Health Policy for Low-Income People in Alabama

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An Urban Institute Program to Assess Changing Social Policies

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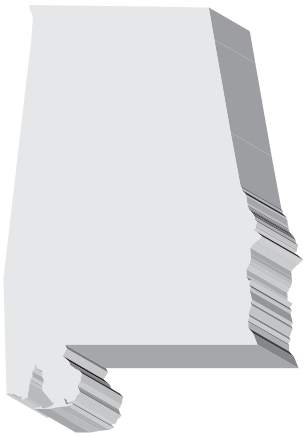

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This report is part of The Urban Institute's *Assessing the New Federalism* project, a multi-year effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Project codirectors are Anna Kondratas and Alan Weil. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, Inc., the project studies child and family well-being.

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About the Series

Assessing the New Federalism is a multi-year Urban Institute project designed to analyze the devolution of responsibility from the federal government to the states for health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, Inc., the project studies changes in family well-being. The project aims to provide timely nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's Web site. This paper is one in a series of reports on the case studies conducted in the 13 states, home to half of the nation's population. The 13 states are Alabama, California, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington, and Wisconsin. Two case studies were conducted in each state, one focusing on income support and social services, including employment and training programs, and the other on health programs. These 26 reports describe the policies and programs in place in the base year of this project, 1996. A second set of case studies to be prepared in 1998 or 1999 will describe how states reshape programs and policies in response to increased freedom to design social welfare and health programs to fit the needs of their low-income populations.

The income support and social services studies look at three broad areas. Basic income support for low-income families, which includes cash and near-cash programs such as Aid to Families with Dependent Children and Food Stamps, is one. The second area includes programs designed to lessen the

dependence of families on government-funded income support, such as education and training programs, child care, and child support enforcement. Finally, the reports describe what might be called the last-resort safety net, which includes child welfare, homeless programs, and other emergency services.

The health reports describe the entire context of health care provision for the low-income population. They cover Medicaid and similar programs, state policies regarding insurance, and the role of public hospitals and public health programs.

In a study of the effects of shifting responsibilities from the federal to state governments, one must start with an understanding of where states stand. States have made highly varied decisions about how to structure their programs. In addition, each state is working within its own context of private-sector choices and political attitudes toward the role of government. Future components of *Assessing the New Federalism* will include studies of the variation in policy choices made by different states.

Contents

Highlights of the Report

Alabama is a fairly small state with substantial low-income and minority populations (almost entirely black) and very few immigrants. Politically, the state is very conservative, with traditional values playing an important role. According to some observers, race is still a major factor in determining welfare and health policy for the low-income population, although not nearly as important as it was in the past. Alabama's social programs are very limited and are designed primarily to meet basic federal requirements (and in part to maximize federal funds while minimizing state spending).

The budgetary environment for social programs is severely constrained because of the relatively low average income of the population, the fact that most tax revenues are earmarked for education, and the strong anti-tax sentiment of the state (vigorously promoted by Governor Forrest "Fob" James). The Medicaid program is very heavily dependent on intergovernmental transfers, provider taxes, and disproportionate share hospital (DSH) payments and relies on minimum federal requirements to determine eligibility and coverage policy. Consequently, the program is extremely vulnerable to federal policy changes regarding DSH, eligibility, and coverage. As a result, potential funding calamities are routine. For example, expansion of Medicaid eligibility for pregnant women and children has added substantially to the Medicaid rolls, and restrictions on DSH have forced the development of complicated financing schemes. Political support is higher for Medicaid than for cash welfare assistance, in part because several well-financed provider groups, especially the for-profit nursing home association, lobby to protect the program.

As elsewhere, Medicaid in Alabama is the primary state health program, accounting for 17.5 percent of total state expenditures in 1995. Total Medicaid

expenditures grew from $829.5 million in 1990 to nearly $2 billion in 1995, at an annual growth rate of 19.2 percent, which was faster than the national average. As with the rest of the country, expenditure growth rates were much faster between 1990 and 1992 than between 1992 and 1995. Although growth in DSH expenditures in the early 1990s explains a significant share of the rapid rate of growth, benefit payments for all service categories and eligibility groups increased rapidly as well. The Alabama Medicaid program covers relatively few services and places limits on many of them (e.g., the program covers only 16 hospital days per year for adults).

Most observers acknowledge that Alabama ranks near the bottom on many measures of health, welfare, and educational expenditures. As a result, most people interviewed are not concerned that the state will become a "welfare magnet." Although the state successfully engaged in a tax-incentive bidding war with other states to induce Mercedes-Benz to build a factory in Tuscaloosa, levels of welfare and Medicaid benefits seem mostly determined by the tight fiscal environment and by the political culture, which is hostile to government programs. The governor was a strong proponent of a federal Medicaid block grant, a position opposed by most consumer and provider groups, who feared the grant would result in inadequate state funding and the loss of the ability to go to court to force the state to meet federal rules.

The uninsurance rate in Alabama is 16.9 percent of the state's nonelderly population, higher than the national average. Alabama has very strict financial eligibility criteria for its health and welfare programs, although federal rules make eligibility for Medicaid broader than for cash welfare. Because of the high level of poverty, nearly half of all births are Medicaid-financed. In 1995, approximately 10.4 percent of the state's nonelderly population was enrolled in Medicaid. This represents 47 percent of the population with incomes below 150 percent of the federal poverty level, well below the 64 percent for the country as a whole. Because of the large number of uninsured children, the state is eligible for a total of $86.4 million in federal funds in FY 1998 ($397 million for the FY 1998–2002 period) for the State Children's Health Insurance Program (S-CHIP) established by the federal Balanced Budget Act of 1997. Even with an extremely high federal match rate, however, the state may have difficulty raising its share. The state's initial plan, which was implemented on February 1, 1998, increases Medicaid eligibility to all children whose family income is below 100 percent of the federal poverty level. However, further expansion to 200 percent of the federal poverty level is likely to use private insurance rather than Medicaid. Currently, the state does not have any state-run insurance program for persons ineligible for Medicaid. Moreover, health insurance reform appears to be a low priority, with the state seeking only to comply with the minimum requirements of the Health Insurance Portability and Accountability Act of 1996 (Kassebaum-Kennedy).

Compared to some other states, the health care market in Alabama has yet to experience either the expansion of managed care or the conversion of nonprofit hospitals to for-profit status on a broad scale. In addition, Blue Cross/Blue

Shield is by far the dominant insurer, with approximately 70 percent of the insured population. The lack of strong health maintenance organizations (HMOs), as well as the antagonism of much of the medical establishment to managed care, has led the Medicaid program to rely on less comprehensive approaches to managed care, such as primary care case management. A decade-old freedom-of-choice Medicaid waiver mandating case management for pregnant women is credited by many (along with the federally imposed Medicaid eligibility standards) with substantially reducing infant mortality. In addition, the state has obtained a Medicaid research and demonstration waiver for a sole-source HMO in Mobile County.

Federal law requires state Medicaid programs to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. Alabama has aggressively used these DSH payments in conjunction with intergovernmental transfers and provider taxes to maximize federal revenues to support the Medicaid program as a whole, at little or no cost to the state. As a result, only about a quarter of the state's roughly 30 percent Medicaid match is financed by general revenues, and these outlays have remained fairly constant in nominal dollars over the past several years. Faced with potential reductions in federal DSH payments as a result of the rules imposed by the federal Omnibus Budget Reconciliation Act of 1993, the state worked with hospitals to create eight prepaid health plans (PHPs) to receive capitated payments for hospital care. DSH payments are folded into the capitation rate, and the PHPs are able to distribute DSH payments any way they like without regard to federal rules. Although many observers believe that the PHPs are transparent efforts to evade federal rules, the Medicaid agency resolutely maintains that these organizations really do provide managed care. The Balanced Budget Act of 1997 grandfathered the Alabama PHP structure for the short term; however, the law raises questions about the ability of the state to continue to use these entities to distribute DSH funds in the future. The law also reduces the state's federal DSH allotment over time.

The safety net in Alabama, which provides health care to the uninsured and Medicaid populations, is reasonably solid, partially compensating for the limits of Medicaid and other insurance coverage. The lack of aggressive price competition in the health care market gives providers the ability to cross-subsidize care for the uninsured. The state health department, operating out of county health departments, plays an important role in providing services, especially maternal and child health and home health care. In recent years, use of health department services by Medicaid beneficiaries has declined as managed care has linked patients to private physicians. Alabama's local public and state-university-owned hospitals and community health centers provide a substantial amount of health care to the uninsured. Birmingham, with its wealth of health care providers, is a city where the uninsured can obtain care for acute episodes or emergencies, but where ongoing management of health problems can be difficult. Access to health care in rural areas can be particularly difficult because of transportation problems and the lack of providers. With the

expected expansion of managed care in the employer-sponsored and Medicaid markets and the development of a more competitive market, the question is whether the existing facilities will continue to provide substantial levels of uncompensated care in the future.

Long-term care for the elderly and for younger people with disabilities is a critical component of the state's involvement in health care and a significant part of the Medicaid program. The long-term care delivery system has a strong institutional bias. Nonetheless, for the mentally ill and people with mental retardation or developmental disabilities, substantial strides have been made in shifting care toward home and community-based services. In 1997, Medicaid reimbursement for nursing homes was a fairly bitter issue between Governor James and the nursing home industry, with the governor proposing 20 to 30 percent reductions in nursing home rates to solve a significant Medicaid budget overrun. This proposal was rejected by the legislature, which chose instead to establish a commission to make recommendations on nursing home reimbursement, increase the nursing home provider tax, and make modest reimbursement rate changes. Reliance on the provider tax means that the federal government will finance most of the budget shortfall through its Medicaid match.

Alabama faces several challenges for the future. First, how will the state adjust to changes in the federal rules on DSH? Second, how and to what extent will Alabama implement the S-CHIP? Third, will Alabama be able to expand managed care in a way that does not undermine the safety net? And, finally, will the repeal of federal rules on nursing home reimbursement reduce reimbursement rates, and what will be the consequences of doing so?

Thumbnail Sketch of Alabama

Alabama is a southern state with large low-income and black populations. Its citizens generally favor a small role for government, and low levels of revenues leave policymakers with little choice but to provide health and welfare benefits at only minimal levels. Race, although no longer the defining issue that it once was, is still important. The state depends on intergovernmental transfers and health care provider taxes to finance the state Medicaid match, a practice that has created tensions with the federal government.

Sociodemographic and Economic Overview

Alabama is a fairly small state, in terms of both population and geography. In 1994–95, about 4.3 million people lived within its approximately 50,750 square miles (see table 1). Despite its image as a rural state, only a third of its population live outside of Metropolitan Statistical Areas. The lack of affordable transportation in both cities and rural areas is often cited as a problem in a wide variety of contexts, but Alabama's relatively small size makes it fairly easy to travel from one part of the state to another by automobile. As a result, unlike the situation in some larger states, officials and other observers rarely stress the differences between one part of the state and another. Nonetheless, although some areas are bustling and prosperous, others, especially rural areas, face enormous problems, with high rates of poverty and a lack of even basic public health facilities (e.g., no sewage treatment of any kind).

The racial and ethnic composition is dominated by whites and non-Hispanic blacks, with relatively few immigrants or other minorities. In

Table 1 *State Characteristics*

	Alabama	United States
Sociodemographic		
Population (1994–95)[a] (in thousands)	4,314	260,202
Percent under 18 (1994–95)[a]	27.4%	26.8%
Percent 65+ (1994–95)[a]	13.6%	12.1%
Percent Hispanic (1994–95)[a]	0.8%	10.7%
Percent Non-Hispanic Black (1994–95)[a]	28.9%	12.5%
Percent Non-Hispanic White (1994–95)[a]	69.6%	72.6%
Percent Non-Hispanic Other (1994–95)[a]	0.7%	4.2%
Percent Noncitizen Immigrant (1996) *	0.9%	6.4%
Percent Nonmetropolitan (1994–95)[a]	36.8%	21.8%
Population Growth (1990–95)[b]	5.3%	5.6%
Economic		
Per Capita Income (1995)[c]	$19,181	$23,208
Percent Change in Per Capita Personal Income (1990-95)[c, d]	26.0%	21.2%
Percent Change in Personal Income (1990-95)[c, e]	32.4%	27.7%
Employment Rate (1996)[f, g]	60.3%	63.2%
Unemployment Rate (1996)[f]	5.1%	5.4%
Percent below Poverty (1994)[h]	17.6%	14.3%
Percent Children below Poverty (1994)[h]	23.8%	21.7%
Health		
Percent Uninsured—Nonelderly (1994–95)[a]	16.9%	15.5%
Percent Medicaid—Nonelderly (1994–95)[a]	10.4%	12.2%
Percent Employer Sponsored—Nonelderly (1994–95)[a]	66.3%	66.1%
Percent Other Health Insurance—Nonelderly (1994–95)[a, i]	6.4%	6.2%
Smokers among Adult Population (1993)[j]	18.5%	22.5%
Low Birth-Weight Births (<2,500 g) (1994)[k]	9.0%	7.3%
Infant Mortality Rate (Deaths per 1,000 Live Births) (1995)[l]	10.2	7.6
Premature Death Rate (Years Lost per 1,000) (1993 [m, n]	67.1	54.4
Violent Crimes per 100,000 (1995)[o]	632.4	684.6
AIDS Cases Reported per 100,000 (1995)[j]	15.1	27.8
Political		
Governor's Affiliation (1996)[p]	R	
Party Control of Senate (Upper) (1996)[p]	23D-12R	
Party Control of House (Lower) (1996)[p]	71D-34R	

a. Two-year concatenated March Current Population Survey (CPS) files, 1995 and 1996. These files are edited by the Urban Institute's TRIM2 microsimulation model. Excludes those in families with active military members.

b. U.S. Bureau of the Census, *Statistical Abstract of the United States: 1996* (116th edition). Washington, D.C., 1996. 1995 population as of July 1. 1990 population as of April 1.

c. *State Personal Income, 1969–1995*. CD-ROM. Washington, D.C.: Regional Economic Measurement Division (BE-55), Bureau of Economic Analysis, Economics and Statistics Administration, U.S. Department of Commerce, October 1996.

d. Computed using mid-year population estimates of the Bureau of the Census.

e. Personal contributions for social insurance are not included in personal income.

f. U.S. Department of Labor. *State and Regional Unemployment, 1996 Annual Averages*. USDL 97-88. Washington, D.C., March 18, 1997.

g. Employment rate is calculated using the civilian noninstitutional population 16 years of age and over.

h. CPS three-year average (March 1994–March 1996 where 1994 is the center year) edited using the Urban Institute's TRIM2 microsimulation model.

i. "Other" includes persons covered under CHAMPUS, VA, Medicare, military health programs, and privately purchased coverage.

j. Normandy Brangan, Danielle Holahan, Amanda H. McCloskey, and Evelyn Yee. *Reforming the Health Care System: State Profiles 1996*. Washington, D.C.: American Association of Retired Persons, 1996.

k. S.J. Ventura, J.A. Martin, T.J. Mathews, and S.C. Clarke. "Advance Report of Final Natality Statistics, 1994." *Monthly Vital Statistics Report*, vol. 44, no. 11, supp. Hyattsville, MD: National Center for Health Statistics, 1996.

l. National Center for Health Statistics. "Births, Marriages, Divorces, and Deaths for 1995." *Monthly Vital Statistics Report*, vol. 44, no. 12. Hyattsville, MD: Public Health Service, 1996.

m. ReliaStar Financial Corporation. *The ReliaStar State Health Rankings: An Analysis of the Relative Healthiness of the Populations in All 50 States*, 1996 edition, Minneapolis, MN: ReliaStar, 1996.

n. Race-adjusted data, National Center for Health Statistics, 1993 data.

o. U.S. Department of Justice, FBI. *Crime in the United States, 1995*. October 13, 1996.

p. National Conference of State Legislatures. *1997 Partisan Composition, May 7 Update*. D indicates Democrat and R indicates Republican.

1994–95, non-Hispanic blacks accounted for nearly 29 percent of the population, compared with about 13 percent for the country as a whole. Only about 1 percent of the state's population are noncitizen immigrants, and less than 1 percent are Hispanic, compared with national percentages of about 6 and 11 percent, respectively. Very small Asian and Hispanic populations work largely in chicken-processing and agricultural industries.

Economic Status

Historically, Alabama has been a very poor state. However, it is not as poor as it once was, relative to the rest of the country. Its per capita income was $19,181 in 1994–95, 17 percent below the national average; but between 1990 and 1995, income grew faster in Alabama than in the country as a whole. The percentage of the population below the federal poverty level (FPL) in 1994–95 was 17.6 percent in Alabama, compared to the national average of 14.3 percent. The percentage of children below the FPL is also higher in Alabama than in the country overall.

The economy of Alabama has been doing well in recent years. Personal and per capita income have been growing faster than the national averages, and the unemployment rate is slightly below the national average. The state's economy, which relied in the past on agriculture and steel production (particularly in Birmingham), has diversified into services, especially health care and high-technology services.

Political Landscape

Alabama is a very conservative state politically, a characterization that holds true for both Democrats and Republicans, although the conservatism has historically been mixed with populism. Fundamentalist Christians play an important political and cultural role in the state.[1] The legacy of George Wallace and his wife Lurleen is substantial, reflecting the fact that one or the other was governor during much of the past three decades. As in most of the South, Republicans have made very dramatic gains (especially in attaining higher office) in a state that was previously solidly Democratic. Republican Forrest "Fob" James is the governor, but the legislature remains heavily Democratic. Governor James is a "hard right" conservative, gaining national notice with his contention that the federal Bill of Rights does not apply to the states, his threat to use the National Guard to block a court order to remove the Ten Commandments from a Gadsden courtroom, his reintroduction of chain gangs for state inmates, and his support of creationism and corporal punishment in schools.[2] According to some observers, the state's conservatism is rooted in maintenance of the status quo rather than in a philosophical commitment to competitive

markets. Complaints about the "good old boys" who run the state were voiced by several advocates for the low-income population.

Alabama—along with Mississippi—is inextricably intertwined with the civil rights revolution of the 1950s and 1960s. To many people, the bus boycott in Montgomery, Governor Wallace standing in the schoolhouse door, and the violence against marchers in Birmingham and Selma helped define both the movement and the state in national consciousness. Issues of race are still important in Alabama, although much less so than in the past. All observers agree that overt racism by public officials has disappeared, but many analysts, especially blacks, believe that race is still an extremely important determinant of state and local policy.

Structurally, Alabama state government is characterized by a strong governor and a weak legislature. For example, in 1997, when the legislature and the governor were unable to agree on a welfare reform plan to replace the Aid to Families with Dependent Children (AFDC) program, the Department of Human Resources implemented one on its own using its regulatory authority.[3] The part-time legislators meet for only 30 working days within a 105-calendar-day period each year and have very little staff. Legislators have a strong local focus, reflecting the unusually tight restrictions that Alabama's constitution places on the power of county government. As a result, matters of local interest are often taken up by the state legislature. The short length of the legislative session, the lack of legislative staff, and the emphasis on matters of local interest often mean that little time is available to address issues of statewide importance other than the budget.

Health and welfare programs in Alabama are strongly centralized in the hands of state government. With the exception of Birmingham and a few other large cities, local governments are relatively minor players compared to those in many other states. Counties and municipalities often sponsor public hospitals, although local funding is often minimal.

Political support is higher for Medicaid than for cash welfare assistance. This is in part because several well-financed provider groups that are financially dependent on Medicaid funds lobby to protect the program, while few groups lobby in support of welfare. In the health arena, the for-profit nursing home association in the state is widely believed to be the most powerful interest group on Medicaid-related issues.[4] Long-term care is particularly important in generating political support for Medicaid because it is recognized by the executive branch and the legislature that Medicaid funding of long-term care provides a safety net for the middle class as well as for the poor.[5] Physicians and hospitals are also politically powerful; in contrast, health maintenance organizations (HMOs) are politically weak, reflecting their minor market position. On non-Medicaid health issues, Blue Cross/Blue Shield is extremely important and influential.

Consumer advocacy groups, especially in the health area, are few in number and are not very strong. Alabama Arise is the best-known advocacy group for

low-income people, but its focus is on welfare rather than health care. Racially oriented groups, such as the National Association for the Advancement of Colored People, do not concentrate on health issues. In the past, legal services organizations were important advocates, but federal legislation restricting their activities has sharply reduced their role. Organized advocacy groups for the elderly are lacking, but older people are believed to be a political force to be reckoned with, a factor that the for-profit nursing home industry effectively uses in its lobbying.

Budgetary Environment

The budgetary environment is determined by two interrelated factors. First, a very strong anti-tax sentiment exists in Alabama, and welfare is viewed with disfavor. While there is a modest state income tax and a relatively high sales tax, property taxes are among the lowest in the country. Overall, state and local taxes per capita are very low.[6] Governor James has repeatedly insisted that the state has all the revenue it requires and merely needs to be more efficient in providing services. Despite the recent growth in income, the state's relative poverty also makes it difficult to increase taxes.

Second, the vast majority of Alabama taxes are earmarked for one of two funds—the general fund and the Alabama Special Educational Trust Fund. Sales and income taxes, which account for the bulk of revenues, are earmarked for education purposes, while a wide variety of miscellaneous revenue sources, including insurance premium taxes, interest income, and excise taxes, fund the rest of state government, including Medicaid, public health, welfare, and public safety. In recent years, the income and sales taxes have grown fairly rapidly, reflecting the overall strength of the economy, while the miscellaneous taxes have grown slowly. Thus, only limited funds are available for social programs.

The net consequence of these two interrelated factors is that financial resources for health and welfare are unusually constrained. As a result, policy must be crafted within the context of available resources, which are extremely modest. Referring to social programs, one observer described the situation this way: "You can't have more money because there isn't any." A commonly stated observation is that "Alabama is a poor state and can't afford to do any better than it does in providing services." Social programs tend to be limited in their eligibility and benefits, mostly following minimum federal standards. Because state matching funds are usually not available, Alabama has not attempted to maximize the amount of federal dollars flowing into the state by increasing its own spending and capitalizing on its high federal matching rates.[7] Instead, federal funds have been used to stabilize state spending for Medicaid and other social programs by financing the expenditure growth.

As a result of these constraints, the state is always close to budgetary crisis and is particularly vulnerable to changes in federal rules that require additional

spending. During 1996, the state faced major problems in meeting federal requirements for its disproportionate share hospital (DSH) payment program; failure to do so could have meant the loss of very large amounts of federal dollars.[8] Alabama has been extremely aggressive in its use of the DSH program in conjunction with intergovernmental transfers and provider taxes to maximize federal revenues in place of state spending; in 1995, DSH accounted for 21 percent of Alabama Medicaid expenditures. In fact, Alabama's use of intergovernmental transfers and provider taxes goes far beyond providing state matching funds to finance DSH and accounts for the vast majority of the state's match for Medicaid. During 1997, the Medicaid program had budget overruns, which a gubernatorially appointed commission blamed largely on rapid increases in prescription drug and nursing home expenditures, allegedly caused by an overly generous reimbursement methodology.

Roadmap to the Rest of the Report

The rest of the report is divided into eight topics. The next two sections briefly describe the policy, budgetary, and administrative context of Medicaid and other health programs for the low-income population in Alabama. These descriptions are followed by a section assessing how the state views its role in providing health care and other services to the low-income population and how that role might change if the state were given additional flexibility to run Medicaid and other social programs. The next section gives an analysis of eligibility for third-party health care coverage for the low-income population, particularly Medicaid, and is followed by a section dealing with the financing of health care to the low-income population. The next section describes the public health system and other providers that compose the health care safety net. The section after that describes long-term care for the elderly and younger people with disabilities. Finally, there is a discussion of the major health care challenges facing the state for the future.

Setting the Policy Context

Alabama's health care agenda is driven by the need to control state general revenue expenditures and ensure that adequate levels of federal funds continue to flow into the state. The Medicaid agency would like to gradually shift beneficiaries into a managed care system, but due to the lack of health maintenance organizations (HMOs) and the opposition of the medical establishment to managed care, the agency must move cautiously.

Health Care Environment

Two characteristics of the health care system in Alabama are crucial to understanding the state's health care politics and policy. First, in some parts of the state (including Birmingham and Mobile), public hospitals sponsored by county and city governments and by branches of the state university system play an important role in providing health care to Medicaid and uninsured patients. To some extent, these hospitals fill some of the gap that is created by low Medicaid eligibility standards.

Second, unlike some other states, such as Texas, neither managed care nor for-profit takeovers of hospitals are significant factors in Alabama, resulting in less competitive markets than seen elsewhere. Enrollment in HMOs, of which there are few, is very low, amounting to less than 10 percent of the population. Most observers believe that managed care will be a more significant force in the future, and hospitals and other providers are beginning to position themselves for that eventuality. To a significant extent, Blue Cross/Blue Shield of Alabama dominates health care in the state, insuring or processing claims for

70 percent of the insured population. It has been aggressive in protecting its market position, in part by using its market power and transforming itself into a semi-managed-care organization. For example, Blue Cross/Blue Shield now limits its contracts with new providers and offers a product that restricts choice of physicians.

State Health Care Indicators

Alabama is below average among the states in health status of the population and has a higher proportion than average of uninsured people. In the ReliaStar rankings of the relative healthiness of the populations in all 50 states, Alabama ranked 41st in 1996.[9] Alabama's rates of low birth weight, infant mortality, and premature death are significantly higher than the national average (see table 1). Infant mortality rates in particular are quite high but have declined substantially in recent years, a trend that observers attribute largely to the expansion of Medicaid eligibility for pregnant women and the Medicaid maternity waiver.

Lack of health insurance in Alabama is a major problem, with 16.9 percent of the nonelderly population uninsured in 1994–95. However, somewhat surprisingly, given the state's low Medicaid coverage, the state's uninsurance rate is only about two percentage points higher than the national average. A higher rate of employment-based health insurance than in the rest of the South helps keep the uninsurance rate from being larger.[10]

Many urban areas, such as Birmingham, have a wealth of health care providers. In the state as a whole, however, physicians are less prevalent and hospital beds more common than in the country overall.[11] In 1995, there were 179 physicians per 100,000 population in Alabama, compared with 228 physicians per 100,000 in the nation. Of Alabama's 67 counties, 61 are designated by the federal government as whole- or partial-county Health Professional Shortage Areas. In contrast, the state had 526 hospital beds per 100,000 population, while the country as a whole had 411 hospital beds per 100,000 population.

State Health Programs

Alabama's state government administers a standard array of health programs, most of which receive some level of federal funding. The state operates few, if any, programs of fiscal significance that do not qualify for federal support. And in many areas in which federal law grants discretion to states in defining program features, Alabama elects to provide relatively low levels of assistance and seldom implements optional coverage or benefits. State health programs reside in several independent departments or agencies, including the Medicaid Agency, Department of Public Health, Department of Rehabilitation Services, and Department of Mental Health and Mental Retardation. In addition, the Department of Human Resources shares responsibility for Medicaid eligibility determinations with the Medicaid Agency.

Medicaid

As in other states, Medicaid is the principal state health care program in Alabama, accounting for 17.5 percent of total state expenditures in 1995 (see table 2). Because of inter- and intragovernmental transfers implemented to maximize federal revenues, commonly reported state expenditure trends (such as those reported in table 2) must be viewed with caution. "True" general-fund expenditures for Medicaid constitute only about 24 percent of the state Medicaid match, and the nominal level of state spending has been fairly stable over the past several years. In effect, federal DSH funds largely go to fund the overall Medicaid program rather than to provide hospitals with additional funds to care for the uninsured and Medicaid beneficiaries.

Table 2 *Alabama Spending by Category, 1992 and 1995 ($ in Millions)*

Program	State General-Fund Expenditures[a] 1992	1995	Annual Growth	Total Expenditures[b] 1992	1995	Annual Growth
Total	$3,636	$4,237	5.2%	$9,481	$11,390	6.3%
Medicaid [c, d]	129	213	18.2	1,552	1,996	8.7
% of Total	(3.5)	(5.0)	—	(16.4)	(17.5)	—
Corrections	130	197	15	153	242	16.5
% of Total	(3.6)	(4.6)	—	(1.6)	(2.1)	—
K–12 Education	1,980	2,178	3.2	2,398	2,571	2.3
% of Total	(54.5)	(51.4)	—	(25.3)	(22.6)	—
AFDC[e]	23	24	1.4	90	82	(3.1)
% of Total	(0.6)	(0.6)	—	(0.9)	(0.7)	—
Higher Education	849	1,029	6.6	2,530	3,021	6.1
% of Total	(23.3)	(24.3)	—	(26.7)	(26.5)	—
Miscellaneous[f]	525	596	4.3	2,758	3,478	8.0
% of Total	(14.4)	(14.1)	—	(29.1)	(30.5)	—

Source: National Association of State Budget Officers, 1992 *State Expenditure Report* (April 1993) and 1996 *State Expenditure Report* (April 1997).

a. State spending refers to general-fund expenditures plus other state fund spending for K–12 education.

b. Total spending for each category includes the general fund, other state funds, 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., is included in state spending because states cannot separate them. Alabama reported other state funds of $298 million in 1992 and $379 million in 1995. In 1992, Alabama included an unknown portion of direct Medicaid matching funds in the other state category, causing the amount listed under state spending to understate spending on direct matching purposes.

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. State total includes retained child support collections. Alabama does not break out this expenditure amount from state dollars used for direct AFDC matching purposes.

f. This category includes all remaining state expenditures (e.g., environmental projects, transportation, housing, and other cash assistance programs) not captured in the five listed categories.

Total Medicaid expenditures grew from $829.5 million in 1990 to $1.99 billion in 1995. This represents an annual growth rate of 19.2 percent, which was higher than the national Medicaid average (see table 3). As in the rest of the country, expenditure growth rates were much higher between 1990 and 1992 than between 1992 and 1995. Although growth in DSH expenditures in the early 1990s explains a significant share of the rapid rise, benefit payments for all service categories and eligibility groups increased rapidly as well.

The Alabama Medicaid program provides limited benefits and has very low expenditures per enrollee. For example, for adults (except pregnant women), the Alabama Medicaid program covers 16 hospital days, 14 doctor visits, and three nonemergency outpatient hospital visits per year per person, whereas most states have no restrictions on these benefits. (As required by federal rules, all medically necessary services required as a result of an early and periodic

Table 3 *Medicaid Expenditures by Eligibility Group and Type of Service, Alabama and United States ($ in Millions)*

	Alabama					United States				
	Expenditures			Average Annual Growth		Expenditures			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**$829.5**	**$1,537.7**	**$1,993.8**	**36.2%**	**9.0%**	**$73,662.2**	**$118,926.0**	**$157,872.5**	**27.1%**	**9.9%**
Benefits										
Benefits by Service	$647.0	$1,082.9	$1,536.7	29.4%	12.4%	$69,168.7	$97,602.4	$133,434.6	18.8%	11.0%
Acute Care	364.9	618.3	930.3	30.2%	14.6%	36,904.5	55,059.9	79,438.5	22.1%	13.0%
Long-Term Care	282.1	464.6	606.4	28.3%	9.3%	32,264.2	42,542.5	53,996.1	14.8%	8.3%
Benefits by Group	$647.0	$1,082.9	$1,536.7	29.4%	12.4%	$69,168.7	$97,602.4	$133,434.6	18.8%	11.0%
Elderly	$234.6	$385.2	$497.9	28.1%	8.9%	$23,334.3	$31,757.9	$40,087.4	16.7%	8.1%
Acute Care	76.3	103.0	126.4	16.1%	7.1%	4,925.4	6,911.5	9,673.7	18.5%	11.9%
Long-Term Care	158.3	282.2	371.5	33.5%	9.6%	18,408.9	24,846.4	30,413.7	16.2%	7.0%
Blind and Disabled	$258.7	$404.5	$630.3	25.0%	15.9%	$25,771.6	$35,684.6	$51,379.4	17.7%	12.9%
Acute Care	135.9	228.4	400.2	29.6%	20.6%	12,929.2	19,483.6	29,760.7	22.8%	15.2%
Long-Term Care	122.8	176.1	230.1	19.8%	9.3%	12,842.4	16,201.0	21,618.7	12.3%	10.1%
Adults	$82.9	$139.4	$185.2	29.7%	9.9%	$8,765.0	$12,710.1	$16,556.9	20.4%	9.2%
Children	$70.8	$153.9	$223.2	47.4%	13.2%	$11,297.8	$17,449.8	$25,410.9	24.3%	13.3%
DSH	$156.7	$417.5	$417.5	63.2%	0.0%	$1,340.9	$17,525.6	$18,988.4	261.5%	2.7%
Administration	$25.8	$37.3	$39.6	20.2%	2.0%	$3,152.6	$3,797.9	$5,449.4	9.8%	12.8%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

Table 4 *Medicaid Expenditures per Enrollee by Eligibility Group, Alabama and United States*

	Alabama					United States				
	Spending per Enrollee			Average Annual Growth		Spending per Enrollee			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**$1,500**	**$1,984**	**$2,472**	**15.0%**	**7.6%**	**$2,397**	**$2,729**	**$3,202**	**6.7%**	**5.5%**
By Group										
Elderly	$3,079	$4,939	$6,279	26.7%	8.3%	$6,839	$8,422	$9,738	11.0%	5.0%
Cash	1,770	2,407	2,809	16.6%	5.3%	3,329	4,017	4,818	9.8%	6.2%
Noncash	6,421	9,268	10,198	20.1%	3.2%	10,377	12,192	13,521	8.4%	3.5%
Blind and Disabled	$2,674	$3,499	$4,325	14.4%	7.3%	$6,378	$7,320	$8,022	7.1%	3.1%
Cash	2,205	2,906	3,699	14.8%	8.4%	4,969	5,927	6,686	9.2%	4.1%
Noncash	18,058	16,605	19,304	–4.1%	5.1%	12,047	12,574	12,660	2.2%	0.2%
Adults	$1,022	$1,381	$1,918	16.2%	11.6%	$1,301	$1,518	$1,728	8.0%	4.4%
Children	$400	$612	$744	23.8%	6.7%	$770	$931	$1,178	9.9%	8.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.

screening, diagnosis, and treatment [EPSDT] examination are covered.) Until recently, Medicaid did not cover medically necessary transportation, as required by federal law. In part because of the coverage restrictions, Alabama's expenditures per enrollee averaged only $2,472 in 1995, which was 77 percent of the national average; average expenditures per child enrollee were $744, which was only 63 percent of the national average (see table 4).

Department of Public Health

Alabama's Department of Public Health is responsible for administering a wide range of health programs. With nearly 6,000 employees, the department provides prenatal care (mostly Medicaid-reimbursed) to about half of all pregnant women in the state and conducts more than 1.7 million home health visits, as well as offering traditional public health services that promote health and safety. Distinct from all other states, Alabama's public health system is governed by the state medical society. The 12 members of the board of the medical society serve as the State Committee of Public Health. The state health officer is appointed by this committee and functions independently of the governor. Physicians in Alabama have held this responsibility for more than 100 years.

Alabama's Department of Public Health relies heavily on federal funds and reimbursements to support its activities. In FY 1997, 36 percent of its budget consisted of federal grant funds—more than two-thirds of which were for the Women, Infants, and Children (WIC) program—and 48 percent was composed of reimbursements, mainly Medicare and Medicaid. These shares have changed somewhat over time, as third-party payments have taken on increasing importance: From 1992 to 1997, third-party reimbursements for public health services increased 81 percent. Although state funding has increased significantly as well, it comprises a small portion of the department's total funding, and efforts are under way to reduce this share further.

The department's Bureau of Family Health Services administers the WIC, Women's Health, Child and Adolescent Health, and Oral Health programs. In terms of federal grants, the bureau manages Title X (family planning) and Title V (maternal and child health) with the exception of the Children with Special Health Care Needs program, which is run by the Department of Rehabilitation Services. Other divisions within the Department of Public Health include Primary Care and Rural Health, Environmental Services, Disease Control, and Health Promotion.

Department of Mental Health and Mental Retardation

The Department of Mental Health and Mental Retardation administers programs that address mental illness, mental retardation/developmental disabili-

ties, and substance abuse. The mental illness division operates five general and three specialty mental hospitals. The division provides funds to 24 boards, located across the state, to deliver community-based services. State and federal spending for community care has risen in recent years. Medicaid funding of mental health services, including DSH payments, has also increased in recent years. Similar in form to the mental health division, the mental retardation division operates five intermediate care facilities for the mentally retarded. It contracts with nonprofit providers and community boards for community-based services, including supported employment and other day programs. A majority of the mental retardation budget is financed by Medicaid.

Assessing the New Federalism: Possible State Responses to Additional Flexibility and Reduced Funding

Alabama takes a minimalist approach to health and social welfare programs, with the major focus on complying with federal requirements. Alabama culture is highly antigovernment, and welfare recipients are generally thought not to warrant higher levels of assistance. Health care, especially long-term care, receives somewhat more political support.

Interstate Competition and the "Race to the Bottom"

A current theory of federalism holds that states engage in interstate competition to attract and retain businesses, primarily through keeping tax rates low by offering minimal welfare, social service, and Medicaid benefits.[12] The austerity of public programs further serves to discourage persons from entering the state for public aid, thus limiting the possibility that the state will become a "welfare magnet" and incur additional costs. In this model, a major role of federal standards is to restrain this "race to the bottom."

State officials and consumer and health care provider groups readily acknowledge that Alabama ranks at or near the bottom on many measures of health, welfare, and educational expenditures. A common sentiment in Alabama is "Thank heavens for Mississippi," referring to the neighboring state

that often ranks lower on various measures. As a result, most observers in Alabama are not concerned about a race to the bottom since it is inconceivable to them that the state could be a welfare magnet: that is, that individuals would move to Alabama to obtain welfare or Medicaid benefits.[13]

In general, the level of Medicaid coverage seems more a result of Alabama culture and values than interstate competition to draw businesses into the state. By and large, Alabama officials do not look to other states to establish their welfare and Medicaid benefit levels. To the extent that they do look elsewhere, Alabama policymakers compare themselves to Arkansas, Mississippi, and Tennessee—but not to Florida, which is not thought to be similar. In the early 1990s, the state did engage in a tax-incentive bidding war with neighboring states in its effort to induce the Mercedes-Benz Corporation to build a manufacturing plant in Alabama. At least some observers believe that their state got carried away in this competition and offered Mercedes benefits that were excessive, but welfare and Medicaid benefit levels did not play a part in the debate in determining what incentives could and should be offered.

Medicaid and Federal-State Relations

Like virtually all states, Alabama would like more flexibility in running its Medicaid program. The Medicaid block grant passed by Congress in 1995 and 1996 and vetoed by President Clinton was viewed positively by almost all state officials because the funding level was thought to be adequate and it would have freed the state from the financial schemes used to draw down federal funds that had little to do with health care for the poor. Changing to a block grant, however, would have dramatically altered the financial incentives for the state.

Federal-State Relations under Existing Law

While chafing under federal law and regulations, Alabama officials have had generally good personal relations with federal Health Care Financing Administration (HCFA) personnel. State officials felt that the requirement that states obtain Medicaid waivers for managed care and for home and community-based care was particularly burdensome, especially because applying for the waivers was a heavy drain on limited staff, and response time from HCFA was often slow. The officials also believed that HCFA made it too difficult for the state to "try things out" or implement locale-specific programs that made sense in one part of the state but would not in another (for example, the Mobile managed care demonstration). In all of these areas, however, the state eventually obtained the waivers it sought.

Other policy areas where Alabama felt unnecessarily constrained by federal rules included the EPSDT program, coverage of abortion in limited circumstances, the open formulary for prescription drugs, and required coverage of qualified Medicare beneficiaries. While some state officials voiced a desire to

reduce nursing home reimbursement rates, they acknowledged that their reimbursement rates were considerably above that required by federal rules (rules that have since been repealed by the Balanced Budget Act of 1997). State officials supported coverage of certain low-income children and pregnant women who are not eligible for cash assistance. They admitted, however, that the state probably would not have covered them without a federal mandate.

Medicaid Block Grants

Governor James and most state officials interviewed supported the Medicaid block grant passed by Congress in 1995 and 1996. Interviewees were very critical of savings estimates by the Congressional Budget Office and the Office of Management and Budget. They believed the estimates greatly overstated the size of the cuts the state would have to make. State officials liked the flexibility of the block grant and believed that they would have had enough funds to run the program without having to forcibly reduce caseloads or services, partly because Medicaid caseloads have leveled off. In general, state officials did not envision radical changes in the Medicaid program if it was converted to a block grant. State officials professed no desire to reduce eligibility, but consumer groups were worried about what might have happened without federal rules. One observer speculated that older low-income children might not have gained the Medicaid eligibility as required under current law. Older low-income children, however, are the target population in the state's planned implementation of the State Children's Health Insurance Program (S-CHIP) enacted as part of the federal Balanced Budget Act of 1997.

Under block grant legislation, changes in the financing structure could have affected the level of total Medicaid spending. The higher Medicaid match rate included in the block grant plan meant that Alabama would have drawn down its allocated federal funds much faster than under the current formula. Beyond their allocated funds, states would have to use 100 percent state money for Medicaid. In Alabama, state spending without a federal match requirement is extremely difficult to obtain and might have resulted in reduced state general revenue spending for Medicaid.

In contrast to state officials, interest and advocacy groups were generally opposed to a Medicaid block grant, fearing that the program would be cut substantially. Advocacy groups have relied heavily on the federal courts to accomplish their goals, and Alabama has been involved in a variety of lawsuits involving Medicaid, mental health, mental retardation, corrections, welfare, and other programs. A block grant with only minimal requirements would eliminate that leverage.

Intergroup Competition for Resources

In terms of resource allocation among groups, there is currently very little direct competition within the Medicaid program between the elderly and nonelderly populations or between acute and long-term care recipients. There

is a little competition between nursing homes and home and community-based services based on the belief that the state is not willing to fund all of the long-term care that is needed. However, nursing home occupancy rates in excess of 95 percent mean that nursing homes are not fearful of competition with home care for clients. In general, the legislature views Medicaid as a single program and does not delve into expenditures by group. Within Medicaid, spending for each group is largely determined by federal mandates and the entitlement structure of the program, and the legislature and the state Medicaid Agency largely do what they have to do to meet those minimum requirements. As such, there is competition for resources between entitlement and nonentitlement programs, with entitlement programs almost always winning.

Although not much competition among groups exists now, virtually everyone believed that would change dramatically under a Medicaid block grant because resource allocation would be a zero-sum game—one group's gain must come as a result of some other group's losing resources. In general, most observers thought that the elderly would do well under a block grant. Long-term care for the elderly has a more positive public image than does acute care for low-income families. Even though the elderly do not have a strong lobbying presence, the state's for-profit nursing home association was likely to be a critical factor in the expected success of the elderly in claiming resources.

Providing Third-Party Coverage for the Low-Income Population

Alabama has very strict financial eligibility criteria for its health and welfare programs. Largely because of federal requirements, Alabama standards are somewhat less austere for Medicaid than for cash welfare programs, but they are still very low compared to other states. As of 1997, the state had no major initiatives or programs to increase health insurance coverage for the poor other than to expand Medicaid eligibility for children in response to S-CHIP. Federal law has also prompted private insurance reforms in the state: Before the passage of the Health Insurance Portability and Accountability Act (Kassebaum-Kennedy), Alabama had not initiated significant health insurance reforms; little political pressure now exists to do more than required by federal law. Despite these factors, Alabama's uninsurance rate of 16.9 percent in 1994–95, although higher than the national average, is not as high as one might expect, because there is a substantial amount of employer-sponsored coverage. Overall, little public or provider pressure exists to tackle the issue of the uninsured. This is in part because very limited managed care penetration has meant that hospitals have maintained large enough financial cushions to provide uncompensated care.

Medicaid Eligibility

In 1995, approximately 10.4 percent of the state's population was enrolled in Medicaid, compared with the national average of 12.2 percent. During that year,

47 percent of the state's population below 150 percent of the FPL was enrolled in Medicaid, which is significantly below the national rate of 64 percent.

The rate of increase in Medicaid enrollees roughly paralleled national experience from 1990 to 1995. Statewide, the number of Medicaid enrollees increased nearly 13 percent a year between 1990 and 1992, with growth slowing to 4.4 percent a year between 1992 and 1995 (see table 5). The vast majority of the eligibility growth was attributable to low-income (but not cash-assistance-eligible) children and pregnant women. While coverage of these groups has been increasing, Aid to Families with Dependent Children/ Temporary Assistance for Needy Families (AFDC/TANF) caseloads have been dropping. Overall Medicaid enrollment was stable between 1995 and 1996 and is projected to stay fairly constant over the next several years.[14]

Medicaid and Welfare Eligibility Standards

Alabama provides Medicaid eligibility to categories required by federal law and to few others. About a quarter of the Medicaid population is composed of women and children who gain eligibility because they meet the criteria to receive AFDC/TANF.[15] Some state officials and many advocates are chagrined that the state's Medicaid eligibility levels are lower than Mississippi's.

Because the state's income eligibility for the AFDC/TANF program is very restrictive, federal Medicaid requirements to cover certain low-income children not receiving cash assistance have had a major impact on Alabama. Federal law requires that states cover pregnant women and children under age six who are in families below 133 percent of the FPL and children born after October 1, 1983 (age 14 as of 1997), who are in families below 100 percent of the FPL. Between 1990 and 1995, the number of non-cash-assistance children covered by Medicaid increased by 238 percent and accounted for 69 percent of the total enrollment increase over that time period (see table 5).[16] (With eligibility changes enacted in the federal Balanced Budget Act, the state now guarantees 12 months of continuous eligibility to children.) State officials were enthusiastic about the expansion of Medicaid eligibility for pregnant women, which is believed to have had a direct positive impact on the state's infant mortality rate. Although praised from a public health perspective, this mandatory coverage created a substantial financial burden on the state that led it to use creative financing mechanisms, most notably DSH payments. In addition, some state officials complained that the federal income standards do not take into account the lower cost of living in Alabama.

The state does not have a medically needy program and does not make use of state options to cover additional pregnant women or children. In lieu of a medically needy program, nursing home and other institutional service eligibility is extended to persons with incomes below 300 percent of the Supplemental Security Income (SSI) benefit level (300 percent of SSI was $1,452 a month in 1997).

Table 5 *Medicaid Enrollment by Eligibility Group, Alabama and United States (Enrollment in Thousands)*

	Alabama					United States				
	Enrollment			Average Annual Growth		Enrollment			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**431.2**	**545.7**	**621.6**	**12.5%**	**4.4%**	**28,856.7**	**35,765.1**	**41,672.0**	**11.3%**	**5.2%**
By Group										
Elderly	76.2	78.0	79.3	1.2%	0.6%	3,412.2	3,771.0	4,116.6	5.1%	3.0%
Cash	54.8	49.2	42.1	–5.2%	–5.1%	1,713.1	1,739.2	1,789.2	0.8%	1.0%
Noncash	21.4	28.8	37.2	15.8%	9.0%	1,699.1	2,031.8	2,327.3	9.4%	4.6%
Blind and Disabled	96.7	115.6	145.7	9.3%	8.0%	4,040.9	4,875.1	6,405.2	9.8%	9.5%
Cash	93.9	110.6	139.9	8.5%	8.1%	3,236.8	3,853.4	4,973.5	9.1%	8.9%
Noncash	2.9	5.0	5.9	32.3%	5.4%	804.1	1,021.7	1,431.7	12.7%	11.9%
Adults	81.1	100.9	96.6	11.6%	–1.5%	6,738.7	8,373.3	9,584.2	11.5%	4.6%
Cash	50.5	57.4	48.5	6.7%	–5.4%	4,651.6	5,342.5	5,441.4	7.2%	0.6%
Noncash	30.6	43.6	48.0	19.3%	3.3%	2,087.2	3,030.9	4,142.8	20.5%	11.0%
Children	177.2	251.2	300.0	19.1%	6.1%	14,664.9	18,745.7	21,566.0	13.1%	4.8%
Cash	122.4	129.1	114.3	2.7%	–4.0%	9,946.2	11,281.8	11,314.6	6.5%	0.1%
Noncash	54.9	122.1	185.8	49.1%	15.0%	4,718.7	7,463.9	10,251.4	25.8%	11.2%

Source: The Urban Institute, 1997. Based on HCFA 2082 data.

Issues in Medicaid/Welfare Reform

Alabama, like many southern states, provides a very small cash welfare benefit. In 1996, the annual payment for a family of three with no other income was $1,968 (15 percent of the FPL), compared with the national median for states of $4,668 (36 percent of the FPL).[17] Only Mississippi has a lower payment level. Partly as a result of low eligibility criteria, less than one-quarter of people with children and with incomes below the FPL received AFDC/TANF assistance in an average month during 1995.[18]

Alabama's low cash welfare payments in part reflect a view that welfare beneficiaries do not want to work and should not be "rewarded" for this behavior. The state has had some welfare reform initiatives but did not have a major welfare reform waiver program before the passage of the federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA).

Welfare Reform[19]

Although Alabama has not had a welfare reform waiver of the magnitude of some other states, the state operated a food stamp and AFDC waiver from 1991 to 1994 called ASSETS (Avenues to Self-Sufficiency through Employment and Training Services). ASSETS aimed to simplify and streamline the eligibility process for AFDC and food stamps and to develop more effective programs for work, training, and child-support enforcement.

In response to PRWORA, the governor proposed welfare reform that included a family cap, a five-year lifetime limit on assistance, a requirement that recipients work within two years of receiving assistance, an exemption from participation in work or training programs when the youngest child is less than 12 months old, and sanctions for noncompliance. A key issue in the legislative debate was a proposal in the House to raise Alabama's maximum monthly benefit to the average of the southeastern states.

Welfare reform legislation died in the final hours of the 1997 regular legislative session without agreement. Contending that legislation was not really necessary, the governor indicated his intention to implement all of the required federal welfare changes (with the exception of child support) through regulation. It is expected that welfare reform will be taken up again in the 1998 legislative session. In assessing welfare reform, state officials and advocacy groups are concerned about whether jobs can be found in rural areas (where many welfare beneficiaries live) and whether adequate transportation exists to get welfare beneficiaries to places of employment.

State officials and advocacy groups are also worried about the severing of the eligibility link between AFDC/TANF and Medicaid required by PRWORA. The state does not intend to create separate application processes for Medicaid and TANF, partly to avoid significant numbers of people falling between the cracks, that is, losing TANF eligibility and not realizing that they are still eligi-

ble for Medicaid. In addition, the state fears that some people will not apply because they do not want to comply with the new work requirements of welfare, although they would still qualify for Medicaid. Alabama officials were also concerned about the administrative burden and cost of administering two eligibility systems. Since TANF and Medicaid use slightly different rules, an application has to be processed separately. Moreover, while assessment of an applicant's cash welfare eligibility is automated, Medicaid eligibility has to be processed manually.

Medicaid eligibility determination is a shared responsibility of the Medicaid Agency and the Department of Human Resources. County departments of human resources process joint TANF/Medicaid applications. They then notify the Medicaid Agency about persons eligible as a result of the joint application. However, for applicants who are Medicaid-only (such as poverty-related children or families terminated from TANF), applications are processed by local Medicaid staff stationed in county health departments, federally qualified health centers (FQHCs), and hospitals. Sometimes the Medicaid staff are located in county departments of human resources.

Immigration

Changes to the immigration law enacted in 1996, as amended by the Balanced Budget Act of 1997, allow most legal immigrants who were in the country on August 22, 1996, to retain Medicaid eligibility; new immigrants are excluded for five years. In addition, current immigrants who become disabled will be eligible for SSI (and therefore Medicaid) if they meet the eligibility criteria. These changes are expected to have scant impact on Alabama because an extremely small percentage of residents are immigrants, although the numbers have increased somewhat in recent years, a trend in part related to the growth in chicken farming. Because expenditures are very small and the administrative burden of excluding immigrants would be large, state policy is geared toward inclusion rather than exclusion of them. However, the state will not use its own funds to provide coverage during the five years when new immigrants are barred from Medicaid coverage. In the case of undocumented aliens, Medicaid pays for emergency care, most of which has been the delivery of babies.

State Children's Health Insurance Program

The Balanced Budget Act of 1997 established the State Children's Health Insurance Program (S-CHIP), which provides $24 billion in federal matching funds over five years to provide health insurance for children below 200 percent of the FPL. States have a great deal of flexibility in how they design their new S-CHIP programs. Using the Current Population Survey, the U.S. Census Bureau estimates that there are 179,000 uninsured children below the age of 19 in Alabama, or 15.1 percent of children (which is also the national percentage).[20] Based on the number of uninsured children, Alabama has been allo-

cated almost $86 million for 1998 in federal S-CHIP funds, for a five-year estimated total of over $397 million.

The state's initial plan, which was implemented on February 1, 1998, is to extend Medicaid eligibility to children through age 18 in families with incomes below the FPL. However, further expansion to 200 percent of the FPL is likely to use private insurance rather than Medicaid. Alabama's general-fund budget, signed by Governor James on December 1, 1997, allocates $5 million in state funds to expand coverage for uninsured children for FY 1998. However, a total of $23 million is needed to fully match the federal funds that Alabama is eligible to receive for FY 1998. Unless Alabama can use intergovernmental transfers, it may have difficulty raising the state match to draw down all of the available funds. A legislatively established commission has been created to develop a comprehensive plan on how to design and administer the program.

Insurance Reforms

A couple of attempts have been made to improve access to private insurance in recent years. Before the passage of Kassebaum-Kennedy, the Alabama Health Care Reform Task Force recommended limiting preexisting condition exclusions, establishing open enrollment periods, requiring minimum benefits, and guaranteeing renewability. The state does not plan to undertake any additional reforms beyond the implementation of the federal insurance reform legislation. In order to meet the requirements of Kassebaum-Kennedy for an insurer of last resort, the state is establishing a high-risk pool for those unable to obtain commercial insurance.

Financing and Delivery System

The changes in the financing and delivery system that have shaken the health care system in many parts of the country have established only a toehold in Alabama. Blue Cross/Blue Shield is still the dominant insurer, and full-risk managed care is uncommon. The lack of aggressive price competition affords providers an ability to cross-subsidize care for the uninsured. The infancy of the state's HMO infrastructure has led Alabama Medicaid to implement other types of managed care. Finally, like many other states, Alabama has used the DSH payment program as a way of minimizing its Medicaid state match rather than increasing the revenues of safety net hospitals.

The Health Care Market and Access for Low-Income Populations

Health insurance in Alabama is dominated by Blue Cross/Blue Shield, leaving HMOs with a relatively small, but growing, enrollment. Characterized as a "benevolent dictator," Blue Cross/Blue Shield insures, or is the third-party administrator for, 70 percent of Alabama's privately insured population. The company has maintained good relationships with providers through satisfactory payment levels and with consumers through generous benefits. An additional advantage that Blue Cross/Blue Shield enjoys is exemption from most Department of Insurance oversight because of its special status as a nonprofit organization. According to some observers, its autonomy and control of the state's insurance market have stymied insurance reforms to some extent.

The near-monopoly power exerted by Blue Cross/Blue Shield may hinder competition in the health insurance market. In fact, some HMOs have appar-

ently experienced difficulty entering the market. With $1 billion in reserves, Blue Cross/Blue Shield is reportedly able to maintain its rates just low enough to ward off new entries and prevent existing plans from expanding substantially. For example, pressed for lower premiums by a purchasing cooperative representing more than 20 large employers, Blue Cross/Blue Shield agreed to a large discount from its usual rate and managed to retain the accounts. Employers continue to vigorously seek savings, and Blue Cross/Blue Shield has responded by developing a selective physician panel for its preferred provider organization, placing a moratorium on payments to new outpatient facilities such as ambulatory surgi-centers,[21] and introducing a health plan that features a limited network of primary care gatekeepers. Thus, Blue Cross/Blue Shield has reinvented itself somewhat in the managed care mold.

HMOs are making inroads in the state, although penetration has been slowed not only by Blue Cross/Blue Shield but also by anti-HMO attitudes, low physician supply, and the rural nature of the state, all of which make selective contracting difficult. Despite these obstacles, more than 300,000 persons are enrolled in HMOs, representing about 11 percent of the privately insured population; and this number continues to rise. As of October 1996, 13 companies held 15 HMO licenses, and another six organizations were seeking HMO licensure. Most HMOs in the state have corporate headquarters outside Alabama.

Overall, HMOs in the state are struggling financially for several reasons. Because they lack market share, they have not been able to secure price discounts from hospitals and physicians comparable to those of Blue Cross/Blue Shield. In addition, because Blue Cross/Blue Shield has a fairly rich benefit package, HMOs cannot compete by offering dramatically more generous benefits. Further, because of the priority that people in Alabama place on "choice," HMOs have had trouble attracting new enrollees in mass numbers.

HMOs are regulated by both the Department of Insurance (on issues of solvency) and the Department of Health (on issues of quality). HMOs charge that the regulatory environment is unfair, in that more is demanded of them than of Blue Cross/Blue Shield. Regulations, they claim, slow development, sales, and marketing efforts, placing them at a competitive disadvantage. HMOs and other insurers have also been subjected to the legislature's attempts to counter limits on patient care and physician participation imposed by insurers. Recent statutes provide for self-referral to obstetricians/gynecologists, two-day maternity hospital stays, and "any willing provider" requirements. The last provision was challenged in court by Blue Cross/Blue Shield, which was successful in its suit and is now exempt.

Because of the modest presence of HMOs in Alabama, hospital and physician markets have been relatively immune to competitive pressures and thus have been able to absorb much of the costs of caring for the uninsured. Yet some early signs of market evolution are present, including increases in HMO membership, physician-hospital organizations, and hospital mergers.

At present, hospitals in Alabama appear to be in good financial health, despite pockets of excess capacity. Although the state has maintained its certificate-of-need regulations to curtail hospital expansion, there is speculation that market-driven downsizing will occur eventually. One hospital administrator predicts that consolidations and mergers will result in only a few systems operating in the state. Although there is some for-profit takeover activity, state officials do not appear concerned about any potential negative ramifications. Most of the activity involving nonprofit conversions to for-profit has originated from Columbia/HCA, which owned eight hospitals in Alabama as of October 1996.

Nearly every hospital has formed, or is in the process of forming, a physician-hospital organization in order to position itself to contract with HMOs. Hospitals are assuming a central role in the health care system, whereas in the past, physicians tended to dominate, serving on the staff of every hospital in town. Physicians are increasingly aligning themselves with a single hospital, and some are even selling their practices to hospitals to ensure a stable income for the future.

Medicaid Managed Care

Alabama has taken a multifaceted approach to incorporating managed care into its Medicaid program, employing case management models as well as capitation in various regions of the state. Despite its efforts, Alabama lags behind many other states in the area of Medicaid managed care. Attempts to pursue a managed care strategy more aggressively and comprehensively have been hindered in part by the lack of an HMO infrastructure in the commercial insurance sector. Given these constraints, the state's strategy has consisted of incrementally introducing managed care programs for targeted populations without relying on commercial HMOs. The state anticipates eventually moving beyond gatekeeper models to full capitation of Medicaid beneficiaries. The managed care programs currently in operation or nearing implementation are (1) maternity case management, (2) primary care case management, (3) Mobile County Section 1115 waiver, and (4) hospital prepaid health plans. (The hospital prepaid health plan is deeply intertwined with the state's policy on DSH payments and is discussed later in this section.)

The underlying objective of Alabama's managed care reforms is to provide its Medicaid recipients with a medical "home" as well as to control spending. From the state's point of view, managed care is primarily about the organization of the delivery system, rather than a financing structure that will create a more competitive marketplace. As such, unlike Medicaid managed care in other states, some of the initiatives can be seen as stabilizing providers' market share of Medicaid. This may reflect the relative importance of the primary care case management model and may change over time as the marketplace becomes more competitive.

Maternity Waiver Program

Alabama's maternity waiver program dates back to 1988, when the state first received a Medicaid freedom-of-choice waiver to coordinate the health care of pregnant Medicaid beneficiaries. Under the waiver, the Medicaid agency contracts with one local organization in each county to serve as the care coordinator, paying them a predetermined global fee for maternity care. More than half of the contracted agencies are local health departments. These organizations provide case management services and may provide additional maternity care. Other services, such as physician care and hospital stays, are provided under contract with providers outside of the local agency. The global fee, established at 97 percent of the fee-for-service reimbursement, averages $3,500 and covers prenatal care, labor and delivery, 60 days of postpartum care, and other specified services. Physician participation in the waiver program has been relatively high, which can be attributed in part to increases in obstetrical payment rates for the entire Medicaid program. The program operates in 43 of the state's 67 counties and enrolls approximately 40,000 pregnant women from all eligibility groups. There are plans to expand the waiver to additional counties, contingent on the availability of participating providers. With 50 percent of deliveries in the state reimbursed by Medicaid, the program has far-reaching effects.

The maternity waiver program was established with the objective of reducing the state's high infant mortality rate, which was 14 per 1,000 live births in 1988. With the infant mortality rate currently at an all-time low of 9.8, the program has been credited with much of the reduction.[22] Other statistics offer evidence of the program's positive impact: Women in the waiver program now receive an average of nine prenatal visits compared with only three before the establishment of the program. In addition, babies born in waiver counties average fewer days in neonatal intensive care than those born in nonwaiver counties.

Primary Care Case Management

Building on the success of its maternity waiver program, Alabama submitted a Medicaid freedom-of-choice waiver (and received approval in October 1996) to institute primary care case management for all Medicaid recipients—with the primary exception of the dually eligible—beginning in 1997. In the first two years, the waiver program will be implemented in 26 counties, most of which are rural and currently have a high rate of physician participation in Medicaid. Other counties will be folded into the waiver over time. Primary care physicians (or, in some cases, specialists) will serve as case managers. They will be paid on a fee-for-service basis and will receive an additional $3 per month for each Medicaid recipient for whom they are responsible. The expectation is that providing Medicaid recipients with a primary care physician will reduce the use of hospital outpatient departments and emergency rooms, laboratory and radiology services, and specialists.

Under the waiver, beneficiaries will be allowed to choose their physician case manager. Those who do not select a physician will be auto-assigned by

the state. Patients will be entitled to change providers on a monthly basis; however, if three changes are made within a six-month time frame, the state can lock in the beneficiary with a provider.

Alabama officials view the primary care case management program as an important step toward full capitation of Medicaid beneficiaries. There is also speculation that the primary care case management program will subsume the maternity waiver.

Mobile County Medicaid Research and Demonstration Waiver

Alabama does not presently have sufficient commercial HMO penetration on which to build a capitated managed care program for Medicaid recipients statewide. The state instead is attempting to launch full-risk capitation in a limited geographic area. In 1997 the state began implementing managed care in Mobile County (which includes the city of Mobile) through a Medicaid research and demonstration (Section 1115) waiver.

The five-year demonstration project in the Mobile County area mandates enrollment of all Medicaid beneficiaries (except persons eligible for both Medicare and Medicaid, those in institutions, and foster children) in a single HMO, created solely for Medicaid. The HMO—BAY (Better Access for You) Health Network—is a product of a private firm, PrimeHealth, which will administer the program. BAY Health is a collaborative effort of traditional Medicaid providers, including University of South Alabama Hospitals, federally qualified health centers, and Mobile County's mental health department.[23] BAY Health is required to contract with physicians who accounted for 80 percent of the services to the Medicaid population. Other providers that have served the Medicaid population will be given a "fair" opportunity to participate. The philosophy is to include providers in the BAY Health panel, rather than to narrow the list of providers by excluding them.

Enrollment will be phased in over several months, beginning with the AFDC population and ultimately including the aged, blind, and disabled. The state expects enrollment levels to reach 40,000 by the end of the demonstration. Once eligible, beneficiaries will have three months to enroll with a primary care physician from the BAY Health network before they are auto-assigned. Once assigned to a provider, beneficiaries will be allowed to switch at any time. BAY Health is guaranteed that enrollees will be eligible for Medicaid for six months under the terms of the Section 1115 waiver.

The program has many features to promote beneficiary access and satisfaction. Family planning benefits are extended beyond the 60-day postpartum period to 24 months postpartum. PrimeHealth will fund the state match for this benefit. The HMO will offer unlimited office visits (there are visit caps in fee-for-service Medicaid), and adult screening will be added to the benefit package. Hospital days will remain capped except for children, who can receive unlimited hospital stays that are deemed medically necessary by an EPSDT examination.

Alabama's original Section 1115 waiver included an eligibility expansion. The state proposed to increase eligibility for low-income children ages 6 to 13 from 100 to 133 percent of the FPL. It further proposed to increase eligibility for adolescents (ages 13 to 18) from 16 percent of the FPL to 133 percent. These provisions of the waiver application will not be implemented because the state failed to meet HCFA's budget-neutrality requirements. In its original application, the state counted a supposedly planned expansion of Medicaid eligibility in its baseline projection of costs without the waiver. HCFA rejected this inclusion of not-yet-implemented expansions in the calculations because the demonstration program is not statewide and it did not believe that the state would expand eligibility in the rest of the state.

Alabama's demonstration program is unique in that it tests the use of a "sole source" contract as well as the collaboration between a private administrator and traditional public providers. Despite its approval of the waiver, HCFA has expressed some concern over beneficiaries' being limited to a single HMO. After the initial three years of the demonstration, the state plans to introduce competitive bidding. There are no plans as of yet to expand the model statewide, in large part because the requisite relationships among providers (e.g., networks) do not exist elsewhere.

Medicaid Physician and Hospital Reimbursement

The Alabama Medicaid program is a relatively generous payer of physician and hospital services. The state has very high DSH payments, although expenditures are largely used to subsidize the Medicaid program as a whole rather than adding revenues to safety net hospitals.

Physician Reimbursement

Physicians, like hospitals, have fared relatively well under the Medicaid program. Of all the case-study states in *Assessing the New Federalism*, Alabama ranks highest in physician fees. Its Medicaid-to-Medicare fee ratio for 28 services in 1993 was 0.91, compared with a national average of 0.73. In addition, compared with a U.S. index value of 1.00 for Medicaid fees, Alabama had a value of 1.45.[24] Under the primary care case management program, some physicians also receive a $3 per person per month case management fee. Although generous compared with other states, Medicaid payments to physicians are lower than commercial rates; thus, in some places, such as Jefferson County (Birmingham), private physicians are reluctant to participate in the program. Rural physicians are more likely to accept Medicaid patients since they recognize that the patients may have nowhere else to turn; also, given the high rate of uninsurance in rural areas, Medicaid patients are relatively more attractive.

DSH Payments[25]

Federal law requires state Medicaid programs to "take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs" when determining payment rates for inpatient hospital care. It would be difficult to overstate the importance of these Medicaid DSH payments to the state's Medicaid program. Alabama has one of the largest Medicaid DSH programs in the country—only a handful of states have programs that are larger as a percentage of total Medicaid expenditures. In 1995, DSH accounted for $417.5 million, or 21 percent of Alabama Medicaid spending, which is almost twice the national average (see table 6).

The DSH program has been crucial to the state's ability to fund its overall Medicaid program. While total spending for Medicaid in Alabama grew from $480 million in 1988 to $2 billion in 1995, the state's general-fund spending on Medicaid has remained roughly constant—around $140 million—over the same period. By effectively using intergovernmental transfers and provider taxes to fund Medicaid DSH payments and other components of the Medicaid program, the state has been able to finance nearly all of the increased spending with federal rather than state dollars.[26] With its high federal match rate, Alabama receives much more federal funding from matching intergovernmental transfers than it transfers to providers as DSH payments. Thus, Medicaid dollars remain in the health system, but almost all of the state's health funding comes from the federal government. By relying heavily on intergovernmental transfers and provider taxes, the state is free to use its general-fund money for other purposes.

While providing support for the overall Medicaid program, the Alabama DSH payments do not provide much additional funding to hospitals that provide services to a large number of Medicaid and uninsured patients. Although these providers are often scornful of the "games" that Medicaid officials play in order to maximize federal Medicaid funds, their cooperation is critical to the success of the DSH strategy and to maintaining Medicaid funding.[27] There is widespread belief among providers and state officials that the state would not be able to sustain even its very modest benefits and eligibility were it not for DSH, intergovernmental transfers, and provider taxes.

Not surprisingly, then, much of the Alabama Medicaid Agency's time and energy has been spent trying to maintain federal DSH dollars in the face of federal legislation in 1991, 1993, and 1997 aimed at curbing DSH spending. This struggle has contributed to an ongoing series of state "crises" regarding Medicaid funding. In recent years, the development of a statewide network of prepaid health plans for inpatient care has been seen by many primarily as a mechanism to evade federal requirements on DSH, although the state strongly maintains that the plans are legitimate managed care entities. Moreover, the state will face a significant problem in coming years because the Balanced Budget Act of 1997 reduces Alabama's DSH spending cap from $417 million to $293 million as of 2002.

Table 6 *Disproportionate Share Hospital Spending, 1988–1996: Total and as a Percentage of Total Medicaid Spending, Alabama*

	DSH Total Spending				DSH as a Percentage of Medicaid Spending			
					Alabama		United States	
Year	Inpatient	Mental Health	Total	Annual Growth	Benefits plus DSH	Total*	Benefits plus DSH	Total*
1988	$190,607	—	$190,607	—	0.0%	0.0%	0.9%	0.8%
1989	$272,000	—	$272,000	43%	0.1%	0.0%	1.1%	1.1%
1990	$156,700,000	—	$156,700,000	57,510%	19.5%	19.0%	1.9%	1.9%
1991	$209,000,000	—	$209,000,000	33%	19.8%	19.0%	6.1%	5.8%
1992	$417,458,000	—	$417,458,000	100%	27.8%	27.1%	15.2%	14.7%
1993	$419,026,838	$109,473	$419,136,311	0%	25.6%	25.1%	13.6%	13.3%
1994	$148,991,949	$268,466,050	$417,457,999	0%	23.6%	23.0%	12.3%	11.8%
1995	$413,006,228	$4,451,770	$417,457,998	0%	21.4%	21.0%	12.5%	11.9%
1996	$346,707,637	$48,180,868	$393,888,505	–5%	19.4%	19.4%	10.2%	10.3%

Source: Urban Institute analysis of HCFA 64 data.
* Total spending includes spending on medical services, DSH, administration, and other spending adjustments (which may be negative for some states).

DSH Spending Levels

Like many states, Alabama faced sharply increasing Medicaid expenditures during the late 1980s and early 1990s because of rising health care costs and an increasing number of Medicaid beneficiaries. In the view of state officials, new federal mandates related to coverage of low-income children and pregnant women, coverage of all medically necessary services under the EPSDT program, and higher nursing home quality standards played an important part in increasing expenditures. Faced with a significant budget shortfall in 1990, state Medicaid officials turned aggressively to the DSH program as a way to increase funding. As shown in table 6, DSH expenditures grew from $272,000 in 1989 to almost $157 million in 1990. From 1990 to 1992, the program almost tripled in size, reaching $417 million. At this point, the federal Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 capped the federal government's liability for DSH spending at this amount.

Although the distribution has changed somewhat over time in response to federal requirements, the vast bulk of DSH payments are made to state, county, and other local public hospitals, which provide the money necessary for the state match through inter- and intragovernmental transfers and provider taxes. In some other states, public hospitals provide the intergovernmental transfers to finance DSH but must share the DSH payments with private providers that serve a large number of Medicaid and uninsured patients. In Alabama the public hospitals provide the large majority of Medicaid and uncompensated care, so the "leakage" of DSH funds to private hospitals is minimal.

DSH Financing

The state has used a variety of methods to finance its share of Medicaid. In the late 1980s and early 1990s, the state relied on voluntary donations. Hospitals sent funds to the Alabama Hospital Association, which in turn sent a single check to the Medicaid Agency. In 1991 the state switched to a set of provider taxes, including hospital and nursing home taxes that were levied solely on Medicaid-provided services or hospitals that received DSH funds. To coordinate the flow of these taxes, the state established the Public Hospital Transfers and Alabama Health Care Trust Fund (PHTAHCT). The original system of taxes lasted only a short time, since the federal Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 invalidated both the nursing home and hospital taxes by requiring that provider taxes be "broad-based," that is, apply equally to all providers and payers. After the 1991 amendments, the state broadened the taxes but switched to intergovernmental transfers from public hospitals to raise the bulk of the money to be used for DSH. Again, PHTAHCT was used to channel the funds to Medicaid.

Table 7 shows the major financing sources for the Medicaid program for 1995. Only 24 percent of the state's share (7 percent of total Medicaid program costs) was financed through general state funds. Almost two-thirds of the state share ($370 million) was funded through PHTAHCT, which generated another $872 million in federal funds. Assuming that providers are fully reimbursed

Table 7 *Source of State Medicaid Funding, 1995, Alabama*

	$ in Millions		
	Medicaid Funding Generated by		
Source	State Contribution	Federal Contribution	Total
General Appropriations	140	329	468
Public Hospital Transfers and Alabama Health Care Trust Fund	370	872	1,243
Other State Agency Transfers	74	175	249
Other Sources	7	17	24
Total	591	1,393	1,984

Source: Authors' calculations based on Alabama Medicaid Agency, *FY 1995 Annual Report*, Montgomery, AL, 1996.

(through DSH and other provider reimbursements), this exchange nets the state about $500 million. And since the total $1.243 billion far exceeds the state's DSH cap of $417 million, the state is using intergovernmental transfers for far more than merely financing DSH. It is using the transfers as the state match for most of the Medicaid program.

There has been substantial federal criticism of high-DSH states regarding the uses to which states put these funds. While some states have used the additional federal funds generated by DSH for purposes unrelated to Medicaid, the uninsured, or even health care, Alabama has retained all of the money for support of the Medicaid program. Nonetheless, the additional federal money has meant that the Medicaid program has been able to grow without additional state funding. In essence, the growth of Medicaid expenditures has been almost entirely derived from federal funds, leaving more state funds—in relative terms—available for other purposes. Since the new federal funds are kept within the Medicaid system, Alabama hospitals have been cooperative with the state and with each other both in raising the necessary revenue and in disbursement of DSH payments.

Prepaid Health Plans

Before 1995, Alabama reimbursed hospital inpatient services on a prospective, all-inclusive per diem basis. Rates were calculated using prior year Medicaid cost reports and trending them forward by inflation to the current year rate. Hospitals were divided into six peer groups, largely by hospital size, and paid the lower of their own trended rates or their peer group ceilings (which were set at the 80th percentile of costs).

In 1995, the state drastically revised its inpatient payment methodology in the face of provisions in the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993). Federal law now limits DSH payments to individual hospitals to the shortfall created by providing services to Medicaid and uninsured patients.

Although Alabama has high levels of uncompensated care, there were difficulties in matching DSH payments to hospitals that were large contributors to the PHTAHCT. As in other high-DSH states, the OBRA 1993 caps posed a real threat to maintaining the existing flow of federal DSH dollars.

In response, the Alabama Medicaid Agency changed from paying hospitals directly to paying them through a statewide network of prepaid health plans (PHPs), which are managed care organizations that receive capitation only for certain services—in Alabama's case, only for inpatient hospital services. The state contracts with the PHPs to provide hospital care to all Medicaid patients in their geographic areas, and the PHPs in turn contract with the individual hospitals within their respective boundaries. The eight PHPs are entirely new, for-profit organizations owned and governed by the hospitals located within each geographic boundary. All hospitals in the designated area that participate in Medicaid (both public and private) contract with the local PHP; thus, individual Medicaid beneficiaries have complete freedom of choice of providers. The PHPs act as a managed care organization by accepting capitated payments from the state Medicaid Agency on a per member per month basis.[28] The hospitals within the district are then reimbursed on a per diem basis from the PHP in the district in which they are located.

The most important feature of the arrangement is that Medicaid makes DSH payments directly to the PHPs and not to the hospitals. The state simply calculates the total uncompensated care and Medicaid shortfall for all hospitals in the PHP district, divides the amount by the number of Medicaid eligibles, and then adds the amount to the per-person reimbursement to the PHP. The disbursement of the DSH funds is then under the discretion of the individual PHPs. Some hospitals also receive so-called "enhanced payments" from the PHP, which are separate from DSH payments.

Since DSH payments are added to the capitation rates, the state claimed that the Medicaid Agency does not have to be concerned with the hospital-specific DSH caps as specified in OBRA 1993. The state noted that HCFA has long maintained that managed care organizations are not bound by federal hospital and nursing home reimbursement standards. In negotiations with HCFA, the state claimed that it was not paying more for DSH in the *aggregate* (at the level of each PHP) than allowed under current law and that DSH payment rules do not apply to managed care organizations (i.e., the PHPs), which can determine reimbursement as they see fit.

HCFA initially alleged that the PHPs were not really managed care organizations, but just a charade designed to evade the OBRA 1993 hospital-specific DSH limits. This view was widely shared by the individuals we interviewed, who used such terms as "sham," "not really managed care," "a shell game," "hogwash," and "paper shuffling" to refer to the PHPs. For its part, the Alabama Medicaid Agency strongly contended that the PHPs were real managed care, albeit limited, and something on which to build. For example, the state requires that each PHP establish a quality assurance committee.

Despite broader concerns, HCFA formally objected to the PHPs on more technical grounds, namely, that they violated the freedom-of-choice requirement for Medicaid beneficiaries and that the contracts were not competitively bid. HCFA's position was that the state Medicaid Agency could not involuntarily enroll beneficiaries into the PHPs (i.e., "managed care") without a freedom-of-choice waiver. In November 1996, however, the state received approval from HCFA to proceed with the PHP plan for two years, after which the PHPs would have to be chosen through a competitive bidding process. The state plans to continue the PHP system but has not finalized the new system's structure. Invitations to bid are being developed and will be released in 1998. The federal Balanced Budget Act of 1997 includes a provision prohibiting the practice of folding DSH payments into capitation payments, but existing programs are allowed to continue. It is unclear how this will apply to Alabama in the long term after the initial two-year waiver expires.[29]

Delivering Health Care to the Uninsured and Low-Income Populations

The health care safety net in Alabama is fairly strong. Health care for the indigent is reasonably accessible because of limited competition among providers and insurers and the availability of public providers in some areas (e.g., Birmingham and Mobile). The lack of intense competition means that resources are available to meet the acute care needs of the poor (though not necessarily their preventive and primary care needs). Public hospitals, community health centers, and county health departments also help secure moderate access to health services for the uninsured and Medicaid populations. Nonetheless, changes in the health care marketplace are on the horizon that may constrain resources available to underwrite uncompensated care.

The Public Health System

In Alabama, as in many southern states with physician shortages, the public health system has traditionally been a key part of the health care safety net, especially in the areas of maternal and child health, family planning, and home health. Alabama's largest home health agency, in fact, is operated by the state through its county health departments. Moreover, local health departments play a key role as case managers in the state's Medicaid maternity waiver program.

Control of the public health system is highly centralized at the state level, with services delivered in each of the 67 counties by local health departments,

whose staffs consist of state employees. With the exception of Jefferson (Birmingham) and Mobile counties, the state Department of Public Health maintains significant control over its county "outposts." In a unique arrangement, the Alabama Department of Public Health is governed by the state's medical society. While some contend that this arrangement results in physicians being more cognizant of the needs of the poor, others argue that the economic interests of the medical profession impede public health reforms, with physicians mostly concerned about potential competition from the local health departments.

The public health system relies heavily on federal funds and third-party reimbursements, which accounted for about 85 percent of expenditures in 1997. Reimbursements from third parties, mainly Medicaid and Medicare, have assumed increasing importance over the past several years and now represent about half the budget. In 1993, for the average local health department in the United States, Medicaid comprised 7 percent of the budget and Medicare, 3 percent; the respective figures for Alabama's local health departments were 25 and 32 percent.[30] Home health and maternal and child health services were responsible for a large share of third-party payments.

Alabama's public health system is in the early stages of transformation, mirroring a trend across the country to redefine the mission of public health. With the introduction of some managed care in the state's Medicaid program, private providers are assuming more responsibility for the care of Medicaid patients than before. Consequently, public health agencies are finding that demand for personal health services that have characterized their role in recent years is diminishing. For instance, from 1992 to 1996, the number of Medicaid child health screening (i.e., EPSDT) patients in health departments dropped by 24 percent; maternity clients dropped by 15 percent during this same period. Bracing for continued expansion of Medicaid managed care, the public health system is placing more emphasis on disease control and prevention, needs assessment, and "enabling" services that enhance access to the health care system. Yet health departments are also attempting to maintain some services that qualify for third-party payment. They recognize that they must continue to deliver some reimbursable services in order to cross-subsidize traditional public health activities and serve the uninsured.

Other Providers in the Safety Net

Because Blue Cross/Blue Shield and HMOs have not significantly squeezed providers' bottom lines by demanding steep discounts and because Medicaid is a relatively generous payer, hospitals and physicians have typically been able to meet the demand for uncompensated care and have done so with minimal protest. Modest DSH payments on top of ample reimbursement rates help to ensure that hospitals have the resources to provide uncompensated care.

The provision of care to the Medicaid and uninsured populations varies across the state. In Montgomery, there is a system of rotating emergency rooms that ensures that no one hospital must provide an unfair share of the uncompensated care.[31] In Mobile, a public facility (the University of South Alabama Hospital) is the principal provider of health care to the poor. In Birmingham, as described in more detail below, two public facilities (the University of Alabama Hospital and Cooper Green Hospital) and one private pediatric facility that draws patients from all across the state (Children's Hospital) provide the vast bulk of uncompensated care. In rural areas, there may be only one hospital in a community and thus no opportunity to "dump" the uninsured. While there is a very large number of county-affiliated "public hospitals" in Alabama, many of these facilities receive little in the way of local funds and often do not function primarily as safety net facilities. Nonetheless, the state constitution places the "ultimate financial obligation for the medical treatment of indigents" on the county in which the person resides.[32] Community health centers are also important safety net providers in many Alabama communities and have grown from about 50 sites in 1990 to 74 sites as of October 1996.

Despite the relative strength of the health care safety net in Alabama, many low-income individuals still face access and quality-of-care problems. According to some observers, cultural, socioeconomic, and racial factors may prevent some low-income people from seeking care and therefore contributing to the demand for uncompensated care. Lack of public and private transportation in both rural and urban areas creates barriers to care. Another concern is that the safety net serves chiefly to treat acute problems on an episodic basis, instead of providing for a continuum of care and ongoing management of health problems. Finally, although price competition among health care providers has not been heated, there are some signs that it is increasing, especially in areas where there is excess hospital capacity. With greater competition may come less willingness to provide free medical care because providers will be less able to shift these costs to third-party payers.

Although Alabama's Medicaid managed care reforms have not been dramatic, the safety net has been affected to some extent and is preparing itself for additional changes that may ensue. Many community health centers from around the state have joined together to create a managed care network, called Alabama Community Health Centers, which is looking for an HMO with which to partner.

Physicians and hospitals have fared relatively well under the Medicaid program and, as a result, have generally been willing to accept Medicaid patients. However, it remains to be seen whether the state will continue to be able to support payments at current levels. In particular, the Medicaid program, as it faces federally mandated reductions in DSH and budget overruns, may seek cuts in provider fees, which may curtail providers' willingness to accept Medicaid patients or provide free medical care.

Impact of Government Policies and Market Changes on Safety Net Providers: Birmingham

Birmingham in Jefferson County is the largest city in Alabama. Overall, it is a thriving metropolitan area; however, pockets of substantial poverty exist, particularly among the city's black population. Birmingham serves as a window into how state and local policy and market forces shape health care delivery for low-income populations.

The safety net in Birmingham appears fairly strong, as a result of shared responsibility for indigent care among several providers and adequate financing through Medicaid payments and the Indigent Care Fund, which is supported by a 1 percent county sales tax. Each of the major providers that composes the safety net has assumed a unique yet complementary role. For instance, Cooper Green, the county hospital, delivers a significant amount of primary and secondary care for adults. Its outpatient clinic serves an estimated 70 percent of the county's indigent adult population. The state-supported University of Alabama Hospital cares for adults who need specialty care, many of whom are referred by Cooper Green. Low-income children, including some from other parts of the state, are typically treated at the private, nonprofit Children's Hospital for their specialty and primary care needs. It was estimated that 85 to 90 percent of Medicaid and uninsured patients in the county are seen by these three hospitals. Regarding primary care services, the Jefferson County health department claims to serve 95 percent of Medicaid patients in the county. Community health centers, by contrast, have only a small presence in Birmingham. West Alabama Health Services manages two very small centers in the city. Although safety net hospitals and clinics have apparently maintained reasonable access to health care in the county, one person noted that there is a long waiting list for adults to receive primary care at public facilities, and many often resort to the emergency room.

There is a significant amount of collaboration among the safety net providers in Birmingham. West Alabama Health Services reported that its clinics are working with the health department to eliminate duplication of services. It envisions that the health department will manage maternal and child health, sexually transmitted diseases, HIV/AIDS, and tuberculosis, while other primary care needs will be referred to West Alabama Health Services clinics. As another example, the health department has a new arrangement with Children's Hospital under which it contracts with the hospital to staff a pediatric clinic, paying Children's less than it would cost for the county to run it.

Perhaps the most ambitious attempt at cooperation among Jefferson County providers is a project to integrate safety net providers into a more cohesive system of indigent care. The health department, Cooper Green, University Hospital, and Children's are considering ways of coordinating eligibility and information systems. The plan is to provide eligible patients with a card to use at each of the sites to identify them as eligible for services. In addition, med-

ical records and other relevant data on patients would be accessible electronically, regardless of where the patients seek care. Another goal is to structure the system in such a way that other hospitals in the area share some of the burden of indigent care.

Interspersed with the spirit of collaboration among Birmingham safety net providers is the desire of each to retain its insured patient base and ensure fair distribution of care for the uninsured. Additionally, competition is building between the safety net and private hospitals that have not traditionally cared for Medicaid patients. Because of the excess capacity in the system (some hospitals in the Birmingham area reportedly operate at 30 to 50 percent of capacity), Medicaid patients are becoming increasingly attractive to private hospitals. Some of these hospitals have established primary care sites in order to channel more patients to their hospital. As a result, safety net providers are witnessing some erosion in the number of their Medicaid users.

Safety net providers are discussing and implementing strategies to enable them to compete better. For example, Cooper Green has proposed to serve as the hub of the coordinated system that is under development in the county. Cooper Green recognizes that it cannot compete with the University of Alabama Hospital on technology; rather, it proposes to direct its resources toward outpatient care for the indigent and rely on other hospitals to provide inpatient care to these patients. Two stumbling blocks that Cooper Green may face in forging ahead with its plans are that (1) other hospitals may not want to assume responsibility for more indigent care, particularly if they do not receive commensurate Indigent Care funds, and (2) downsizing Cooper Green could be politically difficult because of the number of people it employs and the role it plays in the black community.

A key issue for all the hospitals is the level of uncompensated care they provide, an issue that is particularly important to the University of Alabama Hospital. Although the hospital has resources to provide care to significant numbers of Medicaid and uninsured patients, it does not want to be a magnet for indigent patients. Rather it is seeking to draw more paying patients, even from outside the county. The hospital has also been vigilant in increasing its efficiency, reducing its staff by 700 over the past three years (even as admissions have risen), reducing the cost per case, and shortening length of stay. These steps give the hospital a competitive advantage, should HMOs increase their penetration of the market.

A strategy adopted by all safety net providers is greater involvement in managed care. The University of Alabama Hospital has made plans to develop a for-profit HMO, although the state attorney general has questioned the legality of a state entity's involvement in a for-profit enterprise. Children's Hospital administers a global capitated program with 5,000 lives (half are from a business coalition, and the other half are children of University of Alabama employees) and is pursuing an HMO license. Cooper Green also operates a managed care plan, called HealthPlus Community Care Plan, which is available to the

uninsured for a nominal fee and entitles enrollees to services in two off-site clinics as well as the services of the hospital. The plan had enrolled 600 individuals as of October 1996.[33] Finally, the Jefferson County health department recognizes that it too must be prepared for the emerging prominence of managed care in the health care system, especially within the Medicaid program. The health department has concerns about its level of efficiency and ability to compete with private physicians. However, it hopes to maintain its role as a primary care provider in the emerging managed care environment and has discussed with the state the possibility of accepting capitation for its Medicaid patients, thereby bypassing the incremental step of serving as a case manager for the new primary care case management program.

Long-Term Care for the Elderly and Younger People with Disabilities

Long-term care for the elderly and younger people with disabilities is a critical component of the state's involvement in health care and plays a critical role in the Medicaid program. The delivery system for long-term care, especially for the elderly, has historically been dominated by institutions. However, like other states, Alabama is reducing its reliance on institutional services, particularly for the mentally ill and persons with mental retardation and developmental disabilities.

Supply, Utilization, and Expenditures

Medicaid long-term care services for the elderly and younger persons with disabilities in Alabama totaled $606 million in 1995, up from only $282 million in 1990 (see table 8). Approximately 61 percent of these funds were spent on the elderly and 39 percent on younger people with disabilities. Expenditures grew by 28.3 percent per year between 1990 and 1992—largely because of higher payment rates and largely reimbursable provider taxes on nursing homes—but the rate of increase slowed to 9.3 percent per year between 1992 and 1995.

Alabama has a nursing home bed supply that is lower than the national average and has a substantial number of home health agencies; it also has a declining number of institutional mental health and mental retardation beds. In

1996 Alabama had 23,249 nursing home beds in 223 facilities (42 beds per 1,000 elderly, compared with a national average of 51 beds per 1,000 elderly).[34] The state directly operates five general mental hospitals, three specialty mental health facilities, and five intermediate care facilities for the mentally retarded.[35] In addition, there are more than 430 small residential facilities serving persons with mental retardation.[36]

Reflecting the recent increases in Medicare home health use, the number of home health agencies in Alabama has been increasing rapidly. As of 1995, there were 180 Medicare-certified agencies, up almost 50 percent since 1989. Historically, the Alabama Department of Public Health has been the largest provider of home health services in Alabama, especially in rural areas. In addition, many rural hospitals have begun their own home health agencies in an attempt to remain economically viable.

Long-Term Care for the Elderly

In 1995, Alabama spent $371 million on long-term care for the elderly, almost entirely for institutional services. No major initiatives are under way to maximize non-Medicaid financing or to integrate acute and long-term care services. Moreover, while state policymakers express interest in expanding home care, relatively little money is available to do so. Instead, the state has relied on more traditional methods of cost containment, including, until recently, a long-standing moratorium on new nursing home construction. (The moratorium was ended in 1996 by the governor, largely as a result of pressure by the legislature. Moreover, during the ban, numerous exceptions to the moratorium resulted in an increase in the number of beds.)

In recent years, nursing home reimbursement has been fairly generous, in part responsible for a Medicaid budget overrun in 1997 that led the governor to propose dramatic cuts in nursing home rates, which were successfully resisted by the legislature and the nursing home industry. A strong political force in Alabama, the nursing home industry has a history of successfully rallying public sentiment in favor of nursing home and, more generally, Medicaid spending.

Private-Sector Initiatives and Medicare Maximization

Alabama does not have major initiatives to reduce Medicaid long-term care spending by maximizing Medicare nursing home and home care revenues or by promoting private-sector initiatives. Only a very small number of people have long-term care insurance, and although the state recently enacted tax incentives to stimulate purchase of this insurance, the change is unlikely to have a major impact on the number of people with policies.

The state has not actively attempted to discourage or prohibit asset transfer, as it is perceived to be a relatively modest problem, albeit one that causes concern for nursing facilities when residents are retroactively denied Medicaid eligibility. Similarly, Alabama is not aggressively pursuing estate recovery, in part because the state already requires Medicaid nursing home residents to sell their homes after six months in a facility if they are not expected to return home. In 1995, Alabama recovered about 0.6 percent of Medicaid nursing home spending for the elderly.

The state has not developed a Medicare maximization program beyond requiring nursing homes and home health agencies to file with Medicare before they bill Medicaid. However, for home health, Medicaid reimbursement rates are low; thus, economic incentives, not policy, dictate that agencies seek reimbursement from Medicare whenever possible.

System Reform

Alabama has not devoted much attention to overall reform of the delivery system and financing of long-term care. The state covers only limited home and community-based services (although it has a Medicaid home and community-based waiver for the elderly). In addition, the lack of managed care organizations has limited possible interest in integrating acute and long-term care services.

Medicaid home care for the elderly in Alabama consists of mandatory home health services and a home and community-based waiver program, but the state does not cover personal care as an optional service. In 1995 home care accounted for about 4.4 percent of Medicaid long-term care spending for the elderly (see table 8 for the spending levels), well below the national average. There is no state-funded home care program, and only a very small amount of money is available for home care through the federal Older Americans Act. As in some other southern states, the Alabama Department of Public Health is an important home health provider to the low-income population. In part because of nursing homes' very high occupancy rates, the nursing home industry does not view home and community-based services as a threat, nor does it feel that nursing homes directly compete for funds with these services.[37]

The elderly and disabled component of the Medicaid home and community-based waiver program is administered partly by the Department of Public Health and partly by the Commission on Aging.[38] While the Commission on Aging contracts out for its services, the Department of Public Health provides most of its services directly. In order to be eligible for the waiver, a person must be Medicaid-eligible and be at the nursing home level of disability, but no other risk of institutionalization is required. Services include skilled and unskilled respite care, personal care, homemaker services, adult day health, and case management. Individual expenditures are capped at about $450 per month, but this cap rarely causes a problem. In 1996, a total of 6,513 people received care under this waiver at a cost of $3,978 per recipient.[39] Importantly, the state

Table 8 *Medicaid Long-Term Care Expenditures by Eligibility Group, Alabama and United States ($ in Millions)*

	Alabama					United States				
	Long-Term Care Expenditures			Average Annual Growth		Long-Term Care Expenditures			Average Annual Growth	
	1990	1992	1995	1990–92	1992–95	1990	1992	1995	1990–92	1992–95
Total	**$282.1**	**$464.6**	**$606.4**	**28.3%**	**9.3%**	**$32,264.2**	**$42,542.5**	**$53,996.1**	**14.8%**	**8.3%**
Elderly	$158.3	$282.2	$371.5	33.5%	9.6%	$18,408.9	$24,846.4	$30,413.7	16.2%	7.0%
Nursing Home Care	133.3	250.6	341.8	37.1%	10.9%	15,131.3	20,542.9	25,571.5	16.5%	7.6%
ICFs/MR*	1.7	2.1	1.6	12.7%	–9.1%	348.9	452.0	615.8	13.8%	10.9%
Mental Health	4.6	10.0	11.6	47.8%	5.0%	973.0	1,286.0	1,107.3	15.0%	–4.9%
Home Care	18.8	19.4	16.5	1.7%	–5.2%	1,955.7	2,565.6	3,119.1	14.5%	6.7%
Blind and Disabled	$122.8	$176.1	$230.1	19.8%	9.3%	$12,842.4	$16,201.0	$21,618.7	12.3%	10.1%
Nursing Home Care	34.8	59.1	85.8	30.3%	13.2%	3,161.3	3,968.0	4,813.3	12.0%	6.6%
ICFs/MR*	62.5	78.6	77.1	12.1%	–0.6%	7,241.3	8,380.4	9,321.1	7.6%	3.6%
Mental Health	0.6	4.9	5.2	196.5%	2.0%	457.9	682.1	881.3	22.1%	8.9%
Home Care	24.9	33.6	62.0	16.1%	22.7%	1,982.0	3,170.5	6,603.0	26.5%	27.7%
Adults and Children	$1.0	$6.3	$4.8	145.8%	–8.5%	$1,012.9	$1,495.1	$1,963.7	21.5%	9.5%

Source: The Urban Institute, 1997. Based on HCFA 2082 and HCFA 64 data.
* Intermediate care facilities for the mentally retarded.

does not fund all of the slots for home and community-based services that have been approved by HCFA.

Alabama Medicaid officials expressed some frustration with the waiver process, which they considered unnecessarily time-consuming. Moreover, compliance monitoring by HCFA is viewed as repetitious and more focused on chart review than on outcomes. However, the state's overall relationship with HCFA is good, and there are no serious barriers to the state maintaining its waiver.

The volume of Medicaid home health services is limited, partly because of low reimbursement. Medicaid reimburses home health agencies $27 per visit, the same rate it paid in 1981. As a result, most private agencies refer Medicaid patients to the public home health agencies, while private home health agencies focus on Medicare patients.

Providing home health in the rural areas of the state creates some special problems. Providing home care in rural areas requires traveling long distances and working under very difficult conditions. In some situations, no running water, electricity, or air conditioning exist. However, because there are often no other jobs available, recruiting and retaining lower-level home health staff in rural areas is not difficult.

Finally, like many other states, Alabama is examining the potential role of assisted living facilities. Advocates of assisted living facilities contend that providing Medicaid reimbursement in assisted living facilities could help alleviate the rising costs of nursing home care, a contention disputed by the nursing home industry, which argues that nursing home residents require too much skilled care to be efficiently provided for elsewhere.

Traditional Approaches to Cost Containment

Alabama has generally relied on more traditional strategies to slow growth in the cost of long-term care. The state is now actively debating reducing Medicaid nursing home reimbursement, and until recently it had a moratorium on construction of new nursing home beds.

Medicaid Reimbursement for Nursing Homes

In 1997, Medicaid reimbursement for nursing homes became a highly contentious issue, with the governor proposing major reductions in nursing home rates. In Alabama, nursing facilities are reimbursed by Medicaid on a cost-based, facility-specific, prospective basis.[40] In 1995, the average Medicaid reimbursement rate was $72, compared with $85 nationally.[41] However, by 1997 the average rate had increased to over $100 per day.

There is widespread agreement that Medicaid nursing home reimbursement rates are rather generous, although the nursing home industry considers higher

rates to be compensation for low payments in the past. Rates jumped 15 percent between 1993 and 1994 and costs continue to rise, partly as a result of costs associated with conforming to federal quality standards and the relatively recent rise in the minimum wage. To help offset some of the state's costs and draw down additional federal funds, the state also imposed a provider tax of $1,000 per bed per year.

Relatively high payment rates in Alabama have meant no lawsuits over failure to meet federal nursing home reimbursement standards (i.e., Boren amendment), although there have been threats of litigation.[42] In October 1996, the time of our site visit, most observers thought that repeal of the Boren amendment would not make a great deal of difference in Alabama, in part because the nursing home association was so politically powerful.

The political environment changed dramatically in March 1997 when the state's Medicaid commissioner announced that the Medicaid program was running an $80 million (federal and state) deficit, amounting to about 4 percent of total spending. The costs of nursing home care and prescription drugs were identified as the principal reasons for the overspending. Some legislators proposed an increase in the cigarette tax to help close the gap, but Governor James strongly rejected any tax increase, preferring instead to cut spending. State officials argued that Alabama nursing home rates had increased much faster, and were much higher, than rates in comparable southern states, including Mississippi, Georgia, and Tennessee, and that the existing system offered no incentives for cost containment. The nursing home industry rejected the notion that its rates were unreasonably high. It warned that cost cuts would cause a decline in the quality of care and might even result in existing residents being forced out of their nursing homes. It blamed regulatory changes for the cost increases.

In April 1997, the legislature killed a plan by the Medicaid Agency to reduce nursing home rates. Hoping for a compromise, the nursing home industry proposed a plan to cut rates somewhat and increase the provider tax. This proposal proved unacceptable to state officials, who contended that it would lock in a payment system that is favorable to the nursing home industry. In May 1997, the gubernatorially appointed Medicaid Reform Task Force proposed dramatically changing the nursing home reimbursement system from a facility-specific, cost-based prospective system to a flat daily fee at a level that would reduce spending by as much as 30 percent. The proposal was endorsed by Governor James even though the nursing home industry argued that it would be devastated by the changes. Responding to charges that quality would decline and jobs would be lost, Governor James accused the industry of "relying on scare tactics and diversions in order to hide the all-consuming greed that drives them."[43] In August 1997 the governor sent out letters to 32,000 Alabama nursing home residents and their families, attempting to refute the allegation that the reduction in payment levels would cause them to be turned out of their nursing homes.

In the fall of 1997, a compromise was reached that was very close to what the nursing home industry had proposed in the spring. The legislature established a two-year commission to investigate nursing home reimbursement, modest changes were implemented to trim nursing home reimbursement rates, and the nursing home provider tax was raised from $1,000 to $1,200 per bed. Since payment of the provider tax is an allowable expense for Medicaid purposes, the net effect is that the federal government will finance most of the Medicaid shortfall that generated the crisis in the beginning.

Controlling the Supply of Nursing Homes and Home Health Agencies

Alabama has a certificate-of-need process that covers both nursing homes and home health agencies. There was a moratorium on new home health agencies that ended in 1991. The long-standing moratorium on the construction of new nursing homes ended in 1996. Given the high nursing home occupancy rate and the lack of home care, there is widely believed to be an unmet need for long-term care. However, the Medicaid Agency is concerned that increasing the number of beds will increase its expenditures because almost three-quarters of nursing home residents are Medicaid-eligible.[44]

Despite the freeze on nursing home construction, an exception process that allowed for increases in beds at existing facilities made the moratorium fairly "leaky." Nursing homes located in an area with a high occupancy rate could add up to 10 percent of the total beds of the facility, not to exceed 10 beds total, a standard that allowed a significant increase in beds. This process benefited existing providers over new applicants.

Long-Term Care for Younger People with Disabilities

As with the rest of its health and welfare programs, Alabama historically has not spent very much on mental health and mental retardation services. Spending for home and community-based services is increasing, however, largely through increased reliance on Medicaid financing. The state is actively seeking to maximize Medicaid financing, which now accounts for about a third of the spending of the Department of Mental Health and Mental Retardation. Like the rest of the country, Alabama is moving to change the delivery system to provide more noninstitutional services.

Wyatt v. Stickney

For a quarter-century, mental health and mental retardation policy in Alabama has been dominated by *Wyatt v. Stickney*, one of the country's first lawsuits over the right to treatment in the least restrictive environment; it is still an active case. Alabama officials resent the lawsuit, which they believe to be a colossal waste of time and effort that serves primarily to enrich the lawyers

involved. Moreover, the state does not like the federal court telling it what to do. A consent decree establishing what the state would do without further legal action was signed in 1986, and the current activity relates to its implementation. Although the state contends that it is faithfully implementing the consent decree, advocates argue that it is doing so only minimally.

Mental Health

Spending on mental health services by the Department of Mental Health and Mental Retardation totaled $195 million in FY 1995-96.[45] Overall state mental health spending per capita is below the national average but higher than in several other southern states, including Mississippi, Texas, and Florida.[46] Over the past 10 years, the balance of funding has shifted somewhat toward community-based services, so that by FY 1995-96, community-based services accounted for 39 percent of the department's spending on mental health.

Utilization of the state's mental hospitals has declined, falling by 30 percent between FY 1988-89 and FY 1995-96, and it is expected to continue to decrease.[47] The remaining population in state hospitals consists mostly of people with severe long-term needs. Because of changes in the state's use of Medicaid, the state's own spending on institutional care is declining while federal spending is increasing. Advocates contend that too much money goes for institutional care, but they are not necessarily opposed to all inpatient services.

Community-based services are administered through 24 nonprofit boards, which receive funds mostly on a formula basis. Case management, supportive housing, and day treatment are available, along with more traditional mental health services. Spending for community services has increased sharply, more than doubling between FY 1988-89 and FY 1995-96.[48] Both state and federal expenditures on community services have increased, with state spending rising more than federal spending. In addition, there has been a pronounced shift within community mental health centers toward providing services to the more severely mentally ill. Despite these expansions, advocates complain that the "pieces of the puzzle" do not fit together and that the amount and quality of services are inadequate.

Mental Retardation

As with mental health, the state's goal is to change the focus of the mental retardation delivery system from institutional care to home and community-based services. Department of Mental Health and Mental Retardation spending on mental retardation services totaled $144 million in FY 1995-96, with expenditures about evenly divided between institutional care and home and community-based services.[49] State mental retardation services are heavily dependent on Medicaid, which accounts for about two-thirds of expenditures.

Alabama has a long history of low levels of institutionalization, which some attribute to a cultural preference not to send family members away and others

attribute to the lack of state funding. The census in state mental retardation facilities has fallen from about 1,400 in 1986 to 724 in 1996. Consistent with this trend, institutional expenditures declined about 25 percent between FY 1993-94 and FY 1996-97 (estimated). Despite this progress, the state does not view itself as at the end of the line in terms of deinstitutionalization.

Because the *Wyatt* litigation has taken so long to resolve, the state did not build large numbers of small intermediate care facilities for the mentally retarded, as many other states did. Instead, it leapfrogged over that stage to provide more individualized services to people in the community. Total community expenditures have increased substantially, rising 79 percent between FY 1993-94 and FY 1996-97, and they now slightly exceed spending for institutional services.[50] Importantly, state expenditures have stayed almost level in nominal terms, with virtually all the increase accounted for by increased federal funds, primarily Medicaid.

Nationally, the major financing mechanism for community services for the mentally retarded population has been Medicaid home and community-based care waivers—Alabama applied for and received one of the very first of these waivers. The state's relationship with HCFA in running the waiver program has been good, with the federal agency's regional office perceived as being helpful and responsive. The state's principal frustration is that it can provide supported work only to the 30 percent of clients who have been in institutions, as limited by HCFA regulations. In 1995, while Alabama ranked 20th in the number of home and community-based care waiver clients per capita, it ranked 46th in waiver expenditures per capita, which the state attributes to heavy use of low-cost day programs.[51]

Challenges for the Future

Alabama is a small, high-poverty state that has traditionally provided relatively minimal health and welfare benefits beyond what is required to receive federal funds. Alabama culture is antigovernment and unsupportive of welfare (although somewhat more sympathetic to health care), with traditional southern values held in high regard. The tax base is relatively weak, and no support exists for raising state taxes to fund a more extensive set of health or welfare programs for the low-income population.

The state faces five major challenges for the future in meeting the health care needs of its low-income population. The first and most pressing is financial. Alabama's heavy reliance on disproportionate share hospital (DSH) payments, provider taxes, and intergovernmental transfers to finance the state share of the Medicaid program, combined with its limited eligibility and benefits, has left the state highly vulnerable to changes in federal rules. Medicaid funding crises are perennial and force policymakers to spend much time and energy on "creative" financing mechanisms.[52] The federal Balanced Budget Act of 1997 included reductions in the state's DSH allotment and set new rules on how the money can be allocated to managed care organizations (such as the state's prepaid health plans), both of which may contribute to budget problems for Alabama. Virtually all other state health policy for the low-income population will depend on how the state addresses these issues.

The second challenge is the lack of health coverage for much of the low-income population. The state has a fairly high rate of uninsurance, although a solid base of employer-sponsored coverage helps keep the level down. The state has low Medicaid eligibility standards, which are as high as they are primarily

because of federal rules; moreover, the state does not run an insurance program of its own for the uninsured. As in the rest of the country, the combination of a strong economy and welfare reform in Alabama is leading to a sharp reduction in Aid to Families with Dependent Children/Temporary Assistance for Needy Families (AFDC/TANF) caseloads, which may result in declining Medicaid caseloads and an increase in the number of uninsured. Administrative coordination between TANF and Medicaid to ensure that individuals no longer eligible for TANF but still eligible for Medicaid will continue to be covered is likely to be a significant administrative burden. Another key coverage issue is how, and to what extent, Alabama will decide to participate in the State Children's Health Insurance Program (S-CHIP) established by the federal Balanced Budget Act of 1997. Even with the enhanced federal matching rate, the state must contribute what for Alabama is a significant sum of money in order to draw down all the available federal funds.

Although Medicaid coverage is minimal and no state-only insurance programs exist, access to health care for the uninsured is not as restricted as it might be. Although transportation is a problem in both rural and urban areas, the state is small enough that travel to providers is not too difficult, providing one has access to a car. In part because of the lack of a price-competitive marketplace for health care, hospitals—especially state university and local government facilities—are able to provide a significant amount of uncompensated care, which is financed by cross-subsidies from third-party payers and government funds. Birmingham, in particular, has a wealth of providers that supply care to the low-income population. On the other hand, rural areas have a particular problem with access to services because of the difficulty of attracting providers there.

The third challenge, which is directly related to the second, is how the market and the state will try to shape the growth of managed care in Alabama. At present, there is not much managed care in Alabama, but few expect things to remain that way. If the growth of managed care results in a much more competitive health care market, hospitals and other providers may not believe that they can continue to provide as much uncompensated care as in the past because they will be less able to shift costs to private third-party payers.

From the perspective of Medicaid officials, managed care is a useful strategy to improve the quality of care (especially accountability) and achieve cost savings, and they are committed to its expansion. So far, however, they have been constrained by the relative lack of availability of health maintenance organizations (HMOs) and the hostility of much of the health care establishment toward managed care. They have proceeded cautiously and have not tried to invent a Medicaid-only managed care system, as has neighboring Tennessee. Both the state and local departments of health are struggling with the question of how they would fit into a new system. Alabama's creation of the prepaid health plans for Medicaid hospital care—which most observers see primarily as a way of retaining DSH funds rather

than as actual managed care—complicates considerably any potential capitated managed care expansion. Through its use of prepaid health plans, the state has taken the potential control of hospital care out of the hands of more comprehensive managed care entities, leaving only ambulatory care to be capitated. The key question is whether the state will be able to expand Medicaid enrollment in full-risk, capitated managed care in a way that does not undermine the ability of providers to finance care for the uninsured.

Fourth, the health care safety net in Alabama is under less pressure than elsewhere in the country. The lack of heated competition, the result in part of the modest presence of HMOs in the state, has maintained excess resources in the system to meet the essential needs of the poor. DSH-supported hospitals, community health centers, and county health departments have also secured access to health services for the uninsured and Medicaid populations. Nonetheless, changes are on the horizon that suggest future constraints in the resources available to underwrite uncompensated care. Managed care is increasing, although slowly, in the state, including within the Medicaid program. In addition, excess hospital capacity exists in some areas. These forces will likely lead to greater competition among providers and more efficiency, potentially curbing funds available for the medically indigent. Moreover, as health department clients continue to shift into Medicaid managed care plans, the public health system will have to refocus its mission, directing resources away from clinical services and into population-oriented activities.

Fifth, Alabama is reassessing its long-term care system for the elderly, the mentally ill, and the developmentally disabled/mentally retarded populations, which historically has been very institutionally oriented. Working within the confines of a court case that has lasted 25 years, the state has substantially reduced its populations of mental health and mental retardation/developmental disabilities inpatients. Medicaid budget overruns in 1997 have focused attention on nursing home reimbursement methodologies, and the recent repeal of federal standards will give Alabama unprecedented legal freedom to alter its payment system. Given the political strength of the nursing home industry, however, reducing rates may be easier said than done, even with the legal barriers gone. In addition, as in most other states, state policymakers want to expand home care, but the funds available to do so are limited unless the state can divert funds from institutional care, which seems unlikely to occur, at least for elderly services.

The case of Alabama provides evidence for both those who favor greater devolution of social programs to the states and those who oppose it. Alabama, like the rest of the South, has made remarkable strides since the days of the civil rights struggles in Montgomery, Birmingham, and Selma. Health and welfare programs for the low-income population are far better now than they were and lack the overt discrimination that was their hallmark 20 or 30 years ago. Some initiatives, such as the maternity waiver, have substantially improved care of the low-income population.

On the other hand, social programs in Alabama are minimal, and Medicaid is only as generous as it is because of federal standards. The state's use of DSH and other financing mechanisms has resulted in Alabama dramatically decreasing its "real" share of Medicaid expenditures while increasing federal spending. In Alabama, a high federal match rate for Medicaid has not been enough to induce the state to expand Medicaid coverage and benefits beyond federal flows. Large numbers of people are uninsured, and the state has done little to provide them with coverage beyond what federal law requires.

Notes

1. Kevin Sack, "In South, Prayer Is a Form of Protest," *New York Times*, November 8, 1997, Section A, p. 9; and Kevin Sack, "Alabamians Weigh Prosperity against Social Issues in Election Choice," *New York Times* (online), September 28, 1997.

2. Keven Sack, "Alabama G.O.P. Governor Sees a Different New South," *New York Times*, August 29, 1997, p. 1.

3. Sandra J. Clark and Sharon K. Long, with Krista Olson and Caroline Ratcliffe, *Income Support and Social Services for Low-Income People in Alabama*, Assessing the New Federalism (Washington, D.C.: The Urban Institute, 1998).

4. Compared to other health care providers, nursing homes are particularly dependent on Medicaid financing and therefore Medicaid policy is particularly important to them. Even public hospitals have a lower percentage of their patients dependent on Medicaid.

5. At one point a few years ago, the state was considering Medicaid cuts that would affect nursing homes. The Alabama Health Care Association ran some very effective television advertisements showing a frail elderly woman being wheeled out of a nursing home with the question, "What will happen to Momma?"

6. In 1992, Alabama's state and local taxes of $1,436 ranked 49th among all states. *CQ's State Fact Finder: Rankings across America, 1996.*

7. In 1996, Alabama's federal medical assistance percentage was 69.85 percent. In 1997, it was 69.54 percent; that is, for every dollar the state spent on Medicaid, the federal government would reimburse the state 69.54 cents.

8. The disproportionate share hospital portion of the Medicaid program requires states to make additional payments to hospitals that serve a "disproportionate share" of Medicaid and uninsured patients.

9. ReliaStar, "The ReliaStar State Health Rankings, 1996 Edition" (Minneapolis, MN: ReliaStar Financial Corporation, 1996).

10. For example, in 1994–95, while 66.3 percent of the nonelderly population in Alabama had employer-based health insurance, the comparable figure for Florida was 59.2 percent; for Mississippi, 59.2 percent; and for Texas, 58.0 percent. It is not clear why Alabama has a higher employer-based insurance rate. Urban Institute tabulations of the Current Population Survey.

11. JoAnne Lamphere, Danielle Holahan, Normandy Brangan, and Robin Burke, *Reforming the Health Care System: State Profiles, 1997* (Washington, D.C.: American Association of Retired Persons, 1996).

12. Paul E. Peterson, *The Price of Federalism* (Washington, D.C.: The Brookings Institution, 1995).

13. Although observers generally did not believe that the notion of "welfare magnets" played an important role in keeping benefit levels low, some noted that some legislators and others would be sympathetic to the argument.

14. Data from Alabama Medicaid Agency.

15. AFDC has been replaced by Temporary Assistance for Needy Families (TANF), but federal law requires the old AFDC criteria to be used to determine eligibility for Medicaid.

16. Almost all of the rest of the increase is due to blind and disabled SSI beneficiaries.

17. In 1990, the maximum benefit was $1,416 per year; in 1992, it was $1,788 per year. Committee on Ways and Means, U.S. House of Representatives, *The Green Book: Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means* (Washington, D.C.: U.S. Government Printing Office, 1996).

18. Sandra J. Clark and Sharon K. Long, with Krista Olson and Caroline Ratcliffe, *Income Support and Social Services for Low-Income People in Alabama*, Assessing the New Federalism (Washington, D.C.: The Urban Institute, 1998).

19. For further information about the Alabama income support and social service system, see: Sandra J. Clark and Sharon K. Long, with Krista Olson and Caroline Ratcliffe, *Income Support and Social Services for Low-Income People in Alabama*, Assessing the New Federalism (Washington, D.C.: The Urban Institute, 1998).

20. Because of income restrictions in the federal program, not all of these uninsured children could be eligible for the S-CHIP program.

21. Blue Cross/Blue Shield assumes that new facilities will increase utilization, which will increase reimbursements.

22. Low birth-weight infants, a primary contributor to infant mortality, actually increased from 7.5 percent to 9.1 percent between 1985 and 1994. Since the maternity waiver should operate indirectly on the infant mortality rate by reducing the rate of low birth-weight infants, some argue that heroic medical treatment after delivery, not preventive efforts fostered by the waiver, is keeping infants alive.

23. Mental health services will be included in the capitation.

24. Stephen A. Norton, "Medicaid Fees and the Medicare Fee Schedule: An Update," *Health Care Financing Review*, 17(1, Fall 1995):167–182.

25. For a more extensive explanation and analysis of the Medicaid disproportionate share hospital program, see: Teresa A. Coughlin and David Liska, "The Medicaid Disproportionate Share Hospital Payment Program: Background and Issues," *New Federalism: Issues and Options for States*, Series A, No. A-14, (Washington, D.C.: The Urban Institute, October 1997); and Teresa A. Coughlin and David Liska, "The Medicaid DSH Program: Background and Current Issues," *Health Affairs*, forthcoming.

26. Tracking how DSH affects state finances is quite complicated but can be illustrated by the following example. Assume the state receives $10 million in intergovernmental transfers from a public hospital; subsequently, the state makes a DSH payment of $12 million to the hospital. The state then bills the federal government for its 69.54 percent federal match and receives $8,344,800. At the end of this transaction, the provider has received a net $2 million, while the state has received a net $6,344,800 ($8,344,800 received from the federal government less $2 million paid to the provider along with returning its intergovernmental transfer). The federal government has paid four times as much as the net amount of money received by the provider.

27. For example, one provider referred to DSH as "funny money." Another observer referred to it as "fake," while another described it as a "cash cow."

28. HMO representatives contended that the development of the PHP network would hinder increased use of managed care organizations in the Alabama Medicaid program. Since the PHPs have a lock on managing the inpatient side, HMOs could only be responsible for managing the nonhospital part of the benefit package. There was little interest in this since the big savings come from reducing hospital use.

29. The text of the legislation states that a DSH payment is only valid if it *"(A) is made directly to the hospital by the State; and (B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals. (2) EXCEPTION FOR CURRENT ARRANGEMENTS.—Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997."* The exception applies to Alabama's two-year agreement with HCFA but is unclear about the status afterward. Regardless, the PHP system design will have to be revisited in 1997 because of HCFA's insistence that the contracts be awarded through a competitive bidding process.

30. National Association of City and County Health Officials, unpublished data.

31. Each day, the emergency room in only one of the city's main hospitals is fully staffed and open to all walk-in patients. The location of the open emergency room is announced in the newspaper and on television and radio.

32. Alabama Code Section 22-21-291.

33. Although the plan was not created as an insurance product, the state Department of Insurance ruled that it had to meet insurance regulations. To satisfy these requirements, the plan was subsequently incorporated into United Healthcare as one of its product lines.

34. American Health Care Association, *The Nursing Facility Sourcebook: Facts and Trends, 1997* (Washington, D.C.: American Health Care Association, 1997).

35. Alabama Department of Mental Health and Mental Retardation, *Alabama Department of Mental Health and Mental Retardation, FY 1994-95 Annual Report* (Montgomery, AL: Alabama Department of Mental Health and Mental Retardation, 1996).

36. Lynda Anderson, Barbara Polister, Robert Prouty, and K. Charlie Lakin, "Services Provided by State and Nonstate Agencies in 1995," in Robert Prouty and K. Charlie Lakin, editors, *Residential Services for Persons with Developmental Disabilities: Status and Trends through 1995* (Minneapolis, MN: Institute on Community Integration, University of Minnesota, May 1996), pp. 43–63.

37. The nursing home occupancy rate averaged 94 percent in 1996. American Health Care Association, *The Nursing Facility Sourcebook: Facts and Trends, 1997* (Washington, D.C.: American Health Care Association, 1997).

38. In addition, there is a "homebound waiver," which serves disabled adults between the ages of 21 and 64 with specific medical diagnoses who are at risk of being institutionalized. In 1996, there were 355 recipients.

39. Alabama Medicaid Agency, *Alabama Medicaid Agency, FY 1996 Annual Report* (Montgomery, AL: Alabama Medicaid Agency, 1996), obtained from the Alabama Medicaid Agency Web site, www.medicaid.state.al.us.

40. Barbara Bedney, Helen Carrillo, James H. Swan, and Charlene Harrington, *1995 State Data Book on Long Term Care Program and Market Characteristics* (San Francisco: University of California, San Francisco, November 1996).

41. American Health Care Association, *The Nursing Facility Sourcebook: Facts and Trends, 1997* (Washington, D.C.: American Health Care Association, 1997).

42. The Boren amendment, enacted as part of the Omnibus Reconciliation Act of 1980, required that states pay nursing homes enough to cover the costs of an economically and efficiently operated facility that meets the quality standards. The Balanced Budget Act of 1997 repeals these requirements.

43. Health Policy Tracking Service, "Governor's Office Attacks Nursing Home Association" (Washington, D.C.: Intergovernmental Health Policy Project, June 9, 1996).

44. American Health Care Association, *The Nursing Facility Sourcebook: Facts and Trends, 1997* (Washington, D.C.: American Health Care Association, 1997).

45. Data from Mental Health Division, Alabama Department of Mental Health and Mental Retardation, October 1996.

46. National Association of State Mental Health Program Directors, "Profiles Output Report," data obtained from its Web site, www.nasmhpd.org, October 22, 1997.

47. Data from the Mental Health Division, Alabama Department of Mental Health and Mental Retardation, October 1996.

48. *Ibid.*

49. Data from Mental Retardation Division, Department of Mental Health and Mental Retardation, October 1996.

50. *Ibid.*

51. Gary A. Smith and Robert M. Gettings, *The Medicaid Home and Community-Based Waiver Program: Recent and Emerging Trends in Serving People with Developmental Disabilities*

(Alexandria, VA: National Association of State Directors of Developmental Disabilities Services, Inc., August 1996).

52. According to U.S. Representative Spencer Bachus (R-AL), the "state must stop relying on temporary fixes. . . . Alabama cannot continue to ask for waivers and exemptions whenever problems arise. We must focus on the future and make the right decisions that will improve Alabama's Medicaid program and ensure there are no more financial crises." "Alabama: Summit Will Confront Medicaid Crisis," from *Birmingham News*, cited in *American Health Line*, October 10, 1997.

APPENDIX

List of People Interviewed

Montgomery

Alabama Medicaid Agency

Gretel Felton
Sharon Gaither
Jackie Gray
John Hay
Arnita Howard
Vicki Huff
James Jones
Mike Lewis
Phyllis McCalman
Mike Murphy
Joan Salter
John Searcy, M.D.
Jean Stone
Gwendolyn Williams
Harriette Worthington

Alabama Department of Mental Health and Mental Retardation

Ross Hart
Cathy Maddox

Alabama Department of Public Health

Clyde Barganier
James Cooper
Ed Davidson
Sherry George
Thomas Miller, M.D.
Fern Shinbaum
Michele Williams
Donald E. Williamson, M.D.

Alabama Insurance Department

Saleta Billingsly
John Hyden

Legislature

Representative Steve Flowers
Senator Dewayne Freeman
Joyce Bigbee
Frank Gitschier III
Victor Vernon

Commission on Aging

Robert Franklin
Edgar Wyatt Stephens

Provider Associations

Lon Conner — Medical Association of the State of Alabama

J. Michael Horsley — Alabama Hospital Association

C. Bernell Mapp	Alabama Primary Care Association
Byron W. McCain	Alabama Association of Health Maintenance Organizations
Tom McDougal	Alabama Gerontological Society
Margie Sellers	Alabama Nursing Home Association

Health Maintenance Organizations

James Ludwig	Health Partners of Alabama, Inc.
Mark Miranda	Health Partners of Alabama, Inc.
Alan Creighton	United HealthCare of Alabama, Inc.
Christine Nye	United HealthCare of Alabama, Inc.
James Outland	United HealthCare of Alabama, Inc.
Linda Baker	United HealthCare South, Inc.
Bill deShazo, M.D.	United HealthCare South, Inc.

Advocates and Experts

Richard Deibert	Immanuel Presbyterian Church
Lawrence Gardella	Legal Services Corporation of Alabama
Ann Marshall	Alabama Disability Advocacy Project
Robert Osborne	Alabama New South Coalition
Albert Sankey	NAACP
Vee Stalker	University of Alabama-Birmingham

Birmingham

Hospitals

Eleanor Barnes	The Children's Hospital of Alabama
Jim Dearth, M.D.	The Children's Hospital of Alabama
Sherry Mills	The Children's Hospital of Alabama
Supora Thomas	The Children's Hospital of Alabama
Max Michael, M.D.	Cooper Green Hospital
William Higdon	University of Alabama Hospital
Richard Telkamp	University of Alabama Hospital

Other Providers

Mike Fleenor, M.D.	Jefferson County Department of Public Health
Alex Baker	Northport Health Services, Inc.
April Puccetti	Northport Health Services, Inc.
Pamela Faust	Seton Home Health Services
Sandral Hullett, M.D.	West Alabama Health Services
James W. Coleman, Sr.	West Alabama Health Services

About the Authors

Joshua M. Wiener is a principal research associate in the Urban Institute's Health Policy Center, where he conducts research on Medicaid, long-term care, and health care for the elderly. He is the coauthor or editor of seven books and over 60 articles. Prior to coming to the Urban Institute, Dr. Wiener did health care research and policy analysis for the Brookings Institution, the Health Care Financing Administration, the Massachusetts Department of Public Health, and the New York City Department of Health.

Susan Wall is a research associate in the Urban Institute's Health Policy Center. Previously, she served as an analyst for the Physician Payment Review Commission. Her research has centered on access to care for low-income populations, including issues of health professional maldistribution, Medicaid managed care, and public health departments.

David Liska is a research associate in the Urban Institute's Health Policy Center. Mr. Liska's research has focused on Medicaid and national and state health care reform. He also retains ongoing responsibility for maintaining the Institute's database on Medicaid enrollments and expenditures.

Stephanie Soscia, at the time when this research was conducted, was a research assistant in the Urban Institute's Health Policy Center. Her research centered on the interaction between Medicare and Medicaid home health and the health care for the low-income population.

Errata

Several published *State Reports* and *Highlights* include an error in Table 1, "State Characteristics." Incorrect figures were included for noncitizen immigrants as a percentage of the population. Corrections were made on August 13, 1998 to both the HTML and PDF version of these reports on the *Assessing New Federalism* website.

Correct figures for 1996

	Noncitizens as a Percent of the Population
UNITED STATES	6.4%
Alabama	0.9%
California	18.8%
Colorado	5.1%
Florida	10.0%
Massachusetts	5.4%
Michigan	2.3%
Minnesota	3.0%
Mississippi	0.9%
New Jersey	8.8%
New York	11.9%
Oklahoma	1.5%
Texas	8.6%
Washington	4.3%
Wisconsin	2.1%

Source: Three-year average of the Current Population Survey (CPS) (March 1996-March 1998, where 1996 is the center year) edited by the Urban Institute to correct misreporting of citizenship.

The error appears in the following publications:

State Reports:
Health Policy: Alabama, Colorado, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Texas, Washington

Income Support and Social Services: Alabama, California, Massachusetts, Michigan, Minnesota, Texas, Washington

Highlights:
Health Policy: Alabama, Florida, Massachusetts, Michigan, Minnesota, Mississippi, New Jersey, New York, Oklahoma, Texas, Washington

Income Support and Social Services: Minnesota, Texas

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