

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE OF ALABAMA

Payment for Medical Care and Services, Excluding
Inpatient Hospitals and Long Term Care Services

A description of the policy and methods to be used in establishing payment rates for each type of service, except for inpatient hospital and long term care services, listed in Section 1905(a) of the Social Security Act and included in the Alabama Medical Assistance Program, is set forth in this attachment. Payment methodology for inpatient hospital services is covered in Attachment 4.19-A. Payment for long-term care services is covered in Attachment 4.19-D.

1. Rural Health Clinic Services and Other Ambulatory Services
Furnished by a Rural Health Clinic

Effective Date: 01/01/01

- a. The Medicaid Prospective Payment System (PPS) for Rural Health Clinics (RHCs) was enacted into law under Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Until the final methodology approved by HCFA is implemented, the Alabama Medicaid Agency will reimburse in the interim based on the provisions contained in our State Plan as of December 31, 2000.

In the first phase of the PPS (January 1, 2001, through September 30, 2001), Alabama Medicaid Agency will pay RHCs 100% of the average of their reasonable costs of providing Medicaid covered services by calculating a per visit rate, computed from the RHC cost reports, for FY1999 and FY2000 separately, then add those rates together and divide by two. This rate will be adjusted to take into account any increase (or decrease) in the scope of services furnished during FY 2001 by the RHC. When our new system is approved by HCFA, in place, and tested, all claims paid under the old payment methodology during calendar year 2001 will be reversed and will be paid under PPS.

The Alabama Medicaid Agency fiscal year is from October 1st through September 30th. Beginning in FY 2002, and for each fiscal year thereafter, each RHC is entitled to the payment amount (on a per visit basis) to which the RHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the RHC during that fiscal year.

A new RHC provider or a provider who constructs, leases, or purchases a facility, or has a Medicaid approved change in the scope of services, can request reimbursement based on an operating budget, subject to the ceiling established under this rule. After the actual cost report is received and desk reviewed for the budget period, an actual encounter rate will be determined. In this event, the RHC may be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. This difference may be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference. After the initial year, payment shall be set using the MEI methods used for other RHCs. A RHC that has a change of ownership can retain the previous owner's encounter rate if desired.

2. Other Laboratory and X-Ray Services

Effective Date: 04/01/83

- a. Payment to laboratories and x-ray facilities will be based on customary charges calculated by methods consistent with Federal Regulations.

- c. For crossover claims the allowable payment to the provider is determined not by the Alabama Medicaid Agency but by Medicare. The Alabama Medicaid Agency will pay no more than the part of the allowable payment not paid by Medicare and other insurers who are obligated to pay part of the claim.

3. Physicians and Other Practitioners

Effective Date: 01/01/2015

- a. Physician Fee Schedule Payment: A statewide maximum payment will be calculated for each service designated by a procedure code recognized by the Alabama Medicaid Agency as designating a covered service. To determine payments for procedure codes without an established Medicaid rate, the Alabama Medicaid Agency will base rates on the current Medicare rate, and if not available the average commercial rate. Except as otherwise noted in the state plan, state-developed fee schedule rates are the same for both governmental and private physicians and other practitioners. The Agency's fee schedule rate was set as of 01/01/2015 and is effective for services provided on or after that date. All rates are published on the Agency's website at www.medicaid.alabama.gov.
1. Rural Physician (Enhanced) Payment:
 - (i) Providers in rural counties whose specialty is OB/GYN, Family Practice, General practice or Pediatrics, will be paid an enhanced rate for global delivery codes and delivery codes only. These rates can be found at the following link:
http://www.medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_Rural_Rate_Fee_Sched_3-25-12.pdf
 - (ii) In order to increase provider participation and improve access to care, both governmental and non-governmental providers of all specialties in rural counties will be paid an additional \$1.00 per office visit or hospital visit.
 2. Physician Access (Enhanced) Payment: In order to maintain adequate access to specialty faculty physician (all specialties including general practice, family practice, and general pediatrics) services as required by 42 USC 1396(a) (30) and 42 CFR 447.204, enhanced rates will be paid to teaching physicians. Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds. The provider's average commercial rate demonstration will be updated annually. Enhanced rates have been established based on average commercial rates effective during the State fiscal year proceeding the current State fiscal year for each service designated by a procedure code recognized by the Alabama Medicaid Agency as designating a covered service. The Agency's rates were set as of 01/01/2015, and are effective for services provided on or after that date. All rates are published on the Agency's website at www.medicaid.alabama.gov.

- a. Calculation of the rates for teaching physicians is described as follows:
- (i) Recognize the non facility Medicare physician fee schedule for the most recent full calendar year.
 - (ii) Obtain the rates paid by the top five commercial insurance companies in Alabama for each public university system and children's hospital healthcare system, specified in section 3 a 2, for the most recent full calendar year.
 - (iii) Obtain the adjudicated units of service by procedure code for the most recent full calendar year. The State identifies adjudicated claims through Medicaid's MMIS system that were processed during the most recent full calendar year for services performed by eligible physicians at approved places of service. Approved places of service include a hospital sponsored location such as an inpatient hospital, outpatient hospital, hospital-based clinic or a hospital-affiliated clinic. The following services are excluded from these claims: clinical diagnostic lab procedures, services provided to dual eligibles, and the technical component of radiology services.
 - (iv) Anesthesia payment is based on a fifteen minute unit of service as well as a base payment.
 - (v) Calculate the aggregate commercial payment equivalent for the most recent full calendar year by multiplying the Medicaid units identified in (iii) above by the commercial rates identified in (ii), then combine the payments for all services. This produces the Total Commercial Equivalent Payment Amount.
 - (vi) Calculate the equivalent Medicare payments for the most recent full calendar year by multiplying the Medicaid units from (ii) above by the Medicare rates identified in (i), then combine the payments for all services. This produces the Total Medicare Equivalent Payment Amount.

- (vii) Divide the Total Commercial Payment Amount by the Total Medicare Equivalent Payment Amount to determine the aggregate Average Commercial Rate Percentage of Medicare.
- (viii) Based on the average commercial rate demonstration results, the rates for the teaching physicians calculated percentage is noted as 158.43% of the Medicare rate effective for the calendar year 2015.
- (ix) Calculated reimbursement rates for all numeric procedure codes will be rounded to the nearest dollar. Rates for procedure codes starting with an alpha character will be rounded to the nearest penny.
- (x) Reimbursement rates for numeric procedure codes not recognized by Medicare, but recognized by the Alabama Medicaid Agency will be the average rate paid by the top five commercial insurance companies in Alabama for that numeric procedure code for each public university system and children's hospital system, identified in section 3 a 2, for the most recent full calendar year.

Effective Date: 04/01/90

- b. For Medicare crossover claims, refer to item 19 in this attachment.

Effective Date: 01/01/12

- c. Payment to Certified Registered Nurse Anesthetists is 80% of the maximum allowable rate paid to physicians for providing the same service.

Effective Date: 01/01/12

- d. Payment to physician-employed Physician Assistants and Certified Registered Nurse Practitioners is 80% of the maximum allowable rate paid to physicians for providing the same service except for injectables and laboratory procedure. Injectable and Laboratory procedures are reimbursed at 100% of the amount paid to physicians.

Effective Date: 01/01/12

- e. Pharmacists, employed by pharmacies participating in the Alabama Medicaid program, are reimbursed a vaccine administration fee established at the same rate paid to physicians. The Agency's rate for vaccine administration was set as of January 1, 1999, and is effective for services on or after that date. All rates are published on the Agency's website at www.Medicaid.alabama.gov. Except as otherwise noted in the plan, state developed rates are the same for both governmental and private providers.

Physician Services

Attachment 4.19-B: Physician Services

The state will continue to reimburse for services provided by physicians with a primary specialty designation of family medicine, pediatric medicine or internal medicine as if the requirements of 42 C.F.R. § 447.400 remain in effect. The rates will be those in effect for these services and providers during CY 2014. State of Alabama, general fund fiscal year 2015 appropriations allow for enhanced payments with dates of service October 1, 2015 through August 1, 2016. A provider must meet one of the following requirements listed below to qualify for the Alabama Medicaid Physicians Primary Care Enhanced Rates “Bump” Program.

- a. A provider must be Board certified with a specialty or subspecialty designation in family medicine, general internal medicine, or pediatrics that is recognized by the American Board of Medical Specialties (ABMS), the American Board of Physician Specialties (ABPS), or the American Osteopathic Association (AOA), and must actually practice in their specialty.
- b. A NON-board certified provider who practices in the field of family medicine, general internal medicine, or pediatrics or a subspecialty under one of these specialties, is eligible if he/she can attest that sixty percent of their paid Medicaid procedures billed are for certain specified procedure codes for evaluation and management (E&M) services and certain Vaccines for Children (VFC) vaccine administration codes during the most recently completed CY or, for newly eligible physicians, the prior month.

Method of Payment

The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

Primary Care Services Affected by this Payment Methodology

This payment applies to Evaluation and Management (E&M) billing codes 99201 through 99499 that are considered reimbursable by Alabama Medicaid. A list of codes and current rates are published and maintained on the agency’s website at http://medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_ACA%20Primary_Care_Fee_Schedule_Revised_3-1-14.pdf

Physician Services – Vaccine Administration

The state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 C.F.R. § 447.400(a) at the regional maximum administration fee set by the Vaccines for children program.

The Alabama Medicaid Agency requires VFC administration fees to be billed using the specific product code (vaccine codes).

The following single product (vaccine) codes have been billed in lieu of vaccine administration codes since the inception for the VFC Program in Alabama.

90633 90636 90645 90647 90648 90649 90650 90655 90656 90657 90658 90660
90669 90670 90680 90681 90696 90698 90700 90702 90707 90710 90713 90714
90715 90716 90718 90721 90723 90732 90733 90734 90744 90748.

These codes will be cross walked to procedure 90460 for vaccine administration for eligible providers under 42 C.F.R. § 447.400.

Effective Date of Payment

This reimbursement methodology applies to services delivered between October 1, 2015 and August 1, 2016. All rates are published at (www.medicaid.alabama.gov).

Vaccine Administration

This reimbursement methodology applies to services delivered between October 1, 2015 and August 1, 2016. All rates are published at (www.medicaid.alabama.gov).

Supersedes Page: None

4. Prescribed Drugs

Effective Date: 07/01/91

a. Medicaid pays for covered outpatient drugs prescribed by doctors of medicine, osteopathy, and dentistry legally licensed to prescribe the drugs authorized under the program and dispensed by a licensed pharmacist or licensed authorized physician in accordance with state and federal laws.

Effective Date: 10/01/13

b. Multiple Source Drugs. Reimbursement for covered multiple source drugs in the Medicaid Program shall not exceed the lowest of:

- (1) The federally mandated upper limit (FUL) for certain multiple source drugs as established and published by CMS plus a reasonable dispensing fee; or
- (2) The Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee. AEAC is defined by Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, Wholesale Acquisition Cost (WAC) + 0%; or
- (3) The provider's Usual and Customary charge to the general public for the drug; or
- (4) The Alabama State Maximum Allowable Cost (State MAC) plus a reasonable dispensing fee. The Alabama State MAC is defined as the AAC of a drug multiplied by 1.0 that will apply to all multiple source drugs within a particular grouping.

(a) **Reimbursement Methodology for the Alabama State MAC**

The State MAC reimbursement will apply to certain multiple source drug products that meet therapeutic equivalency, market availability, and other criteria deemed appropriate by the Alabama Medicaid Agency.

- Drugs are subject to a State MAC if there is at least one non-innovator multiple source alternative product available.
- The Alabama Medicaid Agency or its designated representative will collect and review pharmacy invoices and other information deemed necessary by the Alabama Medicaid Agency in an effort to determine AAC in accordance with applicable State and Federal law.
- This information will be collected from Medicaid-participating pharmacies via surveys. The AAC is multiplied by 1.0 to derive the State MAC rate that will apply to all multiple source drugs within the particular grouping.
- If the AAC no longer represents a drug's market price due to a drug shortage or other emergency situation, the Alabama Medicaid Agency will conduct a review and, if applicable, adjust the AAC to represent the drug's current market price, or apply WAC +0%.

EXCEPTION:

The FUL and/or State MAC may be waived for a brand innovator multiple-source drug. For these cases the prescriber must provide documentation of the medical necessity for the brand name rather than the available generic equivalent and receive an override.

- c. Other Drugs. Reimbursement for covered drugs other than multiple source drugs shall not exceed the lowest of:
- (1) The Alabama Estimated Acquisition Cost (AEAC) for the drug plus a reasonable dispensing fee. AEAC is defined by Medicaid as the Average Acquisition Cost (AAC) of the drug or, in cases where no AAC is available, Wholesale Acquisition Cost (WAC) +0%; or
 - (2) The provider's Usual and Customary charge to the general public for the drug; or
 - (3) For blood clotting factor products, the Average Sales Price (ASP) + 6% plus a reasonable dispensing fee.
- d. Dispensing Fees. A reasonable dispensing fee is set by the Agency. This fee is reviewed periodically for reasonableness and, when deemed appropriate by Medicaid, may be adjusted. The dispensing fee paid by the Agency effective 9/22/10 is \$10.64.

No payments made pursuant to methods and standards described in this Attachment 4.19-B will exceed upper limits established in 42 CFR Section 447, Subpart D.

- e. The upper limits detailed in 42 CFR §447.512 which govern Medicaid State Agency reimbursement to providers of prescribed drugs shall also apply in cases where prescribed drugs are furnished as part of SNF or ICF services or under prepaid capitation arrangements. Contracts between the State Agency and the underwriter, carrier, foundation, health maintenance organization, or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement of prescribed drugs.
- f. The Medicaid recipient shall pay the maximum allowable copayment under Federal law or administrative regulations for each prescribed drug received under the Medicaid program, except for designated exemptions. The allowable copayment amount shall be collected by the dispensing pharmacy and credited against the Medicaid payment to the pharmacy for drugs per copay table in Attachment 4.18-A. Designated exemptions include prescriptions for pregnant women, Family Planning drugs, those used for Medicaid recipients under 21 years of age, and drugs for Medicaid recipients institutionalized in long term facilities.

5. Prosthetic Devices

Reasonable, customary charges submitted by the vendor, not to exceed the amount payable under Title XVIII, Part B or the amount paid by the general public.

Effective Date: 10/1/14

The pricing methodology is 80% of the 2005 Medicare allowable amount as listed on the Alabama Supplies, Appliances, and DME Fee Schedule. The agency's fee schedule rate is in effect for services provided on or after October 1, 2014. All rates are published on the Medicaid Agency's website (www.medicaid.alabama.gov). Except as otherwise noted in the plan, the Medicaid developed fee schedule rates are the same for both governmental and private providers.

6. Eyeglasses

- a. Eyeglasses are procured from a central source selected through the State competitive bid system. Payment is based on reasonable charges, obtained through the bidding procedures, which are included in a contract between Medicaid and the central source contractor. The contracted charges will not exceed the amount paid by the general public or other third party organizations.
- b. The contract between Medicaid and the central source contractor will be on file and available for review in the office of the Single State Agency.
- c. Eyeglasses may, at the option of the provider, be procured from the central source contractor or from any other source, but at a price not to exceed the contract price charged by the central source. However, the quality of the eyeglasses must be equal to or better than that provided by the central source contractor.

Effective Date: 01/01/92

7. Early and Periodic Screening Diagnosis and Treatment of Individuals under 21 Years of Age
- a. Screening providers (including physicians - not included elsewhere in this State Plan) - Governmental providers will be paid on an interim rate which will be the present rate paid to the Department of Public Health for screening. This rate will be adjusted to actual cost for each governmental agency. Non-governmental providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.
 - b. Hearing aid vendors - Providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.
 - c. Physical Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19-B, Number 3a of the State Plan.
 - d. Occupational Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - e. Speech-Language-Hearing Therapy - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - f. Psychology - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - g. Chiropractic - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - h. Podiatry - for the covered procedure codes the reimbursement is the same as that for a physician. The reimbursement methodology is the same as identified in Attachment 4.19B, Number 3a of the State Plan.
 - i. Christian Science - the reimbursement methodology is 75% of the usual and customary charge for licensed Christian Science providers in the State of Alabama.

- j. Private Duty Nursing - the reimbursement methodology is based on an hourly rate for a registered nurse or licensed practical nurse. Rates are established using the lowest rates for agencies surveyed.
- k. Transplant (heart-lung, pancreas-kidney and lung) - the reimbursement methodology is the same as identified in Attachment 4.19-B, Number 18 of the State Plan.
- l. Air Ambulance - the reimbursement methodology is the same as identified in Attachment 4.19B, Number 11 of the State Plan.

- m. School Based Services: Medicaid services provided in schools are services that are medically necessary and provided in schools to Medicaid recipients in accordance with an Individualized Education Program, (IEP) or an Individual Family Service Plan (IFSP). Covered services include the following:
1. Audiology Services
 2. Occupational Therapy
 3. Physical Therapy
 4. Counseling Services
 5. Personal Care Services
 6. Speech/Language Services
 7. Nursing Services
 8. Transportation Services

For the purpose of making interim Medicaid payments to LEA providers, the Alabama Medicaid Fee Schedule will be applied to claims submitted to the Medicaid Management Information System (MMIS) for the above services. Except as noted otherwise in the plan, state-developed fee schedule rates are the same for both governmental and private providers of Audiology Services, Occupational Therapy, Physical Therapy, Counseling Services, Personal Care Services, Speech/Language Services, and Nursing Services. The agency's fee schedule rate is in effect for services provided on or after 4/1/12. All rates are published at:

http://medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx.

For transportation services, an interim rate will be determined based on a rate that represents the actual cost of providing the transportation service, upon final approval of the SPA and cost allocation plan

- (A). Direct Medical Services Payment Methodology:
Beginning with cost reporting period April 1, 2012, the Alabama Medicaid Agency will begin settling Medicaid reimbursement for direct medical services at cost for all Local Education Agencies (LEA's). This reimbursement at cost methodology will include a quarterly Random Moment Time Study, an annual cost report and reconciled settlement as well as quarterly interim settlements. The quarterly interim settlements for services will be based on the quarterly Random Moment Time Study and use of the interim cost reports compiled on a quarterly basis. However, for transportation services, Item (b) provides the transportation payment services methodology.

Effective for services provided on or after April 1, 2012 school based services will be reimbursed at cost according to this methodology described in the state plan.

To determine the Medicaid-allowable direct and indirect costs of providing direct medical services to Medicaid-eligible clients in the LEA, the following steps are performed:

1. Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation of direct services personnel listed in the descriptions for the covered Medicaid services delivered by school districts. Other direct costs include costs directly related to the approved direct services personnel for the delivery of medical services, such as purchased services, direct materials, supplies, and equipment. Medical devices and equipment are only allowable for the provision of direct medical services. For items not previously approved, the LEA must use a pre-approval process to determine suitability, coverage, and reimbursement of medical supplies, material, and equipment. The following process must be followed by the schools at a minimum:
 - a) The medical device must be approved and effective (i.e., not experimental) and within the scope of the school based services shown as covered in the Medicaid state plan;
 - b) The use of the device must be determined suitable for the individual; and
 - c) The service or device must be approved by one of the covered medical professionals and reviewed by the Alabama Medicaid Agency.

These direct costs are accumulated on the annual cost report, resulting in total direct costs. The cost report contains the scope of the cost and methods for cost allocation that have been approved by the Centers for Medicare & Medicaid Services (CMS).

2. The net direct cost for each service is calculated by applying the direct medical services percentage from the CMS-approved time study to the direct cost in 1 above. A time study, which

incorporates a CMS-approved Random Moment Time Study methodology, is used to determine the percentage of time medical service personnel spend on IEP-related medical services, and general and administrative time. This time study will assure that there is no duplicate claiming relative to claiming for administrative costs.

3. Indirect costs are determined by applying the school district's specific unrestricted indirect cost rate to its net direct costs. Alabama public school districts use predetermined fixed rates to indirect costs. The State Department of Education (SDE) is the cognizant agency for the school districts, and approves unrestricted indirect cost rates for school districts for the US Department of Education (USDE). Only Medicaid-allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.
4. Net direct costs and indirect costs are combined.
5. Medicaid's portion of total net costs is calculated by multiplying the results for Item 4 by the ratio of the total number of Medicaid covered children with IEPs and IFSPs by the total number of children with IEPs and IFSPs.

(B) Transportation Services Payment Methodology

Effective dates of services on or after April 1, 2012, providers will be paid on an interim cost basis. Providers will be reimbursed interim rates for school based health services, specialized transportation services at the lesser of the providers billed charges or the interim rate. On an annual basis, a cost reconciliation and cost settlement will be processed for all over and under payments.

Transportation to and from school may be claimed as a Medicaid services when the following conditions are met:

- 1) Special transportation is specifically listed in the IEP as a required service;

- 2) A medical service is provided on the day that specialized transportation is provided; and
- 3) The service billed only represents a one-way trip

Transportation costs included on the cost report worksheet will only include those personnel and non-personnel costs associated with special education. The cost identified in the cost report includes the following:

- 1) Bus Drivers
- 2) Bus Aides/Monitors
- 3) Mechanics
- 4) Substitute Drivers
- 5) Fuel
- 6) Repairs and Maintenance
- 7) Rentals
- 8) Contract Use Cost
- 9) Vehicle Depreciation

The source of these costs will be audited Chart of Accounts data kept at the school district and the Department of Education level. The Chart of Accounts is uniform throughout the State of Alabama. Costs will be reported on an accrual basis.

- 1) A rate will be established and applied to the total transportation cost of the school system. This rate will be based on the *Total IEP/IFSP Special Education Department (SPED) Students in the District Receiving Transportation*. The result of this rate (%) multiplied by the *Total District or Department of Education Transportation Cost* for each of the categories listed above will be included on the cost report. It is important to note that this cost will be further discounted by the ratio of *Medicaid Eligible SPED IEP/IFSP One Way Trips* divided by the total number of *SPED IEP/IFSP One Way Trips*. This data will be provided from transportation logs. The process will ensure that only one way trips for Medicaid eligible Special Education children with IEP's are billed and reimbursed for.
- 2) Indirect costs are determined by applying the school districts specific unrestricted indirect cost rate to its net direct costs. Alabama school

systems use predetermined fixed rates for indirect costs. The State Department of Education is the cognizant agency for the school systems, and approves unrestricted indirect cost rates for the school systems for the US Department of Education (USDE). Only Medicaid allowable costs are certified by providers. Providers are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate.

3) Net Direct Costs and Indirect costs are combined.

(C). Certification of Costs Process:

On a quarterly basis, each provider will certify through its cost report, its total actual, incurred Medicaid allowable costs/expenditures, including the federal share and the nonfederal share. Providers are permitted only to certify Medicaid-allowable costs and are not permitted to certify any indirect costs that are outside their unrestricted indirect cost rate.

(D). Cost Report Process:

For Medicaid services listed in Paragraph (a) 1-10 provided in schools during the state fiscal year, each LEA provider must complete the following:

1. Quarterly Interim Settlement Cost Report. This Interim Settlement Cost Report is due within 90 days from the close of a quarterly reporting period,
2. Annual Settlement Cost Report. An annual cost report to reconcile the LEA's final settlement is due on or before April 1 following the reporting period.

The primary purposes of the cost report process are to:

1. Document the provider's total CMS-approved, Medicaid-allowable costs of delivering Medicaid coverable services using a CMS-approved cost allocation methodology.

2. Reconcile any interim payments to its total CMS-approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The Quarterly Interim Settlement Cost Report and the Annual Settlement Cost Report includes a certification of costs statement to be completed certifying the provider's actual incurred costs/expenditures. All filed annual Cost Reports are subject to desk review by the Alabama Medicaid Agency.

(E). The Cost Reconciliation Process:

The cost reconciliation process must be completed by the Alabama Medicaid Agency within twenty-four (24) months of the end of the reporting period covered by the Annual Settlement Cost Report. The total Medicaid-allowable costs based on CMS-approved cost allocation methodology procedures are compared to any LEA provider's Medicaid interim payments delivered during the reporting period as documented in the Medicaid Management Information System (MMIS) as well as amounts received from Quarterly Interim Settlements, to determine the final cost reconciliation and settlement. For the purposes of cost reconciliation, the state may not modify the CMS-approved scope of costs, the CMS-approved cost allocation methodology procedures, or its CMS-approved time study for cost-reporting purposes.

Any modification to the scope of cost, cost allocation methodology procedures, or time study for cost-reporting purposes requires approval from CMS prior to implementation; however, such approval does not necessarily require the submission of a new state plan amendment.

(F). The Cost Settlement Process

EXAMPLE:

- For services delivered for the period covering January 1, through March 31, the Quarterly Interim Settlement Cost Report is due on or before June 30.
- For services delivered for the period covering April 1, through June 30, the Quarterly Interim Settlement Cost Report is due on or before September 30.

- For services delivered for the period covering July 1, through September 30, the Quarterly Interim Settlement Cost Report is due on or before November 30.
- The Annual Settlement Cost Report will reconcile the costs and payments received through the Interim Claiming process and will be due by April 1 of each year.

If a provider's interim payments exceed the actual, certified costs for Medicaid services provided in schools to Medicaid clients, the provider will remit the federal share of the overpayment at the time the Annual Settlement Cost Report is submitted. The Alabama Medicaid Agency will submit the federal share of the overpayment to CMS within 60 days of identification. If the actual, certified costs of a LEA provider exceed total interim payments, the Alabama Medicaid Agency will pay the federal share of the difference to the provider in accordance with the final actual certification agreement and submit claims to CMS for reimbursement of that payment in the federal fiscal quarter following payment to the provider.

Effective Date: 04/01/12

8. Dental Services (Clinics)

All dental clinics, including orthodontic clinics, are paid fee for service.

The agency's rates were set as of April 1, 2012, and are effective for services on or after that date. All rates are published on www.medicaid.alabama.gov. Except as otherwise noted in 4.19-B of the plan, state developed fee schedule rates are the same for both governmental and private providers.

Effective Date: 04/01/12

9. Home Health Care

a. Nursing and Home Health Aide Services

Reimbursement for skilled nursing services and home health aide services will be at a per unit of service rate established by Medicaid. Payments to governmental providers will not exceed actual costs and will meet all requirements of Circular A-87.

Medicaid will reimburse governmental providers at interim rates for skilled nursing and home health aide services. Interim rates will be established based upon final costs per discipline according to the most recent home health cost report settled and approved by the provider's fiscal intermediary. At least annually, reimbursement at interim rates will be reconciled to actual costs per discipline when submitted costs are finalized and approved by the provider's fiscal intermediary. In order to find the Medicaid cost, the average cost per visit from the Medicare cost report will be applied to Medicaid visits per discipline to arrive at total Medicaid costs.

The agency's rates were set as of April 1, 2012, and are effective for services on or after that date. All rates are published on www.medicaid.alabama.gov. Except as otherwise noted in 4.19-B of the plan, state developed fee schedule rates are the same for both governmental and private providers.

Effective Date: 04/01/13

The pricing methodology is 76% of the 2005 Medicare allowable amount as listed on the Alabama Supplies, Appliances, and DME Fee Schedule. The agency's fee schedule rate is in effect for services provided on or after April 1, 2013. All rates are published on the Medicaid Agency's website (www.medicaid.alabama.gov). Except as otherwise noted in the plan, the Medicaid developed fee schedule rates are the same for both governmental and private providers.

Effective Date: 06/01/93

If no Medicare price is available, Medicaid will establish a price for supplies, appliances, and durable medical equipment using the manufacturer's generated invoice to determine provider's actual cost after all discounts are applied. Medicaid will reimburse provider at their actual cost after all discounts are applied, plus 20% markup. If documented invoices cannot be obtained, reimbursement will be based on the Manufacturer Suggested Retail Price (MSRP) minus 40%. Freight and delivery, evaluation and fitting charges are included in the markup percentage for specially constructed wheelchairs.

Effective Date: 08/12/94

If no Medicare price is available, reimbursement rates established by Medicaid for EPSDT-referred wheelchair systems will be based on a Discount from Manufacturer Suggested Retail Price (MSRP). Providers are required to submit available MSRPs from three manufacturers for equipment appropriate for the individual's medical needs. Provider must document nonavailability of required MSRPs to justify not sending in three prices. The established rate will be based on the MSRP minus the following discounts:

1. Manual Wheelchair Systems - 20% discount from MSRP.
2. Power Wheelchair Systems - 15% discount from MSRP.
3. Ancillary (add-on) products - 20% discount from MSRP.

Effective Date: 06/01/11

(d) In-Home Monitoring

Reimbursement for skilled nursing, licensed practical nurse services will be at a per unit of service rate established by Medicaid. Equipment, necessary to upload patient data and support the data base, will be based on a monthly service fee. Rates will be established by Medicaid and based on usual and customary charges.

The agency's rates were set as of April 1, 2005, and are effective for services on or after that date. All rates will be on the agency's website at www.medicaid.alabama.gov. Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers.

Effective Date: 07/01/87

- (2) The Medicaid recipient shall pay the maximum allowable copayment for each prescribed item covered under the Medicaid Supplies, Appliances, and Durable Medical Equipment Program, except for eligible recipients under (18) years of age. The allowable copayment amount shall be collected by the dispensing supplier and credited against the Medicaid payment to the provider for items per copay as explained in Attachment 4.18-A.

10. Family Planning

Effective Date: 01/01/92

- a. Physicians - Payment is made pursuant to the method described in section 3 of this attachment.
- b. Hospitals - Payment is made pursuant to the method described in Attachment 4.19-A.
- c. Laboratory and X-ray Services - Payment is made pursuant to the method described in section 2 of this attachment.
- d. Family Planning Agencies - Payment will be a provisional rate based on the cost study conducted according to cost principles outlined in 45 CFR Part 74 and HIM 15 (Medicare)

Provider Reimbursement Manual). Rates will be renegotiated upon mutual agreement between the agencies and will not exceed the allowable costs according to the principles for cost determination cited above.

Effective Date: 01/01/92

- e. Covered Family Planning drugs prescribed (oral contraceptives and supplies) are paid pursuant to the method described in section 4 of this attachment.

Effective Date: 01/01/92

- f. Covered Drugs prescribed for treatment of conditions identified and referred from an EPSDT examination are paid pursuant to the method described in section 4 of this attachment.

11. Ambulance Services

Effective Date: 10/01/2011

Payment for ground or air (for children under the age of 21 years old) ambulance services shall be based on the lesser of the submitted charge or Alabama Medicaid's statewide ambulance service rates. Air transportation for adults 21 years of age and older will be reimbursed at the emergency ground rate. The amount to be paid to out-of-state providers shall be their usual and customary fees not to exceed the maximum allowable charges or benefits established by Medicaid. Except as otherwise noted in the plan, payment for ambulance services is based on state-developed fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of May 14, 2010 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustments and all current rates are published and maintained on the Alabama Medicaid Agency's website as follows:

http://www.medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Ambulance_Rates_12-21-11.pdf

12. Nurse-midwives

Effective Date: 10/01/2011

Payment to nurse-midwives shall be based on payments made to physicians for similar services. Payment to midwives shall be 80% of the amount paid to physicians. Except as otherwise noted in the plan, payment for nurse-midwife services is based on 80% of the state-developed physician fee schedule rates, which are the same for both governmental and private providers. The agency's rates were set as of January 15, 1992 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustments and all current rates are published and maintained on the Alabama Medicaid Agency's website as follows:

http://www.medicaid.alabama.gov/documents/6.0_Providers/6.6_Fee_Schedules/6.6_Physician_Fee_Sched_8-12-11.pdf

13. Outpatient Hospital Services

Effective Date: 10/01/2013

a. Definitions Related to Payments for Outpatient Hospital Services

(1) Supplemental Payment: Eligible hospitals may receive a supplemental hospital payment for services provided to Medicaid recipients. These payments will be in the form of an access payment or enhanced payment as outlined in paragraph c on page 8.2 (Upper Payment Limit Calculation).

(2) Hospital: For purposes of Medicaid base fee schedule payments, access payments, enhancement payments, and DSH payments for the period from October 1, 2013, through September 30, 2016, a facility, which is licensed as a hospital under the laws of the State of Alabama, provides 24-hour nursing services, and is primarily engaged in providing, by or under the supervision of doctors of medicine or osteopathy, inpatient services for the diagnosis, treatment, and care or rehabilitation of persons who are sick, injured, or disabled.

15. Case Management Services

Effective Date: 04/01/95

- (1) The following documentation must be maintained in the recipient's record when billing for services:
 - (a) There must be a current comprehensive service plan which identifies the medical, nutritional, social, educational, transportation, housing and other service needs which have not been adequately accessed and a time frame to reassess service needs.
 - (b) Services must consist of at least one of the following activities:
 1. Establishment of the comprehensive case file for development and implementation of an individualized service plan to meet the assessed service needs of the recipient;
 2. Assisting the recipient in locating needed service providers and making the necessary linkages to assure the receipt of services identified in the service plan;
 3. Monitoring the recipient and service providers to determine that the services received are adequate in meeting the identified needs; or
 4. Reassessment of the recipient to determine services needed to resolve any crisis situation resulting from changes in the family structure, living conditions, or other events.
- (2) For target group 4 (Foster Children) and target group 8 (Adult Protective Service Individuals) reimbursement will be as follows:
 - (a) Reimbursement rates will be established based on cost as determined by the quarterly Social Services Work Sampling Study. Rates will be adjusted annually based on the results of the previous four quarters. Random Moment Sampling may not be used as a method of documenting services provided to recipients. The Work Sampling Study must provide an audit trail that identifies each client whose case is included in the data used for rate formulation, and identifies that at least one of the services listed above in B. 1, 2, 3, or 4 has been provided.
 - (b) A maximum of one unit of case management services will be reimbursed per month for each eligible recipient receive-

ing case management services. A unit of case management service is defined as at least one telephone or face to face contact for the purpose of providing at least one of the services listed above in B. 1, 2, 3, or 4 with the recipient, a family member, significant other, or agency from which the client receives or may receive services. All contacts must be documented in the clients record and must be for the coordination or linkage of services for a specific identified recipient.

- (3) Payment for case management services of target group 4 (Foster Children) will be limited to one child per family unit, per month when there is more than one child within a family unit and no child is in an out-of-home placement.
- (4) Payment for case management services of target group 8 (Adult Protective Service Individuals) will be limited to one person per family unit.
- (5) Reimbursement for services provided by other governmental agencies will be paid on a negotiated rate basis which will not exceed actual costs and which will meet all requirements of Circular A-87. Non-governmental providers will be reimbursed on a negotiated rate basis which will not exceed the upper limitation of 42 CFR §447.325.

(3) Medicare Cost Report: The electronic cost report (ECR) filing of the Form CMS Form 2552-96 or CMS Form 2552-10 Hospital and Hospital Health Care Complex Cost Report, as defined in CMS Provider Reimbursement Manual (PRM) 15-II (hereinafter referred to as "CMS Form 2552").

(4) Privately Owned or Operated Hospital: For purposes of Medicaid base, access and DSH payments for the period from October 1, 2013, through September 30, 2016, a hospital in Alabama other than:

(a) Any hospital that is owned and operated by the federal government;

(b) A hospital that is a state agency or unit of state government, including without limitation a hospital owned by a state agency or a state university.

(c) A hospital created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government pursuant to Code of Alabama of 1975, Section 22-21-1.

(d) A hospital that limits services to patients primarily to rehabilitation services as authorized by Alabama Administrative Code 410-2-4-.08; or

(e) A hospital defined as a Long Term Acute Care Hospital by Alabama Administrative Code 410-2-4-.02(8).

(5) Non State Owned or Operated Government Hospitals: For purposes of Medicaid base fee schedule payments, quarterly adjustment and DSH payments for the period from October 1, 2013, through September 30, 2016, a hospital in Alabama created and operating under the authority of a governmental unit which has been established as a public corporation pursuant to Ala. Code, Chapter 21 of Title 22 or Chapter 95 of Title 11, or a hospital otherwise owned and operated by a unit of local government pursuant to Code of Alabama of 1975, Section 22-21-1.

(6) State Government Owned or Operated Hospital: For purposes of Medicaid base fee schedules, quarterly adjustment and DSH payments for the period from October 1, 2013, through September 30, 2016, a hospital in Alabama that is a state agency or unit of state government, including without limitation a hospital owned by a state agency or a state university.

(7) Rehab Hospitals and Long Term Acute care hospitals referenced in paragraph (4)(d) and (4)(e) above are not included in UPL or reimbursed by Medicaid for base payments, access payments under section 4.19-B.

b. Outpatient Medicaid Base Payments.

For State fiscal years 2014 through 2016, Medicaid shall pay each in-state hospital a base amount from approved rates based on procedure codes. The Agency's outpatient rates will be set using the fee schedule adopted by the Agency as of October 1, 2011, with a one-time six percent (6%) inflation rate applied for each procedure code at October 1, 2013.

Payment for all out-of-state outpatient hospital services will be from approved rates based on procedure codes. The Agency's rates were set as of October 1, 2009 and are effective for services on or after that date.

Except as otherwise noted in the plan, state developed fee schedule rates are the same for both governmental and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published on the Alabama Medicaid Agency's website as follows:

http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx

Certified emergency room visits must be properly documented by the attending licensed physician, nurse practitioner or physician assistant in the medical record. The costs of providing additional care for all non-certified emergency room visits shall be accounted for and reported to Alabama Medicaid as a cost of providing care to Medicaid eligible recipients.

c. Upper Payment Limit

For the period from October 1, 2013, through September 30, 2016, in addition to any other Medicaid covered outpatient service base payments paid to hospitals for outpatient hospital services to Medicaid patients, each eligible hospital, except for hospitals as outlined in d. below, shall receive outpatient hospital access payments each state fiscal year. The outpatient hospital access payment shall be calculated as follows:

Due to the Children's Hospital of Alabama's Medicare population being dramatically different from other acute hospitals in the State of Alabama, the Upper Payment Limit for this hospital shall be calculated separately and added to the aggregate amount for private owned and operated hospitals as outlined in paragraph (7) below.

- (1.) Hospitals cost reports with a fiscal year ending during the rate year one year prior to the beginning of the rate year (ex. Cost reports ending in rate year 2012 would be used for rate year beginning October 1, 2013) will be used to determine the upper payment limit. Children's Hospital of Alabama will be calculated separately for the rate year beginning October 1, 2013 and October 1, 2014, reference paragraph (7).
- (2.) From the CMS Form 2552-10 cost reporting forms, an outpatient ancillary cost to charges ratio was calculated as follows:
 - a. Total cost for each of the following cost centers on Worksheet B Part I Column 24 are obtained: CMS Lines 50-76.99 and 90-93.99.
 - b. Outpatient charges for each of the following cost centers on Worksheet C Part I Column 7 are obtained: CMS Line 50-76.99 and 90-93.99.
 - c. Total charges for each of the following cost centers on Worksheet C Part I Column 8 are obtained: CMS Line 50-76.99 and 90-93.99.
 - d. Outpatient charges for each CMS Line in paragraph b. will be divided by the total charges for each CMS Line in paragraph c. to determine an outpatient percentage of charges.
 - e. The total cost for each CMS Line in paragraph a. will be multiplied by the outpatient percentage of charges for each CMS Line in paragraph d. to determine the outpatient cost.
 - f. Total outpatient cost determined in paragraph e. Will be divided by total outpatient charges from paragraph b. to determine an outpatient ancillary cost to charge ratio.
- (3.) Total Medicaid hospital outpatient covered charges were obtained from the Alabama Medicaid MMIS system for claims incurred for services for each hospitals cost reporting period which meet the definition of a paid claim for SFY 2014 through SFY 2016. Consistent with paragraph (1.) above, the applicable cost reporting period for each hospital will be the cost report with a fiscal year ending during the rate year one year prior to the rate year (ex. Cost reports ending in rate year 2012 would be used for rate year beginning October 1, 2013.) Additionally, documentation will be submitted by hospitals for charges that were reduced on Medicaid claims from the standard charges of the hospital related to 340B pricing of claims that the Alabama Medicaid Agency required to be billed at the cost of drugs versus the hospital's standard charge. The Alabama Medicaid Agency changed this billing requirement on October 1, 2012.

(4.) Total Medicaid outpatient charges in Step (3) are multiplied by the cost to charge ratio calculated in Step (2) to determine Medicare cost of Medicaid services for each hospital's cost report year. The Medicaid cost will be increased by the Medicaid outpatient percentage of CRNA cost removed on Worksheet A-8 and RCE Disallowance cost from Worksheet C Part I Column 4. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges by total charges for the hospital. The Medicaid cost amount will be multiplied by an increase in cost due to the CMS Market basket Inpatient Hospital PPS (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf>) and a separate utilization increase based on change in paid ICN claim counts between the State Fiscal Year ended during the rate year used for cost reports and the preceding State Fiscal Year for outpatient hospitals in Alabama. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.

(5.) The Medicaid cost for the State Fiscal Year being calculated will be increased by the Medicaid outpatient percentage of provider assessment for the State Fiscal Year being calculated for each privately owned and operated hospital. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges from the cost reports outlined in paragraph (2) by total charges for the hospital from the cost reports outlined in paragraph (2).

The amount calculated in this paragraph will constitute aggregate Upper Payment Limit for State owned and operated hospitals and Non-state government owned and operated hospitals as set forth in 42 CFR 447.321. The amount calculated in this paragraph for privately owned and operated hospitals plus the amount calculated in paragraph (7)k will constitute the Upper Payment Limit for privately owned and operated hospitals as set forth in 42 CFR 447.321.

- (6) The Medicaid allowed amount for claims included in Step (3) was obtained from the MMIS to constitute the Medicaid payments for cost reporting periods ending in the rate year one year prior to the beginning of the rate year. The utilization increase identified in paragraph (4) and the cost report factors in paragraph (4) was applied to the Medicaid allowed amount to standardize all hospital payments to the State Fiscal Year ending in the cost reporting year. The standardized Medicaid payments for mid-point of the State Fiscal Year the cost reporting year ends during were multiplied by the utilization increase amount and adjustment factor in paragraph (5) to determine the Medicaid payments for the rate year and the preceding rate year.

- (7.) For the rate year beginning October 1, 2013, and for the rate year beginning October 1, 2014, Children's Hospitals of Alabama's upper payment limit will be calculated as follow:
- a. For the rate year beginning October 1, 2013, Children's Hospital will prepare a cost report meeting the requirements of the CMS Form 2552-10 for the period of October 1, 2012 through June 30, 2013. For the rate year beginning October 1, 2014, Children's Hospital will use the December 31, 2013 cost report filing.
 - b. Total cost for each of the following cost centers on Worksheet B Part I Column 24 are obtained: CMS Lines 50-76.99 and 90-93.99.
 - c. Outpatient charges for each of the following cost centers on Worksheet C Part I Column 7 are obtained: CMS Line 50-76.99 and 90-93.99.
 - d. Total charges for each of the following cost centers on Worksheet C Part I Column 8 are obtained: CMS Line 50-76.99 and 90-93.99.
 - e. Outpatient charges for each CMS Line in paragraph c. will be divided by the total charges for each CMS Line in paragraph d. to determine an outpatient percentage of charges.
 - f. The total cost for each CMS Line in paragraph b. will be multiplied by the outpatient percentage of charges for each CMS Line in paragraph e. to determine the outpatient cost.
 - g. Total outpatient cost determined in paragraph f. will be divided by total outpatient charges from paragraph c. to determine an outpatient ancillary cost to charge ratio.
 - h. Total Medicaid outpatient charges will be determined as follows:
 - i. For the rate year beginning October 1, 2013, MMIS claims will be obtained for dates of services occurring between October 1, 2012 through June 30, 2013.
 - ii. For the rate year beginning October 1, 2014, MMIS claims will be obtained for dates of services occurring between January 1, 2013 through December 31, 2013.
 - iii. For the rate year beginning October 1, 2013, MMIS claims will be annualized for a full year by multiplying the Medicaid charges per the MMIS by 1.33 to account for a change in the charge rates for Children's Hospital during the period.
 - i. The allowable charges in paragraph h. will be multiplied by the cost to charge ratio in paragraph g to determine the Medicaid outpatient cost. The Medicaid outpatient cost will be increased by the following:
 - i. The Medicaid cost will be increased by the Medicaid outpatient percentage of CRNA cost removed on Worksheet A-8. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges by total charges for the hospital.
 - ii. The Medicaid cost will be increased by the Medicaid outpatient percentage of RCE hospital related administration component of the RCE Disallowance cost from Worksheet C Part I Column 4. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges by total charges for the hospital.
 - j. The annualized Medicaid outpatient cost in paragraph i will be multiplied by a factor calculated as follows:

- i. For rate year beginning October 1, 2013
 1. The increase in cost due to the CMS Market basket outpatient Hospital PPS (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf>) for FFY 2014.
 2. The increase percentage as outlined in paragraph (5).
 3. An adjustment factor of 1 to bring the cost to the mid-point of SFY 2014.
 - ii. For rate year beginning October 1, 2014
The amount determined in paragraph (6) will be multiplied by an increase in cost due to the CMS Market Basket Inpatient Hospital PPS (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/Downloads/mktbskt-actual.pdf>) and a separate utilization increase based on change in paid days a linear regression completed for the previous four State Fiscal Years and the fiscal year ended during the preceding cost reporting year and preceding rate year. Both inflation and utilization will be applied from the mid-point of cost report year to the mid-point of rate year.
- k. The Medicaid cost will also be increased by the Medicaid outpatient percentage of provider assessment paid for the State Fiscal Year being calculated. The Medicaid outpatient percentage is determined by dividing total Medicaid outpatient charges for the cost report identified in paragraph (7)c by the total charges for the hospital for the cost report identified in paragraph (7)d.
- l. The Medicaid payments will be determined as follows:
 - i. For the rate year beginning October 1, 2013, the Medicaid payments from the MMIS claims information for dates of service occurring between October 1, 2012 and June 30, 2013
 - ii. For the rate year beginning October 1, 2014, the Medicaid payments from the MMIS claims information for dates of services occurring between January 1, 2013 and December 31, 2013.

- iii. For the rate year beginning October 1, 2013, the total Medicaid payments will be annualized for a full year by multiplying the Medicaid charges per the MMIS by 1.33 to account for a change in the charge rates for Children's Hospital during the period.
- m. The annualized Medicaid payments from paragraph l will be multiplied by the adjustment factor and utilization increase in paragraph j.
- n. The estimated Medicaid cost in paragraph k less the estimated Medicaid payment in paragraph m will be the upper payment limit gap for Children's Hospital.

- (8) The difference between Medicare cost of Medicaid services determined in Step (5) and the Medicaid payments in Step (6) plus the amount determined in paragraph (7)(n) will be the Upper Payment Limit Gap for each hospital type.
- (9) Privately owned acute care hospitals, that meet the criteria in (a) and (b) below, shall be paid an enhanced payment not to exceed an amount as may be set annually by Medicaid based on amounts paid in prior years and consistent with paragraph (10) and subject to any applicable limits related to the individual hospital's billed charges under provisions of Medicare reimbursement regulations:
- a. The hospital must be located in a county with a population greater than 200,000 (according to the latest U.S. census), and
 - b. the hospital must participate in the county's largest city's outpatient/emergency room assistance program.
- (10) Each hospital, excluding private free-standing psychiatric hospitals, may receive outpatient access payments. Additionally, qualified hospitals under paragraph (9) shall receive enhancement payments. The total amount of outpatient access payments and enhancements payments shall not exceed the aggregate hospital type Upper Payment Limit Gap set forth in paragraph (8).
- a. State owned and operated hospitals' outpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then set University of South Alabama Women and Children's at 115% of UPL. All remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.
 - b. Non state government owned or operated hospitals' outpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then allocating remaining access based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.
 - c. Privately owned and operated hospitals' outpatient access payments will be distributed first by removing any negative Upper Payment Limit Gap then reallocate Access necessary to cover the enhancement payments per paragraph 9. The remaining access will be allocated based on the hospitals Upper Payment Limit Gap in relation to the total Upper Payment Limit Gap.
- (11) Access payments are paid quarterly.

16. Psychiatric Facilities for Individuals Under 21 Years of Age

Effective Dates: 10/01/88 through 09/13/89

Payment for inpatient services provided by psychiatric facilities for individuals under 21 years of age shall be the lesser of the hospital's current Medicare per diem rate, or the prevailing charges in the locality for comparable services under comparable circumstances, or the Alabama Medicaid flat rate, which shall be composed of the average of the per diem rates paid to in-state hospitals for inpatient services. This flat rate shall be subject to change.

Effective Dates: 9-14-89 and continuously thereafter

Payment for inpatient services provided by psychiatric facilities for individuals under 21 years of age shall be at the inpatient hospital rate as computed under the methodology found at Attachment 4.19 A of this Plan.

17. Clinic Services Provided by Prenatal Clinic Providers

Effective Date: 07/01/88

Reimbursement for prenatal clinic services will be at a per visit rate established by Medicaid. Reimbursement shall not exceed the following upper limits: (a) for governmental entities providing these services, the lower of the upper limits under 42 CFR 447.325 or the actual costs of the provider; (b) for Free Standing Clinics other than governmental entities, the upper limits of 42 CFR 447.325 shall apply.

18. Heart, Liver, Bone Marrow and EPSDT Referred Transplants

Effective Date: 03/01/96

Providers will be paid at the lesser of charges or a global payment up to a maximum of \$145,000 for liver transplants and \$135,000 for heart transplants. This global payment includes pre-transplant evaluation, organ procurement, hospital room, board, and all ancillary costs both in and out of the hospital setting, inpatient postoperative care, and all professional fees.

Providers shall be paid at the lesser of charges or a global payment up to a maximum of \$90,000 for bone marrow transplants. This global payment includes the pre-transplant evaluation, organ procurement, hospital room, board, and all ancillary costs both in and out of the hospital setting, inpatient postoperative care, and all professional fees.

These payment maximums in no case shall exceed amounts customarily paid for comparable services under comparable circumstances. These services are not counted toward a recipient's routine benefit limits.

No payments made pursuant to the methods and standards described in this Attachment 4.19-B will exceed upper limits established in 42 CFR §447, Subpart F.

TN No. AL-96-07
Supersedes
TN No. AL-91-36

Approval Date 3/13/96 Effective Date 03/01/96

Providers will be paid at the lesser of charges or a global payment for EPSDT referred non-experimental organ transplants. Global payment includes pre-transplant evaluation; organ procurement; all transplant services including hospital room, board and ancillaries, inpatient post-operative care and professional fees. Global payment maximums are \$150,000.00 for a heart/lung transplant, \$100,000.00 for a kidney/pancreas transplant and \$135,000.00 for a lung transplant.

Any other medically necessary EPSDT referred non-experimental organ transplants will be paid at the lesser of charges or a global payment determined by the Agency. Payment amounts are determined by review of charges made by transplant centers performing the transplant to determine an amount that is reasonable and adequate to secure the required transplant service.

Effective Date: 02/01/01

As an alternate payment methodology to the above, Medicaid may use an approved prime contractor. Medicaid's approved prime contractor will be responsible for the coordination of and reimbursement for all Medicaid reimbursable organ transplants with the exception of cornea transplants. Payments to providers for heart, lung, heart/lung, kidney, pancreas, kidney/pancreas, liver, small bowel, liver/small bowel and bone marrow transplants shall be made based on the lesser of the charge for the service or the fixed global fee specified by Medicaid based on reasonable cost. This global payment includes pre-transplant evaluation, organ procurement, hospital room, board, and all ancillary costs both in and out of the hospital setting, inpatient postoperative care, and all professional fees. These payment maximums in no case shall exceed amounts customarily paid for comparable services under comparable circumstances. These services are not counted toward a recipient's routine benefit limits.

19. Payment of Title XVIII Part A and Part B Deductible/
Coinsurance

Effective Date: 11/10/97

Reimbursement for Part A nursing home claims shall be based on the coinsurance amount due minus prorated recipient liabilities not to exceed the Medicaid per diem rate. Recipient liabilities will not be applied to QMB eligibles.

No payments made pursuant to the methods and standards described in this Attachment 4.19-B will exceed upper limits established in 42 CFR §447, Subpart F.

TN No. AL-01-01
Supersedes
TN No. AL-98-13

Approval Date 02/05/01

Effective Date: 02/01/01

Effective Date: May 14, 2010

Reimbursement for Part B outpatient claims shall be based on the lesser of the coinsurance and/or deductible amount or the Medicare allowed amount times the outpatient percentage rate minus the Medicare paid amount. Reimbursement for Part B medical crossover claims and Part B nursing home claims shall be limited to the payment of the Medicare Part B deductible and coinsurance to the extent of the lesser of the level of reimbursement under Medicare rules and allowances or total reimbursement allowed by Medicaid less Medicare payment.

20. Federally Qualified Health Center

Effective Date: 07/01/03

The Medicaid Prospective Payment System (PPS) for Federally Qualified Health Centers (FQHCs) was enacted into law under Section 702 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000. Until the final methodology approved by CMS is implemented, the Alabama Medicaid Agency will reimburse in the interim based on the provisions contained in our State Plan as of December 31, 2000.

For the period January 1, 2001, through September 30, 2001, Alabama Medicaid Agency will pay FQHCs 100% of the average of their reasonable costs of providing Medicaid covered services by calculating a per visit rate, computed from the FQHC cost reports, for FY1999 and FY2000 separately, then add those rates together and divide by two. This rate will be adjusted to take into account any increase (or decrease) in the scope of services furnished during FY 2001 by the Federally Qualified Health Center. When the new system is approved by CMS, in place, and tested, all claims paid under the old payment methodology during calendar year 2001 will be reversed and will be paid under PPS.

Effective June 1, 2003, the 95% percentile cost ceiling was removed to allow all FQHCs to receive 100% of the average of their reasonable cost for providing Medicaid covered services. The Alabama Medicaid Agency fiscal year is from October 1st through September 30th. Beginning in FY 2002, and for each fiscal year thereafter, each FQHC is entitled to the payment amount (on a per visit basis) to which the FQHC was entitled to in the previous year, increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services, and adjusted to take into account any increase (or decrease) in the scope of services furnished by the FQHC during that fiscal year.

A new FQHC provider or a provider who has a Medicaid approved change in the scope of services, can request reimbursement based on their facilities submitted operating budget. After the actual cost report is received and desk reviewed for the budget period, an actual encounter rate will be determined. In this event, the FQHC may be subject to a retroactive adjustment based on the difference between budgeted and actual allowable costs. This difference may be subject to settlement within thirty (30) days after written notification by Medicaid to the provider of the amount of the difference. After the initial year, payment shall be set using the MEI methods used for other FQHCs. A FQHC that has a change of ownership can retain the previous owner's encounter rate if desired.

Effective Date: 04/01/98

Reimbursement for out-of-state FQHCs will be the lesser of their encounter rate established by the Medicaid Department of the out-of-state FQHC, or the average encounter rate established by Alabama Medicaid for in-state facilities.

No payments made pursuant to the methods and standards described in this Attachment 4.19-B will exceed upper limits established in 42 CFR §447, Subpart F.

TN No. AL-03-04
Supersedes
TN No. AL-01-02

Approval Date 12/24/03

Effective Date 07/01/03

21. Rehabilitative Services

The Medicaid reimbursement for each service provided by a rehabilitative services provider shall be based on the following criteria as found in 42 CFR 447.325 and 447.304 and shall not exceed the lower of:

- (1) the customary charges of the provider but not more than the prevailing charges in the locality for comparable services under comparable circumstances;
or
- (2) the amount billed; or
- (3) the fee schedule established by Medicaid as the maximum allowable amount.

Actual reimbursement will be based on the rate in effect on the date of service. Only those services that qualify for reimbursement will be provided under this program.

22. Hospice Care Services

Effective Date: 10/01/90

- a. With the exception of payment for direct patient care services by physicians, payment is made to the hospice for all covered services related to the treatment of the recipient's terminal illness for each day during which the recipient is Medicaid eligible and under the care of the hospice regardless of the amount of services furnished on any given day.
- b. Payment for hospice care shall be in the methodology and amounts calculated by the Health Care Financing Administration (HCFA). Each rate is a prospectively determined amount which HCFA estimates equals the costs incurred by hospice generally in efficiently providing that type of hospice care to Medicaid beneficiaries. The rates are adjusted by Medicaid to reflect local differences in wages.
- c. With the exception of payment for physician services, Medicaid reimbursement for hospice care will be made at one of the four rates for each day in which a Medicaid recipient is under the care of hospice. The payment amounts are determined within each of the following categories:
 - (1) Routine home care. The hospice shall receive reimbursement for routine home care for each day the recipient is at home, under the care of the hospice, and not receiving continuous home care. This rate is paid without regard to the volume or intensity of routine home care services provided on any given day.
 - (2) Continuous home care. The hospice shall receive reimbursement for continuous home care when, in order to maintain the terminally ill recipient at home, nursing care is necessary on a continuous basis during periods of crises. Continuous home care is intended only for periods of crises where predominately skilled nursing care is needed on a continuous basis to achieve palliation or management of the recipient's acute medical symptoms; and only as necessary to maintain the recipient at home. A minimum of eight (8) hours per day must be provided. For every hour or part of an hour of continuous care furnished, the hourly rate will be reimbursed to the hospice up to 24 hours a day.
 - (3) Inpatient respite care. The hospice shall receive reimbursement for inpatient respite care for each day on which the recipient is receiving respite care. Patients admitted for this type of care are not in need of general inpatient care. Inpatient respite

TN No. AL-91-36
Supersedes
TN No. AL-90-29

Approval Date 10/2/92

Effective Date 01/01/92

care may be provided only on an intermittent, non-routine, and occasional basis and may not be reimbursed for more than five consecutive days, including date of admission, but not date of discharge.

- (4) General inpatient care. The hospice shall be reimbursed for general inpatient care for each day in which the recipient is in an approved inpatient facility for pain control or acute or chronic symptom management. Payment for inpatient care (general or respite) is subject to a limitation that total inpatient care days for Medicaid patients does not exceed twenty percent of the total days for which these patients had elected hospice care. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating the inpatient care limitation.
- d. Reimbursement for drugs not related to the recipient's terminal illness may be made to the dispensing pharmacy through the Medicaid Pharmacy Program.
- e. Medicaid will not restrict hospice services based on a patient's place of residence. If a beneficiary residing in a nursing home elects the Medicaid Hospice benefit, the Medicaid Program will pay the hospice directly a room and board rate in lieu of payments directly to the nursing home. The payment rate will be 95% of the rate Medicaid would have paid the nursing home directly for the same patient.

Effective Date: 10/01/91

23. Prenatal Parenting Education (Extended Services to Pregnant Women)

Governmental providers will be paid on a negotiated rate basis which will not exceed actual costs which result from efficient and economic operation of the provider. Reimbursement of non-governmental providers will be based on reasonable charges which will not exceed the prevailing charges in the locality for comparable services provided under comparable circumstances. These services are limited to 12 visits per recipient during each two-year period beginning with the first date of service.

No payments made pursuant to the methods and standards described in this Attachment 4.19-B will exceed upper limits established in 42 CFR §447, Subpart F.

Effective Date: 10/01/91

24. Postnatal Parenting Education (Preventive Health Services)

Governmental providers will be paid on a negotiated rate basis which will not exceed actual costs which result from efficient and economic operation of the provider. Reimbursement of non-governmental providers will be based on reasonable charges which will not exceed the prevailing charges in the locality for com-parable services provided under comparable circumstances. These services are covered for Medicaid eligible pregnant women, post-natal women, and the eligible caretaker relatives of eligible children. Only one payment per family unit on the same date of service is permitted. These services are limited to 16 visits per recipient during each two- year period beginning with the first date of service.

Effective Date: 10/01/91

25. Adolescent Pregnancy Prevention Education (EPSDT)

Governmental providers will be paid on a negotiated rate basis which will not exceed actual costs which result from efficient and economic operation of the provider. Reimbursement of non-governmental providers will be based on reasonable charges which will not exceed the prevailing charges in the locality for comparable services provided under comparable circumstances. Services are limited to non-pregnant recipients of child-bearing age who are eligible for treatment under the Early and Periodic Screening Diagnosis and Treatment (EPSDT) Program, regardless of sex or previous pregnancy. There is no limit on the number of visits.

Effective Date: 01/01/92

26. Clinic Services Provided by Children Specialty Clinic Providers

Clinics will be reimbursed at a cost rate per visit (encounter). Governmental providers of such services will be paid at an interim rate which will approximate cost. This rate will be adjusted to actual cost for each service/agency. Nongovernmental providers will be paid their usual and customary charge not to exceed the maximum allowable rate established by Medicaid.

Effective Date: 01/01/2014

27. Tobacco Cessation Counseling Services for Pregnant Women

A statewide maximum payment for tobacco cessation counseling services will be calculated based on 75% of the 2008 Medicare fee schedule rate. These services are covered for Medicaid eligible pregnant women beginning in the prenatal through the postpartum period (the 60 day period following termination of pregnancy) and are limited to four (4) visits per recipient during a 12 month period.

Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates effective January 1, 2014. Current rates are published and maintained on the agency's website at http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.6_Fee_Schedules.aspx. Payment rates are the same for both governmental and non-governmental providers and reimbursed at a per visit rate.

Effective Date: 10/01/13

27. Non-Emergency Medical Transportation

Non-emergency medical transportation provided by the Alabama Department of Mental Health for Medicaid clients receiving allowable mental health services will be reimbursed a rate of \$17 per trip. This rate applies to government and non-governmental providers.

Listing of Outpatient Supplemental Payments

Outpatient access payments per Attachment 4.19-B Page 8.3.b paragraph (10) distributed to individual hospitals include consideration of the following factors; Hospital Cost, OBRA limits, hospital charges, overall UPL GAP by hospital category, and other special circumstances. The payments for each hospital are noted below for rate year 2014.

Outpatient enhanced payments per Attachment 4.19-B Page 8.3.b paragraph (11) are included in this Exhibit as necessary. The payments for each hospital are noted below for rate year 2014.

Outpatient Supplemental Payments for the State Fiscal Year Ended September 30, 2014

State Owned and Operated Hospitals

Facility	Total Outpatient Supplemental Payments
UNIVERSITY OF ALABAMA	13,401,731
USA CHILDRENS & WOMENS HOSPITAL	4,669,740
USA MEDICAL CTR HOSP	3,754,678
Total State Owned and Operated Hospitals	21,826,149

Non-State Government Owned and Operated Hospitals

Facility	Total Outpatient Supplemental Payments
ATHENS LIMESTONE HOSP	1,247,272
GULF HEALTH HOSPITALS DBA THOMAS HOSPITAL	1,027,656
BAPTIST MEDICAL CENTER EAST	1,515,118
BAPTIST MEDICAL CTR SOUTH	4,751,697
BIBB MEDICAL CENTER HOSPITAL	327,183
BRYAN W WHITFIELD MEMORIAL H	892,861
CALLAHAN EYE FOUNDATION HOSPITAL	840,522
CLAY COUNTY	292,276
COOSA VALLEY MEDICAL CENTER	1,412,439
CULLMAN REG MEDICAL CENTER	2,134,081
D.W. MCMILLAN MEMORIAL HOSPITAL	815,388
DALE MEDICAL CENTER	767,409
DCH REGIONAL MEDICAL CENTER	5,849,624

Facility	Total Outpatient Supplemental Payments
DECATUR GENERAL HOSPITAL	2,125,878
EAST AL MEDICAL CENTER	4,740,996
ECACH INC/ATMORE COMMUNITY H	301,119
FAYETTE MEDICAL CENTER	145,650
GREENE COUNTY HOSPITAL	498,468
GROVE HILL MEMORIAL HOSPITAL	645,944
HALE COUNTY HOSPITAL	425,116
HELEN KELLER HOSPITAL	2,271,647
HIGHLANDS MEDICAL CENTER	1,573,592
HILL HOSPITAL OF SUMTER COUN	84,743
HUNTSVILLE HOSPITAL	7,676,812
JACKSONVILLE MEDICAL CENTER	1,142,556
JPAUL JONES HOSPITAL	297,485
LAWRENCE MEDICAL CENTER	570,800
MARSHALL MEDICAL CENTER SOUT	2,341,274
MEDICAL CENTER BARBOUR	730,094
MEDICAL WEST	1,072,707
MONROE COUNTY HOSPITAL	953,790
NORTH BALDWIN INFIRMARY	1,001,229
NORTHEAST AL REGIONAL MED CT	2,193,934
PARKWAY MEDICAL CENTER	1,099,513
PICKENS COUNTY MEDICAL CTR	537,035
PRATTVILLE BAPTIST HOSPITAL	689,574
RED BAY HOSPITAL	159,495
SOUTHEAST ALABAMA MED CTR	4,187,133
TROY REGIONAL MEDICAL CENTER	1,523,165
WASHINGTON COUNTY HOSPITAL	149,018
WEDOWEE HOSPITAL	50,686
WIREGRASS MEDICAL CENTER	937,594
Total Non-State Owned and Operated Hospitals	62,000,573

Privately Owned and Operated Hospital

Facility	Total Outpatient Supplemental Payments
ANDALUSIA REGIONAL HOSPITAL	558,048
BULLOCK COUNTY HOSPITAL	79,839
CHOCTAW COMMUNITY HOSPITAL	2,142,850
CITIZENS BAPTIST MEDICAL CTR	1,216,813
COMMUNITY HOSPITAL	180,709
EVERGREEN MEDICAL CENTER	288,356
FLORALA MEMORIAL HOSPITAL	43,416
FLOWERS HOSPITAL	1,173,082
GEORGIANA HOSPITAL	166,743
HEALTHSOUTHLAKESHORE HOSPITAL	0
JACK HUGHSTON MEMORIAL HOSPITAL	808,795
JACKSON HOSPITAL & CLINIC	18,698,258*
LAKE MARTIN COMMUNITY HOSPITAL	167,329
LV STABLER MEMORIAL HOSPITAL	571,819
MOBILE INFIRMARY	2,819,975
NORTHWEST MEDICAL CENTER	458,936
RIVERVIEW REGIONAL MED CTR	569,172
RUSSELL HOSPITAL	1,121,544
SHOALS HOSPITAL	1,247,032
SPRINGHILL MEM HOSP	0
ST VINCENTS EAST	0
THE CHILDRENS HOSPITAL OF ALABAMA	79,748,662
TRINITY MEDICAL CENTER	771,812
WALKER BAPTIST MEDICAL CENTE	1,724,229
Total Privately Owned and Operated Hospitals	114,557,419

*This includes enhancement payments as outlined in Attachment 4.19-B Page 8.3.b paragraph (11)

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

Eligible Designated Provider: PMP; Network; Other governmental and private providers of case management and care coordination

Description

PMPs are provided a monthly payment of \$8.50 if the following requirements are met:

- The person is identified as meeting health home eligibility criteria on the State's MMIS and in the Care Management Information System;
- The person is enrolled as a health home member at the PMP; and
- At a minimum each individual has received care management monitoring for treatment gaps or another health home service was provided that was documented in the Care Management Information System. The state will provide the PCNA on a monthly basis reports by individual that indicate potential gaps in service delivery. The PCNA on a monthly basis must review each individual's data and where there is a gap in service delivery, take appropriate action or request the PMP to take appropriate action or meet with the patient to assure the providers and/or patients are addressing the identified issue(s).

PMPs receive the standard Medicaid FFS payment for other State Plan non-health home direct services. For their health home activities under this SPA, they will receive an overlaying per-member-per-month (PMPM) payment of \$8.50.

Network: The PMPM health home network payment will be \$9.50 for each patient who meets the chronic conditions eligibility. The state will provide the PCNA on a monthly basis reports by individual that indicate potential gaps in service delivery. The PCNA on a monthly basis must review each individual's data and where there is a gap in service delivery, take appropriate action or request the PMP to take appropriate action or meet with the patient to assure the providers and/or patients are addressing the identified issue(s)

Other governmental and private providers of case management and care coordination: Except as otherwise noted in the plan, payment for these services is based on state-developed fee schedule rates, which are the same for both governmental and private providers of case management and care coordination. The agency's rates were set as of January 20, 2012 and are effective for services provided on or after that date. The fee schedule is subject to annual/periodic adjustment. All rates, including current and prior rates, are published and maintained on the agency's website. Specifically, the fee schedule and any annual/periodic adjustments to the fee schedule are published at www.medicaid.alabama.gov

Strategy to not duplicate services/payments:

Eligible Designated Providers are The "Eligible Team of Health Care Professionals": Primary Medicaid Providers (PMPs), including physicians, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) who have direct responsibility to provide comprehensive care management services in coordination with a other members of the team of health care professionals; Patient Care Networks of Alabama (PCNAs); the Alabama Department of Public Health (ADPH); and the Alabama Department of Mental Health (ADMH) contracted Community Mental Health Centers (CMHCs) and SA providers who are authorized to provide care management (care coordination under the SPA). PCNAs include a medical director, pharmacy director, nurse or social worker care coordinator, BSN chronic care champion and someone with expertise/knowledge in MH/SA who work with the Primary Medical Providers (PMPs) to support eligible chronic care enrollees. All mandatory Health Home PCNA team members' time will be covered by the PMPM rate described in the Payment Methodology section. ADPH and ADMH will be reimbursed for health homes services when one of them serves as a care management provider. The current reimbursement for FQHC's and RHC's under the prospective payment system includes compensation for management of those populations who meet the definition of a chronic health condition. The AMA assures that the population meeting the health home definition will not receive Targeted Case Management and Health Home Services simultaneously. Attachment HH_SPA_Diagram3.TrangleModel illustrates how the "PMP relates to the other members of the "Eligible Team of Health Care Professionals" and how the other "Eligible Team of Health Care Professionals" relate to each other.

PMPs receive a payment of \$.50 PMPM to participate in the 1915(b) waiver, which is for care management services. Since the Patient 1st case management fee for Health Home eligible recipients pays for Health Home care management services, the PMP will receive an additional \$8.00 in Health Home care management PMPM to avoid duplication of payment.

Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

N/A

Description

N/A

Tiered?

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ALABAMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid Agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, , and designated with the letters "MR".
3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item(s) 1 and 2 of this attachment, for those groups and payments listed below and designated with the letters "NR".
4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

Provider-Based Rural Health Clinics MR
Rural Health Clinics NR
Federally Qualified Health Centers NR

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ALABAMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

QMBs:	Part A	<u>MR</u>	Deductibles	<u>SP</u>	Coinsurance
	Part B	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance

Other	Part A	<u>MR</u>	Deductibles	<u>SP</u>	Coinsurance
Medicaid	Part B	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance
Recipients					

Dual	Part A	<u>MR</u>	Deductibles	<u>SP</u>	Coinsurance
Eligible					
(QMB Plus)	Part B	<u>SP</u>	Deductibles	<u>SP</u>	Coinsurance

This same information is outlined on approved Page A, of Attch. 4.19-B in the Alabama State Plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ALABAMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

1. Medicare Part B Deductible/Coinsurance will be reimbursed up to the Rural Health Clinic's (RHC) encounter rate established by the Medicaid Agency.
2. Medicare Part B Deductible/Coinsurance will be reimbursed up to the Federally Qualified Health Center's encounter rate established by the Medicaid Agency.
3. Medicare Part B Deductible/Coinsurance will be reimbursed up to the Provider-Based Rural Health Clinic's (PBRHC) encounter rate established by the Medicaid Agency.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

STATE ALABAMA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES-
OTHER TYPES OF CARE

Item Payment to Title XVIII Part A and Part B Deductible/
Coinsurance

Except for a nominal recipient co-payment, if applicable, the Medicaid agency uses the following method:

	Medicare-Medicaid Individual	Medicare-Medicaid/QMB Individual	Medicare-QMB Individual
Part A Deductible	<u> </u> limited to State plan rates*	<u> </u> limited to State plan rates*	<u> </u> limited to State plan rates*
	<u> X </u> full amount	<u> X </u> full amount	<u> X </u> full amount
Part A Coinsurance	<u> X </u> limited to State plan rates*	<u> X </u> limited to State plan rates*	<u> X </u> limited to State plan rates*
	<u> </u> full amount	<u> </u> full amount	<u> </u> full amount
Part B Deductible	<u> X </u> limited to State plan rates*	<u> X </u> limited to State plan rates*	<u> X </u> limited to State plan rates*
	<u> </u> full amount	<u> </u> full amount	<u> </u> full amount
Part B Coinsurance	<u> X </u> limited to State plan rates*	<u> X </u> limited to State plan rates*	<u> X </u> limited to State plan rates*
	<u> </u> full amount	<u> </u> full amount	<u> </u> full amount

*For those title XVIII services not otherwise covered by the title XIX State plan, the Medicaid agency has established reimbursement methodologies that are described in Attachment 4.19-B, Item(s) 19.

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