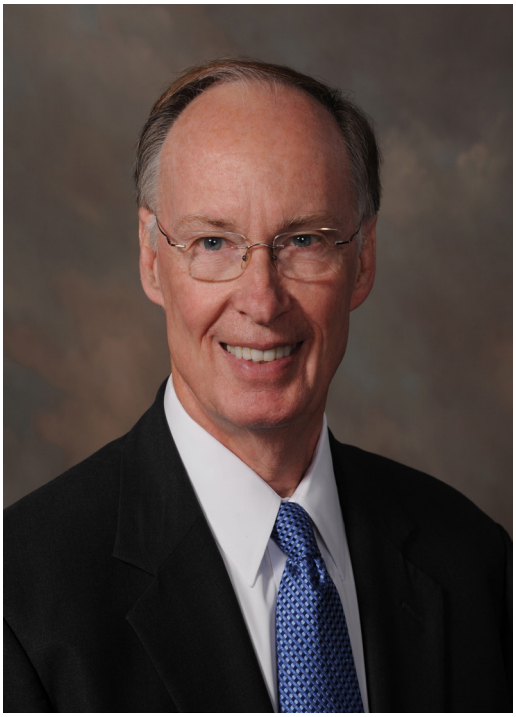
Alabama Medicaid Agency Annual Report

Fiscal Year 2013
October 1, 2012 - September 30, 2013



Robert Bentley
Governor
State of Alabama

Stephanie McGee Azar
Acting Commissioner
Alabama Medicaid Agency

Dr. Don Williamson
Chairman
Alabama Medicaid
Transition Task Force

Robert Bentley
Governor

Alabama Medicaid Agency

501 Dexter Avenue
PO Box 5624
Montgomery Alabama 36103-5624

Stephanie McGee Azar
Acting Commissioner

Dear Governor Bentley,

It is my honor to present you with the Alabama Medicaid Agency's Annual Report for Fiscal Year 2013.

This report is a testament to the outstanding work of a diverse and committed team of state employees and numerous Alabama citizens who participate on the agency's various committees and workgroups. I trust that you will find this report helpful in gaining additional insight into this complex and vital program.

During this year, Alabama Medicaid began its transformation by taking the first steps to develop Regional Care Organizations, which ultimately will coordinate patient health care for most Medicaid recipients in a designated region. I am pleased to report that this effort is on schedule to comply with state law.

While this transformation was a highlight of Medicaid in Fiscal Year 2013, it was by no means the only activity taking place in the Agency. New initiatives included collaboration with other agencies that resulted in a new eligibility and enrollment system; development of a more accurate data collection system that further streamlines the eligibility determination process; and initiation of an expedited nursing home enrollment application.

Through all of our new initiatives, the Agency and its staff maintains focus on the needs of our recipients while honoring our obligation to be good stewards of the funds provided to us. We hope this overview of the program will help you understand the steps we are taking to achieve these goals.

Sincerely,

Stephanie McGee Azar

FY 2013

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Managing Medicaid's Assets

The Medicaid Agency

MISSION:
To provide a system of financing health care for eligible Alabamians in accordance with established statutes and Executive Orders.

VISION:
To play a key leadership role in ensuring availability and access to appropriate health care for all Alabamians.

VALUES:

- Respect
  We are a caring organization that treats each individual with dignity, empathy, and honesty.

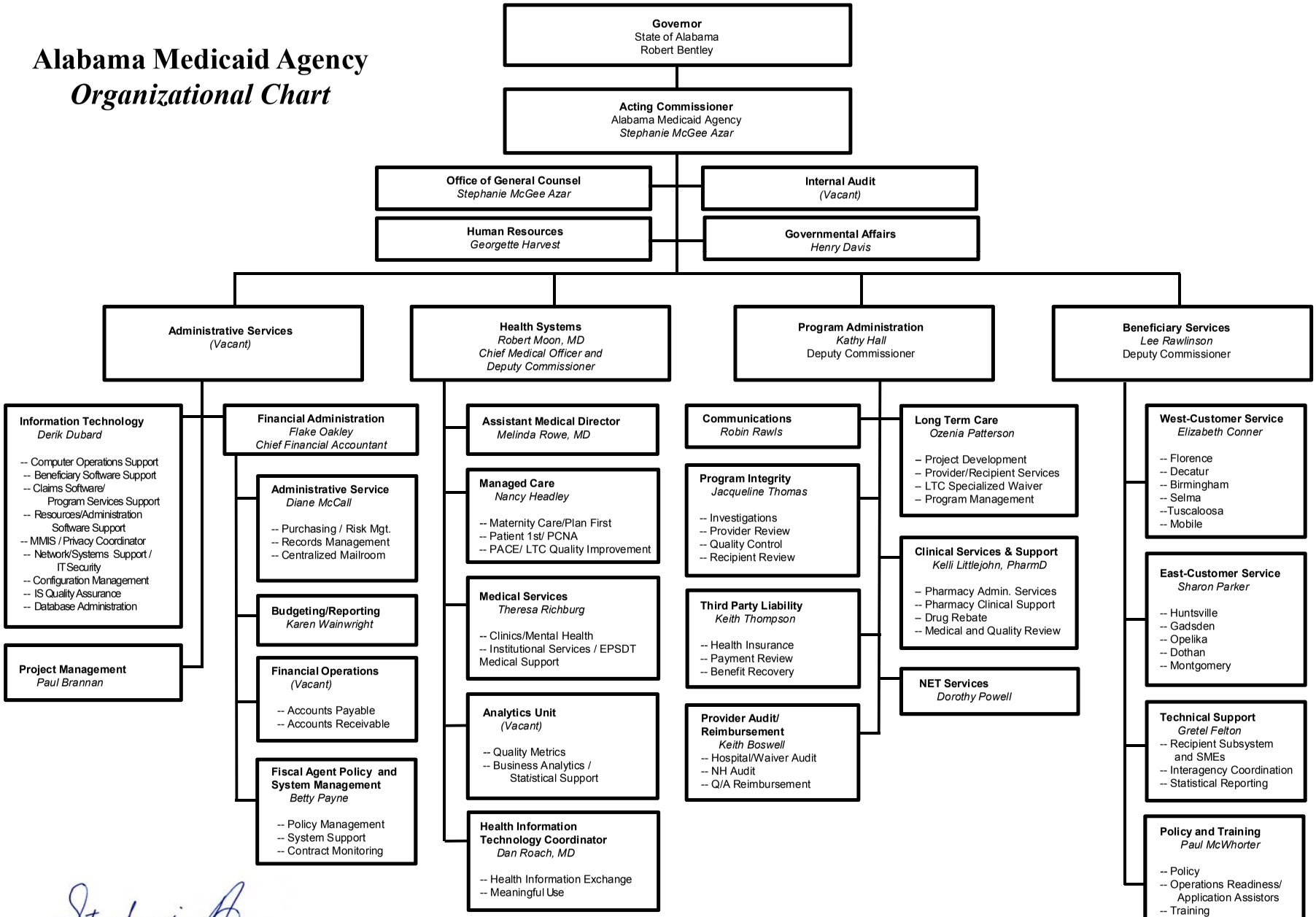
- Integrity
  Our stakeholders can depend on the quality, trustworthiness, and reliability of our Agency's employees and representatives.

- Excellence
  We are committed to maximizing our resources to ensure the residents of Alabama have access to quality health care.

- Teamwork
  Our success depends upon establishing and maintaining effective collaborative partnerships.

- Innovation
  We willingly embrace new ideas and new ways of doing things to effectively meet a changing health care environment.

Alabama Medicaid Agency
Organizational Chart



Stephanie McGee Azar
Acting Commissioner

Effective Date October 1, 2012

9/27/12

Highlights of the year

Formation of Regional Care Organizations (RCOs), key components in Medicaid's transformation to a capitated managed care system, began moving forward at the start of the Fiscal Year 2013 as Governor Robert Bentley created the Alabama Medicaid Advisory Commission. By May, reform legislation facilitating a more efficient and cost effective health care delivery system was approved by the Alabama Legislature and signed into law by the Governor. Four months later, five regional RCO service areas were established. Among other highlights was approval of a $28 million grant for rebalancing the state's long term care system. Medicaid was also involved in two successful collaborative efforts. One, with Alabama Department of Public Health, resulted in a new eligibility and enrollment system. The other, with Alabama Department of Human Resources, streamlined and simplified Medicaid enrollment and renewals.

Alabama receives "Money Follows the Person" grant funding

Alabama Medicaid was notified on October 2, 2012, that it was approved to receive up to $28 million over four years for a Money Follows the Person Rebalancing (MFP) Grant Demonstration project. The Agency had received a $200,000 grant earlier in the year to conduct a comprehensive planning effort to implement an MFP program.

Grant funds will cover the upfront costs associated with transitioning each individual as well as administrative costs of operating the program and will be paid during the first year of each person's transition.

The majority of the expenditures will be to fund home and community-based services for Medicaid-eligible individuals who are elderly or have disabilities and who choose to transition from nursing facilities or a state-operated psychiatric hospital (only applies to recipients under 21 or over 65 for this type of facility).

Most are expected to transition to one of Medicaid's seven HCBS waiver programs or to a PACE program.

The Money Follows the Person program is designed to help states "rebalance" their long-term care systems by increasing the use of home and community-based services and decreasing the use of institutional care. Instead of institutional care, states will use MFP funds to expand services and supports in the community to make it possible for more individuals to live in the community.

Alabama's goal is to ultimately transfer approximately 600 people from institutions to the community. This not only enhances the quality of life for those participants, but the state will benefit from significant cost savings as well.

State eligibility simplifications recognized

Alabama qualified for performance bonuses of $15 million in FY 2012 based upon achieving

Highlights Fiscal Year 2013

Oct. 2012

- Governor Bentley creates Medicaid Advisory Commission to evaluate Medicaid
- Money Follows the Person grant approved

Nov. 2012

Dec. 2012

- Agency hemophilia standards spotlighted by Medicaid Integrity Institute and CMS
- Agency awarded CMS Quality Measures Grant

Jan. 2013

- Medicaid Advisory Commission submits findings to Governor
- ACA required "Bump" payments begin for primary care physicians

Feb. 2013

- Medicaid, ADPH build new eligibility & enrollment system
- Medicaid, maternity care providers launch project to combat premature births in at-risk mothers

March 2013

- Governor expresses support for Medicaid transformation

eligibility simplifications in Medicaid and CHIP and gains in enrollment for Medicaid children.

One of the recognized simplifications is a streamlined joint application process in which individuals may apply online, by mail, or in person for both Medicaid and ALL Kids using the same form.

Other simplification achievements that qualified the state for recognition included elimination of face-to-face interviews; 12 months continuous eligibility for children; elimination of the asset test; and use of pre-populated renewal forms.

The Medicaid Agency has also strived through the years to eliminate unnecessary verification requirements of families.

Alabama hemophilia effort featured by Medicaid Integrity Institute

Alabama Medicaid's efforts to improve the quality of services provided to patients with hemophilia and to prevent fraud and abuse were showcased in an online presentation in December 2012, sponsored by the Medicaid Integrity Institute and the Centers for Medicare and Medicaid Services.

The presentation, "Alabama Medicaid Hemophilia Standards of Care," described the background and history, the standards of care, and the consequences for failure to comply. The Agency implemented these measures to ensure better oversight and treatment of hemophilia patients five years ago. The effort not only helped to ensure that all patients with hemophilia received a minimum standard of care but also significantly boosted the Agency's ability to head off fraud and abuse associated with the use of expensive clotting factor.

CMS awards grant to expand Agency's data analytics capabilities

A new $2 million, two-year grant from the federal government played a major role in helping Alabama Medicaid obtain new technology and resources during FY 2013 to improve health outcomes for adults covered by the program.

Announced by the Centers for Medicare and Medicaid Services on December 21, 2012, the Adult Health Quality Measures Grant was used to increase the Agency's capacity for standardized data collection and reporting of the data on the quality of health care provided to the

April 2013

- Medicaid, DHR Express Lane Eligibility recognized at national conference
- CMS okays Health Homes for Medicaid Patient Care Networks

May 2013

- Governor signs Medicaid reform legislation into law
- General Fund budget provides $615.1 million for Medicaid

June 2013

- Governor establishes Pharmacy Study Commission
- RCO districts proposed

July 2013

- Expedite online nursing home online application launched
- Pharmacy cost-cutting measures implemented

Aug. 2013

- Pharmacy Study Com-mission evaluates options for pharmacy program

Sept. 2013

- Five RCO regions established
- New mobile app puts Medicaid at fingertips

approximately 453,000 adults currently eligible for Alabama Medicaid.

Grant funds have been used to build a quality unit in the Data Analytics Division with the capacity to collect, analyze and report on data from claims, electronic health records (EHR), One Health Record®, the state's health information exchange (HIE), and the Real Time Medical Electronic Data Exchange (RMEDE), and other sources.

CMS selects Alabama anti-fraud measure as "noteworthy pick"

Alabama Medicaid's longtime practice of deactivating enrolled providers if mail is returned due to a bad address was one of several "noteworthy picks" or best practices to combat fraud cited by the Centers for Medicare and Medicaid Services (CMS). The measure, along with other state Medicaid fraud practices, is listed in a searchable database published January 31, 2013, by the Pew Center on the States.

The database was compiled from a list created by CMS's Medicaid Integrity Group (MIG) which reviewed all state Medicaid fraud practices and highlighted those they believe to be effective in reducing fraud, waste or wasteful errors in Medicaid programs.

Since Alabama began deactivating providers with bad addresses in 1999, nearly 2,000 providers have been removed. Many more have updated their addresses with the Agency to ensure that records are accurate. Other measures taken to prevent fraud include an in-person visit to all Durable Medical Equipment (DME) providers before enrollment or re-enrollment to ensure that the business has a legitimate physical location.

Other Alabama Medicaid fraud prevention measures listed in the database included routine checking of excluded providers with the Alabama Department of Labor to see if any excluded persons are working elsewhere and anti-fraud measures for mobile dentistry that requires that patients be given an information sheet that notes treatment, billing service codes, fees, and tooth numbers when appropriate.

Medicaid, ADPH collaborate to build new eligibility and enrollment system

Building on the past successes between the two agencies' programs, Alabama Medicaid and the

Alabama Department of Public Health collaborated during FY 2013 to build a new eligibility and enrollment system to comply with federal requirements. As a result, significant administrative dollars were saved by using departmental employees.

The new system replaced the architecture and structure of the 30-year-old Medicaid system which suffered from inefficiencies common to older, outdated systems.

Project designed to prevent pre-term births in at-risk recipients

To combat the problem of prematurity, the Alabama Medicaid Agency teamed up with the state's maternity care providers to reduce the number of premature, or pre-term, births among Medicaid-eligible women.

The two-year project, which began February 1, 2013, was based on the American College of Obstetricians and Gynecologists' recommendation that all pregnant women with a prior history of a spontaneous pre-term birth at 37 or fewer weeks gestation be counseled on the benefits of taking 17-Alpha Hydroxyprogesterone Caproate, or "17P" to prevent a second pre-term birth.

In Fiscal Year 2011, the Alabama Medicaid Agency financed more than 50 percent of all deliveries in the state. Of the 31,028 Medicaid deliveries, 3,538 babies – 11 percent – received care in a neonatal intensive care unit at a cost of $57.8 million, or an average cost of $16,345 per baby.

The first phase of the project took place between February 1, 2013, and September 30, 2013. During this phase, maternity care coordinators were trained to screen, educate and refer maternity patients at risk of having a pre-term birth.

After the screening and education process, data will be collected to determine how many patients were screened, how many recipients received educational materials and how many were referred to their delivering health care provider.

In the second phase of the project, the Agency will determine how many recipients who were referred actually received the medication and if the number of pre-term births among at-risk patients improved while receiving the drug. This phase is scheduled to begin December 1, 2013 and continue through July 13, 2014.

Provider payment accuracy focus for state-based RAC program

Mandatory provisions of the Affordable Care Act required the Alabama Medicaid Agency to select and provide oversight for a Medicaid Recovery Audit Contractor (RAC) to perform provider audits. The RAC program is designed to improve payment accuracy by identifying underpayments and overpayments in Medicaid.

The RAC reviews and audits were conducted by physicians, pharmacists, certified professional coders, and experienced clinicians who analyzed claims data to identify patterns of utilization or billing which looked atypical based on Alabama Medicaid and/or national standards.

Emergency psychiatric care project experiences early success

Federal regulations now prohibit private institutions for mental diseases (IMDs) from receiving Medicaid reimbursement for emergency care. However, Alabama's innovative approach to caring for patients experiencing a psychiatric emergency is showing encouraging results.

The Alabama approach was chosen for testing by the Center for Medicare and Medicaid Innovation. The Center was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care.

The demonstration project is designed to test if recipients who are experiencing a psychiatric emergency get more immediate and appropriate care when IMDs provide care as opposed to acute care hospitals in the community. Early indications suggested that Alabama's plan can provide

improved access to care at a lower cost. Other successes of the first year included a low readmission rate and a reduction in the number of patients waiting in hospital emergency departments.

Four freestanding psychiatric hospitals in Alabama participated in the project: EastPointe Hospital in Daphne, Hill Crest Behavioral Health Services in Birmingham, BayPoint Hospital in Mobile and Mountain View Hospital in Gadsden.

Collaboration results in more accurate data, streamlined process

When studies confirmed that the Alabama Medicaid Agency and the Alabama Department of Human Resources shared many of the same clients, the two agencies joined forces to examine ways to save money and remove barriers to care by streamlining and simplifying Medicaid enrollment and renewals.

The resulting effort between the two state agencies now makes it possible for Medicaid to determine eligibility by using verified data supplied by DHR. The collaborative effort was featured April 23, 2013, in a national presentation sponsored by the National Academy for State Health Policy (NASHP).

Dubbed "Express Lane Eligibility" or ELE, the process resulted in eligibility determinations for more than 350,000 Alabamians while maximizing the skills and time of eligibility workers.

The Agency first collaborated with the Alabama Department of Human Resources in 2009 when Medicaid-enrolled children receiving SNAP (food stamps) or TANF (cash assistance) benefits were renewed because the Medicaid income limits for children were the same or higher than the two DHR programs.
In 2010, applications for children were added to the automated process leaving Medicaid only responsible for checking citizenship through a matching process with the Social Security Administration in most cases.

In February 2013, Medicaid implemented an automated renewal match with DHR. Now, instead of getting a packet of information that has to be mailed back in, each family receives a letter explaining their case has been renewed using information from DHR or Medicaid records and that no further action is necessary. Now, approximately 44 percent of cases are automatically renewed through ELE each month.

CMS approves "Health Homes" for Alabama Medicaid networks

The Centers for Medicare and Medicaid Services (CMS) notified the Agency on April 9, 2013, that it had approved the Agency's request to implement comprehensive care management in the four Patient Care Networks, also known as "health homes."

Federal approval allowed the state to draw down 90 percent federal matching funds for a two-year period between July 1, 2012, and June 30, 2014.

The approval provided extra funding and support needed by the Agency to provide enhanced services for patients with high cost, chronic health conditions while reducing overall expenditures to the state.

Qualifying participants must have two chronic health conditions or one chronic health condition and be at risk of developing another condition. Approved conditions included asthma, diabetes, heart disease, cardiovascular disease, chronic obstructive pulmonary disease, cancer, HIV, mental health conditions, substance abuse disorder, sickle cell anemia and transplant patients.

The program will also financially support the

efforts of two other state agencies: The Alabama Department of Public Health which will provide case management services and the Alabama Department of Mental Health which will provide targeted case management services.

Physicians overseeing medical care of participating patients will receive enhanced fees as well.

Governor signs General Fund budget

As the 2013 Alabama Legislature ended, Governor Robert Bentley signed a $1.7 billion General Fund operating budget on May 20, 2013 that provided $615.1 million for the Alabama Medicaid Agency. The Agency, the largest consumer of General Fund dollars, also was allocated funds from the Children First Trust Fund and from other tobacco settlement funds received by the state.

Agency launches new mobile app

Each year, more than a million Medicaid recipients, providers and applicants turn to the Alabama Medicaid Agency for information on how to apply for, provide or be reimbursed for covered services. To increase access to this information, the Agency launched a new mobile app, or application in September 2013.

The new mobile app is available to link smart phone and iPod Touch and iPad users to breaking news and alerts while providing direct access to the Agency website and contact information.

Expedite online system streamlines nursing home application process

A new online application system to help streamline the process of applying for Medicaid in the Nursing Home was launched on July 1, 2013. The new Expedite online application system was designed in response to feedback from nursing home administrators and admissions representatives, Medicaid eligibility staff and recipients who asked for a system that would not only allow for the entering and tracking of applications, but one that had the flexibility to accommodate the complex nature of the Medicaid nursing home application.

Benefits of the system include the ability to verify that the application and any supporting documents have been received; the ability to date-stamp the application to ensure the accuracy of accrual rights; the ability to add documents as needed and attach it to a previously submitted application; the ability to track the application as it moves through the eligibility determination process; the ability to add additional representatives; the elimination of the need to re-key data from paper applications; and the prevention of duplication arising from multiple paper applications for the same client.

Within the first month, 99 nursing home users located in 75 different facilities signed up to enter applications online.

Primary Care Physicians receive "bump" in payments

Approximately 2,100 Alabama primary care physicians who qualified for an enhanced federal payment rate known as the "bump," received more than $8.8 million in additional reimbursement as of August 2013.

Authorized by the federal government to begin payments on May 29, 2013, the Agency began paying the enhanced rate to qualified providers on June 8 and started reprocessing claims paid under the old rate in July so eligible providers could receive the difference for services provided since January 2013.

The increased reimbursement was the result of the Affordable Care Act which required state Medicaid programs to increase or "bump" up payments to certain physicians for specified primary care services beginning January 1, 2013.

The Affordable Care Act required states to pay 100% of the Medicare rate for 2013 and 2014, or if higher, the Medicare rate for primary codes using the Calendar Year 2009 Medicare conversion factor.

The increased payments are funded entirely by the federal government for 2013 and 2014. However, the responsibility of maintaining the higher fees will fall to the state in 2015.

Eligible physicians include board-certified family medicine, pediatric medicine, general internal medicine and related specialties or eligible physicians who can verify that 60 percent or more of the Medicaid codes they billed in the previous year were primary care codes and certain codes associated with vaccine administration listed in ACA. Health departments, federally-qualified health centers (FQHCs) and rural health clinics are not eligible for the fee increase.

New commission to review Alabama Medicaid's pharmacy program

A new Pharmacy Study Commission to review Medicaid's pharmacy delivery and reimbursement system and evaluate options for reform was established by Executive Order of Governor Robert Bentley on June 6, 2013. The group's first meeting took place August 23, 2013.

Commission members were specifically charged with analyzing the current system, comparing Alabama's program with other states' operations, identifying alternative pharmacy systems that could maintain quality and save money for Alabama and the estimated savings and economic impact for each described system if implemented. A report to the Governor is due in December, 2013.

State Health Officer Dr. Donald Williamson, who served as chair of the Alabama Medicaid Advisory Commission, chaired the new Alabama Medicaid Pharmacy Study Commission. Acting Alabama Medicaid Commissioner Stephanie Azar served on the new commission as well.

Other commission members included legislative officials, providers, consumer advocates, and others appointed by the Governor.

Pharmacy program changes to preserve access, save money

At the end of FY 2013, Agency officials made the decision to employ a combination of financial, clinical and administrative strategies to reduce pharmacy-related costs while preserving access to most critical medications.

The first cost-cutting measures were implemented July 1, 2013, and included reimbursement changes for compounded drugs, increased co-payments on drugs and a change to prevent stockpiling of medications via early refills.

The next round of changes included prescription drug limits, a mandatory three-month supply for certain drugs used to treat selected chronic diseases, and an end to coverage of over-the-counter drugs with exceptions for insulin, specialized nutritional products and second generation (e.g. non-sedating) antihistamines. Other measures included a change to the Agency's "lower of" payment method and expanded efforts of the Agency's Drug Utilization Review board.

Recipients were to be limited to a total of five drugs per month, four of which may be brand-name drugs. However, recipients who require anti-psychotic, anti-epileptic (seizure) and/or anti-retroviral (HIV/AIDS) drugs will be allowed to have up to five additional (10 total) brand-name or generic versions of these drugs.

RCOs Mark Year of Change for Alabama Medicaid

Almost immediately after the start of Fiscal Year 2013, the topic of Medicaid transformation and reform emerged as a primary issue for state and agency officials.

Alabama Medicaid Advisory Commission

The Alabama Medicaid Advisory Commission played a pivotal role in the effort to transform the Agency. Governor Robert Bentley created the commission by executive order in October 2012, tasking the group with evaluating the financial structure of the Alabama Medicaid Agency and identifying ways to increase efficiency while also helping ensure the long-term sustainability of the Agency. A final report of the group's findings was submitted to Governor Bentley on January 30, 2013.

Commission members met several times over three months to hear presentations from other state Medicaid programs, commercial managed care organizations and Alabama Medicaid's Patient Care Networks and to review cost and other data before preparing its report.

The commission was comprised of more than 30 individuals representing health care providers, legislative leaders, state health and human service agency officials, consumers and insurers appointed by the Governor. State Health Officer Dr. Don Williamson who also served as Chair of the Medicaid Transition Task Force, was Commission chair.

RCO legislation drafted

Governor Robert Bentley visited Jackson Hospital in Montgomery March 12, 2013, to highlight his support for proposed legislation designed to transform the Alabama Medicaid Agency into a more efficient and more affordable program for the taxpayers of Alabama.

The legislation was later introduced by Senate Health Committee Chair Greg Reed (R-Jasper) and House Health Committee Chair Jim McClendon (R-Springville).

Governor Bentley emphasized that the legislation would give Alabama a chance to turn Alabama Medicaid into a program that provides better care while making more efficient use of taxpayer dollars. The legislation will help the Alabama Medicaid Agency end its current "fee-for-service" model in favor of regional managed care networks. The networks would then work to provide better, more efficient care for patients while also working to control costs to the state.

A new law

Passage of Medicaid reform legislation that would ultimately restructure the state's health care delivery system for low-income citizens won approval in the Alabama Legislature and was signed into law in May 2013 by Governor Robert Bentley.

The approved bill was based largely on the earlier recommendations of the Alabama Medicaid Advisory Commission which recommended in January 2013 that Alabama be divided into regions, and that a community-led network coordinate the health care of Medicaid patients in each region, with networks ultimately bearing the risks of contracting with Alabama to provide that care.

Implementation

Within weeks of the law's enactment, Medicaid staff, stakeholders and others moved quickly to

comply with the law by creating the legal and operational foundation upon which to build the new healthcare delivery system.

The first two challenges under the new law centered on determination of actuarially-sound districts and how to facilitate collaboration outlined in the law while remaining within state and federal law.

During June 2013, the Agency met with hospitals, physicians and other provider groups and worked with an actuarial consultant to propose districts for the planned Regional Care Organizations. The map and the required state Administrative Code changes were submitted on June 28. Public input on the new map was received at a public hearing held on July 15 and additional comments were received by the Agency through August 2.

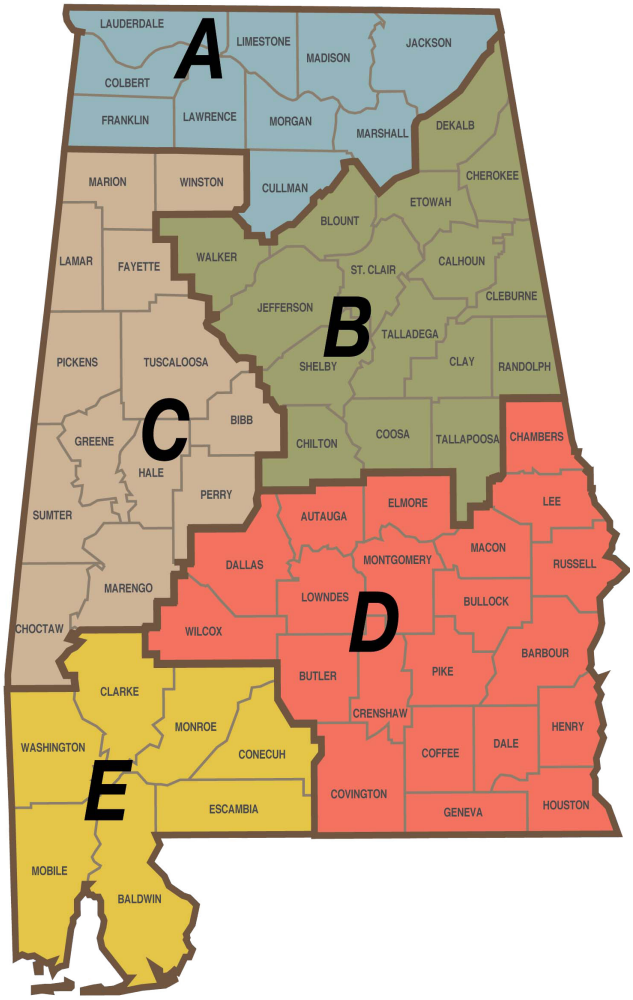
At the same time, the Agency quickly began work to develop the rules for collaboration, for governance and for what probationary or provisional certification of an RCO should entail.

RCO regions established

The Agency achieved its first official milestone toward the establishment of regional care organizations in the state with the establishment of five regional service areas on September 17, 2013. State law required that the regions be in place by October 1, 2013.

The regions were determined based on several factors, including actuarial soundness. In addition, the districts were drawn in an effort to honor existing referral patterns and when possible, to keep various health systems together.

Regional Care Organization Districts established in FY 2013



FY 2013

Eligibility: Who Medicaid Serves

During FY 2013, more than 1 million Alabama citizens, or 22.5 percent of the state's population, were eligible to receive Medicaid benefits for at least one month of the year.

The state's youngest citizens made up the largest category of Medicaid eligibles with 42.8 percent Alabama children having their health coverage paid for by Medicaid. Over 38 percent of these children were in families with at least one working caregiver. Medicaid also paid for more than half (51%) of all babies born in Alabama during fiscal year 2013.

Medicaid-eligible Alabamians over the age of 65 qualify for a variety of services. While about two-thirds of all nursing home residents depend on Medicaid to cover the cost of their care.

Qualifying Agencies

Several agencies determine Medicaid eligibility. Medicaid certifies applicants for Elderly & Disabled programs; Medicaid for Low Income Families (MLIF); the SOBRA program for children under age 19 and pregnant women; Plan First (Family Planning) Program; Breast and Cervical Cancer Program; Department of Youth Services children; and Emergency Services for non-citizens.

The Alabama Department of Human Resources certifies foster children and children who receive state or federal adoption assistance.

The Social Security Administration certifies aged, blind, or disabled persons who have very low income and qualify for cash assistance through the Supplemental Security Income (SSI) program.

To qualify for Alabama Medicaid, all individuals must live in Alabama, be a U.S. citizen or be in this country legally and meet income and age requirements that vary according to program.

Those who apply for assistance through a program for the elderly or disabled must also meet certain medical criteria and have resources below a certain limit, which also varies according to the program.

Eligibles

Under federal regulations, states must provide coverage for certain groups in order to be eligible for federal funds. These groups include low income families who meet the eligibility requirements in the state's AFDC plan in effect on July 16, 1996; Supplemental Security Income (SSI) recipients; infants born to Medicaid-eligible pregnant women; children under age 6, and pregnant women whose family income is at or below 133 percent of the federal poverty level; children ages 6-18 whose family income is up to 100 percent of the federal poverty level; recipients of adoption assistance; children in foster care or custody of the Department of Youth Services; certain Medicare beneficiaries; and special protected groups, including those who lose eligibility for cash assistance or SSI due to an increase in earnings from work, Social Security benefits or child/spousal support.

FY 2011 - FY 2013
Medicaid and Alabama
Overview

	FY 2011	FY 2012	FY 2013
Total Alabama Population[1]	4,802,740	4,845,389	4,878,189
Medicaid Eligible Population[2]	1,070,781	1,110,037	1,095,266
Percent of Total Population that was Medicaid Eligible	22.3%	22.9%	22.5%
Total Adult Population[1]	3,455,983	3,494,584	3,525,813
Medicaid Eligible Adults[2]	452,644	473,580	516,923
Percent of Total Adult Population that was Medicaid Eligible	13.1%	13.6%	14.7%
Total Child Population[1]	1,346,757	1,350,805	1,352,376
Medicaid Eligible Children[2 and 3]	618,137	636,457	578,343
Percent of Total Child Population that was Medicaid Eligible	45.9%	47.1%	42.8%
Total Medicaid Expenditures[4]	$5,208,232,283	$5,566,749,987	$5,545,788,697
Medicaid Expenditures Per Capita	$1,084	$1,149	$1,137
Monthly Average Eligible Recipients	912,767	939,576	947,594
Average Annual Cost per Monthly Average Eligible[5]	$5,706	$5,925	$5,852
Overall Federal Funding Percentage	73.6%[6]	67.6%[6]	67.6%
Overall State Funding Percentage	26.4%	32.4%	32.4%
State General Fund Percentage	7.8%	10.2%	11.0%

1. Population figures are based on U.S. Census data from the Center for Business and Economic Research, University of Alabama. The 2011 population count is an estimate based on Census data from CBER; 2012 is a projection based on the 2010 U.S. Census on Jan. 23, 2013, and the 2013 population is a projection based on Census data reported March 2014. The child population figure is apportioned from the same data, calculating the 20-24 age group to reflect that Medicaid stops for children at age 21.

2. An unduplicated count of individuals who qualified for full or partial Medicaid coverage and were enrolled in Medicaid for at least one month of the fiscal year.

3. Child/Children defined as those under age 21.

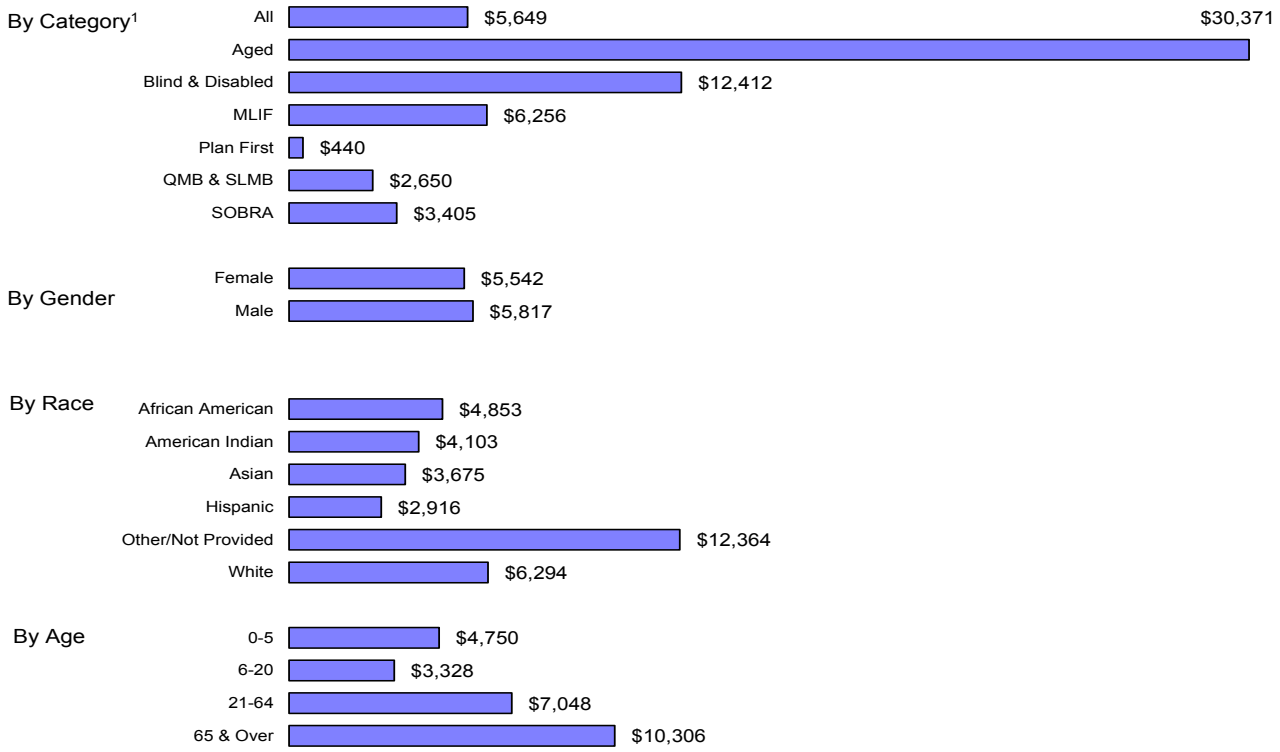
4. Total Medicaid expenditures exclude Health Information Exchange expenses, which were $32,398,855, $60,209,095 and $40,224,122 in FY 2011, 2012 and FY 2013, respectively, and are almost 100% federally funded.

5. Average annual cost includes all expenditures except the Health Information Exchange.

6. Federal match rates in the first quarter of FY 11 were enhanced due to federal stimulus provisions of the American Reinvestment and Recovery Act of 2009 (ARRA). This enhanced match rate resulted in the state receiving additional federal funds during this period.

FY 2013

Annual Cost Per Eligible for Medical Care[1]
By Category, Gender, Race, and Age



1. The annual cost per eligible for medical care is calculated based on total expenditures for medical care of $5,352,659,596 in FY 2013 (excludes administrative expense and school-based services. - includes encumbrances and payables at the end of the fiscal year) divided by the annual average of monthly eligibles of 947,594.

Definitions of Eligibles and Recipients

Potential Eligibles

Potential Eligibles are individuals who potentially qualify for Medicaid but have not applied. It is typically an estimate based on census or other demographic data.

Annual Eligibles

An unduplicated count of individuals who qualified for full or partial Medicaid coverage and were enrolled in Medicaid for at least one month of the fiscal year.

Annual Recipients

An unduplicated count of Medicaid eligibles who received at least one medical service that Medicaid paid for during the fiscal year. This count excludes SLMB and QI-1 recipients who only receive the benefit of having their Medicare Part B premiums paid as well as those eligibles whose third-party payer covered their medical costs resulting in a zero payment by Medicaid.

Monthly Average Eligibles

An arithmetic average of the unduplicated number of individuals who qualified for full or partial Medicaid coverage in each month of the fiscal year.

Monthly Average Recipients

The arithmetic average of the unduplicated number of Medicaid eligibles in each month of the fiscal year who received at least one medical service that Medicaid paid for during the month. This excludes SLMB and QI-1 recipients who only receive the benefit of having their Part B premiums paid.

FY 2004 - FY 2013
Medicaid Annual Eligibles as a Percent of Population by Year

Year	State Population[1]	Annual Eligibles[2]	Annual Eligibles as a % of Population
FY 2004	4,603,594	935,539	20.3%
FY 2005	4,642,736	963,600	20.8%
FY 2006	4,681,833	988,678	21.1%
FY 2007	4,720,976	932,521	19.8%
FY 2008	4,760,046	920,937	19.3%
FY 2009	4,799,189	964,171	20.1%
FY 2010	4,779,735	1,026,429	21.5%
FY 2011	4,802,740	1,070,781	22.3%
FY 2012	4,845,389	1,110,737	22.9%
FY 2013	4,878,189	1,095,266	22.5%

1. Population figures are based on U.S. Census data from the Center for Business and Economic Research, University of Alabama. The 2011 population count is an estimate based on Census data from CBER; the 2012 population is a projection based on the 2010 U.S. Census on Jan. 23, 2013, and the 2013 population is a projection based on Census data reported March 2014. The child population figure is apportioned from the same data, calculating the 20-24 age group to reflect that Medicaid stops for children at age 21.

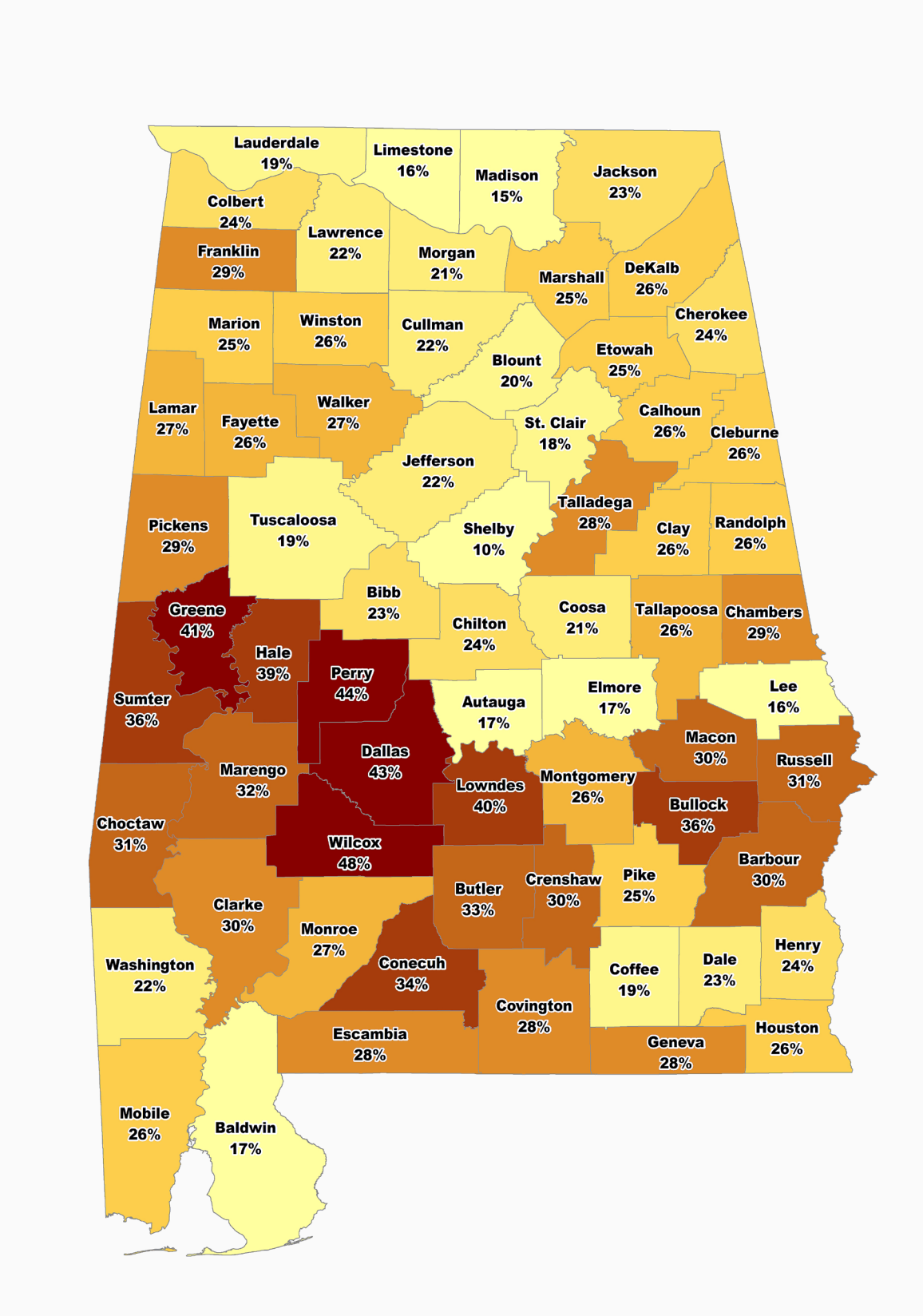
2. An unduplicated count of individuals who qualified for full or partial Medicaid coverage and were enrolled in Medicaid for at least one month of the fiscal year.

FY 2004 - FY 2013
Monthly and Average Annual Medicaid Eligibles[1]

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
October	770,938	810,259	840,428	769,076	746,397	787,515	834,747	894,496	949,808	933,907
November	771,567	800,590	840,777	746,561	735,163	782,764	828,165	890,932	938,776	930,019
December	771,340	800,177	819,256	738,971	734,810	782,786	825,655	891,327	934,512	930,965
January	777,292	805,956	814,988	739,342	741,620	790,064	832,160	897,984	939,100	935,580
February	783,436	809,000	780,510	737,447	748,861	794,954	835,136	902,351	939,021	941,429
March	789,661	812,725	789,201	735,476	755,318	801,523	842,963	911,268	941,197	945,267
April	793,293	816,260	789,493	728,489	759,935	804,925	851,089	913,068	941,707	949,439
May	796,316	818,767	791,830	724,680	762,390	808,273	855,952	914,397	940,538	953,232
June	800,569	820,629	785,949	724,424	764,914	812,220	862,949	922,321	937,851	955,355
July	796,446	821,593	780,400	728,054	770,387	817,174	872,501	930,736	935,778	959,607
August	804,647	824,988	778,452	731,458	777,111	825,421	883,443	939,943	935,901	966,066
September	806,899	827,392	774,561	740,324	781,857	830,621	889,627	944,375	940,722	970,267
Annual Average	788,534	814,028	798,820	737,025	756,564	803,187	851,199	912,767	939,576	947,594

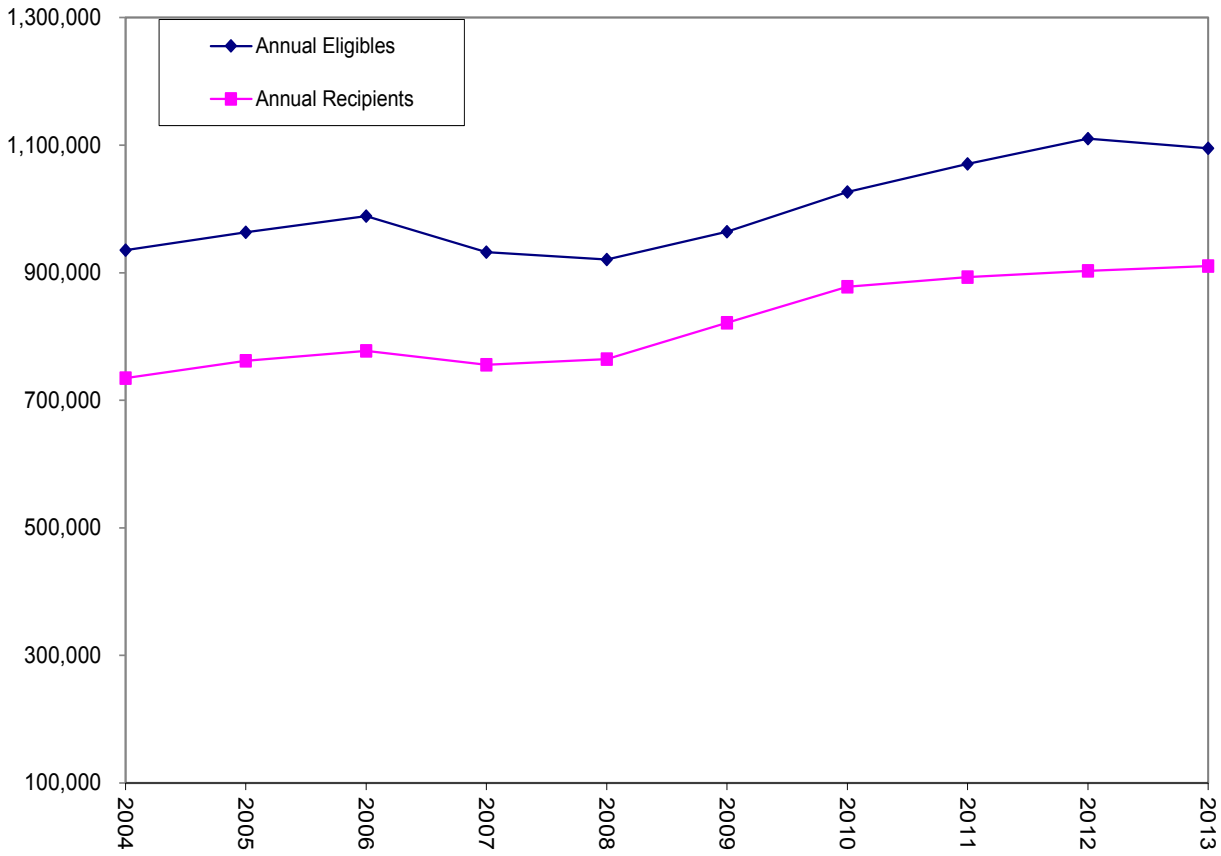
1. An unduplicated number of individuals who qualified for full or partial Medicaid coverage in each month of the fiscal year. Annual average is the arithmetic average of the twelve months.

FY 2013
Percent of Population Annually Eligible[1] for Medicaid by County



1. Individuals who qualified for full or partial Medicaid coverage and were enrolled in Medicaid for at least one month of the fiscal year.

FY 2004 - FY 2013
Annual Eligibles[1] and Recipients[2]
Utilization



Year	Annual Eligibles[1]	Annual Recipients[2]	Percentage[3]
FY 2004	935,539	734,905	78.6
FY 2005	963,600	761,903	78.1
FY 2006	988,678	777,374	78.6
FY 2007	932,521	755,856	81.1
FY 2008	920,937	764,420	83.0
FY 2009	964,171	821,602	85.2
FY 2010	1,026,429	878,232	85.6
FY 2011	1,070,781	893,312	83.4
FY 2012	1,110,037	902,870	81.3
FY 2013	1,095,266	910,562	83.1

1. Annual Eligibles: An unduplicated count of individuals who qualified for full or partial Medicaid coverage and were enrolled in Medicaid for at least one month of the fiscal year.
2. Annual Recipients: An unduplicated count of Medicaid eligibles who received at least one medical service that Medicaid paid for during the fiscal year. This count excludes recipients who only receive the benefit of having their Medicare Part A, B and/or D premiums paid by Medicaid.
3. Percentage of Annual Eligibles who received at least one medical service during the fiscal year.

FY 2013

Medicaid Annual Eligibles[1] by Category of Aid and County

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	PLAN FIRST	TOTAL
Autauga	965	201	1,600	4,714	565	8	530	1,268	9,851
Baldwin	2,608	500	3,890	17,879	1,753	20	1,681	4,575	32,906
Barbour	1,141	246	1,426	3,457	519	9	403	875	8,076
Bibb	359	146	1,144	2,473	373	8	311	634	5,448
Blount	803	263	1,651	6,229	752	3	772	1,196	11,669
Bullock	482	152	813	1,634	241	2	168	423	3,915
Butler	1,030	212	1,225	2,865	405	6	365	838	6,946
Calhoun	4,878	594	5,403	12,921	1,799	40	1,523	3,644	30,802
Chambers	952	351	1,748	4,349	594	10	680	1,114	9,798
Cherokee	830	168	956	2,837	491	4	501	580	6,367
Chilton	1,091	218	1,549	5,677	643	6	630	1,120	10,934
Choctaw	436	165	835	1,628	324	5	219	474	4,086
Clarke	629	243	1,627	3,225	439	9	346	971	7,489
Clay	146	142	581	1,783	261	3	265	426	3,607
Cleburne	425	96	609	1,797	246	3	256	446	3,878
Coffee	1,110	312	1,627	4,832	627	5	472	1,125	10,110
Colbert	1,131	294	2,337	5,692	872	12	735	1,834	12,907
Conecuh	745	125	854	1,711	352	4	258	409	4,458
Coosa	89	68	558	967	227	5	236	211	2,361
Covington	1,035	398	1,696	4,933	741	6	631	1,188	10,628
Crenshaw	688	169	668	1,594	315	2	256	488	4,180
Cullman	1,155	627	2,875	8,667	1,197	10	1,318	1,851	17,700
Dale	1,453	279	2,132	5,021	643	8	508	1,376	11,420
Dallas	2,259	551	4,665	7,028	1,139	16	842	2,042	18,542
DeKalb	1,292	485	2,400	10,800	1,162	7	1,090	1,593	18,829
Elmore	1,195	272	2,551	6,670	772	15	689	1,721	13,885
Escambia	1,513	244	1,623	5,085	597	7	503	1,254	10,826
Etowah	2,670	583	5,018	12,063	1,748	16	1,692	2,844	26,634
Fayette	517	174	809	1,906	288	3	262	483	4,442
Franklin	840	216	1,299	5,007	566	5	510	782	9,225
Geneva	934	232	1,361	3,325	519	5	503	762	7,641
Greene	318	126	859	1,530	208	3	136	451	3,631
Hale	477	217	1,322	2,521	405	4	267	787	6,000
Henry	311	159	681	1,871	338	6	282	500	4,148
Houston	3,052	627	4,570	12,618	1,501	21	1,333	3,168	26,890
Jackson	911	368	1,977	5,855	927	12	811	1,256	12,117
Jefferson	12,060	3,007	28,531	66,834	8,241	123	7,382	17,721	143,899
Lamar	517	154	691	1,543	314	6	273	363	3,861
Lauderdale	1,083	466	3,120	8,495	1,273	10	1,125	2,594	18,166
Lawrence	788	195	1,186	3,409	507	5	454	893	7,437
Lee	2,373	388	3,496	12,469	989	20	953	3,136	23,824
Limestone	826	332	2,157	7,599	889	11	756	1,841	14,411
Lowndes	602	116	845	1,644	365	7	232	490	4,301
Macon	1,140	192	1,212	2,331	361	6	256	836	6,334
Madison	3,573	1,128	7,652	28,219	2,411	45	1,914	7,209	52,151
Marengo	670	223	1,505	2,579	471	4	288	816	6,556
Marion	824	239	1,208	3,365	581	3	569	819	7,608
Marshall	1,925	571	3,413	14,088	1,330	13	1,198	1,831	24,369
Mobile	10,273	2,111	16,410	53,447	5,289	73	4,586	15,199	107,388
Monroe	589	187	1,109	2,936	393	1	303	688	6,206
Montgomery	8,632	1,170	11,159	26,783	2,910	54	2,338	8,292	61,338
Morgan	1,821	632	4,152	13,271	1,191	29	1,044	2,894	25,034
Perry	456	148	1,129	1,692	332	2	202	530	4,491
Pickens	400	242	1,307	2,352	376	3	275	720	5,675
Pike	988	216	1,725	3,513	490	7	370	1,199	8,508
Randolph	454	186	949	2,988	365	3	369	653	5,967
Russell	2,547	375	2,672	7,538	700	15	763	2,012	16,622
St. Clair	1,890	210	2,200	8,001	886	15	876	1,836	15,914
Shelby	1,843	341	2,485	11,857	929	9	912	2,702	21,078
Sumter	607	183	1,237	1,700	284	4	168	645	4,828
Talladega	3,390	517	4,741	9,353	1,476	58	1,530	2,519	23,584
Tallapoosa	1,000	337	1,964	5,018	745	8	702	1,226	11,000
Tuscaloosa	2,769	821	7,649	18,777	1,876	38	1,536	5,623	39,089
Walker	1,415	457	3,742	7,697	1,187	11	1,177	1,895	17,581
Washington	341	116	784	1,725	252	5	215	419	3,857
Wilcox	532	165	1,609	1,993	304	2	179	629	5,413
Winston	646	232	1,109	2,623	542	3	512	567	6,234
Youth Services	0	0	0	196	0	0	0	0	196
STATEWIDE	107,444	25,880	190,087	519,199	62,808	901	55,441	133,506	1,095,266

See Aid Categories Explained.

1. Annual Eligibles: An unduplicated count of individuals who qualified for full or partial Medicaid coverage and were enrolled in Medicaid for at least one month of the fiscal year.

Aid Categories Explained

Note: Amounts are after any deductions taken for work expense or disabled adult/child care expenses. SOBRA adults (pregnant women), QMB, SLMB, Plan First, and QI-1 eligibles receive limited or partial benefits.

MLIF - Medicaid for Low Income Families – Parents and/or qualifying caretakers of related children under age 19 who live in the home and whose family income is approximately 11 percent of the Federal Poverty Level (FPL) or less. In 2012, this was $194 per month for a family of four. Count also includes foster children, refugees and infants of SSI mothers.

For the purpose of simplifying this report only, the following four categories are included in the MLIF category.

- Refugee Medical Assistance (RMA) - Time limited medical assistance benefits are provided to refugees determined eligible through the refugee resettlement program, who are not otherwise eligible for any Medicaid program.
- Foster / Adoptive Child – Federal - Foster children and children receiving adoption subsidies who meet federal requirements for title IV-E eligibility are automatically eligible for Medicaid.
- Foster /Adoptive Child – State - Children in foster care or state adoptive placements who do not meet title IV-E requirements for federal foster care payments but meet income levels for MLIF and have special circumstances
- Newborns of SSI mothers **-** Children under 1 year of age who are born to mothers certified for Medicaid through SSI who are eligible for Medicaid up to the child's first birthday.

Aged - Individuals who are age 65 or older and meet income and asset (resource) requirements. Aged recipients fall into one of three general categories: 1) Institutional care recipients in nursing homes, hospitals and ICF-MR facilities; 2) Elderly or disabled people who live in the community and receive services through one of seven Medicaid Home and Community-Based Waiver programs; or 3) people who no longer receive Supplemental Security Income (SSI) payments but have their Medicaid benefits protected under certain laws.

Disabled (by Social Security standards) – Individuals who have been certified as disabled by Social Security Administration or the Alabama Medicaid Agency. Recipients must also meet income and asset (resource) requirements. Disabled recipients fall into one of three general categories: 1) Institutional care recipients in nursing homes, hospitals and ICF-MR facilities; 2) Disabled people who live in the community and receive services through one of seven Medicaid Home and Community-Based Waiver programs; or 3) People who no longer receive Supplemental Security Income (SSI) payments but have their Medicaid benefits protected under certain laws.

SOBRA (Sixth Omnibus Budget Reconciliation Act) – Medicaid's largest eligibility group includes pregnant women and children under age 6 whose family income is 133 percent of the FPL or less, plus children ages 6 up to 19 whose family income is 100 percent of the FPL or less. SOBRA adults (pregnant women) receive pregnancy-related services only. Children receive full coverage.

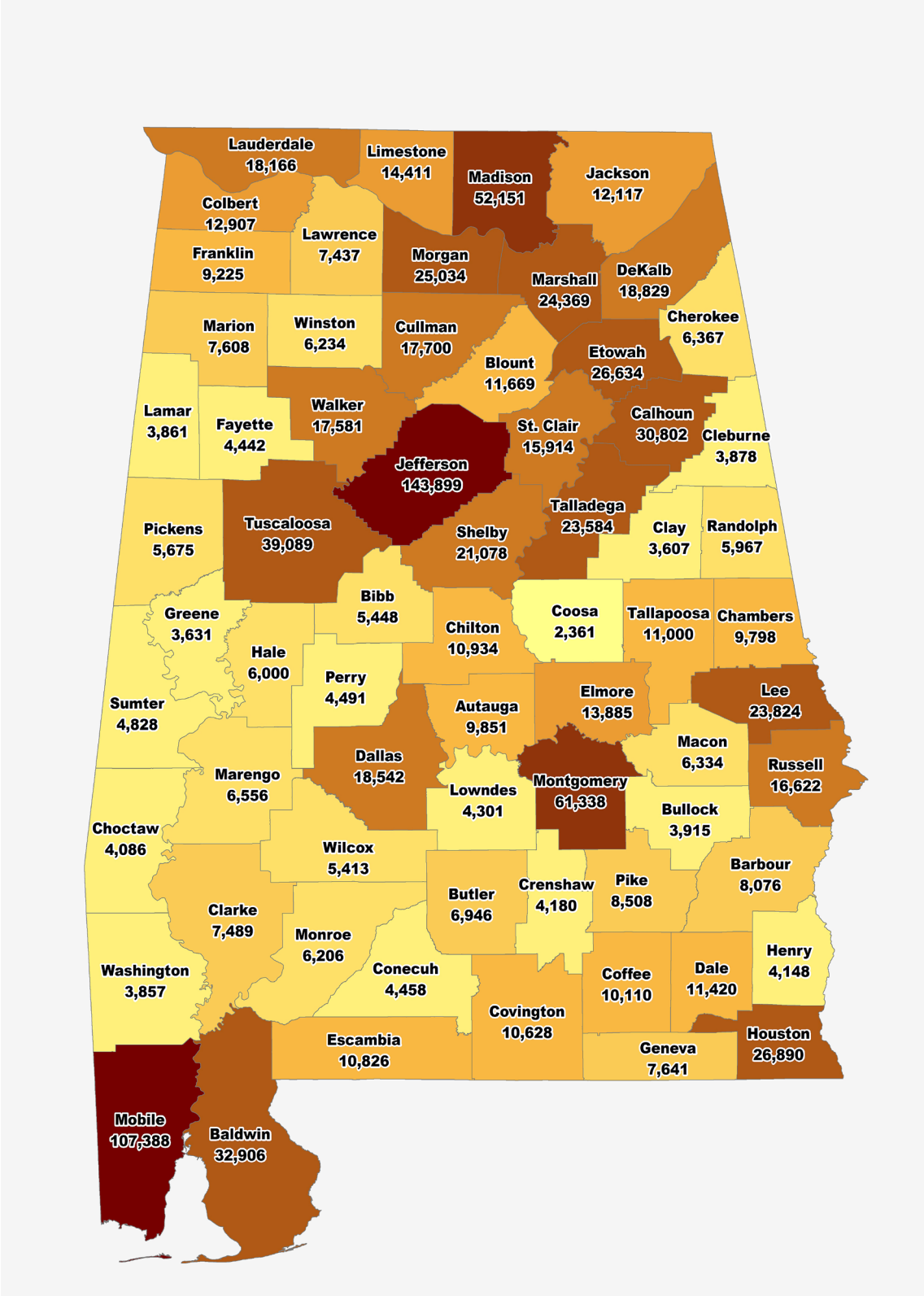
Qualified Medicare Beneficiary (QMB) only - Medicare beneficiaries whose income is at or below 100 percent of the FPL. In 2012, this was $951 per month for an individual. No asset test is required. Coverage is limited to payment of Medicare monthly Part B premiums, plus Medicare deductibles, coinsurance and co-payments.

Blind – Blind individuals who receive Supplemental Security Income (SSI) assistance.

Specified Low Income Medicare Beneficiary (SLMB) only and QI-1 – Limited coverage programs that pay for the Medicare Part B premium only. To participate in either program, applicants must have Medicare Part A coverage. No asset test is required. SLMB recipients have incomes of more than 100 percent and less than 120 percent of the FPL. QI-1 recipients must have income between 120 -135 percent of the FPL.

Plan First – Women age 19 through 55 years and whose income is below 133 percent of the FPL qualify for family planning services only from Medicaid. They must not have creditable insurance coverage or otherwise qualify for full Medicaid coverage.

FY 2013
Number of Annual Eligibles[1] by County



1. Individuals who qualified for full or partial Medicaid coverage and were enrolled in Medicaid for at least one month of the fiscal year.

FY 2013
County Impact
Average Annual Benefit Payments[1] Per Average Annual Eligible[2] by County

County	Benefit Payments	Monthly Avg. Eligibles	Avg. Payment Per Eligible	County	Benefit Payments	Monthly Avg. Eligibles	Avg. Payment Per Eligible
Autauga	$ 41,627,905	8,386	$4,964	Houston	$ 124,865,510	23,362	$5,345
Baldwin	132,624,083	27,208	$4,874	Jackson	61,050,228	10,365	$5,890
Barbour	39,708,733	7,184	$5,527	Jefferson	836,208,396	123,681	$6,761
Bibb	27,771,972	4,819	$5,763	Lamar	22,189,503	3,470	$6,395
Blount	50,809,843	9,972	$5,095	Lauderdale	86,680,767	15,917	$5,446
Bullock	23,004,675	3,576	$6,433	Lawrence	34,708,953	6,608	$5,253
Butler	33,249,129	6,155	$5,402	Lee	93,639,838	19,916	$4,702
Calhoun	145,028,161	26,783	$5,415	Limestone	62,768,141	12,179	$5,154
Chambers	46,755,754	8,494	$5,505	Lowndes	18,017,941	3,973	$4,535
Cherokee	30,625,918	5,423	$5,648	Macon	28,878,390	5,599	$5,158
Chilton	47,924,985	9,438	$5,078	Madison	223,639,193	43,472	$5,144
Choctaw	17,858,722	3,652	$4,890	Marengo	35,315,968	5,869	$6,017
Clarke	35,828,463	6,714	$5,336	Marion	38,335,037	6,679	$5,739
Clay	18,751,633	3,133	$5,986	Marshall	109,573,853	21,111	$5,190
Cleburne	18,014,371	3,280	$5,493	Mobile	530,715,212	92,262	$5,752
Coffee	52,307,462	8,621	$6,067	Monroe	29,427,808	5,473	$5,377
Colbert	61,281,885	11,256	$5,444	Montgomery	275,263,028	54,010	$5,097
Conecuh	21,760,849	3,987	$5,458	Morgan	130,555,106	21,489	$6,075
Coosa	12,694,962	2,135	$5,945	Perry	20,567,002	4,161	$4,942
Covington	51,145,570	9,234	$5,539	Pickens	29,960,098	5,076	$5,903
Crenshaw	22,276,929	3,700	$6,021	Pike	41,309,320	7,560	$5,464
Cullman	95,289,878	15,271	$6,240	Randolph	28,258,104	5,225	$5,408
Dale	52,021,368	9,889	$5,261	Russell	58,186,876	13,690	$4,250
Dallas	86,635,831	17,052	$5,081	St. Clair	73,384,492	13,705	$5,355
DeKalb	87,355,500	16,346	$5,344	Shelby	83,998,100	17,533	$4,791
Elmore	73,671,791	11,774	$6,257	Sumter	20,913,878	4,383	$4,772
Escambia	43,356,623	9,362	$4,631	Talladega	119,854,561	20,902	$5,734
Etowah	149,357,294	22,992	$6,496	Tallapoosa	54,988,092	9,747	$5,641
Fayette	26,138,963	3,927	$6,657	Tuscaloosa	212,830,091	33,740	$6,308
Franklin	39,904,608	8,013	$4,980	Walker	101,515,323	15,492	$6,553
Geneva	35,798,762	6,699	$5,344	Washington	18,092,264	3,373	$5,364
Greene	17,338,489	3,292	$5,268	Wilcox	24,338,257	5,035	$4,834
Hale	27,973,359	5,442	$5,140	Winston	33,450,561	5,505	$6,077
Henry	21,296,466	3,663	$5,814	Youth Services	1,988,770	163	$12,239
				Statewide	$5,352,659,596	947,594	$5,649

1. Total expenditures for medical care in FY 2013 excludes administrative expense, school-based services and expenses of the Health Information Exchange.
2. The annual average of monthly eligibles.

FY 2013
Average Annual Eligibles and Medical Expenditures[1]

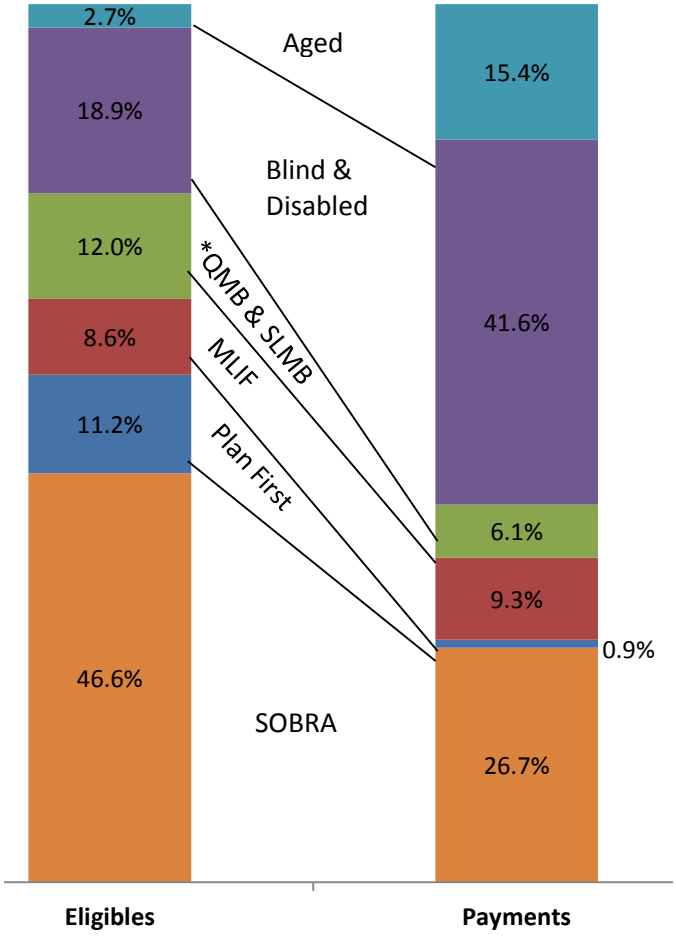
FY 2013

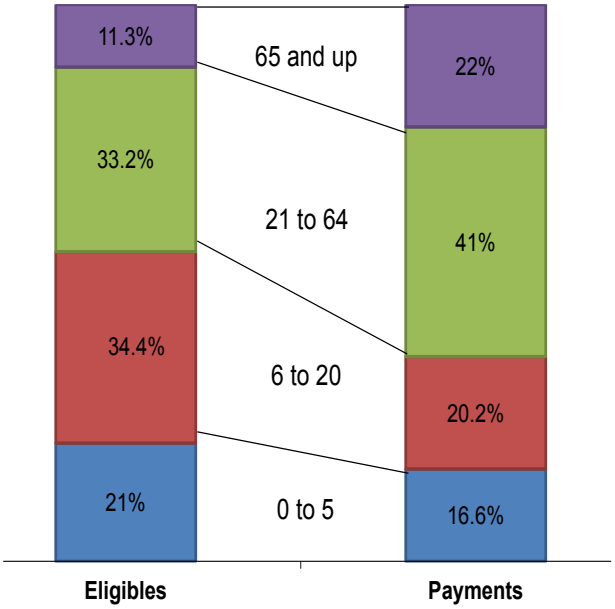
Eligibles and Payments

Percent Distribution

Claims Data Only

By Category of Aid





FY 2013

Eligibles and Payments

Percent Distribution

Claims Data Only

By Age

1. Total expenditures for medical care in FY 2013 were $5,352,659,596 (excludes administrative expense and school-based services - includes encumbrances and payables at the end of the fiscal year) and the annual average of monthly eligibles was 947,594. Medical care costs not associated with a specific recipient, such as enhancement payments to hospitals, Disproportionate Share Hospital payments and Certified Public Expenditures by hospitals, were allocated to recipients based on their related direct expenses incurred by hospitals.

* QMB & SLMB = Qualified Medicare Beneficiary and Specified Low Income Medicare Beneficiary are Low-Income Medicare beneficiaries and have certain premiums, co-insurance, or deductibles paid for by Medicaid.

Programs and Services

Medicaid provides a wide range of covered services. Some recipients receive full coverage while others are eligible for limited services, such as pregnant women on Medicaid's SOBRA program. Thousands of health care providers throughout the state give care to eligible Alabama Medicaid recipients each year.

Managed Care

Managed Care is the cornerstone of Medicaid's health services and one of the initial building blocks of the Agency's transformation plans.

PACE

The PACE Program (Program of All-Inclusive Care for the Elderly) provides community-based care and services to elderly and disabled adults who would otherwise need nursing home care. Participants receive comprehensive medical and social services in an adult day health center that is supplemented by in-home and referral services as needed.

Patient 1st

Based on the medical home concept, the Patient 1st program links the Medicaid recipient with a physician or clinic that serves as the primary care provider to encourage a strong doctor/patient relationship. Program recipients benefit from patient education, in-home monitoring of chronic conditions, and a care coordination referral program for those who need assistance in using services appropriately.

In FY 2013, the Agency implemented Health Homes in four Primary Care Networks to provide enhanced care coordination for recipients with specific medical conditions.

Each month in FY 2013, an average of 548,880 Alabamians were enrolled in the Patient 1st program, including 450,169 children under age 21.

Family Planning

Family Planning services are designed to help Medicaid-eligible men and women prevent or delay pregnancy. Females of child-bearing age and males of any age who meet Medicaid requirements may receive family planning services. The Plan First waiver program provides family planning services to eligible women and men who otherwise do not qualify for Medicaid.

Maternity Care

The Maternity Care Program's goal is to ensure that pregnant woman have access to medical care, with the goal of lowering Alabama's infant mortality rate and improving maternal and infant health. Care is provided through a network of 14 Maternity Care Districts. In FY 2013, Medicaid paid for more than half the births in the state.

Medical Services

Medicaid patients get medical care from a variety of sources. Primary care services are available through rural health clinics and Federally Qualified Health Centers (FQHCs) in addition to private offices and practices. Inpatient and outpatient services are provided by more than 100 acute care and specialty hospitals.

Covered medical services also includes dental, eye, and hearing care, inpatient and outpatient hospital care, and doctor visits. Lab and X-ray services are diagnostic procedures provided in conjunction with other covered services while renal dialysis and transplant coverage extend and improve hundreds of lives each year.

In addition to acute care services, some hospitals offer post hospital extended care and swing beds. Medicaid also covers mental health services for eligible children and adults, providing both community-based and inpatient services.

Medicaid's Well Child Check-Up program, or EPSDT, offers preventive health services to Medicaid-eligible children under 21 years of age, except those who receive pregnancy-related or family planning services only.

Long Term Care

A comprehensive program of long term care services offers eligible patients a range of care choices as well as increased opportunities to receive services at home or in the community. These long term care services include home health services, private duty nursing, and hospice care, as well as care in nursing and other long term care facilities.

During FY 2013, more than 15,000 Alabama residents participated in one of seven waiver programs as an alternative to institutional care. They include the Elderly and Disabled, Intellectual Disabilities, HIV/AIDS, Technology Assisted, State of Alabama Independent Living (SAIL), Living at Home and the Alabama Community Transition (ACT) waivers.

Gateway to Community Living is Alabama Medicaid's initiative to expand home and community-based resources for aging or disabled recipients who prefer to receive services in their own home rather than in a nursing home.

Clinical Services and Support

Clinical Services and Support Division includes Medicaid's Pharmacy Services and the Durable Medical Equipment (DME) Unit. Pharmacy Services takes advantage of several electronic systems and tools to aid providers in complying with Medicaid's Preferred Drug List (PDL), brand limit requirements and prior authorization and override programs.

Pharmacy Services relies on the Pharmacy and Therapeutics (P&T) Committee to review and recommend drugs to be included in the PDL, and the Drug Utilization Review (DUR) board to review prescription claims history and recommend prospective criteria to promote optimal pharmaceutical therapy.

The Agency's Drug Rebate Program is responsible for invoicing, collecting and processing federal and supplemental drug rebates due from and paid by drug manufacturers.

The DME Unit coordinates between providers and recipients the delivery of supplies and appliances that are medically necessary and suitable for use in the home. These include prosthetics, orthotics and pedorthics for eligible recipients between the ages of 21 and 65.

Transportation Program

Medicaid covers two types of transportation to and from medical facilities for eligible recipients: ambulance transportation and non-emergency. These services are coordinated by the Non-Emergency Transportation (NET) Program that helps recipients pay for rides to dental and doctor offices, hospitals and other medical facilities.

FY 2009 - FY 2013
Optometric Services
Cost and Utilization

	Payments[1]	Recipients[2]	Cost Per Recipient
FY 2009	$12,230,518	137,363	$89
FY 2010	$13,413,138	148,326	$90
FY 2011	$13,660,579	153,130	$89
FY 2012	$13,686,938	158,429	$86
FY 2013	$13,772,693	153,098	$90

FY 2009 - FY 2013
Eyeglasses Only
Cost and Utilization

	Payments[1]	Recipients[2]	Cost per Recipient
FY 2009	$4,210,554	103,690	$41
FY 2010	$4,751,566	113,301	$42
FY 2011	$4,641,623	116,310	$40
FY 2012	$3,338,044	114,565	$29
FY 2013	$3,093,988	106,531	$29

1. Claims Data Only - Claims data excludes medical costs not associated with a specific recipient such as Enhancement payments and Disproportionate Share Hospital (DSH) payments to hospitals, Certified Public Expenditures (CPEs) for indigent care, health insurance premiums for Medicare enrollees and "clawback" payments to the federal government for Medicare Part D recipients.
2. Recipient count is an unduplicated count of individuals who received at least one eyeglass or optometric program service.

FY 2009 - FY 2013
Physician Program
Cost and Utilization by Age Category

Benefit Payments[1]

Age	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
0 to 5	$93,583,030	$96,418,238	$96,381,582	$96,412,806	$108,122,608
6 to 20	$56,935,159	$62,050,018	$64,208,357	$64,622,217	$71,467,515
21 to 64	$119,688,063	$132,731,684	$134,216,535	$137,548,448	$141,815,081
65 and up	$9,975,770	$10,343,938	$7,180,788	$8,013,766	$10,035,342
All Ages	$280,182,021	$301,543,879	$301,987,262	$306,597,238	$331,440,546

Recipients[2]

Age	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
0 to 5	183,419	194,681	197,630	196,250	196,967
6 to 20	194,008	212,226	221,107	224,793	233,427
21 to 64	156,069	167,357	174,968	178,613	179,951
65 and up	61,819	61,524	59,729	57,555	55,612
All Ages	584,006	623,569	641,790	645,263	653,170

Cost Per Recipient

Age	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
0 to 5	$510	$495	$488	$491	$549
6 to 20	$293	$292	$290	$287	$306
21 to 64	$767	$793	$767	$770	$788
65 and up	$161	$168	$120	$139	$180
All Ages	$480	$484	$471	$475	$507

1. Claims Data Only - Claims data excludes medical costs not associated with a specific recipient such as Enhancement payments and Disproportionate Share Hospital (DSH) payments to hospitals, Certified Public Expenditures (CPEs) for indigent care, health insurance premiums for Medicare enrollees and "clawback" payments to the federal government for Medicare Part D recipients.

2. Recipient count is an unduplicated count of individuals who received at least one physician program service.

FY 2009 - FY 2013
Lab and X-Ray Program
Cost and Utilization

	Payments	Recipients	Annual Cost per Recipient
FY 2009	$68,383,202	466,864	$146.47
FY 2010	$80,069,652	499,899	$160.17
FY 2011	$81,950,413	511,208	$160.31
FY 2012	$81,270,711	508,195	$159.92
FY 2013	$84,968,624	515,575	$164.80

1. Claims Data Only - Claims data excludes medical costs not associated with a specific recipient such as Enhancement payments and Disproportionate Share Hospital (DSH) payments to hospitals, Certified Public Expenditures (CPEs) for indigent care, health insurance premiums for Medicare enrollees and "clawback" payments to the federal government for Medicare Part D recipients.
2. Recipient count is an unduplicated count of individuals who received at least one Lab and X-Ray program service.

FY 2009 - FY 2013
Long Term Care Program
Intermediate Care Facility for Intellectually Disabled

	Claims[1] Payments	Recipients	Average Cost per Day	Average Cost per Recipient
FY 2009	$38,024,252	242	$445	$157,125
FY 2010	$34,861,353	223	$462	$156,329
FY 2011	$32,104,030	202	$496	$158,931
FY 2012	$10,584,848[2]	123	$553	$ 86,056
FY 2013	$1,784,376	39	$190	$ 45,753

FY 2011 - FY 2013
Long Term Care Program
Recipients and Claims[1] Payments by Gender, Race and Age
Claims Data Only*

	Recipients			Claims Payments[1]			Annual Average Cost Per Recipient		
	FY 2011	**FY 2012**	**FY 2013**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2011**	**FY 2012**	**FY 2013**
By Gender									
Female	17,564	17,129	17,171	$651,538,129	$653,054,687	$635,965,462	$37,095	$38,126	$37,037
Male	7,318	7,201	7,428	$264,855,572	$265,376,876	$265,593,458	$36,192	$36,853	$35,756
By Race									
African Am.	7,324	7,247	7,375	$280,079,783	$283,113,949	$282,420,560	$38,241	$39,066	$38,294
Am. Indian	6	11	16	$275,076	$420,567	$525,296	$45,846	$38,233	$32,831
Asian	51	56	67	$2,000,805	$2,385,170	$2,478,394	$39,231	$42,592	$36,991
Hispanic	47	53	75	$1,756,919	$2,334,787	$2,839,399	$37,381	$44,053	$37,859
Other	22	18	19	$792,358	$747,174	$803,919	$36,016	$41,510	$42,312
Unknown	394	420	438	$11,252,988	$11,632,251	$12,529,583	$28,561	$27,696	$28,606
White	17,038	16,525	16,609	$620,235,773	$617,797,666	$599,961,769	$36,403	$37,386	$36,123
By Age									
0-5	18	20	21	$1,159,263	$1,191,743	$1,149,847	$64,404	$59,587	$54,755
6-20	100	106	100	$6,340,177	$6,585,670	$6,524,349	$63,402	$62,129	$65,243
21-64	4,768	4,866	5,287	$178,696,216	$186,718,902	$195,590,626	$37,478	$38,372	$36,995
65-74	4,439	4,466	4,581	$160,148,080	$166,277,845	$168,607,267	$36,078	$37,232	$36,806
75-84	7,277	7,057	6,912	$262,928,617	$259,538,457	$257,946,394	$36,131	$36,777	$37,319
85 & Over	8,280	7,815	7,698	$307,121,347	$298,118,947	$271,740,437	$37,092	$38,147	$35,300
Statewide	**24,882**	**24,330**	**24,599**	**$916,393,701**	**$918,431,563**	**$901,558,920**	**$36,830**	**$37,749**	**$36,650**

1. Claims Data Only - Claims data excludes medical costs not associated with a specific recipient such as Enhancement payments and Disproportionate Share Hospital (DSH) payments to hospitals, Certified Public Expenditures (CPEs) for indigent care, health insurance premiums for Medicare enrollees and "clawback" payments to the federal government for Medicare Part D recipients.government for Medicare Part D recipients.

2. The reduction in payments for FY 2012 is due to termination of a public intermediate care facility (Partlow Developmental Center) effective Dec. 31, 2011.

FY 2009 - FY 2013
Long Term Care Program
Utilization

	Total Nursing Home Patients (Unduplicated)	Percent Change	Avg. Length of Stay During Year	Total Patient Days Paid for Medicaid Recipients	Percent Change	State Licensed Beds[1]	Percent Change	Medicaid Bed Days as % of State Bed Days
FY 2009	26,145	-1.5%	241	6,297,605	-2.2%	26,756	-0.7%	64%
FY 2010	25,421	-2.8%	243	6,179,912	-1.9%	26,046	-2.7%	65%
FY 2011	24,882	-2.1%	248	6,170,511	-0.2%	25,687	-1.4%	66%
FY 2012	24,330	-2.2%	245	5,963,914	-3.3%	26,649	3.7%	61%
FY 2013	24,599	1.1%	237	5,840,977	-2.1%	26,653	0.0%	60%

FY 2004 - FY 2013
Long Term Care Program
Patients, Days and Costs

	Nursing Home Patient-Days Paid By Medicaid	Nursing Home Claims[2] Paid By Medicaid	Average Cost Per Patient Day	Nursing Home Tax[3]	Tax as % of Claims	Nursing Home Cost to Medicaid Net of Tax	Average Cost Per Patient Day Net of Tax
FY 2004	7,735,215	$744,420,675	$96	$36,387,275	4.9%	$708,033,400	$92
FY 2005	7,890,883	$773,327,685	$98	$50,005,708	6.5%	$723,321,977	$92
FY 2006	7,868,861	$804,607,572	$102	$49,242,459	6.1%	$755,365,113	$96
FY 2007	7,441,542	$822,291,163	$111	$49,586,826	6.0%	$772,704,337	$104
FY 2008	6,437,501	$832,682,281	$129	$50,457,654	6.1%	$782,224,627	$122
FY 2009	6,297,605	$875,858,049	$139	$50,092,004	5.7%	$825,766,045	$131
FY 2010	6,179,912	$874,469,195	$142	$49,409,534	5.7%	$825,059,661	$134
FY 2011	6,170,511	$916,393,701	$149	$77,904,662	8.5%	$838,489,039	$136
FY 2012	5,963,914	$918,431,563	$154	$106,049,403	11.5%	$812,382,160	$136
FY 2013	5,840,977	$901,558,920	$154	$103,250,591	11.5%	$798,308,329	$137

1. The number of licensed nursing home beds is derived from the State Health Planning and Development Agency's (SHPDA) annual reports and the Alabama Department of Public Health's Healthcare Facilities Directory. (This number represents the number of licensed nursing home beds as of June 30 of each year and includes skilled nursing facilities (SNFs), nursing facilities for individuals with developmental delays (NFIDDs))This number does not include intermediate care facilities for the intellectually disabled (ICF/MR report) and swing beds (temporary nursing home beds in hospitals), and veterans' homes.

2. Claims Data Only - Claims data excludes medical costs not associated with a specific recipient such as Enhancement payments and Disproportionate Share Hospital (DSH) payments to hospitals, Certified Public Expenditures (CPEs) for indigent care, health insurance premiums for Medicare enrollees and "clawback" payments to the federal government for Medicare Part D recipients.government for Medicare Part D recipients.

3. Nursing Home provider tax data provided by the Alabama Department of Revenue.

FY 2009 - FY 2013
Pharmacy Program
Cost

	Benefit Payments[1]	Clawback Payments[2]	Pharmacy Expenditures[3]	Drug Rebates	Pharmacy Provider Tax	Net Cost to Medicaid[4]	Rebates as % of Benefits	Clawback as % of Net Cost	Pharmacy Tax as % of Benefits
FY 2009	$467,574,479	$65,721,030	$533,295,509	($155,712,772)	($8,407,870)	$369,174,867	33.3%	17.8%	1.8%
FY 2010	$502,254,947	$33,567,187	$535,822,134	($170,598,876)	($8,629,329)	$356,593,929	34.0%	9.4%	1.7%
FY 2011	$496,128,925	$50,798,631	$546,927,556	($218,474,908)	($8,938,136)	$319,514,512	44.0%	15.9%	1.8%
FY 2012	$526,082,696	$67,028,930	$593,111,626	($235,235,762)	($9,262,104)	$348,613,760	44.7%	19.2%	1.8%
FY 2013	$525,307,376	$67,938,260	$593,245,636	($239,585,283)	($9,217,778)	$344,442,575	45.6%	19.7%	1.8%

FY 2009 - FY 2013
Pharmacy Program
Annual Utilization

	Net Cost to Medicaid[4]	Pharmacy Recipients[5]	Monthly Pharmacy Average Eligibles	Recipients As % of Pharmacy Eligibles[6]	Cost Per Recipient[7]	Number of Prescriptions	Prescriptions Per Recipient[8]	Net Cost Per Prescription[9]
FY 2009	$369,174,867	541,561	715,512	76%	$682	7,844,949	14.49	$47.06
FY 2010	$356,593,929	578,734	765,179	76%	$616	8,603,799	14.87	$41.45
FY 2011	$319,514,512	605,543	821,291	74%	$528	8,867,049	14.64	$36.03
FY 2012	$348,613,760	608,500	842,824	72%	$573	8,961,210	14.73	$38.90
FY 2013	$344,442,575	610,872	833,778	73%	$564	8,960,863	14.67	$38.44

1. Benefit payment data based on Executive Budget Office financial records and includes expenditures, purchase orders and year-end encumbrances.

2. Clawback (also called "phasedown") - Mandatory state payments to federal government to help finance the Medicare Part D benefit for dual eligibles. The size of the state's "clawback" payment for any given month depends on three factors: 1) a per capita estimate of the amount the state otherwise would have spent on Medicaid prescription drugs for dual eligibles; 2) the number of dual eligibles enrolled in a Part D plan; and 3) a "takeback" factor set at 90% in 2006, declining to 75% for 2015 and later years.

3. Pharmacy Expenditures = Benefit Payments plus Clawback payments.

4. Net Cost to Medicaid = Pharmacy expenditures less Drug Rebates and Pharmacy Provider Tax Receipts.

5. Pharmacy recipients who received at least one drug prescription during the fiscal year.

6. Pharmacy recipients as % of Pharmacy Eligibles = Number of Pharmacy Recipients divided by the number of monthly average pharmacy eligibles.

7. Cost Per Recipient = Net Cost to Medicaid divided by Number of Pharmacy Recipients.

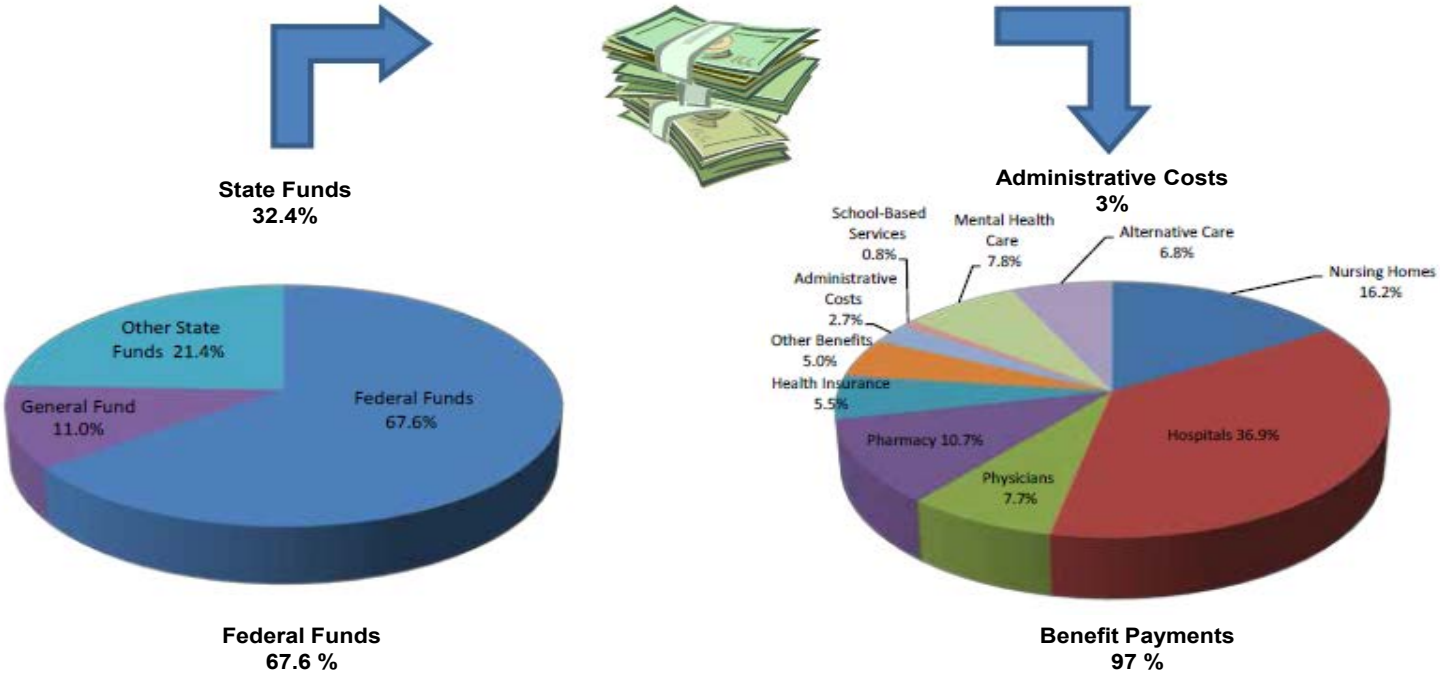
8. Prescriptions Per Recipient = Number of Prescriptions divided by Number of Pharmacy Recipients.

9. Net Cost Per Prescription = Net Cost to Medicaid divided by Number of Prescriptions.

Revenues and Expenditures

In FY 2013, Medicaid paid $5,352,659,596 for health care services provided to Alabama citizens. Another $148,755,326 was spent administering the Medicaid program. This means that about 97 cents of every Medicaid dollar went directly to providing care and services to recipients. During Fiscal Year 2013, the agency's Federal Medical Assistance Percentage (FMAP) matching rate was 68.53 percent.

FY 2013
Medicaid Budget
Composition and Disbursement



FY 2009 - FY 2013
Expenditures by Type of Service (total Federal and State dollars)[1]

Service	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Nursing Facilities	$958,916,510	$872,633,303	$898,684,381	$932,613,072	$899,428,257
Hospital Care	$1,108,187,131	$1,533,370,569	$1,499,870,826	$1,546,116,066	$1,651,041,414
Hospital Care CPE[2]	$366,943,640	$419,270,791	$258,240,638	$504,091,906	$395,375,218
Physicians	$363,073,104	$393,671,379	$394,295,050	$397,504,473	$426,992,044
Pharmacy	$533,295,509	$535,822,134	$546,927,556	$593,111,626	$593,245,636
Health Support	$183,606,786	$241,118,981	$206,590,686	$215,512,000	$ 214,165,029
Alternative Care	$442,367,686	$384,075,482	$396,450,006	$395,014,560	$376,600,493
Mental Health Facilities	$41,923,805	$34,859,102	$32,663,368	$10,626,732	$1,794,348
Mental Health Waivers	$273,470,968	$275,738,103	$285,804,858	$287,322,840	$ 304,528,666
Mental Health Other	$104,704,308	$123,205,822	$126,149,169	$132,413,000	$123,496,077
Health Insurance	$238,943,257	$266,472,795	$303,737,351	$296,483,036	$304,686,039
Family Planning	$52,486,112	$53,755,687	$62,825,818	$64,265,900	$61,306,375
Total for Medical Benefits	**$4,667,918,816**	**$5,133,994,148**	**$5,012,239,707**	**$5,375,075,211**	$5,352,659,596
Administrative Costs	$137,168,925	$134,966,896	$126,893,693	$146,345,301	$148,755,326
School-based services	$35,693,051	$40,443,057	$69,098,883	$45,329,475	$44,373,774
Total Medicaid Expenditures	**$4,840,780,792**	**$5,309,404,101**	**$5,208,232,283**	**$5,566,749,987**	$5,545,788,697
Health Information Exchange			$32,398,855	$60,209,095	$40,224,122
Agency Total Expenditures	**$4,840,780,792**	**$5,309,404,101**	**$5,240,631,138**	**$5,626,959,082**	**$5,586,012,819**

FY 2009 - FY 2013
Expenditures by Type of Service (as percent of total)[1]

Service	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Nursing Facilities	19.8%	16.4%	17.3%	16.8%	16.2%
Hospital Care	22.9%	28.9%	28.8%	27.8%	29.8%
Hospital Care CPE	7.6%	7.9%	5.0%	9.1%	7.1%
Physicians	7.5%	7.4%	7.6%	7.1%	7.7%
Pharmacy	11.0%	10.1%	10.5%	10.7%	10.7%
Health Support	3.8%	4.5%	4.0%	3.9%	3.9%
Alternative Care	9.1%	7.2%	7.6%	7.1%	6.8%
Mental Health Facilities	0.9%	0.7%	0.6%	0.2%	0.0%
Mental Health Waivers	5.6%	5.2%	5.5%	5.2%	5.5%
Mental Health Other	2.2%	2.3%	2.4%	2.4%	2.2%
Health Insurance	4.9%	5.0%	5.8%	5.3%	5.5%
Family Planning	1.1%	1.0%	1.2%	1.2%	1.1%
Total For Medical Benefits	**96.4%**	**96.7%**	**96.2%**	**96.6%**	**96.5%**
Administrative Costs	2.8%	2.5%	2.4%	2.6%	2.7%
School Based Services	0.7%	0.8%	1.3%	0.8%	0.8%
Total Medicaid Expenditures[3]	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

1. Data is based on Agency's financial records and includes expenditures, purchase orders and year-end encumbrances.

2. CPE - Certified Public Expenditure - The uncompensated cost incurred by public hospitals in serving Medicaid recipients that can be claimed by Medicaid as an expense and reimbursed by the Federal Government at the applicable FMAP rate.

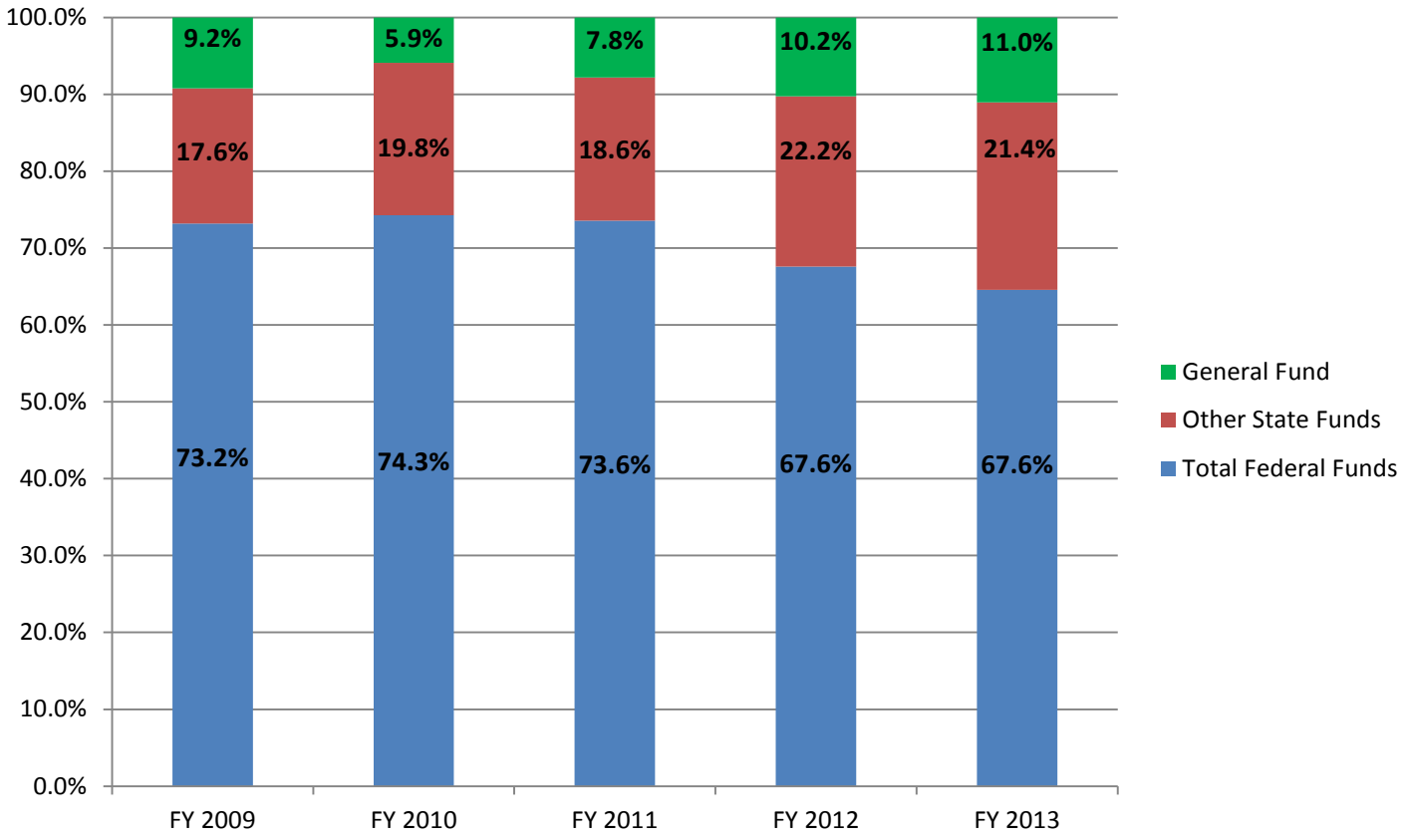
3. Total Medicaid expenditures excludes Health Information Exchange expenses, which were 0.7%, 1.1% and 0.6% of total Medicaid Agency expenditures in FY 2013, FY2012 and FY 2011, respectively.

FY 2009 - FY 2013
State Share Funding Sources

						% of Total State Share Funding				
	FY09	FY10	FY11	FY12	FY13	FY09	FY10	FY11	FY12	FY13
General Fund										
Current Year Appropriation	$622,478,155	$307,968,537	$345,310,381	$643,788,706	$603,125,607	47.6%	22.5%	25.5%	35.4%	33.4%
Adjustments	-171,748,477	6,999,282	54,976,729	-68,370,361	12,000,000	-13.1%	0.5%	4.1%	-3.8%	0.7%
Total General Fund	450,729,678	314,967,819	400,287,110	575,418,345	615,125,607	34.5%	23.0%	29.6%	31.6%	34.1%
Certified Public Expenditures										
Hospitals	54,610,747	422,973,043	270,871,386	499,912,172	395,375,218	34.8%	30.9%	20.0%	27.5%	21.9%
Admin. Assistance and										
School-Based Services	18,357,202	21,627,419	34,377,361	22,704,404	22,107,068	1.4%	1.6%	2.5%	1.2%	1.2%
Total Certified Public Expenditures	472,967,949	444,600,462	305,248,747	522,616,576	417,482,286	36.2%	32.4%	22.6%	28.7%	23.1%
Alabama Health Care Trust Fund										
Hospital Provider Tax	-	211,242,108	215,521,701	226,276,852	241,930,276	0.0%	15.4%	15.9%	12.4%	13.4%
Nursing Home Provider Tax	50,092,004	49,409,534	77,904,662	106,049,403	103,250,591	3.8%	3.6%	5.8%	5.8%	5.7%
Pharmacy Provider Tax	8,407,870	8,629,329	8,938,136	9,262,104	9,217,779	0.6%	0.6%	0.7%	0.5%	0.5%
Total Ala. Health Care Trust Fund	58,499,874	269,280,971	302,364,499	341,588,359	354,398,646	4.5%	19.7%	22.4%	18.8%	19.6%
Intergovernmental Transfers										
State Agencies										
Dept. of Mental Health	126,478,973	112,279,686	131,619,537	148,104,358	150,391,339	9.7%	8.2%	9.7%	8.1%	8.3%
Dept. of Human Resources	32,238,259	24,928,735	33,107,350	39,411,775	34,876,380	2.5%	1.8%	2.4%	2.2%	1.9%
Dept. of Public Health	36,271,219	31,721,219	30,583,658	26,714,938	20,174,821	2.8%	2.3%	2.3%	1.5%	.1%
Dept. of Senior Services	12,439,209	11,360,842	12,497,563	16,623,308	25,029,938	1.0%	0.8%	0.9%	0.9%	1.4%
Dept. of Rehabilitation Services	6,444,613	4,926,530	5,177,379	6,466,094	6,372,435	0.5%	0.4%	0.4%	0.4%	0.4%
Dept. of Youth Services	3,155,344	3,436,914	3,742,082	5,080,662	6,090,951	0. 2%	0.3%	0.3%	0.3%	0.3%
Dept. of Education	2,952									
Total State Agencies	217,030,569	188,653,926	216,727,569	242,401,135	242,935,864	16.6%	13.8%	16.0%	13.3%	13.5%
Other Governmental Bodies	25,987,933	14,268,298	2,967,067	29,134,723	29,663,131	2.0%	1.0%	0.2%	1.6%	1.6%
Total Intergovernmental Transfers	243,018,502	202,922,224	219,694,636	271,535,858	272,598,995	18.6%	14.8%	16.2%	14.9%	15.1%
Other Funding Sources										
Drug Rebates- Federal and State	34,914,364	38,828,121	55,833,463	64,963,187	69,522,963	2.7%	2.8%	4.1%	3.6%	3.9%
Medicaid Trust Fund - Tobacco	35,111,965	36,925,675	29,956,125	30,644,931	30,700,104	2.7%	2.7%	2.2%	1.7%	1.7%
Other Miscellaneous Receipts	12,393,558	62,838,171	39,197,658	13,281,513	44,780,946	0.9%	4.6%	2.9%	0.7%	2.5%
Total Other Funding Sources	82,419,887	138,591,967	124,987, 246	108,889,631	145,004,013	6.3%	10.1%	9.2%	6.0%	8.0%
Total State Funds	$1,307,635,890	$1,370,363,443	$1,352,582,238	$1,820,048,769	$1,804,609,547	100%	100%	100%	100%	100%

FY 2009 - FY 2013
Sources of Medicaid Funding

	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Federal Funds					
Match FMAP[1]	$3,212,464,019	$3,540,721,118	$3,492,130,946	$3,734,479,126	$3,730,138,013
Stimulus Funds	355,003,009	416,456,973	240,226,571	-	-
Health Info Exchange	-	-	32,163,520	60,114,778	39,247,858
Total Federal Funds	**3,567,467,028**	**3,957,178,091**	**3,764,521,037**	**3,794,593,904**	**3 ,769,385,871**
State Funds					
General Fund	450,729,678	314,967,81	400,287,110	575,418,345	615,125,607
Other State Funds	856,906,212	1,055,395,624	952,295,128	1,244,630,424	1,189,483,940
Total State Funds	**1,307,635,890**	**1,370,363,443**	**1,352,582,238**	**1,820,048,769**	**1,804,609,547**
Total Funding	**$4,875,102,918**	**$5,327,541,534**	**$5,117,103,275**	**$5,614,642,673**	**$5,573,995,418**



1. Federal Medical Assistance Percentage (FMAP) is the share of the cost of Medicaid that the federal government bears. That share varies by state depending on a state's per capita income. The average state FMAP is 60%, but ranges from 50% in wealthier states up to 74% in states with lower per capita incomes (the maximum FMAP is 83%). FMAPs are adjusted for each state on a three year cycle to account for fluctuations in the economy.

Federal match rates in FY 09, FY 10 and the first quarter of FY 11 were enhanced due to federal stimulus provisions of the American Reinvestment and Recovery Act of 2009 (ARRA). This enhanced match rate resulted in the state receiving additional federal funds during this period.

Managing Medicaid's Assets

Maximizing all available taxpayer dollars for recipient services is an ongoing priority for the Agency. While all program areas seek to manage funds efficiently, two divisions specifically work to ensure that public funds are spent or managed in accordance with state and federal rules and regulations.

The Program Integrity Division is responsible for planning, developing and directing Medicaid's efforts to identify, prevent and prosecute fraud, abuse and/or misuse by providers, recipients or others.

The Third Party Division saves taxpayers millions of dollars each year through coordination of benefits, cost avoidance activities and recoveries from liens, estates and recipients.

Program Integrity

Five units within this division work to detect, prevent and/or eliminate all forms of fraud and abuse to ensure that all available funds go to provide health care to those in need. Program Integrity staff verify that medical services are appropriate and rendered as billed to eligible recipients by qualified providers, that payments for those services are correct, and that all funds identified for collection are pursued.

Provider Review Unit

The Provider Review Unit examines medical provider billing to assure proper claim payment and recovery of identified overpayments. In FY 2013, reviews of 134 medical providers resulted in $2,258,152 in identified recoupments and $1,140,059 in collected recoupments.

Sanctions against providers and recipients resulted in $921,660 in cost savings for the Agency. In all, 56 providers were suspended from participation as Medicaid providers due to sanctions by their licensing boards and/or the U.S. Department of Health and Human Services Office of Inspector General. These provider sanctions netted a cost savings of $335,097. Suspension of 302 recipients from the Medicaid program resulted in a cost savings of $586,563.

Recipient Review Unit

The Recipient Review Unit investigates recipients who appear to have abused or misused their Medicaid benefits. If inappropriate behavior is found, the recipient is placed in the Agency's Restriction Program for management of his or her medical care.

In FY 2013, the Recipient Review Unit conducted 1,565 reviews. As a result, 925 recipients were restricted or "locked-in" to one doctor and one drug store resulting in $790,668 in cost savings for the Agency.

Investigations Unit

The Investigations Unit conducts preliminary investigations of provider cases and full investigations of recipients cases based on referrals, including calls to the confidential hotline. Medicaid refers cases to local district attorneys or the Alabama Attorney General for legal action.

Quality Control Unit

The Quality Control Unit reviews eligibility determinations for accuracy to ensure that only eligible individuals qualify for Medicaid. Alabama's quality control (error) rate for FY 2013 was 0.3257 percent.

Enrollment and Sanction Unit

The Enrollment and Sanction Unit is responsible for the management and performance of all provider enrollment and reenrollment activities including those activities performed by the Fiscal Agent, and all activities related to Medicaid provider sanctions, suspect providers, and recipient sanctions.

Third Party

During FY 2013, the Third Party Division was successful in saving Alabama taxpayers more than $883 million.

Through coordination of benefits, savings were achieved through a combination of: 1) cost avoidance of claims where providers are required to file with the primary payer first, 2) direct billing by Third Party to primary payers, 3) payment of Medicare and health insurance premiums, 4) liens and estate recovery, and 5) recipient recoveries.

Medicaid also made premium payments to Medicare Advantage Plans for Medicaid enrollees, resulting in an avoidance of payments for Medicare deductibles and co-payments/coinsurance for certain Medicaid recipients.

FY 2011 - FY 2013
Collections

	FY 2011	FY 2012	FY 2013
Third Party Liability			
Includes reported and estimated third party collections by providers, retroactive Medicare recoupments from providers, and collections due to health and casualty insurance, estate recovery, and misspent funds resulting from eligibility errors.	$31,134,766	$34,853,998	$36,285,497
Program Integrity Division			
Provider Recoupment			
Medical Provider Recoupments Collected	$2,666,832	$2,091,548	$1,140,059
Pharmacy Recoupments	–	–	–
Recovery Audit Contractor	$740,260	$727,514	$727,514
Investigations	$228,224	$90,636	$90,636
Pharmacy Program			
In-House Processed Claims Corrections	$51,830	$93,436	$77,084
Total Collections	**$34,602,569**	**$37,857,132**	**$37,940,164**

FY 2011 - FY 2013
Measureable Cost Avoidance

	FY 2011	FY 2012	FY 2013
Third Party Claim Cost Avoidance Savings			
Traditional Medicare Net Savings (includes Provider Payments/Costs Avoidance/Recoupments less premium cost of:	$686,854,615	$709,994,047	$666,560,140
FY 2010 $245,820,370			
FY 2011 $276,136,212			
FY 2012 $258,244,762			
Provider Reported Collections - Health and Casualty Insurance	$52,400,553	$51,985,828	$54,016,740
Medicare Advantage Capitated Program Net Savings	$3,532,297	$3,153,562	$3,528,487
Claims Denied and Returned to providers to file health/casualty	$117,671,354	$119,846,479	$122,721,934
Health Insurance Premium Payment Cost Avoidance	$310,873	$100,286	$615,333
Waiver Services Cost Avoidance			
Elderly and Disabled Waiver*	$386,869,912	$391,776,045	$460,780,277
State of Alabama Independent Living (SAIL) Waiver	$22,751,412	$22,673,900	$26,922,054
Intellectual Disabilities Waiver**	$531,162,294	$157,948,560	$101,887,254
Living at Home Waiver**	$80,414,205	$38,234,568	$32,657,211
HIV/AIDS Waiver	$7,251,160	$6,582,309	$5,866,443
Program Integrity Cost Avoidance			
Pharmacy Cost Avoidance _	–	–	
Provider Review Cost Avoidance	$2,260,408	$2,504,401	$5,848,529
Recipient Review Cost Avoidance	$430,415	$351,568	$790,668
Investigations Cost Avoidance	$1,075,302	$266,282	$92,092
Sanctioned Provider and Recipients	$707,223	$2,651,360	$921,660
Total Measurable Cost Avoidance	**$1,893,692,023**	**$1,508,069,195**	**$1,483,208,822**

* FY 12 included fundamental changes to program; Program moved from ADPH to ADSS.

** FY 12 State's largest ICF/ Intellectually Disabled closed in December 2011; therefore cost avoidance is lower.

FY 2011 - FY 2013
Program Integrity

Provider Reviews

	FY 2011	FY 2012	FY 2013
Medical Providers	110	53	134
Medical Providers Recoupments - Identified	$2,818,423	$3,053,958	$2,258,152
Medical Providers Recoupments - Collected	$2,666,832	$2,091,548	$1,140,059
Pharmacy Providers	-	-	-
Medical Providers Recoupments - Identified	-	-	-
Medical Providers Recoupments - Collected	-	-	-
Recovery Audit Contractor	534	93	70
Recoupments - Identified	$1,796,421	$434,293	$496,821
Recoupments - Collected	$740,260	$727,514	$337,299

Recipient Reviews

	FY 2011	FY 2012	FY 2013
Reviews Conducted	1,171	1,281	1,565
Restricted Recipients	918	938	925
Recipient Review Cost Avoidance	$430,415	$351,568	$790,668

Investigations

	FY 2011	FY 2012	FY 2013
Provider & Recipient Recoupments - Identified	$1,174,912	$581,577	$218,199
Provider & Recipient Recoupments - Collected	$228,224	$90,636	$100,225

Tax Intercept Receipts

	FY 2011	FY 2012	FY 2013
Tax Intercept Receipts	$38,680	$33,189	$37,202

Program Integrity Cost Avoidance Savings

	FY 2011	FY 2012	FY 2013
Provider Review Cost Avoidance	$2,260,408	$2,504,401	$5,848,529
Recipient Review Cost Avoidance	$430,415	$351,568	$790,668
Investigations Cost Avoidance	$1,075,302	$266,282	$92,092
Sanctioned Provider and Recipients	$707,223	$2,651,360	$921,660

FY 2013 Annual Report
October 1, 2012 - September 30, 2013
Alabama Medicaid Agency
PO Box 5624 (501 Dexter Avenue)
Montgomery, AL 36103-5624

Statistical data provided by the Alabama Medicaid Quality Analytics Division

This report can be viewed at
www.medicaid.alabama.gov