medicare beneficiary. The Medicaid Agency also paid from $311.00 to $342.10 per month Part-A buy-in premiums for certain Medicare eligibles. Medicaid paid a total of $81 million in Medicare buy-in fees in FY 1997. 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 appears 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 more than doubled the dollars recovered this year compared to last year.

FY 1997 PROVIDER REVIEWS	
Medical Providers Reviewed	278
Pharmacies Reviewed	83
Medical Provider Recoveries	$2,021,006
Pharmacy Recoveries	$68,017

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 his medical condition. The recipient is locked in to 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.

FY 1997 RECIPIENT REVIEWS	
Reviews Conducted	861
Monthly Average of Resticted Recipients	341
Cost Avoidance	$239,014

During FY 1997 Medicaid investigators closed 235 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, 1996 Medicaid benefits have been suspended for 140 recipients. At the present time, a total of approximately 1,700 recipients are suspended from the Medicaid program for fraud and/or abuse. In addition, 18 recipients were referred to local district attorneys for prosecution, of which eight indictments or convictions have resulted.

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 recent error rate was within a comfortable margin below the three percent maximum for the six month period from April to September 1997. This projection was based on the actual payment error rate of approximately 1.75 percent for the previous year. Nationally, Alabama has consistently been among those states with the lowest payment error rate.

Third Party Liability

Medicaid's Third Party Liability (TPL) Program is responsible for ensuring that Medicaid pays 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 such as health and liability insurance. The TPL Program also ensures that Medicaid recovers any costs incurred when available resources are identified through its liens and estate recovery programs as well as seeks reimbursement from recipients when Medicaid payments were made erroneously as a result of eligibility-related issues. 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.

Alabama's Third Party Division oversees a comprehensive TPL Program which was successful in saving Alabama taxpayers approximately $55 million in FY 97 and over $370 million since 1988. This has been done through a combination of cost avoidance of claims where providers file with the primary payor first, direct billing of third party payors for reimbursement to Medicaid, continuation of private health insurance coverage for certain Medicaid recipients, recovery of Medicaid's costs through estate recovery and liens activity, monitoring of Medicare edits, and recoupment from recipients of incorrectly paid claims due to ineligibility.

Significant accomplishments for the TPL Program in FY 1997 included substantial expansion of cost avoidance edits for prescription drug claims, expansion of electronic billing to third party payors in lieu of paper billing; and development of procedures to expand the estate recovery program.

Health Insurance Resources

In FY 1997 approximately, 13% of Medicaid recipients under the age of 65 were covered by some type of health insurance. The majority of these recipients were covered by group health insurance through their own employers or those of parents or spouses. A significant number of the plans offered by these employers require their insured to use participating providers and obtain precertification of certain services, resulting in substantial savings to Medicaid. For individuals age 65 and older, approximately 20 percent were covered by a Medicare supplement or other health plan prior to 1991. Since that time, however, there has been a significant decrease in the number of recipients who carry a Medicare supplement policy. This decrease began after laws were enacted preventing insurers from selling Medicare supplements to individuals who already had a supplement to Medicare. Since Medicaid was defined in this legislation as a supplement, insurers are now prohibited from selling these policies to individuals who have Medicare and Medicaid. As a result, third party savings for this group has dropped significantly.

In FY 1997, Medicaid's Third Party Division collected over $3.5 million in reimbursement from health insurance carriers. In addition, Medicaid returned to providers almost $37 million in claims due to health insurance edits. From these claims, Medicaid saved $4.4 million which providers reported collecting from health insurance carriers, and it is estimated that Medicaid saved an additional $5.5 million from claims paid in full by the primary payor and never submitted or resubmitted to Medicaid. In all, health insurance resources saved Medicaid, at a minimum, $13.4 million in FY 97.

Medicaid Buy-In

Medicaid purchases Medicare Parts A and B for eligible recipients. The Third Party Division oversees the payment of premiums for this coverage and ensures that Medicare benefits are used as a primary resource to Medicaid. In FY 1997, Medicaid denied over $27 million in claims which were submitted to Medicaid without first being paid by Medicare. In addition, Medicaid recouped from providers over $8.6 million in claims which Medicare should have paid as primary payor.

Medical Support

Many Medicaid eligible children are also eligible for coverage of their medical care through a non-custodial parent'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 not covered by the NCP's health plan but could be. 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 1997 approximately $92,000 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

When Medicaid identifies recipients whose claims for treatment of an injury were paid by Medicaid, the Third Party Division is required to look for other sources which may pay for the recipient's medical care. Other sources of payment may include homeowner's, automobile, malpractice, or other liability insurance as well as payment by individuals such as restitution ordered by a court. Once a potential third party payor is identified, then Medicaid must seek reimbursement of payment for related medical bills paid by Medicaid. In FY 1997, Medicaid collected over $1,000,000 from liable third party payors.

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 Third Party Division's Recoupments Unit received 2,100 complaint reports from Medicaid's District Offices, TANF or SOBRA workers in FY 1997. The unit identified over $1.2 million for collection and collected over $840,000 in misspent dollars.

Estate Recovery and Liens

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 1997, the division's Liens Program recorded over 500 new TEFRA liens cases and collected a record $2.8 million. Also, in FY 1997 efforts were begun to expand Medicaid's Estate Recovery Program. Through this program, Medicaid can initiate collection against estates of individuals and recover Medicaid's costs for all claims incurred after the individual reached age 55. Through the efforts of this new program, 78 income trusts were recorded and approximately $49,000 was collected.

Premium Payment

When cost effective, Medicaid has the option of paying health insurance premiums on behalf of individuals who are unable to continue payment of their premiums because of loss of job or high cost of premiums. Many of the individuals enrolled in this program have lost employment and cannot afford to pay the high cost of COBRA premiums. This is a very effective program as it allows individuals with high cost medical conditions to continue to receive health care through their established providers, and at the same time it provides substantial savings to the Medicaid program. In FY 1997, premiums were paid for an average of 70 individuals each month resulting in savings to Medicaid of approximately $600,000. Individuals who have benefited from this program include pregnant women, accident victims and recipients diagnosed with hemophilia, cancer and HIV.

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 6,725 claims were manually reviewed during FY 1997 and over $84,000 was recouped.

Provider Audit/Reimbursement

The mission of the Provider Audit/Reimbursement Division is to monitor Agency expenditures in the major program areas (nursing facilities, alternative services, managed care plans, health maintenance organizations and other prepaid health plans) to ensure that only allowable costs are reimbursed. Provider Audit has three branches: Nursing Home Audit, Alternative Services Audit, and Quality Assurance/Reimbursement.

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 is completed at least once every five years, and for all ICF/MRs at least once every three years. During FY 1997, this unit completed 38 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 Control Unit with the information.

Quality Assurance/Reimbursement performs desk reviews/audits of nursing home costs and makes adjustments to set nursing home reimbursement rates, recomputes reimbursement rates due to audit findings, and computes over/underpayments based on audits, additional information, etc. The unit also analyzes data necessary for determining capitated rates for managed care plans, health maintenance organizations and other prepaid health plans and reviews all audits performed by nursing home auditors and alternative services auditors for compliance with generally accepted accounting principles and systems, and state/federal regulations.

Limited scope financial audits of providers in selected waiver programs are performed by the Alternative Services Audit section. This section verifies revenue, expense, and other 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/Developmentally Disabled Waiver, and the Homebound Waiver. This section also sets rates for federally qualified health centers, provider based rural health clinics, targeted case management (adult protective services and foster children), children's specialty clinic services, and the Hospice Program using the provider's cost reports. Providers always have the right to appeal audit findings.

FY 1997 **COLLECTIONS AND MEASURABLE COST AVOIDANCE**	
COLLECTIONS	
DRUG REBATE PROGRAM The collection of rebates plus interest by the Fiscal Division from drug manufacturers for the use of their products. Claim Recoupment/Adjustments	$47,170,513 $86,675
THIRD PARTY LIABILITY Includes reported third party collections by providers, retroactive Medicare recoupments from providers, and collections due to healthand casualty insurance, estate recovery and misspent funds resulting from eligibility errors	$21,522,920
OTHER RECOUPMENTS Includes recoupments originating from monthly audits of 25 percent of Medicaid admissions in delegated hospitals and random audits of other hospitals.	$111,075
PROGRAM INTEGRITY DIVISION Provider Recoupments	$2,089,023
PROGRAM INTEGRITY DIVISION Tax Intercept Collections	$19.802
FISCAL AGENT/SYSTEMS AUDIT DIVISION Claim Collections	$84,386
TOTAL COLLECTIONS	$71,084,394
MEASURABLE COST AVOIDANCE	
PRIOR APPROVAL AND PREPAYMENT REVIEW Results from denials in psychiatric hospitals participating in Medicaid's Under 21 Psychiatric program	$49,106
THIRD PARTY CLAIM COST AVOIDANCE-MEDICARE Claims denied and returned to providers to file Medicare.	$27,076,643
THIRD PARTY CLAIM COST AVOIDANCE-HEALTH INSURANCE Claims denied and returned to providers to file health casualty insurance.	$36,822,264
THIRD PARTY PREMIUM PAYMENT COST AVOIDANCE	$591,622
WAIVER SERVICES COST AVOIDANCE-ELDERLY AND DISABLED	$105,744,492
WAIVER SERVICES COST AVOIDANCE-PREGNANCY RELATED	$6,251,000
WAIVER SERVICES COST AVOIDANCE-HOMEBOUND	$6,342,602
WAIVER SERVICES COST AVOIDANCE-MR/DD	$180,058,570
TOTAL MEASURABLE COST AVOIDANCE	$362,936,299
GRAND TOTAL	$434,020,693

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 1997 include implementation of the BAY Health Plan of Mobile, automation of posting payments from recipients that owe Medicaid money, conversion of the Bendex system for Year 2000, revision of the district office Annual Reviews, new baseline reporting systems for the Patient 1st program and for HEDIS measures, and the automation of Level III Pricing File Update Procedures. Changes also include new software development for HCFA-372 reporting for the Home and Community-based Service Waiver, a Managed Care Claims Statistics data base, electronic claims submission to CHAMPUS for Third Party, and completion of the Partnership Hospital Program (PHP) Quality Assurance project. In addition, a new system was created to accept quarterly data from the Department of Public Health to be incorporated into a Medicaid Maternity Waiver data base. Changes were required for the new MAC (Maximum Allowable Cost) Drug Program to allow dual pricing at both brand and generic levels. The expansion of acquisition cost and reimbursement amount fields within all the Drug Pricing and Claims records to allow proper drug pricing was completed for claims data from FY 1993 through FY 1997, and the Eligibility and State Data Exchange Systems were revised to incorporate new federal policies regarding termination of recipient benefits for the disabled population. A BAY Health Plan Financial Reporting System was created to fulfill requirements for the HCFA-64 Annual Report, revisions were made to report Patient 1st information on the Eligibility File, NET (Non-Emergency Transportation) on-line software was expanded to include additional data, and an automated SOBRA Annual Review System was created to save work time and effort by sending the review forms directly to the beneficiaries to fill out. The development of a new crosswalk for Medicaid “Z” procedure codes to standard CPT codes reduced the number of third party liability claims denied due to invalid procedure codes.

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 1997, Medicaid served 247,909 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; from 12.1 infant deaths per thousand births to 10.5 deaths per thousand in 1996.

Prenatal Care

The latest birth statistics revealed the number of births to women aged 10-19 decreased in Alabama from 11,175 in 1995 to 11,115 in 1996. There were 311 births to teenage women under 15 years of age, a decrease from 324 births in 1995.

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 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 recipients 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 18 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 327,000 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 injection. 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, begun 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 1997, there were 40 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, Henry, Houston, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Mobile, Montgomery, Pickens, Russell, Shelby, St. Clair, Tuscaloosa, Washington, Wilcox, and Winston. The waiver plans to expand so that eventually all Medicaid eligible pregnant women can participate in this innovative and successful approach to improving 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 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 six 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 postpartum 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 1,477 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.

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 EPSDT program is a Medicaid funded program available to all Medicaid eligible children under 21 years of age. The success of the program is fostered by the cooperation of the Alabama Medicaid Agency, the Department of Human Resources, the Department of Public Health, and Medicaid providers. Medicaid beneficiaries are made aware of EPSDT and referred to screening providers by eligibility workers at the Department of Human Resources, Medicaid District Office eligibility specialists, and SOBRA Medicaid outstationed workers located in health departments, hospitals, federally qualified health centers, and clinics throughout the state. The Medicaid Agency sends information to the parent or guardian of each child under 21, notifying them of the availability and benefits of the EPSDT program. Medicaid providers such as public health clinics also inform patients about the program.

Currently there are more than 1,953 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 the appropriate intervals between birth and age 21.

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 10,827.75 calls monthly during FY 1997 (more than 129,933 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 a.m. to 4:30 p.m. Monday through Friday. In FY 1997 the unit was staffed with four full time operators and Agency managerial staff (senior staff, directors and associate directors) who rotated assignments on a daily basis. Additionally, new Medicaid employees spent five days in the unit in order to be more fully acquainted with the Agency and the individuals it serves.

Managed Care

A managed care program called Patient 1st began operating in FY 1997. Patient 1st is a 1915(b) waiver that allows the Agency to link Medicaid beneficiaries with one primary care physician. This primary medical provider (PMP) is responsible for serving as a medical gatekeeper. The goal of Patient 1st is to create a medical home for Medicaid beneficiaries, thereby reducing inappropriate utilization of services, especially emergency room services. PMPs are required to contractually agree to certain program requirements including 24 hour a day/7 day a week overage, provision of EPSDT and immunizations, and participation in the quality assurance and grievance process.

Patient 1st was implemented in 17 counties during FY 1997 and plans are to have all counties (except Mobile) operational by October 1998.

Medicare HMOs and CPMs

Medicaid continued 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 must 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 1997, about $2.7 million was spent to provide services to approximately 15,500 clients.

On April 1, 1994, the mental health program was expanded to allow the Department of Human Resources and the Department of Youth Services to provide rehabilitative services to the children and adolescents in their custody. DHR and DYS are presently involved in the process of implementing the provisions of federal court consent decrees (R.C. and A.W., respectively). One of the critical mandates of both suits is the maximization of federal dollars, specifically Medicaid funding. DHR has become an active provider. On a monthly average during FY 1997, about $700,000 was spent to provide services to approximately 700 clients. A wide array of mental health services was 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), 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. Over 25,000 Medicaid beneficiaries received targeted case management service this year at a 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 disabled adults with specific medical diagnoses. 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 1997, there were 6,263 recipients served by this waiver at an actual cost of $4,294 per recipient. Serving the same recipients in nursing facilities would have cost the state $21,138 per recipient. This waiver saved the state $16,884 per recipient in FY 1997.

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 Public Health and the Alabama Commission on Aging.

HCBS Waiver for the Mentally Retarded and Developmentally Disabled (MR/DD)

This waiver serves individuals who meet the definition of mental retardation or developmental disability. 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 1997 there were 3,295 recipients served by this waiver at an actual cost of $18,448 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $77,094 per recipient. The MR/DD waiver saved the state $54,646 per recipient in FY 1997.

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 age 18 or above, and meet the nursing facility level of care. All income categories from SSI to 300% of SSI are included. The waiver is administered by the Department of Rehabilitative Services. 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 1997, there were 362 recipients served at a cost of $5,358 per recipient. Serving the same recipients in an institution would have cost the state over $22,879 per recipient. The state saved at least $17,521 per recipient in FY 1997 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 1997, the Medicaid Agency served 655 hospice patients at a total cost of about $5.5 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

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 173 agencies participating in FY 1997.

Up to 104 home health visits per year per recipient may be covered by Medicaid in Alabama. During FY 1997, over 6,000 recipients received visits costing a total of approximately $10 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 1997, over 700 Medicaid DME providers throughout the state furnished services at a cost of approximately $13 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 in other settings when activities such as school or other normal life activities take him or her away from the home. Private duty nursing services are covered for Medicaid recipients who have medical problems that require education of the primary caregiver and/or stabilization of the recipient's medical problem or problems. For Medicaid coverage, at least four hours of continuous skilled nursing care are required per day.

Private duty nursing services must be prior authorized by Medicaid. All services require monitoring on a regular basis, generally every 60 days, with the physician providing recertification of the continuing need for care. During FY 1997, Medicaid paid approximately $3 million for services provided through 53 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 remain a critical link in providing medically necessary health care to Alabama Medicaid recipients. A managed care initiative called the Partnership Hospital Program (PHP) changed the way hospital days are reimbursed in Alabama. 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. The PHP covers 112 Alabama hospitals in 66 counties. Not included in the PHP are Mobile county hospitals, 28 hospitals in neighboring states, four Under Age 21 Psychiatric hospitals, and one Over Age 65 Psychiatric hospital.

The objective of the managed care initiative was to provide inpatient hospital services to eligible Medicaid beneficiaries through arrangements that:

- Assure access to delivery of inpatient care.
- Promote continuous quality improvement.
- Include utilization review.
- Manage overall inpatient hospital care and efficiency.

Inpatient hospital days were limited to 16 days per calendar year in FY 1997. 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.

Quality Assurance Program

The Quality Assurance Program monitors inpatient hospital services for Alabama Medicaid recipients in accordance with federal regulations. Inpatient hospitalizations provided must be based on medical necessity. All admissions to psychiatric hospitals are reviewed and authorized to ensure that criterion has been met.

Medicaid's Quality Assurance function now monitors the activities of the PHP's internal Quality Assurance Committee in accordance with federal regulations. This monitoring function is accomplished through Semi-Annual Medical Reviews, Reliability Surveys, and Focused Study(ies) Reviews. The Quality Assurance Committee is also responsible for the handling of grievances, appropriate corrective action, follow-through and referral. In addition to on-site visits, the Quality Assurance Program reviews system generated data based on inpatient days utilized on a statewide basis.

Hospital admission reviews are designed to accomplish these goals:

- Ensure medically necessary hospital care to recipients.
- Ensure medically necessary hospital care to recipients.
- Identify funds expended on inappropriate services.

Outpatient Services

There were also limitations on outpatient hospital services during this fiscal year. Medicaid pays 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 approved outpatient surgical list.

FY 1993-1997
Hospital Program
Outpatients

	FY '93	FY '94	FY '95	FY '96	FY '97

Number of outpatients	214,568	225,568	229,622	249,712	265,030
Percent of Eligibles Using Outpatient Services	36%	37%	36%	39%	42%
Annual Expenditure for Outpatient Care	$35,960,064	$40,185,514	$42,466,443	$53,790,133	$67,965,193
Cost Per Patient	$168	$178	$185	$215	$256

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, and pregnant women 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 1997, there were four 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 1997 there were 25 ASC facilities 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 facility 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 facility, 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 facility. For these patients the hospital is reimbursed a daily rate equal to the average daily rate paid to nursing facilities 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 costs by using the centers' annual cost reports. At the end of FY 1997 there were 16 FQHCs enrolled as providers, with 83 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 1997 there were 33 independent rural health clinics (including four out of state) 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 based on their yearly cost reports. At the beginning of 1994 there were 11 PBRHCs enrolled as providers in Medicaid. There are now 30 PBRHCs enrolled as Medicaid providers.

Medical Services

Physicians Program

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. This service to beneficiaries, as with 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 facility 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 65 percent of Alabama's Medicaid eligibles received physicians' services in FY 1997.

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 by Medicare, less the applicable copayment amount.

FY 1997
PHYSICIAN PROGRAM
Use and Cost

	Payments	Recipients	Cost Per Recipient
Aged	$12,751,082	58,061	$220
Blind	$430,830	1,190	$362
Disabled	$57,584,460	118,248	$487
Dependent	$59,819,325	266,599	$224
All Categories	$130,585,697	417,330	$313

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 1997, pharmacy providers were paid approximately $226.6 million for prescriptions dispensed to Medicaid recipients. 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 $3.00, 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, almost 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 1997, over $47 million was collected. These rebates are used to offset increasing drug program expenditures.

The drug utilization review (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. The DUR process also enhances the quality of care received by Medicaid recipients by educating physicians and pharmacists with regard to issues concerning appropriateness of pharmaceutical care thereby minimizing expenditures.

During FY 1997, savings generated from the retrospective DUR process were approximately $1,346,430. The retrospective element of DUR is complemented 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, therapeutic duplication, 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.

FY 1995-1997
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*
1995	413,076	65%	7,352,754	17.80	$24.62	$438	$180,994,335
1996	412,757	65%	7,612,847	18.44	$26.77	$494	$203,794,120
1997	413,981	65%	7,976,383	19.27	$28.40	$587	$226,533,080

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

FY 1995-1997
PHARMACEUTICAL PROGRAM
Cost

Year	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx.	Net Cost Per Recipient
1995	$180,994,335	$33,979,616	$147,014,719	$19.99	$356
1996	$203,794,120	$35,792,661	$168,001,459	$22.07	$407
1997	$226,533,080	$47,170,513	$179,362,567	$22.49	$433

FY 1997
PHARMACEUTICAL PROGRAM
Counts of Providers by Types

Retail	1,355
Institutional	3
Governmental	0
Dispensing Physician	0
Total	***1,358***

Eye Care Program

Medicaid's Eye Care program provides beneficiaries 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 1997, Medicaid extended its current contract for another year. The contractor is required to furnish eyeglasses that meet federal, state and Agency standards. The selection of frames includes styles for men, women, teens, and preteens.

FY 1997
EYE CARE PROGRAM
Use and Cost

	Payments	Recipients	Cost Per Recipient
Optometric Service	$3,594,056	62,537	$57
Eyeglasses	$1,197,582	39,943	$30

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.

FY 1995-1997
LAB and X-RAY PROGRAM
Use and Cost

Year	Payments	Recipients	Annual Cost Per Recipient
1995	$10,235,259	170,659	$60
1996	$11,074,885	187,349	$59
1997	$10,616,907	188,587	$56

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.

Medicaid financed 65 percent of all nursing home care in the state during FY 1997. The total cost to Medicaid for providing this care was over $523 million. Almost 96 percent of the 226 nursing homes in the state accepted Medicaid recipients as patients in FY 1997. There were also 20 hospitals in the state during FY 1997 that had long term care beds, called swing beds, participating in Medicaid.

In the past all Medicaid patients 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 no longer have to apply any of their income toward the cost of the Medicare coinsurance for nursing home care. The coinsurance is 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 are covered.

FY 1995-1997
LONG-TERM CARE PROGRAM
Number and Percent of Beds Used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	% of Beds Used by Medicaid in an Average Month
1995	23,798	15,902	66.8%
1996	24,305	16,112	66.3%
1997	25,497	16,696	65.5%

FY 1995-1997
LONG-TERM CARE PROGRAM
Patients, Months, and Costs

Year	Number of Nursing Home Patients Unduplicated Total	Average Length of Stay During Year	Total Patient Days Paid for By Medicaid	Average Cost Per Patient Per Day By Medicaid	Total Cost to Medicaid
1995	21,959	276	6,053,127	$70	$426,185,003
1996	22,755	273	6,219,387	$71	$444,142,454
1997	23,656	275	6,511,241	$80	$532,034,923

FY 1997
LONG-TERM CARE PROGRAM
Recipients and Payments by Sex, Race, and Age

	Recipients	Payments	Cost Per Recipient
BY SEX:			
Female	18,361	$411,553,801	$22,415
Male	5,295	$111,481,122	$21,054
BY RACE:			
White	18,266	$398,440,567	$21,813
Non-white	5,390	$124,594,356	$23,118
BY AGE:			
0-5	19	$705,824	$37,149
6-20	113	$4,629,712	$40,971
21-64	1,910	$46,127,863	$24,151
65 & Over	21,614	$471,571,522	$21,818

Long Term Care for the Mentally Retarded and Mentally Disabled

The Alabama Medicaid Agency, in coordination with the Department of Mental Health and Mental Retardation, includes coverage for Medicaid-eligible mentally retarded and mentally diseased persons who require care in Intermediate Care Facilities (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, the Lurleen B. Wallace Developmental Center in Decatur, and the W.D. Partlow Developmental Center in Tuscaloosa. In FY 1997 the average reimbursement rate per day in an institution serving the mentally retarded was $241.48.

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 1997, the Glenn Ireland II Developmental Center was closed with the majority of its residents being transferred to community group homes.

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 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 1997, 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.

FY 1997 **Long-Term Care Program** **ICF-MR/DD**		
	ICF/MR	ICF/MD-Aged
Recipients	837	476
Total Payments	$58,298,287	$15,902,225
Annual Cost Per Recipient	$69,651	$33,408

Alabama Medicaid and AIDS

During FY 1997, there were 530 new AIDS cases reported in Alabama making a cumulative number of cases reported totaling 4,644. Of this number, 1,112 (24 percent) received services funded by Medicaid. Expenditures for AIDS -related cases in FY 1997, including prescription drugs, hospitalization and medical services totaled nearly $8 million.

Educating the public about AIDS continues through the Facts From Your Pharmacist: Answers about AIDS. Through this program, educational brochures and information are available to the general public in participating pharmacies statewide. In addition, Alabama received 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 have been made available through the U. S. Agency for Health Care Policy and Research to Medicaid providers.

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

A large share of expenditures for services for AIDS patients goes for inpatient hospital care. In 1997, Medicaid provided inpatient care totaling approximately $668,000. As AIDS progresses, infected patients are more likely to receive medication to treat opportunistic infectious diseases. Adult AIDS patients can easily exhaust their hospital limit of 16 inpatient days per year.

Prescription Drugs

The largest share of expenditures for HIV+ individuals and persons with AIDS is represented by drugs used to prolong life and health. Because of the high cost and the number of drugs available to treat AIDS-related infections, drugs represent the fastest growing Medicaid expenditure for AIDS patients. While the number of claims remained fairly stable, drug expenditures increased to nearly $4 million for the past year.

Home and Community Based Waiver Program

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

Targeted Case Management

Case management services are provided to beneficiaries 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.