1999 Annual Report

Introduction:

Statistical Topics:

Topics of Review:

Recipient Inquiry Unit

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- Maternity Care Program
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- Targeted Case Management

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Long-Term Care

Long-Term Care for the Mentally Retarded/Mentally Disabled

Highlights

Introduction

During FY 1999 Medicaid worked cooperatively with other state agencies in order to accomplish the Governor's goal of making sure that every child in Alabama has health insurance. Managed care continued to be a priority for the agency as the Patient 1st program was expanded to additional counties, a targeted case management component was added to Patient 1st and the Maternity Waiver program was changed to a state plan program. Services to the elderly population were expanded when the Non-Emergency Transportation program was made available to nursing facility residents. The agency was also awarded a March of Dimes grant, which will continue our efforts to improve birth outcomes in the state.

ALL KIDS Joint Application Helpful

When ALL KIDS, the second phase of the first Children's Health Insurance Program (CHIP) in the nation, began just prior to FY 1999, the Alabama Medicaid Agency and the Department of Public Health had already developed a joint application for Medicaid and ALL KIDS.

By using this joint application, Medicaid is able to screen applications referred to us by the State Employees Insurance Board (SEIB) for Medicaid eligibility. Applications that are above the Medicaid income limits are then forwarded for ALL KIDS processing. Applications that are found to also be ineligible for ALL KIDS are forwarded to the Alabama Caring Program for Children, a charitable foundation of Blue Cross/Blue Shield of Alabama.

During the period of time the CHIP has been operational, enrollment of SOBRA children has increased from 202,491 at the end of FY 1997 to 255,974 at the end of FY 1999.

Patient 1st Operating in 66 Counties

The last few counties enrolling in Patient 1st, Jefferson, Monroe, and Baldwin took place near the beginning of FY 1999. With this expansion, the program was in 66 counties and served over 300,000 eligibles monthly.

The emphasis of the program so far has been on implementation activities and establishing networks of care by which the beneficiaries can be served. The focus for the coming year will be education of providers and beneficiaries. The focal point of the beneficiary education will be understanding the system and how the system can enhance and benefit the physician-patient relationship. Provider education will be aimed at understanding the Patient 1st system and identifying ways the Agency can better help its providers manage their patients.

Addition of Targeted Case Management to Patient 1st Program

During FY 1999 the Health Care Financing Administration (HCFA) approved an amendment to the Targeted Case Management Program, which added a case management component to Patient 1st. The case managers assist recipients in complying with their medical regimen by arranging needed services, such as transportation to physician visits, or contacting social support agencies on behalf of the recipient as indicated by the physician.

Maternity Program Changes Names

In an effort to combat Alabama's high infant mortality rate, the Medicaid Agency has been providing care to pregnant women since 1988,through a 1915b waiver called the Maternity Waiver Program. The Balanced Budget Act of 1997 gave Medicaid the authority to convert the Maternity Waiver Program into a State Plan based program. Although the program has changed from a waiver to an operational program, many of the same components are present under the Maternity Care Program. The program will continue to ensure that eligible pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through a network established by contractors.

The program was implemented in phases with the first district starting in June of 1999 and the last ones starting in October of 1999. The Agency anticipates that this program will continue to be successful and further increase the number of good birth outcomes in the State of Alabama.

Expansion of Non-Emergency Transportation Services

On July 1, 1999 Medicaid expanded its coverage of non-emergency transportation for Medicaid recipients in nursing facilities. Coverage is provided to beneficiaries who are being transported to an appointment for a Medicaid covered service, and who have not exhausted their benefit limitations for that service. There are two levels of transportation covered under the program: transport for ambulatory patients and wheel chair van transport.

Medicaid Receives March of Dimes Grant for Educational Project

Medicaid was awarded a March of Dimes Grant to educate high-risk women about HIV and STDs. During FY 1999 Medicaid began work with the AUM School of Nursing to develop educational protocol and to train physicians on how to effectively use the an educational materials. The goal of the project is to 1) provide beneficiaries and potential beneficiaries with accurate, understandable information regarding family planning and STD/HIV prevention and 2) provide counseling to all high risk Medicaid eligible women.

Looking Ahead

At the start of the new fiscal year the Medicaid Agency faced several challenges. On October 1, 1999 the BAY Health program ended and work began to convert Mobile County to Patient 1st. As this report goes to press, that conversion has been successfully completed. Another challenge taking place at the beginning of the new fiscal year was the conversion to a new Medicaid Management Information System (MMIS) under a new fiscal agent contract with EDS. During

FY 1999 many hours of staff time were spent preparing for this conversion, and work continued into FY 2000 training employees and making changes to the new system. At the same time that Agency employees were involved in the new MMIS, preparations were being made for Y2K conversion. The Alabama Medicaid Agency was well prepared and the Y2K conversion presented no problems.

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 1999, 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, Medicaid will make a determination 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 up to age 19 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. 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) and Qualifying Individuals-1 (QI-1) have low income above the QMB limit. Persons in this group may be eligible to have their Medicare Part B premiums paid by Medicaid. Medicaid District Offices determine eligibility for these programs.
- The Qualifying Individual-2 (QI-2) program assists with a small portion of the Medicare premium for people with incomes below 175% of the federal poverty level. This program has limited funds and is provided on a first come first served basis. Medicaid District Offices determine eligibility for the QI-2 program.
- 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 50 and 64 who are not eligible for Medicare Part A and who have lost SSI because of receiving widows/widowers benefits from Social Security can qualify for Medicaid. Medicaid District Offices determine eligibility for this group.

Persons in most categories may receive retroactive Medicaid coverage if medical bills were incurred in the three months prior to the application for Medicaid or in the two months prior to eligibility for SSI and if they meet all requirements for that category in those months (exceptions are: QMB and HCBS waiver beneficiaries).

Persons in most categories may receive retroactive Medicaid coverage if medical bills were incurred in the three months prior to the application for Medicaid or the receipt of the first SSI check and if they meet all requirements for that program in those months (exceptions are: QMB and HCBS waiver beneficiaries).

Some persons in eligibility categories are protected by federal law from losing their Medicaid benefits:

- Continuous Medicaid (sometimes referred to as the Pickle program) keeps people on Medicaid who lose SSI eligibility because of a cost of living increase in the Social Security benefit and continue to meet all other SSI eligibility factors. The Medicaid District Offices processes applications for Continuous Medicaid.
- Disabled Adult Children (DAC) may retain Medicaid eligibility if they lose eligibility because of an entitlement or increase in a child's benefit, providing they meet specific criteria and continue to meet all other SSI eligibility factors. Medicaid District Offices process applications for DAC cases.

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 two 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 1999, Medicaid paid $2.5 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 $7.5 billion worth of business in Alabama in FY 1999.

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 97 percent of the Agency's budget goes toward purchasing services for beneficiaries.

FY 1999
COUNTY IMPACT
Year's Cost Per Eligible

	Benefit Payments	Eligibles	Payment Per Eligible
Autauga	$10,164,451	4,932	$2,061
Baldwin	$31,340,664	12,730	$2,462
Barbour	$15,107,670	6,215	$2,431
Bibb	$7,090,723	3,331	$2,129
Blount	$14,901,840	5,492	$2,713
Bullock	$8,549,042	3,430	$2,492
Butler	$14,036,006	5,457	$2,572
Calhoun	$48,063,292	18,403	$2,612
Chambers	$16,586,637	6,413	$2,586
Cherokee	$10,021,585	3,582	$2,798
Chilton	$11,558,991	5,017	$2,304
Choctaw	$8,887,131	3,664	$2,426

Clarke	$14,912,144	7,092	$2,103
Clay	$9,134,219	2,501	$3,652
Cleburne	$5,545,135	2,150	$2,579
Coffee	$19,992,788	6,350	$3,148
Colbert	$21,873,627	8,398	$2,605
Conecuh	$9,097,194	3,963	$2,296
Coosa	$3,657,202	1,824	$2,005
Covington	$23,602,374	7,385	$3,196
Crenshaw	$10,172,210	3,032	$3,355
	Benefit Payments	**Eligibles**	**Payment Per Eligible**
Cullman	$34,801,553	10,423	$3,339
Dale	$20,323,995	7,790	$2,609
Dallas	$32,547,487	15,877	$2,050
Dekalb	$31,125,122	9,939	$3,132
Elmore	$26,472,974	7,074	$3,742
Escambia	$16,075,584	6,689	$2,403
Etowah	$55,160,870	15,643	$3,526
Fayette	$9,557,189	2,957	$3,232
Franklin	$17,234,279	5,431	$3,173
Geneva	$14,085,792	4,807	$2,930
Greene	$7,027,022	2,969	$2,367
Hale	$11,687,268	4,464	$2,618
Henry	$8,468,574	2,971	$2,850
Houston	$35,857,476	14,862	$2,413
Jackson	$21,297,727	7,690	$2,770
Jefferson	$228,442,423	82,230	$2,778
Lamar	$10,246,319	2,589	$3,958
Lauderdale	$33,481,211	10,886	$3,076
Lawrence	$11,957,538	4,508	$2,653
Lee	$30,605,992	11,631	$2,631

Limestone	$18,959,774	7,398	$2,563
Lowndes	$6,062,485	3,949	$1,535
	Benefit Payments	**Eligibles**	**Payment Per Eligible**
Macon	$13,222,848	5,754	$2,298
Madison	$61,321,168	24,788	$2,474
Marengo	$12,488,315	5,589	$2,234
Marion	$14,366,898	4,170	$3,445
Marshall	$36,667,167	13,287	$2,760
Mobile	$177,471,304	66,592	$2,665
Monroe	$10,705,852	4,782	$2,239
Montgomery	$92,531,498	39,380	$2,350
Morgan	$58,225,656	12,449	$4,677
Perry	$9,782,693	4,539	$2,155
Pickens	$13,782,402	4,738	$2,909
Pike	$17,133,501	7,044	$2,432
Randolph	$11,070,988	3,960	$2,796
Russell	$22,613,714	9,695	$2,333
St. Clair	$14,618,171	6,994	$2,090
Shelby	$19,680,913	5,484	$3,589
Sumter	$10,912,057	4,952	$2,204
Talladega	$38,156,557	14,771	$2,583
Tallapoosa	$25,515,182	7,298	$3,496
Tuscaloosa	$102,822,248	23,678	$4,343
Walker	$39,263,104	12,170	$3,226
Washington	$8,820,400	3,573	$2,469
Wilcox	$9,877,966	5,382	$1,835
Winston	$13,524,362	3,898	$3,470
Other	$1,586,930	384	$4,133

Revenue & Expenditures

In FY 1999, Medicaid paid $2,498,417,679 for health care services to Alabama citizens. Another $82,565,322 was expended to administer the program. This means that almost 97 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 1999 **Sources of Medicaid Revenue**	
Federal Funds	$1,774,858,862
State Funds	$799,215,982
Total Revenue	$2,574,074,844

FY 1999 **Components of Federal Funds (net)**	
Family Planning Administration	$89,311
Professional Staff Costs	$7,399,128
Other Staff Costs	$45,796,800
Other Provider Services	$1,716,457,845
Family Planning Services	$5,115,778
Total	$1,774,858,862

FY 1999 **Components of State Funds (net)**	
General Fund Appropriations	$205,849,712
Public Hospital Transfers and Alabama Health Care Trust Fund	$455,622,743
Other State Agencies	$118,484,160
Drug Rebates	$15,298,954
UAB (Transplants)	$456,164
Miscellaneous Receipts	$3,504,249
Total	$799,215,982

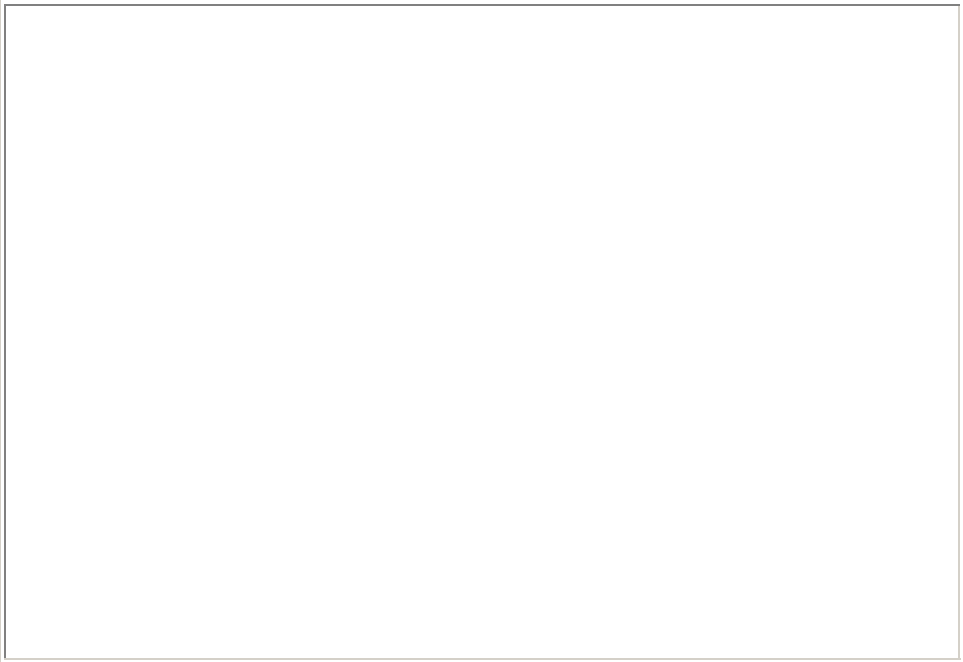
FY 1999 **Composition and Disbursement of Medicaid's Budget**

FY 1999

EXPENDITURES **By Type of Service (net)**		
Service	**Payments**	**Percent of Total Payments**
Hospitals:	$860,545,550	34.44%
Disproportionate Share	$388,335,499	15.54%
Inpatient	$406,711,963	16.28%
Outpatient	$47,811,861	1.91%
FQHC	$11,582,679	0.46%
Rural Health Clinics	$6,103,548	0.24%
Nursing Facilities	$570,237,131	22.82%
Waiver Services:	$213,446,386	8.54%
Maternity	$74,989,534	3.00%
Elderly & Disabled	$46,152,434	1.85%
Mental Health	$89,643,266	3.59%
Homebound	$2,661,152	0.11%
Pharmacy	$273,914,327	10.96%
Physicians:	$124,847,018	5.00%
Physicians	$91,964,951	3.68%
Physician's Lab and X-Ray	$13,952,110	0.56%
Clinics	$14,556,840	0.58%
Other Practitioners	$4,373,117	0.18%
MR/MD:	$777,516,278	3.10%
ICF-MR	$57,893,769	2.32%
NF-MD Illness	$19,622,509	0.79%
Insurance:	185,209,652	7.41%
Medicare Buy-In	$84,824,772	3.40%
Managed Care	$90,408,553	3.62%
PCCM	$9,040.801	0.36%
Humana QMB Plan	$334,594	0.01%
Medicare HMO	$388,164	0.02%
Catastrophic Illness Insurance	$212,768	0.01%
Health Services	$53,935,129	2.16%

Screening	$19,550,367	0.78%
Laboratory	$10,516,386	0.42%
Dental	$11,854,281	0.47%
Transportation	$6,390,673	0.26%
Eye Care	$3,103,417	0.12%
Eyeglasses	$1,819,293	0.07%
Hearing	$299,287	0.01%
Preventive Education	$401,425	0.02%
Community Services:	$77,228,539	3.09%
Home Health/DME	$34,883,832	1.40%
Family Planning	$6,699,039	0.27%
Targeted Case Management	$28,530,485	1.14%
Hospice	$7,115,183	0.28%
Mental Health Services	$61,537,669	2.46%
Total for Medical Care	**$2,498,417,679**	100.00%
Administrative Costs	$82,565,322	
Net Payments	**$2,580,983,001**	

FY 1999
Benefit Payments - Percent Distribution



Population

The population of Alabama grew from 3,893,888 in 1980 to 4,040,587 in 1990. In 1999, Alabama's population was estimated to be 4,351,999. 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 15.2% in FY 1999.

More significant to the Medicaid program now and in the future is the rapid growth of the elderly population. Census data show 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 United States Census Bureau reveal that between the year 2000 and the year 2025, the over 65 population will grow from 582,000 to 1,069,000 in Alabama. 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 1997-1999
POPULATION
Eligibles as a Percent of Alabama Population by Year

Year	Population	Eligibles	Percent
1997	4,141,341	632,472	15.3%
1998	4,155,080	637,489	15.3%
1999	4,351,999	659,489	15.2%

Eligibles

During FY 1999 there were 659,489 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 522,447. The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

FY 1999 Eligibles Monthly Count	
October '98	512,967
November	512,085
December	511,513
January '99	509,953
Febuary	511,898
March	525,909
April	527,729
May	530,492
June	526,352
July	530,311
August	534,454
September	535,701

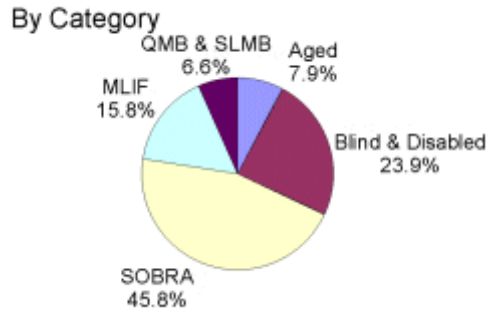
FY 1985 - 1999
Medicaid Eligibles and Recipients

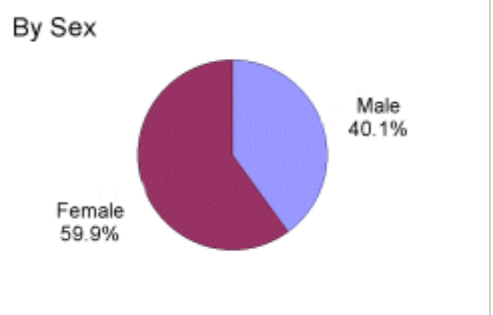
Medicaid Eligibles by Aid Category & County

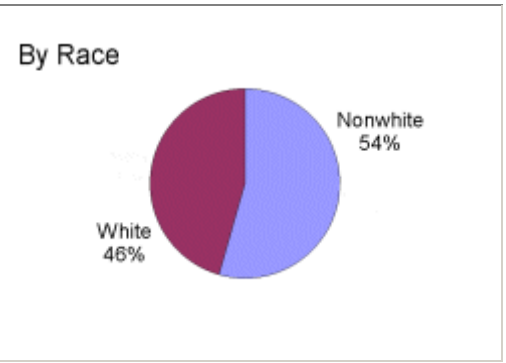
A Microsoft Excel spreadsheet (14k) showing the number of Medicaid eligibles in each of Alabama's 67 counties broken out by aid category (e.g., aged, disabled, SOBRA, etc.) can be downloaded .

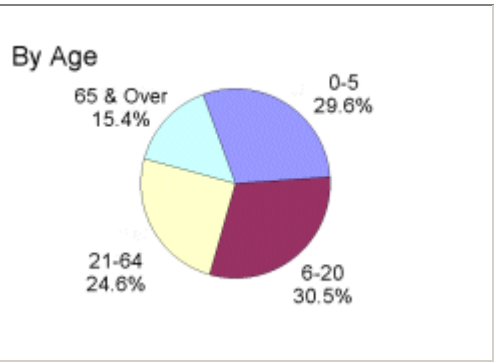
FY 1999
Percent of Population Eligble for Medicaid

FY 1999
Eligibles - Percent Distribution









Recipients

Of the 659,489 persons eligible for Medicaid in FY 1999, about 86 percent actually received care for which Medicaid paid. These 570,146 persons are referred to as recipients. The remaining 89,343 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 1999
RECIPIENTS
Monthly Averages and Annual Total

Category	Monthly Average	Annual Total
Aged	40,313	51,121
Blind & Disabled	102,473	155,083
SOBRA	106,419	293,788
MLIF	37,125	107,070
QMB & SLMBE	6,663	33,842
All Categories(unduplicated)	292,600	570,146

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 may receive, 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 1999 was $83. The yearly average number of days for recipients of this service was 274. Most recipients of long-term care are white females who are categorized as aged or disabled and are 65 years of age and over. It is not surprising that these groups have a large percentage of Medicaid payments made on their behalf.

Some low-income Medicare beneficiaries are eligible to have their Medicare premiums, deductibles, and coinsurance covered by Medicaid. For Part B coverage, Medicaid in FY 1999 paid a monthly buy-in fee to Medicare of $45.50 per eligible Medicare beneficiary. The Medicaid Agency also paid from $309.00 to $339.90 per month Part-A buy-in premiums for certain Medicare eligibles. Medicaid paid a total of $85 million in Medicare buy-in fees in FY 1999. 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 covering the premiums, deductibles, and coinsurance.

Y 1999
ayments - Percent Distribution

Y 1999
ost per Eligible
Category, Sex, Race, and Age

By Category	
By Sex	
By Race	
By Age	

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.

In the Provider Review Unit, statistical computer programs are used to identify patterns of potential overbilling or program abuse. Specially trained nurses then examine providers' Medicaid claims using computer programs and review of patient medical records. Both quality and quantity of services are examined. The primary purpose of this review process is to recover overpayments and identify potential Medicaid fraud and abuse.

FY 1999 PROVIDER REVIEWS	
Medical Providers Reviewed	196
Pharmacies Reviewed	533
Medical Provider Recoveries	$1,314,855

Corrective actions include recoupment of funds, education on proper billing procedures, and peer review by appropriate licensing authorities. There were 196 reviews completed in FY 1999 and recoupments for this period totaled over $1.3 million.

Intentional fraud cases are referred to the Attorney General's Medicaid Fraud Control Unit for legal action.

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 medications. Additional limitations may be placed on the recipient's ability to obtain certain drugs. Follow-up reviews are performed annually.

FY 1999 RECIPIENT REVIEWS	
Reviews Conducted	716
Monthly Average Number of Resticted Recipients	316
Cost Avoidance	$472,461

During FY 1999 Medicaid investigators closed 81 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, 1998 Medicaid benefits have been suspended for 242 recipients. At the end of FY 1999, a total of approximately 1,900 recipients are suspended from the Medicaid program for fraud and/or abuse. In addition, 23 recipients were referred to local district attorneys for prosecution. Ten referrals were adjudicated in FY 1999.

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 (HCFA) may impose 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 October 1998 to March 1999. Nationally, Alabama has consistently been among those states with the lowest payment error rates.

Prior Authorization Program

The mission of the Prior Authorization Program is to ensure that only medically necessary services are provided in a cost effective manner. The program constantly reviews its scope of responsibility in order to maximize efficient use of the resources of the program and the agency.

As a result of this review, prior authorization as a requirement was dropped on services/items for which there was no cost avoidance benefit (e.g., nebulizers). Working in conjunction with other programs within the agency, criteria for some items and services were changed to make the criteria more appropriate (e.g., apnea monitors).

The scope of this program has been enlarged to include prior authorization functions for newly covered services and for those services previously handled by other programs within our agency. New areas include prior authorization functions for Augmentative Communication Devices, Reduction Mammoplasties, Gastric Bypass surgeries, and Inpatient Psychiatric Services for recipients over 65 years of age and under 21 years of age. The program has also placed increased emphasis on educating Medicaid providers.

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 has been successful in saving Alabama taxpayers a minimum of $62 million in FY 99 and over $482 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, and continuation of private health insurance coverage for certain Medicaid beneficiaries. Money is also saved by recovery of Medicaid's costs through estate recovery and liens activity, monitoring of Medicare edits, and recoupments from beneficiaries of incorrectly paid claims due to ineligibility.

Health Insurance Resources

In FY 1999, some type of health insurance covered approximately 14% of Medicaid recipients under the age of 65. 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 15 percent were covered by a Medicare supplement or other health plan.

In FY 1999 Medicaid's Third Party Division collected over $4.6 million in reimbursement from health insurance carriers, and providers reported an additional $3.5 million in savings as a result of payments to them by primary health plans. In addition to these savings, $41 million in claims were returned to providers because of states edits that indicated potential primary health insurance coverage. It is conservatively estimated that, of this $41 million in claims, Medicaid saved a minimum of $6.1 million as a result of claims paid in full by the primary payor and never reported to Medicaid by providers. In all, primary health insurance resources saved Medicaid a minimum of $14.2 million and, potentially, $49 million.

Medicare Buy-In

Medicaid purchases Medicare Parts A and B for eligible beneficiaries. 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 1999, Medicaid denied over $38 million in claims that were submitted to Medicaid without first being paid by Medicare. In addition, Medicaid recouped from providers over $4 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, an NCP may be under a court order to reimburse Medicaid for medical bills paid by Medicaid on behalf of the dependent. In FY 1999 approximately $55,000 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 a recipient whose claims for treatment of an injury were paid by Medicaid, the Third Party Division is required to look for other sources that 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, Medicaid must seek reimbursement of payment for related medical bills paid by Medicaid. In FY 1999, Medicaid collected approximately $1.3 million 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 caseworkers. The Third Party Division's Recoupments Unit receives complaint reports from Medicaid and DHR workers. In FY 1999, the unit identified over $1.3 million for collection, and collected over $858,000 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 1999, the division's Liens Program recorded over 600 new lien cases and collected $2.6 million. Also, in FY 1999 Medicaid's Estate Recovery Program initiated collection against estates of individuals to recover Medicaid's costs for all claims incurred after the individual reached age 55. Through the efforts of this program, 215 income trusts were recorded and approximately $127,000 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 1999, premiums were paid for an average of 91 individuals each month resulting in savings to Medicaid of approximately $500,000. 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

The Fiscal Agent Liaison Division monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews of forced claims, denied claims, processed refunds and adjustments are also performed. In addition, targeted reviews of claims are performed when potential systems errors are found. During this fiscal year, approximately 3,050 claims were manually reviewed and $4,523 was identified for recoupment.

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, home offices, and all ICF/MR facilities is completed as necessary. During FY 1999, this unit completed 50 audits. 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 annual desk reviews/audits of nursing home and ICF/MR 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 providers' cost reports. Providers always have the right to appeal audit findings.

FY 1999 **COLLECTIONS AND MEASURABLE COST AVOIDANCE**	
COLLECTIONS	
DRUG REBATE PROGRAM The collection of rebates plus interest by the Fiscal Division from drug manufacturers for the utilization of their products	$49,522,291
THIRD PARTY LIABILITY Includes reported third party collections by providers, retroactive Medicare recoupments from providers, and collections due to health and casualty insurance, estate recovery, and misspent funds resulting from eligibility errors	$24,162,183
OTHER RECOUPMENTS Recoupments originating from audits of fee-for-service Medicaid inpatient admissions not meeting medically necessary criteria	$66,410
PROGRAM INTEGRITY DIVISION Provider Recoupments	$1,314,855
PROGRAM INTEGRITY DIVISION Tax Intercept Collections	$48,232
FISCAL AGENT/SYSTEMS AUDIT DIVISION Claim Corrections	$4,523
TOTAL COLLECTIONS	$75,118,494
MEASURABLE COST AVOIDANCE	
PRIOR APPROVAL AND PREPAYMENT REVIEW Results from prior authorization denials for various services/items requiring prior approval and not meeting medically needed criteria such as DME, Private duty Nursing, Inpatient Admissions or continued stays in specialized psychiatric hospitals (under 21 years of age or over age 65)	$2,581,759
THIRD PARTY CLAIM COST AVOIDANCE - MEDICARE Claims denied and returned to providers to file Medicare	$38,294,339
THIRD PARTY CLAIM COST AVOIDANCE - HEALTH INSURANCE Claims denied and returned to providers to file health casualty insurance	$35,043,647
THIRD PARTY PREMIUM PAYMENT COST AVOIDANCE	$500,000
WAIVER SERVICES COST AVOIDANCE - ELDERLY AND DISABLED	$98,537,582
WAIVER SERVICES COST AVOIDANCE - HOMEBOUND	$5,286,990
WAIVER SERVICES COST AVOIDANCE - MR/DD	$248,401,608
TOTAL MEASURABLE COST AVOIDANCE	$428,645,925
GRAND TOTAL	$503,764,419

Medicaid Management Information System

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

Major effort was made to make the Agency Year 2000 (Y2K) compliant. In house systems (systems not assigned to the fiscal agent) were made compliant and placed in production by July 31, 1999. Additional projects included the expansion of the eligibility file to accommodate the PCCM and Bay Health Plans, addition of the new 1998 ICD-9 diagnosis codes, and the creation of a new Maternity Program Patient Database. New values were added for prior authorization drug claims and the annual HCPCS and COLA processes were successfully completed. New federal poverty level enhancements and income ceiling amounts were incorporated for automated budgets. Documentation for the new fiscal agent contractor of systems covered by the Invitation to Bid (ITB) was completed.

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 of 1979. In June 1998, the Alabama Medicaid Agency and EDS signed a contract for a new Y2K compliant MMIS. The new MMIS was operational on October 1, 1999.

Maternal and Child Health Services

During FY 1999, Medicaid served 301,823 women and children through the expanded eligibility group for pregnant women and children called SOBRA (Sixth Omnibus Budget Reconciliation Act). Coverage of this group has contributed to an improvement in Alabama's infant mortality rate since 1989, from 12.1 infant deaths per thousand births to 10.2 deaths per thousand in 1998.

Prenatal Care

Competent, timely prenatal care has proven to result 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. The program curricula are designed to teach disease and disability prevention and to prolong life and promote physical and mental health. These classes go beyond the limited service and information offered under

existing Medicaid programs. Physicians or other licensed practitioners of the healing arts who present detailed adolescent pregnancy material provide these services.

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 16 providers of adolescent pregnancy prevention services. These include hospitals, county health departments, FQHCs, 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 335,000 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 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 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.P> The Department of Public Health is the lead agency in administering this program.

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 childbearing age, including minors who are sexually active and desire such services. The law also provides for 90 percent federal funding for these services. This is a higher match than for other Medicaid services.

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

Family planning services are covered for Medicaid eligible women, including SOBRA women 10-55 years of age and men of any age who desire such services. Recipients have freedom of

choice in selecting a contraceptive method and/or a provider of family planning services. Acceptance of family planning services must be without coercion or mental pressure.

Recipients are authorized one annual physical and up to four additional visits per calendar year. These visits do not count against other benefit limits. 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. HIV pre and post testing counseling services are also available if performed in conjunction with a family planning visit.

Providers include county health departments, federally qualified health centers, rural health clinics, private physicians and Planned Parenthood of Alabama. Family planning providers are available statewide.

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 1,620 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. With statewide implementation of the Patient 1st Program and BAY Health in Mobile County, primary care providers are obligated to ensure that all Medicaid recipients under 21 years of age receive screenings on time. It is anticipated that the number of screenings will increase due to this requirement.

In 1995, Medicaid added an off-site component of the EPSDT program. This allows 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. Licensed dentists provide all Medicaid dental services. These services are limited to those that 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 21,118 calls monthly during FY 1999 (more than 253,400 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 third of all calls deal with Primary Care Case Management (PCCM) provider assignment and about one-fourth are information-only calls. About 10 percent of calls deal with Medicaid card replacement and 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 1999 the unit was staffed with four full time operators and 9 temporary operators.

Managed Care

Partnership 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 this managed care initiative is 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 per calendar year in FY 1999. 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.

Patient 1st

The Patient 1st program expanded during FY 1999 into a total of 66 counties serving approximately 315,000 beneficiaries. The Patient 1st Program is a primary care case management system that links each participating Medicaid beneficiary with a Primary Medical Provider (PMP). The PMP is responsible for providing care directly or through referral. Additional responsibilities include 24-hour day/7 days a week coverage, coordination of EPSDT and immunizations, and coordination of medical needs.

The program has been successful in meeting its goal of creating medical homes for Medicaid beneficiaries. Access to a PMP has resulted in medical doctor shopping, more appropriate utilization of services, and reduced expenditures for primary care in an emergency room setting.

With the expansion of Patient 1st completed, the focus during FY 1999 moved toward patient and provider education. A video presentation for providers to show patients in their waiting rooms which explains the Patient 1st program was developed. This video includes information about how to access medical care, when to go to the emergency room, and instructions on contacting their PMP before going to other physicians or places for medical care. In addition to the video, new Patient 1st beneficiaries also receive a welcome packet with helpful information about how the program works.

BAY Health Plan (HMO)

BAY (Better Access for You) Health Plan represented the first comprehensive managed care program in the state for Medicaid beneficiaries. BAY Health Plan was administered by PrimeHealth, an Alabama-based health maintenance organization affiliated with the University of South Alabama. BAY operated under an 1115 research and demonstration waiver approved by the federal Health Care Financing Administration (HCFA) in December 1996. The program became operational in May 1997 and ended October 1, 1999.

Maternity Care Program

Since 1988, the Medicaid Agency has been providing care to pregnant women in an effort to combat Alabama's high infant mortality rate through a 1915b waiver called the Maternity Waiver Program. This program has been very successful in getting women to begin receiving care earlier and in keeping them in a system of care throughout the pregnancy. The end result has been increased numbers of prenatal visits and fewer neonatal intensive care days, which has resulted in healthier babies and decreased expenditures for the Agency.

The Balanced Budget Act of 1997 provided Medicaid the authority to convert the Maternity Waiver Program into a State Plan based program. Although the program has changed from a waiver to an operational program, many of the same components are present under the Maternity Care Program.

The program will continuous to ensure that eligible pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through a network established by Primary Contractors. Under this program, women are allowed to choose the Delivering Healthcare Provider of their choice to provide their delivery care. 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 needed services.

The Maternity Care Program has been expanded statewide with the exception of Mobile County which was part of BAY Health Plan during FY 1999. The state has been divided into 13 districts with one primary Contractor responsible for each district. It is anticipated that the program will serve approximately 27,000 women each year.

The program was implemented in phases with the first district starting in June of 1999 and the last ones starting in October of 1999. The Agency anticipates that this program will continue to be successful and further increase the number of good birth outcomes in the State of Alabama.

Managed Care Quality Assurance Program

The Managed Care Quality Assurance Program is responsible for monitoring and oversight of Quality Assurance Activities for Medicaid's Managed Care initiatives. During fiscal year 1999, Medicaid's Managed Care Initiatives included:

- PHP (Partnership Hospital Program)
- Bay Health Plan (Better Access for You)
- PCCM (Primary Care Case Management)
- MCP (Maternity Care Program)

Each Managed Care initiative is mandated to have an active Quality Assurance System with reporting requirements. Administrative aggregate systematic data collection of performance and patient results is a requirement. The System must provide for the interpretation of this data to the practitioners and provide for making needed changes. Each Plan's reports are monitored and reviewed by Medicaid on an ongoing basis. Findings may initiate a need for further review of

areas of interest, potential utilization and quality concerns. The System must also provide for review by appropriate health care professionals.

At a minimum, each Plan is required to designate an active Quality Assurance Committee within established guidelines. The Committee is formally delegated the responsibility to review potential quality concerns identified through the Quality Assurance Process and initiate appropriate corrective/preventative action. The Committee must track/follow potential and positive concerns until resolution is established. Complaints and grievances are reviewed and followed by the Committee with guidelines. Utilization Management issues are addressed and followed as well. The Quality Assurance monitoring and review process is an ongoing assessment that promotes quality improvements over time.

In addition to monitoring and oversight functions, Medicaid's Managed Care Quality Assurance Program must perform formal Annual Medical Audits to assure the Quality Assurance System activities are effective, meet standards, and within guideline compliance. The areas reviewed include administration, utilization management, quality activities, corrective actions, continuity/coordination of care, and complaints and grievances.

Medicare HMOs and CMPs

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 HCFA to enroll Medicare beneficiaries and other individuals and groups. The HMO or CPM 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. The HMO or CMP must offer all services covered by Medicare 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 by Medicaid, but not 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 1999, about $5.3 million was spent to provide services to approximately 16,000 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. Since May 1998, DYS has been an active provider. A wide array of mental health services is provided to children in state 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. Approximately 22,000 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 1999, there were 6,098 recipients served by this waiver at an actual cost of $6,612 per recipient. Serving the same recipients in nursing facilities would have cost the state $22,771 per recipient. This waiver saved the state $16,159 per recipient in FY 1999.

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 1999 there were 4,038 recipients served by this waiver at an actual cost of $21,994 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $83,510 per recipient. The MR/DD waiver saved the state $61,516 per recipient in FY 1999.

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, medical supplies, personal emergency response system, and assistive technology. During FY 1999, there were 354 recipients served at a cost of $7,836 per recipient. Serving the same recipients in an institution would have cost the state over $22,771 per recipient. The state saved at least $14,935 per recipient in FY 1999 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 1999, the Medicaid Agency served 976 hospice patients at a total cost of about $7 million. The expense was offset by a reduction in hospital costs for Medicaid.

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

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

Home Health and Durable Medical Equipment (DME)

Skilled nursing and home health aide services prescribed by a physician are provided to eligible homebound recipients on a part-time or intermittent basis. These services cover preventive, restorative, and supportive care to persons who meet Medicaid home health criteria. Nursing and personal care provided under the home health program must be certified by licensed physicians and provided by home health agencies under contract with Medicaid. There were 128 agencies participating in FY 1999.

Medicaid in Alabama may cover up to 104 home health visits per year per beneficiary. Medicaid may authorize additional home health visits for beneficiaries under age 21 who have exhausted the home health benefit of 104 nursing visits per calendar year. For approval, the service must be referred from an EPSDT screening and prescribed as medically necessary by a physician. During FY 1999, over 7,860 recipients received visits costing a total of approximately $22 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 1999, over 752 Medicaid DME providers throughout the state furnished services at a cost of approximately $12.5 million.

In-Home Therapies

Physical, speech, and occupational therapy in the home are 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 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 1999, Medicaid paid approximately $1 million for services provided through 46 private duty-nursing providers.

Medical Services

Outpatient Services

There were 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 1995-1999 Hospital Program Outpatients					
	FY '95	FY '96	FY '97	FY '98	FY '99
Number of outpatients	229,622	249,712	265,030	222,375	190,517
Percent of Eligibles Using Outpatient Services	36%	39%	42%	35%	29%
Annual Expenditure for Outpatient Care	$42,466,443	$53,790,133	$67,965,193	$38,175,343	$36,482,841
Cost Per Patient	$185	$215	$256	$172	$191

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 cornea transplants, which do not require prior approval, Medicaid benefits cover prior authorized heart transplants, lung, heart/lung, liver transplants,kidney, 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' 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 approved by the Joint Commission for Accreditation of Healthcare Organizations and with distinct units and separate treatment programs for children and adolescents can be certified to participate in this program. At the end of FY 1999, 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. Admissions to psychiatric hospitals are reviewed and authorized prior to payment to ensure that appropriate criteria have been met.

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 Agency and furnished to all ASCs. The Agency encourages outpatient surgery whenever possible. Ambulatory surgical centers must have an effective procedure for immediate transfer of patients to hospitals for emergency medical care beyond the capabilities of the center. Medicaid recipients are required to pay the designated copayment amount for each visit. At the end of FY 1999 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 no longer need that level of care. These patients needed to be placed in nursing facilities but for reasons such as lack of an available bed, or the level of care needed was such that they could not be accommodated 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 be 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 using Medicaid's fee schedule adjusted to reasonable cost. Medicaid establishes reasonable costs by using the centers' annual cost reports. At the end of FY 1999 there were 16 FQHCs enrolled as providers, with 97 satellite clinics.

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 1999 there were 35 independent rural health clinics 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 22 PBRHCs enrolled as Medicaid providers.

Physicians Services

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 58 percent of Alabama's Medicaid eligibles received physicians' services in FY 1999.

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 1999
PHYSICIAN PROGRAM
Use and Cost

	Payments	Recipients	Cost Per Recipient
Aged	$5,317,294	53,539	$99
Blind	$321,227	1,018	$316
Disabled	$48,095,469	113,099	$425
Dependent	$53,620,124	245,338	$219
All Categories	$107,354,114	389,005	$276

Pharmacy Services

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 1999, pharmacy providers were paid approximately $273 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 1999, over $49 million was collected. These rebates are used to offset increasing drug program expenditures.

The drug utilization review (DUR) process involves retrospective reviews conducted by the Alabama Quality Assurance Foundation under contract with the Medicaid Agency. 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.

Medicaid continues to operate a drug utilization review (DUR) program. 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 1997-1999
PHARMACEUTICAL PROGRAM
Use and Cost

Year	Number of Drug Recipients	Recipients as a % of Eligibles	Number of Prescriptions	Rx Per Recipient	Price Per Prescription	Cost Per Recipient	Total Cost to Medicaid*
1997	413,981	65%	7,976,383	19.27	$28.40	$547	$226,533,080
1998	397,041	62%	7,932,759	19.98	$29.85	$596	$236,819,290
1999	405,140	61%	8,487,157	20.95	$32.24	$675	$273,603,400

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

FY 1997-1999
PHARMACEUTICAL PROGRAM
Cost

Year	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx.	Net Cost Per Recipient
1997	$226,533,080	$47,170,513	$179,362,567	$22.49	$433
1998	$236,819,290	$36,677,093	$200,142,197	$25.23	$504
1999	$273,603,400	$49,522,291	$224,081,109	$26.40	$553

Eye Care Services

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 surgeons to optometrists for follow-up management.

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

FY 1999 EYE CARE PROGRAM Use and Cost			
	Payments	Recipients	Cost per Recipient
Optometric Service	$3,340,095	62,126	$54
Eyeglasses	$1,570,785	46,884	$34

Laboratory and Radiology Services

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. Each independent laboratory and free-standing facility must be approved by the appropriate licensing agency within the state in which it resides, be certified as a Medicare provider and sign a contract with the 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 1997-1999 LAB and X-RAY PROGRAM Use and Cost			
Year	Payments	Recipients	Annual Cost Per Recipient
1997	$10,616,907	188,587	$56
1998	$9,520,445	158,578	$60
1999	$10,355,256	149,460	$69

Renal Dialysis Services

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, there is wider range of sanctions 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 are 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 64 percent of all nursing home care in the state during FY 1999. The total cost to Medicaid for providing this care was over $560 million. Almost 96 percent of the nursing homes in the state accepted Medicaid recipients as patients in FY 1999. There were also 20 hospitals in the state during FY 1999 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 1997-1999
LONG-TERM CARE PROGRAM
Number and Percent of Beds Used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	Percent of Beds Used by Medicaid in an Average Month
1997	25,497	16,696	65.5%
1998	25,696	16,680	64.9%
1999	26,051	16,684	64.0%

FY 1997-1999
LONG-TERM CARE PROGRAM
Patients, Months, and Costs

Year	Number of Nursing Home Patients Unduplicated Total	Average Length of Stay During Year	Total Patient Days Paid for by Medicaid	Average Cost per Patient per Day to Medicaid	Total Cost to Medicaid
1997	23,656	275	6,511,241	$80	$523,034,923
1998	24,046	279	6,719,368	$79	$529,335,564
1999	24,592	274	6,730,139	$83	$559,981,886

FY 1999
LONG-TERM CARE PROGRAM
Recipients and Payments by Sex, Race, and Age

	Recipients	Payments	Cost per Recipient
BY SEX:			
Female	18,981	$441,626,329	$22,267
Male	5,611	$118,355,557	$21,093
BY RACE:			
White	18,719	$421,855,713	$22,536
Non-white	5,873	$138,126,173	$23,520
BY AGE:			
0-5	23	$832,932	$36,214
6-20	115	$4,899,383	$42,603
21-64	2,051	$50,487,621	$24,616
65 & Over	22,403	$503,761,951	$22,486

Long Term Care Quality Assurance

The Long Term Care Quality Assurance Program is designed to organize and provide direction for quality assurance activities for the purpose of monitoring and improving the quality and appropriateness of care to Medicaid recipients. The Long Term Care Quality Assurance Program provides oversight and monitoring for three Home and Community Based Waivers: the Elderly and Disabled Waiver, the Homebound Waiver and the Mentally Retarded and Developmentally Disabled Waiver.

Quality assurance is the process of monitoring and evaluating delivery of care and services to ensure that they are appropriate, timely, accessible, available and medically necessary. Oversight and monitoring refers to the appropriate implementation of services and evaluating of client satisfaction and optimal outcomes. The key components associated with oversight and monitoring include: 1) Access to care, 2) Community care, 3) Continuity of care, 4) Freedom of choice, 5) Health and welfare, 5) Optimal outcomes 7) Quality improvements, and 8) Client satisfaction. All of these assurances are monitored through annual on-site reviews, recipient satisfaction surveys, provider profiling, complaint and grievance tracking, and review of the administering agency internal quality assurance program. The program also approves any corrective actions for deficiencies that may be cited.

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 federal law. The programs provide treatment that 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 1999 the average reimbursement rate per day in an institution serving the mentally retarded was $234.57.

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 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 1999, in cooperation with the 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 1999 **Long-Term Care Program** **ICF-MR/DD**		
	ICF/MR	ICF/MD-Aged
Recipients	708	478
Total Payments	$59,125,391	$19,623,436
Annual Cost per Recipient	$83,510	$41,053