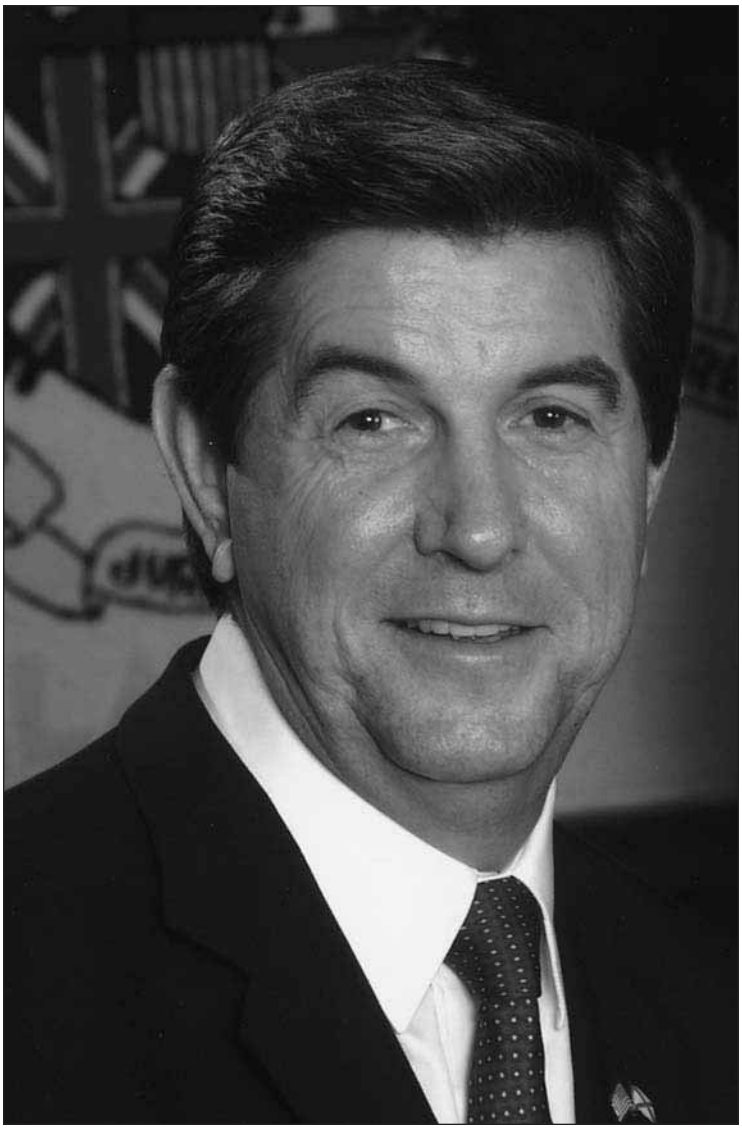
Annual Report FY2003

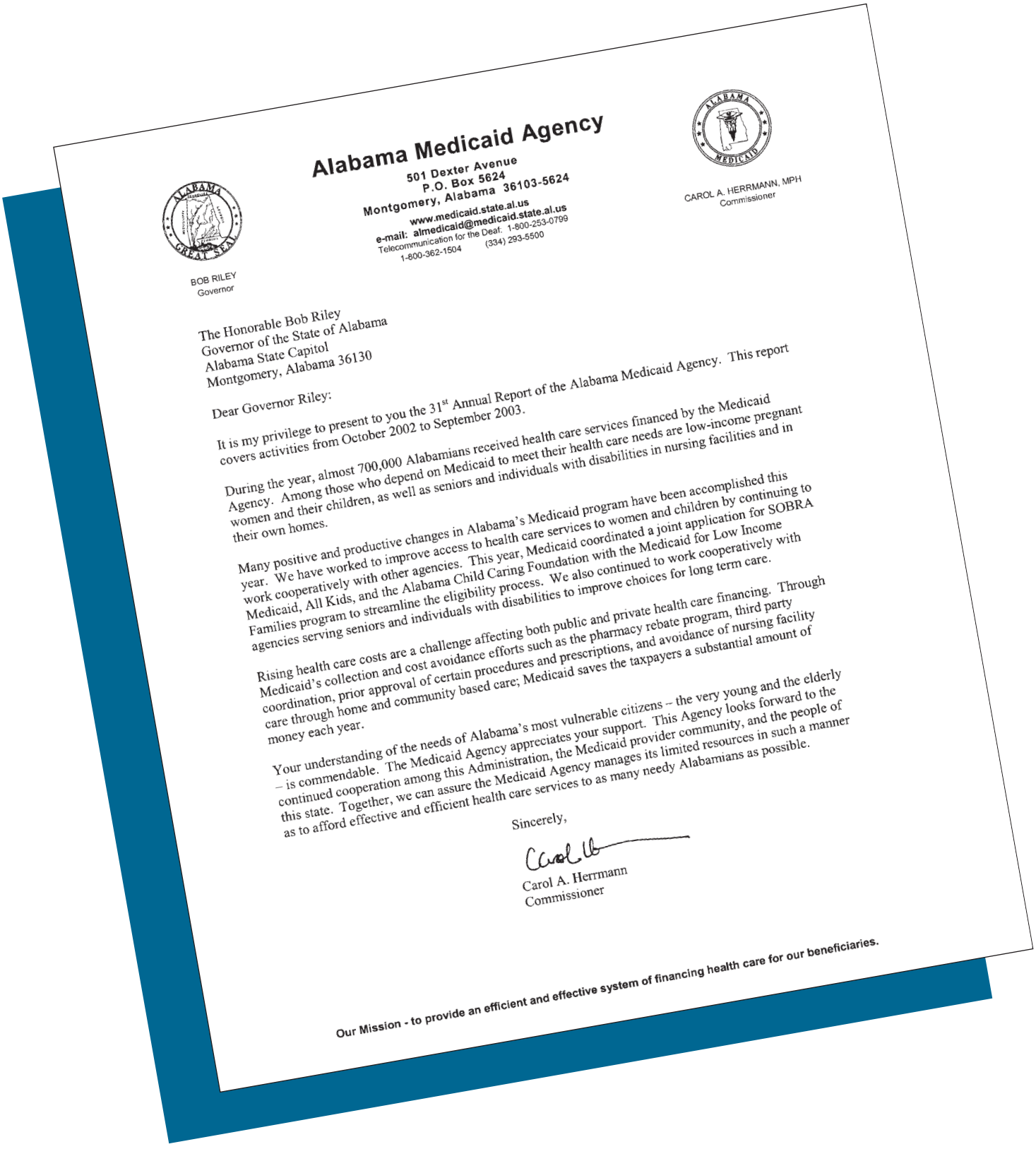
Alabama Medicaid Agency



Governor
State of Alabama
Bob Riley

Carol A. Herrmann, MPH
Commissioner
Alabama Medicaid Agency

Alabama Medicaid Agency
FY 2003 Annual Report
October 1, 2002 - September 30, 2003



Alabama Medicaid Agency

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BOB RILEY
Governor

CAROL A. HERRMANN, MPH
Commissioner

The Honorable Bob Riley
Governor of the State of Alabama
Alabama State Capitol
Montgomery, Alabama 36130

Dear Governor Riley:

It is my privilege to present to you the 31st Annual Report of the Alabama Medicaid Agency. This report covers activities from October 2002 to September 2003.

During the year, almost 700,000 Alabamians received health care services financed by the Medicaid Agency. Among those who depend on Medicaid to meet their health care needs are low-income pregnant women and their children, as well as seniors and individuals with disabilities in nursing facilities and in their own homes.

Many positive and productive changes in Alabama's Medicaid program have been accomplished this year. We have worked to improve access to health care services to women and children by continuing to work cooperatively with other agencies. This year, Medicaid coordinated a joint application for SOBRA Medicaid, All Kids, and the Alabama Child Caring Foundation with the Medicaid for Low Income Families program to streamline the eligibility process. We also continued to work cooperatively with agencies serving seniors and individuals with disabilities to improve choices for long term care.

Rising health care costs are a challenge affecting both public and private health care financing. Through Medicaid's collection and cost avoidance efforts such as the pharmacy rebate program, third party coordination, prior approval of certain procedures and prescriptions, and avoidance of nursing facility care through home and community based care; Medicaid saves the taxpayers a substantial amount of money each year.

Your understanding of the needs of Alabama's most vulnerable citizens – the very young and the elderly – is commendable. The Medicaid Agency appreciates your support. This Agency looks forward to the continued cooperation among this Administration, the Medicaid provider community, and the people of this state. Together, we can assure the Medicaid Agency manages its limited resources in such a manner as to afford effective and efficient health care services to as many needy Alabamians as possible.

Sincerely,

Carol A. Herrmann
Commissioner

Our Mission - to provide an efficient and effective system of financing health care for our beneficiaries.

Mission Statement

The Mission of the Alabama Medicaid Agency is to provide an efficient and effective system of financing health care for our beneficiaries.

This annual report was produced by
the Division of Program Support
of the Alabama Medicaid Agency.

This report can be
viewed at our web site
http: //www.medicaid.state.al.us

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Highlights

Introduction

During the past year Alabama Medicaid has accomplished a major system change to further protect our beneficiaries' privacy, added responsibility for certification of the Medicaid for Low Income Families Program, initiated a dental education program, and improved choices for long term care to seniors and individuals with disabilities. All of these initiatives have made tremendous contributions toward our goal of improving the health care delivery system for the Alabama citizens who depend on us to ensure they have access to quality medical care.

HIPPA Compliance Implemented

Alabama Medicaid was one of many health and insurance-related organizations that met an April 14, 2003 deadline to ensure their clients' personal information is handled in a secure manner. The new requirements are the result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). During FY 2003 Medicaid also worked toward meeting other requirements of the act which were implemented by the end of the calendar year.

The national law required Medicaid Agencies across the nation to establish privacy policies to protect their recipients' personal information. The privacy rules are intended to replace a patchwork of federal and state laws that did not fully protect patients' privacy. The Agency has sent nearly 500,000 notices to recipients about their rights to privacy and access to their personal information. Medicaid also appointed a privacy officer within the Agency and trained all employees to conduct business in compliance with the new policies.

In addition to privacy HIPAA provides for administrative simplification, requiring the development of standard identifiers for the electronic exchange of health care information. The Alabama Medicaid Agency finished the fiscal year ready to implement the required HIPAA transactions and code sets before the end of calendar year 2003. Many major tasks were completed including system changes and testing and the installation of new equipment to allow for web based submission of claims and eligibility information.

HIPAA is the single most significant Federal legislation affecting the healthcare industry since the creation of the Medicare and Medicaid programs in 1965.

Medicaid Begins Certifying MLIF Cases

On April 1, 2003, the Medicaid for Low-Income Families (MLIF) program was transferred from the Department of Human Resources to the Alabama Medicaid Agency. This transfer, the result of welfare reform changes and recommendations from the Governor's Task Force on Children's Health Insurance, affected about 75,000 recipients at the time of the change. MLIF recipients continue to receive the full Medicaid services they received in the past and there were no changes to the procedures for claims processing or eligibility verification for these individuals. DHR and Medicaid worked together during the transition period when all pending cases were completed and transferred to Medicaid.

As a result of the change, individuals now apply for MLIF through the Agency's out stationed workers located in county health departments, hospitals, and clinics throughout the state. MLIF was added to the joint application used for SOBRA Medicaid, All Kids, and the Alabama Child Caring Foundation.

Recipient Education Works to Increase Patient Understanding

Helping Patients learn how to access care through Medicaid's Patient 1st program continued as a priority through FY 2003. Goals of patient education include helping recipients understand the policies and procedures of the program, such as the number of physician office visits allowed per year or when to go to the emergency room. Efforts such as these not only reduce ER visits for non-emergencies but also encourage recipients to get periodic checkups, immunizations and other preventive care.

Head Start Students To Benefit From New Oral Health Curriculum

A new oral health curriculum for the state's Head Start programs is now being distributed statewide with the goal of improving the oral health of more than 20,000 low-income Alabama pre-schoolers and their families. The "Healthy Teeth, Healthy Mouth, Healthy You!" curriculum is the centerpiece of a self-contained classroom kit that also includes templates and supplies for the activities suggested for teachers. The curriculum's four lessons are Functions of the Mouth, Tooth-brushing, Healthy Eating and Visiting the Dentist.

The project is an outgrowth of the Smile Alabama! Initiative and is funded through the support of the 21st Century Challenge Fund of the Robert Wood Johnson Foundation. Medicaid's Research and Development Unit developed the kit with curriculum assistance from the Auburn University at Montgomery's School of Education.

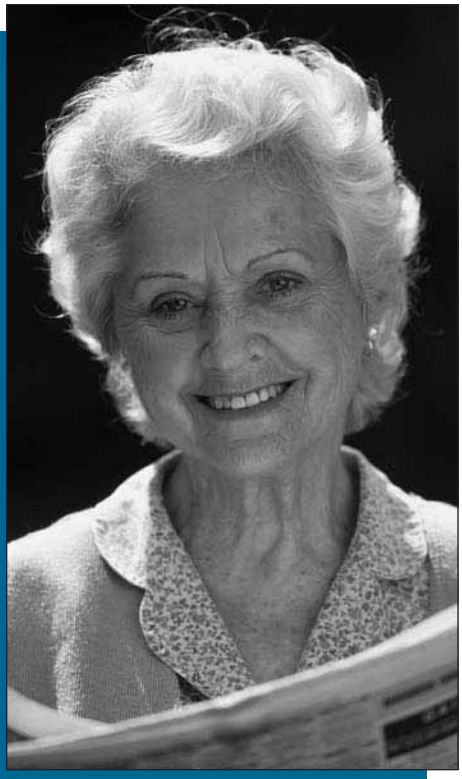
Medicaid Preferred Drug List Program

In accordance with Alabama Act Number 2003-297, the Preferred Drug List is being developed with the Medicaid Pharmacy and Therapeutics Committee. This list is based on Clinical efficacy, safety and patient care factors. Prior authorization is required for non-preferred brand name drugs in selected classes. All covered generic and over the counter products are considered preferred for this program. Prescrip-

tions written for brand preferred drugs, generic and over the counter drugs do not require prior authorization. Non-preferred brands in these classes will remain covered but will require prior authorization prior to Medicaid payment. The PA request form available on the Medicaid website will be utilized by the prescribing physician or the dispensing pharmacy in requesting prior authorizations. Many drug classes have already been implemented and several more classes will be implemented in early 2004.

Ticket to Work/Medicaid Infrastructure Grant

This grant, awarded to the Agency beginning January 1, 2002 in the amount of $625,000, has enabled Medicaid to establish a consumer-based Policy Consortium. The Policy Consortium meets on a monthly basis to review existing policies relative to Medicaid SAIL Waiver clients who have physical disabilities and have a desire to maintain their employment status or obtain employment with the help of a personal assistant on the job site.



Implementation of the Real Choice Systems Grant Continues

The Alabama Medicaid Agency is leading the way in taking an innovative approach to building an infrastructure to provide needed services as voiced by the consumer through the Real Choice Systems Change Grant. President Bush has strongly encouraged states to take on this role resulting form the 1999 Supreme Court case, Olmstead vs. L C. Although the Supreme Court decision did not increase Medicaid's Budget, it did allow for state solicitation of federal grant funds.

The Real Choice Systems Change Grant was received from the Centers for Medicare and Medicaid Services (CMS) in the amount of $2 million for a three-year period (September 28, 2001 – September 27, 2004). The state appropriately entitled its grant proposal, Sweet Home Alabama: Under Construction.

The grant has been used to develop systems that change the way individuals enter long term care for individuals with disabilities and seniors. The new systems will ensure that these services are provided in the least restrictive setting. Instead of services being provided based on age and disability, an infrastructure to provide services based on the choice of the consumer have been put in place.

Outreach and educational activities developed by staff as a part of the grant initiative address the Olmstead Plan, Institutional Deeming, the Auto Approval process, Home Health, and the State Plan. Presentations are made to providers and consumers of long term services. The unit also plans to develop educational presentations of other long term care programs and services, to design a catalog displaying all presentations available through the Outreach and Education Unit, and to create a standard form to be completed and submitted by all organizations requesting presentations by Unit staff.

New Home and Community Based Waivers

The HIV/AIDS Waiver was approved on May 1, 2003 by CMS. This waiver is designed to address the needs of individuals with diagnoses of HIV, AIDS, and related illnesses. These individuals must meet the nursing facility level of care criteria as determined by the Alabama Medicaid Agency. The Alabama Department of Public Health (ADPH) is the operating agency for this waiver. Their main focus is to manage the program by focusing on providing quality care to the client.

The Technology Assisted Waiver for Adults, also known as the TA Waiver, was approved by CMS on February 22, 2003. TA services are restricted to individuals, who received private duty nursing on the Early and Periodic Screening Diagnostic Treatment (EPSDT) Program, but have now reached the age of 21 and no longer qualify under the EPSDT Program. If they still have a medical need for private duty nursing after age 21, they qualify for the TA Waiver which is administered by the Alabama Medicaid Agency.

Looking Ahead

In December 2003 Governor Bob Riley appointed Carol A. Herrmann as the Commissioner of the Alabama Medicaid Agency. Ms. Herrmann had previously served in the position from 1988 to 1992 and was recognized nationally for her work in Alabama. Herrmann has worked with Medicaid on both a state and national level. Prior to her earlier appointment to head the state agency in 1988, she worked in a variety of positions with the Health Care Financing Administration (HCFA) in Washington, D.C. HCFA was the federal agency responsible for Medicaid and Medicare. It was renamed the Centers for Medicare and Medicaid Services in 2001. After leaving state service in 1992, Herrmann worked for the March of Dimes in New York and as director of The Survey Companies, LLC, a Birmingham-based consulting company for long-term care institutions and long-term care providers. She left this position to accept the appointment as Medicaid Commissioner. A 1981 graduate of Birmingham Southern College, Ms. Herrmann received her Masters in Public Health from the University of Alabama in Birmingham in June of 1994.

Alabama's Medicaid Program

History

Medicaid was created in 1965 by Congress along with a sound-alike sister program, Medicare. Medicare is a health insurance program primarily for elderly persons, regardless of income. It is financed through Social Security taxes and premiums. Medicaid is jointly financed by the state and federal governments and is designed to provide health care to low income individuals. Medicaid started in Alabama in 1970 as a Department of Public Health program. In 1977, the Medical Services Administration was made an independent state Agency. In 1981, it was renamed the Alabama Medicaid Agency.

A State Program

Unlike the Medicare program, Medicaid is a state-administered health care assistance program. All states, the District of Columbia, and some territories have Medicaid programs. Medicaid is governed by federal guidelines, but state programs vary in eligibility criteria, services covered, limitations on services, and reimbursement levels.

Funding Formula

The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because the average income in Alabama is relatively low, its federal match is one of the largest. During FY 2003, the formula was approximately 70/30. For every $30 the state spent, the federal government contributed $70.

Eligibility

Persons must fit into one of several categories and must meet necessary criteria before eligibility can be granted. The Medicaid Agency, the Department of Human Resources, and the Social Security Administration determine eligibility for Medicaid in Alabama.

- Persons receiving Supplemental Security Income (SSI) from the Social Security Administration are automatically eligible for Medicaid in Alabama. Children born to mothers receiving SSI payments may be eligible for Medicaid until they reach one year of age. After the child's first birthday, Medicaid will make a determination as to whether the child qualifies for another Medicaid program.
- On April 1, 2003, the Medicaid for Low-Income Families (MLIF) program was transferred from the Department of Human Resources to the Alabama Medicaid Agency. This transfer, the result of welfare reform changes and recommendations from the Governor's Task Force on Children's Health Insurance, affected about 75,000 recipients at the time of the change. MLIF recipients continue to receive the full Medicaid services they received in the past and there were no changes to the procedures for claims processing or eligibility verification for these individuals. DHR and Medicaid worked together during the transition period when all pending cases were completed and transferred to Medicaid.

  As a result of the change, individuals now apply for MLIF through the Agency's out stationed workers located in county health departments, hospitals, and clinics throughout the state. MLIF was added to the joint application used for SOBRA Medicaid, All Kids, and the Alabama Child Caring Foundation.
- Pregnant women and children under six years of age with family income which does not exceed 133 percent of the federal poverty level are covered by Medicaid. Also covered are children up to age 19 who live in families with family income at or below the federal poverty level. Medicaid eligibility workers in county health departments, federally qualified health centers, hospitals, and clinics determine their eligibility through a program called SOBRA Medicaid. Once children under 19 years of age are determined eligible for Medicaid through any program, they receive twelve months of continuous eligibility without regard to changes in income or family situation as long as they live in Alabama.
- Women who are aged 19 - 44, who have not been sterilized, and with family income which does not exceed 133 percent of the federal poverty level are covered by Medicaid for the Plan First Program.

This program covers family planning services only.

- Persons who are residents of medical institutions (nursing homes, hospitals, or facilities for the mentally retarded) for a period of 30 continuous days and meet very specific income, resource and medical criteria may be Medicaid eligible. Persons who require institutional care but prefer to live at home may be approved for a Home and Community Based Service (HCBS) Waiver and be Medicaid eligible. Medicaid District Offices determine eligibility for persons in these eligibility groups.
- Qualified Medicare Beneficiaries (QMBs) have low income. Persons in this group may be eligible to have their Medicare premiums, deductibles, and coinsurance paid by Medicaid. Medicaid District Offices determine eligibility for QMBs.
- Specified Low-income Medicare Beneficiaries (SLMBs) and Qualifying Individuals-1 (QI-1) have low income above the QMB limit. Persons in this group may be eligible to have their Medicare Part B premiums paid by Medicaid. Medicaid District Offices determine eligibility for these programs.
- The Qualifying Individual-2 (QI-2) program assists with a small portion of the Medicare premium for people with incomes below 175 percent of the federal poverty level. This program has limited funds and is provided on a first come first served basis. Due to lack of funding by the Federal Government this program ended December 31, 2002.
- Qualified Disabled Working Individuals (QDWIs) are individuals who have limited income and resources and who have lost disability insurance benefits because of earnings and who are also entitled to enroll for Medicare Part A. Medicaid will pay their Medicare Part A premiums. Medicaid Central Office determines eligibility for QDWIs.
- Disabled widows and widowers between ages 50 and 64 who are not eligible for Medicare Part A and who have lost SSI because of receiving widows/widowers benefits from Social Security can qualify for Medicaid. Medicaid District Offices determine eligibility for this group.

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

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

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

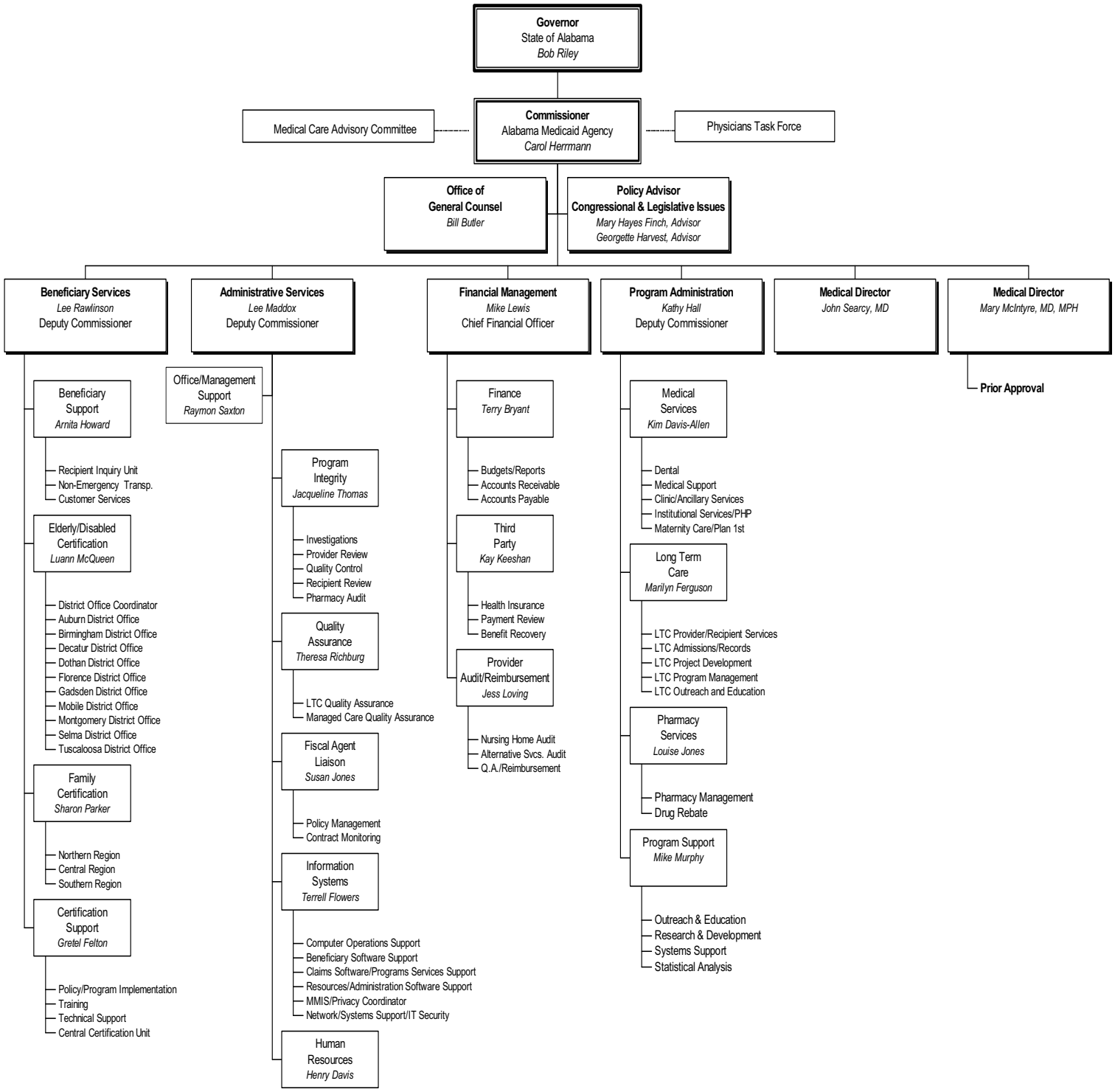
Covered Services

Medical services covered by Alabama's Medicaid program traditionally have been fewer and less comprehensive than most states'. In recent years, however, federal mandates and the Agency's own initiatives have expanded and improved the overall program. Alabama's program is aimed at providing the best possible health care to the greatest number of low-income people at the most affordable cost to the taxpayers.

How the Program Works

For many years Medicaid recipients were issued monthly paper cards signifying their eligibility. In November 1992, the Agency converted to plastic cards that are issued on a more permanent basis. It is the option of providers to accept Medicaid recipients as patients, and it is the responsibility of the providers to verify eligibility when delivering care to recipients. Providers include physicians, pharmacies, hospitals, nursing homes, dentists, optometrists, and others. These providers bill the Medicaid program for their services.

ALABAMA MEDICAID AGENCY



Carol Herrmann
Commissioner

Medicaid's Impact

Since its inception in 1970, Alabama's Medicaid program has had a significant impact on the overall quality of health care in the state. Medicaid has provided over four million citizens access to quality health care they could not otherwise afford.

Citizens who are not eligible for Medicaid also benefit from the program. Health care is one of the state's most important industries, and Medicaid contributes to that industry in a significant way. For instance, during FY 2003, Medicaid paid over $3 billion to providers on behalf of persons eligible for the program. The federal government paid approximately 70 percent of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services and paid taxes in the state. Using the common economic multiplier of three, Medicaid expenditures generated over $9 billion worth of business in Alabama in FY 2003.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. With the current administrative rate, almost 97 percent of the Agency's budget goes toward purchasing services for beneficiaries.

FY 2003 COUNTY IMPACT Year's Cost Per Eligible

County	Benefit Payments	Eligibles	Payment per Eligible	County	Benefit Payments	Eligibles	Payment per Eligible
Autauga	$16,923,953	7,421	$2,281	**Houston**	$60,334,039	20,804	$2,900
Baldwin	$62,027,641	19,878	$3,120	**Jackson**	$31,217,711	10,530	$2,965
Barbour	$20,719,145	7,542	$2,747	**Jefferson**	$357,799,545	117,368	$3,049
Bibb	$10,626,432	4,542	$2,340	**Lamar**	$14,157,888	3,825	$3,701
Blount	$24,810,021	8,658	$2,866	**Lauderdale**	$50,952,671	15,883	$3,208
Bullock	$11,280,599	3,943	$2,861	**Lawrence**	$18,017,319	6,521	$2,763
Butler	$20,758,546	6,811	$3,048	**Lee**	$46,621,391	17,638	$2,643
Calhoun	$80,171,704	26,129	$3,068	**Limestone**	$29,992,400	10,481	$2,862
Chambers	$25,188,980	8,431	$2,988	**Lowndes**	$10,774,112	4,659	$2,313
Cherokee	$14,989,984	5,000	$2,998	**Macon**	$20,209,093	7,200	$2,807
Chilton	$20,406,333	7,892	$2,586	**Madison**	$99,276,456	35,958	$2,761
Choctaw	$12,795,004	4,394	$2,912	**Marengo**	$18,203,686	6,577	$2,768
Clarke	$21,003,738	8,091	$2,596	**Marion**	$22,411,918	7,000	$3,202
Clay	$11,427,179	3,180	$3,593	**Marshall**	$55,763,759	18,446	$3,023
Cleburne	$8,827,022	3,220	$2,741	**Mobile**	$257,310,289	87,022	$2,957
Coffee	$27,871,288	8,807	$3,165	**Monroe**	$15,793,588	6,118	$2,581
Colbert	$32,626,489	11,433	$2,854	**Montgomery**	$140,019,000	52,023	$2,691
Conecuh	$11,802,014	4,265	$2,767	**Morgan**	$77,352,671	18,978	$4,076
Coosa	$7,375,965	2,512	$2,936	**Perry**	$15,980,043	5,167	$3,093
Covington	$30,356,551	9,749	$3,114	**Pickens**	$18,624,931	6,246	$2,982
Crenshaw	$12,619,540	3,878	$3,254	**Pike**	$24,259,478	8,812	$2,753
Cullman	$53,125,840	15,700	$3,384	**Randolph**	$16,925,769	5,296	$3,196
Dale	$28,702,508	10,371	$2,768	**Russell**	$34,133,980	12,447	$2,742
Dallas	$47,478,353	18,785	$2,527	**St. Clair**	$31,525,774	11,025	$2,859
Dekalb	$49,661,824	14,807	$3,354	**Shelby**	$31,577,413	10,702	$2,951
Elmore	$42,576,176	10,754	$3,959	**Sumter**	$14,568,671	5,752	$2,533
Escambia	$24,849,323	9,569	$2,597	**Talladega**	$58,094,311	19,850	$2,927
Etowah	$79,753,914	21,564	$3,698	**Tallapoosa**	$35,420,170	9,491	$3,732
Fayette	$14,259,635	4,118	$3,463	**Tuscaloosa**	$126,097,283	31,703	$3,977
Franklin	$25,497,988	7,704	$3,310	**Walker**	$58,624,575	16,569	$3,538
Geneva	$19,261,814	6,460	$2,982	**Washington**	$11,914,239	4,403	$2,706
Greene	$9,259,291	3,907	$2,370	**Wilcox**	$14,902,815	6,216	$2,397
Hale	$15,326,816	5,755	$2,663	**Winston**	$20,120,642	6,344	$3,172
Henry	$11,964,694	4,122	$2,903	**Other**	$3,405,711	502	$6,784

Revenue and Expenditures

In FY 2003, Medicaid paid $3,553,531,236 for health care services to Alabama citizens. Another $128,275,150 was expended to administer the program. This means that almost 97 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 2003 SOURCES OF MEDICAID REVENUE

Federal Funds	$2,644,908,890
State Funds	$1,047,444,290
Total Revenue	$3,692,353,180

FY 2003 COMPONENTS OF FEDERAL FUNDS

(net)	Dollars
Family Planning Administration	$979,855
Professional Staff Costs	$9,692,560
Other Staff Costs	$70,332,242
Other Provider Services	$2,539,065,728
Family Planning Services	$24,838,505
Total	$2,644,908,890

FY 2003 COMPONENTS OF STATE FUNDS

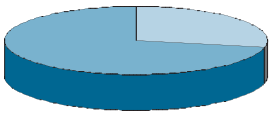
(net)	Dollars
General Fund Appropriations	$222,031,795
Public Hospital Transfers and Alabama Health Care Trust Fund	$538,526,822
Other State Agencies	$160,209,636
Drug Rebates	$28,782,562
UAB (Transplants)	$1,346,114
Miscellaneous Receipts	$21,985,627
Medicaid Trust Fund (with interest)	$74,561,734
Total	$1,047,444,290

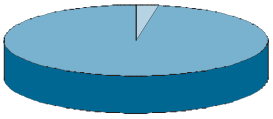
FY 2003 COMPOSITION AND DISBURSEMENT OF MEDICAID'S BUDGET

Where it comes from…Where it goes

State Funds 27.93%

Administrative Costs 3.48%





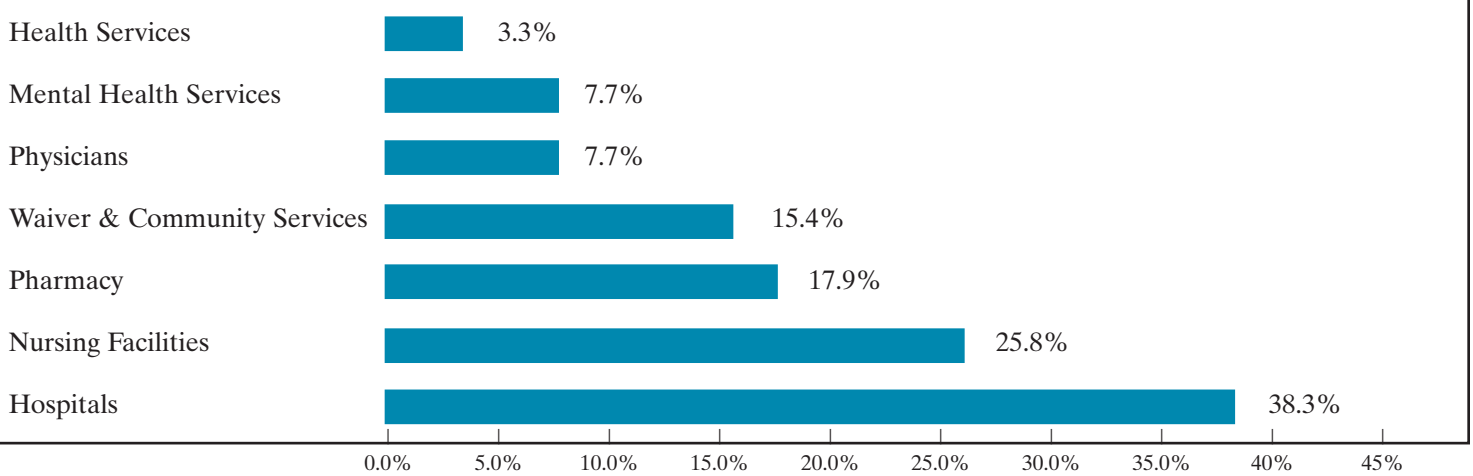
Federal Funds 72.07%

Benefit Payments 96.52%

FY 2003
EXPENDITURES By Type of Service (net)

Service	Payments	Percent of Total Payments
Hospitals:	**$1,140,733,304**	32.10%
Disproportionate Share	$353,668,355	9.95%
Inpatient	$645,956,824	18.18%
Outpatient	$106,143,133	2.99%
FQHC	$24,383,170	0.69%
Rural Health Centers	$10,581,822	0.30%
Nursing Facilities	**$766,752,234**	21.58%
Waiver Services:	**$197,301,798**	5.55%
Elderly & Disabled	$53,986,114	1.52%
Mental Health	$138,667,983	3.90%
Homebound	$4,647,701	0.13%
Pharmacy	**$534,091,480**	15.03%
Physicians:	**$228,452,044**	6.43%
Physicians	$165,148,471	4.65%
Physician's Lab and X-Ray	$29,158,613	0.82%
Clinics	$27,110,807	0.76%
Other Practitioners	$6,764,153	0.19%
MR/MD:	**$64,893,206**	1.83%
ICF-MR	$51,190,573	1.44%
NF-MD/Illness	$13,702,633	0.39%
Insurance:	**$95,843,066**	2.70%
Medicare Buy-In	$83,363,803	2.35%
PCCM	$10,915,349	0.31%
Medicare HMO	$1,213,590	0.03%
Catastrophic Illness Insurance	$351,674	0.01%
Health Services:	**$99,187,156**	2.79%
Screening	$23,839,369	0.67%
Laboratory	$15,383,074	0.43%
Dental	$40,476,145	1.14%
Transportation	$8,840,031	0.25%
Eye Care	$6,777,052	0.19%
Eyeglasses	$3,200,132	0.09%
Hearing	$493,772	0.01%
Preventive Education	$177,581	0.00%
Community Services:	**$260,937,495**	7.34%
Maternity Program	$113,601,103	3.20%
Home Health/DME	$39,919,683	1.12%
Family Planning	$27,625,193	0.78%
Targeted Case Management	$50,071,416	1.41%
Hospice	$29,720,100	0.84%
Mental Health Services	**$165,339,453**	4.65%
Total For Medical Care	$3,553,531,236	100.00%
Administrative Costs	$128,275,150	
Net Payments	$3,681,806,386	

FY 2003
BENEFIT PAYMENTS PERCENT DISTRIBUTION



POPULATION

The population of Alabama grew from 4,040,587 in 1990 to 4,419,280 in 2000. In 2003, Alabama's population was estimated to be 4,564,479. Because of increases in Medicaid coverage in recent years, the segment of the population eligible for Medicaid services has risen from 10.4 percent in FY 1990 to 19.9 percent in FY 2003.

More significant to the Medicaid program now and in the future is the rapid growth of the elderly population. Census data show that, in the United States, the 65 and older population grew twice as fast as the general population from 1970 to 1990. This trend is reflected in population statistics for Alabama. Population projections published by the United States Census Bureau reveal that between the year 2000 and the year 2025, the over 65 population will grow from 582,000 to 1,069,000 in Alabama. The Center for Demographic Research at Auburn University Montgomery reports that white females 65 years of age and older account for almost one-half of the elderly population in the state. Historically, Medicaid's costs per eligible have been higher for this group than for other groups of eligibles.

FY 2001-2003
POPULATION
Eligibles as a Percent of Alabama Population by Year

	Population	Eligibles	Percent
2001	4,486,580	802,215	17.9%
2002	4,526,059	860,107	19.0%
2003	4,564,479	906,948	19.9%

Note: The FY 2003 Eligibles include 116,319 Plan First Eligibles

Eligibles and Recipients

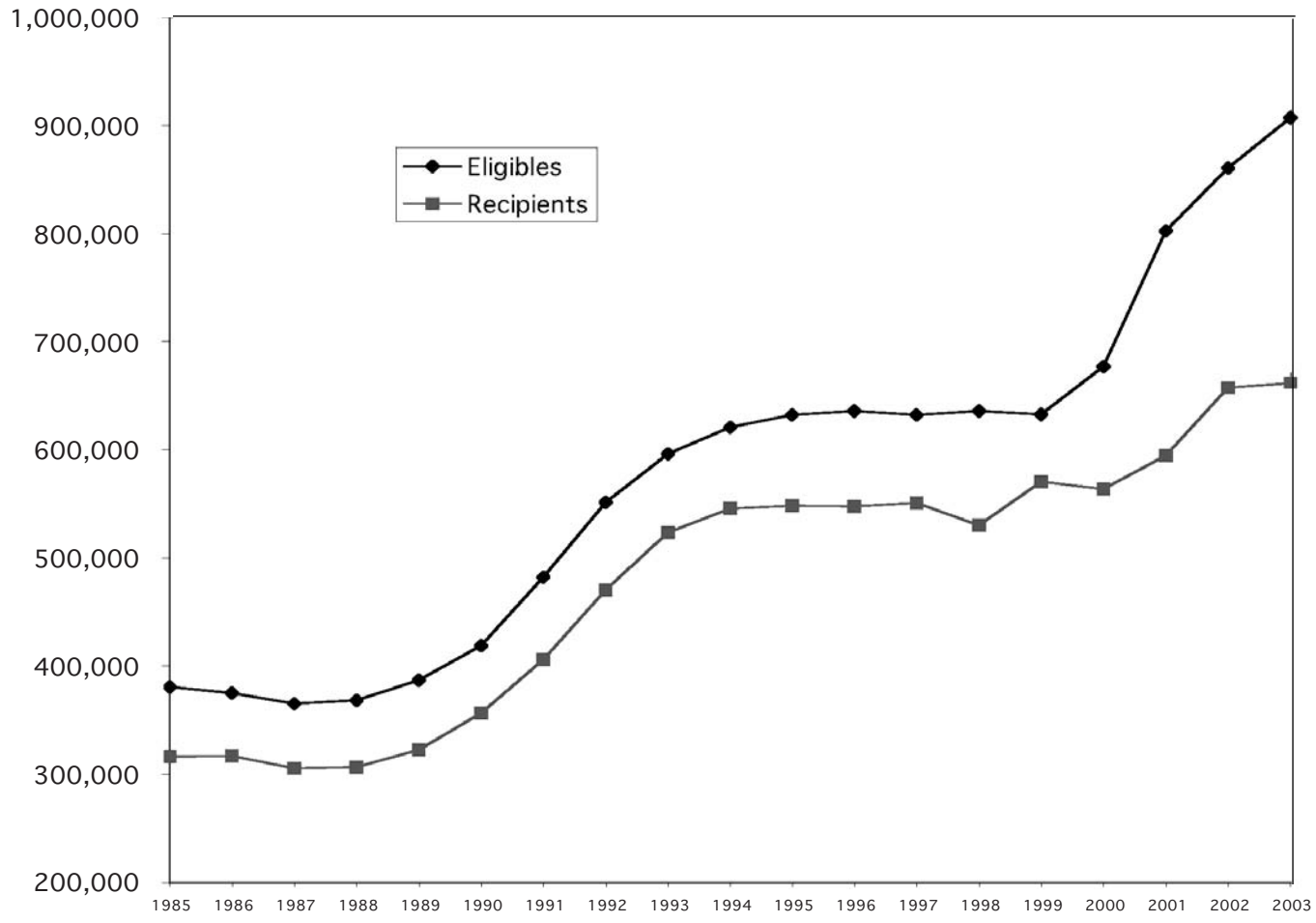
During FY 2003 there were 906,948 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 704,155. The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

Of the 906,948 persons eligible for Medicaid in FY 2003, about 77 percent actually received care for which Medicaid paid. These 699,989 persons are referred to as recipients. The remaining 206,959 persons incurred no medical expenses paid for by Medicaid. Many of these individuals who had no medical expenses paid for by Medicaid were partial eligibles such as Qualified Medicare Beneficiaries (QMBs) only or Specified Low-income Medicare Beneficiaries (SLMBs) only.

FY 2003
ALL ELIGIBLES
MONTHLY COUNT

October '02	746,376
November	745,022
December	744,903
January '03	743,846
February	749,731
March	757,620
April	759,139
May	760,101
June	760,527
July	761,433
August	769,360
September	770,516

FY 1985 - 2003
MEDICAID ELIGIBLES AND RECIPIENTS



FY 2003
MEDICAID ELIGIBLES BY CATEGORY

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	PLAN FIRST	TOTAL
Autauga	1,044	263	1,301	3,274	304	6	300	929	7,421
Baldwin	1,048	767	3,179	9,970	945	32	1,142	2,795	19,878
Barbour	846	442	1,574	3,180	369	14	312	805	7,542
Bibb	337	231	991	1,910	216	4	234	619	4,542
Blount	764	443	1,211	4,269	493	5	597	876	8,658
Bullock	358	295	821	1,754	177	5	109	424	3,943
Butler	559	438	1,248	3,004	416	10	383	753	6,811
Calhoun	2,759	983	4,927	11,088	1,236	55	1,311	3,770	26,129
Chambers	1,263	570	1,401	3,274	467	21	573	862	8,431
Cherokee	510	268	777	2,228	330	8	342	537	5,000
Chilton	905	337	1,281	3,444	444	10	525	946	7,892
Choctaw	426	326	866	1,779	212	5	234	546	4,394
Clarke	1,084	474	1,645	3,066	407	12	412	991	8,091
Clay	168	253	511	1,372	231	4	258	383	3,180
Cleburne	366	141	508	1,389	184	3	270	359	3,220
Coffee	832	591	1,463	3,845	509	10	527	1,030	8,807
Colbert	619	507	1,994	5,334	614	12	697	1,656	11,433
Conecuh	588	225	837	1,745	248	6	218	398	4,265
Coosa	225	128	563	980	176	3	180	257	2,512
Covington	877	659	1,633	4,133	671	13	736	1,027	9,749
Crenshaw	289	311	668	1,675	271	1	256	407	3,878
Cullman	731	1,006	2,437	7,306	1,079	21	1,215	1,905	15,700
Dale	1,265	510	2,011	4,504	483	14	462	1,122	10,371
Dallas	2,739	1,019	4,765	6,792	779	24	668	1,999	18,785
Dekalb	1,359	924	2,092	7,067	912	12	931	1,510	14,807
Elmore	985	518	2,194	4,894	407	13	407	1,336	10,754
Escambia	836	457	1,445	4,683	445	14	410	1,279	9,569
Etowah	1,374	1,214	4,713	8,933	1,250	34	1,377	2,669	21,564
Fayette	481	250	756	1,629	251	4	272	475	4,118
Franklin	800	427	1,198	3,483	509	3	521	763	7,704
Geneva	602	406	1,147	2,643	521	7	497	637	6,460
Greene	471	259	843	1,592	144	9	105	484	3,907
Hale	374	410	1,103	2,559	221	9	232	847	5,755
Henry	448	310	678	1,625	326	7	287	441	4,122
Houston	1,844	979	3,803	9,505	1,102	23	1,044	2,504	20,804
Jackson	769	610	1,795	4,735	713	16	716	1,176	10,530
Jefferson	15,927	5,024	24,618	45,796	4,873	154	5,407	15,569	117,368
Lamar	320	265	627	1,525	298	8	284	498	3,825
Lauderdale	948	836	2,883	6,860	906	11	993	2,446	15,883
Lawrence	477	372	1,117	2,729	427	8	433	958	6,521
Lee	1,672	604	2,871	8,089	637	24	640	3,101	17,638
Limestone	672	581	1,734	4,856	573	16	539	1,510	10,481
Lowndes	704	249	911	1,967	173	6	117	532	4,659
Macon	1,280	350	1,278	2,799	234	6	163	1,090	7,200
Madison	4,471	1,551	6,264	15,456	1,451	47	1,326	5,392	35,958
Marengo	712	428	1,462	2,612	318	6	220	819	6,577
Marion	429	435	1,033	3,110	499	7	530	957	7,000
Marshall	1,544	1,044	3,025	8,946	980	18	1,115	1,774	18,446
Mobile	14,214	3,214	14,795	37,481	2,906	105	3,047	11,260	87,022
Monroe	504	327	1,067	2,875	280	8	299	758	6,118
Montgomery	8,846	2,074	9,993	21,367	1,700	62	1,355	6,626	52,023
Morgan	1,115	978	3,356	9,165	966	35	978	2,385	18,978
Perry	885	358	1,174	1,855	188	3	130	574	5,167
Pickens	576	443	1,360	2,428	268	7	270	894	6,246
Pike	1,032	459	1,676	3,634	337	18	362	1,294	8,812
Randolph	652	308	809	2,271	306	9	331	610	5,296
Russell	2,208	604	2,179	4,873	548	21	544	1,470	12,447
St. Clair	1,096	434	1,646	5,385	505	11	586	1,362	11,025
Shelby	854	446	1,705	4,854	549	5	661	1,628	10,702
Sumter	1,291	353	1,128	1,958	184	9	151	678	5,752
Talladega	2,008	781	4,419	8,103	1,057	69	1,068	2,345	19,850
Tallapoosa	811	677	1,951	3,994	530	12	553	963	9,491
Tuscaloosa	2,496	1,447	6,620	13,650	1,022	43	1,216	5,209	31,703
Walker	926	808	3,530	7,402	765	19	890	2,229	16,569
Washington	579	232	823	1,764	199	7	246	553	4,403
Wilcox	804	390	1,694	2,277	235	12	128	676	6,216
Winston	607	395	1,086	2,728	449	3	434	642	6,344
Youth Services	5	0	0	497	0	0	0	0	502
STATEWIDE	101,610	44,418	169,213	387,969	42,425	1,218	43,776	116,319	906,948

FY 2003
ELIGIBLES
PERCENT OF POPULATION ELIGIBLE FOR MEDICAID

Comparison of Eligibles and Payments

The percent distribution of Medicaid payments has changed very little from last year. Most payments are made on behalf of eligibles in the aged or disabled categories, females, whites, and persons 65 years of age and older.

The largest group of eligibles is the SOBRA group, which covers low-income pregnant women and children. Alabama Medicaid pays for about one half of all pregnancy-related services in the state, and over 50 percent of children in Alabama less than six years of age are enrolled in the program. However, even at 45 percent of all Medicaid Eligibles, the SOBRA group of eligibles accounts for only 25 percent of Medicaid expenditures. Another group that covers parents and their children is Medicaid for Low-Income Families (MLIF).

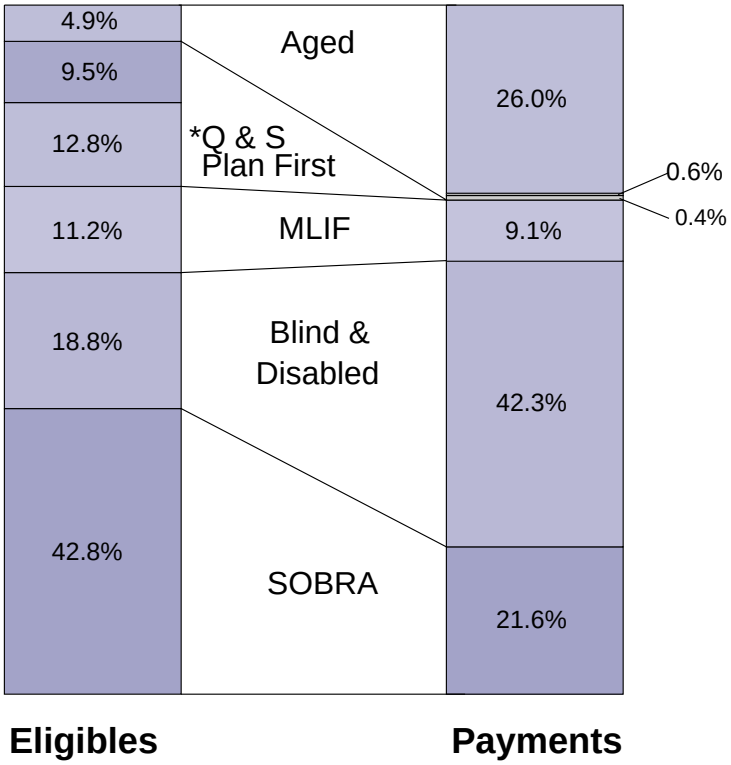
When combined, these two groups that cover families account for 57% of the Medicaid population, but only 35 % of the payments. Other eligibles, such as QMB, SLMB, and Plan First comprise a total of over 23% of Medicaid Eligibles, while only one percent of payments for services are made on their behalf. This is because these groups do not receive full Medicaid. OMB's and SLMB's qualify to have their Medicare premiums, deductibles, or coinsurance paid for by Medicaid. Plan First eligibles receive family planning services only.

The structure of Medicaid covered services has been designed to meet the diverse need of our beneficiaries. For example, pregnant women require prenatal and maternity care, while children require services such as immunizations, well-child care, and primary care services. Children with special needs may also need home-based care, medical equipment, and in some cases, institutional care. Adults with disabilities may need personal attendants and other supportive services to remain independent. Frail elderly individuals may require home health care or nursing facility care. Medicaid covers a broad range of services to meet all these needs. Primary care services and pregnancy related services are much less costly than the specialty care required for disabled or elderly individuals. Many of the services included in the Medicaid program, particularly costly long-term nursing facility care, are not covered by private health insurance or Medicare.

FY 2003
Eligibles and Payments
Percent Distribution

By Category Of Aid

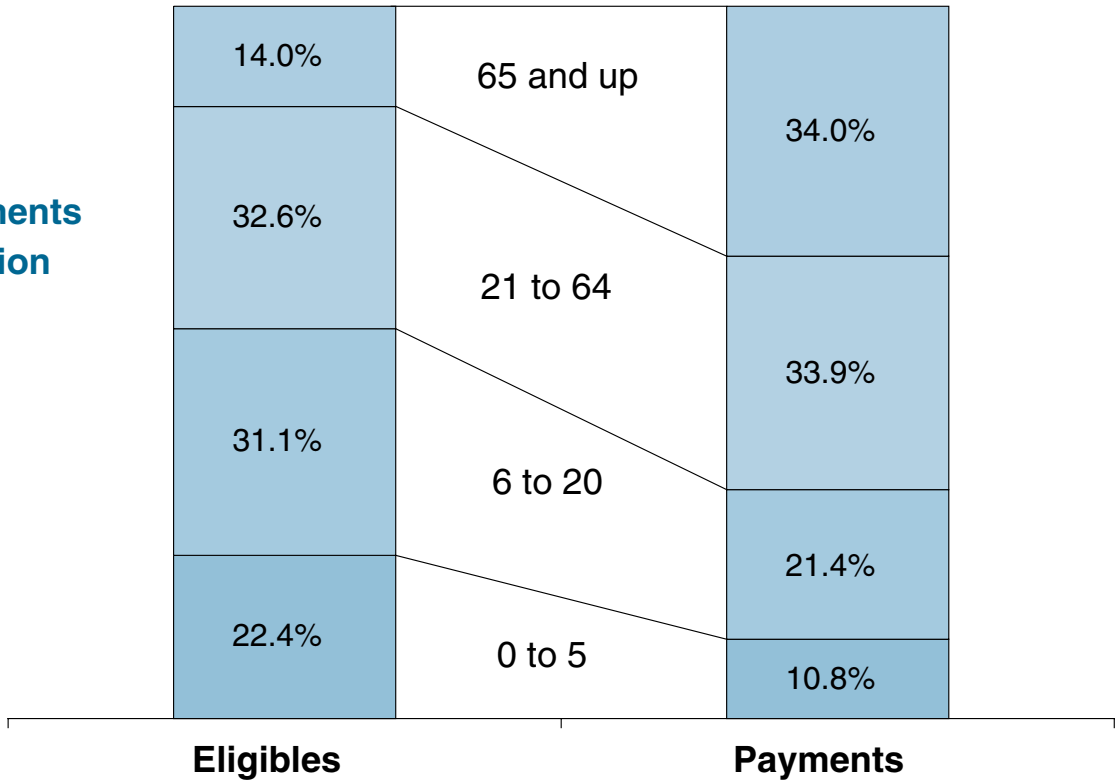
* QMB & SLMB



FY 2003

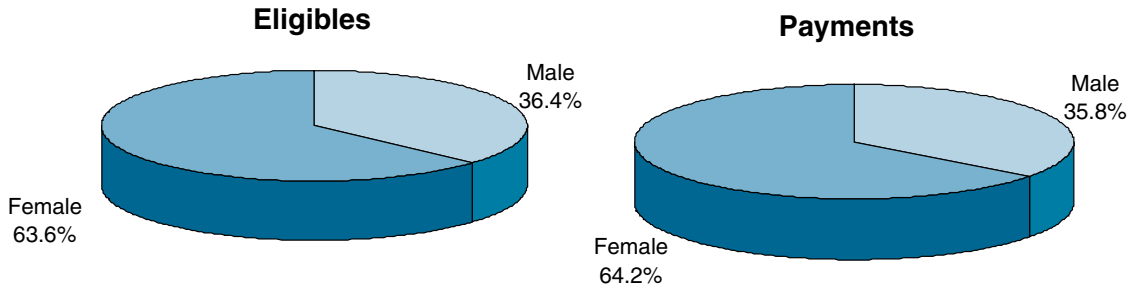
Eligibles and Payments Percent Distribution

By Age



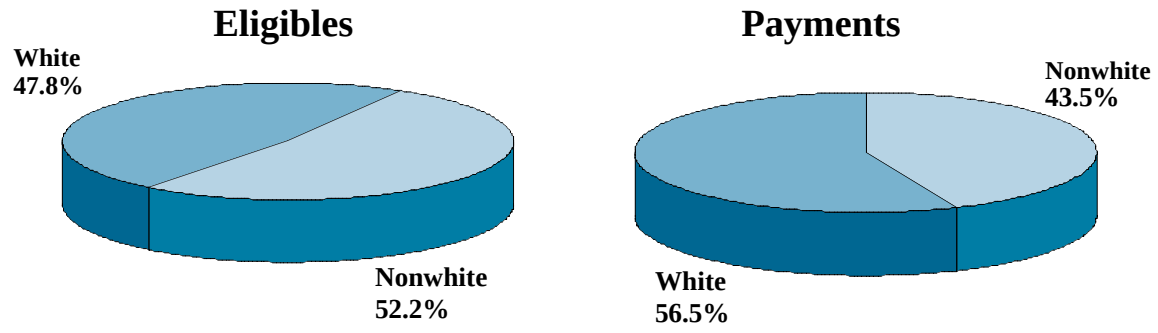
FY 2003 Eligibles and Payments

Percent Distribution by Gender



FY 2003 Eligibles and Payments

Percent Distribution by Race



FY 2003
TOTAL PAYMENTS
By County of Recipient (in millions of dollars)

Use and Cost

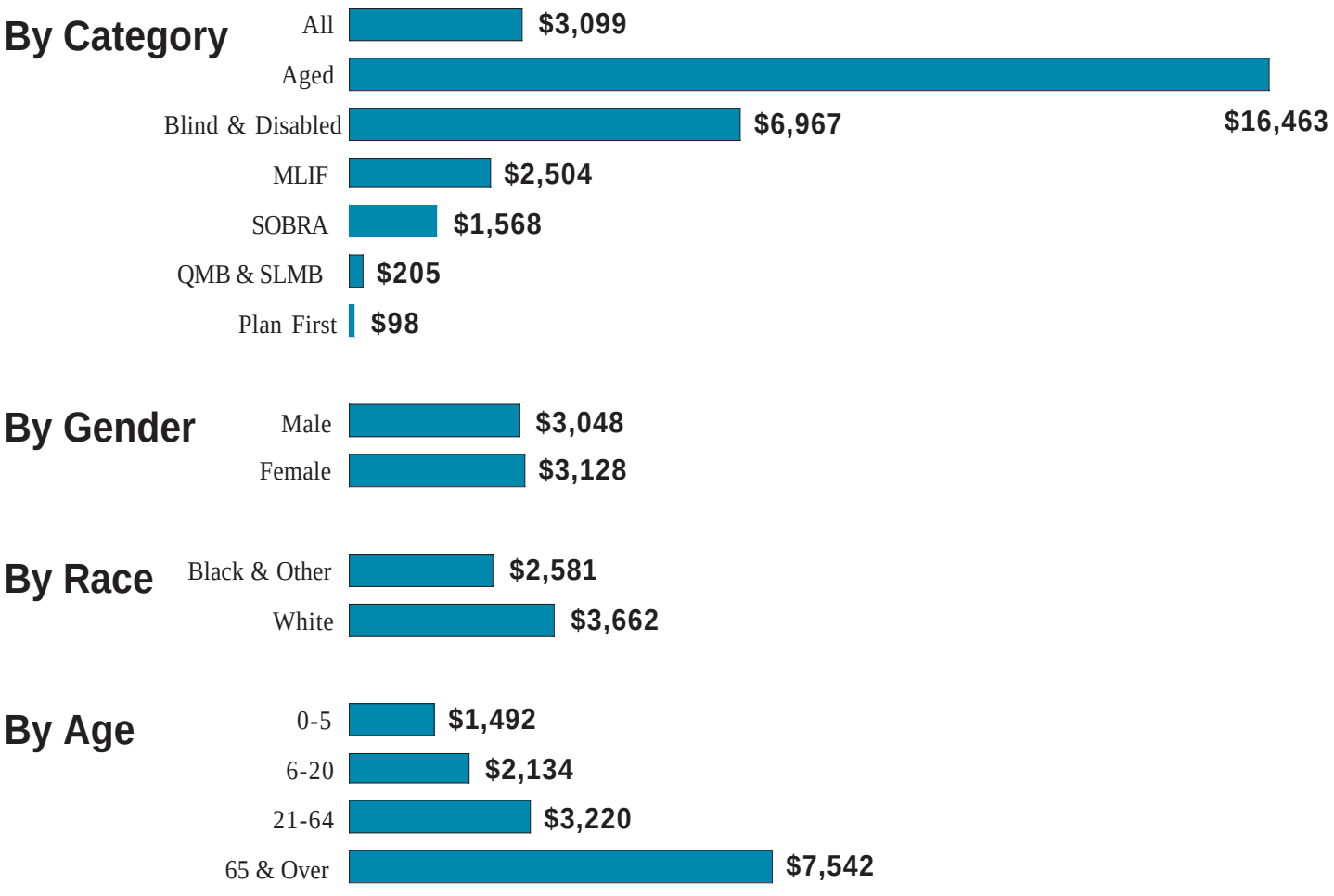
A useful way to compare costs of different groups of Medicaid eligibles and predict how changes in eligibility and utilization will impact Medicaid is to measure cost per eligible. This measure is determined by dividing total payments for services by the total number of persons eligible during the year.

Statistics reveal that certain groups are much more expensive to the Medicaid program than others. The reason for the difference is that some groups tend to need more expensive services. Any Medicaid eligible may receive, within reasonable limitations, medically necessary services.

A good example of this is the pattern of use of long-term care. This type of care has a high cost per unit of service, and recipients of long-term care have a high frequency-of-service rate. The average Medicaid payment for a day of long-term care in FY 2003 was $92. The yearly average number of days for recipients of this service was 276. Most recipients of long-term care are white females who are categorized as aged or disabled and are 65 years of age and over. It is not surprising that these groups have a large percentage of Medicaid payments made on their behalf.

Some low-income Medicare beneficiaries are eligible to have their Medicare premiums, deductibles, and coinsurance covered by Medicaid. For Part B coverage, Medicaid in FY 2003 paid a monthly buy-in fee to Medicare of $58.70 per eligible Medicare beneficiary. The Medicaid Agency also paid from $300 to $351 per month Part-A buy-in premiums for certain Medicare eligibles. Medicaid paid over $136 million in Medicare buy-in fees in FY 2003. Paying the buy-in fees is cost effective for Medicaid because, otherwise, the Agency would incur the full payment for medical bills instead of only covering the premiums, deductibles, and coinsurance.

FY 2003
COST PER ELIGIBLE
By Category, Gender, Race, and Age



Cost Avoidance and Recoupments

Program Integrity

The Program Integrity Division of the Alabama Medicaid Agency is tasked with identifying fraud and abuse of Medicaid benefits by both health care providers and recipients. Computer programs are used to identify unusual patterns of utilization of services. Medical desk reviews are conducted on those providers and recipients whose medical practice or utilization of services appears outside established norms. Additionally, the division performs follow-up on referrals made from many internal and external sources, including calls made to the Medicaid Fraud Hotline.

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

PROVIDER REVIEWS FY 2003	
Medical Providers Reviewed	**180**
Pharmacies Reviewed	**141**
Medical Provider Recoveries	**$1,317,747**
Potential Recoveries Identified	**$1,177,205**

Corrective actions include recoupment of funds, education on proper billing procedures, and peer review by appropriate licensing authorities. There were 180 reviews completed in FY 2003 and recoupments for this period totaled over $1.3 million.

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

The Investigations Unit within the Program Integrity Division is charged with identifying criminal fraud or abuse as related to providers and recipients through on-site investigations, interviews, and electronic evidence gathering. Completed cases are then referred to appropriate law enforcement agencies, Medicaid's Utilization Review Committee, or to State Licensing Boards for appropriate action. During FY 2003, five previously referred cases were adjudicated along with 75 cases investigated and closed, and three referrals for prosecution.

When a recipient review indicates a pattern of over or misutilization of Medicaid benefits, the recipient is placed in the Agency's Restriction Program for management of his medical condition. The recipient is locked in to a physician who is responsible for primary care. Referrals to specialists are allowed if they are made by the recipient's primary care physician. The recipient is also restricted to one pharmacy for obtaining medications. Additional limitations may be placed on the recipient's ability to obtain certain drugs. Follow-up reviews are performed annually.

Since October 1, 2002 Medicaid benefits have been suspended for 38 recipients. At the end of FY 2003, a total of approximately 2,000 recipients were suspended from the Medicaid program for fraud and/or abuse.

Through the Quality Control Unit, the Medicaid Agency makes sure eligibility determinations are as accurate as possible. In-depth reviews of eligibility determinations are performed on a random sample of Medicaid eligibles. If a state's payment error rate exceeds three percent, the Centers for Medicare and Medicaid Services (CMS) may impose a financial sanction. The Agency's most recent error rate was within a comfortable margin below the three percent maximum for the six-month period from October 2002 to March 2003. Nationally, Alabama has consistently been among those states with the lowest payment error rates.

RECIPIENT REVIEWS FY 2003
Reviews Conducted 523
Monthly Average # of Restricted Recipients 330
Cost Avoidance $200,746

Prior Authorization Program

The primary mission of the Prior Authorization Program (PA) is to ensure that only medically necessary services are provided in a cost-effective manner. The program also takes care to ensure that medically necessary services are not denied to recipients. Requests for prior authorization are processed in a timely manner.

Constantly seeking increased efficiency, responsibilities within the unit are periodically reassigned to personnel within the unit. This promotes cross

training so that all personnel within the unit may assist all providers.

The program continues to increase its emphasis on quality assurance. Staff makes visits to providers and recipients to determine the quality and necessity of approved services. Providers are monitored for unusual and inappropriate submission of PA requests. Findings are reported to appropriate units in Medicaid. The program works with other units in identifying, researching and resolving various issues.

Third Party Coordination of Benefits

Federal regulations require state Medicaid agencies to identify other payers (third party payers) that may be available to pay for the care and services provided to Medicaid recipients and ensure that Medicaid pays secondary to those payers. In Alabama, this effort is conducted by Medicaid's Third Party Division. This coordination of benefits program has been successful in saving Alabama taxpayers hundreds of millions of dollars since its inception in 1970. These savings have been achieved through a combination of cost avoidance of claims where providers file with the primary payer first, direct billing by the Third Party Division to third party payers to obtain health insurance benefits payable for services paid by Medicaid, and continuation of private health insurance which avoids future Medicaid costs. The Third Party Division realizes other program savings through estate recovery and liens activity, establishment and monitoring of Medicare and other third party edits, and recoupments from certain established trusts as well as from beneficiaries of incorrectly paid claims due to ineligibility.

Health Insurance Resources

In FY 2003, the Third Party Division's insurance database indicated approximately 130,000 individuals were covered by health insurance other than Medicare and Medicaid. The Third Party Division is responsible for identification, verification, and documentation of health insurance resources as well as establishment of claims processing edits so that claims are submitted to the primary payer before Medicaid makes payment. When primary coverage is identified after Medicaid makes payment, the Third Party Division seeks reimbursement from the primary coverage. Through a combination of cost avoidance and collection of health insurance benefits (other than Medicare), Medicaid's Third Party Division saved Alabama taxpayers over $83 million in FY 2003.

Trauma Resources

Medicaid also looks for potential third party payers when a Medicaid recipient receives treatment for an injury. Third party sources of payment include homeowner's, automobile, malpractice and other liability insurance as well as court-order restitution. Once these resources are identified, the Third Party Division then seeks reimbursement of its payment for medical bills related to a recipient's injury. In FY 2003, Medicaid collected in excess of $1.5 million from third party payers for trauma-related claims.

Liens / Estate Recovery

State Medicaid programs are required to recover the costs of nursing facility and other long-term care services from the estates of Medicaid recipients. In addition, Medicaid seeks reimbursement of correctly paid claims from estates and income trusts of Medicaid recipients. As a result of the efforts of the Third Party Division's Liens / Estate Recovery Program, Medicaid collected over $4.1 million in FY 2003.

Recipient Recovery

Medicaid recovers funds from individuals who received Medicaid services for which they were not entitled. In most instances, these cases involve individuals who, through neglect or fraud, did not report income or assets to their eligibility caseworkers. The Third Party Division's Recoupments Unit identifies these cases from complaint reports submitted by the individual's caseworker. In FY 2003, Medicaid received reimbursement of over $1 million from these type cases.

Premium Payment

Federal regulations allow Medicaid to pay health insurance premiums for individuals when it is cost effective to do so. Continuation of an individual's health plan ensures savings to the Medicaid program by deferring costs to the primary payer. Alabama Medicaid's Health Insurance Premium Payment Program (HIPP) accepts applications from individuals who have high cost medical conditions and cannot continue to pay their health plan premiums due to job loss, medical leave, etc. Individuals enrolled in this program include pregnant women, cancer and HIV patients, and low birth weight and preterm babies. In FY 2003, Medicaid paid premiums for approximately 155 individuals each month, resulting in savings to Medicaid of over $2 million.

Medicare Resources

Medicare is also a primary payer to Medicaid, and Medicaid's Third Party Division is responsible for ensuring that Medicare coverage is maximized. Medicaid purchases Medicare Parts A and B coverage for eligible beneficiaries and the Third Party Division monitors the payment of premiums for this coverage. In addition, the Third Party Division ensures that Medicare is a primary payer to Medicaid through establishment and monitoring of Medicare claims processing edits. In FY 2003, system edits denied almost $18 million in claims that were filed to Medicaid as the primary payer, and Medicaid recouped almost $5 million in claims that should have been filed to Medicare as the primary payer. Medicaid costs were further reduced as a result of payments by Medicare to providers in excess of $645 million for Medicaid covered services.

Summary

As a result of coordination of benefits efforts by providers and Medicaid's

Third Party Division staff in FY 2003, the Alabama Medicaid program saved in excess of $115 million in claims costs by deferring those costs to the appropriate primary payers.

Agency Audit

Fiscal Agent/Systems Audit

The Fiscal Agent Liaison Division/Contract Monitoring Unit monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews of forced claims, denied claims, processed refunds and adjustments are also performed. In addition, targeted reviews of claims are performed when potential systems errors are found. During this fiscal year, approximately 6,802 claims were manually reviewed and $92,400 was identified for recoupment.

Provider Audit/Reimbursement

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

Nursing Home Audit conducts on-site financial audits and makes necessary adjustments to the reported costs. This adjustment information is provided to reimbursement specialists, who adjust current payment rates, recoup overpayments and make up for underpayments. An in-depth, on-site audit of all nursing home facilities, home offices, and all ICF/MR facilities is completed as necessary. During FY 2003, this unit completed 28 audits. Both positive and negative adjustments are made to insure that all reimbursable costs are included and that all non-reimbursable costs are removed from provider per diem rates. If it is determined that a provider may be intentionally filing a fraudulent cost report, or if the provider continues to claim known unallowable costs in the reimbursement cost total, the Nursing Home Audit section provides the Attorney General's Medicaid Fraud Control Unit with the information.

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

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

FY 2003
COLLECTIONS AND MEASURABLE COST AVOIDANCE

COLLECTIONS

DRUG REBATE PROGRAM The collection of rebates plus interest by the Fiscal Division from drug manufacturers for the utilization of their products.	$102,987,398
THIRD PARTY COORDINATION OF BENEFITS Includes reported and estimated third party collections by providers, retroactive Medicare recoupment from providers, and collections due to health and casualty insurance, estate recovery, and misspent funds resulting from eligibility errors.	$24,624,685
PROGRAM INTEGRITY DIVISION	
Provider Recoupments	$1,317,747
Pharmacy Recoupments	$51,658
FISCAL AGENT/SYSTEMS AUDIT DIVISION	
Claim Corrections	$92,400
TOTAL COLLECTIONS	***$129,073,888***

MEASURABLE COST AVOIDANCE

PRIOR APPROVAL AND PREPAYMENT REVIEW Results from prior authorization denials for various services/items requiring prior approval and not meeting medically needed criteria such as DME, Private Duty Nursing, Inpatient Admissions or continued stays in specialized psychiatric hospitals (under 21 years of age or over age 65).	$3,965,646
THIRD PARTY CLAIM COST AVOIDANCE SAVINGS	
Provider Reported Collections - Medicare	$645,156,435
Provider Reported Collections - Health and Casuality Insurance	$23,950,925
Claims denied and returned to providers to file Medicare.	$17,990,516
Claims denied and returned to providers to file health casualty insurance.	$46,884,784
Health Insurance Premium Payment Cost Avoidance	$2,287,398
WAIVER SERVICES COST AVOIDANCE - ELDERLY AND DISABLED	$140,823,112
WAIVER SERVICES COST AVOIDANCE - HOMEBOUND	$7,474,632
WAIVER SERVICES COST AVOIDANCE - MR/DD	$543,984,336
TOTAL MEASURABLE COST AVOIDANCE	***$1,432,517,784***
GRAND TOTAL	**$1,561,591,672**

Medicaid Management Information System

The Agency's Information Systems (I/S) Division maintains recipient eligibility and provider information, keeps track of all Medicaid program expenditures, and furnishes data through reports, charts, graphs, spreadsheets, documents, files and databases to its management and administrators and other outside entities as needed to assist them and to monitor the program.

Major projects completed by the Information Systems Division during FY2003 included implementation of the new MLIF (Medicaid for Low-Income Families) program. To incorporate this new program into the Eligibility System, modifications were required to the SOBRA online system to allow for the new state aid categories, deprivation reason codes, and tracking codes. This required expansion of our existing files and the recompiling of all mainframe programs using the eligibility file. Another major project included compliance with HIPAA, the Health Insurance Portability and Accountability Act signed into federal law August 21, 1996. Compliance by Alabama's Medicaid Agency included major changes to many of Medicaid's computer functions performed by its contracted fiscal agent Electronic Data Systems (EDS). I/S staff have also performed many tasks, independent of EDS, in order to meet HIPAA compliance requirements. In-house online screens identified as having private health information (PHI) are now restricted. All laser letter self-mailers that contain PHI data were modified to now contain a "PHI" message, as required by law. A new HIPAA-compliant transaction code set was created to provide electronic eligibility matching between Medicaid and various state agencies and other outside providers. Programs were created and run to generate address information for new Notice of Privacy Practices (NPP) that now runs monthly, password protection was added to database systems not previously protected, and various summary reports were generated to help identify HIPAA costs.

Other major projects completed this fiscal year by the Information Systems Division included the closing out of a federal program, the Qualifying Individual II Program, which required changes to eligibility software, and expansion of the Eligibility File to add fields for Buy-in Part A and Part B begin and end dates. The SDX (States Data Exchange) master file was expanded to accommodate a newly expanded federal file, which required modifications to all of the online and batch software for that system. A new process was developed to be used as needed to audit the N.E.T. (Non-Emergency Transportation) program for efficiency and cost effectiveness, and a pilot project was completed to oversee implementation of newly purchased software and hardware to be used in the near future to create GUI (graphical user interface) screens over existing CICS online screens.

I/S staff assisted the Agency's eligibility divisions and units, including in-house workers and out-stationed SOBRA and District Office workers by implementing an Agency Call Center, creating reports for newly implemented programs such as the recently created Breast and Cervical Cancer Program, and expanding our sponsor/client notices generated for District Offices to include the"1-800" Call Center phone number to make it easier for recipients to contact Medicaid.

Work to assist users, speed up work processes and increase security was also accomplished this year. Staff assisted the Financial Management Division by creating requested AS/400 files to transfer to desk top computers and modified selection criteria on specific reports as needed. Appropriate changes were made throughout the year to the Time and Attendance Report for Personnel. Other projects included acute care comparison reports for Long Term Care, archiving user work requests on our online I/S Projects System, assisting the N.E.T. program in changing the way vouchers are captured and reported to banks, providing Internal Audit requested reports as needed and creating a new managed care file based on data provided monthly by EDS to be used in federal reporting processes.

Several annual processes were completed this year with no problems such as the annual HCPCS (Health Care Finance Administration Procedure Coding System) process, the annual transfer of account balances in the CROCS System, production of the annual EPSDT letters to parents of all Medicaid eligible children on our files, and the annual Bit-shift process. The Bit-shift process was modified to no longer purge old occurrences of data, but rather, retain that information for future reference and research efforts.

In addition to all of the above areas where I/S staff assisted the Agency and outside users, I/S staff also served on various committees and work groups throughout this fiscal year, including HIPAA work teams, ITB (Invitation to Bid) committees, task forces and pilot project teams.

Maternal and Child Health Services

During FY 2003, Medicaid served 387,969 women and children through the expanded eligibility group for pregnant women and children called SOBRA (Sixth Omnibus Budget Reconciliation Act). Coverage of this group has contributed to an improvement in Alabama's infant mortality rate since 1989, from 12.1 infant deaths per thousand births to 9.1 deaths per thousand in 2002.

Prenatal Care

Competent, timely prenatal care has proven to result in healthier mothers and babies. Timely care can also reduce the possibility of premature, underweight babies. Studies consistently show that for every dollar spent on prenatal care, approximately $3 is saved in the cost of caring for low birth weight babies.

In 1988, the Medicaid Agency implemented a policy that would allow pregnant women at or below 100 percent of the poverty level to qualify for Medicaid benefits. In April 1990, Medicaid expanded eligibility for pregnant women to 133 percent of the federal poverty level. With this expansion, prenatal care has been made available to more women than ever before. Utilization of Medicaid services can help pregnant women in two ways: the provision of adequate prenatal care to Medicaid recipients is expected to increase the likelihood of a successful outcome for both mother and child, and the family planning services that are available can help Medicaid eligible women control the size of their families.

Prenatal care for Medicaid recipients is provided through the Maternity Care Program, which includes private physicians, hospitals, public health department clinics and federally qualified health centers. Some of the maternity-related benefits covered under the Maternity Care Program are unlimited prenatal visits, medical services to include physical examinations with risk assessments, prenatal vitamins, nutritional assessments, counseling and educational services, appropriate medically indicated lab tests, and referral services as needed. Referral services include family planning services after delivery, pregnancy related referrals to specialty providers and medical services for the newborn under the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). Medically indicated procedures such as ultrasound, nonstress tests, and amniocentesis are examples of other services covered by Medicaid. In order to complete the pregnancy cycle, one postpartum checkup is covered during the 60-day postpartum period.

Adolescent Pregnancy Prevention Education

Adolescent Pregnancy Prevention Education was implemented in October 1991. The program is designed to offer expanded medically related education services to teens. The program curricula are designed to teach disease and disability prevention and to prolong life and promote physical and mental health. These classes go beyond the limited service and information offered under existing Medicaid programs. Physicians or other licensed practition-

ers of the healing arts who present detailed adolescent pregnancy material provide these services.

The pregnancy prevention services include a series of classes teaching male and female adolescents about decision-making skills and the consequences of unintended pregnancies. Abstinence is presented as the preferred method of choice. Currently there are approximately 20 providers of adolescent pregnancy prevention services. These include hospitals, county health departments, FQHCs, and private organizations.

Vaccines for Children

In an effort to increase the number of Alabama children who are fully immunized by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program in October 1994. This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations, if they obtain vaccines from a federally qualified health center or rural health clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 460,000 of Alabama's children are Medicaid eligible. Medicaid has taken the previous vaccines and administration fee costs to calculate an equivalent administration reimbursement fee of $8 per injection. When multiple injections are given on the same day, Medicaid will reimburse for the administration of each injection. When injections are given in conjunction with an EPSDT screening visit or physician office visit, the visit and each administration fee will be paid.

Providers may charge non-Medicaid VFC participants an administration fee not to exceed $14.26 per injection. This is an interim rate set by CMS based on charge data. No VFC-eligible participant should be denied services because of the inability to pay.

The Department of Public Health is the lead agency in administering this program.

Family Planning

The origin of the Family Planning Program dates back to the time when Medicaid started in Alabama. The Social Security Amendments of 1972 mandated coverage of Family Planning services for categorically needy individuals of childbearing age, including minors who are sexually active and desire such services. The law also provides for 90 percent federal funding for these services. This is a higher match than for other Medicaid services.

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

Family planning services are covered for Medicaid eligible women, including SOBRA women 10-55 years of age and men of any age who desire such services. Recipients have freedom of choice in selecting a contraceptive method and/or a provider of family planning services. Acceptance of family planning services must be without coercion or mental pressure.

Recipients are authorized one annual physical and up to four additional visits per calendar year. These visits do not count against other benefit limits. A family planning home visit is available for newly delivered mothers. This allows recipients to begin the birth control of their choice prior to the postpartum visit in the clinic. An extended contraceptive-counseling visit is also covered on the same day as the postpartum visit. Contraceptive supplies and devices available for birth control purposes include pills, intrauterine devices, diaphragms, implants, and injections. Sterilization procedures are also covered if federal and state regulations are met. HIV pre and post testing counseling services are also available if performed in conjunction with a family planning visit.

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

PLAN FIRST

Plan First, an 1115 waiver, is a collaborative effort between the Alabama Medicaid Agency and the Alabama Department of Public Health. This program extends Medicaid eligibility for family planning services to all women age 19 - 44 with incomes at or below 133 percent of the federal poverty level that would not otherwise qualify for Medicaid. The primary goal of the waiver is to reduce unintended pregnancies.

The great thing about Plan First is that the eligibles are able to receive oral contraceptives directly from their enrolled provider of choice without

having to go to a pharmacy to get a prescription filled. All other covered family planning methods are available through the pharmacy.

Also, direct services provided under this program are augmented with psychosocial assessment available to all participants and care coordination for high-risk or at risk women (lack of education, domestic violence, transportation, multiple pregnancies, first time birth control user). The purpose of these added services is to allow for enhanced education on appropriate use of chosen methods and to encourage correct and continued usage.

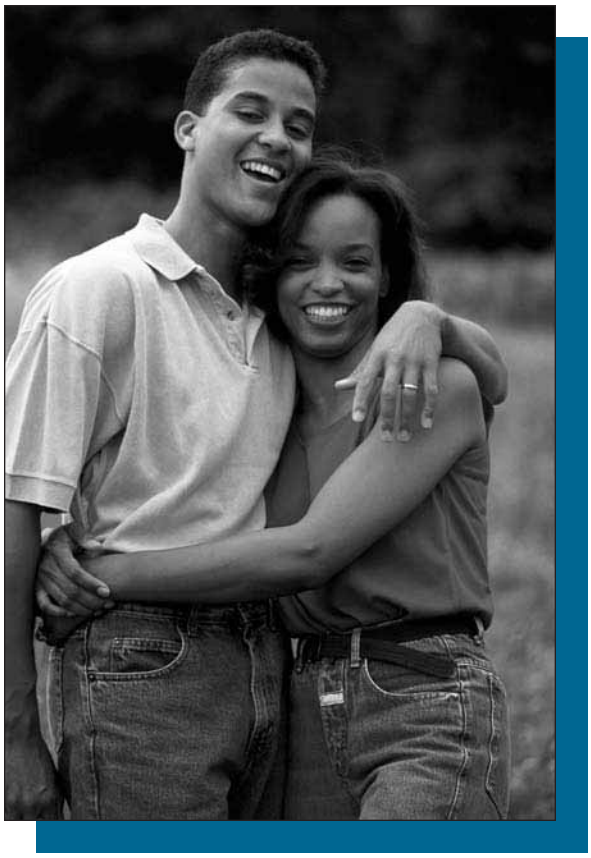
Plan First was implemented in October 2000 and at that time there were 61,971 that started with the program. As of September 2003, there were 111,101 women enrolled in the Plan First Program.

The budget neutrality calculations for this family planning waiver show that the demonstration not only has met the budget neutrality requirements, but that the Medicaid program expended dramatically less on SOBRA pregnant women and infants that it would have in the absence of the waiver. This demonstration has saved taxpayers millions of dollars since it began.

EPSDT

The Early and Periodic Screening, Diagnosis and Treatment Program is a preventive health program designed to detect and treat diseases that may occur early in a child's life. If properly used, the program can benefit both the child and the Medicaid Agency. Many health problems begin early in life and, if left untreated, can cause chronic illness and disability. When an illness is diagnosed and treated through the screening program, the child benefits through improved health. All medically necessary services to correct or improve the condition are unlimited if the condition was identified during or as a result of a screening. The Medicaid program realizes long term savings by intervening before a medical problem requires expensive acute care.

The EPSDT screening program can detect many problems before they become acute. Problems such as hypertension, rheumatic fever and other heart conditions, diabetes, neurological disorders, venereal disease, anemia, urinary infections, vision and hearing disorders, and even cases of child abuse have been detected and treated in past years. The cost of screening is relatively small - an average of $70 per screening. The cost of treating acute illness is considerably higher.



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

Currently there are more than 1,620 providers of EPSDT services, including county health departments, federally qualified health centers, provider-based rural health clinics, independent rural health clinics, hospitals, private physicians and some nurse practitioners. With statewide implementation of the Patient 1st Program, primary medical providers are obligated to ensure that all Medicaid recipients under 21 years of age receive screenings on time.

In 1995, Medicaid added an off-site component of the EPSDT program. This allows providers who meet specific enrollment protocols to offer EPSDT screening services in schools, housing projects, Head Start programs, day care centers, community centers, churches and other unique sites where children are frequently found.

Since screening is not mandatory, many parents do not seek preventive health care for their children. Steps have been taken in recent years, however, to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of intensive outreach statewide, enhancement of physicians' reimbursement for screening, and an increase in the number of screenings for which Medicaid will pay. Because of these added efforts, there have been more screenings performed. A Medicaid goal is to screen all eligible children at the appropriate intervals between birth and age 21.

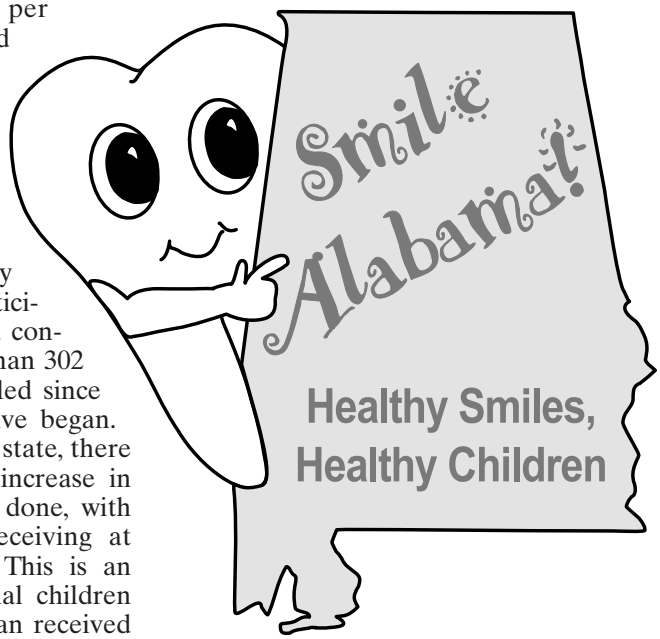
Dental Services

Medicaid pays for routine dental care for children under 21 years of age with full Medicaid eligibility through the EPSDT Program when provided by

licensed dentists who are enrolled as Medicaid dental providers. Some of the routine care available includes a cleaning every six months, x-rays, filings, extractions, root canals and crowns. Examples of dental services not covered by Medicaid include surgical periodontal and prosthetic treatments. If justified by the attending dentist, some services may be prior authorized by the Medicaid Agency. These services may include nonsurgical periodontal treatment, third and subsequent space maintainers, hospitalization and some out-of-state care.

SMILE ALABAMA!

In October 2000, Medicaid kicked off an initiative to recruit and retain a solid dental provider base for Medicaid children by asking dentists to accept at least one new Medicaid child per week. The program, named *Smile Alabama!*, is a multi-faceted campaign designed to improve access to Medicaid children for routine and preventive dental care through education, provider support, and fair reimbursement. By the end of FY 2003 the participating dental providers had continued to grow with more than 302 new dental providers enrolled since the *Smile Alabama!* Initiative began. With more providers in the state, there has been a corresponding increase in the number of procedures done, with almost 153,000 children receiving at least one dental service. This is an increase of 21,000 additional children receiving dental services than received services last year.



FY 2003
SOBRA ELIGIBLES

Recipient Inquiry Unit

Implemented in late 1992, the Recipient Inquiry Unit has increased recipients' access to the Agency via toll-free telephone service from throughout Alabama. Averaging 25,404 calls monthly during FY 2003 (more than 304,831 annually), the Inquiry Unit provides replacements for lost and stolen Medicaid cards to eligible persons, while responding to callers' questions about various eligibility, program and other topics.

Each month, approximately one-third of all calls deal with Primary Care Case Management (PCCM) provider assignments and about one-fourth are information-only calls. About 20 percent of calls deal with Medicaid card replacement and the remaining calls are referred to a certifying agency or worker (Medicaid District Offices, SOBRA workers, Social Security or the Department of Human Resources) or an Agency program office (Hospital, Physicians, and Pharmacy, among others) for action.

The hotline (1-800-362-1504) is open from 8 a.m. to 4:30 p.m. Monday through Friday. In FY 2003, the unit was staffed with four (4) full time operators and eleven (11) temporary operators.

Managed Care

Partnership Hospital Program

Hospitals remain a critical link in providing medically necessary health care to Alabama Medicaid recipients. Implemented in 1996, a managed care initiative called the Partnership Hospital Program (PHP) changed the way hospital days are reimbursed in Alabama. Through this program the state is divided into eight districts. Medicaid pays each PHP a per member, per month fee for inpatient hospital care to most Medicaid patients living in the district. While Medicaid patients are automatically enrolled in the district where they live, the patient may be admitted to any Alabama acute care hospital that accepts Medicaid as payment.

The objective of this managed care initiative is to provide inpatient hospital services to eligible Medicaid recipients through arrangements that:

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

Inpatient hospital days are limited to 16 per calendar year. However, additional days are available in the following instances:

- When a child has been found through an EPSDT screening to have a condition that needs treatment
- When authorized for deliveries (onset of active labor through discharge).

There are some instances when inpatient days are unlimited:

- Children under one year of age
- Children under age seven when in a hospital designated by Medicaid as a disproportionate share hospital.

Patient 1st

The Patient 1st Program is active statewide and serving approximately 423,000 beneficiaries. The Patient 1st Program is a primary care case management system that links each participating Medicaid beneficiary with a Primary Medical Provider (PMP). The PMP is responsible for providing care directly or through referral. Additional responsibilities include 24-hours a day/7 days a week coverage, coordination of EPSDT and immunizations, and coordination of medical needs.

The Program has been successful in meeting its goal of creating medical homes for Medicaid beneficiaries. Access to a PMP has resulted in

Patient 1st
Health Care Close To Home

reduced doctor shopping, more appropriate utilization of services, and reduced expenditures for primary care in an emergency room setting.

The focus of Patient 1st is patient and provider education. A video presentation for providers to show patients in their waiting rooms which explains the Patient 1st Program was developed. This video includes information about how to access medical care, when to go to the emergency room, and instructions on contacting their PMP before going to other physicians or places for medical care. In addition to the video, new Patient 1st beneficiaries also receive a welcome packet with helpful information about how the program works. Case management for the medically at risk is available upon referral by a PMP or dentist to assist with various social or environmental needs.

Maternity Care Program

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

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

The program will continue to ensure that eligible pregnant women receive comprehensive, coordinated, and case managed medical care appropriate to their risk status through a network established by Primary Contractors. Under this program, women are allowed to choose the Delivering Healthcare Provider of their choice to provide their prenatal care and delivery. Care Coordinators work with the women to set up a plan of care, make appropriate referrals, provide education, follow-up on missed appointments, assist with transportation, and provide other needed services.

The state has been divided into 14 districts with one Primary Contractor responsible for each district. It is anticipated that the program will serve approximately 27,000 women each year.

The Agency anticipates that this program will continue to be successful and further increase the number of good birth outcomes in the State of Alabama.

Managed Care Quality Assurance Program

The Managed Care Quality Assurance Program is responsible for monitoring and oversight of Quality Assurance Activities for Medicaid's Managed Care initiatives. During FY 2003 Medicaid's Managed Care Initiatives included:

- PHP (Partnership Hospital Program)
- PCCM (Primary Care Case Management)
- MCP (Maternity Care Program)

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

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

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

Medicare HMOs and CMPs

Medicaid continued a program in which health maintenance organizations (HMOs) and competitive medical plans (CMPs) for dual eligibles may enroll with the Medicaid agency to receive capitated per member per month payments to cover, in full, any premiums or cost sharing for beneficiaries for which Medicaid is responsible for payment of medical cost sharing.

The HMO or CMP must have an approved Medicare risk contract with CMS to enroll Medicare beneficiaries and other individuals and groups. The HMO or CMP must deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to Medicare enrollees. Medicare beneficiaries must receive Part A or Parts A&B coverage to be eligible for this program. The HMO or CMP must offer all services covered by Medicare at no cost to the beneficiary. The HMO or CMP may offer additional services to the beneficiary, such as hearing exams, annual physical exams, eye exams, etc. Services covered by Medicaid, but not Medicare, are not included. The beneficiary is given freedom of choice in selecting a primary care provider through the Medicare HMO or CMP.

Mental Health Services

Through mental health centers under contract with the Department of Mental Health and Mental Retardation, Medicaid provides services for eligible mentally ill adults and emotionally disturbed children. These services include day treatment, crisis intervention, medication checks, diagnostic assessment, pre-hospitalization screening, and psychotherapy. The program serves people with primary psychiatric or substance abuse diagnoses. There are 24 mental health centers around the state providing these services.

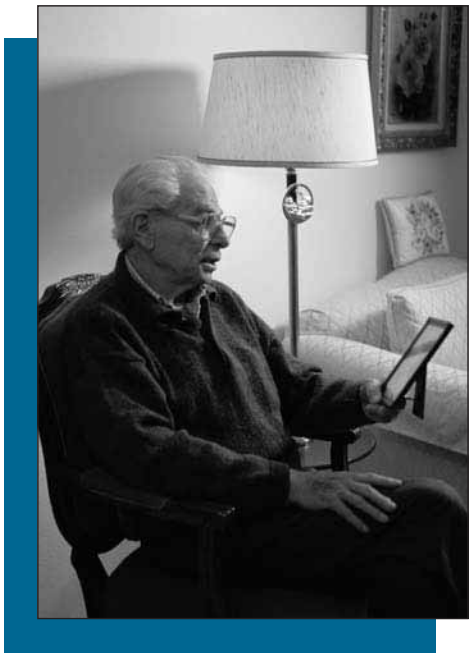
The mental health program was expanded in 1994 to allow the Department of Human Resources and the Department of Youth Services to provide rehabilitative services to the children and adolescents in their custody. DHR and DYS are presently involved in the process of implementing the provisions of federal court consent decrees (R.C. and A.W., respectively). One of the critical mandates of both suits is the maximization of federal dollars, specifically Medicaid funding. A wide array of mental health services is provided to children in state custody in a cost-effective manner.

Targeted Case Management

The optional targeted case management program assists Medicaid-eligible individuals in gaining access to needed medical, social, educational and other services through coordination, linkage, and referral. The Alabama Medicaid Agency currently serves mentally ill adults (target group 1), mentally retarded adults (target group 2), handicapped children (target group 3), foster children (target group 4), pregnant women (target group 5), AIDS/HIV positive individuals (target group 6), adult protective service individuals (target group 7), medically at risk individuals (target group 8), and technology assisted waiver (target group 9). With the addition of new providers coordinating services for these target groups, there was a reduction in nursing home placement, emergency room visits and hospitalization. Dental visits have also increased as a result of case management services. Approximately 40,000 Medicaid beneficiaries received targeted case management service this year at a cost of $45.5 million.

Home and Community Based Service Waivers

The State of Alabama has developed Home and Community Based Service (HCBS) waivers that provide alternatives to institutionalization for some Medicaid recipients. The waiver programs are aimed at helping recipients receive extra services not ordinarily covered by Medicaid in this state. Home and Community Based waiver programs serve the elderly and disabled, mentally retarded and developmentally disabled, and disabled adults with specific medical diagnoses. These programs provide quality and cost-effective services to individuals at risk of institutional care.



HCBS Waiver for the Elderly and Disabled

This waiver provides services to persons who might otherwise be placed in nursing homes. The seven basic services covered are case management, homemaker services, personal care, adult day health, respite care, companion services and home-delivered meals. During FY 2003, there were 7,636 recipients served by this waiver at an actual cost of $7,070 per recipient. Serving the same recipients in nursing facilities would have cost the state $25,512 per recipient. This waiver saved the state $18,442 per recipient in FY 2003.

People receiving services through Medicaid elderly and disabled waivers must meet certain eligibility requirements. Those served by the waiver are recipients of Supplemental Security Income (SSI) or State Supplementation who meet the medical criteria for nursing facility care financed by the Medicaid program. This waiver is administered by the Alabama Department of Public Health and the Department of Senior services.

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

This waiver serves individuals who meet the ICF/MR level of care for mental retardation or developmental disability. The services provided by the waiver are residential habilitation training, day habilitation, prevocational training, supported employment, occupational therapy, speech therapy, physical therapy, behavior management, companion service, respite care, personal care, environmental modification, specialized medical equipment and supplies, assistive technology, and skilled nursing care. During FY 2003, there were 4,941 recipients served by this waiver at an actual cost of $28,065 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $138,161 per recipient. The MR/DD waiver saved the state $110,096 per recipient in FY 2003. This waiver is administered by the Alabama Department of Mental Health and Mental Retardation.

Homebound/SAIL Waiver

The State of Alabama Independent Living (SAIL) waiver serves disabled adults with specific medical diagnoses who are at risk of being institutionalized. To be eligible an individual must be age 18 or above, and meet the nursing facility level of care. All income categories from SSI to 300 percent of SSI are included. The waiver is administered by the Alabama Department of Rehabilitation Services. The services provided under this waiver include targeted case management, personal care, respite care, environmental modification, medical supplies, personal emergency response system, assistive technology and personal assistance service. During the waiver year of 2003, there were 506 recipients served at a cost of $10,704 per recipient. Serving the same recipients in an institution would have cost the state $25,512 per recipient. During FY 2003, the Homebound Waiver saved the state $14,772 per recipient.

Home Care Services

The Medicaid home care services program helps people with illnesses, injuries, or disabilities to receive the quality of care they need at home. Through the utilization of registered nurses, licensed practical nurses, home health aides/orderlies/homemakers, physical therapists, occupational therapists, speech therapists, respiratory therapists, medical equipment and supplies, orthopedists, prosthetists, physicians, and hospices, recipients are provided services that are needed for them to remain at home and maintain their highest level of independence at a cost savings to Medicaid.

Home care services to Medicaid eligibles under the age of 21 have been greatly expanded because of the Omnibus Budget Reconciliation Act of 1989. This law states that any service necessary to treat or ameliorate a condition must be provided to any Medicaid eligible under 21 years of age as long as the condition is discovered as a result of a medical check-up through the EPSDT program. This provision of OBRA '89 has greatly increased the number of children that are served in the community. Occupational therapy, physical therapy, durable medical equipment, and other services as necessary to maintain Medicaid eligibles in the home have been available to Medicaid eligibles under 21 since April 1, 1990.

Due to changes in the health care delivery system, the demand for home care services has been increasing. Advanced medical technology has made it possible to provide more sophisticated care and equipment in the home rather than incurring the expense of institutional care. In addition, expansions mandated under the EPSDT program have made Alabama Medicaid's home care services one of the most comprehensive medical assistance programs for children in the country.

The Medicaid home care services program is based on the philosophy of family and patient participation in providing patient care. Working together, families and patients are taught care which can reasonably and safely be rendered in the home.

Hospice Care Services

Hospice care is a comprehensive home care program which primarily provides reasonable and necessary medical and support services for terminally ill individuals. The goal of hospice is not to cure a terminal illness, but rather, to provide relief of symptoms. During FY 2003, the Medicaid Agency served 2,841 hospice patients at a total cost of about $30 million.

In adding hospice services for eligible patients, the Medicaid Agency follows the same rules the Medicare program uses. Hospice services must be provided by Medicare certified hospice programs and are available for unlimited days. Hospice care through the Medicaid Agency is provided on a voluntary basis, and when it is chosen, the patient waives the right to any other services that treat the terminal illness. Services included are nursing care, medical social services, physician's services, counseling services, short-term inpatient care, medical appliances and supplies (including drugs and biologicals), home health aide services, homemaker

services, physical therapy, occupational therapy, speech language pathology services, and nursing home room and board.

Home Health and Durable Medical Equipment (DME)

Skilled nursing and home health aide services prescribed by a physician are provided to eligible recipients on a part-time or intermittent basis. These services cover preventive, restorative, and supportive care to persons who meet Medicaid home health criteria. Nursing and personal care provided under the home health program must be certified by licensed physicians and provided by home health agencies under contract with Medicaid. There were 128 agencies participating in FY 2003.

Medicaid in Alabama may cover up to 104 home health visits per year per beneficiary. Medicaid may authorize additional home health visits for beneficiaries under age 21 who have exhausted the home health benefit of 104 nursing visits per calendar year. For approval, the service must be referred from an EPSDT screening and prescribed as medically necessary by a physician. During FY 2003, over 6,000 recipients received visits costing a total of approximately $9.2 million.

Supplies, appliances, and durable medical equipment are mandatory benefits under the home health program. Medicaid recipients do not have to receive home health services to qualify for DME services, but all items must be medically necessary and suitable for use in the home. During FY 2003, over 752 Medicaid DME providers throughout the state furnished services at a cost of approximately $21.6 million.

In-Home Therapies

Physical, speech, and occupational therapy in the home are limited to individuals under 21 years of age that are referred from an EPSDT screening. If certified as medically necessary by a physician, services must be provided through a Medicaid certified home health agency. All therapy services rendered in the home require prior authorization by the Medicaid Agency.

Private Duty Nursing

Private duty nursing services in the home are covered for eligible recipients requiring continuous skilled nursing care. The services are available only for recipients under age 21 and prescribed as a result of an EPSDT screening referral. Private duty nursing care is provided in a recipient's home. The service also may be provided to the recipient in other settings when activities such as school or other normal life activities take him or her away from the home. Private duty nursing services are covered for Medicaid recipients who have medical problems that require education of the primary caregiver and/or stabilization of the recipient's medical problem or problems. For

Medicaid coverage, at least four hours of continuous skilled nursing care are required per day.

Private duty nursing services must be prior authorized by Medicaid. All services require monitoring on a regular basis, generally every 60 days, with the physician providing recertification of the continuing need for care. During FY 2003, Medicaid paid approximately $2.3 million for services provided through 46 private duty-nursing providers.

FY 1999-2003
HOSPITAL PROGRAM
Outpatients

	FY '99	FY 2000	FY 2001	FY 2002	FY 2003
Number of outpatients	190,517	218,078	245,726	322,818	328,029
Percent of eligibles using outpatient services	29%	32%	31%	38%	36%
Annual expenditure for outpatient care	$36,482,841	$36,141,056	$44,166,407	$50,376,944	$58,034,730
Cost per patient	$191	$166	$180	$156	$177

FY 2003
PAYMENTS FOR HOSPITAL SERVICES
By County of Recipient

In Millions of Dollars

Excludes public hospital enhancement payments

Medical Services

Outpatient Services

Medicaid pays for visits to the emergency room if they are certified as true emergencies by the doctor at the time of the visit. Benefits include visits for chemotherapy, radiation therapy, lab and x-ray services and approved outpatient surgical procedures.

Hospital Co-payments

Most Medicaid hospital patients are required to pay a copayment for hospital care. The copayments are $50 per inpatient admission and $3 per outpatient visit. Recipients under 18 years of age, nursing home residents, and pregnant women are exempt from copayments. A provider may not deny service to a Medicaid eligible due to the recipient's inability to pay the copayment.

Transplant Services

In addition to cornea transplants, which do not require prior approval, Medicaid benefits cover prior authorized heart transplants, lung (both single or double), heart/lung, liver transplants, pancreas, pancreas/small bowel, kidney and bone marrow transplants. Other medically necessary transplants are also covered for recipients under 21 years of age when the need is identified during an EPSDT screening and is prior authorized by the Medicaid Agency. Eligible recipients' transplants must meet the medical criteria in the Alabama Medicaid Organ Transplant Manual.

Transplant services are limited to in-state providers unless there are no in-state providers available to perform the procedure. All prior authorized transplants must be coordinated through UAB's transplant staff.

Inpatient Psychiatric Program

The inpatient psychiatric program was implemented in May 1989. This program provides medically necessary inpatient psychiatric services for recipients under the age of 21. Services must be authorized by the Agency and rendered in Medicaid contracted psychiatric hospitals. Alabama psychiatric hospitals approved by the Joint Commission for Accreditation of Healthcare Organizations may participate in this program.

Inpatient psychiatric services for recipients age 65 or over are covered when provided in a free-standing hospital exclusively for the treatment of mental illness for persons age 65 or over. These services are unlimited if medically necessary and if the admission and continued stay reviews meet the approved psychiatric criteria. These hospital days do not count against a recipient's inpatient day limitation for treatment in an acute care hospital.

Persons participating in the programs must meet certain qualifications and the services performed must be expected to reasonably improve the patient's condition or prevent further regression. Reviews are performed by Medicaid to determine the medical necessity of admissions and continued need for hospitalization. Admissions to psychiatric hospitals are reviewed and authorized prior to payment to ensure that appropriate criteria have been met.

Ambulatory Surgical Centers (ASC)

Medicaid covers ambulatory surgical center (ASC) services, which are procedures that can be performed safely on an outpatient basis. Services performed by an ASC are reimbursed by a fee schedule established by the Medicaid Agency. A listing of covered surgical procedures is maintained in the Provider Billing Manual.

Ambulatory surgical centers must have an effective procedure for immediate transfer of patients to hospitals for emergency medical care beyond the capabilities of the center. Medicaid recipients are responsible for the co-payment amount for each visit.

Post-Hospital Extended Care Program

This program was implemented in 1994 for Medicaid recipients who were in acute care hospitals but no longer needed that level of care. These patients needed to be placed in nursing facilities but for reasons such as lack of an available bed, or the level of care needed was such that they could not be accommodated by an area nursing facility, the patient was forced to remain in the hospital. In response to this problem the Agency initiated the Post-hospital Extended Care Program (PEC). Patients in this program remain in the hospital, but they receive services ordinarily provided in a nursing facility. For these patients the hospital is reimbursed a daily rate equal to the average daily rate paid to nursing facilities in the state. The hospital is obligated to actively seek nursing home placement for these patients.

Swing Beds

Swing beds are defined as hospital beds that can be used for either hospital acute care or skilled nursing facility care. The hospital must be certified as a Medicare swing bed provider. Reimbursement for a Medicaid recipient receiving skilled nursing facility care in a swing bed is at a per diem rate equal to the average per diem rate paid to participating nursing homes.

Federally Qualified Health Centers (FQHC)

The Medicaid federally qualified health centers program was implement-

ed April 1, 1990, as a result of the Omnibus Budget Reconciliation Act of 1989. Certain community health centers, migrant health centers, and health care for the homeless programs are automatically qualified to be enrolled, with others able to be certified as "look alike" FQHCs.

Services covered by the FQHC program include ambulatory services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers employed by the FQHC. Federally qualified health centers are reimbursed using an all inclusive encounter rate. Medicaid establishes reasonable costs by using the centers' annual cost reports. At the end of FY 2003, there were 17 FQHCs enrolled as providers, with 102 satellite clinics.

Rural Health Clinics (RHC)

The Medicaid rural health program was implemented in April 1978. Services covered under the program include any medical service typically furnished by a physician in an office or a home visit. Limits are the same as for the physician program. Independent rural health clinic services, whether performed by a physician, nurse practitioner or physician assistant, are reimbursable. A physician, nurse practitioner or physician assistant is available to furnish patient care while the clinic operates. Independent rural health clinics are reimbursed at the reasonable cost per visit established for the clinics by the Medicare fiscal intermediary. At the end of FY 2003, there were 38 independent rural health clinics enrolled as providers in the Medicaid program.

Provider Based Rural Health Center (PBRHC) services were implemented in October 1993. PBRHCs are an integral part of a hospital, skilled nursing facility, or home health agency. Services covered under the program may be provided by a physician, physician assistant, nurse practitioner, certified nurse midwife, and/or specialized nurse practitioner. Visits to a PBRHC are included in the Medicaid-allowed 14 physician office visits per year.

PBRHCs are reimbursed on an all inclusive encounter rate based on their yearly cost reports. At the beginning of 1994, there were 11 PBRHCs enrolled as providers in Medicaid. There are now 20 PBRHCs enrolled as Medicaid providers.

Physicians Services

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. This service to beneficiaries, as with all other Medicaid programs, is based on medical necessity, with physicians determining the need for medical care. Physicians provide this care directly and prescribe or arrange for additional health benefits. The majority of licensed physicians in Alabama participate in the Medicaid program. Some Medicaid eligibles such as QMB only and SLMB only do not receive any medical services that are paid for by Alabama Medicaid. Of those Medicaid eligibles who do receive medical services paid for by Alabama

FY 2003
PHYSICIANS PROGRAM
Use and Cost

Age	Payments	Recipients	Cost per Recipient
0 to 5	$52,079,779	140,801	$370
6 to 20	$36,624,049	160,005	$229
21 to 64	$61,862,142	121,656	$509
65 and up	$9,158,549	61,010	$150
All Ages	$159,724,519	483,472	$330

Medicaid, almost 60 percent received physician services in FY 2003.

Recipients visiting a physician are required to pay a $1 copayment per office visit. Recipients under 18 years of age, nursing home residents, and pregnant women are exempt from copayments. Certain physicians' services do not require copayments. These include family planning services, physicians' inpatient hospital visits, physical therapy, and emergencies. Physicians may not deny services due to the recipient's inability to pay the copayment.

In general, the per capita cost of Medicaid services to the aged is higher than for other categories of recipients. One reason is that older people are more likely to have health problems. However, Medicaid physicians' care costs for the aged are lower than for most categories. This is because most of Medicaid's aged recipients also have Medicare coverage. In cases when individuals have both Medicaid and Medicare, Medicaid normally covers the amount of the doctor bill not paid by Medicare, less the applicable copayment amount.

Pharmacy Services

Although the pharmacy program is an optional service under federal Medicaid rules, it is economically vital to the Medicaid program. Treating illnesses with prescription drugs is usually much less expensive and often as effective as alternatives such as hospitalization and/or surgery. For this reason, the pharmacy program represents one of the most cost-effective services.

Realistically, modern medical treatment would be impossible without drugs. In recent years, medical professionals have been very successful in finding medications that make more expensive alternatives unnecessary.

In FY 2003, pharmacy providers were paid $547,782,433 million for prescriptions dispensed to Medicaid recipients. This expenditure represents 15.3 percent of Medicaid payments for services. The Medicaid Agency's reimbursement to participating pharmacists is based on the ingredient cost of the prescription plus a dispensing fee. The dispensing fees and the pricing methodology remain unchanged from previous years.

Primarily to control overuse, Medicaid recipients are asked to pay a copayment for each prescription. The copayment ranges from $.50 to $3.00, depending on drug ingredient cost. The Omnibus Budget Reconciliation Act of 1990 (OBRA) expanded Medicaid coverage of reimbursable drugs. With the exception of allowable published exclusions, almost all drugs are now covered by the Medicaid Agency. The OBRA '90 legislation also required states to implement a drug rebate program and a drug utilization review program (DUR).

The Rebate Program collects rebates from drug manufacturers based on Medicaid utilization of their drug products in Alabama. During FY 2003, over $102 million was collected. These rebates are used to offset increasing drug program expenditures.

The DUR process involves retrospective reviews conducted by Health Information Designs, Inc. under con-

FY 2001-2003
PHARMACEUTICAL PROGRAM
Use and Cost

Year	Number Of Drug Recipients	Recipients As a % Of Eligibles	Number Of Rx	Rx Per Recipient	Price Per Rx	Cost Per Recipient	Total Cost To Medicaid*
2001	464,313	65%	9,796,980	21.10	$40.25	$849	$394,359,263
2002	499,967	64%	10,607,589	21.22	$43.52	$923	$461,617,088
2003	526,058	65%	11,429,977	21.73	$47.93	$1,041	$547,782,433

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

FY 2001-2003
PHARMACEUTICAL PROGRAM
Cost

	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx	Net Cost Per Recipient
2001	$394,359,263	$76,713,460	$317,645,803	$32.42	$684
2002	$461,617,088	$85,007,636	$376,609,452	$35.50	$753
2003	$547,782,433	$102,987,398	$431,104,082	$37.72	$819

Note: Data for 2001 and 2002 have been adjusted to reflect updated claims information

tract with the Medicaid Agency. The purpose is for identification of drug usage characteristics of Medicaid recipients in order to prevent or lessen the instances of inappropriate, excessive, or therapeutically incompatible drug use. The DUR process also enhances the quality of care received by Medicaid recipients by educating physicians and pharmacists with regard to issues concerning appropriateness of pharmaceutical care, thereby minimizing expenditures.

Medicaid continues to operate a DUR program. The retrospective element of DUR is complemented by a prospective element. Prospective DUR is an on-line, real-time process allowing pharmacists the ability to intervene before a prescription is dispensed, preventing therapeutic duplication, over and underutilization, low or high doses and drug interactions. Medicaid has implemented a prospective DUR system that screens prescriptions for early/late refills, therapeutic duplication, drug interactions, high dose, and product selection (preferred drug status).

Eye Care Services

Medicaid's eye care program provides beneficiaries with continued high quality professional eye care. For children, good eyesight is essential to learning and development. Through the optometric program, Medicaid eligibles receive a level of eye care comparable to that of the general public.

The eye care program provides services through ophthalmologists, optometrists and opticians. Adults (21 years of age and older) are eligible for one complete eye examination and one pair of eyeglasses every two calendar years. Hard or soft contact lenses are available when prior authorized by the Medicaid Agency for aphakic (post-cataract surgery) patients and for other limited justifications. Post-cataract patients may be referred by their surgeons to optometrists for follow-up management.

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

Laboratory and Radiology Services

Laboratory and radiology services are essential parts of the Medicaid health care delivery system. Many diagnostic procedures and methods of treatment would be impossible without the availability of these valuable services. Since lab and x-ray services are ancillary parts of other services, Medicaid will not pay for lab and x-ray services if the other services performed are not covered. There are over 116 independent laboratories and over 10 free standing radiology facilities that are enrolled with Alabama Medicaid. Each independent laboratory and free-standing facility must be approved by the appropriate licensing agency within the state in which it resides, be certified as a Medicare provider and sign a contract with the Medicaid Agency in order to be eligible to receive reimbursement

FY 2003
EYE CARE PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
Optometric Service	$6,884,235	82,723	$83
Eyeglasses	$2,762,365	66,074	$42

FY 2001-2003
LAB AND X-RAY PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
2001	$37,294,304	357,197	$104.41
2002	$42,394,321	395,125	$107.29
2003	$45,318,047	378,882	$119.61

Note: This includes Physicians Lab and X-Ray

from Medicaid. Laboratory and radiology are unlimited services and if medically necessary can be covered even if other benefit limits have been exhausted.

Renal Dialysis Services

The Medicaid renal dialysis program was implemented in 1973. Since that time, enrollment of renal dialysis providers in the Medicaid program has gradually increased to its present enrollment of 64 freestanding facilities.

Renal dialysis services covered by Medicaid include maintenance hemodialysis and CAPD (Continuous Ambulatory Peritoneal Dialysis) and home treatments, as well as training, counseling, drugs, biologicals, and related tests. Patients are allowed 156 treatment sessions per year, which provides for three sessions per week.

Recipients who travel out of state may receive treatment in that state. The dialysis facility must be enrolled with Medicaid for the appropriate period of time. Although the Medicaid renal dialysis program is small, it is a life-saving service without which many recipients could not survive, physically or financially.

Long Term Care

Care for acutely ill, indigent residents in nursing facilities was mandated in 1965 with the enactment of Medicaid (Title XIX). On October 1, 1990, OBRA '87 was implemented and provided for improvements in health care for residents in nursing facilities. The law included more rights and choices for residents in controlling their lives and surroundings, and more opportunities for restorative care to help residents reach their full physical potential.

As of July 1, 1995, the last major phase of nursing home reform was implemented. On that day, new enforcement regulations took effect to assure high quality care in nursing facilities. Nursing home reform has included a resident "bill of rights" and requirements for individual resident assessments and plans of care, as well as nurse aide training and competency requirements and the establishment of a nurse aide registry.

With the new enforcement regulations, there is wider range of sanctions tailored to different quality problems. Adopting "substantial compliance" as the acceptable standard, the new rules are meant to ensure reasonable regulation while at the same time requiring nursing facilities to correct problems quickly and on a long-term basis. An important goal of the new enforcement plan is to ensure that continuous internal quality control and improvement are performed by the nursing facilities themselves.

The regulations provide for the imposition of civil money penalties and other alternative remedies such as denial of payment for new admissions, state monitoring, temporary management, directed plans of correction, and directed in-service training. Almost all facilities will be given the opportunity to correct the deficiencies and avoid remedies. Only chronically poor performers and facilities with deficiencies that present direct jeopardy to residents will be assessed with an immediate remedy, which may involve termination or civil money penalties.

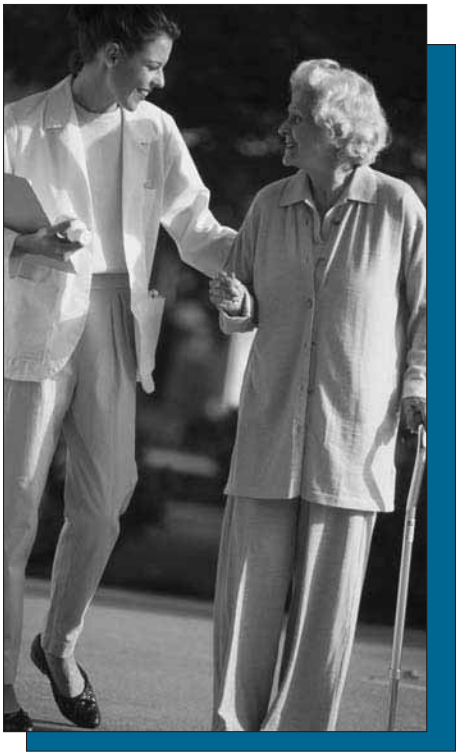
The total cost to Medicaid for providing nursing home care in FY 2003 was over $715 million. Almost 96 percent of the nursing homes in the state accepted Medicaid recipients as patients in FY 2003. There were also 20 hospitals in the state during FY 2003 that had long term care beds, called swing beds, participating in Medicaid.

In the past all Medicaid patients residing in a nursing facility have had to apply their available income to the basic nursing facility per diem rate; however, effective April 1, 1994, Qualified Medicare Beneficiaries (QMBs) residing in a nursing facility no longer have to apply any of their income toward the cost of the Medicare coinsurance for nursing home care. The coinsurance is paid entirely by Medicaid for this group.

Long Term Care Quality Assurance Program

The Long Term Care Quality Assurance (LTC/QA) Program is part of Medicaid's Quality Assurance Division and is responsible for providing an effective quality assurance system for the Home and Community Based Services (HCBS) waiver programs. The LTC/QA Program provides quality assurance oversight of several operating agencies (OA) that are responsible for the daily operation of the waiver programs. The oversight is to assure that the OA is providing services as outlined in the specific HCBS Waiver document. Quality Assurance for HCBS Waiver programs is the process of monitoring and evaluating the delivery of care and services to ensure that they are appropriate, timely, accessible, available, and medically necessary to safeguard health and welfare of the participants and to prevent institutionalization

The key components in the process are: 1) Health and safety. 2) Responsiveness of the plan of care. 3) Qualifications of providers. 4) Appropriateness of services. 5) Freedom of choice. 6) Client satisfaction. 7) Complaint and grievance process. 8) Accessibility to waiver services. 9) Availability of other community care options. 10) Continuity of care. 11) Quality improvements. These assurances are through annual review of case management and direct service provider records, visits to participants homes, group homes, adult day care centers, day habilitation worksites, satisfaction survey results, tracking and resolution of participants complaints and grievance, and review of operating agencies internal quality assurance programs and activities.



FY 2001-2003
LONG-TERM CARE PROGRAM
Patients, Days, and Costs

Year	Number Of Nursing Home Patients Unduplicated Total	Average Length Of Stay During Year	Total Patient-Days Paid For By Medicaid	Average Cost Per Patient Per Day To Medicaid	Total Cost To Medicaid
2001	26,361	280	7,372,715	$90	$666,221,211
2002	27,177	273	7,407,712	$95	$704,151,335
2003	28,056	276	7,749,218	$92	$715,766,681

FY 2002 - 2003
LONG-TERM CARE PROGRAM
Number and Percent of Beds Used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	Percent of Beds Used By Medicaid In An Average Month
FY 2002	26,687	17,152	64%
FY 2003	27,038	17,467	65%

FY 2003
LONG-TERM CARE PROGRAM
Recipients and Payments by Gender, Race and Age

	Recipients	Payments	Cost Per Recipient
By Gender			
Female	21,331	$549,607,153	$27,302
Male	6,725	$166,159,528	$26,179
By Race			
White	20,361	$510,707,072	$26,577
Nonwhite	7,695	$205,059,609	$28,237
By Age			
0-5	13	$528,858	$40,589
6-20	118	$5,353,477	$45,233
21-64	3,225	$84,452,154	$26,188
65 & Over	24,700	$625,432,192	$25,321

FY 2002
PAYMENTS TO NURSING HOMES
By County of Recipient

Long Term Care for the Mentally Retarded and Mentally Disabled

The Alabama Medicaid Agency, in coordination with the Department of Mental Health and Mental Retardation, includes coverage for Medicaid-eligible mentally retarded and mentally diseased persons who require care in intermediate care facilities (ICF). Eligibility for these programs is determined by categorical, medical and/or social requirements specified in federal law. The programs provide treatment that includes training and habilitative services intended to aid the intellectual, sensorimotor, and emotional development of residents.

Facilities in which intermediate care for the mentally retarded are provided include the Albert P. Brewer Developmental Center in Mobile, the J. S. Tarwater Developmental Center in Wetumpka, the Lurleen B. Wallace Developmental Center in Decatur, and the W.D. Partlow Developmental Center in Tuscaloosa. In FY 2003, the average reimbursement rate per day in an institution serving the mentally retarded was $450.

In recent years there has been a statewide reduction of beds in intermediate care facilities for the mentally retarded. This reduction is a cooperative effort by the Department of Mental Health and Mental Retardation and the Medicaid Agency to deinstitutionalize as many clients as possible and serve clients in the least restrictive setting. In 1997, the Glenn Ireland II Developmental Center was closed, with the majority of its residents being transferred to community group homes.

In addition to contributing the federal share of money for care in large residential facilities, Medicaid also covers intermediate care of mentally retarded residents in three small facilities of 15 or fewer beds. Those facilities include Arc of the Shoals in Tuscumbia, Volunteers of America #20 in Huntsville, and Volunteers of America #40 in Hartselle. Institutional care for the mentally diseased (IMD) is provided through Alice Kidd Nursing Facility in Tuscaloosa, Claudette Box Nursing Facility in Mobile, and S. D. Allen Nursing Facility in Northport.

In terms of total Medicaid dollars expended and the average monthly payment per patient, the ICF-MR and IMD program is extremely costly. However, the provision of this care through the Medicaid program is saving the taxpayers of Alabama millions of state dollars. These patients are receiving services in state-operated mental health institutions. If the Medicaid program did not cover the services provided to these patients, the Alabama Department of Mental Health and Mental Retardation would be responsible for the total funding of this care through its state appropriation. In FY 2003, in cooperation with the Medicaid Agency, Mental Health was able to match every $30 in state funds with $70 of federal funds for the care of Medicaid-eligible ICF-MR and IMD patients.

FY 2003
LONG-TERM CARE PROGRAM
ICF-MR/DD

	ICF/MR	ICF/MD-Aged
Recipients	410	351
Total Payments	$56,646,079	$14,373,100
Annual Cost per Recipient	$138,161	$40,949

In Memoriam

Betty J. Miller

January 4, 1948 – December 11, 2002

Betty was a valued co-worker for over three years

Linda C. Belcher

January 16, 1949 – December 11, 2002

Linda was a valued co-worker for a year and a half.

Alabama Medicaid Agency
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