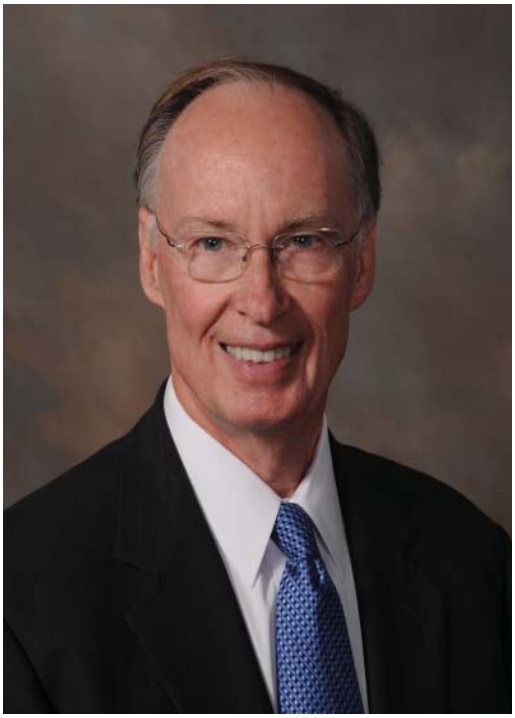
Alabama Medicaid Agency Annual Report - FY 2012

October 1, 2011 - September 30, 2012



Robert Bentley
Governor
State of Alabama

Stephanie McGee Azar
Acting Commissioner
Alabama Medicaid Agency

Dr. Don Williamson
Chairman
Alabama Medicaid
Transition Task Force

Robert Bentley
Governor

Alabama Medicaid Agency
501 Dexter Avenue
PO Box 5624
Montgomery Alabama 36103-5624

Stephanie McGee Azar
Acting Commissioner

Dear Governor Bentley:

Monetary concerns, a far-reaching U.S. Supreme Court decision on the Affordable Care Act, and tremendous progress in compassionately and efficiently caring for Alabama Medicaid recipients combined to be the predominant factors shaping the Alabama Medicaid landscape in Fiscal Year 2012. This annual report highlights these challenges, along with other successes the Agency realized during the year.

Despite funding challenges, a 2012 economic impact study found that every dollar the state invested in Medicaid in 2010 generated a return of $8 to the state. Overall, nearly $9 billion in monetary impact was attributed to Medicaid.

Due to improved patient care outcomes and savings from the Agency's Patient Care Networks, Alabama Medicaid was honored with a 2012 Innovative Alabama Governments Award for attaining new levels of efficiency and responsiveness.

As always, the support of Alabama Medicaid by the Governor's Office is instrumental in the great strides the Agency is making and this support is greatly appreciated. It is with great pride that I present the Alabama Medicaid Agency's 40th Annual Report for Fiscal Year 2012.

Sincerely,

Stephanie McGee Azar
Acting Commissioner

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The Medicaid Agency

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

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

VALUES:

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

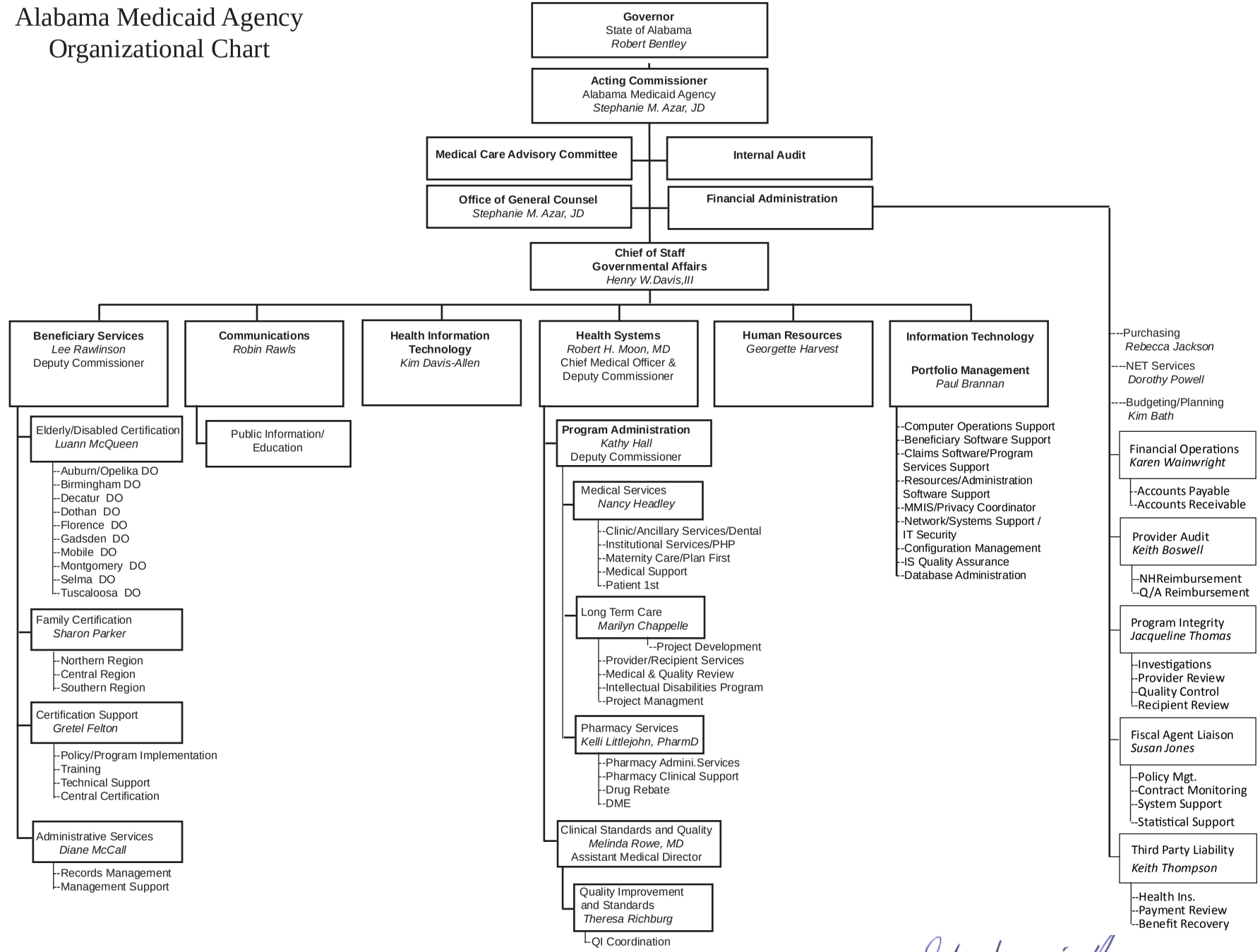
- Integrity
  Our stakeholders can depend on the quality, trustworthiness, and reliability of our Agency's employees and representatives.

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

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

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

Alabama Medicaid Agency Organizational Chart



Effective May 1, 2012

Stephanie M. Azar, JD
Acting Commissioner

Highlights Fiscal Year 2012

Medicaid financial issues dominated the headlines for much of the year as the state continued to struggle financially due to an increased demand for services and a decline in tax revenues. Proration was declared in March 2012, and six months later, voters agreed to a constitutional amendment to help fund Medicaid and other General Fund agencies. The U.S. Supreme Court decision on the Affordable Care Act in June added a new element of uncertainty while a change in leadership ushered in a new era in the Agency's history.

Agency leadership changes

Alabama Medicaid Commissioner R. Bob Mullins, Jr., M.D., announced his resignation on March 26, 2012. State Health Officer Dr. Donald Williamson was chosen by Governor Bentley to conduct a review of Medicaid's operations and finances and to lead the Agency's transition. Governor Bentley also appointed Stephanie McGee Azar as Acting Commissioner of the Agency effective May 1, 2012.

Proration reduces budget by $68 million

On March 16, 2012, Governor Robert Bentley declared 10.6 percent proration of the state General Fund. Proration required that the Agency's original $643 million allocation from the state General Fund be reduced by approximately $68 million for the current fiscal year.

As a result, cuts were reluctantly made to optional benefits for adults and provider payments were reduced starting June 1. The budget reductions were achieved by a combination of administrative and program cost savings, use of one-time funds, voluntary increases in provider taxes and other sources following an in-depth financial analysis led by State Health Officer Dr. Don Williamson.

The cuts were implemented in three ways: Reduction of payments to certain provider groups by 10 percent, reduction in optional services to adults (including a one brand drug limit and coverage of eyeglasses and routine eye exams) and reduction in optional coverage of cough and cold drugs for all recipients.

Much of ACA ruled constitutional; States given option on Medicaid expansion

The greatest uncertainty of the year was the potential impact of the Affordable Care Act. Officials waited much of the year for the U.S. Supreme Court's decision on the controversial federal law. On June 28, 2012, the court upheld most of the provisions of the ACA as constitutional, but unexpectedly ruled that states cannot be penalized if they choose to not expand their Medicaid programs to all people below 138 percent of the federal poverty level.

State Health Officer Dr. Don Williamson, appointed by Governor Bentley to oversee Medicaid's transition, emphasized that cost would be a major consideration when the governor and legislature make that decision.

Beginning in 2017, the state would have to contribute 5 percent of the cost for benefits provided to the new eligibles which would increase to 10 percent in 2020 and subsequent years. Dr. Williamson also noted that there would be significant administrative costs to certify, enroll and manage the new recipients which will not covered by federal dollars.

Highlights Fiscal Year 2012

Oct. 2011	Nov. 2011	Dec. 2011	Jan. 2012	Feb. 2012	March 2012
• New PA rules for Antipsychotic drugs designed to increase patient safety	• Agency fraud and abuse prevention efforts result in low error rate	• Agency's Eligibility simplification efforts recognized	• Medicaid economic impact study released • Maternity Care Town Hall meetings begin	• "Direct" messaging begins in Alabama • *My Medicaid* Recipient web portal launched • Radiology Management reduces cost to Agency	• Medicaid District Office opens in Huntsville • Alabama chosen to test Emergency Psychiatric Care • PACE Program begins in Mobile

Voters approve amendment; Agency reverses provider pay cuts

Alabama voters' approval of a constitutional amendment on September 18, 2012, not only funded the Medicaid Agency's "bare-bones" budget for the 2013 Fiscal Year, but also made possible the reversal of several reductions implemented earlier in the year due to proration of the state's 2012 General Fund Budget.

Passage of the constitutional amendment enabled Medicaid to receive some of the money transferred to the General Fund from the Alabama Trust Fund. Without passage of the amendment, the Agency would have potentially faced a $100 million minimum shortfall for the 2013 fiscal year.

Passage of the amendment also made it possible to reverse provider payment and benefit reductions made earlier in the year, including a 10 percent payment reduction for physicians, dentists, physician lab and x-ray providers, independent lab and x-ray providers, durable medical equipment providers and other licensed practitioners.

Also reversed were payment cuts to durable medical equipment and supply providers. In addition to the payment changes, the Agency also reinstated the coverage of eyeglasses for adults to one pair every two years and reinstated the coverage of routine eye exams from once every three years to once every two years.

Other highlights of the year:

Antipsychotic PA requirements designed to increase patient safety

Advances in the use of antipsychotic medications have significantly improved the quality of life for many Medicaid recipients. Some people with intellectual disabilities, for example, depend on antipsychotic medications to protect themselves or others from harm. Others benefit from medication that allows them to successfully live in the community. At the same time, these powerful medications can lead to health problems such as diabetes, lipid disorders, and weight gain when used inappropriately.

To increase patient safety and appropriate prescribing, the Alabama Medicaid Agency instituted new requirements for prior authorization (PA) of all antipsychotic medications starting Oct. 3, 2011. The PA process applies to all recipients (children and adults) and all antipsychotics (brand and generic, first and second generation).

Highlights Fiscal Year 2012

April 2012	May 2012	June 2012	July 2012	Aug. 2012	Sept. 2012
• Waiver approved to simplify Plan First eligibility • First to add smoking cessation to state's family planning program • Agency receives grant to help "rebalance" long-term care	• Patient Care Networks receive top honors for innovation • Azar named Acting Commissioner • State honored for efforts to improve children's health care	• Most of the Affordable Care Act (ACA) ruled constitutional • Williamson appointed to oversee Medicaid's transition	• Agency reinstates four brand-name drug limit for adults	• ACT waiver helps recipients live in community	• Alabama voters approve constitutional amendment to fund Medicaid budget for 2013

Agency lowers error rates through its fraud and abuse prevention efforts

The U.S. Department of Health and Human Services ranked the Alabama Medicaid Agency among the nation's best in terms of payment and eligibility accuracy. The rate was established following an audit of the Agency's records in conjunction with the Payment Error Rate Measurement (PERM) program.

The federal report noted that the state's Medicaid Error Rate was 2.4 percent, significantly below the national error rate of 6.7 percent. The Agency's previous rate of 3.68 percent in 2007 was also substantially below the national average of 10.6 percent.

Eligibility simplification efforts recognized

Alabama qualified for a performance bonus of $19 million in FY 2011 based upon achieving eligibility simplifications in Medicaid and CHIP and gains in enrollment for Medicaid children.

One of the recognized simplifications is use of a streamlined joint application process in which individuals may apply on-line, by mail, or in person for both Medicaid and ALL Kids using the same form. Other simplification achievements that qualified the state for recognition included elimination of face-to face-interviews; 12 months continuous eligibility for children; elimination of the asset test; and use of pre-populated renewal forms.

Medicaid economic impact study released

An Auburn Montgomery Center for Government study released in January 2012 documented the economic impact of the Agency on Alabama's economy.

According to the study, Alabama Medicaid was responsible for nearly $9 billion in total monetary impact, for approximately 147,000 jobs created or supported, and for $592 million in taxes generated in 2010. This means that for every dollar Alabama invested in Medicaid, the state gained about $8 return overall.

"Direct" messaging begins in Alabama

A new provider-to-provider messaging system was launched in February 2012 for physicians and other health care providers who want to exchange information electronically but are not yet in a position to adopt and use a certified electronic health record system.

The "Direct" system operates within the secure environment of One Health Record®, the state's two-way, or interoperable, data exchange system for providers who have federally-certified electronic health record systems.

For providers who previously depended on mailing or faxing to transmit paper-based records, the new direct messaging system offers a higher level of accuracy and security. Using a provider's existing computer, an enrolled participant can go online to the One Health Record® web portal and immediately view ALL Kids or Medicaid patient data and send a secure, encrypted message with attachments to another enrolled provider.

Recipient web portal launched

"My Medicaid," a user-friendly website for Alabama Medicaid applicants and recipients, was launched in February 2012 to better meet the needs of its customers while saving money.

"My Medicaid" helps expedite the process of requesting a replacement ID card, checking benefit limits, changing Patient 1st primary care doctors and updating address or other personal information. It also allows applicants to track the status of a pending application. The website is an important milestone in the Agency's strategic plan to reduce costs and increase efficiency through innovation and technology. In the past year, more than 28,000 people have accessed this site.

Radiology Management reduces Agency cost

An annual review of Medicaid's Radiology Management program indicated that the program produced a net savings of about $4.5 million between March 2011 and February 2012.

The program requires prior review and approval of expensive elective outpatient radiology procedures such as Magnetic Resonance Imaging, CT scans and PET scans for most Medicaid recipients who have full benefit coverage. Scans performed for hospital inpatients, emergency room patients and those covered by Medicare are excluded.

By implementing the program, the Agency hopes to prevent unnecessary imaging exposure while ensuring that recipients receive the most clinically-appropriate advanced-imaging services.

Medicaid office opens in Huntsville

With the help of social workers on loan from the Alabama Department of Public Health, the Agency officially opened a new District Office in Huntsville to provide services to applicants and recipients in the Huntsville area. A zip code analysis of the Medicaid population showed a great need for a Medicaid office in the Huntsville area. The new office coincided with the reorganization of the Agency's Beneficiary Services operations to better meet the needs of applicants and recipients.

Alabama to test emergency psychiatric care

Medicaid programs in Alabama and in 10 other states and the District of Columbia were selected by the Centers for Medicare and Medicaid Services to test whether Medicaid recipients who are experiencing a psychiatric emergency get more immediate, appropriate care when private institutions for mental diseases (IMDs) receive Medicaid reimbursement for emergency care.

The demonstration is sponsored by the Center for Medicare and Medicaid Innovation, which was created by the Affordable Care Act to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing quality of care.

OB care collaborative begins

A statewide series of "Town Hall" meetings addressing maternity care issues in Alabama were held in Montgomery, Huntsville, Birmingham and Mobile during January and March of 2012. The meetings were the first step toward the development of a collaborative of obstetric care providers and maternal-fetal medicine specialists to develop evidence-based guidelines and best practices, quality initiatives and resources to link community providers and patients to tertiary care for high-risk patients.

Since that time, the group, now known as the Alabama Perinatal Education Collaborative (APEC) has been meeting to review and approve guidelines on routine prenatal care as well as several more specific, but common issues such as management of chronic hypertension, elective deliveries prior to 39 weeks, and history of a prior preterm birth. The collaborative has also added a

community-based OB/GYN and a family physician that performs deliveries to APEC to provide perspective from outside the academic medical center.

PACE Program begins in Mobile

The state's first PACE program opened in Mobile, offering a new choice for elderly and disabled Medicaid recipients as a part of the Agency's ongoing commitment to providing a "continuum of care."

The PACE program is for people who would otherwise require nursing home care, the Alabama Community Transition (ACT) waiver to help nursing facility residents move into the community, and a specialized program that will allow ventilator-dependent Medicaid recipients to get care within the state. Two of the three programs are statewide initiatives, while PACE is currently limited to recipients in Mobile and Baldwin counties who are age 55 or older.

Alabama first state to add smoking cessation to Medicaid family planning program

To address one of the most preventable causes of infant mortality and improve the overall health of mothers and babies, the Agency added smoking cessation to its Plan First family planning program, the first state to do so.

The state received federal approval in April 2012 to extend the Plan First program through December 31, 2013, and to add smoking cessation counseling and medications to the services now provided.

In Alabama, 15 percent of all females smoke while they are pregnant, according to data from the Alabama Department of Public Health. However, estimates of up to 35 percent have been calculated for low-income women with Medicaid coverage.

Research studies suggest that smoking cessation saves money for Medicaid programs as well. A January 2012 study published by The George Washington University Center for Health Policy Research found that for every dollar invested in a smoking cessation program, Medicaid programs could expect approximately $3.12 in medical savings.

The Plan First program began in October 2000 to provide family planning services to uninsured women who would not qualify for Medicaid unless pregnant.

Grant helps "rebalance" long-term care

The Agency received a $200,000 federal grant in April 2012 to conduct a comprehensive planning effort required for implementation of a Money Follows the Person program in the state.

The Money Follows the Person program is designed to help states "rebalance" their long-term care systems by increasing the use of home and community-based services and decreasing the use of institutional care. Instead of institutional care, states use funds to expand services and supports in the community to create new options for people who want to transition into the community from nursing home or other institutional care. The grant will be used to develop an operational plan and meet other requirements in order to apply for additional federal grant funds later in 2012.

Plan First eligibility simplified

In April 2012, the Agency received formal approval for an 1115 waiver using Express Lane Eligibility (ELE) for Plan First women, making the process for certifying their eligibility much simpler at application and renewal. The Agency's implementation of ELE in May 2012 made Alabama the first state in the nation to implement Medicaid ELE for adults.

Patient Care Networks honored for efforts to innovate and improve responsivness

The Agency was one of five state and local government organizations honored in May 2012 as the recipient of a 2012 Innovative Alabama Governments Award from Auburn Montgomery Center for Government and Public Affairs and the Center for Advanced Technologies. The awards honor recipients for their use of new and innovative methods to help Alabama state, county, and municipal government agencies reach new levels of efficiency and responsiveness.

Six months after the Patient Care Networks of Alabama began in August of 2011 numbers indicated that PCNs not only can improve patient care, but they can save money for the state as well. Two indicators – the per member/per month rate and the Emergency Room Use Rate – suggested the program is performing well. Between July 2011 to February 2012, the total per member/per month rate for Patient 1st recipients in

network areas decreased by 7.7 percent, while the rate for the rest of the state only decreased by .6 percent or a 7.1 percent difference. The networks also appear to be particularly effective in controlling emergency room use. Data showed the three network areas experienced a 15 percent decrease in their ER Use Rate from July 2011 to January 2012.

Alabama honored for efforts to improve health care for state's children

The Centers for Medicare and Medicaid Services (CMS) recognized Alabama at the Second Annual CMS Medicaid-CHIP Quality Conference in Baltimore in June 2012. Along with Vermont, Washington and West Virginia, Alabama was cited for the collective efforts of Medicaid and ALL Kids to encourage children to access needed health care services and to track and report on quality measures related to children's dental care.

Agency reinstates four brand-name prescription drug limit for adults

Alabama Medicaid Agency ended its one brand-name drug limit on prescription drugs for adults two months early thanks to the effectiveness of the temporary limit combined with funds from a recent national fraud settlement.

The Agency announced to providers on July 19 that it would reinstate its four brand-name drug limit beginning August 1, 2012. The Agency implemented reductions in covered services and provider payments starting June 1 in order to balance its budget following the 10.6 percent proration of the state's General Fund budget in March 2012. The reduction in optional services to adults included limiting drugs to one brand-name drug per month.

Acting Medicaid Commissioner Stephanie McGee Azar said the decision to return to the higher limit of brand-name drugs is based on a number of factors, including the receipt of $2.8 million of the state's share of a recent national fraud settlement with GlaxoSmithKline (GSK). The settlement, coupled with the savings the Agency estimated it would net from reducing the brand limit to one during June and July, brought the projected savings close to the Agency's estimate of what it would have received from the brand-limit reduction during the remaining months of fiscal year 2012.

Alabama Community Transition waiver helps recipients live in community

Six Alabama Medicaid recipients now live at home, thanks to a new Medicaid waiver program for people with disabilities or long term illnesses who wish to live in the community instead of an institution.

Offered statewide, the Alabama Community Transition (ACT) Waiver is one of seven Home and Community-Based Service waivers offered by the Alabama Medicaid Agency for qualifying recipients who desire to live in the community. The ACT waiver resulted from the Long Term Care Rebalancing Advisory Committee's recommendations and to comply with federal requirements such as MDS Section Q (return to the community). To qualify, the recipient must have been living in an institution for at least 90 days and be able to live safely in the community.

The ACT waiver is unique in that it funds transitional services that are not covered in the other HCBS waivers such as rental and utility deposits to facilitate the transition home. Additional services available through the waiver include home modifications, installation of a personal emergency response system, medical equipment, skilled nursing, respite care, personal care and other services.

The ACT Waiver also includes a consumer-directed option which gives individuals the opportunity to have greater involvement, control, and choice in identifying, accessing, and managing long term services and community supports. Alabama was the first state to make consumer-directed (also known as self-directed) care for Medicaid home and community-based services a permanent part of its State Plan in 2007.

Eligibility: Who Medicaid Serves

During FY 2012, more than 1.1 million Alabama citizens, or 23 percent of the state's population, were eligible to receive Medicaid benefits for at least one month of the year.

The state's youngest citizens made up the largest category of Medicaid eligibles with 47 percent Alabama children having their health coverage paid for by Medicaid. Nearly 40 percent of these children were in families with at least one working caregiver. Medicaid also paid for more than half (52.6%) of all babies born in Alabama during fiscal year 2012.

Eligibles

While the elderly Medicaid population is a much smaller group, Medicaid-eligible Alabamians over the age of 65 receive a variety of services. Approximately two-thirds of all nursing home residents depend on Medicaid to cover the cost of their care.

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

Qualifying Agencies

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

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

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

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

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

FY 2010 - FY 2012
Medicaid and Alabama
Overview

	FY 2010	FY 2011	FY 2012
Total Alabama Population[1]	4,779,735	4,802,740	4,845,389
Medicaid Eligible Population[2]	1,026,429	1,070,781	1,110,037
Percent of Total Population that was Medicaid Eligible	21.5%	22.3%	22.9%
Total Adult Population[1]	3,423,611	3,455,983	3,494,584
Medicaid Eligible Adults[2]	436,535	452,644	473,580
Percent of Total Adult Population that was Medicaid Eligible	12.7%	13.1%	13.6%
Total Child Population[1]	1,356,124	1,346,757	1,350,805
Medicaid Eligible Children[2 and 3]	589,894	618,137	636,457
Percent of Total Child Population that was Medicaid Eligible	43.5%	45.9%	47.1%
Total Medicaid Expenditures[4]	$5,309,404,101	$5,208,232,283	$5,566,749,987
Medicaid Expenditures Per Capita	$1,111	$1,084	$1,149
Monthly Average Eligible Recipients	851,199	912,767	939,576
Average Annual Cost per Monthly Average Eligible[5]	$6,238	$5,706	$5,925
Overall Federal Funding Percentage	74.3%[6]	73.6%[6]	67.6%
Overall State Funding Percentage	25.7%	26.4%	32.4%
State General Fund Percentage	5.9%	7.8%	10.2%

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

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

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

4. Total Medicaid expenditures exclude Health Information Exchange expenses, which were $60,209,095 and $32,398,8955 in FY 2012 and FY 2011, respectively, and are almost 100% federally funded.

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

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

Definitions of Eligibles and Recipients

Potential Eligibles

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

Annual Eligibles

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

Annual Recipients

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

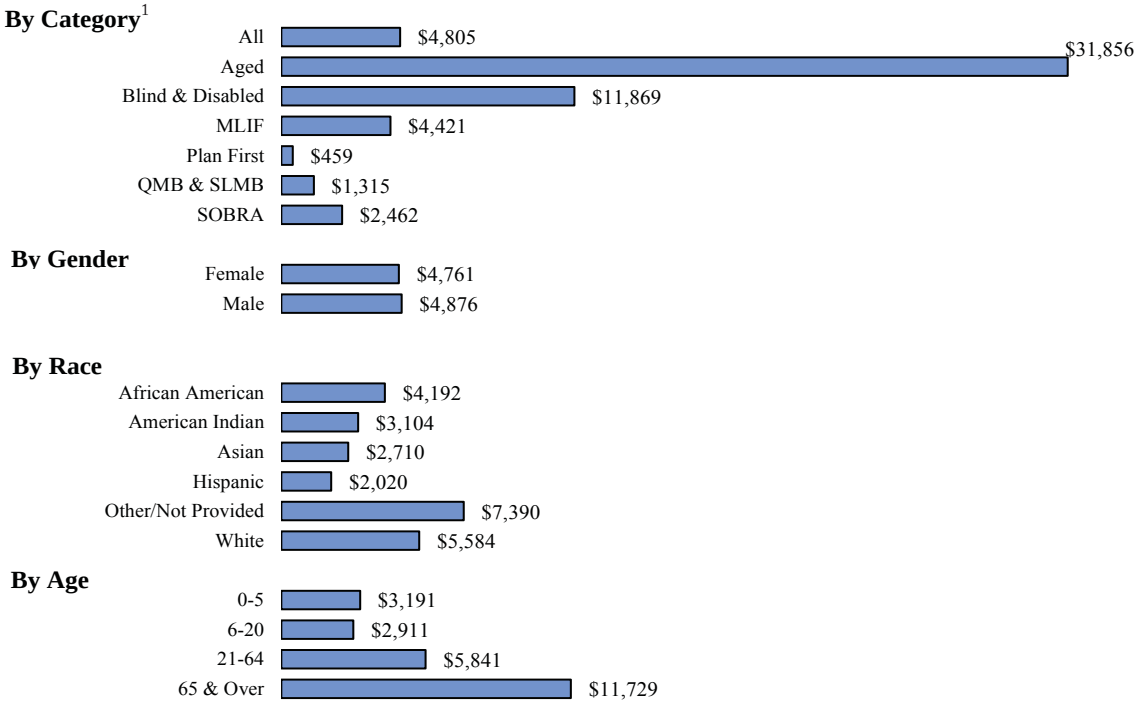
Monthly Average Eligibles

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

Monthly Average Recipients

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

FY 2012
Annual Cost Per Eligible for Medical Care [1]
By Category, Gender, Race, and Age



1. The annual cost per eligible is calculated based on unduplicated annual eligibles.The cost excludes administrative costs and encumbrances and payables at the end of the fiscal year. The annual cost per eligible per year using monthly average eligibles and total Medicaid expenditures was $5,925 in FY 2012.

FY 2003 - FY 2012
Medicaid Annual Eligibles as a Percent of Population by Year

Year	State Population[1]	Annual Eligibles[2]	Annual Eligibles as a % of Population
FY 2003	4,564,479	906,948	19.9%
FY 2004	4,603,594	935,539	20.3%
FY 2005	4,642,736	963,600	20.8%
FY 2006	4,681,833	988,678	21.1%
FY 2007	4,720,976	932,521	19.8%
FY 2008	4,760,046	920,937	19.3%
FY 2009	4,799,189	964,171	20.1%
FY 2010	4,779,735	1,026,429	21.5%
FY 2011	4,802,740	1,070,781	22.3%
FY 2012	4,845,389	1,110,037	22.9%

1. Population figures are based on U.S. Census data from the Center for Business and Economic Research, University of Alabama. The 2010 and 2011 population figures are estimates based on Census data received by CBER; 2012 is a projection based on the 2010 U.S. Census on Jan. 23, 2013.

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

FY 2003 - 2012
Monthly and Average Annual Medicaid Eligibles[1]

	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
October	746,376	770,938	810,259	840,428	769,076	746,397	787,515	834,747	894,496	949,808
November	745,022	771,567	800,590	840,777	746,561	735,163	782,764	828,165	890,932	938,776
December	744,903	771,340	800,177	819,256	738,971	734,810	782,786	825,655	891,327	934,512
January	743,846	777,292	805,956	814,988	739,342	741,620	790,064	832,160	897,984	939,100
February	749,731	783,436	809,000	780,510	737,447	748,861	794,954	835,136	902,351	939,021
March	757,620	789,661	812,725	789,201	735,476	755,318	801,523	842,963	911,268	941,197
April	759,139	793,293	816,260	789,493	728,489	759,935	804,925	851,089	913,068	941,707
May	760,101	796,316	818,767	791,830	724,680	762,390	808,273	855,952	914,397	940,538
June	760,527	800,569	820,629	785,949	724,424	764,914	812,220	862,949	922,321	937,851
July	761,433	796,446	821,593	780,400	728,054	770,387	817,174	872,501	930,736	935,778
August	769,360	804,647	824,988	778,452	731,458	777,111	825,421	883,443	939,943	935,901
September	770,516	806,899	827,392	774,561	740,324	781,857	830,621	889,627	944,375	940,722
Annual Average	755,715	788,534	814,028	798,820	737,025	756,564	803,187	851,199	912,767	939,576

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

FY 2012

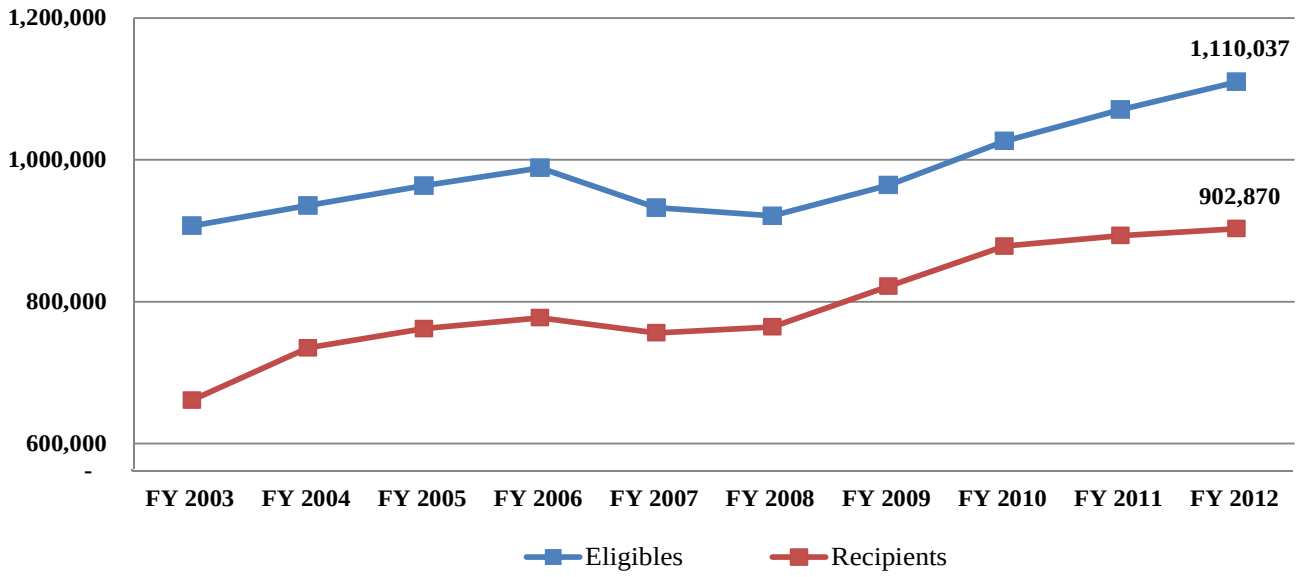
Percent of Population Annually Eligible[1] for Medicaid by County

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

FY 2012
Number of Annual Eligibles[1] by County

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

FY 2003 - FY 2012
Annual Eligibles[1] and Recipients[2]
Utilization



Year	Annual Eligibles[1]	Annual Recipients[2]	Percentage[3]
FY 2003	906,948	699,989	77.2
FY 2004	935,539	734,905	78.6
FY 2005	963,600	761,903	78.1
FY 2006	988,678	777,374	78.6
FY 2007	932,521	755,856	81.1
FY 2008	920,937	764,420	83.0
FY 2009	964,171	821,602	85.2
FY 2010	1,026,429	878,232	85.6
FY 2011	1,070,781	893,312	83.4
FY 2012	1,110,037	902,870	81.3

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

FY 2012
Medicaid Annual Eligibles[1] by Category of Aid and County

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	PLAN FIRST	TOTAL
Autauga	965	247	1,604	5,080	578	7	427	1,198	10,106
Baldwin	2,458	581	3,953	18,233	1,759	20	1,364	3,927	32,295
Barbour	1,302	294	1,489	3,521	507	9	333	754	8,209
Bibb	429	184	1,172	2,621	377	8	250	623	5,664
Blount	774	350	1,613	6,648	777	2	613	1,089	11,866
Bullock	492	182	819	1,759	238	3	135	396	4,024
Butler	1,042	253	1,256	2,935	419	5	283	762	6,955
Calhoun	4,966	763	5,569	13,461	1,858	46	1,203	3,509	31,375
Chambers	964	430	1,813	4,585	610	12	529	1,083	10,026
Cherokee	964	207	991	2,908	499	6	393	574	6,542
Chilton	1,160	268	1,602	6,048	695	6	518	1,048	11,345
Choctaw	408	194	872	1,732	326	5	179	471	4,187
Clarke	646	296	1,653	3,432	450	9	265	909	7,660
Clay	168	184	623	1,849	281	3	214	398	3,720
Cleburne	444	107	602	1,831	267	1	190	427	3,869
Coffee	1,209	381	1,619	4,831	615	5	385	957	10,002
Colbert	1,085	393	2,372	6,037	920	11	571	1,732	13,121
Conecuh	817	153	885	1,758	373	4	200	369	4,559
Coosa	105	84	586	1,130	247	5	204	243	2,604
Covington	1,132	489	1,702	5,076	791	9	490	1,005	10,694
Crenshaw	629	217	695	1,673	334	2	189	438	4,177
Cullman	1,099	784	2,936	9,403	1,262	10	1,026	1,764	18,284
Dale	1,736	342	2,139	5,130	668	6	421	1,259	11,701
Dallas	2,340	643	4,797	7,242	1,191	18	626	1,880	18,737
DeKalb	1,399	584	2,506	11,550	1,232	12	878	1,575	19,736
Elmore	1,310	371	2,542	7,009	768	14	520	1,527	14,061
Escambia	1,530	309	1,617	5,312	651	4	368	1,181	10,972
Etowah	2,544	765	5,177	12,745	1,784	14	1,338	2,680	27,047
Fayette	547	200	839	1,963	305	3	214	455	4,526
Franklin	923	270	1,345	5,190	603	4	421	762	9,518
Geneva	962	271	1,378	3,431	553	5	402	699	7,701
Greene	392	152	919	1,569	211	3	109	428	3,783
Hale	530	241	1,344	2,687	394	3	209	754	6,162
Henry	323	191	703	1,933	351	6	234	421	4,162
Houston	3,093	728	4,640	13,070	1,551	20	1,092	2,956	27,150
Jackson	1,103	458	2,044	6,104	967	14	617	1,249	12,556
Jefferson	12,650	3,573	29,036	68,975	8,358	124	5,682	16,679	145,077
Lamar	514	193	700	1,739	329	6	208	350	4,039
Lauderdale	1,160	579	3,302	9,172	1,313	7	912	2,565	19,010
Lawrence	892	261	1,180	3,660	498	6	355	874	7,726
Lee	2,447	480	3,530	12,444	1,012	21	779	2,702	23,415
Limestone	966	398	2,122	7,835	915	13	582	1,692	14,523
Lowndes	540	154	904	1,766	350	7	171	459	4,351
Macon	1,181	232	1,306	2,450	363	8	208	790	6,538
Madison	4,180	1,335	7,707	28,689	2,454	43	1,489	6,660	52,557
Marengo	702	260	1,537	2,652	485	5	209	748	6,598
Marion	889	340	1,208	3,676	619	4	426	794	7,956
Marshall	2,044	742	3,443	14,823	1,400	13	948	1,741	25,154
Mobile	9,867	2,363	16,666	54,344	5,437	77	3,606	13,648	106,008
Monroe	729	233	1,133	3,101	409	1	232	621	6,459
Montgomery	8,431	1,383	11,343	27,827	2,971	51	1,682	7,699	61,387
Morgan	1,963	808	4,193	14,155	1,231	29	848	2,859	26,086
Perry	486	188	1,155	1,790	342	2	150	489	4,602
Pickens	379	282	1,369	2,555	380	4	202	719	5,890
Pike	1,081	286	1,778	3,632	497	8	281	1,034	8,597
Randolph	432	230	961	3,042	405	5	273	593	5,941
Russell	2,401	443	2,677	7,693	714	17	595	1,814	16,354
St. Clair	1,859	274	2,207	8,402	920	14	702	1,768	16,146
Shelby	1,935	397	2,432	12,119	977	6	734	2,379	20,979
Sumter	673	226	1,268	1,829	295	5	143	618	5,057
Talladega	3,812	623	4,889	9,881	1,546	55	1,221	2,442	24,469
Tallapoosa	1,007	414	2,001	5,415	767	7	564	1,181	11,356
Tuscaloosa	2,951	998	7,784	19,827	1,889	37	1,227	5,421	40,134
Walker	1,471	582	3,930	8,390	1,227	13	912	1,857	18,382
Washington	325	155	814	1,867	276	3	165	441	4,046
Wilcox	618	198	1,648	2,032	303	2	127	564	5,492
Winston	685	266	1,174	2,810	563	4	400	514	6,416
Youth Services	0	0	0	196	0	0	0	0	196
Statewide	**111,260**	**31,462**	**193,813**	**540,274**	**64,657**	**911**	**43,443**	**124,217**	**1,110,037**

See Aid Categories Explained on page 21.

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

Aid Categories Explained

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

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

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

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

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

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

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

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

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

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

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

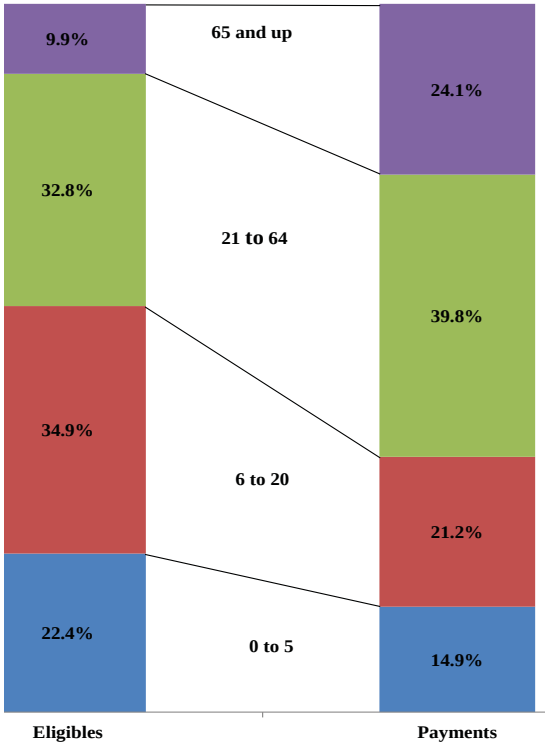
FY 2012
County Impact
Average Annual Benefit Payments[1] Per Annual Eligible[2] by County

County	Benefit Payments[1]	Annual Eligibles[2]	Avg. Payment per Eligible	County	Benefit Payments[1]	Annual Eligibles[2]	Avg. Payment per Eligible
Autauga	$ 34,784,758	10,106	$3,442	Houston	$ 102,942,002	27,150	$3,792
Baldwin	111,918,157	32,295	$3,465	Jackson	51,804,432	12,556	$4,126
Barbour	31,198,728	8,209	$3,801	Jefferson	647,827,380	145,077	$4,465
Bibb	21,641,365	5,664	$3,821	Lamar	20,058,684	4,039	$4,966
Blount	44,314,730	11,866	$3,735	Lauderdale	76,286,962	19,010	$4,013
Bullock	18,413,160	4,024	$4,576	Lawrence	27,491,666	7,726	$3,558
Butler	27,014,175	6,955	$3,884	Lee	79,014,298	23,415	$3,375
Calhoun	124,707,525	31,375	$3,975	Limestone	52,485,357	14,523	$3,614
Chambers	37,688,226	10,026	$3,759	Lowndes	14,506,965	4,351	$3,334
Cherokee	25,452,718	6,542	$3,891	Macon	24,766,334	6,538	$3,788
Chilton	39,649,578	11,345	$3,495	Madison	189,526,937	52,557	$3,606
Choctaw	16,604,114	4,187	$3,966	Marengo	28,681,168	6,598	$4,347
Clarke	30,315,398	7,660	$3,958	Marion	32,431,067	7,956	$4,076
Clay	17,793,789	3,720	$4,783	Marshall	92,251,083	25,154	$3,667
Cleburne	15,300,197	3,869	$3,955	Mobile	429,931,915	106,008	$4,056
Coffee	43,662,709	10,002	$4,365	Monroe	26,101,748	6,459	$4,041
Colbert	50,238,434	13,121	$3,829	Montgomery	224,919,535	61,387	$3,664
Conecuh	18,130,917	4,559	$3,977	Morgan	110,440,567	26,086	$4,234
Coosa	11,001,654	2,604	$4,225	Perry	17,404,913	4,602	$3,782
Covington	45,145,304	10,694	$4,222	Pickens	24,726,992	5,890	$4,198
Crenshaw	17,820,731	4,177	$4,266	Pike	37,702,487	8,597	$4,386
Cullman	77,165,864	18,284	$4,220	Randolph	24,687,847	5,941	$4,156
Dale	43,087,377	11,701	$3,682	Russell	47,916,556	16,354	$2,930
Dallas	74,092,873	18,737	$3,954	St. Clair	64,225,134	16,146	$3,978
Dekalb	74,439,415	19,736	$3,772	Shelby	66,448,958	20,979	$3,167
Elmore	61,150,981	14,061	$4,349	Sumter	17,272,896	5,057	$3,416
Escambia	36,687,078	10,972	$3,344	Talladega	102,694,853	24,469	$4,197
Etowah	125,590,487	27,047	$4,643	Tallapoosa	48,815,731	11,356	$4,299
Fayette	21,908,579	4,526	$4,841	Tuscaloosa	182,055,107	40,134	$4,536
Franklin	34,258,712	9,518	$3,599	Walker	87,616,033	18,382	$4,766
Geneva	31,161,952	7,701	$4,046	Washington	15,706,234	4,046	$3,882
Greene	14,305,590	3,783	$3,782	Wilcox	18,589,822	5,492	$3,385
Hale	21,615,163	6,162	$3,508	Winston	29,759,220	6,416	$4,638
Henry	16,808,772	4,162	$4,039	Youth Services	2,154,826	196	$10,994
				Statewide	$4,434,314,921	1,110,037	$3,995

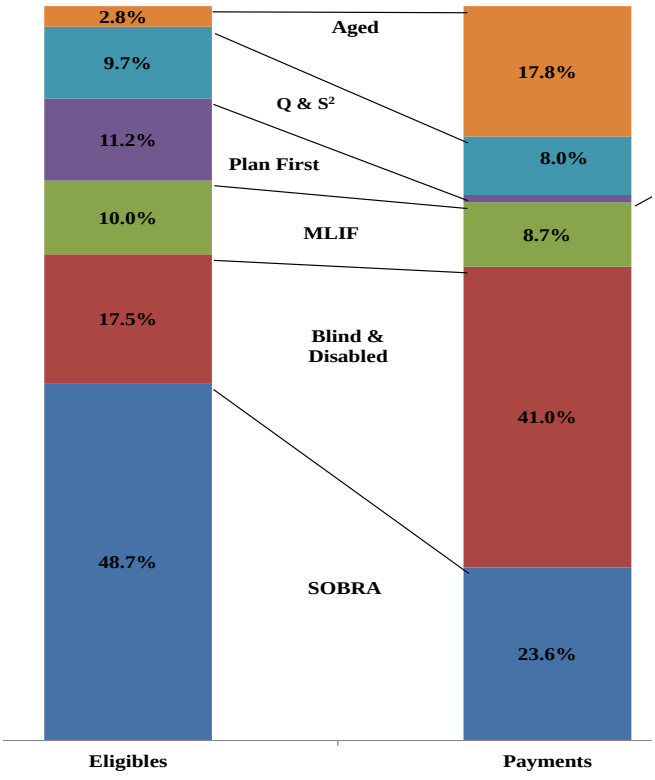
1. Excludes $1.2 billion of FY2012 Medicaid Agency expenditures (21% of the total) related to certified public expenditures by public hospitals, health insurance premiums for Medicare recipients, clawback payments for Medicare dual eligibles, administrative expenses, expenses of the Health Information Exchange and year end encumbrances. Inpatient/outpatient hospital payments and disproportionate share hospital payments that are included ($645 million) are not directly assocated with a recipient and have been allocated to recipients prorata based on their share of direct expenses.

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

FY 2012
Annual Eligibles and Claims Payments[1]
Percent Distribution By Age



FY 2012
Annual Eligibles and Claims Payments[1]
Percent Distribution By Category of Aid



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

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

FY 2012

Programs and Services: What Medicaid Provides

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

Patient 1st

The Patient 1st program is the cornerstone of Medicaid's health services and one of the initial building blocks of the Agency's transformation plans. Based on the medical home concept, Patient 1st links the Medicaid recipient with a physician or clinic that serves as the primary care provider to encourage a strong doctor/patient relationship.

Each month in FY 2012, an average of 545,153 Alabamians were enrolled in the Patient 1st program, including 450,253 children under age 21. In operation since 1997 and revamped in FY 2005, the Patient 1st program encourages appropriate use of the emergency room by Medicaid recipients and has increased the number of generic prescriptions written.

Recipients in the program benefit from patient education, in-home monitoring of chronic conditions, and a care coordination referral program for recipients who need assistance in using services appropriately.

Physicians participating in the Patient 1st program receive a monthly case management fee based on the components of the program that the physician uses to assist in the management of the recipient's health care needs.

Medical Services

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

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

Covered medical services include preventive and well-child care through Medicaid's Early, Periodic, Screening, Diagnosis and Treatment (EPSDT) program, eye and hearing care, inpatient and outpatient hospital care, and doctor visits. Lab and X-ray services are diagnostic procedures provided in conjunction with other covered services while renal dialysis and transplant coverage extend and improve hundreds of lives each year.

Some services, including dental, are limited to children under the age of 21 who have full Medicaid coverage, while

other services are limited to pregnancy-related care or family planning services. Some services or doctor visits are limited as well.

Medicaid also provides family planning services to help prevent or delay pregnancy; the Preventive Health Education program works to reduce unintended adolescent pregnancies while the Maternity Care Program serves pregnant women.

Long Term Care

A comprehensive program of long term care services is administered by the Alabama Medicaid Agency. This program offers eligible patients a range of care choices as well as increased opportunities to receive services at home or in the community.

These long term care services include home health services, private duty nursing, targeted case management, hospice care and durable medical equipment, as well as care in nursing and other long term care facilities.

In FY 2012, Alabama Medicaid paid claims of $918,431,563 for 5,963,914 nursing home bed-days of care at an average daily cost of $154 per day. Thousands of other recipients benefitted from hospice care, home health visits and access to supplies, appliances and durable medical equipment.

During FY 2012, more than 15,000 Alabama residents participated in one of seven waiver programs as an alternative to institutional care. They include the Elderly and Disabled, Intellectual Disabilities, HIV/AIDS, Technology Assisted, State of Alabama Independent Living (SAIL), Living at Home and the Alabama Community Transition (ACT) waivers.

Pharmacy Services

During FY 2012, the Pharmacy Services Division continued to seek out opportunities to further Medicaid's transformation transition. The program takes advantage of several electronic systems and tools to aid providers in complying with Medicaid's Preferred Drug List (PDL), brand limit requirements and prior authorization and override programs.

In FY 2012, the brand limit was limited to four brands per month. The number of prescriptions increased from the previous year to more than 8.96 million prescriptions dispensed while generic and over-the-counter utilization increased to 84 percent, representing a substantial savings to taxpayers.

Additionally, the program continued quality improvement efforts, including its Hemophilia Standard of Care Program as well as the Positive Antipsychotic Management Program.

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

Transportation Program

Medicaid covers ambulance transportation to and from medical facilities for eligible recipients. Approved services include ambulance service for emergency and non-emergency situations as well as non-emergency transportation coordinated by the Agency's Non-Emergency Transportation (NET) Program.

The NET Program helps eligible recipients pay for rides for medical care that can be planned ahead of time. In FY 2012, Medicaid funded 483,499 rides for 46,149 recipients at a cost of $7,459,866.

FY 2008 - FY 2012
Physician Program
Cost and Utilization by Age Category

Benefit Payments[1]

Age	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
0 to 5	$91,282,364	$93,583,030	$96,418,238	$96,381,582	$96,412,806
6 to 20	$50,436,856	$56,935,159	$62,050,018	$64,208,357	$64,622,217
21 to 64	$101,085,942	$119,688,063	$132,731,684	$134,216,535	$137,548,448
65 and up	$7,889,645	$9,975,770	$10,343,938	$7,180,788	$8,013,766
All Ages	$250,694,808	$280,182,021	$301,543,879	$301,987,262	$306,597,238

Recipients[2]

Age	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
0 to 5	173,829	183,419	194,681	197,630	196,250
6 to 20	179,277	194,008	212,226	221,107	224,793
21 to 64	145,239	156,069	167,357	174,968	178,613
65 and up	60,838	61,819	61,524	59,729	57,555
All Ages	549,418	584,006	623,569	641,790	645,263

Cost Per Recipient

Age	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
0 to 5	$525	$510	$495	$488	$491
6 to 20	$281	$293	$292	$290	$287
21 to 64	$696	$767	$793	$767	$770
65 and up	$130	$161	$168	$120	$139
All Ages	$456	$480	$484	$471	$475

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

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

FY 2008 - FY 2012
Lab and X-Ray Program
Cost and Utilization

	Payments[1]	Recipients[2]	Cost Per Recipient
FY 2008	$67,990,353	448,688	$152
FY 2009	$68,383,202	466,864	$147
FY 2010	$80,069,652	499,899	$160
FY 2011	$81,950,413	511,208	$160
FY 2012	$81,270,711	508,195	$160

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

2. Recipient count is an unduplicated count of individuals who received at least one Lab and X-Ray program service.

FY 2008 - FY 2012
Optometric Services
Cost and Utilization

	Payments[1]	Recipients[2]	Cost Per Recipient
FY 2008	$10,027,303	113,126	$89
FY 2009	$12,230,518	137,363	$89
FY 2010	$13,413,138	148,326	$90
FY 2011	$13,660,579	153,130	$89
FY 2012	$13,686,938	158,429	$86

FY 2008 - FY 2012
Eyeglasses
Cost and Utilization

	Payments[1]	Recipients[2]	Cost per Recipient
FY 2008	$3,656,837	92,738	$39
FY 2009	$4,210,554	103,690	$41
FY 2010	$4,751,566	113,301	$42
FY 2011	$4,641,623	116,310	$40
FY 2012	$3,338,044	114,565	$29

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

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

FY 2003 - FY 2012
Long Term Care Program
Utilization

	Total NH Patients Unduplicated	Avg. Length of Stay During Year	Total Patient-Days Paid For by Medicaid	Licensed Beds[1]	Medicaid Beds	Avg. % of Beds Used by Medicaid
FY 2003	28,056	276	7,749,218	26,618	17,467	66%
FY 2004	26,665	290	7,735,215	26,801	17,474	65%
FY 2005	27,213	290	7,890,883	26,681	17,380	65%
FY 2006	27,173	290	7,868,861	26,750	17,321	65%
FY 2007	26,431	282	7,441,542	27,001	16,902	63%
FY 2008	26,549	242	6,437,501	26,957	16,607	62%
FY 2009	26,145	241	6,297,605	26,756	16,587	62%
FY 2010	25,421	240	6,179,912	26,046	16,445	63%
FY 2011	24,882	248	6,170,511	25,687	16,139	63%
FY 2012	24,330	245	5,963,914	26,649	15,843	59%

FY 2012
Long Term Care Program
Patients, Days and Costs

	Nursing Home Patient-Days Paid By Medicaid	Nursing Home Claims[2] Paid By Medicaid	Average Cost Per Patient Day	Nursing Home Tax[3]	Tax as % of Claims	Nursing Home Cost to Medicaid Net of Tax	Average Cost Per Patient Day Net of Tax
FY 2003	7,749,218	$715,766,681	$92	$30,995,183	4.30%	$684,771,498	$88
FY 2004	7,735,215	$744,420,675	$96	$36,387,275	4.90%	$708,033,400	$92
FY 2005	7,890,883	$773,327,685	$98	$50,005,708	6.50%	$723,321,977	$92
FY 2006	7,868,861	$804,607,572	$102	$49,242,459	6.10%	$755,365,113	$96
FY 2007	7,441,542	$822,291,163	$111	$49,586,826	6.00%	$772,704,337	$104
FY 2008	6,437,501	$832,682,281	$129	$50,457,654	6.10%	$782,224,627	$122
FY 2009	6,297,605	$875,858,049	$139	$50,092,004	5.70%	$825,766,045	$131
FY 2010	6,214,316	$874,469,195	$142	$49,409,534	5.70%	$825,059,661	$134
FY 2011	6,170,511	$916,393,701	$149	$77,904,662	8.50%	$838,489,039	$136
FY 2012	5,963,914	$918,431,563	$154	$106,049,403	11.50%	$812,382,160	$136

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

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

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

FY 2008 - FY2012
Long Term Care Program
Intermediate Care Facility for Intellectually Disabled

	Claims[1] Payments	Recipients	Average Cost per Day	Average Cost per Recipient
FY 2008	$34,936,471	241	$401	$144,965
FY 2009	$38,024,252	242	$445	$157,125
FY 2010	$34,861,353	223	$462	$156,329
FY 2011	$32,104,030	202	$496	$158,931
FY 2012	$10,584,848[2]	123	$553	$ 86,056

FY 2010 - 2012
Long Term Care Program
Recipients and Claims[1] Payments by Gender, Race and Age
Claims Data Only*

	Recipients			Claims Payments[1]			Annual Average Cost Per Recipient			
	FY 2010	FY 2011	FY 2012	FY 2010	FY 2011	FY 2012		FY 2010	FY 2011	FY 2012
By Gender										
Female	18,124	17,564	17,129	$627,394,066	$651,538,129	$653,054,687		$34,617	$37,095	$38,126
Male	7,297	7,318	7,201	$247,075,128	$264,855,572	$265,376,876		$33,860	$36,192	$36,853
By Race										
African Am.	7,502	7,324	7,247	$266,888,959	$280,079,783	$283,113,949		$35,576	$38,241	$39,066
Am. Indian	8	6	11	$249,303	$275,076	$420,567		$31,163	$45,846	$38,233
Asian	58	51	56	$2,055,782	$2,000,805	$2,385,170		$35,445	$39,231	$42,592
Hispanic	46	47	53	$1,698,225	$1,756,919	$2,334,787		$36,918	$37,381	$44,053
Other	20	22	18	$648,158	$792,358	$747,174		$32,408	$36,016	$41,510
Unknown	370	394	420	$10,530,354	$11,252,988	$11,632,251		$28,460	$28,561	$27,696
White	17,417	17,038	16,525	$592,398,414	$620,235,773	$617,797,666		$34,013	$36,403	$37,386
By Age										
0-5	16	18	20	$814,976	$1,159,263	$1,191,743		$50,936	$64,404	$59,587
6-20	109	100	106	$6,980,041	$6,340,177	$6,585,670		$64,037	$63,402	$62,129
21-64	4,649	4,768	4,866	$163,759,995	$178,696,216	$186,718,902		$35,225	$37,478	$38,372
65-74	4,464	4,439	4,466	$149,485,561	$160,148,080	$166,277,845		$33,487	$36,078	$37,232
75-84	7,539	7,277	7,057	$254,077,117	$262,928,617	$259,538,457		$33,702	$36,131	$36,777
85 & Over	8,644	8,280	7,815	$299,351,504	$307,121,347	$298,118,947		$34,631	$37,092	$38,147
Statewide	**25,421**	**24,882**	**24,330**	**$874,469,195**	**$916,393,701**	**$918,431,563**	**Statewide**	**$34,399**	**$36,830**	**$37,749**

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

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

FY 2008 - FY 2012
Pharmacy Program
Cost

	Benefit Payments[1]	Clawback Payments[2]	Pharmacy Expenditures[3]	Drug Rebates	Pharmacy Provider Tax	Net Cost to Medicaid[4]	Rebates as % of Benefits	Clawback as % of Net Cost	Pharmacy Tax as % of Benefits
FY 2008	$438,884,239	$63,755,181	$502,639,420	($140,021,971)	($8,325,447)	$354,292,002	31.9%	18.0%	1.9%
FY 2009	$467,574,479	$65,721,030	$533,295,509	($155,712,772)	($8,407,870)	$369,174,867	33.3%	17.8%	1.8%
FY 2010	$502,254,947	$33,567,187	$535,822,134	($170,598,876)	($8,629,329)	$356,593,929	34.0%	9.4%	1.7%
FY 2011	$496,128,925	$50,798,631	$546,927,556	($218,474,908)	($8,938,136)	$319,514,512	44.0%	15.9%	1.8%
FY 2012	$526,082,696	$67,028,930	$593,111,626	($235,235,762)	($9,262,104)	$348,613,760	44.7%	19.2%	1.8%

FY 2008 - FY 2012
Pharmacy Program
Annual Utilization

	Net Cost to Medicaid[4]	Pharmacy Recipients[5]	Monthly Pharmacy Averge Eligibles	Recipients As % of Pharmacy Eligibles[6]	Cost Per Recipient[7]	Number of Prescriptions	Prescriptions Per Recipient[8]	Net Cost Per Prescription[9]
FY 2008	$354,292,002	507,343	672,047	62%	$698	7,263,645	14.32	$48.78
FY 2009	$369,174,867	541,561	715,512	63%	$682	7,844,949	14.49	$47.06
FY 2010	$356,593,929	578,734	765,179	62%	$616	8,603,799	14.87	$41.45
FY 2011	$319,514,512	605,543	821,291	63%	$528	8,867,049	14.64	$36.03
FY 2012	$348,613,760	608,500	842,824	61%	$573	8,961,210	14.73	$38.90

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

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

3. Pharmacy Expenditures = Benefit Payments plus Clawback payments

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

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

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

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

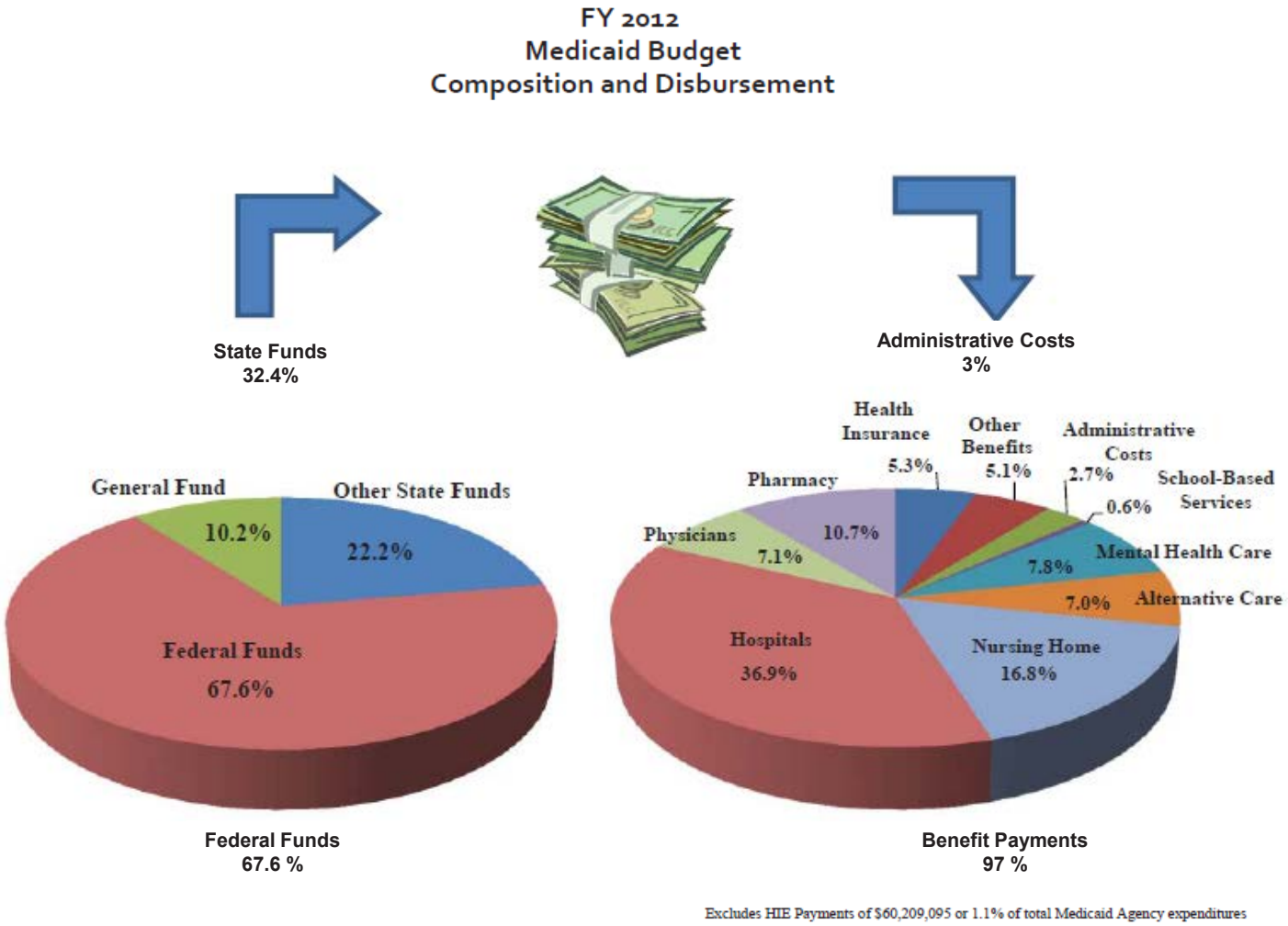
8. Prescriptions Per Recipient = Number of Prescriptions divided by Number of Pharmacy Recipients.

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

FY 2012

Revenues and Expenditures

In FY 2012, Medicaid paid $5,375,075,211 for health care services provided to Alabama citizens. Another $146,345,301 was spent administering the Medicaid program. This means that approximately 97 cents of every Medicaid dollar went directly to providing care and services to recipients. During Fiscal Year 2012, the agency's Federal Medical Assistance Percentage (FMAP) matching rate was 68.62 percent.



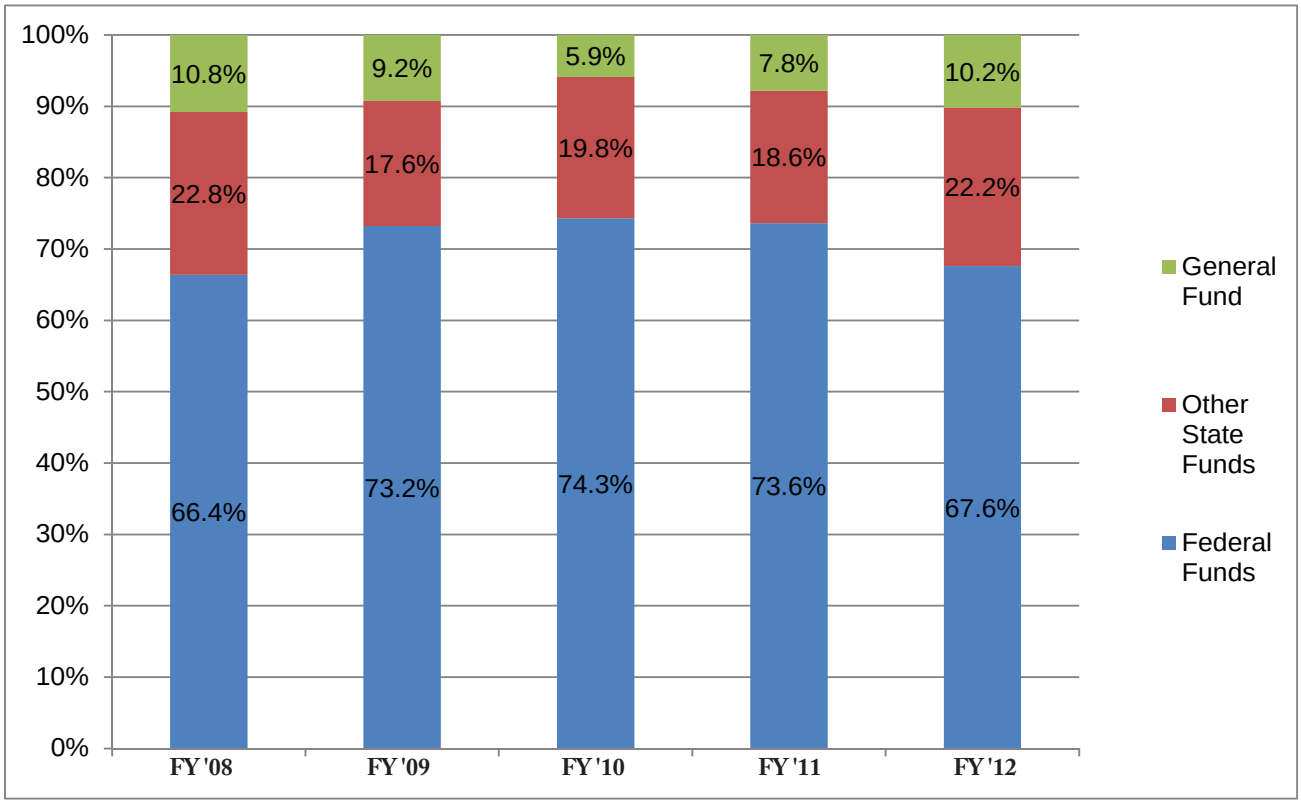
FY 2008 - FY 2012
State Share Funding Sources

						% of Total State Share Funding				
	FY08	**FY09**	**FY10**	**FY11**	**FY12**	**FY08**	**FY09**	**FY10**	**FY11**	**FY12**
General Fund										
Current Year Appropriation	$470,262,858	$622,478,155	307,968,537	$345,310,381	$643,788,706	32.0%	47.6%	22.5%	25.5%	35.4%
Adjustments	866,943	-171,748,477	6,999,282	54,976,729	-68,370,361	0.1%	-13.1%	0.5%	4.1%	-3.8%
Total General Fund	471,129,801	450,729,678	314,967,819	400,287,110	575,418,345	32.1%	34.5%	23.0%	29.6%	31.6%
Certified Public Expenditures										
Hospitals	582,155,986	454,610,747	422,973,043	270,871,386	499,912,172	39.7%	34.8%	30.9%	20.0%	27.5%
School-Based Services	10,500,000	18,357,202	21,627,419	34,377,361	22,704,404	0.7%	1.4%	1.6%	2.5%	1.2%
Total Certified Public Expenditures	592,655,986	472,967,949	444,600,462	305,248,747	522,616,576	40.4%	36.2%	32.4%	22.6%	28.7%
Alabama Health Care Trust Fund										
Hospital Provider Tax			211,242,108	215,521,701	226,276,852			15.4%	15.9%	12.4%
Nursing Home Provider Tax	50,457,654	50,092,004	49,409,534	77,904,662	106,049,403	3.4%	3.8%	3.6%	5.8%	5.8%
Pharmacy Provider Tax	8,325,447	8,407,870	8,629,329	8,938,136	9,262,104	0.6%	0.6%	0.6%	0.7%	0.5%
Total Ala. Health Care Trust Fund	58,783,101	58,499,874	269,280,971	302,364,499	341,588,359	4.0%	4.5%	19.7%	22.4%	18.8%
Intergovernmental Transfers										
State Agencies										
Dept. of Mental Health	135,982,379	126,478,973	112,279,686	131,619,537	148,104,358	9.3%	9.7%	8.2%	9.7%	8.1%
Dept. of Human Resources	39,000,000	32,238,259	24,928,735	33,107,350	39,411,775	2.7%	2.5%	1.8%	2.4%	2.2%
Dept. of Public Health	25,519,404	36,271,219	31,721,219	30,583,658	26,714,938	1.7%	2.8%	2.3%	2.3%	1.5%
Dept. of Senior Services	13,685,000	12,439,209	11,360,842	12,497,563	16,623,308	0.9%	1.0%	0.8%	0.9%	0.9%
Dept. of Rehabilitation Services	6,113,377	6,444,613	4,926,530	5,177,379	6,466,094	0.4%	0.5%	0.4%	0.4%	0.4%
Dept. of Youth Services	3,000,000	3,155,344	3,436,914	3,742,082	5,080,662	0.2%	0.2%	0.3%	0.3%	0.3%
Dept. of Education	89,162	2,952								
Total State Agencies	223,389,322	217,030,569	188,653,926	216,727,569	242,401,135	15.2%	16.6%	13.8%	16.0%	13.3%
Other Governmental Bodies	24,562,871	25,987,933	14,268,298	2,967,067	29,134,723	1.7%	2.0%	1.0%	0.2%	1.6%
Total Intergovernmental Transfers	247,952,193	243,018,502	202,922,224	219,694,636	271,535,858	16.9%	18.6%	14.8%	16.2%	14.9%
Other Funding Sources										
Drug Rebates- Federal and State	45,162,454	34,914,364	38,828,121	55,833,463	64,963,187	3.1%	2.7%	2.8%	4.1%	3.6%
Medicaid Trust Fund - Tobacco	37,452,533	35,111,965	36,925,675	29,956,125	30,644,931	2.6%	2.7%	2.7%	2.2%	1.7%
Other Miscellaneous Receipts	14,356,452	12,393,558	62,838,171	39,197,658	13,281,513	1.0%	0.9%	4.6%	2.9%	0.7%
Total Other Funding Sources	96,971,439	82,419,887	138,591,967	124,987,246	108,889,631	6.6%	6.3%	10.1%	9.2%	6.0%
Total State Funds	**$1,467,492,520**	**$1,307,635,890**	**$1,370,363,443**	**$1,352,582,238**	**$1,820,048,769**	**100%**	**100%**	**100%**	**100%**	**100%**

Note: Data is based on Agency's Executive Budget Office financial records and includes expenditures, purchase orders and year-end encumbrances.

FY 2008 - FY 2012
Sources of Medicaid Funding

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Federal Funds					
Match FMAP[1]	$2,901,014,526	$3,212,464,019	$3,540,721,118	$3,492,130,946	$3,734,479,126
Stimulus Funds	-	355,003,009	416,456,973	240,226,571	-
Health Information Exchange	-	-	-	32,163,520	60,114,778
Total Federal Funds	**2,901,014,526**	**3,567,467,028**	**3,957,178,091**	**3,764,521,037**	**3,794,593,904**
State Funds					
General Fund	471,129,801	450,729,678	314,967,819	400,287,110	575,418,345
Other State Funds	996,362,719	856,906,212	1,055,395,624	952,295,128	1,244,630,424
Total State Funds	1,467,492,520	1,307,635,890	1,370,363,443	1,352,582,238	1,820,048,769
Total Funding	**$4,368,507,046**	**$4,875,102,918**	**$5,327,541,534**	**$5,117,103,275**	**$5,614,642,673**



1. Federal Medical Assistance Percentage (FMAP) is the share of the cost of Medicaid that the federal government bears. That share varies by state depending on a state's per capita income. The average state FMAP is 57%, but ranges from 50% in wealthier states up to 75% in states with lower per capita incomes (the maximum FMAP is 82%). FMAPs are adjusted for each state on a three year cycle to account for fluctuations in the economy.

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

FY 2008 - FY 2012
Expenditures by Type of Service (total dollars)[1]

Service	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Nursing Facilities	$768,346,373	$958,916,510	$872,633,303	$898,684,381	$932,613,072
Hospital Care	$1,031,531,932	$1,108,187,131	$1,533,370,569	$1,499,870,826	$1,546,116,066
Hospital Care CPE[2]	$380,902,474	$366,943,640	$419,270,791	$258,240,638	$504,091,906
Physicians	$324,659,629	$363,073,104	$393,671,379	$394,295,050	$397,504,473
Pharmacy	$502,639,420	$533,295,509	$535,822,134	$546,927,556	$593,111,626
Health Support	$157,476,351	$183,606,786	$241,118,981	$206,590,686	$215,512,000
Alternative Care	$408,018,361	$442,367,686	$384,075,482	$396,450,006	$395,014,560
Mental Health Facilities	$39,897,359	$41,923,805	$34,859,102	$32,663,368	$10,626,732
Mental Health Waivers	$261,549,532	$273,470,968	$275,738,103	$285,804,858	$287,322,840
Mental Health Other	$95,109,253	$104,704,308	$123,205,822	$126,149,169	$132,413,000
Health Insurance	$238,574,122	$238,943,257	$266,472,795	$303,737,351	$296,483,036
Family Planning	$41,228,172	$52,486,112	$53,755,687	$62,825,818	$64,265,900
Total for Medical Benefits	**$4,249,932,978**	**$4,667,918,816**	**$5,133,994,148**	**$5,012,239,707**	**$5,375,075,211**
Administrative Costs	$120,033,448	$137,168,925	$134,966,896	$126,893,693	$146,345,301
School-based services	$27,813,379	$35,693,051	$40,443,057	$69,098,883	$45,329,475
Total Medicaid Expenditures	$4,397,779,805	$4,840,780,792	$5,309,404,101	$5,208,232,283	$5,566,749,987
Health Information Exchange				$32,398,855	$60,209,095
Agency Total Expenditures	**$4,397,779,805**	**$4,840,780,792**	**$5,309,404,101**	**$5,240,631,138**	**$5,626,959,082**

FY 2008 - FY 2012
Expenditures by Type of Service (as percent of total)[1]

Service	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
Nursing Facilities	17.5%	19.8%	16.4%	17.3%	16.8%
Hospital Care	23.5%	22.9%	28.9%	28.8%	27.8%
Hospital Care CPE	8.7%	7.6%	7.9%	5.0%	9.1%
Physicians	7.4%	7.5%	7.4%	7.6%	7.1%
Pharmacy	11.4%	11.0%	10.1%	10.5%	10.7%
Health Support	3.6%	3.8%	4.5%	4.0%	3.9%
Alternative Care	9.3%	9.1%	7.2%	7.6%	7.1%
Mental Health Facilities	0.9%	0.9%	0.7%	0.6%	0.2%
Mental Health Waivers	5.9%	5.6%	5.2%	5.5%	5.2%
Mental Health Other	2.2%	2.2%	2.3%	2.4%	2.4%
Health Insurance	5.4%	4.9%	5.0%	5.8%	5.3%
Family Planning	0.9%	1.1%	1.0%	1.2%	1.2%
Total For Medical Benefits	**96.6%**	**96.4%**	**96.7%**	**96.2%**	**96.6%**
Administrative Costs	2.7%	2.8%	2.5%	2.4%	2.6%
School Based Services	0.6%	0.7%	0.8%	1.3%	0.8%
Total Medicaid Expenditures[2]	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

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

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

3. Total Medicaid expenditures excludes Health Information Exchange expenses, which were 1.1% and 0.6% of total Medicaid Agency expenditures in FY 2012 and FY 2011, respectively.

FY 2012

Managing Medicaid's Assets

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

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

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

Program Integrity

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

Provider Review Unit

The Provider Review Unit examines medical provider billing to assure proper claim payment and recovery of identified overpayments. In FY 2012, reviews of 53 medical providers resulted in $3,053,958 in identified recoupments and $2,091,548 in collected recoupments.

Sanctions against providers and recipients resulted in $2,651,360 in cost savings for the Agency. In all, 59 providers were suspended from participation as Medicaid providers due to sanctions by their licensing boards and/or the U.S. Department of Health and Human Services Office of Inspector General. These provider sanctions netted a cost savings of $2,048,833. Suspension of 238 recipients from the Medicaid program resulted in a cost savings of $602,528.

Recipient Review Unit

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

In FY 2012, the Recipient Review Unit conducted 1,281 reviews. As a result, 938 recipients were restricted or "locked-in" to one doctor and one drug store resulting in $351,568 in cost savings for the Agency.

Investigations Unit

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

Quality Control Unit

The Quality Control Unit reviews eligibility determinations for accuracy to ensure that only eligible individuals qualify for Medicaid. Alabama's quality control rate between October 2011 and March 2012 period was 0.3257 percent.

Third Party

During FY 2012, the Third Party Division was successful in saving Alabama taxpayers more than $915 million. Through coordination of benefits, savings were achieved through a combination of: 1) cost avoidance of claims where providers are required to file with the primary payer first, 2) direct billing by Third Party to primary payers, 3) payment of Medicare and health insurance premiums, 4) liens and estate recovery, and 5) recipient recoveries. Medicaid also made premium payments to Medicare Advantage Plans for Medicaid enrollees, resulting in an avoidance of payments for Medicare deductibles and co-payments/coinsurance for certain Medicaid recipients.

FY 2010 - FY 2012
Collections

	FY 2010	FY 2011	FY 2012
Third Party Liability			
Includes reported and estimated third party collections by providers, retroactive Medicare recoupments from providers, and collections due to health and casualty insurance, estate recovery, and misspent funds resulting from eligibility errors.	$27,743,186	$31,134,766	$34,853,998
Program Integrity Division			
Provider Recoupment			
Medical Provider Recoupments Collected	$862,066	$2,666,832	$2,091,548
Pharmacy Recoupments	$299,033	_	_
Recovery Audit Contractor	_	$740,260	$727,514
Investigations	$191,592	$228,224	$90,636
Pharmacy Program			
In-House Processed Claims Corrections	$185,951	$51,830	$93,436
Total Collections	**$29,281,828**	**$34,821,912**	**$37,857,132**

FY 2010 - FY 2012
Measureable Cost Avoidance

	FY 2010	FY 2011	FY 2012
Third Party Claim Cost Avoidance Savings			
Traditional Medicare Net Savings (includes Provider Payments/Costs Avoidance/Recoupments less premium cost of:	$739,490,040	$686,854,615	$709,994,047
FY 2010 $245,820,370			
FY 2011 $276,136,212			
FY 2012 $258,244,762			
Provider Reported Collections - Health and Casualty Insurance	$33,421,290	$52,400,553	$51,985,828
Medicare Advantage Capitated Program Net Savings	$12,363,582	$3,532,297	$3,153,562
Claims Denied and Returned to providers to file health/casualty	$136,447,025	$117,671,354	$119,846,479
Health Insurance Premium Payment Cost Avoidance	$205,519	$310,873	$100,286
Waiver Services Cost Avoidance			
Elderly and Disabled Waiver*	$390,144,684	$386,869,912	$391,776,045
State of Alabama Independent Living (SAIL) Waiver	$23,375,891	$22,751,412	$22,673,900
Intellectual Disabilities Waiver**	$526,979,209	$531,162,294	$157,948,560
Living at Home Waiver**	$77,103,789	$80,414,205	$38,234,568
HIV/AIDS Waiver	$6,299,328	$7,251,160	$6,582,309
Program Integrity Cost Avoidance			
Pharmacy Cost Avoidance	$543,905	_	_
Provider Review Cost Avoidance	$3,321,149	$2,260,408	$2,504,401
Recipient Review Cost Avoidance	$489,387	$430,415	$351,568
Investigations Cost Avoidance	$2,074,139	$1,075,302	$266,282
Sanctioned Provider and Recipients	$1,676,803	$707,223	$2,651,360
Total Measurable Cost Avoidance	**$1,953,935,740**	**$1,893,692,023**	**$1,508,069,195**

* FY 12 included fundamental changes to program; Program moved from ADPH to ADSS.
** FY 12 States larges ICF/ Intellectually Disabled closed in December 2011; therefore cost avoidance is lower.

FY 2010 - FY 2012
Program Integrity

Provider Reviews

	FY 2010	FY 2011	FY 2012
Medical Providers	48	110	53
Medical Providers Recoupments - Identified	$1,858,066	$2,818,423	$3,053,958
Medical Providers Recoupments - Collected	$862,066	$2,666,832	$2,091,548
Pharmacy Providers	424	-	-
Medical Providers Recoupments - Identified	$543,905	-	-
Medical Providers Recoupments - Collected	$299,033	-	-
Recovery Audit Contractor	-	534	93
Recoupments - Identified	-	$1,796,421	$434,293
Recoupments - Collected	-	$740,260	$727,514

Recipient Reviews

	FY 2010	FY 2011	FY 2012
Reviews Conducted	1,401	1,171	1,281
Restricted Recipients	840	918	938
Recipient Review Cost Avoidance	$489,387	$430,415	$351,568

Investigations

	FY 2010	FY 2011	FY 2012
Provider & Recipient Recoupments - Identified	$1,066,888	$1,174,912	$581,577
Provider & Recipient Recoupments - Collected	$191,592	$228,224	$90,636

Tax Intercept Receipts

	FY 2010	FY 2011	FY 2012
Tax Intercept Receipts	$38,543	$38,680	$33,189

Program Integrity Cost Avoidance Savings

	FY 2010	FY 2011	FY 2012
Provider Review Cost Avoidance	3,321,149	$2,260,408	$2,504,401
Recipient Review Cost Avoidance	489,387	430,415	351,568
Investigation Cost Avoidance	$2,074,139	1,075,302	266,282
Sanctioned Provider and Recipients	$1,676,803	$707,223	$2,651,360

FY 2012 Annual Report

October 1, 2011- September 30, 2012

Alabama Medicaid Agency

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Montgomery, AL 36103-5624

Statistical data provided by the Alabama Medicaid Quality Analytics Division

This report can be viewed at our website

www.medicaid.alabama.gov