

Recent Changes in Health Policy for Low-Income People in Alabama

Barbara A. Ormond and Alyssa Wigton

Overview

In the past three years there has been renewed attention to health care in Alabama. The current governor, Donald Siegelman, elected in 1998, was the driving force behind Alabama's State Child Health Insurance Program (SCHIP) when he was lieutenant governor. Alabama's SCHIP, the first to be approved nationally, began in February 1998 as a Medicaid expansion, with a second phase that included a private insurance option starting in September 1998. Since becoming governor, Siegelman has turned his attention to long-term care for the elderly, particularly those with dementia. In addition, he has stated his commitment to expand home and community-based long-term care services for older people and younger persons with disabilities.

Alabama has made several important changes in recent years to increase access to health care for its low-income population. An aggressive and effective outreach program for SCHIP has resulted not only in strong SCHIP enrollment but also in increased enrollment of children in Medicaid. The state streamlined the enrollment and recertification process for Medicaid and other insurance programs for the uninsured poor to improve the take-up rate and enrollee retention and to reduce administrative costs. In addition, the state has raised Medicaid reimbursement rates for physicians and dentists in an effort to increase provider participation and improve access for enrollees.

Alabama's public programs continue to be constrained by the limited availability

of state revenues. The Medicaid program in particular is heavily dependent on inter-governmental transfers and disproportionate share hospital (DSH) payments and, in the past, has been subject to nearly annual budget crises.¹ A portion of tobacco fund revenues has been earmarked for the program and set aside in a trust fund against such shortfalls in the future. The tobacco-financed trust fund plus a carryover of some FY2000 funds into FY2001 have given the program a measure of financial security for the near future.

Officials say that the state is heading into an economic downturn. The events of September 11, 2001, have accelerated the downturn in the national economy. The deterioration in the overall economy will likely create fiscal problems for Alabama and may increase the general budgetary pressure. The Medicaid program budget has yet to be affected, although there are fears that the downturn will lead to increased program enrollment. Indeed, over the past year enrollment has increased somewhat faster than expected.

Given the low likelihood of increased resources for public programs, the governor sees improved fiscal management and greater accountability as a means to achieving his priorities without increasing spending. In addition, he emphasizes prevention in his policies in health and other areas as a way to contain costs.

Managed care penetration in the state remains low in both the private and the public sectors. The introduction of capitated managed care into the Medicaid program in 1997 failed to achieve the necessary

Under Governor Siegelman, there has been renewed attention to health, but the cost of expanding public programs means that progress is likely to come in small increments.

momentum in its pilot phase. Primary care case management has replaced the capitated program, with the goal of establishing a medical home for all Medicaid recipients.

Currently prominent health policy issues include stabilizing funding for the Medicaid program using tobacco fund revenues, investigating long-term care options other than nursing homes, increasing the participation of dentists in the Medicaid program, and simplifying the administration of public programs to contain administrative costs.

Motivation. This study of Alabama is part of a series of reports on 13 states that examines state priority setting, program operations, and health policy affecting the low-income population.² The past five years have given states new opportunities in health policy for low-income people but have also put new pressures on policy formulation. Many developments led to increased state flexibility, including welfare reform and delinking of Medicaid from cash assistance, new funding for children's health insurance coverage SCHIP, a repeal of federal minimum standards for nursing home and hospital reimbursement that had constrained states' control over Medicaid payments, and a federal willingness to grant waivers under Medicaid (and now under SCHIP). Fiscal capacity also rose from booming revenues during the long economic expansion of the 1990s and from new tobacco settlement funds.

However, new pressures on revenues and state policy arose from recent federal economizing under Medicaid and Medicare, notably including cuts in safety net support, which was believed to have been abused by some states; political pressures for state tax cuts; and, starting in 2001, an economic slowdown and fears of recession. New pressures also arose from the Supreme Court's *Olmstead* decision that detailed a right to home and community-based services under the Americans with Disabilities Act, rapid growth in pharmaceutical spending, and the difficulties faced by Medicaid managed care. Political demands for public action arose from developments such as the rise in uninsurance, growth in private and public managed care, rising pharmaceutical costs, hospital fiscal woes, and from events specific to each state.

Five major sets of issues are addressed in this set of reports examining how states have responded to both federal constraints and state flexibility during the last half decade. First, how have the political and fiscal circumstances of the state changed over the last several years? Second, has the state expanded public or private health insurance coverage, through Medicaid, SCHIP, Medicaid research and demonstration waivers, or state-funded programs? Third, how have Medicaid managed care and other acute care issues changed? For example, has access been affected by managed care plan withdrawals from Medicaid or backlash against plans by providers or beneficiaries? How are states coping with cuts in the federal DSH program? Fourth, how are states responding to their new freedom to set reimbursement rates, pressures to expand home and community-based services for disabled persons, and the labor shortage? Fifth, what other issues are prominent?

This report on Alabama assesses changes and continuities in the last five years, building on an earlier study.³ Information came from in-person interviews on-site in April 2001, supplemented by telephone and written responses. Interviewees included state officials, consumer and provider associations, and other knowledgeable observers. Secondary sources included publicly available documents, newspapers, and Web sites; written sources are cited in the endnotes. Interviewees were given the opportunity to comment on a draft, and changes were tracked through the end of June 2001.

Background

Demographics and Insurance Coverage

Alabama is a southern state with sizable rural, low-income, and minority populations (see table 1). Compared with the national average, a higher proportion of the state's population is black; a lower proportion is Hispanic. The state ranks poorly on some key indicators when compared with the rest of the country. Findings from the 1999 National Survey of America's Families (NSAF),⁴ for example, suggest that 23 percent of Alabama's children live below the federal poverty level (FPL), significantly more than the national average of

18 percent. Twenty-eight percent of Alabama's low-income nonelderly adults were in fair or poor health in 1999, a number that was significantly higher than the average of 23 percent for all low-income nonelderly adults in the United States.⁵

In contrast, 1999 rates of uninsurance for both children and adults in Alabama (9 percent and 14 percent, respectively) were significantly lower than the national average of 13 percent and 16 percent, respectively (see table 2). The percentage of low-income children covered by Medicaid, SCHIP, or another state program was significantly higher in Alabama than in the United States as a whole (39 versus 35 percent).⁶ Children's uninsurance rates in Alabama declined between 1997 and 1999. Data from the first two rounds of the NSAF show a decline of 9.7 percentage points, half of which is attributable to increased Medicaid and SCHIP enrollment.⁷ Case study respondents pointed to a strong tradition of employer-sponsored insurance as another factor in the low uninsurance rate. The rate of employer-sponsored insurance for children and adults both below and above 200 percent of the FPL is higher than the national average, significantly so for those over 200 percent of the FPL. However, because of the high share of the population below 200 percent of the FPL, when the two income categories are combined the rate of employer-sponsored insurance for children is below the national average, although the difference is not statistically significant.

The health status of Alabama's citizens has improved in recent years. The infant mortality rate, for example, decreased from 13 per 1,000 in 1986 to 9.5 per 1,000 in 1997.⁸ State

TABLE 1. Selected Alabama Characteristics

	Alabama	United States
Population Characteristics		
Population (2000) (in thousands) ^a	4,447	281,422
Percent under age 18 (1999) ^a	25.3%	25.7%
Percent Hispanic (1999) ^b	0.8%	12.5%
Percent black (1999) ^b	27.6%	12.8%
Percent Asian (1999) ^b	0.9%	4.1%
Percent nonmetropolitan (1996) ^b	33.7%	20.3%
State Economic Characteristics		
Per capita income (2000) ^c	\$23,471	\$29,676
Percent change per capita income (1995–1999) ^d	6.8%	10.8%
Unemployment rate (2001) ^e	5.3%	4.5%
Family Profile		
Percent children in poverty (1998) ^f	23.3%	17.5%
Percent change children in poverty (1996–1998) ^f	–14.7%	–15.0%
Percent adults in poverty (1998) ^f	14.2%	11.2%
Percent change adults in poverty (1996–1998) ^f	–16.5%	–10.4%
Political		
Governor's affiliation (2001) ^g	Democrat	NA
Party composition of senate (2001) ^h	24D-11R	NA
Party composition of house (2001) ^h	68D-37R	NA
Percent of Poor Children Covered by Welfare		
1996 (AFDC) ⁱ	25.7%	59.3%
1998 (TANF) ⁱ	17.3%	49.9%
Income Cutoff for Children's Eligibility for Medicaid/State Children's Health Insurance Program (Percent of Federal Poverty Level)		
1996 ^{j,k}	88%	124%
1998 ^{j,l}	200%	178%
2000 ^{j,m}	200%	205%

Table 1 notes begin on page 24.

health officials attribute the change to a decrease in maternal smoking and teen pregnancies and an increase in local programs that improve access to prenatal care.⁹ The birth rate for teens ages 15 to 17 decreased between 1990 and 1997—from 47 to 43 per 1,000.¹⁰

Political Developments

Donald Siegelman, a Democrat, was elected governor in November 1998, and improving the health of Alabama's citizens, particularly the elderly, was a key focus of his campaign against former governor Forrest "Fob" James, a Republican.¹¹ Structurally, state government is characterized by a strong executive and a relatively weak legislature; therefore, the change in governor had the potential to significantly influence policy. In his 2001 state of the state address, Siegelman also emphasized expanding children's health insurance, improving education and child care facilities, and reducing crime.¹²

Democrats are the majority political party in both the state senate and house. Both the state legislature and governor, however, favor conservative fiscal policies. Reflecting this conservative philosophy, the state's social programs are relatively limited, designed primarily to meet minimum federal requirements. Most state tax collections go to either the general fund or the Education Trust Fund.

Market Developments

Private health insurance continues to be dominated by Blue Cross/Blue Shield, which insurance officials estimate holds 70–75 percent of the market (measured as a percentage of premiums paid). While Blue Cross/Blue Shield is generally viewed as a "benevolent dictator" by providers,¹³ other insurers have complained that the concentration in the mar-

TABLE 2. Health Insurance Coverage, by Family Income and Type of Insurance, Alabama and the United States, 1999

	Children (Ages 0–18) ^a (%)		Adults (Ages 19–64) ^b (%)	
	Alabama	United States	Alabama	United States
Below 200% FPL				
Employer-sponsored	40.8	38.7	45.9	41.7
Medicaid/SCHIP/state	39.4	35.2	12.1	14.7
Other coverage	5.1	3.8	13.0	8.8
Uninsured	14.7	22.4	29.3	34.9
Above 200% FPL				
Employer-sponsored	88.6	85.3	87.6	83.7
Medicaid/SCHIP/state	3.6	3.8	0.7	1.1
Other coverage	4.1	4.9	4.2	5.8
Uninsured	3.7	6.0	7.5	9.4
All Incomes				
Employer-sponsored	65.7	66.7	74.2	72.3
Medicaid/SCHIP/state	20.8	16.4	4.4	4.8
Other coverage	6.3	4.5	7.0	6.6
Uninsured	6.5	12.5	14.4	16.3

a. Kenney, Genevieve, Lisa Dubay, and Jennifer Haley. 2000. "Health Insurance, Access, and Health Status of Children." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

b. Zuckerman, Stephen, Jennifer Haley, and John Holahan. 2000. "Health Insurance, Access, and Health Status of Adults." In *Snapshots of America's Families II: A View of the Nation and 13 States from the National Survey of America's Families*. Washington, D.C.: The Urban Institute.

Notes: Figures in bold represent values that are statistically significantly different from the national average at the 0.10 confidence level or lower.
FPL = federal poverty level
SCHIP = State Children's Health Insurance Program

ket makes it difficult for them to negotiate with providers. Employer-sponsored insurance is by far the most common form of insurance, with only one insurer offering individual plans. Insurance officials report that small group insurers are leaving the market. Alabama is participating in the National Association of Insurance Commissioners (NAIC) “Speed to Market” initiative and has adopted much of NAIC’s proposed legislation to facilitate entry into the insurance market. These changes are new and have yet to bear fruit.

There are six health maintenance organizations (HMOs) licensed to operate in the state, most of which have been in operation for more than 15 years. These plans are said to have found a niche within the market and cover some 10–12 percent of the population, a percentage that has remained stable over time. Respondents did not expect the managed care penetration rate to increase in the foreseeable future. The HMO market is concentrated in Birmingham, the largest city, with a smaller presence in Mobile. Capitated managed care was tried on a pilot basis in Medicaid in the Mobile region but failed, as discussed below. Although the HMO penetration rate is low relative to most states, satisfaction among HMO enrollees is reasonably high. A survey of several HMO members, conducted by the state Department of Public Health, showed that 58.4 percent of members of five HMOs (Health Partners, Merit Health Plans, PrimeHealth, UnitedHealthcare, and Viva) were completely or very satisfied. This satisfaction rate is comparable to the national average of 56.2 percent released by the National Committee for Quality Assurance.¹⁴

Alabama hospital margins are below the national average, and the Balanced Budget Act of 1997 (BBA) was said to represent a major source of stress for hospitals. Officials estimated that about two-thirds of Alabama hospitals are currently losing money on operations, and the recent slow-down in the stock market has meant that investment earnings offer a less reliable cushion against operating losses than in recent years. The Benefits Improvement and Protection Act of 2000 (BIPA) provided some relief, but rural hospitals, in particular, with their historically higher uncompensated care burdens, are still seen as financially vulnerable. Four hospitals have closed since 1997, but respondents did not predict additional hospital closures.

At the time of the site visit, discussions were under way about the fate of the public hospital in Birmingham.¹⁵ It was reported that the physical plant was in need of substantial capital investment and that the hospital was in financial difficulty. The options being considered for its future were to renovate or completely replace the facility or to turn it over to a private partner to operate, with the county becoming a purchaser of hospital and clinic services for the poor.

Fiscal Circumstances of the State

Alabama has one of the lowest tax burdens of any state in the country. In 2000, total state taxes per capita equaled \$1,448, or 6.4 percent of personal income as compared with the national average of 7.0 percent.¹⁶ Respondents noted that property taxes are also extremely low. Sales taxes are an important source of revenue, but this type of tax falls relatively heavily on the poor. Income taxation also begins at very low income levels.¹⁷ A recent study determined that the tax burden on the poor in Alabama is among the greatest in the nation. An Alabama family of two or three living at the federal poverty level pays the highest amount of taxes in the nation at this income level.¹⁸

The strong anti-tax sentiment limits the extent to which benefits can be provided under most of Alabama’s government-sponsored social programs. Lacking other secure sources of revenue, the current governor is looking to reduce waste and inefficiency in order to fund his priorities. He has pledged to improve fiscal management and has instituted performance-based budgeting for state services. In addition, he has established incentives for state workers to identify ways to save money in government operations.

The economic slowdown that has recently affected many states is also being felt in Alabama. The events of September 11, 2001, have accelerated this downturn. The deterioration in the national economy will likely create fiscal problems in Alabama, which was already facing serious budget pressures. The slowing economy over the last year led to

mid-2001 budget cuts in some programs, notably education, which is financed from the Education Trust Fund (ETF). The state reports that expenditures for state programs are on target for 2002 and that neither tax cuts nor, as promised by Siegelman during his campaign, tax increases are likely. Alabama's general fund revenues are growing at about \$20 million a year and are consistent with the estimates on which fiscal year 2001 budgets were built. State revenue collections for the ETF were reported to be more of a concern, particularly in light of a new law that earmarks a portion of the ETF for K-12 teacher salaries, putting pressure on other programs it funds. Officials reported that the state is preparing for an economic downturn and that the education budget has decreased for FY 2002.

The Medicaid Trust Fund, established with tobacco settlement revenues, is expected to protect the Medicaid program from both the likely economic downturn and the budget shortfalls that have plagued it in recent years. Officials hope that they will not have to dip into the Trust Fund until 2003. They reported that they are also looking to Medicaid Trust Fund revenues to cushion the program from the effects of changes in the DSH program and even to allow a restructuring of the intergovernmental transfers associated with both DSH and the upper payment limit (UPL) program that have long been critical to financing the state's share of the Medicaid program.¹⁹ The implementation of these programs in Alabama and five other states has been investigated by the Office of the Inspector General of the U.S. Department of Health and Human Services, and changes may be required.

The total payments to Alabama from the tobacco settlement have been estimated at \$3.17 billion through 2025,²⁰ although declining cigarette sales may lower this total. In 2000, Alabama received \$131.8 million; it will receive another two payments of equal amounts in 2001. Alabama was one of several states to enact legislation on how the tobacco settlement money would be appropriated, even though at the time of the legislation—1999—no funds had yet been received. There was initially some controversy over how much would go to Medicaid. The law disburses up to \$60 million in 2000, up to \$65 million in 2001, and up to \$70 million in 2002 and annually thereafter to a package of programs called the Children First Trust Fund.²¹ The remaining funds will be transferred to the 21st Century Fund to pay the debt service on industrial development bonds for the state, and to the General Fund. Of the money transferred into the General Fund, up to \$40 million will be appropriated to Medicaid in 2001 and \$45 million a year thereafter. If the total tobacco settlement is revised downward, these allocations will likely fall proportionately.

Medicaid Trends

Overview

The Medicaid program currently enjoys a higher level of support at the executive level than in the past. Medicaid expenditures are increasing as a percentage of general fund revenues—5 percent in 1995 versus 6 percent in 2000 (see table 3). Officials report that the increase in general fund revenues is attributable to transfers from other agencies that are used to draw down additional federal funds. Overall, general fund revenues are decreasing as a percentage of total expenditures, representing 36.4 percent in 1995 but only 31.3 percent in 2000 (see table 3). Medicaid takes a smaller proportion of total expenditures in 2000 (16 percent) than in 1995 (17 percent), but officials say that the decline should be attributed more to an increase in other categories than to a decrease in Medicaid. The data in table 3 support this contention, showing large increases in federal funds going to transportation and other expenditures. General fund appropriations, however, represent an increasing percentage of the state funds dedicated to the Medicaid program. In 1995, 23.6 percent of the state share of Medicaid expenditures of \$591.2 million came from the general fund. In 1999, 25.8 percent of the \$799.2 million state share came from the general fund. Over half of the state share in both 1995 and 1998 came from intergovernmental transfers through the Public Hospital Transfers and Alabama Health Care Trust Fund (PHTAHCT).²²

Some 15.2 percent of the Alabama population was enrolled in Medicaid in 1999, a significant increase over the 10.4 percent in 1990, but about the same proportion as in 1995,

when 15.4 percent were enrolled. Expansion of eligibility to children in families with incomes up to 100 percent of the FPL in 1998 under Phase I of Alabama's SCHIP program and the spillover effect on Medicaid enrollment from the SCHIP outreach have contributed to recent enrollment growth. Further eligibility expansions are not planned at this time.

While Governor Siegelman has declared his support for insurance coverage for all children and is generally supported in this effort by the legislature, the limitations imposed by the tax structure continue to be the most important influence on the Medicaid program. The tobacco-funded Medicaid Trust Fund provides some relief, but there are competing demands for these funds within Medicaid. In particular, the growth of the elderly population and the strength of the state nursing home lobby are driving expenditures for long-term care under Medicaid. In fact, some see the Medicaid Trust Fund as protection for the nursing home industry.

The state is making efforts to contain program costs. Administrative expenditures rose from 2.2 percent of total Medicaid expenditures in 1995 to 3.3 percent in 1999, although they remain below the national average. Officials are focusing on reducing these expenditures in order to devote a larger proportion of expenditures to client services. Capitated

TABLE 3. Alabama Spending by Category, 1995 and 2000 (\$ in Millions)

Program	State General-Fund Expenditures ^a				Total Expenditures ^b			
	Actual 1995	Estimated 2000	Annual Growth (%)		Actual 1995	Estimated 2000	Annual Growth (%)	
			AL	U.S.			AL	U.S.
Total	\$4,161	\$5,238	5	5	\$11,421	\$16,725	8	6
Medicaid^{c,d}	\$213	\$320	8	5	\$1,996	\$2,624	6	4
% of Total	5%	6%			17%	16%		
K-12 Education	\$2,116	\$2,816	6	7	\$2,571	\$3,761	8	7
% of Total	51%	54%			23%	22%		
Higher Education	\$1,029	\$1,095	1	5	\$3,021	\$1,702	-11	5
% of Total	25%	21%			26%	10%		
Public Assistance	\$9	\$2	-26	-6	\$83	\$32	-17	-5
% of Total	0%	0%			1%	0%		
<i>AFDC/TANF</i>	\$9	\$2	-26	-9	\$82	\$31	-18	-7
% of Total	0%	0%			1%	0%		
Corrections	\$197	\$176	-2	6	\$254	\$229	-2	6
% of Total	5%	3%			2%	1%		
Transportation	\$1	\$-	-100	5	\$740	\$1,326	12	6
% of Total	0%	0%			6%	8%		
All Other^e	\$596	\$828	7	5	\$2,756	\$7,050	21	8
% of Total	14%	16%			24%	42%		

Source: National Association of State Budget Officers, 1996 State Expenditure Report (April 1997) and 1999 State Expenditure Report (June 2000)

a. Expenditures included here as "state general-fund" expenditures include expenditures from both the general fund and the Education Trust Fund but exclude other state funds and bond expenditures.

b. Total spending for each category includes the general fund, other state funds, bonds, and federal aid.

c. States are requested by the National Association of State Budget Officers (NASBO) to exclude provider taxes, donations, fees, and assessments from state spending. NASBO asks states to report these separately as "other state funds." In some cases, however, a portion of these taxes, fees, etc., do get included in state spending because states cannot separate them.

d. Total Medicaid spending will differ from data reported on the HCFA 64 for three reasons: first, NASBO reports on the state fiscal year and the HCFA 64 on the federal fiscal year; second, states often report some expenditures (e.g., mental health and/or mental retardation) as other health rather than Medicaid; third, local contributions to Medicaid are not included but would be part of Medicaid spending on the HCFA 64.

e. This category could include spending for the State Children's Health Insurance Program, institutional and community care for mentally ill and developmentally disabled persons, public health programs, employer contributions to pensions and health benefits, economic development, environmental projects, state police, parks and recreation, housing, and general aid to local government.

TABLE 4. Medicaid Enrollment and Expenditures in Alabama, 1998

	Alabama, 1998			Average Annual Growth (%), 1995–1998					
	Total Annual Expenditures (in millions)	Avg. Monthly Enrollment (in thousands)	Avg. Annual Expenditures per Enrollee	Total Annual Expenditures		Avg. Monthly Enrollment		Expenditures per Enrollee	
				Alabama	United States	Alabama	United States	Alabama	United States
Total Expenditures	\$2,384	–	–	6.1	3.9	–	–	–	–
Medical Services									
By Eligible Group	\$1,937	498	\$3,888	8.0	5.1	0.3	–1.0	7.7	6.1
Elderly	\$607	67	\$9,010	6.9	4.3	–1.3	0.1	8.3	4.2
Blind and disabled	\$868	152	\$5,702	11.5	8.5	4.7	3.6	6.5	4.7
Adults	\$127	31	\$4,046	–11.6	–1.4	–18.6	–4.4	8.6	3.1
Cash assistance	\$38	13	\$2,820	–20.2	–10.4	–27.0	–14.9	9.4	5.3
Other enrollees	\$89	18	\$4,956	–6.6	7.8	–8.9	9.3	2.5	–1.4
Children	\$335	247	\$1,356	13.5	2.7	2.0	–1.5	–11.3	4.3
Cash assistance	\$47	44	\$1,057	–13.7	–8.8	–21.4	–12.2	–9.7	3.9
Other enrollees	\$289	203	\$1,420	22.5	12.4	12.5	9.8	8.9	2.4
By Type of Service	\$1,937	–	–	8.0	5.1	–	–	–	–
Acute care	\$1,149	–	–	7.3	4.0	–	–	–	–
Long-term care	\$787	–	–	9.1	6.5	–	–	–	–
DSH Administration	\$394	–	–	–1.9	–7.3	–	–	–	–
	\$54	–	–	10.8	8.5	–	–	–	–

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports.

Notes: Does not include the U.S. Territories. Enrollment data shown are estimates of the average number of people enrolled in Medicaid in any month during the fiscal year. Expenditures per enrollee shown reflect total annual expenditures on medical services for each group, divided by the average monthly enrollment within that group. “Cash assistance” refers to enrollees who receive AFDC/TANF or SSI, or who are eligible under Section 1931 provisions. “Other enrollees” include the medically needy, poverty-related expansion groups, and people eligible under Medicaid Section 1115 waivers. “Acute care” services include inpatient, physician, lab, X-ray, outpatient, clinic, prescription drugs, EPSDT, family planning, dental, vision, other practitioners’ care, payments to managed care organizations (MCOs), and payments to Medicare. “Long-term care” services include nursing facilities, intermediate care facilities for the mentally retarded, inpatient mental health services, home health services, and personal care support services. “DSH” stands for disproportionate share hospital payments.

Figures may not add to totals due to rounding.

managed care was introduced as a pilot project in the Mobile area in 1997 as Better Access for You Health Plan (BAY Health), but the project was terminated in September 1999. Primary care case management (PCCM) was introduced in 1997 and by the fall of 1998 was statewide (with the exception of Mobile county, which did not convert to PCCM until 2000). Although this program has been credited for several positive effects, including cutting costs in the 26 counties in which it was operating during 1997 and improving doctor-patient contacts, some rural areas have reportedly had trouble finding enough doctors to participate.²³

Alabama has aggressively sought increased federal funding for its Medicaid program, particularly through the use of the DSH and UPL programs and intergovernmental transfers. Changes in federal regulations regarding these programs have the potential to undermine the current mechanisms Alabama uses to finance its program, but the state believes that the structure of its program is grandfathered under the old rules. The U.S. Inspector General is investigating Alabama's UPL program as part of a six-state study.

In light of its constrained revenue opportunities, Alabama's Medicaid program has long relied on minimum federal requirements to determine eligibility and coverage policies. There is no medically needy program; instead, Alabama extends nursing home and other institutional service eligibility to persons with incomes below 300 percent of the Supplemental Security Income (SSI) benefit level and assists some individuals with catastrophic illness by paying their insurance premiums. The state covers few optional services,²⁴ and there are some restrictions on mandatory services.²⁵ In October 2001, Alabama will begin covering an optional eligibility group for breast and cervical cancer treatment as provided under the federal Breast and Cervical Cancer Treatment Act of 2000.

Enrollment

As shown in table 4, the average monthly enrollment in Alabama's Medicaid program expanded slightly (0.3 percent annually) between 1995 and 1998.²⁶ During the same period, enrollment levels nationwide fell by 1.0 percent.²⁷ The largest groups to experience declines both nationally and in Alabama were children and adults receiving cash assistance, falling by 21.4 percent and 27.0 percent, respectively. These reductions are greater than those observed nationwide (12.2 percent for children and 14.9 percent for adults). When non-cash assistance children and adults are included, the accumulated change in enrollment from 1995 to 1998 was a 2.0 percent increase for children and an 18.6 percent drop for adults overall (compared with a 1.5 percent drop and a 4.4 percent drop nationally in these categories).

Some of the drop in adult enrollment is likely due to the delinking of Medicaid eligibility from welfare eligibility under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). Some recipients did not understand that they could remain on Medicaid when their welfare benefits were terminated, and many states found it necessary to revise their outreach and enrollment procedures to address this issue. In a study of Alabama's post-PRWORA enrollment practices in November 1999, the Health Care Financing Administration (HCFA, now CMS) identified several steps that Alabama needed to take in order to meet the new requirements.²⁸ The rebound in the enrollment figures suggests that the steps taken were largely successful.

Additional data from the Alabama Medicaid Agency show that enrollment increased from 491,452 in December 1997 to 554,350 in December 2000.²⁹ These data include children in the Medicaid expansion funded by SCHIP (which table 4 excludes). The growth in enrollment in 1998 and 1999 was driven by increases in the number of children and pregnant women eligible through poverty-related programs, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs). While there were no changes in the eligibility guidelines for QMBs or SLMBs, the enrollment process was streamlined. The SLMB population accounted for over half of the increase in total enrollment from December 1998 to December 1999.

Medicaid officials noted that enrollment has increased substantially since the beginning of the SCHIP program. Alabama uses a joint application for Medicaid, SCHIP, and the Alabama Child Caring Foundation, a small, privately sponsored subsidized insurance program with limited benefits for children who do not qualify for Medicaid or SCHIP. The SCHIP program has extensive outreach and some 50,000 Medicaid enrollees have been identified through this process. In addition, Medicaid has taken steps to streamline eligibility determination and recertification, including expanded disregards for income under 1902(r)(2) provisions. Selected counties are testing other streamlining activities. The institution of 12-month continuous eligibility in April 1998 is credited with reducing administrative costs and eliminating some churning.

The effect on children's health insurance rates has been substantial. Between 1997 and 1999 Alabama saw a statistically significant decline in children's uninsurance rates. Data from the first two rounds of the NSAF show a decline of 9.7 percentage points, half of which is attributable to increased Medicaid and SCHIP enrollment.³⁰

Expenditures

Medicaid expenditures were approximately \$2.4 billion in 1998, up from about \$2 billion in 1995, representing an average annual growth rate of 6.1 percent (see table 4). This rate is significantly faster than the national rate of 3.9 percent for this period. Expenditure growth continued at the rate of 6.1 percent between 1998 and 1999³¹ but slowed to 1.7 percent between 1999 and 2000.³² National rates for these years were 6.5 percent and 5.7 percent, respectively. Acute care services, long-term care services, and administrative expenditures all grew faster than the national average over the 1995–1998 period, and DSH payments declined less rapidly (-1.9 percent for Alabama versus -7.3 percent for the United States). Notably, prescription drug costs grew more slowly in Alabama between 1995 and 1998 than nationally. Medicaid officials noted, however, that in the past year prescription drug costs have risen 12 percent, with the growth attributable to the rising cost of drugs and not increased utilization. A prior authorization rule for pharmaceuticals was instituted in 1996 along with a prospective Drug Utilization Review program.

Medicaid reimbursement rates for physicians had not been increased across the board since 1994, although some adjustments had been made. In the fall of 2000 the Medicaid agency raised reimbursement rates for primary care physicians and dentists with the goal of improving access to these services by increasing provider participation. Under the "Smile Alabama" initiative, reimbursement for dentists was raised to match Blue Cross rates and 35 new dentists started seeing Medicaid patients, adding to the approximately 80 dentists previously participating.

Alabama has a strong nursing home lobby that has been successful in protecting nursing home reimbursement rates under Medicaid. Industry representatives agreed that the rates are good but noted that they cover a broad range of services. Efforts by the previous governor to bring nursing home reimbursement rates in line with neighboring states were unsuccessful. Medicaid expenditures on long-term care are growing more rapidly than the national average, but per-enrollee costs remain below the national average. The second fastest growing category of Medicaid expenditure from 1995 to 1998 was home care, which grew by approximately 20 percent per year, consistent with the national trend.

Expenditures per Enrollee

Although Alabama Medicaid spending growth is high when compared with the nation as a whole, expenditures per enrollee are still below national averages. Alabama spent an average of \$3,888 per Medicaid enrollee in 1998, approximately \$700 more than in 1995 (see table 4). Alabama's 1998 average spending per enrollee ranked 44th in the nation. Between 1995 and 1998 Alabama's spending per enrollee grew by an average of 7.7 percent per year compared with 6.1 percent for the entire country. Both acute care and long-term care spending per enrollee grew more quickly than the national rates during this period.

Spending per enrollee exceeds the national average for only one category of enrollees: poverty-related adults. The high spending per enrollee for adults is likely due to the limited eligibility for nondisabled adults in Alabama's Medicaid program. Those nondisabled adults who are eligible are mostly pregnant women or parents with very low incomes.

Budgetary Perspective and Expectations for the Future

Although Alabama respondents expected an economic downturn, they did not expect the Medicaid program budget to be affected. Because of the governor's interest in health, the substantial federal monies the program brings into the state, and the cushion provided by tobacco settlement revenues, the Medicaid budget was seen as secure for the near future. Officials did express some concern, however, that enrollment would be greater during economic hard times.

Capitated managed care is not likely to be a part of any cost-cutting initiative, although primary care case management will continue. Both the governor's office and the Medicaid agency are looking to streamline administration for cost savings. Some respondents saw a restructuring of the Alabama tax code as the only means to expanding the funds available for public health care programs.

Health Insurance Coverage

Alabama's SCHIP Program

On January 30, 1998, Alabama became the first state to receive federal approval of its Children's Health Insurance Program (SCHIP) proposal. The first phase of this plan expanded Medicaid eligibility to children up to age 19 in families with incomes up to 100 percent of the FPL. Prior to this expansion, Alabama's Medicaid program covered children up to age 6 in families with incomes up to 133 percent of the FPL and children up to age 15 (born after September 30, 1983) in families with incomes up to 100 percent of the FPL.³³ Older adolescents in the state were only eligible up to the state's AFDC level of 15 percent of the FPL—the lowest in the nation.

The Medicaid Agency convened a working group with representatives from both Medicaid and non-Medicaid agencies to decide what form Phase II of its SCHIP program should take. The debate covered issues of administration, cost, access, creation of an entitlement, stigma, and the scope of the benefit package.³⁴ In the end the group decided to create a non-Medicaid program, chiefly for reasons of improving access for recipients. Participants in the working group felt that low provider reimbursement and a history of provider payment moratoriums had led to inadequacies in the Medicaid provider network which limited access to Medicaid services. Access to dentists and pediatric specialists were cited as areas of particular concern. While reimbursement has improved and payment moratoriums have become rare in the last two years, the program also suffered from a perception by many in the state that it was inefficient and cumbersome.³⁵

The benefit package was chosen to match that of the state's largest commercial HMO, UnitedHealthcare, but using the Blue Cross/Blue Shield network. In addition to inpatient and outpatient health services, benefits include inpatient and outpatient mental health and substance abuse benefits, dental services, home health services, durable medical equipment, and vision services. While some advocates favored a Medicaid-based program because of its more extensive benefits package, the argument was made that the broader Blue Cross/Blue Shield provider network offered the potential for improved access for enrollees even with a less generous benefits package. This debate continues in the state, led chiefly by advocates for children with special health care needs.

The second phase, which is called ALL Kids, received federal approval in August 1998 and began in September 1998. ALL Kids provides a private insurance option for children up to age 19 in families with incomes up to 200 percent of the federal poverty level. Modest premiums and low copayments are required for children in families with incomes over 150 percent of the FPL. No copayment is required for any preventive service.

ALL Kids is administered through the Alabama Department of Public Health (ADPH), which is independent of the executive branch and therefore shielded to a certain degree from political forces. The previous governor was not a strong supporter of SCHIP, and the impetus for ALL Kids came from then-Lieutenant Governor Siegelman. The ADPH contracted with the State Employees Insurance Board (SEIB) to conduct the enrollment functions of ALL Kids for the early years of the program.

Together, Phase I (the Medicaid expansion) and Phase II (ALL Kids) of Alabama's SCHIP program provided coverage for 80,000 children. ALL Kids provides 12-month continuous eligibility for enrollees. In order to minimize crowd-out of private insurance, the state requires that a child be uninsured for a minimum of three months prior to enrollment in ALL Kids if insurance was voluntarily terminated. In contrast, children enrolled through Medicaid expansions under SCHIP do not have to be uninsured and are allowed to have other insurance, as permitted under Medicaid regulations. State officials estimate that 60 percent of enrollees reenroll each year, with the rest moving to Medicaid or private insurance. With the need to replace 40 percent of enrollees each year, outreach and enrollment efforts will have to remain strong.

The state issued a Request for Proposals for a provider of benefits and services and chose Blue Cross/Blue Shield of Alabama as offering the best price and the most extensive network. PrimeHealth, then the administrator of the state's Medicaid managed care plan, won the right to provide services in certain counties and, in these counties, enrollees initially had a choice of Blue Cross/Blue Shield or PrimeHealth.³⁶ The Blue Cross/Blue Shield network includes some 80 percent of the state's providers. Nonetheless, ALL Kids staff decided to add some providers to make it more "child-friendly." Providers from the Title V/Children with Special Health Care Needs agency's Children's Rehabilitation Services were added as preferred specialty providers, as were pediatric mental health providers. In addition, ALL Kids established a policy for reimbursement of nurse practitioners, who are key providers of services to children living in rural areas of the state.³⁷

The state's SCHIP plan was amended in May 1999 to create a supplementary set of services, ALL Kids Plus, for children with special health care needs.³⁸ Following enrollment in ALL Kids, a child that is identified as having a special condition or need can qualify for ALL Kids Plus, which offers additional benefits such as case management, counseling, basic/adaptive living skills, audiology, durable medical equipment, and physical and occupational therapy. To help preserve continuity of care, ALL Kids Plus is designed to allow services to be provided through agencies already serving this population.

Alabama's SCHIP matching rate is about 21 percent. In other words, Alabama contributed 21 cents on the dollar, while the federal government contributed 79 cents.³⁹ During FY 1998, Alabama was eligible for nearly \$86 million in federal funds to provide services to uninsured children through SCHIP.⁴⁰ Between FY 1998 and FY 2002, the state will be eligible for \$397 million for the program.⁴¹ The state finances its share of the program using a mix of general funds and tobacco settlement funds. Of the state's share of the tobacco settlement, \$8.3 million was originally earmarked for ALL Kids.⁴² In addition, some of the ALL Kids Plus services were already being provided by state agencies with 100 percent state funds; under cooperative agreements with other state agencies, these state funds can now be used as the SCHIP match.

By 2004, the state's matching funds obligation will increase. Officials see state funding for ALL Kids as secure through 2003. The preceding year, 2002, is an election year for both the governor and the legislature with any newly elected officials taking office in 2003. With the possibility of legislative and/or executive changes, there is some concern that the program will not be able to maintain the same favor it currently enjoys. In addition, an economic downturn could increase demand for the program at the same time it reduces revenues. Nonetheless, SCHIP is likely to retain its standing as a program for the "deserving poor," while Medicaid is seen as welfare, despite efforts to dissociate the two programs, and thus is potentially more vulnerable.

If funding can be maintained, the first priority for SCHIP will be to streamline the enrollment process. For political reasons SCHIP implementation was put on a fast track using the SEIB for enrollment. As the program matured, its administrative and data needs no longer matched those of the SEIB. As of June 2001, most of the enrollment functions were transferred back to ADPH with full enrollment functions moving to ADPH by September 2001. Officials would also like to expand eligibility, adding the parents of SCHIP eligibles to the program, but believe that it would be too expensive. The idea of premium support for parents with employer-sponsored insurance is popular with the business community, but CMS regulations may make this extension of the program difficult.

Some people in Alabama see SCHIP as providing an opportunity to investigate solutions to some of the problems seen in the Medicaid program. The higher provider reimbursement and greater provider participation in ALL Kids was mentioned as a catalyst for change in the Medicaid reimbursement rates. The ALL Kids program's experience with fewer verification requirements in the enrollment process has led to a Medicaid pilot project in three counties. For some, ALL Kids is seen as a possible model for the privatization of Medicaid. The learning process runs both ways. For example, in 1999, ALL Kids adopted 12-month continuous eligibility following a year-long experience of the Medicaid program. ALL Kids is also adopting the income disregards used by the Medicaid program.

Alabama Health Insurance Pool

The Alabama Health Insurance Pool (AHIP) was established in August 1997 to comply with the group-to-individual portability requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Currently there are just over 3,000 people enrolled in AHIP; 20–40 of these enrollees use most of the benefits. Enrollees can stay in the AHIP until they find other insurance, and turnover is typically about 50 percent per year. The premiums are subsidized through assessments on plans and a tax on premiums but remain expensive. HIPAA's guaranteed renewal requirement for individuals will be enforced by CMS because the state did not enact such a requirement.⁴³

Acute Care Issues

Medicaid Managed Care

Historically, Medicaid managed care has not been a large part of health care in Alabama.⁴⁴ Commercial managed care penetration is low and much of the state is rural, hindering the development of provider networks. In 1997, under a Section 1115 waiver, Alabama instituted capitated managed care in Medicaid, the Better Access for You (BAY) Health Plan, in Mobile County. By February 1998, the BAY Health Plan had 41,000 enrollees.⁴⁵ However, in October 1999, the community health centers, who felt they were not getting a fair share of the patients or adequate reimbursement for their services, withdrew from the plan network. This withdrawal left the state in violation of the terms of the waiver under which the program operated, and the state terminated the project. Encounter data and HEDIS requirements were cited as additional problems.

Alabama's primary care case management program, Patient First, also began in 1997 under a Section 1915(b) waiver. State officials sought to provide a medical home for Medicaid enrollees, many of whom lived in rural areas, and they developed a primary care case management program based on models from South Carolina and Kentucky. Within two years the program was expanded throughout the state, with the exception of Mobile County where the BAY Health pilot project was operating. When BAY Health ended, its enrollees were transferred first to fee-for-service and then in the spring of 2000 to Patient First in what was said to have been a smooth transition.

Patient First providers are paid on a fee-for-service basis in addition to a \$3 per month case management fee. Over 6,000 physicians currently participate, 2,000 of whom are primary care providers. The Medicaid Agency restructured physician reimbursement in October 2000, and rates for primary care providers rose. Relative to national average Medicaid reimbursement for physicians, Alabama physicians fare quite well, although the

relative generosity of the Medicaid fees varies substantially by type of service.⁴⁶ In the restructuring, some fees were raised while others were lowered, and provider participation increased substantially. State officials report that primary care reimbursement is currently at 90 percent of Medicare rates; specialists are paid 70 percent of Medicare rates.

Medicaid officials report that most primary care physicians appear satisfied with the Patient First program. Specialists, however, are less satisfied and complain about referral procedures and denial of claims. Some advocates question whether any true case management occurs. The program also provides proactive case management for the “medically at-risk.” At the request of a physician or dentist, the health department sends a case manager to the patient to address issues that contribute to health problems or hinder access to health care, such as lack of transportation.

Hospital care is reimbursed on a capitated basis through eight regional Partnership Hospital Programs (PHPs). The PHP program began in 1996 under a Section 1915(b) waiver and is administered by the Alabama Hospital Association. Medicaid pays each regional PHP a per-member, per-month fee for inpatient hospital care for each enrollee in the PHP’s region. Individual hospitals within the region are reimbursed on a per diem basis by the PHP for treatment provided to Medicaid patients. Payments to the PHPs include both per capita inpatient allowances and DSH payments. The distribution of DSH to hospitals within each region is under the discretion of the individual PHPs. Some hospitals also receive “enhanced payments” from the PHP, separate from the DSH payments.

While cost control was not a goal of the PCCM program, it has probably been a result. Inpatient and specialty care have declined somewhat. There has been only a slight decline in emergency room use; the existence of prudent layperson standards has limited the program’s success in this area. Program officials report that an independent assessment of the program was positive.

Medicaid DSH Program

The Balanced Budget Act of 1997 had a negative impact on hospital operating budgets in Alabama by reducing both Medicare reimbursement rates and DSH spending. Even prior to the Act, DSH spending was on the decline in Alabama, as it was across the nation. DSH spending was \$417.5 million in 1995 and declined slowly through 1998 at an average annual rate of just under 2 percent. By comparison, the average annual decline for the nation as a whole was 7.3 percent for the same period (see table 4). In 1998, DSH represented 21.0 percent of Alabama’s Medicaid benefits spending as compared with only 11.9 percent for the United States.⁴⁷

With passage of the 1997 Balanced Budget Act, the state was granted a two-year waiver to fold DSH payments into capitation payments. This waiver was important to Alabama because it allowed the state to maintain its PHP reimbursement system for hospitals. Under this system, the DSH program has become an important source of funding for Alabama’s entire Medicaid program. Alabama also has used the upper payment limit (UPL) mechanism aggressively in conjunction with intergovernmental transfers. Together, DSH and UPL have allowed greatly increased federal participation in Medicaid financing in the state, increasing the size of the Medicaid program that the state can support and freeing up state funds to be spent in other areas.

By folding DSH into the capitation payment, Alabama avoids the hospital-specific caps on DSH payments. However, Alabama is a high DSH state and its PHP program does not allow it to avoid the requirement that DSH remain below 12 percent of total Medicaid expenditures. As this DSH percentage is phased down, Alabama will lose an important source of financing for its Medicaid program. Hospital officials are less concerned about the decline, because hospitals keep a relatively low percentage of the DSH payments so that DSH represents a relatively minor contribution to hospital revenues. Small, rural hospitals will be most affected.

The Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services undertook a study of Alabama’s Medicaid hospital payment methodology

between October 1996 and July 2000, of both the enhanced DSH payments made to hospitals under the PHP program and the use of the UPL. The OIG issued three reports on various aspects of the issue.⁴⁸ In these reports, the OIG alleges that the state has made no actual outlay of its own funds for the PHP program contrary to the “spirit” of the matching arrangement. Specifically, the OIG report states that Alabama changed its methodology for calculating enhanced payments to hospitals and that the changes, while legal, were not always in accordance with the State Plan Amendment of 1994. The reports raise the possibility, but do not confirm, that the federal funds generated through the intergovernmental transfers from participating hospitals were returned to the state to fund the Medicaid program and therefore might have been used to draw down additional federal dollars. Furthermore, the OIG finds that in the implementation of the UPL program, Alabama decreased the percentage of DSH funds that state-owned hospitals were allowed to retain.⁴⁹

If the OIG’s findings are upheld, Alabama will be required to reimburse the federal government for federal share of the allegedly excessive payments to hospitals, which the OIG calculated to be \$168.3 million. In addition, the OIG wants the state to justify retroactive payments made to hospitals by the state after the OIG audit period or repay the federal share of these payments, an additional \$68.7 million. Together these payments are greater than the 1999 general fund appropriation to Medicaid of \$205.8 million.⁵⁰ Alabama disagrees with the OIG findings and in its response to the reports states its belief that its payments to hospitals were made in accordance with federal regulations. Alabama Medicaid officials also point out that the Medicaid program’s share of general fund revenues has increased. At the time of this report, a final decision was pending on repayment. Beginning in June 2001, however, CMS began withholding a portion of Alabama’s quarterly payment.⁵¹ With the revisions to the regulations on calculation of the UPL, the state stands to lose \$12.6 million a year.

A second potential threat to Medicaid financing comes from the requirement under the BBA that states with a managed care payment methodology must make DSH payments directly to hospitals and not as part of capitation payments. Programs established prior to July 1, 1997, are exempt. Alabama Medicaid officials contend that the PHP program, which began prior to that date, is not affected. CMS has been skeptical of the PHP as managed care since the inception of the program,⁵² and more recently it has suggested that it considers the PHP program to be new (with respect to the BBA requirements) since it was renewed in 1999. The PHP arrangement is crucial to the financing of the state’s Medicaid program and its phaseout would represent a serious problem for the state. Alabama has applied for a renewal of the waiver authorizing the PHP program; a decision is expected in early 2002.

Issues in Long-Term Care for Older People and Younger Persons with Disabilities

The governor has identified increased access to home and community-based services as a priority for his administration. Despite this public commitment, long-term care is heavily skewed toward institutional care with policy strongly influenced by the nursing home industry. Eligibility criteria are strict and the supply of services, both institutional and community-based care, is controlled to help contain costs. Nursing home bed supply is relatively low and reimbursement relatively generous. While the nursing home industry does not oppose expansion of home and community-based services nor does it see home care as competition, its annual rate increases take a large share of any Medicaid funding increases, leaving little to direct toward new services in the community.

As in other parts of the Medicaid program, cost remains the most important obstacle to major change. From 1990 to 1992, Medicaid long-term care costs in Alabama increased by an average 28.3 percent per year. Since then, spending has slowed—from 1995 to 1998 long-term care costs in Alabama increased by an average of 9.1 percent per year (see table 4). In establishing the Medicaid Trust Fund, the governor created the Seniors’ Safety Net to

protect funding for long-term care and other services for the elderly for the rest of the decade.⁵³

In addition to cost, respondents raised several areas of concern about services for the elderly and people with disabilities. All of the Medicaid-funded long-term care programs are medically oriented with respect to both the eligibility criteria and the services they provide. Industry officials note that there is little integration among the various services that recipients need—acute, preventive, and long-term care—and eligibility standards differ among the programs, hindering coordination. Home health visits are limited and reimbursement is low. Oversight offices are understaffed, which threatens to affect quality assurance activities.

In January 2000, the governor appointed a Long-Term Care Task Force to advise his administration on how to improve long-term care services for seniors.⁵⁴ This task force is charged with performing a needs assessment, reviewing and revising Medicaid admission criteria as appropriate, identifying needed legislation and regulatory changes, and developing a reconfigured service delivery system in partnership with stakeholders, advocates, and families that focuses on care within the local community. While there have been other such task forces in the past, the governor's ongoing interest and participation in this one have raised expectations for its success. Dramatic shifts in policy, however, are not expected.

Nursing Home Reimbursement and Capacity

Medicaid is an important player in the nursing home market. During FY 1999, 64 percent of all nursing home care in the state was financed by Medicaid.⁵⁵ In 1999, 71.8 percent of Alabama's 23,308 nursing facility residents were Medicaid recipients.⁵⁶

Ninety-one percent of the nursing home population are elderly; 9 percent are younger persons with disabilities. Nursing home eligibility standards under Medicaid are strict, based on medical criteria rather than on limitations in activities of daily living (ADLs). Industry officials assert that nursing home resident acuity is high when ADLs are considered and, consequently, a high level of direct care is required. Indeed, staffing levels per resident are 9 percent higher in Alabama nursing homes than the national average and 17 percent above the regional average.⁵⁷

Medicaid nursing home reimbursement is also above the regional average by 20–25 percent, driven, industry officials assert, by the higher staffing ratios. The nursing home lobby has been very successful at keeping reimbursement rates high and fought an attempt by the previous governor to reduce rates after the repeal of the Boren amendment.⁵⁸ Rates are reviewed semiannually and adjusted for inflation. More than a quarter (26.2 percent in 1999) of total Medicaid expenditures are dedicated to long-term care for the elderly and younger persons with disabilities, which is above the national average. Nonetheless, spending per elderly beneficiary, at \$5,237 in 1997, remains below the national average.⁵⁹

A long-standing moratorium on nursing home beds was lifted in 1996 but had been effective in limiting the supply of nursing home beds. Alabama has 101 beds per elderly resident over the age of 75, which is below the national average of 113. Industry representatives believe that current access to nursing home care is good despite the low supply of beds. Outside of the Medicaid program, there is little funding for noninstitutionalized services in Alabama.⁶⁰ Partly as a result, the state has a very low supply of nonmedical residential facilities. In 1998, there were 27.6 beds per 1,000 elderly people age 75 and over compared with the national average of 52.8 beds per 1,000 elderly people age 75 and over. In 1998, Alabama had 180 certified home health agencies, many of them affiliated with rural hospitals.⁶¹

Community-Based Care Initiatives

The bulk of Medicaid long-term care expenditures (87.2 percent in 1999) finance institutional services, with only 12.8 percent for community-based services.⁶² Between 1997 and 1999, institutional expenditures grew 9.8 percent, while home and community-based ser-

vices grew 45 percent, albeit from a much smaller base, suggesting the beginning of a shift in focus. There are several initiatives under way to provide more services in a community setting, some dating from the early 1980s.⁶³ In addition, new 1915(c) waiver programs for persons with dementia or with HIV/AIDS are being considered for the future. Medicaid officials see the long-run goal as increasing the range of services available along a continuum of care. Individual needs would be assessed and options offered along that continuum.

Alabama's 1915(c) waiver for elderly and disabled adults was originally approved in 1984 and serves recipients of Supplemental Security Income (SSI) or State Supplementation who meet the medical criteria for Medicaid nursing home care. Covered services include case management, homemaker services, personal care, adult day health, respite care, and companion services. The program is administered by the Alabama Department of Public Health and the Department of Senior Services and in 1999 served 6,098 people. The state estimates that nursing home care for these individuals would cost over \$16,000 more per recipient.⁶⁴ Nonetheless, competing demands within the long-term care budget and rising labor costs have led Alabama to leave some waiver slots unfunded, and there remains a waiting list for services.

A second 1915(c) waiver program serves individuals with mental retardation or developmental disability (MR/DD). Covered services include 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. This waiver is administered by the Department of Mental Health. In 1999, this program served 4,038 individuals. The Medicaid Agency estimates savings per enrollee at more than \$61,000 per recipient.⁶⁵

A third waiver, known as the "homebound waiver," served 354 recipients with severe physical disabilities in 1999 at an estimated savings of nearly \$15,000 each.⁶⁶ Recipients must be over age 18, have a specific medical diagnosis (such as traumatic brain injury or multiple sclerosis), and have income under 300 percent of the SSI level. In addition to case management, services include personal care, respite care, environmental modification, transportation, medical supplies, personal emergency response system, and assistive technology. The waiver is administered by the Department of Rehabilitative Services. Like the MR/DD waiver, it has open slots and no waiting list.

While the theoretical savings from providing long-term care services in a community setting are substantial, expansion of these programs is unlikely to lead to any real savings to the state. Medicaid officials contend that waiver enrollees would not be drawn from among current nursing home residents. Strict eligibility criteria for nursing home entry and the constrained supply of nursing home beds has led to high acuity among residents so that most current nursing home residents are not considered likely candidates for home and community-based services. Therefore, any new community-based services would be in addition to, not instead of, nursing home care. As in other state programs, cost becomes the issue.

The labor shortages seen across the country are also a factor. While officials did not think that the problem is as severe in Alabama as in other states, they do see some shortages in direct care workers, particularly skilled workers such as licensed practical nurses and registered nurses, that might affect the ability of the state to expand home and community-based care. They cited the high turnover among these workers and the low pay. Reimbursement for home health is below the average for southern states and Medicaid officials would like to see it raised to allow better pay for direct care workers. They may also consider raising the pay of private duty nurses in an effort to address staff shortages. Cost remains the chief obstacle to improvements in these areas.

Services for Persons with Mental Illness, Mental Retardation, or Developmental Disabilities

In 1998, Alabama had seven Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) with 869 beds. The number of both ICF/MR facilities and beds has decreased since 1996 largely due to a court order to move residents out of such facilities. The ratio of licensed ICF/MR beds per 1,000 population in Alabama was 0.20 as compared with the national ratio of 0.47.⁶⁷

In 1999, Governor Siegelman settled the longest-running mental health lawsuit in America, *Wyatt v. Stickney*. The state had been in litigation over Wyatt for 29 years, with the case surviving eight Alabama governors and four commissioners, costing Alabama taxpayers over \$10 million in litigation fees. Under the settlement agreement no state mental institution will close. The state is now in the process of moving 600 citizens with mental illness and mental retardation out of state facilities and into community-based settings. As a result of this settlement, the Alabama Department of Mental Health and Mental Retardation will need a cash infusion of \$7.8 million in 2002 to keep all its facilities open.⁶⁸

Quality of Care Issues

The Medicaid Agency has several quality of care programs under way and, following a number of deaths in Alabama's assisted living facilities, the governor brought renewed attention to the area of quality assurance, not just for assisted living, but for all home and community-based services. Intense debate surrounded this issue throughout 2000, with the governor calling for tighter regulation of the assisted living industry to protect elderly consumers. The Department of Public Health, however, stated that it had insufficient staff and funding to enforce the existing regulations governing assisted living. Since then, the Department of Public Health has adopted revised rules that provide stricter state oversight and regulation relating to licensure, administration, personnel and training, storage of medications, care of residents, and physical requirements for facilities. Rules for assisted living specialty care dementia facilities were adopted concurrently with the revised rules for regular assisted living facilities, establishing a two-tiered licensing system that allows specialty care dementia facilities to be licensed to provide a higher level of care for dementia residents than regular facilities.⁶⁹

Other Issues

Rural Health Care

Nearly one-third of Alabama's population lives in rural areas. A major source of direct services to rural residents comes from the 15 federally qualified community health clinics that operate in over three quarters of Alabama's 67 counties. The proportion of the rural population covered by insurance is lower than in urban areas and the proportion in poor or fair health is higher. In spite of their poorer health status, rural residents are less likely to have seen a physician or other health professional. Not surprisingly, they are less confident that they can get medical care when they need it.⁷⁰ Members of the academic and public health communities in Alabama recognize these disparities and are working to bring the issue to greater prominence in the state and to find resources to address identified problems.

The Robert Wood Johnson Foundation is providing financial support to improve access to primary care in Alabama and seven other states through its Southern Rural Access Program. The program has five components—rural leadership pipeline, rural health networks, recruitment and retention of primary care providers, community development, and a revolving loan fund. The revolving loan fund provides matching funds to rural communities for health care facility improvement and equipment purchases. The Alabama Primary Health Care Association and the Alabama Family Practice Rural Health Board are co-grantees.

The University of South Alabama (USA) has established a telemedicine program with financial support from the federal Office of Rural Health Policy and is expanding this service across the southern part of the state. Rural health officials see great potential for

telemedicine to broaden the range of medical services available in rural communities. Not every community can support the full range of provider specialties, and telemedicine can make many specialist services available to rural residents without their having to travel. Officials note, however, that the issue of reimbursement for such services needs to be addressed before telemedicine can be more widely used. USA is also home to the Area Health Education Center state program (AHEC), which provides education and training assistance to both rural and urban providers, with regional AHECs throughout much of the state.

The University of Alabama has long been active in training and recruiting health care workers for rural areas of the state. In April 2000, it convened the first annual Rural Health Conference. The second annual conference was held in April 2001, and a third is planned for 2002. The goal of the conferences is to produce an Action Agenda for health system reform, improving personal health choices and building healthy communities in rural areas. The conferences bring together a broad range of health care workers at all levels to increase the involvement of communities in their own health care and to share the experiences of different communities across the state. Outside presenters provided information on the range of programs available at the federal level for rural health care promotion and development. In addition, the University of Alabama has recently established the Alabama Institute for Rural Health Research to integrate the research efforts of six Alabama colleges.

Provider recruitment and retention remains a major problem in rural health care delivery. The Family Practice Rural Health Board (FPRHB) was created by the state legislature to enhance training and preparation of family physicians for rural areas. A report released in 1998 by the FPRHB and the Office of Primary Care and Rural Health estimated a health practitioner retention rate of less than 10 percent in Alabama's rural areas.⁷¹ Alabama has implemented several programs to try to address its problem of provider shortages. With its policy of enhanced reimbursement for rural providers for a specified set of preventive services, Alabama is one of only three states to provide increased reimbursement in rural areas.⁷² Efforts to improve provider availability in rural areas include merit scholarships and loan forgiveness and repayment programs for health professions students. In addition, the National Health Service Corps, a federal-state loan repayment program, offers physicians and dentists financial assistance to offset educational loans in return for services provided in underserved areas. Alabama Community Scholarship Program provides scholarship support to eligible medical, family nurse practitioner, and physical assistant students who are focusing on primary care in exchange for a minimum two-year service commitment in a health practitioner shortage area.⁷³ The J-1 visa program, which arranges for foreign medical graduates to practice in underserved areas, remains important in rural Alabama. In 2000, there were 119 J-1 physicians practicing in Alabama.⁷⁴

The 1997 BBA created the Medicare Rural Hospital Flexibility Program, which establishes standards for limited service or critical access hospitals in rural areas and authorizes grants to each of the states to help them respond to this opportunity. In 1999 Alabama established a task force to oversee the program and to provide technical assistance to hospitals that are considering applying for critical access hospital (CAH) status. Initially, 28 hospitals were identified as candidates for CAH status based on their capacity, average daily census, and average length of stay. Financial assessments at these hospitals, however, showed that CAH conversion only rarely offered the predicted improvements in financial stability. As of May 2000 only 10 Alabama hospitals were still considering this option.⁷⁵ Rural health officials see greater benefits for Alabama's rural hospitals coming from recent proposals at the federal level to adjust the wage index to better reflect costs in rural areas.

Dental Care

The drive to increase access to dental care for low-income children in Alabama has focused on increasing the participation of dentists in the Medicaid program. The Medicaid Agency undertook a new dental initiative—Smile Alabama—in October 2000. Smile Alabama has two major components: recruitment and retention of providers, and education of Medicaid

recipients and the public about the importance of preventive dental care.⁷⁶ Medicaid reimbursement for dentists was raised to a rate equal to the prevailing Blue Cross/Blue Shield rate. Prior to the initiative there were some 300 dentists in the program but only 93 of these saw a significant number of children. There were no participating dentists in 20 Alabama counties. Since the increase in rates in October 2000, 83 dentists have joined the program. In addition to raising reimbursement rates, the Medicaid Agency is working with dentists to set up information systems, providing free claims software and information on how to file claims properly.

Advocates confirm that the program has had a positive impact. Hospitals are also supportive of the initiative, because children with serious unmet dental needs often show up at hospital emergency rooms when they are unable to find a dentist to treat them. Hospital officials believe that improved dental care for Medicaid clients could reduce expenditures for hospital treatment for oral infections resulting from inadequate dental care.

State Regulation of Health Care

In the past few years, the Alabama legislature has passed legislation to regulate several different aspects of health care provision. In its 1997 session, the Alabama legislature mandated that insurance companies cover mammography screenings once every two years for women in their 40s and annually for women age 50 and older.⁷⁷ In the same year, the legislature also passed a law that prohibits health benefit plans from using the results of a genetic test to set rates or benefits.

In 1999, a mandate was enacted that brought the state into compliance with the federal Newborns' and Mothers' Health Protection Act of 1996. Governor Siegelman signed Rose's Law, which requires insurance companies to pay for a minimum of 48 hours of postpartum care for normal deliveries and 96 hours of postpartum care for cesarean deliveries. The law also requires health insurance companies to pay for a complete blood count with blood work and other tests before the mother is discharged from a hospital after delivery.

In May 2000, Governor Siegelman signed the Domestic Abuse Protection Act, prohibiting insurance companies from engaging in an unfair discriminatory act or practice on the basis of an applicant's history of suffering domestic abuse. This legislation states that no insurer may deny; refuse to issue, renew, or reissue; cancel; or otherwise terminate, restrict, or exclude coverage on an insurance policy or health benefit plan on the basis of an applicant's abuse history. It also prevents insurers from adding a premium differential to an insurance policy based on an applicant's abuse history. Previous Alabama law did not specifically prohibit discriminatory acts by insurers against victims of abuse.

Governor Siegelman also signed the Mental Health Parity Act, ensuring that persons are offered the opportunity to purchase mental health insurance equal to physical health insurance coverage. The act outlines minimum health benefits insurers must include in a plan and requires insurers to make an annual report to the Commissioner of Insurance relative to their experience offering mental health coverage. This law also expands coverage of mental health treatment. Group policies now are required to offer coverage for the treatment and diagnosis of mental illnesses under the same terms and conditions that are provided for treating physical illnesses. Under the new law, a contract holder may elect to provide the additional mental health benefits on an optional basis or to conform its policies, contracts, or certificates and adjust its premium costs to reflect the additional benefit costs. This new law is not considered full parity because it requires insurers to offer coverage but does not require employer sponsors of group health plans to purchase the additional coverage for mental health services. In addition, the law does not apply to groups with 50 or fewer employees. Furthermore, Blue Cross/Blue Shield, the largest insurer in the state, is exempt, which limits the likely impact of the legislation.

Conclusion

Alabama is characterized by political and fiscal conservatism, and has historically taken a minimalist approach to public health and welfare programs. Under Governor Siegelman,

there has been renewed attention to health, but the cost of expanding public programs means that progress is likely to come in small increments. The ability to generate revenues is the biggest constraint the state currently faces. Alabama has a regressive tax structure with a heavy reliance on sales taxes and very low property taxes. The state is currently facing serious budget pressures. The slowing economy over the last year led to mid-year budget cuts in some programs, notably education, although health programs were spared.

Medicaid has been shielded somewhat from these budget pressures. For every 30 cents spent by the state, the federal government contributes 70 cents; state officials are reluctant to cut a program that brings in so much outside revenue. The local share of the program has been largely funded through aggressive Upper Payment Limit and Disproportionate Share Hospital programs so that the true local share of the program is likely well below 30 percent. Despite this creative financing, in the past, Medicaid has suffered nearly annual budget crises, often leading to moratoriums on provider payment. In the last couple of years, however, Medicaid has found a cushion in the tobacco fund. Alabama has dedicated most of its tobacco settlement revenues to health care and established a Medicaid Trust Fund against future budget crises.

Problems, however, remain for Alabama's Medicaid program. The economic slowdown is seen as likely to continue. Medicaid enrollment is rising and, should economic conditions deteriorate further, there could be an increase in the number of people eligible for Medicaid. Without fundamental reform to the structure of its tax system, Alabama's ability to increase revenues will remain very limited. Finally, the UPL and DSH programs that have been critical to financing the Medicaid local share are under scrutiny by the federal Office of the Inspector General. For a Medicaid program that is perennially near financial crisis, the Inspector General's rulings on DSH and UPL and the phaseout of these programs, in addition to the uncertain future of the PHP arrangement, represent the most important current threats to the program.

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Table 1 Notes

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k. In 1996, the threshold represents the state Medicaid threshold for poverty-related eligibility or AFDC- related eligibility. Higher thresholds for separate state-financed programs (such as in New York) are not represented here.

l. The figure for 1998 represents the higher of the state threshold for Medicaid eligibility, or the state threshold for Medicaid expansions or stand-alone programs enacted under the SCHIP legislation.

m. The figure for 2000 represents the higher of Medicaid or SCHIP eligibility. In 2000, all states covered at least some children through SCHIP; certain groups in some states are only eligible through Medicaid.

About the Authors

Barbara A. Ormond is a research associate in the Health Policy Center of the Urban Institute. Her work there has focused on the impact of health system change on uninsured and publicly insured populations. In addition, she has studied the rural health care safety net, Medicaid managed care, and children’s access to dental care. Prior to coming to the Urban Institute, she conducted research on hospital provision of uncompensated care in the United States and on the demand for curative care in rural Indonesia. She also spent several years working at the U.S. Agency for International Development, with a focus on population, environment, and rural health systems.

Alyssa Wigton at the time of this research was a research associate for the Urban Institute’s Assessing the New Federalism project. While at the Institute, she worked on crosscutting research and assisted with core management of the project. She currently works as a Senior Project Officer for Medical Care Development International.

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