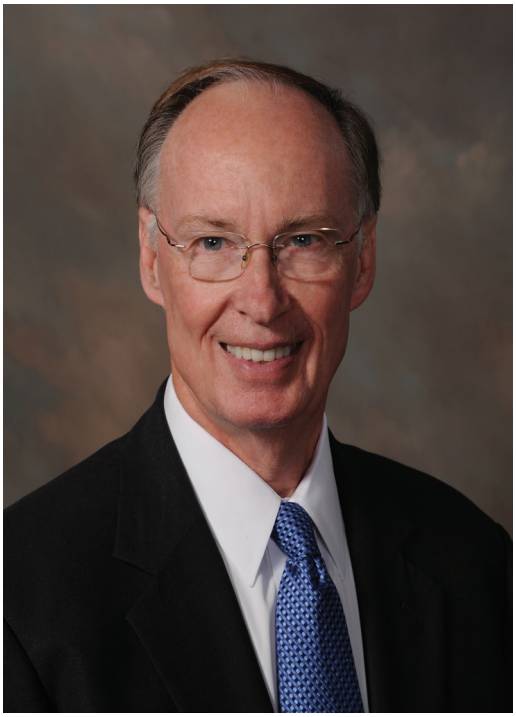
Alabama Medicaid Agency

Annual Report Fiscal Year 2015

October 2014-September 2015



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,

I am pleased and honored to present you the Alabama Medicaid Agency Annual Report for Fiscal Year 2015.

Pivotal milestones were met in the development of Regional Care Organizations (RCOs), locally-led managed care vehicles that are moving Medicaid away from a volume-based, fee-for-service patient health care system.

After meeting initial state requirements, including formation of a governing board and bylaws, 11 organizations were certified as probationary RCOs. The RCO Quality Assurance Committee established 10 measures to be incentivized under the new managed care system. By the end of the fiscal year, the probationary RCOs had reviewed the contract to be submitted to the Centers for Medicare and Medicaid Services.

Concurrent with statewide expansion of the Alabama Medicaid Health Home program, six probationary RCOs were contracted to operate these programs that coordinate care for patients with certain chronic conditions to achieve improved health outcomes.

Alabama Medicaid appreciates the tremendous support of the Governor's Office as we continue to take steps to make landmark changes to address the health care needs of thousands of citizens across the state.

Sincerely,

Stephanie McGee Azar
Acting Commissioner
Alabama Medicaid Agency

FY 2015

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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.

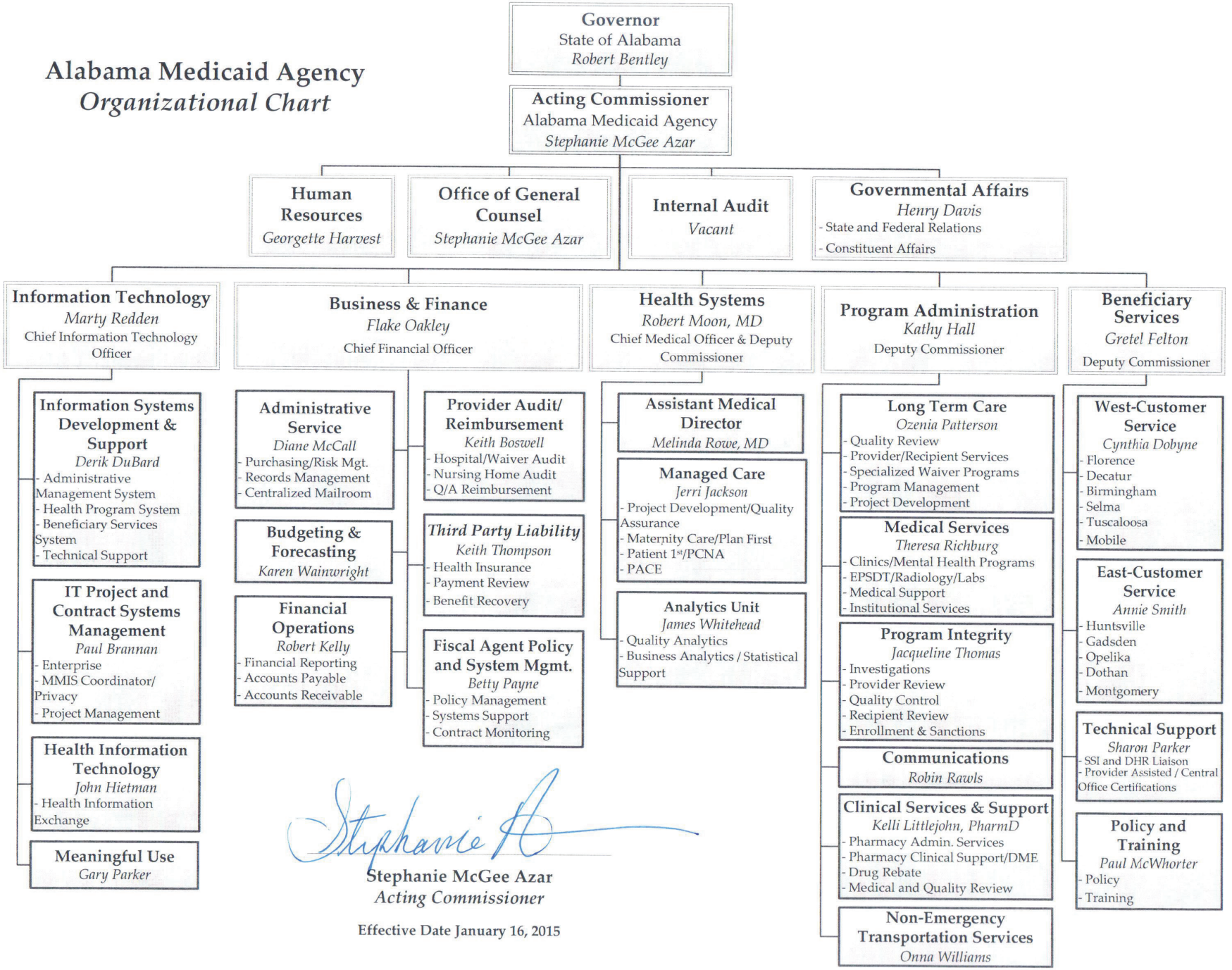
- Integrity
  Our stakeholders can depend on the quality, trustworthiness, and reliability of our Agency's employees and representatives.

- 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



Stephanie A

Stephanie McGee Azar
Acting Commissioner

Effective Date January 16, 2015

FY 2015

News through the Year

In Fiscal Year 2015, Medicaid moved closer to its goal of creating locally-led Regional Care Organizations (RCOs) that will ultimately provide healthcare services to most Alabama Medicaid recipients. Medicaid's transformation plans moved forward with certification of 11 probationary RCO applicants.

Other highlights of Fiscal Year 2015 included six probationary RCOs agreeing to operate Health Home programs after Alabama Medicaid expanded the program statewide and the Agency's final push to implement the ICD-10 diagnois codes after years of groundwork.

Eleven probationary Alabama RCOs certified

All 11 organizations that applied to be Alabama's first Regional Care Organizations received probationary certification in December 2014.

Probationary certification means that the various groups met initial requirements established by the state including formation of a governing board and bylaws, formation of a Citizens' Advisory Board, among others. The next step toward final approval requires the probationary RCOs to demonstrate that they can provide an adequate provider network and have financial solvency to operate a viable program no later than October 1, 2016.

The newly certified organizations included:

Region A (North Alabama): Alabama Community Care – Region A, Alabama Healthcare Advantage North, and My Care;

Region B (Central/East Alabama): Alabama Care Plan and Alabama Healthcare Advantage East;

Region C (West Alabama): Alabama Community Care – Region C and Alabama Healthcare Advantage West;

Region D (Central/Southeast Alabama): Alabama Healthcare Advantage and Care Network of Alabama; and,

Region E (Southwest Alabama): Alabama Healthcare Advantage South and Gulf Coast Regional Care Organization.

Improved health outcomes goal for RCO quality assurance incentive measures

In addition to assuming the financial risk of providing health care, Medicaid's planned Regional Care Organizations will also be responsible for improving enrollees' health outcomes once the new system is underway in October 2016.

Agency officials announced that 10 quality assurance measures will be incentivized under the new managed care system. The announcement came at a November 2014 meeting of the RCO Quality Assurance (QA) Committee.

The 10 measures are a subset of 42 measures unanimously approved by the QA Committee earlier in 2014. Those 42 measures will be used for monitoring RCO performance, but the ten will be used in the incentive program. All but one of the 42 measures are nationally recognized and validated, allowing Alabama to compare its performance to other states and national benchmarks.

The QA committee was created under the 2013 law establishing Regional Care Organizations, and is comprised of healthcare professionals of which 60 percent or more must be physicians.

October	November	December	January	February	March
• Provider payment reductions reversed	• Connection time reduced for providers connecting to HIE	• 10 RCO measures to be incentivized announced	• 11 RCO applicants certified as probationary RCOs • Hospital outpatient visit reimbursement limit removed	• Public comment sought for HCBS Waiver statewide transition plan & SAIL Waiver transition plan compliance response	• One Health Record continues to emerge as vital tool

Health Home expansion to help patients with chronic health conditions

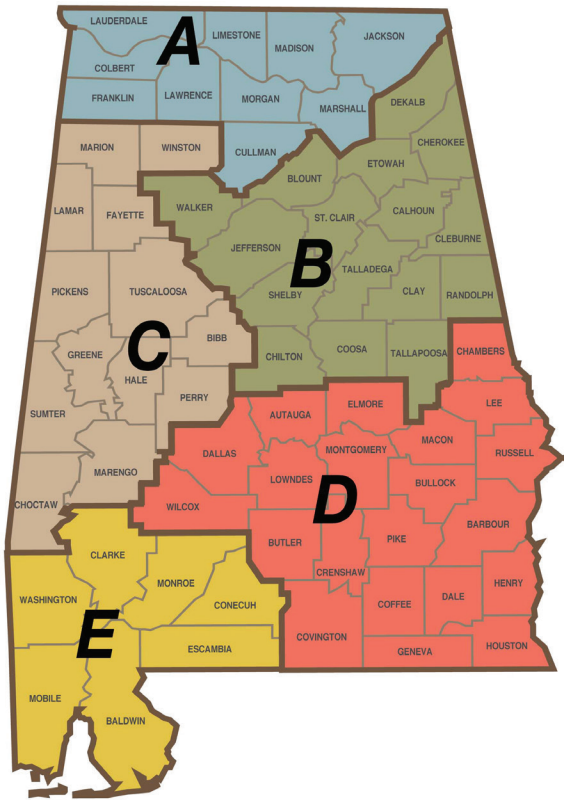
More than 250,000 Medicaid recipients with chronic health conditions began receiving access to enhanced care coordination and other services to improve their overall health when the Alabama Medicaid Agency expanded its Health Home program on April 1, 2015.

Six probationary Regional Care Organizations (RCOs) contracted to operate Health Home programs. The groups include: Region A: Alabama Community Care – Region A and My Care Alabama; Region B: Alabama Care Plan; Region C: Alabama Community Care – Region C; Region D: Care Network of Alabama; and Region E: Gulf Coast Regional Care Organization.

The program, which has operated since 2012 as Patient Care Networks in 21 counties of the state, expanded statewide as an interim step toward implementation of full-risk RCOs.

The Health Home program is defined by the federal government as an optional Medicaid program that integrates and coordinates care for patients with certain chronic conditions to achieve improved health outcomes.

In Alabama, the Health Home program adds an additional level of support to Patient 1st Primary Medical Providers (PMPs) by intensively coordinating the care of patients who have or who are at risk of having certain chronic conditions: asthma, diabetes, cancer, COPD, HIV, mental health



conditions, substance use disorders, transplants, sickle cell, BMI over 25, heart disease and hepatitis C.

Care management, or coordinated care, in the Health Home program is done by connecting patients with needed resources, teaching self-management skills, providing transitional care and bridging medical and behavioral services, among other efforts.

April	May	June	July	August	September
• Health Home expands statewide to Medicaid recipients with chronic health conditions	• Health Home & RCO topics covered in series of online programs • Five percent Agency cut included in General Fund budget	• Plan First 1115 Demonstration Waiver public forum held	• Dental Workgroup formed to study and report to governor	• Public comment sought for Living at Home Waiver renewal	• Probationary RCOs review CMS draft contract • Providers ready for ICD-10 code launch • Level funding approved for Medicaid

Contracts, rate development and data dominate RCO meeting discussions

Representatives of the state's 11 probationary Regional Care Organizations met in Montgomery to review the draft contract to be submitted to the Centers for Medicare and Medicaid Services in early October. The group also received updated information on various issues related to RCO implementation, including provider standards committee formation, encounter data and capitation rates.

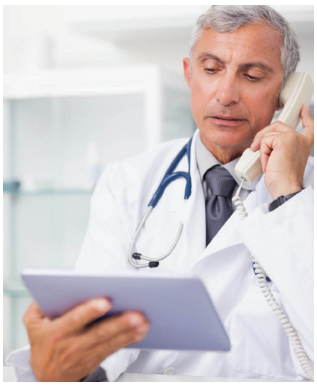
The updated version of the contract reflects the input of over 1,100 comments on a December 2014 version of the contract. Comments generally focused on finance, health IT, enrollment, encounters and legal issues.

The updated draft contract is also written with the expectation that CMS will require the Agency to maintain freedom of choice with the participation of at least two organizations in each region.

A short comment period will precede the document being submitted to CMS for approval. Federal approval of the contract is required before final RCO certification can take place.

Dental workgroup created to study and report to Governor, State Legislature

While Medicaid's dental program was not initially included in RCO-covered services, the 2013 RCO law required the Agency to evaluate its existing Medicaid dental program and report its findings to the governor and legislature at the beginning of FY 2016.



The group formed in the summer of 2015 and met during August and September. During the study period, the group heard presentations about Medicaid dental programs in other states and examined various models of care, including managed care, fee-for-service and hybrid models. The workgroup consisted of dental providers and organizations, plus physician groups, consumers, and other stakeholders.

Provider payment cuts started in 2013 reversed

Payment reductions made to certain providers during 2013 were reversed starting October 1, 2014. The cuts, made in order to help balance the Agency's 2014 budget, impacted physicians, dentists, lab and X-ray providers, durable medical equipment providers and renal dialysis providers.

Physician payments – including payments to physician assistants and nurse practitioners – had been reduced 7.5 percent on October 1, 2013. A 5 percent payment reduction to the other providers was implemented in April 2013. The reduction did not impact the federally-mandated payments to primary care physicians.

Annual limitation for hospital outpatient visit reimbursement removed

Outpatient visits were no longer limited to three per calendar year effective for dates of service January 1, 2015, and thereafter. As a result, Alabama Medicaid began reimbursing all in-state and out-of-state hospitals claims for medically necessary outpatient visits without regard to an annual limitation.

Public comments sought for Statewide Transition Plan & three HCBS waiver renewals

The Agency sought public comment in February and March on its proposed Statewide Transition Plan for Alabama Home and Community-Based Waiver programs. The Statewide Transition Plan is the vehicle through which states determine their compliance with regulation requirements for home and community based waiver programs and describes to Centers for Medicare and Medicaid (CMS) how they will comply with the new requirements.

The CMS final rule requires that all HCBS waiver programs meet certain qualifications. The Statewide Transition Plan is designed to ensure that individuals receiving long-term services and support through home and community-based service waiver programs have full access to benefits of community living and the opportunity to receive services in the most integrated setting that is appropriate.

The Statewide Transition plan will include the individual waiver transition plans from Intellectual Disabilities, State of Alabama Independent Living (SAIL) and Living at Home Waiver that were also presented for public comment during waiver renewal in 2015.

The Statewide transition plan includes actions the state proposes to ensure compliance with HCBS requirements for all waivers. The individual waiver renewals address all aspects of each program. The Statewide Transition plan only focuses on the settings in which services are delivered and their compliance with CMS' Final Rule.

Annual forum held for input on Medicaid's Plan First 1115 Demonstration Waiver

Providers, recipients and other interested individuals had the opportunity to provide input on the Alabama Medicaid Agency's Plan First program during a June 11, 2015 public forum in Montgomery.

The annual forum is a requirement by the Centers for Medicare and Medicaid Services (CMS) for the 1115 Demonstration Waiver under which the Plan First program operates. The waiver was originally approved in 2000 and renewed by CMS on December 29, 2014.

The goal of the Plan First program is to reduce unintended pregnancies and improve the well-being of Alabama's children and families by extending Medicaid eligibility for family planning services to eligible women ages 19-55 whose income is at or below 141 percent of the Federal Poverty Level.

New technology reduces connection time to state health information exchange

Changes to the state's health information exchange (HIE) technology make it possible to connect providers to One Health Record® in substantially less time than before, according to a report given during a November 2014 state Health Information Exchange (HIE) Commission meeting.

Under the previous technology platform, connections normally took around 90 to 100 days. But, the purchase of a new interface software engine allowed the HIE to successfully connect a clinic or hospital in less than one day.

The HIE commission provides oversight/guidance for the development and operation of One Health Record®.

State Legislature approves Fiscal Year 2016 level funding for Alabama Medicaid Agency

After two special sessions and much debate, the state of Alabama received a General Fund Budget for the fiscal year that began October 1, 2015. Gov. Robert Bentley signed the state General Fund budget on September 16 after days of discussions by legislators over how to fund Medicaid and other General Fund agencies.

The Alabama Legislature adjourned after approving a $1.75 billion General Fund budget which included $685 million for the Medicaid Agency's operations and a conditional appropriation of $40 million to continue reforms of its payment and delivery systems. Legislation to provide an

additional $16 million in provider taxes for Medicaid was approved as well.

While many state agencies experienced substantial cuts, Medicaid was level funded, thanks to legislative approval of a 25-cent-per-pack cigarette tax and the transfer of $80 million from education funds to cover the projected $200 million shortfall in the General Fund.

State workgroup evaluating wide range of Alabama Medicaid long term care services

Members of a state workgroup tasked with evaluating Medicaid long term care services began studying potential ways to improve quality and outcomes for Medicaid recipients in February. The group is looking at a wide range of services including institutional and community-based long term care.

The 17-member workgroup commissioned in 2013 by the legislation that created RCOs includes long term care and home care providers as well as state agency officials and consumer advocates. Long term care services are currently exempted under the RCO law.

National implementation of ICD-10 code set

Alabama Medicaid providers spent much of the year preparing to implement an updated standardized medical code set for medical diagnoses and inpatient hospital procedures to comply with requirements of the Health Insurance Portability Accountability Act (HIPAA).

The October 1, 2015, nationwide implementation date for the new ICD-10 codes culminates a multi-year transition effort. The new code set will replace the ICD-9 code that has not been updated in the U.S. for more than 35 years. All providers, with the exception of dental and pharmacy providers, will be affected by this change.

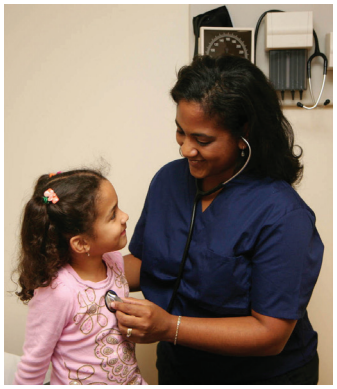
Medicaid joins state task force in tackling chronic health problems, access to care issues

Under the leadership of Dr. Don Williamson, chairman of the Medicaid Transition Task Force, the Alabama Health Care Improvement Task Force took its first steps toward finding potential solutions to some of the state's most compelling health care challenges.

Created in April 2015 by Gov. Robert Bentley, the 38-member task force is comprised of legislators, physicians, state agency officials, consumer advocates, and health care professionals from around the state. Acting Commissioner Stephanie Azar joined the group that is expected to explore possible reform ideas over the next three years and offer suggestions for policy changes to the Governor as early as the 2016 legislative session.

In the Executive Order creating the task force, Gov. Bentley cited a shortage of primary care doctors, the prevalence of chronic conditions and the closure of 10 hospitals between 2011 and 2013 as some of the major issues the task force hopes to solve.

Making health care accessible and affordable are only two of the challenges addressed by the group. At its second meeting chairs of the task force's three committees – Personnel, Infrastructure and Quality of Care outlined their focus areas. These include more telemedicine options; improving or ensuring access to hospitals, clinics or other facilities in rural or underserved urban areas; making sure communities have enough medical professionals; improving the integration of care for mental health and physical health; and improving the overall general health of Alabamians.



FY 2015

Eligibility

Bolstered by the 2014 overhaul of Medicaid's eligibility and enrollment system, and updated eligibility rules under the federal Affordable Care Act, the total number of Alabama residents eligible to receive Medicaid benefits for at least one month of the year during FY 2015 again exceeded 1.2 million, or 26.1 percent of the state's population.

The state's youngest citizens made up the largest category of Medicaid eligibles during the fiscal year with Medicaid paying for the health coverage of 55.6 percent of Alabama children under age 21. Over 36 percent of these eligible children were in families with at least one working caregiver.

A variety of Medicaid services are available to Medicaid-eligible Alabamians over the age of 65 and Medicaid covers the cost of care for approximately two-thirds of all nursing home residents.

Eligibles

Under federal regulations, states must provide coverage for certain groups in order to be eligible for federal funds. These groups include Supplemental Security Income (SSI) recipients; infants born to Medicaid-eligible pregnant women; children under age 19; pregnant women; 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

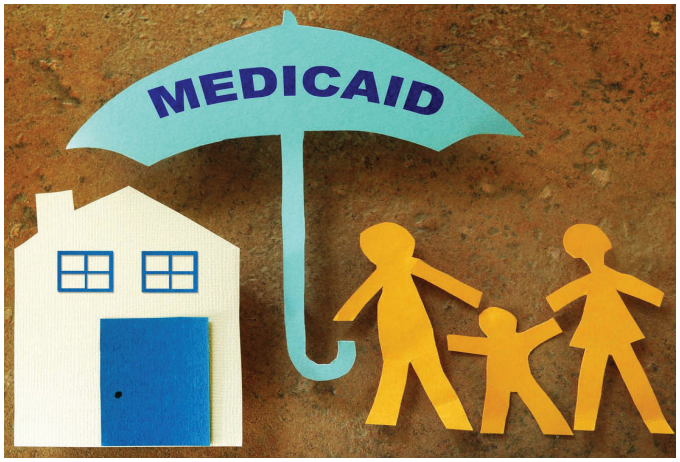
Several agencies determine Medicaid eligibility. Medicaid is responsible for certifying applicants for Elderly & Disabled programs; Parents and Other Caretaker Relatives (formerly known as MLIF); the program for children under age 19 and pregnant women; Plan First (Family Planning) Program; Breast and 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 live in Alabama, be a U.S. citizen or be in this country legally and meet income and age requirements that vary according to program.

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

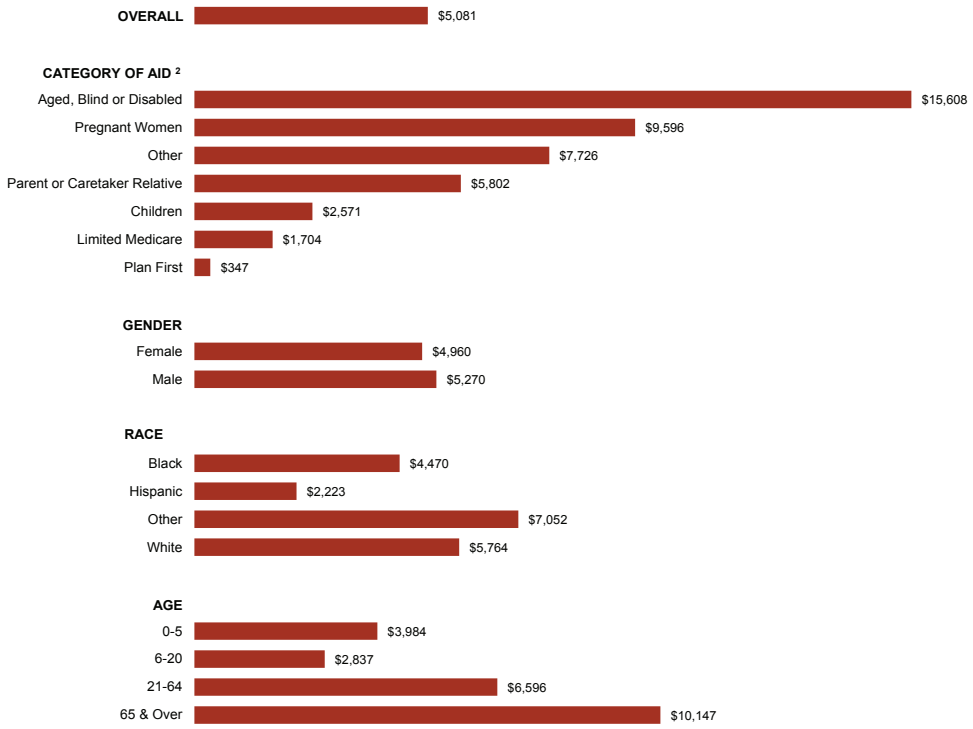


FY 2013 - FY 2015
Medicaid and Alabama Overview

Expenditures and Funding Sources	**FY 2013**	**FY 2014**	**FY 2015**
Expenditures			
Medicaid Agency Expenditures[1]	$5,586,012,819	$5,783,130,402	$6,073,280,030
Percent Change from Prior Year	-0.7%	3.5%	5.0%
Medicaid Medical Services Expenditures[2]	$4,874,240,794	$5,079,977,508	$5,335,816,017
Percent Change from Prior Year	-0.8%	4.2%	5.0%
Average Medicaid Medical Services Expenditures per Monthly Average Eligible[3]	$5,144	$5,019	$5,081
Percent Change from Prior Year	-1.6%	-2.4%	1.2%
Medicaid Medical Services Expenditures per Capita[4]	$1,008	$1,048	$1,098
Funding Sources			
Overall Federal Funding Percentage	67.6%	67.6%	68.4%
Overall State Funding Percentage	32.4%	32.4%	31.6%
State General Fund Percentage	11.0%	10.7%	11.3%
Utilization			
Alabama Population[5]			
Total	4,833,996	4,849,377	4,858,979
Adults	3,521,425	3,544,648	3,561,719
Children[6]	1,312,571	1,304,729	1,297,260
As a Percent of the Alabama Population	27.2%	26.9%	26.7%
Eligibles			
Monthly Average Medicaid Eligibility[7]			
Monthly Average Eligibles	947,594	1,012,125	1,050,117
Percent Change from Prior Year	0.9%	6.8%	3.8%
As a Percent of the Alabama Population	19.6%	20.9%	21.6%
Monthly Average Eligibles (Excluding CHIP)[9]	947,594	981,114	1,011,500
Percent Change from Prior Year	0.9%	3.5%	3.1%
Monthly Average Adult Eligibles	420,881	447,230	462,743
As a Percent of the Alabama Population	12.0%	12.6%	13.0%
Monthly Average Child Eligibles[6]	526,713	564,895	587,374
As a Percent of the Alabama Population	40.1%	43.3%	45.3%
Monthly Average Child Eligibles[6] (Excluding CHIP)[9]	526,713	533,884	548,757
Annual Medicaid Eligibility[8]			
Annual Eligibles	1,095,266	1,206,970	1,268,695
Percent Change from Prior Year	-1.3%	10.2%	5.1%
As a Percent of the Alabama Population	22.7%	24.9%	26.1%
Annual Eligibles (Excluding CHIP)[9]	1,095,266	1,153,944	1,210,928
Percent Change from Prior Year	0.9%	5.4%	4.9%
Annual Eligible Adults	516,923	523,323	547,221
As a Percent of the Alabama Adult Population	14.7%	14.8%	15.4%
Annual Eligible Children[6]	578,343	683,647	721,474
As a Percent of the Alabama Child Population	44.1%	52.4%	55.6%
Annual Eligible Children[6] (Excluding CHIP)[9]	578,343	630,621	663,707

[1] As reported by the Executive Budget Office.
[2] Total Medicaid medical services expenditures excludes Agency administrative costs, administrative costs of the school-based services program, payments to hospitals under the Disproportionate Share Hospital program and expenses of the Health Information Exchange.
[3] Total Medicaid medical services expenditures divided by the number of monthly average eligibles. See footnote 2 for a definition of the expenditures.
[4] Medicaid medical services expenditures divided by the total Alabama population. See footnote 2 for a definition of the expenditures.
[5] Population figures are extrapolated from the 2010 U.S. Census data by the Center for Business and Economic Research at the University of Alabama.
[6] Child/Children defined as those under age 21.
[7] The arithmetic average of the unduplicated number of individuals who qualified for full or partial Medicaid coverage in each month of the fiscal year.
[8] 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.
[9] CHIP includes children ages 6-18 with family income between 107% and 141% FPL. These children were transferred to Medicaid 1/1/14 to comply with ACA.

FY 2015
Annual Cost Per Monthly Average Eligible for Medical Care[1]
By Category of Aid, Gender, Race, and Age



[1] The annual cost per monthly average eligible for medical care is calculated based on total expenditures of $5,335,816,017 in FY 2015 divided by the annual average of monthly eligibles of 1,050,117. Total expenditures exclude the Medicaid Agency administrative expense, school-based services administration, expenses of the Health Information Exchange and Disproportionate Share Hospital payments, and include encumbrances and payables at the end of the fiscal year.
[2] See page 19 for definitions of aid categories.

Definitions of Eligibles and Recipients

Potential Eligibles

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

Annual Eligibles

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

Annual Recipients

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

Monthly Average Eligibles

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

Monthly Average Recipients

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

FY 2006 - FY 2015
Medicaid Annual Eligibles as a Percent of Population by Year

Year	State Population[1]	Annual Eligibles[2]	Annual Eligibles as % of Population	Monthly Average Eligibles[3]	Monthly Average Eligibles as % of Population
FY 2006	4,681,833	988,678	21.1%	798,820	17.1%
FY 2007	4,720,976	932,521	19.8%	737,025	15.6%
FY 2008	4,760,046	920,937	19.3%	756,564	15.9%
FY 2009	4,799,189	964,171	20.1%	803,187	16.7%
FY 2010	4,779,735	1,026,429	21.5%	851,199	17.8%
FY 2011	4,801,695	1,070,781	22.3%	912,767	19.0%
FY 2012	4,817,484	1,110,037	23.0%	939,576	19.5%
FY 2013	4,833,996	1,095,266	22.7%	947,594	19.6%
FY 2014	4,849,377	1,206,970	24.9%	1,012,125	20.9%
FY 2015	4,858,979	1,268,695	26.1%	1,050,117	21.6%

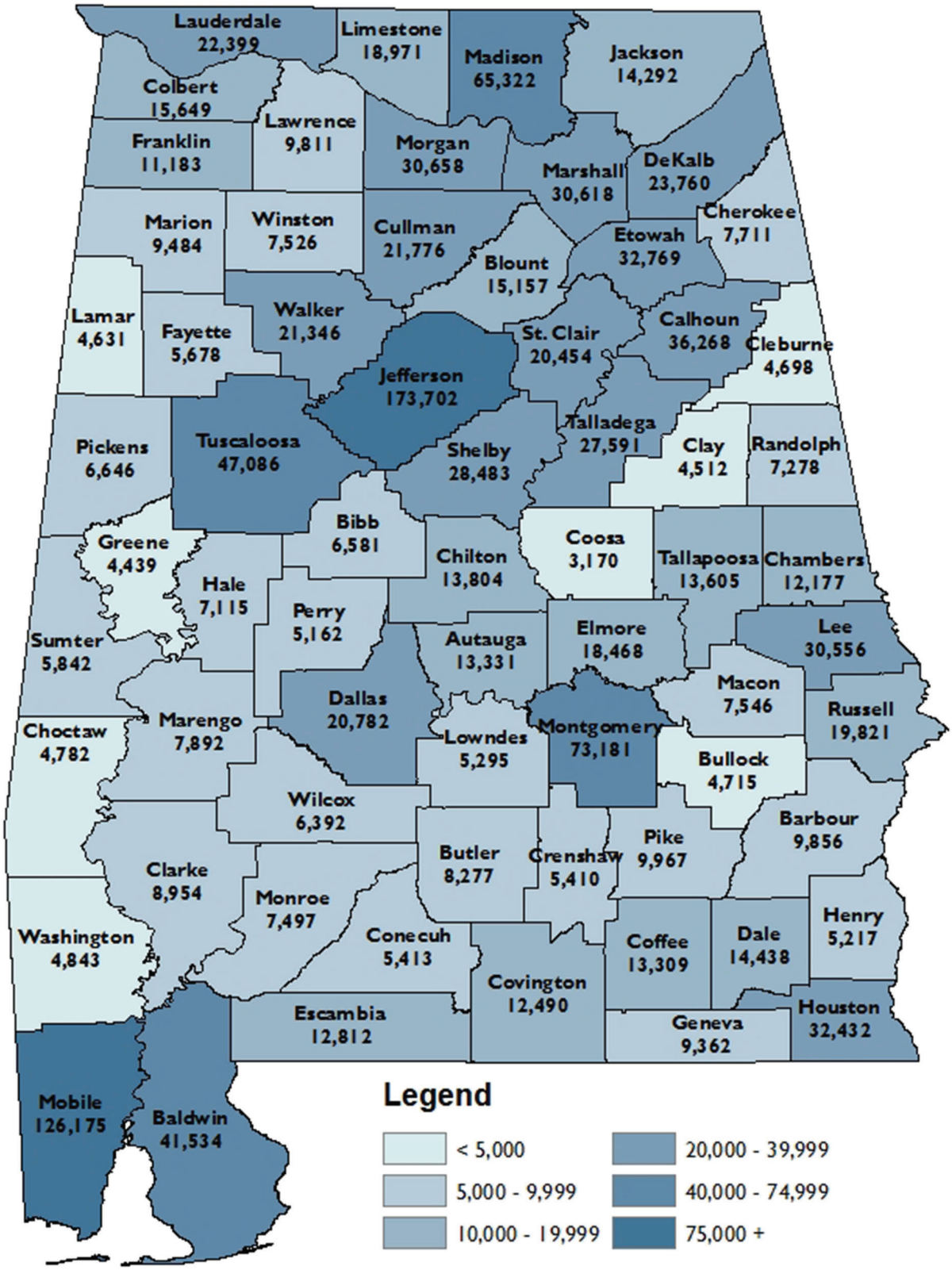
[1] Population figures are based on 2000 and 2010 U.S. Census data from the Center for Business and Economic Research, University of Alabama.
[2] An unduplicated count of individuals who qualified for full or partial Medicaid coverage and were enrolled in Medicaid for at least one month of the fiscal year.
[3] The arithmetic average of the unduplicated number of individuals who qualified for full or partial Medicaid coverage in each month of the fiscal year.

FY 2006 - FY 2015
Monthly and Average Annual Medicaid Eligibles[1]

	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
October	840,428	769,076	746,397	787,515	834,747	894,496	949,808	933,907	972,720	1,047,882
November	840,777	746,561	735,163	782,764	828,165	890,932	938,776	930,019	973,349	1,050,254
December	819,256	738,971	734,810	782,786	825,655	891,327	934,512	930,965	972,173	1,049,711
January	814,988	739,342	741,620	790,064	832,160	897,984	939,100	935,580	997,545	1,055,938
February	780,510	737,447	748,861	794,954	835,136	902,351	939,021	941,429	1,000,824	1,044,093
March	789,201	735,476	755,318	801,523	842,963	911,268	941,197	945,267	1,014,931	1,047,623
April	789,493	728,489	759,935	804,925	851,089	913,068	941,707	949,439	1,020,802	1,050,432
May	791,830	724,680	762,390	808,273	855,952	914,397	940,538	953,232	1,024,358	1,053,532
June	785,949	724,424	764,914	812,220	862,949	922,321	937,851	955,355	1,034,955	1,044,251
July	780,400	728,054	770,387	817,174	872,501	930,736	935,778	959,607	1,041,588	1,050,989
August	778,452	731,458	777,111	825,421	883,443	939,943	935,901	966,066	1,047,957	1,053,898
September	774,561	740,324	781,857	830,621	889,627	944,375	940,722	970,267	1,044,302	1,052,800
Annual Average	798,820	737,025	756,564	803,187	851,199	912,767	939,576	947,594	1,012,125	1,050,117

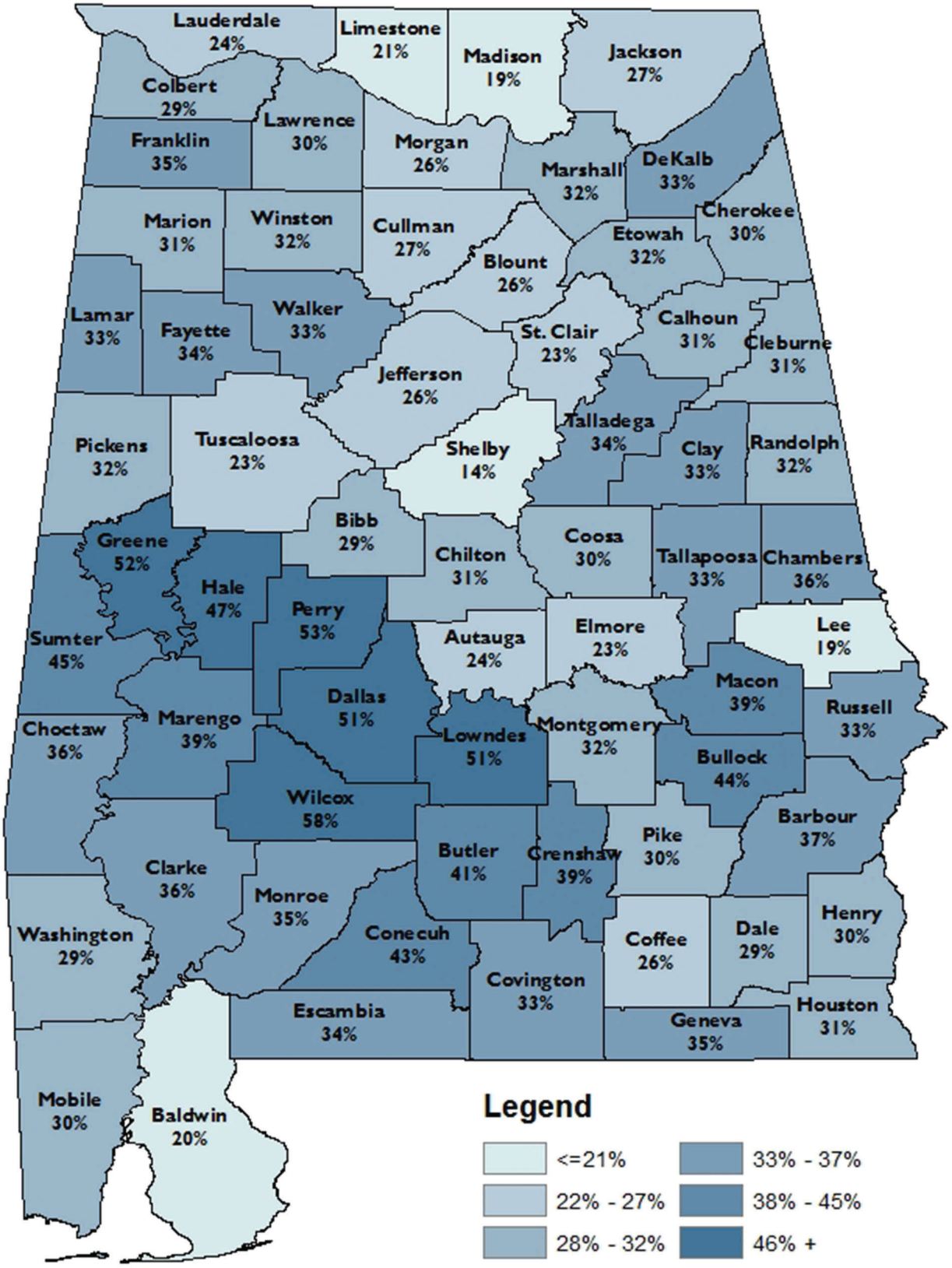
[1] An unduplicated number of individuals who qualified for full or partial Medicaid coverage in each month of the fiscal year. Annual average is the arithmetic average of the twelve months.

FY 2015
Medicaid Annual Eligibles[1] by County



[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.

FY 2015
Percent of Population Annually Eligible[1] by County



[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.

FY 2015
Medicaid Annual Eligibles[1] by Category of Aid[2] and County

County	ABD	Children	Limited Medicare	Other	POCR	Plan First	Pregnant Women	GRAND TOTAL[3]
Autauga	2,316	6,949	1,457	114	1,109	1,531	371	13,331
Baldwin	4,961	24,177	4,210	491	3,080	4,792	1,352	41,534
Barbour	2,044	4,880	1,172	87	826	1,065	259	9,856
Bibb	1,469	3,205	791	50	460	707	169	6,581
Blount	2,523	8,379	1,831	198	939	1,453	373	15,157
Bullock	1,090	2,244	511	47	379	528	102	4,715
Butler	1,622	4,113	916	65	647	1,111	267	8,277
Calhoun	6,756	18,342	3,929	330	3,372	4,152	1,085	36,268
Chambers	2,425	6,052	1,495	94	911	1,399	316	12,177
Cherokee	1,464	3,795	1,208	41	652	646	179	7,711
Chilton	2,197	7,627	1,519	186	984	1,387	357	13,804
Choctaw	1,106	2,176	603	35	431	542	94	4,782
Clarke	2,043	4,203	941	56	799	1,139	174	8,954
Clay	890	2,218	653	40	234	544	154	4,512
Cleburne	832	2,450	589	36	389	461	134	4,698
Coffee	2,342	7,118	1,371	152	1,134	1,390	353	13,309
Colbert	3,027	7,582	1,954	126	1,171	2,055	445	15,649
Conecuh	1,131	2,595	705	35	501	544	121	5,413
Coosa	792	1,352	554	22	191	292	81	3,170
Covington	2,389	6,229	1,598	71	1,027	1,388	390	12,490
Crenshaw	1,088	2,521	721	33	497	628	157	5,410
Cullman	4,139	11,074	3,017	257	1,216	2,216	804	21,776
Dale	2,954	7,197	1,531	113	1,245	1,609	424	14,438
Dallas	5,469	9,454	2,304	114	1,655	2,270	382	20,782
DeKalb	3,567	13,898	2,744	446	1,331	1,983	635	23,760
Elmore	3,334	9,772	1,920	146	1,292	2,135	617	18,468
Escambia	2,086	6,860	1,381	96	1,103	1,471	401	12,812
Etowah	6,586	16,514	4,216	311	2,392	3,236	814	32,769
Fayette	1,331	2,642	751	37	487	539	151	5,678
Franklin	1,729	6,305	1,277	248	748	996	297	11,183
Geneva	1,888	4,622	1,223	56	815	887	237	9,362
Greene	1,082	1,987	441	39	611	435	98	4,439
Hale	1,680	3,276	851	26	536	950	153	7,115
Henry	1,006	2,546	749	34	361	596	126	5,217
Houston	5,980	16,779	3,444	241	2,912	3,699	983	32,432
Jackson	2,562	7,274	2,053	150	1,006	1,288	446	14,292
Jefferson	33,627	90,964	18,267	2,418	11,997	19,351	4,251	173,702
Lamar	999	2,135	689	43	374	480	113	4,631
Lauderdale	3,994	11,131	2,876	226	1,362	3,094	690	22,399
Lawrence	1,919	4,851	1,156	77	891	1,071	277	9,811
Lee	4,779	17,177	2,475	427	2,423	3,448	990	30,556
Limestone	3,042	10,507	2,039	242	1,125	2,113	584	18,971
Lowndes	1,203	2,387	724	30	455	606	106	5,295
Macon	1,631	3,563	778	51	708	978	142	7,546
Madison	9,789	37,386	5,385	918	4,129	7,893	2,477	65,322
Marengo	2,031	3,486	933	35	639	942	182	7,892
Marion	1,840	4,533	1,411	65	741	988	270	9,484
Marshall	4,636	18,107	3,115	690	2,097	2,195	774	30,618
Mobile	20,188	69,206	11,573	1,206	8,974	16,612	4,406	126,175
Monroe	1,490	3,865	811	39	598	815	181	7,497
Montgomery	13,311	38,259	6,415	948	6,076	9,697	2,083	73,181
Morgan	5,560	16,845	2,779	474	2,053	3,251	1,002	30,658
Perry	1,394	2,282	634	24	349	616	105	5,162
Pickens	1,726	2,970	788	46	474	776	155	6,646
Pike	2,190	4,720	1,016	78	667	1,422	336	9,967
Randolph	1,355	3,802	890	73	460	799	217	7,278
Russell	3,317	10,748	1,738	146	1,832	2,215	495	19,821
St. Clair	2,961	11,097	2,343	138	1,991	2,095	607	20,454
Shelby	3,845	16,887	2,285	655	1,906	2,955	820	28,483
Sumter	1,561	2,347	538	38	880	721	124	5,842
Talladega	5,882	13,438	3,511	167	2,066	2,857	758	27,591
Tallapoosa	2,779	6,732	1,775	104	954	1,484	389	13,605
Tuscaloosa	9,510	24,012	4,237	578	3,071	6,363	1,633	47,086
Walker	4,805	10,081	2,801	184	1,598	2,155	520	21,346
Washington	1,035	2,436	545	38	436	465	84	4,843
Wilcox	1,883	2,812	622	22	467	768	89	6,392
Winston	1,579	3,546	1,214	52	499	720	212	7,526
DYS		445		1		3	1	448
STATEWIDE [3]	224,618	672,809	135,605	14,552	95,106	146,350	36,560	1,268,695*

[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] See definitions of aid categories descriptions on next page.
[3] Rows/columns do not equal the overall unduplicated count of eligibles* because during the year some persons live in multiple counties and some qualify for benefits under different categories.

Aid Categories Explained

Aged, Blind, and Disabled (ABD) – Individuals who are eligible for Medicaid services because they are 65 years of age or older, blind, or disabled. This includes individuals eligible or deemed eligible for SSI through the Social Security Administration, and other aged, blind or disabled individuals who meet Medicaid income, resource and medical level of care criteria and receive services in a certified Long Term Care facility or Medicaid waiver services in the community.

Children – Includes foster children, newborns of Medicaid eligible mothers, and all children under age 19 whose family income is at or below 141% of the federal poverty level.

Limited Medicare Programs – These are programs for low income Medicare beneficiaries who receive no Medicaid services but are eligible for Medicaid to help pay some of their Medicare cost sharing expenses. Programs include:

> **Qualified Medicare Beneficiary (QMB)** – People with income at 100% FPL. Medicaid pays Medicare co-insurance, deductibles and some premiums.
>
> **Specified Low-Income Medicare Beneficiary (SLMB)** – People with income from 101% FPL to 120% FPL. Medicaid only pays Medicare Part B premium.
>
> **Qualifying Individual (QI)** – People with income at 121% FPL to 135% FPL. Medicaid only pays Medicare Part B premium. This program is 100% federally funded as long as federal funds are available
>
> **Qualified Disabled and Working Individuals (QDWI)** – People with income at 200% FPL. Medicaid only pays Part A premium for individuals in this group.

Other – Individuals who are eligible for smaller eligibility groups such as:

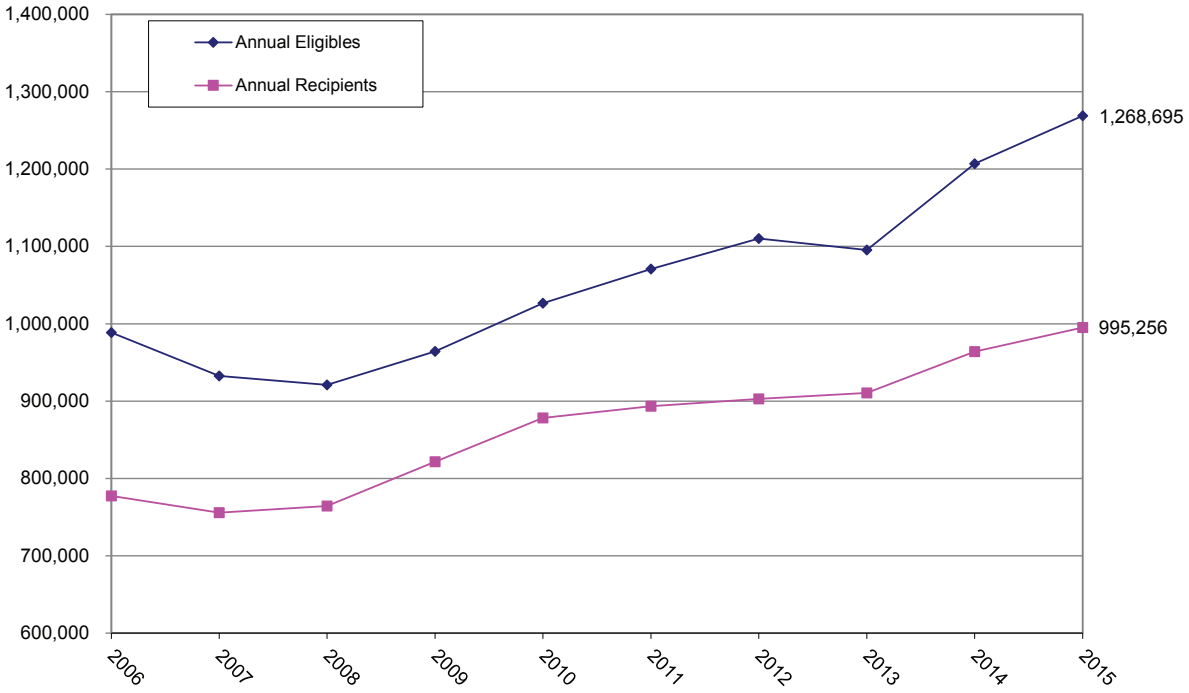
> Former Foster Care – Individuals who aged out of foster care in Alabama who are under age 26;
>
> Women under 65 who have been screened and diagnosed eligible for the Breast and Cervical Cancer Program;
>
> Non-Citizens who meet income and other requirements for Medicaid, but are eligible only for emergency services.

Parents and Other Caretaker Relatives (POCR) – Individuals with family income at or below 13% of the federal poverty level, who are parents or close relatives of a dependent child under age 19 who live with and assume responsibility for the child's care.

Plan First – A limited Medicaid program that only provides family planning services to women 19 through 55, and vasectomies to men age 21 and up with income at or below 141% of the federal poverty level, who would not otherwise qualify for Medicaid.

Pregnant Women – Pregnant women who are only eligible for Medicaid during pregnancy and sixty days post-partum, with family income at or below 141% of the federal poverty level (FPL).

FY 2006 - FY 2015
Annual Eligibles[1] and Recipients[2]
Utilization



Year	Annual Eligibles[1]	Annual Recipients[2]	Percentage[3]
FY 2006	988,678	777,374	78.6%
FY 2007	932,521	755,856	81.1%
FY 2008	920,937	764,420	83.0%
FY 2009	964,171	821,602	85.2%
FY 2010	1,026,429	878,232	85.6%
FY 2011	1,070,781	893,312	83.4%
FY 2012	1,110,037	902,870	81.3%
FY 2013	1,095,266	910,562	83.1%
FY 2014	1,206,970	963,883	79.9%
FY 2015	1,268,695	995,256	78.4%

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

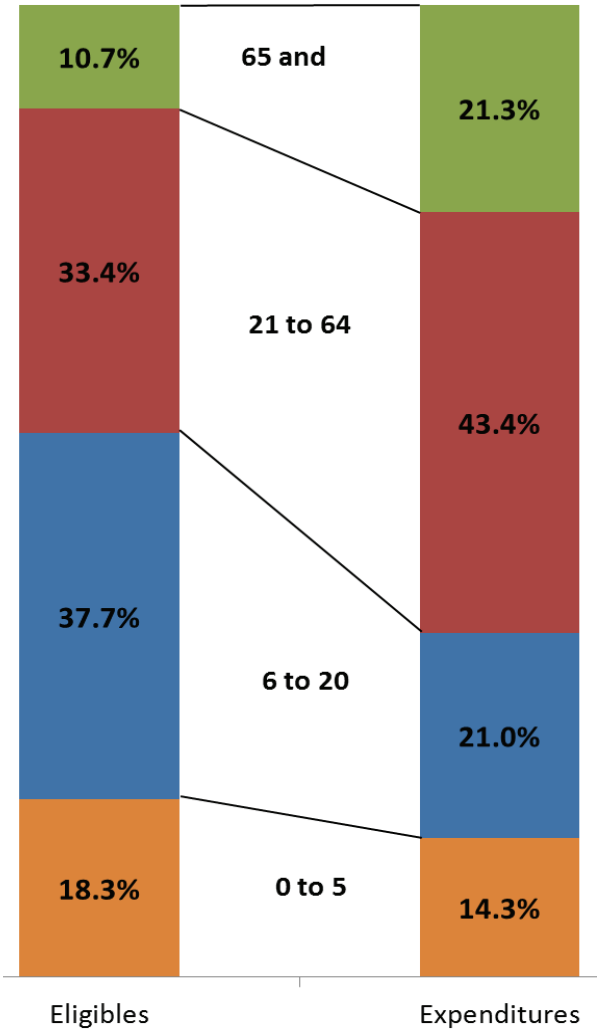
FY 2015
County Impact
Average Annual Benefit Payments[1] Per Monthly Average Eligible[2] by County

County	Benefit Payments	Monthly Avg. Eligibles	Avg. Payment Per Eligible	County	Benefit Payments	Monthly Avg. Eligibles	Avg. Payment Per Eligible
Autauga	$50,300,710	9,758	$5,155	Houston	$135,113,995	25,964	$5,204
Baldwin	$132,364,842	31,104	$4,256	Jackson	$56,323,946	10,894	$5,170
Barbour	$42,559,807	8,051	$5,286	Jefferson	$774,984,219	138,289	$5,604
Bibb	$25,717,172	5,196	$4,949	Lamar	$23,828,381	3,704	$6,432
Blount	$56,225,697	11,213	$5,014	Lauderdale	$83,632,555	17,346	$4,821
Bullock	$20,398,468	3,582	$5,695	Lawrence	$33,494,013	7,523	$4,452
Butler	$33,679,397	6,818	$4,940	Lee	$94,692,415	23,090	$4,101
Calhoun	$150,956,139	28,948	$5,215	Limestone	$64,256,504	14,383	$4,467
Chambers	$46,968,380	9,523	$4,932	Lowndes	$20,506,876	4,207	$4,874
Cherokee	$31,367,541	5,866	$5,347	Macon	$25,667,564	5,875	$4,369
Chilton	$51,459,115	10,595	$4,857	Madison	$226,848,256	50,362	$4,504
Choctaw	$17,204,992	3,855	$4,463	Marengo	$32,040,686	6,361	$5,037
Clarke	$35,952,008	7,388	$4,866	Marion	$38,730,134	7,176	$5,397
Clay	$18,909,773	3,460	$5,466	Marshall	$106,607,334	23,457	$4,545
Cleburne	$16,731,866	3,592	$4,658	Mobile	$549,835,512	102,463	$5,366
Coffee	$51,724,642	10,070	$5,136	Monroe	$30,101,163	5,912	$5,091
Colbert	$60,150,742	12,284	$4,897	Montgomery	$274,850,033	59,193	$4,643
Conecuh	$22,473,156	4,262	$5,273	Morgan	$127,056,508	23,531	$5,400
Coosa	$10,496,868	2,217	$4,734	Perry	$19,559,905	4,233	$4,621
Covington	$55,129,579	9,980	$5,524	Pickens	$30,333,683	5,410	$5,607
Crenshaw	$22,885,629	4,177	$5,479	Pike	$41,793,052	8,110	$5,153
Cullman	$92,196,721	16,980	$5,430	Randolph	$30,157,979	5,825	$5,177
Dale	$56,634,949	10,928	$5,183	Russell	$51,808,106	14,981	$3,458
Dallas	$85,633,899	17,634	$4,856	St.Clair	$75,035,544	15,349	$4,889
DeKalb	$87,167,599	18,504	$4,711	Shelby	$91,016,575	20,933	$4,348
Elmore	$78,006,374	13,848	$5,633	Sumter	$19,441,870	4,578	$4,247
Escambia	$44,033,910	10,178	$4,326	Talladega	$114,791,515	21,908	$5,240
Etowah	$152,377,145	25,163	$6,056	Tallapoosa	$59,596,756	10,612	$5,616
Fayette	$26,617,155	4,321	$6,161	Tuscaloosa	$201,248,547	37,749	$5,331
Franklin	$42,880,066	8,644	$4,961	Walker	$104,161,316	16,862	$6,177
Geneva	$38,155,743	7,372	$5,176	Washington	$20,930,908	3,807	$5,497
Greene	$15,780,963	3,543	$4,454	Wilcox	$22,932,535	5,230	$4,385
Hale	$25,207,978	5,725	$4,403	Winston	$31,826,099	5,791	$5,496
Henry	$22,480,270	4,033	$5,574	Youth Services	$1,782,238	193	$9,214
				Statewide	**$5,335,816,017**	**1,050,117**	**$5,081**

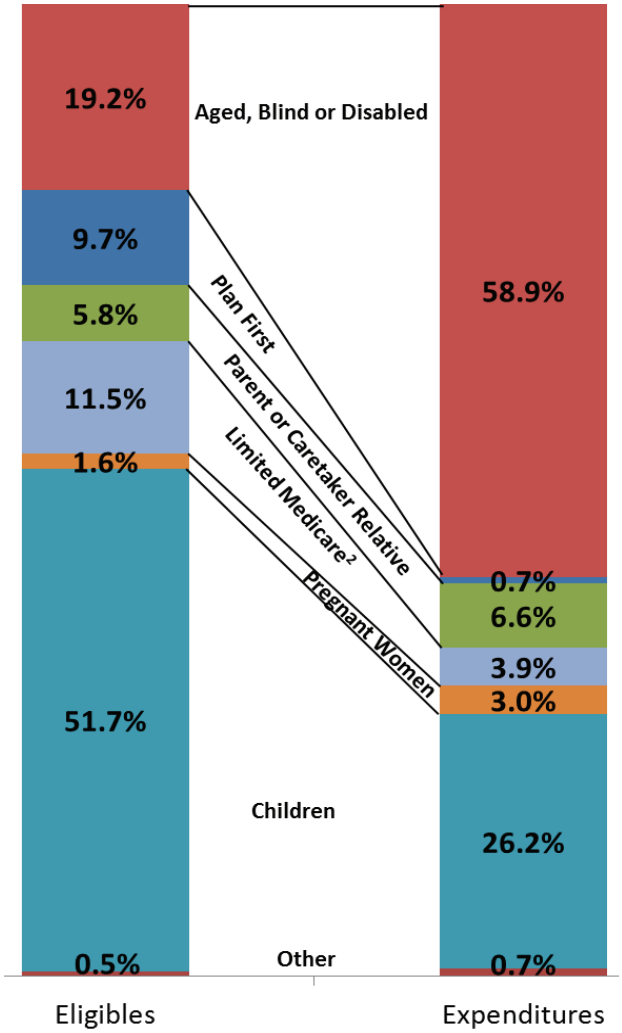
[1] Total Medicaid medical services expenditures excludes Agency administrative costs, administrative costs of the school-based services program, payments to hospitals under the Disproportionate Share Hospital program and expenses of the Health Information Exchange.
[2] The annual average of monthly eligibles.

FY 2015
Monthly Average Eligibles and Medical Expenditures[1]

FY 2015
Percent Distribution
By Age



FY 2015
Percent Distribution
By Category of Aid



[1] Total expenditures for medical services and support in FY 2015 were $5,335,816,017. Total expenditures exclude the Medicaid Agency administrative expense, school-based services administration, expenses of the Health Information Exchange and Disproportionate Share Hospital payments, and include encumbrances and payables at the end of the fiscal year. The average of monthly eligibles was 1,050,117.

[2] Limited Medicare - Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary and Qualifying Individual are low-income Medicare beneficiaries that have certain premiums, co-insurance, or deductibles paid for by Medicaid.

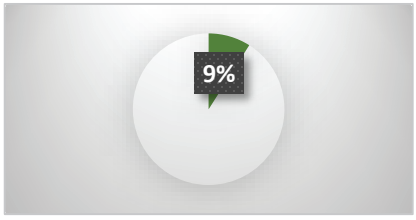
FY 2015
Who Alabama Medicaid Serves

Alabama Medicaid provided coverage to a monthly average of more than 1 million people during the fiscal year. These individuals fell into four main categories: children (under age 19), aged, blind and disabled, and other categories such as caretakers, pregnant women, and family planning recipients. The largest group served by Medicaid were children (51%). However, the blind and disabled segment of the population incurred the highest percentage of total expenses.

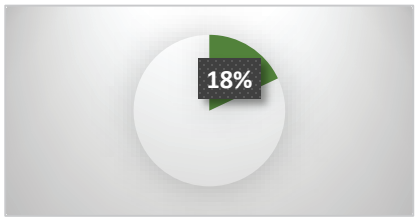
Aged

Age 65 & Over—Adults who are in poverty. Almost all are also covered by Medicare.

% of Members



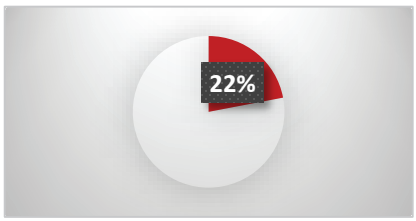
% of Expenditures



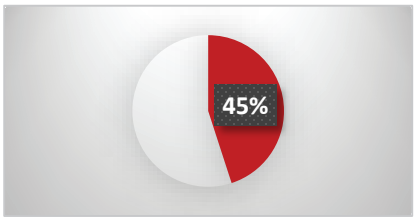
Disabled & Blind

Any Age—Determined by the Social Security Administration and have automatic Medicaid eligibility.

% of Members



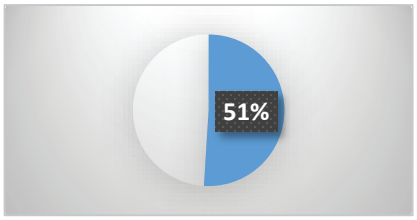
% of Expenditures



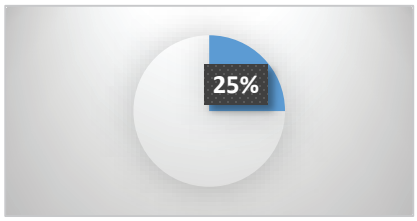
Children

Age 0-18—Children in families below 146% of the federal poverty level.

% of Members



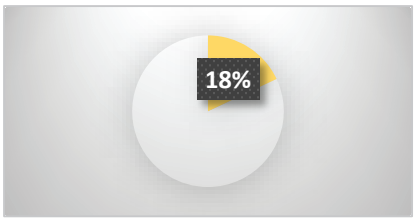
% of Expenditures



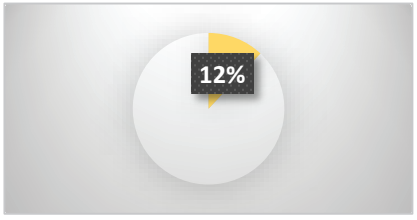
Other Categories

Age 19-64—Including pregnant women, parent caretakers, and family planning services.

% of Members

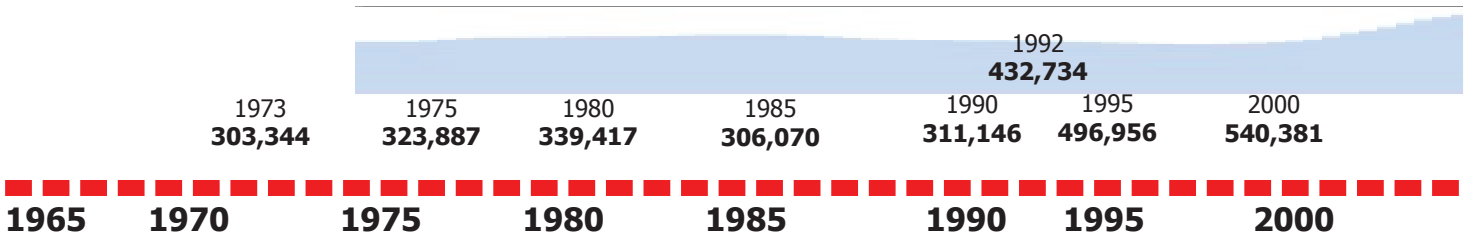


% of Expenditures

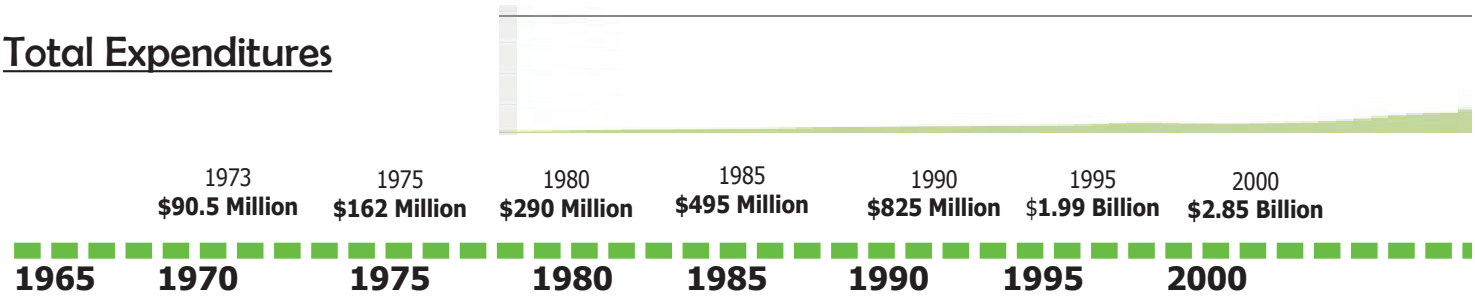


Expenditures based on dates of service in FY 2015. Membership includes eligibility applied retroactively as of March 2016.

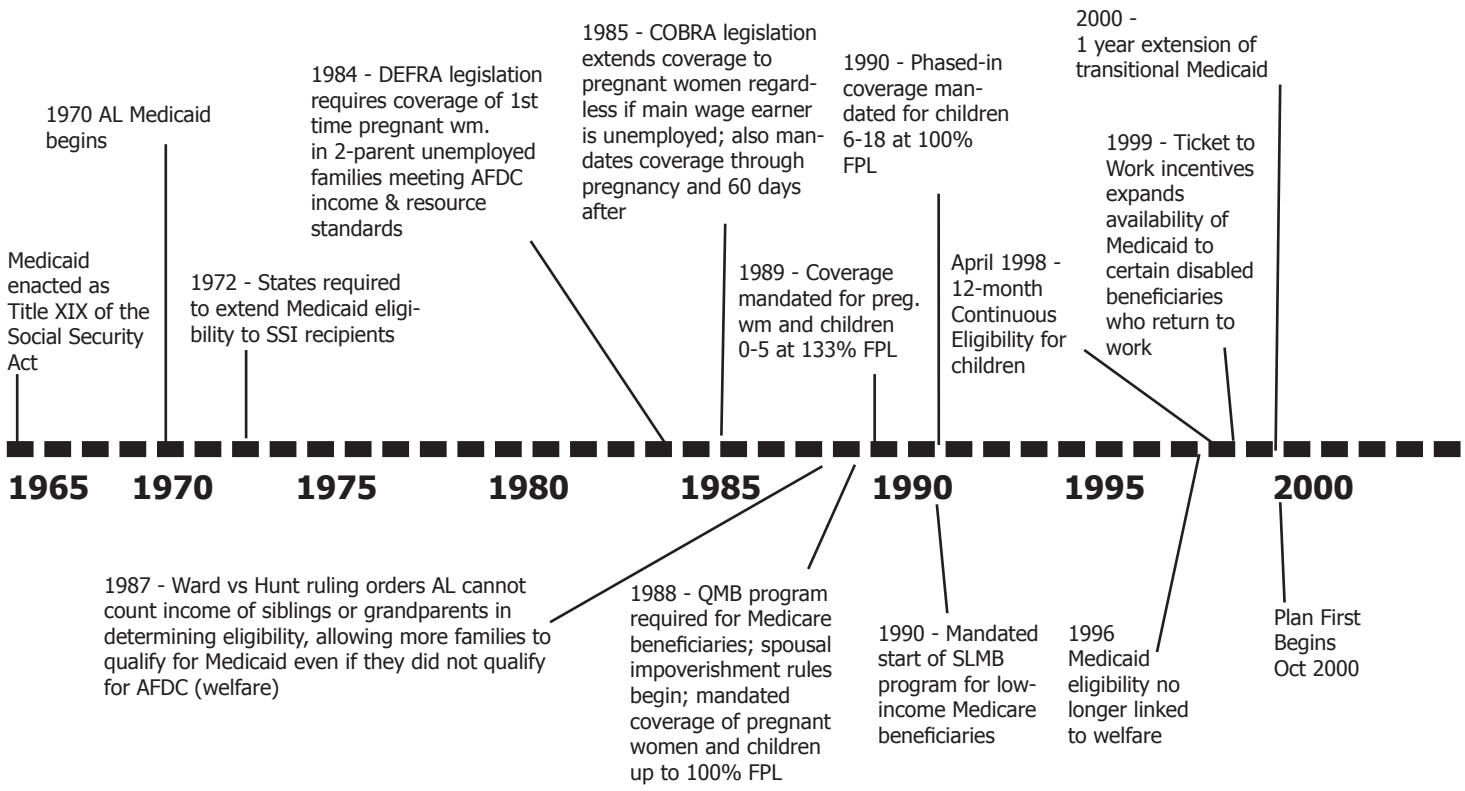
Average Monthly Eligibles



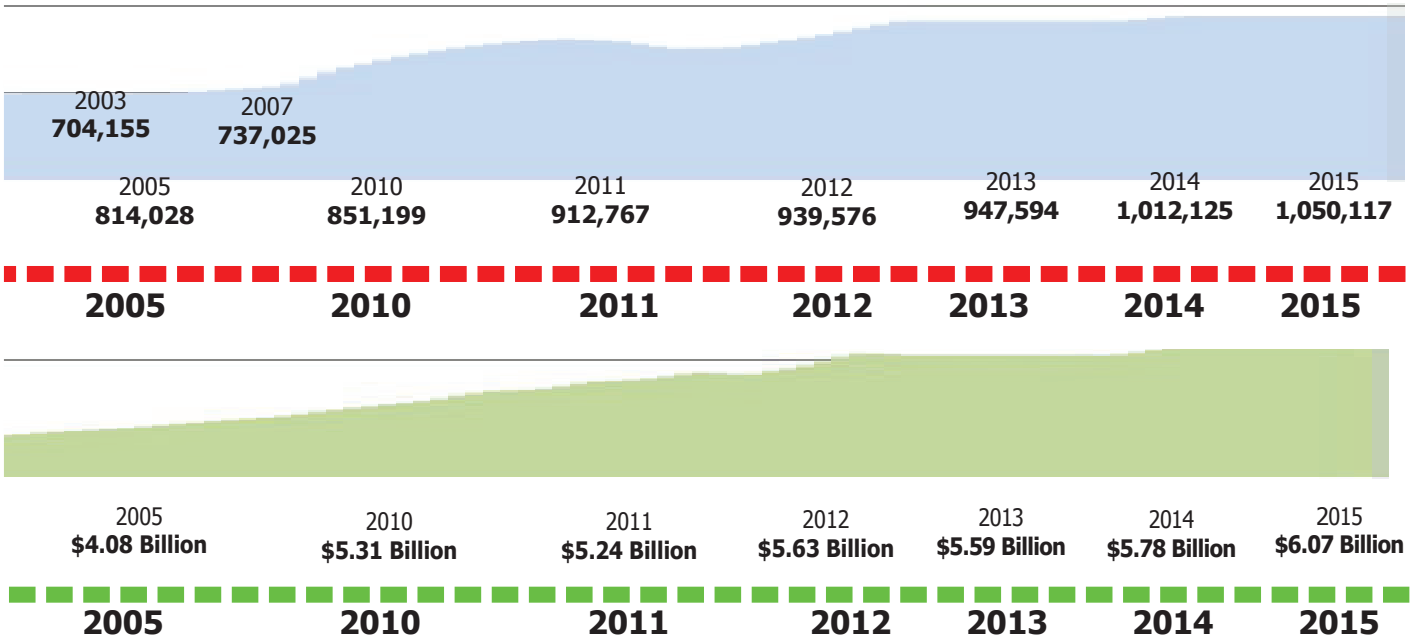
Total Expenditures

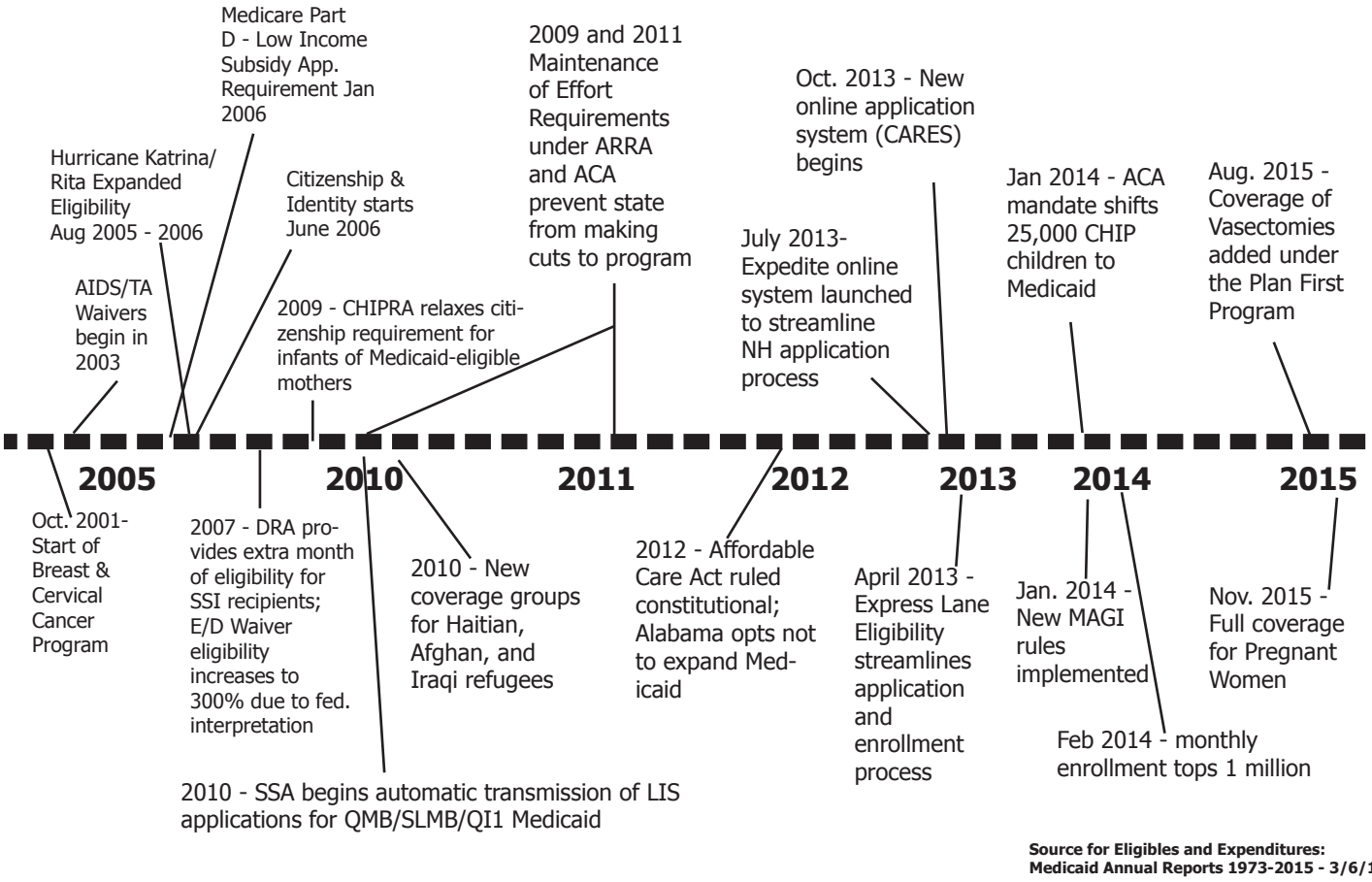


Mandates & Efficiencies



Alabama Medicaid - External Influences on Eligibility





Source for Eligibles and Expenditures:
Medicaid Annual Reports 1973-2015 - 3/6/16

FY 2015

Programs and Services

In FY 2015, nearly 1 million Medicaid recipients received at least one medical service, ranging from hospital care and doctor visits to medication, transportation or medical equipment. Medicaid-covered services are furnished in a variety of locations such as hospitals, private physician offices, drug stores and federal clinics, among others.

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

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

Medicaid offers Family Planning services that are designed to help Medicaid-eligible men and women prevent or delay pregnancy. Females of child-bearing age (ages 8 through 55) and males of any age who may be sexually active and meet the criteria for Medicaid eligibility may receive family planning services. Family Planning expenditures for Fiscal Year 2015 totaled $42,545,182. A total of 74,658 recipients received Plan First program services.

Clinical Services and Support

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

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

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

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

Transportation Program

Medicaid covers two types of transportation to and from medical facilities for eligible recipients: ambulance transportation for emergency and non-emergency situations and non-emergency transportation coordinated by the Agency's Non-Emergency Transportation (NET) Program that helps recipients pay for rides to dental and doctor offices, hospitals and other medical facilities. A total of over 932,000 trips were paid for by Medicaid in Fiscal Year 2015.

FY 2011- FY 2015
Lab and X-ray Program
Cost and Utilization*

Year	Payments	Recipients[1]	Cost per Recipient
FY 2011	$81,950,413	511,208	$160
FY 2012	$81,270,711	508,195	$160
FY 2013	$84,968,624	515,575	$165
FY 2014	$85,744,753	523,784	$164
FY 2015	$96,524,783	551,535	$175

[1] Recipient count is an unduplicated count of individuals who received at least one Lab or X-ray program service.

* Payment amounts come from claims data only and do not include any non-claims based financial transactions or medical costs that cannot be associated with a specific recipient.

FY 2011 - FY 2015
Optometry Services
Cost and Utilization*

Year	Payments	Recipients[1]	Cost per Recipient
FY 2011	$13,660,579	153,130	$89
FY 2012	$13,686,938	158,429	$86
FY 2013	$13,772,693	153,098	$90
FY 2014	$13,722,166	154,230	$89
FY 2015	$15,687,176	171,558	$91

FY 2011 - FY 2015
Eyeglasses Only
Cost and Utilization*

Year	Payments	Recipients[1]	Cost per Recipient
FY 2011	$4,641,623	116,310	$40
FY 2012	$3,338,044	114,565	$29
FY 2013	$3,093,988	106,531	$29
FY 2014	$3,209,895	110,331	$29
FY 2015	$3,710,231	126,638	$29

[1] Recipient count is an unduplicated count of individuals who received at least one eyeglass or optometry program service.

* Payment amounts come from claims data only and do not include any non-claims based financial transactions or medical costs that cannot be associated with a specific recipient.

FY 2011 - FY 2015
Physician Program
Cost and Utilization by Age Category*

Benefit Payments[1]					
Age	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
0 to 5	$96,381,582	$96,412,806	$108,122,608	$121,076,564	$125,213,434
6 to 20	$64,208,357	$64,622,217	$71,467,515	$79,367,134	$90,887,966
21 to 64	$134,216,535	$137,548,448	$141,815,081	$152,540,801	$163,376,921
65 and up	$7,180,788	$8,013,766	$10,035,342	$12,218,842	$11,247,886
All Ages	**$301,987,262**	**$306,597,238**	**$331,440,546**	**$365,203,340**	**$390,726,207**

Recipients[2]					
Age	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
0 to 5	197,630	196,250	196,967	203,836	199,719
6 to 20	221,107	224,793	233,427	243,850	270,079
21 to 64	174,968	178,613	179,951	186,684	195,821
65 and up	59,729	57,555	55,612	55,588	53,075
All Ages	**641,790**	**645,263**	**653,170**	**674,417**	**706,198**

Cost Per Recipient					
Age	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**
0 to 5	$488	$491	$549	$594	$627
6 to 20	$290	$287	$306	$306	$337
21 to 64	$767	$770	$788	$817	$834
65 and up	$120	$139	$180	$220	$212
All Ages	**$471**	**$475**	**$507**	**$542**	**$553**

[1] Payment amounts exclude lump sum payments made retroactively to physicians at Paid Teaching Facilities due to changes in reimbursement policies.

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

* Payment amounts come from claims data only and do not include any non-claims based financial transactions or medical costs that cannot be associated with a specific recipient.

FY 2011- FY 2015
Pharmacy Program
Expenditures*

Expenditures				Clawback Payments as % of Pharmacy Expenditures
Year	Benefit Payments [1]	Clawback Payments [2]	Pharmacy Expenditures	
FY 2011	$496,128,925	$50,798,631	$546,927,556	9.3%
FY 2012	$526,082,696	$67,028,930	$593,111,626	11.3%
FY 2013	$525,307,376	$67,938,260	$593,245,636	11.5%
FY 2014	$560,729,827	$66,736,487	$627,466,314	10.6%
FY 2015	$621,333,757	$64,122,006	$685,455,763	9.4%

FY 2011 - FY 2015
Pharmacy Program
Member Utilization*

Medicaid Eligibility Only (Non-Dual)					
Year	Monthly Average Pharmacy Eligibles [3]	Number of Prescription Recipients	Recipients as % of Eligibles	Number of Prescriptions	Prescriptions Per Recipient
FY 2011	627,243	592,688	94%	8,568,094	14.46
FY 2012	640,347	594,296	93%	8,636,945	14.53
FY 2013	640,431	594,665	93%	8,616,219	14.49
FY 2014	695,930	575,194	83%	7,051,269	12.26
FY 2015	740,438	606,491	82%	6,964,241	11.48

FY 2011 - FY 2015
Pharmacy Program
Cost Per Member and Recipient*

Medicaid Eligibility Only (Non-Dual)					Full Medicaid Dual Eligibles[4]	
Year	Benefit Payments[1]	Cost Per Prescription	Per Member Per Year Cost	Cost Per Recipient	Average Monthly Eligibles	Average Annual Clawback Payment
FY 2011	$496,128,925	$57.90	$791	$837	84,916	$598
FY 2012	$526,082,696	$60.91	$822	$885	85,067	$788
FY 2013	$525,307,376	$60.97	$820	$883	85,372	$796
FY 2014	$560,729,827	$79.52	$806	$975	85,568	$780
FY 2015	$621,333,757	$89.22	$839	$1,024	85,499	$750

[1] Pharmacy benefit payments exclude pharmacy benefits paid for family planning and alternative care.
[2] Clawback payments are the amounts states pay to the federal government as required by the Medicare Prescription Drug Improvement and Modernization Act of 2003 for Medicare Part D coverage.
[3] Monthly average pharmacy eligibles is total Medicaid eligibles less Plan First eligibles and members that are eligible for Medicare benefits ("dual eligibles").
[4] Full Medicaid dual eligibles are individuals that are eligible for Medicare and also for full Medicaid coverage. Some dual eligibles only qualify for partial Medicaid coverage and are therefore not subject to the Clawback payment.

* Payment amounts come from claims data only and do not include any non-claims based financial transactions or medical costs that cannot be associated with a specific recipient.

FY 2015

Managed Care

Medicaid uses a variety of managed care programs to ensure improved health outcomes through coordinated care. The Agency's Patient 1st program operates as a Primary Care Case Management program with the Health Home program providing additional care coordination service support for providers to recipients with chronic illnesses. Routine and high-risk maternity care services are available to pregnant women through Medicaid's regional care systems. Medicaid's PACE program provides an alternative to nursing home care for qualified individuals age 55 or older in Mobile and Baldwin counties.

Patient 1st

Based on the medical home concept, the Patient 1st program links the Medicaid recipient with a physician or clinic that serves as the primary care provider to encourage a strong doctor/patient relationship. 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.

Each month in Fiscal Year 2015 an average of 796,020 Alabamians were enrolled in the Patient 1st program, including 638,730 children under age 21.

The Health Home program expanded statewide in April 2015 from four networks serving 21 counties to provide improved overall care for more than 250,000 recipients with specific medical conditions.

Six probationary Regional Care Organizations (RCOs) signed contracts to operate the Health Home programs. The expansion was an interim step toward implementation of full-risk RCOs.

The Health Home program has operated since 2012 as Patient Care Networks to provide an additional level of support to Patient 1st Primary Medical Providers. The program intensively coordinates patient care for those who have or who are at risk of having chronic conditions such as asthma, diabetes, cancer, COPD, HIV, mental health conditions, substance use disorders, transplants, sickle cell, BMI over 25, heart disease and hepatitis C.

PACE

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

Maternity Care

The Maternity Care Program is designed to ensure every pregnant woman has access to medical care, with the goal of lowering Alabama's infant mortality rate and improving maternal and infant health. Services for Medicaid-eligible pregnant women include prenatal care and delivery services, care coordination, home visits to help improve the infant's health outcome, and educational programs including family planning.

In Fiscal Year 2015, Medicaid paid for more than half of all deliveries in the State of Alabama.

FY 2015

Long Term Care

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

During FY 2015, more than 16,000 Alabama residents participated in one of seven Home and Community Based Waiver programs as an alternative to institutional care. Waiver services are available to eligible Medicaid recipients who qualify for nursing home level of care in a nursing home, hospital or other institution.

More recipients began moving back into the community since Alabama Medicaid's Gateway to Community Living initiative operating plan was approved in 2013. This initiative expanded home and community-based resources for aging or disabled recipients who prefer to receive services in their own home rather than in a nursing home. Gateway supports individuals who wish to transition from nursing homes and institutional settings to community living. Gateway uses the state's existing long-term care system as a foundation, allowing individuals currently living in institutional settings to enroll in one of seven Home and Community-based Waiver programs.

GATEWAY to community living

Elderly and Disabled Waiver

This waiver allows qualified elderly and/or disabled individuals who would otherwise require care in a nursing facility to live in the community. The basic services covered are case management, homemaker services, personal care, respite care, adult day health, adult companion services and home delivered meals.

Intellectual Disabilities Waiver

Under this waiver, intellectually disabled adults and children who would otherwise qualify for care in an intermediate care facility for the intellectually disabled are able to receive services in the community.

FY 2011 - FY 2015
Long Term Care Program
Intermediate Care Facility for the Intellectually Disabled
Utilization and Cost

Year	Payments[1]	Recipients	Average Covered Days Per Recipient	Average Cost Per Day	Average Cost Per Recipient
FY 2011	$32,104,030	202	320	$496	$158,931
FY 2012	$10,584,848	123	156	$553	$86,056
FY 2013	$1,784,376	39	241	$190	$45,753
FY 2014	$1,582,024	28	311	$182	$56,501
FY 2015	$1,655,211	26	346	$184	$63,662

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

Technology Assisted Waiver

The Technology Assisted waiver is designed for individuals over age 21 who have had a tracheostomy or who are ventilator dependent and require skilled nursing services. This waiver allows continuation of private duty nursing services in an effort to allow qualified participants to remain at home.

Living at Home Waiver

Children age 3 or older and adults who have a diagnosis of intellectual disabilities who would otherwise qualify for care in an Intermediate Care Facility for Individuals with Intellectual Disabilities receive services under this waiver.

State of Alabama Independent Living

The State of Alabama Independent Living (SAIL) waiver serves adults age 18 or older who have specific medical diagnoses and who would otherwise qualify for care in a nursing home. The diagnoses include, but are not limited to quadriplegia, traumatic brain injury, Amyotrophic Lateral Sclerosis, Multiple Sclerosis, Spinal Muscular Atrophy, Muscular Dystrophy, severe Cerebral Palsy, stroke and other neurological or severely debilitating diseases or rare genetic diseases.

Alabama Community Transition (ACT) Waiver

The ACT waiver serves individuals with disabilities or long term illnesses who currently live in a nursing facility and who desire to transition to the home and community setting.

HIV/AIDS Waiver

Qualifying adults diagnosed with HIV, AIDS and/or related illnesses who would otherwise require care in a nursing facility or institution are able to receive home and community services under this waiver.

FY 2011- FY 2015
Long Term Care Program
Utilization

Year	Total Nursing Home Patients (Unduplicated)	Percent Change	Avg. Length of Stay During Year	Total Patient Days Paid for Medicaid Recipients	Percent Change	State Licensed Beds[1]	Percent Change	Medicaid Bed Days as % of State Bed Days
FY 2011	24,882	-2.1%	242	6,025,614	-2.5%	25,687	-1.4%	64%
FY 2012	24,330	-2.2%	245	5,963,114	-1.0%	26,649	3.7%	61%
FY 2013	24,599	1.1%	237	5,840,469	-2.1%	26,479	-0.6%	60%
FY 2014	24,248	-1.4%	246	5,971,896	2.3%	26,316	-0.6%	62%
FY 2015	25,438	4.9%	232	5,909,069	-1.1%	26,374	0.2%	61%

[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), and nursing facilities for individuals with developmental delays (NFIDDs). This number excludes intermediate care facilities for the intellectually disabled, swing beds (temporary nursing home beds in hospitals) and veterans' homes.

FY 2011 - 2015
Long Term Care Program
Patients, Days and Costs

Year	Nursing Home Patient Days Paid by Medicaid	Percent Change	Cost of Nursing Facilities	Percent Change	Average Medicaid Cost Per Patient Day	Percent Change	Nursing Home Tax[1]	Tax as % of Nursing Facilities Cost	Cost to Medicaid Net of Tax	Average Medicaid Cost Per Patient Day Net of Tax
FY 2011	6,025,614	-2.5%	$898,684,381	2.8%	$149	5.4%	$77,904,662	8.7%	$820,779,719	$136
FY 2012	5,963,114	-1.0%	$932,613,072	3.8%	$156	4.9%	$106,049,403	11.4%	$826,563,669	$139
FY 2013	5,840,469	-2.1%	$899,428,257	-3.6%	$154	-1.5%	$103,250,591	11.5%	$796,177,666	$136
FY 2014	5,971,896	2.3%	$929,139,998	3.3%	$156	1.0%	$102,860,996	11.1%	$826,279,002	$138
FY 2015	5,909,069	-1.1%	$945,274,066	1.7%	$160	2.8%	$103,762,829	11.0%	$841,511,237	$142

[1] Nursing Home provider tax data provided by the Alabama Department of Revenue.

FY 2013 - 2015
Long Term Care Program
Recipients and Claims Payments by Gender, Race and Age

	Recipients[1]			Claims Payments[2]			Annual Average Cost Per Recipient		
	FY 2013	**FY 2014**	**FY 2015**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2013**	**FY 2014**	**FY 2015**
By Gender									
Female	17,171	16,831	17,512	$635,965,462	$652,681,285	$658,151,644	$37,037	$38,779	$37,583
Male	7,428	7,417	7,926	$265,593,458	$279,995,103	$292,799,174	$35,756	$37,750	$36,942
By Race									
African Am.	7,375	7,270	7,671	$282,420,560	$294,760,053	$301,749,853	$38,294	$40,545	$39,336
Am. Indian	16	19	14	$525,296	$619,412	$598,772	$32,831	$32,601	$42,769
Asian	67	71	81	$2,478,394	$2,929,869	$2,818,788	$36,991	$41,266	$34,800
Hispanic	75	71	77	$2,839,399	$3,068,221	$2,804,115	$37,859	$43,214	$36,417
Other	19	20	17	$803,919	$758,036	$585,812	$42,312	$37,902	$34,460
Unknown	438	470	530	$12,529,583	$15,016,242	$16,966,146	$28,606	$31,949	$32,012
White	16,609	16,327	17,048	$599,961,769	$615,524,555	$625,427,332	$36,123	$37,700	$36,686
By Age									
0-5	21	12	17	$1,149,847	$657,147	$932,671	$54,755	$54,762	$54,863
6-20	100	92	91	$6,524,349	$6,128,217	$5,861,913	$65,243	$66,611	$64,417
21-64	5,287	4,912	5,654	$195,590,626	$192,195,283	$216,460,663	$36,995	$39,128	$38,285
65-74	4,581	4,574	5,016	$168,607,267	$175,723,880	$190,918,674	$36,806	$38,418	$38,062
75-84	6,912	6,481	6,928	$257,946,394	$247,877,803	$257,715,791	$37,319	$38,247	$37,199
85 & Over	7,698	6,481	7,732	$271,740,437	$310,094,057	$279,061,105	$35,300	$37,923	$36,092
Statewide	**24,599**	**24,248**	**25,438**	**$901,558,920**	**$932,676,388**	**$950,950,818**	**$36,650**	**$38,464**	**$37,383**

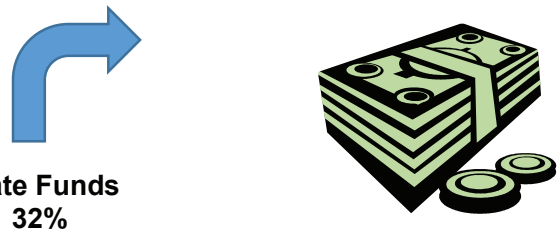
[1] Recipient count is an unduplicated count of individuals who received a nursing facility service.
[2] Claims Data Only - Claims data excludes medical costs not associated with a specific recipient such as access payments and disproportionate share hospital (DSH) payments to hospitals, Certified Public Expenditures (CPEs) for indigent care, health insurance premiums for Medicare enrollees and "clawback" payments to the federal government for Medicare Part D recipients. Total amounts differ from the "Cost of Nursing Facilities" due to non-claims based financial transactions.

FY 2015

Fiscal

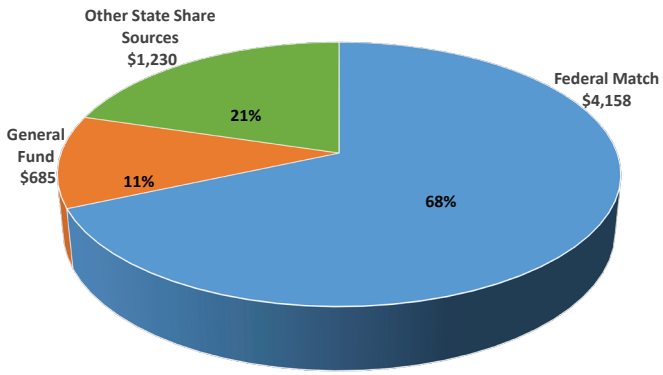
In Fiscal Year 2015, approximately 96 cents of every Medicaid dollar went directly to providing care and services to recipients. Medicaid paid $5,816,027,264 for health care services provided to Alabama citizens. Another $182,130,584 was spent administering the Medicaid program. The agency's Federal Medical Assistance Percentage (FMAP) matching rate was 68.99 percent*.

FY 2015
Medicaid Budget
Composition and Disbursement*
(dollar amounts in millions)

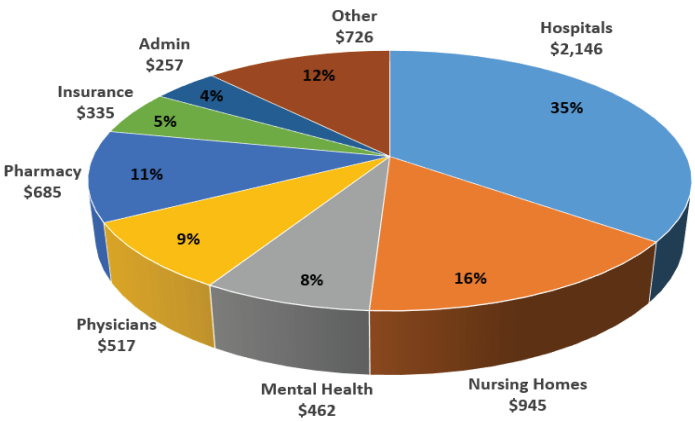


State Funds
32%

Agency Administrative Costs
4%



Federal Match
68%



Benefit Payments
96%

* Difference between FMAP figure and Federal Funds figure is FMAP inclusion of HIE Payments of $29,360,011 or 0.5% of total Medicaid Agency expenditures.

FY 2011 - FY 2015
State Share Funding Sources[1]

						As a % of Total State Share Funding				
	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
General Fund										
Current Year Appropriation	$345,310,381	$643,788,706	$603,125,607	$615,125,607	$685,125,607	25.5%	35.4%	33.4%	32.9%	35.8%
Adjustments	54,976,729	(68,370,361)	12,000,000		78,208	4.1%	-3.8%	0.7%	0.0%	0.0%
Total General Fund	**400,287,110**	**575,418,345**	**615,125,607**	**615,125,607**	**685,203,815**	**29.6%**	**31.6%**	**34.1%**	**32.9%**	**35.8%**
Certified Public Expenditures										
Hospitals	270,871,386	499,912,172	395,375,218	154,436,077	152,373,253	20.0%	27.5%	21.9%	8.3%	8.0%
School-Based Services	34,377,361	22,704,404	22,107,068	34,294,178	31,044,132	2.5%	1.2%	1.2%	1.8%	1.6%
Total CPEs	**305,248,747**	**522,616,576**	**417,482,286**	**188,730,255**	**183,417,385**	**22.6%**	**28.7%**	**23.1%**	**10.1%**	**9.6%**
Ala. Health Care Trust Fund										
Hospital Provider Tax	215,521,701	226,276,852	241,930,276	261,287,050	257,442,043	15.9%	12.4%	13.4%	14.0%	13.5%
Nursing Home Provider Tax	77,904,662	106,049,403	103,250,591	102,860,996	103,762,829	5.8%	5.8%	5.7%	5.5%	5.4%
Pharmacy Provider Tax	8,938,136	9,262,104	9,217,779	9,159,988	8,776,161	0.7%	0.5%	0.5%	0.5%	0.5%
Total Ala. Health Care Trust Fund	**302,364,499**	**341,588,359**	**354,398,646**	**373,308,034**	**369,981,033**	**22.4%**	**18.8%**	**19.6%**	**20.0%**	**19.3%**
Intergovernmental Transfers										
State Agencies										
Dept. of Mental Health	131,619,537	148,104,358	150,391,339	154,853,521	155,444,620	9.7%	8.1%	8.3%	8.3%	8.1%
Dept. of Human Resources	33,107,350	39,411,775	34,876,380	35,990,775	34,972,503	2.4%	2.2%	1.9%	1.9%	1.8%
Dept. of Public Health	30,583,658	26,714,938	20,174,821	27,050,212	29,695,927	2.3%	1.5%	1.1%	1.4%	1.6%
Dept. of Senior Services	12,497,563	16,623,308	25,029,938	22,334,201	21,303,522	0.9%	0.9%	1.4%	1.2%	1.1%
Dept. of Rehab Services	5,177,379	6,466,094	6,372,435	5,967,221	7,372,483	0.4%	0.4%	0.4%	0.3%	0.4%
Dept. of Youth Services	3,742,082	5,080,662	6,090,951	5,513,677	6,590,924	0.3%	0.3%	0.3%	0.3%	0.3%
Dept. of Education										
Total State Agencies	216,727,569	242,401,135	242,935,864	251,709,607	255,379,979	16.0%	13.3%	13.5%	13.5%	13.3%
Hospital IGTs	-	-	-	233,957,510	229,065,567	0.0%	0.0%	0.0%	12.5%	12.0%
Other Governmental Bodies	2,967,067	29,134,723	29,663,131	52,582,652	28,472,932	0.2%	1.6%	1.6%	2.8%	1.5%
Total Intergovernmental Transfers	**219,694,636**	**271,535,858**	**272,598,995**	**538,249,769**	**512,918,478**	**16.2%**	**14.9%**	**15.1%**	**28.8%**	**26.8%**
Other Funding Sources										
Drug Rebates	55,833,463	64,963,187	69,522,963	87,310,845	97,943,098	4.1%	3.6%	3.9%	4.7%	5.1%
Medicaid Trust Fund - Tobacco	29,956,125	30,644,931	30,700,104	30,375,487	30,034,161	2.2%	1.7%	1.7%	1.6%	1.6%
Other Miscellaneous Receipts	39,197,658	13,281,513	44,780,946	35,289,216	33,920,207	2.9%	0.7%	2.5%	1.9%	1.8%
Total Other Funding Sources	**124,987,246**	**108,889,631**	**145,004,013**	**152,975,548**	**161,897,466**	**9.2%**	**6.0%**	**8.0%**	**8.2%**	**8.5%**
Total State Funds	**$1,352,582,238**	**$1,820,048,769**	**$1,804,609,547**	**$1,868,389,213**	**$1,913,418,177**	**100%**	**100%**	**100%**	**100%**	**100%**

[1] Data is based on Agency's Executive Budget Office financial records for the Medicaid Agency and includes expenditures, purchase orders, and year-end encumbrances.

FY 2011 - FY 2015
Expenditures by Type of Service (total Federal and State dollars)[1]

Service	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Nursing Facilities	$898,684,381	$932,613,072	$899,428,257	$929,139,998	$945,274,066
Hospital Care	1,149,906,070	1,398,531,841	1,354,835,782	1,573,467,865	1,665,967,742
Hospital Care CPE[2]	83,365,628	189,752,920	213,162,048*		
Physicians	394,295,050	397,504,473	426,992,044	537,851,048	516,999,078
Pharmacy	546,927,556	593,111,626	593,245,636	627,466,314	685,455,763
Health Support	206,590,686	215,512,000	214,165,029	212,761,945	222,112,501
Alternative Care	396,450,006	395,014,560	376,600,493	352,131,320	363,469,312
Mental Health Facilities	32,663,368	10,626,732	1,794,348	1,830,948	2,060,211
Mental Health Waivers	285,804,858	287,322,840	304,528,666	318,973,130	324,170,321
Mental Health Other	126,149,169	132,413,000	123,496,077	127,956,081	135,967,879
Medicaid - CHIP (All Services)				22,804,953	80,481,377
Health Insurance	303,737,351	296,483,036	304,686,039	315,446,895	334,802,957
Family Planning	62,825,818	64,265,900	61,306,375	60,147,011	59,054,810
Total Medicaid Medical Benefits	**$4,487,399,941**	**$4,913,152,000**	**$4,874,240,794**	**$5,079,977,508**	**$5,335,816,017**
Disproportionate Share for Hospitals[3]	524,839,766	461,923,211	478,418,802	481,382,789	480,211,247
Total Medical Benefits	**$5,012,239,707**	**$5,375,075,211**	**$5,352,659,596**	**$5,561,360,297**	**$5,816,027,264**
General Administrative Costs	126,893,693	146,345,301	148,755,326	149,417,813	182,130,584
School-Based Administrative Costs	69,098,883	45,329,475	44,373,774	44,264,248	45,762,171
Total Medicaid & DSH Expenditures	**5,208,232,283**	**$5,566,749,987**	**$5,545,788,697**	**$5,755,042,358**	**$6,043,920,019**
Health Information Exchange[4]	32,398,855	60,209,095	40,224,122	28,088,044	29,360,011
Agency Total Expenditures	**$5,240,631,138**	**$5,626,959,082**	**$5,586,012,819**	**$5,783,130,402**	**$6,073,280,030**

*Final provider payroll.

FY 2011 - FY 2015
Expenditures by Type of Service (as percent of total)[1]

Service	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Nursing Facilities	17.3%	16.8%	16.2%	16.1%	15.6%
Hospital Care	22.1%	25.1%	24.4%	27.3%	27.6%
Hospital Care CPE[2]	1.6%	3.4%	3.8%	0.0%	0.0%
Physicians	7.6%	7.1%	7.7%	9.3%	8.6%
Pharmacy	10.5%	10.7%	10.7%	10.9%	11.3%
Health Support	4.0%	3.9%	3.9%	3.7%	3.7%
Alternative Care	7.6%	7.1%	6.8%	6.1%	6.0%
Mental Health Facilities	0.6%	0.2%	0.0%	0.0%	0.0%
Mental Health Waivers	5.5%	5.2%	5.5%	5.5%	5.4%
Mental Health Other	2.4%	2.4%	2.2%	2.2%	2.2%
Medicaid - CHIP (All Services)				0.4%	1.3%
Health Insurance	5.8%	5.3%	5.5%	5.5%	5.5%
Family Planning	1.2%	1.2%	1.1%	1.0%	1.0%
Total Medicaid Medical Benefits	**86.2%**	**88.3%**	**87.9%**	**88.3%**	**88.3%**
Disproportionate Share/Hospitals[3]	10.1%	8.3%	8.6%	8.4%	7.9%
Total Medical Benefits	**96.2%**	**96.6%**	**96.5%**	**96.6%**	**96.2%**
General Administrative Costs	2.4%	2.6%	2.7%	2.6%	3.0%
School-Based Administrative Costs	1.3%	0.8%	0.8%	0.8%	0.8%
Total Medicaid & DSH Expenditures	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

[1] Data is based on the Executive Budget Office Form 1 for the Medicaid Agency and includes expenditures, purchase orders and year-end encumbrances.

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

[3] Disproportionate Share Hospital (DSH) - Payments provided to hospitals for serving a disproportionately high share of Medicaid and uninsured individuals.

[4] Primarily payments to doctors for the meaningful use of electronic health records and is almost 100% Federally funded. The expenditures shown are from the Medicaid Agency's financial records and do not include year-end purchase orders and encumbrances.

FY 2015
Expenditures for Medical Services by Coverage and Aid Category[1]
(dollar amounts in millions)

Coverage and Aid Category	Inpatient Services	Outpatient Services	Nursing Home	Physicians	Mental Health	Pharmacy[5]	Dental	Other Professional Services	Medicare Premiums[5]	Managed Care Networks[6]	Grand Total[7]	% of Total
Dual Eligibles												
Full Medicaid Dual Eligible												
Aged and Non-Disabled (65+)	$15.0	$49.4	$664.0	$3.6	$15.1			$26.3	$52.8		$826.6	15.5%
Blind or Disabled (all ages)	39.2	16.4	171.2	11.6	216.3	2.2		45.2	139.0		641.1	12.0%
Non-Disabled Adults (21-64)	1.0	1.1	2.3		0.8				1.0		7.1	0.1%
Total Full Medicaid Dual Eligible	55.1	66.9	837.5	15.4	232.2	3.0		71.8	192.8		1,474.8	27.6%
Partial Medicaid Dual Eligible												
Limited Medicare (all ages)[2]	14.2	1.2	7.1	9.9				3.3	169.7		205.5	3.9%
Total Dual Eligibles	**69.4**	**68.1**	**844.6**	**25.3**	**232.3**	**3.0**		**75.1**	**362.5**		**1,680.4**	**31.5%**
Non-Dual Eligibles												
Full Medicaid												
Aged and Non-Disabled (65+)			2.0								2.9	0.1%
Blind or Disabled (all ages)	560.2	169.5	102.4	167.8	195.4	365.4	5.5	103.6		7.9	1,677.7	31.4%
Non-Disabled Children (0-20)	419.0	128.9		260.4	30.4	232.1	91.8	215.8		18.6	1,397.1	26.2%
Non-Disabled Adults (21-64)	217.8	77.5		67.1	6.5	61.2		93.4		2.8	526.5	9.9%
Total Full Medicaid	1,197.3	376.0	104.7	495.4	232.2	658.9	97.3	412.9		29.3	3,604.2	67.5%
Partial Medicaid												
Non-Disabled Adults (21-64)[3]	11.9			3.0							15.0	0.3%
PlanFirst (all ages)[4]	1.7	1.1				3.0		29.7			35.9	0.7%
Total Partial Medicaid	13.9	1.3		3.3		3.0		29.8			51.3	1.0%
Total Non-Dual Eligibles	**1,211.2**	**377.3**	**104.7**	**498.7**	**232.2**	**661.9**	**97.3**	**442.7**		**29.3**	**3,655.5**	**68.5%**
Total Expenditures	**$1,280.6**	**$445.4**	**$949.3**	**$524.0**	**$464.5**	**$664.9**	**$97.4**	**$517.8**	**$362.6**	**$29.3**	**$5,335.8**	**100.0%**
% of Total	24.0%	8.3%	17.8%	9.8%	8.7%	12.5%	1.8%	9.7%	6.8%	0.5%	100.0%	

[1] The overall total of $5,335,816,017 in expenditures in FY 2015 represents the amount expended during the fiscal year regardless of when the service was rendered to the Medicaid recipient. The numbers shown by category of aid and type of service rendered represent very close approximations of these expenditures and are derived based on the amounts incurred during the fiscal year using the date the service was rendered to the Medicaid recipient. Expenditures exclude Agency administrative costs, administrative costs of the school-based services program, payments to hospitals under the Disproportionate Share Hospital program and expenses of the Health Information Exchange.

[2] Limited Medicare - Qualified Medicare Beneficiary, Specified Low Income Medicare Beneficiary and Qualifying Individual are low-income Medicare beneficiaries that have certain premiums, co-insurance, or deductibles paid for by Medicaid.

[3] Primarily emergency services.

[4] Family planning services.

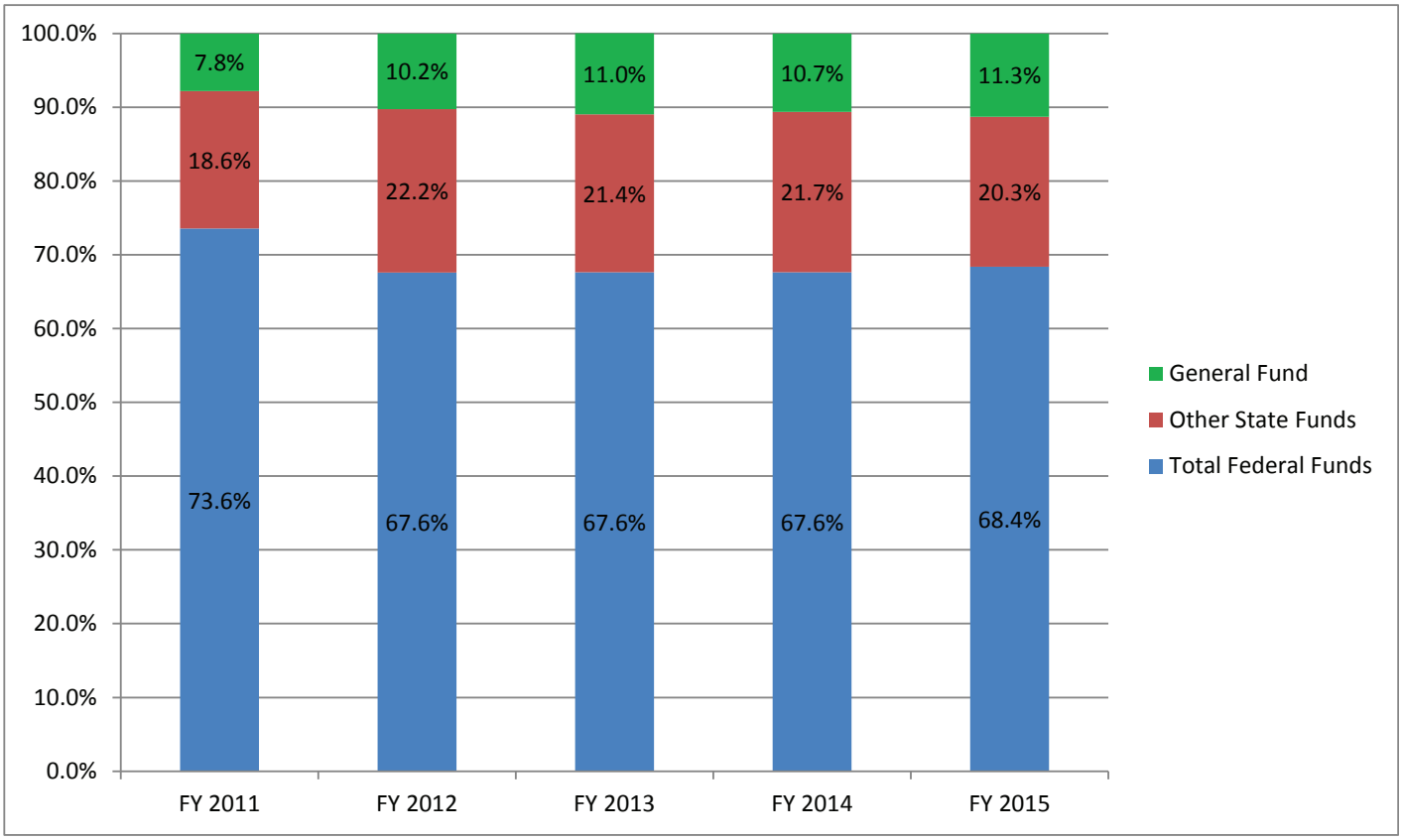
[5] Clawback payments are the amounts states pay to the federal government as required by the Medicare Prescription Drug Improvement and Modernization Act of 2003 to share the cost of Medicare Part D coverage. In this schedule the amount is shown as Medicare Premiums.

[6] Monthly capitation payments to primary care providers, and the Health Home networks that support them, to manage the care of assigned Medicaid members.

[7] Totals do not foot due to amounts below $500,000 not being shown because of rounding.

FY 2011 - FY 2015
Sources of Medicaid Funding

	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015
Federal Funds					
FMAP[1]	$3,492,130,946	$3,734,479,126	$3,730,138,013	$3,876,791,070	$4,112,422,744
Stimulus Funds[2]	240,226,571	-	-	-	-
Health Information Exchange	32,163,520	60,114,778	39,247,858	27,754,916	28,235,800
Total Federal Funds	**$3,764,521,037**	**$3,794,593,904**	**$3,769,385,871**	**$3,904,545,986**	**$4,140,658,544**
State Funds					
General Fund	400,287,110	575,418,345	615,125,607	615,125,607	685,203,815
Other State Funds	952,295,128	1,244,630,424	1,189,483,940	1,253,263,606	1,228,214,362
Total State Funds	**$1,352,582,238**	**$1,820,048,769**	**$1,804,609,547**	**$1,868,389,213**	**$1,913,418,177**
Total Funding	**$5,117,103,275**	**$5,614,642,673**	**$5,573,995,418**	**$5,772,935,199**	**$6,054,076,721**



[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 59%, but ranges from 50% in wealthier states, up to 73% in states with lower per capita incomes (an FMAP cannot be less than 50% or more than 83% by statute). FMAPs are adjusted for each state on a three-year cycle to account for fluctuations in the economy.

[2] Federal match rates in the first quarter of FY 2011 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 2015

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.

Third Party

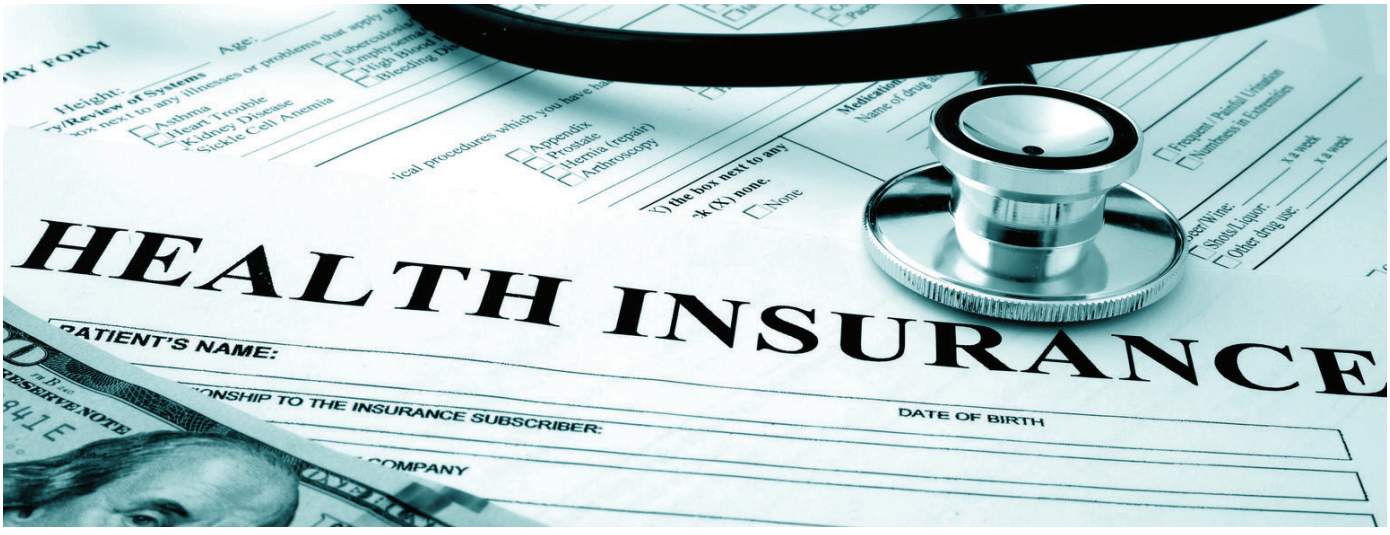
During Fiscal Year 2015, the Third Party Division was successful in saving Alabama taxpayers over $1 billion.

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.

Program Integrity

Five units within this division work to detect, prevent and/or eliminate all forms of fraud and abuse to ensure that all available funds go to provide health care to those in need. Program Integrity staff verify that



medical services are appropriate and rendered as billed to eligible recipients by qualified providers, that payments for those services are correct, and that all funds identified for collection are pursued.

Provider Review Unit

The Provider Review Unit examines medical provider billing to assure proper claim payment and recovery of identified overpayments. In Fiscal Year 2015 reviews of 53 medical providers resulted in $382,779 in identified recoupments and $540,614 in collected recoupments.

Sanctions against providers and recipients resulted in $1,808,829 in cost savings for the Agency. In all, 109 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 $354,743. Suspension of 423 recipients from the Medicaid program resulted in a cost savings of $1,454,086.

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 Fiscal Year 2015, the Recipient Review Unit conducted 1,380 reviews. As a result, 684 recipients were restricted or "locked-in" to one doctor and one drug store resulting in $186,771 in cost savings for the Agency.

Investigations Unit

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

Quality Control Unit

The Quality Control Unit reviews eligibility determinations for accuracy to ensure that only eligible individuals qualify for Medicaid. Alabama's quality control (error) rate for Fiscal Year 2015 was 0.3257 percent.

Enrollment and Sanction Unit

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

FY 2013 - FY 2015
Collections

	FY 2013	FY 2014	FY 2015
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.	$36,285,497	$27,409,578	$32,912,734
Program Integrity Division			
Provider Recoupment			
Medical Provider Recoupment Collected	$1,140,059	$570,925	$540,641
Enrollment and Sanctions	-	-	$1,449,596
Recovery Audit Contractor	$337,299	$1,386,151	$1,380,412
Investigations	$100,225	$72,813	$158,662
Pharmacy Program			
In-House Processed Claims Corrections	$77,084	$23,700	$92,894
Total Collections	**$37,940,164**	**$29,463,167**	**$36,534,939**

FY 2013 - FY 2015
Measureable Cost Avoidance

	FY 2013	FY 2014	FY 2015
Third Party Claim Cost Avoidance Savings			
Traditional Medicare Net Savings (includes Provider Payments/Costs Avoidance/Recoupments less premium cost of FY 2015-$271,262,637, FY 2014-$264,953,694 and FY 2013-$260,843,578	$666,560,140	$687,150,232	$777,226,670
Provider Reported Collections - Health and Casualty Insurance	$54,016,740	$60,632,235	$66,303,717
Medicare Advantage Capitated Program Net Savings	$3,528,487	$6,386,566	$3,428,195
Claims denied and returned to providers to file health/casualty	$122,721,934	$129,007,170	$159,345,376
Health Insurance Premium Payment Cost Avoidance	$615,333	$684,059	$712,503
Waiver Services Cost Avoidance			
Elderly and Disabled Waiver*	$460,780,277	$413,133,650	$492,924,470
State of Alabama Independent Living (SAIL) Waiver	$26,922,054	$21,653,080	$25,893,180
Intellectual Disabilities Waiver**	$101,887,254	$436,379,945	$489,940,748
Living at Home Waiver	$32,657,211	$65,058,930	$69,586,781
HIV / AIDS Waiver	$5,866,443	$4,775,558	$4,930,403
Program Integrity Cost Avoidance			
Provider Review Cost Avoidance	$5,848,529	$707,533	$290,156
Recipient Review Cost Avoidance	$790,668	$697,489	$186,771
Investigations Cost Avoidance	$92,092	$69,590	$361,565
Sanctioned Provider and Recipients	$921,660	$664,011	$1,808,829
Total Measurable Cost Avoidance	**$1,483,208,822**	**$1,827,000,048**	**$2,092,939,364**

* In FY 2012/FY 2013, fundamental changes occurred as program management transitioned from Department of Public Health to Department of Senior Services.
** In FY 2012 Alabama's largest ICF/Intellectually Disabled facility closed. Therefore, cost avoidance is lower.

FY 2013 - FY 2015
Program Integrity

PROVIDER REVIEWS			
	FY 2013	**FY 2014**	**FY 2015**
Medical Providers	134	53	80
Medical Providers Recoupments-Identified	$2,258,152	$382,009	$382,779
Medical Providers Recoupments-Collected	$1,140,059	$570,925	$540,614
Recovery Audit Contractor	70	95	57
Recoupments - Identified	$496,821	$1,977,979	$1,176,938
Recoupments - Collected	$337,299	$1,386,151	$1,380,412

RECIPIENT REVIEWS			
	FY 2013	**FY 2014**	**FY 2015**
Reviews Conducted	137	1,511	1,380
Restricted Recipients	925	619	684
Recipient Review Cost Avoidance	$790,668	$697,489	$186,771

INVESTIGATIONS			
	FY 2013	**FY 2014**	**FY 2015**
Provider & Recipient Recoupments - Identified	$218,199	$155,143	$227,230
Provider & Recipient Recoupments - Collected	$100,225	$72,813	$158,662

TAX INTERCEPT RECEIPTS			
	FY 2013	**FY 2014**	**FY 2015**
Tax Intercept Receipts	$37,202	$40,502	$57,939

FY 2015 Annual Report
October 1, 2014 - September 30, 2015
Alabama Medicaid Agency
PO Box 5624 (501 Dexter Avenue)
Montgomery, AL 36103-5624

Statistical data provided by the Alabama Medicaid Quality Analytics Division

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