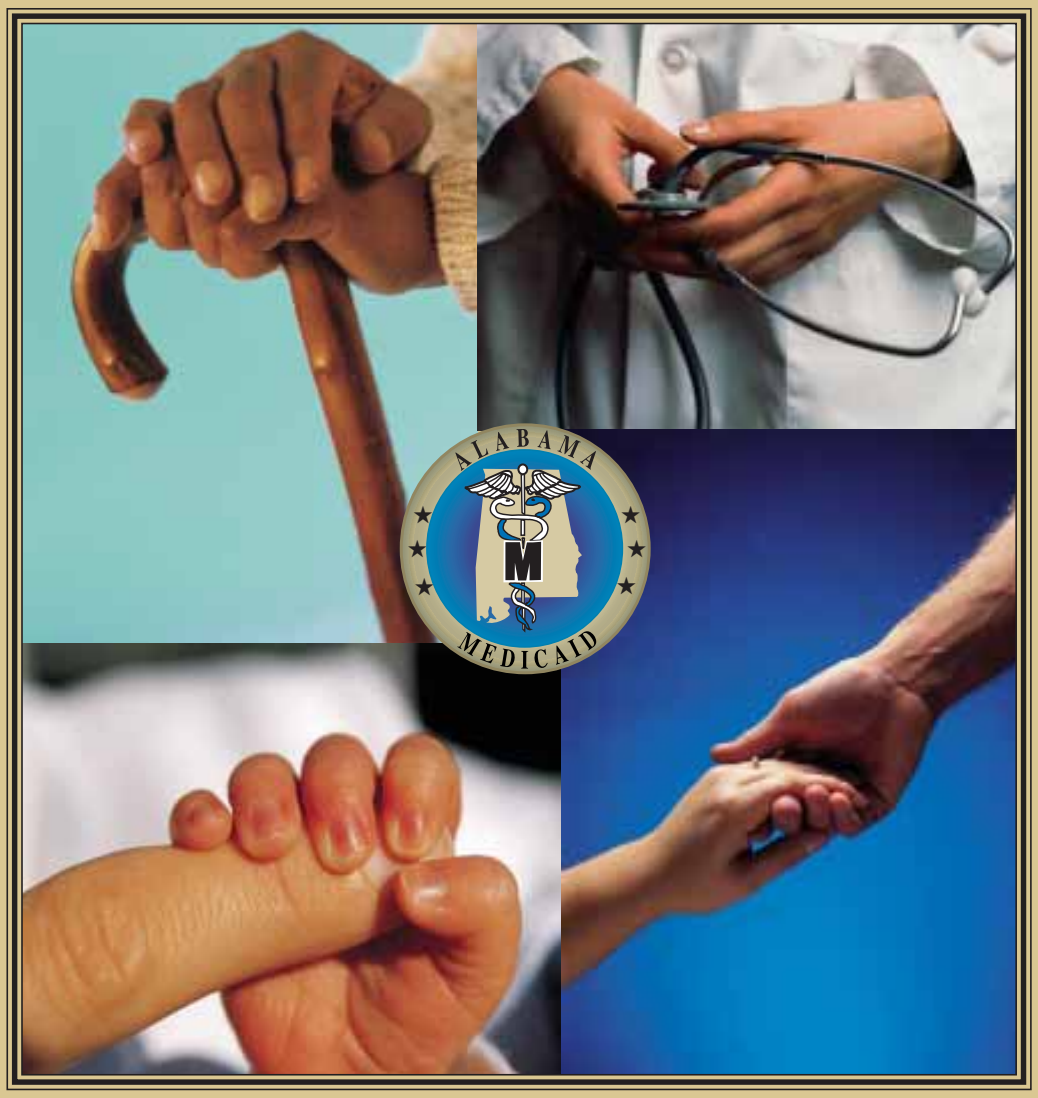
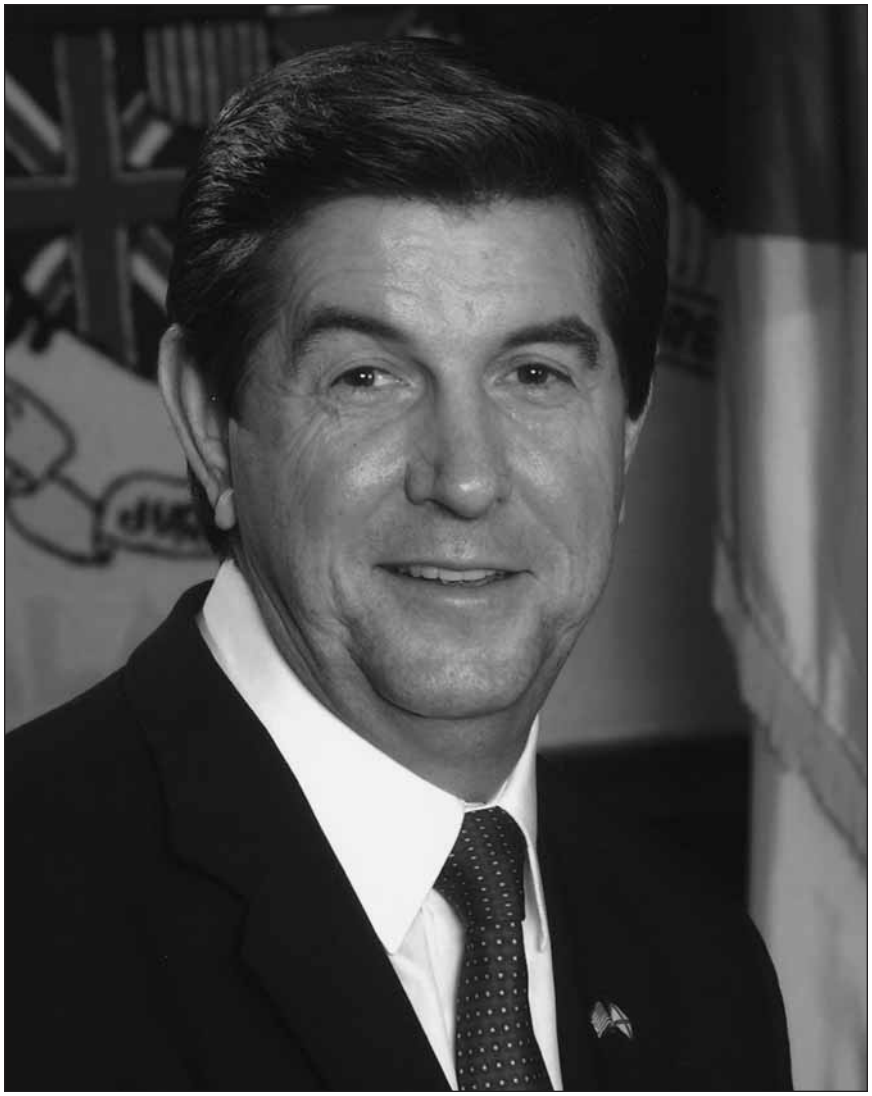
Alabama Medicaid Agency



Annual Report
FY 2005



Bob Riley
Governor
State of Alabama

Alabama Medicaid Agency
FY 2005 Annual Report
October 1, 2004 - September 30, 2005

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BOB RILEY
Governor

CAROL A. HERRMANN-STECKEL, MPH
Commissioner

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

Dear Governor Riley:

It is my privilege to present to you the 33rd Annual Report of the Alabama Medicaid Agency. This report covers activities from October 2004 to September 2005.

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

Our agency continues to seek out new and innovative approaches to address the challenge of improving services while reducing costs. These efforts are sometimes complicated by factors beyond our control. We began and ended the fiscal year with activities related to two separate hurricanes. The startup of our Patient 1st Program was delayed by Hurricane Ivan, and September of 2005 found us in a leadership role as we helped to coordinate Medicaid's response to the health care needs of Hurricane Katrina evacuees from our sister states.

Rising health care costs are a challenge affecting both public and private health care financing. Through our collection and cost avoidance efforts such as the pharmacy rebate program, third party coordination, prior approval of certain procedures and prescriptions, the Medicaid Agency saves the taxpayers a substantial amount of money each year. In addition to these continuing efforts, the Patient 1st Program was initiated this year to combine state-of-the-art technology with accountability controls that will give us the tools to better manage the increasing cost of health care and to promote better care for the elderly, the sick and children on Medicaid.

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

Sincerely,

Carol A. Herrmann-Steckel
Commissioner

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

Mission Statement

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

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

This report can be viewed at our web site http://www.medicaid.alabama.gov

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HIGHLIGHTS OF FISCAL YEAR 2005

Fiscal Year 2005 at the Alabama Medicaid Agency began and ended with activities related to hurricanes. After Hurricane Ivan, implementation of the Patient First program scheduled to take place in southwest Alabama counties at the start of FY 2005 was delayed due to recovery efforts that were ongoing. At the end of the Fiscal Year, Alabama Medicaid was heavily involved in activities to help Katrina evacuees from Alabama, Mississippi, and Louisiana access needed health care services. During the year, Medicaid did fully implement the new enhanced Patient 1st Program, the Agency's website was expanded to offer more on line services, the Pharmacy program implemented an electronic prior authorization program, and Pharmacy staff were very involved in the transition of drug coverage for Medicaid's dual eligible population.

PATIENT 1ST

The Patient 1st Program was fully implemented statewide. The Program is designed to create a medical home for Medicaid patients by linking each patient with a primary medical provider (known as a PMP). The patient must either receive services directly from their PMP or receive a referral from their PMP to go to another provider. The goal of Patient 1st is to ensure that patients receive the most appropriate care in the most appropriate setting; areas offering the most opportunity for improvement include inappropriate use of the emergency room and prescribing patterns.

Program enhancements include collaboration with the University of South Alabama to place in-home monitoring equipment for patients with chronic diseases. This equipment will monitor the patient's condition on an on-going basis and will help ensure that the patient's condition does not worsen over time without the appropriate intervention. Daily reports are provided to the patient's PMP and problems are monitored by 24-hour nursing personnel. Additionally, Medicaid has partnered with Blue Cross Blue Shield (BCBS) to provide information about medications a patient is receiving to physicians. Oftentimes, a physician writes a prescription for a patient, but the patient does not have the prescription filled or may also have other medicines from other physicians. Through this partnership, physicians will have access to paid claims information from BCBS and Medicaid so that they can track all medications being taken by a patient. Both of these initiatives are being provided at no additional cost to the State or to the physicians.

UPDATED MEDICAID WEBSITE OFFERS EXPANDED ARRAY OF ONLINE RESOURCES

A major update to the Alabama Medicaid Agency website in June 2005 not only expanded the Agency's ability to quickly communicate with providers, recipients and the general public but also played a central role in providing information to providers, evacuees and others in the aftermath of Hurricane Katrina.

Averaging more than 60,000 individual visits each month, the Agency's updated website now makes it easier for medical providers, Medicaid recipients and the general public to access a wider array of online resources and downloadable documents within an easy-to-navigate interface. The new site, which also includes interactive and online forms and several searchable databases, may be accessed by going to www.medicaid.alabama.gov .

Organized by program or function, the site offers multiple features to easily locate needed information. Some of these features include a search engine at the top right hand corner of every window, a Find-It-Fast shortcut menu for frequently requested items, and toolbar tabs at the top of each page.

Additionally, providers, recipients and the general public can go to the site's "Apply for Medicaid" section to get up-to-date information on qualifying and/or applying for Medicaid, including contact information for Medicaid District Offices. The site also includes helpful resources such as consumer education materials, online education courses and links to other sites.

The website is maintained by the Agency's Research and Development Unit. Questions or comments may be sent to the website's content manager by email at webwork@medicaid.alabama.gov or by telephone at 334-353-9363.

MEDICAL HOME – HEALTH LITERACY PROGRAM EXPANDED TO AGENCY WEBSITE

In September 2005, the Alabama Medicaid Agency continued its efforts to encourage improved health outcomes through the development of an online educational program for physicians, nurses and other health care professionals.

Based on the Agency's "Medical Home * Health Literacy" program produced previously, the online presentation is designed to strengthen the physician-patient relationship through increased knowledge about medical homes, health literacy and the Alabama Medicaid program. In addition, the online program offers a complete tutorial of the Agency's updated Patient 1st program for primary medical providers and others with an interest in the program.

Patient 1st primary medical providers (PMPs) who successfully complete the activity are eligible for an enhanced case management fee. Continuing education credit hours are also available at no cost to other physicians

and health professionals. The program is available at http://www.medical-home.alabama.gov/

Electronic Prior Authorization

Effective December 1, 2004 the Alabama Medicaid Agency implemented an electronic prior authorization (PA) system for pharmacy claims that require PA. The electronic PA (EPA) system checks pharmacy and medical claims history to determine if PA requirements are met when a pharmacy claim is submitted. If it is determined that all criteria are met and the request is approved, the claim will pay and no manual PA request will be required. To date, there are 16 drug classes implemented into the EPA, and Medicaid continues to phase in other classes as they are reviewed. The EPA system has resulted in faster claim processing for providers by reducing the amount of total claims being entered manually and by returning an approval or denial to the pharmacist at the point of sale within seconds.

In addition, at the request of the provider community, Medicaid will phase in an online submission form for prior authorization. Providers will be able to complete the form online and send it directly to the pharmacy PA help desk for review. Both the prescribing physician and the dispensing pharmacy will continue to receive a faxed approval or denial for documenting purposes.

Hurricane Katrina

Hurricane Katrina, possibly the largest hurricane of its strength to approach the United States in recorded history, resulted in devastation many miles from its center which made landfall in southeast Louisiana in the early morning hours of August 29, 2005. The storm surge caused major catastrophic damage along the coastlines of Louisiana, Mississippi, and Alabama. The Alabama Medicaid Agency's response to this storm was swift and comprehensive.

The Alabama Medicaid website served as the primary communication tool to immediately disseminate information to help evacuees access health care and to assist providers in providing that care.

Prior to the storm, Alabama Medicaid providers and various provider associations were notified via the website and email regarding procedures for filling of emergency prescriptions, transportation of clients residing in nursing homes to safety and other pertinent information.

Immediately prior to and after the storm, Medicaid eligibility staff held conference calls to identify a plan of action for office closures and contingency plans for where workers could be placed to assist those who might be displaced by the hurricane.

Within one day of the storm making landfall, Alabama Medicaid staff obtained and posted to the Agency's website information needed by Alabama providers to enroll and file claims to Louisiana and Mississippi Medicaid, helping hundreds of evacuees access health care in Alabama.

Within one week of the storm (and prior to any guidance from the federal government), streamlined procedures including a shortened application form for enrolling evacuees temporarily into Alabama's Medicaid program were developed to ensure displaced individuals could access needed medical care while providing a mechanism for tracking recipients and expenses.

Daily staff briefings were held for the first two weeks and involved other state departments, including the Department of Mental Health and the Department of Public Health.

On September 16, 2005, Alabama Medicaid submitted an 1115 waiver request to CMS to cover evacuees for a temporary period of time. On September 22, 2005 CMS approved Alabama's waiver request for expedited eligibility for hurricane evacuees as of August 24, 2005. During early September, computer programming was accomplished to identify and track the evacuees in our system with reporting to CMS on a daily basis.

Medicare Part D

Pharmacy staff was very involved in the transition of drug coverage for Medicaid's beneficiaries who have both Medicare and Medicaid (called dual eligibles). Considered the most extensive change to the Medicare program since its inception, the conversion of pharmacy coverage for this vulnerable population has involved careful analysis and oversight.

Alabama's Medicaid Program

History

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

A State Program

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

Funding Formula

The federal-state funding ratio for Medicaid varies from state to state based on each state's per capita income. Because the average income in Alabama is relatively low, its federal match is one of the largest. During FY 2005, the formula was approximately 70/30. For every $30 the state spent, the federal government contributed $70.

Eligibility

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

- Persons receiving Supplemental Security Income (SSI) from the Social Security Administration are automatically eligible for Medicaid in Alabama. Children born to mothers receiving SSI payments may be eligible for Medicaid until they reach one year of age. After the child's first birthday, Medicaid will make a determination as to whether the child qualifies for another Medicaid program.
- Persons approved for "Medicaid for Low Income Families" (MLIF) which as of April 1, 2003, is determined by the Alabama Medicaid Agency. Low-income families may apply for Medicaid through the Agency's eligibility workers located in county health departments, hospitals and clinics throughout the state. Medicaid may be approved if the children are deprived of parental support due to absence, divorce, separation, death, or unemployment of the primary wage earner. Also, foster children under custody of the state may be eligible for Medicaid.
- Pregnant women and children under six years of age with family income which does not exceed 133 percent of the federal poverty level are covered by Medicaid. Also covered are children up to age 19 who live in families with family income at or below the federal poverty level. Medicaid eligibility workers in county health departments, federally qualified health centers, hospitals, and clinics determine their eligibility through a program called SOBRA Medicaid. Once children under 19 years of age are determined eligible for Medicaid through any program, they receive twelve months of continuous eligibility without regard to changes in income or family situation as long as they live in Alabama.
- Women who are aged 19 - 44, who have not been sterilized, and with family income which does not exceed 133 percent of the federal poverty level are covered by Medicaid for the Plan First Program. This program covers family planning services only.
- Persons who are residents of medical institutions (nursing homes, hospitals, or facilities for the mentally retarded) for a period of 30 continuous days and meet very specific income, resource and medical criteria may be Medicaid eligible. Persons who require institutional care but prefer to live at home may be approved for a Home and Community Based Service Waiver and be Medicaid eligible. Medicaid District Offices determine eligibility for persons in these eligibility groups.
- Qualified Medicare Beneficiaries (QMBs) have low income. Persons in this group may be eligible to have their Medicare premiums, deductibles, and coinsurance paid by Medicaid. Medicaid District Offices determine eligibility for QMBs.
- Specified Low-income Medicare Beneficiaries (SLMBs) and Qualifying Individuals-1 (QI-1) have low income above the QMB limit. Persons in this group may be eligible to have their Medicare Part B premiums paid by Medicaid. Medicaid District Offices determine eligibility for these programs.
- Qualified Disabled Working Individuals (QDWIs) are individuals who have limited income and resources and who have lost disability insurance benefits because of earnings and who are also entitled to enroll for Medicare Part A. Medicaid will pay their Medicare

Part A premiums. Medicaid Central Office determines eligibility for QDWIs.

- Disabled widows and widowers between ages 50 and 64 who are not eligible for Medicare Part A and who have lost SSI because of receiving widows/widowers benefits from Social Security can qualify for Medicaid. Medicaid District Offices determine eligibility for this group.

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

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

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

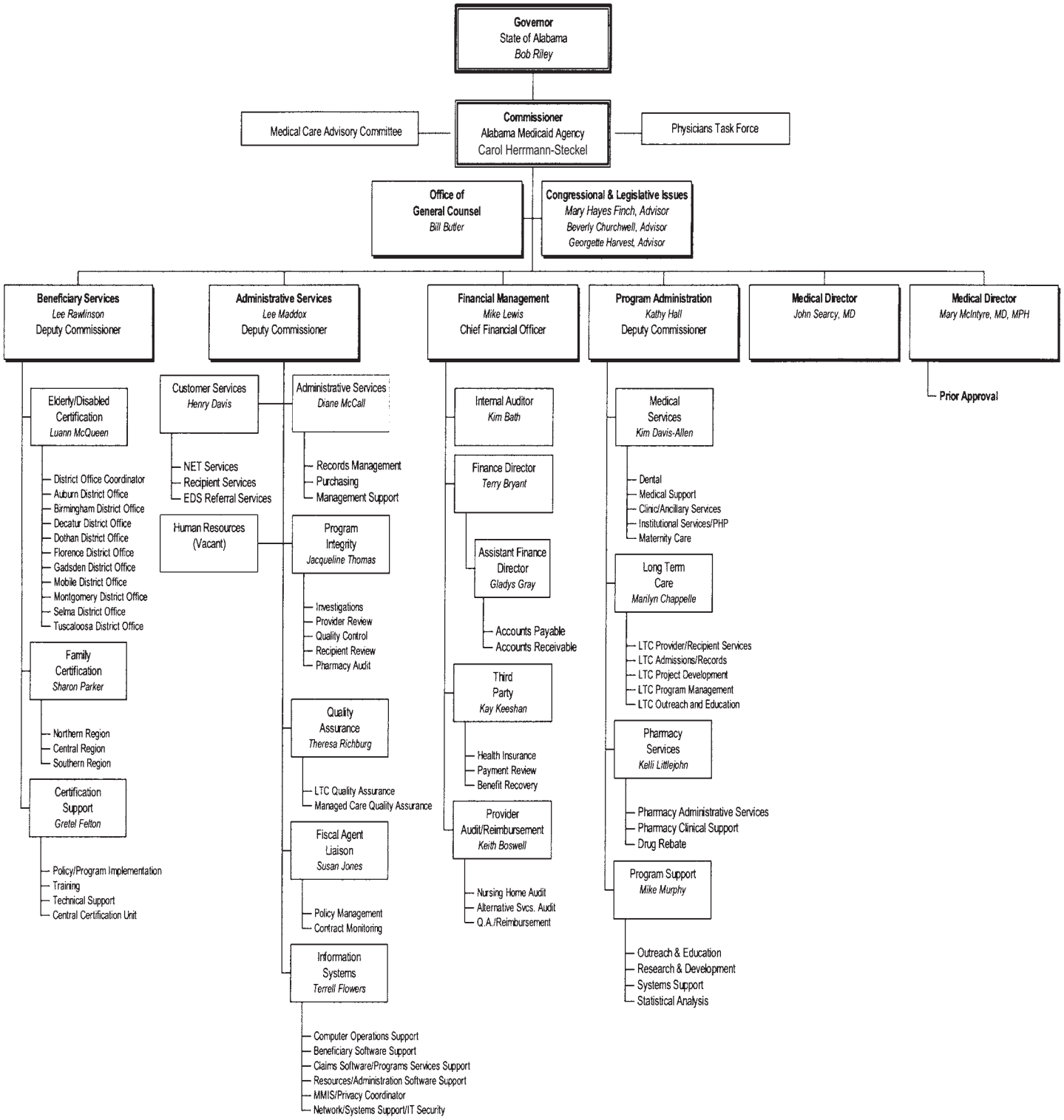
Covered Services

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

How The Program Works

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

Alabama Medicaid Agency



Medicaid's Impact

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

Citizens who are not eligible for Medicaid also benefit from the program. Health care is one of the state's most important industries, and Medicaid contributes to that industry in a significant way. For instance, during FY 2005, Medicaid paid over $4 billion to providers on behalf of persons eligible for the program. The federal government paid approximately 70 percent of this amount. These funds paid the salaries of thousands of health care workers who bought goods and services and paid taxes in the state. Using the common economic multiplier of three, Medicaid expenditures generated over $12 billion worth of business in Alabama in FY 2005.

Alabama's Medicaid program has established a tradition of having one of the lowest administrative costs in the nation. With the current administrative rate, almost 98 percent of the Agency's budget goes toward purchasing services for beneficiaries.

FY 2005
COUNTY IMPACT
Year's Cost Per Eligible

County	Benefit Payments	Eligibles	Payment per Eligible	County	Benefit Payments	Eligibles	Payment per Eligible
Autauga	$21,625,093	8,357	$2,588	**Houston**	$69,095,680	22,144	$3,120
Baldwin	$67,767,186	22,937	$2,954	**Jackson**	$38,999,653	11,172	$3,491
Barbour	$22,044,105	7,775	$2,835	**Jefferson**	$423,411,961	125,068	$3,385
Bibb	$12,804,168	4,899	$2,614	**Lamar**	$15,631,357	3,968	$3,939
Blount	$30,364,650	9,344	$3,250	**Lauderdale**	$62,235,234	17,193	$3,620
Bullock	$11,906,292	4,174	$2,852	**Lawrence**	$21,962,820	6,923	$3,172
Butler	$23,336,850	6,908	$3,378	**Lee**	$49,165,952	19,350	$2,541
Calhoun	$87,764,585	27,786	$3,159	**Limestone**	$36,587,668	11,405	$3,208
Chambers	$28,215,783	8,632	$3,269	**Lowndes**	$11,335,882	4,583	$2,473
Cherokee	$19,199,733	5,738	$3,346	**Macon**	$21,472,460	7,292	$2,945
Chilton	$24,895,562	8,716	$2,856	**Madison**	$127,513,536	39,702	$3,212
Choctaw	$13,813,795	4,359	$3,169	**Marengo**	$20,870,228	6,548	$3,187
Clarke	$23,117,286	7,967	$2,902	**Marion**	$27,590,730	7,620	$3,621
Clay	$13,168,238	3,309	$3,980	**Marshall**	$69,488,698	21,026	$3,305
Cleburne	$10,552,469	3,416	$3,089	**Mobile**	$289,391,218	90,964	$3,181
Coffee	$31,649,897	9,008	$3,514	**Monroe**	$17,951,626	6,093	$2,946
Colbert	$38,504,219	12,038	$3,199	**Montgomery**	$159,699,165	55,570	$2,874
Conecuh	$14,506,921	4,391	$3,304	**Morgan**	$78,396,172	20,668	$3,793
Coosa	$7,567,470	2,475	$3,058	**Perry**	$17,824,111	4,969	$3,587
Covington	$37,178,762	9,940	$3,740	**Pickens**	$20,754,565	6,066	$3,421
Crenshaw	$13,391,963	3,887	$3,445	**Pike**	$28,022,522	9,000	$3,114
Cullman	$60,620,808	16,073	$3,772	**Randolph**	$17,998,396	5,362	$3,357
Dale	$33,631,421	10,906	$3,084	**Russell**	$35,961,251	13,850	$2,596
Dallas	$55,919,520	18,863	$2,965	**St. Clair**	$39,791,044	12,521	$3,178
Dekalb	$60,441,636	17,463	$3,461	**Shelby**	$38,736,232	12,970	$2,987
Elmore	$41,006,067	11,826	$3,467	**Sumter**	$14,809,578	5,598	$2,646
Escambia	$28,031,432	9,843	$2,848	**Talladega**	$67,000,914	21,383	$3,133
Etowah	$93,619,050	22,776	$4,110	**Tallapoosa**	$38,373,735	10,243	$3,746
Fayette	$16,988,762	4,125	$4,118	**Tuscaloosa**	$143,842,253	33,367	$4,311
Franklin	$28,174,520	8,392	$3,357	**Walker**	$66,814,856	17,018	$3,926
Geneva	$22,154,975	6,551	$3,382	**Washington**	$13,397,597	4,288	$3,124
Greene	$10,596,983	3,970	$2,669	**Wilcox**	$16,923,107	6,023	$2,810
Hale	$17,728,518	5,702	$3,109	**Winston**	$23,702,814	6,481	$3,657
Henry	$13,777,135	4,177	$3,298	**Other**	$4,383,739	449	$9,763

Revenue and Expenditures

In FY 2005, Medicaid paid $4,002,643,142 for health care services to Alabama citizens. Another $81,461,051 was expended to administer the program. This means that almost 98 cents of every Medicaid dollar went directly to benefit recipients of Medicaid services.

FY 2005 SOURCES OF MEDICAID REVENUE

	Dollars
Federal Funds	$2,871,447,220
State Funds	$1,195,393,280
Total Revenue	$4,066,840,500

FY 2005 COMPONENTS OF FEDERAL FUNDS

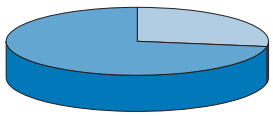
(net)	Dollars
Family Planning Administration	$474,086
Professional Staff Costs	$9,521,744
Other Staff Costs	$44,339,859
Other Provider Services	$2,793,120,251
Family Planning Services	$23,991,280
Total	$2,871,447,220

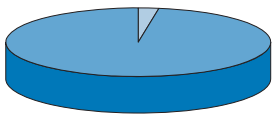
FY 2005 COMPONENTS OF STATE FUNDS

(net)	Dollars
General Fund Appropriations	$364,440,334
Public Hospital Transfers and Alabama Health Care Trust Fund	$554,620,632
Other State Agencies	$185,194,530
Drug Rebates	$41,911,288
UAB (Transplants)	$2,419,287
Miscellaneous Receipts	$11,845,221
Medicaid Trust Fund (with interest)	$28,793,262
Funds Carried Forward	$6,168,726
Total	$1,195,393,280

FY 2005 COMPOSITION AND DISBURSEMENT OF MEDICAID'S BUDGET

Where it comes from…Where it goes

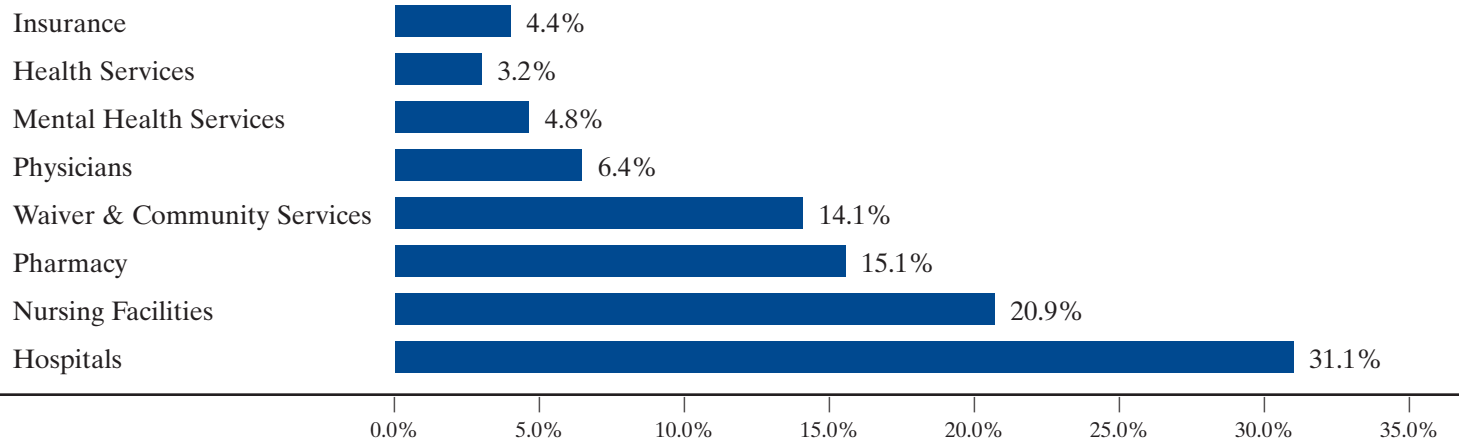




FY 2005
EXPENDITURES By type of service (net)

Service	Payments	Percent of Total Payments
Hospitals:	**$1,244,580,718**	31.09%
Disproportionate Share	$408,923,339	10.22%
Inpatient	$667,073,748	16.67%
Outpatient	$131,350,132	3.28%
FQHC	$24,271,481	0.61%
Rural Health Centers	$12,962,018	0.32%
Nursing Facilities	**$835,681,339**	20.88%
Waiver Services:	**$264,091,974**	6.60%
Elderly & Disabled	$62,830,947	1.57%
Mental Health	$194,593,545	4.86%
Homebound	$6,667,482	0.17%
Pharmacy	**$603,752,029**	15.08%
Physicians:	**$256,241,693**	6.40%
Physicians	$186,794,613	4.67%
Physician's Lab and X-Ray	$35,323,024	0.88%
Clinics	$26,995,262	0.67%
Other Practitioners	$7,128,794	0.18%
MR/MD:	**$30,236,989**	0.76%
ICF-MR	$27,248,060	0.68%
NF-MD/Illness	$2,988,929	0.07%
Insurance:	**$177,595,236**	4.44%
Medicare Buy-In	$169,344,208	4.23%
PCCM	$6,207,700	0.16%
Medicare HMO	$1,935,915	0.05%
Catastrophic Illness Insurance	$107,413	0.00%
Health Services:	**$128,083,247**	3.20%
Screening	$35,032,902	0.88%
Laboratory	$21,274,406	0.53%
Dental	$48,317,855	1.21%
Transportation	$11,639,551	0.29%
Eye Care	$7,857,751	0.20%
Eyeglasses	$3,298,107	0.08%
Hearing	$595,026	0.01%
Preventive Education	$67,649	0.00%
Community Services:	**$298,717,419**	7.46%
Maternity Program	$118,005,933	2.95%
Home Health/DME	$54,229,498	1.35%
Family Planning	$29,152,662	0.73%
Targeted Case Management	$51,969,556	1.30%
Hospice	$45,359,770	1.13%
Mental Health Services	**$163,662,498**	4.09%
Total For Medical Care	$4,002,643,142	100.00%
Administrative Costs	$81,461,051	
Net Payments	$4,084,104,193	

FY 2005
BENEFIT PAYMENTS Percent Distribution



POPULATION

The population of Alabama grew from 4,040,587 in 1990 to 4,419,280 in 2000. In 2005, Alabama's population was estimated to be 4,642,736. Because of increases in Medicaid coverage in recent years, the segment of the population eligible for Medicaid services has risen from 10.4 percent in FY 1990 to 20.8 percent in FY 2005.

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

FY 2003-2005
POPULATION
Eligibles as a Percent of Alabama Population by Year

	Population	Eligibles	Percent
2003	4,564,479	906,948	19.9%
2004	4,603,594	935,539	20.3%
2005	4,642,736	963,600	20.8%

Note: The FY 2005 Eligibles include 143,993 Plan First Eligibles

Eligibles and Recipients

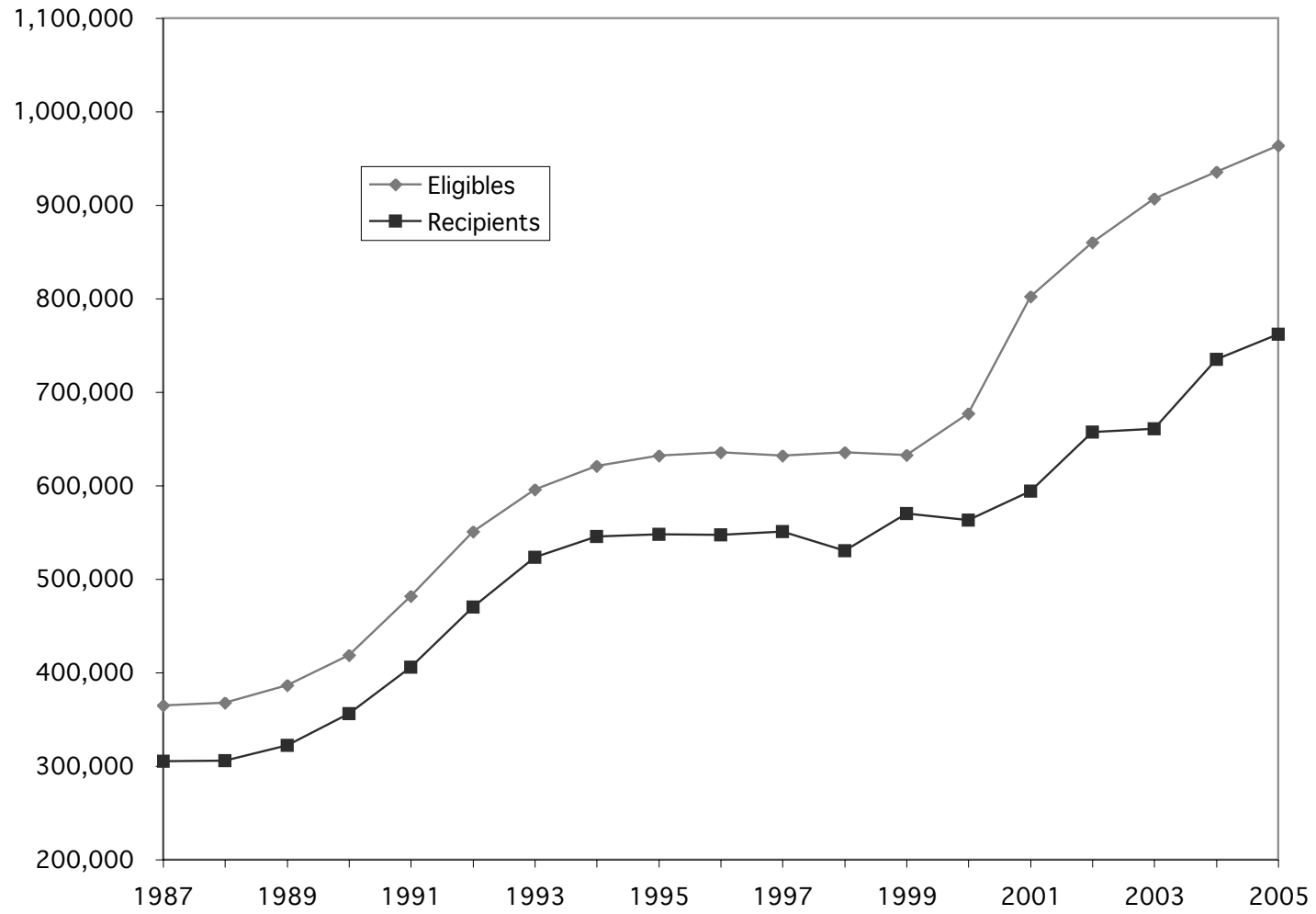
During FY 2005 there were 963,600 persons eligible for Medicaid in at least one month of the year. The average number of persons eligible for Medicaid per month was 814,028. The monthly average is the more useful measure of Medicaid coverage because it takes into account length of eligibility.

Of the 963,600 persons eligible for Medicaid in FY 2005, about 79 percent actually received care for which Medicaid paid. These 761,903 persons are referred to as recipients. The remaining 201,697 persons incurred no medical expenses paid for by Medicaid. Many of these individuals who had no medical expenses paid for by Medicaid were partial eligibles such as Qualified Medicare Beneficiaries (QMBs) only or Specified Low-income Medicare Beneficiaries (SLMBs) only.

FY 2005
ELIGIBLES
Monthly Count

October '04	810,259
November	800,590
December	800,177
January '05	805,956
February	809,000
March	812,725
April	816,260
May	818,767
June	820,629
July	821,593
August	824,988
September	827,392

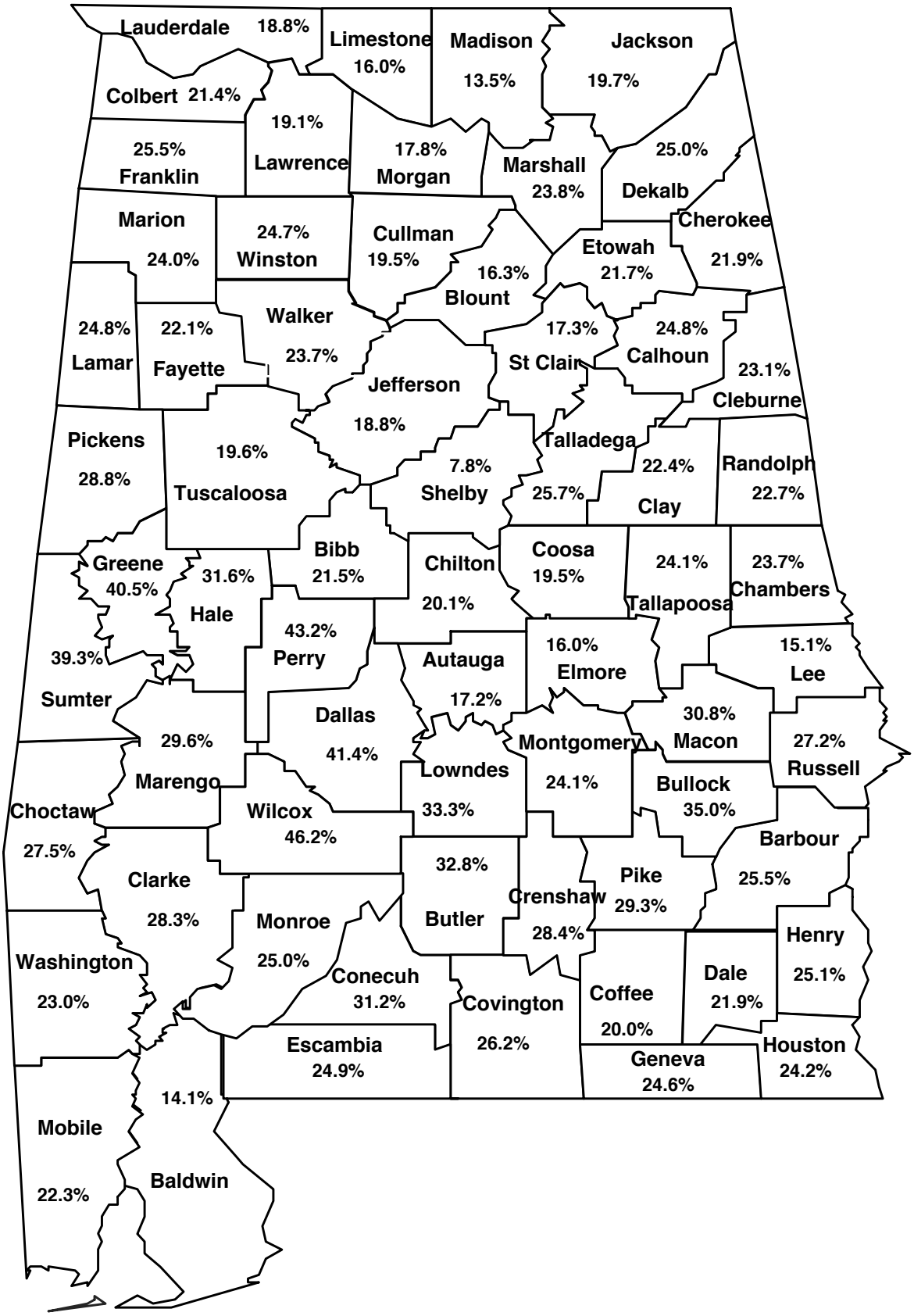
FY 1987 - 2005
MEDICAID ELIGIBLES AND RECIPIENTS



FY 2005
MEDICAID ELIGIBLES BY CATEGORY

COUNTY	MLIF	AGED	DISABLED	SOBRA	QMB	BLIND	SLMB	PLAN FIRST	TOTAL
Autauga	991	267	1,428	3,721	383	11	260	1,296	8,357
Baldwin	1,506	731	3,138	11,492	1,186	28	1,077	3,779	22,937
Barbour	907	375	1,551	3,355	433	13	251	890	7,775
Bibb	264	201	1,077	2,148	264	3	204	738	4,899
Blount	724	384	1,285	4,722	616	7	523	1,083	9,344
Bullock	421	258	841	1,861	200	3	94	496	4,174
Butler	723	407	1,249	2,953	440	10	266	860	6,908
Calhoun	3,600	865	5,090	11,243	1,419	58	1,008	4,503	27,786
Chambers	901	510	1,543	3,630	538	16	425	1,069	8,632
Cherokee	872	258	817	2,401	390	7	316	677	5,738
Chilton	576	303	1,325	4,119	604	11	490	1,288	8,716
Choctaw	481	292	883	1,699	255	5	137	607	4,359
Clarke	854	428	1,650	3,226	426	10	259	1,114	7,967
Clay	107	241	564	1,521	246	5	197	428	3,309
Cleburne	338	130	545	1,555	216	2	191	439	3,416
Coffee	881	536	1,536	3,896	556	7	395	1,201	9,008
Colbert	969	434	2,131	5,268	740	12	566	1,918	12,038
Conecuh	1,034	197	813	1,510	273	4	138	422	4,391
Coosa	112	114	582	1,002	198	2	148	317	2,475
Covington	842	629	1,615	4,260	744	10	588	1,252	9,940
Crenshaw	328	288	687	1,596	319	2	188	479	3,887
Cullman	822	932	2,516	7,537	1,171	19	962	2,114	16,073
Dale	1,462	459	1,991	4,697	542	12	341	1,402	10,906
Dallas	2,043	937	4,804	7,367	937	20	511	2,244	18,863
Dekalb	1,821	857	2,282	8,834	1,078	16	729	1,846	17,463
Elmore	1,143	494	2,275	5,363	527	11	391	1,622	11,826
Escambia	1,179	391	1,467	4,633	452	9	325	1,387	9,843
Etowah	1,609	1,110	4,717	9,765	1,378	29	992	3,176	22,776
Fayette	523	240	756	1,554	279	3	207	563	4,125
Franklin	888	388	1,274	3,883	592	3	425	939	8,392
Geneva	613	369	1,193	2,719	500	7	371	779	6,551
Greene	389	213	851	1,686	170	5	81	575	3,970
Hale	372	353	1,172	2,517	259	8	150	871	5,702
Henry	372	275	687	1,741	340	7	211	544	4,177
Houston	1,908	922	3,831	10,329	1,176	19	809	3,150	22,144
Jackson	838	561	1,838	5,158	786	17	539	1,435	11,172
Jefferson	10,337	4,708	25,571	52,379	6,262	143	5,403	20,265	125,068
Lamar	483	246	630	1,457	344	10	186	612	3,968
Lauderdale	1,295	787	3,014	7,075	1,135	8	842	3,037	17,193
Lawrence	599	324	1,180	2,911	483	7	385	1,034	6,923
Lee	2,130	578	2,957	8,586	713	23	549	3,814	19,350
Limestone	790	554	1,799	5,305	652	18	462	1,825	11,405
Lowndes	688	219	867	1,863	220	6	105	615	4,583
Macon	970	320	1,282	2,939	279	9	158	1,335	7,292
Madison	3,264	1,508	6,654	18,256	1,621	51	1,063	7,285	39,702
Marengo	614	372	1,470	2,647	335	7	151	952	6,548
Marion	790	416	1,082	3,279	572	7	389	1,085	7,620
Marshall	2,244	988	3,116	10,512	1,107	20	885	2,154	21,026
Mobile	10,497	2,975	14,650	41,700	3,660	102	3,006	14,374	90,964
Monroe	611	309	1,078	2,746	311	7	210	821	6,093
Montgomery	7,463	1,829	10,324	23,828	2,127	62	1,316	8,621	55,570
Morgan	1,470	938	3,425	10,114	1,028	37	737	2,919	20,668
Perry	777	320	1,158	1,755	237	3	106	613	4,969
Pickens	397	373	1,376	2,405	293	6	175	1,041	6,066
Pike	942	412	1,748	3,680	366	18	273	1,561	9,000
Randolph	453	278	820	2,468	356	12	227	748	5,362
Russell	2,502	539	2,207	5,548	651	20	499	1,884	13,850
St. Clair	1,369	412	1,795	5,940	660	14	613	1,718	12,521
Shelby	1,147	456	1,918	5,899	696	7	640	2,207	12,970
Sumter	928	322	1,195	1,989	203	7	110	844	5,598
Talladega	2,638	730	4,393	8,428	1,305	56	993	2,840	21,383
Tallapoosa	1,007	626	1,937	4,355	580	10	493	1,235	10,243
Tuscaloosa	2,426	1,275	6,843	14,329	1,137	40	889	6,428	33,367
Walker	1,103	713	3,609	7,303	899	15	851	2,525	17,018
Washington	533	209	832	1,707	235	5	180	587	4,288
Wilcox	640	332	1,681	2,264	260	10	92	744	6,023
Winston	682	340	1,141	2,637	519	3	392	767	6,481
Youth Services	5	0	0	444	0	0	0	0	449
STATEWIDE	95,207	40,757	173,756	421,709	49,879	1,154	37,145	143,993	963,600

FY 2005
ELIGIBLES
Percent of Population Eligible for Medicaid



Comparison of Eligibles and Payments

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

The largest group of eligibles is the SOBRA group, which covers low-income pregnant women and children. Alabama Medicaid pays for about one half of all pregnancy-related services in the state, and over 50 percent of children in Alabama less than six years of age are enrolled in the program. However, even at 44 percent of all Medicaid Eligibles, the SOBRA group of eligibles accounts for only 23 percent of Medicaid expenditures. Another group that covers parents and their children is Medicaid for Low-Income Families (MLIF).

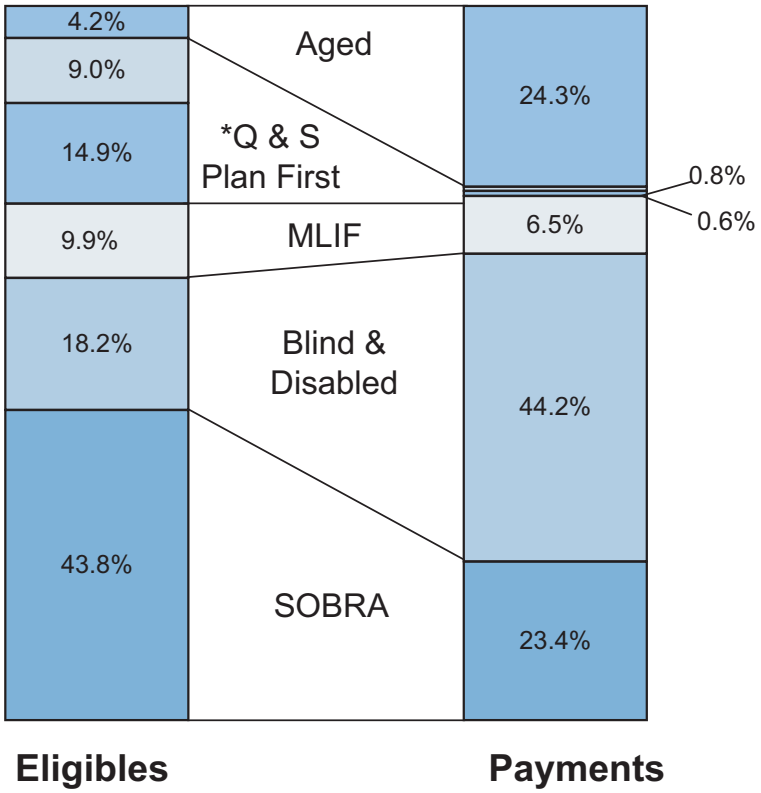
When combined, these two groups that cover families account for 54% of the Medicaid population, but only 30 % of the payments. Other eligibles, such as QMB, SLMB, and Plan First comprise a total of over 24% of Medicaid Eligibles, while only a little over one percent of payments for services are made on their behalf. This is because these groups do not receive full Medicaid. QMB's and SLMB's qualify to have their Medicare premiums, deductibles, or coinsurance paid for by Medicaid. Plan First eligibles receive family planning services only.

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

FY 2005
Eligibles and Payments Percent Distribution

By Category Of Aid

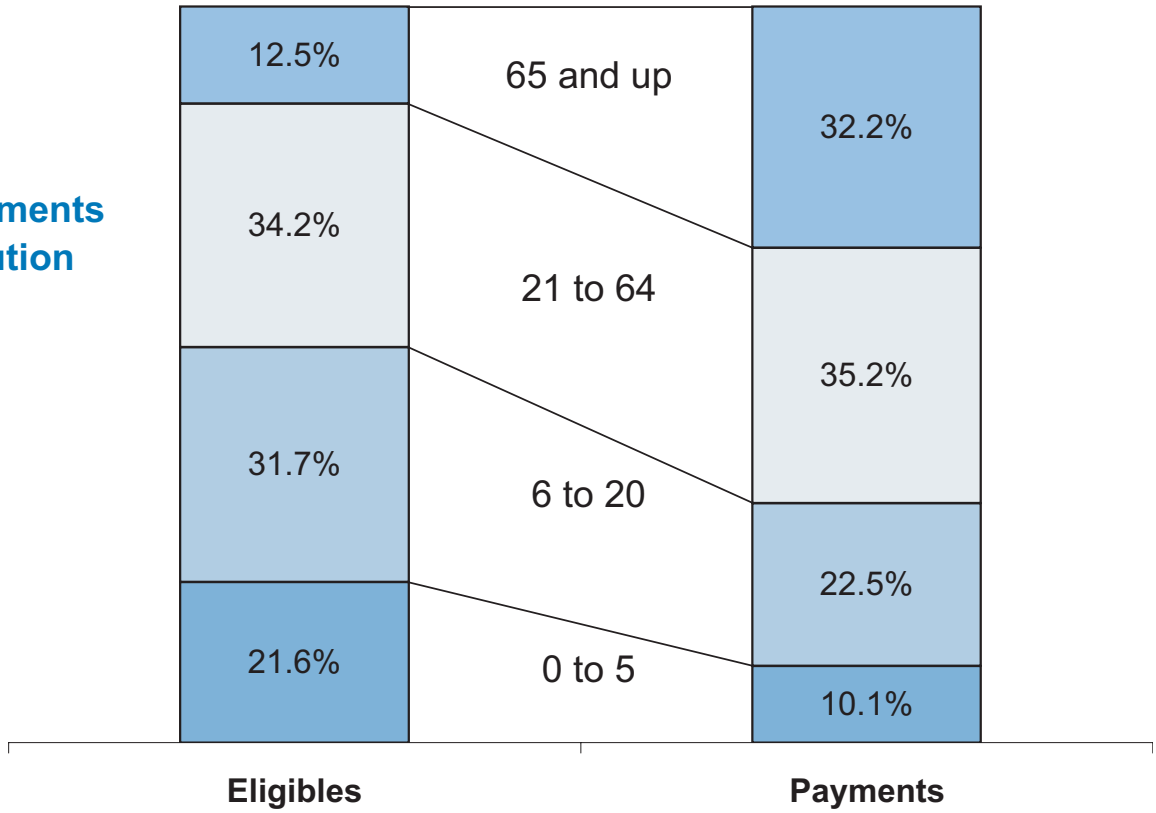
* QMB & SLMB



FY 2005

Eligibles and Payments Percent Distribution

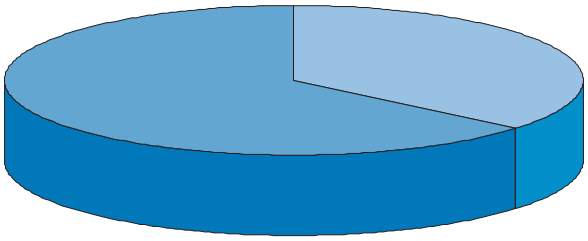
By Age



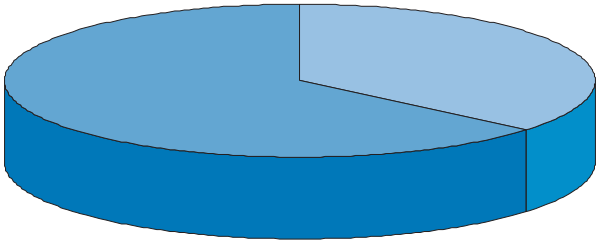
FY 2005 Eligibles and Payments

Percent Distribution by Gender

Eligibles



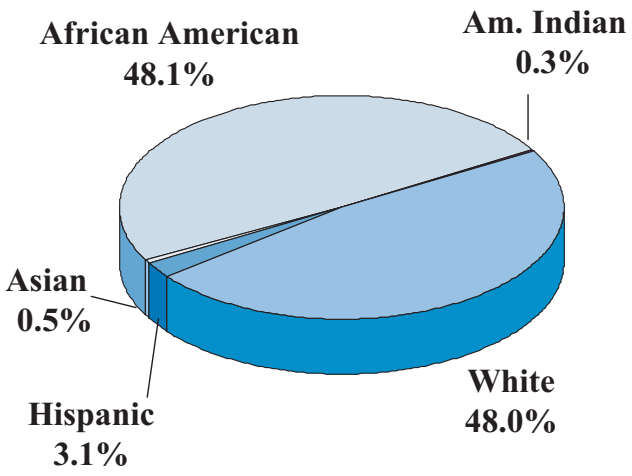
Payments



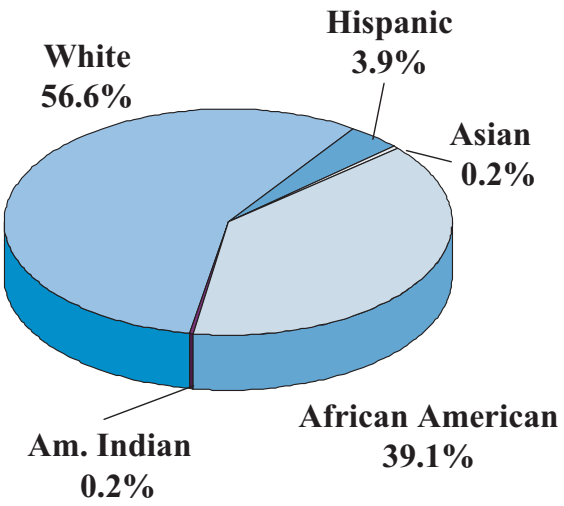
FY 2005 Eligibles and Payments

Percent Distribution by Race

Eligibles



Payments



FY 2005
TOTAL PAYMENTS
By County of Recipient

Use and Cost

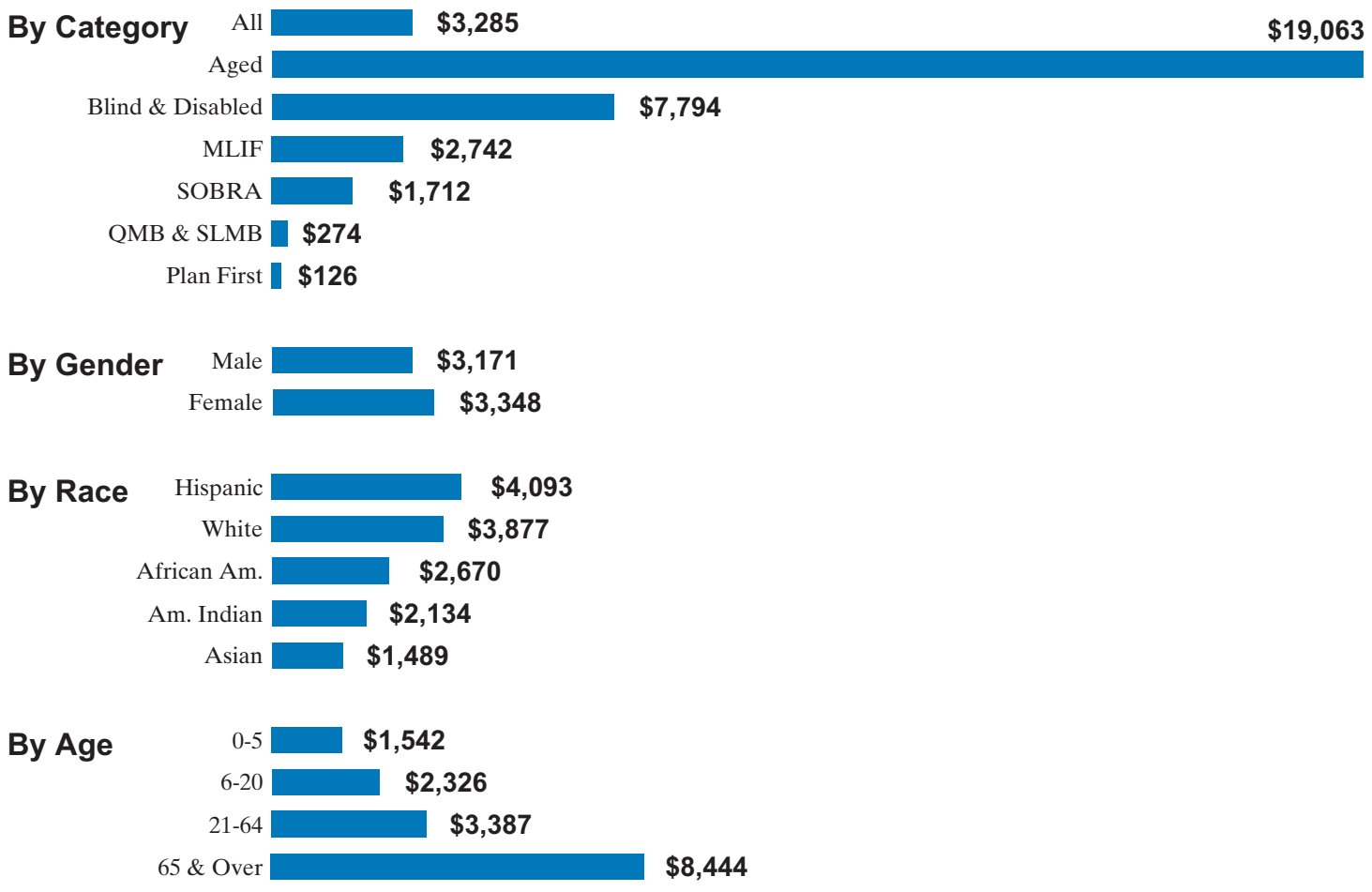
A useful way to compare costs of different groups of Medicaid eligibles and predict how changes in eligibility and utilization will impact Medicaid is to measure cost per eligible. This measure is determined by dividing total payments for services by the total number of persons eligible during the year.

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

A good example of this is the pattern of use of long-term care. This type of care has a high cost per unit of service, and recipients of long-term care have a high frequency-of-service rate. The average Medicaid payment for a day of long-term care in FY 2005 was $98. The yearly average number of days for recipients of this service was 290. Most recipients of long-term care are white females who are categorized as aged or disabled and are 65 years of age and over. It is not surprising that these groups have a high cost per eligible for the year.

Some low-income Medicare beneficiaries are eligible to have their Medicare premiums, deductibles, and coinsurance covered by Medicaid. For Part B coverage, Medicaid in FY 2005 paid a monthly premium to Medicare of $66.60 during October through December 2004 and $78.20 during January through September 2005 per eligible Medicare beneficiary. The Medicaid Agency also paid from $343 to $377.30 per month during October through December 2004 and $375 to $412.50 during January through September 2005 for Part-A Medicare premiums for certain Medicare eligibles. Medicaid paid over $169 million in Medicare premiums in FY 2005. Paying the Medicare premiums is cost effective for Medicaid because, otherwise, the Agency would incur the full payment for medical bills instead of only covering the premiums, deductibles, and coinsurance.

FY 2005
COST PER ELIGIBLE
By Category, Gender, Race, and Age



Cost Avoidance and Recoupments

Program Integrity

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

The Provider Review Unit uses computer generated statistical reports to identify overbilling or potential fraud and program abuse. The Unit also responds to referrals from other program units, outside agencies, and the Fraud Hotline. Specially trained nurses perform medical audits using specialized computer programs and reviews of patient medical records. Both medical necessity and quality of care are examined. The primary purposes of these reviews are to assure proper claim payment, recovery of overpayments, and to identify Medicaid fraud and abuse.

When problems are identified as the result of a review audit, several corrective actions may be taken: recoupment of funds, education on proper billing procedures, and referral to appropriate oversight Agencies. Suspected fraud cases are referred to the Attorney General's Medicaid Fraud Control Unit for possible legal action.

FY 2005 PROVIDER REVIEWS	
Medical Providers	**165**
Medical Provider Recoveries	**$1,385,642**
Pharmacies	**287**
Pharmacy Recoveries	**$68,281**

The Investigations Unit within the Program Integrity Division is charged with identifying criminal fraud or abuse as related to providers and recipients through on-site investigations, interviews and electronic evidence gathering. Completed cases are then referred to appropriate law enforcement agencies, Medicaid's Utilization Review Committee, or to State Licensing Boards for appropriate action. During FY 2005, 17 previously referred cases were adjudicated along with 159 cases investigated and closed, and 19 referrals for prosecution.

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

Through the Quality Control Unit, the Medicaid Agency makes sure eligibility determinations are as accurate as possible. In-depth reviews of eligibility determinations are performed on a random sample of Medicaid eligibles. If a state's payment error rate exceeds three percent, the Centers for Medicare and Medicaid Services (CMS) may impose a financial sanction. The Agency's most recent error rate was below the three percent maximum for the six-month period from October 2004 to March 2005. Nationally, Alabama has consistently been among those states with the lowest payment error rates.

Beginning in April 2004, the Pharmacy Audit Unit was established as a separate unit of the Program Integrity Division. The purpose of a pharmacy audit, in general, is to obtain a reasonable assurance that pharmacy providers abide by the rules, regulations, and policies set forth by the Alabama Medicaid Agency and CMS, and in particular, to determine that no Medicaid funds are misspent. Experienced auditors in this unit interpret and apply Medicaid policy regarding the concept of accountability for public resources. Criteria used in selection for audit purposes includes but is not limited to high volume providers, date of last audit, previous audit results, and specific requests or referrals. Examples of discrepancies noted for review and possible recoupment include controlled substances dispensed without an original prescription on file, unauthorized refills, invoice verification, duplicate billing, and unauthorized price overrides. Based on the findings of a desk review or an on-site audit, corrective action is recommended when necessary. If significant fraud or abuse is discovered during the course of an audit, a referral for further investigation is made to the appropriate division or agency.

FY 2005 RECIPIENT REVIEWS
Reviews Conducted 498
Monthly Average # of Restricted Recipients 321
Cost Avoidance $165,687

Prior Authorization Program

The primary mission of the Prior Authorization Program (PA) is to ensure that only medically necessary services are provided in a cost-effective manner. The program also takes care to ensure that medically necessary services

are not denied to recipients. Requests for prior authorization are processed in a timely manner.

Constantly seeking increased efficiency, responsibilities within the unit are reassigned to personnel within the unit. This promotes cross training so that all personnel within the unit may assist all providers.

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

Third Party Coordination of Benefits

Federal regulations require state Medicaid agencies to identify other payers (third party payers) that may be available to pay for the care and services provided to Medicaid recipients and coordinate payments with those primary payers so that Medicaid pays secondary. In Alabama, this effort is performed by Medicaid's Third Party Division. This coordination of benefits program has been successful in saving Alabama taxpayers millions of dollars each year since its inception in 1970. *In FY 2005 alone, third party savings exceeded $800 million.*

These 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 the Third Party Division to primary payers, 3) payment of Medicare and health insurance premiums, 4) liens and estate recovery, and 5) recipient recoveries. In addition, Medicaid also makes capitated payments to Medicare Advantage Plans for Medicaid enrollees, resulting in an avoidance of payment for Medicare deductibles and co-payments/coinsurance for certain Medicaid recipients.

Health Insurance and Trauma Resources

In FY 2005 the Third Party Division's health insurance database indicated 10.6% of current Medicaid eligibles were covered by health insurance other than Medicare and Medicaid. The Division is responsible for identification, verification, and documentation of health insurance resources as well as establishment of claims processing edits so that claims are submitted to the primary payer before Medicaid makes payment. When primary coverage is identified after Medicaid makes payment, the Third Party Division seeks reimbursement from the primary payer.

Medicaid also looks for potential third party payers when a Medicaid recipient receives treatment for an injury. Third party sources of payment include homeowner's, automobile, malpractice, and other liability insurance. Once these resources are identified, Third Party Division's Trauma Unit then seeks reimbursement of Medicaid payment for medical bills related to a recipient's injury.

As a result of the diligent efforts of Third Party staff, Medicaid collected or avoided costs in excess of $13,900,000 in FY 2005 due to coordination of benefits involving health and liability insurance, tort settlements, and court-ordered restitution.

Liens / Estate Recovery

In accordance with federal requirements, Alabama has developed a strong program of recovery of the costs of nursing facility and other medical services from the estates and property of Medicaid recipients as well as recovery of claims from income trusts of Medicaid recipients. As a result of the efforts of the Third Party Division's Liens / Estate Recovery Program, Medicaid collected over $5.7 million in FY 2005.

Recipient Recovery

Medicaid recovers funds from individuals who received Medicaid services for which they were not entitled. In most instances, these cases involve individuals who, through neglect or fraud, did not report income or assets to their Medicaid caseworkers. The Third Party Division's Recoupments Unit identifies these cases from complaint reports submitted by the individual's caseworker. In FY 2005, Medicaid recovered over $1.3 million from these type cases.

Health Insurance Premium Payment (HIPP)

Alabama Medicaid pays health insurance premiums for individuals with high cost medical conditions when it is cost effective. Continuation of an individual's health plan ensures savings to the Medicaid program by deferring costs to the primary payer. Alabama's HIPP program accepts applications from individuals who cannot continue to pay their health plan premiums due to job loss, medical leave, etc. Individuals enrolled in this program include pregnant women, cancer and HIV patients, and low birth weight and preterm babies. In FY 2005, Medicaid saved over $600,000 as a result of the HIPP program.

Medicare Resources

Medicare is a primary payer to Medicaid, and the Third Party Division's Buy-In Program is responsible for ensuring that Medicare coverage is maximized. Medicaid processes Medicare Parts A and B enrollments for selected recipients and monitors and makes premium payments for Medicare Parts A and B coverage for eligible beneficiaries. In addition, Third Party staff ensure that Medicare is a primary payer to Medicaid through establishing and monitoring Medicare claims processing edits. In FY 2005, Medicaid saved over $658,000,000 as a result of these activities.

Medicare Advantage (MA) Plans

Medicare Advantage Plans (formerly Medicare + Choice Plan) may contract with the Medicaid Agency to receive a capitated payment per member per month to cover Medicaid's cost sharing responsibility for full Medicaid and QMB only recipients. This cost sharing responsibility includes Medicare deductibles and coinsurance / co-payment for Medicare covered services. MA Plans may include Medicare Managed Care Plans (HMOs), Medicare Preferred Provider Organization Plans (PPOs), and Medicare Private Fee-for

Service-Plans. The Plans must have an approved Medicare risk contract with CMS to enroll Medicare beneficiaries and other individuals and must deliver a specified comprehensive range of high quality services efficiently, effectively, and economically to Medicare enrollees.

During FY 2005, Medicaid had agreements with three HMO MA Plans to cover recipient cost sharing through a capitated payment. These MA plans continued to expand across Alabama and, by the end of FY 2005, Medicaid was making capitated payments for 12,308 Medicaid recipients who were enrolled in an MA Plan. This resulted in cost avoided savings to the Medicaid program in the amount of $9.4 million for FY 2005. With an agreement in place with Blue Cross Blue Shield of Alabama's PPO plan for FY 2006 and an expansion in coverage by the existing MA plans, the Agency expects these savings to continue to increase.

Agency Audit

Fiscal Agent/Contract Monitoring

The Fiscal Agent Liaison Division/Contract Monitoring Unit monitors the processing and payment of Medicaid claims through the Claims Processing Assessment System (CPAS). Periodic reviews of forced claims, denied claims, processed refunds and adjustments are also performed. In addition, targeted reviews of claims are performed when potential systems errors are identified. During this fiscal year, approximately 2,285 claims were manually reviewed and $67,881.74 was identified for recoupment.

Provider Audit/Reimbursement

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

Nursing Home Audit conducts on-site financial audits and makes necessary adjustments to the reported costs. This adjustment information is provided to reimbursement specialists, who adjust current payment rates, recoup overpayments and make up for underpayments. An in-depth, on-site audit of all nursing home facilities, home offices, and all ICF/MR facilities is completed as necessary. During FY 2005, this unit completed 31 audits. Both positive and negative adjustments are made to insure that all reimbursable costs are included and that all non-reimbursable costs are removed from provider per diem rates. If it is determined that a provider may be intentionally filing a fraudulent cost report, or if the provider continues to claim known unallowable costs in the reimbursement cost total, the Nursing Home Audit section provides the Attorney General's Medicaid Fraud Control Unit with the information.

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

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

FY 2005
COLLECTIONS AND MEASURABLE COST AVOIDANCE

COLLECTIONS

DRUG REBATE PROGRAM Collection of rebates plus interest from drug manufacturers for the utilization of their products.	$145,249,482
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.	$18,693,831
PROGRAM INTEGRITY DIVISION	
Provider Recoupments	$1,385,642
Pharmacy Recoupments	$68,281
FISCAL AGENT/SYSTEMS AUDIT DIVISION	
Claim Corrections	$67,882
TOTAL COLLECTIONS	**$165,465,118**

MEASURABLE COST AVOIDANCE

THIRD PARTY CLAIM COST AVOIDANCE SAVINGS	
Traditional Medicare Net Savings (includes Provider Payments/Cost Avoidance/Recoupments *less premium cost of $169.4567.52*	$7,481,003
Provider Reported Collections - Health and Casuality Insurance	$28,739,681
Medicare Advantage Capitated Program Net Savings	$74,481,003
Claims denied and returned to providers to file health/casualty insurance.	$146,213,377
Health Insurance Premium Payment Cost Avoidance	$663,891
WAIVER SERVICES COST AVOIDANCE - ELDERLY AND DISABLED	$173,151,850
WAIVER SERVICES COST AVOIDANCE - HOMEBOUND	$9,934,398
WAIVER SERVICES COST AVOIDANCE - MR/DD	$367,754,578
WAIVER SERVICES COST AVOIDANCE - LIVING AT HOME	$2,050,272
TOTAL MEASURABLE COST AVOIDANCE	**$810,470,053**
GRAND TOTAL	**$975,935,171**

Medicaid Management Information System

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

FY 2005 work efforts reflected an approach to modernization and use of newer, faster technology to speed up work processes and increase security. For example, the Agency now has a new Medicaid Personnel System (MPS) that replaced the mid-range personnel system. In addition, a new web-based Security awareness Training (SAT) System began production and is a required component of Agency "employee" briefing procedures as well as EDS training procedures and Call Center staff. In January 2005, Network and Systems Support implemented FootPrints®, a web-based help desk, customer support tool designed to help track, manage and improve service activities throughout the Agency. As state departments move toward a pure Microsoft (MS) Windows Network Operating System (NOS), transition from a traditional Novell Netware NOS to MS Windows NOS was begun. Several automated patch management tools were implemented that perform services such as enabling Network and Systems Support to deploy the latest MS product updates to the network's Windows Server operating system, managing distribution of those updates to computers in our network.

Other major projects completed this fiscal year by the Information Systems Division include the comparisons between current pharmacy claims utilization reports to the entire current pricing methodology used by the Agency's pricing company, First Data Bank. New software was created and implemented to extract data from the Federal Government's Medicare Enrollment Database, incorporating the most current Medicare information for Alabama Medicaid recipients or potential recipients into the Agency's database files and systems to be used in eligibility determination. Federal approval was received for the Medicare Modernization Act (MMA) for Part D coverage. Software modifications were made to allow active Medicaid recipients whose Medicare premiums are no longer being paid by Medicaid to be resubmitted automatically to CMS for buy-in. Additionally, four new district office program codes were added and put into effect statewide, with all associated software programs (about 60) changed accordingly. Software changes were incorporated concerning the Department of Industrial Relations (DIR) wage match process. Various changes were made to the SOBRA online application process to accommodate new information concerning the ALLKIDS program. To ensure improved accuracy and efficiency in the creation, sorting and sending of all our Agency letters, forms and handouts through self-mailers, all affected mainframe software was modified to first be processed through purchased software that would correct zip codes, assign bar codes to the self-mailers, and then sort and create bag tags/tray tags according to federal postal regulations. I/S programming staff created new software and modified vast amounts of existing software to assist and provide needed emergency Medicaid services to the evacuees of hurricanes Katrina and Rita.

Data processing services and research as needed was provided for other in-house areas and for outside entities such as various hospitals for data matching, several utility companies, specific providers, other state agencies and departments, the state data center (ISD) and the state's Attorney General's Office.

Maternal and Child Health Services

During FY 2005, Medicaid served 421,709 women and children through the expanded eligibility group for pregnant women and children called SOBRA (Sixth Omnibus Budget Reconciliation Act). Coverage of this group has contributed to an improvement in Alabama's infant mortality rate since 1989, from 12.1 infant deaths per thousand births to 8.7 deaths per thousand in 2004.

Prenatal Care

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

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

Adolescent Pregnancy Prevention Education

Adolescent Pregnancy Prevention Education was implemented in October 1991. The program is designed to offer expanded medically related education services to teens. The program curricula are designed to teach disease and disability prevention and to prolong life and promote physical and mental health.

The pregnancy prevention services include a series of classes teaching male and female adolescents about decision-making skills and the consequences of unintended pregnancies. Abstinence is presented as the preferred method of choice. Currently there are approximately 15 providers of adolescent pregnancy prevention services. These include hospitals, county health departments, FQHCs, and private organizations.

Vaccines for Children

In an effort to increase the number of Alabama children who are fully immunized by two years of age, the

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

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

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

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

Family Planning

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

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

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

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

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

Plan First

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

The great thing about Plan First is that the eligibles are able to receive oral contraceptives directly from their enrolled provider of choice without having to go to a pharmacy to get a prescription filled. All other covered family planning methods are available through the pharmacy.

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

Plan First was implemented in October 2000 and at that time there were 61,971 enrollees who started with the program. In FY 2005, there were 146,993 women served by the Plan First Program. The Program has been renewed for an additional three years.

EPSDT

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

izes long term savings by intervening before a medical problem requires expensive acute care.

The EPSDT program is a Medicaid-funded program available to all Medicaid eligible children under 21 years of age. The success of the program is fostered by the cooperation of the Alabama Medicaid Agency, the Department of Human Resources, the Department of Public Health, and Medicaid providers. Medicaid beneficiaries are made aware of EPSDT and referred to screening providers by eligibility workers at the Department of Human Resources, Medicaid District Office eligibility specialists, and SOBRA Medicaid outstationed workers located in health departments, hospitals, federally qualified health centers, and clinics throughout the state.

Currently there are more than 2000 providers of EPSDT services, including county health departments, federally qualified health centers, provider-based rural health clinics, independent rural health clinics, hospitals, private physicians and some nurse practitioners. With statewide implementation of the Patient 1st Program, primary medical providers are obligated to ensure that all Medicaid recipients under 21 years of age receive screenings on time.

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

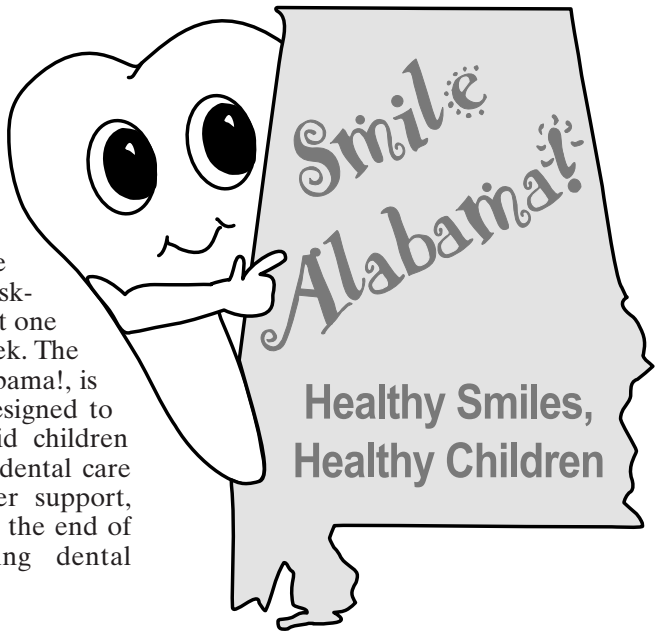
Since screening is not mandatory, many parents do not seek preventive health care for their children. Steps have been taken in recent years, however, to increase the number of children receiving screening services. These initiatives include more publicity of the EPSDT program, implementation of intensive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

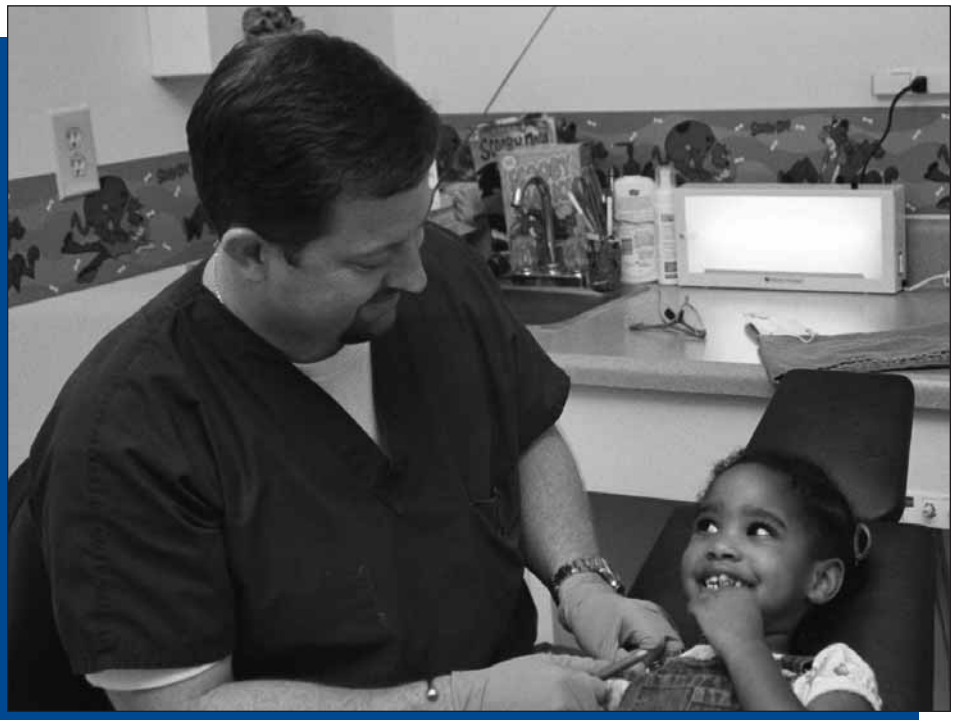
Dental Services

Medicaid pays for routine dental care for children under 21 years of age with full Medicaid eligibility through the EPSDT Program when provided by licensed dentists who are enrolled as Medicaid dental providers. Some of the routine care available includes a cleaning every six months, x-rays, fillings, extractions, root canals and crowns. Examples of dental services not covered by Medicaid include surgical periodontal and prosthetic treatments. If justified by the attending dentist, some services may be prior authorized by the Medicaid Agency. These services may include nonsurgical periodontal treatment, third and subsequent space maintainers, hospitalization and some out-of-state care.

Smile Alabama!

In October 2000, Medicaid kicked off an initiative to recruit and retain a solid dental provider base for Medicaid children by asking dentists to accept at least one new Medicaid child per week. The program, named Smile Alabama!, is a multifaceted campaign designed to improve access to Medicaid children for routine and preventive dental care through education, provider support, and fair reimbursement. By the end of FY 2005 the participating dental providers had continued to grow with more than 425 new dental providers enrolled since the Smile Alabama! Initiative began. With more providers in the state, there has been a corresponding increase in the number of procedures done, with almost 169,597 children receiving at least one dental service.





FY 2005
SOBRA Eligibles

Customer Service

Medicaid's Information Call Center

In an attempt to provide more efficient service to the Agency's beneficiaries and providers, the Alabama Medicaid Agency implemented an Information Call Center in November 2002. The Agency's recipients can call and get the help they need via a toll-free telephone service throughout Alabama by calling 1-800-362-1504. The caller will be given choices that will connect them to one of the five (5) areas. The areas included in the Call Center are:

Recipient Inquiry Unit, Non-Emergency Transportation, Customer Service, Long Term Care, and District Offices.

With the various automated features of the Information Call Center (1-800-362-1504), more calls can be answered in a timely manner. The Information Call Center lines are open from 8:00 a.m. to 4:00 p.m., Monday through Friday.

Recipient Inquiry Unit

Implemented in late 1992, the Recipient Inquiry Unit has increased recipients' access to the Agency via toll-free telephone service from throughout Alabama. Averaging 32,552.58 calls monthly during FY 2005 (more than 390,630 annually), the Inquiry Unit provides replacements for lost and stolen Medicaid cards to eligible persons, while responding to callers' questions about various eligibility, program and other topics.

Each month, approximately one-third of all calls deal with Primary Care Case Management (PCCM) provider assignments and about one-fifth are information-only calls. About 37.5 percent of calls deal with Medicaid card replacement and the remaining calls are referred to a certifying agency or worker (Medicaid District Offices, SOBRA workers, Social Security or the Department of Human Resources) or an Agency program office (Hospital, Physicians, and Pharmacy, among others) for action. In the wake of Hurricane Katrina the Recipient Inquiry Unit has assisted in providing valuable assistance, guidance, and direction to improve the lives of the evacuees from Alabama, Mississippi, and Louisiana.

The hotline (1-800-362-1504) is open from 8 a.m. to 4:00 p.m. Monday through Friday. In FY 2005, the unit was staffed with nine (9) full time operators and eight (8) temporary operators.

Managed Care

Partnership Hospital Program

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

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

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

There are some instances when inpatient days are unlimited:

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

Patient 1st

Patient 1st Program was re-implemented statewide February 1, 2005. The Patient 1st Program is a primary care case management system that links each participating Medicaid beneficiary with a Primary Medical Provider (PMP). The PMP is responsible for pro-

viding care directly or through referral. Additional responsibilities include 24-hours a day/7 days a week coverage, coordination of EPSDT and immunizations, and coordination of medical needs. Services provided through the program are augmented with new technologies including in-home monitoring and Blue Cross/Blue Shield's Info Solutions. The in-home monitoring allows for a physician to have equipment placed in the patient's home. The data from the equipment is then fed into a centralized database which alerts healthcare providers when the patient is out of compliance with prescribed parameters. The in-home monitoring project is a collaborative effort between Medicaid, the University of South Alabama and the State Department of Public Health. Info Solutions is a claims based database that allows a physician to review a patient's pharmacy history. The Preferred Drug List (PDL) is also available to a physician through a PDA or desk top model.

The Program has been successful in meeting its goal of creating medical homes for Medicaid beneficiaries. Access to a PMP has resulted in reduced doctor shopping, more appropriate utilization of services, and reduced expenditures for primary care in an emergency room setting.

Maternity Care Program

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

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

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

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

Managed Care Quality Assurance Program

The Managed Care Quality Assurance Program is responsible for monitoring and oversight of Quality Assurance Activities for Medicaid's Managed Care initiatives. During fiscal year 2005, Medicaid's Managed Care Initiatives included:

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

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

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

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

Mental Health Services

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

The mental health program was expanded in 1994 to allow the Department of Human Resources and the Department of Youth Services to provide rehabilitative services to the children and adolescents in their custody. DHR and DYS are presently involved in the process of implementing the provisions of federal court consent decrees (R.C. and A.W., respectively). One of the critical mandates of both suits is the

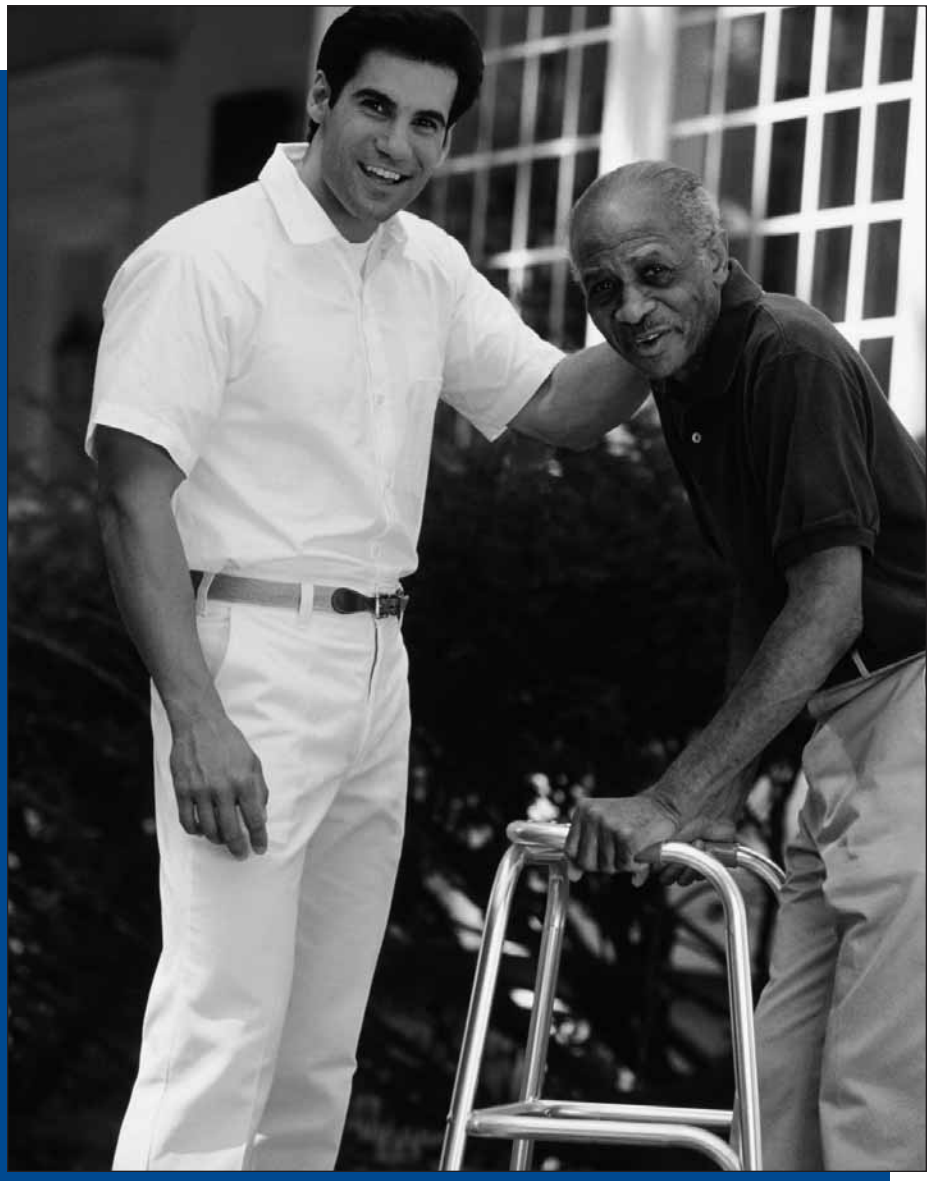
maximization of federal dollars, specifically Medicaid funding. A wide array of mental health services is provided to children in state custody in a cost-effective manner.

Targeted Case Management

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

Home and Community Based Service Waivers

The State of Alabama has developed Home and Community Based Service (HCBS) waivers that provide alternatives to institutionalization for some Medicaid recipients. The waiver programs are aimed at helping recipients receive extra services not ordinarily covered by Medicaid in this state. Home and Community Based waiver programs serve the elderly and disabled, mentally retarded, disabled adults with specific medical diagnoses, adults who received private duty nursing through EPSDT prior to age 21, and individuals with a diagnosis of HIV, AIDS, and related illnesses who meet the nursing facility level of care. These programs provide quality and cost-effective services to individuals at risk of institutional care.



HCBS Waiver for the Elderly and Disabled

This waiver provides services to persons who might otherwise be placed in nursing homes. The seven basic services covered are case management, homemaker services, personal care, adult day health, respite care, companion services and home-delivered meals. During FY 2005, there were 7,823 recipients served by this waiver at an actual cost of $7,159 per recipient. Serving the same recipients in nursing facilities would have cost the state $29,293 per recipient. This

waiver saved the state $22,134 per recipient in FY 2005.

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

HCBS Waiver for Persons with Mental Retardation (MR)

This waiver serves individuals who meet the ICF/MR level of care for mental retardation. The services provided by the waiver are residential habilitation training, day habilitation, prevocational training, supported employment, occupational therapy, speech therapy, physical therapy, behavior therapy, companion service, respite care, personal care, environmental accessibility adaptation, specialized medical equipment and supplies, assistive technology, skilled nursing care, crisis intervention, and community specialist. During FY 2005, there were 5,002 recipients served by this waiver at an actual cost of $39,073 per recipient. Serving the same recipients in intermediate care facilities for the mentally retarded (ICF/MR) would have cost the state about $112,595 per recipient. The MR waiver saved the state $73,522 per recipient in FY 2005. This waiver is operated by the Alabama Department of Mental Health and Mental Retardation.

Homebound/SAIL Waiver

The State of Alabama Independent Living (SAIL) waiver serves disabled adults with specific medical diagnoses who are at risk of being institutionalized. To be eligible an individual must be age 18 or above, and meet the nursing facility level of care. All income categories from SSI to 300 percent of SSI are included. The waiver is operated by the Alabama Department of Rehabilitation Services. The services provided under this waiver include case management, personal care, environmental accessibility adaptations, medical supplies, personal emergency response system, assistive technology, personal assistance service, assistive technology repair, and assistive technology evaluation. During the waiver year of 2005, there were 553 recipients served at a cost of $11,328 per recipient. Serving the same recipients in an institution would have cost the state $29,293 per recipient. During FY 2005, the SAIL Waiver saved the state $17,965 per recipient.

HCBS Waiver for HIV/AIDS

The HIV/AIDS Waiver provides services to individuals age 21 and over with a diagnosis of HIV/AIDS and related illnesses who are at risk for institutionalization. In addition, individuals must meet the nursing facility level of care. All income categories from SSI to 300 percent of SSI are included. The waiver is operated by the Alabama Department of Public Health. Four basic services are offered through the waiver: personal care, respite care, skilled nursing and companion service. Case management services will be provided under the existing Targeted Case Management Program (Target Group 6) as a State Plan service.

Living at Home Waiver (LAH)

The Living at Home Waiver serves individuals living in their own home rather than group homes or other facilities. To be eligible an individual must be age 3 or above and meet the ICF/MR level of care for mentally retarded or related conditions. Financial eligibility is limited to those individuals receiving SSI. The services provided under this waiver include in-home residential habilitation, day habilitation, supported employment, prevocational services, in and out of home respite care, personal care, personal care transportation, physical therapy, occupational therapy, speech therapy, behavior therapy, skilled nursing, environmental accessibility adaptations, specialized medical equipment and supplies, community specialist and crisis intervention. This waiver was approved with an effective date of October 1, 2002 and was implemented in January 2003. During FY 2005, 100 recipients were served at a cost of $8,790 per recipient. Serving the same recipients in an institution would have cost the state $29,293 per recipient. This waiver saved the state $20,503 per recipient in FY 2005. It is operated by the Alabama Department of Mental Health and Mental Retardation.

Technology Assisted Waiver for Adults

The Technology Assisted Waiver for Adults serves individuals who received private duty nursing services through the EPSDT Program under the Medicaid State Plan and would have lost eligibility for private duty nursing services upon turning age 21. To qualify the individual must meet the nursing facility level of care, have income up to the institutional income limit (FBR X 300%), be receiving private duty nursing services through Medicaid the month prior to their 21st birthday, and continue to medically require these services. Services provided include private duty nursing, personal care/attendant service, medical supplies, assistive technology and targeted case management. This waiver is administered by the Alabama Medicaid Agency.

Home Care Services

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

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

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

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

Hospice Care Services

Hospice care is a comprehensive home care program which primarily provides reasonable and necessary medical and support services for terminally ill individuals. The goal of hospice is not to cure a terminal illness, but rather, to provide relief of symptoms.

This service is not only compassionate but also cost efficient. During FY 2005, the Medicaid Agency served 1,598 hospice patients at a total cost of about $45 million.

Effective June16, 2005, all hospice providers are required to use criteria specific to the Medicaid Program. The Medicaid Agency no longer follows the same rules the Medicare program uses. Hospice services must be provided by Medicare certified hospice programs and are available for unlimited days. Hospice care through the Medicaid Agency is provided on a voluntary basis, and when it is chosen, the patient waives the right to any other services that treat the terminal illness. Services included are nursing care, medical social services, physician's services, counseling services, short-term inpatient care, medical appliances and supplies (including drugs and biologicals), home health aide services, homemaker services, physical therapy, occupational therapy, speech language pathology services, and nursing home room and board.

Home Health and Durable Medical Equipment (DME)

Skilled nursing and home health aide services prescribed by a physician are provided to eligible recipients on a part-time or intermittent basis. These services cover preventive, restorative, and supportive care to persons who meet Medicaid home health criteria. Nursing

FY 2001-2005
HOSPITAL PROGRAM
Outpatients

	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005
Number of outpatients	245,726	322,818	328,029	365,389	405,907
Percent of eligibles using outpatient services	31%	38%	36%	39%	42%
Annual expenditure for outpatient care	$44,166,407	$50,376,944	$58,034,730	$59,169,313	$61,059,949
Cost per patient	$180	$156	$177	$162	$150

and personal care provided under the home health program must be certified by licensed physicians and provided by home health agencies under contract with Medicaid. There were 128 agencies participating in FY 2005.

Medicaid in Alabama may cover up to 104 home health visits per year per beneficiary. Medicaid may authorize additional home health visits for beneficiaries under age 21 who have exhausted the home health benefit of 104 nursing visits per calendar year. For approval, the service must be referred from an EPSDT screening and prescribed as medically necessary by a physician. During FY 2005, almost 7,000 recipients received visits costing a total of approximately $16 million.

Supplies, appliances, and durable medical equipment are mandatory benefits under the home health program. Medicaid recipients do not have to receive home health services to qualify for DME services, but all items must be medically necessary and suitable for use in the home. During FY 2005, over 750 Medicaid DME providers throughout the state furnished services at a cost of approximately $27 million.

In-Home Therapies

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

Private Duty Nursing

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

Private duty nursing services must be prior authorized by Medicaid. All services require monitoring on a regular basis, generally every 60 days, with the physician providing recertification of the continuing need for care. During FY 2005, Medicaid paid approximately $2.1 million for services provided through private duty-nursing providers.

FY 2005
PAYMENTS FOR HOSPITAL SERVICES
By County of Recipient

Medical Services

Outpatient Services

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

Hospital Co-payments

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

Transplant Services

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

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

Inpatient Psychiatric Program

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

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

Ambulatory Surgical Centers (ASC)

Medicaid covers ambulatory surgical center (ASC) services, which are procedures that can be performed safely on an outpatient basis. Services performed by an ASC are reimbursed by a fee schedule established by the Medicaid Agency.

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

Post-Hospital Extended Care Program

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

Swing Beds

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

Federally Qualified Health Centers (FQHC)

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

Services covered by the FQHC program include ambulatory services provided by physicians, physician assistants, nurse practitioners, nurse midwives, clinical psychologists, and clinical social workers employed by the FQHC. Federally qualified health centers are reimbursed using an all inclusive encounter rate. Medicaid establishes reasonable costs by using the centers' annual cost

reports. At the end of FY 2005, there were 18 FQHCs enrolled as providers, with 116 satellite clinics.

Rural Health Clinics (RHC)

The Medicaid rural health program was implemented in April 1978. Services covered under the program include any medical service typically furnished by a physician in an office or a home visit. Limits are the same as for the physician program. Independent rural health clinic services, whether performed by a physician, nurse practitioner or physician assistant, are reimbursable. A physician, nurse practitioner or physician assistant is available to furnish patient care while the clinic operates. Independent rural health clinics are reimbursed at the reasonable cost per visit established for the clinics by the Medicare fiscal intermediary. At the end of FY 2005, there were 38 independent rural health clinics enrolled as providers in the Medicaid program.

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

PBRHCs are reimbursed on an all inclusive encounter rate based on their yearly cost reports. At the beginning of 1994, there were 11 PBRHCs enrolled as providers in Medicaid. There are now 21 PBRHCs enrolled as Medicaid providers.

Physicians Services

Physicians are a crucial component in the delivery of health care to Medicaid eligibles. This service to beneficiaries, as with all other Medicaid programs, is based on medical necessity, with physicians determining the need for medical care. Physicians provide this care directly and prescribe or arrange for additional health benefits. The majority of licensed physicians in Alabama participate in the Medicaid program. Some Medicaid eligibles such as QMB only and SLMB only do not receive any medical services that are paid for by Alabama Medicaid. Of those Medicaid eligibles who do receive medical services paid for by Alabama Medicaid, over 55 percent received physician services in FY 2005.

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

Pharmacy Services

Although the pharmacy program is an optional service under federal Medicaid rules, it is economically vital to the Medicaid program. Treating illnesses with prescription drugs is usually much less expensive and often as effective as

alternatives such as hospitalization and/or surgery. For this reason, the pharmacy program represents one of the most cost-effective services.

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

In FY 2005, pharmacy providers were paid $603,752,029 million for prescriptions dispensed to Medicaid recipients. This expenditure represents 15 percent of Medicaid payments for services. The Medicaid Agency's reimbursement to participating pharmacists is based on the ingredient cost of the prescription plus a dispensing fee. The dispensing fees and the pricing methodology remain unchanged from previous years.

FY 2005
PHYSICIAN PROGRAM
Use and Cost

Age	Payments	Recipients	Cost per Recipient
0 to 5	$60,490,711	151,845	$398
6 to 20	$43,790,595	184,929	$237
21 to 64	$78,807,940	138,738	$568
65 and up	$9,962,413	61,590	$162
All Ages	$193,051,659	537,102	$359

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

The Rebate Program collects rebates from drug manufacturers based on Medicaid utilization of their drug products in Alabama. During FY 2005, over $145 million was collected. These rebates are used to offset increasing drug program expenditures.

Medicaid has implemented a Preferred Drug List (PDL), in which the Agency utilizes a Pharmacy and Therapeutics (P&T) Committee, as well as a clinical contractor, to conduct in-depth clinical reviews to determine safe, effective, and cost efficient pharmaceutical products to be placed on our PDL. In addition, Medicaid maintains several classes on Prior Authorization (PA) outside the scope of the PDL. Health Information Designs (HID), Inc., is under contract with the Agency to administer the PA and override program. In addition, HID, in coordination with EDS, our fiscal agent has developed an Electronic Prior Authorization (EPA) system to reduce the administrative burden of completing forms for our providers.

Medicaid also has implemented a four (4) brand drug limit, with no limitations for generics or over-the-counter medications. Allowances are made for antipsychotic drugs, antiretroviral drugs, and certain 'switchover' classes. Children under the age of twenty-one (21) and recipients residing in a Long Term Care facility are exempt from the brand prescription limit.

Medicaid continues to operate a prospective and retrospective DUR program. HID conducts retrospective reviews on recipients' drug utilization to identify potential inappropriate, excessive, or therapeutically incompatible drug use. The DUR process also enhances the quality of care received by Medicaid recipients by educating physicians and pharmacists with regard to issues concerning appropriateness of pharmaceutical care, thereby minimizing expenditures. Prospective DUR is an on-line, real-time process allowing pharmacists the ability to intervene before a prescription is dispensed. EDS is on contract with the Agency to coordinate the prospective DUR system that screens prescription claims for early/late refills, therapeutic duplication, drug interactions, maximum units, and product selection.

Eye Care Services

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

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

FY 2003-2005
PHARMACEUTICAL PROGRAM
Use and Cost

Year	Number Of Drug Recipients	Recipients As a % Of Eligibles	Number Of Rx	Rx Per Recipient	Price Per Rx	Cost Per Recipient	Total Cost To Medicaid*
2003	526,058	65%	11,429,977	21.73	$47.93	$1,041	$547,782,433
2004	541,235	60%	11,578,877	21.39	$51.29	$1,097	$593,835,608
2005	542,823	56%	11,617,801	21.40	$51.97	$1,112	$603,752,029

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

FY 2003-2005
PHARMACEUTICAL PROGRAM
Cost

	Total Payments	Drug Rebates	Net Cost	Net Cost Per Rx	Net Cost Per Recipient
2003	$547,782,433	$102,987,398	$444,795,035	$38.91	$846
2004	$593,835,608	$126,717,758	$467,117,850	$40.34	$863
2005	$603,752,029	$145,249,482	$458,502,547	$39.47	$845

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

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

Laboratory and Radiology Services

Laboratory and radiology services are essential parts of the Medicaid health care delivery system. Many diagnostic procedures and methods of treatment would be impossible without the availability of these valuable services. Since lab and x-ray services are ancillary parts of other services, Medicaid will not pay for lab and x-ray services if the other services performed are not covered. Laboratory and radiology are unlimited services and if medically necessary can be covered even if other benefit limits have been exhausted.

Renal Dialysis Servicces

The Medicaid renal dialysis program was implemented in 1973. Since that time, enrollment of renal dialysis providers in the Medicaid program has gradually increased to its present enrollment of 75 freestanding facilities.

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

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

FY 2005
EYE CARE PROGRAM
Use and Cost

	Payments	Recipients	Cost per Recipient
Optometric Service	$7,883,423	103,850	$76
Eyeglasses	$3,285,913	88,149	$37

FY 2003 - 2005
LAB AND X-RAY PROGRAM
Use and Cost

	Payments	Recipients	Annual Cost per Recipient
2003	$45,318,047	378,882	$119.61
2004	$47,461,916	407,953	$116.34
2005	$56,597,430	444,517	$127.32

Note: This includes Physicians Lab and X-Ray

Long-Term Care

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

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

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

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

The total cost to Medicaid for providing nursing home care in FY 2005 was over $773 million. Almost 96 percent of the nursing homes in the state accepted Medicaid recipients as patients in FY 2005. There were also 20 hospitals in the state during FY 2005 that had long term care beds, called swing beds, participating in Medicaid.

In the past all Medicaid patients residing in a nursing facility have had to apply their available income to the basic nursing facility per diem rate; however, effective April 1, 1994, Qualified Medicare Beneficiaries (QMBs) residing in a nursing facility no longer have to apply any of their income toward the cost of the Medicare coinsurance for nursing home care. The coinsurance is paid entirely by Medicaid for this group. Effective July 15, 2005, over-the-counter drugs are covered under the nursing facility per diem rate with the exception of insulin covered under the Pharmacy program.

Long Term Care Quality Assurance Program

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

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

FY 2003 - 2005
LONG-TERM CARE PROGRAM
Patients, Days, and Costs

Year	Number Of Nursing Home Patients Unduplicated Total	Average Length Of Stay During Year	Total Patient-Days Paid For By Medicaid	Average Cost Per Patient Per Day To Medicaid	Total Cost To Medicaid
2003	28,056	276	7,749,218	$92	$715,766,681
2004	26,665	290	7,735,215	$96	$744,420,675
2005	27,213	290	7,890,883	$98	$773,327,685

FY 2003 - 2005
LONG-TERM CARE PROGRAM
Number and Percent of Beds Used by Medicaid

Year	Licensed Nursing Home Beds	Medicaid Monthly Average	Percent Of Beds Used By Medicaid In An Average Month
FY 2003	27,038	17,467	65%
FY 2004	27,087	17,474	65%
FY 2005	26,433	17,380	66%

FY 2005
LONG-TERM CARE PROGRAM
Recipients and Payments by Gender, Race and Age

	Recipients	Payments	Cost Per Recipient
By Gender			
Female	20,299	$582,081,776	$28,676
Male	6,914	$191,245,909	$27,660
By Race			
White	19,408	$540,961,361	$27,873
African Am.	7,480	$222,895,411	$29,800
Hispanic	299	$8,852,194	$29,604
Asian	22	$548,242	$24,418
Am. Indian	4	$70,477	$17,264
By Age			
0-5	12	$529,888	$42,838
6-20	111	$6,110,789	$54,891
21-64	3,713	$107,853,658	$29,048
65-74	3,997	$112,109,196	$28,045
75-84	8,287	$234,898,388	$28,347
85 & Over	11,093	$311,825,766	$28,112

FY 2005
PAYMENTS TO NURSING HOMES
By County of Recipient

Long Term Care for the Mentally Retarded And Mentally Disabled

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

Intermediate Care for the mentally retarded is provided through the W.D. Partlow Developmental Center in Tuscaloosa. In 2004 the Albert P. Brewer Developmental Center in Mobile, the J.S. Tarwater Developmental Center in Wetumpka, and the Lurleen B. Wallace Developmental Center in Decatur were closed. In FY 2005, the average reimbursement rate per day in an institution serving the mentally retarded was $334.

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

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

In terms of total Medicaid dollars expended and the average monthly payment per patient, the ICF-MR and IMD program is extremely costly. However, the provision of this care through the Medicaid program is saving the taxpayers of Alabama millions of state dollars. These patients are receiving services in state-operated mental health institutions. If the Medicaid program did not cover the services provided to these patients, the Alabama Department of Mental Health and Mental Retardation would be responsible for the total funding of this care through its state appropriation. In FY 2005, in cooperation with the Medicaid Agency, Mental Health was able to match every $30 in state funds with $70 of federal funds for the care of Medicaid-eligible ICF-MR and IMD patients.

FY 2005
LONG-TERM CARE PROGRAM
ICF-MR/MD

	ICF/MR	ICF/MD-Aged
Recipients	242	262
Total Payments	$27,248,060	$9,927,263
Annual Cost per Recipient	$112,595	$37,890

In Memoriam

Arnita Howard

November 7, 1950 – February 17, 2005

Arnita was a valued co-worker for over fourteen years

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